Initiative for sexual and reproductive rights in health sector reforms: Latin America¹

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Sexual and Reproductive Health and Financial Reforms

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Sexual and Reproductive Health and Financial Reforms

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Introduction

The purpose of this paper is to analyze the existing literature on the effect of sexual and reproductive health reforms, so as to identify the non-approached subjects. In spite of the importance of this proposal, studies with empirical evidence about the impact of financial reforms on sexual and reproductive health are limited. Also, and given the diverse characteristics of the reforms applied in Latin America, the documented results are highly contrasting. In some cases, as in those related to the partial payment of services in order to recover hospitalization costs, they are not conclusive, and indicate that the effect of reform on the use of sexual and reproductive health services depends on the context in which these services are applied. The use of basic services packages as a way to organize the social security financing structures or subsidies to unprotected groups has proved to be a usually useful tool to identify and carry out specific health interventions. Yet, the need for a research agenda to look further into the impact of each intervention, in order to establish a taxonomy that correlates the different kinds of financial reforms and their impact on each one of the sexual and reproductive health alternative interventions is evident.

Section two presents a brief summary of the financial reforms applied in the Latin American health systems, characterized by highly segmented and fragmented structures. Section three identifies the potential impact and the incentives generated by the financial reforms on the provision of sexual and reproductive health services. Section four discusses the experiences documented in the reviewed literature.

Financial Reforms in the Latin American context

The main objective of health systems reforms has been the enlargement financing options (social and private insurance, reorientation of public funds, co-payment systems), so as to mobilize resources, control the unnecessary demand and promote risk diversification. The development of incentive mechanisms to improve the quality and efficiency of services, even by the participation of the private sector, is included within these options.

In a context of structural adjustment of every time scarcer resources, the capacity of governments and the possibility to provide free services to large low income population groups is every time more limited. The analysis of household surveys that include health modules shows that

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health system financing mechanisms are very diverse, and are closely related to the wealth and poverty levels of the population and the income distribution among the social groups.

The Latin American health systems may be classified in four groups on the basis of their organizational characteristics and their financing sources (Maceira, 1996). These groups present a highly segmented service provision and financing structure, where the public sector hopes to cover the demands of poor patients who also have a relatively more deteriorated epidemiological profile than the average, and therefore this sector has financial resources deriving from general taxes.

Health public services are provided by a network of hospital providers, health centers and regional institutions. Parallel to this, there are the so called social security institutes which have the purpose of providing health coverage and other social benefits to formal workers and their families. Their financing sources are those funds resulting from withholds made to employees and from employers’ contributions. The services offered are circumscribed to these population groups and, except for exceptional cases, there are no coordination mechanisms between the public sector and the social security system.

Finally, the private sector is highly developed in the Latin American region, especially in relation to health ambulatory services. Paradoxically, in those nations with lower relative income, the proportion of their total health expense is mostly concentrated in pocket expenses. This shows the little regulatory and financing capacity of the public sector to reduce information and payment asymmetries pertaining to those markets that provide health services.

This Latin American prevailing model, segmented in service financing and provision, is different from that of a second group present in the British Caribbean area and in Cuba, where the service financing and provision system concentrates on a national health insurance supported by tax contribution from the whole population. Costa Rica is a similar case, where the social security system and the public sector are strongly coordinated, dividing their tasks and sharing provision structures.

Brazil is an exception to the Latin American model. In the 80’s this country organized a universal health system called Unique Health System, supported by tax financing and organized on the basis of the transfer of funds per capita from the federal state to the local administrations. The coverage of this service, at least, theoretically speaking, includes the whole of the population, and the provision is in charge of the sub-contracted private and public providers. Despite the improvements in the Brazilian model, 20% of the population is affiliated to private health insurances.

Finally, the Southern Cone Nations – Uruguay, Argentina, Chile – are highly developed as regards private health insurance, co-participated in the financing with coverage social insuring structures relatively large as compared to the regional average. The Colombian case, considered to be a paradigm of health financing reforms, can be added to the previously mentioned ones, for it combines a restructuring of the social security system with administration and decision making decentralization from the national sector to the departments and municipalities.

To discuss the financing reforms in the Latin American region, first it is necessary to make a distinction between a reform and the execution of a program that tries to modify a provision structure, and the use or financing of services. Second, it is important to establish those types of reform related to the Latin American pattern, and the motivations underlying each one of them.

We make a difference between a health sector reform and the execution of a program in that the objective of the former one is to restructure the strategic relationship among the participants from different sectors, i.e. System Financers, System suppliers, and system regulators or consumers. The
final objective of the reform is to find sustainable financing mechanisms for a cost-effective and fair
health care model. Instead, the goal of a health program is to cover basic needs of a specific
population group. A program does not necessarily need a restructuring of the rules of the game and
thus its objective is not to identify sustainable mechanisms to go on applying in the future those
activities originated in the program.

The Latin American health system financing reforms may be classified in six groups. The
goal of the first one is the creation, modification or restructuring of social insurance
mechanisms. One of the most obvious inconveniences in a segmented health system is the creation of dual or multiple
care structures which cause inequities in resource distribution in relation to the users’ needs. The
social security reforms attempt to find mechanisms to enlarge the social insurance sustaining base in
order to produce more sustainability and coverage for a series of defined basic services. The aim is
to avoid the existence of unwanted crossed subsidies among sub-systems, and to articulate
coordination structures in service financing and provision among the participating groups. The
ultimate purpose of a social insurance reform is to identify a risk reduction mechanism in the system,
to make the provision of health services viable in nations with relatively low incomes.

The second reform mechanism, complementary to the previous one, is based on determining
priorities from the definition of a basic package of sanitary interventions. The purpose of these
reform tools is to improve resources allocation in relation to the nation’s epidemiological patterns, in
response to the demand and allowing more control not only of costs, but also of the quality of care.

Based on these principles, most of the reform efforts aim at a greater division between health
services financing and provision roles. The argument behind this statement is known as
"agency theory", and has the purpose of limiting the risks and monetary costs related to the
opportunistic behavior of actors in an asymmetric information context. The division of functions on the
basis of clearly-defined rules allows for a better control and follow-up of health interventions, which
would in turn encourage a more efficient use of resources while covering the needs.

From this statement, four kinds of reform are presented. One is related to the
decentralization process, and its goal is to separate functions between the different government
levels, to improve resources allocation and to assure a better coverage of the population’s needs.
From this point of view, the second kind of reform takes the decentralization process to the service
provider, incorporating the concept of hospital autonomy or self-managed hospitals. This would allow
an increase in efficiency and equity in resource allocation, using cost recovery mechanisms as a tool.
This kind of intervention implicit risk is that intensification of inequities, or the generation of adverse
selection mechanisms on the providers’ side.

Reforms that attempt to redefine the monetary incentives in the provision of services based
on changes in payment mechanisms to health care institutions and health care professionals use the
same separation of functions to promote control argument. These mechanisms represent a deviation
from the traditional fixed salary or budget payment situation, towards structures of payment per capita
related to performance. Finally, and in a similar direction, the last kind of reform has to do with
increased cooperation and participation of the private sector in the provision of services, with the
purpose of expanding the use of socially available resources and of reducing moral risk.

One of the traditional criticisms to financial health reforms has to do, in some cases, with the
use of criteria related to cost recovery. One of the arguments in favor of using co-payment systems in
public institutions or in the private sector participation is that at present most of a large portion of
health expenses comes from the participants’ pockets. This is a result of the relatively deficient
quality of public services and/or the existence of hidden costs associated with the use of those services (transportation costs, waiting time, lack of medicines, etc.). Yet, co-payment policies generate controversies, since the potential improvement of the sector’s financing may hinder the access of people whose health needs are most urgent.

In the following sections we will discuss the impact of this type of reforms on SRH and comment on the experiences reported in the Latin American literature.

**Impact of the reforms on sexual and reproductive health: identification of incentives**

The design of a social security system aims at improving women’s access to health systems and to reduce inequities related to bad income distribution. Many countries in the region have introduced health insurances to diversify the risks of events which though unlikely to occur, imply very high costs for the homes (pregnancy complications, certain aspects of obstetric care, treatment for reproductive tract cancers, etc.). However, the development of private health insurances tends to increase inequities, generating a dual system which "cream skims" the insurance structure and reduces the financing of public insurance. To compensate for this failure, it is necessary to implement regulatory mechanisms to limit public absorption of sanitary and actuarial risk, and to avoid discriminatory mechanisms. This is the case of the ISAPRES in Chile, where women of reproductive age pay a higher premium, since they are expected to make greater use of health care services.

Selective co-payments systems have been proposed as an alternative policy. When carefully designed, they guarantee equity and promote improvements in the quality of care and access to health care. Many developing countries have differential co-payment fees which give a priority to socioeconomic criteria. Colombia is successfully applying the System for the Selection of Beneficiaries of Social Programs (SISBEN) to identify groups with unsatisfied basic needs. However, this system still needs some design adjustments so as to focus the subsidy on populations with greater needs.

The use of basic service packages combined with financial coverage based on social insurance is an exceptional policy tool to establish sexual and reproductive health priorities. It also facilitates resource coordination and limits operational costs. Given its nature, many countries in the region have implemented basic service packages: the Unique Health System in Brazil, the Colombian Social Insurance System, or the Social Security Mandatory Medical Package in Argentina, among others. In Bolivia, for instance, the program focused on maternal-child health (Mother and Child insurance) served as foundation for the generation of a broader scheme, the Basic Health Insurance.

Basic services package incentives basically depend on four aspects: (a) the extent of the package, so as to cover the necessary SRH (and other health services) interventions without reaching a dimension that would compromise its fulfillment, (b) the capacity to absorb differential risk profiles so as to maximize its effectiveness, (c) the scope of the package to include groups with financial difficulties, and (d) the payment mechanisms associated with the package.

It is said that in some countries, provider payment mechanisms foster unnecessary, and even ethically questioned, clinical or surgical interventions. C-sections are a paradigmatic case in the field of SRH, which have reached epidemic dimensions in most of the Latin American and Caribbean countries. To revert this situation, an option would be to design service packages with prospectively
determined costs (for C-sections, from the beginning of pregnancy), in order to guarantee integral care and to establish good quality care as the only stimulus for health care providers.

There are two reasons why the incorporation of performance-based payment mechanisms is one of the most controversial elements in the region’s health care reforms: (a) it stimulates the negotiation process between financiers and service providers with different relative power, and (b) it increases the system’s capacity to follow-up and control the results of the intervention in order to evaluate its effectiveness.

Generally speaking, fixed salaries or budgets not related to performance negatively affect quality of care and discourage preventive interventions. The same results, though with an additional risk of increasing costs, are characteristic of the fees for service payments. Recent reforms promote the incorporation of per capita formulas. These motivate preventive care and promote those services essential for women’s health, trying to maintain the provision of the necessary services. In Brazil, health care workers organized in cooperatives with this payment system have significantly reduced waiting times and hospital stays, and users’ satisfaction has increased. However, the success of its implementation depends on the offer structure in each case: a per capita payment system may produce expected results in a city or region with a high degree of agents’ competition, but it may promote under-provision in isolated areas (Maceira, 1998).

There is a marked deficit of information and of regional studies on the impact the different modalities of provider payment have on the population. There is a need for conceptually comparable information to identify the most affected groups. Gender, age, socioeconomic status and geographical location are important inequity indicators. In the context of impact assessment and identification of affected population groups, it is important to measure:

- Costs, hidden and not hidden: transportation, medicines, transportation time to the consultation or to purchase medications, waiting time, opportunity cost of women’s time, etc.,
- Household members service consumption patterns, and
- Proportion of women’s and men’s income spent on out-of-pocket health expenses.

Private providers’ participation and hospital self-management require strong monitoring to avoid risk selection against the poorest groups in greater need for services. Also, these controls are necessary to establish the limit between efficiency (through mechanisms of cost recovery to reduce the eventual existence of moral risk) and equity (extension of coverage to low income groups).

Measures of cost recovery may specially affect women, with serious consequences on their reproductive health. Medicines, medical consultations, and medical exams which used to be free, may generate, after a self-management reform, a cost which may transcend the economic possibilities of many women, forcing them to delay their searching for help to their health problems. As a result, they face a higher risk of illness and death. In a survey carried out in 70 countries, co-payments are mentioned as the main obstacle to achieve the goals of reproductive health programs (WEDO, 1999). Many women are in a particularly vulnerable position as regards this, since:

1) Most of them are outside the labor market, and if employed they earn lower salaries than men,
2) They are disproportionately represented in part-time jobs and in the economy informal sector, with occupations usually not covered by social security and health insurance,
3) They have a greater need for health care services than men due to their reproductive role and their greater longevity, and
4) Women’s social responsibility in caring for children is not only restricted to looking after the house: frequently it means expending money from their own pockets to cover medical care expenses.

Thus, health care becomes an out-of-pocket expense with possible effects on the family’s budget. This leads to the need to make health goods a priority over other consumer products in the basic family shopping basket, such as food and housing. As a result, households do not invest in prevention and use health services only in emergencies or critical situations, reinforcing a strictly curative view of health.

Financial reform experiences reported in the literature

Colombia: redefinition of the Social Security System

In December 1993, Colombia initiated a deep transformation of its health system with the passing of Law 100. This transformation attempts at establishing a regulated competition model so as to achieve universal and mandatory insurance for all the inhabitants through access to a basic benefit package. This model substantially modifies some of the sector’s critical variables, for it ensures a greater availability of financial resources by changing the payment mechanism (from supply subsidies to demand subsidies) and favoring health promotion and prevention activities.

The reform incorporates the design of basic care packages, making a difference between those services for the contributive plan (contributors above the basic package’s value) and those for the subsidized plan. The initially designed basic package was then enlarged to include health interventions for women’s health care (reproductive health, pregnancy complications, C-sections, etc.). To reduce unnecessary demand and mobilize additional resources, fees and co-payments were introduced depending on the payment capacity of each user.

The proportion of people insured increased since the reform was introduced, from 20% in 1993 to almost 60% in 1998. The subsidies plan covers approximately 8 million Colombians who previously had no access to health services. The proportion of insured households in the two lower income quintiles grew from less than 12% in 1993 to approximately 53% in 1998, a situation which could be seen in the increase of use rates between 1993 and 1997. The introduction of subsidies had a re-distributive effect, increasing from 0.4% to 1.3% of the GDP for those in the first quintile, while decreasing from 0.4% to -0.2% for those in the fifth quintile.

At the same time, these reforms could also potentially threaten the already reached goal on sexual and reproductive health and/or become an obstacle for the adequate response to the population’s needs. Among these risks, the following can be mentioned:

1) The fragmentation of reproductive health programs into specific activities, included in the benefit plans offered by many insurance companies and providers, leads to lower quality of care and

loss of health care opportunities, while reducing the effectiveness and efficiency of the interventions;

2) The subsidies to the demand-financing scheme may generate a process of risk selection as long as the insurer prefers healthier populations, leaving aside those more likely to get ill. This phenomenon has especially important implications on reproductive health, since the most vulnerable groups are in fact those that suffer complications. This requires an adequate risk adjustment in the per capita payment (including variables such as gender, age, geographical area) on the one hand and a close monitoring of the insurers’ performance by regulating agencies on the other.

3) Imposing high fees to certain services may lead to the excessive provision of some procedures or services; on the contrary, very low fees can cause a reduction in the offer of services. Both effects have a negative effect on reproductive health care.

4) High rotation of affiliates among the insuring institutions eliminates the providers’ original motivation to promote prevention practices among their beneficiaries.

The Colombian experience is a source of learning for those interested in connecting reproductive health programs with sectorial reforms. Colombia offers lessons that could be used in other countries with similar characteristics as regards the reaction of the system to different sexual and reproductive health incentive structures.

**Bolivia: the PROSALUD experience and the integrated primary care package**

PROSALUD is a Bolivian non governmental organization that has achieved significant progress in the provision of an integrated primary care package to the poorest population in urban and suburban areas through a network of clinics operating with a high degree of autonomy. The package includes access to free preventive services (prenatal and postnatal care and sexual education) as well as access to a large number of medical services with the payment of fees (obstetric and gynecological care, deliveries, family planning, ambulance and emergency services). PROSALUD also carries out complementary activities such as selling condoms, contraceptives and vitamins at a low cost.

The financing structure of PROSALUD is formed by a network of crossed subsidies among three levels of services: those payments received for the provision of curative services subsidize the free preventive services; the medical centers with surplus funds finance those with losses; and the users who can pay subsidize those who cannot.

In general, the price of all curative services is a bit higher than that of those provided by public health and much lower than that of those charged by private clinics. Though its rates are low, PROSALUD provides 10% of its paid services for free to indigents. The “fees for service” system was designed to compete with the private sector, charging medical consultations, lab exams and drugs separately. This payment method represents 95% of PROSALUD incomes.

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4 This section and the following one were elaborated on the basis of Cuéllar, C.J., 2000, "Resource Mobilization and Health Sector Reform in Bolivia: the PROSALUD Experience", and Langer, A. y Nigenda, G. (comp.) , 2000, "Salud Sexual y Reproductiva y Reforma del Sector Salud en América Latina y el Caribe: Desafíos y Oportunidades"
Also, PROSALUD provides companies with a personnel enrollment system, charging for the services used. According to Cuéllar, the NGO serves 13% of the urban population, with a cost recovery record (70.9%). Also, this author suggests a positive impact in the generation of competitive pressures that improved the quality of the services in the sector causing price reductions.

**Bolivia: National Maternal-Child Insurance and Basic Health Insurance**

The National Maternal-Child Insurance (Seguro Nacional de Maternidad y Niñez) (SNMN) on May 24, 1996 by Decree 24.303 grants women the right to receive prenatal, delivery and postnatal care, as well as health care for their small children in any public health and social insurance facilities. This program also represented a subsidy to the offer of services, with incentives for obstetric care providers.

This program received a percentage of the municipal budget for its financing, so as to pay the recurring costs pertaining to maternity care and to pathologies related to the main causes of infant mortality.

The SNMN was then replaced by the Basic Health Insurance (Seguro Básico de Salud), a general package for extremely poor groups, an estimated 11% of the Bolivian population. The new package includes different activities for maternal and reproductive health, such as prenatal care, delivery care and management of obstetric complications and emergencies, though it excludes the provision of contraceptives.

An evaluation of the program 18 months after its implementation showed the following results:

- A significant increase in the use of maternal-child services
- Focalized groups of poor and adolescents, which prior to the implementation of the program did not use any formal health services, increasingly began to use the services provided by the subsidy;
- Primary care centers increased their availability of medication thanks to improvements in the control of funds; and
- The use of public health services increased, and evidence suggests that they still work below their total available capacity.

However, the study identifies some limitations, such as:

- Staff motivation was negatively affected by an increase in the flow of patients without a financial compensation. Though users report satisfaction, the staff indicates a drop in the quality of care due to the increase in the demand;
- Reimbursements were insufficient to cover the costs, especially in those services which depend on social security;
- Since the implementation of the SNMN, the percentage of maternal-child services provided in secondary and tertiary level institutions increased, while they decreased at the primary level;

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NGOs and social security provided limited collaboration since the SNMN did not cover the costs associated with equipment depreciation, professionals salaries and maintenance expenses;

- Part of the costs, especially those related to payment of medicines and, in some cases, the co-payment for maternity services, has been transferred to consumers.

**Ecuador: co-payments and price elasticity in the demand for sexual and reproductive health services**

In order to analyze the impact of an eventual increase in the price of the services, Ecuador's CEMOPLAF (Medical Center of Orientation and Family Planning) conducted a study in all its centers from August 1996 to June 1997. The purpose of the study was to determine the demand for sexual and reproductive health services in response to the variations in the amount of co-payments, and to compare the results with those obtained in real life.

The results obtained applying the Willingness to Pay (WTP) approach show small differences between the estimated and the observed elasticity, and do not have a significant effect on the predictions made on profits and use of services as consequence of price changes.

In the case of CEMOPLAF, the services studied (obstetric and gynecological check-ups, prenatal care and IUD check-up) were non-elastic to current prices (between 2.39 and 3.19 USD). The study estimates a non-elastic demand up to 5 USD for gynecological and obstetric care, and up to 3.89 for prenatal care and IUD. The study also suggests a significant margin for price increase without a dramatic downfall in use. There is not a clear relationship between higher prices and a drop in the provision of medical services to lower income population groups.

**Chile: participation of the private sector in health insurance**

The ISAPREs (provisional health institutions) are private entities which, on the basis of the principle of a “subsidiary State”, take part in the allocation and financing of health benefits for their contributors and beneficiaries. As private entities, they seek the highest utility margin per risk assumed. Thus, they either reject, or charge higher prices to those users who increase their operative costs with greater health care needs. As regards this, three elements affect the quality of coverage in the private system: age, sex and income level of the contributor. This results in a discriminatory and gender inequity policy.

A study carried out by SERNAM in 2001 in six ISAPRES showed that in the different life stages and up to age 70, women pay over 100% more than men for their health plans, with a 310% maximum in the 30-35 age group. Also, the ISAPRES have the legally granted power of revising the

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6 Based on a document elaborated by CEMOPLAF, 1998, "Price Elasticity of Demand for Reproductive Health Services at an Ecuatorian Private Voluntary Organization".

7 Section elaborated based on Matamala Vivaldi, M.I., 2001, "Género, Salud y Derechos Sexuales y Reproductivos de las Mujeres en el Contexto de la Reforma", and OPS, Subcomité sobre la Mujer, la Salud y el Desarrollo, 1999, "Las necesidades de las mujeres y las prespuestas de la reforma del sector de la salud: Experiencia en Chile"
health contracts once a year. However, the system does not include mechanisms for risk redistribution for the insurer, for a risk balance among affiliates, or for preventing adverse selection practices against vulnerable groups.

**Conclusions**

Despite the importance of the relationship between financial reforms in the health sector and their impact on sexual and reproductive health indicators, the evidence presented in literature as to this connection is scarce and shows varying results. Given the lack of reform evolution monitoring systems, it is difficult to assess financial reforms based on SRH indicators.

Generally speaking, it can be said that financial reforms are successful as long as the priorities defined by the strategy for change fulfill the priority needs of the population. In the case of those financial reforms which include the definition of a service package on the basis of which resources are allocated, their effectiveness has to do with the way in which sexual and reproductive needs are adequately reflected in the definition of the package, and whether its benefits translate or not into effective access.

Also, given the fact that women tend to suffer higher morbidity than men along their lives, and that they use health services more often (OPS, 2002), any financial reform which defines a cost-effective service package or mechanisms to insure the social security risk pool structures, will tend to improve the life standard of the population, reaching at the same time efficient and equitable results.

The lack of contact between SRH defenders and specialists on health reforms can be seen in the diverging analysis regarding the impact of health reforms. From the point of view of those promoting reform, it has been said that the changes in social security health networks increase coverage and usually reduce inequities in the access to health services. On the contrary, there is very little information regarding successful experiences in self-managed hospitals and on the incorporation of alternative payment methods to the health sector, except for those analyzed in this chapter. However, the analysis on how these reform mechanisms and SRH interact at the intersecting point is limited, and the results are related to experiences than can hardly be generalized, since they lack a shared analysis methodology. Therefore, it is necessary to define an agenda that combines the analysis of the impact the reforms had in the region with the results achieved in the field of SRH.

From this perspective, the research agenda must include elements that range from the cost-effectiveness analysis of incorporating different SRH interventions to the evaluation of women’s role in the care of family health and in the definition of health priorities within the home.

For that purpose, it is important to identify a series of indicators to measure the evolution of SRH throughout time and throughout the different reforms, allowing for international comparisons. This material will in turn provide the opportunity to assess the importance and the benefits or damages posed by changes in the financing and insurance structures of the health system in SRH.
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