

The Politics of Health and Education Reforms: Themes from Latin American Experience

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Introduction

The 1990s saw sharply increased emphasis on education and health in strategies of economic growth and poverty reduction in Latin America and in other poor and middle-income regions. In Latin America, this trend was partly a return to earlier concerns, before financial crisis and austerity in the 1980s had forced neglect and erosion of social services. The renewed emphasis also reflected recent democratization and increased concern about the profound inequalities of Latin American societies. And as more and more Latin American nations shifted from closed to open economic strategies, political and economic leaders realized that high-quality human capital was essential to compete successfully in international markets.

In varying degrees, education and health services in Latin America at the beginning of the 1990s faced tremendous problems. Coverage and quality of primary and secondary education and of health care were extremely unequal between city and countryside, wealthy and poor regions, and rich versus poor within each region. In most countries, administration of social services was extremely centralized and highly inefficient. Funding was strongly biased toward universities and hospitals, while preventive health programs, primary care clinics, and primary schools were starved for funds. Improvements would require not only increased resources, but also far-reaching changes in organization, administration, financing mechanisms, and incentive systems – that is, structural reforms.

Throughout the world, in rich as well as poorer countries, structural reforms in education and health pose formidable political problems. This paper focuses on the politics of reforming education and health sectors in Latin America, from the early 1990s to the present day. The paper draws on many sources, but primarily on a recently completed collegial research project sponsored by the Woodrow Wilson Center of the Smithsonian Institution. The project commissioned six country case studies in each of the two sectors. Both education and health sectors were analyzed for Argentina, Brazil, Colombia and Mexico. In addition, the project studied education reforms in Nicaragua and Venezuela, and health sector reforms in Costa Rica and Peru. These twelve sector studies provided the basis for comparative discussions for each sector, and a broader analysis of dynamic patterns common to both sectors.¹

This paper will briefly survey the status of education and health sectors in Latin America at the beginning of the 1990s, to provide a baseline and context for the discussion that follows. The second section of the paper discusses the rationale for analyzing education and health sectors together, rather than separately. The third section examines the cast of characters in sector reform stories: supporters, opponents, the uncommitted, and the resulting imbalance of power. The following section considers how reforms are launched, despite the obstacles. The

¹ Robert Kaufman and Joan Nelson, eds., *Crucial Problems, Weak Incentives: The Politics of Health and Education Reform in Latin America*, Baltimore: Johns Hopkins University Press, forthcoming Sept.2004.

fifth section sketches how political challenges, arenas and actors change as reforms move from design through implementation phases, and (with luck) to consolidation.

The main lines of argument in this paper are as follows:

- Politics pervades reform efforts, from top-level political leaders down to the classroom and clinic, and from the initial phase of getting onto the agenda through design, authorization, implementation, revision, and (sometimes) consolidation. The politics of each phase involves somewhat different actors and arenas. However, sector politics are embedded in national politics at every phase.
- Despite the recognized importance of the education and health sectors and public desire for better services, effective support for structural changes is surprisingly weak, and opposition is often extremely strong.
- Politicians face weak incentives for action. Reforms bring prompt costs and delayed benefits, and delay incurs few penalties.
- Major sector reforms often are launched because political leaders view them as means to broader and more urgent goals. In other words, linkage is often key.
- Implementation is by far the longest and most difficult phase of reform, and generates different political challenges than earlier phases.
- It is far harder to change the incentives and operations of established institutions than to introduce new programs and institutions.
- Effective reforms demand thorough and sophisticated attention to political challenges.

I. Baselines and Context: Education and Health in Latin America in 1990²

Education status and the education sectors

In the decades after World War II, many Latin American governments vigorously recruited teachers and built schools. By the beginning of the 1980s, almost all school-aged children attended primary school, and adult illiteracy rates declined to about 13%.

However, repetition and drop-out rates were extremely high. In the early 1990s, almost one out of every two students repeated first grade. The urban workforce averaged just over five years of schooling, well below the levels in middle-income countries in other regions. Academic achievement at primary and secondary levels was disastrously low. The very few Latin American countries that participated in international test programs scored near the bottom of the list. (Wolff and Castro, 191) Inequalities remained marked: in the best cases (Argentina and Uruguay) the wealthiest 20% of the population had about twice as many years of schooling as the poorest fifth; in the worst cases (Brazil and Mexico) the ratio was four to one. (PREAL 2001, Table A-12). Public spending favored universities; many middle- and upper-middle income families sent their children to private primary and secondary schools and then to heavily subsidized public universities. According to World Bank estimates, in Chile, Costa Rica, the Dominican Republic and Uruguay the richest fifth of the population received more than 50% of higher education subsidies. (WB 1990, 79)

Health status and the health sectors

² In this section and throughout the paper, most material is drawn from Kaufman and Nelson, 2004. Annex I provides the Table of Contents for that volume, including case studies and their authors. Additional sources are shown in the list of References.

General health status had improved rapidly in most of the region in the decades following World War II. Between 1960 and 1990, average life expectancy increased from fifty-four to seventy years; child mortality dropped from 161 to 60 per 1,000 births (World Bank 1993, table A.3). Yet these and more detailed indicators varied tremendously, both among and within countries. In Haiti, infant mortality was still 156 per 1,000 births as the 1990s began; in Bolivia, the rate was 125; while Colombia had pushed infant deaths down to 21 and Cuba to 12. During the 1980s, 57 percent of children in Guatemala between the ages of two and five years were stunted as a result of inadequate nutrition; in Venezuela and Chile, the corresponding figures were 7 and 10 percent.

By 1990, the Southern Cone countries were well advanced in the demographic transition from high to low birthrates and death rates. Substantial fractions of their populations were more than sixty years of age (16 percent in Uruguay, 13 percent in Argentina), and the pattern of health problems had shifted increasingly to non-communicable diseases typical of wealthier countries. But parts of the region (including poor and remote areas within more advanced countries) were still characterized by sharply different patterns: an average of four or five children born to each woman, high infant and child mortality rates, relatively low life expectancy, and the continued prevalence of communicable diseases, parasites, and maternal and prenatal problems typical of poor countries (World Bank 1993, tables A.3 and A.6).

Health outcomes of course are determined not only by the amount and quality of health care but also—indeed, more importantly—by nutrition, housing, and related services (especially the supply of clean water), income and education, environmental factors, and an array of public health measures. The variation sketched above reflects differences in all these factors. But weaknesses in health care systems in much of the region contributed to health and life expectancy outcomes well below those achieved outside the region in countries with comparable per capita income. In the mid-1990s, more than 40 percent of the population in eight Latin American countries, and a third of Brazil's citizens, lacked access even to basic health services. The quality of public health care services was poor or declining in many countries, in part as a lingering result of budget pressures during the difficult 1980s, but more fundamentally as a result of weak structure, perverse incentives, and misallocated resources in the systems themselves. Those who could afford to do so increasingly relied on private insurance, especially in the middle-income countries of the region (IDB 1996, 301).

Most Latin American health systems were (and still are) segmented. They generally include three subsystems: social security health care finance and delivery systems for formal-sector workers, funded by payroll contributions from employers and employees; public systems funded from general tax revenues, serving that part of the population not covered by social security; and diverse private systems for the wealthy and increasingly for middle and poor classes, financed by private insurance (for better-off people) and out-of-pocket expenditures. The segments overlap to varying degrees. In some countries, the social security segment operates its own clinics and hospitals, but workers covered by social security may also seek care from public or private providers. Elsewhere, the social security segment may operate by reimbursing public and private providers. Private hospitals and clinics play a significant role in much of the region; pharmaceutical production and distribution is largely private in most cases. However, Costa Rica, Cuba, Panama, and the English-speaking Caribbean countries have predominantly public systems

The 1990s Context

In most Latin American countries, attempts to improve the education and health systems had long histories. But momentum increased dramatically in the 1990s. The economic crisis of the 1980s had blocked reform efforts while deepening problems in both sectors. The improved economic climate of the early 1990s gave reformers somewhat greater leeway. In a number of countries, preoccupation with macro-economic stabilization and “first-wave” structural adjustment measures was replaced by a new focus on “second wave” institutional reforms, including attention to education and health.

At the same time, recently revived democracy in some countries and pressure for more open and responsive governments in others generated increased attention to social sectors. This push was particularly clear in the constitutional conventions in Brazil in 1988 and Colombia in 1991. Reacting against recently ousted authoritarian governments, many Latin American countries increased the autonomy and powers of provinces and local governments. This broad trend almost everywhere carried with it more decentralized administration of health and education services.

In international circles as well, the 1990s saw a surge of attention to health and education sector reforms. The UNESCO-sponsored World Conference on Education, held in Thailand in 1990, several regional conferences in following years, and the 1998 meeting of American heads of states in Santiago, Chile all underscored the crucial role of education. The World Bank’s 1993 World Development Report, focused on health issues, was widely influential. The World Bank and the Inter-American Development Bank (IDB) sharply increased their loans and grants in the health and education sectors, as did several of the major bilateral aid agencies.

Heightened priority was accompanied by intensified discussion and debate, and the introduction of new and controversial ideas. The new approaches sought the same basic goals as older reform efforts: increased equity, efficiency, and quality. But much more emphasis was placed on heightened efficiency and cost containment, to stretch the impact of limited resources in the new climate of more cautious macro-economic management. Altered incentives were seen as a key to efficiency, and institutional and structural changes in turn were needed to alter incentives. Ideas such as voucher and charter schools, merit pay and promotion for teachers, national tests and their use to assess performance of schools and teachers as well as students, increased autonomy and accountability of hospitals and clinics, and new payment mechanisms for health services became part of the menu of possible reforms.

The broadened sector reform agenda emphasized three additional themes: decentralization, autonomy for operating units, and increased citizen participation. As noted above, *increased authority for provinces and municipalities* was driven by broad anti-authoritarian, pro-democratic goals. But reformers also hoped that bringing decision-making authority closer to the actual delivery units and the people receiving services would make education and health systems more responsive, accountable, and efficient. Many also pressed for much more *autonomy at the level of individual schools, clinics and hospitals*. El Salvador and Nicaragua are too small for decentralization to play a major role, but school autonomy was the central theme of education reform in both countries. Similarly, hospital autonomy became an element of health sector reform in Costa Rica. Increased *citizen participation* in sector governance was a closely related reform proposal. Many reformers were convinced that community councils could and should play major roles in monitoring and even administering individual schools, clinics, and hospitals. In addition, they often proposed health and education councils at the level of the municipality, the province, and the nation, to give the public a larger voice in policy and program decisions.

Struggles over sector reforms in the 1990s therefore dealt with a considerably wider menu of proposals and ideas than earlier debates and reform efforts. Reform efforts were not only more intense, but also more varied in design and content.

II. Education and Health: How Similar? How Different?

Most analyses of reforms in education and health deal with one or the other sector, not with both. Is it sensible to consider the politics of reform in the two sectors together?

Similarities.

The sectors share a number of structural similarities that lead to parallel political patterns. Perhaps most obviously, education and health workers are usually the two largest categories of public sector employees. Moreover, in Latin America, teachers, doctors and non-medical health service workers are organized in strong unions or influential associations. Teachers' unions often dominate ministries of education, and ministries of health tend to be controlled by doctors. Labor relations are often highly contentious, with frequent strikes and demonstrations. Service providers' unions are commonly regarded as the major political obstacles to reform.

A second problem common to both sectors is widespread patronage. In many (though not all) Latin American countries, local or national politicians use the two sectors as massive patronage pools. Often working in collaboration with unions affiliated with their party, politicians control appointments, promotions, transfers and other benefits, and use this control to build political support. Where this pattern exists, politicians predictably resist reforms that reduce their control.

Education and health sectors share a third, very basic characteristic: the quality of service depends to an unusually large extent on the capacity and motivation of teachers, doctors and nurses in schools, clinics and hospitals scattered across the country. Put slightly differently, principal-agent problems are extremely important in both sectors. That structural feature has political implications: the design of reforms must include ways to gain not merely the reluctant compliance but the active co-operation of the service-providers themselves.

Education and health sectors in Latin America also share other problems already mentioned above: public resources disproportionately focused on the highest levels of the sectors (universities, specialized hospitals); middle-class flight to private schools and private health insurers and providers; and pervasive inequality of services across urban vs. rural areas, regions, and income groups. In the early 1990s, most education and health systems were also highly centralized. (Reforms since 1990 have changed this pattern in many countries.) Similar problems in the two sectors prompt somewhat similar reform efforts, and parallel patterns of political resistance to reform.

Contrasts.

Despite the substantial similarities just listed, important structural differences between Latin American health and education sectors generate some significant political contrasts.

The segmented structure of most health care systems, and the extent to which private interests intertwine with public and semipublic segments of the sectors, have no real parallels in the region's education sectors. Underlying the segmentation of the health sector is a fundamental contrast in the predictability and uniformity of individual needs for education versus health

services. Individual needs for health care (other than routine preventive services) are episodic, unpredictable, and highly variable. Therefore, health care lends itself to partial financing through insurance (private, or social security); modest sums can be collected on a regular schedule from many people, whereas only a fraction of them will require payment for health services in any one time period. In contrast, education does not lend itself to insurance.

Private schools are important components of the education systems in many Latin American countries, though in the early 1990s in all but a very few countries they enrolled less than a fifth of primary students and less than a third of secondary students (IDB 1996, table 5). Most private schools operate entirely independently of the public school system. In contrast, in the health sector private, social security, and public doctors, hospitals and clinics are intertwined in a variety of ways. For instance, a great many doctors hold public sector positions and also engage in private practice. Private sector hospitals often provide treatment for patients with social security insurance.

These structural contrasts lead to patterns specific to the politics of health sector reforms:

- Social security institutes are frequently important players in health sector reforms. Their autonomous legal status and substantial independent financing gives them considerable power. Their relations with the ministries of health are often strained, and in some countries the institute is considerably more powerful than the ministry. They have been much more likely to resist than to promote change.
- Because a major segment of the health sector is linked through social security payments to pensions and payroll taxes, ministers of finance and other powerful politicians on the economic team are often interested in health sector reforms. No similar links focus their attention on education reforms.
- In some countries, the segmented character of the health sector creates pressure for a more unified system—an issue that does not come up in education.
- In most cases, where unification is not a goal, reforms in the social security and public segments of the sector are often two quite separate stories.
- As a result of the insurance component of health systems, sector reforms often include restructuring financial arrangements to separate payers from providers—a reform component that has no parallel in the education sector.
- Because private and public components of health sectors are often tightly intertwined, private health interests are more likely to seek to influence reforms than are their counterparts in education.

In short, while important structural similarities in the two sectors generate many parallels in the politics of reform, other structural contrasts lead to differences in key actors and in the complexity and scope of reform efforts.

III. The Politics of Reform: The Cast of Characters

Health and education are so basic to human welfare, and dissatisfaction with Latin American health and education systems is so widespread, that one would think reformers should be able to mobilize substantial support. However, the cases in our study and other evidence make clear that there are surprisingly few influential proponents of sector reform in most countries, while there are many strong opponents. Some of the groups one would expect to support reform in fact have played very little role.

Who initiates and supports reform?

In our cases, reforms were usually initiated by *public health and education specialists*. In Brazil, a network of health analysts and officials called the *sanitaristas* had long advocated more emphasis on preventive and primary care, decentralization, and unification of the social security-financed and public segments of the health system. They succeeded in incorporating most of their proposals into the new 1988 Constitution, and thereafter worked to ensure that the reforms were carried through. In Peru, several very small groups within the Ministry of Health initiated important reforms in primary health care delivery. Colombia's comprehensive health system reform reflected years of analysis and debate by health specialists, and was triggered by demands from several key senators with medical backgrounds. In Nicaragua and Brazil, major education reforms were put in place by ministers of education with long careers as analysts of education problems. There are many more examples.

Ministers of Finance and other high-level economic officials were sometimes the main instigators of sector reform, more often in health than education. In Mexico, the Ministry of Finance and the economic team more broadly took the lead in pressing for basic changes in the finance and structure of the social security-funded segment of the health system, made necessary by reforms in the pension system. The team placed their own nominees within the social security administration to design the reforms. Mexico's economic team also backed decentralization of education. In Colombia, the minister of health and his team had recently transferred from the Department of National Planning and had close ties to the government's economic team. In both Mexico and Colombia, the economic team's interest was driven by links between pension reform and health sector reform. In Argentina, the Ministry of the Economy supported the effort to introduce competition among (and thereby fundamentally restructure) Argentina's unusual system of monopolistic union-controlled health care organizations (*obras sociales*).

More generally, high-level economic officials are likely to turn their attention to the health sector in the context of a concern with high payroll taxes and their impact on investment, and a broader interest in the modernization of the state. Among our cases, this concern was evident in Mexico and Argentina (where basic pay-roll taxes, for health and other purposes, amounted to 56% of base wages in the early 1990s.) Contrary to a good deal of speculation, reform proposals by ministers of finance and economy were only rarely driven by the goal of reducing pressures on the federal budget, and government expenditures on education and health increased during the 1990s in most of the region. In Argentina, the powerful minister of economy did transfer responsibility for secondary schools to the provinces early in the 1990s, in large part to create pressure on provincial governments to manage their finances more responsibly. Even in that case, however, governors, teachers' unions, and legislators eventually forced significant increases in federal education

International organizations, especially the World Bank and the Inter-American Development Bank, were a third source of initiative for reforms in health and education. They were important sources of information and advice, especially regarding the experience of other countries and regions. In several instances they provided technical assistance at the design stage. International experts' assessments sometimes helped to strengthen the credibility of national reformers. In many cases the development banks and other multilateral and bilateral aid agencies provided technical assistance and substantial funds to support implementation of reforms. However, domestic actors were pivotal in the initiative and design of reforms. International institutions did not typically seize the initiative in launching and designing reforms. In those rare instances where they attempted to do so, the measures they advocated were often abandoned, or at best made very slow progress.

Missing voices: the public and business interests

Democratization in Latin America in the 1980s and early 1990s was expected to create strong public pressure for better social services. Opinion polls do indeed show widespread public concern with education. Among the eight countries covered in our study, between 10 and 30% of respondents named education as “the most important issue facing the country” in 2000. (Far fewer, however, pointed to health as the most important issue.) (Data from LatinoBarometro 2000, adapted from Grindle 2002, Table 2.13) Yet pressures from citizens in general, or from non-governmental organizations (NGOs) played little or no direct role in prompting national education reforms, and had still less impact on health sector reforms.

One reason for this is that the worst-served groups are poor urban and particularly rural people, who usually are not organized or active in politics. The more vocal and influential middle classes have chosen “exit” over “voice.” Formal sector and government workers have social security and/or private health insurance. They use private clinics to avoid long waiting periods or to choose the doctor they prefer. In much of Latin America, most middle class children attend private primary and secondary schools. Therefore middle class groups are not likely to mobilize around improving the quality and equity of public schools and hospitals. Where popular pressures for better service do emerge (often channeled through local NGOs or political parties), they are likely to focus on improved service from local facilities, not on major revisions of national policy.

There is another reason for the lack of citizen support for many reforms: the links between the proposed reform and better service may not be clear to most of the public. This is particularly true for health sector reforms. For instance, increased hospital autonomy and changes in how hospitals and doctors are paid are not likely to excite much public interest. Beyond indifference, citizens are likely to *oppose* certain kinds of reforms, especially those perceived as moving toward “privatization” (contracting out by public services of some functions), imposing financial or convenience costs on users (e.g., requiring that primary care physicians authorize visits to specialists), or diluting the quality of service (expanding nurses’ or paramedics’ authority to treat simple illnesses). Such “efficiency-oriented” measures are widely viewed either as intrinsically undesirable, or as dubious means toward better health services. All these considerations help to explain the limited public support for major health sector reforms at the national level.

Business and industrial interests would seem to have a considerable stake in improved social services. Private employers usually stand to gain from better educated and more flexible workers. Recently, better education has been a theme in debates in Mexico and elsewhere about how to cope with growing competition from China and other low-cost producers. Improved health also should improve productivity and reduce days lost through illness. Employers pay hefty wage taxes for the health component of social security systems. Some employers (often of large and medium-sized enterprises) are so dissatisfied with the services of the national social security system that they also purchase private health care plans for their employees, in effect paying twice.

Despite these stakes, business interests have played little role in promoting sector reforms. A few progressive business associations funded programs of direct assistance to schools (for instance, providing computers), but in our cases businesses did not lobby for reforms in education policy and programs. Nor was there significant organized business support for measures designed to increase the efficiency or improve the quality of the social security segment of health sectors. In several countries, business interests did press for wage tax reductions; in Argentina, this was one of the private sector’s goals in tripartite negotiations to

recast labor relations in the mid-1990s. Mexican business groups were also interested in changing social security financial arrangements, and they financed a major analysis of health sector reform options in the early 1990s. Widespread evasion of payroll taxes may dilute business concern about health care finance and provision in some countries. More generally, it seems likely that most businessmen and industrial managers simply see other policy issues as much more directly relevant to their interests, and focus their political energies on those issues.

Who opposes reform?

In contrast to the short list of likely sources of education and health reform initiatives and the lack of effective support from the public and from business interests, many powerful groups and institutions are likely to oppose reforms, or at least to harbor serious doubts and withhold support.

Ministers of health or education are often reform advocates. But most of the *bureaucracy* in their ministries is hostile, or at best cool to many reforms. The ministries are often essentially controlled, or at best influenced, by teachers' unions or doctors' associations. They oppose decentralization because it shifts resources and decision-making authority away from their control; other kinds of reforms demand disruptive changes in long-established procedures or threaten traditional professional standards and approaches.

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control; other kinds of reforms demand disruptive changes in long-established procedures or threaten traditional professional standards and approaches.

Any discussion of the politics of education and health reforms in Latin America quickly focuses on resistance to reform from *teachers, doctors and other health workers, and their unions and associations*. Teachers' unions are particularly militant: unlike health workers, teachers' career paths go almost entirely through the public sector, and they are therefore more likely to resort to political pressures to press their demands. (Maceira and Murillo 2001) In most cases, teachers' unions strongly objected to decentralization initiatives that would weaken their bargaining leverage with the national ministry. They also vigorously (and usually successfully) resisted efforts to link performance to rewards through merit pay, or to use (and publicize) test results to assess teachers and schools as well as students.

Throughout the world, doctors and other health service providers predictably oppose aspects of reform that seem to them to threaten their income, status, independence, and established working routines. Mechanisms that link pay to performance, both for individual hospital and clinic staff, and for clinics and hospitals as units, are perceived as threats on all these counts. Doctors also deeply dislike administrative and financial management systems that place them under the control of non-doctors, or give representatives of the community some voice in administration. They are suspicious of efforts to shift the emphasis, and the allocation of resources, away from secondary and tertiary levels of health care to buttress primary and preventive care in poor urban and rural areas. Such measures imply lower salaries, less sophisticated equipment, pressures to serve where living conditions and career prospects are unattractive, and the substitution of less highly trained health workers (nurses, public health workers, midwives) for doctors in performing certain services. Moreover, doctors' training and the Hippocratic Oath focus their attention on individual patients' needs. Reform proposals based on broader social benefits and costs often seem irrelevant or wrongheaded to them.

Health care workers other than doctors also often oppose many aspects of sector reforms. Where health workers' unions traditionally negotiate wages and working conditions at the national level (with the Ministry of Health and/or the social security institute), they bitterly contest reforms that shift some control over personnel matters to provincial or municipal governments or to hospitals and clinics. Non-doctor personnel and some doctors in the public sector also strongly resist measures that increase private participation in the sector, usually by contracting out specific services or by permitting large firms to "opt out" of the public system and make independent health care arrangements.

These patterns applied without exception in the cases analyzed in our study. Even in Costa Rica—and despite that country's proud record of social integration and concern for poor people—some doctors complained that the new system of integrated community medical teams would convert them into public health officials, "dragging the medical profession back into the days of fighting parasitic diseases." Efforts to restructure payment mechanisms and modernize hospital administration in Colombia provoked bitter complaints. In none of our cases except Peru did reform measures significantly decentralize control over salary and personnel decisions (though in Brazil and Argentina, sub-national authorities already had control of those functions for the public segments of the system, long before 1990.)

Although service providers and their unions and associations were generally hostile to reforms, their *capacity* to block reforms varied widely, both among countries and over time within individual countries. The main Colombian and Mexican teachers' federations dominated their sectors and negotiated major compromises in the design of reforms – in the Colombian case totally gutting the intent of the reformers. In Brazil's already decentralized education system, teachers' unions were fragmented and unable to coordinate a national response. In Nicaragua,

the main teachers' union was affiliated with the defeated Sandinista government, and could not block reforms that were partly motivated by the desire to undermine the union itself. The unity and influence of health sector unions also varied tremendously. In Peru, the political and economic chaos of the 1980s had virtually destroyed public sector health unions. Not coincidentally, Peru offers a possibly unique case in Latin America where terms of employment in primary care clinics were radically revised, introducing short-term contracts with renewal based on performance. At the opposite extreme, Mexico's Social Security Institute union (unusually combining doctors, nurses, and administrative personnel) is the largest in the country, and until recently it had a fixed quota of seats in the national legislature. In effect, the union stripped all proposed reforms except favorable new mechanisms of finance from major legislation sponsored by the Ministry of Finance in the mid 1990s.

One might expect that *hospital administrators and school directors* would favor those aspects of reform packages that increase their autonomy in day-to-day operations. Yet hospital administrators often oppose such reforms, and school principals are at best luke-warm. This is because increased autonomy usually comes packaged with less welcome measures. School autonomy is frequently paired with increased authority for parents' or community councils, which principals and teachers dislike. Increased clinic and hospital autonomy is usually linked to new financing mechanisms: a shift from annual budgets (based largely on the previous year's budget) to payment for services actually provided to patients. These changes in finance arrangements require extensive and difficult changes in hospital routines and regulations. Moreover, in many countries public hospital administrators' control over their personnel is extremely limited. They can not hire, fire, or promote staff, nor can they set salaries; sometimes even their control over work schedules is restricted by union guidelines negotiated at the national or state level. Personnel costs often absorb between 60 and 80 percent of total budgets, so administrators have little room to maneuver. Furthermore, altered funding arrangements imply much greater uncertainty and risk. Directors lack confidence in the reliability of the new mechanisms to ensure timely payment for services. All these concerns are powerful counterweights to the attractions of increased autonomy.

At first glance, decentralizing reforms seem to benefit *provincial governors and local mayors* and their education and health departments. But local officials usually are not eager to take on sharply increase responsibility for education and health programs traditionally operated by the national government. In Latin America during the late 1980s and 1990s, decentralization was introduced (or earlier partial decentralization was deepened) in a hasty and poorly thought through manner (Rojas 1999). Procedures and criteria for transfers of funds from center to provinces, and (directly or indirectly) to municipalities often were not clearly spelled out. Governors and mayors (and their health departments) had little confidence that funding would arrive promptly, or at all. In several countries, including Brazil and Colombia, confusion and delays were compounded by national economic crises a few years after the reforms began.

Moreover, in most of our cases, central funds for provincial and local social services were at least partly earmarked. The requirement that central funds be spent for specified activities enabled national ministries to determine the norms and standards to be met by state and local health programs. In Brazil, much of the politics of health sector reform after 1994 focused on the tug-of-war between state and local officials, on the one hand, and national ministry officials, on the other, regarding the precise ministry norms for centrally funded programs. State and local governments did not welcome closer monitoring by central officials. Nor were they eager to take more responsibility for dealing with assertive health care workers' unions.

At all levels, *politicians'* attitudes toward health sector reforms are also influenced by the extent to which patronage opportunities are destroyed or created. In Mexico and Colombia, the

social security institutes provided massive political patronage—that is, individual politicians’ or party influence over appointments to the bureaucracy or to health care jobs. In Argentina, PAMI—the agency responsible for providing health services to pensioners—traditionally has been a large-scale patronage pool. In all three cases, important politicians quietly or openly opposed reforms that would dilute or remove their control over appointments.

In short, the balance of forces supporting and opposing structural reforms in the education and health sectors is strongly weighted in favor of opponents. (Increased resources or new programs are much more attractive; that point is discussed later in this paper.) Therefore it is not surprising that high-level political leaders usually do not rush to promote such reforms, even if they themselves have considerable interest in health or education issues. They confront a classic “time inconsistency” problem. The opponents of reform are organized and assertive; political costs of promoting major social service reforms are predictable and prompt. In contrast, the benefits of such reforms often will not become evident for several or many years. When benefits do emerge, voters may not recognize how better services relate to earlier reforms. Even if the connections are fairly clear, the beneficiaries are not organized politically. Therefore the political pay-off to social service reforms is often both uncertain and long-delayed – quite probably delayed until the political leader has left office.

Moreover, even where education and health services are very poor, the political cost of avoiding action is low. The politician who delays appropriate action to deal with a worsening balance of payments problem, or hyperinflation, can expect much deeper economic and political problems very soon. In contrast, failure to address problems in health and education services is not likely to provoke a serious political crisis. In short, even though social service reforms are crucial, *they are almost never urgent from a political perspective.*

IV. Launching Reforms in the Face of the Obstacles

Despite this bleak analysis, there was considerable reform in many Latin American education and health sectors during the 1990s. The most widespread structural change was decentralization, especially in the education sector. In several cases, decentralization was accompanied by changes in the formulae for transferring central funds to sub-national governments, in order to increase funding for the poorest regions. Decentralization in turn permitted innovative local experiments, particularly in the education sector. Brazil created a unified and universal system of health care coverage, replacing the earlier segmented system; Colombia created a framework for and took long strides toward a single universal system. Costa Rica and Peru introduced important changes in delivery of primary health care. Nicaragua, El Salvador, and the province of Minas Gerais in Brazil implemented school autonomy and established citizen councils with extensive powers for primary and secondary schools. A great many other changes could be listed.

How could these changes occur, in the face of the obstacles described in the last section? The story is different in each country, and indeed for each specific reform. Reform was certainly easier where unions or other major opponents were relatively weak and divided. But the balance of forces by itself cannot account for the extent of reform, especially since the resources and alliances of these forces can change, and reformers can sometimes successfully manipulate these factors.

Two other kinds of explanations help to account for much of the actual change. First, different kinds of reforms entail markedly different political challenges. Not all reforms are extremely contentious; some are fairly noncontroversial; some are popular.

Second, powerful political leaders supported some difficult reforms because they regarded them as means to, or intrinsic aspects of broader, high-priority goals.

The politics of different kinds of reforms

This paper has focused on structural reforms: changes in organization, administration, financing mechanisms, and incentive systems. However, improving the equity and quality of education and health services in Latin America also requires *increased in-puts*: expanded coverage of health services and secondary education; improved facilities, materials and equipment; better training and salaries for teachers and health workers. These measures are popular or non-controversial. They are often combined with more difficult reforms. Colombia's health reforms, for instance, expanded health insurance coverage from a fifth to over half of the population, while introducing a complex set of more controversial changes intended to increase efficiency. The Brazilian health reforms expanded coverage even more dramatically. Mexico's decentralization of primary and secondary schools was accompanied by a hefty increase in teachers' salaries.

New (targeted or universal) programs that do not disturb established organizations are also fairly easy politically. For instance, pre-school programs for three-to-five year old children expanded rapidly in many Latin American countries in the 1990s, in part in response to compelling recent evidence on the importance of early childhood education (and nutrition) for later performance. Similar political logic applies to "categorical" or "vertical" health programs like immunization campaigns or efforts focused on specific diseases (HIV/AIDs in Brazil, or Chagas disease in Bolivia).

Creating new organizations is somewhat more difficult but has been a prominent feature of reforms in several countries, even when the new entities imply some changes in modes of operation of established parts of the system. Examples include the new health care purchasing organizations (quasi-health maintenance organizations) in Colombia and, on a limited scale, Peru; or the broadly representative National Health Council created to provide policy guidance to Colombia's Ministry of Health. Often, however, establishing a new structure turns out to be easier than integrating its operations with those of established organizations. Form is comparatively easy; function is harder.

Changes in rules governing financial flows among different levels of government can be intensely controversial, but once authorized can be put into effect fairly rapidly. For instance, Brazil adopted a constitutional amendment that changed the formula for allocating federal education funds among provinces and municipalities, in order to provide more support to poorer regions.

Changes in structure and function within the administrative core of the system—*reforms requiring substantial changes in the standard operating procedures of established ministries, schools, and hospitals*—are much more difficult politically. They entail shifts in control over staff and budget, and changes in working relations and relative status. For example, attempts to shift from annual budgets for public clinics and hospitals to the principle of "money follows patients" have aroused strong resistance and have progressed very slowly. While decentralization has been widely adopted (for reasons explored a bit later in this paper), *changes in the locus of control over personnel decisions and labor policies* have been bitterly, and usually successfully opposed. So have *measures to monitor performance and establish links between performance and reward*: for instance, using national testing not only to assess individual students' progress, but also to monitor the performance of teachers and schools.

Some other kinds of attempted changes in the operations of established organizations do not usually provoke open political opposition, but are delayed or diluted in the implementation stage. This has been the fate of many attempts to *reorganize national ministries* of health and education. Efforts to *establish and empower parents' or community councils* to oversee aspects of the operation of schools or clinics have had similar effects. Citizen participation is an article of faith in international circles, and the principle has been incorporated in laws and decrees throughout Latin America. There have been some striking cases of success, mainly in the education sector. But school principals and clinic and hospital directors have little respect for the councils, and they usually are inactive, or are used only to raise supplementary funds.

Social values and the balance between equity and efficiency objectives

In addition to their varied costs and benefits, proposed social service reforms trigger value judgments. Social values such as individual self-reliance versus solidarity, equity, the responsibilities of the state to its citizens, and religious or secular orientations are built into and reflected by education and health systems. Proposed changes are defended and attacked not only for their expected impact on material, professional, organizational and status interests but also for their perceived effects on social values. Our case studies suggested that reactions to proposed reforms are often shaped by public and stakeholder perceptions of dominant goals—especially the balance between equity and efficiency goals.

In practice, efficiency and equity objectives are intertwined in many kinds of reforms. For example, targeting expenditures on primary schools or clinics often serves both equity and efficiency goals. Despite mixed goals, some reforms *appear to be* mainly driven by equity goals, or they offer unusually obvious and quick improvements in equity: for example, the subsidized insurance component of the Colombian health reforms that rapidly expanded access to medical care for poor people. It is difficult for politicians and providers to oppose such reforms. Other measures are (or appear to be) mainly focused on efficiency: for instance, hospital autonomy and associated changes in payment systems. Efficiency-oriented measures rarely arouse enthusiasm; instead, service providers are indifferent or hostile. And the public tends to oppose efficiency reforms because they assume cost cutting means reduced quality or quantity, or because they view certain measures (for instance, contracting out some tasks) as “privatization”—interpreted as gains for the few, at the expense of the public.

A striking (and unexpected) finding in our research project was that most of the aborted or stalled initiatives in the health sector were those directed mainly to efficiency goals. These included the effort to introduce competition among union-based health organizations (*obras sociales*) in Argentina; the even less effective attempt to reform PAMI (the Argentine organization providing health and other services to the elderly); several of the proposed innovations in health care that were removed from Mexico's 1995 social security law; and the very-slow-moving efforts to increase hospital autonomy in Costa Rica and in the Argentine provinces. This pattern suggests that reformers should try to combine efficiency measures (or reforms that are likely to be interpreted as efficiency-focused) with other measures obviously directed to equity. Colombia's complex health sector reforms proved sustainable, despite a very difficult beginning, largely because it combined efficiency elements with strong and effective equity themes.

Linking sector reforms with broader goals.

Although some measures do not provoke strong opposition, most major structural reforms will not be approved without a political struggle. Given the uneven balance of forces favoring and opposing change, the support of top political leadership is usually imperative. But

we have seen that political leaders usually view such reforms as high cost, low benefit in the near term, and as less urgent than other issues on their agenda. In our cases, *most major education and health reforms were possible because of linkage: high-level political leaders viewed the reforms as elements of or means to high-priority goals outside of the sectors themselves.* Conversely, where social sector reforms were seen to jeopardize more urgent goals, the reforms were trimmed, postponed or dropped.

The logic of linkage is particularly clear with regard to decentralization. As noted earlier (page 5), in much of Latin America decentralization of social services was driven by objectives broader than the sectors themselves: desire to deepen democracy and encourage more responsible and accountable government. However, precisely because decentralization was driven by goals outside of the education and health sectors, it was carried out with little attention to the detailed revision of laws and regulations or the training of local officials that would have been necessary to permit a smooth transition.

Other social service reforms also have been viewed as means to, or components of other high-priority objectives. Colombia offers an unusually explicit example of linkage. In 1992-3, the Gaviria government was eager to pass pension reform, but could not agree within its own ranks regarding health reform. However, a few key Senators insisted that they would block the pension reform unless health reforms were included in the legislation. An energetic and innovative minister of education then seized the opportunity for far-reaching changes. In Nicaragua in the early 1990s, the government that had replaced the Sandinistas was eager to reduce lingering Sandinista influence in society. The Minister of Education introduced a far-reaching program of school autonomy and community councils, intended in part to undermine the influence of the Sandinista teachers' union. In Brazil in the late 1990s, President Cardoso launched a broad program designed to modernize the state and reduce extreme inequalities. As part of this program, he selected strong ministers of education and health, and backed their measures.

V. Phases and Tactics of Reform

Thus far, this discussion has focused on the constellation of political forces favoring and opposing reforms, and on how reforms have moved onto the political agenda despite the obstacles. The process of introducing and consolidating major changes in education or health care systems takes years, sometimes decades. Once reforms are on the political agenda, they must move through three phases: reaching agreement within the executive branch of government; winning legislative approval and public acceptance; and launching and sustaining implementation. The key players and arenas for action, the major political challenges, and the relevant tactics differ in each phase. In practice, of course, the phases overlap, and the reform process may backtrack or become derailed (for instance, if a new minister or government takes office). Nevertheless, an overview of the phases of reform provides a useful way to think about the different political challenges reformers face, and some of the tactics and devices that may prove useful.

Reaching agreement within the government.

Reconciling different views. Major reforms usually require the cooperation of several central government ministries or agencies. The process of moving from recognition that new policies and programs are imperative, to action proposals, requires gaining the agreement or at least the acceptance of all the major agencies involved. Since there are multiple models for and limited technical consensus regarding education and health sector reforms, different agencies

may hold quite different views of what is needed. Each also has its own institutional interests and concerns that will be affected by the design of reforms. Gaining sufficient agreement within the government to move ahead with a specific proposal therefore is a major political challenge. Disagreements within governments often cause initial reform ideas to be scaled back drastically or dropped.

Winning high-level support. The degree of high-level political support interacts with the process of building consensus within the government. If the President (and sometimes other top political leaders) are known to strongly favor reforms, ministers and ministry bureaucracies are under pressure to work out an agreement. But influence also flows in the other direction: an initially supportive President or Minister of Finance may decide to set aside an issue on which his government is deeply divided. Health sector reforms may be particularly vulnerable to this problem, because of the wide range of conflicting views regarding models for reform.

The roles of change teams. In several of our cases (most clearly in Costa Rica, Colombia, and Mexico), a small group of reformers with fairly clear ideas regarding the direction and design of reforms established a change team that played a key role in building consensus. Sometimes the team was located within the central planning or economic agency, sometimes in the main responsible ministry, occasionally in a special unit attached to the Presidency. Such a team plays a central role in designing proposals and co-ordinating inter-agency discussions. It builds informal networks of like-minded officials in different agencies, and may try to influence the appointment or promotion of supporters in those agencies, thus “colonizing” the government. Change teams may also play a major role at later phases, educating the public regarding reform options, dealing with stakeholder interests, shepherding reform bills through the legislature, developing detailed regulations to implement new laws, and acting as trouble-shooters in the early stages of implementation.

Reformers must decide how much they should consult with stakeholder groups, legislators, and even the public (via polls and media) during the period when the government itself has not yet developed an agreed position. There are trade-offs between early and delayed consultation. Early consultation risks provoking so much protest and lobbying by vested interests that government leaders back away from serious reform. At a minimum, consultation complicates the already complex and delicate process of engineering consensus within the government itself. But dialogue with stakeholders and key legislative leaders while aspects of the reform design are still fluid is likely to facilitate the later tasks of gaining legislative approval and setting reforms in motion. The design itself may be modified, or the very process of consultation can ease suspicions of top-down, closed-door decision-making. If early dialogue demonstrates less-than-expected stakeholder resistance to aspects of proposed reforms, opposition within the government itself may dwindle. Among our cases, consultation was usually delayed until the basic design of the reform had been agreed upon within the executive branch. However, there were exceptions to this pattern. In Mexico, the Minister of Education (and to some extent the President himself) discussed proposed decentralization plans with the powerful teachers’ union from early in the process – but only after engineering the replacement of the intransigent union leader with a more moderate person.

Authorization: choices, challenges and tactics

After a proposal has gained enough support within the executive branch, it must be authorized. Depending on the scope of the reform and on the country’s political and legal context, authorization may take the form of a ministerial order, presidential decree, or legislation. Among our cases, a fair number of reforms were authorized in a low-key manner, with little or no public debate or interest group involvement. In Peru, during Fujimori’s autocratic regime,

two important Ministry of Health initiatives to strengthen primary health care delivery were put into effect by decree, and funded through a single article buried in the sweeping 1994 budget bill. In Nicaragua, after the Sandinistas lost control of the government in 1990 (but remained powerful in the legislature and the unions), the Minister of Education took a strategic decision to launch education reforms by decree, avoiding confrontation with a hostile legislature. The Autonomous Schools Program operated for a decade before finally receiving Congressional approval in 2002. That course, however, was risky, since policies authorized by ministerial decree can be reversed by the same process.

Most major structural reforms do require legislative approval. How hard that task is depends partly on political institutions and political circumstances, such as the numbers and discipline of the government party (or coalition) in the legislature, whether the legislature is unicameral or bicameral, and the influence of congressional commissions before a bill reaches the floor. In some of our cases, including health reforms in Colombia and education reforms in Argentina in 1993, active legislatures took substantial initiative and re-shaped executive proposals. More often, legislatures played only modest roles, largely approving the bills presented to them.

In most of our cases, however, reformers had already negotiated directly with key stakeholders, before submitting proposed reforms to the legislature. As noted above, education reforms in Mexico had been worked out in consultations with the teachers' union (but not with the less powerful provincial governors) from the beginning of the process. Mexican health sector reforms fared less well in negotiations: the extremely strong Social Security Institute's union insisted that almost all non-financial reforms be diluted or removed, before the bill was sent to Congress. Brazil's reform of financing mechanisms for allocating federal education funds was discussed with the organizations representing provincial and municipal education officials before being sent to the legislature.

In short, at the authorization stage, reformers must meet the challenge of *reducing or neutralizing opposition from vested interests*. There are many tactics for coping with vested interests: education and persuasion, compensation, dividing opposition forces (and isolating the groups most strongly opposed to reform), compromise, and veiled or open threats of sanctions. Major reform efforts usually use most of these, in varying combinations.

Often stakeholders (service providers, service clients, state and local officials, private suppliers, etc.) have exaggerated fears of reform, or have mixed feelings about different aspects of the proposals. Their opposition may be reduced or even removed by fuller information and explanation. In this phase, informal and formal meetings with representatives of unions, professional and trade associations, sub-national governments, and user groups are crucial. Persuasion is the first line of action; to the extent that it fails, reformers must consider further tactics, such as compensation and compromise.

Compensation can take a wide variety of forms. Direct financial compensation is the most obvious. In many of the cases our project examined, wage concessions accompanied reforms. (Often better pay is viewed not only as a way to reduce opposition and ensure approval of the reform package, but also as important to improve incentives for desired performance.) Non-financial or indirect forms of compensation are less obvious, but can play important roles. Health sector reforms in the Brazilian state of Ceara increased the prestige and professional satisfaction of the nurse supervisors in charge of new home-visitor health agents, while mayors gained prestige and perhaps political support from the highly visible and successful program (despite their loss of control over jobs that had earlier been a source of patronage)(Tendler, 1997). Mexican education reforms included a restructured career framework for teachers.

The groups opposed to reforms are seldom monoliths. Often moderates can be divided from hardliners. In the Venezuelan state of Merida, six teachers unions were active, affiliated with different political parties. Reformers discussed their plans in detail with the more moderate groups. The union most strongly opposed (which was affiliated with the current administration, and therefore sought to protect its control over appointments) was isolated. On one issue—extending school hours—reformers surveyed teachers and discovered overwhelming support. The survey results were used to weaken union opposition (Lowden, 1996).

Another widely used tactic is simply to postpone (perhaps indefinitely) confrontation with particularly powerful opponents. Efforts to reform components of health systems financed from social security contributions tend to exempt particularly powerful groups with separate, privileged health insurance provisions, such as the military, the police, the judiciary, or petroleum workers. Education reform efforts may well hesitate to tackle the thorny issue of university fees.

Beyond neutralizing opposition, the authorization stage is often the time when reformers seek to build alliances and mold public opinion. For example, Colombia's health reform team launched an intensive program of conferences and workshops, media briefings and speeches throughout the country to explain the complex proposals before the legislature. They directed their efforts both to sector specialists and to the general public. Health reformers in Costa Rica and education reform advocates in Argentina used similar techniques.

Meanwhile, the legislature itself is also an active battlefield. An additional array of tactics is likely to be used, including reports and expert testimony before specialized commissions, and bargaining and linkage approaches specific to the legislative process (such as trading support on certain bills for the promise of support on others). In the lengthy struggle over Colombia's health reform bill, the President himself intervened with key legislators; in Costa Rica, reformers sought and gained the support of the leader of the opposition party. Colombia's experience with education reforms, introduced at the same time as the health reform, offers a cautionary lesson. The executive branch failed to provide effective leadership, because the Education Ministry was largely controlled by the dominant teachers' union, and the government was distracted by other simultaneous reforms and by political pressures unrelated to reform. The legislature passed two contradictory laws, resulting in almost a decade of confusion and paralysis in the education sector.

Implementation: the longest and most difficult phase

Sector specialists and economists interested in promoting reforms recognize the basic problem that organized opponents are likely to outweigh support. Therefore, they focus on the crucial role of top-level political support in the early stages of design and authorization. They tend to pay little attention to the politics of implementation.

Yet implementation is often the most challenging phase of social service reforms. Presidents and other high-level officials whose support may have been crucial in earlier phases are likely to turn their attention to other issues. Others whose cooperation is essential—middle-level bureaucrats within the ministry; state and local politicians and health and education authorities; school, hospital, and clinic directors; and ultimately the teachers, doctors, and nurses—are likely to be skeptical or hostile. Their tendency is to wait, hoping that the reforms will be delayed or reversed. Sometimes key opponents such as providers' unions hold their fire until after reform decrees or laws are in place, judging that they will be in a better position to

block or reshape the measures in the course of implementation (Gonzalez-Rossetti 2001, 234–35).

Implementation therefore shifts the arena of politics from the cabinet and legislature back to the sector bureaucracies, national and subnational. This phase also opens up the micropolitics of change at the level of individual schools, hospitals, and clinics. At the center, reformers usually face a lengthy struggle to persuade, isolate, or replace their own skeptical or hostile staffs. The problem was particularly acute in Brazil's Ministry of Health, because the first step in the 1990s reforms was the transfer into the ministry of a large number of former Social Security staff bitterly opposed to unification. In this struggle, dedicated and stable leadership is a great asset: Nicaragua's education reforms prospered in part because the same committed minister held office across two administrations. In contrast, Colombia's health reforms stalled during the first two years after Law 100 passed, under a hostile new president and minister of health.

Where education or health services are already decentralized, or the reform itself shifts responsibilities from national to lower levels of government, reforms predictably confront not only professional disagreements but also limited capabilities (especially in poor regions), resistance to central "meddling," and entrenched patronage networks linking local bureaucracies to unions and parties. Decentralization does not remove politics from sector reforms; it simply transfers the politics to provincial and local levels. Decentralization also magnifies the importance of additional political arenas: relations between the center and provincial governments, and between provinces and local governments.

National ministries typically lack detailed and timely information on state and local systems, nor do they have effective arrangements to monitor and evaluate reforms. Poor information and communication, patronage and politics, and misaligned incentives extend all the way to the individual schools, hospitals, and clinics where teachers', health workers', and administrators' actions ultimately determine the quality and efficiency of service. In short, education and health sector reforms confront monumental principal-agent challenges (Castaneda, Beeharry, and Griffin 1999).

Decentralization does, of course, permit provinces and cities to experiment with innovative policies. Our cases included a number of impressive sub-national initiatives, such as charter schools (and over-all improved administration) in Bogota, Colombia, or school autonomy and powerful community councils in the Brazilian state of Minas Gerais. In general, reformist provinces or cities were those with more wealth and human resources. The result was to widen the gaps between the performance of education and health systems in richer versus poorer regions.

To combat that trend, in several cases central governments developed new formulae for allocating central government funds among regions. These new formulae were fairly effective in both sectors in Brazil, and in Colombia's health sector. However, the rules governing the flow of central revenues to subnational governments vary among countries. Those rules determine the degree to which national governments can try to bolster the resources of poorer regions, and use central funds to leverage reforms at the provincial and local levels. In Brazil, federal funds for education and health are largely channeled to provincial and local governments through the national education and health ministries. In Argentina, in contrast, provinces receive block grants. Argentine national ministries have virtually no financial leverage over provincial policies and programs, except through special programs funded with supplementary federal funds or foreign assistance.

Assuring as smooth as possible a launch. Minimizing confusion, uncertainty, and delays (in communication, financial flows, etc.) in the early days of a reform are mainly technical and administrative tasks, but they have extremely important political implications. Enemies of reform are poised to pounce on any problems as evidence that the reforms are wrong-headed and unworkable. Media are always ready to spread bad news. Much of the public and most of the administrators and service delivery workers, if not outright opposed, are skeptical about the reforms. Rough beginnings will harden opposition. Conversely, a relatively smooth launch, preceded and accompanied by on-going community and interest-group briefings, can create an atmosphere where at least some initial problems are accepted as temporary, and opponents begin to view change as inevitable. Damage control (perhaps in part through roving help teams) and public relations must be priority concerns in early stages of implementation, for political as much as administrative reasons.

Generating early winners is another tactic to protect vulnerable new reform efforts. Colombia's health reforms provide a particularly clear example. After the reform law was passed in 1993, the reformers had only eight months before a new (and probably hostile) government was to take office. They concentrated on rapidly drawing up detailed guidelines for creation of new health services purchasing organizations and the registration of low-income citizens to become eligible for basic health insurance. By the end of the Gaviria government's term, several hundred purchasing organizations had been created and almost a million Colombians enrolled in the new system. These new stakeholders barred reversal of the reforms, though many obstacles to other aspects of the new design still had to be addressed.

Reversal or consolidation

The history of education and health sector initiatives is littered with abandoned or discredited initiatives. Even reforms widely regarded as successful can be partially reversed. In Minas Gerais, Brazil, in 2000 a new governor dismantled key aspects of education sector reforms that had been in place for eight years and were recognized both in Brazil and internationally as quite promising. Similar changes seem to be under way in the city of Bogota, Colombia in 2004. New political leaders and governments often are eager to discredit their predecessors' programs and launch their own initiatives. Where education and health systems are decentralized, they may be particularly attractive targets, because they account for a large share of governors' and mayors' portfolios.

Nevertheless, quite a few reform attempts in Latin America have been fairly successful in overcoming political obstacles and achieving their objectives. Among the list are Costa Rica's EBAIS health teams, Peru's two primary health care programs, and Nicaragua's and El Salvador's autonomous school programs. Others, like Colombia's radical restructuring of the health sector and Brazil's altered systems of financial incentives for state and local education and health programs, have changed their sectors' basic paradigms; they continue to evolve while drawing both criticism and praise.

Indeed, social sectors are and should be constantly evolving. Reform efforts are ongoing; reforms do not and cannot "fix the system" and remove the need for further change. What does it mean, then, to describe a reform as "consolidated?" A working definition might be that an initiative is consolidated when it is accepted and valued by many stakeholders and parts of the public, and efforts to reverse it would be politically difficult. Stated slightly more precisely, a measure may be viewed as consolidated when the political costs of reversal are higher than the gains of reversal. A consolidated reform is likely to persist until broader demographic, technological, or other trends make the arrangement no longer appropriate to sector and national needs and resources, prompting a new cycle of debate, conflict, and experimentation.

Before reaching that point, most major health or education reforms are likely to go through several cycles of “reforming the reform.” This is almost inevitable: the sectors themselves are complex; specialists disagree on the best designs for improving performance; political obstacles are formidable; and changes in the broader political and economic context make today’s innovative solutions become tomorrow’s liabilities. A realistic goal is cumulative understanding, based on improved data and analysis, which can support growing areas of agreement among specialists and the public. That consensus is the basis for consolidation of reform.

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Annex I

Crucial Needs, Weak Incentives: The Politics of Health and Education Reforms in Latin America (Johns Hopkins University Press, forthcoming September 2004)

1. Introduction : The Political Challenges of Social Service Reform
Robert R. Kaufman and Joan M. Nelson

Part One. The Politics of Health Sector Reforms

2. The Politics of Health Sector Reforms: Cross-National Comparisons
Joan M. Nelson
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