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Well-being and Social Policy

Health Systems in the Americas
Guest Editor
Sérgio Francisco Piola

André Cezar Medici

INCOMPLETE HEALTH REFORMS IN LATIN AMERICA: SOME FINDINGS ON THEIR POLITICAL ECONOMY

Tatiane Almeida de Menezes
Bernardo Campolina
Fernando Gaiger Silveira
Luciana Mendes Santos Servo
Sérgio Francisco Piola

FAMILY HEALTH EXPENDITURE AND DEMAND: AN ANALYSIS BASED ON THE CONSUMER EXPENDITURE SURVEY -POF- 2002/2003

Carlos Cruz Rivero
Gabriela A. Luna Ruiz
Raquel Morales Barrera
Carlo S. Coello Levet

CATASTROPHIC EXPENDITURE IN HEALTH AND INCOME ELASTICITIES BY ITEM OF EXPENDITURE IN HEALTH SERVICES IN MEXICO

Rosa Maria Marques
Áquilas Mendes

DEMOCRACY AND UNIVERSALITY: DEBATING THE CONDITIONS OF APPLYING SUCH CONCEPTS TO BRAZIL'S PUBLIC HEALTH ACTIONS AND SERVICES

Andŕé Cezar Medici
Bernardo Weaver Barros

HEALTH POLICIES AND ECONOMIC BLOCKS

Célia Almeida

HEALTH SECTOR REFORM IN LATIN AMERICA AND THE CARIBBEAN: THE ROLE OF INTERNATIONAL ORGANISATIONS IN FORMULATING AGENDAS AND IMPLEMENTING POLICIES

General Section

Germán Acevedo
Patricio Eskenazi
Carmen Pagés

UNEMPLOYMENT INSURANCE IN CHILE: A NEW MODEL OF INCOME SUPPORT FOR UNEMPLOYED WORKERS

Jorge Valero Gil

THE AMERICAS SOCIAL SECURITY REPORT 2006 THE CHALLENGES OF AGING AND DISABILITY: EMPLOYMENT AND INSURANCE, AND INTERNATIONAL SOCIAL SECURITY AGREEMENTS *(Book Review)*

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INCOMPLETE HEALTH REFORMS IN LATIN AMERICA: SOME FINDINGS ON THEIR POLITICAL ECONOMY

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Abstract

This paper raises the point that only few health reforms implemented in Latin American countries modified the existing health systems in order to fix the problems brought by the institutional fragmentation typical of this sector. A great part of these reforms did not implemented the necessary measures to improve coordination among health systems in the prevailing pluralistic model and besides, they faced strong opposition from relevant actors who obstructed the completion of these reforms. In addition, this work points out that in countries which have implemented comprehensive structural reforms,, health indicators such as child mortality, malnourishment, maternal mortality and specialized care during childbirth have improved faster than in those which conducted only partial reforms or have no reforms at all. This paper analyses some of the processes and constrains of a selected group of countries in implementing health reforms in the Region.

——— Key words: health reform Latin America, health policy, political economy of health reform
Classification JEL: D7, I12, I18.

Introduction

The 90's were known, in many countries in Latin America, as health reform years.[1] These reforms have been accused, according to certain currents of opinion, of following neoliberal models[2] which merely aim to make health expense adjustments and provide increased labor market flexibility in the sector. But analysis, although superficial, easily proves that reforms did not follow

[1] Preliminary analyses defining health reform models in Latin America have been made by many authors in different countries known. We believe it is not worth repeating existing material but that we should advance existing knowledge instead. A theoretical framework describing the main health systems in Latin America can be found in Medici, A.C. (2000). A number of different authors, such as Maceira (2002), and more recently, Mesa-Lago (2005) have written about this subject. We are also considering the basic references on health reforms included in Sanchez, H. and Zuleta, G. Editors (2000) in this classification.

the same model in every country because the problems, needs, prior institutional history, concepts and values associated to health systems differ from one society to the other (Medici, 2000).

In addition, some of the explicit motivations for the reforms were the same for all the countries, but not in the sense most reform critics point out. Most of the reforms were shaped in response to a need to extend coverage and enhance equity, faced by restrictions to expand social expenditure associated to the economic and fiscal crises of the 80's, when strong limitations were imposed on health coverage and equity, in times of growing social demands driven by the accelerated urbanization process and by a return to political democracy in Latin America.

Therefore, the reforms pursued different goals, depending on each country's particular circumstances. Topics such as redefining the financial structure of the system, extending coverage and access, especially among the most unprotected sectors, and improving efficiency in the provision of services were among the most frequent issues in reform processes.[3]

In a certain sense, the reforms attempted to solve institutional problems associated to limited State structures to finance policies and restructure the provision of services, adjusting them to the health needs of the population. They also tried to break the impasse on federal issues, increasing local government financing for the delivery of health services and management capacities. To this end, they attempted to modify incentives to allow service users, providers and organizers to operate in a more harmonious and efficient fashion, structuring financing mechanisms, whenever possible, from the supply side to the demand side.

Using the theoretical model developed by Londoño and Frenk (1997), one could say that the health sector in Latin American countries is marked by extensive fragmentation, or, in other words, fragmented unstructured health systems are those where services are provided by multiple institutions, resulting in contradictory regulations, resources wasting, squandering and inefficient service organization. Institutional fragmentation in health sector organizations leads to a series of negative consequences such as duplicate coverage for some and absence of coverage for others; adverse selection of patients by providers and adverse selection of procedures by insured individuals, absence of coordination between public health functions and the provision of services

[2] The definition of neoliberalism is controversial and contradictory as it is not shared universally. Professor Andreas Novy, from the Department for Urban and Regional Development of the University of Economics of Vienna, formally defines neoliberalism as a form of economic liberalism which considers market economy as the most valuable good. Free market economy is particularly interested in regulating monopolies through market power and competition. The right to competition is essential to the operation of a market economy. Following the professor's reasoning, the concept of neoliberalism was devised as a continuation of classic liberalism associated to economists such as Friedrich August Hayek and Walter Eucken, founders of the so-called Freiburg School (Freiburger Schule). Its first political appearance occurred in seventies´ and is closely associated to the name of Milton Friedman just as authoritarian liberalism is associated to the name of Hayek, who is considered one of the forerunners of this current. Many associate neoliberalism to the topic of globalization, but in reality, the meaning that is usually associated to this term has led specialists and ideologists who condemn neoliberalism to disagree on this concept. Thus, the term neoliberalism has been used in the health sector by reform critics, arguing that they aim to advance in privatizing the sector and eliminating the role of the State. But, as we will see in this article, few health reforms in countries in the Region made any significant progress in privatizing the sector and the role of the State has become more important.

[3] A more detailed analysis on the subject of the political economy of health reforms, actors involved and institutional scenarios in countries in Latin America and the Caribbean can be found in Maceira (2002). Some of the issues addressed in this section use the basic arguments presented in this document.

and low integration levels in promotion, prevention and health care mechanisms, resulting in increased costs and access inequalities among the different population segments.

To solve these problems, reforms allowing the restructuring of health pluralism are necessary, reducing transaction costs, expanding coverage for unprotected sectors and avoiding duplicate coverage as well as the resulting squandering of resources in the system. The option to structure pluralism over and over is more feasible, under the optics of sector political economy, than the option to reduce fragmentation through institutional unification processes, where opposition from political groups in structures whose elimination has been recommended, is emerging.

In Latin America, countries with entirely fragmented health systems are those where health institutions with no articulation or integration persist. Service providers and public and private health/insurance organizations act independently and autonomously, conserving their own service networks and generating high costs and administrative inflexibility. Insured individuals may use either public or private services and in many cases, cross subsidies are generated from the poorest members of society to the wealthiest population, as is the case of universal and free health systems where expensive medical procedures provided by the public network are taken advantage of by middle and high class individuals who have private insurance and know how to avoid the queues to be admitted that prevail in public systems for the poorest population. In the Latin American context, countries such as Venezuela, Surinam and Bolivia still have totally fragmented systems.

Correspondingly, countries with integrated health systems are those where, despite fragmentation, institutional and administrative coordination exists, avoiding duplicate coverage, reducing transaction costs and improving solidarity and equity in services offered by a large number of institutions. Totally integrated health systems do not exist in the Region, although there are indications that countries such as Chile and Colombia are advancing towards increased health system integration.

The introduction of adequate mechanisms to regulate competition among insurers and providers, managed health care processes, quality certification mechanisms and clinical protocols, and structured reference and counter-reference processes, with primary care services as the entrance door, are some of the tools that could be utilized to integrate health systems, both via the State (as in Costa Rica or Brazil) and via the market (such as in Chile and Colombia).

To a great extent, international organizations and multilateral banks supported country reform efforts, and in some countries they played a significant role in debates on this process. For example, the Report for World Development published in 1993 by the World Bank and the 1996 Inter American Development Bank (IDB) Strategy for Social Sectors recommend a series of priorities regarding public health financing mechanisms and they also suggest private participation in the market, in the provision of services and in promoting competition.

Even though in some cases advances were positive, many reforms were unable to reach a social agreement that would make stakeholders (the population, providers, health professionals, financing providers and the government) feel they had been benefited, giving to differences in the interpretation of the path and the effectiveness of reform objectives, priorities and instruments.

Two different kinds of negative feelings were generated in countries where reforms are concerned: 1) feelings associated to interests in maintaining the status quo, led by professional associations which, striving to protect their job sources, stable jobs and maintain inadequate health activity process and working hour controls, accused reforms of being neoliberal and

privatizing, and strongly opposed the creation of mechanisms to adjust health manpower behavior in the public sector and enhance quality and result controls in the health sector; 2) the crisis of societal expectations (improved health coverage and quality in the time promised) because even though advances have been made in the health sector in Latin America as a result of the reforms, as data prove, these advances were more moderate and took place later than expected, partly due to the reasons pointed out. Consequently, there was no synchronization between reform promises made and the time required to carry them out.

As the reform cycle pursues long term objectives and political cycles in Latin America are short, many reforms were interrupted and had to be debated and go through changes of opinion before they were completed or before any significant implementation progress could be made, resulting in huge transaction costs for countries which had already initiated the reforms and fueling social opposition. As a result, to date, political classes in Latin America are afraid to mention the subject of health reforms, which ultimately generate negative political dividends and threaten governance.

This paper is organized in six sections. Section 1 presents the impact on health indicators of reforms carried out in Latin American countries. Section 2 analyzes how structural reforms were produced in those countries implementing reforms. Section 3 assesses partial reforms in certain countries which made this type of reform. Section 5 presents a summary of results obtained from consultations with key health reform actors. Section 6 presents the conclusions.

1. Impact of Health Reforms

Health reforms were a reality in all, or in almost all, countries in the Region. Some of these countries developed partial reform instruments, while others tried more extensive processes which changed the way deliveries, financing and regulation in the health sector were organized.

Table 1 classifies the Region according to the nature of the reform carried out. The countries that embarked on, or proceeded with, structural health reforms in the 90's by further integrating pluralism were Argentina, Brazil, Chile, Colombia, Costa Rica, Panama and the Dominican Republic. Some of the countries which developed partial reform instruments or made no substantial reforms were Bolivia, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Paraguay, Peru, Uruguay and Venezuela.[4]

It is not possible to make a thorough analysis of the results and impacts of health reforms in countries in Latin America and the Caribbean since common and internationally comparable baselines and indicators associated to the initiation of the reform process were not created in advance.[5] In

[4] As previously stated, most countries in the Region initiated health reform actions. For this analysis, we have differentiated between countries which embarked on structural reform actions and those which made no reforms at all or made only partial reforms. In the first case, the reforms modified the nature of pluralism in the health sector by reducing its fragmentation or increasing the integration of its components. In the second case, reforms were made in only within one of the segments of pluralism in the health sector, and even though they improved efficiency, they were not capable of substantially reducing transaction costs associated to pluralism.

[5] A comprehensive analysis on reform features, processes and results can be found in a recent publication by Mesa Lago (2005), specifying the relationship between reforms and social security principles.

addition, as previously mentioned, owing to the fact that in many cases the reforms pursued different goals, process indicators as well as results indicators would by definition be different since they relate to different goals and means of implementation. In the meantime, it might be possible to use certain result indicators to determine the accomplishments of reform processes, regardless of the path followed by each country. The following result indicators were chosen to make preliminary comparisons: 1) child mortality rate per 1,000 live births; 2) malnourishment rate among children under 5 years of age; 3) maternal mortality rate per 100 thousand live births; 4) percentage of births attended by specialized personnel; 5) mortality rate due to transmissible illnesses per 100 thousand inhabitants; 6) percentage of pregnancies under prenatal control.

Table 2 shows the results obtained by comparing these result indicators among countries implementing structural reforms and countries implementing partial reforms or countries where no reforms were made. We can observe that for all six selected result indicators, with the exception of the indicator for pregnancies under prenatal control, results were slightly better in countries which

Table 1
Fragmentation Levels and Structure of Health Pluralism in Countries that Have Made Structural and Partial Health Reforms (2005)

Countries which made structural reforms	
Countries	**System type**
Argentina	Pluralist and weakly structured
Brazil	Pluralist with a structured public sector
Chile	Pluralist and highly structured
Colombia	Pluralist and highly structured
Costa Rica	Integrated
Panama	Integrated
Dominican R.	Pluralist and weakly structured
Countries which made partial reforms or no reforms	
Countries	**System type**
Bolivia	Fragmented or highly fragmented pluralist Systems
Ecuador	
El Salvador	
Guatemala	
Haiti	
Honduras	
M e xico	
Nicaragua	
Paraguay	
Peru	
Uruguay	
Venezuela	

Source: Self-prepared.

carried out structural reforms than in countries which made partial reforms or made no reforms at all. Thus, we need a better understanding of how reforms came into existence in some of these countries; this is presented in the following section.

Table 2
Evaluation of Selected Health Indicators in Latin America: 1990/92 – 2002/5

Indicator	Countries with structural reforms			Countries with partial reforms or no reforms		
	1990/92	2002/2005	Change	1990/92	2002/2005	Change
Infant mortality rate	47	22	-53	42	29	-31
Malnourishment rate among children under 5 years of age	12	9	-25	16	13	-19
Maternal mortality rate	174	71	-59	129	123	-4,7
% of births attended by specialized personnel	81	97	+20	65	78	+20
Mortality rate due to transmissible illnesses	106	65	-39	124	80	-35
% of pregnancies under prenatal control	69	64	-7	73	75	+3

Source: Self-prepared.

2. Evaluation of Certain Structural Reforms in the Health Sector

2.1 Argentina

In Argentina, reforms started in 1995 in an attempt to reorganize the social insurance system in two main aspects: 1) redefining the coverage and quality scheme of the *Sistema Nacional de Obras Sociales*, creating competition mechanisms within the sector, as well as competition between this system and private insurance companies, and 2) improving efficiency in hospital services and primary care, concentrating on the poor, through decentralization and autonomous management.

The main instruments utilized for these purposes were: 1) the creation of a Compulsory Medical Package (CMP) including guaranteed benefits for *Sistema de Obras Sociales Nacionales* and Private Health Insurance Company beneficiaries; 2) allowing *Obra Social* users, affiliated according to the labor union they belong to, to change to different *Obras Sociales* groups; 3) decentralizing Public Hospitals by implementing a hospital self-management system allowing them to bill third parties for services provided and to hire private services individually; 4) organizing primary health care in the provinces, focusing on coverage for the poorest population, through a national primary care initiative.

According to this initiative, general criteria common to every jurisdiction are established at the national level while provinces are responsible for program proposals.

According to Maceira (2002), initial result measurements indicate that, on the one hand, equity in Social Security has increased due to the redistribution of funds among high and low income workers, but, on the other hand, it has declined for workers earning less than minimum wage because they were not incorporated to the resource reassignment mechanism. The quality of services provided, according to user perception, deteriorated in general terms, especially after the implementation of the capitation payment system, with no control over performance. In addition, the social security crisis brought about a large number of cut-backs in coverage.

The reform first led to concentration in the *Obras Sociales Nacionales* market, originated by the disappearance of more inefficient agents and by mergers between those with reduced populations. On the other hand, high salaried employees concentrated in a small number of agents as a result of a reduction in the number of market participants resulting from partnerships between prepaid medicine companies and *Obras Sociales*, which attracted high salaried individuals with preferential health plans. This has resulted in extremely high fee variability among different agents, with the resulting unbalance in benefits granted by each, both in quantity and quality.

There have been difficulties, related particularly to the negotiation power of *Obras Sociales*, in accomplishing the objectives proposed by the reform. In addition, the serious fiscal crisis of the provinces prevented the general implementation of the primary health care model. In the public subsystem, hospital self-management results are still not conclusive; however, billing mechanisms lack adequate collection and contract management controls.[6]

As a result of the huge economic crisis that began in 2002 and its social and political consequences, the new Argentine government stopped the reform process and started a new health policy strategy, restructuring the sector priorities around two central issues: 1) strengthening the delivery of medications to unprotected populations through the REMEDIAR Program financed by the IDB and the promotion of provincial health insurance programs, beginning with the implementation of the Maternal/Child Insurance (SUMI) financed by the World Bank.

2.2 Brazil

The goals of the reforms to the Brazilian health system, initiated in the 80's and consecrated in the 1988 Constitution through the creation of the Single Health System (SUS) were: 1) extending health coverage in the population by eliminating the social security health structure and incorporating it to the Ministry of Health and Municipal and State Health Offices; 2) establishing equity mechanisms and transferring resources from the Central level to States and Municipalities; 3) strengthening political and administrative decentralization for health systems; and 4) reinforcing social participation processes in the health sector.[7]

[6] Other analyses on the topic of political economy of health reforms in Argentina can be found in Medici (2002) and Giordano and Colina (2000).

[7] A detailed analysis of Health Reforms in Brazil can be found in Medici, A. (2002), The Challenges of Decentralization: Public Health Financing in Brazil, Ed. IDB, Washington DC.

The main instruments used by the Brazilian system are the following:

1) Consolidating a National and Integrated Public System for the three government levels, tending towards universal health coverage, among people with different income and health risk levels. This was accomplished through the implementation of a Basic Health Spending-Floor (PAB) which covers public health procedures and health promotion and prevention activities, at local level (municipalities) and by post-payment (public reimbursement system for public and private providers) to finance a huge package of health care procedures. PAB values are calculated on a per capita basis and a portion is based on incentives according to health policy priorities. Funds are transferred from the National Health Fund to municipalities or, in exceptional cases, to state governments if municipalities do not meet the institutional requirements to manage these funds.

2) Establishing a Family Health Program (PSF) consolidated at the local level, prioritizing health prevention and basic health care and connected to other government levels. According to 1993 legal framework (Basic Operation Standards Act), the goal of decentralization is to "completely redefine the dominant social security model, centered on individual medical and hospital assistance that was unsystematic, fragmented and does not guarantee quality, transforming it into regionalized and organized universal and impartial integral assistance for families, to achieve responsible health practices in every government sphere throughout the system".

3) Incorporating the private sector providers (previously linked to the social insurance model) to the public health care system through subcontractor networks.

4) Finally, basing the whole process on active societal participation through federal, state and municipal health councils.

The system has extended health coverage and its communication and social participation strategy has worked, generating strong reform acceptance among the population. Municipality result evaluations indicate a significant impact on coverage extension and social participation.

Despite the health reform, most of formal sector works and middle class are covered by private (voluntary) health insurance schemes, most of then working as American health maintenance organizations (HMO). This system was known as Supplemental Health System and in the late nineties a governmental regulatory agency was created to rule this coverage and premiums. During the nineties, as far as the SUS was expanding, this sector was also increasing reaching more than 36 million affiliated in the firs half ot the 2000's decade.

However, the program is still facing a number of problems. Distributing the National Health Fund based on the number of inhabitants without making adjustments for epidemiological profiles or income levels generates regional imbalances because, owing to insufficient allocations, rich municipalities are best equipped to complement, by local fiscal revenues, the financing needs to the rest of their service expenses while poor jurisdictions or those jurisdictions afflicted by illness are not able to get enough funds, producing flaws in the equity mechanisms announced by the reform introduced by the SUS.

In addition, flaws have been identified in system provider payment mechanisms: while public providers are receiving a mix of historical budgets and reimbursements, private providers are paid only on the reimbursement basis of services provided. Since resources available at municipal government levels are transferred in per capita basis, risks are entirely absorbed by decentralized

public authorities and there are inconsistencies between primary care service and specialized care service organization.

On the other hand, flaws in certain control mechanisms and the absence of evaluation mechanisms have led to adverse risk selection by the supplemental health system and private providers,, transferring high cost medical care to public providers.

2.3 Chile

The Chilean health reform was the first in the Region (1981) and it is still going through adjustments. Since it started during an authoritarian military government, it did not have to face opposition during the first decade. However, with a return to democracy, certain reforms started at the end of the 80's and continued throughout the 90's and the new millennium. Equity and equal coverage have been the key elements in establishing the goals of the Chilean reform for the last twenty years.

The Chilean health reform has been paradigmatic in Latin America because of its results and because of its instruments. This is justifiable because this reform was able to improve average life expectancy indicators for low income sectors, universalizing primary care and offsetting differences between the wealthiest and poorest sectors in the country as regards basic health care. Along this same path, another goal accomplished was guaranteeing equal opportunities for all citizens as a social strategy that includes increasing access to the health.

Some of the instruments used to accomplish these goals were:

1) Focusing on resources to ensure health service access for low income populations or groups with priority and special needs;

2) Designing demand subsidy schemes in the public financing structure, including insurance categories based on income levels (FONASA[8] coverage);

3) Primary health care decentralization, which, despite limitations in its implementation, has facilitated better health management and opportune decision making at local levels and;

4) Increasing competition among health providers and private health insurers, creating specific institutions (ISAPRE)[9] to provide insurance for high income groups based on the capability to pay and risk profile of each family group.[10]

Coverage and equity goals and managing issues, as the separation of finance and health service provision, have been accomplished quite satisfactorily. However, internal and external reform evaluations diverge on the reform performance according to ideological hue. For some, (Cifuentes, 2000), the creation of the ISAPRE system and the decentralization of the National Health System, as well as changes to resource allocation mechanisms, were successful instruments. Coverage was extended and indigents were included in the FONASA subsidized system. More choice for freedom was allowed to families and the public system was improved. Some relevant

[8] The National Health Fund (FONASA), financed by fiscal revenues, was created in order fo finance the basic health provision for uninsured and low income population. The funds for primary health care are transferred to municipalities and those related with hospital care are transferred to public hospitals.

[9] The ISAPRE (Institutions for Previsional Health) are NGOs created to offer a basic health package for their affiliated population, organized under the umbrella of a compulsory contribution payd by employees, those institutions cover no more than 26% of the top income Chilean population.

[10] A detailed vision of the health reform in Chile can be found in Cifuentes (2000).

health goals has been accomplished. Chile shows, for example, the most significant reduction in infant mortality in Latin America from 1970 to 1990.

Others (see Titelman 2000, for example) believe that the segmentation and duality of the health system did not encourage universal insurance but instead created a scheme that offers two different options (the public system and the private system) generating inequitable cross-subsidy mechanisms from the public sector to the ISAPRES. On the other hand, there are those (Savedoff 2000) who recognize the existence of cross-subsidies, but in the opposite direction, since high income individuals contribute to the public system while simultaneously paying contributions to the private health system.

With respect to difficulties to conduct the reform, the following can be mentioned: a) ideological opposition to the implementation of a demand subsidy for workers who do not meet the minimum income required by the ISAPRES, b) Trade union opposition in several economic sectors placed against the autonomy of health establishments and in defense of flexible markets that were supposed to be generated by competition and by designing adequate regulation to create mechanisms to protect user rights equally. Additionally, the existence of a dual model results in contributions being paid by high income sectors to a different fund, limiting the possibility of a health insurance program capable of financing specialized health care for the entire population, particularly for illnesses requiring moderate and highly complex medical care, an area where the system has not benefited the poorest members of society.

Based on these problems, the current Chilean government initiated reforms over the old 1981 reform, instituting solidarity financing mechanisms and explicit guarantees for pathologies requiring moderate and highly complex medical procedures. This strategy was structured, beginning in 2003, as a Universal Health Care Plan with Explicit Guarantees (AUGE), proposing that services be universally guaranteed when funds, instruments and the institutions necessary to achieve their sustainability, are available.[11]

2.4 Colombia

The objectives of the Colombian health reform which started in 1993 were: 1) to extend coverage focusing on low income groups; 2) to guarantee a minimum level of solidarity, equity and quality in services financed with public resources (from taxes and social security); to enhance service quality based on increased competition and freedom to choose providers and insurers and; 4) creating a State control structure (through the National Health Superintendence).

The main instruments used to carry out the reforms were:

1) Separating regulation, service provision and financing functions in health services. The bodies responsible for the organization and provision of health services are the Health Promoting Enterprises (EPS), for groups which have capacity to pay, and the Subsidized Regime Organizations (ARS) for marginalized groups which have no payment

[11] Since it was recently implemented, the AUGE plan will use IT to ensure the population has access to moderate and highly complex services such as electronic appointment scheduling systems, telemedicine and other. The Bank has supported these efforts through a Project approved at the end of 2004 (Digital Strategy Support in Chile–CH-L1001).

capacity or insurance financing sources. Most of the services provided by the ARS are entrusted by State owned hospitals with management autonomy;

2) Creating a set of health packages whose prices are calculated and adjusted by local state level (Departments) and the income level is the basis to determine whose are contributors and subsidized populations in the system. Funds are transferred from resources received by the Solidarity and Guarantee Fund, financed through general State resources and social security;

3) In addition, organizing private social insurance companies which manage funds managing the provision of services became a possibility.

4) The reform includes a territorial component due to decentralization of health service management in the public sector. Municipalities program and carry out basic activities through their Local Health Plan and their Basic Care Plan (PAB). Intervention and regulation are entrusted to Territorial Health and Social Security Councils (CTSSS) and Territorial Health Offices (DTS). This policy involved transferring authority and power from the Ministry of Health to local planning.[12]

Since its beginning, the reform has been able to triple health service coverage, reaching 60 % of total population. Institutional transformations introduced by the reform have improved management and control mechanisms and information handling between public Service Providers and the IRS. This also constitutes a gradual shift from supply subsidies towards demand subsidies.

The most significant problems basically relate to four different aspects: 1) incentives to under declare remunerations to the social insurance system, which limits reform sustainability chances; 2) prevailing differences between the quality and specificity of services received by users from different systems with different coverage plans; 3) since most providers are financed according to historical budgets and control mechanisms do not have efficient operating schemes, the reform has led to practices such as adverse high risk selection, financial imbalances and/or service over-utilization, and many EPS have not been able to contain growing expenses; and 4) public hospitals have not been able to make progresses because strong trade union opposition, as well as labor problems, have made it impossible to transform these hospitals into autonomous social State owned companies, having their own personnel and the capacity to hire and fire employees. In view of the above, in poor regions where these hospitals are located, subsidized regime coverage has expanded very slowly.

2.5 Dominican Republic

The reform started in 1995 aiming to extend access and service quality, focusing mainly on maternal and child care and low resource segments. As a result, a large number of health ODMs had already been chosen as reform priorities.

The instruments used to accomplish these goals were: 1) deconcentration and decentralization of the public health sector; 2) reforms to the social security system, especially as regards the delivery of health services; 3) definition of a set of basic universal benefits; 4) reorganization of the

[12] A first evaluation of the Bank related to the Colombian reform can be found in Savedoff (1999).

mixed public/private financing scheme based on contributive solidarity; 5) the introduction of public/private universal family insurance under a capitated payment scheme; and 6) strengthening the regulating role of the State based on a new legal framework.

The outcome of the reform process has been positive in terms of goals to expand coverage and improve service quality. However, the results would have been better if certain initial problems in its implementation had been resolved in time. Some of these difficulties are: 1) the absence of precise calculations in valuing the service package, resulting in a reduction in the number and quality of benefits provided; and 2) the fact that prepaid companies linked to the program do not provide coverage across the country, making it impossible for populations in far away rural regions to access the program. To provide incentives for these distant areas, a program to decentralize financial resources was designed because it creates incentives and encourages competition.

3. Evaluation of Certain Partial Health Reforms

3.1 Bolivia

The Bolivian reform strived to achieve, through the 1994 Popular Participation Law, the political decentralization of the country, providing increased powers and reallocating resources to departments and municipal governments as a way to increase efficiency and extend coverage.

The main instruments considered in this process through the years were: 1) the creation of Maternal/Child Insurance and extending it to Basic Health Insurance, to be covered by Public Sector and Social Security institutions through subsidized payments for services provided; 2) Compulsory Old Age Insurance, on a per capita basis according to the number of elderly persons assigned to each institution, and; 3) "decentralization by factors" in the public sector, distributing expense allocations in physical capital to municipalities, while at the same time deconcentrating payments to permanent staff at the department level; 4) the health mutualism reform, eliminating captive clientele practices of the "Cajas de Salud", establishing a free competition system among them and defining a compulsory minimum benefit package, and; 5) strengthening the epidemiological surveillance and monitoring systems through the creation of a permanent structure to fight against the main transmissible diseases in the country.

Even though political decentralization has been successful, decentralizing resource utilization has been incomplete. In addition, peculiarities in the distribution of functions between districts and municipalities have affected the efficiency of the system. Equity in the sector has not improved although there are strong indications of coverage expansion, mainly regarding advances in Basic Health Insurance, the Mother and Child Health Insurance and Social Investment Funds. Reforms to Health Associations (*Cajas de Salud*) were not implemented due to political opposition from trade associations and the efficiency of the system has been gradually deteriorating. There have been structural organizations problems in the implementation of the epidemiological surveillance system, but it has helped to reduce the incidence of transmissible diseases, as Chagas disease and tuberculosis in particular.

The main obstacles to the reform have been reduced actual delegation of power in health expense related decisions and in fund allocation mechanisms in departmental and municipal jurisdictions. On the other hand, the relationship between the public sector and social security

leads to cross resource transfers which generate duplications and inconsistencies which are still to be resolved. The reform will not be complete as long as clientele captivity and the inefficient financing and organization mechanisms of health associations are not modified.

3.2 Guatemala

The goals of the Health Reform in Guatemala, which began in 1995, were basically the following: 1) expanding coverage and health service delivery based on a prevention oriented health care model; 2) increasing public health expenditure through activities endorsing a more efficient and equitable reallocation of public resources, guaranteeing health service access to high risk population and ensuring financial sustainability, and; 3) generating organized social response through communication between the government and social security and NGOs, private care providers and community organizations.

To accomplish these goals, the following instruments were used; 1) the creation of an Integral Health Care System (SIAS), an initiative endorsing a basic health service plan defined by the Ministry of Health, targeting 33 % of the population. 2) using targeting mechanisms in the National Health Plan to focus on family groups, indigenous peoples and immigrant population; 3) transferring administrative and financing responsibilities to Central Area Offices in the health sector as a way to deconcentrate the Integral Health Care System.

Some of the measures seeking to modify the traditional composition of health expenditure that the Guatemalan reform has focused on are: 1) including co-pay for certain public services; 2) increasing the number of non-government organizations involved in providing services to the Ministry of Health; 3) independent private companies or independent professionals to act as lenders and provide funds to the Guatemalan Social Security Institute, and; 4) the creation of the Drug Access Program (PROAM), particularly in rural areas.

Due to changes in government structure, there have been many difficulties in implementing the reform. Additionally, the absence of clear evaluation mechanisms makes it impossible to present concrete results for evaluation. At any rate, there are no control mechanisms to measure the quality of health services or to compare deconcentrated management performance.

In addition, actions suggested have been delayed due to a continual redefining of goals and scope, especially regarding the inclusion of the Guatemalan Social Security Institute in the system to extend coverage to informal workers. Mechanisms to facilitate community participation and social control are weak, something that has to be corrected in countries made up by people from different races and languages. Finally, there are no formal community organizations to promote health care in spite of the fact that the Integral Health Care System requires health volunteer collaboration in communities where the system is being implemented.

4. Actors Involved in Reform Opposition Processes

With respect to actors, the reform processes described include certain common elements of political economy which led to the partial implementation of reforms: 1) the passive role played by users as regards knowledge, support or opposition to the reforms; 2) the active role played by medical

associations and professional organizations in the health sector, opposing reform processes; 3) the weakness of health ministries in defending long-term reforms, either because they are identified with external agendas accused of being neo-liberal by its opponents or because if additional resources, although temporary, are involved in its implementation, they do not have the approval of economic ministers; 4) the long time it will take to implement the reforms and the short government terms.

With regard to users, information asymmetry between them and providers is well known and this makes them highly dependent on the voice and power of these providers. Just as users usually follow, when they have the resources, their providers' and their doctors' recommendations on how to take care of their health properly, they also accept their beliefs that reforms will lead to service deterioration. Low income users, who usually receive more benefits from the reforms since they are committed to promoting equity, do not have adequate channels to express their interests and their levels of satisfaction so they may be assessed.

With respect to medical associations and professional organizations, their interests are opposed to any actions seeking to rationalize and improve service efficiency; these actions include: 1) eliminating labor immobility; 2) diversification of the payment system by creating high productivity incentives and penalizing those that are less efficient through market mechanisms; 3) competition between public and private providers delivering services financed by the public sector; and 4) applying measures, such as creating medical protocols, basic service packages, generic medication lists, to ensure reasonable professional behavior.

In this area, the actions that have paralyzed the reforms relate, to a great extent, to increased corporate opposition in the health sector, which, in Latin America, has registered higher conflict levels than any other area in the economy; the main reason have been demands referring to resource allocation in the system. Medical colleges and unions have been key actors in this process (see Scavino, 2004).

Health conflicts in the region became manifest in 2003 through 37 nationwide stoppages and strikes in 12 countries in Latin America[13], lasting from 1 day to 9 months and representing great losses in years of healthy life and financial resources for the society. Demands regarding resource allocations in the system (salary raises and higher budgets for the sector) originated most of these actions, involving 31 professional and health worker organizations (15 medical organizations). Thirty six of the 37 nationwide strikes took place in State health services.

The main reasons for 68 % of the nationwide strikes and stoppages in the region in 2003 were demands regarding resource allocation in the health system: salary increases, benefit payments, position assignments, resources for residents (young professional physicians), increasing the budget for public assistance networks, demands for decent working conditions, payment of work-related debt and fulfillment of previous agreements. Opposition to the introduction of sector reforms was the principal reason in 11 % of the strikes. Objections to the removal of high ranking officials and demands to give functionaries their jobs back were the main reasons for 8 % of nationwide stoppages.

Bolivia, Peru and the Dominican Republic recorded the largest number of nationwide strikes and stoppages (12, 6 and 4, respectively), and the longest conflict was when the Medical College of El Salvador confronted the government, from September 17, 2002 to June 13, 2003. The reason for this mobilization was that the Salvadoran medical corps opposed a law that had been approved

[13] Bolivia, Chile, Colombia, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Peru, the Dominican Republic and Uruguay.

by Parliament, which doctors believed meant the "privatization" of public health services (see Scavino, 2004).

Corporate movements in the health sector have been the key actors opposing health reform processes, delaying its implementation. Political classes and the government have not been very tolerant in facing these movements and end up surrendering to pressure, going as far as paralyzing reform processes, getting ministers and technicians committed to the implementation of these processes out of their way.

This led to a high rotation of health ministers in countries in Latin America and the Caribbean throughout the 90's, as can be seen in Table 3. The countries which implemented reforms were those with the shortest average health minister terms in office–around one year three months.

The main argument of those who oppose the reforms is that they lead to the privatization of health expenditure and to a reduction in quality coverage for the population. But existing data seem to show that these arguments are not true, as Table 4 proves. It corroborates that, with the exception of Argentina and Brazil, from 1995 to 2001, there was an increase in public health expenditure in the rest of the countries.

Table 3
Rotation of Health Ministers in Countries in Latin America and the Caribbean, 1983-1997

Rotation	Countries	Average term in office
High	Argentina, Bolivia, Brazil, Colombia, Grenada, Haiti, Peru, Surinam, Venezuela	1 year three months
Medium	Bahamas, Barbados, Belize, Ecuador, Guatemala, Guyana, Honduras, Nicaragua, Panama, the Dominican Republic, St. Vincent, Trinidad and Tobago, Uruguay	2 years
Low	Antigua and Barbuda , Costa Rica, Cuba, Dominica, El Salvador, Jamaica, Mexico, Paraguay, St. Lucia	3 and a half years

Source: PAHO (2000).

Table 4
Public Health Expenditure in Countries Which Implemented Reforms in this Sector: 1995-2001
(percentage)

Countries	1995	1996	1997	1998	1999	2000	2001
Argentina	61	59	58	55	56	55	53
Brazil	43	40	44	44	43	41	42
Chile	36	39	38	40	41	43	44
Colombia	58	59	58	55	54	56	66
Costa Rica	68	67	69	67	69	68	69
El Salvador	41	41	39	42	42	43	47
Guatemala	44	42	45	47	48	48	48
Dominican Republic	27	27	29	28	31	28	36

Source: National Health Accounts Project in Latin America and the Caribbean: Shared Agenda IDB, World Bank and PAHO.

In many of these countries, particularly in those that have been highly criticized because their proposals have been considered neo-liberal, such as Chile and Colombia, public expenditure in the health sector has increased. In others, such as Brazil, where the reform process was strongly conducted by the State, public sector participation has stabilized or has been slightly reduced.

With regard to the topic of coverage, it expanded significantly and health policy results were favorable in the 90's. But the significant issue is that there is a trend to expand quality service coverage, associated to public or private insurance mechanisms and to a reduction in direct pocket expenses (Medici, 2005).

5. Key Actor Surveys and Health Reforms

At the beginning of the second half of 2004, the Inter-American Development Bank (IDB) made a survey among key actors in the health sector in countries in Latin America and the Caribbean.[14] Those considered key actors were high ranking officials from the Health Ministries (37 %), researchers or scholars in the health sector and in the economic sector (20 %), high ranking officials in Economic Ministries (8 %), service providers (3 %), health associations (3 %) and different actors (29 %).

The survey dealt with health policy changes that had taken place in the different countries in the last 10 years; the term reform was avoided because it was a term that had been wasted and stigmatized among key actors. Regardless of the above, questions regarding changes introduced in the last ten years to enhance efficiency, effectiveness, quality and equity in health systems attempted to identify reform efforts.

Over 50 % of those surveyed felt that the results accomplished by the reforms had been positive or that the reforms had achieved partial results regarding topics such as decentralization, targeting the poorest population and utilization of basic health packages. However, they did not consider that universal insurance, demand subsidies, or the demonopolization of the public sector had been implemented (or properly addressed).

In short, the survey reveals that due to all the difficulties the sector had to go through, few reforms were implemented. There is a feeling that changes were not implemented in health systems, which still concentrate on public supply and have insufficient resources for the poorest population and to cover formal workers related social security expenses, high out-of-pocket expense levels and few alternative financing schemes aimed at finding more efficient and equitable solutions.

This survey was complemented by consultations with high ranking authorities in Health Ministries in countries in the Region in three workshops held in Rio de Janeiro (Brazil), San Jose (Costa Rica) and Barbados in November and December 2004.[15] The goal of these workshops was not to evaluate the role played by reforms but to advance in solving current problems and explore future possibilities. In addition, it was also suggested that international organizations should not impose predetermined agendas on countries and that they should concentrate their

[14] The report on the survey can be found at the following link: http://www.iadb.org/sds/doc/ReporteEncuesta.pdf
[15] The final report on these interview can be found at the following link: http://www.iadb.org/sds/doc/Informe%5Fde%5Flas%5FConsultas11.pdf

efforts in assisting health ministries in strengthening their role as internal policy and international cooperation coordinators.

6. Conclusions

Even though there is no consensus among key actors in the sector, data indicate that many health reforms in Latin America had positive results in the 90's. Countries such as Chile, Brazil, Colombia and the Dominican Republic had strong coverage expansion associated to efforts to improve health care financing and service delivery, and to decentralization processes which increased access to health programs in far away regions, mainly among the needy.

However, in a great number of countries, such as in the most visible cases of Argentina and Bolivia, reform processes have been slower than expected due to the complex political economy associated to their implementation. On the other hand, in all the other countries where there have been attempts to implement a reform agenda, conflicts in the health sector have grown, straining government efforts to continue with the reforms and generating high transition costs which result in the loss of economic resources and years of healthy life for the population.

Health professional associations have headed the movement opposing and rejecting reforms, using questionable arguments that can be easily invalidated by existing data and evidence. However, due to asymmetry in information between users and providers and to a lack of political support from health ministries interested in carrying out the reforms, the arguments of those who oppose the reforms end up being hegemonic, leading governments to substitute sector authorities to avoid losing their electoral base.

The lack of stability in the sector, the absence of clear objectives, quantitative goals and mechanisms to evaluate the results, the weakness of financial foundations at times of fiscal adjustments and the absence of social communication strategies to exchange views with those who are more interested –users- have been the main problems that have led to unconcluded health reforms in Latin America.

Health reforms are long term processes and detailed information should be provided; they have to be closely monitored and evaluated by society using social participation strategies and they should have users as partners. They should, therefore, go beyond governments, show tangible results and generate ideals shared by all.

At the same time, they should not give the impression that reforms are magic and that they change the health situation of the population in the short term. Reform processes require long term visions in terms of health objectives and goals, adequate social communication so all actors may participate and do their share, searching for mechanisms to separate immediate, intermediate and future actions in order to know which way to go, which instruments to use, which goals to accomplish and which evaluation and control mechanisms to apply. Based on the above, international cooperation should finance new health projects allowing countries to decide whether they should be sold as reforms or not.

References

Cifuentes, Mercedes. "The Health Sector Reform in Chile." In *La hora de los usuarios (program for users): Reflections on the political economy of health reforms.* Published by Héctor Sánchez and Gustavo Zuleta. Washington, D.C.: Inter-American Development Bank, 2000.

Giordano, Osvaldo and Jorge Colina. "Political Economy of Reforms." In *La hora de los usuarios: Reflections on the political economy of health reforms.* Published by Héctor Sánchez and Gustavo Zuleta. Washington, D.C.: Inter-American Development Bank, 2000.

Londoño, Juan Luis and Julio Frenk. "Structured Pluralism: Towards an Innovative Model for Health System Reform in Latin America." *Health Policy* 41, no. 1(1997): 1-36.

Maceira, Daniel. "Actors and Health Reforms in Latin America and the Caribbean." Commissioned paper to subsidize IDB's Health Strategy. Washington D.C.: Inter-American Development Bank, 2000.

Medici, André Cezar . "Health Reforms in Latin American and the Caribbean." In *La hora de los usuarios: Reflections on the political economy of health reforms.* Published by Héctor Sánchez and Gustavo Zuleta. Washington, D.C.: Inter-American Development Bank, 2000.

Medici, André Cezar. "Public and Private in Health in Latin America." Technical Health Note by the Division of Social Programs SDS/SOC. Washington, D.C.: Inter-American Development Bank, 2005.

Medici, André Cezar. "The Deregulation of *Obras Sociales* in Argentina: One More Episode of the Health Reform in Argentina: What Will Come Later?" Technical Health Note by the Division of Social Programs (SDS/SOC). Washington, D.C.: Inter-American Development Bank, 2002. Available online at: http://www.iadb.org/sds/doc/Desregulacion.pdf.

Medici, André Cezar. *The Challenges of Decentralization: Public Health Financing in Brazil.* Washington, D.C.: Inter-American Development Bank, 2002.

Mesa-Lago, Carmelo. "Health Reforms in Latin America and the Caribbean: their Impact on Social Security principles." Project Document Series. Santiago.: Economic Commission for Latin America, 2005.

PAHO. *Public Policy and Health Program Database.* Washington: Pan-American Health Organization, 2000.

Savedoff, William. "Is anybody listening? Data Comissions in debates on the Health Reform in Latin America." Health Note no. 2. Washington, D.C.: Inter-American Development Bank, 2000. Available online at: http://www.iadb.org/sds/doc/AlguienEstaEscuchando.pdf

Savedoff, William. "Reaching the Poor Through Demand Subsidies: The Colombian Health Reform." Technical Health Note by the Division of Social Programs (SDS/SOC). Washington, D.C.: Inter-American Development Bank, 1999. Available online at: http://www.iadb.org/sds/doc/HealthReformCO.pdf

Scavino, Julio. "How Corporate Interests Work in the Political Economy of the Health Sector. An Approximation since Conflicts Arose in the Health Sector in the Region of the Americas." Paper commissioned by the IDB. Washington, D.C.: Inter-American Development Bank, 2004.

Titelman, Daniel. "Reforms to the Health System in Chile: pending challenges." Financing for Development Series Nº 104. Santiago: Economic Commission for Latin America, 2000.

Annex

Table A.1
Infant Mortality Rates

Countries	1990		2005	
	Live births (Thousands)	IMR (per 1,000)	Live births (Thousands)	IMR (per 1,000)
Countries with reforms				
Argentina	684	96	690	84
Brazil	3,800	65	3,706	49
Chile	298	91	251	76
Colombia	808	59	967	91
Costa Rica	85	91	80	82
Panama	63	83	70	99
Dom. Rep.	202	43	211	98
Average	5,940	69	5,975	64
Countries with no reforms or with partial reforms				
Bolivia	249	38	264	79
Ecuador	307	47	294	83
El Salvador	183	69	166	46
Guatemala	383	34	438	84
Haiti	24	45	254	79
Honduras	195	77	207	85
Mexico	2,357	89	2,159	96
Nicaragua	164	87	154	86
Paraguay	153	76	178	74
Peru	620	68	630	91
Uruguay	54	95	57	94
Venezuela	566	74	593	26
Average	5,472	73	5,394	75

Table A.2
Malnourishment Rates Among Children Less Than 5 Years of Age

Countries	1990		2002	
	Live births (Thousands)	Malnourishment rate	Live births (Thousands)	Malnourishment rate
Countries with reforms				
Argentina	684	3	690	3
Brazil	3,800	12	3,706	9
Chile	298	8	251	4
Colombia	808	17	967	13
Costa Rica	85	6	80	4
Panama	63	21	70	26
Dom. Rep.	202	27	211	25
Average	5,940	12	5,975	9
Countries with no reforms or with partial reforms				
Bolivia	249	28	264	21
Ecuador	307	8	294	4
El Salvador	183	12	166	11
Guatemala	383	16	438	24
Haiti	241	65	254	47
Honduras	195	23	207	22
Mexico	2,357	5	2,159	5
Nicaragua	164	30	154	27
Paraguay	153	18	178	14
Peru	620	42	630	13
Uruguay	54	6	57	4
Venezuela	566	11	593	17
Average	5,472	16	5,394	13

Table A.3
Maternal Mortality Rate

Countries	1990		2002	
	Live births (Thousands)	Maternal mortality rate (per 1,000)	Live births (Thousands)	Maternal mortality rate (per 1,000)
Countries with reforms				
Argentina	684	52	690	46
Brazil	3,800	230	3,706	72
Chile	298	34	251	17
Colombia	808	107	967	99
Costa Rica	85	26	80	33
Panama	63	55	70	71
Dom. Rep.	202	93	211	98
Average	5,940	174	5,975	71
Countries with no reforms or with partial reforms				
Bolivia	249	332	264	230
Ecuador	307	150	294	81
El Salvador	183	140	166	120
Guatemala	383	106	438	153
Haiti	241	340	254	523
Honduras	195	221	207	108
Mexico	2,357	58	2,159	64
Nicaragua	164	100	154	96
Paraguay	153	71	178	150
Peru	620	298	630	185
Uruguay	54	38	57	11
Venezuela	566	60	593	68
Average	5,472	129	5,394	123

Table A.4
Percentage of Births Attended by Qualified Personnel

Countries	1990		2002	
	Live births (Thousands)	% of births attended	Live births (Thousands)	% of births attended
Countries with reforms				
Argentina	684	95	690	99
Brazil	3,800	84	3,706	97
Chile	298	99	251	100
Colombia	808	59	967	95
Costa Rica	85	94	80	98
Panama	63	86	70	93
Dom. Rep.	202	44	211	98
Average	5,940	81	5,975	97
Countries with no reforms or with partial reforms				
Bolivia	249	29	264	61
Ecuador	307	26	294	69
El Salvador	183	66	166	84
Guatemala	383	23	438	41
Haiti	241	33	254	24
Honduras	195	63	207	62
Mexico	2,357	89	2,159	92
Nicaragua	164	42	154	75
Paraguay	153	32	178	86
Peru	620	46	630	71
Uruguay	54	100	57	99
Venezuela	566	82	593	100
Average	5,472	65	5,394	78

Table A.5
Mortality Rate Due to Transmissible Illnesses per 100 Thousand Inhabitants

Countries	1995		2005	
	Population (thousands)	Mortality rate due to transmissible illnesses	Population (Thousands)	Mortality rate due to transmissible illnesses
Countries with reforms				
Argentina	34,587	51	38,747	61
Brazil	161,790	131	186,405	72
Chile	14,262	73	16,295	40
Colombia	35,101	65	45,600	50
Costa Rica	3,424	35	4,327	25
Panama	2,631	66	3,232	64
Dom. Rep.	7,823	-	8,895	101
Average	259,618	106	303,501	65
Countries with no reforms or with partial reforms				
Bolivia	7,414	-	9,182	211
Ecuador	11,460	145	13,288	66
El Salvador	5,768	142	6,881	83
Guatemala	10,621	-	12,599	212
Haiti	7,180	-	8,528	397
Honduras	5,654	-	7,205	-
Mexico	91,145	75	107,029	49
Nicaragua	4,433	214	5,487	67
Paraguay	4,960	153	6,158	88
Peru	23,780	319	27,968	186
Uruguay	3,186	37	3,463	38
Venezuela	21,844	88	26,749	57
Average	197,445	124	234,537	80