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Índice

Presentación 9

Introducción
Visiones comparativas de las transformaciones sociales
y los sistemas de salud en América Latina 11
William F. Waters

SECCIÓN 1
SISTEMAS Y SERVICIOS DE SALUD EN
ECUADOR Y AMÉRICA LATINA

Buen gobierno en salud: un desafío de todos 27
Nilhda Villacrés

Los modelos de atención de salud en el Ecuador 49
Fernando Ortega Pérez

Los servicios públicos de atención de salud del DMQ:
cantidad, calidad y costos 65
Ruth Lucio

Los contenidos de la agenda local de salud:
heterogeneidades y problemas transversales en municipios
del Conurbano Bonaerense, Buenos Aires, Argentina 85
María Mercedes Di Virgilio y María Canel

Un acercamiento al pluralismo médico en los Andes 101
Jos Demon

Sección 2
Políticas de salud y prestación de servicios
en el ámbito nacional e internacional

Desde el diseño a la implementación de políticas públicas: el caso de la reforma de salud en Chile 123
Óscar Arteaga

A politica de saúde e o Programa Saúde da Família no debate da seguridade social no Brasil: o olhar do serviço social 145
Laurita Wiese

Educación ciudadana y políticas públicas en salud 163
Juan Camilo Salas Cardona

Ecuador offers an alternative option to international aid and health policies 177
Jean-Pierre Unger, Nancy Vásconez y Pierre De Paepe

Salud familiar integral y Asamblea Constituyente 189
Edgar Rodas Andrade

Sección 3:
Prácticas en las profesiones de salud

Formas simbólicas y tránsitos identitarios: una aproximación teórico-metodológica a las percepciones, usos y apropiación de la noche entre los enfermeros y enfermeras nocturnos 207
Andrés López Ojeda

De la identidad institucional a la figura de estatus en la profesión de enfermería: un estudio de caso con enfermeras del sector público en la Ciudad de México 227
Hedalid Tolentino Arellano

Medicalización e industria del nacimiento 249
Raúl Mideros Morales

Ecuador offers an alternative option to international aid and health policies

Jean-Pierre Unger*
Nancy Vásconez**
Pierre De Paepe***

Introduction

We review here the evidence base for the health care / disease control policy promoted by international agencies in developing countries. As an alternative, we underline some of the President Correa Government's health policy features.

Worldwide, up to 50% of people are barred from access to care and essential drugs. Despite an unprecedented increase in external financing, disease control, the paradigm of international aid, is in total disarray in low and middle-income countries. AIDS kills more than 8000 people every day (of which more than 6000 in sub-Saharan Africa) and malaria, up to 3 million every year (1 million twenty years ago). However, in 2004, 21% of all health aid was allocated to HIV (8% in 2000). Total funding for HIV/AIDS programs in low and middle-income countries reached 8.3 billion US$ during 2005. Realizing the extent of the waste, the Financial Times requested that less money be spent on AIDS – instead of proposing to correct the causes of program's inefficiency (The Financial Times, 2006).

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One may ask if international aid policy, as defined for the health sector of low-income countries (LIC) and middle-income countries (MIC), shares a responsibility for such failure.

International agencies do have a doctrine on aid and international aid policies: whenever possible, these policies allocate disease control to the public and curative health care to the private sector (De Paepe, Soors, Unger, 2007: S273-S281).

Such policies are neoliberal in their promotion of commoditization and privatization. Since a few years, World Health Organisation (WHO) is also promoting private sector providers involvement in Tuberculosis (TB) control, a component of the new Stop TB Strategy and the Global Plan to stop TB (The Stop TB Partnership, 2006: 36).

Impact of orthodox international health policies on health care quality and accessibility

In this section, we outline the responsibility of neoliberal health policy for the failure to control diseases in developing countries using a three-strand hypothesis.

Integration: a key to success for disease control

Disease control activities implemented by specialized organizational structures, sometimes bringing together several disease control programs (such as maternal and child health) are dubbed vertical programs. In specific cases vertical programs can be justified on technical grounds. Nevertheless, the number of diseases requiring clinical interventions makes it impossible to consider vertical programs as the gold standard template for disease control organization, even where these programs would be, allegedly, closely co-coordinated amongst themselves. In Congo, for instance, there are 52 such programs, and in Central African Republic, more than 20. No one single private company would ever dare to adopt an organigram whereby a worker or a professional would have to respond

to 52 or 20 different managers. This is however the situation of these developing countries' public services obliged to limit the activities of their public services to disease control – at the exclusion of curative care, the only activity truly responding to the demand of peoples and communities.

However, many authors stressed the need to integrate programs into local health facilities in order to achieve a reasonable prospect for successful disease control. They also point to the merit of integrating curative and preventive care. Examples include the potential for detecting a patient with tuberculosis amongst those with cough, or suggesting vaccination to a patient or to a population with whom the practitioner has established trust. Such a scenario couldn't succeed when patients are sent to private practitioners while TB patients are expected to be detected and followed by the public ones.

Public rather than private disease control: understandable caution

In theory, both the public and the private sector can carry out disease control activities, but historically the public sector has taken this responsibility. Despite the widespread promotion of public-private partnerships, international aid agencies have been cautious about contracting out disease control to the private sector.

Instead, such agencies have promoted continued involvement of government facilities in disease control under the general label of 'prioritization' of their interventions. Their caution is understandable. The results of contracting out disease control to the private for-profit sector are not promising, except for tuberculosis control under specific conditions in some Asian settings. Furthermore, private providers may not oppose the provision of disease control by the public sector, as they often work part-time in public services providing the opportunity to refer the selected patients to their own private consultation.

Public disease control & private health care: a catch-22

While disease control remains public, aid agencies have been encouraging a market approach to health care delivery in LIC for over a decade. The transfer of 'public' care to the private for-profit sector is a core message of their policy on the grounds of the supposed higher efficiency of the for-profit sector and the poor responsiveness of the public one. Once predominantly providers, governments now have new roles as 'stewards', steering care by regulation and supervision. In theory, such privatized care could be funded publicly. Figure 1 indicates these roles of the public and private sectors as promoted by neoliberal health policy.

Figure 1
International aid-promoted health policy

	Ministry of Health (MoH) facilities	Private facilities
Health care		✓
Disease control	✓	

This doctrine was introduced in LIC and MIC where the market was seen as attractive, such as in parts of Asia and Latin America. It was seen as less relevant in contexts where the market could not be developed easily, as in many parts of Africa. It was also not promoted in countries where geo-strategic considerations dictated an aid policy with clear social goals, as is the case in Jordan, the Southern Philippines and those central Asian republics close to Afghanistan.

One outcome of this policy was a disease control focus to MoHs, with less support for health care delivery. The continued concentration on vertical disease control efforts by the international aid community is reflected in the efforts to set up and channel significant aid through the Global Fund to Fight AIDS, Tuberculosis and Malaria and which has been criticized strongly for ignoring the needs of, or even weakening, the wider health system.

This aid and health policy precluded effective integration in the field and led to a true catch-22; the pool of patients was cut off from disease

control interventions and ended up achieving substandard detection and follow-up rates. This point has been mathematically demonstrated in a recent paper (Unger, d'Alessandro, De Paepe, Green: 2006: 314-322). In order to assess the potential for integrating malaria control interventions in underused health services, a Piot predictive model was used to estimate malaria cure rates. Parameters from the best performing African malaria programmes influencing treatment at home and in health facilities were applied to a rural district in Mali, where access to care was very limited. It was demonstrated that, with a low utilization rate, adequate control combining home treatment and professional treatment was impossible, even applying the best parameters from other countries. On the contrary, cure rates with a higher utilization rate were 62% better. Thus, if malaria patients are to be treated and followed up early, basic health services need to deliver integrated care and be attended by an adequate pool of users. Another example of failing disease control is Colombia, where TB case finding decreased after neoliberal reform.

Furthermore, disease control programs strained first line public health care delivery. This occurred through pressure exerted by disease control managers, by multiplication of disease-specific divisions in (inter)national administrations, by ill-defined priority-setting and increasing opportunity cost, unrealistic costing, inadequate budgets, and financial overruns, failure to make clear the lines of command; tension between health care professionals over income disparity, treatment discrepancies and opportunity costs and problems with sustainability. Management by objective, the philosophical cornerstone of such programmes transformed health organizations into what Mintzberg classifies as mechanistic bureaucracies.

Impact of orthodox international health policies on health care quality and accessibility

International health policies recommend marketing of curative care together with prioritization of disease control within the public sector (De Paepe, Soors, Unger, 2007: S273-S281).General Agreement on Trade in Services (GATS) article 1.3.c. makes this recommendation compulsory: "a

service supplied in the exercise of governmental authority means any service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers". Subsidies to publicly oriented services owned by ministries of health, city councils, and non-governmental organizations could be barred on the ground of GATS article 1.3.c. Politicians who endorse it carry thus a heavy moral responsibility.

To assess the impact of these international health policies on access to decent quality health care, we refer to an analysis of health policies of three countries showing how health care privatization failed in Colombia and Chile, and what an alternative health policy can achieve in Costa Rica (Unger, De Paepe, Buitrón, Soors: 2007) and Chile. We conclude that together with other factors, such as Structural Adjustment Programs and World Trade Organisation –WTO- GATS negotiations (Unger, Marchal, Green: 2003: S79-S88) orthodox policies are responsible for poor access to care.

The reform of the health sector in Colombia in 1993 was founded on the internationally advocated paradigm of privatisation of health care delivery. Taking into account the lack of empirical evidence for the applicability of this concept in developing countries and documented experience of failures in other countries, Colombia tried to overcome these problems by a theoretically sound, although complicated, model.

Some 14 years after the implementation of "Ley 100" revision of the literature shows that the proposed goals of universal affiliation and equitable access to good quality care have not been reached. Despite an explosion of costs and a considerable increase in public and private health expenditure, more than 40% of the population is still not covered by a health insurance securing access to a decent health care package, and access to health care itself proves more and more difficult.

What does 'affiliation to a health insurance plan' really mean? Basically nothing more than people holding an insurance card. Indeed, several obstacles keep cardholders from accessing health care services, e.g.

- Some insurance companies declared persons or families, especially the poor, to be registered for their scheme without issuing an insurance card, thus collecting premiums without providing service.

- The poor were frequently unaware of their rights. They did not know how to use their insurance card and continued to pay for the services they received.

- Sometimes, they simply didn't use the services because of a lack of psychological, intra-institutional, financial (see below) or geographical accessibility.

Two data will enlighten the problem. Between 1997 and 2003, the insurance coverage rate grew from 54% to 62% but at the same time, the consultation rate dropped from 23.8% to 9.5% in outpatient (Acosta, Ramírez, Carrión, 2004: 25). Furthermore, each year, 6.26% of the population suffer catastrophic health expenditure. This is 52 times more than Costa Rica (Xu, Evans, Kawabata, Zeramdini, Klavus, Murray, 2003:111-117).

Precisely, Costa Rica is a middle-income country with strong governmental emphasis on human development. For more than half a century, its health policies applied the principles of equity and solidarity to strengthen access to care through public services and universal social health insurance. It is featured with a unified public system allowing integration; publicly oriented services as dominant, though non monopoly, delivery institutions of care; a system of contracting in but there is no real purchaser-provider split, nor hospital managerial autonomy; 'users and communities' participation in health services management (in contradiction to what the private-for-profit sector permits); Government expenditure represent the bulk of total expenditure; finally, there is a single, public insurer (no private insurance).

In 2002, its health expenditure per capita was 5.9% of its Gross Domestic Product (GDP) per capita (Purchasing Power Parity (PPP) US$), while the USA health expenditure was 14.2% and while its GDP per capita was 27.6% of the USA GDP. However, its life expectancy was 78 years against 77 in the USA, second only in the Americas after Canada – and this outcome as well as others can be linked to the performance of the health care system.

Finally, Chile's health system is characterized by a private insurance market (compulsory contribution to health care of those who voluntarily aban-

doned the public health care sector.); the purchaser provider split in the public health system, the Fondo nacional de salud (FONASA, National Health Fund) to collect and distribute payroll taxes; a national health system (e.g. 28 autonomous Health Services) decentralised during Pinochet regime which managed to survive and municipalisation of Public Health Care (PHC). The democracy did not bring pivotal change in dictatorship's policy design although it improved control (superintendencia) on and reduced support to Institución de Salud Previsional (ISAPREs, private insurance companies); improved public financing of health sector; developed family medicine in public first line services and set 56 priority diseases (Plan Auge) mainly in hospital settings. Although first line health services' utilization rates are good, accessibility to specialties may be deficient in public services (waiting lists up to 4 years for some specialists, e.g. ophthalmologists). The ISAPREs administrative costs are four times those of FONASA and they consume 43% of total health expenditure with only 16% of the population insured. In 2003, with demographical and epidemiological indicators close to those of Costa Rica, the health expenditure per capita was exceeding those of Costa Rica by 16%.

As a conclusion, one may wonder why privatisation and related techniques are so high on the agenda of international policies while in North and Latin America the most efficient health systems evade the recommendations of the Bretton Wood agencies.

The new Ecuadorian integrated health policy

The backbone of the proposed policy, which remains to be implemented and evaluated in the country, is a publicly-oriented health sector. Figure 2 visualizes it, as an alternative to the dominant neoliberal.

Figure 2
The new Ecuador health policy

New Ecuador health policy	Publicly oriented facilities	Private facilities
Health care	✓	✓
Disease control	✓	

Publicly-oriented, as opposed to private-for-profit, health care organizations are facilities and systems whose raison d'être is response to the health demand and needs of the population. Publicly-oriented services aim to balance the concerns of the patient, the community, the state and professionals in care delivery and management. In contrast, private-for-profit services focus primarily on financial profitability and treat corporate and health professionals' income as an end in itself. This classification enables the formulation of quality standards for publicly-oriented health care delivery (Unger, Marchal, Green, 2003:S79-S88), which can inform teaching, research, partner identification, contracting, management, evaluation and health policy design. In the future, providers from non-governmental including denominational organizations as well as from community-owned or other social security facilities would belong to this publicly-oriented health sector alongside government facilities belonging to the MoH and city councils. Their social mission and management would be to balance the interests of individuals and society. Such a broadened publicly-oriented sector will allow wide geographical coverage, integration of disease control in services in a manner that attracts patients together with equitable access to quality health care. Management contracts can be designed to secure a co-management of publicly oriented facilities. It involves the participation of key stakeholders including the community in all publicly-oriented facilities and the delivery of health care responding to specific quality criteria to a defined population. Such contracts could help to distinguish those with a social mission from those with a commercial one. At operational level, mid level managers from different publicly oriented institutions could work together in the context of inter-institutional district executive teams. This would help overcome the deep fragmentation of public services inherited

from the neoliberal era – while taking into account its field consequences.

To implement such plan, there is a need to finance offer rather than demand. Not only MoH facilities - but all socially motivated (non for profit, non commercial) health facilities will need the public financing and technical support.

To improve curative health care accessibility, acceptability and effectiveness in not-for-profit (not commercial, socially motivated, publicly-oriented) services, Ecuador has now initiated a series of horizontal programs. They can at the same time contribute to control diseases since those clinical services in charge of disease control need patients for early detection and continuous care. Some of the proposed strategies were tested internationally, others in Ecuador. They are to be understood as action hypotheses to be adapted locally. These programs are:

- The access to care program. Province and district supervisors will be trained to use a frame designed to measure the accessibility to each particular dispensary and hospital, understand their specific mix of obstacles to access and improve it with tailor-made strategies. Obstacles to be detected and assessed are: lack of drugs, high out-of-pocket costs, recurrent absence of doctors, lack of technical credibility, long travel distance and lengthy queuing for patients. Tailor-made strategies will combine relevant tools found in toolboxes defined in advance and progressively enriched with relevant experiences.

- An in-service initiative to disseminate patient centred care in first line health services.

- Another to promote holistic nursing in hospitals.

- A modernization of the Bamako Initiative, conceived as a way to endow public services with essential generic drugs managed by the community, revolving funds, and payment per sickness episode.

- An initiative to develop local health systems around hospitals (micro-redes).

- A program to improve clinical skills in publicly oriented health centres and hospitals.

- Improved conditions for health professionals working in the sector.

- Administrative integration of disease control programs at district level.

Conclusion

Late WHO Director Lee advocated strengthening health systems while controlling diseases in developing countries (Jong-Wook, 2003: 2083-2088). However, directors of disease control programs across the world could easily claim that this is precisely what they have been doing during the last 15 years. Training MoH staff in seminars mobilizing them up to 50% of their time (and paying them to stop working instead of paying them to work)? An investment to strengthen health systems. Providing cars for parallel mobile teams? Another such investment. Multiplying authority lines? A way to strengthen systems. Focusing skilled labour on the control of 3 diseases, kindly requesting doctors to forget their medical knowledge and training? A way to make them more effective. In short, the concept of “systems strengthening” is so vague that virtually any initiative can fall in this category.

The new Ecuadorian Government initiative to promote health care accessibility and the development of a wide non for profit health sector paves the way for a new aid and international health policy.

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