Socialist government health policy reforms in Bolivia and Ecuador: The underrated potential of comprehensive primary health care to tackle the social determinants of health

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Abstract

Background: Selective vertical programs have prevailed over comprehensive primary health care in Latin America. In Bolivia and Ecuador, socialist governments intend to redirect health policy. We outline key features of both countries' health systems after reform, explore their efforts to rebuild primary health care, identify and explain policy gaps, and offer considerations for improvement.

Methods: Qualitative document analysis.

Findings: Neoliberal reforms left Bolivia's and Ecuador's population in bad health, with limited access to a fragmented health system. Today, both countries focus their policy on household and community-based promotion and prevention. The negative effects on access to care of decentralization, dual employment, vertical programming, and targeting have been not received much attention. The neglect of health care services can be understood in the light of a particular, rigid interpretation of social medicine and social determinants, international policy pressures, reliance on external funding, and institutional inertia. Current policy choices preserve key elements of selective care and consolidate commodification. These reforms might not improve health and may worsen poverty.

Conclusions: Health care can be considered as a social determinant in its own right. Primary care needs to be founded on an integrated model of family medicine, taking advantage of individual care as one of the ways to act on social determinants. It deserves a central place on the policy-makers' priority list in Bolivia and Ecuador as elsewhere.

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Introduction

Primary health care has been the subject of debate ever since its proclamation in 1978. The multifaceted description of primary care in the Alma-Ata declaration[1] is a prime example of an elaborate but ambiguous compromise: as hard to repudiate as to agree on its implementation. While the appealing catchphrase "Health for All" received widespread rhetorical approval, the declaration's pertinent call for socio-economic change was largely ignored. Especially unfavorable to what has since been called "Comprehensive Primary Health Care" was the development of "Selective Primary Health Care," a concept launched in 1979 by Walsh and Warren with the support of the Rockefeller Foundation and then World Bank president Robert McNamara.[2] In an influential publication, Walsh and Warren hailed the Alma-Ata goal as "above

reproach" yet "unattainable", deemed Comprehensive Primary Health Care as "unlikely in the near future", and put forward Selective Primary Health Care as an "interim strategy" on the grounds of cost-effectiveness.[3] Based on a questionable reading[4] of the Alma-Ata declaration and incorrect[4;5] in addition to inappropriate[6] use of cost-effectiveness, Selective Primary Health Care perfectly fitted vested interests and was eagerly adopted by major donor agencies.[5] It turned out to be far from a temporary stopgap. Preceding the Washington consensus[7] by a decade, Selective Primary Health Care was adopted and reinforced as one more targeting strategy in the blueprint of 1990s' neoliberal health reform for low- and middle-income countries all over the world. Today, the mutual and devastating effects of Selective Primary Health Care, targeting, privatization, and deregulation on health, equity, and development are obvious.[8-10]

In Latin America, the neoliberal health reforms of Chile and Colombia became templates for the 80s and the 90s respectively. Their effects were no less detrimental than in other parts of the world.[11-13] Only Nicaragua (in the 1980s), Costa Rica and Cuba (up to now) resisted neoliberalism and successfully applied the Comprehensive Primary Health Care model, translating a political commitment into a strategy to provide universal health services.[14] In 1990 following the re-establishment of democracy, Chile started reversing its neoliberal reform.[15] In 1994 Brazil introduced its Family Health Program (FHP, *Programa Saúde da Família*), which is increasingly becoming a delivery model of comprehensive primary health care embedded in a wider social policy.[16] In the first decade of the 21st century Latin American countries have continued to distance themselves from neoliberal models and are playing an active role in the revival of primary health care.[17]

Modern history suggests that political commitment is key to implementation of Comprehensive Primary Health Care. With this perspective in mind, we examine recent efforts to rebuild Primary Health Care in two less prominent Latin American countries: Bolivia and Ecuador. Until recently, both countries had health systems marked by 15 years of neoliberal reform. However, newly elected socialist governments in both Bolivia and Ecuador have begun to redirect national health policy. We explore their ongoing efforts to rebuild primary health care and try to identify and explain observed policy gaps, with a special focus on the integration of the different aspects of care and the embedding of health in wider social policy. We conclude by offering considerations for improvement.

Health conditions in Bolivia and Ecuador before 2005

Within the Latin American spectrum of development and health, Bolivia and Ecuador are clearly on the lower end. With a per capita income of $ 2,590 in 2004, Bolivia is the poorest Latin American country. Ecuador ranks somewhat better ($ 3,690); nonetheless, this is still less than half of the region's average.[18] In 2004, life expectancy at birth was 65 years in Bolivia (underperformed only by Belize) and 72 years in Ecuador[19]; the probability of dying under age of five was 69 and 26 per 1,000 respectively.[19] Maternal mortality follows a similar pattern with 420 (Bolivia) and 130 (Ecuador) deaths per 100,000 live births by latest estimates,[18] despite targeted initiatives (*Seguro Nacional de Maternidad y Niñez* - SNMN in Bolivia since 1996, *Maternidad Gratuita y Atención a la Infancia* in Ecuador since 1994). These data are not only alarming; they point to a persistent, and inequitable problems with access to health care. In Bolivia, the proportion of the general population able to make use of health services in case of illness dropped from 50 to 45% between 1999 and 2002.[20] Population coverage of social health insurance dropped from 21 to 16% over the same period, and access was concentrated among the better off.[20] In Ecuador, these indicators of utilization and insurance were 75% and 23% in 2002.[21] Out-of-pocket payment as a percentage of private expenditure on health was as high as 79% in Bolivia and 88% in Ecuador by 2003, with private expenditure respectively amounting to 36% and 61% of total expenditure on health.[19] In 1999, 5% of all Bolivian households incurred catastrophic health expenditures; against 4% in 2002.[20] This decrease is no reason for celebration, as it correlates with reduced health services utilization during neoliberal

reform. No comparable catastrophic health expenditure analysis is available for Ecuador.

When Evo Morales in Bolivia (January 2006) and Rafael Correa in Ecuador (January 2007) assumed the presidency of their respective countries, each faced a largely poor population in bad health with limited access to a fragmented and segmented health system of questionable quality. Both promised a change.

Health policy of the New Socialist Governments

Bolivia

At the 2007 Ibero-American Summit, Spain's president José Luis Rodriguez Zapatero asked his Bolivian counterpart how he could help improve health in Bolivia. Morales' laconic reply "I need ambulances"[22] reflected his country's urgent need to improve access to health services. It might also have expressed his uncertainty about how to move forward.

In 2006, the Bolivian Ministry of Health presented a framework for redesigning health policy.[23] A close look at the document reveals a strong political will and appealing novelties. The authors make the state guarantor of the people's right to health. New is the recognition of cultural preferences and a participatory approach in health services management But there are also evident contradictions. For example, while improved access is discarded as key determinant of health, it is still regarded as an objective.

The Ministry of Health's new operational model for primary health care is called SAFCI (*Salud Familiar Comunitaria Intercultural,* Intercultural, Community and Family Health).[24] The model places great emphasis on health promotion in the community; this is seen as a key task for health personnel. At the same time it considers access to institutional care at any level as an unfulfilled need that should be addressed through a broad series of measures, including: the increased integration of traditional medicine, the inclusion of social workers in health teams, controls on health services by community organizations, and improved co-ordination of the three-tiered health system. In parallel, extension of the population coverage of mother-and-child insurance (formerly SNMN, then SUMI – *Seguro Único Materno Infantil*, Unified Maternal and Infant Insurance, now renamed *SuSalud – Seguro Único de Salud,* Unified Health Insurance) to the 5-21 age group is envisaged and a conditional cash-transfer strategy has been implemented to attract users.

The Political Constitution approved in 2008 (Estado Plurinacional de Bolivia, Constitución Pólitica del Estado) states: "All people have the right to health and the State guarantees (this right). The Unified Health System will be universal, free, equitable, intracultural, intercultural, and participatory, with quality, warmth and social control." Regulations and legislative actions to implement this right have yet to be taken.

Ecuador

Understandably, two years after the change of government the situation in Ecuador is less developed. In March 2007, president Correa declared what became a 10-month state of emergency for health and approved an additional $255 million dollar funding to improve the infrastructure and equipment of 1,861 health centers and 127 state-owned hospitals as well as to hire 4,500 extra staff. To overcome at least partly the pre-existing segmentation in the public sector, President. Correa has insisted on integrating the service delivery networks of the Ministry of Health and the Social Security system.[25]

A recent document by SENPLADES, the new and powerful planning authority, proposes a radical transformation of the health sector. According the plan, the health services of the Ministry of Health and of Social Security will be integrated over the course of six years and health care financing will be entirely tax-based. It is a well-written technical document, but it has yet to be enacted. It remains to be seen whether the Government will be able to resist the powerful Social Security lobby[26] and whether or not the Ministry of Health has the capacity to lead this transformation.

A redesigned health policy has yet to be formally unveiled, but alongside these interesting proposals for change there is also strong indication of a very different model, closer to the Bolivian one. As

leading health officials put it, the new "integrated" health care model should depart from the previous biomedical ones and concentrate on health, human development, and quality of life. Health promotion and prevention activities would be in the forefront, while curative (discretionary) care would be a second-line priority.

Problems with Policy Implementation & Lost Opportunities

Both Bolivia and Ecuador face considerable difficulties in putting their intended policies into practice. In Bolivia, the anticipated doubling of the Ministry of Health budget in 2007 could not be carried out, as the law allocating a portion of hydrocarbon profits to *SuSalud* was rejected. In Ecuador, the goal of integrating public services faces strong opposition from the Social Security institution and the private health providers subcontracted by it.

Assessing the impact of these "new" policies at this time would be an inappropriate and unfair exercise. However, identifying policy gaps based on recognized weaknesses and problems is a timely task. We will analyze these policy gaps for Bolivia and Ecuador together, as the inventory of lost opportunities shows striking similarities.

Decentralization: Decentralization has been repeatedly advocated as a system to improve governance through co-responsibility between central, regional, and local institutions.[27] It has been a key feature of health sector reform in Latin America. Long criticized by opponents of neoliberal reform,[25] its practical disadvantages are increasingly recognized by critics and promoters alike. A recent World Bank analysis points to decentralization – as applied in Bolivia – as a setback for service provision and financing.[28] Far from reversing the process, Bolivia – facing a difficult political context with strong centrifugal forces – currently plans to extend decentralization in its *SuSalud* program. In Ecuador, a law on decentralization has only partially been implemented until present.

Dual Employment: Dual public/private employment among doctors is a widespread practice in Latin America, limiting access to public health services, and favoring the private ones. Doctors in public services work 6 hours a day in Bolivia and 4 hours a day in Ecuador. The rest of the day is typically spent in private practice. With the exception of newly contracted staff in Ecuador, little effort is planned to eliminate the part-time employment of public health care employees in these two countries.

Vertical Programs: In Bolivia and Ecuador, as elsewhere, disease and problem-focused programs are well-known to be poor performers unless they are supported by comprehensive and responsive health services. Moreover, vertical programs typically have a detrimental impact on access to care.[29] Yet neither of these countries plans to administratively embed existing vertical programs into their horizontal services. In the case of Bolivia, malnutrition control remains as a stand-alone program (still funded at only 57% of the projected $82 million) and is not integrated into the system. Combating domestic violence is yet another vertical program. First line service teams in the two countries are required to regularly visit homes and communities to deal with the social determinants of health yet without consideration of whether or not these are integrated with clinical interventions and processes where needed.

Universal versus targeted programs: Targeting social services to vulnerable groups is more often than not inferior to universalism. Service targeting rarely achieves its assumed cost-effectiveness because of leakage and under-coverage, defined as inclusion and exclusion errors respectively.[30] The uptake of services under the Bolivian SUMI scheme illustrates both problems. A World Bank analysis identifies how leakage and under-coverage have resulted in a program which preferentially benefits the better off.[31] As far as financial protection is concerned, a WHO analysis of *SUMI's* predecessors documents higher incidences of catastrophic health expenditure and impoverishment among the poor than among the non-poor, with a limited protective effect in some of the targeted age groups.[20] However, Bolivia has not abandoned the principle of a targeted health insurance program which grants a fraction of the population access to a limited package. Bolivia now extends the coverage of *SuSalud* to adolescents, while the elderly, the most

vulnerable sector of the population,[20] would remain unattended. Ecuador, on the other hand, plans to phase out its selective insurance program (ironically called universal health insurance, *Aseguramiento Universal en Salud*) replacing it with free services as the Ministry of Health budget increases.

Surprisingly or not, these unaddressed issues – the adverse effects of decentralization, dual employment, vertical programs, and targeting – can all have a negative impact on health care, particularly on access to care. Two questions could then be raised. First, what made Bolivian and Ecuadorean policy-makers fail to appreciate the importance and potential of comprehensive primary health care? Second, what are the likely consequences of such neglect?

Exploring the whys…

A variety of external and internal factors can be identified to explain the current neglect of health care by policy-makers in Bolivia and Ecuador: 1) a particularly narrow interpretation of social medicine and social determinants, reinforced by global health policy; 2) reliance on external financing; and 3) institutional inertia.

Latin American Social Medicine has a long and strong tradition. More than two centuries ago, Eugenio Espejo recognized social causes of disease outbreaks in Ecuador years before Rudolf Virchow did so in Germany.[32] In 1939, Salvador Allende – Minister of Health in Chile at that time – refined and broadened the concept to include the social conditions of ill health and underdevelopment. In the 1970s, the Argentinean physician and sociologist Juan César García strengthened the school of social medicine from within the Pan American Health Organization and used PAHO as a window to the world for social medicine itself. Advocating change in the socio-political determinants of health, Latin American Social Medicine certainly helped introduce a political dimension in Comprehensive Primary Health Care at Alma-Ata. In Latin America, social medicine found an organizational expression in the Latin American Social Medicine Association (ALAMES, Asociación Latinoamericana de Medicina Social),[33] founded in 1984. The influence of social medicine can explain the developmental and community-based approach of Bolivian and Ecuadorean policy today. But social medicine cannot be held responsible for the neglect of access to care. On the contrary, history shows that action on social determinants of health and on access to care can go hand in hand. In 1950, social medicine exponent Salvador Allende introduced the first national health service in the Americas and thus guaranteed universal access to care.[32] Today, ALAMES still includes the development of universal and free primary care in its political agenda.[33] Similarly, the Commission on Social Determinants of Health advocates universal coverage, the revitalization of the comprehensive primary health care approach, and the prioritization of primary care to address health inequities.[34,35]

The neglect of access to care becomes understandable in the light of a particularly restrictive interpretation of the social determinants of health, which was espoused by an influential regional actor. In a 2007 position paper,[17] the Pan American Health Organization described the Primary Care concept - "the place for continuing health care for most people, most of the time" – as "the most narrow definition ... directly related to the availability of practicing physicians with specialization in general practice or family medicine." The relevance of this model was felt to be confined to Europe and other industrialized countries. PAHO's appraisal makes no mention of the added value of family medicine at the individual level of care. The paper also stressed promotion and prevention as paramount for "renewed" primary health care. Clearly, health care services were not recognized as a health determinant *per se*.

Apparently, Bolivian and Ecuadorean policy-makers have adopted this perspective. Their attitude becomes more understandable by taking into account the combined effect of their countries' relative dependence on external financing and the fact that donor-driven international health policy tends to allocate care provision to the private sector.[29] Most national policy-makers today were intellectually shaped by a concept of public health skewed towards disease control. This – together with institutional inertia – helps explain why past

commitments prevail over current political determination.

… and estimating the consequences

Of equal significance as understanding the whys is estimating the consequences of a given policy choice. We here explore the likely consequences of not addressing critical issues related to access to care and of policy shifts already announced in Bolivia and Ecuador.

Further decentralization carries the risk of aggravating the segmentation and fragmentation of the health system, as acknowledged by the previously mentioned Word Bank analysis.[28] In the case of Bolivia, regional autonomy – approved by referendum and for immediate execution in five of the nine regions – could further disarticulate the health system and reduce national solidarity. Retaining the practice of dual employment will further weaken the public health system. Retaining and deepening a disease and problem-focused approach – without embedding vertical programs in primary care – will continue to reduce access, which in turn will maintain the failure of disease control by cutting off the pool of patients the latter needs for early detection and follow-up.[29] Making promotion and prevention in the community a key task for health staff will also reduce access to care. Retaining social targeting – with its inherent[30] and confirmed[31] leakage and under-coverage – offers little prospect of efficiency.

One by one, these policy options are strikingly similar to the former recommendations of neoliberal reform and their revised versions. Taking targeted health insurance as an example, it is clear that the rationale behind Bolivia's *SuSalud* and Ecuador's *Aseguramiento Universal en Salud* is identical to that of so-called "basic universalism," the latest offspring of Selective Primary Health Care; basic universalism has already been criticized as targeting in disguise.[36] Not surprisingly, most options are backed by reform-related external loans, which the governments did not renegotiate in their crucial points. At least in Ecuador, this targeted health insurance is now being dismantled and in the medium term universal coverage is planned through a tax-based unified health system.

Overall, this combination of options holds the possibility of preserving and/or re-introducing key elements of Selective Primary Health Care and targeting, while consolidating the commodification and privatization of health care. It is doubtful that it will improve health and may worsen exclusion and poverty. Taking into account the governments' commitment to equity and health, this combination of options is counterproductive.

Conclusions: A Proposal to Use the Potential of Comprehensive Primary Health Care

Our motive is not to deny the need for action on social determinants, certainly not in Latin America, the most inequitable society in the world. We argue here that health care by itself is a key social determinant and that action on social determinants integrated with family care in health services is the most effective way forward.

Health care in the form of primary care – operationally defined as care providing first-contact access for each new need, long-term person-focused care, comprehensive care for most health needs, and coordinated care when it must be sought elsewhere[37] – deserves dedication for more than ethical reasons. Starfield and her colleagues have provided strong evidence for primary care as delivering better health outcomes at lower cost and being more equitable than other forms of care.[37] The 2007 Pan American Health Organization position paper mentioned earlier[17] argues that the validity of these findings might be restricted to high-income countries. Yet, there is no reason to believe so. Several Latin American experiences – in low and middle-income countries – are proof of the contrary. Cuba embedded its health promotion and prevention activities in primary care services in 1983, producing outstanding results at a low cost ever since.[38] Costa Rica has been offering universal access to primary care for decades now, also with exceptional outcomes and at affordable cost.[39] Between 1970 and 1980, infant mortality in Costa Rica fell from 68 to 20 per 1,000 live births; more than 40% of this mortality reduction was attributable to primary care.[40] Similarly, in Brazil the 36% increase of population coverage by the Family Health Program between 1990 and 2002 was

associated with a 39% reduction of the infant mortality over the same period, even after controlling for all other health determinants.[41]

The findings of Starfield and colleagues regarding the positive contributions of primary care to health and equity were confirmed by the research of the Knowledge Network on Health Systems[34] and recognized in the Final Report of the Commission on Social Determinants of Health. Health care can now rightly be seen as a social determinant of health.

On the grounds of their literature review, Starfield and her colleagues conclude that superior access and quality (among other factors) contribute to the accomplishments of primary care. On the grounds of our experience with primary care in three continents for two decades, we would stress the central importance of family and community medicine. Indeed, by its very definition family medicine delivered in health care services takes advantage of the opportunities of individual care to act on proximal social determinants (with entry points like alcoholism and drug addiction, malnutrition and domestic violence, among many others).

The Ecuadorian and Bolivian populations show a transitional epidemiological profile.[42] (see Table, page 233) Non-communicable diseases are emerging as leading causes of death and disability while infectious diseases and infant mortality remain an essential part of total mortality.

Action on the social and economic determinants of these chronic health problems relies both on mass campaigns and on actions over individual risk factors that can be effectively implemented by first line family health practitioners. The "positive power" of physicians over their patients, which embodies a continuing responsibility for the person and the family that integrates a wide range of social and behavioral problems,[44] places doctors in a privileged position to act upon individual health determinants. By taking advantage of the recent increase in utilization of first line health care services which is linked to the free care policy and the availability of drugs, Ecuadoran general practitioners are in a favorable position to do this.

Integrating health promotion into the primary medical-care practitioner's activities and using the long term nature of the physician-patient relationship have the potential to increase the physician's effectiveness.[45] Indeed, physical activity prescribed by the family physician is more effective than exercise programs adopted by patients on their own initiative.[46] Comprehensiveness of counseling (tobacco, alcohol, and diet) is positively related with user satisfaction[47] and improvement in patient's health is related to the incorporation of preventive activities into the regular family medicine practice.[48] Action upon more collective health determinants could also rely on the community medicine wing of the first-line service team, based on its patient-centered relationship with community members. Family and community medicine act upon health determinants without overloading health services, thus allowing for a genuine multi-sectoral approach. In our opinion, these arguments justify integrating prevention and promotion in primary care service delivery.[49]

The message to take home (and abroad) is that a correct implementation of family and community care can make a substantial change. When WHO Director-General Chan addressed the Pan American Health Organization's Hemisphere's Health Authorities Open Annual Session on September 29, 2008, she rightly remarked that "We need to ground public health action in a clear understanding of the multiple forces that affect health. Primary health care is the best way to do so."[50] Comprehensive primary health care deserves a central place on the policy-makers' priority list, in Bolivia and Ecuador as elsewhere.

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Table: Estimated mortality rate, per 100,000 population

	Bolivia		Ecuador	
Communicable, maternal, perinatal and nutritional conditions	317,53	38%	144,77	24%
Non-communicable diseases	458,05	54%	376,58	63%
Injuries	69,84	8%	78,40	13%

Death and DALY estimates for 2002 by cause for WHO Member States (ref 43)

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