



**Health Sector
Reform and
Sexual and
Reproductive
Health in
Latin America
and the
Caribbean:
Trends and
Interrelations
—a Review**



UNITED NATIONS POPULATION FUND (UNFPA)
COUNTRY SUPPORT TEAM FOR LATIN AMERICA AND THE CARIBBEAN

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Introduction

In November, 2000, UNFPA, the United Nations Population Fund and the Country Support Team (CST) Mexico, held a regional meeting to start a dialogue with the regional offices, LACD (Division for Latin America and the Caribbean) and the TSD (Technical Support Division/*UNFPA Headquarters*) and together build an integrated and strategic vision for the area of sexual and reproductive health (SRH). The traditionally known SRH problems, such as maternal mortality, adolescent pregnancy, the expansion of the AIDS epidemic, the use of abortion as an alternative in the absence of accessible options of contraception, should also be associated with the increase in levels of poverty in the region. Here, the central question was how UNFPA could act in the face of these challenges, and how it could collaborate with governments, since it is on government agendas that are found the increase in poverty, and the social policies that have to be formulated and applied in a scenario of structural reforms, especially in the areas of health and education. New working strategies had to be tested, especially the development of concepts to respond to the new ways the problems present themselves, the development of local and regional technical skills, even for discussing the reform models being implemented in the region with their advantages and limitations, the analysis of the basic packages of service provision to check if they include all the components of SRH; and the formation of alliances with key actors, to help in national and regional discussions and in the development of transparent and participative reform processes monitored by the civil society.

During 2001 and 2002, a large part of the region's efforts were directed to supporting new programme cycles to operate in the reproductive health area in the context of the health sector reforms, seeking a programme design that incorporates new requirements for high-level technical and political dialogue. At the same time, LACT and the CST promoted other initiatives:

- a) Organising and disseminating specific bibliographical references to raise awareness of the subject of health sector reform and encourage a debate about the insufficient incorporation of sexual and reproductive health activities in its processes.
- b) Supporting consultants to make a first approach to the subject of health sector reform and the cost analysis of integrated reproductive health services.

- c) Supporting the participation of members of UNFPA staff (local and CST) in various health sector reform capacity building initiatives promoted by the World Bank (WB).
- d) Formulating a specific strategy for training and linking up human resources and key actors in seven countries in the region (Ecuador, Nicaragua, Haiti, the Dominican Republic, Guatemala, Honduras, Peru), in collaboration with the Pan American Health Organization (PAHO) and the World Bank.

The aim of the present work, designed under the responsibility of the CST,¹ is to collaborate with these efforts, discuss health sector reform (HSR) in Latin America and the Caribbean and its possible interrelations with that of the populations' sexual and reproductive health (SRH), to facilitate understanding them, and give a critical, strategic view of the reforms under way in the region, to show how the approach to and resolution of the of sexual and reproductive health problems and those of reproductive rights, depend largely on the structure of health systems.

The final purpose is to support the initiative of UNFPA CST in building an institutional strategy to encourage the inclusion and permanence of the SRH agenda within national health systems in the region.

This Document consists of eight interconnected parts. Part I presents a brief review of the historical development of the main concepts of the area of SRH, and a critical analysis of the approaches developed by some important HSR and SRH studies. Part II presents a theoretical framework for the analysis of HSR and equity in the Latin America region, and proposes an analytical framework for approaching SRH in the context of HSR. Part III analyses the context in which HSR processes are taking place in the region and the reform agenda that is generated in that context. Part IV discusses the presence of the international organizations in the region and their impact, whether in the formulation of health sector reform agenda, or in the implementation of strategies or specific programmes. Parts V, VI and VII present overviews of the Latin America region in the 80s and 90s, in the economic and social planes and in those of health in general and of SRH, based on the most recent indicators available. Part VIII discusses the proposal of child maternal insurances (in the context of so-called "public health insurances") and, very briefly, their implementation or development in some selected countries – Ecuador, Bolivia,

1. This work was prepared under the responsibility of the CST México. The author, consultant and principal investigator was Celia Almeida, MD, MPH, PG. D, investigator and titular professor in the National School Public Health "Sérgio Arouca", Oswaldo Cruz Foundation (ENSP/ FIOCRUZ), Health Administration and Planning Department (DAPS), Rio de Janeiro, Brazil. Advisor of the Presidential Area of the FIOCRUZ, Ex- Executive Secretary from the research network on Health Systems and Services in the South of Latin America. (November 1996 to January 2005). E-mail: calmeida@ensp.fiocruz.br.

Peru, Argentina and Mexico. And Part IX presents a summary of the five case studies made – Brazil, Colombia, Chile, Costa Rica and Belize. It ends with a comparative analysis of the findings of the case studies *vis à vis* the theoretical and conceptual framework discussed throughout the work, as well as some ideas about the possibilities of progress in this complex discussion.

1 Sexual and Reproductive Health and Health Sector Reform in Latin America and the Caribbean: a critical analysis

SEXUAL AND REPRODUCTIVE HEALTH: A BRIEF HISTORICAL SKETCH

Since the mid-70s of the 20th century, Latin American feminist groups have been discussing topics related to sexuality and reproduction in a profoundly modernizing way that, going beyond the merely revindicative that aims to be included in a previously defined order external to women, sought also to introduce these topics in public debate with the aim of transformation. This movement accompanied other feminist activities that emerged worldwide as from the 60s and 70s, even in Latin America, and linked up internationally, making significant contributions to this debate. The originality of the feminist debate in the region consisted precisely in that *the question of women's sexual and reproductive autonomy was combined and developed together with other great political discussions in the countries of the region, such as those related to the chronic problems of an extremely weak and incomplete social and civil citizenship, the issue of fragile or absent political democracy, and the persistence of authoritarian, hierarchical and discriminatory cultural and social patterns* (Jannotti, 2002:3).

These social movements had their ups and downs, but the central idea that always drove them was the uncovering of the historical processes that had led to women's deprivation of power and the inherent relations of inequality; and with demonstrating that any emancipation project must necessarily deal with the question of rights and autonomy (Jannotti, 2002).

A variety of expressions and concepts were thus formulated at different times. Until the mid-80s, the notion of *the woman's overall health* was the central concept of the "woman question" in its broadest aspects: historical, biological, social, and cultural and that of citizen's rights. "*Women's health*" arose as a semantic strategy to translate,

in terms of public debate and policy proposals, the feminist slogan of the 70s: "Our body belongs to us" (*The Boston Women's Health Collective, 1984, in Correa and Ávila, 2003:19*). This phrase used as a slogan had an individual and a collective meaning. It defined the primacy of the body of every person in their daily experiences and in historical processes, and expressed the political claims, that included demands directed fundamentally at the State. Some of them were legal in nature and others were directed at the health systems and medical issues (contraception, pre-natal check-ups and quality childbirth, the doctor-patient relationship, access to information about anatomy and medical care procedures).

In 1984, feminists formulated the expression *reproductive rights*, as a more complete and suitable concept than *women's health* to translate *the broad principle of women's reproductive self-determination* (Correa and Ávila, 2003:20).² From then on, the concept would be debated and refined, theoretically and politically, not only by feminists, but also by human rights activists, finally achieving acceptance in 1994 at the International Conference on Population and Development – ICPD, in Cairo, and again in 1995 at the Fourth World Conference on Women, in Beijing.³

This process of building and legitimising both concepts ran in parallel with the rise of the notions of *sexual and reproductive health*, which were not originally formulated by the social movements, but are more the result of concomitant efforts in the institutional context. Likewise, as a fruit of the preparation of the Cairo Conference in 1988, the concept was created of *reproductive health*, in the ambit of the World Health Organization (WHO), as an extension of the overall concept of health in the area of human reproduction.⁴ Its formulation aimed to widen the conventional perspective on population control and family planning. In the following decade, the impact of the

2. This concept achieved recognition in the 4th International Women and Health Meeting, held in Amsterdam in 1984, organized by ICASC – International Contraception, Abortion, and Sterilization Campaign, from Europe, and CARASA – Committee for Abortion Rights and Against Sterilization Abuse, from the USA. During this meeting, the Women's Global Network for Reproductive Rights was founded (Correa and Ávila; Janotti, 2002).

3. There are various texts on this topic, mentioned by Correa and Ávila, 2003:20.

4. [...] reproductive health must contain the following basic elements: (a) that everyone has autonomy both for reproduction and for regulating fecundity; (b) that women have safe pregnancies and childbirths; and (c) that the result of the pregnancy should turn out well in terms of the welfare of the mother and the survival of the newborn child. As well as this, couples must be able to have sexual relations without fear of unwanted pregnancies or of contracting sexually transmitted diseases (Mahamod S. Fathalla, of the WHO, in Berquó, 2003:7).

pandemic of HIV/AIDS and concern about the increase in sexually transmittable diseases led to the formulation of the idea of *sexual health*, and both definitions were also debated and accepted in the Programmes of Action of Cairo and Beijing (Correa and Ávila, 2003:22; Berquó, 2003:7).

As a result of these processes, all these concepts were included in the international documents⁵ emerging from the Cairo and Beijing Conferences (Correa and Ávila, 2003; Cottingham and Myntti, 2002).⁶ And the Programme of Action approved in the Cairo ICPD also refers to reproductive health care, including sexual health:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being, preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases. (ICPD, Programme of Action, paragraph 7.2 in Correa and Ávila, 2003:65). (Our emphases).

Another important term for this discussion is the concept of *gender*.⁷ Coined in the second half of the 20th century, in the 70s, but deepened in the mid-90s, the concept of gender has been defined as *a constitutive element of social relationships founded on the perceived differences between the sexes, and a first mode of giving meaning to power relationships* (Scott, 1995 in Villela and Arilha, 2003:114). Since it is a social relationship, *gender is not a fixed structure, and is in constant transformation on the basis of concrete demands as they present themselves in the lives of men and women*. On the other hand, it is important to also stress *the existence of other power dimensions, as well as those of gender, that structure social relationships* (Villela and Arilha, 2003:115-116).

To put it quite simply, as opposed to sex, a term generally used to designate the biological differentiation between men and women, the concept of *gender refers to the social constructions that limit and articulate power relationships, the contexts culturally defined as “female” and “male” ... [constituting] the social and political meaning acquired in time and space by the biological difference of sex* (Gómez, 2000:8-9). Thus, the conception of maleness and femaleness that emerges from the process of giving cultural meaning to the difference between the sexes – gender – is present as a social organiser in every human culture (Loyola, 1998, in Villela y Arilha, 2003:112). And even though, in general terms, different cultures interpret sexual difference in function of the meaning attributed to the role of men and women in reproduction, this interpretation is always modelled on a polarised relationship (complementarity or hierarchy), in which women occupy a subordinate place, and gender becomes the operative mode of the power relationship between men and women (Villela and Arilha, 2003:112-113).

Although there are academic debates on the nature of the organization of gender in society, some writers mention that two complementary dimensions are articulated by the concept of gender at a macro level: the existence of an unpaid sphere where the work-force is reproduced, disciplined and put into circulation (*reproductive work*), which, on the other hand, conditions the options of individuals in the ambit of paid work (*productive work*) (Gómez, 2000:9). On the other hand, in practice, facts such as *population growth, the availability of conceptive and contraceptive technologies, changes in the processes of the production and consumption of goods and others, have shifted the debate on the relationships between men and women from the focus on biological reproduction, around which the ideas on gender were initially developed, to seek to understand how gender runs through social reproduction in its broadest sense* (Villela y Arilha, 2003:113). According to the Human Development Report, of 1999, social reproduction refers to the task of taking care of children, the family, the sick, the old and the rest of the population that need it, in order to maintain and restore health and energy for work (UNDP, 1999 in Gómez, 2000:18). Finally, it stresses *the importance of discarding the conceptual overlaps between gender and sexuality*. (Correa, 1999 in Villela and Arilha, 2003:121).

Gender analyses played an important part in formulating the principles of reproductive health established in Cairo and they are fundamental for understanding these

5. Thus, according to a United Nations document: [...] *reproductive rights cover certain rights already recognised in national laws, international documents on human rights and in other consensual documents. Those rights are anchored in the recognition of the basic right of every couple and every individual to decide freely and responsibly on the number, spacing and occasion for having children and to have the information and the means to do so, and the right to enjoy the highest possible pattern of sexual and reproductive health. It also includes their right to take decisions on reproduction free of discrimination, coercion or violence, as expressed in documents on human rights (UNFPA and CNPD, paragraph 7.3 in Correa and Ávila, 2003:20).*

6. Cottingham and Myntti (2002:83) mention several texts discussing the concept of reproductive health and its acceptance in the Cairo and Beijing Conferences.

7. Villela and Arilha (2003:117) mention that there is a polemic about the theoretical status of gender: an explanatory concept or a category of analysis, an instrument for breaking down reality into different fragments to be able to understand it better. They also point out the banalisation of the term, that has begun to be used more descriptively than analytically, or even as a substitute for “sex”. This discussion is not the aim of our study, but it is worth recording.

8. As well as the bibliography mentioned in this text, see also the list of references and the text prepared by Rama Lakshminarayanan, 2003, Gender and Health Sector

(Cottingham and Myntti, 2002:84). For Cottingham and Myntti, gender analyses make it possible to examine the power relationships between men and women; to question the way in which the social roles and identities attributed to them (as boys and girls, men and women, fathers and mothers, and others) influence their sexual behaviours and their health; and to examine how the social system, from public policy and health care services to private intimacy, incorporate the inequalities of power between men and women. They even make it possible to explore how the social roles imposed on women, and their subordinate position in terms of power in society, determine their exposure to risks, their access to social benefits and medical technology, and hamper the satisfaction of their rights. In addition, they help to understand the effects of cultural behaviours on health and reveal that societies allocate resources preferentially to men.

The Programme of Action of the Cairo Conference devotes a whole chapter to gender inequality, equity and the empowerment of women. It declares that this means increasing their autonomy and improving their political, social, economic and health status, which, as well as being important ends in themselves, are also essential for population programmes in the long term (*United Nations, 1995, in Cottingham and Myntti, 2002:84*). The acceptance of these principles attracted significant attention around the world to feminist demands and managed to place fundamental questions on the political agenda of various countries, even considering that the documents in which they are recorded *are not binding as treaties or conventions [...]*, which means that *they do not oblige the member States to incorporate these international principles in their legislation*. In other words, *even though the programmes of action of the two conferences mean a moral commitment of the signatory States, they do not imply their automatic incorporation in national legislation, as happens with conventions and treaties* (Correa and Ávila, 2003:23).

Moreover, the great theoretical and conceptual complexity underlying these definitions and principles substantially complicates their being put into practice in the different national situations. So it is a huge challenge to translate the definitions of reproductive rights and the principles of the programmes of action adopted in the past decade into concrete policies, whether in the field of rights or in that of social policies, including health policies.

According to Cottingham and Myntti (2002:84), since Cairo, in speeches on development and in the academic area, the concept of *reproductive health has been used with three different meanings*: as a set of physical and psychological conditions; as a principle for organizing a set of *health-specific services*; and as a *paradigm for social change*. In reality, the concept of *sexual and reproductive health* is made up of different, interconnected *dimensions*, which can be read, in our opinion mistakenly, as *different meanings*, depending on the point of view from which it is regarded or analysed. These *meanings* are useful for describing what we

call different *dimensions*, which can really only be separated for analytical purposes.

Thus, as a spectrum of *conditions*, life events and processes, reproductive health would bring together different positive and negative aspects of the health of men and women, given that, in general terms, interest in the health sector is always focused on illness, whether from medical bias, or from the pressing need to confront the huge burden of illnesses suffered by the world's population. This is not the place to go into the reasons for this bias, which has been the object of vast theoretical, conceptual and operational discussion in the public health field. However, it is important to stress that the Cairo and Beijing talks saw the concepts of affection, tenderness, pleasure, self-determination and equity as intimately related among themselves and to health, as Cottingham and Myntti (2002) explain. This implies a much broader vision, both as regards the analysis of health determinants in men and women, as well as in relation to health care services, which requires complex theoretical elaboration and deep changes in the *status quo* when considering any kind of operational intervention.

In relation to the dimension of *sexual and reproductive health care services*, there is a range of quite well-established programmes, activities and procedures that have been being implemented for decades, although not always very effectively, nor under this heading, especially in the Latin American region, such as: family planning, cervical-uterine cancer monitoring, prenatal, childbirth, newborn and under-fives care (mother and child care), and monitoring and care of infectious/contagious diseases, etc. The Cairo and Beijing documents argue for the integration of those programmes, activities and procedures, fundamentally questioning the so-called "vertical programmes" that, in general, have been the way in which these are being implemented in health systems around the world. They also declare that improvements in sexual and reproductive health depend too on the incorporation of other non-medical interventions related to the removal of pernicious legal restrictions (such as the prohibition of sexual education for young people, restrictions on the use of contraceptives, among others), and call for action in legal, economic and other areas, to guarantee more dignified living and working conditions for men and women, and the overcoming of the inequality between them. So, questions related to *integrality* in health care service systems and to *intersectoriality* are core points to be considered and highly relevant topics present in the broader sector debate.

Finally, the perception of sexual and reproductive health as a *paradigm of social change* calls for a review of the different social and health practices from a new perspective, beyond the traditional bio-medical paradigm, to situate health/illness in the social, political and economic context where they are "produced", which includes subjects related to human rights (including social rights) and to equity, which are not restricted to the health sector.

This brief sketch of the historical and conceptual

development of the area of sexual and reproductive health and of the principles legitimised in the Cairo and Beijing conferences is an important starting point for reflecting on the relation between this area and sector reforms, specifically in the health sector.

HEALTH SECTOR REFORM (HSR) AND SEXUAL AND REPRODUCTIVE HEALTH (SRH): A BRIEF REVIEW

There is already a reasonable amount of literature discussing questions related to gender inequality, SRH and HSR, produced mainly as from the second half of the 90s. Without aiming to make an exhaustive coverage, we will cite some of the texts reviewed in this work.⁸

Part of the literature analyses the relationship between globalisation, State, market, gender and their interfaces (Sen, 1996; Maclean, *et al.* 2003). Other texts relate globalisation and HSR, in the perspective of gender or of reproductive health (Meacham, 2002; Evers and Juárez, 2002; Petchesky, 2002; Nigenda, 2002; Cook, 2002). Or they discuss the connections between gender, sex and health (Krieger, 2003). Some of the studies also aim to formulate a theoretical conceptual framework for analysis of the interrelation of HSR and SRH (Standing, 1999, 2002; Lubben, Mayhew, Collins and Green, 2002; Maclean, *et al.* 2003; Langer and Nigenda, 2000; Langer, Nigenda and Catino, 2000).

Another part of this literature looks more specifically at the discussion of gender questions, SRH and equity in contemporary reforms (*The Working Group on Reproductive Health and Family Planning*, 1998; Standing, 1997, 1999, 2002, 2002; Hardee and Smith, 2000; Gómez, 2000, 2002; Onyango, 2001; González, 2001; Sen, George and Östlin, 2002; Roses, 2003).

And a fourth group, apparently the majority, analyses the “impacts” of the implementation of the HSRs in SRH, in some cases with reference to specific countries, or, on the other hand, are evaluations of the implementation of the sexual and reproductive health agenda (or of aspects and dimensions of SRH) in the processes of sector reform (Aitken, 1998; Lush, Cleland, Walt and Mayhew, 1999; Aitken, 1999; Hanson, 1999; Merrick, 2000; Vlasoff and Garcia Moreno, 2002; Janotti, 2002; Alonso, 2003; Bronfman and Denman, 2003; Krieger, 2003; Kawonga, Nunn and Maceira, 2003; Weller, Ravindran, Moorman and Alonso, 2003; Weller *et al.*, 2003; Alvarez-Castillo, Oluwu, Maceira and Mercer, undated). These studies use as a starting point elements presented in the Cairo Programme of Action, such as the integration of SRH activities or programmes in the health care service systems under reform, taking into consideration some “components” of those reforms such as

decentralisation, co-payments, public/private relationships, privatisation and their effects on the SRH of the populations.

These studies are mostly analyses about Asian and African countries, with specific references to Latin America, not always based on concrete studies since the Latin American bibliography on the topic of HSR and SRH is still scant. There are also very good theoretical and conceptual publications on the topic of SRH (such as Berquó, 2003; Bronfman and Denman, 2003; Sen, George and Östlin, 2002; Giffin and Costa, 1999) and diagnoses of the SRH situation in specific countries of the region (for example: Shiappacasse *et al.*, 2003; Villamizar *et al.*, 2002; among others).

Such analyses are in fact devoted more properly to reproductive health (RH), without referring explicitly to the subject of sexuality. In addition, although they describe themselves as gender analyses, they are mostly restricted to topics related to women’s health. Although this may be justified since gender inequalities are considerably more pronounced and evident in women, this preferential focus legitimises the gender bias in the organization and provision of health care services restricted to women, generally those of reproductive age (more specifically pregnancy and childbirth), without making any progress in the construction of a possible new paradigm for SRH in health system reforms.

We do not aim to summarise this literature here, nor comment on it in detail, but limit ourselves to indicating critical points of the conceptual frameworks developed and of the assessments that are seen as particularly important for a critical analysis of the subject. That is, faced with the great complexity involved in reflecting on SRH and sector reform, our idea is to contribute to this debate constructively, using already existing knowledge gathered in these two areas as raw material. Nevertheless, a detailed analysis of the bibliography, contrasting different viewpoints and research findings in different countries, could well be an agenda point for a future study.

Discussing the relationship between globalisation, health and gender, or even globalisation, gender and HSR, the studies correctly point out that, although it is not a new phenomenon, the modern process of globalisation has some particularities. Differentiating between “globalisation” and “internationalisation”,⁹ Maclean *et al.* (2003:7) adopt quite a clear definition of globalisation (based on Cameron and Stein, 2000): the term *globalisation describes the way in which nations, companies and persons have become more interrelated and interdependent globally on the basis of trade, finances, the production of goods and a dense network of international agreements and institutions*. According to Lee (2000) and UNDP (1999), among others (*in* Maclean *et al.*, 2003:7), *the process has changed the nature of human*

Reform: An Annotated Bibliography, for International Women’s Health Coalition (op. cit.).

9. “Internationalisation” refers to the geographical extension of economic, social and cultural activities, while “globalisation” is related to the functional integration of these activities in a hitherto unseen historical perspective (Lee and Scholte, 2000; Lee, 2002 in Maclean *et al.*, 2003:7).

10. An interesting conceptual chart interrelating “globalisation and health” is presented in Figure 1 in Maclean *et al.* (2003:6).

relations, reducing the barriers of time, space and the spread of ideas, separating (at the same time) persons and nations into broad spheres of action, including health and environment, society and culture, knowledge and technology, from a political and institutional point of view (free translation).

In general terms, the writers agree that the particularities of the modern globalisation process not only differentially affect the capacity of governments to define their own policies, whether in economic or social contexts, but also have a significant impact on people's living and health conditions in different countries, negatively or positively, mainly as a result of macroeconomic policies and their prescriptions (trade liberalisation, privatisation, minimal State) (Maclean *et al.*, 2003; Evers and Juárez, 2003). However, these relationships have only recently received greater attention, while studies about the differential impact of this process on men and on women are still rare and brief. The key question remaining unanswered is whether the modern globalisation process has led to an economic and social development that enables women to play a greater positive role, compared to men, as regards health, education and legal rights. In other words: who wins and who loses, and to what extent does this winning and losing affect men and women disproportionately? (Maclean *et al.*, 2003:3).¹⁰ There are some statements in the literature about negative impacts of the structural adjustment processes, above all in women's health and in reproductive rights, but it is argued that these relationships are not direct or "causal" and need to be further studied (Standing, 1999, 2000; Evers and Juárez, 2002; Maclean *et al.* 2003).

As for the specific discussion about HSR and SRH, a first point to be stressed is that, in a general way, a significant number of these studies accept the modern reforms of health systems without taking into account the historical context in which they are formulated, whether in terms of the reform agenda, or in relation to the "models" that are actually implemented. This lack of historical sense makes it difficult to comprehend the sector reforms in general, and those of health in particular, as part of a broader, interrelated process of the transformation of nation states which is guided, in turn, by particular premises, formulated in specific spaces, declaring a significant paradigm change in the principles that historically guided public policy in the social area, including that of health.

From this first theoretical and conceptual problem flows another: the concept of health sector reform used in the analyses made. Although it is stated that health sector reform has a *long history* (Onyango, 2001), and is a broad concept, changeable over time (Standing, 1999), the references used to mark this history and conceptualise the reform in the health sector, such as the chronology described by Standing (1999) and accepted also by Evers and Juárez

(2002) do not fit. This writer establishes a chronology of sector reforms beginning with the structural adjustments of the 80s, the "Bamako Initiative" at the end of that decade, the "health sector reforms" at the end of the 80s and the early 90s, and the so-called "sector wide approaches" formulated in a meeting between international agencies, including the WHO and the WB and donor countries, at the end of the 90s. To our judgment, these are not different "generations of sector reform", as the author would like, but are really successive institutional strategies or proposals that fit into one and the same ideological and theoretical framework, formulated, in general, by international agencies, and implemented as a response to a broader dynamic that is not identified or even mentioned in these studies. In addition, the analysis begins from the discussion of the effects of the reforms on the SRH of the population, mainly of women, without clarifying the concept of reform, and does not provide elements to explain why these policies were formulated in this way and had the disastrous results shown. Although the criticism is repeated of the economicist conceptual and theoretical approaches, that they do not take gender inequalities into account, there is no discussion of why this bias became so omnipresent in the language and tools of contemporary analyses.

In this perspective, Lubben *et al.* (2002) point out the importance of the multiple ideologies underlying current debates, whether on the HSR, or on SRH policy, that reflect different perspectives of different actors, in varied national and international contexts, and they develop a "theoretical framework for policy dialogue" in which they stress the different premises and starting points of both movements – of HSR and of SRH – as well as their different action strategies.

Some writers state that, in theory, the SRH and HSR agendas *have much in common* (Nanda, 2000, in Kawonga, Nunn and Maceira, 2003), given that they are both change initiatives formulated out of concerns that are similar to, for example, equity, social participation and development of primary health care. In practice, however, this *potential synergy* is said not to have occurred due mainly to the different conceptual approaches and presuppositions from which they emerge. For Standing (2002), the HSR agendas are technocratic, essentially focused on structural changes in the health systems (without specifying what these changes would be), while the defenders of SRH centred their action strategies on advocacy, calling for what should be done, but making little progress in how it should be implemented. This statement reinforces the impression that the development of SRH programmes and the underlying debate tend to occur in isolation, without a clear understanding of the wider changes under way, whether in the public sector in general or in the health sector in particular.

We add that the SRH agenda of transformation is in fact

a “parallel agenda” to that of sector reform in health, as various writers state (such as González, 2001; Evers and Juárez, 2002), and that the two change processes are simultaneous (Alonso, 2003), with points of contact in terms of the topics that they include, but with different objectives in their implementation. But we see that this parallelism is perfectly coherent with the history of the feminist movements, always non-conformist, claiming rights and emancipatory, tuned in to the critical situation of the adjustment processes and macroeconomic reforms of the 80s and 90s and their terrible results, above all in social and health areas. Rather, it was no accident that the Cairo and Beijing conferences occurred in the mid-90s: those were tough years, where the empirical data emerged strongly to

show the disaster provoked in a large part of the world, above all in the South, by the economic changes. At the same time, the sector reform agenda formulated and in process of implementation was extremely restrictive and significantly questioned social and citizens’ rights, and among them health care as a public good. It is thus a parallel agenda because it is formulated and debated in different political and institutional spaces, but is entirely convergent with the “critical spirit of the age” and with the tone that has always marked women’s movement.

As a way of contributing to this debate, we shall present some elements of context and content that have supported the formulation and the implementation of the HSRs in Latin America and the Caribbean.

2 Health Systems Reform and Equity: a theoretical framework

Reform and equity are ideas that have been constant parts of political speeches, technical documents, and scientific literature in recent decades. As a rhetorical resource, these terms have served a broad ideological spectrum, adapting themselves to varied proposals and purposes. As concepts, they have aroused innumerable discussions without reaching any consensus on their definition and operationalisation. In technical and methodological terms, they have attracted considerable attention from academics, consultants and researchers, developing pro-equity policy measurement and implementation instruments that, once again, grow out of different agendas and policy projects.

This can be seen in the general context of the discussions on economic and social development, as well as in the field of sector policies. Here, the debate is being guided by the discussion of new models for the reorganization of social protection systems and by the redefining of packages of benefits and services, reviving false dilemmas and old confrontations, such as public *versus* private, State *versus* market. This debate is also marked by the search for empirical evidence and by the confirmation of inherent contrapositions that such sector reform processes have faced, mainly between efficiency, equity and quality. And even though the implementation of the changes and the discussion of reform policies itself may contain numerous details and be unique to each country, whether of the North or the South, agendas and arguments have spread and been adapted to varied realities, translated into proposals aimed at overcoming inequalities.

The lack of conceptual and strategic precision surrounding both topics – health sector reform and equity – is not new. Santos has already warned that the lack of conceptual clarity about “what social policy is”, has allowed any policy aimed at “social problems” to be identified as such, *independently of the value judgments about the social order they endorse* (Santos, 1998:35). This role thus includes any assistentialist activity or one focusing on the “poor and needy”, with the justification that in this way they overcome inequalities, even though they seek no more than to relieve the severe negative results of other policies and offer nothing in terms of social justice. It is publicly announced that this is the best way to overcome the huge, evident inequalities in the Latin America region, historically accumulated we must admit, but dramatically exacerbated in the last two decades closing “the long (and intense) 20th century”.

On the other hand, the notion of “development with equity”, which has been gaining force in recent decades, in the face of the global disaster of increased inequalities driven by neoliberal policies, also enables the building of a consensus

between different political-ideological currents, given that it does not *a priori* harm individual interests, as progress towards overcoming inequities can be so slow and gradual that, in practice, the adoption of equity as a principle can be completely innocuous or meaningless.

It is worth, therefore, making a brief historical and conceptual review of these two terms.

THE REFORM QUESTION: CONCEPTUAL NOTES

Although the origin of the term “reform” is more historically defined, centred on the classical reform-revolution antithesis, characterising the ancient (but always renewed) opposition between different social change strategies within the development of the workers’ movement, it has kept from its legacy the essence of this antithesis, i.e., it refers to *the way in which the change occurs and not to the result* (Bobbio, 2000:579, *in* Almeida, 2002b:25).

Both strategies start from a conception of history understood as change and progress. But, underlying non-revolutionary reformism, there is a positivist, evolutionary idea of history, in which transformation occurs accumulatively and gradually. And behind the revolutionary movements, the idea of progress is a succession of positive and negative movements, permanently advancing, either in objective reality, or in knowledge about it; thus the historical process does not work in successive increments, but through dialectical changes, each containing the germ of their own dissolution, where the negations represent the obligatory passage to subsequent affirmations (Bobbio, 2000:590-1, based on Marx and Engels, *in* Almeida, 2002b:26). Reform movements thus seek to improve and perfect, even in a radical way, but never destroy the existing order, and this narrower reformist perspective is the great winner at the end of the 20th century and the start of the 21st.

In 1995, the World Health Organization, (WHO) defined health sector reform as a sustained process of fundamental changes in health policy and institutional arrangements, coordinated by the State, with the aim of improving the functioning and performance of the sector, to reach better levels of health in the population (WHO, 1995). Health reform is thus concerned with the definition of priorities, with refining health policy and the reform of the institutions implementing these policies (Janovsky and Casels, 1995). In 1997, Knowles and Leighton, recognising the absence of precise definitions and the multiple and different connotations, defined health reform by stressing the list of aims and the extent of the reform as more important than its precise definition, reiterating the premises already

mentioned (Knowles and Leighton, 1997:2). Other authors define health sector reform as specific transformations for improving efficiency, equity and effectiveness in service systems (Berman, 1995), ignoring the inherent antitheses implied in these relationships.

Reform typologies are also formulated: some taking into account the breadth of the change and the means of implementation (Ham, 1997) – *big-bang* reform, incremental, “bottom up” and incipient – and others based on the definition of “strategic dimensions” or “macro-functions” of the health systems, which should be the object of reform (Berman and Bosert, 2000) – financing, service provision, incentives, regulation and information.

None of these reflections move forward in conceptual terms, starting from the basic premise that health sector reforms are technocratic processes, natural consequences of the “great transformation” in which the world has been involved for more than two decades. That presupposition allows, on the one hand, “reform” to be identified only with those changes that match particular criteria, as for example, “market-oriented reforms”, not considering, therefore, all the other changes in health policy that do not take that paradigm into consideration. On the other hand, it allows the social character of health policy to be particularised, i.e., redefining the right to health, excluding it from the range of social benefits, segmenting different beneficiaries, determining priorities and focusing benefits and services for “poor and needy”, alleging the scarcity of resources and the impossibility of attending an intrinsically infinite demand.

From another perspective, we define health sector reform as structural change processes in the health care area, i.e., historical moments in which there are changes in the conceptions (and the beliefs) about health and illness, as well as the perspectives under which services for the population are organised, and the roles of the State (with its institutions) and of private organizations (both of civil society and of the business sector) acting in the health care sector.

Given this definition, we can say that the 20th century that has just ended passed through at least three great “waves” (or generations) of health sector reform (Almeida, 1996):¹¹

1. The first began at the end of the 19th century, with state subsidies and specific programmes for the poor and workers with low wages, and extended to the first decades of the 20th century, before and after the Great War, the First World War.
2. The second happened after the Second World War (1948), with the extension or universalisation of old programmes or the creation of national health systems, transforming the right of access to sector services into a citizens’ right.

3. The third is more recent and occurs at two different moments, but they are the same face of the coin: the first occurred in the 60s and 70s, and was seen as a specific expansion of medical care services; the second moment was the crisis of this model that resulted in the 80s in the formulation of the *new post-welfare agenda* also for the health area, the essence of which was the questioning of the foundations that had structured health systems up to then.

While in the first wave of reforms the German model (national health insurance) was spread and copied in various countries, in the second, the British model was absolutely innovative, with the creation (totally new in the western world) of the National Health Service and, most importantly, with the spread of the idea of access to services as a citizen’s right and of national health planning principles to attend the health needs of the population; and in the third, the neoliberal hegemony and the “reform models” formulated in the United States (USA) were crucial.

The core of these transformations lies in the significant intervention of the State in guiding this sector development process, that has several dimensions, but, agreeing with Immergut (1992), we should stress that health systems differ among themselves, mainly in the interconnection of four principal dimensions of this state intervention that, together, affect the State’s capacity to govern the sector. These are:

1. The extent and type of public financing.
2. The type of regulation (public and private) that this financing structure provides.
3. The role of the State as owner of the means of production of services and goods.
4. The role of the State as employer (direct or indirect).

The way in which these dimensions overlap is the concrete result of the historical development of the different health systems, which was always located around the debate between public and private, between State and market.

THE EQUITY QUESTION: CONCEPTUAL NOTES

As regards the term equity, conceptually and historically its formulation is related with the notions of liberty and equality, which go back to the issue of justice, of human and citizen’s rights and duties and those of the State. The antecedents of these debates lie in the 17th and 18th centuries, culminating in the Declaration of the Rights of Man and of the Citizen, of 1789, after the French Revolution, and later, in the 20th century, in the Universal Declaration of Human Rights, in 1948, and the European Convention on Human

11. There is no consensus in the literature on the different “waves” or “generations” of sector reforms. However, most writers limit themselves to describing contemporary reforms, i.e., those of recent decades, without taking into consideration the historical development of health care service systems.

Rights (1950), that mark the new post Second World War era and served as a guide for later constitutions in various countries. In this process, even though the words are the same – liberty and equality – the judicial validity and the conceptual meaning changed substantially, in a way closely related with each other, broadening and enriching their content (Bobbio, 2000:488-90 in Almeida, 2002b).¹²

These two values are rooted in conceiving the human being as a person, in determining the concept of a human person, and have been linked to each other throughout political thinking and history. Equality, on the one hand, as a supreme value for ordered, happy and civilised cohabitation, as a permanent aspiration of people in society and, on the other hand, as a constant theme in ideologies and political theories, is always coupled with liberty, and both have a predominantly positive meaning in political language. However, as regards their descriptive, axiological and conceptual meaning, the two terms are very different, although they frequently appear ideologically connected.

Synthetically, *liberty* indicates a state and *equality* a relationship: a state of the individual and a general, desirable, relationship between individuals in society (Bobbio, 2002:7-8). In terms of the descriptive meaning of each term, the difficulty in the case of liberty is its ambiguity in political language, which permits various meanings (quality or property of the person); and in the case of equality, the difficulty lies in its lack of precision, since it is necessary to specify what entities we are dealing with and in relation to what they are equal. In this situation, the concept and value of equality are not clearly distinguished from the value and concept of justice, going back to the problem of attributing advantages and disadvantages, benefits or harm, rights or duties, to individuals in society, as well as the distinction between a just and an unjust equality. This presupposes the establishment of the so-called *rule of justice*, i.e., the way in which the principle of justice should be applied, the rule according to which equals should be treated in an equal way and unequals in an unequal way. This becomes important in the face of the determination of justice, *conceived as the value presiding over the preservation of the social order* (Bobbio, 2002:20-1). The definition of equality then that needs to be discussed is equality affirmed as a property of the rules of distribution (Oppenheim, 1993), i.e., what is important to analyse is the distributive character of the rule itself.

From this perspective, equality and justice in fact have an important characteristic in common: both can only be sustained by rules that specify the way in which particular benefits or burdens should be distributed. Thus the classification of any distribution rule as *egalitarian* or *non-egalitarian* cannot escape value judgments, and not all egalitarian distribution is equitable.

The notion of equity in health follows on from this tradition. At the start, as from the mid-60s, the issue of inequalities emerged in health as part of the discussions on the “health crisis”, arguing that this had not been overcome, despite the large financial investments made in the health systems, and that the positive modification of the macro indicators (like mortality, for example) was mainly due to changes external to the sector. And the first programmes of the international agencies aimed at examining the relation between unemployment, poverty and health date back to the second half of the 70s. Gradually, this idea broadened until it included the discussion of “vulnerable groups”, and networks of specialists were established to work on the subject. Production intensified and the process culminated in inserting the subject of equity in health into the policy agenda, pointing to the complexity of the object under study. By the end of the 80s, the main interest was in the use of research results on this topic within the health sector decision process, in the perspective of formulating equity-related health reform. That period saw the start of efforts to elaborate both an operational definition of equity in health, as well as instruments suitable for use by sector policy makers.

This mobilisation around the topic of inequalities in health was expressed both in scientific production in the area and in the reports and documents of international agencies. Reviewing the literature, equity generally refers to *differences that are unnecessary and avoidable, as well as being considered unjust* (Whitehead, 1992:431) and that are thus susceptible to intervention through policies in several sectors, including that of health. For a particular situation to be determined as unjust, its *causes* must be examined and judged in the wider context of the society (Mooney and Jan, 1997), which leads back necessarily to the values and moral, ethical and political-ideological principles guiding sector policy in any given country and historical moment. Thus, in function of the set of dominant values, the term equity can gain different connotations over time and in different societies, with different meanings and with consensus around a definition being rare (Almeida *et al*, 1999a). There is also a variety of ways of measuring social justice and each of them produces different results. So the definition of equity chosen to be operationalised and the ways of measuring it reflect the values and choices of a particular society at specific moments. These considerations are by no means trivial, and reveal the strategic objectives of different definitions.

As from the 80s, therefore, the conceptual debate about equity gathered force in the context of reform policies which, as the same time as they questioned the extensive state intervention in health (that is, the amount of public financing, the state provision of services, etc.), encouraged

12. A more detailed discussion of this topic can be found in Almeida, 2002b. The text presented here is a synthesis of the main points of that discussion.

state and health systems reform, to perform more efficiently and effectively and with better results in terms of equity. From then on, it began to be asserted that even though social policy may have the search for equity as a guiding principle, it became necessary *to suitably define the way of applying such a principle* (Cohen and Franco, 1993:27; Almeida, 1997a), with policy limits clearly defined by the decision about the destination of the resources. For health care services, a compensatory policy was recommended, based on principles of territorial-based selectivity and focusing on the most needy, as well as a definition of priorities, working *with a synthetic concept of what is social* (Cohen and Franco, 1993:30). The principle of equity was evidenced in a restricted perspective, i.e., one of public intervention reduced to the basic level, prioritising the more deprived population groups, which could lead to less equitable results (Almeida, 1997a). Throughout the 90s, this debate broadened considerably, becoming one of the main points of the discussion agenda on health sector reforms in national and international forums.

In the current situation of health sector reforms, the principle of equity, present in the reform agenda, is frequently conditioned to the aims of efficiency, which is subordinate to “cash limits”, and of cost-effectiveness that, in turn, does not include the analysis of the aims of a particular policy and explicitly excludes the evaluation of the ends justifying it, the definition and implementation of which belong to the policy field and not to technical analysis. In that way, the policies are restricted to determining the most efficient alternative for reaching specific objectives, but do not take into consideration the results of a particular action for society as a whole. In other words, even though it may be desirable and necessary for health activities to be more efficient, as well as effective, the question of the different needs of different population groups is reduced to minimising state intervention and public financing, translated into the policies of focusing on the poorest and of privatising, proclaimed as being more equitable.

Since this is an *ideal goal* that marked the 20th century, was most present at the end of the millennium, and is more and more present at the start of the current century, and whose urgency can no longer be ignored, *it is surprising that it should be subsumed into an adoration of the free market* (Bobbio, 2000:507).

OPERATIONALISATION OF THE CONCEPT OF EQUITY IN HEALTH SECTOR REFORMS: SOME NOTES

The development of the concept of equity in health has been the object of a wide-ranging debate around the problem, stimulating discussion about its operationalisation, either to grasp the determinants of inequalities in health, or to formulate policies and priorities to be implemented with a view to reducing social differences in the health field. In parallel, it has become increasingly important to draw up instruments and indicators for monitoring systems reform

processes and evaluating the results from the perspective of equity, and some critical aspects have arisen during this debate.

The most evident among these, pointed out by various writers (Friedman, 1980; Mooney, 1986; Whitehead, 1994; Pereira, 1995; Porto, 1997, among others), refers to the fact that equitable results presuppose unequal redistribution of resources, as a product of adjustments made in function of the biological, economic, social, political and organizational determinants of existing inequalities (Almeida *et al*, 1999).

A distinction should also be made between difference and diversity. Diversity is determined by factors beyond human will or as the result of individual wills, while what is considered socially unjust includes values, ethical, moral and political questions, referring to “undesirable” and avoidable differences (Almeida *et al*, 1999). The point to be stressed is that the social differences are intrinsically linked to social stratification, i.e., to the fact that the individuals inserted in social relationships have differentiated opportunities for realising their well being (material interests) (Wright, 1989). In other words, it is social relationships that determine the processes by means of which people have unequal access to material resources and to the social benefits resulting from the use of these resources. Thus, the policies aimed at reducing the effect of social relationships on differences between population groups should seek to minimise the existing inequalities between persons in their opportunities to improve their well being (Travassos, 1992). On the other hand, the distinction between difference and diversity is complex and can often only be made theoretically.

The explicit or implicit operational definitions of equity in the health care area will always work, to some extent, alongside the notion of differentiated needs of different social groups, in which in general the determinants of diversity (sex, age, race, etc.) overlap with those of differences due to social injustice (income levels, access to goods and services, etc.) It is worth also stressing that even factors linked to diversity, such as gender and race, can take on, beyond diversity, connotations of inequity in function of existing social relationships (Almeida *et al*, 1999).

From an operational point of view, it is also necessary to distinguish between equity in health and equity in the consumption of health care services, given that the design of policies differs according to each of these objectives, because the determinants of inequalities in getting ill and dying are different from those of the inequalities in consuming health care services. Inequalities in health reflect principally social inequalities and, in function of the relative effectiveness of health care activities, equity in the use of health care services is an important, but not sufficient, condition for reducing the inequalities in getting ill or dying that exist between social groups (Travassos, 1992; Almeida *et al.*, 1999).

On the other hand, an analysis of equity in the use of services must consider the geographic and social dimensions of the inequalities, complementary and necessary dimensions for reaching greater equity (Travassos, 1992). Geographical

variations reflect, to a great extent, differences in the volume of resources available for the sector in each region, affecting the size and quality of the service network. They also reflect the health policy options that condition the definition of the local assistentialist model.

The social dimension of inequalities in the use of health care services, in turn, shows the variations between different social groups in their opportunities for service consumption. The plural and fragmented structure of the different health markets generates social selectivity, provoking an unequal pattern of service use. However, the existing variations in the set-up of the health systems can reduce or widen these inequalities. The local public/private mix, i.e., the relative size, the technological complexity of the service supply in the public and private health markets, as well as the spatial distribution of these services, will mark the pattern of social inequality in each area (Almeida *et al*, 1999).

There is no one definition or one single methodology for measuring health needs. In general terms, the writers agree that the concept of need is not absolute, since the different ways of grasping the needs profile of specific population groups will always express partial views, limited both by methodological issues (e.g., the validity of the diagnostic methods), as well as by perceptions and values, either of the individual, or of the evaluator. There are also significant difficulties in relation to the concepts and forms of operationalising the variables related to the social conditions of individuals (Almeida *et al*, 1999).

So, operationalising the principle of equity requires the concept to be refined, as well as the definition of the methodologies and indicators that underlie not only the formulation and implementation of policies aiming at equity, but also the monitoring and evaluation of the results of these policies.

The option for equity implies, on the one hand, defining it according to ethical and moral principles related with the degree of social inequality that a society accepts (or manages to bear) and, on the other, operationalising it in accordance with theoretical and political logic that guides the ways in which the social groups are conceptualised, and the technological tools available for putting the intervention into effect and evaluating it as a reduction in health inequalities.

HSR AND SRH: A THEORETICAL AND CONCEPTUAL FRAMEWORK OF ANALYSIS

It is not easy to draw up a theoretical and conceptual framework for analysing the interrelations between the health system reform processes and sexual and reproductive health, due to the complexity of the two topics and the number of variables involved.

Among the bibliography reviewed, a framework drawn up by Lubben *et al.* (2002:670) that merits attention, could also be taken as a starting point for this discussion (Figure 1, Appendix 3). The writers draw up an analytical framework where they interrelate in an interesting way the key

determinants of the condition of the population's SRH and indicate where these would be affected by the *components* of health system reform, stressing some core points. Taking this framework as a basis, we adopt the proposal, adapting it to our framework of reference, and we define the following points as fundamental for the aims of this analysis:

1. The population's state of SRH should be localised at the core of health actions and activities and thus at the core of the model of analysis. This is because there is a tendency in most countries to centre the discussion on health care services, or programmes launched for SRH, generally in a narrow sense, centred on a few medical care activities, generally directed towards the woman of reproductive age or to the phase of reproduction, i.e., for pregnancy, childbirth or puerperium. That is, the goal is not an improvement in the state of the population's SRH but rather the efficiency of the health care services, generally focused on this phase of the life cycle and, even more, theoretically on the poorer social groups. This perspective shows why it becomes so important to situate the state of the population's SRH as the core of the framework in this approach.
2. The determinants of SRH are analysed both at macro and at micro level. At the macro level, the analysis is about the complex interrelations between economic, social, political, demographic and epidemiological factors; factors are then added that interfere in the formulation and implementation of the reform health policy, whether in the international context and its influence in the national ambit, or in the national and the local context. At the micro level, factors are inter-related that influence the topic of SRH more directly, such as the existence of specific programmes in the health care services and in health reform proposals, the manner of service provision (public/private interrelation), the integrality of attention, etc., as well as the existence of intersectorial actions; the empowerment of communities and individuals in relation to this topic, that is, the performance of civil society organizations; and associations between different sub-sectors, organizations and communities.

This range of factors is correlated in a particular way in the different countries with positive or negative impacts on the SRH of their populations. The impacts are mediated by the health system reform processes. This connection is shown in Figure 1 by the larger circle surrounding the status of the SRH. The key question is the compatibility or coherence between the contextual factors, analysed above, that affect it, and the changes proposed or implemented in the health system reform processes.

Another instrument developed by the same writers (Lubben *et al.*, 2002:670), and which seems useful for this debate, is the matrix of research policies and evidence. Although it was thought up in the perspective of encouraging

dialogue on the topic of HSR and of SRH between the different actors and policy networks, as well as for identifying what the areas are that still need research, the matrix can also be used in the perspective of prioritising the identification of problems faced by the reform processes in order to reach better levels of SRH. In the same way, we propose to adapt the matrix developed by Lubben *et al.* (20002:670-672) for this identification.

On the vertical axis of the matrix are the main elements of the reform agendas and way in which the new arrangements incorporated into the health care services are translated, i.e., in the design of the health system; and on the horizontal axis are indicated the key principles designated for improving the population's state of SRH, each of which can be broken down into other specific components.

Based on case studies, it is possible to establish positive or negative relations between the two axes, i.e., between each part of the determinants of the SRH and the reform components, indicating problematic situations that need to be faced. An example of how this matrix can be constructed is found in Table 1 of Appendix 3.

Even though this conceptual framework was not developed *a priori* for drawing up the case studies made in the context of this work, the discussion that follows is, to some extent, guided by it. On the other hand, this analytical framework is not being "tested" or applied at this stage of our research. Obviously this is a first approach to an analytical framework that may help to move the discussion forward and, as such, is quite preliminary.

3 Health Sector Reform in Latin America and the Caribbean: contextualization and agenda

The term globalisation is being used currently and inaccurately to refer to a growing interdependence of the world economies, as if this were an ancient phenomenon inherent to capitalism. However, the recent aspects of globalisation are not “natural” phenomena, nor inexorable dynamics, but are actively produced within specific contexts, especially in recent decades (Tavares and Melin, 1998), with serious repercussions in economic, social, political and cultural fields.

It is in this perspective that we see the 70s and 80s of the last century as the stage for simultaneous, large-scale world transformations, that have profoundly altered the nature of economic and power relationships between the nation states, as well as world political and socio-cultural attitudes in relation to values and principles hitherto considered consolidated and broadly accepted. These transformations, unleashed by the economic crisis as from the mid-70s, were seen as much in the economic as in the political and social planes, provoking an intense critical process, to the right and the left, leading to numerous revisions and to the emergence of reform processes in all the world. So change movements must be situated historically in time and space and the premises underlying these reforms, which began to be drawn up in the 80s, identified.

We start from the presupposition that the economic crisis that took over most of the world as from the years 1973 to 1975 dulled the splendour of the “golden years” and decreed the ending of the patterns of development that had guided the world until then. It was a profound transformation that was seen in the economic plane in the domains of the three constitutive elements of the capitalist system – the dynamics of capital accumulation, the relation between the public and private spheres and the market system. And, in the political-social plane, the critical process deconstructed the organising historical-scientific and political-ideological matrices of the collective struggles of societies (Fiori, 1993:387).

In parallel, the criticism of democratic pluralism, of state interventionism (planning, regulation, distributism of social policies, universalism of public protection), made both by right and left, unleashed a fierce attack on the social welfare state.

We also assume that the crisis was contained as from the beginning of the 80s, seen in the overcoming of the destructuring process in the core countries, the ideological recomposition and advance of conservative political forces

(captained by Reagan and Thatcher) and, in the economic plane, by the predominance of US hegemony. In terms of social policy, which health policy is part of, this was apparently the end of the era of universal, socialising government programmes, with the ideological and pragmatic dismantling of the welfare state, and a transition process began. The application of that critical arsenal, directed more specifically at the social policies of the welfare state, although based on very diverse theoretical and ideological reference points, resulted in the reinforcement of the neoconservative positions and contributed to the construction of the most overwhelming neoliberal hegemony, consolidated during the 80s.

The macroeconomics of the adjustment processes and industrial restructuring has constituted the essence of economic reform policies in all the core and periphery countries, strongly conditioned by the neoliberal hegemony that marked the 80s and went on into the 90s, the main aims of which were the deregulation and liberalisation of national and international markets (financial, of goods and factors of production, above all of the labour market), the substantial reduction of the size of the State (and of its social responsibilities), and the privatisation of state companies and of public services. This has meant a reduction in activities conventionally assigned to the public sector, restricting the action of the state to the activities that are “proper” to it, with the idea that, in this way, it would become more efficient. All these dimensions have demanded profound institutional changes with serious consequences for world economic, political and social development.

In social policy, including that of health, this dynamic was marked by the debate on the weakening of the social (Keynesian) welfare state, as the economic crisis shook the mechanisms used up to then for the control and direction of economic and social development, in which the role of nation states was historically preponderant, in both the northern and southern hemispheres.

Independently of the ideological slant driving the debate, the critical approach centred on questioning the validity of social policy as a suitable, legitimate and effective means of making up for the numerous lacks of individuals in society. And the economic crisis imposed objective limits that were used politically.

Analytically, concrete events showed up some of the main fragilities of the social welfare state, above all in European countries, dynamically inserted in their own

growth, as well as the profound structural changes operating as from the mid-70s. Various problems became more visible in this process that, although they are not exclusive to the state sector, acquire particular importance in this critical context, and some topics stand out significantly, such as the question of equity.

However, it was very frequently seen that including the equity principle in the formulation of health policies was not accompanied by an implementation that led to overcoming inequalities and reaching higher levels of equity in health care services provision. This was especially important in contemporary reformist agendas, in which the proposed transformations were oriented towards valuing the market to the detriment of public, and above all state, services, and were recommended as those most effective for reaching better levels of equity. In this case, formulating the question about the possibility of realising equity principles in the current context of economic globalisation means asking about the role of the state, its effectiveness in fighting poverty, and its capacity for guaranteeing peace and social justice, which are issues totally outside the market.

THE CONTEXT OF THE REFORMS IN THE HEALTH SECTOR

Historically, the contexts in which decisive shifts in the structuring of health care service systems have taken place have always been linked to broader economic, social and political processes and aspects that do not necessarily relate to the health care field.

Thus the intense political and social mobilisation of the 60s and 70s stimulated, also in the health care field, a devastating questioning of all the foundations that had guided the structuring of health systems, and above all of medical practice. Initially, broad and multiple in form, this process situated medical attention as the epicentre of the sector crisis, and had as its main target both the doctor and the performance of the health care services. With the fiscal crisis in the state, as from the mid-70s, and the neoliberal hegemony of the 80s, this criticism became gradually more limited and the “health crisis” was reduced to a “crisis of the health care service systems”, in which the issue of costs became more important.

The theoretical basis of the justifications for a health systems reform movement, consolidated in the 80s, was supported on several arguments but, in essence, it was the same as that formulated for decreeing the end of the welfare state.

In practice, there is a clear difference between the 70s and the 80s in the general direction of health policies implemented in different countries. While in the 70s, the reorganizations still kept the perspective of expanding the systems, although in a clearly rationalising way, in the 80s the predominant climate was of an increasingly ideological discourse about health expenditure being uncontrollable, demand being infinite and the professionals and experts the

ones mainly responsible for this situation, thus justifying the inexorability of the reforms.

Or rather, with the economic crisis in the mid-70s, the concern about health care in practically all the core countries changed its meaning and the issue of the high costs of medical attention took over the centre of the public sector agenda. The health services in the core countries absorbed on average 7.5% of the GDP (more than 12% in the USA) and in many countries the public amount of this expenditure was near 76% (5.5% of GDP), and in addition “medical inflation” had remained higher than the values of inflation in the economy in general in most countries in the recent decades (Schieber and Poullier, 1991:24). There was consensus everywhere that these sums should be managed and sector inflation necessarily contained, following the prescriptions of the macroeconomic adjustment policies then in force.

In the second half of the 70s, concern about medical care costs was already evident (in government policies, and in the USA, also in those of companies), and the approach to regulation by means of administrative reorganizations and planned coordination of the systems gradually gave way to cost containment measures and proposals for introducing competition mechanisms in the health market (with the USA in the vanguard).

As from the 70s, on both sides of the Atlantic, governments as well as the others responsible for the payment of health care services (which could be different institutions or actors, depending on the country), began to get actively involved in the struggle to reduce the growth rate of health spending, and it is possible to find, at the same time, great similarities and strong contrasts in the mechanisms and policies for containing costs implemented by the different countries. Where it was possible to connect national macroeconomic goals with sector policies, attempts were made (sometimes successfully) to link increases in sector spending to the growth rates of national income.

Already in the 80s, the generalisation of adjustment and restructuring policies, the organization of regional blocks of countries and the attempt by governments and international agencies to create patterns (and norms) that would enable some kind of world economic coordination and direction, allied to the neoliberal hegemony, spread ideas of the convergence of sector policies. This was justified by the need to control the public deficit, centred on the premises of introducing greater management capacity and regulation in the competitive (or pluralistic) systems, and mechanisms of competition in the public systems traditionally administered in an integrated way.

Health spending in the USA grew steadily and resistantly, from the lack of more effective government instruments for containing medical care costs, and also from the “free market” tradition, and this led to proposals being made that became paradigmatic, disseminated as more effective mechanisms for achieving greater efficiency, and these were incorporated into the reforms in Europe and some countries of the South.

Most of the literature devoted to discussing this crisis shows great consistency in the assessments (with basically economic arguments, whatever the ideological background of the writer), and confirms a coming together of similar problems being faced by all the health systems in the different countries.

The control of public debt and health spending underlies all the reforms, linked to macroeconomic demands, and they incorporate the same premises of less state, privatisation, flexibilisation and deregulation. The core of these proposals is the restriction of professional autonomy, the restructuring of the public/private mix, and decentralisation towards sub-national levels and the private sector.

The way these reform proposals are drawn up tends to centre its criticism on the supply side of services and benefits, with special emphasis on those linked to social protection, i.e., questioning the “supplier” state or the Keynesian welfare state. The central premises underlying this perspective refer, on the one hand, to the overload on the state faced with the demands exacerbated by the economic crisis and lobbying by interest groups, and derive from this the evaluation of the harmful effects for national economies due to an excessive state intervention in private businesses and the high taxes necessary for supporting the social policy. On the other hand, it is stressed that, in general terms, state decisions reflect the preferences of politicians and bureaucrats, moved basically by private aims, trying to obtain or keep power.

Many of the approaches that have turned out to be privileged in this way, and which have guided state reform proposals, originate in the rational choice institutionalist perspective, and some of the key concepts centre on the “principal-agent” relationship and on the problems deriving from the costs of economic and political negotiations (Kaufman, 1995; Przeworski, 1995).

Even though the determination to make the state function better is not new in modern history, there has never been a reform movement with such a homogeneous agenda, nor one so broad, nor that spread so quickly. From an optimistic point of view, this process is seeking new forms of ensuring the *res publica*, i.e., the use of the state to promote the public interest.

From this perspective, the generalised wave of modern reforms takes on, according to Kettl (1996), features of a “global revolution” (of ideas and of politics). Its novelty is not just in the generalisation throughout the world of the same reform agenda, but also in the interest in “managerialism”, alleging that traditional hierarchical bureaucratic structures, with their inherent normative procedures and rigidity, are harmful to public interests, inefficient and ineffective. The reformists build their “revolution” on the affirmation of the erosion of the theories of bureaucratic hierarchic authority that were the support of the modern state management for more than a century. They begin from the presupposition that, like any monopoly, state agencies are intrinsically inefficient, tend

to grow indefinitely and result in poor performance. Attention shifted from the activities or “products” of the government agencies (*outputs*) to the results of these activities (*outcomes*), (Kettl, 1996: 38-41).

Despite their universal appeal and dynamics, two dilemmas remain in the core of the debate: the first is that of building government administrations that function better and with fewer resources (i.e., more efficient), the second is linked to what the proper functions of the State should be, i.e., a “refoundation” of state responsibilities with its consequent organizational restructuring.

It is necessary to separate, however, two distinct moments in this reform process: the first is the time of neoliberal hegemony in the 80s, when the ideological discourse predicated the bankruptcy of the welfare state and the predominant policies were centred on cost containment and spending control, trying to move consideration away from the social issue by means of fiscal stress (France, 1993), under-financing and the exaltation of the individual, in opposition to its “dilution” in the collective; and the second, more recent, period, when analytically and technically founded reform proposals were formulated, with the intention of removing from the State its sole responsibility for some of the activities that up to then had made up the social security net built under the Keynesian perspective.

The reform models emerging in the 90s soften the heightened ideological discourse of the 80s, even starting from a criticism of neoliberal proposals, without this meaning a return to the premises of the previous all-providing state. In reality, the reforms in progress try to take on the “new” problems maximised by the restrictive policies of the decade before, placing them in the centre of the different sector arenas, recovering, under new bases, the perspective of the minimalist state. The main features of this agenda are the centrality of the economic perspective, the dissemination of the same premises for all sectors and the shift of interest towards policy operationalisation, moving away from the principles that gave rise to their formulation.

In Latin America and the Caribbean, the macroeconomic adjustments of the 80s induced severe, disturbing long-term effects, whether in the increase of inequalities, or in public sector structure and financing. Moreover, the reformers paid little attention to administrative restructuring and did nothing against the deterioration of public sector resources (Fanelli, Frenkel and Rozenwurcel, 1992: 48). In addition, this worsening of the problems came about as a result of the implementation of macroeconomic policies that excluded social policies, except as part of the spending allocation of fiscal policies, significantly diminishing public investment with the consequent deterioration of infrastructure, services and management capacity (Hoeven and Stewart, 1993:13). On the other hand, they coincided with the consolidation of democratic regimes, restored through complicated political transitions.

So the central issue of the public agenda for the region in the 90s was (and still is) how to reconstruct the capacity of

the state, at the same time as restructuring it (Fiori, 1993), in order to implement the reform policies necessary for facing the problems aggravated since the 80s. In this process, there is an overlap between the two problems – construction and restructuring – that, beyond their inherent difficulties, also need an increase in investment.

So the inclusion of the theme of health sector reform in the political agenda in our region comes about in a quite complex way: because of the alarming increase in the indices of poverty and the aggravation of the populations' health situation, the reduction of public investment in the area, the emergence and/or visualisation of new actors raising social demands, the conditionalities of economic restructuring and of international creditors, and the need for state reform, in which sector change is a priority.

The institutional reform agenda for Latin America has been strongly influenced by five broad topics, which have been around in the world for more than two decades, developed by the World Bank and other international organizations taking part in the process (Kaufman, 1995:5):

1. The centralisation and political isolation of the control of macroeconomic policy, particularly as regards decisions about public spending and monetary policy, with social policies subordinated to these dictates.
2. The decentralisation and privatisation of bureaucracies responsible for the provision of social services.
3. The introduction of competition among providers of goods and services (public and private) as a way of increasing efficiency and, supposedly, quality.
4. The delegation of regulatory functions to independent agencies, in charge of monitoring service suppliers and handling the externalities associated with privatisation, flexibilisation, deregulation and other market-oriented reforms.
5. The creation of a limited number of posts for "essential", more capable, public officials, with considerable operational power, who would be recruited on the basis of meritocratic criteria and evaluated to specific standards of performance.

THE REFORM AGENDA IN THE HEALTH SECTOR

In the health area, this process has meant the formulation of a post welfare state agenda for this sector too, generally in tune with the broad world movement of state reform, and this has brought about a significant change in the sector policy arena, strongly questioning the way in which, up to that moment, health systems were being organized and fulfilled their functions (Almeida, 1995). This process has led to questioning whether health care should remain among the benefits making up the social policy safety net (Almeida, 1996 a and b; 1997).

The health care services reform agenda formulated in the 80s was centred around a *paradigm change of state intervention in the social field* (OECD, 1987; Bennett,

1990:12-21) and its core was the implementation of policies based on the concept of demand expressed according to consumer preferences and taking the issue of costs into consideration.

In the health field, especially in everything concerned with medical attention, this ideological rhetoric stimulated the formulation of a sector diagnosis common to all countries, stressing the need for particular changes, spread and encouraged by the international bodies (such as the OECD and the World Bank), as well as the USA that exercised a directing role in the formulation of this new post welfare health agenda.

Added to this picture is the reordering of the international arena, with the organizations traditionally in charge of health questions (such as the WHO) losing ground, and the predominance of economic subjects, led by the financing agencies (such as the World Bank and the International Monetary Fund), which encouraged the adjustment and restructuring processes.

Basically centred on economic grounds, this evaluation pointed up several problems, that were in fact present in the sector field, but, in the reformist rhetoric of the time, it preached that:

1. The inexorable scarcity of resources meant that the previous patterns of health spending could not be maintained, as the amounts involved affected the public deficit, thus bringing into question the predominance of public funds in the financing of health care provision and the continuous, frenetic investment in technology. Supply restriction and decentralization (towards sub-national levels and the private sector) were recommended.
2. The lack of involvement of the spending agents (i.e. the professionals) with the costs of services impeded identifying who was responsible in the use of the resources, and so measures were needed to restrict professional autonomy and to displace the monopoly power of the service providers by introducing mechanisms for competition and management changes typical of the private sector. The doctor was thus the target of this criticism.
3. The populations' health situation had not improved to the same extent as investment in health and health system costs had increased, and this indicated waste and a need to redirect priorities, i.e., the relation between levels of care (that is, primary care *versus* hospital care) needed to be rethought.
4. The removal of price barriers for health care services consumption always went back to the excess of demand (both in the case of state as well as private financing), that should be controlled (by the government, companies, and insurance firms), through financial participation by the user or partial forms of coverage. This meant it was necessary to repress demand for services, encouraging "cost consciousness" in the user.

5. The unsatisfactory performance of the services in the face of consumer demands frustrated their freedom of choice and the meeting of their needs. So it was necessary to open the health care services market to consumer choice and, by competition between services, eliminate the inefficient ones (fundamentally those in the public sector).

At first sight, this “package” of diagnoses and prescriptions seemed relevant and necessary and won many supporters, and it was difficult to analyse it in a way very distant from “common sense”, as its defenders sold it as an already late and necessary “management modernisation” of health services, justified by the rhetoric of performance and the quality of care, designed to end the inefficiency, bureaucratic rigidity and professional dominance that had accrued during the expansion periods of the 60s and 70s.

Its fundamental points were:

1. To increase efficiency, always understood as maintaining the cash limits defined by the macroeconomic variables, by means of management changes.
2. To ensure that the costs of services provided were contained, through control mechanisms on the supply and the demand sides.
3. To reinforce regulation, i.e., to keep sector budgets and the workforce under strict control, displacing and weakening professional associations and trade unions.
4. Internal responsibility for service spending (i.e., develop cost consciousness in the professionals and create mechanisms of accountability).
5. A response to consumer preferences (i.e., free choice in services and professionals).
6. (Re)balance in the allocation of resources between the government (at its various levels) and the market (i.e., decentralisation to subnational levels and the private sector), and an increase in the financial participation of the user in payment for services used, whether public or private (co-payments).
7. Reinterpretation of political representations (i.e., of the councils and of the social control and participation mechanisms).

In brief, there was a significant change in the sector policy arena, which Walt and Gilson (1994) analyse as a passing from *consensus* to *conflict* or to *uncertainty* (Walt, 1996).

This meant a change of emphasis in the “direct production of services by the state” towards “provision in an appropriate regulatory environment”, introducing competition mechanisms which, theoretically, would encourage individual activity, provide a better response from the market and non-profit organizations, and would unleash the strengthening of relations between the consumers, service providers and levels of government, and make it

possible to reduce the need for coordination and planning, with greater emphasis, for example, on smaller government units.

The main topic proposed by this agenda was, thus, the assertion of the *inherent inefficiency of the state* (or of state services) and, as the crisis imposed the inexorable necessity of cost-cutting and spending control, the “natural” result, it was argued, would be cutting those areas considered not only as the least efficient, but also as frustrating the aim of reaching an appropriate relation between supply and demand, or between taxes and benefits, or even between consumer and services.

A great part of the aim in the reorganization of health care services has been centred on looking for business incentives as a common factor in the various reform initiatives, passing from the phase of fiscal rationalisation to attempts, at a rhetorical level, to develop within the health systems the *capacity to adapt themselves to a more competitive and dynamic environment* (Poullier, 1990:21).

Obviously, to increase responsibility to the consumer, to improve the organization of service distribution, to innovate in financing and in cost recovery, to implement management reforms and to reinterpret representations can be goals of any government, independent of its ideology or political party. Nonetheless, the major aim behind these reforms in the 80s and 90s was a broad political agenda of changing the frontiers of state intervention in the health field. The consequences of this homogenising strategy of reprivatization have been innumerable and, perhaps, unnoticed by its mentors.

The conservative face of this reform agenda was limited to the question of individual medical care, the nucleus for structuring the health systems in this century in all the world, centred on technological development and on the hospital as the privileged *locus* of distributing this technology. The main aim is to restrict spending in this sub-sector, which consumes a large part of the resources in all the systems, to reinforce the monopsonic power of service purchasers through management means, and to weaken the monopoly power of providers (above all the doctors), undermining professional technical autonomy. On the ideological plane, the main drive is to depoliticise the health arena, to give priority to the actions of managers, displacing the doctor as the main spending agent (demand inducer) and to stress a business structure in institutional affairs that is thought to be more efficient.

The health reform movement that became worldwide as from the 90s produced some models that were disseminated as new paradigms for restructuring health care services systems. Some consensuses were built up on the way and certain practices were also evident being defended as change strategies, the most important of which are:

1. The introduction of different measures to rationalise health care, like the attempt to reduce the emphasis on hospital spending and redirect it towards non-hospital

- practices (out-patient care, homecare, emphasis on primary or basic care) and public health (prevention).
2. The separation between service provision and financing (or between buyers and suppliers) with the strengthening of the state's regulatory capacity.
 3. The construction of "regulated or managed markets" with the introduction of mechanisms of competition (managed care, managed competition, internal markets, public competition).
 4. The use of the most diverse subsidies and incentives (both on the supply and on the demand side), to procure the restructuring of the public/private mix with the bankruptcy of state "monopoly".

In the real world, the health sector reforms have taken place at different times in different countries and with different characteristics but, in general terms, have incorporated and re-elaborated the prescriptions of this world agenda. The paradigm of *managed competition*, conceived in the USA in the 70s, has been dominant (Almeida, 1995, 1996 a, 1996b) and was updated for the Latin American context (Almeida, 2001; Almeida *et al*, 1999 a). In its original formulation, as an organization strategy for a private health care services system, it brings together cost containment and control of use, based on changes in the subsidy structure and incentives in the health care services sector, i.e., in the way of allocating financial resources, reorganizing supply and demand and redefining the roles of financers and public and private service providers. These changes would be achieved with the strengthening of health systems management and would seek greater efficiency and equity, as they would be centred on "consumer choice", to bring order and discipline to the services market in accordance with principles of quality and effectiveness.

These ideas have been reinterpreted in the reform proposals of different countries. In Europe, where the health systems are mainly public, countries have generally implemented changes in the way of allocating resources in the medical care area and have flexibilised management, separating financing functions and service provision. The nucleus of the change is the loss of the automatic transfer of public budget resources and their linking to the definition of the packet of "necessary" services to be purchased, or to meeting performance indicators defined in contracts. Consequently, the survival of the organization is subordinate to its capacity to meet "consumer" demand (in the cases of England and Sweden the state authority, and in the case of the US Health Maintenance Organizations – HMOs – the employers who buy health plans for their personnel). These processes have resulted in profound revisions of the foundations structuring the health care service systems, in an increase or strengthening of state regulatory intervention, in heavy controls for containing costs, in general stabilizing or reducing overall health spending.

In the USA, where the system is mainly private, this has also meant an increase in public and private regulation

(through the *Diagnostic Related Groups – DRGs*, for the payment of hospital care, or managed care in private insurers, managed competition in the California and Oregon systems, among others), with significant interference in professional technical autonomy. However, health spending continues rising, although the speed of its growth has diminished in recent years, with the USA still having the most expensive system in the world and with the lowest coverage, compared to its "peers" with the same level of development.

In brief, despite the underlying false polarisation between regulation and competition, the most obvious result of these reforms up to the present is a more interventionist and regulating state. The European countries, on the other hand, have preserved up to now the principles of universalisation and the original mechanisms for financing health care service systems, not as a vindication of solidarity, but as a crucial dimension of state regulation, to ensure cost containment as well as minimum standards of re-distribution. Models incorporating separate functions for financing and provision have prospered in the different reforms, while the introduction of competition mechanisms has been strongly criticised.

For Latin America and the Caribbean, and the periphery in general, this international reference has been quite important, even though the health sector reform processes, in most cases, have not been set off by excessive spending, but by increased inequalities, in the distribution both of revenue and of services and benefits, with a marked deterioration of living standards of large majorities in each country and the pauperisation of broad bands of the population (ECLAC, 1990, 1993; PAHO/ECLAC, 1994; Bustelo, 1994; Hoenen and Stewart, 1993; Borón, 1995).

The same reform models have been spread and recommended for Latin America by international agencies, above all the World Bank, and are linked to the macroeconomic stabilisation and adjustment plans, mainly in terms of the weakening of state commitment to health care service provision for the population, to the restructuring of the public/private mix, and focusing public action on the poor and most needy (basic packages, subsidies, etc.) (Melo and Costa, 1994; Almeida, 1995, 1997a).

The diagnosis of the sector crisis, formulated in the core countries, will be useful for questioning whether the health system models developed by them (considered expensive, inflationary, inefficient and feasible only with strong public investment, above all in Europe), can be relevant or suitable for confronting the framework of existing deprivation and inequalities in this region.

It should be said that, gradually, this agenda has been re-elaborated on a regional scale, both by policy makers in the different countries as well as by international agencies, by intellectuals and opinion formers, which can be verified in the very reforms that are being put into effect or proposed in countries in the region (World Bank 1989, 1993; Musgrove 1995, 1996; PAHO/ECLAC, 1994; PAHO, 1995; Frenk and Londoño,

1995, Frenk *et al*, 1994). And in the model put forward for Latin America and the Caribbean, called “structured pluralism” or the “tropical version” of US managed competition (Frenk, 1994, 1998; Londoño, 1996; Londoño and Frenk, 1995), social security (public financing) is combined with the separation of functions and introduction of competitive mechanisms (inspired in the Internal Market of the English reform), constituting quasi-markets and creating new (public and private) agencies to guarantee the insurance and provision of services. This new structuring of systems would be able to produce more efficient results in health and, therefore, overcome inequality.

The review of the reforms under way in the region shows that different reform modalities have been adopted in the health care service systems, but that there are common elements in all the processes, introduced within the (theoretical) perspective of conciliating efficiency and equity. In general, the financing rules and benefits have been modified, and the participation of public and private

agents, separating the functions of regulation, provision and financing. In addition, a greater presence of the private sector has been encouraged in management and provision, and the free choice of affiliates and competition between insurance bodies and between service providers has been instituted, establishing quasi-market forms in public service provision. The idea of insurance is predominant and there are significant differences in the combinations between social security (public and voluntary) and private risk insurances with individual contributions, in the structure of financing, access, service provision and benefits (Almeida, 1999; ECLAC, 2000; Sojo, 2001).

We would stress that some of the positive results of these reform processes become diluted in the new problems arising from the reforms themselves, above all in the countries choosing to adhere more radically to the new agenda; and in any country in which the public, universal, mutual system was more consolidated, the management changes introduced have achieved better results (Sojo, 1998, 2001).

4 The Presence of International Organizations in the Region

To understand the leading role of the World Bank in the health sector reforms in the region in the last decades of the past century, and continuing, it is necessary to go back briefly in time and understand the change of leadership that took place in the sector in the ambit of the international organizations.

THE CHANGE OF LEADERSHIP IN THE INTERNATIONAL CONTEXT: THE WORLD HEALTH ORGANIZATION (WHO) AND THE WORLD BANK (WB)

Until the 50s, the WHO was the unquestioned leader of the sector on the international plane, “a stable and pragmatic organization, broadly orientated towards diseases and dominated by medical professionals [or the specialist community]” (Walt, 1994:137). Its line of action institutionalised the western perspective (or rather that of the core capitalist countries) in its definition of its role and its technical cooperation activities.

Historically, the international legitimacy of the Pan American Health Organization (PAHO) was linked to the construction of a consensual conceptual and theoretical paradigm, based on scientific and professional authority guiding practices and strategies able to confront health problems in the world context. This became established as from the end of the 19th and the first decades of the 20th centuries, with the advances of medical technology and therapeutic methods, guiding the creation of the PAHO within the “public health paradigm”, founded basically on the control of vectors and parasites and on the prevention of infectious diseases with the extension of vaccination, i.e., the classic programme of sanitarianism.

As from the 60s, this “consensus” became questioned with the confirmation and growing criticism of the lack of efficacy of traditional public health in the developing countries for tackling the structural issues conditioning health and disease. The PAHO agenda then began to be reconstructed, incorporating topics from public policies not directly related to health. The role that sector planning occupied in this process is exemplary, signalling the first change of direction of the organization. The creation of the Cendes-PAHO Method is a fruit of this process, seeking to introduce a highly normative microeconomic rationality in sector management, through which governments aimed to program social and economic development, within a change

perspective, with the permanent guidance of the PAHO. The lack of a more contextualised problematisation of the political and institutional aspects of the decision making process in implementing sector policy guidelines, would become one of the greatest causes of the relative failure of the method and of the fierce criticism that followed (Uribe, 1989). For Melo and Costa (1994), this strategy repeated the main feature of the PAHO technical cooperation agenda, i.e., *the recreation of an extremely unspecific and multifaceted range of interventions ...* broadening and recombining elements of the earlier sanitarianism at the same time as it avoided confrontations with its tradition of the health agenda as a public good (Melo and Costa, 1994:60). The result was the steady, incremental incorporation of proposals and programmes without a clear differentiation from the previous agenda.

In the 70s, the “developing countries” began to press more and more for a broadening of this agenda, calling for a more incisive institutional performance and a change of direction to look at the socio-economic causes of diseases and ways of tackling them, giving priority to levels of care considered more effective and less costly than hospital medical care. Some experiences of Third World countries, considered successful in the health field (Chile, Cuba, Tanzania, and Vietnam), began to be studied and publicised as innovative alternatives that encouraged the formulation of new paradigms for health system workings. In 1975, the WHO launched the guidelines Health for All by 2000 (HFA 2000) and, in 1978, formulated the Primary Health Care approach to achieve this goal. Member states were encouraged to launch radical reviews of their health policies and systems, actively recommending the implementation and development of the basic levels of care in the perspective of primary care. From that moment, the WHO became a more politicised organization (Walt, 1994:137-144).¹³

The primary care (PC) approach was widely presented as *the way* for reaching the goal set and, in 1978, in Alma Ata, representatives of 155 states solemnly committed themselves to this guideline. This approach interrelated at least two meanings: the first was a general prescription calling for health systems to give priority to basic attention, anticipating and preventing health problems and the aggravation of diseases, and breaking the perverse cycles producing diseases; and the second was a minimum set of activities and services making up PC and extending beyond the field strictly of medical care services, focusing on the

13. The HFA 2000 goal was launched by the Director General of the WHO, Halfdan Mahler, who was in charge of the organization from 1973 to 1988.

populations' living and health conditions, incorporating activities in the areas of education, sanitation, promotion of food supply and adequate nourishment, mother and child health (including family planning), preventive measures, the supply of essential medicines, guarantee of access to services, etc. (Declaration of Alma Ata, 1978). The idea of PC called for a broad intersectorial activity from government, seen as essential for reaching HFA 2000. This approach, also promoted by the United Nations Children's Fund (UNICEF), together with the WHO, was enthusiastically taken up by countries of the periphery, but treated in a much more cautious way in the core world (Almeida, 1995).

This ambitious programme was indirectly overshadowed by the discussion of the "health crisis" (that began in the mid 70s), and the underlying diagnosis, as was analysed earlier, redirected the problem towards a "health care services costs crisis" at the end of the 80s, seeing these as inadequate in their operating capacity, uncoordinated, inefficient and with a serious wastage of resources, as well as low population coverage.

The strength of the WHO was precisely centred on its ability to finance the technical cooperation activities which, supposedly, should follow the institutional guidelines. And this situation set up a "legitimation crisis in international cooperation" in the 80s, with the donors becoming increasingly critical of the organization, calling also for the displacement of "doctor power" in its area, to give way to the incorporation of other professionals, such as economists and administrators. Even the valuable results obtained in the 70s with the great success of the immunisation programmes in underdeveloped countries, led by the WHO at world level, were obscured by this criticism. *The criticisms claimed that the greater fragility [of international technical cooperation] was too centred on the culture of sanitarianism and on the politicised and absolutely non-specific way in which health was associated with topics such as income distribution, housing, education, nourishment, insurance provision, etc.* (Melo and Costa, 1994:61-62). Questions were also raised about the bureaucratic procedures, the high costs, the proliferation of meetings and reports, and the lack of transparency and of evaluations to show the effectiveness of the programmes (Walt, 1993:125).

Throughout these years, changes in the composition of the WHO budget increasingly limited the Director General's power of decision, shifting it to the donor countries. Gradually, the so-called voluntary donations (or extra budget resources) began to have greater weight in institutional financing, as the regular contributions of the member states, which used to be predominant in the composition of the

budget, gave way to other sources which, by 1971, already constituted 25% of the institutional budget and, at the start of the 90s were 54%, with the World Bank and the United Nations Development Programme (UNDP) on the one hand, and the USA and the European countries, on the other, as the main financiers (Walt, 1994:136). This weakened the institution's power of decision and management and undermined the decentralised regional structure of the organization, decreeing the decline of its dominion in the international health arena, since financing passed from the strategic support policy, defined by the organization, to the "priorities" tied by voluntary donors into the specific programmes. In parallel, the participation of World Bank funding increased in the health sector.

Structurally, the WHO was the most decentralised of the specialised international bodies and its six regional offices were a unique set-up in the United Nations system (Walt, 1994:136-7). The regional offices had considerable discretionary power over the allocation of the resources in the regular budget and were responsible for formulating and implementing institutional policy and defining priorities. Even though there was great variation in the technical capacity of these bodies from one region to another, and the regular budget was small and destined mainly for study grants, seminars and modest technical cooperation projects, there were frequently tensions between the headquarters and these regional levels (as, for example, between the PAHO, the historically most independent office, and the WHO). Moreover, the much greater funding made possible by the specific programmes was always more attractive for the health ministers of the countries than any advice on strategic planning for the sector, given that these provided considerable resources and technical assistance, as well as not interfering directly in the formulation of national health policy.

It is worth remarking that underlying this process were not only the repercussions in the "Third World" of the HFA 2000 strategy, specifically as regards primary care, with its "subversive" proposals, but also, and mainly, the battles the WHO faced about child nutrition with mother's milk *versus* artificial formula milk, in the mid 70s, and the programmes of essential medicines, launched in 1978 (where the confrontation was basically with the Nestlé company and the multinational pharmaceutical companies).¹⁴

The advance of the World Bank into the health sector began in the same period, as from the end of the 60s, when it began to finance projects and activities in the area of the control of population growth, under the leadership of the United States of America, and coinciding with a change in its presidency.¹⁵ From the mid 60s, the US government had been

14. See Gill Walt (1994:138-40).

15. The World Bank was also created in the 40s (in 1946), together with the International Monetary Fund (IMF), and the General Agreement on Tariffs and Trade (GATT), as one of the pillars of the Bretton Woods system, composed, in fact, of five closely interrelated institutions, the most important of which in the international health arena are Bank for International Reconstruction and Development - BIRD and the International Development Association (IDA) (created in 1960, to grant highly favourable loans to countries with very low incomes), and the International Finance Corporation (IFC) (created officially in 1956 and starting operations in 1961, to grant loans to the private sector). The functions of these international financial institutions changed considerably since their creation, above all

actively making efforts to include the population issue in the international agenda, defending birth control policies as well as encouraging less developed countries to develop them, urging the participation of other countries as financial donors for these programmes (up to then the USA was the major donor) and mobilising the support of the United Nations for family planning (Walt, 1994:61-3). When Robert McNamara took office, this policy was taken on by the World Bank which, in 1968, created the Population Project Department and began loans in this area. This process coincided with the arrival of oral contraceptives, which were tested in various “developing countries” and used by more than four million women in the USA as from 1965 (Walt, 1994:62).

The criticism current at that time in the health area, the denunciations and mobilisation against this policy, led mainly by the feminists, and widely covered and spread by the media, redefined the problem in terms of its connection with political and socio-economic changes, and managed to some extent to reduce US hegemony in the leadership of population policy.

The health debate sharpened by the 80s, defending the shift from technical cooperation activities in the context of medical attention towards issues related with the management of health, capacity building, policy evaluation in the wider context of economic and social development and, more importantly, to the use of economic instruments as the privileged tool for such activities (Walt, 1993:140). The topics under debate in the 80s began to question the efficacy of the cooperation programmes, on the one hand and, on the other, the notion of health as a public good, historically so dear to the organization. At the same time, the excessive pulverisation of WHO programme activities worsened with the substantial growth of irregular resources. And, at the same time, its international leadership role in the health area was eroded, producing a lack of definition over its place and competency in the international arena.

In precisely the same decade of the 80s, the World Bank would begin to grant loans directed specifically for the health care services. This process did not occur in a vacuum, but in the context of economic crisis, neoliberal hegemony and severe criticism of social policy, on a global level. The hegemony of neoliberal ideology consolidated and shaped a new core position in economic analysis in the sphere of social policy in general and of health in particular.

For Melo and Costa (1994:68-69) *the internationalisation process of the neoliberal-inspired reform agenda was late and conflictive [in the PAHO] due to its sanitarian culture ... and to its “porous” organization structure [in its common meaning], because of the fragility of the objective truths and of the belief system of the epistemic community in public health.* The reaction of the PAHO was to restructure itself in

two directions, that later overlapped: on the one hand, institutionally consolidating in the field of epidemiology, in order to be able to overcome the explicit confrontation with its institutional identity and recover its normative capacity and that of implementing regulatory policies, and on the other hand, focusing interest in the macroeconomic aspects of health, principally in relation to the analysis of funding mechanisms and of the fiscal impact of health spending, as it institutionalised the field of health economics.

To sum up, the legitimacy and leadership crisis of the WHO system occurred at the same time as the increase in the activity of the World Bank in the health area, proposing a new reform agenda for the health sector, extremely economist and marked by “tragic choices” (Santos, 1998) which, in this specific case, focused on redefining some of the classic notions guiding the organization of health systems in the 20th century, such as health as a public good and that of equity and universality in the health field.

According to Melo and Moura (1990, *in* Melo and Costa, 1994:79), the history of the World Bank in the last two decades of the 20th century had three great turning points in its intervention strategy and role in different countries. The first is related to the McNamara period (1968-1981), when there was a change of emphasis. From being a infrastructure projects (transport and energy) financing institution, the Bank became a multilateral agency for fighting poverty on a world scale – its development aims shifted, first, from the area of infrastructure to industrialisation, and later, to that of social development. The second is based on two fundamental contexts (Clausen period, 1981): the rise of conservative governments in the hegemonic member countries (USA and Britain), quite critical of the bureaucratic and submissive performance of the Bank (to the “Third World” countries), and the international economic crisis (fiscal and of indebtedness). It was then that the Bank activities became directed mainly towards structural macroeconomic adjustments and to health sector reforms, with the consequence of a greater politicisation and visibility of the Bank’s activity. The third turning point came at the end of the 80s, when the discussion on fighting poverty returned more fiercely, focusing on the question of the political viability of the reforms, strongly governed by an institutionalist view in which governability and institutional quality became central issues. According to Melo and Costa (1994:80-1), there were apparently three factors that led to this redefined approach: the structural reforms and adjustment programmes that had turned out badly in several countries, with serious political and institutional consequences; the transformations in Eastern Europe that had given high visibility to the role of the institutions in these processes; and the socially devastating impact of the

since the economic crisis of the mid 70s. Five countries hold around 45% of the shares of the Bank (Japan, USA, Germany, Britain and France) and, supposedly, the right of veto, but in practice the management of the policies implemented defines its performance, and from this derives the importance that the World Bank bureaucracy took on in the running of the institution.

reform policies encouraged by the Bank, pointed out by several writers and by international bodies (such as UNICEF).

So, in brief, the Bank began working in the health area on a birth control policy strategy in developing countries, inserted in the broader context of “sustainable development” and of the “need for global sustainability”, and later turned to the fight on poverty, prescribing health sector reforms in a quite particular manner, putting at risk the prevailing principles of equity and universality. The reform of social policies as from the 80s was intensely affected by these redefinitions, producing a *profound realignment of the actors in the international health arena, questioning the mandate of other bodies working in the sector* (Melo and Costa, 1994:85).

THE NEW AGENDA OF THE WORLD BANK FOR THE HEALTH SECTOR

The new Bank agenda called for the reduction of the role of the state and the strengthening of the market; it placed sector financing under the conditioning of structural adjustments, and gave priority to programmes and activities based specifically on cost-effectiveness criteria, thus subordinating the evaluation of health expenditure to concerns about the macroeconomic consistency of the countries under structural adjustments.

However, this debate took place on a worldwide scale as from the second half of the 70s, led by the World Bank, emphasising the contradiction between efficiency (in allocation) and equity, taking up the slogan of growth *versus* distribution, and starting to spread the formula “redistribution [only] with growth”. The “basic needs” approach was also introduced (Melo, 1998; Melo and Costa, 1994). At the same time as recognising the importance of state intervention in the social sector, criticism increased of its effectiveness and ability to solve problems, with the core question of the incapacity of state policies to attend the basic needs of the population, i.e., the most needy. The new challenges that then began arise resulted from *mistargeting*, i.e., the problem was not the irrelevance of public social spending but its “misuse”, as the benefits were not representative in the face of the costs associated with maintaining gigantic, expensive and ineffective structures; *inequity*, understood as a lack of access of the poor to basic health services; *inefficiency* and *cost explosion*, caused by doctors being “demand inducers” and by the availability of highly expensive new technologies.

So the analysis focused on the way of putting the social policy into operation and its bureaucratic, exclusive, inefficient and ineffective nature. Administrative reform and decentralisation (which, as well as bringing policy makers closer to the needs of communities and towns, could also overcome “bureaucratic gigantism”) occupied a high-

profile place in this debate. Starting from institutional “reengineering” and changes “in the rules of the game”, a clear influence of the neoinstitutionalist paradigm, it was hoped to obtain greater efficiency, equity and a concomitant reduction in predatory and harmful behaviours, using mechanisms that encourage competition (Almeida, 1995, 2001; Almeida *et al*, 1999; Melo, 1998). The emphasis was thus put on the reform of laws (Constitutions) and of the legal architecture of the programmes and policies, understood as structures of subsidies and incentives to be redefined to model new behaviours.

Once again, the World Bank was in the vanguard: creating a fund to alleviate the adverse economic and social consequences of the macroeconomic adjustment programmes, it announced its active entry into the processes of sector policy reformulation. The document *Financing Health Care: An Agenda for Reform* (World Bank, 1989) situated health reform financing within the set of conditions negotiated as the bases of economic adjustments. In reality, this more incisive activity of the World Bank in the health area was not an isolated event. It was one of the results of a *qualitative change* in its conduct in the region, taking on a more strategic, long-term perspective, coherent with the broader “*route correction*” guiding its prescriptions in the economic area (Fiori, 1993:137).

In the 1990 World Development Report (*Poverty*) the Bank proposed a dual strategy: on the one hand, promotion of growth based on the intensive use of labour by opening up the economies and investing in infrastructure; on the other, provision of basic social services of health and education for the poor population.

Various studies were ordered and their results proposed a redesign of three fundamental variables for the organization and functioning of health systems: the mode of identifying the health problems guiding policy formulation; the way of defining the profile of service provision; and the way of defining priorities or, in other words, what the governments have the capacity to carry out (Jamison and Mosley, 1991:18). The articulation of these three variables would, as a consequence, make explicit the “tragic choices”.

A more pragmatic approach was then adopted, explicitly aimed at reform prescriptions in the health field. In 1993, the World Bank Annual Report focused openly on the health question, and the strategic choice of the PAHO in the face of this clear leadership threat was to ally itself to the Economic Commission for Latin America and the Caribbean (ECLAC) and produce a document interrelating health, equity and changing production patterns (PAHO/ECLAC, 1994), at the same time seeking to widen communication with countries beyond what was usual with the health ministers, to include the parliamentarians of the new Latin American democracies.¹⁶

16. The program Democracy and Health - Cooperation Project of the PAHO/WHO with the American Parliaments was launched in 1992, with the creation of the Latin Health Parliament (Parlatino), although collaboration activities date from 1990.

It should be pointed out, however, that the dispute between international agencies is nothing new, since there are several episodes in the past of conflicts involving not only the PAHO/WHO and the World Bank, but also UNICEF and the government of the USA (Walt, 1993). Walt, for example, mentions that another confrontation had already occurred between the WHO and UNICEF after the joint launch of the Programme of Primary Health Care, as UNICEF first launched, unilaterally, the GOBI programme of primary health interventions. And in 1987, UNICEF also launched the *Bamako Initiative - BI*, a community management programme for local health funds (Melo and Costa, 1994:72). For Standing (1999:7-8), the *BI* was a response to the crisis provoked by the sinking of public sector budgets and the deterioration of health services in the 80s. It began with a meeting of African health ministers and “assistentialist” agencies of the UNO, held in Bamako, which insisted on protecting the health of women and children, as well as that of all those whose health was more vulnerable to economic fluctuations. Among the most important themes of this initiative was the scarcity of medicines, and the development of rotating funds was proposed to acquire them and thus maintain the purchase and distribution of regular supplies; and the development of community-based health financing schemes, as well as greater community participation in their management. The initiative was restricted to Africa.

The *World Development Report: Investing in Health* (World Bank, 1993c) analysed the health indicators available in the different countries, evaluated according to strictly economic parameters, and established the scenario for a change in health policy. It introduced new concepts for sector planning, such as the *Global Burden of Disease*, basic packages of medical care services and the *DALYS (Disability Adjusted Life Years)*, as more effective measures for defining priorities and intervention packages. The Bank then adopted a significant change in the logic of social policies (including those of health), making explicit the subordination of the equity principle to those of cost-effectiveness, public spending reduction and privatisation of services, establishing that social policies should stop being universal and have a merely “compensatory” role, i.e., directed only at the poorer groups/sectors of the population. This was the basis of the formulation of the selective and focalisation policies.

The dual nature of the health issue for the region – as an end in itself and as a means for encouraging development – had already been pointed out in documents produced by the ECLAC (1990), which also subscribed to the Bank analyses, and the health policy proposal that emerged from the struggle between the international agencies acting in the region was finally also endorsed by the PAHO (PAHO, 1995, PAHO/ECLAC, 1994).

The conditions of international creditors then began to include explicit recommendations for social policy reform, including health policies, arguing that scarce resources

would be better directed towards diminishing the “burden of disease” and be able to be proved cost-effective (World Bank, 1993c).

World Bank recommendations were strongly guided by the results of a review study – *Health Sector Priorities Review* – carried out between 1987 and 1993 (Murray and López, 1994), in which the *DALYs* were used to map the Global Burden of Disease and to analyse different interventions in terms of cost-effectiveness. This study indicated a great cost variation by *DALYs* in about 50 interventions, and was used by the World Bank (1993c) for recommending reforms and new indicators. In other words, the burden of disease was estimated in terms of lost *DALYs* and the cost-effectiveness of the intervention evaluated by the cost gained by *DALYs*. This combination should enable an evaluation of the burden of disease avoided if the interventions were to be implemented, and only when the disease burden is great and the cost-effectiveness high, should the intervention be considered a priority (World Bank, 1993c).

In practice, these measurements are aimed at evaluating alternatives for social policy decisions (*ex-post* and *ex-ante*), establishing *ratios* between costs and “benefits”, and a comparison of the results obtained by the different ways of reaching particular objectives, making a hierarchy of options. In other words, it means taking the greatest advantage of the effectiveness of particular activities, maximising impact at the lowest possible cost (Almeida, 2000a, 2000b). Various criticisms were formulated, mainly about the limited conception of health (restricted to medical assistance); the scant validity of global exercises for realities of each country; the lack of consideration of the issue of equity, seen only as the achievement of high life expectancy for all countries, without any reference to inequalities between social groups; and, most importantly, the unsuitable use of economic methodologies, basically focused on measuring efficiency and cost-effectiveness in order to study health needs and define priorities, ignoring the validity of any other parameter for policy formulation (Paalman *et al.*, 1998).

In 1997, the government of Denmark and the World Bank held an informal meeting with bilateral and multilateral agencies to discuss what were called *Sector Wide Approaches - SWAPs* – for health development. The aim of the meeting was to build a certain consensus about goals and sector support processes for countries, reviewing concrete experiences and discussing options for joint activities between the different organizations, questioning the approach of separate support to projects. The name *SWAPs* indicated that it was not a new international aid programme or instrument that was being discussed but a new action strategy that would include a wide variety of approaches based on those that were being carried out in the health sector reforms and investments in the area, and would be realised directly with the countries based on concerted action between different actors (*stakeholders*). This would

include different bodies of the receptor governments, technical agencies and bilateral and multilateral donors.

In the 2000/2001 World Development Report – “*Attacking Poverty*” – these same strategies are repeated. It is based on the idea that a policy of risk management is, in general, less costly than repairing its effects later. Moreover, the best solutions tend to be those that enable each individual and household to protect themselves instead of looking for assistance from the state (WB, 2003; Titelman, 2003). But the markets may be unable to provide coverage to vulnerable groups or to finance risk reduction. For this reason, social protection by the government would begin where the containment capacity of the macroeconomic context ends.

More recently, the WHO also adhered to the “methodological” strategy of the WDR 1993, using it to defend the “new universalism”, defined in the *World Health Report 2000* (Frenk, 1999; WHO, 2000), i.e., as it is not possible to have everything for everyone, it is necessary to define what is “essential” and can be offered, stressing the evaluation of health service system performance as a structural axis of health sector reform (Murray and Frenk, 1999). Other new indicators were created (*Disability-Adjusted Life Expectancy – DALE*), as well as compound indices used to make a ranking of countries, based on a methodology widely criticised in the literature (Almeida *et al.*, 2001; Blendon *et al.*, 2001; Braveman *et al.*, 2001, Jamison and Sandbu, 2001; Navarro, 2000, to cite only a few). In this way, the current leadership of the WHO adheres explicitly to what is understood as the best management in big business, i.e., the idea that efficiency and productivity are “metavalues” in policy formulation and implementation, and should be obtained in the short term and at any price, based on rigid controls and global normative strategies, aiming to satisfy external “supranational” demands. The irony about this is that “*for more than a decade, the big business sector has been using more collaborative and soft approaches, and valuing the virtues of cooperation, empowerment and interchange of knowledge*” (Lerer and Matzopolos, 2001:434). Apparently, the WHO had adopted *the worst of both worlds*: the worst of private sector management, as described, and the worst of the public sector, for its authoritarianism and the lack of transparency with which it has spelt out the formulation of its international strategies for the health sector (Lerer and Matzopolos, 2001).

At the same time, in the framework of the criticisms of the results of economic adjustments and of reflection on the social and economic risk of the region, and on the insurance markets, the social risk management proposal was formulated for Latin America, postulated for the start of the millennium, spelling out a particular view on insurance policies with strategic proposals on social policy (World Bank, 2000, 2001). The proposal has pretensions to be paradigmatic, above all as concerns the fight against poverty and delimiting the role of the state (of public affairs), reiterating a minimum social responsibility for confronting the economic and social insecurity and vulnerability of the

populations. As opposed to the summary, reductionist focalisation ideas of the 80s and 90s, this proposal attributes some importance to the causes of poverty and resorts to a terminology proper to the context of insurance (Sojo, 2003:134).

Thus, the analysis of social risk management stresses that everybody is vulnerable to multiple risks of varied origins, and interrelates the risk, risk exposure and vulnerability. Social protection is defined as the public interventions that help individuals, households and communities to manage risk and that support the poorest people; moreover, they should establish relationships of mutual reinforcement between the areas of education and health, in the perspective of the development of human capital. A global social policy proposal is thus formulated articulating three fundamental ideas, and to make them work a specific public-private combination is proposed: state responsibilities for social well-being are circumscribed to the fight against poverty; insurance against risks is an individual responsibility, and solidarity in risk diversification is looked down on. It is proposed to increase social spending in basic services and establish guarantees of access, quality, choice and service monitoring. In sum, more than helping to confront risks, the proposal is that policies seek to reduce and mitigate them (World Bank, 2000).

So the new social policy strategy is made up of individual insurance in the market, and the provision of services for the poor through “protection safety-nets”, and focalisation is set against universality, setting a minimum public responsibility in matters of social protection, placing the financing and provision of other services related to social welfare in private hands, and reiterating the disregard for the principle of solidarity in financing (Sojo, 2003:134).

In practice, then, the previous orientation has not changed, as the analogy with the reductionist focalisation proposals put forward as from the 80s is maintained. Although this proposal recognises that the poor are more exposed and vulnerable, as well as having less access to goods in general, which alludes to the causes of poverty and shows a difference with previous focalising proposals, centred basically on the symptoms rather than the causes of poverty, there is however a continuity as regards the role of the state in the social welfare of their populations. The poor are conceived of as the target “group” of social policy and state action is considered a synonym of “social protection networks”, understood as a modular system of programmes, flexible in accordance with the specific patterns of risk. This system would complement existing arrangements in a “suitable mix” of public and private providers, and covers schemes and instruments – such as social funds, micro-insurances, health insurance, unemployment insurances and social assistance programmes (World Bank, 2000).

In relation to Latin America, an excessively positive view is stressed of past policies, contrasting with the critical reviews made by the Bank itself on the topic (World Bank,

2002),¹⁷ and coinciding largely with other criticisms in the literature. It does not take these into consideration, and imputes highly positive characteristics to the proposal of social risk management, which are not supported by any of the existing analyses either (Sojo, 2003).

In the World Development Report 2004 (*Making Services Work for the Poor People* – World Bank, 2003), the Bank explores the way in which “countries can accelerate their development in order to reach the *Millennium Development Goals* – MDGs – making services work for the poor”. And it repeats that its success will depend not on more accelerated economic growth and a greater flow of resources for social areas, but on the “ability” of governments to transform these resources into basic health services, education, drinking water and sanitation, since, very frequently, these services

do not reach the poorest people. The reasons for this would be: a lack of incentives for improved performance, corruption, monitoring and evaluation of imperfections and of administrative and management problems.

More recently, a “harmonisation” has been seen between the different international agencies acting in the health area, induced by explicit guidance from the general management of the United Nations system, which reflects the policy decision of “working together”, collaboration and not confronting each other. Obviously, the World Bank still holds the greater financing power, and ideologically and politically it continues hegemonic in formulating and running the strategic proposals for the social sector, reiterating the reductionist approach in social policy.

17. This review disregards the contradictions within policies oriented to supply or to demand, and gives importance to the consideration of the specific institutional variables of each country, in order to achieve a strategic insertion of funds, not short-term or isolated, to complement the relevant institutions, and also sustainable, not displacing policy reform (World Bank, 2002:45-50 in Sojo, 2003:135).

5 Economic and Social Panorama of the Latin American Region in the 80's and 90's

In general, the balance of the 80s and the 90s in the region is disastrous and very frustrating, with aspects that some consider positive, but which are practically annulled by the concomitant negative effects; so the prospects at the start of the 21st century are not promising.

THE ECONOMIC ADJUSTMENTS

The structural reform process implemented in the 80s, aimed at substituting for the previous state-driven development, looked to open up the economies to outside competition, and to greater participation by the private sector. This model was consolidated in the 90s, although it progressed unevenly in the different countries, whether in commercial, financial, labour, social security or state reform areas.

Even though the economic adjustments, centred on monetary stabilisation policies anchored in overvalued currencies, were successful at controlling inflation and reducing the fiscal deficit (with exceptions), they unleashed a vicious circle driven by very high interest rates, generally above inflation, that encouraged private financial accumulation and made the renewal of sustained economic growth impossible, exacerbating *“the macroeconomic imbalances, that restrict and paralyse public policies, forcing governments to make successive, useless budget adjustments”* (Fiori, 2001:12).

The macroeconomic programmes installed were made possible by various loans from the International Monetary Fund (IMF) to different countries in the region and, obviously, the participation of the multilateral bodies in these processes could be taken for granted, making free use of all the current tools for regulation and control, as well as specific sanctions in the case of insubordination or attempts at unilateral decision-making.

Contrary to what had been predicted, in the 90s, the countries' foreign debts continued increasing, and some entered the new century with severe domestic and foreign debt. The weight of this factor should not be underestimated, mainly because the fragile and uneven “bubbles of growth”, that have been features of Latin American economies, are strongly dependent on foreign investment and very little related to the internal capacity for savings and investment (Altimir, 1998; ECLAC, 2000). On the other hand, most of these foreign investments are extremely volatile financial speculation, which makes the long-term sustainability of a

growth and development process unfeasible. These capital flows are produced by particular international situations that increase comparative interest rates in the Latin American region, stimulating the imbalance between imports and exports and deepening the recession. This is why the rapid growth recorded in some countries in the early 90s was eroding by the second half, with the sole exception of Costa Rica (ECLAC, 2000), as GDP growth in the region was negative in the 2000-2001 period, both in general terms (-0.5%) and per capita (-1.9%) (World Bank, 2003). According to ECLAC data (2003 and 2003a), 2001 showed scant growth (0.3%), and regression was later experienced in 2002 (-0.7%). The period of total stagnation in the region has thus now lasted five years.

This can be considered as the common economic scenario for Latin America and the Caribbean at the end of the 20th and the start of the 21st centuries, with rare exceptions, and the dynamic of instability in economic growth and of permanent financial crises, became significantly stronger. The structural heterogeneity of productive sectors has increased with the establishment of more “world class” companies, in general subsidiaries of multinationals, and of small and medium sized companies that have not managed to adapt themselves to the new context. This has resulted in a deterioration of the labour market and of incomes, an erosion of job quality, an increase of open unemployment and of informality, and a worsening of income concentration, affecting social cohesion and governability, with an accompanying increase in inequalities and violence (ECLAC, 2000).

Unemployment rates have shown a tendency to rise, with an increase in urban unemployment from 5.8% at the start of the 90s to 8.7% in 1999 (ECLAC, 2000), and to 9.4% in 2002 (ILO, 2003). The difference between countries is marked: in 2002, unemployment in the Caribbean reached 13.8% of the economically active population, and among the Latin American countries with a higher unemployment index are Argentina with 17.4% (in 2001 reaching 25%); Panama, 16.6%; Colombia 16.2%; Uruguay, 15.3%; Venezuela 13.5%; Nicaragua 11.3%; and Ecuador 10.4%. Even though unemployment is a world problem nowadays, in the same year (2002) the unemployment rate in developed countries was 6.9%. Only the Middle East (18%), Africa and Eastern Europe had a worse situation than the region. This situation is even more dramatic among young people, since it is increasingly difficult to incorporate them into the formal labour market:

in 1997 the unemployment rate among young people up to 25 years of age was 12%; by 2002 it was 16%. An increase is also seen in the precarisation of labour relationships, shown by the greater number of people working with temporary contracts and without rights to social benefits (ILO, 2003).

POVERTY AND INEQUALITY

These adjustments, in the 80s, contributed to an increase in the number of poor people and of those living in situations of extreme poverty (Altimir, 1998; World Bank, 1993a, 1993b; Borón, 1995; Bustello, 1994; ECLAC, 1990, 1993; Filgueira and Lombardi, 1995; PAHO/ECLAC, 1994), with a stronger trend in this direction in urban and metropolitan areas. This does not mean that rural poverty fell, but that the rural population diminished; meanwhile, the most extreme conditions of indigence were seen in rural areas, with values around 37% of the total population of the region (Filgueiras, 1997). At the beginning of the 80s, the total number of poor reached 135.9 million people (40.5% of which 62.4 million (18.6%) were indigent (ECLAC, 2000 and 2000 b) and, by the middle of the decade, these numbers had reached 170.2 and 81.4 million, respectively (Filgueiras and Lombardi, 1995). In the 90s, the proportion of households in a state of poverty was 48.3% and, although this fell to 43.8% in 1999, the absolute number of poor increased between 1990 and 1999 from 200.2 to 212 million of which 91 million were indigent (ECLAC, 2000; 2000 b; 2003 and 2003a).

The start of the 21st century was marked by stagnation in the process of overcoming poverty in the region. Between 1999 and 2002 the poverty rate fell only 0.4 percentage points, passing from 43.8 to 43.4, at the same time as extreme poverty grew 0.3%, covering 18.8% of the region's population, and the number of poor people increased to 220 million, including 95 million indigent (ECLAC, 2003 and 2003a). To sum up, taking the year 1997 as a reference point, the poverty and indigence rates have remained practically constant, and among the countries, this evolution between 1999 and 2000/2002 was also marked by only small variations, with few exceptions, so that there was a noticeable deterioration in the standard of living of the population, as in Argentina, and, to a lesser extent, in Uruguay. The 2003 forecasts based on the economic growth predicted for the different countries and the region as a whole indicate that there could again be an increase in poverty and indigence rates on a regional scale, mainly driven by a lack of growth of product per inhabitant. Exceptions might be Venezuela, where there could be significant growth (for the drastic drop in GDP since 2002), and Argentina, where the reactivation of economic growth will probably help to reduce the proportion of poor people (ECLAC, 2003 and 2003a).

The countries we want to discuss in particular in this work, Brazil, Colombia and Costa Rica, present small

variations, both positive and negative, in poverty and indigence: the first two upwards and the latter a reduction. Chile, in turn, is among the countries that area early in reaching the goal for reducing extreme poverty by half for the year 2015, as planned in the Millennium Declaration.¹⁸

In parallel, the economic vulnerability of low and middle sectors increased significantly, as a consequence of poor income distribution, placing them nearer the poverty line, especially in metropolitan areas in all the countries. It is worth stressing that this affects the already consolidated, or developing middle classes, with special impact in the groups with a higher educational level (qualified professionals and recently trained), due on the one hand, to the cyclic and selective dynamics of technological restructuring and unemployment, that affects young people and women more strongly, and, on the other, to the composition of new jobs, if any – with low qualifications and productivity. But the vulnerability of the poor is more evident due to the exclusion, both from the production process and from social benefits, of large segments of the population with low capacity for mobilising individual resources, in the face of a narrower and narrower range of options (whether in the market, the state or in society) and a structure of *heterogeneous social poverty* (Filgueiras, 1998) is thus created, for which the traditional social safety net (family, neighbourhood, etc.) and the available social mechanisms or instruments are insufficient or unsuitable.

A common feature seen in all the countries is a situation of “excluding modernisation” (Filgueira and Lombardi, 1995), in which social development and income distribution in general do not correspond to the relative wealth of each country, measured in terms of Gross Domestic Product (GDP) *per capita*, a figure that becomes more relevant in the face of the scandalous concentration of income and the low wages.

Whatever the indicator of inequality used, with the exception of that of Uruguay, a general trend was registered in the region in the past two decades of income concentration in the highest deciles of the population, who increased their share of total income, with the consequent fall in the lower deciles (figure 1, appendix 1).

The numbers indicate that the historically unequal income distribution in the region worsened considerably in the 80s and continued deteriorating in the 90s, showing the most pronounced disparity between rich and poor of all the regions of the world, with Brazil leading the list (ECLAC, 2000; Filgueiras, 1997; Kliksberg, 2000; Londoño and Székely, 1997). The polarisation increases even more when comparing the most extreme strata of the social structure, and the differences between countries are very marked (figure 2, appendix 1).

The evolution of degrees of inequality measured by the Gini Coefficient (ranging from 0 to 1, where 0 corresponds to total equity) indicates that there was improvement in the

18. On this topic we found no data for Belize.

inequality of income distribution from 1970 to 1980, worsening greatly again from 1980 to 1990 and remaining practically unaltered in the 90s, despite greater economic growth. In fact, at the end of the decade, the regional average was estimated to be around 0.57 (Londoño and Székely, 1997), while the world was at 0.40 and that of the developed countries is 0.30 (0.25 in Scandinavia) (Kliksberg, 2000). In the more recent period (1999-2002), the tendency of immobility in the indicators of income concentration and even a tendency to deteriorate in some countries has remained, as ten of the eleven countries analysed by the ECLAC (2003 and 2003a) showed stagnation or even a deterioration of the Gini index, seen most clearly in Argentina, (increasing 7.2% in the urban area); Mexico seems the only exception, as the value of its index fell 5.1%. The new figures thus confirm the enormous downward rigidity that characterises the degree of income concentration in the countries of the region, a factor that undoubtedly limits the possibilities of moving towards the target of reducing poverty.

In Latin America an income pyramid is being consolidated that is a little narrower in the base, very thin in the upper part, and with a large concentration of the population around the poverty line, as a direct result of the adjustments put into effect (Bustelo, 1994; Filgueiras, 1997).

In brief, no country in the region has reduced levels of inequality compared to those current since the 70s and for many inequality is greater than at that time. And a positive ratio can be seen between the increase in inequalities and the increase in poverty, shown by the fact that the increase was greater in the countries with smaller populations. Inequalities also have a strong negative effect on poverty reduction, i.e., poverty reduction was hindered substantially by the increase of inequalities, despite the bubbles of economic growth (ECLAC, 2000; Kliksberg, 2000; Székely, 2001).

The Human Development Index – HDI (UNDP, 2001) of 26 Latin American countries confirms that the greatest world disparities are concentrated in the region, as the HDI of the best placed country, Barbados (HDI 0.864) is almost double that of the worst placed, Haiti (HDI, 0.467), and its income per capita is 10 times higher (even with only a few hundred kilometres between the two islands) (UNDP, 2001).

THE DEMOGRAPHIC TRANSITION

The population of Latin America and the Caribbean represents nearly 8.5% of the world total and went from 165 million inhabitants in 1950 to 509.2 million at the end of the 90s, and to 527 million in 2002. The average birth rate in the region dropped from 3.9 in 1980 to 2.7 children per mother in 1999, remaining the same in 2002. Even though the levels

have fallen in all the countries, the difference between the extreme values has not varied much, which means that the age structure of the majority of the countries is still mainly young: in 2002, 62% of the region's population were between 15 and 65 years of age (nearly 319 million people), 32% were under 15 and 6% were over 65 (ECLAC, 2001; PRB, 2002). A historical series of the main regional data and indicators can be found in Table 1, Appendix 1.

The population growth rate in the region remained around 3% a year until the end of the 70s, when it began to fall; it reached 2.1% in the period 1980-1990 and nearly 1.7% in the period 1990-1999, repeated for 2002, as a consequence of the fall in the birth rate (in 2002 around 2.7 children per woman) (ECLAC, 2001; PRB, 2002). Meanwhile, the differential reproduction of different social strata shows that most of the births are still occurring in the more vulnerable sectors, i.e., the poor, the indigent, and the lower classes. The increase in the number of early pregnancies (in adolescents) and of single mothers, as well as the number of divorces and separations (official or otherwise), the postponement of marriage and the number of women heads of households, point to the disintegration of the traditional family and the loss of the primary support network this should offer (Filgueiras, 1997; PRB, 2002; ECLAC, 2003b).

The “demographic transition”, i.e., the move from high to low indices of births and deaths and the increase in life expectancy at birth, has consolidated as in other regions, but the “demographic bonus”¹⁹ has not been seen, i.e., the growth of the population of productive age and of the economically active population in amounts greater than that of the population growth was not taken advantage of to develop the region's human capital, mainly because of the scant generation of jobs, especially those with high productivity levels, the generalised poverty, the marked inequality and social exclusion that hit children, women or young people hardest in this region (Ocampo *et al*, 2001; ECLAC, 2003b). On the other hand, there was a significant increase in the participation of women in the labour market (Table 1).

In general terms, a greater ageing of the population can also be seen which, for some authors, is a process seen in very varied forms around the region and, only as a trend, significant changes can be foreseen in the epidemiological profiles and in the demand for health care services (PAHO, 1995, 1998). For others, the region seems to be repeating the demographic transition of Europe, but at a different rate, as it seems to be taking much less time to show a significant reduction both in infant mortality and in fecundity. So they warn that there will be important effects in a much shorter time, which will result in growing needs and demands for social services, including those of health (Carvalho, 1998; ECLAC, 2003b).

19. By “demographic bonus” is understood the potentiality that is represented for the countries having a mass of population of productive age, in a proportion never seen before. But this population structure implies, as well as opportunities, great challenges and great risks (ECLAC, 2003b:11).

In fact, to determine the magnitude of these transitions and of the demands that will be generated in this process is a difficult task, either because of the dispersion of the social changes that are taking place in each country and between countries, or for the differences in behaviour of the different social classes and groups in each society, or for the contradictory trend of these transformations. In any case, it is unquestionably a “*mixed transition combining the effects of a – traditional and modern – segmented society*” (Filgueira, 1997:138), aggravated, however, by the high levels of inequality and severe economic conditions.

YOUNG PEOPLE IN THE REGION

Of the total population of Latin America and the Caribbean, around 60% (three in every five) are under 30 years of age. Since nearly 62% of that population is poor or indigent, with a greater birth rate than other social groups, and as America is a young continent, *most of the poor people are under 30 and have severe problems in access to basic services, especially in health and education* (ECLAC, 2003b:3).

According to the United Nations Organization, all men and women between 15 and 29 years of age are considered young people. While this is a demographic criterion, it is recognised that “youth” is a “social construct”: *age serves to delimit a demographic space with a sociological phenomenon – youth* (Brito, 1996:29 in ECLAC, 2003 b).

The increase in life expectancy at birth and the fall in the birth and death rates has led to an ageing of the population, a steady decrease in the segment 0 to 15 years of age and to an unprecedented increase in the youth population, although with marked variations between country groups. The proportion of young people aged 15 to 29 within the whole population reached its maximum in 1990 (28.5%). Even when the low birth rate will lead to a decline in this proportion in the future, reaching an estimated 24% in the year 2020, the absolute size of the youth population will continue increasing in the countries of incipient and moderate transition and also – at least during the first ten years of the 21st century – in those that are in full transition, which contain the bulk of the region’s population (CELADE, 2000:21-22).²⁰

In synthesis, we can record the following trends (ECLAC, 2003b:13):

- The proportion of the youngest group with respect to the total group (15 to 19 and 15 to 29 years of age) shows a

downward trend since the 70s, indicating that group itself has a slight inclination towards ageing, passing from 55% in 1970 to an estimated 51% in 2005.

- The growing ratio between the number of young people (15 to 29) and that of children (0 to 14) shows a tendency to increase: in 1970 there were 61 young people for each 100 children and in 2000 there were 89 per 100, as expected, due to the drop in the birth rate and its probable stabilisation at low levels.
- The ratio between young people (15 to 29) and adults (30 to 64 years of age) reverses the rising trend recorded in the past and as from 1985 falls from 97 to 80 young people per every 100 adults in 2000, and this trend is expected to continue accelerating.
- The ratio showing the greatest change in the population age structure corresponds to young people (15 to 29) and to the senior citizen population (65 and over): while this did remain to some extent stable from 1970 to 1985 (around 62 young people for every 10 older adults), from then on there has been a marked decline – the ratio fell to 52 in the year 2000.

As the youth population grows so rapidly, the demands for basic services, food, health-care, education and the capacity to absorb labour grow at the same rate. In a context of generalised poverty, marked inequality and social exclusion that hits children, women and young people more harshly in our region, the potential opportunity turns into risk (ECLAC, 2003b:11). On the other hand, it also means a challenge, since the growing demand for services from the youth population, above all in the countries in full transition, that contain the greater number of population of the region and in those of incipient and moderate transition, will have to compete with the services needed for mother-child care, since, even though it is falling, there is still a significant rhythm in the birth rate; and also with the services demanded by the older adult population, since the characteristic of population ageing is steadily increasing. If we also consider that in many of these countries there are great deficits in the coverage of basic services, including those of health, above all in the most deprived groups, which in turn are those that will have high levels of fecundity for longer, the need for strong social investment in these groups shows itself as an immense political challenge. To sum up, *as well as their effects on the potential demand for social services (basically, education and health), these trends bring significant challenges, for incorporating young people productively and creatively, as*

20. Previous ECLAC studies identify three groups of countries in terms of demographic transition: *advanced transition*: low or moderate birth rate and death rate and low growth (Argentina, Barbados, Chile, Cuba, Jamaica and Uruguay), that began to decline from the early 90s and contrasting with the progressive growth of the adult and older adult population; *full transition*: moderate birth rate and moderate or low death rate, which determine a moderate natural growth (Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Guyana, México, Panama, Peru, Dominican Republic, Surinam, Trinidad and Tobago, Venezuela), where the youth population reached its highest percentage index in the first half of the 90s, and will probably continue growing during the first decade of this century, and begins to show a tendency to decline; *incipient or moderate transition*: high birth rate and high or moderate death rate and high natural growth (Bolivia, Guatemala, Haiti, Honduras, Nicaragua and Paraguay), which, owing to high fecundity will continue showing significant growth in the number of young people probably until it is situated in the previous group, although the estimates indicate a start of a decline in the fourth decade of this century (ECLAC, 2003b:10-9). According to 1998 data in Belize it will probably be as from the second decade of this century (ECLAC, 1998).

well as for their social, political and cultural participation (CELADE, 2000:21).

It is important to point out that young people are more likely to go out in search of new opportunities when these are not found in their place of origin, and 80% of the youth population may gather in the large urban areas (ECLAC/UNFPA/CELADE, 2000:22 *in*, ECLAC, 2003b), generally men and women who move into low qualified, low paid services, or in the black economy, or join the lines of urban unemployed. If we add to this that the countries of moderate or incipient transition still have a large percentage of rural population, with low and even non-existent levels of education, but which shift towards the urban areas, without the necessary tools for inserting themselves in the urban labour market, we can see how the outskirts of the urban areas grow rapidly with population groups with very low living and work conditions.

In the same way, there is the phenomenon of intra-regional and extra-regional migration, that has always existed, but which saw a significant increase in the 70s, 80s, and 90s, firstly for political problems created by the dictatorships and later, for the deterioration in living and working conditions. The traditional receiver countries (like Argentina and Venezuela) stopped being attractive because of their serious political and economic conflicts, and migration shifted mainly to the USA, until September 11th, 2001, since when migration controls have become stricter. More recently, countries like Spain have become important receivers of migration from Latin America.

In the English-speaking Caribbean, this migration that is traditionally always extraregional migration has gone to the USA and some European metropolises. More recently, intraregional migratory movements have become institutionalised and more visible, as the import of labour has reduced and stronger migration requirements (as in the United Kingdom) have come into force. Around 1990 some 800 thousand English speakers of Caribbean origin were living in the USA, 54% of them women, and young people between 15 and 29 years of age made up 29% of these immigrants, mainly from Jamaica, Guyana and Trinidad and Tobago. This migration was higher in the 80s, and has also reduced considerably in recent times (Mills, 1997).

There is currently a new stage in intraregional migration: a small number of micro-states have become net importers of labour, after having been exporters, especially those with high per capita incomes based on the tourism industry (Bahamas, US Virgin Islands, Guadeloupe, Cayman Islands, Turks and Caicos, Antigua and Barbuda, among others). In several of these territories, the foreign population exceeds 10% of the demographics, with a significant predominance of young adult men and women.

In the Caribbean, young people from the less favoured sectors find themselves forced to earn “easy money” (informal jobs, drug-trafficking and prostitution), as the only possible way to bring income to the family, and these means of “income” are often encouraged by international

tourism, by the traffickers, by the families themselves or the means of communication, often permanently damaging the integrity of these young people (World Bank, 2003b).

Among the diversity of “young peoples” that coexist in the “excluding societies” in the interior of most of the Latin American and Caribbean countries, a great difference can be seen in the structure of opportunities, the formation of individual capacities, and the spaces for realising such individual aspirations. Since it is the poor households in all countries that have the highest birth rates, the statistics show that children, pre-adolescents between 10 and 14 and those from 15 to 19 years of age are the groups most affected by poverty in the region (ECLAC, 2003b). In consequence, many of the health problems of the young people are associated with poverty and social exclusion.

These health care requirements are less visible than those of other groups in the health systems, and it is less likely that their policy and service priorities will stand out. Considering that this is a population group with, in general, relatively low morbidity and mortality associated with natural causes or diseases, in comparison with other age groups, there are few countries that have given priority to these groups in their social policies, among them those of health.

Great efforts have been made in relation to basic education in Latin America and the Caribbean, above all in the 60s and 70s, to widen educational coverage, mainly basic or primary, and this has been achieved in nearly every country. However, there are still great problems of inequality in access and in quality, to the detriment of rural and indigenous populations, and in the urban centres, and particularly in recent decades, there is clear inequality conditioned by people’s economic conditions. The adult illiteracy rate (above 15 years of age) has fallen and the trend is downward (12% in 1999 and 11.5 en 2002) (WB, 2001 and 2003a).

Progress has also been made in secondary and higher education coverage, where the same inequalities can be seen, as well as great disparities between countries. Nonetheless, the problem of quality and ownership at all levels of education is still very serious and, generally speaking, teaching quality has fallen markedly in all the region. The difference in quality between public and private education is, nearly always, abysmal, which increases the gap in inequality and access to opportunities, but with great differences between countries, since in some of them, where public education was better, a deterioration has been seen in recent decades due to economic conditions. And in others there has been an indiscriminate proliferation of private educational establishments of very low quality, but which work at night, so that the groups of young people who work can also study (ECLAC, 2003b).

It is estimated that school desertion rates among adolescents and young people from the 25% of households with lowest income is three times higher than that of the 25% of households with higher incomes. By the year 2000

around 15 million young people between 15 and 19 years of age (30% of the total), had left school before completing 12 years of study. Around 70% of these (10.5 million) had done so early, before completing primary education or as soon as it was finished.²¹ The first place among the reasons for desertion (from a study in eight countries) was economic, followed by lack of access, and family problems, among others (ECLAC, 2002).

In the Caribbean it is estimated that the possibility of getting caught up in risky sexual behaviours drops by 30% among adolescent boys and 60% among adolescent girls, if they are still associated with the school (World Bank, 2003b).

Although it cannot be stated that work is a factor expelling from the education system, it is clear that young people who work have a greater probability of interrupting their formal education. In urban areas, 53% of working young people have abandoned the educational system and in rural areas 71% of young people working have not completed their educational process (ECLAC, 2003b).

This difficult context aggravates a situation that is not new: in nearly every country, youth unemployment is double general unemployment and several times higher than that among people over 45 years of age; and it also the case that for young women, unemployment is always higher than that for men. Obviously, there is very great variation between countries.

POVERTY AND INEQUALITY FROM A GENDER PERSPECTIVE

Latin America already has an overall more educated female population, especially in the upper levels, which must be considered an achievement. During the 90s, the economic activity rate of women increased more quickly than the male, even when they face greater difficulties to enter the labour market: while male unemployment rates increased 2.9% between 1990 and 1999, those of women increased 6.1%, even though economically active women had more years of study than men. And in 1999, the incomes that women received in the labour market were approximately 75% of male incomes and the gap is wider among women with more education (ECLAC, 2003c:20-21).

Female human capital, undoubtedly, in addition to being under-used for development, is the target of many forms of discrimination. *The labour market, as it is currently conceived, relies on domestic work to reproduce the labour force and create the conditions for life to keep running* (ECLAC, 2003c:18).

An analysis of household surveys permits an approach to female poverty from the point of view of “economic autonomy”. The percentage of women over 15 years of age without their own income is much greater than that of men:

45% of women in urban areas and 21% of men; and in the rural area, 59% of women and 20% of men. This difference unfavourable to women is seen in all the age groups, from 15 to 60 years of age and over (ECLAC, 2003c:19).

Household poverty measurements show, in general, a greater number of women heads of household among the poorer strata of the population in the region (Kabeer, 2003). In 1999, women heads of households had less cash income than male heads, whether in poor households or in non-poor, and this is aggravated by data of income per capita. In addition, women with their own income contribute significantly to the reduction of household poverty, which tends to increase without the female contribution, and their rate of participation in these households is increasing, although still much less than that of the non-poor, which confirms that the condition of poverty for women is more significant than for men, above all for their access to the labour market (ECLAC, 2003 and 2003a).²² Occupational segmentation between 1990 and 1999 has remained almost unchanged, with a slight fall among those occupied in domestic service and in the personal services, as well as a slight increase in agriculture and in commerce. In the same period, the gender gap in low productivity sectors has fallen due mainly to the decline in male labour insertion.

SOCIAL EXPENDITURE

Even though the evolution of the economic crisis has varied greatly from one country to another, throughout the 80s there was a general deterioration in social spending, in absolute terms, independently of the method used to measure it, and only in a few countries was there relative expansion, with asymmetrical effects on the different sectors (Bustello, 1994). The share of social expenditure in the total public spending in general also fell, which shows a fiscal policy that did not give priority to social areas. So, in contrast to what happened in Europe, in Latin America in the 80s, social spending was, above all, an instrument of fiscal adjustment, while its compensatory function in relation to salaries was secondary (Cominetti, 1994). Thus, in many cases, the decline in human investment was highly policy-induced and not only caused by the recession (Hoeven and Stewart, 1993). The relatively more vulnerable sectors were housing and education, but also social security and health were affected asymmetrically. The greatest cuts particularly affected investments and not current expenditure, and the deterioration in service quality was general (Carciofi and Beccaria, 1993, *in* Bustelo, 1994). The absence of radical institutional changes – except for isolated reforms in some countries – that would be able to counterbalance the loss of resources with greater efficiency, led to a sharp worsening of access by the population to social

21. Studies made by ECLAC in 18 countries in the region.

22. Data available for 17 countries around 1999, among which are Colombia, Brazil, Chile and Costa Rica.

services run by the state, as well as the quality of patient care.

This situation particularly affected the more vulnerable social groups, as the impact of non-cash income on families is very significant in the region, as social spending represented a significant fraction of the effective income of the poorer sectors, ranging from 26% in Uruguay to 50% in Chile and Costa Rica (Bustello, 1994).

On the other hand, as an attempt to counteract the previous trend, social spending increased considerably in the 90s – from 10.4% of the GDP in 1990-1991 to 12.1% in 1996-1997 (ECLAC, 2001) and 13.8% in 2000-2001, despite the marked reduction in GDP growth per capita in that period, from 2.1% to 0.2% (ECLAC, 2003c). In effect, from 1990-1991 to 2000-2001, social spending per inhabitant rose on average 58% in the region (from 342 to 540 dollars *per capita* annually) (in 1997 US\$) (ECLAC, 2001; ECLAC, 2003c). The public part of this spending also increased – from 42 to 48% of total public spending – as a result of greater fiscal priority. This growth was general (with the exception of Honduras and Venezuela), but did not have the same magnitude in the different countries: the increase was faster in countries with lower income per inhabitant, where this spending tends to be lower, and in some there was an increase of over 100% (Colombia, Guatemala, Paraguay, Peru and Dominican Republic). The increase was not homogeneous throughout the decade, either; in most countries the rate of expansion was higher during the first five years (around 30%) and much lower in the second (16%), especially as from 1998 (ECLAC, 2001; ECLAC, 2003c). However, the social spending increase was not accompanied by a reduction in the existing pronounced disparities between countries at the end of the 80s, maintaining great heterogeneity, and in some the amounts are still inadequate, if compared with the regional pattern itself (ECLAC, 2003c).

This situation is more evident in Latin America than in the Caribbean, which has historically had, and still has in general terms, higher social spending levels, though trends were less favourable throughout the 90s (ECLAC, 2000).

Social security coverage was never very important in the region, compared with the European welfare systems, and there is great variation between countries. Argentina, Chile, Uruguay and Brazil were the pioneers in creating their own social protection systems, but also with differentiated coverage, and at the start of the 80s, around 61% of the region's population was covered by some kind of social security, but with great differences between these countries (PAHO/ECLAC, 1994); the data show that the social security sector was the least affected during 1982-1989. However, these traditionally weak social protection conditions deteriorated in the 90s, even among urban wage earners formally affiliated to social security, who fell from 67% to 62% between 1990 and 1998 (ILO, 1999, *in* ECLAC, 2000). In addition, the number of effective contributors in the

national insurance systems has diminished noticeably. It should be remembered that these figures are an overestimate of effective coverage, as they are based on data about affiliation instead of referring to active contributors; secondly, they exclude independent and rural workers, categories that are generally unprotected. The drop in employment levels in the formal economy, combined with the deregulation of the labour market and the increase in unemployment, contributed to the greater weakening of social protection systems (in the countries where they were more consolidated) and have hindered expansion in the others. In addition, some of those that had progressed in welfare issues, like Chile, were those that adopted the option of more radical dismantling, while others, such as Costa Rica, have borne the crisis better, precisely because they maintained the previous social policy options.

A greater redistributive effect of spending is seen if social security is excluded. The net redistributive effect of public social spending varies according to social group – the relative importance of social spending is much greater in lower income strata, representing nearly 43% of their income; in the upper income strata, however, (fourth and fifth quintiles) it represents between 13 and 7%. Note that this low repercussion of social spending in the income of the richer strata involves a huge volume of resources that in several countries is higher than or even double that destined for poorer households. This is explained by the amount of social security transfers: in the higher stratum, more than 60% of transfers correspond to social security, while in the poorest quintile they represent only some 25% of the total (ECLAC, 2001).

It is estimated that, for the region as a whole, 44% of the expansion in social spending corresponded to increases in education and health (28 and 16% respectively); 51% to widening spending in social security, mainly pensions and retirement, and the remaining 5% to other spending, such as housing, drinking water and sanitation (ECLAC, 2000). However, as from 1998, the resources destined to education and health as a whole absorbed a higher fraction of the GDP than social security (1%, compared to 0.5%), and the trend observed up to 1998-1999 was reversed, but there was a tendency to “protect” education spending more than that of health (Figure 3, Appendix 1). In redistributive terms, it was not the same in all the countries: in those with lower incomes, education and health spending increased relatively more (more progressive in general), representing 56% of the total, while social security represented only one fifth. In contrast, in the higher spending countries, social security captured around half the increase, and the greatest increases were seen precisely in those countries where this takes a considerable fraction of public resources – Argentina, Brazil, Chile and Uruguay. In health terms, the average increase in the region was US\$28, except for Chile, Colombia and Argentina (ECLAC, 2000).

6 Overview of Health in the Region in the 80's and 90's: some indicators

In health terms, too, a pattern of sharp inequalities can be seen in the region. Even though the regional and national averages show improvements in some indicators, mainly when comparing longer historical series, refining the indices by socio-economic levels, geographical regions, gender, ethnic origin, and age shows broad sectors of the population seriously harmed, with different states of health and different opportunities of access to and use of the health care services (PAHO, 1999). Another feature of this regional pattern is the great difference in indicators between the countries, and between regions within the same country.

Average life expectancy at birth is 71 in the region (68 for men and 74 for women), a significant increase compared with the years 50 and 55, when it was 52 years, although it is still lower than the levels of the OECD countries (*Organization for Economic Co-operation and Development – OECD*, 77 years), but higher than the world average (67 years). As extremes in this situation are, on the one hand, Haiti (53.5) and Bolivia (62) and, on the other, Costa Rica (76.5), Cuba (75.3) and Chile (75) (ECLAC, 2001). It is worth mentioning that in many countries of the region the five-yearly increase of life expectancy at birth was lower in the periods 1970-1975 and 1985-1990 and the indicator tends to stabilise as from the 90s, i.e., the rising trend in the populations' years of life is getting smaller.

Similar differences are seen in infant mortality. Although data are not available for all the countries for the same years, there is a remarkable correlation between the infant mortality rates and social development, above all in the countries with similar levels of income. Between 1980 and 1999 the average rate of infant mortality in the region fell from 61 to 30/1,000 live births (LB) (ECLAC, 2001). Although this regional rate is lower than the world average (54 per thousand LB), it is still much higher than that of high-income countries, members of the OECD (around 9.4 per thousand LB). These figures fell in practically all the countries, although with different rates of reduction, either as a result of past policies, or because basic activities and specific assistance programmes were maintained, or because actions in other areas were reflected and positively impeded a worsening of these health macro-indicators. It is therefore no coincidence that Costa Rica (13), Cuba (11.8) and Chile (10) in general maintained their indicators close to those of developed countries (ECLAC, 2001).

Great disparity is also seen between countries, and even within the same country, when the national average of

infant mortality is broken down into different social groups (ECLAC/CELADE/IDB, 1996). For example, infant mortality in Peru was five times higher for children from households in the lower quintile of material living conditions (measured by the assets indices) than for the upper quintile; moreover, the occurrence of diarrhoeal diseases was, respectively, 22 and 13% in the two quintiles, and that of respiratory diseases was 25 and 15% (Gwatkin *et al.*, 1999). The differences are also quite expressive between rural and urban zones, where the infant mortality rates tend to be higher in the countryside. These asymmetries are even more marked in indigenous populations (ECLAC, 2000, 2001; Kliksberg, 1999).

In the epidemiological profile, causes of death have also changed, presenting mixed patterns in which deaths from avoidable diseases – in the different age groups – coexist with those produced by chronic and degenerative diseases; these depend as much on economic-social development as on health sector organization, birth rate, changes in the age structure, in the urbanisation process and in living conditions. There is also worsening of the endemic and epidemic contexts. This means that the countries face a complex picture, with different types of health problems and very different capacities for resolving them. These indicators also vary greatly from one country to another and even within the same country, between different regions, social groups, depending on different income levels, race, ethnic origins, education, gender, among other variables (PAHO, 1999). In general, health inequalities are cumulative, as they combine or add to each other in different ways.

NATIONAL SPENDING ON HEALTH

It is no easy task to make the existing sources of data about national health spending in the region compatible, but some figures are more or less agreed and it is possible to outline some trends.

One of the characteristics of health spending in the Latin American and Caribbean region is its extreme heterogeneity. This, in 1999, the average regional National Health Expenditures (NHE) was US\$498 *per capita*, but, while this average in the British Virgin Islands is nearly two and half times the average and in Uruguay and Costa Rica is almost double, in Haiti it is nearly 17%. It is also noticeable that about six countries allocate less than US\$200 *per capita* per year for health; and spending in Bolivia and Ecuador is very near US\$100 (PAHO, 2000).

Regional health spending as a percentage of GDP is considered high (7.5% in 1995 and 7.3% in 1999), compared with that of other regions “of medium or low income” (around 5%), even though for some writers it is also high in relation to the results obtained (Schieber and Maeda, 1999); but in 11 countries of the region it does not reach 5% of the GDP and in another five it is very close to that figure (PAHO, 2000).

Note that the dynamics of health spending in the Latin American region have shown a different behaviour to that of the developed countries.

In Western Europe, the evolution of spending had three distinct periods: (a) rapid growth in the years from 1961 to 1970 in absolute terms and with relation to the GDP; (b) stabilisation in the 80s, in response to the economic crisis and the need to stop the growth of inflation, which led to the adoption of macroeconomic spending controls, linked to GDP growth and to policies of containing medical care costs, and (c) an increase in the first half of the 90s, *pari passu* with the severe recession, and also in the second half, reflecting other factors such as German unification and the increase in spending in the southern countries, such as Spain and Italy (Almeida, 1995; EOHCS/WHO, 1999). The public share of spending also increased, with a slight reduction in the last years of the 90s, and the private share fell, with a slight increase at the end of the decade.

The dynamics of the Latin American region goes in the opposite direction: in the 60s and 70s health spending in general increased, although heterogeneously; in the 80s the regional average fell, as in 1985 when in some countries this fall was of the order of 70% of the 1980 values (World Bank, 1990); and, in the second half of the decade there was a recovery, with a slight increase in the mid-90s and a reduction in the second half (Tables 2 and 3, Appendix 1). It should be borne in mind, however, that as the GDP dropped in the same period, this increase did not mean more resources for health in absolute terms (Table 3). The public share of spending fell in the 80s, increased a little in the first half of the 90s, falling again at the end of the decade; in parallel, private spending increased, declining slightly at the end of the decade (Tables 2 and 3). In general terms, the majority of this spending was directed to curative care (72.6% in 1995), with barely 7% for prevention, 12% for administration and 8.3% for other expenses (infrastructure, supplies and training of human resources) (Molina *et al.*, 2000).

The composition of spending in terms of public and private sectors shows that between 1980 and 1999, private spending was the most important component of total health spending: around 57% of health spending in all the region (4.0% of GDP) in 1999, having reached 58.5% in the middle of the decade. The public share of this expenditure in 1990 constituted nearly 43.4% of total health spending, which represented 3.0% of GDP. This percentage was little more than half the average of the countries of the European Union

(4.9% of GDP) whose GDP is quite a bit higher (PAHO/ECLAC, 1994). During the 90s, a recovery was seen in public spending, but at the end of the decade, the increase (of 3.0 to 3.4% of GDP) was still quite below the European average and the private share of the spending practically stabilised (from 3.99 of GDP in 1990 to 3.93 in 1998-2000); and the component of public spending attributed to social security fell continuously between 1990 and 1999 (from 1.29 of GDP in 1990 to 1.03% in 1998-2000), while the participation of central government increased 10.8% and that of local governments hardly 1%, with a tendency to diminish at the end of the decade (Table 3).

According to WHO data (1999), calculated on the basis of the National Health Accounts, updated for 2002, the percentage of public spending on health in Latin America and the Caribbean was near 50% in that year; the direct out-of-pocket spending was approximately 34%; and the mix of all the other private spending was 16%, totalling 50% of private spending.²³ Thus, confirming the trend of the late 90s, an increase is seen in public spending and a reduction in private spending, but the direct out-of-pocket spending continued quite high.

Regional disparities in the public-private composition are also significant: in the year 2000, on one side were Cuba, Guyana and Bolivia with low participation from the private sector (10.8, 17.3 and 27.6%, respectively) and, on the other the Dominican Republic, Paraguay and Brazil with a high participation (72, 61.7 and 59.2%, respectively). The ratio of public health spending to total government spending in the region was around 13%, but with great variations between countries, since El Salvador and Haiti were at one extreme (with 26.2 and 22.1%, respectively), and at the other Belize and Jamaica (with 5.5 and 7.0%, respectively). (Giovanni *et al.*, 2003).

The share of external resources in the financing of health spending in the region's countries increased on average from 6% in 1995 to 7.5% in 2000. The countries that have most received these resources are Haiti (from 40.4 in 1995 to 67% in 2000) and Nicaragua (11.9 in 1995 and 30.5% in 2000); Granada and Bahamas do not receive any of these resources; and the largest economies in the region – Brazil, Mexico and Chile – historically receive quite small percentages of them (averaging 0.8, 1.2 and 1.4%, respectively in the 1995-2000 period) (Giovanni *et al.*, 2003).

The share of family expenditure – out of pocket spending – in total health spending is an important part of private spending in the region, nearly 39% on average, with large variations between countries: the Dominican Republic, El Salvador, Belize and Mexico with average shares above 50%; and Cuba and Surinam shares lower than 15% (10.8 and 14.9%, respectively) (Giovanni *et al.*, 2003). During the 90s a shift was seen from direct private spending to spending through pre-payment plans and private health insurance.

23. World Development Report 2004: Making Services Work For Poor People (p.137).

This out-of-pocket spending is destined mainly for medical consultations and medicines, and the majority of the latter is for brand-name medicines (Molina *et al*, 2000). This situation has increased inequality in the region, as inequalities in private spending are closely correlated with inequalities in income and, in general, are more concentrated than the income distribution, since in the countries where private participation is greater, the poorest quintiles spend greater proportions of their income on health than the richest quintiles; and the reverse is seen in the countries with greater public participation in the spending, where the quintiles with lower incomes destine less to health and the percentage increases in the richest quintiles (Molina *et al*, 2000).

To sum up, while in the European Union in the 90s an increase was seen in national health spending, with a reduction of the private share and a concomitant increase in public spending, in Latin America practically the inverse was seen, as the recovery of the public share of spending was relatively modest and private spending remained high, with an increase in the indirect component (insurance schemes and private pre-pays), despite the existing lamentable socio-economic indicators and enormous inequalities.

Table 4 (Appendix 1) summarises the indicators presented above for the countries studied in this work – Brazil, Chile, Colombia, Costa Rica and Belize – which are coherent with the structure of their respective health service systems. A comparison of the data shows that **Colombia** is the country that has the greatest share of total health spending as a percentage of the GDP and in relation to other government expenditure, as well as the highest spending per capita. **Brazil** has the second highest spending on health as a percentage of the GDP, but with a lower percentage of public health spending in relation to other government spending, lower spending per capita, and the largest share of private spending in total health expenditure, as well as an important participation of direct out-of-pocket spending in total health spending. **Chile** has a health spending as a percentage of the GDP similar to that of Brazil, but with a lower percentage of public health spending in relation to other government spending, and lower spending per capita, as well as greater spending with private pre-pays, a significant share of private spending in total health expenditure, and high share of spending with social securities, although this has been falling since the mid-90s. **Costa Rica** is the country that has the highest share of public spending in total health spending, the greatest participation of spending on social securities, the second highest percentage of health spending in relation to other spending, and the least participation of direct family spending in total health expenditure. And, compared to these, **Belize** is the one that spends least on health (as a percentage of GDP and as spending per capita) and which has the highest percentage of direct family spending, as well as receiving the highest contribution of external resources.

INEQUALITIES IN THE HEALTH SERVICES SYSTEM

The fall in public spending led to a deterioration in terms of health care service systems, particularly in relation to investment in infrastructure of the services financed with public resources, which are the majority in the region. The public systems did not manage to overcome the problems of efficiency, coverage and quality of care existing prior to the crisis, and in some cases they even became worse. In some countries, mainly those that made important reforms in health systems (like Chile and Colombia), the public services have had to absorb more customers among those who previously had social security coverage or who were excluded from the new private supply organizations. Formal and “informal” user coparticipation practices began to be adopted in many countries.

Inequalities in access to social health benefits persist not only between different social groups, but also between geographical regions within the same country, and between countries (PAHO, 1995; PAHO/ECLAC, 1994). In 1992 it was estimated that the size of the deficit in the environmental health and health care services sectors meant that there were 130 million people without access to drinking water and 160 million without permanent access to health care services (PAHO/ECLAC, 1994). At the end of the 90s, it was estimated that 25% of the population lacked permanent access to basic services (around 127 million people); another 25% had no access to drinking water and 32% lived in areas without basic sanitation (around 163 million people) (ECLAC, 2001).

A study made in six countries (Brazil, Ecuador, Guatemala, Jamaica, Mexico and Peru) shows that these inequalities include differences in favour of the rich, both in supply of services and of professionals, as well as in the state of health (independent of the *proxy* variables used to measure these), or even in access to health care services, in addition to which, the financing also tends to be regressive. However, inequalities in the state of health tend to be less pronounced than those of access to and use of services; and inequalities in access are less pronounced than inequalities in private spending. Inequalities are also greater in access to preventive care than to medical attention.

Lower income groups in the population get ill more, and use services less than higher income groups. Significant differences are also seen in the type of services used by the different social groups: dispensaries, health centres and public hospitals are more used by the poor and low income groups, and the private services are more used by the higher income groups, with the exception of the large public, general, emergency or specialised hospitals (Suárez-Berenguela, 2000).

The hospital services market shows a complex pattern in the region, with huge disparities, and in some countries (Argentina, Barbados, Cuba and Uruguay) the number of beds per inhabitant is higher than in the OECD countries. The ratio between the public and private sector is changing, with a rapid growth of private infrastructure in the last decade, starting from a base of 20 to 40% of available beds.

There is also great variation from one country to another in the consumption of medicines: from US\$80, in Argentina, to US\$7 *per capita* per year in most of the other countries (PAHO/ECLAC, 1994). The pharmaceutical industry is dynamic in the region in terms of innovations and the making of new products, but it is concentrated in the context of curing and of high costs. Until very recently, in most of the countries the prices of medicines were subject to public control. The deregulation of this market has meant an increase in relative and absolute prices of medicines, with considerable direct cost to the families, given that public institutions have reduced the coverage of medicines distributed to beneficiaries. Health monitoring activities are quite weak in the region, with frequent reports of illegal

laboratories and of the use of products prohibited in other countries. The degree of self-medication in the region is also one of the highest in the world.

Most of the countries have been decentralising their health systems for more than a decade, with more or less difficulty, in many cases in a context of deconcentrating central government spending, or even of summary privatisations, without letting sub national levels of government have the possibility of supporting or increasing the health care of their populations. Successful innovations and decentralisation processes with improvements in local health systems management are also mentioned (Bossert *et al.*, 2000; Levcovitz, *et al.*, 2001).

7 Overview of Sexual and Reproductive Health in the Region in the 80's and 90's: some indicators

There are great gender inequalities in Latin America and the Caribbean, that are seen even in the more equitable countries in general terms (such as Chile, Vega *et al.*, 2001), but still little is known about these inequalities and their manifestations in the health of populations in the region (Almeida Filho *et al.*, 2003). In general terms, the data are different in the different sources available for the same country, and are at times controversial, which makes it difficult to gain a real appreciation of the size of the problem and its comparison.

However, there is consensus in the literature on the impact of poverty on SRH. *The relation between poverty and SRH is not linear, but circular: not only do bad socio-economic conditions determine a bad SRH; a poor SRH also conditions a precarious socio-economic situation* (Langer *et al.*, 2000:4).

As has been mentioned, women tend to live longer than men. However, this survival advantage, the greater life expectancy at birth of the woman, characteristic of the industrialised countries and also a general trend in the region, is not the rule in the poor countries or in the lower income groups. This “advantage” has been seen to be diminished historically and even disappear, in contexts of poverty. Existing evidence suggests that poverty affects the health and survival of women more negatively than that of men. This phenomenon has been noticed, not only among countries of different levels of development, but also internally, among poor and non-poor populations (Gómez, 2000:14; Gómez, 2002:456). According to recent figures, the risk of early death (between 15 and 59 years of age) is almost 2 or 3 times greater for men in the higher income groups in 13 countries studied in the region; but for the poor population this sex difference is considerably reduced, although it is always greater for men (never above 10-20%), and tends even to disappear. And the mortality rate ratios between poor/non-poor, according to sex, *reveals that poverty brings with it a risk of premature death that is 2 to 5 times greater among men and from 4 to 12 times greater among women* (Gómez, 2002:456; Dachs, 2003:20).²⁴ These

data can be interpreted as gender inequality unfavourable to women in this population stratum (Figure 4).

On the other hand, greater longevity is not necessarily the equivalent of better health. Gender equity in the state of health stresses the emphasis on women, considering men's lower life expectancy at birth and greater mortality rate at all ages.²⁵ However, available empirical evidence indicates that women tend to experience greater morbidity than men, which is seen in higher incidences of acute problems throughout life, greater prevalence of non-fatal chronic diseases, and higher levels of short and long-term disabilities, particularly at advanced ages (Gómez, 2000, 2002). Household surveys made in Latin America and the Caribbean in recent years suggest significantly greater prevalence of acute and chronic conditions in women than in men; and this difference is constant throughout countries and different social strata, as well as responding to objective conditions and not to differences in perception or recognition (PAHO/IDB/WB, 2000 *in* Gómez, 2000:14).

In addition, the avoidable causes of illness and death are different in women and in men. Female morbidity is higher, and there are the needs that are exclusive to motherhood, increasing the need for women's health care services. It is estimated that 34% of the disease load of women is due to reproductive health problems.

As for the causes of higher male mortality, particularly in the young adult population, the panorama is very unfavourable for men, especially those related to accidents, high indices of violence, suicides and armed conflicts (Gómez, 2002; Dachs, 2003). Male overmortality in these categories reaches dramatic proportions in the region: 5 to 20 times higher than that of women (Braveman, 1998). Undoubtedly, the greatest sex differences in mortality for causes common to both sexes are concentrated around avoidable causes linked to risk behaviours culturally considered masculine. The greater disease load in men than in women from dependence on toxic substances such as alcohol (seven times greater) and drugs (three times greater) should also be noted; and it is also remarkable in terms of diseases such as lung cancer (ten

24. Data from the WHO, The World Health Report, 1999 in Gómez, 2000, 2000; Dachs, 2003).

25. Male mortality tends to be higher than female at any age, even *in utero*, and the difference is especially great in the perinatal stage. It is partially associated with genetic factors, above all during the early stages of life (Gómez, 2002:456).

times higher), liver cirrhosis (four times higher), and AIDS (three times higher). It is also important to mention the more damaging impact that unemployment and retirement have on the mental health and self-esteem of men (Gómez, 2000:18). These trends are also seen in the countries studied in this work (Table 3, Appendix 4).

It is also stressed that even though there is a general trend towards greater use of health care services by women, due mainly to their biological role in reproduction, but also to their greater morbidity and longevity, poverty disproportionately restricts women's access to these services. If it is tightened by need, public and private service use in the low-income sectors is no greater among women than among men, and there have been instances in developing countries and in strata of poverty, in which their use is lower than that of men (Gómez, 2000:14; Gómez, 2002:458). To sum up, in conditions of broad access by the population to health care, women tend to use the health care services more frequently than men. However, when economic conditions restrict such access, the relation between sex and service use is less clear. For example, recent household surveys in five countries in the region indicate that, in the case of illness, the poor use services with less frequency than the rich, and also that in the poorer strata, particularly within private care services, women use the services less than men (Casas, 1998 in Gómez 2000:31). On the other hand, some studies are controversial, showing inequalities in access to health care services unfavourable to men, as in Brazil (Pinheiro *et al*, 2002), or great inequities of access in urban areas, unfavourable to women, as in Ecuador (Waters, 2000).

This greater need for women's health care services is frequently associated, especially in non-solidarity based privatised systems, with greater health spending, whether because the insurance premiums are higher for women between 18 and 44 years of age (in Chile they are double those of men of the same age), or because the direct out-of-pocket spending in general is considerably higher than that of men. In the USA, women pay from their own pocket 68% more to take care of their health than men of the same age group (WREI, 1994 in Gómez, 2000:27), and in Latin America household surveys suggest that women's average out-of-pocket spending on health is between 15 and 43% greater than that of men (Gómez, 2000:27).

Despite these data, there is little evidence on the relations determining gender inequalities in Latin America and the Caribbean and their reflection in health indicators. This is an area that still needs to be better explored, as these inequalities are often shown in subtle ways and interact with other health determiners in quite particular ways.²⁶

In general terms, the records and reports of data in this area in the region are quite unreliable, which hinders the establishment of baselines and updated, systematic information that would enable the priority problems to be

identified. Moreover, the poor quality of the data available makes intertemporal and international comparisons impossible.

The writers mention that the main health problems related with the SRH area identified in the Latin American region are:

- The issue of the differential birth rate by social groups and by countries.
- The persistence of high rates of maternal mortality.
- The higher incidence of infection by HIV/AIDS, which is increasing more rapidly among women than in men.
- The persistence of a high prevalence of gynaecological pathologies detectable by preventive examinations, such as sexually transmitted diseases, cervical cancer, breast cancer, etc.
- The persistence of high rates of abortions resulting from unwanted pregnancies, despite their under-recording.
- High percentages of pregnancy in adolescence.

As has been mentioned, there was a significant fall in the rate of fecundity in recent decades in Latin America, and family planning programmes in the region are considered a success. Most countries have adopted official family planning policies, implemented by public and private organizations, increasing substantially the use of contraceptives in general, even though in some countries sterilisation has been used in a significant way, at ever earlier ages (Rutenberg *et al*, 1991 in The Alan Guttmacher Institute, 1994). However, even though it is the right of couples (or of women without a partner) to decide on the number of children they want to have, or if they wish to have children or not, the percentage reduction in the birth rate, since the 50s, has been considerably lower in low-income countries, like Haiti, Guatemala and Bolivia (Table 5, Appendix 1). Moreover, poorer young women (25 to 29 years of age) accumulate a significantly greater number of sons and daughters than the average for their countries and much higher than that of the highest socio-economic quintile (CELADE, 2000:38-39). The number of births per 1,000 women from 15 to 19 years of age is also high, (71/1,000 in the region) and is greater in the rural areas and among the poorest (UNFPA, 2001); birth rates are particularly high in women with lower education levels and with lower income levels (UNFPA, 2001); there are great urban-rural differences and between the poorest and richest quintiles, and they are greater in the former (UNFPA, 2001), and in the indigenous populations the birth rates are still higher than national averages (around 6) (CELADE, 2000) (Tables 6 and 6a, Appendix 1). These data reinforce the impression that, as well as the decision or wish to have children or not, other factors intervene significantly in the birth rate in specific social groups.

26. Indicators are not available either for infant mortality, or for malnutrition differentiated by sex, as there are in other regions (Dachs, 2003).

Complications of pregnancy and childbirth continue to figure among the prime causes of mortality of women of reproductive age in the region.²⁷ The maternal mortality rate in Latin America and the Caribbean is still high – an average of 190/100,000 live births (UNFPA, 2001) – which means that every year 23 thousand women die as a consequence of problems in pregnancy or in childbirth, making this the main health problem affecting women in the region. This is due to various problems, especially: the inadequacy of prenatal care services, particularly in the poorer countries, in rural zones and in indigenous areas; low coverage and low quality of care in childbirth (lack of infrastructure and qualified personnel), and unwanted pregnancies, followed by clandestine induced abortions, with complications that can lead to the death of the mother. There are also great variations between countries: they are very high in Haiti (1,100/100 thousand), the highest in the West, followed by Bolivia (550/100 thousand), Guatemala (270/100 thousand), Brazil (260/100 thousand) and Belize (140/100 thousand); and much lower in Cuba, Chile and Costa Rica (24, 33 and 35/100 thousand, respectively) (UNFPA, 2001) (Tables 6 and 6a, Appendix 1).

Most pregnancy- or childbirth-linked deaths occur among the youngest women who already have other children and live in developing countries, and of those who survive many remain affected by some disease, disability or physical damage as a result of the complications of pregnancy (Koblinsky, *et al.*, 1993). These maternal deaths (60 to 80%) are produced by obstetric haemorrhages, obstructed childbirth, septicaemia, hypertension problems of pregnancy and complications derived from an abortion in dangerous conditions (WHO, 1997). To these are added the so-called “other direct causes” including ectopic pregnancies, embolism and complications arising from anaesthetic procedures; as well as the “indirect causes” that include prior maternal pathologies, such as anaemia, malaria and cardiac diseases (*Family Care International*, 1998). At the start of the 90s, the risk of death from pregnancy in the course of the woman’s reproductive life in Latin America and the Caribbean was 1 in 130 (*Family Care International*, 1998), and the highest rate of abortions in bad conditions was recorded in Latin America and the Caribbean (more than 20%) (Tinker, 1997).

Care in childbirth by qualified staff is higher in the group of women with higher level of education, higher income level and in the urban areas (PAHO/PRB, 2003; UNFPA, 2001) (Table 6a, Appendix 1). The percentage of births by Caesarean is also high. The PAHO recommends a maximum of 15% of births by caesarean, but in Latin America and the Caribbean, these births are concentrated among the mothers with higher educational level and often exceed the

recommended maximum. For example, in Brazil, the percentage of births by caesarean in women with secondary level education or higher is 46%, 28% in those with primary level, and 12% in those with no education (PAHO/PRB, 2003).

Most of the complications of pregnancy that cause maternal death cannot be anticipated, and the majority occur within the hours following or a few days after the birth (Li *et al.*, 1996); but others are predictable or avoidable by adequate care services, and *of all the avoidable maternal deaths, those produced by abortions realised in dangerous conditions are probably the most avoidable* (Ingar Brueggemann, Secretary General, IPPF, World Health Day, 1998). Table 6 (Appendix 1) shows this relationship: the countries with the lowest coverage (or supply) of health care services have as the main causes of maternal death conditions that are avoidable or predictable.

When analysing the state of the art on the topic of sexual and reproductive health, one of the less systematically documented components is the knowledge and participation of men in the areas of reproduction, sexuality, the upbringing of the children and their own experience of health. All the works *continue giving priority to women’s experience, limiting the presence of men to a participating factor that affects women’s health and that of their children positively or negatively* (Rico *et al.*, 2003:196). The responsibility for reproduction has been deposited almost exclusively in women, as part of their natural function in life, although in some countries there are places where the decision about when and how many children usually belongs to the men (Rico *et al.*, 2003; Keijzer, 2003). Also, *reproductive health, as the set of effects on health of the reproductive phenomenon, constitutes a real challenge for men ... [and also] before this specialised field was established, the link of men with health and reproduction was already a complex and conflictive relationship. For many men, health and reproduction are alien to them, whether because it occurs in the body of the woman, or for the generalised idea that health care belongs to the woman’s world. This has not always been the case, either historically or through all cultures* (Keijzer, 2003:59). Nevertheless, men’s needs for sexual and reproductive health have rarely been considered in reproductive health policies (Rico *et al.*, 2003). Recently, some pathologies, such as prostate hypertrophy and cancer, erectile dysfunction and infertility have been the focus of specific public health programmes or campaigns, but not linked to SRH policies or programmes.

Finally, the health sector is perhaps the one that has most relied historically on the gender roles assigned to women and on their unpaid (domestic or community) work, for the task of providing care to children, the sick, the old, and to the rest of the population needing it. More than 80%

27. As it is preventable and unfair by nature, the PAHO has declared maternal mortality as the clearest reflection of discrimination, and of how their low social status harms women (Gómez, 2002:456). Moreover, the WHO states that the most sensitive indicator of economic differences is, undoubtedly, maternal mortality (Langer *et al.*, 2000:4).

of the work of early diagnosis and of health promotion and care is done outside the formal services (Gómez, 2000:18). In addition, as regards representation, even though it is women who are most actively involved in community health activities, they have only a minority participation in local councils or in health services decisions and the “spokespersons” of the community are predominantly men, who do not necessarily consult or represent the interests of the women (Gómez, 2000:22).

Here we will point out some especially important SRH topics.

THE USE OF CONTRACEPTIVES

In recent years, the use of contraceptives in the region has been continuously increasing, reaching 60% in 2001. This rate is slightly higher than median world prevalence (55.6%), which is 59.2% for more developed regions and 54.9% for the less developed (UNFPA, 2001). During the 90s, the use of modern methods increased two percentage points annually in at least three countries in the region, and although to a lesser extent, there was a significant increase in at least ten other countries. Meanwhile, some countries continue with percentages of use of around 20% (World Bank, 2003, based on data from UNFPA, 2001).

The prevalence of use of contraceptives among women from 15 to 49 years of age in the region is lower for modern methods (60%) and higher for all methods (69%). It is also higher in urban areas, among women with higher educational levels and with higher levels of income. The same differences are found in different countries, with great disparities between them: 22% use modern methods in Haiti and 70% in Brazil; while for all methods the rates are 78% in Puerto Rico and 28% in Haiti (UNFPA, 2001) (Tables 7 and 7a, Appendix 1).

However, even though in most countries in the Latin American region knowledge about modern contraceptive methods is relatively widespread among women from 15 to 49 years of age, it is observed that the age groups of 15 to 17 and those of lower incomes are less informed (Table 8, Appendix 1). Meanwhile, although they know the methods, many of these women do not use them correctly, either for lack of information, adverse side effects, or lack of confidence in the method. In many cases should also be added the lack of collaboration of the sexual partner, who rejects the use of contraceptives, especially of some methods such as the condom.

In addition, surveys made in 20 countries, among adolescents of 15 to 19 years of age, show quite low contraceptive usage rates in this age group, but they are higher among sexually active women not in unions (Guzmán, Hakkert and Contreras, 2000, *in* CELADE, 2000) (Table 9, Appendix 1). However, adolescent girls in unions, especially the poorest, register a prevalence of modern contraceptive use much lower than the other groups of young people, even in those countries where knowledge

about contraceptives is almost universal, a fact that shows the presence of sociocultural access barriers, or attitudes of rejection (CELADE, 2000:45).

Surgical sterilisation is a 20th century technique, but only in the 60s was there a “rebirth” of this procedure for contraceptive purposes, when there was great interest in voluntary sterilisation, mainly for demographic reasons, but also for the introduction of less invasive technologies, such as laparoscopy. As from the 70s, this surgical technique became consolidated as a contraceptive method, and in the 90s it became the most used contraception method worldwide, with a clear trend in favour of this practice in developing countries (WHO, 1992, *in* Molina, 1999:128-9). In 1992 Ross estimated that worldwide 20.1% of all the partners in unions of reproductive age had opted for sterilisation, of which 15.7% were women and 4.4% men (Ross, 1992, *in* Molina, 1999:129). These figures were higher in developing countries, with percentages of 22.3% for women and 11.4% for men. 1998 data from the *Population Reference Bureau* indicate that for Latin America and the Caribbean, in 10 out of the 15 countries with data available, female sterilisation was already the most used contraceptive practice. Among these were Costa Rica, Brazil and Colombia (Molina, 1999:130-131).

According to data from PRB/PAHO (2003), the percentage of women between 15 and 49 years of age who had sterilisation as a contraceptive method was quite high in some countries where data were available for the period 1993-2001. In Puerto Rico it was 46%, 41% in the Dominican Republic, 40% in Brazil, 32% in El Salvador and 31% in Mexico. The country where the women’s sterilisation rate is lowest is Haiti (3%). Data available about male sterilisation in the region are much scarcer.

YOUNG PEOPLE'S HEALTH: SOME INDICATORS

The causes from which young people become ill and die, traditionally compiled by governments and international agencies, tell us something about their general health conditions and how these are often determined by the social context they live in, but throw little light on issues connected with SRH. As we stated before, mortality among young people is relatively low in comparison with other age groups. An analysis of the death rates in the region in 1997 shows that the main causes of death in the 10 to 14 age group are accidents, violence, malignant tumours, and infectious diseases; while in the population from 15 to 19, the causes are accidents, homicide, suicide, malignant tumours, heart diseases and complications of pregnancy, childbirth and puerperium (PAHO, 1998).

Male mortality from accidents and homicides is three and six times higher, respectively, than that of women. However, it is clear that some behaviours induced by gender conditioning affect the health and physical integrity of men. Violent deaths occupy the first place in nearly all the countries of the region among the causes of death of men

between 15 and 24 years of age (Table 10, Appendix 1) (PAHO, 1998).

In a different dimension of analysis, decisions about reproduction are among the most important that people, especially young people, take, and constitute a most decisive step in their lives. Also, the growing recognition of the rights of individuals and couples to decide in a free and informed way about the behaviours that shape their reproduction is crucial (Langer, Nigenda and García, 1999), since the control that individuals exercise over this expresses the exercise of their reproductive rights and reveals their ability to integrate it functionally into their life project. Biological reproduction is undoubtedly important for individuals and also for the society. A significant fraction of biological reproduction (60% or more) takes place when people are young, and thus the decisions taken at this stage determine their definitive levels of fecundity. Analogously, they will mould the demographic future of the countries, especially because in all of them in the region the relative weight of the specific rates of total juvenile fecundity has tended to increase in the last 30 years (CELADE, 2000:32).

Nevertheless, this stage of life, definitive in many aspects, can also be decisive in the adoption of healthy lifestyles that guarantee a life more protected from illness, or for adopting lifestyles of risk that imply serious dangers for maintaining health and life itself. It is at early ages when people incur in social behaviours that involve serious dangers for health, such as violence or irresponsibility to oneself or others (ECLAC, 2003b:20).

Without doubt, many of the health problems of young people in Latin America and the Caribbean are associated with situations of poverty and exclusion. As we have mentioned, it is in poor households that the highest rates of fecundity are found and where the majority of adolescent pregnancies are also produced, another of the great SRH problems in the region. Even though in most countries the age at which women marry or reproduce has been increasing, information indicates that most women begin sexual activity before 20 years of age (between 53% and 71%), that slightly less than half have formed a union and more than a third have also been mothers before this age (CELADE, 2000:33, based on data from PAHO, 1998).

Although there has been a considerable reduction in fecundity in the region, pregnancy at earlier ages has increased, with girls between 15 and 17 years of age those who show an increasing trend in their probability of becoming mothers. DHS surveys from the mid-90s showed that in Bolivia in 1994, nearly 44% of women under 19 years of age were pregnant or had already had a child; in Colombia this rate was 39% in 1995, and in Paraguay it was 41% in 1996. In the latest DHS surveys, around the year 2000, and in the

same countries, between 15 and 20% of girls between 15 and 19 years of age were pregnant. (Médici, 2003). Adolescent pregnancy is thus still a serious problem to be dealt with in the region.

The relation has been proved between years of education and the improvement in the condition of women, and marriage or early pregnancy: when a woman receives eight years or more of education, an effect can be seen in the reduction of fecundity, and reaching a higher level produces a clear dissuasive effect on fecundity (Rodríguez, 2003). Early pregnancy is also related with gender conditionings that assign the woman a reproductive role outside her decision and control, the presence of low self-esteem, and the lack of a life project or of opportunities to realise it (ECLAC, 2003b). In 1996, health and population surveys in eight countries in Latin America estimated that 50% of adolescents under 17 years of age were sexually active. On the other hand, early sexual activity, associated with low school performance, usually brings about higher birth rates, exposing adolescent girls to the risk of getting pregnant and of contracting HIV infection or AIDS and other sexually transmitted infections, because young people in the region often do not protect themselves against pregnancy and these infections, or do not seek treatment for the diseases, either because of social norms, financial restrictions, the attitude of the care providers, lack of confidentiality and little information (CELADE, 2000:140). While no less than 15% of Latin American and Caribbean girls of 18 and 19 years of age have been mothers before 18, in the countries of Western Europe this percentage is no more than 5% (CELADE, 2000:36).

This situation is particularly dramatic in the Caribbean, and some aspects that spell out the problem are: the age of initiating sexual activity is the earliest in the world (with the exception of Africa), and this results in a high incidence of adolescent pregnancies and HIV-AIDS infections, so that this group is considered high risk;²⁸ there is high incidence of rapes, and physical abuse is extremely frequent and accepted in many countries (it is estimated that one in every ten adolescents attending school has been sexually abused) (ECLAC, 2003b:21-22).

There is a significant group of sexually active adolescents boys and girls (15 to 19 years of age) who have no access to sexual and reproductive information, education and health care services, which prevents them exercising their rights and works against their physiological integrity and life projects (CELADE, 2000:45).

Another aspect that seriously affects the health of young people in Latin America and the Caribbean is the consumption of legal and illegal drugs, and addictions. Although data available are not very reliable, it is clear that in youth and adolescence consumption is more common than

28. In 2000, the financial cost due to AIDS deaths in people infected during adolescence was 0.01% of the GDP in Surinam, Antigua and Barbuda; and 0.17% in Bahamas (World Bank, 2003b).

addiction, which is seen at later ages. However, consumption is the first step towards addictions. The consumption of legal drugs – alcohol and tobacco – especially the latter, is general among young men in the region, without distinction of social class, and there is growing trend to increased consumption among young women (ECLAC, 2003b:23). A considerable proportion of adolescents between 15 and 19 smoke cigarettes in Latin America and the Caribbean: 57% of the men and 40% of the women in Peru, and 41% of men and 28% of women in Cuba, in comparison with 28% and 32% in the USA and Canada – men and women respectively; 17% of the group between 11 and 15 years of age in Mexico, of both sexes (Burt, 1998:19, in ECLAC, 2003b:23). In the Caribbean, where there is little information available, there is clear evidence of alcohol and marijuana consumption among young people, with a broad margin of social acceptance in many countries.

The consumption of legal, but highly addictive, drugs, above all tobacco, is openly promoted in the mass media, which aim at younger people as their target public, and position images that link, its consumption to social success, manliness or sensuality and attraction. The existing regulations in Latin America and the Caribbean to control this type of messages that are extremely harmful for the health of our young people are slight and insufficient (ECLAC, 2003b:23).

In addition, drug-trafficking is present in all the region, and in some countries in particular, and brings great harm to the society as a whole, as well as representing a grave risk for young people, both of falling into consumption, as well as to be used by the traffickers for illegal activities.

So, there are some behaviours induced by gender conditions that affect the health and physical integrity of young people at this time of life, and especially the boys. Risk behaviours, violence, fearlessness and daring, socially assumed as positive male attitudes, are taking many lives in the region. Gang phenomena have become generalised, above all in marginal areas, among those who have abandoned schooling, but also in the middle and even upper classes of society (as was seen recently in Brazil). In the Caribbean, 20% of the male and 12% of the female students have, at some time, belonged to one of these organizations (World Bank, 2003, in ECLAC, 2003b:26). And there are ever-greater percentages of young people who take firearms into school, both in the Caribbean and in Brazil, above all on the outskirts of large cities.

SEXUALLY TRANSMITTED INFECTIONS (STI)

Currently the STIs are the commonest group of infectious diseases notified in most countries of the world. As well as the persistence of infections by the classic bacteria (syphilis, gonococcal infection, urogenital trichomoniasis), during

recent decades there has been increase in the incidence of so-called “second generation” STIs, including chlamydia and virus infections such as the Herpes Simplex Virus (HSV), and the Human Papilloma Virus (HPV). The increased incidence is attributed to various factors including changes in sexual behaviours, a lack of health education, an increase in geographical mobility, taboos about STI, a lack of knowledge that the vast majority are curable, and the development of resistance to antibiotics (Lowndes, 1999:258).

The WHO (1995) estimated that 333 million cases of curable STIs may have occurred in the world, with 36 million in Latin America and the Caribbean (WHO, 1995 in Lowndes, 1999:259). Although data are scarce in developing countries, available information suggests that STIs are, in general, more common and more serious in these countries, mainly because of the earlier start of sexual activity, poverty, lack of information and access to health care services, or of the poor quality of health care, and the generalised practice of self-medication with unprescribed antibiotics.

Current data on STIs, apart from HIV/AIDS infection, for the region of Latin America and the Caribbean are very difficult to find.

HIV/AIDS INFECTION

HIV/AIDS infection was, in the 90s, one of the most important health problems in the Latin American region, particularly in the Caribbean and Central America. In 1999, according to UNAIDS estimates (2000 in Izazola-Licea and Cardona, 2003:3), there were 34 million people worldwide living with the infection. In 2003, an average 40 million adults and children were estimated to be living with HIV/AIDS in the world; around five million had been infected in that year; the prevalence among adults was 1.1% on average²⁹ and the epidemic had taken the lives of over three million people. Out of that world total, some 1.6 million are in Latin America and 470 thousand in the Caribbean; 150 thousand adults and children have been recently infected with HIV in Latin America and 62,500 in the Caribbean; the average prevalence of the disease among adults is 0.6% in Latin America and 2.5% in the Caribbean; and AIDS caused on average the deaths of 59,500 adults and children in Latin America and 40,000 in the Caribbean. In brief, in 2003 there were more than two million people living with HIV in Latin America and the Caribbean, including the approximately 200,000 who contracted HIV in 2002; and at least 100,000 died of AIDS in the same period, the highest number of fatalities on a regional scale after Sub-Saharan Africa and Asia, with a special concentration in the Caribbean (UNAIDS, 2003) (Table 11, Appendix 1).

The national prevalence of HIV is at least 1% in 12 countries in the region, all within the Caribbean basin. The prevalence of HIV among pregnant women reaches or is

29. The prevalence is the proportion of adults (15 to 49 years of age) living with HIV/AIDS in 2003, based on demographic figures of 2003.

more than 2% in six of those countries: Bahamas, Belize, the Dominican Republic, Guyana, Haiti and Trinidad and Tobago. Most of the other countries in the region present highly concentrated epidemics, especially in South America, where Brazil (the most populated country in the region) has the great majority of people living with HIV in Latin America and the Caribbean (UNAIDS, 2003).

In most of the countries, all the main modes of transmission coexist together with high levels of risk behaviours, such as a precocious start to sexual activity, sexual relations with multiple partners without protection, and the use of unsterilised injection material. In most South American countries, HIV is being transmitted basically by intravenous drug consumption or by sexual relations between men (with its subsequent heterosexual transmission to other sexual partners), while in Central America, most HIV infections seem to be produced by sexual transmission (both heterosexual and between men having sexual relations with men). In the Caribbean, transmission is mainly heterosexual (and, in many cases, associated with the sex trade), although in Haiti the serious and unremitting epidemic is now widely present in the population as a whole. One exception worth mentioning is in Puerto Rico, where intravenous drug consumption seems to be the main transmitter of the epidemic (UNAIDS, 2003).

Two of the most serious epidemics in the region are those in Haiti and in the Dominican Republic. In Haiti, where health and development indicators are among the lowest in the region, national levels of HIV prevalence have remained at 5 to 6% since the end of the 80s, but with variations among regions of the country (from 13% in the north-west to 2-3% in the south, along the border with the Dominican Republic); estimates say that the epidemic takes 30,000 lives per year and has already left some 200,000 children orphaned. Condom use is very low among young people, despite the evident fact that knowledge about HIV/AIDS is relatively high (although more among men). In the Dominican Republic, prevention efforts carried out in recent years seem to have stabilised HIV prevalence among the population of 15 to 24 years of age in Santo Domingo (the capital of the country).³⁰ Factors contributing to this reduction seem to be a greater use of condoms and a reduction in the number of sexual partners; however, the situation seems to have worsened in other cities, where a high prevalence of HIV (12%) has been recorded among sex professionals. On the other hand, little is known about the HIV situation among men who have sexual relations with men (UNAIDS, 2003).

The national prevalence of HIV in Central America is around 1% in Guatemala, Honduras and Panama and new data indicate that this prevalence varies significantly in sex professionals: from less than 1% in Nicaragua, 2% in Panama,

4% in El Salvador and 5% in Guatemala, to more than 10% in Honduras. The prevalence among men having sexual relations with men is seen to be equally high in those countries: from 9% in Nicaragua to 18% in El Salvador (UNAIDS, 2003).

In Colombia and Peru, HIV propagation is concentrated mainly among men having sexual relations with men: in Bogotá, HIV prevalence is 18%, with very low systematic use of preservatives in this group. Particular stress is placed on the considerable potential for HIV transmission that the men having sexual relations with men represent for their female partners and for their children: in the city of Lima in Peru, this has increased in prevalence from 18% in 1995 to 22% in 2003; in this city, one in every 10 men surveyed declared they had had sexual relations with other men, and out of these, nine out of ten declared that they also had sexual relations with women. Once again, the systematic use of condoms seems to be a rare exception, especially in heterosexual relations (UNAIDS, 2003).

In general terms, the incidence of HIV/AIDS infection in Latin America and the Caribbean increases more rapidly among women than among men, especially in reproductive age, where the majority of cases are concentrated, despite progress in perinatal prevention (Liguori, 2003). The average percentage of women between 15 and 24 years of age with AIDS in the region is 0.3%, but reaches 2.91% in Haiti, 2.78% in the Dominican Republic, 1.66% in Honduras and 1.36% in Paraguay (Médici, 2003).

In a study made by the IBRD in fifteen countries³¹ the male-female ratio of AIDS cases notified for the 1995-2001 period was higher – i.e., with less female share – in Costa Rica (6.09), Chile (5.82), Mexico (5.58) and Nicaragua (7.86); and was lower – greater female share – in Guatemala (2.08), Brazil (1.96), Dominican Republic (1.45) and Honduras (1.17) (Izazola-Licea and Cardona, 2003:3). According to a World Bank study, around 50% of the new cases in Brazil are among women (Ruiz April, 2003). In the region, in 2001, women as a percentage of adults with HIV/AIDS was equal to or greater than 40% in Bahamas (44%), Belize (45%), Guatemala (43%) and Jamaica (40%); and equal to or greater than 50% in Guyana (50%), Haiti (50%), Honduras (50%), Dominican Republic (51%) and Surinam (50%) (PAHO/PRB, 2003).

Although the epidemic in Brazil has spread from the main urban centres to smaller towns in the whole country, the median prevalence of HIV among pregnant women attending prenatal dispensaries has remained below 1%, with scant variation in the last five years. This is probably the result of the prevention programmes put into effect after the 90s, and also of the efforts to broaden the coverage of damage reduction and prevention programmes in vulnerable groups, as well as an active and effective programme for treating people living

30. After having peaked in 1995 in the capital, HIV prevalence among pregnant women of this age group (15 to 24) has dropped to less than 1% (UNAIDS, 2003).

31. This study used the methodology of national counts and the countries studied were: Argentina, Bolivia, Brazil, Costa Rica, Chile, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, and Uruguay (Izazola-Licea and Cardona, 2003).

with HIV. However, in Rio Grande do Sul, prevalence rates have been recorded of 3 to 6% among women who only rarely attend the public health system³² (UNAIDS, 2003).

The proportion of patients who need and receive antiretroviral treatment in the region varies greatly, and while in some countries the coverage is under 25%, in others it is above 75%. In general terms, it is estimated that antiviral treatment is administered to almost half the patients who need it (UNAIDS, 2003).

Various countries have increased their national budgets to fight HIV/AIDS, while in Central America and the Caribbean, in the past three years external resources for AIDS have practically quadrupled. However, stigma and discrimination are still significant obstacles: a recent study of national spending on AIDS (the SIDALAC/UNAIDS project), declared that the investment in prevention activities and care directed to the most vulnerable populations (men who have sexual relations with men and sex professionals) is not yet on a par with the importance these groups have in the epidemic and the main reason for this trend seems to be discrimination (UNAIDS, 2003).

CERVICAL CANCER AND OTHER GYNAECOLOGICAL CANCERS

The countries of Latin America and the Caribbean are among those presenting the highest rates of incidence of cervical cancer in the world, together with the Sub-Saharan countries in Africa, and south-east Asia. In the year 2000, at least 76,000 incidents of cervical cancer and 30,000 deaths were estimated for the region, which represents 16 and 13% of the world total, respectively. This tumour is the second most common cause of cancer among women (around 40%) and the second cause of cancer deaths (also around 40%) and in general is associated with lack of access to medical services or to lack of qualified staff (Arrossi, Sankaranarayanan and Parkin, 2003; IARC/GLOBOCAN 2000). Although the incidence and mortality from this cancer increase with age, the greatest disease load occurs in women aged between 35 and 54 (IARC/GLOBOCAN 2000).

The variation of incidence between countries is great: there are very high rates in Haiti (93.9/100 thousand), considered the highest in the world, Nicaragua (61.1/100 thousand) and Bolivia (58.1/100 thousand); and rates similar to those of Western Europe, as in Argentina (14.2/100 thousand), Uruguay (13.8/100 thousand) and Puerto Rico (10.3/100 thousand) (Arrossi, Sankaranarayanan and Parkin, 2003:309). And the highest mortality rates estimated for cervical uterine cancer per 100,000 women in the 1993-1997 period, among the countries for which data is available, were 29% in Barbados, 24% in Paraguay, 23% in Nicaragua, and 21% in Anguilla and Dominica (PRB/PAHO, 2003).

This picture is not new and the lack of success in the prevention and control of this cancer contrasts with what is seen in other regions. Historically, cervical cancer is associated with several demographic, cultural and socio-economic variables, such as the early initiation of sexual activity, the multiplicity of sexual partners, a low socio-economic and educational level, smoking, and infection by Human Papilloma Virus (HPV), which has also been described as a necessary factor for its occurrence. There is also evidence that early detection services or programmes for this cancer can potentially reduce incidence and mortality by more than 90%, above all in developed countries. But in Latin America and the Caribbean these screening programmes, when they exist, face a great range of problems – incomplete coverage, lack of quality and of suitable organization – and have not achieved their targets (Arrossi, Sankaranarayanan and Parkin, 2003:307).

When the screening programmes are effective (as in Puerto Rico and in Cali, Colombia), between 1960 and 1994, a persistent downward trend has been seen in mortality, concomitant with the introduction of early detection programmes, and the effect is proved with specific falls in specific ages (30 to 69 years of age) when screening has its best effect. However, in Cuba, Chile, Mexico and Costa Rica, there were few changes in mortality from cervical cancer after introducing screening programmes (Arrossi, Sankaranarayanan and Parkin, 2003:311-12).

Several studies have been carried out to evaluate screening programmes in the region, that point up problems related with frequency, insufficient publicity, inadequate collection and reading of cytological samples, as well as incomplete follow-up of women after the test (Robles, White and Peruga 2002; Restrepo, 1993; Parkin, 1991, among others). On the other hand, “radical” primary prevention of cervical cancer focuses on changes in sexual behaviour and in the eradication of smoking. But whether it is for primary or secondary prevention of its initial stages, the world recognised strategy is the early detection through periodic preventive Papanicolaou examinations (INCA, 2003). Thus, apparently, the main change for the countries of Latin America is in how to organise effective screening programmes and in the integration needed between services at different levels of complexity.

Breast cancer is the second most incident malign neoplasia in women, as well as one of the most important causes of death from cancer (Parkin *et al*, 2001).

The authors mention that there are no specific practical measures for preventing breast cancer in the general population, although observational studies have suggested some association with smoking, alcoholism, obesity and sedentarism, and so the prevention of these problems may reduce the risk of such tumours. Technological advances

32. The Health Ministry in Brazil has just launched an initiative to find, test and (if necessary) treat pregnant women who do not regularly attend prenatal care centres (UNAIDS, 2003).

aimed at early detection and treatment, however, have shown a substantial improvement in the survival and cure of patients (INCA, 2003). International studies show a global increase in women's survival mainly in cases in which the disease is in its initial clinical stages: cumulative survival in Europe is 91% after one year and 65% after five years; in the USA it is 96.8% in the first year (Parkin *et al*, 2001).

Despite being considered a cancer with a relatively good prognosis, if it is diagnosed and treated in time, the rates of this cancer are still high in Latin America and the Caribbean, although the data are very difficult to organise and, most probably, the main reason is that the disease is being diagnosed at advanced stages (INCA, 2003). Thus, between 1993 and 1997, the breast cancer mortality rates estimated per 100,000 women were 45 in Bermuda; 31 in Barbados; 28 in Argentina; and 22 in Antigua and Barbuda (PRB/PAHO, 2003).

It should be mentioned that the data available for these diseases, as well as for other sexually transmitted infections (STI) are quite precarious in the region, whether of incidence or of mortality. Even though in the 90s several countries, such as Argentina, Brazil, Chile, Colombia, Costa Rica, Cuba, Paraguay, Peru, Puerto Rico and Uruguay, started PBCRs - *Population-based cancer registries*, in practice many of them have faced serious problems related to data quality.

VIOLENCE

Violence is a serious problem in the Latin American region, affecting men and women in different ways. And although the available statistics underline the gravity and magnitude of the violence to which women are subject in all the world, they still do not show the true extent of this violation of human rights (Amnesty International, 2004a).

Latin America and the Caribbean constitutes the most violent region in the world, with the highest rates of homicides and crimes, many times higher than the rates in Asia, Europe, Central Asia, the Middle East and North Africa (Fajnzylber *et al*, 1998, *in* Shraber, 2000:2); and violence between men is what most prevails. The homicide rate for the Latin American region (in 1990, the average was 28.4 homicides per 100,000)³³ increased 44% during the period from 1984 to 1994 (PAHO, 1996 *in* Buvinic, Morrison and Shifter, 1999). Of all the homicides, 28.7% were attributed to young men between 10 and 19 years of age (Guerrero, 1997 *in* Arriagada and Godoy, 1999).

Violence between young people is also responsible for many of the serious wounds and non-fatal disabilities. According to estimated data from the PAHO, for every child or adolescent killed violently in Latin America, 15 have serious lesions due to violence (Inter-American Development

Bank, 2001). For Latin America, it is estimated that 3% of the DALYS (*Disability Adjusted Life Years*) are due to violence, but with great variations between countries, with homicides and attacks representing more than 25% of the DALYS (Dane, 1997, *in* Shraber, 2000:2).

In the public sphere, crimes are a daily event in the life of cities, and affect the behaviour of people in relation to transport, work, school, consumption and daily activities. In the private sphere, violence is also very present in the region, given that between 25 and 69% of the women in the Americas suffer abuse from their partners (Population Reports, 1999, *in* Shraber, 2000:2), and the prevalence of child abuse is 65% in some countries such as Chile (Larrain, 1994; WHO, 1990a, *in* Shraber, 2000:2). Around the world, more than 70% of the women murdered are killed by their sexual partners (Amnesty International, 2004a and b).

The sources of primary data most used as indicators of violence are the homicide rates, the crime statistics and the victimisation surveys. Although useful, these sources of data present only a partial overview of violent behaviour in our societies, and the gender differential in violence reinforces the idea that these indicators are ineffective proxies for assessing family, domestic and sexual violence. Various studies have shown that pregnant women are victims of domestic violence by their partners, but the deaths of pregnant women or occurring up to 42 days post-partum are usually recorded as maternal mortality (Shrader, 2000:5-7).

Rape is one of the more common forms of sexual violence and the most violent, and has also been associated with unwanted pregnancies and sexually transmitted infections, including AIDS: one of every five women will be raped or subject to a rape attempt during her life (WHO, 1997 *in* Amnesty International, 2004a). And few countries give special training to police, judicial and medical personnel on how to treat rape cases. In addition, violence against women is, to a great extent, not fought against or punished (Amnesty International, 2004a).

It has even been used "as a weapon of psychological warfare in armed conflicts". Mass rape is frequently used systematically as just another weapon of war. During a conflict too, women are forced, physically and economically, to prostitute themselves, sometimes to meet the basic needs of their families. War also has other repercussions: 80% of the war refugees are women and children (Amnesty International, 2004a).

In the USA, for example, every 90 seconds there is a rape; in France, the number of victims of this crime reaches 25 thousand per year, and these data show only the tip of the iceberg, as many women do not report rape because of social stigma (Amnesty International, 2004). In Latin America, only 5% of the adult victims of sexual abuse report the

33. The homicide rate - the number of violent deaths per 100,000 inhabitants - is the most usual measure for evaluating the level of violence in a society, as it is the least subject to under-estimation or misinterpretation. According to research data (and not judicial data) the concept includes both intentional homicides and violent accidental deaths (involuntary or accidental homicides, etc.). (UNICRI, 1995; Shrader, 2000:5).

violence to the police. Data on women who are victims of their husbands is also under-recorded: 15% in Nezahualcoyotl/Mexico; 20% in San José/Costa Rica; 14% in León/Nicaragua, and 29% in Santiago de Chile. In the case of political violence, particularly linked with abuses against human rights, the difficulties for making a complaint are even greater, which gives rise to high levels of impunity (Shraber, 2000).³⁴

So violence, domestic or otherwise, against women continues to be a great challenge and a huge public health problem, and can take on various forms: beatings (the most common) and other forms of domestic violence; rape, traffic in women and children; forced prostitution; violence linked to armed conflicts, and mutilation of women's genital organs (mostly in women resident in Africa, the Middle East and Asia).

Current socialisation processes consolidate violence against women. Social norms and expectations around gender roles and male identity often incite to violence against women. Cultural attitudes also have their part in this process, as domestic violence is considered a private question between the man and the woman, in which outsiders must not interfere; secondly, shame, guilt and the stigma associated with physical aggression or sexual abuse or rape, impede or hamper women reporting the aggression; and finally, the lack of information and sensitivity in the authorities (police and judicial) about this problem complicate the situation even more.

In Peru, more than 30% of women have been attacked by an intimate partner; in Nicaragua, Mexico and Chile more than 25%; and in Colombia, almost 20%. Haiti is the country with the highest domestic violence rate in the region, with more than 70% of the female population reporting some kind of violence, 37% of which is sexual in nature (Ruiz Abril, 2003:6). The risk of physical abuse against women reduces with higher income levels and schooling, increases with marriage and, most worryingly, with the woman's financial independence. For example, in Colombia, work is associated with an increase of six percentage points in the probability of women suffering some kind of domestic violence and with a four percentage point increase in the probability of suffering grave domestic violence (*idem*).

Data from the PAHO/PRB (2003) report that the percentage of women between 15 and 49 years of age, at some time in a union, who admit having been victim to violence from their husband or partner, in Colombia, is 41% for physical violence and 11% for sexual violence; in Peru 41% for the former and there are no reports for the rapes; in

Nicaragua³⁵ the data are 29% and 10%, respectively; and in Haiti 27% and 17%, respectively. In urban areas, percentages of physical violence are greater than in rural areas; and reduce with the level of education in all four countries (PAHO/RPB, 2003).³⁶

To try to confront this situation, Amnesty International launched a world campaign on March 8th, 2004, to combat violence against women, *a true cancer and atrocity for human rights* (Amnesty International, 2004b).

Another worrying figure is that related to child prostitution: every year two million girls between 5 and 15 years of age are forced to sell their bodies for money, and "the trafficking in women industry" has a turnover of around US\$7 billion in all the planet (Amnesty International, 2004).

Finally, another very important problem, for which there are no reliable official data available, is violence against children, domestic or otherwise, by physical or sexual aggression. Recent studies in the USA indicate that many cases of child homicides were diagnosed as sudden death syndrome (Shrader, 2000).

THE ABORTION ISSUE

Another serious health problem in the region is abortion, but it is very difficult to have reliable, up-to-date information about this in the region, for several reasons, but perhaps the most important is the situation of access to legal abortion in the different countries. The difficulties for the legalisation of abortion in most of the countries are of various orders – religious, cultural, political and social. Although there have been significant advances on the subject in the region, especially owing to the effective activity of feminist movements, only Cuba and Guyana have fully legalised abortion, Chile and El Salvador do not permit it under any circumstances. In several countries it is only allowed to save the life of the mother,³⁷ and in others it is permitted in specific situations, generally related with the preservation of the woman's health, but never at her own request (Berquó, 2003:289-301) (see Appendix 2).

Abortion figures in the world are shocking. Of the total pregnancies in the world (200 million) 75% are unplanned (150 million) (UNFPA, 1997); of the 46 million induced abortions, 19 million (41%) are unsafe abortions (Alan Guttmacher Institute, 2001), and 95% of these are performed in underdeveloped countries (WHO, 1997); 80,000 women die worldwide from unsafe abortions, and 13% of women's

34. The Demographic Health Surveys (DHS), large multi-country surveys, designed to generate transnational data on reproduction, contraception, and child health, carried out in more than 50 developing countries, among women of 15-49 years of age, are the most important source of data available worldwide on the subject, as they also include a module about domestic violence. However, although they capture various key data on a national scale and enable comparisons in the international context, the DHS, they still seem to underestimate the prevalence of abuse and domestic violence, because of failings in their methodology (Shraber, 2000:11).

35. In Nicaragua this information includes violence by the husband, partner or other person (PAHO/PRB, 2003).

36. The source of this data is: Demography and Health Surveys (1997/2000) (PAHO / PRB, 2003).

37. These countries are: Antigua and Barbuda; Dominica; Dominican Republic, Haiti, Guatemala, Honduras, Nicaragua, Brazil, Colombia, Paraguay, Surinam and Venezuela (Appendix 2, *in* Berquó, 2003, Appendix 1, pp. 289-301).

deaths related with pregnancy are from unsafe abortions (Alan Guttmacher Institute, 2001).

In the developed countries, 3 of every 1000 women have unsafe abortions, of which 500 die every year; in Latin America, 30 of every 1000 women have unsafe abortions every year and 5000 die from it (WHO, 1998), i.e., 4 million women have unsafe abortions each year in the region, and 21% of the deaths related with pregnancy are due to unsafe abortions (WHO, 1998).

The adverse consequences of risky, clandestine abortions, for women or for society as a whole, are recognised by various actors. For the women, it can include death from complications owing to unsafe procedures and, in the long term, harmful effects on health (such as gynaecological problems or infertility), and for society, the high costs of hospital medical care of women with severe complications provoked by risky abortions. This has been one of the most important justifications for supporting birth control and family planning programmes.

In 1992, research in six countries of the Latin America region (Brazil, Colombia, Chile, Mexico, Peru and Dominican Republic) showed that women use a great variety of methods to interrupt an unwanted pregnancy, and that most of the poor women in rural and urban areas induce their own abortion (with practices that vary from the use of herbs to physical aggression), or use persons not technically trained, who in turn use very different forms of intervention, some of which are highly risky. Around 50 or 60% of these women present complications (including incomplete abortion),

compared to a risk of complications estimated at 20 to 30% in women using the services of a trained professional, and of 7 to 14% in those who consult a doctor. Poor women undoubtedly have overall risks of post-abortion complications markedly greater than the others. It is considered that more than five out of ten poor rural women and nearly four out of ten poor urban women experience complications after an induced abortion, in comparison with little more than one in ten urban women of a higher income level (Alan Guttmacher Institute, 1994:17-19).

Not all the women with complications induced by abortions are hospitalised. This is due as much to less serious complications (such as haemorrhages for some days) as to the fact that in most countries abortion is penalised by law, which leads to the fear of possible legal consequences, and also to a lack of access to suitable services, mainly in rural areas. In addition, among women who are hospitalised with complications, the reason for the hospitalisation is not always made clear as induced abortion, and these also tend to be the more complicated cases. These “clandestine cases”, or unreported ones, make it still more difficult to trust the abortion statistics in Latin America and the Caribbean, that are in general underestimated, and may also lead to an overestimation of the complications. So the issue of the legal status of abortion in the region and the relationship between risky abortion and maternal mortality, health and the dignity of women, is still a significant public health problem to be faced by the different countries.

8 The child-maternal insurances

This section of the work discusses the proposal of child maternal insurances (in the context of so-called “public health insurances”) and, very briefly, their implementation or development in some selected countries (Ecuador, Bolivia, Peru, Argentina and Mexico).

The availability of bibliography on the implementation of these insurances in Latin American countries is still scarce. For this reason, the following is a first, very preliminary approach to the subject.

THE PROPOSAL

The child-maternal insurance proposal (included in the context of public health insurances) has its place in the World Bank strategies focusing on social programmes, to try to confront the alarming levels of inequality and poverty in the world and, above all, in the Latin American region (Grosch, 1992).

In parallel with the reports published periodically, the World Bank has been generating new instances for fighting poverty, among them the Highly Indebted Poor Countries (HIPC) Initiative, that consists in relieving the foreign debt of these nations, to the extent that they adopt activities recommended by the Bank itself, of state restructuring, fiscal adjustment and focusing of resources on the most vulnerable.³⁸

Another of the initiatives consists in that every country requesting a development credit must make an evaluation of poverty, formulate sector strategies, implement institutional reform and the “social protection safety-nets” that the country in question considers “priority for local success”. The countries must thus show their commitment through a strategy that spells out the main features of an overall poverty reduction plan, as well as its schedule and the participatory process on which its elaboration would be based. These recommendations would be collected in a Poverty Reduction Strategy Paper (PRSP) drawn up by the countries.

For the World Bank, the PRSPs would transform the principles of the Overall Development Framework generated by the institution, into action plans that can be adopted in practice, making it possible to strengthen the identification of the countries with their poverty reduction strategies; to broaden the representation of civil society – especially of the

poorest – in the design of these strategies; to improve coordination between development agencies; and to concentrate the analysis, consultancy and financial resources of the international community on achieving poverty reduction goals.³⁹

In the country documents, the priorities should focus on the areas of public health, preventive services and basic clinical services for mothers and children, ensuring the best possible access of the poor to higher cost services “in case of need” (Claeson *et al*, 2000). This would imply in practice that sector spending should be focused as a priority on these specific interventions. However, the way of measuring “need” is either unclear or is based on cost-effectiveness calculations that define the interventions to be included in the packages.

In the process of formulating the PRSP diagnosis that each of the HIPC must draw up in order to receive the loans, as well as establishing the poverty levels and the strategies for dealing with it, according to the recommendations of the creditor, the World Bank agreed to establish four action areas (IMF/World Bank, 2002):⁴⁰

- Adoption of a “basic health insurance” (i.e., distribution of a basic package of services per person).
- Implementation of a broadened immunisation programme.
- Modernisation of health insurances based on social security systems.
- Decentralisation and institutional strengthening.

In brief, the World Bank declares as its main aims to protect the population from impoverishment based on attenuating the effects of diseases and malnutrition and for this proposes: to support health policies and programmes that ensure sustainable financing or financial alternatives, in order to mobilise suitable levels of resources (broad arrangements of risk grouping, designated as “public health insurances”), mechanisms of community insurance and strategic protection of programmes for vulnerable groups. Mother and child care are part of the basic packages of interventions recommended by the World Bank in the area of health, to be developed by the very poor and indebted countries, in the fight against poverty, arguing that this ensures greater protection against the risks to this social group.

38. “The World Bank Group in the collaboration and transformation of development: new approaches to formulating strategies in the struggle against poverty that countries can consider their own. A new world consensus”. (March 2000).

39. “Examination of the mechanism of strategy documents in the struggle against poverty (PRSP): Principal conclusions”, prepared by IMF and World Bank staff, approved by Masood Ahmed and Gobind Nankani, March 15th, 2002.

40. Idem.

For these activities, the WB provides support through: a) global financial loans; b) investments in the health sector as in other sectors (water, sanitation, transport, infrastructure, environment), with the prospect of improving child health; c) loans for “adjustments” in health policy, and d) studies, analysis and consulting activities (promoting the so-called “National Technical Dialogues” for formulating policies, research and analysis of results). Currently, most countries in Latin America are in different processes of diagnosis, formulation and development of local strategies, for eradicating poverty and reducing social inequalities, under the guidance of the World Bank and the Inter-American Development Bank (IDB), based on the “National Dialogues”.

Up to 2003, the following Public Health Insurances have been financed in the region (World Bank, 2003):

1. Free Maternity Law of Ecuador (1994-2000), linked to the Health Care Services Modernisation Programme (Modersa) (investment).
2. Basic Health Insurance (1998) (investment) and Universal Mother-Child Insurance (SUNI) of Bolivia (2002) (investment).
3. Overall Health Insurance (Peru) (2000) (investment and sector adjustment).
4. Mother-Child Insurance of Argentina 2003 (sector adjustment).
5. Education, Health and Feeding Programme (Progresa) (1996) and Popular Insurance of Mexico (2002 and 2003) (investment).

This financing is the result of the commitments signed in each requesting country, after making the diagnosis of the situations. Despite the declared intention of the WB “not to globalise the strategies”, but to “potentiate localisation”, the developing countries in general seem to reproduce the general formula put forward, with some shades of variation according to each national situation.

Here we present some brief examples of “public health insurances” and “child maternal insurances” that are being implemented in some countries in the region.

THE CASE OF ECUADOR

The situation in Ecuador, like in several countries of Latin America, has been marked by political, economic and social instability in the past 30 years, which has had its effect in the difficulties in establishing effective health policies and continuous and permanent programmes.

The decade of the 90s was particularly marked by the implementation of structural adjustment policies, political instability and weakening of democratic institutions, contributing to a deterioration in the living standards of the population. (CLADEM, 2003). An example of this instability is that in less than five years Ecuador had five presidents, two of whom were overthrown.

In 1999, it passed through one of the greatest economic

crises of the decade, with a 7.3% drop in GDP. During 2000, the economy was dollarised as a strategy for containing the levels of inflation and monetary imbalance. But as a result of this crisis, poverty levels increased irremediably. By that year, 70% of the population were below the poverty line (UNDP, 2001).

Until 1967, most of the functions of regulating and running the health sector corresponded to the Ministry of Social Insurance and Work (MPST), that had a General Health Department, and Central and Provincial Social Assistance Councils responsible for formulating and executing health recovery activities, with resources concentrated in urban areas. The Ecuadorian Social Security Institute (IES) was part of this structure and had the Obligatory General Insurance and the Peasant Social Security under its orbit, supporting most of the medical care services provision in the country. In that year, 1967, the Health Ministry was created, to take charge of health, social care, nutrition and housing, but the General Health Department and the Central and Provincial Social Assistance Councils were maintained under the control of the MPST.

In 1970, policies were started extending health activities to the rural area, in an attempt to improve service access for this population group. As from 1972, the health care services system was restructured and the Central and Provincial Social Assistance Councils were abolished, for the Health Ministry to take over control of almost half of the hospital beds, as well as beginning a process of renewing infrastructure and building up basic care services: Urban Health Centres and Health Sub-centres, as well as rural Health Stations (PHR/LACHSR, 1998).

Despite the modifications to health sector structure made to improve management and population coverage, and the creation of various modalities of social security, by 1994 only 22.7% of the population was affiliated to one of these insurances. Most of the medical care was provided by the public system, made up of the general and peasant services of IES, and the Armed Forces and Police insurances, which together covered 20.5%. To this was added a small portion of insurance through pre-paid medicine companies (2.2%) (PAHO, 2001).

Between 1992 and 1996, the National Modernisation Council (CONAM) presented a social security reform proposal that included medical services, the basic lines of which aimed at organising a National Health System based on the division of functions, in which the Public Health Ministry (MSP) would have a guiding and regulating role, as well as strengthening public health activities and health care for individuals, through a decentralised, mutual “national health insurance” scheme. (MSP, 2003). This structural reform process was again held up by the political changes in the country and by fierce rejection from some sectors to the implementation of what they called “health sector privatisation”.

One important fact to note is that in 1996, constitutional reforms were introduced which stated that “health is a

citizen's right, for which the State and the civil society are responsible", and that it required "the organization and functioning of the National Health System, with participation of the public and private sectors, based on principles of equity, universality, integrality, efficiency and solidarity". Article 42 of the Constitution specifically states that "the State shall guarantee the right to health and the possibility of permanent and uninterrupted access to health care services", and Article 43 declares that "public health programmes and activities shall be free for all" (*idem*).

Faced with the diagnosis of the persistence of huge deficiencies in the health sector, seen in insufficient public spending, poor use of resources, the direction of most health spending towards curative activities in specialised levels of care, excessive private spending and a high proportion of the population unprotected, the Health Ministry in 1997 initiated a new process of reformulating the National Health Policy. This reform defined the roles of the State in health and the basic guidelines of health policy in inter-institutional and sector contexts. The central axes were: a) superintendency; b) equitable access (insurance and financing); c) decentralised service provision, and d) health promotion (PAHO, 2001a).

Meanwhile, prior to the constitutional reforms, in 1994, Decree N° 523 (09/09/1994) had established the Free Maternity Law, born out of the definition that "it is the State's obligation to protect motherhood and protect the child from the moment of conception, guaranteeing the conditions necessary for its mental and physical integrity", and "that it is necessary to grant public health institutions the essential resources for them to provide real and effective free maternity services to Ecuadorian women". This first law specified that every women in Ecuador giving birth in a hospital, centre or public institution would have the right to totally free childbirth (Article 1); in addition, it defined in general terms that the MSP would cover all costs and that the source of the funds would be a special tax on alcoholic drinks, sodas and cigarettes, as well as other investments of international cooperation resources in this area. But, for political and administrative reasons, this law never came into effect, and remained pending until it was reformed in 1998 as a result of the State modernisation process and of the health sector reform.

The reforms to the Free Maternity Law took place in the context of a broad discussion of social security reform and of the new health policy. A cooperative process including various institutions, among them the National Council of Women (CONAMU), the MSP, the CONASA, the World Bank (with a Health Care Services Modernisation project – MODERSA), the PAHO and the Responsible Parenthood Centre (a non-governmental organization – NGO), led to the new law called "Reform Law for the Free Maternity and Child Care Law" being formulated (Decree N° 381, 10/08/1998).

This law proposed a new model of health care aimed at improving access to services for women and children;

improving mother and child morbidity and mortality rates; guaranteeing comprehensive reproductive health care; diversifying service providers; achieving the participation of the health care services, municipal governments and community organizations in managing resources, and strengthening the participation of civil society in decision-making and the social control of service quality (CLADEM, 2003).

The first article of the Law declares: "Every Ecuadorian woman has the right to free, quality health care during pregnancy, childbirth and postpartum, as well as access to sexual and reproductive health programmes. Likewise, health care shall be provided without cost to newborn babies and to children under five years of age, as a public health activity, responsibility of the State".

It also defines the creation of a Health Solidarity Fund (in the same Decree 381), for financing the Free Maternity Law, made up of state resources, coming from taxes and programme funds, and from international cooperation funds. This Fund is made up of general resources from the State, from employees and employers in the formal labour market, as well as employees in the informal sector, as soon as they enrol in the IES, and through donations and loans from national and international organizations. It also creates, as a decentralisation measure, the Local Management Committees of the Local Solidarity Fund (Article 5c of Decree 381), which are in charge of coordinating (federal and local) resources for financing the implementation of the Law, and are liberty to add health service provision, as required from the local epidemiological and socio-economic analysis of Provincial Health Departments.

Fresh modifications were incorporated to the law up the year 2002, broadening the coverage of the beneficiaries and the kinds of services considered free. The Free Maternity Programme currently considers as beneficiaries women of fertile age and their partners, pregnant women, healthy and sick newborns, those under five years of age, and women from 35 to 64 years of age, for the detection of cervical cancer.

But implementing the law in the whole of Ecuador has been limited by the fragmentation of the system, the lack of guarantee of the resources for maintaining the programmes and the lack of communication between the sectors involved. For example, up to 2003, the Local Solidarity Fund Management Committees, responsible for managing the financing of the activities included in the law in Ecuador's different cantons (administrative divisions of the state), have still not been put into effect in all of them, and there are wide sectors of the population still excluded and protected (El Mercurio, 2003).

The alternative report presented to the *Convention on the Elimination of all Forms of Discrimination Against Women - CEDAW*, in July 2003, describes how the Free Maternity Law currently has severe limitations to its fulfilment due to the lack of resources allocated by the state and the lack of organization of their decentralization.

The Free Maternity Law and its reform have not been effective in reducing maternal morbidity and mortality indicators. There have been many difficulties in the implementation of the regulations. Resources collected by the Health Ministry have been directed to purposes different from those legally stipulated. There has also been a lack of political will, especially as regards the decentralisation of the health system, which means that services at a local level do not have the equipment or the medicines to meet demand. Less than 15% of the services included in the Free Maternity Law are really without cost. Hospitals and health centres charge users for services included in the law, or oblige them to buy the supplies necessary for their care (CLADEM, 2003).

During 2002, the National Health System Law was promulgated, as a new instrument for building a universal health system, as the multiple previous attempts to guide the system in this direction were hampered by the fragmentation and segmentation of the sector into various components, paralysing the execution of the programmes.

Also during 2002, the “General Framework for Structural Health Reform in Ecuador” was published, defining the new National Health Policy, and the National Health Agenda, as well as detailing the National Health System Law. In its explanatory leaflet, the intention is stressed to put a “Comprehensive State-Guaranteed Health Plan” into effect for all the population, within a social protection strategy based on the universal right to health (MSP 2002), aimed at extending public social insurance.

In this context, the Free Maternity Law is considered as an initial experiment in allocating resources following a plan of services established for a specific group, and the possibility is being evaluated of it becoming a Mother Child Insurance to the extent that this insurance model has been defined as a Social Protection strategy (MSP, 2003).

THE CASE OF BOLIVIA

During the first half of the 80s, Bolivia went through an acute economic crisis, marked by a steady fall in GDP and hyperinflation. The crisis was aggravated by the problem of the foreign debt, adverse climatic factors, political and social crisis and inefficient macroeconomic management (Jemio, 1999). Between 1980 and 1985, the accumulated fall in GDP reached almost 10%, while in September 1995, annual inflation was 25,000%. The situation led the government of the time (President Victor Paz Estenssoro), in August 1985 (promulgation of Supreme Decree 21.060, of 1985), to apply a radical, orthodox-type, economic stabilisation plan, converting Bolivia into one of the first countries in the region to initiate this type of stabilisation plan. It included, among its most important measures, the devaluation of the official exchange rate, opening up the economy by means of general reduction of tariffs, liberalisation of interest rates, free negotiation of work contracts in the private sector and fiscal adjustment.

The essence of the plan was maintained from 1985 to 1993,

including the government of Paz Zamora (1989-1993). But during the government of Gonzalo Sánchez de Lozada, as from 1993, it broadened and deepened in scope. Most recent reforms include a programme for capitalising public companies, pension, education and health system reform, together with the decentralisation of public investment and popular participation.

The reforms, especially with the stabilisation plan, managed to control the inflation rate, which in 1993 was one digit, and has remained at that level since, to recover a very modest, but sustainable, economic growth rate, and to increase exports and the investment rate. However, the economic growth rates are still too low to improve the standard of living of the population substantially, and there is no certainty that these reforms will achieve the aims of speeding up growth and reducing the poverty indices (Jemio, 1999).

Bolivia currently has one of the highest levels of poverty in Latin America. The Population and Housing Census of 1992 showed that 70% of the population had unsatisfied basic needs. Moreover, at the end of the 90s, 63% of the population was still generating family incomes below the poverty line. Bolivia also has enormous geographical and cultural diversity which creates great difficulties for organizing the social structures of the state. The most important features of the political processes in recent years are: crises of governability, loss of legitimacy of the political system and its institutions, absence of national projects with relative margins of autonomy, very marked by the agenda and the agents of the international community (PAHO, 2001b).

The levels of political exclusion have provoked a growing demand for democratisation, expressed mainly in the growth of and intense participation in indigenous movements. The social conflicts and political instability, especially since 2000, have led the country to political and economic stagnation.

The health system in Bolivia consists of the public sector, that covers about 25% of the population, the Bolivian System of Social Security (SBS), with a theoretical coverage of 15 to 20%, and the private sector (traditional and non-traditional), that supposedly provides coverage to the rest of the population (Maceira, 2003:6). The traditional private sector is made up of non-governmental organizations (NGOs), voluntary institutions, private insurance and pre-paid medicine companies, which cover approximately 19% of the population. Given the cultural diversity, the presence of traditional medicine is very important and is considered part of the health system: it is estimated that 10% of the population make use of these services (PAHO, 2001b). After the social conflicts at the beginning of 2003, the organization of the executive power was modified and the MSP became the Ministry of Health and Sports.

The SBS provides health coverage for employees in the formal labour market and their families, and its financing and management structure is separate from the retirement and benefits programs. It is made up of eight Health Funds,

of which the National Health Fund is the largest, covering 85% of those insured, mainly public administration officials. The other Funds, organised by branch of production, have a captive population in accordance with the Social Security Code of 1956, which regulates their creation and defines which Fund the employer has to make the contributions to, which make up 10% of total wages. All the Funds are subject to the regulation of the Ministry of Health, and to monitoring by the National Social Security Institute (INASES). Each Fund is autonomous as regards its management, collects its contributions and administers the resources in a centralised way, providing health care services through its own resources and infrastructure. These services include coverage of common diseases, maternity and short-term professional risks, and there is very little subcontracting of services to third parties (Maceira, 2003:6).

At the start of 1993, together with the structural reforms, efforts began to reform the Bolivian health sector. In 1994, the government began a process of redistributing functions between national, departmental and municipal levels, and this is still under way (Laws of Popular Participation and of Administrative Decentralisation). The main aim was to push forward focused policies and the main tool for increasing health coverage was public insurances, which led to the institution of the Mother and Child Insurance, and the Old Age Health Insurance. For numerous reasons, these initiatives did not manage to meet the expectations that gave rise to them. The mother-child concept, based on a risk approach, was what marked the normative and operational activity of what would later become the Women's Comprehensive Care Programme.

The Economic and Social Development Plan (PGDES) fixed for the 1997-2002 period what were to be the four pillars sustaining government policy and the structural reforms: equity, opportunity, dignity and institutional development. These reforms were situated in the context of the changes undertaken in the country in recent years and sought to encourage a political and operational process that was economically sustainable.

In the normative plan, the health reform was guided by the pillar of equity, aimed at the fight against poverty, and was implemented as from 1997, with the aim of "improving the indicators of human development in the health area". The dimensions given priority in the reform proposal were: a) institution of the Basic Health Insurance; b) management commitments, c) establishment of the so-called "epidemiological shield", and d) deepening of the decentralisation process. The three lines of strategy defined were: a) reduction of maternal and child mortality; b) prevention and control of prevailing endemic diseases; c) strengthening of institutions, and d) health system decentralisation.

In fact, the National Mother and Child Insurance had been instituted since 1996 (D.S. N° 24303/1996), designed to widen coverage and eliminate the economic barriers to access to public health services in the care of pregnancy,

childbirth and puerperium. It also included care of some of the prevailing pathologies in the group of children under five. This insurance was operating until 1998, when the Basic Health Insurance was created, that also included the aim of improving provision for mother and child, and even with increased contribution of resources to the municipalities for this purpose (Government of Bolivia, 2003).

The Basic Health Insurance (SBS) was thus instituted as the main health sector reform policy at that time (Supreme Decree N° 25.265/1998) and became a broader package of basic health services for children, women and the population in general, offered through the network of health establishments of the Ministry of Health and Social Insurance, as from March 1999.

On November 21st, 2002, the Bolivian National Congress passed the Universal Mother Child Insurance Law (SUMI) (Law N° 2.426/2002), which was universal, comprehensive and free, replacing the SBS, and came into effect on January 1st, 2003. This insurance forms part of the Bolivian Government Plan of National Responsibility (2003), formulating the new National Health Policy. Its aims included free and comprehensive care for all the pathologies that could present in pregnant women up to six months after childbirth. At the same time, without cost to the family, all children under five years of age would be attended for all the pathologies that might occur, including, in both cases, surgeries, diagnostic tests and medicines at all care levels. This new insurance aimed to respond to the urgent need to quickly reduce maternal mortality and that of children under five. The SUMI is considered the "vanguard" of the expansion of health care services coverage, with (theoretical) prospects of opening it up to all the population and, together with the Local Health Boards (DILOS) to be created, constitutes the first step in the reform process that is currently under way in Bolivia.

THE CASE OF PERU

Peru did not escape the crises that hit the countries of the region in the past decade. The governments of Alan García (1985-1990) and Alberto Fujimori (1990-2000) were marked by great economic crises, political and social instability and high levels of corruption that kept the country underdeveloped. After his election, in 1992, Fujimori maintained himself in power with a "self-coup", promoting the breakdown of constitutional order (he dissolved Parliament and decreed the intervention of the judicial branch). Despite this, he was re-elected in 1995 in direct elections and re-established institutional order, starting a tough economic adjustment policy (the "Fujimori shock therapy"), following lines agreed with the IMF (CIDOB, 2001).

Until 1997, economic growth was based on fiscal and monetary austerity, restructuring of public spending, reinsertion in the international economy and incentives to private investment, stimulated by the significant reduction

in violence in the country and market deregulation. As from 1998, economic activity contracted sharply due to internal social and political problems, mainly denunciations of corruption involving Fujimori and his advisers, added to the effect of external factors such as brusque capital outflows associated with international financial crises, environmental catastrophes and variations in the prices of main export products. For this reason the GDP per inhabitant fell greatly during 1998 and 1999, with a slight recovery in 2000 (PAHO, 2001c). The political and institutional crisis ended with Fujimori's flight abroad, while in 2000 54% of the population was considered poor.

With the departure of the ex-president, a transition government was set up after new democratic elections in 2001.

As well as the serious political problems, among the institutional weaknesses that hindered improving the achievements of the adjustment policies, and thus the country's social and economic indicators, there were problems of inter-sector coordination and duplication of activities, absence of superintendent capacity in social sectors, deficient focalisation, regressiveness problems in spending and lack of transparency, lack of state planning, management quality problems in social programmes, postponement of a real decentralisation, functional weakness of the Interministerial Committee on Social Affairs (CIAS) and a lack of articulation of social policy with the economic development policy (PAHO, 2001c).

The main current social and political problems in Peru are connected with poverty, highly associated with the lack of jobs, the broad ethnic and cultural variety with incomplete integration, and a great dispersion of the population especially of Andean and Amazon communities.

The Peruvian health system is a complex mixture of a public sub-sector, running various programmes, and of a wide private sector, which follow an independent course with little coordination between them. Among public bodies is the Ministry of Health (MINSA), that provides services to the poor sectors with a coverage of 40%, the Social Health Security (ESALUD), that covers workers from the formal sector of the economy (20% of the population), concentrating on the main cities of the country, and the services of the Armed Forces (3%). On the other side, the private sector basically consists of private clinics, private health insurances and consulting rooms financed by the direct payment of patients and families, that cover nearly 12% of the population. 25% of the population is estimated not to have health coverage, and nearly 70% of the rural population has no basic services in general (MINSA, 2002).

At the start of the 90s, the government tightened up public administration as part of the State reform process, in order to gradually reduce its participation in the administration of goods and services and reinforce its monitoring and regulating role, which started off the modernisation of various sectors, among them the health sector. Health sector reform took place inside the MINSA

and, to a much lesser extent, in ESALUD. The outlines of the reform were: (a) universal access to public health care services and to individual attention; (b) modernisation; (c) restructuring of financing, provision and monitoring functions; (d) prevention and monitoring of priority health problems, and (e) promotion of healthy life styles and conditions. The main aim of the reform was to guarantee a basic plan of individual attention and of public health for all the population, combining a regime of partial or total subsidy by the State for the poorest population, with a contributory regime for employees with capacity to pay.

To achieve these objectives, the separation of government functions was proposed – financing, administration and provision of services, and the search for new financing, management and spending schemes, and taking maximum advantage of the physical capacity installed in the public and non-public sub-sectors through agreements and ways of selling services.

The health sector reform process in Peru can be divided into three stages. The first began between 1991 and 1994, when the priority was the recovery of the health care services system from the operating collapse of the end of the 80s, for which cost recovery strategies were included for hospitals and establishments of the first level of care (World Bank, 1999a). Thus, the Basic Health for All Programme (PSBPT) appeared in 1994, enabling a great expansion to take place in the supply of services and human resources in rural zones (PAHO, 2001c).

The second stage, from mid-1997, consisted in applying the initial reform experiences in different health regions and sub-regions. Strategies such as the Local Administration Committees (CLAS), Health Care Services Network Management Agreements, Health and Basic Nutrition Programme, Health Care Services Strengthening Programme, and Social Participation in Health Care Services Administration, were thus implemented temporarily and partially.

During the third stage, as from 1999, the problem of the cost of health care services for the poor began to be faced, with the introduction of subsidy schemes for selected groups, such as the Free School Insurance (SEG) and the Mother Child Insurance (SMI).

The SMI thus originated as a contingency strategy for reducing maternal and perinatal morbidity and mortality, and was based on improving the quality of supply and financing demand.

Both projects had the technical and financial support of the World Bank and of the Inter-American Development Bank, as they were part of the activities that both institutions proposed for overcoming poverty in the developing world. However, despite the support provided, the funding of the SEG and of the SMI, declared priorities by the then authorities, reached only 90 million soles per year, i.e., scarcely 5% of the Health Ministry Budget. Among the causes of this were the vulnerability of the spending on the poorest, and the channelling of international cooperation

resources without coherence with the priorities and needs of public health in the country, as a consequence of the lack of a strategic guideline proposal by the Ministry of Health (MINSA, 2003).

Later, as from the promulgation of the new Health Law at the end of 2001, (Law N° 27.657, of 2001), the comprehensive health insurance (SIS) was created, that grew out of the fusion of the SMI and the SEG, as a measure to save management resources and gradually extend coverage to the whole country.

Given the historical characteristics of the health system in Peru (disjointed functioning, duplication of investments and efforts) and to ensure that implementation of the SIS, on August 13th 2002, the Executive Power promulgated the Law No. 27.813, which created the National Coordinated and Decentralised Health System (SNCDs). The first steps of this reform began with the creation of a high-level commission in charge of the organization process, coordinating policies and articulating proposals from all the sector institutions. In October of that year, laws were promulgated on SIS funding sources, and the National Health Council (CNS) was set up, as a body to give life to all the activities of the SNCDs. This is one the main state reforms that the INSA has promoted in recent decades.

The SIS, that started operating in January 2002, is a subsidised health care insurance, focused and directed basically for the population with scarce economic resources and who have no type of health coverage. It is conceived as a social programme aiming to reduce economic barriers of access to services. Through four benefit plans, this health insurance attends children from 0 to 4 years of age, school-age children from 5 to 17, pregnant mothers, directors of community canteens, the Glass of Milk Programme, Mothers' Clubs, informal workers and adults in emergency situations (El Peruano newspaper, 2002). It includes individual type preventive activities (prenatal checks, child growth and development monitoring) and recovery services in outpatient consultancy services, emergency, hospitalisation and surgery, including medicines and supplies, laboratory tests, diagnostic imaging, any special procedures required and burial coverage.

Despite multiple efforts to continue and gradually increase coverage of services and beneficiaries, during 2003 it was difficult to increase the budget and the mother and child segment was the one most affected by the limitations on resources.

THE CASE OF ARGENTINA

Argentina is no exception to the complicated panorama suffered by the Latin American and Caribbean region: the

debt crisis and successive adjustment policies, applied intermittently in the past 20 years in the country, drastically restructured the economy in the context of a transformation process that is linked to the real, political or ideological decay of the fragile historical welfare state (Findling, 2002).

The economic ideas, centred on restoring the market as the guide of social life and on redefining the ambits of state intervention at the end of the 90s, brought as a result a growing instability from economic opening up, privatisations of public companies, and state and financial deregulation. This policy led to uneven growth patterns, regressive income distribution, high indices of poverty and indigence and a greater social exclusion associated with unemployment and labour precarisation. The exit from the convertibility and the abrupt devaluation provoked a drastic fall in wage levels, a strong increase in prices of basic products and a greater number of poor people. During the 90s, and despite the price stability and some years of economic growth, poverty increased in parallel with greater inequality in incomes and a sharp process of wealth concentration. By 2002 poverty was estimated to reach 53% of the population in the whole country, as 24.8% of the people were not in a state to cover the minimum threshold of a basic basket of foodstuffs (indigents made up 47% of the poor). The distribution of poverty is quite varied in the country (Demographic Census, 2000; INDEC, 2002 *in* Findling *et al*, 2002).

Health care in Argentina is channelled through three interrelated sub-sectors – the public sector, the social security⁴¹ and the private sector – that share the financing, production and provision of services. The health policies implemented over time have structured a system whose most striking features are fragmentation, inequality and differentiation of coverage and client groups.

The health sector reforms of the 90s took place in the context of the profound fiscal crisis and the growing sector costs of the 80s, as well as being inserted in the general framework of state reform. Basically, four overall lines were defined for health policies: to achieve the right to health for all the population, with the implementation of a system based on principles of equity, solidarity, efficiency and quality; improve access, efficiency and quality of health care, by extending coverage to all the population; reduce avoidable risks of falling sick or dying, with health promotion and protection activities, and redefine the role of the national state, strengthening the process of federalisation and decentralisation. However, the concrete measures put into effect concentrated on containing costs and were guided by macroeconomic objectives. The main reform strategies applied during the 90s consisted in

41. Social security in Argentina includes three types of institutions: the national social services, organised by branch of productive activity; the provincial social services, benefiting provincial public employees, and the Comprehensive Medical Assistance Programme (PAMI), designed to cover pensioners and retired people (Findling, 2002; Alonso, 2003).

completing the decentralisation (started at the end of the 70s), in promoting self-management in public hospitals and in the deregulation of social security affiliation conditions. *Advances in regulation concentrated on unifying contributions, defining a basic package of services, and the creation of a national programme to guarantee the quality of health care and a superintendency of health care services* (Alonso, 2003:4).

The decentralisation process was completed at the start of the decade and the authors state that the main theme was *the pursuit of financial objectives, with little attention to the requirements of efficiency and equity* (Cetrángolo and Devoto, 1999 in Alonso, 2003:4). In addition, the provincial systems are fed by their own and federal resources, which implies disparities in the allocation of federal resources, *as the provinces with unsatisfied basic needs (UBN) or lower geographical product do not necessarily receive a greater proportion of resources from central government* (Maceira, 2002 in Alonso, 2003:4).

The Social Services, which constitute the base of the social security organisation, are having grave financial difficulties to be able to guarantee an obligatory insurance for the formal wage-earners and their family group. One part of social security spending is financed by items of the general state budget, either from the nation or the provinces, and most is covered by funds originating in taxes on labour. Although they are legally private bodies, given the origin of their resources, their activity forms part of public health spending and they are financed with contributions on wages. The structure of the system covers almost 50% of the population (it is estimated that this was 42% in 2002), reproducing the current inequalities in income in economic activity, and access shows a high degree of heterogeneity. In this way, there are significant differences between the size of the Social Services and their average monthly income *per capita* (Findling *et al*, 2002).

The transformation process of the Social Services (called *reconversion*) was initiated to legitimise the transformation caused by the financial crisis that affected them, that had been building up since the 80s, related to the redefinition of contract mechanisms, new management technologies and the establishment of joint ventures (Belmartino, 2000; Findling, 2002). The government projects of Social Services reconversion in Argentina are situated in the context of the deregulation process in this sub-sector. The main argument for reform was to increase the efficiency and effectiveness of the institutions deregulating their workings. The idea was based on replacing the concept of captive population for one of free choice, with deep changes in the link of the beneficiaries with their health care services provider. But

many proposals have been blocked by the iron corporative logic of the main actors involved in the system. The axes of the process (planned in 1993, but put into effect as from 1997, by means of decrees and specifically omitting the Legislative Power) are based on: a) introducing free choice for the affiliates between trade union Social Services; b) creating an Obligatory Medical Programme (basic basket of health service provision) for the affiliates to Social Services and to private pre-paid medicine companies; c) improving the inequalities of income between bodies through compensation from the Redistribution Solidarity Fund, and d) creating a Reconversion Fund financed by the World Bank to improve the efficiency of the bodies (Findling, 2002).

A large part of the population in situations of poverty in Argentina have grave problems of access to health care services, with geographical, administrative and economic barriers to access being the most frequent ones. All these obstacles could be overcome with a better organization of the services. There has been no service planning at primary care level, where they are provided with overlapping in some areas and insufficient provision in others; the organization grows out of multiple initiatives, by provinces, municipalities and NGOs, with services that are heterogeneous in their levels of complexity. People also have a negative image of this first level. A majority of the population who use the public system ignore the entry door located at the primary care level and go directly to the hospital services (Belmartino, 2000).

Most of the out-patient services are situated in the areas of greatest poverty and are municipal. There are multiple means of financing: municipality, province, private institutions, cooperatives, patients who purchase voluntary bonds. This institutional heterogeneity, with varying capacities for resolution, forms of organization and possibilities of financing, generates a significant deficit in the coordination of health care and encourages erratic behaviour in seeking medical attention, seen in the population under its care (Belmartino, 2000).

During the 90s, a series of vertical programmes were also created in the Health Ministry, including some dimensions of reproductive health and, in certain cases, combining internal and external resources, joining the Ministry units that were already working with mother-child health and health education, and coexisting with almost no articulation with other initiatives in different areas of national government (Alonso, 2003:5).

The reform policies for the provincial health care services systems began in the 90s in Argentina, in general with the advice and financial support of the World Bank and the Inter-American Development Bank.⁴² In some of them

42. The World Bank has an active support programme for the health area in Argentina, based on loans: a) Reform of the Social services and PAMI, as well as the strengthening of the regulatory framework of the social services and the pre-paid systems (PROS - Social Services Reform Programme and SAL - Structural Adjustment Loan); b) Strengthening of the provincial public health system (PRESAL - Provincial health sector reform programme); c) Reform of the provincial health insurance system as part of a broader reform programme (Provincial Reform Programme II); d) Improvement of nutrition and mother-child health (PROMIN) (Health in Argentina, "Fighting poverty through better health" http://alc.gdln.org/sectores/salud/documentos/Lavadenz_BancoMundial_mortalidad_i (consulted December 15th, 2003).

organization strategies of service systems were defined, based on demand subsidy through widening the beneficiary population of the Provincial Social Services, incorporating the indigent population, the traditional users of public institutions, which formed a first model of Provincial Public Health Insurance. In 1999 there was a discussion with World Bank representatives about setting up pilot experiments in public insurance for indigents in the provinces of Rio Negro and Salta. Nowadays, after some years of discussion and tests of different projects of this type in different provinces, it can be pointed out that there are no consistent results that enable hopes to be raised about strengthening these change processes (UNDP, 2003).

The antecedents of the Public Mother-Child Insurance in Argentina are rooted in the Mother-Child and Nutrition Programme (PROMIN), operating since 1993, and in the regular Mother-Child Programme (PMI), financed by the World Bank. Operating since 1994, both are within the jurisdiction of the Health Ministry (MS). These two Programmes carry out parallel and relatively coordinated activities, but do not manage to meet the demand of the neediest sectors of the population, and this situation worsened even more with the economic crisis the country went through in the period 2001-2002. The implementation of the programmes is determined by the institutional capabilities that each particular territory possesses and by the way the services are organised.

The PMI has developed norms, intervention strategies and intervention instruments, but has not progressed in supervising and evaluating the meeting of goals and results, and also faces administrative type obstacles for executing the funds transferred by the nation to the PMI. In relation to the PROMIN, the activities that it proposes in addition to those developed by the municipal Secretaries of Health and Social Action have had difficulties linked to the transformation of the care model in these services. Meanwhile, in general terms, the changes produced have eased an implementation that can be considered successful in most of the effectors.⁴³

According to Health Ministry reports, both programmes present different strengths and weaknesses that derive more from the differences in their modes of intervention than in their aims. While PROMIN has shown great potential in promoting and strengthening processes at the level of municipal health services, the PMI has had impacts – if uneven – at regional levels. The deficits of PROMIN – given the focus of the programme on defining PROMIN and non-PROMIN services and municipalities – may work in the future against its sustainability once the assistance has been withdrawn deriving from subprojects of investment by the World Bank (idem).

According to what was signed in the loans for sector

programmes, the Argentine government committed itself to reduce drastically the indices of maternal and infant mortality through specific, focused activities on a national scale, guarantee the access of all the population to medicines and organize the acquisition of the essential supplies for preventing diseases, and for the recovery and rehabilitation of the health of all Argentines. In this context, one of the first measures adopted by the Health Ministry was the implementation of Public Mother-Child Insurance, universal in intention, and which began to work, as a first stage, in the province of Jujuy, without great results, and more recently there is an attempt to implement it in the province of Buenos Aires. The intervention packages are varied and defined autonomously by the provinces. But the idea is to extend their coverage in the near future to the country as a whole (UNDP, 2003).

THE CASE OF MEXICO

As happened in other countries in the Latin American region, the health sector reform coincided with structural adjustment policies, when the government accepted the conditions of the creditor banks that included a new role for the State in the social sector, including that of health. It is also linked to restructuring of the State and the development model still under way. *The conditions imposed by the structural adjustment, to some extent, coincided with the interests [of the government] ... the Immediate Reorganising Programme (PIRE) announced in 1982, was an indicator that the Mexican government had accepted the severe IMF programme, known as the "orthodox shock plan", which had strong repercussions in the health sector* (Pego and Villafuerte, 2003:5). The resources destined for health and the social sector were significantly reduced and the programmes suffered interruptions. The so-called Structural Reform (1982-1988) brought changes in the Constitution, in the Health Law and in the Organic Law of Public Administration. One of the most important programmes in this period, formulated to overcome the restrictions provoked by the economic policy, was the Health Care Services Support Programme for the Open Society (PASPA), the negotiation of which started in 1987 and lasted till November, 1989. With this Programme *a new dynamic began to resolve the problems of poverty by focusing on groups in extreme poverty with resources from loans from the World Bank and from the International Bank for Reconstruction and Development...[this Programme] also represented the start of a trend to attend grave public health problems through a closed package of services, defined not on the basis of demand from potential beneficiaries, but by technical groups from the government and from the international financing agencies* (Pego and Villafuerte, 2003:9-10).

43. Presentation by Ernesto Báscolo in the "Public Health Insurance Conference", promoted by the Rosario Medical Association and the CEES, Rosario, Argentina, May, 2003.

In the mid 90s, the new Health Sector Reform Programme inaugurated another stage in this process. The new sector reorganization reflected the project of the group from the Mexican Foundation for Health (Funsalud) based on a theoretical model called “Structured Pluralism” (Almeida, 1999; Pego and Almeida, 2002), which brought conflicts and adjustments to the initial proposal. The decentralisation proposal was taken up again *joined to the introduction of a Basic Package of Health Services (PBSS) through the Coverage Expansion Programme (PAC), financed by the World Bank, assistentialist and selective in character, to take services to the most marginalised zones* (complemented with) *the Programme of Education, Health and Feeding (PROGRESA) directed to families in extreme poverty under the strategy of co-responsibility that conditioned the beneficiary families to a set of obligations* (Pego and Villafuerte, 2003:11). At the same time, the increasing tendency of the participation of the private sector and the insurance companies was consolidated and the Specialised Health Services Institutions (ISES) were created, to link up the service providers with the “consumers”, to regulate the private medical insurance market. Simultaneously, the reform of the Social Security Law was applied, instituting single quotas for all the insured parties and transferring the handling of social security funds to the private sector. Meanwhile, all these changes did not manage to promote a new organization of the sector (idem).

At the beginning of 2002, as part of the health system reform process, a pilot programme was put into operation in five states, called Popular Insurance, consisting in applying a public subsidy for financing health service provision for families that had no kind of social security.

In April 2003, the Union Congress approved reforms to the General Health Law, creating a Social Protection System, complementary to social security, and focused in non-wage earning people who were not protected by the Mexican Institute for Social Insurances (IMSS) and the Institute for Security and Social Services of State Workers (ISSTE). These reforms gave formal birth to the Popular Insurance (SP), which was proposed to be put into effect in all the federal entities of the Republic.

Affiliation to Popular Insurance will be gradual over seven years, in each of which 14.3% of the potential beneficiaries will be incorporated; it is voluntary and with tripartite quotas – one part is covered by the federal government, another by the state government and each family makes a contribution according to its economic possibilities. The medical service is provided by the State Health Secretaries.⁴⁴ In practice, it is configured as a public subsidy.

This insurance programme for medical assistance provides a service package that could potentially reduce the direct out-of-pocket spending and the catastrophic spending

on health problems that puts families that have least at risk of impoverishment, while supposedly protecting them from diseases.

The general aim of the Popular Health Insurance, then, is to provide a certain financial protection to the population without rights, by means of a voluntary public health insurance, with financial co-participation from the citizen. Its specific aims spelt out by the government are: to reduce private out-of-pocket spending, to cut the risk of the impoverishment of vulnerable families, to encourage timely health care, to strengthen the public health system, to overcome the gap between holders of rights to social security and those who are not, and to contribute to overcoming inequalities and delays in the distribution of spending between federal agencies.

But up to now, even though there has been wide publicity about the insurance in all levels of government, it has generated a fierce debate and strong rejection by the health unions and other social actors, considering that it goes backwards in the subject of health social security, since it asks the families to invest financially in an insurance that the State has the constitutional duty to provide.

Its implementation is just beginning and at the end of 2003, coverage reached 623 thousand families, which represents 2.5 million inhabitants in 24 states. Up to January 2004, there were 11 federal agencies incorporated in the programme. It is hoped that at national level, in 2004 it will reach the goal of affiliating 1,700,000 families.

SOME OBSERVATIONS

The little time since the implementation of these insurances in the region and the failure of these initiatives in some countries means that no conclusive evaluation can yet be made.

However, as we said above, we can confirm that, in general terms, historically in Latin America the health systems are characterised by significant fragmentation and great segmentation, whether in financing or in service provision. Universal social security has never been effectively consolidated in the region, except in a few countries (such as Costa Rica), which means that the social insurance system in general, and health in particular, is a compartmentalised structure, limiting the possibilities of sharing risks between different social groups or those with different health needs, or revenue transfers between sub-sectors (Maceira, 2001, 2003; Almeida, 2002). In addition, *the different insurances or subsidies designed in the region do not consider the need for these mechanisms* [or do not manage to implement them], *limiting their impact over time.* (Maceira, 2003:2). Examples are frequent in the entire region (Bolivia, Argentina, Chile, Colombia, and Uruguay, among others). The schemes put into practice lack financial

44. Health Secretariat of Mexico, <http://www.ssa.gob.mx/seguropo.htm> (consulted December 15th, 2003).

sustainability, and end up encouraging adverse selection by users and risk selection by insurers, promoting the consolidation (or creation, as in Chile and Colombia) of dual (or even more fragmented) systems of insurance. The public mutual sub-system is then “creamed off” by the private insurers, and overloaded with the demand for care, reducing significantly (or impeding) the possibility of articulating a fair response to the needs of the population.

A social security is defined on the basis of at least four characteristics (based on Maceira, 2003:2; Almeida, 2003): a) a defined pattern of beneficiaries; b) the establishment of a known and accessible package of services, available for any user of the system (or citizen); c) universal criteria of insurance in the design of the care system, in the financial management of funds and in the organization of insurers and service providers, so that cross subsidies between healthy and sick people are identified; and d) criteria of solidarity in the make-up and financial handling of the funds, with the existence of cross subsidies between higher and lower income groups, with this feature being what distinguishes a traditional or private insurance system from a health insurance social system or a public health insurance.

None of these “public health insurances” or “child maternal insurances” that have been being implemented in the region meets the minimum requirements that identify the concept of social security, as we briefly saw in the cases presented. In reality, these initiatives use the name of “public insurance” without any conceptual meaning, as they constitute *essentially varieties of subsidies* (Maceira, 2003:4), i.e., the definition of a package of basic services for specific population groups, as a way of trying to mitigate the serious consequences of poverty and of the lack of coverage in terms of social (and health) policy.

Likewise, Latin American experiences with these forms of focalisation have not been effective, for various reasons and especially:

1. That they give privileges to and strengthen dual health systems in societies already marked by perverse segmentations, i.e., these proposals aim at resegmenting within already existing structural segmentations.
2. Stigmatisation of specific groups with the label of poverty, with the risk that they do not register for the benefit.
3. Risks of worsening inefficiency and in the quality of the care, whenever these service packages are insufficient to meet the care needs of the beneficiary groups, tend to encourage demand and increase costs in a differentiated way, loading referrals on to the public sector, above all in

the more sophisticated and more expensive interventions.

4. Difficulties in defining the eligibility of the beneficiaries differentiated among the neediest (poor), and the composition of the “packages”, since investments must be made in information systems and in the identification of beneficiaries.
5. Problems of incentives, segmentation, fragmentation and plurality of funds, generating opportunistic behaviours and perverse cross incentives, consolidating and reasserting historical inequalities and affecting the fairness of the system.
6. Difficulties of the sustainability of the initiatives as, in general, they are financed with outside funds, partial and time-limited resources. Moreover, in the long term, there is a loss of support from the social groups that are more active, in terms of their ability to verbalise demands (these groups are localised in the formal market or in the middle class and are nearly 30 to 35% of the region’s population), encouraged to buy private health insurances, and more and more impoverished and dissatisfied with the taxes to be paid.
7. Problems with investment and (administrative and operating) transaction costs, which must be kept in mind, given the restrictions on resources and the limitations on institutional organization.
8. Consolidation of the hegemony of the traditional medical model, given that the packages concentrate on medical care, relegating public health, disease prevention and health protection measures to a second plane.

Even though defining a package of interventions in the area of medical attention may be an effective programme tool in countries with huge deficits in the population’s health coverage and, in some cases, the originally focused insurances have been broadened (as in Bolivia, that then went back on it, and as with the proposals in some of the provinces of Argentina, still being developed), the effective lack of articulation with the health system and its various levels of complexity, the lack of coordination and cooperation between the different providers (public and private), as well as the technical lack of implementation capacity, especially in terms of monitoring and evaluation, mean that *these instruments turn out to be valid as short term applications, in that they have no [social effective] insurance features, and their sources of financing are not sustainable over time. Their combination of structural mechanisms requires additional efforts from health and economic policies* (Maceira, 2003:21).

9 The case studies – Colombia, Brazil, Chile, Costa Rica and Belize – a brief comparison

Five case studies were made as part of this work, in order to discuss the different reform processes in the health care services systems, and within them, the issue of sexual and reproductive health. The countries studied were: Chile, Colombia, Brazil, Costa Rica and Belize. These countries were chosen because of their specific features, either in relation to the different health sector reform processes, or in relation to SRH.

We continue with a summary of the case studies and a brief comparative analysis of the main findings in relation to the theoretical and conceptual framework that we develop throughout this work. But some prior observations are necessary, in order to understand the context, the size and depth of each of these studies, as well as the brief comparison made.

The first point to stress is that this part of the work has methodological limitations, which are reflected in the results obtained, since the case studies were made in different countries simultaneously with the discussion of the general theoretical framework and the critical analysis of the bibliography already made on the subject.⁴⁵ In other words, there was no prior discussion of the theoretical framework to guide the elaboration of the case studies, nor a period of joint discussion, although there was, in fact, a single schema to be followed in drawing up the cases. This was the option that was possible, given that there was not sufficient time to develop the two stages simultaneously, which would have been desirable and methodologically more correct.

So, these studies and the comparison that follows them are quite preliminary approaches, since the decision taken was that the cases would be basically descriptive and would serve to support a later deeper discussion in a theoretical framework that would enable the change processes in the health care services systems and in the SRH area to be related analytically.

The second point to stress is that the case summaries and the brief comparison presented here put into consideration the more general regional analysis made in this work, and also add elements from our experience in studying the health sector reform processes in Latin America and the Caribbean. But, as far as the SRH area is concerned, the analysis is

fundamentally based on the data elaborated and presented in each of the cases, as it has not been possible at this stage to go more deeply into the discussion of each country studied.

We now give a summary of the main points of each case and then make a comparison between them. The idea of this summary is not to repeat what the cases analyse in much greater detail, but to point up the facts and data that help us to identify similarities and differences.

A SYNTHESIS OF THE CASE STUDIES

CHILE

Chile is one of the countries of Latin America and the Caribbean that present very good economic and social development indicators. After periods of instability from the mid-70s onwards, since 1987 the country has maintained a continuous economic growth process with increasing degrees of integration into the world economy, with a steady rise both in foreign direct financial investment and in Chilean investment abroad. Exports have also grown at an average rate of 9.3%, centred basically in traditional products (cellulose, fish meal, fresh fruit, wine and others) and copper, the main national product, exported without manufacture.

Different from most of the countries of the region, in the 90s its GDP grew 6.5% on average but, at the start of the new century, there was a significant fall as a repercussion of the international crisis of 1998, hitting all the economic indicators. Nevertheless, between 2000 and 2002, GDP growth was 3.1% (in 1999 it was -1.1%). This reversal of the trend is also seen in the GDP per capita, that rose from US\$1,704 in 1989 to nearly US\$5,000 in 1997, but then slipped back to US\$4,262 in the year 2002. Inflation, traditionally in two figures, has been falling since 1994, and was around 2.6% in 2002 and 2003. Foreign debt, between 1990 and 2002 went from 17,400 million dollars to 41,200 million, but it should be noted that while public sector debt dropped 29%, that of the private sector grew 482.5% (Mideplan, 2001a; 2003).

In its political administrative organization, Chile is a unitary republic with presidential government, including 51

45. The case studies were drawn up by the following writers in the various countries: Chile - María Eliana Labra and Amarilis Tapia; Colombia - Ana Cristina González Vélez and Claudia Lucía Boada Chaparro; Brazil - Celia Almeida and Eliane dos Santos Oliveira; Costa Rica - Raquel Abrantes Pêgo; and Belize - Raquel Abrantes Pêgo and Florence Lise Théodore.

provinces and 342 communes grouped in 13 regions, as well as the metropolitan region of the capital, Santiago,⁴⁶ as a result of the regionalisation process begun in 1974 with the aim of deconcentrating the central administration. The President of the Republic is represented by an Intendant in each region, supported by the Regional Ministerial Secretaries. Provincial administration is under a governor, subordinate to the Intendant, and at communal level, corresponding to a municipality, there is a Mayor and a Council, with decision-making and supervisory functions which the mayor presides. These posts are by popular election, except for the intendants and governors who are nominated by the president.

In its institutional political development, Chile became an independent republic in 1810, and has passed through four different stages, in which democratic institutions were created and consolidated, a modern liberal Constitution was drawn up and promulgated, and a political party system grew that covers the whole ideological spectrum. Between 1925 and 1973 there was a growing popular movement, with the formation of a centre-left coalition (which governed the country between 1938 and 1952), and the extension of civil, political and social rights. During the same period, the social security system was born and consolidated.

After 140 years of steady progress, the democratic political system was brusquely interrupted by the military coup of September 1973, which overthrew the President of the Republic, Salvador Allende, and put General Augusto Pinochet in his place. Under his command, the country lived in a climate of tension for 17 years, intensified by the international crises of 1974 and 1982.

Starting from the principle that the market is more efficient in the allocation of resources than the State and that this therefore has a purely subsidiary role, the military government and neoliberal economists submitted institutions, the economy, society and culture of the nation to profound transformations that were supported in the new Constitution of 1980.

On the economic plane, the country inserted itself in the international markets, diversified its exports, and modernised its agro-industry, while privatising state companies and public services. In the social field, the funds of the insurance agencies were transferred to private, profit-making administrators and the market was opened up to companies selling health plans, as will be seen later. At the social level, party groupings were abolished and social organizations in general were restricted. Culturally, the spread of individualistic, consumer and disciplinarian (and sometimes repressive) values weakened deep-rooted traditions of belonging, solidarity and participation.

The 1980 constitution included the idea of a plebiscite to be held in October 1988, for the citizens to decide about the continuity or otherwise of Pinochet. As the people voted against, the opposition negotiated intensely the constitutional reforms during 1989 that would enable the free and sovereign election of new leaders. In these, held at the end of that year, the transition began to the current phase of the political evolution of Chile.

Democracy returned in March 1990, led by the “Coalition of Parties for Democracy”. This centre-left coalition won the Presidency of the Republic and most of the seats in the newly opened National Congress. From then to the present day, the Coalition has elected three presidents, the first two of whom were members of the Christian Democrat party,⁴⁷ and the present one – Ricardo Lagos – of the Party for Democracy (PPD), from the socialist line, with a mandate which ends in 2006.

The Coalition’s priorities have been: to maintain the economic model, reduce social inequalities inherited from the military regime and to tackle with transparency the issue of human rights. However, it has not been possible to launch institutional reforms in depth in areas vital to democratic life and social justice, due to the rigid clauses of the 1980 Constitution, any changes to which are held up by the conservative control of the Senate. In other words, a large part of the institutional structures erected by the military government is still intact, despite significant progress in social areas.

In spite of the economic development, the unequal income distribution of Chilean families has not varied significantly in the past 30 years. Moreover, income concentration is still very high: in 2000, while the 10% of wealthiest households had a share of monetary income around 41%, the poorest 10% received only 1.5%, which means the ratio of family income between the upper 20% and the lower 20% was 15.3 times. This disparity is confirmed by the Human Development Report 2003, according to which the distribution of family income, measured by the Gini Index is 5.61 (UNDP, 2003).

Meanwhile, it should be noted that the levels of absolute poverty and of indigence fell by half in the 90s, passing from 38.6 and 12.9% respectively in 1990, to 20.6 and 5.7% of the population in 2000. That is, 80% of the Chileans are above the poverty line (Mideplan, 2003). The total of non-poor increased 18 percentage points between 1990 and 2000, and no significant differences in poverty terms are seen in the figures for men and for women.

The improvement in poverty conditions may be partly attributed to the cash subsidies from the public sector focusing on the poorest households,⁴⁸ which had a

46. The regions are, from north to south, Tarapacá, Antofagasta, Atacama, Coquimbo, Valparaíso, Santiago, Libertador General Bernardo O’Higgins, Maule, Biobío, Araucanía, Los Lagos, Aysén y Magallanes and the Chilean Antarctic.

47. The presidents were: Patricio Aylwin (1990-1993) and Eduardo Frei Ruiz-Tagle (1994-2000).

48. The cash subsidies are: assistential pension, family benefit, single subsidy per family, subsidy for payment of consumption of drinking water and sewage service, dismissal subsidy. (Mideplan, 2001c)

redistributive impact in the poorest 10% of households, increasing incomes by 31.5% in 2000. Out of all the subsidies granted, the Assistentialist Pension (PASIS) provides 66% of the total. PASIS is provided to persons over 65 years of age, physically disabled over 18, and mentally disabled of any age, who lack resources and are not included in any insurance system. The beneficiaries have the right to free medical attention in consulting rooms and hospitals in the public health system and to family benefits when appropriate. In 2000, PASIS benefited the poorest 40% of the population, who received 78.5% of the spending under this item. It is important to note that women received 60% of spending related to PASIS (Mideplan, 2001c).

A significant contribution to poverty reduction was also made by the continuing social policies related to housing, basic sanitation and education, which have quite high coverage (generally well above 90 or nearly 100%), as well as specific health programmes.

In round numbers, during the 90s, the percentage of men in the work-force fell nearly 3.7 points, while that of women increased 6.9 (Mideplan, 2001b). Likewise, according to information about the quarter October-December 2003, the work-force (population of 15 years old and over) was 53% of the total population, 72.1% being men and 35.7% women (INE, 2004).

In terms of jobs, in the year 2000, 46.4% of the women worked in communal, social and personal services, while only 17.3% of the men worked in this sector (Mideplan, 2001b). In terms of the job distribution by gender, Health Ministry information about the number of doctors, dentists, biochemists and pharmaceutical chemists in 2004, show that 65.1% were men and a bare 34.9% were women. Among the rest of the staff, 27.4% were men and 72.6% women.

As for unemployment, throughout the 90s the average unemployment rate was around 7%, rising to 8.5% in 2003 (INE, 2002). However, there are great disparities in age terms: in 2003, unemployment in the 15 to 19 age band was 30.5% and that of 20 to 24 was 23.6%; moreover, in the quarter October-December, 2003, the female unemployment rate was 8.2%, while the male was 6.7% (INE, 2004).

The share of men and women in work also showed differences depending on social and educational level: in the middle and high strata with more education, the women's share is 47%, while among poor women with less education it drops to 27.3% (Mideplan, 2001b).

In family terms, single women are the head in 23.1% of the households, and of these households, 16.4% are below the poverty line (Mideplan, 2001b).

To sum up, the main inequalities for women in Chile in relation to their social and work situations are related to: hiring criteria, training and retraining opportunities; lower reward for the same work as men; segregation and concentration in few sectors and in typically female jobs, or concentration in atypical, precarious jobs; little share in economic decision-taking, few promotion possibilities, and

thus a high probability of unemployment and of poverty (SERNAM 2002).

Thus, despite persistent economic inequalities, the main overall social indicators in Chile improved noticeably during the 90s, enabling the country to be classified in 43rd place in the group of countries with high human development, with a HDI of 0.831 (UNDP, 2003), and this has contributed to improving the level of health of the population.

Marked changes are occurring in the demographic dynamics: the birth rate in 2003 was 17.2 and overall fecundity 2.1, while the vegetative growth rate was 1.3. Life expectancy at birth was 72.7 for men and 78.8 for women in 2001. The difference in average life for men and women has been seen for several decades, because mortality is higher in men (Schiappacasse *et al.*, 2003:20).

The gross mortality rate in Chile began to fall significantly as from the 50s. Between 1950 and 1999, it decreased from 15 to 5.5/1,000 inhabitants. In this period there was an important change in the causes of death, as the proportion from infectious and parasite diseases fell, and deaths from circulatory system diseases and malignant tumours increased (Schiappacasse *et al.*, 2003:20). Despite this fall, the specific mortality rate from all causes of death is greater in men than in women. Maternal mortality and infant mortality are also within international parameters and are considered very good. Data about nutrition shows that, in public health terms, the current problem is of overweight and obesity among children and pregnant women, with malnutrition and low body weight on a lower plane.

Maternal and infantile mortality rates have been falling for several decades. In the 1985-2000 period, the maternal mortality rate dropped from 5.0 to 1.9/10,000 live births. The same happened with the infant mortality rate which, between 1990 and 2000, fell from 16 to 8.9/1,000 live births (Schiappacasse *et al.*, 2003:21). Among factors contributing to the improvement of the health of mothers and children should be mentioned those attributable to the broad coverage of services in the public system, and the continuity of care in pregnancy, childbirth and puerperium, with good technical and professional quality, as well as for children in the first six years of life. It is remarkable that professional care in childbirth reaches practically 100%; the early detection of cervical cancer reaches 68.3% of women from 25 to 64 years of age; the National Feeding Programme (PNAC) attends 63.7% of pregnant women and 67.7% of children under six years of age; and the National Immunisations Programme shows a coverage of 98.5% in BCG and of 94.0% in DTP (Minsal, 2002). Added to this is the focusing of health activities on the most needy. The PNAC, for example, in 1998 benefited 65.8% of the poorest households, which also received 86.7% of the subsidies for medical attention (Mideplan, 2001a).

Chile is currently one of the countries of the region and of the world with the best indicators in the field of maternal and child health, situated in the 15th place among 117

countries in the ranking of maternal health indicators, and in fourth place in the infantile health indicators (Schiappacasse *et al.*, 2003:21).⁴⁹

As for causes of mortality according to sex, among the first causes of recorded deaths are diseases attributed to modernity (circulatory system diseases, neoplasias, respiratory and digestive system diseases); in second place, the rates related to the five main causes of death favour women, except in the sixth group of poorly defined symptoms and signs, where the rate is slightly higher.

Lastly, it should be pointed out that, according to the 2000 Casen Survey, most Chileans – 65.6% - consider their health to be good or very good. Perceptions vary, however, depending on sex, age and income. In fact, despite women presenting a better health profile than men and five years more of life expectancy, in all age groups the positive response of men was greater than that of women. The same happens according to the quintile of income, even considering that the perception of good and very good health is directly proportional to income level (Mideplan, 2001d).

In relation to SRH, as numerous studies have pointed out, there is a mainly liberal discourse in Chile in economic and political matters, but there is no articulated discourse of modernity and cultural liberalism that takes account of the changes occurring in gender relations, particularly in the sexual plane. Rather, what is seen is a confrontation between the opinions and behaviours of a large part of the population and the rhetoric of conservative sectors in subjects considered taboo such as abortion, emergency contraception, surgical sterilisation, diversity in sexual orientation and sexual education, for example, not to mention divorce, that only recently is finding ways to parliamentary solution, after a decade of polemics that well illustrate the traditional values dominating the country.

In fact, a recent public opinion poll gave interesting results confirming the contradictions between the hegemonic discourse and what Chileans think. For example, 80.2% favour divorce, 93% support men and women sharing household tasks and childcare, 65% accept sexual relationships before marriage, and 57% approve the legalisation of abortion (Flacso, 2001). These positions show that there have been changes in sexual practices and in the reproductive behaviours of Chilean men and women, seen more strongly in younger groups, as has been shown in the National Youth Survey since 1994.

One first aspect to note is the earlier sexual initiation in both sexes compared with older generations: most of those interviewed (62.6%) had their first sexual relationship between 15 and 18 years of age, with 13.7% of them who had their initiation before 15. The average age for initiating sexual relationships was 16.2 among young men and 17.8 among adolescent girls. The percentage of all young people

who initiate sexual relationships between 15 and 29 years of age increased from 66 to 74 between the years 1994 and 2000. The higher the socio-economic and educational level, the later the sexual initiation, and this is particularly marked in the case of women.

The subject is of great importance because in recent years adolescent pregnancy has increased and become the cause of widespread debate in the country, sharpened by the resistance of many educational establishments to accept the dispositions of the new law of 2000 that guarantees pregnant young women continuity in their studies. It is important to point out that, despite the fall in the general fecundity rate and that the fecundity rate of women between 15 and 19 years of age fell from nearly 54 to 45 live births for every thousand women in the long term (period 1960-2002), in the period 1992-1998 a significant increase was seen in this indicator for adolescents under 18, and the relative weight of adolescent fecundity (under 20 years of age) has increased. Of the total number of births in 1978, 13% corresponded to the group of mothers under 20 years of age, while in 2001, 16.2% of births were in this group. (Minsal, 2003). In this matter, it should be considered that part of the pregnancies that started at 19 years of age and ended after 20, were not registered as adolescent pregnancy, so that there is an under-recording of the events. It is worth mentioning by the way the fact that many adolescent pregnancies end in abortion (spontaneous or induced) and, as this event is only recorded in the case of hospital discharge, the real dimensions of this problem are unknown. Another analysis worth noting is that fecundity rates among adolescents show significant geographical and socio-economic stratum variations, and are considerably higher in the communes and in the poorer social strata.

There is no comprehensive information available in Chile about the use of contraceptive methods (CM) since the only data available is supplied by public health services. According to the National Survey on Health and Quality of Life, carried out by the Health Ministry in 1999, 47% of the people used some CM, with the oral contraceptive (OC) and the intrauterine device (IUD) being the most used. The Second National Youth Survey, in 1997, showed that 57% of young people used modern CM (condoms, OCs), 17% traditional methods (calendar, *coitus interruptus*) and 26% used none, rising to 31% in the year 2000.

In brief, these surveys show that despite the intensification of the spread of CMs by the AIDS prevention campaigns, and easier access to them, the generalisation of their use by adults as well as young people depends on the socio-economic status and educational level of the individuals. Even then, more than a third of all those interviewed use CM sporadically or never.

Under the Health Ministry's Family Planning

49. Save the Children. "The complete Mother's Index and Country Rankings. USA. <http://www.savechildren.org/sown2003/MothersIndex.pdf> (consulted: 06/05/2003).

Programme, the public services distribute CMs to all women of fertile age (15 to 49 years of age), and thus adolescent boys and girls under 15 are excluded. Since 1975, there has been a rule in the public health system that enables women to gain access to voluntary surgical sterilisation under the following conditions: there should be some justified medical state; she should be more than 32 years of age (reducing to 30 if there is some obstetric risk); and/or with four live children; and also have the husband's consent. In 2000, this regulation was modified to allow men and women to be sterilised with no other requirement than their own decision and willingness.

The maternal mortality rate is low – the data show a gradual, steady fall of maternal mortality for all reasons and of deaths for abortions between 1960 and 2000 – with a steady reduction as from the 60s resulting from health policies to protect and care for the mother and the child.

Abortion is penalised in all cases in Chile without exception and the real number of abortions is unknown precisely because its practice is penalised (Schiappacasse *et al.*, 2003:40). Studies show, however, that abortion is the third cause of maternal death, with direct obstetric causes and gestational hypertension the first and second causes, respectively. Complications from abortion cause about 20% of the deaths, in spite of the harsh penalties for those who practice it. There are no official or up-to-date data on the number of abortions practiced in Chile, and for this reason the literature still refers to a 1990 study published by the Alan Guttmacher Institute, whose data about Chile is still used in modern publications. This is why, based on the estimates for that year, Chile seems to have an annual average rate of 50 abortions per 1,000 women between 15 and 49 years of age, the second highest in Latin America after Peru, with 56 abortions. (Deschner and Cohen, 2003).

Anyway, the official statistics show that both maternal mortality and specific mortality for abortions, as well as hospitalisations for this reason, are steadily falling, reflected in the general health indicators (Minsal/Deis, 2003b). Mortality rates from abortion fell drastically after the Family Planning Programme began in Chile in the 60s (from 10.7 to 0.5 deaths/10,000 live births between 1960 and 2000 (Schiappacasse *et al.*, 2003:41).

In Chile, around 60% of the sexually transmitted infections notified are in women, mainly sex workers and housewives. Most are women between 15 and 49 years of age and one in three is under 25. As from 1999, a new Sexually Transmitted Infections Monitoring System began, in which six health care services – called Sentinel Centres for Sexually Transmitted Diseases – receive the obligatory notifications. There is also a National Plan for the Elimination of Congenital Syphilis that obliges the notification of syphilis cases in pregnancy within all the health care services in the country. Syphilis detection tests are also made in the following check-ups: gynaecological, adult health and sexual trade and in persons consulting for other sexually transmitted infections (Minsal/Conside, 2000; Schiappacasse, 2003).

The accumulated incidence rate of AIDS was 37.1 cases per hundred thousand inhabitants in 2001. The age group most affected is that of men and women between 20 and 49 years of age, with nearly 85% of the cases. Cases in women have increased in recent years (feminisation of the epidemic), reducing the man/woman ratio from 28.4/1 in 1990 to only 8.4/1 in 1997 (Minsal/Conside, 2001). The main means of transmission is sexual (93.8%), then by blood (4.6%) and mother-child transmission (1.5%), and there is a National AIDS Commission to deal with the problem. The evolution of the AIDS epidemic towards heterosexualisation indicates a relatively greater growth over time of cases transmitted by sexual relationships between men and women, compared with the cases transmitted between men. The HIV/AIDS Law, approved on December 17th, 2001, was one of the first milestones of formulations and proposals in which civil society organizations worked together with members of the legislature, and the guiding idea behind the Law is based on the human rights paradigm (the affirmation of the right of individuals not to be discriminated against or restricted, and to have access to health care, which are dependent, and not contradictory situations), replacing the “infecto-contagious” paradigm (Schiappacasse, 2003:51).

Breast cancer and cervical cancer are the second and fourth causes of death, respectively, from malignant tumours in women. In women from 35 to 64 years of age, cervical cancer, together with breast cancer, represent 40% of cancer deaths (Minsal, 2003; Minsal/Deis, 2003b). Data show that while deaths of women from breast cancer has increased, those caused by cervical cancer have fallen, and this can be attributed to the coverage of preventive tests for this disease, as was already seen when dealing with health indicators.

According to the analysis of the 2000 CASEN Survey, the PAP exam showed a significant increase in coverage of women from 25 to 64 years of age, from 50.3% in 1990 to 68.2% in 2000. In both cases, test coverage was distributed in a similar way among the income quintiles. The greatest increase of coverage was noted in the public health system, which went from 48.2% in 1990 to 67.9% in 2000 (Mideplan, 2001d).

In the case of men, prostate cancer is the third cause of death from malignant tumours, and its rate has been rising in recent years: in 1997 1,126 deaths were recorded and 1,285 in 2001. In 1999 there were 4,529 recorded prostate tumour surgeries in the public system in the whole of Chile and there was a waiting list of more than a thousand cases (Minsal, 2003).

The menopause is a topic which is little known and understood in Chile, and so its medicalisation is easily accepted. As from 1997, the Women's Health programme of the Health Ministry incorporated specialised consultations about the climaterium, introducing a specific model of care. Its aim is to prevent and detect the most frequent pathologies in this period of the life cycle of the woman. But there is no information available to show the development

and scope of these activities. Considering the multiple aspects related with this condition, there is a great lack of social protection for older adult women because most of them have not been part of the work-force or form part of the poorer strata. As from 2000, all kinds of health attention in the public establishments was established as cost-free, for men and women over 65 years of age enrolled in its services, and this has helped to reduce the lack of protection and the resulting inequalities, but there are still many differences.

In terms of family violence, during the year 2000, 90% of the people affected by acts of violence were women, 5.9% men, 1.8% children and 0.9% elderly people. The same study showed that half the women currently or previously married or living together had experienced situations of conjugal violence at some time in their lives, 16% of which was psychological violence and 34% physical and/or sexual violence. It was also seen that physical and/or sexual violence was less as the educational level increased (SERNAM, 2002b). According to the same source, women who have experienced violence from their partner show at the same time a greater number of mental health problems than those who have not suffered this kind of abuse. Women who have been objects of violence more frequently show a lower use of CM, greater opposition from the partner to their using any CM and to be himself using any alternative. Together with this, they present a higher proportion of unwanted pregnancies. According to the Centre of Attention for Victims of Sexual Attacks (CAVAS), there are 20,000 offences of sexual abuse per year in Chile, and 8 of every 10 sexual offences committed are not reported (“*secondary victimisation*” effect). Despite efforts made in recent years by the authorities to ease reports about aggression, women do not have all the information necessary about how and where to make a complaint, and the mechanisms of dissemination and promotion of this problem are not sufficient and do not reach those who most need them.

Prostitution in Chile is not considered a crime. The consent of the persons for the sexual act prevails in the law and excludes the possibility of sanction, except for the prostitution of minors. The Health Code, however, refers indirectly to this activity when it defines norms about the control and treatment of STIs, so that sex workers have a health credential that they have to keep up to date.

To sum up, during the 90s, important initiatives were undertaken in the field of Women’s Rights and of SRH. The first of these was the “*Women’s Equality of Opportunities Plan, 1994-1999*”, which established the need to incorporate gender equity within public policies. The second was the “*Plan for Equality of Opportunities between Women and Men, 2000-2010*” (SERNAM, 2000). Significant progress has been seen in this context on the legal plane with the approval of significant laws, such as that of Family Violence

(1994), of Filiation (1998), the reform of the Political Constitution to make explicit the legal equality between women and men, as well as another seven laws aimed at protecting women workers in the work-place. Particular mention must be made of the Framework Bill on Sexual and Reproductive Rights presented to the Chamber of Deputies in October 2000, which aims to establish basic judicial norms to respect and ensure people’s sexual and reproductive rights. It is also important to note that SERNAM is building up a virtual databank on the different women-related dimensions, and this is today a fundamental resource for research.

The evolution of the health system in Chile has accompanied the phases of political development of the country. Thus, the transformations that have taken place from the 20s of the past century onwards also reflect the progress that political and social democracy has experienced, as well as the changes of direction that it had to undergo under the military regime.

The first social protection and health care policies were formulated and implemented in the 20s, when the Obligatory Workers’ Social Security was introduced (1924). Up till then, care was fundamentally the responsibility of the charity hospitals, or Public Beneficence, and to professionals of the private liberal medicine. To attend the insured and their families, the Social Security Fund built out-patient consulting rooms and established agreements with the Beneficence hospitals for in-patients. The Social Security was aimed only at workers of the urban labour market, financed with contributions from the resources of the insured parties, employers and the State, and was based on a distributive regime. In contrast, a system of individual capitalisation was created for public and for private employees, with resources administered by pension funds. Health care was provided through agreements with private liberal medicine, and, as from 1942, these began to be administered by the National Medical Service for Employees (SERMENA). There was a distributive insurance system for the Armed Forces, with its own medical care system, administered by the National Defence Fund, which is still in existence.

During the 1940s, the National Congress discussed projects to modify Social Security and to unify the health care services in the country. Finally, in 1952, the law of the new Social Security was approved that rationalised and broadened the benefits, but kept the coverage only for urban workers. This law included an article unifying in the National Health Service (SNS) all the health services and programmes of the country⁵⁰ and incorporating the Beneficence establishments. Since the SNS was included in the new insurance law, its coverage was kept restricted to the workers, who, together with the indigents, continued

50. The idea of progressive legislators was to create a national health service in Chile with comprehensive universal coverage and tax funding, inspired in the Soviet model. The model of the *National Health Service*, in England, was partially followed after this was created in 1948.

receiving free medical and hospital care. Moreover, funding of the SNS was circumscribed by the availability of resources from pensions contributions.

The problem of the lack of coverage for categories of employees remained until 1968, when the new law reform incorporated them into the SNS attention, but under a different regime, similar to that of the SERMENA, based on the free choice of the professional with co-payments for medical activity. This modification was considered transitory because the intention was to create a Single Health Service that would guarantee health care equally for all citizens. Between 1971 and 1973, the then President Salvador Allende moved ahead with this proposal which was interrupted by his overthrow.

As from 1974, the authoritarian government set out on a series of neoliberal style changes aimed at modifying the power structure in the sector and reducing the participation of the State in the supply and financing of services, by privatisation and increasing the contributions of beneficiaries. The bulk of these reforms were made between 1974 and 1982 and gave the health system a new make-up that it has kept up to now, a pioneer in the region, and the most privatising of all, contemporaneously with the discussions of neoliberal reforms in the USA and Europe. The main changes can be summarised as follows:

- Regionalisation of the Health Ministry through the creation of 26 Regional Ministerial Secretariats (Seremi).
- Strengthening of the authority of the Health Minister.
- Elimination of the SNS, creating in its place a National Health Care Services System (SNSS), regionalised in 13 Health Care Services.
- Transfer of the consulting rooms and posts (except those of Santiago) to the municipalities and establishment of Municipalised Primary Care.
- Creation of the National Health Fund (FONASA), an autonomous body responsible for collecting and allocating financial resources, administering the modality of free choice attention and fixing the levels of co-payments. This is the management institution of the SNSS.
- Opening up of health care to the market with the creation of the Health Insurance Institutions (ISAPRES), private profit companies operating health plans.
- Initial setting of a health contribution at 2% of the income of every citizen, increased to 7% from 1987 onwards, and the legal elimination of the employers' contribution to the FONASA.
- Legal decision that the persons who use their 7% contribution to buy a health plan (ISAPRE) are exempt from contributing to the FONASA, creating two modes of access to medical or hospital care: the institutional (public) mode, and that of free choice.

- Legal stratification of access by the population to public services, according to ranges of income (A, B, C and D) and level of care (1, 2 and 3) in the free choice mode.
- Creation, in February 1990, of the Superintendency of Health Insurance Institutions (ISAPRES). Depending on the Health Ministry and with supervisory functions.⁵¹

In brief, the transformations consisted in abolishing the centralised SNS and creating the SNSS, regionalised as far as hospital services are concerned and municipalised for primary care, accessible to beneficiaries of the public system (including indigents), accredited according to their area of residence. The obligatory contribution was maintained, but charged only to the worker (initially 2% and now 7%). The contributor has the constitutional right to choose where to be attended and may affiliate to the “public insurance”⁵² (FONASA), with variable co-payments according to income or free with a certificate of poverty, or to a private insurer (ISAPRES). The Services for the Armed Forces and Forces of Order are maintained, including autonomously fixed co-payments, and the private consulting rooms, hospital establishments and clinical support.

The reform explicitly introduced the risk insurance system (individual accounts and risks) with the ISAPRES, previously practically inexistent in Chile. Market mechanisms regulate the “protection” and the prices, which are translated into the equivalence between the value of the plan, the contribution and the coverage, and are renewed annually, making it possible to choose risk according to the age and sex of the contributor and of the family group (beneficiaries), defining different coverages and benefits for each case. This sector covers nearly 30% of the population, and concentrates the higher income, younger groups with less risk. Effective protection diminishes throughout the life of the person or depending on their financial condition. There are no cross subsidies to guarantee solidarity, in which the State would take on the function of reinsurance, displacing the poorer population and those with greater health risks towards the public sector, with serious consequences for equity, exacerbating the duality of the system in a much more perverse way (Labra, 1995, 2000 a e b; Sojo, 2001).

The manner of institutional attention is through appointments in the public establishments (consulting rooms, centres and hospitals). Services provided include medicines from the National Formulary and dental care, and access to the public system is stratified according to income group.

In 2002 the SNSS covered 67.5% of the population, the Armed Forces 3.1%, the ISAPRES 18.5%, and 10.9% was covered by other kinds of services. That is, 70.6% of the population

51. The creation of the Superintendency of ISAPRE was the last legal act related to the health sector of the military government before leaving power.

52. Since the mid-90s there is a debate in Chile as to whether FONASA is a Public Health Insurance or not. With the regards to the arguments see, for example, Silva (1999) and Lenz (1999).

was attended by the public sector, while in 2002 the distribution of the beneficiaries enrolled in the FONASA, according to income group, was 70.5% in the A and B group, 16.8% in group C, and 12.7% in group D. This means that practically two thirds of the users of the public system are attended free. And in the municipalised Primary Care, the services provided in 2002 covered nearly 50% of the population (FONASA, 2002). At present there are 45 Family Health Centres (CESFAM) in Chile, functioning in 31 communes that together attend approximately 400,000 families (or 1,000,000 people). This represents 14% of the beneficiary population at this care level.

The free choice system applies to appointments given by professionals and private establishments enrolled in FONASA or hospitalisations in public establishments. In this system, the beneficiary always covers a co-payment that fluctuates between 50% and 70% of the cost of the service provided. These services do not include medicines or dental care. All the citizens, once enrolled in FONASA, can make use of the free choice system, except those classified as group A and B. The service is paid for with a Health Care Bond, the value of which depends on the level of enrolment of the professional or providing body. There are three levels of care, with level 1 as the cheapest and 3 as the most expensive. According to FONASA statistics, services provided in 2002 were distributed as follows: level 1 – 33.8%; level 2 – 9.2% and level 3 – 57%. That is, more than half of the services were concentrated in the third level. As regards the location of the professionals by level, a much greater distortion is seen: 93% of them are enrolled in level 3 which, as we have seen, is the most expensive.

Between the years 1999 and 2002, on average, state spending on health as a percentage of GDP was around 1.6% and public spending was 3.1% (including subsidies for work disability). As regards the financing of public health spending, between 1990 and 2002, there was a clear effort on the part of the Coalition governments to increase the fiscal contribution to health funding (from 40.9 to 51.0%). In parallel, there was a reduction in the amount of the contributions (from 44.7 to 34.4%), while the co-payments included in the legislation about modes of care, as well as being proportionately of little importance, did not vary in this period. In any case, adding the contributions and the co-payments, the contributions of individuals enrolled in FONASA fell from 53.2 in 1990 to 42.8% in 2002.

The public budget for health was affected not only by the elimination of the employers' contribution, but also by the loss of income derived from exempting people who used their obligatory 7% quota to purchase a health plan in an ISAPRE

from contributing to the FONASA. As these people are those with higher incomes, the so-called “creaming off” effect is produced in funding and in care. This crucial point has been the target of innumerable criticisms and proposals for correction to make financing more equitable, without managing to reach any consensus to date.⁵³ It should be stressed, lastly, that inequality in funding of the health sector as a whole is well-illustrated by the annual spending *per capita*: in 1999, public sector spending was US\$210 while that of the private sector was more than double – US\$500 (Minsal, 2001b).

The Health Ministry has pointed out a series of deficiencies in human resources such as the lack of a national information system, insufficient planning and regulation, inequalities in geographical distribution and insufficient wages (Minsal, 2002c). In addition, the different laws governing professionals and officials make it difficult to obtain an overall view. Since the figures are not available, or come from different sources and are not comparable, the situation presented here is quite incomplete.⁵⁴ A significant distortion can also be seen: in 1999 it was estimated that only 33.5% of medical hours were destined for attention in the public services, in circumstances in which these covered almost 70% of the population (Minsal, 2001c).

The scenario currently facing the ISAPRES is worrying: created in 1982, they grew steadily until 1994, when they fell into stagnation up the present crisis, which they face as the consequence of a sharp drop in operating profit,⁵⁵ and the rise of the prices of the plans together with a reduction in the number of buyers. This has led to raising the additional voluntary contribution, so that the true users' contribution is no longer 7% but 8.5% (Oyarzo, 2002). On the other hand, its varied portfolio of products includes 48,000 health plans, which undoubtedly affects the transparency of the information and, therefore, the individual's capacity of choice. In addition, the segment is highly concentrated as six ISAPRES (out of a total 22) concentrate 75% of the private market. The vast majority of them do not have their own health services, and those that have medical centres concentrate them in the Metropolitan Region (Navarro, 1999).

In a study on women's participation in the ISAPRES, Ramírez (2002) points out that in mid 2001 the number of contributors was 34.4%, similar to the female rate of participation in the work force. Women users under 40 were 79.3%, those between 40 and 59 were 22.2% and those over 60 were 4.6%. As well as the wage barrier and the “maternity risk” implicit for any woman of fertile age, the exclusions and restrictions to care for women in the ISAPRES can

53. In this respect, a factor of inequity gradually eliminated is the 2% public subsidy granted to people on low incomes for them to acquire a health plan, but there are still indirect subsidies such as the exemption of the ISAPRES from paying the maternity subsidy.

54. One fact that makes analysis difficult is the existence of a special law for doctors, dentists, biochemists and pharmaceutical chemists, who can be hired per hour of work, another for the rest of the staff, and yet another for primary care.

55. The increase in operating costs of the ISAPRES has been attributed to the rise in medical provision, to the excess of medical leave for labour incapacity, and the resulting granting of cash subsidies, more rigid state regulation of the plans to limit exclusions and widen coverage, a rise in the rate of use and an increase in the retired population (Oyarzo, 2002). For others, it is due to high administration and publicity costs, and high salaries for the executives (Ramírez, 2002).

include suicide attempts, provoked abortion, voluntary sterilisation, etc., and extend both to services provided in kind and in cash, such as those related to supplementary medical maternity leave and for caring for a younger child (curative and maternity leave is paid by the State). All of this hits the public services that end up receiving the ISAPRES affiliates, as was shown in the 1998 Casen Survey. For example, out of the women enrolled in the system who gave birth in that year, 26.2% were attended in SNSS maternity units.

Opinions collected by the 2000 Casen Survey among people over 12 years of age about health care in public and private services reported that nearly 96% of the population that require attention have access to the health care services in general. Moreover, 82.4% of those attended in a public establishment considered that the attention had been timely. When asked about the quality of health care in each sub-system, 85.5% of the FONASA beneficiaries considered it very good or good; among the users of ISAPRES, this percentage goes up to 94.9%. It is interesting to note that 95.2% of ISAPRES affiliates attended in a public facility considered that the quality was very good or good. The largest percentage of negative opinions were centred on emergency public health care, considered bad or very bad by 6% of FONASA beneficiaries and by 18.8% of the ISAPRES users. 90.4% of the beneficiaries of the public system felt that hospital care was very good or good (Mideplan, 2002d).

Throughout the 90s, the negative effects of the neoliberal reform in health became increasingly evident, and pressure arose from all sectors for partial modifications to be undertaken or for a complete change to be designed. The repeated appearance of problems like those mentioned led President Lagos to commit himself to reforming the health system as a whole under five guiding principles – right to health, equity, solidarity, efficiency in the use of resources, and social participation – as well as to creating a Reform Commission, to discuss and propose modifications. Between 2001 and 2002, in the midst of great arguments, the following bills were drawn up:⁵⁶ Health Authority and Management, Health Guarantees Regime or Plan AUGE (Universal Attention with Explicit Guarantees), Regulation of the ISAPRES, Financing of Fiscal Spending, Patients' Rights and Duties. Of these projects, the first to be passed and promulgated was the one related to Health Authority; and the Plan AUGE Law was finally approved and sent by the National Congress to the president on August 10th, 2004, after two years of intense and polemical legislative arguments.⁵⁷ The new law and the other bills can be summarised as follows:

*Health authority and management*⁵⁸ - The new law introduces wide changes in the organization of the public

health system. It modifies the Decree-Law creating the SNSS, and introduces important changes in the organization of the public health system. The law mainly presents the separation of the following functions: policy definition, regulation, financing and service provision; and strengthens the policy making and guidance functions of the Health Ministry in the sector to overcome the existing fragmentation, at the same time as it reinforces the deconcentration of activities within the ministry and in the regions. It creates the Under-secretariat of Public Health and the Under-secretariat of Assistentialist Networks, with the latter responsible for integrating all the levels of care, including primary care. It also creates the Health Superintendency, which will be in charge of the overview and monitoring of the FONASA and of the ISAPRES. The new design includes colleges of professionals at all levels, whether technical or consultative, as well as user councils. An important novelty in the law is the "Self-management Network Establishments", the director of which will have autonomy to define productivity goals and made agreements with natural or legal persons of public or private law, among other attributes. The law also creates a nation-wide High Speciality Assistentialist Network. With the new model it is hoped that the system will function entirely in networks, "satisfying the needs of the population in a functional way, with geographical logic, and reference and counter-reference mechanisms".

General Regime of Explicit Guarantees (Plan AUGE) – This part is the nucleus of the reform and was expressed in Law N° 19.966 approved by the National Congress in August, 2004. The progress of the bill was strongly argued over and underwent several modifications. Fundamentally, the new regime "is a health regulation instrument" that forms part of the old regime of service provision that stratified access according to entry levels to the institutional mode and defined the free-choice levels of attention. Put simply, the Plan AUGE guarantees the access of the population to "services associated with a prioritised set of programs, diseases or health conditions", to be defined by joint decree from the Ministries of Finance and Health. Both FONASA and ISAPRES "will have the obligation to ensure such guarantees to their respective beneficiaries". This point is very important because, for the first time, the ISAPRES are ordered to offer their beneficiaries that same level of services defined for the public system, under pain of legal sanctions. In this way, the health authorities seek to diminish inequalities in health, confront the ageing of the population, provide services in accordance with the expectations of the population, and improve the health achievements already made.

56. All the information about the reform is based on documents published in 2002 by the Health Ministry in the series *Towards a Public Health Policy*. (Minsal, 2002)

57. To achieve its approval in its final stages in the Chamber of Deputies, which has a majority of Concertación legislators, the government had to put back the Solidarity Compensation Fund in the ISAPRES Law, which had been previously withdrawn at the request of opposition Senators, in May 2004. The ISAPRES Law began to be discussed in October, 2004.

58. Law 19.937, promulgated February 24, 2004, modifying Decree-Law 2.763 of 1979.

The law stipulates “financial protection”, ratifying that it is free for Groups A and B (indigent and lacking) and a co-payment of 20% for Groups C and D allied to a series of new provisions about “deductibles” that depend on factors associated to the contribution level of the affiliate, among others. In fact, the new law makes the formula about co-payments much more complex.

It should be noted that the Plan AUGE introduces two important modifications about the access of the population to health care by widening the assistentialist network. On the one hand, it includes a substantial reorganization of the primary care establishments for them to serve as a real entrance gate to levels of higher complexity, all of which will involve considerable investments in technology and infrastructure and the mass hiring of personnel, above all of professionals, of whom there was a deficit in municipal establishments that reached 50% in 2002 (Urriola, 2004). On the other hand, it reaffirms the making of agreements with providers “outside the Public Network and in agreement with the FONASA”, something that will mean a decisive reinforcement to the ISAPRES at a time when their survival is threatened by the migration of the population to the public system.

It is also worth making clear that the end goal of AUGE is to include 56 pathologies. To achieve this, since 2003 a pilot plan has been under way that covers 17 health problems and that will be slowly broadened up to 2007. However, to the government’s displeasure, the pilot plan has aroused strong criticism, such as that of the users whose pathologies are not included, as well as showing up the great technical and administrative difficulties and the high costs involved in establishing it.

On the same plane, the College of Medicine has declared that the AUGE is a *minimum plan of services copied from an already failed “managed health” model, and that it means a basic basket that is unnecessary and unsuitable for the country, that only makes sense within a reductionist logic of health insurances..... the inequalities are not going to be resolved starting from a model based on a plan (AUGE) or a Basic Basket. What is more, we firmly believe that these are going to worsen if it is put into effect* (Colegio Médico de Chile, 2003).

Financing – This is the bill aiming to create a Solidarity Compensation Fund (FCS). It has certainly been the most polemical of all and it did not manage to pass the legislature. In Urriola’s (2004) interpretation, the FCS consists in each operator (FONASA and ISAPRES) contributing with a universal premium for each contributor and for each of the respective charges. Beneficiaries in the category of indigents are financed by a direct contribution from taxes. According to this author, the main aim of FCS would be to reduce incentives to “creaming off” that work against solidarity in health. In any case, it should be noted that with the Fund, the idea was to collect resources to finance the Plan AUGE.

The proposal was harshly criticised by a wide variety of

actors, starting with the College of Medicine. In relation to the universal premium of equal absolute value, the Order considers that this is regressive in relative terms and argues that the solidarity it would produce initially is marginal since, in the medium term, the FONASA contributions would end up compensating those of the ISAPRES. It also stresses that the bill guarantees only the fiscal contribution for indigents and does not consider the situation of the “needy”, i.e., those whose annual health contribution is not enough to cover the value of the premium of the Plan AUGE and suggest that the difference will end up being financed within the FONASA by the less poor. It proposes instead, two separate funds: to keep FONASA as a solidarity fund and to create a Risk Compensation Fund for the ISAPRES, formed with individual contributions proportional to the income of the contributors.

This discussion leads to the conclusion that all the alternatives related to financing end up affecting the public system, because there is no clear and viable solution to the problem of “creaming off” or a mechanism proposed that would introduce solidarity in the funding of the health sector considered as a whole. In any case, as the matter is highly important, the government has expressed its willingness to replace a FCS whenever the discussion of the ISAPRES law is taken up again in parliament.

Modification of the ISAPRES – This bill seeks mainly to achieve transparency in the choice of an individual’s private health plan, and also to protect them against abusive increases in prices, restrictions and exclusions. To do this, it proposes to simplify the contracts and eliminate discriminations and incorporate the Plan AUGE, obligatorily, in all current health plans, with the same price for all those affiliated to the same ISAPRE. This is accompanied by a compensation system for different groups to eliminate differences such as those between men and women and between young and old, and the pre-existing conditions. The aim is also to increase fidelity to the plans, correcting arbitrary factors in their coverage, and to offer public health benefits (comprehensive health plans). Among other changes, the aim is for entities to increase their capital in order to give guarantees to the affiliates in case of failure.

In this context, the new health authority strengthens the faculties of the present Health Superintendency (which abolishes that of ISAPRES) so that it can demand timely information from the operators, classify them by risk (liquidity, indebtedness and operational management), apply sanctions, etc.

Despite the evident benefits that the changes in the *modus operandi* of the ISAPRES would bring for the people who choose to buy a health plan, the College of Medicine has argued that the law goes against the free exercise of the profession and against the patient’s right to freedom of choice (Colegio Médico de Chile, 2003).

From the description of the reform components and the discussion that it has provoked, it is clear that it is extremely difficult to design a clear scenario about the

future directions of the country's health system. One of the reasons for this uncertainty derives from the secular polarisation that exists in Chile between groups of different political ideologies, some favouring a greater openness to the health market and others defending the strengthening of state medicine, for whom the historical heritage is a bulwark of democracy and an example of how a fairer, more efficient and effective health system should be (Labra, 2002; 2000a; 2000b; 1997).

Various points of the reform also touch on aspects related with SRH, without managing to constitute propositions articulated around a new gender perspective, but rather updating or emphasising topics that are already part of approaches and activities in existing programmes.

The Plan AUGE is based on the premise that it will offer "explicit guarantees" in health care, including a guideline for women-oriented actions that include specific procedures defined for breast cancer, cervical cancer, depression and childbirth. The reform also declares that primary care should be highly resolute and have the capacity to solve most of the emergencies. For this it will be supported by family and community health teams, have modern technology and the necessary equipment, and must work in coordination with speciality care. For this reason, a Family Health Plan 2 (PSF2) has been designed, that will cover most needs of families according to the epidemiological profile of the population. The Health Plan currently being applied in the consulting rooms of Family Health defines the services and actions that should be carried out, but still with too great an emphasis on mother and child problems.

The basic elements of the family health approach (PSF2) are (Minsal, 2004): a) guarantee continuity of attention and of preventive and promotional care; b) improve diagnostic capacity; c) comprehensive home care; d) individual and family self-care; shared responsibility between all the family members, independent of gender, for the health of the family, particularly encouraging the participation of the partner in the reproductive process (pregnancy, childbirth, puerperium), of the father in the care of the children, (health checks), and of one or more members in the care of people with chronic diseases (arterial hypertension, obesity, etc.), the disabled, older adults, family members discharged early from hospital, the bed-bound or terminally ill; e) transformation of the traditional consulting rooms into Health Centres (CES) and then their consolidation as Family Health Centres (CESFAM); f) process of change and gradual development, and f) guarantee of quality of care.

At present there are 45 CESFAM in Chile, functioning in 31 communes that together attend approximately 400,000 families (or 1,000,000 people). This represents 14% of the beneficiary population of municipalised primary care. To sum up, in tune with the social changes introduced by the Coalition governments in the country in general (as from 1990), numerous partial modifications have been made in the health sector. The first, emergency in nature, were aimed at solving the most crucial problems inherited from the

military government, such as those related to physical installations, staff, working conditions, primary care, etc. Then more structural measures were taken, like those related to the lack of sector financing and the structure of budget sources and other areas that presented flagrant distortion or inequity.

But the recent proposals of the "new reform" (or "reform of the reform") summarised above will depend on large investments and on being able to overcome the resistance of important groups that are very critical of the reform, such as the College of Medicine.

As for SRH, among the range of proposals contained in the present reform, the topic of reproductive rights is not made clearly explicit and when there are responses in this direction, in general they reiterate traditional activities. In other words, the proposals leave on one side dimensions that are crucial for the progress of the "transversality" of gender in the context of SRH, whether as a public policy, or as a life dimension of men and women in their adolescence, adulthood or old age.

Carrying out this case study showed up the existence in Chile of critical gaps relating to gender relationships, needs and specificities and in SRH in particular, which must be urgently overcome: on the one hand, available, accessible, comparable, discriminating information with an intersectorial approach, and on the other, professionals and officials open to listen to people's needs, as well as teachers aware of the new values of common citizens, in particular those of young people. All of this constitutes a set of means that are essential to link everyday life with the understanding that SRH is an essential part of a gender perspective, above all in societies such as ours, in which the subject is, at least, opaque, diffuse or even unknown.

COLOMBIA

In the course of the 90s, Colombia, different from other Latin American countries, reversed the trend that had predominated in the 80s in which, based on a traditional macro-economic management that avoided anti-inflationary shocks, it had maintained a steady, relatively high economic growth process with relative stability. Although up to 1995, growth rates were steady and employment rates kept an upward trend, and those of unemployment and levels of informal labour showed a drop, in the second half of the decade the country entered a recession, with negative GDP growth in 1999 and historically high rates of unemployment (20.4% in 2000), with the greatest impact on, especially younger, women. The deterioration in labour market conditions is clear in the significant growth of self-employed workers, the fall in real terms of average monthly labour incomes (worse for informal workers), the increase in the percentage of working people earning less than one minimum wage (MW), and the corresponding decline in those earning between one and two MWs, as well as the reduction in the population occupied in most of the remaining income scales, between 1997 and 2000. This began

to improve slowly as from 2001, but at the same time the upward trend in unemployment remained, as did the fall in public and private investment, and the continuous decline in household consumption, which had a significant effect on the progressive deterioration of the quality of life in wide sectors of the population (Villamizar *et al.* 2002:5-6).

Public debt increased to levels higher than those of the economy, and the resulting high commitments diminished the availability of resources for financing other development spending. This dynamic, as in other countries in the region, basically brought about the *intensification of financial volatility and the consolidation of the poverty and inequality traps ...* (UNDP, 2001:31-2 in Villamizar *et al.*, 2002:6-7).

The Unsatisfied Basic Needs poverty (UBN) (associated with the availability of public services, housing quality, overcrowding, schooling assistance for children and economic dependence), which had had a continuous downward trend, has been constant in the country since 1997, at near 37%, while poverty by income, or those under the poverty line (PL), has increased systematically since the same year, until in 2000 it reached nearly 60% of the population, while the percentage in a situation of indigence was 23.4% (Sarmiento 2001, in Echeverri López, 2002:88).

In addition, during the 90s in Colombia, there was a worsening of historical situations that have contributed to the deterioration of its social and economic development: drug-trafficking, the armed conflict and the forced displacement of the population from the country to the cities. The internal war being waged in the country for decades *intensified and reached hitherto unseen levels of degradation, in which armed protagonists systematically violated human rights and refused to recognise international humanitarian law* (Villamizar *et al.*, 2002:8). The multiplicity of different actors involved (military personnel, guerrillas, paramilitary, self-defence), confronting each other in various contexts, and the complexity of their interests and alliances (including the illegal drugs business) generated a series of grave problems, from the deterioration of ethics among citizens and institutions to the exclusion of important population groups, expressed in the extreme inequality of opportunities of access to resources, goods and services. This conflict is also the cause of a great number of homicides and murders among the civil population, and massacres and collective homicides have become a brutal form of violence, with the poor peasants and indigenous communities being the most affected (Idem). The percentage of people not reaching 40 years of age went from 9.9% in 1997 to 11.5% in 1999.

The forced displacement of population increased significantly as a result of the hostilities and attacks perpetrated during these conflicts, and although the figures vary according to the source, in 1999 there was an official estimate of around 400,000 persons affected, while other sources calculated that between 1985 and 2000 the figure was nearly two million. 58% of these were women and 36%

women heads of households, 86% of whom were girls and adolescents under 18 years of age (Villamizar *et al.* 2002:9-10).

Thus, Colombia at this moment faces a set of critical situations including severe economic crisis, the highest unemployment levels in its history, natural disasters, armed conflict and high levels of violence, forced displacement, etc., all together forming a context in which poverty has become more acute in the country.

The new 1991 constitution gave priority to public social spending (human capital and capacity, as well as development), and between 1997 and 1999, spending on basic social services (education, health, family planning, water, sanitation, nutrition) increased 2.5% in real terms, and as a share of the GDP went from 5.8% (1997) to 6.5% (1999). *Nonetheless, within total spending, that destined for basic social services has fallen in the same period (16.3 to 14.6%), attributed to greater spending in the state administration and in paying the public debt. Although health and education spending has increased, it has done so at a slower rate than the increase in coverage, which may indicate inefficient resource management* (Villamizar *et al.*, 2002:7).

Even though the increase in public social spending may have had redistributive effects, the final balance is that inequality has increased in both income and wealth terms. In the year 2000, the poorest 20% of the population received 2.3% of total income, while the richest 20% received two thirds of it, increasing the gap between the poorest and the richest and between the ranges of median incomes (Echeverri López, 2002).

Specific resources for the health sector have increased as a percentage of GDP in recent years: while in 1986 these were less than one percentage point of GDP (0.94%), in 1993 they were 1.32% and in the year 2000 they reached 2.7%. Despite this significant increase, the intended impact on the coverage of preventive, curative and assistentialist services has not been seen.

To sum up, during the 90s, the compensatory action of public finances made only modest advances, especially in social spending and health, because the redistributive effects of spending were absorbed by the impact of the concentrating of economic activity and because the structure of public finances was weakened,

These adverse conditions were reflected in changes in health indicators. Although the total fecundity rate fell significantly, fecundity in younger women increased, as well as that of the pregnant women or those who had been mothers in this group. In a general way, infant mortality and life expectancy at birth, which are long term indicators (macroindicators) and do not immediately reflect day to day conditions, improved steadily for decades, but there are still regional inequalities, with marked differences between urban and rural areas, genders and races. The evidence suggests a quite heterogeneous profile of morbidity and mortality in which the diseases of poverty and those of development co-exist, for all social strata; but the transmittable and infectious diseases have more impact and

are more lethal in the poorer strata. The epidemiological profile thus shows the coexistence of transmitted diseases (that cause deaths, such as acute respiratory infection (ARI) and acute diarrhoeal disease (ADD)) with chronic and degenerative diseases that nowadays occupy the first place in morbidity and mortality together with lesions (intentional or otherwise), as well as the resurgence of endemic and epidemic infectious diseases that had disappeared or were controlled, such as cholera, malaria, tuberculosis, dengue fever, among others.

Cardiovascular diseases are the prime cause of morbidity in the country, followed by violent lesions, tumours and transmittable diseases. Perinatal problems and diseases, as well as diseases related to pregnancy, childbirth and puerperium appear in the first ten causes of morbidity (reflecting the size of the problem in the area of SRH), as well as mental problems. Looking at the causes of mortality by age groups, children under one year of age die mainly from perinatal respiratory problems and congenital malformations; in the group from 1 to 4 years, the main causes of death are related to transmittable diseases (ARI), infectious intestinal diseases (ADD) and nutritional deficiencies and anaemia; and in the group from 5 to 14, land transport accidents and lymphatic tissue and haematopoietic organ tumours are in first place.

In the general population, the main cause of death is homicide and the second is accidents. However, in the third place for women are diseases related with pregnancy, childbirth and puerperium, and in fourth place, malignant tumour of the uterus, whereas men present land transport accidents, self-inflicted wounds and HIV/AIDS related diseases. In this age group, women present events related with SRH among the first five causes of death. The group from 45 to 64 years of age presents the main causes of death as ischaemic and metabolic diseases, arterial hypertension and cancer; the 65 and over group coincides in the main causes of death.

The vulnerability factors associated with a precarious state of SRH in Colombia are: low levels of schooling, poverty, location in disadvantaged regions (rural or marginal urban zones), situation of displacement, residence in zones of conflict, limited coverage of the General System of Social Security in Health (SGSSS), risk behaviours and an early start to sexual relationships. There are concomitant factors that make the situation more complex, such as cultural values and stereotypes about sexuality, reproduction and affective relationships in general that condition attitudes and behaviours that do not always favour health and the autonomous development of significant life projects for each person in their specific context.

The most worrying SRH indicators are the high rate of maternal deaths, the increase in the incidence of sexually transmitted infections (STI) (syphilis, gonococcal infection and urogenital trichomoniasis are found above world average levels) and HIV/AIDS;⁵⁹ the increase in pregnancy rates at ever earlier ages; the high percentage of unplanned pregnancies (more than 50% of pregnant women report not to have wanted the pregnancy at that time); the rate of mortality from cervical cancer,⁶⁰ and the high indices of domestic and sexual violence, which is a great public health problem, although up to now the exact magnitude of this is not known but the percentages among displaced women are alarming. The great majority of mistreatment of minors takes place in the domestic environment itself. There is also a lack of comprehensive care services for adolescents.

The right to health and social security are guaranteed by the 1991 Constitution, which establishes it as obligatory under the guidance of the State, and health care is defined as a public service with the State responsible for its organization, direction, regulation, monitoring and policy making. Law 100 of 1993 created the General System of Security in Health (SGSSS) which was put into effect in 1995 and 1996. The same Constitution also included principles that must govern the health system: universality, solidarity and efficiency, through finding sustainable means of financing and a plurality of public and private agents to ensure service provision (Londoño, 1996: 37-39).

The previous health system, as in other countries of the region, was made up of three sub-systems: a) the social security, b) the private sub-system, and c) the official (state) sub-system. The first two were responsible for providing services to people with the ability to pay, either through contributions shared with their employers or by cancelling the direct costs of using the services. The state sub-system was directed and operated by the Health Ministry through hospitals, public health centres and posts, giving services to the population who were unable to pay. Regional bodies (Sectional Health Secretaries) were created in this centralised system, which carried out the activities decided vertically by the national level and care was centred on hospitals, concentrated in the large cities and operating at a 50% occupation rate, concentrating also the public health activities; there was also a wide network of health posts and centres operating precariously.

The health care services coverage was deficient, especially for the poorest and most vulnerable population. In 1992, nearly 25.1% of the population that was sick had no access to health care services, which affected 34% of the poorest deciles and 2% of the richest. Social security affiliated less than 20% of the population and there was

59. The incidence has increased in some population groups, particularly young people and women, as well as homosexual and bisexual men; and between 1986 and 2000, the proportion of women infected increased, changing the male/female ratio of infection from 47 infected men to one woman infected to 7 infected men for each woman infected.

60. Cervical cancer is the prime cause of death from cancer in women between 30 and 59 years of age, and it is presenting in younger age groups due to the tendency to initiate sexual relations at earlier ages.

great dissatisfaction with the corruption, inefficiency and poor quality of the services (Londoño, 1996:39).

The Colombian reform of the health sector was drawn up between 1991 and 1993, by a group “*insulated*” inside the State apparatus, and approved by Parliament in 1993, shortly before the new presidential elections, in which the group in power was replaced. This reform is the most complete translation in the region of the theoretical model of managed or regulated competition (called “Structured Pluralism”), and meant an abrupt, radical change in the structuring the health system. According to those who formulated it (Londoño and Frenk, 1995:18), Structured Pluralism is part of the search for a middle term between extremes that were very pernicious for the performance of the health systems, i.e., on the one hand, public sector monopoly, the atomisation of the private sector and centralised and authoritarian direction procedures (this is the reason for the name *pluralism*, defining the first dimension of the concept) and, on the other, the absences of rules of the game to prevent or compensate for the failings of the market (for this reason the name *structured*, the second dimension of the concept): The central elements of managed competition adapted to the Latin American situation (its “tropical version”) would be the public nature of its funding (recovering under new bases the idea of national health insurance) that for the poor takes the form of a subsidy, and for the rest that of an obligatory contribution; and the “specialisation of the actors” in the system, through a new institutional configuration, creating specific private organizations for this purpose (the *sponsors* of the US *managed competition*). In fact, public financing is what makes this model different from those centred on cost recovery or on US-style managed competition.⁶¹

Colombia is the “laboratory” where this model is being put to the test and its formulation is part of the State reform process, with the aim of overcoming the country’s huge historical inequalities and segmentations in health.⁶²

Based on the antecedents of the decentralisation of spending and of the system (Jaramillo, Olano and Yepes, 1998; Jaramillo, 1999, 2000) and of reforms in the hospital environment (Jaramillo, 2000),⁶³ the SGSSS has as its guiding principles, efficiency, universality, solidarity, comprehensiveness and social participation; it separates the functions of management, financing, insurance, health service provision and monitoring (previously centralised in the Health Ministry), and creates “specialised agents” (new

organizations), transferring the general management of Social Security (previously in the Ministry of Work) to the Health Ministry, unifying the functions of strategic management and health regulation. The new system also has a National Council for Health Social Security (CNSSS) responsible for formulating policies for the working of the SGSSS, and Territorial Councils for Health Social Security.

To “counterbalance” domestic instability, three credits were allocated with the international banks (World Bank and IDB), which generated commitment with implementing the reform, and a group of experts from Harvard was hired to draw up an implementation plan and monitor it. The periodic visits of this technical group of the “Harvard Mission” constituted an “independent critical voice” which was seen as a positive factor in consolidating the reform, for the respect they won among the actors in the system (Londoño, 1996: 52-3).

A single, collective public insurance was established, but with different affiliation regimes. Two ways of incorporating the population into the system were institutionalised: a contributive regime (RC), financed as a social contribution for employees with a labour contract and autonomous workers, independent of income level; each affiliate contributes 12% of their income (8% paid by the employer and 4% by the employee); and a subsidised regime (RS), which must cover the population below the poverty line, classified in three levels with rights to different subsidies (95%, 90% and 70%, respectively), financed by a specific fund and other sources. There is also a third category of persons, the so-called linked, who are not affiliated to either of the two regimes, either because they decided not to contribute or did not manage to affiliate or did not want to submit to being labelled as poor, and these have no kind of formal coverage, but are attended by the public sector when necessary.

The contributive regime ensures the right to a universal package of interventions – Obligatory Health Plan (POS) – which in general is the same as was provided by the Social Security Institute (ISS), and includes all the health services; and the subsidised regime ensures access to a basic package of care – the Obligatory Subsidised Health Plan (POSS) – conceived initially with around 50% of the benefits of the contributive regime and currently with nearly 30% less services, and which should gradually converge towards the POS. The subsidised regime is in practice a demand subsidy, with supposedly increasing degrees of protection. This

61. Juan Luis Londoño, economist, was one of the designers of the reform, as he was Health Minister of Colombia when it was conceived and passed. He returned to the Health Ministry, again as Minister, in the new government in 2002, but he died in 2003, in a flying accident.

62. Between 1980 and 1990, Colombia was the pioneer “laboratory” of various innovations in several sectors of State reform (for example, central bank independence, new forms of association with multinational companies, etc.), and the social security reform is one of these.

63. The Ministry of Health and Social Security was created in 1940. And the appearance of the Social Security System dates back to the years 1945-1946, when the National Insurance Fund (Cajanal) and the Colombian Institute for Social Securities were created. There have been various attempts at decentralisation since 1945. The National Health System was created in 1975, with the aim of seeking effectiveness through the functional integration of activities and institutions, creating inter-relationships and multifunctional bodies or associations of institutions. In 1988 came the creation of the National Health Superintendency, as an autonomous agency, linked to the Health Ministry, with the function of monitoring the collection of funds for health. Law 10, of 1990, complemented by Law 60, of 1993, transfers competencies and resources to departments and municipalities: responsibility for basic health care and establishes community participation – with the creation of the hospital management committees and the Community Participation Committees. At the same time, it transformed hospitals in autonomous bodies with individual legal identity and administrative autonomy.

subsidised insurance is financed with resources from the Solidarity and Guarantee Fund (FOSYGA), made up by 1% of each contribution of the contributive regime and by general state budgets (departmental and municipal) as well as from other sources. This organization is intended to structure solidarity. The strategy of a universal insurance to gain access to an obligatory POS of equal services aimed to solve two of the big problems of the previous system: segmentation – differential systems of services for different groups of population – and the inequalities in access, mainly because of economic barriers. The goal was to universalise a health insurance about the year 2001 that would guarantee an equal package of services for all the population (Echeverri López, 2002; Jaramillo, 1998; Londoño, 1996).

Affiliation is voluntary in both regimes and it was expected that the population would enrol progressively in one of the two insurance systems, which would be possible not only from the significant increase in financial resources and state contributions for health, but also because a period of positive macroeconomic growth or sustainability of the economy was expected and an increase in real income for the workers. Meanwhile, the uninsured population would receive attention, paying part from their own pockets at established rates and the rest as a charge on State resources (supply subsidy). The latter would steadily be transformed, as the population became included in the insurance, into a demand subsidy (Echeverri López, 2002:86, as from Law 100; Jaramillo, 1999).

For operating the system, Health Promotion Bodies (EPS) (public or private) were created for the RC that concentrate the financing and insuring functions (affiliation, collection and financial risk management), and should fulfil an integrating role in the system. In this regime, the affiliates can choose among different public or private operators. And for the RS, the Subsidised Regime Administrators (ARS) or Health Solidarity Companies (ESS), generally community-based, were created. Service provision is supplied by various health care service-provider institutions, called Service Provider Institutions (IPS) (public or private).

The insurers receive contributions directly from affiliates, retaining the Capitation Payment Unit (UPC) for each family member covered, and they are obliged to offer the POS with their service providers (own or hired). The UPC varies according to a risk structure adjusted for age, sex and place of residence (higher cost for children under five, women of fertile age, elderly people and populations in isolated rural areas), and has the same cost in all the country. Minimum proportions of high risk affiliates are established for each agency and compensation mechanisms are established between the EPS (in deficit or in profit), as a way of trying to prevent “creaming off”. The EPS is obliged to return the surpluses from the difference between the amounts collected and the UPC costs to the FOSYGA, and the latter must compensate any EPS that have a negative balance. This mechanism should monitor the balance of resources and conditions of equality. The EPS are obliged to

hire a reinsurance to cover catastrophic risks, and the Law authorises complementary plans – the Complementary Packages (PAC) – whether for risks or for residence, and this stimulated the growth of private health markets (Jaramillo, 1999; Sojo, 2001). In both regimes, users, according to their economic classification and frequency of use, would make co-payments for the use of services, contributing to the rationality and financial sustainability of the system.

Public health activities are separated into the Basic Attention Plan (PAB) and the Environmental Health Plan, and both must be offered by the State in departments, districts and municipalities, with public resources.

Municipal authorities are responsible for identifying the beneficiaries of the RS on the basis of a Beneficiaries Identification System (SISBEN), but there is a great problem of the exclusion from the system of a large part of the population, firstly because the selection of the poor population to be beneficiaries of the RS does not consider the real figures of poverty in the country, that are only estimated; secondly, and following the logic of focalisation, not all those who are insured there should be so, and in third place, the linked are more and more numerous and have fewer concrete possibilities of insurance. Thus, the population base for insurance coverage defined by the National Council for Social Security is that included in the UBN (close to 37% in 1997), which is much less than that below the poverty line (nearly 60% in 2000), and increasing. For 2000 according to UBN, only 59.8% of the poor were affiliated to RS. So the difference between one method of measuring poverty and the other represents more than 10 million Colombians “invisible” to the system. Although it is not possible to establish how many of the latter could be insured under the RC, what is interesting to note is that the focalisation strategy adopted through the SISBEN underestimates the magnitude and heterogeneity of poverty in Colombia, and this leads to reductionist and exclusive policies. At the same time, not all those who are in the RS are poor, as there are reports that some mayors and political bosses have used clientelist criteria for affiliation, or have affiliated people who are not so poor but have high cost diseases in order to evade payment (Echeverri-López, 2002:88). Studies show that there is no statistical correlation between poverty and enrolment in the RS (Málaga *et al*, 2001).

Nearly half the authorised EPS originated in some insurance funds, cooperative groups or non profit unions. The public departmental and municipal EPS are varied and a product of associations between territorial bodies and health institutions. Out of the 1,100 pre-existing public funds, only the Social Security Institute (ISS) and another two funds transformed themselves into EPS. A large percentage have general insurance companies among their partners that had previously created their own pre-paid medicine companies (EMP), and among these some linked up to the system, others associated to each other, and others became shareholders in some insurer groups. Many that remained as EMP can

function as IPS, under contract to the EPS. Finally, some created especially as EPS have a strong presence of foreign capital, and there are funds and medical services for specific branches (called from special services or adapted entities).

The ARS have been numerous from the start and different in form – EPS, Funds and ESS. They are highly criticised for being “intermediaries” using public resources in an unsuitable way, justifying the deficit of the public IPS. In general, they have problems of administrative and insurance weakness, and there are frequent scandals of corruption involving one or another of them.

In the IPS, the hospitals were transformed into State Social Companies (ESE), decentralised public bodies with their own juridical entity, patrimony and administrative autonomy, linked to the territorial (departmental and municipal) authority and disconnected from central authority, with a Governing Council presided over by the mayor or governor, composed of various actors, which had to approve the strategic and investment plans, as well as the budgets and contribution levels, etc. The form of financing is also different, based on different sources, and the logic, access mechanisms, allocation criteria, budget regime and flow of resources are also different.⁶⁴ The conflicts deriving from the complexity of this financing structure are enormous, even between different levels of government (Jaramillo, 1999; Sojo, 2001). At the start there was resistance from public hospitals, which were forced to convert to receive public resources.

The contributive regime is covered mostly by private IPS or institutions belonging to the ISS that existed before the Law 100/1993. The greatest argument is in the context of the subsidised regime and the services for the linked, financed by budget resources. There is marked opposition to the ARS and pressure to link all contracting of services for this regime to the public hospital network (currently, by law, at least 40% of these contracts must be with the public sector), as well as some sectors fighting for the subsidised regime resources for the ARS to be allocated to the territorial health departments, which would make contracts with the public network.

In terms of decentralisation, the departments and the Capital District (DC) have been collecting health resources independently since 1975, in so-called “ceded income” (from lotteries, alcohol, etc.) and coordinate the management of national budget (so-called “fiscal situated”) resources with the Nation, aiming at deconcentration. Since 1990 they have had the faculty to provide public health activities and medical care services based on receiving fiscal support and on a certification process that demands particular standards

to be met. The uncertified are co-administered by the national government. This was a progressive process, and is as yet incomplete in the departments. The municipalities have had the responsibility for developing basic care infrastructure since 1987, using federal resources. As from 1990, with Law 10, they also have the responsibility for implementing public health activities. And since 1994, after being certified, automatic national transfers are made, calculated with a mathematical formula (poverty index and local development indicators), with 40% dedicated to public health and 60% for financing demand subsidies. They can also receive resources from the departments (equivalent to 50% of the national funds), and since 1996 when the subsidised regime started working, they receive a part from the FOSYGA. The certification rate is also quite low (Jaramillo, 2000).

The deterioration in the capacity of the national health authority to exercise the essential public health functions has, in turn, made decentralisation a real problem for system coordination, since the logic of decentralisation towards the market (privatisation) is not coherent with the political and administrative division of the country, nor with that of social participation, epidemiological control, or the organization of the health care services (Málaga *et al.*, 2001; Villamizar *et al.*, 2002).

Undoubtedly, the change has been of great importance and some of the results of the first 10 years of implementing the reform are seen as positive, such as the increase in coverage (nearly 57% of the population in 2002, 31% in RC and 26% in RS),⁶⁵ although universalisation has not been achieved, and with present economic conditions the trend is to reduce coverage, above all in the RC. For this reason, the number of linked is quite high (43 or 46% of the population, according to various sources).

The Social Security Institute is still the cornerstone of the system, although it has huge deficits and great difficulty adapting itself to the new situation (Jaramillo, Olano and Yepes, 1998:9-16). The private sector was restructured and the EPS displaced the pre-payment plans from their position in the market. All the EPS are implementing cost containment measures, and significant improvements are not expected in quality of care and in health indicators, with health situation indicators rather showing a deterioration in recent years, mainly in infant mortality and morbidity and in infectious, endemic, epidemic and immuno-preventable diseases (Jaramillo, Olano and Yepes, 1998; Málaga, *et al.*, 2001; Villamizar *et al.*, 2002; Echeverri-López, 2002).

The implementation of the subsidised regime was delayed, mainly for the political crises, lack of resources and

⁶⁴ Financially, the hospitals work with reimbursement for services rendered, but can also receive direct federal, departmental or municipal transfers, as well as their own resources for sale of services to the EPS. The manager organises spending and can decide the purchase of supplies and investment in technology.

⁶⁵ The figures mentioned in the text are from the Health Ministry, Health Situation in Colombia – Indicators 2002. However, coverage rates vary according to the different sources. For example, calculations made with data from reports of the CNSSS to the Senate and Chamber Seventh Committees (2000–2001), from the Social Security Observatory/Economic Research Centre/University of Antioquia (June, 2001), and from the Dane, Colombia Statistics, the figures are: total coverage 54%, 31.3% in the RC and 22.5% in the RS, with 46% of linked (Echeverri López, 2002:87, Chart 2).

attempts at “counter-reform”. Only in 1996 (with Law 344/1996) was the subsidised regime in fact implemented according to the competition rules envisaged. It is also pointed out that the ARS (whether EPS or others) are far from acting according to the respective roles given them in the model and the reform is facing many problems in this area. The share of public resources has also been significantly limited in the solidarity component of the system, to only a quarter of what was programmed (Jaramillo, Olano and Yepes, 1998:17-21; Jaramillo, 2000).

Public sector officials and independent providers linked to the EPS view with great apprehension, uncertainty and dissatisfaction the development of the new health market. The labour market has widened for the general doctors, especially the young ones, and specialists tend to group together in corporations to defend their interests. On the other hand, the increase in reinsurance for catastrophic risks has opened up new possibilities for broadening the private insurance market, obviously with additional costs for the consumer (Jaramillo, Olano and Yepes, 1998; Jaramillo, 2000).

Nearly 66% of the secondary and tertiary public hospitals and approximately one third of the general hospitals have been transformed into State Social Companies (ESE) by 1999, but the delays in implementing the subsidised regime and in financial transfers to private hospitals mean that the crisis in the hospital sector continues (Jaramillo, 1999).

There are also problems with the means of paying providers, beginning with the procedures and with the uniformity of remuneration scales. Tax evasion (non-payment of the contribution) and avoidance (denial of income) are very frequent, which implies a reduction in resources to the national fund and difficulties in the solidarity mechanisms in the subsidised regime.⁶⁶ There is also a low capacity for guaranteeing the quality of care in the system, and there is glaring lack of suitable information to the population, as well as the exclusion of important groups, due to contradictory transitory regulations and the multiplication of plans (obligatory as well as complementary). The new market seems to be rapidly incorporating many of the problems of the deregulated private markets, precisely because of failings in the State’s regulatory activity and for the ups and downs of the process of implementing the reform. It can also be seen that macroeconomic efficiency is seriously affected by the great increase in national health expenditures, which reached 10% of GDP in 1999, and were estimated at 12% in 2000, without better results in service provision (Jaramillo, Olano and Yepes, 1998; Jaramillo, 2000).

Also noted are the exaggerated segmentation of the

population; insufficient resources for subsidies and attention to linked, not necessarily poor, who are still being attended by the traditional public sector; great fragmentation of the service network; disorganised development of supply; increase in administrative costs; “economic” behaviour by agents; lack of commitment to the health of the population and greater risk of evasion and corruption in the system; delays in the flow of resources; and failures in the capacity to mobilise new resources, together with an increase in needs that cannot be met.

Effective utilisation of services has not changed and the economic barriers (co-payments and moderating contributions) are still the greatest obstacles; lack of money is the reason for non-use in 51% of the cases of persons who need attention. Recent studies show a worsening in the fairness of the system, from its regressive nature and the increase in families’ private spending, as the mean of direct payments increased for the families from the poorest quintile. In addition, 56 and 63% of the non-affiliates are situated in deciles 1 and 2, respectively, of the population (Echeverri, 2002).

The complexity of the new health system presupposes a significant transformation in institutional culture and in business, contract and audit mechanisms, in a learning process for the agents as well as for the population, including technical and professional re-adaptation and the development of regulation capacity. The State did not really have the necessary regulation capacity for putting this model into effect, and no significant progress has been seen in this area, despite intense technical and bureaucratic normative activity.

To sum up, the balance of the results of the reform are not encouraging. Not only have the aims not been met, but for some writers they are not viable, since the difficulties facing the SGSSS are fundamentally linked to the conception of the social policy and of the transformation of the labour market, inherent in the new development model which, despite the alarming official figures on the deterioration of the quality of life and the impoverishment of the population, has deepened at the start of the decade of 2000, i.e., the model itself is not being questioned by the State.

Even so, the spread of the model to developing countries in the region was recommended as an alternative that at the same time makes it possible to broaden coverage with greater equity and better quality care, particularly for the population with greatest needs.⁶⁷

Since the reform, there has been a speeding up of the writing of specific norms for SRH. And the Development Plan “The Change to Build Peace” proposed for the period 1998-2002, different from previous Development Plans,

66. The evasion is the non-payment of social security contributions of a proportion of the population able to pay; and the avoidance is the social security contribution made on the basis of a lower monthly income than the real one. It is estimated that the resources lost in this way are nearly US\$ 680,000/year.

67. The theoretical proposal of structured pluralism was developed by Frenk and Londoño (1995) and Londoño (1995), and presented in the *Special Meeting of Ministers of Health from Latin America and the Caribbean on Health Sector Reform*, held in Washington, in 1995, and promoted by the main international agencies (PAHO, World Bank, IDB, ECLAC, OAS, UNICEF, UNFPA, and USAID).

includes within the Family and Childhood context, the prevention of intra-family violence and guidelines for SRH attention, with practical implementation to be found in the POS, which includes prenatal check-up, childbirth care, post-partum check-ups, and attention for problems related to breast-feeding; and in the POSS there is also a nutritional subsidy established for girls under one year of age and pregnant mothers. Various contraceptive methods are formally included as part of the medicines in the POS, but in practice, access to these is very restricted and they must be purchased by the user. In addition, the PAB was drawn up with the aim of complementing POS activities for the community in general and for some specific population groups, and it includes information spreading and disease prevention activities, birth control, family planning, education and health promotion, early detection, prevention and control of AIDS and of other highly transmitted diseases.

Within the objective of strengthening the PAB, the Health Ministry recently (2002) established the responsible promotion of SRH as a line of action, with emphasis on the adolescent population, abortion care and the strengthening of male responsibility in SRH. Information, education and communication guidelines have also been published for making sexual and reproductive rights known, as well as promoting the protection of women, girls and young people against all forms of violence, and organising rehabilitation and support programmes for victims of violence and sexual exploitation. On the other hand, there are no interventions included for tackling infertility, sexual dysfunctions, menopause, SRH for the elderly, or the various cancers of the female or male reproductive apparatus.

For young people, there is a broad, complete set of standards for SRH care for this population group, but it is made clear that adolescents' access to the SGSSS is as beneficiaries of their parents who are the contributors in the RC. This is maintained up to 18 years of age and is prolonged to 24, as long as they demonstrate economic dependence, which may make access to services more difficult. Also, for the RS, they do not constitute a priority population for being insured.

Meanwhile, it is important to mention that there are initiatives in the country, both in the public and in the private sector, offering SRH services designed exclusively for care of adolescents and young people, which have specialised human resources. However, these services far from cover the demand and need for SRH of this group, and this is confirmed by the indicators shown.

Despite this, neither the POS, POSS or PAB manage to meet the requirements of a suitable SRH programme, as they coincide in a partial focus, very centred on mother and child-based care services, the absence of men as a target population, the almost exclusive identification with prenatal control, vaginal cytology and the lack of SRH promotion. This was confirmed by several of the experts consulted in the study made by Villamizar *et al.* (2002). In addition, the

population insured by the RS does not have access to services and laboratory tests suitable for diagnosing cervical cancer and that of the uterus, such as colposcopy, biopsy, mammography and others, just as in the case of vasectomy in family planning.

As for abortion treatment, there is consensus in pointing out that what prevails is prohibition and legal penalisation; in addition, there are no counselling services for women who approach hospitals to give them treatment for an incomplete abortion, and since 1994 no new studies have been made about abortion in Colombia.

There are thus some progress in terms of legislation about SRH related rights, but there are also many limitations, generally related with the "invisibility" of particular problems (as for example, violence against women) or the lack of compliance with the specific laws or norms.

The greatest obstacles for accessing the benefits of the SGSSS originate in job conditions and the unequal share that women have in the labour market, which, allied with other issues and problems related with implementing the reform, already discussed in this study, determine unequal access to the system and so to the SRH services.

The women's movement in the country is apparently broad and is found mainly in non-governmental organizations and universities, but it has not managed to have significant influence in the formulation or implementation of the reform, and, just like in other countries in the region, women have little relative participation in the forums of social participation and decision-making in the sector.

BRAZIL

Brazil is a continental country, with a variety of demographic, economic, social, cultural and health situations that, combined through the years, made a mosaic characterised by deep internal inequalities. In the Latin American context, it is the country where the inequality among socio-economic groups is most significant. Despite the improvement in various indicators and the slight reductions in income inequality in all regions, the distance between extremes is still very great. National income distribution has historically been concentrated and, throughout the past two decades, this concentration has gradually worsened, showing that that appropriation is more unfair in the poorest regions. Although there was an improvement in the human development index between 1999 and 2000, mainly due to the education factor, there are still "different Brazils" coexisting, since only five states are in the range of high human development, with all the others in the category of medium human development, and the five lowest indices are in the north-eastern region (UNDP, 2003). Nearly 35% of the Brazilian population live below the poverty line, the equivalent of 57.7 million people (IBRE/FGV, 2003), with 29.9% living in the metropolitan zones, 29.1% in the rural area and 41.7% in the urban areas, mainly in the north-

eastern region, followed by the south-east (IBGE, 2003). Of this total, almost 22 million people live in situations of extreme poverty, 26% of them in rural areas, and the north and north-eastern regions are the poorest, with 13.8 million people in this situation (IBRE/FGV, 2003). The highest indices of extreme poverty are found in the municipalities with less than 50 thousand inhabitants, where state and municipal intervention is quite precarious.

Brazil is a Federal Republic, and its political history is marked by long authoritarian periods alternating with short democratic governments. In the second half of the 80s the country went through its most important transition process towards democracy, culminating in the return to direct elections for all levels of government, including that of president of the republic, after more than 20 years of authoritarianism.

The antecedent of this process was in the 60s when there was great political and social turmoil that ended in a military coup (1964), followed by the gradual emergence of a “bureaucratic-authoritarian” state that kept power for 20 years (1964-1985). This state was more repressive and authoritarian than other authoritarian periods in Brazilian politics. The political transition to democracy (1982-1990), materialised in the “New Republic” (1985-1990), was an important turning point, when the country found itself in crisis again, reflected in economic and political problems on a grand scale.

Put briefly, during the 20 years of authoritarian regime the pattern of exclusion in development was maintained; this generated an extremely heterogeneous and fragmented social structure. In the 80s, the statisation, inflation, individual and regional inequalities, and corruption reached levels hitherto unseen. Living and health conditions of the population also worsened greatly as a result of unemployment, low salaries and a process of social marginalisation related with the large number of informal workers and the precariousness of social rights, services and benefits. National sovereignty was permanently questioned by the international creditors, to whom it was financially submitted, as also by the high degree of autonomy that the large multinational corporations had in decision-making. This situation brought growing institutional and political instability, a worsening of the inflation and economic recession, and finally the impossibility of taking decisions and lack of governability, just as happened in 1964 (Fiori 1995 a and b; 2001 in Pêgo and Almeida, 2002 a and b).

In the mid-80s, this cyclic and entropic dynamic led to a dilemma in which the developmentalist Brazilian State reached its limits. The subsequent democratic transition had particular characteristics: it had initially been programmed as “planned decompression” and as the product of an inter-élites pact (Melo, 1993; Melo and Azevedo, 1996; Fiori, 1995b in Pêgo and Almeida, 2002 a y b); then it relaxed for a long period and was conflictive and confused, in a process that combined some institutional reforms with constitutional reform; finally, it kept the armed forces and the most radical

representatives of the different conservative groups in power (Fiori, 1995 a e b; 2001).

The process of macroeconomic structural adjustment, begun at the end of the 70s, during the authoritarian regime, continues up to the present day in a slow and conflictive way. Between 1979 and 1985 there were nine stabilisation plans, five different currencies, five price freezes, 22 proposals for renegotiating the foreign debt and 19 modifications in the exchange rules (Fiori, 1993; 1995 a and b, 2001), before the very successful inflation control strategy applied in 1994, with the Real Plan, the last economic plan of monetary stabilisation.

It could be said that economic, political and social instability have been part of the daily life of the nation for more than two decades, permeated by the great uncertainty of results and periods of relative institutional and political stability. The indirect election of Tancredo Neves (first civil president after 21 years) to direct the “New Republic”, in 1985, was preceded by a great mass movement calling for “Direct Elections Now” (“*Diretas Já*”) and by direct elections for governors, followed by direct elections for mayors of the capitals. The death of the newly elected president led to the vice president José Sarney, a representative of the political right, taking over. Fernando Collor de Mello, elected president in 1989 by popular vote, suffered serious accusations of corruption and strong national rejection and was impeached and removed in September 1992, with the vice president, Itamar Franco, taking over. In the elections of 1994, Fernando Henrique Cardoso was elected president and re-elected in October, 1998, remaining in power till 2002. That year there were presidential elections again, and Luis Inácio Lula da Silva was elected president, the candidate of the largest left-wing party, the Workers Party (PT), and the first worker to occupy the post in Brazilian history. Changes of ministers, disputes in Parliament, denunciations of corruption, conflicts in the countryside and all kinds of strikes, have been a constant part of practically all governments, which has led to cyclical political crises.

The macroeconomic policy adopted by the governments of Fernando Henrique Cardoso (1994-2002), centred on the exchange anchor, made the national economy significantly more fragile, establishing a cycle of regression, high interest rates, an increase in structural unemployment, a continuous reduction in the wages of the population and an accompanying increase in income concentration. Although this process had been structured since the start of the 90s, since 1994, with the Real Plan, and mainly in the second mandate of President Cardoso, the nation seemed to be responding more assertively to the stimuli and conditions defined by the international community, so that state activity and sector policy instruments were subordinated to the main aim of maintaining macroeconomic equilibrium (Fiori, 1993, 2001). The results, that were considered positive, of the economic stabilisation of the 90s, including some improvement in social indicators, control of the increase in inflation, expansion of consumption and a real increase in

wages in specific periods, were not reflected in a reduction in the huge inequalities in distribution of national wealth.

With the new left-wing government, elected in 2002, great hopes were placed in the possibility of radical changes in this dynamic, with a return to economic growth, reversal of unemployment, and a progressive overcoming of the great social inequalities. But up to now, the general situation of the country does not seem to have changed.

At the same time, Brazilian society is going through important demographic changes that, together with the economic and social changes, also result in modifications to the living and health conditions of the population.

In recent decades the country has seen a significant change in the fecundity pattern, causing a severe slowing down in population growth, but the patterns are still differentiated by region. This demographic transition, rapid and intense as from the 70s, is essentially different from the classic transition of other countries, firstly, due to the speed of the change, as Brazil has reached in four decades the level that took one or two centuries in Europe; and, secondly, because this occurred independently of improvement in the material conditions of the population. However, this decline in fecundity was not produced by any deliberate policy, and there was even a refusal by the government to implement family planning, since they were concerned about occupying the border areas and great territorial spaces, given the low demographic density, as well as the strong influence of the Catholic Church. Likewise, in the 70s, the concern of the core countries with population growth in the developing world was translated into initiatives encouraging technically and financially the appearance of national groups and clinics, to spread family planning among poor women, for the purposes of birth control. A *laissez faire* policy characterised the activity of Brazilian governments in this field up to the mid-80s. Even though government speeches were marked for being much more pro-birth than otherwise and, with current laws that hampered access to contraception, the private provision of contraceptives established itself and expanded in the country as from the mid-60s.

That is, there was in fact an implicit policy of population control, which placed low-cost oral contraceptives in the market and eased access to female sterilisation in a privatised way, as well as acting indirectly, as through access to education, increasing participation of women in the workforce and stimulating consumption through television. This position changed as from the mid-70s, and some factors may have influenced this change – the scepticism about economic growth in the face of world recession and external pressures. More concretely, this topic was always controversial and the Brazilian government never took a clear position on population control (Vieira, 2003:157-160). The population age

structure remains predominantly young (29.6% up to 14 years of age, 54.5% between 15 and 49, and 15.9% over 59), with an increase in the percentage of the population over 60 (8.5%) (IBGE, 2003).

The Economically Active Population (EAP) was nearly 50% of the population in 2001, mostly autonomous workers, with a large share of women in the labour market (48.9%) and a high degree of informality, as more than half the active population had no kind of social security coverage. Half the population in Brazil has an average monthly income (from all jobs) of from half to twice the minimum wage, mainly in the north-eastern region. The average national unemployment rate was 6.2% in 2001, but the monthly search for jobs shows that in metropolitan areas it was more than 12% in February, 2004 (IBGE, 2004). As regards gender inequality, women earn less than men in all the Brazilian states and at all levels of schooling. A smaller proportion of them retire than men, and there are more elderly women with no old-age or work pension at all. The active female population is concentrated in the lower income classes: 71.3% of working women receive up to twice the minimum wage, as opposed to 55.1% of men, and wage inequality increases with pay – there is a greater percentage of men who earn more than five times the minimum wage.

According to Prado and Ponchman (1997), the redistributive effects of economic stabilisation of the mid-90s - with the Real Plan, 1994 - ran out as from 1996, before overcoming the previous picture of income concentration, with a widening of inequalities, although with levels of low inflation.⁶⁸ The explanation seems to lie in the government's unsuitable use of the structural elements of income distribution (employment, taxes and social policies). In other words, the increase in inequalities seems to be associated with the weakness of State intervention in incomes and the growth of the EAP with low-income workers, while the macroeconomic policy adopted hindered a more vigorous expansion of the economy and formed a context that was adverse and unfavourable to the workers. Unemployment and the lack of effective public intervention directed towards the low-income classes, above all those who depend on the minimum wage, ended up contributing to the erosion of what was gained in the distribution profile, obtained in the initial post-stabilisation phase. The same situation can also be seen for a large portion of the population involved in the informal labour market. This panorama persisted even up to the start of 2004, with Lula's government, which came to power in January, 2003, as up to that moment no economic growth could be seen that aimed at progressively overcoming the situation, and the interventions in structural terms in income policies and social policy have been only incipient.

68. With the stabilisation of the currency as from the Real Plan, at first, between 1994 and 1996, there was a rapid reduction in the degree of inequality in incomes that enabled, at most, a return to the previous situation. As from 1996, however, this reduction has been seen to stagnate, with a tendency for income dispersion to increase.

In education, the schooling level of the population is slowly rising and the great regional disparities in illiteracy that existed in 1990 are diminishing – the proportion of illiteracy in the period 1992-2002 fell from 17.2 to 12.4%, mainly in the rural areas (IBGE, 2003), but the number of illiterates is still very high, corresponding to 14.9 million people in the 15 year old group, one of the highest rates in Latin America (WHO, 2001). Although inequalities have reduced, they still exist between the regions with some of the poorest states about 10 years behind the wealthiest states, especially in the northeast. Schooling among the EAP is generally low. The mean of years of study in the country is scarcely 6.1 years, and is greater for women (7.3 years) against the 6.3 years for men (IBGE, 2003).

In health terms, life expectancy at birth has risen (68.9 years in 2001 – 72.8% years for women and 65.4 for men), but it is still lower among lower income segments and there are marked regional disparities and also between the sexes. General, specific and child mortality have fallen, but there are still regional differences.

In the period 1992-1999, the infant mortality rate fell more than 20%, from 44.3 to 34.6 per 1,000 live births; and in 2001, estimates suggest a rate for Brazil of 28.7 infant deaths per thousand live births. Mortality of those under five years of age is tending to fall, mainly in those regions where it was very high, with a greater share of the early and late neonatal component, i.e., in those under six days of life and with less than 28 days. It should be pointed out that high rates in this segment reflect not only the socio-economic conditions and health of the mother, but also inadequate prenatal care, in childbirth and to the newborn. Despite a downward trend in the infant mortality rate in all Brazilian regions and states, it is fundamental to point out that, considering the patterns of more developed countries, and even a significant set of countries with development patterns similar to those of Brazil, the average values are still high (IBGE, 2003).

The general mortality rate fell (from 7.5 deaths per 1,000 inhabitants in 1992 to 6.9 per 1,000 in 2001) (IBGE, 2003), but specific mortality persists with interregional differences, especially in the north-eastern region and the state of Rio de Janeiro, which have mortality rates above the national average: 7.5 and 7.1, per 1,000, respectively. Independent of sex, diseases of the circulatory apparatus stand out as the main cause of death in the country (28% for men and 36.9% for women in 2001) in all regions and states. Neoplasias and respiratory system diseases are close behind, mainly among women, but at lower levels. A study made by the National Cancer Institute (INCA) for the year 2002 estimated that breast cancer in women was second in incidence (40.66 per 100 thousand) and first in mortality (10.25 per 100 thousand); and cervical cancer had third place in incidence (19.82 per

100 thousand) and fourth in mortality. For men, prostate cancer was second in incidence (29.76 per 100 thousand) and in mortality (9.14 per 100 thousand), but there are regional differences (Kligerman, 2003). An analysis of historical mortality data for cervical cancer shows an increase in cases of 29% in 20 years (1979-1998); and in the last two decades (1980-1990) the gross mortality rate for breast cancer showed an increase of 68%, becoming the greatest cause of deaths from cancer in the female population, mainly in the age group between 40 and 69 years (INCA, 2003).

The general mortality rate of young people grew from 128 per 100 thousand inhabitants in 1980 to 133 in 2000 (UNESCO, 2003). The proportional mortality pattern changed significantly with a considerable growth in accidents and violence as causes of death, mainly among young males. The great difference by sex is related to external (violent) causes, which have become the second main cause of mortality among males. Moreover, male over-mortality, despite being seen in all the age groups, is more significant in young people, more exposed to the phenomenon of the higher prevalence of violence in Brazilian society, which is becoming general in all the national territory. In 20 years (from 1980 to 2000), the homicide rate in Brazil grew 130% - nearly 600 thousand Brazilians were killed, or 30 thousand victims per year (three times the war in Iraq). From 1991 to 2000 there was an increase of 95% in the rate of male Brazilians from 15 to 24 years of age killed by fire arms - the national index is 30.9 deaths per 100 thousand inhabitants, with the state of Rio de Janeiro first in national statistics (181.9), followed by Pernambuco (179.5), Espírito Santo (121.7), São Paulo (114.6), and the Federal District (112.7). There are more deaths from homicide than from traffic accidents (IBGE, 2004, based on census 2000). It should be noted that the violence figures related to males are almost four times female mortality for same cause.

Finally, the causes of death due to infectocontagious diseases and those originating in the perinatal period have been falling for some time, and figures are lower in the more developed areas of the country (south-east and south). The highest proportions, seen in the north, northeast and centre-west, are related to the populations' still precarious access to basic sanitation, directly related to infectocontagious causes, and the lack of availability of health care services, despite the improvements seen throughout recent years, according to a census made by the *Pesquisa Assistência Médico-Sanitária* (2002). However, infectious, parasitic diseases or those transmitted by vectors in general have not been entirely eradicated, and these still presented a mortality rate of 5.7% for men and 5.2% for women in 2001, and deaths from endemic diseases (like dengue) also increased because of fresh epidemic outbreaks (IBGE, 2003).⁶⁹

69. In 1999, 632,600 new cases of malaria were recorded, the greatest number since the 70s; but between 1986 and 1998, the mortality rate from malaria fell. Dengue epidemics peaked in 1998 and 2002, the third and fourth since dengue cases began to be detected in Brazil. In 1997, there was an measles epidemic outbreak, controlled between 1999 and 2000; 66 cases of neonatal tetanus were notified in 1999 and 41 in 2000; in 2000, 4,263 cases were notified of hepatitis B and cases

Between 1980 and 1990, the HIV/AIDS epidemic also expanded in the country, showing a trend towards interiorisation, heterosexualisation, feminisation and impoverishment. AIDS has been a systematic target of prevention campaigns, given its power of dissemination when it is not properly controlled. In 2000, the male mortality from AIDS was 9 deaths per 100 thousand, almost three times the female rate (3.7), although the prevalence of infection is increasing in women, the male/female ratio is steadily falling and it is estimated that female mortality from AIDS has been increasing in recent years. The highest mortality rates from AIDS occur in the south-east (13.3 deaths per 100 thousand men) and in the south (11.3 deaths per 100 thousand men). In terms of age groups, these are the same regions that show the highest rates, mainly in the 30 to 39 and 40 to 49 age groups. In the south-east, male AIDS mortality rates in these groups are 35.4 and 29, respectively; in the south, they are slightly lower (28.8 and 22.3 deaths per 100 thousand men), three times those for females (IBGE, 2003). Meanwhile, specific AIDS mortality rates have been falling in the population in the country as a whole, although the fall in AIDS mortality among women was less significant than among men, and has been practically stationary in recent years (Corrêa and Piola, 2003).

No less worrying is the increasing incidence of AIDS in female adolescents from 13 to 19 years of age. This is explained by the earlier initiation of sexual activity for these young people in relation to male adolescents, normally with men with greater sexual experience and more exposed to risks of contamination from sexually transmitted infections (STI) and AIDS (MS, 2003). The estimate of pregnant women infected with HIV in 2001 was 17,198, with the largest proportion located in the southeast region (8,045), followed by the south (3,582) and the north-east (3,464) (Corrêa and Piola, 2003). A sentinel study estimated 17,198 cases of seropositive pregnant mothers and, according to data from the Epidemiological AIDS Bulletin published in December 2002, 191 new cases were recorded since 2000 of girls against 152 cases of boys. Although these notifications are only partial, the new data suggest a deepening of the feminisation. Available data also report that the profiles of men and women infected with HIV in the country are different. Low schooling is seen in both cases; the seropositive woman also has on average fewer years of study than the man, which indicates a lower socio-economic level among women (Corrêa and Piola, 2003).

The birth rate, that measures the proportion of live births in relation to the total population, fell from 23 births

per 1,000 inhabitants in 1992, to 20.9 in 2001, reflecting the proportional fall in the number of births. In the same period (1992-2001), the increase in the proportion of pregnancies in adolescence became general in all the states; in the north-east the increase in childbirths of mothers between 15 and 19 years of age was around 40%, while in the states in the centre-west region indices were lower, around 7% (IBGE, 2003). Data from a recent UNESCO study, in 2001 (2004, *Revista Época*, N° 303, March 8th, 2004),⁷⁰ made among students from the main Brazilian capitals, showed that one in every 10 students became pregnant before 15 years of age, while the percentage of students between 10 and 14 who had been pregnant at some time was 33.3% in Fortaleza, 22.2% in Cuiabá and 20% in Manaus; and, between 15 and 19 years of age, this proportion increased greatly, affecting 34.8% in Recife, 27.2% in Manaus and 25% in Fortaleza. This means that, at present, nearly 14% of Brazilian students have the probability of getting pregnant and, in the state of São Paulo, in the last five years (1999-2003), adolescent girls are responsible for 20% of the newborns in that city. The phenomenon is true for the whole social pyramid: 65% of the pregnant adolescents are in families earning up to one MW, almost half of them in the north and north-east, with a greater probability of remaining in poverty. In the middle class, in 10 years, the share of adolescents among pregnancies increased to 34%, and this proportion is not higher because of abortions carried out in clandestine private clinics.

The maternal mortality rate is quite high in the country and some writers report that it is among the highest in the continent. However, the true amount of maternal mortality in Brazil is still little known, mainly for questions related to the registering of female deaths, which is less accurate and of lower quality than that for male deaths in nearly all regions, as well as for problems in the calculation of the indicator (Volochko, 2003). In 1998, estimates drawn up on the basis of official data indicated that the female mortality rate was of the order of 130 per 100 thousand (Rocha and Andalaft Neto, 2003:268). In 2004, a speech by President Lula commemorating Women's Day (March 8th) stated that for every 100 thousand live births, 74.5 women die due to complications in gestation, childbirth and puerperium. Among the causes of these deaths appear factors such as hypertension, haemorrhages, infections and abortions.⁷¹ Data from the SUS (SAI/SUS, 2001) reported that, in 2001, maternal hospital lethality in the SUS was 28.6 per 100 thousand hospitalisations and lethality in childbirth was of 24.2 deaths per 100 thousand hospitalisations (Corrêa and Piola, 2003).

of hepatitis C are rising; in 1999, 78,870 cases of tuberculosis were notified in all its forms, with an incidence rate of 48.1 cases per 100,000 inhabitants, and leprosy is still an important health problem, with a prevalence rate of 4.9 cases per 100 thousand inhabitants.

70. These data are from a study financed by UNESCO in 14 capitals of the country, made by the researchers Mary Castro, Miriam Abramovay and Lorena Bernadete Silva, who interviewed 16 thousand students from 10 to 24 years of age, all matriculated between the 5th series of basic schooling and the 3rd year of middle school of public and private schools. The results of the study were published in a book called *Juventude e Sexualidade*, but we have not managed to find it. The data presented here were taken from material on the subject, published in the magazine *Revista Época*, No. 303, March 8th 2004.

71. *En Questão*, an electronic bulletin published by the Communications Secretariat of the Government and Strategic Management of the Presidency of the Republic, N.161, received on 08/03/2004.

Available, though precarious, information suggests that 65% of maternal deaths occur in the childbirth period, even though more than 90% of the childbirths occur in a hospital environment (Corrêa and Piola, 2003). UNFPA data (2002) report that at the end of 2001, 88% of the childbirths were attended by a health professional. Maternal hospital lethality, in the area of public health services, fell from 34.8 deaths per 100 thousand hospitalisations in 1997, to 28.6 in 2001, as a result principally of the reduction of lethality at the time of childbirth, from 32.5 to 24.2 deaths in 100 thousand childbirths, in the same period (Corrêa and Piola, 2003). Nearly 98% of the cases of maternal death are avoidable, which suggests a lack of access to health care services during pregnancy, childbirth and the puerperium (Parliamentary Committee Investigating Maternal Mortality, August 2001).⁷² Maternal mortality is the eighth cause of death among women aged between 10 and 59 in the north, northeast and centre-west regions. It also has a disproportionate impact on black, mixed race, indigenous, poor and single women living in the most deprived regions of the country.⁷³

The rate of childbirth by caesarean is still quite high: in childbirths attended in the state public sector, in 1995 and 1996, the average percentage of caesareans was 32%, reaching 43.2%, 39.4%, and 36.9% in the centre-west, south-east and southern regions, respectively. In units of the private health care services network this index was more than 70%, generally associated with tubal ligation. Between 1993 and 1996 the number of caesareans also increased among young women from 15 to 24 years of age (Corrêa, Piola and Arilha, 1998:7). Data from the PAHO (2003) report that between 1996 and 2001, 36% of the births in the country were by caesarean.

The prevalence of use of a contraceptive method went from 65.8% among women with a conjugal union (married or cohabiting) in 1986, to 76.6% in 1996 and to 77% in 2001, and 70% of them used modern methods (Corrêa, Piola and Arilha, 1998; UNFPA, 2002; Vieira, 2003). This proportion is higher than the average found in developed countries (72%). And while in developed countries there is predominance in the use of reversible methods, in Brazil a progressive increase and predominance can be seen of the use of female sterilisation, which grew between 1986 and 1996 from 26.9 to 40.1%, while there was a slight fall in the use of the pill (from 25.2% to 20.7%) (Berquó, 1999). In this period, an increase is also seen in the use of contraceptives among women without a conjugal union, and the use of condoms

among these is three times more frequent than among those with a conjugal union, while the use of the pill predominates among younger women, independently of conjugal union. The generalisation of the use of contraceptives is shown in all the country, even in rural areas (idem). In 1998 the most prevalent methods used were tubal ligation (56.8%) and the pill (29.3%) (Corrêa, Piola y Arilha, 1998), and it is estimated that between 1983 and 2001, 40% of women between 15 and 49 years of age used sterilisation as a contraceptive method, and 3% of men were given vasectomies.⁷⁴

According to the PAHO (2003), only 4% of women in conjugal unions between 15 and 49 years of age use the condom as a contraceptive method. Meanwhile, although there are no recent data available on the national prevalence of condom use, specific enquiries indicate that its use is spreading, especially among women more exposed to infection, as in the case of young people, sex workers, users of injectable drugs and companions of drug users. In this field, the introduction of the female condom implied a qualitative leap. 4 million condoms are distributed annually through 420 distribution points in all regions of the country: 50 in the northern region, 130 in the north-east, 70 in the centre-west, 150 in the south-east and 120 in the south. Brazil today consumes 75% of the world production of female condoms (Corrêa and Piola, 2003).

Among male and female young people (students from 10 to 24 years of age) nearly 63% admit using the condom, more in theory than in practice, since they assume that it is not necessary in all the relations, due mainly to lack of correct information on the risks they are running. Moreover, the rejection of the pill is very high (UNESCO, 2004, *Revista Época*, No. 303, March 8th, 2004).

Provision of emergency contraception is specifically authorised for cases of rape up to 72 hours after the event has occurred. The Health Ministry recently approved one of the drugs used in emergency contraception, even though it is not yet available in the national market (CRLP/DEMUS, 2000:30).

In Brazil, it is estimated that in 1998 there were nearly 23 illegal abortions per 100 pregnancies, similar to the situation found in Latin America and the Caribbean.⁷⁵ According to official figures, abortion represents 6% of the total number of causes of maternal death (or 4.7% if we exclude cases of molar and ectopic pregnancy) and, specifically, provoked abortion 3.4% (Rocha and Andalaft Neto, 2003:267-268). In the maternal mortality profile it emerges as the fourth main

72. The Parliamentary Investigation Committee on Maternal Mortality was set up on April 17th, 2000, by the federal legislature to investigate and map the situation of maternal mortality in the country.

73. National Feminist Network for Health and Reproductive Rights, Maternal Mortality Dossier (*in* *Advocaci - Advocacia Ciudadana por los Derechos Humanos*. Alternative Monitoring Report on the situation of maternal mortality in Brazil - International Covenant on Economic, Social and Cultural Rights. http://www.ipas.org.br/arquivos/mortalidade_materna.doc (02/12/2003).

74. The significant increase in female sterilisation in Brazil in the period 1986-1996 was mainly concentrated in the north-east, north and centre-west regions (Vieira, 2003:167). Studies show that the lack of collaboration of partners and the illegality of abortion have been important factors in the option for sterilisation (Ávila and Barbosa, 1985). It is known that women are sterilised at their own choice and that 80% are satisfied, but regret occurs in cases of sterilization among the very young, those lacking counselling, and with a change of partner (Vieira and Ford, 1996). As well as these causes, other studies have identified the training of the doctor and the woman-doctor relationship as important factors in crystallising this practice (Berquó, 1998).

75. This estimate is based on the procedures adopted in research by the Alan Guttmacher Institute on clandestine abortion in Latin America, using the correction factor 5 (The Alan Guttmacher Institute, 1994; Sorrentino, 2001, *in* Rocha and Andalaft Neto, 2003:268).

cause of death for direct obstetric reasons (preceded by eclampsia, haemorrhagic syndromes and puerperal infections) (Tanaka, 2001, *in* Rocha and Andalaft Neto, 2003:268).

Abortion is still illegal in Brazil except for the exceptions the law establishes. This permits, or, more accurately, does not penalise abortion when it is practiced by a doctor in just two situations: when there is no other means of saving the life of the pregnant mother (necessary abortion) and when the pregnancy is the result of rape (Rocha y Andalaft Neto, 2003).⁷⁶ In the context of clandestine abortions, it is important to keep in mind that haemorrhagic syndromes and puerperal infections certainly correspond to the occurrence of many abortions and that the condition of illegality is also responsible for significant consequences in the profile of Brazilian morbidity and mortality (Costa, 1993, *in* Rocha and Andalaft Neto, 2003:268). The high under-reporting of the death of women from abortion is shown by local level research, but even in this scenario of under-information, in general terms, official mortality is high: *one woman died every three days, victim of this aggression, in the year 1998* (Dossier on unsafe abortion in the Health Network, Sorrentino, 2001, *in* Rocha and Andalaft Neto, 2003:268).

Among young students from 10 to 24 years of age in the whole country, there were nearly 72 thousand cases of looking for clandestine abortion in a universe of 4.6 million students (UNESCO, 2004, *Revista Época*, No. 303, March 8th, 2004).

In relation to social policy, of which health policy is part, the pattern of Brazilian state intervention in the social area dates back to the 20s and 30s, when social and citizens' rights were linked to the place of the individual in the formal labour market, through a social protection system organised by professional categories in the Pensions Institutes, that offered differential medical assistance with unequal coverage. Attention to groups excluded from the economic development process and sanitation activities were undertaken by the Health Ministry. The military coup of 1964, not only implied the exclusion of the trade unions from participating in the sector decision-making process, taking for granted and reinforcing a technocratic view, it unleashed an institutional and administrative reform on a large scale: it unified all the Pensions Institutes (1966) and, in the following decade, created the *National System of Social Security* (1977), which included the main medical services institution, the *National Institute of Medical Care in Social Security – INAMPS*: From that time, the power of formulating the health policy was *de facto* withdrawn from the Health Ministry. The result was the predominance of

health care as an assistentialist model and as a volume of resources. For this, the military governments combined strong State intervention as financier and purchaser of services from the private sector, and favouring hospital care to the detriment of basic and preventive care and public health.

It was against this policy that, in the mid-70s, a group began to take form mainly composed of left-wing militant medical sanitarians, who were based in some preventive medicine departments, university or research institutes, and service institutions. From there, based on a medical-social perspective, the fight began for a change in the health policy.

The building of an alternative reform project of the health system in Brazil thus has antecedents in the 70s, even in period of the military dictatorship, and is influenced by the intense transformation of Brazilian society, mainly during the 80s, when the model of relationships between the State and society began to be harshly criticised, above all in the social area. These are the years in which the huge social debt accrued during the military regime began to take its toll, with the emergence of new actors and social movements, with an extensive series of claims for rights, including demands for more and better health services and activities.

From the 70s onwards, those researchers and professionals in the area of public health joined together in the fight against the military power and its health policy, and formulated the concept of Collective Health, recovering the place of social concerns within the health field, as an analytical category explaining the differentiated manifestations of disease in social groups, and as the context of the subjects themselves acting and defining the needs. The context of growing indignation of different social groups in relation to the military regime intermeshed with the discontent provoked by the health policy, and created the conditions for establishing a broad national movement for health system reform – the sanitary reform movement. A general platform for democratisation gathered around this overlapping of claims, including various left-wing (civic and political party) groups, liberal sectors, workers and business people. In this context of broad democratisation and of demands for payment of the accrued social debt, the political and ideological platform of the sanitarian-collectivists enabled health to be recognised not as an exclusively medical problem to be resolved with health care services, but, on the contrary, it had to be defined first as a social problem to be confronted in the public arena, so that the health care services would not have the same results as the economic and social policies. As opposed to the main features of social intervention in the

76. This is legal abortion as provided for in the 1940 Penal Code, the main law on the subject, prohibiting it in nearly all situations. Meanwhile, despite legal incrimination, abortion is widely practiced and judicial condemnation is unlikely; and, on the other hand, in the circumstances in which abortion is permitted, it is relatively rarely practiced, either for lack of access to services, or for fear of condemnation or for lack of knowledge of the legal procedures for carrying it out. The "accounting" costs of this illegality are very high for the women, either for the humanly painful situations to which they are exposed, or for the serious risks to their health (Rocha and Andalaft Neto, 2003:269).

military period – financial centralisation and control of decisions at the federal level, institutional fragmentation, the absence of social and political participation, a tendency towards the privatisation of the bureaucratic apparatus and a favouring of the private sector in public-private relationships – the proposal of the Single Health System (SUS), that included the creation of a national universal, comprehensive system, with social participation in different decision-making contexts, was presented as the necessary means to realise the dreams of social justice on the part of the population. In this process, the concept of collective health was the theoretical and scientific basis on which the SUS was conceived, and ways were sought to institute social and political procedures that would enable even a partial reversal of the tendency to medicalise social problems. The technical context was thus, to some extent, displaced into the political context (Pêgo and Almeida, 2002 a).

Simultaneously, throughout the same period, the feminist movement participated actively in the struggle for the redemocratisation of the country, allying calls for woman's autonomy with those for social justice, and seeking to make ... *The sense of democracy extend itself into the dimensions of everyday life* (Ávila and Corrêa, 1999 in Lago, 2003). At the beginning, the questioning of female oppression in the field of sexuality and reproduction, that marked the decade in the international feminist scenario, was strategically minimised, as the alliance with the Church and with left-wing parties was fundamental for the struggle against the junta (Bastered, 1993 in Lago, 2003).

According to the concept of preventive medicine current at the time, medical care to the woman during pregnancy had the aim of taking care of the new generation from the earliest, intra-uterine, stages, and, secondarily, taking care of the woman's health. Thus, the health centre team made women responsible for following all the guidelines and specifications for the care of the children after the birth, but refused to attend their requests for themselves as soon as the post-partum period ended.

The lack of public provision transferred the responsibility and the costs related to obtaining contraceptives to the woman. Throughout the 70s, urban women had already decided to have fewer children, but their contraceptive options were restricted to oral hormonal contraception, which they purchased in pharmacies, but without medical prescription, at accessible prices. The condom was available, but the men did not want to use it. Women who could not tolerate oral contraceptives looked for doctors who would perform tubal ligation, which at that time was doubtfully considered illegal and so it was not covered by the social security or by private agreements. To hide the surgery, the doctors began to carry it out during the caesarean and the woman paid for the sterilisation. The association of tubal ligation with caesarean helped to increase the frequency of the latter, which had already been increasing since 1971, when the social security began to pay higher medical fees for caesareans than for normal childbirth.

Thus, at the start of the 80s, the panorama of reproductive health for Brazilian women was characterised by an excess of medical intervention in women's bodies, translated into the choice of the caesarean as the best form of giving birth and of female sterilisation as the best contraceptive (Berquó, 1993, in Lago, 2003). This, linked to the return of women who had acted in the international feminist movement during exile, and the political relaxation achieved in the democratic transition, made it possible for feminist discourse to add to the democratisation debate the ending of the domination of the female body and of the submission of female sexuality to the reproductive function.

So the road to building the new Brazilian health system contains innumerable similar features and intersections with the way leading to the conformation of the political and technical field of women's health, which in turn coincides with the building of the field of collective health. Historically, the two movements originate in organised civil society and in the context of the struggle for redemocratisation, and despite the parallel routes, they connect in specific historical moments, in the National Constituent Assembly (1987-1988) and in the defence of *health as a citizen's right and the State's duty* (Constitution of 1988), and the creation of the SUS, by special law in 1990.

Internal divisions, occupying posts in the State apparatus, and drawing up alternative programmes for organising and implementing health activities as a change strategy, were also common to the two movements.

These social and political movements, and the reform process itself, coincided with a combination of economic crisis, democratic transition and the revitalisation of organised civil society and the political party system. These factors had an important influence on the government's political agenda and on the way in which economic and social issues were tackled. For this reason, the implementation of the reform was strongly influenced by these factors of the time, and permanently threatened by contradictions and conflicts inherent to the economic and political situation, on the domestic and international plane, as well as by the internal problems of the sector itself and the priorities given to State reform (Almeida *et al*, 1999).

The Brazilian health reform in practice turned into a change of huge proportions. The reform project and its accompanying agenda were quite advanced for the Brazilian history of meritocratic-particularist social policies. The conception of institutionalised social security in the new Constitution (1988) includes all the population, generalising access to benefits and establishing an integration between the different areas of social protection with the creation of the Social Security Budget (OSS) and of the Single Health System.

Even though the OSS had been created to face the financial crisis of the Social Security and broaden the basis of solidarity among ministers in the area, through the diversification of sources and a reordering of social contributions, this was not respected, and health was drastically penalised in the 90s, both because the regular

transfers were not made, as well as because, as from 1993, the social contributions on wages were destined to scarcely cover even the purely security benefits.

Irregularities, economic fluctuations and other problems, like the instability of sector authorities themselves, with frequent changes of Health Minister and their respective teams, and the relative loss of priority of the health reform in government policies, led the Health Ministry to take on huge debts, which were a heavy charge on the annual budgets of the 90s and exacerbated sector under-financing.

In addition, in the process of putting into effect the constitutional ideals, contradictory dynamics overlapped and hit the health sector in a particular way. While the measures applying the reform gave priority to decentralisation and called for the strengthening of the public sector, resources for health fell significantly in the immediate implementation period, *pari passu* with the coming together of the neoliberal political consensus during the government of Color de Mello (1990-1992), recovering partially in a quite unstable way in the two periods of Fernando Henrique Cardoso (1994-2002), when the country began to clearly accept the conditions defined by the international financial community and the action of the State, and when the instruments of sector policy had been subordinated to the main objective of maintaining macroeconomic balance. In that way, from then on, the logic of economic rationality began to guide the reform, which provoked fierce tensions between the executive and those calling for “citizens’ health reform”, many of whom belonged to the sanitary reform movement, but at that time were deputies and senators, or advisers in Congress to the main opposition parties, and state and municipal health secretaries. The adoption of State administrative reform proposals, aimed at breaking the State “monopoly” in the sector, completed the picture of contradictions in the health sector reform process.

The decentralisation process went ahead and is the central axis on which the SUS is built, with important changes in the responsibilities of different levels of government and in resource allocation rules, but keeping a strong presence of the federal level. Certain dimensions of the decentralisation process took on specific characteristics in the health area: it was implemented on the basis of the Basic Operational Norms (NOB in 1991, 1992, 1993 and 1996) and, more recently, of the Health Assistance Operational Norms (NOAS 2001, 2002), that define different criteria for authorising the states and municipalities in specific decentralisation periods. The municipal levels became the main service providers and regional differences in terms of service supply were reduced. Meanwhile, the intensity of these changes differed considerably between regions, even within the same region or state, in some cases with indices of a worsening of the quality of care (Barros, Piola and Vianna, 1996; Lucchese, 1996; Almeida *et al*, 1999; Travassos *et al*, 2000). In response to these challenges, the federal level created special programmes (such as the Community Health

Agent Programme – PACS – in 1991, and the Family Health Programme – PSF – since 1994) and defined specific strategies for giving priority to basic care and reversing the assistentialist model, considered as excessively hospital-centred. So the Basic Attention Floor (PAB) was created along with the NOB 1996, updated with the NOAS 2001 and 2002, as from when the transfer of per capita resources for this attention level was put into effect.

In brief, in February 2004, the great majority of the Brazilian municipalities were decentralised (99.7%), with 70.6% of them authorised in the Full Management of Basic Attention and 10.2% in the Full Management of the Municipal System, covering practically all the population. The south, southeast and centre-west had nearly 100% of their municipalities authorised, followed by the southeast with 99.9% and the northeast with 99.7% (MS, 2004).

The decision-making process became more complex with the creation in 1990 of the national, state and municipal Health Councils, in colleges for decision and social control, and the Joint Management Commissions – the federal (Tripartite Joint Management Commission – CIT) created in 1991 and the state (Bipartite Joint Management Commissions – CIB) in 1993 – technical negotiation bodies composed of representatives of the health secretaries and of the technobureaucracy of the Health Ministry in the case of the CIT, and by representatives of the municipal health secretaries and of the state health secretariat, in the CIBs. These became decision-making bodies, but gradually the Joint Management Commissions began to dominate the process, especially the CIT, in which the representatives of the state and municipal health secretaries play an important role (Almeida *et al*, 1999a). The National Conferences and the state and municipal Health Councils act in a regular way, but their dynamics reflect the power-games of the local bosses, showing up the dilemma of building a single health system in a continental country, with enormous diversity and heterogeneity in all areas.

All of this affected the process of implementing the SUS and altered the content itself of the original proposal of health reform, with significant, differentiated effects on both the budget allocation in the services system, and the access, utilization and quality of assistance (Porto, 1993; Barros, 1996; Vianna and Piola, 1994; Giovanella *et al*, 1996; Almeida *et al*, 1999, 2000; Travasso, *et al*, 2000). On the other hand, the specific detail of the Brazilian reform process seems to become diluted when it leaves paper and has to face the reality of changes in the various intra- and extra-sectorial contexts – macroeconomic adjustments, administrative reform of the State and the implementation of new system management models.

The implementation of the SUS has thus taken place in different states and municipalities heterogeneously and unequally, with indicators of a worsening in the quality of care, whenever it has not been accompanied by the necessary investments. At the same time, the restructuring of the health care services markets has been looked at, and the

public and private mix works differently among the various states of the federation (Almeida, 1998; Bahia, 2001). In other words, the fiscal stress provoked by the economic adjustment process has helped to damage public services and the private network agreed with the State, as well as the expansion of the private insurance sector that has already reached its “limit” in terms of accelerated growth. In parallel, and in response to the piling up of civil suits against the private insurance sector, in recent years the government and the Congress have got into the arduous process of regulating this sector, that has powerful, well-organised lobbies, strongly rooted in sector politics.

The municipalised SUS hits up against deep regional disparities, bottlenecks placed by the economic situation and the lack of coordination or more effective redistributive mechanisms. Some innovations, such as the creation of autonomous regulating agencies (like health vigilance, private insurance sector regulation), the proposal of the federal executive to give priority to basic attention in the municipal context through payment per capita (PAB), of encouraging special programmes (PACS and PSF) through incentives, without sufficient restructuring of the service network, risks increasing or deepening the fragmentation of the system and promoting a focalisation on particular kinds of care for specific groups. The municipal groups benefiting from new powers ended up incorporating some of the management “innovations” that came out of their own experiences in sector administration, as well as from the mass dissemination of the “new reform models” (outsourcing, introduction of competition models, and of business management) under the charge, above all, of international agencies.

In brief, the SUS is immersed in a stage of standing up to macro-type processes, that set new guidelines for old sector traps, such as the incorporation of innovations, regulation and the question of finance. On the other hand, a definitive percentage of OSS resources were recently approved for health (2004), a significant point in the universalist agenda of reform from the Constituent Assembly, which, meanwhile, is being questioned by the economic area of the current government.

So it is in the interior of the rationalising and universalist dynamics, pushed by the different social and political forces fighting for control of the development model, that the health sector reform process is taking place. Obviously, a new health system is under construction, the main feature of which is its being open to diverse social groups, and which managed to change its decision-making axis, exclusively centred on Brasilia, to incorporate state and municipal actors, although the implementation of the reform does not yet ensure better levels of fairness, particularly in a long-term general context which continues to generate poverty, with no end in sight in the near future.

As regards SRH, the debate about female autonomy starting from the body, understood as the most private space in existence, to their life projects in private and public contexts, is linked with the demand for women’s health care adapted to their own needs. This movement has spread through the country, involving a great number of women of different social classes in meetings and discussion groups, creating specific forums, organizations and committees (in the executive, in parliament and in civil society) to keep the struggle moving forward (Corrêa, Piola and Arilha, 1998; Corrêa and Piola, 2003).

The return of elections for state governments, declared for 1982, encouraged the incorporation of part of the feminist agenda in the government platforms of opposition candidates who managed to be elected in some states, such as São Paulo. In this state, a group made up of women technicians from the Health Secretariat, women scientists, social workers and representatives of the organised women’s movement, was given the task of formulating the state programme of comprehensive health care for women, as soon as the elected government took office at the beginning of 1983. Almost at the same time, a task force was also created by the Health Ministry, composed of feminist technicians from the Ministry and doctors from the University of Campinas, which drew up the document of guidelines for the national programme, later widely debated by the women’s movement (Costa, 1999) and finally published as “Comprehensive Care for Women’s Health: Bases for a Programme of Action”, in 1984, (MS, 1984), and translated the following year into the Women’s Health Comprehensive Care Programme (PAISM, 1985).

Formulated during the discussion process of Brazilian health reform, the PAISM was based on the premises that inspired the restructuring of the health system – priority for basic attention, disease prevention, health protection and comprehensiveness in care – that originally guided prenatal check activities, assistance in childbirth and puerperium, cancer prevention, sexually transmitted infections, adolescent and menopause care and contraception assistance. The PAISM moved away from the mother-child perspective that had dominated the care model for decades. After its formulation, the aim of Brazilian feminists was to combine the demand for the legalisation of abortion with the call for a broad public policy of reproductive health. In 1986, a Commission for the Study of the Rights of Human Reproduction was created in the Health Ministry (Corrêa, Piola and Arilha, 1998). The state councils for women’s rights (created in 1982) and the CNDM (created in 1985) gave support to the premises of the Programme. The CNDM backed the mobilisation of women’s organizations during the drawing up of the new Constitution, and took part in negotiations for obtaining international cooperation resources for the PAISM.⁷⁷

77. An agreement between UNFPA and the Health Ministry, between 1986 and 1990, transferred 25 million dollars for the implementation of the programme. Investments were also made by the OPAS in staff training.

But it was conceived as a special Health Ministry programme, and implemented basically with an emphasis on activities for particular groups and on specific epidemiological problems, structured as a vertical programme, leaving the Health Ministry with the central role in its implementation, even in the distribution of supplies.⁷⁸ In 1984, when the PAISM was formulated, the problems of reformulating the health system would also have repercussions in the programme, affecting the investment of resources, the operation of the activities, the quality of services and access, leading to its gradual distancing from its original formulation.

During its implementation (1984-1998) it became more and more consolidated as a vertical programme, and its components gradually became dismembered. In this way, in 1988, the “adolescent component” was separated, becoming another special programme, the Adolescent Health Programme (PROSAD); and, in 1986, the National Programme of Transmittable Diseases was created, renamed in 1988, as the National AIDS Programme (PNAIDS), and both promoted the creation in the states of centres for training health professionals that did not communicate with each other. In addition, in 1986, a large injection of resources, even international resources, was made to the PAISM, after negotiations with the World Bank, that also included the PNAIDS (in 1992), strengthening national coordination through the setting of norms and monitoring, and encouraging fragmentation and isolation (Corrêa, Piola and Arilha, 1998).

Until very recently, this dissociation reigned in the area of the Health Ministry, and was reproduced in the states and municipalities. Between 1993 and 1997, the central coordination of the programme deepened its links with the State Coordination for Women’s Health, including the transfer of resources. This verticalist logic had shown itself to be quite insufficient in the context of decentralisation, and the general situation has also interfered significantly in the running of the Programme.

For this reason, the implementation of the PAISM was not satisfactory, since it did not manage to incorporate in most of the services the simultaneous supply of all the activities planned in the programme nor the comprehensive personal care perspective in the daily practice of the health care services or of a great many of the professionals. But, alongside these limitations, access was broadened for women to public health services for other reproductive health needs apart from pregnancy care (Lago, 2003). The most important was the attempt to break with the traditional paradigm of utilitarian attention to the mother’s health, which had remained fixed in the thinking of the key theoreticians and managers of the health reform, even though its translation into practice required more time, or rather, the formulation of new knowledge and tools to put it into operation.

In brief, putting the Brazilian health reform into effect presupposes a structural change in the health system on a grand scale, that includes not only redefinitions of sources of resources and suitable incentives, institutional, administrative and management reorganizations, but also deep alterations in the work process, in the way in which health care is produced in the everyday running of the services, from the relation between the professional and the user/client/citizen and of this professional with the community and the population to be attended.

This restructuring has also demanded considerable regulatory activity by the State, bearing in mind the need to link a multiplicity of goals and institutional, technical and social interests around the aim of implementing the SUS, the main axis of which is in the decentralisation policy. This has meant the development of regulatory capacities that cover wide areas of intervention, such as the relations between powers, between institutions of the Executive, between levels of government and between public and private actors; the definition of funding rules and ways of paying for programmes and activities; the monitoring of the sub-sector of private medical care; the training and recycling of human resources, as well as the need to revise and restructure the public and private mix in the health care services system, in all its dimensions.

So the dynamics of implementing the reform involves an infinite number of measures of varied scope and breadth, but a central role in this is certainly occupied by the formal decision-making structure set up with the reform: the Joint Management Commissions and Health Councils (national, state and municipal). Designed from a democratising perspective, these forums constitute the privileged *locus* in which representatives of the various sector interests express their voice and their vote. This dynamic has displaced the movements of participation and expression in the sector area, for the Joint Management Commissions (at federal and state level), which are eminently techno-bureaucratic, which results in discussions that are not exempt from contradictions, lack of synchronisation or overlapping. The CIT plays the role of arbitrator in the complicated negotiations about the political, administrative and financial decentralisation of the SUS, as it brings together the main managers of the sector at the federal context. This institutionalisation reinforces to some extent the power of the techno-bureaucrats and brings the conflicts inherent to the relationships between the various levels of government into this privileged forum of negotiation between managers. This also occurs to the detriment and a certain loss of prestige of the collegiate forums with participation of the civil society, such as the Health Councils, in the different government levels.

However, the way in which the decision-making arena

78. It was located in the National Secretariat for Special Programmes (SNEPS), together with Food and Nutrition, Hanseniasis, Tuberculosis, Dermatology (that included Venereal Diseases), etc.

was structured legitimises the priorities defined by the central level, with the negotiations that guided the elaboration and approval of the Basic Operating Norms (NOB), especially the NOB 1993 and 1996, and more recently the Health Assistance Norm (NOAS 2001, 2002). Without a shadow of doubt, the greater politicisation of discussions on the health sector reform, the complexity of the negotiations and the obligation to expose the different “projects” and perspectives to debate in the implementation of the reform, has been a benefit in itself.

The structuring of the different conditions of decentralised management and the innumerable conditions, demands and rules for transfers, show an excessive setting of norms or *normalising compulsion* (Goulart, 2001:293) making up what some writers call *tutored decentralisation*, in which *there is excessive control on the means of operation and weak instruments for evaluating results*. (Arretche y Rodríguez, 1999:130). On the other hand, there also seems to be a certain “*isonomist*” *utopia* (Goulart, 2001:293), i.e., the tendency to treat the extremely diversified reality, characteristic of a continental country like Brazil, within the limits of the norms. This dynamic seems responsible, on the one hand, for the low capacity for innovation of a large part of the decentralised agencies, transformed into mere “satisfiers of requirements”, without being stimulated to think creatively about the local situation, the needs of the populations under their charge, or even to be trained and supported to develop a greater implementation capacity at local level. And, on the other hand, it seems to strengthen the techno-bureaucracy that historically holds a greater bargaining power. Moreover, the difficulties deriving from the insufficiency of resources, generated by national level financing problems, have taken up a significant part of the debate in these decision-making forums, whose limits are defined by the executive. In other words, the institutional arrangements are shaping the channels of social participation and control and conditioning the terms of the political debate.

These considerations are important for the discussion of the Brazilian health reform, as it is inserted in a broader process of passing from an extreme form of centralised federalism towards some mode of cooperative federalism, still not clearly outlined or implemented. Meanwhile, sector experience is complex in itself, but at the same time quite enlightening.

The new institutional arrangements implemented with the health decentralisation process show an innovative dynamic, undoubtedly, that has changed the correlation of forces in the decision-making arena and permitted the negotiation of policies that, although on one side they may legitimise restrictive schemes, on the other, may point towards a reversal of the assistentialist model, with greater protagonism of state and local systems in the structuring of their respective health systems and, possibly, reach greater levels of equity.

On the other hand, giving priority to basic attention,

with the transference of resources *per capita* and with the emphasis attributed to PSF as the main assistentialist model change strategy, encouraging disease prevention practices, comprehensive health promotion, protection and recovery, if this is not accompanied by substantial investments and reorganisation of the other levels of attention, it may not be effective and may become a focalised way of giving priority to care to particular population groups, as the increase in installed capacity (in the case of PSF teams and community health agents) does not always result in an increase in coverage; nor is comprehensive care guaranteed as the incentives do not give priority to, nor are they directed to promoting, connections between care levels.

Concretely, with the changes in resource allocation towards basic attention, put into effect as from 1998 with the creation of the PAB, some improvement can be seen in resource redistribution. Meanwhile, this new systematic distribution, despite equalling values *per capita* for funding out-patient activities considered basic, does not take inter-regional inequalities into account, either as far as existing needs are concerned, or in the network of assistentialist services in the different regions. So the **homogenising effect** of the PAB, that enabled a broadening of the equal distribution of resources for the set of municipalities which did not reach the production corresponding to R\$10.00 per inhabitant/year, and the insignificance of the reduction for some municipalities, caused by fixing the maximum limit for the PAB (Levcovitz, *et al*, 2001:288), although this may be more redistributive, it may not be more equitable, as achieving equity presupposes an uneven distribution of resources to compensate for the inequalities. The use of the historical series as a basis for calculating the funding of basic care, without adjustments for some needs indicator (although using proxies as morbidity indicators) perpetuates inequality or historic needs (Silva, 2001 in Almeida *et al*, 1999). The different strategies for funding basic care, on the one hand, and the other more complex procedures and hospital care, on the other, do not facilitate the change from the model centred on medical care nor alter the historical asymmetries between the public and private sectors.

The balance of what has been achieved in the SRH area and of the effects of the reform make some interrelated topics stand out, which it is worth reflecting on.

In a context of a lack of resources and of varied political crises, the process adopted for institutional reorganisation on the way to setting up the SUS, centred on decentralisation and implemented specifically, immediately provoked disorder in assistance and, in the case of women’s health care, even a regression in the first half of the 90s. The redefinition of competencies at the different levels of government, the process of decentralising care, and the resistance, or intolerance, of the “reformers” to evaluating the role of the vertical care proposals, led to the discontinuity of the health programmes and the consequent interruption of the implementation of the PAISM (Lago, 2003).

This was worsened by the difficulty of putting it into operation generated by the debate about the concepts of horizontality of assistance and organization of attention through the demands expressed by the users in the services, or by the population's health needs *versus* the organization of the assistance through priority problems or programmes, as well as the discussion about focalisation. In the midst of all this ambivalence, the disconnection in the federal and state context between the programmes that had begun in the previous decade ended up making the basic health services, in most of the municipalities, regress in the organization of programmes for adult care, and begin to attend them based on a "quick response" model, restricting the preventive approach to the traditional programmes of child-rearing, prenatal control and vaccination (Lago, 2003).

The continental size of the country, the administrative scattering in more than five thousand municipalities and the numerical insufficiency of members in the organised women's movement to confront these problems, meant that it was impossible for advocacy work to have more impact. The priority given to women's health, previously won at federal level, was not repeated in the state or municipal levels, with very few exceptions. In fact, there was a regression in standards also in the Health Ministry at this time, with the change in management staff and the return to the mother-child approach.

International cooperation for developing the PAISM, basically provided by UNFPA, was always more technical than financial and provision fell quickly, because national population surveys showed, already in the mid-80s, the accentuated fall in fecundity rates that was the main target of the cooperation, although it was presented as the widening of women's access to contraception.

During the final decade of the 20th century, the women's movement broadened, deepened its organization, and strengthened itself strategically with the creation of the National Feminist Health and Sexual and Reproductive Rights Network⁷⁹ in 1991, which had among its principles the defence of the implementation of comprehensive women's health care activities in the SUS, the recognition of sexual, racial and domestic violence as a violation of human rights and the decriminalisation of abortion (Red Feminista, 2002). This interconnection was fundamental for increasing the number and level of groups of women in the field and to intensify activities together with the legislature, the federal government, the state and municipal governments in the biggest cities, including participation in state and municipal health councils (Corrêa, Piola and Arilha, 1998; Corrêa and Piola, 2003).

Another important fact in this decade was the holding of the International Conferences in Cairo (1994) and Beijing (1995). In the preparation process for the ICPD, the original principles of the PAISM would be revitalised. In September 1993, the women's organizations held an event in the National Congress, in which the implementation of the Programme and the legalisation of abortion were confirmed as priority claims (Corrêa *et al*, 1998; Corrêa, Piola and Arilha, 2003). The action platforms generated in the two Conferences also came to be used as an instrument for pressure on the State to put into practice effective policies for widening the exercise of sexual and reproductive rights. The most expressive case was the impulse given by the Cairo platform to the implementation of abortion care in the cases included in the law. Abortion has been included since 1940 in the Brazilian Penal Code in cases of pregnancy from rape and to save the life of the mother, but up to 1994 there were not more than three public services that performed this, all in the state of São Paulo.

In 1996, at the initiative of the feminist representation in the National Health Council, the Inter-sector Commission on Women's Health (CISMU)⁸⁰ was reactivated, as an advisory body. The commission is responsible for monitoring policy in women's health. All proposals for action from the Health Ministry in this field must be debated in the commission, which later presents its opinions to the plenary of the council. It can also formulate proposals for Resolution to be examined and perhaps approved by the Council. Among the main resolutions approved are the introduction of the notification of maternal deaths and the implementation of abortion care services in the cases permitted by law within the SUS in 1997. This Resolution was signed and published by the Health Minister in March 1998.

There were great difficulties in translating into reality the advances in terms of reproductive rights won in the Constitution of 1988. A constitutional reform proposal to include the right to life from conception in its preamble, was presented to the National Congress in September 1995, and was filed in virtue of the intense mobilisation of feminists, allied politicians, progressive doctors and of the unfavourable reaction of the mass media, since this reform would necessarily imply the abolition of authorisations for abortion in the case of rape and risk to the mother's life, included in the Penal Code (Corrêa *et al*, 1998, 2003; Lago, 2003).

Projects to regulate family planning, according to constitutional principles, were dealt with in the Congress up to 1996 under great pressure from the "controlists", the representatives of the Catholic Church, medical associations

79. The National Feminist Network of Sexual and Reproductive Health and Rights is nowadays a grouping of 113 bodies (women's groups, NGOs, research groups, trades union associations, women's rights councils), feminist activists and professionals working in the field (Rede Feminista, 2002). The Network still keeps an internet page (www.redesaude.org.br), with publications, data and information.

80. The Councils can create advisory committees to examine topics of greater importance and/or specificity, suggesting directions for the debate and deliberation of the plenary. The CISMU had already worked between 1993 and 1994, but it was dismantled in 1996 and, in a new composition, then had four ministerial representatives and seven from the civil society (Corrêa *et al*, 1998, 2003).

and feminists. The law was approved by Congress in 1996, but the articles about access to female and male sterilisation were vetoed by the President. In response to the intense mobilisation of the women's movement and the interference of the National Council on Women's Rights, the veto would later be annulled by the National Congress and the respective articles finally sanctioned by the President in 1997. The law establishes the duty of the State to provide access to information and means for family planning, making the management levels of the SUS responsible at the three levels of government to do it as an integral part of comprehensive attention to women's health. For sterilisation, it establishes as prerequisites, legal majority (at that time 21 years of age and recently changed to 18), having at least two children, or a minimum age of 25 and the signed consent of the partner. The provider can carry out the procedure only after a minimum of 60 days from the request, during which time information must be offered to the petitioner and access to all the non-surgical methods of contraception and, mainly, making clear the negative consequences of choosing this definitive alternative. The law also forbids the realisation of tubal ligation at the time of childbirth, except for specific obstetric situations, and establishes penalties for providers who do not obey any of the conditions included. The negotiation process that made the approval of the law possible in the Congress defeated the position of the Catholic hierarchy that opposes the use of non-natural practices for regulating fecundity, but, as happens in every negotiation, it did not completely meet the wishes of any of the actors involved in the debate. The need for the signed consent of the husband so that the woman can be sterilised means, of course, a restriction on her autonomy over reproduction and her life project, going against basic principles of the feminist struggle.

The medical associations were opposed (and still are) to the interference of the legislature or the State in decisions that they consider exclusive to the doctor-patient relationship, such as the definition of the best moment and means to carry out the tubal ligation. Moreover, the limits of age and number of children divided opinions across all the groups, going from more liberal positions that understand the requirement of two children and the non-adoption of legal majority as the only prerequisite for the petitioner, as a limitation on their decision-making capacity, to the rejection of these, considering that they are too early and encourage high percentages of regret after sterilisation.

The first setting of norms for the law by the Health Ministry included payment for female and male sterilisation procedures, already in 1997, but this was not sufficient, since there was no consensus on the meaning of the "moment of childbirth" as an impediment for sterilisation. This operational definition would not be made by the Health Ministry until 1998, and made it still more polemical, fixing 42 days as the minimum period between childbirth and the procedure.

In the SUS, discussed above, the definition of basic

attention as the priority, with specific financial incentives – the establishment of *per capita* financing – and the direct transfer of these amounts to the municipalities, and with specific special programmes – PACS and PSF, was the most significant advance in the second half of the 90s. The vast majority of the municipalities responded positively to this measure, increasing their coverage of basic attention for the population. In the case of women's health, the number of appointments per year for prenatal check-ups made in the SUS increased 70% between 1997 and 1998 (Lago, 2003).

Women's health would then return as a priority for national health policy only in 1998, with a new change of minister and the creation of the Women's Health Technical Area in the Health Ministry, which defined priorities based on the main health problems of women that had to be tackled. Its ultimate aims were to ensure reproductive rights, reduce female mortality from avoidable causes, in particular maternal mortality, from cervical cancer and from AIDS, and to insert the health sector within the national effort to tackle violence against women. The formulation of strategies for reaching these objectives sought to use SUS management mechanisms that could induce the state and municipal managers to give priority to attention to women, organise and adapt the various levels of care to respond to their needs and to encourage attention to normally excluded women. There was also an effort to identify forms of sustainable financing for attention to women, and to consolidate the involvement of key intra- and extra-system actors in formulating and implementing the actions. The inability to develop a strategy that would enable tackling the main components of comprehensive attention to women at the same time, permitted the option of working with one problem at a time.

In relation to care for women during pregnancy, a set of measures were implemented to humanise childbirth care, to raise the standard of prenatal check-ups, and to broaden women's knowledge about the important components of this assistance, encouraging social control. The measures included a substantial increase in the amount paid to the providers for childbirth assistance, recognition of payment for childbirth assisted by an obstetric nurse at the same value paid to the doctor, the establishment of a maximum and falling percentage of caesareans paid by the SUS in each hospital, cash prizes for hospitals offering humanised attention to women, financial incentives transferred to the municipalities for pregnant mothers attended suitably, according to process indicators, and support to the National Feminist Sexual and Reproductive Rights and Health Network for producing and distributing a leaflet on the rights of the pregnant woman in the health care services. These measures led to a reduction in the rate of caesareans and of hospital maternal lethality in the SUS already in 1999 (Lago, 2003).

To broaden the coverage of early detection and timely treatment activities of the precursor forms and of cervical cancer, in collaboration with the National Cancer Institute,

a national campaign was made in August/September, 1998, calling women aged between 35 and 49, who had never had the cytopathology test done or had three or more years without having had it done. This was preceded by a huge mobilisation of the system and allocation of financial resources to increase the operational response capacity, including temporary hiring of cytopathology doctors mobilised by the Brazilian Cytopathology Society, and the training of health professionals in the collection of material, and of doctors for the high frequency surgery. Agreements were signed with medical and nursing associations to carry out the training sessions. Financial incentives were introduced for the municipalities and medium complexity service providers. Supplies were purchased for the test, and medication and equipment to support the activity over time. A national information system was introduced to monitor the epidemiological pattern of the alterations and enable the localities to have contact with the women needing treatment if they did not obtain the service. Agreements were made with feminist NGOs to form prevention promoters. Some 3 million women took part in the campaign, and nearly 1 million reported having taken the test for the first time. More than 12 thousand women were diagnosed with a precursor lesion or cervical cancer, 9 thousand were treated, but it was not possible to identify what happened with 2700 women (INCA, 2002). All the financial incentives created in the campaign and the information system were incorporated in the SUS routine, to encourage the maintenance of the broadening of operating capacity that had been won, and to give continuity to the activities in everyday services.⁸¹ The results were considered positive by the Health Ministry, which proposed joining with the routine programme, campaigns directed to this population group every three years, as the frequency with which the women make use of health care services diminishes considerably as from 30 years of age, and it is precisely between 35 and 49 when the probability of having a non-invasive cancer is greatest. A second campaign should have been carried out in 2001, but administrative problems meant it was postponed for 2002. The impact of the strategy adopted should be evaluated as from the availability of the deaths registered in 2004, when effects may begin to emerge on the mortality rates.

No specific policy managed to be clearly defined for confronting the AIDS epidemic in the female population. Despite the quality of the Brazilian programme for fighting the epidemic, the interest of the two technical areas (AIDS and Women's Health) and the efforts made to build a joint activity, various obstacles persisted and hindered its formulation. The general understanding that the pattern of gender subordination in relationships between men and women makes the negotiation of safe sex difficult, and increases female vulnerability to infection, is not sufficient

for subsidising concrete and effective prevention proposals. On the contrary, it tends to encourage innocuous, if not erroneous, interventions. A good example of this is the "belief" that heterosexual transmission today in the country affects mainly women "married" with heterosexual men, and sexually faithful to their husbands, without there being a single prevalence study that shows this. This idea derived from inferences based on constant variables from case notification reporting, immediately became transformed into a fact, and ended up launching social communication campaigns encouraging men to use the condom "away from home". This is not an impossible situation, but it is necessary to verify it. On the other hand, the international resistance to accept and spread the scientifically known fact that women are biologically more susceptible to the infection, for fear that men would start to worry even less about protecting themselves, delayed at least a decade the possibility for women to become aware of their greater risks (Lago, 2003). In practice, the most effective activities directed to women have concentrated on sex-workers, for their occupational potential for disseminating the virus, and in the prevention of vertical transmission, which is unquestionably fundamental as there is no way of reducing it drastically. But the lack of investment in broadening opportunities for prevention and early detection of the female infection, based on the size and complexity of the operation required, takes up again the same perspective as the mother-child interventions of the past, quite similar to the perversity of telling a woman during pregnancy that she is HIV positive (Barbosa and Lago, 1997). The delay in intervening and the inadequacy of actions to destroy the epidemic in women, together with its historically later incidence in the female population, is reflected in the lower reduction of female mortality from AIDS (16%) that that seen among men (23%), as from 1997, when the antiretroviral therapy began to be provided free in the country (Barbosa, 2003). So specifically confronting the epidemic in women is still pending and demands urgent solution.

The publication of the technical standard guiding the implementation of care for women in situations of sexual violence, and the sending of federal resources to support the establishment of state and municipal services, contributed to the country having 245 health units by 2002 offering this kind of care. The standard also establishes the technical procedures for interrupting pregnancies arising from rape, and for this reason aroused a furious reaction from the Catholic Church, directed at the Health Minister, the National Congress and through public announcements. Church representatives even used the standard to guide the faithful to vote for other candidates. Bills were presented in the National Congress by members of parliament linked to the Church to suspend the standard, but were tabled because

81. The programme recommended that in the SUS routine, a cytopathological examination should be offered to every woman who had initiated sexual activity. The first two exams should have an interval of one year and, if negative, a regularity of three years.

of the reaction in favour of the standard by the women's movements, political allies, representatives of medical associations and the mass media of communication.

The broadening of access to activities supporting family planning was the most difficult challenge to reach, and in fact it cannot yet be said that this has happened. Throughout these five years, three different strategies have been used for this purpose. The inclusion of contraceptives in the basic list of medicines that can be purchased by states and municipalities with their financial resources⁸² destined for pharmaceutical assistance was a failure, since in only four states did the Bipartite Joint Management Commission include them. The return to the Health Ministry purchasing supplies and distributing them to the municipalities through the states was seen as inefficient in an evaluation made before the purchase programmed for the following year. The matter was discussed in the Tripartite Joint Management Commission, which approved the current strategy as from the second half of 2002, consisting in the centralised purchase of supplies, and sending them directly every quarter to all the municipalities, together with the medicines sent by the Health Ministry for the Family Health Programme. An external evaluation made after the first quarter showed that the strategy was suitable, but indicated the need to increase by 30% the quantity of contraceptives acquired (Faúndes *et al*, 2002). There are still obstacles to suitable care in this field, mainly related to the authoritarian attitude of the professionals and their insufficient technical knowledge. An evaluation of the strategy is about to be made focusing on access and the quality of care (Lago, 2003).

The results of implementing the strategy of the ATSM/MS in recent years (1998-2002) have generally been evaluated quite positively, and this is confirmed by the improvement in specific indicators. However, there are still unsolved problems, which have as much to do with the strategy itself as with problems in implementing the SUS. In this perspective, the limitations and difficulties found in the women's health area are not different from those that other areas, previously structured vertically, have faced.

Just as in other areas of the Health Ministry, the urgent need had to be faced of responding both to old health problems (prenatal care, childbirth and contraception), and to emerging ones, such as AIDS, at the same time as struggling with financial and institutional reorganization restrictions, inherent to the structure of the SUS. The definition of priorities was thus the strategy most indicated for tackling this kind of situation, and this should not be confused with focalisation (Lago, 2003).

The definition of the strategy of the ATSM/MS to deepen the process of consolidating the SUS around problem resolution and to link part of the funding to specific incentives, widened the institutional tensions and the

Health Ministry would be frequently accused of recentralising power in heated debates in the forums of management and of social monitoring. In the case of women's health, to this tension was added the opposition from the organised women's movement to the choice of working by problems, as they understood that this meant breaking with the idea of the comprehensiveness of attention (Lago, 2003; Corrêa and Piola, 2003).

Thus public policy in women's health has to continue looking at long-term objectives, but responding to the present and urgent demands of women, using to the utmost the potential of the mechanisms and the technology available today. The strategy adopted in the national cervical cancer control campaign, directed to a particular population group, as a complement to the continuous and open attention sought spontaneously, is one example. It is a mistake to understand this as focalisation, as this intervention is not a substitute for continuous and potentially universal attention, but complements it, including women who are not habitually within the services for various reasons (Lago, 2003).

According to some actors, one very common feature in the militants of the sanitary reform movement is to pursue the building of the single system with such intensity that the construction process takes priority over the need to obtain concrete results in improving health and attention to the population in the present (Lago, 2003). As an example, almost invariably, when its representatives take management positions in different levels of government, they begin with institutional or administrative reforms that often occupy the first year of office, and if these do not give as a result breakdowns in end care for users, neither do they produce evident improvements. In a similar way, part of the organised women's movement has an exaggerated appreciation of the process and of the indirect gains that this can give to the greater struggle for women's empowerment. It must be kept in mind, however, that in social policy, the function of the process is to make the desired results reach the population, and that these must be defined and measured for the immediate effect – and here are included the reduction of avoidable causes of women's deaths that impose the greatest inequity between rich and poor women, and between black women and white – in the medium and in the long term. The absence of this clear definition easily leads to the process stopping (*idem*).

However, it should be mentioned that the criticisms presented by the women's movement in the heated debates in their representative forums never actually impeded the implementation of the measures proposed by the ATSM/MS. These, together with a significant part of the women's organizations, chose to monitor the working of the actions and their results, without losing the critical point of view. And the same can be said of the sanitary reform movement.

82. The federal government, the states and the municipalities contribute equal shares to this fund, which has an annual total value of approximately US\$1.00 per capita.

In fact a leap in quality has been seen as regards the incorporation of women's health priorities in the management and funding instruments of the SUS, which meant overcoming the isolation that had characterised its policy between the end of the 80s and 1997. It is also interesting to notice the fact that the strategy that the ATSM/MS adopted was not designed to confront isolated problems, but defined priorities for the period, guided by the need to respond to a set of urgent reproductive health and gender problems, with a clear awareness of the limits and current possibilities. It is also well known that it is impossible to solve such a complex and dramatic set of problems in a short space of time.

It does not seem right to state that the agenda of the ATSM was guided exclusively by giving priority to problems and that it exacerbated the fragmentation. The guiding logic behind actions in the gender violence area and the difficulties seen in relation to other parts of the Health Ministry, that look after aspects inter-related with SRH, such as the National AIDS Coordinator – CNAIDS, in the context of strategies aimed at AIDS prevention and treatment among women, or the INCA, in the control of cervical and breast cancers, as well as the Adolescents Programme, suggest that the underlying interest of the activities carried out during the past four years has been progressively defined by trying to achieve comprehensiveness as a process of “image idea” for the future. So it can be said of the experience of recent years that:

- Giving priority to some epidemiological problems (cancer, maternal death, excess of caesareans) has enabled greater coverage, as had not been achieved up to then.
- This strategy choice also made it possible to monitor, evaluate and correct, in a rather more systematic way, the course of actions (which is much more difficult when a broader working guideline is adopted).
- Even though in a partial and limited way, the women's health policy formulated and implemented at federal level between 1998 and 2002, in most cases went far beyond management and implementation capacity in the decentralised levels. On the other hand, in those states and municipalities in which the management was more sensitive to SRH problems, to some extent the priority actions were processed in a shared way and seeking to reach a greater level of comprehensiveness.

However, although one can no longer speak of “verticalisation”, as was experienced in the past, there are still many hindrances to communication between areas; the proliferation of “little programme boxes”, at federal level, or at state or municipal levels has not been overcome (though this trend is more noticeable in the states). The question of intra-sector communication and collaboration is also still an important obstacle to “comprehensiveness”, as it includes various aspects, such as asymmetry of power and resources, different paradigms of understanding of epidemiological problems, institutional inertia, among others.

It is necessary, then, to be careful about implementing innovative strategies and to check if the incentives being applied are the most suitable for changing the everyday practices of the health care services. From this point of view, the SRH agenda is a unique opportunity to reorganize care and, who knows, stimulate a change from the assistentialist model, since, putting forward a wider view of men and women in their different life cycles, may be inducing a wider reformulation of traditional practice focused on particular moments of individual's lives and, more specifically, of the reproductive cycle, such as motherhood and infancy.

To sum up, the formulation and implementation of the health sector reform in Brazil has been taking place in different historical moments and circumstances, which have significantly marked the specific nature of the Brazilian process compared with its Latin American neighbours. Having been formulated *pari passu* with the political “opening” and the democratic transition (1970 to 1980) the health reform process in Brazil bears the mark of opposition to the military dictatorship and to the model of health system - exclusive and inequitable – current at the time.

The history of the construction of the SUS, of the field of collective health, of women's health and of sexual and reproductive rights in Brazil clearly shows the leading role of civil society. It was precisely the organised activity of civil society that defined citizens' rights and managed to get them put into practice as the ultimate aims of health policies. This characteristic probably explains the fact of the country's having one of the few public health systems in Latin America that aims to be universal and that includes social control among its constituent axes. Obviously, this does not mean that universal access has been effectively achieved, as inequality in health has different dimensions and determiners, but it is related more profoundly with social and economic inequality. So, even though they are accumulative, it is more possible to overcome the determiners of inequalities in the health care services, as opposed to the determiners of inequalities in health, by sector policies and, despite the difficulties mentioned, important progress has been made.

To sum up, the Brazilian feminist movement, by choosing women's health as one of the main loci for confronting the historical social subordination of women, led to the debate in the country about the political agenda that ten years later would occupy the international stage: the issue of reproductive rights.

COSTA RICA

Costa Rica, as one of the countries of Central America, is on the strip of land bordered on the east and northeast by the Caribbean Sea, to the west and south by the Pacific Ocean, to the southeast by Panama and to the north by Nicaragua. It is a small country (51,100 kms²), with almost 4 million inhabitants (2002 census) and 59% of its population is urban. It is divided into seven provinces (San José, the

capital, Heredia, Alajuela, Cartago, Puntarenas, Limón and Guanacaste) which are then divided into cantons and districts. Nearly 1.7% of the total population are indigenous people, belonging to eight ethnic groups (PAHO, 2002), and there is also a strong presence of Afro-Costa Ricans (1.91%) and 0.21% of Chinese (Alfaro Salas, 2004:81).

It has been an independent state since 1821, and in 1949 the army was abolished, a decision which has been maintained even in the worst moments of Central American conflicts (Fuentes- Bolaños, 1993).

As defined in its constitution, Costa Rica is a Catholic state, and the National Bishops' Conference is an important moral influence in health and education policies. In October, 2003, the Catholic Church requested the government to change the regulation on voluntary sterilisations, in an attempt to restrict the current individual right to decide freely about surgical sterilisation (Alfaro Salas, 2004:79).

Its system of government is republican and is made up of three powers: Executive, Legislative and Judicial. Presidential and legislative elections are held every four years by universal, secret suffrage and those over eighteen years of age take part. Elections of mayor and councillors for each district, by direct vote of the inhabitants of each canton, were introduced only as from the year 2002.

Costa Rica is considered a stable democracy. Its political life has been characterised by the alternation in government of the two majority parties, the National Liberation Party (PLN) and the Unity Social Christian Party (PUSC), although as from 1992 a strengthening of the left has been seen with the foundation of the Democratic Force Party (FD), whose intention would be to form a block of progressive forces grouping Social Democrats and fractions of the traditional left (Informe Sombra, 2003). The rise of this group, together with the internal divisions in the two main parties, in a context of privatisation, are seen as factors that will contribute to bring an end to the parliamentary two-party system and give rise to a moderate multi-party system. Abstentions increased in the last elections, and in 2002, for the first time there was a second round of voting. Some sectors interpret the results of the elections in February, 2002, as a reaction of the social movements to the privatisation policy, supported by the traditional parties, that gave rise to a third electoral force, the Citizens' Action Party (PAC), formed by the evangelical faith community (Informe Sombra, 2003; Alfaro Salas, 2004: 70-71).

One of the features of Costa Rican political culture that is commented on, but which seems not to have been the object of deeper research, is that of rejecting authoritarian solutions and of the absence of revolutionary movements, so that there is always a search for negotiation. For some writers, one of the indirect effects of this historical feature was that these circumstances become a pole of attraction for people displaced by war in neighbouring countries and, at the same time, the establishment of various humanitarian organizations and foreign cooperation organizations for refugees (Morales and Sojo, 1998:258).

In recent years, the presence of women in economic and political life has increased significantly, although, according to the latest report from the Ombudsman, there has been little progress in terms of full exercise of women's political rights, and this reflects the gap there is between male and female representation. In the year 2000, the political leadership of women was reflected in a parliamentary representation of 19%; their presence among ministry officials is also numerous (PRB, 2002). In the 2002 elections, women were 35.09% of the electorate (Alfaro Salas, 2004:92). They also play an important role in the debate about state policies on health, education, the environment, the economy, and telecommunications, with their proposals in defence of the rights and of the political and social inclusion of women. The Judiciary, for the first time, now has a woman as President of the First Court.

The political and social activity of feminist organizations has led to victories in the legislative field and in important alliances that have enabled advances in the implementation of these laws, even though it is recognised that there is still much to be done. Among these laws and decrees are particularly: the passing of the Law for the Promotion of Social Equality for Women, in 1990, that penalising sexual harassment in work and in teaching, that of equality between people with disabilities, the creation of a counselling service in sexual and reproductive health in the health care services (decree level) and, as a bill, that penalising violence against older women.

Costa Rica is well known for its agriculture, with coffee and bananas as its main export products, as well as for cattle-raising. It has also been noted historically as a country that has carried out a state policy of environmental conservation, with the creation of national parks and reserves.

Just as in other countries of the region, the economic crisis made itself felt at the end of the 70s, reaching its fiercest point with the deterioration of the main macroeconomic indicators in 1982. In the 90s, its Gross Domestic Product (GDP) dropped 6% (-7.2 in 1982), with investment in education falling from 6 to 4% between 1979 and 1992, which affected both the quality and the quantity of the education system. Inflation was around 9% in 2003, slightly higher than the previous year, after several years of two-digit annual inflation, which, in the ECLAC's view, reflects "a consolidation of the stabilisation process". The most vulnerable aspect of the economy was the balance of payments which showed a fall originating in its trade deficit, with a lower entry of foreign capital. The increase in domestic public debt maintained situations of disadvantage in priority investments.

The annual average urban unemployment rate was 5.7% in 1995 and 6.6% in 1996; some 76.3% of all the heads of household are employed. In 1996, the national open unemployment rate was 6.2%, but the poor sectors had a rate of 12.9% and the poorest, a rate of 19% (MSCR, 1977 a:14; ECLAC, 2002a). Preliminary urban unemployment for 2002

indicates a figure near 6.8%. In relation to the insertion of young people from 20 to 29 years of age working 20 or more hours a week, 5.7% are in rural areas against 4.7% in urban areas, and an increase was seen in the youth unemployment rate (15 to 24 years of age) from 10.4% in 1990 to 12.8% in 1998.

The overall context of investments and savings shows significant increases in investment during the first half of 2002 (ECLAC, 2002a:28). The current expectation is of growth even in the context of financial decline.

As a response to this, greater diversification is being seen in the economy, with the introduction of other agricultural products, as well as services and eco-tourism, "maquila" and microprocessors. Technological production has also intensified in the fields of communications, information and energy. The financial system too has been transformed from a monopoly state banking model to one of mixed banking. According to Morales and Sojo (1998), the most dynamic activities in the economy are trade and financial services, and these are seen as little integrated or integrative within the national economic structure, with profits which are transferred abroad en masse. These writers also comment that the broadening of the exportable goods on offer from agriculture and cattle-raising as well as from the banana sector itself, has aggravated environmental problems, together with the attraction of industrial investments without sufficient control over contamination and waste, industrial developments in urban areas, and the building of tourist mega-projects.

Another consequence of the crisis was the stagnation of the expansion of reserves and parks, due to lack of financial resources and the tax restrictions associated with the stabilization plans signed with the international agencies. As from 1986, a new period began in the environmental policy of expanding reserves and recovering the environment with the foundation of the Ministry of Natural Resources, Energy and Mining (MIRENEM).

One of the most important socio-economic indicators as a key to the improvement of the level of health is female literacy, and in Costa Rica this was 93% for the period from 1990 to 1995. In addition, with the aim of generating greater opportunities for the youth population, the coverage of secondary education is to be increased, which at present is at 54.7%. The highest rates of school drop-out among young people from 15 to 19 years of age are seen in rural areas.

Compared to other countries of Latin America and the Caribbean, Costa Rica is characterised by high levels of social investments in general, and in health in particular. The percentage of poverty reported for 1990-1995 was 24%, falling in recent years to near 16%; but it is recognised that there is stagnation in social sector indicators in relation to the fight against poverty, and that women are the heads of 48% of the families in extreme poverty (World Bank, 2002).

It is also in a high position in the Human Development Index (HDI/UNDP, 2000), due among other factors to the results in its health system. However, between 1990 and 2000, it fell from the 28th place to the 48th, due to the drops

in education, in particular in the number matriculating from high school, and to an increase in repetition rates, health system waiting lists and the stagnation of the fight against poverty.

The coverage of the Costa Rican health system is one of the highest in Latin America. In 1987, it covered 89% of the population, including general medicine services, specialised medicine and maternity care, surgery, hospitalisation, laboratory services, dental care, certain optometry services and medicines for insured parties and their dependents. Current coverage is 90% and the bare 10% without coverage have access only to emergency services. Access by immigrants is also facilitated by the Basic Teams of Comprehensive Health Care (EBAIS), because these demand no requirements of any kind, except perhaps a voluntary contribution (Inhabitants' Ombudsman, Report 2003-2004). However, it is recognised that 30% of the poor have difficulties gaining access to the services of the CCSS directed to the uninsured, due to access and information problems (World Bank, 2002).

Use of both out-patient and in-patient services offered by the State is higher in rural areas, which is one of the greatest achievements of the Costa Rican health and social security system (Herrera and Durán, 2001; Household Survey, 1998). Women are those who most use the health care services, both public and private, in all levels.

In 1999, the National Health Expenditure was 6.5% of GDP, and the largest component in this was public health spending, at 7.3% (ECLAC, 2002b). But in the year 2000 it was at 5.7% of the GDP. Private spending on health is among the lowest in Latin America although it is domestically important, as it represents nearly 2% of the GDP (World Bank, 2002).

The rates of life expectancy at birth, of mortality among children under five, and of maternal mortality are among the best in Latin America and the Caribbean. Infant mortality fell between 1970 and 1980 from 63 to 19 per thousand live births, and for the period 1990-2001 from 15.3 to 10.82. Infant mortality among indigenous peoples also fell in the same period, which shows that the gap between different segments of the population has been closing (Inhabitants' Ombudsman, Report 2003-2004).

Infant mortality by groups of causes shows that in 1996 the highest rate, 5.7 per 1,000 births, was in the group of diseases originating in the perinatal period. Congenital abnormalities were in second place in 1996, with a rate of 3.2 per 1,000 births, while in 1993 the rate was 4.3 (MSCR, 1997a). The main causes of infant mortality are due to problems in the perinatal period. The highest infant mortality rates are in the cantons of the border area.

The child population with chronic malnutrition shows a rate below 5%, making it one of the countries with low inequality of access to food consumption. Costa Rica is one of the countries that will probably meet the most demanding goal based in the World Summit for Children in 1990 (ECLAC, 2003d).

For 1990, we find a total rate of 107.6% for men and 42.2%

for women in causes of mortality in young people of 15 to 24 years of age, stressing that external causes have a very high incidence among men: 75.8% against 15.5% for women, the same in relation to poorly defined diseases: men have a rate of 21% and women of 0.9% (ECLAC, 2003b). A high rate of drug consumption is also found among young people. The average age of starting to smoke tobacco was 16.6 years in 1995, and earlier among men (MSCR, 1977b).

Life expectancy at birth rose from 65 to 73 in the 70s, and for 2001 was 77.7 (79 for women and 75 for men). General mortality increased slightly from 3.8 to 4.1 deaths per 1,000 inhabitants in 1996. The highest proportion of deaths that year was among men, with 56.8%, and in women it was 43.2% of the total deaths.

For the period from 1990 to 1996, it was seen that circulatory apparatus diseases were in first place, with rates growing since that date, and among these heart ischemia with 47.6% of the total cases. Second place is held by tumours, with a rate of 8.4 per 10,000 inhabitants in 1995 (MSCR, 1997 b).

The population growth data show a reduction in fertility and an increase in immigration from neighbouring countries. Costa Rica seems to be in full transition with low birth and death rates, determining a moderate natural growth. Even so, the population is mainly young - 11.7% between 0 and 4 years of age and 1.6% over 75; and men are in the majority - 50.5% are male and 49.5% female (MSCR, 1997 b). The rate of fecundity fell from 5.1 to 2.5 between 1970 and 2000, and the birth rate from 25.4 to 22.4/1000 live births between 1992 and 2000. Nevertheless, the year-on-year rate of population growth increased from 2.3% between 1973 and 1984, to 2.9% between 1984 and 2000, which is mainly attributed to the migration of Nicaraguan people, which tripled from 2.9 to 9.1/1000 inhabitants between 1975 and 1980, and between 1990 and 1995, respectively (PAHO, 2002).

The increase in adolescent fertility rates and of HIV/AIDS infection and other diseases is a reality and a cause of national concern. 80% of married women use some kind of contraceptive and 70% of them, modern ones; abortion is permitted to preserve the physical or mental health of the woman (PRB, 2002). However, some research shows that condom use among adolescents is low. A resurgence of tuberculosis, in particular the resistant variety, and dengue fever, is being seen, as well as an increase in HIV/AIDS contagion among younger, married and poor women (Inhabitants' Ombudsman, Report 2003-2004). Women constitute 25% of the 0.5% of the population infected with HIV/AIDS, from 15 to 49 years of age (PRB, 2002).

The most important incidence of malignant tumours in women in 1995 was in skin, followed by breast, and in third place, cervical. Mortality from cervical cancer is not thought to have reduced significantly in recent years and higher rates are found in zones further from the Central Valley.

The health sector has historically been structured under the principles of a public service system, integrated and universalised, with broad coverage of the population. But,

just as in other countries in the Latin American region, sector institutions are divided between Social Security (the Costa Rica Social Security Fund – CCSS) and the Health Ministry, and despite incremental institutional reforms throughout the 20th century, this separation is still maintained.

The Secretariat of Health and Assistance started in 1927 with scant resources, with an orientation towards prevention combined with the activity of the official doctor and later, with that of the health units, almost exclusively to attend sick people with scarce resources. Even though the creation of the Costa Rica Social Security Fund took place in 1941 in a context of ideological and political conflict and economic limitations, it was only in the 60s and 70s that both institutions were consolidated in a framework of integration and universalisation based on the development of community medicine (Miranda- Gutiérrez, 2003). The CCSS is an autonomous institution, financed by the resources of the workers, of companies, and of the government, responsible for providing public services, and forming the core of the health system. The Health Ministry is formally constituted as the overseer.

The universalisation and integration of activities occurred gradually as from the 60s, extending the coverage of the Sickness and Maternity regime of the CCSS Social Security to all the population, initiating a process of widening its programmes by building Peripheral Clinics to decentralise out-patient care, building hospitals, and establishing contracts with practically all the hospitals of the Social Protection Commissions for purchasing services for the insured population, implementing the Mobile Units Programme, that was the start of the decentralisation of services and an instrument for promoting community participation, anti-malaria campaigns, and tuberculosis and leprosy control policies. Despite its successes, the primary care project at community level encountered many opponents together with the medical groups (Miranda-Gutiérrez, 2003). However, despite the opposition, it was as from these community medicine initiatives that the implementation of primary care began, based on prevention and the extension of coverage, and on concern for improving the health situation of the population living in rural areas (Miranda-Gutiérrez, 1997).

The first half of the 70s saw great progress in the direction of setting up a national health system and universalising care, reflecting the growth in the number of doctors, nurses and beds available for the population. As part of this movement, the First National Health Plan was drawn up in 1971, which *established the joint working of the then Ministry of Health and Assistance and the CCSS and the coverage of primary care to all the population by the Ministry, as well as care in the medical attention centres of the Fund* (Miranda-Gutiérrez, 2003: 150). The health system was reorganized in 1973, with the passing of the General Health Law (N. 5.395, of October 30th), in which the name was changed to that of Health Ministry (MS), health was

declared a good in the public interest, under the guidance of the State, and the Ministry was declared the supervisory agency for health sector institutions. In the same year, the process was begun of transferring the hospitals of the Health Ministry, the Social Protection Commissions and the Banana Company, to the Fund, finishing in 1977, in order to build up a national system (Miranda-Gutiérrez, 2003). At the same time a Teaching Centre was inaugurated to help the teaching activities of the health institutions.

The health system now consists of the Ministry, the CCSS, the National Security Institute, the Costa Rica Institute of Aqueducts and Sewage Systems, and the Institute of Drug-Dependency and Alcoholism.

In 1974, the Family Benefits and Social Development Fund was created, with assistentialist type functions for the population below the poverty line, to make the coverage universal (Navarro-Fallas, 2003).⁸³ The CCSS began to provide free health care for the poor in 1975, and started offering its services to independent urban workers who wanted to pay the policy subsidised by the government.

After a period in which there was little support for activities to integrate the Ministry and the Fund, in the 80s, in a context of resource reduction, the PAHO guidelines on Local Health Systems were taken up again, and this continued in the project of the Basic Comprehensive Health Care Teams (EBAIS) in the 90s, introduced by the reform. The movement in the direction of integration aimed to create a National Health System, in which the State would be responsible for the health of the population and the Ministry its supervisory agency.

With the economic crisis in the 80s, and the deterioration of the main macroeconomic indicators, a set of economic reforms crashed in, aimed firstly at stabilisation and, as from 1985-1986, at the structural adjustment of the economy, pushing forward a strongly speculative growth model (Morales and Sojo, 1998). In this period, CCSS finances were hit, with repercussions in the quality and prestige of its services.⁸⁴

Financial resources for the Health Ministry come from various sources: its own funds allocated every year in the national budget (6%), the product of taxes specifically created for hospital maintenance, the income from the national lottery (2%), State subsidies to each hospital, which at the moment of the transfer were 40% of their income, and the income produced by the Family Benefits Law, for school canteens and the rural aqueducts (Miranda-Gutiérrez, 2003). Historically, health spending has concentrated in the CCSS. In 1996, CCSS was responsible for 81.9% of the expenditure, the Health Ministry 6.4%, Aqueducts and Sewage 5.3%, the National Insurance Institute 2% and the Municipalities 2.1% (MSCR, 1997 b: 78 and 79).

Annual spending of the Health Ministry per inhabitant, in dollars, shows that in 1999 it was US\$271, which was a reduction compared to the year 1996, when it was 317 dollars, but an increase in relation to 1993 when spending was US\$223 (ECLAC, 2002).

The activities launched in the 80s, aimed at greater integration between the Ministry and the Fund, began with a review of the norms and procedures for establishing a joint policy based on integrating the programmes, *in an activity the intention of which was to produce more with the same resources* (Miranda-Gutiérrez, 2003:152). An inter-institutional committee was named to articulate the programmes and, in 1983, a committee was set up to transform the Health and Social Security Commissions, established since 1977 as the means of communication between the health institutions and the communities they served. This group was formed by representatives of the Fund, the Ministry, the corresponding municipality and the local development association.

In 1984 regulations were made for the care of "State insured parties", the groups and families without economic capacity, the cost of which would be included in the national budget, with the Health Ministry in charge of identifying and registering them, and the Fund, of providing services. Apparently, the deficient performance of the Ministry meant that the Fund took all the tasks on itself. The same year, an agreement was signed between the Ministry and the CCSS for integration and coordination based on criteria of regionalisation and sectorisation, which established that the functions of the Ministry were those of health promotion and collective prevention, those of the Fund, medical care and rehabilitation, and those of the National Security Institute (INS) of rehabilitation and indemnification of people covered for professional and traffic risks.

It also ratified the care levels that were being established in the medical services, recognising that the first level is in the household, with the mother as the centre of prevention; the second, under the charge of the Ministry and the community; the third, with out-patient care, the fourth, hospital care, and the fifth, the national level high technology centres, came under the Fund (Miranda-Gutiérrez, 2003).

The sector management system was structured around the National Health Council, the Executive Presidents Committee of the respective institutions, the Executive Secretary for Planning, the Sector Technical Committee as process coordinator and promoter, plus other Management Committees. The organization was divided into three levels: Political Management, Standards or Technical Management and the Executive.

83. This is a programme that finances itself with state resources coming from 0.5% of employers' schemes and 20% from the total of tax revenues on sales. It is aimed at poor or street children and young people, marginalised pupils, from rural or urban zones, and poor women heads of households, among others (ECLAC, 1998).

84. In 1978, health spending in Costa Rica was 6.8% of GDP. The economic crisis caused a sharp fall, reaching 5.6% of GDP in 1982. In following years, a slow, steady recovery was seen, reaching 7.6% between 1989 and 1996, to fall again in 1997 to 5.6% and recovering in 1999. In 2000, the percentage was 5.7% (Miranda-Gutiérrez, 2003).

The Law fixed the following objectives for the health sector: a) to provide health care for all the population; b) to maintain and improve mortality indicators; c) to prevent the accelerated growth of problems proper to under-developed countries; and d) to achieve the harmonious and coordinated functioning of the respective institutions.

At the start of the 90s, with the arrival of the Christian Social Party in the government, the adjustment policy was driven more openly, affecting economic growth and the poverty level. Social policy, in turn, approached the neo-liberal compensation model prevailing in other countries of the region. Assistentialist type programmes were launched to deal with extreme poverty, which took the form of bonds for housing and food (Lungo, 1999).

The State has noticeably reduced its support to the sector, and there has also been a systematic retention of cash diverted to strengthen community or first level medicine. Due to the reduction of resources, it is also seen that the CCSS has been gradually financing the cost of the hospital programme with its own income from workers' and employers' contributions, thus increasing the State's debt with the CCSS (Miranda Gutiérrez, 2003: 158).

The organizational and institutional restructuring of the social area coincides with the change of government in May 1994, and the National Plan for Fighting Poverty was also set up at this time. It also occurred in the context of a strengthening of new theoretical and ideological approaches emphasising the potential of the private and the limitations of the public sectors, and of the growth of private interests.

Health sector reform began in the same year (1994), after a period of drawing up documents at the beginning of the decade under the coordination of the CCSS, and running "pilot projects" (Guimarães, 2001). Some writers consider that the process started without launching a formal reform model (Martínez and Mesa-Lago, 2003).

It was drawn up with the support of loans from the World Bank (WB), the Inter-American Development Bank (IDB), and from the Central American Bank for Economic Integration, for funding the changes. The Project Preparation Unit was set up in the Fund, to draw up the Health Sector Reform Project, responsible for coordinating the work of various multi-disciplinary groups created in order to formulate proposals for each of the Project's components. It was decided that the CCSS would be the executive agency for the reform and the manager of all the sector resources (Martínez y Mesa-Lago, 2003).⁸⁵ The

following institutions were also present throughout the process, playing different roles and with different levels of influence: the Pan American Health Organization, the Swedish International Development Cooperation Agency (non-refundable support) for decentralisation and support to institutional development projects, the government of Spain and its Agency for International Cooperation (refundable support) for scientific development, the Japanese government and a growing group of foreign consultants and experts (Miranda Gutiérrez, 1997). But the reform process was seen to originate, in great measure, from World Bank loans, *which brought with it the very active participation of economists* and a search for economic aims, directed to *improving efficiency and rationalising resource allocation* (Bixby, 2004:95).

The reform began to be implemented in 1995, and was presented as an instrument for *correcting and improving operational capacity in Health Sector Institutions and introducing profound modifications in the health provision model and its funding, and to the organization and working of the National Health System* (Summary, Reform Project, 1993).

In the National Health Plan for the 1998-2002 period, made with international technical cooperation, the leading role of the Health Ministry is recognised, and the need to involve the active participation of other social actors in producing and providing medical services. It also presents the new shape of the national health system and the functions of each of the institutions making it up, and defines that all of them are under the coordination of the Health Ministry (Guimarães, 2001). It also confirms, in the context of the law, the principles of universality, equity, solidarity and obligatoriness.

The aims of the reform were broad and ambitious, and were defined as:

1. To guarantee the superintendency of the sector by the Health Ministry.
2. To transfer the corresponding services from the Health Ministry and from the Work Risks Insurance of the National Security Institute to the CCSS, which would take sole charge of running care services, following a health model based on comprehensive and continuous care for the individual, the family, the community and the environment, to be carried out by the Basic Teams of Comprehensive Health Care (EBAIS), financed by IDB resources.
3. To promote the administrative and functional decentralisation of services to local level.

85. The IDB loans were of the order of 60 million dollars, corresponding to 70% of the investment required (the remaining 30% was provided by the country). The Fund received 4 million from the IDB for strengthening the Health Ministry and its superintendency, and another part of the resources were for health care services infrastructure investments. The Central American Bank for Economic Integration provided US\$12.0 million, approximately 63% of what was destined to strengthen the health care services network of the Atlantic Huetar Region (the rest was provided by the country). The WB supported the strengthening of the CCSS with US\$32 million (with a 30% matching from the government), for adapting the health care model, reviewing and improving the financing system, management development and conscious-raising for change, the creation of the National Fund for Training and Formation, and the Institutional Strengthening of the Costa Rica Institute for Nutrition and Health Research and Teaching (INCIENSA) (Summary, Reform Project, s/f:2-3).

4. To develop new administrative models with changes in resource allocation, replacing the historical model with one based on the populations' health needs, to reorganise the basket of services into care levels, to assign people to services on a territorial basis, to introduce division of functions.
5. To strengthen institutionally the Dr. Uriel Badilla Fernández Costa Rican Institute of Research and Teaching in Nutrition and Health, registered under the Health Ministry.

It was defined that universal access would be achieved by offering services to attend the basic health needs of the population, for which 800 health sectors have been set up, attended by EBAIS, forming a total of 90 larger-sized areas. Each EBAIS, consisting of a doctor, nursing assistant and primary care technical assistant, attends around 4,000 people and has a support team, shared with the other EBAIS in the region, consisting of a social worker, nurse, doctor, nutritionist, pharmacist, microbiologist and medical records technician. The second level provides emergency services, diagnostic support, specialised external consultancy and simple surgical treatments, and has Technical Support Groups, made up of specialists in family and community medicine, nurses, pharmacists, microbiologists, social workers and other technicians who, as a whole, interact within a regionalised system of services in the national context (MSCR, 1997 b).

To achieve these aims, profound institutional modifications were proposed both in the Health Ministry and in the CCSS, covering the judicial area, management instruments and policy tools, as well a necessary change of approach and new administrative knowledge for both institutions. To put into practice the component of superintendency and strengthening of the Health Ministry, an executive technical unit was set up, under the Health Care Services Improvement Program Executive Unit, under the control of the Fund. It was made part of this project to define the new functional profiles of the Health Ministry as well as its mission, strategic functions, the role and integration of the other health institutions with the Ministry, the relationship mechanisms and the expected products.

As a result, the Health Ministries began to be organized with results oriented and matrix functioning criteria. One of the first efforts of the Health Ministry in its monitoring role was to adapt the existing norms for evaluating the EBAIS and for authorising hospitals, both public and private, in a context in which there was little definition or clarity around its superintendency role.

The Fund too went through an institutional modernizing process, aimed at adapting its structure and functioning to an evidence-based health policies design. To bring about these changes it was necessary: a) to develop an information system incorporating demographic criteria with which to

anticipate services and determine what the population's health needs are, putting this into effect through work agreements and "management commitments" with each of the providers in the context of the CCSS, requiring them to render accounts in terms of result goals; b) strengthen the central level which is the one that allocates resources, defines the services to be offered in terms of the needs and guidelines defined, and compares the performance of providers within the same level of services, and c) to develop decentralised bodies capable of defining how to carry out these activities.

In the area of monitoring and control, in May 1999, the General Health Care Services Superintendency (SUGESS), a technical body, was created, whose main objectives are centred on the supervision and monitoring of the health care services. Within the same context, the Service Control Bodies were created in each working centre of the health institutions.

Also, under Law N° 7852 (December, 1998) of "Deconcentration of the Hospitals and Clinics of the Costa Rica Social Security Fund", Health Councils were set up, as auxiliary bodies for the hospitals and clinics, *with the aim of improving health care, administrative and financial performance, and promoting citizen participation* (Fuentes-Boloños, 2003: 260). These councils are made up of two management representatives and three of the insured parties of the area of influence of the health centre, as well as by two from the hospital and clinic cooperative associations.

The proposal for financing was to continue with the central administration by the CCSS, by combining resources from the national budget (the minority) and tripartite combinations to the social security (the majority). The change was introduced *in the resource allocation mechanisms between health care service providers in the social security and the encouragement of administrative contracting mechanisms with private bodies* (Martínez and Mesa-Lago, 2003: 51). The introduction of management commitments began in 1999 in five health areas with mutual agreements between purchaser (CCSS) and the provider (public or private services unit), to enable budget allocation in a fair and prospective way, according to the achievement of productivity, quality and coverage goals. This proposal was based on the Spanish experience in health consortia to ease the management autonomy of the health units (Guimarães, 2001).

It is important to note that the private sector in Costa Rica is very small. According to Homedes and Ugalde (2002), private participation in the health sector can occur through three models: a) installation of a clinic in the workplace, with diagnosis, treatment and hospitalisation under the responsibility of the CCSS; b) mixed medicine, which permits free choice in going to a private doctor, paying the consultation directly and continue receiving diagnostic, treatment and hospitalisation services in the CCSS, and c) medical cooperatives that receive resources from the CCSS,

under a capitalisation system, with users referred to CCSS hospitals.⁸⁶

To sum up, Costa Rica keeps and has consolidated social and public responsibility in the health social security system, without modifying either the structure or the sources of funding (obligatory tri-partite contributions), maintaining collective equivalence with a universal security, a single fund and without competition in the insurance regime.

Different from the previous cases, the core of the health sector reform has been improving the efficiency and effectiveness of the public providers of health care services, by introducing management commitments, and it has been being implemented gradually since 1995, when it was managed to separate the competencies of the Health Ministry (guiding function) from those of the Costa Rica Social Security Fund (CCSS). The latter is responsible for the insurance of the population, and consolidated its role of responsibility for all the service provider functions, from prevention to rehabilitation, including primary care (Sojo, 2001:45). Private provision works in a few particular cases, directly contracted by the CCSS (Sojo, 1998, 2001).

This means that, even though the historical structure of the system was maintained, with universal insurance, public management and financial structure, an attempt is being made to introduce competition mechanisms and innovations in management, aimed at improving the system's efficiency, effectiveness and equity, at least in terms of the principles defined by the reform.

In this sense, the health sector reform being carried out in Costa Rica since the mid-90s follows on with the historical tendency to integrate and universalise services, but also maintains the strengthening of the CCSS, giving it the guiding role in the reform, as the institutional body that historically finances, manages and provides services for the population, thus encouraging a strong presence of the public sector in the health system. The novel aspect of this current reform compared to previous practice is that it is centred on the idea of the separation and specialisation of the functions of providing and financing the health care services, introducing hospital self-management and an increase in private sector participation, based on drawing up contracts. This is the concrete translation of the attempt to generate, on the one hand, a new rationality in administration, supposedly based on demand and not on supply, and on the other, to develop "quasi-markets" in the health care services, following the dominant agenda of health sector reform. Moreover, resource allocation is still centralised and its management negotiated through management commitments (contracts), which means limited autonomy in the local context for defining their own care priorities.

The basic idea was to establish the separation and

specialisation of functions without creating new exogenous bodies. In Sojo's terms (2001), this is an "inward-directed quasi-market", and is highly regulated, since the federal CCSS holds the powers of direct collection of funds, control, regulation, and appointment in the key posts. This implies that the negotiations will be strong, as the function of the purchaser is monopsonic and the provider function is deconcentrated into a multiplicity of CCSS bodies and cooperatives. The management commitments with the hospitals and the health areas were established gradually and selectively (Sojo, 2000).

Even though the reform model was drawn up within the country itself, which has its own highly-trained technical and administrative teams, above all in the CCSS, nevertheless, the reform agenda was strongly influenced by the international agencies, and in the process the WB and the IDB were the major protagonists, as is seen in the strong presence of these agencies in the funding of the reform. Even though the priority given to basic care fits into the topics of the international agenda, it occurs in the framework of strengthening this level of care within the perspective of the "old-fashioned" primary care and broadening "community care", giving it the status of "entrance gate" to the system. And although another goal is the reduction of hospital spending, even implementing specific practices for this (increasing outpatient coverage and extra-hospital practices), with some success, it maintains the concern for the comprehensiveness of care, i.e. with making integration more and more effective between the different levels of care, starting from the corresponding reorganization of the second and third level.

According to documents produced by the CCSS, significant progress can be measured in the health system as a result of the reform, basically centred on the increase in the production of services at all levels. Moreover, they managed to continue strengthening the first level of care, which is reflected in the 1.4% increase in the proportion of resources of health insurance dedicated to that level. And 82% of the areas showed progress in the plan set up for improving coordination between the first level and the second and third levels.

At the same time, it is recognised that the waiting time per speciality in out-patient consultations in the national hospitals is between more than 90 and up to 470, and the waiting time for some specialities is 490 days in the regional hospitals, and in the peripheral hospitals the periods are over 190 days. This is one of the main problems of the CCSS. And in relation to the quality of care, in practice, all the regions of the country have experienced reductions in the quality of their coverage compared to previous years. The evaluation of the management commitments also still leaves something to

86. There are four of these cooperatives, integrated into a consortium, and arising from the flexibilisation of service provision, as follows: Coopesalud, Coopesaín, Coopesana and Coopesiba and they are responsible for health care for a half million inhabitants. They are self-managing, as well as the Coopesana in Santa Ana, which is self-managed since the 11 communal associations there also make it up (La Nación, 2004).

be desired and training in this area is still lacking as well as, above all, to deepen the cultural change that the new model has been putting forward. In terms of the equity with which resources are distributed between regions, when analysing the regional networks, without separating levels of care, a situation of less inequity is found than in previous studies, which only looked at spending in health by areas. This is due to the lack of homogeneity of the networks, in terms of the services provided at each level of care.

As regards Comprehensive Care for Women, for the year 2002 quite good indicators were achieved, but with significant differences between the regions. Two regions of the country, the Central North and the Atlantic Huetaar, have been showing gradual reductions in the overall coverage that this form of care has reached in the past three years.

It is seen that total national coverage of prenatal care is among the highest of the different programmes that the institution provides to the population. For the year 2002, total national coverage was 84%. This coverage remained practically the same as that reached in the year 2001, when it was 83% (690 more pregnant women than the year before). And cervical cancer screening, during the year 2002, managed a biannual coverage of 44%, as indicated in the standard, in the group of women between 15 and 35, and of 52% for the group of women over 35 years of age. The same figures show that around 50% of women are making the Papanicolaou (PAP) test in the Social Security health care services. Many women are seen to go to private consultations to make the PAP, because this offers greater privacy and the report is more timely, but the real contribution that the private sector is making to national coverage in taking the PAP is unknown.

In terms of regional coverage of comprehensive care for children, it is felt that all the regions have made progress in total coverage of early treatment of newborns compared with the year before, and in relation to quality of care, and that all the total coverages for children under one year of age have also been kept similar to the previous year.

In terms of adolescent health, this group had traditionally been left on one side in health centre attention, when the biologicist care model ruled, due mainly to the scarce number of occasions on which they became ill and so went for attention. However, it is recognised that the total coverage of this type of care in 2002 was 30%, a 5% reduction on the previous year. The explanation presented lies in the significant effort made in the year 2001, by which coverage was doubled, a situation which it is difficult to maintain over time and that may explain the current behaviour. But differences are also seen between the regions. In addition, in 2002, 28% of the adolescents in the country were screened with the risk classification instrument, and they were also provided with a suitable handling according to the risk established. Even though these figures may seem small, they are a significant advance on the historical data for care of young people, bearing in mind the particular characteristics of demand of this population group.

The Health Ministry's evaluation on the results of the reform is less encouraging and is related to problems in the lack of clarity on its role and supervisory function. The superintendency is structurally weak and there is no specific system of economic regulation to deal with the inherent distortions in the markets for health care services. In addition, the legal faculties of the Health Ministry over the other agents, including the CCSS, are limited, as the Political Constitution guarantees it independence in matters of governance and administration, and the activity of the Health Ministry is based on persuasion and informal leadership. There is a lack of mechanisms to regulate the products of the health care services by costs and quality; there are few protocols of attention to define end service quality standards and other mechanisms that could reduce the so-called "asymmetry of information" between health professionals and users.

A survey made in October, 2002, by the Superintendency and Essential Functions in Public Health group, within the 2002 Health Sector Analysis, *stated that the functions and activities that the Ministry had been carrying out to fulfil its superintendency function were still necessary, but not sufficient* (Fuentes-Boloños, 2003: 131). In particular, in the regulation of spending, of the quantity and quality of human resources in health, in conducting international cooperation and in conducting the management of disasters.

Among the problems found and considered grave were the deficiency of public health activities. The basis of this problem was identified as the system of organizing the EBAIS centred on demand for medical activity for illness, which hinders actions on health perceived as prior to disease and something that should be promoted by the health systems. That is, there is no proactive culture or searching for cases. Also, in the case of cervical cancer, the goal of the EBAIS is to carry out a particular percentage of cytologies, which has led to duplication of activities and a low coverage centred on the pregnant woman looking for prenatal check-up services.

As far as SRH is concerned, it is seen that there is a distance between the amount that has been performed historically in this area and the priorities defined for the reform in relation to the subject.

Since the 70s, there have been public health programmes for women and children in Costa Rica, in the framework of coverage extension (primary care) and family planning policies. And as from the end of the 80s (1988), specific women's health units were created within the CCSS, with local and regional branches. At the end of the 90s (1999), the Inter-institutional Commission on Health and Sexual and Reproductive Rights (CISDSR) was created, with the participation of various actors in the civil society, from the medical area and other health professionals, or representatives of the national women's movement (with several organizations in the country, and historically very active), and from international organizations, such as UNFPA, the United Nations Population Fund.

In the “Health Sector Reform Project” (1993), among the 12 programmes defined as priorities, the following are aimed at women:

- Problems or care needs related with pregnancy, childbirth, and puerperium, perinatal period disorders.
- Cervical cancer, with emphasis on early detection, in all the establishments of the national health system, from cytology to diagnosis and timely and effective treatment.
- Breast cancer.
- Family planning.

The Comprehensive Health Care Programme was defined in the context of the reform in order to respond to these problems, divided for practical purposes into five specific programmes, that have to be run in a coordinated way by the network of services at all levels of care; among these are the Comprehensive Care Programme for Adolescents, the Comprehensive Care Programme for Women, and the Comprehensive Care Programme for Adults.

The Costa Rica Women’s Alliance, with the support of the UNFPA, was one of the women’s organizations that made a diagnosis of the situation from the point of view of the participants, male and female. Various feminist organizations also prepared a report to be presented to the government, the Sombra Report (2003), before the Committee of the Convention for the Elimination of All Forms of Discrimination against Women (CEDAW), revealing the situation of women’s health, with the emphasis on reproductive rights.

The Alliance’s Diagnosis, based on its surveys, showed that it is women who most consult the services related to reproduction and child care, but that in some regions, with varying intensity, both sexes are unaware of the existence of the health centres for programmes for attention to sexuality, and also know nothing about the sexual and reproductive health Counselling Centres.

The women’s organizations considered that the EBAIS are present in most communities, but that sexual and reproductive health care is not satisfactory. They argue, and show through research and different documents that sexual and reproductive health care is carried out as part of routine care, with the family planning and childbirth check-up services, and that there are no specific programmes for men. The same Diagnosis declares that young people are reluctant to consult about their sexual health. It concludes that neither women nor men know where to complain if they are not attended properly, an issue also seen as a problem in the Sombra Report (2003).

In relation to the use of contraceptives, the surveys showed that couples do not plan their children and that it is the women who most use planning methods, and they know more than the men about their sexual and reproductive rights. They denounce cases where the budgets for clinics for reproductive health care have been reduced by the CCSS (as for example in Limon and Turrialba) where previously it was

not a requirement to have insurance, and universality was a reality. The polls also speak of the poor quality of attention in some centres, an issue that the Sombra Report takes up again. Another element dealt with in the Diagnosis was that of instrumentalisation, through the health policies, of women as health promotion agents.

For these actors too, quality attention and fairness in the health care services are not universal, as significant variations are seen between regions and services, although the importance is recognised of the widening of access, made possible by primary care. The training of human resources is not sufficient, either, for the care needs in the SRH area, above all in the first level of care. They state that there are still gaps in attention in some communities that are not covered by the CCSS, and that were previously attended by the Health Ministry promotion and prevention programmes. But now, with the reform, as the CCSS is the operator of these programmes, some feel that it has neglected them and this is the reason for the resurgence of diseases such as dengue, the increase in AIDS and in other infecto-contagious disorders.

One of the main challenges facing the Health Ministry, with the CISDSR, is the formulation of a National Sexual and Reproductive Health Plan, with quite broad aims. There are committees and task-groups to achieve this, in which the Health Ministry participates and it also sets up various links with different research and teaching institutions working on this subject in the country.

Action is also under way in the health care services, coordinated between the CCSS, the Health Ministry and the National Institute for Women (INAMU), such as the construction of the Women’s Hospital (1999), funded by international cooperation, putting into practice a comprehensive care model for women, which includes, among other aspects, elected Health Councils with the participation of service users.

The same is seen in policies for young people and adolescents, which have been running since the 1970s in the country with specific programmes for this population, but that also merit having specific guidelines included in the reform.

It is recognised then that Costa Rica does not have a national policy on sexual health and reproductive health, and that although there are explicit attempts in the National Health Policy, this has not been put into practice. This situation has been expressed by the Sombra Report (2003) and also pointed out by the Ombudsman in its latest report (2003).

In other words, according to the analysis of the case study, the full historical and programmatic breadth of the sexual and reproductive health programmes are much more an expression of the demands of women’s organizations than a proper health policy. On the other hand, the women’s movement apparently makes more effective links with the Health Ministry, the potentially normative agency, even though this does not have the financial and

implementation power of the CCSS, whose ideological and management framework give priority to the biomedical approach. In this sense, the women's organizations identify contradictions between the reform agenda – marked, they say, by its emphasis on neoliberal prescriptions, privatisation, individualisation of the responsibility for health, reduction of resources, policies focussed on confronting the increase in poverty and specific programmes – and the SRH agenda, a rights-based view, which is much broader than what is seen as a priority in the reform programmes. And they are currently struggling to promote changes in the chapter on rights, in which rights are established in terms of sexual and reproductive health. The Law guarantees that women receive health, family reproduction and family planning information and care. Some writers recognise that there is a lack of information for a more complete assessment of the reform, and that what exists is partial and fragmented, coming mainly from official sources. In any case, most of the analyses focus on the reform management mechanisms more than on the health care services themselves, and perhaps the explanation for this lies in the management nature of the reform itself.

In the view of these writers, the progress is in the direction of organizational changes, in particular in the deconcentration process, for which, up to now, there are no signs that this system is better than the previous one or whether deconcentrated agencies are spending better than before. They recognise that deconcentration has allowed the hospitals greater margin of action in terms of “how” they provide services, manage their human resources and their budget, as well as how they carry out the administrative sub-contracting with the private sector that they may consider necessary. Management agreements are being made, but the resources distribution system is following the logic of the historical budget.

Another context that is considered not to be very clear yet is the relationship of the CCSS with the private sector, partly because of a lack of clear definitions about the role of the private sector, and because there is no consensus in the CCSS at management level about the exact role that the private suppliers should play in the health system.

It is recognised that, although there is strong pressure from the World Bank for privatising health sector funding, the government has guaranteed the public financing of all the health services, and all the insurance companies, including those in health, are a State monopoly. On the other hand, it is seen that a market of international private insurances has grown up recently, and that this sector is growing significantly, in particular among higher-income users (Herrero and Durán, 2001).

Some problems are pointed out by different writers:

1. A tendency among families to increase private spending on health, which, based on the household survey, has increased five times between 1993 and 1998, which may

represent a privatisation of service provision. Meanwhile the size of this phenomenon cannot yet be demonstrated because there is no reliable information available.

2. An absence of technically founded criteria for purchasing services in the private sector, which has not prevented the CCSS from continuing to buy services from this sector. The Special Legislative Committee has also documented that the purchase of private services is considerably more expensive than the direct provision of services by the CCSS. It has also been shown that the purchase of private services is not accompanied by parallel measures to help solve an institution's problems in providing the services without these resources, and that, due to a lack of appropriate and timely investment decisions, private purchase stops being temporary, as provided for in the law, and becomes permanent.
3. Confirmation that the purchase of private services does not necessarily express better quality of care, and there are reports of the purchase of low-quality private services, or without controls, which is only noticed after accidents occur and there are complaints about these.
4. The presence of private suppliers threatens the planning of services by levels and territory, one of the aims of the reform, and also goes against the principle of universality and equity.
5. The existence of various conflicts of interest introduced by the private purchase of services, which has the consequence of discouraging public performance and encouraging the violation of institutional norms. One of these is among members of the Board of Management who are simultaneously members of the boards of private clinics selling services to the CCSS.
6. The permanence of another conflict of interests permitted by the design of the institution, that occurs among medical professionals who, remaining as officials of the CCSS, at the same time sell services to it, running the risk of generating a vicious circle in relation to waiting lists: the CCSS officials are privately subcontracted to resolve waiting lists that they may be contributing to generate, or, in the best of cases, that they have no incentive to resolve, given that it is more profitable to sell services to the CCSS than to be employed and, even better if it is possible to combine both activities.
7. The need for very precise control mechanisms of the relations that develop between the firms that sell services to the CCSS (such as radiotherapy for cancer patients) and those who authorise such purchase in the CCSS. This function comes under the Administrative Management and these are situations that allow the use of public resources for private ends.
8. The persistence of evasion, under-declaration and bad debts, structural problems in the financing of the Fund. Estimated evasion is 20% of the annual compulsory revenues, of which 71% correspond to payment of salaried workers and uninsured employers, and 29% to the under-

declaration of wages (CCSS, 1981, quoted by Herrero and Durán, 2001: 13). The mechanisms for fighting these problems were provided for in the reform, but many of them have not been put into effect or have not been started up properly and the financial results achieved are unknown. There are also problems about the increase in cover from contributions, *vis a vis* the investment in health care services and their links with population needs. It is calculated that 30% of the workforce do not contribute to the financing of health insurance even though they can benefit from its services.

In brief, they argue for the need for a deeper assessment of the effects of the reform, since, up to now, the work of the Health Councils – monitoring the performance of the services – has not been realised in a satisfactory way.

In conclusion, the health sector reform in Costa Rica and the struggle of women to introduce changes in reproductive and sexual health policy are two policies that respond to different and even contradictory dynamics, but which overlap, introducing tensions between agendas, and mutually questioning their capacities to respond to their own agendas. The reform is linked to a macroeconomic dynamic that redefines the form of development centred on greater protagonism of the markets, and the reproductive health agenda is linked to more inclusive socio-political processes. Putting these two agendas into practice, moulds and alters the direction of the health institutions, reallocating resources between the programmes and power between the actors.

One of the main challenges of the reform is to promote and implement a comprehensive view of health in a scenario of economic crisis that affects State resources, and that gives priority to the sector of medical care. It is also clear that, even though it is fundamental to give priority to the first level of care, the services and the human resources are not suitably prepared for this task, and there are signs of an increase in some diseases, such as AIDS, closely associated with socio-cultural factors. Within this framework, the CCSS through the EBAIS, gives priority to the first level of care as the entrance to the comprehensive health care system and as a strategy to avoid greater deterioration in the health indicators due to the crisis itself. The importance of some activities aimed at women arises from this.

Another problem is the definition of a new role for the Health Ministry, in view of the distance between the aims expressed in the reform documents and its effective action of sector superintendency and regulation, without a solid technical-administrative capability (since it has lost many of its staff), capable of defining its own aims and activities, and establishing strategic alliances with the civil society, building up a political strength to face up to the power of the CCSS in negotiations, which are permanent in the national sector arena.

The health sector reform in Costa Rica maintains the

historical tendency of the system, and its structural features remain, but it introduces management mechanisms kin to those in the international agenda, attributing a more prominent role to the private sector. Meanwhile, it seems that the privatisation processes is advancing slowly, in a still limited way, with a model adapted from Spanish experiences, but strongly influenced by the agendas of international bodies. It also presents problems of corruption, and does not necessarily mean a reduction in costs.

As in all the reforms in the Latin American region, the presence of the IDB and of the WB in funding have been important, even overshadowing to some extent the role of the PAHO. However, it is possible to find views in Costa Rica calling for the power and capacity of the CCSS to define its own projects and directions, based on the existence of a highly-trained technical and administrative sector for discussing and negotiating its own project.

Finally, the target of the reform is not the programmes of sexual and reproductive health. In consequence, no policies are provided for many of the problems that women complain about, even though there is a recognition that women and adolescents constitute a sector with specific needs. Nevertheless, men are still absent from the sexual and reproductive health programmes and, in health policy, women are still seen as an agent for promoting health, loading on them the vaccination campaigns, health tours, mother and child care, and family planning. Moreover, there are no specific records about SRH in men and women during the different stages of the life cycle, which may be an indicator that the gender perspective was not incorporated comprehensively to the whole of the health policy.

The full breadth of sexual and reproductive health programmes are the result much more of the demands of women's organizations than of the reform policy, and in this sense, depend as much on the capacity of this social group to put pressure on for its full realisation, as on the existence of professionals and decision-makers sensitive to the cause, who are trying to progress in this direction, even in the face of financial, moral and biomedical barriers.

BELIZE

Belize, with an area of 22,963 square kilometres, is located in Central America, neighbouring Mexico on the northwest, Guatemala to the southeast, and its east coast with the Caribbean sea. More than 60% of its territory is covered with tropical jungle.

Until the start of the 80s it was a British colony. The change of name took place in 1973, when it dropped the name British Honduras, and became Belize. It was granted independence by England in 1981. Its system of government is a parliamentary democracy, in which the Queen Elizabeth of England is the Head of State, and is represented in the country by a Governor General. The Prime Minister (leader of the majority party, named by the Governor General) and the cabinet form the executive power, while the legislative power consists of a Chamber of Representatives of 29

members, elected by vote (for a period of five years) and by a Senate, with nine nominated members. The Chamber and the Senate constitute the National Assembly.

The government is currently made up by the People's United Party – PUP – which won the general elections in 1998 and in 2003. The two opposition parties are: The United Democratic Party – UDP – and the Independent – IND.

According to the 1992 census, the Anglophone population of African origin, that historically had been the majority, dropped to second place behind the growth of those of Spanish-speaking mixed-race. The main ethnic groups on Belize are: mestizos (44%), creoles (30%), garifunas (7%), mayas (11%), and others (8%) (UNICEF, 2003). In the last national census, made in 2001, the total population reached 249,800 inhabitants, with a growth rate of 2.7% per year in the past ten years, and with an age pyramid of a young country: in 2001, 50% of the population was under 20, while those over 60 were 5% of the total population. The population is distributed relatively evenly in the urban and rural areas.

The illiteracy rate fell between 1998 and 2002, from 7.3% of the total population over 15 years of age in 1998 to 6.3% in 2002. Between 1992 and 2001, the primary school attended 92% of the boys and 90% of the girls of primary school age, and in 2001, 87.4% of primary pupils entered secondary school.

In 1998, the only year for which the World Bank has data, 17% of all the roads of the country were paved. According to figures from UNICEF (2003), 100% of the urban population of the country and 82% of the rural had access to drinking water, i.e., a national average of 92%, and 71% of the urban population, and 25% of the rural, have adequate sewerage facilities in their homes, i.e. a national average of 50%.

Agricultural exports (sugar cane, citrus concentrates, bananas and sea products) are the main source of income of Belize, to which have been added in the past thirty years tourism and foreign investments. The fall in international prices in the markets, especially of sugar cane, brought difficulties, such as a large increase in the trade deficit, and thus a deterioration in public savings, which has led to a substantial increase in the government debt.

According to World Bank data (2003), the GDP in 2002 showed an increase of 3.7% compared to 2001, mainly concentrated in the service sector (52.3%). National income per capita was 2,940 US dollars at current values in 2001, and 2,960 in 2002. The deficit in the trade balance in 2001 was significant: in products and services it exported the equivalent of 55.1% of the GDP, while importing 74.1%. Annual inflation between 1990 and 2001, according to UNICEF data (2003) was 2%.

The country has experienced some economic development as from the start of the 80s, which was accompanied by an improvement in the standard of living of a significant portion of the population, and also in their social indicators

(life expectancy at birth, infant mortality rate, illiteracy rate, etc.). Meanwhile, in 1995, the Caribbean Development Bank, the country's Ministry of Economy and the Central Statistics Offices concluded that 33% of the population are poor and 13% are very poor, most of whom live in the rural area of the districts of Toledo and Cayo. In some very poor areas, like the Toledo district for example, which is a Maya area, the percentage of poor reaches 41%. The poor are made up mainly of the indigenous Maya population, refugees, emigrating agricultural workers from countries of Central America, and also by peasant farmers.

In 1999, the government formulated a five-year Action Plan to fight against poverty (*Five-year National Poverty Elimination Strategy and Action Plan – NPESAP*), thanks to the support of foreign agencies such as the Caribbean Development Bank and the UK Department for International Development – DFID. The government's main goal is to reduce poverty from 33% of the inhabitants of the country to 28% in 2004, by better access to social services, in particular in the poor districts of Toledo, Cayo and Stann Creek. Among other activities, the plan includes a reform of the health system.

The health budget increased nearly 1.3% in US dollars between 1992 and 1995, which represented in 1995 8% of public spending as against 9% in 1992 (WHO, 1998:77-88). The relative allocation of resources was characterised by a special stress on curative services (74% to the hospitals), and within these, to secondary care (28%). Staff costs represent more than 75% of the spending of the Health Ministry and have increased recently. According to data from the Pan American Health Organization (PAHO), updated for 2001, more than 60% of capital spending of the Health Ministry is covered by foreign aid. So available funding is scarce for routine maintenance.

In 1999, the main social investments were distributed as follows: education sector (40%), water and sanitation (30%), health (25%) and human development (5%), and most of these financial resources were allocated to infrastructure and administration, and not for implementing activities or programmes (PAHO, 1999).

Life expectancy at birth in 2001 for the general population was 70 years - 67.7 years for men and 72.7 for women. Healthy life expectancy for men was 56.3 years and for women 61.6.

For adults of between 20 and 49 years of age, during the period 1992-1996, the prime cause of death was external (mainly highway accidents) and represented 24% of deaths, followed by heart diseases (12%) and respiratory diseases (7%).⁸⁷ In the case of women under 42 and of reproductive age, the main cause of death was cervical cancer, which is directly associated with having contracted a STI, while among men over 40 years of age, prostate cancer was the most lethal.

87. Adult mortality m/f (per 1000): 191/124 adults. Data from the Population Reference Bureau. MEASURE Communication. *Las mujeres de nuestro mundo*. 2002.

In 41 years, the infant mortality rate fell from 74 per 1000 live births in 1961, to 34 in 2002. Infectious diseases were the main cause of mortality among children under one year of age. Belize is in the 84th position in the world for the mortality rate for children under five. In other words, 40 children in Belize of every 1,000 die before the age of five. The average rate of coverage for the different vaccinations for children of one year of age is around 90%, and it is the State's responsibility to apply them.

Between 1986-1996, HIV/AIDS was the ninth cause of death for the general population, but it was the second cause for the group from 20 to 45. Between 1996 and 2001 the male/female ratio for HIV infection has reduced to 2.1 men with AIDS for each woman with AIDS. Another alarming figure is related to the exposure of young people to HIV/AIDS: in 1997, according to information from the *National Health Information Surveillance Unit (NHISU)*, STIs and HIV/AIDS are very common in young people between 15 and 25 years of age. In addition, in 2000 this population group contained 21% of the cases of STI/HIV/AIDS (ONUAIDS, 2002).

Taking into account the infection among women, Belize in 1999 was, after Guyana, the second country in Latin America most exposed to HIV/AIDS, with an infection rate of 2% of the adult female population.⁸⁸ The main manner of transmission among those diagnosed was heterosexual for the total population, with 41.2% of the reported cases. In the case of women in particular, the two main modes of transmission were heterosexual (87% of female cases), and perinatal (8.7%). AIDS cases are concentrated in the three most populated districts, the cities of Belize, Stann Creek and Cayo. In 2001, it was estimated that 2% of the adult population (15 to 49 years of age) live with HIV/AIDS. The prevalence of HIV/AIDS among the blood tests of the Control Medical Laboratory rose, from 1.5% of the tests to 4.1%, between 1995 and 2002 (UNAIDS, 2002).

In 2001, the fecundity rate of each woman was 3.7 children, which was down compared with 1991 (average of 4.2 children), but with a disparity in fecundity rates according to zones of the country, being higher in the poorer districts (5.6 children per woman in Toledo, and 5.2 in Stann Creek Districts) and the lowest in the city of Belize (3.0). Data show that there is also a significant difference between urban and rural women: 3.1 children as against 4.2 children, respectively.

Since at least the 1950s, Belize, with Guyana and Surinam, belong to the trio of the countries with the highest fecundity rate among young people between 15 and 19 years of age in the Caribbean: in 1950 (Guengant, Orstom and Guadeloupe *in* Jagdeo (1993)), of every 1,000 births, more than 150 were from a young mother and it was in second

place behind Surinam (with more than 175 births from young mothers per 1000 births), but above Guyana (with 140 births from young mothers per 1000 births). However, in the 1970s while this rate began to fall in Surinam and Guyana, the opposite happened in Belize, with the weight of births from young mothers increasing (more than 175 births to young mothers per 1,000 births) up to the start of the 80s. In the 90s, even though the figure dropped, it was still in the first place. However, the proportion of births among young people, according to the Health Ministry, increased between 1992 and 1994, from 15 to 19% of young women between 15 to 19 years of age, and 7% of them have more than one child.⁸⁹

In order to guide and adapt its programmes towards young people and their needs, an NGO, the Belize Family Life Association - BLFA, in 1993, thanks to the financial and logistical support of UNICEF, UNFPA and of the Central Statistical Office of Belize, made a representative survey at national level on pregnancy in adolescents of between 15 and 24 years of age. The poll compiled information about sexuality among young people and about pregnancy and its perception on the part of the adolescents.

The poll is remarkable for the framework within which its promoters carried it out. Two decades ago, pregnancy among young people was handled as a matter of philanthropy; the young women can be helped, particularly those who are in a disadvantaged economic and social situation, and to some extent rescue them from their "error". The reference paradigm of this study placed the young people in the centre of the problem, defining them as actors, both in their participation in interpreting their problems, and in the design and implementation of the interventions performed for them. To some extent, in this project, the attempt was made to give the young women a chance to speak and to deal with the topics of sexuality and pregnancy from their perspectives.

The main results of this poll basically point out the heterogeneity and differences between ideals and practices within the country: the abyss between ideal and practice; the age considered ideal for first sexual relations and the different, earlier, practice; the ideal age for the first pregnancy or child and the earlier practice; the high exposure of the young women to pregnancy and to STIs; the limited use of contraceptives, and the scarcity of programmes for young people in the health area.

In any case, the adolescents only receive family planning services as from 16 years of age, identified as the age of consent. So it is illegal for adolescents to be sexually active before this age, and it is thus considered unsuitable to provide them with such services. Sexual activity below 16 years of age must be reported to the social workers in the

88. This data comes from the following report: Population Reference Bureau. MEASURE Communication. *Las mujeres de nuestro mundo*. 2002.

89. Government of Belize, *Ministry of Health and Sports, Ministry of Human Resources, Women's Affairs and Youth Development, National Women's Commission*. "From Girls to Women. Growing Up Healthy in Belize" (1997:100).

Family Services Division (in the Ministry of Human Development) to be monitored.

According to the responses to the questionnaire, the provision of government family planning services takes place in medical centres, and in general, only mothers have access when they go for the post-natal check-up. These medical centres began with a project financed by UNFPA that ended in 2001. The only available methods were condoms, injectables and the intrauterine device (IUD) and only when these were donated by international agencies.

Between 1995 and 2001, the prevalence of contraceptive use was 56% among the women. It would seem to have increased since 1991, when the first representative national-scale survey was made of fecundity, contraception and mother-child health, which took place in Belize.⁹⁰ In this survey, 33.5% of the women polled said they used some contraceptive method; 12.3% said they had been sterilised, and 12.0% said they used oral contraceptives. According to UNICEF (2002), contraceptive use among married women in 2002 was 47% for all types (including temperature methods) and 44% for modern methods.

In the 1993 poll among young people, 94% of the young women from 15 to 24 years of age used no type of contraceptive, and were thus exposed to an unwanted pregnancy, to STIs and to AIDS. This situation, however, is not related to a lack of information: 30% knew between 1 and 3 different methods, 35% between 4 and 6, and another 35% between 7 and 12 methods. A large part of the young women did not use any contraceptive method because they were afraid of the negative effects.

The Health Ministry does not distribute contraceptives, so its contribution to family planning is limited to health education through the prenatal and postnatal services. In practice, the BFLA is the main distributor of contraceptives in the country.

Over the years, an increase has been seen in childbirths attended in hospital under the supervision of a doctor: in 2000, 77% of births had the aid of specialised staff. It should be pointed out that complications during pregnancy during the period 1993-1996 constituted the prime cause of hospitalisation among adult women (29%). Complications during pregnancy were responsible for 42% of female hospitalisations (all ages), while 37% were related to a provoked abortion. In 2001, for every 10,000 live births, there were 140 maternal deaths, which places Belize in an intermediate position in comparison with other countries of Latin America.⁹¹

A study of family violence, carried out by the Health

Ministry and the Women's Division, pointed out the great variability of forms of abuse and the lack of services and structures to attend them (*Government of Belize, PAHO/WHO, 1998-2002:20*).

In terms of the health system, the Health Ministry is responsible for the definition and design of public health policies and of the regulation and provision of sanitation services.⁹² The central government also supervises and controls public funding. The State is the main financier and provider of health care services and the only provider of sanitation services in the public sector. Until very recently, health care has been free for the patients, as well as the use of services, including provision of medicines. But, in the context of the health system reform, a policy of gradual recovery of costs was introduced, in particular of curative services; it is estimated that between 1995 and 1996, the public hospitals recovered only the equivalent of 4.2% of the total costs.

Around 40% of national health costs are funded with public resources, while 58% comes from the users. The Social Security grants the Health Ministry every year the equivalent of US\$500,000 for care provided to affiliated employees in cases of diseases and injuries related to work.

The government is the main employer of health personnel with almost 75% of the total of those who work in the public sector. Qualified nurses and nursing assistants constitute the most numerous group (83.9% of the health personnel working for the government). A great concentration of health personnel is also seen in the metropolitan district of Belize where more than half of them work: 54% of the doctors, 52% of the nursing assistants and 57% of the qualified nurses. To regulate the disparity created by the concentration of resources in the urban area, Belize signed various technical cooperation agreements with Cuba and Nigeria, countries that send health personnel, mainly general doctors, to work in rural areas.

The private sector is, on the one hand, very small and, on the other, is limited to the city of Belize. It is also mostly restricted to outpatient services or private consultancies and to some secondary care in obstetrics cases and simple surgical operations. In 1999 the private sector had 44 beds. It did double its size, however, in the course of the 90s, as part of the reform process.

Even today, there is no health social security plan in Belize. The Belize Social Security Scheme - BSSS – covers exclusively work-related diseases, and benefits consist of compensation for wages during the period of illness and access to the health services of the Ministry of Health. In

90. This survey was made by an NGO (Family Life Association) in collaboration with the Health Ministry and the Center of Diseases Control (CDC).

91. Figures from Population Reference Bureau. MEASURE Communication. *Las mujeres de nuestro mundo*. 2002.

92. Belize has eight public hospitals in the whole country representing in 1999 a total of 598 beds. There is a hospital in each district, with the exception of Belize and Cayo that have two. Three of these hospitals are considered as Regional Hospitals, providing first and second level care services. Another three are community or first level hospitals with a very limited capacity for second level attention. The Heusner Memorial Hospital acts as the National Referral Hospital for all the country. Finally, located nearly 34 kilometres from the city of Belize is the Rockview Hospital, which is the national psychiatric hospital. There are also 76 public establishments spread throughout the country, 39 health centres and 37 rural health posts providing pre- and postnatal care, immunization, monitoring of the growth of under-fives, treatment for diarrhoea and minor ailments, and lastly, general health education. There are also some clinics specialising in attention to diabetes, tuberculosis, and STI / AIDS.

1997, 67.9% of the work force was affiliated to this social security.

During the last two decades, collective private health plans have been drawn up for the main companies of the country, through international insurance firms. However, private medical insurance is still very limited in Belize. The policy is beyond the reach of most families, since it costs up to US\$100 per month, which represents a large proportion of the income of a worker in Belize. The packages are designed to cover expenses for care outside the country, mainly in the United States of America.

There are also non-profit making services in the sector, such as the Red Cross or the Family Association of Belize, and NGOs, that provide out-patient services, thanks to international aid, donations or cost recovery mechanisms.

Up to 2000, the organization of the health system had a centralised management in technical and programme terms. Until April 1997, this centralisation was also administrative and economic, i.e., the decision-making process depended exclusively on the Health Ministry. As from 1997, finances were decentralised to district level.

Since 1984, there has been a Therapeutic Formulary, which is a list of the medicines which can only be prescribed by qualified doctors, and which was revised in 1997. In 1999, the list contained 241 medicines, which all people in Belize using the public sector had free or nearly free access to, in accordance with available inventories. Several problems were found in the handling of medicines in the public sector, such as the insufficiency of the annual budget, which is not enough to cover the needs of the population, the inefficiency of the purchasing and contracting system, which results in frequent, prolonged shortages of supplies.

The health sector reform initiative began to be drawn up in 1990 based on an initiative from the government of Belize who approached the Inter-American Development Bank (IDB) to request loans for improving the infrastructure of the public hospitals and health centres. The IDB conditioned the loan on a diagnosis and a health system organization proposal being drawn up by external consultants. Officially the implementation of the reform began in 1995-1996, when the Belize government signed the agreement with the IDB and hired the services of an English consultant. The study was completed in 1998 and the period of putting the proposal into practice should have begun.

Meanwhile, with a change of government, another British consultant was hired to develop the framework of putting the proposal into practice, mainly as regards the necessary human resources, the skills, the regulatory framework for the private sub-sector and other aspects. The *Health Sector Reform Programme 1999-2003*, emerged from this work, from the Health Ministry. The model of health care is based on the principles of equity and sustainability

and recognises the need of: a) decentralisation, management-level participative planning and programming, and b) use of a public-oriented approach at programmatic level, at the same time ensuring the provision of a comprehensive set of health care services.⁹³ The reform is presented as the main strategy of the government to be able to improve the level of health of the population, the equity and quality of an efficient and sustainable system, with three objectives:

1. Restructuring and strengthening the regulatory capacity and the central and regional level organization of the public sub-sector, for planning, organizing, producing, providing and hiring good-quality services.
2. Rationalization and improvement of the coverage and the quality of services in the public and private sectors by restructuring public establishments; purchasing selective services from the private sector that encourage the association of these two sub-sectors; provision of mobile services and transport in less accessible zones and community-level training of nursing assistants and other health professionals.
3. Achieving a fair and sustainable financing system by setting up a National Medical Insurance Fund, and concentrating public spending on the poor. The expected results of the health sector reform process are a clear definition of its execution, of the decentralisation process, its legal consequences and the financial and organization models that will be formulated.

In the context of the reform, a Planning Unit was created in 1995 within the Health Ministry, to formulate and plan the policies, and this has two functions: a) to provide technical secretarial services, including planning, advice and assistance to the Health Sector Reform Project (HSRP) Managing Committee, and b) to advise and help the bodies responsible for carrying out the HSRP (OPS, 2003).

Meanwhile, in 1991, the Health Financing and Sustainability Project (HFS) had been formulated by the Social Security, sponsored by the US Agency for International Development (USAID), making short-, medium-, and long-term recommendations for a large-scale reform of the health sector. Two of these recommendations were important for the process: one in the short-term, proposing the elaboration and implementation of a private sector regulation and decentralisation strategy, and the other in the long-term, for the creation of a comprehensive medical insurance system.

With health sector reform proposal set under way by the Health Ministry, the Social Security presented a proposal of a National Health Insurance, and, as a consequence, a period of conflict with the Health Ministry began about the

93. GOB/MOH: "The Quest for Equity: Belize National Health Plan 1996-2000", Belize, November 1996. Quoted in the PAHO report on the profile of the health care services system in Belize.

direction of the reform and, more precisely, about the financial resources for this insurance, leading to a fierce debate between the two institutions. The Social Security proposal was to create a Social Security Number for every citizen, even immigrant workers, as a way of guaranteeing all the benefits that Social Security provides.

The Health Ministry claims for itself the role of provider of health care services, reserving for the Social Security the financing function. The latter, in turn, keeps for itself the function of providing medical services, buying them from third parties, whether public or private, but also reserving for the Health Ministry the task of regulating the medical services market and of encouraging health promotion and disease prevention activities.

In November 1996, the Prime Minister validated the National Health Plan (1996-2000) and the Health Ministry began to implement it, developing new programmes, decentralising services by region, and regulating the private sector. To carry out these proposals, it received two loans from the IDB. One, of about a million US dollars, was to develop the regulatory framework for private medical practice, in terms of quality patterns, determining, among other things, infrastructure standards. This project was to train human resources and to develop technical standards and laws. The second loan from the IDB would be to improve hospital and clinic infrastructure of the Health Ministry, to promote an administrative reorganization of the Ministry, improving its equipment and human resources to act as a regulating body, and a third component would be to develop a funding system. The resources for this third component sought to create the necessary infrastructure for the National Health Insurance, reprogrammed for preventive activities and health education, in the face of the conflict with the Social Security.⁹⁴

A process began at the same time to regulate the private sector, leading to conflict with the medical association, which reserves regulatory tasks for itself. Up to then in Belize, current health legislation came from colonial times without much modification. However, the medical services market, and the social practices around the health-disease-care process take on some complexity and require a new regulation framework, especially as regards the use of medicines and private practice.

At the same time, the Social Security began a pilot project of National Health Insurance, that in principle should have covered a poor urban zone of the city of Belize and a rural zone, but due to inter-institutional conflicts, was restricted to a poor area of Belize, covering about 12% of the population of the country. The proposal was to guarantee the first level to all the residents with the Social Security card, by means of individualised attention, with reproductive health, and

mother and child care activities included. This attention is being carried out provided by four primary care providers, which are an NGO, a public provider and two from the private sector. The proposal of the pilot plan was drawn up by a Costa Rican consultancy, *Sanigest Internacional S^a*, and brought the Belize proposal of National Health Insurance close to the Costa Rican Fund model.

The intention is to extend this programme for all the country as a strategy to achieve primary care in medical assistance for all. The activities to be included are: a) general medicine (including general consultations); b) paediatric and obstetric attention; c) specific programmes including early diagnosis and monitoring of patients with asthma and tuberculosis, and with hypertension; d) counselling services for diabetes; e) early diagnosis of prostate, breast and cervical cancer; f) family planning; g) counselling and services for patients with HIV/AIDS; h) simple surgery, and k) monitoring services (including for HIV and the STIs). Epidemiological vigilance activities are also planned.

At the suggestion of the IDB, faced with the continuing conflict between the Social Security, the Health Ministry and the private medical sector, a multi-sectorial Coordinating committee was set up, responsible for handling and negotiating the reform. Government offices, including the Health Ministry and Social Security, as well as trades unions and the private medical sector through its association, all took part in this. This coordinating committee worked between 2000 and 2003, meeting 3 or 4 times in an atmosphere of conflict and tensions.

The proposal emerged from this committee to set up a technical group to analyse the pilot project, with some decision-making capacity, which has made it possible to make progress in analysing the proposal. Currently the environment is less tense and conflictive, and so some agreements have been reached. From the experience of the pilot project itself, and from the discussions of the technical group, the initial proposal has steadily changed as regards the breadth of the basic package, restricting it, introducing unforeseen co-payments, with a cost of one Belize dollar, and delimiting the geographical areas of influence of the primary care clinics.

The development is also under way of a health information system, with data on socio-economic and cultural aspects of the population, with a gender and reproductive health approach. As part of this project, the Central Statistics office has acquired new equipment and instructed part of its staff in gathering, processing and analysing the data. However, there is a lack of trained personnel to develop and run a social indicators system.

As regards SRH, both civil society and international

94. In practice, international donations and loans have been a fundamental source of capital in Belize for supporting the performance of programmes such as the reform of the health system. Between 1993-1997, Belize received US\$28,367,000 in donations and US\$11,000,000 in loans, corresponding to 61.2% of foreign capital in donations and 38.8% in loans.

organizations have historically had an important role in the country. The Belize Family Life Association (BFLA), for example, founded in 1985, plays a core role in defining and handling family planning problems. It has six centres providing a variety of SRH related services (pregnancy tests, cytology diagnosis, and treatment of dysplasias in their early stages, STI diagnosis and treatment, and client-centred SRH counselling), as well as an itinerant programme of family planning services in the more remote zones.

In the context of profound change in the health system as a result of the reform, the Belize Family Life Association intensified its collaboration with the government and the other community groups, and strives to make its programme economically sustainable. In 2002, it held 28,764 consultations, of which 12,371 were related to family planning and 12,619 with SRH. Nearly 95% of the clients of the BFLA are women, 60% from the rural area and 40% urban.

Moreover, faced with a lack of information on SRH, the BFLA in 1991 held a national survey on fecundity, contraception, and mother-child health, in collaboration with the Health Ministry and with the financial support of international agencies, and a representative poll at national level on pregnancy among adolescents between 15 and 24 years of age, with the logistic support of UNICEF, UNFPA and the Belize Centre for Statistics, the results of which were mentioned earlier. The current aim of the Belize government is to universalise family planning, especially in the poorest areas of the country.

In relation to the issue of family violence, under the initiative of the PAHO and of its 1998-2002 Women's Health and Development Program a model has been designed and promoted for dealing with intra-family violence in the Belizean context.

Based on these two antecedents, a national action plan for fighting intra-family violence was introduced in the 1996-2000 five-year plan, the *leitmotiv* of which is the "*Quest for Equity*". Designed in accordance with the reform principles (multi-sector integration, in this case six important government and non-government agencies, and mobilisation of the national and local levels), the programme was drawn up in the context of the search for gender equity. Organised in Committee (*National Family Violence Task Force*), under the supervision of the Women's Council, various civil society actors and public officials worked on the development, promotion and dissemination of this national fight against intra-family violence.

Among the activities realised can be mentioned the implementation of an intra-family violence information and monitoring system, effective thanks to the setting-up of a network with local bases in all the country, and courses and

manuals were developed to be able to train and raise the consciousness of health professionals of the problem of intra-family violence.

As part of this process the Health Ministry has drawn up a proposal for SRH in the framework of the health sector reform and the struggle against poverty and the Cairo and Beijing conferences, and in particular, the agreements and national treaties taken on by the countries, can be seen reflected at least in normative terms, in the reproductive and sexual health policies in Belize. The activities launched in this framework were the establishment of a population unit in the Ministry of Human Development to write a population policy, and provide training for teachers in demography, and the creation of a Population Sub-Committee of the National Committee for Families and Children (NCFC).

However, the introduction of the gender perspective and the definition and implementation by the Belize government of a systematic, organised SRH policy seem to be very recent. In the Health Ministry document, *Sexual and reproductive health policy* (2002), the need is recognised of having a policy in Belize in the SRH area, even in order to achieve better economic and social performance in the country. It is hoped, then, that this policy, on the one hand, provides a favourable environment for health, which implies fair access to health care services, which is one of the main goals spelt out in the health sector reform. On the other hand, it should generate the conditions for women to be able to be present in all the sectors (work and economic) of the society. The importance of public information and education on SRH matters is also recognised, so that they are able to exercise their rights and take decisions, based on adequate information.

The Ministry is placed as the leading actor in this policy, in particular in its future phases of the monitoring and evaluation of outcomes. It has taken on the task of generating the conditions to ensure the population has access and equity in SRH attention. It also asserts that this policy, just as for all the health policy and medical research, must imply activities founded on a gender and human rights approach, and at the same time be comprehensive and with quality, taking into account the right to sexuality,⁹⁵ to reproduction⁹⁶ and the social, cultural and gender particularities of the users of the health care services. The aim is also to develop it within a legal framework that recognises the national and international human rights laws, such as the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on Human Rights, the Programme of Action of the International Conference on Population and Development, etc.

The principles underlying these interventions assimilate

95. That is, the right to choose the modes, the conditions and the times of exercising their sexuality, independent of any kind of coercion, discrimination or violence.

96. That is, the basic right of couples or individuals to decide in a free and responsible manner the number of children and the spacing between them, which therefore supposes access to suitable information and the health care necessary to achieve these goals. The right to reproduction also includes the right to take decisions about reproduction independent of any kind of coercion, discrimination or violence.

gender policies – for both sexes and different stages of sexual and reproductive life – as a democratic social policy. In consequence, features put forward are an inter-sector approach to encourage the struggle against poverty, and a universal, fair access to basic education, transparency, responsibility and good governance, in all the public, private and international institutions, in the budget process and in the supply of services, at all levels.

Another feature is the participation and collaboration of civil society in the organization of this programme. The Ministry recognises and integrates collaboration with the civil society in all the stages (design / implementation / evaluation) of this policy.

The area of action is defined for: mothers' health, reproductive health, diseases related with reproduction (cervical cancer, prostate cancer, STI / HIV / AIDS), the prevention of maternal / foetal transmission, health of adolescents and young people. These activities must receive the contribution of all, men and women, and will be aimed particularly at the most vulnerable social groups, such as women and indigenous people. It is hoped to guarantee access to the services, taking into account the sex and age of the patient, and to provide information about the prevention of HIV/AIDS and its complications, stressing maternal-foetal transmission. It is important to be precise about the distinction between different populations (men, women, young people, and adolescents) and define the main objectives for each one.

In the area of education and information, the authorities propose to seek greater participation of the mass media in developing significant campaigns on SRH matters, mobilising public opinion and launching campaigns stressing safe motherhood, family planning, gender equity, violence against women, detection and care of breast cancer, pregnancy in young people, etc.

It would seem, at least at the project level of SRH policy, that there is a willingness on the part of the Health Ministry to transfer some elements of organization promoted through the reform, within an SRH policy.

Despite the difficulty of access to the data and the lack of available detailed information, what it has been possible to see indicates that this reform process will be long-term, and its results, in terms of institutional organization will possibly be a mixture between the proposals of Social Security, which has more ability to put pressure, the Health Ministry, with its long background in preventive activities alongside the more needy population, and the private sector, in clear expansion in a market limited by poverty. In this process, the IDB will certainly exercise its influence as a significant provider of funds, which gives it an irresistible capacity for pressure through its lines of financing, and, in a different environment, the role of international consultants will also be fundamental, in drawing up technical proposals that respond now to the guidelines of the IDB itself or to those of the national actors, whether the Health Ministry or Social Security. These consultants may be occupying the

historical place of the PAHO as a technical support agency, with the latter remaining in the sidelines, or more linked to thematic programmes such as SRH, domestic violence, HIV/AIDS and others. Another actor, whose role should be better understood, is the NGOs, which have played a fundamental role in Belize in matters related to AIDS and SRH, among others.

SOME COMPARATIVE NOTES

The comparative analysis of the five case studies described in this work and presented in summary form, repeats the theoretical and conceptual framework defined previously. Although starting from very different situations, and recognising their respective particularities, the health care services system reforms put into effect confirm the dissemination of a common agenda, adapted to national conditions.

Starting from the economic crisis, and encouraged or financed by international agencies, above all the World Bank, all the countries are immersed in sector change processes, of greater or lesser extent, and bearing in mind their different proportions, to some extent all the reforms have included mechanisms for breaking the State monopoly in the sector, separating the financing functions from service provision (contracts), management flexibilisation (self-management), outsourcing, privatisation and giving priority to basic attention.

Chile, the first case, is the pioneer in Latin America, and the health system reform of the end of the 80s, made possible by the authoritarian context, is the most radical and has no equal in the world. It is characterised by adopting privatisation as the core of the reform, combining private insurances, public and private competition in insurance, and segmentation of the financing structure. Despite the system being fed through obligatory contributions, the public sub-sector is based on solidarity while the private sub-sector (the ISAPRES) operates with the logic of a private and individual insurance, applying risk selection.

Compulsory insurance is proper to public or national social insurances, seeking a stable differentiation of risks in the midst of varied public-private combinations. This is why the dual logic of the Chilean system is *sui generis* internationally, since the obligatory contribution, the exclusive responsibility of the workers, allows them to affiliate to the public health system through the FONASA, whose distribution rationality favours solidarity, or to the private institutions (ISAPRES) that, despite the compulsory nature of the insurance, work under the logic of a private insurance associated with individual risk (for example, purchasing the so-called “wombless plan”, which excludes services for pregnancy and maternity), cover nearly 30% of the population and have experienced a price rise in recent years that is many times higher than that of other sectors of the economy. The public sector, lacking entry barriers, covers the population with lower incomes and that with

higher risks, and fulfils an overall reinsurance role for the system. Due to the increase in the coverage of high-cost diseases by the public system, to the discontent of the affiliates to the ISAPRES and to the phenomena of disaffiliation and migration into the public sector (since 1997), the ISAPRES have made adjustments that, since they are optional in nature, do not modify the coverage in which the risk selection is made (Sojo, undated; 1998; 2000).

However, Chile is also quite singular in its explicit exclusion of services by the public insurer, as it has a precise catalogue of services, a polemical measure the introduction of which was made easier in the authoritarian context of the military government. But this catalogue has been substantially increased during the past decade, including high cost services (*idem*).

More recently, a new attempt is being made at reforming the health system, aiming at greater solidarity, but this presupposes an increase in financial resources, important changes in the running of the services and an effective regulation of the private sub-sector.

The proposal implies a significant shift in the system, for which bills have recently been passed, and the core of these is the AUGE plan, including universal, guaranteed care according to need for a quite broad package of services, considered to be priorities for their incidence and high monetary costs for health. Because of the duality of the system, the AUGE has different implications for the public and private (the ISAPRES) systems. In the former, even though none of the services included is new, as they are all included in the FONASA catalogue, insuring a set of services in a universal way implies meeting the total demand of the insured population, up to now limited by financial or policy restrictions on the services, with waiting lists, etc. Attending these effective needs within a particular period and with quality, implies an increase in resources.

The ISAPRES, in turn, due to an absence of regulation, practice risk selection when the individual health plans are renewed every year. With the AUGE, it is hoped to limit the risk selection and broaden the horizontal and vertical coverage, which would abolish the idea of pre-existent diseases, but it will be difficult to prevent the ISAPRES introducing reductions of another kind to compensate for the costs they incur from the AUGE.

So the introduction of guaranteed services through the AUGE, has implications in terms of the degree of solidarity of the health system, but in modest terms, as there is no intention of modifying the duality of the system. In the case of the public sector, there are substantial gaps between the needs of the population and the effective services. This requires increasing the efficiency and efficacy of current resources on which the system relies, and more financing. It is precisely this discussion about the efficiency of the public sector and about the relevant means of financing the plan that has grabbed the attention since the bill was presented. The AUGE would imply for the ISAPRES, albeit only for a package of services, imposing ranges of solidarity on the

logic of the ISAPRES, limiting the selection of risks. The “solidarity compensation fund” is created for this, bringing together only the specific resources for financing the AUGE, but it does not propose any “communicating vessel”, or cross-subsidies between both parts of the system (Sojo, undated: 10; 1998; 2000).

The public discussion has centred on how to finance the plan for the public sector beneficiaries, for which the bill proposes a series of indirect taxes with specific use, for the ISAPRES, the main point of argument on funding has been to maintain the contributions of their affiliates unaffected and that the public sector should obtain independent financing for the AUGE.

The services for maternity leave or for serious illness of the younger child are modified, that up to now have been universal for every woman worker affiliated to public or private health insurance, and charged to the national budget. A “maternal solidarity fund” is set up to pay these expenses to the FONASA and the ISAPRES. These changes have been criticised because it is supposed that it may imply greater adverse selection against women in health plans, or greater barriers to their integration in the labour market. However, this should be attenuated by the fact that both men and women must contribute to this fund and the financing is also progressive, as contributors pay into it according to their wages (Sojo, undated: 12).

It would be necessary, then, to use simulations to know if the potential use of this universal subsidy financed with fiscal funds gives priority to women on lower incomes, as well as to evaluate if other achievements in the area of rights will not regress in the process.

The issue of SRH is thus not dissociated from the change process that is taking place in the system, but is, on the contrary, directly linked to it. It would therefore be necessary to develop mechanisms to be able to monitor these changes and identify to what extent, in fact, they are going to improve or worsen the SRH situation of the population.

Colombia, the second case study, is the one that most shows its almost unconditional support for the new contemporary reform agenda, putting into effect regulated competition in the administration of a universal public insurance and in service provision, with provisions for the progressive integration of financing structures and segmented benefits. Also, from the time of its formulation, the reform could rely on the collaboration of World Bank technicians, and this also financed part of its implementation. Colombia has been considered for more than a decade, the WB’s favourite “laboratory”, whether in its economic plan, or in the sector plan.

Without doubt, the transformation of the health system in Colombia was of great importance and the balance of the results of the reform are not encouraging: the increase in coverage was not what was expected and there is a threat of a reduction of the levels reached up to now; the difficulties facing the SGSSS are fundamentally linked to the conception of social policy and health, and to the transformation of the

labour market, the deterioration of which has deepened in this first decade of the new century with even greater impoverishment of the population and worsening of the quality of life; there are also problems with the exclusion of significant groups, due to contradictory transitory regulations and the multiplication of health plans; tax evasion and avoidance are still rising, leading to a reduction of resources in national funds and hampering the solidarity mechanisms; there is little capacity to guarantee the quality of care in the system, and there is a significant lack of adequate information for the population. The new market seems to be rapidly incorporating many of the problems of the deregulated private markets, precisely because of failings in the State's regulatory activity and for the ups and downs of progress in the process of implementing the reform. It can also be seen that macroeconomic efficiency is seriously affected by the great increase in National Health Expenditures, currently one of the highest in the region.

Also pointed out are the exaggerated segmentation of the population, the insufficient resources for subsidies and attention to the linked, not necessarily poor, who are still being attended by the traditional public sector, great fragmentation of the services network, disorganised development of supply, increase in administrative costs, "economic" behaviour by agents, deterioration in public health activities, delays in the flow of resources, and the running down of the capacity to mobilise new resources, at the same time as an increase in needs that cannot be met, a lack of commitment with the health of the population and a greater risk of corruption in the system.

The effective use of the services has not changed and the economic barriers (co-payments and moderating quotas) are still the greatest obstacles. Recent studies show a worsening in the fairness of the system because of its regressive nature (the non-affiliates are situated in the 1st and 2nd deciles of the population) and an increase in families' private spending, as the mean of direct payments increased for the families from the poorest quintile. Even so, the model itself is not being questioned by the State.

The enormous complexity of the new health system would require a significant transformation in institutional culture and the development of regulation capacity, to monitor the business, contract and audit mechanisms, in a learning process for the agents as well as for the population, and including technical and professional re-adaptation and adequate information for the users/citizens. But no significant progress has been seen in these areas, despite intense technical and bureaucratic normative activity.

The logic of decentralisation towards the market (privatisation) is not coherent with the political and administrative division of the country, nor with that of social participation, epidemiological control, or the organization of the health care services, and so systemic coordination of the new model is quite affected.

In relation to SRH, as from the reform there are now specific norms that include various activities, not related

only to motherhood and children, provided for in the POS and in the POSS, and in 2002 the promotion of responsible SRH was established, with emphases on the adolescent population, abortion care and the strengthening of male responsibility in SRH, as well as guidelines on information, education and communication, protection against all forms of violence and the organization of rehabilitation and support programmes for victims of violence and sexual exploitation. For young people, there are also specific programmes. But these initiatives are far from meeting the requirements associated with an adequate SRH programme, and the approach to assistance is still partial and mostly centred on mother-child care services.

In brief, despite the advances in terms of legislation about rights related with SRH, there are many limitations, generally related with the "invisibility" of particular problems, or the lack of compliance with the specific laws or norms. The greatest obstacles for accessing the benefits of the SGSSS originate in job conditions and in the unequal share of women in the labour market, which, allied with other issues and problems related with implementing the reform, determine an unequal access to the system and so to SRH services.

In **Brazil**, the third case study, the formulation of the reform process was linked to the democratic transition and to the opposition to the authoritarian military government, and is an attempt to consolidate a single health system, public, universal and decentralised, based on the conception of health as a citizen's right and a duty of the State, apparently in a line contrary to world and regional dynamics.

A crucial point in the health system reform process in the Brazilian case, different from the previous cases, was the leading role of the sanitary reform movement and of the women's movement in the inclusion of health as part of the struggle against the military dictatorship, and as a fundamental issue to be dealt with in collecting the enormous historically accrued social debt. Initially in the authoritarian period, and later in the political transition, these essentially militant movements brought together intellectuals, health and other professionals and organizations and civil society associations, opposition party politicians and techno-bureaucrats. An agenda for "Sanitary Reform" was gradually drawn up, that encouraged and gave guidelines for the technical and political debate during the democratic transition. This movement linked up with other social movements and managed to integrate a broad lobby that pushed forward, successfully, in the National Constituent Assembly, the thesis *health as a citizen's right*, the motto of the banner of the sector struggle, written into the new Constitution, and on the banners of the struggle of the feminist movement.

So, different from the reform processes in the other countries analysed here, the Brazilian health reform was not a requirement or consequence of the stabilisation and macroeconomic adjustment policies, current in Brazil since

the 70s and still remaining today. On the contrary, at the start, it entered into a clear collision course with them, and was considered as the area of social policy where most progress was made. However, during its implementation, the economic contraction began to dominate the government agenda and was reflected in the way in which the SUS was structured and has been evolving.

The State administrative reform, perfectly in tune with the international agenda, the worsening of economic conditions, budget cuts and the decline in the population's living standards, as well as the debate provoked by the strategy of giving priority to basic care and the regulation of the private sector, not only mark a turning point in health sector reform but have also gradually led to questioning the idea of the SUS as a national health system, as was originally thought, and have led it to tend to adapt itself to some extent to the premises of containment and selectivity, preached for Latin America.

The difference in relation to the area of SRH is also marked, less in relation with the indicators, many of which are still quite bad, but mainly by the significant performance of the women's movement in several spheres of civil society and of the State apparatus, making great achievements and today being recognised internationally for their capacity for advocacy. Feminists have also occupied important posts, either in government, or in the forums and specific commissions of civil society and parliament.

They also managed to have a determining influence in formulating and implementing a new policy for the area of women's health, restructuring the area within the ambit of the Health Ministry, mainly in the late 90s, and the early 21st century, and achieving some quite positive results in terms of starting a process of reorganising services and inserting this area into the construction of the SUS, with the aim of inverting the historic working of health activities, centred on the mother-child unit, as a vertical programme.

Meanwhile a lot remains to be done, and it cannot be said that these positive results are satisfactory. On the contrary, they are positive from a process perspective, but still leave much to be desired in terms of a more effective paradigm change that would in practice aim at the transformation desired, either in terms of the SUS, or in relation to women's health in a wider perspective.

Costa Rica, the fourth case, is, in turn, the country that maintained the historical structure of the original health system, with universal insurance, public administration and financial structure, but also establishing the separation of function and competitive mechanisms in the running of the system, through the introduction of "management commitments" (contracts), aimed at improving efficiency, efficacy and equity, and is the reform that is registering the best results. It has been being implemented gradually since 1996, when the separation was achieved of the competencies of the Health Ministry (guiding function) from those of the Costa Rica Social Security Fund (CCSS).

But Costa Rica kept and has consolidated social and public responsibility in the health social security system without modifying the structure and the sources of funding (obligatory tri-partite contributions), maintaining collective equivalence with a universal mutual security, single fund and without competition in the insurance regime.

It is also set up in a quite particular way, compared with the other cases analysed here. Firstly, it is a country characterised by high levels of social investments in general, and in health in particular, with low percentages of the population living in a state of poverty (although there is stagnation in poverty reduction at around 16% of the population) and a stable democracy. Social and health indicators are among the best in the region and their health system is known for the high levels of coverage and the quality of care provided to the population.

In spite of the fact that, like the other countries, it also faces problems of economic crises, episodes of instability and concomitant reductions in public budgets, reflected in the population's living conditions and in the environment, the sector reforms, among them that of the health sector, did not modify the historic structure and principles of its public services system, integrated and universalised, with broad coverage of the population. But, just like in other countries in the Latin American region, health sector institutions are divided between the Social Security (the Costa Rica Social Security Fund) and the Health Ministry, and despite growing institutional reforms throughout the 20th century, this separation remains today, and the reform also strengthened the role of the CCSS, the agency in charge of insurance, with responsibility for all the service provider functions from prevention to rehabilitation, including primary care; and there are complaints of a worsening of service quality, reduction of coverage in some areas, differences between the regions, and privatisation.

Costa Rica keeps and has consolidated social and public responsibility in the health social security system, without modifying the structure and the sources of funding (obligatory tri-partite contributions), maintaining collective equivalence with a universal mutual security, single fund and without competition in the insurance regime, thus creating a highly regulated "quasi internal market". On the other hand, the superintendency role of the Health Ministry is still not clearly defined; the CCSS dominates the system and negotiations for putting the reform into effect are permanent and conflictive.

Just as in the other cases studied, even though the reform model was drawn up in the country itself, it received significant influence from the international agencies, such as the World Bank and the IDB, and even great presence in the financing of the reform. But the priorities allocated to primary care are contained in the principles of Alma Ata and of strengthening this level as the gate of entry into the system.

As far as SRH is concerned, they have had programmes directed to particular groups (mainly mothers and children)

since the 70s and 80s, either for women or adolescents, as well creating specific instances for the SRH area in the state apparatus. These SRH programmes are also seen as having a historic and programme perspective that mainly demonstrates the expression of demands from the women's organizations, and not an initiative from the health policy properly speaking.

Belize, the fifth and last case study, is an example of a country that until recently was a British colony, historically has a mainly public health system, a social security with little activity in the health area, and, very recently has become involved in a health sector reform process formulated and coordinated by international agencies, but is quite conflictive and polemical, with disputes between the national sector institutions about the formulation and leadership of the process.

In terms of SRH, the international and civil society organizations have historically had an important role in the country, including with their own health care services that carried out some activities, among them a system of information and monitoring of intra-family violence. As part of this process the Health Ministry has drawn up a proposal for SRH in the framework of health sector reform and the struggle against poverty but, nevertheless, these measures seem to be very recent, which makes a more conclusive assessment difficult.

To sum up, there are some points in common in the case studies worth stressing:

1. All the countries studied, with the exception of Chile, in the past few decades, underwent, to a greater or lesser extent, problems due to economic crises with the consequent instability, increase in unemployment and worsening of living and health conditions. In some, such as Colombia and Brazil, the escalation of violence at all levels is extremely worrying. But the problems of inequality are present in all of them, with more or less intensity, particularly affecting women and young people.
2. Most of them also suffered macroeconomic structural adjustment processes in this same period, with severe economic and social repercussions, above all in Brazil and Colombia.
3. All the cases studied initiated health reform processes that incorporated in a particular way several of the elements of the worldwide reform agenda, translating them according to the respective organizational and political dynamics of their health systems.
4. The participation of international agencies, above all of the World Bank, in the formulation of the health sector reform models and in the implementation processes has been evident in practically all the cases, except that of Brazil, while the participation of civil society either did not occur, or was incorporated later in representative councils, as a form of legitimising the reform or of social control, again with the exception of Brazil.
5. SRH has, in general terms, been the subject of debates and has won some form of inclusion of the area demands within the health reform agendas, in most cases with the active participation of the women's movements, present and active in all cases, with varying intensity and capacity of influence, and saving the respective particularities of each country. Although there has been some progress in specific norms in some cases, this has not yet been translated into concrete and effective actions in all cases, as within the health care services and in the reforms the reductionist perspective of focusing actions on the mother-child unit and the difficulty of access to information and to contraceptive methods, etc., still predominate.
6. Even though the data reveal significant problems in relation to the health of young people in practically all the countries, there are no specific policies directed towards them, except in specific activities and programmes. Moreover, the subject of pregnancy in adolescence has not yet been tackled effectively.
7. Men are rarely the target of specific policies, in the context of SRH, although in some cases there are beginning to be laws aimed at including them (as in Colombia), but without yet being converted into concrete practices and services.
8. The subject of unsafe abortion is still an unresolved problem in most of the countries. Even in those in which most progress has been made, such as Brazil and perhaps Costa Rica, the right to sexual and reproductive health still deserves more achievements.
9. Having good health indicators is not necessarily a solution in the field of rights, which needs actions going beyond the health sector.

In any case, it is important to keep in mind that the problems faced by the area of women's health, or that of rights, in incorporating the premises defined in SRH into the health system, are no different than those found by other areas of the health systems. It is a matter of integrating horizontally and vertically problems that have always been dealt with separately or by vertical programmes, which requires changes in professional and organizational practices, which is neither an easy task, nor a short-term one.

Final Comments

The recent reforms implemented in Latin America have exacerbated some of the perverse elements making up the societies in the region and have created new problems, as they give priority to an economicist, pragmatic, restrictive perspective.

The balance of the Latin American economic and social situation is strikingly negative, and even the efforts to recover, at least in part, from the devastation of the 80s, were not very successful in the 90s. As Sojo (2003) well summarises it, and the data analysed in this work confirm, *the current external scenario of Latin America and the Caribbean is adverse in terms of the demand for its products and the volatility of international capital. The region can be characterised as at high social risk in several senses. Despite positive trends in some countries – for example, the steady reduction of fiscal deficit, the maintenance of macroeconomic equilibrium and the recovery or increase of social spending – economic growth has been unstable and at lower rates than historically. In international comparisons, the high volatility of the GDP of the region is double that of the industrial countries and the volatility of household consumption is even greater, and has increased since the 80s* (De Ferranti *et al* in Sojo, 2003:122).

This social vulnerability is seen in various forms: high poverty levels, in many countries above average; deterioration in the redistribution indicators, with few exceptions; weakness of the labour market, without social security, and increase of unemployment; reduction of incomes, impoverishment of sectors previously inserted in the labour market and the perpetuation of the tendency towards income concentration. All this means that a vast contingent of the middle classes, not poor according to its income, is nevertheless vulnerable. Moreover, there is an increase in households close to the poverty line (Sojo, 2003:123).

Within the health area in general terms the situation is not encouraging. Taking into consideration the particularities of epidemiological profiles and the inequalities in health and in access to services, the different countries face varying degrees of epidemiological transitions, but always polarised, in which transmissible and degenerative diseases overlap, and well-being in health is unequally distributed to the detriment of the poorest. In the last decade of the 20th century, despite this precarious health situation of much of the population, and of the huge regional inequalities, public financing changed little, at the same time as private spending remained high, with a reduction of the direct component of family spending in favour of spending on private insurances and on pre-paid schemes, and those of companies and other society

organizations. Access to and use of the health care services worsened, and installed and mainly public capacity in the sector deteriorated considerably, also with a few honourable exceptions, with severe consequences in terms of equity and in public health activities. The countries that historically had not provided their population with a sufficient health coverage, whether in horizontal terms (population covered), or vertical (effective services in all complexity levels), have been those that most experienced the worsening of the situation.

The situation of sexual and reproductive health in the region is also quite dramatic and, despite the advanced stage of demographic transition, there are still problems associated with poverty, social inequalities, vulnerability, lack of access to health care services and education. High rates of mother and child mortality and of adolescent pregnancy, above all in the lowest strata, with an increase in the incidence of cancers that are curable when they are diagnosed early (such as cervical, breast and prostate cancers); an increase in deaths for external causes (especially from violence and particularly homicides), with greater incidence in young people; an increase in AIDS cases, above all in women and in younger people, showing changes in the epidemic's profile; a worsening of violence against women and in domestic violence; and scarce access to basic health services, to information and to contraceptive methods. This therefore means an almost total absence of possibility of exercising the reproductive and sexual rights approved in the Cairo and Beijing agendas.

In addition, men and youths are rarely the target of specific policies in the context of SRH, although in some cases there are beginning to be laws aimed at including them in these matters, but without yet being converted into concrete practices and services in the health system as a whole. And women's health, in general the core focus of the policies, continues to concentrate basically on the mother-child unit. So the much talked about gender perspective never becomes operative in formulating policies and in the everyday running of the health care services.

In some cases the health system reforms put into effect in the region were much more radical than those in countries of the North, covering several contexts – from financing to the reorganization of the service systems. With these reforms it was hoped *“to achieve greater transparency and financial equilibrium, improve efficiency in the use of resources and incorporate new mechanisms for widening the coverage of the systems and adapt them to the challenges of the demographic and epidemiological transition of the population”* (ECLAC, 2000:38). However, their implementation has led to significant conflicts with the

principles of solidarity and equity that have traditionally guided the contribution and benefits in health, and the organization of the service systems. Moreover, legal principles were approved in some countries that at the same time institutionalised the right to health as a social benefit linked to citizenship, and formalised universal coverage and a commitment to the principle of equity (as in Brazil and Colombia), but putting these changes into effect increased the fragmentation and segmentation of the health systems and has not overcome the inequalities, apart from the fact that they still leave much to be desired in terms of efficiency and equity.

In the past decade, some countries in the region, more backward in health coverage for the population and in the development of forms of solidarity financing, have been precisely the ones that have adopted the separation of functions proper to quasi-markets, and have put the emphasis on establishing basic packages of health services for the poorest sectors of the population. In each case, this policy takes on features in accordance with the particularities of their health systems, their means of financing and their links with the political systems, but in general terms it can be said that the inequalities were deepened. Some countries have established the separation of functions in their health systems and some initial mechanisms of funding based on results, which permits them too to be regarded as quasi-markets. An attempt has also been made to introduce guarantees for health provision, in all cases seeking to increase equity; however, the results have very different repercussions in terms of the general organization of the system, depending on the degree of their development and coverage, and their capacity for implementation. We would stress that some positive results of these reform processes have been diluted in the new problems arising from the reforms themselves, above all in the countries with more radical options in favour of the new agenda.

Even though the implementation of these reform models demands strong regulatory and institutional development capacity, in general terms the corresponding reform of the public bodies was not carried out as was necessary to guarantee the targets set in the reform premises. On the other hand, the development of these capacities was made extremely difficult by the fiscal stress and the destruction of public institutions.

The experiences of focusing on the implementation of basic packages of services for the poor have not been effective, and the critical reviews made by the World Bank itself, its principal mentor of these proposals, have not been sufficient to substantially change the strategic proposals of social policy for the region. The new strategy of handling social risks, proposed by the World Bank, repeats the postponement of vigorous social policies that would provide adequate social investment, capable of driving a greater insertion of Latin America and the Caribbean in the globalised world, with greater well-being and social well-being.

In synthesis, the genuine dilemma between the administration of scarce resources (efficiency) and the overcoming of inequalities (social justice) became much more acute in recent decades, when the belief in the possibility of balancing these two parameters was questioned and neoliberal policies emphasised individualism, and linked social policy strictly to the economic calculus, sharpening the conflict between values and reinvigorating the ethical accounts underlying it (Santos, 1998). And this dilemma is especially important in the Latin American region, where foreign conditioning has met strong national acceptance and experimentation has proliferated acritically.

Moreover, the problems faced by the SRH in contemporary health sector reforms are not very different from others present in other health areas that were historically organised separately and in the form of vertical programmes. Contemporary reform processes have a common agenda in which some elements are present in all the countries, but the connotations that they acquire in the implementation process are quite particular. Thus, the issue of focusing versus universalising is a permanent tension in the reform models and in sector debates, and goes back to the discussion on solidarity in health policies, above all in the manner of putting them into operation. Consequently, there is also a tension in the confusion between prioritisation and focalisation.

Sojo (2003) expresses it well when he says that solidarity in health systems can be expressed fundamentally in two ways: the first, through the public budget, when the financing to ensure solidarity between income or risk groups fixes subsidies for particular groups, and the resources come from direct or indirect national taxes or from international bodies; and the other way is obligatory contributions to forms of universal insurance, that fix cross-subsidies between different income and risk strata, including inter-generational and of the community in general to specific groups. For individuals and families, these cross-subsidies must be dynamic throughout the life-cycle – for example, the degree of insurance in stages that involve less health risk or lower morbidity represent, for the system and the persons, “savings” for those stages in which the use of services is usually more intense.

Obviously this requires a quite complex institutional and regulatory reengineering and effective spending controls and cost containment, as well as the political will and the financial means to put it into effect. As we have seen, the reforms implemented in the countries analysed have had many problems in guaranteeing solidarity and, in most cases, the designs of the new systems, although apparently solid on paper, proved difficult and failed in their implementation.

In relation with the definition of priorities, historically, worldwide, health systems have always defined priorities, given that it will never be possible to provide all the services for all the population, since health demand will always be infinite and the resources limited. So the problem is not in

priority definition in itself, but rather in the way in which they are defined and implemented. Also, even though it is necessary to choose alternatives and define priorities for State activity in the health sector, this dynamic requires an *ordering of preferences*, which implies the introduction of (local and national) conditions imposed by reality, in which the speeches and rhetoric of those who decide and of their critics are made concrete. And this ordering of preferences cannot be deduced logically, which means that it is not possible to resolve it based solely on scientific (technical) logic. In other words, it should be remembered that these are policy decisions that presuppose the distribution of different quotas of benefits and sacrifices among individual members of a society, in order to ensure the reduction to a minimum of social conflict, and certain social order, which requires suitable procedures (Santos, 1998). It thus falls back on the political logic of “the calculus of dissensus”, i.e., what is the possible consensus or the acceptable dissensus within a particular society, in particular circumstances. In the last resort, it refers to the degree of inequality (and of conflict) that a society is prepared (or manages) to bear. It also presupposes a process perspective, with clear definitions of where one wants to reach, and short, medium and long-term procedures.

It is therefore necessary to make a distinction between priority definition and focalisation. Although priority definition means making particular choices at specific moments of time, underlying prioritisation is the idea of incremental process and of the building a road towards universality and integrality. Focalisation, in turn, as it is being put forward by the international agencies, means defining care packages, generally restricted to a few basic procedures for particular population groups, normally labelled as poor and with limited access to health care services. Obviously, the lack of a process view or the impossibility of continuity in the process of change building, with a clear “target image” of what one wants to build, can transform priorities, defined in precise situations, in focalised policies. This subtle difference should not be ignored – on the contrary, it defines the different targets of different policies.

Thus focalisation occurs within a selective, not universalist, policy perspective, and the *definition of priorities for focalisation* is thus conceptually and operationally different, based on criteria of cost-effectiveness, disease load, etc., that in turn do not include an analysis of the targets of a particular policy and explicitly exclude the evaluation of the ends that justify it, the definition and implementation of which belong to the policy field and not to that of technical analysis. In other words, although it may be desirable and necessary for health actions to be more effective and efficient, the issue of the different needs of different population groups is not resolved solely with this “quantification of policy”. Nor is it resolved with by reducing state intervention and public financing to so-called basic minimums, translated into focalisation (on the

poorest) and privatisation policies, that are put forward as fairer, although this is not justified in practice. In reality, this is an attempt to redefine the distributive function of the State in the area of health services, substantially restricting the character of health policy as a social policy.

One of the core problems of contemporary federal forms (conceptually and empirically) is related with the subject of centralisation-decentralisation, as throughout the past century the federal systems, in general terms, underwent profound structural changes (Almeida, 1996). The conceptual impreciseness of the term decentralisation allows it to be used to indicate various degrees of change of role of the federal government, from functions, resources and decision-making powers for the sub-national levels (and so the distribution of power), to the transfer to other spheres of government of the implementation and running of policies defined at the federal plane (deconcentration), or even the transfer of government attributes to the private sector (Almeida, 1995; Almeida, 1996; Barros, 2001). Moreover, depending on ideological challenges, decentralisation can be seen in different ways: to the right of the political spectrum, as a need to deactivate the demands on the political system and reduce the public presence of the State, decentralising administration and decision-making to sub-national levels; and to the left, with the sense of autonomy and reinforcement of local power, defending decentralisation as the only way to deactivate the bureaucratisation of the welfare state and to deepen citizen participation in democratic processes and structures, increasing the visibility and social control of decision-making systems and bringing leaders closer to the needs and demands of the citizens. In fact, both views have been present in the recent reform processes, depending in the aims that drove the sector decentralisation. On the other hand, problems are found in both perspectives: deconcentration of actions and activities (without power of decision) is not always so harmful, just as total local autonomy is not always so virtuous or pernicious.

In the case of federative systems, federalism presupposes *constitutively competitive and cooperative* inter-governmental relationships, with modalities of interaction between levels, *necessarily based on negotiation*. The relations, though, between federalism and decentralisation are always complex, as they show a *particular compromise between diffusion and concentration of political power in virtue of some shared model of nation and of socially desired degrees of political integration and of social equity* (Almeida, 1996: 14). In this respect, the Brazilian case is paradigmatic, as the compromise and the model are not clear and the formats implemented are loaded with contradictions, shaped initially by the political transition and, later, by the dynamic of the macroeconomic adjustments. Decentralisation in the context of social and health policies has also had motivations different from those driving the redefinition of the federative pact, but also aimed at municipalisation. Neither is there consensus on the desired degrees of political integration and of social equity, even

though these terms are common in reformist political discourse (Almeida, 2003). So the reorganization of the health care services system to act in a decentralised way is a long-term process and implies changes, not only at an organization level, but also in building a capacity for implementation, which in most cases does not exist previously at local level.

In brief, the negotiated construction and the sharing of competencies demand coordination and induction, but also imply leadership, evaluation of results and corrections of direction when necessary. *Specialisation of levels of government* must concentrate on redefining roles in which the inducting and coordinating task of the federal level should aim at overcoming local inequalities, deficiencies and lacks, supporting, encouraging and emphasising the training of local and state levels for the necessary complementarity and scope for better results and not merely for monitoring the fulfilment of bureaucratic requirements. This is the great challenge in building decentralised and fairer health systems.

The issue of the comprehensiveness of care (in horizontal and vertical terms) is another problem that covers much more than the reform model or the political will to implement it. As a concept it is quite complex and is loaded with different “meanings” as Mattos defines it (2001), who identifies three great “meanings groups” for the term.

The first is related with the practice of health professionals (not only doctors), and working processes, independently of whether they are public or private, in the sense of an overall view by the professionals of the needs of individuals, families and communities. The second refers to the ways of organising health services and actions, and has to do with the need to link up the promotion activities, disease prevention, and health promotion, attention and recovery, and not concentrate services only on curative activities. And lastly, the third group of meanings is related with government responses to the health problems of the population as a sector policy, or the definition of health policies that establish links and integration between the different levels of the health system, promoting its reorganization. It thus involves passing from “vertical comprehensive” programmes towards forms of organization of services that enable the users’ access to any level of care when they need it.

If giving priority to basic attention, in some cases with the *per capita* transfer of resources (as in Brazil) with emphasis on family health, encouraging comprehensive health promotion, prevention, protection and recovery practices, if this is not accompanied by substantial investments and reorganisation of the other levels of attention, it may not be effective and may become a focused way of giving priority to care for particular population groups, as the increase in installed capacity does not always result in an increase in coverage; nor is comprehensive care guaranteed as the incentives do not emphasise, nor are they directed to promoting, connections between care levels.

Finally, the issue of social participation and control is not resolved. The literature available analysing the performance of Health Councils at their different levels indicates that there are still many problems, from the difficulty of participating in technical discussions, the lack of rotation in representations, to the discredit of the role of the Councils and the practical effectiveness of their discussions and decisions (Cortés, 1998, Valla, 1998, Carvalho, 1995; Labra, 2001).

The “empowerment” of women, above all the poorest, that is fundamental for them to win more and more visibility for their demands and claims about their health needs, must be dealt with in a differentiated form in its different dimensions. Or better, the importance of opening up channels of participation and for channelling women’s demands (and above all of the more deprived population groups), whether in civil society, or in health care services, is unquestionable. This updates the discussion on the most suitable mechanisms for exercising participative democracy, as well as encouraging reflection on the functionality and relevance of current institutional arrangements (Santos, 1998; Lesbaupin, 2000). The greater politicisation of discussions on the health sector reform, the complexity of the negotiations and the obligation to expose the different “projects” and perspectives to debate in the implementation of the reform, is a benefit in itself, but does not eliminate the need for adjustments and revisions of mechanisms. (Almeida, 2003a).

So the implicit contradiction between the aim of reaching comprehensive care for women, or of gender focused SRH, rights, and the historical organization of the system to respond to each of its components separately is quite complex and difficult to overcome in the short term, and is materialised in the daily confrontation between the old form of working and the building of a new practice. And this requires deep structural changes in the reorganization of the health system and its practices, which includes the institutional, professional and population cultures, and the process of working in the health care services (and so, professional formation). This contradiction is also present in the epistemological plane since, even though it may be possible to formulate the idea or concept of comprehensive care, the production of the knowledge underlying the formulation of collective interventions and individual health care practices concentrates on the components of care that should be “integrated”, and tells little about how to operationalise the integrality. Such integration also requires technological density and ways have to be found to build it (Lago, 2003).

Thus public policy in women’s health has to continue looking at long-term objectives, at the same time as it responds to the present and urgent demands of women, and for this it is necessary to work within the “entrails” of the health system and of the reform agendas. And attention on SRH with a focus on gender and rights requires much more intensive dedication, as it means changing radically the classical medical view, moulded by the specialities.

This does not mean the SRH agenda should be abandoned, or that the strategies defined are wrong; on the contrary, the gender perspective, as it was formulated and discussed in Cairo and Beijing, is fundamental for the important transition process in which the health systems are involved in the region and in the world, because of the paradigm transforming the perception of health/illness/care that this concept places on the table.

The greater politicisation of discussions on the health sector reform, the complexity of the new health systems with the reforms implemented and of the inherent negotiations, with the obligation to expose the different “projects” and perspectives to debate in the implementation of the reform, is a benefit in itself, but does not eliminate or

reduce the need for adjustments and revisions of mechanisms.

Finally, the topics of the reform of the health care and of sexual and reproductive health and rights services systems, are complex and even though much has been produced and discussed on the interrelations between both, we still have a long road to run, so it is fundamental to deepen the discussion between the various social movements acting in the area, the different groups of researchers, decision-makers and executors of health policy, and above all the agencies of the United Nations system, in the perspective of progressing in an innovative way towards the achievement of better results.

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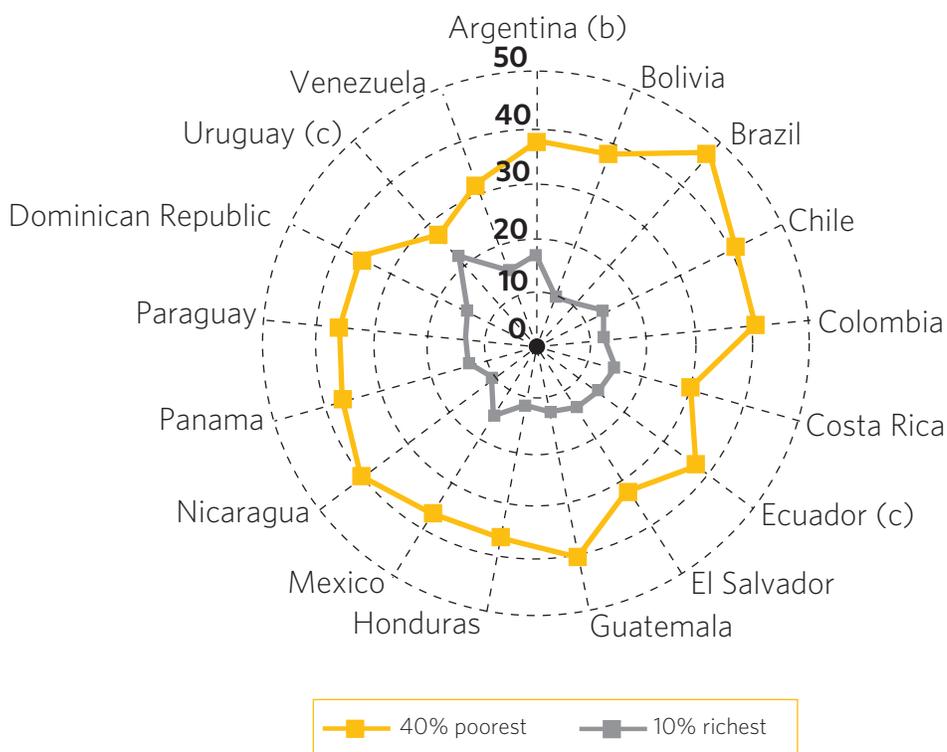
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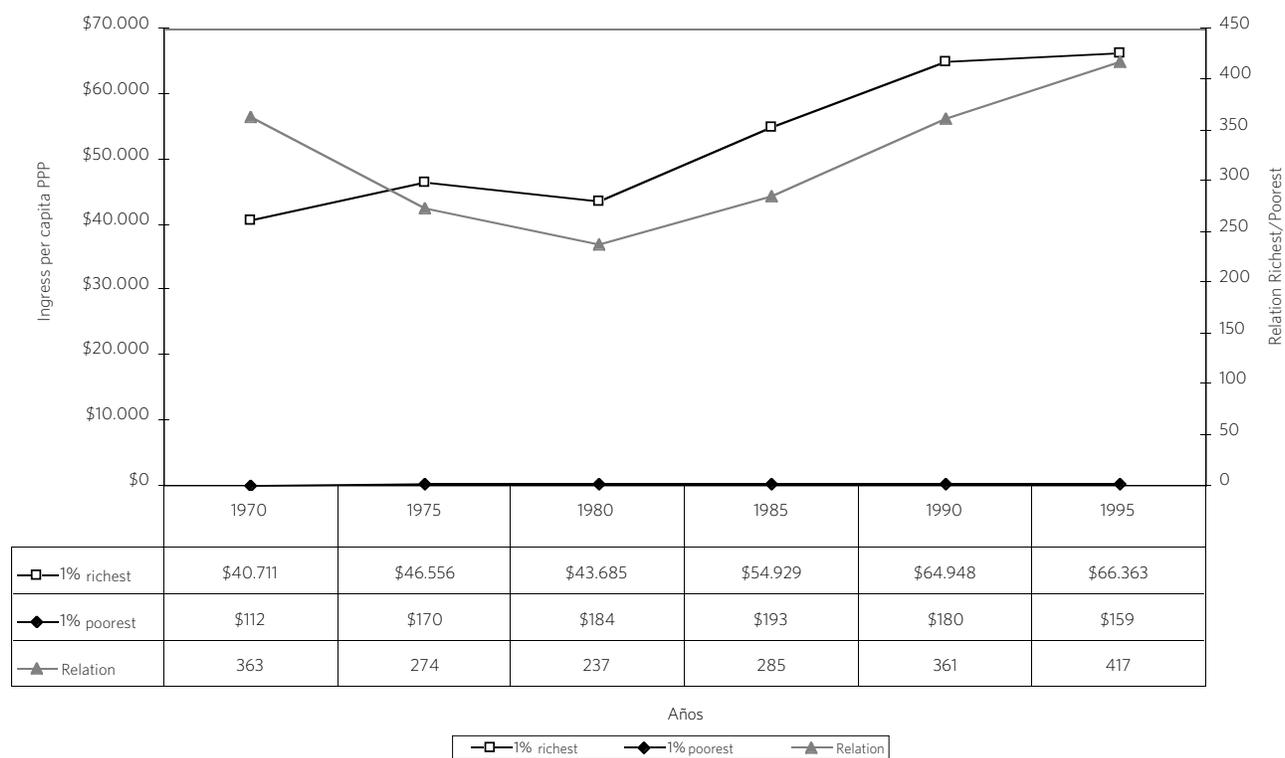
Appendix 1

Figure 1. Latin America and the Caribbean (17 countries): share in total income of 40% of the poorest households and of the 10% richest 1990-1999^(a)



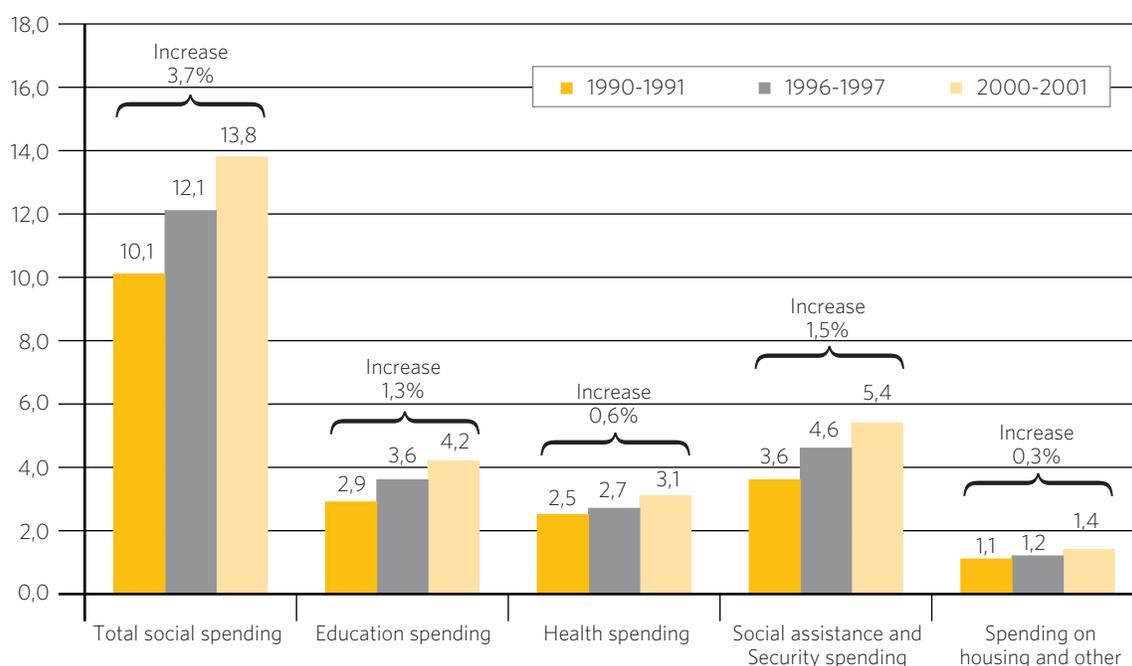
Source: CEPAL, *Panorama Social de América Latina, 2000-2001*, on the basis of special tabulations of household surveys of the respective countries (Chart II.1, p.69).
 (a) Households of the country set ordered by per capita income.
 (b) Households of the country set ordered by per capita income.
 (c) Total Urban.

Figure 2. Growing polarisation of income in Latin America and the Caribbean, 1970-1995



Source: Londoño & Székely, 1997.

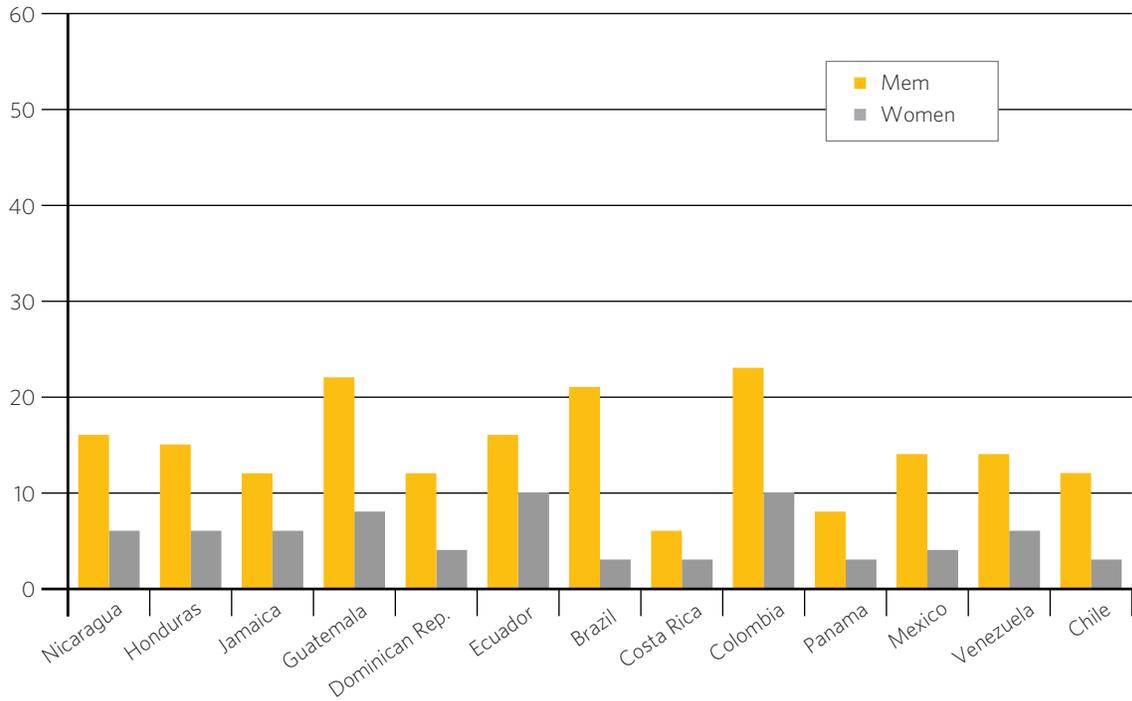
Figure 3. Evolution of social spending by sectors as a fraction of the Gross Domestic Product (GDP)^(a)



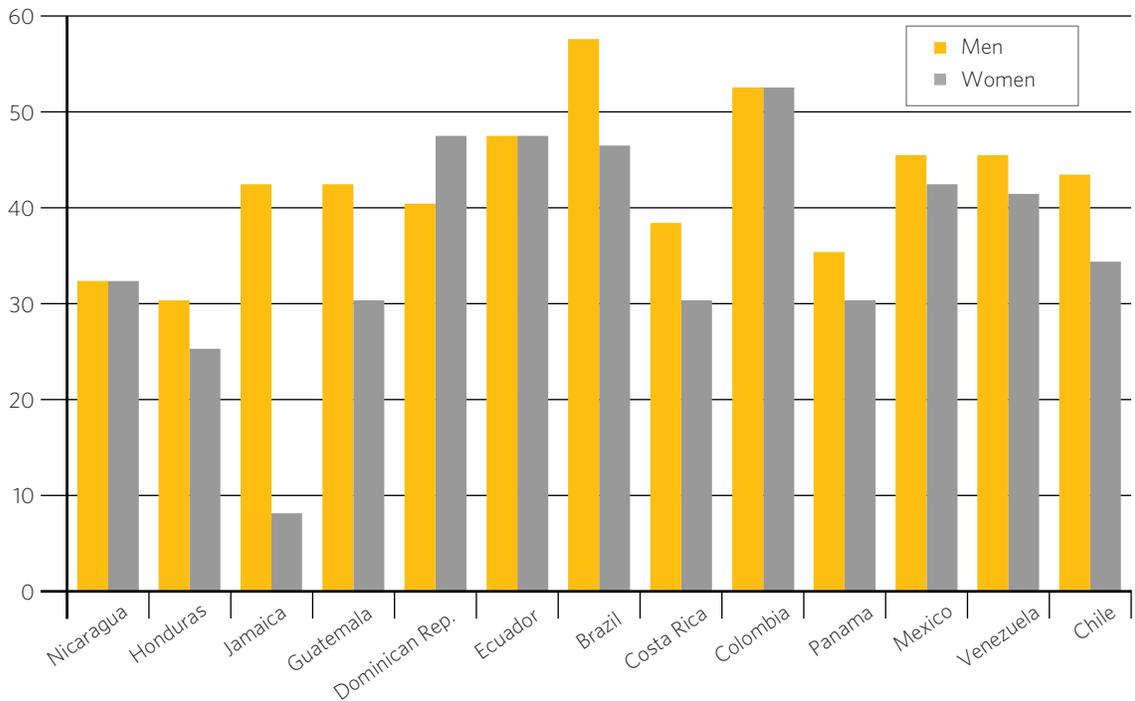
Source: In ECLAC, Panorama Social de América Latina, 2002-2003 - Synthesis, chart 15, p. 27.
 (a) Corresponde al promedio simple de 16 países, excluidos Bolivia y El Salvador.

Figure 4. Probability of dying (per 100 inhabitants) for men and women, between 15 and 59 years of age

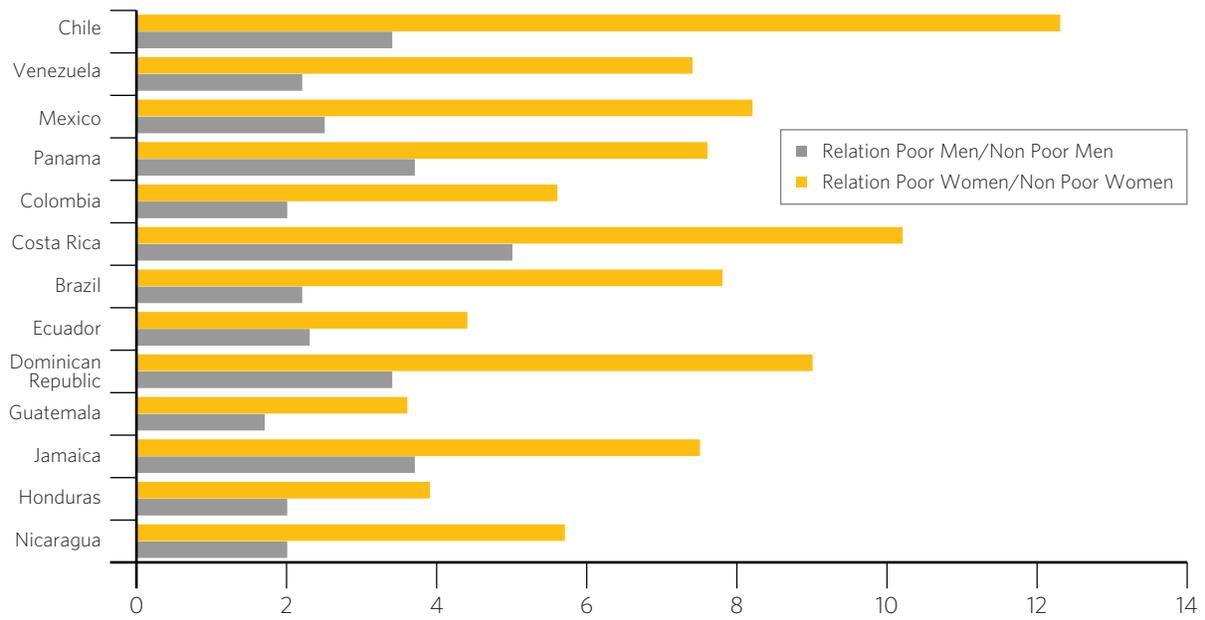
A- Non poor



B- Poor



C - Ration poor/non poor



Source: Prepared by HDW/HDPP/PAHO with data from the WHO, *The World Health Report 1999*.

Table 1 - Indicators of Latin America and the Caribbean - 1950-2002

Indicator	1950	1960	1970	1980	1990	1999	2002
Population (Millions) M = Men W = Women	165 ^(a)	210	275	360.3	432.4	509.2	531 W total - 270 M/100 W - 102
Average annual population growth rate (%)	-	2.9	2.6	2.3	2.0	1.7	1.7
Total fecundity rate (total births per woman)	5.9	6.0	5.0	3.9	3.4	2.7 (1998)	2.7
Urban population (%)	42	50	61.1 (1975) ^a	65	-	75	75
Population by age groups (%)							
0-14 years	40	42	42	40	38.2	31.4	31.5
15-64 years	-	-	-	55.8	-	62.6	63.0
65+ years	-	-	-	6.0	-	6.0	5.5
Economically active population (EAP) (Total millions)	-	-	-	130	-	219	221.56 ^(d)
Average annual EAP growth (%)	-	-	-	-	3.0 (1980-90)	2.5 (1990-99)	3.3 (1990-2001)
Women in the EAP (%)	-	-	-	28	35	41 ^(b)	45 ^(c) (2000)
Children of 10-14 years in the workforce (% of age group)	-	-	-	-	13	9	16.5
Life expectancy at birth (years of life)	52 ^(a)	57.1	61.2	65.4	66 ^(b)	69 ^(b) M- 66 W- 72	71 ^(c) M-68 W-74
Infant mortality (Per 1000 live births)	-	-	-	61	48 ^(b)	31	30
Mortality among under 5s (Per 1000)	-	-	125 ^(a)	78	-	32 ^(a)	34
Prevalence infantile malnutrition (% of children < 5 years)	-	-	-	-	-	8 (1992-98)	9
Access to drinking water (% of population)	-	-	-	73 (1982)	-	75 (1995)	8.6 (1999)
Access to sanitation (% of the population)	-	-	-	46 (1982)	-	68 (1995)	77 (2000)
HDI	-	-	-	-	-	0.760	0.777
Adult illiteracy rate (% > 15 years)	-	-	-	-	-	12 M-11 W-13	11.5 M-11 W-12

Sources: 1950-1970: Frenk et al, 1998; World Bank, World Development Report, 2001 and 2003; Human Development Indicators 2001 and 2003 (UNDP); Statistical Yearbook for Latin America and the Caribbean, ECLAC, 2002, April 2003 (<http://www.cepal.org>) on 09/10/2003; ECLAC, 2003b; except indications.
(a) Human Development Indicators 2001, UNDP. (b) Ocampo et al (2001). (c) PRB, 2002. (d) RICYT, (2002).

Table 2 - National Health Expenditure Indicators (NHE): OECD and Latin America, 90s

Indicators	Unión Europea			Latin America and the Caribbean		
	1990 ⁽¹⁾	1997 ⁽²⁾	1999 ⁽³⁾	1990 ⁽³⁾	1995 ^{(3) (4)}	1999 ⁽³⁾
National Health Expenditures % GDP	7.8%	8.5%	9.3%	7.0%	7.5%	7.3%
Public	4.9%	6.6%	-	3.0%	3.3% ⁽⁵⁾	3.4%
Private	2.9%	1.9%	-	4.0%	4.3%	3.9%
Public National Health Expenditures (%)⁽⁴⁾						
Total	64.6%	76.2%	74%	43.4%	41.5%	43%
Central government	-	-	-	12.2	15.8	23.0
Local governments	-	-	-	7.4	8.5	8.0
Social security	-	-	-	23.9	17.2	14.0
Private National Health Expenditure (%)⁽⁴⁾						
Total	35.4%	23.8%	26%	56.6%	58.5%	57%
Indirect spending (insurance/pre-paid)	-	-	-	-	19.5	18.0
Direct family spending (<i>out-of-pocket</i>)	-	-	-	-	39.0	39.0
Per capita National Health Expenditure (US\$)						
Total	1,620.00	1,771.00	2,063.00	133.00	240.00	498.00
Public	1,010.00			58.00	102.00	214.00
Private	610.00			75.00	138.00	284.00
% of world population⁽⁵⁾		14.6 ^(a)	14.0	6.8	8.5%	8.5%
Average per capita GDP – PPA US\$^{(5) (b)} (in current US\$) ⁽⁶⁾		27,910	28,130	-	-	6,880
				(2,982)	(3,640)	(3,640)

Sources: (1) WHO/PAHO, 1994. (2) European Observatory of Health Care Systems, 2000. (3) Database of Health and Human Development Division – Health and Human Development Programme/PAHO, 2001, except indications. (4) Various sources compiled by Molina et al (2000:77) (Chart 2), cited in bibliography. (5) Human Development Report 2001 (World Bank). (6) www.worldbank.org/selectedcountries (04/11/2001).

(a) 1996. (b) PPA – Purchasing power parity (1990-99), calculated by the World Bank, base year 1996 and extrapolations for 1999 (Notes on the statistics in the Report, pp.

Table 3 - Trend in National Health Expenditures (NHE) as % of GDP in Latin America and the Caribbean, 1980-2000

GSN/GDP ⁽¹⁾	1980	1985	1990	1995	1998-2000
Public	2.89	2.57	3.02	3.45	3.37
National	1.26	1.16	1.16	1.41	1.52
Local	0.44	0.46	0.57	0.95	0.82
Social security	1.19	0.95	1.29	1.09	1.03
Private	3.20	3.21	3.99	4.04	3.93
Direct family spending	3.20	3.17	3.92	2.91	2.85
Private insurance/Plans	0.02	0.04	0.07	1.13	1.08
Total NHE/GDP	6.09	5.78	7.01	7.49	7.30
Average per capita GDP AI and C⁽²⁾ (current US\$)	3,508.4 (1970 – 2,852.4)	3,209	2,982	3,640⁽³⁾	3,680⁽³⁾

Source: (1) Drawn up by Health and Human Development Division – Health and Human Development Programme/PAHO, 2001, Database of the DHH-PDH/PAHO. (2) Own development, based on data from De Gregorio & Lee (1999), cited in bibliography. (3) World Bank (www.worldbank.org/selectedcountries - 04/11/2001).

Table 4 - Principal indicators of National Health Expenditures (NHE) in Brazil, Colombia, Chile, Costa Rica and Belize, 1995-2000

INDICATORS OF HEALTH SPENDING/COUNTRIES	1995	1996	1997	1998	1999	2000
Share of total health spending in GDP (%)						
Colombia	7.4	8.8	9.3	9.3	9.9	9.6
Brazil	7.2	7.4	7.5	7.5	7.9	8.3
Chile	6.7	6.9	7.2	7.5	7.9	8.3
Costa Rica	6.3	6.2	6.3	6.5	6.4	6.4
Belize	3.8	3.7	4.0	4.3	4.7	4.6
Public health spending in relation to other spending (%)						
Colombia	17.5	17.7	18.2	17.4	18.1	18.3
Costa Rica	16.2	17.7	17.2	17.1	17.1	18.2
Chile	10.8	10.8	12.1	12.4	11.8	11.9
Brazil	8.3	8.3	9.1	9.0	9.3	8.4
Belize	5.0	5.0	5.4	5.9	5.7	5.5
Per capita health spending (international dollar rate) (US\$)						
Colombia	260	324	344	329	328	344
Costa Rica	263	254	269	296	320	329
Chile	180	208	242	272	274	297
Brazil	203	203	231	234	243	257
Belize	79	75	89	102	114	124
Per capita health spending (international dollar rate) (US\$)						
Brazil	57.3	59.6	56.5	56.0	57.2	59.2
Chile	64.4	63.3	62.1	60.4	59.2	57.4
Belize	57.8	59.1	57.1	54.1	55.2	54.5
Colombia	42.4	40.8	42.4	45.2	46.3	44.2
Costa Rica	31.6	32.8	33.2	33.5	32.3	31.6
Share of public spending in total health spending (%)						
Costa Rica	68.4	67.2	66.8	66.5	68.7	68.4
Colombia	57.6	59.2	57.6	54.8	53.7	55.8
Belize	42.2	40.4	42.9	45.9	44.8	45.5
Chile	35.6	36.7	37.9	39.6	40.8	42.6
Brazil	42.7	40.4	43.5	44.0	42.8	40.8
Share of spending with health social securities in public spending (%)						
Costa Rica	93.5	93.3	93.8	94.1	94.0	94.4
Chile	89.2	89.1	82.6	75.7	77.3	71.8
Colombia	39.8	40.7	40.3	38.4	37.0	36.5
Belize	-	-	-	-	-	-
Brazil	-	-	-	-	-	-
Share of spending with health pre-paids in private spending						
Chile	33.8	33.8	33.7	33.8	34.5	40.2
Brazil	32.0	31.4	33.1	33.1	32.9	35.1
Colombia	23.8	31.5	38.9	38.6	38.6	34.4
Costa Rica	8.0	7.7	6.9	6.4	6.9	6.3
Belize	-	-	-	-	-	-
Share of family out-of-pocket spending in total health spending						
Belize	57.8	59.1	57.1	54.1	55.2	54.5
Brazil	39.0	40.9	37.8	37.5	38.3	38.5
Chile	42.7	41.9	41.2	40.0	38.8	34.3
Colombia	32.3	28.0	25.9	27.7	28.4	20.0
Costa Rica	26.6	27.6	28.4	28.9	26.8	27.5
Share of external resources in public health spending (%)						
Belize	16.8	17.4	15.0	8.7	7.5	6.8
Costa Rica	1.7	1.6	2.8	2.6	2.4	1.8
Chile	1.7	1.5	1.3	1.2	1.3	1.2
Brazil	0.4	0.4	0.8	1.2	1.2	1.0
Colombia	0.2	0.5	0.5	0.5	0.6	0.4

Source: Own development with data from Giovanni *et al.*, 2003.

Table 5 - Percentage reduction of fecundity rate by countries and regions, by income levels in Latin America and the Caribbean, 1950-1955 and 1995-2000

Countries	1950-55	1995-2000	% Reduction
Latin America	5.9	4.4	54
Low income countries			
Bolivia	6.8	4.4	35
Guatemala	7.1	4.9	31
Haiti	6.3	4.4	30
Honduras	7.5	4.3	43
Nicaragua	7.3	4.3	41
Average income countries			
Colombia	6.8	2.8	59
Ecuador	6.7	3.1	54
El Salvador	6.5	3.2	51
Paraguay	6.5	4.2	35
Peru	6.9	3.0	57
Dominican Republic	7.4	2.9	61
High average income countries			
Argentina	3.2	2.6	19
Brazil	6.2	2.3	63
Chile	5.0	2.4	52
Costa Rica	6.7	2.8	58
Mexico	6.9	2.8	59
Panama	5.7	2.6	54
Uruguay	2.7	2.4	11
Venezuela	6.5	3.0	54

Source: Latin American and Caribbean Demography Centre (CELADE), Regional and Population Project 2000-2003 (2000), in Médecis, 2003.

Table 6 - Principal causes of death, by size of maternal mortality rate and supply of health care services

Services coverage		Maternal mortality rate per 100,000 live births / countries (*)			
		<20	20-49	50-100	>100
Contraception	70-72%	A) 1-Indirect 2-Pre-Eclamp 3-Infections			
Prenatal	100%				
Childbirth	100%				
Contraception	43-70%		B) 1-Abortion 2-Pre-Eclamp 3-Haemorrhage		
Prenatal	90-100%				
Childbirth	90-100%				
Contraception	46-66%			C) 1-Pre-Eclamp-Ec 2-Haemorrhage 3-Abortion	
Prenatal	67-96%				
Childbirth	67-98%				
Contraception	18-56%				D) 1-Haemorrhage 2-Pre-Eclamp-Ec 3-Abortion
Prenatal	53-87%				
Childbirth	55-89%				

(*) Countries: A) Canada, USA, **Costa Rica**, Cuba; B) **Chile**, Uruguay, Argentina, **Brazil**, Mexico; C) Venezuela, Ecuador, Panama, El Salvador, **Colombia**; D) Guatemala, Paraguay, Jamaica, Nicaragua, Honduras, Peru, Bolivia, Haiti.
Source: PAHO (2003), "The PAHO and the Millennium Goals - The CTP as an integral part of the response". Presented in the XVI Meeting of Directors of International Cooperation, Panama, 21-23 July 2003.

Table 7 - Basic data on maternal health in countries Latin America and the Caribbean, 1995

Indicators Countries	Mortality due to maternity 2001 (per 100 thousand live births)	Births (per 1,000 women from 15 to 19 years of age)	Prevalence of use of contraceptives (Women 15-49 years of age)	
			All methods (%)	Modern methods (%)
<i>Latin America and the Caribbean</i>	190	71	69	60
Costa Rica	35	81	75	65
Belize	140	79	47	42
El Salvador	180	87	60	54
Guatemala	270	111	38	31
Honduras	220	103	50	41
Mexico	65	64	67	58
Nicaragua	250	138	60	57
Panama	100	75	58	54
Argentina	85	61	-	-
Bolivia	550	75	48	25
Brazil	260	71	77	70
Chile	33	44	-	-
Colombia	120	80	77	64
Ecuador	210	66	66	52
Paraguay	170	75	57	48
Peru	240	53	64	41
Uruguay	50	70	-	-
Venezuela	43	95	49	38
Cuba	24	65	70	67
Haiti	1,100	64	28	22
Jamaica	120	46	66	63
Puerto Rico	30	63	78	68
Dominican Rep.	110	93	64	59

Source: Own development with data from UNFPA, 2001, <http://www.unfpa.org/swp/2001> (consulted 15/02/2004).

Table 7a - Some data on mother and child health in five countries of Latin America and the Caribbean, 1995

COUNTRIES / SRH INDICATORS	Colombia	Brazil	Chile	Costa Rica	Belize
Total fertility rate (15-49 years of age)					
Urban	2.3	2.3	-	0.4	3.9
Rural	3.8	3.5	-	0.4	5.8
No education / Primary	4.0	5.0	-	0.3	6.0
High level of education	1.5	1.5	-	0.3	3.2
Low provincial level	2.4 (Bogota)	2.1	-	-	-
High provincial level	2.8 (Oriental)	3.1	-	-	-
The poorest	5.2	4.8	-	-	-
The richest	1.7	1.7	-	-	-
Specific fertility rate by age (births per 1,000 girls between 15-19 years)					
Urban	71.0	78.0	-	-	117.0
Rural	134.0	122.0	-	-	174.0
The poorest	180.0	176.0	-	-	-
The richest	24.0	28.0	-	-	-
Adolescent women with children (15-19 years) (%)					
Urban	16.9	16.6	-	-	-
Rural	26.2	24.2	-	-	-
No education / Primary	-	54.4	-	-	-
Highest level of education	3.1	6.4	-	-	-
Low provincial level	16.7 (Bogota)	12.7	-	-	-
High provincial level	23.0 (Pacific)	23.5	-	-	-
The poorest	-	-	-	-	-
The richest	-	-	-	-	-
Coverage of childbirth by specialised staff (%)^(a)					
Urban	94.0	97.9		98.1	92.6
Rural	69.8	94.2		95.2	59.1
No education / Primary	63.0	92.9		93.9	68.7
Highest level of education	99.8	100.0		96.9	95.1
Low provincial level	78.0 (Pacific)	95.3		-	-
High provincial level	97.7 (Bogota)	98.3		-	-
The poorest	60.6	71.6		-	-
The richest	98.1	98.6		-	-
Prevalence of use of modern contraceptive methods (%)					
Urban	66.2	72.9		83.0	49.3
Rural	58.4	61.2		75.0	30.0
No education / Primary	55.5	56.6		71.0	32.0
Highest level of education	63.5	76.3		82.0	51.9
Low provincial level	59.3 (Atlantic)	62.3		-	-
High provincial level	69.0 (Bogota)	81.0		-	-
The poorest	42.2	55.8		-	-
The richest	65.7	76.8		-	-
Children under five years of age with low weight (Severe) (%)					
Urban	0.6	0.5		-	-
Rural	1.1	0.9		-	-
No education / Primary	3.4	1.2		-	-
Highest level of education	0.0	0.0		-	-
Low provincial level	0.5 (Pacific)	0.0		-	-
High provincial level	0.9 (Bogota)	1.4		-	-
The poorest	2.0	1.2		-	-
The richest	0.3	0.3		-	-

Source: Own development with selected data from UNFPA, 2001, <http://www.unfpa.org/profile> (consulted 15/02/2004).

Table 8 - Percentage of women from 15 to 49 years of age who know modern means of contraception, by age groups and socio-economic quintiles. Latin America and the Caribbean, selected countries, 1995-1998

Country, year and quintiles	Age groups (in years)					
	15-17	18-19	20-24	25-29	30 and over	Total
Bolivia, 1997						
Q1	49.1	61.5	61.8	61.9	56.0	57.2
Q5	95.8	94.3	97.6	98.7	99.2	97.9
Total	84.3	88.0	89.5	89.9	85.1	86.7
Brazil, 1996						
Q1	96.5	99.4	98.7	99.7	99.1	98.8
Q5	100.0	100.0	100.0	100.0	99.9	100.0
Total	99.0	99.7	99.5	99.9	100.0	99.6
Colombia, 1995						
Q1	91.0	99.1	99.4	100.0	99.2	98.3
Q5	99.4	99.5	99.7	99.7	99.9	99.8
Total	98.2	99.7	99.8	99.9	99.8	99.6
Guatemala, 1995						
Q1	30.3	48.6	55.2	62.6	58.2	54.1
Q5	89.0	91.4	97.1	94.9	98.7	95.7
Total	64.7	72.6	77.8	83.1	82.5	78.2
Haiti, 1995						
Q1	74.2	93.7	95.3	96.8	97.1	93.8
Q5	98.3	100.0	99.7	99.5	100.0	99.6
Total	92.8	98.5	98.5	98.8	98.7	97.8
Nicaragua, 1998						
Q1	80.9	86.7	93.3	93.1	93.4	90.8
Q5	97.2	99.0	99.3	100.0	99.3	99.1
Total	92.4	96.8	97.9	98.5	98.2	97.2
Peru, 1996						
Q1	64.3	80.7	84.8	90.3	83.3	82.4
Q5	96.3	98.8	99.4	99.9	99.8	99.2
Total	90.9	94.8	96.8	97.8	95.8	95.6
Dominican Rep., 1996						
Q1	98.5	98.1	98.8	99.5	99.3	99.0
Q5	100.0	100.0	100.0	100.0	100.0	100.0
Total	99.3	99.4	99.7	99.9	99.9	99.7

Source: CELADE, 2000, Chart 5, p.45. Processing of the respective databases of the Demography and Health Surveys (EDS), for each country. Q1 = quintile of lowest socio-economic level; Q5 = quintile of highest socio-economic level.

Table 9 - Percentage of women between 15 and 19 years of age (at time of polling), using contraceptive methods, by countries. Total, in unions and not in unions sexually active. Latin America and the Caribbean, selected countries, 1987-1998

Country / survey date	Total	In union	Not in union sexually active
Belize (1991)	-	26.2	-
Bolivia (1998)	5.1	31.1	63.5
Brazil (1996)	14.8	54.0	65.9
Colombia (1995)	10.9	50.9	67.0
Costa Rica (1990)	2.6	52.0	66.0
Dominican Republic (1996)	10.1	35.1	57.7
Ecuador (1988)	3.0	15.3	-
El Salvador (1994)	-	22.5	-
Guatemala (1995)	2.8	12.1	41.7
Guyana (1992)	-	18.1	-
Haiti (1995)	3.6	10.5	24.3
Honduras (1996)	-	27.6	-
Jamaica (1993)	29.3	58.8	-
Mexico (1996)	7.7	43.5	-
Nicaragua (1998)	11.3	39.9	23.7
Paraguay (1998)	-	47.1	-
Peru (1996)	7.5	46.0	69.8
Surinam (1992)	-	29.6	-
Trinidad and Tobago (1987)	9.7	42.4	42.9
Venezuela (1998)	10.3	59.6	40.0

Source: J. M. Guzmán, R. Hakkert & J. Contreras (2000). In: CELADE, 2000, Chart 3, p. 34.
 (-) Data not available.

Table 10 - Mortality rates by causes in young people, 15 to 24 year of age, Latin America and the Caribbean, towards 1990

Countries	Total		Transmitted diseases		Neoplasms		Circulatory system diseases		External causes		Other causes		Poorly defined diseases	
	Men	Wom	Men	Wom	Men	Wom	Men	Wom	Men	Wom	Men	Wom	Men	Wom
Argentina (1992)	119.7	52.3	5.2	4.3	8.3	6.5	10.8	8.0	78.6	19.0	14.3	12.7	2.5	1.8
Barbados (1994)	117.4	81.8	4.3	0.0	13.0	18.2	8.7	0.0	69.6	18.2	21.7	40.9	0.0	4.5
Belize (1989)	110.5	47.4	21.1	5.3	5.3	5.3	15.8	0.0	31.6	10.5	36.8	21.1	0.0	5.3
Brazil (1992)	190.5	59.9	9.6	6.5	5.7	4.2	7.1	6.0	137.2	20.1	17.8	15.6	13.2	7.5
Colombia (1994)	341.2	67.9	6.2	4.7	6.7	5.7	5.9	5.1	306.0	33.1	11.3	15.0	5.1	4.2
Costa Rica (1995)	107.6	42.2	2.4	2.2	10.0	8.7	3.8	2.8	75.8	15.5	13.6	12.1	2.1	0.9
Cuba (1995)	131.0	70.1	4.9	2.9	8.3	6.2	6.5	3.0	91.7	37.6	19.1	19.9	0.7	0.7
Chile (1994)	115.2	36.2	3.3	3.1	7.6	5.2	3.4	2.2	88.8	15.0	10.8	9.9	1.3	0.8
Ecuador (1995)	178.3	89.8	13.4	14.3	6.9	6.2	11.5	8.5	110.3	26.3	20.0	21.4	16.1	13.1
Guyana (1994)	148.1	100.0	17.3	11.0	3.7	2.4	14.8	4.9	76.5	34.1	34.6	45.1	1.2	2.4
Jamaica (1985)	83.3	51.3	5.8	3.8	5.4	5.7	7.8	7.7	32.3	4.2	17.9	24.1	14.0	5.7
Mexico (1994)	142.4	54.4	6.9	5.9	8.3	6.0	5.3	4.6	117.3	16.7	3.5	20.4	1.2	0.8
Panama (1989)	135.0	56.1	5.7	5.8	4.4	3.3	4.0	4.9	102.3	19.8	13.7	20.2	4.9	2.1
Paraguay (1994)	99.3	50.2	5.8	4.8	4.9	4.1	3.3	3.0	72.5	17.3	8.9	16.1	3.8	4.8
Peru (1989)	117.4	83.1	19.7	17.8	5.1	4.6	7.7	4.7	47.3	15.0	13.4	17.4	24.2	23.5
Trinidad and Tobago (1994)	122.0	83.9	5.9	2.6	7.6	8.7	0.8	9.6	77.1	27.1	28.8	34.1	1.7	1.7
Uruguay (1990)	104.6	51.6	1.6	3.7	7.7	5.0	6.5	4.5	75.4	23.5	10.1	12.8	3.2	2.1
Venezuela (1994)	251.4	65.0	7.6	7.1	8.7	6.6	7.5	5.2	208.9	25.3	17.5	20.2	1.1	0.7

Source: Pan American Health Organization (PAHO), Health Statistics on the Americas, Scientific Publication No. 556, Washington, D.C., 1995, CELADE, "Latin America: Population by calendar years and simple ages, period 1995-2005", Boletín Demográfico, year 30, N° 60 (LC/DEM/G.170), Santiago de Chile, July 1997 and "Latin America: Population projections, 1970-2050", Boletín Demográfico, year 31, N° 62 (LC/DEM/G.180), Santiago de Chile, July 1998.

Table 11 - Statistics and regional characteristics of HIV/AIDS, end 2003^(a)

Region	Adults and children living with HIV/AIDS	Adults and children recently infected with HIV	Prevalence among adults (%) ^(b)	Deaths of adults and children and children
Sub-Saharan Africa	25.0 - 28.2 million	3.0 - 3.4 million	7.5 - 8.5	2.2 - 2.4 million
North Africa and Middle East	470.000 - 730.000	43.000 - 67.000	0.2 - 0.4	35.000 - 50.000
South and South-East Asia	4.6 - 8.2 million	610.000 - 1.1 million	0.4 - 0.8	330.000 - 590.000
East Asia and Pacific	700.000-1.3 million	150.000-270.0001	0.1 - 0.1	32.000 - 58.000
Latin America	1.3 - 1.9 million	120.000 - 180.000	0.5 - 0.7	49.000 - 70.000
Caribbean	350.000 - 590.000	45.000 - 80.000	1.0 - 3.1	30.000 - 50.000
East Europe and Central Asia	1.2 - 1.8 million	180.000 - 280.000	0.5 - 0.9	23.000-37.000
West Europe	520.000 - 680.000	30.000 - 40.000	0.3-0.3	2.600 - 3.400
North America	790.000-1.2 million	36.000 - 54.000	0.5 - 0.7	12.000 - 18.000
Australia and New Zealand	12.000 - 18.000	700 - 1.000	0.1 - 0.1	<100
TOTAL	40 million (34 - 46 million)	5 million (4.2 - 5.8 million)	1.1% (0.9-1.3%)	3 million (2.5 - 3.5 million)

Source: UNAIDS, 2003, Introduction, p. 2.

(a) The margins of variations of the estimates presented in this table define the limits within which the real figures are found, and are based on the best available information. These margins are more accurate than those of previous years, and work is being done to increase further the accuracy of the estimates that will be published in mid 2004.

(b) The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 2003, based on demographic figures of 2003.

Appendix 2 – Analytical schema

Matrix of policies and practices

HSR: Elements of the reform agenda and their translation in designing the systems	Equitable access and use of the SRH services	Comprehensive nature of care (integration of programmes)	Multi-sectorial approach	Empowerment of the community (participation and social control)
<p><i>Separation between financing and provision:</i></p> <ul style="list-style-type: none"> Establishment of regulated markets. Contractualizado 				
<p><i>Decentralised:</i></p> <ul style="list-style-type: none"> Deconcentrated Devolution Delegated autonomy Privatisation 				
<p><i>Financing:</i></p> <ul style="list-style-type: none"> Public by general taxes Public by social contributions Co-payments Private health insurances Out-of-pocket payment 				
<p><i>Alteration of the mix of public / private services:</i></p> <ul style="list-style-type: none"> Increase in the presence of the private sector (privatisation of public property, contracts, public definancing, etc.) Tax exemptions or income tax discounts. Subsidies to the private sector 				
<p><i>Increase in regulatory capacity at the different levels of government</i></p>				
<p><i>Human resources management:</i></p> <ul style="list-style-type: none"> Incentives to better performance Precarization of work relations Reduction of public sector workforce 				
<p><i>Sector planning:</i></p> <ul style="list-style-type: none"> Sector wide approaches Sector investment programmes 				

Fuente: Adapted from Lubben et al. (2002:672), Box 1.



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