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Transformation of ministries of health in the era of health reform: the case of Colombia

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Ministries of health are being called upon to lead major health reforms; at the same time they must reform themselves to become more modern institutions and assume new and different functions and roles in the more dynamic reformed system. The literature on public administration and on health reform has recommended many processes of institutional reform and development, building on private sector management techniques, popularized by 'reinventing government' and 'total quality management'. More recently, thoughtful insights have emphasized improving public management through a focus on creating 'public value'; on political, as well as administrative, leadership; improving institutional performance through strengthening the 'task networks' of organizations needed to achieve strategic objectives; and creating a learning culture within the organization. This article applies these recent approaches to the specific needs of ministries of health in order to improve their capacity to lead major health reforms. This combined approach is then used to analyze and make recommendations to the Ministry of Health in Colombia where the authors were providing technical support for a major new health reform.

1. Introduction

Ministries of health in middle and low income countries have a reputation for being among the most bureaucratic and least effectively managed institutions in the public sector. Designed and initiated in the early 20th Century and given wide responsibility for financing and operating extensive public hospital and primary care systems in the post-war period, they became large centralized and hierarchical public bureaucracies, with cumbersome and detailed administrative rules and a permanent staff with secure civil service protections. The ministries were fragmented by many vertical programmes which were often run as virtual fiefdoms, dependent on uncertain international donor funding.

The ministries' role in regulating the private health sector was extremely limited. Ministries usually simply granted licenses for practice to all medical graduates who put in a year or two of social service in ministry facilities. The other regulatory role was limited to sanitary inspections. Few ministries effectively assumed a regulatory role to assure minimum quality of private health services. Few had any role to regulate other public or semi-autonomous services, such as those of the military, municipalities, or social security institute.

As fiscal restraint was imposed on most governments in the late 1970s and throughout the 1980s, ministries suffered severe reductions in budgets which meant salaries could not keep up with inflation. By the end of the 1980s some ministry staff received half of the real wages they had received in the 1970s. Highly qualified administrative staff often left public service for higher salaries in the private sector.

In the 1990s these under-funded, large, bureaucratic, centralized ministries faced a series of challenges that implied significant organizational changes. In the public sector there was a growing movement to 'modernize the state', encouraged by fiscal constraints and technical assistance from donors. This movement was oriented mainly toward reducing staff through voluntary incentive programmes (early retirement, 'golden handshakes'), but it also involved restructuring ministries to strengthen the responsibilities of senior division heads and to reduce bottlenecks.

The second challenge was the pressure to decentralize operations either through 'decentralization' to regional or district offices of the ministries or through 'devolution' of health facilities to elected provincial and municipal authorities.[1]

The third and most difficult challenge has come more recently with the wave of enthusiasm for health reform that was encouraged by the World Bank's *World Development Report 1993: Investing in Health*. This new movement required ministries of health to exercise leadership of sector reform and to develop their own institutional capacity to take on new roles and functions to guide the implementation of the reform. These reforms usually meant changing the financing mechanisms from direct subsidies to some form of social insurance, introducing greater participation of the private sector in both insurance and provision of services, and limiting the benefits packages to be subsidized.

Ministries were advised by donors and international experts to make five major institutional changes (World Bank 1993; OECD 1992; WHO 1993). First, they were to shift their principal role from one of *operating* a public service organization to one of *regulating* a mixed public and private system. Second, they were to change their funding structure from one in which they were both funder and provider to one that established a *social insurance mechanism* to separate these roles. Third, they were to *decentralize* and reduce their control of day-to-day operations of health facilities, transferring these responsibilities to lower administrative units or to elected provincial and municipal governments. Fourth, they were told to prepare to guide the reform effort by adopting a role which emphasized *setting general policy and monitoring programmes* that would be implemented by decentralized or privatized organizations. In order to guide the reform they were also charged with a greater *political role of building consensus* among the many stakeholders within the health sector, in order to be more responsive to their needs and to gain voluntary compliance with regulations. Fifth, they were told to *adopt modern management principles* from the private sector: strategic planning and total quality management. They were supposed to accomplish these transformations while at the same time reducing staff and upgrading professional competence.

The ministries faced these new challenges with little guidance either from the theory of public administration and management or from empirical cases of ministries which had effectively managed health reform. The advice from donors was not supported by a coherent approach to specify what organizational structure a modern ministry of health should adopt; what roles, functions and tasks to perform; what staffing patterns to adopt; what kind of organizational culture to work toward. Nor was there guidance as to how to perform the more politicized role of generating consensus among major stakeholders in the health sector – stakeholders whose own actions would be essential to the effectiveness of the health reform. In other words, the main institution charged with leading the health reforms, transforming itself at the same time as transforming the health system, was without a general guide for its own transformation.

This article will attempt to fill this gap by first reviewing several approaches to the analysis of the transformation of regulatory and governmental institutions in general. We will then develop an approach tailored to the specifics of a ministry of health directing a process of health reform. This approach will include an analysis of public values, leadership, organizational culture, capacities and functions, and public management techniques. Using this approach as a guide, we will then examine the Ministry of Health in Colombia during the initial implementation of an ambitious and innovative reform of the health sector. This process was supported by the Colombia Health Sector Reform Project of the Harvard School of Public Health, and much of the analysis of the Colombian system comes from studies and observations from this project (see Colombia Health Sector Reform Project 1996). We will finally discuss recommendations for the transformation of the Ministry of Health in Colombia and the initial process of implementing these changes.

2. Approaches to public institutions and management

Thinking about, and practice of, public administration is still dominated by a traditional approach that was articulated by Max Weber and championed in the United States by the Progressive-era reformers (Moore 1995; Barzelay 1992). This view emphasized a strong separation between policy-making and implementation. It assigned the technical, implementation or execution role to the institutions of the executive branch which carry out policy decisions made by elected officials in Congress or Parliament

and the President. In this perspective, public administration required a stable, nonpartisan, and expert staff; clearly defined rules and regulations; and respect for hierarchical authority. The model was based on assumptions of rational decision-making with clear goals and objectives defined by policymakers and implemented by an expert staff which would determine the most efficient manner to achieve these goals and objectives.

This model has been under attack for its idealist, normative orientation and many observers have pointed out the limitations that make it an unrealistic model for the actual practice of public institutions. March and Simon were among the most articulate and enduring critics, suggesting that public institutions are not efficient implementors of policy decisions. Like many large institutions, they are likely to be inefficient because they work with imperfect information and do not pursue options which maximize goals. Large organizations rather '*satisfice*', choosing the first solution that appears to be able to achieve the goal, rather than reviewing all options and selecting the best. Bureaucrats in both public and private organizations also seek to avoid uncertainty and follow established repertories of action rather than take new innovative initiatives (March and Simon 1993). Other analysts documented the process of goal displacement in which an organization's survival and growth become higher objectives than the achievement of broader public goals (Warner and Havens 1968).

It was also pointed out that public institutions were subject to influence and penetration by private institutions and were not just responsive to the hierarchy of the elected government 'overseers' who set authoritative policies. Stigler and others pointed out that regulated organizations in the private sector had incentives to 'capture' the public regulatory institutions in order to use them to further their interests (Stigler 1971; Edelman 1967). In health care, the dominance of medical professionals in public institutions has been seen as an example of this capture by penetration (Marmor 1973). Other analysts, including James Q Wilson, found in empirical studies of non-health bureaucracies, that under some conditions public institutions were able to avoid capture and could work toward the general public interest and technical professional objectives (Wilson 1989). For instance, Wilson found that public bureaucracies could avoid capture by regulated interests if they were dominated by professionals who viewed their professional colleagues as important for their career. These professionals would work toward technical expert goals rather than the narrow interest of the regulated industry. He also found that leadership of organizations by 'politicians' or policy entrepreneurs, who sought to gain political recognition for achieving popular objectives, could overcome capture.

Rent-seeking bureaucrats

Recently there has emerged a new set of approaches to public administration which, like the Weberian public administration model, are more normative than empirically based. These approaches build on organizational and management changes which have been recommended for companies in the private sector, and attempt to apply them to public sector institutions. The first such approach we will review here is the theory of rent-seeking bureaucrats (Tullock 1965; Niskanen 1971). This view sees bureaucrats as self-interested careerists who seek ever larger budgets for their administrative units as the path to greater control and career advancement. It recommends the creation of internal competition among bureaucrats and the use of evaluation by results to break up the monopolistic nature of a public bureaucracy and to increase information on what bureaucrats do in order to improve accountability and monitoring. Advocates of this perspective also tend to favour a significantly reduced role for government, especially for provision of services and goods.

Although this theory has had significant adherents in recent public debate, there have been few empirical studies to confirm or deny its hypotheses (Moore 1992; Grindle and Hilderbrand 1995).

Private sector management techniques

A second normative orientation heralds the introduction of current private sector management techniques into the public sector bureaucracies. The most popular presentation of this view is Osborne and Gaebler (1993). One of the more academic presentations of this view is Barzelay (1992) which recommends the adoption of a new paradigm of public administration, one that replaces the Weberian approach with a 'post-bureaucratic' paradigm which emphasizes customer orientation, performance measured by results, teamwork, creating efficient value, and competition.[2] While this approach also has a wide public following and is being introduced in many government programmes, it has little empirical support for its claims for greater efficiency and effectiveness (Bossert 1996).

The role of regulation

Both the theory of rent-seeking bureaucrats and the 'post-bureaucratic' paradigm of Barzelay tend to downplay the fact that the public sector has roles that the private sector does not. Regulation is different from providing products or services (Dubnick 1994). Public sector institutions are expected to set the rules of the playing field; to monitor private markets, private organizations and individuals to make sure that the rules are being adhered to; and to seek public good objectives that are not achievable through the markets. The range of market failures in health in particular is quite wide and justifies a significant regulatory role for public sector institutions (Hsiao 1995).

While public facilities may not be necessary to produce goods and services required to overcome market failures, the role of regulation, monitoring, and shifting subsidies becomes even more important if public facilities are not providing sufficient health care. In order to produce regulation, monitor other institutions and allocate technically effective subsidies, an efficient bureaucracy will be necessary but it may not be able to function under the same incentives and processes as private institutions. Competition among regulatory bureaucracies which results in competing and conflicting regulations is not an advantage. Regulatory institutions which see the regulated industry as a 'customer' may become 'captured' regulators. This critique is not to say that public administration cannot be improved by the introduction of private sector management techniques. It rather suggests that private sector management techniques need to be adapted to the achievement of public value, which in some instances is different from private, especially profit-oriented, objectives.

Insights from institutional analysis

There are four recent works which provide insights that, in addition to the views presented above, may be useful to develop an overall approach to the institutional role of ministries of health in health reform. These works focus on five elements of institutional analysis which appear to be crucial for understanding the role of ministries of health in promoting and implementing a health reform. These five elements are: public value, leadership, organizational culture, public management, and organizational capacity. Public value, leadership and organizational culture examine the interrelationship of values and processes that are necessary for a ministry of health to transform itself and exercise leadership in the health sector. Public management refers to the processes of improving the efficiency and effectiveness of the organization. Organizational capacity refers to the organizational structure and human resources available for carrying out needed functions and tasks.

Public value

Two of the works examined here emphasize the role of public managers in creating 'public value' and in leadership. Both works focus on individuals rather than institutions; however, they identify key orientations that are important for the problem of transforming public institutions. Like much of the work on public administration, they are more normative than empirical, based on a limited number of illustrative cases rather than studies designed to test the propositions. Mark Moore (1995) sees the public manager as having to create public value by responding to the public's desires both for goods and services and for public aspirations (e.g. rights, justice, fairness, efficiency). He also stresses the need to provide evidence of achievement of those values through accountability. This orientation requires that public managers act as political managers – political actors who manage political processes – rather than the simple administrators of the Weberian public administration model. In order for an institution to exercise public management, Moore suggests that it adopt processes which borrow from private sector management – using concepts of corporate strategy which gives it a vision of its customers and competitors.

However, unlike managers in the private sector, public management must pursue a 'strategic triangle' of objectives: (1) substantive value (such as protecting public health and improving equal access and universal coverage); (2) legitimacy and political sustainability; and (3) operational and administrative feasibility. The first two objectives relate to the public nature of the institution. Public institutions must seek justifiable substantive values. Moore uses as an example the fledgling Environmental Protection Agency (EPA), which under William Ruckelshaus was able to establish its vision of 'pollution abatement' as the value which combined the values of environmental protection and economic growth, which were the key value debates at the time the EPA was created.

As actors in the political process, public managers must attempt to maintain the legitimacy of their values and activities, and build political support to sustain them. The operational and administrative objectives

are those that any effective institution must seek. To accomplish these objectives public managers must manage the political process – mobilizing support from political supervisors, media, interest groups and courts – and re-engineer the operational management of the bureaucracy to produce greater public value. This view introduces some of Barzelay's 'post-bureaucratic' vision – with its recommended re-engineering, customer orientation, incentives and competition – but emphasizes the public and political nature of the public institution. It prioritizes the values which are public and orients the institution to the achievement of those values rather than, as in Barzelay, the wholesale adoption of consumer orientations, which may not achieve public values.

Leadership

In order to address the need for ministry leadership of health sector reform, we can draw on Ronald Heifetz (1994) who recommends an approach which is consistent with the value orientation of Moore. Heifetz defines leadership as an activity rather than an individual characteristic, and views this activity as 'adaptive work' which addresses the conflicts in values people hold and reduces the gap between those values and reality. This activity focuses on changes in values and the inclusion of competing value perspectives. Using the same example of the EPA, Heifetz shows how Ruckelshaus was able to use leadership to orchestrate public workshops in Tacoma, Washington, to combine industry, labour, community and agency officials in search of collective solutions to pollution problems, resisting the pressure to impose a unilateral solution fashioned only by the agency.

This orientation complements Moore's view of 'public value' by emphasizing the need for a leader to create consensus and to bring these values in line with reality. This instrumental view of leadership stresses the importance of shaping existing values into a new consensus but does not address the issue of how those values can be sustained in relation to broad political values which evolve more slowly over time, or may change rapidly in times of crisis.

Organizational culture

Organizational culture is another area in which studies of private sector institutions might provide insight into public sector problems. While there has been a significant interest in organizational culture sparked by the emphasis placed on this factor in the successful enterprises reviewed in Peters and Waterman's *In Search of Excellence* (1982), there has actually been little conceptual and empirical work to demonstrate the linkage between organizational culture and institutional performance (Alvesson 1993). One of the more widely recognized analysts in this area, Edgar Schein (1992), suggests that organizations work toward the creation of a 'learning culture' in which 'basic assumptions' emphasize taking actions that are proactive rather than fatalistic or reactive, viewing reality and truth from a pragmatic rather than moralistic and authoritative perspective, seeing human nature as basically good and mutable rather than evil and fixed, taking a near-future rather than a past oriented view of time, seeking high levels of communication and information, and taking a middle road between group and individual orientations.

While Schein emphasizes the unarticulated 'basic assumptions' of an organization as crucial to the power of culture, others view explicit values as equally or more important. They identify values which incorporate the organization's objectives, the importance of clients and competitors, and for officials in the public sector, a view of the legitimate role of the private sector in areas once dominated by public entities, as particularly important (Denison 1990; Kimberly and Quinn 1984). Other authors caution that changing corporate culture is a long-term process. Kotter and Heskett (1992) found that in US corporations the time frame for change was from four years to over ten years, depending in part on the size of the organization.

Institutional capacity

For the crucial area of building institutional capacity, Merilee Grindle and Mary Hilderbrand (1995) have recently proposed a 'conceptual map' which examines the organizational 'capacity to perform appropriate tasks effectively, efficiently and sustainably' in five major areas:

1. an 'action environment' which is the broad economic, political and social milieu;

2. the 'institutional context of the public sector' which defines rules, procedures, and governmental resources;

3. the particularly important arena of 'task networks', i.e. other organizations which must perform essential tasks to achieve the institution's objectives;

4. characteristics of the 'organization' itself, which includes structures, processes, resources and management styles;

5. 'human resources', the managerial, professional and technical talent within the organization.

Grindle and Hilderbrand used this conceptual map to examine the performance of macroeconomic policy and delivery of services by public institutions in six developing countries, and found that the map helped identify important gaps which explained institutional failure. This capacity approach views the ability of an organization to achieve objectives as a function of both its internal capabilities and structures and, perhaps more important, its relationship to its many external environments. Grindle and Hilderbrand also warn, however, that there may be limits to the capacity of an organization to influence its environment and that these conditions may make it impossible for the organization to achieve its objectives. Crucial capacity 'gaps' at other levels in the environment of an organization, over which the organization may not have control, might include the inability of the general state apparatus to enforce its laws and regulations, or the scarcity of skilled personnel in crucial management and analytical functions. These problems would require changes and reforms at an entirely different level.

As should be clear from the discussion above, the empirical and positive theoretical work needed to evaluate the approaches presented above has lagged far behind the claims of the normative approaches. A recent comprehensive review of the state of the art in public administration demonstrates how little has been actually done (Kettl and Milward 1996). Although significant insights may emerge from the use of such positive theoretical approaches as principal agent theory, new economic institutionalism, and the new institutionalism in organizational analysis, very little research necessary to provide current policy advice for the institutions charged with guiding health reform has yet been done.[3]

The situation then is similar to that of a physician treating a gravely ill patient with a series of common diseases for which there is no clear consensus on treatments. This physician may know of many case histories of apparently successful treatments for some of the diseases, but there are no double blind studies confirming the effectiveness of any of the treatments. Like this physician, in the absence of convincing research policy-makers must select treatments which seem most promising, and hope that they will save the patient. Like good physicians, they should also encourage and participate in research designed to confirm the effectiveness of their recommendations.

3. Toward an analytical approach to transformation of governmental institutions for health reform: public management, institutional capacity, and leadership

If a ministry of health is to transform itself into an appropriate institution to lead the reform, the public value orientation of Moore (1995) and the leadership recommendations of Heifetz make definition of goals and objectives crucially important. According to Moore, public managers need to define 'public values' in ways that allow them to exercise leadership. Heifetz suggests that to exercise leadership, public officials must combine different value systems and keep them consistent with realistic conditions and realizable activities. The exercise of leadership through establishing public values is important both within the ministry and for mobilizing support, cooperation, and compliance from key stakeholders and the broader public.

Objectives of reform

Health reform generally defines a series of objectives for ministries of health. In most countries these objectives are the improvement of equity, efficiency, quality and financial soundness of the country's health sector (Berman 1995). Equity is a particularly important value justified by the argument that all members of a society should have access to a basic level of health services because health is a basic human need. Most political philosophies provide grounds for this value, although some political systems, particularly those dominated by social democratic values, justify equal access to more than basic services.[4]

Since health institutions compete with other sectors for access to public funding, they must also justify their expenditures in terms of the efficient use of the common resources. The public perception that large public health services are inefficient has led to pressure to demonstrate that these services are not wasting the common resources. Allied to this argument is the need to demonstrate that the health system is not unduly draining resources from other sectors and that there is some limit to the allocation of public funds to those services, a limit which guarantees the financial soundness of the system. Use of public funds must also

assure that the quality of the services is at least at a minimum for protecting the public health. In some political systems, equal access to high quality services is also a public value.

Following Moore's approach, a ministry interested in adopting these recommended reforms must articulate these 'public values' of health reform in ways that clearly specify the substantive values (equity, efficiency, quality, financial soundness) that are to be valued by the employees of the ministry, stakeholders and the public. It must first articulate these values and generate a broad consensus among the key political actors who are necessary to formulate and ratify the policy. This often involves ministry officials in designing new laws and managing the broad political process of gaining interest group and political party support, as well as managing the specific political processes within executive branch and legislative arenas.

The ministry must make the public values legitimate and politically sustainable through the implementation of the policy by maintaining a broad enough consensus among key stakeholders to assure continued support (Reich 1995). To do this the public values and the policies used to achieve them must have operational and administrative feasibility – in other words it must be possible for the organization and its 'task network' to implement them and to demonstrate their effectiveness to a broad public. The tools for this involve management tasks and processes within the ministry and the political management activities of the environments beyond the ministry, including the task network of institutions whose cooperation, collaboration and compliance is required for the objectives to be met.

Internal capacity for reform

The first task of implementing health reform policy is to create the internal capacity that will then allow the ministry to exercise leadership beyond its walls. Strengthening the internal capacity requires aligning the organizational structure and human resources of the ministry with the new roles and functions dictated by the public values of the health reform. The ministry needs to have sufficient human resources with essential skills and in an appropriate organizational structure to carry out the new tasks required. Some of these tasks are defined by the content of the health reform itself – for instance, if the reform involves the use of private sector markets, then skills in analyzing and monitoring these markets are essential. Other tasks involve the need to exercise political management to create consensus, gain legitimacy, and assure compliance among the major stakeholders and the public.

Changing the role of the ministry

Reform currently means that the role and functions of the ministry shift from simple management of a public sector enterprise to a financing and regulatory institution which manages and regulates many other institutions (both public and private) within its environment, so that they will be able to achieve and sustain the goals of the reform. If competition and incentives are to be a major new force in the new health system then a central role of the ministry will be to provide and enforce the essential regulations to assure that competition and incentives are working to achieve the broader objectives of public good.

Information collection and analysis

A critical task in this new role is to be able to collect and analyze information about the coverage of services and insurance, utilization, market changes, and human resources supply and demand in order to issue and enforce regulations that can protect the public good and assure a level playing field for the competitive forces. This new role requires a much stronger analytical capability and a significantly wider information system than those required simply to manage a public enterprise. In terms of human resource needs, the ministry must have a critical mass of highly skilled analysts – economists, market analysts, management experts and political analysts – probably located in a strong and highly situated unit (near to the Minister) so that the key analytical tasks can be done effectively, flexibly and efficiently. These analysts will also require an upgraded and policy related information system capable of gathering data quickly on major indicators of market conditions, utilization, coverage and collections. The ministry therefore must develop the structural and human resource capability combined with an efficient and not overly cumbersome information system.

Both these tasks – information system and analysis – are essential to exercising the regulatory functions (i.e. choosing the appropriate regulations) and are major tools in the political management of gaining legitimacy and sustained support beyond the ministry. Having this capacity is important in Heifetz's leadership terms as well, for in order to develop a value consensus around a realistic programme, it is essential that the ministry has information about the 'reality' of the health sector, and the ability to analyze that reality and propose appropriate activities to achieve objectives.

Other capability

Other new roles often include assuring the financial soundness of the system by developing an effective mechanism (public or private) for collecting insurance contributions, assuring minimum quality of services and insurance, and informing the public of the quality of service so that they can choose the services most appropriate to their preferences. The tasks required for these functions usually involve coordination with other governmental institutions and may also involve regulating private institutions. The ministry's capacity to gain support from the general public also requires a public relations capacity that is tied to the policy level, so that public health messages go beyond the traditional function of educating the public to change their health behaviours to one that informs them of their rights and duties in the new more competitive markets.

Reforming organizational processes

These new functions also imply leaving aside some of the old objectives of primarily managing the operation of a large bureaucracy that provides services. The previously valued role of managing service operations and their staffs, planning for one large bureaucracy, and supervising activities within the organization will become less important as the reform progresses. These tasks will increasingly be abandoned and transferred to other institutions in the private sector, and in some instances, other levels of the public sector.

The organizational processes of ministries must be addressed through a strategic orientation and a participatory process which focuses on improving efficiency and on an outward orientation in order to satisfy a variety of clients. This approach will use many of the strategic and management techniques associated with the 'post bureaucratic' model of Barzelay, building on participation, incentives and internal competition that have been seen as successful in encouraging efficiency in the private sector. Internal transformation also requires the leadership of the organization to manipulate the control system (internal incentives) and channels of communication to inform and encourage changes in staff behaviour (Roberts and Bluhm 1981). In encouraging an orientation toward clients, several safeguards will be needed to define the 'clients' as the patients and public rather than the providers and insurance companies, in order to reduce the potential for capture. These safeguards include limiting the opportunities for ministry staff to be hired by providers and insurance companies after they leave public service.

Reforming the organizational culture

In order for the institution to implement these changes, its culture will also require changes. An organizational culture based on the public administration model will no longer be adequate to the new functions and conditions. What is likely to be needed is an organizational culture which is outwardly oriented toward clients and competition, flexible, responsive to hierarchy but not slavishly obeying orders, and focused on a vision toward the near future rather than imposing past rules. It will also have to be a culture that views the private sector as a legitimate provider of services and insurance, rather than a threat to public institutions. It will value the new role of regulator rather than that of public provider of services. The transformation of organizational culture is part of the strategic planning process: assuring that individual officials internalize the new mission and participate in the development of new management processes which empower each official to take responsibility for solving problems in ways that achieve the institution's goals. It must be recognized, however, that this process is a relatively long-term proposition for large institutions.

The external institutional environment

Beyond the ministry, in the institutional environment and task networks that Grindle and Hilderbrand discuss, the ministry should develop new institutional arenas in which to gain greater collaboration, consensus, and compliance, without running the risks of becoming 'captured' by the concentrated interests of the providers and insurance entities. These arenas can be councils and commissions with either advisory or decision-making authority, but they must be sufficiently responsive and powerful so that stakeholders grant them legitimacy and feel that their interests are being represented fairly.

Summary

In summary, the approach toward institutional transformation and leadership in health reform outlined here involves:

- defining clear *goals and objectives of the reform* that have the essential characteristics of 'public value' – able to gain legitimacy and sustainability both within and beyond the ministry;
- orienting the structure and human resources of the ministry so that it has capacity to perform *key new functions in the new regulated market setting*, in particular:

- capacity to collect and analyze key indicators of the reform process and to transform this analysis into effective regulations,
- capacity to inform the public of choices and of rights and duties in the reform;
- developing processes of *cultural change* involving strategic planning, client orientation, internal competition and incentives to improve the efficiency and effectiveness of the ministry's staff;
- developing *new institutional arenas* in which the ministry can exercise leadership to coordinate, collaborate, and gain the compliance of major stakeholders.

4. Leadership and institutional transformation for health reform in Colombia

The 'public value' of health reform

The process of health reform in Colombia was largely initiated by the dynamic leadership of a Minister of Health – a political manager in Moore's terms (1995) – who was particularly well equipped to formulate a complex and innovative reform, gain the appropriate support from the President and key members of the Colombian Congress, and, through a wide publicity campaign, gain popular recognition and interest in the reform. This process was accomplished with a small team of consultants hired directly by him, and did not depend much on the institutional capabilities of the Ministry and its staff, many of whom continue to resist the reforms. The process of gaining the initial consensus required for ratification of the major reform law – Law 100, adopted at the end of 1993 – was unique to Colombia's political system.

This process was characterized by the creation of consensus among a small number of individuals from the major political clans.[5] Colombia lacks strong interest groups and has weak and fragmented political parties, so these stakeholders, which are important in other political systems, were not drawn into the aggregation of support for ratification of the law. At the time, the Ministry was seen by reformers as part of the problem, rather than a resource to be used to formulate the reform and to gain political support necessary for its ratification. Individuals, not institutions, were the leaders in this process.

There were, however, some recent political and economic conditions which created conditions favourable to the reforms. The Constitution of 1992 opened new opportunities for decentralization and the modernization of the state. The new administration of César Gaviria attracted and supported teams of technocrats who were committed to reforms in a variety of sectors and who created a climate of reform which legitimized dynamic new approaches to old problems. Specific to the health sector, a financial crisis in the social security and pension system provided immediate pressure for reform of the funding of health care.

The Minister of Health, Juan Luis Londoño, was able to articulate central objectives of the health reform which defined the public values to be achieved. They address the three criteria for public values defined by Moore (1995): substance, legitimacy, and practicality. The reform objectives were to improve equity through expanding coverage, facilitating access, and providing mechanisms for a cross subsidy to the poor; using competition to improve efficiency and financial soundness in a country which in 1993 was already devoting a significant 7% of its GDP to health; and upgrading the quality of services which were seen as deteriorating in the public sector especially. The Colombian reform involved the establishment of an obligatory universal social insurance system with two mandated benefits packages – one for the employed population who contribute a portion of their income (12%) to cover their insurance, and a second, more limited, benefit package (initially at half the value) to cover the subsidized poor population (see Ministerio de Salud 1994).

The reform also introduced the principles of managed competition that Alain Enthoven had conceptualized and that had formed the basis for the Clinton Health Plan in the United States. The system allows private and public health plans (called *Entidades Promotoras de Salud* – EPS and *Empresas Sociales de Salud* – ESS) to compete to affiliate beneficiaries in return for a fixed per capita premium (*Unidad de Pago por Capitacion* – UPC), one for the contributory beneficiaries and a lower one for the subsidized beneficiaries. These health plans contract with both public and private providers for health services. With the separation of financing and provision and the competition among plans and among providers, this managed competition approach was expected to improve efficiency and the quality of service. The universal obligatory insurance earmarks 1% of the employee

contributions to cross-subsidize the coverage for the poor, who are also funded by general revenues and other earmarked taxes to achieve the reform's equity objectives.

Institutional capacity to perform critical functions and manage the task network

The health sector reform was preceded by two other organizational reforms that were general changes in the public sector: the modernization of the state and decentralization. The modernization of the state reforms, begun in the early 1990s, has streamlined the administrative structure, reduced the staff of the Ministry by offering voluntary incentives for early retirement, and created a specific merit-oriented civil service regime (Medellin Torres 1989). Decentralization was promoted by the Constitution of 1991 and Laws 10 and 60 in 1993. It was designed to devolve the regional offices of the Ministry to the governors of the 32 departments, and to transfer responsibility for primary care to the 1050 municipalities.

Each of these initiatives was significantly flawed. The structural changes did not establish an administrative unit within the Ministry capable of providing the analytical capacity needed for the reform. The staff reduction was soon replaced with private consultants; and the civil service reforms, although they created a merit process for recruitment, grandfathered all current staff into the system and guaranteed them secure employment regardless of merit. The decentralization process was implemented so slowly that the institutional rupture implied by devolution of authority, in practice often did not occur. This allowed the central Ministry to exercise continuing control over operational decisions at the department and municipal levels (Jaramillo 1996).

While the Ministry was to be the central leader in the process of implementing the health reform, there were several other institutions in the 'task network' which were also to play important governmental roles in the process of implementation: (1) the National Council of Social Security in Health; and (2) the Superintendencia of Social Security in Health. The National Council was presided over by the Minister of Health and includes representatives of other key ministries, other levels of government, insurers, providers, and beneficiaries. It was designed to create consensus and ratify major policy decisions such as the services to be included in the benefits package, premium rates, and many operational issues. The Superintendencia was a semi-autonomous agency established to monitor and investigate the operation of the system, granting licenses to health plans, collecting data on financing and services from plans and providers, inspecting plans and providers, and responding to complaints from beneficiaries. Both of these institutions were dominated by the Ministry of Health which could veto the decisions of the National Council and to which the Superintendencia was 'ascribed'.[6]

Beyond the central governmental institutions, the task network also included the decentralized governmental units, the insurance companies, and the public and private provider institutions. The new health sector would require that both public and private entities in insurance and provision take appropriate actions to provide efficient and quality services on an equitable basis to the population, within the resources available for health. The Ministry, National Council and the Superintendencia, through the issuing and enforcement of regulations, depend on the capacity of these other institutions to take appropriate actions so that the objectives of health reform can be achieved. This process is even more complicated in that some municipal and department governments assumed greater control over financial resources and service facilities, and they also were crucial actors in the task network.

New functions for the Ministry of Health

What functions does the implementation of the new health reform require of the Ministry? The functions required of the managed competition reform challenged the Ministry to play a more active regulatory role in the system than it had when its major task was to operate a large bureaucratic service delivery system. It would now be required to monitor the market, assure sufficient collection of the obligatory contributions, determine the services that were to be included in the benefits package, establish the level of the premiums, monitor and publicize the quality of both the health plans and the providers, and provide guidelines for human resource training and distribution in the new system (Friedland et al. 1994; Brown and Marmor 1994).

These functions imply several key activities or tasks that have to be performed. First, data on affiliation and coverage, competition among providers and insurance companies, quality of services, collections, and funding flows becomes much more important

than when the Ministry was mainly concerned with operating and managing public sector facilities. The Ministry will need the ability to analyze this data, understand when the incentives of the market system require changes and when new regulations are needed, and then to design appropriate regulations to shape incentives so that the market will respond. This analysis of the market includes the ability to analyze human resource supply and demand in a dynamic and changing system, and to issue appropriate guidelines for educational and training institutions.

The Ministry will also need to monitor and evaluate the quality of services so that the mechanisms of economic incentives do not undermine the quality of service provided. In order for beneficiaries to choose health plans which provide high quality service, the Ministry must ensure that information on quality is available for consumer choice.

In support of the process of decentralization, the Ministry will need the capacity to monitor the certification process which grants authority and responsibility to municipalities and departments. It must also provide technical assistance to these levels of government so that they can gain the skills needed for managing and regulating the services of their territories.

Harvard's Colombia Health Sector Reform Project conducted a survey of senior managers in the Ministry in 1994. This survey found that several key functions needed for the health reform were not sufficiently covered by the Ministry (see Annex). These included:

1. *analytical capability* (capacity to analyze the market, monitor collections, evaluate premiums and reinsurance, evaluate and monitor provider institutions, evaluate needs and supply of human resources, and monitor the financial soundness of the system);

2. *availability of information* (provision of effective information for decision-making);

3. *creation of regulations* (adequate process for formulation, review and promulgation of regulations);

4. *provision of information to the public* (means to publicize information on services and quality to beneficiaries so they can choose health plans and providers); and

5. *revenue collection* (mechanisms for effective collection of the obligatory contributions).

The Ministry itself might not have to perform all the functions that are required by the health reform – for instance, it explicitly shared some functions with other institutions, such as the Superintendencia, for monitoring and inspection, and the National Council for policy formulation and ratification. However, as the leading institution in the health sector, it must ensure that the essential functions are being accomplished by other institutions. The functions described above were not being provided by any official institution. In other words, the Ministry was responsible for assuring that the other key institutions in its task environment perform functions that are crucial to achieving the public value of the reform.

The undermining effects of staff rotation

The Ministry suffered from one crucial weakness that undermined its institutional capacity for leadership. The Minister and high level staff were constantly changing. The Minister responsible for passing Law 100 was in office for one and a half years; after him, there were three Ministers with an average term of 8 months. This rotation was due to the Colombian political process of parcelling out Ministries to different factions within the broad coalition that supports the President. As one of the less important ministries in the government, the Ministry of Health was often one of the chips that the President could offer to maintain his fluid coalition of support.

A significant proportion of the unit directors and professional staff of the Ministry also rotated frequently. As Table 1 demonstrates, the major technical units of the Ministry were probably understaffed in professionals relative to directors, with the average director managing only 2.2 professionals. The directors of these units have held office for an extremely short period of time – 40% for less than one year. This high rotation increased between 1995 and 1996. Similarly, a high proportion (24% in 1995) of the rest of the professional staff was also short term, although this rotation appears to have improved in 1996. At the same time a large portion of the staff was permanent and had held their positions for more than five years. This difference reflected the impact of the civil service reform which grandfathered most of the staff into a protected status. This protection, however, was not afforded to a large number of key management positions (down to the chief of sub-program level) which were classified as 'freely named and removed' by the Minister. As Ministers rotate frequently, their senior staff often change to reflect their own preferences.

Table 1. Colombian Ministry of Health Work Force* (figures shown are percentage of the work force)

	1995	1996
Type of Position		
Directors	15.2	17.1
Professionals	41.1	38.5
Others	43.7	44.4
Total	100.0	100.0
Rotation – Directors		
Less than 1 year	30.5	40.3
1–5 years	52.0	47.8
More than 5 years	17.5	11.9
Total	100.0	100.0
Rotation – Professionals		
Less than 1 year	24.0	14.7
1–5 years	15.5	26.7
More than 5 years	60.5	58.7
Total	100.0	100.1
Rotation – Others		
Less than 1 year	15.0	9.2
1–5 years	16.5	18.5
More than 5 years	68.5	72.3
Total	100.0	100.0

*Harvard study of the 20 major technical units, excluding purely administrative units

Organizational and staffing structure after 'modernization'

The organizational structure that emerged from the 'modernization of the state' process was generally an appropriate structure. The Minister's senior staff included five Directors for key public health functional areas, i.e. management of the Health Reform, Decentralization, General Health Services, Promotion and Prevention, and Financial Management (international loans and grants and the fund for the new health reform); a Vice-Minister with some administrative and planning responsibilities; and a Secretary General with administrative and finance units. This span of control was neither too wide nor too narrow for good management.

While the structure was appropriate, the staffing pattern within that structure was not sufficient to perform the key functions necessary to exercise leadership in the reform. For key areas of the reform (the need for analytical capacity, information collection, formulating regulations, and providing public information), the staff was inadequate, both in terms of numbers and in appropriate professional expertise. The analytical capacity might be met by combining staff from existing fragmented units, in order to create a coherent critical mass of professionals involved in the economic and institutional analysis needed by the new reform.

Some of the monitoring functions were the responsibility of the Superintendencia, which had improved its institutional capacity in key areas of monitoring, inspection, and quality. However, the Superintendencia also suffered from high rotation of senior staff and inadequate staff in key functions. The information system of the Superintendencia, although more adequate than that of the Ministry, was also in need of streamlining and quality control (Casteñeda 1995).

Internal management processes and organizational culture, assessed by the survey and by anecdotal observation, reveal that the Ministry has no clear or shared institutional vision or mission; there is no active process of strategic planning; and newly recruited staff do not receive an adequate induction process. While management style was deemed by the survey of Ministry staff to be appropriate ('participatory directive' rather than the extremes of 'authoritarian' or 'non-directive'), the management practices continued to suffer from too many unproductive meetings and inadequate access to key information. In addition the frequency with which senior and middle level managers were called for last minute duties by their superiors prevented the establishment of predictable and routine meetings. While no systematic study of organizational culture was done, observations by informed participants suggested that there was a split in organizational culture between long-term Ministry officials, who were inculcated with a traditional view of their public administration role, and short-term consultants from the

private sector, who were frustrated because the Ministry appeared unable to be run as a private corporation.

The information systems of the Ministry demonstrated themselves to be particularly inadequate for providing rapid, valid and reliable data on key indicators needed for decision-making about the progress of the reform. Traditional weaknesses of large but poor quality information systems were combined with overreaching interest in the latest complex and costly technology, leading to stalemate and immobility.

Leadership in the sector

The Ministry's capacity to lead consensus-building beyond the Ministry was also weak. The major arena for consensus-building is the National Council for Social Security in Health. The National Council included the Minister of Health, Minister of Labour, Minister of Finance, representatives of municipalities and departments, two representatives of employers, two representatives of workers, a representative of the Institute of Social Security, a representative of private health plans (EPS), representatives of hospitals, a representative of the largest professional association, and representatives of users associations in rural areas. The Council depended heavily on the Ministry for information and for agenda-setting (Silva 1996). The non-governmental representatives did not have a clear relationship with the interests they represented, giving them less capacity to aggregate interest and to be responsive and accountable to these interests. While Ministry dominance could assure some leadership, Council members complained that they had little capacity to carefully review Ministry proposals, suggesting that the consensus was more imposed than forged. Growing resistance to Ministry regulations by health professionals, insurance companies and employers suggested the need for greater leadership in consensus building activities.

5. Recommended institutional reforms in Colombia

The Harvard School of Public Health's Colombia Health Sector Reform project made a series of recommended institutional reforms in order to address the key problems that obstruct the exercise of leadership in the health reform. These recommendations formed part of a Master Implementation Plan for the Reform which was proposed and accepted as the basis for a long-term reform programme to be supported by a US$40 million loan from the Interamerican Development Bank (IDB).

The recommendations started from the expectation that the government was committed to the 'public values' of the health reform and that the Ministry should exercise leadership in achieving the objectives of the health reform. The proposals included recommendations for an internal reorganization to enhance the capacity of the Ministry by:

(1) reforming the internal organization of the Ministry of Health to create a unified Health Reform Policy Analysis Directorate;

(2) revising contracting and civil service protection to reduce rotation of senior staff;

(3) strengthening the information system through interim steps to build an executive information system with a limited number of essential but realistically achievable indicators; and

(4) instituting internal management reforms to address administrative processes and to transform the organizational culture toward the achievement of reform objectives through strategic planning, more emphasis on satisfying beneficiary needs, and other quality improvement techniques.

Other reforms were recommended to strengthen leadership and consensus building capability:

1. strengthening the National Council and creating standing commissions in key policy areas – payments, quality, human resources, and technology assessment – to establish high level technical capacity and consensus building structures to advise the Ministry;
2. creating a Colombian Health Policy and Research Institute – an external analytical capacity that would be respected by all stakeholders and would provide a critical mass of dedicated professionals; and
3. strengthening the Ministry's capacity to inform the public of its rights and duties in the health reform.

Why were these initiatives proposed? These activities were directed toward the approach outlined in Section 3 above. In order to provide leadership of the reform, the Ministry needed to transform its internal structure, staffing and culture so that it would have the capacity to assume its new roles and functions in the reform. The structure of the Ministry needed to establish a strong institutionalized base for performing the demanding and crucial analytical functions required by the reform. In order to do this, a first step was required to create a critical mass of appropriate professionals in a policy and analysis unit.

Since one of the critical weaknesses of the Ministry was the high rotation of senior staff, mechanisms for long-term contracting and reducing the number of staff that can be 'freely named and removed' would begin to address this problem. However, it was unlikely that the current political system would allow reforms that would establish more stability of the Ministers themselves.

Within the Ministry, improved management techniques – borrowed from new initiatives in the private sector but within the public value perspective suggested by Moore – would strengthen the Ministry's capacity to function more efficiently and in the interests of beneficiaries. These reforms would address the transformation of organizational culture through strategic planning and dissemination of the reform mission so that clearly established reform objectives are recognized and valued by all staff.

The crucial problem requiring improved information for policy making was addressed, at least in the short term, by efforts to establish an executive information system of essential indicators which could be used by the analytical unit and senior policy-making staff.

Strengthening the consensus building institutions (the National Council and the creation of new commissions for payments, human resources, quality and technology assessment) would provide arenas in which the leadership could mold various value perspectives and orient them toward reality. These commissions might also provide more stable expertise than that available in the Ministry. For a long-term support for consensus building, the Colombian Institute on Health Policy and Research would provide reliable, apolitical and expert analysis for policy choices.

6. The process of institutional reform

The literature on institutional transformation offers even less guidance on how to implement recommendations for institutional transformation than there is on the recommendations themselves (Kimberly and Quinn 1984). Literature on organizational transformation and 'learning culture' emphasizes the processes of strategic planning and management as integral to institutional transformation. This literature also suggests that the organizational directors have to be fully involved and committed to the transformation and must exercise visible leadership to guide the process. Other observers suggest that there is a temporal pattern of institutional change – equivalent to the aging process in individuals – that might be difficult to engineer. Finally, it may be that institutions make significant changes only when they are threatened by severe budget cuts, bankruptcy or termination. This lack of clear guidance again is similar to the physician: advisers must make recommendations and policy makers must pursue treatments when their patient is sick. They cannot wait for external events or solid research to guide their choices.

In Colombia it was difficult to propose administrative reforms in the Ministry so soon after the modernization of state reforms had been implemented. There was a strong resistance within the Ministry to go through this process again. Any reform was seen as threatening to the current staff. For instance, the proposal to unite existing separate units to create a single Health Reform Policy Analysis Directorate was resisted by the directors of these units who feared that they would lose their job if only one director position was available. Most experiences of institutional reform, however, face these kinds of resistance and usually must overcome them through processes which balance the participation of those to be affected with authoritative decisions of the highest level officials.

This menu of recommendations was first presented to the Minister who approved their incorporation in the Ministry's annual operational plans. In order to gain institutional consensus on the changes, working groups were formed to review the recommendations and to make plans for their implementation. The Minister appointed representatives of key administrative units – always including at least one director – to the working groups, and the Harvard project provided technical and administrative support.

The recommended reforms are to be supported by the Interamerican Development Bank loan and were incorporated in the process of negotiation between the IDB and the Ministry. In this programme, a series of separate contracts are to be let for support in institutional reform and the Harvard Project assisted the government in the design of the terms of reference for these contracts. The working groups created by the Ministry took charge of the process of writing these terms of reference. While this process of incorporation involved a difficult task of consensus-building among groups and individuals who were somewhat resistant to change, the leadership of the Minister provided the required initiative in early

stages, and the deadlines for the preparation of terms of reference provided some benchmarks for achieving consensus. The outside technical advice from Harvard also provided constant reorientation toward achieving the stated objectives.

In addition, there were other reform efforts in public administration with which the project coordinated. These included the Department of Public Service which was seeking broad public sector reforms to improve the civil service law, reduce rotation of senior staff and increase incentives for more efficient public management.

7. Conclusion

The proposals of the Harvard Project were designed to address the transformation of the Ministry of Health in order to assume a new leadership in the implementation of a significant and far reaching health reform. Building on the insights of public management, leadership, capacity building and organizational culture, the recommendations set a large menu of activities for the Colombian Ministry of Health. It will take significant commitment from the responsible officials to implement such changes. The motivation for these changes must come from within the country.

As with any reform, the changes will be resisted by many actors, and the requirements of public management are particularly demanding, as Moore points out. A first condition for successful public management is that the officials running the Ministry take on the task of leadership and the tools of public management, so that they can overcome resistance to change both internally within the organization and externally in the action environment, institutional context and task networks beyond the organization. A second condition, suggested by Grindle and Hilderbrand, emphasizes the limits to the ability of even the most dynamic leadership: the capacity 'gaps' that may exist in the action environment, institutional context and task networks. In Colombia, these gaps were apparent in both the action environment of political and social systems and the institutional environment of the rules and activities of the public sector institutions.

Due to its inability to enforce law and regulation over much of its territory and for many crucial functions, plus the uniquely precarious situation of the scandal-hampered Samper administration, the state is generally weak. This, together with the high rotation of leadership in the Ministry dictated by the demands of national politics and the scarcity of highly qualified technical experts capable of making detailed policy recommendations, may be fundamental gaps that no ministry alone can overcome, regardless of its skills at public management. Finally, the gap between the newly articulated public values of health reform and the broader political culture which is slow to evolve, may still be too great for the reforms to gain legitimacy and the broad support necessary to be sustained.

It is too early to tell if these conditions will prevent the implementation of the recommendations. Without actual implementation, it is not possible to evaluate their impact on the ability of the Colombian Ministry to lead its ambitious health reform. Like a good physician, we have to wait for the patient to comply with the treatment to see if the treatment will actually work.

Endnotes

[1] For a review of the concepts of 'deconcentration' and 'devolution' see Mills et al. 1990.

[2] Other works emphasize the introduction of Total Quality Management techniques into public institutions (Morgan and Murgatroyd 1994; Cohen and Brand 1993). This approach uses a specific set of management tools and principles to achieve the paradigm shift heralded by Barzelay.

[3] On principal agent approach see Pratt and Zeckhauser (1991), on new institutional economics see Williamson (1985) and North (1990), on new institutionalism in organizational analysis see Powell and DiMaggio (1991).

[4] See Reich (1995) for a discussion of health reform values and legitimacy in different political philosophies.

[5] For analysis of the Colombian political system and the role of parties and interest groups see: Leal Buitrago 1995; Delgado et al. 1993; Cardenas 1993; Diaz Uribe 1986.

[6] The Superintendente is appointed by the President, although usually on the advice of the Minister. The Superintendencia retains separate administrative structure, ownership and legal status.

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Annex. Regulatory functions and key problems in Ministry of Health performance

Essential Regulatory Functions	Problems in Ministry of Health Performance
Analytical Functions	*Analytical Functions*
Evaluate Market – Conduct studies of demand and supply, utilization, productivity, distribution of providers, market structure and practices, contracting systems, payment systems, systems of quality assurance, cost of production, administrative costs of competition; tariffs and contracts; establish methodologies to estimate the costs of production, tariffs and payments.	**Evaluate Market** – None of the functions were being implemented by Ministry offices at the time of the interviews, although some activities are being addressed by the Directorate of Sector Analysis and Policy on *ad hoc* teams (e.g. tariffs) and the Harvard team is providing some support for key studies
Evaluate Premium and Reinsurance – Evaluate UPC, specify systems of reinsurance.	**Evaluate Premium and Reinsurance** – No MSP unit is capable of evaluating the UPC; no unit is capable of redesigning the reinsurance system. Several functions are being supported by the Harvard team in conjunction with *ad hoc* teams of Ministry officials.
Establish Information System – Define, regulate, unify and monitor the basic information needed for the functioning of the system.	**Establish Information System** – While there is a current general information system (SIS), significant improvements need to be made.
Human Resources Planning – Collect data, perform surveys, develop human resource planning methodologies and provide projections of human resource supply and demand.	**Human Resources Planning** – The MSP Directorate of Human Resources has not been able to maintain an up-to-date database; does not currently have the capacity to develop adequate and useful human resources planning methodologies.
Evaluate and Control High Cost Technology – Establish criteria for evaluation and control of acquisition of high cost technology.	**Evaluate and Control High Cost Technology** – The MSP Scientific and Technology Directorate is not yet evaluating technology on its cost-effectiveness. There are plans to do so next year.
Insurance Regulation	*Insurance Regulation*
Affiliation – Informing the population, identifying eligible population, reviewing affiliation mechanisms, and controlling the affiliation process.	**Affiliation** – Although there is a public information programme, currently no MSP unit is providing information to the public about affiliation, obligations and rights; no unit is capable of revising mechanisms of affiliation.

Regulate Insurance Plans – Establish criteria for EPS creation, organ. & transformation; certify plans; control adverse & risk selection; monitor compliance with regulations; provide tech. assistance.	**Regulate Insurance Plans** – The Superintendencia is performing most of the required regulation of the EPS and has established certification and reporting criteria of EPS, but no MSP unit is providing technical assistance.
Regulate Benefits Packages – Define the POS, PAB, PAMI; perform cost-effectiveness studies; regulate complementary plans.	**Regulate Benefits Packages** – No MSP unit is currently developing regulation of complementary plans.
Provider Regulation	*Provider Regulation*
Regulation of Provider Institutions – Establish criteria for creation, transformation and strengthening of provider institutions (IPS), provide technical assistance; assist in upgrading infrastructure and equipment, evaluate management in public institutions.	**Regulation of Provider Institutions** – The IPS regulation has not yet been approved, there is no clear unit responsible for management strengthening, although the IDB and World Bank-supported programmes are providing support to management strengthening in hospitals.
Regulation of Quality – Establish norms for licensing, accreditation, evaluation and control of quality; establish a quality information system; monitor quality of providers.	**Regulation of Quality** – The current staff does not have the technical capacity to regulate quality; however, the World Bank-supported programmes are providing consultant support and the Superintendencia has a large staff on quality monitoring.
Responsiveness to Beneficiaries – Define mechanisms for attending beneficiaries; define and promote the community vigilance committees (veedurías comunales); define complaint mechanisms, promote the formation of Leagues of Beneficiaries.	**Responsiveness to Beneficiaries** – No MSP unit is responsible for providing information to beneficiaries. Superintendencia has a programme.
Regulation of Financing	*Regulation of Financing*
Financing of System – Manage the financing provided by law; establish effective & efficient mechanisms of collection; distribute 'solidarity' resources; manage compensation mechanism for contributory regime; control evasion; monitor sources & uses of funds.	**Financing of System** – No MSP unit is responsible for collection of contributions (this function is assigned by law to the EPS) and there is no unit currently monitoring collection. The Superintendencia and FSyG perform many of the other monitoring functions.
Decentralization	*Decentralization*
Provide Technical Assistance – Support and credential territorial units at department and municipal level.	**Provide Technical Assistance** – Although the Directorate General of Decentralization is large and is providing technical assistance, evidence from the field suggests that the need for technical assistance is far greater than the capacity.