INTERNATIONAL COOPERATION IN THE BOLIVIAN HEALTH SECTOR: A WIN-WIN GAME?

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Plan

Acronyms

ABRASCO	Associação Brasileira de Saúde Coletiva
AECI	Spanish Agency for International Cooperation
AIDS	Acquired immune deficiency syndrome
ALAMES	Asociación Latinoamericana de Medicina Social
ALBA	Bolivarian Alternative for the Americas
BCB	Banco Central de Bolivia
CDC	U.S. Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CIDA	Canadian International Development Agency
DALY	disability-adjusted life year
ECLAC	Economic Commission for Latin America and the Caribbean
GATS	General Agreement on Trade in Services
GATT	General Agreement on Tariffs and Trade
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GERM	Groupe d'études pour une Réforme de la Médicine
GHIs	Global Health Initiatives
GNI	Gross National Income
GP	General Practitioner
HC	Health Centres
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HSR	Health Sector Reform
IADB	Inter-American Development Bank
IFI	International Financial Institution
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
IMR	Infant Mortality Rate
INE	Instituto Nacional de Estadística
JICA	Japan International Cooperation Agency
LAC	Latin America and the Caribbean
LMICs	Low and Middle Income Countries
MAS	Movimiento al socialismo
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MEFP	Ministerio de Economía y Finanzas Públicas
MMR	maternal mortality rate
MoH	Ministry of Health
MPH	Master in Public Health
NGO	Non-Governmental Organization
ODA	Official Development Assistance

OECD	Organization for Economic Cooperation and Development
OOP	out-of-pocket
PAHO	Pan American Health Organization
PHC	Primary Health Care
PhD	Doctor of Philosophy
PMNCH	Partnership for Maternal, Newborn & Child Health
PPM	Public-Private Mix
PRSP	Poverty Reduction Strategy Paper
SAFCI	Intercultural Community Family Health
SAP	Structural Adjustment Program
SINCOM	Municipal Accounting System
SSPAM	Seguro de Salud para el Adulto Mayor
SUMI	Seguro Universal de Maternidad y Niñez
SWAP	Sector-wide approach
TB	Tuberculosis
UDAPE	Unidad de Análisis de Políticas Sociales y Económicas
UK	United Kingdom
UN	United Nations
UNCTAD	United Nations Conference on Trade and Development
UNICEF	United Nations Children's Fund
US	United States
USD	United States Dollar
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
WHOSIS	World Health Organization - Statistical Information System
WTO	World Trade Organization

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Thesis summary

In an attempt to produce recommendations, this thesis aimed to study the impact of international (WB and USAID) aid to Bolivia on health system fragmentation and segmentation, on sustainability of promoted reforms and the reasons for these.

We thus explored whether the objectives (e.g. disease control and MCH) and activities of these agencies contributed to mending pre-existing fractures in the (individual) health (care) system, or instead strained access to care and contributed unwittingly to the worsening of avoidable mortality and suffering.

The methodology relied on

1. An historiographical insight into system development, assessing structure and performance across time and examining whether observed changes were linked to the cooperation's stated / 'undeclared' (non-health) objectives, activities and undesired effects.
2. A comparison of USAID / WB projects, exploring their (in-) consistency and complementarity in order to delineate a possible joint strategy
3. The study of their socio-political strategy to promote health system reform (HSR) while comparing the attempts of Bolivian and Ecuadoran socialist governments to reverse it.

The WB / USAID comparison revealed that the aid-promoted HSR reshuffled the Bolivian health system, although with disappointing effects on their own health objectives. Besides, aid deepened the pre-existing system fragmentation and segmentation, thereby maintaining access to care at quite a low level. Costs to high-income countries taxpayers increased significantly but were limited to less than 10 years.

The Bolivia / Ecuador comparison revealed an obstacle to socially motivated health policies in Andean countries: a powerful social and political alliance (of physicians and middle classes). This was built by the studied aid agencies (amidst political instability) to support care delivery and financing commoditization and to consequently open health markets to international economic actors. This aid rationale is visible in the similarities of

- The conditionalities of aid and international loans with
- The terms of international economic agreements such as GATS and ALCA.

Socially, not commercially motivated health policies should initially develop first line health services tailored to deliver in local health networks universally accessible, good quality biopsychosocial care. They should do so within a new, pluralist, not for-profit, multi-institutional health sector. Starting with (supply-side) financing of first line services could probably be politically compatible with financial and care delivery expectations of the above coalition - the middle class and professionals while paving the way to larger, future hospital ambitions.

Résumé de la thèse

Dans une perspective prescriptive, cette thèse a étudié en Bolivie l'impact de l'aide internationale (la BM et USAID y étant ses principales agences) sur l'état de segmentation et de fragmentation du système de santé, la pérennité des réformes promues et leurs raisons.

Nous avons donc examiné si les objectifs (entre autre le contrôle des maladies et la SMI) et les activités de ces agences avaient contribué à résoudre les fractures préexistantes du système de santé ou au contraire avaient entravé l'accès aux soins, contribuant ainsi, involontairement, à aggraver la mortalité et la souffrance évitables.

La méthodologie adoptée ici s'est fondée sur :

1. Une étude historiographique du développement du système de santé, y compris
   - une appréciation de ses structures et performances au cours du temps, et
   - l'analyse des liens entre cette évolution et les objectifs déclarés ou 'implicites' (non sanitaires) ainsi que les activités de la BM et d'USAID
2. Une comparaison des projets USAID et BM conçue pour identifier leurs (in-) consistances et complémentarité - afin de révéler une éventuelle stratégie conjointe.
3. L'étude de leurs stratégies sociopolitiques de promotion de la réforme des systèmes de santé (RSS) en comparant les tentatives des gouvernements socialistes boliviens et équatoriens de la renverser.

La comparaison BM / USAID a montré que la RSS promue par l'aide a profondément remanié le système de santé, quoi qu'avec des résultats désappointants quant à leurs propres objectifs sanitaires. Surtout, l'aide a creusé la segmentation et la fragmentation du système et a donc concouru à la stagnation de l'accès aux soins de santé - à un niveau inacceptable. Les coûts pour les contribuables du Nord ont augmenté de manière appréciable mais pendant moins de dix ans.

La comparaison Bolivie / Equateur révèle une pierre d'achoppement sur laquelle buttent les politiques de santé à finalité sociale dans les régions andines : une alliance socio-politique entre médecins et classes moyennes.

A l'initiative des agences de l'aide, et dans un climat politique très instable, cette alliance a été constituée en appui à la commercialisation de la prestation et du financement des soins de santé et en appui à l'ouverture du marché de la santé aux acteurs économiques internationaux. Cette rationalité de l'aide apparaît dans la similarité

- des conditionnalités assorties aux projets d'aide et aux prêts internationaux
- …avec les termes des accords économiques internationaux comme l'AGCS et le TLC.

Toute politique de santé qui serait inspirée par une logique sociale et non commerciale devrait développer en priorité le réseau des soins de santé du premier échelon, conçu pour assurer, au sein de systèmes locaux de santé, la prestation de soins biopsychosociaux universellement accessibles. Le cadre pourrait être celui d'un secteur nouveau, à orientation publique et finalité sociale, pluraliste et multi-institutionnel. Le financement (supply-side) de

ce secteur devrait pouvoir parvenir à être politiquement compatible avec les exigences (financières et/ou relatives aux soins de santé) de la coalition politique susmentionnée - celle des classes moyennes et des professionnels de santé – et préparer ainsi une politique plus ambitieuse, hospitalière celle-là.

Resumen de la tesis

Con ánimo de emitir recomendaciones, esta tesis estudia en Bolivia el impacto de la cooperación internacional (Banco Mundial y la USAID, la agencias más importantes) sobre la fragmentación y segmentación del sistema de salud, así como la sostenibilidad de las reformas promovidas y sus razones.

Se examina si los objetivos (Control de Enfermedades y Salud Materno-Infantil) y las actividades de estos organismos habrían atenuado las fracturas pre-existentes del sistema de salud o, por el contario, redujeron el acceso a la atención en salud e inconscientemente empeoraron la mortalidad y morbilidad evitables.

La metodología se basa en:

1. Un estudio historiográfico de la evolución del sistema de salud, incluyendo
   • la evolución de su estructura y su rendimiento en el tiempo, y
   • la relación entre estos cambios y los objetivos declarados, los "implícitos" (no relacionados a la salud) y las actividades del Banco Mundial y USAID.
2. Una comparación de los proyectos del BM y de USAID buscando identificar su (di)convergencia y complementariedad - para revelar una posible estrategia conjunta.
3. Un estudio de las estrategias socio-políticas de promoción de la reforma sectorial de salud (RSS) mediante comparación de los intentos de los gobiernos socialistas boliviano y ecuatoriano de revertir la reforma.

La comparación BM / USAID demostró que la RSS promovida cambió profúndame el sistema de salud, aunque con resultados desalentadores en cuanto a sus propios objetivos del estado de salud. Especialmente, profundizando la segmentación y fragmentación del sistema, la RSS contribuyó al estancamiento del acceso a una atención médica de calidad en un nivel inaceptable.

La comparación Bolivia / Ecuador revela que una coalición político-social entre los médicos y las clases medias y altas es un escollo mayor para las políticas de salud con fines sociales en la región andina.

Por iniciativa de las agencias de cooperación, en un clima político muy inestable, esta coalición fue formada para apoyar la comercialización de la prestación y el financiamiento de la atención de salud y la apertura del mercado salud a actores económicos internacionales. Estos objetivos se revelan en las similitudes entre:

- las condiciones asociadas a los proyectos de cooperación y
- ... los términos de los acuerdos comerciales internacionales, como el AGCS y los TLC.

Una política de salud con fines sociales y no comerciales debe desarrollar una red de servicios de salud en el primer nivel, dentro de sistemas locales de salud, diseñados para proporcionar atención bio-psico-social universalmente accesible. El marco para ello podría

ser un nuevo sector sanitario basado en servicios de salud con objetivos sociales, pluralista y multi-institucional. El financiamiento a la oferta de este nuevo sector debería ser capaz de satisfacer los requisitos (financieros y de atención de salud) de la citada coalición política - la clase media y los profesionales de la salud - y preparar así una más ambiciosa contra-reforma que incluya el nivel hospitalario.

The author and the thesis subject

To put the reader in a position to judge value-led statements and understand the empirical basis of this study, the author biography needs to be sketched. He worked for 10 years in Non-governmental organisations (NGOs) and in international cooperation agencies (USAID, JICA, IDB, etc.), mainly in support of the Bolivian Ministry of Health (MoH) but also in other Latin American countries. In consequence, he acquired deep knowledge of the structure of cooperation agencies and their functioning mechanisms, and of the shortcomings and needs of the public sector.

The original idea of this research sprang from his impression that: i) International aid had played an important role in the development of health services in Bolivia and it thus had some co-responsibility for the health achievements and problems of the country; ii) Fragmentation and segmentation were the main problems harming the health services delivery system; and iii) The World Bank and USAID had played a major role in this, through their important funding (24% of the total budget of the Ministry of Health between 1993 and 2003 (Greenbook 2008) and through their political weight.

1. Introduction

1.1. Central question of the thesis

What is the impact of international aid
and, in particular, of
its two main agencies – the WB and USAID
on fragmentation and segmentation of the Bolivian health system?

While trying to answer this question in an academic exercise, we are concerned with issuing practical recommendations (to national and international actors). This concern is the red thread of our thesis.

1.2. Segmentation and fragmentation of health systems: the thesis conceptual paradigms

1.2.1. Segmentation

1.2.1.1. Definition and consequences

A health system is said to be 'segmented' when it encompasses co-existing, parallel and strictly separated subsystems, each featured with different modalities of financing, patient affiliation, monitoring and service delivery. Each subsystem is 'specialized' in different population strata according to their place in the workforce, ability to pay and socioeconomic status. This leads to different socioeconomic groups being covered by different funding pools and served by diverse providers (Fleury 1998).

At the end of the day, health system segmentation means inequitable distribution of avoidable suffering, anxiety and mortality among citizens. Segmentation entails a variable proportion of the population having virtually no access to care and drugs. These social groups thus suffer the highest possible level of avoidable suffering, anxiety and mortality.

1.2.1.2 Mechanism

In terms of socio-political dynamics, health systems segmentation may be viewed as mirroring a balance of conflicting interests, i.e. those of

- Lower social classes, who demand social solidarity in health.
- Wage earning workers, who often enjoy social, state insurances. In Bolivia, they spend on health per capita more than four times what the average Bolivian spends.

- Private health insurance companies which aim at capturing the middle class health budget – an important 'segment' of the health care market (USD 157 per capita in 2007, that is about one third of total expenditure on health per capita).

Each (social, commercial, state) funding sector tends to develop health care services consistent with its financial capacity (and profitability), which is why some populations (in rural areas and shantytowns, in the main) do not have access to any decent quality individual health care.

1.2.2. Fragmentation

1.2.2.1. Definition and consequences

Among the many definitions, we selected the following. A health system is said to be fragmented when its units (e.g. health facilities, administration, logistics) function without proper coordination. Fragmentation is visible in health services organization, in health care delivery and in patients' experience.

At organization level, fully integrated local health systems gather one executive team that oversees a hospital, a network of first line teams, disease control programs, their staff and resources, and manages them along particular health planning principles (Unger and Criel 1995).

From a managerial viewpoint, fragmentation

- Impedes proper standardization (e.g. of clinical decision making and pharmaceuticals procurement),
- Hampers compatibility of problem solving capacity across health facilities (e.g. lack of synergy),
- Strains mutual technical support across health facilities, and thus,
- Generates substandard health care quality,
- Induces unnecessary spending on health care delivery and increased transaction costs (Levcovitz 2007).

Fragmentation may refer to the following breaches: hospital / health centres; social / medical services; individual health care delivery / disease control; management / professional teams; financing / operations; regulation / evaluation; etc.

As a consequence of health system fragmentation for patients, most referred to a hospital by a first line doctor are not in a position to access it. Health system fragmentation also jeopardizes continuity of care via several mechanisms such as

- deficiencies in health information,
- lack of defaulting tracers mechanisms or
- financial obstacles to hospital admission (an issue for referral).

In turn, these problems cause avoidable doctors' and patients' delays, avoidable suffering, inferior prognosis, over-infections, resistance to antibiotics (more than 100.000 deaths in the US only; 150.000 multi-resistant TB worldwide).

With regard to the particular fragmentation that involves individual health care delivery and disease control, it has been shown that, as a consequence possibly lethal to system effectiveness, those health facilities charged with delivering disease control interventions badly require patients – individual health care users – if their epidemiologic control activities ought to be successful (Unger et al. 2006c). Unfortunately, international health policy tends to allocate individual health care delivery to private commercial entities and disease control interventions to public ones (Unger et al. 2010a).

1.3. Historical fragmentation and segmentation of the Bolivian health system

Fragmentation and segmentation are common features of health systems in Latin America as has been documented by many authors (Levcovitz 2007), (Penchaszadeh et al. 2010), (Montenegro et al. 2011), (Fleury 1998), (Conill et al. 2011), (World Health Assembly 2005). Their effects have been identified as among the most serious obstacles that prevent large segments of the population on the continent from accessing good health care (Pan American Health Organization 2008) and that make health systems inefficient.

Bolivia is no exception. Rather, its health system is one of the most fragmented on the continent (Aguilar-Rivera et al. 2006). In the next section, we discuss the importance of the Bolivian history and sociology that explain much of its health system segmentation.

Bolivia is a lower-middle-income country, with the lowest GDP per capita among South American countries (although the *Human Development Report 2000* put it in the Medium Human Development category). Some factors that have impacted on the Bolivian health system (and population health status) are well known.

The 1952 nationalist revolution granted citizenship to indigenous people (60% of the population) who did not have it before; organized a Welfare State for all; redistributed land in the west; and created a Bismarck style social security system. Wage earning workers were key actors in this revolution. Their successful participation in the revolutionary events was rewarded with improved social protection. Today, they still benefit from health insurance granting protection significantly above that of the other Bolivians – while non-workers have seen their access to care reduced over time (see section 7.2).

Social rights and access to health drastically stagnated in the 1970s. The welfare state was undermined by a fragile economy and sky-rocketing foreign debt. Importantly, military dictatorships quelled all forms of popular political participation in state institutions. Affluent classes started ruling the country. As could be expected, they designed public policies largely to meet their own interests. The health system was no exception, so there were no serious attempts to enhance access of the unprotected to care.

With its highly stratified, unequal society, the Bolivian health system has always been segmented and fragmented due to the parallel existence of Ministry of Health and private health services. As discussed above, the 1952 revolution only added one category to this – the social security health care delivery services.

The National Social Security Fund (Caja Nacional de Salud) was created in 1953 to protect factory workers, (newly nationalized) mineworkers and public employees. During the following three decades, fourteen other new social security funds would follow suit: some were specific to new economic sectors, others to powerful social actors, such as were oil workers, university students and roads constructors. Each health fund developed its own facilities and managed its services independently, which explains the inequitable access and heterogeneous quality of care featured in the Bolivian system.

In conclusion, even before the neoliberal revolution, the Bolivian health system was already severely segmented and fragmented – in a particular way that reflected the scars of a terrifying social and political history. It is this particular history that explains why Bolivia still has one of the world's worst GINI indices (see map 1).

The 80's crisis - economic (raw material prices), fiscal (debt) and political (left/ right swing) - that followed the Siles Suazo Government brought a halt to its 3-year PHC strategy. Simply put, those who lost their wage-earning jobs also lost their social protection. Social expenditure was dramatically cut down from 8% of gross domestic product (GDP) in 1981 to 1.8% in 1986, recovering the former level only in 1992 (Cuellar et al. 2000;Loayza et al. 1998). But if the 1983 - 1985 Bolivian economic crisis provided a handy context to promote what would become the Washington Consensus in health, implemented throughout the rest of Latin America (Almeida 2002b;Lustig Nora 1995), the wishy-washy formulation of the Alma-Ata principles certainly eased the move: its vague terminology permitted PHC to be interpreted as a new formulation of the old disease control paradigm (then named "Selective PHC").

The 1983 - 1985 economics and the associated political and social crisis resulted in a rapid increase in poverty, unemployment, and underfinancing of all public services, including health. Mining, once the most important economic sector, still attracted tens of thousands of workers. Their working conditions were extremely unhealthy. At the end of the eighties, a severe price contraction on international markets led to the dismissal of thousands of them. At once, they lost social security, plunged into poverty, migrated with their families (e.g. to the 'Chapare' region and to the wider East), while immense social networks were destroyed.

The health sector reform in Bolivia did not address the social security or the private sector institutions, although they were causing serious problems:

- A figure that summarises well the persistent inequity linked to system segmentation is the 42% of national health expenditures spent on social security in 2004 (thus before the election of President Morales). It contrasts with the 2,311,266 then insured persons (26% of the Bolivian population) (Morales Medina 2012).

- As another historical factor of segmentation and fragmentation, about 100 NGOs were settled in Bolivia before 1980. Between 1980 and 1992, their number rose to 5301, with 62% of them having a health related activity (Graham 1992).

What happened to the public (health) services? In the eighties already, the WB (Akin et al. 1987;Buse and Walt 1996;Evans et al. 1981;Frenk 1990) and USAID (Unger and Killingsworth 1986) were known to promote a health system reform that featured (Frenk et al. 1991):

- Open markets for medical technology and pharmaceutical products of LMICs; health care and insurances
- Limiting taxes on the middle class of recipient countries to increase its buying power (in a quest for a non- health goods market).

In (public) health centres, the disease control health model amounted to changing the output of health care services into disease control interventions. Multilateral agencies were prominent in this policy, promoted in South and Central America by the Pan American Health Organisation (PAHO), UNICEF, the Inter-American Development Bank (IADB) and the WB.

The objectives of the so-called "Structural Adjustment Program" (SAP) are largely acknowledged to be neoliberal in essence (Rapley 2002;Serven and Solimano 1992).

The SAP had a profound, long lasting impact on Bolivian state structures. The health sector was no exception. The underlying health policy model in the country changed the managerial techniques and structures, medical practice, health care delivery and probably health status – which we explore in the present thesis.

The structural adjustment (from 1986 on) aggravated poverty, worsened working conditions and job availability, bankrupted many small urban businesses and ruined small rural producers (Thiele 2003). The Paz Zamora presidency (1989–1993) was confronted with the worst crisis in terms of narcotics traffic and corruption, convicting a high-level politician and extraditing the head of Bolivia's Special Narcotics Forces and a former minister of the government. Nonetheless, it approved a law to privatize national industries. Thereafter, the neoliberal economics would trigger a wave of privatisations – of water, electricity, the oil industry – that featured in the governments of Sánchez de Lozada between 1993-7 and 2002-3, and of Bánzer-Quiroga between 1997-2002.

In fact, as in Europe today, the mid-eighties crisis has been used as an excuse (the lack of public funds) and an opportunity (because social and political movements were 'stunned' and paralysed) to apply economic policies in line with the Washington consensus. As happens so often, the World Bank and the IMF led this process (Armada et al. 2001). And, as in Africa in the eighties, selective primary health care was extensively implemented in public services.

1.4. Analysis of WB and USAID aid in Bolivia

1.4.1. History of aid in Bolivia

International cooperation in health is an old story in Bolivia. The first health interventions were staged at the beginning of the twentieth century, as a function of US charities. Communicable diseases control began in 1929 with programs against whooping cough, diphtheria, dysentery, Chagas disease, yellow fever, bubonic plague, leprosy, recurrent fevers and dengue. The U.S. cooperation was initiated in 1932 by the Rockefeller Foundation to promote hygiene and disease control (Mendizábal Lozano 2002). The creation of clinics aimed at preventing the dissemination of diseases potentially dangerous to the international community, such as tuberculosis and malaria, appears to have structured the health ministry and induced some historical services fragmentation.

The 1950's industrialised countries had neo-Malthusian fears. These emotions triggered massive contraception campaigns in LMICs. The Bolivian government started them in 1956 with U.S. Agency for Cooperation support acting through semi-private organisations (e.g. the Peace Corps). Besides that, in the subsequent decade, the Pan American Health Organization was instrumental in launching immunization campaigns.

In the early 80s, however, popular movements managed to have a say through a State program - a Primary Health Care one – in line with the WHO 1978 Alma Ata conference. This Silez Suazo government initiative was named “Integrated Health Care Areas Program”. Alongside disease control programs, it contributed to shaping the Bolivian health system, as it aimed at developing health districts, that is, local health systems operated as an integrated health services network, and associating at least two health care tiers (first line and hospital).

The WB and USAID were leaders in promoting the HSR in Bolivia (Table 1). This research focuses on the two main cooperation agencies in Bolivia:

- the World Bank, as reform lead;
- and USAID, acting as a financial and management agency, that operated in strategic fields - those essential to the introduction of health care commoditization.

Table 1: A comparison of WB, USAID and MoH budgets (in USD) over the 1995-2003 period

Year	1995	1998	2001	2003	1994 - 2003
Total MoH Budget	55.078.434	64.415.221	95.065.345	120.757.020	777.195.468
WB	5.614.285	1.900.000	8.733.000	9.530.000	58.996.140
USAID	10.528.000	10.687.000	4.496.000	19.194.000	83.712.000
Other agencies		2.476.330	1.130.577	2.963.398	87.174.354
Total	71.220.719	79.478.551	109.424.922	152.444.418	1.007.077.962
% WB + USAID/Total	23%	16%	12%	19%	14%

Source: Data from Contabilidad Fiscal del Ministerio de Economía (Viceministerio de Presupuesto y Contabilidad Fiscal.Ministerio de Economía y Finanzas Públicas 2012)

Notice that bilateral donors did not blindly follow neo-liberal orientations in Bolivia (e.g. Cuba, Venezuela and Belgium).

In Bolivia (see section 2), the health sector reform confined the MoH to deliver pro-poor selective MCH interventions - antenatal care, skilled birth attendance, immunization and treatment of pneumonia and diarrhoea - and control of a few communicable diseases - tuberculosis, malaria and Chagas (Aillón Terán et al. 2006). Until 2007, no public initiative promoted comprehensive care, be it through family, community or hospital medicine.

Today, the public first line structure remains but its expected product has changed: it is not meant to yield what health districts had been conceived for (namely coordination of and support to individual health care delivery), but epidemiological programs.

International health policies also promoted a purchaser/ provider split, one aimed at easing privatization of both health care delivery and financing. In Bolivia, the insurance coverage strategy relied on a policy targeting poor people. In 1996 the MoH created a MCH public insurance (Seguro Nacional de Maternidad y Niñez) based on tax funds (approximately USD 11 million per year) with a 3% contribution from international cooperation, mostly the WB, which also financed most administration costs and, with USAID, infrastructure and equipment investments. With free public provider choice it reimbursed facilities for 26 MCH interventions (Böhrt and Holst 2000) on a fee-for-service basis (102 interventions by 1998). This program was thus consistent with the 'essential package' policy promoted by WHO (Bobadilla et al. 1994;Claeson and Waldman 2000) and UNICEF (Bedregal et al. 2000;Wisner 1988).

This insurance programme proved to be pivotal in the Bolivian health system reform although curiously, it has not been initiated by the WB: 'Endorsed by the MoH under recommendation of UNICEF, the public insurance was hardly accepted by WB officers at the beginning, but later it proved to be compatible with the reform objectives and was strongly supported because of its exclusive focus on MCH', a former reform manager stated. Notice that in the last decade, the expansion of medical insurance to poor population groups became a main feature of health sector reform policies in the Latin American and Caribbean region (Flores 2006).

Throughout the HSR process, the transition between care and disease control has been chaotic in appearance, and the present thesis hopes to contribute to understanding its steps. Such information would be relevant for policy-making, we believe, because the involved processes point the way to important changes in the art of healing: the transition between individual care delivery and disease control in public services has impacted on logistics, hierarchy, public/ private relationships, but much more importantly, on the professional identity of those many doctors who were serving part-time only in the public sector. The medical culture has been changed – which we shall discuss in the Conclusion section.

The present work concentrates on the health sector reform that started in 1986 (admittedly a conventional date) with the Structural Adjustment Program (SAP), a program that has been used as a leverage, in line with the Washington Agreement, to push health sector reform in Bolivia. It has been amazingly effective in doing so: thereafter, the health system would never be the same again.

1.5. Research sub-questions

Policy recommendations

Although an academic exercise, this thesis has a practical goal: to provide a contribution to (national and aid) policies designed to integrate the health care system, while making access to care universal.

If we want this analysis of the role of aid agencies to generate policy, strategic recommendations (strategic orientations to improve access to individual health care), as well as pilot experiment results, we need to understand the genesis of undesirable health systems divisions. Descriptive studies, however, will not be enough to re-orient health policies (in Bolivia as anywhere). Any policy advice aimed at improving access to individual care will need to adopt a strategic planning perspective (Araujo 1972;Sapirie 1998) and to specify the role of each socio-political organization in this endeavour. Such an approach is indispensable, because the number of involved actors is huge and the economic stakes of the health sector potentially represent 5 – 10% of the GDP on top of what is already allocated to it.

Genesis of health sector reform approached by a study of the aid / national actors relationships

In Bolivia as elsewhere, care delivery, health system development and environmental health improvements (e.g. with sanitation) are a product of economic, social and cultural factors. Other indirect social determinants of health are: poverty, labour and nutrition problems, and deficient access to water. Beyond those, there are third line determinants - agricultural, environmental, social, economic, cultural and political in essence. Those of them that shape health care services are our key study objects.

The present thesis explores the genesis of these health systems divisions in international aid to Bolivia, and the relations between local health actors and the most influential aid agencies

in the health sector (the World Bank and USAID), in the country with the worst health indicators in the region. The studied actors aimed at influencing one way or another access to / quality of health care and services, which is one of the most important health determinants (Muldoon et al. 2011;WHO Commission on Social Determinants of Health 2008). Therefore, our research builds on an inter-disciplinary methodology, making plenty of room for historical, social and health management disciplines (see section 1.6).

Symbolic stakes of health sector reform

While scrutinizing actors' relations, we are led to study how a political power can act upon beliefs, interests, abilities, conflicts, alliances and actions of individual and collective actors (e.g. political leaders, MoH decision-makers, health system officials, cooperation managers, health workers unions and professional associations), while exploring how these actors aimed at taking advantage of sector reform features.

Far from limiting this analysis to material issues (economic incentives), we explore the symbolic stakes of this large-scale game. Therefore, we studied

- Knowledge, science and training (see section 10.6).
- Political organisations. As an international player (gathering thousands of health professionals dialoguing throughout Latin America on not-for-profit health care delivery), the Latin American Social Medicine movement, for instance, proved to be capable of influencing contemporary Bolivian health policy (Section 4).

Impact of aid on health

Gifts may have perverse effects. Few researchers have assessed the long-term consequences of the aid and 80s / 90s reforms. This thesis aims to evaluate their effects on health status, care, services and systems in Bolivia e.g. in terms of aid policy relevance. Below, we shall use the term 'output' to name the effect of HSR on health services and care delivery. As a yardstick to assess reforms impact on equitable access to care, we aimed to measure utilization of health services and to assess quality of care, e.g. when disease control interventions substitute for care delivery in public services. We shall use 'outcome' to refer to health status.

Sustainability of HSR

To assess the robustness of those changes brought by reform processes in the health system structure and in the medical / public health culture, we studied the new Bolivian socialist government policy, trying to discover if it really departed from WB and USAID policies.

1.6. Methodology

1.6.1. General orientation

We describe here how each answer to the above-mentioned sub-questions helps to answer the other questions, with some kind of a quantitative / qualitative methodology dialogue. In this dialogue, our thesis uses technical (e.g. public health and health management)

standards and output indicators to assess past policy decisions, systems and services functioning. It uses social and political sciences concepts to decipher failures and policy decisions made against peoples' health interests, e.g. to study the rationale of actors involved in the health systems reform in Bolivia.

How did we answer these research questions?

Impact of aid on health

To explore the aid effects on "equitable access to quality healthcare delivery", we studied the agencies' activities, categorized in terms of the classical Donabedian typology (Frenk and Donabedian 1987) (inputs, processes, outputs and projects impacts).

Our study aimed to deconstruct a political, functionalist discourse justifying the features of aid in terms of its health purpose. Its implicit message can be summarised by the following cause / effect sequence:

Aid (resources)
→ impact on health system
→ positive impact on Bolivians' health
(where arrows represent cause-consequence relationships).

To critically assess this sequence, we propose to use an inductive, reverse chain (possibly with nested deductive ones):

Any change in health status?
→ Any change in access to quality health care?
→ Any change (e.g. fragmentation and segmentation) in health services systems?
→ Aid features (resources and programs)?
→ Social, political and economic determinants of aid features?

The outputs (access to care) and outcome (health status) were thus traced back to inputs and aid related (technical, political and economic) processes. For instance, while decreased MMR is known to be a close consequence of access to quality health services, IMR, by contrast, is more influenced by other factors such as nutrition and food availability – alongside health care. With regard to the particular impact of aid on the Bolivian system segmentation, we analysed a USAID project of private care for the middle class, and WB and USAID projects for the poor – predominantly in (public) health centres. We studied the aid impact on system fragmentation while examining the changes in first line services with health systems research indicators and criteria. Without trying to establish cause/ consequence relationships, we less ambitiously aimed at building "good cases".

In parallel fashion, this inductive, reverse chain called for mobilization of the following disciplines:

Epidemiology and demography
→ Public health and health systems research

→ Historical sciences
→ Social sciences, political economy and political sciences.

In this search sequence, the aid agencies were studied from the angles of their political rationale (mission) and their policy and managerial strategies. To understand how aid explains health services features, we analysed the declared objectives of the aid agencies and the conditionalities of their loans and aid projects. To analyze the unspoken objectives of aid policies, we compared the terms and conditionalities of WB loans and of aid projects with WTO / GATS agreement terms (such as opened markets and interruption of subsidies to public services). We also explored the USAID statutes.

Genesis of health sector reform approached by a study of the aid / national actors' relationships: beyond the alleged quest for functionality

- Sustainability of HSR

To assess the sustainability of HSR features and identify the determinants of its stability, we examined if and how the Bolivian socialist government redirected its inherited health policy - to understand the socio-political factors beyond implementation of health systems reform. To do so, we compared the Bolivia and Ecuador policy of first line health services after their socialist governments were voted in and examined how, if at all, they departed from previous health reforms.

- To explore the actors' roles in HSR and aid processes and the environmental features determining the behaviour of the above actors, we used factual evidence on health policies and management from

    - A literature triangulation (grey and published)
    - An analysis of demographic and epidemiological reports
    - I International epidemiological and demographic data and national access surveys
    - Field visits to health services
    - Key actors interviews (decision makers, health professionals, health workers, socio-political organisations representatives and patients), to reveal the coherence of their objectives, actions and achievements. In each study nested in this thesis, the features of literature review and interviews are specified.
    - Study of government policy papers and declarations
    - Literature review of medical, public health, economic and political sciences
    - Historical research, in which we used official declarations, plans and programs. We also expanded the grey literature research to non-specialised media.

The detailed characteristics of these search activities are provided in each of the thesis chapters corresponding to published papers.

Symbolic stakes of health sector reform

We concentrated on the study of knowledge used to disseminate HSR features in health services organization, the features of its production (research) and dissemination (continuous medical education). We singled out the structural links between the concepts (systems of signs and methods) and the practical consequences of their use by health care professionals and managers.

Policy recommendations

We derived our proposed strategic orientations bearing in mind quality criteria for health care, services and systems typical of not- for- profit health organisations (Unger et al. 2003b), professional experience in not- for-profit services organisation, and the results of our socio-political analysis performed in the three papers, making the core sections (2, 3 and 4) of the present thesis.

2. Revisiting the WB policy

Tejerina Silva H., De Paepe P., Soors W., Lanza O.V., Closon M.-C., Van Dessel P., & Unger J.-P. 2011. Revisiting health policy and the World Bank in Bolivia. Global Social Policy, 11(1): 22-44. Available from: http://gsp.sagepub.com/content/11/1/22.abstract.

3. A comparative analysis of health policies issued by Bolivia vs. Ecuador socialist governments

Tejerina Silva H., Soors W., De Paepe P., Aguilar Santacruz E., Closon M.-C., & Unger J.-P. 2009. Socialist government health policy reforms in Bolivia and Ecuador: The underrated potential of integrated care to tackle the social determinants of health. *Social Medicine*, 4(4): 226-234. Available from: http://journals.sfu.ca/socialmedicine/index.php/socialmedicine/article/view/337.

SOCIAL MEDICINE IN PRACTICE

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 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, J] 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/ 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."~[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/[4] In 1990 following the re-establishment of democracy, Chile started reversing its neoliberal reform." In 1994 Brazil introduced its Family Health Program (FHP, *Programa Saúde da Familia),* which is increasingly becoming a delivery model of comprehensive primary health care embedded in a wider social policy/[6] 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/[7]

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/[5] In 2004, life expectancy at birth was 65 years in Bolivia (underperformed only by Belize) and 72 years in Ecuador[i9]; the probability of dying under age of five was 69 and 26 per 1,000 respectively/[9] Maternal mortality follows a similar pattern with 420 (Bolivia) and 130 (Ecuador) deaths per 100,000 live births by latest estimates/[5] 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/[9] 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 Inter cultural,* 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 coordination of the three-tiered health system. In parallel, extension of the population coverage of

mother-and-child insurance (formerly SNMN, then SUMÍ - *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 preexisting 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 biomédical 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.[25] 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[3i] As far as financial protection is concerned, a WHO analysis of *SUMÍ '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, 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/[7] 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 policymakers 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

... **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.[25] 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[3i] 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[i7] 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.[35] 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/[2] (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/[4] 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/[5] Indeed, physical activity prescribed by the family physician is more effective than exercise programs adopted by patients on their own initiative/[6] 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/[5] 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/[9]

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."[J0] 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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5. Aid policy principles in the light of a comparative analysis of WB and USAID aid in Bolivia: key moves to foster HSR

Section 2 (Tejerina Silva et al. 2011) analysed the World Bank role in reforming the health sector over the 1986-2006 period and assessed its impact on the health care delivery system to date, e.g. with regard to systemic integration/disintegration of services, access to care and disease control. Section 3 (Tejerina Silva et al. 2012) analysed the US-Bolivia relationships in the health sector between 1971 and 2010 on a grey and scientific literature review and on interviews.

In the present thesis, we aim to depict key strategic principles used when introducing neoliberal reforms in a health sector (the extent to which Bolivia is representative of part of LMICs will be discussed below). By doing so, we would like to feed into current democratic debates within LMICs. HSR strategic principles are to be democratically debated and should not remain restricted to academic circles.

To identify these health policy principles, which merit discussion in journals and by socio-political organisations, we comparatively assessed the WB and USAID strategies in the Bolivian health sector so as to identify their common:

- objectives
- interventions
- knowledge
- consistency with Bolivian needs
- impact on health system integration in the intervention areas covered.

Notice that one difference proved important, possibly revealing a coordinated complementarity: while USAID channelled its funds through a myriad of NGOs, the WB financed State social protection via Government institutions.

5.1. Aid inputs: resources, knowledge and strategy

The health projects financed by USAID and the WB were complementary in terms of their geography and the status of supported health facilities. The WB concentrated on the public sector

- because the MoH still had control over the health sector and
- because of political obstacles to directly financing commercial entities in the health sector.

By contrast, USAID directed funds to private organisations.

From an operational, health interventions viewpoint, the two organisations tackled a similar, narrow array of health problems: the control of a few infectious diseases and MCH preventive care.

5.2. Funds in a nutshell

'Kaputt finanzierung' say the Germans… Contrasting with the narrow ambit of operational objectives of the WB and USAID, the financial input of these organisations in the health sector was simply huge during the peak of the health sector reform. This clearly appears in the ratio of functioning to investment budgets: the combined 1995 WB and USAID budgets reached a peak of 161% of the total MoH functioning and investment budget in 1995 (Table 2). Such contrast deserves an explanation.

Table 2: 1985 – 2010 selected WB, USAID and MoH budgets (in USD)

Year	1985	1990	1995	2000	2005	2010
MoH budget	23.230.000	68.904.000	55.078.434	82.622.871	182.388.459	318.414.566
MoH Functioning Expenditures and Investments	1.840.000	23.865.450,13	10.000.920	10.749.900	63.051.047	64.034.262
WB	0	0	5.614.285	6.433.000	3.947.368	0
USAID	714.000	9.084.000	10.528.000	6.783.000	12.485.000	1.265.800
Other agencies	0	-	-	12.461.595	29.515.987	28.048.099
% WB + USAID/Total	3%	12%	23%	12%	7%	0,4%
% WB + USAID/MoH Functioning Expenditures and Investments	39%	38%	161%	123%	26%	2%

Source: Data from : Data from Contabilidad Fiscal del Ministerio de Economía (Viceministerio de Presupuesto y Contabilidad Fiscal.Ministerio de Economía y Finanzas Públicas 2012)

Table 3: A comparison of the 1985-2010 salaries managed by WB, USAID and MoH (in USD)

	1995	2000	2005	2010
MoH Total Budget	55.078.434	82.622.871	182.388.459	318.414.566
MoH Salaries	45.077.514	71.872.971	119.337.412	254.380.304
% of salaries	82%	87%	65%	80%
WB + USAID Total Budget	16.142.285	13.216.000	16.432.368	1.265.800
WB + USAID Salaries	4.350.900	5.036.000	3.876.430	408.000
WB + USAID / MoH salaries (%)	9,7	7,0	3,2	0,2
% of salaries over total public expenditure on health	27%	38%	24%	32%

The rationale of this 'kaputt finanzierung' in the context of a well-known incapacity of the health services to absorb huge amounts of money must be sought in non- functional objectives. The bulk of the expenditures were salaries, much more in MoH than in aid budgets (Table 3). However, the proportion of total salaries covered by these two aid

agencies proved to be important in the nineties and to progressively vanish thereafter. This is a key feature of this paradoxical Kaputt Finanzierung of the Bolivian health sector.

One has to remember that many professionals in the eighties had a family history of resistance against established orders (at local or national level). The HSR principles were radically against their political vision of health care delivery and their professional ethos (family and community medicine for many). The GP of Vallegrande, in the (public) health centre, used to know 'his' families….

The huge funds committed to salaries (see Table 3) served to purchase the political allegiance of the health professionals in the vast regions where the WB / USAID projects were working – while the funds for consultancies were controlled by MoH policy makers and politically influential decision makers. To understand the effectiveness of such over-the-top funding, one has to bear in mind that in 1995, the monthly salary of the MoH planning director was USD750 while his/her consultancy would be paid some USD7.000 a month.

This is how the HSR funds were able to create a true psychosocial evolution amongst intellectuals and professionals involved in the health sector. However, it would be crude to say that money purchased the political will of many.

Rather, there was a need for a complementary psychosocial strategy aimed at a drastic revision of the social and professional ethics of health professionals. The strategy that served this purpose aimed to change concepts and standards amongst health professionals and workers. Here follows a list of such novelties in public health knowledge that favoured changes in the professional identity of decision makers across health care pyramids.

5.3. Knowledge, political principles and scientific ideology

Both USAID and the WB financed a wealth of seminars, continuous medical education courses, in-service training methods, and grants to study public health in foreign universities (MPH and PhD programs). Across these programs, the knowledge transferred appeared to be consistent with a policy agenda, which is what we now examine, based on the content analysis of grey literature (aid projects documents e.g. in training Bolivian staff).

- Primary health care

In 1978, the Alma Ata Primary Health Care International Conference declared that health was a human right. Attainment of the highest possible level of health was said to be a key social goal, to be achieved through development of first line health care services and community participation. Bolivia made health a right in 1980. The Siles Suazo government (1982-5) adopted comprehensive primary health care (PHC) as its main health policy (Mendizábal Lozano 2002). It delineated a strategy conceived to equitably and effectively tackle health needs by addressing underlying social, economic, and political health determinants. It supported universal access to first line health services while emphasizing

disease prevention, health promotion, community participation and inter-sectorial collaboration.

Consequently, access to individual, multifunction curative care was not an explicit priority of the government, although its health districts did encompass HCs and hospitals. No specific knowledge was disseminated to locally improve access to individual health care and to raise its quality. In the subsequent decades, professional culture would continue to systematically overlook know-how in individual health care management. Besides, community participation, although a key PHC element, would generally be understood as a way of improving users' compliance with disease control / MCH interventions, rather than as a method for co-managing (public) health facilities.

- Disease control

International health policy, together with MCH activities, promoted disease control interventions, in order to replace multipurpose, discretionary, individual health care delivery in (public) first line health care services.

Until the end of the seventies, many LMICs offered cost-free disease control interventions in their public sector. In 1964, this package included, according to circumstances in the various countries, smallpox, malaria, tuberculosis, Chagas disease, venereal leprosy zoonosis, plague and yellow fever (Mendizábal Lozano 2002). The related interventions were organized as vertical programs financed by both national and external sources (Audibert et al. 2004).

The underlying epidemiological concept was one of disease eradication – as would succeed with smallpox, an unprecedented but unique achievement. Program management was one of the linear sequence linking inputs, including processes, outputs and impact. The process was bio-technical in essence. Science was offering health professionals a positivist avenue in line with the ideology of an era time that believed in technology as a source of universal progress.

Disease control interventions would remain a prominent feature of contemporary Bolivian MoH services. Most people, of course, including those insured by the Social Security, still benefit from free access to vertical programs care.

The contradiction between the doctor's identity and the hyperstandardisation of clinical decision making in (public) health centres was solved by letting him/her having a consultation room (consultorio) or a clinic in which he / she could poach public services patients and, as importantly, in which he / she would remain a *true doctor*.

- Universal access to a package of efficient health interventions.

How does one make PHC commitments compatible with disease control priorities? That was the political challenge of the time in health policy. From the early eighties, political economics (and debt in particular) constrained public services, limiting their capacity to compete in health care delivery with private outlets. To make it politically acceptable, this restrictive process (limiting access to individual care) was formulated in a positive way e.g. in

terms of its ability to 'secure universal access to a public good'. In an influential paper (Walsh and Warren 1979), had claimed that the goal of Alma-Ata was "irreproachable" but "unachievable" in the near future, and described SPHC as a "temporary strategy" based on cost-effectiveness (Cueto 2004).

In the same spirit, the MDGs in health were conceived to strengthen aid coalitions in LMICs around a universal consensus on social objectives. These disease control interventions and risk protection activities were delivered free of charge in public structures, supported by targeted aid and promoted by national policies.

Health economics provided methods of justifying health care rationing in public services e.g. with cost-effectiveness, cost-benefit analysis and DALYs – that in practice had never been used in Bolivia to decide disease control priorities. With the many Global Health Initiatives as starters, the 2003 array of health interventions in Bolivian public services was larger than the pre- Alma Ata package, as it included eighteen programs, including those for maternal and child health. Throughout the entire HSR, western academia followed suit (Unger et al. 2011).

A decade before the Washington consensus, SPHC had been adopted as the main health policy by most LMICs, a move that probably was the most decisive stroke in promoting American interests in the sector (Werner 1998).

- Management property split

As in China and other countries, management property split was used to reduce public budgets for public health facilities, and at the same time to develop commercial practices in public hospitals – thus erasing public/ private sector differences and enabling unbiased, economic competition between the two sectors.

In Bolivia, management property split was introduced with the Bamako Initiative. This Initiative, launched in 1987 during the 37th WHO African Region Conference, resulted from a UNICEF proposal to expand access to PHC with reasonable financial consumers' contributions, while strengthening the sustainability of health services (Kanji 1989;World Health Organization 1988). Apart from that (World Health Organization.Regional Office for Africa 1999), this program was conceived in order to democratise public services, with community co-management and participation, and to improve local capacity of social management; to secure sustained availability of drugs; to promote use of essential medicines; and to ensure permanent funding sources for health facilities.

In Bolivia however, these theoretical assets, that in Africa proved to be practical, were also used (Levy-Bruhl et al. 1997) to introduce the neoliberal management-property split in public hospitals and health centres. Local governments gave those within their jurisdiction different degrees of autonomy - without MoH regulation or community control. Autonomous management was a tool to contain public expenditure and to promote short-term and flexible personnel contracting mechanisms. Bolivian hospitals could then define their own income-generating activities (Tejerina Silva, De Paepe, Soors, Lanza, Closon, Van Dessel, & Unger 2011).

Initially, public hospitals increased their user fees income from 5.6% of total budget to 22.1% (Aillón Terán, Lanza, Urquieta, & Valdes 2006). As of 2007, up to 33% of a general hospital functioning budget in La Paz came from user fees (Municipal accounting system.SINCOM 2008). But from the user viewpoint, out-of-pocket expenditure rose from 27.8% in 1995 to 35.1% of total expenditure on health in 1999 (World Health Organization 2008b), with 5% of all Bolivian households incurring catastrophic health expenditure (Knaul et al. 2011).

There were thus to be seen the same causes and same effects: as in other countries, the reduction in public expenditure on health, more so than the increased user fees, negatively impacted on access to individual care. - which is why we disagree with those voices that blamed individual out-of-pocket expenditure as the key obstacle to care, without considering public expenditure on health (e.g. (James et al. 2006)).

Throughout implementation of management property split, the absence of knowledge transfer was noticeable: the WB and USAID projects did not contribute to preparing hospital managers to run their facilities on a commercial basis – which is understandable from a political and economic perspective: donors did not want to prepare competitors in a market segment that could in the future attract their corporate sector.

- Health insurance “universal coverage” and purchaser provider split

Separating health care providers and purchasers was a move to ease privatisation of both profitable financing and delivery segments. The LMICs health financing market was thus an important factor in international aid policy. The universal coverage strategy proved to be convenient terminology in depicting this restrictive strategy positively in the public eye.

Alleging negative effects of direct payments on equity, international aid agencies promoted health care pre-payment instruments. As in other circumstances, the priority was public insurance for the poor – in fact, concentration of public funds on the poor – in order to drive the rich and the middle classes towards purchasing private insurances, the profitable part of this market.

Consequently, aid terminology and scientific training continually pointed towards reducing financial risks and improving access, with universal insurance coverage.

In summary, even if the separation of financing and service provision (purchaser/provider split) remained partial, Bolivia assumed all the general principles of health reforms promoted by the World Bank and USAID e.g. devolution of management and financing of public health systems, to sub-national levels; contraction of the public health budget; restriction of publicly delivered health activities to a package, ruling out individual health care delivery; disease control and maternal and child health focused on the poor; separation of ownership and management of public health facilities; management autonomy of public hospitals; and universal, public insurance to finance demand in respect of a limited number of health problems.

From this viewpoint, the fate of the ‘purchaser/ provider split’ concept is interesting. It vanished from official speeches even as the separation was becoming effective. However the

'universal coverage' theory that covertly promotes the privatisation / commoditisation of financing in the wealthy purchaser segment progressively replaced it and occupies the same function in the discourse of multilateral agencies.

Independently of these terminology changes, Bolivian health professionals, managers and policy makers all adopted the concepts, representation, 'science' and managerial technologies of the WB and USAID reforms[?].

6. Aid influence on system segmentation and fragmentation

6.1. Section objective

In many countries, as a result of HSR, quality of care and availability of drugs decreased, direct formal and informal payments expanded, and access to health services by the poorest part of the population shrank dramatically (Creese 1997).

In sections 2 and 3, we saw that Bolivia applied quite comprehensively the WB / USAID recommendations e.g. with regard to limiting universal access to a basic package of essential care (in public services), concentration of the same on epidemiological interventions, and decentralisation in the form of devolution of health facilities[1] to local governments.

Per se, this is a major achievement, obtained amid major political instability. Constant changes in governments were responsible for high ministry turn over. This instability was aggravated by the high attrition rate amongst civil servants – everybody in the MoH changing with the party holding the ministerial seat.

Nevertheless, the HSR protagonists managed to overcome this major obstacle to any dissemination of a policy in LMICs. We shall now explore how they proceeded, while at the same time analysing the health cost of their manoeuvres.

[1] De-concentration is the handing over of some amount of administrative authority or responsibility to lower levels within central government ministries and agencies. It is a shifting of the workload from centrally located officials to staff or offices outside of the national capital. Delegation transfers managerial responsibility for specifically defined functions to organizations that are outside the regular bureaucratic structure and that are only indirectly controlled by the central government.
Devolution is the creation or strengthening--financially or legally-- of sub-national units of government, the activities of which are substantially outside the direct control of the central government. Under devolution, local units of government are autonomous and independent, and their legal status makes them separate or distinct from the central government.
Privatization is the divesting of government responsibility for functions and its transfer to voluntary organizations or private enterprises. These parallel organizations are given the responsibility to license, regulate, or supervise their members in performing functions that were previously performed or regulated by the government (Rondinelli et al. 1983).

Although the synergy of WB and USAID projects often made it difficult to disentangle the effects of the two (see section 2), this section analyses the aid strategies to reform the health care system, in particular

- the influence of HSR related activities on health system segmentation and fragmentation
- and in addition, the quality of and access to health care, and health status in general.

6.2. Aid impact on segmentation

6.2.1. Health system segmentation: worst after HSR than before?

We saw that, mirroring a society and a history criss-crossed by violent social conflicts, the Bolivian health system was historically segmented. Since 1953, the Bolivian health system had been structured along three segments:

- tax funded public health services and charity organisations (for the poor);
- a Bismarck-type social insurance system (for wage earning workers and public employees);
- and private commercial clinics (for the rich).

Financially, the HSR worsened this health care system segmentation via 3 main mechanisms:

- The HSR promoted out-of-pocket payments by users of public services because the public service could not be abolished even though public funds were being minimized. As discussed above, its function was (and still is) to offer a market in LMICs to manufacturers of medical and pharmaceutical goods used in disease control; and generating indicators that are politically palatable.

- The public MCH insurance reimbursed facilities on a fee-for-service basis. The combination of both payment mechanisms – out-of-pocket and fee-for-service – in a context in which users and communities were not collectively associated in revenues management (as mutual aid associations are in Belgium, for instance), led to inefficiency and over-consumption both from the providers' and the users' points of view.

- The Bolivian tax revenues allocated to public health were minimised by the international aid organisations as part of their technical recommendations and conditions associated with loans. Local middle classes were more than happy to avoid taxes, as they did not wish to take advantage of a system that was implicitly and explicitly tailored for the poor. This mechanism directed their political will to parties struggling against solidarity across social divides. They devoted most of their household expenditures on health to private, commercial care delivery and financing.

Until today, the proportion of the population in each sector has not evolved much over time. Inequity remained, although the array of social strata-specific expenditure on health per

capita tended to reduce across the MoH / social insurance divide (Table 4). In 1983 72% of the population remained uninsured and public expenditure was as low as USD 5,05 per capita. In 2010, coverage with MoH health funds only was still 67% of the population (Table 4 below) but their expenses per capita were at USD 97.

Table 4: Social Security coverage and expenditure. Bolivia 1956 - 2010

Year	Total Population	Covered population	% of coverage	MoH per capita expenditure (current USD)	Social security per capita expenditure (current USD)
1956	3.070.434	425.027	13,80%		
1966	3.834.333	514.256	13,40%		
1972	4.421.130	759.044	17,20%		
1976	4.878.792	1.029.006	21,10%		
1983	5.674.755	1.589.307	28,00%	5	8
1987	6.145.185	1.245.593	20,30%	17	12,7
1997	7.619.081	1.900.518	24,90%	45	20,19
2007	9.827.522	2.765.271	28,10%	65	18,04
2010	10.426.154	3.397.079	32,60%	97	23,546

Source: Data from Social Security Bolivian Institute (INASES) and WHOSIS

Table 5 reveals the heterogeneity of average expenditure on health for each population segment insured in the public sector.

Table 5: Theoretical coverage; social security and public health insurance in Bolivia (2009)

Age Groups	Total Population (INE 2008)	Population covered by Social Security	Population covered by Public Insurance		Population theoretically covered		Uncovered Population	
			SUMI	SSPAM	Nº	%	Nº	%
0 to 4 years	1.297.050	281.656	1.015.394	0	1.297.050	100	0	0
5 to 59 years	8.054.606	2.276.352	0	0	2.276.352	28.3	5.778.254	71.7
> 60 years	675.987	500.994	0	174.993	675.987	100	0	0
Total	10.027.643	3.066.598	1.015.394	174.993	4.256.985	42.5	5.770.658	57.5

Source: Data from Social Security Bolivian Institute (INASES) and National Institute of Statistics (INE)

The segmentation system is also reflected in the 16 different insurance funds, each with their own funding source and healthcare structure (Table 6).

Table 6: Expenditure and coverage of health insurance funds. Bolivia, 2009

Institution	Annual Expenses (in USD)	Protected Population	Per Capita Expenditure (in USD)	Coverage %
National Health Fund	152.940.198	2.509.632	60,9	84,14%
Oil workers Health Fund	48.884.503	178.469	273,9	5,98%
Private Banks Health Fund	22.675.677	51.172	443,1	1,72%
Public Banks Health Fund	1.322.108	4.462	296,3	0,15%
CORDES Health Fund	9.246.288	60.219	153,5	2,02%
Roads workers Health Fund	4.496.613	28.037	160,4	0,94%
SINEC Health Fund	2.010.287	7.097	283,3	0,24%
University Social Security La Paz	7.245.532	10.982	659,8	0,37%
University Social Security Cochabamba	2.920.156	61.576	47,4	2,06%
University Social Security Santa Cruz	5.018.429	8.528	588,5	0,29%
University Social Security Sucre	1.711.020	4.603	371,7	0,15%
University Social Security Oruro	1.402.175	28.083	49,9	0,94%
University Social Security Potosí	2.204.805	16.933	130,2	0,57%
University Social Security Tarija	1.165.655	2.142	544,2	0,07%
University Social Security Beni	724.322	10.712	67,6	0,36%
Total	263.967.765	2.982.647	88,5	100,00%

Source: Data from Social Security Bolivian Institute (INASES) and National Institute of Statistics (INE)

In 2009, a household survey (INE 2011) showed that the public health sector covered 65.8% of the people attending health facilities, followed by the private health sector (20.2%, while its theoretical population coverage was one third of the population), and the social security sector with 14% only (Dupuy and Ministerio de Salud y Deportes 2011).

To conclude, there are convincing clues to the fact that in 2010, segmentation in the Bolivian health sector had worsened since 1980.

6.2.2. The role of aid in this deterioration

A superficial view could associate this worsening segmentation record with both the HSR and the socialist government's activities. We shall try to disentangle the facts and provide an interpretation of it (see section 4).

We should start by examining the responsibility of aid and its associated health sector reform in the apparently negative evolution of the historic segmentation of the Bolivian health system.

6.2.2.1. Bolstering care for the rich: the PROSALUD experience

Since the mid-eighties, most aid interventions have aimed at commoditizing care delivery and preventing subsidised public services from competing with the private sector in health care delivery – e.g. by limitation of the array of health activities in first line services, and purchaser/ provider split in hospitals. USAID incentivised the development of individual health care services – mostly for the middle class – with the creation of an NGO, PROSALUD, tailored to deliver decent quality, but expensive, individual health care to (poor and) middle income populations.

Today, PROSALUD is the largest Bolivian NGO in health. It was created to be self-sustained from out-of-pocket and fee-for-services payments – but 18 years after its beginning, US cooperation still finances it to the tune of 12% of its operational budget.

PROSALUD has been widely viewed in international cooperation circles as a successful, replicable experiment in private delivery of Primary Health Care. We should like to nuance these views.

In unpublished data, we compared PROSALUD costs, accessibility and quality of care to those of Bolivian public services in a sample of 8 PROSALUD / MoH-paired health centres (HC) over the 2005-2007 period. Our cost-accounting analysis consisted of studying operational costs recorded in HC accounts and in sensitivity analysis, done in order to assess the stability of the conclusions reached. At the side of this central methodology, a literature review, direct observation of health activities and HC staff interviews were aimed at confirming and elaborating the conclusions. Our findings were that

- PROSALUD better integrates health care than MOH facilities, but its quest for self-financing strained both care quality and affordability:
    - PROSALUD HC unit costs are consistently higher than those of MoH and are not affordable for at least two thirds of the Bolivian population.
    - the sub-standard quality of curative care in MoH HCs results from over-standardisation, non-patient-centred care and poorly integrated activities
- Its HCs produce consistently fewer preventive and more curative care than MoH ones.
- PROSALUD cannot be labelled a “for-profit NGO” (a category worth mentioning in national policies, if only in connection with tax), as no private investment is permitted and no benefits shared due to a chronic deficit.

The PROSALUD model can thus rightly be criticised from an equity viewpoint. Being financed by out-of-pocket payments (and a decreasing USAID subsidy), this NGO reduces middle class capacity to contribute to national solidarity in health and shrinks its political will to do so.

Nevertheless, although accessible mainly to wealthier urban Bolivians, the PROSALUD model is probably replicable in settings in which poor populations predominate, and costs and prices charged are decently subsidized by the government. Instead, being restricted to

wealthy neighbourhoods, this model harms national solidarity by not favouring any solidarity in health across social divides. Its experience could nevertheless usefully inspire the design of public HCs. Extrapolating this conclusion at national policy level, Bolivia could finance a multi-institutional, not- for-profit health sector, e.g. on the ground of management contracts. Key contract conditions would be community participation, with co-management and regulation by community organisations (see section 10.4).

6.2.2.2. Pulling care for the poor: efficient disease control programs in (public) health centres

In many rural and peri-urban areas, people once relied upon (public) health centres for individual care. Admittedly, the extent to which these care centres abided by contemporary standards such as bio-psychosocial care and patient-centeredness is debatable: they varied from the best, with a rural GP, married to a local woman, to the worst, controlled by an urban absentee doctor...

Hence, in these health centres disease control and protection of high risk groups replaced individual health care … with negative consequences not only for access to care, but for the new function of public services – primary and secondary prevention - as both require some level of individual care.

As with WB and USAID projects, the HSR made access to care worse amongst the poor - the 80% Bolivian population that relied on public services for delivery of individual health care. The numerous aid disease control programs practically eliminated individual, discretionary health care from first line health services, that is, the facilities delivering highly decentralised individual care, close to where people live. Meanwhile, care remained at an unacceptably low quality level in public hospitals.

We have seen in sections 2 and 3 that the mechanisms of care substitution by disease control activities were relatively classical (Unger et al. 2003a), with changes in public services at various levels: structural (in the mid-level health administration in particular), operational (with hyper-standardisation of clinical practice), psychological (with new professional identities) and cultural (with representations, terminology and knowledge largely extracted from neoclassical economics).

The aid projects aimed at securing segments in the poor population with selective health insurance. This was the case of the selective insurance for pregnant women, under-fives and the elderly. Each of these insurances had its own management structure and financing. Recently, the health system integration further suffered, because new insurances came in as UN- promoted “health coverage” initiatives (Buse and Walt 2000;Hafner and Shiffman 2012;Harmer and Bruen 2011;McKee et al. 2012;Murray et al. 2011;Subramanian et al. 2011) and as public private partnerships came in (Public-Private Mix (PPM) for TB Care and Control (World Health Organization 2012a), Corporations, GAVI’s funding needs (GAVI Alliance 2012), Partnership for Maternal, Newborn & Child Health (PMNCH) (The Partnership for maternal 2012)) - which will further deepen segmentation.

Recently, the system segmentation has also been aggravated by a political factor. Simultaneously, 3 regional governments (Beni, Tarija and Santa Cruz) implemented an insurance system limited to formal workers, with resources from the newly nationalized hydrocarbons industry. The Bolivian health system thus finds itself segmented along both social and geographical fracture lines.

6.2.2.3. Contemporary aid and host health systems: deepening segmentation

We have seen that international aid deepened a pre-existing segmentation. In turn, this segmentation led to fragmentation (see section 6.3) and ineffective use of sector resources, all concurring to strain the access of the poorer and more vulnerable populations (Pan American Health Organization 2007b). With economic competition as the only driving force, health care delivery concentrated on the urban wealthy, and, to a lesser extent, on the salaried population in general - leaving unprotected the economically and socially marginalized – in a country where 60.1% of the population lives in poverty (based on a headcount ratio at the national poverty line) (The World Bank 2012a).

For most Bolivians, segmentation of health financing (e.g. with heterogeneous benefits plans) has merely meant increased health costs and catastrophic expenditures.

For those many who were reliant on (public) health centres, HSR has meant loss of access to general practice care.

The future is not bright since the recent development of the health insurances market (and its political wing, the 'universal coverage' movement) will deepen health systems segmentation.

6.3. Aid / HSR impact on system fragmentation

In first line services, vertical programs reduced the availability of GPs for curative care in (public) health centres, which was compounded by multiple hierarchic lines – one of these being the disease control program. It should be observed that such a managerial pattern imposed on public facilities is particularly noticeable in the corporate world because it violates the basic principle of command unity. Curative care was entrusted to a wealth of private for-profit organisations (e.g. PROSALUD). Public hospitals were excluded from assistance in the functioning of their systems by granting them managerial autonomy (see section 5.3)

As a consequence, USAID objectives – administrative and political decentralisation, fertility and disease control, protection of maternal and child health - may have worked against each other while competing (Tejerina Silva, De Paepe, Soors, Lanza, Closon, Van Dessel, & Unger 2011) for the limited MoH resources that were constraining the health system operations (see section 2).

To illustrate the importance of these bottlenecks, one must recall that between 1996 and 1998, salaries represented 95% of the MoH functioning expenditures (Viceministerio de Presupuesto y Contabilidad Fiscal.Ministerio de Economía y Finanzas Públicas 2012).

Fragmentation of the Bolivian health system was such that four different official powers (municipal, regional and national government bodies and international aid agencies) had a mandate on each health centre, with regard to infrastructure, drugs, salaries and disease control programs.

Likewise, serious mistakes were made in national HR management – because of poorly planned HSR. For instance, human resources of public services belong today to:

(1) those dependent on regional authorities
(2) those in charge of vertical programs, often paid with aid funds
(3) health professionals and administrative staff contracted by municipalities
(4) personnel hired with autonomous funds, often on the basis of political affiliation.

The four categories coexisted in one health facility, which made public hospitals virtually ungovernable, paralysed local health systems and negatively impacted on the entire health care pyramid. Besides, the peripheral (district) State authorities administering care coordination (that in fact had never been very effective) were operationally, if not administratively, neglected.

Competing health priorities among organisations, vertical program approaches, and lack of coordination among governments and development partners has resulted in missed opportunities.

Numerous uncoordinated, competing health agents have led to inefficiencies in the health system: overlaps, duplications, serious deficiencies in medical communication, incompatible technologies, service delivery vacuum and medical deserts.

Segmentation in itself has contributed to fragmenting the Bolivian health systems, via three mechanisms:

- excessive decentralisation in public institutions (Collins and Green 1994;Green et al. 2000);
- multiple and contradictory authority lines due to parallel and segmented financing, insurance dictating to health services' organisation, their terms of reference and managed care;
- With devolution, hospitals depending on local governments (municipios) were less accessible to patients referred from outside their municipality. Regional hospitals fell under local government's authority while retaining, in theory, regional responsibilities.

7. Aid influence on access to care and health status

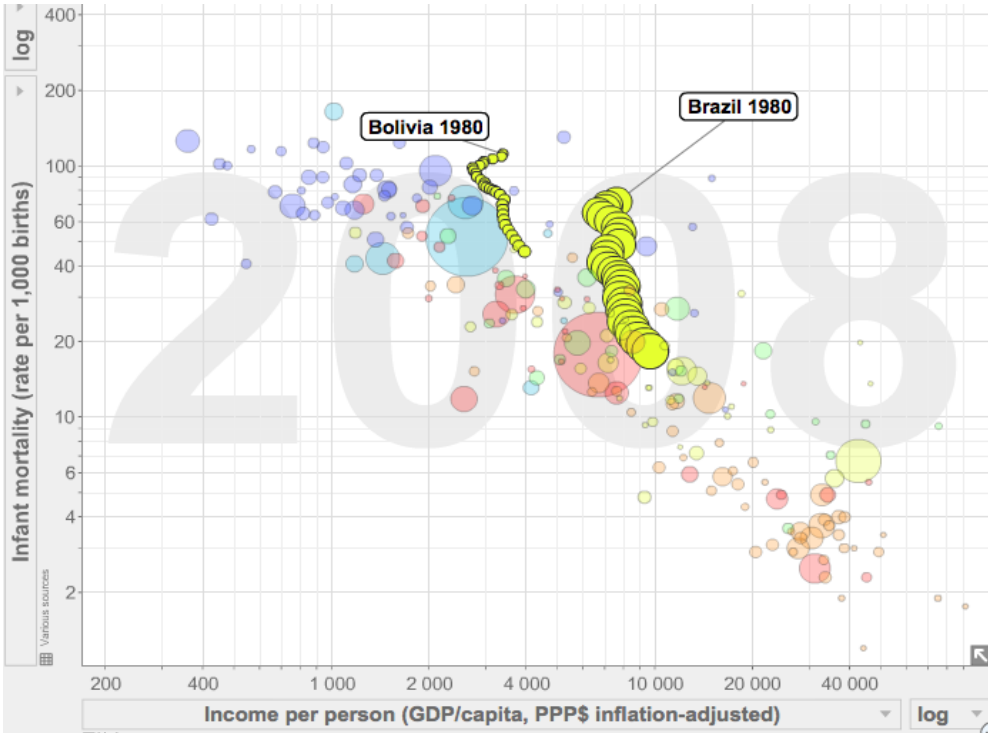
7.1. Influence on population health status – an international comparison

As in the last three decades of the 20th century, Bolivia was still scoring lower than any other Latin American country in health and related equity indicators in 2005 (Pan American Health Organization 2009): an under-fives mortality rate of 63 per thousand live births (105 in the lowest income quintile), a maternal mortality ratio of 229 per 100,000 live births (354 in Potosí, the poorest Bolivian region), and 99% vs. 34% of births attended by skilled staff in the highest and lowest income quintile respectively (De La Galvez-Murillo 2002; World Health Organization 2008b).

IMR and MMR, two key indicators of MDGs did progress over time in Bolivia. However, progress was slower in both sectors than that achieved in Brazil (diagrams 1 and 2), for instance, a country proportionately much less aided than Bolivia (USD 2.122 per capita in Bolivia against USD18 in Brazil in 2005). This slower development is unexpected, because

- the initial situation of Brazil was far better than that in Bolivia in 1980 (about 50% lower)
- it is known that demographic progress becomes harder to achieve and cost increases, as mortality indicators go down.

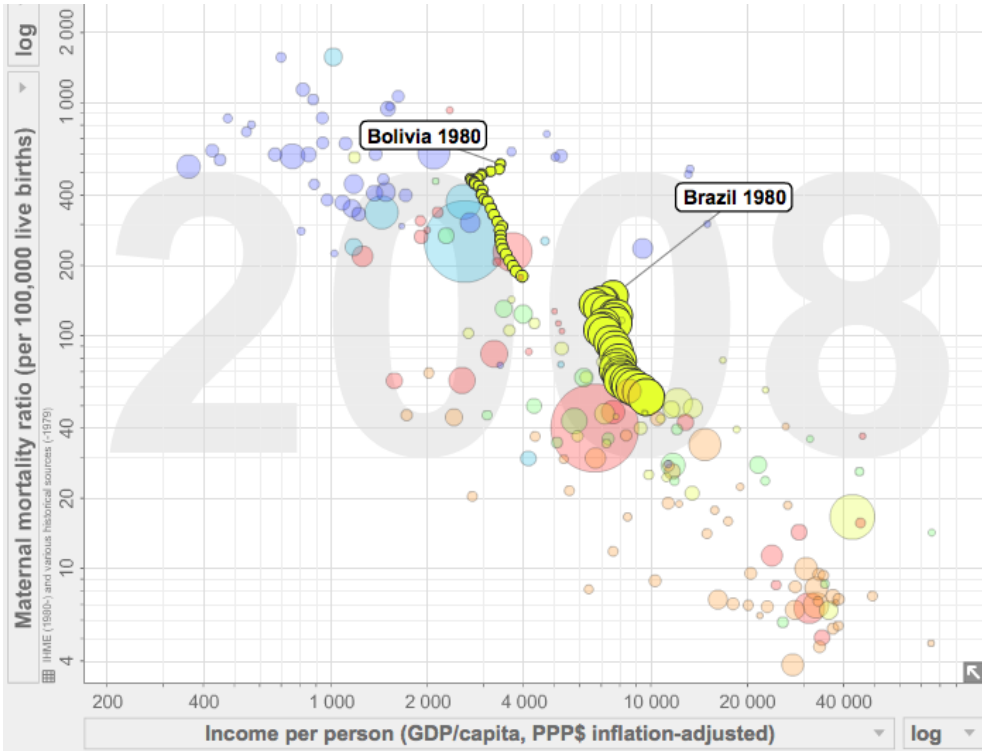
Diagram 1: 1980 – 2008 evolution of Brazilian and Bolivian IMR



Caveat: we have already said that MMR is more exclusively influenced than IMR by equitable access to quality health care. Consequently, the IMR evolution revealed by diagram 1 cannot merely be attributed to the consequences of aid and HSR related activities. It represents an

argument among many others in a multitude of clues suggesting a rather slow improvement in Bolivian demographic indicators.

Diagram 2: 1980 – 2008 evolution of Brazilian and Bolivian MMR



In 2005, before the socialist party ('MAS') gained victory in the elections, Bolivia was still scoring lower in health than any other Latin American country (Pan American Health Organisation, 2009) with:

- an under-5 mortality rate of 63 per thousand live births (105 in the lowest income quintile);
- a maternal mortality ratio of 229 per 100,000 live births (354 in Potosí, the poorest region in Bolivia).

While bearing in mind the relatively narrow domains of aid intervention, these health status indicators raise particular concern.

7.2. Aid impact on access to / utilisation of individual care

Access to and quality of care are key determinants of a population's health status:

- Several studies (Dowling 1998;Lee et al. 2003;Wan et al. 2002) have shown that an integrated health care delivery system improves accessibility of care, efficiency and responsiveness of care services

- To the contrary, most problems in poor countries health systems (Pan American Health Organization 2011) are known to be closely linked to their fragmentation and segmentation (Pan American Health Organization 2007a).

Consequently, the Bolivian demographic and epidemiological indicators, 'which remain the worst in South America, shed a crude light on the present health system's fragmentation and segmentation.

If most people were lacking adequate access to care even before the health sector reform – an estimated 54% in the 1970s (Iriarte 1997) - they did not gain access after its implementation either.

In a 2002 survey, 54% of the population reported having been sick during the last month but 23% did not receive any institutional care when it was needed (Narvaez and Saric 2004).

Again in 2002, the MoH was delivering health care to 38% of the population, the social security system formally covered 26%, but only 15.8% in practice (Pan American Health Organization 2009), and the not-for-profit facilities fewer than 10%. The remaining 36% had resort only to commercial services, often meaning they had no access at all (Aillón Terán and Lanza 2005).

A national survey found that in 2002, 77% of the poorest population quintile did not have any health insurance and only 4% were covered by social security. In the richest quintile these indicators were at 57% and 37% respectively.

The same year, 59% of the non-poor population accessed services when needed, while just 44% of the poor and 35% of the extreme poor were able to do so (Narvaez & Saric 2004).

As shown in section 4, in 2005, even public services were financially inaccessible to around 70% of the population and were used only by the richest quintiles (1.1 sickness episode/ inhabitant/ year in quintiles 1 and 2) while the poor remained underserved (0.5 sickness episode/ inhabitant/ year in quintiles 4 and 5) (Cuellar, Newbrander, & Price 2000).

Accessibility issues in public services were not limited to financial obstacles: 99% versus 34% of births were attended by skilled staff in the highest and lowest income quintile respectively (De La Galvez-Murillo 2002;World Health Organization 2008b). These figures reveal the importance of other factors that may hamper utilisation of care (geographical accessibility, psychological, intra-institutional, pharmaceutical, cultural).

In 2009, 42,8% of people needing healthcare did not get institutional services, and 3,5% perceived care as inadequate (Table 6). 46,3% of the population still had no adequate access to health services that year (Dupuy & Ministerio de Salud y Deportes 2011). Furthermore, 53% of public facilities were health posts led by an isolated nurse with very limited clinical training and problem solving capacity (Aillón Terán, Lanza, Urquieta, & Valdes 2006).

Table 7: 2009 Access to institutional and non-institutional care amongst the population in need (in the month prior to the survey, by subsector)

Place of Care	**Care for the ill**	
	N°	**%**
Public Subsector (institutional)	831.041	36,4%
Social Security (institutional)	177.501	7,8%
Private Subsector (institutional)	251.751	11,0%
Institutional care in other places	48.287	2,1%
Pharmaceutical	197.363	8,6%
Traditional Medicine	35.556	1,6%
Other People (family / other)	392.889	17,2%
Not Attended	351.225	15,4%
TOTAL Bolivia	2.285.613	100%

Source: (Dupuy and Ministerio de Salud y Deportes 2012).

To conclude:

- either, access to care improved quite moderately over the last two decades or, more probably, stagnated during this period
- one can reasonably admit that the health policies consistently implemented during the 1986 – 2005 period critically contributed to segment and fragment Bolivian health services
- most people either lost access to general practice or retained their existing lack of access to it over this 20 years
- epidemiological and demographic statistics improved very slowly.

These are the elements available to us in answering the research sub-question on the impact of aid and HSR on access to individual care.

8. Did the socialist government prove capable of correcting the problems?

After a severe political crisis, Bolivians elected a government that espoused a socialist and indigenous discourse in 2006.

The social dislocation caused by the neoliberal revolution and the repression associated with the US-inspired coca eradication programme catalysed popular uprisings and mass rejection of neoliberal economics (Kohl and Farthing 2006;Zegada et al. 2008). Inevitably, the liberal democratic system, which had returned in 1982 after two decades of military rule and was plagued by high levels of corruption, collided with the increasingly dispossessed Bolivian citizens.

The poor, still 60% of the population in the middle of the last decade, were now looking for alternative forms of association and political activism. This is how the *Movimiento al socialismo* (MAS) (Movement towards socialism) surged: as an umbrella for the social movements and for alternative political actors. This process culminated in the election of Evo Morales to the presidency in 2005 (Hylton and Thomson 2007).

One of the main objectives of the new, socialist government was to pass a new political constitution. These two events could have paved the way to in-depth revision of health care policy. With regard to our research question attempting to gauge the sustainability of HSR over time, the thesis section 3 (Tejerina Silva et al. 2009) assessed the health services policy of the current socialist government since 2006 and contrasted it with previous policies.

To this end, it comparatively analysed the health policies of the socialist governments of Ecuador and Bolivia, in order to compare the long-term effects of neoliberal health reforms and relevance of current public health policies in these two countries. Section 4 thus examined and compared if and how Bolivia and Ecuador socialist governments redirected their inherited health policies. After sketching the post-reform features of the two health systems, it explored efforts to rebuild primary health care, identified gaps in health care policies, and delineated avenues for improvement in countries in which neoliberal reforms have left populations with restricted access to care in fragmented health systems.

In the present section, we:

1. review the recent history of socialist health policy in Bolivia
2. present the features common to Bolivian and Ecuadorian socialist policies
3. provide evidence of commonalities in their policy features, with reference to past policies and neoliberal economics principles
4. provide evidence of those aspects neglected by the two socialist health policies
5. make general policy recommendations to governments concerned
   - with improving equity in access to quality individual health care
   - and not primarily with universal (insurance) coverage.

8.1. Recent history of the Bolivian socialist health policy

The following policy historiographical sketch *sheds light on* the features revealing continuity / consistency between Bolivian health policy and neoliberal health policies.

This exercise does not show any absence of will on the part of decision makers to eliminate the consequences of neoliberal policies on health system structure(s). On the contrary, many were sincerely committed to a health policy endowed with a social, not commercial mission. We sincerely appreciate this commitment and know the price that many have paid for remaining consistent with a demanding social and political program.

But it is precisely because the loyalty of many of these health policy makers cannot be questioned that the socialist experience of these two countries permits identification of the factors of long term stability of health systems geared towards commoditisation of health care delivery and financing (in the Bolivian environment at least).

In this section, we use social sciences concepts to articulate the practical difficulties encountered by the key actors in the Bolivian health system.

8.1.1. First years government

Under the constitution approved in 2009, the state had to guarantee universal right to health and access to care e.g. with a united health system. In addition, care was to be given free for users at the point of delivery.

We have seen (section 4) that the government operational model for Primary Health Care (2008), named Intercultural Community Family Health (SAFCI), put emphasis on community health promotion as the key task (the "mission') of first line health care teams. This primary care model also included a range of measures spanning from traditional medicine to health services control by community organisations, and from inclusion of social workers in health teams to coordination between the three system levels. Access to individual health care was not mentioned as such: the SAFCI model had *no apparent concern for modern, curative health care delivery*.

Although the new Constitution foresees a comprehensive and universal model of health care delivery, the application model is worth discussing. Named Intercultural Family and Community Health (Salud Familiar y Comunitaria Intercultural, SAFCI), it is based on four declared principles: community participation, inter-sectorial coordination, inter-cultural care delivery and care integration (Ministerio de Salud y Deportes Bolivia 2007).

This model allocates a few tasks to public first line services: health education and promotion; disease prevention; identification and improvement of socioeconomic, environmental and cultural determinants of health. Importantly, it does not require a comprehensive, effective pharmaceutical policy in the publicly oriented sector – which is, however, a key concern of the Bolivian population. Effective supply-side strategies were needed in the socially oriented sector but were unequally implemented. Additionally, the drug market should have been

controlled and regulated but the Supreme Decree 1008 (Gaceta Oficial del Estado Plurinacional de Bolivia 2011) has not yet been implemented.

On the ground, in field conditions, the SAFCI health care model has largely overlooked curative care delivery, leaving scarcely any public and cooperation resources earmarked for disease and control of specific health problems (family planning, HIV/AIDS, malnutrition). Therefore, individual (family medicine and hospital) health care has remained largely privatized and commoditized.

In 2009, the MoH started securing *conditional cash transfer* to attract pregnant women and under-two children to health services. Besides being an implicit recognition of the public services lacking public acceptability, this move showed that public policy continued to be *focused on prevention* in high-risk groups, which were still seen as the object of vertical programs.

Meanwhile, control of malnutrition was also reorganised as an independent program partly *vertical* and partly integrated into the health system[2]. All these initiatives had vertical management, structure and provision of services.

Caveat: we do not criticise the existence per se of vertical programs, *but merely the fact that disease control and prevention programs should not be vertically organized (Unger, De Paepe, & Green 2003a)*. By contrast, spraying insecticides in urban neighbourhoods should be organised along vertical lines.

Medical practice in public services remained stubbornly fragmented: biomedical on the one hand, and social on the other…with no practical connections between the two.

One particular instrument illustrates well the continuity of disconnected bio-psycho-social clinical practice inherited from past health policies: an administrative tool promoted by the new government administration named 'family folder'. This family medicine-specific document, influenced by its Cuban equivalent, was a document held in each health centre that gathered information on the composition of each household and the health risks that its members were undergoing (e.g. access to water and sanitation, promiscuity, number of people living under the same roof, etc.).

First line services teams gathered this information while regularly visiting households and communities -– and thus being absent in (public) health centres where patients required care. Allegedly, these health professionals were 'working' on the social determinants of health but had no resources committed to the quite expensive investments required for water and sanitation activities or for large-scale psychosocial programs (e.g. to tackle urban violence).

[2] Actually, 57% of the USD 82 million projected were actually financed.

Even if the implementation of the health promotion model of care in (public) health centres remained partial, and even if survey data are not yet processed, some of its consequences may yet be evidenced:

- The absences of health staff drove many who had the needed resources to use private clinics;
- Information on individual / family social determinants of health was not used by doctors during curative consultation because of the lack of adequate training on bio-psychosocial care delivery;
- A huge amount of information remained idle in large piles of documents.

From a health system viewpoint, this vertical strategy, introduced by the socialist government and not yet fully implemented in 2012, further *fragmented* the health system, further *bureaucratised* health care delivery, and *reduced accessibility* of (general practice / family medicine) health care a little further too.

8.1.2. Recent proposals

In 2011, the Ministry of Health appeared to realise the importance of a sound health care policy. It successively tried, but failed, to pass three laws:

- a first was aimed at integrating social security into one single health system. It was rejected by the national confederation of workers unions with street demonstrations, on the ground that the government was confiscating the social insurance funds, which workers considered their property.

  N.B. In the absence of any alternative option (public care unacceptable, private care unaffordable), the behaviour of these workers was to be expected. This observation will be revisited later to justify a health policy focus on publicly oriented first line health care services, aimed at generalizing access to bio-psychosocial care (see section 10.2).

- A second project was aimed at creating a system with universal coverage, unlimited access to integrated health services at all levels of care in public facilities, and with the option to integrate social security funds, if agreed. The ministry of economy rejected it because of incompatibility of the funding projected until 2015 (USD 827,688,075 yearly) with government resources.

Table 8: Planned functioning costs for the United Health Systems by levels of care and beneficiary groups (in US Dollars)

Health care activities	1st year	2nd year	3rdyear	4th year	5th year
Full health care services for under 5	10,430,001	10,358,302	10,275,645	10,197,483	10,095,452
Full maternal care	2,253,865	2,228,504	2,199,679	2,170,648	2,135,318
Full care services for elderly	36,872,343	38,298,162	39,743,678	41,270,431	42,765,915
Full care services for disabled	585,247	595,723	606,088	617,270	627,572
Full care in first line centres	51,121,129	52,170,433	53,214,769	54,335,644	55,383,832
Outpatient consultation in basic hospitals	2,391,878	2,440,973	2,489,836	2,542,280	2,591,323
Outpatient consultation in complex hospitals	473,099	482,810	492,475	502,848	512,548
Prioritized package of care in hospitals	3,991,110	4,098,124	4,205,563	4,319,891	4,429,270
TOTAL	108,118,672	110,673,031	113,227,733	115,956,495	118,541,230

Source: Informe Técnico sobre el Anteproyecto de Ley del Sistema Único de Salud. Presentado al Gabinete de Ministros en noviembre de 2011 (Ministerio de Salud y Deportes Bolivia 2011)

N.B. The issue here was that no priorities, no sequence, in fact no strategy had underpinned this proposal –whereas the available envelope could have been sufficient initially to finance decent first line services, as well as their management and coaching. (see section 7)

- A third draft, with an estimated cost of 118.5 million (additional to the current budget for salaries) (Table 8) is currently discussed amongst several ministries and in civil society. It foresees several benefits in public facilities over a five year period:

    a) Integrated services in the three levels of care, free for children under five, women during pregnancy, childbirth and postpartum, people over 60 and people with severe disability. Only this last group is thus added to those currently protected by the public insurance;
    b) free (medical and dental) diagnosis, treatment and drugs in HCs;
    c) free outpatient consultations in public hospitals for patients referred by HCs;
    d) and a free package of services for selected health problems in all level facilities.

We contend that this policy still abides by neoliberal health economics principles, that is, in order:

a) *Segmentation* of 'benefit' users

b) The *most expensive care for the patient remains user-paid* (admission in hospitals). Notice that, by contrast, first line out of pocket payment does not really strain access to care (Carrin and James 2005;Orem et al. 2011) and is open to co-management of public services with the community, an option that was not considered by the government.
c) Same comment.
d) This free package amounts to restricting use of the term 'public good' merely to *disease control* in the health care sector – although, by comparison with past neoliberal health policies, this package may possibly be extended to the control of a range of diseases from communicable to chronic.

8.2. A comparative study of Bolivian vs. Ecuadorean socialist governments' health policies: a common, persisting neglect of access to - and quality of - individual health care

8.2.1 Common concerns

Here follows the list of health policies priorities common to the Bolivian and Ecuadorean socialist governments (see Section 4):

Control of health-related social determinants (through health services)

This priority activity entailed brigade home visits to identify family social risks. Today, both countries focus their primary care policy on household and community-based promotion and prevention. No strategy to tackle each detected social risk was released by either the Bolivian or Ecuadorean administrations. This was to be expected since most social determinants identified in quantitative surveys are not manageable via health services, but require sanitation engineering, housing and water supply.

Health care policy

The two countries' governments repeatedly attempted to unite their financing and delivery health care systems. They especially aimed at bridging the key segmentation that split the public service from the social security service. All these attempts have so far failed.

Whereas in Bolivia, three MoH plans for universal access to care in public services have been rejected by the government, Ecuador appears to be ahead of Bolivia in improving access to GP and hospital care (Table 9).

Health economics

Both governments have aimed at relatively stable health economic indicators. Social and international configurations have been stable enough to explain constancy of macroeconomic health indicators after the HSR period and during the socialist government. Here are some data (Table 9):

Table 9: Evolution of the proportion of insured, and of public expenditure on health per capita and the proportion of government expenditure on health in Bolivia and Ecuador.

	Bolivia		Ecuador	
Indicator	**2005**	**2010**	**2015**	**2020**
Per capita government expenditure on health at average exchange rate (USD)	39	61	41	122
General government expenditure on health as a percentage of total government expenditure	10,9	7,3	5,6	7,3
Social security expenditure on health as a percentage of general government expenditure on health	44,4	38,6	53	39,6
Social security coverage	27%	33%	15%	27%
Public Health Insurance coverage	13%	14%	22%	28%

Source: World Health Organization Statistical Information System (World Health Organization 2012b)

- In 2010, the national health insurance fund was providing 13,6% of Bolivians with access to individual health care at a cost of 70 USDUS per capita. This unit cost had been relatively stable over time during the previous decade (61 in 2003, 69 in 2006).

> Based on this figure (echoing major administrative overheads), the MoH requested in 2007 (when national health expenditure was USD652.765.000 and the public sector's was USD264.573.778) a budget of USD827,688,075/year to cover the 10,290,003 Bolivians. The Minister of Economy rejected this proposal in 2008.
>
> Today, the national health budget is likely to increase by USD118,541,230 only in 2016 and has been designed to remove users' costs from public health centres and to secure free access to a minimal package of hospital care (MoH economic projection (Ministerio de Salud y Deportes Bolivia 2011)). The majority of municipalities and regional governments approved a plan of 'partial universal coverage' foreseeing no cost for users at first level and a free package of health benefits in the public hospitals.

- Prospects to increase public expenditure on health are unlikely to significantly reduce out-of-pocket expenditure. Over a period of (albeit modest) political changes, the out-of-pocket expenditure declined only from 33% to 27% between 2003 and 2010 and increased in absolute terms from 1,158 to 2,086 (10^3) bolivianos. This happened in spite of the sustained growth of the Bolivian gross domestic product since 2004 (Table 10).

Table 10: Economic and health economic indicators, Bolivia (2002 to 2007)

	2002	**2003**	**2004**	**2005**	**2006**	**2007**
	(1USD=7.50)	**(1USD=7.84)**	**(1USD=8.06)**	**(1USD=8.08)**	**(1USD=8.03)**	**(1USD=7.67)**
GDP (in 10^3 USD)	7.790.133	7.895.976	8.638.476	9.532.651	11.425.628	13.430.141

Health Exp (in10^3 USD)	541.546	452.549	499.080	506.892	579.055	652.765
Health Exp as GDP %	6.95%	5.73%	5.78%	5.32%	5.07%	4.86%
PH Exp. as % of GDP	1.46%	1.95%	2.01%	2.04%	1.94%	1.97%
Expense in Social Sec. as GDP %	2.86%	1.84%	1.86%	1.78%	1.61%	1.39%
Private Health Expense as % of GDP	2.64%	1.94%	1.91%	1.50%	1.52%	1.50%

Source: Data from Health sector national accounts (Avila et al. 2012)

Notice: although the yearly per capita health expenditure increased from 389.3 in 2003 to 723.3 Bs in 2010 Bolivia still ranked at the lowest level in the region. (World Bank 2012b)

- Although the 2010 public sector health expenditure (2,969.1 million bolivianos) was 2.8 times higher than in 2003, the 2010 social security expenditure on health still represented 68% of it (allocated to less than 15% of the total population).
- The proportion of public (to total) expenditure on health decreased from 10.9% in 2005 to 8.4% in 2010 (Table 9) – with 5% allocated to the entire population and 3.4% to the insured (Avila, Alvarez, Cardenas, & Ministry of Health and Sports Bolivia 2012). Notice that public expenditure on health essentially mirrors salaries and two general health insurances targeting specific population segments (mother and child, SUMI, and the elderly, SSPAM).
- In 2009, the local governments still limited health facilities funding to 13% of their resources.

It is likely that this stability in macro-economic health indicators mirrored some socio-political stability in government spheres, or rather a new balance of powers within the middle class – not in the entire society – because economic behavior with regard to health care is similar in any of its components.

We do not dispute a real power shift after 2006 within the middle classes, entailing power swings from metis to Indians, from East to West, from Santa Cruz to La Paz, from cattle ranchers to agriculture landowners, from rural to urban, from wage earning to self-employed, from Quechua to Aymara. Obviously, this list should be interpreted cautiously, as reflecting subtle rather than major changes in state decision-making spheres.

8.2.2. Common neglects in the 2 countries

Here follow a list of what both countries' socialist health policies ignored or did not treat as a priority, in the form of several themes key to individual health care policies:

- Absence of reflexive methods to improve the quality of individual health care (in first line facilities or in hospitals)

- Neglect of bio-psychosocial and patient centered care in first line services
- Vertical programming of activities in first line services
- Deficient management of individual health care delivery.

Again, this should not be read as revealing deficiencies in MoH decision makers, but may sometimes be a result of conflicts. For instance, the Bolivian Government rightly aimed at reducing doctors' dual employment (and the associated patients' poaching practices). Unfortunately, an acrimonious conflict over work hours and salaries terminated this attempt.

Nevertheless, these are reasons to suspect that the socialist government will not easily alter the historical Bolivian health system segmentation and fragmentation, because of the country's social political configurations – unless it more clearly defines its health development strategy.

8.3. Why could the socialist governments not reverse the (neoliberal) health system reform? Reasons for long term HSR sustainability

Alongside SAP reforms, Latin American health policies were subject to contradictory initiatives. In 1990, following the re-establishment of democracy, Chile started reversing its neoliberal reform (Unger et al. 2008). In 1994 Brazil introduced its Family Health Program (*Programa Saúde da Família*), promoting an integrated care model embedded in a wider social policy (Cohn 2008). In the first decade of the 21st century, more Latin American countries distanced themselves from neoliberal models and played an active role in the revival of primary health care, translating a political commitment into a strategy aiming at universal provision of health services (Rifkin and Walt 1986). Bolivia, however did not manage to reverse the consequences of HSR.

We have seen that the stumbling block of the socialist governments' health policy has to be found in one of its components: individual health care delivery policy.

Unlike many other Low and Middle Income Countries, however, and unlike most of their own former governments, Bolivian and Ecuadorean socialist health policies did not neglect individual care, although they failed to issue a new, socially motivated policy or to implement it.

With regard to implementation, the burning issue in implementing a new health care policy appears to be in the middle line management (Unger et al. 2000): health care is not produced as easily as Coca-Cola cans. In post-HSR Bolivia, most doctors were not familiar with the practice of bio-psychosocial and patient-centered care and the knowledge of the old village doctors had been lost. Mirroring this medical concern at policy making level, staff was generally lacking a vision of good quality care, because during more than a generation, they had gained experience in public and private services ruled by neoliberal principles.

To understand this apparent "lack of vision", two viewpoints may be usefully explored: the cultural and socio-political dimensions of HSR.

8.3.1. A cultural insight into health system reform

This tale is about an unequal struggle, between a 'scientific ideology' promoted by the most powerful multilateral and bilateral agencies trained in highly praised academic departments and one of a few left wing social activists who eventually acquired senior decision making positions in public policies.

8.3.1.2. A 'scientific knowledge' monopoly

During the HSR, many staff at the central level of MoH had no concern nor vision of the changes needed to improve access to quality care, and still less to patient-centred and bio-psychosocial care. Furthermore, hospital activities were generally perceived as not being required to provide good first line medicine.

Aid agencies experts had the monopoly on 'scientific knowledge' in the face of their Bolivian counterparts, not only because they supported their statements with funds, but because they had been trained in Western academia (public health academic departments). Besides having this prestige, they knew well the 'scientific' knowledge that supports decisions based on neoliberal economics (as, for example, whether to treat individual health care as a public good or not), and which is available in scientific publications.

These public health publications were increasingly concerned with issues such as: governance, purchaser / provider split, management property split, contracting out, efficient disease control, performance based management, universal insurance coverage, etc.

These originally English, economic terms that have vaguely associated managerial and medical connotations, have been said to have limited validity (Grindle 2007).

Unwittingly, many Bolivian health professionals became intellectually submissive to neoliberal thinking by allowing their (medical, social, political, cultural) knowledge to be substituted by economists' concepts. Local experienced doctors were not involved in the policy discussions held at La Paz. And local academics rarely disputed the dominant scientific paradigms related to HSR.

Some did, with great courage, but faced great difficulties in communicating their critical observations and analysis to social political organisations, in attempts to feed political debates on health policies. No independent science means no democracy…

After surveying several years of literature research on this topic, I am tempted to say that problems with the scientific literature addressing health care in Latin America are numerous. The first is its relative scarcity. Second, the available evidence is contradictory. I should like to underline here two such fractures revealing systematic contradictions:

a. between grey and some scientific publications; and
b. between medical and political sciences journals.

a. Grey, official and scientific publications have been at odds in numerous circumstances. This clearly appears when we disentangle the analysis of health sector reforms that appeared as being an apology for, or rather a criticism of, the neoliberal health economics that grounded the 80-90s Latin American Health Reforms.

i) Those documents produced by the cooperation agencies themselves usually highlighted the reform achievements, and explained some of their shortcomings as errors e.g. in project implementation (Akin, Birdsall, De Ferranti, & The World Bank 1987;Berman 1995;Blas 2004;Blas and Hearst 2002;Commonwealth Business Council. and Commonwealth Secretariat. 2004;Crocco et al. 2000;Granados 2002;Hearst and Blas 2001;Krasovec and Shaw 2000;Londono and Frenk 1997;The World Bank 2004;Vidal Fuertes and UDAPE 2002;Walt and Gilson 1994;World Bank Human Development Department 2001). Each bi- and multi-lateral agency had its own body of concepts and criteria - often available on the net – which led WHO to try to order them, with limited success (World Health Organization 2007) in steering country-specific cooperation plans but with some success in spreading the health economists' terminology while identifying it with public health science.

ii) The scientific literature is more contrasted. In addition to the many publications supporting the neoliberal reforms or featuring their technical tools, there is an array of scientific public health and health economics publications reflecting the impact of negative reforms on care, services and health status (Abrantes Pego and Almeida 2002;Almeida et al. 1999;Almeida et al. 2000;Almeida 2002a;Almeida 2002b;Almeida 2006;Armada, Muntaner, & Navarro 2001;Chernichovsky et al. 2009;Homedes et al. 2005;Homedes and Ugalde 2002;Homedes and Ugalde 2005a;Homedes and Ugalde 2005b;Homedes and Ugalde 2005c;Unger, De Paepe, Cantuarias, & Herrera 2008;Vargas et al. 2002).

b. The second breach in the literature related to Latin American reforms opposes medical and political sciences journals.

- Scientific medical journals often addressed the desirable features of international aid e.g. state-of-the-art policy papers – such as SWAPs (ready-made sector strategies). Contrasting with the scarcity of health care delivery and organisation papers, the literature in these journals devoted to disease control projects was particularly plentiful.
- On the other hand, the political and development sciences journals critically analysed industrialized aid to developing countries – but rarely addressed the health sector and, only in exceptional cases, field projects.

Evidence on HSR in Latin America was thus filtered by discipline-specific biases. The political sciences literature lacked raw material to explore the determinants and consequences of aid policy design, while implementation and medical journals were not often independent enough (which is why they consistently addressed health care management issues from the managed care angle (Unger et al. 2010b). Themes in between, lying across two disciplines (like epidemiology and management) would generally be ignored by the scientific literature,

as it has been, for instance, in the case of aid projects' integration within national health development, a topic that raised only limited interest in the scientific community.

In conclusion, the lack of inter-disciplinary collaboration (in particular between public health and political scientists and between policy makers and health care managers) in policy analysis prevented international aid from being properly questioned.

These tight discipline boundaries, and limited independence of public health research, led decision-makers increasingly to turn a blind eye to an evident contradiction: if 'aid only works under *good governance* conditions' then it makes no sense to admit that 'aid advantages would systematically outweigh its drawbacks in terms of health benefits for recipient countries'.

Such a hypothesis is only acceptable if public health science systematically rules out political contextualization when analysing health policies and researching health systems.

At the end of the day, the most costly consequence of this epistemological imbroglio resulting from the HSR period was probably that decision makers, whether national or international experts, did not perceive the importance for health care, and for avoidable mortality and suffering, of defragmenting the health system. In the health system, most decision makers had no knowledge whatsoever of individual health care management, and even less of systemic health management.

8.3.1.2. A weak opposition

In Bolivia as in most other Latin American countries, two movements, ALAMES (through the continent) and ABRASCO (in Brazil) organized the political opposition to neoliberal health care policies. Many health policy leaders of the socialist governments were influenced by the concepts and thinking of these vast organisations gathering thousands of health professionals and workers. Not many European countries have a similar professional sociology…

Historically, these organisations were crucially influenced by the theories of Eugenio Espinosa and Salvador Allende (and to a certain extent, by those of Che Guevarra). Accordingly, social determinants of health do not centrally include equitable access to good quality health care. At that time, in the early eighties, it is probably fair to say that the Latin American movement most concerned with health care policy was in Brazil.

Another factor in the neglect of care in health policy design, large sectors of ALAMES and the movement of social medicine shared a sometimes undeserved anti-medical ideology, that in turn led many socialist militants to ignore the importance of accessing quality individual health care even, paradoxically, in public services.

Lack of technical knowledge could in theory also have been indicted as a cause of system fragmentation. But Latin American policy makers had an early opportunity to be exposed to the medical stakes of health system segmentation and fragmentation (Espejo and Estrella

1993). Unfortunately, left wing health militants failed to underline the importance of this system feature.

At the end of the day, in terms of their respective models, early neoliberal public health specialists underlined the control of biological risks of disease in the public sector, while ALAMES experts were insisting on the control of second line causes: the social risks beyond the unequal distribution of disease and of biological risks to health in the society. This conflict over the nature of health risks led both of them to ignore health care as a crucial social determinant – in spite of current popular demand.

8.4. A sound socio-political strategy beyond HSR

We have seen (section 4) that continuity was a feature of the Bolivian socialist health care policy. However, while the governments continued to rely on external funding, the volume of finances committed to the Bolivian health sector was not comparable with levels attained in the second half of the nineties. We are tempted to say that this aid, from the viewpoint of the donor, was no longer a priority because the market had been opened.

Pushing HSR through in a country like Bolivia is rather surprising. The challenge was huge in a State that featured a high turnover of both policy makers and health care managers (due to an average functional expectancy of ministers of health of less than one year), a turn over that precludes interest in long-term policies.

One key factor of effective HSR introduction and sustainability was in the synergies between national and aid actors – between thousands of agents, technicians, and professionals on the one hand, and a few international experts on the other. HSR introduced into the Bolivian health system a radical change involving economics, care and even psychological issues as regards doctors' professional identities.

Progressive health planners are now led to consider an array of factors, from social to historical to deal with this enormous task of reversing the HSR in this vast ensemble of services, decision makers and socio-political organisations. From this perspective,

- socio-economic analysis would determine the effective cost of wages
- historic analysis would reveal and explain health system inertia.

With regard to history, sections 2 and 3 evidenced that the aid agencies, facing challenges with major social, political and economic forces in Bolivia, managed to build an effective socio-political coalition to promote commoditisation of care delivery and financing. This coalition steered by experts and diplomats, was joined by Bolivian actors: by most health professionals, by health workers to a lesser extent, by the middle and upper classes, by the corporate sector and its decision makers.

We have seen that, in particular, the health professionals derived substantial benefit from the aid projects. As stated earlier, huge amounts were spent during a relatively short period of time (5 – 10 years, after which aid vanished, Table 3).

This social political coalition armored by the multilateral agencies proved long-lived and effective in influencing the national health care policy, way beyond / after the presence of the HSR international coalition in Bolivia. As a sign rather than as a cause of HSR sustainability, the socialist governments stabilized public expenditure on health and continued to rely on international aid (including WB funds) to finance many first line activities (see section 4 and 8.2).

A description of the Bolivian political scenery would not be complete without referring, in this vast country (1.09 million km^2), to the regionalisms and centrifugal forces (that were sometimes teased) and their effects on health care fragmentation. In this context, socialist governments had a hard time reversing the partial devolution of the health system to municipalities. The central government did not treat the health sector as a priority stake in negotiations between the regions and the central government.

Notice that it is USAID that promoted administrative decentralisation in the form of devolution. This move had both economic and political justifications:

- the devolution of hospitals to local governments reduced the operational function of government structures in individual care delivery
- it strengthened the allied economic and political forces (e.g. at regional level, a political issue extremely sensitive in the Bolivian context).

These are some explanations for the longevity and robustness of (neoliberal) health sector reform under social democrat governments in Latin America.

8.5. Aid reduced under socialist governments: no political acquaintance or job done?

It is not by chance that the evolution of aid to the Bolivian health sector reveals its loss of importance to Northern countries ten years ago (Table 11): it is possible they considered that the economic job was complete and further investment in HSR would have been a wasted cost, since the market was now open.

Table 11: Comparison of 1985 – 2010 total expenditure and functioning budgets of WB, USAID and MoH

Year	1985	1990	1995	2000	2005	2010
% WB + USAID/Total Health Expenditure	3%	12%	2,91%	2,61%	3,10%	0,4%
% WB + USAID/MOH Functioning Expenditures and Investments	39%	38%	161%	123%	26%	2%

Source: Data from Social Security Bolivian Institute (INASES) and National Institute of Statistics (INE)

Clearly, some political stakes are still attached to the health sector, but it is now merely a Bolivian issue, and it is probably with these lenses that the continued presence of aid projects in the Bolivian health sector should be viewed.

Five years after the first election of a socialist government, Bolivia hosted fresh USAID projects. Its funds were channelled through WHO and UNICEF. Bolivia also kept WB projects on board in the health system. Ecuador scrapped its WB projects in 2008, but still has one USAID project (channelled as usual through a NGO known as University Research Co.

Aid to the health sector dried up, unlike others such as environmental issues and education. This suggests that it is not the very political nature of the Bolivian regime that kept aid funds away, but something within the health sector that made it less attractive to international aid funds.

From what has been discussed above, it is plausible to claim that donor agencies considered that the job was done, the health care market open, and that there was no further need to convince health professionals and to train health managers: the continuous development of a monopolistic health care market is a self-fulfilling process.

Cynically, some WB experts recently stated that they would not be so imperious in the future (The World Bank 2010).

Meanwhile, in spite of terminology changes, the two public policies still abide by neoliberal principles: public services focus on selective care and ignore bio-psychosocial care (in any sector); governments still promote commodification of individual health care delivery and financing. These choices will not contribute to improving equity in health nor reducing poverty in households' care-related expenditure.

9. Cross sectional analysis

Our familiarity with the relevant literature suggests that few studies have researched the long-term consequences of the 80s and 90s reforms. Our conclusions derived from the Bolivian experience with HSR could enlighten many health systems features in Low and Low Middle Income Countries - where one day, an international coalition was in a position to take over the first line health services.

In this category, at the side of Andean and Central American countries, the Bolivian experience enlightens health systems features of many Sub-Saharan African and South East and Southern Asian countries. In these countries, indeed, governments spent so little on health that the donor agencies room for manoeuvre was extremely wide in setting the agenda of national health policies.

Reflecting interactions between Bolivian and international aid actors, our analysis suggests that in a HSR aimed at commoditizing health care,

- external affair policies of industrialized countries aimed at opening health care markets to their
    - managed care industries
    - medical high-tech and pharmaceutical manufacturers and
    - health insurance sector.
- In this environment, basic market rules could apply to health care services and their actors e.g.
- neoclassic economic criteria do foresee properly the economic behavior of professionals

Here follows some details of actors' motives and strategies during the Bolivian HSR.

9.1. Health professionals and workers

Health professionals and workers (in these included many national authorities) were keen to retain a dual, public and private employment. They wanted the (public) health services alive for their own training and more importantly, as a place where to identify profitable patients to pilfer / poach.

However, they needed these services ill-functioning because most professionals and health workers would not want any competition of (subsidized) public care delivery with their own clinical activities. This is why they practically supported the international motto: 'Public services should be compelled to provide basic interventions only'.

The many professionals involved in externally financed interventions channeled through public services managed to raise their income largely above their government salary while accomplishing the agenda of the international aid agencies.

Consequences of democratic deficits, the consultancies funds directed to MoH policy makers and politically influential decision makers represented an important stake in the political party competition: aid funds did not land in a political desert.

9.2. International aid agencies

Bi- and multilateral organisations did not aim at directly privatizing care delivery and financing. In the Bolivian health sector nothing such as full privatisation of services occurred (unlike in Russia or Nicaragua, for instance). While promoting the health market, aid agencies assigned to the public sector the role of a market for pharmaceutical goods purchased by aid funds and the role of a socio-political pacifier / stabilizer. Not only would the health services remain apparently public but they would act upon health indicators conveying a political valence (e.g. under-five and pregnant women mortality).

Consequently, industrialized countries pushed many LMICs to enter their health sector in the WTO / GATS negotiations package – to open their urban, high and middle classes neighbourhoods market to high-tech care delivery while constraining public services in these areas. Bolivia however resisted and didn't sign its health care sector (during the 1994 Uruguay round).

Nevertheless, the international coalition managed to enforce: the partial privatisation of public hospitals (e.g. with the managerial autonomy) and management property split); deregulation; strict public health / medical split; purchaser provider split; and concentration of public health funds on "the poor" (to ease privatisation of health insurance in middle classes). Notice that HIC achieve such diplomatic success in LMICs more effectively when their cooperation activities are directly ruled by the foreign policy (as in the UK (The Lancet 2010) or in Belgium).

Paradoxically, powerful interests in the North also contributed to save the existence of (public) health services in LMICs because the public private partnership involved in global health initiatives (in fact international disease control programs with public and private funds) needed them to disseminate their goods.

Notice that these GHIs may be seen as a tool to conquest otherwise insolvent disease control markets in LMICs. They permitted medical and pharmaceutical industries to sale pharmaceutical and medical material where there was no buying power (Tejerina Silva, Soors, De Paepe, Aguilar Santacruz, Closon, & Unger 2009) (Vázquez et al. 2009) nor demand.

Being flanged, the Bolivian public services reconciled the GATS / SAP prohibition of health care competent public health care services and the need to secure a market for disease control goods. This economic rationale led high-income countries governments to subsidize their (mainly pharmaceutical) industry at the cost of largely forsaking public international aid support to access to care in LMIC countries, and in Bolivia in particular.

Besides, aid agencies aimed at stabilizing the recipient, allied government with material and symbolic resources. It is difficult to assess the importance of the demographic achievements

(as are the reduction in MMR and IMR) to secure political stability but it is likely that they had a cosmetic utility in elections times as the related health activities were not responding to a demand.

With regard to disease control, the strategy was designed in theory to contain the consequences for HIC populations of reduced access to care in LMIC by combating their epidemics hence treated as a public "good". As said earlier, this wasn't very effective in the case of TB and AIDS e.g. because of issues with pharmaceutical resistance.

Two features characterized the international aid during the last two decades favoured its capacity to pour a large amount of money in the Bolivian health system:

- To cope with the international agreed commitment to allocate GDP 0.7 % (Devarajan et al. 2002), (The Millennium Project 2006) to aid, many HIC converted most of their technical aid in finances, which drove several cooperation agencies to consistently undergo a lack technicians mastering health care management – while disease control specialists where provided by GHIs. Meanwhile, they constituted these huge amounts of funds invested in seminars, training and other events aimed at purchasing the professionals' good will and to help them socializing in the newly structured health system.

- Fast aid disbursement was a general aid concern. While bilateral cooperation agencies were coping with budget constraints, the financing agencies (IAB, WB, IMF) permitted rapid disbursements even where the absorption capacity of LMIC health systems was constrained by other (technical, professional, institutional) bottlenecks. This explains in Europe the steady increase of indirect aid and the reduction of its direct one.

This rationale also explains the importance of international banks as prominent, macro-economic HSR actors. If the World Bank (WB) and the International Monetary Fund (IMF) were aid leaders in Bolivia (Armada, Muntaner, & Navarro 2001), the order of institutions progressively adopting and promoting their concepts is enlightening: initially the Rockefeller Foundation (representing private interests although a charitable foundation), than USAID and UNICEF (then led by a US CEO), then the WB (with the structural adjustment program and health sector reforms), then WHO (after the USA had withheld its financial contribution to WHO), then other bilateral aid agencies (most bilateral agencies e.g. Japan, the UK and Canada effectively advocated and supported the reform). More recently, the GATS negotiations within the WTO was used to force LMICs to drop individual health care delivery in public services – with the exception of those activities belonging to disease control programs.

In conclusion, we can reasonably admit that:

- judging from the health output, aid agencies poorly technically planned care reform.

- Contrasting with this, their underlying socio-political plan proved to be quite consistent and effective, especially if one considers the history of political instability in Bolivia, one of the most unstable and violent in the world (26 coups on a total of 65 governments).

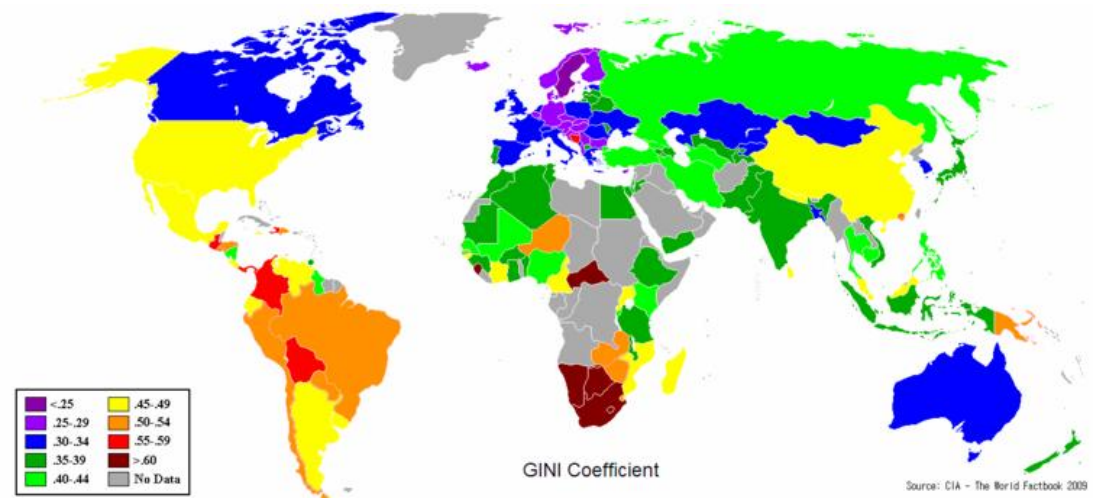
The weak health output is understandable at the light of contradictory donor interests in the health sector. For instance, improving maternal indicators required better access to public hospitals (for the sake of getting decent C-section rates) – against the care market rationale. It has been argued that the renewed Bolivian health system contains a number of contradictions between its aims and the means by which these aims are being pursued, notably in the durability of an extremely vertical health system (Johnson and Stoskopf 2011).

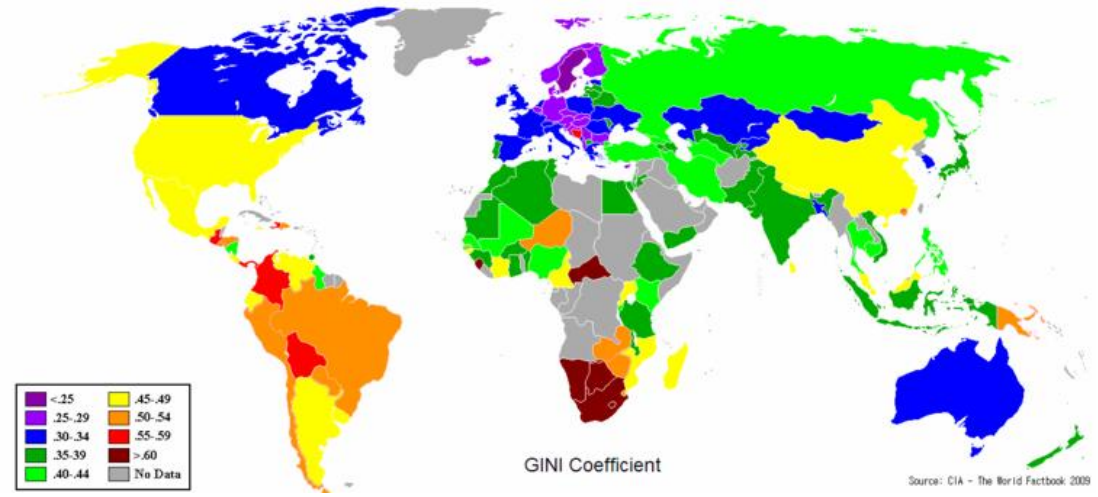
But these contradictory interests were compatible with a long-term consistency of HSR over two decades, across projects and experts. This consistency originated in an ideology largely shared by all aid actors and in a coordinated role distribution between key aid players. In this ideology, symbolic stakes such as 'scientific' knowledge and language proved important in easing intellectuals to abide by their short term interests while claiming to do so in the name of the collective national one (see section 8.3.1).

9.3. Representation of social interests in designing of LMICs public policies

The worldwide distribution of GINI-indexes reveals the sad situation of Bolivia at the side of Colombia and slightly ahead of South Africa: it is one of the most inequitable country. The GINI, we contend, sheds a light on the degree of wealth redistribution performed by the government. The map below reveals that such redistribution is not contradictory with economic and industrial development, against a propaganda aimed at deterring direct taxation.

Diagram 3: Map of 2009 GINI index world distribution





Bolivia illustrates the mechanisms whereby the State refuses to play any role in the wealth redistribution. Its local politicians mainly represented the rich and the middle class because

- the poor had no consistent political representation in the parliament and the government (one political sciences reference needed)
- the rich could purchase the State decision at low price. Bolivia was ranked 117th on perceived corruption in a 2005 country classification by Transparency international (Transparency International 2006)(Transparency 2006).

Not wanting to invest in health care for the poor, the Bolivian government handed over health financing to international cooperation (with the exception of salaries).

The Bolivian middle class thus did not finance most public health subventions with their taxes while benefiting from international cooperation and oil and mines exports. This permitted health and non-health markets to grow, and more importantly, to create a political buffer supporting (oil and minerals) export-oriented governments.

To understand these facts, our historical analysis of the Bolivian health system confirms the pivotal influence of the small elites that excluded the indigenous and rural majority from the social, political and economic State decision-making until 2006 - with the exception of the 1952 revolution aftermath (Crabtree and Whitehead 2008).

How did these groups interact with the neoliberal reform promoted by bi- and multi-lateral cooperation agencies? Although the industrialized countries were those that initiated the health reform, these small elites – and the health professionals in general - were more than interested to collaborate because of the importance of the funds invested during the SAP era.

While exploring the difficulties met by socialist officials to enforce an individual health care policy with a social, not commercial rationale, we understand at the same time the reasons of long-term sustainability of HSR. It is precisely because it is a social-political self-sustained process that aid funds in the health sector could decrease so dramatically (Table 12), long before the socialist government, in Ecuador. If in Bolivia, aid remained at a high level (Table

B), USAID and the WB weren't anymore the most important donors long before the socialist government (see Table 3).

Table 12: External resources for health as a percentage of total expenditure on health

Year	Proportion of external resources on total expenditure on health	
	Bolivia	Ecuador
1995	6,9	0,5
1996	5,2	0,5
1997	7,4	2,1
1998	6	2,4
1999	5,7	3,2
2000	6	4,1
2001	7,1	1,8
2002	6,9	1
2003	9,3	0,3
2004	11,7	0,4
2005	9,8	0,3
2006	9,9	0,6
2007	9,1	0,7
2008	6,6	0,9
2009	7	0,7
2010	5,3	0,4

Source: Data from WHOSIS (World Health Organization 2012b)

9.4. Declared and unspoken objectives of aid

The HSR was the first time that international cooperation organisations openly advocated a particular government policy, health systems features, managerial characteristics, care delivery models and the organisation pattern of public structures in Bolivia. We saw that the aid promoted policy abided by the general neoliberal principles. There was a tight congruence between its declared objectives and the general political economy principles of the structural adjustment program (Berman and Bossert 2000;Collins et al. 1999;De Vos et al. 2006;Stocker et al. 1999). We have seen that these principles favoured Western exports in the health sector.

The USA was the main direct and indirect donor country to Bolivia. Its cooperation in Low and Middle Income Countries had and still has an explicit mandate to defend its interests (U.S.Department of State and U.S.Agency for International Development(USAID) 2012). These span from economic to security and political to geostrategic and include:

- opening/sustaining markets for American goods, e.g. medical technology and pharmaceutical products; services, e.g. health care (Stocker, Waitzkin, & Iriart 1999) and/or investments, e.g. health insurances and financing;
- securing the provision of strategic supplies to the USA - oil, gas, tin;

- limiting taxes on the middle class of recipient countries to increase its buying power (which helps creating markets for non-health goods). Notice that this may create tensions between different economic agents;
- minimizing threats to US national security caused by:
    - diseases with pandemic potential (Fidler 2008;Leavitt 2007;National Intelligence Council 2000;The United States President's Emergency PLan for AIDS Relief 2012),
    - illicit drug traffic,
    - illegal migration (Osborne 2002),
    - terrorism,
    - poor countries' demographic pressure;
- stabilizing allied governments.

With regard to the latter, the State Department remains explicit in aiming at creating / strengthening national feelings and in promoting popularity of allied governments – those that support anti-communist fight and promote democracy (U.S.Department of State - Diplomacy in Action 2010). The welcome page of the official website of the Bureau of Democracy, Human Rights, and Labour of the US Department of State states: "Promoting freedom and democracy and protecting human rights around the world are central to U.S. foreign policy. …. The United States supports those who long to live in freedom and under democratic governments … uses a wide range of tools to advance a freedom agenda, including bilateral diplomacy, multilateral engagement, foreign assistance, reporting and public outreach, and economic sanctions. The United States is committed to working with democratic partners" ((U.S.Bureau of Public Affairs 2008)).

Chapter 2 (Tejerina Silva, Closon, De Paepe, Van Dessel, & Unger 2012) analysed the US-Bolivia relationships in the health sector between 1971 and 2010 on a grey and scientific literature review and on interviews. It reveals that in practice USAID failed to properly promote US interests in Bolivia such as anti-drug policies, support to political allies and trade.

The 2004 social unrest represented a setback for US political interests. These led to political changes and in 2006, the so-called socialist government of Evo Morales (himself would sometimes call his political orientation of the 'Andean capitalism' sort (Dunkerley 2007), was elected while hydrocarbons and telecommunications were nationalized soon after. In 2008, the American ambassador, Philip Goldberg, was expelled (McDermott 2008) on the ground that he had interfered with internal political affairs and supported the political opposition. Since then, Bolivian newspapers often evoked threats to evict the US cooperation agency (USAID) but this did not happen so far.

In fact, rather than a market, the key function of Bolivia in USA economics was an exporter country of row material which is why, during 30 years, weak economic administrations and parties with poor legitimacy were sustained by their northern ally. The USA aid contributed to this result - together with other policies regarding for instance defence and internal security. Although petrol wasn't exported to USA after 2006, minerals still were. Being oil and gas control nationalized in 2009 (50% + 1 of ownership participation) and mainly traded to neighbour countries, the remaining strategic supplies exported from Bolivia to the USA

were minerals. Today, transnational companies still produce and trade them although new nationalisations cannot be ruled out.

An important Northern concern, anti-narcotics Bolivian achievements (control of coca/cocaine production and trade) were and are uncertain, with the country remaining among the first three cocaine USA providers (U.S.government 2012).

Although its size has grown across time, Bolivia remains an insignificant market by US standards:

- Its 1989 GDP was worth the wealth of a 539,000 inhabitants' US city equivalent to Tucson or Albuquerque =2,819 X 6,423,000 / 33,587 (Table 13).

Table 13: A 1989 US Bolivia comparison of GDP per capita

Indicator	Bolivia	USA
1989 GDP/capita (USD PPP)	2,819	33,587
Total population	6,423,000	247,342,000

- its 2009 GDP was worth the wealth of a city of 910160 inhabitants (say, San Jose, California), equivalent to 4,007 X 9,371,000/41,256 (Table 14).

Table 14: A 2009 US Bolivia comparison of GDP per capita

Indicator	Bolivia	USA
2009 GDP/capita (USD PPP)	4,007	41,256
Total population	9,371,000	306,551,000

Source: The World Bank Data - GDP (The World Bank 2012b)

Bolivia is not any important market for US health medical technology, pharmaceutical products and insurance (those are unlikely to be privatized), but its market remains the object of political efforts aimed at enlarging it. In theory, to steer trade in health, a policy favourable to the international industries should enlarge coverage with subsidized privately delivered health services - without effectively regulating the supplies market. This is precisely what the Socialist government did. Recently (12 Oct 2011), it passed a new regulation (Gaceta Oficial del Estado Plurinacional de Bolivia 2011) allowing the MoH to select drug suppliers through bids that could be accessed by private insurances.

10. Recommendations

We discussed in chapter 9 the commonalities of the Bolivian health system with a series of other health systems that share its key (fragmentation, segmentation) features: in Central and Andean America, in Sub-Saharan Africa, in some Middle-East countries (e.g. Yemen), in Southern and South-East Asian countries. These countries represent the tentative domain of validity of the following recommendations.

The use of this term 'recommendations' simply implies that they are worth, in our view, discussion by decision makers and social political organisations in these regions.

We aimed at making these recommendations relevant to the 2005 World Health Assembly call for universal coverage in health systems (Carrin and James 2004), (Carrin et al. 2008b), (Carrin et al. 2008a), which WHO defined as ensuring (Chan 2009) access to adequate health care at an affordable price (Evans and Etienne 2010).

10.1. Challenges to health system development in Bolivia

The socialist government tried to tackle key challenges posed by the consequences of the 1980s - 1990s Health Sector Reform, that remain acutely felt in Bolivia. It aimed to act upon social determinants of health and to develop a united national health system. Unfortunately (chapter 3),

- The control of social health determinants was not much integrated in curative care e.g. because GPs were not properly trained and exposed to appropriate continuous medical education;
- Fragmentation (with parallel disease control programs in first line services, multiple authorities on public health centres and lack of patients' access to referral hospitals) and segmentation (e.g. with the inequitable social protection system, tables 1 and 2) survived government attempts to reverse them.

Decentralisation in the form of devolution deepened the health system fragmentation (chapter 1). Local governments were often too small to afford any decent techno-structure for their health system and city governments refused to ease access to care for patients from rural areas in 'their' hospitals (as they belong to other local governments).

In a country crossed by regional tensions, the political configuration inevitably impacted on the health sector. A regional autonomy was voted during a national consultation in 2008. Given the country's geography, this could have been compatible with developing integrated health systems. Unfortunately, the Bolivian regions did not manage to develop regional and local health systems because of lack of vision, scattered decision centres, blurred responsibilities and politicised human resources management.

The national capacity of stewardship in the health sector remains deeply undermined by the reform and effective steering structures are lacking within the MoH (see section 2).

Under-financing of public services led to health care privatisation. In fact, with 81% of MoH budget earmarked for salaries (as in 2001), there is no way the government could seriously amend the neoliberal reform.

The bulk of infrastructure investments had been left to international cooperation during two decades but in 2006, when the socialist government was elected, Bolivia was badly in need of health centres and hospitals. Until 2011, the MAS government invested some 12% of its USD 366,656,800 (ERBOL - Educacion Radiofónica de Bolivia 2012) budget in health infrastructure in the context of a political program named "Bolivia cambia, Evo cumple." Without these investments being part of an explicit health sector strategy, the underlying technical and financial plan was lacking.

10.2. Access to individual health care

Bolivia and Ecuador should not forget that access to care is a social determinant on its own. Contemporary professional knowledge stresses family medicine (e.g. patient-centred and bio-psychosocial care) and community medicine as key tools for primary health care-based strategies. Individual care provides unique opportunities to professionally act on social determinants – and to do so in a highly individualized way.

On this ground, we delineated our recommendations, starting from the key health system product - individual health care delivery – that, we suggest, should become the key concern of Bolivian authorities.

Universal access to individual (and community) care should become the explicit objective of the Bolivian government. Access should not be confused with universal health coverage that only refers to its financial dimension. Accessing individual health care requires overcoming far more obstacles than mere financial ones, e.g. geographical, chronological, psychological, technical, etc. (Unger et al. 2003c).

We see three key reasons for such a policy commitment, i.e. ethical, technical and political:

- policy makers should not do to others what they do not want others to do to them and their own families, that is: “restricting access to individual health care”.

- in services where disease control interventions are integrated, there are scientific reasons to believe that the relative failure of disease control mentioned in chapters 1 and 2 is related to insufficient utilisation of individual health care in those health centres where epidemiological interventions were integrated (Unger et al. 2006a).

- For the sake of health and political stability, the Bolivian health policy should centrally address access to – and quality of – (family and hospital medicine) care.

We suggest revision of the SAFCI health care model as promoted, at least in publicly oriented services, adding the below criteria:

- patient-centeredness and bio-psychosocial care. Explicitly, such care would permit tackling the *social determinants* of health and ill-health individually *when* it is the more relevant e.g. when the person is sick;
- continuity of care;
- an appropriate balance between the quest for the patient's autonomy and security, and between effectiveness and efficiency.

This care should be promoted in publicly oriented, socially motivated health facilities with a contracting-in system that requires the development of a national health fund, possibly used to finance those health services willing to abide by the constraints and obligations attached to being part of the publicly oriented sector.

Finally, actual access needs to be continuously monitored and assessed in each health facility of publicly oriented services, in local health systems (integrated networks of services), in regions and at national level. Particularly important are the utilisation rates of first line health care services, hospital admission rates and skilled attended delivery rates (together with more specific indicators in laboratory, radiology, nursing and pharmacy).

10.3. A national health policy meeting socio-political *and* technical concerns

If a socialist government ought to show its social commitment, it is precisely in the social, not commercial, rationale applied to social sectors such as health and education that this commitment should appear as a priority.

10.2.1. First line services as a priority (general hospitals somewhat later…)

So far, no effective strategy has been implemented to integrate the social security system into a United Health System. De-segmenting the health system would require a unique, universal, public financing scheme – which under the prevailing political configuration is not within reach: workers refuse to have the property of insurance funds questioned as they are not keen to lose their fragile access to care. They perceive the MoH system as basically unacceptable and see the insurances services as the only, albeit unsatisfactory, solution to accessing individual care.

The issue of re-financing the health system cannot be separated from services development and to do this, we contend, the government should prioritize first line health care services because of their following advantages:

- they respond to more than 90% of demand for health care,
- their operational budget is limited,
- they can channel disease control interventions,
- they can offer some kind of family and community medicine that can tackle social determinants of health,
- they are simple enough to allow a co-managerial structure with users' organisations,
- the needed investment is limited inasmuch as communities often have alternative solutions (social centres, MCH centres, hiring an apartment) to reduce building needs,

- The functioning budget is comparatively limited.

10.2.2. Publicly-oriented, integrated local health systems (new 'districts') and their multi-institutional executive teams

In fact, the main challenge of developing decent, accessible first line services is technical: there is a need to train doctors in bio-psychosocial and patient-centred care. To do this, in-service, continuous medical education techniques are available that enable relatively large areas to be covered with limited budgets (Unger et al. 2002).

From a political perspective, such networks of health centres would reduce the workers' pressure to have their own services – provided that health care delivered in this network was acceptable. To achieve this, a single, united health fund could be developed progressively, while initially leaving untouched the resources for the social insurance networks – until proper availability of the above-mentioned first line service.

The development of this united first line could build upon the myriad of health NGOs (USAID financed some 50 of them in 2007). Most are specialized, often in reproductive, Maternal and Child, and environmental health. Others are not, such as PROSALUD (chapter 3), an organisation with experience in integrated care delivery. If, in theory, all of them are to be part of the network, several obstacles will have to be overcome:

- The NGO managers will have to be convinced - with financial inputs, public health training and negotiations;

- Each type of NGO has specific requirements to become a structure capable of delivering individual, multifunction health care

- Public sector management severely suffered as a result of neoliberal reform – particularly at the level of local health systems ('distritos de salud'). The Bolivian health policy should decisively tackle the organisation of their executive teams if clinical decision-making, bio-psychosocial care and staff coaching are to be improved and if services networks are to improve system efficiency (Pan American Health Organization 2011). Managers of local health systems ought to be intellectually equipped to accompany such transformation. These technical supervisors should be experienced. Their key function, and their required technical capacity, would be to coach health teams, to coordinate the network health facilities, to conceive top-down planning that uses field realisations when available, and to support bottom-up planning while being linked to communities, trade unions and professional organisations.

- Preferably, district executive teams should belong to the several institutions involved in the publicly oriented health care sector. In the Bolivian context, district executive teams could be made of staff with family practice experience belonging to the MoH, social protection institutions and NGOs.

- Negotiations with donor agencies will also be required.

The issue of technical / psychological coaching of health professionals raises the issue of groups of highly motivated, effective leaders working as a team to coordinate local health systems. If the different providers with a social orientation (belonging to MoH, to social health funds, municipal services, NGOs, etc.) are to be integrated in one sector, its local governance should gather the best staff of all the organisations that compose it. Only then could de-fragmentation be based on common, negotiated values and similar care quality standards.

Such revamped, multi-institutional district health teams would permit coordination of all not for-profit health facilities and providers serving a defined population. These teams, we contend, should manage a budget to supply-side finance all publicly oriented facilities agreeing to abide by some contract terms e.g. foreseeing co-management (see section 10.5) (tentatively MoH, NGOs, municipal and social security services) instead of MoH entities only.

10.2.3. Regional and central initiatives

Regional initiatives (such as refreshers in health services organisation and on the spot coaching by experimented health care managers) can improve the effectiveness of the inter-institutional teams leading local health systems. However, if this is done without at the same time improving the reliance of health facilities on social structures, embezzlement and poor responsiveness of care services are likely to continue.

All these challenges justify conducting field experiments designed to pilot national health policies - health services used for demonstration, training and research.

Importantly, the middle class needs to be taken into consideration while designing coverage plans with publicly-oriented services, as its political influence is crucial to maintain the overall services quality (Gérvas 2008), (Unger, De Paepe, Ghilbert, Soors, & Green 2006c), (Unger et al. 2006b) and its taxes can make a difference in the entire network (Freire Campo 2010).

Our proposal does not require abolishment of the private for-profit sector but development of a socially motivated sector at its side. Experience suggests that if efforts are made to regulate both sectors, it is the competition between a subsidised, contracted social sector with a commercial one that is most likely to improve the standards of the latter (HESVIC Consortium 2009).

Bolivia should strengthen its health governance mechanisms with experienced middle line care managers. The government should also steer a publicly oriented services system – which requires a legal, institutional and operational framework ensuring co-management of public facilities with users, trade unions and professionals. In particular, competition between subsidized community health centres and hospitals with commercial health care delivery should explicitly be permitted.

Finally, with regard to decentralisation, the issue of devolution of health services to municipalities should be reconsidered. Assuming that reverting from devolution back into

de-concentration is not a political option, technical and managerial skills should urgently be strengthened in large municipalities, particularly with regard to their planning and management capacities.

10.3. Doctors' economics

The health system reform promoted short-term, flexible personnel contracts, which hampered teamwork development. Unfortunately, the underlying legislation has not been amended since.

In theory, all human resources in the publicly oriented services should depend on a single contractor, report to it and to the population and enjoy similar, decent work conditions (e.g. salary, social benefits and responsibilities). In Bolivia, doctors were intellectually shaped by their experience in the prevailing segmented services and many have a hard time imagining any other system. More importantly, most doctors and civil servants are keen to retain their dual employment that provides them with private payments and public resources, their patients being poached from the public to the private practice. Indeed, doctors work 6 hours a day in public services and are allowed to have one and a half full-time contracts with public institutions. The rest of the day is typically spent in private practice.

A 2012 projected law putting their work time at 8 hours a day incited a 45 days strike and public demonstrations. The government room for manoeuvre shrank, but some still remains: it lies in the large number of unemployed doctors who could be appointed in new health centres under exclusive contracts and decent salaries.

To the extent that the priority of the national health policy would be first line services (see section 10.2.1), it would be reasonable to lift administrative obstacles to selectively, but dramatically, raise the salary of general practitioners working in publicly oriented services. This move would bear much smaller financial consequences than a general wages increase in the sector.

With regard to the program managers financed by aid agencies, who are not keen to lose their privileges, Mozambique has shown that negotiations with donor agencies can reduce salary scales across segments and national divides and contribute to improvement of efficiency in manpower utilisation and nationwide distribution. It is likely that in this post HSR period, this issue is less sensitive than at an earlier stage.

10.4. A plea for the co-management of publicly oriented health care facilities

The contracts between the single health fund and health facilities making up the not-for-profit sector should crucially foresee their co-management with users' organisations (e.g. in health committees). In the long run, failure to accept this condition should rule out any participation in the sector and bar organisations from receiving public funds directly from the government (although local arrangements with publicly oriented facilities would remain possible).

Managerial autonomy had been granted to hospitals and health centres during the HSR period (alleging political instability, staff turnover and weak management in public services). It would be misleading to consider these only too real managerial problems as merely technical ones: they are also political and call for strategies aimed at making the public services more democratic (MoH, local government *and* NGO ones), because, for instance, several issues key to proper functioning of health centres and hospitals are related to deficient regulation by government services – an issue common to many LMICs (HESVIC Consortium 2009): These issues include:

- political appointments of staff,
- poaching of patients,

use of public goods for private purposes. These all require some control and repression.

If users are not in a position to enter into national governance , they should at least be integrated into the managerial structures of health facilities and services systems. Notice that this holds for government health facilities but also for NGOs, denominational structures and municipal institutions.

There is a problem, though. Communities and socio-political organisations are unlikely to be interested in participating in such co-management if they are not humanely treated in health facilities. Besides, a doctor who refuses to dialogue with a patient, or is not capable of doing so, is unlikely to discuss things with a community or a large organisation. This is a further reason to strengthen first line services and to promote patient-centred care in the same centres – as a step towards democratisation of publicly oriented health care services.

Implementing strong users' co-management structures would be a key protection against new attempts to privatize care and to restrict access and quality in publicly oriented health services.

The new Political Constitution was aware of and foresaw such social control over all public institutions. Accordingly, the SAFCI model promoted social participation in health systems[3]. To defend the users' interests, their representatives, organized in health committees, should address access to and quality of care as a priority and do this in the context of a real co-management of first line health centres and general hospitals.

10.5. Financing

Financing mechanisms used during the HSR in the public health sector mirrored a configuration of interests and power relationships. These mechanisms (out-of-pocket payment, targeted universal social insurance, individual health care insurance for the wage-earning workers, etc.) have not been amended after six years of socialist government.

As they are the result of social political factors, recommendations to policy makers and socio-political organisations on strategies to achieve universal access to care need to be

[3] Community participation levels were created: the Local Health Authority (LHA who is a community leader); the Local Health Committee formed by LHAs of the communities covered by a health facility; and the Municipal, Departmental and National Social Health Boards.

progressive and modest. This is why we advocate a phased strategy, partly relying on a united health fund directed to the not-for-profit health system, where first line services would be a priority, followed by the development of district, general hospitals.

In these health centres, there is a need for (new) pilot experiments to promote partial co-payment in publicly oriented, co-managed health facilities, with the objective of

- Developing community health committees managing the HC funds
- Empowering them in management of publicly oriented social facilities.
- Securing long term functioning and sustainability of (publicly-oriented) health services.

Notice that, if we recommend out-of-pocket payment in first line services, we do not advocate fee-for-service but fee per sickness episodes (in health centres).

Tentatively, these pilots would show that household expenditure on health can be lowered when some costs (like purchasing drugs and laboratory tests) are made collective in health centres. Obviously, the conclusions would be limited to first line services and could not be extended straightforwardly to hospitals without further tests assessing access to care.

At a later stage, the united health fund could progressively finance hospitals of both MoH and social insurance sectors to let them accept patients referred by the socially oriented first line services. It is likely that such a move would be more acceptable to wage-earning workers if they had previously had a positive experience in first line services.

One of the functions of this fund, if it manages to expand in the future, would then be to compensate for inequitable financial and technical capacities of rich and poor municipalities.

10.6. The role of public universities in LMICs

We advocate a public investment in schools of public health. Not at any cost, though: to deserve access to public funds, public health academic units should have a social commitment and be involved in the following activities (in addition to others chosen by the academics themselves, of course):

1. preparation of health professionals and accompanying them in their career so as to maximise equity in access to good quality health care
2. development and involvement in action research to test alternative health care organisations, that would aim at operating with a social mission, be democratically managed and deliver acceptable health care
3. critical analysis of health systems and policies, with the eyes of the patients and the tax payers.

We now expand these three themes.

10.6.1. Preparation of professionals

The most urgent task in this domain is related to continuous medical education. Universities should be associated with the in-service dissemination of methods to improve quality of individual health care delivery e.g. supervision; coaching; teamwork organisation; audits; and other reflexive methodologies.

10.6.2. Action research in health services organisation

If academic public health activities financed with public funds are to be socially relevant, academics need to make management of individual health care their priority mission in research and teaching. To be able to cope with this challenge, they need to be involved in action research aimed at studying in practice publicly oriented health centres, hospitals and local health systems that could serve as places for training, research and demonstration.

10.6.3. Deconstructing the official, functionalist aid discourse

The available scientific insights into the determinants of ill-conceived projects are limited. Systematic flaws cutting across many bi- and multi-lateral projects are even more rarely published. However, we believe they should be researched and understood to improve future aid policies design.

Our study assessed the official discourse justifying the aid features by its health goals and alleged achievements. It puts into perspective those policy concepts promoted by aid agencies and largely used by decision-makers and academics.

Functionality is by definition the referent by which any health policy claims to abide. To critically assess any such assertions against the features of each country's environment, scientists need to be interested in technical decision-making standards and know-how, and also in the conditions that made possible at a specific time in history decisions that were blatantly in contradiction to peoples' health status and access to individual care - such as unbalanced, biased political representation, economic factors including corruption, and scientific 'truth' attached to academic concepts (see section 8.3.1).

Our critical analysis of a dominant policy is built on a particular epistemological configuration. To undermine the functionalist justification of HSR, we started with technical concern (utilisation rates, referral completion rates, admission rates, systemic health management) and ended up shedding a political and social light on the health sector history. This is why health systems research is dedicated, we believe, to mobilising concepts from history and political sciences.

10.7. The role of International Cooperation in Health

Bolivia participated to the 2002 Monterrey Consensus, the 2005 Paris Declaration on Aid Effectiveness to Development and the Doha Declaration on Financing for Development in 2008. But at the end of this academic work, reminding donor agencies of their political commitments and public declarations appears out of step. USAID activities were and are constrained by legal boundaries that make its national interest a key yardstick of its aid activities. Similarly, the World Bank is bound by private and public industrialized countries'

funds. Being a bank, it will retain a mandate to maximise loans and increase speed in funds utilisation. Although some of its officials recently said that, in the future, the Bank would no longer apply ready-made solutions to all LMICs and be less prescriptive (The World Bank 2010), there are reasons to believe that the bank will remain prescriptive when new markets have to be opened. These new officials' comments probably only expressed the fact that the bulk of their work (e.g. enforcing commoditisation of individual health care delivery) was over in many countries and many sectors.

Nor is it reasonable to expect USAID to invest much in the Bolivian health system if privatisation of individual health care delivery largely succeeds and if local decision makers meet its political agenda without external interventions. This, perhaps more than visible political gesticulation and diplomatic tensions, explains the reduction to one third of the international aid to the Bolivian health sector during its socialist period (Table 15). Indeed, international cooperation did not disappear but moved to other sectors: today, both USAID and the World Bank remain active in Bolivia although in 2010 only 2.9% of external funds went to the health sector, as compared to 11% in 2004 (The World Bank 2012a).

Table 15: Health financing sources in Bolivia (2003-2010)

Source	2003	2004	2005	2006	2007	2008	2009	2010
Total Health expenditure	3.506	3.771	4.338	4.474	4.907	6.028	7.090	7.631
External Credits	3,6%	3,5%	4,3%	3,0%	1,7%	0,3%	0,0%	0,1%
External Donations	4,0%	6,6%	4,4%	5,1%	5,8%	5,0%	4,9%	2,6%
NGOs	1,7%	1,5%	0,9%	1,6%	1,4%	1,3%	1,0%	1,2%

Source: National accounts of health

The next commercial objective of industrialised countries' banks will be to expand private health insurances in LMICs middle classes (in Latin America, they aim at close to 15% of the population – as in Chile, an old, mature such market). This commercial ambition does not require system restructuration. Lacking access to decent care in public services, middle class people are likely to spontaneously purchase such insurances. From this standpoint, sending a few Cuban doctors to Bolivia (Section 4) or Venezuela will not make a difference although it will make a short-term difference to their (often rural) patients.

In theory, all new cooperation agreements should be explicitly aligned with public policy or be rejected. Lacking a public health policy that favours equitable access to individual care, Bolivia is unlikely to be in a negotiating position to make large international aid actors work for the majority of its population.

Annex: Definitions

1. Health care quality criteria: comprehensive, integrated and continuous

WHO defines health systems as all organisations, people and actions whose primary intent is to promote, restore or maintain health (Blas & Hearst 2002). Health systems have three principal functions: stewardship, financing, and health services delivery. The specific characteristics of each health system depend on the history and political and socioeconomic conditions of each country as well as the degree of influence exerted by different interest groups and political forces.

Our approach to a Health System is strongly influenced by the values and principles that have been explicated by the GERM and the Tavistock group (G.E.R.M. 1971), ;(Smith et al. 1999). They include health care as a right for all, social justice, equity and solidarity, health as one among other valued goods that need to be assessed in its socio-economic and socio-cultural context, protection of the population balanced with responding to individual suffering, autonomy (the right to self-determination and ownership at national, local and individual level) balanced with providing safety, and security, effectiveness balanced with efficiency, sustainability, participation and negotiation between (groups in) the population and professionals, trust and accountability (Van Olmen et al. 2010).

Comprehensive health care includes care initiated by a patient demand as well as by health professionals and disease specific programmes. First-line health services include family and community medicine, which encompasses individually tailored prevention and promotion activities in health institutions as well as mass prevention and clinical interventions. It is delivered by multi-functional services and includes hospital medicine able to handle at least medical, obstetric and surgical emergencies. Such care may be delivered by an array of professionals, from physicians and assistant medical officers, to clinical officers or nurses, but not community health workers (Unger, De Paepe, Ghilbert, Soors, & Green 2006b;Unger, De Paepe, Ghilbert, Soors, & Green 2006c).

Quality of care comprises the components of effectiveness, efficiency, safety, patient-centeredness - giving information, shared decision making, combining a biomedical, psychological and social perspective, integrated and comprehensive care - addressing the needs for curative care, prevention and health promotion, continuity within and beyond a single episode of disease (dimension of time) and continuity beyond the visits to one specific health institution (dimension of place) (Unger, Marchal, & Green 2003b), (Unger, De Paepe, & Green 2003a), (World Health Organization 2008a).

Integrated local health systems: demarcate a well-defined population of responsibility; ensure legitimacy and accountability towards a population; and initiate planning on the basis on rational criteria and pragmatism with the aim to be responsive to the local needs and context (Unger & Criel 1995).

Access to health care relates to how many people have access to a health facility or particular service. It has different dimensions: financial accessibility (affordability), psychological and cultural accessibility (acceptability) and geographical accessibility.

Universal access implies organizing a health system to provide health services that are accessible to all in all its dimensions.

In practice, a health system should meet the following criteria to be called integrated as opposed to fragmented and segmented: (i) It has no functional gaps: people should find appropriate solutions somewhere within the system for the vast majority of their health problems; (ii) It has no functional overlaps: every level plays its own specific role; (iii) The best fit level takes care of a patient's problems and the first level of health care is the entry gate into the system, as it holds infrastructure likely to solve up to 90% of health problems; (iv) All information relevant to a patient's problem always accompanies him/her when moving from one level of care to another in the system (Unger & Criel 1995); (v) A management team – as close to the peripheral level as possible - is charged of giving administrative and technical support to the facilities within a structured network or district; and (vi) There is consistency between the management line and the decision-making process (Van Lerberghe and Lafort 1990).

2. Integrated health services

First-line health services include family and community medicine, which encompasses individually tailored prevention and promotion activities in health institutions as well as mass prevention and clinical interventions. It is delivered by multi-functional services and includes hospital medicine able to handle at least medical, obstetric and surgical emergencies. Such care may be delivered by an array of professionals, from physicians and assistant medical officers, to clinical officers or nurses, but not community health workers (Unger, Marchal, & Green 2003b), (Unger, De Paepe, & Green 2003a).

The following definition of comprehensive, integrated, and continuous health services is proposed by WHO (World Health Organization 2008a): "the management and delivery of health services such that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services, through the different levels and sites of care within the health system, and according to their needs throughout the life course."

Integrated Health Service Delivery Networks can be defined as: "a network of organisations that provides, or makes arrangements to provide, equitable, comprehensive, integrated, and continuous health services to a defined population and is willing to be held accountable for its clinical and economic outcomes and the health status of the population served." Furthermore, integration can also have different modalities such as horizontal integration, vertical integration (Shortell and McCurdy 2010) (Table 16).

Table 16: Concepts of horizontal and vertical integration

Concept	Definition	Observations
Horizontal integration	Refers to the coordination of activities across operating units that are at the same stage in the process of delivering services.	Examples of this type of integration are consolidations, mergers, and shared services within a single level of care.
Vertical integration	Refers to the coordination of services among operating units that are at different stages of the process of delivering services.	Examples of this type of integration are the linkages between hospitals and medical groups, outpatient surgery centres and home- based care agencies. There is forward vertical integration, which is toward the patient or user, and backward vertical integration, which is toward the supply side such as medical equipment and supply companies. Furthermore, there is the possibility of vertical integration with the health insurer.

Essential attributes of Integrated Health Service Delivery Networks: a unified system of governance for the entire network; broad social participation; inter-sectorial action that addresses wider social determinants of health; an integrated management of clinical, administrative and logistical support systems; sufficient, competent and committed human resources for health; an integrated information system that links all network members with data disaggregated by sex, age, place of residence, ethnic origin, and other pertinent variables; and an adequate funding and financial incentives aligned with network goals.

3. Segmentation and fragmentation of health care delivery systems

Segmentation: when parallel and strictly separated subsystems coexist within a health care delivery system, with different modalities of financing, patient affiliation, monitoring and service delivery. Each subsystem is 'specialized' in different population strata according to their place in the workforce, ability to pay, socioeconomic status. This leads different socioeconomic groups to be covered by different funding pools and served by diverse providers (Fleury 1998). Health care delivery is said to suffer.

Fragmentation: wherever parallel units or entities function separately without proper coordination within a health care delivery system. Fragmentation impedes the proper standardisation and compatibility of contents, quality and cost of health care delivery, which leads to lack of synergy and increased transaction costs

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