

# Colombia and Cuba, contrasting models in Latin America's health sector reform

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## Summary

Latin American national health systems were drastically overhauled by the health sector reforms the 1990s. Governments were urged by donors and by the international financial institutions to make major institutional changes, including the separation of purchaser and provider functions and privatization. This article first analyses a striking paradox of the far-reaching reform measures: contrary to what is imposed on public health services, after privatization purchaser and provider functions are reunited. Then we compare two contrasting examples: Colombia, which is internationally promoted as a successful – and radical – example of ‘market-oriented’ health care reform, and Cuba, which followed a highly ‘conservative’ path to adapt its public system to the new conditions since the 1990s, going against the model of the international institutions. The Colombian reform has not been able to materialize its promises of universality, improved equity, efficiency and better quality, while Cuban health care remains free, accessible for everybody and of good quality. Finally, we argue that the basic premises of the ongoing health sector reforms in Latin America are not based on the people's needs, but are strongly influenced by the needs of foreign – especially North American – corporations. However, an alternative model of health sector reform, such as the Cuban one, can probably not be pursued without fundamental changes in the economic and political foundations of Latin American societies.

**keywords** Latin America, Cuba, Colombia, health sector reform, privatization, national health system

## Introduction

Most, if not all, Latin American national health systems, which are traditionally characterized by the coexistence of a private, a social security and a public sector, were drastically overhauled by the health sector reforms of the 1990s. The general framework of these reforms was provided by the World Bank's 1993 World Development Report ‘Investing in Health’, that advocated cost recovery and user fees, separation of the purchaser and provider functions, and privatization (World Bank 1993).

Governments were urged by donors and the international financial institutions to make five major institutional changes. First, they have to shift the role of their health ministries from that of an operator of public health services to that of a regulator of a mixed public and private system. Secondly, they had to change the funding structure of their health systems: whereas before the government was both purchaser and provider of care, these functions now had to be separated through an insurance system. Thirdly, they had to decentralize the administration. Fourthly, central governments were supposed to focus on setting general

policies and monitoring programmes while decentralized units and private companies were implementing the reforms. Fifthly, they had to ‘streamline’ their bureaucracies, lay off part of the workforce and cut costs (Bossert *et al.* 1998).

In 1994, during the ‘Summit of the Americas’, and in 1995, during the ‘Special Meeting on the Reform of the Health Sector’, the Pan-American Health Organization (PAHO), the World Bank, the Inter-American Development Bank (IADB) and representatives from Latin American governments agreed on concrete strategies for health sector reform in the continent. Subsequently in 1997, PAHO together with the US Agency for International Development launched a ‘Regional Initiative of Health Sector Reform in Latin America and the Caribbean’ to support the reform agenda (Crocco *et al.* 2000; Infante 2000).

Granados and Gómez (2000) noted that – in spite of the pressure to copy the standard model – the actual implementation of the reforms has been significantly different between countries. The implementation of the reform agenda since the 1990s tends to be heavily influenced by

existing power relations between political and social forces, not unlike the development of health systems throughout the 20th century (Navarro 1989). Despite differences in pace and concrete implementation, the main reform features are similar all over the continent: public sector funding is gradually reduced, resulting in a deterioration of the quality of public services. Reforms tend to prioritize the role of the private sector over the government's. Patients' financial contributions increase through the introduction of user fees at all levels, and reforms encourage privatization and the creation of a 'market' for health services with a rationale that runs counter to the principles of equity, solidarity and universal coverage (Franco-Aguledo 2002).

Cuba is a notable exception, however. It has consistently resisted the dominant model of reform and continues to develop its comprehensive, unified public health system set up after the 1959 revolution (Feinsilver 1993; PAHO 2002).

#### **The paradox of reform: managed competition and mismanaged care**

While the separation of financing and provision of health care is one of the basic tenets of health sector reforms, presumably to promote cost-efficiency, the model of managed care has been gaining ground throughout Latin America during the reform period. This is remarkable because in the United States, managed care organizations (MCOs) tend to reunite both purchaser and provider functions in private hands. In Latin America, this tendency is still incipient but growing. This apparent paradox is also present in certain European health care systems: under the guise of improving efficiency, provider and purchaser functions are split, leading to the gradual privatization of health services. Once privatized, however, the separation between both functions tends to disappear because after all, integration is more efficient (De Vos *et al.* 2004).

Managed competition, in reality 'market care', reveals the final stage of privatization: a model dominated by large private insurance groups operating with the support of the government. The driving forces are competition and profit, with health care turned into a commodity. Consequently, the principles of social insurance and universal health care and coverage are compromised (Woolhandler & Himmelstein 1999; Geyman 2003).

The advance of managed care has been the most notable in Colombia, Argentina, Chile and partially also Brazil, the countries with the largest economies in the region, and has steadily boosted private sector participation in health service delivery and health insurance (Stocker *et al.* 1999). With the introduction of managed care, the private sector

is also becoming more prominent in the sector of social security. Corporations participate today as administrators of social security funds and health service providers at the same time. Moreover, large chunks of the health care market are now consolidated at the international level.

Transnational corporations are eyeing the Latin American social security trust funds, previously under the control of the government or public institutions, as a source of financial capital (Stocker *et al.* 1999). In Argentina and Chile, private penetration of the health insurance market is advancing, while it has also started in Brazil and, to a lesser extent, in Ecuador. Iriart *et al.* (2001) describe how transnational corporations like Aetna, CIGNA, the EXXEL group, the American International Group (AIG), the International Medical Group (IMG), Prudential, and International Managed Care Advisors (IMCA) put themselves in a position to manage contracts with social security organizations through the acquisition of private pre-paid plans. In Argentina financial groups were able to directly buy a social security organization.

The expansion of managed care into Latin America is closely related to the developments in the US economy (Waitzkin & Iriart 2001). As the North American market becomes increasingly saturated and the rate of profit begins to fall, MCOs and insurance corporations are forced to look for new opportunities abroad (Ginzberg & Ostow 1997). The US government is lending a helping hand through free trade agreements, like the North American Free Trade Agreement, a series of bilateral free trade agreements, and the developing Free Trade Agreement of the Americas (Stocker *et al.* 1999). In addition, the General Agreement on Trade in Services of the World Trade Organization is opening up new health care markets for transnational corporations (Lipson 2001).

While transnational corporations are reaping the profits, evidence suggests that the introduction of managed care restricts the access of vulnerable groups to health services and reduces the funds for clinical services while increasing the administrative costs (Iriart *et al.* 2001). Moreover, the introduction of MCOs tends to promote a dual health care system where MCOs attract healthier patients who are better off, while the chronically ill and the poor have to rely on the public sector. For example, only 3.2% of the patients covered by Instituciones de Salud Previsional, the major private insurance scheme in Chile, are older than 60 years, compared with 8.9% in the general population and 12% in the patients of the public sector (Estrada *et al.* 1998). Iriart *et al.* (1998) describe how after the introduction of 'self-management' and user fees in public hospitals in Argentina and Brazil, indigent patients had to undergo lengthy means testing before they were eligible for free care. Almost 40% of the requests are denied, however.

In the Argentinean experience, when MCOs took over the administration of public institutions, administrative costs increased drastically. The public hospitals of Buenos Aires now hire the services of a private company to attract patients with social security or private insurance. These companies receive a fixed percentage of the patient's eventual hospital bill. (Iriart *et al.* 1998) In Chile, the costs for administration and promotion reach up to 19% of the total annual cost of the health institutions involved (Estrada *et al.* 1998).

As in many other Latin American countries, the health sector reform in Argentina was accompanied by the privatization of social security and pension schemes in 1994. The case of Argentina is worth mentioning because of the role the social security reforms played in the economic collapse of the country in 2001. Following the prescriptions of the World Bank and International Monetary Fund (IMF), Argentina moved rapidly from a retribution scheme in which the government used income from those at work to fund its pension commitments, to a capitalization scheme, where individuals saved for their own retirement. The problem was the transition period, during which the government no longer received pension contributions, but still had to pay out. Government debt skyrocketed with debts of the social security system accounting for 70–80% of the deficit during the 1990s. In 2000, the IMF still praised 'the substantial progress made by Argentina in recent years in structural reforms, particularly in privatization, deregulation, pension reform' (IMF 2000), but this policy was an important contributing factor to the total collapse of the country's economy in December 2001 (Baker & Weisbrot 2002).

Generally, the outcome of the health sector reform has been similar, regardless of differences in actual implementation. In the highly unstable economic, political and social context of Latin America, reforms were mainly directed towards some aspects of (internal) economic management and efficiency. Problems of equity, social and health protection, and public health are being marginalized. The editorial committee of the *Revista Panamericana de Salud Pública* stated in 2000 that the health sector reforms in the Americas did not contribute to the reduction of inequities in the distribution of resources and services. According to the authors, general improvements of the systems' efficiency were marginal while inequities between classes increased. Quality of health care did not improve, nor did user satisfaction. Moreover, the productivity and the methods of obtaining basic resources improved, but not the adequate orientation of these resources towards the most pressing needs or towards increasing social protection. While only few countries address the question of long-term financial

sustainability, which has to ensure expansion and maintenance of the services, dependence of health systems on external financing is worsening and there are no alternative mechanisms to substitute these resources. Finally, the authors underline that the social mobilization on the theme of health failed to obtain sufficient influence in the reorientation of the reform policy towards the real needs of the population (López-Acuña *et al.* 2000).

### **Colombia and Cuba – two contrasting models**

Colombia's health care reform has been cited as a model for Latin America. In 2000, for example, the World Health Report ranked the Colombian health system as the most responsive in Latin America, and the number 22 in the whole world (World Health Organization 2000). Nevertheless, Navarro (2000) criticized this WHO evaluation of Colombia's health system, pointing out that it rather reflects the ideological bias of the report's authors than the actual performance of Colombia's health system.

Being an example of drastic remodelling of the health system, in which privatization and minimal state involvement in care delivery are pivotal, the Colombian reform is quite the opposite of the 'conservative' Cuban health system reform and its adaptation to the new economic realities since the 1990s. Cuban authorities ratified the principles of state responsibility – for policy issues but also for service delivery – and free universal coverage. The Cuban health care system did not turn to privatization of health care services nor cost recovery schemes (Feinsilver 1993; Delgado 1998).

### **Colombia, a 'model' reform for the Latin American health sector?**

Like most other Latin American countries, the Colombian health system used to be organized in three distinct sectors: a private sector for the patients that could afford it, a compulsory social security system for workers and employees and public health services for the poor. At the end of the 1980s, some 40% of the population was covered by the public sector and 18% by the social security, while 17% used private health services. This means that about 25% of the population remained without any coverage (Hernández 2002).

In 1993, after the approval of 'Ley 100' (Law 100), Colombia instituted far-reaching reforms in its health sector, creating the General Social Security System for Health (GSSSH), which incorporated the various existing modalities. The reforms were heavily influenced by the agenda of the international financial institutions. This is not surprising, as the policies were formulated by a small

team of technocrats with a strong neo-liberal bias under the leadership of Minister of Health, Juan Luis Londoño, who later moved on to the World Bank and IADB (González-Rossetti & Ramírez 2000).

Faithful to the prescriptions of the World Bank, the reforms emphasized a reduction of the state's role as health care provider and the need for 'competition' between different actors in a 'market' for health services and insurance. Instead of subsidizing supply of health services, the system was reorganized to subsidize demand, according to the principles of managed competition. It therefore makes a distinction between 'individual services' (curative care) and 'collective services' (mainly preventive activities). The former were to be largely privatized while the latter were retained in the hands of the state.

For the 'individual services', the reforms introduced the principle of a 'market of insurances', combined with elements of what is called 'managed care'. Regulation of the competition is organized through an obligatory insurance system that is supposed to ensure universal coverage through two types of affiliation. The contributory regime covers those who have the ability to pay. The employed contributes 12% of their salary (two thirds of which is paid by their employer) while self-employed pays 12% of their declared income. The subsidized system takes care of the indigents who are not able to pay the necessary contributions. Patients in this system are entitled to receive a minimal package that initially provided a mere 50% of the benefits provided under the contributory system. That has gradually increased and was supposed to reach 100% by 2001. The subsidized system is partly funded by the contributory regime, as anyone who earns more than four times the minimum wage has to pay an extra 'solidarity' contribution.

Several insurers are now competing for contributors, while the different health services compete for the patients, who are refunded by their insurers. At the same time, public health centres and hospitals are required to be self-reliant. The idea is that the public and private insurers and providers are competing in the same regulated 'health market' and will therefore strive to provide optimal care to the patients. The state assumes the role of regulator, provides subsidies for the poor and, through a highly decentralized system, takes care of the 'collective' health needs (PAHO 1998; Ayala-Cerna & Kroeger 2002).

#### Assessment of Colombia's new system

Several studies have made a positive assessment of the effects of Colombia's *Ley 100*. The WHO's 2003 World Health Report cites Colombia again as an example of

expanding health coverage to the poor. According to the report, the number of contributors to the mandatory health insurance system rose from 9.2 to 18.2 million people from 1995 to 2001. At the same time, the number of people benefiting from the subsidized system is said to have grown from 3 million in 1995 to 11 million in 2001. 'Thus, millions of non-contributing individuals gained access to roughly the same package of benefits as those who made the contributions, in the public or private facility of their choice, and in the same way as those more affluent citizens who regularly contribute', trumpets the report (World Health Organization 2003). Comparing data from 1993 to 1997, Málaga (2000) observed a similar expansion of insurance coverage and a better access to essential drugs. He concludes that the reform has a positive impact on inequities in access to care, while the effect on inequities in health services utilization is said to be inconclusive.

Other authors, however, have questioned these positive assessments. They observe serious limitations and problems. In its 'report to the Congress 1999–2000', the Ministry of Health reported that 32.8% of the population is participating in the contributive system, and 22.5% in the subsidized system, while between 5% and 10% participate in pre-paid schemes outside the GSSSH. Assuming that these figures are correct, critical voices underline that up to 13% of the affiliates of the contributive system could be double-counted – this implies that coverage was around 60–65% or more or less 25 million people (Hernández 2002). This means that the overall coverage of the Colombian health system – comparing the present coverage with the coverage of the three former subsystems – did not improve at all.

Franco-Aguledo (2003) underlines that there are even strong indications of a reduction in coverage after the initial expansion. He insists that, 10 years after the start of the Colombia's reforms, the overall assessment is negative. While he acknowledges an increase in health care coverage during the first years, he argues that coverage has gone down again. The United Nations Development Program (UNDP) (2000) confirms that 46% of the population had no health care coverage in 2000, an increase of 4.6% compared with 1997. The poorest fifth of the population has been affected proportionally more by the reduced coverage (Franco-Aguledo 2003).

That universal health care coverage has not been achieved is not surprising in a country that suffers from a permanent economic crisis and armed conflict, with an official unemployment rate of 20%, and a continuous deficit on the government budget. The country's dramatic economic situation tends to increase the number of people who have to rely on the subsidized system while limiting

the number of contributive affiliates. Moreover, the Colombian government is not able to assume its commitment to contribute to the subsidized regime, which accumulated a debt of 400 000 Colombian pesos (150 million US\$) over the period 1996–1999. If the state does not take its responsibility to support the subsidized system, this has to rely on the 1% cross-subsidization from the contributive system, which endangers its sustainability (Hernández 2000).

Public hospitals are now forced to compete in the 'health market', which is supposed to make them more efficient and less expensive while providing better quality care. In reality, most of these hospitals have insurmountable problems, not least because of the enormous outstanding debts the government have with them. While public hospitals are closing down, private facilities are booming (Franco-Aguledo 1998). The increase in public and private health expenditure is uncontested, however. Total expenditure for health care has increased from 7% of the gross domestic product (GDP) in 1990 to 10.5% in 1999. But increasing cost mainly seemed to have induced increasing health care inequities (Hernández 2002). An important proportion goes to private profit and is not reinvested. Large amounts of public money are being deviated from its social objectives (Franco-Aguledo 1998).

For the preventive 'collective health services', a decentralized system has been put in place at the level of the municipalities. Very few local governments and local health authorities have the ability, however, to ensure an adequate delivery of these services, including vector control and the prevention of epidemics. As a consequence, some authors have observed an increase of the morbidity and mortality from malaria, dengue, tuberculosis, syphilis and other communicable diseases (Hernández 2002). For example, a study of the consequences of the reform on malaria control identified a range of problems and shortcomings. According to the study, the 'organizational chaos' has led to a decrease in vector-control activity, which in turn has been associated with more malaria cases (Kroeger *et al.* 2002). An assessment of the tuberculosis control programme came to similar conclusions (Ayala-Cerna & Kroeger 2002). Immunization coverage has likewise decreased dramatically (PAHO 2001). Moreover, the increased participation that decentralization was supposed to bring about did not materialize (Mosquera *et al.* 2001).

Colombia's new health system is clearly not able to solve the continuing problems of accessibility, equity and efficiency. Serious contradictions exist between the theoretical objectives of the reform law and its actual implementation. This is not surprising, as health care has been placed in a market context, where economic efficiency and profitability are the primary objectives.

### Cuba's 'great job'

In comparison with its neighbours in the region, Cuba stands out in many ways. With a Gross Domestic Product (GDP) of US\$ 1100 per person in 2000 (only half of that of Colombia, and a fifth of Mexico's), Cuba achieves a life expectancy of 76 years (71 in Colombia and 73 in Mexico), an infant mortality rate of 7 per 1000 life births (25 in Colombia and Mexico) and a maternal mortality rate of 33 per 100 000 (80 in Colombia and 55 in Mexico) (Ministerio de Salud Pública 2002; UNDP 2002; World Bank 2002).

In contrast to other Latin American countries, Cuba is neither a member of the World Bank nor a member of the IMF. This makes it even more remarkable that the country was praised by the World Bank President, James Wolfensohn, who acknowledged that 'Cuba has done a great job on education and health' (IPS 2001). The World Bank's 2001 World Development Report also cites Cuba's social performance among the best in the world, in spite of the economic hardships it had to overcome after the collapse of the Soviet Union (World Bank 2001). This admission raises the question why the World Bank has always advocated policies that run counter to those implemented by Cuba.

During the 1990s, Cuba also implemented a health sector reform, although significantly deviating from the standard package of reform measures imposed on other Latin American countries by the international financial institutions. The country remained faithful to the basic premises of its system: an integrated national health system that is exclusively public as a political government priority. Actually, health care has such a prominent place in government policy making that Cuban leaders are said to be viewing health indicators as measures of government efficacy (Erikson *et al.* 2002).

In addition, for Cuba external factors were an important motive for reforms. The collapse of socialism in eastern Europe and the Soviet Union severely affected Cuba's economy. In 1993, Gross National Product (GNP) was 34% lower than that in 1989 and the budget deficit reached 37% of the GNP. At the same time, the United States tightened its economic embargo. In this critical period, many foreign advisors tried to persuade the Cuban government to apply the structural adjustment therapy the international financial institutions also imposed on other Latin American countries.

A number of other plans were implemented to adjust the health care system to the new situation. The further improvement of first-line health care was one of the foremost priorities. Of all graduating medical students, 97% became general practitioners. During 3 years they are trained, while practising, as specialists in the 'integral

general medicine' (family medicine). Special programmes have to ensure increased attention for some general priorities including preventive activities, extension of emergency medicine and improvement of the supply of drugs (De Vos 2005).

Throughout the whole reform process, health care remained exclusively in public hands. All costs of health care are covered by the state, except for first-line medication, which is offered at subsidized prices. By sticking to the principle of health as a human right and socialism as the basis for its economic and political systems, Cuba has apparently weathered the storm much better than its Latin American neighbours.

A recent World Bank commissioned review of the country's social services identifies general characteristics that are almost opposite to the advice the Bank usually gives:

1. The public sector is dominant and health is a government priority.
2. Cuba's social policy objectives have remained unchanged since 1960.
3. Government spends a relatively large part of the GDP on health and this spending remained high, even during the mid-1990s crisis, at the expense of defence.
4. Cuba has demonstrated a remarkable capacity to mobilize the population, and community participation is rather well ensured.
5. Policies are based on comprehensive monitoring and evaluation, backed up with quality data (Erikson *et al.* 2002).

Remarkably, Cuba is now providing assistance to other Latin American countries whose health systems have collapsed or are in serious trouble (De Vos 2005). In October 2003, Argentina and Cuba agreed on a 'drugs for debt' deal, in which Havana's 1.9 billion US\$ debt to Argentina will be reduced with 75% in return for drugs, vaccines and access to Cuban health services for the low-income Argentinians (Iglesias 2003). Ironically, the region's outcast is coming to the rescue of one of the poster children of the neo-liberal development model.

Interestingly, Nicaragua built a similar health system during the period of the Sandinista revolution from 1979 to 1990 (Braveman & Siegel 1987; Garfield & Williams 1992). After the electoral defeat of the Sandinistas in 1990, the country's policies changed radically. For the health sector, this implied sweeping reforms like the hasty introduction of new financing mechanisms based on user fees, the redevelopment of a separate social security system and a disproportionate reliance on the private sector, including private health insurance (Garfield 1993). In spite of the ample funds provided by the international financial

institutions, Nicaragua's actual health sector reform promises of coverage expansion and quality improvement remained highly illusory (Nigenda & Machado 2000).

### **Political economy of health sector reform and privatization**

The comparative study of Cuba and Colombia, or any other Latin American country for that matter, also shows the importance of general trends in the global economy for the national health sectors. What sets apart Cuba is that it has largely been immune for the penetration of foreign capital in its health sector. Other countries' reform policies (and their ideological justifications), on the contrary, seem to be driven by finance capital and its need of new market opportunities to ensure their profits. Thereby, the burden of the economic crisis in the industrialized world, particularly the United States, is shifted to the South.

In the industrialized capitalist economies, economic growth and net profit rates have slowed down since the 1970s. Average annual economic growth was at a meagre 2.4% between 1990 and 1997 in the countries of the Organization for Economic Cooperation and Development (OECD) – only half of the 4.9% growth in the period 1960–1973. Average net profit rates in the G7, the world's most important industrialized economies, fell from 17.6% in the 1950–1970 to 13.3% in the 1970–1993 (Brenner 2002). The saturation of the rich countries' markets becomes a constraint to growth and profitability. Intensifying competition between transnational corporations forces them to cut costs and expand their markets.

Moreover, the rich economies' capacity to absorb investment funds was constraining further growth. Governments of industrialized countries provided the transnational consortia an outlet for their capital glut through an increasing public debt, privatization programmes and other new investment opportunities, including the social sector (Shutt 1998). Through the structural adjustment programmes of the IMF and the World Bank, also Third World economies were put on the path of further liberalization, privatization and deregulation to provide the transnational corporations with an outlet for excess capital.

Since the 1990s, the international financial institutions have dramatically changed the way they define their own missions. The IMF has taken it to task to reform national economic structures – e.g. in Latin America – to prepare them for the new liberal financial order. Qualitative targets, set in terms of structural reforms and new legislation, such as the privatization of public assets, health services and social security systems, became routine demands. These long-term policies are designed to ensure

the interests of foreign investors and preclude any interventionist adventure by national governments that could jeopardize ‘investors’ sentiment’ (Cardim de Carvalho 2000).

### Consequences for health policies

Especially for North American companies, Latin America became a hunting ground for cheap labour and raw materials as well as for emerging consumer markets. In these circumstances, cut-throat competition inevitably led to a process of mergers and acquisitions, which consolidated international markets in a few monopolies.

The health sector is no exception to the other sectors of the economy. It is increasingly dominated by a few transnational corporations. For example, the global value of mergers and acquisitions in the health sector jumped from US\$ 336 million in 1996 to US\$ 3.4 billion in 1997 and US\$ 9.1 billion in 2001 (UNCTAD 2002). Health sector reform in Latin America has catered to the needs of these giant monopolies, providing them with new markets and investment opportunities.

With the expansion of ‘managed care’ plans in the United States, the market got saturated and profit margins started to fall. In 2000, 80% of the American population was ensured through one or other MCO. With 70% of all MCOs being ‘for-profit’ organizations, these companies needed new markets to ensure their growth and an adequate return on investments. This explains why these big corporations have set their eyes on the Latin American markets (Lewis 1996; Ginzberg & Ostow 1997; Iriart *et al.* 2000). The World Bank and other international institutions have been supporting reforms in the health sector of Latin American countries that accommodate ‘managed care’ as an official policy while stimulating the privatization of public health institutions and social security funds (Armada *et al.* 2001; Iriart *et al.* 2001). Latin American governments, which are dependent on the international financial institutions and the United States because of their external debt, have no option but adopting these reforms. Moreover, health sector reform is often introduced as one of the conditions for IMF loans.

We believe that Cuba’s experience provides an interesting alternative to the standard package of health sector reforms that has been applied throughout Latin America. Even under difficult circumstances, not in the least an economic embargo and other hostilities, the country was able to continue prioritizing its population’s health needs. This has been possible because of the country’s political priorities and its health system’s independence from foreign capital – which sets it apart from other Latin American countries. The continent’s dominant model of health sector

reform seems to be driven by the demands of global finance capital (debt payment, privatization and liberalization). An alternative model of health sector reform, such as the Cuban one, can, however, probably not be pursued without fundamental changes in the economic and political foundations of Latin American societies.

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#### Colombie et Cuba, deux modèles opposés de réforme du secteur de santé en Amérique Latine

Les systèmes de santé nationaux d'Amérique Latine ont été révisés de façon drastique par des réformes du secteur de santé depuis les années 1990. Les gouvernements, poussés par les donateurs et les institutions financières internationales, devaient mettre en place des changements institutionnels majeurs, incluant la séparation des fonctions de financement et de prestation de services et des privatisations. Cet article analyse premièrement un paradoxe frappant dans les mesures de réforme de grande envergure: contrairement à ce qui est imposé aux services de santé publique, après la privatisation les fonctions de financement et de prestation de services sont réunies. Deuxièmement, nous comparons deux exemples opposés: la Colombie, qui est promu internationalement comme un exemple radical de succès sur la réforme des soins de santé «orientée sur le marché», et Cuba, qui suit une trajectoire hautement «conservatrice» pour adapter son système public aux nouvelles conditions depuis 1990, allant contre le modèle des institutions internationales. La réforme Colombienne n'a pas été capable de mettre en place ses promesses d'universalité, d'amélioration de l'équité, de la qualité et de la rentabilité, alors que les soins de santé cubains restent gratuits, accessibles à tous et de bonne qualité. Enfin, nous discutons sur le fait que les prémisses des réformes actuelles dans le secteur de santé en Amérique Latine ne sont pas basées sur les besoins du peuple, mais sont fortement influencées par les corporations étrangères, spécialement d'Amérique du Nord. Cependant, un modèle alternatif de réforme du secteur de santé, comme celui de Cuba, ne peut probablement pas être développé sans changements fondamentaux des fondements économiques et politiques des sociétés d'Amérique Latine

**mots clefs** Amérique latine, Cuba, Colombie, réforme du secteur de santé, privatisation, système de santé national

#### Colombia y Cuba, dos modelos contrastantes en la reforma del sector sanitario de América Latina

Los sistemas de salud de América Latina fueron drásticamente reacondicionados por las reformas del sector sanitario desde los años 90. Los gobiernos fueron presionados por donantes e instituciones financieras internacionales para realizar profundas reformas institucionales, incluida la separación de las funciones de financiamiento y de prestación de servicios, y la privatización. Este trabajo primero analiza la chocante paradoja de las medidas de reforma a largo plazo: contraria a lo que es impuesto a los servicios de salud pública, después de su privatización las funciones de financiamiento y de prestación de servicios son reunificadas. Luego comparamos dos ejemplos contrastantes: Colombia, que es internacionalmente promocionada como un ejemplo de exitosa y radical reforma sanitaria de orientación mercantil, y Cuba, que sigue un camino sumamente 'conservador' para adaptar su sistema público a las nuevas condiciones que se dan desde los 90, yendo en contra del modelo de las instituciones internacionales. La reforma colombiana no ha sido capaz de materializar sus promesas de universalidad, mejorada equidad, eficiencia y mejoras cualitativas, mientras que el sistema de salud cubano continúa siendo gratuito, accesible para todos y de buena calidad. Finalmente, argumentamos que las premisas básicas de las actuales reformas en curso en el sector sanitario de América Latina no están basadas en las necesidades de las poblaciones, sino que están profundamente influenciadas por las necesidades de las corporaciones extranjeras, especialmente norteamericanas. Sin embargo, un modelo alternativo de reforma del sector sanitario, como el cubano, probablemente no podrá ser conseguido sin cambios fundamentales en las fundaciones económicas y políticas de las sociedades latinoamericanas.

**palabras clave** América Latina, Cuba, Colombia, reforma del sector sanitario, privatización, sistema nacional de salud