

An Overview of Contemporary Latin American Health Policies and Discourses

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Introduction

It is now 15 years since the publication of *Investing in Health* (World Bank, 1993), a report which set the course for health care system reform in Latin America and around of the world. Since that time a great many studies about the reforms have been published and new reforms have been launched to “correct” the defects of the earlier ones. The objective of this paper is to call into question the entire current political debate over health care, as well as to clarify key concepts and practices. To this end I will analyze the current vogue of interrelated proposals for a second reform of the state. I will examine debates over insurance as a way of grant universal coverage; the separation between the regulation, financing and provision of health services; and the public private partnerships for the construction, financing, and management of hospitals. This paper will also examine the development of a new scientific discourse around “evidence-based policies” and academic referral networks. The goal of this paper is not to offer a comprehensive treatment of these issues, but rather to question some assumptions and contribute to the larger debate.

The second reform or modernization of the state

When the negative effects of social reforms which minimized the role of the state became apparent – i.e. a rapid and regressive redistribution of income and an alarming increase in poverty – international organizations such as the World Bank (WB) and the Inter-American Development Bank (IADB) proposed a second reform or modernization

of the state (WB, 1997; WB 1998; González y Munar 2003; IADB 2003). This reform once more emphasized the importance of the role of the State in social policies, mainly in regulation and in certain specific actions designed to strengthen governability, governance, and social cohesion.

According to Ozslak (1988), this reform would seek greater effectiveness in state actions. To be successful it need to meet the following conditions: mission driven, results and evaluation oriented; entrepreneurial outlook (i.e. “earning” and “investing” as opposed to “spending”); forward thinking, decentralized and market oriented; service oriented (i.e. serving “clients” or “consumers”) and catalytic.

With this Second Social Reform, the World Bank (Holzmann and Jorgensen, 1999; Holzmann, Sherburne-Benz and Tesliuc, 2003) switched from a “social protection” strategy towards one of “social risk management (SRM).” Poverty became “vulnerability.” The SRM strategy involves all parties with an interest in a given area including individuals, families, NGOs, businessmen, workers, national and regional governments; the policy emphasizes the creation of a “social dialogue” among these parties. It also emphasizes inter-sectorial action and prioritizes the labor market, employment, social assistance to the poor, and pensions.

Nevertheless, these texts do warn that the blending of different policy spheres (economic, social, labor) should not interfere with the canons of the new economics, i.e. the market as guiding force in the economy, free competition, labor flexibility, balanced budgets, open market policies, no unfair competition by the state with the private sector, etc. Social aspects are only discussed when it comes to “the poverty trap” and “human capital”. It is worth noting that the IADB (2003) adopts a neoliberal

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position that is more orthodox than that of the WB in its documents on state modernization, a posture reiterated in a recent document about the current crisis (IADB, 2009).

These positions suggest that the new strategies are not oriented towards some form of welfare state which accepts social rights and the mandate for the state to guarantee them. For example, access to health care services gets short shrift in these plans. It is considered as social assistance for the poor and only then because of its impact on “human capital.” The primary objective of this reform seems to be that of offering legitimacy to the “new social order”, i.e. a society profoundly restructured along neoliberal principles. Paraphrasing Offe (2007), the excessive emphasis on new forms of capital accumulation left out the second great task of the State: maintaining legitimacy.

This explains why the second state reforms place special emphasis on cohesion and social dialogue. Meanwhile, the “new economy” remains unchanged both in its principles and implementation. The list of involved social actors leaves out any mention of their relative importance. Dialogue and agreement typically occur within the bilateral or trilateral pattern established by social security systems. There are clearly defined actors: employers, workers, and the state (as mediator, catalyst or tie-breaker). However, if the set of participants in the social dialogue is amorphous and ill-defined, then the position of the “reformed” state as “catalyst” gives it wide latitude in deciding who is a valid interlocutor and who is not. This further strengthens the techno-bureaucracy.

Universal insurance in health care

Another current topic of debate is the role of insurance schemes in healthcare systems. Insurance is an emerging alternative to exclusively public healthcare services for providing universal coverage. Healthcare insurance is either included within social security program or offered by private insurance companies. It is important to review and consider the precise implications of the insurance based proposals already implemented in Latin America.

We begin by observing that health care insurance programs are closely related to the second reform of the state. Indeed they incorporate several of the

reform’s premises. Private insurance follows the lead of *Investing in Health* by presenting health care services primarily as an economic activity; medical services are commodities to be consumed by individuals. In this manner, it centers the discussion on financing and service transactions, rather than on the model of health care delivery or access to health care.

Health care insurance schemes come in several variants. There are single mandatory insurances; mixed insurances that combine mandatory social security insurance and voluntary social protection coverage; insurance that is part mandatory, part subsidized; private and public insurances. Despite the differences, under all of these schemes, insurance companies receive important subsidies from public tax funds, either directly or indirectly.

During the past decade most Latin American countries have adopted “universal insurance coverage” as a short or medium term objective; it is seen as a form of social protection. The phrase “social protection” contributes towards the ambiguity of debate since it can refer to two distinct trends in public health policy. In countries like Chile today, it means something like “a right to health care” (FONASA, 2007). In other countries, such as Colombia, it has meant a neoliberal model in which health care has been offered to the forces of the market; this has been true both of administration of public funds as well as service delivery with state subsidies being focused only on the poor. (Arbelaez *et al.*, 2004).

However, no insurance based strategy has achieved the objective of universality. This is as true of Chile 30 years after the introduction of health insurance (Ministry of Health, 2008) as it is of Colombia after 15 years of mandatory coverage (Torres, 2008). We also note that in many countries insurance based healthcare has resulted in new forms of inclusion/exclusion. Instead of integrating healthcare systems it has fragmented them further. This new stratification of the excluded is closely related to the logic and procedures of state subsidies and the state’s discretion in assigning them.

For example, in Colombia, a set amount is allocated for subsidized insurance. This funding is insufficient and leaves uncovered some of the very poor and a significant proportion of the poor who cannot pay for their own insurance (Torres, 2008).

The Mexican *Seguro Popular* (Popular Health Insurance), a voluntary insurance offers another example. Only the poorest 20% are exempted from fee payment, while the rest of the families must make a contribution of 4-5% of their income; in many cases this is beyond their means. Additionally, in the poorest Mexican states and those with the largest number of families without insurance coverage, the state governments have difficulties paying their compulsory premium for each insured family (Laurell, 2007).

As is clear from the above, the assumption that insurance would remove the economic barrier to health care access has proven wrong. We should also note that most of these insurance schemes include co-insurances, co-payments and administrative fees which add additional obstacles to access.

Insurance schemes generally cover a predetermined set of medical interventions. This adopts a commercial view of health care characteristic of for-profit insurance companies. This is closely linked to a structure in which health care purchasers (i.e. the insurance companies) relate to health care providers through the competitive structures of a market. A price must be set for all services provided in order for this market to work. An important part of the current debate relates precisely to the methodology used for determining the cost of service packages and how to increase the range of services provided in these packages. Yet the precise content of these packages is often ambiguous. In some cases the content of these packages is made explicit by a listing of the covered interventions (Popular Health Insurance *Seguro Popular*, Mexico). In others the covered health interventions are implicit, albeit subject to important restrictions (POS-S^a, Colombia); others list a set of guaranteed services (GES^b, Chile) that does not in principle exclude other services. Finally, there are schemes with explicit exclusions, such as cosmetic surgery or costly odontological treatment; this is seen in many insurance schemes within social security systems.

^a POS-S: Mandatory Package of Subsidized Services. After the Columbian Constitutional Court ruling in 2008, this scheme should have disappeared but as of November 2009 it was still in place.

^b GES, Explicit Health Guarantee, also known as AUGE.

Coverage packages are generally determined using actuarial and cost-benefit analyses; the WB, IADB and IMF give priority to economic sustainability Sustainability however is not an absolute; it depends upon a given government's priorities in the distribution of tax revenues among different activities. The second major consideration for policy design is the morbidity and mortality profile; however, a program based on actuarial considerations analysis may only roughly approximate the actual health needs of the population. Some insurance plans, such as those of Mexico and Colombia, exclude common diseases because of their high cost, while others, like the GES in Chile, do not. It is only in rare instances that the health priorities of citizens are actually taken into account.

We must further consider the problematic relationship between population coverage and actual timely access to required services. Certainly, the relationship between need, demand, and service access is a complex one within any system. However, insurance based health care has presented itself as an option that would guarantee access to services. This is not the case for the majority of health care insurers in Latin America. Beyond the restrictions imposed by the packages of covered services, we need to add in costs related to co-payments and transportation. The simple lack of health care infrastructure and bureaucratic barriers are additional problems. We can conclude that, in general, "universal" insurance coverage does not translate in actual, timely access to health care services.

Recent literature warns against the inclusion of private purchasers/administrators within insurance schemes. All empirical evidence suggests that this organizational structure increases costs substantially (Gottret y Schieber, 2006; Drechsler y Jütting, 2005). Insurers expect to make a profit and this can only come from the global health budget which may run a deficit despite increases in health care spending. Experience demonstrates that, once established, it is almost impossible to eliminate private health insurance companies or even to regulate them. This happened with ISAPRES^c in Chile as well as in the sadly notorious case of the

^c Previsional healthcare institution

United States, where insurance companies have played an important role in blocking legal attempts to guarantee universal coverage.

Nevertheless, private service providers are generally seen as a necessary and important part of reforms; the free choice of service provider is seen as a tool for controlling costs and improving quality of service. According to the theory, the marketing of health services and competition between various providers – both public and private – is the ideal structure. In practice, the availability of multiple insurance schemes and many service providers requires a considerable administrative structure and leads to additional costs. (PNHP, 2003, Clavijo, 2008) The bureaucracy itself ends up generating additional obstacles to service access.

The buying and selling of health services, particularly in capitated plans, places a great burden on public service providers; it is harder for them to reduce fixed costs in the same way private providers can (Gottred and Schieber, 2006:264). For example, public sector services can not violate labor laws, while private provider can use flexible and subcontracted labor. This has led to the deterioration and closing of public health care units under the pretense of their inefficiency. This has happened even when the health care infrastructure was already inadequate, a situation which results in further reductions in access to health care (Unger *et al.*, 2006). Massive dismissal of healthcare workers has resulted as well as the creation of new contractual arrangements, such as cooperatives, which may result in decreased worker benefits (Aricada, 2008).

The commercial nature of service provision, the logic underpinning budgetary allocations, and the limitations of inclusion/exclusion inherent in pre-defined packages all have adverse consequences (Laurell, 2007). They weaken public, or collective, health which is not incentivized in this system. Within the neoliberal viewpoint, individual care is incentivized as “private goods” while “public goods” (i.e. those goods or services which cannot be sold for profit) are cast off as a responsibility of the state. This starts a trend towards the increasing divorce between health care service delivery and public health, a divorce heavy with consequences. The other tendency is to break-up of the integrated process of prevention, detection, treatment, and rehabilitation into the hands of distinct service

providers. In some cases, individual links of this chain are specifically excluded in different health packages.

Separation of functions and structured pluralism

The separation of functions within health care systems – regulation, insurance, buying services, and providing services – is yet another aspect of proposals to abandon integrated universal public health systems and replace them with the universal insurance model. (Londoño and Frenk, 1997). This arrangement is completely in line with the second reform of the state; the state’s role is limited precisely to that of regulating private initiative and making competitiveness more efficient, without violating neoliberal economic principles.

This separation creates new markets: fund management, service acquisition, and service provision. All this is necessary for the commodification of health care, and each new division creates opportunities for private firms to make profits. Fund management turns out to be the most profitable area. On top of the fees charged for the actual management, there are opportunities for financial speculation provided by the control and allocation of funds (Laurell, 2001).

The buying and selling of health services creates conflicting economic interests between two parties, each of which is trying to maximize their revenues. Insurance companies try to transfer risk to the providers, for example, through the use of capitated systems. Providers prefer fee-for-service. Nonetheless, experience demonstrates that in addition to the multiple and imaginative ways each side tries to gain the upper hand, both sides manage to transfer part of the risk to the “client”, i.e. the insured individual who is sick.

The first mechanism is that of “adverse selection.” Those who are considered “high risk” because of age or pre-existing health conditions cannot get insurance. Then there is the ever-present option of denying of services (within the paid insurance systems) or providing unnecessary services (within fee-for-service systems). Both work to the detriment of the patient.

An extensive body of literature agrees on the difficulty for the state to act as an efficient regulator of these systems. The net result is that neither “cost containment” nor quality improvements have

resulted from the implementation of these insurance based provision-acquisition schemes.

The private finance initiative in hospitals

A basic principle of neoliberal economics is the expansion of market opportunities for capital. Health care is no exception. This is certainly not a new phenomenon; what has been called the “medical-industrial complex” bears witness to this. As in other areas of the economy, we see the infiltration of financial capital, for example, in fund management and insurance. Another important way financial capital is entering the health field is through “Private Finance Initiatives (PFI)” created for the “funding, construction, and administration” of health care infrastructure. This scheme was set up under right-wing governments, for instance, in Canada, Spain and Australia but, paradoxically, it has had its fullest development in Great Britain during Labor governments (Stationary Office, 2000).

PFI’s have been intensively promoted in Latin America; the IADB has even provided them with financial support.^d PFI’s currently exist in Chile, Paraguay and Mexico. The idea has its origins in the European Union agreements to limit public debt to 60% of the GDP. In order to circumvent this rule, PFI’s were created to – in essence – convert public debt service into an operating or current expense. Thus, the funding, construction, equipment, and management of a hospital (in our case) are contracted out to the private sector and a monthly payment is made to the contractor over 25 to 30 years (Federación de Defensa de la Sanidad Pública, 2006). It is similar to a mortgage. The monthly payment covers construction, equipment and management costs, repayment of the debt and interest on the loan.

The reasons cited for these agreements include: increased availability of funds for public investment, greater efficiency of the private sector in fund management, shortened construction times, and superior management by the private sector. As we shall see, these reasons do not stand up when examined closely.

^d For example IADB loan #2043/OC-ME of 45 million dollars to Mexico for the period 2009-2010.

More funding is not made available to the public sector; payments are simply spread out over time. Privately derived funds carry a higher interest rate than government bonds since they carry a higher risk of default. Strictly speaking, therefore, since the cost of financing is higher, fewer funds are available to the government.

The case of Mexico is quite illustrative in this respect. Two hospitals are managed under PFI schemes, but operating under the euphemism of “Service Provision Projects (SPP)”. The first – the Bajío Medical Specialties Hospital (HAEB in Spanish) – was negotiated at a higher cost than a competing proposal for a public hospital. The actual investment in construction and equipment was 604 million pesos, but the total cost will be 3.6 billion pesos to be paid out over 25 years without including adjustments for inflation. The contract also stipulates that the monthly payment to the contractor takes priority over all other healthcare expenses and is guaranteed by the Federal Ministry of Health. This cost, it must be emphasized, does not include providing medical services (health care personnel, medications, medical supplies, etc.). The construction and equipping of the hospital were 30% late and actual service implementation has been very slow. Three years after its opening, the hospital is currently working at 30% of capacity. The second SPP hospital in Mexico, located in the state of Tamaulipas, has a similar but even less favorable history in terms of funding, construction, and costs. Nine months after its opening there are only a few offices in operation.

The experience with the PFI hospitals in Great Britain is similar and has been well documented by the Centre for International Public Health Policy in Edinburgh. In its review of PFI hospitals since the economic downturn, Liebe and Pollock (2009) emphasize these hospitals are worth £12.3 billion and will require payments totaling £70.5 billion of which 41.4% corresponds to the “availability cost” for the buildings. This results from the high revenues paid to the private investors over their capital; these average 2.5% higher yearly than the average costs in the public healthcare sector. They document that 96% of the PFI hospitals do not appear as debt in the public accounting books and that there is no transparency in their economic management. It may be added that their report is

largely based on official information by the Ministry of Finance, the National Auditory Office, and the regulating organism of the National Health Service. In another recent work (Hellowell and Pollock, 2009) they conclude that this mechanism of financing and management puts the functioning of the health care sector at risk. They find that, as in the case of Mexico, the projects are not delivered in a timely manner and that they exceed their estimated cost. There are studies that suggest a lower quality of service and we can foresee that in the long run service capacity will be decreased by these initiatives.

The available evidence, suggests that the SPP hospitals are a means for private accumulation, but not a way to solve the health care infrastructure problems in Latin America. We can also add that this is yet another way of transferring public funds to the private sector. This is a crystal-clear expression of what is meant by the “modernization” of the State, as can be appreciated in a government policy statement from the United Kingdom (Stationary Office, 2000).

A New Dominant Discourse for Health

Altering the course of health care policy to meet the demands of neoclassic economics and neoliberal ideology requires a new discourse that legitimizes it and presents it as “scientific”. We can see this discourse emerging now along with new values and new “catch phrases.” It is accompanied by scientific rationale, “objective” studies and “success stories” all of which propose policies “based on evidence”.

Certain social values still have an important weight in society and their incorporation into the new discourse is remarkable. This is accomplished by fostering a great ambiguity regarding certain concepts and redefining certain words. A useful to analyze this process is by considering what has been said above. “Social rights and individual guarantees” have become increasingly limited in different ways. No longer are they inalienable rights of citizens and thus obligations of the State. “Universality” has come from meaning “for all and guaranteed by the State” to now mean a few goods and services restricted to the truly needy. “Democratization” has been redefined as the opportunity to choose from options provided by the market. “Equity” has replaced “inequality” and has

become the buzz-word for all targeted programs, further blurring the very notion of universality. “Solidarity” has been transformed into “subsidy” by the State while “citizens” have come to be “clients or consumers”. The successive ruptures between old and new meanings make debate difficult; as we consider this new discourse we need to watch our words carefully.

Neoliberalism, like any other ideology, creates its own scientific justification. In relation to health care policy it adopts a clearly positivistic framework to measure the outcomes of “evidence-based public health policies” in the image of “evidence-based medicine”, which some have criticized as the new ‘regime of truth’ in health (Holmes *et al.*, 2006). In their critical revision of the use of research results in the formulation of policy Almeida and Bascolo (2006:12) point out that: “... the political force of the empirical evaluation and analytical constructs resides in the “scientific” character they lend to the reform proposals, reinforcing positions already adopted by decision makers...”

Evaluation studies allow programs to be classed as “successful” and thus to designate “best practices.” These studies are frequently commissioned and financed by the very institutions that promote the policy changes.

Popular Health Insurance in Mexico (*Seguro Popular*) is a concrete example. It was launched by then Minister of Health Julio Frenk as an evidence-based reform after research conducted by the National Public Health Institute (NPHI), also under his direction. The justification for the program is repeatedly cited the “World Health Report 2000”, a report coordinated by Frenk during his stay at the WHO. This report was strongly criticized by the majority of WHO member countries as well as by respected researchers (Navarro, 2000; Almeida *et al.*, 2001; Musgrove, 2003). Once the program was legislated, Frenk commissioned and paid for an evaluation by Harvard University and the NPHI for approximately \$US 6.5 million. Towards the end of 2006 five articles were published by Frank’s team and several Harvard researchers in the influential journal *The Lancet* (Frenk, 2006a; Frenk, 2006b; Gakidou *et al.*, 2006; González-Pier *et al.*, 2006; Lozano *et al.*, 2006). These articles supposedly demonstrated the success of the program through a

series of analyses that have been impossible to duplicate. (Laurell, 2007).

These five articles became the basis for the presentation of *Seguro Popular* by international organizations as a “successful experience” (Scott, J^a, 2006; Kelly et al^b, 2007 p. 134; World Bank^c, 2008; Frenk, Gómez-Dantés, Knaul^d, 2009). However, when Harvard’s final evaluation was published, the widely publicized positive results were not verified. The Harvard study found – among other things – that those insured under *Seguro Popular* had no greater access to health care services or medicines than the population without insurance. Further, their health status did not improve. This confirmed other evaluations of *Seguro Popular* (Laurell, 2009). Nevertheless, this crucial report has not had much publicity and *Seguro Popular*’s reputation as a “successful experience” remains intact. This way of creating “scientific authority” through networks whose members refer to each other has been studied by Greenberg (2009) in other fields, but his findings can be generalized to other contexts.

The creation of a new discourse and its “scientific” basis are part of a political strategy in which social communication plays a central role. Another face of social communication is apparent in those messages targeted at a public which gradually becomes convinced of the virtues of policies through repetition.

The dominance of this discourse is strengthened by the new philanthropy or “philanthro-capitalism” of the big transnational corporations. The Bill & Melinda Gates Foundation, which donated on the order of \$US30 billion in 2008 is the best known example; it has had a decisive influence on global health policies.

In Latin America, the Carso Institute for Healthⁱ holds a special interest. It was created by Mexican Carlos Slim, one of the richest men in the world. While its funding levels are modest compared to other large foundations, it has carefully picked its

areas of activity. For example, through its work with the governments of Colombia, Mexico, and Central America in the construction of the *MesoAmerican Health care System*, the foundation has acquired considerable influence on the health care policies of these countries. Another of its projects is Casalud,^j which aims to create primary care health providers for both public and private clients. The Slim Corporation has entered the health care sector through a variety of companies involved in the production and sale of medicines, construction of hospitals, hospital management for lower middle class neighborhoods, provision of limited insurance policies, etc.

Final remarks

The brief review of current debates in health care policy in Latin America highlights their genesis in the project outlined in *Investing in Health*. An important difference is that over the past fifteen years a new dominant discourse has been forged and this now muddies up the policy debates. A sustained effort in epistemological vigilance is needed in order to reveal the foundations of this new discourse as well as its implications. Right now a counter-hegemonic discourse limited to appeals to the right to health care, restatement of the obligation of the state to guarantee health, and a defense of public institutions, is insufficient. We need to look beyond this and learn from the experiences of progressive governments. We need to discuss real problems, which have been used to justify this new ideological discourse in health. Denunciation and resistance are both needed. But we also need to turn the premise of dominant policy on its head.

While it is laudable to increase spending in the health sector, it is necessary that this spending be used to best possible advantage by increasing access to health services and responding to real health needs within a suitable administrative structure.

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a The author thanks Julio Frenk for his help in the elaboration of the article.

b The only text cited in this paper is Frenk, 2006.

c The text states: “This review will list recommended practices....”

d All references, except one, are to works written by the authors.

i <http://201.116.23.233:81/Paginas/homeCarso.aspx>

j <http://www.casalud.org>

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