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TAKING STOCK OF HEALTH SECTOR REFORM IN LATIN AMERICA[1]
Trends and Challenges for Health Reform

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"...The perfection of the means and the confusion of the goals seem to be the characteristic of our century...".

Albert Einstein

1. INTRODUCTION

Most countries in LAC (as in OECD countries) are designing and/or implementing important reforms of their health care systems. What are the objectives of the reforms, and why are they necessary? Where do these reforms leave the health care system in LAC? Is there a trend and/or pattern of specific reforms across countries in the region? How are equity, efficiency and population satisfaction being served by reform processes?

In a preliminary effort to answer these questions, this paper briefly examines some of the characteristics of the reform process in Latin America in an attempt to distinguish trends and to draw from the experience of the region. The paper aims to be a motivation document for a training module being proposed for HD Week 1998. It is the result of brainstorming sessions of the author with several Task Managers in the LAC region with experience in health sector reform, the LAC HNP Lead Specialist, the HDD Network Manager, Country Sector Leaders in LAC, as well as the author's own experience.

Due to time and financing availability, the paper is more an educated essay on health sector reform in LAC than a technical research paper. Being a motivational essay, the

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paper does not intend to prove each of the suggestions and comments, and hard statistical data to support statements made here is lacking. Instead, the paper aims to stimulate discussion among experts by simply presenting proposed conclusions and recommendations, some of which are controversial and subject to debate. The author believes, however, that further research of existing statistical evidence and additional in-depth analyses would significantly support some of the paper's conclusions while challenging others. Given the magnitude and importance of the issues at stake, this is certainly a priority for policy and operational research.

The paper will focus only on the so-called "last wave" of reforms (from the mid' 80s to the present). It does not intend to ignore, though, the importance of earlier stages of reforms in the region (such as the "Integration" and "Decentralization" reforms within the public health sector).

2. WHY HEALTH SECTOR REFORMS IN LAC?

Examining some of the reform processes in LAC, the most frequent explicit reasons for health sector reform are efficiency and equity. There are, however, implicit reasons that, although not openly discussed, in many cases are the real impetus for the reform process. Among them: the country macroeconomic situation and its associated requirements; politics and ideology; corporate and union interests; and donors' agendas. Possibly also of special importance in LAC, citizen pressure in general may be playing a significant role due to a slow but profound change in the relationship between the State and the Citizen occurring in the Region.

Most reforms respond to a combination of these implicit and explicit reasons in their initial conceptualization and implementation. Health sector reform, as a result, is not a pure Ministry of Health (MoH) plan or objective but usually conceived beyond the MoH, strongly counting on influence from the Ministries of Finance (MoF), the Presidency, and some key political actors for success.

Although equity is always mentioned as an explicit reasons for reform, in practice, as the paper will show later, the reforms have been concentrated mostly in improving efficiency within the health sector, and within that objective, the reforms have focused mainly on attempting to improve technical efficiency. To do so, the reforms have introduced a combination of changes at the microfinancing level and the Finance Management Institutional Organization within the sector (i.e., changes in reimbursement mechanisms and the introduction of private compulsory health insurance competition).

Among all reasons, efficiency, macroeconomic requirements and societal pressures seem to be the most common and significant catalysts for triggering health sector reform in the region. Following is a brief examination of these factors.

a. The fiscal issue and the perception of Ministries of Finance.

Macroeconomic requirements and the perception of the Ministries of Finance (MoF) seem to play a very important role in stimulating governments to intervene and "improve things" in the social sector in general and in the health sector in particular.

Health Sector financing is an important fiscal issue due to the relevance the public health sector has reached within governments budgets following the privatization and state size reduction efforts of the last two decades. It is also an important economic issue in some LAC countries due to the increasing burden health service financing is imposing on labor costs, potentially threatening countries' export competitiveness.

In the'80s, LAC economies experienced significant macroeconomic instability, triggering urgent need for reducing fiscal deficits and/or lowering costs for private business in order to boost the economy and ensure its international competitiveness. As part of the first wave of fiscal adjustment, privatization of public enterprises and reduction of the size of the state in all areas were implemented all over the region, helping to reduce the deficit via reduction of expenditures. However, social sectors remained a significant part of governments' budget and to further reduce the size/expenditures of the public sector and/or labor cost for the private sector, the social sectors have been increasingly under scrutiny searching for ways to improve efficiency and cost control. The question seems to have been how to contain costs (in some cases how to reduce public expenditures) while maintaining as many services as possible and without upsetting politically relevant segments of the population.

Adding to the objective need of reducing fiscal expenditures, there seem to be a generalized and ill-defined impression among Ministries of Finance that the public health sector is highly inefficient and that aggressive introduction of privatization would result in improved efficiency all across the sector. Usually, the criticism about efficiency is centered on technical efficiency with little consideration to allocative efficiency and cost control. Under such a paradigm, the introduction of the private sector (for health service and health insurance provision), and the introduction of competition into the health insurance market would improve efficiency. It is not yet clear, as this paper discusses extensively, that such an assumption has proved to be right in LAC. In contrast, there is evidence that equity may have suffered in the process.

Since the' 80s and 90s (and most probably always), Health Sector Reform seems to have been approached with lack of experience and consideration of international experiences and may be with excess of ideology. After the wave of public enterprise privatization and before evidence of the risks of privatization in the absence of effective regulatory capacity by the state was available, there was a strong push for expanding the privatization process for health service delivery and health insurance, without the same effort in strengthening state health sector regulatory capacity.

A curious phenomenon, however, is beginning to emerge after the last ten years of reform. After initially championing reform efforts to "modernize" the health sector, Ministries of Finance often become one of the major obstacles for reform implementation. This is the result of MoF's frequent double mission of maintaining fiscal discipline and, simultaneously, providing incentives to efficiency within the public sector. Often in LAC, after realizing the potential consequences of the health sector reform process, MoFs prioritize fiscal issues over efficiency issues, realizing that modernization of health sector could necessarily mean loosing fiscal control of the sector. Often, MoFs have some form of control of social security revenues in the non-reformed situation, which most probably they would loose in the event of the reform. All this set the stages for not supporting the reform due to contradicting fiscal objectives. Two good examples of this are Argentina and Chile were social security revenues are somehow included in the fiscal budget (*Obras* contributions and *Solidarity Fund* in Argentina and all contributions to the Public Social Insurance—*FONASA*-- in Chile).

b. Societal pressures for a new Citizen-State relationship in the Region?

Less evident than the fiscal issue but probably equally important in middle income countries in the region, is a new "Citizen-State" relationship emerging from the consolidation of democracy in the continent and the introduction of significant market oriented reforms. Political and economic reforms reduced the role of the state and are increasingly making citizens participate in the economy, more through their role as consumers than in a traditional political role.

The introduction of market oriented reforms and the resulting growth and consolidation of the private sector as the main pillar for economic development in LAC, left state bureaucracies (many times unwillingly) focused on regulation and financing abandoning most production and service delivery functions, except in the social sectors. The same reforms and private sector consolidation has significantly increased service provider orientation toward customer satisfaction in most areas of LAC economies. Public expectations of what service quality should be might have risen significantly as a result, especially among the middle class, which in many LAC countries is politically decisive. The increasing contrast between state service delivery and private sector service delivery and customer orientation appears to be producing significant tensions in the public health sector. Consumer dissatisfaction with public provision of services is a common issue in LAC. It is so probably not only as a result of a possible objective deterioration of the quality service delivery by public health service providers but most importantly as the result of "customers" having the possibility of a daily comparison of such quality with private sector service delivery.

Consolidation of democracy might also be playing a role. What formerly were paternalistic, and often "police", relationships between the beneficiary and the State in the social sectors, are becoming more and more a relationship between citizens/customers with rights and quality demands and a service-State with obligations towards them. This new relationship is significantly increasing tensions in the culture of state owned health service providers and it is, and it will be even more in the future, an important thrust of the reform process in LAC.

3. GENERAL TRENDS IN HEALTH SECTOR REFORM IN LAC

There are three important trends related or resulting from health sector reform in the region:

(a) The formal and informal emergence and rapid growth of "for-profit" private health services and health insurance providers and the introduction of private health insurance institutions competition;
(b) The effort to shift from a "command and control" to a "market" logic within the public sector and a "painful" transition from a supply side to a demand side type of health service provider financing mechanisms; and
(c) The change from a traditionally professional "self-regulated" to a "management driven and customer oriented" culture of the organization within health service providers.

These are general trends in all sectors of the economy in the region but the introduction of reforms following these trends in the health sector have been specially difficult technically and politically in the region.

a. The formal and informal emergence and rapid growth of "for profit" private health services and private insurance providers and the introduction of health insurance institutions competition.

As described earlier, the reforms of the mid' 80s and the 90s directly or indirectly allowed for the introduction and/or significant growth, of the private sector in both, the provision of health insurance and the provision of health services.

Such is the case of the Chilean reforms of the early' 80s, where a National Health Service was replaced by the combination of a Public National Health Fund (FONASA) and private insurance companies (ISAPREs) competing among each other. As a result, very significant growth of the private provision of services has occurred.

A similar, although improved model, was introduced in Colombia through Law 100 in the early' 90s. The Colombian Social Security Fund (ICSS) and the MoH roles in managing financing were replaced by multiple private insurance companies (EPS). Private provision is also beginning to grow significantly.

The reform of payment mechanisms and the incentive for private provision of health services during the' 80s, explain the importance of the private sector in Brazil where the private sector is providing today more than 50% of all health services.

Similar phenomena are beginning to occur in Peru and Mexico. In Peru recently enacted legislation allows for a partial "opt-out" of the National Social Security Institute (IPSS) to seek coverage only for "primary basic care" in private health insurance institutions. In Mexico, "opt-out" ("R*eversion de Cuotas"*) will also allow members of the Mexican Social Security Institute (IMSS) to stop contributing and abandon it and seek coverage in a private insurance institution of their choice.

Although the Argentina "Biskmarian" health sector organization tradition, in contrast with the NHS-Social Security model of other LAC countries, includes multi insurance/multi provider markets for decades, recent reforms also call for introducing competition among quasi-public sickness funds (*Obras Sociales Nacionales--OSN*) and with Private Health Insurance (*Pre-Pagas*) in the near future.

Costa Rica and Venezuela are currently debating the possibility of introducing "opt-out" from their social insurance systems to get coverage from private competing health insurance.

As it will be discussed later, evidence is emerging about the equity, efficiency and cost control problems of insurance privatization and competition. Evidence also is emerging on the possitive impact of such a process for customer satisfaction among middle and high income populations.

b. The effort to shift from "command and control" to "market" logic for resource allocation within the public sector and the "painful" transition from supply side to demand side type of health service provider financing mechanisms.

As is happening in the rest of the sectors of the economy in the region, the health sector reforms in LAC are oriented to introduce changes to set up a transition from a "Command and Control" to a more "Market" oriented logic for resource allocation within the public health sector.

As examples of the trend, the Chilean and Costa Rican reforms (at FONASA and the Costa Rica Social Security Fund, respectively), have been struggling to introduce provider payment through the so-called "Purchasing Model" (*Modelo de Compra*) during the last seven years. This model introduces a departure from traditional line-item budgets to a combination of case related and other reimbursement mechanisms. Similar efforts are beginning to take off within the public sector in Argentina, Ecuador, Uruguay, Nicaragua, Peru and, probably, Colombia if public provider's re-conversion is deemed to be successful.

In practice, all these reform efforts are attempting to depart from a traditional supply side to a demand-side subsidy for health services within the public sector. As will be discussed later in this paper, the difficulties in re-converting public providers into this logic are almost stalling the reform process all over the region.

c. The change from a traditional professional "self-regulated" to a more "management driven and customer oriented" culture of the organization within health service providers.

Pubic health sector organizational culture is traditionally characterized as a Professional self-regulated environment. Efforts to introduce a "market" logic in the sector and tensions emerging from a new citizen/customer-provider relation all over the economy, are somehow forcing a change in the culture of public sector health service provider organizations. Most remaining public service providers are moving towards a more customer oriented and management driven institutions. Unfortunately, public health service providers lag far behind other sectors.

The implementation of provider payment reforms and the resulting new reimbursing mechanisms and competition among public providers, and even more between public and private providers, requires a tremendous effort from providers to increase customer satisfaction and respond efficiently to always evolving price signals. It is evident that labor regulation flexibility and its resulting potential reduction of employment stability, are at the basis of public provider capacity for responding effectively to the new challenges. As a result, a variable restriction of professional autonomy and a shift of power from health professionals to customers and managers are evident when implementing such financial reforms. These are probably the most powerful reasons explaining the strong opposition health sector reform has encountered among professional associations and unions in LAC.

3. CHARACTERISTICS OF HEALTH SECTOR REFORM PROCESSES IN LAC.

The next sections of the paper discuss health sector reform in the region through analysis of the characteristics regarding two central axes, graphically presented in Figure 1. These are:

(a) The Financial axis, with Sector Financing (Macro level) and provider payment (Micro level); and
(b) The Organizational axis which considers Finance Management Institutional Organizations (including Insurance), and Health Service Provider Organization.

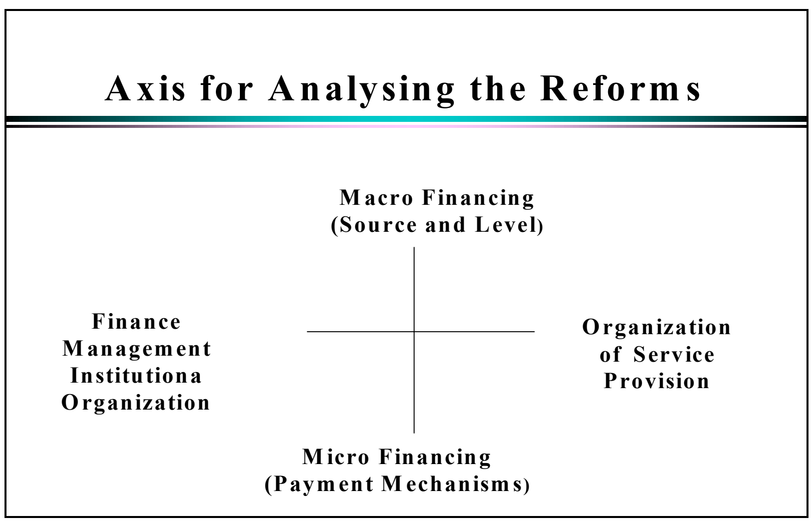

Figure 1

5. SECTOR FINANCING REFORMS.

a. <u>What do country cases show about the trends in the Region?</u>

Since the early' 80s, important Sector Financing reforms have occurred in the Region. Although not evident in all countries, either a reduction in contributions from general taxation and/or a reduction in employer contributions have occurred or are being implemented. As discussed before, reactivation of economic growth and economic competitiveness via reducing fiscal deficit and/or reducing labor costs, seem to be at the core of the arguments supporting such changes.

The reforms of the 1980s in Chile and in Colombia during the 90's are examples of sector financing reforms. Also recent efforts in Mexico, Perú and possibly Venezuela and Costa Rica show a similar trend. Decreasing health public expenditure trends during the' 80s and 90s in Ecuador are also an example of the tension imposed in the health sector by macroeconomic adjustment. Also, some of the recent reforms introduced to the Argentine Social Insurance system may be responding to the same needs.

In the case of Chile, the early 80s found the country in a very difficult macroeconomic situation with an urgent need for reducing fiscal deficit through lowering fiscal expenditures and increasing internal savings to increase the long-term rate of investments. In that context, broad and significant reforms in social security (pensions) and in the financial and banking system were introduced in the early 80's, which also included the health sector. Together with the introduction of "opt-out" from public sector and the creation of private health insurance (both to be discussed later in this paper), there was a significant reduction of public health sector revenues.

The Mexican case may initially appear different. Recent reforms introduced simultaneously with Pension Reforms, reduced employer contributions for health care and will also allow for the implementation of "opt-out" from the Mexican Social Security Institute (*IMSS*), allowing for the formal existence of private health insurance institutions for that purpose. The law also calls for fiscal contributions to IMSS (from general taxation) to replace lost revenues for the system. Such contributions will have to be negotiated annually between MoF and IMSS.

b. Are equity and/or efficiency being improved after Sector Financing reforms?

It could be argued that equity is not relevant as a sector discussion but more a supra-sector State level issue. Therefore, equity should not be an issue to specifically be addressed through health sector reform but instead through State fiscal and tax reform. This is the "old" discussion if income redistribution is a sector objective or if it is a supra sectoral one. Under that argument, if equity is a state policy objective, it should not be served through cross subsidies from each worker contribution for social insurance but through direct subsidies from general taxation. An other possible argument is that equity is not important at all in health. As we tend to accept it for housing that some will live in a 200 square meter house and others will live in a 40 square meter house, we should accept that people will have access to very different quality of health services. Fortunately for this paper, most health sector reforms include equity as a specific objective of health reform, so it is important to analyze whether this objective is being achieved.

Two main trends emerge from case analysis above: a) macroeconomic adjustment and the reduction of fiscal/employer contributions for health; and b) allowing for opting-out of national social insurance.

Apparently, the reduction of fiscal contributions from general taxation and/or employer contributions and the "opt out" trend are separate issues. It may well be that the simultaneity of both reforms was only a coincidence resulting from the state-of-the-art health sector financing knowledge at the time. However, if the question for "reformers" was how to reduce fiscal/employer contributions while making it palatable for politically influential segments of the society, there was a need to reduce the impact of adjustment on that population segment. In that case, both reforms may be complementary.

The impact on middle and high income populations of reducing fiscal/employer contributions could have been mitigated if "compulsory" cross subsidies to the poor from such populations' increased pay-roll tax would have been eliminated. Shifting from single social insurance to individual risk-based private health insurance, in which contributions match the benefits, might have done exactly that. This still would be consistent with the view that equity is important, and most sector financing reforms state it explicitly, but it should be a national macro objective and not a sector objective. To check if policy statements in this regard actually showed up in practice, it is important to examine if actual increases on percapita fiscal expenditures for the poor and the higher risk populations occurred to compensate for the elimination of intrasector cross-subsidies.

Unfortunately/fortunately, "opt-out" from social security is too recent in most LAC countries to have multi-country evidence on equity of such reform. Mexico and Peru reforms are too recent. Venezuela and Costa Rica are just beginning to discuss it. This paper will at least review the Chilean case, where data for evaluation is available after 18 years of experience. Colombian reform should also be discussed despite being recent, because it attempts to deal with some of the issues resulting from the Chilean experience, although it is not yet clear whether it will be able to do so.

The Chilean case. After "opt-out" was enacted in 1981, as insurance theory would predict, the highest income population left the national social insurance (FONASA) and joined individual risk based private insurance institutions (ISAPREs). After 18 years, two different systems are in place, basically differentied by income, besides their individual v/s population approach differences. Figure 2 shows income distribution among private insurance companies (ISAPREs) and Social Insurance (FONASA). Thus, a significant reduction of cross subsidies from the rich to the poor at the sector level was achived.

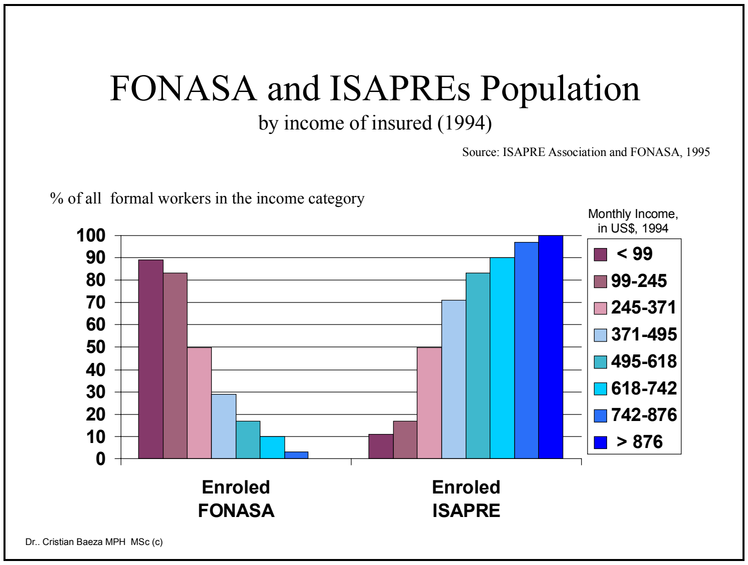

Figure 2

But what about the second part of the deal, if equity is indeed relevant? Did fiscal contributions from general taxation increase to compensate for revenue reduction (at least up to certain level), making in practice equity a State issue instead of a sector issue? Ten years after the reform, fiscal per-capita health expenditures in real terms had diminished significantly. In 1990, per-capita expenditures in the public sector were about US$65 (58% of which were pay-roll tax revenues), while average per-capita expenditures for the ISAPRE sector was about US$250 (90% of which were pay-role tax revenue and 10% state subsidies). There was a significant shift in the financing of public sector from general taxation being more than 80% of total revenues in 1976, to being less than 40% in 1990. This shift is explained by a simultaneous increase of the mandatory pay-role tax (from 1% in 1974 to 7% in 1986), and a significant reduction of fiscal contribution (in real terms) to FONASA. Considering risk selection and the increasing role of FONASA as insurance of last resource, per-capita figures are even more shocking. Fiscal contribution reduction did not respond to a technical decision to reduce contribution to the level of a basic package level, as someone could have argued that the FONASA population was overconsuming luxury health services. Despite having had been explicitly a reform objective, it is not clear that equity was a main concern in the 1980s sector financing reforms in Chile.

Mexico is planning to compensate the revenue reduction for IMSS resulting from "opt-out" and employer contribution reduction, through additional fiscal contribution. Fiscal contribution will be negotiated annually between IMSS and MoF. It is too soon to say but it seems that, in practice, the objective of reducing labor costs is on its way. It remains to be seen whether fiscal revenues will actually compensate for revenue reduction for IMSS during IMSS-MoF negotiation. Under new conditions, there is a potential for reducing fiscal contribution through the negotiation process and through fiscal budget discussions given that IMSS will now be included in it. In addition, from now on existing competition for fiscal funds between the Secretary of Health (*Secretaria de Salud*), which takes care of the poor and informal workers, and IMSS may lead to important additional equity implications depending on both institutions' bargaining capacity.

Why all the effort of Sector Financing reforms to increase fiscal control and reduce welfare cost? Wouldn't that have been achieved much more efficiently through single social insurance under fiscal control with expenditure caps? It is clear, though, that this option would not have been able to address the satisfaction issue with middle and high-income politically relevant segments of the population. **However, making sector financing reforms more acceptable for the middle and high-income segments, despite making them politically feasible, has shown to conflict with the equity improvement objective claimed by most reform processes.**

5. FINANCE MANAGEMENT INSTITUTIONAL ORGANIZATION: HOW TO ORGANIZE THE PURCHASING/FINANCING FUNCTION?

The paper uses the term "Finance Management Institutional Organization" to refer to the different organizational arrangement health systems may use to manage financial resources within the system which may include, inter alia, Social Health Insurance, private multiple insurances, national health services, and/or Ministries of Health. Depending on the epidemiological profile of the country, the degree of formality of its economy, the level of per-capita expenditures, and its history and tradition, one or a combination of these arrangements may be the model they have chosen and/or the most suitable for their requirements.

Until the early' 80s, most countries in Latin America, except the few with a "Biskmarian" tradition of multi-insurance organizations (Argentina, Uruguay), had a single institution (or one very predominant among others) managing financial resources for the sector. They usually managed together financial resources and health service provision within the health sector, and frequently the pension systems. Private health insurance was almost non-existent during that time in the region.

The most common arrangement for finance management is usually a Social Security Institution, as is "IMSS" in Mexico, "CCSS" in Costa Rica, "IESS" in Ecuador, "ICSS" in Colombia or "IPSS" in Peru. The existence of a National Health System with a small social security institution coexisting with it is also a typical arrangement (Chile until 1981, Ecuador, Peru, Venezuela and Colombia until 1993). In both cases, management of the financing and management of the provision of services are under a single centralized authority, with no organizational or functional differentiation of those two functions. Under such organization, the central authority has the simultaneous mission of maximizing the impact of public financing on health status of the population, financing and ensuring financial viability of its own providers, and regulating the system. Historically, that combination of missions has created incentives to ensure a stable flow of revenues for their own providers and ensuring their financial viability, frequently obstructing the entrance of private providers, leaving the other two missions in a secondary and tertiary role, respectively.

The most significant reform in this regard is the trend towards the introduction of Private Health Insurance and insurance competition in the health sector all over the region.

a. Introduction of Private health insurance and insurance competition

Reasons why governments have chosen to introduce private insurance and competition are discussed in this paper in section 2.a. The trend began with the Chilean reforms in the early'80s, followed by the Colombian reforms of the 90's and, since then, the Mexican and Peruvian reforms and probably the Venezuelan and the Costa Rica reforms soon to come. Additionally, the Argentine multi Social Security model (in which "Obras Sociales Nacionales" did not compete among each other before) has moved towards competition, and soon they will compete with private insurance.

In the case of Chile, together with the privatization of the pension system and its change from a pay-as-you-go system to an individual capitalization system, "opt-out" from FONASA to the newly created Private Health Insurance Institutions (ISAPREs),was introduced in 1980. At that time FONASA covered more than 85% of the total population on Chile.

In contrast with FONASA, which is an atypical social insurance institution (it also receives general tax funds to finance services for the poor), ISAPREs are typical private health insurance institutions based on individual risk contracts. Since then, all people opting out of FONASA should buy compulsory health insurance from one ISAPRE. Law prohibits contributing to both systems. In addition, as an incentive for opting out of FONASA, a tax credit was created for employers who would pay an additional premium (up to 30% more than the mandatory payroll tax, known as the "2%" subsidy) for any of his/her workers who would leave FONASA and join an ISAPRE. No regulatory agency, except for a very constrained MoH, was set to regulate ISAPREs.

As a result of the Health Insurance reform of the' 80s and the consequent significant growth of private insurance (from covering 2% of the population in 1981 to more than 27% in 1996), private providers developed aggressively and private provision of services went up from about 15% of the total in the' 70s to more than 50% in 1994. Although the new legal framework did not prohibited ownership of health service providers by ISAPREs, most of them chose to become pure third party payers and vertical integration did not occur until very recently.

In the Colombian case[3], "Law 100", enacted in 1993, mandated radical changes in Finance Management Institutional Organization. When fully implemented the reforms were supposed to significantly expand coverage and reduce or eliminate income-determined differences in access to a package of integrated health services.

The new law established the separation of financing and provision of services all across the sector, through the existence of private insurers and providers which, together with public insurers and providers, can provide services for pay-roll tax payers and/or indigent people according to consumer choice.

The Law also establishes Universal Coverage for the population, which would receive two kinds of basic coverage according to income. Pay-roll tax payers will have access to a minimum coverage defined by the "Contributive Compulsory Health Plan" (*Plan Obligatorio de Salud—POS*) and non pay-roll tax payers, or indigents, would have access to the "Subsidized Compulsory Health Plan" (*Plan Obligatorio Subsidiado de Salud—POS-S*). Pay-roll tax payers can also choose to purchase additional coverage with their for-profit or not-for-profit Health Insurance Institutions (*Empresas Promotoras de Salud—EPS, or Empresas Solidarias de Salud—ESS*). The new system creates solidarity among pay-roll tax payers through a fund which collects all pay-roll tax contributions and then distributes resources among EPSs and ESSs according with the number of enrollees and their demographic profile (age and sex). This mechanism is aimed to reduce risk selection incentives for insurers, as it has been the main problem in

[3] This section (Colombia Case) draws heavily from Mr. Patricio Márquez's paper: "Health System Reforms: A long-term response to social policy challenges in Latin America" (1996).

the Chilean reforms will be discussed later. General taxation would finance the premium for the POS-S for indigents in any of the EPSs or ESSs of their choice, avoiding, at least in theory, a two tier system, which is also a main issue in the Chilean system.

EPSs contract services with Health Services Provision Institutions (Instituciones Prestadores de Servicios—IPS). Public providers can participate in the system through their transformation into IPS, requiring some kind of autonomy to become such.

Argentina has a long "Biskmarian" tradition in its health sector. The country presents a combination of Social Insurance Sickness Funds at the provincial and national level (*Obras Sociales Provinciales and Obras Sociales Nacionales, respectively*), and Provincial Health Systems headed by each province's Ministry/Secretary of Health. In 1995 there were about 300 National Sickness Funds, covering about one third of the country's population (basically formal workers and their dependants). Additionally, there were 24 Provincial Sickness Funds covering about one fifth of the country's population (public provincial employees and their dependants). The rest of the population (47%) was covered by the Provincial Ministries/Secretaries of Health (about 30%), by a Retirees Sickness Fund (12%), or not formally covered (under voluntary private prepayment systems or with no coverage at all). There is a significant overlapping of coverages among the different funds and systems.

Workers were required by law to enroll in the Sickness Fund of his/her area of work, and did not have the option of choosing the Fund. As a result, revenue distribution and probably health risk was very unevenly distributed among Funds. One significant characteristic of the system before the 1996 reforms began was that competition was not allowed among any of the social insurance institutions mentioned above, nor between them and the private prepayment system.

As in the Chilean case, the public sector (provincial for informal workers and unemployed population, and the Federal Ministry of Health, for some catastrophic events such as AIDS), act as the "Insurance" of last resource.

In 1996, the Argentine government[4] initiated an aggressive health insurance reform process based on the following explicit objectives: a) improve efficiency in the Health Insurance Market; b) improve equity; c) improve control over rising health expenditures; d) increase consumer satisfaction; and, somehow less explicit, e) improve financial stability of sickness Funds.

[4] From "Argentina, Facing the Challenge of Health Insurance Reform", World ESW, Report 16402-AR, May 1997.

Argentina focused Health Insurance Reform in the National Sickness Fund market as its first step towards a wider reform in the country. Since 1996, Argentina strategy for reforming the National Sickness Fund Market is based on three main pillars:

(a) Regulated competition among Sickness Fund and free choice of Fund by formal workers and their dependants. Soon, competition between Funds and Prepayment Private firms;
(b) Enforcing a mandatory Benefit package for all Funds' beneficiaries; and
(c) Restructuring and improving an already existing "Solidarity Fund" (Redistribution Fund) to allocate resources to compensate for risk and income differentials to avoid risk selection (when a beneficiary has not enough to pay for the mandatory Benefit package).

b. From single social insurance to multiple private insurance and insurance competition: does it improve equity and/or efficiency?

Discussing private insurance competition is obviously a complement to the "opt-out" trend discussion developed earlier in the paper under the analysis of macrofinancing reforms. As discussed under 2.a. before, privatization and competition within the health insurance market responded to the perception, by influential reformers and possibly corporate interests, that competition is basically a good way to improve efficiency, and private sector initiative and flexibility in a competitive environment will assure efficiency gains. Again, it seems there was too much focus on technical efficiency and economic ideology and too little on health insurance competition evidence and economic theory.

Evidence on incentives and results of health insurance competition has been out there for a long time, mainly from US experience. Examining the determinants of the insurance premium in a competitive health insurance market, it is easy to conclude that existence of incentives for risk selection and adverse selection is inherent to such competitive markets. Loss of cost control may also occur not only depending on what payment mechanisms are used, but also due to reduced monopsony advantages regarding production factors (especially personnel) if too many insurance institutions are allowed to exist. Premium cost determinant analysis and evidence also shows that individual risk based insurance competition lead to higher administrative and financial cost resulting from high information and transaction cost and due to higher financial costs determined by higher "solvency margins" and "technical reserves" if risk pool fragmentation is allowed. Consumer satisfaction, though, may be increased by the existence of options and by the natural consumer satisfaction orientation of any service in a competitive market.

Why choose private insurance competition then? It might be that it was the state-of-the art technical knowledge in the region at that time, which is not clear given the international evidence. May be evidence and economic insurance theory where nor thought to be valid for LAC or it was thought that economic incentives towards risk selection and other problems could be controlled by legislation and regulatory control.

To examine equity, it would be necessary to examine the questions of whether risk selection has been a problem and whether regulation, legislation and some incentive mechanisms have been able to avoid it. To examine if efficiency is being improved with the reforms, administrative costs under social single insurance v/s private insurance will be examined.

Again, as with the implementation of "opt-out", private health insurance competition is too recent in most LAC countries to have multi-country evidence on the equity and efficiency effects of such reform. However, again, we will at least review the Chilean case where data for evaluation is available and we will also discuss some elements of the Argentine and Colombian reforms.

In Chile, due to the inherent incentives within a competing private insurance market, and stimulated by the almost complete absence of regulatory agency for the first 10 years of the system, significant risk selection and cream skimming took place in the health insurance market in Chile. The role of the public sector serving as a last resource insurer (implicit "free reinsurance") has also facilitated ISAPRE development. FONASA has had to deal with the results of the significant risk selection and cream skimming set by the ISAPRE system in the last 18 years. As shown in Figure 3, while the population older than 60 years represents more than 9.5% for the country's population, population 60 years or older represent less than 3.2% of ISAPRE population. Conversely, population younger than 40 years old represents less than 34% of the country's population while the same population represents more than 41% of all ISAPRE beneficiaries.

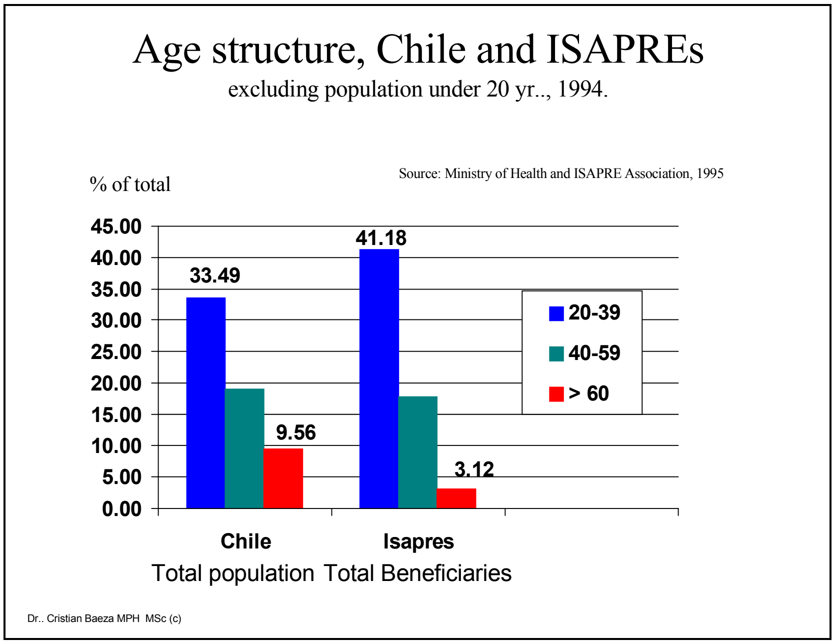

Figure 3

Regarding efficiency, as shown in Figure 4, ISAPRE system administrative costs on average accounted for about 20% of total costs in 1995. They were about 18% in 1997. As also shown in Figure 4 , the trend is toward the reduction of administrative costs. That trend may be reflecting the aggressive merging effort of the last 5 years as well as important changes in provider payment mechanisms. However, even considering the trend, administrative costs are exceedingly high, although in line with the administrative costs in US private health insurance market, when compared with FONASA administrative costs of less than 1.8% of total costs for 1997.

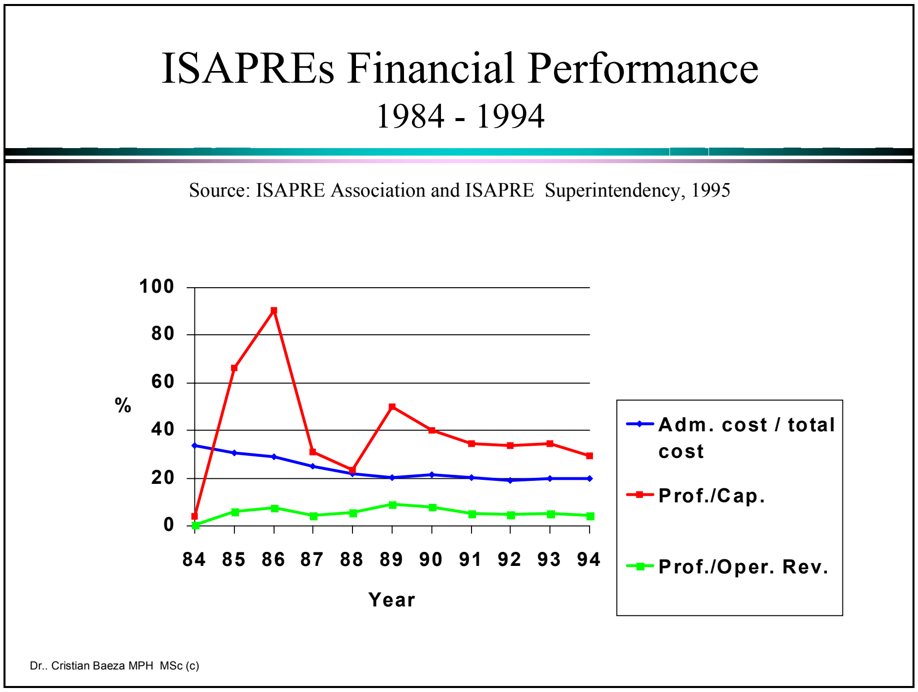

Figure 4

One area where ISAPREs clearly outperform FONASA is consumer satisfaction. The first example of that is the fact that every FONASA customer who has the possibility to "opt-out" to go to an ISAPRE does so. Also, well-performed population surveys show increasing satisfaction differences. A word of caution though: ISAPRE and FONASA populations, as shown before, are not comparable populations in terms of age, income and health risk. However, it is well accepted in the country that the satisfaction issue is real. The author shares that perception.

Another positive result of private insurance competition is the development of a strong private provision market allowing reformers at least to discuss the posibility, if political conditions permit, of setting up a contestable market between private and public providers in the sector.

Colombian reforms have resulted in impressive coverage increases for the contributive system (the system for pay-roll taxpayers, the richest segment of the population). More than 25 HMO-like EPSs have been created since the beginning of the reform, extending formal health insurance coverage to nearly 8 million people and increasing availability of additional financial resources in more than 1 percent of the GDP. However, the question of how successful the reforms were for the poorest segment of the population is still pending. Reforms attempted to explicitly address the equity issue through subsidizing (from general taxation) a Compulsory Health package for non-pay-roll tax payer (POS-S), but obstacles in shifting from supply side subsidy to demand side subsidy within the public sector are impeding the enjoyment of the reform benefits by the poor. It would be a sad paradox that the reform that made the most in LAC to avoid negative impacts on equity would end up benefiting mostly the richest segments of the population.

Colombia is using the "Redistribution Solidarity Fund" to compensate for risk selection. As in the case of Argentina, it is also necessary to evaluate if risk adjustment through redistribution is actually eliminating risk selection behavior by EPSs, given that demographic parameters being used for adjustment are only general proxies of actual service utilization. Also, as expected from a system where benefits and benefit package costs do not match, and worsened by the lack of responsibility for revenue collection by EPSs, a trend towards undercontribution and evasion seems to be strongly emerging in the system.

Colombia's Basic Package (POS) is intended to address the equity issue assuring everybody, regardless of their income, access to a certain level of service. However, in the contributive system, the comprehensiveness of the health package and its relatively inflexibility in terms of adjusting benefits with revenues, could explain most of the financial problems EPSs are facing in the country. In addition, the possibility for an EPS to offer the POS mixed with additional coverage and the resulting inter-package comparability complexity, as in the Chilean case, is creating severe lack of information transparency for pay-roll taxpayers at the moment of selecting their health insurance provider and for enforcing coverage of POS by all EPSs.

The POS-S actual coverage by any EPS according to consumer choice is still waiting for the public sector to solve the problem of transitioning to a demands side subsidy.

Argentina's reforms of OSN are counting on addressing the issue of risk selection through refurbishing the already existing "Redistribution Solidarity Fund" to allow for automatic allocation of the fund's resources to compensate for income differences to the level of the basic package of services (Medical Compulsory Program—*Programa Médico Obligatorio--PMO*). Using income and eventually age in the "risk compensation formula" to be used by the "Solidarity Fund" may well eliminate incentives for risk selection but, being those variables only proxies of health risk and service consumption, it remains to be seen if risk selection will not be an issue of ONS competition in Argentina.

Argentina also plans to address the equity issue through enforcing coverage of the PMO by all OSN. However, it allows OSN to mix PMO and additional voluntary coverage under the same agreement. As in Colombia (see bellow) this may severely hamper the enforcement of PMO coverage.

It is too early to draw any conclusions yet. The free choice of OSN right has been exercised only once by a significant but small number of Fund's beneficiaries (less than 10% of the total), although the second round of free OSN choice is due in May 1998. The Regulatory Agency was not in place at the moment this paper was written and regulation for market transparency and competition is still being designed and discussed. It is not clear yet how the Redistribution Solidarity Fund is working (the MoF manages it and the allocation mechanism is not publicly known and accountable yet). There are serious concerns that Fund resources are not being totally redistributed and that MoF is using those resources for fiscal deficit reduction purposes.

The Chilean case is a useful example of the issues to be addressed under privatization and competition in the health insurance market in the region. Unfortunately, although data have been available for some time now, most countries moving towards this model have not been able to show the feasibility of effectively putting in place mechanisms to counterbalance the problems.

Is then the answer to remain with single public social insurance as it is in the region today? A single public social insurance model would at least in theory, better address most problems described for private health insurance competition. However, in the absence of competition and real threats for the single social insurance inefficiencies there are many significant problems to be addressed. If single social insurance is to stay as an alternative, reforms should make it possible to:

(a) set incentives for Social Insurance to focus on customer satisfaction and continue product improvements in the absence of competition;
(b) empower the citizen/customer vis-a-vis the state social insurance and providers;
(c) ensure independence of the Government/State so it will not use contributors' money for other purposes; and
(d) set social insurance accountability in a way that would eliminate direct interests group influence (political parties, unions, MoF) on the public social insurance program.

To implement such reforms is proving to be as difficult as setting up regulations to address the problems of competing private insurance markets.

6. PUBLIC SECTOR PROVIDER PAYMENT AND PROVIDER ORGANIZATION REFORMS: IN SEARCH FOR FEASIBLE

TRANSITION FROM SUPPLY SIDE SUBSIDY TO DEMAND SIDE SUBSIDY FOR HEALTH SERVICES?

a. Provider Payment reforms: price signals and incentives for improving technical efficiency of health service providers.

Most LAC country health systems, either in a multi-insurance setting or a single financial agency setting (with exceptions like *Obras Sociales in Argentina and IAMS in Uruguay*) have traditionally had integrated provider-financer systems. The financial institution owns the providers or somehow has overwhelming non-purchasing influence in their management. Most resource allocation have been done through classical "line- item budgets", often included under national budget laws or controls. In most cases, line-item budgets normally allocate resources to providers on an historical basis, with no regard to the amount and quality of services and with little consideration given to customer demand and satisfaction.

This historical behavior, together with the traditional "line-item-budget" type of mechanism for resource allocation, has consolidated among relevant sector actors, a profound believe that the only way to finance availability of services for public sector beneficiaries is through a supply side subsidy for public providers. This deeply rooted perception among very important players in the system until today explains, in part, the strong defense of such subsidy by medical associations, unions and many politicians all over LAC.

As part of health sector reform efforts, most LAC countries are beginning to implement (or have been struggling to do so for a relatively long time), "provider payment reforms" through the implementation of the "Purchasing Model". The introduction of Purchasing Models aims to set correct incentive environments for public providers to increase technical efficiency, customer orientation and productivity. Such a model, is an attempt to depart from introduces significant changes attempting to depart from traditional historical line-item budgets to a combination of case related, capitation or similar reimbursement mechanisms. Good examples of these efforts are Brazil (during the' 80s), Chile (since the early' 90s) and Costa Rica (since the mid' 90s). Preliminary efforts are also being made in some provinces of Argentina (Salta and Mendoza), Nicaragua, and Ecuador.

In all these cases, reforms attempt to create the conditions for an "Internal Market" within the public sector and, eventually, to set a contestable market between public and private providers. This has been done through designing and implementing new payment mechanisms and through the design and implementation of "quasi" contracts between the financing institution and providers and/or network of providers. The final goal (implicit or explicit) has been to set up a feasible transition from supply side subsidy to demand side subsidy for health services within the public sector.

In the case o f the Chilean Public Sector, a local version of 28 DRGs (*Pago Asociado a Diagnostico—PAD),* which represent almost 75% of all public hospital discharges, was designed (1991-1992), pilot tested (1993-1994) and implemented (since 1996) within the public sector. Currently, additional 12 PADs are being designed to reach up to 85% of all public hospital discharges. Apparently no more PADs will be designed in the near future due to the fact that expansion beyond that number is estimated not to be cost/effective. The remaining 15% are being paid under a fee-for-service type of mechanism known as PPP (*Pago por Prestación).* "Quasi Contracts", in the Chilean case, took the form of "Performance Agreements" (*Compromiso de Gestión)* between two actors, MoH and Regional authorities at the beginning of the process. Since 1996, three actors negotiate these agreements: a) the National Health Fund, FONASA, as the purchasing agency; b) the Undersecretary of Health, as the National Provider Holdings Coordinator; and c) the regional health authorities, acting on behalf of their providers.

In the case of Costa Rica Social Insurance, a similar "Purchasing Model" was designed in 1994-95 by the Social Security Fund (*CCSS*). It includes Performance Agreements (*Compromisos de Gestión*) and new payment mechanisms. The system is in the piloting stage and has not been implemented nationwide yet. However, as in the Chilean case, some of the issues about resource management flexibility and cost structure adjustment at the provider level seem to be emerging during this trial phase. The *CCSS*, though, has begun to design a new management framework for its providers in a much more decisive way than in the Chilean case.

Some provinces in Argentina, like Salta and Mendoza, have begun to design and implement Purchasing Models similar to the Chilean and Costa Rican cases. In **Salta**, the Provincial Government is currently reforming the provincial Social Insurance Institution *(Obra Social Provincial*), to transform it as the single provincial purchaser. It is also introducing new payment and "quasi-contract" mechanisms between the "Purchaser" and public and private providers. The Salta case is especially interesting because simultaneously with the microfinancing reforms, reforms of labor regulations and flexibility for human resource management at the hospital level have been introduced to the public sector. In **Mendoza**, since the early' 90s, new payment mechanisms and more autonomy for resource management have been introduced within the public sector.

Argentina having a federalist system, the health sector is a provincial responsibility and the Federal Government does not have the possibility of directly reforming the system. However, it has taken the lead to promote hospital autonomy. Contrary to the Chilean, Costa Rican, Salta and Mendoza cases, emphasis on hospital autonomy without introducing provider payment reforms could lead to jeopardizing the achievement of expected efficiency gains.

Uruguayan "reformers**"** are beginning to discuss the need to design and implement provider payment reforms within the public sector, while struggling in their initial efforts to reform and decentralize the functions of the State Health Service Administration (*Administración de los Servicios de Salud del estado—ASSE)*

It is very interesting how, **in the Colombian** case, which introduced the most sophisticated Finance Management Institutional Organization Reform in the Region, it was assumed that somehow the public sector would shift from supply side subsidy to demand side subsidy logic "automatically" after Law 100 was enacted. Therefore, besides the legal possibility of public hospital becoming Service Provision Institutions (IPS), apparently no specific provider payment and/or provider organization reforms were designed at the moment Law 100 was enacted. Now, Colombia is struggling to implement provider payment reforms within the public sector to make it possible for the implementation of the Subsidize Regime aspects of Law 100.

The need for provider payment reforms is not only a public sector problem in the region. In the Chilean case, for a long time, private insurance used a fee-for-service based reimbursement mechanism, which has led them into a significant cost explosion in the last 10 years. Service costs for ISAPRE affiliates went up, in real terms, 5% in 1995, 6.8% in 1996 and 11.7% in 1997. ISAPREs are now moving towards reimbursement mechanisms that include cost containment incentives, in some cases drawing form the experience of public sector provider payment reform. A similar case occurs with the OSN in Argentina and the IAMCs in Uruguay.

b. Health Service Public Provider Organization reform: responding to a new challenging environment

Among all four areas of reform, Provider Organization change reform is the least common. Most reform processes have focused either on Macro, Micro and/or Finance Management Institutional Organization. Despite being present in many reform plans and cooperation projects, in practice, there are very few clear examples of Provider Organization Reform actually being implemented and the few cases that exist are very recent.

At the core of Provider Organization reform is the introduction of flexibility in resource allocation within a provider organization, giving managers the power and the means to do so. This is the main aspect of what has become somehow the paradigm of Provider Organization reform: “The Autonomous Public Hospital”.

In the Argentine case, the Federal Government has been promoting, since 1993, the creation of Autonomous Hospitals (*Hospital Autogestionado--HPA*) in the provinces. In 1993, a Ministerial decree was passed setting the characteristics of such hospitals and calling for voluntary enrollment by provincial hospitals. More than 100 hospitals had subscribed the decree by 1997. However, the characteristics necessary to be considered an HPA are very unspecific and it is unclear what, in practice, is the difference between “*HPA*” and normal public hospitals. Again, two important exceptions are the provinces of Salta and Mendoza. Also, the province of Buenos Aires is beginning to address the issue of resource management flexibility within each public provider institution. In **Salta**, the provincial government enacted a 1996 a law allowing for hospital managers to hire and fire personnel with substantive flexibility, as well as to manage other resources to buy and sell services and engage in new purchaser-provider relations with the MoH and the Provincial “Obra Social”. **Mendoza** has an even a longer tradition of setting flexible environments for resource management within public hospitals promoting this since the early 1990’s. However, legal changes have not been enacted yet. The province **of Buenos Aires** passed a law in 1996, allowing flexibility for hospital managers regarding personnel and other production factors. However, it is not clear that managers are actually using this power.

Uruguay recently passed a Presidential decree to create “Decentralized Managed” Public Hospitals (HPGD). Under such a regime, public hospital managers would have much more flexibility in managing all hospital resources, including personnel and would work with ASSE (State Health Service Administration Agency) in a purchaser-provider type relationship. Unfortunately, the decree had to be overruled less than one month after having been enacted, due to political and union pressures.

Costa Rica has also pilot tested new management environments for public hospitals (Sickness Fund Hospitals) and a new purchaser-provider relation between the National Sickness Fund and the hospital. However, the issue of flexibility in personnel management is still pending.

Brazil has a long tradition of private sector provision of services, but few states have given public hospitals total resource management flexibility. An interesting is being carried out in the Municipality of Sao Paulo, where public provider institutions ownership (mainly ambulatory facilities) have been given to Doctor’s

Cooperatives and a contract has been set for those cooperatives to sell services to the municipality.

In the Chilean case, the municipalization process of primary care facilities, in the early 80's was meant to introduce total resource management flexibility for managers at each ambulatory facility. However, during the early'90s, union pressure forced the government to enact the "Statute of Primary Care" (*Estatuto de Atención Primaria*) which norms all contractual relations and salaries for personnel, significantly rigidifying resource management.

c. Provider Payment and Provider Organization reforms: Price signals and the "black boxes", can we afford this approach any longer?

The basis for provider payment reform is to set up a financing system which would send the right price signal to public providers and the incentives for improving technical efficiency, increasing productivity and empowering consumers vis a vis health service providers.

If provider payment reforms are successful and continue being implemented, a change from supply side subsidy to a demand side subsidy for health services within the public sector would require significant flexibility in resource management by service providers. They need to be able to adapt their service production functions and cost structures to the continuing evolution of price signals determined by the new payment mechanisms and competition with private providers.

The potential implications of provider payment changes on the need for flexibility of labor regulations for public providers have been significant obstacles for the introduction of the reforms. Those implications have largely been ignored in the reform processes. This is so not only in the Chilean and Costa Rican reforms but for Colombia, Uruguay and Argentina. The importance of addressing this issue is stressed by the emergence of the private sector that is formally or informally competing with public providers for public funds. If private-public provider synergistic participation is desirable for health service delivery, then introduction of market resource allocation logic within the public sector is urgently needed. Otherwise, the different microeconomic incentives that public and private providers are facing today (supply v/s demand financing models) will determine perverse incentives for both subsectors with significantly negative financial, equity and quality results.

Among all production factors, flexibility of personnel management is an essential component of the problem, considering that on average public providers expend 70% or more of their budgets on salaries. However, provider payment reforms seem to have assumed (explicitly or implicitly) that only by the merit of those reforms:

i. Managers of public providers would receive and understand the price signals in the new payment mechanisms;
ii. Managers will know how to respond and will be willing to act accordingly despite the culture of their organizations
iii. Managers would have the legal and administrative adequate flexible environment to make the correct changes.
iv. Political authorities in the sector and the government would be willing and able to deal with the political problems associated with such flexibility; and

Experience over the last 10 years is showing that all these assumptions seem to be wrong and it appears that this is the most important obstacle for reform implementation in the region. **Reforms of "Labor market/Labor regulation" within the public health sector are sadly missing from the agenda all over health sector reform efforts in the region.**

All this is evident in the case of Chile (the most advanced of the provider payment reforms). The main problems resulting from DRG implementation in Chile came from two sources. One has been the intermediary role of regional authorities that are somehow distorting price signals through different kinds of redistribution of revenues among the providers, setting perverse incentives for efficiency within the biggest public hospitals. The other, much more important, is the lack of political feasibility in adjusting cost structure of providers which former budgets do not match the revenues they should receive on the basis of DRG only. In practice, the difficulties adjusting provider cost structure has stalled the implementation of the new payment mechanisms and purchaser provider split reforms.

The assumption that somehow the public sector would be able to deal with these constraints has been a key element in considering that provider public ownership is of secondary relevance in the process. It has been assumed that it is more important to set up the correct incentive framework for managers and public provider institutions than caring about provider ownership in the health sector. That is the whole idea behind the "Autonomous Public Hospital" and "Trusts" effort. **However, if lack of flexibility for resource management among public providers is an inherent unchangeable structural component of public ownership, as it seems to be the evidence emerging from the experience in health and public enterprise reforms, it might be time to bring the issue of ownership back to the agenda**.

In any case, even if ownership proves to be a first order consideration in this debate, the issue of what to do with public providers and how to set a feasible transition, now all the way to privatization and not only to autonomy, is still a missing piece of the reform effort. It is urgent that health sector reform coordinates more closely with and draws from the experience of civil servant and public enterprise reforms in this area.

Additionally, and consistently with their focus on reforming provider payment mechanisms in the sector, health sector reforms have treated provider institutions as "black boxes". With the exception of very preliminary efforts in a few reform processes in the region (Argentina and Costa Rica), reforms have not dealt with the organization of internal services and with improving production functions and service delivery models at the hospital level. It is unlikely that public provider institutions would be able to reconvert their own production process and organizational culture by themselves.

In addition to the new regulatory environment, adding flexibility of resource management for public providers to respond effectively to changing price signals under the "Purchasing Model", reforms would need to decisively support the process of changing the internal organization, production procedures and organizational culture. This is especially important for public complex hospitals. It usually seems to be unappealing for "reformers" to deal with these aspects of the design and implementation of the reform process and the projects supporting it. It appears to be too micro and there are many hospitals. However, at the end this is what it's all about. **Either the reform process allows for continuous service and cost improvement by providers to better serve their customers or lack of public provider flexibility to manage their resources could become a formidable obstacle to health sector reform, leaving it as no more than a self centered academic exercise.**

7. BURNING QUESTIONS AFTER 10 YEARS OF HEALTH SECTOR REFORM IN LAC.

a. <u>How and when do ordinary people, and especially the poor, win through Health Sector Reform? : Need for accountability.</u>

As in no other sector of the economy in LAC, the public health sector borders among the interests of the unions, the politicians interests, the fiscal interests and the consumer interests are very fussy and overlapped. The consumers, and specially the poor, are not usually allowed at the reform "design/negotiation table".

The predominance of supply side subsidy gives consumers no effective way of influencing the resource allocation decision making process, besides the election time. This leaves a profound culture of provider protection, sometimes in open contradiction with the interest of the customers. Providers are the dominant figure in the sector even for the design and implementation of health sector reform.

How to know when and how a proposed reform will actually positively impact users? Most of the time reforms are managed by inexperienced health authorities, whose default conception of the sector is from the traditional provider point of view; or, by financial authorities who's fiscal interests are as evident as their lack of sector and health economics knowledge. Most reform efforts begin with setting objectives to benefit the consumers (improving equity and efficiency) but very soon the effort of the reform focuses completely on instruments and reaching the goal of input implementation. It is assumed that some day reforms will achieve the ultimate objective of positive impact on the satisfaction and health of the population. As the paper intends to argue, health sector reform in LAC until today has not necessarily improve equity or efficiency in favor of the poor.

As has happened in most of the reforms in LAC recently, even when changes would evidently have a positive effect, the reform and its communication process frequently become a self-centered exercise, unintelligible for the population and therefore not perceived by it as necessary. People, then, do not support the process and let union, short term fiscal and corporate interests block it.

There is a tremendous need for clarity and accountability with respect to measurable objectives and time frames for specific positive impact on the population, not only for government authorities supporting reform but also for cooperation agencies financing it. There is also an urgent need for serious work on social marketing of reform and a more professional approach for an "evidence based" reform process.

b. Policy Questions

(a) Are current Health Sector Reform trends in LAC improving equity and/or efficiency. How to make sure they will do so?
(b) Is the move towards private compulsory health insurance competition just a result of macroeconomic adjustment strategies or is it to remain as a trend for the whole region in the future?
(c) Is private compulsory health insurance competition improving equity and/or efficiency? Is there a model, which has proven in practice its effectiveness, to eliminate inherent insurance competition problems?

(d) Is there a way to “modernize” single social insurance in LAC? Is it politically feasible?
(e) Is lack of flexibility for resource management among public providers an inherent unchangeable structural component of public ownership, making the “Autonomous Public Hospital a dream of public sector dinosaurs and calling for the resurrection of the provider privatization agenda?