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"HEALTH POLICY IN LATIN AMERICA: THEMES, TRENDS AND CHALLENGES"

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INDICE

Through the 1980s and 1990s, public policies in Latin America were the subject of increasing scrutiny and radical reforms. These processes of change were driven by economic crises in the 1980s and by a subsequent shift from state-led development to an almost unquestioning belief in neo-liberalism. At the same time, international development banks took a growing interest in the "social sectors", and had a significant influence on the direction of change.[1] In no area of policy were these processes more apparent than in health services. However, less has been written about health and health care in Latin America than for other aspects of social policy, and what has been written is mainly from a public health perspective which contributes little to broader social policy debates. To some extent, this reflects the disinclination of social scientists to study a field that is considered highly technical, and the reluctance of clinical scientists to take a "soft" approach to a subject which before the 1980s was largely viewed as the domain of public health specialists and physicians.

There are many reasons for taking a deeper academic interest in Latin American health care. The challenge of responding to demographic, epidemiological and technical changes must be put in a broader social, economic and political context. Furthermore, the health sector may itself have a major impact on social and economic development. As well as promoting welfare and human capital formation, health care is an industry and a major employer in its own right, connected with pharmaceutical companies, the insurance sector and equipment manufacturers. Health services account for between one third and one half of total social expenditure in most Latin American countries. However, the Pan American Healthcare Organisation (PAHO) has estimated that in the early 1990s around 130 million people in Latin America and the Caribbean had no access whatsoever to formal health care (Mesa-Lago, 1992). As such, the region remained a long way from achieving the 1978 Alma Ata Declaration of Health For All by the year 2000.[2]

Latin American health care systems and services display a number of distinctive features, which justify the regional focus taken in this book. Most systems suffer from a level of segmentation and a bias towards hospital care, which is extreme even by developing country standards. Table 1 indicates that the richer Latin American countries devote relatively large amounts of funding to health, but do not compare well to other middle income countries in terms of outputs and performance. The region has witnessed arguably the most radical set of neo-liberal inspired health sector reforms in the world. These include the pioneering experience of Chile in the early 1980s and more recent initiatives in Mexico and Argentina. Considerable diversity exists in the region, including Colombia's ambitious programme to develop a unified and universal health system, and the singular success of socialist Cuba. Despite the persistence of the US trade embargo and the collapse of the USSR, the country is still among the top 5 per cent of developing countries in terms of social welfare indicators.

Table 1 Selected health statistics by world region, cerca 1990.

1 In 1993 the flagship publication of the World Bank, The World Development Report, was entirely devoted to changing health systems (World Bank, 1993). The following year, it published a major policy document on reforming pension programmes (World Bank, 1994).

2 The Alma Ata Declaration, that all people in all countries have access to health (including psychological and social welfare) became the central strategy of the World Health Organisation and provided the impetus for primary health care programmes across the world (WHO, 1978).

	Total per capita health spend, 1990 (dollars)	Doctors per 1,000 population, 1988-92	Perinatal mortality rate per 1,000 1990
Latin America	105	1.25	33
Former Socialist Economies	142	4.07	19
China	11	1.37	25
India	21	0.41	64
Other Asia	61	0.31	49
Established Market Economies	1,860	2.52	9

Source: World Bank (1993).

Latin America is also diverse in terms of its health care needs (PAHO, 1999). The larger cities of the Southern Cone contain aged populations and suffer high rates of chronic disease. Conversely, some rural districts of the poorer countries show no signs of entering any recognisable form of demographic or epidemiological transition, and continue to experience very high levels of mortality (often from easily preventable conditions). The region has not been immune to the global re-emergence of infectious diseases such as TB, nor to the appearance of new ones, such as HIV/AIDS. Whilst there has been considerable success in controlling the cholera outbreaks of the early 1990s, progress with long-established diseases such as chagas or malaria has been negligible. More general improvements in population health ultimately depend on the capacity of macro-economic policies to deliver an improved standard of living to the poorest and most vulnerable: as yet there are few signs that this is happening.

Health issues and health care systems are extremely diverse and highly complex, touching on a wide range of academic disciplines. It is vital to take a multi-sectoral approach, since factors such as income, education and housing may have as much impact on health outcomes as health care *per se*. Studying health policy may give us valuable insights into a range of other important debates, including good governance, and the relationships between the public and private sectors. Clearly, it is beyond the scope of any single volume to deal with all of these questions in detail for a region as large and diverse as Latin America. This book (and the conference out of which it arose) seeks to take a preliminary, exploratory approach and to highlight a number of key themes.

Before proceeding, a number of potential pitfalls in the use of health data should be identified. Table 1 provides a selection of health statistics for different world regions for around 1990. This sort of information can sometimes be of use for making very broad generalisations, but should be treated with extreme caution. First, and most obviously, such geographically aggregated data are bound to hide more than they reveal. The same is true of data given for individual countries, which often mask sharp internal variations.

For example, the number of doctors per capita varies by almost ten-fold between different parts of Mexico in the late 1980s (McGreevy, 1990). Second, great care must be taken when considering cause and effect. Standard health indicators, such as mortality rates, only give an extremely indirect view of the performance of health services, since they are determined by many additional factors, such as nutrition, housing and income. Likewise, measurements of health care infrastructure can sometimes be misleading. In many Former Socialist Economies there is a problem of over-supply of certain services, particularly trained medics, which waste resources and distort patterns of provision. Similar problems are evident in much of Latin America. A more fundamental difficulty is the reliability and completeness of the data for the region, and problems of incomplete reporting are often compounded by technical and political flaws.[3]

HEALTH CARE AND THE STATE.

It is generally accepted that guaranteeing health for society as a whole should be a core responsibility of any state (Mackintosh, 1992). In Latin America there is huge diversity, both in terms of the overall nature of states, and their relationships to social welfare (Grindle, 1996; Hartlyn and Morley, eds, 1996; and Teitel, ed., 1992). These include:

1. The all-embracing welfare state under siege (notably Cuba).

2. The incomplete welfare state in retreat (observed in different contexts in Argentina and Nicaragua).

3. The 'restored' liberal' democracy, for which economic growth and democratic consolidation are higher priorities than a social policy that is either coherent in conception or all-embracing in coverage (Chile and Brazil).

4. The disarticulated state in partial decomposition, as in Colombia, where health-care resources have in places been distorted by conflict and violence.

5. The near-absent state that implicitly delegates social policy responsibilities to NGOs, such as Haiti.

Despite this diversity, over the past decade the region as a whole has experienced a trend towards the restoration of liberal democracy in some states and a drive to deepen democracy in others (Ai Camp, ed., 1995; Tulchin and Romero, eds, 1995; Dominguez and Lowenthal, eds, 1996). It is essential to understand how health care fits into this context of change. A key concern is how far Latin American states have broken habits of using health policy and delivery systems as instruments of political patronage, so that finances are regularised and so that vote-winning actions do not by necessity prevail over other considerations (for example, the construction of a new hospital is not by definition preferred to the maintenance of existing ones). In addition, it is useful to assess how open, honest and inclusive

[3] Perhaps surprisingly, Cuba is one of the few exceptions to this problem. Independent auditing checks have shown its vital statistic and health reporting systems to be among the most complete and accurate in the developing world.

debates about health care reform have been. The book contains two examples (El Salvador and Argentina), which portray the reform process as relatively secretive and closed, despite a democratic rhetoric of accountability and transparency.

Often, discussion of public policy is pervaded by an uncritical confidence among liberal professionals in the capacity of liberal democracy to achieve their goals. Some doubts should be expressed about over-optimistic equations between democratic government and better social services; of state reform and a reduction in clientelism; and of economic growth and positive health effects. We should not take it for granted that a consolidated liberal democracy intrinsically means better health care. It would be both misleading and retrograde to argue that more progress in health care has been usually achieved under dictatorships: in Haiti, the Dominican Republic and pre-Revolutionary Nicaragua, abusive dictatorships were associated with pitifully inadequate health care systems. Nevertheless, recent experience suggests that neither leftist nor centrist democratic parties have placed health issues boldly on their agendas, and liberal democracies have often favoured the private sector at the expense of issues of public concern. Indeed, Venezuela, at times seen as the most durable example of effective liberal democracy in Latin America, has witnessed some of the most brutal and insensitive cuts in social policy spending in the continent.

In health, as in other spheres of public policy, attention must be paid to the capacity, competence and willingness of state agencies to implement policy and in meeting their responsibilities. National health ministries may be constrained by constitutional or other statutory provisions that confine their role to setting norms, rather than enforcing them, and by competition between different levels of government and with other ministries also responsible for health issues. The continuing politicisation of posts and a high level of turnover of officials at the regional and local levels often frustrates even the routine performance of basic tasks, let alone innovative practice. Stressing “accountability” may simply mean a higher level of turnover and greater emphasis on marketing policy, rather than a growth in competence.

Many Latin American republics have experienced a recent stress on local democratisation in which programmes of municipal reform and decentralisation have played an important part (Araujo Jr., 1997; and Collins and Green, 1994, Nickson, 1995). There would appear to be a regional (or even global) consensus that decentralisation can improve the quality, efficiency and responsiveness of health services, whilst deepening democratisation (Cassels, 1995). However, the evidence is variable and does not always stand up to these claims.[4] Although the abstract logic of decentralising health care may appear to make sense, in the context of some Latin American states it can sometimes do more harm than good. In decentralised systems, policy formulated at the centre may not be applied in the locality or may be carried out in a diluted or distorted form for lack of human or fiscal resources (Grindle and Thomas, eds, 1991). Decentralisation may sometimes be little more than an all-purpose panacea for ministers and senior policy-makers, who are determined to be seen to be active but have few other ideas. Too easily, a policy of decentralisation can be an instrument for shunting off responsibilities for crucial issues like the supply of drinking water to local authorities, that lack the funds and the competence to handle them. Health ministries in several countries have appointed advisers to help municipal government prepare plans and projects. But it is unlikely that there are sufficient advisers of sufficient quality to give more than routine assistance to the majority of municipalities. Where a few countries may have the resources to realise the

[4] Rogers (1996); Gonzalez-Block et al (1989) and Cassels (1995) all question the supposed benefits of health care decentralisation in the region.

objectives of municipal reform and decentralisation nation-wide, the poorest clearly do not, and countries of intermediate ranking may have the resources in some regions and cities, but not others. In such countries, the overall impact of the policy will be to exacerbate disparities.

THE ROLES OF THE PUBLIC AND PRIVATE SECTORS.

The potential of the public sector to develop an effective regulatory role, both for its own services and for the emergent private health care sector, is an issue of increasing concern. If the state has failed as a direct provider of health services, then it seems fair to question its capacity for regulating the activities of other actors. This is made more difficult by the high level inter-penetration of state and private sector interests in the region, both at the institutional level (for example, state subsidies for national drugs manufacturers) and at the individual one (government officials who also run private health clinics and consultancies). Timidity of the state in the face of the private sector is a recurring theme in this book. Health ministries and other state agencies often lack competent personnel to cope with an expanding range of problems of legitimate concern to the private health care sector, trade unions, peasant organisations and other representative bodies. Particular areas of interest include regulating private health care financers and providers, as well as occupational and environmental health (ironically, outside the remit of the British National Health Service from its inception.) This raises related questions of how far employers (including public sector agencies) can, especially in rural areas, resist or ignore state surveillance of health risks for lack of legislation or qualified personnel, and even whether they are aware of state regulations.

At the centre of these debates is a concern with privatisation, or, perhaps, better put, a shift from public to private sector management. This process has affected all aspects of health care systems in Latin America, including financing and providing services. The Inter-American Development Bank estimates that by the mid-1990s private prepaid medical plans served almost 50 million people in the region, the great majority coming from high income groups (IADB, 1996). Predictions that private insurance will continue to expand rapidly have aroused interest beyond the region. Latin America is now perceived as a major emerging market for U.S. insurance firms and healthcare maintenance organisations (Stocker et. al., 1999). Across the region, there is little debate about the virtue of embracing the U.S. model of private health care, which has failed to abjectly in its own country.

One aspect of privatisation, which has received little attention in the general literature, is the training of health professionals. Long admired by the World Bank and economic liberals as a paragon of low taxation, good debt management and freedom for entrepreneurial initiative, Colombia illustrates the risks associated with attaching a low priority to social policy over a long period in a context of turmoil and violence. Among other things, this has given rise to under-regulated private security and 'self-defence' groups, operating with few official constraints in the absence of an efficient police force. These problems are equally evident in the medical education sector, where controls over the development of new private faculties were increasingly relaxed during the late 1970s and early 1980s. This trend was associated with the rise of a new business ethic and profitable opportunities offered by founding new private medical schools. It encouraged the proliferation of barely regulated schools, with inadequate laboratory facilities, poor-quality teaching and inferior access to hospitals for clinical training. Fears for a new generation of

inferior medical graduates seem well-grounded. Despite the promises of successive governments to improve the quality of health services, it is suspected that the calibre of medical graduates continues to slip. Professional and business interests have impeded even token attempts to restrain the proliferation of medical schools: three in the Caribbean city of Barranquilla alone, more in Bogotá than in Paris.

A further area of concern is the consequence of globalisation and transnationalisation for the health sector. A standard question of the 1960s that has long been submerged should be allowed to re-surface in fresh form: how far is the health sector being reshaped around the requirements of the transnational pharmaceutical (and, perhaps, hospital equipment) industries (Gereffi, 1983; Silverman, 1976; and CEPAL, 1987)?

During the import-substitution industrialisation[5] ascendancy of the 1950s and 60s, numerous family-size pharmaceutical enterprises sprang up in the main manufacturing cities of Latin America. Nationalist strategies of developing generic drugs in large quantities and at low prices were mooted but seldom followed through. More recently, aggressive price liberalisation programmes have enlarged the range of pharmaceutical products, gone some way to stabilising supplies, and have simplified the role of the state. However, these policies have also had a range of negative effects. Overvalued exchange rates have reduced the cost of imported pharmaceuticals and, together with the liberalisation of import controls, the de-regulation of product registration and the imposition of patent protection for chemicals developed overseas, they have undermined small domestic producers. In the poorest countries, pharmaceutical firms remain monopolistic, or at best oligopolistic, and any notion of competition is fictional. Yet, even where competition in the pharmaceutical sector is obviously absent, finance ministers, especially the more doctrinaire neo-liberals, are likely to resist moves which hint at a revival of protectionism and regulation, let alone subsidies for the poor. In the medium term, particularly if national currencies are devalued, price liberalisations may well increase the cost of drugs, creating further budgetary problems for health ministries and reducing access for the poor. In addition, liberalisation can be blamed for excessive promotion and advertising, along with over-consumption in a continent where entrenched traditions of self-prescription make for excessive usage: pharmaceuticals typically account for 25-30 per cent of health care budgets (Madrid, 1998). The scope for the introduction of new generic strategies, a potentially efficient option involving limited controls on specified drugs, is restricted in the current economic climate.

At the local level, long-standing reservations about the content and quality of information diffused to customers of pharmacies remain relevant. Until mid-century graduate pharmacists formulated and dispensed affordable pharmaceuticals in their shops. However, in recent decades pharmacies have increasingly shifted to the sale of pre-packaged drugs; and pharmacy graduates, once `independent' professionals, have found that their only job outlets are as agents of the national and transnational pharmaceutical industries, so that little information from outside the industry is available to consumers.

5 Policies that place state-led industrialization behind tariff boundaries at the centre of economic strategy. For an introduction, see Thorp in Abel and Lewis (1991).

HEALTH, POVERTY AND SOCIAL EXCLUSION.

Increasing credence is being to the view that investing in basic education and health services is the best way to reduce poverty in the developing world (Morley, 1995.). The development of appropriate health policies could go a long way to reducing the two-way relationship between poverty and ill health. However, entitlement and access to health care in most Latin American countries mirror the stratification and inequity of their societies as a whole, reinforcing rather than mitigating social divides. The policy responses are often obvious: it is more difficult to explain why they are so rarely put into practice. This can only be done by understanding the dynamics of poverty and exclusion across the region, how social problems are perceived and labelled, and how perceptions change over time. Concepts such as social exclusion and vulnerability have come to the fore relatively recently, but should be viewed as only the latest in a succession of attempts to understand (and justify) the extent of social problems facing regions such as Latin America (de Kadt, 1994).

In the 1910s and 1920s liberal intelligentsias spoke of the 'social question', and some liberals moralised feverishly about how far visions of economic development were obstructed by a low-wage, low-productivity labour force of the 'undeserving poor', supposedly characterised by alcoholism, abject laziness, venereal diseases and poor nutritional habits. The Catholic Church and its corporatist allies appropriated the concept of “Social Action” in the 1930s and 40s as their response to continuing poverty and misery. Piety, conformity and the strengthening of hierarchical bonds and the patriarchal family unit would, lead, or so it was claimed, to moral redemption, and would make possible the personal and social discipline necessary to generate an employable, adequately nourished workforce, that engendered a habit of small savings (Ivereigh, 1995). The concept of `social justice' obtained some momentum from the 1940s. In a period of accelerating urbanisation it had a manifest appeal to elements of the lower middle class and organised labour, which supported governments in exchange for social 'interventions' that provided some guarantee against illness and unemployment and that mitigated hardships in the troughs of economic cycles. However, as evidence mounted across Latin America that large swathes of the population especially in the countryside had slender or no access to even low-quality social services, despite decades of promises of 'social action' and 'social justice', `social revolution' emerged as a viable and enduring concept. It was proclaimed with greatest commitment in revolutionary Cuba, but also enjoyed considerable purchase elsewhere. Temporarily in abeyance in government circles since the Nicaraguan counter-revolution, the theme of 'social revolution' is still to be heard among radical movements of the rural poor in Mexico and Brazil.

Concepts such as social exclusion and vulnerability raise various problems of definition. We need to distinguish those groups excluded from all social services from those excluded from one but not estranged from another (health but not education) from those excluded from good-quality services. Secondly, we need to distinguish families and households where some members are excluded from the benefits of official provision from those where all are. Thirdly, we need to distinguish the long-term excluded from the once included and newly excluded and dispossessed: uprooted internal migrants in Colombia; refugees from Nicaragua elsewhere in Central America; and the victims of disasters, like Hurricane Mitch in Honduras and Nicaragua. We need, finally, to identify the self-excluded, who opt in preference for the services of the traditional healer or midwife.

Here a mental picture of the urban household excluded from all aspects of social provision impinging on health may be of assistance. Such a household may be the victim of a cumulative series of social insults: the closure of a popular hospital, the delegation of its functions to ineffective health posts, and exclusion from the price benefits of streamlined food supplies through modern supermarket chains, exclusion from a clean drinking water-supply caused by the unwillingness of a privatised supplier to operate in loss-making slums. If social exclusion is, in some instances, becoming a more acute problem, then some broader questions of ideology and policy arise. How far does a democratic strengthening imply notions of citizenship that go beyond civil liberties to embrace social rights? Have `new social movements' succeeded in incorporating once excluded kin and neighbourhood networks, or have their leaders been co-opted and much of their followings re-excluded?

HEALTH AND VIOLENCE.

In recent decades, Latin America has experienced little of the international warfare that has plagued other developing regions, but it has been subjected to high levels of political and social violence and also of criminality. Estimates for Brazil have indicated that three people are murdered every hour, with 67.3 officially-reported murders per 100,000 inhabitants in Rio de Janiero during 1992 (Flynn 1993). Domestic violence is increasingly being recognised as a key health policy issue in the region. A recent survey of women in Managua, Nicaragua found that over half had experienced from some form of abuse, as defined by PAHO. These women had suffered significant losses of earnings and made twice as much use of health care services as did other women (Morrison and Orlando, 1997).

In various countries high indices of crime, domestic violence and road accidents have been complemented by armed violence by the agents and allies of governments, by guerrillas and paramilitaries, and by networks of narcotics and armaments dealers. Psychological violence connected with torture, disappearances and forced migration, has also occurred. Orphans, and traumatised, abandoned and immunologically weak children, some of them street children persecuted by vigilantes in cities like Rio de Janeiro, Sao Paulo and Cali, have been victims too. With political violence the physical infrastructure of health-care has been dislocated and destroyed; the vigilance and control of transmissible diseases have been significantly disrupted; the movement of equipment in vaccination campaigns has been delayed (or the campaigns postponed); and personnel displaced (Ugalde and Zwi, 1994)

Violence can lead to a shrinking of coverage and an `atomisation' of health programmes; it can provide a pretext for reducing costs by excluding populations in areas of conflict. In several countries hospital resources have been diverted from routine operations to the casualties of violence. In some cases, resources allocated to primary care have been transferred to tertiary care and rehabilitation. Similarly, violence frequently signifies the disruption of the food supply and its appropriation by soldiers or guerrillas, the eviction or flight of rural populations, bad harvests, and breakdowns in systems of distribution. These may have inflationary and nutritional consequences for the poor and, in particular, for the dispossessed and displaced, who are also exposed to infectious diseases.

In some areas of violence, doctors and nurses have themselves been political actors. Denounced by the Contras in Nicaragua as disguised military advisers, Cuban aid workers were sometimes singled out as

targets (Garfield, 1989). More recently, in some Andean countries doctors and nurses have strongly voiced their disillusionment about the quality of official health care in the hospitals and health posts of violent frontier zones. Some, rejecting the official appropriation of medical language (for example, the "virus of Communism"), continue to join guerrilla movements. The memory of the Argentine doctor who took part in the Cuban revolutionary struggle, Ernesto "Ché" Guevara, continues to have some appeal and resonance.

HEALTH PROFESSIONALS.

An issue which has attracted scant attention in recent decades is the appropriateness of western medical education to Latin American conditions. As early as the late 1940s and 1950s, the displacement of the French ascendancy in medical education by that of the United States raised anxieties about the stress on an expensive, curative high-technology medicine and the downgrading in some countries of preventive concerns and some areas of 'tropical medicine'. The curricula content and priorities of many medical faculties are much better-geared to prosperous surgeries and middle-class patients than to under-funded health posts and the poor. When a surplus of doctors and nurses exists to serve the requirements of the upper and middle classes, inappropriate training may foster professional emigration to North America and Western Europe. Across Latin America, medical faculties have produced too many specialists pursuing prestigious employment and too few general practitioners. In some districts doctors should be trained to cope with conditions where villagers combine elements of diverse therapeutic traditions pragmatically (Brodwin, 1996). Also, there are few signs that medical anthropology has been integrated effectively into medicine curricula, as envisaged twenty years ago.

In most OECD countries, there are three or four trained nurses for every physician. In Mexico, their numbers are roughly equal, while in Argentina and Colombia there are several doctors for every nurse. An acute shortage of trained nurses compounds the problems caused by a lack of generalist physicians. The preponderance of doctors wastes resources through a top-heavy wage structure and reinforces the bias towards specialist hospital-based care. It is difficult to identify a clear explanation for this imbalance in human resources. Contributing factors include the failure of states to regulate private medical schools and a deep-seated tradition that medical treatment from a nurse is inherently inferior. Indeed, nursing remains a low status activity across the region, particularly in the public sector, where salaries and working conditions are often appalling (Stillwaggon, 1998).

A related issue is the geographical distribution of health professionals. The case for all graduates undertaking a year of rural service is, of course, a strong one. But it presumes a quality of public administration, which is only too often absent. During the 1930s, Mexico pioneered the concept of the "rural year" in Latin America, by which every newly graduated physician was required to spend one year ministering to the needs of villagers before being formally qualified (Nigenda, 1997). Emulated in rural Colombia in the 1950s, and later extended to slum areas in Bogotá, Cali and elsewhere, the year of social service was so poorly administered by the late 1980s that the Medical Faculty of the National University was sometimes compelled to improvise positions for its outgoing students as keepers of instruments, so that they might comply with the legal requirement to undertake a social service before entering full-time professional practice. This occurred because the public health ministry did not have the administrative

competence to create positions for young men and women in areas - rural or urban - of greatest medical need. Likewise in rural Ecuador, despite the presence of a similar programme, only 30 per cent of births were attended by a health professional by the mid-1990s (IADB, 1996).

HEALTH CARE REFORMS.

Readers should beware of the overuse of the term 'reform'. Most governments have a tendency to market all changes as 'reforms'; and many ministers wish to be seen to be undertaking new and far-reaching reform projects, rather than consolidating existing schemes. Health care systems in all Latin American countries have, throughout their existence, been subject to continuous attempts at reform, most of which were rarely implemented. However, the 1990s have seen an intensification of the reform process across the region. Particular emphasis has been given to a shift in the private-public sector mix in finance, the development of new management strategies, and policies of decentralisation. At the same time, the concepts of equity and efficiency have come to the fore.

The increased attention paid to equity reflects a concern that public spending in general and health spending in particular are often markedly regressive (Lloyd-Sherlock, 2000). However, the prominence given to equity may be, in part, because it is a concept around which social democrats, liberals and conservatives can build a consensus. The notion of a `progress towards equity' does not offend or challenge propertied interests as a stress on equality does; and indeed, a `progress towards equity' may be fast or slow to the point of being barely perceptible. Moreover, equity is extremely hard to define or measure and can be understood from a range of philosophical viewpoints.[6]

The stress on equity may mean that past commitments to protect the weak citizen from market dependency and past objectives of universal welfare have been compromised. If this has occurred, should it be viewed as a more realistic and pragmatic approach to health policy or a retrenchment of welfare? To what extent has it been associated with the retreat from a notion of health care as an entitlement of citizenship rather than as a privilege or commodity? In areas of acute poverty where the market economy is especially weak a view of health care as a commodity is especially questionable.

When seeking ways to promote equity in Latin America, a key consideration has to be the segmentation of health care systems. In much of the region, social security programmes account for almost as much health expenditure as the public sector, but often only provide for a relatively privileged minority of the population (Lloyd-Sherlock, 2000). Social security programmes usually capture a number of substantial indirect subsidies from the state sector, such as the training of doctors and the dumping of chronic or expensive conditions on public hospitals. In some countries the situation has been further complemented by the emergence of a significant private insurance sector, which sometimes works alongside social security programmes and sometimes competes against them (Barrientos and Lloyd-Sherlock, 2000).

[6] Mooney (1987) provides an excellent review of different philosophical approaches to social equity, including, entitlement, utilitarian and egalitarian.

In the new wave of health care reforms, equity concerns have gone hand in hand with debates over the efficiency of health care systems. During the 1980s it became apparent that health services had been extended with insufficient regard to issues of cost or effectiveness (World Bank, 1989). In 1985 the WHO Regional Committee for the Americas estimated that around 30 per cent of health spending in Latin America was wasted (WHO, 1985). A separate study calculated that between 10 and 30 per cent of hospital treatments performed were of no clinical value (Banta, 1988). The most widely-cited example of this is the over-use of caesarian sections, with rates of 50 per cent or higher in several countries, notably Brazil.

This range of issues explains, at least in part, why health policy has increasingly become the domain of economists, finance ministries and new "entrepeneurial" managers (as evidenced by the recent appearance of masters courses in health administration in several Latin American countries). In their wake have come cost-benefit analyses and other forms of economic evaluation, which some consider to be a magic bullet for all the ills of social and economic policies.[7] These saw their clearest expression with the 1993 World Development Report; still the prime reference work for health economists working in developing countries. One particular concern has been to develop more "sustainable" sources of revenue, which generally involve the promotion of private insurance and the implementation of user fees. Both of these policies are empirically unproven in the Latin American context and the small number of studies published to date disagree about their appropriateness (Gertler et al., 1989; Gilson, Russel and Buse, 1995; La Forgia, 1989). Moreover, there are few signs that the most fundamental causes of inefficiency of health care services have been addressed by these developments. Health care systems across the region continue to suffer from an extreme curative and urban bias, inappropriate staffing structures and poorly-coordinated, fragmented administrations. Also, the new economic imperative does little to resolve what is doubtlessly the largest sources of health services inefficiency: ineffectual regulation and widespread corruption. It is unlikely that many Latin American states will be able to benefit from a drive towards efficiency without a thorough administrative reform that introduces and generalises Weberian concepts of administrative neutrality, and that eliminates both clientelism and high levels of turnover of public officials. Nor is it likely that relatively high levels of health spending will lead to improved health indicators until significant reductions in income inequality are also obtained.

The rise of the health economist is paralleled by the changing fortunes of the different international organisations interested in health policy. The influence and impact of the World Health Organisation (WHO) and its Latin American sub-division the Pan-American Health Organisation (PAHO), along with UNESCO and the ILO, has diminished in relative terms during the 1980s and 90s. Over the same time, the voices of World Bank and the Inter-American Development Bank (IADB) have grown. The former organisations traditionally championed the "Health for All" and primary health care movements of the 1970s. The latter have promoted the new wave of neo-liberal inspired health sector reforms across the region. In some countries, these organisational divisions and cultures are mirrored in government, with health ministries retaining close links with the WHO, finance ministries with the Banks, and social security agencies with the ILO. The diminishing relative influence of PAHO (and its growing ties with the World Bank) may mean that NGOs, with their broadening of activities to embrace themes of absolute poverty, have become the principal opposition to the neo-liberal orthodoxy in social policy.

[7] In fact, the use of cost-benefit analysis in planning health services at the national level goes back at least as far as the 1960s, when the PAHO/Centre for Development Studies (CENDES) programme in Venezuela attempted to operationalise a model which aimed to minimise deaths (taken as a crude indicator of health benefit) from a fixed health budget (Ahumada, 1965).

Several contributors to this volume refer to resistance to recent reforms. Some reasons for resistance to reforms are evident: that assumptions widely prevalent among officials are not widely shared by junior professionals or public opinion (for example, an often doctrinaire assumption that the private sector is by definition more efficient than the public one; the belief that levels of taxation are too high even for the highest-income groups, even given problems of evasion; an assumption that taxation has only a small redistributive function; and an orthodoxy that 'downsizing' of public provision is desirable). Only too readily 'reformers ' explain the failure to convert large numbers of patients and other users of health services to reform in terms of a failure to explain policies to public opinion or to carry out political analysis prior to reform.[8] Only too frequently are 'reformers' blind to the fact that vulnerable sections of the population have little confidence in reforms which are shaped from outside, and whose main impetus frequently comes from the fiscal imperatives of federal government, rather than a desire to improve and extend services.

Despite the shift in reform priorities, up-grading primary health care services is still on the agenda for some Latin American countries. Indeed, the adjustment policies of the 1980s and early 1990s may have forced some governments into overdue reappraisals of priorities and restored, if only rhetorically, an emphasis on primary health. However, this may have been driven by fiscal imperatives, and especially a stress on cost reductions, as much as by broader considerations of the eradication of poverty and inequality (Abel and Lewis, eds, 1993; Bulmer-Thomas, ed, 1996 and Berry, ed, 1998).

Calls for less emphasis on the hospital sector and the devolution of resources to primary health posts are hardly new. As early as the 1930s, public health reformers called for a reallocation of resources to local health units, particularly to deal with the health of mothers and infants, whom it was felt imprudent to expose to the then considerable risks of contracting diseases in charity and public hospitals. Yet hospitals remain resilient institutions, with considerable bargaining strength in struggles over budgets. Officials demanding a shift from funding of hospitals to primary health posts sometimes forget that local hospitals are symbols of successful, past struggles, involving trade unions, junior professionals and government agencies, and are usually regarded with affection even where the quality of their services is not uniformly good.

A key objective of primary health care has been to “enlist the poor” in community decisions –there has been less emphasis on ”enlisting the rich” and their role as responsible citizens. However, it is of little surprise that populations exposed on a daily basis to the rhetoric of accountability and consultation, have more confidence in sceptical views expressed by nurses and physicians whom they meet on a regular basis than in politicians and bureaucrats. Many health professionals see the consequences of neo-liberal policies on a daily basis, and recall the slowness with which policies designed to mitigate the most severe effects have been drawn up and implemented.

[8] The form of political analysis currently in vogue is known as “stakeholder analysis”. Glassman et al. (1999) apply this approach to health reform proposals in the Dominican Republic.

THE CHAPTERS IN THIS VOLUME.

The book begins with a general proposal for a new approach to health care systems, which, it is claimed, could be applied in most Latin American countries. Londoño and Frenk's model of `structured pluralism' sets out a blueprint for a new arrangements in which the private and public sectors collaborate in the pursuit of equity, market contestability and allocational efficiency. Londoño and Frenk are anxious to avoid what they perceive as the extremes of authoritarian controls and a monopolistic denial of choice to patients in the public sector, and the atomisation and lack of structures found in the private one. They propose a specifically Latin American model, which is distinct from European public contracts, Canadian provider autonomy and U.S. managed competition.

In the structured pluralism model the role of the health ministry would primarily be one of 'modulation', in which it sets transparent and fair rules throughout both the private and public sectors. Health financing would become the essential function of social security institutes, and New Organisations for Health Services, would be responsible for the management of care and organisation of networks of providers. The authors identify the risk that an incomplete application of this model would add a new segment to an already over-segmented health-care system, instead of achieving a comprehensive approach to "structured pluralism". But they are open to other questions. Can a model designed for Latin America as a whole embrace the diversity of health-care traditions and socio-economic conditions in the region? Also, the model has no overtly political dimension, and so it does not set out to give practical proposals for the consultation of actors whose resistance might impede its implementation. Thus, the model has considerable merits, particularly as a stimulus for debate, but it should not be taken as a definite blueprint for policy.

Nuria Homedes and her colleagues suggest that too many plans and projects are drawn up and too few fully implemented. They argue that reform should be anchored in national 'culture'. They also raise questions about how far reform efforts are moving satisfactorily in practice, whether they are more evident on paper, and whether orthodoxies of 'downsizing' are compatible with a language of participation and accountability. Homedes and her colleagues mention the preference of the World Bank for working with agencies with which its staff are already familiar, and in particular, its preference for working with autonomous government agencies on the grounds that they are more efficacious and responsive than ministries. Further study could usefully explore how far this emphasis has negative consequences that are already manifest: encouraging a wasteful duplication of effort and a destructive competition for prestige and resources between agencies with overlapping functions.

Homedes et al. go on to look at these issues with reference to a recent health care reform initiative in El Salvador. This process was led by the World Bank, along with a special Health Reform Group set up as a separate entity from the Ministry of Health. The authors characterise the reform process as highly secretive –indeed they were themselves unable to obtain basic items of information. The proposals followed a standard neo-liberal approach: a combination of privatisation, decentralisation and some selective primary health care initiatives. Homedes et al. point out contradictions in the reform process, including its purported goal of promoting participation in health policy, whilst suppressing debate about the reform itself. However, before implementation could begin, disagreements between the national government and the World Bank led to the collapse of the reform process.

The difficulties of implementing "rational" health care reforms at the micro level are clearly depicted in Sarah Atkinson's chapter on decentralisation in the Northeast of Brazil. Looking at three different districts within the state of Ceará, she finds considerable variation in patterns of interpretation and implementation of the national reform programme. These largely reflect the complex micro-political dynamics operating in each district, including the degree to which clientelism or *coronelismo* influences local health policy, and the different perspectives and attitudes of health professionals. Atkinson draws attention to the limitations of short and superficial fact finding visits by foreigners, observing that Brazilians are very adept at presenting policy and practice in a way which satisfies international norms and models, even if the reality is often very far from this. The same could be said about most other Latin American countries. This tendency often involves an element of collusion between international agencies, who are not prepared to probe or see what they are not meant to see (or what does not fit within their particular agendas). The development of appropriate health policies needs researchers who are familiar with the region and who do not gloss over the "messiness" of local contexts.

Despite these barriers, sweeping health reforms are sometimes implemented largely as planned. This would appear to have been the case in Chile during the Pinochet dictatorship. The absence of any form of democratic process helped to speed up the reform process and prevented any significant modification of the original project as it was put into practice. However, it also precluded debate or participation in the reform process, and gave rise to policies which some argue have been detrimental to the majority of the population. Too often, accounts of health care reforms in Chile fall into the trap of taking sides in the ideological debates about neo-liberalism. Left-wing critics are inclined to label every aspect of the changes as iniquitous (Trumper and Phillips, 1997). Conversely, the development banks and free-marketeers portray the IAPREs as a partly flawed but redeemable policy initiative, much of which could serve as a model for Latin America and beyond (World Bank, 1993). The chapter by Barrientos avoids either of these approaches, and gives a cautious, objective appraisal of the initial reforms and the modifications made to them under subsequent democratic administrations. He observes that the first set of changes sought to promote the participation of private health insurance funds and to decentralise public services through the "municipalisation" of primary health care. In many respects, the reforms succeeded in these objectives, although Barrientos argues that their principal impact was to increase segmentation, with private insurers attracting high income groups and state programmes increasingly becoming an insurer (if not a provider) of last resort. During the 1990s there were attempts to shore up the public health care sector, with particular efforts to ensure a satisfactory level of service to poorer groups. However, the basic structures established in the 1980s still remain, and Barrientos asks how the continuing division between private and state provision can be justified either in terms of efficiency or equity.

Cuba is, of course, a special, and, in public health, a most interesting case. Garfield and Holtz outline the problems that a health system erected in the 1960s and 70s built upon socialist assumptions of universality of access from cradle to grave, has confronted in the face of a sustained US embargo, the collapse of the Soviet Union and domestic economic crisis. Falling protein and caloric intakes have contributed to the under-nutrition associated with outbreaks of optic neurotherapy, which placed new strains on the public health budget, already over-stretched, by, for example, the problem of rising costs of improved drugs as the *peso* lost value. Meanwhile, deteriorating housing, and a decline in sanitary conditions and access to a clean water supply contributed to a reappearance of tuberculosis.

From the 1960s free health-care, like free education, was a means by which the revolutionary regime led by President Fidel Castro won popular legitimacy. And physicians and nurses played an important part in sustaining popular opposition to the United States by stressing that the embargo embraced even pharmaceuticals, medicaments and hospital equipment required urgently by children. In the 1970s a surplus of nurses and doctors that was exported as part of aid programmes to Nicaragua, Angola and elsewhere was invaluable to the regime for propaganda purposes in Latin America and Africa. And a domestic bio-technology programme gained some momentum in the 1980s. Yet by the mid-1990s Cuba had ceased to be a net exporter of health-care. Hampered by breakdowns in electric energy and shortages of spare parts for hospital equipment, the health system lurched from crisis to crisis. But yet it survived.

Thus the problems that confronted Cuba were not those of the mainland liberal regimes. A high level of equity had been achieved; and efficiency was evident in successes in the 1990s in targeting that secured a continuing decline in death rates of mothers and children. But, as the private sector grew in other areas of activity in Cuba, so too did inequalities of income, so that doctors and nurses came to figure among low-income groups, by comparison, for example, with private farmers. And professional morale sagged further.

Cuba's success in extending health provision to the poor is a stark contrast to the situation in most Latin America countries. Goméz-Dantés provides a frank critique of a recent extent to extend health care coverage to the poor in Mexico. The Programme for the Extension of Coverage (PEC) was instituted in 1996 and aims to ensure that 10 million Mexicans previously without any access to formal care receive a minimum package of basic interventions. Goméz-Dantés puts PEC in the broader context of Mexican health reforms, noting that any benefits in terms of equity will be more than out-weighed by a major increase of government financing for the privileged social security sector. He argues that the resources being devoted to PEC and the way in which it has been developed mean that it will only have a minimal impact on the health of the poor. The chapter makes the pertinent observation that reform which benefits the poor is only politically acceptable under a number of circumstances: when it does not divert resources from other groups with more capacity to mobilise politically, when it does not offend entrenched professional interests, and when it is financed by an external loan (in this case, World Bank money), rather than tax increases. Gomez-Dantés also notes that evaluations of the PEC have been minimal and that they have not been made publicly available: this would seem to contradict the World Bank's stated policy goals of promoting accountable government.

Lloyd-Sherlock's chapter investigates the history of failure to bring about systematic reform of health care in Argentina. By the first decades of the twentieth century there already existed haphazard, unregulated networks of mutual associations and "health firms". The degree of fragmentation of services that Lloyd-Sherlock depicts is perhaps not as surprising as he presents it. Absence of co-ordination was just as apparent in British, French and US provision before the First World War. However, in Argentina the main elements of this organisational structure were allowed to continue up to the early 1990s, with trade unions having appropriated the management of most health funds. The weaknesses of this system in terms of cost, quality, coverage, equity and the unsystematic cross-subsidisation of the private and public sectors were evident by the 1970s and 80s; and health was often seen as an element of negotiation between trade unions and the government rather than as a goal in itself.

In the 1990s the government of Carlos Menem obtained lavish external funding for a new reform programmes. Indeed, officials from poorer countries might with reason query why the international agencies, usually complaining of their own lack of resources, have been so generous in assisting a relatively rich society. Lloyd-Sherlock outlines Argentine proposals for a transition from union funds to a new model of flexible, consumer-led private provision, together with decentralisation of the public sector and an emphasis on training general practitioners. He expresses doubts about the implementation of a new regulatory framework, and the effectiveness of a safety-net for market failures in an environment where a culture of de-regulation pervades the highest echelons of the federal bureaucracy.

Colombia's health reforms provide in some respects a case opposite to Argentina. According to Yepes, this reform process has responded to several factors: an awareness of deficiencies of coverage and quality of the health-care; a stress on political decentralisation and municipal reform; and the Constitution of 1991 (the first in Colombia since 1886), which proposes the principle that social security should be a right of all citizens. These reforms have two main thrusts. First, they seek to establish a unified and universal national health insurance scheme, which will include low income groups who are unable to pay contributions. Secondly, they delegate responsibilities and resources to municipal governments. Many elements of the new system correspond closely to Frenk and Londoño's model of structured pluralism.

The reforms are ambitious and imaginative and, on paper at least, could do much to improve the lot of poor and vulnerable social sectors. Their immediate impact has apparently been positive, but it remains to be seen how successful they will be in the long-run. For example, the reforms seek to assemble information on the financial capacity to pay of the entire population, but do the resources exist to update the data-base? Moreover, what is the quality of expertise in the health ministry, and are there sufficient consultants to supply more than routine assistance to the 1080 municipalities that are entitled to draw up local health plans? Might decentralisation funding be appropriated by established political bosses, or serve as bases of patronage for new ones? Does not the problem of political and social dislocation - political violence in all departments and large numbers of internal refugees - pose significant obstacles to the normal functioning of the health sector, let alone the implementation of bold reform strategies? Yepes seeks to answer many of these questions, but they can only be fully resolved by complementary studies at the local level in both cities and the countryside. One fear is that the health-care reform might suffer a similar fate to the Colombian Campaign against Absolute Poverty (1986-90). This was coherent, well conceived, carefully formulated and intelligently advocated, but ultimately collapsed due to a lack of sustained support from the President and the ruling party, and its failure to achieve credibility among the poorest groups for whom it was intended (Puyana, 1993). In short, is the reform heroic, but divorced from reality; or does it represent a dramatic break with the past, and could it become an inspirational model for other countries in the region?

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