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Health Sector Reform in Central and South America – The Failure of Policy Transfer across National Boundaries

International health organisations are making increased use of the widening evidence-base for the generation of policy and recommendations for practice across national boundaries (Lambert *et al*., 2006). However, it is reasonable, and perhaps advisable, to challenge the appropriateness of policy transfer between settings to ensure that what is successful in one place is likely to be successful in another.

In the United Kingdom the majority of health care is provided through the National Health Service, funded by taxation and largely free at the point of delivery (Delamothe, 2008). However, other developed countries, notably the United States, make heavy use of the private sector to deliver these services (McDonough *et al*., 2010). Within this private sector model, the costs of health care are typically met by the individual either directly or, more commonly, through the use of private health insurance (PHI) (*ibid*). The 2004 World Bank World Development Report, 'Making Services work for Poor People' (World Bank, 2004), expresses the view that private providers, rather than Governments, should be encouraged to expand health care services within developing countries as part of broader neoliberal health sector reforms (HSRs). These reforms include elements such as the structural separation of provision and financing functions, increased participation of private companies, increased reliance on market mechanisms, decentralisation, and a shift away from social insurance funds to PHI (Lloyd-Sherlock, 2005). As in the US, those individuals wealthy enough to pay for their treatment (either directly or indirectly) would do so, while those too poor to pay would be subsidised by their Governments through contracts with for-profit and not-for-profit providers (World Bank, 2004). This paper seeks to define the background underpinning the policy of the World Bank, the International Monetary Fund (IMF) and other key international bodies to push neoliberal HSRs as the solution for health care provision in the developing world. It then explores some of the historical failures associated with the transfer of this policy approach to several Central and South American countries during the 1980s and 1990s and further considers its appropriateness for adoption by other developing countries in the future.

The World Bank was founded in 1944 at the Bretton Woods Conference and provides low-interest loans, interest-free credits, and grants to developing countries (World Bank, 2012). The institution is based in Washington DC and has historically been headed by Americans - in fact, every President of the World Bank has been a US citizen. Interestingly, and perhaps tellingly, several past Presidents have come from a non-banking background, including Robert McNamara (a former US Defence Secretary) and Barber Conable (a New York State Senator and US Congressman) (Philips, 2009, p276). The strong political ties between the World Bank and the US Government have led some commenters to suggest that one role of the World Bank is to act as a vehicle for the implementation of key aspects of US foreign policy within developing countries (Peet, 2003; Philips, 2009). It might, therefore, be reasonable to consider the neoliberal model of health care proposed by the World Bank as simply a natural extension of the US health care system - one facet of the broader desire for globalisation and an international free market economy. This is not to suggest anything inherently sinister but simply that private health care is a model that the US administration believes in and is something that they feel to be broadly appropriate across all settings (McDonough et al., 2010). However, the relationship between the World Banks HSR approach and the US Governments health care ideals does need to be recognised, and in

consequence, the possibility that HSRs may not be an independently considered and impartial solution to health care provision in the developing world.

The World Bank utilises several approaches in order to impress its HSR policy on developing countries. Primarily, the Bank links funding provision to investment in the private sector or to solutions that require private sector involvement (Lloyd-Sherlock, 2005). This offers Governments the stark choice between either receiving funding for private health care solutions or receiving no funding at all. Further barriers to Government-funded health care provision emerge when the World Bank requires often already impoverished States to cut public spending in order to receive loans (Oxfam, 2009). Known as Structural Adjustment Programmes (SAPs), the stated justification for requiring public spending cuts is the desire to encourage responsible spending by the State (World Bank, 2004). However, these requirements have historically had the effect of applying a particularly crushing pressure on Government health spending, so enhancing opportunities for the private sector to fill the subsequent vacuum in health care provision (Kanji et al, 1991).

During the 1970s and early 1980s the health care systems of many Central and South American countries were in a very poor state (Homedes and Ugalde, 2005). Nations such as Brazil and Argentina were crippled by tremendous levels of public debt, which was exacerbated by a widespread economic crisis in the latter part of the 1980s (Lloyd-Sherlock, 2000). Consequently many States were unable to properly maintain their public services and health care systems largely descended into chaos (Lloyd-Sherlock, 2005). At this point the World Bank and the IMF began to press for reforms to the healthcare system in return for allowing these struggling economies to borrow money. In particular these bodies stressed the need for structural adjustment, with a focus on social services expenditure in particular, through the widespread adoption of SAPs designed to pare down public debt (Homedes and Ugalde, 2005). Combined with SAPs and systematic cuts in central Government spending, the World Bank began to drive HSRs linked to lending and supported by the belief that the private sector was intrinsically more efficient than the public sector in delivering services (*ibid*).

As part of the SAP process, the IMF encouraged the decentralisation of public services spending, away from central Governments to provincial bodies. The argument for this approach was based on the idea of localisation and democratisation of public service spending (Bowser and Mahal, 2009), similar to that that professed to underpin the recent Health and Social Care Act (2012) in the UK (Ham, 2012). However, then as now, there were also implicit broader financial reasons behind this decentralisation as the devolution of historic central fiscal responsibilities freed up funds for Governments to use in order to service their debts (Oxfam, 2009).

A number of countries in Central and South America began to implement SAPs and HSRs during the 1980s and early 1990s, in line with the recommendations (and funding requirements) of the World Bank. However, the majority of these have faced difficulties with the implementation of this neoliberal approach, including political and financial barriers to change (Homedes and Ugalde, 2005). Early attempts at decentralisation in Mexico collapsed amongst a public outcry surrounding flagrant abuses of power by regional officials (Ugalde and Jackson, 1995). Gonzalez-Block *et al*. (1989) report major inequalities in health care service provision arising in Mexico during this time that placed the rural indigenous population at particular disadvantage and empowered regional politicians to provide or deny health services as they deemed fit, often in such a way as to benefit themselves politically.

Despite these problems in Mexico, countries such as Argentina, Brazil, Chile and Colombia continued to drive forward the reforms demanded of them by the World Bank and moved towards the privatisation and decentralisation of their health care systems, to a greater or lesser extent.

Chile was one of the first South American countries to embrace the World Banks neoliberal HSR ideals of under the dictatorship of Augusto Pinochet (de la Jara and Bossert, 1995). Prior to this, Chile had a National Health Service, providing universal access to health care for citizens and managed centrally by the Government (Unger *et al*., 2008). With their roots in the health financing reforms of 1979, sweeping changes began in earnest in 1981 through the implementation of an SAP and widespread decentralisation of authority for health care provision across several levels of local administration (de la Jara and Bossert, 1995). The Chilean Government then developed a system of private health care (Las Instituciones de Salud Previsional, usually referred to as simply the 'Salud') whereby individual companies could offer private health insurance as an alternative to State provision. Participants in the new scheme were permitted to direct the 7% of their salaries, normally paid to the Government for health care services, into one of these private alternatives (Sapelli, 2004). However, as participation in the Salud was voluntary, it tended to be much more popular with the wealthy for whom 7% of their salary represented a great deal of money and allowed them to purchase a higher standard of private health care (Homedes and Ugalde, 2005); Ironically, the wealthier members of society (those typically paying for private health care) tended to be the youngest, healthiest and better educated amongst the population with less need, overall, for high quality health care (Biggs *et al*., 2010). For the poor it was often only be possible to stay within the subsidised State system and accept the usual standard of care. However, as a result of this ability to self-select, the public sector lost much of the revenue that it used to receive from wealthier citizens paying their 7% into the social security 'pot'. This reduction in income led to an overall increase in costs for the State and a subsequent decrease in the quality of the Government-funded health care services provided to poorer members of society (Homedes and Ugalde). Castaño *et al*. (2001) found that between 1984 and 1997 (during the period of reform) Government expenditure on health care in Chile rose by 174%. In addition, the authors found that in order to compensate for a falling quality of provision, individual citizens were forced to spend additional sums of money to maintain their health and per capita expenditure on health care almost doubled during this time.

Because wealthier people tended (and still tend) to live in different areas than poorer people (Neilson *et al*., 2008), differences in the level of health service utilisation were also geographically distributed. As a result, the costs of providing health care services in a decentralised Chile not only increased overall but also varied substantially from place to place, producing distinct inequalities (Agostini *et al*., 2010). Arteaga *et al*. (2002, in Homedes and Ugalde, 2005) describe the utilisation of publically funded primary care services in some areas (particularly within rural communities) as being up to 2.8 times higher than in other areas and the emergency care utilisation as almost four times higher due to the unaffordability of private health care by the majority of residents. These extreme differences also extended to mortality rates, where same authors found that the standardised mortality rate varied between 30 and 160 across different municipalities (*ibid*).

Following the adoption of the HSR policies promoted by the World Bank, Chile had moved from possessing a functional National Health Service and low levels of health inequality (Homedes and Ugalde, 2005) to acquiring a socially fragmented, market-driven and unequal healthcare system (Unger *et al*., 2008), a fact that is sometimes masked by the country's

dramatic economic growth over the same period (de la Jara and Bossert, 1995). Efforts to reduce these inequalities are on-going in Chile and form the basis of more recent health reforms (Régimen General de Garantías en Salud**)** in that country (Vargas and Poblete, 2008).

Health care reform took a slightly different route in Colombia. Since the country began its reforms in 1990, a decade later than Chile, it was able to benefit somewhat from the mistakes made there (Tsai, 2010). A key concern for Colombia was the effect of Chiles HSR on health inequalities across social strata, with indigenous people being the most disadvantaged (Agostini *et al*., 2010). Where Chile devised a two-tiered system of health care (the Salud or the State), Colombia's approach was offer all its citizens the same options in an attempt to blend out inequalities (Homedes and Ugalde, 2005). Early and rapid decentralisation to the municipal level in line with the World Banks guidelines was combined with the engagement of private companies (Health Promotion Enterprises or ESPs) to collect insurance premiums and deliver health services within the country (*ibid*). However, while the services available to all Colombians remained the same and ESPs were legally obligated to provide health care for all - something that the Chilean Salud was not - inequalities still began to emerge from the onset. Wealthier citizens were able to purchase enhanced services from the ESPs and some ESPs, in turn, sought ways to escape their wider health care responsibilities, particularly for poorer members of isolated or rural communities (Plaza *et al*., 2001). Tsai (2010) reports that in 2008 more than 143,000 legal claims related to health care provision were brought before the Colombian Constitutional Court and the majority of these concerned a denial of treatment that was supposed to be covered by ESPs. Although Colombia's HSR was heralded as a success by the World Bank (Bossert *et al*., 1998), a crisis within the health care system continued to develop. In 2009, on the back of rising costs and falling quality, the Colombian Government declared a state of emergency within its health care system (Bernal *et al*., 2012) and, like Chile, many of these difficulties remain to be resolved.

Brazil's version of HSRs was somewhat less committed than either Chile's or Colombia's and primarily involved the States move away from using public hospitals and towards commissioning private hospitals to provide tertiary care services (Homedes and Ugalde, 2005). At the same time additional autonomy was provided to public in the belief that this freedom from centralised control would help to improve efficiency (La Forgia and Couttolenc, 2008). This interpretation of the World Bank's policy is particular to Brazil and resulted from a general understanding that, in most cases, Brazilians seeking medical treatment will to go directly to a hospital rather than seek out a primary care physician (*ibid*). However, the neither the utilisation of the private sector nor the provision of autonomy to the public sector appeared to improve the quality of the service, with both neonatal mortality and nosocomial infection rates worsening post-reform (La Forgia, 2003, in Homedes and Ugalde, 2005).

In Argentina, HSRs formed just part of a broader range of structural reforms taking place within the Country during the 1990s, including the privatisation of pension funds. During this period Argentina was undergoing tremendous economic and social reform following a hyper-inflationary economic crisis in 1990 (Lloyd-Sherlock, 2005). With the encouragement of the World Bank, the Inter-American Development Bank and the United Nations Development Programme the Argentinian Government undertook a major HSR based on a model of competitive private sector involvement (Lloyd-Sherlock, 2000). In a similar manner as many countries within the region (and for similar reasons) the Argentinian health service had suffered from decades of neglect, underfunding and abuse (World Bank, 1997). Public hospitals were often used to provide treatment but were rarely paid for these services, allowing health insurance providers to retain a much greater proportion of their income

(Lloyd-Sherlock, 2005). The reforms of the 1990's opened the market to large scale privatisation of the health care sector aimed at adding competition and driving efficiency in health care provision. However, the regulatory environment was poor – something that suited the private providers but disempowered both the citizen and the State (*ibid*). In addition to these funding reforms, and in a similar fashion to what occurred in Brazil, public hospitals were encouraged to adopt a self-managed status (Jack, 2000) although this 'autonomy' was primarily concerned with deferring cost recovery away from the State rather than empowering the hospitals in any meaningful way (Escudero, 2003). Although HSRs and the widespread reliance on PHI to fund health care were not initially detrimental to the Country, in 2001 Argentina experienced a widespread economic crisis that saw the National GDP fall by 28% (Lloyd-Sherlock, 2005). Both private sector and public sector providers were hit (the former from the inability of insured persons to maintain their premiums and the latter from capacity failure due to a massive surge in demand for services after years of neglect) (Lloyd-Sherlock, 2006). The system that worked reasonably well during times of prosperity was simply unable to sustain itself during an economic downturn due to the highly fragmented nature of revenue collection, service delivery, long-standing structural weaknesses and a history of poor governance (Lloyd-Sherlock, 2005).

Of all the attempts made by Central and South American countries to implement neoliberal HSRs, the experience of the Dominican Republic, as described by La Forgia *et al*. (2004) was perhaps the most catastrophic. It starkly echoes McPake and Bandas (1994) criticism of the application of managed competition theory to developing world settings, since the Dominican Government initiated privatisation without any regulation – the ultimate free market. Unfortunately, as predicted by Tudor-Hart in 1971, the Market took full advantage of the situation with a range of unethical, although not unlawful, practices being adopted by health insurance companies seeking to exploit this new opportunity. Health insurance plans could be cancelled by the issuing company if, for example, the insured individual were diagnosed with an illness that would be expensive to treat – so-called 'high cost events' (La Forgia *et al*., 2004). Regulation has followed, but as the private sector (through the Dominican Medical Association) has gradually managed to manoeuvre itself into a political position such that it is able to influence National health policy, reform has been slow and grudging (*ibid*). The situation in the Dominican Republic clearly highlights the very real risks to Governments that take a back seat to the Market during policy reform as they face a very real risk of extended disempowerment. The Country did retain an element of State health care provision in its Secretaria de Estado de Salud Publica Y Asistencia (SESPAS), although this service became hugely over-stretched and urban-focused, disenfranchising much of the rural population (Whiteford, 1992). The policy of rejection of claims for 'high cost events' by insurers increases the pressure on State-funded health care by forcing patients to seek expensive treatment from SESPAS when they are denied it by their PHI provider (La Forgia *et al*., 2004). The entire system, therefore, is structured towards protecting the profits of PHIs to the frequent detriment of the physical health of the individual and the financial health of the State.

As a result of HRS reforms, many Central and South American countries have acquired health services that are vastly more expensive to run than previous systems, being supported for now by foreign loans provided by the World Bank and IMF in return for HSR compliance (Homedes and Ugalde, 2005). However, there is very little evidence that these reformed health care services are any more efficient or more equitable – in fact evidence from Chile (Castaño *et al*., 2001), Argentina (Lloyd-Sherlock, 2005), Brazil (La Forgia and Couttolenc, 2008) and Colombia (Tsai, 2010) all suggests that HSRs can both raise health care costs and widen inequalities in a dramatic fashion. Those that appear to have benefited the most from

the proliferation of neoliberal HSRs are international companies capitalising on emerging markets in health care provision (Stocker *et al.*, 1999). Here they are able to reap financial benefits for themselves and their shareholders while leaving debt (often in the form of World Bank loans) their wake.

Some resistance to the World Banks health policy reforms does linger in parts of Central and South America and it may be useful to consider how these Countries have fared over the same time period. Costa Rica is one Nation that has largely managed to keep control of its health care provision and relies on a combination the Caja Costarricense de Seguro Social (CCSS) (a National social security fund paid for through taxation) and not-for-profit health care providers, in stark contrast to the Dominican Republic. As a result of this low cost, high quality and centrally managed approach, Costa Rica has achieved a high standard of health care with an average life expectancy of 78 years - higher even than the United States (Rosero-Bixby, 2004). Only Cuba, which operates a centralised, fully nationalised health care system in diametric opposition to the ideals of the World Bank, achieves better regional health outcomes than Costa Rica (Offredy, 2008).

Certainly there may be some advantages in utilising private health care providers. The International Finance Corporation (IFC), part of the World Bank, provides six arguments in favour of expanding the provision of private health care in its 2007 report (IFC, 2007). Firstly, that since many countries already rely on private health care providers it would be more efficient to scale this provision up than to develop new Government-funded health services; secondly, that private provision can take some of the strain off State-funded services, allowing finite resources to be spent elsewhere; thirdly, that private providers are more efficient and less wasteful than State providers; fourthly, that private health care is not only more efficient but also of a higher quality than that provided by the State; fifthly, that private health care can reach even the poorest in society and, lastly, that through competition, private providers are more publically accountable. It would appear from this argument that maximising private health care provision would be an obvious choice for any Government determining its overall health policy. The purported quality, efficiency and accountability of private provision would suggest that this approach could offer the best overall value for money. Further, the idea that private health care would be within the reach of even the poorest in society only serves to strengthen this argument. However, the IFCs arguments fail to match the experiences of many of the Central and South American countries that have endeavoured to implement them and therefore warrant some degree of critical consideration.

The IFCs first argument that much of the health care provision in the developing world is already provided by the private sector is misleading. Oxfam (2009) suggests that the ‘private sector’ in many parts of the developing world may be primarily composed of small, independent drug retailers and traditional healers who charge a fee for their services. Scaling-up from here to provide effective national coverage through modern private providers, as envisaged by the IFC and the World Bank, would appear to be a somewhat daunting task.

The notion that private health care provision can ease the financial strain on Governments also appears logical at face value. However, products and services in health care, like products and services in any sector, are required to be paid for by someone. In some settings, such as in Brazil (Homedes and Ugalde, 2005), the Government may pay to subsidise the private sector, particularly to help to pay for the health care of poorer people. However, in other settings there may be no Government subsidisation and the patient may need to cover their own treatment costs in full, either personally or through PHI membership (Oxfam,

2009). Unfortunately, even in the US, where the Gross Domestic Product (GDP) is over US$14.5 trillion dollars and the Gross National Income (GNI) exceeds US$47,000 per person (World Bank, 2010), there is still widespread health poverty (Ayanian *et al*., 2000). The transfer of US-like, market-driven HSR policy to countries, such as Honduras with a per capita GNI of US$1,870 or Nicaragua with a GNI of US$1,110 (World Bank, 2010), could have serious public health implications and risk adding to the already substantial health inequalities found throughout the developing world (Drummer and Cook, 2008). In the 2005 United Nations Development Programme Human Development Report, Sridhar (2005) draws links between the poor in America, their lack of private health insurance and the consequent lower health status of this demographic. She explains that the uninsured or those without the means to be able to afford treatment will consistently postpone seeking care in comparison to those with the means to pay. It is this postponement, possibly rationalised through self-treatment at home, which Sridhar associates with poorer health outcomes. If this is the case in the US, it is reasonable to assume that the situation would be considerably worse in poorer countries and Peters *et al*. (2008) indeed found this to be true across a number of countries, including Honduras and Brazil. Ultimately, there is no incentive for private health care providers to treat those who cannot pay. This means that unsubsidised private providers may simply refuse to treat patients unable to pay or may provide a lower standard of care – either openly or because of the underlying information asymmetry that empowers them to do so (Bloom *et al*., 2008).

The IFCs arguments, that private providers are more efficient or in some way improve the quality of healthcare, are understandably popular amongst those with interests in private sector health care provision (Uplekar, 2000). While this may be true for some developed countries, it is clearly not the case across much of the developing world. Oxfam (2009) highlight research from across the globe where public healthcare provision has not only been more cost effective than private provision but also more clinically effective – something which may be suggested retrospectively, in Chile at least, from the work of Castaño *et al*. (2001). Health care in Cuba, for example, is held by many as a model for how effective and efficient Government-funded healthcare can be. Offredy (2008) not only highlights that Cuba has a lower infant mortality rate than the US but that it also has a greater number of doctors per capita than the US and most other developed countries, a lower prevalence of HIV and has successfully eradicated polio, diphtheria, measles, mumps and rubella. With a GNI of US$5,460 (World Bank, 2010) - less than 12% of the GNI of the United States - it remains a moot point as to whether the neoliberal approach favoured by the World Bank could ever have achieve as much.

The question of private sector accountability and competition as being drivers of quality service delivery is also discussed in the 2007 IFC report. This notion of competition is underpinned by Enthoven's theory of managed competition (Enthoven, 1978) in which ‘payers’ are provided with the opportunity to choose health services selectively and aggressively, so lowering prices and raising quality. This would, ordinarily appear to be a good thing for consumers of health care, providing them with better provision at a lower price. However, the theory relies heavily on the presence of effective, centralised management, and its application to poor counties assumes a similar business and regulatory environment across all settings – something that is simply not the case (McPake and Banda, 1994); the experiences of the Dominican Republic are a prime example. Although competition, either driven by consumer choice or through a formal, independent tendering process, may work reasonably well in wealthy countries, there are typically very different mechanisms at play elsewhere (Bloom *et al.*, 2008).

The IFCs further assertion that the private sector is somehow more accountable and transparent than the public sector is also not necessarily the case. In India, for example, Qureshi (2001 cited in Oxfam, 2009, p. 25) describes a report sponsored by the National Government that found that several private hospitals paid by the State to offer free health care to the poor were simply pocketing these payments without offering the services. Researchers such as Scheffler (1989) and Ellis (1998) refer to this type of behaviour as 'creaming, skimping and dumping'. Creaming refers to the over-provision of services where a payment is associated with each service event or by choosing to treat only those individuals whose treatment will be associated with appropriate financial return. Treatment may then either be skimped for those patients unable to pay or poor patients may even be 'dumped', being denied any treatment whatsoever; this has been part of the experience of ESPs in Colombia (Plaza *et al*., 2001; Tsai, 2010). In 1971 Julian Tudor-Hart defined his 'inverse care law' as an expression of the view that market forces have the effect of magnifying existing health inequalities rather than reducing them. He notes that the availability of good health care is usually inversely related to the needs of the population, and that market forces only seem to exacerbate this disparity. Although writers like Watt (2002) and Cookson *et al*. (2010) argue that Tudor-Harts original law is too simplistic for practical application, they acknowledge that it does contain some truth, particularly in its notion that "*no market will ever shift corporate investment from where it is most profitable to where it is most needed*". This is essentially the nub of the problem - that while socioeconomic equality in health care is a primary goal of publicly funded health care services (Cookson *et al*., 2010), such is not the case in the private sector and nor is it likely to ever be.

While policy transfer between settings can be a useful way to learn from the experience of others and expedite improvements in health care service provision, no policy can ever be a one-size-fits-all solution. Every setting will be different with regard to its social, economic and political landscape and direct transfer would be almost like taking a piece from one jigsaw puzzle and assuming that it will fit right into another. The bulk of available evidence suggests that health service reforms based on private health care solutions and imposed on poor developing countries does not work. Its negative effect on reducing health inequalities has been outlined by both its opponents and even by some of its supporters, albeit considered by these as an unfortunate side-effect of broader structural improvements. Even within some areas of the US administration, while remaining supportive of the World Banks approach to international structural health care reforms, there is some admission of weaknesses. Weissman (2009), writing on behalf of the US House of Representatives acknowledges that some HSRs have historically led to very fragile health care improvements and been associated with the exacerbation of inequalities. He acknowledges that foreign decision makers have been insulated from national realities and suggests that in the future equality, as well as economic growth, should form an important element of HSR design.

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