
Public service reforms and their impact on health sector personnel in Colombia

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Preface

Over the past decade many countries have undergone public service reforms of some kind, however the consequences for employment and working conditions in the health sector have hardly been documented. This gap in information needs to be addressed, as any public service reform should be judged in terms of its influence on various sectors. The health sector is in most countries predominantly a public sector and therefore influenced by public service reforms. Achievement and improvement in the health sector are crucially dependent on the performance of staff at all levels which, in turn, is intimately related to their general employment and working conditions.

In 1998 the International Labour Office (ILO) and the World Health Organization (WHO) therefore launched a joint research programme to document selected reform processes and detail their impact on health care personnel. The lessons drawn from the individual cases are designed to assist international advisers, governments and organizations of civil society to implement more effective health sector reforms. Six countries from different regions of the world were selected as the focus for this international research (Cameroon, Colombia, Jordan, the Philippines, Poland, Uganda) and studies on public service reforms and their impact on health sector personnel in these countries were carried out in 1998 and 1999. Colombia and Uganda served as pilot country studies in 1998 and the other country studies followed in 1999. They all were discussed at an international round table. The Public Administration Promotion Centre of the German Foundation for International Development (DSE), Public Services International (PSI) and the International Council of Nurses (ICN) together with their affiliates assisted this joint effort of WHO and ILO throughout the whole process by providing technical advice and information at national, regional and interregional levels. The reasons for ILO and WHO launching this programme had different origins, but led to the same interest in the theme for the joint programme.

The 1998 sectoral meeting on health services requested the ILO to facilitate the exchange of experiences among countries through regional meetings and network arrangements of representatives of employers, workers and governments and to facilitate research activities on the impact of reform processes on the workforce. The joint programme with the WHO and the round table were a first response to these requests. For the ILO, this programme contributes to the follow-up of a series of sectoral meetings on reforms in both the health services and the public service sectors which concluded that “reforms are most likely to achieve their objectives of delivering efficient, effective and high-quality services when planned and implemented with the full participation of the public sector workers and their unions and consumers of public services at all stages of the decision-making process. Continuing dialogue between governments and the citizenry as a whole, including public sector workers, should be ensured” (1995) and that successful “health care reforms cannot be imposed from above and from outside” (1998).

For the WHO, the study of the impact of public sector reforms on health human resources is part of a programme to better understand the environment, factors and conditions that have an impact on health workers. With these data and information, discussion papers have been developed and disseminated to enable and increase debate on the key issues. These issues include: education and training, motivation of health care providers, policy development, planning, recruitment, retention and deployment. The

research is intended to provide the basis from which policy options can be developed for use by decision-makers in different countries. The WHO's workplan in the area of health workforce, education, performance and policy includes:

- a review of the changing roles of health professionals in many countries, through a reprofiling of different methods of health provider mix under different institutional arrangements;
- strengthening national capacity to use existing computer-based tools for health workforce planning and management;
- development of a set of standards for quality in the education of health workers;
- development of a set of policy options for improving provider performance;
- direct country support in overall human resource policy development and more specifically in nursing educational issues.

The WHO is working with countries as well as bilateral and multilateral partners in forwarding this agenda.

At an international round table of experts hosted by the DSE in October 1999 in Berlin, the experiences documented in the country studies were analysed and complemented. This round table was attended by the authors of the country studies, representatives of governments, private employers' and workers' organizations from the countries, as well as by officials from the organizations cooperating in this programme. The result of the discussions was the formulation of critical questions which were meant to facilitate the design, implementation and evaluation of human resource policies in public service and in particular health sector reform. This set of "Critical questions for initiating and reviewing public service reforms" is published in the report of the round table in Berlin in October 1999 and can be obtained from the organizers. With the present working paper the ILO and the WHO make also available the full text of the country studies which were revised by the authors in the light of discussion at the round table in Berlin. The opinions expressed in the studies are those of the authors and not necessarily those of the ILO and the WHO. Working papers are preliminary documents circulated to stimulate discussion and obtain comments.

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Executive summary

The present study is part of a joint effort between the ILO and WHO to elaborate six country case studies on public service reforms and their impact on health sector personnel. The Public Administration Promotion Centre of DSE (German Foundation for International Development) and Public Services International (PSI) together with their affiliates assisted this joint effort by providing technical advice and information. The objective of the case studies consists in analysing the factors contributing to or hindering the proper functioning of health sector personnel. This should inform the discussion of best practices and help to address relevant questions concerning the design of appropriate human resources policies.

In the case of Colombia, the analysis was focused on public services in the health sector since considerable changes took place in this sector between 1990 and 1993. While the major legislative acts of the Colombian health sector reform took place in this period – Law 10 of 1990, Laws 60 and 100 of 1993 plus a number of subsequent decrees and resolutions – other relevant public services regulations on career and employment issues were not formulated until June/August 1998. In order to assess the impact of reform in the larger context of democratization, decentralization, and more recent public service regulations, the whole period from 1988 to 1998 was taken into account.

The methodology suggested by WHO/ILO was a desk study on the basis of information and documentation available to the consultant. The ILO and DSE provided additional information. Also, local resource persons facilitated further contacts in Colombia, and helped interview experts by telephone following a structured set of questions. They provided valuable feedback regarding lessons to be learned from the Colombian case, as well as on the interpretation of legislation and of a health workers' strike which happened to coincide with this investigation. The methodology had its limitations due to the distance and the impossibility to substantiate judgements and recommendations by interviewing key informants in Bogotá in person. Considering that the reform process goes on and major changes regarding civil service career were legislated as recently as August 1998, it is too early to draw final conclusions, and recommendations are made only tentatively.

Objectives of reform: Law 100 transforms the old national health system based on government-assisted, vertically organized, free-of-charge services into a general social security system for health. The new system is based on comprehensive insurance and on managed competition among insurance administrators and health care providers. It fosters solidarity by providing access to a mandatory health plan for all Colombians, and aims at achieving universal coverage through the gradual expansion of services to all beneficiaries by the year 2001. In a nutshell, the major objectives of the reform are:

- improved access to health services for the neediest populations;
- improved quality of care;

- equity in health care;
- universal health insurance coverage;
- increased efficiency through better use of financial, technical and administrative resources.

Major achievements: (1) the reform generated additional employment in the health and social insurance sector. To offer the services included in the mandatory health plan, providers hired more general physicians, nurses, and dentists. There was also an increased demand for administrative staff, managers, and management consultants at all levels and in all types of entities; (2) the reform started off defining two types of insurances: a contributory scheme for those having regular income, and a subsidized scheme for people unable to pay. In 1997, the first milestone towards reaching universal coverage was reached: coverage of the contributory health insurance plan had tripled from 7.6 million to 21.7 million people within four years. The subsidized scheme now covers almost 7 million, or 48 per cent of the population with unsatisfied basic needs. Total coverage now reaches over 70 per cent of Colombians compared to 27 per cent prior to reform; (3) public expenditure for health increased; (4) the reform put in place a public-private partnership model of services, which replaced the former national health service with limited coverage and access problems. The Ministry of Health, in the new health system, concentrates on policy-making, regulation and control, while functions such as financing and providing health care are divided among insurances and health facilities; (5) community participation and auditing was strengthened and institutionalized.

This study has revealed a number of limitations and setbacks in the reform process:

- Despite favourable conditions for coordination, the reform of the health sector remained a vertical effort: there is little if any institutionalized coordination with the National Planning Department (DNP), the civil service commission, and the education sector.
- Despite thorough planning of the contents of a mandatory health care plan and financial organization, the reform-makers did not anticipate the difficulties arising in the implementation process. While the expected results were determined in the new health policy, the way to get there was not (compare Kolehmainen-Aitken, 1994).
- Strategic planning for human resources development was not an issue of reform. The reformers neglected the importance of the workforce for achieving the objectives of the reform. Health workers were not seen as instrumental for change.¹

¹ This point, as well as the following, are common complaints of health workers (not) involved in reform processes, according to Public Service International (PSI), an international federation of public sector trade unions, including those of health sector workers. Personal communication, December 1998.

- The planning process took place at the MOH within a small circle of experts, with practically no participation of the operational levels. Hospital directors, health professionals, and regional/local civil servants were expected to apply the new legislation without having been involved prior to reform, and with no support during implementation.

The shortfalls are strongly felt at the operational level. A number of strikes in recent years may put at risk the achievements so far and even discredit the Colombian model. The strike of Colombian health workers in October 1998 is symptomatic for the lack of information and communication between the decision-making and the operational levels. Since there were problems in the financial administration of contributions and delays in the payments of hospital services (which could have been foreseen), confusion is big. Short-term hiring and firing of professionals in times of transition and stagnation increases the general unease.

If the Colombian health sector reform is referred to as a success story, this is no doubt due to rapid expansion of coverage and to the deliberate adherence to social redistribution and competition, which do not have to be mutually exclusive. Moreover, the reform reflects a compromise of the political elites in order to foster their legitimization and power.

For lasting impact and coherence, the reform needs to link up with concurrent reform processes in other sectors. The support of the workforce as the principal change agent is of prime importance in this context.

Abbreviations and glossary

ACOFAEN	Asociación Colombia de Facultades de Enfermería	Colombian Association of Nursing Faculties
ANEC	Asociación Nacional de Enfermeras de Colombia	Main association of professional nurses
ANTHOC	Asociación de Trabajadores Hospitales y Clínicas	Hospital workers' union
ARS	Administradoras del Régimen Subsidiado	Health insurance entities administering the subsidized scheme for the low-income population
ASMEDAS	Asociación Médica Sindical	Physicians' union
ASSALUD	Asociación Colombiana de la Salud	Research and consulting institute in Bogotá
CENTRA	Centro Regional de Educación para el Desarrollo	Training institute with a variety of programmes in Palmira, Valle
CNSSS	Consejo Nacional de Salud y Seguridad Social	National Board on Health and Social Security. There are also departmental and municipal boards, monitoring the implementation of reform
CONPES	Consejo Nacional de Planeación Económica y Social	National Planning Board, attached to the National Planning Department
CORPES	Consejo Regional de Planeación Económica y Social	Regional Planning Board
CUT	Central Unitaria de Trabajadores	One of the main unions
DNP	Departamento Nacional de Planeación	National Planning Department
DSE	Deutsche Stiftung für Internationale Entwicklung	German Foundation for International Development
ENE	Estudio Nacional de Enfermería	National Nursing Survey, 1989
EPS	Empresas Promotoras de Salud	Private health insurers
ESE	Empresas Sociales del Estado	Privatized state hospitals
ESS	Empresas Solidarias de Salud	Public health insurers
FASESS	Fundación para la Asesoría a Programas de Desarrollo Social	Consulting NGO, Cúcuta
FIS	Fondo de Inversión Social	Social Investment Fund
FOSYGA	Fondo de Solidaridad y de Garantía	Solidarity Fund
FUNDAPS	Fundación para la Asesoría a Programas de Salud	Cali-based public health consulting NGO
HRD		Human resources development
ICFES	Instituto Colombiano de Fomento de la Educación Superior	Entity adscribed to the Ministry of Education. Authorizes, registers and convalidates academic titles
ILO	Oficina Internacional de Trabajo	International Labour Office
ISS	Institutos de Seguridad Social	Social security institutes: largest EPS after reform
MINSALUD,	Ministerio de Salud	Ministry of Health

MOH		
NBI	Necesidades Básicas Insatisfechas	Index for basic needs assessment
PAB	Plan de Atención Básica	National Plan for Health Promotion and Sanitation
POS	Plan Obligatorio de Salud	Compulsory health plan – contributory scheme
POS-S	Plan Obligatorio de Salud – Régimen Subsidiado	Compulsory health plan – subsidized scheme
PSI	Internacional de Servicios Públicos	Public Services International
SENA	Servicio Nacional de Aprendizaje (adscrito al Ministerio de Trabajo)	National vocational training service (Ministry of Labour)
SILOS	Sistemas Locales de Salud	Latin American district health system
SINDESS	Sindicato de Empleados de la Salud y Seguridad Social	Health workers' union
SINTRASALUD	Sindicato Nacional de Trabajadores de Salud y Seguridad Social	Health workers' union
SISBEN	Sistema de Identificación de Beneficiarios	System to identify those who are eligible for the subsidized health care scheme (ethnic groups, population below the poverty line, population in very remote areas)
SSO	Servicio Social Obligatorio	Compulsory service year for recent graduates
Supersalud	Superintendencia Nacional de Salud	Highest supervising authority attached to the MOH. Controls and certifies EPS/ARS, and the financial performance of hospitals
WHO		World Health Organization

1. Introduction

In the first part of the country study, a close look into the reform legislation is provided in order to identify to what extent key aspects of working conditions, employment, and human resources development were considered.

In part two, an analysis is made of the developments in the public service reform, which in Colombia produced more regulations and provisions with regard to employment and career issues than those created by the government health sector itself.

Part three highlights what worked and what did not in the Colombian health reform. Some general conclusions are drawn concerning the adoption of a more strategic approach towards labour and human resources development within the context of health sector reform.

Colombia has fairly good health and social indicators. According to UNDP, it ranks in the upper third in terms of human development (rank 53), gender-related development Index (rank 41), and gender empowerment measure. Why reform the health sector?

The average indicators hide considerable inequities in access, coverage, chances for education, and health status. Health insurance coverage under the monopoly of the social security institutes (ISS) had been stagnating for years at around 27 per cent of the population. Local hospitals were underutilized while specialized hospitals, where financial and human resources were concentrated, were overburdened with petty health services. The old system focused on the provision of free-of-charge curative services and neglected prevention and promotion activities. There was no link between the vertical administration of the Ministry of Health and local authorities, who were not responsible for health care nor did they pay attention to the health concerns of the populations they served. In itself, the old system could probably not be transformed. Poor performance, inefficiency, and a high proportion of costs paid for directly by the consumer – this was the scenario before the reform.

Neither decentralization nor health sector reform are unique processes in the Latin American context. Rather, Colombia can draw upon and benefit from a number of experiences and lessons already learned. However, what makes the Colombian experience unique is the convergence of three major processes, which influence and enrich each other. These processes are of political, administrative, and technical nature: democratization, public administration decentralization, and health sector reform. They are interdependent because the political Constitution which stands in the middle of these processes rules the participation of all sectors of society in the shaping of sectoral plans and in the monitoring

of public authorities, at all levels. The Constitution also guarantees the right of unions to represent their interests and negotiate labour relations and working conditions.²

Overall, the health sector reform today is far from being accomplished. While there are synergistic effects thanks to the concurrent reform processes and to the political consensus reached among the political elites and technocrats at the central level, key aspects of career and employment in the public services were not reformed until 1998. Moreover, obstacles to smooth implementation remain which are difficult to be overcome with a blueprint legislation alone: there are hidden agendas, shortfalls in communication, vested interests, group pressures and resistance to change both at central level and at the municipal level, in health facilities and insurance institutions, and from professional associations and unions. However, it is important to mention that the political will to proceed with the reform persists.

1.1. Methodology and data collection

While it was generally difficult to gather the data presented, a user-friendly website of the Colombian Ministry of Health and the Public Administration Department permitted access to a considerable number of legal documents.

An in-depth analysis of perceptions, acceptance, and impact of the reform, and of the latest career regulations from the National Civil Services Commission, would have required a field trip to Bogotá. Instead, this investigation was guided and assisted by two colleagues in Colombia, Dra. Socorro Barona from the Departmental Health Secretariat, Cali, and Dr. Germán Wilches from FASESS, Cúcuta. Those contacted in Colombia in writing did never get back to the writer, despite considerable time spent on following up by phone within the country.³ To complete this study, it therefore would be desirable to carry out personal interviews in particular with representatives from the unions, professional associations, as well as with MOH officials and employees at health facilities, municipalities, and the new health insurance entities.

² However, PSI notes that Colombia ranks high among countries where assassinations, threats, disappearances, intimidation, and organized violence against trade unionists are concerned. Constitutional guarantees of trade union freedom are not always secure.

³ Socorro was told either that our questionnaire was being processed, or that she or I should make appointments and travel to Bogotá for further information. I am insisting on this not only for the scarcity of some of the data (degree of unionization, gender issues, budgetary repercussions, data for the private sector) but also because of the judgements made, based on knowledge of the country, on literature, and to some extent on educated guess.

2. Synthesis of public service reform in the country

2.1. Origin and context of reform efforts

On 8 October 1998, Colombian health workers went on an open-ended, country-wide strike. They challenged the newly elected Government of President Pastrana with what they felt were the apparent failures of the health sector reform initiated in 1993, protesting against the closure of hospitals, insecure employment conditions and a situation of general confusion caused by the legislative overhaul of the old national health system.⁴ The health workers strike is symptomatic of the difficulties in implementing a complex and ambitious health sector reform, and to transmit its goals and procedures to the operational level.

Health sector reform in Colombia started in the early nineties. It consists of three major legislative initiatives with long-lasting repercussions on structure, organization, and actors of health care. Law 10 of 1990 ruled the municipalization of health services, Law 60 of 1993 made provisions on resources and responsibilities at the different levels of public administration with regard to health, and Law 100 of the same year created an integral social security system. Law 100 of 1993 (*Sistema de Seguridad Social Integral*), covers pension fund (Book 1), health insurance (Book 2), professional risks insurance (Book 3), and a number of related issues. Book 2, entitled “General Social Security System for Health” (*Sistema General de Seguridad Social en Salud*), is generally referred to as “the health sector reform” (see page 57 for presentation of objectives of reform) Since its enactment in 1993, this law was amended by an impressive number of organic laws, decrees, and regulations, a process which has not yet come to an end.

While Law 100 has undoubtedly been *the* landmark in the process of health sector reform, it has been closely entwined with and embedded into at least two other major transformations which took place at the time.

In the first place, Law 100 has to be seen within the context of political change and constitutional reform. Political change in Colombia started off with the Legislative Act No. 1 of 1986, paving the way towards the first free elections of mayors in 1988, followed by elections of regional governors in 1992, and towards the strengthening of responsibilities at lower levels of government. Also in 1986, Law 12 regulated a gradual increase of the transfers of the recurrent national revenue to lower level administrative units from 26 per cent to 40 per cent to 2001. The political change culminated in the enactment of the new political Constitution in 1991, which with regard to health and the role of the State, grants equity in health care and universal health insurance to all Colombians, thus setting the ground for the forthcoming legislation.

⁴ Above all, strikers demanded a pay raise for 1999 compensating for the annual inflation at an average rate of 20 per cent. The strike nearly lasted a month – longer than any of the previous strikes. Health workers went back to work only on 2 November after a weighted pay raise (15 per cent) had been agreed upon. Source: personal communication, Germán Wilches, FASESS, Cúcuta, 4 Nov. 1998.

Secondly, Law 100 builds on and fits into the broader context of decentralization, democratization and public service reform all of which began in the eighties and were accelerated in the early nineties. Decentralization in Colombia has its roots in the structural adjustment period of the eighties. It responds to the global neo-liberal call for state modernization in order to reduce bureaucracy and public spending, and to increase efficiency of the public services. It also pays tribute to the richer regions in Colombia, which had been challenging the central administration for lack of efficiency and lack of attention for regional concerns for many years. On the other hand, decentralization also has supporters among those who challenge Colombia's political system as rule by political elites and for the lack of democracy. These critiques at least partly attribute the phenomenon of political violence to the lack of democratic political participation, elitism, and structural social disparities. In this view, decentralization contributes to the country's political reconciliation and stabilization, and increases the legitimization of the elected Government (Castro, 1998). Von Haldenwang, in his doctoral thesis on decentralization and adjustment in Latin America, states that the main cause for institutional change in Colombia was the perceived crisis of legitimization of the political regime, and concludes that the internal regulation of conflicts within the political elites was a key factor for the advancement of the reforms (1994:27, 316). Furthermore, decentralization in Colombia follows the general shift towards democratization and good governance that occurred in Latin America in the last decade.

Thirdly, public service reform proper was initiated only recently. Law 443 of June 1998 addresses the reform of administrative career and public services in general terms; it has been specified in August 1998 by a number of subsequent decrees. Article 15 of Decree 1569 (August 1998) specifically deals with career issues in health and social security institutions.

Last but not least, the Colombian reform is not unique in Latin America, except perhaps for the favourable concurrent processes described above. Under the guidance of PAHO, Latin America was the first continent to introduce district health systems (*Sistemas Locales de Salud* = SILOS) in the eighties. Bolivia, Chile and Mexico also passed health sector legislation, with different degrees of decentralization, types of funding, donor influence, and community participation. Other countries reformed the health sector without issuing new laws. However, they have a few issues in common: democratization generally preceded decentralization of health care. In many countries, one of the driving forces of reform came from structural adjustment policy, i.e. pressure to reduce public spending or increase efficiency of resource allocation through decentralization. The paradigms "modernization of state" and "new public management" also form part of this policy. Interestingly, other sectors do not usually follow the trend of decentralization, social participation and public auditing.⁵

2.1.1. The old system

Prior to reform, health services in Colombia were provided through public sector facilities, the monopolistic social security system (ISS), and private providers. While the national health system was laid out to reach 65 per cent of the population, real coverage of government health services was estimated below 40 per cent (MOH). Coverage through

⁵ For a recent comparison of Latin American health systems and reform experiences, see DSE, 1998.

the social security health facilities was 22.4 per cent, and the private health sector offered 12.6 per cent of curative services (in-patient services).

The national health system came into being in 1975 as a response to the growing need for rendering services more available and accessible throughout the country. In itself, it was a well-thought, coherent system, consisting of a referral system from smaller first-level care hospitals to levels of intensive care. Vertically organized and managed by the central Ministry of Health (MOH), the peripheral branches – departmental and municipal health services – were technically and managerially isolated from the regional and municipal authorities who held neither responsibilities nor resources for health.

Local hospitals were in charge of curative services and of broader public health issues such as sanitation, epidemiology, prevention, and health promotion within their administrative boundaries. However, the services delivered were mainly curative. Services were entirely tax-funded and provided free of charge to the patients. Provision and financing of services was combined. The hospitals were financed on the basis of annual historical budgets; the budget volume was positively influenced by (fictive) deficits presented by political friends and by forthcoming elections. In other words, financial control was almost inexistent. Staffing decisions – appointments – were taken at central level. Remote health facilities were maintained on a basic level with the help of the compulsory social service year scheme, introduced in the mid-seventies to cope with the increasing number of university graduates and to secure medical and other services in peripheral areas. Young doctors, nurses, and bacteriologists had to spend a year of “rural service” as a precondition to receive their degrees, and for the admission to further postgraduate training. Despite the compulsory service, fluctuation and drop-out rates at peripheral health facilities were high. Supervision was rare, and so were supplies and means. In addition, political violence made life and work nearly impossible in some areas of the country.

In theory, health structures were well developed and a health facility was at reach within a two hours’ walk for everyone in Colombia (PAHO). Although public sector facilities were distributed fairly evenly in the country, utilization was not. Patients avoided the local hospitals and sought treatment at the more specialized, usually better-equipped hospitals of the secondary and tertiary level. Occupancy rates at municipal hospitals were very low, with beds at times occupied by orphaned elderly, homeless people, or cases requiring care with no other place to be taken care of. Managerial deficits, lack of qualified staff, equipment and supplies, high staff turnover, and poor accessibility at first-level facilities (service hours, staff attitude) were notorious prior to reform.

2.2. Reform objectives and strategies

Law 100 does not spell out the objectives of the reform explicitly. Rather, it contains *universal principles* and *rules of conduct* guiding quality and public service in health care. According to article 152 of Law 100, the universal principles guiding the general social security system for health are efficiency, solidarity, universality of coverage and services, and community participation.

From the analysis of the context of reform and those principles, one can deduce the *major reform objectives*, which are similar to the stated objectives of health sector reform elsewhere:

- improved access to health services for the neediest populations;
- improved quality of care;
- equity in health care through universal health insurance coverage to be reached by the year 2001;
- increased efficiency through better use of financial, technical and administrative resources through decentralization of responsibilities and resources, separation of financing and provision of services, and by way of managed competition among providers.

Article 153 further outlines the fundamental rules of public service in health and social security, which are:

- equity (gradual transition to complete coverage);
- mandatory insurance for all citizens under either the contributory or the subsidized health care plan;
- comprehensive care (promotion, prevention, curative services, rehabilitation);
- free patient choice of insurers and of service providers;
- autonomy of providers;
- administrative decentralization;
- social participation;
- concertation;
- quality.

In addition, article 154 of Law 100/93 specifies the objectives of state intervention in the public service of health insurance. The main ones are:

- to control and watch over the adherence to the constitutionally guaranteed principles as well as over the compulsory character of the social health insurance for all citizens;
- to develop responsibilities for guiding, coordinating, monitoring and controlling the social security services and the regulation of services;
- to achieve the incremental increase of insurance coverage, and thereby, access to health promotion, prevention, curative care and rehabilitation services.

From an analytical point of view, the *main features of the reform* (Jaramillo, 1998:63-71) are:

- strict segregation of functions and institutions at all levels;
- establishment of a subsidized system and expansion of the contributory insurance scheme;
- integration of the private sector. In addition to the compulsory health care plan (POS) remunerated according to the existing regulations (Law 100, article 177), private insurers can offer extra insurance services to cover more services or better hospitalization conditions;
- emphasis on prevention and health promotion. Creating the basic attention plan (PAB), public health programmes⁶ were separated from individual curative services and put under the responsibility of the local authorities. The PAB is to be funded with a determined proportion of the national transfers to the municipalities;
- introduction of social and regional redistribution mechanisms;
- cost-control mechanisms (per capita funding of health insurances under the compulsory health care plan, payment of hospital services on the basis of diagnostic treatment groups, gate-keeper functions of first-level facilities, co-payment charges for direct access to superior-level facilities or specialists);
- hospital reform. Shift from supply-oriented to demand-based financing, modern management, competition;
- redefinition of norm-and-control functions of the MOH.

⁶ In the literal sense of “public health”, these programmes in Colombia are interventions with externalities for the health status of the population, i.e. promotion, prevention and sanitation measures, as opposed to individual health care without externalities.

2.2.1. Hidden agenda

Malcolm Bryant (1997) of Management Sciences for Health, Boston, argues that often reform objectives, or the purpose of decentralization, are not clearly spelled out by politicians to disguise a less popular rationale behind the official version and avoid “unnecessary” discussions. For smooth implementation, though, acceptance and legitimization are important. Post-reform resistance and protest can be avoided through clearly spelled goals, early information and communication with the operational level. Late communication will result in protest, even longer discussions and may as well discredit the whole reform – as was the case in Colombia.

In Colombia, decentralization was neither openly declared as part of a structural adjustment policy nor would any politician admit that decentralization was a stabilizing strategy of the ruling elites to increase their own political legitimization. Instead, since democratization and decentralization occurred at the same time, it was easier to present decentralization as a part of the political reform process, towards more public control over policy and budgetary decisions at the local level through community participation in different committees and forums.

Some politicians even see decentralization as a step towards ending civil war and political violence (Castro, 1998), although the effect could be quite the opposite, leaving remote areas alone with their combatants, unable to establish peace and security (see below p. 63).

2.3. Reform processes and actors

2.3.1. Actors and by-standers

The protagonists of the health sector reform were:

- Ministry of Health, namely Juan Luis Londoño, Minister of Health during the Gaviria Administration (1990-94);
- Ministry of Labour and Social Security;
- Ministry of Finance;
- National Planning Department;
- National Board of Social Security in Health;
- IDB/World Bank advisers.

One of the driving forces of the social security reform in Colombia was the Ministry of Labour and Social Security (now Ministry of Labour) for the purpose of modifying the pension scheme.⁷ During the technical discussions, it was decided to broaden the issue and to embark on a major reform of the national health system and the deficient health insurance system as well. This decision was not uncontested. The National Planning Department (DNP), where neo-liberal influence was particularly strong at the time, had favoured a “smaller” health sector reform consisting mainly of the decentralization of health services to local and regional administrations, and the privatization of public or publicly funded hospitals, but certainly no universal health insurance.

While the reform was to be debated by all levels of society, most discussions took place within a small circle of experts at the MOH. The acting Minister of Health himself, Juan Luis Londoño, very actively pursued the work on Law 100, which was drafted, discussed and enacted in only 18 months. International organizations and development banks played a key role in the financing of a number of projects (IDB Municipal Health Services Project, World Bank hospital management project).

It is interesting to review who participated in the debate following the pronouncement of the 1991 political Constitution, who did not, and what those discussions were about. Under the leadership of the Ministry of Labour and Social Security, a multipartite Constitutional Commission on Social Security was established in January 1992. A subcommission on health dealt with contents of a basic health care package, “personal and non-personal” integral health services, etc.

Despite other official claims, professional associations, health personnel from the operational level, and patient organizations or community representatives were not officially involved. The broad discussion of the reform proposal at all levels of society did not take place, nor were there any hearings with operational level professionals from the departments, districts, or municipalities (Bossert, 1998:67).

Another actor who apparently did not fully participate in the debate of the reform proposal and in the subsequent implementation process is the National Planning Department (DNP), with its civil service divisions. Although the DNP is responsible for public services decentralization at municipal level, and even though the DNP carries out annual surveys on the decentralization process,⁸ it is not clear to what extent a dialogue between civil service and health authorities has taken place prior, during, and after reform, and/or whether coordination and exchange of information has ever been institutionalized. Also, it is not clear how the results of the yearly mayors’ survey – which regularly reveals gaps and information needs on management and specific sector knowledge – are shared with the MOH, and whether the DNP and the MOH collaborate on jointly resolving these problems.

⁷ See PAHO Country Health Profile Colombia, 10 Apr. 1998.

⁸ Through its National Health and Education Planning Board (CONPES).

2.3.2. Topics of discussion and reform outside the Government

Outside the Government, the articles of the Constitution regarding equity in health and health insurance as a public service were discussed in different professional and political settings. Statements exist from a variety of stakeholders (FESCOL, 1992): representatives of the social security institutes (ISS), health NGOs (Gonzalez Posso, 1995), interim commissions called into life by the Congress (see above), even seldom-heard opposition politicians⁹ engaged in the extra-parliamentary debate. However, the influence of smaller interest groups on politics in Colombia is known to be weak unless they have direct access to elites or decision-makers.

These discussions centred around the scope and limits of a universal comprehensive social insurance system (FESCOL, 1992). Specialists considered the contents of a basic health care package, and calculated the known and the unknown costs and expenditures of prepaid health care. With the objective to influence the reform outcome, studies were undertaken on the financial feasibility to reach the goal of equity in health (and insurance coverage) for all Colombians by the year 2001, on the right mix of welfare and market elements, on how best to split responsibilities between service providers and insurance administrators, and on how to avoid a “chilenization” (patient selection, two-tiers system) of the Colombian health insurance system. Unions were concerned about equity issues and a possibly unconstitutional disparity between the contributory and the subsidized system.

2.3.3. Neglected issues

It seems that no one was concerned about the potential repercussions of a major structural health sector transformation on job security, salary development, and working conditions for health personnel – not even the unions. Also, none of the papers reviewed from the period prior to reform legislation dealt with the implementation process and possible difficulties to be encountered during a transitional period.

Law 100 only dedicates a small article (No. 246) to human resources. Compared to the length and detail, other topics of the reform law were dealt with – Law 100 was succeeded and amended by more than 100 decrees from 1994 to 1996 – none of these regulations followed up on art. 246. Human resources development (HRD) was not an issue of reform. Until 1998 there was no explicit MOH policy on how best to develop managerial skills and financial absorption capacity at all levels, nor on how to meet future staffing needs and prepare, involve, and train health sector personnel for new responsibilities and tasks.

2.3.4. Division of work within the MOH

If cooperation with health sector staff, professional associations, and interest groups did not take place, how about coordination within the Ministry of Health?

⁹ Alvaro Cardona of the Unión Patriótica, in: FESCOL 1992:197-211.

It is interesting to take a look at the current structure of the Ministry of Health. There are the following subunits:

- Minister's Office;
- Vice-Minister's Office;
- General Secretariat;
- General Directorate of Financial Management;
- General Directorate of Social Security;
- General Directorate of Decentralization and Territorial Development;
- General Directorate of Promotion and Prevention;
- General Directorate of Development of Health Services;
- associated entities: National Council on Social Security for Health, amongst others.

All of these directorates – except for the Minister's Office and the health promotion directorate – have subdirectorates and divisions which deal with partial aspects of reform. Two or even three units are in charge of human resources (Human Resources: Vice-Minister's Office; Development of Personnel: General Secretariat; Assistance to Territorial Units: General Directorate of Decentralization and Territorial Development).

While there are arguments for a strong central level administrative unit in charge of monitoring the health sector, the MOH's current internal division of competencies is not coherent with regard to interdependent health reform issues such as decentralization, social security, financing, and human resources. Moreover, from the organigram it is not clear whether there are institutionalized links to the DNP, to the Administrative Department of the Public Function, or to the National Civil Service Commission (NCSC), which regulates and monitors administrative career issues (see pages 73, 81 for details).

Bossert,¹⁰ a political analyst from the Harvard Colombia Health Sector Reform Project, argues that at the time of initiating reform, the MOH suffered from high staff

¹⁰ The MOH itself was the subject of a survey of senior managers conducted in 1994 by Harvard's Colombia Health Sector Reform Project (Bossert, 1998). The main findings from that study make it clear that to be efficient, the structure of the Ministry has to be reorganized, and become more concentrated. While in the past many divisions with many positions were useful to post and relocate "political staff" whenever the Government or the Minister changed (between 1992 and 1996,

turnover and insufficient managerial and analytical capability to handle and support all aspects of reform. Martineau and Martínez (1997) from the Liverpool School of Tropical Medicine's Health Sector Reform group, point out that leadership at central level is crucial for human resource development to be successfully integrated into and implemented within health reform. It seems obvious that the Colombian MOH lacked both leadership and a capable and visible reform clearing unit. Lack of leadership after the departure of Londoño and continuously high fluctuation at the MOH probably contributed to the slowdown of the reform implementation process after 1995.

2.4. Focus and scope of reform implementation

2.4.1. Scope of reform: Decentralization

The Colombian health sector reform falls under what can be administratively defined as a functional devolution of competencies (Haldenwang, 1994:11), complemented by limited economic decentralization. Classifications of decentralization processes never completely match with reality, but they can help compare these processes against a set of criteria to measure scope and depth of changes, and they allow comparisons across countries. Compared to other Latin American experiences, decentralization has gone relatively far and has been considered a success (Heieck in KAS, 1996:77). However, the central Government retains important intervention functions. For this purpose, it created Supersalud (National Superintendency in Health, see below p. 84) as a superior control instance, and it determined that national transfers be geared to certain sectoral investment priorities. In fact, the earmarking of the national transfers has been criticized by mayors and governors as inconsistent with the goals of decentralization. Clearly, Colombia does not have, or want, a true federalist political system. In a country where large territories are under military control or in the hands of armed groups, it might be difficult and too dangerous to pursue a "more complete" decentralization.

2.4.2. Sector policies: Key issues of Law 100

1. Law 100 introduces a mandatory health insurance system for all Colombians. In part, the initiative to establish comprehensive social insurance originated from the Ministry of Labour and Social Security, who wanted to introduce a pension scheme. The idea was soon taken up to address social insurance as a whole and to overcome the obvious deficits and inefficiencies of the old health system.
2. Decentralization: The responsibility for health and other social services (education, sanitation, environment) had been returned to the municipal level by Law 60/93. Law 100 adds a new actor to the local scenario, the Health Promotion Enterprises (EPS), or insurances. Departments hold supervisory and training responsibilities, while policy-making and control remain the main responsibilities of the central Government.

Colombia had five Ministers of Health), frequent changes do not allow to build an institutional memory or technical continuity.

3. Shift from supply-funded public hospitals to demand-funded, administratively and financially autonomous hospitals (ASSALUD, 1996).
4. Separation of provision of services and financing: hospitals and other health facilities no longer receive an annual budget. They are reimbursed by the health insurances on the basis of services provided and have to be managed as private companies, competing for patients and/or contracts with health insurance companies. Health insurances have the right to examine the quality of services provided. Hospitals who lose patients for lack of quality of services or those unable to enter into agreements with health insurances may be forced to shut down.
5. Mixed financing system – contributions and subsidies: Health insurers collect contributions from their affiliates and negotiate the cost of service delivery with hospitals and/or private practitioners. The contributions (12 per cent of the monthly salary) are divided among employers (8 per cent) and employees (4 per cent). They are calculated high enough to allow for family coverage (spouses/partners, dependants, parents in some cases), and for the funding of the subsidized health plan; 1 per cent of the collected contributions is passed on to the Solidarity Fund, which together with national transfers to the municipalities and local tax revenue is used to finance the subsidized health care system for those unable to pay and for certain vulnerable groups. The financial means of the solidarity funds are administered by special entities, called subsidized regime administrators (ARS), EPS and welfare entities (Decree 2357/95, article 5).
6. Budget ceiling: Each insurance company has a budget calculated upon estimated yearly costs per person insured. This capitation fee was initially calculated on the basis of figures available prior to reform (mainly from the ISS health services), taking into account the costs of a basic health services package.¹¹ To avoid patient selection, a redistributive financing mechanism among health insurances balances out higher versus lower revenues from contributions. While patients can choose their doctors freely, there is a built-in disincentive for patients to seek specialists' treatment, or treatment at specialized hospitals, before having seen a general physician or a nurse, or without having been referred.
7. Consumer orientation: Law 100 emphasizes the role of community participation in local health policy management and in the management of the local health care facilities.

2.4.3. Administrative structures

Colombia has 32 departments, four districts, and 1,065 municipalities.¹² Ninety-six municipalities have more than 50,000 inhabitants, but in these towns live 62.4 per cent of the total population. The rest of Colombians live in municipalities with less than 50,000

¹¹ Capitation fee and basic care services are regularly reviewed by the National Social Security Council, one of two planning/control authorities established by Law 100.

¹² PAHO (1998) website Colombia, based on CONPES data.

inhabitants. As much as in population size these towns differ in terms of financial dependency from national transfers. On average, the small towns receive 86 per cent of their resources through the transfer, which means that they have to dedicate a large portion to recurrent costs.¹³

In order to ensure that only those municipalities who had the proven managerial and institutional capacity participated in the transfer of resources and responsibilities from the central level, Law 10 of 1990 outlined a number of criteria allowing for differences in size and resources between municipalities and departments, and established a timetable for achieving decentralization, to be completed between 1993 and 1995. Still, the decentralization process was implemented at a slower than expected pace. To date, 17 departments and 150 of the 1,065 municipalities – mostly larger towns – have achieved decentralization. This means that decentralization is much harder to assume for smaller municipalities. The same is true for the autonomous handling of health and hospital management at this level.

Table 1. Hospitals and health centres (PAHO, 1998)

	Public sector	Private sector
Hospitals (all)	555	340
First level	397	
Secondary level	126	
Tertiary level	32	
Health centres	904 (128 with beds)	
Health posts	3 340	

There is little qualitative information about the effectiveness and quality of care provided since the reform started.

2.4.4. Health insurance companies¹⁴

The reform started off defining two types of insurance: a contributory scheme for those having regular income, and a subsidized scheme for people unable to pay. The contributory scheme, based on the system of the old ISS for salaried workers of the private sector, was modified by three fundamental measures: The contributions to the new general social security system for health were increased from 6 per cent to 12 per cent. The monopoly of the ISS in health insurance was abolished, allowing competition among private enterprises – profit and non profit – cooperative entities and public or mixed enterprises. All these enterprises were named “health promotion enterprises” (abbreviated EPS after the Spanish initials). Today there are 32 private and public health insurances in Colombia. In the contributory system, there are ten public health promotion enterprises (EPS), 21 private, and a mixed company (the former Institute of Social Security (ISS)). The widest geographical coverage throughout the country is provided by public EPS. Together they have a total capacity to insure 21.7 million people (affiliates plus

¹³ Figures taken from Kure, Ileana, 1995:91.

¹⁴ Figures taken from PAHO (1998): website on Colombia.

dependants), or 60 per cent of the Colombian population.¹⁵ The health insurance market is still growing: of 32 Health Promotion Enterprises, five were established in 1997.¹⁶

In addition to the EPS, 30 existing entities have been adapted to the system, including social security and welfare funds and medical departments, which to date have a membership of 342,739.

The subsidized system, supposed to reach a third of the Colombian population, is administered by 236 entities: 18 EPS, 49 family compensation funds, and 169 collective health enterprises (*Empresas Solidarias de Salud*), which, as of December 1997, had a membership of 6.9 million (49 per cent of the goal proposed for the quadrennium), of which 33.1 per cent belong to the collective health enterprises, 53.2 per cent to the EPS, and 13.7 per cent to the family compensation funds (SaludColombia, website).

2.4.5. Health expenditure in Colombia

Total health expenditure rose from 6 per cent of GDP in 1993 to 7.4 per cent in 1994, the year following reform legislation. Public spending on health prior to reform represented about half of total health expenditure (49 per cent). In other words, public expenditure increased from 2.07 per cent of GDP in 1990 to 3.2 per cent in 1994 and 4.7 per cent in 1996.

Private household expenditure on health was estimated at 3 per cent of GDP in 1993, of which 40 per cent was spent on drugs, 14 per cent for outpatient consultation, 20 per cent for hospitalization, 5 per cent for diagnostic testing, and 20 per cent for other items.

2.4.6. Financing of the general social security system for health

Contributions of members/affiliates. The core piece of the social insurance scheme is contributions from affiliates. With the goal of universal coverage to be reached by 2001, this part of the reform is where the welfare approach has been most influential. The insurance companies collect from their affiliates 12 per cent of the monthly income, 8 per cent is paid for by the employer, and 4 per cent by the employee. Independent professionals pay the full amount.

Out-of-pocket payments. The reform provides pecuniary disincentives for patients seeking treatment at specialized institutions without having been referred.

¹⁵ The goal of expanding coverage to 21.6 million people was reached at the end of 1997 – four years after the reform was launched.

¹⁶ According to the Web information service of SaludColombia, two powerful unions managed to stay exempt from this scheme searching to protect their extraordinary benefits (one for the National Petroleum Enterprise and one for teachers).

Solidarity fund (FOSYGA). The solidarity fund provides payments to entities administering the subsidized health care plan. The distribution mechanism takes into account local tax income, population size, location of the municipality, and the poverty index of a municipality and/or department.

Royalties from oil wells and other natural resources, and revenues from ECOSALUD, the national lottery and game funds, add to the financial resources sustaining the subsidized insurance scheme.

National transfers (Situado Fiscal) to municipalities already existed prior to reform. The difference is that under present legislation, transfers were increased (50 per cent of national revenue) and a larger proportion of the transfers (25 per cent) is passed on to the municipalities directly, without being handled by the departmental level, which also receives 25 per cent. Transfers cannot be budgeted freely; these funds are earmarked for recurrent costs in the health and education sectors; 15 per cent of the *situado fiscal* is divided evenly among the departments, whereas the other 85 per cent takes into account similar weighting criteria as the FOSYGA.

Co-financing schemes. To support local investments in infrastructural development, Colombia has four co-financing schemes, one of them targeting health projects: The social investment fund (FIS) helps municipalities to carry out previously elaborated and approved projects in the fields of education and health. In 1995, 15 per cent of the FIS resources went into health, the larger part, 76 per cent, was invested in education.

2.4.7. Cost-control measures

The reform introduces several mechanisms to control costs and patient selection both at health facilities and at the EPS. These mechanisms are: per capita budgets for EPS, payment of hospitals on the basis of tariffs for diagnostic treatment groups, and disincentive co-payments, so-called “*cuotas moderadoras*” of patients who seek treatment at a specialist’s clinic or higher than first-level hospital without seeing a general physician first.

2.4.8. Management

According to Law 10, and reinforced by the Constitution and subsequent legislation (article 21, Law 60/93), municipalities are responsible for the provision of health services at the first level of care (health posts, health centres, municipal hospitals).¹⁷ Annually, they have to elaborate a local health plan, specifying local health policy priorities and planned activities. Municipalities also have to carry out the household survey on unsatisfied basic needs (NBI) to determine the eligibility of people for services under the subsidized health

¹⁷ Health sector legislation is not always coherent: while Law 60/93 devolves the responsibility for first-level attention to the municipalities, the reform Law 100, of the same year, defines the compulsory health plan and hands over the management to the EPS.

plan (SISBEN). The measurement of the scope and depth of poverty in a given community is a precondition for the calculation of the national transfers.

Responsibility for hospitals of secondary and tertiary level of care was transferred to the departmental health authorities. Departments are further responsible for the supervision and guidance of municipal health services within their jurisdiction.

Responsibility, regulatory and normative authority, quality control and auditing functions remained with the central Ministry of Health. The tasks at central level are divided between the Ministry of Health (policy-making, legislation), Supersalud (financial and managerial control, monitoring of reform process), and the National Health Institute, in charge of epidemiological surveillance.

2.4.9. Schedule for implementation

The reform set two deadlines: Within four years, the contributory system was to expand coverage to 21.7 million Colombians. This goal was within reach since the law obliged the insurances to include, in addition to the employed affiliates, their family members and dependants. By the year 2001, the subsidized system which initially offers only a reduced health care plan to its beneficiaries at 50 per cent of the costs of the contributory system, will have been gradually adapted and expanded to cover all services of the contributory health care plan. It can be said that successful expansion of health insurance coverage by 2001 is a key indicator for the reform's successful implementation.

There is recent information, that under the new administration, the process of adapting the subsidized plan to the level of the contributory plan will be slowed down. It appears that the MOH prefers to stabilize those already fully ensured rather than putting at risks the achievements to date by pushing too hard for the implementation of the schedule.¹⁸

2.5. Overall achievements, constraints and failures

The enactment of a comprehensive social insurance legislation in itself is perhaps the most substantial achievement. Colombia wanted a specific solution to its own national problems. Both the classical, or Bismarckian, social insurance model, and the neo-liberal model of privatization and managed competition and its application in Chile during the eighties were thoroughly studied before the specific Colombian mixed model was developed (Jaramillo, 1998:257).

While it is too early to evaluate the long-term impact of the Colombian reform, some achievements, and major constraints, can be highlighted as follows:

¹⁸ Personal communication, 04/11/98, Germán Wilches, FASESS, Cúcuta.

1. Public expenditures for health went up from 3.2 per cent of the GDP in 1994 to 4.7 per cent in 1996.
2. Insurance coverage in the contributory system increased very fast and beyond expectations, from 7.6 million in 1994 to 21.7 million people in 1997. In 1995 alone, coverage rose about 15 per cent. In December 1996, 13.9 million were covered under this scheme, and in 1997 the goal was reached.
3. Insurance coverage in the subsidized scheme was raised from 6 million affiliates in 1996 to 7 million in 1997, covering now more than 50 per cent of the population with unsatisfied basic needs.¹⁹
4. The reform generated new jobs; there were positive effects on employment in the official health sector both in terms of number of positions and salary conditions.

The remaining challenges of the health reform are to increase access, strengthen management and develop training programmes for health administrators under the new legislation. Access still differs widely among regions and social strata. Human resources development was not an issue during the debate of the scope and contents of health sector reform. Furthermore, incongruencies in the existing legislation have to be eliminated. It is also a good idea for the responsible units at the MOH to cooperate more closely with the civil service commissions as far as recruiting, training, and performance evaluation is concerned.

Clearly, Colombia's health sector reform was not a bottom-up process but a technocratic exercise induced from and orchestrated at the central level. The reform discussions took place within the traditionally predominant political elites of liberals (in Colombia closer to social-democratic values) and conservatives (neo-liberals); other sectors of society had to discuss elsewhere and were lucky if they were heard. From a theoretical point of view, the outcome of the negotiations perfectly reflects the political culture of the country – still untouched – where two contrasting ideologies, social-democratic welfare thoughts, and the neo-liberal market theory, were discussed and then somehow combined and balanced out. So the outcome indeed is a very Colombian arrangement.

Given the circumstances, the outcome probably was the best one could expect. It adheres to the provisions made in the Constitution. Many of the changes introduced are structural, substantial, and their effects can only be measured in the long run. Community participation and public control of authorities is rapidly gaining popularity in Colombia and will certainly make it difficult to step back from the goal of universal coverage and affordable health care for all.

However, the recent health workers' strikes cannot surprise. Not only have working conditions and training needs not been considered, important actors or resource institutions

¹⁹ There is a discussion on how the population groups with NBI are to be identified and counted. The estimated numbers of people to be covered by the subsidized scheme vary from 12 million to approximately 15 million.

did not participate in the debate prior to Law 100: higher education and professional training institutions were not among the reform-makers, nor were the professional associations who now show the strongest resistance to the new situation. Also, preparation of health administrators and local staff had not been planned.

For the employees and managers of the recently founded EPS, ARS, and ESE (public hospitals converted into autonomous “social state enterprises”), the reform, above all, meant confusion and brought along a foreseeable deterioration of the situation (short-term contracts, liquidity problems). It is easier to blame “the reform” as such and reject it as something that has been invented and imposed by central level bureaucrats than to look at it more closely. The shortfalls are on both sides: hospitals have not yet adjusted to being financially directed by the EPS and produce poor bills which are returned to them. While the hospitals run out of money, the EPS and ARS are accumulating contributions claiming they cannot reimburse the hospitals on the basis of poor documentation and deficitary accountability.

In the long run, a negative attitude of health workers, professional associations and patients (who as the main beneficiaries of the new system are the first to perceive its deteriorations due to change) could discredit the reform as a whole and put at risk the entire process. Resistance also comes from within the Ministry of Health, as changes and new values, particularly those attached to performance and staff evaluation, are threatening and challenging the old system where high level positions were distributed according to political interests and not so much based on technical considerations (Bossert, et al., 1998:67).

Action is needed to increase acceptance of the reform, a deeper understanding of its goals and procedures, and, finally, to achieve that bureaucrats at the Ministry and health workers at facilities and public health insurances perceive themselves as change agents. We know from organizational development and change management how crucial it is that employees can identify themselves with the organization and its mission if changes are to succeed. To get them there, the minimum is to disseminate information in time, provide space for communication and feedback, and involve them in a genuine social dialogue in order to assume responsibility as change agents and take pride in it.

While failures are so obviously due to deficient preparation and training, it was not until late in 1998 that the IDB project in support of the health sector reform launched an international call for consulting services in support of four projects in the area of training and education, covering all aspects of pre-service and on-the-job training and the development of a personnel information system.²⁰

²⁰ Prequalification announcement seen in BFAI (German commercial news bulletin), 28 Oct. 1998.

3. Assessment of the impact of public service reforms²¹ on health sector employment and working conditions

3.1. Implications for human resources policies in the health sector

3.1.1. Institutional changes and capacity-building

Institutional changes have already been mentioned in Chapter 2.4. This part is therefore limited to a brief enumeration of changes relevant for workforce issues and future human resources policies.

Insurances: A new type of insurance entity, EPS and ARS, was created. The insurance market grew considerably in the years following reform. These insurances have ample responsibilities in terms of collection and administration of contributions, negotiation with and contracting of providers, payment and cost controlling of hospitals, and they need staff and assistance in institutional capacity-building.

Municipalities: Decentralization (devolution): Resources and responsibility for health, education, environment and welfare were delegated to municipalities. A new responsibility is the implementation of the entirely tax-funded basic attention plan (PAB), which aims at health promotion and prevention activities. Municipalities have to carry out the household survey (SISBEN) to determine eligibility of certain populations to register with the subsidized scheme. They also work out sectoral plans which form part of the territorial development plans. Municipal institutions, too, will require skilled personnel to comply with their new tasks. At present, however, many small municipalities do not have local health offices, or secretaries. The smaller the location, the less likely it is to have specialized offices. In these cases, the local hospital director, or ESE manager, assumes the task of the local health officer.

Departments: Training, guidance and supervision of municipalities is the responsibility of these regional authorities. New units may have been created.

Hospitals: will have to strengthen the administrative, planning, and accounting units. They will also have to adjust their services to the requirements of the POS, i.e. strengthening gate-keeping functions (general physicians), health prevention and promotion, etc. through the hiring of additional professionals.

²¹ The literal translation from the Spanish denomination of this commission is civil service. The expressions “public service” and “civil service” are used synonymously in this paper.

3.1.2. Overall costs, fiscal restraints and availability of human and financial resources

With the new legislation, transfers from the national level to the departments and particularly to the municipalities increased considerably. The share of transfers out of the recurrent national revenue is being increased by 1 per cent per year since 1986 to reach 40 per cent by 2001. Law 60/93 changed the distribution of the national transfers to increase the funds destined for smaller municipalities. The introduction of the contributory systems raised additional financial resources. The share of the health insurance budget increased from 3.2 per cent in 1994 to 4.7 per cent in 1996.

Availability of resources: Colombia does not lack highly qualified personnel. The main problem continues to be the flawed distribution of staff and services between urban and rural areas, and between departments. Low pay and lack of other income opportunity, as well as violence, are the causes for inadequate staffing of peripheral health facilities. However, the health sector reform does not provide a feasible solution to overcome these structural problems.

3.1.3. Reduction and migration of staff

Internal migration has always been a typical Colombian issue. More than 120,000 families in Colombia were displaced due to political violence between 1985 and 1994 (PAHO). Many professionals chose to move to safer places within the country rather than being threatened or forced to collaborate with either side of the violent factions. Others leave the remote areas in search of a better-paid position, or a more attractive environment.

The health sector reform did not generate additional migratory effects.

In contrast to what might be expected, reduction of staff did not occur either. Rather, the reform with its requirements for the health plan and an increase of functions in the newly established health insurances had a positive impact on the job market in the health sector: what could be expected is a further increase of demand for qualified professionals (see page 71). The implementation of the compulsory health care plan revealed, after only a few years, a shortage of certain specialists (orthopaedic surgeons, dentists). Also, the execution of the plan requires an increased number of general physicians and specialized nurses (see tables 3 and 4).

During the 1960s, Colombia suffered from health sector brain drain to the United States caused by poor working conditions and low income. The 1975 national health system helped to slowdown this emigration process. With the introduction of the compulsory service year for doctors, nurses, and other health professionals, the Government gave a guarantee for young professionals to be posted temporarily.

3.1.4. Educational systems

Public service regulations

Entry requirements and administrative career conditions for public service employees have been recently regulated by Law 443/98 and a subsequent series of decrees. Decree-law 1567/98 is of particular interest in this context, creating a national training scheme and an incentive scheme for government employees. The decree specifies incentives such as on-the-job training (four months' introductory briefing = *inducción*), compulsory recycling of knowledge and skills (*reinducción*) for all staff every two years, according to the needs of the service entity as well as of the individual employee, aspects of a stimulating work environment and of organizational culture, pecuniary and non-pecuniary sanctions, and instruments of staff performance evaluation.²²

Two government entities are explicitly mentioned to guide and supervise the adaptation process according to Law 443, the Administrative Department of Public Functions and the National Civil Service Commission. The former has to develop the framework of a training system for state employees; the latter monitors employment patterns such as vacancy announcements, recruiting process, contracts, staff performance evaluation, sanctions and incentive schemes. Meanwhile, public service entities are called upon to develop their own training plans. Once the framework has been approved, public sector institutions will have to develop yearly training plans according to these guidelines.

Law 443 also rules conditions for vacancy announcements of both external (open) and internal (career) positions. There are provisional appointments for a maximum length of three years ("freely named and removed"), and there is a probationary period of four months for newly selected staff both from outside and from within the entity. If the probationary period is successful, the employee obtains the public career rights and entitlements and will be inscribed in the Public Registry of Administrative Careers.

Obviously, these regulations do not only apply to public sector health facilities but to all public service entities in Colombia. To date, it is too early to make any judgements about acceptance and feasibility of both the training system and the incentive scheme. The general guidelines still have to be elaborated by the Administrative Department. Also, Law 443 and five or more subsequent Decree-Laws and Decrees (5167-5173, see Literature) were passed from June to August 1998, during the last months of the Samper administration. It remains to be seen how the issue of career development for public servants will be reinforced by the new Pastrana administration.

While public service regulations are elaborated at central level, local health institutions deal with the new regulations in a very pragmatic way. They adopt what seems useful; in any case, there is a lot of uncertainty about how to match the new requirements with the MOH regulations, and there is no reinforcement or guidance by central level supervisory entities. The experience in Colombia is that larger municipalities adapt to new changes faster, while in small towns appointments continue to be made in the best interest of local leaders. The traditional way of paternalistic decision-making (Heiek in KAS,

²² For a detailed framework of analysis, see ILO 1998:7-10.

1996:77) continues to coexist with modern managerial regulations emphasizing education, performance, and merits.

3.1.5. Professional standards, rule of practice

Professional standards are set by the *Consejo Nacional de Seguridad Social en Salud* (CNSSS, see below p. 84) for the composition of the basic health care package. EPS have quality control authority vis-à-vis the service providers (hospitals and private clinics).

3.1.6. Labour relations

The Colombian Constitution, in its articles 38, 39 and 55 grants all citizens the right to unionize and negotiate salaries and working conditions. Bargaining at the workplace can also be initiated by a non-unionized group of workers (Cerón del Hierro, 1996:94-95). The right to establish unions is derived from the fundamental right of freedom of association. Central level negotiations are held by the Central Workers' Union (CUT) and other health sector unions (SINDESS, coordinating union of the strikes, and others).

Health workers, as well as other public services employees, have gone repeatedly on strike since Law 100 was enacted in late 1993. The most recent strike of public servants started early in October 1998 and became the longest ever called for under the new Constitution. While affecting and paralyzing most of the health sector in Colombia, union representatives at national level are fighting for appropriate pay raises, against the closure of municipal state social enterprises (hospitals), and what they perceive as undue budget ceiling. The current general strike reflects the confusion due to lack of leadership, guidance, and other weaknesses of the Samper administration.

It was not possible to obtain an up-to-date figure on the degree of unionization among health workers, nor on size of some of the unions. There are both unions and professional associations, often linked to the postgraduate schools or universities where titles were obtained. The most important ones are:

- ANEC: With an increased number of professional and specialized nurses, the National Nurses Association of Colombia (ANEC) became the leading pressure group for nurses.
- SINTRASALUD, formerly FENTRASALUD, is a nationwide umbrella association founded in 1983 by 24 health worker unions.
- SINDESS, the health workers union which organized the October 1998 strike.

- ASMEDAS – Association of Unionized Doctors,²³ with several regional sub-chapters.

3.2. Impact on the health workforce in general

The information given in this chapter refers to the health workforce in the public sector. From the overall improvements in terms of employment opportunities, it can be derived that the private health providers also benefited from the legislative changes which induced an increased demand for health professionals at all levels, and for administrative staff to fulfil the new administrative and managerial functions.

3.2.1. Development of employment (structures and levels), including gender implications

The National Civil Service distinguishes the following six levels of public service employment in the health sector (Decree 1569/98, article 15):

- Directory: Hospital Director, Local Health Director,²⁴ Manager ESE, Departmental/Municipal Secretary of Health, Subdirectories.
- Advisory: Advisers to the directors, Office Chiefs.
- Executive: Heads of Departments, Sections, Divisions, Directors/Chiefs of Health Centre.
- Professional: Physicians, specialists, professional nurses, health trainers, nutritionists, social workers, psychologists, etc.
- Technical: Statisticians, occupational health technicians, sanitary technicians, store auxiliaries, lab technicians, x-ray technicians, etc.
- Auxiliary: Auxiliary nurses, health promoters, other auxiliary employments.

The changes in table 2 show an increase of positions in public service entities for general physicians, dentists, and auxiliary administrative staff as a result of the reform, due to a shift in the health services to be provided within the Compulsory Health Plan (POS).

²³ Both ANEC and the leading medical union, ASMEDAS, were invited to give their opinion on how the impact on the health reform was felt by their members and by the institution itself. Despite personal follow-up no feedback was received to date.

²⁴ In many small municipalities, local administration does not have a health secretariat. In these cases, the hospital director assumes the function of the local health director as well.

The reform thus created more employment opportunities for all professional groups. Since private providers can also offer services under the POS, it can be expected that the increase in employment also occurred in the private sector, although we have no data to support this assumption.

Table 2. Availability of human resources for health in the public service, by positions, expressed in full-time posts (TCE), 1994-97²⁵

Cargo	TCE 1994	TCE 1997	Dif. 1997-94	Variation %
General physician SSO* and specialist	6 797	9 490	2 693	39.6
Nurse SSO* and specialist	2 960	3 673	713	24.1
Dentist SSO* and specialist	1 498	2 180	682	45.5
Bacteriologist and SSO*	1 370	1 829	459	33.5
Sanitation technician	1 886	2 100	214	11.3
Auxiliary	4 456	5 104	648	14.5
Administration auxiliary	2 073	3 440	1 367	65.9
Secretary	3 484	3 705	221	6.3
General services staff	10 826	12 111	1 285	11.9
Auxiliary nurse	21 347	24 179	2 832	13.3
Health promoters	5 839	6 537	698	12.0
SUBTOTAL	62 536	74 348	11 812	18.9
Other positions	21 968	27 977	6 009	27.4
TOTAL	84 504	102 325	17 821	21.1

Source: Censo de Recursos Humanos Sector Salud Oficial, Ministerio de Salud 1998 (MOH Human Resources Survey – Official Health Sector).

This upwards trend is particularly remarkable since it runs counter to the overall employment trend in the public sector. A recent cross-country study of the ILO (1998b:12) shows that public sector employment in Colombia decreased from 1991 to 1995 at a rate of 4 per cent per year. A total of 82.600 posts were eliminated. Also, the public sector share of total employment went down from 10.7 per cent in 1991 to 7.9 per cent in 1995. In the same period, overall employment rose at an annual average rate of 2.9 per cent.

3.2.2. Legal status of staff and contract flexibility

Under the new legislation, with the shift of the funding mechanisms of public hospitals, new staff is generally offered short-term contracts of three or four months.²⁶ Therefore, the proportion of public service professionals permanently employed by the official health sector (“*de planta*”) is decreasing, favouring new arrangements (see table 3).

²⁵ Tables made available by Socarro Barona, Secretaría departamental de salud, Cali, Valle.

²⁶ Personal communications with counterparts from Cali and Cúcuta.

Table 3. Number of positions in the official health sector by type of employment (1994-97)

Type of employment	1994		1995		1996		1997	
	Total # of positions	TCE*	Total # of positions	TCE	Total # of positions	TCE	Total # of positions	TCE
Permanent	83 401	81 372	86 214	84 044	90 993	88 916	92 072	90 002
Contract	3 292	3 132	5 973	5 669	10 505	9 935	13 163	12 323
TOTAL	86 693	84 504	92 187	89 713	101 498	98 851	105 235	102 325

Source : *TCE : Full-time posts equivalent (*Tiempos completos equivalentes*).

Official Census of Health Sector Human Resources, MOH, 1998.

Also, many professionals are contracted as advisers (“*asesores*”), or associate consultants, by an EPS or by a hospital, hired on a fixed-term basis. While short-term advisers can be seen as an instrument creating some flexibility for hospitals to handle shortages of know-how or of qualified personnel, this contractual form cannot replace regular career positions, nor is it in the interest of the professionals.

Apart from short-term contracts, a growing number of medical doctors are also hired as external advisers, remunerated on the basis of services provided (“*nómina paralela*”). The revenue of the institution – based on the fee for the relevant diagnostic treatment groups – is then divided between the specialist and the institution 60:40.²⁷ Payment is apparently quite high, but these advisers are left without any kind of social insurance – just as those remunerated by way of “*salarios integrales*” a decade ago (see p. 81). There is little information on labour conditions of those external medical advisers, or on how they are controlled.

Another trend observed is that new contracts tend to be full-time working contracts. Whereas part-time contracts were quite common in the health sector, allowing personnel to additionally earn some extra income in the private sector, pressure can now be increased to work full time and full capacity for the hospital. Interestingly, whereas elsewhere this would affect women more than men, in Colombia no gender bias has been observed. However, the loss of a potential second source of income can be perceived as a threat to maintaining a standard of living.

A recent survey undertaken by the MOH in the “official health sector” shows the following distributions of permanent and contract employment, as well as the amount of full-time positions out of the total health work force:

Table 4 shows that fixed-term employment almost tripled in three years, while the increase of permanent positions was considerable (11 per cent), but far behind the growth of contract employment.²⁸

Moreover, requirements for the compulsory social year were loosened. While this service was established to guarantee a minimum of trained health workers in smaller localities, with three-month contracts instead of one-year commitments, basic service

²⁷ Personal communication, Socorro Barona, Oct. 1998.

²⁸ Figures for the private sector are not available.

provision in remote areas is even more at stake and fluctuation seems to be officially accepted. It remains to be seen whether the new ruling will have a negative impact on the implementation of the reform. If first-level health facilities can no longer be staffed properly, people will continue to turn away and seek treatment, even for minor ailments, at secondary and tertiary level hospitals. Skewed demand could once again increase already existing technical inefficiencies and a concentration of resources in urban areas at the expense of the under-served populations.

3.2.3. Training, and retraining, career opportunities, mobility

As has been stated, the Colombian reform did not address training and career issues until 1998.

Today, the main requirement for entering any of the professional positions in a health facility is that the candidate be a graduate from a recognized university, which means that the institution is certified by the ICFES. Otherwise, universities are very autonomous in the courses they offer, in curriculum development and in the selection of their students. As a result of Laws 30 and 115 of 1994 (concerned with education), which gave autonomy to educational institutions creating programmes, there has been an expansion of schools and programmes of all kinds without any consultation or control mechanisms considering labour market requirements. Access to medical schools and other institutions of higher education is not regulated by the State.

There is no link between the production of human resources and the health sector needs for specific skills or specialities. The National Board for Human Resources Development in Health, established in 1977 with representatives from the Ministries of Health, Education, and Labour, does not seem to be operational at the moment. Departmental committees of this board were created in 1994, but are poorly managed, and lacking infrastructure, support, and a specific decree regulating their performance and tasks (PAHO, 1998).

Technical careers are offered at the different SENA institutes throughout the country (auxiliary nurses, electro-medical technicians, etc.). The CENTRA offers a programme in management training for mid-level personnel and has signed an agreement with MINSALUD for that purpose. The programme consists of five modules and includes additional training documents related to the institutions of the participating students.

Training programmes offered at the local level need to be registered with the Departmental Secretaries of Education whenever the course duration exceeds 160 hours. For all programmes involving the handling of patients, institutions need an MOH authorization.

While there were few modifications in the regulation of technical professions in the health area, none of them occurred in relation with the 1993 health sector reform. The 1980 higher education reform, for instance, had a lasting impact on the training of nurses. Mid-level technological institutes were converted (upgraded) into masters' programmes, a change which was reinforced in 1992 by Law 30. The Colombian Association of Nursing

Faculties, ACOFAEN, participated in the formulation of the goals and contents of postgraduate training and in the curriculum development for nursing.

However, there have been a few isolated projects, such as the IDB municipal health services project. Planned in 1993 for implementation in nine of the 32 Colombian departments, it included training components to increase institutional capacity and managerial skills at the local level.²⁹ The project also proposed a wide range of training interventions in support of the basic package of services, including training in principles of primary care, service delivery, community participation, and data collection and monitoring techniques.³⁰ Specific training was prepared for health promoters, nurses and nurse assistants. Nurses were to receive training for community work, diagnostic skills, standard treatment protocols, recording of basic data, and referral management. As for physicians, the focus of support was to be laid upon management, leadership and communication skills, personnel development, and epidemiological tools for baseline and assessments and follow-up of epidemiological changes.

In addition, another project worth mentioning is the regional training course in applied epidemiology and management for local health professionals, which was developed and carried out in two departments, Valle and Norte de Santander. This course was initially assisted by the development cooperation and then, in 1995, successfully integrated into the public health postgraduate course at the Universidad Javeriana, in Cali. In 13 teaching modules, the course integrated epidemiological tools and current health policy analysis, and prepared health workers to assume their new roles as local health planners and managers under decentralization. Participants were carefully selected to ensure sustainability of the methods taught. For instance, to avoid setbacks caused by fluctuations, participants had to commit themselves prior to the course to remain in their positions for at least another two years.

3.2.4. Work organization, responsibility/accountability, supervision/management, participation of workforce, and users

Work organization follows the principle of subsidiarity: what can be done at the lowest level should be done there. Supervision is organized along the same lines. Cases of mismanagement, bankruptcy or hospital closure are reported to Supersalud (see p. 84). In the case of the Department Valle, several hospitals were devolved from the regional level into the responsibility of Supersalud, for lack of resources and managerial deficits.

Participation of employees is regulated in Law 152 and in two MOH resolutions (1757/94 and 4288/96). Employees can further use the same participation channels which are open to users and the larger community: in approximately half of the social state enterprises, or hospitals, user associations have been formed. In 441 municipalities public

²⁹ We were unable to get in touch with the responsible project officer, so, unfortunately, no results can be presented on this project.

³⁰ However, these interventions were limited to the municipal health personnel within the project area. The project area of the World Bank pilot project consisted of nine departments: Atlántico, Bolívar, Córdoba, Sucre, Chocó, Cauca, Nariño, Vaupes, Santa Fé de Bogotá.

auditing committees exist (“*veedurías*”). Another 247 municipalities established community participation committees (COPACOs, see p. 82) to develop local health plans together with users.

3.2.5. Working time (part-time work and flexibility, shift and night work, rest periods)

Weekly working time is 40 hours for public sector professionals. In hospitals of secondary and tertiary levels, where services are available 24 hours, health workers do shifts of eight hours a day. It was not possible to obtain information on whether working time patterns differ in private health facilities, and private EPS.

3.2.6. Staff performance, remuneration, incentives and other entitlements

Remuneration and incentives

In Colombia, health workers in the public sector are currently better off than their private sector colleagues. The average income of professionals in the private health sector is about 30-40 per cent higher than in the public sector. The administrative career has a number of bonuses and incentives available: there are 12 regular salaries, two extra salaries (summer holiday and Christmas), technical bonuses, bonuses for positions in remote areas, and other types of pecuniary and non-pecuniary sanctions and incentives. In the private sector, there is only one extra salary paid in two lots (summer and Christmas).

Salary regulation issues and the adjustment between public and private salaries were dealt with in the Decree 439/95, article 5. According to the provisions made in this Decree, the remuneration of public health sector professionals (permanent positions) for 1998 was fixed as follows.

Table 4. 1998 monthly salaries of public health sector professionals

Post	Monthly salary (Colombian pesos)*	US\$
Nurse	630 700	400
Specialized nurse	670 000	419
General physician	1 071 000	679
M.D. specialist	1 392 300	883
Dentist	834 304	529
Specialized dentist	860 000	545
Optician**	630 700	400
Minimum salary	204 000	129

Despite rather good salary conditions, health sector unions nevertheless called a strike in October 1998. The negotiations about salary increases for 1999 had come to a halt since the Government only offered a 14 per cent weighted increase while the unions demanded an increase equal to the inflation rate of around 20 per cent. The conflict was settled at the end of the month at 15 per cent (about 10 per cent in real terms). The increase also applies to the minimum salary.

It is obvious that these rather favourable conditions only apply to those already on the public services permanent payroll. However, in times of high unemployment – Colombia currently experiences one of its worst economic crises, leaving 17-20 per cent of its workers in the formal sector unemployed – employers can dictate the conditions of work contracts, a fact well known from the eighties. At that time employers favoured all-inclusive fixed-term contracts, so-called “*salarios integrales*”. Workers were paid a sort of lump-sum salary which supposedly included the employers’ share of social insurance and fringe benefits. In fact it led to a situation leaving many health workers unprotected, forced to buy their own insurance, and it led to a de facto decrease of remuneration.

Staff performance

The evaluation of staff performance is regulated in Decree 1572/98 in articles 104-119. The National Civil Service Commission sets the conditions for this evaluation, which is to be carried out annually by the immediate superior of the employee. The evaluation helps determine career issues, eligibility for bonuses, training needs, or post-induction requirements of each individual employee.

3.2.7. Work environment, staff perceptions, attitudes, absenteeism

As far as possible the current work environment has already been described. Health workers, unions and professional associations are likely to protest against “the reform” as a whole due to a climate of general confusion and uncertainty about future changes. From their perspective, the salary issue is the most immediate concern and the easiest point for entering discussion.

In theory, the reform could contribute a lot to improving the work environment and organizational culture of either social state enterprise or EPS/ARS. However, the current perception is that of being overburdened and left alone without sufficient supervision and guidance, be it from the territorial health boards (CNSSS, see p. 84), or from the civil service.

3.2.8. Occupational health effects (especially hazard protection)

The general social security system deals with occupational health and professional risks in a separate book (Law 100, Book 3). These risks are insured by 18 specialized insurance companies (ARP). Each institution has to negotiate coverage for their employees according to the type of work performed. The ILO classification of occupational hazards is applied, but not all health and social securities institutions have already categorized their posts according to this standard (“*panorama de riesgos*”) which is a prerequisite to negotiate insurance conditions with the ARP. No information could be obtained regarding changes (increases) in occupational diseases, accidents, or stress as a result of sector reform or transitional difficulties.

3.3. Effects on public-private mix in the health sector

3.3.1. *Participation of NGOs, local communities, and the private sector in service delivery systems*

Health NGOs as such never played a major role in the provision of health services in Colombia, although some NGOs are engaged in other developmental areas such as human rights, environmental, ethnical issues and other issues of social concern. There are a number of private foundations which engage in health sector consultancies and research. They contract with local entities, cooperation agencies and political foundations from abroad.

It was a major concern of reform legislation to strengthen community participation in local health planning, management and decision-making within facilities, and in the auditing of health facilities for the sake of transparency and ethical control.

In 1994, Decree 1757/94 was passed dealing with all aspects of “participation in health” granted by the Constitution. Social participation covers two main aspects:

- civic participation, the obligation of the individual to participate in the conservation of his or her own health and to contribute to the planning, management, evaluation and control of health facilities;
- community participation, which defines the rights of community organizations (NGOs included) to also actively engage in the above activities.

The Decree (article 7) defines the composition of the main community participation committee, the COPACO (*Comités de Participacion Comunitaria*). COPACOs are composed of:

1. the mayor (president);
2. chief of section, municipal health service;
3. director of the most representative local ESE (vice-president);
4. representative of each social organization or community group such as:

- (a) committees around health: UROS, UAIRAS, COE, COVE,³¹ Madres Comunitarias, Gestores de Salud, Empresas Solidarias de Salud;
- (b) local boards of administration;
- (c) community organizations of neighbourhoods, rural locations, etc.;
- (d) recognized user associations;
- (e) educational sector;
- (f) church.

Reinforced by legislation, committees and functions for community participation, self-management and public auditing proliferated³² to the point where it becomes unclear what the purpose really is: how efficient is community participation if it is split among many different committees? Who follows up on all the appeals, recommendations, and suggestions developed from below? Whom do the groups and committees address for what specific issue?

Participation can as well be diluted, frustrating those who engaged in the new participatory forums with enthusiasm and a strong belief in democratic forms of influencing politics. At the local level, it is felt that non-governmental assistance – by NGOs, universities or other sponsors – could be most helpful in times of transition and reform implementation, particularly in view of the absence of governmental assistance. Mayors have criticized the low quality of technical assistance received so far by either national or departmental staff. Given the complexity of the new health and social security system, continuous orientation and training of municipal employees throughout the local institutions, NGOs, and political leaders, is needed (DNP, 1996:160).

3.3.2. Repartition of roles for enforcing standards, quality, fair competition and appropriate service

The role of the MOH has already been described earlier.

³¹ UROS: oral rehydration units, UAIRAS: units for the attention of acute respiratory infections; COE: emergency committees; COVE: epidemiological surveillance committees.

³² See D. Ochoa Jaramillo in: González Posso 1994:112.

Superintendencia Nacional de Salud

Supersalud authorizes, supervises, and controls private and public EPS. Article 230 of Law 100/93 regulates that Supersalud as the principal control authority can impose financial sanctions or withdraw the authorization to exercise administration of the compulsory health plan (POS), in one of the following cases:

- upon request of the EPS;
- if the entity no longer fulfils any of the requirements of the authorization;
- if the entity practices adverse selection;
- if there is proof that the EPS does not effectively offer the services fixed in the POS.

The control functions of Supersalud are explicitly supplemented by community inspection committees , or “*veedurías*” (article 231).

Consejo Nacional de Seguridad Social en Salud (CNSSS)

The National Board for Social Security in Health (CNSSS) is a permanent directory established to define technical issues such as the POS and the list of essential drugs, as well as financial issues such as the contribution to be collected from the EPS affiliates, the value of the per capita unit, the value per person covered by the subsidized system, and criteria of eligibility for the subsidized system (article 172, Law 100/93).

The Board is composed as follows (article 171, Law 100/93):

- Minister of Health (president);
- Minister of Labour;
- Minister of Finance;
- representatives of the corresponding departmental and municipal entities;
- two representatives of employers;
- two representatives of employees;

- the legal representative of the ISS;
- one representative of each of the following entities: EPS (except for ISS), IPS, the major health professional association, user committee from a rural area.

In addition, the CNSSS is permanently advised by scientific and professional associations: Academia Nacional de Medicina, Federación Médica Colombiana, Asociación Colombiana de Facultades de Medicina, Asociación Colombiana de Hospitales and a representative from the public health faculties in the country. The Board is meant to be a forum for negotiations and conflict settlement between the different actors and interest groups in health.

Despite the composition of the central level Board, participation of social and professional sectors was not satisfactory, nor was the participation or flow of communication between the Board and the operational level. Also, it is not clear to what extent the territorial boards, which supposedly were formed accordingly in the departments and municipalities, became operational, and what their contribution has been in terms of guidance and operationalization of the national policies.

National Civil Service Commission

The National Civil Service Commission with its territorial branches watches over the fulfilment of contracting, employment, performance evaluation conditions etc. (see above p. 81).

3.3.3. Budgetary repercussions

Overall, the availability of financial resources for health increased considerably. In 1996 the health share of the GDP had increased to 4.7 per cent – 1.5 points up from 3.2 per cent in 1994. However, the current problems in the health sector are not only financial deficits (4.7 per cent is not high by international standards) but deficits in the management of available resources.³³

At this point it is not known what the costs of a thorough strategic plan for human resources development would be. Certainly, reorganization, temporarily brought-in external consultants for management, and the implementation of information and training activities will generate both short-term investment costs and long-term budgetary commitments.

The reform has had budgetary repercussions both at territorial and institutional levels. Public services in general and health facilities in particular have in common that they have to adjust to new public management and assume additional functions. Whereas the

³³ Statement translated from a newspaper quotation, *El Tiempo*, 22 July 1998, column La Oportunidad de Carlos Caballero Argáez.

municipal and departmental authorities have to cope with new responsibilities (planning for social sector spending), health facilities have to adapt their internal management to completely different financing patterns.

Not surprisingly, there have been transitional problems on both sides, EPS and IPS/ESE (hospitals). Above all, the lack of preparation, and thus of managerial and financial absorption capacity, was soon felt. Hospitals had to close claiming that the reimbursement rates do not let them do their work, and professional associations claim that their incomes have decreased. At the EPS, there certainly is a bottleneck in the settlement of bills and payments which again leads to liquidity shortages in the hospitals. It seems that some of the privately run EPS have encountered more problems in the financial execution than the public ones.

As for the budgetary situation in the hospital sector, there is a new draft law which, as an emergency intervention, foresees the elimination of all intermediary entities – the EPS/ARS – in order to pass on the budget to the hospitals directly.³⁴ The responsibility of a number of hospitals had to be handed over to Supersalud, facing bankruptcy. The State thus continues to intervene – troubleshooting – in the complicated public-private partnership in health service delivery.

4. Lessons learned from Colombia: Transferability of reform experiences and open questions

4.1. Timing and political consensus

The context of democratization, pacification, pressure for legitimization of political power (Castro) provided a receptive, stimulating environment for the decentralization of the health sector. The 1993 reform benefited from the broad political consensus among key stakeholders and key leaders of the political elites to transform the health sector. As Bossert points out, the process of consensus building was unique in the sense that the "individuals, not institutions, were the leaders in this process" (1998:67).

The result of the health sector reform is a well-thought mixed system combining (the best?) of social-democratic and neo-liberal thought. Universal coverage, access and the provision of a standard health care package for all Colombians by the year 2001 are goals formulated out of a welfare, or communitarian approach, whereas the privatization and introduction of competition among insurers and providers under state regulation show a neo-liberal, or utilitarian, influence. The mix in fact shows that the planners were well aware of the insufficiencies and inefficiencies of a completely liberalized health sector, leading to moral hazard, adverse selection, and certainly not to better health for all. Also, the reform explicitly takes care of the neediest population groups, introducing

³⁴ Personal communication, Germán Wilches, 4 Nov. 1998.

redistributive mechanisms from the national to the municipal level on the basis of needs and income potential, among municipalities and among departments.

4.2. Political stability and sustainability

The Pastrana administration will continue the reform. Pastrana's health advisers are the same experts who drafted the reform under Gaviria in 1991-93. There are fears that the new Government might favour neo-liberal solutions; however, it seems that the new MOH wants to stabilize the situation as it is before seeking to expand coverage beyond what has already been achieved.

4.3. Key functions for health reform

It has been criticized that the MOH failed to establish a leading advisory unit in charge of monitoring and analysing the reform process. According to Bossert, during a reform process any MOH needs to assume a number of key functions essential for the health reform. These functions are information collection, analytical capability for decision-making, creation of regulations, provision of information to the public, revenue collection. While in the years following reform the regulatory productivity was impressive, a more systematic collection and analysis of information might have facilitated the consideration of labour and human resources as an instrumental essential issue of sector reform.

4.4. Coordination at central level

Despite the political opportunity the parallel implementation of decentralization and health sector reform did not lead to a close coordination with other government entities such as the National Planning Department or the Civil Service Commission. The verticality of the technical health sector still persists. Also, there was considerable resistance to just another reform within the MOH (Bossert, 1998:67-69), where political staff rotation and the lack of a health sector monitoring unit imposed further obstacles to cooperation within the MOH and with other government entities. The relationship to the Ministry of Education or other education boards and institutions were not strengthened during reform.

4.5. Intersectoral participation

Despite the existence of intersectoral planning committees prior to reform and later on, participation did not take place as expected. The Colombian reform process was a top-down planners' exercise. Stakeholders at municipal and institutional levels such as personnel of the affected health facilities, unions, and public service offices were not involved in the conceptual phase of the health sector reform. "*Los profesionales de la salud, incluso las asociaciones, estuvieron ausentes de los escenarios de la reforma y de la*

reglamentación y fueron aún más ajenos los usuarios potenciales afiliados al nuevo regimen.” (González Posso, 1994:122).

4.6. Stakeholder analysis

Experts from Liverpool and Harvard universities have developed very useful analytical tools to thoroughly investigate the setting of stakeholders, group competition, policy networks, and power relationships (Martineau/Martínez, 1997, Reich, 1994-96) in the health sector. If applied, these tools can assist the situation analysis prior to reform, the outline of reform goals, and detect and respond to possible difficulties during the process of reform implementation.

4.7. Strategic planning for human resources development

A systematic assessment of human resources development, of which staff development and labour relations and negotiation conditions form part, could follow, for instance, the framework for analysis as proposed by Martineau/Martinez (1997).³⁵ To each item under consideration, they offer questions to help in the analysis. It is suggested that these questions and guidelines be considered for the finalization of the TOR of the country case studies.

4.8. Win health workers as change agents through good information

The regular information to and from health workers at all levels is key for facilitating implementation, for they help increase the understanding of the reform, acceptance and appropriation of its goals by the workforce, and raise tolerance for temporary transitional difficulties. In Colombia, the reform was drafted and discussed without involving the implementing levels, training institutions, unions, and professional associations. The recent strike shows what happens when communication does not take place in time. *“Solo si los profesionales de la salud y todos los trabajadores del sector se sitúan como los impulsores centrales de la reforma, esta podrá hacerse en esta década.”* (González Posso, 1994:146).

³⁵ It could as well benefit from the discussions, conclusions and the resolution from the ILO Joint Meetings on Terms of Employment and Working Conditions in Health Sector Reforms and on Human Resource Development in the Public Service held in Geneva in 1998.

4.9. Preparation, capacity-building and ongoing training needs

Managers, health workers and general public servants at both the municipal and departmental level have to be prepared from the onset of reform. In Colombia, despite thorough discussions about philosophy, scope and feasibility of a comprehensive social insurance scheme, the human resources issue was not on the agenda until 1998.

4.10. Involvement of higher education and vocational training institutions

Higher education for nurses and physicians still is vertically organized and planned for from within the universities, with no specific directions from or collaboration of health sector planners/reformers. In the long run, it is important that faculties and school adjust their programmes. The MOH should show its willingness to establish a dialogue on HRD together with higher education and vocational training institutions.

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Appendix 1

List of resource persons

Directions from WHO (terms of reference)

Dr. Hernán Málaga, WHO representative, Colombia

Sr. Hector Galindo, Coordinator, PSI Subregional Office for the Andean Region

Dr. Thedieck, Managing Director, DSE-Public Promotion Administration Centre, Public Health Promotion Centre, DSE, Berlin, Documentation Centre of DSE, Bonn

Dr. Gabriele Ullrich, International Labour Organization (ILO)

Alan Leather, Mike Waghorne, Public Services International (PSI)

Local resource persons

Personal communication

Dra. Socorro Barona, Secretaría Departamental de Salud, Cali, Valle

Dr. Germán Wilches, FASESS, Cúcuta, Norte de Santander

Other experts contacted

Tim Martineau, Liverpool School of Tropical Medicine

Dr. Francisco Yepes, ASSALUD, Bogotá

Dra. Beatriz Carvallo, ANEC, Bogotá

Dr. Jairo Reynales Londoño, Municipal Health Services Project, BID/MINSALUD

Websites

MINSALUD (homepage of the Colombian Ministry of Health)

Departamento Administrativo de la Función Pública

Saludcolombia.com

El País – Bogotá

PAHO/OPS Country Health Profiles

The World Bank: Health Sector Reform Modules

UNDP – pages on Decentralization; Human Development Report 1998

Management Sciences for Health, Boston: Decentralization and Human Resources

Harvard School of Public Health: Data Decision-Making

Appendix 2

Documents suggested for further discussion: Planning for decentralization

What is true to make decentralization work can also be applied to health sector reform. Bryant (1997), in a presentation delivered at the 1997 APHA meeting, gives pragmatic hints on how to motivate and actively integrate local health managers and health workers into the reform process. Also, it is worth looking at the guidelines for HRD developed by the Liverpool School of Tropical Medicine on behalf of the European Commission in 1997. Excerpts of both papers are presented below.

For a more detailed analysis on site, we would like to recall the tools of the 1993 WHO “Training manual on management of human resources for health” on the management of organizations, leadership and motivation (section 1) and on management-staff relations and staff development (section 2).

Bryant, Malcolm: *Is it possible to plan for decentralization?* Boston, 1997, Paper presented at APHA workshop on decentralization (website Management Sciences for Health).

1. GOOD, APPROPRIATE INFORMATION IS THE ONLY WAY FORWARD

Be prepared with good information – Demographics, politics, service delivery statistics and health statistics. This work cannot be omitted if you are to have compelling data to support your approach, convince health workers, politicians and community members of the value of change, and most importantly, provide a baseline against which you can measure change (positive or negative), as you implement your plans.

2. DO NOT TRY AND DO THINGS ALONE

Seek assistance often and from people who can help: Do not be too proud. You cannot know everything. You will need the input of people with similar experience.

Look for allies in health and in other sectors: Even if other sectors are not decentralizing, they will be affected by what you are doing. It is important not to approach decentralization in such a way that you alienate people in other sectors. If many sectors are decentralizing at the same time, it is important not to make this a competitive process, but a mutually supportive one.

3. UNDERSTAND WHAT YOU ARE DOING AND COMMUNICATE IT TO OTHERS

Be clear in your own mind what you are doing, what the decentralization is all about, and what your role is in it: Are you simply following a political agenda that is being thrust on you? Are you doing this only because you will lose your job if you do not? Do you believe that this decentralization is the single most important step to improve the health of the people in your country's history?

Whichever it is, make sure that you understand.

Be honest about what you are doing: If you are doing this to save money then be prepared to say so, do not insult people's intelligence by saying it is designed to improve their services. People may not like the truth, but they like deception less. This applies to both health staff and the population.

Know what is legal and what is not: If there is the need for legal changes in order to implement your plans, identify this early on. This means that you must know the legal framework for service delivery, and understand how flexible this is. Plans that require health care providers to break the law will not work. Some laws can be changed and others cannot. If the laws cannot be changed, then you probably need a different plan.

Involve the community at the local level: Make sure you know what they might want and need, and make sure that you have mechanisms to communicate with them to let them know what you are actually doing.

Do not discount the importance of local politicians: They can be neutral, they can be allies, or they can be against you, but they cannot be ignored.

4. MAKE SURE YOUR PRIORITIES ARE RIGHT

Focus on what matters: You cannot have a system without the basic supports. Your situational analysis and data-gathering will have identified the key issues. Make sure that you know what is critical, and ensure that it is addressed. For example: a system without essential drugs does not work, not matter how well everything else works.

Focus on what is already working well (or what the population thinks is working well), and make it stronger AND take what is not working well and remove or reform it: Acknowledgement of these two elements and visible action may cost little but will make the process of change much smoother.

5. PREPARE YOUR COLLEAGUES AND CO-WORKERS

Educate health workers: Take the time to involve the health workers in the system. Let them know not only what is going on but involve them in decision-making.

Educate the population: As with health workers, involve the community.

Ensure everyone has the necessary tools: Clearly health workers need the knowledge and skills required to facilitate the process you are planning, but so does the community. For example: to demand of a community that they do a needs assessment, requires that they have the knowledge and tools to do so without wasting time and resources, and without developing frustrations. Invest the resources in making sure that people have the tools, expertise and money required to do the basic tasks.

Appendix 3

Core HRD functions

Excerpts from: Martineau, Tim; Martínez, Javier: *Human resources in the health sector: Guidelines for appraisal and strategic development*, European Commission, Health and Development Series, Working Paper No. 1. Brussels, 1997.

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| A. Staff supply | Ensuring that the health system obtains an adequate supply of staff to achieve its objectives within agreed budget constraints. This includes using staff from the existing labour pool in the most cost-effective way, or influencing the production of different types of staff to those currently available. |
| B. Performance management | Optimizing productivity and quality of work of the workforce. This includes designing or adapting performance management and performance appraisal systems. |
| C. Personnel administration and employee relations | Setting pay levels and conditions of service; career structures; incentive systems; structuring, managing and harmonizing relations between employers and staff. This includes managing labour relations and finding ways for effective involvement and communication between employers and staff, including their representing bodies. |
| D. Education and training | Producing appropriately skilled personnel for the labour market. This includes interventions on curriculum design and enforcement of training standards on the basis of a process of continuous appraisal of needs generated within the labour market. |