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Why neoliberal health reforms have failed in Latin America

Núria Homedes [a,*], Antonio Ugalde [b]

[a] School of Public Health, University of Texas–Houston, El Paso, TX, USA
[b] Department of Sociology, University of Texas–Austin, Austin, TX, USA

Abstract

This paper reviews Latin American neoliberal health reforms sponsored by the IMF and the World Bank, and analyzes the impact on the region of decentralization and privatization, the two basic components of the reforms. The second part of the paper examines in some detail the Chilean and Colombian reforms, the two countries that have implemented closely the principles of the neoliberal reform. The two case studies confirm that neoliberal reforms do not improve quality of care, equity, and efficiency. In the discussion the authors identify the beneficiaries of the reforms: transnational corporations, consultant firms, and the World Bank's staff. The recognition of the beneficiaries helps to explain some of the reasons behind the Word Bank continuing pressures to implement neoliberal health reforms in spite the growing evidence of their failures.

Keywords: Health reform; World Bank; Privatization; Decentralization; Latin America; Chile; Colombia

1. Introduction

The inefficiencies and inequities of the Latin American (LA) health systems have been known for many decades, but by the late 1970s and early 1980s LA political leaders, users, providers, and researchers were all well aware that some changes were needed to reverse to revert the increasing users' dissatisfaction and decreasing quality of care, and improve the equity and efficiency of the systems. The economic crisis of the 1980s only accentuated these problems and by the end of the decade it was more evident than ever before that the health status of the LA population did not correspond to the level of development of the region nor to the amount of resources spent on health care.

The International Monetary Fund (IMF) and the World Bank (WB) took advantage of the crisis and pressed for health reforms as a condition for borrowing. The IMF required structural adjustments to reduce the huge public debts that governments had contracted in previous years and were in part responsible for the crisis [1]. Because a large part of public expending correspond to social services (health, education, and welfare), the IMF and the WB required governments to reduce them [2,3]. It was at this juncture that the WB began to have a prominent role in international health policy; by the end of the 1980s, the WB had become the major international health lender [4] and began to assist countries to prepare health reforms based on neoliberal economic principles. The mission of the WB was to provide technical guidance,

* Corresponding author.
E-mail address: nhomedes@utep.edu (N. Homedes).

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loans, and directives to implement the reforms; other international agencies such as the Inter-American Development Bank (IDB), US Agency for International Development (USAID), and some private foundations followed the WB's neoliberal ideology and provided additional logistic and financial support to the health reforms.

The underlying principle of the neoliberal health reforms is the belief that the private sector is more efficient than the public sector. Based on this belief, neoliberal health reforms advocate for a reduction of the role of governments. In the WB's vision of a neoliberal state, the government function in public health is to regulate while the private sector provides health and medical care services.

One of the objectives of the reforms was to free central government funds to pay for the huge public debt [5,6], and shifting the financial burden of public services from central governments to provinces was an expedite way to accomplish it. The policy of decentralization was wrapped under the hard-to-oppose principle of transferring power from unconcerned and inefficient central bureaucrats to the people, and marketed as part of a democratization process—even in countries under dictatorial and authoritarian regimes.

In 1993, the WB devoted the World Development Report to the health sector. In this document [7], in addition to reinforcing the decentralization and privatization strategies, the WB included the need to improve equity and allocative efficiency through guaranteeing universal access to a basic package of services, determined according to what each country could afford and based on cost-effectiveness principles. The governments and the rest of the population would subsidize the provision of the services included in the basic package to the indigent.

The WB model included the creation of third party administrators responsible for collecting and administering mandatory health insurance fees and government subsidies, and for contracting and paying service providers. Users, based on what their insurance premiums could afford, would be able to select among different types of health plans and providers. The WB's expectation was that the reforms would increase equity and efficiency, and improve quality of care and users' satisfaction.

During the 1980s several LA countries, including Brazil, Mexico and Chile started implementing some of the policies promoted by the World Bank while many others did not begin until the 1990s. Colombia is the country that followed the 1993 WB's guidelines most closely. Chile had started a neoliberal health reform in the 1980s. The main difference between the Chilean reform and the reform promoted by the WB is that, as it will be explained later, Chile maintained a large network of public services and did not define a basic package of services.

With the exception of Chile and Colombia, all other countries have faced difficulties in implementing the IMF and WB's envisioned reforms. Technical, logistic, political, and financial problems have surfaced everywhere, and most countries have implemented only some aspects of the reform, for example decentralization, or the definition of a basic package, and/or some limited privatization of medical care. The truncated reforms have produced confusion among civil servants and users, while countries have wasted scarce resources.

In this paper, first we discuss briefly the attempts and results of privatization and decentralization in a few countries of the region. Then, we present in some detail our findings from Chile and Colombia, the two countries that have followed most closely the neoliberal reforms, and examine the impact of the reforms on the stated objectives (to improve efficiency, equity, and quality of care). The analysis of the two countries is followed by a discussion of the factors that need to be in place to enable a successful implementation of some components of the reforms. Finally, we offer some suggestions explaining why the IMF and the WB continue to press on countries to adopt neoliberal health reforms in view of the documented failures.

2. Privatization

The WB attempts to increase the role of the private sector in the management and delivery of health services has had limited success in Latin America. Only a handful of countries, namely, Chile, Colombia, and Brazil, partially privatized the management and/or delivery of publicly financed health services. The rest have made small changes to increase the role of the private sector through service contracts for specific interventions or other limited schemes. For

example, Mexico's attempt to allow private firms to compete and provide services historically delivered by the Mexican Institute of Social Security (IMSS) [8] did not materialize due to the labor unions' opposition. The IMSS has contracted out the provision of selected services but contracts are not always renewed because the prices of the private sector vary and on occasion may be higher than those of the IMSS [9].

Brazil contracted out to private hospitals the delivery of a sizeable amount of tertiary care. In addition, it passed a law allowing foreign capital to purchase hospitals, and foreign health insurance and health maintenance organizations to provide services that until then had been restricted to Brazilian firms and the public sector. Soon after the passage of the law, several US firms took advantage of the liberalization, and began to offer health insurance and care to the middle and upper classes.

Twenty-five years ago an assessment of the Brazilian health sector by a WB economist made the following frank statement of the private health sector:

> Data show that the predominant form of delivery of medical–hospital services is through the private sector with reimbursements of expenses by the government ... this 'non-system' has been called chaotic, elitist, corrupt, irrational and uncontrollable. Recent audits of physicians and bills submitted ... for payments found 'irregularities' in 90% of all bills ... (including) nonexistent patients, false diagnoses, double billing for the same hospital stay, unnecessary hospital admissions, bills for medicines not administered ... improper charges for special services such as intensive care units and operating rooms [10: 26–7].

In spite of this admonition, the WB pressed for privatization of services in Brazil and other countries of the region. Recently, the comments made by another WB bureaucrat confirm that hospital autonomy in Brazil has not improved the quality of care:

> ... quality remains the 'forgotten component' of (hospital) health care delivery ... it has not improved dramatically. In some aspects, the situation may have worsened ... the capability to deliver high quality services is in serious doubt. This is evidenced by ... low quality of care in birthing rooms and neonatal units that contribute to infant and maternal mortality ... occurrence of avoidable deaths ... high hospital-acquired infection rates ... [11: 10].

In the early 1990s Costa Rica began experimenting with privatization through non-profit providers' cooperatives in a few geographical areas [12]. The cooperatives receive a capitation payment from the Social Security Fund (CCSS) and refer patients for tests, specialty care and hospitalization to the CCSS. Medicines are also provided by the CCSS. Residents in the selected geographical areas have to join the cooperatives at no cost and continue to use the CCSS for all non-primary health services and emergencies. Only four cooperatives have been organized and there are no plans to expand this model.

Evaluations of the cooperatives suggest that the model is less efficient than the CCSS, it is more costly without evidence of improved quality [13]. Users' satisfaction is high because the waiting periods for consultation are considerably lower than at the CCSS's clinics. The evaluations also indicate that there are more referrals not because of medical need but as a mechanism of reducing the cooperatives' expenditures and physicians' workloads; obviously, unnecessary referrals increase costs to the CCCS and the workloads of the CCCS' personnel, and reduces the overall efficiency of the Costa Rican health system. Profits of the non-for-profit cooperatives are distributed mostly among physicians and some small amounts among other staff members [ibid].

The CCSS has also contracted out some high tech services to the private sector while attempts to do so for hostelry services were unsuccessful because there were no responses to the bids. The WB continues to pressure the government to privatize the CCSS, the most successful health care system in the region, that provides full care-including medicines- to 90% of the population.

In 1998 the Social Security Institute of El Salvador (ISSS) began a pilot privatization project by contracting out the delivery of primary care to two for profit clinics in two geographical areas within the metropolitan area of San Salvador. All ISSS beneficiaries who resided in the selected areas were obligated to receive care at the clinics that were financed by the ISSS on a capitation basis [14]. These two clinics offered

general, internal, gynecological and obstetric services and medicines, and referred patients for other specialty care and hospitalization to the ISSS. After 2 years, the experiment was ended abruptly.

An evaluation of the project identified a variety of problems. The per capita amount paid to the clinics was insufficient to cover the expenditures, and physicians preferred to dispense expensive brand name drugs instead of generics. The use of brand names forced clinics to purchase directly from manufacturers or importers and, given the small amounts involved in the transaction, the cost of medicines was much higher than in the ISSS clinics, which benefited from the lower cost of generic drugs and from economies of scale due to larger purchase orders [ibid].

In addition, the ISSS spent considerable resources monitoring the private clinics without providing useful feedback, which, in this type of pilot project, was badly needed. The directors of the clinics felt that the inspections were too frequent and aimed at controlling rather than at facilitating solutions to the unavoidable conflicts that emerge in experimental projects; and complained that the continuous inspections took a considerable amount of time and resources. Moreover, according to the directors, the ISSS failed to fulfill its financial part of the contract; a reason why, in their view, both clinics were bankrupt by the end of the second year.

An official explanation for ending the project was never offered, but the World Bank and other international agencies continued to press for privatization of public hospitals [15,16]. The reaction of labor unions was swift. ISSS and public sector health workers entered in a long and successful strike that by 2003 brought to a closure the idea of privatizing public hospitals [17].

In LA the privatization of hospitals has been accompanied by large investments in improving hospital financial information, estimating costs, and developing contract and payment systems, but there is little evidence that these efforts and expenditures have had a significant impact on the quality of care and the efficiency of the systems; hospital corruption persists according to a multi-country study sponsored by the Inter-American Development Bank [18], and as indicated earlier in the case of Brazil efficiency and quality of hospital care have not improved.

3. Decentralization

The WB and other international agencies have been more successful in promoting the decentralization of health services. Practically all countries of the region have transferred some decision-making powers to state/provincial/departmental governments. In most cases it would be more accurate to say that there has been some deconcentration of decision making from the central government to the next lower administrative level, and in a few countries to municipal governments.

As indicated earlier, the underlying principle to promote the decentralization of health services was to transfer fiscal responsibilities to the provinces to free central government funds to pay national debts [19,20]. This was clearly stated in a WB document [21] and this is the way it was understood by local governments. Thus, in the first phase of health decentralization in Mexico (1983–1988), the states were given the option to decentralize or continue depending on the federal government. About half of the states (17 out of 31) decided to remain centralized because of the well-founded fears that the federal government would transfer the responsibility to provide health care without the needed resources [19]. Even at the outset of the second decentralization phase (1995–2000) some of the states that had remained centralized continued to oppose decentralization because they had learned from the first phase that the federal government decentralized the implementation of some programs without transferring the resources needed to implement them [22]. Finally, in 1996, after making some financial commitments and using strong political pressure, the federal government had the reluctant governors join the rest in signing the National Decentralization Agreement. The rationalization for decentralizing health services in Latin America can be summarized in the following points [23–26]:

(1) Local decision-makers know and respond better to community needs, and avoid costly errors made by distant bureaucrats who tend to be ignorant of local health conditions.
(2) Community involvement in planning and supervision of local services increases participation of local communities, which in turn promotes democracy.

(3) Local controls and adjusting services more closely to local needs contribute to a more efficient use of resources and produce greater user satisfaction.

Evaluations of the decentralization efforts conducted in different countries in LA suggest that these expectations are rarely met.

Local politicians do not always make the best decisions for their communities. Frequently, they choose health interventions that are hard to justify technically, or allocate health funds transferred by the central government to other programs because it is politically expedient for them. In Bolivia, for example, mayors spent health and education funds on road development [27]; in Colombia, health funds were directed to building hospitals in municipalities, which, according to the infrastructure plans, were not needed [28]; in Mexico, some states have diverted federal health funds to other activities [29]; in Piura (Peru), the board of directors of a primary health center decided to increase cost recovery fees to finance the construction of a hospital, and in another center they discontinued the generic drug program and began to sell brand-name drugs [30]. Communities themselves do not always make the correct health decisions or they fail to follow technical recommendations. In Nicaragua, the Ministry of Health donated sacks of cement to rural households to build latrines; instead many families sold them [31].

In an evaluation for the Inter-American Development Bank of the first decentralization phase in Mexico, Gershberg [32] found that decentralization had led to a dramatic deterioration of the quantity and quality of services of the IMSS-COPLAMAR program (later named IMSS-Solidaridad and now IMSS-Oportunidades), one of the few successful primary and hospital care programs for the poor rural population.

Decentralization creates coordination problems among administrative levels, causing an inadequate and inefficient use of resources. Very often the municipality pays for the provision of primary health care and the state/provincial/departmental government pays for hospital care. In this case there is a tendency among first level physicians to unnecessarily refer patients to the second level of care to diminish their workload and reduce the expenditures of the referring unit. The case of the cooperatives in Costa Rica has already been mentioned, and Chile, as it will be seen, is also a good example of unnecessary referrals.

There are additional reasons for lower efficiency in Latin American decentralized health systems. When the purchasing of medical supplies and drugs is decentralized, economies of scale are lost. The benefits of centralized purchasing can be significant; when the Caribbean countries jointly prepared international tenders for the purchase of medicines through the Caribbean Development Bank they saved 44% of the previous cost [7]. Large international bids can greatly reduce costs, but for many decentralized provinces the lack of technical knowledge to prepare the tenders and the quantities needed pose severe limitations. In some countries there have been programs that have centralized purchases with different degrees of success but many decentralized hospitals and municipalities continue to purchase all or part of their pharmaceuticals and other supplies directly from local wholesalers or even retailers.

Decentralization widened existing urban–rural and inter-regional inequities. Urban dwellers exert more political pressure than rural dwellers and, therefore, obtain a disproportional amount of health resources [33,34]. Similarly, large cities have more political clout than smaller ones and get more per capita resources. Geographical inequities are aggravated by the well-established fact that rural dwellers' health needs are larger than those of urban populations.

Several authors argue that decentralization is a means or even an excuse to privatize health services [14,35–37]. When public hospitals are decentralized, many enjoy the same autonomy as private hospitals and behave like them; when provincial or municipal health departments are decentralized and the central government reduces or stops funding them, a de facto privatization of financing takes place as the decentralized units set up or increase cost recovery fees to pay for the services.

Decentralization of some functions could be desirable when enabling conditions are present. When and how, and what countries should decentralize specific functions are decisions that cannot be imposed by economists working at international agencies[1].

[1] Our criticism of decentralization in LA's current reforms is not a criticism of decentralization. In some countries and under certain circumstances, with appropriate safeguards (none of which

Now we turn to review in more detail the reforms of Chile and Colombia, the two countries that have followed more closely the neoliberal blueprints and examine the effects of the reforms on equity, efficiency, and quality. It should be noted that in the absence of baseline information, quantitative assessments could not be made; the evaluation we present is based on a few available indicators and on the expert experience of local researchers.

4. The Chilean reform

Prior to the 1973 military coup, Chile had a national health system with universal coverage financed by the central government. It was considered the most comprehensive and one of the best organized in the region [38]. With the military dictatorship, and under the influence of economic consultants from the University of Chicago, Chile was the first Latin American country in LA to implement a neoliberal economic reform.

In 1981, the public health system was decentralized; the first level of care was transferred to the municipalities, and hospital care to Health Areas (Áreas de Salud), administrative health divisions that typically include more than one municipality. The government also opened opportunities for the private sector through the Instituciones de Salud Previsonal (ISAPREs). The ISAPREs are private health insurance companies; some of them are foreign firms or subsidiaries of US-HMOs. Chileans can opt-out of the public system by channeling their mandatory health contribution (7% of the salary) to the ISAPRE of their choice.

The ISAPREs offer different types of policies, depending on family size and total contribution, and each policy has distinct deductibles and co-payments. In 1995, they offered a total of 8800 health plans. Until the early 1990s when it became illegal, the ISAPREs could restrict or void the contract with the beneficiaries when they presented an expensive or chronic health problem, a practice that the Superintendence of Health responsible for regulating the private sector has not been able to eradicate entirely. When beneficiaries reach the age of 65 their health care is transferred to the public sector.

The creation of the ISAPREs has fragmented the system along socio-economic lines The wealthy tend to join the ISAPREs, because the 7% of their salary represents a considerable amount of money and with it they can buy an expensive comprehensive plan or a very attractive supplemental package to the mandatory basic plan. Those who cannot afford to purchase the packages offered by the ISAPREs receive care either from: (1) the national health care network that is paid by FONASA (the public third party payer), the municipalities, and since 1986 user fees, or (2) through their choice of a private physician who is paid according to pre-established fees by FONASA and a co-payment, for hospital care these patients are referred to the public health hospitals. The costs of accessing private physicians have increased throughout the years and the number of patients able to afford them has diminished. Hospital care for those who select the second choice is provided by national health care network.

Today, in Chile—one of the wealthiest LA countries—only about 22% of the population is enrolled in ISAPREs, and they spend 43% of all health expenditures. In other words, most Chileans cannot afford to join an ISAPRE and those covered by them spend double the rest of the population, despite being younger, healthier, more educated, and having smaller families than those covered by the public health sector. Furthermore, because of geographical convenience and more frequently because the public system is better equipped, ISAPREs' beneficiaries at times prefer to use government services. For example, in 1998, 11% of all public hospital surgeries, 9% of deliveries, and 4.5% of public hospital days were incurred by ISAPRE beneficiaries [39]. It is estimated that cross-subsidies amount to 4% of public expenditures.

During economic downturns or when the government is unable to control private health costs, citizens who are enrolled in ISAPREs or select private physicians may have to shift to the public sector and the public sector is expected to cope with the sudden increase in patient loads. The shift is a heavy burden for the public sector because public employees are career civil servants, and hiring personnel to satisfy the sudden increase of users represents a long-term commitment that cannot be easily reversed because civil ser-

are present in the majority of LA today) decentralization of some functions could have positive outcomes.

vants are tenured. This is a limitation that the private sector does not have to face.

By geographic areas, the utilization of primary care services can be 2.8 times higher in one area than in another, medical emergency care 3.9 times higher, and hospital discharges double [40]. Moreover, after the elimination of extreme values, standardized mortality by municipalities oscillates between 30 and 160 in relation to the national mean of 100 [ibid].

The rural–urban and the large–small city gaps persist, and geographical and social class disparities continue in spite of the attempts to minimize inequities with two solidarity programs [41–45]. One of the solidarity programs is through FONASA. FONASA allocates funds according to capitation fees and on an index-based poverty formula that distributes a slightly higher amount to poorer municipalities. The second solidarity program is based on a Robin Hood law that requires transfers from wealthier to poorer municipalities. It appears that these programs are insufficient to reduce the gaps. In 1996 municipalities in the top income decile spent 9000 pesos per capita more on health than those in the lowest decile (one US dollar equaled 407 pesos). The result is that there are large geographic differences of public sector physician to patient ratios, ranging from 0.28 to 1.92 physicians per 1000 people; and as indicated earlier, there are also significant health status differences by geographic area.

Recently, the Ministry of Health acknowledged that the Chilean health system was "extremely inequitable" [46]. Citing the World Health Report of 2000, the Ministry reminded fellow Chileans that the country ranked 168 out of 191 nations regarding users' financial burden, and fared poorly regarding other variables such as timely access, access to social assistance during treatment, quality of the setting, relations with providers, and ability to select providers [ibid]. In all of these indicators Chile was behind more than 100 nations. In a bold statement, the Ministry blamed the creation of the ISAPRES and the derogation of the employers' contribution to the health system for the inequities.

The recognition of the inequities prompted the launching in January of 2003 of the program AUGE (Proyecto de Régimen de Garantías de Salud) to guarantee that all Chileans have opportune access to health care for 56 catastrophic conditions (such as polytrauma, various types of cancers, and ischemic heart disease) and to ensure that all Chileans are treated for these conditions regardless of their ability to pay, nobody will be required to pay more than his/her family's 1-month income.

Since the early 1950s when the National Health Service (NHS) was created, almost 30 years before the inception of the neoliberal reform, all Chileans had access to health care. The reform has not resolved the equity and access problems that lingered since the beginning of the NHS. The beneficiaries of the neoliberal reform have been the ISAPREs that have operated with profit margins in some years as high as 20% and administrative costs of 20%. A combination of strategies such as a very careful selection of clients (the better educated and the wealthiest), limiting access to a defined package of services, increasing deductibles and co-pays, excluding those above 65 years of age, finding loopholes to bypass the prohibition to exclude beneficiaries with expensive chronic problems, establishing short-term contracts, and cross-subsidies from the public sector explain the high profits.

To summarize, in Chile, there is little evidence that the reforms have reduced inequities and inefficiencies that existed in the National Health Service. On the other hand, the new model has fragmented health care among social classes, a small percentage of the population consumes a sizeable amount of the health resources, and co-payments represent a heavy economic burden for those with lower incomes may even postpone needed care.

5. Colombia's reform

The case of Colombia is important because its first Health Reform Law in 1990 began a comprehensive decentralization to the municipal level, and in 1993 the government passed a new Health Reform Law that followed closely the recommendations advanced by the 1993 World Development Report [7]. In addition, in 2000 the WHO 2000 World Health Report ranked Colombia's health system at the top of all LA health systems [47]. As a result, the Colombian system is offered to other countries as the model to follow. WHO staffers who had previously worked at the WB promoting its health reforms heavily influenced the ranking. Scholars, professionals and civil servants in many countries decried the ranking and blamed the decision

to the undue influence and bias of former WB staffers [48–50] and even one of the six principal authors of the World Health Report has questioned the methodology [51].

The Colombian reformers tried to avoid some of the negative features that had been detected in the Chilean reform, particularly the social class segmentation. To this effect, the model offered all Colombians regardless of their income the same choice of providers, but as it will be seen the attempt was not successful.

The essence of the health reform in Colombia is to universalize access to a relatively large package of mandatory services. To access services, citizens have to affiliate to the social security system. There are two types of affiliation one for salaried workers and those with ability to pay, and another for the poor. The former contribute 12% of their salary, 11% to pay their insurance premiums and the remaining 1% is deposited in a solidarity fund. The government and the solidarity fund pay the premiums for the indigent.

Another component of the reform is the participation of the private sector in collecting premiums and delivering health services. The collection of premiums has been delegated to Health Promotion Enterprises (EPSs) that must offer the mandatory minimum plan. For those willing to pay higher premiums the EPS offer other complementary plans. The EPS enter into contracts for the provision of services with public or private health delivery institutions or alternatively provide services through their own delivery networks. The EPSs have the freedom to design payment methods for health care providers. Users can select the EPS and the health plan that best responds to their needs and their financial situation.

To avoid social class segmentation, the EPSs have the legal obligation to offer care for the indigent whose premium is paid by the government and the solidarity fund; in practice, many find loopholes to bypass the law and most indigent persons receive care from the Administrators of Subsidized Systems (Administradoras de Regímenes Subsidiados or ARS). ARS are a modality of EPS created by departments and municipalities to administer and provide care through public or private networks to those who cannot enroll in EPSs; such is the case of small town residents and rural dwellers. Due to financial considerations, EPSs are not interested in offering services to these populations. In addition, the reform has transformed public hospitals into autonomous entities with freedom to establish their own institutional goals and generate resources. In Bogotá, many autonomous public hospitals have encountered grave financing problems and have been forced to close down.

The health reform in Colombia has been accompanied by a significant increase in total health expenditures. It is estimated that between 1984 and 1997 expenditures increased by 178%. In per capita terms, health expenditures grew from US$ 50 in the 1980s to US$ 90 in the late 1990s [52]. However, the increase in public expense has benefited predominantly the wealthy, who have seen their co-payments reduced especially in the late 1990s [53]. For example, in 1993, households in Bogotá in the lowest quintile paid yearly in direct payments 17,881 pesos (of 1997, US$ 1 = 1064 pesos) and households in the highest quintile paid 50,043 [52]. In 1997, the payments were 24,658 for the lowest quintile and 30,674 for the highest. All except the lowest quintile saw their direct payments reduced in the 1993–1997 period. By 1997, those in the lowest quintile were paying more that those in the fourth and third quintiles, a trend that questions the equity of the reform.

Affiliation to social security has been greatly expanded, especially for those in the lowest income bracket including rural areas. Some authors have indicated that the expanded affiliation does not imply higher coverage. Hernández Álvarez [54], for example, claims that in 1999 only 61% was covered by the new social security system, while in the pre-reform days it was estimated that 75% of the population had access to some type of health care services.[2] In addition, hefty co-payments for some services do not allow many poor with insurance to access them. In fact, access for the poor may have decreased.

Public health funding for medical care increased substantially until 1997, and the distribution of

[2] There is no consistency regarding coverage figures in Colombia. The civil war may be a possible explanation for the lack of consistency because it is difficult in a war to establish the precise population figure under each contending party. The territory under guerrilla control is estimated to be about one-third. Also, official figures for membership with the various health plans are only estimates. For example, in rural areas an ARS (generally a NGO) is contracted by the municipality to cover the entire population of a municipality; in practice, geographical distance reduces the coverage significantly.

national funds between 1993 and 1997 became geographically more equitable. Poorer departments and municipalities received from the central government higher per capita transfers than those economically more developed [55], but the attempt to make central government fund transfers more equitably has not translated into more equitable coverage. Nationwide, rural dwellers continue to have less coverage than urban dwellers. In 1993, 77% of urban dwellers had access when in need against 58% of rural dwellers; by 1997 the gap continued, 79 and 60%, respectively [52].

Subsidies do not always reach the neediest. A 1999 report from the General Finance Office called attention to the irregularities in the identification and classification process of the poor: 30% of people who should have been classified as poor were not, while 31% of those classified as such were not poor [56].

There are some questions regarding the efficiency of improvements brought by the reform. In 1994 personnel costs represented 50% of all hospital operational costs, by 1997 it had increased to 70% [57]. An analysis of the production of the first and second level public hospitals showed that between 1996 and 1998, the operational costs grew by 24% in real terms, while production grew only 4% [58]. This could be explained by an increase in the complexity of care provided at public hospitals, by time-consuming activities required to prepare invoices, and/or lower productivity.

The information on quality of care is very limited but one study suggests that the quality of nurses' work has deteriorated. A study of nurses in Colombia, Argentina, Mexico, and Brazil [59] illustrates some aspects of the negative influence of privatization. According to the authors, the market approach to health care has increased the nurses' level of stress and job dissatisfaction; it has led nurses to seek multiple employments to make ends meet and to ensure a steady income due to the job insecurity that emerges from flexible employment contracts; it has raised malpractice concerns, inter-institutional migration, and the number of new bureaucratic tasks for which the nurses were not trained. It is easy to guess the impact of these changes on quality of care: less direct patient care, and in the words of one of the interviewed Colombian nurses: "Patients may feel that we really don't care that much about them, because we just don't have enough time to spend with them to really know what is going on" [ibid: 351].

According to a recent survey of Colombian medical specialists, 62% considered that the quality of care had deteriorated [60], a fact that is supported by evidence from other sources [61]. According to the same survey, 66% of the specialists believed that disease prevention and health promotion had not improved, a response in agreement with the information provided by Sarmiento [62] who affirms that immunization coverage has decreased, the prevalence of vector transmitted diseases (dengue and malaria) has risen, and the program to control tuberculosis has been severely weakened.

The literature about the Colombian health reform presents growing evidence that the system is at the edge of collapse [63]. The EPSs and the government owe hospitals and clinics a huge sum: the accumulated debt as of 30 June 2002 was 6401 billion pesos (US$ 1 = 2348 pesos) [ibid].

In sum, in Colombia, the country that has followed very closely the WB reform blueprints, in spite of a very substantial increase in health care expenditures, a large percentage of the population continues to be uncovered, the poor continue to have difficulties in accessing services because of high co-payments, there are no measurable efficiency and medical care quality improvements, public health care has deteriorated, and health equity has suffered.

6. Discussion

As mentioned above, under the WB model, the health sector achieves maximum efficiency when services are provided by the private sector under state regulation. The complexity of regulating the health sector should have raised a red flag when the WB promoted neoliberal reforms in LA. Even industrial democratic nations that regulate public utilities with more or less success public utilities have faced difficulties in regulating the health market. Reformers should not have taken for granted that governments in the region had sufficient regulatory capabilities. Historically, authoritarian executives and very weak legislative and judicial systems have characterized the Latin American political systems. This political reality is not conducive to having effective regulatory institutions.

When the health reforms were introduced, Latin American governments did not have the institutions

needed to regulate private health insurance companies, managed care organizations, or other private providers and pharmaceutical companies, and, in health care, market regulation is essential to ensure access to quality services and protect consumers. Gómez-Dantés [8] comments on Mexico can be extrapolated to other countries of the region: "Health authorities ... lack a monitoring and evaluation culture and there are no formal accountability mechanisms". Bolis [64] goes further. According to this author, countries in the region need legislation to correct existing knowledge asymmetries between suppliers and recipients, to protect consumers against unnecessary risks, and to help them make the right decision when choosing among different treatment options. Bolis also suggests that countries need legislation to guide the behavior of private agents, and institutions to supervise, monitor and conduct technical and financial audits of private providers.

Many years before the 1990 and 1993 reforms in Colombia, the government of this country created the Superintendence of Health to regulate and coordinate the social security and public health services, but all concerned parties largely ignored its efforts. Similarly, the superintendencies in Chile, Argentina, and Peru have shown little capacity to regulate the private sector and have difficulties demanding accountability from public agencies. The experience in the US shows that even with strong regulatory agencies the privatization of health services is unlikely to increase equity and efficiency; without them, the results could be catastrophic.

A recent study [65] in the Dominican Republic presents an excellent example of the disastrous consequences of privatization without regulation. The authors document that the publicly subsidized privatization of the health sector took place before the government issued norms to insure competition among private providers, establish minimum quality standards, and was able to regulate the unethical behavior of health insurance firms. The result has been multiple abuses and exclusions. The study concludes by stating that in this country the health reform was implemented backwards.[3] Unfortunately our review of the literature suggests that this has been the rule more than the exception in Latin America.

The WB ignored many of the problems that had been identified as causing the pre-reform failures. If it had looked into them it would have found that they were related to the inability of governments to regulate the decentralized social insurance systems, to enforce legislation, to control physicians' behavior, and to control ubiquitous corruption. The WB reforms have done little to resolve these basic problems that continue unabated today [18].

It is not surprising that many observers claim that the reforms have failed to achieve the stated objectives and have in fact caused the opposite results: increased inequity, less efficiency, and higher dissatisfaction, without improving quality of care [61,66–73].[4]

Our research confirms that Latin American countries, 10 and 20 years after the implementation of neoliberal reforms are spending more resources in health care without corresponding improvements in efficiency; high—and in some countries higher—percentages of the population continue without access to care; in some regions there are higher inequities; and often there is administrative uncertainty. The financial sustainability of the sector has been placed into question because of increased health expenditures: today there are more administrators, higher salaries, higher expenditures for medicines, and more foreign debt as a result of the WB and IDB reform loans.

6.1. *The beneficiaries of the neoliberal health reforms*

The question that needs to be asked is why, in view of the mounting evidence that neoliberal reforms do not accomplish the intended goals, the WB continues to promote its health reform model. Identifying the beneficiaries of the neoliberal reforms clarifies the reason for the WB's persistence in promoting unsuccessful policies. The principal beneficiaries include transnational corporations, consultant firms, and the WB's own staff.

[3] The leading author is a senior public health specialist at the WB with many years of field experience in Latin American. It is unfortunate that top WB economists do not pay attention to their own field experts.

[4] Research and evaluation of the reforms funded by the WB or agencies such as USAID tend to suggest that there have been some equity improvements in the financing of health services [79,80] or that decentralization has produced "performance improvement" [81].

6.2. Transnational corporations

The prime beneficiaries have been the HMOs and private health insurance firms, and—in some countries—the more affluent classes through decreases in out-of-pocket expenses and access to care that offers more luxury hostelry services. The interests of the US insurance firms in LA have been well documented [74]. The inclusion of privatization as a core policy responds to those interests and cannot be explained by any technical rationale. The increasing failures of HMOs and private hospitals in the US—in spite of all the resources and regulating capabilities available in this country—should by themselves have alerted WB staff that the US model was inappropriate for LA, but the interests of the firms prevailed.

The IMF and the WB are the overt actors that promote the reforms. According to Stiglitz [75], a Nobel prize laureate and economist who occupied key posts within the WB and was an economic adviser to President Clinton, the two multilateral agencies represent interests of groups articulated through the US Treasury. Stiglitz observed decision-making from an advantageous participant–observer position and describes in great detail how the US Treasury has imposed its ideology and interests, which are those of Corporate America, on the IMF and WB. In a globalized economy, the well-being of European and Japanese transnational corporations depends to some extent on the well-being of US transnational corporations, and for this reason the governments from the EU and Japan do not object to the US Treasury's dominant role in the IMF and WB.

Thus, we can understand the neoliberal ideology that permeates the two multilateral agencies and their health policy choices and exclusions. For the US Treasury the main concern is profits for transnational corporations. Excluded health policies are those that have a negative impact on corporate profits such as safety programs in factories and agriculture, accident reduction in vehicle transportation, tobacco reduction, the promotion of generic drugs, and the promotion of essential drug lists; all of which at a very low cost would have improved significantly the health of the populations [76]. Programs to reduce violence, health education programs, and the promotion of some well-established public health interventions have also been excluded from the neoliberal reforms. We can suggest that they have been left out because they: (1) do not require the types of large loans that the WB is accustomed to provide and (2) do not generate profits for corporations.

6.3. Secondary beneficiaries

There are other beneficiaries that can be considered secondary because the benefits they receive are relatively small compared to those of the transnational corporations. Among them we can include consultant firms, universities, and WB staff.

Multilateral banks and bilateral aid agencies contract out directly or through the government of the loan recipient country technical assistance, health assessments, intervention evaluations, and some "academic research". Generally, the WB or the country prepares bids, but the bidding system, pre-selection procedures and other factors lead frequently to the selection of the same small number of contractors.

A consultant firm can easily be removed from the short list if findings from a previous contract contradict the ideological tenets of the agencies. For smaller firms the contracts are a matter of survival. It takes very little time for the WB (and other assistance agencies) and the consulting firms to know what to expect from each other. The funding agencies anticipate evaluations without strong critical comments and policy recommendations in tune with the neoliberal ideology; the consulting firms anticipate new contracts.

The WB, USAID, and some foundations have also contracted out health assessments, research and health interventions to prestigious universities. For the universities, the contracts and grants—even if small by WB standards—represent attractive incomes. Overheads could be 50% or more. If these institutions want to continue receiving funds from the international agencies they have to avoid outright criticism of neoliberal reforms even when the failures are obvious. To do so without compromising their academic integrity is like walking on the tight rope. How researchers accomplish this merits a close examination, but is beyond the scope of this paper. For the WB and other funding agencies the non-critical reports and publications from the prestigious centers of learning

provides assurance and validation before the broader audience, including the US Treasury and the Corporate World.

The WB, as any other bank, needs to lend and, even if it is not explicitly written in the job description, WB officers are expected to sell loans. The number and amount of the loans are important aspects for achieving merit and status within the WB bureaucracy. In some instances, the countries may not want a health loan, but the WB imposes one as a condition to lending to other sectors of the economy. This has been the case for example in Costa Rica [77], where against the wishes of health authorities, the WB forced a health loan under the threat of halting loans to other sectors. The health loan was an excuse to open the doors to neoliberal health interventions that health policy makers did not want. So far, Costa Ricans have resisted the WB's pressures to dismantle one of the most equitable and efficient health systems in LA but it is not clear how long they will be able to continue to do so in view of the mounting pressures from the WB and the US government.[5]

Today, the WB is the major lender in international health, and as a result has become the leading international health policy maker. Other multilateral banks such as the Inter American Development Bank (IDB) and bilateral agencies have by and large followed its neoliberal policies, even if on occasions there have been some disagreements [78]. The formidable concentration of power in the hands of a few IMF's and WB's policy makers and bureaucrats weakens national health policy making and the finding of correct answers to each country's health problems based on local political, cultural, and historical realities more than on a generic formulation based on ideology.

[5] Recently, in December 2003, the Costa Rica government walked out of the Central American Free Market Agreement's final discussions because among other reasons, it could not accept the US conditions regarding insurance companies. In Costa Rica the insurance business is a state monopoly, and the fear of powerful US insurance companies entering the market including the health market was something that the government of Costa Rica considered that it was not in the best interest of its citizens. It should be remembered that the financial resources of some insurance companies are much larger than those of the government of Costa Rica. If the government of Costa Rica had given in, within a short time all insurance business would have been under the control of a few foreign corporations.

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