

**EQUITY AND HEALTH SECTOR REFORM IN
LATIN AMERICA AND THE CARRIBBEAN
FROM 1995 TO 2005:
Approaches and Limitations**



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ABSTRACT

The purpose of this report is to document the experiences and lessons learned in health sector reforms (HSR) initiated during the years of 1995 to 2005 and their effects on equity in the access and delivery of services. As a result, this report involved searching and compiling studies published in international journals, both in English and Spanish, as well as looking at grey literature. The evidence gathered reveals that for most countries, the implementation of HSR has not delivered the effects expected. In Colombia, even though there have been some achievements in reducing inequities in access and resource allocation, the health expenditures have also increased greatly (above 10% of GDP), which makes the extension of the benefits to the other half of the poor population who encounter themselves outside the system, unsustainable and unrealistic.

In other countries, the characteristics of the health care systems that have created inequities in access to and distribution of resources, such as favouring urban areas and wealthier populations, have persisted, even after the implementation of HSR (e.g. Brazil). In these contexts, HSR could have been an opportunity to correct the imbalance of the health systems. Instead, observations show that reform has contributed to inequity in access to healthcare.

For other countries, decentralization has been implemented simultaneously with a reduction in public spending on healthcare (e.g., Nicaragua and Guatemala). This has hindered the possibility of reducing inequity in the allocation of resources. There is also evidence that user fees in autonomous hospitals have negatively affected access to and use of health care by the poorer segments of the population (e.g. Honduras and Peru).

Due to the scarcity of positive results for the Latin American and Caribbean regions, the last ten years of HSR can be considered a lost decade in the search for equity in health care systems. The latter is the result of the implementation of policies that had no adequate theoretical base and did not consider furthering equity in health or health services. Fortunately, a new stage is being perceived in which lessons from previous years and new types of sustainable reform are being taken into account, primarily in primary care. These renewed efforts bring hope for better achievements in the future.

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INTRODUCTION

This report resulted from a need to systematically review the health policies that affect equity in health in the Latin American and Caribbean region (LAC). Consequently, this study will focus on 'Health Sector Reform' (HSR) policies that were implemented during the 90s and that are still ongoing in some countries. HSR has resulted in the implementation of different policies that affect specific areas of the health care system (i.e. financing, human resources, service organization), which, in turn, may have a positive or negative, direct or indirect, impact on equity in health.

Several efforts have been made before to document the reform process. The Pan-American Health Organization (PAHO) has produced country profiles that include descriptions of the processes of defining and implementing HSR¹. Another article analyzes the production of knowledge in relation to equity in the Americas region for the period of 1971-2000². This current report attempts to complement the above efforts by systematically examining the evidence available, in the published literature and in some grey literature, regarding the effects of these recent policies on either reducing or exacerbating inequities in the LAC over a specific period (1995-2005).

The key questions that this report attempts to answer are:

- Which equity-related policies have been implemented in the region and what is their relationship to equity in health, if any?
- What have been the effects (both expected and unexpected) that these policies have had on equity in health?
- What lessons have been learned in the implementation of these reforms and in equity?

Methodology

The following inclusion & exclusion criteria were applied to the literature search:

Inclusion:

- Studies evaluating specific changes in equity: changes in the equity situation, reduction or increase in inequities associated with political reforms in the health sector, supported by original or secondary data.
- Studies evaluating policies in HSR with (direct or indirect) effects in equity in health
- Studies published during the period of 1995-2005.

Exclusion:

- Personal opinions that are not supported by facts (from primary or secondary data).

¹ Country profiles are available at: <http://www.lachsr.org>

² Almeida-Filho N, Kawachi I, Filho AP, Dachs JN. Research on health inequalities in Latin America and the Caribbean: bibliometric analysis (1971-2000) and descriptive content analysis (1971-1995). *Am J Public Health*. 2003 Dec;93(12):2037-43.

The literature search included the following databases:

DATABASES	Search Terms Used
PUBMED (www.pubmed.com)	'Health sector reform AND evaluation' 'Health sector reform AND equity' 'Health sector reform AND Latin America' 'Decentralization AND equity'
PARTNERSHIP FOR HEALTH SECTOR REFORM (http://www.phrplus.org)	'Health sector reform' 'Equity; inequity'
Database journal Health policy (http://www.sciencedirect.com/science/journal/01688510)	'Health sector reform' 'Equity'; inequity'
Database Health Policy and Planning	'Health sector reform' 'equity'; inequity'
Health Economics (www.interscience.wiley.com)	'Health sector reform' 'equity'; inequity'
SciELO (www.scielosp.org)	'Health sector reform' 'equity'; inequity'
POPLINE	'Health sector reform' 'equity'; inequity'

In addition, some grey literature, which was accessed during the search process was reviewed. This literature was identified via searches on the web pages of institutions related to the health care systems in the LAC region.

Limitations of this Report

It is important to note that there are only a small number of evaluative studies on HSR and equity. This situation has also been identified by other authors (Blas & Hearst 2002).

The review of grey literature (consulting reports or studies not published in international journals) was directed to those sources known to the author. It is therefore possible that additional information may exist in other sources.

CONCEPTS AND DEFINITIONS

Health Care Systems and Reforms

The health care system is the framework into which actions of reform are inserted. All reforms seek to change one or more elements or aspects of the ‘health sector’ or ‘health care system’. An adequate understanding of what constitutes HSR³ requires initially, a comprehension of the elements or components that comprise a health care system.

What is a Health Care System?

The World Health Organization (WHO) defines a health care system as that which “*includes all the activities whose principal purpose is to promote, restore or maintain health*” (WHO 2000). WHO also states that health care systems should be analysed and compared in their performance with relation to four functions: management, resource creation, service delivery, and financing.

Roberts et al (2004) makes more explicit the different elements or components included in a health care system:

- All individuals who offer public or private health care services, using western medicine or traditional medicine, with or without a license (doctors, nurses, hospitals/clinics, pharmacies, health promoters and traditional healers).
- The mechanisms that allow the flow of money for financing the system, be they official or not, through intermediaries or user fees.
- The activities of those who lend specialized resources to the health care system, such as schools of medicine and nursing and the producers of medicine, resources and medical teams.
- The professionals, whose task is to plan, regulate and act as financial intermediaries and whose purpose is to control, finance and influence the providers of health care services. These professionals work for the ministries of health, finance and planning, both public and private insurance institutions, and regulatory institutions.
- The activities of organizations that provide preventive health care services such as immunization, family planning, control of infectious diseases and health education. These organizations may be public, private, local, national, or international.

Health Sector Reforms

Health sector reform is a ‘*significant and intentional effort to improve the performance of the health care system*’ (Roberts et al 2004). The authors use the term depending on what they propose defines a health care system which includes immediate performance results (efficiency, quality, and access) and performance goals (health status of population, citizens’ satisfaction, protection against financial risk). The authors add that reforms carried out by countries may be

³ Various authors use the terms ‘health sector’ and ‘health care system’ as interchangeable terms. These terms will be used similarly in this report.

differentiated by two dimensions: a) the number of aspects or components that are 'changed' in a health care system and b) how radical the 'changes' are in comparison to the previous practices. The authors suggest that reforms introduce changes that incorporate different interventions in the areas of financing, payment, organization, regulation, and the influence on the behaviours of patients and service providers.

On the theme of equity, the current study uses the following definitions:

Equity in Health:

The absence of systematic and potentially remediable differences in one or more aspects of health across population groups defined socially, economically, demographically, or geographically (ISEQH 2005).

Inequity in Health:

Systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically (ISEQH 2005).

Equity in health and health care

There is a difference between equity in the health of a population and equity in the delivery of health care services. The World Health Organization (WHO 1996) has defined equity in health as a notion where the entire population should enjoy the highest level of physical, psychological and social well-being that are permitted by biological limitations. On the other hand, equity in the delivery of health care services implies that the resources and services of the health sector are distributed and delivered in accordance to the needs of the population, and that they are financed in accordance with the population's capacity to pay.

More concisely, it can be said that when one speaks of equity in health, we refer to the levels of mortality and morbidity experienced by different social groups. Equity in the delivery of health care services refers to the levels of access, utilization and financing of health care services experienced by different population groups.

Vertical and Horizontal Equity

Horizontal equity is the equal treatment of equals while vertical equity suggests an unequal treatment of unequals. For example, if applied to the analysis of equity in financing, horizontal equity requires that all individuals with equal resources pay equally, whereas vertical equity requires that consideration be given to the capacity to pay, i.e. individuals with more resources contribute more to finance the system. In other words, vertical equity is related to subsidies and progressiveness in the financing of the health care system (Vargas et al 2002).

Conceptual framework to analyze health sector reform and equity

In order to analyze the effects of policy reforms on equity, one must first identify the different categories of equity goals, the barriers affecting them and interventions that can be implemented to address those barriers. In this report, we have identified 6 categories of equity goals, their relative barriers and potential interventions to address them. (see Table 1 below).

Table 1. Categories of equity goals and interventions

Equity goals	Barriers	Interventions
Category 1: Equity in access to health care services	<ul style="list-style-type: none"> Physical (distance, topography). Organizational (limited schedules at health facilities). Cultural (providers not acquainted with local culture and language). 	<ul style="list-style-type: none"> Delivery of services through mobile teams (public providers or private under contract). Extending opening hours of health care facilities. Service delivery by providers who speak local languages
Category 2: Equity in the utilization of health care services	Financial: <ul style="list-style-type: none"> User-fees in public facilities High cost of services in private clinics 	<ul style="list-style-type: none"> Exemption mechanisms for poor/vulnerable users at public facilities. Expansion of medical insurance.
Category 3: Equity in resource allocation	Tendency by which the central government favors urban centres and rich/influential territories with a higher allocation of public resources	<ul style="list-style-type: none"> Implementing progressive formulae to allocate resources Financial decentralization to local health authorities. Return of infrastructure and financial resources to local governments.
Category 4: Equity in the delivery of quality services	Tendency to deliver services of lower quality to poor/disenfranchised population groups	<ul style="list-style-type: none"> Accreditation and certification of public and private service providers
Category 5: Equity in the delivery of effective services	Tendency by which new and effective interventions and/or services are delivered preferentially to population groups with more resources (due to cost and availability)	<ul style="list-style-type: none"> Delivering interventions based on primary health care. Delivering comprehensive services (beyond packages of basic services/prevention).
Category 6: Equity in health	Utilization of effective services in the reduction of inequities in health Other social determinants of health (education, employment, income, etc)	<ul style="list-style-type: none"> Implementation of interventions based on the model of primary health care Implementation of comprehensive and multi-sectorial interventions (health, education, employment, etc)

From the six categories, five include barriers and interventions that can be addressed directly by health systems. The latter implies that health systems play a very important role in pursuing equity that goes from concrete strategies to improve access (category 1) to promoting and delivering services that are effective in reducing health equity gaps among population groups (category 5)⁴.

⁴ Recent evidence is showing that health care systems based on primary health care achieve greater health equity among population groups. (Starfield 2006; Starfield et al 2005).

Category 6: Equity in health, is the most complex one to address since it is affected by social determinants that surpass the health system. In addition, the health status of population groups are affected by context or community characteristics (social, environmental, economic, behavioural, health system) in conjunction with the individual characteristic of each person conforming to that community (Starfield 2002).

Once the different categories of equity goals have been identified, the next step is to identify and classify the different policy reforms implemented in the region during the period 1995-2005 and its relation with the equity goals' categories (see Table 2 below).

The first element to highlight from Table 2, is the fact that policy reforms have only addressed three categories of equity goals (out of a possible six). In addition, the goal of equity in access of health services is characterized by the implementation of 'basic packages of services', which means equity in access to basic services and not to the entire range of health services available through the health care system.

It is important to clarify that other countries in the region, apart from those named in this report, are also implementing one or several of the policy reforms identified in Table 2. However, they are not included in this report since published literature was not located on the evaluation of the effects or impact of such policies.

One must also accept that there is not a definite division or classification for the different policies that have been implemented. Some readers may think about different categories and organization from the ones outlined in Table 2.

The next sections of this report will address each one of the policy reforms identified in Table 2. Each policy includes a brief description of relevant characteristics, including equity intentions and their assumptions. After that, there is an analysis of documented evidence around each policy and its impact upon different types of equity.

Table 2. Policy reforms related to equity implemented by countries in the region during the period 1995-2005

Equity Goal	Reform policies (1995-2005)	Objective in relation to equity	Countries implementing such policies (as presented in this report)
Equity in access to health care services	Implementing mobile teams of possible private providers (under contract) or public providers to deliver basic packages of services	Improve access to basic packages of services by reducing physical barriers of population groups living further away from a network of health care facilities	Guatemala (private providers under contract) Costa Rica (public providers)
	Defining and implementing basic packages of services of universal access.	Regulate universal access to a basic package of services within a medical insurance model	Colombia México
Equity in the utilization of health care services	Expanding medical insurance	Reduce financial barriers to service utilization by expanding private and public models of medical insurance	Colombia & Chile (managed competition model) Brasil* (public insurance model)
	Granting autonomy to public health facilities	Expand user-fees in public hospitals. Revenue collected will subsidized services delivered to poor/vulnerable users.	Peru Honduras
Equity in resource allocation	Decentralizing financing	Improve resource allocation by transferring authority for resource allocation to local level authorities within the ministries of health	Guatemala Nicaragua
	Returning infrastructure and resources to local governments	Improve resource allocation, access and utilization by transferring infrastructure, financial and human resources to local governments	Colombia Chile Brasil*

* It is important to clarify that Brasil has recently been implementing interventions through the unified Health system, aimed at Categories 4 (equity in the delivery of quality services) and 5 (Equity in delivery of effective services) of equity goals. However there is no evaluation yet of these efforts.

CHARACTERIZATION OF HEALTH SECTOR REFORM POLICIES IN THE LATIN AMERICAN AND CARRIBEAN REGION (LAC) DURING THE PERIOD OF 1995-2005 AND THEIR EFFECT ON EQUITY

In this section the following policies will be analysed: expansion of medical insurance, contracting of private providers, decentralization, and the delivery of essential or basic services. At the end, the experience of the Cuban health system is presented as a separate case, since it differs from the process implemented by the rest of the countries in the region.

Expansion of medical insurance

Reforms to the health sector through expanding medical insurance have (mostly) been implemented primarily in middle income countries such as Brazil, Chile, Argentina, and Colombia⁵. These reforms are intended to improve equity of access to and the efficiency of the health system using medical insurance⁶ coverage as the vehicle. The specific aspects of these reforms that touch on efficiency are not dealt with in this report. In the case of equity, the reforms aim to extend the coverage of medical insurance to the entire population and reduce the negative impact of out-of-pocket expenditures associated with health care utilization by poor population groups.

It is possible to identify two models that have been used to extend medical insurance coverage. Both models are based on the mandatory insurance for people who are formally employed and public subsidies for people unable to pay, or those without formal employment. In the first model, the delivery of services is carried out by private and quasi-private entities (for example in Colombia, Chile and Argentina). The second model (e.g. Brazil) involves public universal insurance, financed through taxation with a mix of public and private entities involved in the delivery of services. The first model, which expands private insurance, has been associated with other economic policies such as privatising pension funds (Madrid et al 1998).

In the first model, the role of the State in promoting the expansion of private insurance has been through dismantling the monopolization of social security (i.e. tax-funded) programs. As a result, people have the option of selecting the medical insurance provider that they prefer (private or public). If they opt to remove themselves from the public system of social security, the individuals take their premium with them and are able to 'choose' from the private insurance options that are available. The objective is to generate competition between the various insurance companies (including the social security institute) in the affiliation of individuals. The State no longer takes on the role of exclusive service provider, but rather the role of 'steward' or 'regulator' of competition and of the system in general. This is known as 'managed competition'⁷.

In the second model, as implemented in Brazil, people can, if they desire, affiliate themselves with a private insurer but they cannot take their insurance premium with them.

Impact of expanded insurance on equity of access

The two cases most studied are those of Colombia and Chile. In the case of Colombia, it has been reported that during the period of 1993-1997, the percentage of the population with private

⁵ There are also countries from the English Caribbean region that have defined reforms targeting medical insurance. However those policies are in their initial stages of implementation with no evaluation results as yet. (Análisis de las reformas del sector salud en la subregión del Caribe de habla inglesa. LACHSR (2002)

⁶ Services delivered during illness. We do not refer to pensions and other contributions that are associated with social insurance in some countries.

⁷ It has been assumed that managed competition promotes the efficiency of the system and improves the quality of services and the satisfaction of the client. A body of evidence exists that refutes these assumptions (see Iriart et al 2001; Plaza et al 2001; Homedes & Ugalde 2005).

insurance more than doubled (from 23.7% to 57.2%). Although the increase was in all income quintiles, the major increase occurred in the lowest income quintile, which rose from 3.1% to 43.7% (Jaramillo 2002).

There is also evidence of a reduction in the inequity of affiliation with private insurance, as measured through the concentration index ⁸. However, even though the proportion of the “insured” population increased, this same study did not find evidence that affiliation resulted in increased utilization of and access to services. (Céspedes-Londoño et al 2002)

There is inconclusive evidence of a reduction of inequities in out-of-pocket expenditures. One study in Colombia analyzed out-of-pocket expenditures⁹ using data from three national surveys (1985, 1993, 1997) and found an inverse relationship when comparing expenditures to household income (the higher the income, the lower out-of-pocket expenditures) and a positive relationship when comparing expenditures to household expenses (the higher the expenses, the higher out-of-the-pocket expenditures) (Castano et al 2002).

The achievement in Colombia of extending medical insurance coverage to poor population groups has been mainly the result of cross-subsidies (through contributions from insurance payers and the State). However, several authors have expressed concerns. The first concern relates to a massive increase in health expenditure during the same period. In Colombia in 1990, health expenditure was estimated at 4% of GDP, and in 1998 it rose to 10.5% (Yépez & Sanchez 2000). It has been estimated that this huge increase is not only due to the cross-subsidy but also to the transaction costs associated with the private administration of the system and the inefficiencies that still exist. (Homedes & Ugalde 2005)

A second concern is the fact that socioeconomic population groups have contributed differentially to health expenditure. Data for the capital, Bogota, revealed that during the period of 1993-1997, the highest income quintile decreased its contribution to health care spending by 40% while in the poorest quintile increased its contribution by 45% (Homedes & Ugalde 2005).

A third concern is the fact that despite a major increase in health expenditure, more than 40% of the poorest segment of the population is not yet covered by medical insurance. This segment of the population suffers the greatest levels of inequity (Flórez & Tono 2002).

The final concern in Colombia relates to the differentiated package of benefits received by the population. Those affiliated with the subsidised system receive a package of services that is equivalent to only one fifth of the package of services received by regular insurance payers. It is argued that this situation converts the right to health (as recognized in the Colombian political constitution) into a situation with two types of citizens: those who contribute to the insurance system and receive greater benefits and those whose lack of formal employment and poverty results in very limited benefits (Hernandez 2002)¹⁰.

In Chile, the reforms have created two segmented subsystems of medical insurance: public and private. The public system covers low income people with high health risks while the private system covers people with the highest income and low health risk (Sapelli 2004). Additionally, the public system serves individuals who, although they have private insurance, do not utilize their services because they cannot afford the co-payments imposed by insurance companies. (Estrada et al 1998).

⁸ Index of concentration 1993 (0,34) and 1997 (0,17).

⁹ using the Kakwani index.

¹⁰ Additional issues will be addressed under basic packages of services.

In Brazil, the unified health care system (UHCS), which is based on public universal coverage, still has not been able to reach the poorest segments of the population in the poorest regions (north and northwest). The services available in these regions continue to be inadequate to meet the needs, compared to the rest of the regions in the country (Collins et al 2000). It is believed that the unsatisfactory results of the universal coverage system are mainly due to a lack of adequate funding and an unequal distribution of the available funding (Almeida et al 2000)¹¹. Moreover, the quality of services delivered through the UHCS does not satisfy the expectations of high and medium income groups who prefer private coverage. This includes workers in the formal sector who were previous users of the social security system (Collins et al 2000).

Contracting Out to Private Providers

Contracting out to private providers for the delivery of health care services has been defined as a strategy to improve the efficiency and quality of health care services (Abraham 2001). Contracts are mechanisms whereby the buyer is the public sector or an organization from the social security system and the provider is an autonomous or private organization (either for profit or non-profit). Contracts with private health care service providers can include services that range from medical services to non-clinical services, for example, cleaning services for a hospital (England 2002).

Two types of scenarios can be identified for contracting out. In one, a public network of services exists but certain medical services (for example, laboratory services, ambulatory care) are contracted with private providers. In various Central American countries, the social security subsystem has implemented this type of sub-contracting¹².

In the second scenario, providers are contracted to deliver services in geographical areas where the public health facilities network is limited or non-existent. This second scenario, aside from attempting to improve efficiency, has been regarded as a policy for improving equity in access to basic health care services. This report concentrates on the second scenario, using the documented experience of Guatemala and Costa Rica¹³.

In both Guatemala and Costa Rica, contracting out is based on per capita payments to deliver a certain health care package (MSPAS 2002; Rosero-Bixby 2004). These packages differ substantially in the level of services they offer. For example, the Costa Rican package has greater coverage and is provided by a team of medical professionals. In Guatemala, the package is basic and it is provided by one doctor who is supported by a network of volunteers at the community level. The objective of this report is not to evaluate and compare the effectiveness of both packages, but rather focuses on identifying the effects that contracting out services has had on the internal workings of the health care systems of Costa Rica and Guatemala.

Impact of Contracting Out on Equity in Access

The situation of contracting out in various geographic areas of the country where the public network of services is inadequate appears to have potential in improving equity in access. This is relevant if we take into account the proportion of the population of Latin America who lack access to the public network of health care services and who also lack access to social security programs at large. (López-Acuña et al 2000; OPS-ASDI 2003).

¹¹ Issues around equity in resource allocation will be addressed under decentralization.

¹² Verbal information provided by health authorities from Guatemala and El Salvador.

¹³ Providers in Costa Rica are not private but public. Apart from this, it resembles key characteristics associated with contracting-out.

In Costa Rica, it has been possible to reduce the inequality gap in geographic access to health care services at the primary care level (Rosero-Bixby 2004)¹⁴, as a result of delivering services through basic integrated health care teams (BIHCT) and focusing on the population with least accessibility.

In Guatemala, household surveys have documented an increase in coverage of basic health care services (i.e. immunization and prenatal care) in rural areas of the country (Gragnotati & Marini 2003).

The case of Guatemala has received most attention in the literature, since contracting out to private providers has been implemented on a grand scale. (Hecht et al 2004) In the last five years, contracts have been established with over ninety-two private providers (mostly NGOs) that offer a basic package of services to approximately 25% of the country's population (MSPAS 2002).

However, this large-scale contracting out has been associated with managerial problems, particularly in regards to the monitoring and supervision of contracts and service providers (DFID 2000). Case studies have identified a lack of accountability and fulfilment of contractual duties by both the ministry of health and contracted providers. Late payments to service providers are frequent and service providers, in turn, deliver an incomplete health care package or do not serve the entire population as agreed upon in the contract. Furthermore, different levels of quality in service delivery among providers have also been identified (INS 2003).

The implication of the situation previously described is that, although there is evidence of some reduction of inequity in access to basic health care services, those services are not being delivered with the same quality to all population groups.

Decentralization

Decentralization is understood as the transference of authority to define policies, make decisions, implement managerial functions, and make use of resources. This transference of authority occurs within a determined government (Collins 1994). Decentralization is the most used policy within HSR packages in the region (BID 1996).

Different processes and models exist within decentralization such as de-concentration, delegation, devolution, federalism and autonomy in service delivery units (MSH 2001; Ugalde & Homedes 2002). The main difference among these different models and processes is the level of responsibility, authority and autonomy that is transferred from the central level to the peripheral level. It is important to note that decentralization, as a policy, is not exclusive to one sector (health or education), but it corresponds to policies dealing with State reorganization. Consequently, it is possible to find decentralization policies in more than one sector or agency in the government of a given country.

Improving equity in resource allocation is a central claim and justification to implement decentralization (among other outcomes). Nevertheless, it has been identified that decentralization, when implemented inadequately, does not improve equity; rather it exacerbates inequity (Collins & Green 1994).

The following section will discuss three forms of decentralization that have been implemented in the LAC region a) de-concentration, b) devolution, and c) autonomy in health care facilities.

¹⁴ It should be noted that geographic access is defined in this study as the physical distance from a first level provider (within 4 kilometres). This type of 'access' does not ensure the utilization of existing services.

De-concentration

This involves transferring some authority and responsibility to peripheral levels that are part of the ministry and/or agencies of the central government (Rondinelli et al 1984). In the health sector, de-concentration implies that some managerial functions, such as budget development and resource allocation, are transferred from the central level to peripheral levels within the same ministry, yet, the control remains in the central level (FPM 1995).

The main activity that has been “de-concentrated” in LAC has been budget development and the use of public financial resources. De-concentration has been justified in that it improves the capacity to respond to the needs of the population at the local level and this includes improving equity in the allocation of resources to the geographical units (municipalities, districts) within the jurisdiction of the de-concentrated authority.

Impact of De-concentration on Equity in Resource Allocation

Guatemala is one of the countries where de-concentration has been implemented from the central level to health provinces which in turn are responsible for allocating resources to health districts. If de-concentration is to reduce inequities, then one would expect to find that the ‘de-concentrated’ authority (i.e. Provincial Health Authority) would allocate resources to jurisdictions or health districts based on needs. However, this has not been the case in Guatemala. Provincial authorities continue applying allocation criteria based on historical budgets, despite the fact that they now possess the authority of decision-making to re-distribute the budget. The needs of health districts are not part of the criteria that determine resource allocation (Daniels & Flores 2004, Flores 2004).

It is important to note that public spending on health in Guatemala fell by 10% during the de-concentration process of 1997-2003 (Bitrán & López 2003). A similar situation was reported in Nicaragua, which also implemented a process of de-concentration from the central level of the ministry to the local health care system (SILAIS). During the period of 1992-1996, public spending on health care in Nicaragua fell by more than 12% (Birn et al 2001). The decrease of public spending on health care is not a direct result of de-concentration but, rather, a result of government and state reforms (such as structural adjustment reform). The relevance of this for the analysis on equity resides in the fact that transference of responsibilities to sub-national levels has occurred during periods where public spending on health care has decreased.

Devolution

Devolution is defined as the transference of power to sub-national units of the government whose activities are outside the direct control of the central government (Rondinelli et al 1984). In the case of the health sector, devolution implies that the responsibility, authority and accountability are transferred to a regional, provincial, departmental or municipal level of government (FPM 1995).

It is assumed that if jurisdiction has been ‘devolved’, health care services will invest additional resources (in addition to the funding received from the central government) from their treasury to increase the quality of services provided, and to expand into territories or poor areas with the highest needs. This can be positive for equity since potential benefits can be attributed to devolution. Generally, these benefits are limited by the economic capacity of a province or municipality that has been given political and administrative authority. If one takes into account the great economic inequality that is experienced in countries of the LAC region, devolution can be counterproductive for those territorial units of low socio-economic levels, if they do not receive sufficient funding from the central government. In a devolution scenario, the inequalities throughout a country can be exacerbated (Collins et al 2000).

Impact of Devolution on Equity in Resource Allocation

The available evidence comes from studies carried out in Colombia, Chile, and Brazil. In the case of Colombia, devolution was accompanied by an allocation of resources that gave priority to poorer municipalities. As a result, the inequity gap in resource allocation between municipalities from highest and lowest income reduced during the period of 1994-1997¹⁵ (Bossert et al 2003).

It is believed that the improvement observed in Colombia was possibly due to two factors, a) implementation of allocation formulae rather than historical budgets and b) a significant increase in public spending in the health sector, which rose by 175% during the period of 1984-1997 (Castaño et al 2001). As a result, even the richest municipalities saw a 50% increase in transfers received from the central government (Bossert et al 2003).

In the case of Chile, even when allocation from the central level followed progressive formulae, there was no decrease in the inequity gap as witnessed in the case of Colombia. This is due to the fact that rich municipalities use a far greater quantity of their own resources to finance health care (Arteaga & Darras 2003).

In the case of Brazil, the per capita allocation to the states and from there to the municipalities was according to a formula based on population size. Such allocation has not taken into account the historical inequity that has accumulated amongst the various regions of the country. For example, the transfer of payments for hospital services does not take into account the geographic disparities in health, the epidemiological profile, or the socio-economic conditions of the territorial units.

Transfers from the central level to the states for ambulatory service expenses (provided by public agencies, private and philanthropic) follow a similar pattern. A ceiling is imposed on transfer of funds, which is based on historical budgets. This does not reduce inequalities in financial distribution; rather it consolidates them and perpetuates inequity between regions (Almeida et al 2000).

In Brazil in 1998, the states of greatest wealth received a per capita allocation that was more than twice the allocation received by states with the greatest poverty, despite having fewer needs than those states in poverty (Collins et al 2000).

Granting autonomy to health care facilities

Under this policy, autonomy is transferred to health facilities (hospital or health care centre) in the public sector for the management of interventions and resources needed for the delivery of health care services. Granting autonomy includes authorizing the introduction of user fees (Ugalde & Homedes 2002). Autonomy also allows hospitals to generate income from the sale of services to insurers or private doctors. In Managua, Nicaragua, hospitals can generate almost 50% of their resources from the sale of services (Jack 2003).

Generating resources through user fees and the sale of services to third parties may have an effect (positive or negative) on equity in access to health care. Resources generated by hospitals through the sale of services can have a positive effect if mechanisms are put in place to subsidize the delivery of services to poor populations groups who receive treatment. On the other hand, user

¹⁵ The inequity gap in resource allocation, although reduced during that period (1984-1997) still exists and recent studies identify that is widening yet again due to a fiscal and economic crisis in the Colombian government, among other factors (Rodríguez-Monguió & Infante 2004).

fees can negatively affect equity if these fees become a barrier to poor populations in accessing health care services at these respective health care facilities.

Impact of Granting Autonomy on equity in access and utilization of services

Documented evidence refers to the implementation of user fees in public health care facilities in Peru and Honduras. In Lima, Peru, user fees in hospitals had different effects on utilization of service for different socio-economic strata. During the period 1988-1997, hospital use by the higher income groups increased from 35% to 53%, while use by the lowest income groups in the population decreased from 25% to 20%. Even use of hospital services by middle income strata persons decreased from 39% to 27% (Arroyo 1999).

In Honduras, user fees were introduced throughout the whole network of health care facilities with a highly regressive structure of payments for services. For example, the cost of an ambulatory consultation is higher in a health post than in a hospital. The exemption of payment, which is meant to be a measure of protection for the poor population, is ineffective in providing that protection. Almost 90% of the population attending out-patient services in a health post pay, while less than half of those who go to a hospital pay. Most users who pay for services at health facilities belong to the poorest strata (Fiedler & Suazo 2002).

The data from Honduras demonstrates that user fees, in addition to being counterproductive for equity, are also inefficient. The resources generated from user fees do not surpass 2% of the Ministry of Health's budget. More than two thirds of the funds collected are used for the administration of the user fee system (Fiedler & Suazo 2002).

Basic Packages of Services

Efforts to prioritise needs and to focus resources have been in existence for many decades in developing countries. In fact, the debate surrounding the PHC-Selective¹⁶ is one of the first proposals of prioritisation, proposing that developing countries invest their resources in a limited number of services or interventions. Child survival programs are an example in which resources are concentrated in interventions that are considered as cost-effective.

This indicates that focusing resources and services is a policy or strategy that has been implemented by the health sector of developing countries for several decades. Nevertheless, the focus on reform programs of developing countries received renewed emphasis after the 1993 World Bank Report in which new tools were introduced to link an estimation of the health burden (morbidity and mortality) of countries with the cost-effectiveness of available interventions to address them. Most countries have, since then, included policies directed in concentrating resources and services through a package of basic or essential services (BPS).

It is important to note that the methods used to estimate the essential packages (such as DALY's) do not enjoy a universal acceptance among academics and researchers, many of whom question the technical robustness of the measuring methods and the ethical principles that support them¹⁷. The objective of this report is not to analyse these methodologies and tools, but to focus on analysing whether the delivery of BPS improves or exacerbates inequity.

If universal access exists for a determined package, then it can be said that equity in access to certain benefits (as contained in the BPS) has been improved. Nevertheless, it has been argued

¹⁶ The PHC-selective urges countering the strategy of PHC-integrated or comprehensive where it is suggested that more widespread services and benefits be delivered to the population. The main argument of PHC-selective is that PHC-integrated is too costly for developing nations, which should therefore focus on a limited number of interventions. See: Warren (1998) and Newell (1988).

¹⁷ See: Williams 2000; Murray & Lopez 2000; Williams 1998; Sen & Koivusalo 1998; Ugalde & Jackson 1995

that delivering BPS with an equity objective is moving backwards in the efforts to deliver health care services for the poor since it reduces the benefits. From a vision of delivering integrated services,¹⁸ the focus is now shifted to a package of 'minimal' services. Universal access is therefore reduced to this 'minimal package' (Laurell 2001) rather than an integral package.

Impact of basic packages on equity in access

Documentation available looks at the different service packages is available in Colombia and Mexico. In Colombia, the population that contributes to the universal social security system receives a package estimated in value at \$100 US, while the population that is subsidized (based on poverty or lack of formal employment) receives a package estimated in value at \$20 US. Even when some authors (Céspedes et al 2002) have identified the delivery of BPS to the poor who previously had no coverage as a positive equity result, other authors identify it as the 'legalization of inequity' in the Colombian health care system (Hernández 2002).

In Mexico, it has been argued that the poor population loses benefits as a result of implementing BPS. The package of services provided free of charge is smaller than those traditionally offered by the Ministry of Health (without BPS). In addition, the cost per capita of delivering service to populations with no insurance through BPS was in 1997 half of the cost in 1982. Therefore, universal access to the BPS is both less costly and with fewer benefits for the poor (Laurell 2001).

The Cuban experience and health sector reform: an example of a broader approach to equity

This review of the Cuban experience is not exhaustive.¹⁹ Rather, the objective is to point out the key aspects specific to the Cuban experience that can be compared with the rest of the region and to point out the difference between the comprehensive reforms implemented in Cuba with those of limited scope that were implemented in other countries in the last decade.

The literature search conducted for this study did not produce any published study on health sector reform in Cuba. This could be explained by two factors; the most important reforms in the Cuban system occurred in the 1970s and 1980s, whereas reforms in the rest of the countries occurred in the 1990s and, additionally, these reforms were carried out without support from the international financial organizations (World Bank and Inter-American Development Bank). These aspects imply a different timing and dynamic for health sector reforms in Cuba from the reforms implemented by other countries in the region.

The achievements that the Cuban health system has made in relation to access and delivery of services and the impact that that has had in improving the health status of the population are undeniable. These achievements have also been recognized by the World Bank authorities (Lobe 2001). Therefore, it is relevant to point out key developments in the process of health sector reform in that country. The first development to note is the process of decentralization (focussing on de-concentration) that occurred during the 1970s. This process included planning and delivery of services up to the municipal level and expanded and organized the network of services around health units called "policlínicas". (De Vos 2005).

The introduction of family medicine in the 1980s marked another important reform process in the health system which allowed the expansion of primary care in an important way to the population in a relatively short time. By the year 1995, 95% of all population was registered with a family doctor (Figueras et al 1998; MINSAP 1996).

¹⁸ Delivering integrated services was supported by the primary health care strategy that countries were implementing in response to the principles enunciated by Alma Ata (1978). This vision was still present in most countries before the implementation of efficiency-driven health sector reforms.

¹⁹ For a comprehensive review consult: De Vos P (2005) "No one left abandoned": Cuba's national health system since the 1959 revolution. *International Journal of Health Services*, Volume 35, Number 1, Pages 189-207.

The most critical period occurred when the system was negatively affected by the economic collapse of the 1990s. As result of the fall of the Soviet Union and other Eastern European countries, Cuba lost 80% of its foreign trade, experienced a decrease in gross national product (30%) and an increase in the fiscal deficit amounting to 40% of the GNP (De Vos 2005). This economic crisis had effects upon the nutritional status of the population and the rapid loss of resources was associated with a resurgence of infectious diseases. In the second part of the 1990s, the economic situation stabilized and infectious and other communicable diseases were controlled and the country was incrementally improving its health indicators to levels attained prior to the economic crisis.

A comparison of reforms in Cuba and the other countries highlights the fact that Cuba implemented its processes of decentralization and reorganization of services 15 years before some countries (i.e. Brazil, Bolivia) and 29 years before the rest of the countries of the region. The model of family medicine is innovative for developing countries and has been adapted and extended to other countries in the region (Brazil). Perhaps the most relevant fact of the Cuban experience is that throughout the last 30 years, reforms have been focused on strengthening and expanding primary health care. The latter is contrary to the experience of the rest of the countries in the region, which have been immersed in efficiency-based reforms (López-Acuña et al 2000).

The Cuban system currently faces major challenges to improve efficiency and quality in the delivery of services. It is estimated that 25% of patients' first contacts are in emergency hospitals and not with a family doctor as intended. These challenges are being addressed by strengthening primary health care, particularly the role of the family doctor (De Vos et al 2004). These policy interventions are again in contrast to the experience of the other countries in the region where efficiency and equity is being addressed through 'user fees', private insurance and managed competition among other policies.

LESSONS LEARNED

The effort to identify lessons learned, regarding reforms, is affected by the lack of follow-up and evaluation on the implementation of policies. In general, countries do not define the criteria for the evaluation of their own reforms (OPS 2002). Even in countries such as Costa Rica, that have a tradition of quality in the production of information, it was found that the reforms did not foresee the establishment of evaluation and follow-up systems (Rosero 2004). This lack of evaluation of reforms is a major concern if one takes into consideration that reforms are social experiments that have a direct or indirect impact on the health and opportunities of citizens (Daniels 2005).

In spite of this, countries have been involved in the implementation of HSR and will continue to be. For this reason, it is important to propose lessons learned based on the information that is available and that has been discussed in this report.

Limited focus of policy reforms upon equity goals

As it has been discussed in earlier sections, policy reforms addressed mostly equity in access and to a lesser extent equity in utilization and equity in resource allocation. In general, reforms have not transcended to other equity goals such as equity in quality, equity in effectiveness, and much less to promoting integrated and intersectorial efforts aimed at affecting equity in health. Even within equity in access, policy reforms have concentrated mostly on interventions based on efficiency criteria (cost-effective packages) and less on comprehensive approaches aimed at reforming the organization of health care systems towards a pro-equity model. The Cuban system of the 1980s is an example of comprehensive reforms that are pro-equity. Costa Rica and Brazil have also recently implemented some policy reforms based on primary health care principles and criteria²⁰.

Analysis of the Pre-Reform and the Reform periods

Various studies on HSR provide a limited description and evaluation of the situation of health care systems prior to HSR. It is necessary to objectively consider the problems existing in the health care systems of the region prior to the HSR in order to analyse its effect on equity and determine whether the reform efforts were based on theoretical or empirical underpinnings that could be expected to reduce inequity in health. It is suggested that evaluative studies of HSR address more deeply the pre-reform era of the country.

Extending coverage of medical insurance

In Brazil, public coverage is available to all but mostly used by socio-economically disadvantaged populations. In Chile, due to adverse selection, the public system covers the sickest and poorest, while the private sector cares for the upper classes that have fewer health problems. In Colombia, the achievements in extending coverage seem limited if one takes into consideration that almost half of the population requiring medical insurance is still not covered by the system. The case of Colombia, which is the most publicized due to its achievement in extending coverage to the poor population, seems not to be a feasible model if one considers that those achievements are associated with an increase in public spending on health care (above 11% of GDP) that most likely no other country in the region can sustain.

²⁰ As mentioned earlier, Brazil has recently initiated the implementation of reforms that are more comprehensive and integrated. Results of those policies have yet to be evaluated.

Contracting Out to Private Providers

The delivery of services by private providers financed from public resources (without user fees) is a mechanism that can improve the coverage of basic services to populations with little access to the public network of services. This type of intervention should be accompanied by close supervision in order to ensure quality of care in delivering services. If not, then a risk exists of extending services of inferior quality to the poor, which may exacerbate existing gaps in access to services between rich and poor populations.

User fees in health care facilities

The experiences of Honduras and Peru demonstrate undeniably that granting autonomy to hospitals has not had good results in terms of equity in access and utilization of services. User-fees create barriers to access and furthermore, are inefficient in generating revenues for hospitals (2% of the budget in Honduras). Therefore, the only way to justify charging user fees is to charge those who have public or private insurance (or the capacity to pay) for services provided to help offset the costs created by the private and public sectors.

Decentralization

Colombia is the only case where decentralization has been accompanied by a reduction in the gap of inequity of resources allocation between rich and poor municipalities in a given period (1994-1997). This change was made possible as a result of increased public spending in health care. In the other countries (Nicaragua and Guatemala), decentralization has been accompanied by a decline in public spending on health care, which makes it difficult to reduce gaps in the areas of highest needs.

Another lesson learned is that the opportunity offered by decentralization to improve equity in resources allocation becomes irrelevant if the 'decentralized' authorities continue to use historical budgets to allocate funds within their territories (Guatemala). The lack of allocation of resources based on differences in needs in different areas can also exacerbate inequity in geographical regions (Brazil).

Basic or Essential Service Packages

Delivering integrated health care to all citizens was the goal prior to the appearance of HSR reform (based on PHC concepts and constitutional rights) but is now, with HSR, been reduced to a 'basic package'. These packages are not even universally accessible by the entire population (e.g. Colombia, Mexico) which therefore in practice, creates further segmentation in the benefits received by the population. In relation to access in health care, three categories of citizens have been identified: a) those with the capacity to pay for comprehensive and integrated services, b) those in situations of poverty with access to an 'essential package' of services, and c) those in situations of poverty without access to any type of service.

The Lost Decade in the Search for Equity in Health

Can we speak of a lost decade in the search for equity in health? Probably. However, one cannot ask that the health care systems of the region return to what they were before the implementation of HSR. Of all the countries considered in this report, only Costa Rica has a history of a pro-equity health care system prior to the reform. For the rest of the countries, HSR was inserted into health systems that were historically inequitable.

Next Steps

There is talk of the need for a third generation of reform (Lopez-Acuña et al 2000; PAHO 2005) and of new reforms in equity in health (Gwatkin 2002). The latter can still be very beneficial when these 'new reforms' use democratic and inclusive procedures in their definition and monitoring. Until now, the absence of a broad framework for conceptualizing and implementing reforms is one of the greatest weaknesses in the majority of countries (OPS 2002). Currently, experiences and tools exist for decentralized regions and civil society to actively participate in the monitoring of the implementation process of health policies related to improving access to effective health care services (Daniels & Flores et al 2005).

It is necessary to look beyond policies strictly related to the health sector and expand efforts to the improvement of equity. The current effort by PAHO in analysing and intervening on 'social protection in health' appears highly relevant since it involves those conditions beyond the health care system that create inequity and exclusion (Levcovitz & Acuña 2003).

Finally, it seems essential to recover and renovate primary health care as the framework for reform, not only because of its demonstrated contribution to equity, but also for its potential to obtain better results than those obtained in the past from the financing and management reforms characterizing HSR. Some reform efforts dating before the period of 1995-2005, like those that occurred in Cuba and Brazil in the 1980s, were based on the philosophy and principles of primary health care as expressed in the Alma Ata declaration. These reforms proved more enduring and relevant than the more recent financing and management reforms, in addressing the need for greater equity not only in access to services but also in health indicators of the population. Evidence exists, at least for industrialized nations, that those health systems that are based on primary care achieve better results in the health of the population at a lesser cost than those systems based on medical specialization (Shi et al 2004; Politzer et al 2003; Macinko et al 2003; Starfield et al 2005 *Milbank Quarterly*).

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