

H health benefits guarantees in Latin America: equity and quasi- market restructuring at the beginning of the Millennium

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Abstract

Health quasi-markets aim to introduce competition into the public sphere by separating functions in order to improve efficiency and quality. In different public-private mixes, according to the morphology of health systems, different regulations can govern insurance, financing, and provision of services. The objective is to link financing to productivity, coverage, performance, and accomplishment of goals. Specifying guarantees to provide services for determined beneficiaries implies the formation of a purchase function based on strategic criteria involves three financing decisions: which interventions will be purchased, how they will be purchased, and from which providers.

Some health systems in the region have established a separation of functions and some initial finance mechanisms based on results that allow them to be considered developing quasi-markets. On the other hand, some of them have introduced guarantees for various health services. Although such guarantees in all cases aim to improve equity in the level of health enjoyed by the population, they have very different repercussions in terms of the general organization of the related health systems depending on the level of development and the characteristics of the health coverage that the population already has.

This study considers in the first place the introduction of health benefits guarantees in quite underdeveloped health systems, analyzing with more detail the case of Guatemala and briefly, Bolivia. Afterwards, a thorough analysis of Chile is done, showing how the health guarantees imply a partial overcome of the fundamental duality

of the health system. Finally is considered the recent experience of the popular health insurance in Mexico, whose health insurance system is highly segmented. As we shall see in all the experiences, both the decentralization process and the specific public-private mix play an important role in the organisation of the health guarantees.

Introduction¹

Quasi-markets in health care promote competition among health providers and insurers, but they differ from conventional markets in some respects. In terms of demand, buying power is expressed through a budget that the public purchasing entity establishes and agrees upon, and where prices are negotiated or administered in a budget framework. Consumers are represented by agents, that is, by the purchasing entity, whose character is determined by the quasi-market's organization and the insurance and financing rules associated with it. Supply, on the other hand, is composed of a variety of providers – state, municipal, trusts, consortiums and non-profit organizations – that can be ruled by diverse financing regulations (Bartlett and Le Grand, 1993: 23-4).

Elements of competition can come into play on different levels: expanding private participation in the public-private mix, changing the public provider institutions' statutes to give them greater autonomy in the use of resources in a competitive atmosphere governed by the regulating framework of a contract, or even by making it possible for public providers to resort to private law. Various mechanisms can promote competition among providers, such as freedom of choice in terms of the reference system, professionals, and budgetary competition among hospitals.

¹ Paper presented at the Fifth Congress of the International Health Economics Association: Investing in Health, at the session on Health Reform in Middle Income Countries in Latin America, for a presentation on Health Service Guarantees in Mexico and Quasi-markets in Health Reform in Latin America, Barcelona, July 2005. Translation from Spanish, that has not been subject to revision. I would like to thank Juan Carlos Moreno for his valuable comments and suggestions.

Quasi-markets aim to introduce competition into the public sphere by separating functions in order to improve efficiency and quality. In different public-private mixes, according to the morphology of health systems, different regulations can govern insurance, financing, and provision of services. The objective is to link financing to productivity, coverage, performance, and accomplishment of goals.

Specifying guarantees for the provision of services to determined beneficiaries requires the construction of a purchase function based on strategic criteria that involves three financing decisions: which interventions will be purchased, how they will be purchased, and from which providers (Figueras et al., 2005: 45).

Some health systems in the region have established a separation of functions and some initial finance mechanisms, both of which are based on results that allow them to be considered budding quasi-markets. Some of them have introduced guarantees for various health services. Although such guarantees in all cases aim to improve equity in the level of health enjoyed by the population, they have very different repercussions in terms of the general organization of health systems, depending on the level of development and the characteristics of the health coverage that the population already has. Consider, for example, the cases of Guatemala and Bolivia, where health systems are underdeveloped in terms of equity and coverage; Chile, regarding the duality of their health system; and finally Mexico, whose insurance system is highly segmented. As we shall see, both the decentralization process and the specific public-private mix are important for organizing guarantees of service.

I. The guarantee of basic services in underdeveloped health systems

Taken as a whole, the region is at a virtual equilibrium in epidemiological areas. However, considering individual epidemiological profiles and health inequalities, countries in this region are, to different degrees, dealing with a polarized epidemiological transition, in which transmissible and degenerative diseases overlap and good health has an unequal distribution, to the detriment of the poorest people (Bobadilla et al., 1990). Countries that traditionally have not provided adequate health coverage to their populations, either in horizontal terms (the amount of the population covered) or in vertical terms (services provided), are precisely the countries where the problems associated with this polarization are most strikingly apparent.

In the last decade, some of the countries that are most underdeveloped in terms of health coverage and development of financing guided by principles of solidarity have established a separation of functions such as the framework of quasi-markets, and they have emphasized the establishment of basic packages of health services for the poorest sectors of the population. In each case, this policy has been adjusted according to the health systems' characteristics, financing systems, and relationship with the political systems.

1. Guatemala: Primary care as a focus of reform

The health reform project in Guatemala, designed under the framework of the peace agreements signed in 1996 initially had a broad scope. Radical transformations were proposed which, upon implementation, would have substantially modified the political equilibrium and incentives to public providers, in a framework in which the State, the non-governmental sector, and the mechanisms of the market would have played very important roles. Various political factors impeded the successful implementation of fundamental components such as: separating the provision of services, purchasing, and insurance functions; encouraging decentralization; modifying hospital services; and increasing resources earmarked for health (González Rosetti, 2005).²

In the framework of such political restrictions, the guarantee of providing a primary health care package became a central focus of reform at the beginning of the Millennium.³ In a country where more than half the population lives in poverty, extending coverage by guaranteeing a basic primary care package has consistently been a central focus despite changes in the government. The expansion has had some success, such as reducing maternal mortality in areas including Alta Verapaz.⁴ The population's access to medicine has also improved. However, some say that while medicine has traditionally been free in health centres, this is not the case with some provider entities. In this respect, some NGOs are criticized for charging interest on debts for medicine.

On the contrary, raising the low percentage of people insured in the country, that go hand to hand with low income (see table 1) through a reform of the IGSS (Guatemalan Institute of Social Security) or other mechanisms, has not been a priority objective. However, the IGSS has participated in the coordinated implementation of programs to extend coverage to people working in the informal rural and urban sectors (Slowing, undated). Measures to develop the second and third levels of care are just beginning.

The basic package established in 2000 includes 26 obligatory interventions at the primary level of care, including curative, preventative, early detection, nutritional, and health promotion measures, with an emphasis on transmissible diseases. Half the interventions are directed towards mothers and children, with the rest allotted to emergencies, prevalent diseases, and measures for household hygiene and environmental health (Guatemala, 2001). They are subject to annual reviews but have not been modified in three years, since the Ministry has not undertaken such action nor has it been requested.

Financing for the basic package is low: in 2001 US\$ 8 was allotted annually per beneficiary, which was soon raised to US\$ 12. Reassigning resources from other levels was controversial (Sánchez, undated: 49); the issue is complex given the limited financing that the entire sector has traditionally received. In this context the Medical College has noted the importance of also investing in hospitals and resolving deficiencies in nursing staff and inputs for diagnosis and treatment (Sánchez, 2001:9).

The basic team in charge of providing services is composed of an institutional facilitator, five community facilitators and 100 community health volunteers, traditional midwives, and a travelling doctor or nurse, as well as having a community centre, equipped insofar as is possible with a first

² For a detailed political analysis of the reform stages see González Rosetti (2005).

³ In the case of Guatemala, it was very useful to exchange information with Zoel Leonardo, Miguel Angel Pacajó, and Jean-Marie Tromme. The meeting on health reform organized by the UNDP on 12 May 2001 in Guatemala City, in which the author participated, also allowed fruitful discussions with the following people: Edgar Barilla, Pastor Castell, Joel Cical, Miguel Garcés, Luis Lara, Iván Mendoza, Jacobo Meléndez, Patricia O'Connor, Luis Ovidio Ortiz, Angel Sánchez, Karin Slowing and Carmen de Vásquez.

⁴ Mortality rates for each 100,000 children born alive in this area are still very high. From 2000 to 2004 rates are the following: 254.28, 214.40, 196.73, 239.62, 233.72. This data were provided by Edgar Hidalgo, Technical Director of the National Maternal and Infant Health Survey (ESEMI), and are adjusted according to corrections made to the basal line 2000. (Not sure if basal is specific term or you mean base-line value).

aid supply of 20 basic medicines, and the support of collaborators for vector control. A large population must be covered as each jurisdiction includes an average of 10,000 inhabitants; thus, each health volunteer is assigned 20 families. According to the system, activity planning, training, epidemiological surveillance, and day-to-day provision and recording of basic services are the responsibilities of, variously, the facilitators, volunteers, and midwives. Doctors and nurses should offer medical attention at least once per month in community centres (Ibidem).

Table 1
GUATEMALA: PERCENTAGE OF POPULATION WITHOUT HEALTH INSURANCE (PRIVATE AND PUBLIC), BY PER CAPITA INCOME ACCORDING TO THE POVERTY LINE, 2000

| | |
|-----------------------------|------|
| Of the total population | 89.0 |
| EPL or below | 98.2 |
| Above EPL up to PL | 92.6 |
| Above PL up to 1.25 PL | 86.9 |
| Above 1.25 PL up to 1.50 PL | 85.0 |
| Above 1.50 PL up to 1.75 PL | 84.9 |
| Above 1.75 PL up to 2 PL | 84.0 |
| Above 2 PL up to 3 PL | 76.9 |
| Above 3 PL | 67.6 |

Source: Table 30, ECLAC (2003), constructed with special tabulations of the National Family Income Survey, 1998-1999.

Note: EPL= Extreme poverty line, PL= poverty line.

The extension of coverage has taken place in the framework of a separation of functions that distinguishes health service administrators (ASS), responsible for the management of funds, from health service providers (PSS), with which the Ministry of Health establishes annual agreements. The contracts provide for records of the principal services as well as administrative and accounting records. ASS and PSS technical teams are in charge of the running and evaluation of the insurance extension coverage.. Health volunteers, community and institutional facilitators, traditional midwives and doctors rely on service providers for their training. The general evaluation of the process and its stages, based on criteria established by the Ministry of Health, is the responsibility of sub-national levels of government such as municipalities, departmental councils, and municipal health districts (Guatemala, 2000; Guatemala, undated; Guatemala, 2001).

As of September 2000, 136 agreements with 88 organizations were signed. It is worth highlighting the diversity of the organizations involved, namely: cooperatives, municipalities, the IGSS, churches, Cuban medical assistance, non-governmental organizations (NGOs) and others. This raises questions about the effective technical capacity of such dissimilar entities, especially considering that during the period 1997-1999 they were "implicitly qualified to act", that is, qualified without undergoing a thorough evaluation process. This initial absence of supervision over providers and private administrators was modified in 2002, and standards were established that must be met at different stages of formalization (Guatemala, undated). During this process, some resistance to supervision has emerged on behalf of NGOs.

Norms and financing for the basic package were defined in a uniform way, with certain adjustments and changes in priorities according to the diseases prevalent in different locations, such as dengue and malaria on the coast and respiratory infections in the high plains region (*altiplano*). However, the effective availability of resources and the dissimilar technical capacities to provide

services have created an uneven development and in some cases the program for vector-borne diseases has not received appropriate attention. Moreover, the package does not have an effective, integral implementation with respect to other levels of care, and it has been criticized for not focusing on institutional aspects in terms of expanding and improving personnel and infrastructure in clinics and health centres, and for involving NGOs that lack the required technical capacities (Sánchez, 2001: 5, 7). It is deemed positive that the use of clinical protocols and norms of care has expanded.

Among the project's vulnerabilities, it has been noted that its sustainability is at risk due to various factors such as: poor or indigent community health promoters who do not receive remuneration; little technical support; and a heavy reliance on Cuban volunteers whose future substitution has not been planned (Sánchez, undated). In fact, in the beginning qualified personnel, such as nurses, had greater responsibility, but this has been modified with the increasing importance of "health volunteers".

With respect to progress made in locations such as Escuintla, where the official package is larger and includes mental health, it is important to consider several factors. For example, economic resources in the area, the degree of social security participation, the payment of an economic stipend to health promoters, and the greater presence of qualified personnel, among whom a significant contingent were Cuban.

2. Bolivia: Guarantees regarding maternity and infant care⁵

Bolivia is another country whose health reform centred on offering a basic care package. In 1996 the Ministry of Health created the National Insurance Program for Maternity and Childhood, which was expanded in 1999 to the Basic Health Insurance (SBS). Taking into account the highly pre-transitional epidemiological profile and the restricted resources destined for health, this consisted of a package of 75 services focused on the principal causes of maternal and infant mortality and on transmissible diseases.

From 1994 onwards, as a result of the laws regarding popular participation and administrative decentralization, the responsibilities of the different levels of government (in circumstances where the public system was responsible for 85% of health services) were fragmented. In this context, the property of health establishments, infrastructure maintenance, and SBS investment and financing were decentralized to the municipal level; the administration of human resources was delegated to the Department of Health Services (SEDES); and the new health districts (which were dependent upon the SEDES) became the responsibility of local health policies.

Several problems have arisen due to this distribution of responsibilities. Some examples are: the duplication of functions due to their imprecise distribution; health personnel that are not named in accordance with technical criteria or needs, and whose level of remuneration is the same for different levels of responsibility; absence of incentives to stimulate service production and demand; very little financial autonomy (resources generated by establishments were deposited in the municipal account and only partially reinvested in those establishments); municipal investment in infrastructure and equipment that often does not emphasize health care needs and is carried out without coordinating with the departmental level to monitor the availability of human resources; and the lack of an integrated service network, since health districts are responsible only for primary care and do not have authority to develop reference and counter-reference networks in coordination with hospitals.

⁵ Synthesis based on Lavadenz et al. (2001).

The cost calculations of the SBS do not differentiate prices according to different levels of complexity. The SBS is financed by municipalities with specifically assigned resources from tax contributions that they receive from the nation's general treasury. The service network may include multiple providers such as NGOs, churches, social security, and private providers.

The reform aims at reorganizing providers to improve service quality, efficiency and administration. In order to do so, some trial programs have taken place establishing goals and results to be obtained in the framework of management commitments with public and private providers. These have had initial positive impacts in terms of expanding coverage, improving healthcare and better integrating the levels of health care.

Attaining the goals of SBS requires systems of supervision for the appropriate behaviour of officials. A study that included 30 municipal hospitals found that, although the SBS should offer the services in question free of charge, 40% of the 301 patients interviewed said they had paid for them, which is illegal (Gray-Molita et al., 2001: 44).

II. Chile: The guarantee of advanced benefits as a new articulation of the dual health system

The guarantee of benefits commenced in Chile in 2005, after a complex process of political negotiations. In light of the characteristics of the Chilean health system, we will analyze the more prominent elements of the original project outline for reforming the guarantee of benefits which started in 2002, and the approved law in 2004, which, even though it has a smaller scope than the initial project, modifies the basic morphology of the health system, by reducing its distinguished duality.

As will be shown here, the challenges of the health system reform are concerned with different topics related to coverage, financing and efficiency of the system: desirable and possible solidarity levels; financing of the system according to solidarity principles, concerning the relationship between contributions and national general taxes; the determination of guaranteed benefits within a contradictory public-private mix: how to increase the efficacy of the entire system: how to strengthen the management reform of the public sub-system; how to strengthen regulation.

In contrast with countries whose health sectors are lagging behind and that aim to take a step forward in guaranteeing the poorer basic health attention, the benefits guarantee that is the basis of the

projects sent to the Chilean Congress since 2002,⁶ is a tool that modifies partially the morphology of the dual health system⁷ and that does not comprise basic benefits, but basically high cost and complex benefits. The law approved in 2005, was the result of political restrictions that hindered a deeper reform linked to those guarantees, but nonetheless means a step forward for the solidarity of the health system.

1. The origins of the dual health system

The duality of the Chilean health system was crowned by the health reform during the 80's, whose radicalism – made possible within the authoritarian context – has had no comparison in the world. In contrast, the British conservatives who radically fought the financing methods, the range of services and the public-private mix of the British National Health Service (NHS) could not put their plan into action due to various political circumstances (Porter, 1999: 236-59). While the growth rate of spending was reduced, the NHS did not undergo a thorough reform under the administrations of Thatcher or Major, but rather it experienced a deeper separation of functions to encourage competition.⁸

Compulsory insurance is characteristic of the social insurances, public or national, that seek a stable risk diversification in the context of varied public-private mixes. So, the dual logic of the Chilean health system is *sui generis* at the international level, since obligatory contributions on the exclusive part of the worker allow him or her to be affiliated either with the public health system through the National Health Fund (FONASA), whose distribution rationale favours solidarity, or with private health insurance institutions (Instituciones de salud provisional, ISAPRES) that, in spite of the obligatory nature of the insurance, operate under the logic of private insurance, which is associated with individual risk. For example, women of childbearing age have had to pay higher rates for health plans or sign up for a “plan without uterus,” which excludes services for pregnancy and birth.

FONASA gives access to public services through the “institutional modality” or to private services through the “free choice modality” that is subject to different co-payments, and beyond member contributions there are other inputs from the public budget. Contrary to the logic of the solidarity characteristic of compulsory insurance, obligatory contributions, channelled to the ISAPRES, are reflected by insurance through individual plans which allow an adverse selection when each plan is renewed annually, by adjusting the price and coverage to the age, health risk and gender of the person insured. ISAPRES cover close to 30% of the population, and their price increases have been above increases in other economic sectors.⁹ On the other hand, the public sector, with no entrance barriers, covers the lower-income and higher-risk population and fulfils the function of providing comprehensive reinsurance for the system.

Before the benefits guarantee project, called AUGE, was proposed in 2002, some changes that compensated slightly for the selection risk of private health plans had already been proposed. These risks are associated with the demonstration effect caused by the increase in coverage of high-cost illnesses by the public system, the discontent of its members with co-payments and exclusions, and the phenomenon of dis-affiliation¹⁰ and migration towards the public sector that has taken place

⁶ Complete law proposals can be downloaded at http://www.tercera.cl/documentos/reforma_salud.

⁷ See <http://www.minsal.cl/sitionuevo/AUGE>.

⁸ There was already a contraction of ambulatory care among general practitioners (GPs). Later a measure giving hospitals autonomy to function under the control of the public health system was introduced, which led to the grouping of providers into “trusts.”

⁹ Some figures illustrate this affirmation: while in 1990 the additional average contribution for ISAPRES contributors was 0.7% of the average remuneration of the system, in 1996 that figure had risen to 1.3%. Between 1990 and 1996, the value of private medical practices rose by 55% in real terms (Baeza et al., 1998: 18-19).

¹⁰ The maximum number of ISAPRES beneficiaries was 3.9 million in December 1997. From then until December 2000, the number of beneficiaries diminished by approximately 790,000, that is, by 20.4% of the total. See <http://www.minsal.cl/sitionuevo/AUGE/reformaley2.htm>.

in recent years. Because of this, the ISAPRES spontaneously began to adjust their insurance plans but, by being optional, did not modify the base coverage where the adverse selection is made. This was the case of the plan to guarantee health (PGS) and of the additional coverage for catastrophic illnesses (CAEC).¹¹

2. The original AUGE benefits plan of 2002

a) Expansion of coverage

The inherent political difficulties when public health insurers explicitly exclude health benefits are well known. On such an issue relies the relative success of a participative program that employs strict clinical criteria to ration benefits and expand coverage such as the health plan in Oregon (Ham, 1998). Chile is also unique in this area, since the FONASA has a specific catalogue of services, the polemic introduction of which was facilitated by the authoritarian context of the military government. However, it is necessary to highlight that the catalogue of services has been substantially enlarged over the past decade, including high-cost benefits.

In 2002, some lawmaking projects, with the AUGE plan as their central axis, proposed for the first time some modifications in the dual logic of the health system. Its main component was the AUGE plan that consisted of universal access, with explicit benefits, for the treatment of 56 illnesses considered priority from the health standpoint and due to their incidence, high monetary costs, and high health costs (Lagos, 2002).

Because of the health system's duality, AUGE had different implications for the public system and for the ISAPRES. In the public system, a review of the list showed that none of the proposed services were new, since all were already included in the FONASA catalogue (see Appendix). Many of them had been offered since 1994 in the framework of new resource allocation mechanisms by FONASA, used in special, specific service programs such as the Program for seniors and the Program for prompt attention (POA), which channelled resources to public providers and, in a subsidiary fashion, to private providers.

For example, in the POA (created in 1997), the resources that the FONASA granted to each Health Service were based on additional actions committed to reduce waiting lists¹² by resolving certain pathologies in determined time frames. These additional actions are valued according to a payment associated with diagnosis (PAD), which groups standardized costs for surgical packages. It is relevant to highlight that these obligations have been established according to the institution's capacity to resolve the issues in question, and not in relation to the population's total unmet demand. The institutions' capacity limits have impeded the inclusion of more pathologies in the programs or increased coverage of more specific local pathologies (Jaramillo and Bidot, 1999).

¹¹ In the case of the catastrophic coverage provided by the PGS, according to member income, a minimum co-payment of 600,000 Chilean pesos was established up to a maximum of 2 million pesos, after having completed disbursements for equal co-payments corresponding to a biennial deductible of 30 times the monthly fee. Services of the curative medicine program of the PGS were provided through a defined network of providers and benefits were grouped into eight groups and 19 co-payments. It was regulated that all ISAPRES charge the same amount for services and that each determine its own care network. Some ISAPRES offer this coverage in all their plans, allowing clients the opportunity to expressly decline it; other ISAPRES have withdrawn this coverage from their plans and offer it to those who expressly request it; and still others evaluate case by case to determine whether to offer the CAEC (ISAPRES Supervision, undated). The biennial co-payment increased to a minimum of 60 UF (unidades de fomento) and a maximum of 126 UF, depending on the client's income and the minimum co-payment was reduced to 30 UF. It is useful to note that UF are units whose monetary value adjusts daily according to inflation rates: prices set in UF are protected against inflationary effects (see <http://www.isapres.cl/mostrar-actenero00.htm>, <http://actualidad.elarea.com/documentos/imprimir.asp?dc=1099463>).

¹² Previously, in 1992 the initially successful plan to reduce waiting lists had been implemented and delivered additional resources to health services to augment their resolution capacity. In 1994 a new pilot program was created to reduce waiting lists in the Santiago Metropolitan Region and in the Viña del Mar-Quillota Region, which linked financing of these social insurance programs to carrying out additional activities to deal with waiting lists for some pathologies (Jaramillo and Bidot, 1999). During the Lagos administration there has been an effort to reduce waiting lines in municipal health clinics.

Even though all the illnesses considered for the AUGE guaranteed services were part of the FONASA catalogue, the proposal of the AUGE introduced a radical change by universally guaranteeing a set of services, some of which are expensive and highly complex. Coverage was universal because it did not discriminate by age, sex, economic condition, or the health system that client was affiliated with; it was obligatory for all FONASA and ISAPRES members. In addition, the proposal included three financial protection guarantees: a fixed per capita value of services; maximum co-payments set between 0% and 20% for clients in both systems, with limits according to family income; and a package free of charge for indigent people.

The proposal also considered access and opportunity guarantees. In the case of public insurance, waiting times for receiving treatment were defined, which implied resolving the insured population's total demand with respect to 56 illnesses: it was, therefore, a horizontal expansion of coverage – that is, of services – for its members. While these services were already part of the FONASA catalogue, AUGE guaranteed that they would be realized effectively, since they had earlier been subject to the system's financial restrictions and limited capacity to resolve issues, constraints that were shown by the waiting lists, which are in fact an implicit form of resource rationing. For that reason, attending to the population's needs within determined time frames and meeting certain quality standards would require an increase in resources.

In the public sector, some guarantees considered by plan AUGE regarding promptness were at that stage, being fulfilled in but a few cases (family health plan, acute respiratory illness plan) for age groups such as children and seniors. Under the project, these were expanded to include other age groups. However, for the majority of the 56 pathologies, the proposed guarantees of timeliness had not previously existed.

The project established access and quality guarantees for benefits that would become universal and that at that time were being provided only by programs that had several restrictions. Some of them were offered as stand-alone guarantees, for example, integral dental care; others had insufficient coverage, as was the case for the use of anaesthesia in institutional births, which provided only 70% coverage. Some were offered only through special programs such as the POA, as was the case for breast cancer surgery: Others had low or very low coverage, such as treatments for strokes and heart attacks, breast and stomach cancer, palliative care for terminal cancer, HIV/AIDS, pneumonia among seniors, depression, and arterial hypertension.¹³

On the other hand, from their inception the ISAPRES have practiced adverse selection almost without restriction due to the absence of regulations, using annual renewal of individual health plans as a mechanism to adjust price and coverage according to the age, health risks and gender of the insured party.¹⁴ Given this, the AUGE plan's guarantees of determined services would result in a horizontal and vertical expansion of the coverage included in ISAPRES plans. The expansion is horizontal in terms of services, because it stipulates a basic group of universal benefits for all insured people, and vertical in terms of the number of people insured, since the major beneficiaries are those who, due to their risk level or income, have been excluded in three ways: limited coverage, high prices, or high co-payments.

In this way, the original version of the AUGE plan attempted to narrow the adverse selection made by the ISAPRES. In addition, by including high-cost illnesses, AUGE's guarantees actually partly invalidated the pricing of pre-existing illnesses in the ISAPRES compulsive insurance plans. However, one crucial aspect that is difficult to regulate because of the individual and private nature of this insurance must be taken into account, namely: to what extent such new, guaranteed services

¹³ These observations were made by analyzing a chart that establishes one base-year for the AUGE Plan and compares it to the current public sector situation. This chart was provided by the Executive Commission on Health Reform.

¹⁴ The law makes it possible for ISAPRES to annually review the price of each health plan and to "propose" new price and/or benefit conditions to members. Changes can also take place because the insured party changes age group, a variation contained in the "Table of Plan Factors," in which case the ISAPRE is not required to give prior notice of changes in the contract.

may lead the ISAPRES to diminish other types of benefits in their plans to compensate for the new costs incurred.

b) Solidarity in the health system

Solidarity in health can basically be expressed in two ways. First, through the public budget, when financing assures solidarity among income and risk groups, or establishes specific subsidies for determined groups such as indigent people. These funds come from direct and indirect taxes at the national and sub-national levels.

Second, solidarity can be expressed through obligatory contributions to forms of universal insurance, since they establish cross-subsidies between different income strata and risk groups: from high-income to low-income groups; from low-risk to high-risk groups; from young people to older people; and from the general community to specific groups. Considering individuals and families, these cross-subsidies are dynamic throughout the life cycle: in the case of health, for example, the degree of insurance in stages of low health risk or low morbidity is, for the system and for people, a saving for the stages in which there is a more intensive use of services.

As has already been reiterated, in spite of the fact that the health system is funded by obligatory contributions, the public system is based on solidarity whilst ISAPRES operates according to the logic of an individual, private insurance and practices adverse selection.

Therefore, this differs substantially from the Colombian model, which seeks to achieve both universal provision of services and competition among insurers and providers in a decentralized system with social solidarity, whose benefits and obligations are grouped into two regimens: the contributive, which is funded by worker and employer contributions, and the subsidized, which is focused on the poorest people. These are respectively regulated by the Obligatory Health Plan (POS) and the Subsidized Plan (POSS), with the idea that they will gradually converge. Insurance for the two regimens is the responsibility of, respectively, the authorities that promote health (EPS) and those who administer the subsidized plan (ARS); Health Provider Institutions (IPS) provide services. All of these entities can be either private or public. For its part, the Fund for Solidarity and Guarantees (FOSyGA) monitors the equilibrium of resources and conditions of equality in the contributive plan, through a per capita payment that is adjusted to avoid adverse selection in the provision of services. This fund has four sub-accounts divided according to their functions (compensation, solidarity, promotion, and catastrophic events and traffic accidents) and it transfers 1% of the contributions from the contributive regimen to the subsidized regimen, an amount that is added to the fiscal solidarity that funds the subsidized regimen through taxes.

The introduction of guaranteed services through the AUGE plan had implications for the degree of solidarity in the health system. In the public sector, there is currently a substantial gap between the population's needs and the current services. This requires improving the efficiency and effectiveness of the system's current resources as well as necessitating more financing. Since these guarantees are universal, which is in accordance with the FONASA insurance strategy, the financing of the AUGE plan in the public sphere was also oriented by solidarity. An ensuing discussion about public sector efficiency and pertinent financing for the plan has captured much attention since the project was presented.

As has been reiterated, obligatory insurance is characteristic of public or national social insurance and, based on principles of solidarity, and as such seeks a stable risk differentiation. But when it operates in markets with competitive health plans, adverse selection problems arise and must be faced, since they interfere with the central objective of guaranteeing good health (Van de Ven and Ellis, 2000; Cutler and Zweckhauser, 2000). The modifications that the AUGE required in the health system's morphology, in terms of modifying the solidarity and financing to the scale of the system, were modest, since the plan did not attempt to overcome the duality at the contribution level, nor the logic of duality for insurance. In fact, after the plan, obligatory contributions

continued to be completely transferred to the ISAPRES or to FONASA, so as to keep operating with different strategies in terms of solidarity and adverse selection.

In this respect, no link between the two components of the system, so as to modify the insurance strategy, was proposed, as it is certainly provided by the FOSyGA in Colombia. Given the above, the efforts were not meant to create a health system organized according to principles of solidarity for all contributions that insurers channel to FONASA or to the ISAPRES, in which case there would have been a fund to gather all obligatory contributions paid to public and private providers to achieve an equilibrium among all resources and to avoid adverse selection through transfers to insurers, adjusted to the risks faced by beneficiaries and the current services covered.

Therefore, the proposed solidary compensation fund had to gather the specific resources to exclusively finance the AUGE, both from FONASA and from the ISAPRES, calculated according to a universal premium. The Fund had to compensate each insurer in terms of a risk adjustment for each of their respective beneficiaries. For this reason, the fund's name should not be misleading. Its scope was strictly delimited to AUGE services and for that reason the duality of the system was not questioned with regard to the different strategies of the FONASA, the ISAPRES and the obligatory contributions that these two receive, with the exception of the benefits guaranteed by the AUGE.

However, although the purpose was not to attempt a radical change of the basic dual morphology of the health system, the modifications with respect to solidarity in financing that the AUGE has proposed should not be underestimated. These modifications have taken place mainly in two areas. On the one hand, solidarity increased with the rise in public sector financing to offer these services universally to its members and to the indigent. The resources would come from general or specific national taxes, according to how the debate over how proposed financing is resolved. That is to say, solidarity was to increase if the public budget to fund the AUGE became larger, but without affecting the insertion of the obligatory contributions into a dual system.

On the other hand, the other modification in the degree of solidarity has to do with obligatory contributions received by the ISAPRES. The AUGE implied that a range of solidarity was to be imposed upon the ISAPRES' strategy, although exclusively for one package of benefits. To limit the adverse selection within the ISAPRES system, resources would be redistributed through the solidarity compensation fund, that is, a risk compensation mechanism that operates like a collective insurance.¹⁵

In spite of being controversial, the impact of the AUGE's guaranteed services on the ISAPRES paradoxically did not receive a great amount of attention from the press. Up to September 2002, the public discussion over financing the AUGE centred on how to finance the plan for beneficiaries in the public sector, for which purpose the project finally proposed a series of specific indirect taxes. For the ISAPRES, the main point of contention about financing has been to leave member contributions untouched and to ensure that the public sector obtains independent financing for the AUGE.

The AUGE also considered modifying services for maternity leave or leave for the serious illness of a child under one year of age. Until that point services had been universal for every working woman covered by the public or private health insurance funded by the national budget although those women who worked without a contract or for commission or those who were out of work during their pregnancy were excluded: women with high incomes were entitled to a leave with a remuneration that could not exceed 60 UF.

As an alternative to these benefits, a "maternal solidarity fund" was considered to pay the FONASA and the ISAPRES for such expenses, financed with 0.6% of members' taxable

¹⁵ See <http://www.minsal.cl/sitionuevo/AUGE/reformaley2.htm>. According to Mario Marcel, Budget Director of the Ministry of Finance in Chile, at a seminar on Social Policy organized by ECLAC and the Ministry of Planning at ECLAC in Santiago, Chile, on 24 May 2002 estimated simulations indicate that financing was viable and would permit maintenance of surpluses.

remuneration, with tax contributions from the budget and with the so-called compensatory subsidy for contributions to this fund. But only members with taxable remuneration, income or pension under 24.5 UF would have an entitlement to the leave, financed through this fund. The financing of the “maternal solidarity fund” was also outlined as progressive, since contributions varied according to the contributors’ remuneration.

This proposal was criticized, and there were accusations that modifying maternity services or those for the serious illness of a child under one year of age would entail negative effects for women in their health plans and greater barriers to their integration into the workforce. This argument, however, weakened upon consideration of the fact that both men and women contribute to the fund. This plan was so controversial that it initially distracted from the discussion of the main point about defining the health objectives to be pursued.

Table 2
CHILE: CONTRACTED OCCUPIED WOMEN WHO GAVE BIRTH IN THE 12 MONTHS
PRIOR TO THE STUDY AND WHO EARN LESS THAN 24.5 UF PER MONTH,
ACCORDING TO HEALTH SYSTEM AFFILIATION AND INCOME
QUINTILE AT THE NATIONAL LEVEL, 2000
(Percentages)

| Entity of affiliation | Total | Per capita household income quintile | | | | |
|----------------------------------|-------|--------------------------------------|-------------|--------------|-------------|------------|
| | | Quintile I | Quintile II | Quintile III | Quintile IV | Quintile V |
| Total | 84.8 | 100.0 | 100.0 | 98.6 | 88.9 | 52.2 |
| Public system Group A (indigent) | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 0.0 |
| Public system Group B | 98.8 | 100.0 | 100.0 | 100.0 | 92.2 | 100.0 |
| Public system Group C | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Public system Group D | 97.2 | 100.0 | 100.0 | 100.0 | 100.0 | 87.5 |
| Public system (group unknown) | 100.0 | 0.0 | 100.0 | 0.0 | 0.0 | 0.0 |
| Armed Forces | 100.0 | 0.0 | 100.0 | 0.0 | 100.0 | 0.0 |
| ISAPRE | 67.6 | 100.0 | 100.0 | 96.4 | 83.0 | 36.8 |
| Other System | 100.0 | 0.0 | 0.0 | 0.0 | 100.0 | 0.0 |
| Does not know | 100.0 | 0.0 | 0.0 | 100.0 | 0.0 | 0.0 |

Source: special ECLAC cross-tabulations of the 2000 CASEN survey.

Note: income is calculated according to the value of the UF (*Unidad de Fomento*) as of 30 November 2000 (\$15,708.20 Chilean pesos).

In order to consider the potential distribution effect of the maternal selective subsidy, we carried out a proxy calculation using the National Socioeconomic Characterization (CASEN) Survey of November 2000. As can be indirectly observed (see Table 2), there is scope for the subsidy to be provided in a targeted basis to lower income levels. Table 2 shows, in the sections shown in ‘unidades de fomento’ (UF), a clear concentration of women that receive medical attention for situations related to giving birth with higher income for those with private insurance, and women with lower incomes having public insurance in different modalities. This brings to light a major issue of the criteria related to the convenience of transforming, or not, a universal benefit into a selective one.

c) Additional restrictions on adverse selection

The reform project of 2002 also considered an important restriction on adverse selection, which inhibits equity in the ISAPRES system: namely, price regulation for the plans of the so-called "captive contributors". Since plans are adjusted annually according to age, gender and health conditions, and ISAPRES set prices for new members according to the information they require concerning preexisting illnesses, there exist members that the reform project called "captive contributors". Because of their age or deteriorating health, such members have only limited possibilities to reject the contract conditions that are annually offered by their ISAPRE, and they have no real option to move to another ISAPRE, where they would have to declare preexisting conditions.

Therefore it was proposed that there be regulation of contract prices for contributors or beneficiaries by age or by health history, limiting increases to a maximum index that would be decided by the ISAPRES Supervision. Also, in another area of adverse selection, there was a proposal that health protection for beneficiaries who become contributors should be maintained without restrictions, regardless of their health history.

Another important aspect of the project that aimed to make the ISAPRES system more transparent was the establishment of homogenous tariffs. This reform was to be the first step in the path towards a single-tariff system. Currently, the multiplicity of tariffs has been a mechanism of adverse selection which is not only difficult for clients to understand but also hinders regulation of ISAPRES and also raises the system's administrative costs.

d) Are there new areas for management reform?

The Chilean health reforms carried out since the nineties have left performance – which is the heart of management – at the mercy of providers, since this area has not even been completely integrated into the management contracts. In this sense, the following have been marginal: the organizational objectives, or the definition of intermediary products upon purchase; the introduction or improvement of information systems; the optimization of processes that have not been functioning adequately; and the development of new procedures to increase efficiency and to better systematize the provision of services. Improvements in recordkeeping as an instrument to strengthen management capacity have also been irrelevant. The management contracts appear to have been confused with planning for objectives, whose indicators related to completing specified tasks in terms of goals and coverage are many and are not organized hierarchically. The changes in processes and in the use of information systems have no clear basis, and the changes appear to indicate that stages have not been planned to consolidate their implementation (Sojo, 1998 and 2001).

Management contracts, for instance, could play a role in spheres that have been fundamental obstacles to reform in order to achieve substantial changes. For example, in tariff and cost policies, hospitals' information bases are deficient and in the complex pathologies program there is no national network of explicit derivation. If process innovation was included, it would be possible to gather relevant information regarding cost and quality of care or to implement criteria of efficiency and effectiveness in clinical decisions. The weak integration of management aspects in contracts limits their impact, because it restricts beneficial and efficient interactions with the sector's reform process. For example, the payment associated with diagnosis (PAD) has not replaced the historical budget assignment but rather has been used in a parallel, experimental manner in specific programs such as the Complex services program and the Prompt attention program. Consolidating the management sphere, either through contracts with health services or through other means, would permit the PADs to be implemented with the support of processes such as agreeing on the use of clinical protocols (Ibidem).

However, there is work still to be done in terms of modifying current hiring and payment methods to increase human resource productivity and overcome various rigidities in human resource management that impede management innovation. Professional associations have blocked modifications to the Law N° 15,076, which governs hiring and payment methods for health care professionals, including the modifications proposed in the 1995 project to significantly decentralize staffing decisions and make staff structures more flexible; to recognize performance, merit, and efficiency in addition to length of service; to promote the assignment of individual responsibilities; to link individual and institutional performance recognition; and to require participation in competitive tests to remain in the system (Sojo, 1996).

In this context, it must be highlighted that guarantees considered by AUGE of 2002 placed management reform on the table, given that the issue was not only one of gathering resources, but also of optimizing the use of the current resources of the health system, and of facing structural problems that have been postponed, such as the growing hospital debt.

In terms of management, the reform project dealt with various aspects. One issue that clearly concerns the quasi-market nature of the system is deepening the separation of functions. Under the proposal, the functions of the health and regulatory authority in this sphere are the responsibility of the Ministry of Health, as well as strengthening its regional authorities; health services are organized to strictly carry out the role of providers. The first and second levels of care must improve their capacity to resolve issues and to optimize their reference and counter-reference networks.

Although in the project health service directors remained government officials trusted by the President, it was proposed that their selection be through public competition according to experience requirements and their accredited capacities. The directors would coordinate health actions in their care network and in particular, would assure that primary care was strengthened, which would be a new element since primary care was until then delegated to the municipal level.

Moreover, a very important power was divested upon the health service director: the transfer of government employees to any public establishment in the care networks, with no limitations on the period of such transfers. The creation, modification, merging or new classification of service establishments could also be proposed by the directors to the Ministry. The President of the Republic was invested with powers to order the transfer of personnel from one establishment to another through one-year term decrees. Such personnel would retain the same legal rights and obligations, job level, and remuneration.

The mobility of personnel would have allowed fundamental changes given that the potential rise in the health sector's productivity with the increased resources of recent years has been restricted due to various reasons, one of the most important being the irrational expansion of personnel and its inadequate structure. The dissociation between increasing medical hours and performance as a global phenomenon has brought important problems to the fore, including: excessive hiring in areas where there was not adequate care for the combination of inputs required; inflexibility in the management and hiring of human resources, which means that changes had to constantly involve more hiring; resources not being adjusted to changes in epidemiological profiles and new intervention techniques; few specialists in intensive care units and redundant personnel in other specialties; and the need to rejuvenate the personnel base by imposing a retirement age of 65 (Sojo, 1996: 139).

In light of these issues, it must be highlighted that the agreement reached with health sector unions in May of 2002, after strikes and demonstrations a few days before the presidential announcement of the AUGE plan, asserts in one of its items that “the reform will not entail attacks

against employment stability, which is necessary for all workers, but this does not indicate that employment will be immobile."¹⁶

The “self-managed network hospital” was also created, which was able to be implemented once various conditions regarding management modifications were satisfied, including: improvements in clinical management and management of personnel, customer service, and financial resources according to indicators and standards; achieving a financial equilibrium; and achieving set satisfaction levels among clients. Among other aspects, this status enabled hospitals to: administer and spend their own incomes from donations, billing and sales to private entities, etc.; sign accords with FONASA to carry out valued service programs; establish accords with individuals or legal entities for services, especially in relation to the AUGE; their directors would have new responsibilities in management and intern administration of the resources. One must consider on the other hand that due to the fact that these hospitals must reach a financial equilibrium, one preset condition for this aspect of the reform would have been a structural solution for the enormous hospital debt, which to an important degree is due to unpaid services that represented cross-subsidies for the ISAPRES.

3. The general regimen of health guarantees in 2004: a viable version of the AUGE¹⁷

Finally, after many debates arising from the AUGE proposals in relation to both the ISAPRES and the public sector professional associations, in 2004 a law was passed establishing a general regimen of health guarantees (Garantías explícitas en salud, GES). The latter is a restricted version of the AUGE plan that left out substantial and controversial aspects that have been described in earlier sections of this paper. As a result, the package of services has been reduced, the solidarity compensation fund was not introduced, and public sector management reforms are not implemented.

But the Explicit Health Guarantees (GES), in spite of their limited coverage, are a step forward in overcoming the duality of the Chilean health system since they ensure effective, uniform and obligatory access to some services in both public and private health insurance systems.

For those insured by the public system, effective coverage for some services is expanded and guaranteed. Thus, insured people are more certain of receiving the benefits, which must also meet quality standards and be delivered in a timely manner. But the ISAPRES are able to set prices according to the chosen providers, which will evidently stratify services according to payment capacity taking into account differences in quality and lodging.

At issue is a single health plan, with the same coverage, with a schedule of co-payments and obligations. The GES deals with access, quality, financial protection and timeliness: access, since the FONASA and the ISAPRES have an obligation to grant them; quality, since services must be delivered by registered or accredited providers; timeliness, since a maximum time limit is set to receive services; and financial protection, since co-payments and free services are regulated. The state’s responsibilities in terms of healthcare is set, responding to administrative organisms for “lack of service.”

Both FONASA and the ISAPRES must offer a stipulated coverage to their members, a process which will be overseen by the Health Supervision. Moreover, no ISAPRES plan in the future will be able to offer coverage inferior to the services included in what is denominated the ‘modality of free choice’ of the FONASA. The ISAPRES cannot deny coverage due to pre-existing

¹⁶ In “La reforma solidaria de salud: acuerdo por una mejor salud y atención de salud para todos los habitantes de Chile”. Author’s emphasis.

¹⁷ See related documents at http://www.bcn.cl/pags/home_page/muestra_documentos.php?id=30.

conditions, although they may determine the provider network and the conditions under which services will be provided. This is fundamental to partially overcoming the adverse selection that ISAPRES traditionally use when subscribing clients to annual plans.

The indigent and those lacking resources who are FONASA beneficiaries (groups A and B) will receive services free of charge. All other insured parties, either through ISAPRES or through FONASA, will only contribute up to 20% of the total cost of services, according to the tariff established by the Explicit Guarantees. A wide range of co-payments has been fixed by law. These are scaled by income and they consider the severity of the expense incurred according to the type and range of illnesses, taking the family unit into account.

To be eligible for the Explicit Guarantees, the beneficiaries of Law N° 18,469 must access the care network at the primary level, except in urgent or emergency cases; but beneficiaries will be able to access the corresponding level of care when they are diagnosed by a provider outside the public network that has an accord with FONASA. Beneficiaries of Law N° 18,933 must be seen in the provider network agreed upon by their ISAPRES.

Of the 56 illnesses that were initially considered for coverage by the AUGE program, the GES established currently that both FONASA and the ISAPRES must assure their beneficiaries of coverage for 25 health conditions; these include 17 that are experimental programs in the public system, plus eight additional programs. As we have noted, some included illnesses have had very low coverage in the public system, such as heart attacks, breast cancer, stomach cancer, palliative care for terminal cancer, HIV/AIDS, pneumonia among seniors and arterial hypertension. According to law, after a participative process involving diverse sectors to decide what the range should be, the illnesses will be specified by a decree. They will be revised and modified every three years, unless there are well-founded circumstances that make it necessary to modify them sooner.

The Guarantees will also affect management, since protocols have been established for each treatment. Dispositions have been laid out regarding access conditions, financial coverage, timeliness, and the system of appeals, all of which will also have serious repercussions in terms of new demands on management.

These services came into force on 1 July 2005 and they cannot be waived; that is, no member can refuse to have them incorporated into their health contract. The 25 health conditions explicitly guaranteed were included as of that date and must be incorporated into all new health contracts that come into effect on or after that date. Health contracts effective before that date must be adjusted to the new norms, and modifications must have been made by 30 August 2005. The ISAPRES must have informed all of their clients of the medical provider network they were offering by 31 July 2005. The price charged for the new services by each ISAPRES must be the same for all beneficiaries and must be published by the ISAPRES Supervision in the official newspaper 30 days before the guarantees take effect.

The free preventative medical exam that ISAPRES have been traditionally required to offer has been modified too. It has been expanded with health programs for youngsters and adults, including a total cholesterol test, hypertension measurement, cervical-uterine and breast cancer tests and tests for problems related to obesity, tobacco use and alcoholism. There are also tests to detect possible pathologies such as tuberculosis and syphilis, and testing for diabetes and AIDS for pregnant women is a priority.

III. Guarantee of basic benefits and challenges of service segmentation in Mexico

1. Some basic benefit packages prior to the Popular Health Insurance

The Popular Health Insurance program (*Seguro Popular de Salud*, hereafter SPS) in Mexico has a history of measures, beginning in the 1980s, to expand coverage and health insurance including a package of basic services.

Such expansions in coverage were modifications to a health system that had serious problems in terms of equity and that had certainly been affected by basic segmentation going back to the 1940s when the Secretary of Health and Social Assistance (SSA) and the Mexican Institute of Social Security (IMSS) were formed. The former was in charge of the general population and the latter was responsible for health insurance and pensions exclusively for workers in formal industries, through obligatory contributions that came from the government, employers, and employees. Upon being formed, the IMSS was the cornerstone of a corporate arrangement between the government and the politically organized social groups. The bureaucracy and the unions of these groups became increasingly important as intermediaries and public resources were distributed so as to disproportionately favour their members. Since its inception, various administrations have supported the institute and even protected its financial equilibrium at times of economic crisis when the SSA underwent significant budgetary cutbacks (González, 2005).

In Mexico, over the last two decades several basic service packages have been proposed.¹⁸ So when a package was finally introduced, due to various political restrictions, it constituted a “path-oriented” measure. That is, even though it was possible to expand specific health service coverage to unprotected sectors, there were no profound modifications to public health insurance regulations, which – among other things – made universal insurance impossible. As will be seen, major modifications did not occur until 2004 when the Popular health insurance program was introduced.

The 1995 Program for Health Sector Reform (PRSS) stands out in recent developments. It was inserted into the National Development Plan and its main goal was to establish instruments to promote the quality and efficiency of public health services. It also aimed to expand social insurance coverage through affiliation mechanisms for the uninsured population and informal workers. In terms of the provision of health services by the Secretary of Health and Social Assistance (SSA), the goal was to continue the process of decentralization to the states that, after having delegated care for the uninsured population by the IMSS, had been affected by the economic crisis of 1986. In addition, there were efforts to reform IMSS management and service provision by introducing medical choice at the primary level and increasing productivity incentives. The possibility of opting-out, named *reversión de cuotas* in México, was proposed: for businesses that contracted private health services for their employees (Ibidem).¹⁹ This last device could radically modify insurance regulations by eliminating the obligatory nature of contributions to the IMSS.

For the IMSS union, participation by private providers was the beginning of a weakening of the IMSS and it set a dangerous precedent, since it would bring modifications to the collective contract. As was later shown, the initial proposal was politically unviable, the reform of IMSS health services included only some elements related to rationalizing the use of resources. Those elements requiring modifications to the collective IMSS work contract or that could have had an impact on working conditions, such as the introduction of a care model and productivity vouchers based on personnel performance and patient satisfaction, were withdrawn from the initiative or stayed in the testing phase, as was the case with medical choice by clients and productivity incentives. Legislation on the opting-out was not altered, but its implementing was postponed until regulations should be elaborated. On the other hand, a family medical insurance (Seguro médico familiar, SMF), to offer IMSS services to the population without formal employment, was initiated as a pilot program with limited coverage and did not include mechanisms that would allow a significant part of excluded people to be incorporated into the insurance framework (Ibidem).

In terms of health coverage expansion with specific service packages, an important antecedent of the SPS is the Program to Expand Coverage (PAC), undertaken by the PRSS in 1995-2000, whose goal was to provide a basic health service package (PBSS) to 10 million people without regular access to such services, specifically to eight million people located in the poorest and most scarcely populated areas of 18 states. In 1996 its sphere of influence was made explicit, including a set of priority clinical, public health, and health promotion procedures that were established considering risk factors, injuries and illnesses. These procedures were feasible, low-cost and high-impact. Various factors were considered in order to establish them, including the most prevalent causes of death, illness and incapacity as well as effectiveness and low cost. The package, destined for extremely poor groups with little or no access to health services, was complementary to essential health programs that the decentralized states had the obligation to offer to the uninsured population. It was financed through federal transfers to public bodies of decentralization (OPDs) which were responsible for implementing it at the state level. Decentralizing health services, both from the Health Secretary and the IMSS-Solidarity program, was expected to give the system

¹⁸ The idea to propose minimum service packages in different parts of the region based on the 1993 World Bank Report on World Development is dealt with in Bobadilla and Saxenian (1993) and Bobadilla et al. (1994).

¹⁹ With the opting-out, companies who demonstrated having contracted private insurance had no obligation to sign their employees up with IMSS.

greater flexibility, a higher capacity to respond to the health needs of each region, and the ability to avoid duplicating care (Rovira et al., 2003).

A milestone theoretical proposal for a service package was made by the Mexican Health Foundation (FUNSALUD) in a pioneering effort to define and quantify the cost of a package called the universal package of essential health services (PUSES) using health result indicators.²⁰ The PUSES was defined as “the (health) services to which all Mexicans should have access, without regard to their place of residence, occupation or income.” Financing was proposed through a universal health insurance, whose premiums could be administered by progressively signing this population up or through the IMSS itself, which would collect respective payments and would receive subsidies from the corresponding state. Three types of services were considered: public health, directed towards populations or the environment; community outreach, offered to population groups and centred on the places where these groups carry out their main tasks (home, school, factories, etc.); and clinics, requiring medical personnel. Isolated interventions, such as treatment for tuberculosis, were considered as well as groups of interventions required to control one or various illnesses, injuries or risk factors. Twenty-four interventions or groups of interventions were included: four in public health, five in community outreach, and 15 clinical services. Priority public health services were related to three risk factors that most influence on the disability adjusted life years (DALYs)²¹ in Mexico, namely: alcohol abuse, road insecurity and anemia among women and children. Community outreach services principally involved prevention activities.

Costs were calculated for more than 100 interventions, assuming technical efficiency in providing services and intervention effectiveness according to international scientific literature²² and taking market prices into consideration, except for those medicines and inputs obtained through consolidated purchase by the health sector. Data on effectiveness became gains in terms of DALYs, and priorities were established according to intervention cost-effectiveness and efficiency in controlling illnesses and groups of illnesses that were epidemiologically relevant to the country, that is, illnesses that had a rate of 1% or higher in 1991. Once the interventions were selected, the incremental cost of implementing them was calculated in relation to the coverage that was then in force. Per capita costs were obtained by adding the cost of each intervention performed and dividing the incremental cost by the total 1991 Mexican population.

Taking efficiency, effectiveness, coverage for that year, and expected coverage for the year 2000 (90% of urban and 80-85% of rural population) into account, it was calculated that the loss of approximately 2.5 million DALYs could be avoided annually by providing the services in the package. These were equivalent to 20% of the DALYs observed in 1991 taking the expected 2000 coverage. Taking into account the number of people that were to be treated or provided with services and the cost per person and per year of present and expected 2000 coverage, it is estimated that the marginal cost of the package would be 100 Mexican pesos per person, approximately 28% of the public expenditures and 14% of total health expenditures in 1991. That is, with an increase of 14% in health spending, 20% of DALYs loss could be avoided annually.

2. Aspects of the SPS and potential causes of tension

At the beginning of 2004 the Social Health Protection System (SPSS) was created with the goal of increasing coverage for universal health services, of defining and differentiating the steering functions which was related to the financing and provision of services, and of integrating them horizontally. Strengthening the governing role of the Ministry of Health was fundamental. The SPSS complements health services directed at the community and those personal services with benefits to third parties that form part of public health programs (National Commission on Social

²⁰ The presentation of the FUNSALUD proposal here presented draws from Rovira et al. (2003).

²¹ As can be seen, this was clearly inspired by the approach in World Bank (1993).

²² Repercussions of the approach of evidence-based medicine.

Health Protection, 2004). Social health protection, according to the current General Law on Health, is a mechanism through which the State should guarantee the entire population access to surgical medical procedures, pharmaceutical services, and hospital services to cover their health needs through health promotion, disease prevention, diagnoses, treatment, and rehabilitation. This access should be effective, timely, meet quality standards, and free of charge at the time of treatment.

Financial inequalities in the National Health System (SNS) have been analyzed on three levels. In terms of inequalities between the insured and the uninsured, average per capita public spending on those covered by social insurance is 85% greater than spending on the uninsured. The IMSS receives a direct per-member subsidy in the form of a federal voucher similar to the new federal contributions (*cuota social*) to the SPSS, which is not the case for the uninsured or for other social insurance institutions. The proportion of the population covered by social insurance is much higher in richer states than in poorer states, which accentuates the inequalities at the total level of spending on health by social insurance. Health coverage is regressive. Financing from the State Health Services (SESA) is also unequal: richer states tend to have better state health providers. The principal source of SESA financing is federal government transfers with specific destinations, established in 1998 as part of the decentralization process; however, differences in initial provisions of resources have caused differences of 5 to 1 between states in the amount of federal transfers per uninsured family. Additional financing for health services through individual states' budgetary resources shows differences in the ratio of per capita health spending of up to 100 to 1, and in general poor states spend less because they have fewer financial resources (Frenk et al. 2004, cited in OCDE, 2005).

A catalogue of essential health services (CASES) has been designed based on epidemiological criteria, and the selected interventions are estimated to cover 90% of medical care reported in the Single information system for epidemiological surveillance (SUIVE) as well as in the Health information system for the general population (SISPA). For hospitalization and surgery services, the current catalogue covers 66% of the main diagnostic and therapeutic procedures reported as the motive for hospital admittance through the Automated hospital admittance system (SAEH). Considering those that are not duplicated, the following were also reviewed: the current basic intervention package offered by the SSA under the Program to expand coverage (PAC); the essential package that the Health quality, equity and development Program (PROCEDES) offers in both rural and urban areas; and the interventions included in federal-level programs (adult and senior health, reproductive health, vector-transmitted diseases, microbacteriosis, child and adolescent health, HIV/AIDS and STDs, oral health, accidents, cholera and rabies, and the Even start in life program, and health promotion). The interventions were the subject of discussion among diverse work groups in the National Health System, professional teams in states that participated in implementing the SPSS, authorities in involved federal programs, and the Sub-secretary of disease prevention and health promotion that lead to a wide consensus (Ibidem).

This service consolidation makes evident what was alluded to with regard to the profusion of different health service packages in Mexico that have been introduced over time. The catalogue establishes brief clinical protocols and, in various cases, production functions. The detection, diagnosis and treatment procedures that make up the conglomeration of services are explicitly described for each of the selected interventions. Decision trees have been designed where possible, which permit basic functions of service provision to be established, as well as inputs and resources for each intervention. To this end current norms were consulted as well as technical manuals of programs used, medical literature and specialists. The emphasis is placed on prevention, with programs such as annual medical exams for adults, disease prevention and health promotion throughout life, and detection of tuberculosis (Ibidem).

Medications to which system members have a right have been listed, as well as medicinal formulas, whose costs can be clearly defined and facilitate the analysis of different pharmaceutical

purchasing schemes for the provision of services. The basic group of medicines for primary care is included, classified according to groups established by the General Health Regulation Council. The SPSS only offers some key medications for the second level of care in order to stimulate autonomy in hospital management and to permit hospitals, with their clinical and acquisition committees, to decide which inputs and medicines are most necessary for their specific population and for the interventions they perform (Ibidem).

a) The scope of SPS

The SPS was founded in 2002 as a pilot program and officially began in 2003 under the charge of the Sub-secretary for disease prevention and health promotion in the Ministry of Health, which carries out the purchasing function. It was initiated to expand public insurance coverage, reduce out-of-pocket costs, and promote timely health care for those who are not covered by insurance institutions because of their employment or socioeconomic status. The program is voluntary and open, and its target is the “open population,” that is, those with no social insurance. In 2004 there were 58 million people in this situation. To guarantee that the entire uninsured population, especially the poorest people, has access to health services at a viable cost, family contributions are scaled according to income.

The insurance is portable and is composed of a standard coverage through an explicit package of cost-effective health interventions, including medicines. It covers the insured party, his or her spouse, children until the age of 18, and parents over 65 years of age who are his or her economic dependents. Unmarried people over 18 years of age are considered one-member families.

When implemented, beginning in January 2004, SPS care coverage included vaccines, general medical consultations, physical examinations for men and women, diagnosis and treatment of 39 illnesses, dental care, family planning methods, reproductive health care over different life stages, diagnosis and treatment of fractures, and 16 different surgical procedures. It is noteworthy that the package exceeds the minimum coverage extension criteria of previous programs, by including secondary level attention and coverage of some catastrophic diseases (Nigenda, 2005, p. 18).

Attention is offered in health centres of the Ministry of Health system which have the human resources and infrastructure to meet determined standards. This is determined through an obligatory service provider accreditation. Institutions that provide care under the Fund for Catastrophic Services (FPGC), which we will discuss below, must be certified as well.

Understanding and acceptance by the population of the fact that the insurance covers only certain medical procedures is a constant controversial issue when rationing benefits. Even though the package contains primary and secondary level medical attention, in some entities the access to secondary level is not effective, in spite of the fact that the package specifies it. Some field information also shows a deficient knowledge of the insurance on behalf of doctors and managers, which generates rejection of patients sent from the primary level of attention (Ibidem, pp. 8 and 9). These aspects show how important it is to further the standardized setting of the package, by establishing additional guarantees that ensure effective access to benefits.

All institutions that provide services to those insured through the SPS must join a master plan for offering services that allows the identification of service availability. Ten service and hospital training areas for second and third level care have been identified as a function of health service needs and their socioeconomic, demographic and epidemiological characteristics. In the event that an institution does not meet requirements, a quote is offered for improving equipment or infrastructure, or services can be contracted from entities such as the IMSS. Federal authorities must certify that new service providers and new high-cost technological investment are necessary, and priority will be given to areas of the country where health services are most deficient.

Overcoming historical deficiencies of infrastructure, doctors and medicine, which have been inherent in the attention system to the public, stands out among the challenges for the implementation of the SPS, particularly in rural areas.²³

b) Virtual changes in the public-private mix

It should be emphasized in this context that various proposals for the introduction of benefit guarantees through packages that tend to expand health coverage have also been part of more general health reforms in which proposals can be identified to modify the public-private mix in terms of insurance as well as the provision of services.

In that sense, in the framework of the IMSS reform of the 1990s, there was also an attempt to increase private sector participation in insurance and provision of services through opting-out and introducing medical choice by clients at the primary care level. Those proposals were abandoned because of their controversial nature and also to ensure the political viability of the reform to the pension system (González, 2005).

The SPS also has implications regarding the public private mix in the Mexican health system. According to regulations, states may acquire services from the private sector; with the expanded coverage foreseen with the new insurance, it will be possible for the private sector to participate more fully in providing services. With the SPS, the IMSS will also become, depending on circumstances, a possible service provider.

With the goals of modifying the public-private mix in provision of services and improving service quality at public institutions, it is fundamental to have certification mechanisms to measure service quality according to determined norms. Regulatory capacity will be strengthened if verification of the execution of such norms was obligatory rather than voluntary. Certification can be considered a continuous program of quality improvement and, with the goal of improving transparency, it would be positive if specialized service providers belonging to the Protection Fund for Catastrophic Expenses were certified and accredited (OECD, 2005).

One aspect of the reform that exhibits contradictory incentives is the private-public mix, since many doctors in the public sector also have private practices. For this reason, regulations must assure that this situation does not lead to moral hazard behaviour that expands private participation to the detriment of the coverage and quality of public services (Ibidem).

The possibility of competition for members arising between SPS and IMSS must also be considered. Since the total cost of IMSS is much higher than the family contributions to SPS, although it covers a wider array of health risks and includes other areas such as pensions, both employers and employees might be attracted to the SPS, where they could choose a work arrangement not based on salaries. This could be the case with employees who work on commission, rural workers who have other payment terms, or young, healthy people who do not value the more complete coverage offered by IMSS and its other components. Also, pressure on employers in the informal sector to have their employees join IMSS might be lessened (Ibidem).

The Popular Insurance program (SPS) is expanding and offers significant service coverage, but being different to a global social insurance, it still does not cover an important number of afflictions that cause a significant proportion of deaths in Mexico. As the SPS is an additional package, insurance segmentation continues with its negative impact upon health system segmentation (Ibidem).

²³ Clara Brugada Molina (coordinator), *Popular Insurance, some ideas for debate*, PRD Parliamentary Group, Chamber of Deputies, Union Congress, LXI Legislature; OECD (2005), p. 160.

c) The complexity of the SPS finance system

The SPS aims to inject new resources into the government's health service system and correct inequalities among the states.²⁴ Resources could come from federal taxes, which would provide for a contribution called the social quota (CS) to states per registered family (see table 3), which is equivalent to the federal quota paid to IMSS per insured worker. Both federal and state entities must also make contributions for each family that joins, respectively called the Federal Solidarity Contribution (ASF) and the State Solidarity Contribution (ASE).²⁵

Table 3
FEDERAL BUDGET: TRANSFERABLE RESOURCES TO THE SPS, END OF 2004

(Number of insured families, thousands of current pesos)

| State entities | Families (end of 2004) | Transferable resources, end of 2004 | | |
|---------------------|------------------------|-------------------------------------|---------------------------------------|---------|
| | | Social quota | Federal Solidarity Contribution (ASF) | Total |
| Aguascalientes | 64 234 | 52 054 | - | 52 054 |
| Baja California | 50 000 | 68 803 | 62 735 | 131 538 |
| Baja California Sur | 12 674 | 17 282 | - | 17 282 |
| Campeche | 35 000 | 43 042 | - | 43 042 |
| Chiapas | 60 000 | 74 297 | 66 795 | 141 092 |
| Chihuahua | - | - | - | - |
| Coahuila | 9 769 | 7 732 | - | 7 732 |
| Colima | 67 479 | 81 852 | - | 81 852 |
| Distrito Federal | - | - | - | - |
| Durango | - | - | - | - |
| Guanajuato | 119 888 | 71 142 | 94 691 | 165 832 |
| Guerrero | 12 000 | 17 473 | 17 864 | 35 337 |
| Hidalgo | 43 838 | 46 767 | 29 911 | 76 677 |
| Jalisco | 94 825 | 104 385 | 92 469 | 196 854 |
| México | 78 425 | 71 811 | 70 931 | 142 741 |
| Michoacán | 10 000 | 10 758 | 11 241 | 21 999 |
| Morelos | 24 997 | 28 766 | 26 893 | 55 659 |
| Nayarit | 34 974 | 20 772 | 6 711 | 27 483 |
| Nuevo León | 26 000 | 21 575 | 8 840 | 30 415 |
| Oaxaca | 52 530 | 57 336 | 44 871 | 102 208 |
| Puebla | 112 912 | 60 447 | 72 874 | 133 321 |
| Querétaro | 9 749 | 4 045 | - | 4 045 |
| Quintana Roo | 7 976 | 13 306 | 2 172 | 15 478 |
| San Luis Potosí | 52 211 | 84 349 | 74 526 | 158 875 |
| Sinaloa | 95 000 | 156 947 | 97 749 | 254 696 |
| Sonora | 29 038 | 45 715 | 2 006 | 47 720 |
| Tabasco | 187 726 | 262 410 | 26 5219 | 527 629 |
| Tamaulipas | 150 000 | 177 903 | 79 479 | 257 383 |

²⁴ The description of financing is taken from OECD (2005).

²⁵ See precise amounts in OECD (2005), Box 3.1.

Table 3 (Conclusion)

| State entities | Families (end of 2004) | Transferable resources, end of 2004 | | |
|----------------|------------------------|-------------------------------------|---------------------------------------|-----------|
| | | Social quota | Federal Solidarity Contribution (ASF) | Total |
| Tlaxcala | 16 855 | 13 358 | 8 737 | 22 094 |
| Veracruz | 73 836 | 61 624 | 76 748 | 138 372 |
| Yucatán | 10 000 | 9 174 | - | 9 174 |
| Zacatecas | 21 636 | 33 776 | 31 484 | 65 260 |
| | | 1 718 900 | 1 244 945 | 2 963 845 |

Source: Ministry of Health, Priority programmes. Popular Health Insurance. Coverage at: <http://www.salud.gob.mx>, may 2005.

Families pay the family payment (CF), determined by their income levels. In order to calculate the payment, families are grouped in deciles, and according to law in article 77, bis 21, today those families in the two lowest deciles make no contribution at all. One of the main goals of the SPS is to offer financial protection to all Mexican citizens, to avoid catastrophic expenses. According to estimations from the OECD, payments were halved in comparison to the pilot SPS program because of polls regarding the families' ability to pay (OECD, 2005: 139-40). All economic dependents of the insured are partly covered. As for possible equality problems, it has been outlined that families that do not qualify as poor could be excluded due to difficulties paying the annual family quota in advance. The relationship between the family payment and the average income, shows that the payment is progressive, except for the richest decile; but in that case, it can be assumed that due to self-selection the insurance will not be used by this income group.

Table 4
POPULAR HEALTH INSURANCE: % FAMILY PAYMENT VALID
UNTIL APRIL 2005 WITH RESPECT TO AVERAGE INCOME
(DECILES)
(in current pesos)

| Income deciles | Household current income average A | Family Payment Annual B | (B/A)*100 |
|----------------|------------------------------------|-------------------------|-----------|
| I | 4 716 | 0 | 0 |
| II | 8 212 | 0 | 0 |
| III | 11 192 | 640 | 5.71 |
| IV | 14 276 | 1 255 | 8.79 |
| V | 17 712 | 1 860 | 10.50 |
| VI | 22 012 | 2 540 | 11.53 |
| VII | 27 480 | 3 270 | 11.89 |
| VIII | 34 944 | 5 067 | 14.50 |
| IX | 50 000 | 6 740 | 13.48 |
| X | 120 296 | 10 200 | 8.47 |

Source: Author's construction according to database: http://www.isea.gob.mx/inicio_sp.asp, September 2005.

The ASF is assigned according to a formula that considers the number of member families in the SPS, the health service needs and aspects each state lacks and, perhaps in a later period, the magnitude of state efforts in health services, the state systems' performance, and the amounts

obtained through labelled transfers²⁶ registered in the FASSA.²⁷ States that currently receive small amounts from the federal budget will receive more, and those that now receive larger amounts will receive less. The ASE will depend on whether resources assigned to health services before the creation of the SPS are sufficient to cover families signed up to the SPS.

The program will gradually be introduced between 2004 and 2010 to ensure that it will be feasible. The voluntary nature of its affiliation and its state financing depending on the number of SPS member families affiliated, should together encourage states to improve services in order to retain and attract new members, and increase the focus of the system upon the needs of the insured.

The Fund for contributions for community health services (FASC) finances the provision of public and community health services that are defined as public goods, such as epidemiological surveillance. It has resources specified for certain activities, such as preventative medicine, with the goal of protecting these programs from budget cuts. The Fund receives a portion of the FASSA, branch 33, employed to finance public health services and community services at the state level (called FASSA-C)²⁸ and it is possible that these funds are able to be supplemented from the Ministry of Health budget, from branch 12, when services are classified as “public goods” at the national or regional level.

In this way, the new FASC fund will receive funds that were already conditional and that will now be assigned to states through a formula that takes the following into account: population, public health requirements, health risks, and states’ public health program efficiency, so that resources are first channelled to those states with lowest incomes. However, the mechanism to evaluate the use of these funds at the state level has not yet been established (OECD, 2005).²⁹

Additionally, the Fund for contributions to personal health services (FASP) covers services that are not public goods and provides for private health services that, as they should be insured, will be insured through the Popular Insurance program. This fund includes the resources of the social quota (CS), the federal solidarity contribution (ASF), and the state solidarity contribution (ASE) already mentioned. It is divided into three components that are also called “funds.”

The first component, financed with 89% of FASP’s total resources, is a combined, decentralized fund at the state level for low-risk, high-occurrence health service expenses. It finances an essential, cost-effective package for primary and secondary level ambulatory and general hospital care. Such care is free of charge at the time services are provided.

Secondly, the Fund for budgetary forecasts (FPP), financed with 3% of FASP’s total resources, must assist system operation and improve relationships between states by carrying out

²⁶ In Mexico, resources are called “labeled” (*etiquetados*) when they are earmarked for a specific destination.

²⁷ Since 1998, the main public goods and services in Mexico are provided by state and municipal governments in the framework of decentralized transfers known as branch 33 transfers (*transferencias del ramo 33*). The resources transferred from the federal to the state/municipal level are divided into unconditioned transfers (*participaciones*) and conditioned transfers (*aportaciones*). Conditioned transfers are included under branch 33 of the federal budget and are made up of seven programs, one of which is the Fund for Conditioned Transfers (*Aportaciones*) for Health Services (FASSA). In budgetary terms, the FASSA uses 12% of the branch’s resources. The majority of branch 33 are funds created to transfer resources to state governments along with administrative responsibilities that earlier belonged to the federal level. The creation of the FASSA in 1998 formalized a process of decentralization that had begun earlier (Díaz-Cayeros and Silva, 2004: 15).

²⁸ According to the Law of fiscal coordination introduced in 1998, features, distribution and operation of conditional transfers were placed under branch 33 of the federal budget. The law establishes that resources should be assigned for each of the funds in the federal annual budget according to the federal tax collection process. Specific criteria for the distribution of education, health and public safety resources among entities and the two main municipal funds, is also established. These conditional transfers, which would be named contributions (*aportaciones*) from that time onwards, were transformed from being decentralized programs and funds, to being part of the federal pact between the State and entities. Being attached to an ordinary law, different from the budget, the Senate acquired a veto to subsequent changes, although in Mexico normally only the Chamber of Deputies and not the Senate have duties in relationship with the federal budget. Secondly, from that moment on, state entities start conceiving funds as rigid resources guaranteed by the federal pact, instead of resources attached to discretionary decisions of the executive branch of the Government (Díaz-Cayeros y Castañeda, 2004).

²⁹ This is crucial, if it is also considered that it was alleged that in Mexico there were no clear evaluations of the efficiency of decentralized spending (Díaz-Cayeros and Silva, 2004: 8).

compensatory functions. Some examples of the latter are the financing of excesses in service demands, the guarantee of payment between states for people from other states, and the contribution to finance the infrastructure with a restricted offering of basic health services.

In the third place, the Protection fund for catastrophic expenses (FPGC), financed with 8% of the FASP's resources, permits risk diversification at the national level by pooling insurance risks that cannot be diversified for populations at the state level, due to the fact that high-cost treatments are involved. Gradually it will cover treatments for high-cost illnesses that require specialized treatment in third-level hospitals, up to a total of 58 illnesses separated into nine groups. They will be selected according to cost-effectiveness, social acceptance, technology, available services, and available financial resources. Currently, inclusion of treatment for six conditions is being considered, and coverage will be progressively extended depending on available resources.³⁰

It should also be noted that the governing function of the popular insurance system – in charge of buildings, regulations, oversight, and evaluation – is considered a public good by the reform that will be financed through a specific fund whose size has not yet been decided.

The nomenclature of finance itself, summarized briefly here, provides an idea of the SPS's complex financing system which is due to having resources channelled through different funds with specific purposes (see diagram).

The complexity of financing brings a non-trivial issue to the fore, which is an institutional and organizational challenge: that is, how providers use and efficiently combine different resources, including resources that have singular access mechanisms, criteria for assignment, budgetary regimes, types of transfers, programming and implementation of resource flows, and implicit or explicit incentives in terms of how they are managed. This is even more critical when elements are considered such as the relative indivisibility of health services and the heterogeneity of capacity to manage providers when faced with such diverse financing sources. Transaction costs are also relevant, as they may be associated with the many sources of financing and may turn out to be higher or more difficult to deal with precisely for those providers who provide services to the neediest population and who generally have less economy of scale in the use of resources and are more precariously managed. From this comes the importance of mechanisms to coordinate these resources on a larger scale than that of service providers, and a reflection of the internal consistency of incentives (Sojo, 2001).³¹

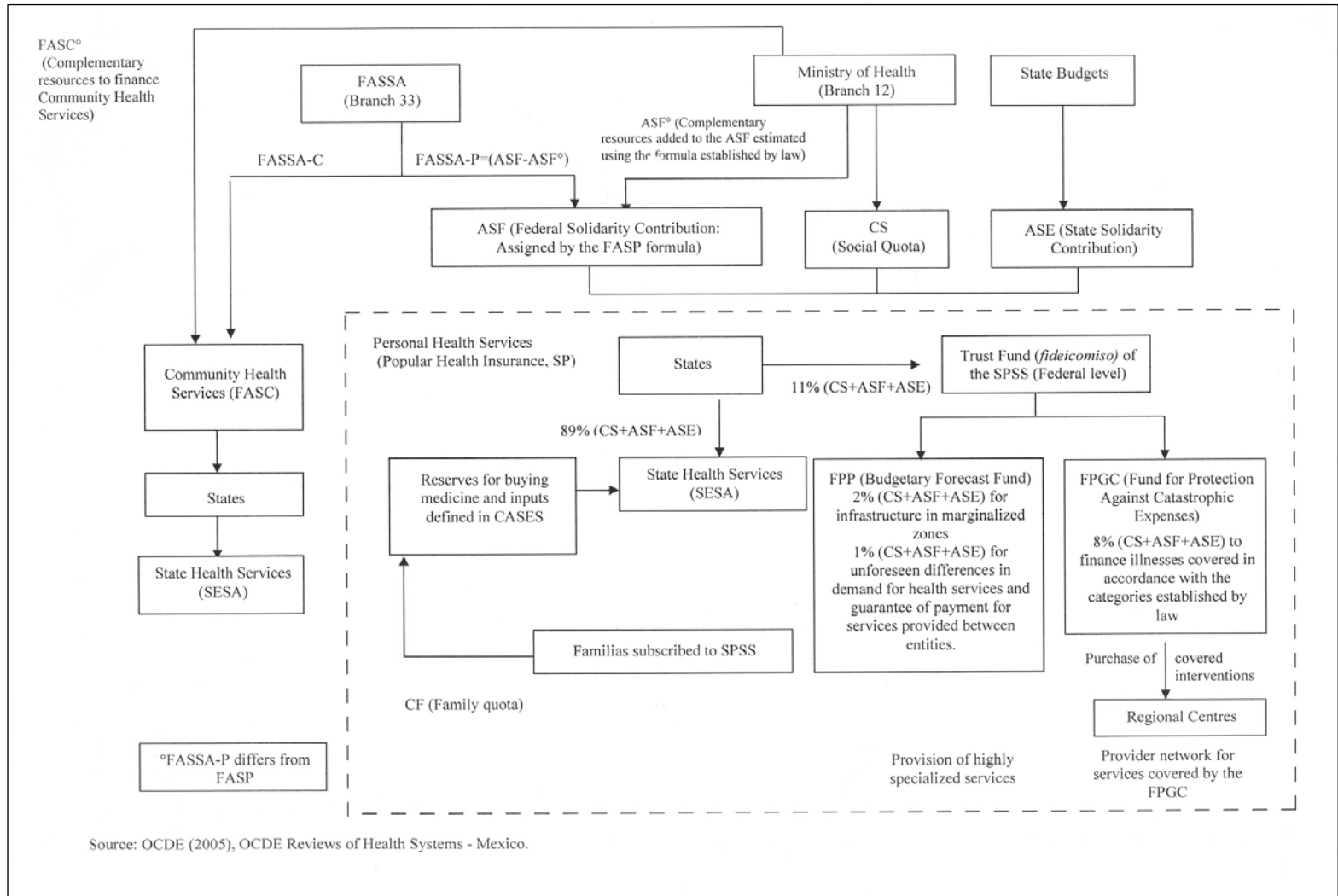
With respect to effectively meeting both health necessities and political objectives in strategic purchasing, international experiences show us the advisability of having health objectives supported by management systems (Figueras et al., 2005: 57). Financing of Popular Insurance, for now, seems to leave this on the back burner as it is governed almost exclusively by the magnitude of health needs and risk structure that must be covered.

The fragmentation of the purchasing function caused by the multiplicity of funds is an institutional element that could be dealt with promptly. Potentially it can increase the fragmentation of the health system at the insurance level.

³⁰ In the region, various ways of financing catastrophic illnesses among sectors with low levels of insurance have been tried. In Colombia, the Health Promoting Entities (EPS), which carry out financing and insurance functions, must contract a backup to cover catastrophic risks both in the contributive system and in the subsidized system. This backup has promoted the convergence of the two systems since it finances more expensive and complex services for beneficiaries of the subsidized system (Sojo, 1999).

³¹ These reflections are an extension of some ideas proposed originally about the complicated hospital financing that characterizes the Colombian reform (Sojo, 2001). Obviously, they are made based on two situations that are not in any way comparable. However, in both cases the reflection on complexity permits us to abstract elements to make more general affirmations.

Diagram
ALLOCATION OF HEALTH SECTOR FUNDING TO THE PUBLIC HEALTH INSURANCE PROVIDERS, BY SOURCES AND USES OF SPSS FINANCING



IV. Conclusions

Wealth created in a society, its distribution and the management of macroeconomic variables compose the fundamental macroeconomic framework for the level of feasible redistributive capacity of the State. This macroeconomic framework, along with political realities, determines not only the fiscal capacity of the State, but also the amount and use of resources. In the case of the solidarity of health systems, this may go hand to hand with systems of obligatory contributions.

The goals of social policy and the instruments used to pursue it are based upon a desired level of social welfare which can be enshrined in a system of social rights. Guarantees, from the legal point of view, are ideal instruments to ensure the effectiveness of the norms and acknowledgment of rights. Rights to freedom and property rights are each clearly established by legally enforceable guarantees. However, social rights lack a comparable set of well-defined guarantees that provide adequate capacity for their control and regulation. Without these guarantees, the development of social rights, even across the European welfare states, has mostly been due to an increasingly discretionary role of the bureaucracy (Ferrajoli, 2002).

A lack of guarantees is a significant factor for the inefficient application of social rights. In the light of this, the lack of appropriate social guarantees may lead to bureaucratic practices inherent in the welfare State, oriented to satisfy political clients, which paves the way for arbitrary decision making and corruption. Some recent social policy reforms have sought to address this problem. The Users' Charter of Human Rights is one example that contains legally

enforceable guarantees of these rights. The guarantee of health benefits, which covers a broad variety of experiences in the region, can be studied from that perspective. To some extent, the adequacy of these reforms to enforce social rights is determined by factors including the characteristics of the health system in which the guarantees are applied, political constraints and evidence of pending challenges.

Many countries are characterized by less developed health systems and poor levels of insurance for low income earners and are also undergoing transitions in epidemiological polarization. Within these countries, the guarantee of benefits has been concentrated upon guarantees in terms of primary health care interventions, maternal and infant health care. These benefits, although relatively low cost, represent an important first step. However, further progress can be made because the current extent of the guarantee of benefits has only a marginal effect in terms of the global reorganization of the health system; in the case of Guatemala, the distinction of functions within the health system, as outlined at the beginning, was omitted. In Guatemala and Bolivia, guarantees exist within a package of benefits but without any specification about opportunity and access, and they have no repercussions in terms of insurance.

Of the case studies presented here, Chile has been the most progressive, particularly in terms of the benefits guarantee, introduced in 2005. This includes high-cost benefits and guarantees of opportunity, access, financial protection and quality. In addition, the system of guarantees in Chile has repercussions with respect to the private-public mix of resources, such that it partially impugns upon the basic duality of the insurance system, delimiting adverse selection practices of ISAPRES, and increasing coverage transparency. The progress of the reform highlights political difficulties that have hindered the establishment of measures that would have provided greater solidarity to the dual insurance system.

Mexico is also looking towards a system of universal coverage, with a benefits guarantee being introduced through a partial insurance reform. However, in this case the insurance system is further segmented, because it provides a new insurance with additional resources and links to existing providers, but no links with the traditional insurers at the level of financing. The complexity of the financing is highlighted by the diversity of funds used to feed the SPS and the financing mechanisms associated with them. It involves modifications of the public-private resource mix by widening the participation of private providers. In contrast with Chile, coverage is not supported by additional guarantees.

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Acronyms

| | |
|--------|--|
| ARS | Administradoras del régimen subsidiario |
| ASE | Aportación solidaria estatal |
| ASF | Aportación solidaria federal |
| ASS | Administradoras de servicios de salud |
| AUGE | Proyecto de garantía de prestaciones en salud |
| CAEC | Cobertura adicional de enfermedades catastróficas |
| CASEN | Encuesta de caracterización económica nacional |
| CASES | Catálogo de servicios esenciales de salud |
| CCSS | Caja Costarricense de Seguro Social |
| CF | Cuota familiar |
| CS | Cuota social |
| DALYs | Disability adjusted life years |
| EPS | Entidades promotoras de salud |
| ESEMI | Encuesta nacional de salud materno infantil |
| FASSA | Fondo de aportaciones para los servicios de salud |
| FASC | Fondo de aportaciones para los servicios de salud a la comunidad |
| FASP | Fondo de aportaciones para los servicios de salud |
| FONASA | Fondo nacional de salud |

| | |
|----------|---|
| FOSyGA | Fondo de solidaridad y garantía |
| FPP | Fondo de previsión presupuestal |
| FPGC | Fondo de servicios catastróficos |
| FUNSALUD | Fundación Mexicana para la Salud |
| GES | Garantías explícitas en salud |
| GP | General Practitioners |
| IGSS | Instituto Guatemalteco de Seguridad Social |
| IMSS | Instituto Mexicano de la Seguridad Social |
| IPS | Instituciones prestadoras de salud |
| ISAPRES | Instituciones de salud provisional |
| NHS | British National Health Service |
| OPD | Organismo público de descentralización |
| PAC | Programa de ampliación de cobertura |
| PAD | Pago asociado a diagnóstico |
| PBSS | Paquete básico de servicios de salud |
| PGS | Plan garantizado de salud |
| POA | Programa de oportunidad en la atención |
| POS | Plan obligatorio de salud |
| PROCEDES | Programa de calidad, equidad y desarrollo en salud |
| PRSS | Programa de reforma del sector salud |
| PSS | Prestadoras de servicios de salud |
| PUSES | Paquete universal de servicios esenciales de salud |
| SAEH | Sistema automatizado de egresos hospitalarios |
| SBS | Seguro básico de salud |
| SEDES | Servicios departamentales de salud |
| SESA | Servicios estatales de salud |
| SISPA | Sistema de información en salud para población abierta |
| SMF | Seguro médico familiar |
| SNS | Sistema nacional de salud |
| SPS | Seguro popular de salud |
| SSA | Secretaría de Salud y Asistencia Social |
| SPS | Seguro popular de salud |
| SPSS | Sistema de protección social en salud |
| SUIVE | Sistema único de información para vigilancia epidemiológica |
| UF | Unidades de fomento |

Appendix

AUGE coverage according to the initial proposal

I. Basic services of the first phase of the AUGE, for FONASA and ISAPRES clients:

- All women will be guaranteed professional care during childbirth with anaesthesia or inhaled analgesics (if desired), with the right to be accompanied by the father of the child or by a family member.
- Patients with diabetes, high blood pressure and epilepsy have the right to integral treatment including controlling the development of the disease while reducing its effects and minimizing the handicaps it causes.
- All children, pregnant women, and HIV/AIDS patients will have the right to antiretroviral treatments according to clinical indications. Services will be provided a maximum of seven days after they are requested. Services will be free of charge for children and pregnant women, while adults will pay a co-payment of between zero and 20% depending on family income.
- Adults over 60 years of age with cataracts will receive services within three months after being diagnosed.
- Pacemakers are guaranteed for all patients who require them.
- All children born with cleft lip and palate will have the right to surgery, aural care, dental care, and complete rehabilitation to the age of 15.
- Patients suffering cysts or tumors of the central nervous system are guaranteed immediate care and neurosurgery depending on the seriousness of their condition. Timely operations for those suffering cyatic hernias who has high pain levels or urgent motor or sensory deficits.
- Patients with aneurisms with have access to cerebral angiographs, neurosurgery and endovascular therapies.
- Patients will have the right to palliative care for terminal cancers as well as programs to ease pain, which must be begun within 15 days of diagnosis.
- Ischemic heart conditions will receive immediate integral care, including medicines that today allow the prevention of heart attacks and improve the life expectancy when administered at the correct time.

II. Illnesses which will receive priority care

- Childbirth with Analgesics
- All childhood cancers
- Cervical and Uterine Cancer
- Breast Cancer
- Leukemia (Adults)
- Lymphoma (Adults)
- Testicular Cancer
- Prostate Cancer
- Stomach Cancer
- Gall Bladder Cancer
- Terminal Cancers (palliative care)
- Ischemic conditions (miocardial heart attacks)
- Heart arrhythmias
- Operable Congenital Cardiopathy
- Neural Tube Defects

- Cleft Lip and Palate
- Chronic Renal Insufficiency
- HIV/AIDS
- Cataracts
- Large Burns
- Multiple Traumas with or without Spinal Injuries
- Cyatic Hernia
- Tumors and Cysts of the Central Nervous System
- Aneurysms
- Diabetic Retinopathy
- Vision Problems
- Tooth Loss among Seniors
- Surgery Requiring Prostheses
- Hearing Loss
- Benign Prostatic Hyperplasia
- Pneumonia among Seniors
- Orthotics for Seniors (canes, wheelchairs, etc.)
- Hemophilia
- Cystic Fibrosis
- Scoliosis
- Depression
- Drug and Alcohol Dependence
- Psychoses (severe psychiatric conditions)
- Bronchial Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- High Blood Pressure
- Stroke
- Diabetes Mellitus Types I and II
- Premature Birth
- Retinopathy among Premature Babies
- Respiratory Difficulties among Newborns
- Accidents requiring Intensive Care Units (ICU's)
- Rheumatoid Arthritis
- Degenerative Osteoarthritis
- Epilepsy (improvement program to manage the disease among children)
- Ocular Trauma
- Detached Retina
- Squinting (children under 9 years of age)
- Acute Respiratory Infections (children under 15 years of age)
- Complete Oral Health
- Dental Emergencies

Source: <http://www.minsal.cl/>

AUGE illnesses selected in 2005

Operable congenital cardiopathy

Terminal chronic renal insufficiency

Childhood cancers (children under 15 years of age)

Cervical and Uterine Cancer

Pain relief and palliative care for advanced cancers *

Acute Miocardio Heart Attack *

Neural Tube Defects – open and closed spinal dysraphias
Breast Cancer*
Diabetes Mellitus Type I
First Episode Schizophrenia
Testicular Cancer among Adults (15 years of age and over)
Lymphoma among adults (15 years of age and over)
Cataracts surgical intervention in adults over 65 years of age
Total Hip Replacement for Seniors over 65 years of age
Cleft Lip and Palate
Scoliosis surgical intervention in those under 25 years of age
HIV/AIDS: Tritherapy through the third stage, with tests and controls, for all children and adults with clinical treatment criteria *
Diabetes Mellitus Type II
Acute Respiratory Infections on an outpatient basis among children under 5 years of age
Pneumonia acquired in the community, treated on an outpatient basis, among adults 65 years of age and over* Essential or primary high blood pressure among adults 15 years of age and over *
Nonrefractory epilepsy among children between 1 and 15 years of age
Integral oral health for 6-year-old children
Premature Birth Prevention of premature childbirth, and retinopathy, bronchopulmonary dysplasia, and bilateral neurosensorial hypoacusia among premature babies
Heart arrhythmias in adults of 15 years of age and over, requiring a pacemaker



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