

HEALTH, INCOME AND PUBLIC INSTITUTIONS: EXPLAINING CUBA AND COSTA RICA

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ABSTRACT

The World Bank in 2004 sought to explain socialist Cuba's success in public health, and juxtaposed Costa Rica as a contender for similar public health gains, through the orthodox model which stresses 'broad based growth', backed by increased private investment. However a unique public institution (the *Caja Costarricense de Seguro Social*) for health and social security insurance better explains Costa Rica's health advances, and its superior performance to some higher income Latin American countries such as Mexico and Argentina. The relationship between increased income and improved health is positive, but weak and fragile. Other factors which may be more important are: levels of education (especially of women), numbers of trained health workers, universal access regimes for health services, well coordinated public health institutions, decent housing, and the adoption of new technologies. The experience of Latin America tells us that greater attention must be paid to well-organized public institutions, including those which train health workers, arrange universal access to health services and ensure adequate water, sanitation and housing.

I INTRODUCTION

In 2004, the year that infant mortality in Cuba fell below that of the US, the World Bank (2004a) ventured a brief explanation of Cuba's success in public health. Yet socialist Cuba represents the antithesis of World Bank style 'open market' development. To compensate for this apparent anomaly, the World Bank proposed Costa Rica as its contender for similar public health gains, through the orthodox model which stresses 'broad based growth' in income, backed by increased private investment. However a unique public institution for health and social security insurance (the *Caja Costarricense de Seguro Social*) better explains Costa Rica's health advances than simple income growth.

Neoliberal arguments for gains in public health, predicated on income growth, have been outflanked by the evidence of recent years. While income growth does correlate with improved health, there are several other factors than are as important or more important: levels of education (especially of women), numbers of trained health workers, universal access regimes for health services, well coordinated public health institutions, decent housing, and the adoption of new technologies. Deficits in one or more of these areas can negate the supposed benefits of increased income.

Making use of critical health indicators for Latin America, and some detail of the public health institutions of Cuba and Costa Rica, this article will interrogate the neoliberal

argument that income levels and gross investment are central to improvements in public health. The first section will examine the neoliberal explanations against global and regional data. The second section will evaluate the World Bank explanations for health advances in Cuba and Costa Rica, against the experiences of those countries. The third section will broaden this discussion to some other countries in Latin America. Finally, some informed observations can be made about health, income and public institutions.

II NEOLIBERAL EXPLANATIONS OF ADVANCES IN PUBLIC HEALTH

Neoliberal arguments on public health (such as the suggested positive link between income and health outcomes) are important, because aid and development decisions are often predicated on neoliberal assumptions. For example, whether aid money is used to build a hospital or train health workers is strongly influenced by the prevailing views of the ‘user pays’ principle in education and the practice of ‘competitive tendering’ for aid moneys. But why are these issues not re-examined, at their roots, in the face of stressed health systems and the many critical health challenges?

“Broad based growth” in income, backed by increased private investment, remains the major theme of development stressed by all neoliberal agencies – the World Bank, the Inter-American Development Bank, the US Government (World Bank 2004b; IDB 2006; US State Department 2001). The phrase is sometimes supplemented by “sustainable” and “pro poor growth”, but the theme remains constant. It is a theme that rapidly links to arguments for ‘open door’ private foreign investment, public-private partnerships, competition policy and outright privatization.

On the other hand, in more recent years, critical mortality indicators (in particular infant, child and maternal mortality) have become leading indicators of progress in public health. The World Health Organization (WHO) now refers to ‘high mortality’ and ‘low mortality’ regions (eg. WHO 2003), rather than high and low income regions; and two of the eight UN Millennium Development Goals target child and maternal mortality, while a third targets major diseases (UN 2005). The World Health Organization now has a Commission on the Social Determinants of Health, stressing a range of important social and institutional factors (WHO 2006b). These institutional factors have been neglected by simple economic analyses.

There are good reasons for an emphasis on effective and critical health outcomes, rather than one supposed means to achieve such results (that is, aggregate income growth). First, survival is the ‘sine qua non’ of development. Second, a child’s survival has nothing to do with its participation in economic markets. Third, the reduction of infant, child and maternal mortality is a substantial social achievement, requiring coordinated efforts to overcome disadvantage and social exclusion. It is no simple or technical matter, for example, to ensure that the poorest 20% of mothers have skilled birth attendants, or that the poorest 20% of children are vaccinated. Yet failures in these areas drag down national indicators. Conversely policies of social inclusion, such as those in Cuba, have allowed that country to have less than a third the infant mortality of Mexico, a country with 60% higher per capita income (see Table 1).

Table 1: Infant mortality, maternal mortality and income in 18 Latin American countries.

2004 Figures	Infant mortality	Maternal mortality	GDP per capita
Argentina	16	82	13,298
Bolivia	54	420	2,720
Brazil	32	260	8,195
Chile	8	31	10,874
Colombia	18	130	7,256
Costa Rica	11	43	9,481
Cuba	6	33	*5,700
Ecuador	23	130	3,963
El Salvador	24	150	5,041
Guatemala	33	240	4,313
Honduras	31	110	2,876
Mexico	23	83	9,803
Nicaragua	31	230	3,634
Panama	19	160	7,278
Paraguay	21	170	4,813
Peru	24	410	5,678
Uruguay	15	27	9,421
Venezuela	16	96	6,043
LATAM Average	22.5	156	6,688
USA	7	14	39,676

Source: UNDP (2006: Tables 1 & 10)

‘Broad based growth’ backed by increased private investment, is a theme consistent with the founding mandate of the World Bank, set out in its 1944 Articles of Agreement. These require the Bank to "assist in reconstruction and development... by facilitating the investment of capital" (Article 1.1) and "promote private foreign investment... and supplement private investment" (Article 1.2). This emphasis suggests that private investment in health systems can be seen as an unmitigated good, as it swells the health resource pool. This is a handy argument for private investors. No down sides - in the form of fragmentation, duplication, commercial conflicts of interest, compounded problems of access, or waste through surplus extraction – are suggested. Yet many such problems seem likely.

The demand for ‘big money’ in health is well entrenched. The OECD’s Development Assistance Commission (DAC) argues that "scaling up financial resources for health should be a priority" (OECD 2003: 14). Similarly, the World Health Organization’s committee on 'Macroeconomics and Health', chaired by Jeffrey Sachs, pushed for a massive expansion of foreign capital in poor country health systems:

The level of health spending in the low income countries is insufficient ... poor countries can increase their domestic resources that they mobilize for the health sector and use those resources more efficiently ... donor finance will be needed to close the financing gap ... [this will mean] approximately \$27 billion per year in donor grants by 2007 (Sachs 2001: 16)

“Donor finance” generally means a core of public 'seed' money, grants or loans, which sets the conditions for entry of a consortium of private, commercial capital. Developing country health systems thus become fields for private and foreign investment in infrastructure and service provision. These reports sustain the emphasis on scaling up resources in developing country health systems, in particular by the inclusion of private foreign investment.

However an important World Bank-funded longitudinal study, covering 115 developing countries (Wang et al 1999), found that increased income came third amongst three broad factors linked to improvements in critical mortality. On average for the 115 countries, increased income contributed only 17% to the reduction in child mortality rates, while education contributed 38%. A third factor, called ‘technical progress’ – really including a range of other organization and technical developments, such as improvements in immunization, health service regimes, and improved drug access – contributed the other 45%. The three factors were assessed for their impact on adult mortality rates, with adult female mortality being even more strongly associated with education (see Table 2).

Table 2: Global average (115 developing countries)

Contributions (%)	Income	Education	Technical progress
Under 5 mortality rate	17	38	45
Female adult mortality rate	20	41	39
Male adult mortality rate	25	27	49
Total fertility rate	12	58	29

Source: Wang et al, (1999:18–19)

General progress has been the order of the day in reduced child mortality. The salient questions are ‘what rate of progress?’, and ‘by what means?’ Ahmad et al (2000) noted that while over 10 million children died in 1999, this figure was 17.5% fewer than the thirteen million child deaths a decade earlier. Collating the child mortality data from 1955 to 1999 they noted that rates had fallen globally, except in the Western Pacific.

Yet China, the contemporary ‘miracle’ of economic growth, is not a top performer in health. Wang et al (1999: 13) noted that China showed a “deterioration in performance [in reducing under-5 mortality] ... relative to what would be predicted from the country's income level”. Worse than this, China’s reductions in child mortality were below the global mean. China’s average growth rates of 9% in the 1980s and 1990s were more than three times the global mean; yet China’s under-5 mortality reduction of 24% in that same period compared unfavorably with a global mean of 28% (see Table 3). While China’s take-up of telephones, internet and other commodities was strong, the country’s progress in access to sanitation and clean water was unimpressive (UNDP 2006: Tables 7 and 13). This, combined with privatization of (and consequent uneven access to) health services may have contributed to its relatively poor progress in child mortality.

Table 3: China's poor progress in child mortality despite strong growth.

	1955-59	1970-74	change 1	1980-84	1995-99	change 2
China - U5M rate	225	104	54%	50	38	24%
Av. econ growth rate		5.5 %		9.1 %	9.0 %	
Global mean - U5M rate	180	128	29%	97	70	28%
Av. econ growth rate		3.2 %		3.0 %	1.4 %	

Sources:

Ahmad et al, 2000: 1180–1182 (U5M), World Bank (1995; Table 2), UNDP (2006: Table 14)

If China shows that strong economic growth might not be associated with strong health performance, the US demonstrates that massive investment in health can be wasted. With total health spending at 13.9% of GDP (the next biggest spender is Germany, at 10.7%), US health expenditure is far above that of any other country, both in absolute and relative terms (Reinhardt et al 2004: 11). Yet US infant and maternal mortality outcomes are well below the OECD average. In fact, we have to descend to Number 29 on the Human Development Index (Barbados) to find an infant mortality figure worse than that of the US (UNDP 2004: Table 9). One important reason for this poor performance is that the US, unlike most of the OECD and all western European countries, does not guarantee free access to health services, and there is an associated high level of privatized services (Schoen et al 2006; Anderson 2006a). The US experience demonstrates both an inefficient waste of health resources in a highly privatized system, and the fragility of the ‘high income equals good health’ link.

Faced with growing evidence of the weak and uneven positive relationship between generalized income growth and health improvements, neoliberal arguments often appear rather schizoid. In its 1993 report, with a focus on ‘investing in health’, the World Bank listed the “virtuous necessity” of “user charges and prepaid insurance schemes” as the main item of “community control and financing” in low income countries. Yet aware that such fees exclude the poor, the Bank calls for reduced fees or selective exemptions for poor people (World Bank 1993: 159). Of course, poor people are often the majority in low income countries. In its note on Cuba and Costa Rica, while aware of the important institutional factors at work, the World Bank presents the case for Costa Rica, and tentatively suggests “one way to attain good health from initially low income is surely to stop having a low income” (World Bank 2004: 157). In its 2006 report, while noting unevenness in immunizations and that life opportunities are formed very early for children, the Bank repeats its neoliberal theme, saying that “wealth matters for the immunization of children” (World Bank 2006: 5). This constant reversion to crude income and wealth aggregates suggests unwillingness on the part of the World Bank to learn the more particular lessons of institution building in public health, even when these lessons arose from its own literature. With this in mind, let’s examine the experiences of Cuba and Costa Rica.

III EXPLAINING CUBA AND COSTA RICA

In this section I will look a little closer at the Bank’s ‘big money’ argument, with reference to the development of public institutions in Cuba and Costa Rica. In 2004 total births in Cuba fell by 7% to 127,062, and there were 735 infant deaths (De La Osa 2005). This led to the 5.8 infant deaths per 1,000 live births, just after the US rate had risen (for the first time in over 40 years) to 7 per 1,000 (Medical News Today 2004). In answering

its own question “how has Cuba done it?” the World Bank correctly notes “the sustained focus of the political leadership on health for more than 40 years... [as well as] universal and equitable health care”. The Bank points out that the Cuban system had “concentrated on health care to rural areas”, created a unified public system in health services, and had pursued mass immunizations and monitoring. The Cuban system also relied on “highly motivated staff”. However the Bank suggested Cuba spends “substantially more” of its GDP on health than most other countries and questioned whether a system “that relies on a publicly paid doctor for every 150 families can be sustained in times of economic hardship” (World Bank 2004: 157-158). Whatever sting there might have been in the tail of this picture has been removed by Cuba’s strong economic growth, throughout 2005-06. Yet this explanation certainly does cover some of the institutional elements stressed by Cuban experts.

Two additional elements deserve attention. Cuban health workers and administrators stress ‘intersectoral coordination’ and education as key elements of their health system and their major health programs (e.g. De La Osa 2005; Ochoa Sato et al 2004). That is, the epidemiological vigilance, thoroughness in tracking vector born disease (such as dengue), systematic nature of health education (e.g. concerning HIV education, in schools and on television), and general institutional solidarity play a critical role in getting very good results with limited resources. Cuba’s central coordination of health and education services is important. However participatory debates, for example during the country’s depression in the 1990s (the ‘Special Period’), that have backed the maintenance of free health services, have also been very important (Espinosa Martínez 1999: 83-84; Mellor 2001). Cuba’s institutional development is unique, but a disaggregation of its institutional features can, I suggest, be instructive.

There are some particular institutional features relevant to Cuba’s very good performance in infant mortality. There is a special maternal-infant program which has been given priority within the Cuban health system since the late 1970s. Pregnant women are given a large number of examinations, tests, and nutritional supplements. Infants are also given special care and 13-disease vaccinations. There is also a great deal of official and moral pressure on doctors, to give special attention to mothers-to-be, under their care.

Within Cuba’s public health debates there is constant reference to the ‘integral health system’ (De La Osa 2005). Many US observers are well aware of these discussions (eg. Gorry 2005). Particular public institutions of the Cuban health system include an integrated family doctor network, involving one or more doctors in a small office serving between 120-160 families, or 600-800 persons (Rojas Ochoa 2003); intermediate health centers or ‘policlinics’ at a municipal level, which carry out 80% of specialist services (including dental services and test laboratories) but have virtually no hospital beds (Portilla 2004); and a hospital system, including universal hospital-based childbirth. Other integral features of the system include Cuban production of a wide range of medicines and vaccines (PAHO 2003b) and a regular monitoring and review of the system, which includes review of dietary support and social assistance, development of natural medicines, and research (Ramirez Marquez 2002). Despite pressures imposed the US economic blockade, the Cuban system retains its public and universal character, with just a few private expenses through private payment or part-payment for imported items such as wheelchairs, glasses and hearing aids (PAHO 2003b; Anderson 2006b).

While the US blockade (Cubans call it a blockade, the US calls it an embargo) does create serious problems for imports of health technology, it has also fostered a relatively self-sufficient pharmaceutical industry. Domestic production of drugs grew into the 2000s, with 521 of the 827 listed ‘essential’ medicines being locally produced (ESPICOM 2007). Yet while health standards were largely maintained during the economic crisis of the 1990s, failures in infrastructure did have health consequences. The lack of investment in water, sanitation and housing, for example, no doubt contributed to a surge in diarrheal illnesses and some deaths, in the mid 1990s (see Anderson 2006b).

Costa Rica has also demonstrated substantial progress in public health. Between 1969 and 1990, with a lower per capita income than either Chile or Mexico, Costa Rica clearly out-performed both countries in child mortality rates (see Table 4). In 2004, Chile and Costa Rica competed for second place to Cuba in health indicators, amongst the better performing countries of Latin America (see Table 5). However, the World Bank’s explanation of Costa Rica’s progress in public health is seriously deficient. The Bank claims that:

Since 1960, progress in Costa Rica has been rapid, but not too difficult to explain ... Costa Rica’s real income per capita increased by 25% from 1960 to 1970 – the same rate coincidentally that infant mortality declined. Income growth of 40% by 1980 along with the universalisation of health care saw a further decrease of 60% in infant mortality. After recessions in the 1980s growth has resumed and progress on health status continues. One way to attain good health from initially low income is surely to stop having a low income (World Bank 2004: 157).

This is misleadingly simplistic and, with the exception of the phrase “along with the universalisation of health care”, ignores the country’s institutional development.

One might begin with Costa Rica’s 1948 abolition of its army, a move which enhanced the capacity of its public finance. However the principal relevant public institution is the *Caja Costarricense de Seguro Social*, (CCSS or the ‘Caja’) a peculiarly Costa Rican body which underwrites health care and pensions for all citizens. The CCSS developed, as a public institution, over several decades, beginning in the 1940s with a law which drew from European thinking and the Chilean experience. Health services backed by the CCSS include general and specialized medical care and subsidies for medicines, testing and dentistry.

The CCSS was made autonomous from the executive government by the social security law of 1943, the main principles of which were then reinforced in Article 73 of Costa Rica’s 1949 Constitution. Amended in 1961, this section establishes a tripartite social security system, with employee, employer and state contributions, administered by the financially ‘autonomous’ CCSS (Editec Editores 2005a). Regulated subscription to this fund is compulsory for all employees. Article 74 of a special law set up for The CCSS further protects the funds of the institution, and guarantees the “universalisation” of social security to the entire community (Editec Editores 2005b). This universalisation, which extended coverage past other Latin American contributory systems, was proposed in 1961 and finally occurred in 1974, with the creation of the Social Development and Family Payments Fund (FODESAF). Through this fund, supported by two taxes, coverage by the CCSS has been extended to those low income Costa Ricans who have not been able to make the normal contributions. The aim of the system is to guarantee:

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The well-being of all ... and to give individuals and families the assurance of knowing that their quality of life will not be affected by any adverse circumstance (CCSS 2005: 2-6).

So Costa Rica, like Cuba, has guaranteed universal access to health services and a very high proportion of births attended by skilled assistants (see Table 5). Presence of a skilled birth assistant is the major factor in preventing maternal and perinatal deaths (De Brouwere, Tonglet & Van Lerberghe 1998).

One example may help us identify some underlying causes of the superior performance of these two countries. If we compare infant deaths in Cuba and Costa Rica with those of a poorer Latin American cousin, Bolivia, we can see some striking differences in the reasons for infant death, other than perinatal. In Bolivia, 14.3% of infant deaths were due to diarrheal illness, compared to 3% in Costa Rica and 1.3% in Cuba. (2000 figures, WHO 2006: 23). With what we know of diarrheal illness in children, three factors could be making the difference: access to safe drinking water and improved sanitation, parental education in hygiene and access to health services to assist with oral rehydration, the major treatment for diarrhea (Vesikari et al 1994: 135-146). The UNDP reports educational levels as being highest in Cuba, with adult illiteracy at 0.2%, compared to 5.1% in Costa Rica and 13.3% in Bolivia. Populations without access to improved drinking water were reported at 9% in Cuba, 3% in Costa Rica and 15% in Bolivia (2004 figures, UNDP 2006: Tables 1 and 3). So better performance in education and water sources, combined with better access to health services, are likely to explain the lesser risk of infant death through diarrheal illness in Cuba and Costa Rica. This is essentially an institutional explanation, rather than one based on income.

IV HEALTH, INCOME AND PUBLIC INSTITUTIONS IN LATIN AMERICA

Looking more broadly at the Latin American region we can see further evidence of the fragile positive relationship between income and health outcomes. In a highly unequal region, there are many departures from that orthodox notion; departures which I suggest are best summed up as the development of public institutions. Nevertheless, the idea of gross investment continues to be advanced by neoliberal institutions, in the region.

The two biggest countries of the region, Mexico and Brazil, show above average incomes but below average infant mortality rates. Argentina, the country with the highest income in the region, ranks only equal 5th in infant mortality rates (see Table 1). Cuba is the most striking counter example, with less than average income but the best infant mortality rate. But Venezuela and Paraguay also have less than average incomes and better than average infant death rates (Table 1).

This is a static picture, so let's look at some of the longitudinal evidence, of under-five mortality, income and female education rates in Brazil, Chile, Costa Rica and Mexico between 1960 and 1990 (see Table 4). We can see that, while Mexico started at the same income level as Chile in 1960, by 1990 Mexico had substantially higher average income but Chile had substantially lower child mortality. What did Chile do, with less resources, than Mexico could not? Mesa-Lago, in my view, pays too little attention to institutional development in his detailed empirical study of the economies of Chile, Costa Rica and Cuba (Mesa Lago 2000). His focus on growth aggregates, and his advocacy of open

markets and privatization (Mesa Lago 2000: 624), leads him to neglect the public institutions that have underwritten education and health gains in each country.

Table 4: Changes in child mortality, income and female education, 1969–1990

	1960	1965	1970	1975	1980	1985	1990
Brazil							
under-five mortality rate	177	159	135	111	86	81	na
income per capita	1660	1891	2139	3151	3982	3914	4226
female education (yrs)	3.1	3.2	3.2	2.9	3.1	3.3	3.7
Chile							
under-five mortality rate	155	121	97	67	37	24	19
income per capita	2738	3133	3505	3579	3431	3524	4008
female education (yrs)	5.1	4.9	5.5	5.6	6.3	6.4	6.7
Costa Rica							
under-five mortality rate	124	104	85	54	29	20	14
income per capita	2001	2262	2692	3189	3671	3195	3381
female education (yrs)	4	4.2	3.9	5.1	5.2	5.4	5.6
Mexico							
under-five mortality rate	134	123	111	94	76	54	47
income per capita	2723	3078	3730	4587	5351	5791	5457
female education (yrs)	2.5	2.7	2.9	3.3	4.4	4.9	6.4

Source: Wang et al, (1999: 156, 158, 162, 180)

From Table 4 we could surmise that higher levels of female education in Chile, at least until the late 1980s, may well have played a role in Chile's better-than-Mexican health outcomes. Female education most obviously translates into improvements in nutrition and sanitation for children, as well as women. It is also a major determinant of lower fertility rates, which are in turn associated with lower infant deaths (e.g. Browne and Barrett 1991; Mellington and Cameron 1999; Sivamurthy 2003). The female education deficit in Brazil might also help explain that country's relatively poor progress in reducing child deaths. We know that Costa Rica developed a unique public institution, and this probably explains why it out-performed Chile in child death rates, despite a lower level of female education.

Yet while high levels of education require significant institutional development, considering only one factor additional to income seems unsatisfactory. Let's look a bit closer at Mexico, and the arguments over health reform there. Mexico has a private subscription health and social insurance system which, although compulsory, extends to only 55% of the population. Yet an OECD view of the system criticized the "public integrated model" which existed within the national hospital system, calling it a "quasi-monopoly", and abusing Mexican public health as a "command and control" system which provided "no effective consumer choice" (OECD 1998: 100-102). Such assaults on public institutions are common in neoliberal discourse. However the fragmented Mexican system suffers from such failures of access that "choice" is barely relevant for the 45% who are not enrolled in any of the compulsory social security schemes (PAHO 2002).

The OECD accepted there were serious problems in Mexican access to health services, and in poorly coordinated services, and that there was a need to “reduce disparities in health status” (OECD 1998: 88, 91-97). However, in its conclusion, the OECD backs an expansion of private health insurance through voluntary affiliation, family insurance packages and the delegation of financial responsibilities to the Mexican states (OECD 1998: 104-111). Such a process failed, in the following few years, to lift health insurance rates more than 2 or 3 percent (PAHO 2003a).

While Chile also has a private contributory health system, it resides within a unified national health system dating back to 1952. This system has undergone a number of changes, with both ‘private choice’ of health care provider and ‘health as a basic human right’ being embedded in the 1980 constitution. Employees can contribute to their private funds, but a National Health Fund (FONSA) finances care for the rest (PAHO 1998: 173-174). National government subsidies provide more than half the funds of the decentralized municipal health services (Bossert 2000: 21). One important result is that virtually all births in Chile occur in a hospital. This is not yet the case in Mexico (see Table 5). Further, Chile made progress in covering its housing deficit, using public funds to support the construction of almost a million houses, throughout the 1990s (Ravinet 2001). Mexico, by contrast, has an ongoing deficit of more than 4 million houses (OACNUDHM 2003: 70). This difference no doubt contributes to Chile’s sanitation advantage. Chile reports 91% of households having access to improved sanitation, while Mexico reports just 79% (UNDP 2006: Table 7). A Chilean Minister for Housing explained the country’s progress as through: “sustained economic growth, fiscal balances and a steady increase in public social investment in sanitation, housing and habitat” (Ravinet 2001). So it is the way in which Chile has used its resources - mobilizing public institutions in support of health, education and housing - that seems to have made the difference.

Such progress can be reversed through attacks on public institutions. For example, one consequence of Costa Rica’s impending accession to the regional ‘free trade agreement’ with the US (CAFTA) would be the partial privatization of telecommunications in that country (Stanley 2006). In the longer run, private investors may also have their eyes on pension funds. If Costa Rica’s central public institution, the CCSS, were to be subjected to ‘competition policy’ (and therefore partial privatization) by the introduction of new contributory schemes, there is a significant risk that introduced inequalities and problems of access would undermine that country’s health achievements.

V CONCLUDING REMARKS

The World Bank’s (2004: 157) suggestion that the road to good health is principally based on broad based income growth, backed by increased private investment, ignores the evidence, including evidence commissioned by the World Bank. Wang et al (1999) place income in third place (after education and new technology) in the major factors linked to critical health outcomes. Yet the World Bank’s approach is consistent with its constitutional mandate to facilitate, supplement and promote private foreign investment. The OECD’s Development Assistance Committee (DAC) similarly collapses these two issues – supporting the improvement of health systems in developing countries and promoting its own member states’ foreign investment ambitions. Consistent with

neoliberal discourse, there is no recognition of potential conflicts of interest (Anderson 2006a).

Both bodies have adopted a rather schizoid approach to health in developing countries. On the one hand, they recognize some of the social and institutional determinants of health yet, on the other hand, they condemn publicly-integrated systems, instead promoting private investment and user pays regimes. In view of this ideological offensive, it seems important to point out the conflicts of interest inherent in 'growth-based' private investment arguments, particularly when there are threats to undermine the very public institutions which are critical to public health.

Many countries demonstrate that, while resources are important, political will and social organization are critical. Cuba is the best example of this, with below average income but the best health outcomes in Latin America. It relies on a single, integrated public system with guaranteed, free access to health services. It's important notion of 'intersectoral coordination' in health stresses the relationship between its various public bodies, including the schools, public nutritional programs and infrastructure. Costa Rica has developed a unique public institution, the *Caja Costarricense de Seguro Social*, which guarantees health services and pensions to all citizens. This institution helps explain its better health performance than higher income Latin American countries such as Mexico and Argentina. Recognizing these institutional features help us better appreciate the differing outcomes in each country.

The relationship between increased income and improved health is positive, but weak and fragile, in the highly unequal societies of Latin America. Institutional factors which may be more important are: levels of education (especially of women), numbers of trained health workers, universal access regimes for health services, well coordinated public health institutions, water, sanitation and decent housing, and the adoption of new technologies.

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Table 5: Health-related indicators: select Latin American Countries.

	Argentina	Brazil	Mexico	Venezuela	Cuba	Chile	Costa Rica	Uruguay	DC av.
Life expectancy at birth (2004)	74.6	70.8	75.3	73.0	77.6	78.1	78.3	75.6	65.2
Adult illiteracy (2004)	2.8	11.4	9.0	7.0	0.2	4.3	5.1	2.0*	21.1
Children underweight for age (>5) (1996-2004)	5	6	8	4	4	1	5	5	na
Births attended by skilled personnel % (1996-2004)	99	96	95	94	100	100	98	100	59
Infant mortality/1,000 (2004)	16	32	23	16	6	8	11	15	57
Maternal mortality/100,000 adj (2000)	82	260	83	96	33	31	43	27	na
TB cases/100,000 (2004)	53	77	43	52	12	16	15	33	275
HIV prevalence % ages 15-49 (2005)	0.6	0.5	0.3	0.7	<0.2	0.3	0.3	0.5	1.1
Doctors/100,000 (2004)	301	115	198	194	591	109	132	365	na
Public health exp (%GDP, 2003)	4.3	3.4	2.9	2.0	6.3	3.0	5.8	2.7	na
Private health exp (%GDP, 2003)	4.6	4.2	3.3	2.5	1.0	3.1	1.5	7.1	na
GDP per capita (US\$PPP) (2004)	13,298	8,195	9,803	6,043	5,700*	10,874	9,481	9,421	4,775
Gini index for income / expenditure	52.8	58.0	49.5	44.1	na	57.1	49.9	44.9	Na

Sources: UNDP (2006: Tables 1, 3, 6, 9, 10 & 15), UNDP (2004: Table 1), based on a distinct method.