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Global Social Policy 2011 11: 22
DOI: 10.1177/1468018110391999

The online version of this article can be found at:
http://gsp.sagepub.com/content/11/1/22

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Article

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11(1) 22–44

DOI: 10.1177/1468018110391999
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Abstract

This article analyses the influence of the World Bank on reforms of the health sector in Bolivia during the period 1986–2006, and assesses their impact on the health care delivery system to date. The article examines the transformation of health services undertaken by the current socialist government since 2006. A literature review and interviews with decision-makers critically examine the outcome of reforms on criteria linked to health system integration. The study illustrates that Bolivia applied quite comprehensively the WB recommendations. Among others these included indirect privatization through public health services' restriction of access to a basic package

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of care and decentralization with devolution. In consequence, the segmentation and fragmentation of the health system was exacerbated, accessibility and quality of care suffered and health status barely improved. The article attempts to locate the relationship between policy, health care delivery and health systems functioning.

Keywords
Bolivia, health policy, health sector reform, integration, World Bank

Background

Health policy-makers around the world, especially in developing countries, are exposed to two conflicting, pressing global trends. On one hand, the pathway marked by the reforms of the 1980s and 1990s is still acutely felt in different forms and is reinforced by the liberalizing trends of economic globalization. On the other hand, several new health policy issues, such as the need to act on social determinants and to strengthen national health systems, explicitly challenge those policies. Both anti-globalizing thinkers and international organizations now agree on some of the main past failures (McMichael and Beaglehole, 2000). At the 63rd World Health Assembly, Dr Chan (WHO, 2010) recognized that policies and behaviours of donors could have been failing to invest adequately in basic health systems, infrastructures, training of staff, information systems, regulatory capacity, and systems for social protection, having contributed to fragmentation and duplication, decreased national ownership and weakened health systems. Bolivia is a good example of the battle-field between these tendencies.

Bolivia, South America's poorest country, underwent a deep economic crisis between 1983 and 1985. Millions of Bolivians were plunged into poverty. That crisis was used to push through social and economic policies, including the health sector, in line with the Washington Consensus, otherwise implemented throughout Latin America (Almeida, 2002; Lustig, 1995). The World Bank (WB) and the International Monetary Fund (IMF) were key leaders of that process (Armada et al., 2001). 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). The Siles Suazo government's (1982–5) adoption of comprehensive primary health care (PHC) was replaced by selective primary health care (SPHC), as promoted by the World Health Organization (WHO), UNICEF, USAID and the WB at the time (Cueto, 2004) and still present in contemporary disease-specific initiatives such as the Global Fund and others (Labonte and Schrecker, 2006). Until 2006 these neoliberal policies[1] prevailed.

In 2005 – before the socialist party currently in power won the elections – Bolivia scored lower than any other Latin American country in health and related equity indicators (PAHO, 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; WHO, 2008). Health policies consistently implemented over a 20-year period critically contributed to produce these poor statistics. Most of these policies were aimed at securing targeted access to a few 'cost-effective' interventions (PAHO, 2007). However more

recently the WHO director M Chan attributed the lack of progress on Millennium Development Goals (MDGs) to this narrow approach (Brown, 2007). While basically agreeing with this diagnosis, we contend that a closer examination of the institutional mechanisms at stake could possibly contribute to avoiding the repeat of the mistakes of the health sector reform (HSR) implemented in Bolivia since 1990. These were integral to structural adjustments carried out under the influence of WB projects and policy. While in disagreement with the basic principles of neoliberalism, the Bolivian government decided in 2006 to proceed with the implementation of the WB-financed 'Health Sector Reform' project (Republic of Bolivia, 2006). In addition, the Ministry of Health (MoH) required first-line health services to tackle social, economic and environmental determinants of ill health (Ministry of Health and Sports, 2006). Bolivia was at this time at a crossroads to reconcile its (stated) preference for family and community health and its (practised) selective interventions.

This article scrutinizes the influence of the WB on health sector reforms in Bolivia. In order to do so, it analyses Bolivian health policies during the period 1986–2006 (end of the second phase of the HSR project) and their determinants. It also examines their impact on the health system (dis)integration, access to care and disease control. It then examines whether the current government (2006–) has shifted from the previous policy rationale, and – if not – why it was unable to do so. Finally, the article proposes key elements to be included in a Bolivian health strategy in order to reverse the negative impact of earlier reforms (Almeida, 2002).

Methodology

First, we set out criteria for health care delivery systems. Then, we sketch the Bolivian health sector reform since 1990 – with a focus on WB-influenced interventions – in comparison with these criteria. To do so, we complemented a scientific literature search with 1987–2010 official reports of the Bolivian government and the WB and assessments of other organizations, such as the Pan-American Health Organization (PAHO)/WHO, the USAID Health Sector Reform Initiative and AIS-Bolivia, concerning the HSR and the Bolivian health system. We conducted interviews with six health care providers and eight decision-makers who had experienced the HSR process at the regional and national level. Findings were triangulated between the literature review and stakeholders' interviews. Finally, to draw recommendations for health policy, we isolated their main determinants and compared them with the policy choices made by the current socialist Bolivian government.

Benchmark used to assess integration and comprehensiveness of a health care delivery system

A health system should meet the following criteria to be called integrated as opposed to fragmented and segmented: (1) it has no functional gaps: people find appropriate solutions somewhere within the system for the vast majority of their health problems; (2) it has no functional overlaps: every level plays its own specific role; (3) 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 95% of health problems; (4) all information relevant to a patient's problem always accompanies him/her when moving in the system (Unger and Criel, 1995); (5) a management team – as close to the peripheral level as possible – gives administrative and technical support to the facilities within a structured network or district; and (6) there is consistency between the management line and the decision-making process (Van Lerberghe and Lafort, 1990).

Comprehensive health care includes care initiated by 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 multifunctional 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 et al., 2006a).

The World Bank and Bolivian health sector reform

Since as early as 1987, the WB advocated less public involvement and greater reliance on the private sector for health care provision in developing countries (Akin et al., 1987). In its 1993 World Development Report, the WB adopted a selective PHC approach pleading for restricting public delivery to a basic package of services targeted to the poor, hand-in-hand with the allocation of discretionary care to private providers (World Bank, 1993).

The Washington Consensus (Williamson, 1990) reinforced the case for decentralization, privatization and deregulation of economic and social policies in Latin America, including health (Williamson, 2000).

Undermining national stewardship

Structural adjustment is how the Washington Consensus recommended Latin American countries to react to financial crisis in the 1980s and 1990s. Bolivia assumed the Structural Adjustment Programme (SAP) as the economic and social policy paradigm in 1986. From 1990 on, the World Bank became actively involved in Bolivian health sector reform with the Integrated Health Services Project (Proyecto Integrado de Servicios de Salud, PROISS). With 50% of its funding coming from the World Bank, it paved the way for a central role of the Bank in the Bolivian health sector (Ugalde and Homedes, 2005). As a current MoH official states: 'Knowing the negative effects of the Structural Adjustment Program (SAP) shock, the WB and the Inter-American Development Bank (IADB) promoted the Sectoral Health System Reform process to mitigate it and to avoid social conflicts.'

In 1998, the MoH embraced the sector reform as an explicit goal. In 2002, the former MoH National Planning Unit became a WB-financed Reform Unit. Subsequently, all WB recommendations were almost automatically endorsed. 'The reform project was a parallel Ministry of Health where national health policy was defined because, managing the only flexible resources, it had the real power', as a public health insurance officer told us. The WB projects were responsible for 30% of the MoH non-salaries expenditures and

investments between 1993 and 2003 (Ministry of Economy and Public Finance, 2008; Vice-Minister of Budget, Public Accounting, 2007) and 65% in 1996–7 (Mostajo, 2000). Furthermore, '[Before 2006] key instruments, such as technical information, were in reform project hands and that gave it the real power over the system', specified a former doctors' union leader.

Privatizing health care

Three complementary mechanisms favoured privatization of health care: the reduction in social security coverage, the under-financing of public services, and therefore the need for restrictions towards subsidized MoH interventions (Homedes and Ugalde, 2005a):

1. The SAP reduced social security coverage by increasing labour flexibility, lifting the employers' obligation to co-finance their employees' insurance. As a consequence, more demand was created for private practitioners (most of them public staff with dual practice), who concentrated on cheap general practice among the lower middle classes, on the one hand, and on highly specialized care and expensive tests for the wealthy, on the other.
2. Successive governments under-financed public services other than mother and child health (MCH) and disease control. They left the bulk of the MoH budget earmarked for salaries – 51% of MoH budget in 1990–4 and 81% in 2001 – without additional resources and hence at the expense of investments, which fell from 15% to 6% in the same period (Cárdenas and Partnerships for Health Reform Project, 1998), and other running costs.
3. The MoH restricted its subsidized interventions to transmissible disease control, immunizations and MCH, in line with a 1997 WB strategy paper (World Bank, 1997).

While Bolivian governments strictly followed these WB-induced mechanisms, one particular initiative was not adopted. Although advocated by the PROISS project (Homedes and Ugalde, 2005b), contracting-out was never implemented because public budgets were not viewed as attractive by private practitioners. Moreover, as commented on by an MoH officer, 'All neoliberal policy [in the health sector] cannot be attributed to the [World] Bank. It was a set of factors, especially the will of the right-wing governments. For instance, the whole MoH structure during the government of Paz Zamora [1989–93] was devoted to the reform process and not simply to the WB financed project.'

Comprehensive and universal vs selective and targeted programmes

In 1990, the PROISS project, jointly with the Child and Community Health USAID project, decisively focused the public system on a pro-poor selective approach through MCH interventions and control of a few communicable diseases (tuberculosis, malaria and Chagas) (Homedes, 2001; Villena, 2006). 'The WB sought to target the public health system actions. In fact, it concentrated the vast majority of the health efforts of the country in a number of clear priorities', argued a former reform project manager.

WB financing was limited to antenatal care, skilled birth attendance, immunization and treatment of pneumonia and diarrhoea (Aillón and Lanza, 2005). The MoH policy documents from the 1989–93 (Ministry of Health and Welfare, Bolivia, 1989) and 1994–7 (Ministry of Human Development, Bolivia, 1994) periods clearly followed this orientation. The second WB project (the first health sector reform, US$44.0 million for five years, $23.3 million from WB, 1998) focused on implementing the decentralization of the sector and training health personnel to attend births, to implement family planning and to treat child diarrhoea and acute respiratory infections only (World Bank, 2004).

By contrast, not one single public initiative promoted comprehensive care be it through family, community or hospital medicine. Improvement of clinical decision-making in public services was solely based on disease programmes and MCH standardized guidelines. These factors contributed to separate comprehensive care from disease-specific clinical interventions, MCH activities and preventive health care (De Paepe et al., 2007).

In 1996 the MoH created an MCH public insurance (Seguro Nacional de Maternidad y Niñez) based on tax funds (US$11 million per year approximately) with a 3% contribution from international cooperation, mostly the WB, 'which also financed almost all administration costs and, with USAID, all infrastructure and equipment investments', as a former MoH official recalls. This programme followed the 'essential package of health services' policy promoted by WHO (Bobadilla et al., 1994; Claeson and Waldman, 2000) and UNICEF (Bedregal et al., 2000; Wisner, 1988).

This insurance programme strongly influenced the Bolivian health system reform. 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). '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. 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).

System segmentation and fragmentation

Health care delivery is said to suffer segmentation when parallel subsystems, with different modalities of financing, patient affiliation, monitoring and service delivery, are strictly separated. Each of these subsystems is then '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, which reduces the possibilities for income and risk cross-subsidies in the overall health system (Fleury, 1998).

Health care delivery is said to suffer fragmentation wherever parallel units or entities function separately without proper coordination. Fragmentation impedes the proper standardization and compatibility of contents, quality and cost of health care delivery, which leads to lack of synergy and increased transaction costs (Levcovitz, 2007).

Like many other countries in Latin America, the Bolivian public health system has always been segmented (PAHO, 2001), because of strictly separated MoH, social security and private facilities (Alleyne, 2000). However, the WB projects in our view consolidated this segmentation and deepened the fragmentation in several ways.

The HSR project financed the MCH public insurance managerial unit from 1996. Consequently, it acquired a large degree of autonomy in relation to the MoH and funded municipalities and health practitioners almost independently, thus exacerbating the fragmentation. As a former public insurance manager said, 'Developing parallel structures was a strategy to overcome the civil service difficulties: its political instability, the subsequent high staff turnover and the general weakness of public management.'

The reforms also added to fragmentation in applying a management–property split to public hospitals and health centres. Local governments gave hospitals within their jurisdiction different degrees of autonomy, without any MoH control. An MoH authority stated that, 'The hospital autonomy was a tool to contain public expenditure and to promote short-term and flexible personnel contracting mechanisms. This action impeded the creation of united teams in the public services and in the Ministry itself.'

This managerial shift permitted hospitals to define their own income-generating activities and all public health facilities were entitled to contract new staff with up to 15% of their user-fees revenue. From a hospital budget point of view, the impact was positive. For instance, during the first year of managerial autonomy, public hospitals increased their user fees income from 5.6% of total budget to 22.1% (Aillón et al., 2006). As of 2007, up to 33% of a general hospital functioning budget (1.049/2.1 million Bs [bolivianos]) in La Paz came from user fees (Municipal Accounting System, SINCOM, 2008). From a health care user point of view, out-of-pocket expenditure rose from 27.8% in 1995 to 35.1% of total expenditure on health in 1999 (WHO, 2008), with 5% of all Bolivian households incurring catastrophic health expenditure (Aguilar Rivera et al., 2006).

Like in most Latin American countries, the WB actively promoted decentralization, as part of the sector reform (Partners for Health Reform Plus, 2002). In 1994–5, the law of people's participation and the decentralization law transferred several competences and all public services' goods from central to local governments. This was applied to the health sector in the form of devolution (the transfer of authority for decision-making, finance and management to quasi-autonomous units of local government with corporate status) (Rondinelli, 1999) but was not accompanied by the necessary strengthening of the steering function of the central level. It also increased inequity between rich and poor municipalities, as the latter had to implement administration with few resources and managerial skills (Bossert, 2000).

During the sector reform process, strong opposition of professional associations and workers unions prevented full devolution of education and health facilities to municipalities in spite of two attempts in 1994 and 2001 (Aillón et al., 2006). MCH and vertical communicable disease control programmes remained centrally managed. Decentralization remained thus partial, and resulted in a multiplication of decision centres and heterogeneous responsibilities even within one single health facility. From 1997 onwards, finances were channelled to public facilities through four parallel routes: (1) salaries, mid-level management costs and technical support were transferred to the regions; (2) health

facilities maintenance and selective public insurance were passed on to municipalities; (3) funds for 28 [*sic*] vertical programmes remained centrally managed; and (4) international cooperation funds were either centrally and/or autonomously administrated. This authority mosaic frequently paralysed decision-making in health facilities and districts as the four channels responded to different rationales, authorities and sometimes political parties. This process increased transaction costs and undermined the MoH steering role (Barillas, 1997).

The reform also divided human resources into: (1) those dependent on regional MOH authorities; (2) those carrying out or in charge of vertical programmes; and (3) health professionals and administrative staff contracted by municipalities. The three categories could coexist in one hospital, alongside supernumerary politically affiliated personnel hired with autonomous funds.

The 1994 People's Participation Law (part of the SAP) also created a new participatory authority over health facilities (named municipal health boards or DILOS). Contrary to what might be expected, the boards didn't permit users to co-manage health services. With just one of three DILOS members (usually with a strong political background) representing the community, patients had no influence over health facilities (Aillón et al., 2006). As a result of their lack of power in comparison with the DILOS, district and hospital managers lost a lot of their capacity to integrate curative health care, the centrally managed MCH and disease programmes and the various aid projects. This new managerial pattern severely reduced the executive capacities and resources of existing district health teams (renamed health net managers).

Governments used central control of financial resources as a policy-enforcement tool for public management before the reform. Later, most public facilities operative costs became financed by insurance and user fees. Local managers began deciding how to use those resources at their own discretion (Aillón and Lanza, 2005).

Under the WB-led health sector reform, the finances, management and health facilities of the historically employment-based social health insurance remained untouched. At the expense of national solidarity, this insurance consumed a budget similar to that of the public service delivery system (41% of total health expenditure) while covering just 21% of the population (Aillón and Lanza, 2005).

System wise, the public budget breakdown remained unbalanced (Latin America and Caribbean Regional Health Sector Reform Initiative, 2004) – 13% for first-line services between 1990 and 1994, 17% between 1995 and 1999 and 18% between 2000 and 2004 – the bulk of it being allocated to hospitals (79% of non-salary costs during the first semester of 2008 in La Paz city).

To cap public expenditure, prospective budgets, MCH performance-based regional agreements, budget control, standardization of priority clinical practice and reduction of non-insurance earmarked public hospital supplies were used.

In 2002, the HSR project phase 2 (US$70 million, representing about 11% of MoH budget, 50% WB-funded) virtually converted MCH into another vertically managed programme, creating *Extensa* – mobile teams designed to visit poor municipalities three times a year to deliver limited MCH care (World Bank Human Development Department, 2001). As a measure of care without continuity,[2] the *Extensa* teams were yet another example of an uncoordinated fragment added to the public sector and at a high price (46% above the cost per patient treated).

Impact upon accessibility and quality of care

MCH public insurance improved access to services for the urban middle-class children and pregnant women. However, the majority of people lacking adequate access before the reforms – estimated at 54% in the 1970s – 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% of them did not receive any institutional care when needed (Narvaez and Saric, 2004). That same year the MoH provided health care to 38% of the population, the social security system formally covered 26% (but only 15.8% in practice) (Bossert et al., 2000), and the not-for-profit facilities fewer than 10%. The remaining 36% had as their only resort the private-for-profit health sector, often meaning no access at all (Aillón and Lanza, 2005).

Overall, there were few signs of improvement in access. Although access to care had increased in proportion, it was concentrated in better-off populations (PAHO, 2008) and outpatient utilization rates and hospital admission rates remained at very low levels. Under-fives care (13% of the population) was the only satisfactory area of progress, with outpatient consultations in this population segment almost quadrupling between 1996 and 2005 (Table 1). Under-fives detection rates for diarrhoea and pneumonia increased by 117% and 173% respectively. However, part of the success of the child survival programmes was linked to concurrent global initiatives led by UNICEF such as the GOBI (Growth Monitoring, Oral Rehydration, Breast-Feeding and Immunization) programme. Complete antenatal consultation – although a priority target – grew by a more modest 58% (Health Information System, 2009). This prioritized service, which needs good access to general health care, increased likewise non-prioritized activities. With this indicator still at 60% after 10 years of the MCH insurance programme, there is still room for improvement.

'People receiving subvention are those who couldn't pay a private consultation but already had (geographic, cultural, etc.) access to the facilities. All formerly excluded rural areas and the indigenous population remained uncovered', said an MoH officer and former MCH insurance programme manager. A government assessment (Ministry of

Table 1. Child, maternal and general care indicators, 1996–2005

Indicator	1996	2005	Increase %
Child care			
New outpatient public consultation rate (under-5s, %)	62.5	212.2	239%
Diarrhoea detection rate (under-5s, %)	21.2	46.0	117%
Pneumonia detection rate (under-1s, %)	8.4	23.0	173%
Maternal care			
Institutional delivery (%)	32.8	61.1	86%
Complete antenatal consultation (4 consults, %)	26.0	41.0	58%
General care			
New outpatient consultation (> 5, %)	21.8	36.0	65%
Admitted patient discharge (public, per 1000)	19.9	31.8	60%
Surgeries (public, per 1000)	4.0	6.5	61%

Source: Sistema Nacional de Información en Salud; at: www.sns.gov.bo/snis/default.aspx.

Planning, Bolivia, Economic Policy Analysis Unit, 2006) found that the population most using MCH public insurance services were high-income, highly educated urban mothers. The per capita insurance expenditure in the capital exceeded by 50% that in other municipalities (US$9 vs US$6 in 2000); 84% of insurance total expenditure in municipalities went to the regional capitals in 2000–4.

Thanks to international aid, access to child health care improved significantly. Instead, indicators of general care showed more modest advances and maternal care gave mixed results. Such a situation was compatible with one where there is limited access to PHC. Progress on prevention coverage contrasted sharply with family medicine and hospital care (Table 1). The system's fragmentation and segmentation hampered access to and quality of health care, especially in low-income quintiles through several mechanisms.

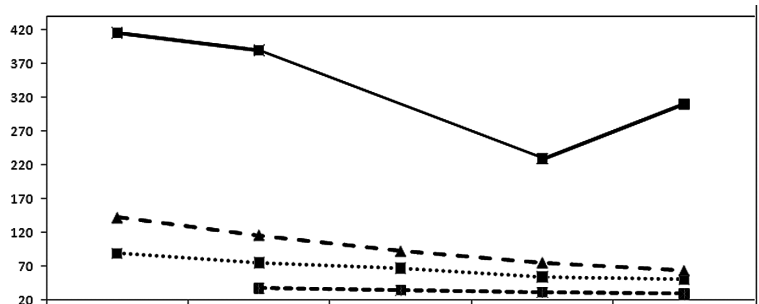
First, the system's segmentation made the earlier mentioned 36% of the population, allegedly served by the private sector, invisible to those in charge of securing access to care. Second, due to the ongoing inequitable allocation of resources between the social security and MoH facilities, the latter could only cover 38% of the otherwise uninsured (74%, see above). A national survey found that in 2002, 77% of the poorest quintile of the population didn't have any health insurance and only 4% was covered by the social security. In the richest quintile this was 57% and 37% respectively. That same year, 59% of the non-poor population acceded to services when needed, while just 44% of the poor and 35% of the extreme poor were able to do so (Narvaez and Saric, 2004). Third, the quality of care in public health services suffered from the health centres' focus upon MCH problems. Receiving supervision from each vertical programme and being evaluated only on programme goals, operational staff lost all incentives to offer comprehensive, bio-psychosocial care. Almost all the health care providers and decision-makers we interviewed agreed that the lack of coordination between the numerous fragments – health centres and hospitals, capital and rural municipalities, public insurance and general services administrations – hampered the quality of care.

Large parts of the population were not covered by the MCH insurance programme (besides the entire adult male population, 41% of the female). Although the total number of health facilities increased by 30% from 1996 to 2004, a national survey stated that in 2004 10% of people in rural areas still had no geographical access at all (National Institute of Statistics, 2005).

Under the HSR project, drugs management was decentralized. However, without strengthening managerial capacity, this resulted in 'arbitrary purchasing, frequent stock ruptures and under-provision of other than insurance-package essential drugs', as a former district manager stated. In 2000, 77.5% of the US$98.5 million spent on drugs in Bolivia was financed out-of-pocket. In 2004, the Pan-American Health Organization put at 30% of the population those who had no adequate access to essential drugs (PAHO – Bolivia, 2004).

Impact on health status

According to national statistics (Ministry of Health and Sports, 2005) (National Institute of Statistics and Ministry of Health and Sports, 2009), the infant mortality rate (IMR)



	1989	1994	1998	2003	2008
Infant mortality rate*	89	75	67	54	50
Under-fives mortality rate*	142	116	92	75	63
Maternal mortality rate**	416	390		229	310
Neonatal mortality rate*		37	34	31	29

Figure 1. Mortality indicators from national surveys, 1989–2003
*per 1000 live births.
**per 100,000 live births.
Each survey covers the five preceding years.
Sources: Encuestas Nacionales Demografía y Salud (ENDSA) 1989, 1994, 1998, 2008; National Health Information System, at: www.sns.gov.bo/; National Statistics Institute, at: www.ine.gov.bo/.

dropped from 89 to 50 per 1000 live births (44%); maternal mortality rate (MMR) from 416 to 299 per 100,000 (28%) between 1989 and 2008; and neonatal mortality rate (NMR) came down from 37 to 27 (27%) between 1994 and 2008 (Figure 1). The modest improvement in the two last indicators, MMR and NMR, is compatible with problems at the level of access to general health care. However, these values mask huge regional variations (Narvaez and Saric, 2004) and the achievements in IMR rates remain way below those of countries with similar socioeconomic conditions for a similar period (Table 2) (PAHO, 2009; World Bank, 2009a). Furthermore, rates had already started to decline before the WB projects – 2.2% average annual reduction of IMR from 1970 to 1990, 2.9% in 1989–98 (World Bank, 2009b) – which makes it difficult to attribute it to WB-induced policies.

A recent study (Ministry of Planning, Bolivia, Economic Policy Analysis Unit, 2006) showed that no infant death risk reduction can be attributed to public insurance in rural areas (1989–2003) and just 14.4% in urban areas. Under-fives risk reduction was only 10.2% in the country, with similar reductions in higher and lower income quintiles.

The HSR project failed to contribute to controlling diseases. After 15 years of prioritization, Bolivia still has the region's worse indicators (after Haiti) in tuberculosis and malaria, targets of two of the programmes (Table 3). The situation of non-prioritized health problems also stagnated (malnutrition: 26.8% in 1998, 26.5% in 2003) or even deteriorated (anaemia in pregnant women: 27.9% in 1998, 35.8% in 2003; syphilis: from 31/100,000 cases in 1996 to 53/100,000 in 2000). Leishmaniasis incidence increased from 12 to 38/100,000 (1992–2004) and the *Aedes aegypti* mosquito (virtually eradicated in 1948) spread over two-thirds of the territory in 2005 causing a dengue epidemic in 2008–9 (Ministry of Health and Sports, 2005).

Table 2. Infant mortality rates (per 1000 live births) in selected countries, 1994 and 2008

Year	1994	2008
Ecuador	47	22
Guatemala	60	39
Guyana	63	22
Honduras	49	23
Nicaragua	56	31
Bolivia	89	50

Sources: PAHO (2009); World Bank (2009a).

Table 3. Tuberculosis and malaria indicators in selected countries

Location	Bolivia	Ecuador	Guatemala	Guyana	Honduras	Nicaragua	Paraguay
Tuberculosis treatment success under DOTS[a] (%), 2005	78.0	83.0		67.0	88.0	85.0	91.0
Deaths due to tuberculosis among HIV-negative people (per 100,000 population), 2005	30.0	27.0	11.0	22.0	10.0	9.0	12.0
Incidence of tuberculosis (per 100,000 population per year), 2005	204.0	132.0	80.0	151.0	78.0	61.0	71.0
Deaths among children under 5 years of age due to malaria (%), 2000	0.7	0.5	0.4	0.7	0.4	0.4	0.3

[a] Directly observed therapy, short-course.

Source: WHO Statistical Information System (WHOSIS), at: www.who.int/whosis/data/Search.jsp?indicators=[Indicator].Members.

The Expanded Programme for Immunization (EPI) was highly centralized before HSR, but MoH financial and managerial responsibility over the EPI suffered with devolution. Measles was controlled in 1985 but 2567 new cases were confirmed between 1998 and 2000, representing 51% of all Latin American cases. Between 1991 and 1998, the malaria annual parasitic national incidence increased from 0.010 to 0.025 and to 0.275 in some regions, recovering former control levels only in 2002 (public insurance covered inputs for TB, malaria and cholera in adults until 2001). Meanwhile, the MoH's

financing for the EPI fell from US$258,000 in 1996 to just US$57,500 in 1997, with 25% (US$9.4 million) of its 2000–4 budget coming from the WB programme (Esquivel, 2005). From its 1998 peak, the number of malaria cases fell to 5000 in 2002 with the IADB support to the programme (World Bank, 2009b).

In conclusion, targeted programmes weakened the capacity to provide comprehensive care, which in turn explains poor results in health outcomes. It also explains the exception of Chagas vector control, which scores extremely well (infested households passing from 66% in 1999 to 2% in 2004) precisely because it does not require access to care but vector control.

The MAS government: Similarities and differences with WB-induced policies

In this section we examine if the MAS-led government (Movement towards Socialism) substantially shifted away from the World Bank rationale, or if it just 'bended and moulded' (Panizza, 2005) the neoliberal model. Our assessment is limited to policies initiated or announced in the first years (2006–9) of the MAS government's administration. Our hypothesis is that government policy-makers aimed at transforming what they name a 'ministry of diseases' into a public structure in charge of health maintenance, basically through intersectoral promotional activities – without altering the nature of past neoliberal health care policies.

Some apparent efforts do not support this thesis. Communicable disease control programmes were allegedly 'nationalized'. The MoH substituted aid funds and technicians with nationals. Aiming to recover lost stewardship, but with little concrete action at the operational level, the MoH requested all official cooperation projects to integrate their management units into a ministry structure.

The main government efforts were devoted to getting approval for a new political constitution. The new constitutional text (Plurinational State of Bolivia, 2008) states: 'All people have the right to health and the State guarantees [this right]. The Unified Health System will be universal, free, equitable, intra-cultural, inter-cultural, and participatory, with quality, user-friendly and prone to social control.' Comprehensive primary health care, delivered in publicly oriented – well-managed and equipped – services, is reported to be the best strategy to achieve these goals (Starfield, 1994; Starfield and Shi, 2002; Starfield et al., 2005; WHO, 2009).

A Supreme Decree (Government of Bolivia, 2008) stated that 'health facilities should deliver comprehensive care in relation to the family, the community, the nature and the spiritual world; assume both biomedical and traditional indigenous epistemological approaches; pay family visits regularly and adapt their functioning schedule to the culture and dynamic of the community'. It also established that a first-line basic health team should assume responsibility for the physical, mental, social, economic, spiritual, cultural and environmental health care of a given number of families. However, to our knowledge, none of these initiatives had been undertaken up to 2009.

More importantly, the vertical rationale of the public services policy was not questioned – in line with the paradigm of neoliberal policies (Unger et al., 2006b). In spite of declared rights and goals, maternal and child mortality, infectious diseases control and

malnutrition remained the major targets of the MoH policy, which coincided with the implementation of a third phase of the sector reform project, actually renamed Expanding Access to Reduce Health Inequities Project. While reduction of social exclusion appears as its main goal, the relationship of the new project with past neoliberal policies remains unclear.

Acknowledgedly, these disease- and risk-specific ambitions contrast with the government discourse – to promote universal access to a new primary health care model, named Intercultural Family and Community Health (Salud Familiar y Comunitaria Intercultural, SAFCI), based on four declared principles: community participation, intersectoralism, interculturalism and integrity (Ministry of Health and Sports, 2007a).

The former SUMI (Seguro Universal Materno Infantil) insurance, aimed at the 5–21 age group, was rechristened Universal Health Insurance (Seguro Universal de Salud, SUSALUD) with a projected budget of US$138 million. However, the necessary allocation of 14% of oil and gas income (doubling the preceding annual budget) was rejected by the National Congress in 2007 (Ministry of Health and Sports, 2006). There were no concrete plans to integrate the expensive social security system and SUSALUD. The insurance model remained grounded on a selective, demand-side financing pattern and still excluded adults. The responsibility of users' enrolment and the follow-up of service quality were entrusted to municipalities which were to sign agreements with health facilities (Ministry of Health and Sports, 2007a).

While the National Sector Development Plan, aimed at diminishing out-of-pocket and catastrophic health expenditure and high fees in public hospitals was criticized (MAS-IPSP, 2005), no measure was announced to cap the latter or to reduce hospital autonomy (Ministry of Health and Sports, 2008).

Under the SAFCI model the following tasks were allocated to public services: health education, health promotion, disease prevention and identification and modification of the socioeconomic, environmental and cultural determinants of health. Special attention was to be devoted to vulnerable groups, especially people with disabilities (Ministry of Health and Sports, 2006; Republic of Bolivia, 2006).

The SAFCI health care model hasn't been implemented so far and lacks the budget and tools to convert, for example, the 1438 health posts, where only an auxiliary nurse is now in charge. The 150 SAFCI resident doctors scattered over the country were expected to be the catalysts of the process but results so far remain unknown. In contrast to this modest team, a Cuban collaborative project sent 1921 doctors (Colaboración Médica Cubana, 2008) to remote areas to provide free discretionary care with a mixed and unclear relationship with existing MoH facilities. This important contribution to access to health care did not rely much on the existing public health authorities and possibly added to the system fragmentation.

The SAFCI model was aimed at strengthening and deepening social participation in decision-making within the health system. It created five pyramidal community participation entities in the sector – the Local Health Authority (LHA), which is a community leader; the Local Health Committee formed by LHAs of the communities covered by a health facility; and the Municipal (equal to the previous DILOS), the Departmental and the National Social Health Boards. The role of these entities was to identify and tackle health problems related to the environment, such as water and

Table 4. WB promoted public health interventions before and after MAS government

Public focus for PHC	Before 01/06	After 01/06
Disease control	++	++
Immunizations	++	++
Mother and child care	++	++
Curative individual care	−	−
Preventive health services	++	++
Purchaser–provider split	−	−
Management–property split	++	++
Cost recovery in health facilities	++	++
Decentralization with devolution	++	++
Focus on health promotion	+	++
Intercultural and indigenous medicine	+	++
Focus on social and economic health determinants	−	++
Social security reform	−	−
Community co-management	−	+
Selective public insurance	+	+
Coverage of the 5–21 age group	−	+

sanitation. To our knowledge, no such committee had been granted a legal framework or resources as of 2009.

Malnutrition control, the best developed strategy so far, was revamped as a vertical programme with a budget of US$84 million to be funded by voluntary municipalities, Canadian, French, Belgian and WB cooperation and possibly SUSALUD funds. As one vertical component, integrated nutrition units (UNIs) were created outside first-line health services. Combating domestic violence appeared as a new programme, with a clear vertical approach (Ministry of Health and Sports, 2007b).

Table 4 summarizes the main features of the policy promoted by the WB and its evolution throughout the Bolivian political transition from January 2006 onwards.

Conclusion

Admittedly, the political conditions in the country led the MoH to lose more regulatory capacity. Under strong political pressure, a new political constitution was passed, establishing further autonomy for regions, municipalities and indigenous nations. The president has announced greater devolution of social services to subregional levels like municipalities, social movements and indigenous communities. The result is that MoH normative and regulatory functions will be reduced and solidarity between richer and poorer regions may be weakened.

However, not all health policy features were influenced by the breakaway regions problem. The current structure for health care delivery is still based on devolution, management–property split, vertical programmes and public services' focus on prevention and promotion. Besides the lack of resources, implementation tools and proper planning,

there are many reasons for this status quo. Some are circumstantial. Continuous clashes with the political opposition make the government hesitant to open yet a new area of conflict with professional associations, unions, social security beneficiaries and doctors, many of whom feel quite comfortable with present social security and health systems.

We would suggest more structural reasons for the lack of policy change. Civil servants and professionals seek to maintain the status quo to secure their income and the use of public resources (Aillón and Lanza, 2005). Furthermore, the current generation of MoH civil servants were intellectually shaped by the experience of public services devoted to a targeted approach and many cannot imagine another policy. As stated by an MoH official: 'The [WB] rhetoric and communication campaign during the last 20 years successfully eliminated the conception of any other conceptual and operational health care model from the heart of the system and the minds of the managers – almost all trained under the SPHC model.'

Bolivia was and still is dependent on funds and technology from international aid. It is difficult to assess the actual importance of WB loans against the Venezuela-financed programme of direct social investments ('*Evo cumple*'), but public expenditure on health remained limited and strained by bureaucratic rigidity. With 80% of the national 2007 MoH budget earmarked for salaries and 61% of the budget for infrastructure and equipment arising from loans and grants, it may still be useful for MoH managers not to strain working relations with the WB inasmuch as past commitments (the international debt) still taint government policy.

Finally, Latin American left-wing health policy-makers often have a narrow interpretation of social medicine. They tend to divorce the control of social determinants of health from curative care delivery and to limit the role of public services to the former (Tejerina et al., 2009).

In conclusion, Bolivia followed WB recommendations for 25 years. Public health systems concentrated on vertical MCH and communicable disease programmes, which permitted the private sector 'to fill the void' (Lagomarsino et al., 2009), inasmuch as the market was barely regulated. These recommendations were effective because Bolivian interest groups viewed them as opportunities and some health programmes were necessary to guarantee social and political stability. This is why the WB-led health sector reform never intended to privatize all health services – only profitable individual health care. This policy did not change the poor's access to either family or hospital care and health indicators remained the worst in South America, i.e. because selective public MCH insurance and devolution to municipalities consolidated the system segmentation and deepened its fragmentation.

The odds haven't changed much. While adding health promotion to its portfolio, the socialist government's SAFCI model has not reversed hospital autonomy, demand-side financing and devolution. It still focuses public services on prevention, disease control and targeted programmes while abandoning individual curative care to the private sector with the usual consequences of system segmentation, weak mid-level management, catastrophic out-of-pocket expenditure and poor quality of care in public hospitals and health centres.

If the government is serious about the well-being of Bolivian families ('*Para vivir bien*') and about the universal access to health services which the new political constitution refers to as a human right, political leaders should realize that access to comprehensive

primary health care is essential to reach both goals, and that it requires the development of a publicly oriented health services sector.

Its de-segmentation could be based on integrating the social security facilities and MoH services (and their finances) into a subsystem, with a unique, universal public financing scheme. De-fragmentation could be based on using common public values and quality standards as a way to lead to integrated networks of different health subsectors, to be promoted by mixed district executive teams led by the government. Refurbishing district health teams would permit coordination of all health facilities and providers (including private not for profit) in their area, for a well-defined population. This power would be strengthened if these teams could manage a budget for supply-side finance of all publicly oriented facilities (MOH, NGOs, municipal and social security services) instead of demand-side financing MoH entities only. Family and community medicine providers could then integrate individually tailored health care with prevention, clinical disease control interventions and the control of social determinants of ill health.

Health policy-makers and scientists should be attentive to the Bolivian health system's further development to derive lessons on how developing countries could deal with globalization's pressing trends and donors' policies while attempting to give universal social protection to their peoples. Moreover, if Bolivia wants to improve the very poor health status of its citizens, it is five to midnight for the government.

Acknowledgements

The authors wish to thank Dr Christian Darras (PAHO representative in Bolivia) and Dr. Kasturi Sen (ITM researcher) for their valuable contribution.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Notes

1. Namely, reduction of the state, deregulation of labour and financial markets and elimination of borders and barriers to stimulate commerce and investments. The translation in the health sector meant a decline of public expenditures in health care, a privatization of the health care services and the impoverishing, if not the dismantling, of public health infrastructures (Navarro, 2008).
2. Understood as care experienced as coherent and connected and consistent with the patient's medical needs and personal context (Haggerty et al., 2003).

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Résumé

Une révision de la politique de santé Bolivienne et de celle de la Banque mondiale en Bolivie

Dans cet article, nous analysons l'influence de la Banque mondiale sur les réformes du secteur de la santé en Bolivie au cours de la période 1986-2006, et nous évaluons leur impact sur le système de soins de santé à ce jour. Nous examinons la transformation des services santé menée par l'actuel gouvernement socialiste depuis 2006. Une revue de la littérature et des entretiens avec certains décideurs permettent de jeter un regard critique sur les résultats des réformes, basé sur des critères liés à l'intégration du système de santé. L'article montre que la Bolivie a mis en application les recommandations de la Banque mondiale de manière assez exhaustive. Entre autres, la Bolivie a indirectement favorisé la privatisation des soins en limitant l'accès aux soins dans les services publics de santé à un paquet minimum de soins. La Bolivie a aussi décentralisé l'administration sanitaire par un processus de dévolution aux municipalités. En conséquence, la segmentation et la fragmentation du système de santé ont été aggravées, l'accessibilité et la qualité des soins en ont souffert, et l'état de santé des populations ne s'est guère amélioré. L'article tente de clarifier les relatiosn entre politique, prestation des soins et fonctionnement des systèmes de santé.

Resumen

La política de salud en Bolivia y el Banco Mundial. Una revisión

Este artículo, mediante revisión bibliográfica y entrevistas con tomadores de decisión, analiza la influencia del Banco Mundial en las reformas del sector de la salud en Bolivia durante el período 1986–2006 y evalúa su repercusión sobre el sistema de prestación de servicios sanitarios hasta la fecha; se examina también los cambios realizados por el actual gobierno socialista desde el 2006 en los servicios de salud. Se examinan críticamente los resultados usando criterios de integración de sistemas de salud. Se demuestra que Bolivia aplicó integralmente las recomendaciones de Banco Mundial, incluyendo la privatización indirecta mediante la restricción de los servicios de salud pública a un paquete básico de prestaciones y la descentralización con devolución. En consecuencia, la segmentación y fragmentación del sistema de salud se acentuaron, la accesibilidad y calidad de atención empeoraron y el estado de salud apenas mejoró. El artículo ilustra las relaciones entre las políticas de salud, la organización de los sistemas sanitarios y la prestación de servicios.

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