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Comparative Analysis of Social Insurance in Latin America and the Caribbean

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ACRONYMS

List acronyms in alphabetical order as needed.

DDM	Data for Decision Making
FPMD	Family Planning Management Development
LAC	Latin America and the Caribbean
PAHO	Pan American Health Organization
PHR	Partnerships for Health Reform
USAID	United States Agency for International Development

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1. INTRODUCTION

Healthcare systems in Latin America and the Caribbean widely differ both in their coverage and access levels, equity, organizational and financial structures, as in their outcomes (whether these are measured in terms of infant mortality or life expectancy, among other indicators.) A great deal of the heterogeneity in outcomes is attributable to the present relationship they bear with each country's average levels of wealth;[1] this becomes even more evident when the differences in distribution are observed within each country. Stated differently, there is a significant association between high poverty levels and poor health outcomes. This is shown in Table 1, where income and poverty indicators are depicted per country, together with health indicators (infant mortality at age one and five, life expectancy, and access to health care services.)

This association between wealth and health poses a challenge for economic and health policies, i.e., how to set up a health care system able to offset budgetary limitations and to provide a better quality of life to the population in terms of health. Some countries, even some of the region, have shown that it is possible to design health systems with such characteristics. The "menu" of possibilities to be selected when defining a health reform that combines both effectiveness and low cost exhibits new concepts, as well as others that are already known. They range from acknowledging the value of preventive medicine and vaccination programs to designing mechanisms aimed at fostering the supply of services.

In this context, this paper will make a comparative analysis of regional experiences in the organization of health care systems and, specifically, the role of social insurance, bearing in mind the mixed nature of health financing in Latin America and the Caribbean. The ultimate goal is to contribute to the debate on public policies concerning the organization, funding, and provision of services in the area.

While keeping in mind the region's heterogeneity, this study analyzes the various sources of financing of social health insurance schemes found in Latin America and the Caribbean, the principles of solidarity between high- and low-income populations, and the risk sharing criteria between healthy and unhealthy individuals. Special emphasis is placed on the analysis of contractual structures and coordination mechanisms between the social insurance subsystems participating in the region and their effects on health care coverage and access.

On the basis of these criteria, two dimensions of the social health insurance structure are identified in this study: a vertical and a horizontal one. The former makes explicit the criteria that link each of the subsystems' sources of financing with the way in which the funds appropriated to health care are organized, the various insurance plans, and the criteria for paying and engaging services (both for hospitals and clinics and health care professionals.) Concurrently, the horizontal dimension focuses on studying the criteria that associate health care and financing among the different sub-sectors –public, private, and, if any, social security institutes, and the private sector.

[1] Using information from countries in the five continents and different income levels, Murray et al. (1994) shows that there is a highly significant correlation between Gross National Product –as a wealth indicator– and health indicators (life expectancy and infant mortality.)

In this context, the advantages and limitations of implementing a social insurance system are analyzed, and different examples of social insurance schemes in the region are discussed.

This study used a questionnaire that was distributed among twenty-seven countries in the region.[2] This questionnaire was complemented with an extensive review of the literature and interviews with experts and officials from the sector in each country.

[2] The questionnaires were delivered to Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Colombia, Costa Rica, Chile, Cuba, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, Surinam, Trinidad & Tobago, Uruguay, and Venezuela.

TABLE 1: HEALTH INDICATORS FOR COUNTRIES IN LATIN AMERICA AND THE CARIBBEAN

Country	Per Capita GNP	% Pop. below the poverty line	% GDP in health (total)	% GDP in health (public)	Total per cap. expenditure in health	Life expectancy	Infant Mort. rate (under 1 yr)	Child Mort. rate (under 5 yrs.)	% population with no access to health care services
Bahamas	11,790	n.a.	4.3	2.53	518	74.2	12	17.6	n.a.
Argentina	8,970	25.5	9.8	1.71	795	73.3	22	24.6	29.0
Barbados	6,530	n.a.	6.4	4.00	421	76.5	12	13.8	n.a.
Uruguay	6,180	14.5	10.0	2.24	516	74.3	16	19.0	0.0
Chile	4,810	23.2	8.0	0.46	331	75.4	11	14.8	3.0
Brazil	4,570	17.4	7.6	2.56	280	67.2	34	47.2	26.0
Trinidad & Tob.	4,430	21	4.7	2.10	176	74.2	12	n.a.	0.0
Mexico	3,970	34	4.8	0.58	160	72.6	31	37.2	7.0
Venezuela	3,500	31.3	7.6	1.82	229	72.9	21	24.4	n.a.
Panama	3,080	37	9.2	3.77	253	74.0	21	27.2	30.0
Costa Rica	2,780	22	8.6	0.50	224	76.9	12	14.6	20.0
Belize	2,610	35	3.9	1.80	106	74.8	32	36.2	n.a.
Colombia	2,600	18	7.3	1.80	140	71.0	24	37.8	19.0
Peru	2,460	49	5.5	1.46	128	68.5	40	63.2	56.0
El Salvador	1,850	48	6.8	1.18	158	69.6	32	39.8	60.0
Dominican Rep.	1,770	21	5.3	1.51	77	71.0	40	45.0	22.0
Paraguay	1,760	21.8	5.0	1.02	85	69.8	23	47.4	37.0
Jamaica	1,680	34	5.0	2.43	76	74.7	12	26.4	10.0
Guatemala	1,640	75	4.2	0.97	56	67.4	37	54.6	43.0
Ecuador	1,530	35	5.1	0.78	71	69.9	33	59.0	12.0
Suriname	1,240	n.a.	8.0	n.a.	95	71.6	29	32.2	n.a.
Bolivia	1,000	67	6.0	1.43	48	61.7	67	85.4	33.0
Guyana	770	43	7.5	5.21	44	64.6	58	76.0	n.a.
Honduras	730	50	7.4	2.96	44	69.9	36	48.0	31.0
Haiti	410	65	3.5	1.32	9	54.5	71	103.2	40.0
Nicaragua	410	50	9.2	4.01	35	68.4	43	56.8	17.0
Cuba	n.a.	n.a.	9.0	7.80	106	76.1	7	11.8	0.0

Source: Situación de la salud en las Américas - Indicadores básicos 1999, Pan-American Health Organization / World Health Organization

2. OBJECTIVES OF A HEALTH SYSTEM AND MIXED FINANCING MODELS

Overall, a health system is expected to provide the population with extended, equitable and cost-effective access to its services. These services can have specific characteristics or "market flaws" that may require government intervention. Such flaws range from asymmetrical information between patients, physicians, and insurers, to interdependencies between an individual's health status and that of his family and the community. From the point of view of efficiency, market flaws provide a justification for the development of equity policies, irrespective of motivations for solidarity that may exist in any society.

However, resource restrictions within the public sector, often coupled with inefficiency in the implementation of social policies, restrict governments' abilities to uphold cited principles of equity, cost-effectiveness, and access. Limited coverage and quality force large sectors of the low-income population to either seek care in a fractured private sector –where health insurance is practically non-existent– or else to do without medical attention altogether. This situation makes it possible to develop a *"by default" argument:* the private sector develops in the shadow of the public sector's ineffectiveness, and the greater the public sector's lack of quality and effectiveness, the greater the out-of-pocket expenses (Maceira, 1996 and 1998.) Where this phenomenon takes place, the private sector implies visits to private physicians with in-kind payments, consultations at drugstores or, in some countries in the continent, visits to traditional providers. These health care alternatives enable low-income groups to use private health care providers and explain why the region's countries with higher poverty levels exhibit a large share of private expenditure with respect to the total health expenditure. At the same time, this share of private expenditure is larger than the one generally found in more developed nations (see information in Govindaraj et al., 1995.) The *"by default"* argument implies that there is a trade-off between price and quality, also expressed in the proportions of outpatient visits among sectors in countries with a poor performance of its public health services. While the demand for hospitalization is satisfied to a large extent by the public sector, amounting to an average 70% of the total number of visits, outpatient treatments at Ministry of Health facilities only amount to 30%; the rest is being directed to the private sector.

The argument that associates income and health status, presented in the preceding section, combined with this second *"by default"* argument , suggests that countries with relatively higher income levels –or lower percentages of the population below the poverty line– have higher health expenditure levels and better indicators. At the same time, less economically developed countries have less satisfactory indicators and higher private expenditure percentages. Table 1, however, shows exceptions to this pattern. Such is the case of Costa Rica, whose health indicators are more satisfactory that those associated with their income level, Chile, with high performance in its health indicators, or Brazil and Mexico, whose outcomes are lower than expected. This leads to the conclusion that the overall organization is an important factor in whether a health system is able to impact the quality of life of a society.

Social security institutes, originally created in the region's Latin countries as a branch within the public sector, arose as an alternative financing method based on obligatory contributions by formal employees and their employers. In the beginning, this insurance

covered mainly occupational accidents. At a later stage, the coverage of enrollees was extended to their families, not only in the health sector, but also in geriatric care, funerals, recreation, etc. Even though these social security institutes succeeded in extending the sector's sources of financing, they segmented the market into two independent funds. In the meanwhile, the English-speaking Caribbean countries continued with an universal public insurance system that offered variable coverage, depending on the budgets of the relevant Ministry (Mesa Lago, 1989.) Later efforts in a limited number of countries gave rise to private insurance modalities, with significant coverage in Uruguay, Argentina, and Brazil, all of them without a proper regulatory framework managed by the public authority.

The last few decades have witnessed a drastic shortage of financial resources in the health sector due to reasons associated with macroeconomic volatility, whether as a result of high inflation levels or sharp fiscal imbalances. This has impacted the levels of coverage and equity in the delivery of health services. Since then, important transformations can be observed in the sector in terms of segmented delivery structures, cross-subsidies, and transfer of risk between and within subsystems. Among these transformations are those related to the resizing of social insurance structures. In some cases, insurance reforms stressed the existing funding and delivery schemes. In others, new insurance schemes were developed as a result of the privatization of public social security services, such as the case of Chile and Colombia, with significant differences in the definition of a basic package of benefits and the reallocation of solidary funds to lower-income sectors.

The criteria for defining a social insurance system, the objectives and advantages of its implementation, and its limitations will be discussed in the coming sections.

3. CHARACTERISTICS OF A SOCIAL INSURANCE SYSTEM

A social insurance mechanism is aimed at providing the health system with sustainable financial support over time, in order to allow larger sectors of the population to gain access to health services. The macroeconomic fluctuations, which affect public budgets, as well as the frequent discretionary use of such budgets, require complementary mechanisms to provide greater and better access to health care. In this sense, the contribution of a social insurance system may be summarized as follows:

- It extends **coverage** to workers of the formal sectors, their families and dependent beneficiaries, and articulates mechanisms to incorporate unprotected populations.

- It provides **financial sustainability**, since salary contributions constitute a complementary source of income, often less difficult to collect than direct taxes.

- It is a potential tool to provide greater **access** and **equity**, to the extent that solidarity criteria (transfer of funds) are incorporated between the social insurance system and the public health coverage.

- It systematizes, coordinates, and monitors supply by including incentives in provider payment methods and contracting out services from other (public and private) subsystems. This task is of great relevance in the "ordering" of the provider market, generating certain relative quality standards and making the delivery of health services more efficient and competitive. In other words, a social insurance system is bound to play a strategic role in the **efficient allocation of resources** within the sector.

- **It shares the costs and risks of the health care** associated with traditional characteristics of a health insurance.

In order to establish a pattern to compare social insurance systems in terms of their health service delivery in the region, four general principles have been set forth to define "social insurance." This does not preclude, however, that there may be other alternative definitions, more or less strict than the one presented in this paper. The following elements were taken into account when making this definition:

- There should be a defined pattern of beneficiaries.

- The insurance system should have a defined package of services, and such package should be available to users.

- There should be insurance criteria in the financial management of the funds, so that there are cross-subsidies between healthy and unhealthy users.

- There should be solidarity criteria in the financial management of the funds, so that there are cross-subsidies between rich and poor groups.

As the coming sections will confirm, very few social insurance systems in the region feature these four elements in the structure of their social insurance systems. In those health systems where social insurance depends exclusively upon the Ministry of Health, the pattern of beneficiaries is not defined, and a "self-selection" criterion prevails in the demand for health services. At the same time, in most cases in both the public sector and the social security institutes, the package of services, although on occasion explicitly stated, is actually defined by the supply: only those services that are available are delivered.

Likewise, many systems called "insurance" in the region fail to meet the criteria which identify the notion of insurance and transfer of risk, such as risk-adjusted premium, which is paid directly by the beneficiary or by the State. Consequently, the types of available insurance basically are varieties of subsidies often targeted to specific groups of the population that fail to consider sustainability. Finally, the segmentation of health systems in the region limits, some times dramatically, the allocation of subsidies between the rich and the poor, thus decreasing the possibility of becoming solidary funds.

4. SOCIAL HEALTH INSURANCE MODELS IN LATIN AMERICA AND THE CARIBBEAN

Just as the per capita income levels and sources of health system financing vary among the region's countries, organization of their health systems also differs. This difference is associated both with the stakeholders and with the manner in which they are articulated and coordinated to set up different health care models. The characteristics of each stakeholder and its relative power in the funding and delivering health services bear directly on the outcomes of the sector and, together with other exogenous variables, on the health indicators of each country, department, or municipality.

Thus, a public sector that enjoys a high budget and high quality of care makes it possible for large sectors of the population, at all income levels, to have access to health services. This leads to the development of a relatively small private sector, but with a high level of complexity so as to differentiate itself from the public sector. The opposite example is the one presented in the preceding section, where the relatively low quality of the public service leads to the rise of a large private sector, with small-added quality differentials.

Similarly, the organization and characteristics of the private sector (for example, the ratio of profit to nonprofit institutional stakeholders) affects the structure of competition. Obviously, incentives generated by a market mostly organized as private insurance, with capitation payments, differ from those where health care is articulated through individual doctor visits and fees-for-service. Cross-subsidy and patient transfer mechanisms are also subject to the nature of the participating actors and institutions, where social health insurance mechanisms play an outstanding role.

On the basis of their organizational structure, the region's health systems may grouped under four health care models (Maceira, 1996.)

Integrated Public Model

The English-speaking countries of the Caribbean (Bahamas, Barbados, Jamaica, Trinidad and Tobago) and Costa Rica mainly constitute this group. In every case, the public system pools the largest share of funding, ownership of services, and health care coverage. Overall, these countries' coverage indicators are high, and their health indicators are satisfactory and above the regional average.

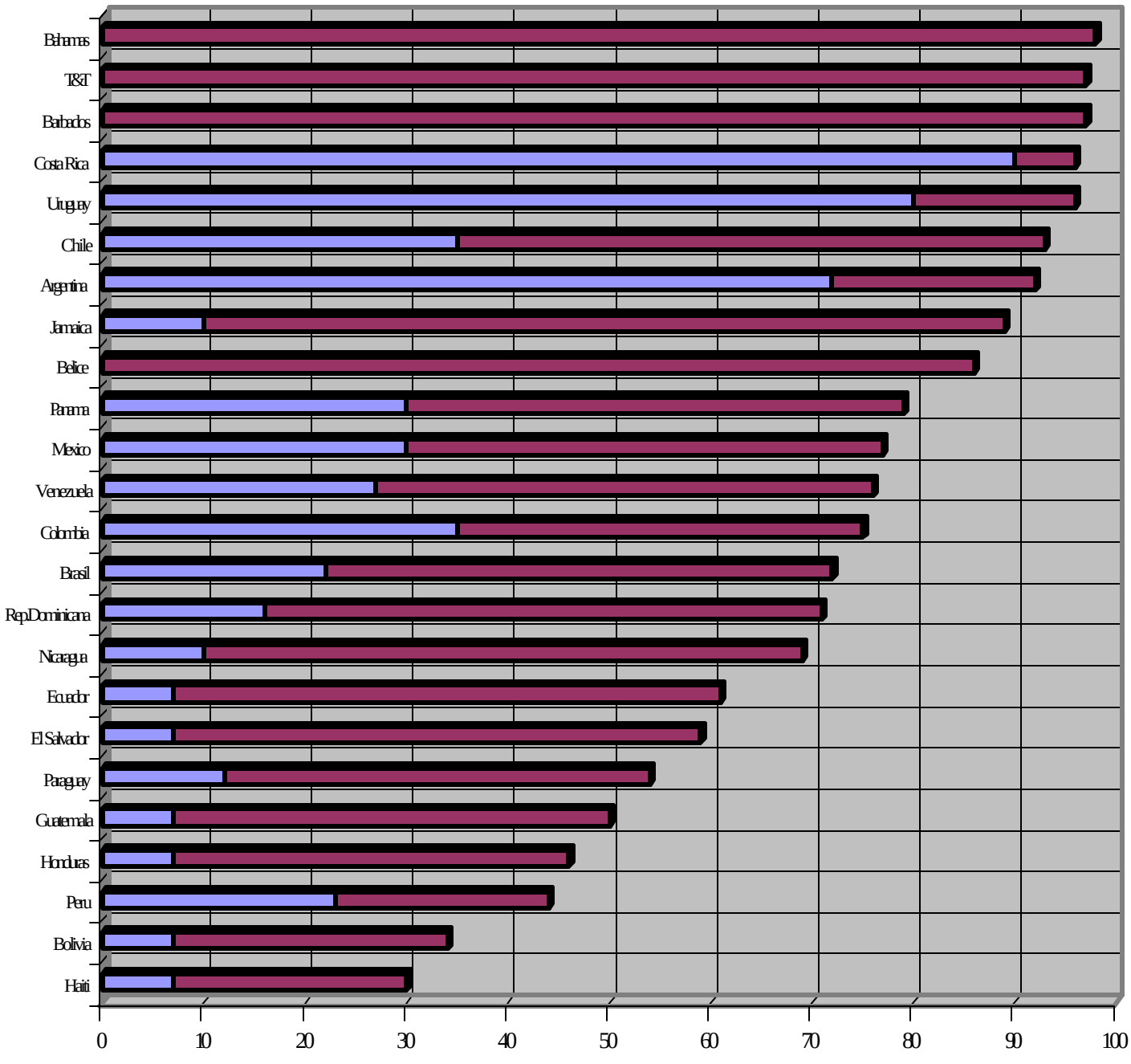
In terms of the organization of their social insurance systems, except for Costa Rica, they all have a social insurance system organized under the universal public care model, without an explicitly defined package of services. Costa Rica has a public sub-sector depending from the Ministry of Health, and a Social Security Institute (*Caja Costarricense de Seguro Social.*) Both institutions work in a coordinated manner, where the preventive and primary care is in charge of the public sector, and the more complex care in charge of the *Caja.*

Segmented Model:

Most Latin American countries are in this group, featuring a marked segmentation in the provision of health services. Three subsystems may be identified. Within the public sector, but acting with little or no coordination, are (1) the public subsystem dependent upon the Ministry of Health, with a large installed capacity, strong budget restrictions and low performance; and (2) the social security institute, providing coverage to formal, mostly urban workers. The third subsystem is the private sector, with low presence of private health systems, and mainly consisting of a network of individual physicians, drugstores, and other health care professionals.

In these cases, the social insurance system is concentrated in the social security institutes, which provide limited coverage (see Figure 1,) and in the public sector. Coordination mechanisms are limited and focus on cross-subsidy systems among institutions (cases of Mexico and Panama.)

Acceso a Servicios de Salud y
Participacion de los Sistemas de Aseguramiento Social



Public Model with Subcontracts:

Brazil is the only country in the region featuring a universal health service financed by the public sector, which provides health care through its own network of services and through others contracted out to the private sector. The *Sistema Unico de Salud* (Single Health System) provides theoretical coverage to all of the country's inhabitants and has a theoretical package of services. The private sector has approximately thirty-five million beneficiaries, mostly enrolled in private health insurance systems.

Contract-Intensive Model:

Four countries with markedly different health systems form this group: Chile, Colombia, Argentina and Uruguay.

Chile has a public sector that provides theoretical coverage to 60% of the population, with the remaining population participating in the private health insurance system or ISAPREs.

Colombia's system is similar to the Chilean one, providing 65% theoretical public coverage, and contributions being made to the private insurers system or EPSs. Unlike Chile, though, Colombia has a single contribution fund to EPSs which allocate resources on the basis of a basic benefit package adjusted by solidarity criteria.

Argentina and Uruguay have a large system of *Obras Sociales* and social security institutes coordinated through delivery subcontracts with the private health care subsystem. Coverage of social insurance systems is large (over 55% of the population,) and the public sub-sector has a theoretical coverage of approximately 30%. The private sub-sector is mainly financed through private health insurance and subcontracts with the social security subsystem

Based on this diversity of social insurance models in the region, the following subsections will delve more deeply into the main characteristics of each of them. Some examples of integrated public (Costa Rica) and segmented (Mexico) systems are presented along with descriptions of specific elements of the insurance systems in Bolivia, Surinam, Uruguay, Ecuador and Jamaica. At the same time, the cases of Argentina, Brazil, and Colombia are discussed as alternative social insurance models.

4.1 INTERMEDIATION AND REFORM IN THE OBRAS SOCIALES SUBSYSTEM IN ARGENTINA

The social insurance system in Argentina may be defined as one that provides large coverage, is segmented in terms of the number of participant funds, has a growing transfer of risk to providers, and a marked separation between the insurance and the provision functions. Legislation passed in the last few years tends to a system with a higher concentration of funds, and the generalization of a compulsory medical package financed by cross-subsidies between individuals of different income and risk. The self-managed hospital system, although incomplete, allows for a more effective billing of public services delivered to members of the *obras sociales*, thus reducing the subsidies of the past. However, the employment crisis cuts down the system's total source of financing, endangering the sustainability of this supply model.

Health service coverage in Argentina is shared between the public *Obras Sociales* sector and the private sector, with strong interrelationships both in terms of health service provision and the funding and coordination of social insurance. Approximately 6% of the population have health coverage on the basis of individual contributions to some of the 150 existing prepaid (*prepaga)* medical companies. In spite of the large number of companies in the market, only 10% of them cover 50% of the sub-sector's members.

The social insurance system –i.e. facilities dependent upon the Ministry of Health and social security institutions (*Obras Sociales*)– provide coverage to 93.8% of the population, according to the information supplied by the *Superintendencia de Salud de la Nación* (National Superintendency of Health – Table 1.) There are three types of social security institutions in Argentina: (1) *Obras Sociales Nacionales*, nearly 270 institutions organized by line of business, managed by workers' unions, and coordinated by a national institution (ANSeS,) (2) *Obras Sociales Provinciales*, 23 institutions whose members are the public employees in each province, and (3) PAMI (*Programa de Asistencia Médica Integral* – Integrated Medical Assistance Program,) focused on covering retired and pensioned individuals.

TABLE 2: COVERAGE BY SUB-SECTOR (1999)
IN MILLION OF PEOPLEAND % OF TOTAL

Obras Sociales Nacionales	11.6	32.8%
Obras Sociales Provinciales	6.8	18.1%
PAMI	4.2	11.8%
Prepaid	2.2	6.2%
Theoretical public coverage	11.0	31.1%
Total Beneficiaries	**35.8**	**100%**

Obras Sociales Nacionales (OSNs) are nearly 300 institutions defined by line of business, with a large dispersion in income and coverage. Thirty of them account for 5.7 million beneficiaries, i.e., 73% of the total, and 150 million pesos of the collection (75%.) In the last few years, total income for the group has increased, but its distribution has become more inequitable due to changes in relative salaries in the labor market and in employment levels in different industries. Until 1988, membership to the *Obra Social* was associated with the member's occupation, which prevented competition among institutions. At present, shifting membership from one OSN to another is allowed.

Its funding comes from a payroll tax, whereby the worker contributes 3% of his/her income and the employer 5%. Out of the total income from *Obra Social*, the *Administración Federal de Ingresos Públicos* (AFIP) withholds (1) 0.9% for a Solidary Reallocation Fund, managed by the ANSeS, whose function is to allocate resources more equitably among entities, and (2) the expenses incurred in benefits delivered to members of the *Obra Social* at public, self-managed hospitals.

The Reallocation Fund is used to cover the difference between the worker's contribution and the per capita payment of the *Programa Médico Obligatorio* (PMO - Mandatory Medical Program,) set at 40 dollars per month and member. Thus, the solidarity of the system and a minimum coverage are ensured. However, the ANSeS still maintains discretionary authority over the remaining subsidies (nearly 7 million dollars per month.)

The high level of member dispersion among *Obras Sociales* results in increased average administration costs. At the same time, managers of *Obras Sociales* seek to reduce the risk associated with macroeconomic variables. This leads to an increase in administrative costs and loading fees, and to a larger transfer of risk to providers. Given the levels of competition in the private health care market, it seems no longer efficient for *obras sociales* to maintain installed capacity. The reference price for health care within the OSNs' own facilities were replaced by usage review practices by the new risk managers. The end result was a 45% decrease in the number of beds and 25% decrease of facilities between 1980 and 1995.

TABLE 3: BEDS AVAILABLE PER ADMINISTRATIVE FACILITY (MINISTRY OF HEALTH, 1995)

YEAR	OFFICIAL	OBRAS SOCIALES	PRIVATE	MIXED	TOTAL
1980	91,034	8,045	46,611	-	145,690
1995	84,094	4,375	67,198	82	155,749

PAMI is the leading social insurance institution in the country, and therefore constitutes a strategic piece in the definition of contracts with and methods of payment to private health care providers and the pharmaceutical sectors. It operates not only in the area of health services, but also in recreation, geriatric and funeral assistance. Its funding comes from various sources: (1) active workers' and employers' contributions equal to 5% of the salary (3% and 2%, respectively); (2) contributions from pensioners, ranging between 6% and 3% of revenues, depending on whether or not contributors' exceed the minimum pension, and (3) contributions from the national treasury amounting to 20% of revenues. In 1995, PAMI was included in the national budget and ANSeS was authorized to manage its resources. By 1999, PAMI's expenditure –after interest on debts and payment of services rendered by self-managed public hospitals– amounted to $2.7 million, out of which a 70% was allocated to the delivery of health services. Out of this percentage, 76% was for subcontracted services, mainly through capitation payments.

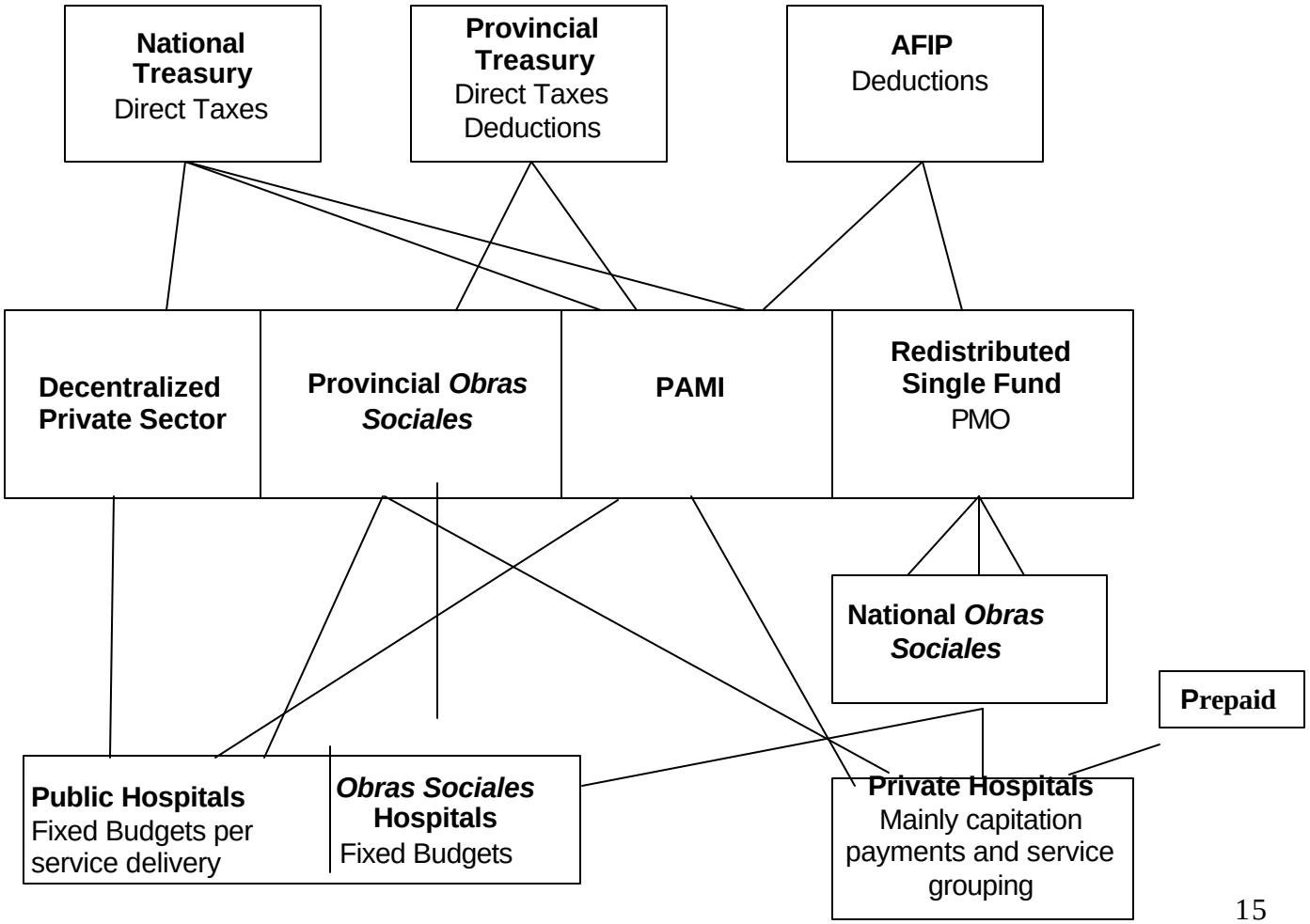
There is one ***Obra social provincial (OSProv*** – Provincial Obra Social) for each of the twenty-three provinces that provide health coverage to public employees in each jurisdiction. Together with PAMI, these institutions account for more than 50% of the financial resources of the provincial health services. Coverage levels vary from province to province. The lowest coverage level is in the Buenos Aires province, whose *obra social* finances the provision of 8% of the population, while this percentage exceeds 40% in Catamarca or Jujuy. On average, most *OSProvs* cover between 11% and 30% of the total population in their jurisdictions. Their sources of financing are public employees' salary contributions and the contribution from the province in its capacity as an employer. Thus, there are no coordination or joint management mechanisms among them. As state organizations, they are also the agents that withhold the employees' and employer's contributions per province. Since the latter depends on the budgetary planning of the relevant Finance Ministries, cash flows of *obras sociales* are subject to the individual government's financial imbalances and availability. For this reason, differentiated rate systems have been set up, which are presently applied in thirteen of the twenty-three institutions.

As compared with *Obras Sociales Nacionales*, up to date there is no generalization in risk transfer mechanisms to providers, whether in payment methods nor in the process of vertical disintegration in service delivery. By the beginning of 1995, however, one-third of contractual mechanisms were handled through capitation payments, and in many provinces the service grouping (similar to the DRGs in the United States) has become generalized. At the same time, the level of service intermediation is higher in public hospitals than among *OSNs*.

In conclusion, Argentina has an intricate network of health services, mostly financed by social insurance mechanisms. Together with public institutions, these provide theoretical coverage to more than 90% of the population. Even though funding comes mainly from salary contributions and tax contributions to the public treasury, these funds do not feed a single social insurance system, but are scattered between the PAMI fund, with solidarity contributions from active and passive workers, the provincial funds, 23 in all, and the *Obras Sociales Nacionales,* which are managed by the ANSeS on a centralized basis. Unlike most of the insurance systems in other countries of the region, in Argentina there is a marked separation between insurance institutions, whether *Obras Sociales*, prepaid or special funds, and the increasingly private sphere of service providers. The network of contracted out services is large, just as the variety of intermediary institutions, incentive mechanisms inherent to the contracts, and risk transfer systems, even within health centers.

FIGURE 2: SOCIAL INSURANCE IN ARGENTINA

Various Funds - Public decentralization - Network of private contracts



Box 1
Bolivia: Basic Health Insurance in a Segmented Care Model

Health coverage in Bolivia is spread out between the public sector, which serves nearly 25% of the population, the *Sistema Boliviano de Seguridad Social* (SBSS - Bolivian Social Security System,) whose theoretical coverage amounts to 15%-20%, and the (traditional and non-traditional) private sector.

The SBSS is organized into eight health funds and its financing and management structure is separated from the retirement and pension schemes. Out of these eight institutions, the main one is the *Caja Nacional de Salud* (National Health Fund,) covering 85% of the system's insured, who are mainly public servants. The social insurance system is complemented by the *Caja Petrolera*, *Cajas Bancarias Privada y Estatal*, *Caja de Caminos*, *Caja de Corporaciones*, *Seguro Universitario*, and *Corporación del Seguro Social Militar*. Each of these health funds has a captive population, based on the Code that regulates their inception since 1956. Together, they provide coverage to formal workers and their families, excluding farmers, miners, and micro-enterprise employees. All health funds are subject to the regulations of the Ministry of Health and to the supervision of the *Instituto Nacional de Seguro Social* (INASES - National Social Security Institute.) The Executive appoints INASES' authorities, just as those from the Caja Nacional and the Caja Petrolera. Likewise, the Social Security Code defines the health fund where employers must make their contributions, which amount to 10% of the workers' total salary. Each health fund is self-managed, collects its own contributions, manages its resources on a centralized basis, and delivers health care services by means of its own infrastructure and resources. These services include coverage for common illness, maternity, and short-term occupational risks. The level of service contracting out is very low.

Since 1994, with the People's Participation and Administrative Decentralization Acts, the National Government has launched a function redistribution process among the national, departmental, and municipal levels, which has not been completed yet. During this period, its main tool to increase health coverage has been the Mother-and-Child Insurance, presently the *Seguro Básico de Salud* (SBS - Basic Health Insurance.) SBS, together with the *Seguro Obligatorio de Vejez* (SOV - Obligatory Old-Age Insurance,) are the first steps towards an increased coverage through the coordination of actions between social security and the public sector. Services provided by the *Seguro Obligatorio de Vejez* and the *Seguro Básico de Salud* are delivered at facilities of both subsystem and the funds are allocated on the basis of a basic package of seventy-five interventions which, by means of a fee-for-service, reimburse payments incurred in delivering services to non-members, except for personnel payments. Thus, these health funds deliver a subsidy to the Ministry of Health equal to the unit cost in personnel per intervention, and at the same time pay 5% of their collections for health promotion and prevention tasks.

4.2 BRAZIL: UNIVERSAL PUBLIC INSURANCE WITH PRIVATE SUBCONTRACTS

The provision of health services in Brazil focuses mainly on two sectors: the public sector, formed by the Single Health System (SUS) and established as an universal coverage system, and the private sector, organized through health insurance plans. The latter, which is used by higher-income population groups (between 35 and 40 million people,) represented 5% of the GNP in 1995 and 4% in 1990 (65% and 60% of the total health expenditure, respectively.)

The SUS is linked to the Federal Government, which contributes nearly 65% of its resources, and is greatly decentralized among the 27 states and the municipalities, which contribute the remaining funds in equal shares. The Ministry of Finance collects the funds from the general revenues and appropriates the budget to the Ministry of Health through line items such as "social contributions" (71% in 1998,) the "fiscal stabilization fund" (13.3%,) and other regular resources. In the case of states and municipalities, main sources of income are consumer taxes and property taxes, respectively.

The Ministry of Health, in turn, allocates resources both at the state and the municipal level, through the National Health Fund, reserving part of them to cover expenditures of programs and services managed directly from the central echelon. The SUS resource allocation is made through two mechanisms. One is the transfer of a fixed per capita amount (10 *Reales* per inhabitant annually) to each municipality, in order to provide for basic outpatient care of the population, or *Piso de Asistencia Básica* (PAB - Basic Assistance Floor,) established on the basis of a set of specific health interventions. The fixed per capita amount has not been corrected for any indicator related with poverty levels, gender, or epidemiological patterns. In practice, the appropriation of per capita PAB funds is insufficient. Therefore, each jurisdiction needs to contribute its own funds in order to finance total coverage. This is a source of inequity, given that relatively poorer states and municipalities lack the differential resources to make up for the shortage of federal financing.

Furthermore, the central budgetary appropriation has a variable component, established on the basis of state projects or programs with "priority interventions" at the jurisdictional level. Examples of these are family care or basic medicine programs. These variable appropriations are aimed at generating decentralized incentives to carry out specific activities related to the needs of the population in each jurisdiction. The ultimate objective is to establish mechanisms aimed at reducing inequities in the delivery of health services among jurisdictions. However, there is a relationship between a decentralized proposal-making capacity and the relative development level of the state or municipality, whereas the capacity for designing and implementing programs is linked to factors such as the availability of managers and medical staff at the local level.

Each of the three levels (Federal Ministry, State and Municipal Health Secretariats) pays for the services delivered to the network of public facilities of each jurisdiction and to private providers. At present, and until the decentralization process is completed, states and municipalities are divided into those which are "fully decentralized" and those which are "not fully decentralized", each with different provider payment structures. In the case of fully managed municipalities, the decentralized authority is directly responsible for payments to public hospitals, PAB management, and the hiring and paying of private providers.

Conversely, in those cases which are not fully decentralized, also known as “basic care management”, municipalities receive the PAB component and payment to hospitals is channeled directly from the federal Ministry of Health.

Public provider payment is made by means of historical budgets, associated with equipment and number of beds, in the case of clinics and hospitals, and on the basis of a fee-for-service in the case of subcontracted private providers. The fee-for-service system of payment has been strongly criticized since the application of the SUS, mainly because it encourages over-utilization and over-billing of services. In addition, the per capita income received from the federal state, combined with the fee-for-service payment, leads to a risk concentration at the decentralized administration level.

The different contract structures within each jurisdiction, together with the flaws in certain control mechanisms, has led to risk selection by some private providers, who opt for referring those patients requiring costly interventions to public hospitals in the area.

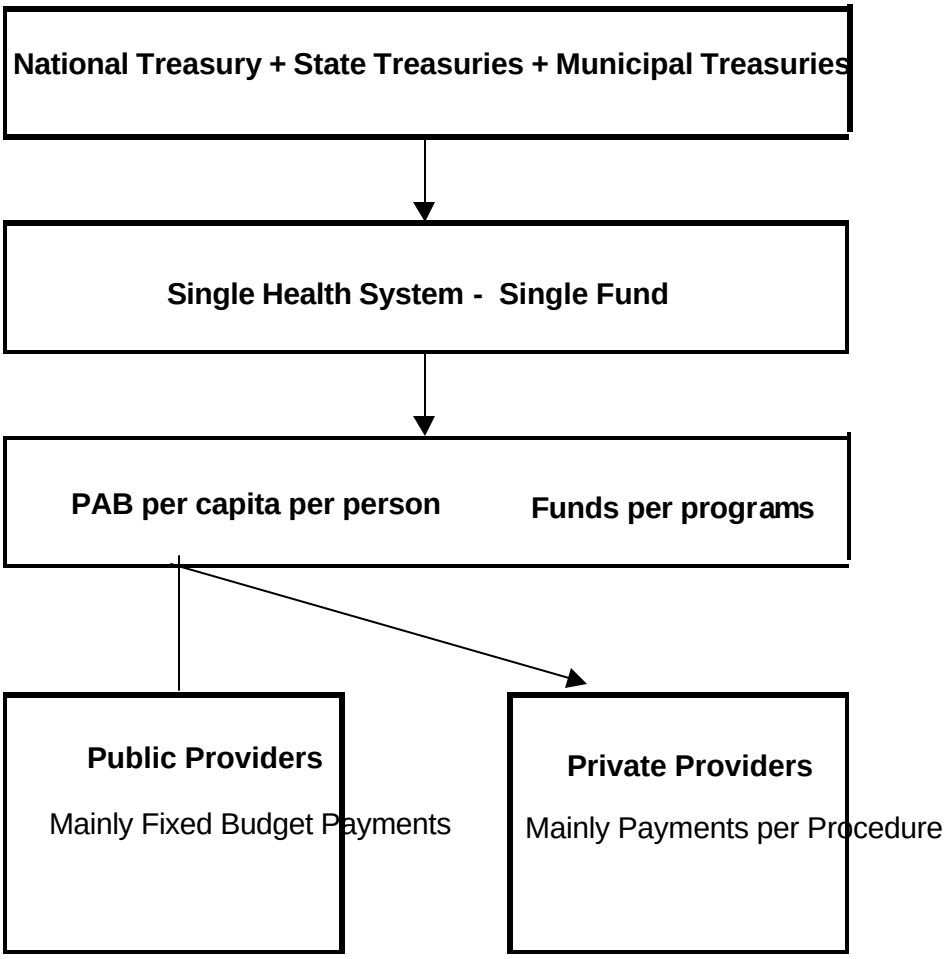
Coordination by the SUS is achieved through inter-management commissions for each management level. At the state level, there are bipartite commissions (CIBs) composed of state and municipality representatives, technical-political bodies in charge of defining the strategy for executing the decentralized activities. The 26 CIBs are represented in the Tripartite Inter-Management Commission, which includes members of the Federal Government. At the same time, consortia have been formed at the municipal level to organize specific local services, such as odontological services.

Finally, there are three monitoring and control instances. First, the Municipal Health Councils, in charge of controlling the expenditures of the Municipal Health Fund, an organism in charge of local management. Second, the state and municipal Accounts Courts and, finally, the directorate of Procedural System Control, which operates at the municipal level and is responsible for determining the applicability and effectiveness of the inpatient registration system.

In sum, the implementation of the SUS has created important achievements in terms of coverage, based on the development of an integrated, coordinated, locally managed network. However, there are still deficiencies in the narrowing of the equity gap in health care, whether measured among states and municipalities with different income levels, or among patients within each jurisdiction.

FIGURE 3: SOCIAL INSURANCE IN BRAZIL

One fund – Decentralization – Public/Private Contracts



4.3 CHILE: TARGETING AND THE ROLE OF THE FONDO NACIONAL DE SALUD

The organization of the Chilean social insurance system is based on two key institutions: the Ministry of Health and FONASA or *Fondo Nacional de Salud* (National Health Fund.) The former is the system's regulatory body, whereas the latter acts as a specific social insurance entity. A third institution, the Ministry of Finance is in charge of drawing funds for FONASA, and completes the group of public institutions in the social insurance system. In this way, and irrespective of the decentralization and/or fund de-concentration within the public subsystem, the Chilean model separates the funding functions (managed by the Ministry of Finance) from the delivery of services (managed by FONASA) and from regulation (managed by the Ministry of Health).

The health insurance system distributes the Chilean population into three large groups. The first group is comprised of those who can afford their own insurance and who opt for channeling their salary contributions to the private system pay into an ISAPRE (*Instituciones de Salud Provisional* – Prospective Health Institutions). These ISAPREs possess payment structures, benefits and regulations that are independent from the social insurance system. The second is made up of those who can afford their individual insurance, but decide to contribute to the public health insurance through FONASA. And finally, the indigent population, who theoretically is covered by FONASA and is not required to make direct contributions. This third group is financed through general revenues, following the general legal provisions for public sectors in the region. The direct subsidy from the second group, who contributes to FONASA, to the third, who is a net beneficiary of the system, is the central axis of the social insurance system in the Chilean model.

In relative terms, the social insurance system (FONASA and the public network of providers) provides theoretical coverage to nine million people (77% of the total population.) The private insurance system concentrates the remaining 23% of the population, out of which 70% are pooled in the three or four larger ISAPREs. The members of ISAPREs are made up of the higher-income and lower relative risk group: 70% of the population between 0 to 20 years old in the richer quintile is enrolled in an ISAPRE, whereas only 1% of the elderly (older than 65) in the poorest quintile contributes to this sector (Larrañaga, 1997).

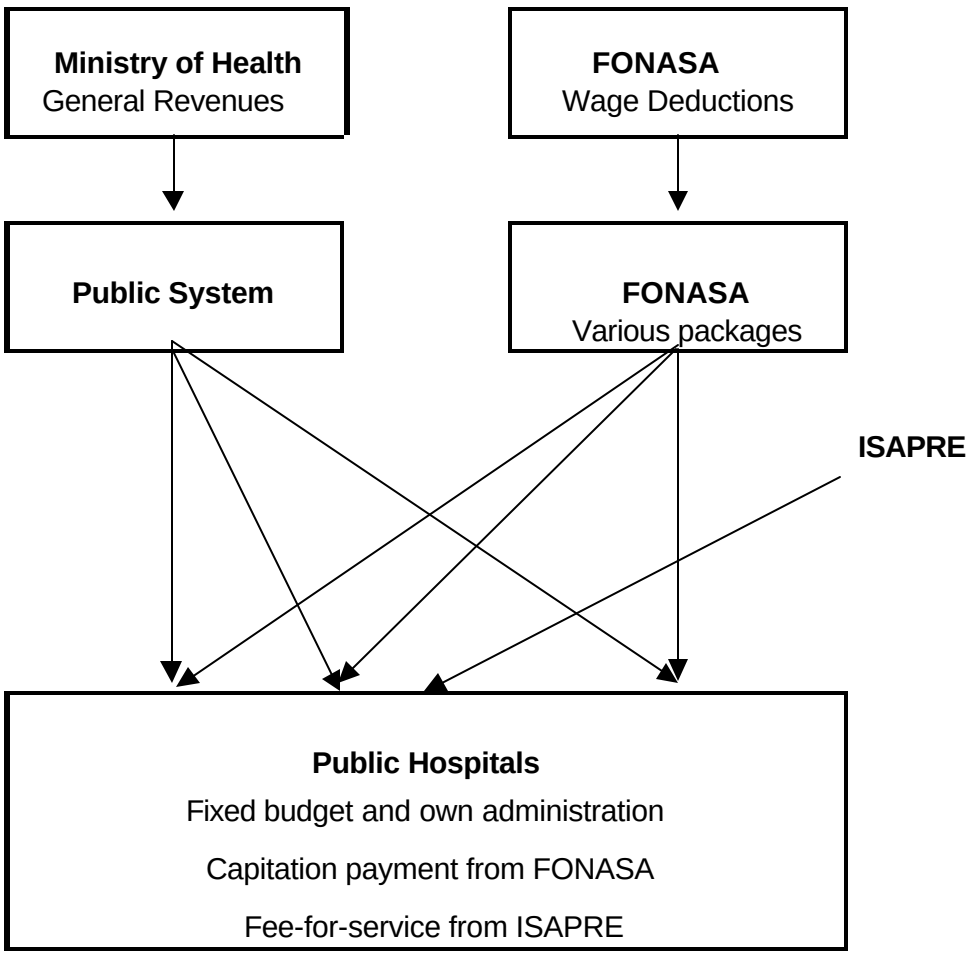
Concurrently, the organization of the social insurance system based on FONASA distributes the population into four groups: A, B, C, and D. Groups C and D are the system's net contributors, whose income exceeds the minimum set forth by the regulations. They pay the mandatory salary contribution and also a copayment or rate (fixed by FONASA's benefits vector) per service delivered. Patients are free to choose the health care provider, but differ in the proportion of the consultation fee they pay. For example, group D with the highest relative income pays 50% of the consultation cost, group C contributes 25%. Group B includes individuals whose income does not exceed the poverty line, but who contribute to the system on a mandatory basis. In these cases, there is no charge and they freely choose providers. These three subgroups (A, B, and C) are comprised of 2.5 million people, nearly 28% of the members of the social network. Finally, group A consists of indigent people, who are financed through the public budget plus the cross-subsidy coming from groups C and D.

Regarding the provision of services, groups B, C, and D, with differentiated rates receive health care through a network of public and private providers for both hospitalization and outpatient care. Group A, known as "institutional" by contrast to the "free choice" system, has access to both national and municipal public health institutions, both national and municipal. Paying a fee, they can choose to receive care at another facility in the network. Public hospitals depend directly on the Ministry of Health and are contracted by FONASA for furnishing services in the social insurance network. These institutions are paid by the public network out of an appropriated budget, plus the income arising from the collection of charges from private patients. These changes are generally paid on a per-service basis.

The Chilean system, though segmented, has proved to be capable of increasing cost-effectiveness by targeting its approach on groups and interventions, combined with the division of funding, provision and control tasks. At present, a more administratively decentralized system is under study, which incorporates alternative performance-related systems of payment.

FIGURE 4: SOCIAL INSURANCE IN CHILE

Public Fund – Hospital Decentralization – Private Insurance



Box 2
Role Division in Surinam's Social Insurance System

Surinam's health sector organization is based on the separation between financing agents and health care service providers. The sector's main financing agents are the Ministry of Social Affairs and Housing, which provides coverage to the population accredited as poor (42% of total population); the State Health Insurance Fund (SIF), which covers 35% of the population (45% of public employees, or approximately 22% of total population, plus their direct relatives) and *private enterprises* (20% of total population,) who pay for their employees' health care. The main health care providers are: the *Public Health Office* dependent on the Ministry of Health and the main institution in charge of health care through various family-health and disease-control programs; the *Regional Health Service*, a semi-private institution subsidized by the Government that provides primary health care to 34% of the population; the *Medical Mission*, a group of religious NGOs designated by the Ministry of Health to deliver medical assistance in the country's rural areas (12% of the population;) and *private practice*, mainly serving private sector workers (and their direct relatives) registered in trade unions and who are insured by their employers through collective bargaining.

Public sector workers pay 4% of their salaries to the SIF, while the government contributes another 5%. Additional revenue comes from taxes to subsidize the SIF. Insured workers and their families only incur in minimal expenses for buying medicines. The SIF' benefits package includes both preventive and curative health services. The private sector's insurance plans feature similar benefits, and workers must contribute between 2% and 3% of their salary.

The payment policy set forth by HIF largely determines the practices followed by the system's other financing agents. HIF pays general practitioners a fixed monthly amount per each registered person, while specialists are paid on a fee-for-service basis. Even though since 1995 these amounts are adjusted annually on the basis of cost studies, it has not been possible to avoid excess referrals to specialists. On the other hand, neither do reimbursements to hospitals contribute to control costs: both the Ministry of Social Affairs and the State Health Insurance Fund pay on a per diem basis, thus encouraging longer hospital stays.

HIF operates as a passive financing agent, rather than as an insurance fund that groups and manages risk. The largest share of the HIF expenditures corresponds to hospital reimbursements for medical consultations (37% of the total,) 17% corresponds to medicines, while payment to medical staff involves another 30% of the budget.

On the other hand, the main health care service provider –the Regional Health Service– is undergoing a restructuring process. This restructuring includes administrative and budgetary decentralization to district health centers, and community participation through local and regional health councils.

4.4 SOCIAL INSURANCE IN COLOMBIA: SOLIDARITY FUND AND PRIVATE INSURANCE

The health sector reform in Colombia at the beginning of the '90s involved the search for options for the *lack of universality*, evident in the population's insufficient health coverage protection; the *lack of solidarity*, reflected by huge differences in the resources appropriated to various population groups with different health needs; the *lack of efficiency*, reflected in its institutional organization, deficient outcomes in relation with the sector's total expenditure, and growing user dissatisfaction; and *lack of participation and commitment* of *departments and municipalities* in the health management. These were the conditions that drove the transformation of the National Constitution in 1991 and the passing of Act 100 in 1993.

The social insurance system with different actors assuming overall leadership for different system functions as follows:

- Management, Regulation and Control- Exerted at the national level by the Ministries of Health and Labor, the *Consejo Nacional de Seguridad Social en Salud* (CNSSS - National Social Security Health Council) and the *Superintendencia Nacional de Salud* (National Health Superintendency), and at the territorial level by the Health Directorates and departmental, district and municipal *Consejos Territoriales de Seguridad Social en Salud* (Territorial Social Security Health Councils.)

- Management and organization- *Empresas Promotoras de Salud* (EPS - Health Promoting Enterprises,) *Administradoras del Régimen Subsidiado* (ARS - Subsidized System Administrators) –which may be the EPS–,*Empresas Solidarias de Salud* (ESS – Solidary Health Enterprises,) and *Cajas de Compensación Familiar* (Family Equalization Funds) are responsible for the enrollment, member registration, and collection of contributions. They may be public, private, or mixed, and compete with each other for the enrollment of the population.

- Provision of Care- Performed through the *Instituciones Prestadoras de Servicios de Salud* (IPS - Health Service Provider Institutions).

- System Financing- Resources are managed through the *Fondo de Solidaridad y Garantía* (FOSYGA,) made up of four sub-accounts: compensation, solidarity account, health promotion account, and catastrophic risks account.

The system consists of the contribution and subsidized system. The contribution system is managed by the EPSs and regulates enrollment of individuals and their families by means of a contribution that is directly financed by the member or jointly with his/her employer.

The subsidized system is managed by entities authorized by the *Superintendencia Nacional de Salud* (EPS, ARS, ESS, and *Cajas de Compensación*). It regulates enrollment of individuals to the Sistema General de Seguridad Social en Salud (SGSSS), by fully or partially subsidizing the contribution either with fiscal resources or with monies from FOSYGA's solidarity subaccount to finance the health care for those people and their family groups who cannot afford the dues. The population who cannot afford to pay and has been

unable to enroll through the subsidized regime (related population) is entitled to the health care services provided by public institutions and those private ones under State contract.

The SGSSS provides benefits to persons in order to maintain or recover health through the following plans:

- *Plan Obligatorio de Salud* (POS - Mandatory Health Plan)- Includes health-promotion, disease prevention, disease care in general, diagnosis, treatment and rehabilitation, and the provision of essential drugs, as well as the grant of an economic subsidy for temporary disability resulting from diseases in general as well as maternity. There is a set of resources available to finance the POS; to that end, the CNSSS (*Consejo Nacional de Seguridad Social en Salud*) determines the capitation payment (*Unidad de Pago por Capitación*- Per Capita Payment Unit) applicable to each beneficiary in the system.

- *Plan Obligatorio de Salud Subsidiado (POSS* - Subsidized Mandatory Health Plan*)* – A plan targeted to the population that cannot afford to pay and therefore subsidizes the premium. This plan initially provided 50% of the benefits provided under the POS but has gradually increased to equalize the benefit level. Membership includes family coverage.

- *Plan de Atención Básica (PAB)* – Covers services that focus directly on the community and on individuals, but with a great deal of externalities. Services are free and mandatory. It is financed with fiscal resources, both from the National Government and the territorial entities responsible for delivering them.

- *Planes de Atención Complementaria (PAC* - Complementary Health Care Plans*)* – They consist of pre-paid contracted services and are offered by the EPSs. PACs include actions and activities that are not included in the POS.

- *Atención en Accidentes de Tránsito y Riesgos Catastróficos* (Traffic Accident Care and Catastrophic Risks) – It provides medical-surgical services, indemnity for permanent disability and death, funeral expenses and transport to a medical institution, natural catastrophes, and other events approved as such by the CNSSS, which are financed by the FOSYGA.

- *Atención en Accidentes de Trabajo y Enfermedad Profesional (ATEP* – Care for Occupational Accidents and Diseases*)* - Guaranteed by the *Entidades Administradoras de Riesgos Profesionales* (ARP - Occupational Risk Administrating Entities) and delivered by the EPS where the worker is affiliated.

There are approximately 8,504,000 members affiliated under the subsidized system (equal to 20.9% of the total population) and approximately 15,954,000 through the contribution system, equal to 39.1% (including contributors, beneficiaries, and additional dependent beneficiaries.) On the basis of the total population, it is deemed that approximately 40% of the Colombian population are affiliated to the SGSSS.

Since the enactment of Acts 10/91 and 100/93, funding has been strengthened by the creation of the following sources of financing:

- *New Central Government subsidy*, calculated on the basis of the Nation's current income (tax and non-tax); it is appropriated to departments and districts for direct health care, or channeled through the municipal health and education services.

- *Municipal participation in the nation's current income (ICN;)* the Act sets forth a floor of 14% in 1993 and a ceiling of 22% for 2002. Municipalities must focus these resources on social investment. Out of the total ICN received by municipalities, 60% is aimed at funding the subsidized system and 40% at reinvestment.

Since the reform, it was assumed that the inception of the EPSs would put an end to monopolies in the enrollment process and to the separation between the financing and service provision systems. However, the EPSs are not deploying competitive contracting or negotiating processes to induce competition in fees or quality. Currently, the main payment methods to physicians and hospitals are still fee-for-service, capitation (at the primary care level,) fixed salaries, and in some cases, a premium paid to general practitioners who refer patients to other health care levels. The *Instituto de Seguros Sociales* (ISS - Social Security Institute,) the largest EPS in Colombia, was the first one to introduce "diagnosis package" payments to hospitals in lieu of fee for rendered services. Another problem that continues to exist despite the reform is the lack of technical studies to determine the standard cost of health care, and for that reason IPSs must resort to their own cost accounting to fix the amount of payments.

As can be noted, the Colombian social security health system has two large interdependent components: insurance and territorial management. Colombia's joint decentralization and insurance process gives geographic municipalities the responsibility for health management at the local level, guaranteeing public health and monitoring the quality of services and their impact on the population's health. Municipalities also have autonomy in the organization of services and the provision of health care for indigent people. However, there still remain restrictions in the financial area (for example, decision-making in expenses and setting fees) and in human resources. This latter aspect relates to the fact that the municipality can hire medical staff, but not dismiss them, because they are public servants.

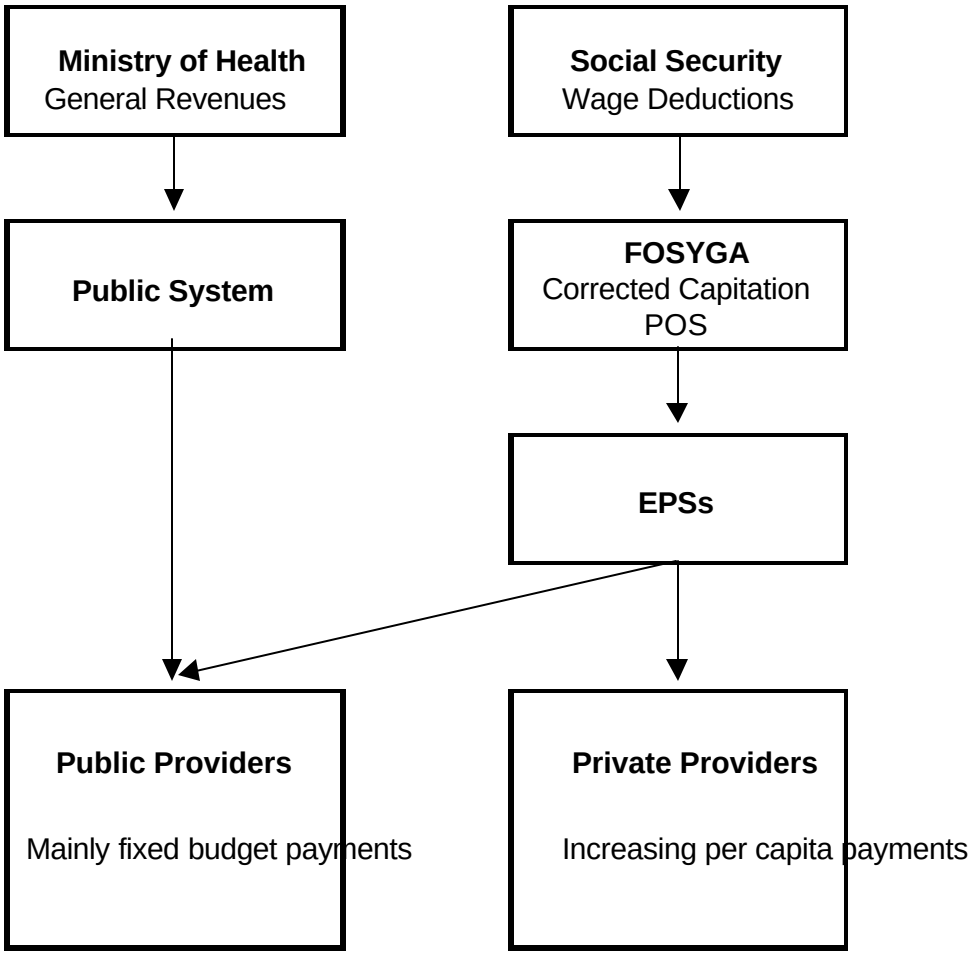
Departments on the other hand, are responsible for coordinating the health actions of their municipalities for participating in health service quality surveillance, and for providing technical assistance to facilitate compliance with public health care obligations. Their autonomy is also limited with regards to human resource management. However, they are much more autonomous from a financial perspective, to the point that most of the decisions about service organization and coordination with other sectors are made by departmental authorities.

There are, however, problems in the management of the new health system due to the great number of rules, requirements, and procedures that make it less transparent and more complex. Among them, the following are worthy of notice: lack of incentives to stimulate accreditation of departments and municipalities as decentralized entities; improper management of non-members, particularly of the poor, and strong restrictions on the health workers' market. This means that in such critical aspects as labor linkage, motivation, work conditions, and formative supervision, the EPSs lack autonomy to make modifications and, consequently, to improve their personnel's productivity and the quality of care provided to their beneficiaries.

Nevertheless, the EPSs have implemented mechanisms to control medical quality through regular visits to the IPSs, which requires auditing medical records and interviewing patients. Likewise, some EPSs require that IPSs report on the quality of the services they deliver.

FIGURE 5: SOCIAL INSURANCE IN COLUMBIA

Solidarity Fund – Private Insurers



4.5 INSTITUTIONAL COORDINATION IN COSTA RICA'S SOCIAL INSURANCE SYSTEM

Costa Rica illustrates how an average income Latin American country is able to design and manage an equitable and cost-effective social insurance system with a per capita expenditure in health care which amounts to only 6% of that of the United States yet with resulting health status levels comparable to higher income countries.

The Costa Rican health system consists of the following: Ministry of Health, *Caja Costarricense de Seguro Social* (CCSS-Costa Rican Social Security Fund,) *Instituto Nacional de Seguros* (National Insurance Institute,) *Instituto Costarricense de Acueductos y Alcantarillados* (Costa Rican Aqueduct and Sewage Institute,) and Health Faculties of the *Universidad de Costa Rica.* Its health care model, developed in the '70s, went through four stages that were decisive for building the health system of Costa Rica: (1) the adoption and application by the Ministry of Health of the primary care strategy in the development of the *Programa de Salud Rural y Salud Comunitaria* (Rural Health and Community Health Program,) (2) the development of the *Programa del Hospital Sin Paredes* (No-Walls Hospital Program,) (3) the universalization of the Social Security, and (4) the transfer of hospitals to the CCSS.

In order to meet the population's health requirements, and given the shortage of economic resources coming from the public sector, significant steps were taken in the delivery of health services, such as developing the service integration process between the Ministry of Health and the CCSS, and the development of the *Sistemas Locales de Salud* (SILOS – Local Health Systems,) among others. In the context of the sector's reform, the Ministry of Health assumes a governing role, with the strategic functions of preventive care, management, control, and regulation; the CCSS takes charge of service delivery.

CCSS theoretically covers 100% of the population. At present, 90% of the population is insured, and the rest is covered by the State. Total enrollment (contributors + beneficiaries) amounts to 3,284,100 inhabitants. The CCSS provides services to the contributors' families. It is estimated that 50% of the covered population is urban, while 80% are formal workers.

There are cross-subsidies among institutions within the health system. An example is the *Caja al Instituto Nacional de Seguros* (INS - National Insurance Institute Fund,) responsible for insuring the workforce against occupational and traffic accidents. The insurance policy covers accidents and the CCSS finances medical attention.

Organization and Operation of the CCSS

The CCSS consists of a central level in charge of the institutional policies, a regional level consisting of seven regional medical care directorates, and a local level constituted by health areas and sectors. The CCSS has a listing of contributors and beneficiaries who may request medical attention. However, it has not defined a basic package of services that is explicitly known and available to each enrollee. Instead, it set up preventive care service programs for key groups: pregnant women, children up to 5 years, teenagers, the elderly, etc. Likewise, vaccination programs are included in the operation of the primary care network.

Funding of illness and maternity insurance comes from three sources of mandatory contributions of mandatory percentages on workers' salaries as follows: employers (9.25%,) the State (0.25%,) and workers (5.5%,). Other contributions are resources from the *Instituto Costarricense de Acueductos y Alcantarillados*, whose revenue comes mainly from the sale of water supply services. In the case of voluntary enrollees, workers contribute 13.25% and the State 0.25%. The indigent are covered by the State through a direct amount that is transferred to the Fund.

The collection is decentralized (enterprises pay their workers' percentage, whereas voluntary contributors pay at banks,) but is concentrated in a single fund run through the CCSS' Financial Management Office. Resources are appropriated by means of one budget per line item, based on budgets prepared by each hospital and health area and subsequently negotiated at the CCSS.

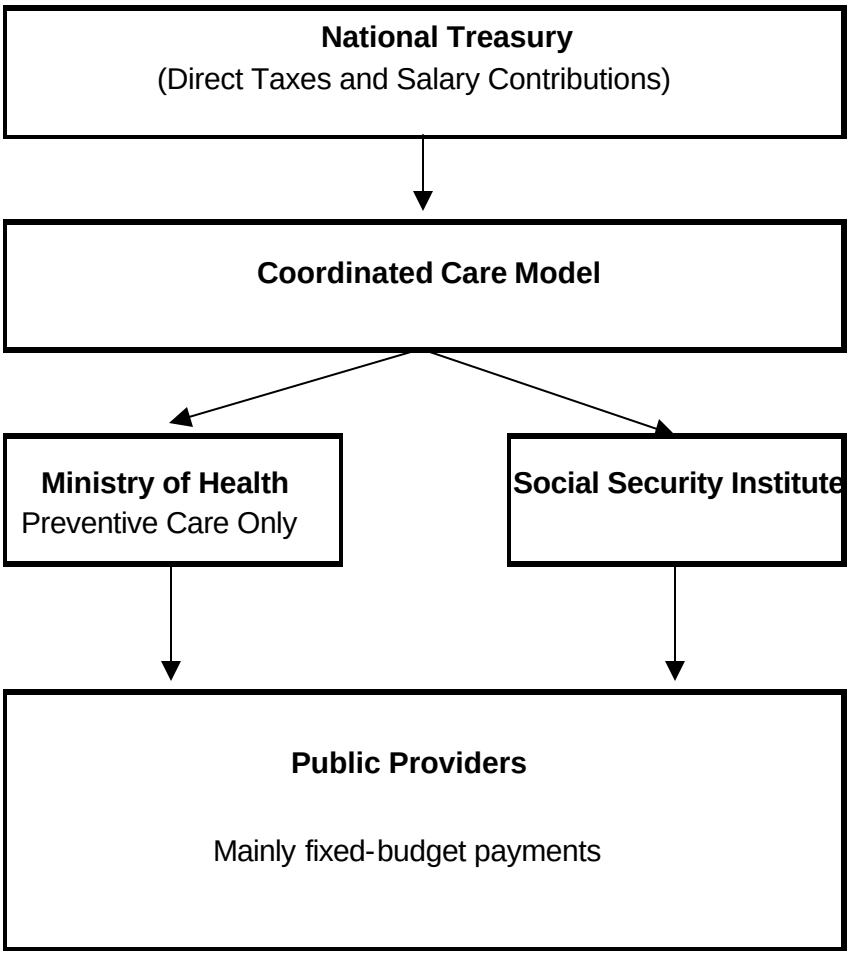
Recently, the Fund has introduced a resource allocation model whose main purpose is to promote a readjustment of health care levels based on health requirements and demands. This resource allocation model features an operational tool that works under a contractual logic called "Commitment to Management". Hospital budgets associated with given performance criteria are being implemented to some extent through this mechanism, although it is estimated that only 2% of the total hospital budget is allocated to this incentive. Instruments such as prospective payment per case, or capitation payments, are also under development for the primary care level. At the same time, the level of services contracted out is low, not exceeding 5% of the budget.

Concurrently, the CCSS has implemented two outpatient programs: *Medicina Mixta* (Mixed Medicine – whereby the patient pays the fees to the physician and the CCSS provides the medicines and laboratory tests,) and *Medicina de Empresas* (Enterprise Medicine – whereby the enterprise pays the physician's fees and the CCSS covers the medicines and support services.)

To date, provincial and municipal authorities have no decision-making authority on hiring or dismissing hospitals' directors. Likewise, contracting out private services requires the approval from the central echelon. With the enactment of the *Ley de Desconcentración* (De-concentration Act,) which grants instrumental corporate existence to various establishments, it will be possible to implement this procedure without the approval from the central echelon. Based on this project, procurement of supplies and equipment, and the management of human and financial resources are expected to become decentralized.

FIGURE 6: SOCIAL INSURANCE IN COSTA RICA

One fund – Minsalud & ISS Coordination



Box 3
The Social Insurance System in Uruguay and the Role of the Private Sector

The public sub-sector of the Uruguayan health system includes the facilities dependent on the Ministry of Public Health delivered through the *Administración de Servicios de Salud del Estado* (ASSE - State Health Service Administration,) which provides health care to the lower-income population (28% of total population) and to the *Universidad de la República* through the *Hospital de Clínicas* (Clinical Hospital.) The latter completes its medical services with those from other public entities and autonomous bodies (*Banco de Previsión Social* (BPS - Social Security Bank) –which is the organism in charge of planning, coordinating and managing social security for a wide sector of workers from the formal sector of the economy–, and the *Banco de Seguros del Estado* (BSE - State Insurance Bank) –which covers occupational diseases and occupational accidents of workers covered by the *Dirección de los Seguros Sociales de Enfermedad* (DISSE - Directorate of Social Insurance against Illness)– and the municipal health care services.

Out of all the public and private health sector institutions, however, the most important ones are the collective health care institutions (IAMC,) which deliver health care to nearly 55% of the country's population. The IAMCs are private, non-profit institutions that provide medical assistance services through pre-paid health insurance. They may be of different types: medical assistance associations, professional cooperatives, or medical assistance centers. At present, the prevailing type of organization has become consolidated around professional cooperatives. Workers in the formal sector of the economy subscribe through DISSE to a mandatory insurance against illness which enrolls them in the IAMC of their choice, but without covering their dependent beneficiaries. Family members of those enrolled in the public or private system may also enroll on an individual basis. Thus, the incidence of social insurance in the IAMCs' operation is significant, given that nearly 50% of their enrollees are channeled through this institution and the State fully assumes the role of an intermediary between the service provider and the user.

IAMCs are mainly financed by means of workers' and employers' contributions, and to a lesser extent by means of copayments/charges. Currently, there are fifty-two IAMCs with their own collection system. Although there are no cross-subsidies among these institutions, there is a cross-compensation mechanism with the *Fondo Nacional de Recursos* (National Resource Fund.) This is the agency responsible for collecting and managing resources to pay services delivered by highly specialized medical institutions (IMAEs). This is also the agency that receives contributions from IAMCs to cover health care for their members in such specialty areas as cardiovascular surgery and kidney transplants. The *Fondo Nacional de Recursos* also receives contributions from the ASSE – which is empowered to subscribe agreements with the IAMCs to partially or fully use their facilities.

4.6 SOCIAL INSURANCE IN MEXICO: SEGMENTATION IN FINANCING AND PROVISION

The organization of the Mexican health care system is closely associated with the formal sector of the economy. Private sector employees, self-employed workers, the public sector and State enterprise workers are covered by different institutions that are financed by contributions from employees, employers, and the State. A small segment of the population resorts to private health care and the remainder (more than 40 million people) resort to the facilities of the *Secretaría de Salud* (Ministry of Health) and to the social security system, operated by the ministry in given regions of the country.

There are 5 institutions within the social insurance system: *Instituto Mexicano de Seguridad Social* (IMSS, Mexican Social Security Institute), *Instituto de Servicios de Seguridad Social para Trabajadores del Estado* (ISSSTE - Social Security Services Institute for State Workers,) *Servicios de Salud de la Secretaría de Defensa* (SEDENA - Ministry of Defense Health Services,) *Servicios de Salud de la Secretaría de la MARINA* (Ministry of the Navy Health Services,) and *Servicios de Salud para los Trabajadores de Petróleos Mexicanos* (PEMEX - Health Services for Petroleos Mexicanos' Workers.) Each of these institutions has its own collection system. In the case of SEDENA and MARINA, both receive resources from an intermediary, ISSFAM (Public Finance Account.)

Instituto Mexicano de Seguridad Social (Mexican Social Security Institute)

The IMSS has a defined register of beneficiaries that includes all contributors plus their families. The total population enrolled is currently estimated at approximately 45 million people, out of whom 80% live in urban areas and 95% are formal workers. Health services offered by the IMSS are dependent on the availability of facilities and there is no defined basic package of services. Until 1995/96, the most important sources of financing of the IMSS were families and enterprises (wage deductions + employer's contribution.) But federal and state contributions have increased by approximately 30% since 1997. There are no copayments in place.

The IMSS has a centralized collection system and there are few cross-subsidies with other social insurance institutions. Overall, there is no transfer of funds; the enrolled population simply seeks the services delivered by another institution. The only exceptions are transfers received by the IMSS from the ISSSTE in payment of substitute services. As of 1995, the IMSS agent allocated 96.6% of expenditures to the IMSS and 3.4% to the private sector.

In 1995, the IMSS' pattern of expenditure by type of service was as follows: curative care 74.3%, administration 16.6%, and preventive care 4.8%. The IMSS' pattern of expenditure by budget line item was as follows: personnel 48%, general services (maintenance and repairs, basic administrative services, advisory services, banking and commercial expenses, etc.) 36.6%, materials and supplies (including medicines) 12.4%, and investment in infrastructure 3.2%.

The Health Sector Reform Program launched in 1995 sets forth the system's reorganization, so that (1) the Ministry of Health may play a governing and normative role, (2) health care for the general population may be integrated and coordinated, and (3) the

IMSS may separate the financing and service provision functions to introduce competition among service providers, with greater transparency to the system. The reform also proposes:

- free choice of physicians by social insurance beneficiaries- based on this, professionals would receive a bonus depending on the number of people who register in their practices;

- creation of a family insurance by the IMSS for the voluntary enrollment of individuals who can afford to pay;

- transfer of health care services for the open population to federal entities;

- increased municipal participation in health through the healthy municipalities program;

- expansion of coverage by means of a basic package of health services (PBSS) consisting of 75 health actions grouped into 12 basic interventions, aimed at the population with limited or no access to health services in rural areas;

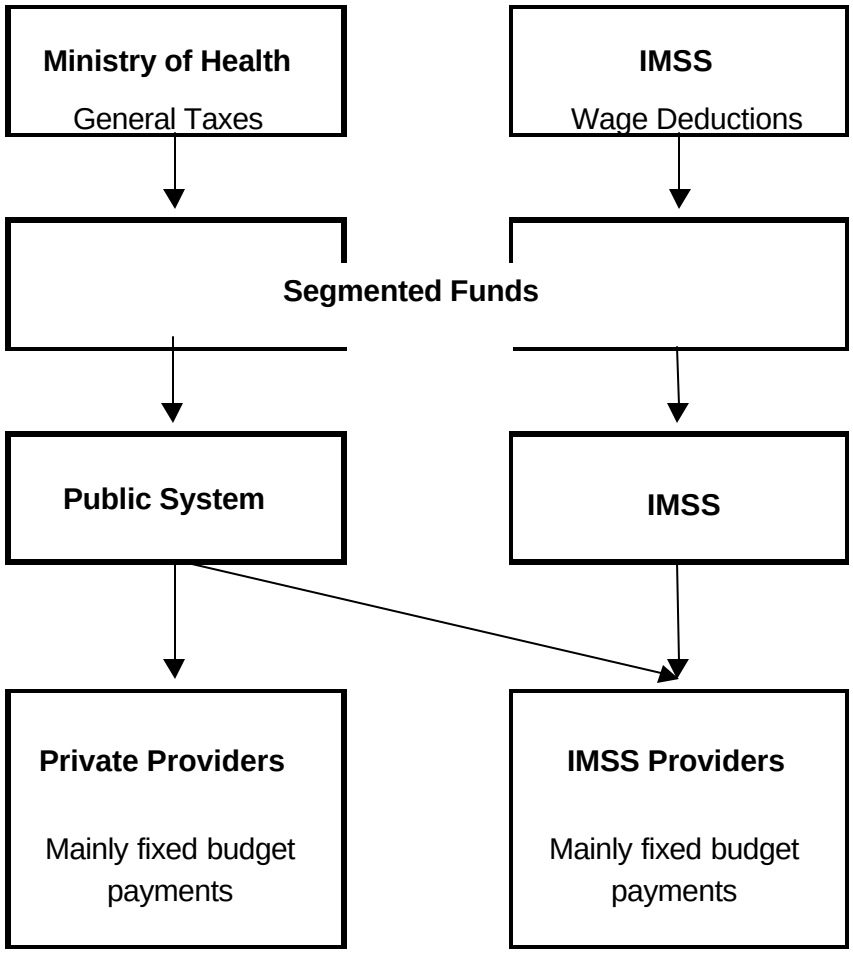
At the present time, most of the utilized facilities belong to the IMSS and the payment method to hospitals and professionals is fixed. Given that very few services are contracted out to private entities, there is no frequently used external monitoring method. In the case of the public sector dependent on the Ministry of Health, the *Dirección de Evaluación y Seguimiento del Ministerio de Salud* (Ministry of Health's Evaluation and Follow-up Directorate) does not monitor the performance of IMSS services. On the other hand, the IMSS conducts regular customer satisfaction surveys among its users.

Neither state authorities nor municipal authorities have decision-making power over the hiring or dismissal of hospital directors, or in contracting out services. Hospital directors, in turn, have limited power with hiring or dismissing personnel and with contracting out services. The IMSS is currently implementing 139 de-concentrated medical areas (which do not overlap with the states,) where resources will be allocated depending on their population. Thus, institutions will be able to use their own resources and to subcontract private services.

The most frequent problems affecting the IMSS have to do with the quality of primary care. Because of the lack of definition of a basic package of services, there are waiting lists for surgical interventions, and other specialty services such as dialysis. In the case of secondary and tertiary care services, the problem is noticeably smaller.

FIGURE 7: SOCIAL INSURANCE IN MEXICO

Various Funds – Segmented



Box 4
The Rural Insurance Experience in Ecuador

The social health insurance scheme in Ecuador is mainly based on institutions that depend on the Ministry of Health (MOH,) and on the *Instituto Ecuatoriano de Seguridad Social* (IESS - Ecuadorian Social Security Institute.) One of these institutions, the Seguro Social Campesino (SSC - Rural Social Security) has its own budget and is autonomously managed. From its inception in 1968, the purpose of the SSC was to provide primary health care to Ecuador's rural population through a solidary financing system. In 1999, the number of beneficiaries amounted to 900,000, or approximately 20% of the country's rural workers.

Out of an annual budget of nineteen million dollars for 1999, ninety percent of financing comes from solidary contributions of formal workers (1% of their total salary.) Rural contributions reach only 2.4% of all available resources, while the remainder is covered by other income or grants.

SSC's method of attracting members is not a classic system of mandatory contributions of formal urban workers, as in the case of the IESS. On the contrary, the rural population gathers together and applies for enrollment in the insurance network. The unit of contribution is the family rather than the individual. SSC requirements are that applicants "live and work in the countryside", are not landowners or are dependent employees. Once the application for enrollment has been submitted, the SSC authorizes the construction of a health delivery unit on behalf of the SSC provided that three conditions are met: (1) there is at least an eight kilometer-distance to any other health unit of the same or higher level of complexity, (2) it should serve at least 1,200 people, and (3) there is a permanent access road from the IESS' administrative unit. At the present time, the SSC has 575 health units with these standard characteristics throughout the country. They only provide basic health care and medicines out of a list of ninety-seven drugs. Physicians receive a base salary for a six-hour working day, and each of them regularly works at more than one health unit, with bonuses for rural work and mobility. SSC beneficiaries are entitled to use the more complex health units hold by IESS in urban centers, and the SSC need not make any disbursements for those services. However, referrals to private services that are contracted out by the IESS, include a fee-for-service.

Box 5
Social Insurance in the British Caribbean: The Case of Jamaica

The Jamaican social health insurance system is defined on the basis of a universal coverage model, organized through a single system dependent on the Ministry of Health. This organization receives the funds from the Ministry of Finance, which are obtained by means of direct taxes from enterprises and individuals (33% and 27% of total sector revenue, respectively,) and from indirect taxes (15%.) Approximately 20% come from grants and 10% from cost-recovery mechanisms (payments.) Just as in other countries in the British Caribbean and unlike most Latin American countries, Jamaica does not have a social security institute. Thus, the solidarity of the social insurance system depends on the regressivity or progressivity of the tax system and on the fund appropriation mechanisms for health care. Furthermore, the system has no defined basic health care package, nor does it have patient targeting criteria as a function of income levels, gender, or geography.

In accord with the 1997 regulatory framework, the delivery of services is organized through four regions, each of which is subordinated to decentralized health authorities. Payment of salaries –as well as the investment policy– depends directly on the Ministry of Health, whereas the regional parties in charge have the power to allocate funds among hospitals, purchase medicines, and recommend the dismissal or hiring of medical staff. Furthermore, the regional level is authorized to contract out services, even though this modality of public-private cooperation is not frequent in the country. Resources of regional offices mainly come from ministerial line items. There is a generalized hospital payment pattern for all regions, which aims at matching ten percent of the budget received from the Ministry. In order to prevent risk selection by hospital authorities, however, any income from this source that exceeds the 10% threshold is automatically deducted from the budget appropriation. Conversely, a lower collection than the threshold results in a decreased financing capacity by the provider.

Concurrently, Jamaica features a growing system of private insurance, independent from the social insurance system. Insurance companies receive resources from specific funds (which get contributions from public employees, especially telephone and cement companies, and other public services,) as well as from contributions from small- and medium-size enterprises. All these firms or institutions pay global premiums, which are used by the funds to pay for the health care services contracted by the insurers. These, in turn, contract physicians and public and private hospitals. In all cases, the prevailing payment method is that of a fee-for-service. This subsystem of private funds and insurers covers a total of 450,000 people, or 20% of the country's population.

Reforms currently under analysis are aimed at maintaining the satisfactory quality of the delivered services. At the same time, new reforms will attempt to improve equity in access, based on the new epidemiological situation in Jamaica where chronic diseases, mental health, and accidents are on the rise.

4.7 SOCIAL SECURITY INSTITUTES IN CENTRAL AMERICA

Agencies participating in the social security health system of Central America are the following: *Instituto Salvadoreño del Seguro Social* (ISSS - Salvadoran Social Security Institute), *Caja de Seguro Social* (CSS - Social Security Fund) of Panama, *Instituto Hondureño de Seguridad Social* (IHSS - Honduran Social Security Institute IHSS), and *Instituto Nicaragüense de Seguridad Social* (INSS - Nicaraguan Social Security Institute). Founded in the '50s and the '60s, the region's social security institutes have prominent features in common, which characterize the segmented Latin American model.

The ISSS provides pensions and extended health care coverage to workers from public and private enterprises and their direct relatives, covering 15% of the country's population in 1999. The case of Honduras is similar in terms of the population served (approximately 20% of the population,) although coverage is lower not only in terms of the delivered theoretical services, but also with respect to its area of action –ten out of the eighteen departments in the country. Conversely, the CSS of Panama covers a theoretical population exceeding 55%. Just as in the Panamanian CSS, the population covered by the ISSS and the IHSS is entirely urban (in the case of the IHSS, 65% of the coverage is focused on only two cities, Tegucigalpa and San Pedro Sula). In the three cases, there is no defined basic package of services, except for an early diagnosis scheme at the communal level in the case of El Salvador.

The ISSS in El Salvador and CSS financing in Panama comes from employee and employer contributions, plus an annual subsidy from the relevant governments (in the case of El Salvador, this contribution is fixed and annual since its inception.) The level of voluntary enrollees is not very significant in either case. By law, the IHSS has a wage deduction ceiling, which does not exceed 40 dollars annually, and its revenues were drawn from three separate sources until recently, when the State withdrew its contribution. No fees or copayments are in place. Fund collection and allocation is centralized in all cases and does not go through the national budget. Decision-making in financing, human resource, maintenance, acquisition, and investment matters is also centralized.

The ISSS is organized into four regions (western, eastern, central, and the capital city,) with an installed capacity of 15 hospitals and 62 outpatient facilities. Contracting out public or private services is not very significant –just as in the case of the IHSS–, and does not exceed 15% of expenditures. In the case of its Panamanian par, the level of subcontracted public or private services is apparently higher and more de-concentrated at the hospital level. At the same time, the Panamanian insurance has a formal agreement with the Ministry of Health. Thus, part of the institution's budget is allocated to the payment of services provided by the Ministry, on account of agreements with the *Hospital de Niños* (Children's Hospital,) the *Instituto Oncológico* (Oncological Institute,) and the *Hospital Integrado San Miguel Arcángel* (San Miguel Arcangel Integrated Hospital,) among others. Along the same lines, the IHSS holds service agreements with the Ministry of Health in those places where no coverage is available. In all cases, service payment is on the basis of a fee-for-service.

The payment method is through fixed salaries and budgets for personnel and own facilities, respectively, whereas contracted-out services are paid on a fee-for-service basis. In the cases of contracting out by the IHSS, there are bidding mechanisms aimed at increasing supply, with annual per capita payments.

The Nicaraguan INSS used to be similar to the Central American model presented above. In 1993, the INSS implemented a new social security model that turned the institution into a financing and regulatory agency of health services by subcontracting public and private service providers. On the one hand, this model has managed to separate financing from service delivery and, on the other, has put in place a system to purchase health services through the capitation payment method. These reforms, however, have been applied to a limited extent due to the institution's financial problems. The model operates with a basic basket of defined benefits that include outpatient care, hospitalization, diagnosis tests, medicines, and short-term benefit payments (subsidies.) Through medical insurance enterprises (EMPs,) the INSS provides a limited basket of benefits (pathologies of low- and medium-level complexity, and medicines) defined beforehand according to a higher usage frequency. On the other hand, for those services not covered by the EMPs, in special cases the INSS provides direct financial assistance to the insured in order to cover their cost. Based on the 1997 review of the benefit basket, prevention and education were included as components, as well as immunizations forming part of the *Programa Ampliado de Inmunizaciones* (PAI - Extended Immunization Program) of the Ministry of Health.

At present the INSS provides coverage for workers in the formal sector of the economy and to their direct relatives (children up to 16 years.) Total enrolled population (contributors plus beneficiaries) amounts to 250,000 people, out of which 60% are formal workers (17% of the working population) and 60% are urban population. The model excludes pensioners and retired people, who continue to be served by the Ministry of Health.

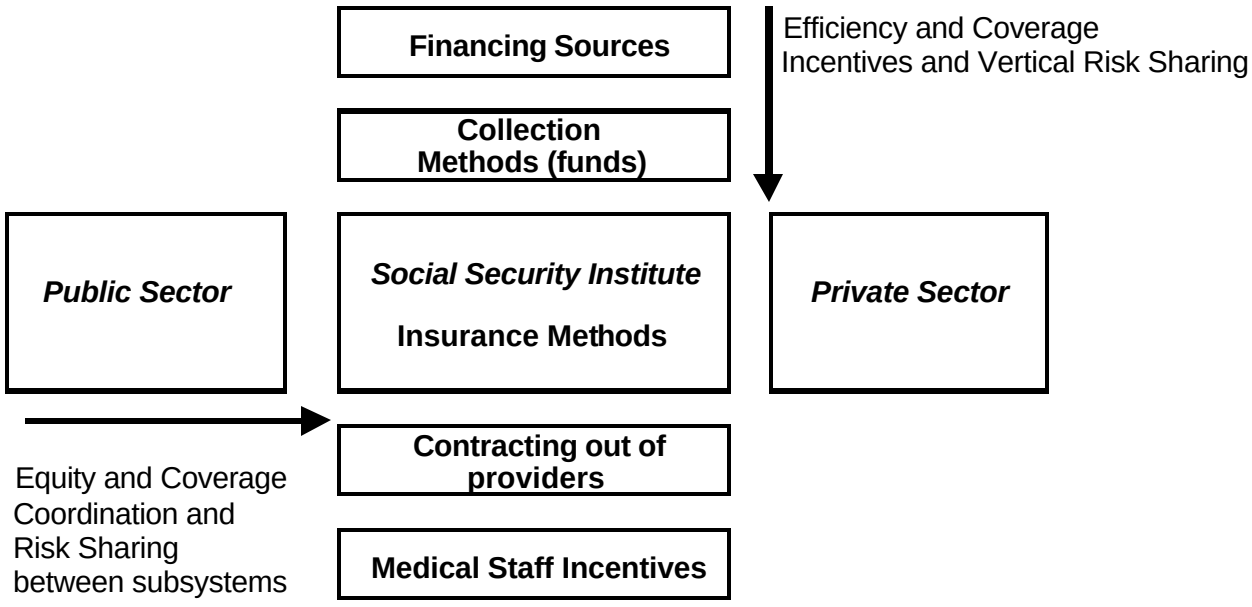
5. TWO DIMENSIONS IN THE SOCIAL INSURANCE STRUCTURE

From the countries presented in the preceding section, it can be postulated that there are two dimensions in the organization of a social insurance system: a vertical and a horizontal one, as depicted in Figure 8.

In the ***horizontal dimension,*** relationships are established among each of the participating actors or subsystems participating in the health care, which in turn are part of the social insurance network. This dimension acquires special importance in those cases where the nature of the health system is mixed and therefore requires coordinating instances in order to maximize health coverage for the population. Furthermore, risk sharing criteria between subsystems, as well as their impact on patient selection and referral patterns, are specified in this dimension. In other words, the horizontal dimension describes coverage patterns from the pint of view of ***system equity.***

In the ***vertical dimension,*** relationships for each of the structures participating in the social insurance network are established based on the internal operating structure. Each level in this dimension has been subjected to analysis in the Latin American cases, and no consistent implementation criteria have been found. As Figure 9 shows, the vertical dimension consists of five levels referring to: (1) sources of financing, (2) fund collection methods, (3) insurance criteria, (4) service provision structure, and (5) medical staff incentive system. This dimension presents the various aspects of the social insurance system coverage from the perspective of ***internal efficiency.***

FIGURE 8: THE TWO DIMENSIONS OF SOCIAL SECURITY



5.1 HORIZONTAL DIMENSION

Table 2 shows a horizontal comparison structure between the different social insurance systems in the region's countries. The comparison is made on the basis of three factors:

- the existence of social security institutes and their level of coordination with the public sector dependent on the Ministry of Health;
- coverage levels of the social security institutes, private insurance, and non-profit agencies, based on indicators that range between zero –low coverage– and four, and
- risk transfer mechanisms between public sector institutions dependent on the ministry and the social security institute, whether through patients or through subsidies.

Table 2 presents the typical differences between integrated public sectors (without Social Security Institute or highly coordinated) and segmented public sectors (with public Social Security Institutes, not coordinated with the ministry's facilities, and not integrated into public health care networks.) The differences in social insurance between Brazil, Chile, Colombia, Argentina, and Uruguay are also shown, with higher social and private insurance coverage levels.

TABLE 4: HORIZONTAL DIMENSION IN SOCIAL INSURANCE SYSTEMS IN LATIN AMERICA AND THE CARIBBEAN

Country	Social Security Institutes (ISS)	ISS coverage	Private insurance coverage	NGOs	*Patient Referrals*			Public
					from	to	Payments	subsidy to ISS
Brazil	no ISS + private contracts*	0	2	1	na	-	-	-
Bahamas	no ISS	0	0	1	na	-		-
Barbados	no ISS	0	0	0	na	-	-	-
T&T	No ISS	0	0	0	na	-	-	-
Jamaica	No ISS	0	1	1	na	-	-	-
Belize	Public ISS, only accident coverage	0	0	2	na	-	-	-
Costa Rica	Public ISS - integrated/coordinated	4	0	1	Public S	ISS	yes (joint)	-
Mexico	Public ISS - non integrated/coordinated	3	0	0	Public S	ISS	yes (Solid IMS)	-
Panama	Public ISS - non integrated/coordinated	3	0	1	Public S	ISS	yes (rural)	-
Nicaragua	Public ISS – integrated/non coordinated	1	0	2	ISS	Public S	no (lottery)	yes
Haiti	Public ISS – non integrated/non coordinated	1	0	4	-	-	-	-
Guatemala	Public ISS - non integrated/non coordinated	1	0	3	-	-	-	yes
Ecuador	Public ISS - non integrated/non coordinated	1	0	3	Public S	ISS	yes	-
Bolivia	Public ISS - non integrated/non coordinated	1	0	2	-	-	-	yes
El Salvador	Public ISS - non integrated/non coordinated	1	0	2	-	-	-	yes
Honduras	Public ISS - non integrated/non coordinated	1	0	2	ISS	Public S	yes	-
Paraguay	Public ISS - non integrated/non coordinated	1	0	2	-	-	-	yes
Peru	Public ISS - non integrated/non coordinated	2	0	3	ISS	Public S	no	-
Dominican Rep.	Public ISS - non integrated/non coordinated	1	1	2	-	-	-	yes
Venezuela	Public ISS - non integrated/non coordinated	2	1	1	ISS	Public S	no	-
Chile	Public ISS**	1#	4	0	na	-	-	-
Uruguay	Public ISS + private contracts	3	0	0	-	-	-	yes
Argentina	Public ISS + (for)public*** +private contracts	4	2	0	Soc.Sec. @	Public S	no	yes
Colombia	no ISS – private insurance w/public intervention	0	3##	1	Soc.Sec.@	Public S	no	yes

References	**4**	**3**	**2**	**1**	**0**
Public ISS Coverage	> 35%	25-35%	15-25%	5-15%	< 5%
Private Insurance Coverage	> 35%	15-25%	10-15%	5-10%	< 5%
NGO Coverage	> 20%	10-20%	5-10%	2-5%	< 1%

"na": not applicable; "-": non-existent or missing information.

"#" FONASA coverage; "##": this coverage includes cross-subsidies among EPSs' enrollees.

* The *Seguro Unico de Salud* maintains contracts with private providers.

** Possibility of enrolling in the public health system.

*** Social Security System managed by Trade Unions, by line of business, plus independent provincial health systems.

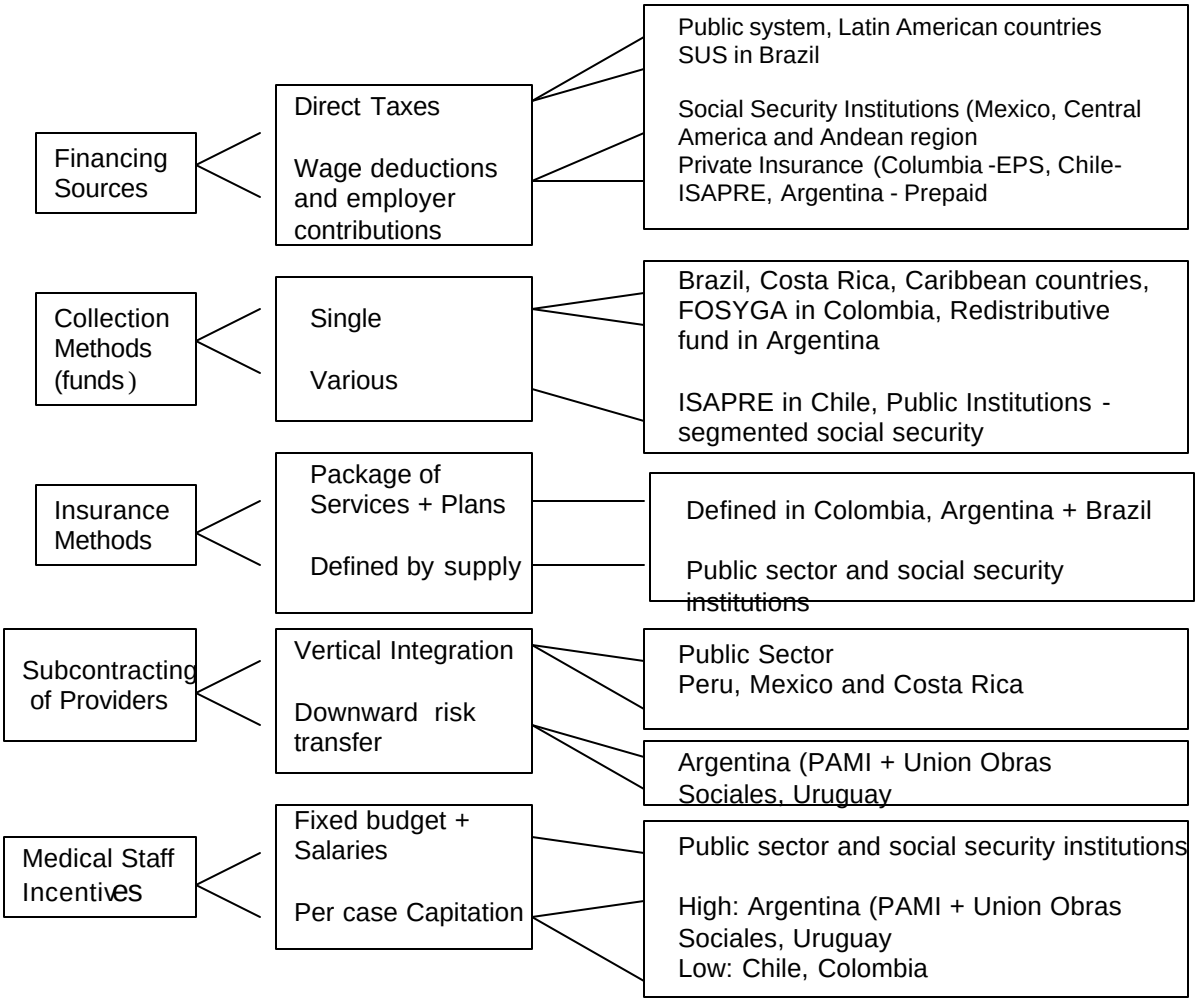
@ Public funds directed to PAMI in Argentina and Fosyga in Colombia.

Source: Update, based on Maceira (1996.)

5.2 VERTICAL DIMENSION

Figure 10 presents the most frequent options utilized by social insurance systems in Latin America, for each of the five levels of the vertical dimension (financing, fund, insurance, service integration, and payment method,) together with some examples.

FIGURE 9: VERTICAL DIMENSION OF SOCIAL SECURITY



5.2.1 Sources of Financing

Social health insurance systems have two main sources of income: those arising from direct taxes, collected by the national Government and used to finance the health system, or those collected through contributions of workers and employers to a health insurance. Among the former, there are the social insurance systems dependent on a ministerial authority, such as the British Caribbean systems, the Brazilian S.U.S. and, in general, the public coverage network in all countries of the region. The Social Security institutes of Latin American countries, on the contrary, rely on varying percentages of worker and employer contributions. This financing method is also used by the private insurance systems of Chile (ISAPREs) and Colombia (EPS). In other cases, such as Argentina or Brazil, private insurance is put in place by means of voluntary payments of enrollees, subject to an agreement on the premium and service package.

An analysis of the sources of financing of social insurance systems leads to several recommendations that could foster the development of this type of health coverage.

- Social insurance systems based on direct taxes should consider the level of progressivity or regressivity of fund collection, as well as the appropriation and utilization criteria.

- The possibility of collecting funds from sources unrelated to the national treasury prevents likely shortages of funds arising from macroeconomic volatility, and are independent from the level of regression in tax collection. However, given that the population contributing to insurance systems via wage deductions is limited to the formally employed proportion of inhabitants, the scope of these insurance models is limited.

- A solidarity system of social insurance based on salary contributions has the advantage of setting up subsidization rules among participants, just as those that are financed by direct revenues. In both cases, net receiver groups of subsidies and net contributor groups should be recognized, in order to promote equity in health service access.

- In all cases, priority should be given to those collection methods that may contribute to the system's *financial sustainability*, and whose funds are independent from alternative uses (pensions, tourism, for example.)

5.2.2 Collection and Fund Management Methods

The insurance concept underlying all social security system reforms is based on *risk sharing* among the system's enrollees. Even though the proposal of *multiple insurers* helps to solve operating inefficiency problems related with traditional public insurance systems, it segments the insurance market. This can lead the health system in an opposite direction to that of an efficient solution.

In some cases, such as the EPSs of Colombia or the *Obras Sociales Nacionales* in Argentina, fund collection is separate from the insurance task, which remains in hands of various actors in the system. In both cases, there is a single fund that gathers the salary contributions and allocates them according to criteria mainly associated with the cost of a basic package of services. This cost may be corrected for epidemiological risk, age, gender, etc. In turn, there are reallocation funds in both cases that provide subsidies to those groups whose contributions are below the cost of the minimum package.

Countries included in the segmented system have two funds, which are used independently from each other. However, as mentioned in the preceding section, there are cross-subsidies which attempt to introduce more solidarity into the health care system. If there are *no transfers* among sectors, non-integrated social security systems are at risk of generating a *dual health system*, where the public sector has fewer resources and receives the "more expensive" patients, while the health insurance "cream-skims" the market (captures the higher-income groups).

5.2.3 Service Management and Organization

Finally, four topics are associated with the delivery of health services in the context of a social insurance system. They are:

The **existence of a basic package of services**, as opposed to health coverage based on the availability of supply. A basic package ensures the organization of a financing system based on a group of services associated with the population's needs. In many cases, however, the available facilities are insufficient to cover such needs and require an associated health care network. Even though there have been developed basic health packages or mandatory health plans in some countries of the region, their actual application is limited.

A centralized / decentralized system in the organization of delivery systems. Even though it is a theoretically suitable tool for improving efficiency in the resource allocation, the region still lacks sufficient assessments of successful decentralizing processes. Social insurance systems have adopted this strategy in the area that depends on the Ministry of Health and in the social insurance institutions of Argentina, Uruguay, and Colombia. However, public social security institutions of the segmented models have not progressed in this direction and there are only few efforts for administrative de-concentration.

The processes of vertical disintegration and/or contracting out health care services have three possible purposes: (a) to expand coverage by contracting out services that are beyond the scope of the insurance network, (b) to seek improved efficiency in resource allocation, and hence separate financing from the provision of services, or (c) to transfer the risk to the provider. Except for the social security systems of Argentina and Uruguay, where contracting out services is frequent, or of Surinam, where the public sector contracts an NGO to expand coverage to rural areas, there are no systematic efforts in this direction.

Payment methods to providers and physicians: Social insurance systems, whether dependent on the Ministry of Health or on Social Security Institutes, lack incentive mechanisms in the pattern whereby they pay their institutions and professionals. In all the cases analyzed, appropriations are made through fixed budgets per institution, and standard salaries per agent. The exceptions to the rule are, once again, the social insurance systems of

Argentina and Uruguay and, to a lesser extent, the insurance systems of Chile and Colombia, which use capitation and per-case payments.

6. TRENDS IN THE REGION'S SOCIAL SECURITY REFORMS

Originating from various health care service structures, a general trend can be observed in the social insurance systems of the region. This trend points to the unification of contributory funds, risk sharing among population groups with different health statuses, and increased efforts towards solidary models. However, the internal organization of the system is still left out of the scope of most reform efforts. Trends observed in the region's social insurance systems may be outlined as follows:

British Caribbean	From the integrated public sector towards national health insurance + hospital autonomy.
Costa Rica	Continuance of public coordination of social insurance, with greater hospital autonomy and initial development of insurance structures.
Argentina and Uruguay	Public decentralization + deregulation of social security systems; intense network of incentive and service delivery contracts among the public sector, social security, and private insurance.
Chile, Colombia, Peru	Participation of the private sector in insurance; decentralization in the public sector dependent on the Ministry of Health.
Brazil	Decentralization of the Single Health System; review of incentives in public-private contracts.
Mexico – Panama	Deconcentration and decentralization; continuance of separate funds by the Ministry of Health and Social Security Institutes.

7. FINAL REMARKS

According to the analysis presented throughout this study, there is no single reform formula. The strategy of reformulating the social insurance system is associated with the basic conditions of the system, such as the current percentage of formal employment and the proportion of the population living in rural areas. This is in turn associated with the macroeconomic characteristics of the country and the volatility of its structure. However, the study of social insurance systems in Latin America and the Caribbean brings to the fore some important concepts that should be considered in future reform processes. These concepts may be summarized as follows:

Experience shows that the existence of *single or coordinated funds* promotes greater *solidarity* in the health care system.

In cases where the health care system is based on the principles of *preventive and comprehensive care*, the social insurance model tends to be more *equitable*, reducing allocation inefficiencies.

The definition of a *basic package of services*, corrected for epidemiological patterns of the population, is difficult to implement. However, its existence is important, since it sets consistent levels for comparison among services, thus leading towards *resource allocation efficiency*.

The implementation of *performance-based methods of payment*, as well as the possibility to generate competition in service provision, continues to be a pending subject in most health systems in the region. A greater discussion about the advantages and limitations of these methods is required, in order to have additional mechanisms available to support the *sustainability* of the ongoing reforms.

Finally, and to provide a proper regulatory framework, the *participation of the private sector and the coordination of service provision* appears as the most cost-effective mechanism to increase *coverage*, given the current budgetary restrictions in the average public sectors of the region.

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