14 Progressive alternatives in primary health care in Latin America

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The history of primary health care (PHC) in Latin America is a complex one that has been deeply impacted by the introduction of neoliberal policies from the 1970s onwards. Country-level success stories are rare, and although there are progressive pilot programmes still in operation in some parts of the region, these initiatives have had little or no national-level support and have not been very effective at resisting commercialisation trends in the sector.

This chapter explores four settings in the region where PHC services are in public hands, have been well funded by governments, and have been integrated into a broader set of social and economic policy making and practice. At a country level, Cuba and Costa Rica stand out as having national health programmes that prioritise PHC and which have explicitly aimed to remove or keep out private sector health operators. They have also been in place for many decades, providing useful historical records on the requirements for realising "alternatives to privatisation" in the PHC sector and the challenges of operating these systems in a neoliberal era.

More recently, Venezuela and the Federal District of Mexico City have introduced non-commercialised PHC initiatives with a more localised focus, in part driven by a desire to integrate these into local participatory management systems (in the case of Venezuela) and in part because of the ideological and fiscal constraints of collaboration with higher levels of government (in the case of Mexico City).

The summaries offered here are far from comprehensive, but they do provide an overview of the key successes (and failures) of these initiatives and attempt to place them within a broader set of social, economic, and political norms operating in the region. What is clear in each case is that without strong and committed support from the state – ideally in combination with participatory engagement with citizens and health care providers and users – it is difficult, if not impossible, to create and sustain effective public PHC delivery.

Background information is provided for each of the cases, followed by a discussion of how "successful" they have been. The latter discussion is informed in part by the "criteria for success" developed for all of the studies in this book (see Chapter 2, this volume, for a detailed discussion of

methodology). We focus specifically on issues of *participation, equity, quality,* and *efficiency*. What is evident in our review is that none of the cases are successful on every success criterion, and there are inherent tensions within and across the criteria applied (e.g. efficiency gains can come at the loss of some equity or sustainability). Nonetheless, our objective was not to find perfect or internally consistent models but rather to investigate in a methodologically transparent and comparative manner the kinds of criteria that make for successful alternatives to privatisation in the PHC sector in Latin America. The fact that we ask as many questions as we answer is indicative of the ongoing tensions within the "alternatives" movement, as well as the friction these initiatives create with neoliberal capitalism.

FROM "COMPREHENSIVE PHC" TO "SELECTIVE PHC" IN LATIN AMERICA

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The International Conference on Primary Health Care (ICPHC) in Alma-Ata, Kazakhstan, in 1978 resulted in an agreement signed by 134 nations committing themselves to incorporating PHC within the core planning of their country. The declaration is seen as a milestone in progressive PHC and established the following criteria for what is referred to as "comprehensive PHC" (WHO and UNICEF 1978):

- Health is a human right.
- There are enormous inequalities between and within developed and developing countries.
- There is a need for a New International Economic Order.
- Governments should assume responsibility for the health of their people.
- From the point of view of social justice, PHC should be the principal strategy for reaching "Health for All" in the year 2000.
- States should develop promotion and preventive health care models rather than just curative.
- PHC should be integrated within larger national health systems, leading to the increasing of coverage of comprehensive health care.
- Community participation in planning, organising, running, and regulating PHC is critical.
- It is important to have cooperation amongst governments, workers, and communities.

The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) committed themselves to this declaration and gave advice on PHC to the countries involved (WHO and UNICEF 1978). Worldwide enthusiasm for the declaration was strong. With the help of international institutions and non-governmental organisations (NGOs), the strategy was adopted by nearly all countries in Latin America, with Cuba, Costa

Rica and Brazil demonstrating exceptional community participation and government commitment (Werner et al., 2000, Giovanella et al., 2009). In Latin America today, there are many local comprehensive PHC teams, which continue to be inspired by this declaration and run integrated health systems that involve professional health care providers and the participation of communities. Two examples are the *Clínica Comunal* (Community Clinic) called *Ana Manganaro Guarjila* in El Salvador (Barten et al., 2009) and the community organisation in a local health system in the *Región de Marqués de Comillas*, Chiapas, Mexico (Heredia 2007).

However, the Alma-Ata Declaration contradicted the emerging neoliberal dictates of the 1980s in most of Latin America, particularly with the implantation of structural adjustment programmes created by the World Bank and the International Monetary Fund (IMF), which promoted privatisation in the health care sector along with the reduction of state investment in health and education (World Bank 1993). Most Latin American countries acceded to these pressures, eroding their public health services and allowing private operators and commercial principles to dominate. The only notable exception to this trend was Cuba (because of its socialist system), although Costa Rica and, to some extent, Brazil showed considerable resistance to the implementation of neoliberal health policies.

According to the neoliberal orthodoxy of the day, the comprehensive version of PHC articulated in the Declaration of Alma-Ata was "too expensive and too unrealistic", with market-friendly policy makers suggesting it would be more efficient to redirect government spending towards low-cost, high-impact areas such as immunisation. By 1983 UNICEF had also replaced the notion of comprehensive PHC with a group of specific interventions oriented to increasing child survival. This situation gave place to a much more limited policy known as GOBI – Growth Monitoring, Oral Re-Hydration Therapy, Breastfeeding, and Immunization (Wisner 1988). This new, more limited, version of service delivery has become known as "selective PHC" (Wisner 1988, Werner et al., 2000). As a result, the goal of Health for All was not reached, and was subsequently replaced by the Millennium Development Goals (MDGs).

Thus came about a succession of neoliberal health policy interventions, introduced mainly by the World Bank and the IMF, which gradually replaced the more progressive influence of the WHO and the Pan American Health Organization (PAHO). Amongst these interventions can be found the push for a "public-private mix" of service provision, which saw the development of national health policies headed by ministries/departments of health but in which the financing and ownership of services were both public and private (Eibenschutz 2007). After nearly 30 years of this neoliberal shift, the private sector has grown in every country in the region, yet equity in access to the services has not been achieved.

In Latin America, private expenditure on health – as a percentage of gross domestic product – rose from 3.2% in 1980 to 3.8% in 1990, due

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Table 14.1 Health care expenditures in selected Latin American countries (as percentage of GDP): 1995, 2000, and 2007

	General government expenditure on health			*Prepaid and risk-pooling plans*			*Private households' out-of-pocket payment*		
	1995	*2000*	*2007*	*1995*	*2000*	*2007*	*1995*	*2000*	*2007*
Argentina	5.0	5.0	4.6	0.9	1.3	2.7	2.3	2.5	2.1
Barbados	4.3	4.1	4.2	0.5	0.5	0.5	1.5	1.7	1.9
Belise	2.8	2.4	2.8	NA	NA	NA	2.2	2.6	2.1
Brazil	2.9	2.9	4.9	1.2	1.5	1.2	2.6	2.7	2.4
Chile	2.5	3.0	3.0	1.5	1.6	1.2	1.6	1.5	1.4
Colombia	4.3	6.2	6.4	0.5	0.6	0.6	2.6	0.9	0.4
Costa Rica	5.0	5.0	5.9	0.0	0.0	0.2	1.3	1.3	1.9
Cuba	5.2	6.1	9.9	0.0	0.0	0.0	0.5	0.6	0.6
Dominican Republic	1.2	2.2	1.9	0.8	0.8	0.6	3.2	3.0	2.1
Ecuador	2.3	1.3	2.4	0.3	0.1	0.2	1.3	2.4	2.7
Guatemala	1.3	2.2	2.0	0.1	0.1	0.2	2.2	3.0	4.1
Haiti	3.1	2.6	6.2	NA	NA	NA	3.5	3.2	2.3
Mexico	2.4	2.6	3.0	0.1	0.1	0.2	3.2	2.8	3.3
Nicaragua	4.8	3.7	4.9	0.0	0.2	0.1	1.3	3.1	5.0
Panama	4.8	5.3	5.7	0.4	0.5	0.4	1.9	2.0	1.7
Paraguay	2.4	3.7	2.6	0.4	0.6	0.5	3.9	4.9	4.0
Peru	2.2	2.5	2.6	0.2	0.4	0.4	2.0	1.8	1.5
El Salvador	2.5	3.6	3.6	0.0	0.2	0.3	3.9	4.1	2.0
Uruguay	4.6	3.5	3.5	2.6	5.2	3.2	2.0	1.8	1.4
Venezuela	2.3	3.2	2.7	0.1	0.1	0.1	2.0	2.5	2.4
Average	3.3	3.6	4.1	0.5	0.8	0.7	2.3	2.4	2.3

Source: Elaborated with data from WHO (2009).

mainly to increases in household out-of-pocket expenditures and growth in private health insurance and prepaid medical plans (PAHO 2007). Since then there continues to be a general trend towards out-of-pocket expenditures and prepaid plans (see Table 14.1). Mexico, Venezuela, and Costa Rica are notable in this regard. In the Mexican case, it is more clearly a result of privatisation.

On the other hand, Cuba stands out in terms of its relatively low out-of-pocket private expenditures (which refer principally to programmes for foreigners) and its high levels of government spending on health care (which have almost doubled since 2005 and are two-and-a-half times the average of the countries listed in Table 14.1).

PHC IN TIMES OF CRISIS

There are, however, signs of change. Since abandoning the Alma-Ata principles, PAHO and the region's governments are now talking about revisiting comprehensive PHC. A growing number of academics, health workers, and NGOs have joined this initiative as well. Significantly, PAHO declared recently that "the principles that maintain a health system based on PHC require a process of renovation and include the responsibility and accountability of governments, as well as the capacity of the systems to meet, in a fair and sustainable way, the health needs of the people through participation, orientation towards quality and inter-sectoriality" (Macinko et al., 2007, 75).

Nevertheless, despite these enthusiastic efforts the social, economic, and political realities of long-term structural crisis in Latin America pose significant obstacles to meaningful change. By this we do not wish to dismiss the actions of governments in the region that appear committed to comprehensive PHC, but rather aim to point out obstacles that need to be overcome, including the ongoing push for privatisation, the challenges of meeting citizens' rights, and the limited regulatory and delivery capacity of the region's states after three decades of liberalisation. Of particular interest are questions of how we stimulate community participation in a context in which services depend on different public/private institutions of health and how we obtain participation among a polarised population (one that is increasingly divided into those who have private health insurance and those who do not).

THE SEARCH FOR ALTERNATIVES

In our search for public sector alternatives, we focused our attention on national-level programmes which have explicitly attempted to prohibit (or at least minimise) private sector involvement in PHC. Cuba is exemplary

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in this regard, but Costa Rica is notable as well for its efforts to create health systems with the leadership of the public sector. We also look at the cases of Venezuela and Mexico City (the latter being a separate jurisdiction within the national Mexican state), both of which have experienced dramatic changes of government, with anti-neoliberal and anti-imperialist stances, creating opportunities for changes in health policy. Although more recent than Cuba and Costa Rica, these two cases provide valuable insights into an ongoing and dynamic state of change.

In all of these cases, we are exploring health provision by a formal state agency, working in part with local communities but largely as a single provider. Although there is some collaboration across different state agencies, we do not see the "public-public partnerships" that are increasingly common in other sectors in Latin America (notably in water) or the state-NGO collaborations found in the PHC sector in other parts of the world (see Chapters 8 and 11 on Asia and Africa, this volume). Nevertheless, the cases in this chapter demonstrate how the principles of Alma-Ata can be guaranteed through state-led national or subnational health systems because they can provide all three levels of care (clinic, general hospital, and specialty hospital) and can take advantage of economies of scale and reduce the disparities between geographic regions and social groups, none of which can be accomplished by disparate private providers or grassroots NGOs on their own. In addition, unlike non-commercialised initiatives in other sectors such as water, which lend themselves more easily to autonomous management options, PHC services require coordinated, multifaceted interventions by skilled professionals at a state level. In this regard, "alternatives to privatisation" in PHC in Latin America are more limited and more narrowly defined than in some of the other sectors/regions discussed in this book but not necessarily less effective.

Information collection on the four cases was carried out primarily through the use of digital databases on the Internet (e.g. Academic Search Premier, Scielo, Medline), specialised health journals, data from ministries and departments of health in the selected countries, and relevant texts from the libraries of the Faculty of Medicine of the National Autonomous University of Mexico (UNAM) and the Autonomous Metropolitan University campus Xochimilco (UAM-X). We also consulted with the regional coordinators of the Latin American Association of Social Medicine (ALAMES, in its Spanish abbreviation), with detailed e-mail communication with representatives of Cuba and Costa Rica.

This information is very schematic, however, particularly the online material, making it difficult to find details on concrete processes and implementation of public health policy strategies and local-level experience. This difficulty demonstrates the absence of a systematisation of documentation at both the local and national levels and highlights the challenge of conducting comparative research on this topic as well as the need for better coordination of information if progressive PHC policies and experiences

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are to be shared in the region. In this regard this research should be seen as a starting point for (re)constructing "alternative" experiences in Latin America and a step forward in the gathering, organisation, and analysis of information, but there is much work that remains to be done on a more detailed case study basis.

THE CUBAN NATIONAL HEALTH SYSTEM

Following the triumph of the 1959 revolution, the organisation and consolidation of the public health system in Cuba has passed through various stages. Before the revolution, health care was organised into three sectors: state, private, and mutual (or social security; Delgado 1996). During the post-revolutionary stage, there was a development of a universal and entirely public organisation of the health system, guided by the principle of cost-free services as a way of ensuring universal access to health care. The first interventions were the nationalisation of private clinics and drugstores, the reduction of prices of drugs and the creation of a Rural Medical Service with the objective of facilitating access to the remote communities (Delgado 1996).

In 1961 the Ministry of Public Health took on the leadership of all the country's health services, which led to the National Health System and the Cuban state eventually becoming the only provider of health care services in the country. In the 1970s, the services were reorganised, establishing "health areas" in the 14 provinces and 169 municipalities, which implanted a new model of community polyclinics (De Vos 2005). During that decade herbal medicine was also incorporated into formal health services.

The decade of the 1980s was the stage of the family physician model, known as "the family physician and nurse", giving PHC an added sense of priority within the Cuban National Health System (Rojas 2009). In the 1990s, with the loss of its main commercial partner and political ally due to the collapse of the Soviet Union, the "Special Period" saw a number of restrictive economic actions, including a lack of growth in the National Health System. Nevertheless, health programmes and education remained national priorities.

In the second half of the 1990s the economy began to grow again, which strengthened health services (De Vos 2005). In 2002 the Ministry of Public Health launched the "Revolution" project, which includes the following actions: maintenance on the facilities infrastructure; modernisation of technology and services; training of staff at management level; updating the training of other staff; and extending to the polyclinics services that until then had only been available in hospitals (e.g. ultrasound, rehabilitation, endoscopy, and biliary drainage) or in certain clinics (e.g. optometry, dentistry, and traditional and natural medicine; Sansó 2005).

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PHC is provided through the family medicine system and the family offices, secondary-level care through the polyclinics, and tertiary-level in hospitals and medical institutes. In Cuba PHC emerged, from 1984 onwards, through the family physician-and-nurse office model. In 1988 the "Family physician-and-nurse, polyclinic and Hospital Work Program" was established with the goal of "improving the population's health through comprehensive actions for individuals, families, the community and the environment, carried out in the context of close ties with the community itself" (MINSAP 1988, 3). The family physician and nurse's work was mainly aimed at health promotion, disease and damage prevention, rehabilitation, contributing to the improvement of environmental sanitation, teaching, and research.

The physician and nurse work as a team and live within the community in which their office is located. In the mornings they do medical consultations at the office, and in the afternoons they make home visits. In terms of promotion and prevention, they carry out educational activities addressed at the reduction of health risk factors and early detection of disease. They also perform nutritional monitoring of family members and implement vaccination schemes. In addition to this, they carry out group activities for senior citizens, adolescents, children, and pregnant women, to encourage physical exercise, social integration and emotional well-being.

Regarding medical care, they guarantee regular and systematic attention for the community at the physician-and-nurse office, regular care for pregnant women, and childcare consultations for newborns (MINSAP 1988). They have to provide medical care according to the community's needs, offer specialised consultations and emergency care at the family physician-and-nurse office or at home, and accompany the patient to the polyclinic or hospital if needed. They also do rehabilitation activities for new mothers, psychiatric patients, the mentally handicapped, or those with disabilities. The teaching tasks consist mainly of carrying out scientific activities with undergraduate medical students and with family physicians that have not yet begun their specialisation.

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Participation

After the revolution, social and community participation was very extensive and went through various stages according to the country's social, economic, and political organisation. Social organisations such as Committees of Defence of the Revolution and the Cuban Woman's Federation contributed in very important ways to health education of the people and to the evaluation of services. Most recently, councils of health were organised starting in 2009. These actions have generated a set of activities to resolve problems of social concern, primarily deaths by transmissible and avoidable diseases (Sanabria 2001).

In the mid-1990s the National Council for Health Education and Promotion (NCHEP) was created, whose goal was to promote social participation and intersectoriality. The NCHEP is made up of Health Councils at different levels of government (national, provincial, municipal, and local; NCHEP 2009). Each of the three levels of government is involved not only in the planning but also in the delivery of the services (the National Health Council, the Provincial Assemblies of People's Power, and at municipal level the People's Council). These entities were created as part of the process of administrative decentralisation and to promote community participation.

The system is not perfect, of course. In one study carried out in communities in Havana city and province, it was found that the weak aspects of social participation were a lack of adequate knowledge of the mechanisms of individual participation created in the community or by certain groups, a predominance of individual participation, and the limited influence of the community in the planning and implementation of the programmes (Sanabria 2001). It was found that there was a lack of training and information about specific participation mechanisms for both the health workers and the community. Equally, the practice of physicians and nurses focuses predominantly on curative actions at the expense of community health.

However, there have been successful experiences of social participation throughout the country. In one case study (Martínez 1998), in a neighbourhood attached to the People's Council *Balcón de Arimao* in the municipality of Lisa, it was found that health and socio-economic indicators improved as a result of the work with, and the close ties to, the Health Council, the People's Council, and the health team with the community.

In another case in a health area in the province of Havana, they turned to popular education as a means to increase community participation in the struggle against dengue fever. In this case they encouraged community participation in activities for learning about and investigating problems in order to find causes and to suggest and implement solutions. Over a two-year period (2002–2004), this process resulted in the reduction of vector density, and not one case of dengue was identified. In this case, "the leadership of health staff went from being paternalist to being shared with community leaders, as it took into account their opinions on action planning" (Sánchez et al., 2008, 61).

Equity

The Cuban government defines equity as equal opportunity to access resources, democratic distribution of power and knowledge within the health system, and a health policy that benefits all regardless of race, gender, nationality, disability, or any other form of individual or group trait (Gorry 2005). Due to the universal and integral character of the Cuban National Health System, this model covers virtually the entire population (99.4%), with 33 015 physicians in 14 074 offices (PAHO 2001; Presno and

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González 2007). With regard to access, "no deaths occur without any form of medical care" (PAHO 2001, 19), and for the year 2004, 99.9% of births were attended by a professional health team (Gorry 2005).

With regard to access to drugs, although there is a shortage of supplies, there have been sustained efforts to ensure the population has access to them (*Granma* 2008). At present, the essential drug list consists of 866 drugs, of which 63% are produced domestically. In 2007, over $1 million was invested in buying drugs that are not included in the list to treat certain patients; the production of drugs grew by 26% compared to 2006, and 25 new drugs were introduced, of which 15 were created to replace imported ones.

The health services are funded directly by the national budget, with funding from general taxes, which means they are free for the public (WHO 2009). Statistics from the WHO indicate that for the year 2006 the total spending on health as a percentage of GDP was 7.7%. External resources for health as a percentage of the total expenditure on health represent 0.2% of GDP (WHO 2009).

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Efficiency

From a macroeconomic perspective, Cuba has attained high levels of efficiency because it is the country with the best health indicators in Latin America, while its income level is relatively low (PAHO 2007). When the analysis is taken to the microeconomic level, we find a less even situation. In one evaluation of the efficiency of services in the province of Matanzas, it was estimated that between 60% and 80% of the polyclinics were deemed efficient (García et al., 2007). All of the polyclinics were classified efficient in seven of the 14 municipalities (Varadero, Jovellanos, Perico, Los Arabos, Calimete, Ciénaga, and Pedro Betancourt), while in two municipalities (Martí and Limonar), all the polyclinics were classified inefficient; and in the municipality of Jagüey, 66% of its units were found to be inefficient. It was concluded that amongst the causes of inefficiency were "weaknesses of management...inadequate monitoring of the most vulnerable groups of the population, poor preparation of human resources, and the lack of community participation in the health actions developed in the area" (García et al., 2007, 107).

The allocation of resources takes into account the assessment of the services and has been modified in relation to the efficiency of the care model. Between 1990 and 1994, expenditure on hospital care was reduced, while PHC expenditure was increased (Cárdenas and Cosme 2000). In 1998, as a consequence of home care, hospitalisation was significantly reduced. The number of visits to hospital emergency departments was reduced, and visits to the emergency polyclinics increased.

Health indicators show that between 1994 and 2004, there was a fall in the infant mortality rate (from 9.9 to 5.8 per 1 000 live births), maternal

mortality (from 57.0 to 38.5 per 100 000 live births), and the prevalence of newborns with low birthweight (from 8.9% to 5.5%) (Gorry 2005, PAHO 2001).

Quality

Evidence with respect to quality comes mainly from case studies. For example, between June 1998 and October 1999, the structure and process of medical care for workers in workplaces in the municipality of Santiago de Cuba was assessed (Sánchez et al., 2002). The availability of care materials and the number of physicians and nurses in the Family Physicians Offices were assessed as adequate, whereas the equipment (i.e. scales, stadiometers, multipurpose tables, autoclave sterilisers, examination lamps, sphygmomanometers, and stethoscopes) was considered inadequate. To assess the professional competence of the medical staff, there was an examination on relevant knowledge and procedures related to the specific health problems of the community. In this case, the results for 10 out of 11 indicators were inadequate.

In one polyclinic in the Playa municipality, the satisfaction of families, patients, and health staff concerning home care was studied (Márquez 2002). In this case 83.5% of patients and/or families said they were satisfied with the care, but 16.4% proved dissatisfied due to the lack of systemisation of medical care. On the other hand, most of the physicians were satisfied with the home care as it allowed them to carry out closer monitoring of illness and improved physician-patient-family relationships; however, a significant number expressed dissatisfaction due to limited resources, overload of bureaucratic work, and lack of support by specialists.

In one polyclinic in the municipality of Yaguajay, it was reported that most of the patients were satisfied with the nurse care service (68.5%), while 98.4% said they trusted in the nurse, and 96.2% were satisfied with the level of interest the nurses showed in the patient (Pérez de Alejo and García 2005). Indicators of kindness and efficiency showed lower percentages of 70% and 63.1%, respectively, while 64% of those interviewed had known their nurse for over three years.

What these statistics indicate is a Cuban public health care system that is still in need of improvement but one with a remarkable record of success and a willingness to critically investigate and evaluate itself.

THE COSTA RICAN SOCIAL SECURITY SYSTEM

A number of institutions were created in Costa Rica in the 1940s, which together began to gradually integrate the Costa Rican health system. In 1941 the Costa Rican Social Security Fund (*Caja Costarricense de Seguridad Social*, CRSSF) was established, through the Law on Compulsory

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Social Security, establishing universal health coverage (Gómez 2003). The subsequent Health Code (1949) stated that "the protection of health is a state duty" and charged the Ministry of Public Health with "the organization and supreme administration of the republic's hygiene and medical care, as well as of the centralization and coordination of all national, municipal and particular public health actions" (Villegas de Olazával 2005, 25).

In 1961 a law universalising Compulsory Social Security was decreed, forcing the CRSSF to guarantee total coverage of social security benefits, as well as timely, comprehensive and equitable access to the health services (Gómez 2003). However, by the end of the 1960s health services were directed by various autonomous institutions (CRSSF, Social Welfare Boards, the Ministry of Health, and the National Insurance Institute), which rarely coordinated their efforts, with the result that actions were sometimes duplicated without improvement in outcomes.

In 1975 the CRSSF assumed responsibility of the administration of the non-contributive pensions scheme to protect low-income citizens. In the 1980s a process of integration between the CRSSF and the Ministry of Health began, and in 1993 the former took on full provision of health promotion, preventive, curative, and rehabilitation services.

At the end of the 1990s the Costa Rican health system underwent a reform, which included the strengthening of primary-level health care, providing resources according to efficiency, and the deconcentration of CRSSF hospitals and clinics in order to grant it greater autonomy for budget management, administrative contracting, and human resource administration (Rodríguez 2006).

The CRSSF, built on the principles of universality, solidarity, and equity, is responsible for health promotion, prevention of disease and rehabilitation, as well as for disability, senior citizens, and death pension schemes. The health services are planned by hierarchical and administrative levels of the CRSSF and are made up of six central offices, seven health regions, and 94 health areas (PAHO et al., 2004).

Primary-level health care is provided through the Basic Teams for Comprehensive Care (*Equipos Básicos de Atención Integral*, BTCC). Secondary-level care is composed of 11 clinics, 14 peripheral hospitals, and seven regional hospitals. Tertiary-level care takes place in three national general hospitals and five specialised hospitals. Primary-level care is organised into 94 health areas and provides the services through the BTCC, made up of a physician, an auxiliary nurse, and one or more technical primary care assistants. In 2002 the CRSSF had 812 assigned BTCC; however, not all health areas have a complete team (PAHO et al., 2004).

The objective of the BTCC is to ensure real access to health services, focusing on the health-illness process and emphasising promotion, prevention, and community participation. The BTCC covers a geographic area with a population ranging from 2 500 to 6 000 inhabitants. This area is defined by demographic criteria, means of transport and communication

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and accessibility, allocation of resources according to necessity, use of lower cost-benefit infrastructures, and economies of scale (CRSSF 2009). The main activities and services of the BTCC are general medical consultations, educational talks, vaccination, home visits, and child, adolescent, women, adult, and senior citizen health care programmes.

Participation

The directive board of the CRSSF defines social participation as a process of interaction, negotiation and agreement between the people, the CRSSF, government, and non-governmental institutions (CRSSF 2004). The health committees are the principal mechanisms responsible for organising participation in health and are defined as an auxiliary body to the health services. The committees are made up of seven members (three representatives from insured people, two representatives from the pro-health organisations and associations, and two representatives from the employers sector) from the catchment area of that health area; they are elected by vote for a period of two years, with the possibility of being re-elected (CRSSF 2004). Despite these formal structures, in a study carried out by the Ministry of Health (MS 2004) on primary-level care given by the BTCC, participation was the worst performing element, a situation that has not improved since then.

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Equity

In 2002, through the PHC model, 812 BTCC covered 3 547 401 inhabitants (90% of the population). Costa Rica has one of the highest levels of coverage in Latin America, at 81.8%. However, there is no universal coverage, and the excluded populations are generally the poorest, the indigenous, and immigrants (PAHO et al., 2004).

It is important to point out that coverage is extended through other strategies but always under the direction of the CRSSF (Homedes and Ugalde 2002). One of these is the six cooperatives (NGOs) from whom the CRSSF buys services. Another strategy is "mixed-medicine", which means that the insured person pays for a consultation with a private physician registered with the CRSSF, and the CRSSF covers the laboratory tests and supplies the drugs. A third strategy is the "company physician" in which the corporate entity hires a physician who attends to its workers, and the CRSSF provides diagnostic services and medicine. Unlike the Cuban process, with predominance of the public sector, this situation in Costa Rica reflects a trend towards privatisation.

In one case study carried out in Barrio Nuevo, in the region of San José, the coverage rates for different services were 100% for first-time prenatal consultation, 82% for growth and development monitoring, 47.8% for preventive medicine, and 7% for family planning (Bonilla et al., 2006).

Concerning physical or geographical access to health services, 50% of Costa Ricans live 1 km away or less from medical care or primary care centres, but only 8% live this distance from a hospital (Rosero and Güell 1998). The average distance from a hospital is just over 5 km. The threshold of 4 km identifies 9% of the population with poor access to PHC and 13% with poor access to medical care. The reduction of the statistical difference in access is linked to the creation of the BTCC during the reforms of the 1990s. Thus, in the year 2000, inadequate access to health services was reduced from 30% to 22% in the areas where the reform was applied, while in the areas in which the reform had not been implemented, this proportion increased from 7% to 9% (Rosero and Güell 1998).

The CRSSF is funded by the contributions of salaried and non-salaried workers (35.3% of the total in 2004), employers (51.5%), pensioners (4.1%), and the government (8.9%; Rodríguez 2006). Part of the government contributions represents subsidies for salaried and non-salaried employees and pensioners.

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Efficiency

Between 1990 and 2004, the number of consultations per inhabitant increased for general medical services (from 1.19 to 1.56) and dentistry (from 0.21 to 0.46). On the other hand, specialist consultations, decreased (from 0.72 to 0.64; Rodríguez 2006). These tendencies may be a reflection of improved problem-solving capacity at the primary level of care. However, the number of emergency consultations also rose (from 0.51 to 0.95), which is worrying, since as well as being more expensive, it could mean that other services do not resolve all cases or that people use the emergency services to avoid the administrative paperwork of PHC.

Taking a longer historical perspective, in 1941 the infant mortality rate was 123.5 per 1 000 live births (32.3 for neonatal mortality and 91.2 for post-neonatal mortality), while in 2003 this had fallen to 10.10 (6.98 for neonatal and 3.13 for postneonatal; Villegas de Olazával 2005). According to the Ministry of Health, in 2008 the infant mortality rate decreased again to 8.9 per 1 000 infants (IPS 2009). Figures for maternal mortality are much less positive, however, with a significant rise of 85% between 2007 and 2008 (from 14 to 25 deaths per 100 000 live births). The causes of this rise are not yet known (IPS 2009).

Quality

In 2004 the Ministry of Health carried out a community study to assess the quality of health services provided by the BTCC (MS 2004). The classifications were as follows: less than 70% agreement was considered critical; from 70% to 79%, low; from 80% to 89%, acceptable; and from 90% to 100%, adequate. On a national level, the results obtained were 82% for

physical structure, 78% for human resources, 93% for material resources, 82% for rules and procedures, 62% for programming and administration, 95% for supplies, and 84% for health education. Although people are generally satisfied with the public health services, users are dissatisfied with the long waiting lists for surgical interventions and specialised services, the ways in which services are disorganised, and wait times for services or pharmacies (Homedes and Ugalde 2002). A national opinion survey found that 70.3% of Costa Ricans agreed with the phrase "The CRSSF is irresponsible because it does not have enough drugs for the insured" and 70.8% agreed that "Hospital services have deteriorated" (Poltronieri 2006).

In general, the public acknowledges the important role of the CRSSF in the development of the country. In an opinion survey (Poltronieri 2006), 70.4% of the population disagreed with the phrase "Social security must be privatized", 72.3% interviewees believed that "The CRSSF is too important to be run by politicians", 40.3% disagreed with the phrase "It is a good thing that the CRSSF brings in private health services", and 40.2% agreed with the phrase "The physicians are destroying the CRSSF in order to set up their own clinics".

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THE MINISTRY OF HEALTH IN THE FEDERAL DISTRICT OF MEXICO CITY (2000–2006)

Mexico is a federation formed by 31 states and a Federal District (or Mexico City), often with competing policy frameworks between states and the federal government. From the 1980s onwards, national governments have implemented neoliberal policies promoted by the World Bank and the IMF, including the privatisation and commercialisation of health care. In contrast, the local administration of the Federal District (during the period of 2000–2006) created policies aimed at restoring public institutions. Although this government was voted out in 2006, it is worth exploring the policies it implemented during that time.

To put these reforms in context, public health services have improved considerably since the 1940s but have never reached universal coverage, with services organised by people's work status: workers in the private and public sectors are covered by social security institutions, while the informal sector or non-salaried population and rural areas have services provided by local governments (called "states" in Mexico). According to the 2005 census, the coverage of both of these service groups is only 45.8% of total population (NISG 2005). The institution responsible for delivering these services is the *Secretaría de Salud,* which corresponds to a Health Ministry.

From the 1980s different measures have been implemented that have drastically affected these services, such as the decentralisation of PHC services from the national level to the states, the reduction of the governmental

budget for health from 3.4% of GDP in 1980 to 2.6% in 2000 (Tamez and Valle Arcos 2005), the introduction of a package with 12 specific health measures (as opposed to "comprehensive" care) that included prenatal care, family planning, growth monitoring, immunisation, home treatment of diarrhoea and respiratory infections, and prevention and management of diabetes, hypertension, and injuries (Gomez-Dantes et al., 2004), and finally the promotion of health insurance (*Seguro Popular*) financed by the government but which can be used both in public and private services (Laurell 2007). These changes to the public sector have happened alongside the growth of private health services (Eibenschutz et al., 2007).

The assessment carried out to form the basis upon which to build the local government of Mexico City's health policy identified the following problems: poor and unequal quality of services due to chronic underfunding and deficient and/or deteriorated infrastructure of public institutions; high rates of corruption and embezzlement of resources; an institutional culture that views health services as a handout and not a right; and inequality in accessing the benefits of the Federal District health system, given that the uninsured population had to pay directly for the services and pharmaceutical drugs (HMFD 2002).

Consequently, the target group of the Health Ministry of the Federal District (HMFD) was the population without social security, which represented up to 3.9 million people (Laurell et al., 2004). In addition, the uninsured population is more prevalent in neighbourhoods with higher levels of marginalisation (COPO-DF 2000, Laurell et al., 2004). Amongst the goals established by this administration were the reduction of inequality of health between social groups and geographic zones; the increase of timely access to required treatment; the decrease of inequality of access to sufficient and quality services; and the implementation of stable, sufficient, equitable, and supportive funding mechanisms (HMFD 2002). Consistent with the Mexico City government's social inclusion policy, the principle of public health policy is "the right to health as a civic right and, therefore, the government's responsibility to guarantee collective or common interest" (HMFD 2002, 21). Thus, the health programme for this period defined six strategies (HMFD 2002, Mussot 2007):

- The Free Medical Services and Drugs Programme (*Programa de Servicios Médicos y Medicamentos Gratuitos*, FMSDP) aimed at the uninsured population, which was free and included all services provided by the medical units of the Health Ministry of the Federal District and the pharmaceutical drugs listed in the institutional table of essential drugs. The HIV/AIDS programme and emergency services were also free, regardless of a person's insurance and place of residency.
- The Territorial Units Regionalisation System was created to try to locate and identify highly marginalised groups to give them intensive care and thus to allocate resources according to demand.

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- A new health care model, called the Expanded Health Care Model (*Modelo de Atención Ampliado a la Salud*) was implemented. This model consists of a series of integrated actions that cover four basic areas: sanitary and epidemiological vigilance, health promotion and education, building of a Unified Medical Emergency System (UMES), and extending citizen participation. The local government was committed to transparency in the use of public resources, and, therefore, the participation of citizens was promoted to supervise the application of programmes and definition of the health priorities in their neighbourhoods.
- Improvements to the buildings and maintenance or replacement of equipment; improvement of the technical quality of care and change in the institution's organisational culture; new organisational culture based on honesty, service vocation, and institutional loyalty values; good planning rather correcting bad actions; and promotion of the rationality and transparency criteria in the use of resources.
- To make the administrative process simpler and transparent and to optimise the medical supplies.
- Encouragement of citizen participation and social audits.

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Participation

Through the territorial units, the participation mechanisms for health services users were formalised, with 1 325 territorial units created (HMFD 2005). Formally, social participation took place in the neighbourhood assembly, whose principal objective was to inform and make transparent both the administration of the budget and the correct application of the social programmes. Another level of participation took place within these assemblies, as they elected local committees by universal vote. The aim of these was to involve citizens in specific tasks such as the environment, health, and crime prevention, amongst others. With respect to health, the local committees were made up of two levels of health committees (local and regional) through which were promoted and put into action the citizens' initiatives and proposals to the assemblies.

Information about the programmes and accountability would pass initially through the local assemblies, which would also be responsible for publishing and distributing it door to door. Data from 2006 provide indications of the access to and availability of the information in quantitative terms: from 2001 up to the first quarter of 2006, approximately 11.4 million letters were delivered door to door. These gave information on the social programmes for each territorial unit, informed inhabitants about the budget allocated to each of the social programmes applied in the territorial units, the number of actions and beneficiaries, and the institutions responsible for administrating them (DGPC 2006). However, this quantitative

data do not identify the beneficiaries' level of comprehension of the information received, nor do they tell us whether the population gave feedback to those in charge of the programmes.

Although social participation was a strategy of the health programme, no evidence of its successful implementation was found. The government employees in charge of the health policy have described the difficulties they faced in this field, acknowledging that the "historic absence of democratic and representative organizations has prevented the health commissions from being institutionalized" (Laurell 2008, 178). Likewise, there is no evidence of how the decisions, initiatives or observations of citizens during the participation activities were taken into account or not in the decision making or modification of programmes.

Equity

Within the health programme of this government, equity was defined as equal access to services for those with the same needs, which implies a commitment to guaranteeing the same level of services for all (HMFD 2002). One strategy that promoted equity of access was the convention signed by the public health institutions of Mexico City to create the Unified Medical Emergency Systems, which enabled emergency medical teams to see patients regardless of insurance and residency status. With the UMES there was a fall in the number of rejections and the time of journey to a hospital.

The government also initiated the universal pension scheme through a law that established the right to food pensions for seniors (*Gaceta Oficial* 2003), which consisted of monetary transfers to all citizens over 70 years of age residing in Mexico City, regardless of insurance or active job. In 2006, the coverage of this programme was 93.6% (IAAM-DF 2009).

Two speciality hospitals were created in the departments where highest demand was identified. One of these was located in a zone with a high density of people without social security insurance and a high level of marginalisation (Iztapalapa County), and it also had adequate transport and communication access to other counties.

The FMSDP, in order to confront the economic barriers to accessing health services, simplified the procedure of affiliation, which could be realised even at the time of receiving a service (*Gaceta Oficial* 2006). Between 2002 and 2006, it is estimated that this programme represented a savings of around US$356 million for affiliated families (Laurell 2008). The programme's "no-cost" principle was achieved through the health expenditure that came from fiscal resources; therefore, financial sustainability was ensured. In 2001, the Federal District government distributed local tax funds to health and social programmes operated by the HMFD to a sum of US$27.3 million, which represented an increase of 171% with respect to the previous year (HMFD 2005).

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Efficiency

By modifying the regulations, the HMFD achieved shorter delays for the purchase of medicine, the reduction of unused products, and savings in acquisition of materials (HMFD 2005). To ensure access to the services and to implement anti-discriminatory policies, the HIV/AIDS programme was assumed as priority, resulting in reduction of the AIDS mortality rate by 16% in four years and an improvement in detection and prevention (Laurell 2008).

Quality

In one assessment carried out on the FMSDP, it was observed that its beneficiaries – in comparison with those who were not insured – reported an equal waiting time (Laurell et al., 2004). In general, a high proportion of insured users rated the treatment received in public health services as good or very good (>85%). However, there was no difference between the beneficiaries of the programme and other services (i.e. social security services) in the quality of care.

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Transparency

The HMFD administration paid special attention to correcting the prevailing culture of corruption. This culture was seen in practices such as *clientelismo* (i.e. obtaining work benefits in exchange for being a loyal supporter of a leader or political party), position inheritance (when an employee "bequeaths" his or her position to a family member), or payments for a particular job or bureaucratic position.

The strategies implemented to fight corruption included applying rank guidelines for newly hired staff; setting selection exams based on the job profile diagram; improving the time of the payments and benefits systems (by decentralising the HMFD payroll, the delay for first payment of recently hired employees was reduced); improving the training and development programmes in all sectors of the institution; and ensuring that employees fulfil their obligations and remain in the service by applying work regulations and promoting a relationship with the union based on communication and respect (HMFD 2005). Finally, in order to comply with the Law of Transparency, in January 2004 the HMFD set up the Public Information Office (HMFD 2005), which supplied information on the services provided to different entities when requested.

VENEZUELA: "INSIDE THE NEIGHBOURHOOD MISSION"

In Venezuela, health care provision has historically come predominantly from the private sector. In 1997 this sector provided 73% of health services (Muntaner et al., 2006). The arrival of Hugo Chávez's government

represented a turning point in this regard. In 1999 the New Constitution of the Bolivarian Republic of Venezuela established that health is "a fundamental social right which is an obligation of the State, who will guarantee it as part of the right to life" (Article 83), that "the State will create, govern and manage a public national health system...integrated with the social security system, ruled by principles of no-cost, universality, comprehensiveness, equity, social integration and solidarity", and that "public assets and services are the property of the State and cannot be privatised" (Article 85). In addition, Article 84 of the Constitution establishes the participation of organised communities in the management of the health system.

The main health proposals implemented by the government of President Chávez since 1999 are, in chronological order: the application of the Comprehensive Health Care Model (1999) and the formulation of the Social Strategic Plan (2003; Alvarado et al., 2008). The Comprehensive Health Care Model was created to promote the PHC principles of the public establishments that existed at that moment and was replaced by the Inside the Neighbourhood Mission in 2003. The Social Strategic Plan was a policy instrument created to define the strategies to improve quality of life and health, which included the reorientation of public policies, the change of health care modelling, and the training of new public health leaders. This plan established the principles for the National Plan for Economic and Social Development 2001–2007 and the creation of new health norms and a national health system.

The Inside the Neighbourhood Mission programme originated from an act of solidarity by Cuban physicians when, in December 1999, they came to the help of communities affected by a flood in Vargas state. Following this experience, the mayor's office of the Libertador municipality signed an agreement with the Cuban government to implement this project in low-income neighbourhoods of Caracas (MPPSP 2009). The project was subsequently extended to other states, and, in December 2003, President Chávez created a Presidential Commission – the "*Misión Barrio Adentro*" in Spanish – whose objective is the implementation and institutional coordination of the Comprehensive Programme for the provision of PHC. This special commission was made up of the Secretary of Health and Social Development (currently the Ministry of Popular Power for Health), the president of Venezuelan Oil (*Petróleos de Venezuela*), the president of Inside the Neighbourhood, the president of the Unified Social Fund, the mayors of the municipalities of Libertador and Sucre, and representatives of the Francisco de Miranda Venezuelan Social Fighters Front (MPPSP 2009).

The Inside the Neighbourhood concept refers to the idea of penetrating into the heart of marginalised neighbourhoods and is characterised by the following (Alvarado et al., 2006, Armada et al., 2009, MPPSP 2009):

- Popular clinics are created for primary-level care. These offer general medicine services, pediatrics, care for senior citizens, pre- and

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post-natal monitoring, and emergencies. Vaccination, dentistry, and smear testing are provided in some clinics. Catchment areas are defined in which each unit attends to between 250 and 400 families, representing around 1 250 people.

- It is a comprehensive care model as physicians and nurses give six hours of medical care in the popular clinic and then carry out home visits. Dentists and community promoters also participate.
- Health promotion activities are carried out at the health units and in schools and workplaces.
- Social participation is promoted through the health committees, which are formed by formal and informal leaders elected by the community and supported by the medical staff. The health committees formulate specific interventions for health promotion, which can be granted by the government.
- Each medical unit gives training for community health promoters and health technicians, at a professional and post-graduate level.
- It includes intersectoral action as it aims to improve living conditions through the coordination of health actions with other social interventions. The Inside the Neighbourhood Mission is articulated with other Missions, with foci on education (Simoncito, Ribas, and Sucre Missions), land and property (Zamora Mission), employment (*Vuelvan Caras* Mission), food security (Mercal Mission and Programme of Scholar Meals), housing (*Hábitat*), and sports and recreation (*Barrio Adentro Deportivo*).

The Inside the Neighbourhood Mission has nationwide coverage, with 13 000 physicians, 8 500 assistant nurses, and 4 600 dentists. It provides care at 8 500 consultation points and covers nearly 17 million people (MPPSP 2009). There are also approximately 200 community leaders of the Promotional Strategy of Equity as Life and Health, who deal with the needs of about 150 communities in the metropolitan area of Caracas. Each of these communities collects socio-demographic information and identifies high-risk sectors of the population. This information must be used as the basis for plans and projects in these communities.

These reforms have not been introduced without resistance, however. In 2002, the Venezuelan Medical Federation organised a strike of physicians because the government forbid medical fees in public establishments (Alvarado et al., 2006). In 2003, the Federation discouraged its members from working with Inside the Neighbourhood Mission, and since that time, the Federation has opposed the participation of Cuban physicians in these missions.

Notwithstanding these protests, the Venezuelan government has maintained its stance on free public health care and has attempted to deepen its regulation of the costs of private clinics and strengthen its supervision of private insurance companies. Until now little resistance has been put up by

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the private sector on these latter initiatives, possibly because the sector is composed primarily of small medical companies.

Participation

The health committees are the organ of social participation in health and are elected in neighbourhood assemblies. Their main tasks include identifying the community's health problems in order to prioritise them and then define the actions to be taken (Alvarado et al., 2006). They perform management tasks that support the work of the popular clinic and the comprehensive diagnostic centre. In 2006 there were 8 951 registered committees, and these had held 1 432 815 community health assemblies.

The activities carried out in the Libertador municipality, a pioneer for Inside the Neighbourhood Mission, provide an illustration of social participation. In 2008, they held meetings with communities from different neighbourhoods within the municipality aimed at identifying and prioritising local problems and constructing a strategy of political advocacy in the municipal government. The result was a citizen's agenda that was proposed to candidates running for elections that year. Community councils, residents from various neighbourhoods, an environmental group, a neighbourhood association, and a technical institution all participated in drawing up this agenda (Unión Vecinal 2009).

Conversely, in one case study carried out in a health unit in the municipality of Campo Elías in the Mérida state, it was observed that there was no culture of solidarity or participation in resolving its problems within the community (Romero and Zambrano 2007). However, signs of incipient awareness of their obligations and rights as citizens were also identified by some members of the community. The population also showed that they believed that health was a subject of "shared responsibility between the State and the community" (Romero and Zambrano 2007, 207). Medical staff studies provided further evidence of the need for greater communication with the communities they served.

Equity

The Inside the Neighbourhood Mission was created to provide care for the population of marginalised areas, which, generally speaking, have less access to health services; hence, equity is the core of the programme. Article 85 of the Constitution of Venezuela stipulates that "the funding of the public health system is the obligation of the State", while Article 86 establishes that "every person has a right to social security as a non-lucrative public service...Absence of contributory capacity will not be a motive for excluding people from its protection...The contributions...may be administered for social purposes only by the governing body of the State."

In regard to access to prescription drugs, in 2003 drug modules were created, the task of which was to distribute 106 essential pharmaceuticals

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for free. A fortnightly distribution scheme delivers drugs to the popular clinics according to the demand made by the medical staff, based on the health needs of their area (Alvarado et al., 2006).

Sustainability

The programme's resources come from the Ministry of Health's regular budget, as well as from extraordinary resources from the sale of oil and a development fund (Alvarado et al., 2006). This is worrying as the latter two sources are not stable resources, bringing into question the long-term sustainability of the programme.

Efficiency

The number of medical visits has risen as a result of these reforms. While at the start of the Inside the Neighbourhood Mission less than 10 000 000 medical visits were registered, in 2004 there were 76 152 978 (Muntaner et al., 2006), and in 2007 approximately 236 458 980 (MPPSP 2009). Infant mortality dropped between 1998 and 2005 from 21.4 to 15.5 cases per 1 000 live births, while maternal mortality increased from 50.6 to 59.9 for each 1 000 live births (MPPSP 2009; with the latter figure possibly due to a higher rate of reporting that has accompanied the expansion of formal health care provision and not necessarily a rise in actual incidence of maternal mortality). Nevertheless, a long-term assessment of the Inside the Neighbourhood Mission is called for.

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CONCLUSIONS

Given the social, political, and economic structures of the countries selected for this review, we have four very different experiences. Cuba is a socialist country that has based its social and health policy on collective well-being and a social distribution of resources that has given total predominance to public action for five decades. Venezuela is a country that, under the presidency of Chávez, has decided to try to implement socialism at a time with few international allies and internal corporate resistance. Costa Rica has social policies more advanced than other capitalist economies of the region but still experiences problems trying to contain the effects of neoliberalism, while Mexico is a country marked by an almost blind adoption of the policies of the IMF and of the World Bank for more than 30 years but which nonetheless saw the election of a social democratic government in the Federal District based on the principles of civil participation and social justice. That is to say, national health systems in general, and their primary health programmes in particular, cannot be examined in isolation; nor can they be seen as a simple question in terms of addressing the

health-sickness profiles of countries. Health care services are determined by socio-economic structures, the historic trajectories of a country, and power distribution within a society.

Cuba and Costa Rica are outstanding insofar as they have achieved high coverage levels through the provision of public services financed through contributions from employers and employees (in the case of the latter country) and general taxes. These two cases are evidence of how the principles of solidarity and equity can be achieved in peripheral countries, either through a social-democratic (Costa Rica) or socialist system (Cuba, and more recently Venezuela). The countries also suggest that it may only be possible to have equitable and/or universal health care systems when there exists a dominant public sector that guarantees access to medical care services and which is relegated sufficient resources.

The four cases discussed here have in common restricted financial resources, which limit the provision of public services in vital areas such as health. Thus, despite placing health at the centre of the governmental agenda, in each of the cases public service funding is still a constraint. Venezuela's ability to draw on oil revenues has allowed that country to increase its social spending rather dramatically, but it also raises serious questions about the long-term sustainability of that government's initiatives. On the other hand, the case of Costa Rica, and especially that of Cuba, demonstrates that even low-income peripheral countries can guarantee financial sustainability of national health services, ensuring long-term health access.

Regarding efficiency, we found that Cuba and Costa Rica, with the strongest public health systems, are amongst the countries with the best performance in health indicators. They also present the best epidemiological profiles, a product not only of health services, which have been developed over the past 40 years, but also due to the generally higher quality of living conditions in these countries as compared to other states in the region.

The use of "efficiency" to measure performance can be problematic, however, as it is one of the key principles used to promote neoliberal reforms in the health sector, whereby health services are evaluated using narrow cost-benefit principles and intervention-time ratios. From a social medicine perspective, efficacy takes priority (i.e. the improvement of health) over efficiency. What is more, it is possible to increase the efficiency of services by carrying out a large number of activities (e.g. health education talks) which have minimal impact on a population's health.

Although in all the cases discussed, there are formal structures of participation, the available data show little evidence that the population exerts any determining control over the programming and provision of health services. Adequate social participation exists only in isolated cases (certain cities or municipalities), but the general assessment shows that participation has decreased. The absence of social participation could be the result of the conservative or non-democratic nature of Latin American states (Barba

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2008). As a result, only certain segments of populations have achieved real social citizenship (i.e. their economic, social, and political rights are realised), while other ones are excluded. This conservative character could explain the absence of information on accountability and transparency as well.

Citizenship could be built by participating in organisations that are independent of the state such as organisations fighting for health on an individual and collective level and for the right to health in broad and collective terms. This growth of civic awareness is also a goal of PHC but is not always taken into account (Eibenschutz 2000). To summarise, incomplete citizenship is an obstacle and a challenge for PHC.

The role of the physician's guild must also be considered. For example, at the beginnings of the revolution in Cuba, and more recently in Venezuela, physicians have been reluctant to participate in PHC services since hospital work is generally valued over primary care work. In addition, in Venezuela private practice has been protected over the public one. In both countries part of the solution found for dealing with the bias of the physician against PHC has been the incorporation of research and teaching activities into PHC services.

It is a known fact that successful experiences of the so-called public-private mix in health care rest on the regulatory capacity of the state to ensure the complementarity of the private services and the quality of the public services, supported by a reasonable budget with which to run it. On the other hand, the experience of Latin American countries indicates that promotion of the private sector nearly always entails the progressive deterioration of public services, as part of the government's resources are allocated to the private sector.

In future debates the question of regulation – referred to by some authors as modulation – must also be covered (Londoño and Frenk 1997). In other words, although in most societies it might not be feasible to eliminate private sector participation in medical service provision, this participation must be complementary to the governing role that the state plays in the funding, management and provision of health services. Therefore, in parallel to the opening up of the health systems into more open and diverse structures, regulations would have to be strengthened.

The regulation process must happen transparently and through public offices that act neutrally. Additionally, offices that participate in this activity must be predominantly public. The regulation must include policy building, strategic planning, establishing of priorities for the allocation of resources, intersectorial action, social mobilisation for health – including community participation – and the development of criteria and standards to evaluate the performance of financial agencies, coordinating organisations, and individual and institutional benefits. The fact remains that some Latin American states do not have the governance capacity or competence to achieve this.

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