International Journal of Health Services
2015, Vol. 45(2) 363–377

DOI: 10.1177/0020731414568514
joh.sagepub.com
SAGE

Sociopolitical Determinants of International Health Policy

Pol De Vos[1] and Patrick Van der Stuyft[1,2]

Abstract

For decades, two opposing logics have dominated the health policy debate: a comprehensive health care approach, with the 1978 Alma Ata Declaration as its cornerstone, and a private competition logic, emphasizing the role of the private sector. We present this debate and its influence on international health policies in the context of changing global economic and sociopolitical power relations in the second half of the last century. The neoliberal approach is illustrated with Chile's health sector reform in the 1980s and the Colombian reform since 1993. The comprehensive "public logic" is shown through the social insurance models in Costa Rica and in Brazil and through the national public health systems in Cuba since 1959 and in Nicaragua during the 1980s. These experiences emphasize that health care systems do not naturally gravitate toward greater fairness and efficiency, but require deliberate policy decisions.

Keywords

health care system, international health policy, social and political determinants, Alma Ata, Brazil, Chile, Colombia, Costa Rica, Cuba, Nicaragua

Social and political changes in the new millennium are pushing toward a renewed debate, in Latin America and beyond, on the need to strengthen health systems with a primary health care logic based on the right to health.

[1]Institute of Tropical Medicine, Nationalestraat 155 2000 Antwerp, Belgium
[2]University of Ghent, B-9000 Ghent, Belgium

Corresponding Author:
Pol de Vos, Institute of Tropical Medicine, Nationalestraat 155 2000 Antwerp, Belgium.
Email: PDVos@itg.be

In an aim to contextualize actual evolutions, we look back and analyze how international sociopolitical and economic tendencies over the last half-century have influenced dominant health care system paradigms.

The Alma Ata Declaration

Defining health as "one of the fundamental human rights" in its constitution, the World Health Organization (WHO) was created in 1948 to support its member states in making that right a reality (1). But it was not until 1978, with the WHO Conference in Alma Ata, that hopes for a real breakthrough emerged (2). The Alma Ata Declaration's (AAD) concept of an integrated and comprehensive approach toward health and health services was a milestone in contemporary health policy. Health was defined as "*a fundamental human right . . . whose realization requires the action of many other social and economic sectors in addition to the health sector*." This declaration was based on—and ought to reinforce—dominant political views of that era's developing national public health systems, complementing the setup of accessible, equitable, and qualitative health services with social and economic policies and addressing a broad array of health determinants. The AAD advocates an integrated approach to the political, social, economic, and ecologic determinants of health, and asserts that "*governments have a responsibility for the health of their people*," while the people "*have the right and duty to participate individually and collectively in the planning and implementation of their health care*."

The AAD was a negotiated compromise between more progressive and more conservative currents, reflecting the corresponding global balance of forces at that time (3). In 1974, the G-77 countries—mainly developing countries, many of which had recently liberated themselves from colonialism—had been able to put a New International Economic Order (NIEO) on the agenda of the United Nations. This NIEO concept, mentioned explicitly in the AAD, illustrated their increasing unity and defiance of Western political and economic domination on the world stage (4). The conference also reflected the importance of the then-socialist world. China and the Soviet Union, where the conference was held, played a key role in the declaration's genesis (5). In a period when United Nations organizations such as UNCTAD, UNESCO, FAO, WHO, and the Institute on Transnational Corporations were reoriented to promote and help implement "social contracts" in favor of developing nations, the AAD was the expression in the health field of the progressive agenda—albeit with serious limitations (6).

1980s—The Lost Decade

But times were already changing. The post-World War II economic boom had come to an end. During the 1950s and the "golden '60s"—a period of sustained economic development and productivity growth—transnational corporations

had become an increasingly powerful sector of the world economy, with investments and production spread over dozens of countries. This long and stable period wavered in the early 1970s. The productivity growth slackened and the production capacity was underutilized. Investments were not optimized and profit rates decreased. Markets saturated and the first signs of an overproduction crisis appeared. The Organization of the Petroleum Exporting Countries (OPEC) decision to drastically increase the oil price (from $2 to $9 per barrel) (all dollar amounts in U.S. dollars) exacerbated these economic tensions, leading to a full-blown economic crisis (7). From the 1974–1975 worldwide recession onward, the general economic trend was one of long-term decline, with real growth rates in the industrialized economy falling from an average 4.9 percent per year in the 1960s to 3.8 percent in the 1970s to 2.7 percent in the 1980s (8). The stagnation of productive investments in the early 1970s pushed Western banks to lend billions of dollars to developing countries, as interest rates started to plummet. Rising prices of the primary commodities (which remained the major exports of the developing countries) temporarily drove their growth rates above those of their industrialized counterparts in the late 1970s (9).

In the early 1980s, industrialized economies recovered. Increasing debt interest rates and falling prices for export products made it impossible for the Southern countries to pay off their loans. The debt problem was born. In 1982, Mexico defaulted on its debt payment, an event that seriously threatened the international credit system (10).

Moreover, to ensure their economies' recovery and growth, U.S. and U.K. governments imposed drastic liberalization schemes. U.S. President Ronald Reagan and U.K. Prime Minister Margaret Thatcher appointed leading proponents of neoliberalism in senior positions and were able to extend these policies globally through the International Monetary Fund (IMF) and the World Bank. During the 1980s, neoliberalism became the dominant economic paradigm globally (11).

In the name of sound financial governance, economic development, and poverty reduction, the IMF and the World Bank linked new loans to conditionalities—massive lay-offs in the public sector, decrease of social sector financing, etc.—in line with neoliberal thought (12), leading to a downward spiral of further borrowing in order to pay the debt service. Dependency on foreign loans increased, and the international debt problem became unbearable (13).

These "solutions" attained the objective of protecting the international monetary system, but left the South in misery (14). The U.S. "Marshall Plan" for Europe after World War II was about $90 billion in today's dollars. Between 1983 and 1992 only, the *net* capital flow from South to North was six times that amount (15). Nevertheless, while in 1980 the South's debt stocks amounted to $540 billion, in 2004 the stock had increased to $2.600 billion, almost five times as much (16).

The much-needed, broad implementation of Alma Ata's "health for all" policies could not be realized in the South, because these structural adjustment policies dramatically limited human and material resources for health. Already in 1979, Walsh and Warren had launched their proposal for "selective primary health care" (17). This selective approach was touted as a more realistic and cost-effective alternative to the allegedly "costly and unrealistic" comprehensive primary health care (18). It robbed primary health care of its community engagement, broader social change, and redistributive vision (19), limiting its content to selective interventions and cheap "minimal packages" from the first line. Apart from its "cost-cutting" potentials, international agencies also appreciated the potential of "community participation" to neutralize resistance to the socioeconomic reforms that were imposed (20). In addition, the health care system underwent a never-ending series of reforms: public-sector funding had to be gradually reduced, leading to a deterioration of public services. At all levels of the health care system, the introduction of user fees became a mechanism to ensure the financing of services. These financial barriers have been identified as important sources of exclusion from needed care (21) and can quickly precipitate families' descent into poverty (22).

1990s—Investing in Health

After the collapse of the Soviet Union and the Eastern Block, a "new world order" was imposed, in which global power relations became increasingly unilateral. From 1990 onward, international financial institutions dramatically changed the definition of their mission, accelerating the reform of national economic structures. "Temporary" stabilization policies evolved toward imposed structural reforms, in terms of trade liberalization, financial and labor market reforms, reduction of the public sector and privatization of public assets, and drastic social policy shifts (23). Qualitative targets, set in terms of new legislation, structural reforms, and privatization, including health services and social security systems, became routine demands (24, 25). These policies led to a dramatic increase of the unequal distribution of income and wealth between socioeconomic groups (26). At the end of the decade, WHO acknowledged that if public financing for social programs and health were not drastically increased, the situation would deteriorate further (27).

During the early 1990s, structural, managerial, and policy changes were introduced in most of the world's health care systems: enhancing the role of markets, growing competition, and increasing importance of the private sector. These changes took place in the industrialized world and in developing countries alike. But these reforms were driven by financial, political, and ideological concerns of governments and international institutions, rather than by the health needs of the populations (28). Between 1990 and 1997, the average annual economic growth rate in the Organisation for Economic Co-operation and

Development countries further slackened to a meager 2.4 percent (29). As the saturation of industrialized markets became a constraint on further growth (occurring as well in the services and health sectors), intensifying competition between international corporations forced them to cut costs and find new markets. At home, tax reductions and privatization programs provided an outlet for these corporations. Abroad, developing economies were forced to accept further liberalization, deregulation, and privatization, providing transnational corporations an outlet for their excess capital (30). The Latin American health sector was not an exception, and its profitable parts were increasingly infiltrated by managed care organizations (31). The World Bank and other international institutions stimulated and supported health sector reforms in which managed care organizations gained investment opportunities through the privatization of public health services and social security funds (32, 33).

With its 1993 report *Investing in Health*, the World Bank temporarily took the lead from the WHO as the most influential international institution in reshaping national health policies. Based on arguments that tend to equate the public sector with inefficiency and wasting of resources, this institution imposed its prescriptions on governments all over the world (34).

These international policies exacerbate the contradictions between increasing unmet health needs and growing profits (35, 36). While privatization responds to the needs for markets for the medical industry of health maintenance organizations (HMOs) to ensure their profitability, financial accessibility becomes a barrier for a growing number of people in need of adequate medical care and quality services (37). As Dr. Mahler, former director-general of WHO and promoter of the 1978 Alma Ata Conference, stated in his address to the 61st World Health Assembly at the 30th anniversary of the AAD in 2008: "When people are mere pawns in an economic and profit growth game, the game is mostly lost for the underprivileged" (38).

In Latin America during the 1990s, neoliberal reform processes imposed by multilateral organizations have deepened inequity and reinforced financial and health polarization. State and health system reform policies became a central obstacle for development (39, 40). The official discourse refers to equity, participation, inter-sectorial approach, health promotion and prevention, and decentralization (41). Reality looms differently: cost recovery programs, the introduction of competition, and privatization initiatives led to a step-by-step transformation toward a "health market"-based system, while shifting from "(the highest attainable state of) health as a right for all" toward "health care as a *commodity* for the rich and a *charity*—a (sub)minimal safety net—for the poor" (42).

The Neoliberal Reform Model

In line with the global picture, in Latin America the socioeconomic context prevented the realization of the Alma Ata proposals. But the discussion on

the universal right to health, guaranteed by the state through a comprehensive public system, remained vivid (43).

In a context where popular struggle for social or economic rights was seen through the glasses of the Cold War, the Latin American continent lived under a long series of dictatorships. Contrary to the oligarchic and nationalist character of the dictatorships during the 19th and first half of the 20th century, from General Branco in Brazil in 1964 until the resignation of Augusto Pinochet in Chile in 1990, their essential feature was to ensure the integration of the region in a United States-dominated economy. This blocked the development of integrated, national public health systems, and in most of the region, the classic combination was maintained of a threefold health care system with private health services for the rich, a social security system for the relatively small segment of salaried workers (primarily in state companies), and an underfinanced public health care system for the majority of the population.

During the 1980s, Pinochet's Chile became the world's laboratory and pioneer in neoliberal health sector reform. Between 1952 and 1981, Chile's national public health care system had universal coverage and free access to health services financed by the state. But from 1981 onward, the Pinochet government started to break up this public system, diminishing its public financing dramatically. Private health insurance institutes (ISAPRE) were created, some of which were linked to United States-based HMOs, receiving wage-based financing of the insured through a unified national health fund (FONASA). Copayments at the point of care delivery increased dramatically and depended on the type and cost of the chosen scheme among thousands of insurance packages (called "health plans"). Annually, ISAPRE can change the contract according to a worker's risk profile or illnesses. This financing strategy ensured profit margins of about 20 percent for HMOs, while administrative costs took another 20 percent. The government has limited capacities to control them. In 2002, they only insured 22 percent of the population, accounting for 43 percent of the national health expenditure. The rest of the population, the poorest and those most in need of health care, has only partial coverage in the public health care system, financed through FONASA (44). Chile is now drastically turning back this erroneous policy.

The Chilean experience served as a showcase for the health sector reform initiatives of the 1990s, when most health care systems in Latin America were drastically overhauled. With financial support of the World Bank, all types of public-private partnerships and other privatization schemes were promoted (45, 46).

Beginning in the 1990s, with strong influence and financial support from international financial institutions, Colombia set up a far-reaching health sector reform, propagated as a modern and democratic version of the health sector reform experience in Chile (47). A provider-purchaser split was organized, with private and public entities competing in a regulated market on both purchasing and providing sides. In 2000, WHO considered the Colombian health

reform to be the fairest in the world (48). But a series of studies challenge this claim. The Colombian reform has not been able to materialize its promises of universality, improved equity, efficiency, and better overall quality (49). While health insurance became one of the most profitable industries in Colombia, in rural and poor urban areas, public services with no resources are finding it more and more difficult to survive. By 2004, five of the largest national public hospitals had closed and 10 more were in the process of liquidation (50). Also, out-of-pocket payments drastically increased, mainly for the poorest quintile of the population. Today, the administration and advertising costs of Colombian health insurers are between 15 and 25 percent of the overall cost, similar to those found in the United States and much higher than administrative costs in health care systems without competitive insurance plans (51). The role of the state as a regulator and leader of public health was lost in the national and municipal sphere. Public health is also an important victim of the reform (52, 53).

The neoliberal model in Colombia did not address existing problems and created additional harmful consequences. Market mechanisms have accentuated social inequality in Colombia (54). These serious contradictions between the theoretical objectives of the reform law and its actual implementation will be further analyzed below.

Some Alternative Experiences

Even during these decades of neoliberal health sector reform, alternative models coexisted in the region. In general, political will for developing an integrated social security model (in Costa Rica and Brazil) or a national public health system (in Cuba and Nicaragua) was linked to democratic and emancipatory processes.

Since 1941, Costa Rica's health care system developed toward a European-style, integrated social security system (Caja Costarricense de Seguro Social), applying the principles of equity and solidarity to strengthen access to care through public health services and universal social health insurance (55). In 1973, this social security system absorbed the governmental and not-for-profit private hospitals, becoming the sole institution to organize and deliver public hospital care. Later, first-line health services also were integrated. At the same time, a comprehensive Rural Health Program for primary care was launched and later extended to urban areas through the Community Health Program. The first level provides comprehensive health care through a network of Basic Comprehensive Health Care Teams and is supported by a referral level and a tertiary, specialized care level (56). A relatively modest supply of doctors apparently serves the country's needs quite well because of extensive use of auxiliary nurses and health assistants working in rural health posts, health centers, and hospitals (57).

The Costa Rican health care system developed through several waves of challenge and reform (58). Step-by-step liberalization was imposed. Since the 1990s, a contracting-out system has been developed in coordination with the World Bank, based on performance agreements (59). Over the last decade, Costa Rica has been engaging in more profound privatization strategies.

Under the dictatorial regime of the 1960s and 1970s, Brazil had one of Latin America's most sophisticated private health industries with highly unequal access. When representative democracy was restored in the mid-1980s, a broad health movement had a decisive impact on the inclusion of progressive health sector reform in the 1988 constitution (60). A Unified Health Care System (Sistema Único de Saúde [SUS]) was developed and modeled on the conceptual frame of European Social Security, with universal and equitable access to integrated services. The SUS has a single managerial structure, while social control is organized through Health Councils at national, state, and municipal levels with representatives from governments and users. In the 1990s, a Family Health Care Program (Programa Saúde da Família) was started (i.e., a new care delivery model in which interdisciplinary teams ensure the follow-up of a defined population in a specific geographic area). One of the most remarkable achievements was the provision of AIDS care to all in need through the public sector. Acting on the constitutional right to health care, this was an international breakthrough (61, 62). But comprehensiveness remains a challenge, and equity is compromised by the existence of the private medical system in the country. While in 2007, $23.4 billion in tax revenues was spent for 143 million potential beneficiaries of the SUS, this amount is not sufficient to meet historically unmet health needs. In the same year, 40 million people with private insurance spent $35 billion (63).

Within the system itself, equal opportunity of access for equal needs is not guaranteed. Despite regulatory measures to increase efficiency and reduce inequalities, delivery of health care services remains extremely unequal across the country. Utilization rates vary by type of service among income groups, positions in the labor market, and level of education (64). The SUS is strongly embedded in society, and the representation of the interests of the poor makes it robust to interference by private interests. But further integration toward one unified public system remains unrealistic (65).

In Nicaragua, the Sandinista revolution in 1979 created a Unified National Health System in which the public system, social security, and a series of nongovernmental and municipal programs merged. Free first-line health services based on an integrated health concept were gradually extended (66). Mother and child health received particular attention. Health promotion and prevention programs were developed with a broad participatory approach and had—together with important social measures, including nationwide land reform—a significant impact on the population's health. Popular mobilization in mass

vaccination campaigns was successful in eradicating polio and drastically reduced other immuno-preventable diseases (67, 68).

From 1983 onward, the United States-funded "contra" war and the economic embargo aggravated the economic situation. While the government's public policies were able to limit the damages of these adverse circumstances, popular support for the Sandinista government was undermined step by step, leading to profound political changes after the 1990 elections (69, 70). Structural adjustment policies imposed radical social policy shifts and health sector reform, leading to a disintegration of the comprehensive health care model (71, 72). Rampant inflation made health centers and posts quickly run out of supplies. Utilization rates declined steadily, as more and more people had to purchase medicines on the market after getting a prescription. Non-acute and preventive activities—such as nutritional rehabilitation and child health promotion—declined. The budget for human resources was dramatically reduced to pay higher salaries to fewer staff and to ensure basic supplies (73). Consequently, private practices boomed. In 1993, the social security system was separated again from the national public health system, and the country went back to the "classic" Latin American health care system with a private sector for the rich, a social security system for the formally employed, and a public system for the poor majorities (74). Social security health services are now organized through dozens of private medical companies (75).

Since 1959, Cuba has developed its exclusively public health system in the broader frame of a socialist reform process. The country has followed its own path since 1959. Its national health system used many ideas of the Semashko health system that was developed in the USSR, a national health system in which health initiatives were in the first place preventive and social. In this approach, the policlinic played a central role. Nevertheless, the country always had a strong public health academia (76) and over the years developed a local model that emphasizes comprehensive and participatory community care. Until the 1980s, the first-line policlinics primarily offered "first-line specialist care" in addition to multisectorial preventive and health promotion activities. A critical review of this model, and the study of diverse, family doctor-based health care systems, led to a fundamental restructuring of Cuba's first-line services, in which a dense network of family doctor cabinets became pivotal for comprehensive and integrated family care. While in most of the world during the 1980s a "selective primary health care" approach led to the development of a more vertical, disease-oriented approach, in Cuba the comprehensive approach was reinforced through the introduction and development of family doctor-based, integrated first-line health services. Since the 1990s, Cuba has been under constant economic strain. Nevertheless, its national public health system was not only able to survive, it could continue to ensure the right to health care of the whole population, even in the most difficult periods of crisis (77).

In 2008, the 30 years of Alma Ata were an occasion for worldwide discussions on the continued relevance of the main messages and proposals of the Declaration. In a context of overall economic and social crisis, the place and role of public health systems and services were being reconsidered. WHO's *World Health Report 2008* (78), the report of the Commission on Social Determinants of Health (CSDH) (79), and the second Global Health Watch report (80) are all testimonies to the ongoing evolution toward a more critical approach to the liberalization paradigm. The CSDH even considered that "*the toxic combination of bad policies, economics, and politics is, in large measure, responsible for the fact that a majority of people in the world do not enjoy the good health that is biologically possible*."

"Health Systems Strengthening" in the New Millennium

Neoliberal policies push toward a growing contradiction between increasing health needs and the pursuit of private profits. The market-oriented health reform in Colombia proved to be unable to solve this contradiction. We underscored the direct link of these reform policies to critical trends in global economy in which the saturation of rich countries' markets leads to pressures toward further liberalization, deregulation, and privatization.

When, during the 1990s, neoliberal policies led to a dramatic situation in terms of social (under)development and (lack of) health care, social struggle boosted all over the continent (81–83). In many countries over the last decade, this popular opposition materialized in a broad array of progressive governments. Today, Latin American political realities are changing in terms of economic growth, but also in terms of regional integration and increasing social participation in political processes (84–86). Strong economic development and shifts in power relations throughout the continent create a possibility for stronger public strategies toward equitable health (care).

WHO's *World Health Report 2008* critically assessed the way health care is organized, financed, and delivered in rich and poor countries. It ascertained that "*inequities in access to care and in health outcomes are usually greatest in cases where health is treated as a commodity and care is driven by profitability, leading to unnecessary tests and procedures, more frequent and longer hospital stays, higher overall costs, and exclusion of people who cannot pay*" (87). The report concluded that it is high time to go back to a holistic approach to primary care. It added that health care systems would not naturally gravitate toward greater fairness and efficiency, but that deliberate policy decisions are needed (88).

Besides ensuring access to care, this right to health includes an adequate strategy toward social determinants of health. The CSDH did its part to ensure renewed attention to the importance of these social determinants and

advocated for corresponding strategies to improve them. Its 2008 final report concludes that inequities of power, money, and resources have to be tackled (79). The CSDH joined WHO in appealing for political action, insisting that "*community or civil society action on health inequities cannot be separated from the responsibility of the state to guarantee a comprehensive set of rights and ensure the fair distribution of essential material and social goods among population groups*" (89). The recent development of rights-based approaches to health underscores this crucial role of the state in respecting, protecting, and fulfilling the right to (the highest attainable state of) health (90).

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

References

1. WHO. *Preamble to the Constitution of the World Health Organization*. International Health Conference, New York, 1946. www.searo.who.int/LinkFiles/About_SEARO_const.pdf.
2. WHO. *Alma Ata Declaration on Primary Health Care*. WHO International Conference on Primary Health Care, Alma-Ata, USSR, September 6–12, 1978. www.who.int/hpr/NPH/docs/declaration_almaata.pdf.
3. Navarro, V. Neoliberalism and its consequences: The world health situation since Alma Ata. *Glob. Soc. Policy* 8:152–154, 2008.
4. Amin, S. *Unequal Development: An Essay on the Social Formations of Peripheral Capitalism*. Monthly Review Press, New York, 1976.
5. Cueto, M. The origins of primary health care and selective primary health care. *Am. J. Public Health* 94:1864–1874, 2004.
6. Navarro, V. A critique of the ideological and political position of the Brandt Report and the Alma Ata Declaration. *Int. J. Health Serv*. 14:159–172, 1984.
7. Cottenier, J., and Houben, H. De systeemcrisis. In De Systeemcrisis, ed. H. Lerouge. *Marxistische Studies* 84:11–33, 2008. IMAST, Brussels.
8. Shutt, H. *The Trouble with Capitalism. An Enquiry into the Causes of Global Economic Failure*. Zed Books, London and New York, 1998.
9. Amin, S., et al. *Dynamics of the World Economy*. Monthly Review Press, New York, 1982.
10. Boughton, J. M. *Silent Revolution: The International Monetary Fund, 1979–1989*. International Monetary Fund, Washington, DC, 2001.
11. Richard, C. *Thinking the Unthinkable: Think-Tanks and the Economic Counter-Revolution 1931–83*. Fontana, London, 1995.
12. Chossudovsky, M. Policing countries through loan conditionalities. The globalisation of poverty. *Third World Network* 51:72, 1997.

13. UNCTAD. Statistical Pocket Book 1989. In *Fair Trade*, ed. M. B. Brown (1993). Zed Books London, 1989, p. 61.
14. Payer, C. *Lent and Lost. Foreign Credit and Third World Development*. Zed Books, London, 1992.
15. George, S. *L'Effet Boomerang. Choc en Retour de la Dette du Tiers Monde*. Editions La Découverte, Paris, 1992.
16. George, S. Down the great financial drain: How debt and the Washington consensus destroy development and create poverty. *Development* 50:4–11, 2007.
17. Walsh, J., and Warren, K. Selective primary health care: An interim strategy for disease control in developing countries. *New Engl. J. Med.* 301:967–974, 1979.
18. Newell, K. W. Selective primary health care: The counter revolution. *Soc. Sci. Med.* 26:903–906, 1988.
19. Baum, F. E. Health for All now! Reviving the spirit of Alma Ata in the twenty-first century: An introduction to the Alma Ata Declaration. *Soc. Med.* 2:34–41, 2007.
20. Cornwall, A., and Brock, K. *Beyond Buzzwords* "*Poverty Reduction,*" "*Participation*" *and* "*Empowerment*." Development Policy, UNRISD Overarching Concerns Programme, Paper No. 10. UNRISD, Geneva, 2005.
21. Bigdeli, M., and Annear, P. L. Barriers to access and the purchasing function of health equity funds: Lessons from Cambodia. *Bull. World Health Org.* 87:560–564, 2009. doi: 10.1590/S0042-96862009000700019.
22. Xu, K., et al. Household catastrophic health expenditure: A multicountry analysis. *Lancet* 362:111–117, 2003.
23. Granados, R. La reforma de los sistemas de salud: Tendencias mundiales y efectos en Latinoamérica y el Caribe. *Gerencia y Políticas de Salud* 1:16–46, 2002.
24. Bienen, H., and Waterbury, J. The political economy of privatization in developing countries. In *The Political Economy of Development and Underdevelopment*, Ed. 5. McGraw Hill, New York, 1992, pp. 376–402.
25. Brand, H. The World Bank, the Monetary Fund, and poverty. *Int. J. Health Serv.* 24:567–578, 1994.
26. World Health Organization. *World Health Report 1995: Bridging the Gaps*. Geneva, 1995.
27. World Health Organization. *World Health Report 2000: Making a Difference*. Geneva, 2000.
28. Lister, J. *Health Policy Reform. Driving the Wrong Way?* Middlesex University Press, Middlesex, 2005.
29. Brenner, R. *The Boom and the Bubble: The US in the World Economy*. Verso, New York, 2002.
30. De Vos, P., De Ceukelaire, W., and Van der Stuyft, P. Colombia and Cuba, contrasting models in Latin America's health sector reform. *Trop. Med. Int. Health* 11:1604–1612, 2006.
31. Ginzberg, E., and Ostow, M. Managed care – a look back and a look ahead. *New Engl. J. Med.* 336:1018–1020, 1997.
32. Armada, F., Muntaner, C., and Navarro, V. Health and social security reforms in Latin America: the convergence of the World Health Organization, the World Bank, and transnational corporations. *Int. J. Health Serv.* 31:729–768, 2001.

33. Iriart, C., Merhy, E., and Waitzkin, H. Managed care in Latin America: The new common sense in health policy reform. *Soc. Sci. Med.* 52:1243–1253, 2001.
34. World Bank. *World Development Report 1993: Investing in Health*. Washington, DC, 1993.
35. Laurell, A. C. Health reform in Mexico: The promotion of inequality. *Int. J. Health Serv.* 31:291–321, 2001.
36. Janes, C. R., et al. http://www.ncbi.nlm.nih.gov/pubmed?term=%22Janchiv%20K%22%5BAuthor%5D Poor medicine for poor people? Assessing the impact of neoliberal reform on health care equity in a post-socialist context. *Glob. Public Health* 1:5–30, 2006.
37. Homedes, N., and Ugalde, A. Why neoliberal health reforms have failed in Latin America. *Health Policy* 71:83–96, 2005.
38. Mahler, H. *Address to the 61st World Health Assembly*. May 20, 2008.
39. Stocker, K., Waitzkin, H., and Iriart, C. The exportation of managed care to Latin America. *New Engl. J. Med.* 340:1131–1136, 1999.
40. Iriart, C., Merhy, E., and Waitzkin, H. La atención gerenciada en América Latina. Transnacionalización del sector salud en el contexto de la reforma. [Managed care in Latin America: Transnationalization of the health sector in the context of reform]. *Cadernos de Saúde Pública* 16:95–105, 2000.
41. Collins, C., and Green, A. Decentralization and primary health care: Some negative implications in developing countries. *Int. J. Health Serv.* 24:459–475, 1994.
42. Laurell, A. C., and López Arellano, O. Market commodities and poor relief: The World Bank proposal for health. *Int. J. Health Serv.* 26:1–18, 1996.
43. Laurell, A. C. Bringing Latin America's progressive health reforms out of the closet (Editorial). *Soc. Med.* 3:54–56, 2008.
44. Homedes, N., and Ugalde, A. Privatización de los servicios de salud: Las experiencias de Chile y Costa Rica. *Gaceta Sanitaria* 16:54–62, 2002.
45. World Bank. *Financing Health Services in Developing Countries*. Washington, DC, 1987.
46. Aiyer, S., Jamison, D. T., and Londoño, J. L. Health policy in Latin America: Progress, problems and policy options. *Cuadernos de Economía* 32:11–28, 1995.
47. Unger, J.-P., et al. Chile's neoliberal health reform: An assessment and a critique. *PLoS Med* 5(4):e79, 2008. doi:10.1371/journal.pmed.0050079.
48. World Health Organization. *World Health Report 2000. Health Systems: Improving Performance*. Geneva, 2000.
49. De Groote, T., De Paepe, P., and Unger, J. P. Colombia: In vivo test of health sector privatisation in the developing world. *Int. J. Health Serv.* 35:125–141, 2005.
50. Paredes, N. La salud pública: Entierro definitivo. In *Reelección: El Embrujo Continúa*, ed. C. Borrero. Plataforma Colombiana de Derechos Económicos, Sociales y Culturales, Bogotá, 2004, pp. 109–119.
51. Bossert, T. *Privatization and Payments: Lessons for Poland from Chile and Colombia*. 2000. www.hsph.harvard.edu/ihsp/publications/pdf/No-77.PDF.
52. Ayala Cerna, C., and Kroeger, A. La reforma del sector salud en Colombia y sus efectos en los programas de control de tuberculosis e inmunización. *Cadernos de Saude Publica* 18:1771–1781, 2002.

53. Kroeger, A., et al. Community cooperatives and insecticide-treated materials for malaria control: A new experience in Latin America. *Malar. J.* 1:15, 2002.
54. Londoño, E., Dario-Gómez, R., and De Vos, P. Colombia's health reform: False debates, real imperatives. *Lancet* 375:803, 2010.
55. Unger, J. P., et al. Costa Rica: Achievements of a heterodox health policy. *Am. J. Public Health* 98: 636–643, 2008.
56. PAHO. *Profile of the Health Services System of Costa Rica, Ed. 2*. Washington, DC, 2002.
57. Roemer, M. *National Health Systems of the World – Volume I: The Countries*. Oxford University Press, New York and London, 1991.
58. Connolly, G. *Costa Rican Health Care. A Maturing Comprehensive System*. Global Health Council, 2002. www.cehat.org/rthc/paper5.htm.
59. Economic Commission for Latin America and the Caribbean. *Performance Agreements. Shaping the Future of Social Protection: Access, Financing and Solidarity*. Montevideo, 2006.
60. Elias, P. E., and Cohn, A. Health reform in Brazil: Lessons to consider. *Am. J. Public Health* 93:44–48, 2003.
61. Bacon, O., et al. *AIDS/HIV in Brazil*. AIDS Policy Research Center, University of California, San Francisco, 2004. http://bvsms.saude.gov.br/bvs/publicacoes/15Brazil_Country_Profile.pdf.
62. Portela, M. C., and Lotrowska, M. Health care to HIV/AIDS patients in Brazil. *Rev. Saúde Pública* 40S:70–79, 2006. www.scielo.br/pdf/rsp/v40s0/en_10.pdf.
63. Cohn, A. The Brazilian health reform: A victory over the neoliberal model. *Soc. Med.* 3:71–81, 2008.
64. Almeida, C., et al. Health sector reform in Brazil: A case study of inequity. *Int. J. Health Serv.* 30:129–162, 2000.
65. Marten, R., et al. An assessment of progress towards universal health coverage in Brazil, Russia, India, China, and South Africa (BRICS). *Lancet* 384:2164–2171, 2014. http://dx.doi.org/10.1016/S0140-6736(14)60075-1.
66. Envio. Un pueblo más sano: La salud en la nueva Nicaragua. *Envio* 23, 1983. www.envio.org.ni/articulo/77.
67. Donahue, J. M. Planning for primary health care in Nicaragua: A study in revolutionary process. *Soc. Sci. Med.* 23:149–157, 1986.
68. Frieden, T., and Garfield, R. Popular participation in health in Nicaragua. *Health Policy Plann.* 2:162–170, 1987.
69. Braveman, P., and Siegel, D. Nicaragua: A health system developing under conditions of war. *Int. J. Health Serv.* 17:169–178, 1987.
70. Garfield, R. M. War-related changes in health services in Nicaragua. *Soc. Sci. Med.* 28:669–676, 1989.
71. Garfield, R. Letter from Nicaragua. Desocializing health care in a developing country. *JAMA* 270:989–993, 1993.
72. Lane, P. Economic hardship has put Nicaragua's health care system on the sick list. *Can. Med. Assoc. J.* 152:580–582, 1995.
73. Garfield, R., and Williams, G. *Health Care in Nicaragua. Primary Care under Changing Regimes*. Oxford University Press, New York, 1992.

74. Rizo Castellón, S. *La Reforma de la Seguridad Social en Nicaragua*. INSS, Managua, 1996.
75. Antón-Pérez, J. I. La reforma de la seguridad social en Nicaragua: Una propuesta de pensión no contributiva. *Cadernos PROLAM/USP* 6:37–66, 2007.
76. Rojas-Ochoa, F. Orígenes del movimiento de atención primaria de salud en Cuba. *Revista Cubana de Medicina General Integral* 19:56–61, 2003.
77. De Vos, P., et al. Public health services, an essential determinant of health during crisis. Lessons from Cuba's 'special period' (1989–2000). *Trop. Med. Int. Health* 17:469–479, 2012.
78. WHO. *World Health Report 2000. Making a Difference*. Geneva, 2000.
79. Commission on Social Determinants of Health. *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. Final Report of the Commission on Social Determinants of Health. World Health Organization, Geneva, 2008.
80. People's Health Movement, Medact, Global Equity Gauge Alliance. *Global Health Watch 2. An Alternative World Health Report*. Zed Books, London, 2008.
81. De Vos, P. Venezuela: Anti-imperialisme en socialisme. *Marxistische Studies* 77:11–76, 2007. IMAST, Brussel.
82. Rodgers, D. *Unintentional Democratisation? The Argentinazo and the Politics of Participatory Budgeting in Buenos Aires, 2001–2004*. Crisis States Programme Working Paper 61. Development Studies Institute, London School of Economics and Political Science, London, 2005.
83. Knudson, J. W. Rebellion in Chiapas: Insurrection by Internet and public relations. *Media, Culture & Society* 20:507–518, 1998. doi: 10.1177/016344398020003009.
84. Muntaner, C., et al. Venezuela's Barrio Adentro: An alternative to neoliberalism in health care. *Int. J. Health Serv*. 36:803–811, 2006.
85. Muntaner, C., et al. Venezuela's Barrio Adentro: Participatory democracy, south-south cooperation and health care for all. *Soc. Med*. 3:232–246, 2008. http://journals.sfu.ca/socialmedicine/index.php/socialmedicine/article/view/250/531.
86. Laurell, A. C. Health reform in Mexico City, 2000–2006. *Soc. Med*. 3:145–157, 2008. http://journals.sfu.ca/socialmedicine/index.php/socialmedicine/article/view/222/444.
87. WHO. *World Health Report Calls for Return to Primary Health Care Approach*. Press Release, October 14, 2008. www.who.int/mediacentre/news/releases/2008/pr38/en/index.html.
88. World Health Organization. *The World Health Report 2008. Primary Care. Now More Than Ever*. Geneva, 2008.
89. Marmot, M., et al. on behalf of the Commission on Social Determinants of Health. Closing the gap in a generation: Health equity through action on the social determinants of health. *Lancet* 372:1661–1669, 2008.
90. De Vos, P., et al. Health through people's empowerment: A rights-based approach to participation. *Health Hum. Rights* 11:23–35, 2009.