Health Reform in Latin America and Africa: decentralisation, participation and inequalities

KATIE WILLIS & SORAYYA KHAN

ABSTRACT  As part of broader neoliberal economic policies most governments of Latin America and sub-Saharan Africa have implemented reforms of the formal health sector since the early 1980s. Driven both by the need for greater efficiency and calls for increases in patient choice and participation, these reforms have taken on different forms across the regions, but the main features have been decentralisation, increased user fees and the introduction of forms of health insurance. This paper considers the nature of these reforms, how the broad category of ‘neoliberal health sector reform’ has played out in different places and the impact of these reforms across socioeconomic groups.

Shifts in the relationships between state institutions, citizens and private sector organisations are at the heart of processes of neoliberalisation. However, the particular nature of these shifts and their outcomes within specific places and communities cannot be assumed. While some research on neoliberalism and development has attempted to identify general trends, research in development studies, geography, anthropology and sociology is increasingly engaging with the diversity of neoliberalisation processes and their effects.1 Thus, what may be regarded as a ‘global’ process is, as the burgeoning literature on scale demonstrates, constructed through the ‘local’. This focus on the ways in which policies are created and developed through the actions of individuals and institutions is key in both describing and explaining how ‘global’ processes are created, but also to highlight how ‘local’ differences exist and how spaces for alternative possibilities may be created.

Access to health care and improvements in health status are often at the heart of concepts of ‘development’, as conceived as an improvement in an individual’s quality and standard of living. For example, life expectancy at birth is used as part of the UNDP’s Human Development Index,2 and the Millennium Development Goals (MDGs) include a number of health-related targets.3 Amartya Sen also uses good health as a route to greater freedoms and therefore ‘development’.4 With good health individuals have greater
ability to participate in work activities (both paid and unpaid) and education, so improving their life chances and choices.

While formal healthcare provision has experienced change since its inception, the shifts associated with neoliberal policies since the 1980s have been regarded as particularly dramatic. The provision of health care is increasingly being incorporated into the logic of the market, where it is viewed as a ‘commodity’ to be bought and sold, rather than a service which is provided to individuals as citizens of a nation-state. While ‘good health’ may be regarded as a basic human right, rather than ensuring this through state provision, the tendency is towards a market-led approach, with varying degrees of safety-net provision for marginalised groups. This process is found throughout the world, although, as mentioned earlier, the processes of implementation and the effects of such policies have local specificities. The involvement of the private sector in direct healthcare provision and health insurance has been a key element of health sector reform in many parts of the world, including the global South. However, the wider introduction of user fees in state-provided services has also been evident as part of the wider cost-recovery agenda.

Associated with a growing use of fees and private-sector actors, health sector reform has often involved decentralisation of healthcare provision within the state sector. Such moves are aimed at promoting greater patient participation and choice, as well as improving efficiency in service delivery. In seeking to achieve ‘Health for All’ as the World Health Organisation (WHO) declared in the Alma Ata Declaration of 1978, decentralisation and marketisation have been increasingly adopted as the key processes through which this will be achieved.

In this paper these general trends in health sector reform will be discussed in the context of sub-Saharan Africa and Latin America. After a brief overview of neoliberal health sector reform, we focus on the two regions in turn. Considering differences within and between the regions highlights the ways in which neoliberalisation within the health sector is implemented and experienced differently. While many Latin American countries had reasonably well established state healthcare and insurance systems which covered a significant proportion of the population before reform, albeit with highly differential services, in sub-Saharan Africa state healthcare provision was often, and continues to be, very limited, both geographically and socially.

Decentralisation and participation

Neoliberal policies throughout the world have been associated with attempts to decentralise decision making in order to promote greater involvement of people and communities. Such processes are supposed to lead to greater efficiency and democracy through processes of inclusion and participation. Geographically decentralisation is meant to shrink the distances between central decision-making institutions and the people, so diffusing power throughout a national space, bringing the state nearer to the citizens and enhancing democratisation in previously autocratic regimes.
Within health care, decentralisation has been regarded as a key element in promoting greater equity in access while also recognising limited government budgets. In sub-Saharan Africa decentralisation within health care was institutionalised through the 1987 Bamako Initiative (see below), but similar agendas have been followed in other parts of the global South. Decentralisation implies a transfer of authority and responsibility from the central level of government to the district and local levels, which are thereby strengthened. By bringing governance structures down to the local level, state health care is supposedly more responsive to community needs.11

Community involvement is often encouraged through the setting up of consultative processes, whereby community members are able to respond to local health initiatives or even contribute to their development. Throughout the world, including in countries of the global North, state health providers are increasingly developing new forms of ‘inclusive governance’ in an attempt to promote greater patient participation in framing local health policy.12 However, as the UNDP concludes in its evaluation of decentralisation policies in the context of the MDGs, decentralisation does not inherently lead to greater participation, democracy or accountability. For example, prerequisites for successful decentralisation include sufficient local administrative capacity and a well developed civil society which can lobby for change.13

An associated concern has been that decentralisation of decision making has not always been associated with the parallel decentralisation of finance and budgeting. Rather, decentralisation may be associated with local health authorities having to raise money from the local tax base and/or through the charging of user fees in health facilities.14 In both cases, these may exacerbate existing social and spatial inequalities (see below).

Marketisation and inequalities
A key element of neoliberal policies in relation to health care has been the growing role of the market in both healthcare provision at all scales and in health insurance. The growing commodification of health care is a reflection of a number of interlocking processes: first, the inability of national governments to provide sufficient funding, particularly in the context of Structural Adjustment Programmes (SAPs) or the more recent Poverty Reduction Strategy Papers (PRSPs); second, the view that state healthcare provision is usually inefficient—both in resource terms and in providing a good service to patients—has led to a belief in the market as an impartial and efficient arbiter of service provision;15 and, third, the growing discourse of patients as consumers, linked to neoliberal ideas around individualisation and the importance of individual choice in allowing people to improve their own life chances.

Such policies have led to the greater use of user charges for clinic visits and medicines, as well as to shifts in health insurance schemes (where they existed) from social security schemes partly funded by government towards greater private sector involvement. As was found in relation to SAPs,16 health reform policies have increasingly included basic health provision for the very poorest in the form of a guaranteed basket of basic health services, usually including
childhood inoculations and information about common diseases such as 
malaria (where appropriate). The introduction of such provision is a recognition 
of how market-driven health care excludes large sections of the population 
based on income. A more recent trend in many parts of the global South, 
including Latin America and sub-Saharan Africa, is to expand health insurance 
schemes to include economically poorer or informally employed individuals.

The role of the government in health expenditure differs both between and 
within Latin America and sub-Saharan Africa (see Table 1). There is no clear 
pattern. This reflects the range of situations and alternative sources of 
healthcare expenditure as it is much more complex than a government/ 
market dichotomy. In some cases, such as Cuba, government spending as a 
percentage of total health expenditure reflects state commitment to health 
provision for the entire population. However, in most cases high shares of 
health expenditure coming from government represent overall low levels of 
expenditure by state, market, community and individual sources.

The role of non-governmental organisations (NGOs) in providing healthcare 
services has grown significantly as a response both to the withdrawal of the state 
from formal provision, and the growth of large donors within the health sector 
who channel funds through national and local NGOs, as well as through 
national governments. The importance of NGOs is also interpreted as increasing 
the potential for democratisation and participation for local service users, 
despite the evidence that NGOs are not inherently participatory and often 
reinforce existing inequalities at a community level.17

The remainder of the paper considers these broad themes within the 
context of Latin America and sub-Saharan Africa. While these trends are 
apparent in both regions, the implementation and impact of health reforms 
differ widely.

**Perspectives from Latin America**

In general Latin American health and social security systems have been viewed 
as more extensive and inclusive than equivalent systems in most other parts of 
the global South. However, as part of neoliberal restructuring policies, state 
health provision and insurance throughout the continent are being recon-
stituted to increase the role of the private sector. Reform in the health sector is 
not new in Latin America as change has always occurred.18 However, it is 
important to recognise the extent of this change in the past 20 years and how the 
changes have been packaged under a heading of ‘reform’.

Health reform in Latin America and the Caribbean has been a key focus of 
external assistance in health, both in terms of funding and technical support. 
For example, 35% of OECD health aid to Latin America and the Caribbean 
during 1998–2000 was targeted towards ‘health policy and administrative 
management’, compared with 29% for all aid recipients.19 Health sector 
reform at a government level takes place within a discourse of promoting 
‘health for all’. The language clearly resonates with neoliberal perspectives on 
resources. For example, Dr Héctor Acuña (Chair of the Pan American 
Health Organization (PAHO) in the 1970s and 1980s) stated:
The challenge of achieving the goal of health for all will require the unflagging commitment of governments, the allocation of required resources, and the reform and restructuring of health systems in order to obtain maximum equity, efficiency and effectiveness.  

Within the region healthcare provision as part of a welfare state has been achieved in only five countries. Cuba is the only one which has achieved
universal coverage, while access has been partial in Argentina, Chile, Costa Rica and Uruguay. In other parts of the region health care has been provided by the state to different degrees. Access to such health care has, however, been greatly limited by income, leading to inequalities between rural and urban areas, between class groups in towns and cities, by gender and between ethnic groups. In all cases, apart from Cuba, these systems have experienced reforms since the 1980s which are broadly identifiable as fitting into a neoliberal agenda. While these reforms have been conducted within a discourse of promoting equity and participation, this has rarely been the case in practice.

Decentralisation

In most countries in the region decentralisation in the health sector has been implemented alongside decentralisation in other spheres as part of a general goal to promote efficiency and participation. In Mexico health reform started in 1989 and decentralisation of health as well as education services was completed in 1997. However, in Mexico, as in other parts of Latin America, decentralisation took place within certain limits; most notably, while decision-making power and responsibility was transposed to state and municipal levels, funding did not always follow.

Decentralisation in Chile has had the longest history, dating from attempts under the Pinochet regime in 1974–75 to move responsibility for service provision away from the national to the sub-national level. In 1980 the responsibility for primary health care was given to municipal authorities, with health professionals being employed by those authorities. This took place within a system of mandatory health insurance with FONASA, the public sector health financing institution, being the main provider. Jasmine Gideon’s research in a low-income district of Santiago highlights how the system failed to provide the equitable and quality service which decentralisation promised. The main problems were insufficient funds, as the entire national healthcare budget was not decentralised, there was a lack of staff (both medical and administrative) and local decision making regarding the level of user fees was constrained. Thus decentralisation came with increased responsibilities for the municipal authorities but often without the freedom and economic resources to deliver. An additional problem was the use of the public sector facilities by users who were registered for private health care through ISAPRES, the organisation of private health insurance companies.

The national health system (Sistema Único de Saúde, SUS) in Brazil has had similar diverse outcomes in the government’s attempts to develop a universal health service based on individuals’ rights as citizens. Developed in the post-military dictatorship period of the 1980s and in response to grassroots activist campaigns for health reform, the SUS involved the almost complete decentralisation of primary healthcare provision to municipalities by 2002 from a position of only 25% municipal control in 1994. Health councils (conselhos de saúde) at state and municipal levels include user and service provider representatives, as well as state officials. These then feed into larger
scale health conferences, with national health conferences involving representation from throughout the country. While these processes of decentralisation have resulted in much greater debate around health provision and participation by a broader range of people, including women, indigenous peoples and Afro-Brazilians, existing problems of clientelism, bureaucratisation and power inequalities remain.

The setting up of the SUS in Brazil was partly driven by non-governmental activist movements mobilising around community health concerns and the need for health reform. In Latin America, as elsewhere in the global South, NGOs have been viewed as key actors in health provision in decentralised systems. Both local and international NGOs in the region tend to focus their activities on certain illnesses (such as malaria and HIV/AIDS) or particular populations, most notably mothers of young children and indigenous populations. NGO activity in the health sector varies greatly across the region because of factors such as the state of official healthcare provision, funding availability and the nature of civil society. While NGOs can make important interventions to improve the health status of marginal populations, they sometimes rely on the unpaid or undervalued contributions of community members, usually women.

**User fees and insurance**

The pattern of health expenditures across the region varies greatly (see Table 1), but there is agreement that out-of-pocket expenses by individuals at the point of service is the least desirable form of expenditure. As user fees rise, without appropriate safety nets for the poorest and most marginalised sectors of society, health sector reform will exacerbate inequalities within what is already the most income-unequal region of the world. For example, at the start of the 1990s public expenditure represented 58% of total health spending in Mexico, with 40% from households and 2% from private insurance companies. Less than a decade later the figures were 52% from households, 46% from public spending and 5.7% from private insurance.

Promoting health insurance schemes to cover both regular and emergency health care has become a key focus of Latin American government policy and has also begun to receive significant attention in sub-Saharan Africa (see below) and other parts of the global South. Mexico’s Seguro Popular and Chile’s Plan AUGE are particular high-profile examples which will be considered in more depth below.

Seguro Popular (‘Popular insurance’) is part of the Sistema de Protección Social en Salud or System for Social Protection in Health (SSPH) scheme which was piloted in Mexico in 2001–03 and was then rolled out across the country. Under the Seguro Popular scheme, insurance covers 94 medical interventions at both primary and secondary care levels, so it is much more comprehensive than the safety net coverage which exists to provide 18 medical services for free to the very poorest households. The aim of Seguro Popular is to provide coverage to the roughly 50% of the Mexican population not currently covered by insurance (provided through the state schemes for
public sector workers (ISSSTE) or private sector workers (IMSS) or through private sector provision). Premiums are based on financial capacity, with the first and second income deciles not paying anything. This is trying to move away from the user fees system which went before and had resulted in the exclusion of the economically poor from formal health care, or in households being forced to use savings on emergency health treatment, with longer-term implications for vulnerability.

Seguro Popular has been successfully taken up across the country, with significant differences (see Table 2). For example, in Oaxaca State, one of the poorest states in the country, in 2005 28.7% of the population was covered by a form of health insurance, with just over a third of these having Seguro Popular. For the country as a whole, over 50% were already insured and Seguro Popular only accounted for 20% of these beneficiaries. The government’s aim is to have universal coverage through Seguro Popular by the end of 2010.

In Mexico, as in a number of other Latin American countries, conditional cash transfer payments have become an increasingly important dimension in social policy. The Oportunidades programme is targeted at the poorest households, with payments being given to women if they ensure that their children attend school and they attend appropriate health and nutrition workshops. In 2005 over 50% of Oaxaca state’s population had access to health care through this scheme (see Table 2). Most beneficiaries of the programme are found in rural areas, as this is where income poverty is disproportionately concentrated. Similar cash transfer programmes in the region include Bolsa Familia in Brazil, Red de Protección Social in Nicaragua and Juntos in Peru.

The targeting of women as recipients of cash transfers in such schemes reflects both an assumption that it is women who are largely responsible for family health and the care of children, as well as attempts to empower women by providing funds and training. However, within the broader field of social policy, and particularly reforms in health insurance, an awareness of gendered processes has often been lacking, leading to the exclusion or marginalisation of women. For example, Chile’s Plan Acceso Universal con

### Table 2. Health sector use by insurance status, Mexico and Oaxaca State, 2005

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<tr>
<th></th>
<th>Mexico (%)</th>
<th>Oaxaca State (%)</th>
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<tr>
<td><strong>Insured</strong></td>
<td>56.1</td>
<td>28.7</td>
</tr>
<tr>
<td>IMSS</td>
<td>62.8</td>
<td>39.5</td>
</tr>
<tr>
<td>ISSSTE</td>
<td>12.9</td>
<td>22.2</td>
</tr>
<tr>
<td>Seguro Popular</td>
<td>20.4</td>
<td>33.8</td>
</tr>
<tr>
<td>Other institutions</td>
<td>3.9</td>
<td>4.4</td>
</tr>
<tr>
<td><strong>Non-insured</strong></td>
<td>43.6</td>
<td>71.3</td>
</tr>
<tr>
<td>SSA</td>
<td>76.2</td>
<td>48.2</td>
</tr>
<tr>
<td>IMSS–Oportunidades</td>
<td>23.0</td>
<td>51.8</td>
</tr>
<tr>
<td>Others</td>
<td>0.8</td>
<td>0.0</td>
</tr>
</tbody>
</table>

*Source: INEGI, Anuario Estadístico, Oaxaca Tomo I, Mexico City: INEGI, 2006, Table 2.4.1.*
Garantias Explicitas en Salud (Universal Access and Explicit Guarantees in Health Plan—Plan AUGE) is an attempt to ensure that the diagnosis and treatment of a number of specified health conditions (currently 56) is covered regardless of whether patients have public or private sector insurance (see above). Plan AUGE is not based explicitly on a male breadwinner/female homemaker distinction, but it still has important gendered impacts, not least the need for unpaid care of patients, which would usually be carried out by women.35

Perspectives from sub-Saharan Africa

The trend towards decentralisation within healthcare provision in sub-Saharan Africa has been supported by donors as a key strategy for good governance and as a pragmatic response combined with neoliberal economic policies to encourage international healthcare reform since the 1980s.36 In 1987 WHO and UNICEF sponsored the Bamako Initiative, which called for the decentralisation of the public health systems and strengthening of community participation in health and included suggestions for cost-recovery programmes at the community level, via the establishment of user fees for services and essential drugs and revolving drug funds. However, its lack of comprehensiveness has resulted in limited effects.

In assessing the impacts of health sector reform, a variety of elements need to be considered, such as how reforms have influenced provider and user behaviour, patterns of service provision and whether these have improved services by extending health coverage and raising quality.37

In most parts of sub-Saharan Africa decentralisation of government to local communities has led to the decentralisation of health services, with the aim of bringing greater efficiency in local governance in the periphery. Examples from Botswana and Senegal38 suggest that decentralisation brought the ‘government closer to the governed’ through increased and more effective community involvement in their own welfare, improved intersectoral collaboration and faster and more appropriate handling of administrative problems, although the structures used differed. In Botswana community involvement was facilitated by existing structures at district level, including district councils, village development committees and family welfare educators,39 while in Senegal community involvement was centred on health committees, which were given responsibility to gather and utilise resources to improve the quality of care in health facilities.40 In Ghana management and decision-making functions have also been transferred to the local level, leading to management and technical efficiencies where appropriate training was provided to facilitate the move from a centralised system.41

However, such reforms have not been without obstacles. These have included opposition by health personnel, lack of qualified personnel to implement reform, the inability of management committees to ensure efficient management of health centres, and scarcity of resources through the lack of both financial and skills transfer to the local level to ensure effective delivery.
of primary health care. These obstacles have wide resonance in West Africa, and studies have been conducted to see the impact of such schemes in several countries in the region.\textsuperscript{42}

\textit{Decentralisation, structural adjustment and their impact on health}

Sahn and Bernier also question whether the process of structural adjustment has improved the quality and quantity of vital services, improved economic well-being of households, thereby increasing demand for health care, and enhanced the environment for the private sector as a provider of health care.\textsuperscript{43} They suggest that these are three aspects that reform must enhance for it to improve health.

The introduction of user fees as a result of the Bamako Initiative of primary health care in 1987 has led to mixed results in terms of healthcare utilisation among the most deprived and vulnerable sections of the populations of many African countries. Charging fees for service at the point of delivery has meant that many of those most in need of care do not access the health services because of the financial burden placed on their already meagre subsistence livelihoods. In Mali, for example, many pregnant women do not visit the health centre not only because of the cost of transport to the facility, but also because of the subsequent charges for service and prescriptions. Similarly, in other parts of Africa, user fees have led to a decrease in health service utilisation, where an already existing paucity of health care has had a negative impact on overall health of communities.\textsuperscript{44}

There has been considerable discussion between governments, multilateral and bilateral agencies and advocacy groups on whether user fees in the health services in developing countries should be abolished.\textsuperscript{45} An experiment in the elimination of user fees from first-level government health facilities in Uganda in March 2001 led to a much more rapid increase in the utilisation rate of health services among the poor than by the non-poor. While the utilisation rate increased, the incidence of health expenditure did not fall, possibly because of the frequent unavailability of drugs at government pharmacies forcing patients to purchase these from private providers, as well as increased informal payments to health workers to offset lost revenue from fees.

However, there are studies which suggest that, where the introduction of user fees is matched by an improvement in quality of service, increased health service utilisation occurs, for example in Cameroon and Senegal. In the Adamaoua province of Cameroon this was investigated though household surveys before and after the introduction of a scheme involving user fees and quality improvement measures, using communities excluded from the scheme as a control.\textsuperscript{46} User fees in primary healthcare facilities in Pikine in the suburbs of Dakar, Senegal were also associated with increases in utilisation in the 1980s, from rates as low as 5\% to around 60\% in most districts. A safety net of free provision was provided for some particularly vulnerable individuals, such as blind people and widows. The introduction of fees was accompanied by the setting up of an elected community health committee.\textsuperscript{47}
Health insurance schemes

Mutual health organisations (MHOs) are voluntary membership organisations providing health insurance to their members to improve access to health care. Such schemes have arisen out of a need to improve health service utilisation rates and as a means for providing financial risk protection. The concept of mutual health insurance schemes aims to increase the availability of resources and to enhance the quality and reliability of services, thus making health workers become more accountable to their ‘clients’. The recent growth of such insurance schemes throughout West Africa has enabled rural populations to access health care by reducing out-of-pocket expenses faced by households. Such organisations, known as tontines (revolving savings groups) and mutuelles de santé in parts of francophone West Africa, have resulted in more people seeking health care, particularly in Ghana and Mali, for modern curative treatments. However, some countries, such as Burkina Faso, offer some of its state employees social health insurance through national social security funds. The provision of such insurance schemes inevitably leaves out a significant proportion of the rural population who are not public sector employees. More broadly such health insurance schemes are being advocated as a viable alternative to user fees in developing countries, as in the Latin American examples discussed earlier, and recent studies have shown the positive impact of such mechanisms on health service utilisation. However, measuring equity in access and utilisation of health care remains an important further research area.

Health insurance schemes in East Africa are not widely established. However, a number of studies elucidates similar issues with enrolment levels in Uganda and Sudan: mixed understanding of the basic principles of community health insurance, lack of good information, poor quality of health care, problems in ability to pay premiums and lack of trust. Some schemes are also too rigid in their regulations for people to feel comfortable in joining.

Awareness raising in health insurance schemes is taking place in Mali, where a few such schemes have recently begun forming part of the national health policy. There are two main actors in the health insurance arena. The first includes the technical services of the social development department at the regional level and the health service at the district level (Centre de Santé de Référence—CSREF). Information is disseminated by the technical staff in the villages on what health insurance schemes are and the advantages of joining such a scheme.

The second actor is the national Union Technique de la Mutualité (UTM), created in 1998, to which certain schemes adhere and which serves as a national umbrella organisation. In such schemes there is household membership which allows each member to benefit from belonging to such insurance schemes, where the UTM covers 75% of the costs with 25% borne by the patient’s household. However, membership may only be affordable for certain sections of the population.
Another such scheme is the MiPromo—*mutuelle interprofessionelle de Mopti*, where salaried employees benefit from a health insurance scheme. However, despite efforts to disseminate the virtues of health insurance schemes widely, membership has been low as it depends on capacity to pay. Even in the district of Bamako and the regions of Sikasso and Ségou, where there are more established health insurance schemes than in other regions in Mali, membership levels are not very high. Various explanations are likely: the level of understanding of health insurance and the uncertainty of the future inhibits people from joining where daily income is more important than saving for the future. In addition, where there is only one chief earner who has to bear the cost of each family member, this impedes joining health insurance schemes. Furthermore, there is a lack of confidence in the management of such schemes; communities’ lack of trust in office bearers echoing to feelings towards village-based organisations which are run on similar lines.

The lack of enrolment in such schemes may also reflect cultural reticence on the part of the communities. Where health is not seen as a priority, enrolment in such schemes remains low, particularly in rural areas. However, the average number of members per health insurance scheme is about 200. A study by De Allegri et al carried out in the Nouna district of Burkina Faso in 2004, highlights the importance of taking into account consumer preferences and decision-making factors in enrolling in community health insurance programmes which may lead to increased participation rates in the schemes.

**Conclusions**

In this paper we have outlined key dimensions of health sector reform which are often bundled together under the heading of ‘neoliberalism’. The reform policies and processes experienced in both Latin America and sub-Saharan Africa share some characteristics, most notably a reduction in state provision of health care, growing private sector healthcare and health insurance services, and an increase in the charging of user fees and in attempts to expand insurance schemes to the most marginal. However, the ways in which these policies have been implemented and their impacts differ widely. Despite political and activist rhetoric to the contrary, the outcomes of health sector reforms can rarely be pre-judged as either positive or negative in social justice or equity terms. Instead, the impacts of reforms need to be examined within the broader context of existing healthcare provision, poverty levels and capacity (to both manage and provide health services). In addition, while attempts to promote community participation in health service decisions and provision have been effective in a number of cases, often decentralisation leads to a reinforcement of existing inequalities and power relations.

Finally, given the nature of change in healthcare provision in both Latin America and sub-Saharan Africa, and the importance of context, future research needs to examine how policy changes operate in particular
situations. This will be of immense importance in examining the impacts of the growing number of ‘popular’ or ‘community’ insurance schemes in both regions. The challenges of implementing such policies and ensuring growing social equity remain significant. The global economic crisis of 2008 onwards has added pressure to existing systems of healthcare provision and new and innovative forms of healthcare support for poor and marginal groups will be in even greater demand.

Notes

The research on which this paper is based was partly funded by The British Academy (Willis), the University of London Central Research Fund and The Helen Shackleton Fund, Royal Holloway, University of London (Khan).
2 See www.undp.org for further information on the calculation of the Human Development Index (HDI).
3 MDGs 4, 5 and 6 explicitly refer to health: MDG 4 ‘Reduce child mortality’; MDG 5 ‘Improve maternal health’; MDG 6 ‘Combat HIV/AIDS, malaria and other diseases’. Other MDGs, most notably MDG 8 on global partnerships for development, also include health-related aspects.
5 The concept of ‘formal health care’ usually refers to health care provided in or through hospitals and clinics based on ‘Western’ biomedical health traditions. ‘Informal’ healthcare provision may include informal trading of pharmaceuticals and self-diagnosis, or health-seeking behaviour based on non-biomedical approaches to health, such as those using what are classified as ‘traditional’ or ‘alternative’ medicines or therapies. However, the distinction is often difficult to make. For example, in the state of Oaxaca, Mexico, in 2001 Article 16 of the Ley de Derechos de los pueblos y comunidades en el estado de Oaxaca, ‘traditional medicine’ and its practitioners were granted the same legal status as ‘Western’ medicine by the state legislature. This was meant to lead to increased financial support for ‘traditional medicine’ but this has been limited, despite the efforts of organisations such as the Comision Nacional para el Desarrollo de los Pueblos Indigenas (National Commission for the Development of Indigenous Populations—CDI) and the Consejo Estatal de Medicos Tradicionales de Oaxaca (State Council of Traditional Healers of Oaxaca—CEMITO).
7 See http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf.
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49 Chankova et al, ‘Impact of mutual health organizations’.
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