UNIVERSAL, DUAL, OR PLURAL?
HEALTH CARE MODELS AND DILEMMAS IN LATIN AMERICA

SONIA FLEURY*

- Address: Brazilian School of Public Administration – Getulio Vargas Foundation
  Praia de Botafogo 190
  22 253-900 Rio de Janeiro - RJ – Brazil
  sfleury@fgv.br

I- INTRODUCTION

In the last twenty years, Latin America has experienced a progressive process of transformation of the previous institutional arrangements responsible for the social policies and social systems, delivering education, health care and social security.

Although health care reforms in Latin America have the same objectives of similar ones in other regions - to increase efficiency while controlling the inflationary prices and rising demand - the great difference is that this process in the region is being carried out in a peculiar situation. In the region, one can find an enormous portion of the population without a regular source of care and not entitled to the benefits of, paradoxically, some of the oldest and mostly deeply rooted Social Security systems.

This context is stressed by the increasing demand for access to health care services since the region is experiencing an especially democratic period. But, on the other hand, there is a strong pressure upon national governments to cut down public expenses in order to stabilize their economies. Another new element of contradictions in this scenario is the expansionist dynamic of private health care providers and insurance companies, mostly depending on governmental incentives although without any regulation.

The recent intents to adjust the economies of the region to a more competitive and international market have deeply changed the role of the State in heading the process of industrialization, as well as in the provision of social policies. In accordance with this general movement, many tents of reforming health care system have been launched in different countries. All of them are facing the challenges of increasing equity in benefits, efficiency in management and effectiveness while looking forward to satisfying health needs of the population. The governmental authorities have to cope with the shortage of public expenditure as well as the enlargement of the private providers' participation. Decentralization, privatization, increasing of competitiveness, and empowering users, these are some of the tools of the ongoing reform processes.

The objective of this paper is to analyze how these reforms are changing the health sector structure of power, by means of the emergence of new models for social policies, as well understand their consequences in terms of equity and governance in different countries of the region. In other words, the purpose is to point out the actual dilemma between efficiency and social integration that seems to be the core of the problem of democratic self-government in Latin America.

II- THE HISTORICAL PATTERN OF DEVELOPMENT[1]

Despite the many differences among Latin America countries, the region showed a common pattern of social economical development from the 50's to the 80's which

[1] The English-Speaking Caribbean countries have not been considered in the study due to their different pattern of development that has resulted more extensive social protection systems.

was characterized by a strong and active presence of the state, led by the import substitution model of industrialization.
Concerning the political system, authority in the region is ruled in an oligarchic way, combining mechanisms of **patrimonialism**, **populism and exclusion.** We understand as **patrimonialism** any kind of private appropriation of public goods by the elite; as **populism**, the exchange of privileges by means of workers co-optation by the governments; and as **exclusion**, the process of denying the citizenship status and social rights to the poorest people. As a consequence, the region presents a strongly **authoritarian political culture** and the worst income distribution in the world.

According to the IADB report[2] for 1999, a mere 5 percent of the population receive a quarter of the national income and the top 10 percent stay with 40 percent, leaving the poorest 30 percent of the population with only 7.5 percent of the total income.

During the second half of the century, one could witness an intense, although dissimilar, process of urbanization in all the countries. Nevertheless, the period of rapid growth in the region - from 1945s to 1973s – did not led to a notable improvement in income distribution. This result is attributed to the institutions generated by the political, social and economic structures.[3]

Therefore, the modernization of social economical life did not allow the labor market relationship enlargement to the whole work class. On the contrary, the economic development in the region was particularly known by the structural heterogeneity of the labor force insertion in the productive process. As a consequence, half of the labor force is permanently in the informal market, which means, additionally, to be excluded from the social security system.

The economic crisis and inflationary process in the 1980s and the adjustment economic measures in the 1990s were responsible for the turn back in the tendency of income distribution so that the gap widened again and the improvements in distribution from before the debt crisis just wiped out.

From 1995 to 1998, Latin America score of Human Development Index dropped from 0,823 to 0,737.[4] – This record - varying from 0.340 for Haiti to 0.889 for Chile - was situated between the score of the industrial countries in the rank of UNDP and that of all developing countries. (Annex 1, tables 1 and 2)
According to the World Bank report, extreme poverty (living on less than $1 a day) represents 15% and poverty (living on less than $2 a day) achieves 36% of the total population. But, “both the share and the numbers in poverty remains stubbornly stagnant, apparentely immune to the growth in the 1990s because of high leves of inequality”.[5]
Moreover, the international agency concluded in the Okinawa Summit –G8 Report that “the poor are often the most severely affected by adverse shocks of macro and

[2] IADB – Facing up to inequality in Latin America – Economic and Social Progress in Latin America-1998-1999 Report, Washington, DC, 1999
[3] Thorp, Rosemary – Progreso, Pobreza y Exclusión – Una Historia Economica de América Latina en el Siglo XX, IADB, Washington, 1999, chapter 2
[4] 1995 and 1998 – Human Development Report, UNDP, Oxford University Press, NY
[5] 2000/2001 World Development Report, Attacking Poverty, World Bank, Washington

micro origin… and that “most Latin American and Caribbean countries do not have mechanisms to mitigate the impact of adverse shocks to the poor”. [6]
This situation affects the quality of life of different groups in the regional population, as one can see in some basic indicators.
By the late 1980s, life expectancy at birth in Latin America and the Caribbean was 70 years of age, an important increase over the 62 years of age registered in 1975. At the same time, the region annually lost nearly 233 years of disability-adjusted life years (DALYs) per thousand populations, placing it halfway the industrialized and the developing countries. Infant mortality shows tremendous variation, ranging from 68,0 to 9.0 per 1,000 live births.

In the early 1990s, health expenditure per capita in Latin America and the Caribbean was close to US $122 and represented 6% of the regional GDP, ranging from $9 to $564. Major differences can be observed in the regional population’s access to health service across the region: average national hospitalization rates ranged from 2.3% to 14.2% of the population, and the average national coverage ranged from 0.5% to 6.3% medical consultations per inhabitant per year.

[6] IMF, WB, IADB, EBRD, ADB, ADB, 2000 – Global Poverty Report, Okinawa Summit.

Latin America Countries – Variation

Indicators	Maximum	y/s	Minimum	y/s	y/s	y/s	y/s
Economic, Social and Demographic		***B***					
Total population (thousands)	164.000 (Brazil)	97a	2.700 (Panamá)	97a	97a	97a	97a
GNP (millions US$)	820.381 (Brazil)	97a	1.971 (Nicaragua)	97a	97a	97a	97a
GNP per capita (thousands US$)	9.028 (Argentina)	97a	375 (Haití)	97a	97a	97a	97a
Life expectancy rate (years)	77,0 (Costa Rica)	97a	54,0 (Haití)	97a	97a	97a	97a
Global fecundity rate	4,9 (Guatemala)	98b	1,6 (Cuba)	98b	98b	98b	98b
Infant mortality rate (per 1000)	68,0 (Haití)	98b	9,0 (Cuba)	98b	98b	98b	98b
Maternal mortality rate (per 100,000)	456,0 (Haití)	93d	2,4 (Cuba)	94c	93c	95c	96c
Illiteracy (%)	97,5 (Uruguay)	94d	21,0 (Venezuela)	97a	97a	97a	97a
Access to potable water (% population)	100,0 (Costa Rica)	94d	39,0 (Paraguay and Haití)	96a	96a	96a	96a
Access to sewage (% population)	95,7 (Costa Rica)	94d	14,8 (Paraguay)	94d	95c	94c	95c
Health Expenditure							
Total health expenditure (millions US$)	29.151 (Brazil)	95c	65 (Haití)	95c	-	-	95c
Health expenditure (% GNP)	13,4 (Uruguay)	95b	3,2 (Guatemala)	95b	95b	95b	95b
Health expenditure per capita (US$)	564 (Uruguay)	95c	9 (Haití)	95c	-	-	95c
Public Expenditure (% total health expenditure)	74,0 (Costa Rica)	95b	32,0 (República Dominicana)	95b	95b	95b	95b
Resources and Services							
Doctors (per 1000 inhabitants)	5,5 (Cuba)	92d	0,1 (Haití)	92d	96c	93c	96c
Nurses (per 1000 inhabitants)	6,9 (Cuba)	92d	0,1 (Paraguay and Haití)	92d	96c	93c	96c
Health coverage (%)	100,0 (Cuba, Costa Rica and Paraguay)	93d	40,0 (Bolivia and Haití)	93d	93d	95c	93d

Source: NAADIR database

These differences are found not only among the countries but also within them and take a disproportionate toll among the underprivileged rural and urban groups,

indigenous groups, and many other disadvantaged classes.[7](See major variations among the countries in Annex 1, tables 3, 4, and 5)

Nevertheless, some of the oldest, powerful, complex and institutionalized social security systems could be found in the region, specially in those countries considered the pioneers, where the systems have been set up at the turn of the century: Argentina, Brazil, Chile and Uruguay.[8] The institutions of social protection were one of the most important channel, relating the populist leader to the urban labor class and performing the significant function of exchanging support and legitimacy to the government by differential benefits to each labor fraction. Due to this bargain game, the social security system was built up as a very fragmented structure. The benefits were expanded in a cumulative process, to the same entitled workers; the coverage was enlarged as part of the political game of pressure and bargain, while its financial basis was completely rooted in taxes and contributions upon salaries.

In this sense, it's possible to affirm that social policies and social security systems in the region, wherever and whenever they existed, played an important role in the statecraft process, but they did not succeed in spreading a civic culture and in extending the citizenship status.[9]

Inscribed in this process were the main actors in the social policy arena, such as, the technical bureaucracy, the professional workers in social field extracted from the middle class, the urban labor force organized in unions and the traditional populist politicians as well. Thus, social protection was rooted in the inner core of the political system, characterized by the main role of the state in the industrialization process combining industrial protectionism with the controlled political incorporation of urban workers' demands. This apparently strong state interventionism was weakened by its paramount circle of compromises, like the increasing intervention of the state in social and economic life to meet all their demands and the incapacity of the government to impose progressive taxes on the productive sectors.
The ever-growing complexity of the political structure, the dissatisfaction of the expectations generated by this process, and the incitement of the contradictions between co-optation and control, turned the possibility of fulfilling emerging political and social demands very difficult throughout the course of the industrialization process. As a consequence, the expansion and maturation of the social security system in the region manifested itself as a crisis, insoluble in the inner circle of its original framework.

Within the common pattern of stratified social protection one can find huge differences between the countries in the region. While some countries spend almost 18% of their gross national product (GNP) on social policies, others spend no more than 8%. Social security coverage also varies, ranging from 20% to 90% of the population.

---

[7]- PAHO/WHO - "Equitable Access to Basic Health Services: Toward a Regional Agenda for Health Sector Reform", September 1995

[8] C. Mesa-Lago - Social Security in Latin America - Pressure Groups, Stratification and Inequality, University of Pittsburgh, 1978

[9]- To compare the development of social protection in the pioneers countries see S. Fleury- Estado sem Cidadãos, Fiocruz, 1994

According to their social public expenditure in the 90s, the countries of the region can be grouped in three classes[10] - differences inside each country being not considered. In the first group are the countries which social public expenditure represents more than US$400 per capita (Argentina, Brazil, Chile, Costa Rica, Mexico, and Panama, Uruguay). The second group is composed of those countries with social public expenditure per capita varying from US$200 to US$400, (Colombia, Ecuador, Nicaragua and Venezuela). The last group is composed of those countries with the lowest social public expenditure per capita, meaning less than US$ 200 yearly (Bolivia, El Salvador, Guatemala, Honduras, Paraguay, Peru and Dominican Republic).

On the other hand, if one decides to consider not only the social public expenditure amount but also the coverage and the results in terms of some social indicators, the former groups are changed. In order to differentiate the countries in the region, the new classification combines the degree of inequality with the amount of exclusion from social benefits. In this sense, Figueira[11] identified three types where the stratification was always presented and the degree of exclusion varied greatly, from a "stratified universalism" (Argentina, Uruguay and Chile), through a "dual regimen" (Brazil and Mexico), to a more "exclusive regimen" (Dominican Republic, Guatemala, Honduras, El Salvador, Nicaragua, Bolivia and Ecuador).

Adding another group for the countries with “universal” systems without significant stratification, the cases of Costa Rica and Cuba can be plot as exceptions to the common stratification of social policies in the region.

This prevalent pattern of social policies appears in the following characteristics of the health sector:

- stratification and/or exclusion of certain population groups;
- fragmentation of institutions (social security and health ministry);
- narrow and fragile financial basis, relying mainly on contributions from salaries;
- highly concentrated health care services network;
- centralized and inefficient management;
- orientation toward curative practices instead of preventive and collective public health measures; and
- Strong actors with vested interests represented in the political arena.

The demand for health care reform arose after had become apparent that this widespread pattern was incompatible with expanding the coverage, increasing the efficiency, and improving the quality of health care services in a context of financial shortage and democratic regime.

[10]- CEPAL - Panorama Social de America Latina, Santiago, 1998

[11] - Filgueira, Fernando – Tipos de Welfare y Reformas Sociales en America Latina: Eficiencia, Residualismo y Ciudadania Estratificada, in Melo, Marcus A. (ed) – Reforma do Estado e Mudanca Institucional no Brasil, Fundacao Joaquim Nabuco, Recife, 1999

III- THE CONTEXT OF REFORMS

The structural reforms implemented in the late 1970s and throughout the 1980s entailed the emergence of a new style of economic development based on the leading role of private investment and exports, on the expansion of private consumption, and on a limited role of the state. In most countries of the region, adjustments to the financial crisis led to regressive income distribution and acute decline in real wages, further increasing inequality and, even more, poverty.

Nevertheless, it did not manage to reverse the long range of positive tendencies regarding social conditions. It just reduced the rhythm of social improvement that is still reflected by some indicators, such as, coverage of educational system, access to water and sewer, reduction in child mortality rates, increase of life expectancy at birth.

Such phenomenon must be accredited both to the social services network that has been installed in several countries during the period of economic expansion and to the other social-demographic characteristics associated to the accelerated pace of urbanization.

As fertility rates have been declining rapidly since the middle of 1970's, lowering the rate of population growth in all countries of the region, the myth of overpopulation is broken. But it still remains a challenge to grasp the favorable opportunity of launching social programs to protect the young poor and prevent against the financial problem of social security systems.

Besides considering the reduction of fertility rates, it is necessary to give thoughtful attention to the deep economic and social changes the region has been undergoing in the last decades, with an intense process of urbanization, migration and aging of the population. Both features altered the demand structure since the urban demands became more visible and the demographic changes draw for an alteration of the regional epidemiological profile. Some of the typical diseases related to underdevelopment situations have been added by the blooming of those prevalent in industrialized societies (cardiovascular, chronic, accidents and violence).

The economical dynamic of health sector is powerful, since the labor market in this sector employs around 5% of the economic active population in the region and the health expenditure participation represents an average of 5,7% of the GNP in the countries of the region.[12]

However, when an international comparison of economic resources destined to the health sector is established, it shows that the region is under an extremely unfavorable situation, providing only US$121 per capita for health, while the world's average is of US$323. Public expenditures with health represents 2,2% of the GNP, what corresponds to less than half the world's average.[13]

[12]CEPAL - Salud, Equidad y Transformacion Productiva en America Latina y el Caribe, Santiago, Julio 1994

[13]World Bank - World Development Report 1993, Washington

Regarding health financing, it is observed that during the last decade there has been a reduction in public financing concomitant to an increase in the families', enterprises', and NGO private expenditure. The NGO participation growth in health financing in the region assumes very significant proportions, having destined a total of US$6 billion during the period 1980-1989. In the poorer countries, this participation is similar or even superior to that of local governments.

The health care provision brought about a tendency to deterioration of public services as a consequence of the reduction of public expenditure, during the economic adjustment. Besides, it provoked the rising of the meaningful technological gap between public and private hospital services, in addition to a loss of efficiency and effectiveness in the health care public management and provision. Simultaneously, there was a growth in the supply of services on the side of the private insurance sector with a significant increase, in recent years, in terms of affiliations and number of hospital beds.

Together with the changing in market dynamics in Latin America, there was also a great transformation in the social fabric and institutional political framework. Since the 1970's, the old pattern of relationship between state and society - the corporative pact emerged in the earlier years of industrialization - seemed to be insufficient to embrace a complex and pluralistic network of political actors, emerging as part of the urbanization and industrialization processes. Besides, the region experienced a huge change in structure, with the traditional actors that supported this social pattern loosing power while new emerging actors (private providers, insurance companies, local governments, community organizations, multinational agencies etc.) are pushing for transforming the social protection systems.

The intense reforming dynamic in all social policy systems in every country in the region is also a response to this pressure towards the transformation of the role of the state. There is a twofold movement propelling the reforms in these countries: the one to displace the institutional and political context in the health care sector from the central to the local level, and the other to the moving from the public sphere to the private one. Although this phenomenon represents a common tendency guiding the process of reshaping the health sector, there are many different possible arrangements to be considered as the reform strategy.
Even though one can identify some common trends and characteristics in these reforms, it is important to recognize that this is not a homogeneous process. First, because the starting point represented by the existent social policy systems is different in terms of coverage, expenditure, benefits, and main political actors and institutions involved.

Second, because its instruments generate stress and contradictions, the reform is never a straightforward process. Besides, the reform coalition has to face the economic and political constraints and adapt the original proposal to these conditions.

Third, because the social policies are not only a technical and organizational arrangement but also political options based on values supported by the main actors in each society. In this sense, technical instruments and institutional trends are

adopted and organized in different political models of social protection. There is not a unique and inexorable course for the social reform, as can be detected in the comparative studies.

Even taking into account the singularity of each case of health care reform in the region, it is possible to abstract some common features and design clusters of tendencies that can be captured in an analytical model. In this sense, one could identify three different models for health care reforms in the region, namely, dual, universal and plural.

Each of these models was constructed on the basis of the concrete experience of a country, although one can find the same tendencies in other countries in the region. Nevertheless, the consistence of the reform implemented in Chile, Brazil and Colombia gives the possibility to take these models, far way from the actual experiences, as analytical models and regional tendencies in health care reforms.

III – THE CHILEAN DUAL MODEL

The Chilean reform was launched in the early 80s when the country was in a very difficult macroeconomic situation and under a dictatorship government. The social reforms of health and social security systems were part of the measures to reduce the fiscal deficit through lowering fiscal expenditure and increasing internal savings to expand the long-term rate of investments. Politically, it represented the break down with the corporative pact of power in favor of a market-oriented policy.

The Chilean reformation consisted of the transposition of pension and health public funds to private institutions created for that purpose, in such a way that the state remained responsible just for the poorest portion of the population, which did not manage to acquire private insurance in the market.

Although being a model of liberal inspiration, operates as a compulsory security regulated by the public power. However, the prior tripartite mechanism of funding social protection is now at the entire responsibility of the worker - in case he joins a private insurance company - or the government's - in covering the expenses with preventive medicine for the all, and health care services for the poor.

This reformation broke the spinal cord of the social security system, set up by populist governments with its interdependence logic, since the benefits acquired do not depend anymore on the political power of the workers. The new parameter is productivity, in which the main priority is given to the protection of the portion of worker inserted in the most dynamic sectors of economy, capable to afford a private health insurance plan. Meanwhile, those linked to the most backward sectors and/or to the informal market remain on the responsibility of public programs.

The reform was anchored in the following principals:

- subsidiary role of the state;
- targeting the poor;

- free-choice of consumers;
- cost-sharing;
- separation of the functions financing and delivery; and
- Competition among insurance companies and providers.

The strategy of the reform was based on the introduction of an “opt-out” mechanism from public sector and on the creation of private health insurance (ISAPRES). The public insurance responsibility was due to FONASA, manager of the public health fund. The public health care network of facilities was split in 27 regional Health Services (SS).

Regarding to funding and management of health care system, the most important features were represented by the extinction of the employer compulsory contribution followed by the creation of a subsidy to support the voluntary employer contribution to the private insurance of his/her employees. Also, an important administrative mechanism was the de-concentration of the public primary health care towards the municipalities.

The reform resulted in a dual health care system: a public system under the steering role of the Health Ministry; and a private insurance system represented by the ISAPRES and the private providers scattered in the market. Both of them have their own mechanisms of funding, financing, management and delivery.

In the public system, the Health Ministry is responsible for the health care policy. Although the initial proposal was to give autonomy to the delivery function, implemented by the regional authority and the municipalities, both still depend on the Health Ministry policies and resources.

The prospect of attributing an insurance autonomous function to FONASA didn’t succeed thoroughly. More properly, it came to be the manager of the public funds, instead of a buyer of health care services for the insured in the public sector. In part, this result is due to the lack of autonomy of FONASA and in part to the incipient “free-choice” modality, applied to those insurance-payers that refused to opt for leaving the public system. In this case, however, high levels of co-payments are required for those people, expelling them from the public to the private system.

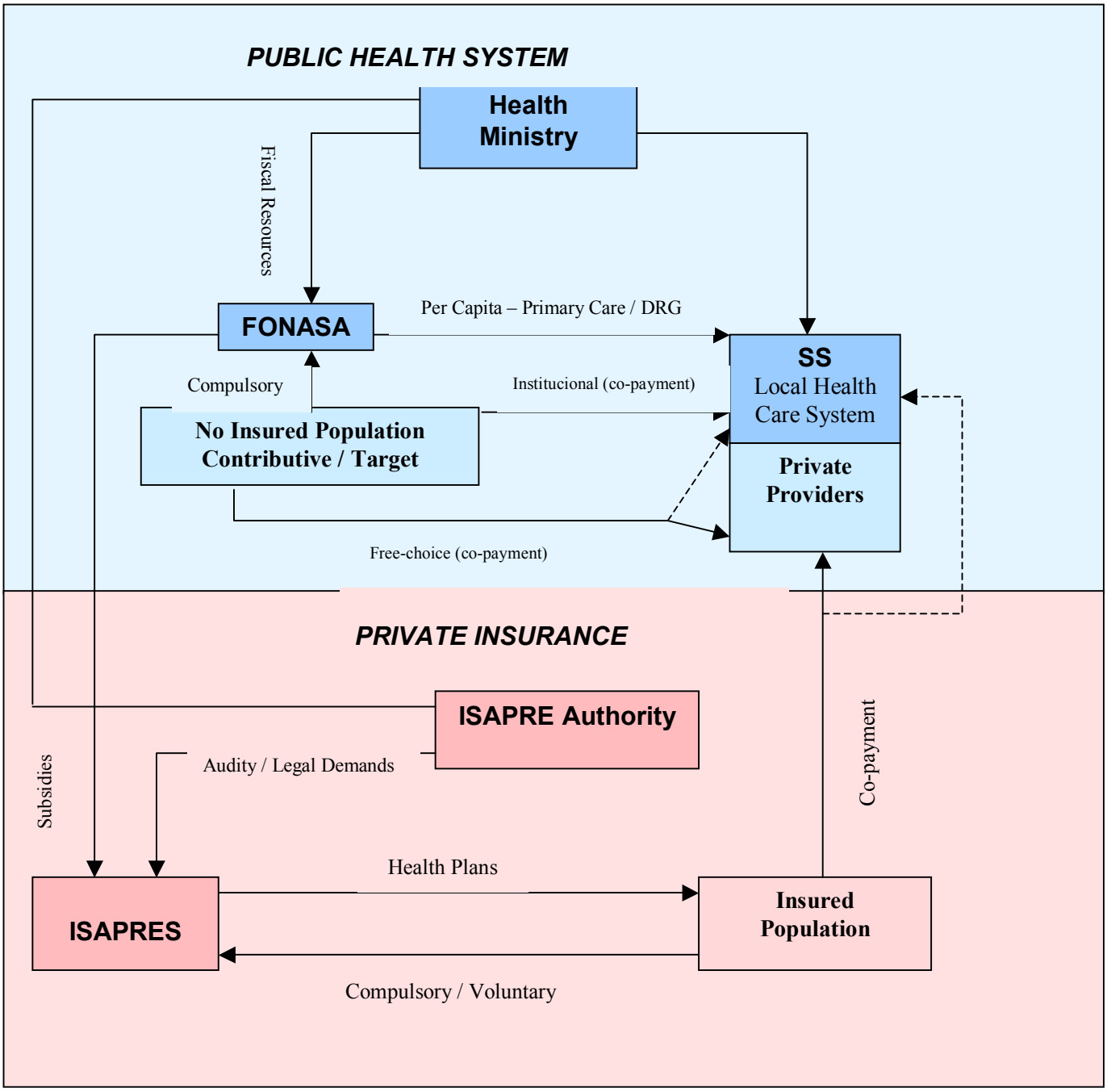
In order to insuring the indigents, FONASA receives fiscal resources from the Health Ministry budget. These indigents are only eligible to the “institutional modality”, which means their access without free choice to the public services. Assignation of resources is made on a per capita basis to the municipalities and on a diagnosis related groups-DRG basis to the public services.

The private insurance system is funded by the compulsory discount of 7% on the salaries, by the public subsidies, and by voluntary contributions to purchase a better plan. The delivery is provided by clinics and hospitals disperse in the market, since the ISAPRE chose to become pure third party payers and vertical integration did not occur until very recently. The main trend is to have a list of providers selected by each insurance company, while the free choice is being restricted to more expensive

plans. The insured population is eligible to different health-care plans, according to the purchase power of each segment.

The dual model can be observed in figure 1, bellow:

Figure 1 – Chilean Health System



The duality of the model is represented by the distinct agents performing each function in the private or in the public system and the relations and flows among them. Contributions to both systems are legally prohibited. Basically, each system

has its own coverage, financial mechanism, organizational structure and delivery network. Since the public system is not reduced to a public insuranceit is functioning as a comprehensive and integral public health care system.

However, there are some interactions between the two systems, in terms of the subsidiary role of the public system, represented by the subsidies in favor of the private system and by the need to guarantee health care to all individuals refused by the private system. The public function of regulation is also a bridge between public and private systems, since the ISAPRE authority is an agency of the Health Ministry.

Some grievous consequences emanated from this model are present in the Chilean experience, such as, segmentation, inequality, risk and adverse selection.
Since the access to health insurance depends on the individual risk-based private health insurance, the population was segmented into different groups; each eligible for different benefits and services. This occurs between the public and private users and within both groups.

The result is that the right to health care is regulated by the purchase power of each individual unless fiscal contributions from general taxation increase to compensate and support those who can not afford health care expenses. According to Baeza[14], after ten years of the reform, in 1990, there was a significant reduction of the fiscal contribution to the public health sector. As a consequence, while per–capita expenditures in the public sector were about US$65 (58% of which were pay-roll tax revenues), the average per-capita expenditure for the ISAPRE sector was about US$250 (90% of which were pay-role tax revenue and 10% state subsidies).In the last ten years, the democratic government heavily invested to strengthen the public sector in order to reduce the mentioned inequalities. In 1997, the per-capita expenditure in the public sector raised to US$221 as a consequence of the increase in the public expenditure associated with the decrease of the number of beneficiaries of the public system, while, in the private sector, it corresponded to US$341 in the same year.[15]

Private insurance companies establish premium cost in a selective basis. Since there is no risk pool, the premium for the elderly and sick people is unaffordable for most of them. In the same way, the high level of cost sharing required for catastrophic diseases expels those people towards the public health care system.

The almost complete absence of a regulatory agency during the first 10 years of the system in Chile represented a significant effect of risk selection and cream skimming. While the highest incomes and young people are covered by the private sector, the poorest and the elderly are covered by the public sector. Besides the poorest groups, the health market also excludes those with major risks, such as the aged and the chronically ill individuals.
The absence of cross subsidies from the rich to the poor, associated with the lack of regulation to constraint risk selection and cream skimming, resulted in putting the

[14] Baeza, Cristian – “Taking Stock of Health Sector Reform in Latin America”, World Bank, 1998, p.11
[15] Zuleta, Gustavo – “Chile: Antecedentes sobre la Reforma del Sector Salud y Escenarios Posibles a Futuro”, Banco Interamericano de Desarrollo, Washington, 1999, p.38

major burden of the responsibility and expenses on the shoulders of the public sector.

In order to get a clear notion of this policy effects, which stratifies social protection in compliance with an economic logic, one can take as example some data on expenditures in the health sector in Chile. In 1991, private securities reached the coverage of nearly 19% of the population and absorbed 50% of the total expenditure with health care (CEPAL, 1994:58). It is supposed that the remaining 50% funds should cover primary attention for all, and provide health care to protect the other 81% of the population.

Nowadays, the private sector covers less than 30% of the healthy and young people, while the public sector is responsible for the other 70% of poor, elderly and severely sick people. These figures represent the limits to the expansion of a profit market in health care.

The Chilean's reform increased the degree of inequality of the social protection system by assuming that social policies should be formatted according to the previous segmentation existing in the economic sphere. To cope with this tendency, there was a huge effort to compensate inequalities in the market with social support policies, although the results are still below the rank of social indicator's existent before the reform.

Although restricting the role of the state in social protection to the compensatory policies, the Chilean experience has demonstrated that it does not mean to liberate the public sector from the demand pressure for health care services, since the bulk of the population cannot afford a private insurance.

To summarize, whereas the dual model requires the consumer options to public or private system, actually, the private system itself chooses the beneficiaries and the possibilities of access and utilization by means of the mechanism of establishing high premiums and cost sharing in undesirable (no profit) circumstances.

The public system became the last resource ("free reinsurance") for everyone who cannot afford a private insurance, and is also responsible for public health for all the population and health care for the poor, elderly and catastrophic diseases. In this sense, one cannot speak of the duality as a competition between both systems because the public system has always a subsidiary role.

To accomplish the responsibilities and onus attributed to the public system, the government had, in the last decade, launched corrective measures in three directions, in order to:

- increase the fiscal resources invested in the public system, as commented before;
- increase the participation in institutional committees and the efficiency in the public system through financial and managerial instruments, such as: allocation of resources on a per capita basis to municipalities and on a diagnostic related basis for SS units, and introduction of contracts of Performance Agreement between the Health Ministry and the Regional Authorities; and

- regulate the private system, aiming at achieving more equity and efficiency. Inefficiency and inequities in the private sector are due to the absence of previous regulation, the existence of incentives from the public system and the lack of competition in a highly concentrated market (77% of the beneficiaries are affiliated to 5 institutions and the administrative costs, on average, accounted for more than 18% of total costs in 1997[16], while the administrative costs in the public sector were less than 1.8% for the same year.)

Nevertheless, the consumer satisfaction with the private system, and the resistance of the insurance companies to the proposed new regulatory measures[17], refrain the more rational distribution of resources and responsibilities. Present tensions between private and public systems account for two plausible scenarios. In one, the public system is able to regulate better the private market, reducing subsidies and redistributing the burden of the unprofitable coverage, becoming morecompetitite; in the other, the public system is reduced to a public insurance buyer contracting health care services in the market for its beneficiaries.

In the first scenario the dual system is changed in favor of a more powerful public system, capable to regulate the private insurance system and to compete for the medium class consumers. In the other possibility, the change means a reduction of the actual public system to the function of insurance for the poor.

IV – THE BRAZILIAN UNIVERSAL MODEL

In Brazil, a strong social movement in the health field began in 1970, gathering professors, parliamentarians, bureaucrats and users around the struggles for the democratization of the country. An organized actor emerges in the civil society - the so-called "sanitary movement" - aiming at a radical transformation of health care in order to unify the fragmented existing system, to decentralize health care delivery, and to introduce a democratic decision-making process.

Directed by this movement, the Sanitary Reform had as its central objective the universalization of access to health care, by means of the creation of a Public National Health System. These proposals were inserted in the 1988 Constitution, in which health was ascribed as a citizenship's right and a state duty, requiring health services to be organized into a single, public, universal system of integral attention. The strategy was to build a decentralized and democratically managed system, with the participation of organized society.

Therefore, the guiding principles and strategies of the health care reform were expressed in the Constitution as follows:

- health as a right of citizenship, since health activities are of public relevance;
- equal access to all citizens to all health care levels;
- health as a component of the social welfare system;

[16] Zuleta op. cit. P. 15 and Baeza, op cit, p.17

[17] Specifically to the elimination of the susbsidies and the creation of an individual fund with the excedent of the contribution, after deducted the price of the plan, to be used in case of catastrofic diseases.

- single public authority in each level of the system, integrating the previous health care network of the Social Security with the Health Ministry and aggregating the public providers in a single public system;
- integrated (preventive and curative) and integral health care provided by means of an hierarchical health care network of services;
- social control and social participation in each level of a decentralized and regional system, allowing greater decision-making and financing autonomy to the municipalities and states, and according to their capacity to bring off the required principles and mechanisms of the reform.

The new design of the health care system represented an important change in the political power and responsibility distribution between state and society and among the different spheres of government - national, states and municipalities. This new design is presented in figure 2, in the next page.

Each elected level of government has its health authority, managing the health care system at this level, as well as a health fund and a health council. The central government is responsible for the design of the system, outlining the standards to be followed by the entire system, and building up the conditions and requirements for the state and municipalities to participate in the health care management. Therefore, the national authority ensures the uniformity and coordination of the system.

In the health funds are gather resources assigned by the municipalities or states for their respective systems, but the major the resources are transferred from the national fund (tax revenues and contributions to social funds). During the last decades, the federal government has been accountable for more than 70% of the total expenditures of the public sector but there has been an increasing participation of the sub-national levels.

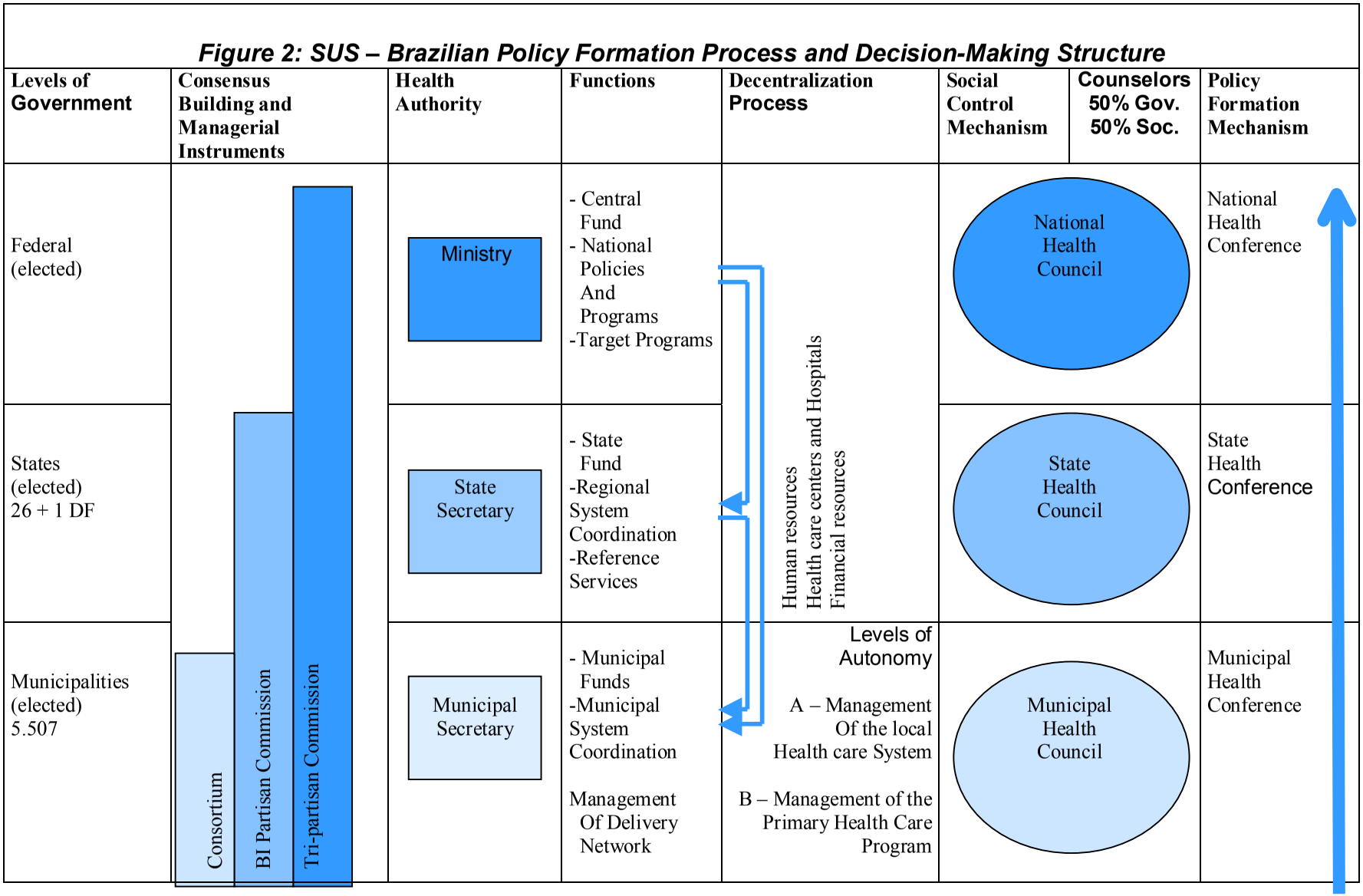
The established mechanism to build up consensus and manage the resources and attribution is the Inter-managerial Partisan Commission (Tri-partisan joining the national, the state and the municipal levels, and Bi-partisan linking the state to the municipal health authorities).

The allocation of resources from the national fund to the state funds and from the state funds to the municipal funds is the result of a negotiation in the respective inter-managerial commission. Similarly, some municipalities had build up a mechanism of Consortium, in order to pact and rationalize the use of services and resources in a network integrated by proximity and necessities.

Under the SUS are the municipalities who have priority in planning, organization, and delivery of the local health care system. The municipalities are responsible for managing the facilities that operate at the primary and secondary levels of complexity while the state manages those of tertiary level and coordinates the regional referral and back-referral networks. Also, the states execute complementary measures and technical and financial cooperation with the municipalities.

The decentralization process was designed in a progressive basis, transposing the facilities and human resources from the higher levels to the municipalities. The self-management of the local health-care system, including the financial resources

Figure 2: SUS – Brazilian Policy Formation Process and Decision-Making Structure



transferred to the municipality, is conditioned by the fulfillment of same requirements and standards. Otherwise, the state became responsible for the resources, leaving the municipality with the management of only the primary health care program.

In each level of the health care system there is a Health Council, with 50% of its seats representing the government and 50% representing the society (users, providers, professionals, etc). This mechanism permits the social participation and control in the processes of policy-making, budging, and policy execution.

Another participatory mechanism is the Health Conference, periodically realized to discuss some selected subject, in order to vote the guidelines and agenda for the health system in the next period. It is realized in a bottom up way, in each level of the system, electing representatives to the National Health Conference.

The main products of this reform were the creation of a legal framework and the implementation of institutional changes capable to unify the public services of the Health Ministry with those of the Social Security. It is also building up a progressively decentralized system, with local levels increasing their technical capacities and assuming the health responsibilities and resources.

There was an increase in the coverage for the poorest as a consequence of the universalization measures implemented through this deep decentralization of public services, as well as an incredible improvement in social participation in the several councils established in each level of the decision-making process. The success of decentralization could be seen in the number of new collective actors performing at both local and central political levels as well as in the increase of participation of municipalities in the public health budget.

But not much could be done on the matter of re-organization of health care services. Also, even some curative medical assistance measures were reinforced in detriment of the preventive actions, as a consequence of the mechanism of funds transference to the municipalities, based on a kind of DRG standard.

During the first two decades, the Sanitary Reform was not able to change the previous reality in terms of the inputs-supply and of the characteristic of the services' organization. As soon as the production of medicines, hospital equipment and other inputs are basically made by transnational enterprises, the government was unable to control neither the offer nor the prices of such products. As the hospital beds for the SUS are predominantly offered by the private contracted sector (77,1%), the distribution of hospital and human resources is highly concentrated in the richer urban regions of the country.

Moreover, the most crucial impediment to comply with the legal determination of assuring health care for all citizens was the brutal reduction of public health expenditures. While in 1989 the expenditure per capita was of US$81.43, in 1991 this amount felt down to US$54.33, and only overcame the health expenditure in the 80s after 1995, reaching US$ 100.5. It was due to the absence of a regular source to fund the health care system and the low priority given to the sector by the government.

As a consequence of the reduction of public expenditures with health, what could be observed was a process of self-exclusion of service producers and users who, being in advantageous conditions in the market, abandoned the public health system. After little longer period, what is observed is a perversion of the public system original proposal: being implemented in dreadful conditions of operation, it ended by keeping its attention turned towards the poorer portion of the population, which did not manage to have access to a private health insurance - either through the state, as employer, or through private employers.

Parallel to the initial degeneration of the public sector, there was a significant growth of private insurance and services, to where the demands of middle class users were canalized. The augmentation of private insurance participation in health care is, nonetheless, favored by public incentives (tax deduction), although not necessarily followed by public regulation.

Despite the intention to create a single universal public system, the actual configuration of the health care system is marked by the existence of a parallel system (see figure 3, in the next page). In one side one can find the unified health system (SUS) comprised of public providers that includes hospital and primary health centers that belong to the federal, state and local governments. It also includes private profit and nonprofit providers under contract to the public system. It's a peculiar mix composed of a unified public system and public contracting system with universal coverage, although actually covering around 70% of the population, due to difficulties in access, utilization or self-exclusion.

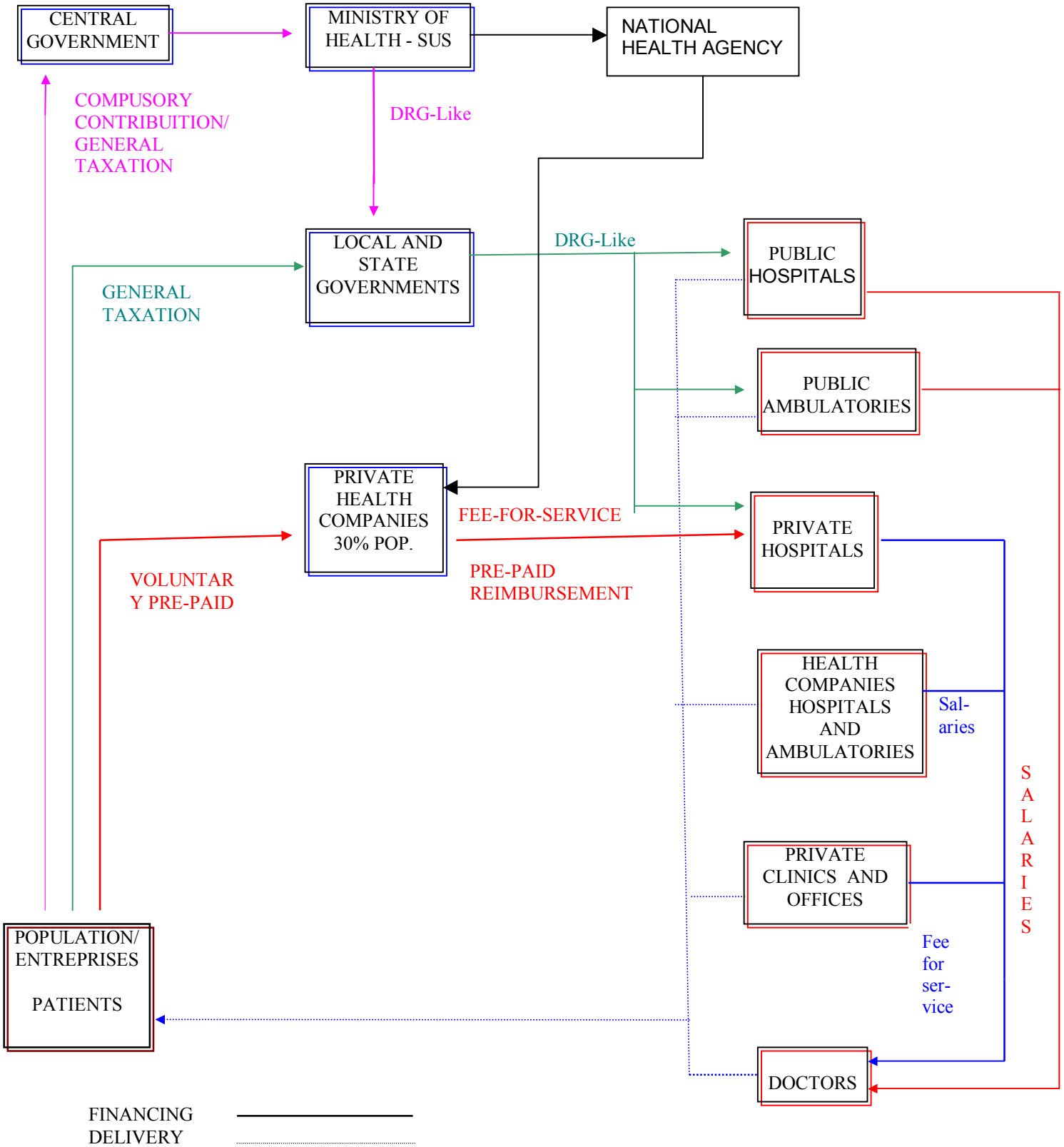
The other side is represented by the market of private plans with voluntary affiliation and of prepaid health plans and insurance companies. Since there is no opt out mechanism from the public system, those who manage to have a private insurance (around 25%) only utilize the public system as a last resource, as is the case of emergencies, sophisticated treatments, and diseases not covered by private plans. In this sense, the voluntary contracted subsystem is seen as supplemental to the public one.

In short, the Brazilian case has as main feature two concomitant, and in some way contradictory, processes living together in the health care sector: the universalization with decentralization of the public system and the boom of different modalities of private insurance. There has been an improvement in the access and utilization of free and/or public services although the quality and volume of health care is still restricted by the fragility of the financial support and poor management. Simultaneously, a stratification of the users according to their capacity to mobilize economic or political resources in order to affiliate to a private insurance is being developed.

.

Recently, some important measures were settled by the Health Ministry to overcome some of the main obstacles to the improvement of health care quality. With respect to the private voluntary market of health plans and insurance companies, the government created an agency to regulate and control them, assuring to consumers the right to a comprehensive coverage. There is also the intention to create legal conditions to charge private plans for the attention paid within SUS facilities to insured people, eliminating this kind of indirect subsidy.

Figure 3: *Brazilian National Health System - SUS*



Source: Adapted from Lobato (2000)
In: Fleury, S., Belmartino, S. & Barris, E. (eds). *Reshaping Health Care in Latin America. Canada*: IDRC, 2000.

Concerning the consumption of medicines, the production and dispensation of generic drugs in public facilities and private pharmacies has been introduced in order to control the prices of essential drugs.

In the unified public system (SUS), the Health Ministry launched two strategic programs of primary health care, aiming to increase coverage and improve efficiency by means of a shifting of the attention measures towards preventive health care. The federal fund transfers resources on a per capita basis to the municipalities in order to support the creation of family health teams and community health workers, propitiating a basic package of primary care. This measure introduces some tensions in the decentralization process since it represents the retaken of the decision power by the federal authority.

A law prescribing a minimal percent of the state and municipal budgets as well as a progression of the federal health budget linked to the performance of the GNP recently was sanctioned.

In spite of some managerial innovations developed to improve the coordination of the system – such as the municipal consortia, interstate clearinghouses for guaranteed referral to higher complexity services, and intensive measures to prevent fraud - there is still a bunch of problems concerning the poor management of public facilities. The results have greater effect on the access, but is also operative on the efficiency and the quality of the attention.

Improvements in financial and managerial features of the unified health system are expected for the next years, as well as the enhancement of the regulation upon the voluntary contracting subsystem. In this scenario, the parallelism of the two systems will end consolidated, as the consequence of the strengthening of the steering role of the Health Ministry and of the financial constraints to expand the voluntary contracting subsystem. In this case, the public authority will need to improve the quality of the attention in the public subsystem and will also have more power to regulate the voluntary contracting subsystem, although the irrationality of the multiple coverage will persist.

A scenario less probable to occur is the SUS deterioration and the creation of public mechanisms to assure private insurance for the poor due to SUS development and some unsuccessful regional intent in this direction.

V- THE COLOMBIAN PLURAL MODEL

The Colombian reform of the health care system started in the middle of the eighties with a series of laws and regulations as part of a broader process of state decentralization. In 1990, Law 10 provided a major incentive to decentralization by establishing the legal grounds for the municipalities to take charge of the first level of health care, and for the provincial government to take the responsibility for the secondary and tertiary levels of care. This law provided for a process of certification and granting authority over care to the department and municipalities, as long as they have fulfilled some basic requirements and qualified for autonomy.

Although the Constitution of 1991 further assigned broader power to territorial entities - province and municipality -, health care decentralization has been implemented quite slowly. In 1994, the government of Colombia embarked on an ambitious reform of the health sector in order to promote access to an efficient delivery and cost-effective health care for the entire population.

The reform main guidelines are:

- universal coverage – to guarantee basic health care coverage in a social insurance system for every Colombian in a progressive expansion of coverage;
- solidarity – to enable every person, regardless of financial means, to have access to basic health services for a fair contribution, implemented by means of the subside of the low-income and poor population by those of relatively higher income; and
- efficiency and quality – to improve health status by reallocating resources to primary health care and minimizing waste in the service provision.

The strategies to implement the reform were the following:

- separation of functions of modulation, financing, insurance and delivery, each to be performed by a specific organization. While modulation and financing are considered as public responsibility, articulation and provision are regarded as market functions. The Health Ministry is responsible for modulating the system (design and regulation); the expanded Social Security is responsible for funding; competitive insurance companies are responsible for enrolling and assuring access to a set of providers; delivery is implemented in a competitive basis by means of public or private institutions; and
- shifting from supply subsidy to demand subsidy. The flow of money would follow the consumer free choice for insurance and provision (in this case from a list selected by the insurance).

A new structure was designed to change from a national health system into a general social security system comprising a plural (public + private) health system. This transformation requires:

- the construction of a social insurance system, headed by the National Social Security Health Board (CNSSS), so that to provide a package of basic services by means of a health plan that covers the interventions considered by a cost-effectiveness analysis as the best investments in health. Membership in these plans will fall into one of two regimes depending on his/her the income level;

- the “Contributory Regime” - RC or contributing membership for those who can afford; formal sector workers (8% of the salary from the employee and 4% from the employer), and (12% from) wealthier self-employed workers. The affiliation of those workers in the informal market was also facilitated by the acceptance of the total household income. The health package is named POS;

- the “Subsidized Regime” - RS or subsidized membership, for the poor and low-income population. The expansion of coverage in this case is progressive (linked to the financial feasibility) and entitles the covered population to a basic package of interventions. This basic package is less comprehensive than that of the

Contributory Regime but is supposed to become identical in few years. A special health package for this regime is called POSs;

- The creation of the National Solidarity and Guaranty Fund (FOSyGA), which handles the finances of the health insurance by means of four major sub-accounts: internal compensation of the contributory system, subsidized health system fund, health promotion; and insurance against catastrophic risks and traffic accidents;

Concerning the RC, FOSyGA realizes an internal compensation among the contributions in order to assure a similar per capita (differentiated by risk) for every enrolled individual. There is a reinsurance plan for catastrophic risks.

Regarding the SR, FOSyGA promotes the solidarity by ensuring the poor. For this purpose it is funded by means of different sources: 1% of the contributions to the RC comes from those who earn above four minimum wages, and the same percentage (*paripassu*), from fiscal resources, specific taxes and others.[18]

The health promotion account is funded by fiscal resources and taxes, and the resources are directed to the local governments, responsible for public health measures.

- the break down of the health insurance monopoly by the ISS – the former public insurance institution - with the introduction of a competitive market of insurance companies, named Health Promoting Entities (EPS), for the contributory regime, as well as the creation of the Administrators of the Subsidized System (ARS) in the subsidized regime. In the first case - EPS - the traditional insurance institution (ISS) became one among other private EPS, although keeping the bulk or the enrollments. The subsidized regime, in its turn, comprises many different types of ARS, one of them being the ESS – Solidarity Health Enterprises -, community enterprises organized after the reform;

All these insurance companies are responsible for enrolling and collecting contributions from those who have opt for this service, and for notifying the FOSyGA in order to proceed the compensation (RC) or the subsidy (RS). The insurance companies play the function of articulation, responding for the organization and management of care consumption, and linking individuals to the financier and to providers. Their essential function is the risk management, guaranteeing the health package to their beneficiaries by means of a variety of services, either from their own property or from other providers. They also offer supplemental plans for those who can afford.

[18] The sources of financing for the subsidized system are: I) 15% of the share of the municipalities in the nation's current income; ii) the health and education transfer payments to the Departments; iii) the income transfered by the National Government to the Departments; iv) resources from ECOSALLUD (gambling taxes, lotteries etc.); v) the voluntary contributions from municipalities and Departments; vi) a share of the royalties from new oil wells; vii) Family Compensation Fund (CCF) contributions: viii) the social VAT; ix) the tax on fire arms and munitions; x) the co-payments and deductibles of subscribers and dependents.

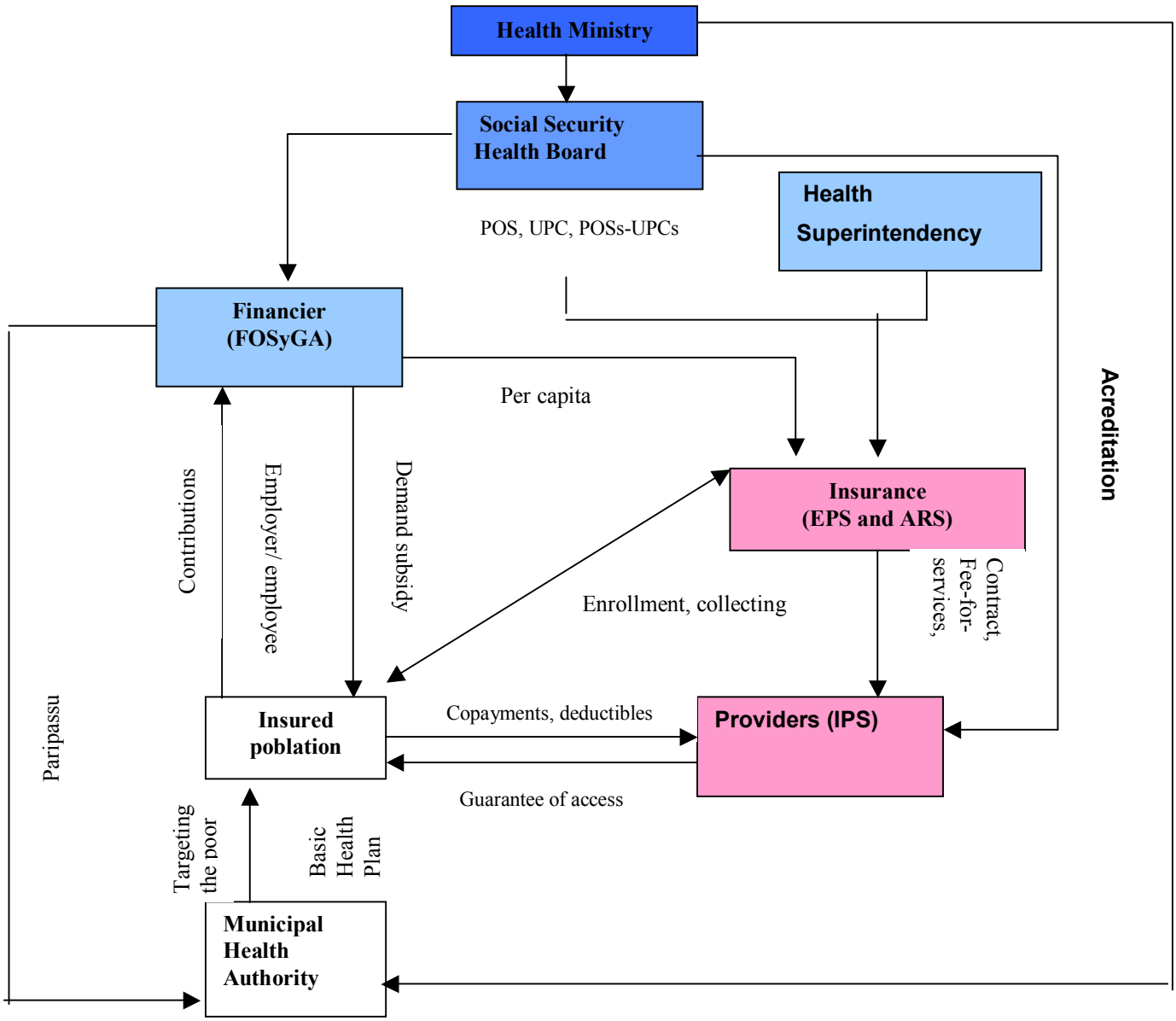
- the transformation of public hospitals in a special category of decentralized public entity, in order to compete in the delivery market. This represents the shift from a historical budget to a demand reimbursement, even though public hospitals have continued to assist the uncovered population based on a supply subsidy;

- the assignment to the municipal health authority of the function of enrolling the poor in the Subsidized Regime and of the responsibility for health promotion activities framed within a basic health plan; and

- The creation of an agency Supersalud to act as the surveillance and control entity.

The new design of the health system is presented in figure 4.

Figure 4: ***Colombian General Social Security System - SGSSS***



Social participation in the system is expected by means of the creation of health committees, the introduction of the ombudsman, and the community participation in the social enterprises. The Compulsory Health Plan has a List of Essential Drugs that accounts for more than 70% of the drugs prescribed in public hospitals. All activities linked with health promotion and disease prevention are patterned in a Basic Health Plan, under the responsibility of the State, and carried out by the municipality.

The most important achievement of the Colombian reform was the insured population coverage expansion. While the former Social Security, in 1990, just covered 20.6% of the population, after the reform, in 1997, the system had affiliated 52.8% of the population (35.6% by means of the contributory system and 17.2% through the subsidized system).[19] Besides, the major increment was in the coverage of the poor in rural areas.

Other important accomplishment of the reform was the increase in the total health expenditure as a percentage of the GDP: the financial resources allocated to the health sector rose from 2.57 in 1993 to 4.76 in 1996.

Nevertheless, the pace of both movements is decreasing in recent years, as a consequence of the economic crisis and as the result of the design and the implementation of the reform in health system. Consequently, the goals of unifying the basic packages of the two regimes and to universalize the insurance coverage in few years are to be postponed.

Regarding the financial problem, some reasons appear to explain the present situation. One of them concerns the reduction of the fiscal resources allocated to the health system, as a consequence of the economic adjustment to the crisis. The established mechanism of "*paripassu*" succumbed to new legal measures.

The other is due to previous overestimation of the affiliation from those in the informal market. In spite of the more attractive conditions, many people did not appear to have interest in the affiliation since they must contribute with 12% of their income. Besides, the EPS has no incentive for their enrollment due to the high the cost of managing the coverage for independents.

Other reasons are the evasion of contributions or underreport of income. The mechanism of collecting contributions through the EPS has no incentive to correctly assess the income of the enrollee, and, besides, their salespeople have more incentive to sell supplemental plans.

Concerning the covered people some problems appeared, such as the number of poor people in the Contributory Regime and the number of no poor people covered by the Subsidiary Regime.[20] This indicates the political use of the subsidiary regime resources in the target process, the absence of conscience of rights by the beneficiaries, and the no existence of effective mechanism of social control as well.

In the Colombian experience, many unsolved questions emerged in consequence of the difficult adaptation of public hospitals to the challenge of a double budgeting

[19]See: www. americas.health-sector Pan American Health Organization, 1999
[20] Encuesta Nacional de Calidad de Vida, 1977, National Department of Statistics - DANE

orientation: both demand and supply subsidy at the same time. Public and private hospitals are also suffering from the insurance delay in transferring the resources to reimburse attention to their beneficiaries, in both regimes.

Even though many of these problems are caused by the way the reform was implemented, there are some basic faults in the design of the model. The first is the constraints imposed by the health system financial basis, which, in turn, refrain the coverage expansion due to the narrow limit of the formal labor market. Secondly, there is the assumption that the health system should be better managed as an insurance mechanism.

The advantage of the insurance is the existence of a clear defined benefit, legally guaranteed. But the logic that organizes an insurance system is a financial one, and, in many ways, confronts the rationality of the health system.

Problems of overlapping concerning the steering role of the system are common when a health authority and an insurance authority act simultaneously. Besides, the logic of the insurance is centralized in the decision-making level and fragmented in the delivery, in contradiction to the presumed articulation of a decentralized and participatory health care system. As a consequence, it is expected to disarrange the public and collective health measures and to privilege the curative health care.[21]

Finally, the population split into segments of purchase power is inherent to the insurance model and leads to the fragmentation of the institutions in different plans and packages. It is possible to add to the former characteristics the absence of interest on profit in order to de-concentrate the institutional offer alongside the territory. Due to these features, the proposed model of structured pluralism[22] has been facing paramount difficulties to achieve the dual proposal of integrating population in a comprehensive coverage while articulating several and plural institutions – public and private ones - to perform different functions.

The expected scenario of a universal health insurance comprising the same rights and benefits, regardless the previous contribution, is been replaced by a less optimistic scenario where the differentiation of the health plans is likely to be kept.

VI- CONCLUSION

Since the seventies, Latin America has experienced many projects of social reform, especially those concerning health care system and social security protection. These intents of reform were part of the changing context of the political system democratization, and, at the same time, of the economical productive model updating. There was also a redesign of the state role as a way to face the fiscal crisis and to create the necessary conditions to reinsert the regional economies in a more integrated and competitive global productive process.

[21] As an example, in Colombia the coverage in all kind of inmunizations felt, comparing the data from 1994 and 1999, according the Health Ministry. Even considering the existence of other factors as the presence or armed groups, the situation is seen as a consequence of the fragmentation of the delivery network.

[22] J.L Londono and J. Frenk – Structured Pluralism: Towards a New Model for Health System Reform in Latin America, IADB, Washington, 1995.

The reforms of Health Care and Social Security systems are, therefore, important aspects of the comprehensive state reform that has been carried out in the region, changing the previous relationships between the government and the social and economical agents.

The present reforms have to face the main problems of low coverage, exclusion of the poorest, increasing prices, inefficient management, institutional fragmentation, and poor quality of health services.

The outcomes of the reform process depend on a set of variables that are different in each country. They are: the values to orient the reform policy, the existent institutional structure of health care services, the stakeholders in the health sector and their strategies to support or to oppose to the reform measures, the governmental capacity to implement actions, etc.

Moreover, the timing of the health reform with respect to two main macro processes – the economic crisis with the structural adjustment policies, and the transition to more democratic regimes – seems to be a crucial variable to explain the differences among proposals, contents, instruments and supportive coalition. [23]

Nonetheless, some general trends can be pointed out in those processes, such as the decentralization of health care management; the build up of a pluralistic network of providers, public or private ones; and the complex web of relationships involving financiers and providers.

Furthermore, in most countries of the region, trade unions are losing their previous control over the Social Security system since the governments have introduced market mechanism in order to increase the competition among the providers. As a consequence, the traditional division between the Health Ministry system and the health system of the Social Security is experiencing huge transformations. One possible outcome is the integration of both systems, generating a national health system. Another possibility is the creation of a private insurance system to replace the traditional social insurance. A third one could be the expansion of the social health insurance by means of a public insurance for the poor.

The increasing importance of the role of private providers and insurance companies is changing the sector power structure in the region. As it has been occurring simultaneously with the weakening of the state bureaucracy, a lack of experience and capacity to regulate the new health market can be observed.

Another important feature observed is the difficult to have any stable public additional financial source to implement the coverage expansion. As a consequence, the health care systems are still heavily dependent of insured workers' contributions, either the compulsory or the voluntary ones.

The trend toward decentralization is common to all the countries in the region, although this process varies greatly among the countries. The prevalence of an insurance logic in the organization of health care system, in many ways, contradicts

[23] For more details see: Fleury, Sonia, Belmartino, Susana and Baris, Enis – Reshaping Health Care Systems in Latin America, IDRC, Ottawa, 2000

the dynamic of territorial and articulated organization. Besides, there is a permanent tension between preventive and curative approaches to health care attention, stressed by the conflict between insurance and territorial organization.

The health care reform could be an essential mechanism to consolidate democracy in the region because the health sector could be an important medium in the inclusion of the poor as beneficiaries of public policies. It is due to its capacity to empower the citizenship through a decentralized participatory decision-making process, creating the condition to increase the quality and efficiency of public services, with a new format of public management.

The three examples of reform analyzed in this paper are trying to resolve the same problems to increase efficiency guaranteeing universal access to health care services with different institutional arrangements: dual, universal or plural systems. It cannot be denied that health care systems are undergoing major changes with regard to their political constituency as well as organizational and financial modalities, and are being addressed toward a more pluralistic and competitive configuration. First and foremost, the reforms are expending the coverage to the poor and, therefore, reducing the exclusion. Nonetheless, the stratification of users and benefits still persists within all of them, and is even stressed in some new models.

So far, the final result seems to be a poor public health sector charged with the poor population coverage, and a private insurance market covering less than 30% of the population. This market lacks from public regulation although relying upon public funds and/or compulsory contributions to Social Security system. Other possibility is the expansion of the insurance market, beyond the purchase power of the population, with the transformation of the public assistance into a public insurance for the poor.

The new design of the health care system is part of a process by which Latin American societies are assuming a new profile**,** with a more pluralistic and comprehensive system of social protection.

Instead of denying membership to some groups, there is a movement for stratifying the population in accordance with the purchase power of each group. The possible outcome is the entitlement of each individual to rights and services, to a greater or lesser degree, according to the population group to which that individual belongs. While citizenship is based on an egalitarian notion of rights, the social protection in the region is still based on social and institutional mechanisms of discrimination.

While the former stratification was grounded in the collective action of the group, the new stratification is going to be determined by the individual's capacity to contribute - directly or by means of public subsides - to his/her own benefit plan. If this situation continues, the reforms will succeed in modernizing the sector at the cost of moving the region even further away from the ideal of fairness.

REFERENCES

ALTIMIR, Oscar. 1993. Income Distribution and Poverty Trough the Crisis and Adjustment - paper presented in the Seminar "Reformas de las Políticas Públicas y Gasto Social" .CEPAL, Santiago.

BAEZA, Cristian – "Taking Stocks of Health Sector Reform in Latin America", World Bank, Washington, 1988

CEPAL . 1994. Salud, Equidad y Transformacion Productiva en America Latina y el Caribe, Santiago, Julio.

CEPAL . 1996. Panorama Social de America Latina. Santiago, Chile.

DOS SANTOS, W.G. 1979. Cidadania e Justiça, Campus.

ENTHOVEN, A. 1988. Theory and Practice of Managed Competition in Health Care Finance, Elsevier Science Publishing Co., INC.

ENTHOVEN, A. – " Managed Competition; An Agenda for Action", Health Affairs, 15(1):39-57, 1993

FIELDER, J. 1996. "The Privatization of Health Care in Three Latin American Social Security System" in Health Policy and Planning, Oxford University Press.

FILGUEIRA, Fernando – Tipos de Welfare y Reformas Sociales en America Latina: Eficiencia, Residualismo y Ciudadania Estratificada, in Melo, Marcus A. (ed) – Reforma do Estado e Mudanca Institucional no Brasil, Fundacao Joaquim Nabuco, Recife, 1999

FLEURY, Sonia, Belmartino, Susana, and Baris, Enis. 2000. Reshaping Health Care in Latin America – A Comparative Analysis of Health Care Reform in Argentina, Brazil, and Mexico. IDRC. Otawa

FLEURY, Sonia. 1991. "Health Policies in the Conservative Transition to Democracy in Brazil", in Altenstetter, Christa and Haywood, Stuart – Comparative Health Policy and the New Right – From Rhetoric to Reality. Macmillan, London

FLEURY, Sonia. 1997. Estado sin Ciudadanos, Lugar Editorial, Buenos Aires.

GUTIERREZ, Jose Ancizar – "La Reforma de Salud en Colombia- Transicion y Ajuste", INDES/BID, Washington, 20000

http://www.americas.health-sector-reform.org

IADB – Facing up to inequality in Latin America – Economic and Social Progress in Latin America- 1998-1999 Report, Washington, DC, 1999

IMF, WB, IADB, EBRD, ADB, ADB, 2000 – Global Poverty Report, Okinawa Summit.

INTER. - American Development Bank. 1997. Report: Economic and Social Progress in Latin America.

LOBATO, Lenaura , 2000 – " Reorganizing the Health Care System in Brazil" In FLEURY, BELMARTINO and BARIS, 2000, op. Cit.

LONDOÑO, J. L. and Frenk, J. 1995. "Structured Pluralism: Towards a New Model for Health System Reform in Latin America", World Bank.

MEDICI, A. 1996. "Managed Care and Managed Competition in Latin America and the Caribbean" in *Inovations in Health Care Financing*, World Bank.

MESA-LAGO, C. 1978. Social Security in Latin America - Pressure Groups, Stratification and Inequality, University of Pittsburgh.

NAADIIR/AL,2000 – Database, http://www.insp.mx/ichsri

PAHO/WHO. 1995. "Equitable Access to Basic Health Services: Toward a Regional Agenda for Health Sector Reform", September.

THORP, Rosemary, 1999 – Progreso, Pobreza y Exclusión – Una Historia Economica de América Latina en el Siglo XX, IADB, Washington.

UNDP. 1995. Human Development Report, Oxford University Press, New York.

UNDP 1998. Human Development Report, Oxford University Press, New York.
WORLD BANK. 1993. World Development Report, Washington.
WORLD BANK, 2000/2001 World Development Report, Attacking Poverty, Washington
ZULETA, Gustavo – " Chile: Antecedentes sobre la Reforma del Sector Salud y Escenarios Posibles a Futuro", BID, Washington, 1999.