Postneoliberal Public Health Care Reforms: Neoliberalism, Social Medicine, and Persistent Health Inequalities in Latin America

Several Latin American countries are implementing a suite of so-called "postneoliberal" social and political economic policies to counter neoliberal models that emerged in the 1980s. This article considers the influence of postneoliberalism on public health discourses, policies, institutions, and practices in Bolivia, Ecuador, and Venezuela.

Social medicine and neoliberal public health models are antecedents of postneoliberal public health care models. Postneoliberal public health governance models neither fully incorporate social medicine nor completely reject neoliberal models.

Postneoliberal reforms may provide an alternative means of reducing health inequalities and improving population health. (*Am J Public Health.* 2016;106:2145–2151. doi:10.2105/AJPH.2016.303470)

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Issues related to inequality in public health have played a prominent role in Latin America. Since the mid-20th century, the Latin American social medicine (LASM) movement, which addresses the unequal health consequences of capitalist development for social groups, has brought inequality to the forefront of public health discussions.[1] Proponents of LASM typically conceptualize health as socially determined and as a social right, and advocate for state-provided health care.

In recent decades, neoliberal reforms have overshadowed the LASM movement. Neoliberalism typically refers to minimal government intervention, laissez-faire market policies, and individualism over collectivism[2] and has been adopted by—and pressed upon—the majority of national governments and global development institutions. Although some health outcomes have improved in the past several decades, neoliberal policies have contributed to the privatization and individualization of health care, resulting in growing health inequalities in Latin America[3] and globally.[4] Recently, several leftist governments have introduced so-called "postneoliberal" reforms to push against neoliberalism.

Here I contend that postneoliberal public health governance models neither fully incorporate social medicine nor completely reject neoliberalism. Consistent with the LASM movement and social medicine perspectives, postneoliberalism firmly recognizes public health as a sociopolitical endeavor, democratizes health reform, and ensures that health is a state-guaranteed social right. Furthermore, postneoliberalism pushes the boundaries of social medicine by emphasizing interculturality and "collective well-being." Yet, postneoliberal models maintain many neoliberal characteristics, including expanding extractive industries to fund social programs such as health care and preserving a partially privatized health care system that contributes to segmentation and fragmentation. Examining these changes and paradoxes is critical to understanding and ameliorating public health in Latin America and globally.

To assess key features of emerging postneoliberal public health governance models, I briefly review the history and influence of social medicine theory and practice and examine the characteristics of neoliberalism and its effects on public health in Latin America. Also, I explore the similarities and differences among social medicine, neoliberalism, and postneoliberalism in Bolivia, Ecuador, and Venezuela, with examples from across Latin America included when pertinent. I reviewed published and unpublished literature as part of my analysis, including policy and development reports and peer-reviewed articles written in Spanish and English by researchers, state officials, and nongovernmental organizations.

LATIN AMERICAN SOCIAL MEDICINE

LASM traces its origins to the mid-19th century. German physician and social scientist Rudolph Virchow situated health and disease in their social context and argued in favor of prevention, a state-sponsored health worker program, and state-guaranteed material security such as employment.[1,5] Virchow influenced Salvador Allende, who, first as minister of health (1938–1942) and later as president of Chile (1970–1973), introduced social medicine policies nationally and inspired change across Latin America.[1,6]

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LASM recognizes that health is determined by myriad social, political, economic, and environmental factors,[1,7] thereby distinguishing itself from the biomedical focus of mainstream medical practice. Furthermore, and in line with the Alma-Ata Declaration,[8] social medicine prioritizes healthy equity, intersectoral collaboration (i.e., promotion and coordination of health actions by different sectors), and citizen participation. However, whereas LASM views health as a goal in itself, the Alma-Ata Declaration conceives of health both as a goal and "as an avenue for social and economic development."[9(p80)]

According to Waitzkin et al.,[1] LASM is distinguishable from contemporary mainstream public health in 2 essential respects.[1] First, in "[conceptualizing] health-illness as a dialectical process and not as a dichotomous category,"[1(p1594)] LASM avoids positivist and reductionist public health frameworks[10] that fail to recognize the relation between health and illness as well as the continuum on which they are situated. Second, LASM focuses on social units of analysis, including economic production and social class.[1,7,11] By contrast, contemporary mainstream public health defines populations as the sum of individuals' characteristics. Social medicine, in its pursuit of social justice and health equity,[10] is a political project insofar as it promotes a dialectical relationship between theory and practice—termed praxis—to address the sociopolitical origins of inequalities and illness.[1,11,12]

LASM is implemented at various levels throughout Latin America and influences health movements and reform around the world. Since the 1970s, numerous centers of investigation and pedagogy, academic journals, organizations (e.g., the Latin American Association of Social Medicine [ALAMES]), and grassroots groups (e.g., the People's Health Movement) have assisted in the dissemination of social medicine theory, pedagogy, and practice.[7,13–15] Interest in and awareness of LASM have increased as a result of persistent health inequalities[16] and widespread acceptance of the social determination of health model.[17]

Since the 1990s, the LASM movement has worked to "demystify" and evaluate the failure of neoliberalism and its effects on Latin America's health care system.[3,14] In recent years, well-known leaders in social medicine have occupied high-ranking positions in national governments: Nila Heredia, former general coordinator of ALAMES, was twice the minister of health of Bolivia, and Oscar Feo, former deputy general coordinator of ALAMES, is the national coordinator of a community health program for physicians in Venezuela.

NEOLIBERAL PUBLIC HEALTH

The Latin American debt crisis of the early 1980s, coupled with US-supported dictatorships and democracies, resulted in a wave of neoliberal and structural adjustment policies developed by economists from the United States and Latin America alike. The International Monetary Fund (IMF) and the World Bank perceived mounting public debt to be a result of state inefficiency, bloated social spending, and economic policies that hindered the market economy.[3] In exchange for economic loans, these 2 organizations required Latin American countries to adopt a suite of neoliberal ideological reforms that cut social spending (particularly in the health sector[18]), reregulated the economy in favor of free and open markets, privatized state-owned corporations and services, and opened borders to foreign investment.[2] At present, neoliberal ideology emanates from states, global development institutions, multinational corporations, and nongovernmental organizations.[19]

Although the application of neoliberalism varies by context, broad patterns have emerged. In contrast to social medicine perspectives and the Alma-Ata Declaration,[8] a fundamental belief associated with neoliberal health reforms is that the private sector is more efficient than the public sector. Under neoliberalism, the private sector is contracted to provide health services and insurance, with the state monitoring and regulating the health care sector. In practice, market-oriented policies have precipitated selective over comprehensive primary health care to cut costs; the latter, although described as a "best solution," was deemed too expensive and complex to implement.[18,20(p967),21] Market-oriented policies prioritize profit and efficiency over delivery of services, cost–benefit analyses, freedom of consumer choice, decentralized decision-making, and competition among private entities.[22]

In emphasizing biomedical, specialized, and curative health care practices, neoliberalism minimizes the social determination of health model foundational to social medicine.[23] In addition, the public sector typically provides health interventions that do not yield profits for corporations or are not sponsored by loans from the World Bank.[3] Finally, under neoliberalism, what is deemed acceptable practice according to "expert" knowledge curtails individual decision-making and disparages local and indigenous beliefs and practices.[24] Negative health outcomes are perceived to be the result of individual choice as opposed to market deficiencies.

Neoliberalism deeply transformed the Venezuelan, Ecuadorian, and Bolivian health care systems. Following World Bank mandates, Ecuador and Bolivia slashed their health care budget and decentralized health care decision-making and funding, resulting in wide-scale privatization of health care services, delivery, and insurance, which led to structural segmentation and fragmentation.[25–27] Because of the high costs of private health care, significant disparities in health care spending by sector were common: the Ecuadorian state spent less than one fourth as much on citizens with public insurance as it did for those covered by social security.[28]

In addition, each country introduced a fee-based program to recover costs, thereby further excluding the poor from accessing health services. In Ecuador and Bolivia, particularly, neoliberal reforms focused on curative and hospital-based care, drawing attention away from the social determinants of health.[27,29] Moreover, the cultural beliefs and practices of indigenous groups often clashed with health reforms grounded in Western biomedicine, thereby negatively affecting health care use.

THE POSTNEOLIBERAL ERA

Latin American countries have seen the emergence of

postneoliberalism, a budding alternative political economic model stemming from growing social inequalities, since the turn of the century and, in particular, the 2008–2009 global economic crisis. In adopting core values including equality, solidarity, and indigeneity and reforms such as redistributing capital surplus, strengthening state–society relations, prioritizing marginalized populations, and promoting alternatives to development discourses, postneoliberalism draws from liberal, Marxist, socialist, postmodern, and postcolonial thought and is championed by social movements, left-of-center political parties, indigenous populations, and international nongovernmental organizations.[30–33]

Postneoliberal transformations are visible in Venezuela, Bolivia, Ecuador, Chile, Brazil, Argentina, Uruguay, Mexico, Nicaragua, Honduras, and El Salvador, although conceptualizations and implementation vary by context. Importantly, postneoliberalism typically exists alongside neoliberalism, resulting in contradictions and paradoxes.[34] Consequently, some academics perceive changes as the rise of a socially conscious variant of neoliberalism labeled "inclusive neoliberalism"[35] or "social neoliberalism."[36(p8)]

POSTNEOLIBERAL PUBLIC HEALTH

As political ideologies and practices profoundly affect public health governance, health outcomes, and health inequalities,[37] postneoliberal changes influence public health in Latin America. In the remainder of this article, I examine how emerging postneoliberal public health care models draw on and transform both social medicine and neoliberal models to reconfigure public health governance in Latin America. Analyzing unified single public health systems, comprehensive and intersectoral health care, solidarity participation and financing, interculturality, the concept of "living well," and equity-oriented health care, I explore the foremost changes to health care discourses, policies, institutions, programs, and practices introduced in Venezuela, Ecuador, and Bolivia.

Unified Public Health System

The majority of health care systems in Latin America are fragmented, segmented, and laden with inequalities because of privatization reforms.[25] Although some view universal health coverage (UHC) as a panacea,[25,38] Heredia et al. aptly noted that it is "an ambiguous term."[39(p35)] Social medicine proponents typically conceive of UHC as a single public health system that is the obligation of the state.[39] However, under neoliberalism in Mexico City, the World Bank–inspired notion of UHC refers to market-oriented universal health insurance coverage.[40] Therefore, adoption of UHC does not necessarily signal postneoliberal change, as reforms may be part of neoliberal restructuring.[40]

Against World Bank and IMF advice and resistance from the private health care sector, physicians, and economic elites, several Latin American countries are taking steps to institutionalize a public, free, single health care system.[41] Cuba, Brazil, and Costa Rica have functioning, advanced single health care systems, although the private sector perseveres in Brazil and, to a limited extent, in Costa Rica.[41–43] Buoyed by constitutional guarantees of state-provided, equitable, universal, and cost-free primary and preventive health care, Venezuela, Bolivia, and Ecuador have increased funding for public health care and are advancing toward a single health system.[25,41,44]

In neoliberal contexts, the private sector typically governs the majority of the health care sector, whereas the state attends to low-income populations. However, the rewritten constitutions of Bolivia (2009), Ecuador (2008), and Venezuela (1999) define health as a state-guaranteed social right. The Venezuelan and Bolivian constitutions explicitly prohibit privatizing public health care services, although both recognize and promise to regulate the existing private health care system.

At present, each of the 3 countries is characterized by a public and a private system. Venezuela has made the greatest steps toward a single health care system. The public sector comprises the Ministry of Popular Power for Health and several social security institutions.[45] *Misión Barrio Adentro* (Inside the Neighborhood Mission; hereafter MBA), created in 2003 by the Venezuelan state to increase access to health care services in marginalized neighborhoods,[46,47] serves noninsured populations.[45] Ecuador's public health care sector is divided into 3 user groups: people of low socioeconomic status, government workers, and formal sector employees and rural populations.[29,44] Although Ecuador has proposed a unified single public health system, it has yet to materialize. Bolivia's public sector is decentralized to 4 levels (national, departmental, municipal, local).[48] Public health services are divided into 2 user groups: people of low socioeconomic status and the formal sector.[49]

Comprehensive and Intersectoral Health Care

In recent years, several Latin American countries have adopted comprehensive public health models (Table 1) that engender rights-based, intersectoral, participatory, and equity-oriented health care.[50] The models recognize and incorporate a multiple-determinants-of-health perspective and reinforces the notion that health is the responsibility of the state rather than the individual. Variation exists across national contexts. For example, Bolivia's public health care model, termed intercultural community family health, encourages broad participation while incorporating both Western and indigenous (traditional) medicines.[51]

Intersectoral health care involves collaboration among various public sectors,[50] leaving behind the neoliberal notion of health as best addressed by vertical and isolated programs. In Bolivia, Ecuador, and Venezuela, new national-level institutions fundamentally link health to other state-guaranteed rights. In general, the ministries (Table 1) discuss health and well-being in relation to gender equality, plural economic models, and respect for and incorporation of indigenous culture, among other determinants of health. In addition, intersectoral community health worker programs increase health access for traditionally marginalized groups (low-income, rural, and indigenous populations) and underscore prevention, countering the outdated neoliberal

TABLE 1—Examples of Postneoliberal Institutional Changes, Public Health Models, and Local Health Worker Programs in Latin America

Country	State Institution or Position	Public Health Model	Community and Health Worker Programs[a]
Bolivia	Vice Ministry of Traditional Medicine and Interculturality; Vice Ministry of Decolonization	Family, community, and intercultural health	Local health committees; mobile teams
Ecuador	Ministry of Economic and Social Inclusion; secretary of Buen Vivir	Family, community, and intercultural comprehensive health care	Basic health care teams; comprehensive health care service teams
Venezuela	Ministry of Popular Power for Health; Ministry of Popular Power for Ecosocialism, Habitat, and Housing[b]; Ministry of Popular Power for Women and Gender Equality[c]	Communitarian comprehensive health	*Misión Barrio Adentro*; health committees

[a]State-supported community health worker programs.
[b]Formerly 2 ministries: Ministry of Popular Power for the Environment and Ministry of Popular Power for Housing and Habitat.
[c]Formerly Ministry of Family.

logic of care that is hospital based, individual, and curative.[41]

In Bolivia, mobile health teams include a sociologist or social worker who functions as an intercultural broker, works with traditional healers, and assists in organizing local health committees. These teams represent an improvement on the health brigades financed by the World Bank, which lacked an intercultural component and did not report to Bolivia's Ministry of Health.[52]

Solidarity

Solidarity participation in health care. Solidarity is a key factor in achieving health goals under postneoliberalism[53,54] and can refer to participatory democracy or shared financial resources. In the former, the state expects citizens from all socioeconomic backgrounds to work collaboratively to ensure that the constitutional requirement of health as a social right is met.[46] By contrast, under neoliberalism health care decision-making is decentralized from the national government to a lower administrative level (i.e., remaining out of citizens' reach) and incorporates expert knowledge from global institutions. Furthermore, community participation serves as a means to devolve state responsibilities to individuals to cut state health care budgets.[55]

Participation in Venezuela differs from neoliberal health models insofar as it is collaborative and occurs alongside increased state provision of health care.[56] Venezuelans participate in local health councils, lead public health campaigns, and make decisions about services, thereby democratizing health care decision-making and reform (Table 1) and exemplifying a horizontal power and solidarity model.[46,57]

International cooperation among nation-states with similar social, political, and economic orientations promotes solidarity at the macro level. South–South cooperation slightly disrupts neoliberal political economic hegemony in the region insofar as it interrupts how a fraction of all trade and aid policies are dictated. The Bolivarian Alliance for the Peoples of Our America, for instance, developed in 2004 as an alternative to the proposed Free Trade Area of the Americas, an extension of the North American Free Trade Agreement.[58,59] The alliance promotes self-sufficiency, participatory democracy, and collective development through interregional trade and public service cooperation among its members: Venezuela, Cuba, Bolivia, Ecuador, Nicaragua, and several Caribbean nations.[58,60] Notably, market fluctuations may affect aid as cooperation is driven by the alliance's articulation to the petroleum market.

In addition, Cuba disrupts the typical North–South flow of health discourses and practices of the World Bank, IMF, and the US Agency for International Development, among others, that have long influenced Latin American public health governance.[46,51,61,62] Cuba implements social medicine in Latin America by attending to impoverished populations and educating and training thousands of Latin American medical personnel annually. More needs to be done to integrate graduates into health systems that differ structurally and strategically from that of Cuba.[63]

Solidarity health care system financing. Solidarity health financing schemes are recognized as being integral for expanding access to health care.[64] Solidarity-based schemes, which are implemented in various configurations across Latin America, pool financial contributions from several sources (e.g., citizens, private enterprises, the state) to ensure access to health care services regardless of citizens' financial contribution to the system.[64] Solidarity-based financing schemes are necessary because of the failures of neoliberal capitalist development. Consider that the World Bank's *World Development Report 1993: Investing in Health*,[65(p5)] a blueprint for neoliberal health policy,[18] advocates for public funding for "essential clinical care [since] private markets will not give the poor adequate access to essential clinical services or the insurance often needed to pay for such services." Postneoliberal governments differ, however, in that they seek to provide citizens with both cost-free primary and preventive services regardless of socioeconomic status.

As classified by financing sources, Bolivia, Ecuador, and Venezuela demonstrate a tripartite (public, social insurance, and private) health system.[26] Social security and public funds continue to be segmented.[26] In Venezuela, health care financing remains centralized,[66] whereas Bolivia and Ecuador continue to adhere to the decentralization model imposed by the World Bank.[67] Each maintains financial solvency through mandatory contributions from diverse sources, including employers, formal sector employees, private and public health insurance

providers, and the state.[29,44,45,49,53] In addition, profits and taxes from neoliberal and colonial resource extraction industries, which have a negative impact on the environment and undermine indigenous territorial rights, are crucial to maintaining social medicine health care practices.[68–73]

Interculturality

Bolivia and Ecuador, both of which contain a high percentage of indigenous people, ground health care in the principle of *interculturalidad* (interculturality). Interculturality denotes the dialectical relationship between 2 people "that should optimally occur in an environment of respect, reciprocity, and honest exchange of beliefs and practices, resulting in mutual growth, enrichment, and transformation."[51(p141)] That health systems reflect interculturality exemplifies the notion that health care systems are simultaneously social and cultural.[74] The Bolivian and Ecuadorian constitutions guarantee access to health care that respects and incorporates indigenous cosmologies and practices into Western medicine, thereby threatening the medical establishment's dogmatic and dominant biomedical health discourses.

In practice, indigenous traditional medicine perspectives complement—but do not replace—Western biomedicine. In Bolivia, recognizing indigenous health practices is crucial to increasing access to health care in rural areas. Some regions have succeeded in promoting intercultural health and traditional medicines by establishing an accreditation program for healers.[51] However, the majority of indigenous groups remain underrepresented.[75] Also, conflict in cross-cultural interactions continues to exist (e.g., some Western-trained physicians refuse to work alongside traditional healers), necessitating additional cultural training of biomedical health care providers.[76] In Ecuador, mental health services remain Western oriented and fail to recognize traditional medicine or incorporate intercultural perspectives.[77] Such shortcomings demonstrate racial discrimination, the hierarchical character of health knowledge, and a general lack of medical pluralism, thereby contributing to the persistence of health inequalities.

Living Well and Collective Well-Being

Further drawing from indigenous cultures, Ecuador and Bolivia have redefined the goal of development from economic improvement to the *Buen Vivir*[78,79] ("living well") model. Similar to social medicine, *Buen Vivir* conceptualizes health and illness in relation to one another.[30] The model opposes neoliberalism's propensity for individualism by considering individual health and well-being in relation to society, which is interconnected with sociocultural, environmental, and political economic processes. Indigenous knowledge and practices displace Western-inspired conceptualizations of development, progress, and modernity.[30,78,79] As a post-development policy, *Buen Vivir* challenges capitalist development models that are remnants of the colonial period.[30] Importantly, critics point out that *Buen Vivir* depoliticizes the class, gender, and ethnicity inequalities that led to its emergence at the national level.[41]

In Ecuador, *Buen Vivir* is written into the country's constitution as a set of rights that guarantee health, housing, and access to a healthy environment. In addition, *Buen Vivir* secures rights for citizens and the physical environment,[80] both of which are commonly exploited in neoliberal capitalist development.[81] *Buen Vivir* influences Ecuador's comprehensive familial, community, and intercultural health care model, particularly its focus on examining the social and biological determinants of health across levels (individual, family, and community).[82] In Bolivia, *Buen Vivir* is a set of ethical and moral principles, plays a prominent role in the national development plan,[83] and is promoted by the Vice Ministries of Interculturality and Decolonization.[79]

Equity-Oriented Health Care

Across Latin America, health is a right regardless of the political economic orientation of a country.[25] Venezuela, Bolivia, and Ecuador guarantee access to health care without discrimination; people of low socioeconomic status, women, the elderly, and indigenous peoples are identified as populations historically underserved under neoliberalism. A major objective of the country's national and regional programs is to increase access to care by providing free health care and reduced-cost medicines; in Latin America, private, out-of-pocket spending represents 45% of total health spending.[64] Despite recent advances, decades-old neoliberal policies have contributed to the creation of limited public health sectors in Venezuela, Ecuador, and Bolivia; consequently, each country contracts services to the private sector.

In Venezuela, MBA has resulted in increased numbers of medical personnel and cost-free health sites for primary care, diagnostics, and rehabilitation; notably, citizens from all income groups use MBA services, although the lower one half of the population by income accounts for two thirds of all users.[46,54,84] According to government data, 70% of the population that previously lacked primary health care had received it as of 2003.[54] Under the Hugo Chávez regime, 55.1% of government health spending in 2008 was allocated to the private sector, a decrease from 73% in 1997 (during the pre-Chávez era).[45,70] Rural areas remain least likely to have access to health care, and some citizens refuse to seek out public health care services owing to political ideology differences with the Chávez and Nicolás Maduro administrations.

In Ecuador, recent advances, including cost-free health care services, have increased health care access and reduced segmentation.[28] In the first year of the Rafael Correa administration, the Ministry of Health's budget increased by 70% and morbidity consultations by 50%.[29] Despite the provision of cost-free health care services by public institutions, the poor are more likely to seek out private (52%) than public health care owing to better-quality care, easier geographic access, and reduced waiting times.[29] Notably, rural and Amazonian provinces are more likely than urban provinces to experience decreased access to health care, service provisions, and public health posts.[28] The mechanisms for delivering care—namely, contracting services to the private-for-profit sector, as occurred under neoliberalism—have not changed.[29] In addition, there are concerns that the Ministry of Health cannot

adequately regulate and control private health care providers.[29]

It is unclear whether access to health care has improved in Bolivia, although data show that inequalities in access to health care persist. Today, the populations most likely to be excluded from health care services are rural, between 10 and 59 years old, indigenous, or illiterate; live in extreme poverty; or lack health insurance.[27] Also, the private sector dominates the individual health care market, whereas the state attends to communicable disease programs and maternal and child health.[52] Conditional cash transfer programs sponsored by the World Bank increase access to health services in Bolivia and Ecuador and across Latin America.[44,85] However, critics point to conditional cash transfer as an example of "inclusive neoliberalism" because it fails to address the structural causes of inequalities (e.g., a capitalist system), is funded through natural resource exports, and does not incorporate *Buen Vivir*.[86]

CONCLUSIONS

A public health experiment with global relevance is under way in several leftist Latin American countries. Populist reforms in Bolivia, Ecuador, and Venezuela seek to democratize health care planning and delivery, emphasize state and civil society collaboration around health and social issues, implement intercultural approaches to health care, and improve access to health care services. However, against perceptions of a divide among leftist (i.e., Bolivia, Ecuador, and Venezuela) and neoliberal states,[55] my analysis shows that neoliberalism and inequalities persist in nations considered to be most socially progressive.

That health care services, delivery, and insurance remain privatized, resulting in segmentation and fragmentation, is but one of several indications that Venezuela, Ecuador, and Bolivia have not implemented transformative structural changes. The perseverance of neoliberalism and inequalities is not necessarily an indication that reforms have failed; we must recognize that health care achievements in Venezuela, Ecuador, and Bolivia increasingly are threatened by destabilization attempts, including economic sanctions and direct interventions in the health care system, military, and media, as well as fluctuations in the global hydrocarbon market.

Despite the limitations of postneoliberal reforms, as public health scholars we should pay attention as they offer a suite of potential alternatives to neoliberalism, alternatives that may provide a clearer (and better) path toward reducing health inequalities and improving overall population health. Public health officials, practitioners, and scholars need additional data to determine to what extent so-called postneoliberal health governance models have translated into practice and improved health outcomes, particularly for traditionally marginalized populations. Understanding and analyzing recent reforms is crucial for overcoming the limitations of neoliberal health care models and implementing a socially just health care model that reduces health inequalities in Latin America and globally. AJPH

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