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Health systems reforms in Latin America: neoliberal influences and challenges to the Sustainable Development Goals

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Abstract *This study analyzes the characteristics of health system reforms in Latin American and Caribbean (LAC) countries, the trend of public health spending, and the achievement of the Millennium Development Goals (MDGs). It also discusses the neoliberal influences on public health reforms and the possible consequences for the upcoming Sustainable Development Goals (SDGs). The study is a comparative, non-exhaustive literature review of selected countries, with data extracted from CEPALStat, Global Health Observatory, MDG Indicators platforms, and the Health in the Americas reports available in the Institutional Repository for Information Sharing of the Pan American Health Organization. The reforms were divided into three periods, namely: up to 1990, with a prevailing regulated national solidarity logic; 1990-2000, moving towards a market-oriented competitive logic; 2001-2015, evolving towards public logic programs, maintaining competition between service providers. Public spending fluctuated over time, and the MDG targets analyzed were not completely met. Changes in health systems followed the models prescribed by neoliberalism, with market-oriented competitive logic, weakening the care system and the achievement of the SDGs.*

Key words *Health system, Health reform, Latin America; Millennium Development Goals*

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Introduction

This paper enquires whether the neoliberal nature of health system reforms in the 1990s in Latin American and Caribbean (LAC) countries can contribute to explain the incomplete achievement of the Millennium Development Goals (MDGs) and points toward challenges to achieve the Sustainable Development Goals (SDGs).

The MDGs were defined in 2000 at the Assembly of the United Nations (UN) as a commitment of the 191 member countries, with targets set for achievement by 2015[1-3]. The post-2015 Agenda came into play from then on, expressed in the Sustainable Development Goals (SDGs), which aspire to transcend the MDGs by 2030, incorporating other dimensions in health policies[2-4].

While representing a commitment to health care outcomes, the MDGs/SDGs tend to homogenize health policies, with a basic care package mainly aimed at some infectious and contagious diseases. The MDGs/SDGs also materialize health strategies promoted by international organizations committed to the neoliberal agenda of creating and expanding markets, especially in health insurance. They are based on the adoption of *Universal Health Coverage*, a concept compatible with economic neoliberalism and which conceives health as a commodity. This conception is in line with a reduced state intervention, restrictions to the regulation of the system, and a separation between the financing and purchasing functions of health services. In contrast, based on social welfare, the *Universal Health Systems* are in the hand of the state, which are responsible for financing, managing and providing health services, and ensure that health is a universal right[4-5].

The territorial and geopolitical space called LAC comprises 20 countries that are very diverse in terms of history, culture, sociodemographic, and economic characteristics. These countries have all experienced radical changes in the processes of colonization, emigration, immigration, and commercial and technological exchange[6]. Their economic and social development has been characterized by cycles, with different politico-social consequences in each of them.

The 1980s feature the LAC debt crisis that led countries across the continent to default on loans, starting with Mexico in 1982 and spreading across the continent[6-10]. As of October 1983, 27 low- and middle-income countries, many in the Americas, were defaulting on their loans or were in the process of debt rescheduling[6]. During this period, the International Monetary Fund (IMF) and the World Bank (WB) were called upon to provide loans to debtor countries. Associated with these loans were recommendations (conditionalities) for implementing economic measures aimed at opening markets and meeting the neoliberal prescriptions of the Washington Consensus. Proposed reforms included drastic cuts in government spending (particularly in health and other social sectors) and policies that dismantled the fragile and incompletely implemented welfare state in LAC[9-11].

For the health sector, the agenda of economic adjustments proposed by international organizations, especially the World Bank[12], went against what existed in developed countries. LAC countries were encouraged to reduce the state's responsibility in health, to concentrate on services that served everyone, and to restrict themselves to some essential items such as vaccines and the control of vector-borne diseases. International Organizations recommended the imposition of charges on public health system users in curative care services; encouraged the provision of health services by non-governmental and private institutions; promoted the decentralization of health services to local governments, with financial, administrative, planning, budgeting, and implementing autonomy of public health services; and encouraged the establishment of an upfront payment system, such as mandatory health insurance[13-15].

These recommendations implied a reduction in public spending, economic opening to international competition, price liberalization, and measures to improve the economic efficiency of public spending and the proper functioning of the market economy. It was hoped that health conditions would improve in the long run due to more significant economic growth and that the first results would be seen within at least five years[-16].

Reforms should distinguish between the various public health goods and guarantee services with a high positive externality; consider public funding of essential clinical care as a means of poverty alleviation; decentralize and adjust the large public health system by limiting new investments in public tertiary care hospitals, defining a package of essential clinical services and ensuring basic services as recommended by Alma-Ata since 1978[9-11,13-15]. The focus was also on the reduction of expenses through transfers to local governments and non-governmental and private initiatives, meeting the rationale of neoliberalism[16].

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The transition from the economic model centered on the welfare state, albeit incompletely implemented in LAC, to a neoliberal model, disseminated in the 1970s and 1980s, reduced state social protection systems and assigned the market to meet the social needs, resulting in a deterioration in the quality of life of populations[9-10]. In the 2000s, with the so-called "pink wave" of LAC, economic regulation and social protection mechanisms were reintroduced by several countries, triggering a "social cycle" that allowed health to play a prominent role, as reflected in the definition of three out of eight MDGs[2,13-15].

The period that we are interested in evaluating here is that of the growing neoliberalism in the region. This process took place in LAC in the 1980s and mainly in the 1990s. This paper analyzes the main characteristics of the health systems reforms carried out in LAC in the last decades, the trend of public spending on health, and the achievement of the MDGs, to reflect on the neoliberal influences on the reforms of these systems and the current challenges in achieving the SDGs. It is assumed that the domination of neoliberalism characterized the reforms carried out in Latin America, leading to an excessive focus on health services and the dismantling of public health systems and policies as a result of the sector's commodification and financialization.

Methods

We carried out a comparative study of the health systems of selected LAC countries and of the trend in public spending. We then discuss the neoliberal characteristics of the reforms in relation to the difficulties in meeting the MDGs goals.

Countries with the largest populations and for whose analysis of health indicators data were available were selected: Argentina, Brazil, Chile, Colombia, Mexico, and Peru. Venezuela was excluded due to its structural problems in recent years, which could compromise the results. Cuba was included as a counterfactual in the analysis of reforms, allowing to observe results when the logic is not that of the market.

Statistical data were extracted from: *CEPALStat* (https://estadisticas.cepal.org/cepalstat/portada.html), *Global Health Observatory data repository* (https://www.who.int/data/gho) and *MDG Indicators.* (http://mdgs.un.org/unsd/mdg/Data.aspx). We analyzed the reports *Health in the Americas* available from the *Institutional Repository for Sharing Information of the Pan American Health Organization* (PAHO) (https://iris.paho.org/xmlui). The literature review was not exhaustive.

The main features of health systems before 1990 were synthesized from these data and the bibliography on health systems in LAC, comparing them with those resulting from neoliberal reforms in the 1990s and those existing more recently after the 2000s (Chart 1). Also, we examined the trend of public spending on health (Table 1) and the fulfillment of the goals to achieve the MDGs (Tables 2 and 3).

Results

Health systems reform processes in selected countries

Chart 1 shows the evolution of health systems in LAC in the pre-1990 period, when neoliberal reforms had not yet been carried out, traversing the 1990s to the 2000s, when the neoliberal package had been widely installed.

As can be seen in Chart 1, the pre-1980s saw predominant national, solidary, and regulated systems. This is the case of Social Works evolving into the National Institute of Social Works in Argentina and the National Institute of Social Security, which evolved into the Unified Health System (SUS) in Brazil. Other examples are the National Health Service in Chile, the National Health System in Colombia, the Mexican Health Foundation (FUSALUD), the National Institute of Public Health (INSP) in Mexico, and the Peruvian Social Security Institute.

A general trend toward a market-oriented logic was observed in the 1990s. Fiscal concerns have led to the redistribution of service delivery from national to local governments and to the private sector. It is the period of decentralization of responsibilities, creating various forms of financing and the organization of the private provision of health services, the growth of private health plans, a segmented population coverage, and a fragmented provision of services (popular, social insurance, public, and private). The case of Colombia stands out among the most segmented systems, and its segmentation began before 1990. In this period, Brazil followed the opposite path, toward the universal Unified Health System, albeit decentralizing it to municipalities and sharing health services with private plans under a dual system. After the 2000s, we note a gener-

Chart 1. Historical context and trajectory of Latin America countries from 1990 to 2015.

Country	Up to 1990	1990-2000	2001-2015
	Prevalence of regulated solidary national logic	**Advancement of competitive market logic**	**Specific programs of public and community rationael, maintaining the competition of service providers**
Argentina	1944 - Creation of Social Works; 1977 - Extension of social works to workers' families. 1984 - 75% of the population covered by the expanded social works.	1990 - Trade liberalization, privatization, fiscal concerns, funding cuts, provinces responsible for providing health services. 1995 - Introduction of the health insurance sector, choice by the worker. 1999-2002 - Low response capacity of Social Works in the face of economic crisis.	2003-2007 - Adjustments to the mixed public-private pension system and the Federal Health Plan: national pharmaceutical policy, maternal and child health, public health insurance, specific programs and Public Health Coverage (PHC). 2008 - 90% coverage of the population with the renationalization and unification of the mixed public-private pension system. 2011 - Prepaid Medicine Law. 2015- Segmented and fragmented health system, with low levels of efficiency and equality. National, provincial and municipal services.
Brazil	20th century - Focus on the control of specific diseases and on a segment of workers. 1960-1970 - State subsidies to the private sector and expansion of social security coverage for rural workers. 1974 - National Health System. 1988 - New Federal Constitution defines health as a right and creates the Unified Health System (SUS).	1995-2002 - Federal government decentralization to municipalities. Family Health Program, mental health, HIV/AIDS control, and tobacco control. 1998 - Regulation of the private subsector (Regulation Law). 2000 - Creation of the National Supplementary Health Agency.	2003 to 2014 - Strengthening of the PHC/ESF; Mais Médicos Program, oral health, emergency and pharmaceutical care; national production of strategic inputs for health, education and management of work in health and regulation of health plans and insurance. 2011 - Decree 7508 regulating LOS No. 8.080/1990. 2012 - Law 142 regulates EC No. 29 with the definition of minimum percentages for states and municipalities to apply in health. 2014-2015 - Law authorize the opening of the health sector to foreign capital.
Chile	1924 - Creation of the Ministry of Hygiene, Social Assistance, and Labor. 1948 - Creation of the Chilean Medical Association. 1952 - Law establishing compulsory insurance against the risks of illness, disability, old age, and death and creation of the NHS. 1980 - Military dictatorship, privatization of insurance and medical care	1990 - The *Fondo Nacional de Salud* (National Health Fund, FONASA) is created, financed by public resources and contributions from beneficiaries. The *Institutos de Salud Previsionales* (Pensions Institutes of Health) ISAPRE) is created. 1995 - PHC Statute Law No. 19.378 2000-2006 - Strengthening of the public system, with dual configuration.	2003 - Financing Law No. 19.888: increase in the value of VAT. 2005 - Law on *Instituciones de Salud Previsional* - ISAPRE Nº 20.015. 2012 - Law on Health Rights and Duties No. 20.584. 2017 - Guidelines for Network Planning and Programming, based on the RISS logic.
Colombia	1975 - National, departmental and municipal NHS, integrating the public, private, and social security subsectors, and the *Instituto Colombiano de Seguros Sociales* (The Colombian Institute of Social Insurances, ICSS). 1977-1980 - Laws nº 1650, 1651, 1652, and 1653 of 1977, convert the ICSS into *Instituto de Seguros Sociales* (Institute of Social Insurances, ISS) with administrative decentralization measures.	1990 - Law N° 10 that delimited national and territorial powers and responsibilities of the nation, departments, and municipalities, in terms of health management. 1991 to 1993 - FC and Laws Nº 60 and Nº 100, define resources, responsibilities of territories in health, unification of mandatory contributions and benefit plans and new funding sources: specific taxes and participation in oil revenues.	2000-2015 - The structure and organization of health services apply the guidelines of N° Law 100/1993. 2001 - Regulation of the decentralization process through Law N° 715/2001. 2007 - Law N° 1122 introduced adjustments to the Colombian health system to promote universal access. 2015 - The Congress of the Republic enacted Statutory Law N° 1751.

it continues

Chart 1. Historical context and trajectory of Latin America countries from 1990 to 2015.

Country	Up to 1990	1990-2000	2001-2015
	Prevalence of regulated solidary national logic	**Advancement of competitive market logic**	**Specific programs of public and community rationael, maintaining the competition of service providers**
Mexico	1943-1959 - Establishment of the Mexican Institute of Social Security (IMSS) and the Institute of Security and Social Services for State Workers (ISSSTE). 1977 - Creation of the General Coordination of the National Plan for Depressed Zones and Marginalized Groups (Coplamar). 1979 - IMSS-Coplamar – agreement for the coordination of social solidarity services 1983 - Constitution recognizes the right to social health protection. 1982-1988 - Reform with emphasis on rationalization, decentralization and diversification of service providers. The Mexican Health Foundation (FUNSALUD) and the National Institute of Public Health (INSP) were created.	1988-1994 - IMSS-Coplamar Program changes to IMSS-Solidaridad with expansion of health services to marginalized locations, with growth of service infrastructure. 1995 - Beginning of the second wave of decentralization to expand state responsibilities in financing, managing and providing services. IMSS reduces the participation in the States and transfers the responsibility to them for some services.	2002 - IMSS-Solidaridad is renamed IMSS-Oportunidades 2003 - General Health Law nº 37 created the Social Protection Health System (SPSS) – with Popular Health Insurance, Universal Catalog of Essential Health Services, and Catastrophe Health Fund. Federal, state, and affiliate funding. 2011-2013 - IMSS-Oportunidades starts to provide health care to beneficiaries of the Popular Insurance, resumes participation in States and expands services.
Cuba	1960s - FC endorses the humanist and solidarity principles of Public Health, construction of the service network, the Faculty of Medicine, the Ministry of Health, and the pharmaceutical industry. 1961 - Creation of an integrated NHS, with full fiscal financing, universal access, and free care. 1963 - International Medical Cooperation. 1975 - Health care for all citizens in the Constitution.	1990 - The Cuban Health System emphasizes: Primary Health Care.	2001 - Cuba carries out international cooperation with several countries. 2002 - Health Revolution Programs, Reformulation of the organizational structure of health services, in particular the PHC, deepening the work of the family doctor and nurse. 2004 - University Polyclinic, as a new training model.
Peru	1978 - Formation of the National Health Services System, around the Peruvian Social Security Institute (IPSS), offering health services through cooperation with private entities. 1980s - economic management difficulties and low economic contribution of the State.	1990 - Creation of the NHS by Legislative Decree No. 584. 1997- General Health Law created dual system with universal access to public health and a private subsector; eliminates guarantees of absolute financing by the State, creates the Health. Service Provider Institutions (IPRESS), which manage public, private and mixed health centers registered with SUNASA.	2002 - Law N° 27.813 establishes the National Coordinated and Decentralized Health System (SNCDS). 2009 - Law N° 29.344 and its regulatory Decree redesigned the system with separation of functions of assurance and provision of services, incorporating market mechanisms and space for the performance of the private sector. 2015 - Law N° 1751 Universal Health Assurance Framework – modifies the fundamental right to health and the policy of access to the system.

Captions: EC – Constitutional Amendment; PHC – Primary Health Care; IVA – Value Added Tax; RISS – Integrated Health Services Networks; NHS - National Health Service; SUNASA – National Health Insurance Superintendence; CF: Federal Constitucion.

Source: Author´s elaboration.

al tendency to return to public health concerns, with the emergence of public and community logic programs and concerns about regulation and coordination, although maintaining competition among health service providers and carrying on a market-oriented logic.

Table 1. Distribution of total public and private expenditures as % of GDP.

Country	Years	% of GDP health expenditure	% of public expenditure	% of private expenditure
Argentina	1985[1]	8.2	65.9	34.1
	1990	10.5	40.2	59.8
	1995	8.2	44.5	55.5
	2000	8.6	55	45
	2005	8	51	49
	2010	9	65	35
	2015	6.8	72	28
Brazil	1982[2]	8	71.5	28.5
	1990	6.6	45.9	54.1
	1995	7.2	48.7	51.3
	2000	8.3	40.8	59.2
	2005	8	42	58
	2010	8	45	55
	2015	8.9	43	57
Chile	1980[1]	7.4	60	40
	1990	4.8	45.6	54.4
	1995	6.7	46	54
	2000	7.2	42.6	57.4
	2005	7	53	47
	2010	7	59	41
	2015	8.1	61	39
Colômbia	1980[5]	3.9	50	50
	1990	5.6	21.3	78.7
	1995	7.4	45.1	54.1
	2000	9.6	55.8	44.2
	2005	6	72	28
	2010	6	70	30
	2015	6.2	66.7	29.3
México	1982[4]	2.9	54.8	45.2
	1990	4.4	40.9	59.1
	1995	5.6	39	61
	2000	5.4	46.5	53.5
	2005	6	42	58
	2010	6	50	50
	2015	11	52	48
Peru	1980[3]	5.6	90	10
	1990	8.2	15.6	84.4
	1995	4.6	44.5	55.5
	2000	4.8	59.2	40.8
	2005	5	55	45
	2010	5	52	48
	2015	5.9	62	38

Source: 1990-2000 data: (1) PAHO 31; (2) PAHO30; (3) World Bank,1993 12; (4) Jaramillo, 2002 32. 2005-2015 data: Global Health Expenditure Database (http://apps.who.int/nha/database/ViewData/Indicators/es).

This is the case of the expansion of specific public programs in Argentina, the regulation of health plans in Brazil, the increase in taxes for health financing, the regulated freedom of the ISAPRES in Chile, and the expanded public services in some states and the IMSS – Opportunities for beneficiaries of Popular Insurance in Mexico, and the Law Framework for Ensuring Universal Health in Peru.

Cuba was analyzed as a counterfactual. It is usually admitted that it is a successful country in terms of health indicators. Its health reform path goes in a completely different direction than the other study countries. From a system already public and universal since the beginning of the analysis, it has evolved towards deepening and expanding the provision of health services and articulating this provision with internal health training. Externally, the expansion of international cooperation is growing in this country.

Public and private spending on health and against gross domestic product (GDP)

Table 1 shows that, except for Argentina, the countries increased spending on health against GDP in the 1980-2015. However, in all of them, the participation of the public sector in the provision of health care falls between 1980 – when neoliberalism had not yet become widespread in the region – and subsequent years – a period of more significant neoliberalism expansion. In some countries, such as Brazil and Chile, this reduction extends to the 2000s. In the following period that witnessed the so-called pink wave of left-wing governments, the participation of the public sector in health expenditure increases in all countries, albeit in different proportions. However, the effects of the neoliberal resumption could only be analyzed with data after 2015, for which there is still not enough consolidated information.

In this regard, it should be noted that the withdrawal of national states from health spending compromises access to these services. On the one hand, differentiated packages arise in terms of prices, and, on the other hand, plans are segmenting the population's access by income, class, and functional category, as we saw in the health reforms in Chart 1. This mechanism tends to reduce the population's pressure for high- quality and -quantity health services, since it treats differently those who are capable to demand improvement.

Country performance in the MDGs and their transition to the SDGs

Regarding the performance of the MDG indicators, Tables 2 and 3 show that most countries did not reach all the agreed goals. As for the goal of reducing child mortality in children under five years of age by two-thirds, from 1990 to 2015, only five countries in the region, three of which were selected and studied in this paper, reached the goal, which was a reduction of 66%: Brazil (-75.1%), Mexico (-67.0%) and Peru (-80%). Cuba and Chile show the best performance in this indicator during the study period: while they did not reach the reduction target, their mortality rate is by far the lowest in absolute numbers.

Only Peru (-78%) and Brazil (-73.3%) reached the goal of reducing the infant mortality rate (IMR) by 66% among children under one year. Chile and Cuba again had the best overall performance, with the lowest IMR since the 1990s. Brazil, Colombia, Cuba, Mexico, and Peru achieved a final positive change for the proportion of 1-year-old children immunized against measles. The best results are in Brazil and Cuba (99% in 2015). The Maternal Mortality Ratio (MMR) goal was to achieve a 75% reduction. While none of the countries achieved this goal, they all reduced the number of preventable maternal deaths, with the most significant reductions occurring in Peru (-72.9%) and Chile (-61.4%). Chile has the lowest MMR (22/100,000 LB), followed by Mexico (38/100,000 LB).

As for the indicator "proportion of births attended by qualified health personnel" (doctors, nurses, or midwives), according to partially available data, all countries improved, but the overall goal remained unachieved. Not all countries have data available on the percentage of mothers aged 15-19 years (MDG5). Argentina, Colombia, and Cuba show increases in the adolescent birth rate from 2000 to 2015. The other countries have reduced the number of births among adolescents, although the data for Colombia, Peru, and Mexico are incomplete.

Goal 6 of the MDGs (Table 3) aimed to reverse the spread of HIV/AIDS by 2015. According to available data up to 2014, Mexico and Peru have reversed the spread of AIDS in the 15-49 years age group. As for the goal of universal access to treatment, all countries expanded access, emphasizing Brazil (95%) and Cuba (95%), which achieved the best results.

We also sought to analyze the achievement of targets for reversing the incidence of malaria and

Table 2. Achievement of Goals 4 and 5 of the MDGs - Maternal and Child Health.

Indicator		CMR <5 years (per 1000)	CMR <1 year (per 1000)	% of immunized children	MMR (per 100.000)	Assisted deliveries	Pregnancy of adolescents aged 15-19 years
Goals	**Years**	**66% reduction**			**75% reduction**	**100%**	**Reproductive health (100%)**
ARG	1990	28.6	25.3	93	72		
	1995	24.1	21.5	99	63		
	2000	19.6	17.5	91	60	99,1	64,7
	2005	16.5	14.8	99	58	99,1	63,4
	2010	14.4	12.9	98	58	95	68,2
	2015	11.5	10.2	91	52	99,6	65,1
	Var%	**-59.8**	**-59.7**	**-2.2**	**-27.8**	**0,5**	**0,6**
BRA	1990	63	52.5	78	104		
	1995	47.9	41	87	84		
	2000	34.8	30.4	99	66	98,6	81,4
	2005	24.9	22.1	99	67	98,6	73,9
	2010	18.7	16.7	99	65	98,9	62,2
	2015	15.7	14	99	44	99,1	61,7
	Var%	**-75.1**	**-73.3**	**26.9**	**-57.7**	**0,5**	**-24,2**
CHI	1990	19.1	16.1	97	57		
	1995	13.1	11.1	97	41		
	2000	10.9	9.2	97	31	99	62,7
	2005	9.1	7.7	90	27	99,8	50,4
	2010	8.7	7.4	93	26	99,8	53,5
	2015	7.9	6.7	90	22	99,7	40,6
	Var%	**-58.6**	**-58.4**	**-7.2**	**-61.4**	**0,7**	**-35,2**
COL	1990	35.2	28.9	82	118		
	1995	29.7	24.8	95	105		
	2000	25	21.1	88	97	86,1	80,6
	2005	21.5	18.3	96	80	90,7	96,2
	2010	18.5	15.8	88	72	94,8	...
	2015	15.7	13.5	92	64	95,9	...
	Var%	**-55.4**	**-53.3**	**12.2**	**-45.8**	**11,4**	**19,4**

it continues

tuberculosis (TB) by 2015. Available data on the incidence rate associated with malaria and TB were not fully available for the years before 2000. Table 3 shows that all countries have curbed the incidence and prevalence of these infectious diseases.

Discussion

The paths of health reforms showed different adherences to two opposite conceptions. The first is Universal Health Coverage, which focuses on funding through a combination of funds (pooling), affiliation by insurance modality, and the definition of a limited basket of services. This form predominated mainly in Mexico in 1990 and in Colombia in 1993[4]. The second conception is that of the Universal Health System, financed by public funds from revenue from general taxes and social contributions, which provides greater solidarity, redistribution, and equity[4-5]. This is the model in Brazil, albeit more in legal than real aspects, as it shares the provision of services with private health plans within a dual system. Between the two extremes, intermediate models

Table 2. Achievement of Goals 4 and 5 of the MDGs - Maternal and Child Health.

Indicator		CMR <5 years (per 1000)	CMR <1 year (per 1000)	% of immunized children	MMR (per 100.000)	Assisted deliveries	Pregnancy of adolescents aged 15-19 years
Goals	**Years**	**66% reduction**			**75% reduction**	**100%**	**Reproductive health (100%)**
CUB	1990	13.4	10.9	94	58		
	1995	10.6	8.5	99	55		
	2000	8.5	6.8	94	43	99,9	49,5
	2005	7.2	5.6	98	41	99,9	43,4
	2010	6.1	4.7	99	44	99,9	53,6
	2015	5.4	4.1	99	39	99,9	...
	Var%	**-59.7**	**-62.4**	**5.3**	**-32.8**	**0,0**	**8,3**
MÉX	1990	44.8	35.9	75	90		
	1995	34.7	28.6	90	85		
	2000	26.4	22.2	96	77	88,6	89,7
	2005	20.5	17.5	96	54	...	...
	2010	17.4	12.7	95	45	...	...
	2015	14.8		89	38	97,7	65,4
	Var%	**-67.0**	**-64.6**	**18.7**	**-57.8**	**10,3**	**-27,1**
PER	1990	80.5	56.9	64	251		
	1995	58.3	43.1	98	206		
	2000	38.6	29.6	97	140	59,3	...
	2005	26.7	20.7	77	114	...	64
	2010	20.1	15.6	94	92	83,8	61,1
	2015	16.1	12.5	85	68	91,6	...
	Var%	**-80**	**-78.0**	**32.8**	**-72.9**	**54,5**	**-4,5**

Observation: Variation in % represents the difference between the first and last year analyzed.

Source: CEPALStat and Global Health Observatory Data Repository.

vary in the level of access and breadth of coverage, the modalities of affiliation to insurance, and the level of integration between the public and private sectors to provide services. In this intermediate pole are the other countries analyzed, namely, Argentina, Peru, and Chile[4-5,9].

Private participation in the management and delivery of health services was strengthened in the reforms[11-15,33-34]. Decentralized and segmented health services were produced[26], regarding access and the type of service provided, and fragmented (dual, tripartite, and even quadripartite) regarding the planning and management of resources among service providers, with copayment schemes, in other words, the payment is partially done by patients, instead of public funding[33].

The separation of functions between financing and provision implies the pricing of health services, transforming them into commodities produced and demanded competitively. While health expenditure increased in the countries analyzed, public spending dropped in all countries in the second phase, with the diffusion of neoliberalism in the region. As Dardot and Laval[16] point out, the state is not excluded in neoliberal systems but is called to a role that accepts the logic of the market and works trying to imitate it. Previously related to the behavior of companies, in neoliberalism, competition becomes a characteristic of the behavior of individuals, who function as self-run companies, by planning and competing in the labor market to access the health plan that suits them best, and the state, which starts to behave like a company, competing with other service providers. Thus, one observes *the transformation of public action, making*

Table 3. Achievement of MDG Goal 6 - Access to Treatment for Infectious Diseases by 2010.

Indicator		HIV 15-19 years (%)	Pop. w/HIV w/ access to ARV (%)		Malaria incidence (per 100.000)	TB incidence (per 100.000	TB prevalence (per 100.000	Deaths by TB (per 100.000	% TB cases detected and healed by DOTS*	
Goals	**Years**	**Discontinue in 2015 and reverse the incidence**	**Data years**	**100% HIV/AIDS treatment**	**Stop in 2015 and start reversing the incidence of malaria and other diseases (TB data – 1990-2013)**				**D**	**H**
ARG	1990	0.115					95	4.2	63	…
	1995	0.212					69	3.3	79	12
	2000	0.302			4.75	37	55	2.3	79	47
	2005	0.385	2009	80.5	2.58	31	45	1.9	82	46
	2010	0.446	2010	77.2	0.14	20	37	1.4	66	45
	2014	0.474	2011	78.6	0	25	31	1.4	89	...
	Var%	**312.2**		**-2.4**	**-97.1**	**-32.4**	**-67.4**	**-66.7**	**41.3**	**275.0**
BRA	1990	-					129	5.4	60	…
	1995	-					98	5.3	79	17
	2000	-		84.1	62.79	51	77	4.4	74	71
	2005	-	2009	90.7	38.35	50	60	3.1	85	72
	2010	-	2010	95.0	19.04	44	56	2.8	81	72
	2014	-	2011		7.52	42	57	2.2	82	...
	Var%	**-**		**13.0**	**-69.7**	**-13.7**	**-27.3**	**-36.4**	**9.5**	**323.5**
CHI	1990	0.154					67	5.8	90	…
	1995	0.171					42	3.5	86	79
	2000	0.193			-	23	30	1.9	84	82
	2005	0.227	2009	59.3	-	18	21	1.5	91	83
	2010	0.266	2010	63.7	-	16	22	1.6	84	71
	2015	0.289	2011	66.4	-	17	19	1.2	88	...
	Var%	**87.7**				**-26.1**	**-71.6**	**-79.3**	**79.3**	**-2.2**
COL	1990	0.077					81	5	70	…
	1995	0.28					80	4	56	…
	2000	0.511			35.71	36	65	3.2	68	80
	2005	0.476	2009	25.2	26.34	30	55	2.4	62	71
	2010	0.427	2010	45.1	24.48	31	48	2	71	74
	2014	0.403	2011	45.8	9.54	31	43	1.6	75	...
	Var%	**423.4**		**81.7**	**-73.3**	**-13.9**	**-46.9**	**-68.0**	**7.1**	**-7.5**

it continues

the state a sphere that is also governed by competition rules and subjected to efficiency requirements similar to those that subject private companies[16:272] (own translation).

National, solidary, and regulated health systems predominated until the 1980s, except for Colombia, which showed earlier and broader decentralization and diversification of non-public health sources[33]. In the others, the market logic advances in the 1990s, with some setbacks in this logic in the 2000s onwards, still maintaining, however, an essential role of the private sector and competition in the provision of health services[11,13,29].

Finally, by fragmenting the provision of services, the devolution of essential services and of healthcare delivery to local governments, to non-governmental entities, and to the private sector expands the segmentation of the population and leads to diseconomies due to inefficient

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Goals	**Years**	**Discontinue in 2015 and reverse the incidence**	**Data years**	**100% HIV/AIDS treatment**	**Stop in 2015 and start reversing the incidence of malaria and other diseases (TB data – 1990-2013)**				**D**	**H**
CUB	1990	0.013					57	0.6	21	…
	1995	0.023					30	0.9	76	90
	2000	0.04				12	18	0.4	82	93
	2005	0.076	2009	95.0	-	7.9	13	0.3	74	90
	2010	0.148	2010	95.0	-	8.4	14	0.4	79	90
	2015	0.25	2011	95.9	-	7	13	0.3	72	...
	Var%	**1823.1**		**0**	**-**	**-41.7**	**-77.2**	**-50.0**	**242.9**	**0**
MÉX	1990	0.657					131	7.8	27	…
	1995	0.641					79	5.5	28	75
	2000	0.498			6.55	23	44	3.3	62	76
	2005	0.352	2009	80.3	2.46	21	29	2.5	80	74
	2010	0.262	2010	79.4	0.94	21	27	2.2	83	82
	2014	0.23	2011	83.6	0.37	21	26	1.8	82	...
	Var%	**-65.0**		**4.1**	**-94.4**	**-8.7**	**-80.1**	**-76.9**	**203.7**	**9.3**
PER	1990	0.583					336	34	71	…
	1995	0.575					316	26	79	83
	2000	0.559			23.51	186	243	14	80	90
	2005	0.488	2009	46.2	26.29	153	197	9.7	81	91
	2010	0.401	2010	43.7	9.7	132	174	8.5	80	68
	2014	0.356	2011	60.5	19.67	119	164	7.7	79	...
	Var%	**-38.9**		**31.0**	**-16.3**	**-36.0**	**-51.2**	**-77.4**	**11.3**	**-18.1**

Website/http://mdgs.un.org/unsd/mdg/Data.aspx. Legend: TB: tuberculosis; ARV: antiretroviral; *DOTS: Directly Observed Treatment Short- Course; H: cases healed; D: cases detected.

Source: CEPALStat - https://estadisticas.cepal.org/cepalstat/portada.html. Global Health Observatory data repository https://www.who.int/data/gho and MDG Indicators.

allocation. This fragmented treatment is reinforced by the differentiation made by the target population of different service packages, financing schemes, and coverage of health services[29]. All these differences characterized the health reforms and underlay the lower public spending on health, making the provision of health services precarious, especially for the most impoverished population.

However, this strategy goes against the essence of Goal 3.8 of the SDGs, which aims to *achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all*[21], which is why its potential to stimulate structural changes has been questioned[3].

Based on the Universal Health Coverage model, the strategy of international organizations was insufficient to guarantee the achievement of the MDGs goals. None of them were fully achieved by countries, and some were not met by any country. The high maternal mortality, adolescent pregnancy, and low prenatal coverage in some countries in the region are particularly noteworthy, highlighting the existing challenges to improve womens' sexual and reproductive health[35]. Indicators that refer to women's health, such as the MMR and adolescent pregnancy, point to a perverse effect of health systems in re-

lation to the lack of assistance or the low quality of care offered to reproductive health. The long-term effects disrupt families and the economy as a whole, as maternal deaths often leave children and older adults unassisted. The death of women also affects the offer of family care and, even more, household income[35].

On the other hand, progress has been made in assisted births, in reducing malaria incidence as well as the incidence and prevalence of tuberculosis, but only Brazil and Cuba have come close to the goal of comprehensive care for the population with HIV/AIDS.

One of the limitations of this paper is the descriptive and exploratory nature of its data analysis, which does not allow us to affirm stronger causal relationships between the reforms in each country and the health system outcomes. However, the analysis of the characteristics of the reforms, as shown in Chart 1, and the trend of neoliberalism, show that the role of the state in the provision and regulation of health systems predominates in the first period analyzed (until 1990). The second period (1990-2000) shows a more competitive logic of changes following the logic of the market, while the last period (2001-2015) shows the introduction of public and community programs despite maintaining the stimulus to competition. The analysis of the reforms suggests that the achievement of care results is closely related to the capacity of national states to intervene in a coordinated fashion in social determinants and is related to the increase in public spending on health and the capacity for governance and inter-federative coordination within countries. Inequalities in access to health resources must be addressed through international regulations and national jurisdictions through health systems[34,36]. The trajectory of health systems with strong decentralization, fragmentation of the health coverage, and funding fluctuations in a region with high social inequality shows the need to find new reforms paths to strengthen public health systems.

Conclusions

The significant challenges for health systems continue to be the glaring differences in health outcomes arising from socioeconomic inequalities and differences in the quality of public and private services; the fragmented organization of service provision and the segmented financing that tolerates the existence of access to portfolios of services compatible with the contribution capacity of the population segments; the low regulation of the private sector regarding the offer of services, costs, and profits; and the difficulty of meeting the needs of populations at a time of demographic, epidemiological, and protest movements.

The reforms of the LAC health systems interfered in the countries' health policy trajectories, deepening social and economic inequalities and deteriorating the living conditions of the populations. Such deterioration, aggravated by the economic crises (1980-90, 2008, and post-COVID-19 pandemic), is likely to hinder the achievement of the SDGs and to foster the emergence and resurgence of diseases and public health problems. Moving forward will require a different, broader, and integrated role of the public health system to avoid severe reversal in the population's health situation.

Collaborations

LBD Göttems and LP Camilo worked on the conception, design, collection, analysis, interpretation of data, and paper writing. MLR Mollo worked on the writing of the paper and its critical review. C Mavrot worked on the paper writing and approved the version to be published.

References

1. United Nations. *The Millennium Development Goals Report 2015*. [cited 2021 Nov 04]. Available from: https://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf
2. Gallo E, Setti AFF. Território, intersetorialidade e escalas: requisitos para a efetividade dos Objetivos de Desenvolvimento Sustentável. *Cien Saude Colet* 2014; 19(11):4383-4396.
3. Buss PM, Magalhães DP, Setti AFF, Gallo E, Franco Neto FA, Machado JMH, Buss DF. Saúde na Agenda de Desenvolvimento pós-2015 das Nações Unidas. *Cad Saude Publica* 2014; 30(12):2555-2570.
4. Giovanella L, Mendoza-Ruiz A, Pilar ACA, Rosa MC, Martins GB, Santos IS, Silva DB, Vieira JML, Castro VCG, Silva PO, Machado CV. Universal health system and universal health coverage: assumptions and strategies. *Cien Saude Colet* 2018; 23(6):1763-1776.
5. Laurell AE. Políticas de saúde em conflito: seguro contra os sistemas públicos universais. *Rev Latino-Am Enfermagem* 2016; 24: e2668.
6. Bértola L, Ocampo JA. *Desarrollo, vaivenes y desigualdad una historia económica de América Latina desde la independencia*. Secretaría General Iberoamerica. Agencia Española de Cooperacion Internacional para el Desarrollo; 2010.
7. Birn A, Nervi L, Siqueira E. Neoliberalism Redux: The Global Health Policy Agenda and the Politics of Cooptation in Latin America and Beyond. *Develop Change* 2016; 47(4):734-759.
8. Comisión Económica Para América Latina Y El Caribe. *Panorama social de América Latina, Santiago, 1996*. [acceso 2021 Nov 04]. Disponible en: https://www.cepal.org/es/publicaciones/1253-panorama-social-america-latina-1996
9. Pereira JMM, organizador. *A demolição de direitos: um exame das políticas do Banco Mundial para a educação e a saúde (1980-2013)*. Organização de João Márcio Mendes Pereira e Marcela Pronko. Rio de Janeiro: Escola Politécnica de Saúde Joaquim Venâncio; 2014.
10. Pereira JMM. Banco Mundial, reforma dos Estados e ajuste das políticas sociais na América Latina. *Cien Saude Colet* 2018; 23(7):2187-2196.
11. Chodor T. *Neoliberal hegemony and the pink tide in Latin America: Breaking up with TINA?* Berlin: Springer; 2014.
12. World Bank. *World Development Report 1993: Investing in Health.* New York: Oxford University Press; 1993. [cited 2021 Nov 04]. Available from: https://openknowledge.worldbank.org/handle/10986/5976
13. Levcovitz E, Couto MHC. *Sistemas de saúde na América Latina no século XXI*. [acessado 2021 nov 10]. Disponível em: http://capacidadeshumanas.org/oichsitev3/wp-content/uploads/2019/02/4-Sistemas-desa%C3%BAde-na-Am%C3%A9rica-Latina-no-s%C3%A9culo-XXI.pdf
14. Alvarez MH. Neoliberalismo em salud: desarrollos, supuestos y alternativas. In: *La falacia neoliberal: criticas y alternativas.* Bogotá: Universidad Naional de Colombia; 2003.
15. Machado CV. Políticas de Saúde na Argentina, Brasil e México: diferentes caminhos, muitos desafios. *Cien Saude Colet* 2018; 23(7):2197-2212.

16. Dardot P, Laval C. *Uma nova razão do mundo: ensaio sobre a sociedade neoliberal*. São Paulo: Boitempo; 2016.
17. Almeida PF, Oliveira SC, Giovanella L. Network integration and care coordination: the case of Chile's health system. *Cien Saude Colet* 2018; 23(7):2213-2227.
18. Levino A, Carvalho EF. Análise comparativa dos sistemas de saúde da tríplice fronteira: Brasil/Colômbia/Peru. *Rev Panam Salud Publica* 2011; 30(5):490-500.
19. López-Arellano O, Jarillo-Soto EC. Implicaciones de las reformas de salud en méxico. *Cad Saude Publica* 2017a; 33(Supl. 2):e00087416
20. López-Arellano O, Jarillo-Soto EC. La reforma neoliberal de un sistema de salud: evidencia del caso mexicano *Cad Saude Publica* 2017b; 33(Supl. 2):e00087416
21. Madureira PSP. *Sistema de Saúde Cubano* [dissertação]. Coimbra (Portugal): Faculdade de Medicina da Universidade de Coimbra; 2010
22. Osa JA. Um olhar para a saúde pública cubana. *Estudos Avançados* 2011; 25(72): 89-96.
23. Bermudez AV, Luque FC, Reyes CS. *Flexibilización laboral en el Perú y reformas de la protección social asociadas: un balance tras 20 años*. Serie Políticas Sociales, nº 175, (LC/L.3444). Santiago de Chile: Comisión Económica para América Latina y el Caribe (CEPAL)/Agencia Alemana de Cooperación Internacional (GTZ). [acceso 2021 Nov 08]. Disponible en: https://repositorio.cepal.org/bitstream/handle/11362/6188/1/S1100960_es.pdf
24. Mesa-Lago C. *Sistemas de protección social en América Latina y el Caribe: Cuba.* 2012. [acceso 2021 Nov 10]. Disponible en: https://repositorio.cepal.org/bitstream/handle/11362/4034/LCw510_es.pdf?sequence=1&isAllowed=y
25. Lavigne M. *Sistemas de protección social en América Latina y el Caribe: Perú.* [acceso 2021 Nov 10]. Disponible en: https://repositorio.cepal.org/bitstream/handle/11362/4047/S2013058_es.pdf?sequence=1&isAllowed=y
26. Mesa-Lago C. *Las reformas de salud en América Latina y el Caribe: su impacto en los principios de la seguridad social.* Comisión Económica para América Latina y el Caribe (CEPAL). Documentos de proyetos. 2005 [acceso 2021 Nov 10]. Disponible en: https://repositorio.cepal.org/bitstream/handle/11362/3888/S2005077_es.pdf
27. Sánchez-Moreno F. El sistema nacional de salud en el Perú. *Rev Peru Med Exp Salud Publica* 2014; 31(4):747-753.
28. Gómez-García CA, Builes-Velásquez A. (2018) El derecho fundamental a la salud y la política de acceso al sistema: una mirada desde la Ley Estatutaria 1751 del año 2015. *Rev Facultad de Derecho y Ciencias Políticas* 48(128):135-167.
29. Atun R, Andrade LOM, Almeida G, Cotlear D, Dmytraczenko T, Frenz P, Garcia T, Garcia P, Gómez-Dantés O, Knaul FM, Muntaner C, Paula JB, Rígoli F, Serrate PCF, Wagsta A. Health-system reform and universal health coverage in Latin America. *Lancet* 2015; 385: 1230-1247.
30. Pan American Health Organization (PAHO). Health Conditions in the Americas 1981-1984.Vol. 2. Washington: PAHO; 1986. [cited 2021 Nov 03]. Available from: http://iris.paho.org/xmlui/handle/123456789/28374
31. Pan American Health Organization (PAHO). Health Conditions In The Americas. Vol. 2. Washington: Paho; 1990. [cited 2021 Nov 03]. Available from: http://iris.paho.org/xmlui/handle/123456789/28372
32. Jaramillo I. Evaluación de la descentralización de la salud y la reforma de la Seguridad Social en Colombia. *Gac Sanit* 2002;16(1):48-53
33. Lima LD. Crisis y neoliberalismo: sistemas universales de salud en américa latina. *Cad Saude Publica* 2017; 33(Supl. 2):e00047517
34. Göttems LBD, Mollo MLR. Neoliberalismo na América Latina: efeitos nas reformas dos sistemas de saúde. *Rev Saude Publica* 2020; 54:74.
35. Comisión Económica Para América Latina Y El Caribe (CEPAL). *Horizontes 2030: la igualdad en el centro del desarrollo sostenible (LC/G.2660/Rev.1)*. Santiago: CEPAL; 2016.
36. Niessen LW, Mohan D, Akuoku JK, Mirelman AJ, Ahmed S, Koehlmoos TP, Trujillo A, Khan J, Peters DH. Tackling socioeconomic inequalities and non-communicable diseases in low-income and middle-income countries under the Sustainable Development agenda. *Lancet* 2018; 391:2036-2046.

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