

A3 | SOCIAL STRUGGLE, PROGRESSIVE GOVERNMENTS, AND HEALTH IN LATIN AMERICA

The 1980s witnessed major protests against military dictatorships in several countries of Latin America. Some of these culminated in revolutions, and a new wave of organizations replaced those destroyed by the dirty wars waged by the dictatorships during the 1960s and 1970s (Petras 1997). Faced with the prospect of armed uprisings, civilian governments (with the tacit support of the United States) ‘preventively’ replaced dictatorships in several other countries. Many of these civilian governments followed an explicit neoliberal agenda – such as the governments headed by Collor de Melo in Brazil, Alfonsín and Menem in Argentina, Fujimori in Peru, Caldera in Venezuela, and Aylwin in Chile.

By the late 1990s, economic crises gripped these countries, and were accompanied by major corruption scandals. The period also saw a rise in social struggles and movements, leading to the formation of a second wave of organizations. These included the Caracazo of 1989 (a protest movement against price hikes that was brutally repressed by the Venezuelan army); the struggles in Cochabamba and El Alto in Bolivia against privatization of water and gas, which overthrew the Sánchez de Lozada government; the Landless Workers’ Movement in Brazil, which took over land from large plantation owners; the indigenous peasant uprising by the Zapatista National Liberation Army in Mexico; and large indigenous struggles in Ecuador (Colussi 2008). New political and social movements grew out of these struggles.

Since the beginning of this millennium several progressive governments have replaced neoliberal governments in Latin America. Among such governments were those led by Hugo Chávez in Venezuela, Evo Morales in Bolivia (the country’s first indigenous president), Luiz Inácio da Silva (Lula) and his Workers’ Party in Brazil, Néstor Kirchner in Argentina, Rafael Correa in Ecuador, Fernando Lugo in Paraguay and Mauricio Funes of the FMLN (Farabundo Martí National Liberation Front) in El Salvador. In Mexico, the oligarchy had been forced to commit electoral fraud in 2006 to prevent the election of Andrés Obrador.

All these governments share some common characteristics: they stand in opposition to the local capitalist elite and the United States, both of whom continue to seek ways to ‘restore’ the traditional oligarchies. Their attempts were successful with the coup in Paraguay, but failed in attempted coups in Venezuela and Bolivia. The new governments are comprised of heterogeneous blocs that also include some sectors of the capitalist class that were earlier



Image A3.1 Valparaíso in Chile: while inequities persist, new forms of the welfare state have started emerging (Carolina Ibacache)

marginalized by more hard-line oligarchs (Sader 2008), along with more popular forces. In each country, different power groups have emerged, giving rise to new contradictions and tensions. Such contradictions are typified by the dual nature of criticisms against Dilma Rousseff's government in Brazil – while sections of the media and the elite press for neoliberal reforms, grassroots movements are mobilizing to demand more progressive reforms (García Linea n.d.).

In many of these countries new forms of the 'welfare state' have started emerging, based on social rights and citizenship. Transformations are occurring in types of ownership of national assets ('national' and 'state' ownership, co-operatives of different forms, etc.), linked to new ideas about building socialism. New ways of defining social inequalities and what 'is socially good' are also emerging. Noteworthy, in this context, has been the rise of the idea of 'living well' as a new paradigm, geared towards new forms of communal socialism (see Chapter E1). These transformations are just starting to make inroads into economies where capitalist forms of production continue to be the norm.

Social changes and the health sector

The changes in the landscape of politics and economics in Latin America, which we talk about earlier, have had a profound influence on health and healthcare. Shifts in healthcare models, throughout the twentieth century, had been the result of two contradictory processes: on one hand, the attempt by

capital to make it into an opportunity for accumulation and investment, and on the other social struggles to demand healthcare primarily through public institutions with equal access.

By the end of the twentieth century, the countries of Latin America had health systems that reflected the contradiction between these two processes. Struggles by salaried workers had achieved the creation of their own healthcare institutions as part of social security systems. These existed alongside a more deficient healthcare network for people in rural areas and informal urban workers. The systems – in part – developed as a result of struggles by workers, but were also created as a way of legitimizing the existing social order (Offe 2007). The relative importance of private participation in provision of healthcare continued and grew. Thus, the enormous social inequalities that characterize Latin America were also expressed in inequality in access to and in the quality of medical services.

The economic crisis at the end of the twentieth century triggered reforms aimed at weakening a wide variety of public institutions and favouring private models and market relationships. Policies in the 1980s tended to dismantle the relationships and institutions created to provide some elements of welfare. For those who could not obtain care through the market, ‘targeted’ and temporary programmes were conceived, with the understanding that the beneficiaries of such programmes would eventually join the market (González and Alcalá 2008). The dismantling of public institutions and their replacement by private businesses and the market took the form of strategies that promoted ‘managed competition’ or ‘structured pluralism’. These were aimed at separating the functions of regulation, financing, insurance and service delivery, opening the door for private insurance and medical care consortia to possibly get their hands on health funds.

Neoliberal governments adopted the recommendations of the World Bank’s



Image A3.2 Delegates from Latin America at the People’s Health Assembly in 2012 (People’s Health Movement)

1993 report *Investing in Health* (World Bank 1993), which called for large-scale dismantling of public health institutions, development of targeted programmes, reduction in health spending, and promotion of a basic package of services (rather than comprehensive provision) for the poor (López Arrellano et al. 2009). These policies paved the legal and financial road to privatization. In Chile and Colombia, this process progressed rapidly (Agudelo 2009). Based on the experiments in these two countries, a second phase of reforms was instituted in the rest of Latin America (and in other low- and middle-income countries in the world) under the broad framework of what has come to be called Universal Health Coverage (UHC). As we discuss in Chapter B.1, while UHC appears to respond to people's priorities, it is actually being utilized in many settings to further neoliberal policy (Laurell 2013).

Advances towards universal public health systems

Latin America's health policy map is being redrawn, and neoliberal reforms – which promote segmented, unequal and inequitable health systems – are being questioned and remodelled to differing extents. The new direction foreshadows an unfinished agenda to institutionalize alternatives opposed to neoliberalism and linked to a public, free, single health system (SHS). This new direction, in different countries, is driven in different proportions from the 'bottom up' and from the 'top down', which also influence the form of health systems that are being built. While in Sections B and E of this volume the emerging health systems in many Latin American countries are discussed, we present below a political analysis of the trends that are visible in different regions of the continent.

Cuba, Brazil, Costa Rica – more advanced experiences Of all the experiences with developing an SHS, the Cuban experience continues to be the most complete and advanced. Even with the very difficult conditions created by the blockade and later during the 'Special Period' (after the fall of the Berlin Wall in 1990), the Cuban health system has survived and grown. Cuba has also continued to expand its international support and cooperation, sending tens of thousands of doctors to different Latin American and other developing countries (see GHW 3, ch. E3, www.ghwatch.org).

In Brazil (see Chapter B4) the struggle for democracy in the 1980s incorporated demands for expansion of social rights, which include the right to health. This led to the creation of the Unified Health System (*Sistema Único de Saúde* – SUS) – a single unified, public and free system. However, unlike in Cuba, the SUS coexists with a large private sector that perpetuates social inequality in health and is persistently pushing for public funds through contracts and by offering private medical insurance for certain groups of employees.

In Costa Rica (see GHW 3, ch. B3, www.ghwatch.org), the move towards a

unified system has been led by the government rather than by direct popular pressure.

Recent attempts at advancing towards SHS All the progressive Latin American governments inherited segmented and deteriorating public health systems. These systems were generally iniquitous, plagued with the problem of an inadequate health workforce, and insensitive towards traditional cultures and practices. While attempting to remodel healthcare services the ‘new’ governments face resistance from leading medical organizations and from traditional social security systems that opposed an equitable SHS. Faced with these challenges, progress towards SHS has been partial and uneven. Venezuela, El Salvador, Bolivia and Uruguay fall into this group. In countries such as Argentina and Ecuador, much less progress is evident.

The new constitution in Venezuela, drawn up in 1999, defines health as a human and social right. It requires the state to guarantee this right through the formation of a state-owned National Public Health System that is intersectoral, decentralized and participatory, and governed by the principles of universality, comprehensiveness, equity and solidarity, merging the social security and ministry of health systems, primarily tax funded, and free of charge to individuals for its use (Feo and Curcio 2004). Progress towards a new system, which incorporates these principles, has been opposed by a large proportion of physicians and economically powerful groups interested in keeping the system segmented and maintaining opportunities for the involvement of the private sector in financing and in healthcare provision. There has also been resistance from a section of workers who have private medical insurance paid

Box A3.1 Heard from a community worker

I remember when the doctors came to Caracas, the first ones ... 63 doctors, the communities started calling me ... ‘We’re going to divvy them up.’ The doctors had to be divided amongst the health committees that had been set up, can you imagine? ‘Where are the cars?’ ‘There aren’t any cars!’ ‘Well, there’s my car and there are two others.’ And we had to distribute 63 doctors at five in the morning. They hadn’t eaten breakfast, or dinner; there was no water, there was nothing, no money either. [The doctors said,] ‘well, it doesn’t matter, let’s go!’ And when we got to the communities, it was like, ‘so, he’s going to stay in so-and-so’s house.’ We went to so-and-so’s house, and many already had their ... they were making welcome signs with their own hands: ‘Welcome Cuban Doctor.’ So when the doctors would see that, it would make them happy.

Source: Briggs and Mantini-Briggs (2007)

for by their employers. Venezuela's health system as a whole, however, remains segmented and continues to perpetuate inequality in access and in quality (see Chapter E3). Reforming it from the inside has proved to be extremely difficult and plagued by opposition. People's struggles have had to force the development of a parallel system that offers universal primary care from the grass roots (see Box A3.1).

In El Salvador (see Chapter E2), following the victory of the FMLN in 2009, public spending on health has increased considerably. Direct charges in health centres were immediately eliminated, and this increased demand for care by 25–40 per cent. To the displeasure of pharmaceutical companies, drug costs were reduced and shortages considerably eased. Efforts were made to extend public services to the poorest areas of the country, seeking to counteract the greatest inequalities in healthcare. These changes have led to improved care, manifested in the rise in the proportion of pregnancies and births cared for in the system, an increase in hospital beds, and reduced maternal mortality and hospital mortality (*ibid.*). Much remains to be done, but significant progress is clearly evident.

Bolivia inherited a privatized health system (see Chapter E1) and is now developing 'a single public system that is integrated, decentralised, participatory, has autonomous management and a unified social security system' (Offe 2007). Central to this model is the concept of the development of Intercultural Family and Community Health (Ministerio de Salud y Deportes 2006). Greater resources are being injected into the system, prioritizing socio-economically disadvantaged areas. Progress is slowly being made, with civic engagement through community meetings.

Uruguay too inherited an underfunded health system with enormous disparities in the distribution of resources, with 75 per cent of health spending going to the private sector (Borgia 2008). One of the first tasks of the new government has been to increase funding. A National Integrated Health System is being developed, which brings together public and non-profit private providers. This is financed by a National Health Insurance Plan with funds from a National Health Fund, which remunerates public and private providers using a risk-based capitation system. People pay according to their income; their contributions go into a single fund and the government ensures that everyone gets the care they need (Olesker 2013). Consumers who choose private providers have to make co-payments. The Ministry of Health is making progress towards closing the gap between the care provided by the social security system for employed workers and care from the Ministry of Health (which is traditionally poorer).

Countries where neoliberal reforms dominate

Colombia's neoliberal health reform (see Chapter E4) has been used as an example in other countries seeking to introduce market-oriented reforms



Image A3.3 Movements in Latin America use different forms for social mobilization: street theatre activists in Argentina (Marcela Bobatto)

in their health systems. Begun in 1993, the reforms led to visible negative impacts on health. Public systems were weakened, medical care deteriorated and there was a negative impact on other public health activities and disease surveillance. Working conditions for health personnel also deteriorated. Additionally, barriers to services increased because private providers rejected patients with increased risk factors or because of limits to coverage in insurance policies. In response, various protest movements arose, and attempts were made to unite several of the disparate groups on a common platform. Bogotá city elected a non-neoliberal government in 2003 which tried to change the situation, but it has had to face the many difficulties and constraints created by the national model. In 2013, the national government introduced a new Bill that sought to further deepen the neoliberal reforms (Agudelo 2013). A National Alliance for a New Health Model is fighting in the streets and in the senate against the new proposal and for a complete overhaul in the model (Hernández Álvarez n.d.).

Peru's health system is segmented (see Chapter E5) and there is gross inequality between services available through social security (for salaried employees) and those provided by the Ministry of Health (for the general, often poorer, population) (FMP et al. 2013). Consumer out-of-pocket spending on healthcare is high and has been increasing in recent years, both in absolute

terms and as a proportion of the GDP. Peru's health expenditure as a proportion of the GDP is very low (5.1 per cent) and a considerable portion is private (2.1 per cent) (Ríos Barrientos 2013). Reforms promoted by the government favour insurance mechanisms and the participation of private insurers and healthcare providers, with limited benefits packages (and as in Mexico, there is insufficient funding to pay for these packages) (Laurell 2013).

In Mexico (see Chapter B3) social security institutions, particularly the IMSS (Instituto Mexicano de Solidaridad Social), cover over half the population, and the Ministry of Health (MoH) covers a part of the population outside the social security system. However, unlike in Colombia and Chile, successive neoliberal governments were not able to dismantle and rapidly privatize public institutions in the face of popular resistance. Instead public institutions were starved of funds so that they could be discredited, pensions were removed from the system and transferred to private banks, and laws were amended to permit the purchase of private services. A second phase in the early 2000s overhauled care provided by the MoH and created an individual insurance mechanism that covers a basic package of services much smaller than that provided by the social security system and which permits the purchase of services from public and private providers (*ibid.*). The next step in the reform announced by the government, based on the structured pluralism model of Frenk and Londoño (Londoño and Frenk 1997), will be the creation of Universal Health Insurance, with a basic package of services that reduces social security benefits and permits the creation of financial intermediaries to manage health funds and private companies to provide healthcare.

Conclusions

Today in Latin America, healthcare is one of the major areas of contestations between the neoliberal offensive mounted by multinational corporations and local ruling classes on one side and progressive movements and governments on the other. Some regions are resisting the introduction of neoliberal policies and governments are promoting policies geared to developing single, public, free and universal systems. However, a variety of obstacles that may not be resolved immediately are hampering progress. These include the need to reconstruct public healthcare systems following a decade of deliberate dismantling. There is also resistance from the upper echelons of physicians who control the medical societies and medical schools and who oppose moves to strengthen public services and who also oppose multiculturalism. Resistance from the medical-pharmaceutical-insurance complex is also playing a role in blocking grassroots progress. Nevertheless, partial models that embody health as an equal right for all are making inroads. These experiences must be disseminated, supported and nurtured as seeds of what could be the future health system grounded in the concept of *living well*, to counteract those who would see healthcare as the big transnational business opportunity of the twenty-first century.

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