Health, Equity and Social Exclusion in Latin America: The Cases of Argentina and Mexico

PETER LLOYD-SHERLOCK*

As a region, Latin America has performed relatively well in terms of basic health indicators, even during the crisis years of the 1980s. However, this apparent success belies profound and complex problems of inequity and solidarity, which are rooted in wider processes of political and social exclusion. This chapter provides a short regional overview of some of these issues. Given the complexity of the topic and the brevity of the paper, it is not possible to capture many variations in national experiences. For example, the paper makes no reference to countries such as Cuba, whose health profile and health care system bear little resemblance to the rest of the region. In order to support some of the paper’s generalisations, examples are taken from two countries -Argentina and Mexico- which, though different, in many ways typify the key issues and problems faced by Latin America as a whole. The paper begins by briefly referring to the difficulty of conceptualising health, particularly with reference to exclusion and equity. It then examines equity and health from a number of different angles, including progress towards universal provision of formal services, geographical variations for different health indicators, the segmentation of health care systems, and the historical and political context within which these problems of equity occur. The concluding section looks at recent reform experiences, and finds little evidence that these issues are being effectively addressed.

HEALTH, EQUITY AND UNIVERSALITY

Health is a complex and problematic concept in any part of the world, not just Latin America. This becomes particularly challenging when we attempt to relate health to ideas about equity and social exclusion. The most widely accepted definition of health comes from the World Health Organisation (WHO), which sees it as: “a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity”. This constitutes an embracing and ambitious approach to understanding health, and serves to rebut the narrower, more negative conceptions sometimes

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1 Garfield and Holtz (2000).
2 WHO (1948).
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found among health professionals. The WHO approach stresses that population health is influenced by much more than formal health service provision, and must be understood with reference to general economic, social, environmental and cultural conditions. This is of particular significance in Latin America, whose wider context of development has rarely been propitious to good health for poorer and more vulnerable groups.³

However, the WHO approach to health is not easily translated into obvious policies or clear strategies, and quantitative indicators are unable to capture the complexity of such a concept. Consequently, a more limited approach to measuring and understanding health is usually taken. In regions of extreme resource scarcity, particular attention is given to developing basic packages of services, essential drugs and selective primary health care. In Latin America the focus is rather different, and the traditional conservative, curative/negative approach to health still tends to predominate.

Taking this narrower definition, Latin America appears to have performed reasonably well as a region over recent decades.⁴ Of particular significance has been a large fall in infant mortality (Table 1). The region's performance fits within a wider picture of epidemiological transition. This involves a shift in the main causes of sickness and death from infectious diseases, under-nutrition and inadequate hygiene, to a post-transition phase, where diseases of "wealth and modernity" (including chronic disease, road accidents and stress) are more prominent.⁵ Key motors of this change have included socio-economic change, wider access to sanitation and clean water, and the extension of some basic health services, such as immunisation programmes. The timing of this epidemiological transition has varied across the region. Southern Cone countries are now at a much more advanced stage of transition than poorer Andean and Central American ones. This is seen in Table 2, which shows changes in the prominence of two causes of diseases associated with different phases of the transition.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>BASIC HEALTH AND DEMOGRAPHIC INDICATORS, LATIN AMERICA AND THE CARIBBEAN, 1960-1995</th>
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<tbody>
<tr>
<td>101</td>
<td>81</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td></td>
</tr>
<tr>
<td>56.8</td>
<td>60.9</td>
</tr>
</tbody>
</table>

While the region's general health performance may have been good, a recent report by the Pan American Health Organization (PAHO) observed that: "The characteristics and speed of this improvement have not been the same in all

⁴ PAHO (1998).
countries or in all population groups in any one country". Consequently, organisations such as PAHO have attached a high priority to improving equity in the region.

<table>
<thead>
<tr>
<th>PERCENTAGE OF HEALTHY LIFE YEARS LOST, BY SELECTED CAUSES, 1980 AND 1994</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central America and the Latin Caribbean</td>
</tr>
<tr>
<td>18</td>
</tr>
<tr>
<td>Cancers</td>
</tr>
</tbody>
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But what does equity mean when applied to health? Perhaps ideally, these should consider the degree to which economic and social policies reduce health differences within a population (once we have standardised for things like age and sex). However, in current Latin American health policy discourse equity is usually understood in a much narrower way, to be the guarantee of minimum levels of health and access to services for poorer and more vulnerable groups. To some extent, this approach resonates with universalist agendas. These were given impetus by the "Health For All by the Year 2000" pledge made at the landmark 1978 Alma Ata conference. Every country in Latin America signed up to this commitment, and it is echoed by constitutional guarantees across the region. During the 1980s and 1990s policy rhetoric made much of this "mission" for the region. The challenge of universal health care was considerable: the Pan American Healthcare Organisation estimated that by the early 1990s 130 million people in Latin America and the Caribbean still had no access to any form of modern health care services. However, references to "Health For All" became fewer as the deadline approached, and there were no public attempts to take stock or evaluate progress towards universal access during 2000. In this light, it is difficult to know how seriously we should take similar pledges made by international agencies such as UNFPA's goal of reproductive health care for all women by 2015 or the UK government's aim to halve world poverty by 2020. Do such "mission statements" provide an effective policy focus, or do they give a misleading impression about the solvability of what are often deeply-rooted social problems? Possibly the answer is both.

So how has the region fared in terms of universalising access to health care? Clearly, the starting point for different countries has been very variable. In the case of Argentina, it is often stated that access to basic services is all but universal. However, some studies report increasing exclusion of more

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7 IADB (1996); PAHO (1998).
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vulnerable groups. By contrast, in some of the poorest countries it is thought that the majority of the rural population remains unserved. The case of Mexico falls somewhere between these two extremes, but its efforts to extend access do not give cause for optimism.

Estimates for 1978 show that around 45 per cent of Mexicans lacked access to formal health care services from any source. Efforts to extend coverage to the rural population during the 1980s were led by a scheme known as IMSS-Solidarity. This was managed by Mexico’s main social insurance fund (the Instituto Mexicano del Seguridad Social or IMSS), but was fully financed by the federal government. Claims about the success of this initiative vary. Some studies suggest that 89 per cent of the population could access services by 1990. However, data on actual levels of utilisation suggest coverage was only 56 per cent. There were also doubts about the quality of care provided by IMSS-Solidarity. Its services were never legally defined, and the scheme was not subject to external supervision. The scheme was politically important to IMSS, as it strengthened its redistributive and universalist credentials, and provided an important source of employment. Consequently, IMSS resisted efforts to integrate the programme with Ministry of Health initiatives for unprotected urban groups.

During the 1990s the Mexican ministry of health implemented two further extension programmes. The first of these, el Programa de Apoyo a los Servicios de Salud para la Población no Asegurada (PASSPA), ran from 1991 to 1995 and aimed to improve primary health care infrastructure in the country’s four poorest states. Official sources claim that PASSPA extended potential regular access to health care to around two million people. However, the ministry of health’s own programme evaluation was never made publicly available. A second initiative, el Programa de Extensión de Cobertura (PEC), ran from 1996 to 2000 and aimed to offer a package of 12 basic health services to the entire population which remained unserved. PEC had a broader geographical base, extending to 18 states, and was claimed to have reached around six million people during its first two years. Again, no evaluations have been made publicly available to support this claim, and the credibility of the six million figure remains highly questionable. Gómez-Dantés (2000) argues that even if official data could be believed, key features of PASSPA and PEC raise concerns about equity. These include issues about the narrowness of the basic health package being offered the poor, and the fact that both programmes were largely financed by the World Bank rather than the Mexican government. This raises questions about the commitment of the Mexican state to provide a good standard of care to all its

10 Data on access are very poor for much of Latin America. While some information is available about the supply of services (numbers of doctors, beds, etc), much less is known about actual levels of utilisation by different population groups.
12 González Block and Ruiz (1998).
13 Gómez-Dantés, 2000
citizens. It also suggests that the Alma Ata ideal of universal health care may have been replaced by a narrower neo-liberal safety net approach of poor services for the poor.

GEOGRAPHICAL INDICATORS OF HEALTH AND EQUITY

A second way to examine equity is through geographical variations in health at the sub-national level. As most Latin American countries are characterised by sharp regional disparities in wealth and human development, it is to be expected that health conditions will also vary. Tables 3 and 4 give sub-national data for infant mortality and life expectancy at birth for Argentina and Mexico in the mid-1990s. In the case of Argentina, the probability of a child dying in the first year of life in the poor province of Chaco was more than double that in Buenos Aires city. Variations in life expectancy across Mexico are less acute, although they still account for over 6 years between the richest and poorest states. In the relatively prosperous Nuevo León, life expectancy is almost on a par with developed countries (74.3 years in 1990). In Chiapas it is slightly below that of Western Asia (68.3 years).\textsuperscript{14}

<table>
<thead>
<tr>
<th>TABLE 3</th>
<th>INFANT MORTALITY PER 1 000 LIVE BIRTHS BY PROVINCE, ARGENTINA, 1996</th>
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</thead>
<tbody>
<tr>
<td>Infant mortality per 1 000 live births</td>
<td></td>
</tr>
<tr>
<td>National average</td>
<td>20.9</td>
</tr>
<tr>
<td>Buenos Aires city</td>
<td>14.7</td>
</tr>
<tr>
<td>Chaco</td>
<td>34.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABLE 4</th>
<th>LIFE EXPECTANCY AT BIRTH BY STATE, MEXICO, 1994</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy (years)</td>
<td></td>
</tr>
<tr>
<td>National average</td>
<td>71.6</td>
</tr>
<tr>
<td>Chiapas</td>
<td>67.5</td>
</tr>
<tr>
<td>Nuevo León</td>
<td>73.7</td>
</tr>
<tr>
<td>Source: Frenk, ed (1997), Appendix A.</td>
<td></td>
</tr>
</tbody>
</table>

These general demographic figures give a crude indication about health patterns, particularly with regard to mortality. However, they give no information about variations in the overall health status of the surviving populations. One way this information can be captured is with reference to the epidemiological profiles of different groups or geographical areas in a country. Ideally, epidemiological data should include the overall extent of ill-health and premature mortality, as well as the types of factors which cause

\textsuperscript{14} UN (1994).
these problems. Good epidemiological information is not available at the sub-national level for many Latin American countries (this itself should be a matter of concern). One exception is Mexico, and data for regional health variations are presented in Table 5. The health indicator used, the Disability Adjusted Life Year (or DALY) is a composite measurement of premature mortality and general population health.\(^\text{15}\) This epidemiological information points to a higher level of regional inequity than suggested by demographic statistics. For example, the overall burden of disease in the rich state of Nuevo León compares favourably to that of developed market economies (estimated at 117 per 1000 in 1990), while the poor state of Chiapas is closer to India (344 per 1000).\(^\text{16}\) These differences have led some commentators to refer to the “epidemiological polarisation” of Mexico and other Latin American countries.\(^\text{17}\) The extent of this polarisation might be revealed by data which are more geographically desegregated or which compare the situation of different socio-economic groups. Unfortunately, such data are not available for Mexico or Argentina.

Geographical inequities in health can also be examined is with reference to the distribution of infrastructure and personnel. Care should be taken when interpreting such data for several reasons. First, as mentioned above, formal health care service delivery is only one of many things which may influence health outcomes in a population, and should not be taken as a proxy for health status. Second, crude measurements of things such as the supply of hospital beds ignore important variations in what a bed may actually consist of, which might range from an intensive therapy unit to a trolley in a corridor. Third, such data tell us little about the overall resource mix in service provision. Most of Latin America suffers from an extreme bias towards curative hospital-based care, and towards specialist physicians rather generalists and nurses.\(^\text{18}\) Using data on beds and doctors may serve to promote the misconception that this is what good health is all about. Finally, regional variations may be a misleading reflection of inequity, as hospitals in large cities may function as national referral and teaching centres, serving populations from less well-endowed regions.

<table>
<thead>
<tr>
<th></th>
<th>Communicable diseases, nutrition and reproductive</th>
<th>Non-communicable diseases</th>
<th>Accidental and non-accidental injuries</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>National average</td>
<td>44.4</td>
<td>68.6</td>
<td>30.7</td>
<td>143.7</td>
</tr>
<tr>
<td>Chiapas</td>
<td>90.9</td>
<td>83.5</td>
<td>31.8</td>
<td>206.2</td>
</tr>
<tr>
<td>Nuevo León</td>
<td>23.8</td>
<td>60.9</td>
<td>23.4</td>
<td>108.1</td>
</tr>
</tbody>
</table>

Source: Lozano (1997).

\(^{15}\) For further information about DALYs see World Bank (1993). Paalman et. al. (1998) identify a number of weaknesses and potential biases with this indicator.

\(^{16}\) World Bank (1993).

\(^{17}\) Frenk (2000).

\(^{18}\) Abel and Lloyd-Sherlock (2000).
Table 6 gives some data for the regional distribution of health care infrastructure for Argentina. Data are given for the Province of Buenos Aires instead of Buenos Aires City, to avoid the national referral effect mentioned above. While this province is less prosperous than the capital and contains significant pockets of poverty, it is still relatively affluent compared to northern provinces such as Chaco. According to Table 6, Chaco Province is well-served in terms of hospital beds and out-patient clinics. Whether the quality of these facilities is on a par with standards elsewhere in the country is another matter. Stillwaggon (1998) found very wide variations in the facilities and quality of care provided by Argentine clinics, some of which even lacked running water. The high level of infant mortality in Chaco reported in Table 3, is suggestive of both the low quality of services there, and their failure to compensate for the wide range of socio-economic and environmental risks faced by the local population.

| REGIONAL DISTRIBUTION OF HOSPITAL BEDS AND OUT-PATIENT ESTABLISHMENTS IN ARGENTINA, MID-1990S |
|---------------------------------------------------|---------------------------------|
| Hospital and clinic beds per 1000 population¹ (1995) | Out-patient establishments per 1000 population¹ (1997) |
| National average | 4.8 | 0.18 |
| Buenos Aires province | 4.0 | 0.12 |
| Chaco | 5.0 | 0.38 |

¹ Includes public and private sectors. Source: calculated from INDEC (1998).

In most Latin American countries the geographical distribution of trained medics is strongly biased towards richer regions and urban centres. Efforts to reduce this imbalance through, for example, obliging newly-qualified physicians to take a “rural year” have had little effect. Data from Mexico reveal the extent of this problem. In 1996 there was one physician for every 1,108 inhabitants in Chiapas, compared to a ratio of one to 625 in Nuevo León. Moreover within Chiapas there were large geographical disparities, and in municipalities where indigenous groups accounted for over 70% of the population the ratio was one physician to 3,246 inhabitants. While trained physicians should not be seen as the be all and end all of health care provision (although both they and their patients often think so), such an imbalance is suggestive of a major “quality gap” between privileged and excluded areas.

A SYSTEMIC VIEW OF INEQUITY AND HEALTH

The formal health care delivery system is only of many things that may influence population health. However, it is clear that the structure of health
care systems across the region has significantly contributed to problems of inequity. Traditionally, most Latin American health care systems have been highly segmented, and it is usually possible to identify at least three separate sectors. This structure conforms to the wider conservative/corporatist orientation of the region’s welfare regimes. Public provision is theoretically financed by general revenue, and aims to provide universal, basic coverage. A range of occupation-specific health insurance programmes provide additional protection to the formal urban labour force and their dependants. These may be administered by the public sector (usually by a separate agency from the ministry of health) or, as is the case in Argentina, by organisations such as trade unions. Finally, private health insurance has become increasingly significant in the region, although its coverage remains largely confined to relatively wealthy groups.

Typically, Latin American, social and private insurance programmes account for almost as much health expenditure as the public sector, but only provide for a relatively privileged minority of the population. Tables 7 and 8 provide data on social and private insurance coverage for Argentina and Mexico, and show that the people living in poorer areas are much less likely to be protected. The situation is particularly acute in the Mexican state of Chiapas, where health insurance still remains an option for only a small elite.

<table>
<thead>
<tr>
<th>TABLE 7</th>
<th>POPULATION LACKING HEALTH INSURANCE BY PROVINCE, ARGENTINA, 1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>National average</td>
<td>36.9</td>
</tr>
<tr>
<td>Federal Capital</td>
<td>19.7</td>
</tr>
<tr>
<td>Chaco</td>
<td>52.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABLE 8</th>
<th>POPULATION LACKING HEALTH INSURANCE BY STATE, MEXICO, 1995</th>
</tr>
</thead>
<tbody>
<tr>
<td>National average</td>
<td>62.1</td>
</tr>
<tr>
<td>Nuevo León</td>
<td>37.7</td>
</tr>
<tr>
<td>Chiapas</td>
<td>84.7</td>
</tr>
</tbody>
</table>

It is a widely-held view in Latin America that groups lacking social insurance programmes cover make no financial contribution to it, and so these schemes

22 Most studies overlook other potentially important health sectors, such as traditional medicine, homeopathic medicine and informal caring. Given the brevity of this chapter and the scope of its topic, these sectors are not included.
23 Lloyd-Sherlock (2000a).
have neither a positive or negative impact on equity or distribution. Indeed, it is sometimes argued that the existence of the social insurance sector frees up public resources which can be directed towards unprotected groups. Both of these assumptions are flawed. First, there are many ways in which the non-insured subsidise the social insurance schemes. Where states make a matching insurance contribution to that levied on the payroll, this must be financed through some form of general taxation. Also, employers may recover payroll contributions by raising the prices of their merchandise to the cost of the entire population. Large proportions of occupation groups included in social insurance succeed in evading their contributions but are still able to obtain benefits, either as a result of frequent contribution amnesties or due to administrators’ failure to identify evaders. Furthermore, Latin American governments have frequently resorted to bailing out social insurance funds which have run into financial problems. In the case of Mexico, the 1995 Social Security Law raised direct government funding of the main social insurance fund from 4 to 33 per cent of its total income. In Argentina, the government has over recent years provided substantial support to the ailing health insurance scheme for older people. Finally, social insurance programmes usually capture a number of substantial indirect subsidies from the public health sector, such as the training of doctors and the dumping of chronic or expensive conditions on public hospitals.

The segmented structure of health care delivery systems has led to very large disparities in per capita financing. For example, in 1994 Mexico's social insurance fund for oil workers spent more than 20 times the per capita rate of the ministry of health. In many cases, significant variation can also be found across the social insurance sector. Until recently, Argentina contained several hundred separate funds, each with monopolistic ties to occupation groups. In 1994 average revenue per beneficiary in these funds ranged from US$5 to US$80. In recognition of this, a mechanism had been set up to redistribute resources between the funds, but this was found to actually worsen the disparities.

These financing inequities translate into marked variations in the range and quality of services provided by different parts of the health care system. In many countries it is possible to observe a polarisation within the public sector, with a small number of world-class “flagship” facilities (usually located in major cities), and a rump of poor quality, under-resourced services. Relatively privileged groups are often able to make selective use of the high quality parts of the public sector, and in some cases are able to crowd out poorer groups (especially when hospitals are granted financial autonomy to recover costs from patients).

26 Lloyd-Sherlock (1997).
Problems of equity have been exacerbated by the rapid growth of private insurance plans in the region. The uncritical acceptance of such schemes, both on the part of policy-makers and the population at large, is a matter of concern. Often these funds are directly imported from the US and Chile, both of whose health systems are notoriously inequitable. The capacity of Latin American states to regulate this burgeoning, complex and highly profitable industry is highly questionable. In Argentina, there is no official entity responsible for regulating or even over-seeing the private health insurance sector. No reliable data exist for affiliation, types of health plan or the quality of care, and there is considerable anecdotal evidence of widespread abuses by some insurers. The cheapest health plans, at around US$ 60 a month, are beyond the means of most Argentines, while premia for groups such as elderly people start at around US$ 150.

The sectoral fragmentation of health care in most countries is also associated with a marked bias towards expensive curative provision rather than more cost-effective areas, such as prevention, promotion and basic services. Neither the social nor private insurance sectors are inclined to emphasise the latter. Even in the public sector, there is little evidence of any reorientation towards primary health care. A study of Mexico’s public sector estimated that 68 per cent of its resources were devoted to curative services between 1992 and 1994, and only 7 per cent went to prevention. Argentina has the highest ratio of doctors to per capita GDP in the world, yet easily preventable diseases such as chagas are still endemic in poor rural districts, and immunisation against conditions such as measles is well below that of neighbouring countries. Such an approach to health care is both inefficient and concentrates resources on more privileged groups, rather than distribute them equitably.

**HISTORICAL AND POLITICAL PERSPECTIVES**

The preceding sections have examined health inequities from a range of different perspectives, as far as the data allow. To understand some of the deeper causes of inequity, it is necessary to look at much wider historical and political processes of exclusion. Writing about social policy in the West, Lavalette and Pratt (1996) observe that “..social policies are intimately bound to the societies in which they develop and reflect the priorities of those systems”. The same can be said for health care in Latin America, a region which has historically been characterised much more by elitist political traditions than by pluralism and inclusion. In this context, it may be more enlightening to examine cases where health policies have taken on a more

29 Stocker et. al. (1999); EIU (1999).
30 Ahuad et. al. (1999).
31 Hernández et al. (1997).
33 Wynia (1990); O'Donnell et. al. (1986).
equitable and universal hue, rather than focus on the wider backdrop of exclusion. In this way, it may be possible to identify a number of circumstances in which profoundly inegalitarian social and political systems take an interest in the health of poorer and less powerful groups.

One such spur to solidarity may arise when a health problem is perceived as a public risk against which privileged groups are unable to insulate themselves. Fears of epidemics of infectious diseases, such as cholera and yellow fever, were a driving force behind many of the early public health measures in the region. Often, these responses had a strongly authoritarian and repressive tinge, which viewed the poor as vectors of both moral and epidemiological infection.\textsuperscript{34} The global HIV/AIDS pandemic could represent a contemporary health risk of a similar nature.\textsuperscript{35} However, rates of seroprevalence remain relatively low in Latin America (0.5% compared to over 5% in sub-Saharan Africa in mid 1996), and as yet HIV/AIDS has not come to be seen as a major health threat to privileged groups, saving some parts of Brazil. The region’s most significant contemporary infectious diseases, such as chagas, TB and dengue, are inherently unlikely to affect groups other than the poor. The low priority given these contrasts with the massive response to what were relatively small cholera outbreaks in the early 1990s (fresh fruit and \textit{ceviche} are not only eaten by the poor). Rather than infectious disease, the main public health risk to richer groups is that of crime and violence. Along with road accidents, injury and death through crime and violence accounted for 40% of Colombia’s total burden of disease in 1994.\textsuperscript{36} Even so, most studies of violence in the region show that poorer people are more likely to be affected.\textsuperscript{37}

During the second third of the 20\textsuperscript{th} century, the development of health services in Latin America was driven by a rapid growth of social insurance. This was associated with the “selective populism” pursued by what were still essentially elitist systems, as part of a limited exercise of political legitimation and alliance building. A key element of this strategy was the extension of social protection to parts of the formal sector workforce. This occurred in a highly selective and stratified fashion, reflecting the complexity of power structures and alliance building.\textsuperscript{38} The creation of national insurance funds dove-tailed with the human capital concerns of large employers who were keen that the burden of provision should not fall directly on themselves.\textsuperscript{39} They were also supported by local and international pharmaceutical and medical equipment industries, which predicted the process would create the basis for a burgeoning and highly lucrative market. Moreover, in most countries the extension of health insurance was relatively costless for the state, since services were mainly funded by pension fund

\textsuperscript{34} Prieto (1996).
\textsuperscript{35} Izazola Licea (1997).
\textsuperscript{36} Yepes (2000).
\textsuperscript{37} Golbert and Kessler (2000).
\textsuperscript{38} Mesa-Lago (1978).
\textsuperscript{39} Lewis (1993).
surpluses. This was a major contributory factor in the pension fund crises of the 1980s and 1990s.

Studies of social insurance in some developing countries outside the region claim that its gradual extension can be understood as a prelude to the creation of a more universal system.⁴⁰ There are few signs that this was the case in Latin America. Even in populist regimes where elite interests appeared, albeit temporarily, to be in abeyance, few efforts were made to include rural labour in the spoils being offered to other groups. For example, in Peronist Argentina strikes by sugar workers demanding greater social protection were violently put down. More was done for the rural sectors in Mexico under Cárdenas, but this proved to be short-lived, and provision lagged well behind provision for more powerful urban constituencies. In more recent years, few would dare to hope that these countries are still on the road to universal health insurance.

The use of health services as a tool of political legitimation had much to do with the segmentation of the region's health care systems, the pre-eminence of social insurance and the urban bias of provision. It also led to widespread problems of clientelism, political patronage and sometimes extreme corruption within individual parts of the health system. This has been particularly evident in the better-resourced social insurance sectors, parts of which are still struggling to overcome this unfortunate legacy. Argentina's health fund for pensioners, which manages an annual budget of over US$2 billion, has become notorious as a vehicle for political patronage and financial abuses on a grand scale. At the same time, its capacity to service affiliates has been steadily eroded.⁴¹

The above casts some light on the relationships between the development of health provision and wider political processes in Latin America. From this, it is clear that the commitment of states to extending effective health care has been highly conditional on a range of other factors, and should not simply be taken for granted. Current reformers should ask themselves whether these relationships have changed significantly in recent years, and whether regardless of the rhetoric, states are any more committed to goals of equitable health than in the past.

RECENT REFORMS

Many Latin American countries have recently embarked on what are claimed to be sweeping reforms of the health sector. In some respects, this current wave of reforms should not be seen as a radical departure from the past. Most countries have a long history of (usually failed) attempts at fundamental health care reform. However, there are some important

⁴¹ Bonvecchi et. al. (1998); Lloyd-Sherlock (1997).
differences with previous experiences. First, there has been a shift away from primary health care and universalism towards policies that are more consonant with neo-liberal agendas. This has involved radical changes in the role and responsibilities of the state. Second, multi-lateral lending agencies and finance ministries now play a much larger role in designing health reforms. As a result, the old reform language has been replaced by a three-way policy mantra of efficiency, equity and quality. All of these currents have contributed to the emergence of a recognisable health sector reform package, which includes redefining public and private spheres of action, as well as promoting new management strategies and decentralisation. This package has been put forward as a coherent set of evidence-based, technical, and politically neutral solutions to the region's many health care problems. However, the actual experiences of different countries in implementing the reforms, and their impacts suggest that the reality is rather different.

Attempts to decentralise health services in Latin America illustrate the potential dangers of poorly conceived reforms. In theory, decentralisation should promote accountability, participation and responsiveness to local needs, and thus reduce exclusion. However, the few published empirical appraisals show that it more often serves to foster inequality. Gonzalez-Block et al (1989) found that decentralising health care administration had significantly reduced service provision and utilisation for the poor in Mexico's two poorest states and increased it for the wealthy (who dominated local decision-making). Reducing central government financial responsibility for health services in Argentina has led to large disparities in per capita spend between different provinces. Conversely, the author was unable to find any case where decentralisation was proven to have promoted equity (however equity might be understood and measured).

Cost recovery schemes are another key weapon in the arsenal of health sector reform. These usually take the form of requiring patients to pay an out-of-pocket fee at the point of service. Theoretically, cost recovery may increase overall funding, and exemptions for poor and vulnerable groups reduce the risk of exclusion. A study of user fees in public hospitals in Buenos Aires found that these operated through essentially informal arrangements, and that state regulation was almost entirely absent. Hospitals were given complete freedom to interpret the policy, and no systems were in place to protect the rights of vulnerable social groups. As with decentralisation, this points to the dangers of implementing complex reforms in a context of weak state institutions and flawed governance.

42 Ugalde et. al. (2000).
43 Mills et al. (1987).
44 Lloyd-Sherlock (2000b).
In some countries, reforms have sought to radically restructure the entire health care system, replacing its traditional segmentation with a new configuration. This includes reducing the divisions between social insurance and private insurance, whilst reasserting the role of public provision as a safety net of last resort. In Argentina the virtual merger between social insurance and private funds has meant that the previous stratification based on occupation group has been replaced by one based purely on income. Mexico’s reforms have permitted private health funds to operate within a pluralistic social insurance sector, leading to a large scale influx of US-based organisations targeting “niche” population groups.47 Across the region, the proliferation and high-profile marketing of personal health plans is changing the popular perception of health care from a public good to an item of private consumption.

Rather than upgrade the role of the publicly financed health sector, reforms have sought to reduce it to a decentralised, residual safety net. As such, it is likely that the gap in health care for groups with insurance and the rest of the population will widen. Moreover in many countries, rising poverty, unemployment and informal working will increase the size of the population lacking social insurance. There is an urgent necessity to invest substantial amounts in public health facilities which have been eroded over the past two decades. At the same time, reforms should seek to counter the strong bias towards curative services, strengthening areas such as primary health care, prevention and health education. The role of the state as regulator of the health system as a whole remains highly questionable in most countries. As well as the new challenges created by the growth of private financing and provision, this includes issues such as environmental health and monitoring the responsibilities of employers in increasingly deregulated economies. Whilst advocates of reform pay much lip-service to state regulation, decentralisation and privatisation have tended to undermine what was already a weak capacity.

As with all aspects of social policy, the current wave of health reforms should be understood as part of much wider processes of social, economic and transformation in Latin America. Deepening inequality and social exclusion do not give grounds for optimism that significant progress can be made towards equitable and socially inclusive health. There are inevitably lags between the shift towards neo-liberal development models and their health impacts. However, it is likely that the effects of recent economic and social policy will become increasingly evident in the health status of poor and excluded groups. The prognosis for Latin America in the early 21st century is not good.

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