

# Bringing Latin America's Progressive Health Reforms Out of the Closet

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One of the strategies used by international financial organizations – the World Bank and the International Monetary Fund – in order to create a more favorable climate for their reform proposals, including those involving health care, is to finance and carry out research and publications in which the results of their projects are publicized. In addition this research is frequently assigned to local groups but follows a standard protocol. The great volume of these studies is such that they create a dominant vision or “conventional wisdom” about health care reform. This tendency is reinforced by the classification of these studies, according to where they are published and in what language, into “scientific” literature and “gray” literature. “Gray” literature is made up of those articles which are not published in English and which are to be found in local or regional journals. This situation clearly disadvantages studies, particularly those from the South, which undertake to ask different kinds of questions or adopt alternative points of view.

The premises that underlie social science research orient the process of knowledge generation that follows. These premises cannot be demonstrated empirically and are derived

(consciously or not) from the values of the investigator. It follows from this that researchers should explicitly state their values before undertaking to study a particular problem and try to design their research in such a way as to minimize bias as much as possible. Such a position determines in great measure what questions one asks. No one in the scientific world is unaware of the fact that the answers one gets depend to a large extent on the questions one asks.

The purpose of this edition of *Social Medicine/Medicina Social* is to publicize some of the progressive reforms carried out in Latin America, reforms which set out to guarantee the universal right to health and not to commercialize and privatize health through various mechanisms, be they direct or covert. The national reforms we look at are those of Brazil, Venezuela and Uruguay. We also examine health reforms undertaken by the cities of Bogota and Mexico, reforms which occurred in direction contrary to that of their respective national reforms. Originally we had planned to include the experiences of Bolivia and Rosario, Argentina but the urgent responsibilities of the invited authors made it impossible for us to include their contributions in this issue.

The essential starting point for current progressive health reforms is the Cuban health care system, which has an impeccable record of guaranteeing the right to health for all inhabitants of the island. The concrete steps which turned this right into a reality began in 1959 and were continued even during the most difficult times of the Cuban Revolution. The decline of “real socialism” represented a serious challenge to the health system. However, this challenge was met

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through a decisive investment in medical education and research, and by the production in Cuba of supplies and equipment. This effort has allowed Cuba to be at the frontier of biomedical research. The impact of this long-term health policy can be seen in health conditions in Cuba superior to those of the United States of America, particularly for children.

A universal right to the health, guaranteed by the State through a public system financed through tax revenues, was the goal of practically all countries of the world in the decades that followed World War II. The satisfaction of health needs occupied a privileged position for the majority of governments<sup>1</sup> given its overarching importance for the very life of human beings. Fundamental to the construction of the post-war Welfare State was the concept of democracy or of citizen participation, with implications that went far beyond simple representative democracy. In Latin America the debate during these decades was not on the justice of the right to the health but rather how to guarantee it to all.

Subsequent changes in attitudes towards the right to health were directly tied to the imposition of what were termed structural adjustment programs, with Pinochet's Chile serving as the world's pioneer privatizing neoliberal reform. Beginning in the 1980's we see an attack on social security and public health systems in Latin America bringing in its wake a massive wave of institutional destruction. Onto this devastated terrain various "solutions" are offered, ranging from public-private partnership schemes — which varied depending upon the economic resources of the partners — to packages of minimum services for those who could prove they were truly needy. The successive failures of these schemes are apparent to all. This, then, is context within which it is necessary to discover the progressive reforms on our continent.

The Brazilian Sanitary Reform rests on a constitutional mandate, approved in 1988, and made into law in 1990. It recognizes the right to

health for all Brazilians and the obligation of the State to guarantee that right. It had the great virtue of adopting a conception of universal rights at a time when the continent was undergoing a wave of privatization. This reform has been an example for the movements for the right to health and for other countries. Cohn's article provides a comprehensive account of the reform during the twenty years of its development. This approach allows her paper to be a reference point for those seeking more information on Latin America's most analyzed progressive health reform.

The transformation of the Venezuelan health care system is based on the new Bolivarian Constitution which recognizes health as a right of citizens and an obligation of the State. Fundamental changes received a decisive impulse through the *Barrio Adentro* program and the political decision to turn the constitutional mandate into a reality for all Venezuelans. Alvarado's article demonstrates how health became a high priority within the Venezuelan political process, responding to a heart-felt popular demand, particularly in the poorer neighborhoods and in the countryside. The intense participation of popular committees and the professional and ethical conduct of the internationalist Cuban doctors broke down the barriers to a profound change in health institutions which were incapable of reforming themselves. The construction of a National Public System of Health began from below and has advanced upwards using a model of comprehensive primary health care and benefiting from major public investment.

The third reform we examine is the Uruguayan experience that began with the electoral victory of the *Frente Amplio* (Broad Front) in 2005. Borgia's article analyzes the articulation between the social, economic, and political transformations and the national sanitary reform. This reform has developed in three currents, each complementary and developing progressively: care delivery, management and financing. Beginning in 2005 a *Consejo Consultivo de Salud para los Cambios* (Advisory Council on Health Reform) began working on the reform. The Council, with ample participation by different sectors of the country and the government, is developing proposals for the

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<sup>1</sup> The notable exception is the United States of America which opted for a system of medical insurance and private health care delivery.

creation of an Integrated National Health System (a public-private mix), a National Health Fund (with progressive financing), and a National Health Insurance (universal and comprehensive). The first laws creating this system were adopted at the end of 2007 and early in 2008. This democratic and participatory process is one example of how to resolve the problems that arise when one seeks to guarantee the right to health in a divided, unequal health care system where the private medical sector plays an important part.

The two local experiences of progressive reforms that are included in this issue are those of Bogota, Colombia and Mexico City, Mexico. Both occurred in the setting of national reforms which were going in the opposite direction, i.e. towards the commercialization of health and the separation of regulation, financing, and service delivery; these national models were the work of Londoño in Colombia and Frenk in Mexico; their programs had been designed in the early 1990's.

Bogota's health policy, analyzed by Vega and colleagues, took place in the period from 2004 to 2007 when the national reform was firmly implanted and its serious problems had become apparent. This situation restricted the ability of local authorities to act, since national legislation was supreme. Bogota adopted a strategy of Comprehensive Primary Health Care (*Atención Primaria en Salud Integral –APSI*). The results of this policy show that despite the commercial logic of the national health policy it is possible to carry out local initiatives designed to guarantee equity and the right to health. However, the authors conclude that fundamental changes in national health policy must occur in order for local initiatives to be effective and sustainable.

Mexico City's situation is fundamentally different from the experience in Bogota; the progressive reform in Mexico City preceded by two years the national neoliberal reform, known as the System of Social Protection for Health (*Sistema de Protección Social en Salud*). This meant that the local reform was firmly implanted when the federal reform was launched. In Mexico City the government set out to guarantee the universal right to health through a policy of free health care services and medicines for all people without access to the employment-based Social Security system. This policy was legislated locally; the law, in addition, made explicit the obligation of the government to guarantee this right through public institutions, financed through taxes. However, this local initiative could not grow into a unified health care system given the fragmentation of the Mexican health care system.

After almost two decades of neoliberal reforms we are now seeing a new wave of progressive health policies built around the universal guarantee of a right to health. These policies are directly related to the ideological and political orientation of the governments which promote them. The preliminary results of these new reforms refute the idea that the State cannot guarantee the basic social rights to its population. Nevertheless it is necessary to continue and to deepen the current debate. Faced with the obvious failures of previous market-oriented reform, these are now being modified so as to maintain the primacy of the market. The most urgent task is to analyze different public and/or private health insurances in various national contexts. In this debate we must not forget that in many cases insurance is a mechanism to promote private administrators and providers.

