Health reform in El Salvador: a lost opportunity for reducing health inequity and social exclusion?

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Since the 1993 World Bank Report, health reforms based on market criteria and cost effectiveness studies have become popular.[1] The models from Chile and Colombia, with their respective variations, were introduced as social experiments. Both failed and did not contribute to improved health or health equity.[2] On the contrary, these neoliberal innovations appear to have widened existing health inequity according to critical reviews by institutions such as the Pan American Health Organization (PAHO).[3]

The human development reports (UNDP) have identified Guatemala, Brazil and El Salvador as the most inequitable countries within the planet's most inequitable subcontinent (Latin America). In El Salvador, the post-conflict context is causing a high incidence of violence and homicides that mainly affects young people. A national health system (SNS) is one of the few mechanisms to be established in a state that has been greatly weakened by structural adjustment programmes.[4 5] However, more than 10 reform proposals from different sectors have classified it as:

> "…segmented, inadequately financed in spite of the existing resources, with scarce coverage, emphasis on curative actions and with large groups of the population unable to access health care"

Clearly, a healthcare system with such characteristics has been a constant source of conflict.[6] In November 2006, a pressurised national steering committee for the integral health reform proposal (CNSPRIS), presented the latest version of a proposal for health reform (proposal by the Comisión Nacional de Seguimiento a la Reforma Integral de Salud. (CNSPRIS), Ministry of Public Health and Social Welfare, November 2006).

This has been received with scepticism and the feeling is that it will simply reinforce the status quo defined by social exclusion and conflict.

ITS GREATEST WEAKNESS IS THE LACK OF A SOCIAL AND ENVIRONMENTAL DETERMINANT-BASED APPROACH

This proposal considers health to be the absence of disease. It does not promote the right to have access to essential preconditions for health but only the right to have access to healthcare services. This approach reinforces the current biomedical tendency to focus mainly on curative actions, individual responsibility and lifestyles, without taking into account the state's responsibility to modify the life-context and to address the underlying and structural causes of health inequity. It limits its vision, its potential role, its scope for action and the involvement of other agents. It does not facilitate a process that would release existing community capacity in order to enhance a social determinants approach.

The reformed system should clearly and firmly promote access to health (not only to health services), the creation of a national health and human development plan and a radically different financing policy, increased public investment and protection of families from the health impact of adverse economic and social policy and harm.

This new system should promote food security, nutritional safety, outline regulations and activities which avoid environmentally harmful practices and safeguard workers' health. The public sector should be prioritised over the private arena, and the signing of binding agreements on a regional and international scale should first and foremost guarantee sustainable health and human development. To sum up, this system should have to contribute to healthy public policies.

THE PROPOSAL MAINTAINS THE FRAGMENTED STRUCTURE OF THE PUBLIC SECTOR

Bienestar Magisterial (Teachers' welfare), Sanidad Militar (Military Health Services), Instituto Salvadoreño del Seguro Social (Salvadorian Social Security Institute) (ISSS) and the FOSALUD (a fund created from the taxes collected on tobacco and alcoholic drinks), are autonomous public structures which, alongside the Ministry of Health (MSPAS), manage public funds, fragment assistance and services, hinder a unified negotiation of items such as medicines, create sub-registers in strategic data and are a source of health inequities. For example:

a. ISSS has an annual budget similar to the MSPAS budget. However, ISSS covers only 17% of the population while MSPAS covers 81% (73% belong to the three lowest deciles).
b. Financing of health insurance has recently been fostered for certain segments of the population, such as public school teachers and the armed forces. This situation, as well as opening the door to privatisation, goes against the principle of solidarity and sets a dangerous precedent for similar initiatives that will lead to a stratification of health care depending on the ability of each population group to meet payments or make contributions. In the long run, the public sector will be drained of its resources and will only be able to assist the poor, elderly, unemployed and chronically ill patients.

Accordingly, the solution to this fragmentation can be achieved by creating a public sub-system based on a universal public service network.

Official statements indicating that private sector services must, under no circumstances, be substitutes for the state are contradicted in practice. Non-governmental organisations are currently being hired to provide services in rural areas with funds from external financing (loans), and the government is obliged to continue hiring these same NGOs and paying them with public funds once the loan has expired.

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THE PROPOSED FINANCING MODEL WILL NOT PROVIDE AN ANSWER TO THE INEQUITIES, THE SYSTEM'S WEAKNESSES OR ENHANCE THE RIGHT TO HEALTH

The national health accounts reveal that poor people in El Salvador invest more money on their health each year than the state invests. Public health expenditure as a percentage of the national health expenditure has varied in the last few years from 42% to 45%, which means that most of it comes out of the household expenditure (55–58%). The impact this has on household economies and on the increase in poverty is unquestionable, and the SNS can and should avoid it. To do so, the public sub-system should create a public management and financing model to optimise the scant resources. This would involve proposing and establishing priorities for investment in health care while reducing the overwhelming household expenditure, so that gradually, and in the short term (five years), at least 70% of this expenditure is covered by state funds.

THE PROPOSAL DOES NOT ESTABLISH A NATIONAL DRUG POLICY

Half of household expenditure is used for self-medication, its most inefficient and ineffective element. This is related to, for example, the cost-recovery system that restricts access to services by impinging upon and impoverishing the population; the unavailability and high cost of medicines (El Salvador pays the highest prices in Central America); the lack of support given to the use of generic medicines; the lack of information to and awareness among the population as regards the contents and side effects of medicines, the risks of self-medication and, finally, insufficient quality control of medicine and generalised resistance to social control.

THE CONCEPTS OF INTERSECTORAL COLLABORATION AND SOCIAL PARTICIPATION ARE WEAK

In order to reinforce these ideas, it would be necessary to introduce health and human development into the state's agenda and achieve a social contract between the government and the population. However, the proposal in question barely enables other actors/sectors who perform activities that are relevant and decisive for health to ''collaborate'' with the health services system even less so to ensure integrated multilevel approaches, organisation, empowerment and social mobilisation for health.[7]

Social participation is nothing more than a fashion accessory when key issues such as mechanisms, opportunities, institutional skills development and the organisation of the community have not been specified. Consequently, decision-making, accountability and evaluation processes are limited and will continue to be the prerogative of high-level civil servants who escape the realms of social control.

THE NEED TO DEVELOP SKILLS

This proposal does not mention the need for sustained development within the health sector, which is currently not even growing at the same rate as the population, thereby generating a continual deterioration. Neither does it establish the need for a complete reorientation of curriculum in all health-related studies, including urban planning, social geography, education and social and political sciences.

CONCLUSION

In view of the neoliberal failure to reduce health and social inequities and the resulting social conflict in countries such as El Salvador, the national healthcare system reform is ethically bound not to perpetuate the status quo generated by social experiments. In an increasingly interconnected world, it is no longer possible to delay the revival of the comprehensive primary healthcare (CPHC) principles stated in the Alma Ata Declaration, which was aborted or sidestepped because of the crisis of the 1980s, rise of neoliberalism and the perceived threat to lost political control because of reinforced social organisation and community participation.[8]

Acknowledgements: We thank Dr Maria Teresa Ruiz Cantero from the Public Health Department of the University of Alicante for her valuable comments and contributions to this editorial and to the Cooperation and International Relations Office of the University of Alicante for its support in the translation of the final document.

Competing interests: None declared.

J Epidemiol Community Health 2008;**62**:380–381. doi:10.1136/jech.2007.067066

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