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Social Sector Reform in Latin America and the Role of Unions

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Abstract[*]

This paper analyzes the reaction of teachers' and doctors' unions to a series of social sector reforms in the region, including administrative decentralization, provider payment mechanisms, and the introduction of performance evaluation and private provision. It combines the literature of economics and political science to understand the conditions that shape different patterns of union behavior and their effect on policy implementation. The paper suggests that the main conditions influencing union behavior in the health sector are related to the structure of the market (size and level of competition) due to the predominance of the private-public mix in its employment. In education, where the public sector is the main employer, political alignments and the organizational features of teachers' associations also play an important role in explaining the behavior of providers' organizations. Considering the exogenous character of most of these variables, the paper concludes by making some policy suggestions to align the objectives of unions and policymakers through regulatory reforms.

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Introduction

During the 1990s, Latin America experienced a vast array of social sector reforms in an attempt to improve coverage and service quality. Many analysts assumed the resistance of social service providers as part of the entrenched interests that would be affected by reforms (Inter-American Development Bank, 1996). This paper, instead, tries to illuminate the variables affecting the different interactions between providers' organizations and reforming governments. It argues that the key variable for understanding this interaction in the health sector is market structure. In the case of education, political alignments and the organization of providers also played an important role. Because these variables are exogenous for policymakers, our policy suggestions are based on regulatory decisions that can shape the interaction observed as well as markets in health care and education. The paper is divided into four sections. The first section introduces the context of social sector reforms and the characteristics of providers' organizations. The second section presents our theoretical framework. The third section uses this theoretical framework to illuminate a set of empirical experiences in both sectors, and the last section summarizes our findings and proposes some policy suggestions.

1 Historical Background and Organizational Context

During the approximately forty-year period from the end of the Second World War until the 1980s the world gross national product tripled. The global recession, the rise in real interest rates and the declining terms of trade for the exports of debtor economies produced a global debt crisis and a severe threat to the integrity of the international financial system in the 1980s (Gilpin, 1987). Latin America, as a region, was hard-hit by the debt crisis and the recession of the "lost" decade. In particular, the public debt contributed to fiscal crises that undermined the basic functions of the state. Like other developing countries, and under the supervision of multilateral organizations, Latin American countries carried out structural adjustment packages mandating severe cuts in government spending to balance budgets, eliminating trade barriers and social subsidies, tightening monetary policies, devaluing currencies, and dismantling barriers to foreign investment.

Although these policies were relatively successful at the macroeconomic level (i.e., reduced price instability, opening of the economy to more competitive products, and limited

fiscal deficits), they could not cope with the crisis of the public sector. In particular, the state was unable to provide a safety net to compensate for the cost of adjustment among different income groups and its provision of social services deteriorated. In addition to the public sector crisis, the region suffered chronic problems with inequality, and many analysts argue that expenditures in health and education services were slower to improve the social welfare of large sections of the population than in other regions of the world (Mahon, 1992; McGuire 1995), while others considered these services to be of low quality (Inter-American Development Bank, 1996). As a result, since the beginning of the 1990s, Latin American countries, like many other developing nations, found themselves involved in a second round of structural reforms, this time related to the reorganization of their social sectors, especially health care and education.

These reforms sought to expand the coverage of social services while assuring the sustainability of their provision. Toward this end, many Latin American countries started decentralization programs, and demand-driven social sector financing schemes, where cost recovery aspects were often included. The reforms sought to modify the incentives of social sector providers assuming that the traditional payment structure did not trigger the allocation of scarce resources in a cost-effective manner. Therefore, they tried to change remuneration methods based on fixed wages for health and education workers and historic budgets for schools and hospitals by performance-based payment models, such as capitation and per-case payments in the case of health care, and vouchers or other performance-based payment methods in education. In the case of capitation, a defined payment is associated with the provision of a basket of health care services to a patient or group of patients. It promotes cost containment and, under certain conditions, preventive care and good quality standards. In the case of inpatient care, health interventions can be paid according to a per case mode, where each participant health care procedure within a health intervention is priced, with the additional goal of promoting cost containment. In all cases, reforms involving payment methods look for reducing information asymmetries unfavorable to consumers and payers, and they may enforce the role of demand in the allocation of resources (i.e., managed care in health, vouchers in education).[1]

The technical justification for these reforms is based on three postulates. First, the separation of financing and provision of services creates cross controls in the management of

[1] Cost reduction plus competition among providers contributes to keep good quality standards in the provision of services at the same time that it allows a better allocation of resources. This, from the social perspective, improves cost-effectiveness in the use of funds.

funds because the concentration of resources and social services infrastructure under the same authority reduces the probability of effective monitoring of performance. In the cases of mixed supply of social services (public and private facilities), the separation of functions potentially allows a more effective use of the available physical and human capacities, by allowing public financiers to subcontract private services in locations where public facilities do not exist, and vice versa. Second, decentralization creates incentives to align the allocation of resources with population needs. The reasons are that the lack of interaction between the decision-maker and the target population can reduce the effectiveness of any policy intervention, in terms of the identification of the needs, selection of target groups, and timing of intervention by centralized bureaucratic structures. Hence, the reforms would increase the "voice" of consumers by enhancing their participation in the organization of services to make them more responsive. Finally, these reforms would enlarge the "exit" options of consumers by allowing competition among alternative suppliers of social services.[2]

In the context of fiscal crises experienced in the region, the decline in the delivery of services can galvanize public opinion, pushing them to demand policy changes while increasing the distrust of providers who fear that these reforms aim at cutting expenditures rather than improving quality. Hence, fiscal crises can serve as an incentive for reforms because they constrain resources and often affect the delivery of services while highlighting the cost inefficiencies in their provision.[3] However, fiscal crises also increase the distrust of providers whose real incomes are declining and makes equity and efficiency reforms more difficult to accomplish. Even with financial assistance from multilateral organizations to pay for the transitional costs of reforms, only an adequate fiscal reform can make a credible commitment of linking institutional innovations and income improvement for providers. Hence, fiscal deficits have a double effect. On the one hand, they create incentives for policymakers to make reforms that are cost-effective. On the other hand, they increase providers' fear that reforms are merely a cost-cutting mechanism that would reduce their income.

In a context of fiscal constraint, providers fear the effect of reforms on their income and work conditions as well as on issues associated with labor stability, tenure and promotion. Due to

[2] Hirschman (1970) analyzes the alternative uses of "exit" through the market and "voice" through the political system for the improvement of publicly provided services.

[3] Bates (1984) and Weyland (1998) analyze the effect of fiscal crisis in generating incentives for reform among politicians in the developing world.

the labor-intensive character of many education and health services, the cooperation of providers is key in improving their performance. Hence, the organizations of providers, which represent the participating labor force in the provision of health and education services in the public sector, are key actors for the political economy of reforms. To understand the challenges created for these actors and their reactions, it is necessary to start with a brief description of their characteristics.

1.1 Social Service Providers as Public Sector Unions

Most services in education and a significant proportion of health care services are provided by the public sector. Therefore, the organizations of health and education providers share the characteristics of public sector unions in addition to the features peculiar to their specific sectors. The public sector is different from the private sector in that its labor relations are usually more politicized and influenced by legal developments because the employer is the state (Freeman, 1986).

In this context, two conditions have driven public sector unions in the region towards political rather than industrial strategies. First, most countries in the region have limitations on collective bargaining and on the right to strike in the public sector despite International Labour Organization Resolution No. 151.[4] Second, the public sector in most countries of the region has suffered from the politicization of appointments, even in professional services like those analyzed in this paper. The discretion of the government in controlling human resources along with the political volatility of the region contributed to this politicization. As a result of both factors, most countries of the region implemented by law rule-bound measures defining work conditions, promotions, and remuneration for social service workers in the public sector. For the most part, these statutes included job stability to avoid the risk of political discretion and to promote professional criteria.[5] Because these rules are defined by the Congress or the

[4] Limitations on collective bargaining in the public sector have resulted in the regulation of labor relations by legislation in the form of statutes and restrictions on legal strike activity, which usually includes rules regarding dismissal, payment of lost days, and replacement of employees. The absence of collective bargaining contracts and their replacement by legislation moves the two-party negotiation to a more complex interaction including legislators and the executive power in addition to management and employees. Historically, providers' organizations have claimed the right to bargain collectively rather than depend on the regulatory decisions of executives or legislatures for their labor relations.

[5] Furthermore, the combination of these politicization of labor strategies and the job stability of public employees created ideal conditions for the development of relatively strong union leaders who usually remain in office longer than the policymakers in these areas.

administration, the consequence of this process is the politicization of labor unions that need to lobby governments and legislatures rather than engage in collective bargaining with management. Finally, the dependence of the general public on their services makes the protests of public service unions more visible and more sensitive for politicians, who may have a say in their labor relations through Congress, thus contributing to the use of political strategies by public service providers

The political strategies of public sector unions are further enhanced by other contextual conditions that further increase their propensity to strike. First, the relatively high unionization rates of the public sector in Latin America, either in the form of labor unions or professional associations (when legal limitations forbid the former) facilitates the organization of collective action, as argued by Franzosi (1995). Second, public sector employees are usually in the formal sector and in non-tradable services. In combination with job stability clauses, these two conditions reduce their exposure to competitive pressures (both domestic and international) and make them more resilient to the moderating effect of unemployment on wage militancy.[6]

Finally, the particular regulation of the public sector usually resulted in the organization of unions separately from private sector workers, whereas the centralization of social services concentrated the allocation of resources and induced the centralization of labor organization only at the sector level, which according to Calmfors and Driffil (1988) provokes more labor militancy than if workers are organized at the national level or company level. Thus, these organizational features avoid the tempering effect on militancy of encompassing labor organizations, which are more able to arrange national corporatist arrangements to generate labor support for institutional changes.[7] Thus, the organizational insulation of public sector workers and the centralized nature of these organizations increased their incentives for high militancy and resistance to change. These contextual characteristics make the resistance of public sector providers to reforms that are perceived as costly for them more visible and effective than in the private sector.

[6] Garrett and Way (1995) found higher militancy in the public sector than in the private sector across a sample of OECD countries.

[7] See Cameron (1984), Haggard and Kaufman (1992), Przeworski (1991), Calmfors and Driffil (1988) on the effect of encompassing labor organizations. Garrett (1998) argues that encompassing organizations including both private and public sector workers care more about the general welfare of society.

1.2 Providers, Organizations and Social Sector Reforms

Considering the aforementioned characteristics of providers organizations, in order to understand labor-government interactions it is important to focus on perceptions of the distributive costs of social sector reforms and the incentives of different actors in terms of their agency and their interaction with policymakers.[8] That is, it is necessary to analyze the policy preferences and political incentives of policymakers and social actors regarding institutional innovation as well as other contextual factors that impact on their preferences. In particular, we study the interaction of reforming governments with the organizations of professional providers of health and education (i.e., teachers and doctors).

Due to the uncertainty created by institutional innovation, labor unions' perceptions of the distributive costs of these institutional reforms are key in understanding their reactions. Labor unions feel threatened by reforms that reduce their control over promotion and income, and in some cases, affect their bargaining power by forcing their decentralization. Providers face challenges such as losing monopolies to new competitors and the introduction of performance measures threatening their real incomes. Consumers may face transitional costs and uncertainty about the outcome, but they would receive better service if the reforms are effective. In contrast, the short-term cost of transition is concentrated on providers, who are usually better organized than consumers.

Providers' organizations have two types of concerns regarding these reforms. First, they represent the claims and fears of their constituencies. Union leaders seek to increase their affiliates' market power, employment and income because their success in these tasks influences the ability of union leaders to remain as workers' agents, thus keeping their political power. Second, their organizations face higher transition costs than individuals because they have developed patterns of action that are hard to change. Hence, the transition costs of providers' association involve the adaptation of both organizational and individual practices.

Social sector reforms are generally part of the re-organization of public finances, which is seen by union leaders—and generally also by society—as a way of relinquishing responsibility in social sectors and a source of layoffs or declining real incomes. Therefore, and besides unions' eventual acknowledgement of the need for social sector reforms, they perceive a conflict of

[8] On the distributive consequence of institutions and their impact on the redefinition of the political interest, there is a large literature inaugurated by Bates (1984), Hall (1986), Moe (1990), and Knight (1992).

interest between their affiliates' goals, the society's and their own. This conflict of interest permeates their perception of different reforms, such as decentralization, private sector involvement, or changes in payment structures.

First, labor unions tend to perceive decentralization as a source of power dilution that weakens their bargaining power by hindering their capacity to organize national strategies. It also reduces solidarity among unions in supporting specific protests, which become local, geographically focused phenomena. Second, they perceive changes in payment mechanisms, such as those associated with performance as a way to increase competition among their members, hindering internal solidarity while increasing the probability of lay-offs and uncertainty about their income.[9] Third, they perceive private involvement providing alternative sources of supply to the public sector as a challenge that dramatically changes work conditions and bargaining capacity. The differences between these two sectors are usually larger than diversity in skills, due to the particular characteristics of the public sector. They also conceive of private involvement as resulting from the abandonment by the state of its social responsibilities. This last perception is tied to their ideology of expanding the social responsibilities of the state as guarantees of social rights.

In sum, social sectors reforms are seen by unions as a source of conflict because they increase the probability of unemployment, declining income, and higher level of control over their affiliates while threatening their political sustainability and forcing organizational adaptation. These effects are particularly relevant in a context of internal economic turmoil and globalization where unions' power and strategies are under revision. The following section focuses on the conditions influencing their resistance or acceptance of reforms, which are related to their interaction with policymakers and to the context of such interaction.

2 Theoretical Framework: Market Structure and Political Markets

To analyze the interaction between providers' organizations and policymakers, we use a theoretical framework including three main elements: (i) the structure of the market affecting the preferences, incentives, and bargaining power of governments and providers' organizations; (ii) the political alignments affecting particular public sector markets; and (iii) the organizational

structure of unions delimiting their representation and thus, the impact of reforms on their constituencies as well as their bargaining power vis-à-vis a single employer or multiple employers. This section presents the theoretical arguments for using these variables, which are applied to empirical cases in the following section.

2.1 Market Structure

Reforms in health care and education are applied to markets already established, with their own organization, rules and relative power of the actors involved, among them government and unions. The basic characteristics of those original setups, as well as the distribution of interests and power, affect the impact of the reform, at the same time that they are influenced by it. Therefore, similar policies may have different consequences, depending on the alternative roles played in the market where they are applied.

Incentive mechanisms—like any provider payment mechanism or redistribution of roles, such as decentralization, performance evaluations or private participation—are contracts among several players. However, these contracts are not isolated; they are applied to contexts with different characteristics, alternative sets of institutional rules and resource endowments, and specific union and government reputations. Therefore, different contract structures may impact differently on various health and education markets. Likewise, a different market context may alter the effectiveness of a reform and the success of different actors' strategies. Changes in incentives have a special impact on social sector reforms because unions and governments, as the main actors, are themselves agents of workers and voters, respectively, who are the principals of the reform. Therefore, in order to understand the impact of a certain reform it is relevant to study not only the goals of the average citizen, but also the objectives of his/her representatives.[10]

Therefore, payment mechanisms or any kind of incentives are just one important component of health and education systems. They, along with other basic conditions (e.g.,

[9] Performance based payments do not assure a fixed salary, but create competition among workers to distribute a defined budget. Comparative performance may lead to differences in remuneration for similar tasks, alternative promotion procedures and changes in hiring and firing policies.

[10] The economic literature refers to these types of delegation schemes as agency theory. Agency theory considers the relationship between two actors (principal and agent) where the former delegates on the latter the performance of a task or service. As the goals of both actors do not match necessarily, and given imperfect chances of monitoring the agent's actions, there is room for opportunistic behavior. The topic of opportunistic behavior and contract theory has been vastly developed by the economic literature. Introductory concepts and discussion can be found in Williamson (1975, 1985). For a technical development see Hart and Holmstrom (1987), Hart (1995), Laffont (1990) and Sappington (1991), among others.

infrastructure, health and income patterns, urban concentration) redefine the incentives for providers. Not only unions, but also hospitals and physicians, and schools and teachers, react to the new payment mechanisms in different ways, reshaping the structure of markets in education and health, and affecting their development. The incentives, in turn, modify players' strategies and performances in terms of quantity and quality of learning and patient care and length of stay, among other social sector outputs.

This view is the *structure-conduct-performance* paradigm, supported by the traditional industrial organization perspective,[11] which has been used as a referential framework to study market behavior and changes in incentive mechanisms in a broad sense.[12] According to this approach, *market structure* (i.e., number of providers and their market shares, degree of product differentiation and subcontracting, characteristics of the private sector) determines firm *conduct* (price-setting strategies, investments in capital and research and development, advertising methods), which in turn affects market *performance* (efficiency, cost-effectiveness, profits, equity). Basic conditions, such as socio-economic and epidemiological patterns, human and geographical location of factors, simultaneously influence market structure and supplier conduct. However, it is known that the influences between one element and the others are not always unidirectional: performance feeds back into structure, and changes in conduct affect the basic conditions that link with the structure of the market. These aspects, together with the acknowledgment of each actor's goals, strategies, and expected outcomes are elements to take into account in designing, implementing and interpreting responses to social sectors.

We focus on the characteristics of the market influencing the preference and bargaining capacity of providers and their organizations with regards to social sector reforms. In particular, three characteristics have a strong effect on both preferences and bargaining power of providers: (i) the public-private mix in the provision of social services and employment, (ii) the degree of development of the market in terms of providers' capacities and coverage of insurance schemes, as well as in terms of the epidemiological and educational status of the society, and (iii) the size of the country.

[11] Sherer and Ross (1990).
[12] Maceira (1998).

2.2 Political Alignments

Because public sector markets are different from private markets, they are affected by political variables. The political character of labor unions and their longstanding role in the definition of open polities during authoritarian regimes has further reinforced their political identities. This political character affects their interaction with governments. That is, in addition to their agency role regarding workers, labor leaders also have political links and ideologies. These political identities serve as signals both in their interaction with governments and in their relationship with constituencies, in the cases of inter-union or intra-union competition explained below.

In public sector markets, political alignments affect both the context of the reform and the interaction between policymakers and unions. Political identities shape the policy preferences of governments[13] and, in combination with institutional variables, they influence the opportunities for reform, regardless of providers' attitudes. That is, if the same political party controls the presidency and congress (unified government) and there is partisan discipline in Congress, the government is more likely to pass its social reforms.[14] In contrast, a fragmented party system with no clear majority or lacking partisan discipline, or a setting where the government is divided between rival parties controlling different powers, which is not unlikely in a region characterized by presidential systems, makes reforming more difficult.[15]

Because governments have multiple goals and respond to a diversity of principals (e.g., voters, legislator, political party), which makes the evaluation of their objectives more difficult, political alignments also influence the interaction between decision-makers and labor unions. Governments have multiple goals in implementing social sector reforms (i.e., fiscal, equity, efficiency, political, participatory). For instance, both Di Gropello (1997: pp. 43-47) and Hanson (1997: p. 7) find several goals in the implementation of education decentralization in several Latin American countries, including anti-union goals in the political agenda. In this context, political alignments can serve as a cue for intentions because providers affiliated with the

[13] See Garrett (1998) and Boix (1998) for empirical tests of the effect of political identities on policy preferences in the OECD countries.

[14] See Geddes (1994) on the impact of partisan alignments on institutions and institutional change in Latin America. Corrales (1999) analyzes the effect of partisan links in the relationship between executive and legislative power in Latin America with regards to educational reform.

[15] Mainwaring and Scully (1995) provide a survey of the literature on party systems in Latin America whereas Mainwaring and Shugart (1999) and Shugart and Carey (1998) summarize the regional literature on presidentialism with an emphasis on policy impact.

reforming party are more likely to trust the absence of hidden government agendas in the reform process.

The commonality of interests created by shared political identities facilitates the cooperation of organized providers with reformers in the government. In Latin America, a regional convergence of policy preferences related to the dire economic and social conditions of the 1980s and the spread of the so-called "Washington consensus" seemed to reduce the effect of political alignments.[16] However, even in a context of policy convergence, political affiliation can generate confidence in unlikely policies that would be rejected if they were proposed by another political party due to longer horizons based on previous interactions that generate trust in the intentions of the government.[17] Instead, the absence of political alignments increases the distrust between both parties and makes consensus much more difficult to achieve.

Political alignments also facilitate negotiations because previously established loyalties provide longer horizons based on a long-term relationship that compensates the time inconsistencies of institutional bargaining.[18] Additionally, politically generated trust can be enhanced in the case of organized constituencies with fluid communication channels to the government, which could be used to persuade them of the need for reform.

Ideology as a signal can also help labor unions to establish alliances with other social sectors. These alliances can bring social pressure from the voters on the government. Because public opinion perception of social sector crisis creates incentives for reform among politicians and unions,[19] both sectors seek to win public favor for their own position, and they can use ideology to define common goals with other sectors of society. Therefore, and based again on principal-agent theory, ideology can be used as an instrument for aligning the goals of one agent and the principal (voters-consumers-workers-other social actors), strengthening the agent's bargaining power.

[16] On the regional convergence, see Torre (1998), Edwards (1995). On the worldwide effect of the "Washington Consensus," see Williamson (1994).
[17] For instance, Cukierman and Tommasi (1998) model the political advantages of left-wing parties in implementing right-wing policies based on the trust of their constituencies.
[18] The effect of partisan links between labor unions and government officials both for communication and trust are developed in Murillo (2000).
[19] Geddes (1994) argues that politicians will only commit to institutional reform if there is a social demand that creates electoral incentives for them.

2.1 Organizational Characteristics

Political alignments interact with organizational features as well. Even in the presence of partisan allegiances, the existence of inter-union competition and intra-union leadership competition also affects the relationship with the reforming policymakers.[20]

Cooperation with political allies can be enforced if the organization is centralized. On the other hand, it would be difficult to achieve cooperation if the providers include multiple competing organizations that cannot coordinate their actions. The organizational fragmentation provoked by inter-union competition weakens their capacity to exercise policy input. Fragmentation into a multiplicity of unions makes the coordination of their collective action more difficult due to inter-union competition for members. As a result, competing unions are weaker and have problems establishing sustainable agreements in their bargaining with the government. In the case of negotiations, inter-union competition allows the government to choose allies in the negotiation process among the competing unions and to benefit a particular set of providers at the expense of others whose resistance becomes more ineffectual. More likely, though, coordination problems make bargaining more difficult, leading to resistance as a more probable outcome. The different demands of each organization and the temptation to present diverse strategies to differentiate each organization and attract followers make any consensus harder to achieve. Hence, inter-union competition makes coordination of collective action among the rival organizations more difficult, and especially if it coincides with partisan or ideological differences that broaden the breach among them. Thus, it reduces the bargaining power of providers' organizations and makes consensus more difficult to achieve.

Intra-union competition for leadership also affects the interaction between providers and governments. In a context of high uncertainty about the outcome of reforms, where providers feel threatened by the new policies, the status quo bias provokes contenders for leadership to be more militant than incumbents, in particular if the contenders have no political links with the government. Ideological differences often exacerbate intra-union competition for leadership. For that reason, a context of intra-union competition for leadership often makes even cooperative union leaders more militant because they are afraid of being replaced by anti-reform contenders. In this case, the internal politics of the union becomes enmeshed with the union-government interaction and makes it more difficult to achieve consensus regarding institutional changes.

Finally, the organizational structure of the union shapes the impact of different reforms. That is, the degree of centralization of a union affects its capacity to adapt to new decentralized environments due to its differential impact on the internal balance of power between national and subnational organizations or parts within a single federative union. National agreements by centralized and monopolistic unions are easier to obtain, as pointed out by the corporatist literature. In particular, monopolistic unions are shielded from the debilitating effect of inter-union competition. Centralized organizations, however, feel more threatened by reforms that reallocate the power of decision-making to smaller units and increase heterogeneity among their large constituencies. The former hinders their central authority and the latter makes collective action and solidarity more difficult for their organizations to achieve.

To sum up, based on the theoretical arguments presented here we develop a set of expectations regarding the interaction between providers' organizations and policymakers. Hence, in a comparative context of reform, the outcome of the government-union interaction may differ based on different political conditions related both to the context and the interaction itself, with independent effects. The expectations derived from the hypothesized effects of the variables are the following:

a) Effects derived from the *structure of the market*:

1) Teachers' unions should be more active in facing reforms than physicians' associations, because education services are relatively more concentrated in the public sector than health care services, and also because physicians, as workers in a highly mixed (public-private) system have a more diversified wage structure and are therefore less constrained by public reforms;

2) Relatively more developed markets in terms of organization of providers, hospitals, schools and insurance schemes, should have a higher level of risk transfer to social sector workers, reducing their abilities to response to social reforms;[21]

3) Smaller countries should have relatively greater negotiating power than larger countries in imposing social sector reforms because of power concentration. Additionally, in large federal countries the number of veto points, and potential allies for providers resisting reforms also grows further, thus reducing the power of reforming governments (Tsebelis, 1990).

[20] See Murillo (2000) for a more extensive discussion on the effects of inter-union and intra-union competition.
[21] For an analysis of market structure and risk transfer in health care, see Maceira and Poblete (2000).

b) Effects derived from *political alignments* and institutional context:

1) Unified governments and partisan discipline in Congress should facilitate the implementation of social sector reforms by reducing the number of potential conflicts to be confronted by the government;

2) Political alignments between public sector unions and the government should facilitate bargaining and cooperation between both parties by increasing the trust of unions and providing formal channels of communication.

c) Effects derived from the *organizational characteristics* of provider organizations:

1) Centralized unions should facilitate bargaining between providers and the government and strengthen their bargaining power to participate in the reform. However, centralized unions are more likely to resist administrative decentralization for its effect on their internal distribution of power;

2) Inter-union competition should make bargaining more difficult and more likely to be broken by militancy while weakening the bargaining power of unions;

3) Intra-union competition should mitigate the effect of political alignments by increasing the incentives for differentiation among union leaders, thereby making cooperation more difficult and militancy more likely.

The next section illustrates how these variables affect the distribution of costs of social sector reform and union reactions to them, using empirical evidence from the reform experiences of a variety of Latin American countries.

3 Empirical Cases of Providers' Reactions to Social Sector Reforms

3.1. Decentralization

The centralization of social services has promoted concentration in the allocation of resources and the creation of bilateral monopolies for collective bargaining. In addition, centralization generally reduces the chances of monitoring social sectors' performance by increasing bureaucratic layers between principal and agents.[22] As a result, administrative decentralization

[22] Hausmann (1995).

would imply a territorial reallocation of resources and power within the bureaucracy in charge of service provision, as well as the opportunity to develop monitoring channels.

According to the framework developed in the prior section, it is expected that decentralization will be easier to implement, despite unions' resistance, in more developed markets, where public authorities have relatively higher bargaining power. This resistance from unions/associations will be supported by the fact that decentralization can be seen as a transfer of financial risks from the central government to weaker local authorities, which in turn will affect wages and job stability. In addition, and also based on the "market structure" hypotheses introduced above, resistance to decentralization would be stronger among teachers than among physicians. The reason is associated with teachers' higher dependence on public wages, in contrast to more diversified sources of income in health care markets.

"Organizational variables" would also be important in explaining unions' behavior under a decentralization policy, because territorial reallocation of resources tends to fragment centralized organizations, weakening their bargaining power and the authority of national leadership. Therefore, centralized unions are likely to resist decentralization for fear of losing bargaining power by virtue of the dispersion of decision making to the local level. In contrast, local unions/associations are more likely to support a decentralization process that increases their internal influence and discretion over the definition of work rules and income, except in cases where decentralization is associated with a decline in their membership's real income. However, "political alignments" can permeate the union-government interaction regardless of the effect of reforms on providers' organizations because union leaders interact in a political setting and decentralization shifts the context of interaction with employers that are politically defined at different levels of government.

According to the experiences observed, most teachers' organizations perceived administrative decentralization as a cost-cutting mechanism used to transfer financial responsibility from the national government to the provincial level, thus affecting the income of their constituencies.[23] However, because education is mainly in the public sector, political alignments were more important in defining the reaction of the union than what organizational variables would have predicted. Physicians' organizations, by contrast, showed relatively lower

[23] This situation was particularly marked in the cases of Argentina and Chile, where a study of educational decentralization confirms teachers' fears about government goals (Di Gropello 1997).

resistance to decentralization, as well as a reduced degree of power concentration, especially in more developed countries, with federal structures and/or more diversified health care systems in terms of their public-private mix in the financing of services. The cases observed also suggest that countries with less sophisticated health insurance structures are more active in opposing decentralization, as is seen in Central American nations.

An example of political alignment and union centralization in a relatively big educational market is Argentina. The decentralized nature of the largest teacher union, CTERA (Teachers' Confederation of the Argentine Republic), a confederation of provincial unions, reduced the impact of the 1992 reform on its internal structure. In contrast, those unions restricted to teachers at the national level risked their membership due to the transfer of teachers to the provinces. However, political alignments played a key role in explaining the public opposition of CTERA to the transfer of teachers to the provinces without financial guarantees for their salaries. CTERA, rather than the centralized teachers' unions, led the resistance to decentralization due to its lack of political alignment with the national government. Indeed, due to their political opposition to the government, CTERA's union leaders founded a new peak labor confederation with other opposition unions. However, inter-union competition between CTERA and the other teachers' unions hindered negotiations. As a result, the union had little input in defining the new policy.

Political alignment in combination with organizational monopoly also played a key role in Mexico and Colombia. The Mexican SNTE (National Union of Education Workers) and the FECODE (Colombian Federation of Teachers) were centralized unions that opposed administrative decentralization. In both cases, the political alignment of the unions favored negotiations, and both organizations established participatory mechanisms for the discussion of educational reform. As a result, both organizations took advantage of their monopolistic position and cooperated with inputs into the final design of the reforms. In Colombia, FECODE successfully pressed legislators to include some financial concessions in the legal transfer of resources to the subnational levels, whereas the Mexican SNTE received guarantees on the allocation of resources for teachers' salaries at the subnational level. Additional concessions involved salary hikes and subsidies for teachers. In both cases, concessions were only achieved after teachers' protests that were in part originated by intra-union competition. In these cases,

intra-union competition made policymakers more willing to bargain with moderate leaders politically aligned with them.

Decentralization in health care was widespread throughout the region, with relatively lower resistance from physicians' chambers as compared to teachers' organizations. In several cases, physician professional associations participated in the discussions of the reform (i.e., Chile, Bolivia, Dominican Republic, Nicaragua), although their impact was relatively weaker than that of teachers. The information collected supports the "market structure" hypothesis that associates the involvement of doctors' chambers and teachers' unions with their relative diversification in sources of income. In the case of health care services, the provision is much more fragmented than in education, where the core services are in the public sector. Also, within health care markets, relatively poor countries account for much simpler financing schemes, especially because of the lack of insurance plans and payment mechanisms associated with performance. Health care in Latin America is spread among public, social security and private services, and physicians, the main actors in the provision of care, generally hold posts in more than one sector at the same time. Under this framework, physicians belong to public health centers for academic or curricula reasons rather than for income motives. In Latin American health care services, the private sector is doctors' main source of income, and private care constitutes a significant share of total expenditures on health. Public facilities provide physicians with a basic wage and the chance to organize a clientele and a peer group of professionals. Therefore, they have few incentives to participate in negotiations related to public health decentralization.

In addition, health care workers are not unified in their demands, and two different groups can be identified: one representing the physicians, and the other representing the rest of health care personnel. The first is organized in professional associations, with goals and social characteristics differentiated from the second group. Physicians' viewpoints are more related to the organization of the "model of health care provision," and their interventions are associated with the design of a basic package of services rather than issues such as wages or employment levels. The second group of workers is much weaker, especially because there are no strategic alliances between them and physicians' organizations. In the Latin American experience, the coordination between both groups is not effective and, with the exception of Uruguay and some

municipalities in Argentina, where the physicians are organized as a trade union, doctors do not have strong participation in reforms related to decentralization.

However, a comparative analysis of decentralization processes in health care services in Latin America shows that decentralization has proven to be extremely difficult to implement, but for reasons other than the resistance of providers' organization, such as the shortage of managerial abilities at the local level to carry out the reforms. Indeed, in many cases, decentralization is restricted to deconcentration, where the status of the health care personnel is not fully affected. In the cases where decentralization was more deeply implemented, it was associated either with a longer tradition in federal government, as in the cases of Argentina or Brazil, or with strong participation by multilateral institutions, not always coordinated, as in the cases of Bolivia and the Dominican Republic.

In short, the evidence collected suggests that the variables presented in the prior section related to market structure, political alignment and unions' internal organization are useful in explaining unions' and physician groups' reaction to decentralization. However, the influence of each of them differs. First, the importance of the public sector as the main employer and the principal source of income triggered higher participation by teachers than physicians. In addition, the higher the public-private mix in the financing and provision of services, the lower is the effect on providers and the incentive to organize collective action in that regard. This behavior is seen within the health care sector, when countries with more developed health insurance plans are compared with smaller, more fee-for-service oriented private health systems**.** Although these conclusions can be expanded to other types of reforms, the regional experience in decentralization, especially in health, has proven to be more associated with an administrative deconcentration of roles rather than a redefinition of financial sources, which might affect the participation of unions.

In addition, if the state is the main employer, the effect of these reforms on providers is stronger and the impact of political alignments on a public sector market increases. Hence, political alignments explain the reaction of teachers' unions to this reform although their organizational structure, and to a certain extent intra-union competition, affected their bargaining power. On the other hand, physicians' organizations, which are less associated with the public sector, do not generally have strong political alignments to the government.

3.2. Provider Payment Mechanisms

The previous politicization of appointment decisions in the public sector and the limits to collective bargaining in many countries of the region brought labor unions to seek rule-bound measures for insulating their income and employment from the variation of demand and political context. Yet, these rules, such as seniority, are contradictory with rewards to performance included through new provider payment mechanisms. Hence, new payment mechanisms are perceived as increasing the management discretion at the expense of rules that protect members with the longest commitment.[24]

Provider organizations that support rule-bound income and employment for all their members resist new payment mechanisms increasing management discretion. They are afraid of the difficulty in controlling discretion that might be used to implement hidden agendas hurting their affiliates. Additionally, they fear that by increasing the heterogeneity of their membership and introducing competition among employees for non-fixed income, new payment mechanisms would affect aggregation and collective action.

In health care reforms, changes proposed in provider payment mechanisms provoke two different types of reactions. These different reactions are related to the characteristics of the contracts and incentives proposed by the reform and the private sector involvement in the provision of care, which is directly associated to the "market structure" hypotheses presented in Section 2.

The first and more characteristic reaction to the reform comes from physicians working in public hospitals and health care centers, who are opposed to the reform. The perception is that changes in payment mechanisms (e.g., switching from fixed wages to salaries associated with performance) are related to cost-reduction reforms and threaten the norm of guaranteed stability for public workers. Additionally, changes in payment mechanisms involve not only remuneration methods but also a redefinition in the allocation of resources, as well as in the structure of management and monitoring of results within the health center.

This fact constitutes the main difference between a decentralization process and a change in payment schemes. Decentralization is associated with a jurisdictional issue and involves negotiations between the national government on one side, and the local authority (state,

municipal) on the other. In this case, health care providers are witnesses of a reallocation of funds and responsibilities among jurisdictions. In contrast, a modification of the payment mechanism alters the relation between the financier of the service and the provider. It involves not only health care personnel, but also the allocation of resources to public facilities, which implies a political decision on how to provide health care services and has a stronger effect on health care providers.

These changes in payment mechanism were difficult to implement, however, even in those cases where health care reforms were ambitious and widespread. In the case of Colombia, where the reform has had a strong demand-driven orientation, payment mechanisms in public hospitals remain mainly based on historical budgets and fixed wages, in spite of efforts to implement a social insurance scheme based on demand-side incentives. Chile, an important regional example of public health reform, has undertaken a sequential expense-registration strategy to change payments from fixed wages and budgets to incentive-driven wages. However, this policy has not yet been fully implemented and is currently under revision. In other cases, where decentralization/deconcentration type reforms are under implementation, payment mechanisms are still pending. In these cases, though, health centers rather than health care providers were the main obstacles to the effective implementation of the reform.

In all cases—not only within the facilities under the control of the ministry of health, but also those owned by the social security institutes—physician associations in Honduras, Dominican Republic, Chile, and Argentina, among other countries, participate in the discussion about health care reform, reinforcing their interest in improving the organization of the system. However, they are critical about the linkages between changes in payment structures and health care outputs for two main reasons: (a) the correlation between poor health results and shortage of financial resources, and (b) the perception that changes in payment mechanisms associated with performance are linked to losing their stability as public workers and/or the decline of their income.

The second type of reaction associated with changes in payment mechanisms occurs where public or social security financiers switch payments from fee-for-service to capitation or per case modes. Providers in this case are mainly private, and the reactions of physicians are

[24] Such rules also reduced the opportunity of managers to politicize the use of discretion in discriminating against providers who are unionized or have a different political ideology. Golden (1998) shows the use of seniority rules to avoid the targeting of unionized workers while downsizing in the private sector.

associated with their relative market power, not only in relation to financiers but also in terms of hospitals' bargaining abilities. The higher the level of development (in terms of size and product differentiation) in health care markets, the higher the relative power of health care providers (hospitals and clinics) over physicians. Therefore, changes in payment mechanisms toward capitation contribute not only to transfer financial risks from the payers to the providers, but may also constitute a shift of risks one step down in the provision of care. Hence, the more developed and diversified the market, the lower the power of physicians' associations and the higher the probability of risk transfers. In contrast, the less developed health care markets (e.g., in rural areas) or the more specific the medical technique involved (e.g., anesthesiology). the higher physicians' "market power." Therefore, changes in payment mechanisms are less frequent and the transfer of risks to doctors is lower in the latter cases.

In those countries in the region where the development of health maintenance organizations, generally associated with economic development, is relatively high, doctors' bargaining power is lower. Social security systems in Argentina (PAMI, provincial social security institutes) were able to shift towards capitation payment schemes transferring risks to doctors. However, the development of health markets also explains variations within Argentina. In the province of Mendoza, for example, changes in payment mechanisms and risk transfer from hospitals to physicians were higher in the city capital than in smaller urban centers, such as San Rafael or San Martin, where the *Círculos Médicos* (the association of doctors) still maintain higher bargaining power relative to the Association of Hospitals and were able to resist the changes. The same situation is found in Uruguay, where doctors' market power is stronger outside of Montevideo. In 1997 doctors attempted to block, through strikes and other means, a proposed reallocation of physicians within Montevideo public facilities. However, the unions' political alignment with the *Frente Amplio* (Broad Front), which governed Montevideo, contributed to the acceptance of the reforms.

These experiences show a strong association between market structure and the participation of doctors' associations in health reforms based on changes in provider payments. The size of the market, as well as its level of development, shapes the bargaining power of each party, thus affecting the impact of the reform. However, political variables associated with unions' internal organization and political alignment do not have a strong influence on the reform process. As discussed above, the bias in favor of market variables instead of political

variables might be related to the structure of health care provision in Latin America, which is based on a mixed financing system, more exposed to market-intensive interactions.

The reactions of teachers' unions, however, follow a pattern similar to the one discussed in the section devoted to decentralization. In this case, a strong public presence defines unions' activities as associated mainly with political alignment and their internal organization with lower influence of market variables.

The Mexican SNTE supported the introduction of new payment mechanisms because it allowed teachers to increase their real income, which had been depressed by centralized wage bargaining with ceilings during the 1980s. The political alignment of the SNTE national leadership and the incumbent PRI facilitated the negotiation. At the same time, the previous decline of teachers' salaries and the financial guarantees assumed by the national government made this reform more palatable for the union.

In Chile, changes in payment mechanism were imposed by a non-democratic regime that did not allow teachers' resistance. However, from the democratic transition of 1990 to 1996, the *Colegio de Profesores, A.G.*[25] was controlled by leaders aligned politically with the incumbent governments of the Concertación (Socialists and Christian Democrats). As a result, it had a very fluid relationship with the Ministry of Education in the definition of institutional innovation, thus accepting the design of payment mechanisms. Political variables, though, started to play a role in 1996, when a leader affiliated with the Communist party gained control of the union. The organization became more militant, organizing general strikes in 1996 and 1998, and demanded participation in the mechanisms for teacher evaluation affecting the distribution of performance rewards. The monopolistic conditions of the teachers' association increased its bargaining power and brought about concessions, including changes in the system of teacher evaluation to include union input, the revision of temporary contracts, changes in criteria for evaluating teachers, and a law to cover costs of teacher training.

According to the experiences brought in this section, the comparison of workers' reactions in health and education follows a pattern similar to that displayed for decentralization. The higher the level of development of markets for social services, in terms of private participation and product differentiation, the lower the involvement and effectiveness of unions'

[25] The *Colegio de Profesores, A.G.* is the main association for teachers although it was a professional association rather than a labor union due to limitations on collective bargaining in public education.

participation. At one extreme, education markets and health care sectors in relatively less developed countries had relatively higher union involvement and fewer changes in provider payment schemes. As in the decentralization case, market structure—and economic development—affect the interaction between unions and reforms whereas political variables, associated with alignment and unions' internal organization, are relevant only in education.

3.3 Evaluation Mechanisms

The introduction of measures that account for students' performance facilitates monitoring of teachers, although there are several factors, other than teachers' participation and schools' actions, affecting the learning process. As a result, labor unions are likely to distrust the impact of tests that do not consider socioeconomic or contextual variables in the learning process. If they perceive that the test will be used for measuring their performance in order to define their income, they are likely to resist it. In particular, teachers are afraid to be perceived as the single factor shaping students' performance in exams that do not consider socioeconomic, geographic and cultural heterogeneity. As expressed by the Regional Committee of Education International for Latin America (IEAL), teachers' unions fear that standardized tests ignore the diversity of conditions in which teachers work and the effect of social inequalities on the learning process. Additionally, the IEAL criticizes that exams do not measure factors other than curriculum content such as teaching effort and enthusiasm (Colegio de Profesores, 2000).

The establishment of evaluation tests generates less open opposition from teacher unions than other institutional reforms in most countries of the region. Political alignments and organizational variables have weaker effects because testing is part of a more technical discussion with a microeconomic impact on teachers' labor relations. In large and heterogeneous countries where the impact of other variables on student performance is clearer, teachers' unions are less resistant to exams than those in homogeneous countries. In large countries with more developed education systems, such as Argentina, Chile and Mexico, the unions accepted the test while demanding more participation in setting performance criteria.

In contrast, in smaller and more homogeneous countries, teachers' unions presented a stronger opposition to the establishment of exams. Despite a close political relationship between the administration of Leonel Fernández and the monopolistic teachers' union (ADP or Dominican Teachers' Association) in the Dominican Republic, the ADP resisted exams. In Costa

Rica, ANDE (National Association of Teachers) shares the representation of teachers with various smaller teacher unions. This was a pluralistic union, although politically aligned with the Social-Christian government. It had an active participation in a consensual process organized by the Ministry of Education, which resulted in the reform proposal for the sector. Although ANDE agreed on the need to create an evaluation system for students, it rejected the government proposal, which did not include union representatives in the evaluation committee. In both small countries—the Dominican Republic and Costa Rica—teacher unions rejected evaluations that could be more clearly linked to their performance, even when they shared political alignments with the government.

Because this policy has a stronger effect on providers than on providers' organizations, the influence of market structure is stronger than that of political alignments or organizational structure. Hence, the size of the market seems to be more important than political alignments or organizational structure regarding this policy. In small nations, unions probably have closer control of their members and their work with students. In larger countries the variation in student performance associated with other factors is probably larger, reducing the risk of direct relationship between exams and performance-based payment mechanisms.

3.4 Private Provision

The introduction of new sources of supply or insurance also challenged labor organizations that had traditionally concentrated their efforts on pressuring a single public employer regarding income and working conditions. The introduction of private supply increases diversity among providers' industrial relations and makes it harder to define common goals for their unions. Hence, it not only affects job conditions but also the functioning of providers' organizations.

The difference in working conditions in the public and private sector is larger, for the most part, than the diversity in skills of teachers and doctors who perform activities in one or both sectors. As a result, employers have incentives not only to attract employees who have less power to homogenize their work conditions, but also to find alternative ways to transfer the financial risk to them. In the case of health care services, the interaction of public and private actors (not only financiers, but also health centers and health professionals) is such that a change in contracting modes among actors triggers an array of reactions in doctors' and health centers' associations, some of them already discussed in the section above on payment mechanisms.

Additionally, the reallocation of the education budget from public to private schools impacts on the income of public sector teachers and even on their employment conditions (e.g., effect of vouchers on educational demand).

Under this framework, the inclusion of private providers in the network of publicly financed institutions introduces a redefinition of the role played by unions and professional associations. Clearly, the structure of the market has an important part in the new framework, and the section devoted to changes in provider payment mechanisms, which include the participation of private providers, shows some of the regional experiences. Variables related to the internal organization of unions also play a role, because the introduction of competition from private suppliers increases heterogeneity among workers and often fosters the organizational distinction of affiliates gathered by diverse labor unions. In particular, the existence of separate public and private sector unions would create resistance from public unions and support from their private counterparts in their competition for members. This competition should be stronger in education than in health care because teachers usually derive their main source of income from one of the two sectors and there are usually different unions for private and public teachers. In contrast, doctors are mostly employed both in the public and the private sector at the same time, and they are organized in the same professional association.

Finally, political alignments shape the union-government interaction because private provision of education has traditionally been associated with strong ideological debates about the State's social responsibilities and the non-religious character of public education. This ideological effect is combined with difficulties in unionizing private sector teachers due to the combined effect of employers' distrust and religious influence. As a result, public teachers' unions are concerned about the effects of private provision of education, whereas private sector teachers can expand their membership with the growth of private education.

In Colombia and Venezuela, public teachers' unions opposed the expansion of the private sector. The Colombian FECODE resisted the participation of private schools for the extension of education coverage and so did all Venezuelan teacher unions during the Pérez administration despite their inter-union competition. In both cases, they resisted subsidies to private provision, claiming not only negative effects for the job stability and work conditions of their members, but also a retrenchment of the state's social responsibility in guaranteeing a free, universal and non-

religious education. Ideology and the distribution of the education budget between the private and public sector explain union reactions in these cases.

Most dramatic is the effect of political alignments and private provision in education in El Salvador, where inter-union competition weakened the resisting union. The government established an innovative system of school administration to cover the rural areas, called EDUCO, where the state granted the administration of the school to communities, which organized the schools. The *ANDES 21 de Junio* (National Association of Teachers) is the largest union and the most representative in the elections of teacher career boards. It is politically associated with the opposition FMLN (Farabundo Martí Front for the National Liberation), whereas the other two unions, *Concertación Magisterial* and SIMES (Union of Salvadorean Teachers) are associated with the Center Democratic Party and the right-wing ARENA, respectively. Political and ideological alignments were very strong in this case. Not only the ANDES, but also the union of private teachers (SGEPES) allied with ANDES resisted the EDUCO program as an implicit privatization of education. The response of the government also reflected political alignments. The Labor Minister classified EDUCO teachers as belonging to the public rather than to the private sector, thus reducing their collective rights. As a response, most of these teachers joined *Concertación Magisterial* rather than its competitor *ANDES 21 de Junio*. Thus, the fragmentation of teachers' organization reduced the bargaining power of ANDES and allowed the government to gain labor allies.

In all cases, political alignment variables and inter/intra union organization played an important role in shaping unions' reactions to reforms based on private sector participation. Indeed, the most dramatic growth of private sector provision was experienced in Chile where the reform, which included competition between private and public provision, was imposed by a non-democratic regime, thus repressing the effect of ideological opposition from teachers' unions.

In contrast, in health care, market variables play a stronger role because most systems already include a private-public mix, which is devoid of the ideological content implicit in education. In health care services, the characteristic public-private mix in the financing and provision of services has created a dual system in which physicians hold jobs in both sectors. Despite the fact that many reform plans incorporate the possibility of subcontracting private facilities by public financiers (Brazil is a paradigmatic example, and more recently Nicaragua

and Bolivia through alternative forms of social insurance modes), such a case is extremely rare in the region, and strong union opposition was not registered.

The Colombian case shows a reform indirectly related to private-public coordination, which includes decentralization combined with a change in insurance schemes. In that case, health workers kept in strike during nine months, although their demands were associated not only with the effects of reform, but also with a cut in payments from the Ministry of Health. Finally, the exchange involved doctors' acceptance of the reform in return for the payment of a-year delay in salaries. The Colombian example follows the logic of a mixed public-private system: physicians, as participants in both sectors, facing a financial reorganization in the provision of care, reacted by defending mainly public-job stability and wages, without opposing the structure of the reform. As in the cases discussed before, the participation of doctors in both types of services, public and private, loosened their resistance to the change.

Argentina presents a very special case of private participation and union involvement. More than sixty percent of the Argentine population is covered by one of the many *Obras Sociales*, the social health insurance schemes managed by unions, and divided by branch of activity. Thus unions in general, and not only those related to the provision of social services, are involved in social sector reforms, increasing their ability to influence policy makers. The existence of these health funds created an additional interest in the general unions due to the financial and organizational resources provided by these funds. During President Menem's administration, a proposed competition system among social insurance institutions and between them and private insurance schemes challenged the monopolies on union-run health funds. As a result, the unions used their political alignment with the government and obtained a limitation of competition for health insurance to union-run health funds only, except for managerial employees, and even this limited reform was delayed for three years and compensated with monetary subsidies to modernize their health funds. Private insurance, in this case, did not affect the union of health workers or doctors' associations with membership in both the public and the private sector (Murillo, 1996). Despite this, and as shown in Maceira and Poblete (2000), the participation of unions in the provision of health care reproduces the strategies and reactions related to market structure discussed in this paper. In that sense, *Obras Sociales* with higher bargaining power in the financing of services are the ones that triggered reforms in the health care sector, changing incentives and affecting private providers' strategy to supply services and

transfer risks in the chain of health care. In this exceptional case, thus, political alignments allowed unions in general to delay and shape the competition from private suppliers in a publicly financed but union-run health insurance system.

4. Conclusions

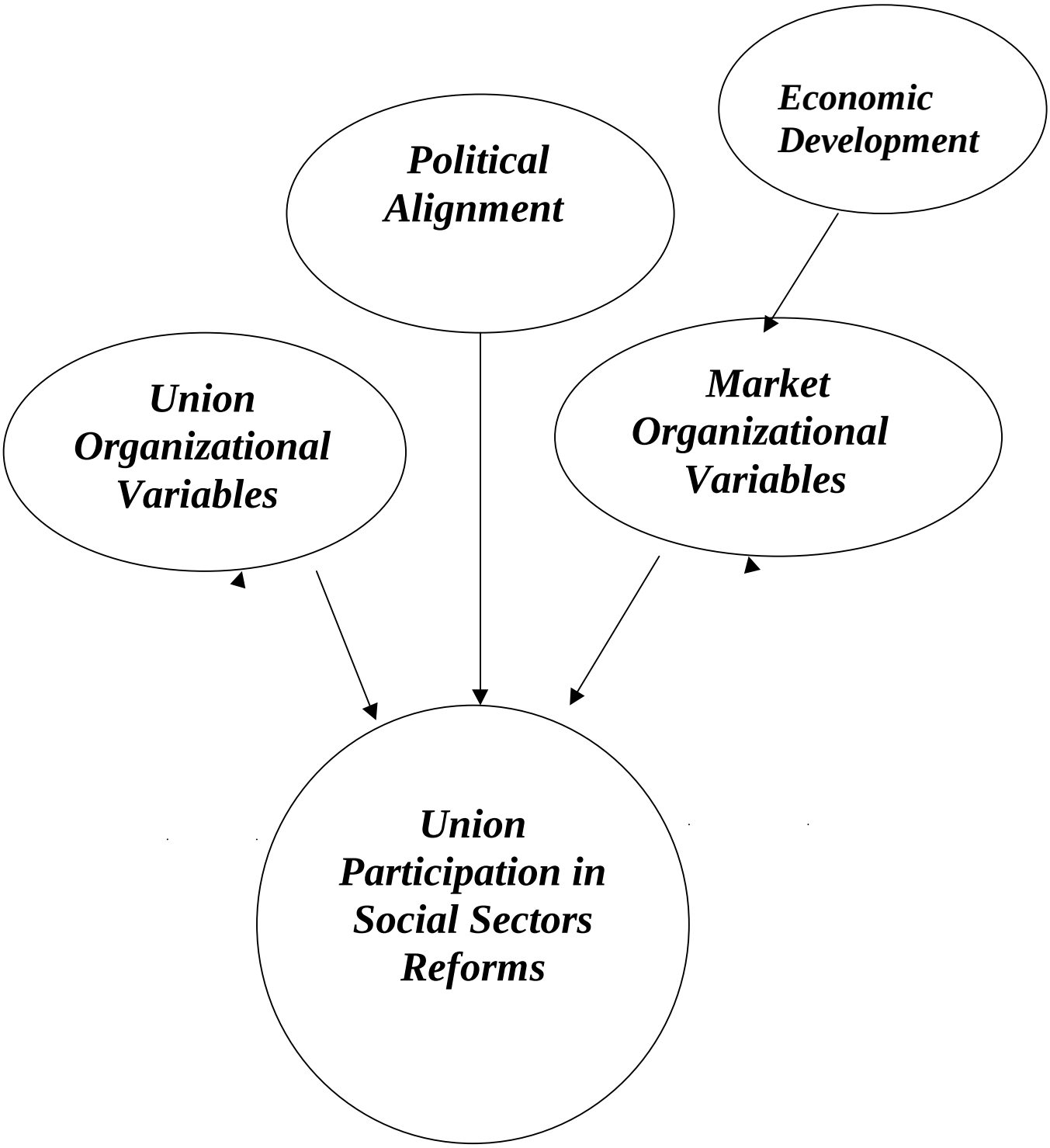
4.1 Summary

Providers have large stakes in the character of the reform and are well-organized relative to beneficiaries, making their attitudes and actions important for the success of reforms. Indeed, because improvements in quality and performance in labor intensive sectors, such as education and primary health care, require the active collaboration of providers, their involvement and support for the process is fundamental. For that reason, even if providers do not have the reform initiative and are not an obvious part of a winning coalition, governments can resort to concessions to avoid their veto to reforms in order to make their implementation more effective. Concessions, however, can modify the effect sought in the reforms that they facilitate. Alternatively, reforming governments can include input from providers in the process of institutional definition to preempt their resistance. In particular, if they are included with clients in a broad process of consultation, their particular interests may be tempered.[26] For those reasons, it is important to analyze which conditions affect providers attitudes towards bargaining or opposition to reforms in order to suggest some policy options to include them as participants in social sector reforms.

The analysis presented in this paper suggests that two main factors influence the reaction of unions to social sectors reforms: the organization of the market (size, level of development and competition), and political and organizational variables associated with historical events in the evolution of unions, which define the ability of workers' representatives to collude and to cooperate among themselves and with the government. Figure 1 presents these main findings. According to them, however, unions involvement in social sector reforms are defined by factors, at least in the short run, which are exogenous to policy makers.

[26] An example of the impact of broad dialogue is the educational reform of the Dominican Republic, where civil society played a key role in bringing both the teachers' union (ADP) and the government to the bargaining table.

Figure 1. Summary of Findings



The size of the country and the institutional context affect the capacity of the government to pass a reform by shaping its grip on potential opposition from other social groups and political parties. At the same time, our examples show that the factors with a stronger effect on the interaction between reforming governing and providers' organizations, although different for health and education, tend to be exogenous to institutional design. The effect of inherited market structures was key in explaining both attitudes and bargaining power of doctors whose income comes from a combination of the public and private markets. Additionally, the level of development of those markets has a strong effect on the bargaining power of doctors vis-à-vis health centers in negotiations regarding institutional reforms transferring risks to providers. In contrast, teachers, for the most part, are dedicated to one of the two sectors full-time, and most of them derive their income from the public sector. As a result, the market structure is dominated by the characteristics of the governments as employers and the organizational features of teachers' associations. Hence, political alignment and organizational features have a stronger impact on attitudes and bargaining power in education than in the health sector.

Table 1 shows that, in addition to the tendency created by sectoral differences, there was a certain variation across institutional reforms within the sector This variation is related to the distribution of reform costs between providers and providers' organizations in the case of education, where public employment prevails. In the cases where providers' organizations concentrated the costs (e.g., decentralization), political alignments prevail, but when providers were mostly affected (e.g., evaluation), market structure was more important. Additionally, the inclusion of unions in the administration of health insurance gives more prevalence to political alignments even for health care.

Table 1. Variables with Strong Influence on Union-Government Interaction in Health and Education Reforms

	Markets' Stage of Development	**Market Structure**	**Political Alignments**	**Inter-Intra Union Organization**
Decentralization	Doctors	Doctors	Teachers	Teachers
Payment Mechanism	Doctors	Doctors	Teachers	Teachers
Evaluation	Teachers	Teachers		
Private Provision	Doctors	Doctors	Teachers	Teachers/ Health (Argentina)

4.2 Policy Implications

The market structure of social sectors and economic development provides the context where reforms are applied, and union organization influences the strategies followed by union leaders. Nevertheless, there is room for policy interventions, which are related to the main political and economic issues introduced in the prior discussion. These are associated with the agency concept of alignment of agents' goals with those of the principal's and the definition of regulatory frameworks providing unions with incentives to cooperate in the reform process.

Hence, considering the difficulty for policymakers in modifying exogenous contextual variables, such as level of market development and political alignments, we suggest that policymakers should consider alternatives that generate incentives for aligning the objectives of providers with those of reformers to facilitate institutional change. In particular, regulations could be used to change the incentives of providers and to affect the market structure in which they perform, in order to induce the participation of providers in the process of reform.

As an example of this type of strategy, we propose aligning the incentives of providers with those of reformers by granting collective rights to public sector workers to make them participant actors in the processes of reform that affect their labor relations. There is a long regional tradition of limiting collective bargaining in these sectors, which are left to be defined by regulators and separated from other service workers. We instead propose making them more similar to other service workers by granting them bargaining rights in order to involve them as participants in both the reform process and the definition of their own working conditions, as well as promotions and evaluations. The terms of their involvement could therefore be defined in more technical ways to avoid the politicization of their militancy—that is, focusing bargaining on concrete and technical issues that could be agreed upon despite ideological differences.

We propose linking this change in status to the institutional reforms related to performance in the social sector. By involving unions in the process of reform and making them effective representatives of providers—including through means such as electoral regulations that guarantee their representativeness—governments can align the objectives of the reform with those of providers. Additionally, the effect of these regulations on the organization of providers is likely to reshape the structure of provision at the same time as institutional reforms promote performance-oriented behavior. Thus, it is necessary to link both objectives to increase providers' understanding of reforms and to reduce their distrust of hidden agendas that provokes

so much opposition to the reform process. Additionally, this strategy would provide unions with more control over their income, even under budgetary constraints.

In the cases of both labor unions and professional associations, another alternative is to align the interest of providers by granting them not only a representative role, which becomes more important in the more developed markets, but also a regulatory role. They can be included in areas such as evaluation, entry exams to the profession, and overseeing roles related to the performance of providers in a public manner that links the interests of providers, management and users of the services. In particular, their role as overseers and evaluators of entrance into the market can help guarantee a certain level of performance, thereby linking providers' associations and professional prestige with reforms to improve their performance. It is important to consider, though, that the risk of this strategy, which can increase support for reforms, is to introduce distortions if markets are not regulated.

In short, after exposing the exogenous variables explaining the reactions of providers' organizations to social sector reforms (i.e., market structures, political alignments, and organizational features), we suggest using regulatory reforms to align the incentives of providers and policymakers. This strategy can be used to facilitate consensual reforms, improve performance, and enhance the professional prestige of providers, thus, providing subjective incentives for better quality to social service providers.

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