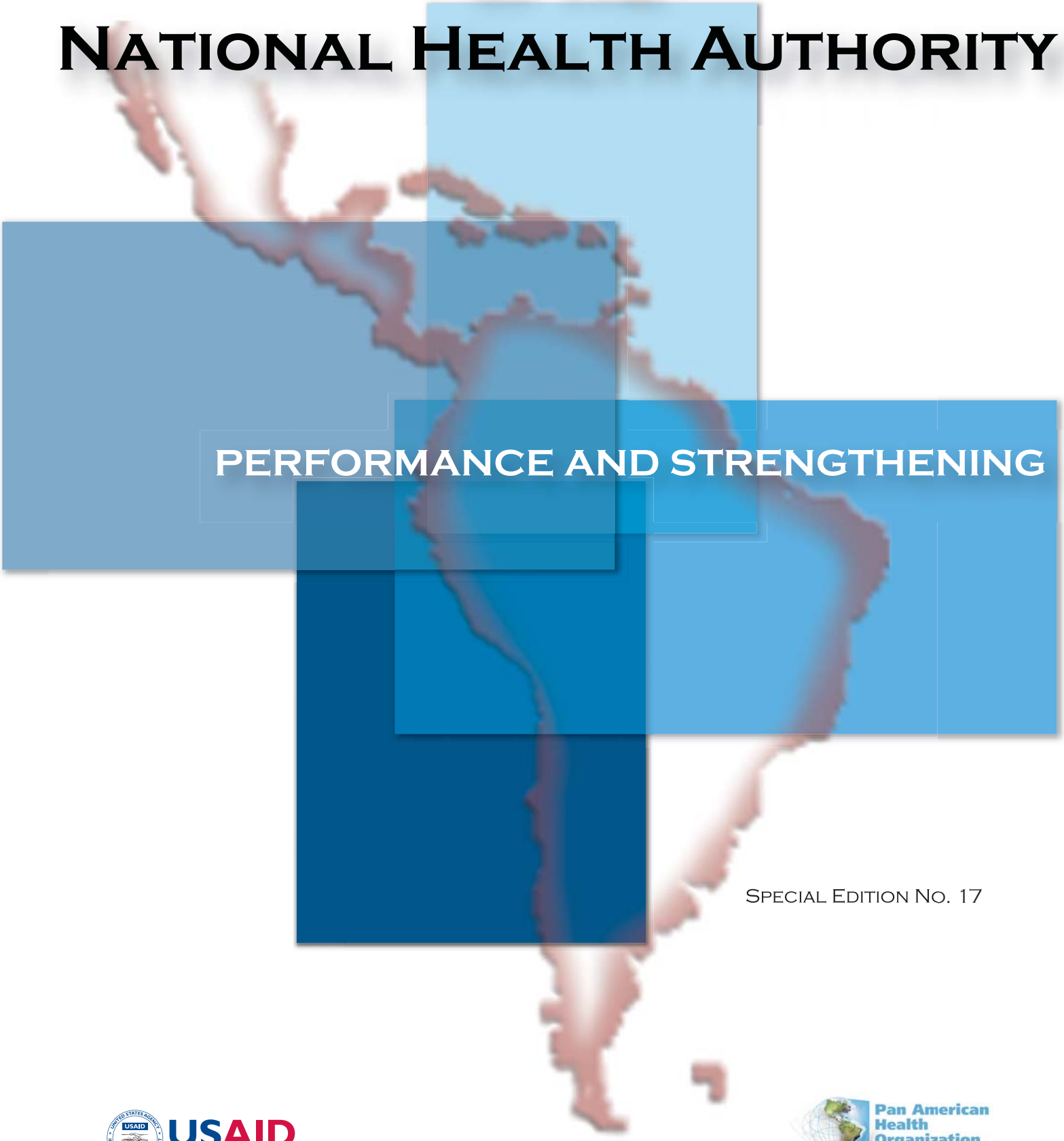
STEERING ROLE OF THE NATIONAL HEALTH AUTHORITY



PERFORMANCE AND STRENGTHENING

SPECIAL EDITION NO. 17

USAID
FROM THE AMERICAN PEOPLE

Pan American Health Organization
Regional Office of the World Health Organization

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Washington DC, 2007

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Area of Health Systems Strengthening
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I. INTRODUCTION

In recent years, the debate over the best conceptual and methodological approaches to analyze and understand health systems has intensified. Some studies have focused on the financing and service delivery models of systems, whether public or private, while other approaches have centered on issues of supply and demand, and on the role of the State.

One of the most important manifestations of the debate regarding the role of the State in health focuses on the definition of the functions of the health systems, the responsibilities they embody and their relationship to the structure of the system. In this regard, the traditional taxonomy of the national health systems has centered primarily on whether public or private providers prevail in the system and on the responsibilities attributed to each concerning financing and delivery of services.

Currently, due to the growing complexity of health systems, new relationships between the State, the public sector, financing and insurance institutions, and the private sector have emerged. Consequently, several new typologies based on health systems functions have since been developed, making it possible to understand health systems in their capacity to integrate different population groups and institutions.[1]

The World Health Report 2000 entitled "Health Systems: Improving Performance" generated an extensive discussion at the international level on the definition of health systems functions and their performance evaluation. The Report proposed the following key health systems functions: (i) service delivery; (ii) resource generation; (iii) financing (collecting, pooling and purchasing); and (iv) governance of the health sector or "stewardship." Also, this report argued that the fundamental objective of health systems is to achieve optimal health outcomes and to eliminate inequities in access.[2] In this regard, performance indicators should include the health of the population, response capacity, and solidarity in financing. This leads to the need to define priorities and to rationalize the distribution of essential health services using criteria for cost-efficiency and social acceptance. Consequently, if this framework is used, state responsibilities in health should be clearly defined.[3]

The Pan American Health Organization/World Health Organization (PAHO/WHO) attributes three basic functions to the health systems, namely: (1) Steering role or "Stewardship;" (2) Financing/Insurance; and (3) Delivery of health services. This classification is based on the analysis of health sector reform and health systems reorganization processes undertaken by PAHO/WHO between the year 2000 and 2003 in the countries of the Region.[4,5,6]

1. José Luis Londoño and Julio Frenk, *"Structured pluralism: towards an innovative model for health system reform in Latin America,"* Health Policy 41 (1) (1997).
2. World Health Organization (WHO), "*World Health Report 2000 – Health Systems: Improving Performance"* (Geneva, Switzerland: WHO, 2000).
3. Oswaldo Cruz Foundation, "*Report of the workshop on health systems performance: The World Health Report 2000"* (Rio de Janeiro, RJ, 14-15 December 2000).
4. Pan American Health Organization/World Health Organization (PAHO/WHO), "*Analysis of Health Sector Reforms in the Sub-Region of Central America and the Dominican Republic"* (Washington, D.C.: PAHO, 2002), http://www.lachealthsys.org/index.php?option=com_content&task=view&id=165&Itemid=94.
5. PAHO/WHO, "*Analysis of Health Sector Reforms in the Andean Sub-Region"* (Washington, D.C.: PAHO, 2002), http://www.lachealthsys.org/index.php?option=com_content&task=view&id=165&Itemid=94.
6. PAHO/WHO, "*Analysis of Health Sector Reforms in the English Speaking Caribbean Sub-Region"* (Washington, D.C.: PAHO, 2002), http://www.lachealthsys.org/index.php?option=com_content&task=view&id=165&Itemid=94.

The fundamental goal of this document is to undertake a conceptual and methodological discussion of the concept of Steering Role. Similarly, it aims to help technical bodies in the measurement and performance evaluation of the Steering Role of the Health Authority. The objective is to improve the capacity of the health sector to generate and evaluate information that will make it possible to identify strategies and specific actions to strengthen the steering role.

II. WHY IS THE *STEERING OF THE HEALTH SECTOR* A PRIORITY ISSUE?

During the 1980s and 1990s, the State Reform processes implemented in the countries of the Americas promoted the systematic reduction of the size of the State, and the transfer of functions traditionally performed by the public sector to the private sector and civil society. At the same time, the globalization process produced an increase in the flow of information, capital, and workers that contributed to the progressive erosion of the autonomy of the Nation-State and to a weak governance capacity.[7]

STEERING ROLE
WHY IS IT A PRIORITY ISSUE?

1. State reform processes
2. Weak governance capacity
3. Transfer of functions traditionally performed by the public sector to the private sector and civil society
4. Globalization

Therefore, one of the critical issues facing the countries of the Region is the insufficient level of institutional development, a factor that impacts the possibility of economic development. In this context, the redefinition of institutional roles and the strengthening of the non-delegable functions of the State, such as security, public health, reduction of inequity and social protection of excluded population groups, have become priority issues for countries.

In light of this challenge, the countries of the Region seek to strengthen the steering role and consolidate the leadership of the Ministries of Health, which are steps necessary for the Health Authority to effectively advocate for health and negotiate with other sectors that impact the health sector.[8]

7. In this context, "weak governance capacity" refers to the lack of institutional capacity to implement and comply with policies, usually caused by the political system's lack of legitimacy.
8. Mirta Rosés, *"Steering Role of the Ministries of Health: Challenges for the 21st Century"* (feature address at the Steering Role of Ministries of Health: Hospital Governance Workshop for Ministers of Health and Permanent Secretaries of the Organization of Eastern Caribbean States, Bridgetown, Barbados, November 5-6 , 2003).

III. IMPACT OF THE REFORMS ON THE *STEERING OF THE HEALTH SECTOR*

Within the framework of public sub-systems and National Health Systems, ministries of health have historically centered their responsibilities on the regulatory role, financing and health services provision. Nevertheless, health sector reform processes strongly promoted decentralization of both the State and the health sector which, coupled with the emergence of new public and private actors, has resulted in a marked tendency to reduce responsibility for health service provision and to increase the scope of action of the steering function.[9]

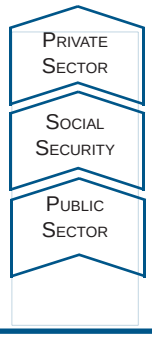
REGIONAL TRENDS DERIVED FROM THE REFORMS THAT INFLUENCE STEERING ROLE PERFORMANCE

1. Decentralization of the state
2. Separation of health system functions
3. Deconcentration and/or decentralization of public health services, of health regulation, and of health care provision.
4. Increase in the proportion of public sector financing from intermediate and local State entities.
5. Emergence of new public and private actors.
6. Creation of national health funds that are separate, often autonomous, from the Ministries of Health.
7. Increase of private health insurances and private prepayment mechanisms
8. Growing participation of private providers and NGOs.
9. New relations between the State and civil society.

Monitoring and evaluation processes of the Health Sector Reforms revealed regional trends that have impacted directly on the countries' capacity to perform the steering role function in health.[10],[11],[12]

GRAPH 1

INSTITUTIONAL AND ORGANIZATIONAL SEGMENTATION



OPERATIONAL FRAGMENTATION

- Overlapping of networks
- Absence of complementary services and continuum of care
- Impossibility of providing comprehensive care
- Absence of mechanisms for reference and counter-reference.

Most countries in Latin America and the Caribbean have mixed health systems, in which ministries of health, social security institutions and private companies serve different segments of population. This scenario in which different subsystems coexist - with distinct financing, affiliation and provision arrangements - generates *segmentation*.[13]

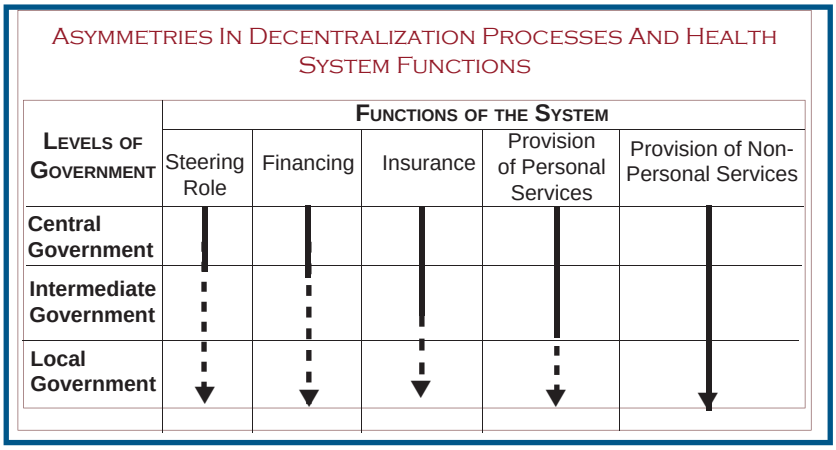
At the same time, the existence of multiple, overlapping agents operating without coordination or integration and often competing against each other engenders *fragmentation*. This raises the cost of health care and promotes inefficient resource allocation within the system as a whole.[14]

9. Pan American Health Organization, "*Desarrollo Nacional de Salud, Desarrollo de Sistemas de Salud y sus Implicaciones para la Cooperación Enfocada a los Países"* (Washington, D.C.: PAHO, 2004).
10. PAHO/WHO, "*Analysis of Health Sector Reforms in the Sub-Region of Central America and the Dominican Republic"*, Op. Cit., p.1.
11. PAHO/WHO, "*Analysis of Health Sector Reforms in the Andean Sub-Region"*, Op. Cit., p.1.
12. PAHO/WHO, "*Analysis of Health Sector Reforms in the English Speaking Caribbean Sub-Region"* Op. Cit., p.1.
13. In segmented systems, there is usually a public subsystem with insufficient resources that covers the lower income and indigent groups, a social security subsystem that covers workers in the formal sectors and their dependents, and a private subsystem with greater availability of resources that covers the richest segments of the population. Adapted from: Eduardo Levcovitz, *"Estructura, Organización y Políticas del Sector",* in Lineamientos Metodológicos: Análisis del Sector Salud (Washington, D.C.: PAHO/WHO, forthcoming).
14. Adapted from Eduardo Levcovitz, *"Estructura, Organización y Políticas del Sector,"* in Lineamientos Metodológicos: Análisis del Sector Salud (Washington, D.C.: PAHO/WHO, forthcoming).

Segmentation and fragmentation negatively impact financing, coverage, equity and efficiency.[15] At the same time, they affect and are affected by the asymmetries that resulted from the decentralization processes (Graph 2) such as the emergence of new public and private actors in the health sector, and the increase in the participation of private insurers.

GRAPH 2

ASYMMETRIES IN DECENTRALIZATION PROCESSES AND HEALTH SYSTEM FUNCTIONS



15. World Bank, "*World Development Report 2006*" (Washington, D.C. The World Bank, 2006),

IV. EVOLUTION OF THE STEERING ROLE CONCEPT

4.1 GOVERNANCE/STEWARDSHIP VERSUS THE STEERING ROLE

Developing an operational definition of the "steering role" has proven to be complex because of the association with the concepts of governance and "*stewardship"*.[16] The World Health Organization (WHO) uses the word "stewardship" to refer to the steering role of the health sector, and defines it as the capacity of the State to take responsibility for the health and well-being of the population, as well as to lead the health system as a whole. In addition, WHO identifies three broad responsibilities that are essential to the governance or *"stewardship"* of the health sector: (i) to provide vision and direction to the health system; (ii) to collect knowledge*/"intelligence";* and (iii) to exercise authority through regulation and other mechanisms. Also, it emphasizes that health outcomes are impacted by how well the government exercises "health sector governance".[17] On the other hand, PAHO employs the term steering role of the health sector to refer to the concept of governance/stewardship used by WHO.

4.2 THE ROLE OF THE PAN AMERICAN HEALTH ORGANIZATION

In 1997, the Member States of PAHO/WHO requested technical cooperation, through Resolution CD40.R12,[18] to develop the necessary capacities for performing the steering role as one of the fundamental axis for the institutional development of the health sector. Support was also requested for the exchange of national experiences among the countries in regard to the steering role performance by the ministries of health and institutional development. Finally, they urged the implementation of a permanent process for discussion, definition of concepts, and reflection about the steering role performance of the ministries of health.

16. In English, the concept of the steering role of the health sector is more often referred to as *"stewardship"*.
17. WHO, *"Report on the WHO Meeting of experts on the stewardship function of health systems"* (Meeting on the stewardship function in health systems, Geneva, Switzerland: September 10-11). See also Travis P, Egger D, Davies P and Mechbal A, *Towards better stewardship: concepts and critical issues* (Geneva, Switzerland: WHO, 2002), http://www.who.int/healthinfo/paper48.pdf.
18. XL Directing Council of the Pan American Health Organization, Resolution CD40.R12: "*The Steering Role of the Ministries of Health in Sectoral Reform Processes"* (Washington, D.C.: PAHO/WHO, September 1997).

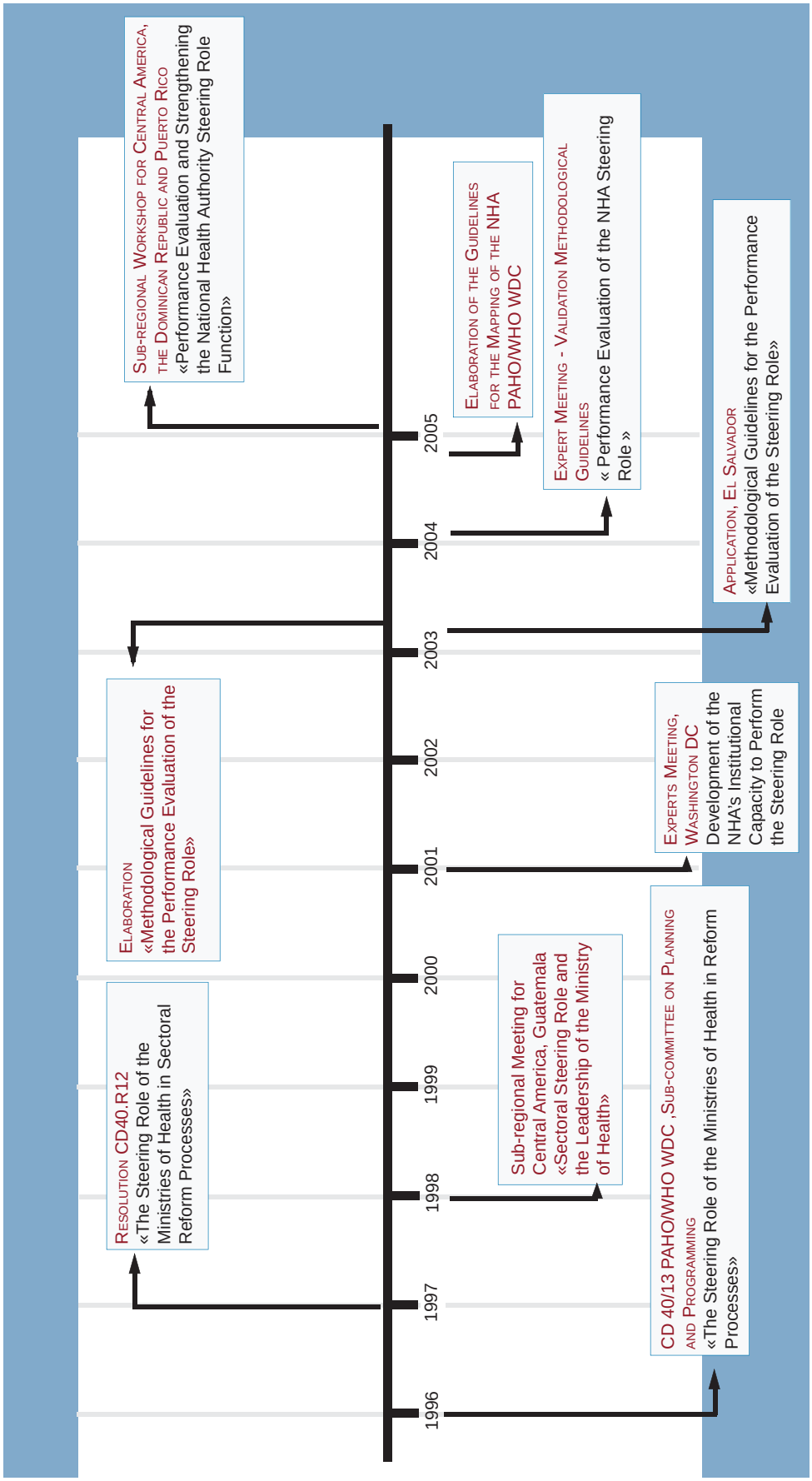
As a result, PAHO/WHO addressed the development of the *concept and practice of the steering role in health* as a priority, intrinsic aspect of the State modernization process. In this regard, since 1996, the Organization has promoted profound debate and exchange about the conceptualization, sphere of action, and mechanisms for strengthening the steering role in health at the regional and sub-regional level. The multiple efforts and rich experience accumulated by the countries of the Americas, particularly during the Reform processes in the 1990s, have served as fundamental inputs to these discussions.[19]

Graph 3 shows a timetable of the milestones in the conceptual and methodological evolution of the Steering Role in Health in the Region of the Americas, facilitated by PAHO/WHO. The following accomplishments stand out: the approval of Resolution *CD40.R12 "The Steering Role of the Ministries of Health in Sectoral Reform Processes*" by Member States in 1997; the Regional Consultation for the Performance Evaluation of Health Systems in 2001; and the development of the instrument for Performance Evaluation of the Steering Role, in 2003-2004.

As part of the process of conceptual development, PAHO defined the steering role in health **as the exercise of public health policy responsibilities and competencies inherent to the NHA, within the framework of relations between government and society in a modern State, which cannot be delegated. It includes the public decisions and actions necessary to guarantee and fulfill, within the national development framework, the health needs and legitimate aspirations of the social actors.**[20]

19. PAHO/WHO, "*Final Report: Sub-regional Meeting on Sectoral Steering Role and the Leadership of the Ministry of Health"* (Guatemala Abril 23-24, 1998). Daniel Lopez-Acuña, "The Nature of Health Reform in the Americas and its Significance for PAHO's Technical Cooperation" (background Paper for the Annual PAHO Managers Retreat, Washington, D.C., October 23-24, 2000). PAHO/WHO, "Steering Role of Ministers of Health in the process of Health Sector Reform" (PAHO Annual Managers Meeting, Washington DC., 23-27 October 2000). PAHO/WHO, "Final Report" (Experts Meeting: Development of the NHA's Institutional Capacity to Perform the Steering Role, Washington D.C., June 18-20, 2001). PAHO/WHO, "Final Report" (Experts Meeting on the Steering Role of the Health Sector in Reform Processes, Washington DC June 14-15, 2004).
20. Eduardo Levcovitz, *"Estructura, Organización y Políticas del Sector,"* Op. Cit. p.3

GRAPH 3: Conceptual and Methodological Evolution of the Steering Role in Health



V. THE CONCEPT OF NATIONAL HEALTH AUTHORITY

The National Health Authority is the custodian of the public good for health and its fundamental objective is the protection and promotion of the population's health. It represents the power of the State to perform its specific, non-delegable substantive functions, responsibilities and competencies in order to effectively monitor health as a public good. There are structural differences in the composition of the Health Authority based on the federal or unitary character of the country and the institutional organization of the health sector.[21]

The Ministries of Health are the principal public depositories of the "*Health Authority*" and are therefore the primary entities responsible for performing the sectoral steering role. Nevertheless, there is a growing trend of not concentrating all of the tasks in a single institution, as tended to happen in the past, but instead creating multiple, complementary institutional mechanisms that carry out different functions in a specialized, separate manner.[22]

BOX 1:

STRENGTHENING THE NATIONAL HEALTH AUTHORITY IN CHILE

The third wave of the health reform process in Chile, initiated in 2000, promoted a profound transformation of the health system, both public and private. The goals of the reform were to increase and improve access to health services, reduce waiting times, expand the network of establishments, and eliminate economic barriers. As part of the reform process, two fundamental actions were implemented, which resulted in the strengthening of the Health Authority. The first action was the prioritization of the concept of "steering role" and its articulation with a series of proposals that have become the basis of the Chilean health sector. Secondly, the Health Authority promoted the active participation of civil society in the identification of problems, planning, and implementation of health actions and of a reform proposal. The reform focused on five main themes, each included in respective draft legislations. The first draft legislation that was approved by the National Congress was the Health Authority Law, which established a new concept of Health Authority. As a result, the health reform process in Chile has succeeded in establishing legal, institutional, and functional mechanisms that have enabled the health authority to direct the health sector to achieve the key principles of the reforms: to increase the sector's effectiveness, equity and solidarity, and to improve the efficiency of the sectoral management.

The scope of public responsibility, the degree of decentralization of sectoral actions, and the structural separation of functions in each country determine whether a greater or smaller spectrum of competencies will fall under the national ministry of health. In some cases, these competencies have been previously defined in laws or regulations.

21. PAHO/WHO, "*Public Health in the Americas: Conceptual Renewal, Performance Assessment, and Bases for Action"* (Washington D.C.: PAHO/WHO, 2002). See also: J.L. Correa, Proyecto de Autoridad Sanitaria. Comunidad Virtual de Gobernabilidad y Liderazgo.
22. During the XL PAHO/WHO Directing Council (1997), Member States discussed and ratified the Dimensions of the Steering Role in Health. The dimensions encompass six substantial areas of institutional responsibility and competencies that correspond to the Health Authority, namely, Conduct/Lead, Regulation, Guarantee of Insurance, Orientation of Financing, Harmonization of Health Services Provision and Execution of the Essential Public Health Functions.

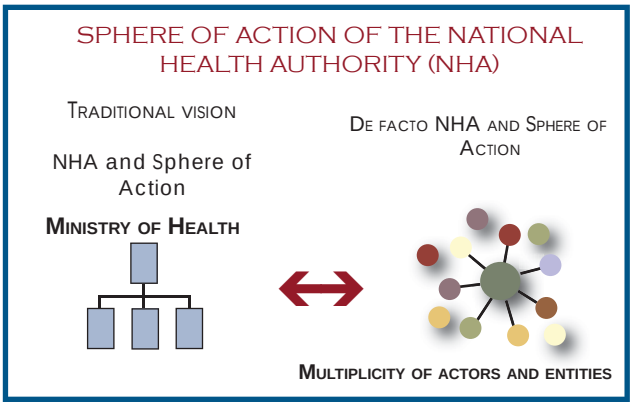
At other times, it entails new responsibilities, which require institutions to strengthen and often adapt their operations and organizational structure, and the profile of their managerial, technical and administrative personnel.[23]

In this context, the concept of "*Health Authority*" is understood *as the group of State organizations/entities/agencies responsible for safeguarding the public good for health.* The Health Authority accomplishes this goal through the implementation of multiple and complementary institutional mechanisms. These mechanisms recognize the existence of different actors that exercise the functions of the health authority, and facilitate the performance of the steering role through more strategic, specialized, efficient organizations that have a high technical and scientific capacity, greater management power and autonomy, and the capacity to delegate operational functions.

5.1 MAPPING OF THE HEALTH AUTHORITY

The steering role is not a monolithic function, but a governmental process that encompasses multiple determinants of health and intervention areas that impact health. Given the diversity of actors and entities involved in steering role activities, and the scope of the functions manifested in the dimensions of the steering role in health, it is necessary and indispensable to explicitly indicate which organizations/entities/agencies comprise the Health Authority and their sphere of action according to each country's context. (Graph 4)

GRAPH 4



Therefore, as a first step toward strengthening the steering role, it is fundamental to identify, describe, characterize and graphically represent the Health Authority, clearly explaining the interrelations between the legal framework that grants power to the State's governmental branches to perform the steering role in health and the institutional scheme that actually performs it. This process is known as the Mapping of the *Health Authority*.

The Mapping process is carried out in three successive stages. The *first stage* includes the identification of the legal framework that protects and determines the sphere of action of the steering role function for each one of its dimensions. The *second stage* seeks to determine the institution(s) that is/are legally responsible for carrying out the steering role. Finally, the *third stage* refers to the organizations/entities/agencies that are actually implementing the activities that correspond to the steering role with or without the legal protection to do so. It is recommended that the three stages be completed at the national level; at the regional, provincial or departmental level; and at the local level.[24]

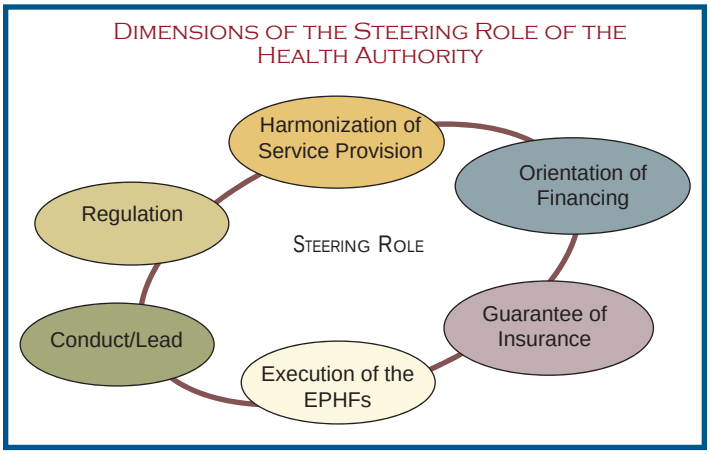
23. PAHO/WHO, "*Public Health in the Americas*", Op. cit., p. 8.
24. Please refer to the Organizing Matrix for the Mapping of the Health Authority for the completion of this exercise. Available at: www.lachealthsys.org.

VI. DIMENSIONS OF THE STEERING ROLE IN HEALTH

During the XL PAHO/WHO Directing Council (1997), the dimensions of the Steering Role in Health were presented for consideration by the Member States. These dimensions include six broad areas of responsibility and institutional competencies that should be overseen by the Health Authority. During the Directing Council, the Member States discussed and ratified the following six *Dimensions of the Steering Role in Health*.

1. *Conduct/Lead* includes the capacity to guide the sector and mobilize actors in support of the National Health Policy.
2. *Regulation* encompasses the design and enforcement of the health regulatory framework that protects and promotes health.
3. *Orientation of Financing* includes the competencies to guarantee, monitor and steer the complementarity of resources from different sources in order to ensure equitable access to health services.
4. *Guarantee of Insurance*, which targets its efforts at guaranteeing access to a health service package for the entire population, or specific plans for special population groups.
5. *Harmonization of Service Provision* is the ability to coordinate various providers and users groups in order to extend health care coverage equitably and efficiently.
6. The execution of the *Essential Public Health Functions (EPHFs)* which is a non-delegable competency of the Health Authority.

GRAPH 5

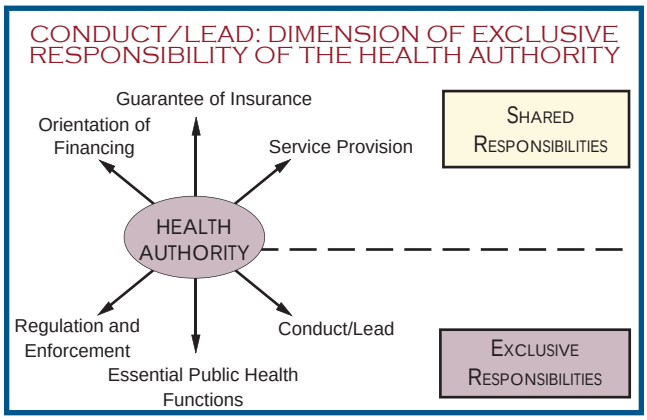


Depending on the degree of decentralization and separation of functions in each country, the dimensions can be exercised at the national, intermediate or local levels of the Health Authority. There are cases in which the dimensions are shared between one or more of these levels. An expanded description of each dimension is presented below, detailing the actions required for their effective implementation, as well as the challenges that must be faced.

6.1 CONDUCT/LEAD

The conduct/lead function consists of the National Health Authority's capacity to formulate, organize and direct the execution of national health policy, through processes that, based on shared values at the national level and the definition of the public good in health, define viable health objectives and implement strategic plans with feasible goals. For that purpose, the efforts of the sector's public and private institutions and other social actors should be articulated in order to achieve through social/policy dialogue and consensus-building the mobilization of the resources necessary for carrying out the proposed actions. The conduct/lead dimension constitutes one of the three dimensions of the steering role of exclusive responsibility of the National Health Authority.[25]

GRAPH 6



The conduct/lead dimension is an essentially political process of extraordinary complexity. It is of particular relevance when the established objectives aspire to significantly change the existing situation.[26] The ultimate result of the exercise of this function should be a political plan that is technically consistent, socially ethical and strategically viable, and that draws on multiple sources of power to generate the necessary support and provide the operational capacity for its implementation.

This implies that the Health Authority needs to develop and/or strengthen its ability to effectively guide the sector's institutions, and to mobilize social actors in support of the national health policy through the following actions:

- *Health situation analysis,* with emphasis on the ability to collect and guarantee the availability and quality of information.
- *Definition of Health Priorities and Objectives,* focused on the elaboration of diagnoses that target key issues; and the institutional ability to set national health priorities and objectives.
- *Formulation, Dissemination, Monitoring and Evaluation* of health strategies, policies, plans and programs.
- *Management, Consensus-building and Mobilization* of the sector's actors and resources.
- *Health promotion, participation and social control in health,* including the design and promotion of public health policies; and the promotion of inter-sectoral coordination.
- *Harmonization of international* technical cooperation in health.

25. Adapted from Levcovitz, E. *"Estructura de la Dimensión de Conducción como uno de los Ejes Fundamentales de la Función Rectora de la Autoridad Sanitaria,"* (presentation given in the training workshop: Performance Evaluation and Strengthening the National Health Authority Steering Role Function for the Sub-region of Central America, the Dominican Republic and Puerto Rico, San Salvador, El Salvador, March 2-4, 2005).
26. PAHO/WHO, "*Desarrollo de la capacidad de conducción sectorial en salud: una propuesta operacional*", Serie Organización y Gestión de Sistemas y Servicios de Salud No. 6. (Washington, D.C.: PAHO/WHO, Health Systems and Services Development Division; 1998).

- *Political and Technical Participation in International and Sub-regional Organizations.*
- *Performance Evaluation of the Health System,* including measurement of the achievement of goals, of the resources used, and of the efficiency of the health system.

6.2 REGULATION AND ENFORCEMENT

The purpose of the regulation dimension is to design the regulatory framework that protects and promotes the health of the population, and to guarantee its effective implementation. Monitoring its application is necessary to guarantee the state's role as organizer of the relations between production and distribution of health resources, goods, services, and opportunities according to principles of solidarity and equity. Nevertheless, due to the prevalence of a market oriented doctrine, there is a tendency to restrict the scope of this dimension.[27]

The framework for the performance of the regulatory role emerges within the State and in the international context. Within the State, the regulatory mandates primarily emerge from the constitutional norms that create rights and duties for individuals and institutions. This leads to the exercise of regulatory power to implement the norms and empower specific entities to enforce them. If this sequence of implementing and enforcing the laws does not take effect, the constitutional precepts lose effectiveness.[28]

The international context also affects the regulation dimension. On the one hand, there are *regulatory pressures* that arise from States' new commitments on the economic sphere–whether through entities like the World Trade Organization (WTO), or as part of supranational organizations such as common markets or integration blocs –, which generate concerns with regard to the possible flexibilization of standards or creation of access barriers. On the other hand are those that arise from international commitments that are more closely associated with health, for example, the recently adopted *WHO Framework Convention on Tobacco Control*, or the revision of the *International Health Regulations (IHR).*

The IHR, a legally binding international agreement to prevent the spread of disease at the global level, were originally adopted in 1969 but underwent a process of revision in 2005 to adapt to current challenges posed by globalization and increased mobility of goods and persons. In preparation for implementing the IHR, PAHO/WHO has been providing Member States with technical cooperation to assess existing public health capacities and implement strengthening plans. Together with WHO and other partners, from 2007-2009, all member countries will begin assessing their existing public health system, and improving its capacity for the detection, reporting and assessment of and response to public health events to meet the minimum core capacity requirements established by the IHR.

27. A. Ferreiro, and L. Sierra, *"El papel de las Superintendencias en la Regulación de los Seguros de Salud: los casos de Chile, Argentina, Perú y Colombia".* (Washington, D.C.: PAHO/WHO, 2001).
28. PAHO/WHO, Meeting on *"Sector Salud en Procesos de Reforma"* (Washington, D.C.: PAHO/WHO, June 14-15, 2004).

The State must recognize the regulatory role as a *non-delegable function* in order to make it effective. Although the State's responsibilities in health have been shifting, regulation has remained a constant. This is due to the fact that regulation fulfills one of the principal mechanisms used by the State to mediate relationships between actors with power asymmetries; and that health regulation addresses the interest of the entire society. As a result, it establishes the foundation for the articulation of the other dimensions of the steering role: conduct/lead, orientation of financing, guarantee of insurance, harmonization of service provision, and execution of the essential public health functions.[29]

In general terms, for the Health Authority to be able to effectively perform its regulatory role, regulation should encompass the following areas:

BOX 2:

REGULATION AND MONITORING OF THE PHARMACEUTICAL SECTOR: THE CASE OF BRAZIL

Brazil is the first developing country that has implemented a program for distribution of antiretrovirals at the national level. The program was established as part of the Brazilian National Drug Policy and aims "to ensure access for the population to safe, effective and quality drugs, at the lowest possible cost." The National Health Authority carries out two types of pharmaceutical regulation: technical and economic. The technical component refers to the creation of sanitary standards to ensure the quality and safety of the drugs, using mechanisms such as registries, inspections and health surveillance. Economic regulation refers to the introduction of policies to reduce the influence of the pharmaceutical industry in the market and to increase consumer access to pharmaceutical products. The instruments used include price control, market monitoring, manufacturing of essential drugs, use of generics, and development of policies that increase access and promote the use of generics. Although economic accessibility of the drugs was always an important issue in the public agenda, it became even more pressing in response to the AIDS epidemic, and price controls assumed a predominant role in economic regulation.

- Institutional and legal framework for the performance of the steering role;
- Enforcement and control to ensure compliance with the regulations;
- Regulation and control of medical supplies and health technology;
- Regulation and control of health goods and services;
- Regulation and sanitary control of the environment;
- Regulation of human resources for health;
- Development of regulatory mechanisms to protect the public and guarantee minimum quality standards in service delivery;
- Regulation and control of public and private compliance with insurance plans, ensuring that no beneficiary is excluded due to age-related risks or pre-existing conditions.

29. Monica Bolis, *"La Dimensión Regulatoria en el Contexto de la Función Rectora de la Autoridad Sanitaria"* (paper presented during training workshop: Performance Evaluation and Strengthening the National Health Authority Steering Role Function for the Sub-region of Central América, the Dominican Republic and Puerto Rico, San Salvador, El Salvador, March 2-4, 2005).

Enforcement and control are essentially technical and aim to ensure compliance with the provisions established by the regulatory function. They require professional specialization and proven independence. The exercise of the enforcement role is highly dependent on the availability of human and technical resources, as well as on the responsibilities specified by the legal framework. Enforcement that results in the application of sanctions should be subject to review by courts of law in order to guarantee due process and prevent abuse on the part of the regulating body.[30]

In some countries new agencies have been created, known as Superintendencies, to perform the enforcement and control functions. Although the normative and enforcement roles are different and should be carried out by different agencies, there are cases in which enforcement agencies also perform normative types of roles; for example, the general memos, instructions or standards issued by the Superintendencies.[31] The overall effectiveness of the regulation depends on the effectiveness of both the regulation and enforcement functions.

6.3 ORIENTATION OF FINANCING

The structural separation of functions that characterizes the sectoral reform processes in the Region demonstrates three significant trends in the financing dimension. The *first trend* relates to the creation of autonomous national funds that are separate from the ministries of health and that include: public contributions from general taxes; contributions from specific health-related institutions when they exist; and worker and/or employer contributions when steps have been taken to combine the contribution schemes for social security in health with the general state allocations for this purpose. This can be linked both to a public insurance scheme and to multiple insurance schemes with public and private modalities.

The *second trend* refers to the increase in the proportion of public sector financing that comes from intermediate and local State entities from tax yields that are specific to each of these levels and/or from the current national fiscal resources, which are transferred to them in block by the central administrations and are assigned to health actions.

The *third trend* is related to the growing participation, in the composition of overall sector financing in some countries of the Region, of private health insurances and some pre-paid service schemes that are financed with resources from the beneficiaries themselves, and/or their employers, at least in terms of some types of coverage that complement the compulsory plans established by the State.

The combination of these three trends poses new challenges and responsibilities for the ministries of health with regard to the organization of sectoral financing.[32] These changes in sectoral financing require the National Health Authority to:

30. PAHO/WHO, XLII Meeting of the PAHO Directing Council. Resolution CD42.R14. (Washington, D.C., September 25-29, 2000).
31. A. Ferreiro, and L. Sierra, Op. Cit., p. 2.
32. Pedro Crocco, *"Estructura de las Dimensiones de Financiamiento, Aseguramiento y Provisión de Servicios"* (presentation given during training workshop: Performance Evaluation and Strengthening the National Health Authority Steering Role Function for the Sub-region of Central America, the Dominican Republic and Puerto Rico, San Salvador, El Salvador, March 2-4, 2005).

1. Formulate policies that make it possible to modulate and correct distortions in sectoral financing and to increase equity.
2. Monitor the sectoral financing process.
3. Negotiate with the principal providers.
4. Redistribute funds in order to compensate for market asymmetries.
5. Define criteria for resource allocation.

6.4 GUARANTEE OF INSURANCE

The current schemes for social health insurance, which consist of social welfare and social security systems, are not sufficient for tackling existing and emerging problems of exclusion.[33] As a result, the fundamental task of the health authorities is to provide citizens, *regardless of their ability to pay,* with universal basic social protection in health as a means to reduce inequality in access to necessary, effective and quality services.[34]

The State has the responsibility to ensure effective social protection in health, guaranteeing access to health services for all inhabitants or specific plans for special population groups. It is therefore necessary to develop the institutional capacity of the health ministries or secretariats to define the contents of the guaranteed portfolio of entitlements for those citizens protected under public social security in health. Additionally, the State should identify the population groups and territories that will be covered, as well as protect and promote users' rights. Finally, the state should establish mechanisms that make possible the purchase and the provision of services, and define service delivery standards.

GUARANTEE OF INSURANCE

ENSURING ACCESS TO HEALTH SERVICES FOR ALL INHABITANTS OR SPECIFIC BENEFIT PLANS FOR SPECIAL POPULATION GROUPS

1. Definition of a Guaranteed Portfolio of Entitlements
2. Identification of population groups and territories that will be covered

6.5 HARMONIZATION OF HEALTH SERVICE PROVISION

The trend towards decentralization and the changing State responsibilities regarding this Steering Role dimension have created a scenario of increasing participation of multiple social actors (autonomous public, non-governmental organizations, and private actors) in the provision of health services. This has impacted the capacity of the State to coordinate multiple suppliers that often operate in the absence of hierarchical structures.

33. PAHO/WHO, "*Exclusion in Health in Latin America and the Caribbean"*, Series No.1. (Washington D.C.: PAHO/WHO, 2004).
34. 26th Pan American Sanitary Conference, 54th Session of the Regional Committee, Resolution CSP26/12*: "Extension of Social Protection in Health: Joint Initiative of the Pan American Health Organization and the International Labour Organization"* (Washington, D.C.: PAHO/WHO, September 2002).

In this context, health ministries and secretariats should behave more as harmonizers of the different decentralized or deconcentrated public service delivery agencies than as direct administrators of service provision.[35] Therefore, the function of harmonization of health service provision is of special importance in health systems characterized by multiple actors, both public and private, all of whom need to be coordinated in order to offset fragmentation. In other words, harmonization represents the Health Authority's capacity to promote the complementarity of diverse providers and users groups in order to extend health care coverage equitably and efficiently.

One mechanism to ensure harmonization and complementarity is through the integration of the different entities that operate in the system in *health service delivery networks*. In order to accomplish this, two types of processes are necessary: *vertical integration* and *horizontal integration.* Vertical integration refers to the integration of different levels of complexity, ensuring coordination between primary care and more specialized levels of attention. Horizontal integration refers to the integration of providers that offer similar health services within the same level of attention. The steering role plays an important part coordinating the different governmental entities that participate in the network, ensuring that the vision and the goal of the network are shared by all of its members.[36]

HARMONIZATION OF HEALTH SERVICE PROVISION

THE CAPACITY TO PROMOTE THE COMPLEMENTARITY OF THE DIVERSE PROVIDERS AND USERS GROUPS IN ORDER TO EXTEND HEALTH CARE COVERAGE EQUITABLY AND EFFICIENTLY

1. Service planning with regional or functional criterion
2. Promotion of coalitions and provision of incentives for self-regulation
3. Integrated/coordinated delivery networks

The Health Authority should also define criteria for the harmonization of action and management plans from different decentralized or deconcentrated public service provision agencies, and for the allocation of the resources granted to them. Criteria should be based on need, performance and impact. In addition, the NHA should specify the contents of basic public health services that fall under the responsibility of the State, and establish the distribution of competencies and resources among different public management areas.

In order to facilitate the process of transfer of responsibilities, as well as the development of the institutional capacity necessary for their execution, the Health Authority should provide technical cooperation to the decentralized or deconcentrated service provision entities. With the purpose of compensating for the inequities that can be generated by decentralization processes, the Health Authority should also devise redistributive mechanisms for operational and investment costs. Finally, it should establish mechanisms for service management contracts or agreements that can serve as the basis for resource allocation based on a series of performance/need/impact indicators expressed both in terms of processes and results.

35. Edgar Barillas, "*Armonización de la provisión de servicios de salud*".(Washington, D.C.: PAHO/WHO, 2001).
36. James Cercone, "*Opciones de Política para la Integración de los Sistemas y Servicios de Salud*". (Washington, D.C.: PAHO/WHO, forthcoming).

There are other dimensions of harmonization that go beyond the regulation of health service provision and coordination among providers. Among them, it is worth mentioning the certification of professionals, the accreditation of health services, the establishment of minimum quality standards, negotiation, the creation of incentives, contracting of providers, etc. All of these should be applicable to both the public and private sub-sectors.

6.6 EXECUTION OF THE ESSENTIAL PUBLIC HEALTH FUNCTIONS

"It is possible to identify a core set of functions and responsibilities belonging to the health authority, the fulfillment of which is, without exception, necessary in order to ensure good public health."[37] These functions and responsibilities comprise what is called the Essential Public Health Functions (EPHF). The effective performance of the EPHF is crucial because of their high externalities. As the agency responsible for safeguarding the health of the population, the National Health Authority is the main actor in charge of performing the EPHF or ensuring their adequate performance by other actors/entities.

Essential Public Health Functions

EPHF 1.	Monitoring, evaluation and analysis of health status
EPHF 2.	Public health surveillance, research, and control of risks and threats to public health
EPHF 3.	Health promotion
EPHF 4.	Social participation in health
EPHF 5.	Development of policies and institutional capacity for public health planning and management
EPHF 6.	Strengthening of institutional capability for regulation and enforcement in public health
EPHF 7.	Evaluation and promotion of equitable access to necessary health services
EPHF 8.	Human resources development and training in public health
EPHF 9.	Quality assurance in personal and population-based health services
EPHF 10.	Research in Public Health
EPHF 11.	Reduction of the impact of emergencies and disasters on health

The performance of the EPHF is related to all other dimensions of the steering role, sometimes overlapping or complementing them. For example, EPHF 5 and 6 refer to the capacity to develop policies and to regulate public health, respectively. There is a clear relationship between these two functions and the conduct/lead and regulation dimensions of the steering role. Without effective steering role, the EPHF cannot be performed adequately and without adequate performance of the EPHF, health systems cannot achieve its ultimate goal which is the health of the population. Graph 7 shows a matrix with the relationship between the EPHF and the Steering Role dimensions.

37. PAHO/WHO, *"Public Health in the Americas"*, Op. Cit. 8.

As part of the "Public Health in the Americas" Initiative, a tool to measure the performance of the EPHF was developed and applied in 41 countries and territories of the Region providing a dynamic starting point for the analysis of the existing strengths and weaknesses in the LAC Region public health sector. Specifically, the results helped to point out some of the gaps in the steering role as it relates to the performance of the EPHF. The countries' national health authorities have the results, which constitute a fundamental input for the development of strengthening strategies.[38]

GRAPH 7: Relationship between the Essential Public Health Functions (EPHF) and the Steering Role Dimensions

Steering Role Dimensions / EPHF	Conduct/ Lead	Regulation	Orientation of Financing	Guarantee of Insurance Coverage	Harmonization of health service provision
1. Monitoring, evaluation and analysis of health status	X				
2. Public health surveillance, research, and control of risks and threats to public health	X	X			
3. Health Promotion	X	X			
4. Social participation in health	X				
5. Development of policies and institutional capacity for public health planning and management	X	X	X	X	X
6. Strengthening of institutional capability for regulation and enforcement in public health	X	X			X
7. Evaluation and promotion of equitable access to necessary health services	X		X	X	X
8. Human resources development and training in public health	X	X			X
9. Quality assurance in personal and population-based health services	X	X			X
10. Research in Public Health	X	X	X	X	X
11. Reduction of the impact of emergencies and disasters on health	X	X	X		X

38. Ibid.

VII. CHALLENGES FOR STRENGTHENING THE STEERING ROLE

The countries of the Region of the Americas have taken important steps toward strengthening the steering role function. However, each country, given its context and opportunities, should undertake a self-evaluation exercise to analyze the performance of its steering role capacity, as well as to define possible strengthening actions.

To this end, countries should consider the lessons learned that begin to arise from the experience at the country level, such as: ***(i)*** *the establishment of priorities and sanitary objectives requires accurate, reliable and timely information;* ***(ii)*** *the elaboration of health policies and strategies should be followed by evaluation efforts;* ***(iii)*** *the legal framework that backs the Health Authority in the performance of its responsibilities should be congruent with the capacity of the Health Authority to lead the sector;* ***(iv)*** *to be effective, the regulatory role should also include monitoring and enforcement;* ***(v)*** *the Health Authority should be involved in the negotiation, coordination and evaluation of technical cooperation to ensure that it will be effective, responsive to the identified needs and sustainable; and* ***(vi)*** *qualified human resources are crucial to the execution of the steering role functions.*

BOX 3:

STRENGTHENING THE STEERING ROLE CAPACITY OF THE MINISTRY OF HEALTH OF COSTA RICA

At the beginning of the nineties, a national debate was initiated on how to face the challenges that affected the Ministry of Health (MOH) and the Costa Rican Social Security Fund (CCSS). Problems such as fiscal deficit, foreign and internal debt, excessive centralization, inefficiency and a reduction in the State's contribution to health sector financing affected the performance of the health sector. In 1994, important structural reforms in the organization, financing, and delivery of health services were carried out, reinforcing the basic principles of universal coverage and the public financing of the CCSS. The Project on Steering Role and Strengthening of the Ministry of Health was formulated to support the MOH to effectively exercise the steering role in health, transferring to the CCSS the functions related to health services delivery and financing while the regulation and management functions were to be developed by the Ministry of Health. The goal was to eliminate duplications with regard to human resources and infrastructure. The redefinition of the institutional roles in the health system, produced by the reforms, required a greater capacity of the Ministry of Health to perform the steering role, which includes leading the sector, regulating health goods and services, measuring EPHF performance, steering the financing of the sector, monitoring insurance, and harmonizing services delivery. The achievements from the beginning of the project in 1994 to date are numerous. In 2002, the Ministry of Health took additional steps to reorganize its role to better respond to the growing demands that required an effective exercise of the steering role for the sector.

The great challenge is to view the steering role as a government responsibility and as a high level function; and to direct strengthening efforts toward the development of planning, financing, resources assignment and development, knowledge generation and public management functions.

VIII. METHODOLOGICAL GUIDELINES

8.1 INSTRUCTIONS

8.1.1 PURPOSE

To generate a discussion centered on analyzing and assessing how the National Health Authority (NHA) carries out its steering role functions. This exercise will contribute to the identification of strengths and weaknesses in the performance of the steering role, with the goal of generating concrete proposals for strengthening the NHA steering role function.

8.1.2 WORK METHODOLOGY

1. Organization of the participants into working groups. Selection of a moderator and a *rapporteur*. Each group will have a facilitator.

2. Group discussion of the questions related to Dimensions 1 (Conduct/Lead) and 2 (Regulation). Individual responses to each question.

3. Group discussion of the questions related to Dimensions 3 (Orientation of Financing), 4 (Guarantee of Insurance) and 5 (Harmonization of Service Provision). The group should agree on the responses; if there are differences of opinion, they should be noted.

4. Evaluation of questionnaires and tabulation of results.

5. Presentation of results.

6. Reflections on strengths and weaknesses of the NHA steering role.

7. Generation of proposals for strengthening the NHA steering role function.

8. Evaluation of the Workshop.

8.1.3 STRUCTURE

The performance evaluation of the NHA steering role consists of two stages: (1) the Mapping of the National Health Authority, and (2) the application of the Instrument for the Performance Evaluation of the NHA Steering Role.

8.1.3.1 FIRST STAGE: **Guidelines for Mapping the NHA**

Who Does It? - Characterization of the National Health Authority

- Definition of the legal framework
- Identification of the organizations/entities/agencies legally responsible for the steering role function
- Identification of the organizations/entities/agencies that currently carry out the steering role function with or without a legal framework.

8.1.3.2 SECOND STAGE: **Instrument for Performance Evaluation and Strengthening of the NHA Steering Role**

What Do They Do? –Performance of the steering role by the organizations/entities/agencies that make up the NHA.

The Questionnaire is organized into 5 sections. Each section corresponds to a dimension of the steering role, and includes the components of each dimension.[1] The first two sections contain closed questions; the last three sections have open questions.

8.1.3.2.1 Closed Questions

Responses are provided as indicated in the Score Chart (see next section). Spaces for responses to open questions are also included in case additional observations are necessary.

1. Conduct/Lead
2. Regulation

1. The only dimension which is not formally included is the execution of Essential Public Health Functions – please refer to graph 7 "Relationship between the Essential Public Health Functions (EPHF) and the Steering Role Dimensions" (page 18).

8.1.3.2.2 Open Questions

The questions are concrete and specific. They are discussed as a group and the responses are agreed upon as a group. A rapporteur is assigned to take notes. It is not necessary that all parties agree; when there is difference of opinion, it should be indicated.

3. Orientation of Financing

4. Guarantee of Insurance

5. Harmonization of Service Provision

8.1.4 SCORE TABLE FOR CLOSED QUESTIONS

The following table presents the scale for the scores that can be assigned as responses to the questions under sections 1 and 2, Conduct/Lead and Regulation. In all cases, scores should be assigned in the 0 to 5 range.

At one extreme, a score of "0" implies that the activity analyzed is not carried out at all. At the other extreme, a score of "5" denotes that the activity is performed with a high degree of satisfaction. Scores between 1 and 4 denote intermediate levels of performance of the activity.

Score	Equivalence	Scale
0	0%	Null
1	20%	Very poor
2	40%	Poor
3	60%	Normal
4	80%	High
5	100%	Very high

8.1.5 COMMENTS AND RESPONSES TO OPEN QUESTIONS

In the first two sections, there are several instances in which it is possible to make observations or comments in a blank space provided for this purpose, so that the participants can expand their responses or add issues they consider important. This does not mean that each one of these blank spaces needs to be filled, but is instead merely an opportunity for feedback if deemed necessary.

The goal of the last three sections, which contain the open questions, is to achieve a discussion centered on the issues addressed in each question. There will be a moderator to guide the discussion to ensure that all questions are answered and that time limits are met, and to avoid discussions of unrelated issues. The responses of each work group will be transcribed and presented together with the responses to the questionnaires from the first two sections, in order to be processed and tabulated.

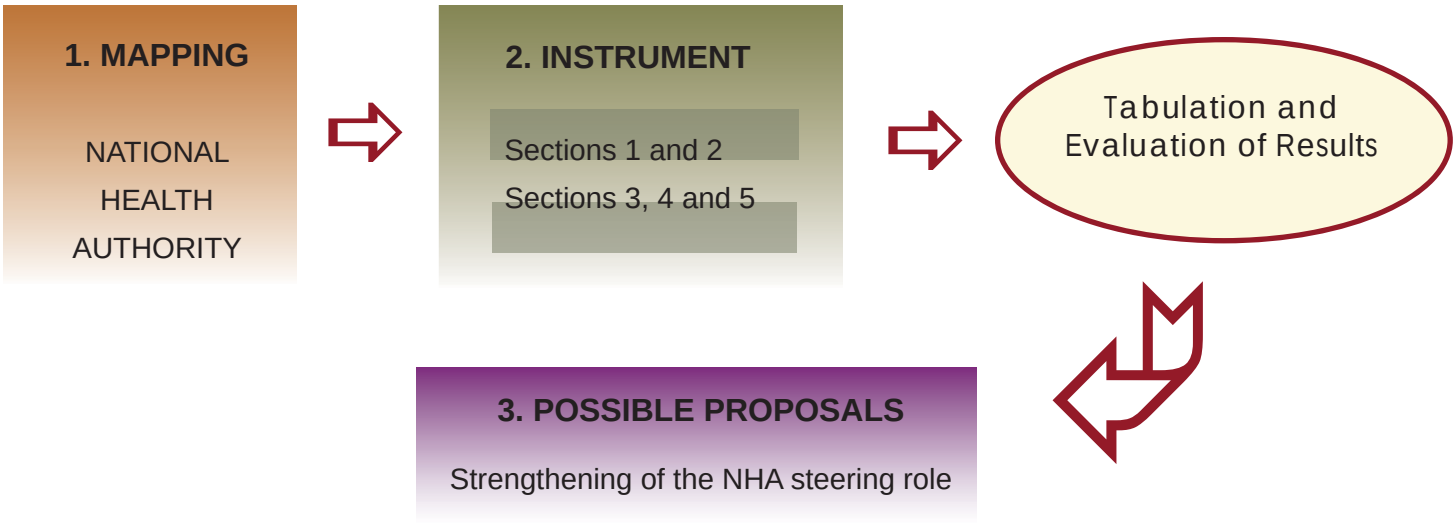
8.1.6 GENERATION OF PROPOSALS FOR STRENGTHENING THE NHA STEERING ROLE

Once the work groups have completed their surveys and responses, these will be submitted. The data will be processed and tabulated and presented to the work groups in preliminary form as input for the subsequent phase: *The identification of proposals for strengthening the steering role.*

The work groups will then reconvene in order to identify possible options for strengthening the NHA steering role. It is important that the options proposed can be translated into concrete actions.

Final Product: Each work group will submit its proposal of strategies and actions to strengthen the steering role of the National Health Authority, using as a foundation the analysis of the results from the application of the Mapping Tool and Performance Evaluation instrument. They will also submit a tentative timetable for the application of the Mapping tool and the Performance Evaluation instrument in their respective countries.

CRITICAL PATH: STEPS TO FOLLOW



Confidentiality

The information provided is strictly confidential and will only be available once it has been processed, so that the absolute confidentiality of participants' individual answers can be guaranteed.

8.2 MAPPING OF THE NATIONAL HEALTH AUTHORITY

The Mapping process is carried out in three successive stages. The *first stage* includes the identification of the legal framework for each dimension of the steering role. The goal of the *second stage* is to determine the organizations/entities/agencies that are legally responsible for carrying out the steering role. Finally, the *third stage* refers to the organizations/entities/agencies that are actually implementing the activities that correspond to the steering role with or without the legal mandate to do so. It is recommended that the three stages be completed at the national level; the regional, provincial or departmental level; and the local level. Please use the following guidelines when filling in the table for each stage and at each of the three levels:

8.2.1 LEGAL FRAMEWORK

Identify the legal instrument(s) that characterizes the scope and responsibilities granted to the organizations/entities/agencies to carry out the steering role. If possible, indicate the law that defines the responsibilities (a copy of the law should be included in the Annex). In case no legal mandate exists to support an activity, draw a horizontal line to indicate nonexistence.

8.2.2 LEGALLY RESPONSIBLE ORGANIZATION(S)

Identify the country's legal mandates for the organizations/entities/agencies that are legally responsible for carrying out the steering role. When no legal mandate exists, draw a horizontal line to indicate that.

8.2.3 EXECUTING ORGANIZATION (S)

Identify which organizations are executing the steering role activities.

Functional Area: Conduct/Lead

Activities	Central Level			Intermediate/Regional Level			Local Level		
	Legal framework	Legally responsible institution(s)	Executing institution	Legal framework	Legally responsible institution(s)	Executing institution	Legal framework	Legally responsible institution(s)	Executing institution
Analysis of health status									
Definition of health priorities and objectives									
Formulation of health policies, plans, programs and strategies									
Management, consensus-building and mobilization of actors and resources									
Health promotion and social participation in health									
Political and technical coordination of international cooperation in health									
Political and technical participation in economic integration agencies at the regional and sub-regional level									
Performance evaluation of the health system									
Monitoring and evaluation									

Functional Area: Regulation

Activities	Central Level			Intermediate/Regional Level			Local Level		
	Legal framework	Legally responsible institution(s)	Executing institution	Legal framework	Legally responsible institution(s)	Executing institution	Legal framework	Legally responsible institution(s)	Executing institution
Development and improvement of national health legislation									
Regulation of public health insurance systems / sub-systems									
Regulation of private health insurance schemes									
Regulation and control of public and private health service provision									
Accreditation of public and private health institutions									
Regulation and control of medical supplies									
Regulation and control of health technology									
Regulation and control of basic consumer goods and supplies									
Regulation and sanitary control of public establishments									
Regulation and sanitary control of the environment									
Regulation and certification of human resources in health									
Regulation and control of initial and continuing education programs in health sciences									
Harmonization of health legislation with that of the countries participating in regional integration processes									

Functional Area: Execution of the Essential Public Health Functions

Activities	Central Level			Intermediate/Regional Level			Local Level		
	Legal framework	Legally responsible institution(s)	Executing institution	Legal framework	Legally responsible institution(s)	Executing institution	Legal framework	Legally responsible institution(s)	Executing institution
EPHF 1 Monitoring, evaluation and analysis of health status									
EPHF 2 Public health surveillance, research, and control of risks and threats to public health									
EPHF 3 Health promotion									
EPHF 4 Social participation in health									
EPHF 5 Development of policies and institutional capacity for public health planning and management									
EPHF 6 Strengthening of institutional capacity for regulation and enforcement in public health									
EPHF 7 Evaluation and promotion of equitable access to necessary health services									
EPHF 8 Human resources development and training in public health									
EPHF 9 Quality assurance in personal and population-based health services									
EPHF 10 Public health research									
EPHF 11 Reduction of the impact of emergencies and disasters on health									

Functional Area: Orientation of Financing

Activities	Central Level			Intermediate/Regional Level			Local Level		
	Legal framework	Legally responsible institution(s)	Executing institution	Legal framework	Legally responsible institution(s)	Executing institution	Legal framework	Legally responsible institution(s)	Executing institution
Formulate policies to orient and correct distortions in sectoral financing									
Monitor the sectoral financing process									
Devise redistributive mechanisms for operational and investment costs, in order to compensate for the inequities that can be generated by decentralization processes									
Influence budgetary distribution									

Functional Area: Guarantee of Insurance

Activities	Central Level			Intermediate/Regional Level			Local Level		
	Legal framework that contains it	Legally responsible institution(s)	Executing institution	Legal framework that contains it	Legally responsible institution(s)	Executing institution	Legal framework that contains it	Legally responsible institution(s)	Executing institution
Define the contents of the guaranteed portfolio of entitlements									
Monitor compliance with the coverage of the plans, guaranteeing that no citizen is excluded									
Identify the population group, the territory and the surveillance mechanisms that will guarantee insurance coverage for the population									

Functional Area: Harmonization of Service Provision

Activities	Central Level			Intermediate/Regional Level			Local Level		
	Legal framework that contains it	Legally responsible institution(s)	Executing institution	Legal framework that contains it	Legally responsible institution(s)	Executing institution	Legal framework that contains it	Legally responsible institution(s)	Executing institution
Organize action plans and service networks of public and private institutions to avoid duplication of health services in the country									
Establish criteria for service management contracts that serve as the basis for resource allocation									
Define criteria for health care quality									
Define criteria for accreditation of provider institutions									
Establish criteria for the incorporation of health technology									

8.3 INSTRUMENT

CONDUCT/LEAD

CAPACITY TO GUIDE THE SECTOR'S INSTITUTIONS AND MOBILIZE INSTITUTIONS AND SOCIAL GROUPS IN SUPPORT OF NATIONAL HEALTH POLICY

1.	ANALYSIS OF HEALTH STATUS	SCORE
1.1	**Collection and Availability of Information**	
a.	Information sources on health status are easily identified and accessible within the National Health System.	
b.	The National Health Authority carries out periodic evaluations of the information systems and strategic information needs, and facilitates the availability of these evaluations.	
c.	The National Health Authority guarantees the availability of morbidity and mortality indicators for the national, departmental and/or local levels.	
d.	The National Health Authority promotes and guarantees the availability of up-to-date information on access to health services by socioeconomic group, geographical division, ethnic group and gender.	
e.	The National Health Authority promotes and guarantees the availability of up-to-date information on lifestyle habits and health risks.	
f.	The National Health Authority promotes and guarantees the availability of information on environmental risks.	
g.	The National Health Authority has effective coordination mechanisms for the exchange of information between the national and sub-national levels.	

1.2	Control of Information Quality	
a.	The National Health Authority has instruments and processes for controlling the quality of the information.	
b.	There is a clear systematization of population statistics.	
c.	The population statistics provide quality information.	
d.	The health information compiled is timely and pertinent.	
e.	The morbidity and mortality information compiled is quality and up-to-date, in terms of coverage and precision.	
1.3	**Institutional Capacity for Conducting Health Situation Analysis**	
a.	The compiled information is analyzed and serves as a resource for generating health intelligence (technical capacity).	
b.	Decision-making is carried out based on the compiled and analyzed information.	
c.	The National Health Authority has the human, material, financial and organizational resources necessary for carrying out the health situation analysis.	
d.	The National Health Authority disseminates information on the state of the population's health through several mechanisms.	

2.	**DEFINITION OF HEALTH PRIORITIES AND OBJECTIVES**	
2.1	**Elaboration of Diagnoses Focused on Key Issues**	
a.	The National Health Authority identifies existing gaps in health needs and the current supply of health services.	
b.	*National Health Objectives* have been defined.	
c.	The health priorities determined by the country are used as inputs for the definition of the *National Health Objectives.*	
d.	The current health status profile serves as the basis for the definition of the *National Health Objectives*.	
e.	The health priorities defined by the country are in accordance with the *Millennium Development Goals (MDGs).*	
2.2	**Institutional Capacity to Set National Health Priorities and Objectives**	
a.	The National Health Authority is responsible for setting health priorities.	
b.	The National Health Authority has funds and allocates them in order to make viable the processes leading to the definition of priorities and *National Health Objectives*.	
c.	The organizational structure of the National Health Authority facilitates the definition of priorities and *National Health Objectives*.	

3.	**FORMULATION OF HEALTH POLICIES, PLANS, PROGRAMS and STRATEGIES**	
3.1	**Preparation and Development of Health Policies, Plans, Programs and Strategies**	
a.	The National Health Authority assumes the leadership in the development of the *National Public Health Policy Agenda*.	
b.	The National Health Authority defines and implements health policies.	
c.	The National Health Authority prepares and periodically updates the country's *National Health Policy*.	
d.	The *National Health Policy* defines the actors and their specific responsibilities for attaining the *National Health Objectives*.	
3.2	**Dissemination of Health Policies, Plans, Programs and Strategies**	
a.	The entities that make up the National Health Authority; other governmental sectors; and civil society have easy access to the country's *National Health Policy* document.	
b.	The National Health Authority disseminates/discusses the *National Public Health Policy Agenda* with the *Unions*.	
c.	The National Health Authority disseminates/discusses the *National Public Health Policy Agenda* with *Private Sector Institutions.*	
d.	The National Health Authority disseminates/discusses the *National Public Health Policy Agenda* with *Municipalities* or *Decentralized Levels.*	

e.	The National Health Authority systematically disseminates/discusses the *National Public Health Policy Agenda* with *Non-governmental Organizations*.	
f.	The National Health Authority disseminates/discusses the *National Public Health Policy Agenda* with *Community-based Organizations*.	
3.3	**Monitoring and Evaluation of Health Policies, Plans, Programs and Strategies**	
a.	The National Health Authority has a monitoring and evaluation system for measuring the impact of health policies.	
b.	The National Health Authority promotes monitoring and evaluation mechanisms that are independent of the implementation of health policies.	
c.	The National Health Authority compiles, analyzes, integrates and evaluates information from multiple sources.	
d.	The National Health Authority uses the information from the evaluation exercise to define and implement public health policies.	
4.	**MANAGEMENT, CONSENSUS-BUILDING, MOBILIZATION OF ACTORS AND RESOURCES**	
4.1	**Consensus-Building and Leadership**	
a.	The National Health Authority promotes the achievement of consensus with the multiple actors in the health sector in order to make viable the definition of the *National Health Policy*.	
b.	The National Health Authority spearheads the national process that leads to the formulation of health objectives and national and sub-national health policies.	

c.	The National Health Authority builds coalitions and partnerships in the process of constructing the *National Health Policy*.	
d.	The National Health Authority internal communication system disseminates information on the performance of the steering role function (directed to institutional personnel at all levels).	
e.	The National Health Authority external communication system disseminates information about the performance of the steering role to interested parties outside the health sector.	
f.	The National Health Authority has a formal definition of its vision and mission.	
g.	The National Health Authority widely disseminates its mission and vision.	
4.2	**Resource Mobilization**	
a.	The National Health Authority mobilizes the health sector's resources (material, human, financial and organizational) to comply with the *National Health Policy*.	
b.	The National Health Authority achieves concrete results with the resource mobilization process.	
c.	The National Health Authority coordinates and collaborates with academic institutions and scientific societies on human resource development for the health sector.	

5.	**HEALTH PROMOTION, SOCIAL PARTICIPATION AND CONTROL IN HEALTH**	
5.1	**Design and Promotion of Public Health Policies**	
a.	The National Health Authority directs the preparation of standards and interventions aimed at promoting healthy behaviors and environments.	
b.	The National Health Authority defines and implements actions to strengthen the sub-national levels in their health promotion activities.	
5.2	**Promotion of Active Participation of Civil Society in the Identification of Problems, Planning and Implementation of Actions in Health**	
a.	The National Health Authority stimulates and promotes the development of civil society participation in the identification of problems, planning and implementation of actions in the health field.	
b.	The National Health Authority requests contributions from civil society/communities for the definition of the *National Health Objectives*.	
c.	The National Health Authority has the capacity to advise and support the sub-national levels in the development and strengthening of social participation mechanisms for public health decision-making.	
5.3	**Promotion of Inter-Sectoral Coordination**	
a.	The National Health Authority periodically convenes representatives from community organizations, the private sector and other State sectors for the purpose of planning actions directed at the achievement of health promotion goals.	

6.	**HARMONIZATION OF INTERNATIONAL TECHNICAL COOPERATION IN HEALTH**	
6.1	**Negotiation with Donors and other International Cooperation Agencies**	
a.	The National Health Authority initiates, leads and carries out negotiation processes with international cooperation agencies in the health field.	
6.2	**Coordination of International Cooperation in Health**	
a.	The National Health Authority develops health projects to submit for consideration by international cooperation agencies.	
b.	Impact of recent cooperation projects on the development and formulation of policies in the health sector.	
6.3	**Monitoring and Evaluation of Counterparts in International Cooperation Projects**	
a.	The National Health Authority monitors the international counterpart(s) in cooperation projects.	
b.	The National Health Authority has professionals trained in the systematic monitoring of international cooperation projects.	

7.	**PARTICIPATION (POLITICAL AND TECHNICAL BODIES) IN INTERNATIONAL, REGIONAL AND SUB-REGIONAL FORUMS**	
7.1	**Political and Technical Articulation with International, Regional and Sub-regional Organizations**	
a.	The National Health Authority actively participates as a spokesperson and representative of the health sector in international, regional and sub-regional organizations.	

7.2	Implementation of Sub-regional, Regional and Global Agreements	
a.	The National Health Authority coordinates, supervises and implements sub-regional, regional and global agreements and commitments in the country.	

8.	HEALTH SYSTEM PERFORMANCE EVALUATION	
8.1	**Measurement of the Achievement of Goals**	
a.	The National Health Authority defines goals that serve as a point of reference for the health system performance evaluation.	
b.	The National Health Authority has mechanisms to measure the achievement of the established goals.	
c.	The National Health Authority has the technical and organizational capacity to determine the amount of progress toward achieving the goals.	

8.2	Measurement of the Resources Used and Estimation of the Efficiency of the Health System	
a.	The NHA allocates technical and financial resources to measure the health system resources that are invested in meeting the targets.	
b.	The NHA allocates technical and financial resources to determine the information that is required to estimate the efficiency of the system.	
c.	The NHA determines the level of efficiency with regard to the utilization of the resources invested to meet the targets.	

8.3	Performance Evaluation	
a.	The National Health Authority identifies its weaknesses in the performance of the steering role.	
b.	The National Health Authority identifies operational bottlenecks in the health sector that may impede the performance of the steering role.	
c.	The NHA is responsible for the performance evaluation of the health system.	
d.	The NHA prepares and implements policies in order to improve the achievements and the efficiency of the health system based on the performance evaluation.	

REGULATION

DESIGN OF THE HEALTH REGULATORY FRAMEWORK THAT PROTECTS AND PROMOTES HEALTH AND GUARANTEES COMPLIANCE

1.	INSTITUTIONAL AND LEGAL FRAMEWORK FOR PERFORMANCE OF THE REGULATORY FUNCTION	SCORE
1.1	**Development and Improvement of the Legal Framework**	
a.	The legal framework confers on the NHA the performance of the regulatory function either directly or through specialized agencies.	
b.	The existing regulatory framework, either directly or through regulatory agencies, promotes equity in access to health goods, products and services.	
c.	The existing regulatory framework, either directly or through regulatory agencies, promotes the participation of the different involved sectors.	
d.	The existing regulatory framework, either directly or through regulatory agencies, promotes transparency in terms of accountability.	
e.	The National Health Authority impacts the formulation of health regulations.	
f.	The regulatory framework in the health services sector is complete, pertinent and up-to-date.	
g.	The regulatory framework in the health technologies sector is complete, pertinent and up-to-date.	
h.	The regulatory framework in the food sector is complete, pertinent and up-to-date.	

i.	The regulatory framework in the medical drugs and supplies sector is complete, pertinent and up-to-date.	
j.	The regulatory framework in the environmental sector is complete, pertinent and up-to-date.	
k.	There are laws that lack enforcement in the health sphere, or in other areas that influence health.	
l.	The NHA updates the regulations directed at protecting the health and safety of the population, with the objective of better responding to changing needs.	
1.2	**Effectiveness of the Legal Framework**	
a.	The existing legal framework is effective in the performance of the regulatory function.	
b.	The performance of the regulatory function has turned out to be positive in terms of its contribution to improving the population's health conditions.	
c.	The National Health Authority coordinates inter-sectorally in order to perform the regulatory function.	
1.3	**Institutional Capacity to Perform the Regulatory Function**	
a.	The dependent bodies that make up the National Health Authority know about the regulations.	
b.	The National Health Authority assumes the regulatory function.	
c.	The National Health Authority is autonomous with respect to political and economic pressures on the formulation of regulations.	

d.	The National Health Authority performs the regulatory function efficiently with respect to trained human resources .	
e.	The National Health Authority performs the regulatory function efficiently with respect to sufficient and available human resources.	
f.	The National Health Authority performs the regulatory function efficiently with respect to available financial resources.	
g.	The National Health Authority performs the regulatory function efficiently with respect to facilities.	
h.	The National Health Authority performs the regulatory function efficiently with respect to supplies and technologies.	

2.	**ENFORCEMENT AND CONTROL**	
2.1	**Capacity of the National Health Authority to Enforce Regulations**	
a.	The National Health Authority enforces regulations by means of clear mandates and procedures established in applicable regulations.	
b.	The National Health Authority enforces the regulations through the existence of effective sanctions with regard to the magnitude of the damage done to individual or collective health.	
c.	The National Health Authority is recognized as “the authority” by the diverse actors involved.	
d.	The National Health Authority enforces the regulations through an acceptable level of interaction with those being regulated with respect to the dissemination of standards and applicable procedures.	
e.	Monitoring or evaluation procedures exist for the health services sector.	

f.	Monitoring or evaluation procedures exist for the technology sector.	
g.	Monitoring or evaluation procedures exist for the food sector.	
h.	Monitoring or evaluation procedures exist for the drugs sector.	
i.	Monitoring or evaluation procedures exist for the environmental sector.	
j.	The National Health Authority shares its enforcement function with other institutions.	
k.	The National Health Authority efficiently performs its enforcement and control function with respect to trained human resources.	
l.	The National Health Authority efficiently performs its enforcement and control function with respect to sufficient and available human resources .	
m.	The National Health Authority efficiently performs its enforcement and control function with respect to sufficient financial resources.	
n.	The National Health Authority efficiently performs its enforcement and control function with respect to facilities.	
o.	The National Health Authority efficiently performs its enforcement and control function with respect to supplies and technology.	

2.2	**Coordination and Transparency**	
a.	The National Health Authority performs the enforcement and control functions with transparency.	
b.	The different sectors involved perceive that the National Health Authority performs its enforcement function with a high level of transparency.	
c.	The central entities assist the sub-national levels with the enforcement and control function.	
d.	The overall performance of the enforcement function is positive in terms of the interrelationship between the regulation and control functions.	
3.	**REGULATION AND CONTROL OF MEDICAL SUPPLIES (DRUGS, EQUIPMENT AND DEVICES) AND HEALTH TECHNOLOGY**	
3.1	**Regulation of the Pharmaceutical Sector**	
a.	The NHA maintains and updates records of drugs dispensed to the public, based on principles of safety and efficacy.	
b.	There are standards for the importation, marketing, advertising, distribution and consumption of drugs.	
c.	The NHA plays an active role in the evaluation or the supervision of the evaluation of generic drugs.	
d.	The NHA implements price control measures to guarantee drug availability and access for the population.	

3.2	**Regulation and Control of Medical Equipment and Supplies**	
a.	The NHA maintains and updates medical equipment and supply records, based on principles of safety and efficacy.	
b.	There are standards for the importation, marketing, advertising, distribution and utilization of medical equipment and supplies.	
c.	The NHA implements price control measures to guarantee availability and access to medical equipment and supplies for the population.	
3.3	**Regulation and Assessment of Health Technology**	
a.	There are standards for the assessment of health technologies.	
b.	There are public or private agencies devoted to evaluating health technologies.	
c.	The NHA uses the information produced in the evaluations to develop effective recommendations concerning the available technology, or concerning suppliers and users.	

4.	**HEALTH REGULATION AND CONTROL OF GOODS AND SERVICES**	
4.1	**Standards on Consumer Goods**	
a.	There are sanitary standards for the importation, marketing, distribution and utilization of consumer goods.	
b.	The NHA enforces compliance with these standards.	
c.	The NHA has institutional mechanisms and resources to effectively perform this function.	

4.2	Sanitary Licenses for Public Establishments	
a.	There are sanitary standards for the operation of public establishments.	
b.	The sanitary standards for the operation of public establishments are complete, pertinent and up-to-date.	
c.	The NHA enforces compliance with these standards.	
d.	The NHA has the institutional mechanisms and resources to effectively perform this function.	

5.	STANDARDS FOR THE SANITARY CONTROL OF THE ENVIRONMENT	
a.	The NHA exhibits a high degree of involvement in the regulation of the environment.	
b.	There are complete, pertinent and up-to-date standards for protection from environmental risks.	
c.	The NHA enforces compliance with environmental regulations that affect health.	
d.	The NHA exhibits a high degree of coordination and collaboration with the environmental authorities to reduce health risk factors.	

6.	REGULATION AND CERTIFICATION OF HUMAN RESOURCES FOR HEALTH	
6.1	**Characterization of the Health Workforce in the Country**	
a.	The NHA characterizes the country's health workforce, identifying the gaps to fill in terms of composition and availability according to the epidemiological and demographic profiles.	
b.	The NHA exhibits a high degree of coordination with the other sectors and levels involved.	
6.2	**Establishment of Standards and Criteria for the Accreditation and Certification of Health Professionals**	
a.	The NHA determines certification procedures for health professionals.	
b.	The NHA employs effective mechanisms to guarantee the quality of human resources for health.	

6.3	Establishment of Standards and Criteria for the Accreditation of Institutions That Train Health Professionals	
a.	The institutions that train health professionals have and implement accreditation procedures.	
b.	The mechanisms used to guarantee the quality of training programs for health professionals are effective.	

ORIENTATION OF FINANCING

TO GUARANTEE, MONITOR AND MODULATE THE COMPLEMENTARITY OF RESOURCES FROM DIVERSE SOURCES IN ORDER TO ENSURE EQUITABLE ACCESS TO HEALTH SERVICES FOR THE POPULATION

1.	**FORMULATION OF POLICIES THAT MAKE IT POSSIBLE TO ORIENT AND CORRECT DISTORTIONS IN SECTORAL FINANCING AND TO INCREASE EQUITY**
a.	Does the NHA formulate and establish policies directed at promoting equity through financial redistribution mechanisms?
b.	To what degree the NHA manages to influence resource allocation in the sector, with the ultimate goal of increasing equity? This includes efforts to ensure that the financing is progressive, sufficient and synergistic.
c.	What mechanisms does the NHA have to influence sectoral financing to achieve equity? Analyze whether they are regulatory, management, supervision, feedback or other types of processes, and whether they are linked to specific policies.
d.	Has the NHA recently achieved, through policy development, the objective of orienting sectoral financing?
2.	**MONITORING OF THE SECTORAL FINANCING PROCESS**
a.	Does the NHA have the capacity to conduct close, systematic monitoring of the sectoral financing process and of the spending of the allocated funds?
b.	What mechanisms does the NHA use to carry out the monitoring of sectoral financing from the perspective of quality, efficiency and transparency? For example: mapping of funds, national health accounts, studies of efficiency and quality.
c.	Does the NHA provide support or feedback to sectoral institutions about the knowledge/expertise acquired in the process of monitoring sectoral financing?

3.	**NEGOTIATION WITH PRINCIPAL PROVIDERS**
3.1	**Negotiation and Coordination with the Treasury**
a.	Evaluate the NHA in terms of its ability to negotiate and coordinate financial resources with the Treasury.
b.	Are there open, fluid communication channels? Is there willingness for dialogue between the NHA and the Treasury?
c.	Is the NHA trained and equipped to effectively express its needs to the Treasury and national fiscal authorities?
d.	What is the actual potential of the NHA to influence the origin and macro-allocation of financial resources for the health sector?
3.2	**International Cooperation**
a.	What is the relative weight of international cooperation in the health sector, in terms of its real financial contribution to sectoral expenditure and investment?
b.	Evaluate the NHA in terms of its ability to negotiate and coordinate financial resources with international cooperation actors, both lenders and donors.
c.	Is the NHA trained and equipped to effectively articulate its needs with international cooperation actors?
d.	Is the NHA aware and does it act to ensure that the different alternative sources of external financing do not affect the sustainability of the system?
e.	What is the NHA's actual potential for influencing the allocation of international cooperation resources in the health sector?

4.	REDISTRIBUTION OF FUNDS TO COMPENSATE FOR MARKET ASYMMETRIES
4.1	**Redistribution of Funds among Insurance Systems/Schemes**
a.	What financial mechanisms can the NHA use to achieve effective redistribution of funds among different insurance systems/schemes in order to guarantee equitable access? *For example, the transfer of subsidies among different schemes (contributory and subsidized), or the creation of national solidarity funds or risk compensation funds*.
b.	Evaluate the NHA's performance in the redistribution of funds among insurance systems/ schemes.
4.2	**Redistribution of Funds among Regional Levels**
a.	What financial mechanisms can the NHA use to achieve effective redistribution of funds among different regional levels in order to guarantee equitable access?
b.	Has the NHA developed expenditure distribution mechanisms in order to compensate for the inequities that can be generated by decentralization processes?
c.	Evaluate the NHA's performance in the redistribution of funds among regional levels in order to promote equity.

5.	DEFINITION OF CRITERIA FOR RESOURCE ALLOCATION
a.	What is the NHA's role in the definition of criteria for resource allocation? (This is understood as the development of criteria for selecting which interventions and services should be guaranteed and prioritized, and in turn allocating the resources necessary for their due implementation.)
b.	Evaluate the NHA's role in the definition and promotion of the use of criteria for resource allocation to decentralized or deconcentrated public health facilities, based on need, performance and impact.
c.	What has been the NHA's role in purchasing health services, from the perspective of representing the interests of the most vulnerable populations?

GUARANTEE OF INSURANCE

GUARANTEE OF ACCESS TO A PORTFOLIO OF ENTITLEMENTS FOR ALL INHABITANTS, OR SPECIFIC PLANS FOR CERTAIN POPULATION GROUPS

1.	**DEFINITION OF A GUARANTEED PORTFOLIO OF ENTITLEMENTS**
a.	Does the NHA inform all inhabitants or certain population group(s), as the case may be, about what health goods and services they have rights to under a guaranteed portfolio of entitlements?
b.	Is the information that defines the scope of the guaranteed health goods and services publicly available and accessible? Is it clearly stipulated that the goods and services should demonstrate an acceptable level of quality?
c.	When the guaranteed portfolio of entitlements is updated or modified—for example, with the incorporation of new HIV/AIDS treatments— does the NHA inform the population and stakeholders about these changes in their rights to certain benefits?
2.	**IDENTIFICATIONS OF POPULATIONS AND TERRITORIES THAT WILL BE COVERED BY THE GUARANTEED PORTFOLIO OF ENTITLEMENTS**
2.1	**Protection of Users' Rights**
a.	Are users' rights regarding the guaranteed portfolio of entitlements to which they are entitled comprehensible and accessible?
b.	Is there a formal entity in charge of protecting users' rights? Are there specific mechanisms established for channeling claims and settling complaints? Is this process backed by an adequate budget allocation for this purpose?
c.	Does the NHA evaluate periodic satisfaction surveys, carried out directly or indirectly, as part of the mechanisms for evaluating insurers and service providers?

2.2	**Dissemination of Rights**
a.	Analyze the degree of dissemination of information about users' rights with regard to the guaranteed portfolio of entitlements to which users are entitled. Is information about these rights widely available and accessible in the health facilities that the users utilize? Is it available and accessible in different geographical areas, for different population groups, and in a format that is understandable and that effectively transmits the message?
b.	Does the NHA promote and disseminate the concept that the user who is informed about his/her rights is one additional enforcement agent?
3.	**REGULATION AND CONTROL OF PUBLIC AND PRIVATE COMPLIANCE WITH INSURANCE PLANS**
3.1	**Definition of Service Delivery Standards**
a.	Do standards exist and are they applied in order to regulate the quality of services provided by the NHA?
3.2	**Monitoring of Public and Private Compliance with Insurance Plans**

The monitoring of public and private compliance with insurance plans is a key part of the regulation of the health insurance market. This implies that once the rules of the game have been defined, the NHA should ensure compliance with coverage plans by both public entities and private insurers. For example:

a. Do they guarantee monitoring mechanisms so that no beneficiary is excluded from insurance schemes due to age-related risks or pre-existing conditions?

b. Is the activity and performance of health insurance providers regulated and enforced (directly or through superintendencies or similar agencies?).

Describe the role of the NHA in the execution of the enforcement function, specifically with regard to the following activities

c. Formulation, dissemination and monitoring of strategies and standards with regard to health services plans, as well as insurance enrollment mechanisms and the contents of health insurance policies.

d. Completion of studies on the health insurance market that characterize the contracting mechanisms, quality control systems, relationships with health service providers, coverage and geographical distribution.

3.3	Monitoring of Insurers' Financial Liquidity and Solvency
a.	Does the NHA monitor the financial solvency of insurers with the goal of protecting consumers from possible solvency problems that could affect the availability and quality of the services they receive?
b.	Does the NHA monitor illicit appropriation and fraud?
c.	What mechanisms does the NHA utilize to carry out the activities described in a. and b., and what type of action does it take in order to intervene? Which are more common, sanctions or incentives?
d.	In general, has the NHA fostered transparent and efficient transactions?

HARMONIZATION OF HEALTH SERVICE PROVISION

CAPACITY FOR PROMOTING THE COMPLEMENTARITY OF THE DIVERSE PROVIDERS AND USERS GROUPS IN ORDER TO EXTEND HEALTH CARE COVERAGE EQUITABLY AND EFFICIENTLY

The harmonization of health service provision is carried out in health systems with multiple actors, both public and private, whose efforts need to be directed in order to achieve common objectives.

1.	**SERVICE PLANNING WITH REGIONAL OR FUNCTIONAL CRITERIA**
a.	Evaluate the work of the NHA in the process of harmonizing action plans and management models for the different decentralized or deconcentrated public health services delivery agencies in the country.
b.	Describe the NHA's role in the evaluation of referral and counter-referral mechanisms and in the development of strategies to ensure access to referrals and counter-referrals.
c.	Describe the NHA's role in the evaluation of the duplication of services, with particular emphasis on the formulation of strategies to avoid the fragmentation of services and promote equity and access.
2.	**DEVELOPMENT OF REGULATORY MECHANISMS FOR THE PROTECTION OF THE PUBLIC AND TO GUARANTEE MINIMUM QUALITY STANDARDS IN HEALTH SERVICES DELIVERY**
2. 1	**Establishment of Basic Health Care Standards**
a.	Evaluate the management and regulatory function of the NHA in terms of the establishment of basic health care standards, or service delivery standards, both at the extra- and intra-hospital levels.
b.	Do these basic standards of care serve as indicators and guides for the development of quality programs, accreditation, performance evaluation and others?
c.	What mechanisms does the NHA utilize to enforce compliance?

2.2	Development of Quality Programs
a.	Has the NHA facilitated the development of quality improvement programs for health services? What mechanisms do the NHA use—licensing, certification, accreditation—to protect the public and guarantee minimum quality standards?
b.	The development of indicators to evaluate quality follows two steps: the development of indicators for internal use about self-evaluation and governance, and the development of indicators for external evaluation, accreditation and control. Which of these types of indicators have been developed or are being developed?
c.	Is a quality improvement program recognized formally and legally? How is it related to the NHA, in terms of its management, financing, auspices and autonomy?
d.	For health services quality assessment instruments to be effective, they should be part of a cycle of standards, evaluation and change. To what degree is the NHA committed to this cycle, which goes beyond the development of standards, to include periodic evaluation and feedback for change?

2.3	Accreditation of Public and Private Health Institutions
a.	Considering accreditation as an external evaluation tool, to what degree do criteria and procedures exist to accredit health institutions?
b.	What is the degree of effectiveness and application of these standards? And the degree of updating of these standards?
c.	Is there an entity for accreditation and evaluation of these standards? Determine the degree of autonomy with which it takes action.

2.4	**Measurement of Services Performance With Regard to Compliance with Established Standards**
a.	Qualify the existence of instruments for measuring health services performance with regard to compliance with established standards.
b.	Does the NHA periodically evaluate health services quality with these instruments?
c.	Describe the results obtained in the measurement and evaluation of health services performance.
3.	**PROMOTION OF COALITIONS AND PROVISION OF INCENTIVES FOR SELF-REGULATION**
a.	Does the NHA promote the concept of "self-regulation," understood as the promotion of responsible conduct by all of the sector's actors?
b.	Qualify the existence and dissemination of measures that positively promote responsible conduct by the sector's actors, both in terms of ethics and efficiency.
c.	Qualify the existence of NHA partnerships with stakeholder groups (groups of health professionals, service providers and consumers, among others) for the promotion of professional self-regulation, such as: support for good practices, certification of conditions of affiliation, and sharing of experiences.

4.	**MEDIATION BETWEEN PAYERS, SUPPLIERS AND USERS TO GUARANTEE THE PROTECTION OF USERS**
a.	What role does the NHA fulfill in the mediation between payers, suppliers and users, in order to protect users' rights? Is there a formal entity responsibility for carrying out this role?
b.	Are there specific mechanisms established for channeling claims and settling complaints?
5.	**REGULATION OF TECHNOLOGICAL INTEGRATION FOR PLANNING AND RESOURCE ALLOCATION**
a.	Evaluate the NHA's capacity to issue regulations on technological integration for the utilization of technology in planning and resource allocation.
b.	Does the NHA maintain updated regulations for technological integration in terms of evaluations of health technologies and other supplies?
6.	**INSTITUTIONAL CAPACITY FOR THE ENFORCEMENT AND CONTROL OF HEALTH SERVICES**
a.	What institutional capacities does the NHA have for handling the responsibility of harmonizing the management of the different decentralized or deconcentrated public serviceprovision agencies?
b.	Qualify the NHA's capacity for applying standards for the measurement of health services performance in terms of: • Trained human resources • Sufficient human resources • Sufficient financial resources • Adequate supplies and technology • Periodic monitoring and evaluation

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