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ILO regional tripartite meeting with the collaboration of PAHO
Extension of social protection in health to excluded groups in Latin America and the Caribbean
Mexico, 29 November - 1 December 1999

**ELEMENTS FOR THE COMPARATIVE ANALYSIS OF EXTENSION
OF SOCIAL PROTECTION IN HEALTH
IN LATIN AMERICA AND THE CARIBBEAN**

FOREWORD

There is consensus in the Americas as to the growing importance and size of the population with no coverage under social security health services, mainly in the informal sector in urban and rural areas. In certain countries coverage is very limited, both in terms of the number of persons protected and the contingencies covered.

In view of this situation, and in keeping with the objectives of the World Summit on Social Development (Copenhagen, 1995), the International Labour Organisation (ILO) and the Pan American Health Organisation (PAHO) have started an initiative seeking alternative forms of health care coverage for excluded population groups. Accordingly, these alternatives should be effective, sustainable, and proven.

The ILO, working through the Social Security Department, its Strategies and Tools against Social Exclusion and Poverty (STEP) Program, the Regional Office for the Americas and the Caribbean (Lima), and PAHO, conducted the following studies:

1. Overview of the Exclusion of Social Protection in Health in Latin America and the Caribbean;
2. Out-of-pocket Health Expenditure in Latin America and the Caribbean: The Efficiency Rationale for Extending Social Protection in Health;
3. Elements for the Comparative Analysis of Extension of Social Protection in Health in Latin America and the Caribbean;
4. Synthesis of Case Studies of Micro-insurance and other Forms of Extending Social Protection in Health in Latin America and the Caribbean;

These studies will serve as the basis for the discussion during the Mexico meeting (29 November – 1 December 1999), that it is the starting point for this initiative.

In addition, ILO and PAHO have prepared a document detailing their position regarding the extension of social protection in health for excluded populations in Latin America and the Caribbean.

The report presented here—Elements for the Comparative Analysis of Extension of Social Protection in Health in Latin America and the Caribbean—examines national policies and reforms to extend social coverage in health that have helped to reduce exclusion.

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ELEMENTS FOR THE COMPARATIVE ANALYSIS OF EXTENSION OF SOCIAL PROTECTION IN HEALTH IN LATIN AMERICA AND THE CARIBBEAN¹

I. INTRODUCTION

1. Objectives and Scope

This study was prepared at the request of the Pan American Health Organisation (PAHO) and the International Labour Organisation (ILO) as a comparative analysis of policies for protection in health promoted by the Latin American and Caribbean countries. Finding compatible initiatives to increase social protection in health requires a broad understanding of social policies in this field, their evolution, and their outlook. Comparing progress of the different countries will make it possible to identify the practices best suited to increasing health coverage within the specific circumstances of each country.

The study looks to define the elements needed to carry out this analysis, with the goal of verifying hypotheses that are broad in scope, combining theoretical and methodological mechanisms that allow for the monitoring of policies governing social coverage in health.

The document attempts to lay the foundation for a detailed discussion that will lead to more specific studies in terms of both the geography and content of social policies.

2. Methodology

In order to accomplish this, the following steps were taken:

- collection of data on social policy in health coverage in the 33 countries of Latin America and the Caribbean;
- collection of specific comparative data on social policies related to the social participation and control of NGOs and other civil society actors, such as health cooperatives, and their impact on the expansion of coverage;
- analysis of theoretical and real coverage in health in selected countries;
- identification of the causes of the gap between theoretical and real coverage;

¹ This document was prepared under the guidance and supervision of the ILO and PAHO/WHO. The Social Security Department, its STEP Program, the Regional Office for Latin America and the Caribbean as well as the ILO Offices in Lima and Santiago, participated on behalf of the ILO. The Organization and Management of Health Systems and Services Program, Division of Health Systems and Services Development participated on behalf of PAHO/WHO. The original study was prepared by the ISALUD Foundation of Buenos Aires.

- identification of trends in the relationship between social policies, the extension of coverage, and health expenditure in the countries of the Region.

Indicators of results, processes, and resources were examined. Concerning the first, the percentage of theoretical and real coverage of the system will be analysed. The second involves the existence of targeted programs, changes in health policy regulation, and the degree of community participation in the health sector, be it the role played by civil society organisations or the service coverage they provide. The study involves not only information about the current situation, but also about the evolutionary dynamic of policies. The third element has to do with the level of resources channelled to the sector.

Two dimensions of analysis were considered that relate to policies for social coverage in health in the 33 analysed countries:

1. public policies (legal framework, policies, programs, plans, etc.);
2. the health system and management model.

Sources for the study included a bibliographical review of specialised literature in the region, official information (when possible), and the copious documentation available on general trends and comparisons of national health policies.

Based on these objectives, a common structured protocol was prepared for all the countries that was used to identify and analyse national policies on social coverage in health and their evolution and trends.

Forms were prepared with the most relevant information on theoretical and real coverage and the causes of the gap between them, a profile of excluded populations, and principal policies and strategies, in order to counteract exclusion in each country.

Detailed studies were then carried out for countries of the Region. The exceptions were Dominica, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Saint Lucia, Grenada, and Antigua and Barbuda, for which only the forms were done because of their small populations and the fact that they replicate the situation in countries with National Health Systems. Also for Belize and Suriname, only the forms were done.

3. Parameters and Limitations of the Research

The analysis centres on the universality of coverage. Therefore, the systematic approach to the level of coverage or the degree of coverage provided by each level of care in each subsector of the national health systems are omitted. As a result, there is no in-depth analysis of either the provider or supply model, and the study is limited to discussing the relationship between financing and service delivery and public versus private management, which is necessary for understanding the operation of the system.

This study is complementary to the others presented to the meeting, particularly the "Overview of the Exclusion of Social Protection in health in Latin America and the Caribbean". This study explains and characterises the exclusion in the Region from the political points of view. However, while information sources for the two reports were shared in some areas, the sources are not always identical. Nevertheless, generally speaking, the two studies come to the same conclusions regarding the profile of exclusion and its causes in Latin America and the Caribbean.

II. STRUCTURAL ELEMENTS OF HEALTH SYSTEMS THAT AFFECT SOCIAL PROTECTION IN HEALTH

1. Legal and Juridical Framework for Social Protection in Health

1.1 *The Right to Health*

a. Recognition of the Right

The vast majority of Latin American countries recognise the right to health as a basic social and human right that permits an individual to become a complete human being and lead a life with dignity. Be it through constitutional law or a lower level of the legal hierarchy, all the States of the Region recognise health protection, or in some cases health care or access to health services, as the right of the entire population.

The following countries, for example, have explicit recognition (information includes the date that the initial legislation on the right to health was passed or the most recent update of the legislation):

<i>Argentina (1994)</i>	<i>Honduras (1982)</i>
<i>Bolivia (1994)</i>	<i>Mexico (1998)</i>
<i>Brazil (1996),</i>	<i>Nicaragua (1995)</i>
<i>Colombia (1997)</i>	<i>Panama (1994)</i>
<i>Chile (1997)</i>	<i>Paraguay (1992)</i>
<i>Cuba (1992)</i>	<i>Peru (1993)</i>
<i>Dominican Republic (1994)</i>	<i>Uruguay (1997)</i>
<i>Ecuador (1996)</i>	<i>Venezuela (1983)</i>
<i>El Salvador (1982)</i>	
<i>Guatemala (1993)</i>	
<i>Guyana (1996)</i>	
<i>Haiti (1987)</i>	

The **non-Latin Caribbean countries**, which are governed by *common law*, recognise the right to health indirectly. Indeed, Suriname and the non-Latin countries governed by common law, except for Guyana, refer to the right to health indirectly by generically indicating that general well-being is the objective of government. Thus, instead of guaranteeing the right to health in categorical terms, their law contains provisions that limit the exercise of other human rights in order to protect health, among other reasons. Even further, lower legislation and/or programs in these countries actually recognise the right to coverage for the entire population.

In general, the countries recognise the definition of health issued by the World Health Organisation and the Declaration of Alma-Ata of 1978. That Declaration establishes the

principles of primary care, individual responsibility for that care, and community participation.

b. Universality

In all Latin American countries, the legal framework recognises that the right to health is universal, either explicitly, as is in Brazil, Cuba, Ecuador, Venezuela, and Guyana, or implicitly.

In the non-Latin Caribbean, the recognition of health as a universal right is implicit in the International Covenant on Economic and Cultural Rights, ascribed to by the vast majority of the countries that were analysed.

Almost all the states analysed (with the exception of Saint Kitts and Nevis, Saint Lucia, Antigua and Barbuda, the Bahamas, and Cuba) ratified the International Covenant on Economic, Social, and Cultural Rights that forms part of the United Nations Charter of Human Rights, which defines health as a universal social and human right.² For this reason, even if this right is not explicitly stated in constitutional law or lesser legislation, subscription to and ratification of the covenant by these countries, along with their participation in other international treaties that expressly recognise the universality of the content of that right, elevates health as a social and universal right within each nation. Some countries such as Argentina even assign a constitutional hierarchy to these treaties.

The constitutions of several countries, such as Uruguay, Venezuela, Nicaragua, and the Dominican Republic, guarantee free health care and services to the indigent population. The text of some constitutions, such as those of Colombia and Nicaragua, have specific provisions with respect to the right to health of children, young people, families, the elderly, workers, and the disabled.

1.2. The Role of the State

Most countries establish responsibilities for the central and local governments with regard to ensuring access to health.

In a sizeable number of countries, high-level legislation defines the role of the central government, local governments, and even intermediate-level entities.

The trend is to assign responsibility to the central government for planning, setting standard, and regulating the health system. This type of definition is found in the constitutions or legislation of Argentina, the Bahamas, Bolivia, Brazil, Chile, Colombia, Ecuador, Honduras, Nicaragua, Peru, Paraguay, and Venezuela. Some constitutions also define the characteristics of service providers, including private providers, as in the case of Chile and Colombia.

² UNDP (1998).

Each designation of responsibility tends to expand the guarantees of recognised rights. In general, lower-level legislation is concerned with designating the areas for establishing and guaranteeing these rights to citizens. In most cases, the Ministry of Health exercises the steering and regulatory role in the system. Some regulations even mandate public services for the indigent population.

The non-Latin countries provide legal protection that depends largely on the judicial precedents in the interpretation of their constitutions. There are no explicit references to human rights, even when they can be demanded to the courts. Under common law, judicial decisions serve as the basis for subsequent decisions by other judges.

In most cases, constitutional guarantees of the right to health facilitate the possibility of judicial protection. Judicial channels and new legal mechanisms such as the Public Advocate, introduced as part of reforms to modernise the State, contribute to operational recognition of these rights. Thus, special courts are created, such as the Special Health Tribunal in El Salvador, whose rulings can be appealed to the Ministry. In several countries, such as Argentina, the Public Advocate is being introduced as one entity more for the defence and recognition of these rights.

The socialist constitutions of Cuba and Guyana commit the authorities responsible for social policy matters to protecting the guarantee to health. Therefore, protection depends not only on the judicial system but also on political structures.

1.3. Civil Society

The constitutions of Bolivia and Brazil promote popular participation in the definition of health priorities and the control of public health services. In the private sector, Argentina tends to delegate this activity to consumer protection entities at the intermediate level.

Legislation, which tends to recognise the community as both the promoter and the object of progress, considers health a social good, defining the parameters that guarantee access to health services—for example, Law 100 of Colombia, the Health Code of Bolivia, the General Health Laws of Costa Rica and Mexico, and the laws creating the National Health System in Chile and the Unified Health System in Brazil. This latter country is perhaps the best example in Latin America of how health can contribute to the democratisation of the State and society.

The inclusion and recognition of the right to health as a collective right is just beginning in the Region and limited to very few States. Some countries (Argentina, Brazil, Colombia, and Paraguay) include various rights in their constitutions that involve the right to health.

Significant is the constitution of Guyana, which is guided by socialist and cooperative principles that promote social participation mechanisms. This constitution recognises the importance of cooperatives and considers NGOs to be part of the health system.

2. The Health System, its Subsectors, and their Role in the Evolution of Legal Coverage

The health systems of Latin America and the Caribbean generally have three subsectors: (1) the public subsector, (2) social security, and (3) the private subsector.

- in *the public subsector*, the Ministry of Health is the most important service provider and also exercises a prevention, sanitation, and curative role. In this subsector it is common to find the armed forces, the police, and even medical schools participating in the health services. Sometimes charitable institutions are also involved in this or in the private subsector, depending on their legal status. In general, this subsector covers most of the population, including the poorest people who have no alternative but to use these services. The public subsector generally accounts for a smaller share of national health expenditure than the other subsections (see Graph 1). Coverage by the public sector is universal, unlike that of public or private insurance systems, which can either be compulsory or voluntary, but which require formal membership and premium payments, and provide services;
- the *social security subsector* generally covers workers in the formal sector and sometimes their dependants. Normally, membership is compulsory. Benefits include care for illness, maternal and child programs, compensation for occupational injuries, and dependency allowances. In some countries, such as Chile and Argentina, social security coverage exceeds that of the Ministry of Health. This subsector generally has greater participation in total health expenditure in Latin America;
- the *private subsector* generally consists of private insurance, prepayment companies and private service providers, either for-profit or nonprofit. There is a trend toward the development of these entities in plans organised by for-profit entities, employers, cooperatives, and communities, particularly with regard to service providers. Traditional and popular medicine is also included here.

We can classify countries according to when they introduced legal coverage for their health system or health insurance:

- the pioneer countries influenced by the Bismark Law at the beginning of the century (Chile, Brazil, Ecuador, Peru, Argentina, Colombia and Cuba);
- a second group, influenced by the Beveridge Report and the ILO beginning in 1940, approved insurance for maternity and/or illness (Venezuela, Costa Rica, Panama, Mexico, Paraguay, Argentina, Colombia, Guatemala, the Dominican Republic, El Salvador, and Bolivia). In the following decade, Honduras, Nicaragua, and Uruguay approved similar plans;
- finally, between the 1960s and 1970s, the countries of the non-Latin Caribbean, having achieved independence from the United Kingdom and other colonial

nations, passed laws including cash benefits in the case of illness, although some of these countries had previously adopted national health systems;

- Haiti was the last country to pass a health insurance law. It was not implemented until 1992.

The starting date of universal legal coverage of each health system considered here—with the “system” per se understood as the subsections that make up the health sector of each country, and not the national health system—corresponds to the moment after which the state is obligated to guarantee the right to access to health to all the population, since that it is the moment after which this right can be demanded. In other words, it is the moment when this right is positively recognised through the establishment of mechanisms to guarantee that the entire population can exercise it.

Accordingly, when one speaks of the starting date of legal coverage for health service delivery, one should go back to the 1940s. This was when the public subsector ceased to exercise a policing role limited to avoiding the spread of disease and providing social welfare to indigents or those in need of resources. Instead, it came to recognise its responsibility as the guarantor of the collective right to health, as carried out proactively in each country, be it through a health *system* (usually in the public subsector) or through *health insurance* (usually its own subsector).

In the case of countries with national health systems, both moments—the beginning of legal coverage by the system and of recognition of the subsector's role as guarantor of the right to health—occurred at the same time.

In the case of countries with social security that is less integrated with the public subsector, the beginning of legal coverage dates back to the moment when the legal framework recognised the State's commitment to and responsibility for health as an individual and social right of the entire population. In these cases, the starting date of social security indicates only the beginning of legal coverage specific to this subsector, except for when a unified social security system had been approved, as occurred in Brazil. It is worth noting that Brazil falls under the category of a unified social security system because of its organisation and financing, but that the system also coexists on a large scale with private insurance.

Since legal coverage began, there has been a differentiation between countries with social security that provides cash as well as in-kind health benefits, and countries with national health systems that provide in-kind benefits, and where social security is limited to granting health benefits in cash.

Tables 2 and 3 show that the larger the share of social security in the total coverage of a nation's health system, the greater is the real coverage of the system, with the obvious exception of countries that have a national health system with broad coverage by definition. The tables show that the consistent trend continues for greater real coverage of the entire population in countries that pioneered the creation of social security, and where that system covers a significant proportion of the population.

Coordination, articulation, and modularization among the three subsections are the object of the reform processes in most countries. These processes tend to recognise the steering role of the Ministry of Health and/or other coordination entities. The general trend is to go further and also to recognise the importance of civil society's participation in the process. The defined lines of intervention are in the planning and setting of priorities, with a tendency toward decentralisation, separation between health services delivery and financing, and a change in the public/private mix.

Countries on this track are generally those with greater integration, such as the non-Latin Caribbean countries or Cuba, with its unified national health system, as well as Costa Rica and Brazil, which make the Ministry of Health the coordinator of the public subsector and social security. All of these countries recognise the value of the primary health care strategy.

The countries that over the past five years had the largest increase in real coverage were those that had segmented organisation of their health systems and that intensified or carried out social security system reforms with greater integration. In general, these countries have high levels of exclusion, with limited development of structures based on patronage and dependent on the State. The changes at hand are therefore more politically viable in these countries.

Bolivia and Peru are first with a 36 percent increase in coverage, followed by Honduras (31 percent), Paraguay (16 percent), El Salvador (14.5 percent), Guatemala (10 percent), Nicaragua (14 percent), Ecuador (9 percent), Colombia (6 percent), and Guyana (5 percent).

In these countries, the operative reforms tend to modify the financing-provision model and achieve greater articulation of the system on the basis of universal insurance models.

Brazil and Mexico have instituted important reforms and also significantly increased coverage, which is remarkable, considering their large sizes and populations. Brazil was moving toward profound changes in the sector back in the 1980s, and that reform is still in progress. Mexico is currently deeply involved in the reform process. The two countries have achieved increases in coverage of 15 and 13 percent, respectively, during the period analysed (1992-1998).

The case of Colombia is also notable. Its adoption of the General System of Social Security in Health is an example of how it is possible to use the general clauses of the constitution as the basis for legislative regulation that develops the responsibilities of the contemporary State in health. It is important to emphasise that the joint effort of Colombia's legislative and executive bodies to modernise the legal infrastructure of the health sector was supported by progressive legal interpretations by two of the highest tribunals of the nation's judicial branch, the Supreme Court of Justice, and the Council of State. These interpretations stabilised the prevailing structures.

Reform in Colombia managed to triple health coverage, which increased from 19 percent of the insured population in 1992 to 61 percent in 1996. Although the remainder of the population is theoretically covered by the public subsector, there is still a large group without coverage.

3. The Gap between Legal and Real Coverage

The available information on real coverage is generally limited. In principle, legal (or theoretical) coverage is determined by the coverage of the different subsections and the degree to which the system is integrated. However, in many cases real coverage is closer to the actual demand for care than legal coverage.

The countries that administer or coordinate a national health system, such as Cuba, Costa Rica, or the non-Latin Caribbean countries, have better information on real coverage of the population. The limited information available in the other countries does not imply they are unaware of the lack of access to health services, as shown by the fact that most of them have taken steps to address the problem. Rather, it is due to an absence of information on the degree of access.

Real coverage, as measured by the percentage of the population with regular access to health services, is far from legal coverage, which stands at 100 percent in all the countries of the Region (see Table 3).

The gap between real and legal coverage can be attributed to two types of causes, (1) exogenous and (2) endogenous.

Examples of exogenous causes are:

- *negative effects of State reforms.* Economic globalisation, regional integration processes, trade liberalisation, and fiscal crises have given rise to first- and second-generation processes of State reform. These reforms are usually undertaken with a view to structural adjustment and privatisation, with the resulting change in social policies. These reforms have generally resulted in a smaller State apparatus, with a consequent increase in the informal sector and pressure on public systems;
- *poverty.* According to ECLAC, 39 percent of households in Latin America in 1994 lived below the poverty line. The percentage of poor families in Latin America declined from 41 to 30 percent between 1990 and 1994, but the reduction in poverty was smaller, since the percentage of families living in these conditions declined only from 18 to 17 percent;
- *distribution of income.* The inequitable redistribution of wealth is the principal problem that separates the different segments of the population and which also influences the coverage of health services. Latin America has the most unequal income distribution of any region in the world;

- *unemployment and underemployment.* In 1996, open unemployment was between 10 and 18 percent in Argentina, Colombia, Panama, Uruguay, and Venezuela. However, for some countries of the Region, underemployment—work with a lower remuneration than the national minimum wage—constituted a most serious problem. These countries include Peru (with 48 percent of the population underemployed) and Colombia (14.7 percent). Regionwide, it is estimated that between 20 and 40 percent of the population earns less than what is necessary to cover the basic food basket. Unemployment particularly affects low-income families, people with low levels of education, young people, and women.

To be able to identify the endogenous causes of the gap between real and legal coverage of systems, it is necessary to analyse the health care models of each country and their correlation with the type of coverage that each provides. Following this criterion, four groups of countries³ have been identified.

A. INTEGRATED PUBLIC SYSTEMS: The Bahamas, Barbados, Costa Rica, Jamaica, Grenada, Cuba, and Trinidad and Tobago

In this first group are countries that have integrated public systems, with public financing and public provision of services.

These countries offer and finance universal coverage through taxes and the allocation of global budgets, generally through public service providers. Costa Rica is the exception in this group because its social security subsector is coordinated with the public subsector. The latter is the dominant insurance and service delivery model.

The private subsector has traditionally had a minor role and has often been seen as complementary to public insurance. More recently, however, there has been a certain boom in this subsector in some countries (such as Jamaica). Under this model, physician professionals can practice in both the public and private subsections.

These are middle-income countries in a more or less advanced stage of the epidemiological transition, which means they are beginning to have to deal with the challenges posed by that shift.

Causes of the gap:

The percentage gap between real and theoretical coverage is low in these countries.

Profile of Exclusion:

Although the excluded population is small, there are vulnerable groups (basically the elderly, some chronic patients, and a migrant population). The policies and strategies to

³ Maceira (1996).

expand coverage are aimed at improving the quality of services and are beginning to be targeted toward vulnerable groups.

The exception in this group is Trinidad and Tobago, where 30 percent of the population is without access to health services because of a lack of geographic access, centralisation of the public subsector, and administrative inefficiencies. The situation is exacerbated by high transportation costs and the scarcity of services in rural areas.

B. COUNTRIES WITH REGULATED, MIXED-INSURANCE SYSTEMS: Argentina, Chile, and Uruguay

This group uses various forms of financing, insurance, and service delivery, but with a significant amount of public regulation. These countries also exhibit significant differences in terms of the percentage of public financing in total health expenditure.

In principle, the public subsector covers the entire population, although its target is the population not covered by the other subsections.

The social security subsector is financed through fees and the premiums of employers and workers, and service delivery is performed by private institutions in the case of Chile (Institution for Health Insurance, ISAPRES), unions in Argentina (Social Benefit Program), and state agencies in Uruguay (Directorate of Social Security for Illness, DISSE). Social security services in the three countries reach more than half the population and are delivered through public facilities or contractors.

The private subsector is organised and offers various health service plans. The private sector, both for-profit and nonprofit, is also an important provider of services of medium to high levels of complexity.

Chile has been a leader in reforming the relationship between financing, insurance, and service delivery in the public subsector. It operates on the basis of regulated competition (which includes the National Health Fund, FONASA and ISAPRES) and the gradual elimination of cross subsidies. Chile's lead is followed by Argentina, which has deregulated the Social Benefit Program (allowing for the possibility of free choice at the national level) and created the Public Self-managed Hospital. Meanwhile, Uruguay heavily regulates the Collective Medical Care Institutions (IAMCs), which provide the social insurance that covers the risk of disease and maternity, and which receive part of their financing from public funds.

Causes of the Gap:

- *difficulties in mechanisms to allocate and distribute resources.* In these countries, primarily Chile and Argentina, there have been advances in decentralisation (to the provinces in Argentina, and primary care to the municipalities in Chile). But the resource allocation mechanisms continue to pose difficulties. Although hospital budgets in Argentina continue to be subject to historical patterns that generally do not take outcomes into account, there have been some interesting

efforts at the provincial level. Similar pilot programs have been tried in Uruguay and Chile;

- *lack of coordination and articulation between subsections.* There are cross subsidies and duplication of coverage for certain groups, to the detriment of those in need of resources;
- *the private insurance and social security expenditure exceeds the expenditure of the public subsector,* which should serve the indigent population and the population not covered by the other two subsections;
- *the reforms implemented have not been able to overcome the fragmentation of the system and the bias of insurance toward high-income subscribers.* This is the case of the ISAPRES with regard to the subscribers to FONASA in Chile, and of the uninsured in Argentina, as well as the subscribers of poorer entities of the country's National Benefit Program.

Profile of Exclusion:

In Uruguay, the family members of social security subscribers lack coverage. This is not the case in Argentina and Chile, where even segments of the informal sector of the economy and other excluded groups have gradually received coverage under the insurance system. Uruguay has managed to incorporate the low-income elderly into the social security system. However, a sizeable number of part-time and rural workers continue to be marginalised from social security in all of these countries.

Colombia has recently implemented a managed competition model with public and partially public financing in the public subsector, public financing of private insurance, and a strong municipal role in establishing the conditions for insurance and service delivery. The idea is to generate a significant increase in insurance coverage. With its characteristics, this system could be included in the mixed regulation insurance group, but the process is too new to draw definitive conclusions.

C. COUNTRIES WITH UNIFIED HEALTH INSURANCE: Brazil

The Brazilian system is defined as a national health system with public financing and mixed service delivery. However, its model of financing, organisation, and high levels of private service delivery make it a form of social security with a tendency toward a unified system.

Brazil is the only country in the Region that has moved toward a unified health system. This country did not opt for breaking up its health insurance entities, but rather for their progressive unification into a public entity with the goal of universal coverage.

Causes of the gap:

- deficiencies in care lead to a high volume of out-of-pocket private expenditure and private insurance markets (sometimes overlapping with public insurance) that cover 20 percent of the population;
- the new model of care has increased real coverage in health. However, regulation needs to be improved to obtain better results.

The lack of articulation with the private subsector and regulation is leading to overbilling and a deterioration in the quality of services.

Profile of Exclusion:

- The population without real coverage is estimated at 10 to 20 percent, including the poorer and rural population (in the north and northeast), the black and indigenous populations, populations that are landless or with very low income, children under 3, the elderly, and women.

D. COUNTRIES WITH SEGMENTED SYSTEMS: Mexico, Haiti, the Dominican Republic, Guatemala, Honduras, El Salvador, Nicaragua, Panama, Guyana, Suriname, Venezuela, Ecuador, Peru, Bolivia, and Paraguay

This is a heterogeneous subgroup both in terms of segmentation (much lower in Panama or Mexico than in Bolivia or Ecuador), and real coverage (much lower in Haiti than in Panama or Mexico). In addition, current efforts to extend coverage vary widely among the countries. In Panama, these effort include the creation of consortia between the Ministry of Health and the Social Security Fund; in Mexico, decentralising services for the uninsured population to states; and in Ecuador, Peru, and Bolivia, developing public subsector insurance schemes for rural or poor populations.

Causes of the Gap:

- *inefficient allocation in the public subsector*, which, theoretically, continues to be the principal insurer, and the relatively poor quality of its services;
- *social security covers varying proportions of populations*—more than 50 percent in Mexico, but only some 15 percent in Bolivia. In many cases, its segmentation into multiple insurance entities creates serious efficiency problems.
- Private insurers are growing but are not still highly developed.
- Profile of Exclusion:
- In the countries where social security coverage is low and access to and/or the quality of public subsector services are deficient, the lower-income sectors also

opt for coverage by NGOs or nonprofit organisations, or for private care. In these countries, the percentage of private health expenditure is greater than that of public expenditure.

- The services offered are located in urban and peri-urban areas, and exclusion primarily involves the poor rural population.

Conclusion:

Of the endogenous causes for the gap between real and legal coverage, the countries with greater coordination and articulation of services (cases A and B and to a lesser extent C) have the highest coverage levels, even with lower levels of health expenditure.

Coordination also favours better control of benefits and thus, the quality of services. In countries that have obtained better results, regulatory measures include decentralisation and involve civil society.

4. Trends in Health Expenditure as a Percentage of GDP

National health expenditure as a percentage of GDP and the percentage share of the health subsections are indicators of the allocative and operational efficiency of health systems, as well as the economic and financing constraints that countries face in implementing their policies.

The average health expenditure in the Region is 7.3 percent of GDP. There is a significant difference between countries with higher expenditure (Uruguay with 10 percent of GDP) and those with lower (Haiti with 3.5 percent)⁴

Countries can be divided into four groups according to the health expenditure-GDP ratio, with one-quarter of the countries in each group.

⁴ PAHO (1998).

Elements for the Comparative Analysis of Extension of Social Protection in Health in Latin America and the Caribbean

Health Expenditure as a Percentage of GDP, 1995⁵

> 6.9%	6.0-6.9%	5.0-5.9%	< 5.0%
Uruguay Costa Rica Panama Suriname (1996) Cuba Colombia (1995) Venezuela Brazil Guyana Honduras Chile	Dominica Nicaragua Argentina (1997) Barbados Antigua and Barbuda Bolivia	El Salvador (1994) Saint Kitts and Nevis Saint Vincent and the Grenadines Dom. Rep. Ecuador Jamaica Grenada Paraguay Saint Lucia	Trinidad and Tobago Bahamas Guatemala Belize Mexico Peru Haiti

Source: Authors' calculations based on data from the countries and from PAHO (see Table 3).

The general trend in the Region between 1994 and the last available year is not uniform for all the countries. There is even a reduction in health expenditure as a percentage of GDP in poorer countries, such as Haiti, the Dominican Republic, Bolivia, Paraguay, Nicaragua, Mexico, Peru, Belize, El Salvador, Nicaragua, and Jamaica, as well as in some of the non-Latin Caribbean countries (the Bahamas, Barbados, and Antigua and Barbuda).

The average for the Region indicates that public spending accounts for 41 percent of national health expenditure, while private expenditure accounts for 59 percent. This confirms that the less developed the country, the lower the proportion of public spending in total national health expenditure. This should serve as orientation for the design and implementation of policies that correct such inefficiencies.

Graph 1 shows that, in general, expenditure goes largely to the private subsector, followed by social security and, finally, the public subsector.

The health expenditure of social security institutions is the largest component of public spending (representing 40 percent of the total). Central government expenditure represents 1 percent of GDP, and that of the local governments 0.6 percent (significant in Argentina and Brazil).

Public expenditure on health includes social security expenditures that cover in-kind benefits for maternity and illness financed by compulsory contributions to health funds administered by public social welfare institutions, social security institutions, cooperatives, or private institutions such as ISAPRES in Chile and the IAMCs in Uruguay.

The countries of the non-Latin Caribbean, with universal coverage, have insurance coverage to compensate for losses in income from employment due to illness. The

⁵ Source: Elaboration from county data and PAHO (see table 3).

curative services of the program for illness and maternity, on the other hand, are provided by the national system.

For insurance systems, there is a close tie between expenditure and social security coverage. There is greater coverage in countries with greater expenditure on public insurance systems.

Private health expenditure represents, on average, 4.3 percent of regional GDP and 59 percent of national expenditure, two-thirds of which are direct expenditures and one-third indirect expenditures (private insurance). This expenditure is particularly high in Argentina and Brazil, representing some 50 percent of the private expenditure of the entire Region.

Private insurance covers approximately 11.4 percent of the population of the Region and represents 19.55 percent of national health expenditure.

NGOs also play an important financing role for the private subsector and in health service delivery in the poorer countries. In some countries, NGOs also receive subsidies from the State, as in Haiti, the Dominican Republic, Guyana, and Suriname.

III. SECTORAL POLICIES AND STRATEGIES

1. Introduction

Health policy reform and implementation throughout the Region of the Americas is set within a context of economic openness, democratic consolidation, and restructuring the State. Analysis of the experiences of the countries reveals that, consistent each situation particular, they have pursued a variety of models and strategies to achieve universal coverage, and services of good quality.

In general, the process of restructuring the State has led to major reforms in current social policies. Along with explicitly establishing the regulatory role of the state, the involvement of the private sector has been regulated, mechanisms have been created for improving access and to protect excluded groups, and alternative financing mechanisms have been defined.

During this decade the process of health sector reform has intensified in many countries, with a view to providing efficient, good-quality services to all, and to respond to the cumulative and emerging needs of the population. Increasingly the need to achieve greater equity and efficiency in the utilisation of resources are stressed, with emphasis on care for the most vulnerable groups, and the control of priority problems, through externally-oriented, cost-effective measures.

In spite of this, and largely in response to the requirements of state reform, health sector policy has generally focused on financing and organisation models, to the point of neglecting its basic goal of improving access and the quality of the benefits of the systems, although there have been some improvements in this regard.

2. Strategies to Expand Social Health Coverage

Analysing the country case studies reveals a set of strategies for expanding coverage that can be correlated to these policies. They are listed in Table 6. This table describes the strategies of the last decade and their trends.

The policies can be divided between those that tend toward universal coverage, and those which are targeted. Within both groups the countries have opted for a variety of strategies, using diverse mechanisms to reach their goal. How the chosen strategy contributes to that end can in some cases be readily identified, although in other cases such a determination calls for a complex set of mechanisms and actions.

The strategies can be organised into the following categories (see Table 6):

a) Strategies for health system reform to improve **efficiency**:

- targeting in primary care
- development and regulation of the private subsector
- participation of NGOs
- separation of supply and financing functions
- decentralisation and strengthening of the steering role
- creation of a National Health System

b) Strategies to improve **productivity and quality** in the services:

- improve management of the supply units and of the system
- strengthen the network of services
- hospital self-management
- incentives to units and individuals
- basic packages or basic services
- essential drugs
- standards and quality criteria
- improved auditing and control

c) Strategies to increase **local participation** and adapt the services to local needs and conditions:

- local health systems
- community participation
- decentralisation

d) Strategies to reduce **financial exclusion**:

- increase health coverage through Social Security in Health
- introduce Models of Basic Health Insurance
- reform the payment and copayment models

e) Strategies to reduce **cultural exclusion**:

- humanise care
- introduce health models while acknowledging the identity of the people

f) **Targeted program strategies:**

- supplementary nutrition programs;
- extension of vaccination programs;
- reinforce programs for disease prevention and control;
- programs to expand coverage in rural areas;
- programs for social protection of low income groups.

3. Analysis of the Strategies

The strategies can be classified according to supply and demand of health care, and as a function of the subsector they impact (for purposes of this table, social security and public subsections are classed as “Public” subsections).

Strategies to Expand Coverage:

Supply		Demand	
Public Supply	Private Supply	Financing	Acceptability
<ul style="list-style-type: none"> - Strengthen the network of services. - Improve management of the provider units. - Standards and quality criteria. 	<ul style="list-style-type: none"> - Develop and regulate the private subsector. - Participation of NGOs. 	<ul style="list-style-type: none"> - Social Security in Health. - Basic Health Insurance. - Reform of payment and copayment models. 	<ul style="list-style-type: none"> - Humanise care. - Community participation.

In general, we can observe that the best results are the fruit of a combination which includes a set of programs to improve supply, and activities to increase demand (especially in vulnerable groups or groups without effective access to care).

Below are some examples of countries with packages of simultaneous strategies for effectively extending coverage to the entire population:

MEXICO As part of the strategies to extend coverage, social security beneficiaries may choose the physician who will treat them. Furthermore, the Mexican Institute of Social Security (IMSS) established a family insurance program and a healthy municipalities program. The Program to expand coverage (PAC) was launched in 1996; it hinges on a health services package for people in rural areas who lack access to medical services; in 1997 this managed to cover 6 million people in 18 states.

NICARAGUA initiated a process of reforms in 1990 to increase administrative decentralisation toward its intermediate structures (Local Health Care Systems–SILAIS) and, at the same time, to extend coverage, adapting it to the needs of each community.

In COLOMBIA, reforms made it possible to triple coverage of beneficiaries from 19% to 61% of the population between 1992 and 1996. The rest of the population is theoretically covered by the public subsector, but there is still a large group who lack effective coverage. The factors expected to influence progress in quality of health care, coverage, and equity in the new system are: promotion and prevention activities, a major increase in the financial contribution of the state for health, increased efficiency of expenditures due to competition, a strong contribution from higher-income groups, and the solidarity inherent in the system. One benefit proposed as part of the reforms is the Compulsory Health Plan (POS-S), which embraces individual, family, and collective actions. It was designed to respond to the needs of poor and vulnerable populations. All actions in the Basic Care Plan are geared to health promotion and prevention, and are community-oriented. This is a territorial plan, which is free, compulsory, and the responsibility of the state.

ARGENTINA is applying measures to increase the effectiveness of extended coverage and decentralisation, develop local networks, define the Self-managed Public Hospital and the Compulsory Medical Program with its package of basic benefits, and to bring in private health care facilities, Social Security, and the Primary Care strategy. The current debate hinges on the feasibility of provincial health insurance or a national public insurance.

BRAZIL created the Unified Health System (SUS), whose purpose is to extend health coverage, for which the following structural changes occurred:

- implement a process of cultural change premised on citizen values and action;
- consolidate the public subsystem;
- organise and regulate the private care subsystem;
- operate the public and private subsystems along competitive lines.

Government actions are centred on improving the state of health, especially with respect to reducing infant mortality, and reorganising and modernising the operating capacity of the health system. Several specific programs to expand coverage were implemented, such as the Social Protection Network (RPS), a variety of actions geared to the delivery of basic social services to low income groups.

In CHILE, the reforms begun in 1990 have sought a balance within Chile's mixed system, by revaluing the role of the state through a process of progressive devolution of autonomy to the provider units, and by a result-based financial reform that provides incentives to management. A set of health strategies was launched to advance government policies to modernise the state and eliminate extreme poverty:

- reduce waiting lists;

- humanise care and improve treatment of the user;
- strengthen and modernise the public health system;
- expand participation and social control in health;
- improve the coverage and quality of care for the elderly;
- strengthen adolescent health care.

Several specific programs to expand coverage were set up or strengthened: to reduce infant malnutrition (National Supplementary Nutrition Program), for health promotion, for disease prevention and control, and for drinking water and sewerage services.

The central lines of the current reforms involve defining the Guaranteed Health Benefits Plan (PGBS), redirecting public subsidies from supply toward users, and establishing a risk-based management system based on community parameters. Reforms are based on the diagnostic of the country's dual health system, which perpetuates shortcomings of the private and individual health insurance schemes, as well as shortcomings of bureaucratically organised public supply schemes financed on the basis of supply.

In URUGUAY, the reform of the state reaffirms the two substantive duties of the Ministry of Public Health. These are, on the one hand, prevention and free care for the indigent and people lacking adequate resources, and on the other, health promotion through the control and reduction of risk factors associated with diseases and the improvement of health care for the entire population.

The policies of the countries in the region have promoted private delivery of health services by means of medical cooperatives, while increasing public financing.

In some cases the strategies applied are extensions of strategies already in place, such as primary health care. Other strategies have not yielded the hoped for results, since they lacked mechanisms to truly expand coverage.

The trend in Argentina, Chile, and Colombia is toward managed competition, for which purpose new state regulatory agencies have been created. Brazil is using a social security program in health which tends to strengthen decentralisation and the separation of the financing and services delivery functions.

Simultaneously with the objective of expanding coverage, some countries are envisaging improvements in their current health system, whose segmentation prevents them from harmonising their objectives and being consistent with the values of universality and efficiency set forth in their sectoral regulations. Some countries have begun to define basic packages of services, as well as essential drug lists to meet the requirements of the low-income populations. There is also discussions about the separation of the financing and supply functions, the steering role of the system, articulation, and modularization.

All countries are opting for strategies that target vulnerable groups. Table 3 documents a trend toward increased coverage in the systems. The more developed countries have sought to reduce exclusion by incorporating rural workers into social security, or by improving the quality of benefits. The reform processes in countries where social security predominates show a clear trend toward the inclusion of excluded population groups within its coverage.

The appearance of programs geared to the elderly has been noticed in some countries with ageing population pyramids. Such is the case, for example, in Uruguay, Chile, and Mexico, which have felt the burden of the demographic transition, and the need to develop structural mechanisms to address it. Argentina also has special programs for the elderly, as well as a special insurance mechanism that, through national social welfare, covers some 4 million members, most of them above age 65.

Also to be noted is the coverage of the indigenous population in the several countries. There are special programs to cover indigenous populations in, for example, Mexico, Argentina, and Guyana.

NGOs participate in the health sector of virtually all countries. The majority of the countries, especially those with a high proportion of excluded persons, have major programs for the indigent, and involve NGOs in direct care activities, or in the financing of health care services. Many of these entities also receive state financing, or the state pays its workers.

IV. CONCLUSIONS

Inequities in the health conditions of the population and in their access to health services are unjust and avoidable. In addition to inequities between countries, health inequities can be observed in all of them. These affect mainly the most vulnerable social groups.

Despite the achievements of some countries, we can confirm that from the regional perspective, social development has not been adequate. Inequities have increased and more than 20% of the population lacks access to social protection in health.

In their process of reform, the countries have adhered to the guiding principle of attaining universal coverage. They have sought to achieve this through a variety of public and private insurance modalities, usually involving state care of the insured population, and strategies that target poorer groups. The strategies proposed range from universal coverage, to free care for persons lacking coverage, to the use of basic on-demand plans, to increasing local response capacity.

In the light of this analysis, the search for alternative solutions should take universal coverage as its goal, regardless of what specific mechanism is adapted to the circumstances of each country.

The legal framework has been a helpful tool, acknowledging the importance of this goal, but it has not been sufficient.

The values of universality, solidarity, sustainability, and equity on which this vision is premised should be built into the goals and actions of the community. Health for all is the most important, far-reaching goal ever posited. Implementing it requires strategies and actions that involve the community as a whole and that allow for creative tension between present and future, the commitment to change, and acceptance of innovation. Accordingly, renewal of the goal of health for all should be a top priority of the political agenda.

As a general rule, changes to extend social coverage in health have started by modifying the legal framework. This condition is necessary, but not sufficient to reach the goals of health for all by the year 2000 in the Americas. It should suffice to remember that the minimum indicators established for the American hemisphere have not yet been reached on life expectancy (70 years), infant mortality (2.4 per 1,000 children), access to drinking water and hygienic wastewater disposal (100%), and access to health services (100%).

The early or late development of social security had an observable influence on the evolution of the State of Well-being of the countries analysed, with the exception of the non-Latin Caribbean. The rise of social security in the countries analysed provides an indicator of each country's capacity to make real the right to health set forth in law.

The countries with the highest degrees of exclusion were those where social security developed late or where there were difficulties in integrating the system (or both). The most significant changes were noticed in countries with reforms to correct this situation.

Countries with large populations, such as Mexico and Brazil, show certain characteristics in common. These nations have regions, sometimes the size of other countries, with highly differentiated indicators, which hinder efforts at reform or such reforms as are accomplished.

Not all states have achieved an intersectoral consensus on promoting equity, reassigning public financing, promoting citizen participation, improving quality, or reaching agreements with providers, to achieve adequate, consistent support in public opinion.

The countries acknowledge the problem of exclusion. In order to address it, they have prepared strategies such as targeted health coverage programs, whether by vulnerable group or by pathology.

Profound changes were also observed in the financing and supply models. Brazil, Chile, and Colombia have perceptibly increased their real coverage pursuing such strategies.

Decentralisation, along with the definition of a basic package of services and essential drugs to meet the requirements of the population low-income, has also helped expand coverage. A majority of the countries have introduced plans and programs to this end. As part of this strategy, several countries defined basic packages of health or basic services.

Another mechanism has been the introduction or extension of social health insurance schemes, basic insurance, additional insurance, or catastrophic health insurance, and the promotion of universal access to such insurance. Targeted programs to complement universal programs have also been developed, directed at vulnerable groups.

A major obstacle in extending coverage is the fact that the groups targeted by this strategy often have trouble accepting health services due to a variety of reasons, including cultural reasons. A few programs are designed to increase cultural access, such as Health with Identity in Bolivia. This area, in particular, lends itself to innovative solutions.

There are also local initiatives, such as microinsurance schemes, through which efforts have been made to improve the coverage of health service, such as the Trenque Lauquen of Argentina, and in the Dominican Republic⁶.

An in depth evaluation of the effects of the different strategies to expand social coverage is beyond the scope of this study. But it is possible to say that the results to

⁶ A number of microinsurance cases are being presented at the ILO Regional Tripartite Meeting with the Collaboration of PAHO, Mexico, 29/11 – 1/12/99.

date are the results of a set of programs to improve services, in combination with activities targeted to increase access for vulnerable groups or groups lacking access to the services.

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RRMEX-PS/EST.3e

ILO regional tripartite meeting with the collaboration of PAHO
Extension of social protection in health to excluded groups in Latin America and the Caribbean
Mexico, 29 November - 1 December 1999

**ELEMENTS FOR THE COMPARATIVE ANALYSIS OF EXTENSION
OF SOCIAL PROTECTION IN HEALTH
IN LATIN AMERICA AND THE CARIBBEAN
ANEXOS**

GRAPHS AND TABLES

- Graph 1: Share of health expenditure as a percentage of GDP
- Table 2: Evolution of legal coverage of social security systems in health
- Table 3: Comparative analysis of policies to extend social coverage in health to Latin America and the Caribbean
- Table 4: Evolution of expenditure and health indicators
- Table 5: Financing-service delivery ratio, integration, and trends in the health systems
- Table 6: Specific mechanisms of strategies to extend coverage

Graph 1: Share of Health Expenditure as a Percentage of GDP

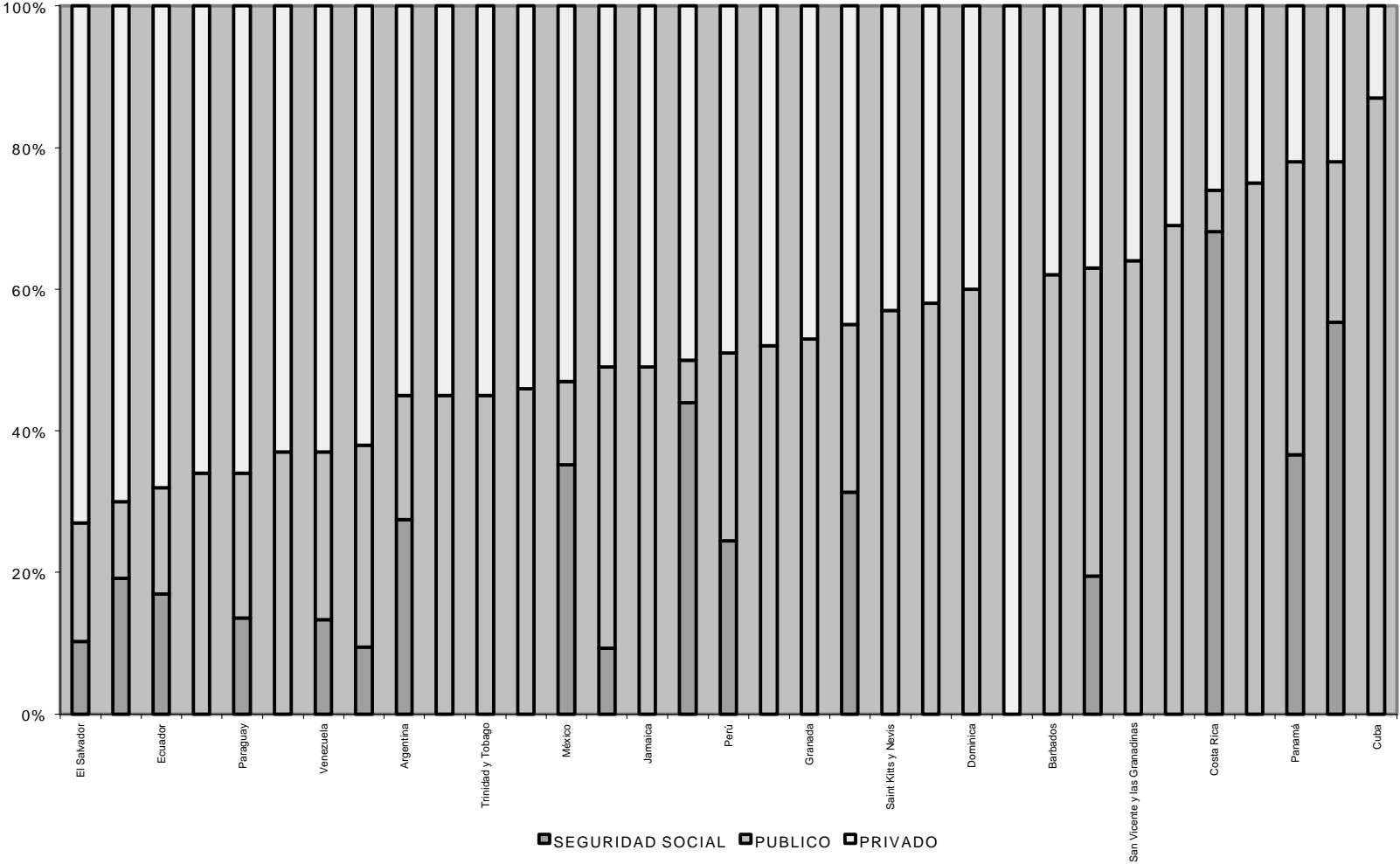


Table 2: Evolution of Legal Coverage of Social Security Systems in Health

	Last constitutional reform	Starting Date (A)	Type of initial service (B)	Initial formal worker population covered (C)	Initial temporary worker population covered (D)	Current coverage system (E)	Population covered by social insurance systems (F)	Structure of non-agricultural informal employment in LAC% (G)	Structures of formal employment (H)	Agricultural sector in the EAP (I)
Bolivia	1994	1949		X	Voluntary	EM	19	63.1	36.9	46.8
Colombia	1997	1938	ME	X	Voluntary	EM	11	57.2	42.8	26.6
Ecuador	1996	1935		X		EM	19	52.9	47.2	33.3
Peru	1993	1936		X		EM	30	57.9	42.1	35.7
Venezuela	1983	1940		Urban		EM	36	47.7	52.3	12
Argentina	1994	1934	ME	X	Voluntary	EM	59	53.6	46.4	12.2
Chile	1997	1924		X	Voluntary	EM	87	50.9	49.1	18.8
Paraguay	1992	1943		X	Voluntary	EM	19	67.9	31.1	39
Uruguay	1997	1958	EM	X		EM	63	37.9	62.1	14.2
Brazil	1996	1923	And	X	Voluntary	EM		59.3	40.7	33.3
Belize	1981	1979		Universal	Universal	IN KIND (EM)	23.2 *	47.2	52.6	
Costa Rica	1997	1941		X	Voluntary	EM	85			26
El Salvador	1982	1949		X		EM	14			36.3
Guatemala	1993	1946	EM	Urban		EM	16			52.4
Honduras	1982	1952		Urban	Voluntary	EM	14	56.3	11.3	41.4
Nicaragua	1995	1955		Universal	Universal	EM	18			14.3
Panama	1994	1941		X	Voluntary	EM	61	41.6	58.3	26.2
Mexico	1998	1943		X	Voluntary	EM	49	60.2	39.8	27.9
Cuba	1992	1934	EM	Universal	Universal	EM	...			18.1
Haiti	1987	1967					1			67.8
Dominican Republic	1994	1947		X		EM	7			24.8
Antigua and Barbuda	1981	1973		Universal	Universal	EM	...			
Bahamas	1973	1972		Universal	Universal	IN KIND (EM)	...			
Barbados	1966	1966		Universal	Universal	IN KIND (EM)	INSURANCE			
Dominica	1978	1975		Universal	Universal	EM	...			
Grenada	1973	1983		Universal	Universal	IN KIND (EM)	...			
Guyana	1996	1969		Universal	Universal	IN KIND (EM)	15 *			21.8
Jamaica	1962	1979	M	Universal	Universal		...			24.8
Saint Kitts and Nevis	1983	1971		Universal	Universal	IN KIND (EM)	...			
Saint Vincent and the Grenadines	1979	1978		Universal	Universal	IN KIND (EM)	...			
Saint Lucia	1979	1978		Universal	Universal	IN KIND (EM)	...			
Suriname	1992			Universal	Universal		33.55			21.3
Trinidad and Tobago	1980			Universal	Universal	IN KIND (EM)	...			1.1

Source: Own preparation based on Mesa Lago (1992) A,B,C,D and E

Table 3: Comparative Analysis of Policies to Extend Social Health Coverage in Latin America and the Caribbean

	Population (in thousands)	Last year with available data	Real Coverage	Legal coverage	Has strategies for extension of coverage	Recognises participation of OCSs in the health sector	Role of NGOs in health sector	Health coverage of NGOs by percentage of population (a)	Trend of coverage	Health expenditure as a % of GDP	Trend of expenditure
Subregion and country											
Andean Area											
Bolivia	7,061	1995	70	100%	U/T	YES	F-A-P	5-10%	↑	6% (1995)	↑
Colombia	39,842	1997	81	100%	U/T	YES	P-F-A	1-5%	↑	7.71% (1996)	↑
Ecuador	11,460	1995	70	100%	U/T	YES	A-P	10-20%	↑	5.1% (1995)	↓
Peru	23,468	1995	80	100%	U/T	YES	P-F-A	10-20%	↑	3.6% (1995)	↓
Venezuela	23,242	1998	70	100%	U/T	YES	F-A	1-5%	↓	7.6% (1995)	↓
Argentina	36,125	1998	71 *	100%	U/T	YES	P-F-A		↑	6.5% (1997)	↓
Southern Cone											
Chile	14,822	1996	97 *	100%	U/T	YES	P-F-A		↑	7%(1995)	↓
Paraguay	4,564	1995	70	100%	U/T	YES	F-P-A	5-10%	↑	5.0% (1995)	↓
Uruguay	3,164	1996	93.2	100%	U/T	YES	F-A-P		↑	10% (1995)	↑
Brazil	163,132	1997	80	100%	U/T	YES	P-F-A	1-5%	↑	7.6% (1995)	↑
Central American Isthmus											
Belize	230	1998		100%	U/T	YES	A-F	5-10%	↑	3.9% (1995)	↓
Costa Rica	3,362	1995		100%	U/T	YES	A-P	1-5%	↑	9.2% (1995)	↑
El Salvador	5,310	1995	73.5	100%	U/T	YES	A-P-F	5-10%	↑	5.86 (1994)	↓
Guatemala	9,980	1995	60	100%	U/T	YES	A-P-F	10-20%	↑	4.2% (1995)	↑
Honduras	5,462	1995	77	100%	U/T	YES	A-F-P	5-10%	↑	7.4% (1995)	↑
Nicaragua	4,139	1995	83	100%	U/T	YES	P-A	5-10%	↑	6.6 (1995)	↓
Panama	2,630	1995	70	100%	U/T	YES	F-A-P	1-5%	↓	9.2 (1995)	↑
Mexico	91,606	1995	90	100%	U/TI	YES	A-F-P		↑	3,04% (1995)	↓
Latin Caribbean											
Cuba	11,068	1997	100	100%	U	YES	P		↑	7.8% (1996)	↑
Haiti	7,180	1995	60	100%	U/T	YES	F-A-P	20%	↓	3.5%(1995)	↓
Dominican Republic	7,374	1995	70	100%	U/T	YES	F-A-P	5-10%	↑	5.3% (1995)	↓
Antigua and Barbuda	67	1998		100%	U/T		WITHOUT DATA		↑	6.1% (1995)	↓
Caribbean											
Bahamas	284	1996		100%	U/T	YES	P-A-F	1-5%	↑	4.3% (1995)	↓
Barbados	263	1998	100	100%	ADJUSTMENTS	YES	P-A-F		↑	6.4% (1995)	↓
Dominica	71	1995	100	100%	U/T	YES	-			6.6% (1995)	S/D
Grenada	93	1998	100	100%	U/T	YES	F-A-P			5.0% (1995)	S/D
Guyana	847	1997	89	100%	U/T	YES	F-A	10-20%	↑	7.5% (1995)	↑
Jamaica	2,527	1996	90	100%	U/T	YES	A-P	1-5%	↑	5.05 (1995)	↓

	Population (in thousands)	Last year with available data	Real Coverage	Legal coverage	Has strategies for extension of coverage	Recognises participation of OCSs in the health sector	Role of NGOs in health sector	Health coverage of NGOs by percentage of population (a)	Trend of coverage	Health expenditure as a %of GDP	Trend of expenditure
Saint Kitts and Nevis	43	1995	100	100%	U/T	YES	F-A		↑	5.6% (1995)	↑
Saint Vincent and the Grenadines	110	1995	100	100%	U/T	YES	WITHOUT DATA			5.5% (1995)	↓
Saint Lucia	142	1994	100	100%	U/T	YES	F-A-P			5.0%(1995)	S/D
Suriname	410	1993	88	100%	U/T	YES	F-A-P	5-10%		8.0%(1996)	↑
Trinidad and Tobago	1,257	1995	70	100%	U/TI	YES	F-A-P		↓	4.7% (1995)	↑

(*) Records only geographical inaccessibility data (UNDP, 1998)

U = Universalization

T = Targeted

F = Financing

A = Health Care

P = Health promotion

Source: Own preparation based on country case studies, PAHO (1998)

Table 4: Evolution Of Expenditure And Health Indicators

	Last year with available data	Real Coverage based on available data (a)	Real Coverage 1993 (b)	Health expenditure as % GDP latest available year (c)	Health expenditure as % GDP 1994 (d)	Health Indicators Professional care at birth 1995 (e)	Health Indicators Professional care at birth 1996 (f)	Infant mortality 1985-1990 (per 1,000) (g)	Infant mortality 1990-1995 (per 1,000) (h)
Bolivia	1995	70	34	6% (1995)	4.3	28	39	90	75
Colombia	1997	81	75	7.71% (1996)	7.4	96	80	35	28
Ecuador	1995	70	61	5.1% (1995)	6.3	59	22	57	44
Peru	1995	80	44	3.6% (1995)	4.6	56	45	68	55
Venezuela	1998	70	76	7.6% (1995)	7.8	95	82	27	23
Argentina	1998	71	92	6.5% (1997)	9.8	95	95.4	27	24
Chile	1996	97	93	5.2%(1998)	7.9	100	98.8	18	14
Paraguay	1995	70	54	5.0% (1995)	5.7	36	27	47	43
Uruguay	1996	93.2	96	10% (1995)	8.5	99	99	24	20
Brazil	1997	75	72	7.6% (1995)	7.4	92	70	55	47
Belize	1998		86	3.9% (1995)	8.2	80	87	36	35
Costa Rica	1995		96	9.2% (1995)	8.5	97	96.4	16	14
El Salvador	1995	73.5	59	5.86 (1994)	6.2	62	31	54	44
Guatemala	1995	60	50	4.2% (1995)	3.5	35	28	59	48
Honduras	1995	77	46	7.4% (1995)	5.3	54	45	53	43
Nicaragua	1995	83	69	6.6 (1995)	8.7	87	40	65	52
Panama	1995	70	79	9.2 (1995)	7.5	86	85	28	25
Mexico	1995	90	77	3.04% (1995)	6.5	74	95.4	39	34
Cuba	1997	100		7.8% (1995)	7.9	100	100	13	10
Haiti	1995	60		3.5%(1995)	3.6	46	40	97	86
Dominican Republic	1995	70	71	5.3% (1995)	5.8	90	85	55	42
Antigua and Barbuda	1998			6.1% (1995)	6.4		100		19
Bahamas	1996		98	4.3% (1995)	4.4		95	27	19
Barbados	1998	100	97	6.4% (1995)	6.8	100	98	13	16
Dominica	1995	100		6.6% (1995)		100	100	15	14

	Last year with available data	Real Coverage based on available data (a)	Real Coverage 1993 (b)	Health expenditure as % GDP latest available year (c)	Health expenditure as % GDP 1994 (d)	Health Indicators Professional care at birth 1995 (e)	Health Indicators Professional care at birth 1996 (f)	Infant mortality 1985-1990 (per 1,000) (g)	Infant mortality 1990-1995 (per 1,000) (h)
Grenada	1998	100		5.0% (1995)		100		28	20
Guyana	1997	89	84	7.5% (1995)	5.2	95	93	56	46
Jamaica	1996	90	89	5.05 (1995)	5.4	90	73	17	17
Saint Kitts and Nevis	1995	100		5.6% (1995)	3.5 *	100	100	20	27
Saint Vincent and the Grenadines	1995	100		5.5% (1995)	5.9	100	100	21	18
Saint Lucia	1994	100		5.0%(1995)		100	100	20	19
Suriname	1995	88	88	8.0%(1995)	4.13		91	33	31
Trinidad and Tobago	1995	70	97	4.7% (1995)	3.9	99	98.7	24	17

Sources: World Bank (1997)

a) Maceira (1996)

b) Own preparation based on country data and PAHO (1998)

c) Own preparation based on data from country case studies

e) Maceira (1996)

Average 1992-1995 (PAHO, 1998)

Table 5: Financing-Service Delivery Ratio, Integration, And Trends In The Health Systems

Country	Public Subsector	Subs. Social Security	Subsidy Social Security	Private Subsector	Subsidy To The Private Sector	Integration	State Of Well-Being	Trends
	Financing-Supply	Financing-Supply		Financing-Supply				
Bahamas	Public-Mixed	Public-Public		Private/Mixed		High	Structured universal	Local health system decentralization and privatization.
Barbados	Public-Public	Semipublic-Public	YES	Private/Private (Compl)		High	Structured universal	More insurance and competition
Costa Rica	Public-Public (Primary level)	Semipublic-Public/Mixed	YES	Private-Private (Compl)		High	Stratified universal/statist	Adjustments
Cuba	Public-Public	...		Private-Mixed	YES	High	Structured universal	PHC Reorientation
Dominica	Public-Public	Semipublic-Public		Private-Public		High	Structured universal	More insurance.
Jamaica	Public-Public	Semipublic-Public		Private-Private		Average	Structured universal	More integration
Grenada	Public-Public	Semipublic-Public		Private-Private		High	Structured universal	More insurance
Guyana	Public-Mixed	Semipublic-Public		Private-Private	YES	Decline	Stratified universal	Promotes cooperation rather than competition
Saint Kitts And Nevis	Public-Public	Semipublic-Public		Private-Public		High	Structured universal	More insurance
San Vincent And The Grenadines	Public-Public	Semipublic-Public		Private-Private		High	Structured universal	More insurance
Saint Lucia	Public-Public	Semipublic-Public		Private-Private		High	Structured universal	More insurance
Suriname	Public-Mixed	Public-Semipublic/Mixed	YES	Public-Private	YES	Average	Stratified universal	Privatization and more insurance.
Trinidad And Tobago	Public-Public	Public-Semipublic/Public	YES	Private-Private		Decline	Exclusive	More insurance, and another service package

Country	Public Subsector	Subs. Social Security	Subsidy Social Security	Private Subsector	Subsidy To The Private Sector	Integration	State Of Well-Being	Trends
	Financing-Supply	Financing-Supply		Financing-Supply				
Argentina	Public-Public	Semipublic-Mixed	YES	Private-Private		Average	Stratified universal/market-oriented	Managed comp. and public health insurance
Chile	Semipub-Public/Private-Mixed	Semipub-Public/Private-Mixed		Private-Private	YES	Average	Stratified universal/market-oriented	Managed competition
Colombia	Public-Public	Semipub-Public/Private	YES	Private-Private		Average	Stratified universal	Managed comp.
Uruguay	Public-Public	Publico-Semipub/Private	YES	Private-Private		Average	Stratified universal/statist	Managed comp.
Brazil	Semipublic and Public-Mixed			Private or Mixed/Private		Average	Dual	More financ. and decentraliz.
Mexico	Public-Public	Semipublic-Public/Mixed	YES	Private/Private		Decline	Dual	Insurance
Peru	Public-Public	Public-Mixed	YES	Private-Private	YES	Decline	Exclusive	Managed comp.
Venezuela	Public-Public	Semipublic-Public/Public	YES	Private-Private		Decline	Exclusive	More insurance Decentraliz. Service package
Paraguay	Public-Public	Public-Semipub/Mixed	YES	Private-Private	YES	Decline	Exclusive	Insurance
Bolivia	Public-Public	Semipublic-Public/Public	YES	Private-Private/Mixed		Decline	Exclusive	Insurance Descentraliz. and PHC
Ecuador	Public-Mixed	Semipub-Public/Mixed	YES	Private-Private	YES	Decline	Exclusive	Insurance
Belize	Public-Public	Semipub-Public		Private-Mixed		Decline	Exclusive	Decentralization and more integration
El Salvador	Public-Public	Semipub-Pub/Mixed	YES	Private-Private		Decline	Exclusive	Insurance
Guatemala	Public-Public	Pub-Semip/Mixed	YES	Private-Private		Decline	Exclusive	Insurance
Honduras	Public-Public	Pub-Semipub/Public	YES	Private-Private	YES	Decline	Exclusive	Strengthen. Public Sector

Country	Public Subsector	Subs. Social Security	Subsidy Social Security	Private Subsector	Subsidy To The Private Sector	Integration	State Of Well-Being	Trends
	Financing-Supply	Financing-Supply		Financing-Supply				
Nicaragua	Public-Public	Parap-Pub/Public	YES	Private-Private		High	Exclusive	Separation. Finan. Provision
Panama	Public-Public	Semipub-Public/Mixed	YES	Private-Private		Decline	Exclusive	Insurance
Haiti	Public-Public	Public-Public		Private-Private	YES	Decline	Exclusive	Strengthening. Sec. Public Decentralization
Dominican Republic	Public-Public	Pub-Semipub/Public	YES	Private-Private	YES	Decline	Exclusive	Insurance
Antigua And Barbuda	Public-Public	Public-Public		Private-Private		High	Structured universal	Decentralization and privatization

Source: Own preparation based on Maceira (1996) and country case studies

Table 6: Specific Mechanisms Of Strategies To Expand Coverage

Strategies of the 1990s	Mechanisms or effects on the expansion of coverage	Examples	Impact on supply or demand	Current Trend	Examples
1 - Primary health care	<ul style="list-style-type: none"> ✓ Contributes to promotion, disease prevention, and health care ✓ Efficiency in expenditure ✓ Increase in primary level coverage 	<ul style="list-style-type: none"> • All countries adhering to Alma Ata 	Increases supply	All countries follow this trend	<ul style="list-style-type: none"> • All • Cuba
2 - Decentralization of services	<ul style="list-style-type: none"> ✓ Close to local needs ✓ Defines priorities by recipients of the service ✓ Better utilization of the resources. Adaptation of supply to demand 	<ul style="list-style-type: none"> • Brazil • Argentina • Ecuador • Grenada • Mexico • Panama • Dominican Republic • Trinidad and Tobago • Venezuela 	Increases supply and demand	Trend continues toward modernization of the State (in order to achieve effectiveness, efficiency, and equity)	<ul style="list-style-type: none"> • Honduras • Haiti • El Salvador • Mexico
3 - Local health systems	<ul style="list-style-type: none"> ✓ Integration into the provider network ✓ Management autonomy ✓ Organizes supply and sets priorities according to the requirements of demand 	<ul style="list-style-type: none"> • Bahamas 	Increases demand	Implementation is emphasized	<ul style="list-style-type: none"> • Bahamas
4 - Creation of control and regulation agencies	<ul style="list-style-type: none"> ✓ Authorities control and regulate the rights of the beneficiaries. Guarantees access 	<ul style="list-style-type: none"> • Argentina • Chile • Colombia • Peru • Ecuador 	Increases supply		
5 - Package of basic services	<ul style="list-style-type: none"> ✓ Guarantees the beneficiary population a basic menu of benefits 	<ul style="list-style-type: none"> • Argentina • Uruguay • El Salvador • Honduras • Jamaica • Mexico • Dominican Republic 	Increases supply	Presented as a priority	<ul style="list-style-type: none"> • Trinidad and Tobago • El Salvador • Peru
6 - Public-private collaboration in the financing and delivery of health services	<ul style="list-style-type: none"> ✓ Introduces new financing alternatives 	<ul style="list-style-type: none"> • Barbados • Peru 	Increases supply and demand	There is a trend toward initiating or promoting implementation	<ul style="list-style-type: none"> • Barbados • Guyana • Mexico

Strategies of the 1990s	Mechanisms or effects on the expansion of coverage	Examples	Impact on supply or demand	Current Trend	Examples
7 – Subsidy of demand. (Public Insurance)	<ul style="list-style-type: none"> ✓ Encourages efficiency and the quality ✓ Permits free choice of the provider 		Increases demand		
8 - Self-managed public hospitals	<ul style="list-style-type: none"> ✓ Encourages cost recovery ✓ Attenuates subsidies 	<ul style="list-style-type: none"> • Argentina • Chile • Brazil 	Increases supply		
9- Community participation in the management and control of services	<ul style="list-style-type: none"> ✓ Encourages the definition of priorities ✓ Contributes to meeting demand ✓ Regards health as a social product defining the parameters that guarantee access to the services 	<ul style="list-style-type: none"> • Bolivia • Brazil • Costa Rica • Mexico • Chile • Bolivia • Bahamas • Honduras • Nicaragua • Dominican Republic • Suriname • Venezuela 	Increases supply and demand	Trend continues	
10 – Development and regulation of the private subsector	<ul style="list-style-type: none"> ✓ Public - private integration ✓ Avoids moral hazard and adverse selection ✓ Increases the quality of benefits 	<ul style="list-style-type: none"> • Chile • Uruguay • Barbados • Brazil 	Increases supply	Attenuated trend	<ul style="list-style-type: none"> • Argentina • Barbados • Mexico
11 – Insurance against catastrophic diseases	<ul style="list-style-type: none"> ✓ Makes it possible to prevent the most expensive risks 	<ul style="list-style-type: none"> • Uruguay 	Increases demand	Trend	<ul style="list-style-type: none"> • Argentina
12 – Healthy municipios	<ul style="list-style-type: none"> ✓ Encourages community participation ✓ Priorities defined by the community 	<ul style="list-style-type: none"> • Brazil • Chile • Argentina • Mexico • Peru • Uruguay 	Increases supply and demand		
13 – Public/private aid networks	<ul style="list-style-type: none"> ✓ Encourage the integration of supply 	<ul style="list-style-type: none"> • Ecuador • Honduras • Panama 	Increases supply		
14 – Participation of cooperatives, mutuals, social works, and NGOs in the health system	<ul style="list-style-type: none"> ✓ Encourages social participation ✓ Contributes to the insurance systems that prevent risks 	<ul style="list-style-type: none"> • Chile • Uruguay • Argentina • Peru • Trinidad and Tobago 	Increases demand		

Strategies of the 1990s	Mechanisms or effects on the expansion of coverage	Examples	Impact on supply or demand	Current Trend	Examples
15 – Recovery and containment of public subsector costs	<ul style="list-style-type: none"> ✓ Helps reduce expenditure ✓ Should not be an access barrier in expanding coverage 	<ul style="list-style-type: none"> • Chile • Uruguay • Argentina • Saint Kitts and Nevis • Saint Lucia 	Increases supply and demand		
16 - Free services in the coverage of the indigent population	<ul style="list-style-type: none"> ✓ Identification of the population of indigent beneficiaries of public Social Welfare 	<ul style="list-style-type: none"> • Uruguay • Chile • Suriname • Panama • Dominican Republic 	Increases demand		
17 – Growing participation of the nonprofit private sector in promotion and prevention	<ul style="list-style-type: none"> ✓ Participate in financing and care for those lacking resources ✓ In some cases intervene in organised plans with employers, communities, and cooperatives 	<ul style="list-style-type: none"> • Bolivia • Colombia • Ecuador • Peru • Argentina • Chile • Paraguay • Brazil • Uruguay • Costa Rica • El Salvador • Mexico • Cuba • Jamaica • Grenada 	Increases supply	Trend continues	
18 – Managed competition	<ul style="list-style-type: none"> ✓ Subsidy of demand ✓ Separation of supply and financing functions ✓ Increase efficiency 	<ul style="list-style-type: none"> • Argentina • Chile • Colombia • Uruguay 	Increases supply	Trend continues	<ul style="list-style-type: none"> • Chile • Argentina
19 – Coordination, articulation, and modularization among the subsections	<ul style="list-style-type: none"> ✓ Makes agreements possible among the subsections in order to integrate them ✓ Improves the utilization of resources 	<ul style="list-style-type: none"> • Argentina • Mexico • Brazil • Dominican Republic • Saint Vincent and the Grenadines 	Increases supply	Is observed as a goal of the health sector	<ul style="list-style-type: none"> • Jamaica • Chile
20-Extension of social security to uninsured groups or increase in care	<ul style="list-style-type: none"> ✓ Progressive inclusion of uninsured groups in insurance schemes (temporary workers for example) 	<ul style="list-style-type: none"> • Ecuador • Grenada • Jamaica • Costa Rica 	Increases demand	Insurance is emphasized or introduced	<ul style="list-style-type: none"> • Argentina • Colombia • Barbados • Saint

Strategies of the 1990s	Mechanisms or effects on the expansion of coverage	Examples	Impact on supply or demand	Current Trend	Examples
	✓ Creation of insurance providing new alternatives for financing and expanding coverage	<ul style="list-style-type: none"> • Mexico • Bolivia • Nicaragua • Paraguay • Dominican Republic • Venezuela • Trinidad and Tobago 			<ul style="list-style-type: none"> • Vincent and Grenadines • Saint Kitts and Nevis • Trinidad and Tobago • Dominica • Grenada
21-Separation of service delivery and financing functions	✓ Increases efficiency, effectiveness, and quality of benefits	<ul style="list-style-type: none"> • Brazil 	Increases supply		
22 - Essential drugs	✓	<ul style="list-style-type: none"> • Cuba • Colombia • Paraguay 	Increases supply		
23 - Standards and criteria for quality of benefits	<ul style="list-style-type: none"> ✓ Allocation of resources according to criteria of accreditation and categorization ✓ Tends to attain user satisfaction 	<ul style="list-style-type: none"> • Argentina • Barbados • Grenada • Saint Vincent and the Grenadines 	Increases supply	Is presented as priority	<ul style="list-style-type: none"> • Guatemala • Grenada • Barbados • Mexico
24 - Changes in the model of care	<ul style="list-style-type: none"> ✓ Strengthening of the secondary and tertiary level ✓ Tendency to increase promotion and prevention ✓ Trend toward dehospitalization 	<ul style="list-style-type: none"> • Argentina • Venezuela 	Increases supply	Is developed as strategy in rural areas, incorporating social security and the private subsector	<ul style="list-style-type: none"> • Bolivia • Nicaragua
25 - Targeted programs: <ul style="list-style-type: none"> ✓ The indigent ✓ Woman ✓ Children ✓ Adolescents ✓ Elderly ✓ Informal workers ✓ Disabled People 	<ul style="list-style-type: none"> ✓ Targeting of vulnerable groups ✓ Better utilization of resources. ✓ Adaptation of supply to demand. 		Increases supply and demand		