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

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Priority setting in sexual and reproductive health within the framework of the health sector reform

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Introduction

All governments take part in the regulation and provision of health services (Tsui and Wasserheit, 1997.) Most of them finance a substantial portion of the expenditures on health, setting up priorities and criteria for the allocation of the economic, human, and physical resources available. In developing countries, decision-making is compounded not only because the health needs of their populations are comparatively more urgent, but also due to budget constraints and to the situation of indebtedness affecting their economies.

The design of an agenda of reform priorities requires the development of a set of technical tools that measure cost-effectiveness and the systematization of case studies that evaluate the clinical effectiveness of the interventions. The goal is to set out present or potential demands, alternative forms of intervention and their impact from an epidemiological perspective. However, the execution of a health care policy based on these criteria takes place in the context of an already existing system where the historical evolution of the sector, the power relationships among its stakeholders, and their interaction mechanisms are preconditions that may either boost or reduce the benefits of such policy, thereby delaying the application of “technically appropriate” priorities. Thus, the implementation of priorities in health care involves a mix of technical competence, political bargaining ability, and leadership.

The prioritization process is therefore a structured, participative, and enriching work procedure, which rests on experience and a sound technical base sustained over time. The setting up of health care priorities in a country, built up on relevant epidemiological-situational grounds, makes it possible to determine, on the basis of the main problems detected, the most cost-effective activities to be developed to timely and effectively meet the population’s health needs. Its design should allow for data generation mechanisms to properly monitor and evaluate the process, outcomes, and impact of the selected interventions.

Prioritization of interventions in health care is a complex process that entails the existence of democratic debate spaces that incorporate stakeholders and institutions according to the logic governing the design and implementation of public policies. The creation of such spaces means a clear acknowledgement and legitimization of the social collective by those who take part in decision-making and in the allocation of resources intended to implement such decisions.

This chapter aims at identifying the status of sexual and reproductive health in the priority setting process within the context of the health sector reform. To that end, and following the methodology of consultation and contrast of sources and documentary material, the general goals are:

1. To characterize priorities in health and sexual and reproductive health in the various countries of the region; and to describe decision-making processes focusing on the
decision-making authority and the evidence and/or criteria used, within the political-institutional-health care framework prevailing in each case.

2. To inquire into resource allocation criteria in the health care sector, especially regarding sexual and reproductive health; to study the existing gap between priorities set and resources allocated; and to examine the role played by the basic benefits packages within the framework of sexual and reproductive health policies and sector reform.

Reform Agenda and Sexual and Reproductive Health

Health sector reforms are governed by some principles on the basis of which countries have developed their programmatic proposals according to their political institutional context. These principles may be summarized as follows (IWO-PHO, 1999):

- The reorganization of the Ministries of Health, as planning, budgeting and management tools.

- The decentralization of the sector’s activities, allowing for more local involvement and social control in service planning and provision.

- The introduction of alternative financing mechanisms, including contracts for service provision to private sectors, contracts with non-government organizations, and insurance and social security systems.

In each reform, the prioritization process may result either from a better understanding of the scope of the problem (taking into account its epidemiological incidence, its significance in terms of public health intervention, and its perception by the collective imagery), or from a construction motivated by sectoral interests. The latter scenario, where health care policies in Latin America are inserted, differs greatly from that existing in developed countries or in countries whose more consolidated institutions guarantee a greater democratic culture.

However, there are a number of common key programs within health care management, regardless of the geographical and historical context in which they take place. These programs comprise child health care (including nutrition), family planning (which may include prevention of sexually transmitted diseases), and prevention and treatment of transmissible diseases.

In the specific case of sexual and reproductive health, priority setting involves complex elements, given the fragmentation existing in the areas of sexual and reproductive health policies, programs and projects. Also to be considered are the differential behaviors across countries with respect to sexual and reproductive health programs, democratization processes, and participation in international debates on the subject.

The Program of Action of the International Conference on Population and Development (ICPD) put forward the essential elements of a reproductive health strategy:

- Supplying information aimed at promoting a safe and satisfactory sex life.
- Providing access to family planning methods that are suitable, safe, effective, affordable, acceptable, and respectful of users’ choices.
• Providing access to services that enable women to go safely through pregnancy and childbirth.
• Providing methods for the prevention, diagnosis, and treatment of sexually transmitted infections.
• Advocating the eradication of harmful practices, such as female genital mutilation, violence against women, and sexual trafficking.
• Creating mechanisms geared to raise involvement of the civil society and the general community in the promotion of better reproductive health, with an emphasis in women’s empowerment and the defense of their reproductive rights.

These components—whether implicitly or explicitly defined—differ according to the interests of each organization or participating country. For the United States Cooperation Agency, for example, the prioritized components of reproductive health programs are family planning and other services related to fertility, safe pregnancy, improvement of women’s nutritional condition, promotion of breast-feeding, and prevention and management of sexually transmitted diseases and HIV/AIDS (USAID, 1994.)

As the process of prioritization of sexual and reproductive health policies in the region goes deeper, a wide range of variables emerge related to the above-mentioned components and to the programmatic policies and proposals included in the reform by the national and local governments. Within this framework of definitions, this study intends to confront the rhetorical characterization of the priority setting process with a series of efforts under way in Latin America and the Caribbean.

Regional Patterns of Response to the Need of Setting up Priorities

The process of setting up and putting priority-based health care strategies in practice is a challenge for policy-makers, planners, and administrators, as well as for insurers and service providers in terms of enabling everyone’s access to a floor of essential health care benefits. This entails the establishment of an erratic break-even point, where the types of interventions to be developed by the countries are decided on the basis of ever-decreasing resources (Mitchell, 1999.) Such a process should incorporate disease prevalence indicators and the experience of previous interventions both at the local and the international levels. However, the data collected in the region show that prioritization mechanisms usually overlook both evidence of the potential impact on the target population and cost-effectiveness studies of the possible menu of interventions.

From the epidemiological perspective, priority setting criteria was traditionally based on mortality indicators. More recently, certain indicators such as DALYs2 (burden of disease) (Murray, 1988) or QALYs (quality of life) have been incorporated as measurements that combine fatal and non-fatal outcomes (PHO, 2001.)

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2 DALY (Disability Adjusted Life Years) is a measure that estimates the years of disability-free life lost as a result of premature death or disability. Life years lost due to disability are obtained by multiplying the expected duration of the state of ill-health (in the form of remission or death) by a weighted measurement of its severity. Once deaths and healthy life losses from disability have been combined, a time-based discount rate is applied in order to establish the homogeneous effect at a given point in time. To avoid biases against the elderly, some researches have proposed the application of age weights (Murray.)
Even so, and although objective measures such as mortality, burden of disease, and cost-effectiveness analyses are appropriate tools for defining priorities, it is other factors that take part in the final decision process.

One of the mechanisms frequently adopted is that of implicit prioritization. This strategy produces a double standard: the political discourse gives priority to certain problems, but when it comes to assigning resources, the discourse becomes devoid of content. In practice, implicit prioritization has given rise to an inefficient spending, where hospital care and its most complex practices take up a big portion of the budget. This situation is detrimental to those services related to sexual and reproductive health, provision of which takes place at outpatient care centers and, when inpatient services are required, perhaps at a medium complexity facility (obstetric care for example.) Likewise, those programs with higher “social visibility” usually receive greater attention from the political power. Thus, when a basic benefits package focused on sexual and reproductive health is defined, planners and decision-makers do not only take into account the health care aspects of the proposal but also its political implications, in addition to alternative ways of generating the necessary support to carry out actions that are feasible and sustainable over time.

More recently, some authors approach the design of priorities from a gender perspective (Juárez de Rorbert, 1998.) From this standpoint, the hegemonic design typical of the organization at the institutions as well as of decision-making mechanisms illustrates a gender-biased culture and system of values. Planning and management, just like institutional communication networks, allocation of public expenditures, and service provision, are symbolic activities carried out within a cultural environment. The proposals put forward by this approach—to reduce existing inequalities by means of the application of active policies promoting equal opportunities and responsibilities—enrich the traditional cost-effectiveness model and could contribute to solve current inequalities. However, their application is frequently distorted and falls short of combining efficiency and equality of opportunities, remaining as a mere additional component that fails to consolidate the participative prioritization process.

The segmented nature of Latin American health care systems has determined the criteria used for setting up financing priorities in the sphere of public health care services. Such segmentation has resulted in coordination and partnership strategies between public and private providers. This approach has been a mainstay in recent reforms largely resulting form the World Bank’s Human Development Report of 1993. This report defines criteria for the prioritization of public resources and public-private collaboration and complementation areas. Such an approach, however, has brought about implementation problems of equity and efficiency.

From the perspective of equity, it becomes clear that low-income sectors do not have access to certain services due to budget constraints as well as to the lack of adequate service provision by the public sector. Especially in the case of outpatient treatments, this leads the poorer populations to outlay higher out-of-pocket sums in private practices, sometimes at the expense of other kinds of expenditures. From the perspective of efficiency, consumers’ lack of information and the presence of public goods and externalities call for a regulatory framework that ensures the proper functioning of the markets (Maceira, 2001.) The scarce ability for developing countries to set up and enforce regulations results in efficiency gaps, with consequent monopolistic rents and underprovision of services.

Expansion of coverage is one of the biggest challenges for the sector reform processes in Latin America. One of the basic principles of the reform in most of these countries, coverage
expansion aims at ensuring universal access to primary and preventive health care services for the whole population, especially for vulnerable groups (PHO, 2001.) To achieve such objective, and taking into account community risk as one of the main components of the health sector reform, basic benefits packages have been designed.

Basic benefits packages may include two forms of alternative benefits: on the one hand, those usually comprising all the phases of health care addressed to enrollees and beneficiaries – health promotion and diagnosis, treatment and rehabilitation of diseases, and the right to receive authorized drugs free of charge--; on the other hand, those pertaining to the collective or public health interest, generally compulsory and free of charge. These include mass information and education activities aimed at promoting social involvement in the management and resolution of health problems, and encouraging induced demand of services. However, the existence of segmented social insurance structures (as a result of decentralization processes and lack of coordination between the public sector and social security systems) has given rise to undesirable situations from the perspective of priority setting strategies, such as the exclusion of certain groups from the basic benefits packages or adverse selection mechanisms regarding gender, age or socio-economic level (Mitchell, 1999.)

The number of interventions included in the benefits packages differs significantly across the various countries in the region. There tend to be gaps between the content of the basic benefits package defined in the regulations and the services effectively provided, which tie in with the supply capability of the service provision network.

Even though the Ministries of Health consider payments and co-payments as suitable mechanisms to control service demand (moral hazard) and simultaneously enabling the recovery of operational costs, they have been one of the most serious barriers to service access, undermining the structure of priorities set up by the public authority at the time of designing the reform.

The following section deals with comparatively diverse sexual and reproductive health strategies based on priorities explicitly set up in Latin America and the Caribbean. This review draws on various consultation sources which complement the records of specific efforts such as:

- Official documentation on sexual and reproductive health programs in countries undergoing health reform processes.
- Budget allocation in related areas (maternal and child health.)
- Definition of research programs and policies focused on sexual and reproductive health.
- Opinions of local stakeholders.
- Definition of explicit policies (rational models based on global burden of disease, express sectoral interests, catastrophic situations, etc.)
- Definition of allocation criteria either in the form of benefits packages (WHO, 1996; González, 2001; Hamerling, 1999; Duarte, 1998) or otherwise.

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3 Such as the Collaborative Study on Second Opinion on Cesarean (ECLAC) CLAP/PHO-WHO, Uruguay, or the CONAPRIS Project on Maternal Mortality carried out in Argentina.
Latin American Efforts in Sexual and Reproductive Health Priority Setting

On the basis of the goals set up, various prioritization efforts and related actions carried out in Latin American countries were selected from existing literature. Each of these efforts, with their distinct features and nuances, make innovative contributions and in some cases manifest the perpetuation of old practices and models in policy management that deviate from proper decision-making tools.

Brazil and the Single Health System

The reform process in Brazil started in the early 1980s. As a result of the economic crisis in the country in the previous decade, the fall in public expenditure in health, and the growing fragmentation of health care providers, the health care system at that time was rather inequitable and provided a meager coverage, with health care services focusing on repairing damages rather than preventing them. This situation was addressed by setting up a council comprised by the political authorities of the federal states, labor union leaders, and professional associations, whose mission was to devise a strategy for costs reduction in health care and rationalization of existing resources. The health sector reform underwent three stages: the first, called Integrated Health Care Actions (AIS, 1984), had the objective of improving coordination within the federal health care system; the second consisted in the creation of the Unified and Decentralized Health Care System (SUDS, 1987-1988), and the third, in the establishment of the present Single Health System (SUS, 1988.)

In 1984, the Ministry of Health developed a specific sexual and reproductive health component within that system, the PAISM (Women’s Comprehensive Health Care Program), which was incorporated into the health care provision network. Implemented as a vertical self-governed program, the PAISM encompasses the full menu of sexual and reproductive health care benefits (prenatal care, childbirth, postpartum, breast and cervical cancer screening, care of sexually transmitted diseases, adolescence and menopause care, and education in family planning and contraception.)

National Health Plan in Mexico

The Mexican government has put forward prioritization criteria in health care on the basis of five political goals comprised in their National Development Plan. Such goals are: 1) to improve the Mexicans’ health condition; 2) to eradicate inequalities in health care; 3) to guarantee an adequate treatment at public and private health services; 4) to ensure an equitable funding in health care; and 5) to upgrade the health care system, especially its public facilities (Mexico, 2000.) These goals resulted in the specification of problems that, given their epidemiological significance, needed to be integrated into the government’s action plan. Sexual and reproductive health has been addressed by means of the incorporation of specific benefits into health care services and the promotion of a gender perspective in the health sector through the PROMUSA (Women and Health Program). The PROMUSA is a multi-sectoral program focused on the definition and design of policies bearing on planning and allocation of budgets in service provision, social security, education, computing, and research.

The actions provided in this program include counseling to women attending family planning services and promotion, during prenatal encounters, of breast-feeding, postpartum family
planning, and postpartum care. The prioritization system is completed with the appeal for citizens' involvement in policy-making. In this respect, the Ministry of Health has encouraged citizens' consultation by organizing forums intended to inquire about top-priority health problems. Women, equity in health, mental health, and violence were some of the emerging topics.

**Decentralization and Social Insurance in Argentina**

The Argentinean is a distinct case since, given the federal organization of the country, the policies and programs in sexual and reproductive health developed by the provinces are under their autonomous management with respect to the national government. As a result, social stakeholders from each jurisdiction take part in priority setting at the local levels (both provincial and municipal.) In this context, the national government has comparatively limited tools, only confined to specific vertical programs that are scarcely coordinated among them and with the initiatives in each province. As a consequence of such heterogeneity, the country exhibits an asymmetrical state of affairs regarding regulatory frameworks and budgetary resource allocation which impacts on the population in various degrees: the provinces lacking regulatory frameworks are those with the lowest incomes, the greatest poverty rates and the worst women’s health indicators, a situation that adds to the inequity phenomena.

In spite of this asymmetric pattern regarding policy development, local reform phenomena can be observed such as sexual and reproductive health programs geared to set up informed mechanisms to take care of top-priority health problems of the population (Díaz Muñoz *et al.*, 2002.) Furthermore, maternal mortality has been given top priority in the national government’s norms issued in 2002 as well as in the health care research programs sponsored by the Ministry of Health.4

At the same time, the Argentinean social security system (national and provincial employees’ health care system) has designed and implemented a benefits package called Compulsory Health Care Program (PMO) to cover its enrollee’s health care needs, largely provided by private contracted providers. As a result of its wide scope—which reveals gaps in the criteria used for setting up priorities— and due to the recent macro-economic crisis in the country, this program has been recently reshaped under the name of Compulsory Emergency Health Care Program (PMOE), to encompass, among others, the classic interventions related to reproduction (pregnancy care) and women’s morbidity, but leaving out contraception issues. However, the lack of coordination among the financing institutions regarding the kinds of benefits guaranteed by the package limits the local efforts in priority setting, to the detriment not only of efficiency but also of equity in the system as a whole.

**Baseline of Health Care Priorities in Bolivia**

The design of reforms that allow for priority setting has not been homogeneous in Latin America. In the case of Bolivia, in contrast to the above examples, the need to provide farther-reaching health coverage led to the design of a special benefits package for sexual and reproductive health and childcare as a first step toward a broader reform.

Since the enactment of the Popular Involvement Act in 1994, the Bolivian health care system has started a process of deep reforms (Bolivia, 1998.) This act, along with subsequent

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regulations on health care, involved a decentralization process by factors, with strong community involvement at the municipal level in the design of social priorities and control. Concurrently, a subsidy system called Mother and Child Insurance was set up, specifically intended to provide coverage to groups below the poverty line and which, though imperfectly, involves not only public providers but also the social security network. This insurance includes various maternal and reproductive care actions such as prenatal and childbirth care, and treatment of obstetric complications and emergencies, but it does not allow for the supply of contraceptives. The effectiveness of this program, shown by independent studies carried out (Dmytraczenko et al., 1998), has encouraged its broadening (Basic Health Insurance.) On the other hand, some studies point to the differential effectiveness of the insurance between large and small communities. Outcomes have proved better in the latter case.

Recent Targeting Efforts in El Salvador

In its Annual Operational Plan (El Salvador, 2002), the Ministry of Public Health and Social Care defined the priorities regarding budget allocation and the strategic framework of action. Its budget has evolved substantially, from USD 150.6 million in 1997 to USD 231.99 million in 2002. In this Plan, thirteen top-priority activities to be performed at the Health Care Units (outpatient services) are mentioned (although not articulated precisely), three of which relate to sexual and reproductive health: women’s care, early cancer detection and family planning.

One of the most tangible actions of the reform is the commitment undertaken by the national government concerning the reduction of the existing gap between populations who have full access to health care and those who do not. The Reform Council raised the issue of targeting as a way of directing public resources to the political goal put forward. The Set of Essential Services proposed by this Council is a mix of collective, family and individual health care interventions. It includes promotion of changes in personal risky behaviors, control of environmental risks, and provision of preventive health care to the population. First-level care at the community level is privileged, in order to eliminate as many access barriers as possible.

Implementation of Priority Setting Systems in Chile

In 1997 the Ministry of Health, through the DISAP (People’s Health Office), carried out a priority setting procedure that accompanied the process of transformation of the national health system. As a result, national and regional priorities were set up both on the basis of epidemiology as a basic tool in health care and on the definition of health care scopes of action related to regulation, financing and service provision. Following the process started by the Ministry of Health, local levels were called to determine priorities that should be negotiated and agreed with the central level. The purpose of such bargaining was to ensure consistency among national, regional and communal health policies and priorities.

In addition, the Ministry of Health made explicit three reasons to prioritize spending on health: a) technical-health care reasons, associated with changes in the epidemiological and demographic profile, as the needs and demands in health outweigh the resources available; b) reasons concerning equity and social justice, to attend to health care needs; and c) economic reasons, to promote cost-effective strategies based on scientific evidences and expert’s opinions. On the basis of these, the concerns taken into account in the priority setting process were: extent
of harm, vulnerability, possibility to evaluate the outcomes of the interventions, and social and economic impact.

A first stage was designed to determine public health care problems and proceed to accomplish the strategies and activities proposed. From the epidemiological standpoint, a list of forty-three diseases was drafted, representing 75 per cent of the burden of disease measured in DALYs for Chile in 1993. Then, and following consensual criteria, the five most relevant programmatic goals within each priority were identified (eighty in all) to reflect the main health problems and the activities required to address them in terms of promotion, prevention, treatment, and rehabilitation. Subsequently, a series of indicators was developed in order to measure both the health care process and its outcomes and impact on the population’s health.

The absence of a single Basic Health Care Program has led Chile to use the sex variable to set up differentiated costs of the system’s coverage and therefore to determine health care benefits, specifying which items increase the cost of women’s care: the degree of female morbidity, greater women’s longevity, and reproductive health costs which are ascribed solely to them.

The final result of the priority setting process would translate itself into management commitments among the Ministry of Health, regional health care authorities, health care facilities, and other institutions. Modernization and management tools of the public sector would be the primary commitment.

**Coverage and Health Care Gaps in the Colombian Reform**

With the enactment of Act Nº 100, Colombia redefined the Social Health Insurance System by integrating the public sector and combining it with a geographic decentralization system. In this way, the country embarked on one of the most ambitious reforms in the region with the purpose of extending coverage and setting up more rational funding and risk sharing criteria. One of its mainstays is the design of differentiated benefits packages for populations contributing to the system (Compulsory Health Care Plan, POS) and for subsidized groups.

The Benefits Plan of the Colombian Social Health Insurance System (Resolution 5.261 of 1994, Activities, Interventions, and Procedures of POS Guidelines) allows for reproductive health by way of the following interventions: promotion of sexual and reproductive rights and duties, encouragement of protection factors and prevention and risk control in sexual and reproductive health, prenatal control, childbirth care, encouragement of breast-feeding, vaccination, family planning for men and women, early detection of pregnancy alterations and of breast and cervical cancer, and care of sexually transmitted diseases and HIV/AIDS.

However, one of the main problems encountered relates to the limited information available to users at the time of requesting the contents of the packages allocated, as well as to access disparities between contributing and subsidized groups, particularly in sexual and reproductive health. By way of example, the Compulsory Health Care Plan in the subsidized scheme does not include such interventions as vasectomy, colposcopy, uterine biopsy, mammography, or breast biopsy, which the contributive population’s plan does include.

Likewise, certain interventions, procedures, and supplies like emergency contraception, are not compulsory and therefore insurance firms do not take any responsibility for their fulfillment or
funding. This is because, although they are included in the Technical Norms and Guidelines, such service deliveries are not part of the POS, and thus female users cannot request their provision (Ministry of Health.)

In addition, and in spite of the steps taken to guarantee universality, the system still allows adverse selection by sex, age, and income. Efforts made by the service promoting entities to avoid mass enrollment of women in reproductive age and over sixty years old have been apparent. Also evident is that women with higher incomes, with some kind of geographical advantage to reach the services, or with higher educational levels and knowledge of their rights in connection with the system have greater access.

Conclusion

Priority setting in health policies in Latin America is a complex process that results from the interaction of manifold factors and stakeholders at a given historical moment. This work has attempted to summarize the concerns provided by the literature on the subject, privileging the analysis of the intervening interest groups over the debate on priority setting mechanisms and techniques, as the literature on health economics and clinical effectiveness has already dealt with those subjects thoroughly.

Within this framework, it can be observed that the National Ministries’ ability to set up priorities is related to the political characteristics of each country, as well as to the extent of fragmentation in the financing sources comprising the “baseline budgets” used for the reforms.

Thus, countries such as Brazil, Mexico, or Argentina require a greater degree of political consensus and debate to set up their goals, given their federal organization, whereas Colombia, Chile, Bolivia or the Central American countries, with greater freedom of action, face the challenge of setting up a thorough program of action that makes room for regional diversities.

From this perspective, the Argentinean case epitomizes the fragmentation in Latin American health care systems. The provinces control over 60 per cent of the public budget, and the social security system, on which resources the national government has no say, provides a theoretical coverage to 50 per cent of the population. This shows a relative weakness of the central government to set up priorities not only with regard to goals but also to management tools. It is at this point that priority setting in health care interventions interweaves with the ability to set up effective regulatory mechanisms, an elusive subject in the literature thus far and, therefore, a crucial issue in the pending agenda.

In any case, and as stated in the Introduction, the priority setting process is not confined to the menu of interventions considered in the reform or to the basic care level established for a compulsory package. Such a process starts earlier, when the main goals concerning change are presented. But they are usually only mentioned by extension (equity, coverage, sustainability, cost control, etc.) so that the need to marshal them becomes apparent. Thus, in countries like Brazil or Bolivia (in spite of their remarkably different approaches to their respective reforms), expansion of coverage has prevailed over equity, while in Chile or Colombia decision-making has received greater technical support than priority setting mechanisms. These decisions respond to the basic conditions in each country at the time of designing a reform. However, in all cases the

5 This debate goes beyond the field of health. Actually, the role ascribed to health (in a broad sense) within budget allocation priorities of a country competes with other areas such as education, justice, etc.
original decision includes “spillovers” on secondary goals: the greater coverage may be identified with a pro-equity movement in countries like Bolivia or the Brazil of the 1980s, and the design engineering of the Colombian reform, with the creation of the Redistribution Solidarity Fund, yielded less inequitable outcomes.

An additional research issue arises from this comparison, also absent in the literature: what is the distance between the explicitly enunciated framework and the degree of effective implementation of the proposals? This debate requires other elements to be included, associated with the “management approach” of the reform and therefore of the sequence of successive changes and the rate at which they materialize.

In connection with this, another element in the analysis is the role conferred in the reforms to the private sector as a cooperative/competitor group in the new strategy conceived. In the cases of Mexico, Chile, Bolivia, and El Salvador, the presence of the private sector as a participating stakeholder is limited, whereas in Brazil, Argentina and Colombia it has a leading role, although for different reasons: in Brazil, the universal coverage model (SUS) presents the private provider as a complement in service provision, while in Colombia there are participation rules for insurance firms (who usually have their own providers), whereby they act as articulating institutions in the new scenario of the sector. In Argentina, any reform and priority setting system concerning social security involves the private sector since, through contracting networks, it is the main service provider.

In connection with the relationship between priority setting policies and interventions in sexual and reproductive health, the literature reveals that this aspect does not have an explicit status within the process of Health Sector Reform. With few exceptions (the Mother and Child Insurance in Bolivia or the provincial Sexual and Reproductive Health Programs in Argentina, for example), priority setting in sexual and reproductive health results from analyzing the level of explicitness of interventions in sexual and reproductive health within the context of the sector’s policy. In this respect, the last conclusion of this review of documented experiences is that either the Latin American region as a whole does not consider interventions in sexual and reproductive health as efficient tools in their priority setting schemes, or the power of advocacy of the sexual and reproductive health agenda fails to impose those tools in the process of bargain and consensus carried out by the various stakeholders with their diverse policy agendas.

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