RESHAPING LATIN-AMERICAN HEALTH CARE SYSTEMS: TOWARD FAIRNESS? *

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Introduction

This paper is the conclusion of a research project* comparing the health reforms in Argentina, Brazil, and Mexico. In this project a common framework was adopted to compare the economic and political contexts were the reforms took place, identifying the dual and contradictory movement of political democratization and economic crisis. The processes of the health reforms in the three countries were analyzed based on the dynamics of interests and pressures from the most important stakeholders upon the decision-makers. The analysis of the reform process guided the research to focus on the main transformations of the health-care systems from 1970 to 1990.

The modular methodology adopted channel the research into a survey, where an open population, selected through some epidemiological tracers' conditions, was canvassed about their experiences of health care access and utilization.

In this chapter, we are presenting the conclusions of this comparison, according to the major economic and social tendencies in the three countries, the health reform processes, considering both the political arena and the reform proposal and strategies, and the new format of the health care systems. The analysis of the results, in the qualitative and quantitative studies, indicated the transformations towards a more modern and competitive health system, although more unequal and segmented.

- The project was sponsored by IDRC, and will be published by the same agency during this year. The research team was under my coordination. The national teams were coordinated by: Argentina – Susana Belmartino; Brazil – Lenaura Lobato; Mexico – Silvia Tamez
- Observation: The literature used in the research is not refereed in this paper.

Major Economic and Social Tendencies

A common pattern for social policies was developed in most Latin American countries, rooted in a similar development model and responsible for some of the most remarkable features of the relationship between the state and the society, as well as for incorporating a particular power structure into a formalized system. The characteristics of this pattern were identified in the health sector as:

- The segmentation and/or exclusion of groups of the population,
- The fragmentation of the institutions,
- The narrow and fragile financial basis of the system, mainly based on contributions upon salaries, and
- The existence of strong actors with vested interests represented in this political arena.

The impossibility of keeping this same pattern while expanding the coverage with the increase in the efficiency and the quality of the health care services, in a context of financial shortage, created the demand for reforming health systems in the region.

In recent decades, the deep economic crisis and the structural adjustment measures introduced by the governments have revealed a common scenario for the Latin American countries where the reform agendas are being carried out. In spite of these similarities, it is indispensable to highlight the variations among the three countries that we are comparing Argentina, Brazil and Mexico, concerning the way they faced this critical period and the effects of the adjustment policies on their recovery. This gives us a picture of the overall setting in which the health-system reforms are being carried out. We should also add data concerning the resources for health systems, to have a better representation of the possibilities and constraints in realizing the health-system reforms.

One of the most important features of the recent economic crisis was the inflation. An acute form of hyperinflation occurred in Argentina in 1989-90 and is now under control due to the economic

policies adopted in this country. Brazil also had high inflation that lasted more than 5 years and it only seems to be under control during the last 2 years. Mexican inflation never reached the same level as in the former two countries, but it is still increasing (Table 1).

Table 1. Average annual growth of consumer prices (%).

Country	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996 [a]
Argentina	85.7	123.1	348.3	3 086.9	2 313.7	171.7	24.9	10.6	4.2	3.4	0.2
Brazil	125.0	233.3	690.0	1 289.0	2 923.7	440.9	1 008.7	2 148.5	2 668.6	84.4	15.0
Mexico	86.2	131.8	114.2	20	26.6	22.7	15.5	9.7	6.9	35.0	34.4

Source: IDB, Latin America after a Decade of Reforms, (1997).
[An] Approximate.

The lesson learned in recent years in Latin America is that control over inflation is very important political capital for the government, as it gives legitimacy to its economic policy, even considering the painful effects it has on salaries and unemployment. Success in defeating inflation, especially in countries where it had achieved very high levels, allows the government to carry out social reforms with more freedom. Even so, they have to face stakeholders and deal with strong lobbies that have veto power in the social decision-making process.

Other important features of economic stabilization and recovery in the region –data on the external debt, the annual growth rate and the level of unemployment- can be seen in Tables 2B4.

Table 2. Total external debt as a percentage of gross domestic product (GDP).

Country	1986	1990	1995
Argentina	39.9	40.6	37.2
Brazil	33.4	32.1	33.3
Mexico	51.7	43.3	56.4

Source: IDB, Economic and Social Progress in Latin America, (1996).

Table 3. GDP per capita: average annual growth rate (%).

Country	1970B80	1980B90	1990B96
Argentina	0.9	-2.5	4.6
Brazil	6.8	-0.6	1.3
Mexico	3.7	-0.7	-0.5

Source: World Bank, Annual Report, (1997).

Table 4. Unemployment, 1996.

Country	Percentage of labor force
Argentina	17
Brazil	5.9
Mexico	5.9

Source: IDB, Latin America After a Decade of Reforms, (1997).

As shown in these tables, the economic situation in Argentina may be characterized as stable, and is moving toward recovery. Although the reforms have accelerated economic growth, they have slowed the pace of job creation. Because the labor situation has not been improved by the economic reforms, the government′ s credibility is threatened, compromising the initially favorable conditions in which to carry out subsequent reforms.

Brazil has a different situation, because inflation has only very recently been brought under control, and recovery is still very slight. The lower level of unemployment gives more legitimacy to the reform process, although an increase is expected in unemployment as a consequence of the economic measures adopted to combat the inflationary process. The persistence of poverty brings instability to the social and political scenes. More than 40% of the population lives in a situation of moderate poverty C 46.3% in 1990 and 43.5% in 1995 C and more than 20% in a extreme poverty C 24.5% in 1990 and 22.9% in 1995 (IDB 1997).

From 1990 to 1995, Mexico saw an increase in percentages of both moderate poverty and

extreme poverty (moderate poverty was 19.9% in 1990 and 22.3% in 1995, while extreme poverty was 11.3% in 1990 and 11.8% in 1995). This country′ s economic situation does not favor the launch by government of social reforms that could affect the interests of important groups in the political arena.

The demographic and social data show other dissimilarities among the three countries. One important trend in the social field is the population growth rate, which is steadily declining in Argentina, suffered a recent clear-cut reduction in Brazil, and is slowing down smoothly in Mexico (Table 5).

Table 5. Total population and average annual growth rates.

Country	Total population (thousands)		Average annual growth rates (%)		
	1990	1996 [a]	1970B80	1980B90	1990B96
Argentina	32.322	34.665	1.7	1.4	1.2
Brazil	149.042	163.976	2.4	2.1	1.6
Mexico	81.25	92.25	2.9	2.3	2.1

Source: IDB, Latin America After a Decade of Reforms, (1997).
[a] Approximate.

Compared with the other two countries, Argentina′ s more favorable situation for tackling social problems is also reflected in the existence of a lower reducible gap in mortality (Table 6).

Table 6. Reducible gaps in mortality.

Country	Total reduction (%)[a]
Argentina	18.1
Brazil	57.1
Mexico	40.2

Source: PAHO, Health Conditions in America, (1994).

[a] Total percentage of reducible death for the population under 65, 1985B89.

From a historical perspective, nonetheless, Argentina′ s favorable situation has vanished, because in this country Athe gaps narrowed up until 1975B79 and then started to widen, ultimately reaching and even exceeding the levels that prevailed in the 1960B65@ (PAHO 1994, p. 22).

Although Brazil presents a difficult position because of enduring inequities, the Mexican situation is the most dissatisfactory one in terms of availability of health-system resources (Table 7).

Table 7. Resources in the health-care system, about 1991.

Country	Population per doctor	Population per nurse	Hospital beds per 1 000 population
Argentina	330	1650	4.4
Brazil	670	6700	3.5
Mexico	1850	2310	0.8

Source: UNDP, Human Development Report, (1994) and PAHO, Health Conditions in America, (1994).

The predominant lack of nurses in Brazil could be explained by the importance of hospital care in its model, to the detriment of outpatient care. An example of the Brazilian inequity, compared to the other two countries, in accessing highly specialized services and hospital units can be seen in Table 8. Table 8, when comparing the existence of professional care during delivery.

Table 8. Professional care during delivery, about 1991.

Country	%
Argentina	95.4
Brazil	70
Mexico	95.4

Source: PAHO, Health Conditions in America, (1994).

Even with fewer resources, Mexico achieved a better level of professional care during delivery, in fact, the same level as Argentina. The variations here could indicate the prevalent health-care model in each country, which gives more or less priority to prevention at the first level of the health-care system.

Considering social-security coverage, we can note important differences among the three countries. These data, however, do not indicate actual access to health-care services.

Although social-security expenditure on health rose in Argentina, it dropped in Brazil and Mexico in the period 1980B90 (Table 9). Considering the deep economic recession in Argentina during this period (see Table 3), the importance of political pressure may be pointed out as the possible explanation for this increase.

Table 9. Social-security expenditure on health and coverage.

Country	% of GDP		% of population covered	1990 expenditure per capita (US$)
	1980	1990		
Argentina	2.8	3.3	74.3	167.8
Brazil	1.5	1.2	100.0	26.3
Mexico	1.3	1.0	59	38.8

Source: PAHO, Health Conditions in America, (1994).

Social-security expenditure per capita on health in these countries varies greatly. As the Argentinean expenditure is more than six times the expenditure in Brazil, it may suggest that, in Brazil, the universality of coverage was made to the detriment of the quality of service. Other measures of health-care use also differ among the countries being compared (Table 10).

Table 10. Hospital use and consultations, about 1991.

Country	Bed turnover	Average stay (days)	Occupancy (%)	Consultations per person
Argentina	22.7	8.4	51.9	1.6
Brazil	34.7	6.9	B	3
Mexico	51.7	B	B	1.7

Source: PAHO – Health Conditions in America, (1994).

The dissimilar use of health-care services in these countries can probably be better explained by means of the configuration of the health system than by the epidemiological profile.

In Mexico, the public sector and social security (including the military services) are responsible for more than 85% of the hospital beds, whereas in Argentina they account for about 57%. In Brazil, the public sector (including social security) owns less than 30% of the available hospital beds, most of them in units with few beds.

The three countries also have different epidemiological profiles, either in terms of the population health conditions or the situation of the health-care system.

In 1994, the major causes of death in Argentina were cardiovascular diseases (a typical profile for an aged population), and malignant tumors.

The major causes of death in Brazil, in 1995, were cardiovascular diseases, symptoms and diseases of uncertain definitions, and external causes. In this case, the epidemiological profile shows the reality of a country with some diseases common in developed societies, together with other classifications that could indicate bad conditions in the health-care system and the existence of violence in large cities.

In 1990, Mexico showed as major causes of death: accidents, cardiovascular diseases, and respiratory diseases. A mixed profile, where violence, age of the population, and poor child nutrition are combined.

Comparing these countries health expenditures and health outcomes shows a positive correlation between public expenditure and positive indicators of health (Table 11). Undoubtedly, Argentina has the best outcomes, both in access to health services and in quality of life.

A comparison of Mexico and Brazil shows a higher expenditure on health in Brazil, although it is

the only one of the three cases in which private expenditure is higher than public. However, the outcomes of the Brazilian system are worse than the Mexican health system results.

Besides the differences in the weigh of the public sector and its possible correlation with the prevalent health care model, certainly, there are other variables affecting these results, such as economic performance and the degree of inequality in the distribution of economic growth.

The Health Reform Process

The Political Arena

In Argentina, the health-care system has historically been characterized by a division into three relatively independent sectors: public, private, and social security. The decline in the public sector from the 1960s to the 1990s has been compensated for by the growth of the social-security sector and by the expansion of private services.

The social-security health-care system, institutionalized in 1970, was composed, until very recently, of a considerable number of institutions. The *obras sociales*, acting as sickness funds, grew under the control of trade unions. These institutions supplied health care to their beneficiaries primarily through contracting for facilities from the private sector and secondarily by using health services of their own. This organizational model generated a high degree of fragmentation and diversity.

The limitations on the state to regulate or coordinate the system created grounds for the feeling that the control was held by two groups of corporate organizations. One group, the *obras sociales*, is composed of financing entities, politically represented by the Confederación General del Trabajo (CGT, General Labor Confederation) while the other group, composed of medical associations and organizations of private hospital owners, controls demand.
This background to the Argentinean social-security health-care system creates a meaningful picture of the political arena where the reform takes place. On one side are the powerful corporate

Table 11. Health expenditures and outcomes by country.

Country	Total health expenditure, 1990						Health outcomes, 1991B92				
	As % of GDP				As % of total						
	Public	Private	Aid flow	Total	Public[a] plus aid	Private	Per-capita (interna- tional $)	1-year immuniz - ation	Infant mortality rate, 1992	Life expectancy, 1992	Access to health care (%)
Argentina	5.85	3.70	0.01	9.56	61.28	38.72	418	87	24	72.1	92
Brazil	2.76	3.64	0.02	6.41	43.20	56.80	296	18	58	66.3	72
Mexico	3.10	2.36	0.03	5.49	56.88	43.12	335	92	36	70.8	77

Source: Various; IDB, Economic and Social Progress in Latin America (1996).

[A] Includes social-security systems.

organizations, either those representing interests of the trade unions and their capacity to finance health care or those representing the entrepreneurs who provide health care. What is singular in this case is the high level of organization of these representative channels of social and political interests, which were, for a long period, the most important actors in the health care political arena. On the other side is a weak bureaucracy, unable to put into effect many of the legal instruments launched and, thereby, reduce the trade unions' control over the system.

Other actors joined this political arena during the reform process, especially with the increasing importance of private health-insurance institutions.

Some concurrent economic factors changed the power structure in the health field, as the deep transformations in the labor market affected the trade unions' prominent position on the political scene.

With the rupture of the corporate pact that had ruled Argentinean society during that half of the century, the government adopted the reform agenda proposed by international agencies, bringing to the health arena the important participation of international policy-makers.

To summarize, the health care system in Argentina was highly fragmented in different institutions –among the Obras Sociales and the Health Ministry-, with the users segmented according their belonging to each of those institutions, producing unequal conditions of access and utilization of health care services. The decision-making process was concentrated on corporate organizations, both in the supply and the demand sides. The deterioration of the Health Ministry public services and the increasing perception of the mismanagement of Obras Sociales by users and professionals created the pre-conditions for the reform process.

The health reform process in Argentina is partly due to the lost of legitimacy of the traditional political actors. For many decades the power in this sector and in the society was ruled by the trade-unions, the professional corporations and the political parties. The recent introduction of

new actors, such as the international bureaucracy and the private health insurance institutions, generated a more complex situation.

Nevertheless, the health reform cannot be understood detached from the entire market-oriented reform of the economy launched by the government during the last decade.
In this sense, the success of the Argentinean reform is highly dependent on the capacity of the government to neutralize the opposition from the trade-unions as well as on to maintain the economic situation under control.

In Brazil, the reform process was based on two different and, in some instances, contradictory pillars. On one side, there is a drive from the democratic transition, with the obligation to incorporate the excluded population into the political and social systems. On the other side, there is the necessity to rationalize and to bring more efficiency to a health system that was frail, both financially and organizationally.

In this context, health-sector reform strategies emerged, with the proposal for a public, universal, and democratic health-care system. This proposal strengthened the social movement and the organizations of civil society and has been partly adopted by the government health bureaucracy.

The democratic transition in Brazil was characterized as an agreement between the traditional elite and the emergent political forces, under pressure from the revitalization of organized social groups and the increasing dissatisfaction of the population. However, the traditional economic and political elite was able to control the process of political and social incorporation of the emerging forces without having to substantially change the power structure.
The inept rule by military and civil bureaucracy was revealed by critical and recurrent crises in the health-care and social-security systems. More than two decades after the dictatorship regime had excluded workers from the management of the social-security institutions and had proceeded to unify and centralize these institutions in the hands of a powerful bureaucracy, the financial crisis was still present.

The inability to create an integrated health-care system, however, was shown by the normalization of the institutional dichotomy, in the 1970s. This attributed to an increasingly decadent Health Ministry the theoretical responsibility for the health care of the whole population, while the strong social-security apparatus was accountable only for providing health care to the beneficiaries of that system.

The expansion of health care by the social-security system during this period was accomplished through the strategy of contracting for private services, on a fee-for-service basis. This strategy generated an intricate network of relationships among the social-security bureaucracy and the private providers, and dishonest activities on both sides.

The regressive financial basis of the system, increasing demands for equal treatment in health services, and an inability to control the increase in costs for health-care services were strong enough to generate a claim for administrative reform of the social-security health-care system.

A combination of factors culminated in the social-security crisis in the 1980s. This crisis was determined by some factors, like:

- the growth in expensive medical care without a corresponding change in financing;
- the method of paying the private sector services that stimulated the use of high-cost specialized procedures and fraudulent operations;
- the difficulty of financial control because of the disorganized structure of the system itself; the worsening of service quality; and the economic crisis in the country

The sanitary movement that appeared as part of the revitalization of the civil society was able to gather many forces opposed to the regime and also to formulate a consistent proposal for health-system reform before any other political actor. This movement's strategy took the reform to the legislative and institutional spheres, as part of the process of rebuilding a democratic apparatus for the health sector.

As usual in Brazilian political history, the principal arena came to be the state, where many different actors played a game of confrontation and coalition, trying to control the decision-making process as well as the financial, technical, and political resources.

The main actors in this process were clustered around the social-security institutions, not only the opponents of reform (represented by the traditional and corrupt bureaucracy, populist politicians, and the private providers under contract to the social-security health-care system), but also those leading the reform process. The latter was a broad coalition of actors led by health intellectuals and technicians, some political leaders and legislative representatives, and some professional organizations and popular movements.

The Brazilian case of health reform is unusual, in Latin American context, because, first, the health care institutions of the Social Security were already integrated into one institution, by the military government and, second, the reform project was formulated as an answer to the political crisis of the authoritarian regimen. Therefore, it was previous to the economic crisis and the adjustment policies. As this reform was executed during the period of economic crisis there were many important changes in the macroeconomics and political environment that generated many constraints to the reform project. In this case, the success of the reform process depends on the capacity of the reformer coalition to adapt the project to the new context, to guarantee technical and political support to the reform and to institutionalize the process. These previous conditions are necessary to avoid the government to adopt a more market-oriented project of health reform. Additionally, the success of the reform depends on the capacity to generate a recognized better health care system in a very unfavorable economic situation.

In Mexico, the health-care system is structured into three independent sectors, each with a segmented group of clients. The social-security institutions, covering the compulsory insured workers from the formal labor market; the public sector, covering the general population not covered by the former system; and private medicine, which developed outside official policies and

still presents a limited coverage.

Many problems arose from this structure, among which were duplication and waste of resources, and creation of monopolies for different segments of the population. Probably the most serious problem was the overlap in demand, because a high proportion of those covered by the social-security system used private sector services or those of the public sector Secretaria de Salud (SSA, Health Department). In addition, despite repeated efforts to encourage decentralization, the system still suffered from the inertia generated by many years of centralization. To summarize, the health-care system presented problems of coverage, stratification by population groups, and centralization, as well as serious problems of duplication of services, poor quality, and inefficiency.

An intent to integrate the system into a single, national, health-care system was formulated in the 1980s as part of the need to reduce public expenditure in a context of economic crisis. To rationalize the functioning of public institutions became an imperative for the government.

The creation of the Sistema Nacional de Salud in 1983 had as its objective to launch administrative and organizational reform, by creating different sectors, decentralizing, modernizing and coordinating, as well as opening the possibility for community participation. This change also gave the SSA, a public agency, the power to plan, and even budget, for all institutions including the Instituto Mexicano del Seguro Social (IMSS, Mexican Institute for Social Security).

Both the development of the reform proposals and their implementation were carried out by the government and the Department of Health (SSA) alone. Only later was there participation by the public institutions that would be affected and by representatives of employers and workers. The success of the proposals depended on the support of all institutions, but especially on support from the most powerful institution in the sector, the IMSS.

The transformation proposed was fundamentally a state project and was based on the results of negotiation between government representatives, employers, and labor organizations.

IMSS resisted becoming controlled by a weaker institution in the sector — the public SSA — and tried to avoid the alteration of the power balance in favor of SSA. The proposed coordination of the health system by SSA was unsuccessful, as the reform terms apparently undermined the basis of the corporate pact. A coalition was formed under the leadership of the IMSS, supported by the organized labor movement, which vetoed the reform.

The conjuncture of an economic crisis with the reduction in public expenditure, along with a growing policy of extending coverage, resulted in a gradual deterioration in public services. In addition, the combined high levels of centralization and fragmentation reduced the effectiveness and efficiency of the services.

The government adopted a focusing strategy to provide target groups, those excluded from health care, with social services. However, the discretionary use of the resources resulted in using the services as a resource to achieve political legitimacy.

The first attempt to reform the health sector was to create an integrated and coordinated health-care system, as part of the government's project to rationalize the public service. As an administrative reform, it was developed by an inner circle of public authorities and did not achieve the necessary social and political support it needed to be implemented.

In Mexico, the political arena was composed of the public sector and social-security bureaucracies; the traditional politicians and government authorities; and the insured workers, who mobilized themselves after perceiving the reform as a threat to their acquired rights.

When we compare the political arena in the three countries, we find in Argentina and Brazil that reform started as part of a crisis of authority, in a context of deep economic change, but as an important feature of the losing of power by some previously dominant actors. The emergence of a new project to reshape the relationships between the state and different groups of society may

come either from organized groups in the society, as in Brazil, or it may come from government authorities, like in Argentina and in Mexico. The ability to implement the project would depend upon the capacity of each side to keep or enlarge its coalition, when many interests started to be affected by the reform measures. Indeed, there is a difference between a project of reform that comes from the society and have to be incorporated by the governments as a public policy and a governmental project that needs to avoid the veto power of some important groups in the society and inside the bureaucracy.

Besides the economic component represented by the reduction in public expenditure and the political component represented by the main actors with the capacity to organize a strategy either to support or to veto the project, there is a further component at the base of the reform process. It is represented by the emergence of a new dynamic in the health-care market favoring the more competitive private providers and insurance companies. The weigh of the private sector represented both by its presence as a health provider as well as its strength in the insurance market is an important variable that could define the scope of the public policies. Specially, in case the public policy depends on the private provision and in case the private insurance could became a strong economic and political actor before the governmental regulation of it activities.

In Mexico's first attempt to reform the health system, many of these components were present, although the scene was quite different from the other countries. At that time, there was no crisis of authority in the political elite nor in the single party that had been ruling the society since the Revolution. The absence of a political and ideological crisis gave an administrative emphasis to Mexico's first reform project.

The lasting economic crisis and the rise of insurgent guerrilla movements, as well as the organization of a legal opposition coalition, have, for the first time, reversed the political situation in Mexico. In this new setting, other attempts to reform the health sector are beginning, this time more rooted in political and economic interests. The success of the reform project in Mexico depends, primarily, on the capacity of the government to enroll the Social Security institution as a

reform supporter since the weight of the institutional power is still conditioning the feasibility of the public policies than the organized society. The other important stakeholder in this arena are the workers. They would fight to retain their privileged situation in terms of services and coverage of Social Security. As soon as they perceive the reform as not a threat to their situation they would support it.

As the society is becoming more organized the role played by the political parties in this arena will also increase, as a veto power, a negotiator and a designer of alternatives for the governmental reform.

The Proposals and the Strategies

In Argentina, reform was inspired by the principles of efficiency and quality, to be achieved through competition in a market regulated by the government.

To be successful, this project needs to create the necessary regulatory capacity in government agencies. This will eliminate the monopoly or the oligopoly either on the demand side or on the supply side. Besides, it is necessary to create a competitive market, by providing services through both public and private organizations. Also, to reduce the responsibility of the national government to subsidize or provide services for those unable to acquire insurance.

The legal instruments that were issued to provide a juridical framework and political guidelines for the reform attempted to reduce the power of the main corporate organizations in the health sector, thus destroying their monopolistic position or oligopoly through developing a competitive setting. The *obras sociales* had to compete for affiliations as well as for contracts with private providers. The banning of collective agreements between the *obras sociales* and the providers' associations, and the deregulation of the *obras sociales*= captive clientele, which allowed the beneficiaries to choose where to affiliate, were the main instruments of the new policy.

Other important measures were taken to transfer public hospitals to provincial jurisdiction through administrative decentralization, and to create a self-management system for the public hospitals. Hospital decentralization occurred at the same time as a movement to develop highly centralized provincial systems, amidst endless negotiations between the provincial level and the national level as to the allocation of resources. Self-management allows the hospital to participate in the competitive market, either to be funded on the basis of production, efficiency, and type of population, or to charge those able to pay for them for the services provided.

These reform measures had to face the powerful opposition of the CGT to deregulating the Obras Sociales, based on the assumption that this is an strategy to open the competition firstly among them and, secondly, to the international health-insurance institutions.

As the reform in the health sector was preceded by the privatization of the Social Insurance system, the capacity of the CGT to block the competition among the Obras Sociales will depend on external factors. Basically, it will depend on the success of the private insurance in getting high profits in their money market transactions.

The other pillar of reform, the liberalization of the contracts, on the contrary, produced a great impact, affecting both the supply of services and the demand for them. The corporations that had traditionally predominated in this sector quickly lost the supply oligopoly, and new competitive forms of contracting were developed.

The dissimilar course of reform generated a paradoxical situation, in which a deregulated supply system saw its competitiveness favored as a result of a fragmented group of demand institutions retaining the control of dissimilar resources.

In Brazil, the proposal for health reform was based on the universality principle, as health was considered an activity of public relevance and a right of the citizen. The state had to assure equal access to all citizens, giving a specific direction to the public system. The public health system was

integrated in a hierarchical and decentralized institutional arrangement, with each level controlled by a council with even participation from government and organized society.

The instruments to implement this aim were both legal and administrative. Concurrently, there was a great concern about the constant effort necessary to rebuilt the reform coalition alongside the process of health reform. The political outlook of the reformers empowered the citizens and local-level public managers.

The successful unification of the public services, with the merger of social-security health care under the direction of the Health Ministry, was preceded by a piecemeal strategy of decentralization, recovery of the public service network, and spread of instruments for planning and budgeting.

As the reform gained a legal framework, the Legislature became part of the arena where conflicting interests were challenged and coalitions rebuilt.

The main obstacle to implementing the reform was represented by the governmental authorities themselves C closely linked to the private providers or influenced by the international agencies C and their strategies to improve efficiency through increased competition.

The restrictive financing basis of the public health system was undoubtedly the main immediate cause of the deterioration of public health-care provision. The creation and organization of the public health system C SUS C occurred in a period of acute economic crisis, that led the government to cut health expenditure deeply during the first years of the reform process.

The systems' gradual decentralization was followed by the spread, to local levels, of the main skills in the management of the system. The differences of opinion between the local and the national managers concerning financial resources still exist. The natural conflict, however, has been channeled through the creation of intermanagerial commissions, which represents a profound

change in the Brazilian centralized federalism.

The empowerment of local managers created a new group of powerful people, which affected not only the health sector but also the entire local power structure, where the traditional elite rooted its power. Community empowerment was also contemplated, with the design of a set of policy-making forums in which to discuss health policy.

The impossibility of shifting away from the curative and highly specialized health-care model led to the paradoxical situation in which the reformers were caught: the SUS became the natural path to expanding the medical curative model in a way that completely favored its former opposition, the private hospital owners. Instead of being threatened by the new system, they kept their power to negotiate fees and prices, ending up as some of the principal winners in this system.

Recently, some incentive measures to develop preventive care have been issued by the Health Ministry, with a subsidy and per-capita payment to the municipalities. This measure has been seen as the possibility to deepen the decentralization since it gives more autonomy to the local authorities to manage the finances. Besides, it is supposed to break the perverse chain of payments according to the services' offer that sustain the curative model and the unequal distribution of the sparse financial resources.

The reformers' concern with the public sector meant that they avoided dealing with the increasing presence of health-insurance institutions in the health-care system. This strategic mistake was responsible for the present situation, where these institutions, although they are increasingly participating in health-care provision, are not controlled by the health authorities. The government has only now approved in Parliament legislation regulating the health-insurance sector.

The government position against the SUS, because of its alleged inefficiency, and in favor of the introduction of a competitive market for health care, has been blocked, so far, by the political strength of the reform coalition. However, the possibility of reforming public administration and

social security would permit a complete change in this process. The scenario, in this case, would be one where public hospitals would acquire autonomy to manage themselves, leaving to SUS the responsibility for a minimum package of preventive and curative measures for the poor population.

In Mexico, the reform process occurred very recently, but differently from the proposal developed in the early 1980s. The main difference is that, currently, a public debate about the reform proposal is underway among different actors and concerning different projects. The government project tries to give an answer to the persistence of segmented, centralized, and uncoordinated actions regarding the transformation of social-security institutions and health services, in order to open up the medical and insurance markets.

The extension of coverage would be implemented through a basic package within the responsibility of the public sector. User segmentation by purchasing power, a public sector focus on a decentralized social-security system, and public provision of a basic package for those in the informal market are the main trends of this proposal.

One important change in the new process was the position of the IMSS. After having blocked the first attempt at reform, the IMSS has now formulated its own proposal. This proposal not only faces the problem of financing and bringing efficiency to its services, but also includes a strategy to incorporate the workers from the informal market. This last point could be not only a solution to the financial crisis of this system, but also could legitimate the IMSS=s position, because the Institute is no longer defending the privileges of a few. The capacity to mobilize employers to debate the proposal was evidence of a new scenario in the Mexican policy-making process.

Other actors, more closely linked to international agencies, are trying to bring their projects to the political arena, as are opposition political parties.

Comparing the three countries, it is possible to note that the reform process has not been straightforward in any case, and has gone backward and forward in accordance with the political and economic context.

Some actors have a privileged role in this process: the Health Ministry bureaucracy, social-security institutions, private providers, and organized societies. Although the relationships among them vary according to the context in each country, there is a common drive represented by the macroeconomic scenario, in which the changing role of the nation state and the liberalization of market competition are the factors reshaping economic and social institutions.

Besides the obvious intentions, what really matters is the way in which these processes are being incorporated into the health-care systems, changing the configurations and the relationships among the most important players in the game.

RESHAPING HEALTH-CARE SYSTEM

When we consider the analytical dimensions of organization, financing, provision, and regulation, the considerable changes in the region in the last two decades and the changes to the health-care setting have been responsible for a profound movement toward reshaping the health-care systems of the three countries being compared. Some outcomes are similar to the reform proposals but, in many other results can be considered as the actions and reactions resulting from tradeoffs by political and economic actors during the reform process.

In Argentina, three different models were identified in the health-care system: the compulsory insurance model, the public integrated model, and the voluntary insurance model. During the last 20 years, it is possible to observe a reduction in the former power of the *obras sociales* and a recent increase in the importance of private insurance.

The reform process in Argentina has mainly affected the compulsory insurance model C through a set of measures to introduce competitiveness among providers and break their oligopoly. Other measures intending to introduce competitiveness on the demand side, however, have so far been vetoed because of the opposition of trade-union organizations.

This sector faced no change with regards to the financial aspect related to compulsory, salary-based contributions as the source of funds. In addition, the collective risk-sharing pool is still composed of sickness funds of various sizes, which means maintaining different conditions for access and different qualities of health-care services. The introduction of freedom-of-choice mechanisms and the compulsory merger of institutions whose resources are insufficient to form an adequate risk pool are expected to change this sector.

So far, the relationship between third-party payers and providers has been the reform's main focus. Contracts between *obras sociales* and providers have ceased to be centralized in the organizations representing the latter, which affects the entire system. The freedom to contract between financiers and providers has affected the services system a great deal, in terms of money flow, payment methods, management, organization, and methods of regulation.

A considerable change was observed with respect to the flow of financial resources, which, although accomplished by means of a third-party payer in both periods being compared, (the 1970s and the 1990s), removed the financial risk from the *obras sociales* and transferred it to the provider networks or intermediary organizations.

This modification also affected the way control was exerted in the two periods. In the 1970s, no mechanisms were developed to curb unnecessary use or overuse of health-care services. The role of the *obras sociales* as third-party payers, paying on a fee-for-service basis, caused the use of the health-care system to be a matter for decision between the patient and the doctor, which ended up as a powerful mechanism to increase health-care demand and costs.

The contracts abandoned the traditional fee-for-service form of payment and adopted per capita payments and some global payments by the DRG (diagnostic-related group).

The transfer of risks to intermediary organizations led to a new situation where an interest in controlling demand and costs is part of the rules of the market, and a product of better management.

It is very likely that the changes mentioned in the contractual relationships between financiers and providers of services will have, as a secondary consequence, a further stratification of the beneficiary population.

Because changes in the system were not followed by redefining and enlarging the public regulation function, the emerging market mechanism for regulation is directed at cost control, and a public mechanism accountable for policies to reduce inequality and control service quality is lacking.

In the organization, as it existed in the 1980s, the main regulatory mode was professional self-regulation. In the present organizational form, professional self-regulation continues to carry weight in the training and accrediting of professionals and in defining standards of practice. However, the association providing technical and bureaucratic supervision of methods and prices, which had been mutually agreed between large providers' associations and the federation grouping the trade unions, was abolished with the reform measures.

This association was replaced by the presence of managers in the intermediary providers' organizations, developing forms of regulation based on management incentives. As the state did not assume a new role in the regulatory function, the private insurance model has so far grown without any regulation.

The public integrated model was changed, especially in its organization and system authority.

Until 1980, the public health services network was centralized at national or provincial levels, while the operation now is at the level of the province, the municipality, or the hospital.
However, the transfer of public health-care service, from national to sub-national levels, was not supported by the subsequent financial and political resources. Decentralizing the provision of public services to subnational levels carried through to the creation of local and provincial health-care systems, although it was not meant to be a process aimed at empowering local levels or increasing community participation.

The self-managed public hospitals, as well, suffered a microeconomic transformation to achieve greater productivity and efficiency. Gaining extra budgetary income by charging for services to patients or insurance institutions is a possible solution to the fiscal crisis in the public services. Nonetheless, without strict public regulation of their public function, those units will inevitably adopt a private profit logic.

The new legislation, strongly backed and supported by the World Bank, intends to introduce the free choice of *obras sociales*, creating a competitive market on the demand side of the health-care system to stimulate efficient management of its resources. The limitation of the services to a minimum basket would be introduced, as well as the possibility of paying a supplementary contribution. This measure would represent the definitive breakdown of the hegemony of *obras sociales* in the health system, and could be followed by the introduction of their competition with private insurance companies.

Our conclusion about the Argentinean case is that it is not possible to recognize a new organizational model, although a very changeable scenario can be found, in which old actors and new ones try to consolidate their presence. The tendency in this scenario, however, is to reshape the system in a highly stratified way, both with regard to the population and its demand for service, and with regard to the appropriation of material and technical resources on the part of the providers.

In the case of Brazil, changes were identified in the number of components and the relationships in the health-care system. As a consequence of the reform proposals, Brazil integrated the social-security health-care system and the public health-care system into one public system.

This public system, although it is the product of the integration, does not exactly fit the public integrated model developed by the Organization for Economic Co-operation and Development (OECD), because it is still operating as a third party, contracting for the services of private providers. The introduction of the same mechanisms of payment in the public-health units means that the whole system fits best in the category of a public contract model, although it retains some features of the public integrated model. For this reason, it is best characterized as a public contract model with some characteristics of the public integrated model. This hybrid situation reflects the unfinished nature of the reform as it was proposed. On one hand, the reformers had to face a lack of public services to create an integrated system, but on the other hand, they were able to propel and consolidate an unprecedented process of reorganization of the public system.

However, this system does not seem to be a stage in forming an integrated public system, as was initially proposed, but instead is the consolidated form of the new public–private mix in the Brazilian system. Besides the institutional changes in the public sector with the introduction of universal coverage, a set of measures was launched to decentralize organization and financing of the new public system — the SUS.

In the same period, the voluntary contracting system increased and diversified its organization and services, assuming an ever-growing role in providing services, although not regulated by public authorities.

Financing of SUS did not change as planned, and it continues to rely on compulsory contributions to social security, which fluctuate and are very unstable because the Health Ministry does not interfere with the decision-making process. However, risk sharing has shifted from a collective insurance model to one of state funding.

The reduction in federal resources was somewhat compensated for by the increasing participation of states and municipalities as financial sources in the composition of the health budget. This change has also been followed by an increased differentiation among the municipalities, according to the weight given to health policy. Recently, a national contribution was created to cope with the financial needs of the health sector. Although it is provisory, it indicates a tendency to create a new mechanism to finance the health sector besides the general contribution for the social security system.

The long, piecemeal, process of decentralization created a series of political, organizational, and legal conditions to be fulfilled by the municipalities in order to receive and manage the health funds. The tension between local and national authorities concerning the transfer of these funds delayed the decentralization process, creating barriers to the transfer of funds and authority to the local level. Even so, this process proceeds, generating considerable interest and actors within the local sphere that could, increasingly, force its improvement.

The flow of money in the 1990s, as in the 1970s, is generated in the public sector (primarily from social security) and from a special contribution upon financial transactions, and transferred to private providers. The difference in these two periods is found in the mechanisms for transfer. Paying for services solely on a fee-for-services' basis was considered uncontrollable and replaced by a type of DRG procedure combined with fee-for-service.

The decentralization did not change the previous situation in which the state was the main provider of funds for health care rendered by private institutions, although it did provoke an increase in local investments in the creation or recovery of the public service network. An effort was made to control costs and rationalize the use of services. However, the payment in a prospective model C in which resources are allocated on the basis of production and not on historical amounts C was, definitively, consolidated as the way to pay for services, rendered either by private or by public health units.

Some recent measures introducing the transfer of funds from the national health budget to the municipalities on a per-capita basis are trying to reverse the natural tendency of the consolidated prospective payment to lead to adoption of curative and specialized medical care.

The flow of resources is based on comparing the management situation in each state and municipality to a standardized scale controlled by the national government, which indicates the stage of autonomy and responsibility each municipality can reach with respect to the use of financial resources.

Although the service network is similar to the one that existed in the 1970s, the main difference concerns the access to health-care services. In the 1970s, access was restricted to the insured population, whereas in the 1990s, it has been opened to all people. However, no difference has been introduced regarding the users' right to choose where and at what level to get into the health-care system.

The relationship between financiers and providers includes the innovations of the Intermanagement Commissions, responsible for determining the amount of resources for states and municipalities and for settling their management situations. The decision-making process has become more transparent, and mechanisms for conflict resolution and negotiation have improved its rationality.

The other important mechanism in the decision-making process is the creation of a health council at each level of government, where providers and users are represented in the same proportion as the bureaucracy. The guidelines for health policy are designed in this atmosphere of negotiation and control.

The relationships between patients and providers in the public contracting system still show many conflicts associated with the lack of access to the services. Other difficulties are linked to long lineups, the absence of medicine, and poor conditions in the public health units.

Even so, the reform in Brazil has opened health-care services to a huge group of people previously excluded from the old social-security system. The highly concentrated service network and the limitations of human and technical resources, however, are still working as a barrier to universal access.

The absence of quality control in the public and contracted services and the lack of motivation among professionals are understood to be responsible for the worsening general image of SUS. Nevertheless, public opinion recognizes those municipalities that provide good management of the public health system.
Voluntary contracting is the other system identified as part of the state entrepreneurial policy to add benefits as indirect salary to their employees. It was born in the 1970s and expanded rapidly in the 1980s and 1990s because of self-exclusion from SUS by both the middle class and the more competitive providers.

Financed on a voluntary basis by employers and employees or entirely by families, the voluntary contracting model operates through prepaid plans with several different types of coverage and fee-for-service payments. The recent association between the financial sector and some health insurance companies or intermediary management agencies demonstrates the increasing dynamics in this market.

This process, however, has not been followed by any kind of health-authority regulation, resulting in the critical situation in which the users face many restrictions on using the services. These restrictions are risk- and age-related, leading some of the insured to the critical situation of coming back to the public system.

A legal structure for the public regulation of the voluntary contracting system was recently issued and is expected to be operating soon, because the middle and upper classes enrolled in this system have a high capacity to vocalize their demands. So far, this system has been controlled solely by the economic authorities, as have the insurance companies. They have usually adopted the table of

prices for medical services issued by the doctors' professional association, as a means of professional regulation.

Regulation of the public integrated system is dependent mainly on the mechanism of funding transfers, not only between different levels of government but also between the public bureaucracy and the contracted private provider.

The introduction of some intermediate management bodies in Brazil, such as the partisan commissions or the Health Councils, opens a door to innovative forms of regulation, although they are not yet fully employed. Undoubtedly, a new form of regulation — neither bureaucratic nor corporate or laissez-faire — should be developed. This new format of regulation could be shared by the government and the organized civil society, in order to defend the public interest. The new joint-management format introduced by the Health Council eases the way toward this aim.

The Mexican case was identified as a health-care system with a fundamental distinction between those who were entitled to social-security health care and those who were not insured.

The population covered by social security was grouped into three different types of institutions:
The IMS, which covered mainly industrial workers;
The Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE, Institute for Security and Social Services for Workers of the State), covering civil servants; and,
Institutions that offered health care for specific employers.
The uninsured population received health care in institutions designed for the population in general, such as those pertaining to the Department of Health (SSA), the System for Integrated Family Development (DIF), and the IMSS–Solidaridad. A tiny segment of the population used prepaid services directly from private suppliers.

According to the terminology adopted, it is possible to identify two models in the 1970s — social-

security health-care services and public services for the population in general. Considering the typology of the OECD, in which the main feature is the integration between the functions of financing and provision, these can both be characterized as integrated public systems. However, the two public systems — one addressed to social-security insured and the other for the general population — were not integrated. On the contrary, they had a segmented approach regarding access by different populations and a fragmented institutional structure. In other words, they were not only not integrated because of their differences in coverage but also because of their different financing and organizational structures.

Even split into these two parts, the public sector was still the most important sector in Mexico, considering the resources available and the scope of coverage. Although they had different financial characteristics, both health sectors had their own institutions: the funds for social security came from compulsory contributions, while the public sector was supported by means of general taxation. The flow of money in both cases was based upon annual budgets for hospitals and fixed salaries for professionals. General practitioners or family doctors worked as gate-keepers to the system, with the power to refer patients to secondary or tertiary levels, but with no incentives in terms of efficiency or quality of services.

The most important changes in the last two decades concern the frustrated attempts to integrate the two parts of the public system and to decentralize the public system covering the general population. It is worthwhile calling attention to the fact that Mexico's is the only case in which the strategy for providing coverage is still focused on the public sector, even having some degree of integration with social security, provided by the IMMS–Solidaridad.

The emerging model in Mexico is represented by the increasing importance of the voluntary contracted model and by the proposal for a public contract model for the social-security system. Although it has been proposed in the Law of the Mexican Institute of Social Security for several decades, the public contract model has shown very limited effect and played practically no role in the general orientation of the National Health System. Nevertheless, the reforms that were

advanced in 1995, both within social security and in the institutions for the population in general, have made feasible a substantial increase in the use of public contracts to access services.

The recent loss of domination by IMSS might ease the transformation of the social-security system into a public contract model. In this proposal, financing would come from compulsory contributions to social security, but organizations could use the mechanism of return-of-contributions to contract directly with private providers of health care. The completion of this proposal would probably lead to a withdrawal from social security by the best-paid workers, generating financial instability in the system.

The combination of this financial mechanism with competition between public and private providers is aimed at achieving better standards of efficiency. As Mexico is a typical example of a corporate financing system with public provision, competition would present a way to introduce private practices, whether or not it was followed by actual privatization within the public health units.

The tendency is toward the further stratification of access to health-care services on the basis of ability to pay. While the highest income groups affiliated with social-security systems will probably transfer funds to the private sector using the return-of-payments mechanism, the lowest income groups will remain in the institutions for the general population. The stratification will thus be as follows: a basic package for the poorest groups; one contributory basic package for the social-security institutions; and an ever-growing number of private options for those who can afford to and are allowed to withdraw from the social-security system.

The different options for meeting needs are tending to become more diversified with the emergence of the public contract model and the encouragement of the voluntary prepaid contract model. Nevertheless, the weakening of the state and the absence of any regulatory body or mechanism provide an unfavorable environment for a balanced exchange between the public and private sectors.

Decentralization in the new proposal was reduced to those services designed to care for the general population, focusing on segments of the population with no access to the health-care system.

Comparing the emergent design of the health care system in the three countries it is possible to identify some commonalties as well as some important differences.

Regarding the differences, the most important feature concerns to the type and degree of decentralization. Although the three countries have the same federate political system, all of them were distinguished by the high level of centralization in terms of the autonomy to make decisions an to control the resources in health care field.

The reform process in Brazil was part of a successful redesign of the relationships among the different spheres of government, moving the political power towards the municipality level. Moreover, the health reform was the most important and sustainable social policy aiming to transfer resources and decision power to the local level. Coming together with the democratization of the decision making process, through the enrollment of the organized civil society, the decentralization in the health field has represented a worthily instrument of empowering, simultaneously, the local government and the local society.

The decentralization in Argentina, on the contrary intent to discharge the national government from the pressures and responsibilities related to the health care system. The main instruments of decentralization were the creation of local and provincial health-care systems as well as the greater autonomy of the hospitals to manage their resources. Although both transformations had impacted the organizational and authority systems, a transfer of financial and political resources did not follow them to the local level.

In Mexico, the first intent to decentralize the health care system failed as a consequence of the

absence of a political drive that could propelled a transformation in the highly centralized political process.

The new proposal for decentralization of the health care system is limited to the public services, responsible for the coverage of the poor with a basic package of health care.

In all three countries the decentralization is restricted to the public sector, identified as the public integrated or the public contracted models. Meanwhile the compulsory and the voluntary models are operating in a market basis, mainly centralized in the big insurance's companies, acting as the third party, and highly fragmented in terms of the provider's network.
The difference is, therefore, due to the role played by the public sector, in the decision-making process in the health-care system.

In terms of organization, there is a common dynamic in the three countries, represented by the important and ever-growing presence of the voluntary model, with the emergence of new and powerful actors as well as the introduction of a more competitive setting for health care provision. At the same time there is a process of weaken the Social Security institutions and their correspondent actors in health care system, either by integrating those institutions to the public health care system or by integrating them as part of the dynamics of voluntary model expansion.

Three theoretical scenarios are design as a consequence of this process: the competitive, the dual and the specialized. The competitive one represents the introduction of market competition as the prevalent modality of organizing the health care system, therefore subordinating and even replacing the remaining debilitated models, either the public integrated or the compulsory.

The dual scenario occurs when both, the voluntary and the public – compulsory or contracted - are forceful enough to keep its own dynamic in parallel with the other. While in the voluntary model the access to health care is dependent on the capacity of payment, the existence of a parallel and vigorous public system is the guarantee of the principles of universal and integral

coverage.

The possibility to maintain this duality depends upon the capacity of the public model to create mechanisms to regulate the voluntary model, in order to avoid the intents to become the only responsible for the burdens represented by the risk groups.

The specialized scenario is one where the institutions are itemized, and the population segmented. In this way that the voluntary and the public models do not exist in parallel neither in competition, but are defined and ranked conforming to the package of health care services they
offer to each parcel of the population. Access and utilization are highly stratified, according to the contributive capacity of each group.

The designs of the reforms process, so far, appears to identify the Argentinean and Mexican processes with the competitive scenario while the Brazilian pushes towards the dual scenario.
One should consider these trends as a general direction since the reform processes are not straight, and some conditions can modify the present scenario, weakening or strengthening each one of its components. In this sense, the competitive scenario seems to be a probably path to the segmented scenario. Also the dual scenario is very unstable since it depends on the possibility of keeping the same pace in the growth and weigh of each component.

The important point is that all these scenarios imply the coexistence of different and not integrated models. Moreover, since there is a stable tendency in the growth of the voluntary model in all three scenarios, this outcome implies a process of restratification of the working population in terms of different social rights and access to social services. Differently from the traditional model of social protection in Latin America, where the benefits were dependent on the political capacity of each fraction of workers to negotiate with the government, the stratification process now is based on the purchase power of each category of workers. As there is a strong positive correlation between the level of salaries and the insertion in the formal market, the probably aftermath of this stratification will be to confine the poor to a minimum consumption.

While the former stratification was grounded on the collective action of the group, the new strata are being defined based on the individual capacity to contribute to his/her own benefit plan. Unless the government establishes cross subsidies among different population groups, the main tendency is to reproduce in the social policies the former segmented economic situation.

Nonetheless, so far, any mechanism was designed to create solidarity among the strata of users in the three countries, as part of the reforms. The renounce of the middle class to the public services and the reservation of this network, basically, to the function of bringing a packet of primary care to the poor, represent a crucial political option.

As became each day more evident in many different experiences of focalized policies, the segmentation of the population implicates the crash of the cultural and political links among the middle class and the poor. The consequence of the rupture of solidarity implies the discrimination of the poor as well as the likelihood of deterioration of the services designated to a parcel of the population without economic resources and political voice.

There is the presumption that through the mechanisms of market competition and financial instruments it would be possible to overcome this tendency and lead the health system to a better condition in terms of efficiency and quality. Considering the complexity of the health market, problems of risk selection, lack of information and absence of coordination are expected to result in cost increasing and not necessarily in best conditions of service utilization.

Another aspect, common to all the countries, is the difficult to create effective mechanisms to regulate the components of the voluntary model. Innovative and suitable instruments are not replacing the traditional mechanisms of regulation, such as the bureaucracy control and the corporate self-regulation. The default of a legal framework and governmental mechanisms of control associated with the absence of accessible justice to the common citizen are bordering the setting were the health market is flourishing in the region.

Comparing the countries' results on the survey of health services utilization with individuals presenting some selected tracers conditions - namely, hypertension, pregnancy, delivery and diarrhea - one can find interesting, although not conclusive, evidences of the determinants of access and utilization.

In all the three countries, although for different tracer's conditions, we found some enabling variables having a direct and significant influence on health-services utilization, specially the availability of health coverage, the existence of a regular source of care, and the out-of -pocket money. In all this situations, the possibility of access and utilization of health services is influenced primarily by enabling variables, not by the perceived need for care. Only in cases of a chronic disease, like hypertension we could found the perceived need having a direct influence in the utilization of the health service.

This result might indicates that chronicle patients, in this case generally elderly people, not only learn to live with their disease, recognizing their symptoms, but also learn how to deal with the health-care system, in order to have their need attended.

Nonetheless, the general tendency is to discriminate the patients according to their entitlement, and to put other limits to access and utilization.

Although it's not possible to attribute this situation to the reform process, certainly is likely to assume that the directions of the health reforms can worsen the problem of access and utilization of health care services in these countries.

The new policy of inequality in Latin America is, therefore, represented by the subordination of the social policies and social protection mechanisms to the market logic, represented by the dynamics of mercantile relationships and orientation for financial profits.

Consequently, the health care systems are suffering an intense transformation regarding their political arena, their organizational and financial modalities, towards a more pluralistic and competitive configuration. Undoubtedly, one can identify the reforms in health sector in Latin America as a kind of modernization of the traditional pattern of social protection rooted in the former populist political relationships. Nonetheless, the direction espoused by the reforms is, by and large, unconcerned on the main problem of the region, the inequality.

The new design of the health care system is part of a process in with the Latin American societies are assuming a new profile. Instead of denying the citizenship to some groups, in this reorganization, the citizenship is being rating. The outcome is the generation of different conditions, with citizenship of high or low intensities in terms of the rights and services each one will be entitle.

If it were true, the reforms would succeed in the modernization of the sector but with the cost of putting the region even further away from the fairness ideals.