OICH
Observatório Internacional
de Capacidades Humanas,
Desenvolvimento e Políticas Públicas

International Observatory of Human Capabilities, Development and Public Policy

Recent Trends in Social Policy in Latin America

Studies and Analysis

3

Universidade de Brasília
Centro de Estudos Avançados Multidisciplinares
Núcleo de Estudos de Saúde Pública

Fundação Oswaldo Cruz
Diretoria Regional de Brasília
Núcleo de Estudos sobre Bioética e Diplomacia em Saúde

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Brasília-DF, Brasil
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Summary

Presentation

The third edition of the International Observatory of Human Capabilities, Development and Public Policy (OICH) focuses on the recent evolution of public policies in Latin America, with emphasis on specific thematic areas such as work, education and social security. This focus is justified by the concern to identify increases in social inequalities in the different countries and their negative repercussions on the health conditions of the population.

Piketty's and other authors' studies have accumulated evidence that income inequality has increased in many countries from the repercussions of the 2008 global economic crisis, albeit at a different pace in each country. The concentration of national income appears as a substantial aggravating factor in the vulnerability of social conditions of life. In Brazil and other countries in the region, the country's 10% richest account for nothing less than 55% of national personal income. In this context, the role played by national states in counteracting the negative social effects of the crisis becomes a priority for all those concerned with public policies in Latin America.

Since Amartya Sen's concept of human capabilities refers to the totality of people in a country, and not just workers in the formal economy or the high tech industries, the discussion about study results cannot be limited to showing that the material living conditions of citizens have improved and the economy has become, for example, more productive, diversified or rich. The perspective of justice implied in the theory of human capability is duly attended only when there is evidence that economic and social development is occurring with the creation of a plurality of lifestyles freely chosen by people.

In this context, one must ask, in a very pertinent way, if capitalist development, as it has been happening in Latin America and other continents, does not inevitably impose certain standardized, controlled and "socially reduced" styles of living in society, where the disclosure of the freedom

horizon promised by Sen's theory becomes extremely restricted. It seems that this horizon is often, in many countries, definitively not possible by the style of development imposed unilaterally by the state, a phenomenon that can occur both in authoritarian and democratic regimes.

Several scholars of the world economy have stated that the crisis that began in 2008 is much more serious and profound than previously thought. It is not a mere cyclical and temporary inflection of capitalism on a planetary scale, but it has a decisive character which can give rise to a much crueler world economic order for a large number of peoples.

The so-called inclusive growth in Latin America has not yet become a fact that can be proven as an important and definitive conquest of democracy. More than ever, it is necessary to evaluate whether there has not been a defeat simultaneously due to the advance of the higher income groups, that is, of the inequalities at the top.

Roberto Passos Nogueira

Guilherme C. Delgado

Health Conditions in Unequal Societies of L.A.: Recent Evolution of Public Action

Ph.D. in Economics at UNICAMP (1984), IPEA researcher from 1976 to 2007 and currently the director of the Brazilian Association for Agrarian Reform (ABRA).

Health Conditions in Unequal Societies of L.A.: Recent Evolution of Public Action

Guilherme C. Delgado

1. Introduction

The title of this text is preliminarily a proposal for thematic fusion of seven texts, elaborated explicitly for this collection, according to a common Term of Reference, which declares as general objective:"[...] the elaboration of specific studies on the political and socioeconomic situation in Latin America from 2010 onwards and its real and potential repercussions on the health conditions of the population of this region".

Using this general reference, the authors selected very different approaches, which, for didactic purposes, would distinguish three approaches to the living conditions of the populations, according to the different focuses – of development and public action in social policy.

A first group of papers approaches the historical-structural approach of development and public action in the respective health systems and the labor relations of the population, showing different lines of adherence to the change in the conditions of inequality and poverty. This analysis, with different degrees of depth, presupposes the social determinations of health conditions as causal factors of the health conditions of the national populations, generally affected by social inequality.

There is a second group of papers that choose the access and performance approach to two systems of great democratic repercussion – the fundamental education system and the social security system, assessing the conditions of proportional access of the population to these systems and the effectiveness of their respective functionalities, as criteria for reducing social inequalities.

A third approach is centered on distinct conceptions of government action, somehow autonomous from the social policy systems mentioned above, but anchored: a) in cash transfer programs, subject to conditionality, focused on the poverty line; b) in strategic actions of intelligence in health or 'for health'.

This pre-classification of the three groups is purely didactic, since in all three groups the authors are aware of the limitations of isolated public actions under any of the three approaches. Particularly in the third group, the authors are aware that the isolated actions of cash transfer programs are not capable of reversing structural situations of poverty and inequality; as well as in the specific text *Human security and intelligence in health*, I do not see the dilution of the public health system within the intelligence system, but apparently a new structuring of health planning to face particular and multiform situations of serious chemical, biological, radiological and nuclear (CBRN) risks to public health.

2. Synthetic exhibition on the works presented

2.1 Historical-structural approach

The first working group contains the following texts:

> i) *Recent trends in social policies in Latin America*, by Ph.D. Félix Rígoli, of USP;
> ii) *Health systems in Latin America in the 21st century*, by Ph.D. Eduardo Levcovitz and Ph.D. Maria Helena Costa Couto, researchers at the Institute of Social Medicine at UERJ;
> iii) *Labor market trends in Latin American: from developmentalism optimism to the failure of liberalism*, by Ph.D. José Celso Cardoso, researcher at IPEA, and S.M. José Carlos dos Santos, researcher at the Federal University of São Carlos.

Despite the differences in the focus of these three studies, the common factor is the diagnosis of the structural inequality of Latin American socioeconomic conditions as a negative determinant of health conditions and general well-being of the population.

The first work assumes it explicitly since the introduction – socio-economic inequality as an effective cause of health conditions. From this observation, it infers that only universal public systems, based on rights and provisioned in public budgets with resources that come close to an international standard of 6% of GDP could effectively act by reversing some structural conditions and some causal factors responsible for social grievances to human health.

The author makes the necessary conceptual differentiations of *universal systems* based on social rights, distinguishing them from *universal coverage*, based on multiple public-private advances in care, and *universal access* (100%) to some specific public health care.

The conclusion is that the structural inequalities persist for the majority of countries analyzed, even in the specific case of Brazil, with its universal public system since the 1990s – although mitigated by the Unified Health System (SUS) in the Brazilian case, albeit insufficiently, due also to visible signs of underfunding of the system, in order to reverse social inequalities through health actions. The very underfunding of the system, which ultimately disfigures it from its universal claims, is a consequence of economic inequality that is trying to be reversed.

The second paper from this first group – *Health systems in Latin America in the 21st century* – is part of a historical analysis of the assembly of social security and public health systems in Latin America from the 1920s to the 1980s/90s of the last century to characterize them under three aspects of inequality: 1) segregation and population stratification (class, income, professional status), associated or not with state social security systems; 2) segmentation of the population into groups with different conditions of access to services; 3) operational fragmentation, with overlapping of service offerings and/or lack of coordination of care facilities.

A movement contrary to this historical tendency occurred in the 1980s and 90s of the last century, with the sanitary reforms of the time or earlier, of universalistic inspiration in Brazil and Costa Rica and/or socialist in Cuba and Nicaragua, later benefited by a pink tide of center-left governments in the 2000/2015 period. But this movement had already been constrained by the initiatives, the programs to focus on the poverty line and institutional underfinancing, and by clear signs of a return to the patterns of inequality

and poverty that preceded the so-called Latin American pink tide. The result is the worsening of the indicators, from 2015/18, on poverty and inequality, which, although implicit in the author's argument, are not explicit in his work.

The third paper, written by José Celso Cardoso and José Carlos dos Santos, *Labor market trends in Latin American: from developmentalism optimism to the failure of liberalism*, shifts the focus relatively towards the health systems, because it deals with labor markets. However, the historical-structural approach and the diagnosis of the structural heterogeneity of the labor market and the external dependence of Latin American economic systems are crucial for the typology that it establishes, very useful to the perception of the different styles of public policy:

> a) countries of dependent and regulated capitalist development, with moderate heterogeneity;
> b) countries of dependent and naturalized capitalist development, with intermediate structural heterogeneity;
> c) countries of dependent and contested capitalist development, with severe structural heterogeneity.

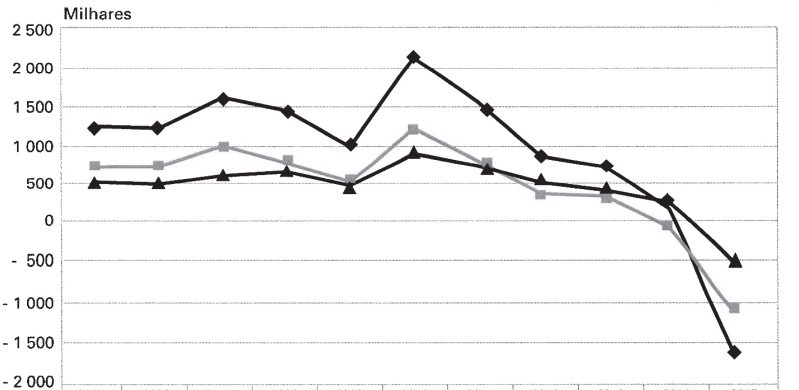
There is an implicit dialectic in this typology, marked by the degrees of external dependence and structural heterogeneity of the world of work, on the one hand, and on the other by national forms of self-assertion tending to contradict the forms of dependence and inequality.

This typology is used to characterize regional labor markets, all of them marked by different forms of structural heterogeneity, whether under the neoliberal labor relations reforms (Brazil and Argentina today), or under the impact of the external blockade that the experiences of external contestation are subjected to (Venezuela). Apparently, type "a" – dependent and regulated development, which experienced a favorable cycle in the years 2000/2014 – would be exhausted, provoking exacerbated indicators of unemployment and social deprotection.

From the analysis of the typology of dependence and heterogeneity in the world of work, whose main indicator is the formalization of labor relations as a sign of social protection by the State, although international statistics to allow comparison are not presented, there are visible and indirect indications of the worsening of situations in all countries.

The case of Brazil is typical for the region. After reaching a peak of formalizations of labor relations by 2013, with about 2/3 of the Economically Active Population (EAP) regulated by protected labor relations, the system rapidly regressed in the period 2015/2018 to high rates of open unemployment, from 12 to 13% of the EAP and/or high rates of informality, returning in a few years to the levels of the early 2000s, when only 43% of the EAP was formalized (see Table 2, attached, according to IBGE, 2016). This situation is marked in the most recent period by the intense process of deformalization of the labor force, revealed in Brazil by the General Register of Employed and Unemployed Persons (CAGED) until 2017 (see Chart 1).

Chart 1. Balance of employees in the formal labor market, by sex – Brazil – 2005-2015



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Total	1 253 981	1 228 686	1 617 392	1 452 203	995 111	2 136 947	1 566 043	868 241	730 687	152 714	(-)1 625 551
Homens	736 963	739 050	1 009 017	790 550	524 081	1 229 899	817 007	359 306	326 104	(-)91 052	(-)1 105 311
Mulheres	517 018	489 636	608 375	661 653	471 030	907 048	749 036	508 935	404 583	243766	(-)520 240

Source: Ministry of Labor, General Register of Employed and Unemployed Persons – CAGED.

2.2. Access and performance approach to social policy systems

The second group of works analyzed adopts the criterion of access to social policy systems, such as social security, and access (and performance) to basic education as implicit or explicit criteria for improving social equality. The texts are respectively: 1) *Trends in social security in Latin America*,

by researchers from IPEA Leonardo Alves Rangel and Matheus Stivalli; 2) *The evolution of access and quality of basic education in Latin America in 2010s*, also by researchers from IPEA – Paulo Roberto Corbucci and Regina Célia Corbucci.

The first text seeks to use the notions of coverage of the active workers in the social security systems, on the one hand, and, on the other hand, the coverage of the inactive (elderly) supported by social security or assistance systems, as indicators of insurance against incapacitating risks to work. The first category the authors call "insurance against contingencies and consumption smoothing". The empirical focus of this coverage, active between 2000/2015, for three specific years (2000, 2006 and 2015), for salaried and non-salaried workers, reveals a significant increase in social security affiliation in all 16 countries in the region, according to the source cited (Inter-American Development Bank). However, the evidence of a cycle of social security unenrollment from 2015 onwards is neither captured nor analyzed, given the predominant empirical/analytical adherence of the text until 2015.

On the other hand, coverage data on old age, which relies heavily on welfare actions, are also increasing in most countries, basically due to the access to benefits similar to the Brazilian Continuous Cash Benefit Programme, with no link to social security, but with some the conditions of poverty.

Finally, the conceptual non-distinction between the three social security systems – Social Security, Public-Sector Pension and Private Pension Plans – and its correlative empirical configuration hinders the understanding of the very meaning of access and its potential characterization in the sense of improving equality and/or social security, explicit in the title of the work. We will return to this issue in section III.

The second work, in turn, analyzes the access and quality of basic education as criteria for the improvement of social equality, and in general, uses data up to 2015, exceptionally until 2016.

On the other hand, the indicators of access to basic education reveal, in a general way, a clear expansion of the coverage between 2000/2013, a trend that remains even until 2016 for all age groups, all socioeconomic levels of the establishments, public and private schools, with few specific exceptions – only in the last age group (14-17 years) in some countries.

In addition, the levels of school access and school attendance reached in relation to the target population, around 90% or more, in the most populous countries – Brazil, Mexico, Argentina and Colombia – show values close to universalization.

On the other hand, the indicators of performance and quality of education, according to the respective school indexes of evaluation, although indicate less strong results, compared to those of school access, do not indicate a worsening of the quality in the standardized indices of performance in mathematics and national language.

There is no empirical information from the last two years – 2017 and 2018 – nor from the effects of the economic crisis on the educational system.

The empirical evaluation is clearly corroborative of improvement in social equality. The expansion of the educational system is associated with the movement of economic growth, driven by the commodity boom, but the effects of the reversal of this cycle either do not appear in the data or are not negatively associated.

2.3. Autonomous forms of social policy: focus on the poverty line and intelligence in health

The two works of this third block are elaborated somewhat autonomously in relation to the social policy systems analyzed in the previous groups – health, education, social security, social assistance and labor relations. The political actions are autonomous, but are complementary to the social policies organized in care systems, and are aimed at focusing on the poverty line and intelligence in health:

> 1 *Current trends in conditional cash transfer programs in Latin America,* by Tatiana Lemos Sandim, Ph.D. in Public Administration and Government by FGV-EAESP;
> 2 *Human security: intelligence in health informed by scientific evidence and human resources*, by Ph.D. Ulysses de Barros Panisset, profesor of Preventive Medicine at UFMG.

The first work does a kind of general identification of a category of programs – called Conditional Cash Transfer – that is focused to the poverty line, which has been greatly encouraged and recommended by the World Bank to Latin American countries for more than two decades.

Objectives, stated purposes, variabilities of these Conditional Cash Transfer Programs (CCTP) since the 1990s are duly recorded.

Probably the most significant and comparative information for a list of 16 CCTP in 16 countries of the region appears in a summary graph (in the case, Graph 1, entitled Annual investment as percent of GDP by CCTP/Country).

The proportion of resources involved varies from 0.2% to 0.5% of GDP in the period considered (2003/2016), except in Brazil, which, with its *Bolsa Família*, spent over 0.5% of GDP between 2007/2016, although this proportion has never reached one percentage point.

The coverage of the population involved varies strongly from a maximum of 25 to 30% of the population in the case of countries such as Brazil, Mexico and the Dominican Republic, to averages strongly concentrated in the range of 5 to 10% of the population, in the case of most countries of the region.

At the same time, the author emphasizes the need to maintain this category of programs and the insufficiency of these isolated programs, in order to improve the distribution of income and the sustained reduction of poverty itself.

Thus, it recovers the idea of social policy systems as a condition for the very effectiveness of the CCTP, whose conditionalities for educational access and/or public health presuppose the functionality and effectiveness of these systems.

The author is aware – and clearly values in her text – the integration of these CCTP in the framework of integrated social protection systems.

A second approach to this group, that of intelligence in health in response to serious challenges to human security, is the final text of this block.

The text is not presented like the others, with formal subdivisions that allow us to identify problems, concepts and methods used in the analysis and in the conclusions of the text.

In any case, by making an interpretation of the text, I would say that there is an implicit introduction (page 1 to the first paragraph of page 2), in which the author identifies macro-level problems in public health arising

from new chemical, biological, radiological and nuclear risks, known as CBRN. These risks have multiform implications on the concept of human security, which will appear in a kind of conceptual approach (p. 2).

The nature of these risks and the multiform grievance, which affect human health in a massive way, called CBRN risks, would justify the formatting and control of strategic intelligence in health actions (pages 4 and 5).

These strategic actions, such as preventive or corrective operations at events such as the Olympics and the World Cup, or the preventive actions – epidemiological, accident or even chemical contamination produced in the routine of economic systems – would depend on a certain planning strategy of intelligence in health.

The text is unclear about the scope of this planning, but apparently it would not apply to the routine of planning the public health system – perhaps to some actions with implications for human security, under the approach of the CBRN risks. Such planning would be under the political leadership of the central authority. It is to act in all detected dimensions, in every territory under threat. There is no more concrete example of this intelligence-health interaction in the functional-administrative sense nor of the explicit context of the specific risks to which the author refers.

Probably, the verbal presentation and interaction with the public will probably complement the text presented. We will return to this specific work in section III.

3. Interpretation of the set of approaches with complements by the author of this synthesis

The main theses in the three different approaches in which we divide the presented works contain, as expected, complementary and contradictory factors to face the implicit issue in the title of the work: the sense of public action in unequal societies of Latin America to face the health conditions of its populations.

Under the prism of the historical-structural approach, universal public health systems, while more effective in serving the majority of the population excluded from the circuits of private medicine, rely on a public funding base permanently under attack from the dominant interests of unequal political economy.

So not only the social policy system, such as the labor market and the very conceptions of development and equity, are constantly threatened by "reforms" contrary to the idea of equity. This implies a kind of permanent rotation of development styles for the typology of the naturalization of inequality.

However, what is implicit in the analysis of the universal health systems is the presupposition of the validity of a democratic order, condition to the maintenance of these systems and the guarantee of their forms of management and financing, attending the basic necessities, with public funding, which needs to grow and never stop or decrease throughout the region. This issue, which affects much more of a genuine sanity of public finances, is clearly inverted in the political and economic debate of so-called fiscal adjustment. So the permanent risk of social policies founded on principles of human development or the theory of basic needs of the population become reasons for attack or discredit in the political debate.

On the other hand, the access and performance theses of the other public social protection systems – basic education and social security – are also under double attack: the underfinancing of these social rights systems and the "reforms" towards "commodification" or mitigation of citizenship rights.

In the case of basic education, there seems to be greater consensus on equity improvements associated with access and performance. In addition, the connection of this thesis with the improvement of the conditions of life and health of the population is indirect, but incontrovertible.

On the other hand, in the case of social security, whose main function is to attend situations of disabling risks to work, the connection with health conditions and general well-being of the population is direct.

However, since the public funding base for universally serving a social security system based on social protection principles requires contributions from public budgets that are never inferior to those required for universal health, the unhealthy game of the distributive conflict of public finances is involved. Discourses and practices of fiscal adjustments are, in the first place, much more of an administrative restriction for the exercise of the right in the routine of the system and, second, in the line of privatizing or very restrictive reforms to the universal social security.

In this case, it is necessary to clarify to the reader that there are three social security subsystems, and not only a general social security system, of

which only social security, which in Brazil is called General Social Security System, has an explicit function of promoting social equity, in line with the concepts of the ILO on Social Security (Convention 102/1952).

The other systems – Social Security Regime of Public Servants (RPPS) and Private Supplementary Pension Scheme, names used in Brazil, but found in other Latin American countries – do not fit into the concept of social security according to the broad concept of the ILO:

> A protection that society provides its members through a series of public measures to compensate for the absence or substantial loss of income from work resulting from various contingencies, notably sickness, maternity, work accident, unemployment, disability and old age and death of the spouse, to provide families with health care and benefits for families with children. (2000, p. 29).

The other systems mentioned (RPPS) are linked to the peculiar ways that each state has to treat its bureaucracies in the concepts of the so-called bureaucratic estates. In turn, private pension, in the concept and in the forms existing in Latin America, has nothing to do with social security, functioning as a system of complementary financial savings, of defined contribution to public and private entities, but without benefits defined in general.

So, in order to link the idea of access to the system and/or the effectiveness of its benefits to social equality and general health conditions, this link would need to be made from social security rather than from the general notion of social security that carries endogenous inequality factors, which deserve specific analysis, but already escape the objectives of this work.

Finally, an interpretation and complementation of the last block, which we call *Autonomous forms of social policy*.

The so-called CCTP are conceived in their origin – the focus of social spending on the poverty line, empirically defined by the World Bank – as competitive with regard to social policy systems, which are considered fiscally very onerous.

Here we have what is at the heart of the distributive dispute with regard to the actual causes, for which we must resort to some enlightening empirical element.

If we use the concept that IBGE uses for the monetary benefits of social policies, plus benefits in kind, according to the statistical notions defined in Tables 1 and 2, we will see that, between 2000/2013, these benefits ranged from 22% to 24.8% of GDP. Even by withdrawing the net contribution of tax resources to finance the RPPSs, included in this IBGE statistic, we must admit that social policy systems – education, health, social assistance and social security (including unemployment insurance) –, offering monetary benefits and benefits in kind, complemented by the CCTP, offering monetary benefits, correspond to at least 1/5 of GDP. *Bolsa Família* in Brazil is about 0.5% of GDP. Hence, the conservative option is to replace social policy based on rights by programs focused on the poverty line. That is at the heart of the dispute over tax revenues.

On the other hand, if we read it differently, that CCTP play a complementary role in the direct approach of the poorest, probably not reached by the classic social security approach, as does the author of the text analyzed, we completely agree with the complementary character of these programs. However, the conservative approach is clearly another – in the line of replacing universal systems with minimalist focal actions or private service delivery systems rather than with public social rights systems.

Finally, the approach to new social risks, expressed through chemical, biological, radiological and nuclear (CBRN) threats, and its association with two distinct approaches – intelligence in health and centralized strategic planning for the prevention, correction and mitigation of these risks – is a very relevant approach, but at the same time still introductory to those not aware of the complexity of the subject in question, as the author of this synthesis.

Addressing the text under consideration, on the so-called CBRN risks, unlike the analysis of the initial texts of the historical-structural approach, the problems of political economy completely disappear. However, the approach to chemical contamination by pesticides or mineral waste necessarily goes through a political process, which is facing organized interests of agribusiness and mining complexes. Under such conditions, strategic health planning to prevent, correct or restrain serious chemical contamination in this field requires considering the political and ideological impact of the various actors involved in these agribusiness and mining systems.

In any case, the issue is relevant and the threats are real and growing, but issues of public awareness are necessary and essential to effective strategic planning for the prevention and correction of CBRN risks.

4. Final considerations

Health conditions, as well as living conditions in general, regarding what depends positively on public action, have entered Latin America, and in Brazil in particular, in an adverse phase. Even if the empiricism of some stylized indicators still does not reveal, many others already warn about the real living conditions of the population, so as not to leave us doubts about the degrading weight of unemployment and working conditions in general.

From the specific studies on health conditions, based on the whole of the social policy of the State, what can be seen and also inferred is the increasing dismantling of these devices, particularly in Brazil, under the protection of Constitutional Amendment 95/2016. In this context, public action for the improvement of equality gives way to other classic social entities, such as the family, organized civil society or explicitly the market.

There is clearly a political tendency to recover neoliberal revenues in social policies, and there the discourse of return to reforms with this profile is clear, with the explicit purpose of dismantling the social finance institutions of the Brazilian federal Constitution, now completing three decades.

However, we are not to be deluded: shadows that accumulate in perspective reveal the blockage of light, but not its absence.

New forms of social self-protection, social resilience, reconstruction, and innovation of structures that are being demolished for years are bound to impose new forms of social policy.

On the other hand, the historical experience revealed by the set of works examined on the universal policy systems and on specific government actions are, due to methodological allegiances strongly linked to observed phenomena, linked to the recent past, when the emergence of a cyclical upset clearly was still not configured. However, it is in this situation and on it that the majority of the grievances are placed to the health conditions of the population from now on.

The exercise of foresight and action for the future, in the face of a cycle of political economy very adverse to the society of citizenship rights, calls for the exercise of a dialectical rationality, beyond the rational instrumental approach that is typical of modernity.

We are probably experiencing the decline of a historical cycle, within which forms of self-protection of human society and forces of nature must occur to prevent us from the tentacles of social barbarism. Applying such reflection to health conditions can be dramatic and even tragic, because the antinomy of life and death, or the classic drives of the movement of the constitutive forces of healthy life and its opposite – degradation and death – take on clear signs of idolatry in social life, of cult to a certain necrophilia, also expressed in theological and political terms as a culture of death or idolatry of the gods of death.

Healthy life in the whole dimension of a true unitary and integral anthropology – physical, psychic and spiritual – is certainly a challenge that escapes the strictly scientific approach of the action systems of public action on health conditions, which is the theme of this collection, and therefore is not up for us to tackle here. However, let us not forget the fundamental anthropological unity of the human being, even to understand the seemingly inexplicable movements of history.

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Statistical annex

Table 1. Monetary social benefits to families and benefits in kind according to the percentage of GDP of social policy as a whole, Brazil – 2000/2009

Benefits \ Years	2000	2003	2004	2005	2006	2007	2008	2009
Gross domestic income	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00
1. Monetary social benefits (%)	13.59	15.09	14.59	14.98	15.46	15.28	14.91	15.65
2. Benefits in kind (%)	8.44	8.38	8.22	7.94	8.39	8.41	8.53	9.12
Total (1 + 2) %	22.13	23.47	22.81	22.92	23.85	23.69	23.44	24.77

Source: IBGE – Sistemas de Contas Nacionais – 2005/2009.

Table 2. Monetary social benefits to families and benefits in kind according to the percentage of GDP of social policy as a whole, Brazil – 2010/2013

Benefits \ Years	2010	2011	2012	2013
GDP	100.00	100.00	100.00	100.00
1. Monetary benefits (%)	14.64	14.74	15.01	15.23
2. Benefits in kind (%)	9.10	9.19	9.08	9.54
Total (1 + 2)	23.74	23.93	24.09	24.77

Source: IBGE – Sistema de Contas Nacionais – 2014/2013.

Table 3. Formal and informal labor market sectors, in demographic censuses from 2000 to 2010 (% of EAP)

Benefits \ Years	2000	2010	Pnad/Caged 2015/17
1. Formal sector (work linked to the public pension)	43.1	55.7	Decreases rapidly
2. Informal sector	54.4	40.9	Increases
Total (1 + 2)			

Source: IBGE, 2004, 2012.

Note: The formal and informal concepts used here are related to work and public pension (DELGADO, 2018).

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Labor market trends in Latin America: from developmentalism optimism to the failure of liberalism

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1. Introduction: structural dependence x national self-assertion

The history of Latin America has been marked, in general, by the critical disjunctive dependence with structural heterogeneity x national self-assertion. On the one hand, over time, there has been a reiteration of the structural features of (i) economic dependence, especially of a financial and technological nature, which reverberate in patterns of production and consumption derived from the dominant patterns at the international level, but unlikely to be extended to the totality of their domestic productive structures and of their populations; and ii) political dependence, ranging from a greater or lesser sense of relative independence to the US, which effectively controls the Latin American geopolitical board.

On the other hand, in turn, social actors and national voices of different shades have been alternating in time, with more or less presence and haughtiness (in terms of local political weight and occupation of symbolic spaces), in search of popular support and reasons (economic, social, political, and cultural) to counterbalance the notorious tendencies of subordination and external dependence, thus justifying calls for greater political freedom and economic autonomy to claim and construct alternative models of development, better aligned with emancipatory projects and national self-assertion .

All in all, it is clear that the pendulum of this critical disjunctive has historically fallen on the side of Latin American structural dependence,

vis-à-vis the universalization of liberal-conservative capitalism as the dominant mode of production and consumption in the region, and the tutelage (and sometimes imposition) of successive US governments on political models (authoritarian or moderately democratic) considered acceptable from the empire's point of view.

This means that Latin American social performance has been a function of a variable combination, country by country, between a more or less dependent capitalist dynamic, on the one hand, and, on the other hand, an equally variable ideological domination in political and cultural terms. It is, therefore, under this more general institutional arrangement that one can observe the specific national cases and their endogenous variations.

In 2000, for example, it was possible to verify the existence of at least three regional variants, as shown in Table 1: (i) countries such as Brazil, Uruguay and Argentina presented, especially until the international crisis started in 2008, trajectories of dependent capitalist development, but minimally regulated by the respective national states; (ii) countries such as Colombia, Mexico, and Chile, in turn, would have shared a type of capitalist development dependent on and naturalized by the explicit supremacy of the market; and (iii) countries such as Venezuela, Bolivia, and Ecuador would have shared a type of dependent capitalist development, but contested by specific national attempts to confront and construct their own alternatives appropriate to structural dependence and ideological domination under way (GARCIA; CALVETE, 2015).

Table 1. Latin America – groups of countries according to the type of capitalist dependence, years 2000

Dependent and regulated capitalist development	Dependent and naturalized capitalist development	Dependent and contested capitalist development
Brazil, Uruguay, Argentina	Colombia, Mexico, Chile	Venezuela, Bolivia e Ecuador

Source: Elaborated and adapted by the authors, from Garcia and Calvete (2015).

According to the classification above, it is possible to regroup the different Latin American realities, considering the relative position of each

country according to the degree of structural heterogeneity of their economies, measured according to the methodology and typology of classification proposed in ECLAC studies (INFANTE, 2011; ECLAC, 2012b), from which we derived Table 2.

Table 2. Latin America – groups of countries according to the degree of structural heterogeneity, 2000

Moderate structural heterogeneity	Intermediate structural heterogeneity	Severe structural heterogeneity
Argentina, Chile, Costa Rica, Mexico, Uruguay	Brazil, Colombia, Panama, Venezuela	Bolivia, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, Peru, Dominican Republic

Source: Elaborated and adapted by the authors, from Infante (2011).

According to this classification, it can be seen that in Latin American countries the incorporation and internal diffusion of technical progress have not occurred in a generalized or homogeneous way. This means that the degree of structural heterogeneity – that is, the differences between the various productive strata in terms of the total productivity of the factors of production, as well as the importance of the activities they carry out and the number of jobs they generate – is higher precisely in the countries with low production capacity and technological diffusion, as a consequence of the precariousness of the productive relationships and chains between the existing economic sectors.

Obviously, the level of structural heterogeneity of economies is related to countries' economic and social performance. In this way, the higher the proportion of workers employed in activities of low aggregate productivity, the greater the heterogeneity of a country and vice versa. The consequence of these differentiated productive dynamics is that both GDP per capita and GDP per employed worker tend to be structurally smaller and more unstable in more heterogeneous countries.

Both approaches suggested above on how to analyze and classify Latin American countries, it's clear that both the capitalist economic dynamics and

the political-institutional attitude of each country are important to explain their historical trajectories and aggregate performance in the pendulum between structural dependence and national self-assertion, as suggested in Table 3 below.

Table 3. Latin America – groups of countries according to the dependence-heterogeneity relation

	Moderate structural heterogeneity	**Intermediate structural heterogeneity**	**Severe structural heterogeneity**
Dependent and regulated capitalist development	Argentina, Uruguay	Brazil	-
Dependent and naturalized capitalist development	Mexico, Chile, Costa Rica	Colombia, Panama	El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, Peru, Dominican Republic
Dependent and contested capitalist development	-	Venezuela,	Bolivia, Ecuador

Source: Elaborated and adapted by the authors, from Infante (2011) and Garcia and Calvete (2015).

Based on this disjunctive is that the rest of this article is organized. After this brief introduction, Section 2 reasons out the central hypothesis of the study, Section 3 describes the recent behavior of some of the main labor market variables for Latin America, Section 4 does so in terms of the labor reforms carried out since the 1990s and sections 5, 6 and 7 detail the Latin American situation based on issues raised by the (in)formalization, social (de)protection and concentration vectors versus income distribution in the developmental and liberal phases already experienced in this XXI century. Finally, in the final considerations, we point out ways for a possible mitigation of the current crisis amid the disjunctive structural dependence versus national self-assertion of the Latin American peoples.

2. Traces of dependence and heterogeneity in the Latin American world of work

Leite (2012, literal translation) is right when he states that "unlike the more optimistic predictions professed especially by the defenders of neoliberal principles and followers of single thinking, globalization was not the solution to all problems. On the contrary, it has brought a host of new problems, including to the developed countries". This means that both capitalist dependence and structural heterogeneity have increased in Latin American countries in recent years, "making analysis of the whole more difficult" (Ibid.).

On the one hand,

> the reality of the Mercosur countries contrasts strongly in social terms with that of countries that continue to follow the neoliberal model, such as Chile (where income concentration has been increasing significantly), Colombia (which is experiencing an ongoing process of social and labor precarization), and above all Mexico, which, because of its dependence on the United States, has been undergoing an intense process of labor market disruption. (Ibid., literal translation).

On the other hand,

> unlike what the neoliberal ideology has always proclaimed, these reflections point to the centrality of the role of the nation-states in the elaboration and implementation of policies that may be fundamental to the destiny of the countries of Latin America. In fact, it was the deliberate intervention of the State in seeking alternative policies to those advocated by the Washington Consensus, which allowed for the inflection of the model of development and the framework of labor market disruption experienced by the Mercosur countries throughout the 1990s. (Ibid., literal translation).

In line with the cited author, Cardoso Jr. and Campos (2013, p. 115) had also stated that,

> after at least two decades (1980s and 1990s) of great political instability, strong economic fluctuations and remarkable social deterioration in virtually all Latin American countries, the end of the first decade of the 2000s brought new life to the region in the political, economic and social dimensions. Perhaps it was no coincidence that, after the great neoliberal wave with its uniform package of liberalizing reforms had generated poor results from an economic standpoint, a certain political-institutional change leftward of the electoral spectrum managed to reconcile the maintenance of price stability with the resumption of economic growth rates somewhat higher than the average for the period 1980-2000.

This combination of factors, which in the mentioned document we call democratization with a certain leftism of political-institutional positions, combined with the resumption of certain economic growth with maintenance of inflationary stability, practically throughout the first decade of 2000, would have allowed the restriction or even the reversal of social trends harmful to the populations of those countries. Particularly, it is important to highlight the somewhat robust movement to restructure the labor market in practically all Latin America, a movement that has been associated with phenomena linked to the recovery of the general occupation of the labor force, the formalization of employment relationships, and a more than proportional increase of the remunerations of the base of the social pyramid, with the consequent distributive improvement within the working class (Ibid.).

So, from the developmentalism optimism practiced in the first decade of 2000 to the reiteration of the failure of liberalism already evident during the 1990s and progressively in vogue on the continent since, above all, the international (financial and productive) crisis of 2008, the countries of Latin America are seeing their economies oscillate once more from national self-assertion to dependence and structural heterogeneity.

In order to empirically substantiate the previous assertion, the rest of the text will cover technical studies by authors and international organizations, such as ILO and ECLAC, in order to contextualize and problematize the current situational moment of Latin American societies, without neglecting more evident national specificities.

3. An overview of labor behavior in Latin American and the Caribbean

According to the ILO's Employment Outlook for the year 2017 (ILO, 2017), the average regional unemployment rate continued to grow, for the third year running, now to 8.4%, driven mainly by economic and labor market deterioration in Brazil.

While in 2016 unemployment increased in 13 of the 19 countries studied, in 2017 this happened "only" in 9 of the 19 countries. As a result of the dependent economic dynamics and the high structural heterogeneity within and between countries, it is clear that the unemployment rate has very different levels and performances depending on the subregions studied. Therefore, the highest rates have been registered in the Southern Cone, where the average subregional rate jumped from 10.7% in 2016 to 11.9% in 2017. Eliminating the negative impact that Brazil has on the region, there is actually a small reduction from 8.5% to 8.2% in the Southern Cone.

A small reduction was also observed in the Andean countries, of only 0.1%. A slightly higher reduction was registered for the group of countries in Central America and Mexico, from 4.5% in 2016 to 4% in 2017. In the Caribbean, unemployment decreased from 7.8% to 7.4% in the same biennium, but it is closer to the Southern Cone than Central America and Mexico.

With regard to gender statistics, the Employment Outlook reports that unemployment increased among women as well as among men, while maintaining the distances between them. Between 2016 and 2017, the unemployment rate for women increased from 9.9% to 10.4%, while for men it raised from 7.2% to 7.6%. But more significant and worrying is the fact that, for the first time in this decade, the female unemployment rate has surpassed the double digits, staying above the rate registered for men by about 1.4 times.

In terms of age, youth unemployment continues to grow at the regional average: from 18.9% in 2016 to 19.5% in 2017. In practical terms, this means that one in five young people seek and don't find work, which is equivalent to a contingent of approximately 10.2 million young people who are not currently employed on the continent. Also in relation to this point, Brazil has been contributing negatively to aggregate overall results.

As a consequence of this set of phenomena listed above, the trends that suggest a qualitative deterioration in the jobs generated are clear, as job creation has been lower in the formal salaried and protected sectors (which fell from 65.3% in 2013 to 63.4 % in 2016), which has been offset by greater job creation on its own (from 21.6% to 23.6% in the same period). Again, this situation has been worse in the countries of South America (impacted negatively by Brazil) than in Central America and Mexico.

As known, this productive heterogeneity is manifested in the fact that industry, which generates better quality jobs in terms of stability, remuneration and social protection, is the sector that has suffered the most from the global crisis adverse effects and the highly dependent and volatile economic dynamics in most Latin American countries. On the other hand, the sectors of trade and services of low productivity are precisely those that employ the least qualified labor force and precisely the sectors that have been increasing in participation in the composition of regional employment.

Finally, in terms of remuneration, looking at data over a broader time horizon, it is possible to understand why the first decade of 2000 had been identified as being of a certain developmentalism optimism. Between 2005 and 2015, there was a positive evolution of remuneration in general for practically all the countries of the region, which lasted until about 2012, when salaries were reduced and redistributive policies were cut back, mainly due to the international crisis in force since 2008 and the internal national adjustments resulting therefrom (ILO, 2017).

Despite the regional trend of wage growth, there were marked differences in its evolution at the subregional level. The largest increases in real wages were observed in the Southern Cone, followed by the Andean countries, which had increases close to the regional average, while in Central America and Mexico the wage increases were below average between 2005 and 2015. In this subregion, Mexico, El Salvador and Honduras experienced

contractions in their average real wages. On the other hand, the superior performance of the Southern Cone countries is related to the positive effects of the commodities rising prices cycle and with active policies of real wage increases practiced by the region's governments, such as the national policy of real appreciation of the minimum wage practiced by Brazil between 2007 and the coup of 2016.

It also helps to explain the difference between subregions the fact that, while in the Southern Cone countries and the Andean countries real wages in the private sector moved along with public sector wages, in Central America and Mexico the real wages of the public sector increased more than proportionately the salaries in the private sector. In addition, although wages for domestic workers have grown in all subregions, they remain the lowest on the pay scale in all countries.

But perhaps it is not an exaggeration to say that the general improvement in remuneration observed until the adoption of new liberal-conservative orientations in most countries since the international crisis that has been taking place on the continent since 2008 has brought significant and generalized improvements in policies aimed at real minimum wages.

As is well known, the aim of minimum wage legislation and policies is to protect workers from unduly low payments. Its effective application contributes, therefore, to workers of lower wages to participate in a more equitable way of the fruits of technical progress, reason why the minimum wage policies are important pieces for economic paths of inclusive growth, poverty reduction, and remuneration inequalities.

In these terms, between 2005 and 2015 there were significant and generalized improvements in real minimum wages in the Latin American continent, which increased by an average of 42% in the period, some 3.6% in real terms per year. The increase was higher in the Andean countries (4% p.a.), followed by the countries of the Southern Cone (3.8% p.a.), and Central America and Mexico (3% p.a.). Internally to the subregions, it can be seen that the greatest positive changes occurred in Honduras, Uruguay and Bolivia; while the smaller ones occurred in Paraguay, Mexico, the Dominican Republic and Colombia.

In addition, when analyzing the effects of the minimum wage on poverty conditions, it is clear that, despite the improvements identified, this

official base salary is still insufficient to remove from poverty most of the households composed of four people on average and which belong to the quota of 50% of the poorest households in each country. In part, this is due to non-compliance with legislation by private sector entrepreneurs, and, in part, this is related to the still very low official level of these remunerations.

In any case, the positive effect that minimum wages have played in the national trajectories of diminishing remuneration levels, that is, in the distributive improvement observed mainly within the working class, is not of minor importance. During the period 2005-2015, there was a significant reduction of the wage gap in all subregions of the continent. In the private sector, there were relatively smaller declines in the wage gap in the countries of the Southern Cone and Central America and Mexico and a slight increase in the Andean countries. Concomitant to this, there was an increase in the wage bill and improvement in the distributive indicators. The largest increase in total wages was in the Southern Cone (9.8%) and the Andes (4.2%), while in Central America and Mexico, the wage bill remained constant in relative terms. In distributive terms, in turn, there was a reduction of labor income inequality in all subregions of the continent. This tendency, however, was only persistent until 2013, confirming the hypothesis of discouragement and failure of the liberal model in its (in)capacity to maintain the impetus and developmentalism optimism of the immediately previous years (ILO, 2017).

4. Reform of labor relations in Latin America and the Caribbean

The scope of labor reforms in Latin America has been at the heart of the regional debate in the last 30 years, at least. Labor flexibility indexes, their scope, magnitude and importance in terms of their potential to create jobs have been the subject of controversial discussion to determine the weight and role of labor legislation on the economic and social performance of the countries of the region.

As shown by the available data and analysis (RUÍZ, 2005), the legal changes introduced in most Latin American countries, which are generally flexible in nature, have been numerous and comprehensive, although in some cases and at specific times they have guaranteed and attempted to strengthen social protection. In a

number of countries, the modifications were limited to redesigning or specifying the existing standards. In Argentina and Peru, for example, reforms have been more profound and more flexible. Brazil, Colombia, Ecuador, and Panama, however, introduced reforms, which, although less extensive, were also guided by a more flexible approach. In Chile, Guatemala, and Nicaragua, flexibilizing reforms were apparently still less extensive, but also because these countries were already (at the time of this study by Ruiz, 2005) on a more flexible basis in terms of allocation and remuneration in the labor market. Finally, in Bolivia, Honduras, Mexico, and Uruguay, one cannot speak of labor reform in the strict sense, given the only punctual content of some measures.

Regarding the content of these reforms, although most of them – implemented throughout the 1990s all over Latin America – attempted to activate flexibilization mechanisms for individual labor relations, the fact is that most of the most recent initiatives in the first 2000 focused on collective labor relations, often drawing inspiration from ILO standards (RUZ, 2005). In this sense, much of the most recent labor reforms in the region reflect some of the most important advances of the ILO Committee of Experts on the Application of Conventions and Recommendations. Among the recommendations, one of the most interesting was the progressive development and social legitimacy of collective agreements as the most appropriate regulatory source for the normalization of formalized labor relations. Nevertheless, in terms of conflict resolution, the scarce development of real content in collective bargaining makes the more progressive regulations even less credible.

Given the set of previous considerations, we can reaffirm the general idea of this article, according to which there is a strong correlation between the poor performance of labor markets in Latin America during the liberal decade of 1990 and the set of liberalizing reforms carried out in those countries, while on the other hand, in the period of developmentalism optimism of the first decade of 2000, when the general orientation of the reforms was less liberalizing and more focused on the ILO recommendations, there was a better and more promising performance of the labor markets in terms of job creation, formalization, remuneration, union representation, social protection, access to labor justice and distributive improvement.

In light of this, the next step is to better evidence these results in formalization, social protection, and income redistribution as positive

traits of the short period of developmentalism, vis-à-vis the situational and progressively negative trends due to the new (but worse!) current wave of liberalization on the continent.

5. Labor formalization: from developmentalism optimism to the failure of liberalism

According to Weller,

> since the succession of crises that affected the region since 1998, grew the questioning of many of the policies applied. In the labor sphere, the proposals for broad deregulations did not disappear from the discussions, but they undoubtedly lost political weight. As a result, reforms have focused more on strengthening active labor market policies than on changing individual or collective labor relations. The high economic growth that benefited the region from 2003/2004 opened space for a favorable context for the generation of employment and the improvement of its quality. In a number of countries, especially under left-leaning governments rather than the predominant one in the 1990s, there was another attempt to regulate the labor market, strengthening trade union organization, social dialogue, training, and formalization of employment. (2012b, p. 38, literal translation).

This quote corroborates the statements made in the previous sections, in order to prove that, during the so-called period of developmentalism, in which a more lofty and active political-institutional attitude of some countries towards capitalist dependence was combined with economic and social dynamics that were stronger and nationally determined in terms of job creation and income, there is a better and more sustainable aggregate performance both from an economic and a political point of view. Still in the words of the same author,

> from 2003-2004, in the context of relatively high and prolonged economic growth for Latin America, the medium and high productivity

> sectors began to generate jobs in significant quantities. Thus, they increased their participation in the urban occupational structure from 48.8% in 2002-2003 to 52% in 2008-2009. At the same time, the widening of productivity gaps was contained. [...] Nevertheless, it is clear that the productive and institutional economic structure of Latin America has not been able to generate the necessary quality jobs to reduce poverty in a substantive way. In fact, at the end of the last decade, in the simple average of 18 countries, 23% of the urban Latin American employed were poor and 7%, indigent. In the case of rural workers (in 16 countries), this proportion rises to 41% and 22%, respectively. On the other hand, although being employed reduces the possibility of being poor, it is far from securing a decent income. Among the employed, poverty mainly affects self-employed workers, unpaid family workers and, to a lesser extent, private wage earners. Another occupational category that usually registers bad indicators of quality is domestic service, both in terms of income and the possibility of having a labor contract and social protection. (Ibid., p. 43, literal translation).

Given this framework, Tokman (2009) suggests five pillars to combat and incorporate the informal economy into a more economically structured and socially more just dynamic[1], namely:

I) productive and regulatory development of informal activities: it is about recognizing to microentrepreneurs and self-employed the right to develop productive activities that allow them to generate income while at the same time reducing the vulnerability derived from their informal status;

II) labor rights in informal enterprises with limited payment capacity: informal firms account for more than a third of Latin America's private sector wage earners, and 68% of them do not have written labor contracts. This means that, for the majority, labor and social protection is not a right since it lacks a recognized

1 See also Tokman (2010), Durán (2011), and Amarante and Arin (2015).

working condition. In turn, the informal productive units have little ability to pay to meet the obligations inherent to the labor relationship;

III) measures against insecurity and the lack of protection of informal workers in formal enterprises: insecurity and lack of protection are associated with the absence of legally and explicitly recognized labor relations, but also with the existence of relationships governed by contracts other than the contract of employment for an indefinite period. Both situations present themselves in both micro and formal enterprises. Nevertheless, the first one predominates in informal enterprises, while the second one in formal enterprises, so that their workers consider themselves members of the informal economy;

IV) regulation of diffuse labor relations: a fourth area of regulation is the so-called diffuse labor relations, because they are difficult to recognize, are hidden or are left unassisted due to omissions of labor legislation or legal supervision. In many cases, the obligations and rights of the parties are unclear, which can lead to the loss of worker protection. In addition, such diffuse relations are increasingly important in the context of globalization and decentralization of production, which is why it is necessary to establish workers' rights and assign responsibilities with respect to the fulfillment of obligations between different companies involved;

V) social protection for informal workers: providing social protection coverage to those in the informal sector requires a strategy that can range from expanding coverage of existing systems to the development of new protection instruments such as insurance and the consolidation of resources provided by the informal workers themselves. Such coverage should include health services, pensions and, given the predominance of women workers in this contingent, maternity coverage. It would also extend to microentrepreneurs workers and to those self-employed. In the case of informal workers in formal enterprises, responsibility for protection should be linked to the improvement of the employment contract and the shared contribution with the employer.

It is evident that such a set of recommendations, although correct, can only have an effective course in developmental contexts of greater national autonomy, in contrast to the current trends of market liberalization and, therefore, an increase in dependence and structural heterogeneity in Latin American societies.

6. Social protection: from developmentalism optimism to the failure of liberalism

Social protection is a phenomenon here understood considering the capacity of social coverage provided by a pre-defined set of social policies – policies that transfer monetary income in the scope of social security, social assistance and employment, labor and income policies, as widely discussed in Castel (2010) or Cardoso Jr. (2013), from where we have removed and adapted Tables 4 and 5 below.

Table 4. The worlds of social protection and deprotection according to the condition of activity of the population of active and inactive age in the dominant models of labor and social protection in Latin America

	WORLD OF WORK	WORLD OF INACTIVITY
SOCIAL PROTECTION	1. protected contributory occupation: urban pension regimes and a specific regime for civil servants; 2. protected contributory self-occupancy; 3. special insured: partially contributory rural coverage schemes; 4. temporary protection: unemployment insurance.	1. social security coverage: urban and rural regimes and a specific regime for civil servants; 2. state + philanthropic assistance coverage; 3. private pension coverage.
SOCIAL DEPROTECTION	1. unprotected occupation: salary without a contract; 2. unprotected self-employment: self-employed non-contributors; 3. involuntary unemployment.	4. absence of social security coverage (state or private); 5. absence of care coverage (state or philanthropic).

Source: Cardoso Jr., 2013. Elaborated by the authors.

Table 5. The degree of social protection by social classes and provider entities in situations typical of Latin America

Obtaining social protection by social classes and providers – Brazil			
	High classes	**Middle classes**	**Low classes**
State	Medium	High	High
Market	High	Medium	Low
Families	Medium	High	High
Civil society	Low	Low	Medium

Source: Cardoso Jr., 2013. Elaborated by the authors.

The theoretical-methodological substrate to understand the definition of restricted protection shown in Table 4 is the observation that every society, at each moment of time, triggers and combines in a differentiated way (whether voluntarily or involuntarily) four large social segments, clearly discernible, in the indispensable task of generating social protection for its population or, more modernly, its community of families and citizens (ESPING-ANDERSEN, 2000).

The four major social segments are: the state, the market, families and civil communities operating in each national space, which include not only the diffused and poorly institutionalized communities' action, but also the so-called non-state public sector or third sector. In the Latin American case, there would be some division of responsibilities or attributions for those four major social segments, as Table 5 below illustrates.

In general terms, we could say that social protection for the upper classes in the distributive pyramid would depend heavily on their access to private education markets (especially at the primary and secondary levels), health and supplementary social security, even if the state appears, to some extent, as provider of certain goods and services, especially in higher education, certain health specialties, public pension pay ceilings, etc. On the other hand, the middle strata of the social pyramid would be mostly covered by public policies of the state, especially in education, health, welfare and public security, with the high participation of family networks in the provision of an important part of goods and services in these same areas. For these strata, the contribution of the market is average in the provision

of goods and services. Finally, the lower social classes of the distributive pyramid would be mainly dependent on the state and the families, with a low participation of the market and an average participation of the organized civil society in the provision of goods and social protection services to these segments.

Having said that, and focusing hereafter only on the link between employment and social protection, we see that historically this linkage is based on the centrality of work as a mechanism for inclusion, access to well-being and also on the dialectic of contributions and acknowledgments of people (ECLAC, 2012b). This articulation presupposes the capacity to modernize the productive structure and the economic dynamism necessary to enable full employment, mostly formalized and contributory to social security, with contributions from different sources, including public social spending. The link between employment and social protection also implies that the actors have functions defined in the institutional framework of negotiation and balance of powers, in which the state plays a fundamental role in ensuring such balance, so that the productive process translates into shared benefits between the actors (Ibid.).

It follows that the structural dynamics of dependence and heterogeneity that dominate Latin America impose regional, sectorial, labor and social inequalities of several orders, so much that, on the one hand, there are restrictions to expressive sectors of the population to integrate into the existing social security networks. There is a large group of excluded from protected formal employment, with precarious insertions, high turnover, low and oscillating wages, almost no patrimony or reserve of assets and human capacities, situations that lead to the absence or precariousness of bonds and contributory contributions for large population groups. On the other hand, the dynamics of informality, flexibilization and new forms of organization and labor contracting have undermined the stability of jobs, weakening the union actors and the protective status of labor, therefore, the capacity of appropriation and transmission of productivity gains produced by the system (ECLAC, 2012b).

In most Latin American countries, the combination of fiscal restraint and economic deregulation left little room for states to meet the welfare needs of their populations. This has reinforced the development of welfare and targeted public policies, very far from a basic universalism of social

welfare. As a result, the links between structural heterogeneity, (un)employment and social (de)protection in most countries of the region appear more clearly than ever before. Hence the correct insistence of ECLAC in several of its official documents (ECLAC, 2010; ECLAC, 2012a; ECLAC, 2012b; ECLAC, 2014; ECLAC, 2016; ECLAC, 2017; ECLAC, 2018), and of other authors (BIELSCHOWSKY; TORRES, 2018; INFANTE, 2011; SOJO, 2017; TOKMAN, 2010; WELLER, 2012a; etc.) in order to affirm that

> without productive convergence, structural inequalities will continue to translate into persistent exclusions and inequalities in the labor market. Without employment, it is difficult to advance to equality of opportunity and to active citizenship, since it constitutes the established mechanism of capitalist society to make contributions and retributions possible, to move from the private to the public, and to give personal life sense as a contribution to collective progress. Without social protection, important sectors of the population will continue to struggle to enter the world of work, and even if they enter, they will continue to be recurrent victims of the inequalities that the labor market reproduces. (ECLAC, 2012b, p. 27, literal translation).

Notwithstanding the fact that the scenario above is Latin America's historical pattern in terms of the relationship between the world of work and social protection, a typical pattern of contexts of dependence and heterogeneity sharpened in moments of liberal-conservative predominance of growth models preached by the market ideology, the region experienced, in a short period of time, in the early 2000s, a set of situations that elicited a certain developmentalism optimism.

First, there was a certain economic dynamic favorable to inclusive growth, with a general improvement in labor market indicators (greater and better employment, formalization, remuneration, social protection, deconcentration of labor income in 11 of the 18 countries studied), poverty reduction and indigence, and a consistent increase in the share of social spending in national income concomitant with the increase in tax revenues without generalized inflationary pressure (Ibid.).

Secondly, the region as a whole demonstrated that it was able to take advantage of the demographic bonus generated by a lower dependency ratio, that is, an increase in the proportion of the employed population of working age over the inactive dependent population (Ibid.).

Thirdly, although in the economic field predominantly exclusionary and even regressive orientations persisted, in the field of social policies the orthodoxy of the eighties and nineties seemed to give room to new ways of thinking about the role of the state in guaranteeing social protection, poverty and inequality reduction. The evidence for this is that in the first decade of 2000, public policies aimed at strengthening the non-contributory pillar of social protection were set in motion in several Latin American countries, and, in a more universalist logic, efforts were made to extend social rights and services in health, education, public welfare and social assistance, especially in the field of money transfer programs to poor and vulnerable segments in each country (Ibid.).

Finally, even in the face of the international economic crisis triggered in 2008, there were unconventional (meaning, non-liberal-conservative) reactions on the part of the Latin American governments that at the time attempted to practice somewhat more autonomous or contestatory orientations to the dominant pattern of policies suggested by international organizations. In such cases, as in Brazil, Argentina, Uruguay, Bolivia, Ecuador, and Venezuela, countercyclical policies to maintain aggregate demand (through public investments and social spending) were implemented with variable success in each specific case (Ibid.).

As demonstrated by the Brazilian experience in 2003-2013,

> not only was it possible to reconcile a certain resumption of economic growth with a general restructuring of the labor market and the maintenance of monetary stability, as that happened without a profound reform – the mantra of liberalism – of the pattern of labor regulation or social protection in the country. (CARDOSO JR.; HAMASAKI, 2014, p. 28, literal translation).

This has demonstrated the intrinsic incompatibility between the historically constituted models in Latin America of structuring labor markets with social protection and the liberal models of development. This incompatibility is fundamentally due to the inadequacy that exists between liberal economic dynamics and the heterogeneous and unequal nature of the Latin American labor market. Liberal models are thus unsuitable for late

peripheral economies such as those in Latin America, and counterproductive to labor markets derived from them (CARDOSO JR., 2013).

7. Redistribution versus income reconcentration: from developmentalism optimism to the failure of liberalism

During the short period of developmentalism optimism in Latin America, basically the first decade of the 2000s, there was a virtuous combination of tendencies present in their national labor markets, which, coupled with the respective models of social protection (labor, social security, and welfare), allowed the coexistence between a dynamic of economic growth favorable to the reduction of the structural heterogeneity in each country, with indicators of reduction of the concentration of labor income in most cases.

This phenomenon, on the one hand, rare in Latin America's long history, and on the other hand dependent on a combination and maintenance of simultaneous public policies of growth and redistribution, had positive effects on the productive dynamics and on critical variables of the labor market, which helped to place equality again at the center of the Latin American debate on development during this period.

ECLAC, for example, argues that this happened for two reasons:

> first, because it endows policies with a rights-based approach at their very foundation, along with a vocation of humanism that embodies the most treasured legacy of modernity. Second, because equality is also a prerequisite for progress with a development model that focuses on closing structural gaps and on convergence towards higher levels of productivity, economic and environmental sustainability for future generations, the dissemination of the knowledge society and the strengthening of democracy and full citizenship. (ECLAC, 2018, p. 19[2]).

Therefore, the central message consisted in affirming that inequality implies great costs of micro and macroeconomic efficiency, from which

2 This page corresponds to the English version of the work cited by the authors.

results the idea that its overcoming is a necessary condition for inclusive and sustainable development.

According to this approach,

> Equality is a necessary condition for maximizing the dynamic efficiency of the economy in that it creates a framework of institutions, policies and efforts that place the highest priority on innovation and capacity-building. From that perspective, equality is more important today than in the past because of the impact of the technological revolution, which makes building capacities and closing gaps a more urgent and unavoidable task. That urgency is heightened by the unsustainable nature of the current pattern of growth, which requires that the technological revolution be put to work in transforming the energy mix and channelling production processes along low-carbon paths in order to preserve the environment and its productive services for future generations. (ECLAC, 2018, p. 21[3])

> The mechanisms through which the relationship between causality and efficiency operates are the much broader diffusion in society of education and skills; the elimination of barriers to creativity and to the effort that any kind of discrimination represents; social welfare provided by the welfare state, which enables agents to accept, to a greater degree, the risks inherent in innovation; and overcoming the culture of privilege and political economy that closes down the way for new agents, sectors and ideas that transform the economy and challenge rentier behaviors based on static comparative advantages or political privileges. (ECLAC, 2018, p. 7, literal translation).

Given this position, which has been corroborated both from the theoretical and the empirical point of view, Weller (2012a) argues that the generation of productive jobs is a necessary first condition to reduce the

3 This page corresponds to the English version of the work cited by the authors.

high heterogeneities and inequalities still present in Latin America. Without this productive and sustainable insertion over time into the production and consumption structure of the Latin American population, regional inequalities are unlikely to be addressed and reduced only on the basis of welfare programs or monetary transfers. Therefore, the creation of productive employment must be the starting point for national strategies to reduce inequalities in the productive structure and labor markets, without forgetting the importance of wage and welfare policies as complementary tools.

Among them, policies to ensure access to education and health, which, by enhancing individual capacities and collective opportunities, promote innovation and increases in systemic productivity. When a person drops out of school before completing primary or secondary education, their productive potential resents for the rest of their active life. The lower salary received, ceteris paribus, in relation to workers with more years of formal education, is an indicator of the loss of productivity and well-being that this abandonment implies. The magnitude of this loss is very high over time. The cost to society does not end in the future loss of income of the person who does not continue his studies, since there are positive externalities associated with the interaction between people with high education level; in other words, the social benefit of investing in education goes beyond private benefit. When inequality impedes access to education, its effects are not local, but spread out, affecting the entire economic system. In Latin America, a very significant proportion of the population over 18 years of age does not reach a level equivalent to the first cycle of complete secondary education, and besides there are notable differences between the first and last income quintile. On the other hand, the situation of the countries is heterogeneous. At one extreme is Guatemala, where only 50% of the population over 18 reaches a level equivalent to the completion of the first cycle of secondary education. At the other extreme is Chile, where this number exceeds 80% (Ibid.).

There are other dimensions of inequality that are closely related to these more traditional ones. One of them is its territorial expression, since poverty or low levels of development are concentrated in certain areas. Cities are part of this territorial dynamic that tends to spatially concentrate development and generate polarization, both in the cities themselves and

in their relationship with the rural world. Other inequalities are related to environmental deterioration: the poorer sectors are those that suffer the most from the negative consequences of pollution in urban areas, and poor peasants work in the most degraded rural ecosystems. On the other hand, the existing infrastructure and investment patterns in this infrastructure consolidate and reproduce territorial and environmental inequalities (Ibid.).

With regard to such dimensions of inequality, the Latin American Regional Development Index (RDI) of 2015, elaborated by ECLAC, offers a broad perspective of territorial inequalities. Differently from the traditional analyzes of territorial disparities that take as a reference the averages of each country, RDI compares the relative development level of 175 territorial entities from eight Latin American countries to the regional averages. This approach incorporates additional dimensions of per capita GDP, such as health, education and access to public services. The RDI of 2015 makes it possible to identify macroregions with the greatest relative shortcomings in economic and social development, such as northeastern Brazil, southwest Mexico and the Andean and Amazonian zones of Bolivia, Colombia, Ecuador and Peru (Ibid.).

Another important dimension highlighted by ECLAC is the relationship between inequality and institutions. The intergenerational transmission of poverty reflects and reinforces the intergenerational transmission of exclusionary institutions. One factor explaining this persistence is that inequality is incorporated into the culture of society, which perceives as natural that certain groups enjoy the rights denied to others. This creates a culture of privilege that is implicitly accepted by both privileged and excluded groups. In short, the direct effect of inequality on learning and skills adds up to a perhaps less visible but no less important effect: the weakening of state capacities and the effectiveness of public policies. The political economy of inequality and its close relationship with the institutions and culture that govern social relations are a barrier to increasing productivity and growth, since they limit the supply of public goods that are essential for the existence of competitive markets and innovative agents. In turn, in a democratic society, public goods are a materialization of equality and a sense of belonging (Ibid.).

For example, the people of African descent, whose ancestors were enslaved and subjected to forced labor, continues to suffer higher levels of

poverty, lower levels of education, greater exposure to the negative effects of territorial segregation and an occupational insertion in the most precarious niches of the labor market. The poverty rates of indigenous and African descent populations are higher than those of the rest of the population, while poor income distribution illustrates the association between ethnicity and social inequality, with a much higher percentage of African descent and indigenous people in the poorer quintile (Ibid.).

From the perspective of development with equality, the culture of privilege is disturbing because it naturalizes the relationship between the place that one occupies in the social scale and the greater or lesser access to education, health, work, security and the habitability of the place in which one lives. This dynamic is disseminated in multiple spheres, in which structural and institutional factors compete to perpetuate or recreate an order of unequals. The tributary system of the region expresses this culture of privilege.

In Latin America and the Caribbean, tax privileges continue to exist, such as exemptions, evasion, elision , and low income tax. Much of the tax burden is indirect and falls on consumption, while the income tax is lower than that on average in the OECD countries. The average tax burden in the region is half the average for a group of 15 European Union countries, and this difference is concentrated in the income tax of individuals. In the region, most of the tax burden comes from consumption taxes and has a regressive effect. The great difference between the redistributive power of fiscal policy in Latin American and Caribbean countries and that of developed economies lies in monetary transfers and direct taxes, since the fall in the Gini coefficient caused by the distribution of spending on education and health is similar in both groups. On average, the region's Gini coefficient falls only three percentage points after direct tax action, while the public provision of education and health services reduces it by six additional points (ECLAC, 2018).

In European countries and other OECD economies, the aggregate redistributive effect of monetary transfers and personal income tax is 19 and 17 percentage points respectively on average, while redistribution through public spending is between 6 and 7 percentage points. The weak redistributive effect of taxation, whether by composition and tax burden, lack of effective

investigation or current benefits, is part of a system of privileges in which those who have more do not perceive the social commitment to contribute to the common good by fiscal means. However, a clear redistributive effect obtained through taxation, which can be perceived as a norm of society, is not only indispensable to promote more equality, but also constitutes a communicative and awareness-raising signal on equal rights.

8. Final considerations

ECLAC is right (2016, p. 29) when it states that

> the dominant type of development has generated enormous imbalances, and its transformation is a complex task. The difficulty lies in political economy, the set of interests and alliances that dominate and define the rules of the game, both internationally and domestically. There is a clear conflict. Several actors, both public and private, have an interest in protecting their investments and the current distribution of profitability; others would have much to gain from the transition to a more inclusive and environmentally sustainable growth pattern. The problem is that the costs of converting to a new standard are immediate and concentrated, while the benefits will be perceived in the future and are diffuse. In particular, the distribution of costs and benefits is in inverse correlation with the distribution of power in the current style, which makes it difficult to build alliances to move forward.

For these reasons, ECLAC (2016) draws attention to the necessary governance mechanisms in four areas: i) an international coordination of economies that favors the sustained expansion of investment, based on fiscal policies that prioritize low carbon and higher efficiency energy projects; ii) a new international financial architecture that reduces real and price volatility and advances on the reform of the international monetary system; iii) trade and technology governance on a multilateral basis, facilitating and expanding access to technology and financing for the decoupling of growth and

environmental impact, thus facilitating the correction of asymmetries between countries and regions; and (iv) shared governance of key components of the digital economy at the global and regional levels. These tasks demand, simultaneously, at the national level in each country, a commitment to the universalization of social protection and the provision of education and health services to generate proactive responses to the uncertainty inherent in globalization and technological revolution.

With regard to macroeconomics, the need for a development-oriented policy, which, in addition to controlling inflation, strengthens the countercyclical instruments, articulating the objectives of financial stability with those of the productive transformation and the improvement of income distribution (ECLAC, 2010). With regard to social policies, the focus on rights and the quest for substantive equality stand as axes of the new welfare regimes, in order to make it possible to take advantage of the synergies between equality and efficiency of the economic system. In environmental matters, attention is focused on three pillars of decarbonization, which include the digitization of society and production (particularly micro-enterprises and small and medium-sized enterprises, due to their weight in job creation and wages), the development of sustainable cities and the emphasis on renewable energies (ECLAC, 2018).

Specifically about the world of work, Weller (2012b) points out guidelines for improving working conditions in Latin America: i) face high instability as a characteristic of the labor market; ii) improve the institutions of existing work; and (iii) address inequality linked to working conditions. However, according to Weller, it is important to emphasize the importance of policies that foster high and sustainable economic growth, stimulate continuous increases in labor productivity, and reduce important productivity gaps between segments of the productive structure, as also emphasize Toledo and Neffa (2010), when analyzing the dominant productive models in Argentina, Brazil, Colombia, Mexico and Venezuela.

In the same line of argument, in a work carried out at the ILO, Infante (2017) points out that, when structural change results in reduction of productivity gaps, diversification of production structure and aggregate productivity increase, the world of work benefits in equality, because wage gaps are reduced and quality employment becomes more comprehensive. To this end, work

must be freely chosen, productive, adequately remunerated and backed up by appropriate social protection – in short, decent work, in ILO terms. This combination of factors was present in Latin America in this recent developmentalism interregnum (2000s), when the feasibility of simultaneous and non-contradictory policies of economic growth and job creation was verified in several countries, in addition to labor and social protection policies designed to ratify – at the same time as feedback – the very growth of the economy.

In this context, formalization policies must contemplate two simultaneous objectives: i) on the one hand, to facilitate the way of the working class to the formal economy and to effectively promote productive employment in the already formalized economy; (ii) on the other hand, to improve the working and living conditions of those in the informal economy, so that the general orientation is of more and better social inclusion than punishment or segregation (TOKMAN, 2009; 2010).

Lastly, Cardoso Jr. and Hamasaki (2014), when studying the Brazilian experience between the decades of liberalism (1990) and developmentalism (2000) regarding the relationship between patterns of development, labor market and social protection, had already pointed to the need for a more explicit, organic and systemic agenda for development, anchored in the following positive transformation vectors:

I) recover and sustain economic growth on a more solid basis and at higher levels than the current ones. That is, the deliberate induction of the state towards a scientific-technical-productive revolution capable of combining stimuli to the so-called green economy and environmental education, with innovative link building in the productive and institutional spheres of processes and products;

II) institutional restructuring of the pattern of public funding in general and of social policies in particular. That is, both tax and fiscal reform that is able to combine progressivity in the collection with redistributive spending;

III) consolidation of civilizational minimums for the regulation (structuring and regulation) of the world of work. That is, deepening of a culture of rights, referenced to the set of human, economic,

social, cultural and environmental rights (the so-called DhESCA Platform);

IV) politically deliberate promotion of the functional and personal distribution of income;

V) construction of new institutions in the state-society relationship for the promotion of broad citizenship and for democratic consolidation. That is, ethical-political reform in the systems of representation, participation and deliberation, valuing the public sphere and citizenship at all levels.

This set of strategic guidelines clearly emerges alongside the political and academic debate advocated by sectors within the progressive field of Latin American society within and outside government structures. As a corollary, it is believed that there is no positive solution within the liberal-conservative path. Defended by atavistic sectors of society, political communities (parties, trade unions and other associations) and the bureaucracy itself, in addition to the media and business sector, this political alternative, aimed at emptying the role of the state, is again bringing dire consequences to Latin America and other places in the world.

In the case of Latin America, the liberal path already tried during the 1990s provoked, among others, productive disarticulation, financialization of wealth, precarization of the labor market, and dismantling of the social protection system, which was then in formation. The liberal path, therefore, makes unviable the sustained paths of economic and social homogenization to the countries that adhere to it, and cannot constitute a credible alternative to the challenges of contemporary times placed in the region already in this second decade of the twenty-first century. Faced with the barbarity of the structural dependence that is once again coming close to the continent, the Latin American countries and peoples still have left the unrestricted search for national reaffirmation as a path to new civilizational achievements.

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The evolution of access and quality of basic education in Latin America in the 2010s

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The evolution of access and quality of basic education in Latin America in the 2010s

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Presentation

The present text is structured in three sections, excluding this presentation. In the introductory section, we succinctly attempt to outline the macroeconomic scenario that favored reducing income inequality in Latin America, taking into account that this variable directly and indirectly affects educational policies and their results. In the second section, the evolution of access and quality of education is analyzed: initially, under a regional approach, and then through the analysis of selected countries. In the final considerations, the main advances and challenges to be overcome are identified, as well as imminent risks that could jeopardize this process.

1. Introduction

Inequality is perhaps the main feature that defines Latin American societies (CEPAL, 2018), and attempts to overcome it seem to occur cyclically. The last cycle occurred at the beginning of this century and lasted little more than a decade.

After the decade of neoliberalism in the 1990s, the countries of the region began to be governed by left-leaning rulers, a few of them with more radical nuances and others with more reformist vocations.

In most cases, these rulers came to power in response to people's disenchantment with broken promises by the neoliberal predecessors, especially those related to reducing unemployment and raising income.

The appreciation of commodities in international trade has allowed these governments to transfer some of the gains to the social area, for example, through income transfer programs, but also by expanding budgets in areas such as health and education.

As a result, reducing social inequality in the region occurred at a faster pace and, mainly, indigence and poverty indices fell, in spite of the minimum levels used in the definition of these cut-off lines. However, according to ECLAC (2018), the rate of reduction has slowed in recent years, when using as reference the annual reduction (simple average) of the Gini Index: from 1.5% in the period 2002-2008 to only 0.4% between 2014 and 2016.

Similarly, an increase in the proportion of poor and indigent persons reinforces the understanding of the emergence of a new socioeconomic cycle. If, in the period 2002-2014, there was a continuous reduction in the proportion of these two segments, from 58.3% to 36.7% of the population, from 2015 onwards, this number went up, reaching 40.7% in 2016.

Faced with this new conjuncture that points to the apparent end of this virtuous cycle, through which it was possible to increase employment and income, reducing inequality, it is still not clear whether there has also been a reversal of the tendency to increase access to education, especially for higher levels of education, as well as to improve the quality of public education. In this sense, the present study aims to analyze the evolution of educational indicators, in the scope of basic education, in the period following this cycle of economic growth, when social inequity was reduced.

2. Educational scenario

In this section, two crucial aspects will be addressed for the effectiveness of educational policy: access and performance. In the first case, frequency indicators in basic education will be analyzed in the region as a whole and in selected countries. The choice of these countries is related not only to the availability of data, but also to the population dimension, since the selected sample corresponds to about 75% of the population of Latin America and the Caribbean. Next, the data on the large-scale ability tests will be analyzed, which have been adopted by several countries in the region as a mechanism for monitoring the quality of basic education.

In both cases, the objective is to verify if these educational indicators are being affected by the new macroeconomic situation.

2.1 Advances in expanding access to basic education

The first educational challenge that has been overcome by Latin American countries, particularly those with the greatest historical shortcomings, is the (almost) universalization of access to basic education, especially regarding primary education. This has been observed more or less widely in all the countries of the region since the end of the last century.

Regarding access by level of education, the countries of the region have generally maintained the growth trend in the period 2010-2015, albeit at a slower pace than in the previous decade. This can be explained in part by the fact that it becomes more difficult to incorporate those segments of the population that are in a situation of social vulnerability and which, as a rule, are the last to be incorporated.

Based on the most current information provided by SITEAL (2015)[1], it was possible to analyze the evolution of access to formal education in the region as a whole in only three moments during this century (2000, 2005 and 2013). Table 1 shows the evolution of school enrollment ratio by age group and socioeconomic level (SEL).

As can be inferred from the data in Table 1, the largest relative increases occurred among children and adolescents belonging to the low SEL. With this, it was possible to reduce inequality of access between them and the students of the other socioeconomic levels. In addition, it is observed that the increase of access was greater in the extreme age groups, in which inequality was and still is higher.

Given the identified gaps and the lack of up-to-date data in the statistical information systems of international organizations, such as ECLAC and UNESCO, other sources, such as national research institutes, were consulted. However, due to the different forms of structuring the levels of education in the countries of the region, the different methodologies used and the collection periods, it was necessary to analyze the selected countries separately.

1 Information System on Educational Trends in Latin America.

Table 1. School enrollment ratio by age group and SEL – Latin America and the Caribbean (2000/2005/2013)

Faixa etária/NSE	Year			Var. %	
	2000	2005	2013	2000/2005	2005/2013
5 years	74.1	79.3	84.3	7.0	6.3
Low SEL	60.4	66.0	71.6	9.3	8.5
Average SEL	81.9	84.9	88.3	3.7	4.0
High SEL	92.4	94.4	95.3	2.2	1.0
6 to 11 years	95.1	96.1	97.2	1.1	1.1
Low SEL	91.6	93.3	94.9	1.9	1.7
Average SEL	97.5	97.8	98.3	0.3	0.5
High SEL	99.0	98.8	98.5	-0.2	-0.3
12 to 14 years	90.2	92.3	93.8	2.3	1.6
Low SEL	82.8	86.3	88.9	4.2	3.0
Average SEL	95.5	96.0	95.9	0.5	-0.1
High SEL	98.7	98.4	98.4	-0.3	-
15 to 17 years	69.4	72.5	76.6	4.5	5.7
Low SEL	55.0	59.8	65.8	8.7	10.0
Average SEL	77.3	77.9	79.3	0.8	1.8
High SEL	89.2	88.9	90.4	-0.3	1.7

Source: SITEAL, based on household surveys in each country.
Note: Figures corresponding to the SEL from 2000 to 2005 do not include Nicaragua.
Elaborated by the authors.

Argentina

In 2014, the obligatoriness of the initial cycle (preschool, in Brazil) was extended to four-year-old children, but since 1993 it was mandatory for those that turned five. So, school enrollment rates (school attendance) of children ages 5 years and older will be analyzed.

Table 2 shows the school attendance data by age group, with two columns for the year 2010: the first one refers to the Population Census and the second one is based on the Permanent Household Survey microdata. Both surveys are not comparable, since the first covers the whole population and the second, besides being sample, is restricted to the urban areas of a certain number of municipalities. Even so, regarding the age group of 6 to 11 years, there are no significant differences between both, since the obligatoriness in this age group exists since the end of the nineteenth century.

Table 2. School enrollment ratio by age group – Argentina (2010/2013/2016)

Age group	2010[1]	2010[2]	2013[2]	2016[2]
5 years	96.3	97.8	97.6	98.3
6 to 11 years	99.1	99.3	99.2	99.4
12 to 14 years	95.3	98.0	98.3	98.5
15 to 17 years	76.4	87.9	89.3	90.9

Sources:

[1] DINIEE/SICE/MED/Censo Nacional de Población 2010/ages adjusted to June 30th.

[2] Microdata from the Encuesta Permanente de Hogares/Instituto Nacional de Estadística y Censos.

Elaborated by the authors.

Regarding the other age groups, the differences widen as the age increases, which may be related to lower coverage in small municipalities and rural areas. However, the rates recorded in 2016 show that there was an increase in the school enrollment ratio in all age groups.

Another relevant indicator that addresses the effectiveness of compulsory education refers to the completion rate. As shown in Table 3, less than half of the students entering secondary school had completed this level of education and about a quarter of them had not even completed the basic cycle.

Table 3. Completion rate for secondary education (basic and targeted cycles) – Argentina (2010-2015)

Educational stages	2010	2011	2012	2013	2014	2015
Secondary	42.4	42.8	44.6	45.4	47.0	48.8
Basic cycle (7th-9th year)	69.6	72.2	72.6	73.2	74.0	75.7
Targeted cycle (10th-12th year)	56.3	56.2	59.0	59.4	61.6	62.4

Fonte: DIEE en base Relevamientos Anuales/RedFie.

Elaboração dos autores.

In any case, when analyzing the evolution of these indicators in the period 2010-2015, there has been progress, although the indices registered in that last year just returned to the level reached in 2001[2].

2 Between 2001 and 2005, there was a continuous reduction in the completion rate of secondary education, reaching a rate of 36% in the last year. From then on, there was a steady increase in the proportion until 2009, when the index reached 44%.

Brazil

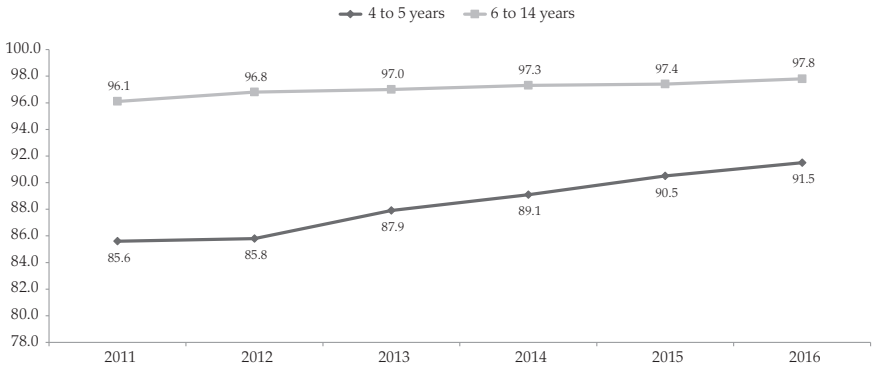
Compulsory education was expanded in 2006, when then elementary school began to be nine years long, starting at six years of age. Subsequently, in 2013, compulsory education was extended from 4 to 17 years to include preschool (4 and 5 years), and for those who could follow the regular flow, high school (15 to 17 years).

It is believed that, due to this change in the legal framework, the expansion of children's access to preschool was accelerated from 2013, whereas in primary education the growth rate was significantly lower, as can be verified in Chart 1.

Regarding 15-17 year olds, age group considered adequate to attend high school[3], the trend in the period is also of growth, but the age-grade distortion is still high when comparing school enrollment ratio (total and net).

Despite the low growth of the Brazilian economy in the period under analysis, including a recession between 2015 and 2016 and an increase in the unemployment rate[4], school enrollment ratio in the age groups corresponding to basic education continued to increase.

Chart 1. School enrollment ratio by age group – Brazil (2011-2016)

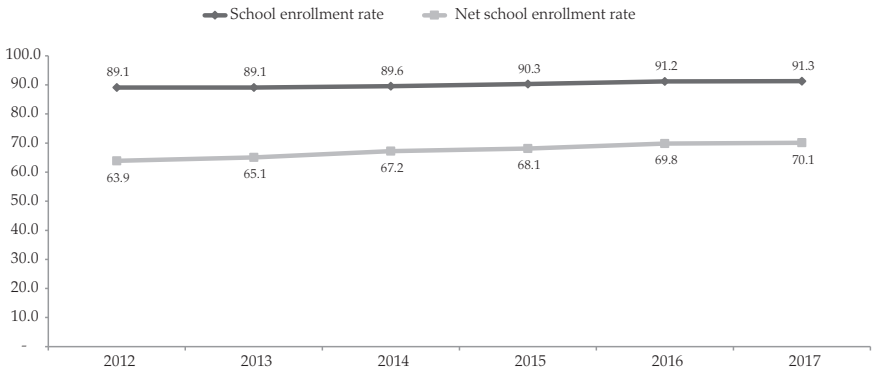


Source: Pnad Contínua/IBGE.
Elaborated by the authors.

3 In the other Latin American countries, it corresponds to the second part of secondary education.

4 In those two years, the Gross Domestic Product (GDP) fell by 3.8% and 3.6%, respectively. On the other hand, the unemployment rate, measured by PNAD Contínua in the June-August trimester, increased from 7.3% to 11.8% between 2012 and 2016.

Chart 2. School enrollment ratio for the population aged 15 to 17 – Brazil (2012-2017)



Source: Pnad Contínua/IBGE
Elaborated by the authors.

Chile

Compulsory education was extended to 12 years of study in 2003, covering, in addition to basic education (8 years), secondary education (4 years). With this, there was an increase in access to this level of education, as shown in Table 4.

Table 4. Net school enrollment rate by age group, for selected years – Chile

Age group	Year					Var. %	
	2000	2009	2011	2013	2015	2000/2009	2009/2015
4 to 5 years	54.9	74.1	82.8	87.4	90.1	35.0	21.6
6 to 13 years	92.3	93.2	92.8	91.9	91.5	1.0	- 1.8
14 to 17 years	64.7	70.7	72.2	73.3	73.6	9.3	4.1

Source: Ministerio de Desarrollo Social - Encuesta CASEN 2000-2015.
Elaborated by the authors.

The first aspect to be highlighted considering Table 4 concerns the substantial increase in school enrollment rate in the first age group, which corresponds to preschool, although it is not mandatory. On the other hand, in basic education there is a small reduction in the enrollment rate, especially when reference

is made to the year 2009. The indices for the age group of 6 to 13 years cause a certain strangeness, especially when taking into account its approximation in 2015 with the attendance rate in preschool, as a level of non-compulsory education. Moreover, because they are lower to those registered by the other countries analyzed, which, as a rule, show rates of schooling at other levels of education lower than Chile. Finally, despite the constant increase in the attendance rate in middle school (14 to 17 years), about a quarter of this universe of young people does not attend this level of education, which is one of the major educational challenges to be overcome and ensure the established legal right.

Colombia

Mandatory education in Colombia begins at age 5, which corresponds to the last year of preschool, and ends at age 14 (last year of secondary education), a total of 10 years of study. Regarding 5-year-olds, the coverage rate is still below 90% and the difference between the extreme SELs was about 15pp in 2016, as shown in Table 5.

Table 5. Schooling rate by age group and household socioeconomic level – Colombia (2003 and 2016)

Age group	Low SEL		Average SEL		High SEL		Total	
	2003	2016	2003	2016	2003	2016	2003	2016
5 years	64.5	80.4	86.0	90.2	ND	95.6	77.7	88.7
6 to 10 years	91.9	96.3	97.6	98.0	ND	98.2	95.1	97.6
12 to 16 years	73.7	84.0	90.6	92.2	96.5	95.5	83.6	90.2

Source: SITEAL, based on the National Household Survey (2003) and the Large Integrated Household Survey (2016).
NA: Not available.
Elaborated by the authors.

As observed in relation to the other countries analyzed in this study, the greatest increases in access occurred in secondary education and in the low SEL segment, for which the coverage rate was farther from universalization.

Given the scarcity of schooling data during the period of analysis of this study, the alternative that remained was to follow the evolution of enrollments in the three levels of basic education. The limitation of this indicator refers to the

fact that the age groups referring to children and young people have undergone negative variations in the period 2010-2015, according to ECLAC projections (2016)[5]. However, when analyzing the evolution of enrollments in this same period, there is a reduction in the three levels of education, as shown in Table 6.

Table 6. Enrollment according to the educational stages, total and in public schools – Colombia (2010-2015)

Educational stages	2010	2011	2012	2013	2014	2015	var. %
Preschool							
Total	1,060,269	1,071,429	1,107,768	1,093,675	1,027,226	1,010,504	-4.7
Public	618,178	607,058	649,215	632,513	570,041	585,569	-5.3
% Public	58.3	56.7	58.6	57.8	55.5	57.9	
Primary							
Total	4,725,834	4,674,511	4,556,278	4,507,269	3,811,609	3,673,388	-22.3
Public	3,809,763	3,752,970	3,641,431	3,603,221	2,838,826	2,796,860	-26.6
% Public	80.6	80.3	79.9	79.9	74.5	76.1	
Secondary and High School							
Total	4,349,971	4,369,161	4,307,005	4,278,218	3,990,059	3,952,459	-9.1
Public	3,486,359	3,493,677	3,446,432	3,429,915	3,129,665	3,173,500	-9.0
% Public	80.1	80.0	80.0	80.2	78.4	80.3	

Source: Departamento Administrativo Nacional de Estadística (DANE) – Investigación de educación formal. Elaborated by the authors.

It is possible that the significant decrease in enrollment in primary education has been partly due to improved school flow (increased approval rate). However, this explanation does not apply to the reduction of enrollments in preschool, given the inexistence of this criterion in this level of education.

Another point that is highlighted in Table 6 is the reduction of public school participation in primary education enrollments, which could also be explained in part by the argument above, since it is precisely where the worst indicators of school delay are registered.

5 In the age group of 5 to 19 years, the reduction would have been around 3%.

Mexico

Compulsory education in Mexico begins at age 3 and ends at age 17, totaling 15 years of study. From the legal point of view, this is the longest cycle between the countries analyzed in this study. When it comes to primary education, the level of coverage is quite high, but as the level of education rises, the proportion of out-of-school children and youth increases. Table 7 presents the school enrollment rates by selected age groups and income quintiles.

Table 7. School enrollment rate by selected age groups and income quintiles – Mexico (2010 and 2014)

Age group	General		1st Quintile		5th Quintile	
	2010	2015	2010	2015	2010	2015
3 to 5 years[1]	71.0	73.1	66.0	69.3	79.3	82.0
6 to 11 years	95.9	97.7	96.5	98.2	99.8	99.9
12 to 14 years	91.2	93.3	85.9	89.2	98.2	97.9
15 to 17 years	67.0	73.2	54.1	66.5	84.0	87.9

Source: INEE/Panorama Educativo de México 2016. Indicators of the Sistema Educativo Nacional, Educación básica y media superior.
[1] Refers to 2014.
Elaborated by the authors.

Table 8. Net enrollment rate by level of education – Mexico (2010/2011 and 2015/2016)

Educational stage	2010/2011	2015/2016
Primary	95.7	97.4
Secondary	80.4	86.2
Upper secondary	62.7	67.2

Source: INEE, calculations based on the Continuous Statistics of Format 911 (beginning of school cycles 2010-2011 and 2015-2016).
Elaborated by the authors.

However, more significant advances are observed at secondary education and high school, which reflect the increase in the number of places available and, above all, the improvement of progression in primary education. On the other hand, the expansion of preschool access tends to be conditioned by the

capacity of public authorities to increase enrollment, either by implementing a better physical infrastructure and/or maintaining new educational units.

Regarding the age-level adequacy of school enrollment, there is also an improvement in this indicator (net enrollment rate) in the period under analysis, as can be seen in Table 8.

Peru

Compulsory education in Peru begins at the age of five (the last year of the Initial Cycle) and covers primary education (six years) and the first cycle of secondary education, a total of nine years of study. To complete basic education, there is the second cycle of secondary education, with a three-year duration, which is elective and diversified (scientific-humanist and technical).

Regarding the access to these levels of education, there was a more intense increase in the school attendance of children of five years of age, as can be seen in Table 9, with an increase of 17 pp in the period 2010-2016.

Table 9. Net school enrollment rate by age group – Peru (2010-2016)

Age group	2010	2011	2012	2013	2014	2015	2016
3 to 5 years	69.4	71.1	73.5	76.7	78.4	80.1	80.7
5 years	77.4	81.6	87.8	89.1	94.3	94.7	94.5
6 to 11 years	93.8	93.6	92.9	92.7	92.1	91.4	91.4
12 to 16 years	78.5	79.6	81.9	81.8	83.1	84.1	83.6
12 years	78.5	79.6	80.3	81.0	82.3	83.4	83.0
13 years	61.8	66.4	64.4	66.0	68.1	67.8	65.6

Source: Encuesta Nacional de Hogares del Instituto Nacional de Estadística e Informática.
Elaborated by the authors.

Inverse trend was outlined in the age range of 6 to 11 years, whose coverage rate was reduced by about 2 pp. Finally, among adolescents aged 12 to 16 who attended secondary education there was an increase of 5 pp. However, when considering the 13-year-old population, only two-thirds of this universe attended this level of education, which points to the enormous challenge which lies ahead in ensuring the access and permanence of these adolescents in the education system.

To some extent, the non-universalization of primary education and the low coverage in the first cycle of secondary education have affected the completion rates of the levels of basic education, especially among the poorest, as can be seen in Table 10.

Table 10. Completion rate of primary and secondary education, by age group and socioeconomic category – Peru (2010-2017)

	2010	2011	2012	2013	2014	2015	2016	2017
Primary education								
12 to 13 years	77.9	79.3	80.7	80.3	81.7	81.7	85.6	87.0
a) Not poor	86.2	86.6	87.1	86.1	87.3	86.6	90.3	90.6
b) Poor	69.8	70.2	73.1	72.7	72.9	73.4	74.9	80.2
c) Extremely poor	53.0	57.0	56.3	54.6	63.3	61.9	72.0	72.5
b/a	81.0	81.0	83.9	84.3	83.5	84.7	83.0	88.5
c/a	61.5	65.8	64.6	63.4	72.5	71.5	79.7	80.0
Secondary education								
20 to 24 years	77.1	80.0	81.4	82.0	82.4	81.1	81.1	84.0
a) Not poor	83.6	86.2	87.5	87.5	87.5	86.0	85.5	88.3
b) Poor	59.6	61.8	59.7	60.7	61.4	60.3	61.4	67.3
c) Extremely poor	37.1	34.8	34.1	37.8	34.7	36.8	36.1	35.9
b/a	71.3	71.7	68.2	69.4	70.2	70.1	71.8	76.3
c/a	44.3	40.4	39.0	43.2	39.6	42.8	42.3	40.7

Source: Encuesta Nacional de Hogares del Instituto Nacional de Estadística e Informática.
Elaborated by the authors.

The most striking fact is the completion rate of secondary education in the extreme poverty segment. Aside from the fact that the index registered in 2017 corresponds to just over a third of this universe, it was also below the level reached in 2010. So, the gap between this segment and that of the non-poor widened.

2.2 Performance and quality of education

The challenge of inserting children and youth from the most vulnerable sections of the population was almost surpassed in most Latin American countries, especially when it comes to primary and lower secondary education

(final years of elementary school in Brazil). However, the greatest challenge facing countries that have achieved almost universal access to compulsory education is to ensure their completion, with quality.

If the provision of places for all requires, for example, large investments in infrastructure, as well as to ensure student attendance, the second challenge seems to be even more complex, since it will involve overcoming social ills that compromise permanence and school success of children and youth who form the basis of the socioeconomic pyramid.

This understanding is supported by the results of the national proficiency tests carried out in several countries of the region, which, as a rule, show very different performance indices among students, due to their socioeconomic status, which, as a rule, is associated with their attendance to public or private schools.

Despite the fact that the quality of education implies different interpretations and definitions, the results of proficiency in large-scale evaluations have been used as a proxy for quality teaching.

As far as proficiency is concerned, it can be seen that its evolution has been less significant than, for example, the expansion of access to educational levels. In addition, it is observed that school performance inequalities are quite pronounced when comparing the population strata that form the base and top of the socioeconomic pyramid or, therefore, the performance among students of public and private schools.

Latin America is considered the most unequal geopolitical region on the planet, and this inequality has been reduced rather slowly. Even in recent times, when the reduction occurred at a slightly faster pace, it was not enough for the region to leave this uncomfortable position. Therefore, we should not expect structural changes in the distribution of wealth, let alone in a short period of time, so that educational inequalities are reduced to acceptable levels.

Although the income and school performance of students are closely associated and, as a rule, such an association has contributed to the school failure of a significant portion of Latin American children and youth, educational management experiences have shown that it is possible to break this vicious circle from interventions on factors or variables intrinsic to school. From this perspective, the school would assume a greater role and leave the condition of a mere variable dependent on social reality.

Considering that the data provided by the countries of the region are not perfectly comparable, it is necessary to analyze them separately. Even so, it is believed that it is possible to establish a minimum of comparability, so that common trends can be delineated in their trajectories.

Argentina

In Argentina, there were changes to the large-scale evaluation system in 2016, which partially compromises the historical series between 2013 and 2017. Only the last two years listed in Table 11 are derived from the same methodology.

Table 11. Distribution of students by level of proficiency in large-scale assessments (ONE and Aprender) – Argentina (2013, 2016 and 2017)

Proficiency level	2013			2016			2017		
Language and communication	**General**	**Public**	**Private**	**General**	**Public**	**Private**	**General**	**Public**	**Private**
. Below basic	28.5	33.4	20.0	23.0	27.1	15.4	17.9	23.0	8.6
. Basic	21.0	23.8	16.1	23.4	26.6	17.7	19.6	23.3	13.0
. Satisfactory	39.5	36.1	45.4	44.2	40.6	50.9	45.4	43.0	49.9
. Advanced	11.0	6.7	18.5	9.4	5.7	16.1	17.1	10.7	28.5
Mathematics									
. Below basic	40.0	48.1	25.8	40.9	49.2	25.8	41.3	49.5	26.7
. Basic	24.7	26.1	22.4	29.3	30.1	27.8	27.5	28.2	26.3
. Satisfactory	27.9	22.0	38.2	24.6	18.2	36.2	27.0	20.4	38.8
. Advanced	7.4	3.8	13.6	5.2	2.4	10.2	4.2	1.9	8.2

Source: Secretaria de Evaluación Educativa/Ministerio de Educación/Argentina.
Note: ONE (2013) and Aprender (2016 and 2017).
Elaborated by the authors.

The first aspect to be highlighted from the data in Table 11 refers to the high proportion of students with substandard performance considered as minimum (satisfactory), especially in mathematics. If in language and communication there was a reduction of this percentage between 2013 and 2017, from 49.5% to 37.5%, in the area of mathematics there was a slight increase, although there possibly are methodological differences between these assessments.

The second dimension to be considered concerns performance differences between public and private schools. In this case, two distinct trends were identified; in language and communication, more than doubled the proportion of students in public schools with an unsatisfactory level of proficiency compared to the proportion of students in private schools. Otherwise, there was a reduction of 7 pp in favor of the students of public schools. However, it must be taken into account that the proportion of these students with unsatisfactory proficiency increased from 74% to 78% in the same period. An increase of 5 pp was also recorded in private schools, which now has 53% of its students with unsatisfactory proficiency in mathematics.

In summary, the evaluation of this period is that very little progress has been made in terms of the quality of education when the students' proficiency in language and mathematics is taken as an indicator. In addition, the deep inequalities persist between the lower and higher income groups, which, in the case of Argentina, have as a proxy the public and private education schools, respectively.

Brazil

The National Basic Education Assessment System (SAEB) was created in 1990 and since then it has expanded in terms of scope (levels of education and students). In 2007, it began to be used to calculate the Basic Education Development Index (IDEB), which became the main indicator of monitoring the quality of basic education in Brazil.

SAEB's assessments are held every two years. For the calculation of the IDEB, the students of the 5th and 9th grade of elementary school (Portuguese and mathematics) and the 3rd grade of the secondary school (Portuguese, mathematics and science) are evaluated.

Taking the 2009-2015 period, there was an improvement in the performance of Brazilian students attending elementary school, especially those in the initial years. Table 12 presents the mean scores in the 5th year of primary education, in Portuguese and mathematics, disaggregated by public and private schools.

The greatest improvements were in Portuguese and in public schools (state and municipal). As a result, the disadvantage of students in these schools was reduced compared to that of private schools, in the proportion of 5 pp.

Table 12. Proficiency in the Prova Brazil, in Portuguese and mathematics, in the 5th year of elementary education, in public and private schools – Brazil (2009-2015)

	2009	2011	2013	2015	var %
Portuguese	184.3	190.6	195.9	207.6	12.6
a) Private	220.2	222.7	229.6	234.6	6.5
b) Public	179.6	185.7	189.7	202.3	12.6
b/a (%)	81.5	83.4	82.6	86.2	
Mathematics	204.3	209.6	211.2	219.3	7.3
a) Private	240.7	242.8	244.5	243.6	1.2
b) Public	199.5	204.6	205.1	214.6	7.5
b/a (%)	82.9	84.3	83.9	88.1	

Source: INEP/MEC.
Elaborated by the authors.

When analyzing the results obtained by the students of the 9th year of elementary school, advances were less expressive. A very similar result was found among students from both public and private schools for Portuguese. In mathematics, where public school students were more disadvantaged than those in private schools, there was slightly greater progress of the students in public schools.

Table 13. Proficiency in Prova Brazil, in Portuguese and mathematics, in the 9th year of elementary education, in public and private schools – Brazil (2009 a 2015)

	2009	2011	2013	2015	var %
Portuguese	244.0	245.2	245.8	253.5	3.9
a) Private	278.6	282.3	280.9	285.9	2.6
b) Public	238.7	238.8	239.4	247.3	3.6
b/a (%)	85.7	84.6	85.2	86.5	
Mathematics	248.7	252.8	251.5	257.7	3.6
a) Private	293.9	298.4	293.9	295.3	0.5
b) Public	241.8	244.8	243.8	250.6	3.6
b/a (%)	82.3	82.0	82.9	84.8	

Source: INEP/MEC.
Elaborated by the authors.

In addition to the fact that the improvement in performance was less significant than in the fifth year of elementary school, the reduction of the disadvantage among students of public and private schools was also smaller. This fact may be associated with the greater difficulties imposed on adolescents belonging to the less favored socioeconomic strata, which compromise their school performance, such as insufficient parental supervision, lack of access to school reinforcement activities and even the need to perform some kind of work, whether paid or not.

In relation to secondary education, which at the international level is better known as upper secondary, there was a slight fall in the proficiency indexes reached by students of this level of education between 2009 and 2015, especially in mathematics, as shown in Table 14.

Table 14. Proficiency in Prova Brazil, in Portuguese and mathematics, in the 3rd year of high school, in public and private schools – Brazil (2009-2015)

	2009	2011	2013	2015	var %
Portuguese	268.8	268.6	264.1	267.9	- 0.4
a) Private	310.2	312.8	306.2	307.1	- 1.0
b) Public	262.2	261.4	256.6	260.9	- 0.5
b/a (%)	84.5	83.6	83.8	85.0	
Mathematics	274.7	274.8	270.2	267.6	- 2.6
a) Private	329.3	332.9	321.6	310.0	- 5.8
b) Public	265.9	265.4	261.1	260.0	- 2.2
b/a (%)	80.8	79.7	81.2	83.9	

Source: INEP/MEC.
Elaborated by the authors.

The disadvantage faced by public schools students compared to those in private ones is greater than that found in elementary school, which is understandable, since there is a significant percentage of students who attend night classes and, as a rule, reconcile studies with a daily workday, resulting in less time to study.

Chile

National proficiency assessments are conducted annually in Chile in the 4th year of primary education, with reading and mathematics tests, while reading, mathematics and science are evaluated in the 8th grade (lower secondary). The results for the 4th year are available including 2017, but for the 8th year only until 2016.

As shown in Table 15, the level of proficiency of 4th-grade students fell in reading and had a small increase in mathematics, due to students belonging to the low socioeconomic stratum.

Another indicator in Table 15 is the percentage ratio between the performances of the two population segments. Regarding the reading, practically the difference existing throughout the historical series has been maintained, which reiterates that the stagnation of the results occurred in an almost generalized way. On the other hand, in mathematics, there was a reduction of the inequality between the two SEL of around 5 pp in the period 2010-2017.

As it has been seen in relation to Brazil, as the level of education increases, the levels of proficiency decrease over the years. In the period 2011-2017, there was an almost generalized drop in students' performance in reading and mathematics, as can be seen in Table 16.

Table 15. Reading and mathematics proficiency of 4th-grade students by selected socioeconomic levels – Chile (2010-2017)

	2010	2011	2012	2013	2014	2015	2016	2017	var %
Reading	271	267	267	264	264	265	267	269	- 0.7
a) High SEL	304	299	301	298	298	300	301	303	- 0.3
b) Low SEL	250	249	248	245	245	245	247	250	-
b/a (%)	82.2	83.3	82.4	82.2	82.2	81.7	82.1	82.5	
Mathematics	253	259	261	256	256	260	262	261	3.2
a) High SEL	300	301	299	297	296	300	300	297	- 1.0
b) Low SEL	225	235	238	234	234	234	237	238	5.8
b/a (%)	75.0	78.1	79.6	78.8	79.1	78.0	79.0	80.1	

Source: Simce/Agencia de Calidad de la Educación.
Elaborated by the authors.

Table 16. Proficiency in reading and mathematics of 8th-grade students, by selected socioeconomic levels – Chile (2010-2017)

	2011	2013	2014	2015	2017	var %
Reading	254	255	240	243	244	- 3.9
a) High SEL	293	288	277	274	275	- 6.1
b) Low SEL	235	237	219	225	224	- 4.7
b/a (%)	80.2	82.3	79.1	82.1	81.5	
Mathematics	259	262	261	263	260	0.4
a) High SEL	311	311	309	312	310	- 0.3
b) Low SEL	236	236	233	233	230	- 2.5
b/a (%)	75.9	75.9	75.4	74.7	74.2	

Source: Simce/Agencia de Calidad de la Educación.
Elaborated by the authors.

The performance in reading had a greater fall among students belonging to the high SEL, reducing slightly their advantage over the students of low socioeconomic level, while the inverse occurred in relation to the scores in mathematics, which resulted in the expansion of the disadvantages faced by students belonging to the Low SEL. However, the median ratio remained positive due to the more favorable performance of students from intermediate SEL.

It should be noted that the differences in performance are more pronounced among the respective socioeconomic segments in the 8th year, especially in mathematics, which indicates that school success for the poor tends to decrease as the level of education rises.

Colombia

In Colombia, proficiency assessments in basic education cover students in 3rd and 5th year of primary education, 9th year of secondary and 11th year (middle school). For this study, we opted to analyze only the results referring to primary and secondary education.

The proficiency indexes in language (Spanish) and mathematics will be analyzed, according to the following approaches: i) temporal (2012 and 2016); ii) socioeconomic level; and iii) public/private. The selected indicators

refer to the distribution of students in the proficiency scale adopted by the ICFES, composed of four levels, namely: unsatisfactory, minimum, satisfactory and advanced; and to the average performance scores by some categories.

Initially, the distribution of students in the 3rd year of primary education, by the level of proficiency in Spanish, the urban public educational institutions and the private schools is presented.

Table 17. Distribution of students in the 3rd year of primary education, by the level of language proficiency, according to public or private schools – Colombia (2012 and 2016)

Proficiency level	2012			2016		
	General	Public Urban	Private	General	Public Urban	Private
Unsatisfactory	23	24	7	19	20	5
Minimum	31	34	19	28	31	16
Satisfactory	30	31	35	32	33	36
Advanced	16	12	40	22	17	44
Average score	298	288	351	313	307	354
Proportion oh the private	84.9	82.1		88.4	86.7	

Source: Instituto Colombiano para la Evaluación de la Educación.
Elaborated by the authors.

As shown in Table 17, there was progress over the period under review, with the reversal of the predominance of the first two levels in favor of the last two. In other words, in 2016, students who performed at least satisfactory were already predominant. Nevertheless, 47% of the Colombian students enrolled in this year of education had proficiency below this level. Another fact that calls attention, but only reiterates the trend identified in other Latin American countries, refers to the performance differential between public and private school students. Although the percentage of students with unsatisfactory proficiency in both educational systems was reduced, the reduction in public schools was less intense than in the private ones.

Another way to show the inequalities of proficiency in the Colombian education system can be through the socioeconomic level of the school (SEL). In this case, the ICFES defined four levels, with SEL 1 being the lowest and SEL 4 being the highest, as can be seen in Table 18.

Table 18. Distribution of students in the 3rd year of primary education by the level of proficiency in language, according to the socioeconomic level – Colombia (2012 and 2016)

Proficiency level	2012				2016			
	SEL 1	SEL 2	SEL 3	SEL 4	SEL 1	SEL 2	SEL 3	SEL 4
Unsatisfactory	37	25	13	4	31	22	9	2
Minimum	33	36	32	16	29	32	24	9
Satisfactory	22	29	38	37	25	31	39	34
Advanced	8	10	17	44	15	16	29	55
Average score	267	285	312	366	291	304	332	369
Proportion oh the SEL 4	73.0	77.9	85.2		78.9	82.4	90.0	

Source: Instituto Colombiano para la Evaluación de la Educación.
Elaborated by the authors.

Although there was a significant reduction of the difference between the average scores of the first three levels in relation to the SEL4 (Proportion of the SEL4) between 2012 and 2016, the decrease in the percentage of students with unsatisfactory and minimum performance was higher in this last socioeconomic level.

Regarding students in the 5th year of primary education, there was a reduction of inequality between public and private schools, in relation to the average math score. However, as was observed among students in the 3rd year of primary education, the reduction in the proportion of students with unsatisfactory performance was slightly lower in the public schools than in the private ones.

Regarding the performance according to the socioeconomic level of the school, there was also a reduction of the inequalities between the scores of the first three socioeconomic levels and the SEL 4, as shown in Table 20.

Regarding the distribution of SEL scores of the schools, there was an increase in the proportion of students with unsatisfactory proficiency, except for SEL 1. In the other levels, increases varied from 21% (SEL 2) to 52% (SEL 4).

Finally, the proficiency results for the students of the 9th year (secondary education) in natural science are presented. Differently from the trends observed in the 3rd and 5th years of primary education, in the 9th year there was a significant decrease of the mean scores in all categories analyzed, as shown in Table 21.

Table 19. Distribution of students in the 5th year of primary education by the level of proficiency in mathematics according to the school – Colombia (2012 and 2016)

Proficiency level	2012			2016		
	General	Public Urban	Private	General	Public Urban	Private
Unsatisfactory	38	39	19	36	37	18
Minimum	31	33	28	29	32	26
Satisfactory	20	20	27	21	20	28
Advanced	11	8	26	14	11	29
Average score	294	290	344	305	300	342
Proportion oh the private	85.5	84.3		89.2	87.7	

Source: Instituto Colombiano para la Evaluación de la Educación.
Elaborated by the authors.

Although there was a general reduction in the average scores in the three categories, the differences between the national average and that of the urban public schools were slightly reduced compared to that of the private schools.

Regarding the distribution of proficiency scores by the SEL of the schools, only for the SEL 4 there was not an increase in the proportion of unsatisfactory levels.

Table 20. Distribution of students in the 5th year of primary education by level of proficiency in mathematics according to the socioeconomic level – Colombia (2012 and 2016)

Proficiency level	2012				2016			
	SEL 1	SEL 2	SEL 3	SEL 4	SEL 1	SEL 2	SEL 3	SEL 4
Unsatisfactory	55	23	13	4	52	40	24	9
Minimum	27	35	31	17	24	30	32	23
Satisfactory	12	27	33	31	15	19	26	32
Advanced	5	15	23	48	10	11	19	36
Average score	261	283	310	359	278	297	324	359
Proportion oh the SEL 4	72.7	78.8	86.4		77.4	82.7	90.3	

Source: Instituto Colombiano para la Evaluación de la Educación.
Elaborated by the authors.

Table 21. Distribution of the students of the 9th year of secondary education by the level of proficiency in natural sciences, according to the educational system – Colombia (2012 and 2016)

Proficiency level	2012			2016		
	General	Public Urban	Private	General	Public Urban	Private
Unsatisfactory	12	13	5	21	22	9
Minimum	48	51	30	49	52	35
Satisfactory	30	29	38	24	23	39
Advanced	10	7	27	6	4	18
Average score	312	303	370	288	282	332
Proportion oh the private	84.3	81.9		86.7	84.9	

Source: Instituto Colombiano para la Evaluación de la Educación.
Elaborated by the authors.

It should be noted that the proportion of 72% achieved by SEL 1 in 2016 corresponds to the largest difference observed in comparison with the results of the 3rd and 5th years. This data reiterates the trend of increasing inequality as the level of education rises.

Table 22. Distribution of students in the 9th year of secondary education by the level of proficiency in natural science according to the socioeconomic level – Colombia (2012 and 2016)

Proficiency level	2012				2016			
	SEL 1	SEL 2	SEL 3	SEL 4	SEL 1	SEL 2	SEL 3	SEL 4
Unsatisfactory	23	15	8	3	36	25	13	3
Minimum	56	55	48	28	51	53	48	25
Satisfactory	18	25	35	41	12	19	32	45
Advanced	3	5	9	29	2	3	8	26
Average score	270	291	319	379	256	274	305	356
Proportion oh the SEL 4	71.2	76.8	84.2		71.9	77.0	85.7	

Source: Instituto Colombiano para la Evaluación de la Educación.
Elaborated by the authors.

Mexico

Large-scale proficiency assessments in basic education have been significantly altered in recent years. Between 2006 and 2013, the ENLACE

(National Assessment of Academic Achievement in Schools) was given annually and in some of the years the EXCALE (Educational Quality and Achievement Tests) was given.

In 2015, PLANEA (National Plan for the Evaluation of Apprenticeships) was created, with the justification that ENLACE was handed out excessively (annually and for several grades), and that the granting of incentives to teachers would have inflated the results. In turn, the results of the EXCALE would have had little social visibility and, consequently, little influence in decision making on educational policy (INEE[6], 2017). In this way, the results of the ENLACE in the period 2006-2013 and of the PLANEA from 2015 onwards will be presented, noting that they are not comparable and therefore do not constitute a historical series.

Table 23. Proportion of 3rd to 6th-grade primary school students with satisfactory/excellent performance in Spanish and mathematics, according to the educational system – Mexico (2006-2013)

	2006	2007	2008	2009	2010	2011	2012	2013	var %
Spanish									
. National	21.3	24.6	30.5	32.8	36.9	40.0	41.8	42.8	100.9
a) Private	52.4	58.8	66.7	65.7	69.3	69.3	67.8	64.8	23.7
b) General	19.3	22.4	28.5	30.8	35.0	38.5	40.1	41.7	116.1
b/a (%)	36.8	38.1	42.7	46.9	50.5	55.6	59.1	64.4	
Mathematics									
. National	17.6	22.3	27.7	31.0	33.9	37.0	44.3	48.8	177.3
a) Private	39.8	47.9	57.2	56.8	58.6	57.4	61.3	62.4	56.8
b) General	16.3	20.8	26.2	29.4	32.5	35.9	43.4	48.2	195.7
b/a (%)	41.0	43.4	45.8	51.8	55.5	62.5	70.8	77.2	

Source: Enlace/Secretaría de Educación Pública/Ministerio de la Educación.
Elaborated by the authors.

The ENLACE comprised students in grades 3 to 6 of primary education and those in grades 1 to 3 in secondary education, equivalent to elementary school in Brazil; in addition to students in grades 1 to 3 of upper secondary education. As evidenced by the results provided by INEE, there has been

6 National Institute for Educational Assessment and Evaluation.

continuous progress since the beginning of its application, having doubled the proportion of students with satisfactory/excellent performance in Spanish and increased by 177% this standard of mathematics proficiency, as can be seen in Table 23.

Although performance inequalities among public and private school students, especially in the area of mathematics, were reduced, more than half of public school students still had proficiency rates in 2013 below what would be considered acceptable. In addition, one can suspect this accelerated rate of progress in view of one of the justifications used for reformulating the Mexican system of evaluation of basic education, according to which these results would have been inflated due to the granting of bonuses to teachers (INEE, 2017). To a certain extent, the results of the PLANEA, from 2015 onwards, corroborate this argument, as shown in Table 24.

Table 24. Percentage distribution of 6th-grade students of primary education, according to the level of proficiency and the educational system in the PLANEA – Mexico (2015)

Area/Proficiency level	Total	Public	Private
Language and Communications			
. Level I	49.5	51.6	13.3
. Level II	33.2	34.1	33.9
. Level III	14.6	12.7	38.9
. Level IV	2.6	1.6	13.9
Mathematics			
. Level I	60.5	62.8	25.9
. Level II	18.9	19.0	23.0
. Level III	13.8	12.9	27.4
. Level IV	6.8	5.4	23.8

Source: PLANEA/INEE.
Elaborated by the authors.

Considering the methodological differences between the ENLACE and the PLANEA tests, levels III and IV and the categories satisfactory and excellent can be considered as equivalent. In this sense, the proportion of acceptable

proficiency indexes in the PLANEA ranged from 17.2% to 20.6% in the 6th year of primary education. Therefore, well below the more than 40% recorded in the last year of the ENLACE. It should be noted, however, that this index refers to the average performance of students in grades 3 to 6 of primary education, while in the PLANEA only 6th-grade students are evaluated[7].

Table 25. Percentage distribution of 3rd year students in secondary education by the level of proficiency and school in the PLANEA – Mexico (2015 and 2017)

Area/Proficiency level	2015			2017		
	Total	Public	Private	Total	Public	Private
Language and Communications						
. Level I	29.4	27.9	10.1	33.8	31.6	10.6
. Level II	46.0	47.9	37.3	40.1	42.8	32.2
. Level III	18.4	18.6	32.8	17.9	18.3	31.4
. Level IV	6.1	5.3	19.8	8.3	7.3	25.9
Mathematics						
. Level I	65.4	67.0	39.9	64.5	66.2	37.0
. Level II	24.0	23.6	33.2	21.7	21.7	29.1
. Level III	7.5	6.8	16.9	8.6	8.0	17.8
. Level IV	3.1	2.5	10.0	5.1	4.1	16.0

Source: PLANEA/INEE.
Elaborated by the authors.

Table 24 also highlights the inequalities of proficiency among public and private school students. Most of the students in public schools were in level I, while more than half of the students in the private schools were in levels III and IV.

Considering that students in the 6th year of primary education were not evaluated in the 2017 edition of the PLANEA, we will present the results obtained by the students of the 3rd year of secondary education, who had

7 In the absence of data disaggregated by grades/year of primary education in Spanish and mathematics, one can use as proxy the data of the PLANEA 2013, referring to Civics and Ethical Studies, according to which the Good/Excellent proficiency indexes in the 6th year corresponded to 49% and the average index of the 3rd to the 6th year was only 45%. Formação Cívica e Ética, segundo os quais os índices de proficiência Bom/Excelente no 6º ano correspondiam a 49% e o índice médio do 3º ao 6º ano era de apenas 45%.

already taken this test in 2015. Thus, it is possible to analyze the evolution of proficiency in language and mathematics, even in a short period of time.

In spite of having increased the proportion of students in level I in language, it can be affirmed that, in general, there was an increase of the percentages in the levels of proficiency III and IV, here considered acceptable, both in language and in mathematics. However, the high proportion of students with below-acceptable performance in both public and private schools is striking.

Peru

Large-scale assessments are conducted in the second year of primary and secondary education. In the first case, data are available from 2007, but in secondary education assessments were undertaken only in 2015 and 2016. Therefore, we opted to analyze only the results of proficiency in primary education. In this case, the assessments cover reading comprehension and mathematics, the results of which are presented in Table 26.

Table 26. Percentage of students in the 2nd year of primary education who have attained learning objectives in reading comprehension and mathematics – Peru (2010-2016)

	2010	2011	2012	2013	2014	2015	2016
Reading omprehension	28.7	29.8	30.9	33.0	43.5	49.8	46.4
a) Urban	35.5	36.3	37.5	38.5	49.7	55.1	50.9
b) Rural	7.6	5.9	7.0	10.4	16.7	18.5	16.5
b/a	21.4	16.2	18.6	27.0	33.5	33.5	32.4
c) Private	48.6	50.3	51.4	47.3	57.4	61.3	51.8
d) Public	22.8	23.0	24.0	27.6	38.1	45.1	44.3
d/c	46.9	45.8	46.7	58.2	66.4	73.6	85.4
Mathematics	13.8	13.2	12.8	16.8	25.9	26.6	34.1
a) Urban	16.4	15.8	15.2	19.4	28.9	29.1	36.6
b) Rural	5.8	3.7	4.1	6.5	13.1	12.3	17.3
b/a	35.2	23.4	27.2	33.4	45.5	42.3	47.2
c) Private	20.9	18.9	16.5	19.6	26.4	24.6	25.4
d) Public	11.7	11.3	11.5	15.8	25.7	27.5	37.4
d/c	56.0	59.8	70.0	80.8	97.3	111.7	147.1

Source: Encuesta Nacional de Hogares/Instituto Nacional de Estadística e Informática.
Elaborated by the authors.

Differently from what was observed in the other countries analyzed in this study, the Peruvian students' proficiency results are not presented in the form of a scale. In this way, it is verified that, as a rule, the majority of students evaluated fell below a minimum standard of proficiency, in reading comprehension and, mainly, in mathematics.

Another aspect to be highlighted concerns the inequalities related to the location of the domicile (rural/urban) and the administrative nature of the school (public/private). It should be noted, however, that such differences have been reduced over the period under analysis and, as shown in Table 26, the performance of public school students would have surpassed that of their peers from private schools, which is an unprecedented fact between the countries of the region.

3. Final considerations

It was possible to identify that, during the period under analysis, there was no reversal of the trend towards increased access to basic education, both in terms of the region's aggregate indicator, despite the lack of more recent data, and the separate analysis of the countries composing this study sample. In addition, it should be noted that the greatest advances occurred in the levels of education that were not recently considered compulsory, such as preschool and upper secondary education.

Another aspect to be highlighted concerns the reduction of inequalities according to the socioeconomic level, the location of the home and the educational system. As a rule, the income strata that make up the base of the social pyramid are the majority in rural households and in public schools. When these factors are associated, they tend to reduce even more indicators of access and school success.

On the other hand, the improvement of the quality in basic education, inferred from the results of proficiency in the large-scale evaluations, also maintained its upward trajectory, albeit at a less accelerated pace than that of increasing access. In this sense, it was possible to verify that the gaps are still very deep, especially when one has by reference the stratification of the income.

It is possible that these trends have been maintained over the period under review because several of these countries have secured minimum percentages of fiscal revenues, or even GDP, for investments in education. In addition, there is a possibility that the reduction of the budget does not immediately lead to a reduction in supply and quality. One of the arguments for this is that the main cost of maintaining education relates to teachers' salaries and that, even if they are compressed, it would not immediately lead to a reduction in the number of staff and a consequent reduction in the supply of education, especially in periods of low economic growth with rising unemployment.

However, the worsening of the economic crisis, or even its continuity, could jeopardize the achievement of the educational goals established by the countries of the region, with a view to overcoming their persistent and deep educational inequalities.

Under an economic crisis, they tend to carry out budget cuts that directly impact the social area. This is Brazil's recent case in which the federal government was able to amend the Federal Constitution in 2016 in order to establish a 20-year spending ceiling that, in practice, should reduce its share in the public education funding and, consequently, the weakening of its supplementary action for the purpose of reducing inequalities among the federated entities.

Therefore, although these impacts have not been identified in this short period of analysis, in terms of access and proficiency, they can hardly be avoided in a context of budget cuts, especially when facing the challenge of overcoming the profound educational inequalities, which, in the final analysis, compromise the universalization of the right to quality education for all.

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Health systems in Latin America in the 21st century

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Health systems in Latin America in the 21st century

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1. Introduction

The original objective of this text, proposed by the organizers of the collection, was to analyze public policy trends in Latin America in recent years, based on the hypothesis of a reversion on the scenario of growth, income distribution and inequality reduction that prevailed in many countries at the beginning of the 2010 decade, specifically in relation to its impact on health policies and systems.

In the process of researching and writing the text, we chose to broaden the scope and period analyzed for the whole of the twenty-first century, due to a set of historical, structural, theoretical, didactic and methodological factors. First, health systems in Latin America are heterogeneous, because of their origins and trajectories and the impacts of the "neoliberal" reforms of the 1980s and 1990s, and their transition processes are slow and gradual[1], demonstrating significant inertia in the subregion's health policies. Second, the two previous reports of the International Observatory of Human Capacities, Development and Public Policies do not present studies on the historical trajectories of these health systems, which would make discontinuous and difficult to understand only the second half of the 2010. Third, the flagship publications (PAHO, 2012, 2014, 2015, 2016, 2017a, 2017b; ECLAC, 2016) that present empirical data on the subject bring updated information until circa 2012/13, not allowing the construction of comparative series between years of expansion of social protection in health and those in which the options of "austere" economic policy suggest a reduction in social policy.

1 In the last ten years, only Uruguay has implemented a structural reform, with the creation of the National Integrated Health System.

Fourth, the major scientific journals that publish critical articles about these changes in political orientation and even the gray literature have a major delay in relation to current events (DHRIFI, 2018; SOUTH AMERICAN INSTITUTE OF GOVERNMENT IN HEALTH, 2012), both because of the academic tradition of distancing from conjunctural analysis and the extended period between the submission of the texts and their publication.

2. Notes on the origins and evolution of health systems in Latin America until the end of the 20th century

The art/science of treating/healing is millenarian, represented in Egyptian hieroglyphs, with inscriptions identified between the year 3000 BC and the fourth century AD, and is described in detail in the Hindu Bhagavad Gita of the fourth century BC, in the Judeo-Christian Old Testament of the second century BC and the Koran of the seventh century AD. However, the brief history of the construction of health systems as public policy is only about 150 years, reflecting the history, structure, and social processes of hegemony-conflict-solidarity between social classes; the correlation of forces between different interest groups; and the political and socioeconomic conditions of respective societies/nations at different historical moments.

Health and social protection policies emerged from the processes of consolidation/reconstruction of national states, such as Bismarck's unification of Germany in the last quarter of the 19th century, through the Bismarckian or corporatist-statist institutional format (ESPING-ANDERSEN, 1991) of social insurance, and expanded during the 20th century to France, the Netherlands and other countries of Continental Europe. In Soviet Russia in 1919, in the context of the civil war that followed the October Revolution of 1917 and the end of World War I, Lenin named Nikolai Aleksandrovich Semashko commissar of public health, responsible for implanting the first universal health system of history, which spread through all the socialist countries of Eastern Europe and Central Asia until the late 1980s.

Almost simultaneous to that, 1920 was the year of the pioneering proposition of universal health protection in Western Europe, which appears in the Dawson Report on Future Provision of Medical and Allied Services (PAHO, 1962). Nevertheless, it would take almost thirty years for it to become

a public policy, retrieved only in the 1942 Beveridge Report[2], conceiving universal medical care as a citizen's right rather than charity, and stating it as essential among one of the "five giants that Beveridge declared should be slain during post-war reconstruction: want, disease, squalor, ignorance, idleness". (BEVERIDGE, 1942 apud RIVETT, 2017).

Despite the well-deserved tributes to Lord Beveridge, whose name designates the Beveridgian model of the National Health Service, they unfairly omit the name of the person responsible for political negotiations with the Conservative Party and the physicians and for the effective implementation in 1948 of the National Health Service: Nye Bevan, Minister of Health and Housing in the Labor government of Clement Attlee, who in 1945 defeated the Tories[3] of Winston Churchill in the post-World War II elections, with a platform centered on solidarity and universality of social policies as inspiration for the reconstruction of a nation seriously destroyed by war, paradoxically in the society that was the cradle of liberal capitalism. This conception expanded during the 20th century to Scandinavia and later to Spain, Italy, Greece and Portugal, constituting the social-democratic or institutional-redistributive format of the Welfare State (ESPING-ANDERSEN, 1991).

This historical journey is indispensable for understanding the origins and evolution of our object of analysis, the health systems of Latin America, since the institutional formats referred to were, to varying degrees, in the different countries of the subregion and at different times the trajectories of their health policies, inspiring the ideas and constitutive of the implanted institutional-organizational models (MESA-LAGO, 2008), although it is not possible to characterize in any Latin American country the full development of a Welfare State.

Also in these latitudes, the implantation of social protection systems in health was a fundamental component of the consolidation of the national states, initially through the sanitary and public hygiene campaigns implemented since the independence of the Ibero-American countries. Later on, they expanded their performance in the health sector by the increasing incorporation of medical and hospital services, with the pioneering establishment of Bismarckian social insurance systems in Argentina, Brazil, Chile

2 William Beveridge's Report, Social Insurance and Allied Services, November 1942, laid the foundation for the British Welfare State, including the creation of the National Health Service.

3 Conservative Party of the United Kingdom.

and Uruguay in the context of the political transformations, the processes of industrialization and the rise of the urban working and bourgeois classes that occurred from 1920/30 onwards. Examples of that are the creation of retirement and pension institutes and their health care programs during the Estado Novo of Getúlio Vargas in Brazil, the various Social Works in Argentina and the Collective Medical Assistance Institutions in Uruguay. Later on, came the Costa Rican Social Security Fund in 1941, of the Social Security Fund of Panama and of the Mexican Social Security Institute in 1943.

These institutional formats followed the socioeconomic development of the countries until the crises of the import-substitution model and the external debt of the late 1970s and early 1980s, reaching population coverage ranging from 50 to 70% of the population (PAHO, 2007; MESA-LAGO, 2008), without, however, tracing the path of universal social health insurance coverage observed in European counterparts.

No less relevant to the countries of Latin America, as indeed for the whole world, was the post-war impact of the creation of the British National Health Service. In the 1950s, 1960s, and 1970s, the subregion countries were inspired by it to deploy a broad array of hospitals, outpatient clinics and state health centers, of general access and free of charge, both under the responsibility of national governments and at state, provincial and municipal levels, depending on their federative or unitary characteristics.

This process took advantage of the unique opportunities created by the democratic wave propagated by the defeat of Nazi-fascism, by the particular conditions of international trade favorable to the agro-exporting economies and to the incipient industrialization oriented to the domestic markets and by the increase of social spending due to the predominance of the Keynesian economic policies, typical of what was considered the Golden Age of Capitalism.

Brazil, Chile, Colombia, Mexico and Uruguay constituted a thriving public subsector of medical and hospital care, including emergencies, public health and "vertical" programs of maternal, child and mental health, and to combat infectious diseases such as tuberculosis and leprosy. In the case of Brazil, in 1974 the National Health System was instituted; in Chile, in 1979, the National Health Services System; and in Uruguay, in 1987, the State Health Services Administration.

Movements of academic origin, such as those of Community, Preventive and Social Medicine, developed in the 1960s and 1970s, also boosted the growth of public services, especially public health centers. International organizations such as WHO and UNICEF led, from the Alma-Ata Conference in 1978, a strong incorporation of the universalizing idea present in the Primary Health Care strategy aimed at achieving Health For All by the Year 2000, with a clear inspiration in the British Welfare State.

However, this expansion of state medical-care provision has been an addition rather than a substitute for social insurance, then fully institutionalized and politically supported by union corporations and bureaucracies of the securitarian organizations, consolidating national situations that little reflect the organizational models of the aforementioned European ideal types. On the contrary, the health policy trajectories in the subregion were characterized by the partial incorporation of characteristics originating in the different institutional formats of the Welfare State, simultaneous to the free expansion of private medical-hospital assistance, initially available to the population groups with the capacity to private purchase these services and subsequently organized in the form of individual, family or business prepaid plans/insurance.

The physical structure of services provision has developed for decades in an autonomous and parallel manner in each of these subsystems – and even within them – without territorial or operational integration, complementarity or formal coordination mechanisms of care, reference and counter-reference.

This process has consolidated the operational fragmentation of our systems, reinforced by multiple factors: deep socioeconomic inequalities; stratification of social classes and segregation of population groups; institutional segmentation resulting from the historical trajectories of health and social protection systems, which generated multiplicity of paying institutions and payment mechanisms, contradictions and "gray areas" in the legal and administrative rules of the different subsystems; weakness of the Sanitary Authority's administrative capacity; models of attention that are contrary to integration, centered in the disease, in the care of acute episodes and in hospital care; vertical programs, focused on diseases and risks, with extreme separation of care services; insufficiencies in planning the quantity, quality and distribution of resources and services; and cultural behaviors and habits of the population and service providers (LEVCOVITZ, 2009).

The results of such historical trajectories constitute strong structural characteristics of the health systems of Latin America, fully consolidated in the 1970s: 1) segregation/stratification of the population according to social class, income, socioeconomic condition, ability to pay, insertion in the formal labor market, ethnic origin and urbanity/rurality; 2) segmentation of the population into groups with different rights and conditions of access and use of services; and 3) operational fragmentation with overlapping and duplication of offers from different providers and the lack of coordination of establishments/care units.

In summary, the first half century of health policy evolution in Latin America has marked a sustained trend in the extension of social protection in health, even though it is limited both in terms of population coverage, amplitude of care provision and benefits as well as equal access, use and quality of services.

In the years 1980-90, there is an opposite trend, when the depletion of the import-substitution development model (BIELSCHOWSKY, 2018), accelerated by the oil price shocks of 1973 and 1978, and by the Federal Reserve's decision to break with the model of international financial regulation in force since the end of World War II[4], drastically raising interest rates and eliminating the dollar-gold parity, pushed the peripheral and dependent economies of the subregion to priceless external debts and strong fiscal, currency and monetary imbalances, disrupting the wide cycle of growth of Keynesian inspiration. Developmentalist economic policies were quickly and radically replaced by macroeconomic reforms centered on rigid fiscal adjustment, restriction of public spending, privatization of state assets, reduction of national state size and functions, and labor market deregulation, following the provisions of the Washington Consensus.

The "health sector reforms"[5] that translated the provisions of the Washington Consensus did not respect the unique historical, political and sanitary organizational characteristics of each country and adopted uniform rules dictated by the "International Financial Institutions". Sanitary issues were left aside, focusing on financial and management aspects, with emphasis on the search for microeconomic efficiency, privatization, decentralization and separation of

4 Known as the Bretton Woods system.

5 Euphemism adopted by the World Bank, the Inter-American Development Bank and USAID to designate "negotiated" technical and financial cooperation projects with countries to "modernize" their health systems in line with the "Washington Consensus" prescriptions.

the functions of rectorship (the only one that should follow as exclusive attribution of the State), financing, insurance and service provision (which should be shared with – or be fully transferred to – private entities). Chile, Colombia, and most Central American countries have adopted this prescription fully, but their impact has been felt in all countries. Chart 2 summarizes these impacts.

Chart 1. Structural characteristics of health systems in Latin America*

Segmentation: subsystems with different financing modalities, affiliation and provision, each of them "specialized" in different strata of the population, according to their labor insertion, level of income, ability to pay and social class.
• Consolidates and deepens inequality in access and utilization among different population groups;
• Coexist one or several public entities, social insurance and several financiers, insurers and private providers.

Fragmentation: coexistence of non-networked units and services
• Services/establishments that do not cooperate mutually, ignore and/or compete with other providers;
• Multiple agents operating without integration prevent the standardization of contents, quality and costs of service provision;
• Generates increases in transaction costs and inefficient allocation of the system's resources.

* Adapted from LEVCOVITZ; ACUÑA; RUALES, 2007.

Chart 2. Impacts of the reforms of the health systems in 1980-90*

Content of reforms	Problems
Reduction of the size and functions of the State	Limitations of the administrative capacity of the Sanitary Authority
Fiscal discipline ("space"), with strict spending control mechanisms	- Drastic reduction of social public spending; - Deterioration of state infrastructure and public sector wages
New sources of funding	Tariffs, "cost recovery quotas" and other mechanisms for charging users and/or payment at the point of attention increased the family out-of-pocket spending
Creation of specific funds for users with contributory capacity, totally separate from those for those who have no ability to pay	Loss of system solidarity, accentuating segregation of population groups and inequalities in access and use of services
Deregulation/informalization of the labor market	Reducing the financial sustainability of social insurance
"Basic plans" for poor and excluded populations, subject to focalization on a means test	Offer with plans of different provisions in quality and quantity of services for different strata of the population

Content of reforms	Problems
"Pluralism", giving the private sector greater importance in the insurance and provision of services	- Multiplication of insurance and provision agents in competition, accentuating the segmentation and fragmentation of the systems; - Selection of affiliates/insured persons with ability to pay and exclusion of poor populations
Decentralization of responsibilities to subnational levels of government	- Deficiency of the rector function and system governance; - Loss of economies of scale in public procurement and contracts
Introduction of quasi-markets and efficiency criteria in the organization of services provision	- Competition between providers deepens the fragmentation of supply; - Deteriorated public health actions and prioritization of individual care and hospital-centered model
Introduction of management methods/ tools in public management	Discredit of the planning function, replaced by microeconomic managerialism

* Adapted and expanded from LEVCOVITZ; ACUÑA; RUALES, 2007.

Twenty years of "reforms" have aggravated institutional segmentation, operational fragmentation, inequalities in coverage and access to health systems in Ibero-America, and have given us lessons that restricting rights, restrictive "fiscal spaces" for social budgets, the exclusion/segregation of population groups, the predominance of market logic in social policies and the weakening of the State deepen social and economic inequalities and deteriorate the living and health conditions of populations.

In the transition to the 21st century, political parties, social movements, government officials and citizens of the largest and most developed countries in Latin America already manifested their awareness and political initiative to return to the path of expanding social protection towards universality. This includes legal and institutional frameworks that recognize the right to health as a social value and universal human right, as shown in Chart 3, "although these societies have achieved better results in formulating laws and regulations than in impelling the profound transformations that are indispensable in their health systems to ensure such rights" (LEVCOVITZ, ACUÑA; RUALES, 2007, p. 318, literal translation).

In the subregion, effective political decisions to build universal health systems are rare. A pioneer state system was implanted in Cuba after the 1959 Revolution,

followed two decades later by the Nicaraguan Health System, a product of the Sandinista Popular Revolution and in vigor from 1979 to 1990, when it was dissolved by the conservative government of Violeta Chamorro, both inspired by the Semashko format of the Soviet Union. The Brazilian Federal Constitution of 1988 established the Unified Health System, strongly inspired by the Welfare States of Great Britain and Italy. Costa Rica expanded the State-subsidized inclusion of the population in the social insurance, inspired by the Western European Welfare State, to universal coverage in the early 2000s. Uruguay, between 2007 and 2016, incorporated almost the entire population into the National Integrated Health System/National Health Fund, which combines contributory characteristics of social insurance with contributions from the country's tax receipts[6].

Chart 3. Legal norms that recognize health as a universal right in Latin American countries

Country	Year	Legal norm
Argentina	1989	*Ley 23.661*
Bolivia	1998	*Decreto Presidencial 25.265*
Brazil	1988	Constituição federal
Colombia	1993	*Ley 100*
Costa Rica	1973	*Ley General de Salud 5395*
Chile	1985	*Ley 18.469*
Cuba	1976	*Carta Constitucional*
Ecuador	2002	*Ley 80 RO 670*
El Salvador	1983	*Carta Constitucional*
Guatemala	2001	*Ley de Desarrollo Social, Decreto 82*
Honduras	1982	*Ley General de Salud*
México	2003	*Ley General de Salud*
Nicaragua	1997	*Carta Constitucional*
Panama	1972	*Carta Constitucional*
Paraguay	1980	*Ley 836*
Peru	2002	*Ley 27.812*
The Dominican Republic	2001	*Ley 87*
Venezuela	1999	*Carta Constitucional*

Source: Elaborated by the author, based on the consultation of official country documents, carried out in 2004 and 2005.

6 Although self-declared as universal, we do not consider Colombia's Social Protection System in this group, due to the extreme segmentation and profound differences in provision plans among contributory, subsidized and tied affiliates.

3. 21st century: rise and decline of the pink tide in Latin America

The first decade of the 21st century witnessed, in most South American countries, the rise to power of left-wing and center-left political parties and coalitions, represented by the Front for Victory in Argentina, the Worker's Party in Brazil, the Broad Front in Uruguay, the Concertation/New Majority in Chile, the Movement Toward Socialism in Bolivia, the PAIS Alliance in Ecuador, the Patriotic Alliance for Change in Paraguay and the Peruvian Nationalist Party, which joined the election of the United Socialist Party of Venezuela in 1999.

This wave has reached even the Central American countries, historically governed by conservative elites, with the return to power of the Sandinista National Liberation Front in Nicaragua and the pioneering elections of the Farabundo Martí National Liberation Front in El Salvador, the Democratic Revolutionary Party in Panama and the National Union of Hope in Guatemala. Costa Rica, traditionally independent and democratic, faces the fourth consecutive progressive government led by the National Liberation Party and the Citizens' Action Party.

Chart 4 presents the periods of presidential mandates of these parties or coalitions that represent a left-wing turn, baptized in the intellectual and academic means as pink tide (SELA, 2018), which adopted the slogan of *Another World is Possible*, launched by the World Social Forum, centered on the opposition to the free-market fundamentalism (Ibid.) hegemonic in the years 1980-90. In the subregion, only Mexico[7], Honduras[8], Colombia and the Dominican Republic were immune to this movement.

The macroeconomic policies of the pink tide were characterized by the strengthening of the fiscal capacities of the States, by progressive tax reforms, by the increase of social public spending and by the reduction of the vulnerability of the external debt, which led, along with broad social policies, to poverty reduction, pulling out of absolute poverty more than seventy million people; to the

7 In Mexico, Andrés Manuel López Obrador of the National Regeneration Movement, a leftist historical politician and head of government of the Mexican Federal District until July 2005, was recently elected and will take office on December 1, 2018.

8 In Honduras, there was a brief period of progressive initiatives with the election of José Manuel Zelaya from the Liberal Party, but they were quickly extirpated by a coup that removed him from the presidency.

reduction of historical inequalities; to income growth and income distribution, shifting the countries from the low to the medium income group (MOREIRA, 2017); and to the increase in formal employment. All that came along with political-institutional initiatives that broadened popular participation, renewed the legal-legal framework and innovated with external and commercial policies that sought both national sovereignty and regional integration.

Chart 4. Periods of left, center-left and "progressive" governments in Latin America in the 21st century[1]

Country	Period	Presidency
Argentina	2003-2015	Néstor Kirchner; Cristina Kirchner
Bolivia	2006-2018	Evo Morales
Brazil	2003-2015	Luiz Inácio Lula da Silva; Dilma Rousseff
Chile	2005-2010 2014-2017	Ricardo Lagos; Michelle Bachelet Michelle Bachelet
Costa Rica	2006-2018	Óscar Arias; Laura Chinchilla; Luis Guillermo Solís; Carlos Alvarado
El Salvador	2008-2018	Mauricio Funes; Salvador Sánchez Cerén
Ecuador	2007-2017	Rafael Correa
Guatemala	2008-2012	Álvaro Colom
Honduras	2005-2008	José Manuel Zelaya
Nicaragua	2007-2011	Daniel Ortega[2]
Panama	2003-2008	Martín Torrijos
Paraguay	2008-2012	Fernando Lugo
Peru	2010-2015	Ollanta Humala
Uruguay	2005-2018	Tabaré Vázquez; José Mujica; Tabaré Vázquez
Venezuela	1999-2013[3]	Hugo Chávez

[1] Elaborated by the authors, based on data from Idiart, 2018, and the official website of the Presidency of the Republic of each country.

[2] Reelected in 2011 and 2016, but we only consider the period up to 2006-2011, due to the conservative turn seen in subsequent mandates.

[3] Despite the power monopoly of the ruling United Socialist Party in Venezuela, we did not include Nicolás Maduro's presidency because of the serious economic and political-institutional crisis in the country that paralyzed any "progressive" initiative.

These policies were sustained by the economic growth of the entire subregion, which took advantage of the "tailwind" of relative high commodity prices, especially oil, gas, minerals, grains and animal protein, largely as a result of the demand generated by the extraordinary China's growth rate, which allowed "[...] to distribute benefits among the poorest groups and to improve the living conditions of the salaried population [...] without altering macroeconomic equilibria or creating a veto coalition between losers of enormous economic weight, social prestige and political power" (Ibid., p. 15).

National health policies in the period benefited from favorable political and economic conditions, and almost all countries developed sectoral initiatives of varying scope and scale to extend coverage of social insurance and public services, eliminate or reduce co-payments at the point of attention, increase the financial protection of families against the risk of illness and partially reorganize their health systems. Chart 5 summarizes the main initiatives in each country.

The Latin American pink tide finds its peak in the period from 2006 to 2009, the year in which the impacts of the global financial crisis triggered from 2008, as a result of the US mortgage crisis, begin to manifest in the subregion. In the period 2010-2014, the subregion GDP only grows 65% of the average of the emerging economies, reducing this proportion to only 40% in the projections for the period 2015-2019.

The "tailwind" effect is rapidly undoing with the fall in international oil, mineral and agricultural commodity prices, largely due to the slowdown in China's growth rate, hindering the continuation of the redistributive and modernizing policies with low distributive conflict. The election of Mauricio Macri in Argentina, the opposition's victory in Venezuela's legislative elections, both in 2015, and Dilma Rousseff's impeachment in Brazil in 2016 are considered the main indicators of the end of the pink tide (MOREIRA, 2017).

In view of the aforementioned insufficiency of historical data series and critical analytical articles on post-2014/15 health policies, we carried out an extensive and systematic literature search in indexed[9] journals and

9 Portals and databases consulted: MEDLINE, accessed via PUBMED; Cinahl (Ebsco), Scopus (Elsevier) and Web of Science (Clarivate Analytics), from CAPES' Journal Portal. Latin American and Caribbean Health Sciences Literature (LILACS) Database, Brazilian Nursing Database (BDENF), Virtual Health Library (VHL). The Scientific Electronic Library Online (SciELO) portal was added.

gray literature[10], based on the qualitative question What are the setbacks of the reduction of the social budget, loss of rights and access in the health policies in Latin American countries? From this question, the standardized terms were identified in the Health Sciences Descriptors (DeCS) and Medical Subject Headings (MESH)[11]. The established limits were documents, articles, books, country profiles, policy reports, technical reports and research reports in English, Portuguese and Spanish.

Chart 5. Initiatives to extend social protection in health – selected countries – 2003 to 2010

- Argentina*: Seguros Provinciales de Salud Materno-Infantil*
- Bolivia*: Seguro Universal Materno-infantil – SUMI*
- Chile*: Garantías Explícitas en Salud – AUGE*
- Costa Rica*: Afiliación subsidiada por el Estado a la CCSS*
- Ecuador*: Ley de Maternidad Gratuita / Transformación del Sistema de Salud para la Garantía Universal de Derechos*
- México*: Seguro Popular de Salud / Programa Oportunidades*
- México DF*: Gratuidad Universal en la Atención*
- Nicaragua*: Modelo de Salud Familiar y Comunitario con Garantías*
- Panama*: Nueva Ley del Sistema Nacional de Salud*
- Paraguay*: Acceso Gratuito a las Unidades Públicas*
- Peru*: Seguro Integral de Salud – SIS / Ley del Aseguramiento Universal*
- Uruguay*: Sistema Nacional Integrado de Salud*
- Venezuela*: Misión Barrio Adentro*

Source: Levcovitz, 2009.

For the systematization of the bibliographic search process, these references were organized by the elements of the PICo (population, interest and context) strategy (THE JOANNA BRIGGS INSTITUTE, 2014). A total of 1,960 articles were found, and after the exclusion of duplicates and

Institutional gray literature has also been contemplated. Institutions researched: Economic Commission for Latin America and the Caribbean (ECLAC), Pan American Health Organization (PAHO), South American Institute of Government in Health (ISAGS), International Labor Office and World Bank eLibrary.

10 On institutional publications commonly called gray literature, we have consulted the virtual libraries of the following organizations/institutions: Economic Commission for Latin America and the Caribbean (ECLAC), Pan American Health Organization (PAHO / WHO), South American Institute of Government in Health (ISAGS), International Labor Office and World Bank eLibrary.

11 Main terms researched: *Administración de los Servicios de Salud; Reforma de la Atención de Salud; Planos e Programas de Saúde; Políticas Públicas de Salud; Programas Nacionais de Saúde; Atención Primaria de Salud; Atenção Primária à Saúde; Saúde Pública; Direito à Saúde; Equidade no Acesso aos Serviços de Saúde.*

clinical studies[12], the selection based on the title resulted in only 45 articles of interest for the present study.

The absolute majority of articles published in scientific journals is about programs focused on restricted population groups, specific diseases and their risk factors, or case studies on local service organization initiatives – they avoid themes related to macro politics of health and its articulations with the set of social and economic policies.

Even more rare are multi-country or regional and subregional studies, which, when available, use historical data series and descriptions of policies and programs from the 2000s and the first half of the 2010s[13], demonstrating a significant omission of international organisms and integration mechanisms (IDB[14]; ECLAC[15]; ISAGS/UNASUL[16]; OIPSS[17]; ILO; PAHO/WHO[18]; MERCOSUR[19]) in relation to one of its main functions: the monitoring and analysis of social policies and transformations in health systems.

4. Conclusions

More than 90 years of history of Latin American health systems has demonstrated that the influence of its origins and its long-term evolutionary

12 For the elaboration of the search strategies, we used Boolean operators OR (union of compound terms and / or grouping of synonyms) and AND (intersection of terms). The total number of documents was 4,160; 1,215 documents were excluded because they were duplicated and 984 because they were characterized as clinical studies.

13 For example: ISAGS/UNASUR, 2015, whose data, analyzes and reports of experiences reach until the year 2013 and Survey on Access, Experience, and Coordination of Primary Health Care in adult populations of Colombia, Mexico, Brazil, El Salvador, Panama and Jamaica, conducted by the IDB between 2012 and 2014, published in *Desde el Paciente. Experiencias de la atención primaria de salud en América Latina y el Caribe.* Washington: IDB, 2018.

14 IDB, *Social Outlook.* Consultation held on the website https://data.iadb.org/ on September 23, 2018.

15 Consultation held at https://www.cepal.org/publications on September 22, 2018.

16 Consultation carried out on *Estudos e Documentos Oficiais do ISAGS/UNASUL* on the website http://isags-unasur.org/publicacoes/ on September 22, 2018.

17 Ibero-American Observatory of Health Policies and Systems: no information related to the System Monitoring and Analysis Project, as per consultation on September 24, 2018 at www.oiapss.org.

18 PAHO/WHO, *Perfiles de Sistemas de Salud / Monitoreo y evaluación de los procesos de reforma*, discontinued in 2009 and available to most countries until 2004/05, as per consultation on September 22, 2018 at https://www.paho.org/hq/index.php?option=com_content&view=article&id=4283:perfiles-sistemas-salud-paises-1999-2009&Itemid=2080&lang=es.

19 Consultation held at http://www.mercosur.int/ on September 23, 2018.

processes is such a determinant of the possibilities/opportunities for reform that the periods of expansion of social protection in health, observed successively since the creation of the first social insurance, in the Golden Era of the Welfare State and during the pink tide of the beginning of the 21st century, are not enough to alter the structural characteristics of population segregation, institutional segmentation and operational fragmentation, even though they demonstrate transitory results of coverage extension and conditions of access and use.

In addition to our own conclusions, the rare articles on the macro policy of health for the period after 2014/15 identified in this bibliographic search describe national and multi-country situations that fully confirm this statement, especially the studies by Machado (2018), Aguillera (2016), Espinosa et al. (2017), Giovanella et al. (2018) and Lopez-Arellano and Jarillo-Soto (2017).

Such transient results accompany economic growth and capital accumulation in development cycles and are interrupted in times of crisis and recession, as in the hegemonic years of neoliberalism and currently under the aegis of macroeconomic austerity and fiscal responsibility, even in countries with progressive or leftist governments. These typical cycles of capitalism have a very dramatic impact on the economies of the peripheral countries of the most unequal subregion of the world, which do not rely on domestic savings, foreign-exchange reserves and mechanisms for protecting the population of central welfare states.

Recognizing the remarkable heterogeneity already described among the different countries, one can observe the common resilience of their health systems to specific initiatives and limited change, as well as the marked inertia in sectoral policies, even when they last for ten or fifteen years. The change processes of these systems are difficult, complex and of long-term; require extensive systemic transformations; isolated and specific interventions are not enough; and demand commitment and cultural changes from users, workers and health professionals, service managers and policy makers (LEVCOVITZ, 2009).

Reform projects with pompous denominations such as "Structured Pluralism", "Basic Universalism", or "Fair Adjustment", did not demonstrate any capacity to change that inertia, deeply rooted in the history, culture,

and sociopolitical structure of Ibero-America, but at least have taught us that it is indispensable to maintain constant vigilance with false prophets and intellectual dishonesty.

The national cases already described here from Brazil, Costa Rica, Cuba and Uruguay are unique exceptions to this inertia throughout the subregion. These countries have carried out processes of structural change in their health systems that configure state policies capable of surviving several national governments and the "recipe" of macroeconomic and social policies of the "International Financial Institutions", under peculiar conditions of correlation of forces between social classes or windows of opportunity created in moments of solidarity mobilization of the majority of society, such as social revolutions or democratic transitions after long periods of dictatorship.

The inertia of Ibero-American health policies can be interpreted as a result of the "trajectory dependence", also identified in Europe by researchers affiliated with the current major analytical trend, both in International Political Science and in Brazilian Collective Health, of historical neoinstitutionalism[20] "[...] that considers the institutional organization of the political community as the main factor for structuring collective behavior and for structuring different results" (HALL; TAYLOR, 2003, p. 195).

From a different perspective, analysts who work with the theoretical-conceptual and methodological approach of Marxist Political Economy prioritize interpretations based on the structure of social classes, their inherent distributive conflict, on power relations, and on durable political-electoral pacts between them, as pioneered described in the canonical text of Esping-Andersen (1990).

The permanence in Latin America of deep inequality and social stratification; of the political hegemony of increasingly individualistic elites; of the employment relationships unfavorable to workers; of the primacy of the export model of "commodities"; of the barriers to industrialization; of the fragility of organized social movements, institutions, parties and state powers; and finally of the absence of values of solidarity and collective belonging to a nation-state impede radical and lasting transformations in social welfare systems, including health care.

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20 Term consecrated in Political Science by Steinmo (STEINMO; THELEN; LONGSTRETH, 1992).

In short, in spite of the profound technological and productive transformations of Latin American capitalism, its growing financialization and the globalization of trade relations, we continue to be peripheral and dependent, as ECLAC (BIELSCHOWSKY, 2018) indicated since the 1950s.

Inequalities; the weak organized political participation of urban and rural workers, industry, commerce, services, agriculture and livestock; and the social exclusion of the economically, ethnically and spatially marginalized populations have changed in form, but they remain the predominant constituent elements in Latin American societies. Under these conditions, the full construction of universal and egalitarian systems of social protection will remain an unfinished political agenda.

It is urgent that international cooperation and integration organizations, such as ECLAC, ISAGS and PAHO/WHO, make available rapidly updated data, information, studies and knowledge, just as it is a fundamental task of researchers and scholars of ethical health policies and politically committed to the social transformation of our countries to prioritize the updated monitoring of sociopolitical conjunctures that impact the development of health systems in Latin America, as well as producing and socializing analyzes and critical reflections.

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South American malaise: universal health systems in unequal societies

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South American malaise: universal health systems in unequal societies

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1. Introduction

The governments of South America had until 2018, as a common premise to implement initiatives to provide access to health services for all. However, as a group of countries, it continues to be a region with wide and deep inequalities.

The political decision to universalize access to health care is related to the process of integration of the countries of the region and implementation of public policies of citizenship rights, impelled by a decade of convergence of progressive governments, which included the expansion of the right to health among its social development guidelines.

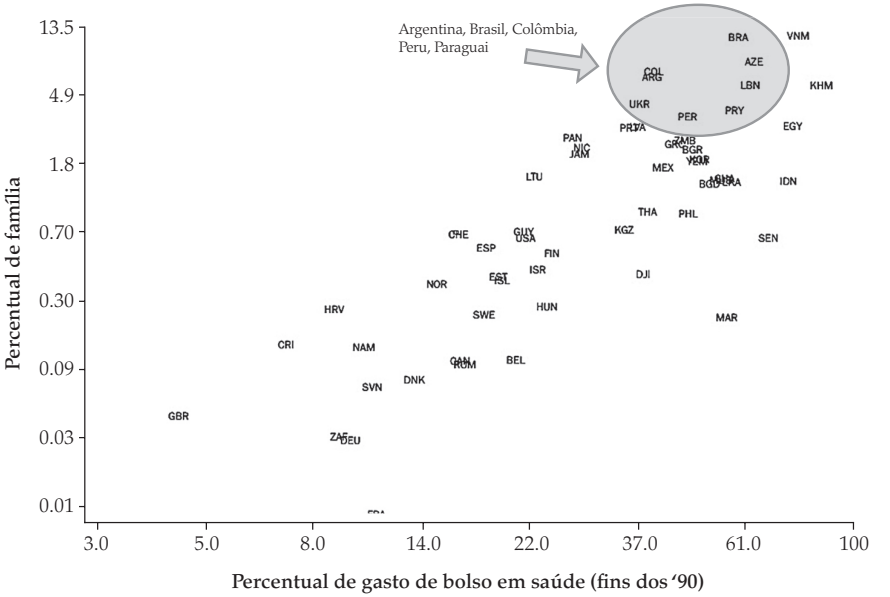
Until the 1990s, health problems in our region were a misfortune that led to poverty between 5 and 15% of South American families in several of the region's major countries. South American countries occupied a prominent place among those where health spending was considered catastrophic because it consumed more than 40% of family income (XU et al, 2003).

Of course, due to structural inequalities, not all were equally affected by these misfortunes, in part because there were social groups that could better avoid some causes of disease, and especially because they were able to afford treatments in the country or abroad. On the other hand, those excluded from society did not even have the possibility of free treatment in public establishments. Even in the early years of the twenty-first century, there were rigorous systems for collecting fees from poor patients in public hospitals, based on the premise of the so-called "cost recovery" proposed (and sometimes required) by the World Bank (O'DONNELL, 2007).

The successive decisions of the governments of South America that expanded and gradually made their health services accessible to the entire population, with the smallest possible financial barriers, were an initiative framed in the expansion of citizenship rights. The withdrawal of financial barriers to

access primary and maternal and child health care in many South American countries has created a phenomenon of "universalizing access right away, but with the same resources as before", with the consequent rapid increase of queues and rationing. This narrowing of existing services and resources was slowly reabsorbed by the increase, even if moderate, in public budgets (CAMPOS et al, 2013). Therefore, as a result of this universalization without a strong budgetary commitment to increase public spending on health, a parallel market was created for the more affluent sectors, an excluding universalization. As pointed out by Faveret and Oliveira (1990, p. 193), the Brazilian case shows that "the best-paid sectors of society (middle classes, including workers in the dynamic sectors) have gradually ceased to have the public health subsystem as reference, becoming clientele for the private subsystem", undermining the support from the middle classes to the universal system.

Figure 1. Percentage of families with catastrophic health expenditure (end of the 1990s)



Xu et al. Household catastrophic health expenditure: a multicountry analysis
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These processes also revealed that, in addition to good intentions and the favorable economic situation, the slow overcoming of other barriers, such as

the expansion of Family Health Strategy coverage in Brazil, implied many other dimensions, such as increasing the capacity of training professionals, overcoming the obstacles created by low management capacity (CABRAL-BEJARANO et al, 2018), improving physical and informatics infrastructure, among others. This process revealed how much the countries of the region needed to expand their health systems in many dimensions, necessitating more comprehensive proposals that were not limited to one or two programs of political impact.

2. Dilemmas on the way: is fighting poverty the same as fighting inequities?

The period of little more than a decade from 2003 to 2014 witnessed significant economic growth in South American countries. This growth led to an increase in poverty reduction programs – in that period, poverty fell from 39% to 28% of the population (CEPAL, 2014). Many of the programs implemented, of conditional cash transfers, of actions aimed at hard-to-reach populations and other targeted actions have been important and are considered successful attempts to reduce the effects of poverty, in many cases for the first time in history. However, a peculiar feature of our region is its high and persistent inequality, on average higher than in other regions of the world, including those poorer than South America. A question that emerges after these years of economic growth is the fact that Latin America can cease to be poor and, nevertheless, remain unequal. Even the most egalitarian countries in South America can be comparatively richer and remain unequal, while other European and Arab countries may be poorer, but always with less inequity (Table 1).

Table 1. Comparison of GDP per capita with constant purchasing power and Gini Index (selected countries circa 2010)

	GDP per capita	Gini Index
Bulgaria	21000	0.282
Uruguay	22000	0.397
Iran	20000	0.383
Argentina	20000	0.445
Romania	24000	0.301
Chile	24000	0.521

	GDP per capita	Gini Index
Algeria	15000	0.353
Brazil	15000	0.547

Source: International Monetary Fund, World Bank.

This persistent socioeconomic inequality, measured by various indices, shows that on the one hand, there was a sharp fall in indigence and poverty during the period 2005-2015, while on the other, inequalities were not reduced to the same extent. The Economic Commission for Latin America and the Caribbean (ECLAC) affirms, with concrete evidence, that inequality in Latin America is the main factor that is holding back economic development. Some studies of specific methodologies even suggest that inequalities may have remained, despite the reduction of poverty and indigence (MEDEIROS; SOUZA; CASTRO, 2015). Poverty and indigence in South America (and in Latin America in general) have roots in the inequities of power distribution in our societies. Fighting this situation, distributing surpluses left by commodity exports or other cyclical factors, has immediate and beneficial effects, but is usually limited to short periods where there are such surpluses. In longer periods or in economic contractions, imbalances of power will again produce conditions of poverty and indigence. ECLAC data for the whole of Latin America show that this indigence is increasing in the last three years, after a decade of gradual decline (CEPAL, 2014). In other words, since policies aimed at the fight against poverty and indigence have been ineffective in relation to inequality, it is possible that the benefits of economic growth have improved the situation of the wealthiest proportionately more than the poorest, in a context of general improvement. While it is possible to state that it was simply a case in which"a rising tide lifts all boats", the finding that economic growth reduced poverty but not inequality in the same proportion indicates at least three troubling circumstances for the interest of collective health. First, in the health sector, policies that are more focused on food supplement programs, services for poor people, actions in remote places and to provide services to indigenous populations are easy targets of adjustment policies, for their own dispersion and low social representativeness of the most vulnerable populations. The second circumstance is that the fight against poverty translates into targeted health programs, while the

fight against inequality drives the universalization of the health system. As predicted by Faveret and Oliveira (1990), SUS, a universal health system that is equal for all, obliges the whole society to defend it, while, as explained in the previous point, programs focused on the poor can easily be disassembled. Finally, it is increasingly clear that health is a product of many determinations and, to a large extent, of the influence of our social structure. Many specific policies confuse social determination (the structure of society as a producer of diseases) with the reduction of specific risk factors (teenage pregnancy, smoking, ultra-processed foods). However, a 2017 paper that studied more than 1.7 million people showed that, in addition to the higher prevalence of risk factors in disadvantaged socioeconomic groups, inequality itself is a major risk factor (STRINGHINI et al, 2017). Regardless of other associated factors, low socioeconomic status decreases life expectancy more than alcohol use, obesity, diabetes or hypertension. This finding is important because this study was done in high-income countries, which shows that there is also an effect derived from relative inequality and not exclusively from absolute poverty, as has been observed in studies with civil servants in the United Kingdom since the 1970s (MARMOT, 2010). Recent studies affirm that the prevention and control of non-communicable diseases depends on the extension of education, the protection of employment and the universalization of the health system, with the same importance of the control of smoking or hypertension (DI CESARE et al, 2013). Delving into the effects of inequalities in health, the studies of the burden of communicable and noncommunicable diseases often veil an epidemic that has a strong impact on the years of life lost due to premature mortality in South American population; and that has even a greater impact in social cohesion, as well as in the provision of health and education services. It refers to the set of morbidity and mortality originated from external injuries, derived from intentional violent actions. Of the approximately 500,000 people who die each year from intentional violent causes (UNODC, 2018), 19% are inhabitants of South America, even though our region represents less than 6% of the world population. Almost every country in the world with the highest homicide rates is in South America or Central America and the Caribbean. Seven of the nine countries where the United Nations Office on Drugs and Crime collects data in our region show increasing trends in their homicide rates. In Asia and Europe, there is only one

country with growth trends in crimes among the 46 nations studied. For these reasons, it is possible to characterize violence as an epidemic in our region.

Therefore, the fight against unjust and avoidable inequalities is a health imperative as urgent and necessary as vaccines and hospitals and even more necessary to build societies with democracy and social cohesion. Social cohesion and the structures of the welfare state, which are its foundation, are being degraded by the concentration of income in an ever smaller number of people, affecting distributions of power and influence. This concentration in groups of overwhelming economic power in some countries can be translated into tax waivers and diminishing state functions that tend to reinforce and perpetuate these inequalities, threatening the tax bases of universal health systems.

A recent ECLAC study shows that tax evasion (meaning: existing but not collected taxes, discounting tax breaks and other mechanisms) amounts to $ 340 billion, equivalent to 6.7% of Latin America's total GDP. In addition, tax evasion in income has a rate of 39% of the total, while the fraction withheld from taxes on consumption is 26%, so the state can be more efficient by raising from the poorest sectors (consumption taxes) than those with high income (income tax) (CEPAL, 2016). This means that Latin America alone could double its spending on health, with fiscal space lost due to unequal tax collection inefficiency. In both rich and poor countries the 1% influence of the top of the pyramid via mechanisms of pressure on politicians is expressed as a resistance to paying more in the form of transfers to those who need it the most. This resistance undermines the basis of the welfare state. The internationalization of a growing group of people who do not pay taxes anywhere opposes the interests of the so-called 99%, the vast majority of people who live from their work and have access to some public services (OXFAM, 2017).

In South America, these challenges are set in a marked way, since in the first decades of the 21st century there was an incipient expansion of the Social State, which was born along with modern demographic and epidemiological challenges. These challenges (urbanization, growing aging, rising chronic conditions) create demands and there is a trend in the mainstream media that it is better to restrict services accessible to all, thereby saving on state spending. This is a paradox, since these trends are in fact a mark of society's success in integrating more people and enabling a longer life.

The region experienced progress not alone, but also acting together. The influence of integration processes on these advances cannot be ignored. The constitution of a common citizenship, of an awareness of rights for all, that permeated the action of UNASUR, also had concrete expression in terms of health. Countries understood that it was important for their citizens to have similar rights and that the reduction of asymmetries that was imperative within society was also a necessity among different countries. At the same time, it is not just the comparison of countries that drives improvement. In a very important way, countries have learned from each other. The joint action of countries sharing best practices and the capacity to learn together, to create information systems and joint planning, are sources of ideas and techniques that each country uses for its benefit and passes on to others. The international joint action was relevant to this process of exchanging experiences of universalization of health systems (GIOVANELLA et al, 2012). Lessons learned from recent history tells us about the virtuous effect of universal health services and education not only to reduce poverty and inequality, but to promote social cohesion and democracy. Recently, a roundtable hosted by Chatham House (2018) brought together various personalities from the world including Helen Clark, former Prime Minister of New Zealand and director of the United Nations Development Programme until 2017. She pointed to a scarcely remembered, but very important fact. When asked whether universal health systems were a luxury that only rich countries could afford, Clark recalled that most of these systems, as well as the great social architecture called the Welfare State, were created when countries were poor or leaving war. They were created to make societies more cohesive and allow the reconstruction of their infrastructure and social capital. Thus, according to Clark, it is possible that universal health systems are one more factor in raising a country's social capital and wealth, rather than its by-product. In 1961, Canada introduced its first universal health service in one of the poorest provinces, Saskatchewan, which served to drive significant economic growth. In 1919, the newly created Ministry of Health in the United Kingdom commissioned a report on the state of health in the country. Lord Dawson presided over a council that produced a preliminary report (DAWSON, 1920) (the final version was never approved), beginning with this definition of its mission: "To consider and make recommendations

as to the scheme or schemes requisite for the systematised provision of such forms of medical and allied services as should, in the opinion of the Council, be available for the inhabitants of a given area". For many academics, this report was the first organized conceptualization of a universal health system and established the principles of the UK National Health Service in 1948 in the aftermath of the destruction of World War II.

Today, some challenges have changed a lot. In 1948, the services were medical in nature and targeted episodic interventions for problems classified as "health woes". In the 21st century, urbanization, the rise of chronic conditions and the progressive aging of the population represent new demands to be faced. At the same time, the growth of informal and temporary employment, known as precariat (STANDING, 2011) or uberization (KHAN, 2016), creates challenges for health systems based on social security schemes and funded with tax bases derived from formal employment.

3. Evolution of the distribution of resources in the processes of universalization of health systems

The shortcomings in the regional distribution of resources (especially of health workers) in South America have been the subject of specific policies, consistent with WHO's dictum: "No health without a workforce" (WHO, 2013, p. iv). These policies were effective in improving the availability of human resources in regions that until the beginning of the 21st century never had access to a doctor, nurse or dentist. This is especially true in remote regions and in hard-to-reach indigenous communities. South America has created state-of-the-art programs to expand access to health for citizens who until recently did not feel integrated into their country (ISAGS-UNASUR, 2015; HUICHO et al, 2012; MEJIA et al, 2016).

The challenge of enabling health professionals (including doctors) to live and work where the most vulnerable citizens need exists both in remote regions (in Brazil, Colombia, Canada or Australia) as among populations living in regions with violence or lack of infrastructure, such as the marginal areas of many cities in South America (RIGOLI, 2016). For example, the largest primary care program in the world, the Family Health Strategy developed by Brazil, has only managed to reach its target of 40,000 health teams by importing Cuban

doctors. Paradoxically, many of the professionals who are unwilling to work in their own countries have been trained through state funds, sometimes in public and free universities. Even so, when deciding where to work, few choose to serve in the places that are most needed. In 1925, Pearl (p. 1026), analyzing how physicians in the United States concentrated on wealthier regions, ironically concluded: "Doctors are intelligent people who want to work in places where there is money and people can pay for their services". In addition to this trend towards financial success, there are other factors that maintain this situation and create serious problems for equity in health systems. In countries such as Australia and Canada, huge investments are made in the technology of telehealth and air and naval transport systems to be able to offer services to the populations living in remote areas. Less susceptible to technological solutions are the challenges in urban areas, with problems of violence and deficits in transportation systems. Once again it is proven that dealing with universal health care is part of the challenges of expanding the rights of citizenship to all. At times, working in health caring for poor communities is presented as a path for those with poor qualifications. This presumption is often accompanied by the reality that remuneration rewards those in large hospitals and dealing with high technology. Another factor is the training and certification systems (of schools and professional practice) that have a tendency to restrict supply below what is necessary under the pretext of high quality. This means that there are not enough professionals in many countries. On the contrary, if there were an excess of supply due to a more abundant training (more universities, scholarship systems) or the entry of professionals from abroad, this group of professionals would be willing to work in more uncomfortable or sometimes dangerous places, since alternative would be to remain unemployed. This strategy of flooding the market (HARRIS, 2016) has been widely used, but has the counterpart of the discontent of a group of professionals who are unemployed for long periods of time and does not solve the problems of maldistribution (DUSSAULT; FRANCESCHINI, 2006). Other countries sometimes give work permits for foreign immigrant professionals only in regions of need for care. So far, several policies are being implemented in South America to address this trend. The most well-known is the creation of so-called Professional Performance Cycles, also known as Social Work, present in Chile and Peru (QUIROGA,

2002; PERU, 2011), generally with compulsory residency in distant regions or peripheral areas. This is an effective and temporary solution that Brazil also tried in the first versions of the Mais Médicos (More Doctors) Programme, but it was observed that this reinforces the image of this type of work as a punishment from which one must exit quickly (usually in one or two years) .

Another strategy is to create an expanded market for those who want to work in disadvantaged areas through the expansion of jobs with adequate salaries, which worked very well in Brazil, with the creation of more than 100 thousand posts of doctors, nurses and dentists in the Family Health Programme. Several countries are also experimenting with formal or informal migration programs for professionals within the region, either by favoring (or tolerating) foreign labor or by encouraging the return of professionals who have immigrated on the condition that they provide services in regions that need it more urgently. Some very special regions, such as jungle or hard-to-reach areas, need military-like regimes that benefit from the state's communications infrastructure and logistical support in those regions. In many cases, the use of telehealth, whether for clinical teleconsultation, continuing education or to increase the efficiency of referral and counter-referral systems for patients, is also an access option. All these strategies have demonstrated that what can really have some impact is a package of interventions that are coherent with one another and aim at the same goal. Unfortunately, many countries implement contradictory measures: on the one hand, they create compulsory residences in unprotected areas and, on the other hand, reward graduates who achieve high qualifications with scholarships and research funds in high-tech areas. Finally, it is important to emphasize that this problem must, first of all, be seen as a crucial condition of universal health systems. If our countries have a commitment to the attention of all citizens in all regions, this commitment has a mandatory step: to create conditions for health workers to understand and accept their role in guaranteeing this right for all.

4. Can universal health systems be privatized?

Part of the tensions with the implementation of universal health systems in unequal societies derives not only from the economic influence but also, in the predominant ideology, on the intrinsic advantages of the

private sector. In many governments in the region, even the left-wing ones, the participation of the private sector in health is desirable because of the alleged inefficiencies that appear when the area is administered by the state. The so-called Public-Private Partnerships (PPP) is becoming common in many health systems, and the trend may be intensified as a result of the economic crisis. In some countries going through fiscal adjustment, outsourcing public services (not just health care) has become a tool for balancing public budgets, allowing investments and payroll to escape the state's cost structure, which is monitored by central banks and international credit agencies. This trend is expanding in many countries in South America, although there is no evidence of its benefits. However, this growth in popularity among governments raises concerns and debates about the relationship between these PPPs and the public interest.

Why is this form of privatization being adopted and why should the public be concerned? From the point of view of citizens' rights, Deng Xiaoping's aphorism seems to apply: "it doesn't matter if a cat is black or white as long as it catches mice, it's a good cat". The reverse option, which is, keeping services strictly in public hands, also seems to generate inefficiencies and little capacity to respond to people's needs. The challenges are hidden in the various dimensions of this process: the widespread tendency of the private sector to influence policies that have to do with expanding its domain of health along with the government's need to reduce its budgets.

This makes any move towards shifting public services and employees to the private sector seems attractive. In most countries, private provision of health services includes pharmaceutical and technological production, construction of infrastructure, including hospitals via private contractors, and peripheral maintenance services, which are carried out by external companies, some of them cooperatives (FIEDLER; RIGOLI; SHERMAN, 1991; RIGOLI; NOWINSKI, 1996).

There is no clear evidence of its results. The UK National Audit Office recently stated: "We have yet to come across truly robust and systematic evaluation of the use of private finance into PPPs at either a project or programme level" (HOUSE OF LORDS, 2009, p. 14). Edwards et al, in turn, conclude that "inadequate financial reporting and lack of accountability for PPPs serve to obscure what the government does not want to disclose"

(2004, p. 223). This lack of transparency and willingness to evaluate seems to serve as a narrative of successes, without any real foundation. Although often used as synonyms, contracting services, public-private partnerships and privatization are not the same. In some countries, privatization is undoubtedly underway, but using different modalities: when copayments are increased or tax incentives are applied to private insurance, the state's intention to transfer some of its function to the private sector is evident. The main issues facing the universal health systems in relation to privatization and PPPs in particular are the areas of efficiency and the assurance that public objectives are achieved. It is important to remember that in such cases there is a risk that the public service will abandon its public objectives and be guided by financial results. On the positive side, a government can benefit from specializing in its control capabilities, rather than trying to develop a framework to directly manage the complexity of the country's health services. In a review of four studies, Liu, Hotchkiss and Bose (2008) observed improved access to public primary health care through private provision between 9 and 26 percentage points, but in other areas such as efficiency, equity and quality, their studies concluded that there were no advantages with privatization or no conclusive results were obtained. Some results were definitely negative. Access seems to improve, but the results in terms of quality are not significant. Efficiency (results vs. costs) was generally lower in privatized services than in purely public services. This is an important point in relation to public health systems in South America, since international experience shows that the use of PPPs to outsource hospitals and primary care has between 13 and 17% additional transaction costs. Studies on the privatization model in Valencia, Spain, show that transaction costs are generally hidden or are not taken into account and are concentrated in three areas: planning, contracting and monitoring (ACERETE; STAFFORD; STAPLETON, 2011). When added to total costs, most PPPs are more expensive than public provision (GRIMSEY; LEWIS, 2007). In addition, the simultaneous presence of PPPs and public providers leads to moral hazard, since there is a tendency to send complex cases to the public system, as well as the predatory behavior of private companies when hiring the best human resources, subtracting the public sector of its excellence (CHRISTIANO; GALENDE, 2007). Several undesirable results

may cause perverse effects when considered in the system as a whole. Unfair competition from private services to public services can lead to a rapidly unbalanced scenario in which the presence of a private provider can cause a sudden deterioration in the quality of the public provider. In addition, a payment system linked to indicators in decentralized suppliers with deficient statistics can lead to false results and records in order to improve their profits as much as possible. Even New Zealand has canceled a large part of its PPPs since 2000, especially in hospitals (MCKEE; EDWARDS; ATUN, 2006). A crucial point is that this type of privatization should not be selected as a way of hiding public spending or keeping the public debt artificially low. As Edwards et al (2004, p. 13) conclude, in a study of investment financing in the public hospital network by the private sector: "While it is premature to say whether the problems experienced relate more to the underlying model or its implementation, it appears that a public-private partnership further complicates the already complex task of building and operating a hospital". PPPs and other forms of outsourcing of public health services may have intrinsic virtues, but they also have intrinsic flaws. Hiring and control efforts are generally not able to record all possible variables that must be taken into account to maintain virtues and avoid failures. Client-side experience of PPP (the public authority) is relatively underdeveloped and does not compare to the capabilities of specialized teams in bidding of suppliers. The main problem is that a state that is interested in privatizing public services because it considers itself a failure as a manager can hardly be better as a contractor.

5. Universal systems, universal coverage, universal access to health services

The expansion of rights and access derived from social program packages (as has been said, often guided by a logic of fighting poverty rather than universalization of citizenship rights and combating inequities) progressively included the recognition of ethnic, cultural, and racial communities, and also communities with diverse identities, who needed not only the absence of financial barriers, but the adequacy of services to their particular needs (BACIGALUPO; ARMADA, 2018).

Regarding the expansion of health systems that claim to be universal, these processes cannot be considered exclusively as technical challenges of resource allocation. As expressed in Brazil at the time of the creation of the Unified Health System (SUS), which could apply to many of our countries, the extension of the health system for all is part of a civilizing process, making all citizens entitled to a life free from misfortunes. In this unfinished process, countries have used many strategies, ranging from creating an entirely new health system to those who have adapted their existing structures, using primary health care as an axis that organizes and concentrates transformation efforts. Even considering these mishaps and challenges for the future, some results are visible, since most countries have reduced their private health expenditures (the so-called out-of-pocket expenditure) and thus the risk of health contributing to or increasing poverty (Table 2). The health care system becomes a factor that frees people from a risk of financial and vital misfortune, helping to equalize opportunities to live a better life.

Table 2. Trends in health out-of-pocket expenditures in South American countries

Gasto de Bolso em Saúde, América do Sul 2000-2015

País	2000	2015	Tendência
Argentina	49.05	17.63	
Bolívia	32.74	25.92	
Brasil	36.43	28.29	
Chile	42.81	32.24	
Colômbia	13.19	18.29	
Ecuador	63.89	43.71	
Guyana	17.53	40.51	
Paraguay	45.80	36.49	
Peru	38.33	30.92	
Suriname	15.36	10.15	
Uruguay	17.53	16.19	
Venezuela, RB	55.48	45.82	

Source: data.worldbank.org.

There is, in this sense, a debate of collective health specialists related to three terms that seem to define very contradictory positions: universal

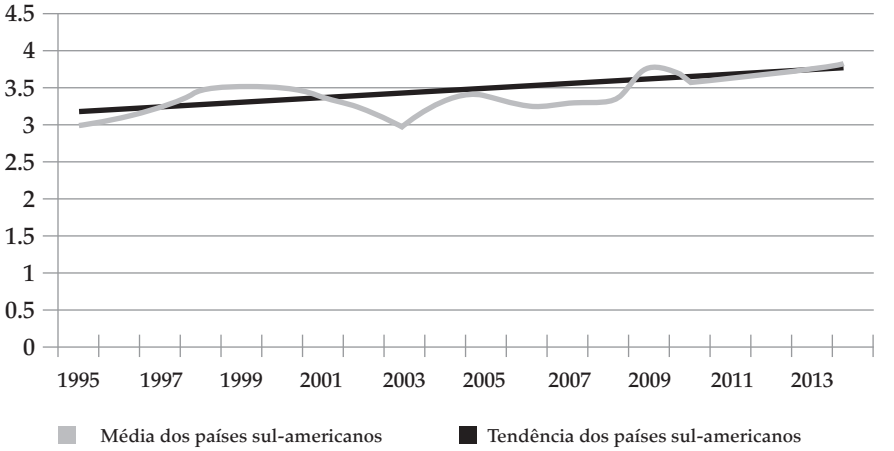
systems, universal coverage and universal access to health services. Until very recently (perhaps less than ten years), the different international health organizations were not speaking in their recommendations on how countries should organize their health systems. Although health has long been recognized as a human right embodied in its constitution and organization in countries in Europe, Asia and the Americas, there was a great deal of reluctance on the part of international organizations to recommend health policies that would publicly care for all citizens. The United States and other countries believed that, despite growing international evidence, it was better to have a market system that would give all citizens what they could buy from their own resources. Sometimes, as in some Latin American countries, this implied that public hospitals should charge uninsured patients for each medical service. There were well-known cases of public hospitals in our countries that illegally retained newborns until the parturient could return with the money necessary to pay the bill. This situation was embodied in terms such as "cost recovery" and introduction of market mechanisms for health efficiency that the 1993 World Development Report had popularized (WORLD BANK, 1993), as a condition for hospital infrastructure rebuilding loans. All this began to change from 2008, when, through the influence of many governments in South America, as well as the United States, after the adoption of an Affordable Care Act, the so-called ObamaCare, and also of other regions, the idea that there was a need for health to be addressed more as a citizen's right and not a commodity for sale began to be accepted. At the same time, the rise of social sectors that were previously in poverty increased the pressure for explicit social policies that allowed access to some education and health services, which should therefore be organized in the form of national or regional systems. The decades-long experience of most European countries and of several in America (Canada, Cuba and Costa Rica), Asia and Oceania (Japan, Korea, Australia and New Zealand) showed the technical and redistributive efficiency of universal systems of health, which was definitely the most economical and equitable option to increase the health of its people. As an intermediary way to meet the important set of countries that did not have a decision on having universal health systems, the major international bodies of the area coined an ambiguous expression: universal health coverage, which includes a large set of institutional adjustments that extend some benefits to

the population. In general, within these adjustments, three dimensions are included: attempts to expand the covered population to 100% (for example, integrating services of needy populations and social security); adjustments that expanded services (including typically maternal and child groups, primary care, and essential drug lists); and schemes for the reduction or elimination of payments at the place of service, often through free or subsidized access to some restricted list of services. These three dimensions were often combined, creating various forms of public maternal and child insurance, free family health programs, coordination of fragmented funds into a single fund, and so on. Each step in these three dimensions entailed an additional cost to be financed by the State, and, in general, budgetary commitments were slow to meet welfare commitments. In many cases, therefore, countries have had to adopt universalization programs in stages, which translated into decades of waiting to reach the universal health system, as in the cases of Colombia, Chile and Uruguay. Therefore, within the scope of universal health coverage, there are two movements: one that started from the recognition of the right to health care without economic, racial, religious or other obstacles; and another that tried, within a set of policies, to include some processes of expansion of health services and the reduction of the collection of other services to the poorest. The first group, even with a radical political option, had to find the resources and structures that would make it possible. In other words, they recognized the universal right to health but did not yet have universal access to health care. The second group focused on incremental steps in line with the willingness of economic decision-makers to expand the health budget space. A paradigmatic case of the first group is Brazil: since 1988, it has a universal and free health system, but did not have enough professionals for its family health teams (partially increased with the importation of doctors), nor succeeded in three decades to prevent the highest percentage of health spending from citizens directly. An example of the second approach was Colombia, which created differentiated schemes for the poorest with a restricted package of services and took a decade to have a nominally universal package (COLOMBIA, 2018). Another exemplary case is that of Chile, which determined a set of health problems for which attention was guaranteed. This set of problems went from 25 in 2005 to 40 in 2006, reaching 56 in 2007, 69 in 2010 and currently 80 (HENRIQUEZ, 2017). Inevitably, this type

of rights-incorporation process with decades of waiting provoked multiple cases of patients who remained (and remain) out of the system, with life risks and permanent damages (ZÚÑIGA, 2011). The implications of these gradual processes may be a success feature, but they had a braking factor embedded, even in countries where the reform has had strong political backing. In Uruguay, the constitution of the so-called National Integrated Health System (SNIS) required a decade to go from 22% to 73% coverage of the National Health Fund, although it had auspicious circumstances in its beginning. At the time of its launch in 2007, the SNIS had four positive features: the collapse of the system before the reform; a design that, at first, generated benefits to all the actors; a scheme of steps and growth of the financing that made it sustainable; a strong and legitimized leadership among health authorities (OLESKER, 2018). But at the same time, the continuity of social change is currently stalled by the limitations of the alliances that propelled it in its first steps, facing important status quo and power situations.

If we measure the advances in the universalization of health systems, using the public health expenditure as a percentage of GDP as the main indicator, the South American countries are improving, but far from the level of 6% considered as necessary for universal access and coverage.

Figure 2. Public expenditure on health as a percentage of GDP in South American countries 1995-2014



Source: ISAGS-UNASUR, 2017.

A universal system that gives universal access to a wide range of services implies a State that wants to recognize this right and is willing to dedicate a significant part of its public resources to health. Global experience indicates that no country with less than 6% of GDP in public health expenditure has reasonably universal coverage (PAHO, 2017).

6. Conclusion

The corollary of these processes is that there are political and economic dimensions that must be combined. Previously, in this chapter, we refer to Helen Clark's view on how universalizing health systems can be a way to aid development. The finding that a country can commit 6 percent or more of its GDP, broadening and universalizing its health system, applies equally to poor and wealthy countries, as Clark made clear, since public health spending is purely a demonstration of the level of priority of public health expenditure as part of the country's total allocation of resources. It is, therefore, mainly a political and budgetary option, and not an economic one. Concomitantly, there are many pressures, especially in times of macroeconomic difficulties, for hegemonic sectors to divert resources from health to other uses (basically debt servicing). Therefore, those interested in improving health in many countries need to monitor health so that it remains a priority not only in speeches, but also in public budget decisions, without neglecting aspects of quality of spending (primary care vs. high technology, for example).

However, and considering the upward march of government rights and financial commitments, it is possible to think that the effects of the expansion of rights and access to health services in recent years must have had consequences in the collective consciousness. In May 2018, British Conservative leader Nigel Farage gave an interview to the Fox News Channel of the United States (FARAGE, 2018). In it, he advised Americans to avoid the implementation of a universal health system: "When the State gives benefits in health to the people, any attempt in the future to reform it or take those benefits back, becomes politically impossible". The effects of this extension of rights and access are felt in the priorities of the governments and in the demands of the communities, allowing the consolidation of these achievements.

However, as indicated at the beginning of this text, these health systems are inserted in societies that maintain important differences in the distribution of resources and power, which maintains a permanent tension between the advances in the universality and the tendencies to maintain a social expense in minimum proportions.

Which of these two trends will prevail in the future? Will more egalitarian health systems guarantee higher levels of equity in South American societies? Or will the increasing trends of the currently prevalent differences drag health systems to earlier stages, with greater exclusions, greater private spending and less access? These questions do not have a predetermined answer; they depend on how much pressure there is in society to deepen change and defend their rights.

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Human security: intelligence in health informed by scientific evidence and human resources

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Contemporaneity illustrates day by day the fact that social, economic, and political crises surpass intra and intercontinental borders rapidly, causing a strong impact on collective health in Brazil and the rest of the world, generating enormous challenges for managers in many sectors and at different levels of responsibility.

The cycles of Debates about Bioethics, Diplomacy and Public Health, promoted by the Center for Bioethics and Diplomacy Studies in Health (NETHIS/FIOCRUZ), created a unique opportunity for the exercise of a transdisciplinary reflection and of actors in various fields of practice, regarding pressing issues of global health and its impacts in Brazil.

Because global health issues permeate the work of people of the most varied professions and institutional insertions, the debates demonstrate, in practice, the need to build multiprofessional networks for the coordinated action of both individuals and institutions. In addition, this article proposes transversal and integrated training in several fields of knowledge that will enable the preparation and strengthening of the necessary skills to carry out the enormous tasks vital to the health and well-being of the population, in order to better face and respond to the complexity of the challenges.

In the debates promoted by NETHIS/FIOCRUZ debates, we were able to interact and reflect together with managers from the Ministry of Health and other ministries, intelligence officers, military planners and researchers from various fields. We saw a high level of professional dedication, a strong commitment to collective health and an effective and creative commitment in addressing highly complex global health problems expressed in strategic and operational planning activities, as well as in the day-to-day management

of challenges and in the analysis of a variety of themes, subjects and areas of action.

Examples of this diversity of thematic issues and areas that require intense preparation, prevention and rapid and effective action, among the priorities are the forms of production of agribusiness and regulation of international trade of ultra-processed foods; regulation of harmful domestic and international tobacco trade; emergencies caused by chemical, biological, radiological and nuclear agents (CBRN); the duality of the threats and opportunities of synthetic biology for health; and the reality of international migration flows in health and the quality of people's well-being.

In this article, we aim to contribute to the considerations on the need to foster permanent and dynamic multiprofessional networks to act in a coordinated manner, to promote intersectoral learning and to strengthen national institutions dedicated to global health and health diplomacy, supported by robust intelligence in health (PANISSET, 2017).

With this objective, we suggest the discussion of concepts of human security of the United Nations (UN) and the construction of strategic and operational mechanisms of intelligence in health, based on the formulation of the World Health Organization (WHO), placing intelligence in health as the mainstay of a state policy that includes the harmonization between national health policies informed by scientific evidence and diplomatic initiatives of international and global health. We propose the discussion within the framework of health diplomacy (BUSS; TOBAR, 2017), confronting some dilemmas of international health and global health and recommending the state of the art development and use of available operational tools. Above all, we seek to guide the discussion of some prerequisites of intelligence in health, examined by the lens of equity – according to which those who have less receive greater attention according to essential needs. That is, with the omnipresent ethical question about what global health and diplomacy we want as a nation, for who and for whom.

We receive daily an ocean of information about threats to human security, directly related to the health of populations, and in many cases by false news with the most varied intentions. How best to organize, analyze and use this information to anticipate, prepare and respond to the potential and real threats to the health of Brazilians and our global health initiatives?

We asked what would be the most effective intelligence in health mechanisms to support the systematic, permanent and sustainable analysis of scientific evidence, indicators and information on health determinants, to address the multiple and complex challenges in an ethical and supportive way among people and populations, with a perspective committed to equity.

In order to explore these issues, we propose to address them in the conceptual perspective of Human Security, arising mainly from the transformation of the bipolarity of the Cold War in the 1990s into other forms of global conflicts and contemporary additional impacts on health and well-being of people around the world.

The concept of Human Security gains relevance in 1994, presented at the Human Development Report of the United Nations Development Programme, UNDP (UN, 1994). It focuses on the security of peoples beyond the security of territory, for the survival, living and dignity of people. It can be inferred the UN recognition of the interrelation between health – which is central to the concept – and six other dimensions essential to human development: economic, food, environmental, personal (threatened by assassinations and other violence), community and political. Although not very clear operationally speaking, the concept is reinforced in 2012 in the UN General Assembly Resolution on Human Security (UN, 2012).

When analyzing the concept of Human Security in global health, Chen and Narasimhan (2003) point out their operational impact on health policies and their implementations. They emphasize that the main objective of this approach is to combine the action of safeguarding human lives from potential or existing threats, while promoting the sustainability of human development. The most diverse health issues, such as those mentioned above, besides violence, poverty and inequity, contribute to the centrality of health-disease processes in human security. The authors point out, however, a certain generality and amplitude of the concept, which often hamper the management of public policies and institutional actions necessary to transform the concept of human security into in public policies, management and daily practice.

On the other hand, they argue that the "person-centered perspective of human security generates a set of priorities different from those of traditional state-centered security" and its military-police apparatus (CHEN;

NARASIMHAN, 2003, p. 189-190, literal translation). They mention the special health needs of conflict refugees and the high risks of infectious diseases in this situation. They draw attention to the fact that the vision and ethos of human security help to "capture the depth and extent of the impact of public health crises [...] and of complex humanitarian emergencies" (Ibid., literal translation). In this context, "surveillance, control and response linked to international trade" (Ibid., literal translation) and its sanitary regulation, migration, CBRN threats and situations of violence are interdependent, even if they are analyzed separately in order to enable crisis management. Thus, the operational concept of human security is defined by the "nature of the threat to which it intends to respond, as much as by its people-centered 'value base', its perceptions of new strategies or its ability to mobilize and energize various circles" of interest (Ibid., literal translation).

The human security perspective focused on people's health is therefore the foundation of our task of reflecting on the diversity of the subjects discussed here and at the same time understanding their connections and tools that facilitate the analysis of international regulation of ultra-processed foods and actions and public policies for the promotion of healthy food and measures for the state regulation of industrial production, or for tobacco regulation – both related to the production of agribusiness and its national and international trade. In both cases, there is the impact of the industries responsible for products associated with the risk factors for chronic diseases.

As to CBRN emergency responses, the concept of human security makes it easier to understand the role of the diversity of actors and public health and safety agencies in the preparation and implementation of response actions needed to address potentially devastating risks to health and security of the population, or of their natural and agricultural resources. The issue of the duality of innovations in synthetic biology for health, as well as the reality of migratory flows, explicitly brings to the surface the duality of national sovereignty, democratic constitutional commitments, and Brazil's global agreements. These themes introduce the need for greater listening, negotiation and participation of individuals and civil society groups who have access to new knowledge of synthetic biology, often in makeshift domestic laboratories.

The UN Sustainable Development Goals (SDGs) are in the field of human security. Agreed among the Member States at the United Nations

Sustainable Development Summit held in New York in September 2015, they seek to be a reference to national policies and international cooperation activities in the period 2015-2030. There are 17 goals, or 169 targets, involving themes that embody the concept of human security, including poverty eradication, food security and agriculture, health, education, gender equality, inequality reduction, energy, water and sanitation, sustainable standards of production and consumption, climate change, sustainable cities, protection and sustainable use of oceans and terrestrial ecosystems, inclusive economic growth, infrastructure and industrialization, governance and means of implementation (BRAZIL, 2018).

However, would such a wide range of goals and targets be an obstacle to the successful implementation of SDGs? Murray (2015) postulates that SDGs are very broad, with vague targets, where health is not the central focus. However, other authors, less reductionist, understand that the health situation will not improve significantly if it is not addressed in an intersectoral way, based on the identification of the social determinants of health in each location and globally (BUSS; PELLEGRINI FILHO, 2007).

Only SDG 3 focuses on healthy lives for all ages. But Tedros Ghebreyesus, the current Director-General of WHO, disagreeing with approaches that reduce public health to biology, emphasizes that health contributes to and interrelates with all SDGs. He cites as an example that universal health coverage, as in the Brazilian Unified Health System, can "reduce poverty (SDG 1) by protecting people from financial difficulties" when exposed to prohibitive cost treatments and that "good health can promote employment and economic growth (SDG 8)" (MOHAMMED; GHEBREYESUS, 2018, p. 590, literal translation). Therefore, he highlights the multisectoral interdependence, affirming that "better health, in turn, impels other objectives" of sustainable development (Ibid., literal translation). Ghebreyesus points out that reaching the health targets of the SDGs and their determinants will require new investments between 2015 and 2030 estimated at $ 3.9 trillion to cover the needs of 67 countries that accommodate 75% of the world's population. To strengthen the viability of these seemingly prohibitive investments in times of economic crisis, the WHO estimates that national expenditures could cover 85% of these costs. He concludes that "for most countries, better health and well-being conditions for all, therefore, is not

fundamentally an economic choice – but a political choice" (Ibid., literal translation).

According to De Leeuw (2017, p. 329, literal translation), the "engagement of sectors other than health in governance, policies and interventions for health" is fundamental, that is, "foundations for a comprehensive health governance" should occur in a "continuum of engagement methods from other sectors" for further integration. This implies transformations ranging from "institutional redesign" to "narratives based on ethical values".

Acharya, Lin and Dhingra (2018) also point out that all other SDGs are interrelated, but that most countries lack robust data, indicators and intelligence mechanisms to analyze them, linking data between different government sectors. They also mention the low coordination capacity between different sectors and limited implementation and monitoring tools.

Therefore, in relation to the management and operation of national and global health, we highlight here the limitation of current intelligence systems for health and the lack of capacity for permanent, real-time analysis of the health impact of all public policies, seeking to support the necessary and successful implementation of SDGs.

One of the limitations of the traditional proposals of intelligence in health mechanisms is precisely the prevalence of a biologicist, biomedical reductionism that focuses mainly on diseases, especially on infectious diseases (BONFADA et al., 2012) and chooses to ignore its determinants in health sector practice.

Morse (2007), for example, states that intelligence in health would be very limited to epidemiological surveillance and analysis of diseases, especially infectious diseases, even admitting to include chronic noncommunicable diseases and animal and agricultural diseases in their analyzes. By mentioning the impact of poverty on health, it does not operationally consider the need for intelligence to encompass social determinants of health, reducing the possibility of monitoring and analyzing the multisectoral impact on the health-disease process.

Even if we take into account the intense global migratory flows or the pandemics across borders, it is obvious that people become sicker or healthier at the local level, rather than regionally or globally. In the context of the discussion on intelligence in health systems, Morse (Ibid., p. 1070,

literal translation) warns that "in most areas of the world, there is no substitute for local knowledge".

Therefore, in intelligence for health, politics and external action must talk organically and permanently with the other sectors that deal with the social determinants of health and their effects in local contexts and in the population as a whole, always remembering that even knowing which interventions are most effective based on the best global evidence, the application of this knowledge happens, in general, locally.

An extension of the operational concept of intelligence in health, still traditional, combines the duality of human security in health and national security, especially in the face of the threats of biological terrorist attacks, but remains, mainly, in the national security arena, one with police and military features. A grand example is the National Center for Medical Intelligence (DOD-NCMI), an agency headed by the powerful and ubiquitous Defense Intelligence Agency of the United States/Department of Defense. The NCMI addresses health security, but through the militarized national security filter. For a more comprehensive view that considers the centrality of health to the determinants of human security, we will adopt the term intelligence for health instead of intelligence in health.

Bowsher, Milner, and Sullivan (2016, p. 269, literal translation) advocate a "medical intelligence" approach, still based on military intelligence, which neglects diplomatic initiatives in global health. They seek, however, a dialogue, even if restricted and with differentiated scales of power, aiming from the juxtaposition of epidemiological intelligence to military national security, in practice accepting the subordination of the first to the second. Examples of such overlapping range from the intelligence to protect the US and its military troops from the Ebola epidemic in West Africa until the use of a vaccination scheme as a gimmick to gather information and assassinate Osama bin Laden in Pakistan, which has had the adverse effect and the discrediting of the vaccination efforts in the country and caused a decrease in the acceptance of the vaccine by significant sectors of the population. Bowsher, Milner, and Sullivan (Ibid.) further point out that NATO practices medical intelligence restricted to information on health systems infrastructure. The NCMI also restricts the collection and analysis of epidemiological intelligence to the military field, prioritizing the protection of its troops.

Bowsher, Milner, and Sullivan (Ibid., p. 270, literal translation) externalize ethical concern with these militarized approaches that "minimize the health problems of the world's poorest populations purely on the basis of threats to their armed elites, rather than a moral or ethical concern", and conclude on the need to harmonize the ethically opposed fields of global health and military intelligence.

The WHO has already advanced from a traditionally reductionist view of intelligence in health, previously restricted to the health sector, advocating for greater capacity to analyze, coordinate, share information, cooperate, intervene and respond effectively to the various dimensions of human security, with integrated action of multiple relevant sectors. Therefore, seeking different approaches to intelligence in health.

The Global Public Health Intelligence Network (GPHIN), developed by the Canadian Ministry of Health in cooperation with WHO, focuses on collection and systematic analysis of reports and rumors of infectious diseases outbreaks, through the monitoring of news permanently extracted from international media sources and social networks on the Internet, with searches conducted in several languages. However, it also includes water, food and chemical events safety, therefore, within some of the topics we discuss in this article. According to the WHO, GPHIN is the first alert of about 60% of epidemic outbreak reports.

Promoting intelligence for health activities, WHO recommends the inclusion of social determinants of health in evaluations of other public health information, via Urban Health Observatories, an intelligence mechanism mainly in the local context or even in macroregions, as in the vast region of the border between the United States of America and Mexico, with a particular cultural profile. This proposal boosts the formulation of new urban public policies and strategies for, for example, the prevention and control of urban violence. In these intelligence mechanisms, "social determinants of health are considered fundamental to understanding and responding to problems of public health and health inequities". The situation analysis of these observatories, therefore, "take into consideration factors other than the health sector" (WHO, 2014, p. 2, literal translation).

The Belo Horizonte Observatory for Urban Health (OSUBH), at the Federal University of Minas Gerais, is a viable and effective example of the

importance of the dialogue between local, national and global to be one of the components of an intelligence in health system proposed by WHO. OSUBH seeks to provide knowledge for the implementation of specific intervention and public policy strategies to address inequities in all sectors that impact health by transforming scientific research into public policies. This approach allows us to determine which urban health actions may work best in specific contexts (OSUBH, 2018).

Another viable component of a comprehensive system based on local approach is the one used by the municipality of Belo Horizonte, which seeks to organize its health system by the classification of each microregion, with about 3 to 4 thousand people, according to the Health Vulnerability Index (HVI). This index – which serves as a reference for the distribution of resources and delivery of services according to the principle of equity – is elaborated using social determinants of health, based on evidence of its impacts. It includes sanitation, housing, schooling, income, social aspects (race/color) and environment (PITCHON et al., 2013).

The continental proportions of Brazil, with its marked and complex inequalities; inequalities between regions, as well as intra-regional, intra-urban and urban-rural inequalities; and our intense global migration and commodity flows require an apparatus for intelligence in health that is comprehensive in analytical capacity, operationally feasible, and includes diverse social, national, and global determinants, operating informed by scientific evidence and tacit knowledge.

The key would be the agile collection and real-time data analysis capability, with inclusive approaches to social and massive determinants, through the processing of Big Data, including active search in the media and social networks, in the so-called Open Source Intelligence (intelligence for health from open sources), including mining relevant data via population data linkage (HAY et al., 2012; KHOURY; IOANNIDIS, 2014; BERNARD et al., 2018). However, relevant technical limitations of the Ministry of Health persist in relation to these innovations, overwhelmed by the burden of disease and the freezing of economic resources (DONIEC; DALL'ALBA; KING, 2018).

The Brazilian State mobilized in an exemplary and intersectoral way to respond to the challenges of intelligence in health during two global mega events, the 2014 FIFA World Cup and the 2016 Olympic Games.

However, the Ministry of Health has prepared the Unified Health System only in the host cities for the World Cup, in a joint action with the Ministry of Sports, creating the Health Thematic Chamber to try to coordinate the three levels of government in the activities of strategic planning, sharing responsibilities and increasing the effectiveness of actions, strengthening the Network of Attention to Urgencies and Emergencies and the Health Surveillance System. In this framework, the National Force of the Unified Health System for "rapid and effective assistance to the population in situations of catastrophes, epidemics, or care crises" (MASSUDA, 2012, p. 358 and 360, literal translation), through the Decree nº 7616 of November 17, 2011. The idea was to develop health actions for the event that could become a legacy for collective health. However, the initiative still needs to be further researched as to the real institutional impact of this legacy, especially in the face of the 20-year public spending cap imposed on the nation in 2017 by Temer's administration, with Constitutional Amendment 95.

The experience of this mobilization could serve as an example for the structuring of permanent and intersectoral mechanisms of intelligence in health for human security that would observe, collect and analyze information, data and indicators in a georeferenced way and also include the social determinants of health in each regional and microregional context to facilitate addressing it through innovative and effective public policies. This initiative, if it had been implemented, could have contributed, in a way that has not been measured yet, also in relation to Brazil's diplomatic initiatives in health and global health.

Danilo Coelho, an intelligence officer and researcher who participated in this Cycle of Debates, contributes significantly to advancing the structuring of a broad, effective and innovative intelligence system that acts in the defense of national security in the perspective of human security and that is sensitive in the capture of multisectoral determinants of health. In this process, he identifies possibilities and obstacles in the construction of a multisectoral intelligence apparatus, with operational aspects of coordinating the actions necessary for human security.

To this end, it is very useful to point out the fundamental need for "a shift from the paradigm of national security to that of human security" (COELHO, 2017, p. 77, literal translation). In this sense, Coelho (Ibid.) proposes a new security paradigm that he calls "transecuritization of state intelligence". In this

proposal of restructuring to achieve the contemporaneousness of the Brazilian intelligence system, the idea is to address simultaneously the "multiple threats from the perspective of human security against Brazilian society" and "increase the efficiency of the Brazilian Intelligence System" (Ibid.).

Currently, the Brazilian Intelligence System (SISBIN) is composed of 39 government agencies, coordinated by security agencies, including the Ministry of Health, the National Sanitary Surveillance Agency, the Ministry of Environment and the Ministry of Agriculture, Livestock and Supply, all essential for thematic areas that we discuss in this article and for the promotion of human security (Ibid.; ABIN, 2018). The participation of the Ministry of Foreign Affairs suggests the possibility of fostering health diplomacy initiatives and better coordinating information on national health, global health and its intrinsic relationship (PANISSET, 2000, 2017).

Coelho's transecuritization proposal meets our need for a strong and coordinated intelligence system for human security that supports confronting health problems in a variety of contexts – from local to global – to support internal challenges and diplomatic health initiatives. But he warns that

> Although the composition of SISBIN and the intelligence guidelines point to the structuring of a broad system that transcends the traditional security area to incorporate strategic themes from different sectors, an institutional framework persists that would hinder this comprehensive action. (COELHO, 2017, p. 77-78, literal translation).

According to Coelho, the militarized composition of the advisory council that coordinates SISBIN (CONSISBIN), mostly from the Ministry of Defense, limits the possibility of a broader role due to "a remnant of intelligence with a police and military bias" (Ibid., p. 78, literal translation), giving priority to external defense and internal security agencies. However, he highlights the governmental state demand "for predictive analyzes of nontraditional security threats and the definition of intelligence guidelines" (Ibid., literal translation) that include human health, environment, agricultural resources and infrastructure. The proposal of "transecuritization of state intelligence incorporates the concept of human security and systematizes

other elements present and necessary for the process of modernization of intelligence" (Ibid., literal translation). Thus, it goes far beyond the reductionism that still prevails regarding national security as protection of the territorial frontier, of the population and of the national interests against external threats. This comes from a nostalgic Brazilian doctrine of national security, developed in 1949 by the Superior School of War, with strong North American inspiration, from the post-World War II (Ibid.), and strengthened in the dictatorial period of 1964 to 1985.

Although the proposal of transecuritization of state intelligence does not yet clarify the operational ways of coping with multiple health problems and their national determinants, or of their role in health diplomacy initiatives, his suggestion of consecrating "a predictive intelligence, under the aegis of evidence-based scientific analysis" (Ibid., p. 84, literal translation) is particularly significant and contemporary.

In this sense, we propose as an integral part of the intelligence for health for human security the process of using integrative and systematic methods developed within the framework of WHO, since the 58th World Health Assembly, which urges Member States to "establish and strengthen mechanisms to transfer knowledge to support public health and evidence-based health care systems, and evidence-based health policies" (WHO, 2005, p. 127, literal translation).

Formulators and implementers of public health policies (e.g. SUS managers at all levels) and other sectors responsible for health and their determinants in various sectors – in addition to managers of health diplomacy initiatives – face constant challenges to expand coverage, improve the quality of health care and simultaneously control the impact of social determinants. Added to these tasks is the responsibility for implementing these policies and assessing their effect on day-to-day decisions and actions in a number of different contexts.

Citizen participation in this process is indispensable for achieving a greater degree of legitimation, implementation and evaluation of the impact of policies on people's health. Policy building benefits from transparency in the process and democratic participation of social control, when it promotes meaningful dialogue on the problem, options and strategies to address it, as well as studying barriers, facilitators, risks, benefits and costs of interventions.

The bioethicist Norman Daniels emphasizes this ethical imperative of social participation and the need to transparently disclose the process of analysis and decision for the formulation and implementation of policies in health systems, emphasizing that the transformations of health systems are often "social experiments that require ethical and scientific review before they are implemented and ethical and scientific monitoring after" the implementation (DANIELS, 2006, p. 447, literal translation). That is, broad population experiments that occur without informed consent.

Mechanisms for formulating policies and practices informed by sound scientific evidence and correctly analyzed information may therefore represent a more operational component of intelligence for health and help to improve significantly the quality and impact on management with positive impacts on the health of populations. Additional and vital benefits are the better use of resources to promote equity in coverage, as well as the standardization at sustainable levels of health judicialization processes, supported by sound scientific bases and tacit knowledge that can be systematized through deliberative dialogues.

The management of these goals requires new ways of thinking and organizing intelligence for health for human security and the formulation of public policies, especially in view of the fact that the construction and implementation of health policies or health in all policies presents great potential risks, reaching tens of millions of people.

As Coelho reminds us, as an "organ of anticipation of facts and support for decision-making, the performance of intelligence helps to shape the very performance of the State". In this case, through actions that benefit human security (COELHO, 2017, p. 89, literal translation).

We propose, therefore, the need to use in intelligence for health systems the state-of-the-art methods used and tested by WHO and its Evidence-informed Policy Network (EVIPNet) in translating knowledge into policymaking. These methods help strengthen the skills and abilities necessary for the policymaking process that benefit from the best available scientific evidence and properly analyzed information (data, indicators, indexes), based mainly on SUPPORT tools (LAVIS et al., 2009).

The term 'evidence-informed policies', rather than 'evidence-based' policies, has been coined to show that the best evidence competes with

other factors in the formulation of policies, such as available resources and societal acceptance, factors that need to be considered in the practice of intelligence for health.

In Brazil, these methods and their tools have also been tested in several workshops in the last decade and in the formulation of policies at the three levels of government, adapted with quality to the needs of our country by EVIPNet Brazil and the work of Jorge Otavio Maia Barreto, participant in the cycle of debates on the theme of this article (BARRETO; SOUZA, 2013; DA SILVA CORRÊA DIAS et al., 2015).

In 2014, there was the publication of encouraging results from a five-year multicenter formative evaluation, stimulated by WHO and the European Union, of managerial and research experiences in about 30 low- and middle-income countries organized institutionally for the systematic use of the best evidence in the construction and implementation of health policies, with inclusive methodologies of social participation.

Two instruments, widely used by managers and researchers working together in these countries, received special attention from these assessments and should compose a contemporary system of intelligence for health: the synthesis of evidence for politics and organization and the reporting of a deliberative dialogue on this policy (MOAT et al., 2014).

The synthesis of scientific evidence prioritizes systematic reviews and other studies evaluated as of proven quality and is organized from the description of a problem and its characteristics, from the possible options of effective and cost-effective interventions — including the identification of potential benefits, risks and costs of each option and implementation strategies, from the identification of barriers and facilitators.

In the deliberative dialogue, the synthesis of evidence serves as the basis for the debates, but the main emphasis is on the tacit knowledge of the participants — from experts to representatives of civil society who will be particularly impacted by a certain subject and health policy — from the experience, values and visions of each (LAVIS; BOYKO; GAUVIN, 2014).

When necessary, operational or implementation research can be added to the process of synthesis and dialogue to help verify the level of implementation and resolution of certain public policies, facilitating the

evaluation process and consequently adjusting the course of action (PANISSET et al., 2012).

Human resources observatories that adopt practices for the analysis of information and indicators integrated with the use of scientific evidence are able to guide actions to implement public policies that best favor the health of populations, in an equitable way. These forms of action must therefore be fundamental components for feeding intelligence for health and strategic planning of health systems (GEDIK et al., 2009).

It is important to emphasize that equity considerations permeate all stages of the process to minimize the risk that certain policies and interventions will benefit those who least need them (OXMAN et al., 2009).

Another practice advocated by evidence-informed policies that can benefit the intelligence in health system is the organization of information repositories with systematic reviews, other high-quality studies, reports from international organizations, policy syntheses, legislation and other necessary inputs for analysis. Successful examples of these repositories include Health Systems Evidence and Social Systems Evidence, organized and maintained by McMaster Health Forum, of the McMaster University of Canada.

The academic application of SUPPORT tools can be long and require a large team, but the agility necessary for intelligence for health can be solved by the rapid response mechanisms (MIJUMBI et al., 2014; HABY et al., 2015) that adopt the same methods, but look for secure simplifications that can deliver results from 24 to 48 hours.

Aware of the risk of the dilemma between intelligence and action in militarized and police systems, especially in authoritarian or hegemonic regimes globally, we highlight the ethical imperative of transparency and systematization of the process and the need to think about health in its aspect of benefit for all and values of equity as social justice. It is worth emphasizing once again that intelligence can shape action. Quality policies generated by a transparent system do not deserve to rot in the drawers and shelves and need to be implemented in multisectoral actions.

Given the need for effective action to effectively address issues that threaten populations, other available operational tools should be considered to address the complexity of intelligence for health tasks, as they help to break the large amount of information into more manageable parts, without losing

an analytical cohesion and the integrality of the studied phenomena, mainly aiming at the better management and operability. The multiplicity of key multilevel actors — whether local, national or global —, who require a degree of coordination for the success of each initiative, presents major difficulties, especially if we take into account the need to work with different government sectors — many times antagonistic —with different motivations and interests. Often, financial interests that are not always explicit or of dispute between markets in different competing countries predominate. In this sense, recalling the health-cooperation-conflict paradox, in which despite the perception that health is a privileged field for cooperation, since it promotes mutual benefits, it is also a field of conflicts, especially those related to market aspects.

Fidler (2011, p. 14, literal translation) suggests a framework for facilitating the capture of"how actors identify and amplify their self-interest", which we suggest can be used both in diplomatic health initiatives and in national initiatives to promote health and address their adverse social determinants. The objective is to identify and negotiate the interests of state and non-state actors, often hidden, and the potential divergences that may hinder joint action (Figure 1). Fidler calls this identification map format"actors, problems, processes and principles"(2011 apud PANISSET, 2017, p. 95, literal translation).

Figure 1. Model suggested by Fidler for the mapping of the bases of negotiations in the diplomacy in global health

Training and articulation of interests			Translation of common interests in collective action	
Problem	**Amplification of interest**	**Actors**	**Negotiation processes**	**Collective action**
		Nation states		
		Intergovernmental organizations		
		Non-Government Actors		

Source: Fidler, 2011, p. 32 apud Panisset, 2017, p. 96.

More than understanding the interests of relevant actors in the formulation and implementation of public policies for health, we need tools

that allow us to organize diverse categories of the vast multisectoral and transdisciplinary information, in a simultaneous and agile way, especially in the acute processes that require prompt and dynamic coping.

The three-dimensional matrix presented (Figure 2) organizes categories of information (data and indicators) and scientific evidence that can facilitate analysis for intelligence and initiative management. It has been proposed and used on other occasions to support the human capacity for global health intelligence and health diplomacy initiatives, such as SARS (Severe Acute Respiratory Syndrome) epidemic and, earlier, to analyze the cholera epidemic in Latin America, in the 1990s. This three-dimensional matrix can simultaneously encompass several types of determinants and help us analyze situations, assess and adjust predictive exercises, prevent or minimize crises, and organize priority actions.

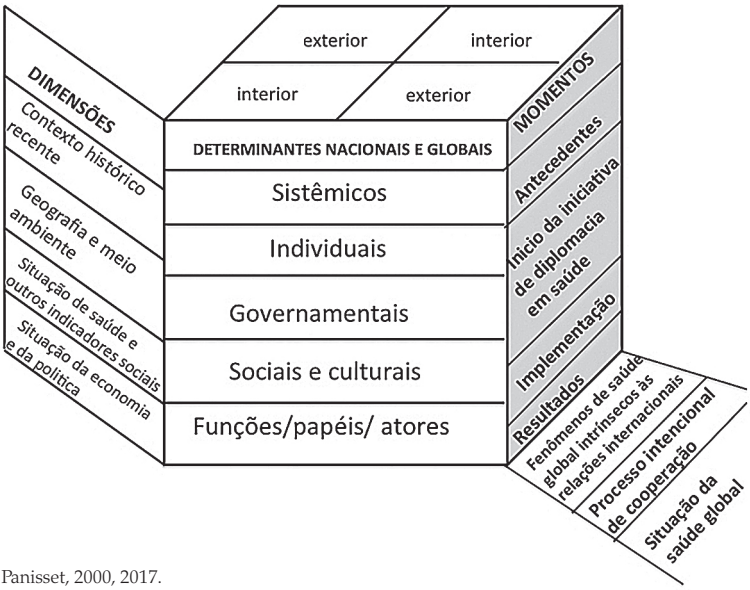
To better use this intelligence tool for national and global health, it is worthwhile to establish collaborations with networks of research institutes and universities interested in the subject and using transdisciplinary arrangements. We have also used this analysis model in crisis simulations with the dual objective of multidisciplinary and intersectoral training and for the formation or strengthening of intelligence for health networks.

Brewer (1999, p. 328, literal translation) warns us that "the world has problems, but universities have departments" and disciplines. On the contrary, multidisciplinary and multi-institutional networks that support intelligence for health act to identify and describe a particular problem, be it current or perceived risk for the future. From there, they examine the characteristics of the problem, its dimensions, its indicators compared to other countries and their current and potential severity. In this process of intelligence, they examine multidisciplinary scientific evidence to guide the implementation of healthy public policies in each context.

In its role of supporting intelligence for health, the model (Figure 2) can be adapted to each context, at each level. It can strengthen research — including historical, operational and implementation — and strategic planning, policy implementation capacity and ongoing evaluation of policy outcomes, whether internally or in international cooperation. In other words, it is designed to support the preparation and management of health diplomacy initiatives. It may be useful mainly to "prevent a crisis by helping to

better prepare in a number of relevant sectors to address it or to manage a global health crisis in which health ministries are at the forefront" (PANISSET, 2017, p. 102, literal translation).

Figure 2. Matrix for the analysis of global health and health diplomacy phenomena



Source: Panisset, 2000, 2017.

The architecture of scientific information and evidence proposed in this model addresses both the local and national context (the interior) and its implications on interactions between nations or groups of nations and on the global context (the exterior). It also contemplates the intrinsic relation between the two spheres, interpreted from the perspective of each observation exercise. In each of the matrix plans, key information is deposited that will integrate the analysis.

As an example, we propose a brief and simple simulation of what would be the categorization of information obtained from the media (Open-Source Intelligence) and evidence from scientific research on some of the subjects discussed in the Cycle of Debates.

In the proposed model, in each of the "boxes" of the matrix planes are deposited key information that will integrate the analysis. In Dimensions, we include, for example, the recent historical conjuncture of the phenomenon to be analyzed, seeking to trace its evolution to the current situation, in order to look for predictable options. In the case of the regulation of the harmful national and international tobacco trade, we would describe and analyze in full what we categorize into separate dimensions to facilitate understanding of the different most relevant factors. However, each "box" must have a way to communicate with the others:

1. *The recent historical dimension* would examine the decision-making process for ratification of the World Health Organization Framework Convention on Tobacco Control in the global sphere and in Brazil. We would discuss how Brazil, the second largest tobacco producer in the world and the largest exporter with a strong agricultural production and of derived industrial products, promoted decisive action by the State in the international negotiations led by the WHO, seeking to safeguard the sovereignty of national interests and ethics of the promotion of the health of its population, exercising in an exemplary way the solidarity in its diplomacy in global health (RANGEL et al., 2017). By advocating for the health of its population and simultaneously taking proactive measures for global health, the high levels of political decision-making and of the health sector can in fact influence negotiations, both to defend sovereignty over decisions and to promote human security. The proposal would be to concentrate mainly on a greater good: health and well-being of the population, in a combination that Yach and Bettcher (1998) call convergence and that Lee, Chagas and Novotny (2010) point out as a defense of the health of its population, simultaneously managing to strengthen global health through the restrictive multisectoral regulation of a disastrous product.

As for the impact of international migration flows on health and the quality of people's well-being, we could have described, in advance, the recent history of Venezuela's political, economic and social deterioration; the enormous global pressures suffered by the country, with the coordinated blocking of international credit and its impact on the health of Venezuelans, leading to an increase in the number of mainly economic refugees; and the history of the degradation of the health system, with its impact on the

levels of vaccination, for example, of measles, with imported cases and the contamination of Brazilians.

The narrative would continue until the violent conflicts between Brazilians and Venezuelans on August 18, 2018, in Pacaraima, Roraima – widely publicized in the media and with implications for the presidential race in Brazil –, highlighting the interconnectivity between the deterioration of the economic and political crisis, economic refugees and the health impact on both sides of the international border.

If we opt for a regional cut, in the state of Minas Gerais we could show how the implementation of Anglo American – a British mining conglomerate – in the municipality of Conceição do Mato Dentro explored the presence of Haitian environmental refugees. The company was assessed in November 2013 due to slave labor of 100 Haitian refugees, attended at the Clinic of Labor Law and People Trafficking of the Law Faculty at the UFMG, fact widely publicized by the Minas Gerais newspapers, with a strong impact on the health of these workers;

2. *In the geographic and environmental dimensions*, we would also explore the natural resources that may be related to the phenomenon studied, for example, the dominance of oil in the Venezuelan economy, as well as the border regions; or the environment of devastated forests in Haiti and the biological contamination of waterways, greatly aggravated by the earthquake of 2010.

In tobacco production, mainly in the south of Brazil, we could verify what Portes et al. (2018) exposed as environmental damages by soil contamination, by burning forest and by deforestation, in addition to excessive consumption of water;

3. *The dimension of the health situation and other social indicators* would also group cultural and anthropological aspects, identifying relevant research on the subject. In the case of refugees, if the approach was mainly in the state of Minas Gerais, we would work with the various indicators (gender, race/color, marital status) presented and analyzed in the quality diagnosis on migration and refuge in Minas Gerais (SOUZA, 2017).

Or, in the case of tobacco, we would see that 7.2 million people die annually in the world due to diseases associated with tobacco use, 156,200

of them in Brazil, among the 22 million smokers over 18 years old (TEIXEIRA; PAIVA; FERREIRA, 2017).

When considering worker health indicators in the Brazilian agribusiness production process – both for processed food regulation and for tobacco production –, we could consider that "a worker dies every 30 seconds in the world for exposure to toxic substances", pesticides, radiation and other harmful substances, according to the International Labor Organization (UN, 2018, literal translation), and seek scientific evidence of the quality regarding pesticides in Brazil, comparing them with those of other countries;

4. As to *the dimension of the economy and politics*, in the process of intelligence we would learn from the Diário do Comércio e da Indústria, in its edition of January 19, 2018, that Brazil is the second largest tobacco producer behind China, but a world leader in exporting this product that clearly is harmful to the health of users, exporting to 94 countries, responsible for approximately 30% of the world shipments, which represents 1% of all our exports. Rio Grande do Sul is the largest exporter, with 78% of the total and revenues of US $ 1.6 billion. However, when proposing decisions and actions informed by scientific evidence, we would take into account that despite apparent financial gains from producers, exporters and tobacco industries, in addition to the jobs generated, the economic burden on society is disproportionately higher (PINTO; UGÁ, 2010; PINTO; PICHON-RIVIERE; BARDACH, 2015). Figueiredo, Turci e Camacho (2017) estimate that tobacco use in Brazil costs about R$ 57 billion annually (R$ 39.3 billion due to medical care and treatment and R$ 17.5 billion due to loss of productivity), threatening 22 million smokers in the country. So we would conclude that the cost to health, not counting the all the deaths, is about ten times higher than the export earnings and seven times higher than the taxes paid by the cigarette industry in the country. Portes et al. (2018) add data on tobacco-derived costs and health-derived costs globally, which represents about 1.8% of the world's gross domestic product.

In the analysis of the political and economic context of the countries involved — or relative to the impact of the current global economic crisis — we would reflect on the degree of the unified response capacity of the State and society, the level of fractionation existing or even the degree of factionalism

existing at a given juncture, which would make it difficult to prepare and respond to society as a whole. In this sense, the analyst needs to be doubly rigorous with the ideological bias and conflicts of interest expressed in the mainstream media. Therefore, we would evaluate some editorial opinions as indicative of factional thinking, often expressing dominant values that deserve to be taken into account in the political calculation of planned actions. In this dimension, it would also be worth examining both the level of international credit blockage and the economic and political misconceptions committed by the Venezuelan government at the national level.

In the frontal dimension of the three-dimensional matrix, we would classify the determinants of national and global health, categorized into more specific sets of factors that can be grouped into:

1. *Systemic*: they would be analyzed first from a national perspective, focusing on the SUS, the Unified Social Assistance System, security systems, funding agencies, external relations and global health management agencies and SISBIN. In global systems, we would examine the role of international agencies. Here we suggest incorporating the systemic thinking adopted by the WHO in relation to health systems, vis-a-vis other sectors (DE SAVIGNY; ADAM, 2009). Regarding national studies, recent reports from IPEA are very useful, such as the one organized by João Brígido Bezerra Lima, participant in the Cycle of Debates, on the demographic profile of refugees in Brazil in the period 1998-2014 (LIMA et al., 2017) or the Atlas on Violence (IPEA, 2018).

The reports of countries prepared by international organizations on different sectors (WHO, World Bank, Inter-American Bank), studies of philanthropic foundations, always safeguarding the analyzes that uncover conflicts of interests that must be investigated are very useful. A recent UNICEF study of social determinants affecting children and adolescents is very useful for intelligence for health in relation to key determinants of health, such as education, access to quality information, child labor, housing, water and sanitation. We would find in this study that more than 13 million children and adolescents live without basic sanitation and almost 9 million do not have access to education. We would incorporate into our analysis the concept of multiple deprivation, which aggravates the impact of social determinants on health (UNICEF, 2018);

2. *Individuals*: representing the characteristics and individual interests of key actors involved in the negotiations that influence the conduct of the initiative within the countries and the potential diplomatic initiative in health, especially at high levels of political decision-making.

In this case, we might ask how, for example, Michel Temer's conduct in the conflicts in Roraima might have been different from Dilma Rousseff's position, which he replaced, not by the roles they both exercised but by markedly different personal characteristics and public domain. The interpretation bias of these characteristics can be diluted with the participation of different analysts, acting separately and then building some level of consensus, explicitly enumerating dissent in order to guarantee a more comprehensive view of the problem to be faced and its various characteristics.

Fidler's model of analysis, presented earlier, could be considered here to indicate the characteristics and interests of each individual key actor in the negotiations, including for individuals in high decision-making positions who should arbitrate on the initiatives to be taken, although originally the model has been designed to analyze institutional actors;

3. *Governmental*: we include in this compartment models of governance that may facilitate or hinder cooperation negotiations and actions, as well as rivalries between different agencies in the conduct of external policies, for example between the Ministry of Health and the Ministry of Agriculture, with interests, in practice, often contradictory; or the vision of military sectors on territorial security and agencies that focus on human security and human rights. In such cases, we would consider identifying the ethics of possible solidarity between nations and identifying mutual interests, such as negotiating tobacco regulation. We include here governance models, as in the case of SISBIN, that may facilitate or hinder negotiations and cooperation actions;

4. *Social and cultural*: meaning various aspects of civil society and adding assessments of institutional cultures that influence their performance inside and outside the country. We can group here "historical and conjunctural characteristics of society during a certain initiative" (PANISSET, 2017, p. 104, literal translation), whether internal or of health diplomacy. It allows revisiting the degree of national identity or fractionation of the

society at a given moment, as expressed in the presidential elections of 2018, and the degree to which this fractionation affects how the nation faces a certain crisis or phenomenon that greatly affects the health of the country or global health."The cultural aspects, values and beliefs of the populations involved in the initiative should be taken into account in this set of factors that determine the outcome" (Ibid.). They are also taken into account in deliberative dialogues that reflect, in part, cultural influences and social relations at a given moment;

5. *Functions and roles*: they are inherent to the formality of the position that the decision maker or other actors occupy, which shapes their official performance in the negotiations and "would probably occur, regardless of the individual characteristics of the occupants of a certain function, unlike the variables called here previously of individual", in item 2 (Ibid., p. 105, literal translation). As an example, we can again mention the need for Michel Temer to maintain – as President of Brazil – the open borders in the Roraima crisis, due to international agreements, even in the face of pressure from leaders of his political party in the region.

To facilitate real-time monitoring or, alternatively, retrospective evaluation of an initiative or event, we describe four stages that provide a chronological assessment of events and their outcomes (background, start-up period, timing of implementation, and expected and/or obtained in practice).

All components of the analytical matrix, in addition to its relation to internal and external approaches, can be categorized as: intrinsic to international relations and trade (commerce, regulations, migration, conflicts); as an intentional and planned process of health diplomacy (international agreements, treaties and conventions, as in the case of tobacco; external cooperation activities; participation in forums and international assemblies); and of global health impact (e.g. tobacco export, and management of the Zika epidemic).

The tool described and exemplified is not rigid, serving as a reference to facilitate the organization of intelligence for health tasks. The necessary improvement is through its application and validations. Therefore, it requires rigor and, at the same time, flexibility and adaptation to each context, phenomenon or function (research, strategic planning or as a facilitator of the analysis on intelligence for health) to ensure better utility and agility.

In order to improve its operability and effectiveness as a motivator of political action, the way of presenting the interrelationships found and analyzed between the different components and the results obtained with the analysis can not be totally neutral. The writing of reports should seek to raise awareness and motivate the decision-makers and other key actors to implement effective policies and actions needed to address a particular problem or a set of them. In evidence-informed policies, the anticipated managers' participation, together with researchers and other analysts in the process of elaborating report, facilitates the implementation of analyzed options. Crisis simulations represent opportunities for multiprofessional training of both analysts and managers.

Multisectoral determinants of health, interrelated in their national or global nature and intrinsic to trade themes and their impact on health; to the migratory flows that make us close to other cultures, but often cause fear; to QBRN threats; and the duality between the benefits and threats of synthetic biology for health, among many other pressing issues, require of us all creativity and constant vigilance to recover and consolidate human security. The complex health challenges that we addressed in the NETHIS Cycle of Debates and the vital goal of human security for all bring about rapid, strategic and effective responses, fueled by strong political will and according to available resources, in a sustainable manner.

They require dynamic intelligence for health mechanisms capable of identifying, processing and analyzing information on a daily basis. These mechanisms require the combination of study activities, ongoing surveillance, and safe preparation informed by the best available evidence, leading to timely and decisive action and anticipation, preparation of responses and coping with possible adverse events. Global intelligence for health processing needs to include strategic planning and day-to-day management, both of which lack the development of a listening capacity of society for feedback and ongoing evaluation of results.

In addition to the available tools and professionals from various areas able to use them, there is a conviction of the urgent need to allocate resources and the political will to face challenges of high complexity. Above all, at the heart of an effective system of intelligence for health and human security are the values of equity, solidarity and mutual respect among peoples.

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Trends in Social Security in Latin America

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Trends in Social Security in Latin America

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1. Introduction

Social security systems are a central part of social protection systems, fulfilling important functions such as: (i) insurance against various contingencies, such as pregnancy, accidents or illness; ii) consumption smoothing, when the individual can no longer generate income from his own work; and (iii) insurance against poverty in old age (BARR; DIAMOND, 2010).

There are different ways of organizing social security systems. Its main characteristics are related to: i) how they are financed; ii) plan of benefits; and iii) how they are administered[1].

Financing retirement-income can be through capitalization – where each person pays a certain amount for its own pension – or funding – in which contributions are collected from insured parties periodically to pay the benefits due, not necessarily constituting financial reserves to future expenditure.

The benefit plan can be either a defined benefit plan (DB) or a defined contribution plan (DC). DB plans are those in which the benefit paid considers the historic, quantity and value of contributions. DC plans, in turn, are those in which the benefit to be paid depends on the amount accumulated throughout the contributory period of each individual.

The administration of a social security system can be public (state) or private, centralized or not. It is important to know that the form of state administration is most commonly observed in international experience.

Each configuration between the possible financing, benefit plan and management options determines how well the social security system can achieve each of its objectives. Considering the countries of Latin America, these

1 For more details on the organization of pension systems, see Bosch et al. (2013), and Rangel (2013).

choices are important, since, at the same time that the social security policy needs to reach a large population group with the objective of protection against poverty in old age, it is also necessary to develop a good consumption smoothing mechanism throughout the life cycle for a significant number of people.

The countries of Latin America have social security systems that aim to protect income and reduce poverty in old age, regardless of the size of their populations and economies. These characteristics, however, together with the historical development and the current functioning, result in a marked heterogeneity among the countries of the region. The classification proposed by Mesa-Lago (2004), which considers the origin and level of development of the systems, helps to understand the present moment of each country in terms of coverage of the working population and the elderly. There are three proposed categories for the systems: pioneer, intermediate and late. A common element in the proposed classification is the contributory characteristic of the system: only those who contribute or have a long contributory historic are covered and entitled to the benefits offered.

Those who instituted their systems in the first decades of the 20th century form the group of pioneer countries: Argentina, Brazil, Chile, Cuba and Uruguay. In the beginning, social security systems protected more organized or economically strong groups: railway employees, post offices employees, military personnel, diplomats, government officials responsible for collecting taxes, among others. The incorporation of other groups, and the consequent expansion of the system, occurred in a gradual and fragmented way (MESA-LAGO; BERTRANOU, 1998).

The other groups – intermediate and late – were instituted in the middle of the 20th century and in the 1960s and 1970s, respectively. They were systems, already in their origin, less fragmented than the pioneers were, but with inferior coverage. This is due to some structural properties of labor markets in countries, such as high incidence of self-employment and high informality – characteristics that do not coadunate with contributory social security systems.

Approximately half a century after the implementation of the most longevous social security systems – in the 1980s and 1990s –, many countries offered low coverage. Rofman and Olivieri (2011) show that coverage among the elderly was little more than 30% in many countries; in some, it barely reached 10%. However, low coverage was not the main concern of

the region's governments in the elaboration and implementation of reforms in the last two decades of the previous century[2], but rather the fragile fiscal situation in many countries (BOSCH; MELGUIZO; PAGÉS, 2013).

On the one hand, the design of social security systems had very optimistic (or even benevolent) criteria regarding the social security dependency ratio, which made the long-term projections for expenditure unrealistic. On the other hand, the rapid aging of the population, which increased the number of beneficiaries and, consequently, social security expenditure, together with the economic crises that affected the countries of the region during the period, resulted in the inability of the states to finance the deficits (conjunctural and structural) of their social security systems. This situation led to a series of reforms – the first in Chile in 1981 – adopted by several countries, starting in 1993[3][4] (ROFMAN; APELLA; VEZZA, 2013).

In addition to the promise to improve the sustainability of social security systems, reforms have also been accompanied by positive expectations regarding their potential labor market impacts, improved labor productivity, increased domestic savings and development of capital and financial markets (MESA-LAGO, 2001).

Specifically regarding the impacts on the labor market, the expectation was that by having a clearer relation between contributions and benefits, there would be more incentives for the formalization of labor relations, which would result in greater coverage of workers and increase of labor productivity in the medium and long term. This greater connection between contributions and benefits can be clearly seen in the reforms that introduced capitalization schemes with individual accounts, but also in some changes in the systems that have maintained financing through funding[5].

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2 Some countries underwent reforms in the 2000s.

3 Chile has served as an inspiration for structural reforms, which have introduced the logic of individual capitalization, either in a substitute or a parallel way, in Peru (1993), Argentina (1994), Colombia (1994), Uruguay (1996), Bolivia 1997), Mexico (1997), El Salvador (1998), Ecuador (2001) – although approved, was never implemented –, Costa Rica (2001), Dominican Republic (2003) and Panama (2005).

4 Brazil, in 1998, underwent a reform in its social security system, but, unlike most other countries in the region, it was a parametric reform.

5 Brazil, through Law 9,876, of 1999, introduced the so-called social security factor in the calculation of the value of the benefits. According to the factor formula, the longer the contribution time of the individual upon retiring, the greater the benefit value tends to be.

The comparison of some indicators before and after the reform, although is not considered an evidence of its impact, suggests that most of the promises made in the different countries were overly optimistic. There was no significant transformation in the capital and financial markets, in the expansion of domestic savings, and especially in the growth of formalization in labor markets (BOSCH et al., 2013; MESA-LAGO, 2001). Thus, the low coverage of the past persisted.

The first wave of social security reforms in Latin American countries improved long-term sustainability (GILL; PACKARD; YERMO, 2005). However, this improvement was due to the reinforcement of the contributive nature of the respective retirement systems, which, in a context of labor markets with high informality and turnover, has limited potential in terms of the increase in coverage.

The scenario of improved sustainability of the systems in parallel with the limitation on the expansion of coverage allowed a shift in focus from studies on social protection beyond the fiscal question. Gradually, the need to expand coverage has gained relevance among scholars and multilateral organizations[6]. Given the aforementioned limitations of the contributory regime, the creation and expansion of non-contributory benefits (or assistance) was the subject of debate about the expansion of coverage. Thus, the debate pointed to the need to expand coverage, albeit by the alternative route of non-contributory benefits.

In the last two decades, the trend observed in the 1980s and 1990s has reversed: at least 18 countries in the region have undergone comprehensive reforms to expand coverage for workers and the elderly (ROFMAN; APELLA; VEZZA, 2013)

The large number of countries in Latin America in a relatively short period undergoing inclusive reforms reflects the need for further reflection on the motivations and results of these reforms. In addition, although in most cases the ultimate goal of the reforms was the same – the expansion of coverage – there were important differences in the initial conditions between these countries.

It is very unlikely for countries to reform their social protection systems for one reason alone. Some studies suggest that the changes were driven by

6 See ILO (2001, 2011) and Holzmann and Hinz (2005).

several factors. For instance, the incapacity to expand social security systems coverage, whose rules date back to the second half of the last century and the improving the fiscal situation of most Latin American countries, due in part to the commodity boom observed in the past decade. Also, social pressure, aimed at guaranteeing protecting policies for the population as a whole, focused on the vulnerable. As mentioned, this incapacity to expand coverage is closely related to informality in these countries; the other two factors need further consideration.

Commodity markets have undergone in the first decade of the 2000s what is conventionally called the commodity supercycle. In this cycle, the growth of the emerging economies, led by China, increased the global demand for primary products, with the consequent rise in the prices of these products. For most Latin American countries, net exporters of primary commodities, such a movement in commodity prices meant unexpected economic gains and served to boost their economies (TORRE; FILIPPINI; IZE, 2016), which widened the fiscal space in their budgets. Parallel to this, many countries have seen growing social pressure for new citizenship rights, which has led to a wave of changes in the governments of the major countries in the region. These changes have led representatives from central and left parties to the presidency of the countries, with the agenda of extending rights. Thus, improved economies, and social pressure for new rights, combined with the rise of party representatives with a more inclusive agenda, resulted in reforms focused on expanding coverage of social security systems.

Thus, the last wave of reforms of the social security systems of Latin American countries between 2008 and 2017 tended to advance the systems administered by the state together with the development of solidarity schemes. It was also a trend in the region the advance of non-contributory systems in order to reach the maximum possible coverage, especially of the elderly population.

It is possible to affirm that the oldest social security systems of the countries of Latin America have already been born with the mission of both insurance against contingencies and consumption smoothing. Only recently have they become more assertive in their role of old-age poverty insurance – although it is necessary to improve the adequacy of benefits for this purpose –, especially through the expansion of the granting of non-contributory benefits.

The purpose of this study is to present the coverage situation and discuss the trends of social security systems in Latin American countries. To do so, it is divided into four sections, in addition to this introduction. The second section of the paper presents the coverage indicators of the active population and the elderly, and discusses the main problems arising from the low coverage. The third section presents the theoretical foundations of policies for expanding coverage, both for active workers and those who have already left the labor market. The fourth section presents some recent experiences for increasing coverage in selected countries. Lastly, the fifth and final section consolidates the issues presented throughout the text, and discusses the unresolved issues and possible solutions for closing the protection gaps in the countries.

2. Social security coverage in Latin America

It is understandable that the existence and good functioning of social security systems are fundamental for the exercise of citizenship rights, since they are mechanisms of protection and guarantee of income against the risks of disability, old age and death, when individuals are no longer able to generate income from their own work (ECLAC, 2018).

Considering that being covered by the social security system is something that reaffirms the condition of a citizen, it is understood that any knowledge about the coverage of the population – active and elderly (or who pays contributions and who receives benefits) – is of sum importance to understand the current flaws in guaranteeing rights and the future challenges to face the situation.

Table 1 shows the coverage of social security systems in several Latin American countries. The data presented show the coverage of the population in different situations.

The data presented in Table 1 show that, between the initial and final years, almost all the countries observed an increase in the coverage of their social security systems. The positive highlight in every scenario is Uruguay: almost 90% coverage among employees, greater coverage among the self-employed, more than 70% coverage of the employed and the economically active population (PEA); conversely, the lowest coverage is

in Bolivia, Guatemala and Honduras. Just to illustrate the size of the challenge of expanding coverage in these countries: even among wage earners, coverage is low; did not reach 40% in 2015.

Table 1. Social security coverage in Latin American countries – several years

		Contribuintes de 15 a 64 anos		Contribuintes de 15 a 64 anos como percentual de	
		Assalariados	Não assalariados	Ocupados	PEA
Argentina	2000	61.6		44.6	38.0
	2006	57.9		44.5	40.3
	2015	67.9		52.9	49.2
Bolívia	2000	37.2	1.7	12.8	12.2
	2006	32.6	2.2	13.5	12.9
	2015	40.7	4.9	18.9	18.3
Brasil	2001	64.5	23.7	48.5	43.9
	2006	67.8	25.4	51.4	47.1
	2015	78.3	37.2	63.9	57.8
Chile	2000	76.1	24.0	62.4	55.8
	2006	78.6	25.0	66.4	62.2
	2015	83.2	23.3	70.7	65.8
Colômbia	2000	41.1			21.7
	2006	52.9	6.9	28.9	24.8
	2015	66.4	11.7	37.7	34.2
Costa Rica	2000		42.9	64.3	61.5
	2006	74.5	39.1	64.0	60.9
	2015	78.3	47.8	70.3	65.7
Equador	2000	46.0	12.0	25.3	24.0
	2006	37.8	11.2	26.2	25.4
	2015	63.7	22.6	46.6	44.8
El Salvador	2000	48.9	3.0	30.9	29.3
	2006	47.3	3.6	31.0	29.8
	2015	45.7	3.4	29.4	28.2

		Contribuintes de 15 a 64 anos		Contribuintes de 15 a 64 anos como percentual de	
		Assalariados	Não assalariados	Ocupados	PEA
Guatemala	2000		0.4	20.2	19.9
	2006	40.0		23.8	23.5
	2015	32.4	1.0	20.7	20.3
Honduras	2000				
	2006	38.6	1.0	19.8	19.1
	2015	38.1	0.7	19.3	18.0
México	2000	52.1		35.7	34.9
	2006	51.2	1.5	35.8	34.6
	2016	40.3	0.6	30.6	29.6
Panamá	2000		18.3	54.2	47.8
	2006	70.0	7.1	47.8	43.9
	2015	75.3	9.0	54.4	51.5
Paraguay	2001	27.3	0.4	13.5	12.5
	2006	25.1	0.6	12.5	11.7
	2015	39.1	1.1	23.2	21.9
Perú	2000	30.4	0.2	14.1	13.4
	2006	29.7	0.1	13.1	12.5
	2015	41.0	0.4	21.0	20.3
Rep. Dominicana	2000				
	2006	48.8		26.7	25.3
	2015	69.2		39.5	37.1
Uruguai (urbano)	2000	51.0	17.5	41.5	35.7
	2006	78.3	38.1	66.9	59.5
	2015	89.0	45.1	77.5	71.6

Source: Database – IDB Labor Markets and Social Security Information System. Available at: https://www.iadb.org/es/sectores/inversion-social/sims/inicio.

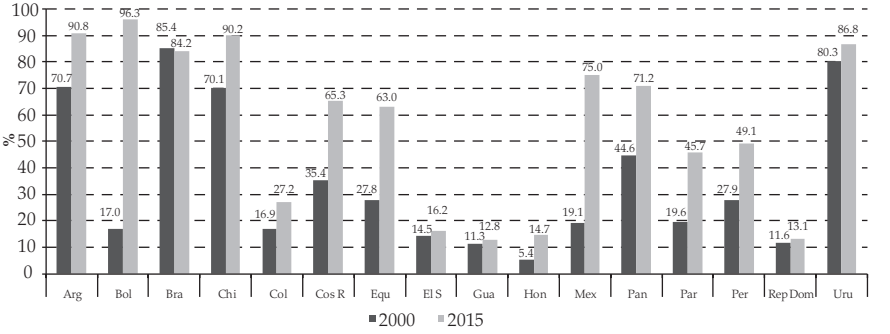
Some countries have noted relative success in expanding coverage among non-wage earners, such as Brazil, Costa Rica, and Uruguay. However, the coverage does not reach 50% of the non-wage earners in these countries. In general,

given the strong presence of self-employed workers in the labor market of the countries of the region, the challenge of expanding the coverage of contributory systems necessarily involves policies that promote the inclusion of this group. Some countries have implemented policies to this end in recent years[7], but some evaluations show that the coverage expansion was much smaller than expected and/or the sustainability of their social security systems deteriorated[8].

Given the functions of the social security system, coverage represents a connection between the worker's present and future situation, when reaching old age. Thus, the level of coverage of the working population today is a proxy of what will be the coverage among the elderly – the greater coverage of the active population tends to reflect, in the future, into a greater coverage of the elderly population.

Chart 1, below, shows the percentage of the population aged 65 or over who receives some contributory or non-contributory benefit in Latin American countries. It is a measure of protection of the elderly population.

Chart 1. Coverage (contributory and non-contributory benefits) of the elderly population (65 years and over) in Latin American countries – 2000 and 2015



Source: Database – IDB Labor Markets and Social Security Information System. Available at: https://www.iadb.org/es/sectores/inversion-social/sims/inicio.

7 See Rofman, Apella and Vezza (2013).

8 See Grushka (2016) for projections of social security benefits granted in the various versions of *moratorias previsionales* in Argentina; Costanzi (2018), for financial and actuarial evaluation of the individual micro entrepreneur program in Brazil; Mesa-Lago (2015), to evaluate the sustainability of the solidary pillar introduced in Chile; Aguila et al. (2013) for an analysis of the effects and sustainability of the *Programa de pensión para adultos mayores* (formerly called 70 y más) introduced by the federal government of Mexico.

Chart 1 shows that there are different coverage patterns and their evolution among the analyzed countries. In 2015, coverage among the elderly ranged from 13.1% in the Dominican Republic to 96.3% in Bolivia. For Argentina, Bolivia, Brazil, Chile and Uruguay, on the one hand, coverage among the elderly was higher than 80%. On the other hand, coverage among the elderly was less than 30% for Colombia, El Salvador, Guatemala, Honduras and the Dominican Republic – this represents a high degree of lack of protection among the elderly.

The increase in coverage among the elderly over the period was mainly due to the growth of non-contributory benefits (BOSCH; MELGUIZO; PAGÉS, 2013; ECLAC, 2018). Highlight for Bolivia, Costa Rica, Ecuador, Mexico, Panama, Paraguay and Peru. In addition, countries that observed high coverage growth in the two periods analyzed, such as Argentina, Costa Rica and Ecuador, underwent reforms in their contributory systems that made this improvement possible.

As seen in the introduction to this study, the original design of social security systems in most Latin American countries intended to protect only a fraction of the working population, especially the formal employees of private companies and civil servants. Inspired by the social security systems that emerged in postwar Europe, Latin American systems would never reach universal coverage with the region's high levels of informality.

Given the rapid population aging observed in the region[9] and the inability of the existing institutional arrangement to universalize social security coverage, the challenge of the countries of the region is to create policies capable of reaching this uncovered population. Alternatives to state social security observed in other social protection systems involve greater dependence on the elderly in their families, an option aligned with the so-called familism of social policy, or the accumulation of assets throughout the working period as a form of savings, an option more aligned with a liberal model of social welfare.

The organization of social protection around the family unit can increase the risk of incursion into poverty – in the case of inactivity in old age, the same group would depend on a smaller income, but the biggest concern with this type of arrangement is the gender problem it creates by imposing more responsibilities on women's domestic tasks (ECLAC, 2017). These are unpaid activities, not covered by any protective system and, in

9 See Acosta Ormaechea, Espinosa-Vega and Wachs (2017).

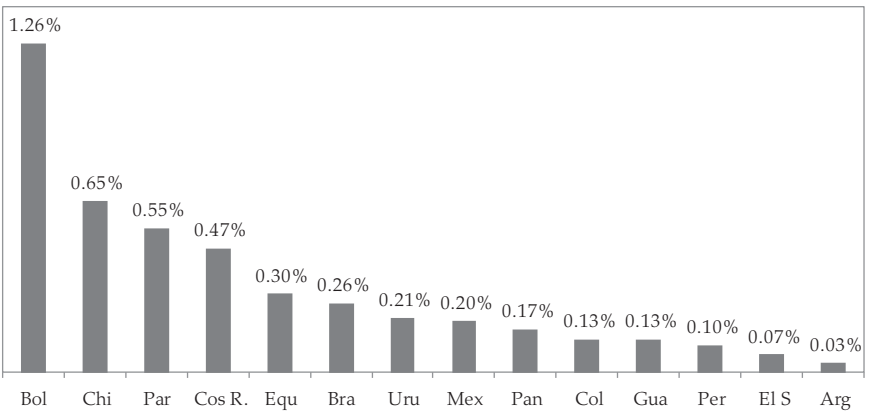
many cases, not socially valued (ILO, 2018). Thus, the consequence of the lack of protection for the elderly is a possible perpetuation of poverty in the family, with the aggravation of having a gender bias.

The use of private savings – financial or real assets – could be an alternative to the absence of social security income; however, the labor trajectory of this population does not allow the accumulation of assets. Informality during the years of economic activity means, for the great majority of these workers, low incomes and the absence of alternative mechanisms of saving for old age. In these cases, the only alternative to social security income is to depend on the family (ILO, 2014).

In addition to social impacts, the low social security coverage can result in what can be called the hidden fiscal cost. It results from the reaction of citizens who demand policies that offer non-contributory benefits so as not to leave the population unprotected, which for different reasons did not receive the contributory benefits nor any other income in the old age.

In fact, when the population not covered by the contributory system receives non-contributory benefits, this hidden cost becomes explicit. This has generated a relevant budgetary effort to allocate the public fund to the elderly population. Chart 2, below, shows the public expenditure with non-contributory benefits for some Latin American countries.

Chart 2. Non-contributory benefits expense in Latin American countries – percentage of GDP



Source: Elaborated by the authors with data from HelpAge (http://www.pension-watch.net/).

Graph 2 shows that, for most countries, except for Bolivia, spending on non-contributory benefits is still relatively small relative to GDP. Maintaining the gaps in coverage of traditional contributory regimes and rapid population aging, however, will necessarily imply the growth of spending on such benefits over the long term.

In short, this section presented some data on social security coverage of the active population and the elderly for Latin American countries; also showed some problems due to this low coverage. The following section discusses some possible policies that can be adopted in order to solve protection gaps as well as mitigate the problems deriving from them.

3. Considerations on policies aimed at increasing the coverage of pension systems

Labor market analyzes in Latin America use different definitions of informality, which may or may not incorporate the link with the social security system as a defining characteristic[10]. However, this aspect throughout the working life is what determines the present and future social security coverage of the worker.

Informality, a concept initially restricted to the set of activities developed without a clear separation between capital and labor, that is, activities that did not involve a wage payment, can also be used to describe workers in other situations. For example, self-employed and unpaid workers (in small family businesses or in agricultural activities), as well as small producers and other forms of relationship of workers with the formal sector. A more comprehensive definition considers as part of the informal sector situations such as small businesses in which the owner directly performs services or production; wage earners without contract; occasional, temporary or seasonal workers; and domestic work (CACCIAMALI, 2000). In addition, there are cases of disguised wage payment, in which workers seem wage earners, but are hired as self-employed or legal entities.

These cases represent different positions in a spectrum of forms of insertion in the labor market. They range from situations of low vulnerability,

10 For example, it is possible to consider self-employed workers as informal regardless of whether they contribute to the social security system or not.

such as workers who choose to work as legal persons with the objective of tax avoidance, even to situations of great vulnerability, such as a seasonal employee without a contract who has no other work option. This large heterogeneity of situations suggests that it takes more than one public policy to foster the bonding of all these groups with the social security system simultaneously. Thus, it is necessary to consider the relative importance of each group without social security coverage in the country under analysis to prioritize policies to increase coverage.

Relatively young workers can be included in social security with specific policies aimed at formalization, such as differentiated rates, preferential treatment or even a profound change in the system so that the general rules incorporate a larger part of the population. This is a form of expansion of preferential coverage, tackling the problem before the loss of work ability due to old age, the main risk insured by the social protection system[11].

Workers who have reached the final ages of economic activity without meeting the eligibility criteria need other types of policy. Such policies aim to create an intermediate alternative between the social security benefit and the welfare benefit. They vary among Latin American countries, ranging from heterodox forms of compliance with the post-retirement eligibility criteria to non-contributory benefits, which are in many ways similar to the welfare benefits.

In both cases, policies aimed at increasing coverage alter the incentives created by the social insurance system, and may even have effects contrary to expectations. Thus, for these policies to be effective, it is necessary to consider in their planning the entire structure of existing social security and welfare benefits, and how the intertemporal decisions of workers and firms will be affected. For such policies to be sustainable, it is also necessary to evaluate their actuarial impact on the social security system.

In the remainder of this section, the main types of policies for expanding coverage, during and at the end of the working years, are analyzed to understand the rationale behind them, as well as the risks they introduce into the system.

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11 By increasing social security coverage during the worker's economically active period, these policies also extend coverage to other protections, against accidents and illness, for example.

4. Expansion of coverage during the working life

Interpretations of the functioning of the labor market and the nature of informality are the base of policies for formalization. Given the impossibility of affecting all types of informal workers at the same time, they are often targeted to one or some of the components of the informal sector mentioned above.

One factor that pervades all these policies is to assess how and to what extent the costs associated with the social security are perceived by the employer – an extra payment – and by the worker – a salary discount. The statutory incidence of social security contributions is largely not relevant, since the different elasticities of demand and labor supply determine economic incidence. In other words, the configuration of each specific labor market will determine who will absorb costs beyond the legal determination. There may be situations where the employer absorbs entirely the cost of the contribution, in the form of higher labor costs; in others, the worker absorbs it entirely in the form of a lower salary.

The second factor to consider is how much workers and employers value social security. If workers perceive social security coverage as insurance against social risks, coverage can have the same value as costs[12] – or even more than the costs incurred by workers. From the point of view of employers, valuing social security depends on two main evaluations: whether social security coverage affects workers' productivity (for giving safety to the workforce, for example), and whether the company will be supervised (in which case the absence of the bond would imply fines and other penalties).

Considering the financing of social benefits with payroll taxes, Summers (1989) proposed to analyze both aspects together, known as the contribution-benefit linkage. This author argues that, given the valuation of social benefits, such as social security, by part of the workers, they would be more willing to accept the economic incidence of tax on payroll[13]. In the

12 "[...] taxes and social security contributions do not necessarily reduce the perceived income of worker. Social Security contributions may also be considered deferred consumption, for example in the case of contributions to public pension programs" (Boeri; Ours, 2008, p. 81).

13 For this reason, tax on payroll to fund such benefits would have an impact on efficiency less than general tax funding.

context of informality, this type of analysis is important because the worker does not evaluate the social security in relation to the lack of income when reaching old age, but in relation to the benefits obtained in special regimes (created to increase the coverage, for example) and the welfare benefits.

Bosch, Melguizo and Pagés (2013) synthesize the different combinations of perceived costs and benefits in a table, reproduced below.

Table 2 - Costs and benefits of formality

		Workers	
		Cost > benefit	**Cost < benefit**
Companies	Cost > benefit	**1) Informality by choice** **Salaried** employees do not value social security and work for companies that are not subject to supervision. **Self-employed** workers do not value the benefits of social security and are not subject to compulsory participation.	**2) Exclusion** **Salaried** employees value social security, but only access jobs in companies that are not subject to supervision. **Self-employed** workers value social security, but are not able to participate in the system due to costs.
	Cost < benefit	**3) Tax avoidance** **Salaried** employees do not value social security and work for companies subject to supervision, but with incentives for tax avoidance. **➔ Disguised wage payment.**	**4) Formality by choice** **Salaried** employees value social security and work for companies subject to supervision without incentives for tax avoidance. **Self-employed** workers do not value the benefits of social security, but are not required to participate in the system.

Source: Adapted from Bosch, Melguizo and Pagés (2013).

Each public policy aimed at increasing social security coverage aims to act on the costs and benefits of workers and companies to move them to quadrant 4 of Table 2.

Thus, an increase in supervision actions can be an effective proposal to move workers from a situation of informality by choice (quadrant 1) to quadrants 3 or 4 by increasing the companies' cost of employing informal

workers. Considering the contemporary problem of transport apps drivers, who would be classified as self-employed in quadrant 1, sector regulation may require that, in order for them to access the market (that is, to join the platform), they are part of the social security system. In that case, the supervision would be on the platform and not on the self-employed workers.

Other situations that would fit in the cases of quadrant 1 would be those in which informality would be explained as effect of the taxation on the payroll or consequence of the high levels of the rates of these taxes. Taxation on the payroll causes a distortion when the value received by the worker and the cost of labor incurred by the company diverge. This difference, called fiscal wedge, would reduce market efficiency, resulting in unemployment and informality. Alternatively, the presence of such taxation would not be the main problem, but the high level of the rates. In this second explanatory line, informality would be a form of manifestation of the Laffer curve (FULLERTON, 2008), that is, losses of collection would occur due to a reaction of the taxpayers – in this case, the employees and the employers – at very high tax rates. Policies based on this type of diagnosis would propose the reduction of rates of contribution or even their replacement by another type of taxation, not linked to the payroll.

As for workers excluded from the formal market, there is a need for policies that reduce the cost for their inclusion in the social security system. Thus, the reduction of the value of the social security contribution[14] for this group depends on an implicit or explicit subsidy by the government to guarantee the sustainability of the system. Many countries in the region have adopted special taxation regimes aiming formalization, reducing financial costs and accessory obligations for self-employed workers and small enterprises (GONZÁLEZ, 2006, 2009).

However, when considering these special regimes from the social security point of view, the actuarial impact got little attention, that is, subsidies are implicitly given when financing the system deficit. In general, there is no explicit provision for contributions from other sources to the system to offset the reduced rates of the special regime. In addition, little attention was paid to the impact of the migration of workers who were already

14 Special regimes for small taxpayers generally cover all taxes and not just the social security contribution.

formal to the subsidized regime. Part of the workers and companies that were already formal (that is, that were already in quadrant 4 of Table 2), with the existence of special regimes, legally starts to contribute with reduced rates, meaning an immediate loss of resources for the social security system.

Incentives for disguised wage payment generally come from a significant misalignment of taxation – contribution to social security and income tax – between individual and legal taxpayers. Thus, a tax policy that approximates the treatment of individuals and legal entities would reduce the opportunities for tax avoidance. Companies would be indifferent between hiring the employee as a wage earner or a legal entity, and workers would obtain similar remuneration, since the amount of taxes would be similar in both situations. In addition to taxation, increased supervision could discourage disguised wage payment, raising the cost to companies.

5. Expansion of coverage after the working life

As already mentioned, social security is an insurance against social risks, especially against the loss of the ability to work through old age, whose coverage depends on the worker's relationship with the system throughout the working life. It is the insurance nature of the social security – pay today to guarantee future income – that creates the contribution-benefit linkage, previously mentioned as an important factor for the valuation of the social security system by the workers.

On the other hand, the insurance nature of social security imputes to it characteristics common to other insurance; particularly, creates incentives for opportunistic behavior and moral risk. In the social security context, opportunistic behavior manifests in the search for the most favorable conditions among the rules of the system, that is, in the search for the best benefit with the milder eligibility criteria available. In this same context, the moral risk manifests in the change of the worker's behavior when insured in relation to his behavior when uninsured. For example[15], reducing old age savings due to the participation of the social security system or even

15 None of these behaviors is illegal or even immoral; they are only responses of the participants to the incentives offered by the rules of the social protection system.

non-participation (voluntary) in the social security system due to the existence of other benefits.

In contrast to social security, social assistance policies have a different logic and complement the social protection system by providing income for those citizens who have failed to meet the social security eligibility criteria when they reach advanced ages and who would otherwise be in a situation of poverty. That is, eligibility for welfare benefits is conditional on the income (and/or wealth) of the potential beneficiary. The proper functioning of the social protection system depends on the fact that social security and social assistance have well-defined limits and act in a concerted way in society.

The expansion of social security coverage in Latin American countries was a result of the creation of non-contributory regimes and fiscal amnesties of unpaid social security contributions throughout the working life.

The introduction of non-contributory social security systems alters the boundaries between policies, and in many cases, non-contributory social security is similar to a welfare benefit without the need for a means test. Insurance coverage is guaranteed for those who did not hire it, drastically changing the incentives of the system.

Although such policies aim workers who have reached the final working years without meeting eligibility conditions, they end up affecting the decisions of those still in the labor market. The non-contributory benefit can break the contribution-benefit linkage so that the worker does not value the connection to the system and leaves it. In this case, there would be an increase in the coverage of older workers at the expense of reducing the coverage of young workers, causing a loss of income for the social security system. One way of avoiding this adverse effect of introducing a non-contributory social security benefit and still increasing coverage would be to differentiate these benefits in relation to the contributory social security benefits and in relation to the welfare benefits. This differentiation could be related to the conditions of eligibility (for example, differentiated ages) and to the value of the benefits, so that the existence of non-contributory (and welfare) benefits did not compromise the contribution-benefit linkage.

The introduction of a system that allows for the amnesty of unpaid social security contributions – paying them after retirement, with some level of subsidy and the resources of the benefit itself – also introduces

significant risks to the social security systems. It guarantees the contracting of the insurance (social security) after the effectiveness of social risk, also changing the incentives of the system.

Initially one must consider that the grace period as an eligibility criterion, that is, the time of participation in the social security system before being able to claim benefits, plays an important role in the containment of moral risk in the social security system. In addition, considering that most social security systems are funded, an expense is created in which the corresponding contribution does not come from active workers in the labor market, but from a discount on the benefit itself.

These characteristics of the institute of tax amnesty weaken the contribution-benefit linkage, affecting the decisions of the active workers in the labor market in order to reduce the value they attribute to the bond with the social security system. A worker who has a good pay history as a young person, for example, may have strong incentives to leave the system and have a lower cost by paying the missing contributions when joining the amnesty.

The next section of this paper presents and discusses some of the recent policies to expand protection coverage in Latin American countries.

6. Recent experiences in expanding coverage in Latin America

This section aims to present some recent experiences of expanding coverage of the elderly in Latin American countries. They are, in the terminology presented in the previous section, policies for the expansion of coverage after the working life.

A broad set of Latin American countries adopted measures for the expansion of the protective coverage of the elderly through non-contributory programs or changes in the access conditions of contributory programs.

Rofman, Apella and Vezza (2013) propose a taxonomy to classify the various measures adopted, as well as present policies adopted in some countries in order to reduce the protection gaps. Table 3 below summarizes some of these measures.

From the different experiences presented in Table 3, some cases were selected for more detailed presentations in the present section of this study: Argentina, Chile, Bolivia and Ecuador.

Table 3. Programs for extending coverage, characteristics and year of implementation

País	Programa	População beneficiada	Integrado ao regime contributivo	Ano de implementação
Colômbia	Colombia Mayor	Focalizado	Não	2013
Costa Rica	Pensión no contributiva	Focalizado	Não	1975
Equador	Subprograma (BDH) Pensión para Adultos Mayores	Focalizado	Não	2006
El Salvador	Pensión Básica Universal	Focalizado	Não	2009
Paraguay	Pensión Alimentaria para Adultos Mayores	Focalizado	Não	2009
Peru	Pensión 65	Focalizado	Não	2011
México	70 y más	Focalizado com objetivo de universalização	Não	2007
Panamá	100 a los 70*	Focalizado com objetivo de universalização	Não	2009
Argentina	Moratoria Previsional	Focalizado com objetivo de universalização	Sim	2005
Brasil	Benefício de Prestação Continuada (BPC)	Focalizado com objetivo de universalização	Não	1993
Chile	Pensión Básica Solidaria	Focalizado com objetivo de universalização	Sim	2008
Uruguai	Reforma da Pensión por Vejez	Focalizado com objetivo de universalização	Sim	2009
Bolívia	Renta Dignidad	Universal	Não	2008
Trinidad e Tobago	Pensión para Ciudadanos Mayores	Universal	Sim	2001

Source: Rofman, Apella and Vezza (2013), Database on Non-Contributory Social Protection Programmes in Latin America and the Caribbean, ECLAC, and Social Pension Database, by Pension Watch.

* Subsequently, in 2014, it was replaced by the program *120 a los 65*.

Moratorias Previsionales, in Argentina, besides having a very positive result in terms of increased coverage, is a program integrated to the contributory regime whose objective is the universalization, even though it focuses on the group of workers who have not been able to contribute to the minimum necessary to obtain their pensions.

Pensión Básica Solidaria of Chile is a change in the country's social security system: the introduction of a solidarity pillar fully integrated with the existing system. *Renta Dignidad*, from Bolivia, is a universal benefit paid to all citizens upon turning 65 years of age. Lastly, the *Subprograma Pensión para Adultos Mayores* of Ecuador is a focused program, not integrated into the contributory regime, paid to all citizens from the age of 65 on, as long as they do not receive any other social security benefits.

Argentina

In 1994, influenced by the Chilean reform of 1981, Argentina's social security system was structurally reformed: a component of individual accounts managed by the *Administradoras de Fondos de Jubilaciones e Pensiones* (AFJP) (ARENAS DE MESA; BERTRANOU, 1997) was established.

A series of parametric reforms began in 2002. Among the main changes, an important one was the movement to value the benefits paid by the public component of the social security system, which operated in parallel to the AFJP (BERTRANOU et al., 2012).

In 2005, the year begins in Argentina with a measure of real impact in expanding the coverage of the elderly population: the establishment of a social security moratorium (or Social Security Inclusion Plan). This measure, a policy of extending coverage after the work period, allowed individuals who were old enough but did not have enough contribution time to request the *Prestación Básica Universal* (PBU)[16], to establish payment plans for the so-called social security debt, equivalent to the remaining time to reach the waiting period for contribution. A debt payment plan was established; the individual would perceive the PBU as long as he complied with contractual obligations.

16 The requirements to receive the PBU are contribution time and age: 65 years for men and 60 years for women, in addition to 30 years of contribution for both.

In December of the same year, the social security moratorium included self-employed workers. For them the monthly installments approved in their social security debt payment plan were deducted from the amount of benefit received.

The 2005 social security moratorium represented benefits for more than two million people, which resulted in more than 90% coverage in 2010: a figure that exceeds the highest historical coverage rates for elderly people in Argentina and in Latin American countries (BERTRANOU et al., 2011).

In 2008, Argentina underwent another structural reform, this time eliminating the capitalization regime with individual accounts. This system was completely replaced by a funding system administered by the State called *Sistema Integrado Previsional Argentino* (SIPA). The purpose of this reform was to broaden the coverage of the social security system – for both workers and elderly beneficiaries – and to recover the amounts of benefits paid (BERTRANOU et al., 2012).

More recently, the Argentine government approved another social security moratorium in September 2014. Self-employed workers and, as a great novelty, workers who joined the *monotributo*[17] regime are the target of this moratorium. Chart 3, below, presents the percentage of the population aged 65 or over who receives some contributory or non-contributory benefit.

Chart 3 shows a strong increase in the coverage of the elderly in 2007, reflecting the effect of the *moratoria previsional*. Coverage rose from 70% in 2006 to more than 90% a few years later.

Since the 2000s reforms in the Argentine social security system have resulted in a large increase in the coverage of the elderly population, and the social security moratorium –implemented in three moments – had the most important role in raising the elderly beneficiary population. The increase in coverage resulted in growth in spending on the social security system (retirements, pensions and non-contributory benefits), which increased from 3.8% to 8.3% of GDP from 2005 to 2017.

In addition to the fiscal consequence, the expansion of elderly coverage also represented a low incidence of poverty in old age and a positive impact on income distribution (LUSTIG; PESSINO; SCOTT, 2013).

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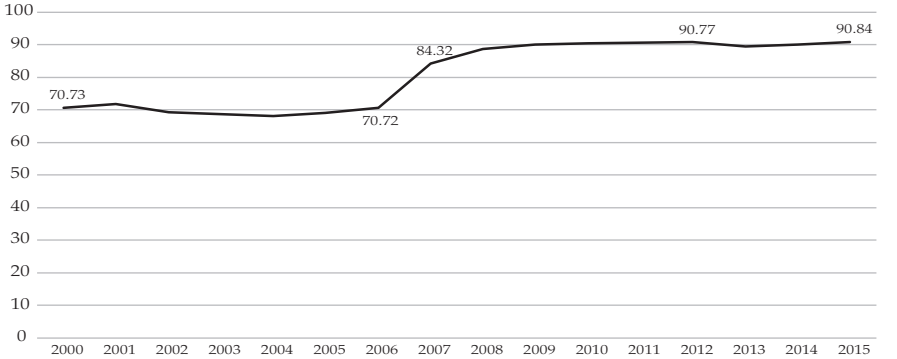
17 *Monotributo* is the simplified and subsidized regime with the objective of formalization, social security inclusion and coverage of health insurance aimed at low-income self-employed workers in Argentina. For more information, access: https://monotributo.afip.gob.ar/public/ayuda/index.aspx.

Chart 3. Population aged 65 or over receiving contributory or non-contributory benefit – %



Source: Database – IDB Labor Markets and Social Security Information System. Available at: https://www.iadb.org/es/sectores/inversion-social/sims/inicio.

Chile

Chile underwent a paradigmatic reform in its social security system in 1981. In that year, the state-funded system, a funded model with defined benefits, had been privatized. This meant replacing that model for a capitalization model based on individual capital accounts and defined contribution.

The Chilean pension reform model, although used as inspiration by different countries, has always been criticized for different reasons: low coverage of the working population, low coverage among the elderly, benefits of unsuitable amounts, high management costs of private funds and others (MESA-LAGO, 2001).

The year 2008 in Chile marked another structural reform in its social security system. The establishment of a non-contributory pillar, integrated with the private contributory – which continues to be the flagship of the Chilean pension model –, publicly funded and administered by the State.

The reform carried out in 2008, based on the creation of the solidarity pillar, aimed at combating poverty in old age (people aged 65 and over). It also sought to increase social security coverage of vulnerable groups (young people, women and self-employed workers) and improve the capitalization pillar by regulating investments, reducing costs and increasing competition among pension fund managers (ARENAS DE MESA, 2010; CORTÊS; FLORES, 2014).

The Chilean non-contributory pillar has two main components, the *Pensión Básica Solidaria* (PBS)[18] and the *Aporte Previsional Solidario* (APS). PBS is for those who do not receive benefit from pension funds, while APS is for people receiving a contributory pension below a certain level, the *Pensión Máxima con Aporte Solidário* (PMAS). The APS value is lower the higher the contributory pension, so that the sum of APS and contributory pension is always less than or equal to the PMAS.

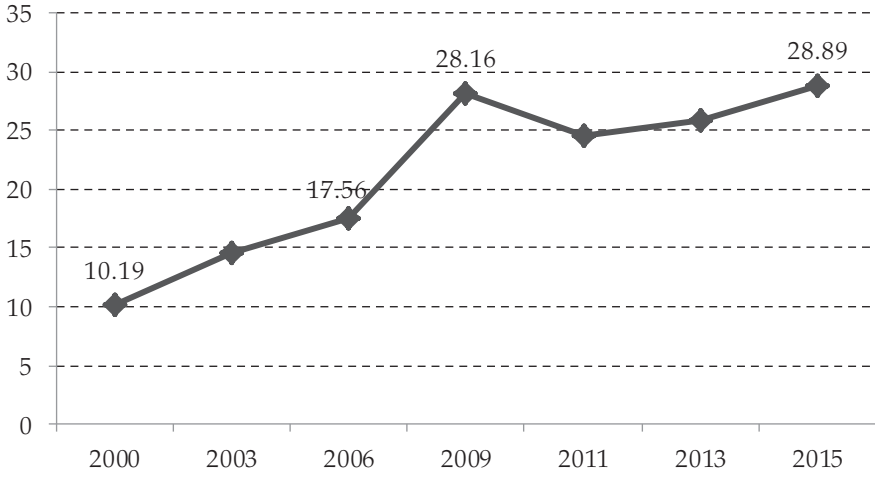
Table 4, below, presents the number of recipients of PBSs and APSs for different years.

Table 4. Number of beneficiaries of the non-contributory pillar in Chile

	2008	2010	junho de 2017
Pensão Básica Solidária (PBS)	596.645	623.508	581.771
Aporte Previsional Solidario (APS)	13.836	387.587	815.620
Total	610.481	1.011.095	1.397.391

Source: ECLAC (2018).

Chart 4. Percentage of elderly (65 years or older) receiving non-contributory benefits in Chile – 2000 to 2015



Source: Database – IDB Labor Markets and Social Security Information System. Available at: https://www.iadb.org/es/sectores/inversion-social/sims/inicio.

Note: Data from 2000 to 2006 correspond to the benefits of the *Programa de Pensiones Asistenciales*, former non-contributory benefits program.

18 Replacing the former *Programa de Pensiones Asistenciales*, this benefit goes to the population group formed by the poorest 60%.

Table 4 shows a strong growth in the coverage of the non-contributory pillar of the Chilean pension system. Because of the increase in the number of beneficiaries of the solidarity pillar, coverage among the elderly population (65 years and over) has increased considerably when comparing the periods before and after the reform. This can be seen in Chart 4, below.

The increase in the number of beneficiaries of the non-contributory pillar has brought about a rise in coverage among women, an improvement in the rate of replacement of benefits and a reduction of the incidence of poverty in old age (ECLAC, 2018; MESA-LAGO, 2015).

Bolivia

In 1997, Bolivia underwent a paradigmatic social security reform: its former public system, a funded model with defined benefit, was replaced by a private system, which operates through capitalization with individual accounts and defined contribution.

The old system was often subject to criticism: (i) high fragmentation; ii) low coverage of the economically active and the elderly population; iii) very low retirement ages (50 and 55 years for women and men, respectively) and others. These criticisms were used as justifications for the 1997 reform (MESA-LAGO; BUSTILLOS, 2013).

In the 1997 reform, as a response to the problem of low coverage among the elderly, a non-contributory benefit called *Bono Sol* was created. This was a benefit paid to all Bolivians from the age of 65 onwards. However, it was only paid until the end of 1997; its suspension, which occurred due to financing problems, lasted until 2002, when the name of *Bolivida* was adopted.

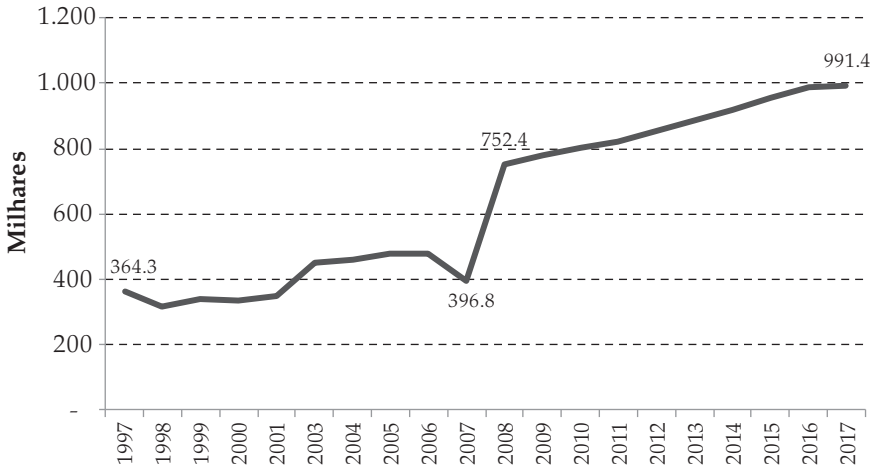
In an attempt to be more sustainable in the long run, *Bolivida* paid lower benefits than *Bonosol* and was not universal. It is worth mentioning that its funding originated from the resources generated by the privatization of some state-owned enterprises.

In 2008, *Renta Dignidad* replaced *Bolivida*: a monthly, lifetime and universal benefit, paid from the age of 60 onwards to all residents of the country – Bolivians and naturalized. The value of the benefit varies according to whether or not the person receives a contributory benefit or any income

from other state programs, being greater for those who do not have any other income. Its financing comes from hydrocarbon taxes (30% of this tax), the National Treasury and resources from municipalities and from the indigenous fund, as well as the dividends of the public companies capitalized (FIAP, 2011).

Chart 5, below, shows the evolution of the number of people receiving non-contributory benefits in Bolivia for several years.

Chart 5. People receiving non-contributory benefits in Bolivia – several years



Source: ECLAC Database.
Note: There is no information for the year 2002.

As can be seen in Chart 5, between 2007 and 2008 there is a large increase in the number of people receiving the non-contributory benefit in Bolivia. During this period, there was a change from *Bolivida* to *Renta Dignidad* that has a more benevolent age criterion (60 years versus 65 years).

In 2017, just under one million people received *Renta Dignidad*, which represented more than 90% coverage for the population aged 60 or over in Bolivia (ECLAC, 2018).

With a fiscal cost of approximately 1% of GDP, the *Renta Dignidad* program was responsible for reducing poverty by between 6 and 7.1 percentage points (UGARTE; BOLIVAR, 2015). There were also positive results regarding the reduction of child labor and the increase in the school

enrollment rate of children living in households with beneficiaries of the program (LOZA; WILDE; CÓRDOVA, 2013).

Ecuador

Through an executive order of September 2006, the Government of Ecuador established the *Subprograma* (from the *Bono de Desarrollo Humano* – BDH) *Pensión para Adultos Mayores*. This program, focused on poor seniors, consisted of a monthly transfer of 11.50 USD[19]. Its purpose was to increase the coverage of the elderly population who did not have access to social security transfers.

The 2008 Constitution of Ecuador brought some new developments regarding the treatment of older people in relation to the previous Constitution of 1998: while the former Constitution treated the elderly as a vulnerable group, the new Charter began to treat them as a priority attention group – there is actually a constitutional chapter on the rights of the elderly.

The constitutional reform was followed by a series of changes in laws and programs as a form of adaptation to the new constitutional precepts. Some of these changes were consolidated in the *Plan Nacional del Buen Vivir*[20] (PNBV): an instrument to achieve the objectives of well living and the guarantee of rights, foreseen in the Constitution of 2008 (ROFMAN; APELLA; VEZZA, 2013).

The main change in the treatment of the elderly group with the PNBV was the implementation of policies for the universalization of the non-contributory benefit, with alterations in the *Bono de Desarollo Humano* (BDH) – aimed at the population of 65 years of age and older living in poverty that does not receive any social security benefits –, improveming the *Subprograma Pensión para Adultos Mayores*. Chart 6, below, shows the number of elderly people receiving the BDH.

Chart 6 shows the evolution in the number of elderly beneficiaries of the BDH from 2003 to 2016. As can be seen, the advent of the *Subprograma Pensión para Adultos Mayores* (2006) and its subsequent changes since the 2008 Constitution resulted in an increase in the number of beneficiaries.

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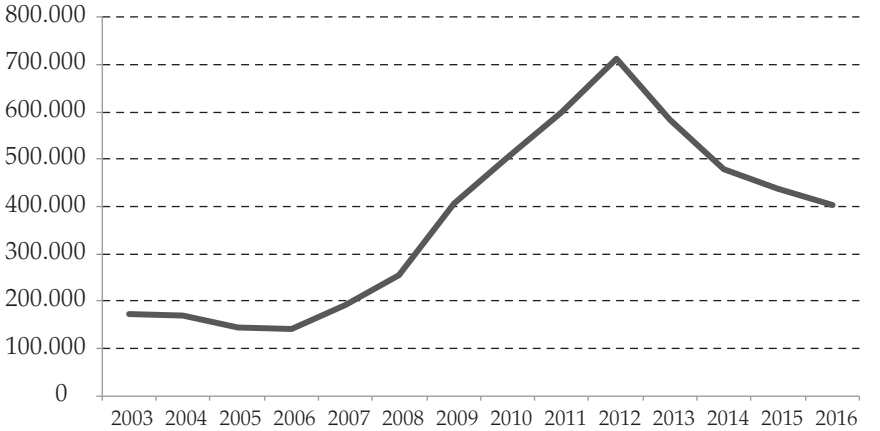
19 Subsequently, the value of the transfer increased to 30.00 USD, still in 2006; 35.00 USD in 2009; 50.00 USD in 2012; and 100.00 USD in 2017, beginning in 2018.

20 For more details on the PNBV, see Rofman, Apella and Vezza (2013) and Ecuador (2012).

Chart 6. Number of elderly (65 years or older) receiving the BDH in Ecuador



Source: Database – IDB Labor Markets and Social Security Information System. Available at: https://www.iadb.org/es/sectores/inversion-social/sims/inicio.

According to IDB[21] data, program coverage reached 41.2% of the population aged 65 and over in 2012. Even though there has been a drop in the following years, coverage is still at a higher level than before the 2008 Constitution.

With an expenditure of approximately 0.3% of GDP in 2016, the non-contributory benefit for the elderly has as main impact the reduction of the incidence of poverty in old age. Dethier, Pestieau and Ali (2010) estimate that the incidence of poverty, when not considered the income from the benefit, increases by 14 percentage points.

In this section, we have presented some successful experiences in the expansion of the protective coverage of the elderly. In the case of Argentina, the advent of the *moratoria previsional* resulted in a strong expansion of coverage within the contributory system. In Chile, the expansion of coverage was also integrated with the contributory pillar of individual accounts, through the introduction of a solidarity pillar (non-contributory) from state transfers to those who have never contributed or, if they have contributed, did not get adequate benefit.

21 Database of the Labor Market and Social Security Information System. Available at: https://www.iadb.org/es/sectores/inversion-social/sims/inicio.

The experiences of expanding coverage for the elderly in Bolivia and Ecuador differ from the cases in Argentina and Chile, as they were a result of the creation and expansion of non-contributory benefits not integrated into the traditional contributory regime.

All of the cases presented resulted in an increase in the coverage of the elderly and an improvement in the adequacy of the benefits paid. However, it is important to pay attention to the fiscal costs and the long-term sustainability of these policies. Bosch et al. (2013) present projections, based on different assumptions, for spending on non-contributory benefits for the elderly in Latin American countries. The results of the projections assuming the payment of non-contributory benefits equivalent to 10% of GDP per capita in each country – value of benefit considered adequate to combat poverty in old age – show a strong increase in spending as a percentage of GDP. Expansion of expenditure as projected always raise issues such as the State ability to pay and the continuity of the population support to such kind of benefit.

Another issue of great importance regarding the design of policies for the expansion of coverage among the elderly concerns the implications that such policies have on the behavior of individuals participating in the labor market, as presented in the previous section. In short, the non-contributory benefit must be thought in such a way as to generate the least possible disincentive to the worker. The idea is that he does not give up seeking formalization and contribution to the contributory regime.

7. Final considerations

The most longevous social security systems in Latin America go back to the first half of the 20th century. Countries such as Argentina, Brazil, Chile, Cuba and Uruguay were pioneers in the social security protection of their workers.

The newer systems differ from the older ones because they are less fragmented. They were thought, from their conception, to be more unified. However, they historically have lower coverage than the older ones. The contributory logic, a feature and premise of the systems, regardless of whether they are pioneers or not, along with a great informality, labor turnover and non-wage-labor – characteristics of the labor markets of the countries of the region – represented a serious constraint on compliance of the functions of any

social security system, namely, insurance against contingencies, consumption smoothing and insurance against poverty in old age.

The beginning of the 2000s brought up the debate about the low coverage of the social security systems of Latin American countries, as well as the incapacity of expanding the systems established in the contributory logic. In parallel to this, many countries have seen improvements in the fiscal situation, and social groups that had no social protection from contributory systems pressured these governments. This combination of factors resulted in the second wave of reforms, from the mid-2000s to 2017. Concerned with the low coverage of the elderly population, it observed the advance of solidarity schemes, most of which were administered by the State.

Data on the coverage of the working population in the Latin American countries show the great heterogeneity that exists, although the majority of countries have observed an increase in coverage between the analyzed years, and the same happened with the coverage of the elderly population: increase in the years analyzed, but persistent heterogeneity between countries.

It is in this context – low coverage of workers and the elderly – that many countries have implemented inclusive reforms. Some have changed the rules of traditional contributory systems, others have instituted policies to encourage the inclusion of the active population. There was also the creation of non-contributory benefits for the elderly, in order not to leave such group unaided. It is possible to cite the successful experiences of Argentina – with the *moratorias previsionales* – and of Bolivia – with *Renta Dignidad* – in relation to the elevation of coverage of the elderly population. *Renta Dignidad* choose to extend coverage through non-contributory benefit and the Argentinean regime changed rules of the contributory scheme. It is noteworthy that even these successful experiences of increasing social security coverage have introduced changes that may affect the functioning of the contributory part of the system, as well as its sustainability, in the long run.

The expansion of coverage of social security systems is essential for guaranteeing citizenship rights. In this way, the experiences for the inclusion of the active and elderly population are understood as positive. However, it is important to pay attention to fiscal costs and long-term sustainability, especially in cases of creation and expansion of non-contributory benefits for the elderly.

Another important issue concerns the implications of policies to increase social security coverage on the behavior of labor market participants. The non-contributory benefit must be designed so as not to discourage the worker in relation to the search for formalization and contribution to the contributory social security regime. Thus, it would be ideal if coverage expansion policies, especially among the elderly, were designed in an integrated manner to the contributory regime, precisely to reduce the possible disincentives derived from the possibility of receiving non-contributory benefits.

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Current Trends in conditional cash transfer programs in Latin America

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Current Trends in conditional cash transfer programs in Latin America

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Since the 1990s, we have witnessed a notable diffusion, especially in Latin America, of Conditional Cash Transfer Programs (CCTP)[1] (BARRIENTOS, 2013). CCTP are government interventions aimed at poverty reduction that have two main objectives. The first one, short-term, is directly related to the material survival of beneficiary families through access to primary goods, such as food and hygiene, made possible through cash transfers. The long-term objective expresses the theory of change underlying the CCTP and presupposes that, with the increase of human capital stock, the necessary conditions to break the generational cycle of poverty reproduction will come about (PASE; CORBO, 2015; ESPÍNOLA; ZIMMERMANN, 2018). In turn, human capital would increase with more schooling and better health conditions for the beneficiaries, especially children and adolescents. These goals determined that the programs focused on the poorest families with children.

Another goal, less mentioned, but no less relevant, refers to the economic and social empowerment of women, as well as the promotion of gender equality. As a contribution to achieving this goal, financial resources go directly to women (TEBALDI; ESSER; DAVIDSEN, 2017).

When this type of intervention emerged, there were many questions about its legitimacy, relevance and, above all, its ability to deliver poverty reduction efficiently and effectively. Twenty years after the first interventions, some of the initial questionings have found adequate answers and no longer make sense. The numerous evaluations that have repeatedly demonstrated the effects on the immediate poverty reduction made possible by cash transfers to the poorest families have contributed to that.

1 In Spanish, the most common translation is *Programas de Transferencias Monetarias Condicionadas* (PTMC).

Besides these studies, others demonstrate the high capacity of focalization of these programs and the increase in the enrollments and the conclusion of years of education among children and adolescents belonging to the beneficiary families.

On the other hand, the lack of capacity to evidence the sustainability of the results in the life of these same families reiterates the questions about the effectiveness of interventions of this nature and it gives rise to new issues associated to the future of these programs. The experience accumulated with the implementation of the CCTP, as well as the social, economic and political crises and transformations experienced by the Latin American countries recently, contribute to form a scenario in which this new group of issues is urgent, indicating that there is little or no disposition to await another two decades for answers. Urgency is also necessary because of the inclusion of poverty reduction as one of the Millennium Development Goals, which foresees the extinction of extreme poverty across the globe by 2030.

Aligning with this debate, we analyze in this text some dimensions of the experiences of current CCTP in Latin America to identify and analyze the most recent transformations, as well as the convergences and dissonances between them. The idea is to contribute to the understanding of the current moment and, above all, to point out some future trends already foreseeable.

In order to analyze what the CCTP have done so far, we will begin with the basic elements that synthesize their origins, their initial purposes and the context of their implantation. To do so, the following section tells a brief historical overview of the CCTP in Latin America. In the subsequent sections prior to the conclusion, we will discuss the main characteristic dimensions of these programs and the trends identified in the recent literature. In this paper, we will discuss four dimensions that we consider worth mentioning. The first one discusses the very existence of this type of intervention. From the analysis of the dissemination and the recent changes, we will discuss the maintenance trends of these initiatives, pointing out that it is still not possible to affirm substantial changes in terms of investment volume and coverage, although some changes in this field are already visible. Next, the focus is on the evaluations carried out in these programs. In this dimension, trends point to the growing search for sustainable impacts or outcomes in the lives of beneficiaries. The difficulties encountered in this field are of

several orders and, according to our perception, contribute to give relevance to another dimension in this context. The last section, therefore, discusses the growing need to articulate CCTP with other strategies, with a view to building collective solutions to poverty.

As a methodological strategy, we have used a bibliographical survey of the most recent publications on the subject, with emphasis on the publications of the Economic Commission for Latin America and the Caribbean (ECLAC) and the Inter-American Development Bank (IDB) and academic articles.

1. A brief historical overview of Latin American CCTP

CCTP have emerged in the context of a reform of the social agenda, and with it, the poverty reduction programs in Latin America and the Caribbean (LAC) [2], strongly guided by the principles of investment rationalization and focus on the poorest. The underlying theory of change assumes that current poverty alleviation, increased household consumption, and the creation of conditionalities are capable of breaking the generational transmission of poverty (IBARRARÁN et al., 2017).

The phenomenon of poverty has been a social concern for many centuries, and has been the subject of numerous studies published since at least the sixteenth century (VIVES[3], 1992). Poverty was gradually integrated into public responsibilities around that same period and has since received a wide variety of treatments. When we observe the process of implantation of the CCTP and we perceive their simultaneous occurrence in many countries of the same continent, one of the first questions that arises has to do with the whys of this movement.

Among the elements indicative of this motivation in the literature is the redemocratization of the Latin American countries, which took place mainly during the 1990s and 2000s. At that moment, the governments welcomed the demand for insertion in the governmental agenda of a

2 There are currently similar cash transfer programs in Africa, the Middle East, and Asia.

3 This author is considered one of the most important Spanish humanists. In 1538 he wrote a Treaty of Relief for the Poor, in which he proposed actions for the population and also for governments with the purpose of extinguishing poverty. This work is considered a milestone in breaking the vision of poverty associated with a divine design, by proposing its inclusion among social themes.

system capable of protecting groups of people who were completely at the margins of progress. In this scope emerged, among others, the urgency in the reduction of poverty in a fast, sustained and consistent way based on the recognition of its political nature and, therefore, as a problem to be denaturalized and equated. This occurred with the rise of reformist and developmental elites, initially oriented by the neoliberal ideology (PASE; CORBO, 2015; ESPÍNOLA; ZIMMERMANN, 2018).

Multilateral agencies have also included this as a priority and have incorporated into their agreements with Latin American countries the need to implement strategies to improve the living conditions of families and individuals living in poverty; with this, they started to stimulate the formulation of public policies in this field. The CCTP began to integrate an orchestrated agenda of reforms that had as one of their purposes to liberate governments of part of their commitments to the population and, at the same time, to respond to the economic crisis that accentuated poverty among the population (BARRIENTOS, 2013). This agenda included a series of attributes, such as stimulating privatizations and decentralization and focusing actions as opposed to universalization, aiming at targeting benefits to specific groups (SOUSA, 2015).

Thus, in their design, the CCTP contemplated neoliberal premises and carried the notion that poverty was, above all, a problem of governance that was an obstacle to the capitalist modes of production (Ibid.; MAGRO; REIS, 2011). In this context, the concept of poverty adopted was based on definitions that exceeded exclusively monetarist perspectives, capable of considering poverty solely as insufficiency of income, including relevant non-monetary needs such as nutrition, housing and social assistance, present in the approach of neglected basic needs.

The adoption of this model of intervention revealed, on the one hand, the intention to prevent the reproduction and the worsening of inadequate living conditions and, at the same time, demonstrated the lack of interest in facing the causes of this phenomenon. In addition, the expansion of the concept of poverty often translated in increasing access to education and health, which, although fundamental and part of the field of social rights guarantees, was imposed to families through conditionalities that should

be fulfilled under penalty of exclusion from the program (ESPÍNOLA; ZIMMERMANN, 2018).

Since 1997, more than 40 initiatives of conditional and non-contributory cash transfer have been implemented in 19 Latin American countries, according to ECLAC[4]. The table below lists these interventions, organized by country and period of operation. In the last column, the absence of the final year denotes a program still in force.

Table 1. CCTP in Latin America by country and period of operation

Country	Program	Period of operation
Argentina (AR)	*Asignación Universal por Hijo para Protección Social*	2009-
	Familias por la Inclusión Social	2005-2010
	Jefas y Jefes de Hogar Desocupados	2002-2005
Bolivia (BL)	*Bono Juancito Pinto*	2006-
	Bono Madre Niño-Niña Juana Azurduy	2009-
Brazil (BR)	*Bolsa Alimentação*	2001-2003
	Bolsa Escola	2001-2003
	Bolsa Família	2003-
	Cartão Alimentação	2003 (finalized)
	Programa Bolsa Verde	2011 -
	Programa de Erradicação do Trabalho Infantil PETI	1996 -
Chile (CH)	*Chile Solidario*	2002-2012
	Ingreso Ético Familiar (IEF)	2012 - 2014
	Programa Familias	2014-
Colombia (CL)	*Más Familias en Acción*	2001 -
	Red Unidos Ex Red Juntos	2007 -
	Subsidios Condicionados a la Asistencia Escolar	2005-2012
Costa Rica (CR)	*Avancemos*	2006 -
	Superémonos	2000-2002
Ecuador (EC)	*Bono de Desarrollo Humano*	2003
	Bono Solidario	1998-2003
	Desnutrición Cero	2011 -
El Salvador (ES)	*Programa de Apoyo a Comunidades Solidarias en El Salvador (ex Comunidades Solidarias Rurales o Red Solidaria)*	2005 -

4 Non-contributory social protection programmes in Latin American and the Caribbean database, Social Development Division, ECLAC. Available at: https://dds.cepal.org/bdptc/#es.

Country	Program	Period of operation
Guatemala (GT)	*Mi Bono Seguro*	2012
	Mi Familia Progresa	2008-2011
	Protección y Desarrollo de la Niñez y Adolescencia Trabajadora	2007-2008
Honduras (HN)	*Bono Vida Mejor (ex Bono 10.000 Educación, Salud y Nutrición)*	2010 -
	PRAF/BID Fase II	1998-2005
	PRAF/BID Fase III	2006-2009
	Programa de Asignación Familiar (PRAF)	1999-2009
Mexico (MX)	*Oportunidades Programa de Desarrollo Humano (ex Progresa)*	1997-2014
	Prospera – Programa de Inclusión social	2014 -
Nicaragua	*Red de Protección Social*	2000-2006
	Sistema de Atención a Crisis	2005-2006
Panama (PN)	*Bonos Familiares para la Compra de Alimentos*	2005 -
	Red de Oportunidades	2006 -
Paraguay (PI)	*Abrazo*	2005 -
	Tekoporã	2005
Peru	*Juntos Programa Nacional de Apoyo Directo a los más Pobres*	2005 -
Dominican Republic	*Programa Solidaridad-*	2005 - 2012
	Progresando con Solidaridad	2012 -
Trinidad and Tobago	*Targeted Conditional Cash Transfer Program (TCCTP)*	2005 -
Uruguay	*Asignaciones Familiares - Plan Equidad*	2008 -
	Plan de Atención Nacional a la Emergencia Social (PANES)	2005 - 2007
	Tarjeta Uruguay Social (ex-Tarjeta Alimentaria)	2006 -

Fonte: Elaboração própria a partir da *Base de datos de programas de protección social no contributiva en América Latina y el Caribe*, da Cepal.

As can be seen, in some countries there was (and still is) more than one CCTP in operation at the same time, such as in Brazil (*Bolsa Família* Program and *Bolsa Verde* Program) in Bolivia (*Bono Juancito Pinto* and *Bono Madre Niño-Niña Juana Azurduy*) and in Ecuador (*Bono de Desarrollo Humano* and *Desnutrición Cero*). Another common situation is a result of the possible redesign of the strategy, with its replacement by another one under a new denomination. This movement is more visible in Honduras, whose program has been restructured three times until reaching a more sustainable format, in force since 2008. Similar circumstances have also occurred

in Mexico, Chile and Uruguay, with the redesign of its interventions, aiming at its improvement.

In this context, Nicaragua is an exception. It was the only country that has developed CCTP for a period and ended them without replacing them with another program (*Red de Protección Social* and *Sistema de Atención a Crisis*) [5].

By 2013, approximately 137 million people in 17 Latin American countries received cash transfers that represented an average of 20% of the household budget, paid with an average investment of 0.4% of the Gross Domestic Product (GDP) (IBARRARÁN et al. al., 2017). Figures from the last decade showed that short-term results were being achieved with relative success. According to ECLAC (2018), poverty and indigence declined in the region, although satisfactory levels had not been reached. In 2002, 44% of the population in Latin America and the Caribbean lived in poverty and 19% in indigence (or extreme poverty). In 2014, the percentages fell to 29% and 12%, respectively.

By 2016, however, the incidence of poverty and extreme poverty has grown in Latin America for the first time in the last decade. In that year, indicators began to show a social setback also in terms of reducing the rate of the fall in income inequality and increasing the incidence of poverty among children, adolescents, young people, women and the rural population (ECLAC, 2018).

These figures made evident the insufficiency of the social protection systems in the region and, more objectively, highlighted the limits and the exhaustion of the CCTP as a poverty reduction strategy, even though the role played by them is of fundamental importance (BARRIENTOS, 2013). The effectiveness of the CCTP has been compromised in an scenario of stagnation or, in some cases, of economic recession and has made evident the need to develop new systems of social protection, based on the reduction of inequality, focused on guaranteeing rights and capable of providing integral and universal protection, in a sustainable manner (ECLAC, 2018).

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5 The country has developed other poverty reduction strategies, such as *Hambre Cero*. In this program, however, the proposal was to distribute inputs for the development of small properties, not cash transfer.

2. The resilience of CCTP in Latin America

The past decade has been characterized, among other advances in the social field, also as a period of implantation of CCTP in several Latin American countries. Between 2005 and 2007, most of the new initiatives have emerged in countries such as Panama, Colombia and Bolivia, which have put into motion for the first time programs of conditioned cash transfer – up to the present day in operation. Brazil and Mexico stand out as pioneers in this scenario, for having implemented large programs, such as *Oportunidades* and *Bolsa Família*. Other countries, however, launched their first interventions in the 1990s, as shown in Table 1.

It is interesting to note that, although with reformulations, CCTP have been consolidated as a poverty reduction strategy and, in this sense, developed what we can call"resilience", since they have resisted shocks of different natures. First, those from governmental changes and the consequent ideological and political changes in the public agenda and in the perception of the legitimacy and pertinence of interventions of this nature. Then, the impact of recent economic crises that lead to revisionist strategies, especially in relation to investments directed towards the poorest.

On the other hand, it seems naive and inconsistent to stick to the fact of the mere existence of a set of programs to assert something about their relevance, effectiveness or effectiveness, or even their ability to act, even if these factors are not negligible. We will then proceed to the objective dimensions involved in the execution of a public policy: the volume of investments and the population coverage. Based on data provided by ECLAC, we identified the volume of investments in relation to GDP (in dollars) and the population reach by country. We present coverage in terms of population percentages. However, since CCTP assume the family as an intervention unit, the number of people served is an estimate calculated from secondary information, with procedures varying by country.

To better observe the behavior of these interventions by country over the years, we have chosen to favor the historical trajectory. Thus, we also use the data from programs already ended, in cases where we identify that

the current program is a reformulation of past intervention[6]. We selected one CCTP per country, notably the one that involved the largest volume of financial resources and had the greatest coverage.

This chart shows that the average investment in percentage terms ranges from 0.1% to 0.4% of the total GDP of each country. Ecuador stands out for investing in the *Bono de Desarrollo Humano* varying percentages between 0.7% and 0.97% for the period between 2007 and 2012. The unavailability of more recent data, however, does not allow us to understand its most recent behavior.

The variation in the volume of investments seems to be influenced by the implementation of new programs, as exemplified by Chile and Honduras. In the case of Honduras, with the implementation of the *Ingreso* Ético *Familiar* program, the investment is halved compared to what was used in the previous program. In Chile, however, although the new program has emerged as a substitute, *Chile Solidario* continued to operate until all families received the expected benefits upon their inclusion in the program. In this case, as we use the values of the new program, what we have identified is the tendency to a future reduction.

In an aggregated way, we observed small oscillations in investments, which by the end of 2016 were not particularly sensitive to the effects of economic crises or government changes and their consequent programmatic changes. On the other hand, this scenario may be indicative of the need for permanence of CCTP, considering that the determinant conjuncture of their demand is still present, either because it is or has become refractory to the model employed, or because the crises and changes in government feedback the very existence of demand.

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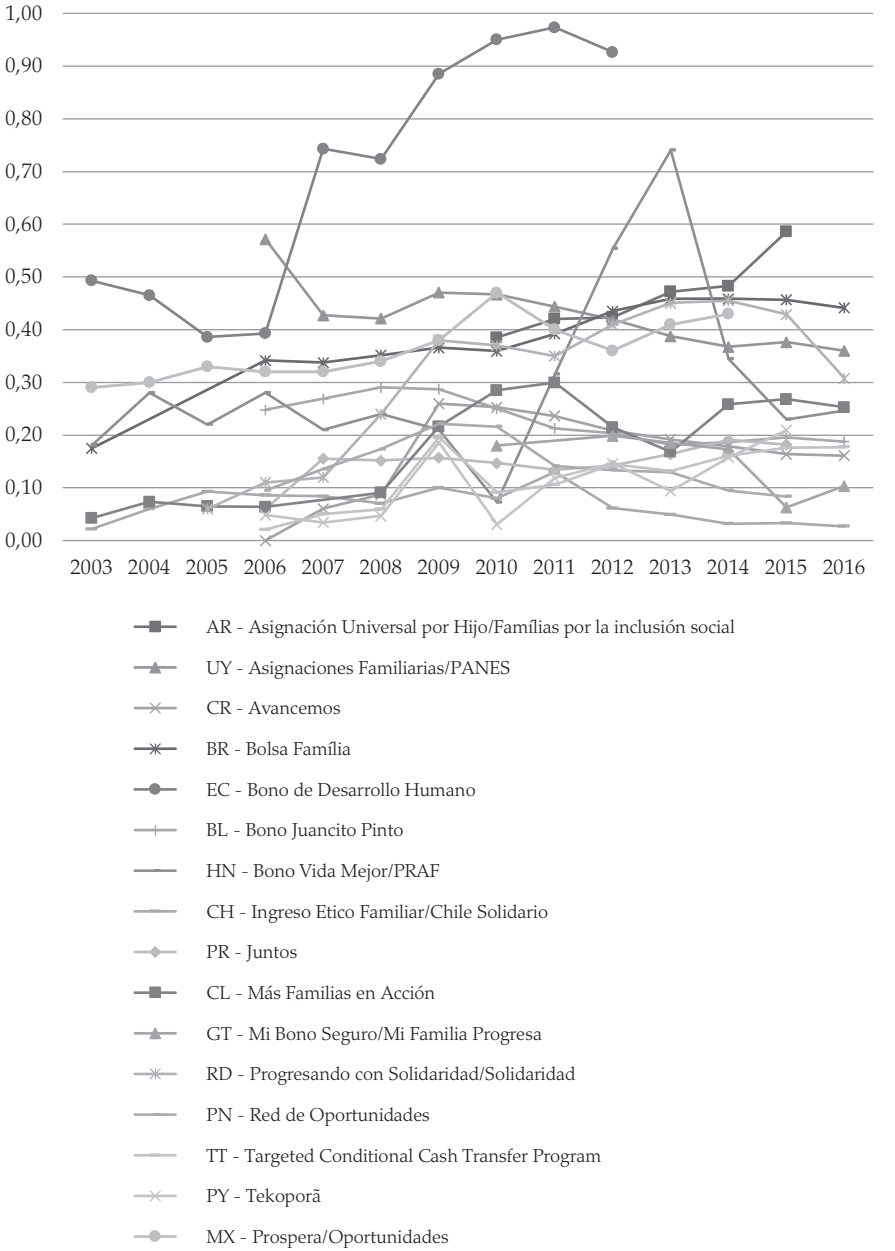
6 Nessa condição, encontram-se: 1) Argentina: com o acréscimo dos dados do extinto programa *Familias por la Inclusión Social* (2005-2010); 2) Chile: apresentamos também os dados disponíveis sobre o programa *Chile Solidario* para o período entre 2002 e 2011; 3) Guatemala: com o programa *Mi Familia Progresa* (2008-2011); 4) Honduras: agregamos ao programa atual *Bono Vida Mejor* os dados do *Programa de Asignación Familiar* para os anos de 2003 a 2009; 5) México: os dados referem-se à execução dos programas *Oportunidades* e *Prospera*, para os períodos de 2003-2013 e 2014-2016, respectivamente; 6) República Dominicana: utilizamos também as informações dos programas *Solidaridad* (2005-2012); 7) Uruguai: com o *Plan de Atención Nacional a la Emergencia Social* (PANES) (2005-2007).

Chart 1. Annual investment as percent of GDP by CCTP/Country



Source: Author's elaboration from the Non-contributory social protection programmes in Latin American and the Caribbean database, Social Development Division, ECLAC.

These hypotheses are clearer when we look at the graph with the coverage of CCTP, based on the population percentage. Again, in several countries, the CCTP still reach around 10% of the population. There is, however, greater dispersion and some countries stand out because they have above-average population coverage, which is also constant over time. In this group are Mexico, Brazil and, in recent years, the Dominican Republic. Guatemala stands out from these groups by the amplitude of the oscillation (between 15 and 37%); and Argentina and Chile, due to the reduction in the number of families served.

It is important to be aware that population percentages similar to some extent refer to quite variable numbers of people. To cite a few examples, the *Bolsa Família* program benefited more than 54 million people in 2016, which represented 26.14% of the population, while the Dominican Republic benefited more than 32% of the population, reaching almost 3.5 million men and women.

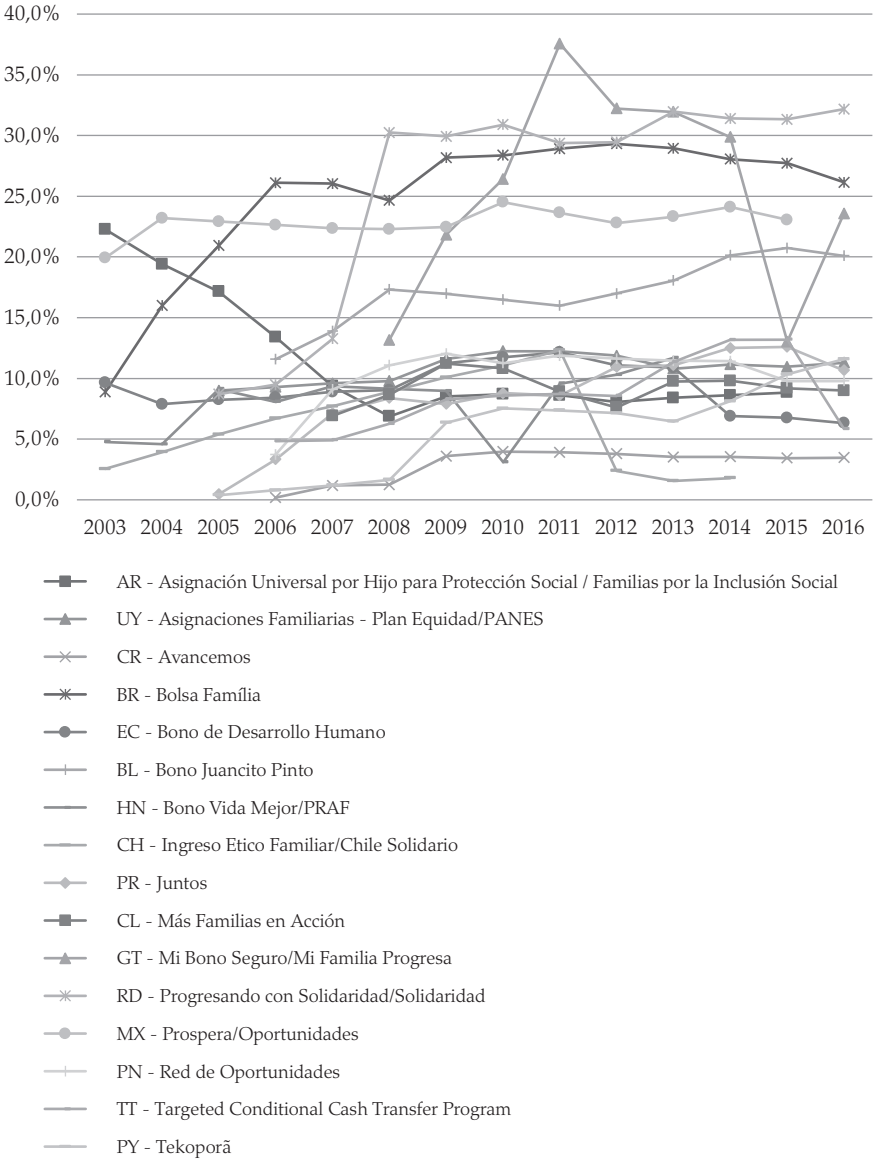
Chart 2 shows the distribution of population coverage estimated in the last 15 years for Latin American countries with currently active CCTP.

As far as the available data allow us to affirm, we observe that the current trend here points to the maintenance of CCTP, although this maintenance takes place at the expense of the redesign of the programs, such as those implemented in the last years. However, although in this scenario, we can see that there are no meaningful changes – or at least not yet visible – in the sense of reducing investment or coverage in most Latin American countries.

3. Evaluations of cash transfer programs: limits and possibilities

In the field of evaluations of policies and programs, there are a number of work possibilities, with different purposes. The evaluation of public interventions has gained increasing space and relevance, and it is already relatively common the evaluation of an increasing group of programs and policies, mainly with a focus on measuring their results. When dealing with CCTP, evaluation is more relevant and has been an especially important topic that gets many investments. There is a profusion of studies on these programs under the most varied perspectives and with objectives aimed at evaluating efficiency, focalization, results and the impacts achieved.

Chart 2. Coverage of the estimated population by country/program



Source: Author's elaboration from the Non-contributory social protection programmes in Latin American and the Caribbean database, Social Development Division, ECLAC.

Looking at the more recent work, we have identified a consistent series of studies that have demonstrated the capacity of CCTP to reduce incidence and the poverty gap. In this group are also works that affirm that the CCTP are effective strategies to improve the immediate conditions of life of the population in situation of poverty, with more emphasis for those that suffer the direct impact of the monetary dimension (ROBLES; AZEVEDO, 2011; MOLINA-MILLAN et al., 2016).

> The CCTP have been unequivocally effective in increasing the consumption of beneficiary households, as well as in reducing the incidence and especially the intensity of poverty and inequality (Fiszbein and Schady, 2009; Stampini and Tornarolli, 2012; Levy and Schady, 2013). Not only have the CCTP increased consumption, but they have also improved their composition in terms of the quality and variety of food consumption. (IBARRARÁN et al., 2017, p. 2, literal translation).

There are also indicators that show a reduction in the incidence of child labor (Ibid.; WORLD WITHOUT POVERTY, 2017), although transfers are not sufficient to cover the difference in domestic income (ARAUJO; BOSCH; SCHADY, 2017).

The studies that show the most expressive results are in the field of education. In a comparative study among Latin American and Caribbean countries, the increase in school enrollment among beneficiaries ranged from 0.5% in Jamaica to 12.8% in Nicaragua. This is particularly important because it is in dialogue with the increase in the stock of human capital, a variable that is present in the theory of change of the program. In addition, there is also evidence that CCTP contribute to increased school progression (IBARRARÁN et al., 2017). In Brazil, one of the evaluations of the *Bolsa Família* also pointed to the program's competence to reduce children's school drop-out rates and increase attendance among adolescents aged 15 to 17 (WORLD WITHOUT POVERTY, 2017).

The Argentine program (*Asignación Universal por Hijo*) has demonstrated the capacity to positively impact the enrollment of children and adolescents between the ages of 15 and 17. The increase in the enrollment

rate for this group was 4% in the group of beneficiaries, and the result was more influenced by the boys. For the younger groups, however, the program proved insufficient to encourage school insertion. On the other hand, it is an important incentive when observed the rate of evasion, which reduced 4 and 7% for the groups between 12-14 and 15-17 years, respectively. The evaluation suggests that these results were possible with the change in the program design, which incorporated penalties for noncompliance with educational conditionalities, articulation with other policies, and creation of extra incentives to fulfill educational stages (UNICEF et al., 2017). Other evaluations have also shown that the conditionalities (or co-responsibilities) associated with cash transfers are important for raising school levels and conducting preventive health screenings, vaccination and monitoring of growth among beneficiary children (ROBLES; AZEVEDO, 2011).

Labor insertion is a much-discussed topic in the context of CCTP. Several studies have already been developed to address a frequent questioning related to the short-term effects: do CCTP create negative incentives for work among beneficiary families? Studies have been decisive in demonstrating that these effects do not exist in most countries investigated; in some countries, they exist in specific segments of the population. For other countries, studies show that influence is restricted to preference for informal jobs over formal ones, especially when cash transfer is associated with the formality of the beneficiaries' employment. A study carried out in Ecuador has shown that the local program does not generate a disincentive to employment, but has an effect on the condition of formality (IBARRARÁN et al., 2017). Similar results were also identified in Uruguay (MEDELLÍN et al., 2015) and in Brazil (WORLD WITHOUT POVERTY, 2017).

Another study that analyzed evidence from seven CCTP in six countries, three of them Latin American (Mexico, Honduras and Nicaragua), states that it has not found evidence that these programs have an effect on the propensity to work or the number of hours worked for men or women (BANERJEE et al., 2015). In 2014, two distinct studies on the Brazilian *Bolsa Família* program found different results (BARBOSA; CORSEUIL, 2013; FIRPO et al., 2014). For one of them there are effects on the reduction of female labor among the beneficiaries, while for the other the effect of the cash transfer in the choice for work (formal or informal) and the amount

of work hours is zero. A more recent study concluded that the risk of a beneficiary ceasing to work is between 7 and 10% lower than that of a non-beneficiary (SANTOS et al., 2016).

In the health area, the impacts are positive in relation to the increase in the use of preventive services and the reduction of mortality in specific age groups, especially with poverty-related causes such as malnutrition (IBARRARÁN et al., 2017). In Brazil, among the municipalities with high concentrations of families participating in *Bolsa Família*, the mortality rate of children under 5 years of age is 19% lower than among the others. When poverty-related causes of mortality, such as diarrhea and malnutrition, are limited, these municipalities have 53% and 65% lower percentages, respectively (WORLD WITHOUT POVERTY, 2017).

Another type of common study on CCTP seeks to qualify their focalization capacity. In 2017, the Brazilian *Bolsa Família* program was the most focalized social program involving cash transfer in the country. This accuracy in focalization was also found in the Chilean and Mexican programs (Ibid.). In Argentina, a study on the *Programa Asignación Universal por Hijo* also concluded that there is a high degree of focalization, with 20% of the poorest families receiving about 50% of the total transfers paid by the program (UNICEF et al., 2017).

Evaluations of CCTP run counter to their limits as the goal moves toward the pursuit of long-term impacts. The studies in this area have been little expressive in the sense of affirming the sustainability of these changes of life occasioned during the participation in the CCTP. That is, the impacts are still not very precise, little evident or little observable as expected when proposing these programs. In general, long-term impact assessment of programs is a difficult task and requires a lot of resources. In the field of CCTP, the result demonstration is more complex due to the methodological constraints involved, which present challenges related to a lack of statistical power or the many difficulties and, in the limit, to the impossibility of creating adequate control and treatment groups for the comparison between experimental strategies, for example (IBARRARÁN et al., 2017).

Nevertheless, a number of studies are been developed in this field. Their evidence, however, is better characterized as mixed (TEJERINA; PIZANO, 2016) or insufficient to state that long-term goals have been achieved. Studies

that seek to evaluate the quality of the educational process, for example, are indicative that the increase in indicators, such as school insertion or approval, did not occur in the company of improved learning outcomes (IBARRARÁN et al., 2017). In other words, increasing school progression is not a guarantee that children and adolescents will learn more while they are in school (ARAUJO; BOSCH; SCHADY, 2017). Therefore, the evidence is still insufficient to affirm that a young person who has accumulated more years of formal education is accessing better jobs or salaries in his adult life (MEDELLÍN et al., 2015).

An analysis of the capacity of CCTP to help families escape the trap of intergenerational transmission of poverty shows that, after a period (three or six years) participating in the program, beneficiary families of the Ecuadorian CCTP (*Bono de Desarrollo Humano* – BDH) had equal or very similar results to those presented by the control group (non-participants) families. In other words, children from families that received cash transfers did not present better results in adolescence, and young adults from beneficiary families had slightly better results in school performance than those in the control group. In the long term, the likelihood of participation in the program causing any impact on the lives of children and adolescents is very modest. This result is particularly important if we remember that Ecuador is the country with the highest level of investment and pays benefits among the highest among Latin American countries, reaching 20% of the total family budget (ARAUJO; BOSCH, SCHADY, 2017).

Another study compared the programs of Mexico, Colombia and Nicaragua and identified positive effects on schooling and the development of cognitive abilities. However, it stated that the evidence on other results is inconclusive with the use of experimental and non-experimental methodologies (MOLINA-MILLAN et al., 2016).

More broadly, there are still studies that point to the recognition that this type of program, by itself, is not able to face the phenomenon structurally, playing the role of lenitive for the bad conditions of life and not for overcoming it (ESPÍNOLA; ZIMMERMANN, 2018).

The difficulties involved in showing sustainable results obtained through cash transfers and the inconsistent results found in addition to the recent context of economic crisis have shed light on the limitations of this type of intervention as a strategy for sustainable solution to poverty.

These findings influence follow-up, which fall into different fields of understanding about what would be the most appropriate solutions to these new contours of the poverty issue. A group of actions advances in search of creating coordinated solutions, articulating various social actors, governmental or non-governmental, aiming to increase the productive capacity of families and, thus, the increase in their conditions of survival and the consequent reduction of dependence on government cash transfers. Another group is dedicated to thinking about improvements aimed at focalization and assessing the beneficiaries' compliance with conditionalities. In this field, strategies seek to create shortcuts to exit CCTP, through constant vigilance over the beneficiary public, both at the time of joining the program and during their stay.

Focalization on the poorest families is part of the initial CCTP strategies. However, recertification (in Brazil called as cadastral update) has gained importance in the debate on the creation of exit strategies, a new topic, since the initial objective of the CCTP was to break with the intergenerational reproduction of poverty. This issue is also a sensitive issue, as population groups are vulnerable to poverty in a peculiar way, with a special focus on children, women and rural communities. In addition, almost 50% of beneficiary families live in chronic poverty (MEDELLÍN et al., 2015).

The context of economic growth experienced by many Latin American countries in the past decade and the consequent increase in job and employment offers for poor people, especially those close to the thresholds established by the eligibility criteria for CCTP, have raised questions about the need to create mechanisms for the exclusion of those who overcame the poverty conditions, so that other families could be included (IBARRARÁN et al., 2017). The question should be, however, whether the exit to be stimulated (and considered) is from CCTP or poverty. It is worth remembering that the most significant part of the beneficiary families' life improvement was not due to participation in the CCTP, but rather to other dimensions of life, such as access to the labor market facilitated by economic growth.

When we focus on the first option, the exit of the CCTP itself involves efforts to create strategies for periodically checking the maintenance of eligibility conditions in the beneficiary family. On the other hand, privileging the second option necessarily inserts CCTP into broader strategies. Some

countries have dealt with this situation in an innovative way for the continent. In Chile, for example, a bonus was created for women beneficiaries who obtain formal work (MEDELLÍN et al., 2015). However, these strategies are articulated with other actions that can potentiate this effect – they will be better addressed in the next section.

4. The integration of cash transfer programs with other programs

A very common tendency identified among the CCTP currently is the articulation with other actions, other programs, other sectors and other governmental or non-governmental strategies. What we see now is the recognition of the insufficiency of this type of program for the sustainable reduction of poverty and, consequently, the attempt to construct an expanded solution, capable of involving lines of action with the potential to affect the labor insertion and the generation of income for the poor families.

When we mention this tendency, we are not disregarding the fact that, since the beginning, for the CCTP that establish conditionalities for the beneficiary families, the implementation design itself determined the need for some level of coordination, especially in relation to the actions related to the measurement of results, education frequency and health monitoring records (IBARRARÁN et al., 2017).

In fact, although there are records of construction of articulation strategies between sectors for the operation of CCTP, the potential of CCTP in this sense is still little used. The promotion of coordination with other sectors and the creation of a synergy capable of mobilizing state intervention broadly to promote qualitatively better offers have been posed as two of the major challenges for the future of CCTP (Ibid.). Some initiatives in this direction have been proposed and developed.

In addition, the articulations for which we would like to draw attention are part of the productive insertion of families. The Mexican program *Prospera*, for example, included in its design four lines of work through which it seeks to coordinate and link actions that go beyond the initial scope of cash transfer programs and reach topics such as financial inclusion and the increase of household productive capacities and of professional and

productive inclusion itself. The implementation of these actions is the new condition for the social inclusion of poor families (Ibid., 2018).

In Chile, the *Familias* program offers psychosocial and socio-labor monitoring for the families included in the program. The psychosocial follow-up sessions aim to promote the development of skills and capacities for social inclusion and autonomous development. There are 19 sessions during the 24 months of intervention with the family. In addition, this axis also intends to link beneficiaries to social services responsible for meeting demands in the areas of education, health, housing, employment, vocational training and family dynamics workshops. The socio-labor monitoring aims to increase the capacity of autonomous income generation in adults, both through the creation of microenterprises and the insertion in the labor market, with the improvement of their conditions of employability (VARGAS; CUEVA; MEDELLÍN, 2017).

In Brazil, in 2011, the *Brasil Sem Miséria* program was launched with three pillars: income guarantee, access to public services and productive inclusion. This last objective aimed at increasing the capacities and work opportunities of families, as well as creating strategies for the generation of income for families in urban and rural environments. The pillar of the guarantee of income counted on the *Bolsa Família* program and with two other programs[7]. The axis of access to services articulated health, education and social assistance programs, in line with what had been practiced in the scope of the *Bolsa Família* until then. The great novelty of the program was the axis of productive inclusion. For the execution of these actions, the Ministries of Social Development, Education, Agrarian Development, National Integration and Environment were involved. The activities involved the promotion of professional qualification courses, microcredit, technical assistance for rural areas, as well as access to water and public markets, through programs such as Água *Para Todos* and *Programa de Aquisição de Alimentos*. Most of these actions already existed and were in operation. What was created again was the great capacity for articulation between actions,

7 One of them was the BPC – *Benefício de Prestação Continuada*. Created through the Social Welfare Organic Law in 1993, BPC guarantees the payment of a minimum wage for people with disabilities and the elderly living in families with a monthly per capita family income of up to ¼ of the minimum wage (BRAZIL, 1993). *Brazil Carinhoso* was a program created to remove from poverty the families with children up to 15 years of age, through cash transfers, paid to the families together with the *Bolsa Família* program.

allowing 22 million people to overcome extreme poverty and more than 1 million people enrolling in Pronatec courses after two years of program execution (MONTAGNER; MULLER, 2015).

Table 2 presents a brief summary of exit strategies developed in some Latin American countries today. As can be seen, the propositions focus on the field of productive insertion in the formal or autonomous market. Ecuador is the only country to offer only microcredit to families, an action that happens in an articulated way in other countries that use this alternative.

Table 2. Conditional cash transfer programs according to the exit strategy

Program	Exit strategy
CL: *Ingreso Ético Familiar*	Entrepreneurship
PR: *Juntos*	*Mi Chacra Emprendedora* program Transfer of productive assets (seeds, fertilizers, livestock) and skills training
BR: Bolsa Família	*Brasil Sem Miséria* program: Urban: Microcredit and funds to start businesses Rural: Skills training, technology transfers (seeds, fertilizers), linkage with markets and public contracts.
RD: *Progresando con Solidaridad*	Entrepreneurship, training and microcredit.
EC: *Bono de Desarrollo Humano*	Microcredit
ES: *Comunidades Solidarias*	Urban: Entrepreneurship, skills training, community work, conditional economic incentive. Rural: skills training, access to productive assets, strengthening links with local markets.
MX: *Prospera*	Several programmes: Skills training, entrepreneurship, linkage with markets, credit.

Source: Adapted from Medellín et al. (2015).

The risk involved in this type of articulation is to move from emblematic poverty reduction programs, as the CCTP have been seen, to others with a similarly transient nature, avoiding the responsibility of establishing permanent, stable policies capable of maintaining poverty under control. In addition, it is necessary to change the perspective, strengthen the action of social assistance and focus on human development and the creation of opportunities for the social and economic inclusions achieved to be sustainable (BARRIENTOS, 2013).

5. Final considerations

The implementation of CCTP is, since its initial proposition more than 20 years ago, a challenge in many ways. Management is complex, after all it sets in motion a whole set of actions that involves the creation of criteria for eligibility, permanence and transfer of resources, through identification and inclusion of the public, verification of compliance with conditionalities, and payment hundreds of thousands or millions of people. Day-to-day implementation also involves the complexity of coordinating ministries, services and public facilities (and, in some countries, also municipal administrations) for guaranteeing access to education and health, for the implementation of checking procedures, and for ensuring that the most poor will remain in the program and may, in the long run, have the resources to break the cycle of poverty reproduction (IBARRARÁN et al., 2017).

The evaluations of these programs are frequent and varied – currently, there are some consensus about their effects. These consensuses refer to the capacity of CCTP to increase the frequency and level of schooling of children and adolescents in practically all Latin American countries. However, there are ambiguous results that show positive and sustainable long-term impacts on people's lives, especially regarding the rupture of the generational reproduction of poverty. Although it is possible to question the methodologies used and the possibilities of empirical assessment of something so complex and multiform, the constructed narrative has shown little effectiveness in breaking the generational cycle of poverty, in the possibility of enabling better professional future insertions for the children and adolescents benefited or even in the improvement of the levels of learning.

Influenced by this observation and the recognition of the limits of the CCTP in solving the issue alone, strategies have been disseminated seeking to articulate actions capable of breaking the intergenerational transmission of poverty. However, sustainable solutions must be viscerally connected to the performance of the labor market, the productivity of the jobs generated by it and the possibilities created for the insertion of the poor – fundamental dimensions still disconnected from the debate on overcoming poverty.

Recognition of the limits of CCTP should not, however, be confused with their inability to generate results. These programs do their job well: they

create conditions for raising human capital among poor families and improve living conditions immediately. In addition, some of its results are compromised by the quality and insufficient supply of health and education services.

Until recently, the direct scope of CCTP responsibilities extrapolated the need to review the quality of service provision or even create strategies directly related to the capacity and productive insertion of beneficiary families. The tendency is for CCTP to be increasingly urged to move in that direction and start acting as protagonist of these changes.

However, it is a reckless strategy, especially if it does not go along with recognizing the crisis of social protection systems and the need to focus the debate on poverty in the field of social inequality, moving towards strategies that contemplate the multidimensionality of poverty and address it in a truly systemic and articulated way.

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The International Observatory of Human Capabilities, Development and Public Policy was created in 2012, through cooperation between the Center for Public Health Studies of the University of Brasilia (NESP/UnB) and the Center for Studies on Bioethics and Diplomacy in Health of the Oswaldo Cruz Foundation (NETHIS/FIOCRUZ-Brasilia), with support from the Pan American Health Organization (PAHO/WHO). It was founded on the recognition of the growing importance of the concept of integrated human development to economic and social development.

This third round of studies of the International Observatory of Human Capabilities, Development and Public Policies (OICH) focuses on the recent evolution of public policies in Latin America, with emphasis on specific thematic areas such as work, education and social security. This focus is justified by the concern to identify increases in social inequalities in the different countries and their negative repercussions on the health conditions of the population.

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