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When social health insurance goes wrong: lessons from Argentina and Mexico.

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Introduction

'Social health insurance systems are a sure recipe for poverty reduction: they are a driving force for development'.[2]

Social health insurance (SHI) has gained popularity in recent years as a health care funding mechanism for developing countries in Latin America and beyond. This is reflected in a number of high-profile conferences sponsored by international agencies, and a profusion of externally funded reform projects. This paper assesses the potential of SHI to provide a sound model of health care financing, drawing on the experiences of Argentina and Mexico. It uses four criteria to assess the performance of SHI: coverage, equity, effectiveness and sustainability. The paper begins by outlining key principles of SHI and comparing it to other models of health care financing. It then gives a comparative overview of four SHI programmes in Argentina and Mexico, before analysing their performance in greater detail. The paper finishes by extracting lessons from this comparative analysis, both for the countries studied and for global debates on SHI.

Social health insurance and other health care financing options

SHI requires affiliates to make compulsory contributions to a fund, which may then provide services in return or contract out to third party providers. Typically, contributions are set at a certain percentage of gross salaries, are deducted from

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[2] Heidemarie Wieczorek-Zeul, German Federal Minister for Economic Cooperation and Development in the opening address for a conference on "Social Health Insurance in Developing Countries", sponsored by GTZ, the ILO and WHO, Berlin 5 December 2005.

workers' monthly payrolls, and may be matched by contributions from employers and the state. Those who do not make contributions or who are not dependents of contributors (usually immediate family members) are not entitled to service provided by SHI funds (Carrin 2002). In Latin America this has led to a separation between contributory SHI schemes and services provided by health ministries for the population at large.

Social health insurance is one of five widely recognized forms of health care financing. The first of these is direct state funding through general taxation. This remains the main source of core funding for health ministries across Latin America, although responsibility has been increasingly delegated to sub-national levels of government. In terms of equity and social solidarity, this form of funding holds many attractions, assuming the fiscal system itself is not regressive. However, direct state funding has been criticized in terms of sustainability, due to continued high levels of tax evasion and a failure to ring-fence budgetary allocations, especially at times of economic downturn (Abel-Smith 1994). This has been evident in Mexico, where total public spending on health is low even by Latin American standards, and is very sensitive to economic cycles: between 1991 and the Tequila Crisis year of 1995, it fell from 9.2 to 5.3 billion US$ (Durán-Arenas et. al. 2000). In Argentina government spending on health fell from US$ 614 per capita in 2001 (immediately before the recent economic crisis) to US$ 480 in 2002 (World Health Organization 2006). More general problems with tax systems in Latin America include a low ratio of revenue to GDP (around 16 per cent in 1999, compared to 25 per cent in South Korea and an OECD average of 37 per cent), and a tendency to rely disproportionately on regressive indirect consumption taxes (Ter-Minassian, 2002).

During the 1980s, organisations such as the World Bank advocated the application of user fees to compensate for the limits of tax financing (Fiedler 1993). These require that patients pay for some of all of their treatment costs at the point of use. Advocates argued that out-of-pocket payments already existed in many countries on an informal basis, and that taking a more formal approach would enable fees to be set and funds to be disbursed more appropriately (World Bank 1993). Since the 1980s, political resistance to user fees mounted, as did the evidence that they did little to improve health services and usually reduced access for poorer groups (Russell and Gilson 1997; Ensor and San 1996). In recent years, organisations like the World Bank have become less

supportive of user fees, although the Bank's latest statement on health policy (a chapter in the 2004 World Development Report) continues to tout the supposed benefits of "pro-poor co-payments", which are essentially a rebranding of the old approach (World Bank 2004). In Argentina, user fees were imposed by the Ministry of Health during the military dictatorship of 1976-83. Since then, they have been levied on an ad hoc basis, with hospitals exercising considerable autonomy in the use and abuse of the system. Since fee payments are not overseen or policed by the Ministry of Health, the sums they generate are unknown (Lloyd-Sherlock and Novick 2001). In Mexico, out-of-pocket payments are estimated to have accounted for at least 3.5 per cent of total health spending in 1999 (Durán-Arenas et. al 2000). However, the high level of informal payments means that this is likely to be a substantial underestimate of the actual level.

A third form of financing is through private health insurance. Even neo-liberal organisations recognize the failures of private funds in terms of equity, reaching the poor and creating incentives for efficient resource allocation. These problems are amply evident in the experiences of the United State and, since the 1980s, Chile (Barrientos 2000). Private health insurance remains relatively limited in Mexico, covering somewhere between two and three per cent of the population (the absence of reliable figures indicates the lack of state regulatory control over the sector) (Frenk et. al. 2005). By contrast, Argentina has experienced a private health insurance boom over the past decade, as is discussed below.

Community-based financing represents a fourth option which has been pursued particularly enthusiastically in low income countries (Abel-Smith 1994). This can take several forms, including revolving drug funds or community-managed insurance funds (Chabot et. al. 1991). Generally speaking, they have proved hard to implement beyond small-scale pilot schemes, and have not played a significant role in Argentina or Mexico.

When considered alongside the limitations of these other funding options, the current enthusiasm for SHI is understandable. This is supported by claims about the relative success of SHI in some countries, notably in the OECD, but also including some developing countries such as Costa Rica, Colombia and South Korea (Carrin and James 2004). These provide encouraging examples of "best practice" which can be disseminated to other countries. SHI also fits well into the current emphasis in development policy on social protection and risk management, which highlights the

vulnerability of poor households to catastrophic health spending (Kawabata et. al. 2002).

However, current debate does not pay sufficient attention to the pitfalls of poorly designed and implemented SHI schemes and the very negative experiences of some countries, particularly in Latin America. Two key problems faced by developing countries which can undermine the performance of SHI stem from the structure of their labour markets and the quality of governance. The first of these effectively reduces the coverage of SHI to a minority of relatively privileged formal sector workers and their dependents. This leads to a financing system which discriminates between population groups according to their socio-economic status, undermining social solidarity at the national level. It also tends to promote distribution away from uninsured groups to insured ones, as the Mexican and Argentine experiences will demonstrate. Efforts to extend coverage beyond the formal sector have been singularly unsuccessful, leading to a new emphasis on creating separate, downgraded systems for the poor (Carrin and James 2004).

SHI programmes are necessarily complex in terms of financial flows, contracts between insurers and different providers, and the range of services on offer. This complexity is much greater than for other areas of social policy such as the provision of pensions or school education. Complexity requires effective state regulation, along with good information systems and accountable and transparent procedures. Where governance is weak, the opportunities for fraud and corruption are equally complex and wide-ranging, as will be clearly apparent in Argentina and Mexico.

Given the long experience of most Latin American countries with large-scale SHI programmes, and given the region's problems of governance and labour market stratification, it is likely to offer both good and bad examples which may inform current thinking on SHI. Mexico has the largest SHI fund in Latin America, and since the 1980s has implemented various initiatives to extend coverage to poorer groups. The country's supposed success with extending SHI has been paraded as part of the current global debate on SHI (Frenk et. al. 2005). During the 1990s, Argentina was a major focus for various externally-funded SHI reforms. These reforms are now universally recognized to have failed to improve performance (Escudero 2003). Indeed, the large public sector deficits generated by Argentina's SHI programmes were viewed by agencies such as the IMF as a major factor in the country's financial collapse in December 2001 (Blustein

2005). As such, Argentine policy-makers have been conspicuously absent from global forums on SHI (which contrasts markedly with the country's 'neo-liberal poster-boy' status of the 1990s).

Argentina: reform and crisis.

Argentina's health system consists of three separate funding components: the publicly-financed sector, social insurance funds (known as *obras sociales*) and private plans. SHI evolved out of worker mutual aid societies dating back to the start of the 20th Century. The sector came under the supervision (but not control) of the Ministry of Labour and Welfare in 1946, and affiliation become compulsory for formal sector workers in 1970 (Lloyd-Sherlock 2000). By the 1990s, SHI was largely in the hands of 300 or so different *obras social*es (social works funds), most of which were run by trade unions, and which were theoretically regulated by but autonomous of the state. Each fund had monopolistic rights over a demarcated sector of the labour force, and workers were not entitled to choose to which fund they affiliated. Most funds were too small to provide services, and contracted out to private clinics and hospitals, giving rise to a large private provision sector. Rather than promote efficiency and competition, however, this purchaser-provider split led to a chaotic and unaccountable system of contracting and sub-contracting (EIU 1998; World Bank 1997). In large measure, this was due to a virtual absence of state regulation.

According to the World Bank in 1997: '…the [Argentine] Government's long-term vision of health insurance –shared by the World Bank- is one of universal coverage of the population; a standard benefits package with a generous set of preventive and health services for every Argentine citizen' (World Bank 1997:22). However, by the early 1990s there was clearly a long way to go. It was widely accepted that, far from providing a sustainable financing strategy, promoting efficiency and the inclusion of the poor, the *obras sociales* were a significant source of social inequality and fostered a range of inefficiencies across the health sector. A large part of the population (essentially those without a close family member employed in the formal sector) remained unprotected, especially among poorer groups. In 1991 national coverage stood at 63 per cent, but more than half the population of the poorest province, Formosa, lacked protection (INDEC 1995). There was also considerable inequity between *obras sociales*, reflecting variations in the salaries of their different memberships: in 1994

average revenue per beneficiary varied from US$5 to US$80. A special fund which had been created to distribute revenue from richer to poorer funds was found to be doing the reverse (Lloyd-Sherlock 2000).

The organisational fragmentation of Argentina's SHI sector, with several hundred separate funds, was seen as a major source of inefficiency, as was the lack of competition between them. There are also indications that the *obras sociales* contributed to the poor allocation of resources across the health sector as a whole, whereby expensive, specialist therapies attracted much more finance than more cost-effective ones. According to the World Bank: 'It is widely acknowledged by Argentines that personal connections and corrupt practices, instead of quality and economy, weigh heavily in the award of capitated contracts and other payments to medical providers and suppliers, and this adds substantially to the inefficiency and high cost of health care in Argentina' (World Bank 1997:7). For example, poorly regulated contracts and general inefficiency in the sector led to high levels of spending on non-essential drugs and treatments (CPCL 2003). Data on service quality are almost non-existent, but anecdotal accounts suggest that this was very uneven, reflecting the different funds' varying revenue (World Bank 1997).

A more general criticism of Argentina's SHI system was that it had undermined the financing and development of a more universal publicly-funded model of health care. The 1940s and 50s had seen the development of an impressive national network of publicly-funded hospitals and other health facilities, under the aegis of the Ministry of Health (MOH). This had led to rivalry with the labour unions and the Ministry of Labour and Welfare, with each side aspiring to establish the dominant national health care system. Over the next decade it became clear that the SHI sector had won, and direct state funding to the MOH was scaled back and became more erratic. By the 1990s Argentina's publicly-funded health sector had suffered from decades of under-funding, leading to a significant deterioration of the quality of public provision (Stillwaggon 1998; World Bank 1997). As well as crowding out the development of the publicly-funded sector, the *obras sociales* had been able to capture substantial resources from it. Both the *obras sociales* and private insurers were permitted to send their affiliates to public hospitals, but in principle had to pay for these services. Large numbers of affiliates used the public sector, particularly for more expensive and complex

treatments, but hospitals were rarely reimbursed. This further reduced the resources available for uninsured Argentines.

Although the SHI system had succeeded in crowding out (and siphoning resources from) publicly-funded health care, by the 1990s its affiliates were becoming increasingly dissatisfied with the quality of care it provided, prompting the growth of private health insurance (Ahuad et. al. 1999). By 1997 it is estimated that 10 per cent of the population had private health cover, of whom four out of ten were also affiliated to an *obra social* (Vassallo and Sellanes 2001). Insurers varied in terms of size and the degree they relied on third party providers, and the sector was criticized for high operating costs and a lack of transparency (EIU 1998).

While the *obras sociales* were a source of inefficiency and inequity for Argentina's health sector, leading policy-makers of the mid-90s were more concerned labour costs. By 1995 SHI was funded by a 3 per cent wage levy on workers, and a 6 per cent levy on employers, with a further 5 per cent going to a separate insurance fund for pensioners (see below). Since the election of Carlos Menem in 1989, economic and social policy had taken a radically neo-liberal line, with the imposition of a new economic model (Navarro 1995). Policy-making had become dominated by a small circle of technocrats around the President, along with the Ministry of Finance, the World Bank and the IMF. In line with neo-liberal thinking, it was argued that breaking down the narrow monopolies of individual *obras sociales* and introducing competition would push down contribution levels. It was also argued that competition would boost efficiency by promoting a smaller number of larger funds and would improve overall service quality.

In 1995 the MOF, with financial support from the World Bank, proposed the introduction of full competition in the SHI sector, by giving workers the freedom to join the *obra social* or private insurer of their choice. Despite the concentration of power in the MOF and its success in pushing through reforms in other areas, union resistance was able to delay and dilute these proposals (Montoya and Colina 1998). *Obra social* affiliates were only given very restricted rights to transfer between funds and direct competition with private insurers was blocked. The limited extent of reform reflected the differing priorities of the MOF and the unions. For the MOF, SHI reform had a lower priority than issues such as pension privatisation. By contrast the *obras sociales* were the main source of revenue for most labour unions, and so they were loathe to give

ground. There are indications that the MOF used the threat of a more thorough SHI reform as a means to achieve other objectives (Acuña and Chudnovsky 2002). In any event, MOF was able to achieve its objective of reducing labour costs without introducing competition: in 1995 employer contributions were cut from 6 to 5 per cent, representing a loss of US$ 3.8 billion for the sector between 1995 and 1999 (Ventura 2000). This compares to employer contributions of 9.25 per cent in Costa Rica's health insurance scheme, calling into question the Argentine government's commitment to a sustainable funding base.

It is clear that the reform process was driven more by concerns about labour costs than concerns about the effect of SHI on the health sector itself. No suggestion was tabled for breaking down the long-standing division between SHI and the publicly-funded sector, and no obvious steps were made towards extending coverage. Regulation of the sector remained largely nominal, despite the creation of a new supervisory entity. One exceptional area of potential progress was legislation which required, for the first time, that all *obras sociales* comply with a minimum package of services (at an estimated cost of US$40 per person per month). It was hoped that this would improve the quality of provision and foster the progressive redistribution of funds between richer and poorer *obras sociales*.

Overall, the reforms of the 1990s did almost nothing to improve the performance of the SHI sector; indeed, in many ways they made matters worse. The sector remained highly fragmented: in 2003 there were still 271 *obras sociales*, of which 196 were theoretically still run by labour unions (INDEC 2005). Many of these funds had started to contract out their administration to private firms, and in some cases they effectively served as fronts for private insurers. As such, the SHI was becoming gradually privatized, but in a context of continued monopoly and weak regulation. Between 1991 and 2001 total health insurance coverage (including private protection) fell from 63 to 52 per cent of the total population (INDEC 2005). In the poorest province of Formosa coverage stood at only 34 per cent. The curative bias of the health sector as a whole also worsened during the 1990s, encouraged by an exchange rate policy which artificially reduced the cost of imported drugs and medical equipment. Between 1990 and 2000, it is estimated that spending on drugs increased 80 per cent (CDSAMA 2002).

The economic collapse of 2001 had a disastrous impact on the *obras sociales*, with some reporting a fall in revenue of over 40 per cent. Early in 2002 as part of an

emergency health plan, employer contributions were restored to 6 per cent. The basic healthcare package was revised, although information about its new notional value in per capita terms is not available. In 2002 the Health Minister admitted that all *obras sociales* were able to flout the terms of minimum package with complete impunity (La Nación 13.3.02).

The long-term problems of the *obra social* sector and the failure of reforms during the 1990s offer a sobering alternative to the relatively successful case studies which are currently informing international debates on SHI. However, Argentina also includes an even more worrying example of the damaging effects of poorly conceived SHI funds. PAMI (*el Programa de Atención Médica Integral*, Integrated Health Care Programme) is a dedicated health insurance fund for pensioners, broadly comparable to Medicare in the USA. Services are funded through a combination of wage levies and a tax on pension benefits. Like the *obras sociales*, PAMI is essentially a financing entity, contracting out service provision to private, and less frequently public, providers. By the 1990s PAMI had an annual budget of over US$2 billion, and covered around three and a half million people. Though PAMI was notionally a non-state entity, its directors were usually political appointments, and they often mobilised PAMI's resources to further their own political careers (Lloyd-Sherlock 2002). PAMI remained almost entirely unaccountable to the general public, and was not required to demonstrate where the funds for new commitments would come from.

By 1994 it was apparent that PAMI faced serious financial difficulties, with a gap between annual income and expenditure of US$ 400 million. This shortfall was initially covered by emergency transfers from the Treasury. Despite this, the Menem government reduced the wage levy from two to one per cent, compounding the effect of falling formal sector employment on its contributions base. Since then, PAMI has continued to receive substantial subsidies from the federal government, as well as loans from the National Social Security Administration

The mid l990s saw widespread claims of corruption and political patronage within PAMI, including over-invoicing and the inclusion of large numbers of ‘ghost workers’ on payrolls. One study identified 26 different categories of corruption in PAMI during the late 1990s (Bonvecchi et. al. 1998). As a non-state entity, PAMI had been shielded from public scrutiny, but it was heavily exposed to political influence. A labyrinthine system of contracts with service providers created opportunities for malpractice. Not

surprisingly, the data (such as they exist) suggest low levels of technical efficiency, and gaps between services promised on paper and actual delivery of them (Redondo 2004).

Efforts to reform PAMI involved cutting staff, reducing services, restructuring contracts, and improving internal controls and regulation. These have received substantial inputs from the World Bank, both in the form of advice and loans. However, there is little sign that significant progress was made (Cervellino et. al. 2003). By the end of 2000, estimates for PAMI's accumulated arrears ranged from US$1.8 billion to US$ 4 billion, depending upon interpretations of existing contractual obligations and the degree to which creditors had written off outstanding debts. No progress has been made in improving the administration and accountability of PAMI. Over-invoicing and other contractual irregularities continue to be widespread, and some employees remain grossly overpaid (La Nación 3.7.03).

Reforming PAMI was a high priority for the MOF, as well as for the World Bank. Their inability to make significant headway reflected the lack of an obvious alternative for financing pensioner health care, and the impact of key interest groups. It is also strongly indicative of the wider failures of governance in Argentina. Political elites continued to use PAMI as a source of patronage and plunder. Private drugs suppliers and clinics also had an interest in preserving the *status quo*. PAMI paid well above real market rates for private services, purchasing expensive drugs and services more often on the basis of private profit than real need (Bonvecchi et. al. 1998).

Mexico: inequitable extension.

The *Instituto Mexicano del Seguro Social* (IMSS) was set up in 1943, the same year the Ministry of Health was established. In 1959, a separate social insurance fund was set up for state workers, the *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado* (ISSSTE). Unlike Argentina's *obras sociales*, both these agencies provide health services themselves, rather than contracting out. When medical personnel are included, IMSS employed a total of 360,000 people in 2001. By 2003, IMSS covered around 40 per cent of the population, ISSSTE 7 per cent, and private insurers around 2-3 per cent (Frenk et. al. 2005). As in Argentina, the unprotected population was disproportionately poor, with coverage of only 10 per cent for the poorest income quintile. For those lacking insurance, services were provided by the Ministry of Health, through a combination of federal and state funding, along with

substantial out-of-pocket payments by the patients themselves. Despite accounting for over half the population in 2003, the uninsured accounted for less than a third of federal health spending. Moreover, the allocation of federal spending across states was very uneven, varying fivefold in per capita terms (Frenk et. al. 2005).

Since the early 1990s IMSS had faced growing problems of financial sustainability. Worker and employer contributions had originally been set when dependents were not entitled to health benefits. When coverage had been extended to dependents there had been no rise in contributions. This, and rising health expenditure per capita (due to factors such as demographic change and changes in the range of services on offer) had taken IMSS into deficit as a social health insurance fund, with balance maintained through the transfer of large sums from the Institute's pension funds. This had been a major factor in the depletion of these pension funds, prompting calls for a pension reform, whereby pension administration would be placed in the hands of a new, separate entity. There were also growing concerns about IMSS's efficiency as a health service provider. This could be seen in various ways. The Institute's overall administration costs were higher than those of similar programmes in almost any Latin American country. Impressively, those of ISSSTE were even higher, reaching 33 per cent of its total budget in 1991 (FUNSALUD 1994). The costs of an initial consultation with a family doctor in IMSS were roughly double those of the publicly-funded sector, and varied fourfold between different health districts. Nor was the Institute viewed as a paragon of good governance: a survey conducted in the late 1990s reported that Mexican businesses ranked IMSS as one the most corrupt institutions in the country (Morris 2003).

Just as in Argentina, the early 1990s saw an ambitious set of reform proposals, which reflected the government's wider neo-liberal agenda. Again, the main momentum for reform came from the Ministry of Finance, the Presidency and the World Bank, with the federal Ministry of Health playing a marginal role. According to González-Rossetti: 'It [the IMSS] was perceived as a major state enterprise that had to be made more efficient, possibly with the participation of the private sector. (González-Rossetti 2004:72). In early 1995 a sweeping reform package was presented as part of a National Development Plan. Along with the separation of the IMSS's pension and SHI functions, the Plan advocated that worker and employer contributions to the Institute be cut and state contributions be increased, as it was argued that this would stimulate formal sector

employment and the economy in general (González-Rossetti 2004). The increased state quota would cover both the reduction in worker/employer ones and the loss of revenue from the pension funds, this providing the basis for financial sustainability (Durán-Arenas et. al. 2000).

While new government funds were no doubt very welcome new for the Institute, various other reforms included in the Plan were less attractive. These sought to introduce a degree of competition into the SHI system and to end IMSS's total monopoly of provision. It was also proposed to take a step towards separating IMSS's purchasing and provision functions by creating new contracting agencies, which would eventually lead to an internal quasi-market within the Institute. IMSS patients would be permitted to choose their own doctors for services provided at the primary health care level. More significantly, employers would be entitled to opt out of IMSS altogether, providing health insurance through private funds. Finally, IMSS would be required to contract out to other agencies for services which it was deemed to provide inefficiently (Gómez-Dantés, et. al. 2004).

The bill as eventually passed was limited to the changes in funding arrangements, without most of the less palatable marketisation reforms. Under the new funding arrangements, direct government transfers would cover 33 per cent of IMSS's budget, with 67 per cent coming from employers and workers. Previously, the respective shares had been 4 and 96 per cent. Clearly, this represented an enormously regressive step. Its relative ease of passage through Mexico's Congress demonstrates the limited extent to which uninsured groups are represented there.

The failure to implement the other reforms was largely down to the strength of IMSS's union and its commitment to resist them –it was even able to get its own man as head of the World Bank-funded change team (González-Rossetti 2004). As in Argentina, it also reflected the high priority given to separating out the pension and SHI system, which was to take precedence over less financially pressing reforms. Following the passage of the 1995 reform further changes to the IMSS became even less of a priority for key policy-makers. Despite occasional proposals to resuscitate the opt-out, the Institute has been able to maintain its monopoly position, almost entirely unchallenged. Since then, IMSS has been subjected to a limited process of decentralisation, possibly as an effort to deconcentrate its power and to open up more

possibilities for competition in the future. However, this process remains slow and somewhat obscure.

Little published information is available about efforts to reduce corruption and promote accountability in IMSS, reflecting the extreme sensitivity of this issue in Mexico. Only in 2001 did legislation require for the first time that the Institute publish a full set of accounts. In 2005 the Federal government's Anti-Corruption Committee (*Comisíon Intersecretarial para la Transparencia y el Combate a la Corrupcíon*) introduced a special anti-corruption programme for the Institute. While admitting that IMSS had a history of widespread contracting and servicing irregularities, the Committee expressed the hope that new reporting systems would end such practices (Oficina de la Presidencia para la Innovacíon Gubernmental 2005). However, no other external evaluations of the IMSS's accountability have been permitted. Available data indicate that IMSS continues to be inefficient, encouraging an emphasis on costly curative services, rather than prevention and health promotion (Frenk et. al. 2003).

A key point of difference with Argentina is that Mexico has seen a number of high-profile initiatives to extend health insurance coverage. These began in 1979 when IMSS was made responsible for managing, but *not funding*, a new non-contributory programme known as IMSS Solidaridad (Laurell 2001). This programme was intended to provide primary health care services for the rural poor, and was run separately from the Ministry of Health (Gómez-Dantés 2000). IMSS's managerial involvement in this programme, along with the programme's name, may have done much to obfuscate the exclusion of those outside the formal sector from IMSS's financial resources[3]. Another example of this obfuscation can be found in the term most widely used to refer to those protected by IMSS –"*derechohabientes*" ("those with rights")-which suggests that other groups do not hold any rights.

As in Argentina, the proportion of population employed in the formal sector of the labour market fell during the 1990s. As such, it was argued that the best prospects for extending social health insurance would lie in establishing a separate, more limited scheme for those who currently lacking protection. Two initiatives have sought to do this, a Family Health Insurance scheme (introduced as part of the 1995 reform), and a Popular Health Insurance (PHI) scheme introduced in 2004.

[3] Laurell (2001), a strong supporter of the IMSS, argues that through its combined SHI and Solidaridad schemes the Institute represented a pillar of national social solidarity.

The Family Health Insurance scheme offers uninsured families access to IMSS services in return for a single annual payment of US$100-250. Based on typical patterns of service utilisation, it was estimated that an additional government subsidy of around US$110 would be needed to ensure the scheme's financial viability. It is claimed that the new scheme had some impact, extending social insurance to 2.5 million individuals by 2000. However, the amount of the annual payment meant that the scheme had a negligible effect on the poorest, and further extensions of coverage are not expected (Gómez-Dantés et. al. 2004).

Popular Health Insurance (PHI) was introduced in the subsequent administration. The proponents of the reform claim that it is expected to provide a limited form of health insurance to the entire unprotected population by 2010 (Frenk, et. al. 2005). PHI is to be funded from three sources. First, the federal government is committed to providing each affiliated family with an amount fixed at 15 per cent of the minimum wage (currently around US$259 a year). Second, a joint contribution is to be made by the federal and state government, on a two to one ratio, whereby the federal contribution is weighted towards poorer provinces. Third, families enrolled in the PHI are required to contribute up to 5 per cent of disposable income, although those in the poorest two income deciles are exempted a monetary contribution, so long as they comply with: 'participation rules associated with health promotion' (Frenk et. al. 2005:10). This draws on Mexico's tradition of incentive-based welfare schemes such as PROGRESA (see chapter by Molyneux in this volume).

Advocates of the PHI reform argue that a key driver of extended coverage will be the direct linking of federal contributions to state governments to the number of families affiliated in the scheme (Frenk et. al. 2005). It is argued that this will lead to a more equitable distribution of federal funds across states than occurred in the past. There are also incentives at the household level: although affiliation is voluntary, unaffiliated families will be required to pay user fees from 2010. PHI should be considered a hybrid of social insurance and financing through general taxation. Many aspects of its design bear comparison with a subsidised health insurance scheme set up in Colombia in 1995 (Trujillio et. al., 2005). However, a key point of difference is that Colombia does not also provide large subsidies to formal sector workers.

Evaluations of the PHI have only been conducted by the reform's designers, and these are unsurprisingly upbeat. According to official data, during 2005 affiliation grew

by around 1.5 million families, 90 per cent of whom were in the poorest income quintile (Frenk et. al., 2005). It is likely that non-poor households who are required to make a contribution will be more reluctant to join the scheme. More generally, the scheme depends on effective targeting of poor households, but this has been impossible to achieve for other targeted welfare programmes. The administrative challenges and costs of assessing household income and ensuring that the 5 per cent contribution is collected should not be under-estimated.

The reform has required a substantial increase in the Federal Ministry of Health's budget (by over 50 per cent, 2002-5), although less spectacular progress has been made in targeting the Ministry's spending on the PHI. Between 2001 and 2004 the share of spending going to the PHI and the uninsured only grew from 33 to 35 per cent, suggesting that a large part of the Ministry's budget increase must have gone elsewhere. While any increase in state funding for uninsured Mexicans is welcome news, the question remains whether the government will be willing and able to guarantee the necessary further budget increments. To a large extent, this will be determined by the country's more general fiscal position, which is not easy to predict. The outcome of the 2006 presidential elections may also increase doubts about PHI's long-term future, given a tendency of new Mexican administrations to dismantle initiatives set up by their predecessors. A simple means to reduce government spending on the PHI would be to allow an inflationary devaluation of the minimum wage.

Given its brief life, the long-term prospects for the PHI are difficult to gauge. Many aspects of its design are admirable, particularly those aimed at promoting a more equitable allocation of federal funds across states. Yet, the reform is premised on the continuation of more privileged social insurance funds for more privileged groups of workers. Whilst providing the poor with a modicum of social insurance is no bad thing, this does not break down the inequitable divisions of entitlement between formal sector workers and those enrolled in "cheap and cheerful" funds. Indeed, it may further enshrine them. As in Argentina, no progress has been made in challenging the fundamentally inequitable basis of social health insurance, which is the very antithesis of the solidarity principles such schemes espouse. Were the enormous federal subsidies paid to the IMSS and ISSSTE channelled into the PHI, the resources would be available for a sustainable programme, offering a reasonable range of services to Mexicans in general.

Lessons

Argentina and Mexico contain a range of SHI funds with different attributes: large-scale funds which combine provision and financing (IMSS and ISSSTE), fragmented funds which contract out (*obras sociales*), a specialist fund for pensioners (PAMI) and a fund designed for informal sector workers and the poor (PHI). Despite this variety of institutional structure, the development of SHI in Argentina and Mexico is strikingly similar, as have been recent efforts at reform. In both countries, large funds were established several decades ago, as part of corporatist regimes' efforts to foster legitimacy with formal sector workers. Initially, it was hoped that coverage would expand, along with the growth of the formal workforce, but levels of informality and exclusion remained high. Instead, SHI led to the crowding out of publicly-funded health care, through the formation of rival administrations and by reducing the stake of insured groups in supporting high quality universal services. This led to a segmented model of financing and provision with different levels of protection for different socio-economic groups. Over time, SHI funds became increasingly unsustainable and reliant on state bale-outs. The available data also indicate high levels of corruption and inefficiency.

During the 1990s both countries saw efforts to reform SHI schemes in a context of wider neo-liberal restructuring. Other than reducing employer contributions, however, little progress was made. This reflected the importance of SHI to labour unions and their power to resist change, as well as the power of the SHI institutions themselves. This indicates the difficulty of changing the structure of SHI schemes once they are established, regardless of their inefficiency and inequity. In neither country were proposals tabled to unify SHI with publicly-funded health care financing and provision: the reform which would probably do the most to improve the overall performance of their respective health sectors.

The only significant point of difference lay in Mexico's efforts to include poorer groups in various forms of SHI. There are several possible explanations for this. First, SHI coverage had historically been somewhat lower in Mexico, increasing the profile of the problem. Second, unlike the *obras sociales*, the IMSS is a state welfare agency, and it is therefore to be expected that it would take some responsibility for uninsured groups. Thirdly, and somewhat cynically, it may be that extending coverage was necessary for justifying the huge increase in direct state funding for the IMSS. Indeed,

the regressive impact this increase will have greatly outweighed any benefits from providing some poor people second class insurance.

Taken together, the Argentine and Mexican experiences provide an important counterweight to the optimistic assumptions made by international advocates of SHI and their tendency to cherry-pick supposed success stories. A key point is the similarity of each case, indicating that these are not one-off examples, but representative of wider experiences in Latin America and beyond. For example, many of IMSS's problems are comparable to those of Indonesia's social insurance scheme for state workers (Lloyd-Sherlock and Schröeder-Butterfill, 2005). These negative experiences do not mean that SHI will inevitably be disastrous wherever it is implemented, but nor do a handful of more positive stories signal SHI's universal virtues. Indeed, even the "success stories" hold some worrying lessons for Latin America: following the 1997 Crisis, South Korea's vaunted SHI programme generated substantial deficits, requiring a bale-out from the International Monetary Fund (Lee, 2003). Thus, whilst carefully designed SHI schemes may be in theory of *some* value in *some* developing countries, the question remains why more effort cannot be put into fostering sustainable state-funded universal services. Or should this be considered a lost cause?

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