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COORDINATION BETWEEN THE SOCIAL SECURITY AND THE PUBLIC HEALTH INSTITUTIONS

This document sets forth the relationship between the major political, economic, and social changes that are taking place in the Region, along with their consequences for health systems development, and the outlook and potential offered by the participation of social security in these systems in terms of attainment of the goal of Health for All by the Year 2000.

Within this approach, the document examines the changes that have taken place in the political, economic, and social conditions in the countries (Chapter II) and their health systems (III). The outlook for social security in the 1990s is analyzed (IV), and a series of aspects (V) are proposed for consideration as part of the definition of a regional strategy for strengthening and upgrading the health sector during the present decade, as follows: improvement of intersectoral relations in the interaction between health and development (V.1); a shift away from the concept of "public assistance" to the extension of social security coverage as an expression of the "right to health," and the corresponding reformulation of national health systems (V.2); a revision of the roles and responsibilities of the Ministries of Health and the Social Security Institutions (V.3); strengthening of leadership in the health systems (V.4); and, as a central element in these processes, the transformation of "social security schemes" into real "social security systems" (V.5).

The difficult economic and social circumstances prevailing in the countries of the Region call for more thorough national and regional policies and strategies in order to achieve genuine functional and operational articulation of institutional resources in the health sector. In this sense, coordination between the Ministries of Health and the Social Security Institutions needs to be analyzed and debated in the context of national programs and responsibilities and not merely in terms of selected population groups.

In dealing with these different aspects, the documents incorporates and addresses suggestions and recommendations made by the Subcommittee on Planning and Programming (December 1989) and the Advisory Committee on Social Security (February 1990) with regard to the orientation of development and technical cooperation in this area. It is hoped that analysis of the subject by the Executive Committee will lead to definitions of policy and lines of operation which, as they are applied to national health and social security policies, will contribute to an upgrading of the health systems, articulation of their existing programs, and improvement in their level of efficiency. It is also hoped that it will be possible to correct the existing imbalances and extend basic protection to progressively larger segments of the population with a view to greater social equity.

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COORDINATION BETWEEN THE SOCIAL SECURITY AND THE PUBLIC HEALTH INSTITUTIONS

I. INTRODUCTION

In the last two decades the concept of the State has evolved significantly. This evolution is in response to meaningful changes in global political thinking and is no doubt closely related to the recessionary behavior of the world economy during the same period.

The ideological currents in the industrialized market-economy countries, generated by these economic phenomena, have focused on improving the efficiency of the State's apparatus and on promoting increased capacity to foster economic growth with more direct intervention in the production of goods and services.

As a result of this changed conception of the ways in which the State acts, there has been a reformulation of the action of regional and local economies in economic and political areas, as well as of the role that companies and private organizations can assume in the production of goods and the provision of certain services that traditionally had been the responsibility of the State. Accordingly, changes were promoted in the political organization of the State; political, economic, and administrative autonomy was granted to the regions and local areas; and ownership of certain State companies, as well as administration of some of the public services, was transferred to the private sector. All this movement of decentralization and reduced State involvement stemming from the industrialized countries was to lead in turn to a variety of manifestations in the countries of Latin America, also facilitated by economic factors.

In the context of this decentralization process in Latin America, an analysis of the State's role in the financing, and in the organization and provision, of basic services has particular importance. This is especially true when, as a result of the negative effects of the economic crisis on the quality of life of the population, the advantages and potential of the social security concept vis-à-vis public assistance in the provision of health services are also beginning to be recognized.

In the political, economic, and financial scenarios, and in the social situation that the countries of the Region will face in the 1990s, it is evident that the Ministries of Health and the social security agencies will not only continue to be central protagonists in the health systems of the Region but will also be facing new and broader demands. The requirement for a wider range of action on the part of these institutions, beyond the traditional provision of services, takes on dual aspects.

The extension of health services coverage to the great masses of the population that still lack it, attainment of the qualitative targets that have been adopted for the year 2000, and the effective application of the principles of equity and social justice in health that arise from the Declaration of Alma-Ata and "Health for All" require a tremendous

effort to shore up institutional capacity so that services can be delivered. The qualitative components of these social targets make it imperative to have a true and effective presence of health in the development processes. In the scenarios that are expected for the 1990s, this participation requires careful consideration of the intersectoral relationships that bear on health. This in turn makes it necessary to strengthen the capacity of the health institutions, in particular that of the Ministries of Health, since their competence in this area and their authority as leaders in the sector, responsible for initiating and formulating its policies, need to be reaffirmed and enhanced. Within this global framework, the interrelationship between the social security institutions and the Ministries of Health assumes dimensions that go beyond their traditional role of coordinating resources and programs.

Under these conditions, it is imperative to facilitate and promote a formal analysis of the relationship of health and social security to the process of development in the Region, as well as to promote discussion and debate that will make it possible to advance toward better definitions of the roles that the institutions should play in the health sector in the future. These analyses and discussions will contribute to the conceptual and operational expansion of social security systems and to the strengthening of their current and potential participation in health care and the development of health.

These definitions are also important in orienting PAHO/WHO technical cooperation with the social security organizations, which has been being strengthened and expanded in recent years as a result of fulfillment of resolutions of the Directing Council and recommendations by subregional agencies.

Within this overall orientation, the issues raised in the initial version of the present document have been examined by the Subcommittee on Planning and Programming (December 1989) and by the Advisory Committee on Social Security (February 1990). The current version of the document reflects concepts and modifications that were suggested in these two reviews of the issues.

II. TRENDS IN DEVELOPMENT AND HEALTH

1. Economic and Social Development

The countries of the Region initiated a long period of economic expansion after the Second World War which was to last until 1980. Between 1950 and 1980 the annual average overall growth rate of the countries was 5.5%[1/].

In the configuration of their development styles, some of the countries have emphasized the goals of growth, while others have formulated objectives for economic and social development in which the goals of growth and distribution were combined. At present these different emphases are reflected in the heterogeneity that characterizes the countries of the Region, and, in particular, in the way that the

different basic services for the population are covered, in the degree of inequity in the distribution of income and wealth, in the evolution of infant mortality and illiteracy, in the nutritional status of the population, in schooling, and in the regional variations in the indexes of quality of life.

2. From Expansion to Crisis

The long period of expansion in the economies of the Region was followed by the most protracted economic crisis that the Region has experienced since the 1930s. This was to a great extent determined externally by the economic recession in the industrialized economies and, at least as important, by internal factors related to excesses and limitations in the economic policy of the countries.

The economic crisis in the Latin American countries has gone through several phases, or stages, in its configuration and development: incubation of the crisis in the market-economy developed countries, acceleration of external indebtedness in the Region, the pre-crisis phase, the early stages of the crisis, the crisis itself, the adjustment and stabilization programs, and the social consequences of the adjustments.

The health sector's interest in these stages centers on the external indebtedness and its relationship to increased public spending in the Region, because this set the stage for the principal factors that threw the macroeconomic variables off balance and ultimately led to the introduction of strict economic adjustment programs in all the countries of the Region. This subject is also emphasized because it is precisely through drastic reduction of public spending that major recessionary effects on economic activity are produced, with their consequences for investment, the provision of basic services, unemployment indexes, real wage levels, and quality of life.

2.1 External Indebtedness and Public Spending

Among the external factors related to the economic crisis in the Region are the exceptional conditions that were created in the world economic picture, particularly with respect to financing, due to the jump in oil prices in 1973. A considerable percentage of additional resources from the oil-producing countries were channeled to the Region in the form of external credit. This income from foreign exchange was supplemented by other income from the boom in Latin American exports between 1976 and 1980.

As a result, the economy of the Region achieved an acceptable economic growth rate during this period, exceeding that of the industrialized countries.

However, the cost of this growth strategy was an unprecedented increase in the foreign debt and a steep rise in the deficit in the current balance of payments account. This cost was to be reflected in a sharp decrease in the Region's economic growth rate in the 1980s, which is expected to recover only partially in the the present decade.

In the 1970s, supported by the greater availability of external resources, the countries of Latin America used public spending in a relatively lax manner to stimulate economic activity. The expansion of public spending permitted significant growth in production and government services in a number of countries, which in turn led to further indebtedness and more imports in order to keep up the rate of production and meet the demand triggered by the increase in economic activity. During this period the imbalances in the countries' foreign exchange were conveniently
covered by foreign credit.

Within a relatively short time an interdependence developed between external financing, public expenditure, and economic activity. In order to maintain the growth rate, with stable prices and a balanced external sector in the economy, there was increasing reliance on external indebtedness.

Disappearance of the favorable conditions for external financing for the Region in 1981 forced the economic authorities in the countries to take the measures needed in order to right the balance between the principal macroeconomic variables and adjust them to the effective availability of internal savings and external credit. These measures, although they appeared to be temporary, were to lead in the long run to the reinstitution of a pattern of economic management in the countries based on austerity and continuing vigilance over the expansion of public spending.

2.2 Social Consequences of the Adjustment

Evaluations of the adjustments introduced by national entities and international agencies show that the results have been mixed, with some achievements in the economic area and at the same time great social sacrifices[2/].

There is also evidence that the internal cost of the adjustment has been distributed inequitably[3/]. A substantial share of this cost has been absorbed by the low-income sectors, as is shown by the employment indexes in some of the countries, the pattern of real wages, and the trend in income for that portion of the workforce corresponding to the informal sector. In 1985, 32% of the urban economically active population of the Region was engaged in informal occupations. In some countries this proportion ranges between 50% and 60% [4/].

In several of the countries the low-income sectors were also directly affected by the cutbacks in public spending on social programs, including those in the areas of health, education, basic sanitation, nutrition, and housing.

2.3 The Adjustment and the Health Sector

While conclusive evidence is not yet in on the effect that the crisis and the adjustments have had on health services delivery and on the population's state of health, and hence generalizations for the entire Region are still not possible, nevertheless some findings are

already available. In one of the countries in the Region the results of careful research show increases in infant mortality in certain areas during the most acute period of the crisis[5]. In other countries the rate of decline in infant mortality has been slowed[6], and in others there are signs of deterioration in the nutritional status of the population[7]. PAHO has promoted and carried out an important series of specific studies on the subject[8].

From the point of view of health care for individuals, empirical evidence shows that it is very probable that in the short term the relative decrease in public spending on health has not significantly affected the totality of services offered. This is not to say, however, that persons covered by these services have not had to make greater contributions than normal, in money and in kind, in order to receive the health care required, or that the quality of the care has remained the same in all cases[9].

2.4 The Adjustment and Social Security

The impact of the crisis and the economic adjustment and stabilization programs has also been felt in the social security institutions and their programs. The magnitude of this impact during a specific period depends to a large extent on the way in which social security is financed, organized, and administered in a specific country and on the range of risks that it covers for its beneficiaries.

As it will be seen later in this document, the main way to finance social security in the Region is through contributions from both workers and employers. This means that the amount of money collected by social security depends to a great extent on the volume of formal employment and on the general level of wages in the economy.

The net impact of the behavior of these variables on social security financing will depend on the specific combination of open unemployment and wage structure in the particular country at a given point in time.[10]

Another important phenomenon that will have an influence in this regard is the impact of the structural adjustment on retirement age--that is, on the eventual increase in expenditures for social security systems due to the pressure for early retirement of public civil servants and private wage earners exerted by employers (usually the State) who are obliged to cut back on staff in order to reduce public spending.

However, it is well to point out that social security, because of the way in which it is financed, is at least theoretically in a better position to confront and overcome difficulties during periods of crisis than public assistance programs, which are financed with general revenues from the State. This depends to a great extent on the financial management of the resources collected.

Finally, there is no quantitative information to document the real impact of the economic adjustment on the financing of social security. However, in the case of Brazil, Mexico, and Costa Rica[11/] there are reports on measures taken by agencies in charge of social security to counteract the recessionary effects of economic adjustments.

3. Long-Term Consequences

The economic crisis and the countries' response to it will inevitably have long-term structural consequences for the economies which have not yet been foreseen in all their magnitude. Even though the definition of some of the strategies and new forms of political and economic behavior, both within the Region and outside it, has already been initiated, it is still not clear what development style(s) these economies will adopt in the 1990s.

What is clear is that the developed and relatively less developed economies of the Region need to adopt new styles and strategies for economic and social development. These new styles and strategies should take into account in both cases the constraints and commitments imposed by the frustrated growth strategy based on external indebtedness that was widely adopted in the past.

With regard to the relatively less developed economies, the most important factors to take into account in the definition of the new styles of development would be:

- Locus of the Region's economy in a changing environment characterized by its scientific and technological complexity;
- The high productivity and competitiveness of the countries that are the major players in international trade;
- The need to achieve satisfactory and rising rates in the areas of productivity, internal savings, investment, and growth of the GDP;
- The decision, which cannot be postponed, to meet the basic needs of the population living in extreme poverty;
- The opening of effective channels of expression and citizen participation in the decisions that affect their daily life;
- The reduction of the inequities in the Region in terms of quality of life;
- Full incorporation of the domestic, agricultural, and informal workers into social security systems that allow them to deal adequately with the social risks to which they are exposed;
- Modernization of the structure of the State and its functions, institutions, and means of financing basic services so that it will be able to respond quickly to changes in the political, economic, and social environments.

The current state of the Region's economies certainly does not make it possible to look to the future with optimism. However, the apparent weakness of the economies in facing the future becomes a strength if it is translated, as appears to be the case, into real economic dynamism and a thorough revamping of the institutions, the structure of the State, the forms of service delivery, and, in the end, a reformulation of accepted traditions in the search for alternatives for State action that are more efficient and effective--and probably more equitable.

4. Health, Social Security, and Development

4.1 The Political Dimension of Health[12/]

Health, understood to be a state of complete physical, mental, and social well-being, may be examined in both its individual and its collective sense. For the individual, health is considered to be a right and a basic need. From the collective point of view, it has been regarded as an important, if not the most important, goal of any society. The problem of health is dynamic in nature and encompasses several dimensions: biological, socioeconomic, and political.

The biological and socioeconomic dimensions of health are widely known, but not the political ones. The political dimension of health is nothing else but the conception and objectives that the State assigns to it in the process of economic and social development, the measures and instruments that it adopts in order to attain them, and the absolute and relative financial resources that it assigns to the different programs and activities that directly or indirectly affect the individual and collective health conditions of the population. This dimension of health includes the intersectoral view and approach that are needed in order to achieve and maintain the targets and goals of the sector.

4.2 Equal Objectives, More Effective Instruments

Of course, this is not a new view of the health problem. What happens is that the behavior of the socioeconomic determinants of health problems and of the capacity of the State and society to deal with them is not linear through time. By making it explicit, one gains a better understanding of why, in light of substantial changes in the economic and social context, different strategies are required in order to respond to the health needs of the population and thus improve the conditions for achieving the institution's objectives.

Up until now the tradition in the management of health problems in most of the countries in the Region has been to emphasize the extension of coverage in the form of public assistance. For this purpose, increasing support has been provided through the limited resources of central government budgets, without covering or fully meeting the growing and changing needs. Health insurance and private health care, in turn, have had their own dynamics and have operated with great autonomy.

Moreover, the manifest vulnerability of public assistance services in the light of political, economic,, and fiscal circumstances and the negative repercussions that this has had for low-income groups of the population, points to the need to effectively move beyond the concept of public assistance to one that firmly establishes the right to health care and makes it possible to guarantee that these same population groups will have continuous protection against social risks.

In keeping with this context, the fundamental issues that should be addressed at the beginning of this last decade of the century by the Ministries of Health and those responsible for the formulation of health policies in the countries, in order to attain the goal of Health for All by the Year 2000, would be:

a) Are the current systems for the delivery of State health services consistent with the level of economic and social development of the countries in the Region?

b) Is it desirable for the future development of the health services to maintain the concept of public assistance that has been used thus far?

c) Does the concept of social security respond to a more updated and modern conception of guaranteed access and timely delivery of health services to the population?

III. THE NATIONAL HEALTH SYSTEMS

The health sector, in all countries of the Region, is composed of many parts, with great diversity in the participating organizations, which vary from one country to another according to their history, their social development, and their political structure. This pluralist situation, which has been described and analyzed in numerous technical documents, has not been taken into account in its true magnitude and depth in the formulation of policies and the operation of health systems.

Within this panorama, a public subsector, represented by the direct action of the State and social security, has been identified, as has a private subsector, in which ownership and operation of the services corresponds to persons or societies that have a different juridical status.

1. The Public Subsector

1.1 Direct Action by the State: The Traditional Public Subsystem

This is represented mainly by the Ministry of Health, by national and regional health entities, by the services of the municipalities, and in some cases by the health services of the universities and the armed forces.

Traditionally, this subsector has carried out functions linked to public health. It is responsible for environmental sanitation, control of endemic and epidemic diseases, health education, food and drug control, and other matters that ensure conditions basic to the health of the entire community. Added to these, as a way of carrying out its public health function and in part as the heritage passed down from the public assistance agency, the State has assumed the organization of medical services for the care of the indigent in order to guarantee a minimum level of health services for the entire population, and in some cases for patients with chronic problems--mental health, leprosy, tuberculosis, etc.

In a large number of countries the installed capacity of the public subsector contributes the greatest number of hospital beds to the system. In a study of 13 countries conducted in 1983, it exceeded 50% of the total in 11 of them[13/], which shows its importance in the overall system and thus the need for it to be fully utilized.

The financing of these services comes from general revenues, which makes them dependent on the capacity of the public budget and on a political decision regarding the assignment of these resources and thus leads to a high degree of instability and uncertainty. This situation has been aggravated by the economic crisis, with variations between the different countries and within each of them depending on the year. The insufficiency of the resources, and the variation thereof, has made it necessary to resort to charging users for the services, which has contributed only a part of their support and at the same time has limited access by the population, thus increasing inequity.

The growth of demand in terms of both quantity and complexity as a result of demographic, cultural, and technological changes has overwhelmed the capacity of these services, leading to unmet demand and increased social tensions.

The model of the "charity hospital" which was generated in this subsector is socially outmoded and should be replaced by new forms that respond to current needs and values. Significant efforts in this regard have been observed in the countries, but they are not enough to effect a transformation in the traditional schemes.

1.2 Social Security: The Social Security Public Subsystem

Social security is one of the most important institutions to emerge in industrialized society in support of its integration, stabilization, and development, and it is regarded into the post-industrial societies as one of the bases for the realization of social justice. Its incorporation in the health systems has not been adequately considered in the formulation and practical implementation of policy, despite the efforts made in several of the countries to focus national health systems or concrete projects on integration and intrasectoral coordination.

Social security is part of the social policy of the State, which defines it legally and then sets its policies and orients their implementation. In some countries, an important role was played in the origens of social security by the action of groups; this led to the formation of

private organizations and collective schemes which were later incorporated into general legislation. In practically all the countries social security is a parastate entity.

Social security had its beginnings in the Region in the 1920s, influenced by the "social insurance" model introduced in Germany by Chancellor Bismarck in 1884 in response to pressures exerted by different groups of workers. In the field of health a significant place in these programs was occupied by the experiences in Brazil (1923), Chile (1924), Argentina and Cuba (1934), Ecuador (1935), Peru (1936), and Colombia (1938)[14]. These experiments were limited to groups of workers in different institutions, they covered few risks, and they had only a limited legal base. Their principal source of financing consisted of the contributions of the employers and the workers, and in a few instances, of the State.

The expansion and strengthening of social security took place in the 1940s, accompanying the industrial development that was generated in some countries and the political and syndicalist movements of the time. Health schemes were introduced in Venezuela (1940), Panama and Costa Rica (1941), Mexico and Paraguay (1943), Guatemala (1946),* the Dominican Republic (1947), Bolivia (1949), and Honduras (1952)[15]. At the same time, the countries already involved went on to perfect their legislation and consolidate their organizations.

The principal risks covered by social security in 35 countries of the Region are old age, disability, and death in all of them; general disease and maternity in 22; occupational hazards in 32; dependents' allowances in eight; and unemployment in six[16].

The trends observed in all the countries of the Region are geared to integration, coordination, and compensation among the institutions, a gradual increase in the coverage of the traditional risks, and incorporation of new situations to be dealt with collectively. Examples are found in Argentina (1988)[17], Brazil (1987)[18], Bolivia (1987)[19], Costa Rica (1987)[20], Mexico (1987)[21], and Venezuela (1987)[22].

The population covered by social security health schemes in the countries of Latin America has been growing steadily. In 1982, in a study of 20 countries, it represented 61.2% of the total population [23]. Universal coverage was the goal. However, there is great variation between the countries and the schemes in terms of the services offered to spouses and children of the subscribers and to retirees and pensioners[24].

* The initial law that established objectives and laid the foundations for the subsequent introduction of specific programs. In 1953 the first maternal and child health program was undertaken, and in 1968, the first health care program (common illness).

Coverage is not extended to include workers outside the traditional subscriber structure--e.g. domestic employees, the self-employed, different types of rural workers, and those in the informal sector--for whom it will be necessary to develop innovative forms of affiliation, financing, and service delivery. For the rural population these have been initiated, and significant experiments are being carried out--mainly in Argentina, Ecuador, Guatemala, and Mexico.25/

The financing of social security systems is traditionally based on collective contributions from workers, employers, and (eventually) the State (calculated as a percentage of the wage, which varies from one country to another and according to the risks covered--all of which constitute appropriate resources, depending on the level of wages and the efficiency of the tax-collection system. This system of financing also ensures, theoretically at least, the active participation of workers and employers in the management of the systems and gives the beneficiary a sense of acquired right to the services.

The social security health services have been evolving from a focus on insurance for sickness and maternity, accidents, and occupational diseases to comprehensive health services for workers and their families. To the extent that social security has increased its participation in the overall health system, it has also become more involved in responding to community problems that have to do with disease and accident prevention, behavior modification, the reduction of violence, and the improvement of quality of life.

Health services under social security are provided in a variety of forms, either directly, in its own establishments and units, or indirectly, through contracts with the public and/or private subsectors. This makes for different forms of organization, operation, investments, and control and different price schedules for services, which vary greatly from country to country.

The planning, standardization, and administration of these services, which are often overly centralized, have been developed independently of the Ministries of Health, so that frequently gaps and overlapping have been produced in the national context. The analysis of these problems, which have been very well documented, together with the efforts to solve them, has taken up three decades (1959-1989) in the historical evolution of health services in Region 26/.

2. The Private Subsector

The private subsector, consisting of a broad range of for-profit and nonprofit institutions and activities organized and implemented in various ways in each country, includes professionals engaged in the liberal practice of the different health professions (medicine, dentistry, chemistry, etc.) on the one hand and the large companies that function in this sector of the economy on the other.

The private subsector for the most part has not been sufficiently recognized in the formulation of policies and the operation of health systems in the Region. The principal concern has been the basic legal

standards for the operation and the control of their activities. Intrasectoral coordination is just now beginning to be developed, starting with contracting with social security. In the countries where contracted services have been predominant, conditions, such as relationships, standards of operation, systems for medical auditing, and forms of payment, were fixed. However, experience shows that these standards by themselves are not sufficient to achieve intrasectoral articulation. True interinstitutional coordination will be needed.

The institutions in the private subsector participate primarily in the provision of curative medical services. The installed capacity of the private subsector varies in the different countries according to the characteristics of the health systems. In 1978 in Latin America there were 6,693 private hospitals with 323,877 beds, which represented 37.2% of the available total. In 1983 there were 440,200 beds, representing 45.1% of the existing capacity. These figures reflect the growth trend during that period. As of 1986 there were 12,390 private hospitals with 1,244,489 beds in the Region, representing 49.1% of the total[27].

The financing of the institutions in the private subsector comes from service fees, either payment for the service after it is rendered or prepayment from the covered beneficiary.

In this subsector, the population's access to the services depends on their economic capacity and therefore favors those groups that have their own resources to pay for the services or the premiums for private insurance. For this reason, it is observed that coverage is greater for services of lesser unit value, such as medical and dental consultations, drugs, and care at childbirth, but they are limited for diagnosis and treatment and for hospitalization, especially if high technology is involved.

The changes that have taken place in the health scenarios and in the economic context have also affected this subsector, requiring different organizational responses and varied types of services. This in turn has called for enhancing the administrative capacity of these institutions. In addition, the serious economic situation has placed this subsector in a critical situation which has checked its growth and and now points to structural adjustments in some of the countries.

3. The Articulation of Health Systems

In the fulfillment of a national health policy, the existence and maturation of the health systems depends more on the relationships that are developed among their components than on their presence as such.

The relationship of the two fundamental components of the public subsector--the Ministries of Health and the social security institutions--is the principal theme in the structuring of health systems and has been widely discussed at the national and international levels. The Directing Council of the Pan American Health Organization has addressed this matter on several occasions since 1964. Document CD32/17, approved by the XXXIV Meeting of the Directing Council in September 1987, gives a complete analysis of the subject[28].

In the 1970s, major efforts were made to formalize the structure of national health systems, but the hoped-for results were not achieved. Since 1981 the emphasis has been focused more on final results (universal coverage) than on the process itself, in a search not so much for administrative consolidation as for functional articulation--the harmonization of objectives and operational coherence[29].

This development is part of the political process taking place in the sector and should be considered as such, affected as it is by the particular interests of the different groups involved. Its realization calls for significant changes in both components of the public subsector, which make it possible to advance toward convergence and to carry out concrete experiments, particularly in the context of decentralization and the resulting organization of local health systems. The achievement of the goal of Health for All by the Year 2000 depends to a great extent on the success of articulation among these entities.

The relationship of social security to the private subsector, in those countries where the latter has developed significantly and social security has resorted to utilizing it to provide its health services, is also an important factor in defining the operation of this subsystem[30].

The creeping trends in some of the countries toward privatization of the services and increased contracting of private services by social security make it urgent to examine in depth the best ways of bringing this subsector together. Thus the implications of these trends take on special importance, as do ways of contracting and paying for services, the standardization of activities, medical auditing systems, and the accreditation and categorization of services.

An analysis of the relationships between these different health system components, together with the participation of social security in them, makes it possible to differentiate four types of national situations that need to be taken into account in conceptualizing the development processes of the systems and in adopting different strategic approaches to technical cooperation.

a) A first group of national situations is characterized by progress toward universal coverage, predominance of the concept of universal solidarity over group interests, and consolidation of the sources of financing. Argentina, Brazil, Canada, Costa Rica, and Cuba would be found in this situation.

b) A second group would correspond to those situations in which formation of the systems is under discussion, particularly with regard to the role of social security and the relationship to the Ministry of Health. Social security coverage would range between 25% and 60% of the total population, and independent group schemes and mixed forms of financing would continue to exist. Bolivia, Colombia, Chile, Ecuador, Mexico, Peru, the United States of America, and Venezuela would constitute examples of this situation.

c) A third type of national situation would be represented by those systems in which social security coverage is less than 25%, the concept of "separate clienteles" for the Ministry of Health and social security is prevalent, and the forms of financing and its channeling contribute to the perpetuation of this division. The Dominican Republic, El Salvador, Guatemala, Haiti, and Honduras would exemplify this situation.

d) The situation observed in the countries of the English-speaking Caribbean presents special characteristics because of the initial conformation of their national health systems and the consideration that is currently being given to relations with the social security systems.

The placement of a specific health system in any of these groups is not hard and fast; the general situation in the countries tends to be highly dynamic and may change significantly within a short time.

IV. OUTLOOK FOR SOCIAL SECURITY IN THE PRESENT DECADE

The outlook may be viewed from different angles. However, because of their relevance for the economic, social, and political development of the Region in the next decade, emphasis here is placed on the extension of health care coverage; on its relationship to the processes of decentralization and reduced State involvement; on the place occupied by the processes of structural adjustment; and on the financing, organization, and development of health systems.

1. In the Extension of Primary Health Care Coverage

In terms of health, evolution from the concept of public assistance to that of social security poses an enormous challenge if the existing social security institutions in the Region are to extend their programs and coverage efficiently. With regard to the latter, there is no doubt that the greatest effort would have to be spent in the design of mechanisms and alternatives for covering health risks for the poorest segment of the population. This heading includes agricultural producers, domestic workers, and workers in the informal sector. Social security, understood in this sense, would not only contribute to the development of additional elements of social solidarity but would also become an effective instrument for the redistribution of income. However, the incorporation of these population groups would involve significant changes in the membership and organization systems traditionally used by social security.

2. In the Processes of Decentralization and Reduced State Involvement

2.1 Decentralization

One of the great advantages offered by the decentralization processes, at least with regard to the services and functions that formally remain under the responsibility of the local authorities, is that the necessary conditions are created for achieving the integrated provision of services and, in the case of health, for making appropriate intersectoral actions by the sector more concrete.

The current fiscal situations in the municipalities will allow for the application of a variety of innovative formulas in order to extend social security in the area of health. Among these one could envisage: the assignment of contributions from the municipalities to the social security agencies in order to extend the coverage of low-income groups; enlistment by social security of the health institutions in the municipality to extend social security in health; promotion of the affiliation of organized community groups and cooperatives with social security; and promotion of the formation of new community groups, and of informal workers and small agricultural and livestock producers, so that they will be affiliated with social security.

2.2 Reduced State Involvement or Privatization

The processes of reduced State involvement and privatization have not been exempt from controversy.

Apart from the ideological position adopted in this controversy, it is important to point out that the movement in the Region toward reduced direct State involvement was favored in part by the economic crisis, by the need to correct the structural deficits in some of the companies administered by the State, and in part by recognition that certain services which have been provided traditionally by the State could be administered better by other means, including private institutions.

However, it is also convenient to point out that, despite the fact that in some cases reduced State involvement is timely and desirable, there are services which, because of their nature and objectives, will continue to be provided preferably by the State and within a rigorous normative framework.

It is reasonable to suppose that in the Region's economic and social scenario for the new decade the State will concentrate on protecting the health situation of its most vulnerable groups. In this regard, social security is certain to play a key role.

3. In the Process of Structural Adjustment

From the doctrinary and institutional perspective, social security can also make an important contribution to the process of structural adjustment that is the hallmark of most of the economies in the Region. This role may be examined from two points of view: one with regard to the expansion of health services coverage without substantially increasing the pressure on expenditures by the central government, and the other with regard to utilization of the resources and reserves from economic benefits covered by social security in the hard financing of economic development projects for low-income groups.

In the field of health, social security mechanisms can constitute an alternative expression of public health action that should be analyzed in depth. The extension of social security coverage, with emphasis on the primary care strategy, could meet the health care needs of individuals

and families who are unprotected or who are not able, because of the economic crisis, to find stable employment at adequate wages. In addition, in several of the countries it might be possible to expand current coverage even further.

The second aspect that requires analysis is the prospect of taking advantage of the internal savings generated in the Region by social security legislation. The accumulation of reserve funds in pension systems financed by partial capitalization systems is still being seen in some countries of the Region.

Recognition of the financial potential of social security suggests that there is an opportunity for social security-managed internal savings by the countries to play an important role in the Region's processes of structural adjustment.

The investment of social security reserves in profitable social-interest projects could become a model for a social economy in which the internal savings collected through this mechanism would contribute to increasing employment, generating regular income, and, in general, contributing to an improved quality of life for the population.

4. In the Financing and Organization of Health Systems

In the context of the crisis and the resulting economic adjustments, social security is in a position, because of its pooled financing and its budgetary autonomy vis-à-vis the government, to offer stability in the programming and development of health services.

With more of the population covered, and with reasonable success in anti-inflation policies, the programming and budget process will enhance the effectiveness and efficiency of social security agencies in serving their beneficiaries.

V. ELEMENTS FOR THE DEFINITION OF A STRATEGY

In the situation described, it is clear that the countries of the Region will be required to exert much effort in different ways in order to maintain the current levels of health and health care for the population, and even more so if they are to reach the health goals they have set for themselves.

The increase in unemployment, the decrease in individual and family income, and the growing difficulties in achieving and maintaining basic levels of well-being in the population as a result of the economic crisis have given more relevance and validity to the goal of HFA/2000 and to the objectives of equity and social justice that sustain it.

Within the constraints imposed by the reduction in public spending and other effects of the adjustment processes on the social sectors, it is essential to develop new forms of organization and use of the health resources in which the presence and clear, vigorous action of the State is maintained in order to guarantee health care for low-income groups.

In this context, the utmost importance must be given to achieving the specific inclusion of health in the development process through the effective establishment of intersectoral relations in national and local milieus.

Within the sector, particular importance should be given to the development of social security and to the extension of its health programs on a priority basis to increasingly larger population groups until universal coverage is attained.

In conjunction with this action, consideration must also be given to:

- Reformulation of the national health systems, with emphasis on the development of functional relations between their various components;

- Redefinition of the roles and areas of action and responsibility of the institutions that make up the system;

- Strengthening of the corresponding processes of management and leadership.

Specific reflections on these different aspects would seem to be appropriate at this point.

1. Development and Health: Intersectoral Relations

In an overall concept of development, the intersectoral nature of health is expressed both from the point of view of economic growth and from the perspective of well-being and quality of life.

From this view, economic growth, well-being, and quality of life are mutually determined, and their results are measured by the way in which the benefits of the first are distributed.

Health services coverage has been expressed traditionally as a numerical ratio of the population that receives services, or that has access to them, relative to the total population.

The above notwithstanding, in the framework of HFA/2000 and primary care the concept of coverage has a much broader connotation than the utilization of services, or even guaranteed access to them. The relationship of health to the development process requires a more wide-ranging concept of coverage, such as the existence of an acceptable minimum level of well-being for the population groups served and the availability of a broad spectrum of services capable of supplying different types of health care in accordance with individual needs and the various manifestations of morbidity.

This concept of coverage, then, requires the adoption of new policies oriented toward establishing and promoting true intersectoral action in health coupled with development of different forms of service organization that will make for efficient utilization of the means and resources to strengthen and develop these relations.

Special importance is being placed on the design of methods and procedures for programming these relations in the local area, on coordination at the highest levels of national management regarding overall economic and social objectives, and on review and harmonization of the policies needed in order to put these objectives into practice.

2. Reformulation of National Health Systems

The need to reorganize the health systems has been widely recognized in the Region. In light of the above, however, there are certain crucial elements in these processes that warrant closer scrutiny.

In the first place, it is necessary to effectively recognize the existence of multiple institutions of diverse origin and nature which carry out activities related to health and health care and which, as a whole, form the health resources of the country. This is true in the case of social security as a component of the public sector and of the entities of the private sector, either profit-making or nonprofit entities. The systems approach will facilitate and make possible the finding and development of elements that are common to these institutions in each national situation in order to articulate them into a true system with shared conceptual and functional objectives.

In the second place, it is necessary to go beyond, and replace, organizational approaches that seek to develop the system primarily based on structural modifications. Experience has not shown much progress with attempts at structural standardization of the institutions that provide health services and make up the health systems. The magnitude and variety of problems in health today, and the nature of urgent commitments to large sectors of the population means that other approaches are still necessary. A true systems approach will allow for treatments that are more flexible and more closely related to the functional components of the system and the interrelationships of its institutions, and which are more in tune with the State's definition of uniform health care policies for application by the institutions and extension to the entire population.

In the best definition of the relations between the institutions and the administrative components, due consideration of the decentralization process is of special interest, since their development calls for new organizational formulas in order to relate the nuclei or central units (the Ministries of Health and social security institutions, essentially) to the organization and local administration of services. Development of these relations requires approaches other than those that have been traditionally employed in order to incorporate the elements of decentralization into the basic conceptualization of the system and promote the strengthening of local components within local health systems. It will be necessary to formulate and carry out specific actions aimed at

developing the local organization of services in accordance with the guidelines of the respective public administration, as well as to achieve effective harmony at the local level both in public institutions, including social security, and in private institutions, for the coordinated utilization of their resources.

In the reformulation of health systems it is critically important to solve the financing problems, which is one of the fundamental functional components of such systems. In Latin America, stability in the allocation of financial resources has not been one of the most outstanding characteristics of health services financed with public funds. In recent decades, moreover, the traditional mechanisms for channeling health financing have become increasingly unsatisfactory.

The extension of services to new population groups and the operation of current services, of course, requires finacing strategies with stable sources that make it possible to ensure an adequate and timely flow of resources.

These financing strategies should ensure, insofar as is possible, that the financing of the health systems contributes effectively to the positive distribution of the national income, and guarantees that low-income groups have been assured financial access to health care.

Under the conditions that are predicted for the countries, financing strategies should also seek solutions that include and combine both aspects of the public sector--State budgets and social security--with actions by the private sector and the organized community.

In this context, consideration of alternative forms of financing clearly points to social security as a stable mechanism with great potential and consequently as a valid and fundamental option. In the current circumstances, the capacity of social security to participate in these processes is constrained by the traditional financing mechanisms and by the restrictions contained in the laws and other legal instruments that created the institutions and regulate their financing and forms of operation. It will be necessary to seek alternatives in order to overcome those restrictions, such as the establishment of national health insurance or other schemes in which the government creates the mechanisms that make it possible, by contribution and/or by imposition, to ensure the financing of services for the entire population, thus breaking free from the present financial stratification.

3. Definition of Institutional Roles and Areas of Action for Health System Institutions

Reformulation of the national health systems requires a restatement of the roles and responsibilities of the institutions that make up these systems. In this process it is especially important to examine the current responsibilities and new mandates of the Ministries of Health.

In the broad and functional concept of health systems that is proposed here, they are multi-institutional, made up of governmental and nongovernmental agencies and entities responsible for different kinds of activities. For the entire system to be fully articulated, the Ministries of Health will have to develop, maintain, and strengthen, a leadership role for the system and for the health sector as a whole. These are universally recognized duties and responsibilities that are beyond discussion. In order to properly fulfill them, the Ministries of Health should strengthen and develop their presence and political authority, their technical capacity, and their coordination with the other agencies that carry out activities in health.

Similarly, it is required to develop the capacity to mobilize and disseminate knowledge on health and available technology in the health sector. Moreover, it is essential to strengthen regulatory functions relative to the production and distribution of human and material resources and the promotion of common, agreed-upon objectives in the effort to ensure that the population is adequately covered with health care of good quality.

Restatement of the Ministries' functions also involves the development of their capacity to advise and support the local service administrations so that they can create and strengthen their own capacity to formulate and manage health programs.

This is an indispensable and fundamental change, although there will have to be a transitional stage during which there will still be direct activities (programs, etc.), with gradual development of capacity on the part of other institutions and operating levels of the services system to promote and support specific actions.

In other words, the evolution of the health systems in the present decade requires that the Ministries of Health revamp their internal organization and their human and technical resources so that they will be able to provide true leadership for the sector.

It will also be necessary to redefine the roles of the social security institutions and to transform their organizational and operational schemes so that they are in a position to assume their task in the health systems area and in the financing of integrated development.

4. Strengthening the Processes of Health Systems Management and Leadership

To put into practice the changes and reorientations proposed will undoubtedly require extensive discussion, with participation of the institutions, groups, and individuals involved, as well as clear determination at the centers of political power. This participation, and the changes proposed, go beyond the efforts normally required for the implementation of new procedures and techniques in the organization of the health services. The nature of these changes points unequivocally to the need to strengthen sectoral management and develop various forms of leadership in health. It is particularly essential to strengthen and develop political leadership in the health sector.

The needed strengthening of political leadership cannot, of course, be achieved through training courses and programs--which do not exist. Rather, it calls for the introduction of a process specifically directed toward bringing the health sector closer to the political decision-making levels and strengthening capacity to participate and negotiate in the political process, which involves health services management, particularly with regard to the introduction and effective incorporation of significant changes.

As a complement to this effort, it will be necessary to review training programs in health services administration and management, and it will also be necessary to design and implement new training programs and systems specifically for the local management and administration of health services.

5. Development of Social Security Systems

In the circumstances predicted for the evolution of health services in the present decade, the characteristic of social security as a basic tool for public action should be fully utilized. This implies the need to adjust or adopt national social security policies that will make it possible to harmonize existing programs, correct imbalances and the privileged status of some groups relative to others, and extend at least basic protection to the entire population.

In essence, this means accelerating the pace at which the concept of social insurance is being transformed into one of social security, and it also means consolidating and expanding the programs and actions that are being implemented. In this process, however, it will be necessary to revitalize the conceptual bases of these programs--bearing in mind their primary function as instruments of public action--adjusting them and adapting their content and orientation to the new requirements posed by the social and economic circumstances of the different population groups in the countries. It will also be necessary to promote the doctrinal and operational development of social security as a means of creating employment instead of subsidizing unemployment. There is need for innovative forms of affiliation and financing that will facilitate the development of programs for purposes of incorporating the informal sector as beneficiaries of social security. It is necessary to establish an order of priorities for orienting the content of the programs. In this sense, it would be desirable, in some of the countries, to open up a debate on which of the programs should be given priority in the political decision-making process and in the allocation of resources, including those for health care programs, whose coverage needs to be constantly extended.

While the conceptual and political reorganization is taking place to guarantee basic protection for the largest possible segment of the population, it is also important to review the role of the social security institutions and redefine it, if necessary, as well as to transform their organization and action mechanisms so that they will be geared up for the new tasks they are to carry out.

There is also need to make qualitative adjustments in the health actions of social security institutions. As greater coverage is achieved, these programs will gradually take on added importance in the overall national system. It will then be necessary to face new and broader responsibilities in promotion and prevention, assistance and rehabilitation, the training of health manpower, and the development and application of new technologies according to each national situation.

In this context the indispensable redefinition and development of social security systems involves, in addition to firm political decision, the development of a clear, wide-ranging capacity for innovation and the full participation of committed institutions and groups in the process.

VI. GUIDELINES FOR TECHNICAL COOPERATION

The changes in the State's role vis-à-vis public services which have been envisaged for the Region during the present decade make it necessary to reaffirm the principles of solidarity, universality, and integrality in social security. The extension of social security programs, as outlined in the preceding pages, calls in turn for the formalization of new and broader doctrinal concepts and guidelines that will make the application of these principles viable amid the changing reality of the political, economic, and social contexts of the different countries.

In these processes of review and adjustment of the political and doctrinal concepts of social security, technical cooperation activities and guidelines are of special importance in reformulating the mission of the institutions and programs, and also as valuable tools to be shared in the application of social policy adopted by governments.

Accordingly, at its first meeting, held in February of this year, the PAHO Advisory Committee on Social Security made a series of recommendations that address the various issues.[31]

In implementing the Organization's policies and priority programs, the technical cooperation with the social security institutions needs to take into account and be guided by a frame of reference that includes the following three cpmponents or areas of strategic development:

1) Elements specific to the political, economic, and social situation of each country and to the interpretation of the mission of the social security institutions and their programs in this context.

   The basic elements in this regard involve:

   a) The place of social security and health systems in the development processes; the relationship of these programs to the development models and their social objectives; social security action in the context of these models as an instrument of government social policy; the role of the State in

implementing these policies; the conceptualization of health systems and their place in this context; and the corresponding identification of priorities for public action.

b) Financing and resources for social security, and the utilization and management thereof

The principal elements in this area have to do with: contributions withheld from wages as a financial basis for the programs; the need and possibilities for changing and diversifying these systems; criteria and areas for the distribution of resources; the cost of services and the role of users in defraying this cost; the streamlining of care delivery and institutional financial management; and the investment of reserves and the improvement of their social return.

c) Health care and social security

This area will primarily include elements referring to the role of social security in the provision and extension of health services coverage; the incorporation of new population groups, particularly from the informal urban sector and from rural areas; the processes of coordination and functional integration of services within a pluralistic concept of the health systems; and the incorporation into the latter of new contents and guidelines for health care delivery.

2) Areas for cooperation

These areas will consist of recognized technical cooperation components, primarily related to:

a) Direct support or assistance in projects for institutional reform or strengthening, in order to:

- Improve the efficiency, productivity, and effectiveness of the health services and expand their capacity to provide care;

- Analyze the operational costs of the services vis-à-vis the extension of coverage, and study models for the adjustment of both variables;

- Formulate strategies that will make it possible for social security systems to respond to the demands for greater participation in the delivery of services through appropriate coordination with other entities in the health sector, while still preserving their institutional identity;

- Carry out feasibility studies on the extension of coverage, including studies of needs and possibilities for investment in accordance with national realities.

b) Human resources development

Human resources development has a key role in the process of health system reformulation and the development of social security health programs. Consequently, it is essential to support a critical analysis and review of training policies and activities, as well as to develop technical and administrative personnel in social security and health institutions.

The processes of changing and developing these entities depend primarily on their personnel, who in addition to having received a good basic training in their respective disciplines must have an accurate perception of the institution's mission and responsibilities within the framework of health policies, given their place in the national economic and social context.

In this light, technical cooperation actions to be carried out on the basis of strategic development criteria and guidelines should mainly take into account the analysis of needs and manpower; the development of leadership in social security and health; and the identification and promotion of academic centers for the training and development of social security and health personnel.

At another, equally important, level, support should be given for designing the content of training programs for all institutional professional, technical, and support personnel and for the establishment of ongoing education programs which are designed above all to inform and transmit knowledge but also to bring about changes in attitudes that will contribute to locating institutional tasks in the context of the national reality and its development policies. Technical cooperation strategies for human resources development should be closely related and should include support for research and institutional strengthening.

c) Promotion and support of research, principally operations research, in the various areas of activity that come under social security

Of particular interest is research directed toward validating empirical knowledge about social security in the Region and improving the study and solution of problems that are recognized by the institutions but which also offer possibilities to compare experiences.

Areas that are particularly critical, and consequently of a priority nature for research, include: functional integration with the Ministries of Health; the design of intra- and extrasectoral coordination models; studies of

problems affecting access to services; studies on coverage, including the identification of problems and an analysis of the possibilities for incorporating the informal sector; and comparative studies on the cost of extending services under different benefit programs and financing schemes.

d) Development of information on social security

In addition to support for the development of information systems in the social security institutions, actions in this area will include the dissemination of knowledge and information in general on social security and its programs, as well as the promotion of forums and debates on the subject. One medium-term objective in this area is the establishment of a permanent communication network that would make it possible to exchange information and do comparative studies on critical elements of common interest for the organization of the institutions and their programs.

3) Spheres for cooperative action

The focus of cooperative actions is unquestionably the national programs and institutions, whose cooperation needs are individual and specific in each case. From this perspective, the following sphere should be considered for the development of cooperation activities.

a) The countries

Based on national priorities, technical cooperation in this sphere should contribute to improving and updating information that will aid and stimulate policy decisions on social security and its programs, support the preparation and implementation of projects for the integral development of social security and health systems, and improve their performance and the utilization of resources in the different components.

b) The subregional groups

In the evolution of social security systems, certain common trends can be identified on the basis of geographic or subregional groupings of the countries which are not necessarily limited to these groups. This makes it possible to propose strategies and activities aimed at responding to shared needs for cooperation within the framework of PAHO/WHO subregional initiatives.

Concrete schemes for subregional cooperation in the field of social security can be proposed for such groupings as: Mexico and the Central American and Latin

Caribbean countries; countries of the Andean Group and Paraguay; countries of the Southern Cone; and countries of the English-speaking Caribbean.

c) Actions of a regional nature and scope

In addition to cooperative actions in support of programs in the countries and the subregional groups, from a regional standpoint it is possible to identify certain other specific fields of action, such as:

- Activities aimed at improving knowledge about social security at the various levels of the Organization (PAHO/WHO) through the publication and extensive dissemination of selected materials and through subject-specific meetings and the inclusion of topics relating to social security in various types of seminars, courses, etc.

- Activities for the exchange of information and the promotion of study and research on subjects of general interest or subjects that involve national groups from several subregions. Suggested among these, for example, are studies and exchange of information on the relationship of social security to nongovernmental organizations, particularly private institutions; comparative studies of various models of care delivery and services organization; analysis of hiring and remuneration systems, etc.

- Coordination with other international agencies in the area of social security (International Labor Organization, International Civil Service Commission, International Social Security Association, ISSO, ASSICCP) that have significant activities in the Region. This is unquestionably a priority area for regional activity. The joint action of these organizations will make it possible to potentiate the use of cooperation resources. It will also contribute by avoiding duplication and possible doctrinal and operational contradictions that might otherwise occur as a result of using information from different sources. It is especially important in this area to establish and develop ways of working together jointly with the development banks and other entities that have begun to engage in technical and financial cooperation with social security entities.

Within the framework outlined, a central strategy for regional technical cooperation in this area must necessarily be geared to promoting and sponsoring extensive debate on the changes required in the definition of social security policy and programs. This is clearly the challenge that these institutions will have to face in the present decade in order to deal with the new situations arising in the countries as a result of adjustment policies, unemployment coupled with the simultaneous growth of the informal labor sector, the lack of capacity of vast sectors of the population to participate in traditional contributory systems, and for all these reasons, the need for more decided, more extensive, and firmer social action and presence on the part of social security.

TABLE 1

SOCIAL SECURITY PROGRAMS IN THE REGION OF THE AMERICAS

(1987)

SYNPOSIS OF SOCIAL SECURITY SCHEMES

COUNTRY	TYPE OF SCHEME				
	OLD AGE, DISABILITY, AND DEATH	SICKNESS AND MATERNITY	OCCUPATIONAL ACCIDENTS	UNEMPLOYMENT	FAMILY BENEFITS
Antigua-Barbuda	X	X.			
Argentina	X	X.	X		X
Bahamas	X	X	X		
Barbados	X	X	X	X	
Belize	X	X	X		
Bermuda	X		X		
Bolivia	X	X.	X		X
Brazil	X	X.	X	X	X
Canada	X	X.	X	X	X
Colombia	X	X.	X		X
Costa Rica	X	X.	X		X
Cuba	X	X.	X		
Chile	X	X.	X	X	X
Dominica	X	X	X		
Ecuador	X	X.	X	X	
El Salvador	X	X.	X		
United States of America	X		X	X	
Grenada	X	X			
Guatemala	X	X.	X		
Guyana	X	X	X		
Haiti	X		X		
Honduras	X	X.	X		
Jamaica	X		X		
Mexico	X	X.	X		
Nicaragua	X	X.	X		
Panama	X	X.	X		
Paraguay	X	X.	X		
Peru	X	X.	X		
Dominican Republic	X	X.	X		
St. Kits and Nevis	X	X.			
St. Vincent	X	X	X		
Saint Lucia	X	X	X		
Trinidad and Tobago	X	X	X		
Uruguay	X	X.	X	X	X
Venezuela	X	X.	X		

"." The asterisk (*) means that the scheme includes medical care and hospitalization in addition to cash benefits for sickness and maternity.

Source: U.S. Department of Health and Human Services, Social Security Schemes in the Americas, 1987, Social Security Administration Research Report No. 61.

TABLE 2

COUNTRIES WITH SOCIAL SECURITY PROGRAMS
IN THE REGION OF THE AMERICAS, 1987

	SCHEMES					
	DOS (1)	SM (2)		OA (3)	U (4)	FB (5)
		X	Y			
LATIN AMERICA	20	19	19	20	4	7
NORTH AMERICA	2	1	1	2	2	1
CARIBBEAN	13	11	2	10	1	
T O T A L	35	31	22	32	7	8

Source: U.S. Department of Health and Human Services, Social Security Schemes in the Americas, 1987, Social Security Administration

X = Cash subsidy in the event of illness or maternity
Y = Includes medical care and hospitalization

(1) Disability, old age, and survival (pensions)
(2) General sickness and maternity (health benefits)
(3) Occupational accidents
(4) Unemployment insurance
(5) Family benefits (subsidies)

TABLE 3

SOCIAL SECUTIY PROGRAMS IN THE COUNTRIES OF LATIN AMERICA,
DISTRIBUTION OF THE LABOR FORCE,
AND INDICATORS OF COVERAGE

Countries	Social Security* as % of GDP (1980)	Health schemes as % of total population		Labor Force Percentage distribution by sectors				%
				Urban		Rural		
		1980	1985-88	Formal	Informal	Modern	Traditional	
ARG	10.0	78.9	74.3	65.0	19.4	8.8	6.3	71.2
BOL	3.0	25.4	21.4	17.9	23.2	5.2	50.9	38.2
BRA	5.0	96.3	-	45.2	16.9	9.8	27.6	65.3
COL	4.0	15.2	16.0	42.6	22.3	15.8	18.7	53.5
COR	9.0	81.5	84.6	52.9	12.4	19.6	14.8	75.2
CUB	9.0	100.0	-	-	-	-	-	88.8
CHI	1.0	67.3	-	54.1	20.1	14.0	8.8	66.7
ECU	3.0	9.4	11.1	22.7	25.4	13.7	37.9	47.6
ELS	2.0	6.2	-	28.6	18.9	22.3	30.1	59.2
GUA	2.0	14.2	13.0	26.7	17.8	22.3	33.1	46.9
HAI	1.0	-	-	-	-	-	-	16.6
HON	3.0	7.3	10.3	-	-	-	-	45.4
MEX	3.0	53.4	59.7	39.5	22.0	19.2	18.4	44.3
NIC	2.0	9.1	37.5	-	-	-	-	-
PAN	7.0	49.9	57.4	45.3	20.9	9.1	24.6	63.3
PAR	2.0	18.2	-	-	-	-	-	36.7
PER	3.0	16.6	18.6	35.0	23.8	8.0	32.0	45.1
R. DOM	2.0	-	5.9	-	-	-	-	51.3
URU	11.0	68.5	67.0	63.3	19.0	9.5	8.0	69.4
VEN	3.0	45.2	49.7	62.6	16.4	4.4	15.1	64.1

* The social security expenditure is included as a health cost.

Sources: Carmelo Mesa Lago - Aspectos económico-financieros de la seguridad social en América Latina y el Caribe. Tendencias, Problemas, y Alternativas para el año 2000 (Pittsburgh, January 1989).
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