ECUADOR'S SILENT HEALTH REFORM

Pierre De Paepe, Ramiro Echeverría Tapia,
Edison Aguilar Santacruz, and Jean-Pierre Unger

Health sector reform was implemented in many Latin American countries in the 1980s and 1990s, leading to reduced public expenditure on health, limitations on public provision for disease control, and a minimum package of services, with concomitant growth of the private sector. At first sight, Ecuador appeared to follow a different pattern: no formal reform was implemented, despite many plans to reform the Ministry of Health and social health insurance. The authors conducted an in-depth review and analysis of published and gray literature on the Ecuadorian health sector from 1990 onward. They found that although neoliberal reform of the health sector was not openly implemented, many of its typical elements are present: severe reduction of public budgets, "universal" health insurance with limited coverage for targeted groups, and contracting out to private providers. The health sector remains segmented and fragmented, explaining the population's poor health status. The leftist Correa government has prepared an excellent long-term plan to unite services of the Ministry of Health and social security, but implementation is extremely slow. In conclusion, the health sector in Ecuador suffered a "silent" neoliberal reform. President Correa's progressive government intends to reverse this, increasing public budgets for health, but hesitates to introduce needed radical changes.

Most countries in Latin America implemented their health sector reforms in the 1990s, with the exception of a few such as Cuba and Brazil, where reform started in the 1960s and 1980s, respectively. Often, reforms were implemented as part of structural adjustment programs during external debt repayment crises and subsequent International Monetary Fund and World Bank interventions. In 1980, health reform in Chile represented a precursor to this wave of neoliberal

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reforms (1). The main reform content usually comprised a purchaser-provider split, limitations on public services for disease control, health promotion, and preventive care, and a minimal package of activities for the most frequent diseases (2). This was a direct incentive for private health insurance and private care providers (3). Public budgets for health decreased, often dramatically. In this article, we describe and analyze the (often failed) attempts to reform Ecuador's health system over the past two decades.

Ecuador is situated on the northwestern coast of South America (area 256,370 km^2). It is a middle-income country, with high inequality (Gini index 53.6 in 1998 and 54.4 in 2009; the country ranked 80th in the 2009 United Nations Development Program's Human Development Index; 4) and ethnic diversity (majority *mestizo*, 25% indigenous, white and black minorities). In 2008, 35.1 percent of the population lived in poverty; in 2005, the rate of poverty was 79 percent among the rural population. In the same year, 2008, the richest 20 percent of the population accounted for 46.5 percent of consumption, the poorest 20 percent for just 7.7 percent; gross domestic product (GDP) per capita (purchasing power parity (PPP), U.S. dollars) in 2008 was an estimated $7,600 (5).

Ecuador has experienced a politically very unstable period over the past 15 years, causing problems in governance, occasional social violence, and lack of continuity in public management. No less than nine ministers of health held office in the 2001–2005 period. National stewardship in health, theoretically a Ministry of Health function, suffered.

ORGANIZATION OF THE ECUADOR HEALTH SYSTEM

The public sector comprises the Ministry of Health (MoH); the Instituto Ecuatoriano de Seguridad Social (IESS), the social security system for workers and employees, with the Seguro Social Campesino (SSC), the rural social security system, a subdivision for the rural peasant population; the Armed Forces and Police Health Services; health services in a few municipalities (Guayaquil and Quito), including the Junta de Beneficencia de Guayaquil (JBG), the Guayaquil welfare board; and Sociedad de Lucha contra el Cáncer (SOLCA), the society for the fight against cancer, for cancer patients. The MoH, the IESS-SSC, and the private sector are completely separate segments of the health sector (6) and basically are aimed at different layers of the population: the poor are served by the MoH and the formally employed by the IESS, while the upper middle class and the rich use private services. The SSC aims at the rural poor and in this sense overlaps with MoH rural services, although the SSC only enrolls families through legally recognized peasant organizations. Urban IESS affiliates contribute a small part of their insurance premium to finance the SSC.

With regard to services offered by the MoH, in 2006 there were 230 health stations, 127 health centers, and 1,226 auxiliary health centers at level I; 82 basic hospitals and 33 general hospitals at level II; 15 higher-level hospitals; and 1 national top-level hospital. The MoH presently operates 17.6 percent of the country's facilities, whereas in 1994 this figure was 27.0 percent (7).

To cover 19.2 percent of the population, for the 10 percent of urban affiliates, the IESS manages 3 third- and fourth-level hospitals, 17 provincial hospitals, 65 first-line centers, 600 dispensaries at the workplace, and more than 100 accredited private providers; for members of the SSC (9.2% of the population), there are 599 rural dispensaries (8). The IESS contracts out many services to the previously mentioned accredited private providers (9).

The Guayaquil welfare board, the JBG, is financed by the national lottery and operates four hospitals in Guayaquil, the main city on the coast. The cancer society, SOLCA, treats cancer patients, is semi-private, and has nine specialized hospitals in the country.

The private sector includes for-profit private entities (e.g., hospitals, clinics, community clinics, physician's offices, pharmacies, and prepaid health care organizations), as well as nonprofit private organizations such as nongovernmental organizations (NGOs), popular health service organizations, and social service associations, which account for 15 percent of facilities in the country. Private health insurance companies cover just 3 percent of the population.

On human resources in health, in 2006 there were 14.4 physicians, 5.6 nurses, and 10.4 nursing assistants per 100,000 inhabitants. Most physicians have dual employment in the public and private sectors. In the MoH, most physicians work on four-hour-a-day contracts.

HEALTH SECTOR FINANCING AND EXPENDITURE

In 1997, public and private expenditure were practically in equilibrium: 50 percent each, according to the National Health Accounts (10). Private health spending was almost entirely out-of-pocket, and poor families spent an average of up to 40 percent of their income on health, compared with 7 percent for the richest decile (11, p. 250).

Public spending on health increased from an extreme low of 0.6 percent in 2000 to 1.5 percent in 2004 and 2.0 percent in 2008 (vs. a debt service total of 11.4% of GDP in 2005) (12). The MoH budget rose from 2.6 percent of the general state budget in 1997 to 10.1 percent in 2008 (about $1 billion; all dollar amounts in U.S. dollars). (The average percentage was above 6 percent in the 1980s and 1990s.) In 2001, the IESS spent $170 per affiliate and $14 per SSC member, the MoH spending $38 per beneficiary.

According to ENDEMAIN 99 (a national household survey), 72 percent of families faced difficulties in accessing services, up to 84 percent in rural coastal

areas. The same survey in 2004 showed that 11 percent of families had spent more than $80 on health care, and 27 percent between $20 and $80, in the past 30 days (13). These figures exist in comparison to a GDP per capita of $6,151 (5).

Overall, Ecuador in the recent past showed insufficient and inequitable public expenditure and high private expenditure on health, mainly out-of-pocket, of which 61 percent was spent on pharmaceutical products. A recent report mentions Ecuador as the country with the largest decrease in pro-poor targeting of public spending on health (14).

HEALTH INDICATORS

Average life expectancy in Ecuador in 1985 was 67.5 years; in 2008, it was 75.5 years. The fertility rate is decreasing fast: in 1950 it was 6.7, in 1975 was 5.4, and in 2008 was 2.5 children per woman. The infant mortality rate now stands at 20.1 per 1,000 live births, a decline from 107 in 1960. The rural rate is twice as high as the urban one. The maternal mortality rate stood at an unacceptable 85 per 100,000 in 2005 and 55 per 100,000 in 2007; in a recent report, Ecuador received special mention for making strides in reducing maternal mortality (15, 16). We comment later on how this might be a positive effect of the Free Maternity Law enacted in 1998. Stunting affects 26 percent of children under five in Ecuador, with a higher prevalence in the rural highlands and among indigenous peoples (17).

ACCESSIBILITY AND QUALITY OF CARE

According to data from the capital, Quito (18), which cannot be extrapolated to the entire country but does show a trend, the population seeks more private than public (MoH, IESS, NGO) services: 70 percent. Even the poor consult more with private providers: 52 percent; 21 percent with pharmacists, 20 percent with private physicians, and 11 percent with other, informal providers (e.g., traditional healers). The poor and the extremely poor, respectively, cite good quality (32% and 39%) and easy geographic access (17% and 18%) as reasons to go private. Waiting times in public services were, on average, 1 hour 43 minutes, and in private services were 22 minutes. Public services are perceived as being of bad quality, both by the general population and by the lowest quintiles (58% and 64%, respectively). It must be stressed that the majority of physicians working in the public sector have achieved a working day of just four hours, an amazing feat that explains a significant portion of patients' complaints about waiting times, inconvenient opening hours, and short consultations.

A survey was performed in Quito on the technical quality of medical services (19). In Quito's public services (the MoH and municipality), guidelines were followed by 63 percent of physicians, and 30 percent of prescribed drugs had no proven efficacy (300 clinical files reviewed). In 28 percent of cases, there was

no coherence between diagnosis and treatment. There was no trace of health promotion or preventive care during consultations for disease problems.

According to the same study, an overwhelming proportion of adult patients in these public services are women (73.3%, and even 94% in the above-mentioned study) (18). Chronically ill patients form just 11 percent of consultation cases, while chronic diseases are responsible for at least 45 percent of mortality (20). Preventive care consultations account for 45.3 percent of consultations, a clear indication of the strength of the private sector in morbidity consultations, a field virtually abandoned by the public sector (we can hypothesize a possible association with the fact that most physicians "enjoy" double employment).

An analysis of data from the 2004 National Demographic and Maternal and Child Health Survey (ENDEMAIN) found a significant negative relationship between household economic status and utilization of preventive and curative services, and the same was found for indigenous ethnicity (21).

In summary, the health system is characterized by deep-rooted structural segmentation and fragmentation, adversely affecting both professional employment and, as will be seen, peoples' access to quality health care.

We now explore how, over recent decades, health policies have impacted the health system's structure and achievements in population health.

REFORM PERIODS

1992–1997

In 1992, the conservative Durán-Ballén government's Law on Modernization created CONAM (National Commission on Modernization), with a clearly neoliberal profile (22–24). The following years under presidents Bucarám and Alarcón brought no distinct health policy, but the MoH budget was abruptly reduced to an absolute minimum: from 4.6 percent of GDP in 1996 to 2.8 percent in 1997. Cost-recovery mechanisms were implemented, followed by long national strikes by the Medical Federation and workers' unions.

A World Bank project, FASBASE, was implemented in 1993 in 41 health areas, with a $102 million budget (25). It worked mainly on the primary health care strategy and emergency services, while offering some training to health staff.

Many reform proposals were launched, the main ones by CONAM, CONASA (the National Council on Health), and the Bi-Ministerial Commission (the MoH and IESS). A World Bank loan stimulated reduction of personnel at the MoH, with many dynamic staff leaving the institution to work in better-paying NGOs. The battle between CONAM and CONASA in the end produced no reform at all, unless the budget reduction were to be called a silent reform. By August 1996, 18 proposals for health sector reform had been elaborated, and 25 for IESS social security reform.

As for the IESS, it experienced an institutional crisis, with administrative and financial problems, a huge unpaid state debt, user dissatisfaction with medical services, patronage, and bureaucratization. The IESS was the perfect objective for privatization, an important potential market for private insurers, like ISAPRES in Chile. CONAM proposed a mix of public and private insurers within a scheme of managed competition (the influence of Alain Enthoven, of Stanford University, contracted in 1995 with World Bank funds) to correct both market and state failures. The proposal included a minimal package for the non-salaried to be subsidized by the state. It was a replica of the Chilean and Colombian schemes, with the inequities inherent to this model (1, 26), and was massively rejected by referendum in 1995.

1997–2007

Ecuador's new 1998 Constitution for the first time established the right to health and confirmed the stewardship of the MoH. The Organic Law of the National Health System of 2002 and its regulation in 2003 insisted on the concept of a national health system as the central axis of health reform, but lack of a coherent social policy and of coordination between the MoH, IESS, SOLCA, and JBG impeded its implementation.

The MoH applied a certain degree of deconcentration of human resources and financial management to the provincial level, and MODERSA (Health Services Modernization Project) (27), a 1998 $45 million World Bank project, approved in 1997, aimed at the development of a "Decentralized System of Universal Coverage in Health," an integrated health network at the local level with public and private providers. The latter was, in fact, an attempt to further weaken the public system through a purchaser-provider split, with direct payment to providers according to differentiated tariffs, corresponding with the economic capacity of users, prepayment plans, or contributions to a common fund (28). Contracting in and out were applied, and the system worked as an incipient insurance system with participation of the private sector, for instance, in the city of Cuenca. City councils became insurers and purchasers of care (Health Promoting Companies), as in neighboring Colombia.

Several National Congresses for Health and Life were held, with the pretense of enhancing people's participation in determining the national health policy.

The 1997 Law of Decentralization and Social Participation (29) was never really implemented, and municipalities, with the exception of Quito, Guayaquil, and Cuenca, never requested the transfer of health services to their realm. There was little enthusiasm to take over underfinanced and inadequately managed health services, without the possibility of managing health service human resources and in the context of looming conflicts with powerful and corporate unions. MoH managers were always strongly opposed to decentralization to municipalities.

The Law of Free Maternity and Child Care (30) was passed in 1998. It was implemented mainly through MoH facilities, managed by users' committees, and had a budget of $25 million in 2006. That year, it performed 7,492,985 consultations and covered 1,300,000 women and 1,567,000 children; institutional childbirth deliveries rose from 63 to 75 percent between 1994 and 2004 (31–33). This might explain the fall in maternal mortality rate mentioned earlier in the article.

The project of reform of the IESS (Social Security Law of 2001) and the Intervention Commission in 2002 introduced a split between the insurance and provider functions. The Constitution of 1998 was not respected, and resources for the IESS were limited, while contracts with the private sector increased.

As for the rural social security, the SSC, the Social Security Law enacted in 2001 and its regulation in 2003, severely restricted new enrollments, and health rights for its members were not upgraded to equal those of IESS members, although this was mandated in the 1998 Constitution.

Although the major reform proposals in this period were all aborted, implicit policies and actions oriented by the neoliberal model (and MODERSA) were implemented: purchasing of health services, benefit packages according to user, hospital autonomy (like the hospital trusts or foundations in the United Kingdom), prepayment systems, contracting per hour and per product, contracting out of public services, outsourcing, and so forth. In the absence of state stewardship, CONAM, World Bank projects such as MODERSA, and private insurers and providers lobbied successfully for these market mechanisms in health to be strengthened.

In 2005, a particular initiative was started, formerly suggested by a World Bank publication on the Economic and Social Agenda for Ecuador (11, 31); first it was called Insurance for the Poor (34), and later, Aseguramiento Universal de Salud (AUS), universal health insurance, and PRO-AUS. Instead of merging existing health insurances (IESS, SSC, Free Maternity Law), this initiative by vice-president Palacio (later president) created a new insurance system for income quintiles 1 and 2, to be financed by the World Bank and the Inter-American Development Bank (35). A separate structure was created, Subsecretaría para los Objetivos del Milenio (SODEM), subsecretary for the Millennium Development Goals, which was dependent on the presidency and later transferred to the MoH.

The AUS was implemented with municipalities in the main cities: in Guayaquil (contracting out to private health providers through a private Colombian company), in Quito (an agreement between Quito municipality and the AUS, with private insurance for quintile 3 and voluntary public AUS health insurance for quintiles 1 and 2; a two-tier system with a poor benefit package for the poor) (36), and in Cuenca.

2007–2010: Three Years of "Citizens' Revolution"

Around this period, left governments won elections in many Latin American countries: Venezuela, Bolivia, Uruguay, Argentina, El Salvador, and Paraguay. In

health, the emphasis of the strategies in Bolivia and Ecuador was very much on control of social determinants of health, without combining it with excellent curative care as in Cuba (37, 38). Perhaps the main exception was Venezuela, which started the Barrio Adentro (39) program with the help of a large contingent of Cuban physicians. In Ecuador, the Correa government, initiated in 2007 and heralding the "Citizen's Revolution," introduced changes in MoH health policy with three main components.

First, there was a large increase in the budget for the MoH, from $615 million in 2007 to $1,047 million in 2008. The recently approved new Constitution required a yearly 0.5 percent of GDP increase in the public health budget. In 2008 it reached 2 percent of GDP, still low but double what it had been in past years. Investment was mainly in equipment, infrastructure, and staff in the MoH. Public investment in 2007–2009 totaled $2,360 million, primarily in drug supplies, ambulances, hospital equipment, specialized mobile units, and human resources for the program of extension of coverage with basic health teams (EBAS).

Second, progressively, all MoH health services were to be free of charge, as of April 2008. This was quite a spectacular change from former cost-recovery mechanisms. The results are not very well documented, but the MoH reports a 50 percent increase in morbidity consultations, which probably indicates a large, formerly repressed demand. More importantly, the use of diagnostic tools such as tomography, echography, and mammography more than doubled as a consequence of demand, and strong government advertising campaigns were conducted on the availability of newly acquired technology in MoH hospitals. The free services induced a "demand crisis," especially in Guayaquil, where MoH hospitals, ill prepared for this higher demand, were unable to cope with the influx of patients and contracted private clinics to stem public discontent.

Third, extension of social protection was to be attained through the EBAS teams. This was a program to reach rural and marginal urban communities. More than 4,000 physicians were contracted for the EBAS program. Teams implemented home visits and offered preventive and curative primary care. No fewer than 1,718 teams are now at work and cover about 1,500,000 inhabitants. These newly hired doctors are still waiting to be fully incorporated into the MoH with regular contracts.

The AUS initiative was completely stopped in January 2010. In Guayaquil, the services have been transferred to the MoH; in Quito, the joint insurance initiative with the municipality has been put on stand-by, and municipal health services are now free of charge.

A reform plan for the health sector as a whole has been presented by the Secretariat for Planning and Development (SENPLADES) (40), a planning organism of the government. The plan is called "transformation," as opposed to reform, and is thus meant to be much more radical. The transformation plan has seven axes: strengthening the National Health Authority, administration of a national health system, a network of public providers, the financing of a national

health system, control and monitoring of the same, an information system, and citizen participation and social control.

The aim of the transformation plan is to establish a single tax-based health system within six years. At the start of the reform, the MoH and IESS would still exist as separate entities, but gradually patients could consult in facilities of their choice, whether belonging to the MoH or to the IESS or SSC (functional integration). One single management unit would be created, above the MoH and IESS authorities, to manage and integrate the facilities of the MoH and IESS.

Eventually, the plan is that financing will be 100 percent tax-based, with the support of oil revenues; the Bismarckian component of the system (the IESS) will cease to exist, and employers and employees will contribute through (increased) taxes. The professional career for the health sector has already been approved in the new Constitution and will gradually align careers and salaries in the MoH, IESS, and SSC.

As a first step toward functional integration of IESS and MoH services, a single tariff system for the MoH and IESS for cross-provision of services has been elaborated by the IESS, but its application has been delayed because of institutional resistance and inertia.

The Ministry of Social Coordination, in charge of the IESS and created as a coordinating ministry with stewardship functions, acts as a competitor of the MoH for this stewardship role. The new ministry has presented its own plan for the IESS, aiming at universal coverage as mandated by the Constitution. It also reserves this goal for MoH services, a fatal case of bicephalism. The IESS has had four medical directors over the past few years and has lavishly spent on the acquisition of equipment. It has failed to hire enough specialists to clear waiting lists and now contracts more with private providers than with its own facilities. Like the MoH, it reports sharp increases in utilization of its services. However, due to a lack of statistical data, since 2007, on the health sector as a whole, and specifically on coverage of each subsector, it is hard to verify this information.

As for the private sector, it benefits from the weakness of the public sector and maintains its steady growth. The Hospital Metropolitano in Quito is expanding, and in Guayaquil, two new private hospitals are under construction.

National Congresses for Health and Life are still being held every two years, with all actors in the health sector, but the influence of civil society on national health policy is scant. The progressive weakening of CONASA is another symptom of the decreasing civil participation in health.

DISCUSSION

Neoliberal health sector reform has failed in Colombia, Bolivia, and Chile (41). Ecuador suffered structural adjustment programs in the 1980s, and a major economic crisis in the 1990s reduced public health expenditure even further, with dire effects on access and quality of public health services. In spite of tens

of proposals over the past few decades, the intended neoliberal reform of the Ecuadorian health sector was not implemented, due to lack of political continuity, low priority of health on the national agenda, conflicts between stakeholders and defense of institutional spaces, resistance from unions, path dependency (42), and reform fatigue after so many failed attempts. Despite the lack of visible reform, a silent reform was completed, with steep decreases in public budgets for health, leaving the MoH weakened, users dissatisfied, and the private sector happy. In fact, behind the scenes, the main protagonist of Ecuador's silent reform was the private health sector, which also benefited enormously from the absurd four-hours-a-day regimen of public staff.

What had been achieved by 2007, after two decades of apparent non-reform? Not much. Segmentation and fragmentation of the health system continued; MoH services still took last place in user surveys, followed by the IESS; and the AUS universal health insurance initiative did not resolve anything and was later dropped. MoH stewardship was as weak as ever, and both the MoH and the IESS had a constitutional and similar mandate to cover the whole population. As a result of the public sector deficiencies, the private sector has thrived—also because of increased contracting out by the IESS.

As correctly stated by Fiedler as early as 1991 (43), the tenure of ministers of health averaged one year, and subsequent changes in mid- and upper-level management translated into frequent abandonment of recently introduced initiatives, a proliferation of vertical programs (on the website of the Ministry of Health, one finds no fewer than 18 vertical programs; 44), and substantial program overlap and duplication, such as between the Program of Free Maternity and Infant Care and the Program of Infant and Child Care.

Correa's investiture in 2007 was a unique opportunity to apply the lessons learned from neoliberal reform failure and to implement a reform or transformation that would benefit those in need of decent, affordable health care provided by appropriately financed public services united in a single system. Reform required political will and a majority in parliament, conditions then, as now, present, together with a new Constitution clearly stating the right to health, the right to social security, and the right to *sumak kawsay*, "living well" in Quechua.

The critical policy question was whether to transfer decently financed services from the MoH to the IESS, or vice versa. Neither of the two institutions has a good reputation for service quality and responsiveness. The Costa Rican model, although substantially different from the health system in Ecuador, seems attractive (transfer of MoH services provision to social security, and the MoH as steward of the system) (45). However, this would mean the MoH would have to change into a small-scale but highly trained organization—which could face political and technical obstacles. Costa Rica started with the transfer of hospitals. In such a scenario, a gradual transition could be appropriate, the SSC should be fully integrated into the IESS system, and Free Maternity Law funds should be subsumed into the global public budget for health.

The Correa government, in its transformation plan, initially opted for the second scenario: a single health system, tax-based, and with functional integration of MoH and IESS health services. This is financially feasible with a supplementary contribution from oil income, and the details of the six-year transition plan have been published. A strong role is reserved for the first level of care, with the EBAS teams. This seems to be in contradiction to the official discourse, which is very much centered on disease control, hospitals, and technology.

So why, after three years of the Correa government, with a convenient majority in Congress, have no concrete steps been taken toward the transformation of the health system, as suggested at the start of this government? The MoH needs to be strengthened. But to reach the goals of equity, universality, quality, and efficiency of services in public health, it is necessary to transform the health sector as a whole so that it works as a single system—and the public services need to be unified in one way or another.

One of the reasons for the lack of transformation of the health sector is that in the polls, the government gets a high vote on its achievement in the health sector: free care in the MoH has been very well received by the population, who responded by visiting, in huge numbers, MoH health services, even if not always completely free of charge. Never change a winning team: it was easier not to push for big changes that would inevitably meet institutional resistance in the MoH and IESS (although many pro-government staff have been hired recently) and among the well-organized members of the rural social security, SSC. President Correa is battling on a number of fronts at the national level and is not in need of any more, especially now that his popularity is not as high as it used to be, according to the latest polls, reducing governability.

Another reason could be that the IESS buys large quantities of government bonds. It is therefore difficult to imagine Correa pushing to install a tax-based system and thus eliminate the Bismarckian system that sustains his government's liquidity.

A recent thesis on the Ecuador reform (46) rightly states that there has been a constant dispute between two models of organization of the health system: targeting with the creation of minimal packages, on the one hand, and decentralized universalization, on the other. While the Correa government seems inclined toward the second model, until now, the weak institutional structure—due to overwhelming corporative forces—has jeopardized any attempt to establish legitimate and consistent referential frameworks for the health sector.

A worrying aspect of the past few years is the growing reliance on service provision by the private for-profit sector: in Guayaquil, private clinics have been under contract to solve the growing demand on MoH hospital services. The IESS contracts out to increasing numbers of private providers (it owns 180 health facilities but has contracts with more than 220 private ones), and even the MoH has now contracted out part of oncology care to a private company, Humana, in Quito, channeling public money to the private sector. Contracting of private

providers is not necessarily a problem, but how will the MoH, which can barely supervise its own services, regulate and control private providers?

Fundamentally, nothing has changed in the structure of the health system in Ecuador, except for the higher budget of the MoH, which has allowed for better equipment and more human resources, though this improvement depends on the economic conjuncture. The MoH budget for 2010 seemed to be lower than that for 2009. Not even the minimal program of creating local networks of public health services has been implemented, though President Correa demanded demonstrative local networks for the second half of 2010, with functional integration of MoH and IESS facilities. The proposed efficient single tax-based system seems far off.

Segmentation and fragmentation of the health sector persist, and both MoH and IESS services suffer from patient dissatisfaction and quality problems. We are afraid that the window of opportunity for major, publicly oriented and socially motivated reform of the health sector in Ecuador is slowly closing and that the dream of reform or transformation of the health sector will continue to be a chimera.

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Direct reprint requests to:

Jean-Pierre Unger
Institute of Tropical Medicine
Department of Public Health
Nationalestraat 155
B-2000 Antwerp, Belgium

jpunger@itg.be