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Potential and limits *of health management* reform in Chile

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Against a background of increased expenditure and improved equity, this reform of public health management in Chile, set in the context of a dual health system, aims to consolidate a cost advantage over the private sector. Emphasis has been placed on the distinction between the regulatory, financial and supply functions in the public sector, and a relative opposition of interests between them has been encouraged, with a view to generating quasi-markets. The "management commitments" entered into between the Ministry of Health and the Health Services mark a departure from the strategy of resource allocation guided by historical budgets and make results the decisive factor of funding. These commitments establish each year the types of service that are to be provided, the allocation and transfer of resources, and the performance indicators, in an overall perspective that includes the areas of programme content, financing, human resources and investment, and they govern the many dealings between the Ministry and the Health Services. The other focus of the reform is the improvement of labour productivity, to which end attempts are being made to change the existing conditions of recruitment and pay. The duality of the health model significantly limits the financial control of aspects that are endogenous to it, such as absenteeism and medical hours not worked. The changes also clash with current budgetary frameworks, which inhibit decentralized resource management. Performance measurement has emphasized micro-economic efficiency more than effectiveness: in order to evaluate quality, the ultimate aim of management reform, there is a need to set standards of performance which will make it possible to measure the quality of the service provided.

I

The starting points: a necessary preamble

Not all modernization or reform of the State comes within the field of management, which encompasses actions aimed primarily at enhancing the effectiveness and efficiency of public organizations, but from the perspective of implementation, i.e., how to achieve results rather than what results to achieve. Organizational efficiency may serve many different purposes, since it acquires meaning in relation to other values that guide institutions (Prats i Catalá, 1992, p. 32). As Paul Romer puts it, management changes represent limited experimentation in the search, within a virtually unlimited range of possibilities, for ways of doing things better.

In Chile, modernization of the State apparatus and its manpower resources and management styles lags far behind. During the military regime, when the State was considered to be inefficient, bureaucratic and anachronistic, the policies adopted were essentially designed to reduce it. Employment conditions and rates of pay conspired against management modernization, and the State administration and enterprises suffered from backward technology and lack of investment (Marcel, 1995).

Social expenditure on health was severely cut back, while vast resources were allocated to privatizing the social security system and to strengthening the provident health institutions (ISAPRES). Primary care was expanded at the expense of the tertiary level, and the priority given to maternal and child care was to the detriment of care for adults and the elderly and of related preventive care measures, causing imbalances in the health system and reducing technical and economic efficiency in the use of inputs (World Bank, 1992).

The main shortcomings in public health management in Chile have been attributed to four structural problems inherent in an organizational culture focused on policies, processes and methods, rather than on results: i) the management objectives of public agencies are ambiguous; ii) individual staff responsibility is minimal, since the responsibilities are diluted and mediatized from the senior authorities down to the rank and file personnel; iii) there is no network of reciprocal obligations and relations *vis-à-vis* the user, since the public sector is unilateral and self-referential; and iv) no serious appraisal is made of management (Marcel, 1995, pp. 11 and 12). The particular features of the public sphere and the need to provide concrete answers necessitate specific timing and heterogeneity in this area of reform (Lahera, 1993, p. 33).

The democratic coalition goverments in office since 1990 have fostered a gradual modernization of public management, which constitutes the framework for reform in the health sector. Although this reform has been relatively independent in regards various aspects, in the case of the bill amending Law No. 15 076 there has been considerable inter-institutional influence.[1] Political support has been strong and the initiatives have been assisted by the presence of professionals trained in various health administration programmes.[2]

The changes are aimed at introducing health economy criteria that will help to build markets, providing agents with a set of standards requiring: identification of suppliers and consumers, granting them certain rights of ownership[3] over assets and the income derived from the exploitation of those assets; fixing of contractual arrangements to encourage agents to engage in interactions that will bring about socially desirable situations; creation of conditions in which prices act as signals that will assist agents', decision-making; and safeguards to ensure that contracts are fulfilled and that ownership rights are respected (Lenz and Fresard, 1995, p. 11).

[1] Interview with Mr. César Oyarzo, Director of the National Health Fund (FONASA), on 5 September 1995.

[2] Opinions expressed by the Minister of Health, Mr. Carlos Massad, in an interview held on 21 November 1995. As an example of support, he cited the solution to the problem caused by the recent opposition of the Comptroller-General's Office to the payment of performance bonuses to the administrative sector; the necessary law was adopted in a very short time with only one dissenting vote, which is unprecedented.

3 "Ownership" understood as the economic relationship that makes possible the disposition of resources, and not as legal ownership, since public institutions are involved.

II

Management reform as an essential need

The reduction which has occurred in social expenditure since the 1980s in Latin America was essentially a financial adjustment that delayed structural changes in the provision of services; combined with inherent deficiencies, it has placed clear limits on the availability and quality of social services. In order to improve the quality and relevance of such services, increase equity and guarantee adequate coverage, while maintaining the macroeconomic balances as a prerequisite for growth, there is a pressing need to enhance their productivity through management reform, within the framework of different degrees of fiscal leeway and different macroeconomic priorities for social spending, regardless of whether resources are increased, maintained or reduced.[4]

In Chile, management reform in the health sector is taking place against a background of increased expenditure and is seen as inevitable, given the low level of efficiency of the public sector in the prevailing dual system, and the weakness of salary control as its main source of competitiveness. Since the inefficiency is not confined to any specific area or wrapped in a "neat package", but relates rather to the way things are done throughout the length and breadth of the institutions (Osborne and Gaebler, 1992, p. 23), it is important to understand what conditions existing at the beginning of the decade have made the need for a change of direction imperative.

1. Poor institutional integration

The health sector was beset by various problems in this area at the beginning of the 1990s. The lack of coordination and complementarity between levels of care shifted pressures to the hospital emergency services and restricted primary care support. Specialized out-patient care had not been developed: primary and tertiary out-patient services were limited and suffered from problems of coverage. There was a certain geographical concentration of physicians, an imbalance was observed between general practitioners and specialists in favour of the latter, and there were few nurses (World Bank, 1992).

Because of its operational and executive functions, the Ministry of Health hampered the functions of the Health Services, which had to consult repeatedly with the Ministry's different departments, and in the absence of coordination this generated duplicated or overlapping requests. The Ministry did not adequately supervise the Health Services, which in turn failed to exercise adequate supervision over the municipalized primary care, owing to staff shortages and inadequate staff skills (World Bank, 1992).

No system or culture of coordination existed to ensure consistency of action. There was a firmly established centralist attitude, combined with distrust towards the managerial levels of the services, and an aversion to risk on the part of the services, which gave rise to a multiplicity of discussions in order for decisions to be taken (Vignolo, Lucero and Vergara, 1993, p. 58).

Furthermore, the privatization process carried out under the military regime led to a dual health system, by reason of its own nature and the inherent rationale of its design, which encourages those in the higher-income brackets to switch from the public to the private subsystem. The two subsystems follow different approaches and do not compete with each other: State insurance functions on a sharing basis and promotes solidarity, while private insurance operates on the basis of individual risks and accounts. The former is the province of the poor and attracts persons with a high health risk; the latter is taken out by the higher-income and low-risk individuals. This inhibits universal coverage of the population and the

[4] Owing to all these factors, it is inappropriate to attribute the increasing importance being acquired by social sector performance indicators to a presumed increase in the percentage of public expenditure earmarked for the social sectors (Newman, 1995, pp. 2 and 3).

efficient use of resources, and prevents a complementary relationship between public and private care (Oyarzo, 1995, point II).[5]

2. Diminishing human resources and competitiveness

Law No. 15 076 was a cornerstone of the health reform in the 1950s. Since then, however, numerous partial amendments have distorted its original purpose, generated negative incentives in the area of manpower resources and introduced high degrees of inflexibility, which have helped to create the "poor pay/steady job" combination and hindered the application of serious performance appraisal mechanisms.[6]

At the beginning of the 1990s there were no systems to evaluate the attainment of targets, compliance with quality standards or local management capability, nor were there any incentives linked to performance quality or results. The system of pay does not adequately reflect the different levels of complexity, responsibility, involvement and commitment connected with the different tasks.

In the case of the public hospitals, the framework for the staff roster is the Health Service and not the hospital, a situation that hinders proper grading. The only incentives are advancement of grade within the corresponding staff roster and attainment of seniority. Ninety-five per cent of staff are graded in list I, corresponding to meritorious performance, despite an absenteeism level of between 20% and 25%. The result is that "... At the very least, the excellent are not distinguished from the merely good and, however excellent they may be, they must wait years before rising to the highest rank in the staff roster" (Montt and Artaza, in Cámara de Diputados de Chile, 1995, p. 112).

Furthermore, the professions were not properly differentiated in the seniority tables. The Nurses' Association is of the view that the seniority tables should be separated by profession, since they cover nurses, midwives, social welfare officers, etc., without distinction (Corral, in Cámara de Diputados de Chile, 1995, p. 134).

The staff rosters of the hospitals in the respective Health Services are rigidly defined, which makes it impossible to introduce flexible working arrangements or dispose of flexible hours in order to hire different categories of staff on a part-time basis, which is a useful way of obtaining personnel in short supply, such as medical technologists and nurses (Montt and Artaza, in Cámara de Diputados de Chile, 1995, p. 114; Acevedo, ibid., p. 107; Corral, ibid., p. 136).

The excessive differences between public-sector rates of pay and market salary levels make it hard to keep and attract professionals who are more skilled, creative and efficient. The inflexibility makes it impossible to adapt the human resources to fundamental changes, such as improvements in the quality of life, changes in the epidemiological profile, scientific and technological progress and the new demands of the population.

Although the health sector is a major employer –leaving aside primary care, it employs some 68,000 staff– it has no human and labour relations experts (Massad, in Cámara de Diputados de Chile, 1995, p. 93).

There is therefore a vicious circle in the public system between spurious sources of competitiveness, low output, high absenteeism from work, inflexibility and low levels of pay as the main cost-cutting factor. This concatenation suffers from distinct limitations in the face of competition from the private system and the potential increase in pay: in recent years, stringent wage control has proved not to be a stable competitive factor, and pay rises are on the horizon. Management reform in the public health sector is

[5] In Colombia, health system reform has been undertaken on the basis of the Chilean privatization experience, but with interesting modifications to promote competition between the public and private subsystems. According to Iván Jaramillo (in ECLAC, 1995), a distinction is made between health promotion enterprises which have responsibility for financing, and enterprises that provide health services. There are two schemes, the contributory scheme, which is funded by employees' and employers' contributions, and the subsidized scheme, which is aimed at the poorest 40%. There is also a system of equalization between the private entities; a per capita calculation is used to establish the amount of the surplus which goes into an equalization and guarantee fund. There are various cost control mechanisms: an amount of $ 150 per person, payment per diagnosis undertaken, and a list of compulsory generic medicines have been established. To ensure equity and to guard against consumer deception, a compulsory health plan has been established and mechanisms have been developed to prevent the rejection of women, the chronically and catastrophically sick and the elderly, by means of an allocation of resources per capita according to age groups. At the same time, health insurance is proposed as a private and individual benefit.

[6] This diagnosis and the one in the following paragraph are contained in the opinions on the reform of the law which were expressed by a bipartite commission comprising representatives of the Government and the Chilean Medical Association established by joint agreement in December 1994 (PAL, 1995a).

thus crucial: it is inevitable if the cost advantage is to be maintained (Oyarzo, in Cámara de Diputados de Chile, 1995, pp. 96 and 97).[7]

3. Inefficient and asymmetrical financing

There was fertile ground for distortions in the fixing of prices and in the pattern of use of Health Services, the transfer of resources was not linked to results, and there were problems in the financing mechanisms: the fee-for-service system adopted for reimbursing municipal facilities (FAPEM) and its monthly ceiling gave rise to large deficits in poor municipalities,[8] and did not promote efficiency in terms of unit costs or an appropriate referral system. For other levels of care, the lag behind inflation exhibited by the ceiling of the reimbursement on a facility-specific basis for the amount and type of services rendered (FAP), which had to be offset by additional transfers, led to a centralization of expenditure decision-making, which took place on the basis of the global budgetary framework without any negotiations to link resources to results.[9]

Both mechanisms generated negative incentives because they encouraged a purely curative approach and reimbursement for individual actions, rather than for comprehensive care, and discouraged cheap treatment or treatment whose costs were not covered; furthermore, they had an adverse impact on the system of patient referral to and from hospitals (World Bank, 1992).

III

The reforms

These are aimed at making the system more equitable, improving quality and consolidating good basic coverage: in general terms, they depend on changes in organizational culture, in legal provisions and in support elements such as staff training and information systems.

1. Harmonious and decentralized institutions

During the military regime, functions that had traditionally shown a high degree of concentration and centralization were separated for the first time. There were three of these, which were to be carried out by different agencies: the rule-making and monitoring function was assigned to the Ministry of Health and the executive function to the Health Services, while for the financial function the National Health Fund (FONASA) was set up. Nevertheless, these agencies retained hybrid functions because the national reorganization left room for ambiguities as regards the powers and responsibilities of the different bodies (Oyarzo and Galleguillos, 1995, p. 40).

Efforts are currently being made to bring about an effective differentiation of functions, promoting an opposition of interests –for example, between purchaser and supplier– that will help to maximize efficiency; each agency's concentration on the appropriate skills to fulfil its function must necessarily develop expertise in the productive process (Oyarzo and Galleguillos, 1995, p. 32).

In order to build up a harmonious and integrated system, the Ministry will have an exclusively supervisory and regulatory role and should not have executive functions. To that end, it has been organized into three divisions (Health Programmes Division, Strategic Planning Division and Management Support Programmes Division) and a Budget and Administration Department, while a unified office

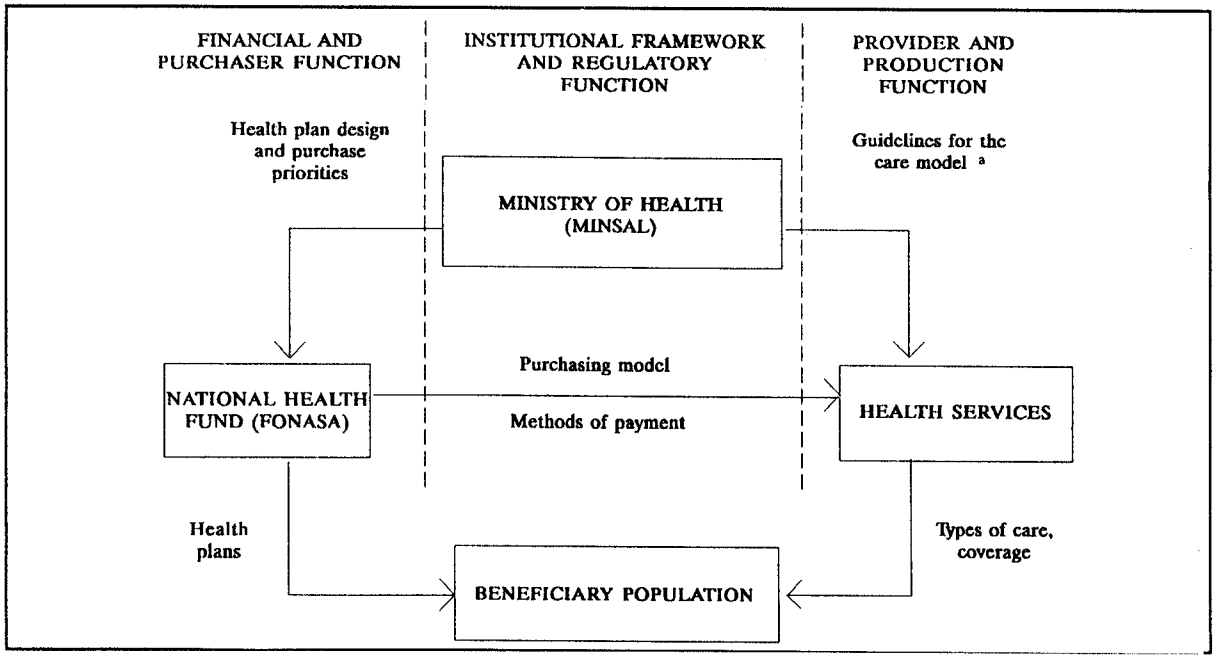
[7] "With pay increases of 25% on average, the costs of care in the public system are greater than in the private system. Some studies conducted on laboratory and other examinations have shown that, in the public system, their cost is higher than for those that FONASA could purchase in the private system. Advantages still exist in areas where there is high salary density and, in particular, in such items as bed-days and surgical operations, since the fees in those areas are manifestly lower than those in the private sector. The problem is viewed as a serious one in the light of the current pressure on pay since, once there is an increase, the public sector may lose one of its biggest advantages" (Oyarzo, in Cámara de Diputados de Chile, 1995, p. 97).

[8] See Fielbaum, 1991; Chile, Ministry of the Interior, 1990; Duarte, 1995.

[9] It must also be pointed out that the financial coverage in the other levels of care was always partial, since it applied only to intermediate inputs –the costs of consumer services and goods– while the items relating to pay, investments and disability allowances were budgeted for retrospectively (Miranda, Loyola and Reyes, 1991, p. 10).

FIGURE 1

Chile: Functional decentralization of the public health system



Source: Prepared by the authour on the basis of Lenz and Fresard, 1995.
[a] Human resources, investment in infrastructure, equipment and technology.

has been set up for the Minister and Deputy Minister.[10] The Financial Resources Department has disappeared, and it is FONASA which now performs the financial and purchasing role. The supply and production role is discharged by the Health Services (figure 1).

FONASA, which, in the past, basically administered the preferred provider system, that allowed some degree of free choice of doctors by patients, and served as a collection and payment agency for the Health Services, is now responsible for the administration, control and purchase of public health insurance on a basis of solidarity: it draws up contracts with public and private suppliers with a view to promoting technical efficiency and the efficient allocation of resources; it monitors the proper use of the insurance by beneficiaries and suppliers in order to minimize misuse of public resources; it supervises the collection of contributions so as to keep evasion to a minimum; it offers, directly or through third parties, a brokerage service to facilitate access to benefits and suppliers' interaction with the system, and it administers the structure of benefits and user-fees according to policy and programme priorities within a framework of equity and efficiency (Oyarzo and Galleguillos, 1995, p. 43).

FONASA has contracted out a number of tasks, such as data-processing operations, which ensure proper identification and recording of beneficiaries in order to prevent leakage of benefits and to provide information for the insurance administration. The accounts relating to the indigent and to contributing members have been separated, which is an important step in dispelling the myth regarding the presumed subsidy for poor persons that encourages the move to the ISAPRES.[11] Knowing who its own beneficiaries are and obtaining from the ISAPRES records of their beneficiaries has made it possible to limit cross subsidies; full records of the dependents of ISAPRE beneficiaries will be available in 1997.

[10] Interview with the head of the Management Support Programmes Division, Mr. Cleofe Molina, on 14 September 1995.

[11] This alleged subsidy is based on a calculation –subtracting from contributions the costs relating to the free choice procedure– which underestimates the actual benefits. However, the National Survey of Socio-economic Status (CASEN) indicates a subsidy for contributors (interview with Mr. Oyarzo).

Furthermore, a new network of specialized outpatient services has been established: the Basic Speciality Centres, which permit inter-district referral from municipalized primary care centres and which are administered by the Ministry of Health, and the High-Complexity Diagnostic Centres, which are attached to hospitals but have administrative autonomy. The hospitals have been rehabilitated, with a high investment component, and resources have been provided for their proper operation and maintenance. As far as primary care is concerned, the fundamental change relates, as we shall see, to per capita funding.

Decentralization occupies a key place in the changes and in the achievement of increased equity: the diversity of the country's health problems and the inequalities inherent in the polarized epidemiological transition[12] are causing demand to rise and require flexibility of supply. Thus, decentralization must bring decision-making closer to the people and follow courses of action that are appropriate to the epidemiological and geodemographic features specific to each region: it is a process for distributing power, resources, risks and opportunities to the Health Services (Chile, Ministry of Health, 1994).

Some executive activities that are still being carried out by the Ministry have yet to be transferred to the local level, so that the size of the Ministry should be reduced. The idea of extending functional decentralization by increasing the capacities of the Health Services, which would be transformed from administrators of the public system into agencies managing autonomous medical care units is again being put forward.[13] In this context, it is interesting to note that the Medical Association is calling for the competitively based appointment of directors of services, and that the authorities affirm that they have no objection provided that the competition process includes managerial and administrative requirements and that the appointees do not have permanent guaranteed tenure.[14]

As regards the private sector, efforts have been made to limit cream-skimming, to guarantee greater transparency and equity in the contractual relations between the ISAPRES and their members, and to control the cross-subsidies and implicit subsidies paid by the public sector (Chile, Ministry of Health, 1995c).

The persistent duality of the system –the different approach in its subsystems and the lack of competition between them– gives rise to controls that might have to be extended and could lead to high administrative costs.[15] The proposals for the most profound changes in the morphology of the sector are currently at a very early stage: prominent among them is the recent suggestion of a comprehensive health plan which, with a reasonable degree of solidarity and universal and compulsory coverage, would guarantee effective freedom to choose health insurance and the supplier of treatment in the public and private sphere, with no possibility of rejection by the insuring institutions (Oyarzo, 1995, item V).

It has been argued that providing this universal service requires joint funding, from individual contributions and a State subsidy, in order to set up a single fund that would be shared by the different administrators of the system, or alternatively a system of adjustment between per capita costs of universal insurance and contributions. The individual contribution could be linked, not to pay, but to the cost of the universal insurance (Massad, 1995, p. 12).

In order to do this, it would be necessary to determine what agency would be responsible for redistribution, and would act as a second-stage insurer to guarantee the per capita amounts that would finance the comprehensive plan; what agencies would act as first-stage insurers, providing direct health coverage; what agency would have responsibility for reinsurance for catastrophic events, and what agency would be responsible for regulating health social se-

[12] The term epidemiological polarization refers to differences in health welfare distribution among the different population groups, to the detriment of the poor. In countries where this occurs, the epidemiological eras overlap. For technical reasons and for reasons of equity, their related problems have to be dealt with simultaneously. In this connection, see Bobadilla et al., 1990, pp. 19 and 20.

[13] Proposed by the Minister of Health, Mr. Carlos Massad, in *El Mercurio*, 1995, p. C15. For a background account on this proposal, submitted by Héctor Sánchez, see *El Mercurio*, 1991. Some have specifically postulated that "the central factor in the sector's improvement must be the independence of the establishments, while maintaining State ownership and the joint controls already described" (Baeza, 1993, p. 53).

[14] Interviews with the then President of the Medical Association, Dr. Vacarezza, on 7 November 1995, and with Mr. Massad, respectively.

[15] Idea put forward by Mr. Oyarzo at the seminar on "Health in the Chilean Development Process", organized by the Ministry of Health, the Pan-American Health Organization (PAHO) and the Association of ISAPRES, in October 1995.

curity. It would also be necessary to evaluate the amount of the current compulsory contribution and its link with income, and to specify the role of the fiscal contribution and the user-fees (Oyarzo, 1995).

With a view to establishing an integrated and social security system based on solidarity which would at the same time have stability and be viable in financial terms, a switch would be made from an approach based on individual insurance to one based on collective insurance, creating an effective insurance control centre. This would not be to the detriment of the private sector and would represent a major challenge for the current public medical care network in terms of increasing its efficiency. It would also be necessary to establish effective measures to contain costs.[16]

2. Performance-related allocation of resources

It has been argued that the problems of health management in Chile are not essentially the result of administrative or institutional limitations, but are due rather to an organizational culture that neither promotes nor requires a well-ordered process of target attainment and result evaluation, which is necessary in any appraisal of efficiency and effectiveness (Marcel, 1993, p. 12).

By contrast, a new contractual tool aimed at delegating authority and permitting the evaluation and supervision of delegated tasks makes the concrete results of management the determining element in resource allocation. This is the system of "management commitments" (*compromisos de gestión*), which are entered into by the Ministry and the directors of the Health Services and which delegate management to the latter. The Health Services in turn negotiate with the hospitals. The annual agreement establishes the services that are to be provided, the allocation and transfer of resources, the growth targets and the performance indicators to evaluate the agreed targets, which are now essentially activity indices (figure 2).

In the first experiment carried out in 1995, the following indicators were established with equal weighting: formulation of a health plan for 1996; preventive medical examination coverage among the working population; perinatal mortality rate; number of districts with less than 90% inoculation coverage; number of specific preventive oral and dental health activities undertaken out of the total on children aged between 0 and 5 years and between 6 and 9 years; incidence of malnutrition among the infant population; agencies for internal participation and community participation and intersectorality in operation within the Health Services and establishments at the end of 1995, and operating theatre time used, compared with total available theatre time. The following performance levels were set: 5 = very satisfactory; 4 = satisfactory; 3 = mediocre; 2 = unsatisfactory; 1 = very unsatisfactory.

This represents a clear break with resource allocation based on historical budgets. Although the resources provided by FONASA during the 1995 commitment period were equivalent to the historical allocations to the Health Services to date, plus additional resources for reasons of equity where applicable, in future all resources will be dependent on the activity carried out by the Health Services. The commitment for one period does not mean the same resources for subsequent periods.

The range of general objectives[17] of management commitment is very broad: to promote effectiveness, decision-making capability and technical quality in the provision of services, and efficiency and transparency in the use of resources; to include equity criteria in resource allocation; to enhance coverage and stimulate user satisfaction; and to modify the administrative culture by transforming a focus on processes into one on achievements, with emphasis on planning and result analysis.

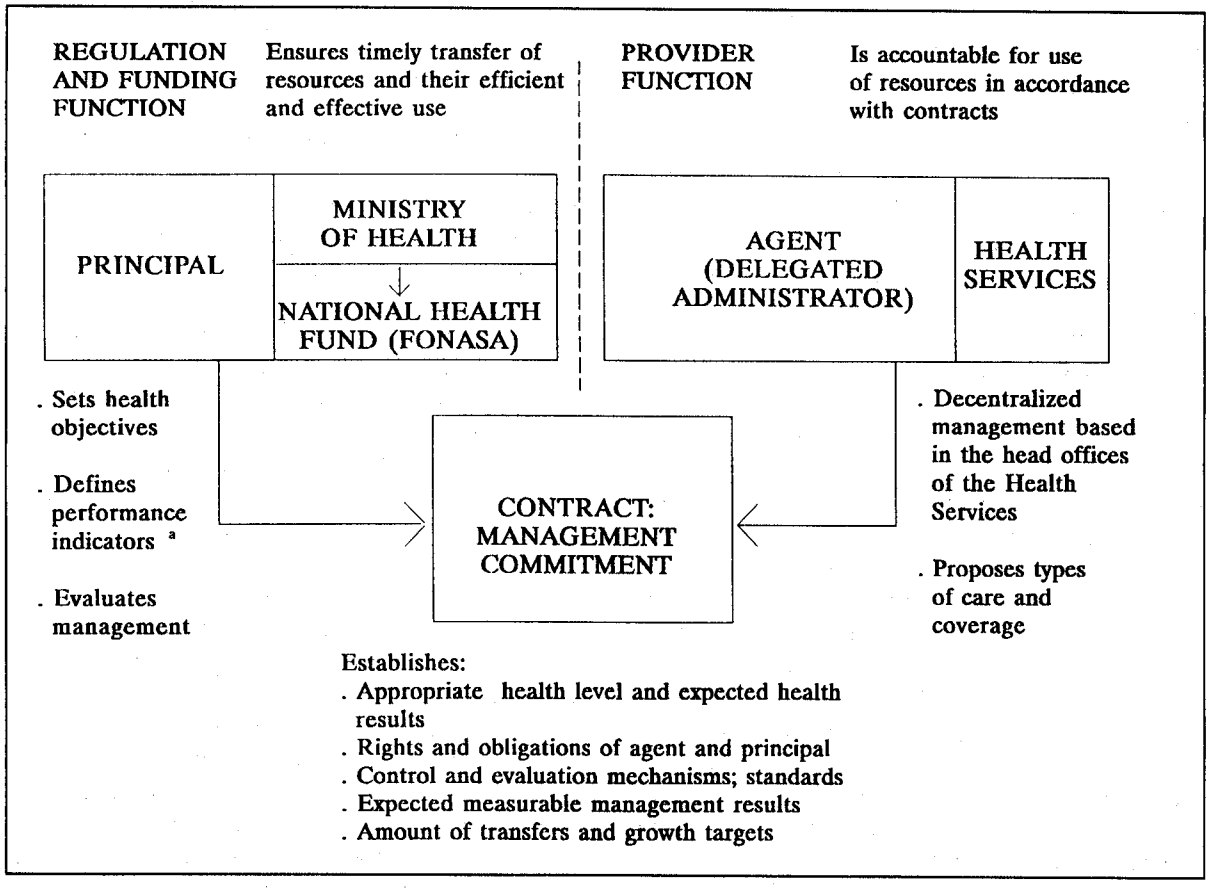
The idea of management commitment is to set clearer objectives, define indicators for monitoring treatment and evaluate the management of delegated tasks. It is a participatory strategy and involves an interplay of power in its negotiation: in conjunction with the Ministry, the Health Services define their mission and their identity, and the related financial requirements, which also reflect the Ministry's targets.

[16] Interview with Mr. Marcos Vergara, Head of the Strategic Planning Division of the Ministry of Health (9 November 1995). In the first half of 1995, the Economic Research Corporation for Latin America (CIEPLAN) organized health workshops, at the request of the Ministry; the conclusions of these workshops also specifically mention the comprehensive health plan (CIEPLAN, 1995).

[17] The general objectives are set out in the 1995 Management Commitment Protocol.

FIGURE 2

Chile: Management commitments



Source: Prepared by the author on the basis of official documentation, and Lenz and Fresard, 1995.
[a] Financial, human resource, operational and health result indicators.

This entails changes in interinstitutional relations on a number of aspects: thus, it is necessary for targets to be fixed between the central level and the respective Health Services with a view to resource commitment, for the technical and treatment areas and the administrative and financial areas to be coordinated and made compatible, and for consistency to be ensured between the activities of the Health Services and the national policies and priorities in the field of health (Lenz and Fresard, 1995).

The commitments are wide-ranging: they include the areas of programme content, finance, human resources and investments. The health system is seen as a macro-conglomerate composed of 27 Health Services (conglomerates) and four autonomous institutions. It involves all the units within the Ministry, plus FONASA and the directors of the Services; FONASA acts as a purchaser of health actions and supervises the attainment of activity targets.[18]

The management commitments also have a fundamental regularizing function: they synthesize the multiplicity of dealings which take place between the Ministry and the Health Services in a single document, which regularizes and explicitly sets out the rules of the game. Traditionally, the Health Services and each specific agency at the central level generated formal and informal bilateral agreements, which led to a lack of coordination, duplication and clashes, and consumed considerable resources in lobbying activities (Lenz and Fresard, 1995, pp. 15, 16 and 37).

[18] Interview with Mr. Oyarzo (see above).

Price adjustments are anticipated in the transfer tariff according to location or where teaching activities are undertaken. Furthermore, in view of the health policy of the Ministry of Health, the Services have to propose a health plan aimed at facilitating access to care, particularly for the very poor, improving hospital management, strengthening protective, preventive and promotional health measures, fostering social participation, and improving health actions from the environmental standpoint.

Management commitments are also being used with the autonomous agencies: in 1995 FONASA, the Public Health Institute, the National Central Supply Office and the Supervisory Authority for ISAPRES signed commitments of this type with the Ministry. In addition, 15 "task forces" of the Ministry, –the same number as the latter's divisions and departments– signed action commitments. These are also being used for municipalized primary care.

The terms agreed have varied greatly from one service to another, for instance regarding coverage targets or the population groups to benefit from preventive medical examinations. The scheme is at an initial learning stage of the evaluation, which has been carried out on a quarterly basis. Although this is a sort of trial run, its use has been perceived as a serious endeavour and an irreversible process, and the evaluation should have an effect on possible removals of directors of Services.

Thought is being given to the quality and relevance of the indicators: those which have been used in the past are specific to the epidemiological pretransition and need to be reformulated to take account of local and regional features, in view of the health plans prepared by the Services.[19] The local health plans must become their interlinking axes, in view of their comprehensive purpose and the need to deal with the singular epidemiological profiles and resulting problems.

As regards similarities with reforms in other parts of the world, particular mention should be made of the United Kingdom's experience, especially concerning the modernization of the national health system, one of the main public-sector modernization initiatives of the 1980s. At that time, internal markets were created by differentiating and separating the role of the district health authorities, as purchasers of services, from that of the hospitals, as providers of services, with both entering into contractual agreements with each other (Naschold, 1993, p. 49; Bartlett and Harrison, 1993).

3. Increased human resource productivity

The management reforms have major political components: introducing new forms of human resource administration means intense conflicts and negotiations, a process that is still under way.

In August 1994, the "Caldera Report", produced by the Ministry of Health, unleashed a fierce debate on the productivity of doctors in the 26 Health Services within the national system of Health Services. The report showed an appreciable drop in three indicators: discharges, medical care and surgical operations in the period 1989-1993. While the contracted doctor-hours had increased by more than 66%, the number of patients discharged per doctor-hour had decreased by 34%, patients attended per doctor-hour had diminished by 34.8% and surgical operations per doctor-hour by 45%.

The calculation did not incorporate adjustments that might have shed light on the causes and factors involved, or on their weighting: for example, taking into account the number of consultations that had to be carried out per hour before and after the expansion of doctor-hours or, with regard to surgical operations, the possibility that a reduction in such operations might reflect efficiency gains at other levels of treatment.

The medical association argued that the report failed to take account of the improvement in service quality, citing as an example the reduced mortality in Temuco, one objective of the increase in doctor-hours; that doctors were being blamed for the general situation in the hospitals, and that the actual increase in doctor-hours was overestimated (Vacarezza, in Cámara de Diputados de Chile, 1995, pp. 127-128).

The doctors put forward some interesting arguments. For instance, they pointed to the need to assess whether the primary level had affected inelasticity of demand, to distinguish subsets in the numerator (e.g., the increase in elective surgery versus the reduction in emergency surgery), to break down the number of hours by speciality, to take account of the increase in some professional hours –corresponding to anaesthetists, haematologists, radiologists and neo-

[19] Interview with Mr. Molina on 14 September 1995 (see above) and interview with Mr. Mauricio Jelves, official of the Ministry of Health, on 25 September 1995.

natologists– that raise quality of care and reduce risk without necessarily being reflected in a rise in the number of discharges, and to examine the reduction in the enrolment in the national system of Health Services as a cause of the drop in demand. They also indicated that the general nature of the indicator, together with the heterogeneous nature of the matter at issue, could lead to deceptive conclusions: an increase in surgical operations, for instance, could even reflect shortcomings in the quality or appropriateness of prior medical care, while a reduction could be partly related to treatment administered on an outpatient basis in line with new procedures and technologies (Colegio Médico de Chile, 1994).

They also stressed the lack of standardization in the calculation of the consultation norm, which dropped, between 1989 and 1993, from six to four patients per hour, and expressed doubts about the quality of the records. They suggested that it was erroneous to identify the number of discharges with the same number of patients: the reduction in discharges could reflect improvements in hospital admission policies and in the curative quality of treatment. Using current standards to calculate the necessary doctor-hours, they even came to the conclusion that there was a deficit of 34,902 hours required for the performance of duties according to quality standards (Colegio Médico de Chile, 1994, p. 7).

CIEPLAN, for its part, applied the same methodology, using a breakdown by Health Services, in order to provide a more detailed diagnostic analysis and contribute to a consensus view of the problem. A national deficit of 30,000 hours, i.e., 9.1% of the total workforce, was estimated, which is less than that indicated by the doctors. However, what was revealing was the contrast between different Health Services: while the Valdivia Service had a deficit equivalent to 46% of its workforce, the Health Services in the metropolitan region, with the exception of the South Metropolitan Service, showed an excess of doctor-hours surplus ranging from 7% to 34% of the actual staffing level. The figures give rise to a number of questions: is this related to failure to fulfil the contracted hours in the metropolitan region, to differences in medical productivity in the different regions, or to differences in the quality of care in the different Health Services? (Celedón, 1994).

The doctors' viewpoint on the relationship between increased doctor-hours and quality improvements has been countered by the argument that the equipment and infrastructure improvements introduced during the period should have been reflected in a simultaneous increase in the quality and productivity of doctor-hours.[20]

In any event, the Caldera Report gives cause for reflection on the irrational expansion of the staffing rosters[21] and, in general, on their unsuitable structure. The dissociation between the increased doctor-hours and global activity highlights major problems:[22] inter alia, overstaffing in areas where the necessary combination of inputs was not adequately ensured; promotion of quality, but viewed as an individual action; considerable inflexibility in manpower administration and recruitment, which means that any change must entail a staff increase; unsuitability of human resources to the new epidemiological profile and new technologies, as well as the need to set 65 years as the retirement age.[23]

The Government's aim to partly link the increase in pay sought by the sector's professional staff to amendments in Law No. 15 076 has made this issue even more controversial, and the measuring of productivity has become a sore point. The Medical Association has categorically rejected the idea that pay should be linked to medical productivity, "since nowhere in the world is there any valid index for measuring it" (Vacarezza, in Cámara de Diputados de Chile, 1995, p. 125). The fact that the changes in human resource management mean considerable transition costs is clearly reflected in a number of

[20] Interview with Dr. Susana Pepper, Director of the San Borja Arriarán Hospital, on 18 August 1995: with reference to surgical operations, for example, more sophisticated technology brings about an appreciable reduction in the time needed for certain operations, such as gall bladder operations. The President of the Medical Association, however, in the course of the interview referred to, stated that the introduction of new fibre optic surgery techniques (e.g., for gall bladder operations) does not appreciably shorten the operating time and that the procedure requires two or three surgeons.

[21] It was Dr. Pepper who initially drew our attention to this problem.

[22] Interview with Mr. Oyarzo (see above).

[23] There are several instances of such irrationality. Some Services have excellent heart surgeons, but do not have adequate equipment. In other Services, general practitioners are becoming redundant. Despite an appreciable reduction in the birth rate in Chile, obstetricians account for 30% of the doctors at one hospital. Moreover, despite the new epidemiological profile, there is a shortage of "intensive care specialists" and of doctors in the Intensive Care Units (ICUs). This information was obtained during the above-mentioned interview with Mr. Oyarzo.

positions adopted by the unions and professional associations.[24]

The obvious political component of the reform makes it possible to identify similar problems that have arisen in other countries. In the reform process in the United Kingdom during the 1980s, it was difficult to institute qualitative indicators, despite their importance in improving quality. The staff unions were of the opinion that these indicators had not been given the same priority as quantitative and financial performance indicators, and the important Treasury and Civil Service Committee pointed to the need to publicize the objectives and to decide on satisfactory indicators in consultation with staff and management (Hardy, Towhill and Wolf, 1990, p. 107).

The debate on productivity in Chile highlights the need to clarify the thinking on efficiency indicators. Productivity relates to the efficient use of resources to restore health or to carry out preventive action that will lower morbidity and mortality rates. Nonetheless, a rise in productivity is sometimes mistakenly identified with an abstract increase in health-care services or medical actions, or with an extension of their duration. [25]

Conversely, an increase in the number of medical care actions may reflect a reduction in productivity or low productivity; this occurs when the funding model encourages overprovision of such actions that unnecessarily increases the number needed to achieve a curative effect and leads to rising costs. It may also occur when there is an increase in actions using inputs that were designed for more sophisticated technical purposes, producing technical inefficiency that in fact causes underutilization of installed capacity and a drop in productivity. [26]

The productivity of increased medical actions for prevention or treatment must be examined as a function of production: it is necessary to consider the costs which it represents in the spectrum of effective technical alternatives for meeting health objectives, the use of installed capacity, and the appropriateness and combination of the inputs used.

After the conflict, talks on productivity [27] have led to important agreements on "measuring results in the area of health", in order to achieve efficiency and equity, and to negotiate resources and adapt them to the epidemiological profile. It was established that the quality standards, measurement methodologies and instruments, and quality indicators for the management commitments should be agreed a priori between those involved and that, in the evaluation of productivity, consideration has to be given also to quality of service and to the satisfaction both of the actors involved in health activities and of the users (WHO/PAHO, 1994b).

Other initiatives have also contributed to the climate of negotiation, such as support for the statute on primary care and the programme to improve the work environment, whose priorities are defined at each hospital and have ranged from improvements in catering to uniforms and changing rooms. Performance incentive schemes are being tried out with the non-professional staff. A significant number of paramedical staff have been granted technician status, entitling them to the professional remuneration allowance. [28]

Two bipartite agreements, reached in February and July 1995 in the midst of disputes, preceded the report submitted on Law No. 15 076, in September of that year, by a joint commission of the Ministry of Health and the professional associations.[29] This report defined the direction of the amendments to Law No. 15 076 and forms the basis of the bill presented on 4 October 1995 by the Ministry of Health to the

[24] The current situation is sometimes defended without any beating about the bush. The National Federation of Health Workers (FENATS) argues as follows: "With reference to economic incentives or the linking of pay to productivity, ... the health authority has not specifically explained how such linking would be carried out and ... has only indicated that it would be connected with grading. This abstract proposal is rejected by the workers, *particularly* because 92% of all staff are at present graded in list 1, in accordance with current legislation, since no sectoral grading regulations have been issued and it is not known how this will be done in the future *given that it has been said that the number of staff graded in list 1 must decrease*" (FENATS, in Cámara de Diputados de Chile, 1995, p. 139 –emphasis added).

[25] This is the case in the WHO/PAHO study, 1994a, pp. 40, 45 and 46.

[26] For an analysis of the topic, see Barnum and Kutzin, 1993, chapter 3.

[27] The workshop on productivity, coverage and quality, held in Santiago, Chile, from 20 to 22 October 1994, was attended by representatives of the Ministry of Health, the Chilean Medical Association, the universities, the Federation of Professional Associations, the Chilean Society for Health Promotion and other institutions. In August 1995, the Santiago Regional Council of the Medical Association organized a seminar on health management.

[28] Interview with Mr. Molina.

[29] For a detailed description of the political negotiations, see PAL, 1995a and 1995b.

Chamber of Deputies, with a view to amending the recruitment, pay and other aspects of the employment relationship of surgeons, dental surgeons, chemists or pharmacists and biochemists who work in the Health Services and do not hold positions directly dependent on top government authorities.[30] Nevertheless, there are still differences of opinion with the medical associations, which, because they still support accreditation based on years of service, argue that competitive examinations do not guarantee a staff career.[31]

The bill provides for considerable flexibility in the design of the Health Services' rosters: staffing levels would be determined on the basis of an annual allocation of chronological weekly working hours, to be made by the Ministry of Health. Decision-making is delegated to the Services' directors: for example, they can adapt the roster to new requirements when hours are released because a professional staff member assigned to the higher cycle (see below) ceases his functions for any reason. The grounds for discontinuation of service may also be determined by the director of the Service concerned.

The standard working contract is fixed at a minimum of 11 hours, with a maximum of 44 hours per week, to be allotted from Monday to Saturday, at the discretion of the directors: within this range, a professional staff member may work in more than one Health Service. Outside the contracted hours, professional staff are free to pursue their occupation.

As regards staff career development, the factors of performance, merit and efficiency are added to length of the service. Two cycles are to be instituted: a training cycle, for professional staff in the process of improving and developing their skills, and a higher cycle, for those who perform duties that require them to regularly apply their knowledge and skills, to train new professional staff, or to coordinate and supervise work teams. The higher cycle would have three levels, each of nine years: entry to each cycle and promotion from one level to another would be by competitive examination. If a professional staff member does not qualify for advancement to the next level, his recruitment could be extended for up to three years, in the current cycle or at the current level, under the same contractual conditions, and he may sit the competitive examinations and will be entitled to the length-of-service allowance.

It is known that, in order to develop managerial capability, it is essential to have senior staff entrusted with that task and to ensure appropriate mechanisms for their selection, advancement and remuneration. This would be encouraged by the new recruitment system, which envisages a varied spectrum of tasks and responsibilities: a distinction is made between strictly medical functions and those with "management responsibility", which require the ability to commit human, physical and financial resources with a view to attaining the objectives set by the plan or programme of the medical establishment concerned. Functions with management responsibility would be open for competitive appointment every five years and could be performed by professional staff from the different cycles and levels established by the law, with a minimum allocation of 22 hours per week, covering at least five days of the week.

The Health Services will be required to assess staff performance annually with the following gradings: oustanding, satisfactory, conditional and deficient. Various bonuses are connected with the grading. Hence there are permanent and temporary pay awards.

Permanent pay is defined as the fixed and continuous monetary remuneration allocated to professional staff in accordance with the cycles and levels stipulated in their contracts or appointments. It comprises:

i) The basic salary, which is the fixed remuneration paid in equal periods to all professional staff governed by this law, and which constitutes the sole basis for calculating the other pay awards;

ii) The length-of-service allowance, which is granted to professional staff recruited or appointed to the Health Services for every three years of effective service, subject to a limit of 10 three-year periods;

iii) The qualifications and experience allowance, which is granted in recognition of the competence of professional staff. It is allotted to the higher cycle in the following proportions: 40% at level 1, 82% at level 2 and 102% at level 3.

Permanency of staff in the service is thus encouraged but linked to competitive examinations. The qualifications and experience allowance also encourages first-rate staff to remain.

[30] See Government of Chile, 1995. The analysis made here of the amendment bill is based essentially on PAL (1995b) and on our reading of the bill in the light of the present study.

[31] Statements in *El Mercurio*, 1995, p. C15.

In addition, significant temporary pay awards and individual performance bonuses are provided for the 25% of staff who achieve the best performance. The temporary pay awards are non-continuous and variable, and are obtained in consideration of duties, working conditions and performance characteristics. They include:

i) Responsibility allowance: this is granted for time spent in discharging management responsibilities. The regulations will fix the levels of complexity of the establishments, the categories of management responsibilities and the functional management posts, which are to be defined by the Health Service concerned. This allowance may not be less than 10% or more than 130% of the basic salary, for the hours assigned to these duties.

ii) Incentive allowance: this is granted for hours of the working week spent on activities, in places or under conditions required by the Health Service concerned for the implementation of health plans and programmes. It is expected to be fixed centrally by the Ministry of Health by means of regulations and endorsed by the Ministry of Finance, which may inhibit management flexibility; whereas according to the general guidelines of the Ministry of Health, each Service's director should be able to establish, by a substantiated decision, the grounds for and specific percentages of the allowance.

iii) Performance bonus: this is granted annually, on an individual basis, to the highest-graded professionals in each establishment and, on a collective basis, to all professional staff of those establishments, or their work units, which meet the institutional performance targets. The individual bonus will be paid annually to the 25% of professional staff who achieved the best performance in the preceding year: 10% for the 15% most highly assessed professionals and 5% for the next 10%, in descending order of assessment. The collective institutional performance bonus may cover 100% of the professional staff of an establishment or work unit and it may be as much as 10% of the basic salary. The regulations will establish the necessary rules for the proper awarding of this benefit.

Furthermore, up to 10% of the total remuneration budget for professional staff governed by this law may be used to engage high-level professionals. It would thus be possible to recruit first-rate professional staff at competitive salaries; however, the effectiveness of this measure may be restricted because it is intended exclusively for "occasional or exceptional" actions, possibly in response to pressure from the medical unions.

Clearly, the staff career structure and the system of pay are compatible both with the allocation of individual responsibilities in the process of generating output and with the performance incentives.

The linkage that the bill establishes between individual performance and institutional performance in the Health Services is interesting. It can be seen in provisions such as the collective performance bonus, or in the possibility that a reduction in the budget of the Service may lead to the departure of a staff member, which may be fundamental in adjusting manpower resources to the demand for services and avoiding over-supply or scarcity of certain resources. From the standpoint of the management commitments, this encourages adaptation between manpower resources and the agreements reached.

The bill also regulates the training that is made available to professional staff according to the activities set out in the Health Services' annual plans, and which includes specialization programmes of up to three years' duration. The beneficiary must repay the Health Service by working for a period equal to the length of the training programme.

Three grounds for cessation of functions are added to the traditional ones: if the hours worked by a staff member in the higher cycle of the Service are eliminated; if a staff member does not qualify for advancement to a higher level; and finally, if the director of the Service decides, on operational grounds, to terminate the functions of professional staff who meet the requirements for retirement.

The proposed three-level competitive system is somewhat different from the previous agreements with the associations, which provided only for one competition for admission to the permanent staff categories constituted by the posts on the roster. Hence the differences of opinion. The doctors maintain that this procedure does not guarantee a staff career and that the measure means the reduction of staff: competitive examinations should be used only as a means of entry, promotion should be by accreditation, and those who are not promoted should be able to remain in their posts. They criticize the directors' independence of action in modifying post allocations, since they think it is too broad, and say that account should be taken of the views of the heads of the

clinical services and of the hospital managers in order to guarantee greater technical judgement. They argue that it is illegal to convert the zone allowance into a discretionary incentive, since it is recognized in all public recruitment systems.[32]

For their part, the authorities stress that competition makes it possible to determine the structure and rationality of the rosters, with the knowledge of how many people are required at each level. By contrast, accreditation would create a technical barrier in that regard.[33]

It might be wondered whether the temporary pay awards could become distorted in the future, leading to an unstoppable increase in salaries. It will be essential to ensure that the flexible components of merit-based pay do in fact act as an individual reward and do not incite demands for equality from the unions,[34] which would not merely eliminate its sole purpose, but would also cause costs to rise. It is also advisable to give some thought to the relationship between the flexible salary components and the current pay negotiation procedures, and to whether the introduction of flexible pay should change the forms of salary negotiation. For example, ideas [35] are being advanced such as that of replacing the current "triple" negotiation –centralized negotiation with the Ministry of Finance, whose outcome is a "lost base level" for the sectoral negotiations and the decentralized negotiations– with an eminently decentralized negotiation in which the discussions with that Ministry would focus strictly on adjustment for inflation.

Proposals of this kind require liberalization of the budgetary system, since they presuppose that the sectoral authorities would be made responsible for taking decisions on salary improvements linked to performance and to increased service productivity.

[32] Interview with Dr. Vacarezza (see above).

[33] Interview with Mr. Massad (see above).

[34] Although it was not related to merit but rather to the discharge of a specific function, the negotiation successfully concluded a few years ago on emergency treatment later prompted a spiral of claims and appreciably raised the base level at which professional staff negotiated, owing to the disparity between such pay and the pay for other functions.

[35] Opinion of Mr. Oyarzo in the interview referred to above.

4. Funding linked to performance and equity

The traditional funding mechanisms are being replaced by ones that are aimed at increasing efficiency and equity in resource use: efficiency because they help to contain costs and improve health promotion and preventive actions; equity because they are designed to limit the chronic lack of funding that was caused by the traditional mechanisms at the levels of care available to the lower-income population groups.

The per case payment associated with diagnosis (PADS) which should be introduced from July 1996, is a system for the transfer of resources to the Health Services for secondary and tertiary care in hospitals by means of a prospective payment for treatment of a group of diseases; payment is made for each disease dealt with and not for each service provided. A first step involved prospective payments by service provided, based on a study of the production costs –including all inputs except capital– of 103 secondary and tertiary services. The payments for separate services are therefore grouped in fixed payments for each diagnosis; payment is made for each complete in-hospital treatment, on the basis of a calculation of the aggregate cost of all the services required, in order to promote the provision of good-quality health services and to discourage over-provision of services; this would also make it possible to adjust the tariffs so that they cover all inputs with the exception of capital.

A study of the most frequent and the most expensive services identified 40 payments linked to diagnosis, of which 20 were selected, since 18 of them correspond to 30% of hospital expenditure; the remainder continue to be funded on the basis of individual services. This arrangement is designed to limit the system's administrative costs.[36]

The payments for each service and those linked to diagnoses will be made prospectively under the management commitments. The differences between the services planned and those actually provided will be reviewed at the end of each period. Initially, consideration will be given only to the inputs that do not correspond to salaries, which will continue to be paid by the Government until the new law on health personnel is adopted.

[36] Interview with Mr. Molina (see above).

The fee-for service method in the primary care level has been replaced by a per capita funding arrangement, which is designed to guarantee a basket of services. The amount to be transferred is fixed prospectively in order to cover the cost of standard treatment in four categories of primary care: infant, maternal and adult care, and oral hygiene. In calculating this amount, the population assigned to each primary health service is multiplied by the recommended standard figure for service frequency per user, allowing for salaries, administrative costs and other expenditure, such as drugs, and is divided by the population of the area served by the establishment. The aim of this is to improve the quality of services, to encourage the promotion of health and preventive activities, to increase the coverage under the management commitments with the municipalities.

IV

The limits of change

The dual health model significantly restricts the effectiveness of these management reforms, which seek to control, from a financial standpoint, aspects which are endogenous to it, such as absenteeism and doctor-hours not worked, and which are related to differences in pay between the public and private sectors. The measures designed to bring about partial equilibrium, however, can hardly prevent transfers between the two subsystems. These reduce the efficiency and effectiveness of the public sector since, in a dual system, it is generally the weak link that loses out and has to adapt to the other.[37]

This highlights the need to overcome the duality of the model, for example by favouring a collective insurance approach, in which case management would also be crucial in guaranteeing the competitiveness of the public subsystem. However, if the dualism is to be efficiently and equitably overcome, there must be creative collaboration over and above corporate interests, to produce genuine and concerted answers. In this regard, the attitude of the sectors linked with the ISAPRES will be decisive.

Furthermore, the excessive statutory and regulatory provisions with which the Health Services have to comply also hinder improvements in their quality and efficiency. These provisions include rigid budgetary rules that require external approval even for small transactions or changes in cost allocations,[38] as well as the prevailing inter-ministerial centralism and an attitude of distrust on the part of the Ministry of Finance, which restricts sectoral management (Chile, Ministry of Health, undated). Proposals have been made, for example, to eliminate the discretionary manner in which resources received by FONASA from the Ministry of Finance are allocated, and to establish a global per capita allocation linked to the fulfilment of certain commitments or to the provision of a set of health plans (Oyarzo and Galleguillos, 1995, p. 45).

The management reforms come into conflict with current legal frameworks. While maintaining reasonable budgetary framework limitations, there must be greater resource management capability: the breakdown into specific items makes it difficult to adapt them to circumstances that are, by definition, fluid. Controls would have to be applied *ex post*, and controlling the quality of managers, who would be subject to removal, should be an essential feature.[39]

The success of this reform will thus depend not only on overcoming the current dual morphology of the health sector and on the effectiveness of the new tools to manage and administer manpower resources, but also on far-reaching changes in the Chilean budget system. There have been some sectoral initiatives to introduce flexibility and to increase discretionality in the use of resources: for instance, since 1995 the

[37] This idea was suggested to us by Jorge Katz.

[38] Interview with Mr. Andrew Edwards, consultant (British co-operation with the Government of Chile), on 17 November 1995.

[39] Opinions expressed by Mr. Massad in the interview mentioned above. The Health Services have expressed opinions along the same lines, with a view to promoting greater decentralization of decision-making and to increasing efficiency. See, in this connection, Chile, Ministry of Health (undated).

transfer of resources to the Health Services for payroll and current supplies has been effected on a global basis. Per capita and diagnosis-linked payment are also more flexible than under the previous systems (Chile, Ministry of Health, undated).

The performance indicators used in Chile are essentially quantitative[40] and are related primarily to inputs and not to outputs, which makes it impossible to measure quality, which is the ultimate aim of management reform.[41] In the health sector, the use of activity indices has emphasized microeconomic efficiency more than efficacy. It is therefore necessary to establish performance standards and measurements that evaluate the quality of service,[42] which are also important because they make it necessary to determine what results are expected in this regard.[43]

For financial and management reforms to be viable and far-reaching, essential requirements are the logistical and operational modernization of entities such as the hospitals and, in general, specialization on the functions proper to the institutions, contracting out any secondary functions. Efficiency gains are necessarily associated with increased responsibilities of the agencies involved and greater freedom of choice, which means intensifying the decentralization process.

There is no economic or social rationale or any determinism that leads inexorably to the modernization of the public administration. On the contrary, the driving force seems to lie in the dynamic processes of political modernization, as suggested at least by recent European experience. If this is lacking, the institutional base of the reform is weak, and courses of action such as management by objectives or by results may easily degenerate into formalism and become a dead letter in the hands of the bureaucracy (Naschold, 1995, pp. 12 and 13).

Reform always requires a balance of differing interests. In the sphere of health, the power of the medical association is a very important factor. The corporativism of the various actors involved in and affected by the reform will underestimate the essential needs facing the sector and could erect obstacles. Creative collaboration, on the other hand, will help to provide genuine and concerted answers.

(Original: Spanish).

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[40] See Chile, Ministry of Finance, Dirección de Presupuesto (undated).

[41] Interview with Mr. Edwards (see above).

[42] In Sweden an attempt has been made to link the changes in productivity and in quality which occurred during the period 1960-1990, and some interesting conclusions were reached on the difficulty of measuring quality changes related to medical diagnoses and treatments affecting morbidity and mortality. Acute and long-term morbidity and the occurrence of complications were measured. The improvements in quality seem to be clearly related not only to the type of treatment but also to the illness, since no progress is observed with regard to some of them. Furthermore, there would appear to be no correlation between quality gains and cost increases: some illnesses are treated with better quality and lower cost, others with better quality and higher cost, and yet others with high costs and little increase in quality. Another conclusion refers to the difficulties with certain indicators for measuring productivity, such as the number of visits to a doctor and hospital admissions, since they do not adequately reflect the treatment received: if the number of visits and admissions increases with no corresponding increase in the treatments provided, the reduction in productivity is underestimated; conversely, if the treatments have increased without a corresponding increase in the number of visits and admissions, the measurements overestimate the decline in productivity (ESO, 1994, pp. 145 and 146).

[43] The establishment of performance standards thus alters, subtly but importantly, the key question in evaluating impact: instead of inquiring as to the effect or effects, the key point is establishing whether the performance standards have been met (Newman, 1995, p. 6).

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