Neoliberalism and Health and Social Policy

HEALTH AND SOCIAL SECURITY REFORMS IN LATIN AMERICA: THE CONVERGENCE OF THE WORLD HEALTH ORGANIZATION, THE WORLD BANK, AND TRANSNATIONAL CORPORATIONS

Francisco Armada, Carles Muntaner,
and Vicente Navarro

International financial institutions have played an increasing role in the formation of social policy in Latin American countries over the last two decades, particularly in health and pension programs. World Bank loans and their attached policy conditions have promoted several social security reforms within a neoliberal framework that privileges the role of the market in the provision of health and pensions. Moreover, by endorsing the privatization of health services in Latin America, the World Health Organization has converged with these policies. The privatization of social security has benefited international corporations that become partners with local business elites. Thus the World Health Organization, international financial institutions, and transnational corporations have converged in the neoliberal reforms of social security in Latin America. Overall, the process represents a mechanism of resource transfer from labor to capital and sheds light on one of the ways in which neoliberalism may affect the health of Latin American populations.

Most Latin American countries have implemented extensive reforms of their welfare states, reforms characterized by a shift, from the public to the private sector, in the delivery and financing of health and other social security services such as old age and disability pensions and workers' compensation. The arguments for the effectiveness of such changes follow the neoliberal paradigm that assigns to the private market the ability to best allocate and use resources, even in the field of public health. The purpose of this analysis is to investigate the role of international financial institutions (IFIs)—the Word Bank, International

International Journal of Health Services, Volume 31, Number 4, Pages 729–768, 2001

Monetary Fund (IMF), and Inter-American Development Bank (IDB)—in the reform of social security in Latin America, evaluate the position toward such policies by the World Health Organization (WHO), and find out who directly benefits from these reforms.

First we present the context in which the social security reforms were implemented in Latin America as part of broader structural changes. We then examine the participation of the IFIs, particularly the World Bank, in health care and pension reform, as well as the position of the WHO as a supporter of these reforms, mostly in strengthening the role of the private sector in health services. Next we show the economic benefits to private corporations resulting from social security reforms. The article concludes with a discussion of the implications of social security reforms in Latin America for the commodification of health and reproduction of social inequalities, and we comment on some possible policy alternatives to the dominant neoliberal dogma.

BACKGROUND: NEOLIBERAL POLICIES IN LATIN AMERICA IN A GLOBAL CONTEXT

Neoliberal reforms of social security in most Latin American countries were implemented along with broader economic structural changes that began in the mid-1980s under strong pressure from the IFIs. These broader policies were directed at stabilizing national economies, controlling inflation, reducing fiscal deficits, opening national economies to international trade, increasing labor market flexibility, and reducing government intervention in the definition and implementation of social and economic policies (1–8). Although the ultimate goal of these measures is supposed to be the promotion of economic growth, they are related to the need of IFIs to ensure that less developed countries can pay their external debts (9).

Navarro has identified several underlying hypotheses in neoliberal thinking: (*a*) public deficits are intrinsically undesirable; (*b*) state regulation of the labor market is also undesirable; (*c*) social protections guaranteed by the welfare state and its redistributive policies hinder economic growth; and (*d*) the state should not intervene in regulating foreign trade or international financial markets (10). The principles behind these postulates are (*a*) the market is the best and most efficient way to create, produce, distribute, and allocate goods and services; (*b*) people follow rational choices mainly determined by their own individual interests; and (*c*) social security services, including health and pensions, are commodities (11).

The implementation of neoliberal reforms in Latin America has reached virtually every country in the region, although there is substantial cross-national variation in the timing, speed, extent, and other characteristics of the programs implemented (12, 13). Overall, the Structural Policy Efficiency Index—a quantitative index of structural adjustment policy implementation, with a maximum

value of 1 indicating extensive reform—increased in the region from 0.34 in 1985 to 0.60 in 1995 (5).

The IFI-promoted social security reforms were implemented despite the lack of rigorous evidence on the benefits of the free market for social policy (14). A key assumption of these IFI-supported projects is that market forces make services more efficient—an argument unsupported by the evidence. In fact, studies in the United States and other nations where market principles have been extensively applied to social services provide evidence to the contrary. For instance, empirical studies show increased inequities resulting from the privatization of health services (15), higher administrative and overall costs among for-profit providers (16, 17), worse health outcomes for patients receiving care in for-profit rather than not-for-profit institutions (18), and barriers to health care access in industrialized countries that heavily rely on private health systems (19). Moreover, user fees effectively reduce consumers' available income and exacerbate health inequalities (20).

THE ROLE OF INTERNATIONAL FINANCING INSTITUTIONS IN SOCIAL SECURITY REFORMS

The World Bank, the International Monetary Fund, and the Inter-American Development Bank have directly intervened in social policy-making by dictating major health care and social security reforms. Loan conditions and negotiation of payments of external debts have been the major tools of political leverage used by IFIs. A general objective of the IFIs has been the alignment of social policies with broader neoliberal changes (21–23). The "letters of intent" that indebted Latin American countries have submitted to the IMF provide evidence of how health and pension reforms are embedded in major economic policies.

These letters include a description of the policies countries intend to implement or have already put in place in order to comply with IMF recommendations and obtain access to loans. For instance, in 1998 Jorge Camet, Peru's Minister of Economy and Finance, and Germán Suárez, president of Peru's Central Reserve Bank, sent a letter to Michel Camdessus, managing director of the IMF, in which they described "the policies that Peru intends to implement in the context of its request for financial support from the IMF." They included details of arrangements to maintain Peru's balance of payments of its external debt and a declaration that the government of Peru intended "to service its debt to all other creditors punctually." The letter also enumerated other measures, including privatization of public enterprises, concessions granted to the private sector for the provision of public services, and continuation of the pension system reform that was initiated in 1993, featuring the issuing of pension bonds to former contributors to the public pension system who chose to transfer to the private system. Furthermore, the letter states, "The government will seek to complement its efforts in the education and health sectors by facilitating private investment in these areas." It also notes that

"in 1997 the government issued a new law allowing private companies to provide health services within the social security system" (24).

We can draw several other notable examples from these documents. The Memorandum of Economic and Financial Policies of the government of Jamaica describes Jamaica's macroeconomic objectives and policies for the years 2000 to 2002 to be implemented in the framework of an IMF-monitored program. The letter stresses the fiscal objectives of the plan and describes several actions directed to strengthening private markets, including development of a supervisory framework for pension funds. The plan also includes implementation of cost-recovery (i.e., self-financing) activities as a way to rationalize operations in the education and health sectors (25). The government of Honduras, in a letter from Hugo Castillo (Acting Minister of Finance) and Victoria Asfura de Diaz (president of the Central Bank of Honduras) to Horst Köhler (managing director of the IMF), reports the accomplishment of "four of the five prior actions required for the IMF Executive Board review of our Second Year Economic Program under the Poverty Reduction and Growth Facility," including elaboration of a plan to reform the Honduran Social Security Institute. In the same letter, as part of the policies that "Honduras intends to implement in the context of its request for financial support from the IMF," the submission to Congress of a draft law to regulate private pension funds was noted (26). The government of Ecuador, in another letter of intent to the IMF, describes the policies it intended to implement in 2000 and some already implemented in the context of a request for financial support of almost $300 million. Some of the measures included replacement of the national currency by the U.S. dollar, restructuring of the payment of the external debt, and reform of the social security system. In addition, it states "the government is undertaking a comprehensive pension reform, and is committed to allowing private sector participation in the provision of pensions" (27).

Although most Latin American and Caribbean countries are represented in the IFIs, the North American and Western European countries control the policy-making process, since shareholding and voting at the World Bank are determined by the size of a country's economic assets (28). For instance, in 1999 the largest industrial countries (United States, Japan, Germany, France, and United Kingdom), with about 37 percent of the shares, controlled the World Bank policies; and the United States, with the largest shareholding (16.53 percent), had an implicit veto power. The other countries assembled in groups to sum their shares, with one country assuming the representation of the whole group. For instance, in 1999, Canada represented a group of several small Caribbean countries with 3.88 percent of the shares. Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Spain, and Venezuela together pooled 4.27 percent of the shares and were represented by Spain (3). Regardless of their country of origin, the boards of directors of IFIs are likely to represent the hegemonic interests of national and transnational corporations (29).

The World Bank has lent billions of dollars to Latin American countries to encourage neoliberal reforms. In 1999 the amount reached $7,737 million (all dollar amounts in U.S. dollars), including a considerable amount for the social sector (Table 1). For example, the Pan American Health Organization (PAHO) reported that World Bank involvement in 30 health projects in 18 countries amounted to $2.5 billion at the beginning of 1997; and participation of the IDB in 49 loans for the health sector totaled $4.3 billion between 1992 and 1996 (30).

Although the IFIs are the major financers of the reforms, the participation of national agencies for international cooperation, based in industrialized countries, is also common in programs that encourage the adoption of neoliberal policies. For instance, the U.S. Agency for International Development (USAID) has assigned several million dollars for health programs through the Child Survival and Disease Fund, the amount requested in fiscal year 2001 reaching $86 million for Latin America (31). Financing is particularly targeted to the poorest countries, such as Bolivia and Guatemala, where privatization of the health sector has been encouraged (32, 33). For instance, a USAID document states, "In the private sector, operational support will continue for Bolivia's model self-financing, high quality, primary health care provider (PROSALUD), and USAID will add more to an endowment for long term sustainability." It also states that USAID will finance Bolivia's largest private provider of family planning services and a federation of 24 private and nongovernmental organizations (NGOs) (34). Moreover, the role of this agency in pushing an ideological agenda in Latin America, even on epidemiological grounds, has also been described (35).

The IFIs have participated actively in the design and implementation of diverse social programs, an activity that, with some exceptions, has not been subject to scrutiny in the public health arena (14, 36–38). The two areas of social policy in which the interventions have been most extensive are health care reform (carried out to some degree in most Latin American countries) and pension reform (mainly in Argentina, Bolivia, Chile, Colombia, El Salvador, Mexico, Peru, and Uruguay) (30, 39–41). We address here the main features of reforms that have encouraged a growth of the private sector in the provision of health care and pensions.[1]

Health Reforms

Health care reforms in most Latin American countries have been supported by World Bank and IDB loans (Table 2). The stated objectives of the loans were to boost the financial sustainability, equity, efficiency, and quality of health services, as well as to extend coverage to the poor (1–3, 42). Ironically, in some cases the

[1] A third area of intervention by the IFIs, within social security, has been workers' compensation programs. In Colombia and Argentina, new companies were created with the sole responsibility of handling workers' compensation and were often owned by the same shareholders as pension fund companies (see Table 5).

Table 1

Lending to Latin America and the Caribbean, fiscal years 1988–2000, millions of U.S. dollars[a]

Sector	FY 88–92[b]	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
Finance	515.8	525	604.5	1,909.50	11.9	630.2	562.5	2,403	1,311.5
Health, population, and nutrition	182	329	331	94.6	1,086.40	136.8	824	604	157.6
Social sector	19.8	85	130	500	262	405	284	1,375	640.6
Water supply and sanitation	261.5	439	521.5	221.5	204	200	190	50	147.3
Total	5,593.80	6,168.50	4,746.70	6,060.40	4,437.50	4,562.70	6,039.70	7,737	4,063.5

Source: World Bank (2–4).

[a]For fiscal year 2000 we used information on a loan-by-loan basis. "Social sector" corresponds to "social protection." The amount and classifications for the same year change slightly from one report to another.

[b]Annual average.

need to alleviate the negative social impact of economic reforms promoted by the IFIs themselves was also included among the goals of the loans (28), for instance in Ecuador (27). The activities financed by the World Bank and IDB include designing new health care systems, strengthening the agencies responsible for designing and regulating health policy, providing health care for low-income groups, decentralizing health services, and conducting research on health policy (1, 30, 43–45). Regardless of the type of intervention, most initiatives have favored the private financing and provision of health care over the former public financing and provision that predominated in most Latin American countries (45–48). The move from public to private represents a major shift in the financing, delivery, and ownership of health services. Even in Brazil, which had a national health system aimed at universal coverage, the private health sector has increased its participation in the provision of health services (49, 50).

Two major and closely related reform strategies promote the privatization of services: separation of the financing and provision of health care and promotion of competition between providers. In contrast to the integrated functions of the traditional public sector, separation of financing from provision allows for the independent functioning of "buyers" and "sellers" of health services (51). The sellers must compete among themselves for the preference of buyers. This system, also favored in North America and Europe, promoted the creation of a market in the provision of health care (52–54). The Chilean and Colombian models exemplify this approach (55, 56).

Every Chilean must choose enrollment in either the public or the private health system, both of which are financed through a compulsory payroll contribution of at least 7 percent of salary. The public system allows a free-choice option, depending on the enrollee's income, in which the enrollee chooses among private providers that are paid by the public system. The private system is dominated by the Instituciones de Salud Previsional (ISAPRES; Private Health Insurance Institutions), which offer health insurance and are financed through fixed mandatory payroll contributions. The ISAPRES act as private financers of health care and often directly provide health services, assuming a role similar to that of North American health maintenance organizations (57). The ISAPRES are expected to compete for patients (in terms of costs and coverage of services) among themselves and with the public system, Fondo Nacional de Salud (FONASA; the National Health Fund) (58, 59).

In Colombia the reform gave rise to separate private financers and providers of health care. The Entidades Promotoras de Salud (EPS; Health Promotion Organizations), private purchasers of health services, compete among themselves for the compulsory payroll contributions of beneficiaries, who are free to choose the EPS they prefer. The Instituciones Prestadoras de Servicios de Salud (IPSS; Health Service Providers), providing health services directly or through contracts with individual providers, are expected to compete for the preference of the purchasing organizations (EPS). Colombia also has a subsidized plan financed

Table 2

Selected World Bank and IDB loans to support health care reforms in Latin America and the Caribbean, 1993–1999

Country	Project name	Cost in U.S.$ millions [a]	Date of approval
Bolivia	Health Sector Reform Project	IBRD: 25	1999
Brazil	Health Sector Reform Project (951/OC-BR)	750 (IDB: 350; World Bank: 300; local: 100)	1996
	Program for the Regulation of Private Health Plans	IMF: 1.55; local: 1.55	199?
Colombia	Program to Support Health Sector Reform (910/OC-CO)	63 (IDB: 38; local: 25)	1995
Dominican Republic	Health Sector Modernization and Restructuring (1047/OC-DR)	75 (IDB: 61.2; local: 5.3)	1997
Guatemala	Program to Upgrade Health Care Services (890/OC-GU and 891/OC-GU)	40.5 (IDB: 38.5; local: 2.0)	1995
Guyana	Health Sector Policy and Institutional Development Program (TC-95-03-11-2-GY)	2.75 (IDB: 2.5)	1997
Jamaica	Health Sector Reform Program (1028/OC-JA) and Technical Support to the Health Reform Unit of the Ministry of Health (ATN/CI-4995-JA)	25.7 (IDB: 17.7; local: 8.0)	1997
Mexico	Support of the Health System Reform	IBRD: 700	1998
	Technical Assistance to Support the Design and Implementation of the Health System Reform Program	IBRD: 25	1998
Nicaragua	First phase of the Health Sector Modernization Program	IDA: 24 Total cost: 32	1998

Table 2

(Cont'd.)

Country	Project name	Cost in U.S.$ millions [a]	Date of approval
Peru	Program to Strengthen Health Services (741/OC-PE)	98.0 (IDB: 68.0; local: 10.0; other: 20.0)	1993
Panama	Health Care Reform Program (803/OC-PN)	52.8 (IDB: 42.0; local: 10.8)	1993
	Health Sector Reform Pilot Project	IBRD: 4.3	1998
Trinidada and Tobago	Health Sector Reform Program (937/OC-TT)	192 (IDB: 134; local: 58)	1996
Venezuela	Program to Strengthen and Modernize the Health Sector (867/OC-VE)	300 (IDB: 150; local: 150)	1995

Source: Inter-American Development Bank, Annual Report 1998; World Bank (2); World Bank, Projects Report, www.worldbank.org; a World Bank projects search tool at www4.worldbank.org/sprojects/default.asp; and the IDB's Web site, www.iadb.org/exr/topics/health.htm.

[a]IBRD, International Bank for Reconstruction and Development; IDA, International Development Association.

through a solidarity fund in which 1 percent of the payroll of all enrollees is invested; this fund provides health care for low-income members who do not contribute through a third kind of institution, the Empresas Solidarias de Salud (ESS; Solidarity Health Companies), which also act as a purchasers' association (60, 61).

In both Colombia and Chile, then, separation of the provision and financing of health care led to creation of new private providers financed through mandatory income transfers from the salaries of beneficiaries and through state subsidies. Other explicit mechanisms for privatizing health care provision are included in World Bank and IDB loans, including "cost recovery" (e.g., user fees) in health care services (62), autonomous administration of hospitals and services, privatization of services, and subsidies to private health insurance. For instance, the Ecuador Health Services Modernization Project included categorization of users according to income, development of a system of copayment, and user charges (63). Another example is a $24 million project for modernizing the health sector in Nicaragua leading to the creation of private wards "catering to those able to pay"

as a mechanism for financing public hospitals. This project is explicitly aimed at the strengthening and growth of the private sector in the provision and financing of health care. The activities of this project included support for the elaboration of comprehensive legislation concerning the Ministry of Health, Social Security, private health insurance, private providers, hospitals, and health professionals (64). These new systems reinforced differential access to health care depending on income in Latin America (50, 65, 66).

In addition to their participation in health care system reform, the IFIs (and in some cases USAID) have also increased their influence in public health through the design and financing of specific public health interventions in Latin American countries (3, 31, 66). For instance, interventions include care for the "vulnerable" sectors of the population: mothers and young children (Dominican Republic, Ecuador, and Nicaragua) and the retired, disabled, and unemployed (Brazil). Programs also cover increased access to water supplies (Paraguay and Bolivia), measures to control the spread of HIV/AIDS (Argentina, Brazil, and Honduras), and strengthening of national disease-surveillance programs (Brazil) and nutrition programs (Honduras) (2–4). The organizations responsible for implementing these programs are often NGOs or new governmental agencies other than the ministries of health (67, 68). Although NGOs have good reputations in liberal circles in the United States (e.g., 69), their role in Latin America has further increased countries' financial dependence for social and health programs, expanded the IFIs' influence over health policy, and limited the role of the state in the provision of health and social services. NGOs backed by this mode of financing take over functions that correspond to national governments. Therefore, contrary to the claimed objectives of reforms, the role of the ministries of health and governments, has been weakened rather than strengthened (29, 70–72).

Pension Reform

Following establishment of a new pension system in Chile in 1981 during Pinochet's dictatorship, in the 1990s other Latin American countries enacted legislation to modify their pension systems: Peru in 1993, Argentina and Colombia in 1994, Uruguay in 1996, and Mexico in 1997 (73, 74). Before this wave of reforms, the dominant pension systems in Latin America were state-administered and state-provided "pay-as-you-go" social insurance schemes. As in the case of health reforms, deficiencies in the financial sustainability, efficiency, equity, and coverage of the pension schemes were presented as major justifications for change, but arguments about aging populations were also prominent (39, 75, 76).

The World Bank provided the major guidelines for pension reform in a report whose title summarizes two aspects of the process: *Averting the Old Age Crisis: Policies to Protect the Old and Promote Growth* (77). Its recommendations for change include creation of three pillars for pension management: a public pillar to alleviate poverty among the old; a second, mandatory pillar that is fully funded by

individual capitalization of contributions and privately managed; and a third, voluntary pillar for those wanting additional income in their old age. Furthermore, the World Bank in this report endorsed and promoted the reforms carried out in Chile, and even pointed out how in Latin America, as "the region entered in the 1990s, the movement to privatize pensions gained momentum, urged by the success in Chile" (77, p. 276).

In contrast to the old systems, the responsibility for pension arrangements is transferred to individuals and the amount of each pension is directly linked to individuals' contributions (78, 79). Mandatory contributions are a fixed percentage of the worker's salary, but the amount of the pension is undetermined. The government may establish a minimum pension amount, which will be covered by national funds if a worker's contributions have not provided for this minimum pension (41). Two major pension options are available: planned withdrawal and life annuities (78). In the latter, the funds are managed by insurance companies, further extending the role of the private sector in social security (80).

The World Bank and its allies expect economic growth among the countries that institute pension reforms. Particularly, the second pillar is expected to promote capital accumulation and financial market development (77). New schemes include creation of private institutions that take sole responsibility for managing the contributions of enrollees. These pension fund management companies, Administradoras de Fondos de Pensiones (AFPs), invest enrollees' money and produce dividends, and the accumulated individual contributions and returns support the payment of pensions when each beneficiary retires. The AFPs' investments will supposedly boost the economy through national capital markets, assuming national savings increase. In addition, the labor market will become more flexible because of the reduction of employers' responsibility for their workers' social security. The strong association between pension reform and economic expectations is evident in the close links between pension reform and the wider structural reforms (based on neoliberal paradigms) in which that reform is framed. Thus, pension reform is viewed as another element of economic liberalization rather than a mechanism of income redistribution and social well-being (81).

The AFPs profit in several ways from this business. A percentage of the compulsory contribution of about 2 percent of a worker's salary goes to these companies and is the basis of their economic gain. The companies can also choose to earn a profit by taking a percentage of the accumulated contributions or a percentage of the returns produced by the investment. They can also charge for financial services. In Argentina an average of 3.37 percent of workers' salary is used to cover the administrative costs and profits of the AFPs (Table 3) (82). Although the Mexican system allows a charge over and above the returns on investments of workers' contributions, only one in 13 pension fund management organizations (called AFORES in Mexico) choose this option (the toll was established in one-third of the net returns). Ironically, most AFORES prefer

Table 3

Mean charges on mandatory contributions (as percentage of salary) by pension fund manager (AFP), Argentina, October 2000

Fund manager (AFP)	Mean charges[a] (as % of salary)
ARAUCA BIT	2.7451
CONSOLIDAR	3.5138
FUTURA	3.0000
GENERAR	2.4666
MÁXIMA	3.5049
NACIÓN	3.0000
ORÍGENES	3.5375
PREVINTER	3.5119
PREVISOL	3.5928
PROFESIÓN + AUGE	3.0000
PRORENTA	3.5000
SIEMBRA	3.5489
UNIDOS	3.4906
Mean	3.3746

Sources: Republica Argentina, Superintendencia de Administradoras de Fondos de Pensiones y Jubilaciones, www.safjp.gov.ar/docs/estc10.htm.

[a]Charges do not include the discount provided to beneficiaries for not changing company for an extended time.

not to derive their profit from successful investing—contrary to their recommendation to their clients, whose pensions will depend on such returns. Rather, for these AFORES, a fixed percentage of workers' salary ensures a secure profit, regardless of a company's degree of success in investing their clients' money (83, 84).

As with health care reforms, IFI loans have played a crucial role in pension system reforms across Latin America (Table 4). IFI financing has covered several pension reform projects, including feasibility studies, changes in legislation, creation of new agencies, and implementation of reforms. For instance, IFIs granted loans for the preparation of legislation in Mexico and Uruguay and for the extension of pension reform to provinces and municipalities in Argentina (Table 4). One of the most recent pension reform projects has been Nicaragua's: "its transformation from a government administered Defined Benefit scheme to a privately operated Defined-Contribution system." Such reforms were expected to "contribute to enhance macroeconomic stability, impact positively on poverty and

inequality and facilitate the development of a private sector provision of services as well as the deepening of financial and capital markets" (85).

Yet, benefits for national economies are not as evident as are those for pension fund managers. Countries that privatized their pension systems had high hopes for its salutary effects in the economic arena, but an evaluation of the Chilean system (which has the longest experience) concludes that (*a*) neither the state burden nor the administrative costs have been reduced, (*b*) the impact on the expansion of labor and capital markets has been less than expected, and (*c*) economic power has been concentrated in the hands of the companies managing pension funds (86). Evidence available so far suggests a similar impact in other Latin American countries (87). Furthermore, as Barrientos points out, the cost of the new private pension systems is much higher than that of the public pay-as-you-go systems, owing to high charges over workers' salaries and the cost of marketing and sales personnel (81). Indeed, the World Bank's former chief economist, Joseph Stiglitz, identified the lack of security of the private pension systems as one of their major weaknesses: "There is a recognition that the private market doesn't provide many types of insurance that individuals need and want for their retirement." Furthermore, he pointed out, referring to the promotion of private pension funds in "developing" countries, "I think there has been an element of ideology in pushing that" (quoted in 88).

VALIDATION BY INTERGOVERNMENTAL HEALTH ORGANIZATIONS: THE PAHO AND THE WHO

The Pan American Health Organization (PAHO), the WHO, and other intergovernmental institutions such as the United Nations Development Program (UNDP) are converging with the IFIs in their policy approach for Latin America: the importance of stressing private approaches for the financing and provision of social security services. This view has been actively sponsored by the World Bank since the 1980s (14)—see, for example, the World Bank's *Financing Health Services in Developing Countries: An Agenda for Reform* (89) and *World Development Report 1993: Investing in Health* (90).

PAHO participates in several cooperative projects with USAID and the World Bank. Together they launched the Latin America and Caribbean Regional Health Sector Reform Initiative (91), a project whose goal is to track the pace and characteristics of health reforms in the Americas. PAHO has also participated in a project in collaboration with the World Bank, IDB, UNDP, and the Denmark Consultant Trust Fund to measure inequalities in the Americas, the EquiLac Initiative (92). In both cases, the IFIs, important stakeholders in the process, finance the evaluation of their own interventions. PAHO has also collaborated with World Bank Health Reforms Projects, for instance a 10-year project in Bolivia (93). Support for the health sector reform process is one of the common strategies included in the Shared Agenda for Health in the Americas, an agreement

Table 4

Selected World Bank and IDB loans to support pension reform, Latin America, 1996–2000

	Project name or description	Cost, U.S.$ millions[a]	Date of approval
Argentina	Support for the government's provincial pension fund reform program	IBRD: 300; total: 400	1996
	Improvement of allocation of pension benefits and payments (National Pension Administration)	IBRD: 20	1997
Bolivia	Financial Markets and Pension Reform Technical Assistance Project. It included among its objectives "establishment of the regulatory structure for the system of individual capitalization pension" and studies of workers' compensation	9	1995
Brazil	Technical assistance to help state governments address pension reform	IBRD: 5; total: 10	1998
	Support Social Security Reform, basing pension on years of contribution, eliminating most special pension regimes, and reducing inequalities between benefits of public and private sector workers	IBRD: 757.6	1999
	Second Social Security Special Sector Adjustment Loan	IBRD: 500	1999
Colombia	Improvement of the regulatory capacity for pension reform	Total: 20; IBRD: 15	1997
El Salvador	Institutional Transformation Support for the Instituto Salvadoreño del Seguro Social		2000

Table 4

(Cont'd.)

	Project name or description	Cost, U.S.$ millions[a]	Date of approval
Mexico	Support for the first phase of the government's Contractual Savings Development Program, which will establish legal, regulatory, and institutional frameworks for reforming the old age security system	IBRD: 400	1997
	Second phase of the above	IBRD: 400	1998
Nicaragua	Pension Reform Technical Assistance (TA) Project, including "introduce new insurance, and capital markets instruments for a pension fund investment, by implementing a revision framework for private sector participation in new pension aspects." "The Pension and Financial Market Reform TA will design and implement: ii) a mandatory, funded, defined contribution pension system of privately managed individual pension accounts."	Government: 2.6; IDA (World Bank): 8	2000
Peru	Pension Reform Adjustment Loan	IBRD: 100	1997
Uruguay	Social Security Reform Program; assistance with implementation of social security reform law; draft any new legislation needed to adapt pension plans that cover certain occupational groups to the new system (921/OC-UR)	IDB: 150	1996
	Support development of the capitalized system of individual pension accounts	IBRD: 100	1998

Sources: World Bank (1–4); World Bank Projects Report, www.worldbank.org; World Bank projects search tool at www4.worldbank.org/sprojects/default.asp; and IDB's Web site, www.iadb.org/exr/topics/health.htm.

[a]IBRD, International Bank for Reconstruction and Development; IDA, International Development Association.

between the World Bank, IDB, and PAHO to develop a common agenda for health in the Americas (94). Furthermore, PAHO has explicitly endorsed a strengthening of private sector participation in health care delivery in Latin America, as is evident in some of its reports (95, 96).

The WHO has also been following the trend to support private participation in health care delivery, and its implicit support, at least in Latin America, is evident in its evaluation of health care systems' performance (97). The health systems of Colombia and Chile—which, as we have noted, have undergone in-depth reforms favoring participation of the private sector in provision and financing—were ranked highest among the Latin American countries. As derived from the report, the lesson to be learned by Latin American countries is to strengthen the role of the private sector in financing and delivery of health care. Moreover, the WHO ranked Colombia first in the world in fairness of financial contributions, one of the five categories of health system evaluation used to rank health systems. This classification does not look at fairness in the distribution, allocation, or use of resources. For instance, the universality of the Colombian health care system is based on two different health plans: one directed to those above a certain economic level, who are enrolled in the private-run system of the EPS; the other a subsidized plan that provides much less comprehensive coverage for those unable to make full contributions to the private system. Thus, stratification of health care according to the ability to pay is institutionalized. The WHO's support for these health systems, as well as its call for strengthening the role of government in supervising private provision as a way to facilitate the role of the private sector in health care, shows its convergence with the World Bank. The WHO report has been questioned for its lack of scientific rigor and its ideological approach (98, 99). Similar concerns about the influence of corporate interests in international institutions have been raised regarding the UNDP (100).[2]

These associations between international health agencies and IFIs, apparently justified by budgetary deficits (102), not only reinforce the power of the IFIs in shaping health policy in Latin America but also jeopardize the independence of international agencies in policy evaluation and design, technical cooperation,

[2] The Directory of Experts and Bibliography about Poverty and Social Development in Latin America and the Caribbean compiled by the UNDP (101) provides another example of IFIs' interventions. Within a project of poverty alleviation and social development, this is a directory of experts on poverty and social development in Latin American countries. Of the 125 listed experts, 16 hold a position within the World Bank or the IDB and an additional 30 declared previous or current working relations with one or both institutions; together they represent 36.8 percent of the experts identified by this agency of the United Nations. Given that most of these experts are part of the ruling class of their countries of origin, they are likely to voice the interests of that group. Furthermore, the absence of experts who are critical of neoliberal policies is notorious; one cannot find scholars such as Asa Cristina Laurell (Metropolitan University, Mexico), Jaime Breilh (Centro de Estudios y Asesoria en Salud, Ecuador), Saul Franco (Universidad Nacional de Colombia), or Howard Waitzkin (University of New Mexico), all of whom have described the negative impact of World Bank policies on social development in the region.

research, and assessment of the social and health effects of economic policies. This is why studies on the impact of neoliberal policies in Latin American countries and policy recommendations for the region are shaped by the interests of the IFIs, even when the studies are carried out by intergovernmental agencies (11, 35). Thus it is not surprising that the same PAHO publication that describes with concern the growth in health and income inequalities also points out that one of the key areas of World Bank assistance to the Latin American countries is "improving health outcomes for the poor by supporting programs that improve the equity and access to a range of preventive and clinical services; enhancing efficiency in the health sector, particularly by *encouraging competition";* and "fostering a balanced public/private mix that involves *greater private sector participation* in areas such as cofinancing, management, public sector service contracts" (30; emphasis added).

A major consequence of these social policies validated by the WHO is the growing privatization of social services in Latin America. These changes in the provision of services have mirrored and complemented the privatization of other public enterprises and services, such as water, telephone, electricity, and airlines, from which local and transnational ruling classes have benefited (103). In the next section we present evidence on the beneficiaries of such privatization.

BENEFICIARIES OF THE PRIVATIZATION OF HEALTH AND SOCIAL SECURITY: THE TRANSNATIONAL AND NATIONAL CORPORATIONS[3]

Several North American and European companies have entered or reinforced their participation in the health and pension markets in the Americas (Table 5 and Figure 1). They belong to an extended network of companies that provide interrelated financial, banking, investment, and insurance services. The review of these companies' reports indicates an increased share of the social services market in Chile in the 1980s, but it was mainly during the 1990s that most transnational companies intensified their presence in Latin American countries as providers of health care or pension management services (104–107).

North American corporations participate significantly in the provision of social security services in Latin America. Stocker and colleagues (108) have provided evidence of the activities of these corporations in a report on the export of managed care to Latin America. Whether using managed care or other similar approaches to health care, Aetna, CIGNA, AIG, and Citibank (Citicorp) controlled large sectors of health care and pension funds in several countries by the end of the last decade.

[3] The main sources of information for this section, unless otherwise noted, are the home pages of the companies and agencies on the World Wide Web. We reviewed data from official Web sites of companies and agencies involved in the regulation, provision, or financing of health, pension, and workers' compensations programs. These Internet sources, retrieved between March and November 2000, are listed in the Appendix.

Table 5

International provision of social security services in Latin America, 1999–2000

National origin	Services[a]	Company	Countries of investment (companies)
Australia	WC	HIH	Argentina (HIH, www.hih.com.ar)
Canada	P	Sun-Life	Chile (Cuprum, www.cuprum.cl)
France	P, WC	CNP Assurance S.A	Argentina (Previsol and Asociart)
Germany	P	Dresdner Bank	Mexico (Bancrecer Dresdner, www.bancrecer.com.mx); El Salvador (Porvenir, www.afpprovida.cl/Internacional)
Italy	P	Assicurazione Generali S.P.A.	Argentina (Generar)
Spain	P, WC	Banco Bilbao Vizcaya	Bolivia (Prevision); Argentina (Consolidar, www.consolidar.com.ar); Mexico (Profuturo G.N.P., www.afpprovida.cl/Internacional); Colombia (Horizonte, www.horizonte.com.co; and Porvenir, www.porvenir.com.co/ *and* www.afpprovida.cl/Internacional/); Chile (Provida, www.afpprovida.cl); El Salvador (Porvenir, www.afpprovida.cl/Internacional); Peru (Horizonte, www.afphorizonte.com.pe/)
		Banco Santander	Argentina (Orignes); Chile (Summa Santander, www.summabansander.cl); Colombia (Santander); Uruguay (Santander, www.santander.com.uy); Mexico (Garante, www.garante.com.mx; Santander Mexicano); Peru (Union Vida, www.unionvida.com.pe)
	WC	Mapfre	Argentina (MAPFRE, www.mapfre.com.ar); Mexico (Tema Vida and Tepeyac)
Sweden	P	Skandia	Colombia (Skandia)
Switzerland	P	Zurmex Canada Holdings, Ltd.	Mexico (Zurich, www.zurich.com.mx/)

Table 5

(Cont'd.)

National origin	Services[a]	Company	Countries of investment (companies)
The Netherlands	P	Aegon Mexico Holding B.V.	Mexico (Banamex Aegon, www.banamex.com.mx)
	P	ING Holland	Peru (Integra Peru); Mexico (Vital, www.bital.com.mx)
U.K.	P	Hsbc Chacabuco Inversiones	Argentina (Maxima, www.maxima.com.ar/)
U.S.A.	WC	AIG	Mexico (AIG Mexico, aigmex.com/index2.htm); Peru (Pacifico Salud, www.elpacifico.com)
	H, P	Aetna	Argentina (Asistencia Medica Social Argentina—Aetna, www.amso.com.ar/); Brazil (SULAPREVI, www.sulaprevi.com.br/); Chile (Santa Maria, www.stamaria.cl); Peru (Novasalud EPS, www.novasalud.com.pe/; Integra Peru, www.integra.com.pe/); Mexico (Bancomer, www.bancomer.com.mx)
	P	Citicorp group	Chile (Habitat, www.habitat.cl); Uruguay (Capital, www.capitalafap.com.uy/); Peru (Profuturo, www.profuturo.com.pe/); Mexico (Garante, www.garante.com.mx); Colombia (Colfondos, svrwebcol.colfondos.com.co/)
	H, P	CIGNA	Brazil (AMICO Asistencia Medica, www.amico.com.br/; Cigna previdencia, www.cigna.com.br); Chile (CIGNA Salud Isapre, www.cigna.cl/)
		Others[b]	Bankboston: Uruguay (Union, www.unionafap.com.uy); Berkley Corporation: Argentina (BERKLEY, www.berkley.com.ar); Unum Corporation: Argentina (BOSTON, www.boston.com.ar); Pension Management Ltd.: Argentina (Siembra, www.siembra.com.ar/); Continental National American Group: Argentina (CNA Omega,

Table 5

(Cont'd.)

National origin	Services[a]	Company	Countries of investment (companies)
U.S.A. (cont'd.)		Others[b] (cont'd.)	www.omega-art.com.ar); General Electric Assurance Company: Mexico (Inbursa, www.gefinancialassurance.com); George Washington University: Peru (Novasalud EPS); Hartford Life Insurance: Uruguay (Union); Principal International Inc. Principal Financial Group: Mexico (Principal, www.principal.com.mx); Liberty: Argentina (Liberty); Inverlink Preferred Market: Chile (Magister, www.magister.cl); New York Life International Inc.: Argentina (Maxima)

Sources: Internet sites as specified in the table and originate from the following national agencies: Argentina (www.srt.gov.ar/home.html); Chile (www.sisp.cl/); Colombia (www.superbancaria.gov.co/); El Salvador (www.spensiones.gob.sv); Mexico (www.consar.gob.mx); and Peru (www.safp.gob.pe/afp. htm *and* www.seps.gob.pe).

[a]WC, workers' compensation; P, pensions; H, health care.

[b]Entries listed by company.

Aetna is one of the biggest North American companies in the Latin American private social service market. It entered early in the Chilean market and created a pension fund management company, AFP Santa Maria, and a second enterprise, Aetna ISAPRES, in charge of health care. It used the first company to open similar businesses in Peru (AFP Integra) and Mexico (AFORE Bancomer). In Brazil in 1997, Sul America Seguros (which reported premiums of $1.2 billion) joined Aetna to form Sul America Aetna. In 1999 Aetna's share of the Argentine market skyrocketed when it acquired the largest health care company in that country, Asistencia Médica Social Argentina S.A. (AMSA), for approximately $100 million. We can find examples of the transfer of money from Latin American countries to the United States in Aetna's 1999 annual report, which records gains in the Americas of $147.5 million in 1999, $112.9 million in 1998, and $83.0 million in 1997. Furthermore, during the first three quarters of 1999, Aetna reported an increase in operative earnings of 72.9 percent, reaching $98.4 million (106). An estimate of how much Aetna benefited from the privatization of social security in Latin America is hard to make, since these amounts include other areas of business and Aetna often purchases or sells pensions and health companies. For instance, in September 2000 Aetna announced its plan to sell a Mexican pension fund manager, AFORE Bancomer, for $693 million to a financial group led by the

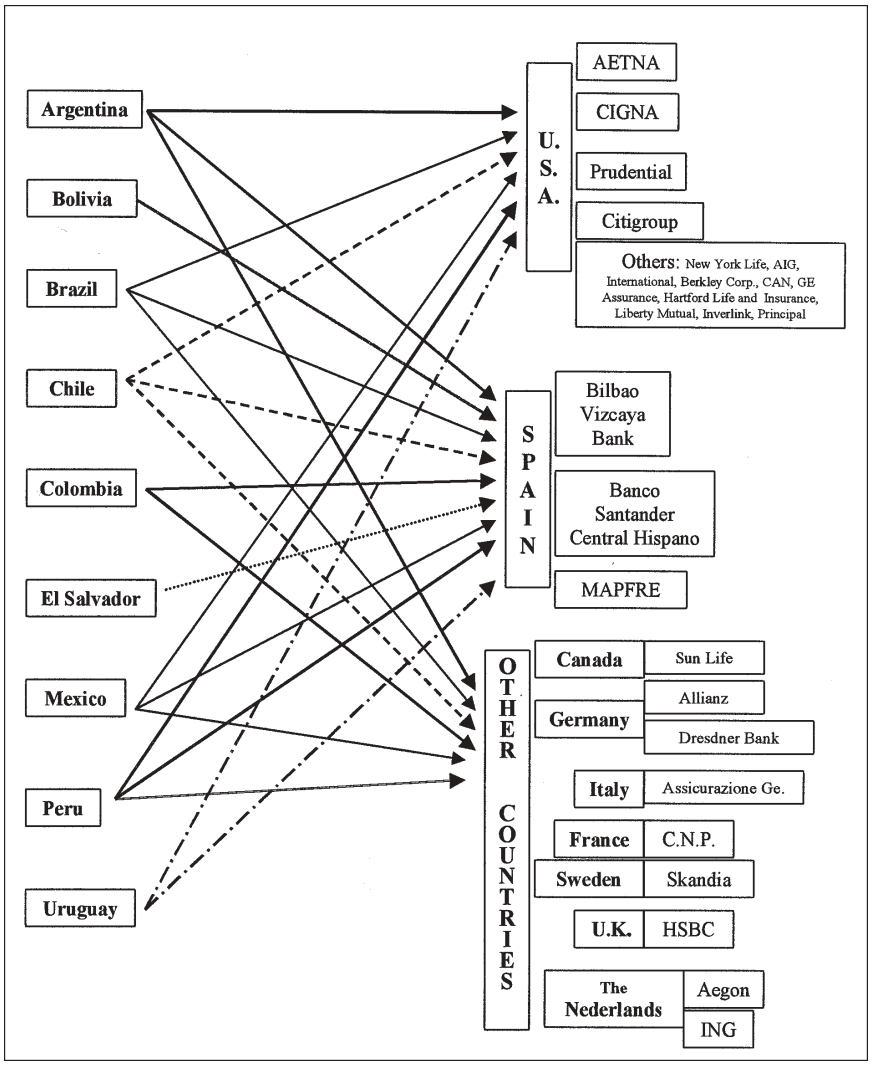

Figure 1. Internationalization of social security. *Source:* World Bank (1).

Spanish Bilbao Vizcaya Bank (BVAB) (109). In November 2000 Aetna called a shareholder meeting to discuss the sale of all its international businesses to a Netherlands-based financial and insurance company, ING (110).

Several other North American companies have taken part in the private provision of health care, pensions, and workers' compensation services. For instance, Citibank owns shares in several pension fund management companies:

Profuturo in Peru, Colfondos in Colombia, Capital in Uruguay, and Garante in Mexico. In Argentina, Liberty Mutual participates in Liberty ART S.A., providing workers' compensation services, and the Berkley Corporation takes advantage of the same field with a different company. New York Life Insurance participates in the private pension business through AFPJ Maxima in Argentina; and Sun Life of Canada joined a Chilean financial group in AFP Cuprum.

The U.S. government, through its departments of Commerce and State, has promoted this participation of U.S. enterprises in the privatization of social security in Latin America. In several reports prepared by these agencies, the loans and projects of the IFIs were included as "business opportunities." For instance, a telegraphic report from the U.S. Embassy in Caracas, in reference to the later-approved Health Sector Modernization Loan from the IDB, stated that a "significant part of the health care modernization project of government will be funded by IDB and the World Bank. In this regard, there is up to 120 USD [U.S.$] million in potential business to U.S. companies" (111). The U.S. Foreign Commercial Service and the U.S. Department of State, in a report on health services in Argentina, identified the provision of managed care through the program of "self-supporting hospitals" (directed at the self-financing of public hospitals) as another business opportunity (112).

European companies have also entered the Latin American health and pension services market. Three Spanish companies dominate the scene: two huge financial groups, Banco Santander Central Hispano (BSCH) and Banco Bilbao Vizcaya (BBVA), and one insurance company, MAPFRE.[4] These companies are present in several countries and are involved in pensions, health care, and workers' compensation in addition to several other businesses. In fact, BBVA claims to be the major manager of pensions in Latin America, with a 31 percent share of the market. BBVA reported a net benefit in 1999 of 13 million euros (AFP Provida, Chile), 28 million euros (AFJP Consolida, Argentina), and 35 million euros (AFJP Siembra, Argentina). In Argentina, BBVA is also involved in providing workers' compensations services (104). These three enterprises participate in a large network of institutions that provide diverse social security services in Latin America. As most of their reports indicate, these services create considerable profits, in addition to an opportunity to expand other financial, banking, and insurance businesses in Latin America (104, 105, 107).

Other European enterprises also provide social security services in Latin America, though to a lesser extent. A Nordic company, Skandia, manages pension funds in Colombia; it claimed to cover 9 percent of the local private pension market in 1999 (115). A British company, HSBC, takes part in the pension fund manager Maxima in Argentina. CNP Assurance, a French state-owned company, is involved in pensions through AFJP Previsol and in workers' compensation

[4] Several Spanish banks, including BBVA, were linked to the fascist Francoist regime (113, 114).

through the ART Asociart, both in Argentina. Businesses based in Germany (General Re and Allianz), Italy (Assicurazione Generalli), the Netherlands (ING), and Australia (HIH) are also stakeholders in the private provision of social security services.

Local companies have also benefited from the privatization of social security in Latin America. Formations of associations with foreign companies or the sale of national businesses to transnational corporations has been a common practice. For instance, the main shareholders of the Mexican fund administrators (AFORES) are both Mexican and international (Table 6). Some AFORES are dominated by Mexican companies, others by transnational corporations, and still others by an association between the two (83, 84).

Some local economic elites have increased their wealth by gaining direct control over health care and pension fund services. For example, after new legislation was approved for the social security reform in Colombia, a well-established financial group, Suramericana, created several companies to participate in the privatization of social services based on compulsory contributions: SUSALUD (Compañia Suramericana de Servicios de Salud) for the provision of health services; Proteccion, S.A., for the management of pension funds; and SURET, in charge of workers' compensation services. These three new companies joined an already diversified business network in the financial arena that paradoxically also included a tobacco company (116).

Chile provides another example of the benefits of privatization to local capital. Banmédica, a company that originally provided health care to bank clerks, had become a large corporation by the end of the 1990s. Its network of companies includes a health care provider (ISAPRE), life insurance, emergency paramedic care, and real estate business. It even explored the international arena with joint ventures in pension funds in Peru (AFP Horizonte) and Argentina (AFJP Previar) and with a health care provider in Colombia (Salud Colmena). In 1997, after acquiring another health care provider (Compensacion) and a clinical center, Banmédica reported income of over $260 million and coverage of 800,000 people in its Chilean health care business (117).

LESSONS FROM NEOLIBERAL INTERVENTIONISM

The World Bank and other IFIs, along with the WHO and international corporations, have engaged in a common quest to replace the traditional role of the public sector in the welfare state with private control of the provision of social services. The IFIs have influenced the design and implementation of health and social policy in Latin America through the promotion of structural reforms in the provision of health care, pensions, and other social services. Complementary intergovernmental agencies in the health arena have reinforced this approach by supporting a growing participation of the private sector in health care. According to our analysis, transnational and national corporations linked to the financial

Table 6

Pension funds administrators (AFOREs) in Mexico: Shareholders, percentage of shares, and country of origin

AFORE	Shareholders[a]	% of shares	Country
Bancomer	Bancomer, S.A., Grupo Financiero Bancomer	51	U.S.
	Aetna International	33	
	Santamaría Internacional, S.A.	16	
Banamex Aegon	Banco Nacional de México, S.A., Grupo Financiero Banamex-Accival	51	
	Aegon Mexico Holding B.V.	49	
Vital	Seguros Bital, S.A., Grupo Financiero Bital	99	Netherlands, Spain, Portugal
Principal	Principal International Inc.	99	U.S.
Inbursa	Banco Inbursa, S.A., Grupo Financiero Inbursa	94	
	General Electric Assurance Company	05	
Tepeyac	Tema Vida	67	
	Caja de Madrid Vida, S.A., de Seguros y Reaseguros	33	
XXI	Instituto Mexicano del Seguro Social	50	
	IXE Banco, S.A., Institución de Banca Múltiple, IXE Grupo Financiero	50	
Bancrecer	Bancrecer, S.A., Grupo Financiero Bancrecer	51	
Dresdner	Dresdner Pension Fund Holdings, LLC	44	
	Allianz México, S.A.	5	
Garante	Citybank México, S.A., Grupo Financiero Citibank	51	
	México, S.A., Grupo Financiero Citibank	40	
	Habitat Desarrollo Internacional, S.A.	9	
Profuturo G.N.P.	Grupo Nacional Provincial Pensiones	55	
	Banco Bilbao Vizcaya, S.A.	30	
	Provida Internacional, S.A.	14	
Santander Mexicano	Banco Santander Mexicano, S.A. Grupo Financiero Santander Mexicano	75	Spain
	Santander Investment, S.A.	25	

Table 6

(Cont'd.)

AFORE	Shareholders[a]	% of shares	Country
Sólida Banorte Generali	Banco Mercantil del Norte, S.A., Grupo Financiero Banorte	51	Italy, Netherlands
	Participatie Maatschappij Graafscghap Holland, N.V.	24	
Zurich	Zurmex Canada Holdings, Ltd.	90	Switzerland
	Individuals	8	

Sources: Comision Nacional del Sistema de Ahorro para el Retiro (CONSAR), www.consar.gob.mx. Original table modified, country of origin added by the authors.

[a]Banco Santander Central Hispanoamericano (Spain) and Banco Comercial Portugués (Portugal) hold 8.3 percent each of the shares of Grupo Vital; www.bital.com.mx. It is not clear whether ING (the Netherlands) owns 50 percent and plans to acquire, or already did acquire, another 50 percent of AFORE Bital.

arena have emerged as the major economic beneficiaries of these reforms, and several companies are currently profiting from the provision of health and pensions services in Latin America. The political process by which the World Bank and other IFIs have promoted such policies, the WHO has backed them, and private corporations have benefited demonstrates the predominance of ideological arguments that favor the interests of capital. This process also imposes a vision of health and pensions as commodities rather than fundamental human and social rights.

We maintain that the implementation of neoliberal policies in the social arenas in Latin America has reproduced already-existing social and economic inequalities by promoting a transfer of resources from the majority of the population to capitalist classes at both the national and international levels. Those capitalist classes are the wealthy owners of financial and physical capital (118). For the neoliberal reform of social security in Latin American countries, alliances between local and international capitalist classes promoted and took advantage of the conversion of social security services to private commodities.

Indeed, some scholars have suggested that neoliberal policies favored the transfer of resources (e.g., income, wealth, environmental security, and political power) from labor to capital within countries and from the peripheral (or "third world") to the core (or "first world") countries (119, 120). We differentiate five dimensions of such transfers.

First, regardless of their labor conditions, all salaried workers are compelled to enroll in social security programs that require compulsory payroll taxes to finance

the system, including a percentage for the profit of private fund managers. (Any welfare state requires workers to contribute, of course, but in a public scheme all the contributed resources are invested in the welfare of the majority and do not profit a particular group of society.) These reforms of social security have led to the creation of private companies that profit from the management of workers' resources; this constitutes a transfer from workers to the capitalist classes.[5] The different systems mandate that a percentage of workers' wages be transferred to cover social security costs, but also including a profit for private businesses. Compulsory contributions from salaries vary among countries. For instance, in Chile it includes 10 percent for old age pensions, 3.2 percent for disability and survivors insurance, and 7 percent for health coverage; and additional voluntary contributions are encouraged, up to 10 percent for pensions and between 3 and 4 percent for better health packages. In Mexico the salary-based contribution for pensions, handled by the privately owned pension fund managers, is 6.45 percent for old age pensions and unemployment. The percentage assigned to pension fund managers for administrative cost (including profits) is frequently fixed to the salary and is about 2 percent; see, for example, the charges of the different private managers in Argentina (Table 3) (41, 83, 122).

Second, the reform of social security required the use of public resources for the transition to a new system. In the case of pensions, governments have to pay with fiscal resources for all the pensions in the former system. In Bolivia the transition costs were derived from the privatization of public enterprises (73). Such use of resources increases the transfer of resources from the majority of the population to small, economically privileged groups.

Third, the external debt, which played an important role in the implementation of neoliberal policies and explains the IFIs' further political and economic leverage over indebted countries for the last two decades (123), is another source of resource transfers from the Latin American countries. Paradoxically, IFI loans to finance social service reforms, including the transition from old to new social security schemes and even special programs to alleviate the negative impact of neoliberalism, further increased or contributed to maintaining the external debt already owed to IFIs by Latin American countries. In addition, most of these loans generate service payments or fees. For instance, consider the following World

[5] Not all local capitalists benefited, nor were all labor groups disadvantaged. Local capitalist classes hold diverse and often contradictory interests and, depending on the source of their capital, have supported different positions on neoliberal policies. However, the core of this social class—that is, owners and managers of large corporations—seems to benefit from and to be supportive of neoliberal reforms. On the other hand, some pension fund managers are owned by unions or cooperatives—for example, AFAP Integración in Uruguay (121). However, these organizations are compelled to follow market rules and are very unlikely to affect the redistribution of wealth. Moreover, these arrangements promote the division of the labor movement because only some groups or unions control and manage their own companies and agreement among different labor groups on a common proposal for social security reform becomes more difficult.

Bank projects: (*a*) the Health Sector Reform Project in Bolivia, which reached $25 million, included a service fee of 0.75 percent (124); (*b*) the Provincial Health Services Project for the Dominican Republic ($30 million) included a commitment fee of 0.75 percent (125); and (*c*) the Health Reform Program for Peru included a commitment fee (0.75 percent) and a front-end fee (1 percent) (126).

Regardless of its origin, the external debt burden constitutes major monetary resources that, rather than being invested in the welfare of the people, are transferred to the core countries (127, 128). Several countries allocated more resources to serve the external debt than to provide health services to their populations. During the past two decades, payment of the debt service (the interest that borrower countries must pay on external debts) by Latin American countries amounted to more than 20 percent of the total exports of goods and services, about 20 percent of central government revenues, and about 8 percent of gross national products (Table 7). Thus, the implementation of neoliberal reforms has contributed to maintaining the external debt owed by Latin American countries to the industrialized countries, a sign of the international power inequalities that reinforce the leverage of IFIs over the Latin American countries and reduce the internal political maneuverability of the indebted countries.

A fourth dimension of these transfers from labor to capital, particularly in the case of pension reform, is the power of the AFPs over capital markets. The AFPs are in charge of investing large amounts of money contributed by workers; they choose where to invest that money and, as a consequence, have a lot of power. Regardless of government regulations on investments, the AFPs' power over capital markets stands in stark contrast to workers' powerlessness in making decisions about the investment of their own money. Furthermore, the AFPs gain a lot of leverage over several companies in which they easily become the biggest shareholders (86).

Finally, the impact of these reforms on reproducing or exacerbating health inequalities shows a different sphere of the transfer of resources from workers to capital. Although the effect of IFI-promoted social policies on the health of the people of Latin America is difficult to disentangle from the effects of other neoliberal measures—as well as other historical, social, economic, and political processes—on the huge social and health disparities among and within Latin American countries, different mechanisms have been suggested to explain the impact of neoliberal policies on health. They include transfer of resources among different groups in the population, a widening of the income gap between the capitalist and working classes, a weakening of the welfare state, and deterioration of labor conditions (11, 129–136). Regardless of optimistic claims that reforms have improved the quality of life of Latin Americans (137), several analyses of the impact of neoliberal reforms suggest that neoliberal policies reinforce or maintain health inequalities. For instance, Fernández (138) has argued that the impact of neoliberalism in Nicaragua was particularly adverse among poor women, because

Table 7

Burden of the external debt, selected Latin American countries and regional averages, 1980–1997[a]

Country	Total debt service				
	1980	1985	1990	1995	1997
	% of central government current revenue				
Chile	15.21	26.35	25.64	20.20	7.32
Costa Rica	23.92	55.72	32.80	22.50	—
Nicaragua	26.28	4.50	2.55	54.40	—
Peru	42.68	27.67	4.89	9.88	20.35
Venezuela	19.07	14.14	36.23	27.25	35.67
Regional	19.45	28.01	25.68	21.30	18.74
	% of exports of goods and services				
Argentina	37.34	60.11	36.99	34.30	58.73
Brazil	63.25	39.10	22.17	36.76	57.36
Panama	6.21	7.30	6.17	3.43	16.38
Trinidad and Tobago	6.82	10.16	19.26	14.73	19.62
Uruguay	18.77	42.59	40.83	22.06	15.44
Regional	25.25	30.88	22.54	22.22	23.39
	% of GNP				
Guatemala	1.85	3.50	2.85	2.42	2.06
Guyana	15.82	18.84	107.36	20.40	19.53
Jamaica	11.55	28.12	17.39	17.22	16.00
Mexico	5.07	8.86	4.45	9.85	10.88
Regional	6.58	8.97	11.74	7.50	8.07

Sources: World Bank world development indicators on CD-ROM 1999, International Economics Dept. Development Data Group, Washington, D.C.

[a]Regional averages include 22 Latin American countries: Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Trinidad and Tobago, Uruguay, and Venezuela.

(*a*) they were more likely to fill the gaps created by the reduction or elimination of social services, both in the household and in the community; (*b*) domestic violence and maternal mortality increased; and (*c*) they were more likely to be the first to leave the formal sector for the informal sector of the economy or to become unpaid laborers. Others have also extensively documented the harmful effects of neoliberal policies on Latin American women (139). Moreover, studies have

shown adverse effects of user fees in Bolivia (140) and of increasing administrative costs, including investment in advertising private health care providers in Chile (141), as well as a lack of success in increasing health care coverage (66). Other health disparities associated with the implementation of neoliberal policies and privatization of services include increased rates of malaria (142, 143) and violence (144) and a deterioration of maternal and child health (145).

ARE THERE ANY POLITICAL ALTERNATIVES?

Given the assumption of an unavoidable globalized society, there are calls for further neoliberal reforms of welfare states and strengthening of those changes already implemented in the third and first worlds. Several institutions present the Latin American reforms, particularly the Chilean pension reform, as an example for the rest of the world. In fact, the privatization of social security has often been suggested for the United States and Europe (146, 147). The Cato Institute, for example, has lobbied for privatization of the U.S. Social Security system; it even hired Jose Piñeira, designer of Chile's pension system, as co-chair for this project (148). Several programs along this line have also been carried out or suggested in former socialist countries; for example, a Chilean AFP has already opened a private pension fund manager in Poland (149). These calls underline the idea that no other choices are possible for the world's welfare states and that national politics matter little given this global trend.

Apart from these international influences, however, implementation of IFI-sponsored reforms in Latin America has been closely related to national politics (e.g., 150, 151). The deepest privatization of social security was carried out in Chile under a repressive military regime that did not allow any political opposition (152). Likewise, privatization in Peru was decreed under a regime that severely restricted political participation (153, 154). On the other hand, the mixed public and private models that were developed in Argentina, Uruguay, and Mexico resulted from active opposition to privatization by political parties and organized labor (122). Costa Rican opposition to the privatization of public enterprises (155) is another example of the effectiveness of both a political party and a labor movement that support a strong welfare state. And despite all the economic sanctions faced by Cuba, that country has succeeded in developing a welfare state that has produced some of the best health indicators in the region and lower health inequalities within the country (156). This concurs with the evidence that countries where social democratic or socialist policies prevail are likely to be more successful in strengthening their welfare states, reducing inequalities, and improving health status (157–161). Huber (75) and Mesa-Lago and colleagues (162) have shown that the development of social security in Latin America was strongly influenced by the strength of the labor movement, and this also determines the extent to which neoliberal reforms are implemented. On the other hand,

the implementation of neoliberal measures has also created barriers to labor organization (163), and social security reforms have contributed to the weakening of labor, particularly by excluding solidarity as a fundamental principle of social security, as we have shown. Union within labor and alliances with other classes are discouraged.

Neoliberal reforms of welfare states are not inevitable (164). There is room for national governments in Latin America to define and carry out redistributive, non-neoliberal policies and to strengthen their welfare states, as several international experiences confirm. From different political perspectives, Cuba and Costa Rica have maintained public universal coverage for health care under strong welfare states. In Venezuela, a 1998 law that decreed the privatization of social security, including health, pensions, and workers' compensation, following the Chilean and Colombian model has been overruled by a new political constitution, which establishes health and social security as universal rights to be guaranteed by the state. It also sets up guidelines for creating a public and not-for-profit social security system, including a national health service that is based on public financing and provision of services and strengthens the principle of solidarity (165). Electoral and non-electoral popular movements, such as those of Chiapas (166) in Mexico and the Landless Workers in Brazil (167), and coalitions between Northern and Southern organizations in opposing IFI policies (e.g., World Social Forum, Porto Alegre; see 168) provide room for the construction of alternatives to neoliberal views.

Note — This article is an expanded version of a paper presented at the Latin American Association of Social Medicine (ALAMES) meeting in Havana, Cuba, July 3–7, 2000.

APPENDIX

All Web site addresses begin htpp//www, unless otherwise noted.

Argentina: Asistencia Medica Social Argentina/Aetna (amsa.com.ar/), Maxima (maxima.com.ar/), Arauca (osde.com/osde/arauca/comac.htm), Siembra (siembra.com.ar/frame_nuevo_grupo.htm), Berkley (berkley.com.ar), Boston (boston.com.ar *and* unum.com), Provincia (bpba.com.ar/banco/pciaart.htm), Consolidar (consolidar.com.ar), Fed Patronal (fedpat.com.ar), HIH (hih.com.ar), Interaccion (interaccion.com.ar), La Caja (lacaja.com.ar), La Segunda (lasegart.com.ar), MAPFRE (www.mapfre.com.ar), CNA Omega (omega-art.com.ar), Prevencion (prevencionart.com.ar), Superintendence of Workers' Compensation Insurance of Argentina (srt.gov.ar/home.html).

Brazil: AMICO Asistencia Medica (amico.com.br/), Cigna previdencia (cigna.com.br/previdencia/2.htm), AETNA Sul America (sulamerica.com.br/), SULAPREVI (sulaprevi.com.br/ingles/produtos.htm#1).

Chile: Aetna (aetna.cl/salud/), Provida (afpprovida.cl), Banmedica (banmedica.cl/), CIGNA Salud Isapre (cigna.cl/), Habitat (habitat.cl/), Superintendence of Isapres Chile (sisp.cl/), Vida Tres (vidatres.cl/), Cuprum (cuprum.cl), Magister (magister.cl), Santa Maria (stamaria.cl), Summa Santander (summabansander.cl).

Colombia: COLFONDOS (http://svrwebcol.colfondos.com.co/Transacciones/Home.htm), Colmena (colmena-arp.com.co), Colmena Salud (colmena-salud.com.co/), Horizonte (horizonte.com.co/), Porvenir (porvenir.com.co/ *and* afpprovida.cl/Internacional/), Proteccion (proteccion.com.co/index.html), Superintendence of Banks Colombia (superbancaria.gov.co/).

Ecuador: Genesis (afpprovida.cl/Internacional/).

El Salvador: Porvenir (afpprovida.cl/Internacional/), Superintendence El Salvador (spensiones.gob.sv).

Mexico: Profuturo G.N.P. (afpprovida.cl/Internacional/), AIG Mexico (aigmex.com/index2.htm), Garante (garante.com.mx/), Inbursa (gefinancial-assurance.com/aboutus/), Zurich (zurich.com.mx/), Inbursa (aforeinbursa.com.mx/), Tepeyac (aforetepeyac.com.mx/), Banamex Aegon (banamex.com.mx *and* aegon.com/top-l-l.html), Bancrecer Dresdner (bancrecer.com.mx/ *and* dresdner-bank.com/index.html *and* allianz.com), Vital (bital.com.mx), Official information on Mexican pensions (consar.gob.mx), Sólida Banorte Generali (generali.com *and* banorte.com.mx/banorte008/empresas/afore.shtml), Principal (principal.com.mx/), Profuturo G.N.P. (profuturognp.com.mx).

Peru: Novasalud EPS (backus.com.pe/), Pacifico Salud (elpacifico.com/PacificoSalud/PacificoSalud.htm), Novasalud EPS (novasalud.com.pe/eps/index.html), Rimac Internacional (rimac.com.pe/eps/quienes.html), Santa Cruz (santacruz.com.pe/), Superintencia de Entidades Prestadoras de Salud del Peru (seps.gob.pe), Superintendencia de Fondos de Pensiones del Peru (safp.gob.pe/afp.htm), Integra Peru (integra.com.pe/), Horizonte (afpprovida.cl/Internacional/ *and* afphorizonte.com.pe/unifram2.htm), Profuturo (profuturo.com.pe/), UnionVida (unionvida.com.pe/).

Spain: Mapfre Group (mapfre.com).

Uruguay: Capital (capitalafap.com.uy/), Comercial (comercialafap.com.uy/home111.htm), Integracion (multimedios.com/cofac/afap.htm), Republica (rafap.com.uy/), Santander (santander.com.uy/), General Information on pensions in Uruguay (srpffaa.gub.uy/sitios_relacionados.htm#instituciones privadas), Union (unionafap.com.uy/).

REFERENCES

1. World Bank. Annual Report 1997. www.worldbank.org (1997).
2. World Bank. Annual Report 1998. www.worldbank.org (1998).
3. World Bank. Annual Report 1999. www.worldbank.org (1999).
4. World Bank. Annual Report 2000. www.worldbank.org (2000).

5. Lora, E. *A Decade of Structural Reforms in Latin America: What Has Been Reformed and How to Measure It.* Inter-American Development Bank, Office of the Chief Economist, Working Paper Green Series No. 348. Washington, D.C., 1997.
6. Terris, M. The neoliberal triad of anti-health reforms: Government budget cutting, deregulation, and privatization. *J. Public Health Policy* 20: 149–167, 1999.
7. Baer, W., and Maloney, W. Neoliberalism and income distribution in Latin America. *World Dev.* 25(3): 311–327, 1997.
8. Glassman, J., and Carmody, P. Structural adjustment in East and Southeast Asia: Lessons from Latin America. *Geoforum,* 32(1): 77–90, 2001.
9. Petras, J. *The Left Strikes Back: Class Conflict in Latin America in the Age of Neoliberalism.* Latin American Perspectives Series. Westview Press, Boulder, Colo., 1999.
10. Navarro, V. Neoliberalism, "globalization," unemployment, inequalities, and the welfare state. *Int. J. Health Serv.* 28: 607–682, 1998.
11. Coburn, D. Income inequality, social cohesion and the health status of populations: The role of neo-liberalism. *Soc. Sci. Med.* 51: 135–146, 2000.
12. Torre, J. C. *Las Dimensiones Politicas e Institucionales de las Reformas Estructurales en America Latina.* Serie Reformas de Politica Publica Comision Economica para America Latina y El Caribe (CEPAL/ECLatin American countries). United Nations, Geneva, 1997.
13. Crisp, B. F., and Kelly, M. J. The socioeconomic impacts of structural adjustment. *Int. Stud. Q.* 43(3): 533–552, 1999.
14. Laurell, A. C., and Arellano, O. L. Market commodities and poor relief: The World Bank proposal for health. *Int. J. Health Serv.* 26(1): 1–18, 1996.
15. Price, M. The consequences of health service privatization for equality and equity in health care in South Africa. *Soc. Sci. Med.* 27: 703–716, 1988.
16. Woolhandler, S., and Himmelstein, D. U. Costs of care and administration at for-profit and other hospitals in the United States. *N. Engl. J. Med.* 336: 769–774, 1997.
17. Silverman, E. M., Skinner, J. S., and Fisher, E. S. The association between for-profit hospital ownership and increased Medicare spending. *N. Engl. J. Med.* 341: 420–426, 1999.
18. Garg, P., et al. Effect of the ownership of dialysis facilities on patients' survival and referral for transplantation. *N. Engl. J. Med.* 341: 1653–1660, 1999.
19. Schoen, C., et al. Health insurance markets and income inequality: Findings from an international health policy survey. *Health Policy* 51(2): 67–85, 2000.
20. Russell, S., and Gilson, L. User fee policies to promote health service access for the poor: A wolf in sheep's clothing? *Int. J. Health Serv.* 27: 359–379, 1997.
21. Sen, K., and Koivusalo, M. Health care reforms and developing countries—A critical overview. *Int. J. Health Plann. Manag.* 13(3): 199–215, 1998.
22. Laurell, A. C. Structural adjustment and the globalization of social policy in Latin America. *Int. Sociol.* 15(2): 306–325, 2000.
23. Paul, S. S., and Paul, J. A. The World Bank, pensions, and income (in)security in the global south. *Int. J. Health Serv.* 25(4): 697–726, 1995.
24. Government of Peru. Letter of Intent from Jorge Camet (Minister of Economy and Finance of Peru) and Germán Suárez (President Central Research Bank of Peru) to Michel Camdessus (Managing Director IMF), Lima Peru, May 5, 1998. www.imf/org/external/

25. Government of Jamaica. Memorandum of Economic and Financial Policies and Letter of Intent from Omar Davies (Minister of Finance and Planning) and Governor Derick Latibeaudiere (Governor Bank of Jamaica) to Horst Köhler (Managing Director IMF), Kingston, Jamaica, Annex, July 19, 2000. www.imf.org/external/
26. Government of Honduras. Letter of Intent from Hugo Castillo (Acting Minister of Finance) and Victoria Asfura de Diaz (President of the Central Bank of Honduras) to Horst Köhler (Managing Director IMF), Tegucigalpa, Honduras, Mary 31, 2000. www.imf.org/external/
27. Government of Ecuador. Memorandum of Economic Policies of the Government of Ecuador for 2000 and Letter of Intent from Jorge Guzmán (Minister of Finance and Public Credit of Ecuador) and Modesto Correa (President of the Board Central Bank of Ecuador) to Stanley Fischer (Acting Managing Director IMF). www.imf/org/external/2000
28. Buse, K. The World Bank. *Health Policy Plann.* 9(1): 95–99, 1994.
29. Banerji, D. A fundamental shift in the approach to international health by WHO, UNICEF, and the World Bank: Instances of the practice of "intellectual fascism" and totalitarianism in some Asian countries. *Int. J. Health Serv.* 29(2): 227–259, 1999.
30. Pan American Health Organization. *Health in the Americas.* Scientific Publication No. 569. Washington, D.C., 1998.
31. USAID. Latin America and the Caribbean Overview (taken from the FY 2001 Congressional Presentation). www.usaid.gov/country/lac/ (March 2001).
32. Fiedler, J. L. Organizational development and privatization: A Bolivian success story. *Int. J. Health Plann. Manag.* 5: 167–186, 1990.
33. USAID. The USAID FY 1998 Congressional Presentation Bolivia. www.usaid.gov/pubs/cp98/lac/countries/bo.htm (1998).
34. USAID. Improved Health of the Bolivian Population, 511-SO03 Activity Data Sheet Program: Bolivia. www.usaid.gov/pubs/cp2000/lac/bolivia.html (March 2001).
35. Aviles, L. A. Epidemiology as discourse: The politics of development institutions in the epidemiological profile of El Salvador. *J. Epidemiol. Community Health* 55(3): 164–171, 2001.
36. Bradshaw, Y., et al. Borrowing against the future: Children and third world indebtedness. *Soc. Forces* 71: 629–656, 1993.
37. Abbasi, K. The World Bank and world health: Changing sides. *BMJ* 318: 865–869, 1999.
38. Buse, K., and Walt, G. Role conflict? The World Bank and the world's health. *Soc. Sci. Med.* 50: 177–179, 2000.
39. ECLAC 2000. Equity, Development and Citizenship. Twenty-Eighth Session of the Economic Commission for Latin America and the Caribbean, Mexico City, April 3–7, 2000. www.eclac.org (November 2000).
40. Infante, A., de la Mata, I., and Lopez-Acuna, D. Reforma de los sistemas de salud en América Latina y el Caribe: situación y tendencias. *Rev. Panam. Salud Publica* 8(1-2): 13–20, 2000.
41. Cruz-Saco, M. A. Introduction: Context and typology of reform models. In *Do Options Exist? The Reform of Pension and Health Care Systems in Latin America,* edited by M. A. Cruz-Saco and C. Mesa-Lago. University of Pittsburgh Press, Pittsburgh, 1998.

42. Inter-American Development Bank. *Supporting Reform in the Delivery of Social Services: A Strategy.* Washington, D.C., August 1996.
43. De Beyer, J. A., Preker, A. S., and Feachem, R. G. A. The role of the World Bank in international health: Renewed commitment and partnership. *Soc. Sci. Med.* 50: 169–176, 2000.
44. Rafeeq, H., and Paul, R. Health sector reform in the Republic of Trinidad and Tobago. Cited in Brito Quintana, P. E. Impacto de las reformas del sector de la salud sobre los recursos humanos y la gestión laboral. *Rev. Panam. Salud Publica* 8(1-2): 43–54, 2000.
45. Fiedler, J. L. The privatization of health care in three Latin American social security systems. *Health Policy Plann.* 11: 406–417, 1996.
46. Kritzer, B. E. Social Security privatization in Latin America. *Soc. Secur. Bull.* 63(2): 17–37, 2000.
47. Birn, A. E., Zimmerman, S., and Garfield, R. To decentralize or not to decentralize, is that the question? Nicaraguan health policy under structural adjustment in the 1990s. *Int. J. Health Serv.* 30(1): 111–128, 2000.
48. Secretaría de Salud Pública de la Municipalidad de Rosario (Argentina). Estudio de Caso: La reforma de las obras sociales en Argentina. Cited in Alvarez, B., Pellise, L., and Lobo, F. Sistemas de pago a prestadores de servicios de salud en países de América Latina y de la OCDE. *Rev. Panam. Salud Publica* 8(1-2): 55–70, 2000.
49. Almeida, C., et al. Health sector reform in Brazil: A case study of inequity. *Int. J. Health Serv.* 30(1): 129–162, 2000.
50. Gerschman, S. Public sector and social and health policy reforms: An inventory on the eve of the new millennium. *Cad. saúde publica* 15(2): 293–302, 1999.
51. Londono, J. L., and Frenk, J. Structured pluralism: Towards an innovative model for health system reform in Latin America. *Health Policy* 41(1): 1–36, 1997.
52. Shackley, P., and Healey, A. Creating a market: An economic analysis of the purchaser-provider model. *Health Policy* 25(1-2): 153–168, 1993.
53. Kirkup, B., and Donaldson, L. J. Is health care a commodity: How will purchasing improve the National Health Service? *J. Public Health Med.* 16(3): 256–262, 1994.
54. Mason, A., and Morgan, K. Purchaser-provider: The international dimension. *BMJ* 310: 231–235, 1995.
55. Bertranou, F. M. Are market-oriented health insurance reforms possible in Latin America? The cases of Argentina, Chile and Colombia. *Health Policy* 47(1): 19–36, 1999.
56. Oyarzo, C. La descentralización financiera en Chile en la década de los novena. Cited in Molina, R., et al. Gasto y financiamiento en salud: situación y tendencies. *Rev. Panam. Salud Publica* 8(1-2): 71–83, 2000.
57. Scarpaci, J. L. HMO promotion and the privatization of health care in Chile. *J. Health Polit. Policy Law* 12(3): 551–567, 1987.
58. Republic of Chile. Ley No. 18933, 1995. www.sisp.cl/intecset.htm (December 2000).
59. Jimenez de la Jara, J. and Bossert, T. Chile's health sector reform: Lessons from four reform periods. *Health Policy* 32(1-3): 155–166, 1995.
60. Republic of Colombia. Ley No. 100, 1993. www.minsalud.gov.co/ (December 2000).

61. Yepes Luján, F. J., and Sánchez Gómez, L. H. La reforma del sector de la salud en Colombia: ¿un modelo de competencia regulada? Cited in Madies, C. V., Chiarvetti, S., and Chorny, M. Aseguramiento y cobertura: dos temas críticos en las reformas del sector de la salud. *Rev. Panam. Salud Publica* 8(1-2): 33–42, 2000.
62. Lewis, M. A., and Parker, C. Policy and implementation of user fees in Jamaican public hospitals. *Health Policy* 18: 57–85, 1991.
63. World Bank. Ecuador—Health Services Modernization. Report No. PID 50505, March 1998. www.worldbank.org
64. World Bank. Project Appraisal Document on a Proposed Adaptable Program Credit in the Amount of SDR 17.9 Million (US$24 Million Equivalent) to the Republic of Nicaragua for a Health Sector Modernization Project. Report No. 17609 NI, May 11, 1998. www.worldbank.org
65. Barillas, E. La Fragmentacion de los Sistemas Nacionales de Salud. *Rev. Panam. Salud Publica* 1(3): 246–249, 1997.
66. Nunez, M. Inequality in the Utilization of Health Services in Chile: Analysis of the Effects of Individual Income and Health Insurance Coverage on Timely Receipt of Health Care Services. Johns Hopkins University, Baltimore, 2001.
67. Inter-American Development Bank. *Annual Report 1999.* Washington, D.C., 1999.
68. Dickson, K. Colaboracion entre las organizaciones no gubernamentales y los gobiernos en la reforma del sector salud. *Rev. Panam. Salud Publica* 1(4): 324–329, 1997.
69. Kim, J., et al. (eds.). *Dying for Growth.* Common Courage Press, Monroe, Me., 2000.
70. Arellano-Lopez, S., and Petras, J. Nongovernmental organizations and poverty alleviation in Bolivia. *Dev. Change* 25(3): 555–568, 1994.
71. Okuonzi, S. A., and Macrae, J. Whose policy is it anyway? International and national influences on health policy development in Uganda. *Health Policy Plann.* 10: 122–132, 1995.
72. Muntaner, C., Lynch, J., and Davey-Smith, G. Social capital and the third way in public health. *Crit. Public Health* 10(2): 107–124, 2000.
73. Queisser, M. *The Second-Generation Pension Reforms in Latin America.* OECD, Paris, 1998.
74. Mesa-Lago, C. Social welfare reform in the context of economic-political liberalization: Latin American cases. *World Dev.* 25(4): 497–517, 1997.
75. Huber, E. Options for social policy in Latin America: Neoliberal versus social democratic models. In *Welfare States in Transition,* edited by G. Esping-Andersen, pp. 141-191. Sage, London, 1996.
76. Laurell, A. C. *La Reforma Contra la Salud y la Seguridad Social.* Fundación Friedrich Ebert Stiftung Ediciones Era Mexico, 1997.
77. World Bank. *Averting the Old Age Crisis: Policies to Protect the Old and Promote Growth.* Oxford University Press, New York, 1994.
78. Gollier, J.-J. Private pension systems. In *Private Pension Systems and Policy Issues.* Series Private Pensions No. 1. OECD, Paris, 2000.
79. Mitchell, O., and Ataliba, F. After Chile, What? Second-Round Pension Reforms in Latin America. Working paper 6316. National Bureau of Economic Research, Cambridge, Mass., 1997.

80. Yermo, J. Institutional investors in Latin America: Recent trends and regulatory challenges. In *Private Pension Systems and Policy Issues.* Series Private Pensions No. 1. OECD, Paris, 2000.
81. Barrientos, A. *Pension Reform in Latin America.* Ashgate, Brookfield, Vt., 1998.
82. Republica Argentina, Superintendencia de Administradoras de Fondos de Pensiones y Jubilaciones. www.safjp.gov.ar/docs/estc10.htm (November 2000).
83. Comisión Nacional del Sistema de Ahorro para el Retiro (CONAR). www.consar.gob.mx/internacional.htm (November 2000).
84. Villaseñor-Zertuche, J. An overview of the new pension system in Mexico. In *Private Pension Systems and Policy Issues.* Series Private Pensions No. 1. OECD, Paris, 2000.
85. World Bank. *Social Security Reform in Nicaragua.* Washington, D.C., 2000.
86. Borzutzky, S. Chile: The politics of privatization. In *Do Options Exist? The Reform of Pension and Health Care Systems in Latin America,* edited by M. A. Cruz-Saco and C. Mesa-Lago. University of Pittsburgh Press, Pittsburgh, 1998.
87. Laurell, A. C. The Mexican social security counterreform: Pensions for profit. *Int. J. Health Serv.* 29: 371–391, 1999.
88. Fidler, S. Bank rethink urged on pension funds. *Financial Times* (London), April 6, 2000.
89. World Bank. *Financing Health Services in Developing Countries: An Agenda for Reform.* World Bank Policy Study. Washington, D.C., 1987.
90. World Bank. *World Development Report 1993: Investing in Health.* Oxford University Press, New York, 1993.
91. Latin America and Caribbean Regional Health Sector Reform Initiative about LAHSR. www.americas.health-sector-reform.org/english/initiative1.htm (March 2001).
92. Pan American Health Organization. EquiLAC Project. http://165.158.1.110/english/hdp/hddeq.htm (March 2001).
93. Pan American Health Organization. Bolivia Benefits from PAHO/World Bank Partnership. www.paho.org/English/HVP/HVI/hvp_efacts_11.pdf (March 2001).
94. Pan American Health Organization. IDB, PAHO/WHO and World Bank Sign Agreement to Work Together in a Shared Health Agenda for Latin America and the Caribbean. June 22, 2000. www.paho.org/English/DPI/PRESS_000622E.htm (March 2001).
95. Pan American Health Organization. *Health Services Financing and Private Sector Participation: Developing a Model Incorporating American and Caribbean Experiences.* Technical Report Series No. 65. Public Policy and Health Program, PAHO, Washington, D.C., 1998.
96. Alleyne, A. O. Health Sector Reform, Financing and the Poor. Paper presented to the Global Council's 26th Annual Conference, Who Pays? Health Care Reform and Financing in Developing Countries, Arlington, Va., June 20, 1999.
97. World Health Organization. *World Health Report 2000: Health Systems: Improving Performance.* Paris, 2000.
98. Navarro, V. Assessment of the World Health Report 2000. *Lancet* 356: 1598–1601, 2000.
99. Van der Stuyft, P., and Unger, J. P. Editorial: Improving the performance of health systems: The World Health Report as go-between for scientific evidence and ideological discourse. *Trop. Med. Int. Health* 5(10): 675–677, 2000.

100. Karliner, J., Srivastava, A., and Bruno, K. United Nations Development Program solicits funds from corporations. *Int. J. Health Serv.* 29: 813–819, 1999.
101. United Nations Development Program. Directorio de Expertos y Bibliografía sobre Pobreza y Desarrollo Social en America Latina y el Caribe. No date. www.undp.org/rblac/poverty/ (June 2000).
102. Vaughan, J. P., et al. Financing the World Health Organization: Global importance of extrabudgetary funds. *Health Policy* 35(3): 229–245, 1996.
103. Veltmeyer, H., Petras, J., and Vieux, S. *Neoliberalism and Class Conflict in Latin America.* Macmillan, New York, 1997.
104. Banco Bilbao Vizcaya. Annual Report, 1999. www.bbva.es/index1.html (June 2000).
105. Banco Santander Central Hispano. Annual Report, 1999. html.www.bsch.es/ (June 2000).
106. Aetna. Aetna Annual Report, 1999, p. 71. www.AETNA.com/99annualrpt/pdfs/AETNA99-financials.pdf.
107. MAPFRE Informacion al Accionista. www.mapfre.com/cormap/ (June 2000).
108. Stocker, K., Waitzkin, H., and Iriart, C. The exportation of managed care to Latin America. *N. Engl. J. Med.* 340(14): 1131–1136, 1999.
109. Aetna. Aetna to Sell Its Mexican Joint Venture Interests to Partner. Press release. Hartford, Conn., September 19, 2000. www.AETNA.com/news/2000/pr_20000919.htm
110. Aetna. Aetna's 3rd Quarter 2000 Financial Supplement, 2000, p. 9. www.AETNA.com/investor/images/q300supp.pdf
111. National Trade Data Bank. *Venezuela—Health Care Market Overview.* National Trade Data Bank Market Reports, March 22, 1995.
112. U.S. Foreign Commercial Service and U.S. Department of State. *Health Care Services Argentina Industry Sector Analysis.* September 1, 1998.
113. Vilar, P. *Historia de España.* Grijalbo, 1996.
114. Riera, I. *Los Catalanes de Franco.* Plaza and Janes, 1999.
115. Skandia. Annual Report, 1999. www.skandia.com (June 2000).
116. Suramericana 2000 Corporativo. www.suramericana.com.co/ (June 2000).
117. Banmedica. www.banmedica.cl/safr.htm (June 2000).
118. Wolff, R., and Resnick, S. *Economics: Marxian and Neoclassical.* Johns Hopkins University Press, Baltimore, 1987.
119. Sklair, L. *Sociology of the Global System.* Johns Hopkins University Press, Baltimore, 1995.
120. Vilas, C. Economic restructuring, neoliberal reforms, and the working class in Latin America. In *Capital, Power, and Inequality in Latin America,* edited by S. Halebsky and R. Harris. Westview Press, Boulder, Colo., 1995.
121. AFAP Integración. www.multimedios.com/cofac/afap.htm (April 2000).
122. Cruz-Saco, M., and Mesa-Lago, C. Conclusions: Conditioning factors, cross-country comparisons, and recommendations. In *Do Options Exist? The Reform of Pension and Health Care Systems in Latin America,* edited by M. A. Cruz-Saco and C. Mesa-Lago. University of Pittsburgh Press, Pittsburgh, 1998.
123. Lafay, J., and Lecaillon, J. *The Political Dimensions of Economic Adjustment.* OECD, Paris, 1993.
124. World Bank Project Appraisal Document on a Proposed Adaptable Program Credit in the Amount of SDR 17.8 Million (US$25 Million Equivalent) to the Republic of

Bolivia for a Health Sector Reform Project. Report No. 18980-Bo, March 31, 1999. www.wds.worldbank.org/pdf_content/000094946990421053145O/multi_page.pdf (March 2001).
125. World Bank Project Appraisal Document for a Proposed Loan in the Amount of US$30 Million to the Dominican Republic for a Provincial Health Services Project. Report No. 17199-DO, December 15, 1997. www.wds.worldbank.org/pdf_content/000009265398021714O157/multi_page.pdf (March 2001).
126. World Bank Project Appraisal Document on a Proposed Adaptable Program Lending in the Amount of US$80.0 Million to the Republic of Peru for a First Phase of the Health Reform Program (Mother and Child Insurance and Decentralization of Health Services). Report No. 19901-PE, November 22, 1999. www.wds.worldbank.org/pdf_content/000094946991204053146O2/multi_page.pdf (March 2001).
127. Feinberg, R. Defunding Latin America: Reverse transfers by the multilateral lending agencies. *Third World Q.* 11(3): 71–84, 1989.
128. Chernomas, R. The debt-depression of the less developed world and public health. *Int. J. Health Serv.* 20: 537–543, 1990.
129. Navarro, V. *Neoliberalismo y Estado del bienestar.* Ariel Sociedad Economica, Barcelona, 1997.
130. Navarro, V. The political economy of the welfare state in developed capitalist countries. *Int. J. Health Serv.* 29: 1–50, 1999.
131. Nash, J. Global integration and subsistence insecurity. *Am. Anthropol.* 96: 7–30, 1994.
132. Muntaner, C., and Lynch, J. Income inequality, social cohesion, and class relations: A critique of Wilkinson's neo-Durkheimian research program. *Int. J. Health Serv.* 29: 59–81, 1999.
133. Coburn, D. Income inequality, social cohesion and the health status of populations: The role of neo-liberalism. *Soc. Sci. Med.* 51: 135–146, 2000.
134. Lynch, J. W. Income inequality and health: Expanding the debate. *Soc. Sci. Med.* 51(7): 1001–1005, 2000.
135. Muntaner, C., Lynch, J., and Oates, G. L. The social class determinants of income inequality and social cohesion. *Int. J. Health Serv.* 29: 699–732, 1999.
136. Breilh, J. La Pobreza Urbana y la Salud; una mirada desde la epidemiología critica. In *La Pobreza y la Salud. I Congreso Brasileño de Epidemiología*. Campiñas, Brazil, 1990.
137. Baeza, S., and Margozzini, F. *Quince años después: una mirada al sistema privado de pensiones.* Centro de Estudios Públicos, Santiago de Chile, 1995.
138. Fernández, A. The disruptions of adjustment: Women in Nicaragua. *Latin Am. Perspect.* 23(1): 49–66, 1996.
139. Breilh, J. *La Triple Carga: Deterioro Prematuro de la Mujer en el Neoliberalismo.* Centro de Estudios y Asesoria en Salud, CEAS Quito, 1991.
140. Kinman, E. Evaluating health service equity at a primary care clinic in Chilimarca, Bolivia. *Soc. Sci. Med.* 49: 663–678, 1999.
141. Larrañaga, O. Health sector reform in Chile. In *Chile: Recent Policy Lessons and Emerging Challenges,* edited by G. Perry and D. Leipziger. World Bank Institute, World Bank, Washington, D.C., 1999.
142. Manfredi, C. Can the resurgence of malaria be partially attributed to structural adjustment programmes? *Parasitologia* 41: 389–390, 1999.

143. Garfield, R. Malaria control in Nicaragua: Social and political influences on disease transmission and control activities. *Lancet* 354: 414–418, 1999.
144. Franco, S. International dimensions of Colombian violence. *Int. J. Health Serv.* 30(1): 163–185, 2000.
145. Whiteford, L. M. Child and maternal health and international economic policies. *Soc. Sci. Med.* 37: 1391–1400, 1993.
146. Du Boff, R. B. The welfare state, pensions, privatization: The case of Social Security in the United States. *Int. J. Health Serv.* 27(1): 1–23, 1997.
147. Dresdner Bank. Demographic pressure and economic growth—The dilemma facing retirement pension systems. *Trends Spec. Econ. Anal.,* January 2000. www.dresdnerbank.com/knowhow/economicresearch/veroeffentlichungen/pub_trends_spezial/trends_spezial_200001.pdf
148. Cato Institute. Social Security Privatization. www.cato.org
149. Wright Perfil de la Empresa. http://profiles.wisi.com/profiles/scripts/yupi01.asp?cusip=C15263140 (March 2001).
150. Haggard, S., Lafay, J., and Morrison, C. *The Political Feasibility of Adjustment in Developing Countries.* OECD, Paris, 1995.
151. De Janvry, A. The political feasibility of adjustment in Ecuador and Venezuela. OECD, Paris, 1994.
152. Reichard, S. Ideology drives health care reforms in Chile. *J. Public Health Policy* 17(1): 80–98, 1996.
153. Cruz-Saco, M. A. The pension system reform in Peru. In *Do Options Exist? The Reform of Pension and Health Care Systems in Latin America,* edited by M. A. Cruz-Saco and C. Mesa-Lago. University of Pittsburgh Press, Pittsburgh, 1998.
154. Cooper, M. Peru and the post-Fujimori future. *Nation* 272: 13–17, 2001.
155. Bound, A. Costa Rica divided as market reform plans do what wars could not. *Financial Times* (London), April 6, 2000.
156. Chomsky, A. The threat of a good example: Health and revolution in Cuba. In *Dying for Growth,* edited by J. Kim et al. Common Courage Press, Monroe, Me., 2000.
157. Cereseto, S., and Waitzkin, H. Economic development, political economic system, and the physical quality of life. *J. Public Health Policy* 9: 104–120, 1988.
158. Navarro, V. Has socialism failed? An analysis of health indicators under socialism. *Int. J. Health Serv.* 22: 583–601, 1992.
159. Nielsen, F., and Alderson, A. Income inequality, development, and dualism: Results from an unbalanced cross-national panel. *Am. Sociol. Rev.* 60: 674–701, 1995.
160. Galbraith, J., Daruty, W., and Jiqing, L. Measuring the Evolution of Inequality in the Global Economy. Center for Economic Policy Analysis Working Paper, Series III, International Capital Markets and the Future of Economic Policy, No. 4. Washington, D.C., 1998.
161. Navarro, V., and Shi, L. The political context of social inequalities and health. *Soc. Sci. Med.* 52: 481–491, 2001.
162. Mesa-Lago, C., Cruz-Saco, M. A., and Zamalloa, L. Determinants of social insurance/security costs and coverage: An international comparison with a focus on Latin America. In *Welfare, Poverty and Development in Latin America,* edited by C. Abel and C. Lewis. Macmillan, New York.
163. La Botz, D. Manufacturing poverty: The maquiladorization of Mexico. *Int. J. Health Serv.* 24: 403–408, 1994.

164. Harnecker, M. *La izquierda en el umbral del siglo XXI: Haciendo posible lo imposible.* Siglo XXI de España, Madrid, 1999.
165. Republica Bolivariana de Venezuela. Constitucion Nacional. 1999.
166. www.ezln.org
167. www.mstbrazil.org
168. World Social Forum. attac.org/fra/asso/doc/doc50en.htm (March 2001).

Direct reprint requests to:

Dr. Francisco Armada
Apartado 3449
Carmelitas
Caracas 1010
Venezuela

e-mail: farmada@jhsph.edu