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HEALTH SECTOR REFORM IN LATIN AMERICA AND THE CARIBBEAN: THE ROLE OF INTERNATIONAL ORGANISATIONS IN FORMULATING AGENDAS AND IMPLEMENTING POLICIES

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Abstract

This article examines health sector reforms in Latin America and the Caribbean to discuss the ideological, theoretical, and conceptual elements that inform the reform agenda and the models put forward for attaining greater equity in the region's countries. Its starting assumption is that the relevant literature generally neglects the economic, social, and political aspects underlying the processes of change, reinforcing the idea that these are purely technical processes and to be settled technically. It presents a brief review of political science literature on the issue of the State, its relative autonomy and its relationship to society, emphasising moments of crisis and reform. It analyses the contemporary health sector reform agenda, the leading role of international organisations – especially the World Bank – and some results of its implementation. It concludes that politics must be restored as essential to the reform process, given that the tendency is to discredit politics and spread the belief that important technical changes can be made to health system structures without contemplating the various contending projects and the resistance from actors opposed to change. It is therefore fundamental to think in depth about the role of the State and its ability to formulate and implement policies, and to analyse national options in the light of the constraints and proposals formulated/induced by outside forces, but also of national contexts, a perspective that has been largely overlooked in health sector studies.

———Key-words: Health reform, international organization and health reform, equity.
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Introduction

At the start of the 21st century, the societies of Latin American and Caribbean countries are heavily marked by inequality and social exclusion resulting from a wide-ranging programme of structural adjustments, which began to be implemented over a decade ago, and included economic and institutional reform processes, as well as substantial sectoral reforms, which included the health sector.

These processes have been influenced by a number of simultaneous endogenous and exogenous phenomena, including changes in the world economy and the attendant turbulence; national States' domestic options in view of globalisation; State fiscal crises and diminishing public investment; the consolidation of democratic regimes restored through complicated political transitions; the urgent need to redeem enormous accumulated social debt; and the inefficiency and poor effectiveness of health sector activities.

The important changes that took place throughout the region the 1980s and 90s led to a discouraging economic and social outcome. The data reveal that the macroeconomic adjustments of the 1980s brought serious, disturbing long-term effects, both in increasing inequality and in the structure and funding of the public sector. Furthermore, reformers gave little attention to administrative restructuring and did nothing to prevent the downgrading of public sector resources (Fanelli, Frenkel and Rozenwurcel, 1992: 48).

In fact, with few exceptions, the political choices that guided Latin America's reintegration into the new world order were not directed to putting appropriate social policies in place. Instead national policies were subject to conditions laid down by the creditor banks of regional debt. The relationship between extremely unequal social development and the difficulties in implementing crucial reforms is now a consensus in the literature, governments and international organisations.

Consequently, the central issue of the region's public agenda in the 1990s was (and continues to be) how to rebuild and, at the same time, restructure the State's capability (Fiori, 1993) in order to implement the policy reforms necessary to confront problems that have been worsening since the 1980s. In addition to their inherent difficulties, these problematic and mutually overlaid processes of building and restructuring, call for increased investment.

This overall situation has made it a priority to combat poverty and review the policies suggested by multilateral agencies in the region. Equity has come to be considered essential to sustained, all-round regional development.

As regards the health sector, although the discourse on guiding principles presents health service system reform as directed to overcoming inequalities and achieving equity, the available evidence does not confirm this as a result.

The notions of reform and equity have dutifully frequented political speeches, technical documents, and scientific literature over recent decades. As a rhetorical resource these terms have served a broad ideological spectrum and have suited a range of different proposals and purposes. As concepts they have sparked endless discussions, which have never reached consensus on how to define or operationalise them. In both technical and methodological terms, they have received much attention from intellectuals, consultants and researchers, and tools have been developed for measuring and implementing equity policies, but once again these endorse different agendas and political projects.

This can be seen in overall discussions of economic and social development, as well in health sector policy. In the latter, the debate is framed by discussions of new models for reorganising social protection systems in health and by redefinition of benefit and service packages, reviving false dilemmas and outdated confrontations, such as public versus private and State versus market. On the other hand, this debate is permeated by the endeavour to produce empirical evidence and by recognition of the inherent trade-offs confronting health sector reform processes – especially among efficiency, equity, and quality. Although implementation of the changes and the policy reform debate itself differ in numerous unique and extremely specific ways in each country, whether in the North or the South, agendas and arguments have been pressed far and wide, adapted to very different realities, and converted into proposals directed to overcoming inequality.

Furthermore, the concept of "development with equity", which has gained strength in recent decades in view of the globally calamitous widening inequalities produced by neoliberal policies, also permits consensus-building among differing political and ideological camps, because *a priori* it does not harm individual interests: progress towards overcoming inequity can be so slow and gradual that, in fact, adopting the equity principle can be completely innocuous and meaningless.

To summarise, conceptual and strategic imprecision in both subject areas – health sector reform and equity – are not trivial matters and reveal the strategic goals of different definitions (Almeida, 2002b; Almeida, 2005).

Although abundant literature is available on the issue of health sector reform, there is still little discussion of the conceptual aspects and the economic, social, and political contexts that define and originate reforms and decisively influence their implementation. Such omissions reinforce the tendency to characterise them as merely technical processes naturalised by globalisation.

There is also a scarcity of health sector literature offering comparative reform policy analyses based on sound conceptual and analytical approaches, which might enable the similarities and differences among specific reform processes to be understood, along with the roles of the State and other national and international players in this process.

Despite their diversity, health systems in the region have common features that warrant a regional perspective, but at the same time demand greater analytical accuracy when examining each particular country. The heterogeneity is very great and the reforms implemented were strongly inspired by neo-liberal ideas and followed an agenda with common elements. However, Chile's pioneering privatisation and the ambitious Colombian experience stand side-by-side with Brazil's unique process of health sector reform, Cuba's singular success with its socialist healthcare model and Costa Rica's equally successful system. Some countries, however, channel substantial funding to health without attaining proportionate results, as compared with some countries of the North or even their more successful neighbours in health terms. This rich regional diversity deserves greater attention from analysts, both academic and otherwise.

This article proposes to examine some aspects of this set of problems. It offers an analysis of the health sector reform agenda, its presuppositions, and the importance of foreign influence in the reform processes. It also examines conceptual and theoretical elements that guide that analysis. The first section is a brief summary of selected authors' theoretical approaches to the subject of state autonomy and reform policy formulation and implementation. The second part analyses leadership changes in the health sector within international organisations, highlighting the leading role played by the World Bank on reform issues, including health sector reforms. The third part

analyses the new reform agenda and its social and health policy guidelines. The final part examines some critical aspects of implementing that reform agenda.

1. Some Theoretical and Conceptual Remarks

It is very often observed that the inclusion into law of principles, such as equity or universal rights and benefits, to guide the formulation of health policies does not automatically guarantee the implementation of policies that actually improve levels of equity in how health services are provided, and much less in how social rights are honoured in practice. Even so, there is little health sector literature analysing the reasons for this discrepancy using clear theoretical frameworks to help understand or explain this reality.

Some concepts important to political science are not considered in health sector reform policy analyses. The following brief and preliminary review is intended to contribute to this debate, even thought it does not intend to articulate an analytical framework.

1.1 Reform agenda

The term 'agenda' can be used with different meanings: as a list of obligations or tasks to be done by an individual in a certain period of time; as a list of subjects or problems and solutions to be addressed or discussed by a given organisation, institution, or group of participants in a special event or regular meeting; as a series of problems and decisions identified by certain actors and which may be guiding their actions even without being made clearly explicit (a "hidden agenda"); or a list of objectives or results to be achieved within a preset future period of time (e.g. "a development agenda for the 2000s", the "Millennium goals").

In the literature of policy analysis the term is given various meanings. Kingdon (1984:3) was one of the authors to define the term as the list of subjects or problems to which governmental officials and people outside of government closely associated with those officials, or interested in the topic, are paying some serious attention, or take into consideration in decision-making, at any given time.

From this standpoint, the notion of 'agenda' relates strictly to public policy makers and their bases of support, negotiation, or inter-relation and constitutes an important moment in the policy-making process involving participation by diverse national and international social actors. It covers not just the specific elements being introduced into policy formulation, but also the problems being identified and the solutions indicated to address them.

'Agenda' is also used to refer to a set of issues, including the problems and the preferred solutions, that an actor argues at certain moments or periods (e.g. the agendas of the World Bank, the Pan American Health Organisation, or a particular political party's agenda on health), very often indicating that the subjects in question are contentious (e.g. a poverty reduction agenda or a reform agenda).

Obviously the list of problems or subjects that make up an agenda varies according to the sector of government (organisation or institution), while the issue of how any particular subject

gets onto the political agenda in a specific country in specific circumstances is discussed extensively in the literature.

Some models have been developed to explain why the State acts on, or prioritises, certain issues; in other words, how certain issues get onto the public agenda ahead of others, which are relegated despite their importance.

One fundamental point in this discussion is the issue of the State and the decision-making process in public policy formulation and implementation. Several authors, starting from critiques of traditional theoretical approaches and building on empirical data gathered from case study comparisons, have sought to refine some of the concepts with a view to grasping the differences among the public policies formulated and implemented by different countries, which although they have made apparently similar choices or been submitted to the same economic pressures, are found to be very distinct when their respective specificities are analysed in detail.

Nevertheless, it is through these distinctions that these authors seek to build analytical categories and alternative theoretical approaches with greater power to explain the different realities. They generally start from critiques of reductionist theoretical approaches – both those that focus on society and those that take the State as an actor in isolation – and discover that, although focussing on diverse problems, several of the studies that, since the 1970s, have revisited the issue of the State converge on complementary arguments and analytical strategies.

They also emphasise the importance of historical comparative studies in this process of theory-building and propose exploring the larger issues addressed by several of these studies, viz.: how the State acts in political and social processes by formulating and implementing public policies; and the models for articulating State and society and for inter-relations among social groups or actors at the national and international levels.

For the purposes of this article, salient issues are the relative autonomy of the State in defining its own policies, especially in relation to the ideas, ideologies and organisations they run through.

1.2 State autonomy and the policy formulation and implementation decision-making process

Since the mid-1970s, severe economic crisis has highlighted the strong global interdependence in capitalism and brought the issue of the State and its actions in reform policies to the centre of the debate. Conceptually and analytically, it has become indispensable to rethink the State both as an actor and as an institutional structure shaped by society, as well as globally inter-related.

Skocpol (1985) argues that, in the 1980s, these revisions led to an important paradigm change that returned to the concepts of well-known classic authors (Weber, for example) and involved a profound rethinking of the role of the State in relation to the economy and society. She points out two dimensions of the discussion that are equally important to that rethinking: *State autonomy* as the *capability* of the State as an independent actor to achieve its own political goals; and the *impact of action* by the State as an *institutional structure* on public policy content and implementation (1985:9).

These currents constitute alternative analytical strategies, but are actually complementary and have emphasised the State's role in social and political change and in changes to decision-making processes. On one hand they point out that the State should be seen as an organisation

from which groups of technicians or appointed, elected or career officials pursue distinct objectives, which they either attain or do not, depending on the coercive, fiscal, judicial and administrative resources available at given social and political conjunctures. On the other hand, it should be analysed as an institutional configuration whose action influences political meanings and methods in all groups in society.

Giving the State its proper, central place in society necessarily entails respecting the historicity of the respective national realities, as well taking account of the inevitable interrelationship between the national level and the world historical context (Skocpol, 1985: 27 and 28).

Skocpol also stresses that the modern State is the product of a system of competition and interrelations among States, where many State structures and activities are conditioned by historical changes in transnational contexts. She therefore concludes that the State necessarily finds itself at the intersection between the domestic social and political order and transnational relationships, between which it has to manoeuvre in order to survive (1985:7).

Like Skocpol, several authors have discussed the issue of the State and decision-making. The concept of State autonomy that they develop in the process coincides largely in its basic formulation. Each author, however, emphasises different dimensions of that autonomy that complement each other to give a more inclusive perspective better suited to apprehending the specific realities of each country. In one way or another, all of them are geared towards the subject of public policy formulation and implementation in times of crisis and change.

In general, they address particularly the role of State institutions and elites in the State's "authoritative" action, along with the role of intellectuals and experts that operate through the permeability of the State as an organisational structure and institutional framework. "State elites" are understood to be actors holding strategic positions in the decision-making process. "Experts" are those professionals or groups who develop the technical analyses that underpin decisions in terms of institutional policies.

The concept of *autonomy* relates to the State's strength or power to impose its own preferences expressed as "authoritative" actions (Nordlinger, 1987:366; Mann, 1986), as its ability to reach its own goals (Sikkink, 1990:23) or as its capacity to perform as an independent actor with preferences of its own, as a locus of authorised, autonomous action that can not be reduced to any of the pressure groups in society (Skocpol and Weir, 1985:118; Quadagno, 1988; Grindle and Thomas, 1989; Kitschelt, 1989).

There is a difference between the *capability to formulate* and the *capability to implement* policies, and one cannot be reduced to the other. That is, a State can formulate objectives of its own without being able to put them into effect, which entails always having a competent organisational structure and some type of societal support base. Setting up an institutional framework itself opens up certain possibilities and closes others, besides which the legacy of existing guidelines and practices that become rooted and crystallised in the perceptions of strategic actors causes certain options to be discarded (Skocpol and Weir, 1985).

Nordlinger's (1987:353) builds theory in some of the dimensions described empirically by the authors, posing the following central questions: a) under what circumstances does the State act on the basis of its own preferences or is in a position to do so; b) when are State actions shaped or commanded by societal demands or expectations; and c) how are variations in autonomy or constraints on the State to be explained.

State preferences are understood here not as consensus or unity. On the contrary, they are outcomes of internal conflicts, competition, bargaining, commitments, alliances, and coalitions. In other words, they depend on the weight of the power resources of the actors involved in the process, which are mediated by the institutional rules and informal standards that permeate the State. Nordlinger also emphasises that the State's ability to act autonomously presupposes a societal base in support of its preferences (1987:369-370).

Grindle and Thomas take this discussion state autonomy further, also focussing on the State elites as the central actor, the institutions through which they act and the political – policy formulation and implementation – arenas, in an effort to identify the factors that influence decision makers. The authors begin from the observation that the process in which political and institutional changes are adopted and sustained is little known or studied, and the crucial phases of policy implementation and maintenance are frequently regarded as mechanical, not political, processes. This converges with the thinking of Quadagno (1988), who explores this dynamics in greater detail.

These authors advance three main arguments, which can be summarised very briefly as follows: a) the behaviour of decision makers and managers in the political process is not as constrained nor as independent as is supposed; b) the specific circumstances of a particular policy – whether the situation is one of crisis or routine – affect the decision-making process even if they do not determine its outcome, and are crucial to understanding the political support, the type of decision maker involved in the decision, the degree of change introduced, and the timing of the decision making; c) the characteristics of any particular reform – how the change's costs and benefits are distributed, its technical complexity, administrative reach, and short- and long-term impact – determine the type of conflict and opposition (resistance) involved in its implementation. (Grindle and Thomas, 1989: 215-216).

The authors also point out several critical elements in the public policy decision-making process that condition the criteria that decision makers adopt when evaluating the options available in a given situation. Factors that limit the available options include societal pressures and interests, historical context, bureaucratic capability, and complicity. In the reform policy decision-making process, at least four criteria influence the process of choosing options (Grindle and Thomas, 1989:223-226): a) technical analyses and expert findings, although Skocpol and Quadagno point out that technical rigour is not enough; the influence depends on the State's ability to bring these experts together in influential positions built into the institutional design, and on the quality of the information and analyses; b) the power of the bureaucracy or the ability and resources to keep coalitions working or allies in power; c) institutional stability and political support, or in other words, the importance of maintaining or building support coalitions; d) international pressure, meaning the presence of international actors (agencies and organisations) in decision-making processes through a wide variety of interactions with the bureaucracy, especially in developing countries. Skocpol (1985) also emphasises this latter point clearly.

The authors also emphasise that the reform implementation process is longer and involves much more conflict than the formulation and decision-making process and, in many cases, this phase determines how the reform will consolidate. Any policy changes significantly during implementation and the final result is generally quite different from what was originally planned (Grindle and Thomas, 1989:235).

Sikkink (1990) discusses State autonomy as regards ideas and ideologies, and the institutions they run through. She rejects a number of comparative studies that discuss the influence of ideas as a type of intervening variable mediating between interests and results. She regards ideas as like "lenses" without which it is impossible to understand interests, insofar as ideas alter how interests are perceived. Sikkink emphasises the absolute centrality of political and ideological factors, not just in determining policy outcomes, but also in influencing the many meanings and interpretations given to the ideas and recommendations behind policy formulation (Sikkink, 1990: 243-244).

Although agreeing with the other authors that implementing and consolidating new models requires capable institutions and broad supporting groups in society, Sikkink adds also the need to be adaptable to ideas and ideologies existing in a given historical situation.

The institutional structure and formal and informal norms that govern the State have a decisive impact on the potential stability of State institutions and on the likelihood of ideas' being incorporated. However, not all institutions are engaged by the ideas alone: vital preconditions are a minimum level of institutional and individual continuity and infrastructure appropriate to the goals the State intends to pursue. It is essential to consider dynamic interaction among the institutions, norms and procedures of State and society, and people, groups, and ideas. These potential resources have to be mobilised through the "political game" that also involves inspirations, leadership and the numerous variables that motivate people's belief and shape their actions (Sikkink, 1990:25).

On the other hand, other institutions outside the State – including foreign ones – also play an important role in conveying ideas. The consolidation and persistence of new ideas also depend on the level of consensus surrounding them, which are structured by existing ideas and historically formed ideologies (Sikkink, 1990: 255). In summary, the options taken, their success or failure and the consolidation in practice of the favoured model and the form in which the policy is implemented depend fundamentally on largely domestic characteristics and factors. The interrelationship between these two sets of variables (international and national), if discussed carefully in the light of the specific historical dynamics of each case, will yield explanations of each of the respective processes of change.

In a different analytical approach, other authors have focused on the spread of ideas and innovations, and developed models and typologies to explain the relationship between specific actors in implementing reform policies. Ikenberry (1990) analyses the international spread of privatisation and proposes a typology that illuminates important aspects of this process by identifying three mechanisms responsible for the spread of ideas for innovation: external inducement, policy bandwagoning, and social learning (Ikenberry, 1990; Melo and Costa, 1994).

"Inducement" is regarded as occurring in processes where the external actor uses mechanisms – incentives, sanctions or even coercion – to induce the adoption of certain policies. One clear qualification, however, is that the role of the external inducer is more complex than the simplistic idea of coercion, where an international agency or organisation imposes policy alterations from abroad. What in fact emerges are coalitions formed around specific strategies or proposals, where external pressure finds fertile soil in the national bureaucracy, and multilateral agencies or other external actors provide information and other resources that help set up or strengthen these coalitions for reform. External pressures may actually be welcomed and manipulated by national elites in order to reinforce their domestic political position. In this connection, the "conditionalities"

associated with external commitments serve to weaken the control of interest groups over policies and agencies.

"Policy bandwagoning" consists in emulating and proclaiming the purported success achieved by other countries in implementing similar policies. The technical elites (or communities of experts) and executive bureaucracy are mainly responsible for this mimetic behaviour in introducing innovations, but the driving force lies in the international sphere where the rule is competitiveness and survival imperatives among countries. Ikenberry emphasises that this evaluation movement is frankly normative, i.e., the success proclaimed is not necessarily related to concrete, objective indicators of results. The search for policies "that work" tends to be more intense in this competitive context, and the less critical information is available on the effects of the policies, the greater the frequency of adaptive behaviour.

The "social learning" process is a dynamics where knowledge "relevant" to understanding the effects and impact of policies is accumulated and distributed in the international system. This knowledge is relatively consensual in specific groups, especially in the community of experts who develop analyses for such organisations. The idea of "epistemic communities" (Hass, 1992; Adler and Hass, 1992; Melo and Costa, 1994) deals exactly with this role of experts in encountering "scientifically proven evidence" in certain problem areas in order to decrease uncertainty with purportedly objective information, contributing input to interests of State, to defining the public agenda and sectoral policies, as well as agendas for negotiations among a variety of actors. The action of such communities is grounded in consensus and persuasion constructed on the basis of specialised knowledge.

1.3 The neoliberal political hegemony and the public choice theory

Central to the development of these reform proposals were criticisms of the supply side of services and benefits, with special emphasis on those associated with social protection. In other words, it questioned the "provider" State or the Keynesian Welfare State. The central premises fundamental to this perspective relate, on one hand, to overload on the State due to demand exacerbated by the economic crisis and pressure from interest groups. The evaluation deriving from this stressed the damaging effects on national economies of excessive State intervention in private business and of the high taxation necessary to support social policies. On the other hand, it was stressed that decisions of State generally reflect the preferences of politicians and bureaucrats, motivated fundamentally by private aims connected with gaining or maintaining power. Many of the avenues that have been favoured by this approach derive from the public choice theory[1] institutionalist perspective and some of the key concepts centre on the "principal-agent" relationship and the problems deriving from the transaction costs of economic and political negotiations (Kaufman, 1995; Przeworski, 1995).

Although the effort to make the State function better is not new in modern history, never has a reform movement had such a homogenous agenda, been so widespread and grown so quickly. In

[1] The success of Public Choice was especially evident between 1970 and 1980, and reached its peak with *Reaganomics*. However, the financial and administrative implications of such postulates had already been enunciated many years before (Tiebout, 1956, cited by Meny and Thoenig, 1992:48).

a positive light, this process seeks new ways to ensure *res publica*, that is, the use of the State to promote public interests. In the meantime, the theoretical foundations substantiate the objectives of these reforms.

The public choice theory is thus a variant of the institutional theories that developed prominently in the United States (Meny and Thoenig, 1992). It directs its attention to collective action and individual behaviour by applying economic theory to human acts. It also considers how organisation and decision-making structures (institutional rules) affect strategic relationships among participants in "the game" and shape individual behaviour. This perspective rests on three main principles: 1) a presupposition that individuals behave and make decisions rationally, in view exclusively of their own personal interests and seeking to optimise the benefits of their decisions, where *group action* figures as the most effective way of obtaining *individual* advantages (Buchana and Tullock, 1962 cited in Meny and Thoenig, 1992:47); 2) insistence on the distinction between private goods produced for the market and public goods that arise out of State services, arguing – in the health sphere – that medical care is not a public good, but a private one[2]; and 3) emphasis on the fundamental issue of allocating funds that, by definition, are limited. These theoreticians attempt to "identify" public goods (packageability) by applying methods used with private goods – by measuring their costs and allocating these to service beneficiaries. In this way they endeavour to gain maximum control over the externalities produced by a given public good.

One of the goals of Public Choice is to transform State administrations (responsive State), but they are almost exclusively directed to public service or administrative returns (central and local), and reject centralised organisational and control mechanisms in modern societies, preferring structures that are decentralised, specialised and small (small is beautiful versus metropolitan government) and proposing alternative structures for organising public administration (Ostrom, Tiebout and Warren, 1961, cited in Meny and Thoenig, 1992:49). From this standpoint a multi-faceted, changing, plural organisation that differentiates the type of service distribution (each "public" will "freely" decide the provision they would like to obtain and are willing to finance) is not considered a problem, because it is analysed in cost-benefit terms, and not in terms of values to be promoted, such as equity and redistribution of wealth. Stress is placed on the merits of fragmentation and superimposition in view of the problems to be solved and the services to be delivered. To do this an array of combinable criteria was proposed: development of regulatory capability; mechanisms capable of achieving the best economies of scale so as to guarantee effectiveness; and changes in political representation. This change was grounded in three elements: a formal organisation corresponding to the size of the unit providing the good; a "public" that groups together only those affected by the provision; and a "political community made up only by those that count in decision-making on the provision.

On this view, according to Kettl (1996), the widespread wave of contemporary reforms takes on the characteristics of a "global revolution" (of ideas and policies). It is new not only in the generalisation world-wide of the same reform agenda, but also the central focus on "managerialism". Traditional, hierarchical bureaucratic structures, with their normative procedures and inherent

[2] The essential difference lies in the fact that goods produced on the market are measurable, saleable and produced in quantities determined by supply and demand. Meanwhile, public goods and indivisible, are available to all (consumption by one does not prevent another from consuming), which is only possible if they are supplied through a public system – understood here as State system – besides having beneficial and adverse externalities (spillover effects), i.e., effects that will benefit or prejudice a group (Meny and Thoenig, 1992: 48).

rigidity are alleged to be damaging to public interests, inefficient and ineffective. The reformists build their "revolution" on the claim that the theories of hierarchical bureaucratic authority, which have been the supporting pillars of modern State management for more over a century, had been eroded. They begin with the assumption that, like any monopoly, state agencies are inherently inefficient, tend to grow indefinitely and result in poor performance. The centre of attention is transferred from the activities or "products" of government agencies (output) to the results of such activities (outcomes) (Kettl, 1996: 38-41).

Despite this universal appeal and dynamics, two dilemmas remain at the centre of the debate: the first relates to building government administrations that work better and use less resources (in other words, are more efficient) and the second relates to what the proper functions of the State are considered to be, that is, it refers to a necessary "re-founding" of state responsibilities with corresponding organisational restructuring.

1.4 Social policies and health policy

There are divergences in the literature as to how to define a policy. Meny and Thoenig (1992) regard a public policy as resulting from the activity of a public authority invested with political power. Considered analytically, a policy is a set of norms and practices issuing from one or several public actors, i.e. expressing a government programme (or action) formulated by public authorities. This definition give rise to two practical difficulties, which the authors themselves point out: how is a public authority to be defined; and what are the specific features and limits of a public policy?

To some authors, the concept of policy refers to the "content" of politics, e.g. the best way to finance health services or organise health services and programmes; to others, the concept relates to "process" and "power", i.e. it refers to the understanding of how decisions are made on a given problematic issue, who influences the formulation of a policy and how a given problem and the related decisions become policies (Walt, 1994: I).

Social policy analysis, or welfare state analysis, is a longstanding subject for specialised literature. To many authors, the welfare state can be understood as the endeavour by the State to modify market conditions and to protect individuals from adverse economic situations. On the other hand, the literature discusses quite thoroughly how the consolidation and increasing complexity of the modern State is connected with political action as a means of building the social order. The belief in a political order fostered from the State and which organises society, hand in hand with the development of the capitalist economic system, provide the basis for expanding the States social regulatory capacity, for creating democratic representations and for the idea of social rights that sustain the principles of citizenship (Santos, 1998; Baltodano, 1997). The timing of this State intervention in the social realm will have important, specific repercussions in each society.

For the purposes of the discussion in this paper, health policy is assumed to be a social policy and, as such, health policy is defined as a set of actions taken by the State that affect the social conditions and chances of life and death of persons, groups and families. In other words, health policy expresses the effort by the State to modify the adverse conditions that favour individuals' falling ill, in the endeavour to prevent this from happening and to attenuate people's suffering when they do fall ill. This endeavour involves the State and its institutions, the government and the political system.

We assume also that the formulation, implementation and evaluation of social policies are strongly guided by the values and conceptions of social realities shared by the leading actors involved at the various levels of the process, or by bureaucratic elites. These values and conception provide the "terms of the debate" *on policies, delimiting and circumscribing the public agenda in a given moment* (Melo, 1998:11). On the other hand, the political, economic and institutional context in which the decision-making process occurs shapes the range of options available and affects decision makers' choices. In addition to which, the policy formulation process is completely different from the implementation process, and a proposal for change rarely retains its original characteristics when put into practice, because it alters the status quo and mobilizes actors to defend their interests. Overall, the central category that emerges from such discussions is power, with its innumerable facets and dimensions.

Based on this brief review of the literature we next offer an analytical interpretation of the role of international organisations in the health reform process in the Latin American region, and some results of the implementation of the reform agenda put forward.

2. The Presence of International Organisations in Reform Processes

The international organisations, especially the World Bank, have played a very important role in the formulation and implementation of contemporary reforms. To understand their leading role in health sector reform in Latin America over recent past decades, it is necessary to briefly go back in time and comprehend the leadership changes that took place in the health sector in connection with the international organisations.

2.1 Change in leadership at the international level: World Health Organisation (WHO) and the World Bank (WB)

In its early years, and until the 1960s, the WHO was the undisputed international leader in its sector, "a stable and pragmatic organisation largely disease-oriented and dominated by medical professionals" (Walt, 1994:137), or the community of experts. Its approach to defining its role and technical cooperation activities institutionalised the western (i.e. the central capitalist countries') perspective.

Historically, the Pan American Health Organisation (PAHO) was set up before the WHO[3]. The international legitimacy of both PAHO and WHO was linked to their building a consensual theoretical and conceptual paradigm based on the scientific and professional authority that guided practices and strategies capable of confronting world health problems. This was achieved in the late 19th century and early decades of the 20th with advances in medical technology and therapeutic

[3] The WHO developed from the *Paris Office Internationale d'Hygiène Publique* (set up in 1909) and the health organization of the League of Nations, in Geneva in 1923 (Brockington, 1975:146 cited by Walt, 1994:125). WHO was formally founded in April 1948, with its head offices in Geneva. The Pan-American Health Organization came into existence earlier, in 1902, and was incorporated with the WHO in the 1950s after much resistance and negotiation.

methods. Accordingly the WHO was set up on the "public health paradigm," founded basically on vector and parasite control and infectious disease prevention by extensive vaccination – in other words, the classic public health programme that had also informed PAHO's development (Melo and Costa, 1994).

From the 1970s onwards this "consensus" was questioned due to the ineffectiveness, and increasing criticism, of traditional public health in developing countries in dealing with the structural issues that condition health and disease. "It was increasingly evident that the disease approach to health policy was problematic" (Walt, 1994:137) and the WHO's agenda began to be restructured to incorporate public policy topics not directly related to health. In the Latin-American region, health sector planning played an exemplary role in this process, signalling the first shift in the organisation's direction. This process produced the Cendes/PAHO method which sought to introduce an extremely normative microeconomic rationale into health sector management, by which governments proposed to plan social and economic development with a view to change with permanent advice from PAHO. One of the major reasons for the relative failure of the method and the heavy criticism that followed, was insufficient contextualisation when stating the problems raised by the political and institutional aspects of the decision-making process in implementation of health sector policy guidelines (Rivera, 1989). Melo and Costa (1994) see this strategy as reiterating the main feature of PAHO's technical cooperation agenda, i.e., re-creating an extremely unspecific and multifaceted range of interventions that broadened and re-combined elements of the previous public health approach, but at the same time avoided clashing with its tradition that the health agenda is a public asset (Melo and Costa, 1994:60). The result was gradual and incremental incorporation of proposals and programmes lacking any clear differentiation from the previous agenda.

In the 1970s, "developing countries" began increasingly to push for a broader agenda, demanding more incisive institutional action and a shift in outlook towards the socioeconomic causes of diseases and how to address them, particularly by prioritising levels of care considered more effective and less costly than hospital medical care. The experiences of "Third World" countries considered successes in the health field (Chile, Cuba, Tanzania, Vietnam) were studied and pointed to as innovative alternatives, stimulating the formulation of new health system performance paradigms. In 1975, WHO launched Health for All by the Year 2000 (HFA 2000) and, in 1978, to reach that goal it formulated the Primary Health Care focus. Member States were encouraged to undertake radical reviews of their health policies and systems, and were actively advised to take a Primary Care approach in implementing and developing basic levels of care. From then on the WHO became more politicised as an organisation (Walt, 1994: 137-144).[4]

Primary Health Care (PHC) was widely argued to be the way to reach the proposed goals and, at Alma Ata in 1978, representatives from 155 countries solemnly committed themselves to such guidelines. This approach inter-related at least two meanings: first, it was a general prescription giving reasons why health systems should prioritise primary care in order to anticipate and prevent health problems, avoid aggravating illnesses and break the vicious circles that produce illnesses;

[4] The goal of HFA 2000 was presented by the director-general of WHO, Halfdan Mahler, who headed the organisation from 1973 to 1988.

and second, it was a minimum set of PHC actions and services that extended beyond the strict field of medical care and focused on the population's conditions of life and health, and included actions in education, sanitation, promotion of food supplies and proper nutrition, mother-child health (including family planning), prevention measures, provision of essential drugs, guaranteed access to services etc. (Alma Ata Declaration, 1978). The PHC concept called for broad inter-sector government action as essential to reaching HFA 2000 goals. This approach, also promoted by WHO and the United Nations Children's Fund (UNICEF), despite some major arguments with WHO, was embraced quite enthusiastically by peripheral countries, but treated much more cautiously by the central countries (Almeida 1995).

This ambitious programme was indirectly masked by "health crisis" discussions dating from the 1960s and 1970s. These addressed a broad spectrum of problems ranging from the dominant power of doctors, medicine, and medical assistance, to the decisive influence of industrial medical complexes in health sector dynamics, the "evils of technology", the health care costs and so on. Neo-liberal political hegemony and the underlying diagnosis of the causes of the "health crisis" have exploited these criticisms in its favour and, by the late 1980s, had re-defined the problem as a "crisis in health service costs". Health services were seen as lacking in operational capability and coordination, inefficient and seriously wasteful with resources, not to mention achieving low population coverage (Almeida 1995). Primary Health Care has also been criticised as being "primitive care" (for the poor) and ineffective because of the way it was being implemented.

The increasingly politicised arena challenged UN agencies and introduced more overt conflict into agencies (Walt, 1994:140)

The WHO's strength was concentrated firmly in its capability to finance technical cooperation activities, which were supposed to follow its institutional guidelines. In the 1980s, this situation led to a "crisis of legitimacy in international cooperation", with donors becoming increasingly critical of the organisation and calling for "doctor power" to be displaced so as to incorporate other professionals, such as economists and administrators. These criticisms obscured even the valuable results obtained in the 1970s with the highly successful WHO-led immunisation programmes in developing countries. They pointed out that the greatest weakness [of international technical cooperation] was that it centred excessively on public health culture and on the politicised and absolutely unspecific manner that it associated health with concerns such as income distribution, housing, education, nutrition, social security etc. (Melo and Costa, 1994: 61-62). Furthermore, they questioned bureaucratic procedures, high costs, the proliferation of meetings and reports, lack of transparency and of programme effectiveness evaluations (Walt, 1994: 125).

Over these years, changes in the WHO budget structure increasingly limited the Director-General's power of decision and shifted it to donor countries. In other words, the so-called voluntary donations (or extra-budgetary funds) gradually gained in importance in institutional financing as member countries' regular contributions, which had predominated in the composition of the budget, yielded ground to these other sources. In 1971, other sources constituted approximately 25% of the institutional budget and by the early 1990s the figure had risen to 54%, the major contributors being, on the one hand, the World Bank and the United Nations Development Programme (UNDP), and on the other, the United States and European countries (Walt, 1994:136). This weakened the institution's decision-making power and sense of direction, and undermined the organisation's decentralised, regional structure, heralding the decline of its authority in the international health arena. Funding shifted from the strategic support strategy defined by the organisation to the

"priorities" that voluntary donors tied to specific programmes. In parallel, the World Bank's share in health sector financing increased.

Structurally, WHO was the most decentralised of the specialised international agencies and its six regional offices constituted a unique situation in the United Nations system (Walt, 1994:136-7). These regional offices had considerable discretionary power over allocating resources in the regular budget and were responsible for formulating and implementing institutional policy and defining priorities. Even though the technical capability of these bodies varied greatly from one region to another, and the regular budgets were small and earmarked mostly for scholarships, seminars and modest cooperation, there were often tensions between the central and regional levels (for example, between PAHO – historically the most independent office – and WHO). Additionally, the far larger funds afforded by specific programmes were always more attractive to countries' health ministries than any strategic planning consultancy for the health sector, because they provided considerable resources and technical assistance, without interfering directly in national health policy-making.

Underlying this process are not only the repercussions of HFA 2000 strategies in the "Third World" – especially regarding Primary Health Care and its "subversive" proposals – but also and especially, the battles fought by WHO over child nutrition (mother's milk versus artificial formulas) in the mid 1970s, and the essential drugs programme launched in 1978 (where the clash was basically with the Nestle corporation and the pharmaceutical multinationals)[5].

Actually, the World Bank began to make inroads into the health sector in the late 1960s, financing population control projects and actions led by the United States, just as a new president came to office. Since the mid 1960s the US government had been actively working toward bringing demographic issues onto the international agenda. They advocated birth control policies and gave incentives to less developed countries to adopt them, as well as encouraging other countries to participate as financial donors to these programmes (until then the United States had been the biggest donor) and mobilising United Nations support for family planning (Walt, 1994: 61-3). With Robert McNamara as its president, the World Bank adopted this policy and, in 1968, set up the Population Projects Department and extended loans in that area. This process coincided with the advent of oral contraceptives, which were tested in several "developing countries" and used by more than four million women in the United States from 1965 onwards (Walt, 1994: 62).

Criticisms from the health field at the time, denunciations and mobilisation against this policy – championed especially by feminists and amply covered and broadcast by the media – redefined the problem in terms of its connection with political and socioeconomic changes. As a result, United States' hegemony in conducting population policies was curbed to a certain extent.

In the 1980s, however, the health debate intensified, and it was argued that technical cooperation activities should be transferred from medical care to concerns relating to health management, capacity-building, policy evaluation in the broader context of economic and social development and, most importantly, the use of economic instruments as the favoured tools for such activities (Walt, 1994:140). The "terms of the debate" of the 1980s began to call into question, on the one hand, cooperation programmes and, on the other, the idea of health as a public asset –

[5] In this regard, see Gill Walt (1994: 138-40).

a notion historically dear to WHO. At the same time, the excessive pulverisation of the organisation's programme activities worsened with the substantial growth of non-regular funding. This, at the same time, undermined its leadership role in international health, causing a lack of definition regarding its place and competency in the international arena.

In exactly the same decade, the World Bank began granting loans directly to health services. This process did not take place in a vacuum, but in a context of economic crisis, neoliberal hegemony and acute criticism of social policies globally. The hegemony of neo-liberal ideology gave form and substance to a new centrality of economic analysis in social policy in general and health policy in particular.

Melo and Costa (1994: 68-69) write that *the internationalisation of neoliberal-inspired reform agendas was tardy and conflictive* [in PAHO] *due to its public health culture* […] *and its "porous"* [in the usual sense] *organisational structure and the weakness of the public health epistemic community's objective truths and belief systems*. PAHO's reaction was to restructure in two, eventually overlapping, directions: one, by consolidating the epidemiology field institutionally so as to overcome its explicitly confrontational institutional identity and restore its normative capability and ability to implement regulatory policies; and two, by focusing interest on the macroeconomic aspects of health, especially in terms of analysing financing mechanisms and the fiscal impact of health spending, by institutionalising the field of health economics.

Disputes among international agencies are not new, however. There have been a number of conflicts in the past involving not only PAHO/WHO and the World Bank, but also UNICEF and the United States government (Walt, 1994). Walt mentions, for example, that there had already been another clash between WHO and UNICEF after they jointly launched the Primary Health Care Programme, because UNICEF unilaterally launched the GOBI programme of primary health interventions first. And in 1987 UNICEF also launched the Bamako Initiative (BI), a programme for community management of local health funds, restricted to Africa (Melo and Costa, 1994:72).

The WHO's crisis of legitimacy and leadership was paralleled by increased World Bank activity in the health field. It proposed a new reform agenda for the health sector that was extremely economistic in nature and characterised by "tragic choices" that, in this specific case, redefined some of the classic notions that had guided health system organisation in the 20th century. These include health as a public good, and universality in the health field.

Melo and Moura (1990) describe the World Bank's trajectory in the final decades of the 20th century as having three major turning points in its intervention strategy and role in specific countries. The first relates to McNamara's term (1968-1981) when there was a change of emphasis: the Bank went from being an institution that financed infrastructure projects (transport and energy) to being a multilateral agency that fought poverty on a global scale – its development objectives went first from infrastructure to industrialisation and then to social development. The second is reinforced by two fundamental frameworks (during Calusen's term, 1981): the rise of conservative governments in hegemonic member countries (United States and England) that were very critical of the Bank's performance, considering it bureaucratic and submissive (to "Third World" countries); and the international economic (fiscal and debt) crisis. This was when the Bank's actions were directed primarily toward macroeconomic structural adjustments and sectoral reforms, and consequently its activities became more politicised and high-profile. The third turnaround occurred at the end of the 1980s when discussions on the fight against poverty returned even more forcefully,

focussing on the political feasibility of reforms and strongly framed by an institutional perspective where governability[6] and institutional quality were key. Melo and Costa (1994:80-1) list three factors that apparently led to this approach being redefined: structural reforms and adjustment programmes failed in several countries with serious political and institutional consequences; changes in Eastern Europe gave greater visibility to the institutions' role in these processes; and the devastating social impact of reform policies sponsored by the Bank, as pointed out by several authors and by international agencies (such as UNICEF).

In short, the Bank began to act in the health field as part of a strategy of birth control policy in developing countries. This was part of the bigger picture of "sustainable development" and the "need for global sustainability," and later, it turned to the fight against poverty, prescribing sector reforms in a very particular manner that called the prevailing principles of equity and universality into question. Social policy reform from the 1980s onward was intensely affected by these re-definitions, which produced *a profound realignment of actors in the international health arena and questioned the mandate of other organisations active in the health sector* (Melo and Costa, 1994:85).

2.2 The World Bank agenda for the health sector

The new World Bank agenda advocates diminishing the role of the State and strengthening the market. It includes sector financing as a conditionality of structural adjustments, and prioritises specific programmes and activities based on criteria of cost-effectiveness, thus subordinating health spending to macroeconomic soundness of countries under structural adjustment.

Nonetheless, from the mid 1970s, this debate ensued worldwide, led by the World Bank, which emphasised the conflict between efficiency (in allocation) and equity, going back to the refrain of growth versus distribution, and spreading the formula "redistribution [only] with growth". The "basic needs" approach was also introduced (Melo, 1998; Melo and Costa, 1994). At the same time as State intervention in the social sector was recognised as important, its effectiveness and resolutive capacity were increasingly criticised. The main issue at stake was the inability of State policies to meet the basic needs of the population, in other words, the most needy. The challenges, it was now announced, lay in: mistargeting – that is, the problem was not irrelevant public social spending, but instead "poor usage" each time the benefits were not representative in view of the costs associated with maintaining gigantic, expensive and ineffective organisational structures; inequity – understood as non-access by poor populations to basic health services; inefficiency and cost explosion – because doctors were "demand triggers" and fostered demand for extremely expensive new technology (Melo and Costa, 1994; Almeida, 1995).

Analysis then centred on the way social policy was operationalised and its bureaucratic, exclusionary, inefficient and ineffective aspects. Administrative reform and decentralisation (which, besides bringing policy makers closer to the needs of their communities and populations, could overcome "bureaucratic gigantism") occupy a prominent place in this debate. Institutional "re-engineering" and changes "in the rules of the game" – clear influences of the neo-institutional

[6] Gobernability refers to the more general systemic conditions in wich power is exercised in any given society (melo, 1998:26; Diniz 2001:21). Governance, meanwhile, has to do with the states capacity for action in implementing policy and attaining collective goals (Diniz, 2001:21).

paradigm – were expected to yield greater efficiency and equity with an accompanying decrease in predatory and harmful behaviour by using mechanisms to encourage competition (Almeida, 1995, 2001; Almeida et al, 1999; Melo, 1998). Emphasis was thus placed on reforming the law (Constitution) and the legal architecture of programmes and policies, understood as structures of subsidies and incentives to be redefined in order to model new behaviour.

Once again the World Bank took the lead. At the same time as it created a fund to alleviate adverse economic and social consequences of macroeconomic adjustment programmes, it announced its active entry into the process of health sector policy reformulation.

A 1987 document entitled Financing health services in developing countries: an agenda for reform, is considered a reference point for action in the health area. It is a World Bank Policy Study prepared by three experts from the bank's Population, Nutrition and Health Department – John Akin, Nancy Birdsall (then head of the Department), and David Ferranti – based on a set of ideas already circulating in the institution since the mid-1980s. Although this document had not been approved by the Bank's board of executive directors, it had already circulated inside the institution and been discussed with the World Health Organisation in an effort to attenuate possible conflicts of ideas and to legitimate it institutionally by toning down some of the political and ideological guidelines for the sector. This document set out clearly the main directions of the health sector reform agenda based on a diagnosis of health service problems that indicated insufficient spending on cost-effective programmes; internal inefficiency of government programmes; and inequity in universal, public health systems. The second part of the document makes suggestions for health sector reform in developing countries that focus basically on four measures: introducing co-payments for use of public health services, especially medical care; giving incentives to develop health insurance; strengthening private service provision; and decentralising. It also includes strategies to be pursued by the Bank to induce these reforms, which are: to include consideration of reforms to health service financing when advancing international loans and aid, to expand loans for these reforms, and to conduct research to sustain them. This discussion is backed by a wide-ranging bibliographical review and presents data on the countries (Mattos, 2000:227; World Bank, 1987). Hernández (2002) states that this document uses the economic concept of public and private good for all health service matters, drawing a sharp line between the responsibilities of market and State in financing health services.

This document framed health reform financing together with the array of conditions negotiated as the basis of economic adjustments. In fact, this more incisive action by the World Bank in the health area was not an isolated occurrence. It was one of the results of a qualitative change in its actions in the region where it took on a more strategic and long-term perspective coherent with the broader "course correction" that guided economic prescriptions (Fiori, 1993:137).

In its 1990 World Development Report (Poverty) the bank proposed a dual strategy: to promote labour-intensive growth by opening up economies and investing in infrastructure; and to provide basic health and education social services for poor populations.

Several studies were commissioned and their results proposed the redesign of three variables fundamental to health system organisation and operations: how the health problems that guide policy formulation are identified; how the profile of service provision is defined; and how priorities

are set, or in other words, what governments are capable of doing (Jamison and Mosley, 1991:18). The interrelation of these three variables would bring out clearly the "tragic choices".

The 1993 World Development Report was dedicated to health. A team of experts was specifically designated to draft it, as is the norm for such reports, different from the previous document that was an initiative by specific technicians. In this document the World Bank adopted a pragmatic approach explicitly directed to prescribing health sector reform. It was the result of dense negotiations involving technicians from the drafting team, their superiors, other World Bank technicians, and donor agency managers, as well as other institutions of the international community (Mattos, 2000:228). The World Development Report: Investing in Health (World Bank, 1993) analyses the health indicators available in the various countries, which were evaluated according to strictly economic parameters. It sets the scene for health policy reform, defining priorities on the principles of cost-effectiveness and focalisation on the poor. It introduced new concepts and indicators into health sector planning, such as basic medical care service packages, the Global Burden of Disease, and the DALY (Disability Adjusted Life Years), as more effective measures for priority-setting and defining intervention packages. The Bank then introduced an important shift in its social (including health) policy logic, making it explicit that the principle of equity was to be subordinated to cost-effectiveness, reduced public spending and services privatisation. It established that social policies should cease to be universal and play a merely compensatory role, that is, be directed only toward the poorest groups/sectors of the population. This gave rise to the formulation of selective and focalisation policies.

This report reflects clearly the shift in international leadership in the health sector, marking the consolidation of World Bank hegemony that had been institutionalising gradually since the 1970s. The dual nature of the health issue for the region – as an end in itself and as a means to foster development – had already been pointed out in documents produced by ECLAC (1990), which also served as input to the World Bank analyses. The compensatory policy option adopted by the Bank for this complex trade-off, which emerged from the confrontation among international agencies active in the region, was also finally endorsed by PAHO (PAHO, 1995; CEPAL/OPS, 1994).

The conditions set by international creditors then began to include clear social – including health – policy reform recommendations. In the health field they advocate better use of scarce resources that should be directed toward interventions to lessen the "burden of disease" and be provenly cost-effective (World Bank, 1993).

In response to the 1993 report, PAHO's strategy to confront this clear leadership threat was to ally with the Economic Conference for Latin America and the Caribbean (ECLAC) and produce a document that interrelated health, equity and changing production patterns (CEPAL/OPS, 1994). At the same time it sought broader dialogue with countries, beyond the usual conversations with health ministers, to include members of parliament in the new Latin American democracies.[7]

The World Bank recommendations were strongly guided by the results of a Health Sector Priorities Review conducted between 1987 and 1993 (Murray and Lopez, 1994). DALYs were used to map out the global burden of disease and to analyse various interventions in term of cost-

[7] The programme Democracy and Health – PAHO/WHO Cooperation Project with American Parliaments was launched in 1992 with the creation of Latin Health Parliament (Parlatino), although collaboration activities date from 1990.

effectiveness. This review indicated great variation in costs per DALY in around 50 interventions, and was used by the World Bank (1993) to recommend the reforms and new indicators. In other words, the burden of disease is estimated in terms of DALYs lost, and the cost-effectiveness of intervention is evaluated by the cost gained per DALY. This combination was considered to make it possible to evaluate the burden of disease avoided if interventions were implemented. Intervention would be considered a priority only when the burden of disease was great and the cost-effectiveness high (World Bank, 1993).

In practice, these measures were designed to evaluate social policy decision-making options (ex-post and ex-ante) by establishing relationships between costs and "benefits," and to compare results obtained through different ways of reaching specific goals, so as to rank the options. In other words, it means taking maximum advantage of the effectiveness of specific actions, and maximising their impact at the least possible cost (Almeida, 2000a, 2000b). This incurred several criticisms, especially regarding the limited concept of health (restricted to illnesses and medical care); the limited value of global exercises to national realities; the disregard of the equity issue, interpreted simply as achieving high life expectancy in all countries, with no reference whatsoever to inequality among social groups; and most importantly, the inappropriate use of economic methodologies centred basically on measuring efficiency and cost-effectiveness to identify health needs and set priorities, while ignoring the value of any other parameter for policy formulation (Paalman *et al*, 1998).

In 1997, the government of Denmark and the World Bank held an informal meeting with bilateral and multilateral agencies to discuss what is called Sector-Wide Approaches (SWAPs) to health development. The aim of the meeting was to reach some degree of consensus on goals and processes in supporting countries' health sectors by reviewing concrete experiences, discussing options for joint action among the various organisations, and questioning the approach of supporting projects separately. The name SWAP indicates that this was not a discussion about a new international aid programme or instrument, but rather a new operating strategy that would include a wide variety of approaches based on those being developed in health sector reforms and investments. These would engage the countries directly through the concerted efforts of a diversity of stakeholders, including various departments of beneficiary governments, technical agencies, and bilateral and multilateral donors.

The 2000/2001 World Development Report – "The fight against poverty" – reiterates the same strategies. It states that a risk management policy is generally less costly than correcting the effects later on. Furthermore, the best solutions are usually those that permit each individual and each household to protect themselves instead of seeking aid from the State (WB, 2003). However, markets may be unable to provide coverage for vulnerable groups or to finance risk reduction. Accordingly, social protection under government care would begin where the ability to contain the macroeconomic context ended.

Recently WHO has also adhered to the WB's "methodological" strategy, using it to defend the "new universalism" defined in the World Health Report 2000 (Frenk, 1999; WHO, 2000). That is, since it is not possible to have everything for everyone, it has to be defined what is "essential" and what can be offered, with emphasis on evolving health service system performance as the structural axis of health sector reform (Murray and Frenk, 1999). Other new indicators were created (e.g. Disability-Adjusted Life Expectancy – DALE), besides compound rates used to rank countries on a methodology widely criticised in the literature (Almeida *et al*, 2001; Blendon *et al*, 2001; Braveman

et al, 2001; Jamison and Sandbu, 2001; Navarro, 2000, to cite just a few). WHO's leaders thus adhered clearly to what is understood as big-business better management, that is, the idea that efficiency and productivity are "meta-values" in formulating and implementing policies, and should be attained, in the short term and at any price, on the basis of strict controls and global normative strategies to satisfy "supranational" external demands. Ironically, "for over a decade big business has been employing milder and more collaborative approaches and setting greater value on cooperation, empowerment, and knowledge exchange" (Lerer and Matzopoulos, 2001: 434). Apparently WHO adopted the worst of both worlds: the worst of private sector management, as described above, and the worst of the public sector, as reflected in the authoritarianism and lack of transparency with which it directed the formulation of its international strategies for the health sector (Lerer and Matzopoulos, 2001).

At the same time – in the framework of criticisms aimed at the results of economic adjustment and thinking about insurance markets and economic and social risk in the region – the WB formulated a social risk management proposal for Latin America, proposed for the start of the millennium since it interrelates a specific view of insurance policies with strategic proposals on social policy (World Bank, 2000, 2001, cited in Sojo, 2003). This proposal aspires to being paradigmatic, particularly as regards the fight against poverty and delimiting the role of the State (the public domain), reiterating minimal social responsibility for confronting the population's economic and social insecurity and vulnerability. Unlike the ideas of summary, reductionist focalisation of the 1980s and 90s, this proposal gives some importance to the causes of poverty and resorts to terminology proper to insurance (Sojo, 2003:134).

Social risk management analysis thus points out that everyone is vulnerable to multiple risks from several sources, interrelating risk, exposure to risk, and vulnerability. Social protection is defined as public interventions that help individuals, households and communities manage risks and that support the poor. They should also establish mutually reinforcing relationships between education and health, with a view to developing human capital. A global social policy proposal was thus advanced that interrelates three fundamental recommendations, and proposes a specific public-private combination to make them work: the State's social welfare responsibilities are circumscribed to fighting poverty; insurance against risks is an individual responsibility; and solidarity in risk diversification is discouraged. The proposals include increasing social spending on basic services and establishing guarantees for access, quality, choice and service tracking. In short, the proposal was that, rather than helping confront risks, the policies should seek to reduce and mitigate them.

Thus, the new social policy strategy comprised individual insurance on the market and service provision for the poor through "safety nets"; focalisation as opposed to universality; only a minimum level of public responsibility for social protection; the financing and provision of other services connected with social wellbeing are placed in private hands; and the principle of solidarity in financing is frowned on (Sojo, 2003:134).

Thus, there was actually no change from the previous approach, given that the analogy with the reductionist focalisation proposals advocated from the 1980s onwards still stands. Although this proposal recognises that the poor are more exposed and vulnerable, as well as having less access to goods in general – which alludes to the causes of poverty and denotes a difference from previous focalisation proposals centred basically on the symptoms, rather than the causes, of poverty – there is nonetheless continuity in the role of the State in the social welfare of its

populations. The poor are seen as "the group" targeted by social policy, and State action is considered synonymous with "social safety nets", which are understood as a modular system of programmes that are flexible according to specific patterns of risk. This system was to complement existing arrangements with an "appropriate mix" of public and private providers, and would comprise schemes and instruments, such as social funds, micro-insurance, health insurance, unemployment insurance and social assistance programmes.

As regards Latin America, what is striking is an excessively positive view of past policies – in contrast with critical reviews by the Bank itself on the subject (World Bank, 2002 cited in Sojo, 2003)[8], which largely coincide with other criticisms in the literature. These are disregarded, however, and the social risk management proposal is presented as embodying very positive features, which are not supported by any of the existing analyses either (Sojo, 2003).

In the World Development Report 2004 (Making Services Work for Poor People – World Bank, 2003) the Bank explores "how countries can accelerate progress towards the Millennium Development Goals (MDGs) by making services work for the poor". It reiterates that success does not depend on faster economic growth or greater influx of funds to social sectors, but instead on the "ability" of governments to turn such funds into basic services such as health, education, drinking water and sanitation, in that these services very often do not reach the poorest people. The reasons are "weak incentives for performance, corruption, imperfect monitoring (if at all), and administrative logjams".

More recently "harmony" can be detected among the different international agencies that work in the health sector. This has been encouraged by explicit guidance from the overall leadership of the United Nations system to reflect the political decision to "work as a team" and collaborate rather than clash. Obviously the World Bank still retains the greatest financing power, and continues its ideologically and politically hegemonic in how strategic proposals for the social sector are formulated and conducted, which reiterates the reductionist approach to social policy.

3. The Contemporary Reform Agenda: Premises and Proposals

This whole process discussed here has been expressed in the formulation of a "post-welfare state" agenda for the health sector too. This reform agenda is closely attuned to the worldwide movement towards State reform, and is driving significant change in the health sector policy arena and seriously questioning the way health systems have been organised and performed their duties (Almeida, 1995). This process also questioned why medical care should continue to figure among the benefits that make up the social policy safety net (Almeida, 1996 a and b; 1997).

The World Bank's leading role was enabled and reinforced by liberal hegemony in the 1980s and 90s, by the ascendancy of economic issues in view of the global crisis and by criticisms of the Social Welfare State and the "inherent inefficiency" of health service systems, especially those centred primarily on public provision.

[8] This review rejects the opposition between supply- or demand-oriented policies and assigns greater importance to the need to consider the specific institutional variables of each country, so that funds can be placed strategically, rather than on short-term considerations or in isolation, in a way that is complementary to the pertinent institutions and sustainable, without displacing policy reform (World Bank, 2002, cited by Sojo, 2003: 135).

The main premises of this agenda and the proposals that emerged as the solution to the problems identified are considered next.

3.1 Premises

Beginning in the 1980s in the wake of the economic crisis, countries committed themselves to in-depth reform processes guided by recourse to the institutional technology advocated by the neoliberal ideology hegemonic at the time. Therefore, the need to reduce fiscal imbalances and create more sustainable macroeconomic conditions focused efforts on downsizing the public sector, isolate the State from special interests, adjust its activities to rules rather than discretionary decisions, and delegate decisions to independent agencies with no incentive to submit to political pressure. This meant reducing the activities traditionally assigned to the public sector and limiting its actions to those "proper" to it, in the hope of in this way increasing its efficiency.

Two separate phases must be distinguished in this reform process however. First came the overwhelming neo-liberal hegemony of the 1980s, when ideological discourse advocated tearing down the welfare state and when policies focussed predominantly on cost containment and spending controls, attempting to downplay social issues on the grounds of fiscal stress (France, 1993), under-financing and the importance of individuals as opposed to their "dilution" in the collective. In the second, more recent period, reform proposals were formulated – with analytical and technical underpinning from experts, generally from international organisations – with the intention of withdrawing sole responsibility from the State in some activities that until than had formed the social safety net constructed on the Keynesian approach.

The models of reform that emerged in the 1990s softened the ideological discourse that had intensified in the 1980s, even building on criticisms of neoliberal proposals, without that meaning a return to the principles of the Welfare State. In fact, ongoing reforms attempt to take on the "new" problems that were maximised by the restrictive policies of the previous decade, and to restore a minimal-State approach in a new guise. The main characteristics of that agenda are that economic concerns are regarded as central, the same premises are to be spread to all sectors, and the focus shifted to policy operationalisation and away from the principles that underlie policy formulation.

Despite the "management revolution" that has spread around the world, the enthusiasm with which the agenda was accepted politically and implemented – uncritically and pragmatically – it has not been accompanied by a corresponding effort to design implementation, monitoring and evaluation. On the other hand, although many of the underlying ideas are attractive on paper, they are not based on empirical data or evidence. Implementing the new models (focused on new public management) has frequently led to great problems often unforeseen by the formulators, both because of the pragmatism of the reforms and because they collided with existing practices.

3.2 Proposals

The health sector reform agenda for the Latin-American region, which forms part of the conditionalities on international loans, is based on the need to address longstanding, historical problems (inefficiency, ineffectiveness, inequalities) that, in fact, are present in health care systems, but which have been aggravated by the successive adjustment programmes that reduced investment

in social policies and degraded State institutions and public administration. It also entails a pragmatic acceptance of the new economic conditions and the inexorability of resource shortages, while advocating selectivity and basic benefit packages for specific groups in need, that is, the poor.

The political agenda of these contemporary reforms, however, has been conditioned by the dynamics of building a "market society" underlying the neoliberal hegemony of the period. Administrative reform, decentralisation and the introduction of competition mechanisms were the bases stipulated in order to obtain greater efficiency and equity, as a result of the large-scale spread of an agenda for the region formulated from the outside and assimilated internationally very little criticism. In several countries, these elements formed part of new health sector reform models, the main challenges of such reform being to reduce health sector spending; break up "monopolies" and redefine roles (of the State and health providers); alter the public-private mix, to increase private sector participation in service delivery; meet "consumer" demand; and achieve greater managerial efficiency and flexibility, as well as greater effectiveness. It was said that these measures would yield better levels of equity.

Some mechanisms have been implemented, meaning a shift "from supply to demand" in the orientation of health service structuring: 1) cost containment and spending controls (to reduce supply and service utilisation); 2) decentralisation; 3) split service provision and financing, including changes in fund allocation; 4) strengthening of the State's regulatory capacity; 5) introduction of competition mechanisms and construction of "regulated markets" or "quasi-markets" (based on the ideas of managed care and managed competition), called the "internal market" in the English reform, "public competition" in the Swedish reform and "structured pluralism" in the Colombian reform; 6) introduction of a wide range of subsidies and incentives (for supply and demand) designed to restructure the public-private mix in health service systems and break up the "State monopoly"; 7) privatisation; and 8) prioritisation of activities and focalisation on the poorest. This process has called the right to health into question as a fundamental human right or as a social benefit.

The (neo-)conservative inspiration for this agenda is reflected in the fact that it centres on medical care, not on the social determinants of health or a broader view of the "health" relating the health sector reform process with multi-sector strategies designed to overcome inequalities. This is due, on the one hand, to the high costs of medical care, which dominate health systems and absorb a large part of the funds available for the sector; on the other hand, this approach is reinforced on the ideological level, which emphasises the economic aspect of the agenda and guides the formulation of models for change.

These ideas were spread worldwide and reinterpreted in reform proposals in numerous countries, resulting in a broad variety of strategies for change in spite of the quite homogeneous agenda.

Elements of this agenda can be identified in practically all health system reform processes in the region and outside, introduced (theoretically) with a view to conciliating efficiency and equity. For that purpose, rules of financing and benefits were modified, along with the participation of public and private agents, separating the functions of regulation, provision and financing. Encouragement was given for greater private sector participation in service provision, competition was set up among insurance and service providers, introducing forms of quasi-market in public service provision. The idea of insurance predominates and there are important differences in the combinations among social security (public and solidary) and private health insurance, thus constituting a complicated public-private mix. (Almeida, 1999, 2002; CEPAL, 2000, 2001; Sojo, 2001).

As an explicit inducement, an ideal model based on managed competition – "structured pluralism" – was prepared specifically for the Latin American region (Londoño and Frenk, 1995, Londõno, 1996)[9]. What does this proposal consist in? It for national health insurance with public funding (mandatory contribution for those who can pay and subsidies for the poorer), to which is added managed competition or the "tropical version" of the above model (Londoño, 1995, 1996). A basic package of mandatory services is defined, but they are different for different social groups; competition mechanisms are brought into the system, setting up quasi-markets and creating new agencies (public and private) to assure service provision. The State is left mainly with the system steering function, centred fundamentally on coordination and regulation, releasing it from service provision. Colombia is the only country in the region where the model was formulated and implemented in complete form (Londoño, 1996), yet the World Bank and the IDB are funding implementation of a similar model in the Dominican Republic, and elements of the theoretical proposal of managed competition can be seen in practically all reforms in the region (Almeida, 1996, 1999, 2002, 2005).

Most of the criticism of these reform models is based on their limited conception of health, their application of global recipes without taking national realities into account, the scant consideration given to issues of equity, lack of reference to inequalities among social groups, the strengthening and consolidation of dual health care systems, with perverse segmentation, and the most importantly, the inappropriate use of efficiency and cost-effectiveness measures to identify health needs and set priorities (Paalman, 1998).

4. Brief Critical Analysis of Health Sector Reforms in the Region

As discussed before, social policy formulation, implementation and evaluation is strongly guided by values and conceptions about social realities, shared by the leading actors involved in the process, at their various levels, whether in the bureaucratic or political elites. These values and conceptions change in different places and junctures. In order to understand this process in Latin American region it is worth going back a little in time.

Very briefly, in a long historical process over centuries, the development of the principle of citizenship, inspired in the liberal idea of equality, was accompanied by growing inequalities generated by expansion of the capitalist mode of economic production. More precisely, in the 19th and 20th centuries, the gradual institutionalisation of social rights led to public policies directed to implementing them, whether to overcome the inequalities produced by the dynamics of capitalist expansion or as a medium of exchange in the political power game.

It must be remembered, however, that these observation are made with reference to the history of the developed capitalist countries of Europe, one central feature of whose States is

[9] The theorical proposal for Structured Pluralism was put fordward in a World Bank document, by Juan Luis Londoño and Julio Frenk, and was presented by Jose Luis Londoño, Colombia´s former minister of health in the period when the reform was formulated and aproved, at the Special Meeting of Ministers of Health from Latin American and the Caribbean on Health Sector Reform, held in Washington, in 1995, and prometed by the International Organisation-PAHO, World Bank, IDB, ECLAC, OAS, UNICEF, United Nations Fund for Population Activities and AID/USA.

generally *a high degree of external sovereignty and a high degree of domestic dependence* (Baltodano, 1997:56), in the sense that, to a greater or lesser extent, they have been able to develop the political and technological skills to extract and redistribute resources, earmarking a considerable portion of them, at least for some time, to promoting social development. In other words, this has permitted some type of confluence between those who make policies and those who receive them.

On the other hand, the historical evolution of Latin America is marked by the constitution of economically dependent States; highly segmented societies with considerable levels of social exclusion and marginality; socially disintegrated territorial bases; institutions with a poor policy implementing and social regulation capacity; and extremely fragile and partial citizens' rights structures.

Baltodano sees in Latin America *States that enjoy a high degree of* [relative] *autonomy in relation to the civil society and a high degree of dependence in relation to the dynamics of the world economy* (1997:56), mainly in terms of a subordinate place in international markets framed by progressive and perverse indebtedness.

To this is added the logic of "regulated citizenship" (Santos, 1979) which guides the particularist form taken by social policy (Malloy, 1993). This favours the corporative systems in society which enabled *the masses to be incorporated into the dynamics of political competition before stability was achieved in institutionalising the rules of that very same competition* (Santos, 1993:29-30), meaning that originally social policy *was not defined as compensatory or redistributive intervention or directed to organising the labour market*, but rather formed part of a movement of "nation-building" and social integration with numerous specific features (Melo, 1998:13).

This model also coexists with various forms of social control of the oligarchic and State-coercion type, which hinder the formation of public spaces and the development of society's capacity to intervene on issues that concern it. Added to this situation is the historical influence of international organisations in policy formulation and implementation in the region, whose "conditionalities", imposed by creditor banks, considerably reduce the autonomy of national states to redefine their policies (Gilpin, 1993; Malloy, 1993; Kaufman, 1995).

Thus, the recent developments of globalisation have *intensified the external dependence and the domestic self-importance of the Latin American State* (in many cases in total submission to external conditionalities), preventing any congruent relations between those who make public policies and those who receive them (Baltodano, 1997:59).

In terms of contemporary reforms, the economic, political and social situation in the 1980s enabled a restrictive, economicist dynamics in the region. As a result, in this period Latin America and the Caribbean underwent serious structural, economic stabilisation adjustments induced explicitly by multilateral organisms. These led to mounting external and internal debt and a reduction in States' autonomy to define their own policies.

These processes worsened the conditions of life in general, and health in particular, of the region's populations, worsening already existing inequalities and generating more poverty, and coincided with complicated political transitions toward democracy, in which social demands increasingly gained voice and visibility.

While the 90s saw partial recoveries and a certain macroeconomic stability, these rested on heavy dependence on external investment, basically by highly volatile speculative capital (Altimir, 1998; CEPAL, 2003, ECLAC, 2004, 2005 and 2006).

The recent reforms implemented in Latin America can be said to have exacerbated some of the perverse elements that are constitutive of societies in the region, besides creating new problems, by favouring an restrictive, pragmatic, economicist approach.

On balance the social and economic situation in Latin America is strikingly negative, and even the efforts to repair at least partially the damage of the 80s were not very successful in the 90s. (CEPAL, 2003, ECLAC, 2004 and 2005). As summarised rightly by Sojo (2003), *the current external scenario in Latin America and the Caribbean is adverse as regards demand for its products and the volatility of international capital*. The region can be described in several senses as of high social risk. In spite of positive trends in some countries – for example, steadily declining fiscal deficit, enduring macroeconomic balances, and renewed or even higher social spending – economic growth has been unstable and slower than historically. By comparison internationally, GDP in the region is twice as volatile as in industrialised countries and household consumption even more so, and increasingly so since the 80s (De Ferranti et al., cited in Sojo, 2003:122).

This social vulnerability appears in several ways: in high, and in many countries above average, levels of poverty; declining indicators of redistribution, with very few exceptions; a deteriorating labour market, with no social security and rising unemployment, declining incomes, impoverishment of sectors previously with formal positions in the labour market and maintenance of the trend towards income concentration (ECLAC, 2006). All the above mean that a vast contingent of middle sectors, which are not poor in terms of income, are nonetheless vulnerable. In addition, the number households at the poverty line is rising (Sojo, 2003:123).

In the health field generally, the situation is not encouraging. Considering singular characteristics of their epidemiological profiles and the inequalities in health and in access to health services, the various countries face epidemiological transitions that vary in degree, but are always polarised, and where transmittable and degenerative diseases overlay one another, and health well-being is distributed unequally to the disadvantage of the poorest (CEPAL, 2003, ECLAC, 2004 and 2005). Also, in the last decade of the 20th century, in spite of the precarious health situation of the majorities and the vast regional inequalities, public financing can be said to have changed very little, while private spending has continued high, with the direct component of family spending falling off in favour of spending on private health insurance and prepaid arrangements in businesses and other organisations. Health service access and use have worsened and, with a few honourable exceptions, the – particularly public – health sector's installed capacity has deteriorated considerably, with serious consequences in terms of equity and public health actions. This worsening situation has most affected those countries that historically had not provided their populations with adequate health coverage, whether horizontally (population coverage) or vertically (effective services at all levels of complexity) (Almeida, 2002, 2005).

Review of the reforms in Latin America reveals that, although different modalities of health service reconversion and reorganisation have been adopted, there are common elements based on this agenda that attempted in one way or another to conciliate efficiency and equity. However, the situation is especially dramatic, whether because of the effects of the economic crisis and the macroeconomic adjustment processes, or for lack of regulatory and implementation capacity, aggravated by the definancing and deterioration of public institutions over recent decades. As a result, the proposed reform models being implemented did not generally enable the enormous existing inequalities to be overcome and have aggravated health services' already weak resolutive

capacity, worsening the inequities. This situation has revived the discussion about equity and how to operationalise policies directed to more equitable health systems.

As regards the national health insurance plans designed and implemented in the region as part of the new reform models, they are prone to the effects of economic cycles. The expansion of informal labour, unemployment and diminishing real wages all limit the historical redistributive capacity of such insurance and reduce the operational capacity of social security institutions, because their funding sources rely on compulsory contributions by employers and employees (ECLAC, 2006). The characteristic volatility of the Latin American macro-economy, whether resulting from high levels of inflation or strong fiscal imbalances, contributes to a dynamics involving lack of financial sustainability and reduction in health care, that is, financial fragility is leveraged by economic crises, and social spending reduced. In any case, social assurance schemes face serious deficits which, worsened by administrative deficiencies, contribute to reduced or insufficient coverage; constraints on health service provision and a more restricted service mix, whether fixed by service packages or supply capacity; and declining quality of care. Thus, such schemes also lose political sustainability, in addition to which, considerable numbers of beneficiaries are deviated to the public sector, which faces equal or greater limitations.

In general, it can be said that the countries of the North, particularly Western Europe and Canada, have not altered fundamentally the bases on which their respective health systems are structured. The ideas of competition in the health sector were strongly criticised and gradually abandoned, while those recommending the separation of functions proliferated; as a result, the State's as regulatory has been steadily strengthened. In Eastern Europe, Latin America, Asia and Africa, meanwhile, the models of reform have been much more radical and complex to operationalise, although conditions were much more precarious and the reforms were subject to considerable financial limitations and a historically deficient regulatory capacity. In some cases, this led to the dismantling of existing health systems, with no guarantee of improving the health care provided to the public or the State's implementation capacity. Greater participation by the private sector has also been encouraged in service management and provision, along with users' freedom of choice and competition among insurers and providers, thus introducing quasi-market strategies into public health service provision. Also making itself felt more incisively in these regions is the large-scale diffusion of the ideas and power of enforcement or inducement of the international organisations.

The separation of functions was implemented in various ways, constituting quasi-markets, but with various specifics: different service packages were created, with distinct breadth and coverage for different social groups, thus segmenting the right to health (Colombia); and some countries that were more backward in terms of solidary, universal coverage of the population's health needs, and facing greater financial difficulties, emphasised focalisation on the poorest (Bolivia, Peru, Honduras). The impact of these changes was very diverse, depending on the historical structure of each health system, the level of organisation, the implementation and regulatory capacity, dimensions that are usually quite weak in Latin American Health systems.

Moreover, the implementation of quasi-markets privileged participation by private organizations, furthering the creation of private insurance markets, even though financed with public resources, where previously private enterprise had been a minority presence (e.g. Chile and Colombia). These markets are practically unregulated. A striking diversity of organisations is involved in service provision (Colombia, Guatemala, Dominican Republic), which raises questions

about the actual technical and ethical capacity of such dissimilar bodies, particularly when they are authorised without any rigorous evaluation process.

The investment and transaction costs of implementing these models are high and must be taken into account given that funding and institutional organisation are so limited. There is little leeway to continue relying on private sources of funding and it is hard to progress without raising the relatively low levels of public spending on health and improving implementation and regulatory capacity.

There is a notable neglect of the epidemiological and programme execution aspects of public health programmes and endemic, epidemic or transmittable disease prevention and control programmes, poor integration of levels of care and difficulties in setting up referral and counter-referral networks, while system restructuring has not been designed according to the population's needs and territorial supply.

Lastly, the weak integration of contract management aspects in these markets considerably limits their impact as regulatory instruments. Even when standards are set that must be met by the various steps in formalising contracts, the lack of adequate and effective supervision mechanisms (or capacity), monitoring and evaluation (Colombia) and the attempts at subsequent regulation (Guatemala, Chile, Brazil), have led to diverse problems, because these new, powerful players are capable of enormous resistance. In short, the implementation of quasi-markets entails modifications that are highly complex in political, technical and human resource terms, and obstacles to their proper functioning are formidable. It is thus appropriate to stress the difficulties of implementing such complex systems that require a high degree of implementation and regulatory capacity in countries whose States historically have never had such capacities.

Some examples are illustrative. In Colombia, although coverage has increased with social security reform, with special gains for the lowest-income quintile (Jaramillo, 2002), this has not been reflected as broader service accessibility and use (Cépedes-Londoño et al, 2002) and more than 40% of the poor population is still not insured (Flórez and Tono, 2002). On the other hand, health spending has rocketed (from 4% of GDP in 1998 to nearly 11% from 2000 onward), due mostly to the transaction costs of privatising insurance (Yépez and Sánchez, 2000; Echeverri-Lopez, 2002), as well as to inefficiency. Moreover, the contribution to health spending increased for the poorest quintile (Homedes and Ugalde, 2005). Finally, the population insured under the subsidised regime receives a service package equivalent to one fifth of the package of the contributory regime (Hernandez, 2002).

The Chilean reform of the 80s has involved more privatisation than any other in the region and is unsurpassed anywhere in that respect. Health insurance, which is clearly segmented, has been split into two subsystems (public and private), the public subsystem insuring lower income and lower risk users (Sapelli, 2004). More recently, in the past decade, major efforts are being made to implement the "reform of the reform", in terms of broadening and ensuring population coverage, besides overcoming the growing inequalities in health service utilisation which increased with the reform.

Obviously, there are exceptions, such as health sector reform processes in Costa Rica, Cuba and Brazil. Cuba is an exception as its health system has continued unchanged in spite of the economic problems imposed by external restrictions, but the other two countries, although strikingly different from the other countries mentioned, have not escaped this contemporary reform agenda.

In Cuba, the most important reforms to the system occurred in the 70s and 80s; they were directed to reorganising the system and, as in Brazil, were implemented without interference from international organisations. System decentralisation, which took place in the 70s, led to service planning and delivery at the municipal level and expanded the service net around polyclinic units (De Vos, 2005). Family medicine, introduced in the 80s, substantially expanded primary care (95% of the population was registered with a family doctor in 1995) (De Vos *et al*, 2004). Even despite the economic crisis of the 90s, Cuba continues to set itself the challenge of improving the quality of its health system (Iseqh, 2006).

In Brazil, construction of an alternative project of health sector reform dates from the 70s, still during the military dictatorship, and interrelates with the intense transformation of Brazilian society, particularly in the 80s, during the transition to democracy when the model of relations between State and Society was harshly criticised, and calls came for the huge social debt accumulated over the preceding decades to be redeemed. The health sector reform movement emerged and consolidated in organised civil society, expanding and forming coalitions that gained political strength in the transition to democracy. As a result of this process, in 1988, the right to health was written into the new Constitution as a civil right and, in 1990, the Unified Health System (SUS) was set up. However, after the reform was approved, implementation of the SUS was hindered because social policy in general, and health policy in particular, was submitted to the dictates of macroeconomic adjustments and to systematic budget cuts, although the Ministry of Health administers the second largest budget nationally. Nonetheless, the decentralisation process is structurally central to the SUS and priority is being given to expanding basic health care on the basis of specific fund transfer mechanisms and special programmes, such as the Family Doctor programme.

On the other hand, the ideas of separation of functions and privatisation were also incorporated into the proposal for administrative reform of the State in the late 90s. In the health field, this led to the creation of independent regulatory agencies (a national health agency and a health surveillance agency) and the institutionalisation of so-called social organisations (a juridical model of non-State public organisations, which are private law entities constituted in the form of foundations or non-profit civil societies). These organisations were to render social services of a public nature, with financial and administrative autonomy and new oversight and performance evaluation instruments. The relation between these organisations and the State was to be regulated by mutual commitments defined in contracts (*Organizações Sociais, Anteprojeto de Lei*, Brasília, April, 1996; Bresser Pereira, 1998:29-30). Although part of this reform of the State has been aborted, some elements remain in the system, because a country of continental proportions like Brazil comprises enormous heterogeneity. The struggle to consolidate and strengthen the SUS, and also the battle with the private sector, is unceasing and relentless. Even so, Brazil can still be said to constitute a model differentiated from other Latin American countries.

Costa Rica, following the European reforms, left untouched both the original structure of its health care system – resting on two central institutional pillars, the *Caja de Seguridad Social* (a social security fund) and the Ministry of Health, the former dominant – and its founding principles. Compared to other Latin American and Caribbean countries, Costa Rica is characterised by high levels of social investment in general and its health indicators are excellent, similar to Cuba's and Chile's and close to those of some European countries. In addition, Costa Rica ranks high in the Human Development Index table due, among other factors, to the results of its health system,

which has one of the highest coverage rates in the region. Although Costa Rica also suffered the effects of the economic crisis in the 80s, it has conserved and consolidated public and social responsibility in its social security system, maintaining the longstanding structure of the system, with universal insurance, and public administration and funding structure. As part of the reform, it has been extending and trying to consolidate primary care. However, it is also introducing competition mechanisms and innovations into administration, separating functions operationalised by management contracts since the mid-90s under the health sector reform financed by World Bank loans. The proposal is to introduce a new administrative rationality, supposedly based on demand and not supply, and to develop quasi-markets in health services, in line with the dominant reform agenda. The central issue, however, was to implement separation and specialisation of functions without creating new entities exogenous to the original system, thus constituting an "inner quasi-market", and a highly regulated one, according to Sojo (2001). The results of this process, which is still ongoing, have yet to be properly evaluated.

To sum up, in most countries, the elites in power can be seen to have adhered, in one way or another, to the reform proposals although the State apparatus did not have the necessary implementation capacity. Very often the previous systems were destructured (Colombia, Chile, Argentina) without achieving the heralded improvements and with even less equity in health service access and use, either because the processes were so radical or because of the high degree of experimentation with which the reforms are being implemented.

The main result of these processes has been that the reforms have not been able to overcome the segmentation and fragmentation in health care systems, and very often introduced perverse re-segmentations into the already existing structural segmentation.

5. Conclusions

The structural adjustment reforms carried out in the 1980s and 1990s, centred basically on privatisation, making the economy more open (liberalisation) and flexible, introducing competition mechanisms and more precarious labour relations, both in the economy and in the various sectors, including the health sector. *They were effective in dismantling the foundations of the old order, so that any approach involving a return to the past was rendered outdated* (Diniz, 2001:13). That is why it is important to analyse the innovations introduced critically, with a view to identifying different strategies frontally opposed to the restrictive intentions of recent decades. In addition, besides the external restrictions, it is fundamental not to lose sight of the historical specifics of each country.

The dominant economicist view, whether in the diagnoses or in the solutions recommended, has various harmful effects, as warned by Diniz (2001), probably the most serious being to mask the role of politics in the process of change. A second important mistake of this unilateral emphasis on the economic aspects is the belief that these reform processes obey a single, cast-iron logic to which all will have to adjust. This reveals a deterministic outlook where the new world order is seen as subject to one inexorable and inescapable dynamic. National governments are treated *as passive objects of forces that they cannot control (…)* [thus] *nullifying political action as a counterweight to the over-valuation of economic mechanisms and voiding governments' responsibility for the failures and successes of the policies applied* (Diniz, 2001:14).

In fact, this new and extremely complex world order is subject to an eminently political logic that has to do with asymmetric power relations – among Nation-states and among international organisations. What emerges are the extremely damaging costs of globalisation, which are not only economic, but also and most importantly political. Most severely affected are the new democracies, brought in with enormous, historical institutional weaknesses. The result is an autocratic style in policy-making and crisis management (O'Donnel, 1991, cited in Diniz, 2001:15).

Diniz (2001:17) stresses that *the practice of State reform under authoritarian regimes had consequences that cannot be ignored*. Thus, firstly, the long periods of dictatorship enabled a form of presidentialism to consolidate that inflates the executive out of all proportion and downgrades the legislative. Secondly, three other characteristic traits of State action in the region are exacerbated: the closed, exclusionary, technocratic style of administration, which reinforced the supremacy of the technical approach in policy-making; the value placed on technical know-how and economic rationality, with a narrower circle of decision-makers formed by senior technocrats, even though in many cases integrated into a system of patronage and clientism; and the primacy of voluntarist and personal values, which denies legitimacy to the action of other relevant actors, such as political parties. *Therefore, the idea of reform and change can be regarded as associated with a model of strong Executive, and of a Legislative, on the contrary, seen as force allied to the past and to defending particular and traditional interests* (2001:18). Insulating the bureaucracy, however, far from producing the desired "asepsis", has led to a *highly politicised bureaucracy* and special pleading, by weakening the legal dimension of the State because of the highly unstable juridical framework, in addition to a lack of accountability for action taken (Diniz, 2001:18).

Concomitantly, from the mid-80s onward, the hegemony of neoliberal thinking reinforced these features: the technocratic paradigm, regardless of the political regime in place; government efficiency as the result of processes to concentrate and close off the decision-making process; and administrative effectiveness reduced to bureaucratic insulation.

Although fragile, the new Latin American democracies enabled numerous problems to be unmasked – corruption, favouritism, nepotism and others – encrusted historically in the activities of both Executive and Legislative, and discrediting politics still further.

What can be seen in fact, as Diniz warns when analysing the case of Brazil (but which serves also for thinking about other cases in the region), is not *hyperactive decision-making* [by the Executive], *but a weak capacity to implement policies* (Diniz, 2001:19), at the same time as some of the proposals for reform that are taken up and operationalised demand a strong implementation and regulatory capability. One of the factors responsible for this infrastructural weakness was precisely the corrosion of the State's ability to perform its basic functions that resulted from the very policies previously adopted and executed. By contrast, the power of the State infrastructure became highly centralised, in an international context of an increasingly pervasive globalisation process whose economic and political effects were spreading on a world scale (Diniz, 2001:19). These contradictions lie at the core of the dilemmas to be faced by the countries in the region.

Kaufman (1995:2) notes also that *reform of the State is not simply a question of the political will* to implement "correct" institutional formulas. Efforts to transform the institutional framework in which policy is formulated and implemented will be affected by the prior history of each society, by negotiations and conflicts among national and international lobbies, politicians and bureaucrats, many of whom draw substantial support from the institutional *status quo*.

In the case of Latin America, macroeconomic policies, balance of payments deficits and international loans have considerably affected the options for reforming national policies, as well as the degree of autonomy available to States faced with an increasingly narrower range of options (Kaufman, 1995:6; Gilpin, 1993). With a view to increasingly the credibility if governments' commitments to macroeconomic policies, national leaderships have received very clear incentives to prioritise and implement certain specific agendas.

However, this political logic runs into difficulties when it leaves the terrain of macro-economic management and enters the broader array of issues such as social well-being (Kaufman, 1995:11), which includes health. The reforms in this area are less "visible" to the international financial sector, except as national spending and a percentage of the public deficit; they entail greater inter-sector coordination and cooperation among the various civil society groups, including the different levels of government. Furthermore, the influence of international actors is more limited outside the macro-economic arena and there is much less clarity as to which reforms should be preferred. Nonetheless, this does not prevent the agendas and "recipes" from being widely advocated, as described above.

In the health sector, the recently implemented reforms in Latin America and the Caribbean have aggravated some constitutive features of the regions' societies and created new problems by favouring a pragmatic, restrictive, economicist approach. The values of solidarity and equal opportunity for all are being replaced by a "radical utilitarian individualism" (Mateucci, 1993) more characteristic of past centuries than the start of a millennium; and the principle of "health needs or need for health services" is giving way to "risk" monetised and defined according to the individual's social and economic situation. Since the 80s, it has come to be believed that it is possible to harmonise selfish, particular interests or to bring public and private utility into harmony by applying – to health, for instance – the concepts of market and of utility formulated for the economy.

In some cases, the reforms implemented can be said to be more far-reaching than in the countries of the North, in that they extend to various spheres – from the funding to the reorganisation of health systems – and have entailed substantial conflicts between the principles of solidarity and equity, on one side, and efficiency and effectiveness, on the other, and have considerably augmented the complexity inherent to health systems. In addition, legal principles have been approved that institutionalised the right to health as a social benefit, formally instituting universal coverage and the commitment to the principle of equity (in Brazil and Colombia). In fact, however, the way these changes have been operationalised has worsened health system fragmentation and segmentation and has not overcome the inequalities, besides leaving much to be desired in terms of efficiency.

The principle of poverty has been preferred over that of citizenship, and privatisation has taken place, all in a context where a powerful private medical care sector is gaining strength internationally, where funding for implementing so-called public goods is scarce and where nation-States' policy-making autonomy is constrained, all constituting an extremely complicated arena for decision making.

In spite of the need for regulatory and implementation capacity, reform of the State was not carried through as hoped, in addition to which this capacity-building was severely prejudiced by fiscal stress and declining prestige of public institutions and State officials.

In summary, the genuine dilemma between administering scarce resources (efficiency) and overcoming inequalities (social justice) has been accentuated to extremes over the past few decades

as the belief in the possibility of balancing these two parameters has been called into question, and neoliberal policies emphasised individualism and linked social policy strictly to economic calculations, exacerbating the conflict among values and reinvigorating the ethical accounting underlying them (Santos, 1998). This dilemma is especially important in the Latin American region, because the external conditionalities have met with strong national acceptance and experimentation has proliferated with little or no criticism.

It seems therefore necessary to re-discuss social policies in general, and health in particular, from another perspective, as Santos (1998:51), for instance, suggests by defining them as *meta-policy,* that is, as the "*matrix of principles that give the rationale for the ordering of any other policies*". This means reinvigorating the discussion of the principles and values underlying it, and defining coherent, substantial principles of justice to rely, in addition to operationalising them effectively. What remains is to include political negotiation in this equation.

Furthermore, although choices do have to be made and priorities set for the State's action in the health sector, the solution does not lie in "*transferring the problem from the political sphere, which is significantly indeterminate and highly valorative, to the universe of logical* [technical] *discourse*", which is supposedly neutral and obeys rules that cannot rationally be refused (Santos, 1998:40), as is being done. This dynamic requires putting *preferences in order*, which means introducing the (national and local) conditionalities imposed by the realities, where discourse and rhetoric of decision makers and their critics operate. This ordering of preferences cannot be deduced logically, which means that it cannot be resolved on a technical (scientific) logic alone. In other words, it has to be remembered that these are decisions on policies that presuppose distributing different quotas of benefits and sacrifices among individuals in society which can ensure social conflict is minimised and some kind of social order maintained; this calls for appropriate procedures. The substantive issue is thus to define what is "*fair distribution of the sacrifice/benefit ratio among the individuals in society*" (Santos, 1998:51). It thus falls to the political logic of the "calculus of dissent", that is, what consensus is possible or dissent tolerable in a given society, in a given scenario. It relates ultimately to the degree of inequality (and of conflict) a society is prepared (or manages) to bear.

Breaking with the technocratic, reductionist focus thus entails thinking about the (State and health sector) reforms on the basis of broader theoretical and conceptual frameworks. In this regard, it is essential to restore politics to the analysis of reform processes, given that the tendency is to disqualify politics and to spread the belief that it is possible to make important changes to how health systems are structured without contemplating the various contending projects and the resistance from actors opposed to change, besides which very powerful new players have been created which have profited from the changes. This means strengthening the connections between State and society, and for that purpose governability and governance are complementary concepts, because the first one refers to the general systemic conditions where power is exercised and, the second one to the State's action in implementing policies and guarantees for attaining collective goals, such as assuring decent conditions of life for its population.

It is thus fundamental to think in greater depth about the role of the State, its formulation and implementation capacity, and to analyse the internal (national) options available for coping with constraints and proposals imposed from outside. This perspective has been largely neglected in health sector studies.

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