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# **THE IDB, THE WORLD BANK, LABOR RIGHTS AND HEALTH CARE PRIVATIZATION IN THE AMERICAS**

**Public Services International**

**WASHINGTON, D.C.**

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# **The International Financial Institutions Project**

## **Public Services International and the The American Center for International Labor Solidarity**

During the past decade, public opinion about the International Financial Institutions (IFIs) has grown increasingly negative. From year to year, the annual Human Development Report of the United Nations Development Program (UNDP) has shown deterioration on indices of well-being for the countries of Latin America, Africa, and Asia where the IFIs continually claim to be making progress in fighting poverty, promoting education and health and protecting the natural environment. In the year 2000, the United Nations Economic Commission for Latin America and the Caribbean had to revise its calculations of poverty upward by 10 percent from those it had projected ten years before.

Nevertheless, in its public statements and documents, the Inter-American Development Bank (IDB) and the World Bank claim to be underwriting and supporting programs and projects designed to address poverty, to modernize the state, to improve systems of health care, social security and production in the region. Each loan and grant of technical assistance is described as a new measure to improve efficiency, resource allocation and governance, and yet the data show declining public services, increasing corruption, a correspondent loss of faith in democratic processes.

Analyses prepared by Public Services International (PSI), together with information gathered from affiliate unions in Latin America and the Caribbean, suggest that the policies of the IDB and the World Bank, allegedly designed to modernize the public sector, actually undermine the rights of public sector workers and lead to a decline in wages and employment. Because the public sector is such a fundamental part of the formal labor force in the region, these policies hurt not only workers themselves, but also their families and communities, and ultimately the public in general.

The super-national status of the IFIs, however, means that few formal procedures exist to oblige these institutions to adopt more transparent and democratic policies. One mechanism that does impose accountability on these institutions is the Sanders-Frank Amendment to the Foreign Assistance Act of 1994 in the United States. This law stipulates that the U.S. Secretary of the Treasury must direct the U.S. Executive Directors at the IFIs to use their voice and vote to promote the adoption of rules that encourage debtor countries to guarantee the internationally-recognized rights of workers.

Various workers' organizations and Non-Governmental Organizations, especially in the environmental sector, have met with representatives of the IFIs to discuss the impact of multilateral programs on workers and communities. While IFI representatives rhetorically recognize the importance of workers' rights and democratic governance, to date they have done little to implement concrete actions to promote these principles.

It is clear, then, that without documentation of the negative effects of IFI policies and programs on workers, their organizations and their communities, discussions with these institutions cannot go much further. Therefore PSI, together with the American Center for International Labor Solidarity of the AFL-CIO, has taken on the responsibility of contributing to the necessary research. In 1998, PSI began the research in Brazil, and in 1999, continued the work in El Salvador, Nicaragua and Guatemala. Selected countries in the Caribbean became the focus of these investigations in 2000, and PSI affiliates explored the following questions:

- Does a debtor country, both in law and in practice, satisfactorily comply with the internationally-recognized rights of workers?
- Do projects financed by the World Bank and the IDB completely comply with the internationally-recognized rights of workers and all applicable national laws?
- Do projects sponsored directly by the Banks comply with rules and regulations of the Banks themselves, particularly with respect to reporting to affected groups and consulting with them?
- Do projects of the IFIs result in increased unemployment as a consequence of privatization practices and structural adjustment?

The four studies included here represent the efforts of PSI affiliates in Central America and the Caribbean to address these questions by examining IFI projects designed to restructure health care in the region. This report is part of a series of project evaluations published by PSI assessing the impact of privatization on public sector unions.

PSI wishes to acknowledge the collaboration of the *Sindicato de Trabajadores del Instituto de Seguro Social Salvadoreña* and the *Sindicato de Médicos del Instituto de Seguro Social Salvadoreña* in preparing the study in El Salvador. In Nicaragua, the *Central de Trabajadores de la Salud* and the *Confederación General Unión Nacional de Empleados* supplied much of the research and analysis. The work of Lucia Ellis and Eduardo Melendez and the Public Service Union of Belize was fundamental to the final study, and the documentation and analysis contributed by Stephen Thomas of the Public Services Association was indispensable to the study prepared for Trinidad and Tobago.

The information presented is designed to support efforts to oblige the IFIs to recognize and respect the rights of labor and the rule of law in both their borrowing and their donor member states.

Beatrice Edwards  
International Financial Institutions Project  
Washington  
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# The IDB Restructures the Health Sector in El Salvador\*

## I. INTRODUCTION

In March 1998, the Board of Directors of the Inter-American Development Bank (IDB) approved Operation No. 1092/OC-ES, The Support for the Modernization of the Ministry of Health and Social Assistance Project. The loan had been nearly five years in preparation, through a process that began in 1993 with the disbursement of World Bank loan SVPA7168 (Social Sector Rehabilitation) in El Salvador. The activities financed by this loan led to the presentation of a health sector reform proposal, known as the ANSAL study<sup>1</sup> and to the subsequent establishment of the National Health Commission (CONASA). The ANSAL study, also financed by the Pan American Health Organization (PAHO), the World Health Organization (WHO) and the United States Agency for International Development (USAID), identified important challenges and deficits in the Salvadoran health care service. While many of the ideas it contained were valid and remain widely accepted, other aspects introduce market mechanisms into health care and would effectively transfer direct service provision to the private sector.

These recommendations from the ANSAL study, which have been reiterated in all subsequent proposals associated with the multilateral development banks, attracted the attention of the Salvadoran Social Security Institute Workers' Union (*Sindicato de Trabajadores del Instituto Salvadoreño de Seguro Social, STISSS*) and the Union of Staff Physicians of the Salvadoran Social Security Institute (*Sindicato de Médicos Trabajadores del Instituto Salvadoreño de Seguro Social, SIMETRISSS*) for two reasons. First, the unions were concerned that the unqualified insistence on private sector health care delivery assigns inappropriate priority to profit-seeking concerns and reduces vital health needs to secondary consideration. This is a problem in a country where nearly 60% of the population is officially poor, and where large numbers of people suffer long-term physical and mental health problems as the result of the protracted and recent civil war. Second, neither union was consulted about proposed changes in the structure of the public health system, although the membership of both unions will be directly affected by national reforms when they come. This exclusion means that reforms have been proposed that did not take into account the experience, the knowledge, or the interests of organized health care workers and doctors.

## II. THE HEALTH CARE SYSTEM AND PROPOSED REFORMS

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\* Prepared with cooperation from the *Sindicato de Trabajadores del Instituto de Seguro Social Salvadoreña* and the *Sindicato de Médicos del Instituto de Seguro Social Salvadoreña*.

<sup>1</sup> USAID, PAHO/WHO, World Bank, IDB, ANSAL. *Analysis of the Health Sector, El Salvador*, Washington, D.C., 1994.

In its Constitution, El Salvador identifies health care as a responsibility of the State and universal coverage as a State function. Nevertheless, public and private health care systems exist side by side, with only minimal connections between them. The public subsector is dominated by the Ministry of Public Health and Social Assistance (MSPAS) and the Salvadoran Social Security Institute (ISSS), which provide services to approximately 58% and 14% of the population, respectively. The private profit sector covers about 5% of the population, and the private non-profit sector, including non-governmental organizations (NGOs) and church facilities, covers about 7%. No exact figure for the number of people uncovered exists, but estimates range from about 10% to 25%.<sup>2</sup> Bearing in mind the number of institutions that provide their own coverage (the military, universities, banks, etc.), this range seems reasonable.

While the variety of institutions providing coverage creates a problem, the lack of cooperation between them aggravates it. This is due to the duplication of effort and under- or over-use of specialized services, all of which reduce the quality of care. At the same time, services are concentrated in urban areas, adding geographic unevenness of care to the national system. These problems reflect a poorly coordinated and weakly regulated system, lacking in national policies (which should be the responsibility of the MSPAS), with few regulatory constraints and even less enforcement capability. The net result for the population is care of widely varying quality and, in turn, frequent complaints about the system.

While it is clear that the objective of universal high-quality coverage has not been realized by the public health system, it remains a worthy goal. The STISSS and the SIMETRISSS believe that it is also an achievable one because, in El Salvador, social indicators show dramatic improvement in health relative to decades past. Since this improvement has occurred despite a lack of corresponding advance in indicators for sanitation, basic services, housing, employment or crime, all of which profoundly affect the health of the population, the public health care system can rightly claim credit.

For example, according to a 1998 survey, 35 infants died per 1,000 live births in 1997, compared to the national infant mortality rate of 45/1000 in the early 1990s. Although the rate is still unacceptably high, it represents a dramatic improvement, largely due to motivated workers and to public health promoters.

By the same token, preventable diseases that can be eliminated by vaccination (tetanus, whooping cough, diphtheria, polio, etc.) have diminished or disappeared. Public health initiatives are largely responsible for this improvement as well, together with effective citizen participation. In fact, the success of the vaccination campaigns shows the importance of social participation and education in health care programs.

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<sup>2</sup> *Organización Panamericana de Salud/Organización Mundial de Salud, El Salvador: Perfil del Sistema de Servicios de Salud.* Washington, D.C., December, 1998.

On the other hand, uterine cancer, an easily treatable disease, is now the primary cause of death in women. The majority of these deaths are caused by a combination of cultural, economic, and medical factors, illustrating the importance of a comprehensive and multidimensional approach to health care. This health problem, however, is one that cannot be addressed without more accessible surgical equipment and better training.

Similarly, nutrition, the foundation of health and an important indicator of how well the basic needs of the most vulnerable (children and the elderly) are being satisfied, has not improved in the past five years. One in four children under five years of age suffers from chronic hunger, and the situation is worse than that in rural areas.

This national health profile suggests that when the public health care system has had the necessary resources, as in the case of the vaccination campaigns, it has been able to achieve ambitious goals rapidly. Further, even when public health workers have suffered under poor working conditions, understaffing and low pay, as they have during the past decade, they have managed to achieve significant improvements in infant mortality. But when they absolutely lack the resources to address serious health problems, as in the case of uterine cancer and widespread malnutrition, indicators do not improve. In other words, problems with the public health system are attributable not to personnel, but to a lack of resources and an unbalanced allocation of national wealth. Dismantling and privatizing the existing health care system will only aggravate these problems.

#### **A. The ANSAL Study**

The table below identifies six important policy recommendations made in the ANSAL study and adopted in different forms for incorporation into the IDB pilot projects for health sector restructuring.

## **ANSAL Proposal to Restructure the Health Sector at the National Level**

1. Redefine the role of the State, transforming it from a direct service provider and facilitating private sector activity.
2. Target tax-supported government services only on the poorest and only on basic health services for them.
3. Target financing at only the ten most widespread health problems.
4. Give priority to low-cost health promotion and illness prevention.
5. Increase financing substantially as service provision shifts to the private sector.
6. Create a highly standardized minimum-cost system.

SOURCES: ANSAL, *La Reforma de Salud: Hacia su Equidad y Eficiencia*. USAID, PAHO/WHO, World Bank, IDB, San Salvador, May 1994. MIPLAN, *Plan de Desarrollo Económico y Social 1994-1999*, vol II: *Texto Principal*, San Salvador, 1994.

One of the most troublesome of these proposals is the insistence on private providers for universal health insurance. As outlined, this insurance would be provided to consumers, who, according to their ability to pay, would purchase two separate categories of services at different fee levels from non-governmental organizations (NGOs), employers, or private companies. A basic fee would buy preventive care and basic primary services, and a higher fee would buy a broader service package that would include access to autonomous, self-financing hospitals. Chronic degenerative illness or, in fact, any non-standard illness requiring individualized care would go untreated for those who could not pay out of pocket.

In 1997 these features of the ANSAL study resurfaced in the *Documento Guía para la Reforma del Sector Salud*,<sup>3</sup> produced by the newly-formed Group for Health Sector Reform, with the support of the MSPAS. At the same time, the ISSS initiated its own reorganization process, so that the two institutions introduced major administrative and management changes, including privatization measures, unilaterally.

The STISSS and the SIMETRISSS have consistently opposed this series of proposals, from the 1994 ANSAL Study through the 1998 IDB loan, arguing that they are unsuitable for providing equitable health care in El Salvador, where such a large percentage of the population is poor. According to the plan described in the ANSAL study, the Government would provide only the poorest 20% of the population with free basic health services, leaving approximately 40% of the public living on less than USD 2 per day to cope with out-of-pocket health care costs when ill. Further, if the ANSAL approach were implemented, both the MSPAS and the ISSS would renounce their function as direct service providers and retain only their financial and regulatory responsibilities for services to be privately provided. In a society with only

<sup>3</sup> MSPAS, ISSS, *Documento Guía para la Reforma del Sector Salud*. San Salvador, 1997



a fledgling private sector in health services and a weak regulatory and enforcement environment, this approach could well be disastrous for the poor and the middle class.<sup>4</sup>

Moreover, this will have an enormous impact on the 30,000 employees who currently work for the public health system. Although the membership of the STISSS and the SIMETRISSS would be immediately and dramatically affected by the implications of the IDB loan 1092/OC-ES, at no time during the four-plus years taken to formulate the loan, were the unions representing these workers consulted about the changes planned.

The proposed reform is thus a serious disappointment both to the workers in the health sector and to those hoping that reforms of the public health system would bring universal and equitable coverage. Because the process of formulating the reforms and proposing pilot projects was characterized by a high degree of secrecy and a lack of transparency, the health sector unions had no opportunity to voice these concerns to policy makers. In contrast, the IDB, USAID, PAHO/WHO, and the World Bank appear to have been systematically consulted throughout the process. The table below identifies the policy recommendations of two of these agencies, and it is clear that the ANSAL study benefited from familiarity with these positions.

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<sup>4</sup> According to PAHO/WHO, inequitable services and facilities, as well as distribution problems, are chronic. In addition, the weakness of the public sector and the lack of policy and regulation lead to situations like the following:

- In 1998, 23,000 different types of medications were registered with the High Council on Public Health, although the essential ones recognized by the WHO number only about 300.
- No national control on the quality of medications exists.
- Each institution buys drugs at its own discretion, usually by requesting bids, and often at the initiative of the laboratories that will benefit from the sale.
- In 1996, MSPAS spent 14.5% of its budget (184 million colons) on drugs, and, for a smaller population the ISSS spent 20.3% (245 million colons).
- Estimates suggest that people spend more on drugs - owing to lack of access or to lack of confidence in the public health services - than on any other health service (for additional information on the needs of the existing health care system, see Appendix).

## Proposals for Health Sector Reform from International Organizations

### World Bank

1. Restrict health interventions to promoting an environment in which individuals may improve their health.
  - Promote economic growth through labor intensive industrialization.
  - Increase public investment in education, especially for girls, once education has been restructured to include private sector providers.
2. Target public expenditures on strict cost-benefit health assessments.
  - Reduce public spending on specialized clinics, training of specialists, and in interventions that provide few benefits relative to cost.
  - Finance only the adoption of a basket of basic primary health care services.
  - Finance only those clinics providing this basket of basic services.
  - Decentralize the administration of public health services through devolution of administrative and budget authority to local levels and through the low-cost subcontracting of services.
  - Provide financial incentives for the private sector to participate in health care.
  - Promote the out-of-pocket purchase of public and private insurance to cover clinic visits not included in the basket of essential services.
  - Encourage contractors to reduce their costs to a minimum in providing clinical services and supplies.
  - Strongly promote all policy changes through the distribution of information presenting the potentially positive outcomes of the new policies.

### Pan American Health Organization

1. Increase the social responsibility of the State with respect to health through:
  - Guaranteed universal access to basic services.
  - Increased expenditures on health care, once the sector has been restructured to include subsidized private providers.
2. Reorganize the sector.
  - Encourage low-cost resource allocation and administrative measures.
3. Effect qualitative change in the provision of services.
  - Target only the poorest; concentrate resources only on the most serious social, occupational, behavioral, and environmental problems. Control or eliminate factors that represent an obvious threat to public health.
  - Increase the public's awareness of individual responsibility for health.
  - Lower health care costs through improved application of knowledge about health care.
  - Mobilize resources and lower health care cost by facilitating international trade in health services and products.

SOURCES: World Bank, *Report on World Development, 1993; Invest in Health*, Washington, D.C., 1993. Carlyle Guerra de Macedo, *Health and Social Development. Social Reform and Poverty: Toward a Integrated Development Agenda, 1993*, IDB/UNDP, Washington D.C., February, 1993

## B. The CONASA Proposal

In 1998 the National Health Commission (CONASA) was established, which formulated the most complete proposal for sector reform, again on the basis of the ANSAL study, the Government's Modernization Program, and the 1997 proposal of the Group for Health Sector Reform. Because this proposal, too, was formulated with the financial support and advice of international organizations (IDB, GTZ, PAHO/WHO and USAID), elements of the health sector restructuring program in Chile and Colombia were also incorporated.

Once again, although international organizations were extensively consulted, the local population was not. The method adopted for formulating the proposal involved collecting information through key informant interviews and focus groups of technical specialists. Only after the proposals were developed were they presented to selected community assemblies.

Nevertheless, it is this CONASA document that stands as the most recent and inclusive strategy for restructuring the public health care system. Because it derives from those previous studies, the CONASA proposal includes and emphasizes the same principles: gradualism, decentralization, private sector participation, commercial competition, legislative modifications, and the separation of administration from service provision. These aspects of the proposal include elements that either explicitly or implicitly transform the public health care system into a private one. A policy of gradual change is adopted in recognition of inevitable popular rejection of this transformation and as a back-channel means of trying to avoid it.<sup>5</sup> Decentralization sets the stage for contracting out services, as does the development of a new legal framework for the provision of health care. Separation of services is a means of leaving the State with only financial and regulatory responsibility, while moving service provision to the private sector.

The proposal also provides for social participation, improved client service, exchange of resources, and emphasis on primary health care. Critics point out, however, that the government of El Salvador and the international donors typically describe their public relations campaigns as social participation; that the focus on clients has come to be a focus on *consumers* (patients who can pay) in Chile and

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<sup>5</sup> The loan document mentioned upcoming elections and popular opposition to the IDB project as a "risk." Project managers feared that election results in 1999 would evidence broad-based rejection of the proposed restructuring and took steps to prevent this. "As a result of the elections of March 1999, changes in the government's project team may occur that would delay execution. We have taken certain steps to avoid this situation, including conversations with the Medical Association, an internal communication strategy for personnel in the Ministry and an external strategy for the general population in order to consolidate support for the project's objectives." Banco Interamericano de Desarrollo, "*Proyecto de Apoyo a La Modernización del Ministerio de Salud Pública y Asistencia Social*," Operación No. 1092/OC-ES., Washington, D.C., 1998 (mimeo).

Colombia; and that the emphasis on primary care means few public resources will be devoted to the more costly curative measures when needed by the poor.

The net effect is one of entrepreneurialism and profit-seeking in health care, as a means to solve El Salvador's ills. Two major features of the CONASA proposal make this readily apparent. First, much of it focuses on financial and administrative models, in which the need for citizens to contribute more for services is heavily emphasized. Secondly, its feasibility is based on the development of relatively cheap prepaid medical packages managed by financial intermediaries and delivered through contracted private and public providers. These proposals come directly from the World Bank and closely resemble the programs the Bank has been developing and funding since the late 1980s.

As a result of recommendations from the ANSAL study and the CONASA proposal, the IDB subsequently approved Project 1092/OC-ES for USD 20 million to finance two pilot projects in two departments of El Salvador. Potentially, these projects are models for the nationwide reforms.

Although the National Assembly of El Salvador delayed approval of 1092/OC-ES, and never mandated that the MSPAS and ISSS implement the reforms proposed in either the ANSAL study or the CONASA proposal, the authorities of both institutions appear to have appropriated a good deal of discretion in this restructuring process. At present, for example, selected proposals are already in execution within the MSPAS, such as decentralization; increased patient charges for examinations, tests, consultations and drugs; pilot projects providing services through NGOs linked to the governing party; private contracting for services such as laundry, security, and food; and the renovation of an autonomous showcase hospital (Zacamil).

These unilateral actions were taken despite constitutional prohibitions and obligations, most notably the articles regarding State responsibility for public health and the collective bargaining agreements currently governing labor relations in the health sector. After vocal protests from the STISSS and the SIMETRISSS, the President of El Salvador, Francisco Flores, announced the creation of the Governing Council for Health (*Consejo Rector de la Salud*), to consider all reform proposals, including two from the unions. For the first time in the then four-year history of this process, union proposals about restructuring the health sector were actually on the table. This process failed to advance, however: the steps necessary to consolidate and empower the Board were never clear, and union leadership was never included in the discussions. In any case, the Council could not be considered representative of civil society: its membership is heavily weighted toward the private sector and toward ARENA, the governing party.

In the end, the manipulation of the Council may not really matter much because its deliberations have been disregarded. Whichever proposal is selected or formulated by the Council, it will confront a reform already in progress as designed by the Executive Branch of the Salvadoran Government, the World Bank, and the IDB.

### **III. THE IDB PILOT PROJECT 1092/OC-ES<sup>6</sup>**

The Support for the Modernization of the Ministry for Public Assistance and Health Project (USD 20.7 million) identifies its objective as “Improving the health conditions for low income groups.” Nonetheless, the authorities at the Ministry have conducted all the advance activities associated with this loan in the strictest confidence. It has therefore been impossible for the diverse sectors that will inevitably be affected either to evaluate the implications of the loan or to participate in its formulation. The project includes two important components:

#### **A. Experimental Actions to Reform the Health Services System (USD17.5 million)**

This project component, in turn, includes two subcomponents for execution as pilot projects, and is allocated 67% of the project’s total financing.

##### **Subcomponent I.a: Modernization of primary care units**

One of the experimental actions referred to here is the financing of a basic health plan for groups currently without medical coverage. Services will be provided through twenty primary care clinics, ten in each of the two selected departments. IDB financing will fund technical assistance to (a) change administrative practices, (b) design patient payment systems, (c) introduce incentive-based pay systems into a unionized sector (d) study computerization of the information system (e) cultivate, organize, and promote local private providers of services and supplies, and (f) advertise the new system.

The population to be covered will be required to pay a single fee, in exchange for which patients will have the right to certain limited services from these clinics. The services are equivalent to the Basket of Basic Health Services.

The government will subsidize the provision of this basic package in the amount of USD 23 per capita, to be paid to insurers. Department-level boards will make the transfers to the model health care units three times a year – in essence, they will “buy” aggregate services from these providers. Providers will be evaluated annually.

These transfers will be made to the model units in a manner parallel to the existing financing mechanism. However, the USD 23 per capita and the units’ discretionary use of funds will be contingent on each unit’s increased administrative efficiency. As these changes take hold, the IDB’s contribution will decline and the MSPAS’ will increase, pressuring the units to establish a patient payment system, and encouraging them to search out minimal-cost suppliers, personnel, and support services.

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<sup>6</sup> Ibid.

## **Subcomponent I.b: Modernization and strengthening of model hospitals and organizational innovations in the health system**

This aspect of the loan targets three public hospitals in three different departments and is designed to change their budgetary administrative procedures and to establish a network of outsourced service and supply providers. The IDB loan document emphasizes that the changes introduced through this component will be a model for administrative restructuring throughout the system of MSPAS establishments.

The hospitals are to become semiautonomous through technical assistance provided by the IDB. Bank experts will instruct administrators on measures designed to step up the pace and volume of work, to establish a local system of medical services and pharmacies based on ability to pay, cut costs and track expenditures, establish a clinical and administrative training program, establish a patient payment system (including some subsidized care for the poorest patients), and develop outsourcing mechanisms for supplies and services. The IDB will provide some funds for equipment purchases, but the availability of financing for this purpose will be contingent on cost cutting in administration and clinical services.

This project component overall will develop an interconnecting system of primary, secondary, and tertiary health care, with emphasis on minimal-cost treatments. The financial structure of the system will overtly discourage clinical practitioners from sending patients for higher-level (higher-cost) care. Further, this interaction will require heavy up-front payments to foreign companies for the information technology needed to guarantee that patients are charged, that they are tracked, and that they pay.

In effect, this pilot project is not designed to obtain information about different forms of administration that would permit broader coverage, or to identify the most pressing health care needs. The delivery model has already been constructed by the IDB, and its experts will simply fine-tune local applications. Rather than focus on the medical, environmental, and social aspects of developing an integrated public health care system, the project constitutes a market study for the establishment of a costly high-tech network of new, private providers. In other words, IDB funding will be used to collect the basic information necessary for these private providers to calculate their costs and profit margins through the commercialization of this new merchandise: health care services.

It should be emphasized here that the IDB and the World Bank have encouraged the incremental transfer of health care and other social service costs previously covered by the Government not only for those groups who can afford to pay, but rather for the entire population, except perhaps the poorest 20%. Low- and middle-income groups must now pay increased rates for services such as education, electricity (for those who have it), and water, as well as health care. At the same time that they have seen no income increases, they are now to be charged fees for services that

were previously financed through tax revenue. The payment for health services that the IDB's Project 1092/OC-ES proposes would accelerate this uncompromising tendency on the part of the Banks to impose more and larger fees for basic services that no one can really do without.

## **B. Modernization of Key Functions at the Central Level (USD 4.3 million)**

This project component includes two subcomponents. The first will reorganize and decentralize national health programs and the financial management system., and the second will develop the regulatory capacity of the MSPAS. Both subcomponents have been formulated through a preconceived World Bank scheme to restructure the health sector, consistently proposed and re-proposed since 1994 and applied in the ANSAL and CONASA studies.

The STISSS and the SIMETRISSS object to this component for a number of reasons. First, the intention to execute shows that the putative deliberations of the Governing Council are disingenuous at best. While the Council considers different reform proposals, the IDB and the Executive Branch of the Government of El Salvador proceed with implementation on their own. Secondly, the transfer of responsibility for health care from the State to the market, has long been rejected by the National Assembly and by popular opinion.<sup>7</sup>

Further, this component will fund participatory assessments of local needs, but whatever the outcome of these consultations, "services will be determined by international models and by cost considerations."<sup>8</sup> The other objectives are to establish new regulatory and procurement procedures in the context of a privatized and fragmented system. Moreover, the project includes a subcomponent intended to change public service law fundamentally, and to restructure the national system of public administration of human resources in conformity with the revised needs of the MSPAS. In other words, despite the IDB's apparent interest in participatory reforms, the project proposes to dismantle the public health care system in opposition to the expressed popular will. In addition, the IDB neglected to consult the 30,000 public health workers and doctors governed by the measures targeted for change.

A final activity of the project provides an explanation for this discrepancy between statement and fact. This activity is called "Formulation and Application of a Strategy for Institutional and Social Communication." This strategy, as described, consists of informing the public and public health workers about the modernization process already formulated and funded. It is essentially an advertising campaign for the project as structured by the IDB, with a public comment feature to be added later. Because 1092/OC-ES is in fact a loan, the public is essentially paying to persuade itself to support a program that it has previously and resoundingly rejected.

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<sup>7</sup> *Semanario de Análisis Coyuntural*, Segunda época, Año 6, No. 361.

<sup>8</sup> Banco Interamericano de Desarrollo, op. cit., p.16.

#### **IV. PROBLEMS WITH IDB 1092/OC-ES: OBJECTIONS OF THE STISSS AND SIMETRISSS**

As we have seen, the health sector reform in El Salvador is increasingly consolidated, in spite of a supposedly ongoing public debate orchestrated by the President and the Governing Council. The Government of El Salvador, the World Bank and the IDB have already embarked on a process that assigns priority to market mechanisms in the provision of health care. This strategy, far from favoring those social sectors historically lacking access to health services, actually favors those who would convert the provision of these services into a new means of enrichment: insurance companies and private healthcare enterprises.

##### **A. Violation of the national Constitution**

The Constitution of El Salvador clearly identifies the responsibilities and functions of the State with respect to public health (articles 2, 65, 66). Consequently, the reform of the health sector must comply with these fundamental principles. Any proposal that does not comply requires amendment of the Constitution. In summary, these articles recognize the right of the citizen to “life and physical integrity. (article 2); “the health of the inhabitants of the Republic constitutes a public good, and the State and the people are obligated to care for its conservation and maintenance. This principle shall orient national health policy” (article 65). “The State shall provide free health care to those who need it because of illness and lack of resources, and to inhabitants in general, when treatment constitutes an effective measure to prevent the transmission of a contagious disease” (article 66). While it is true that public health and the public health service are far from achieving these objectives, the articles of the national Constitution represent the most valuable guide to incontrovertible rights.

##### **B. Loss of meaningful universal coverage**

Universal coverage is a concept that should be incorporated into any humane system of social security and public health care, and it means that the State provides certain social guarantees for all its citizens. With universal coverage, a society establishes a floor of social services beneath which it will not allow its members to fall. Citizens agree that certain living conditions are not negotiable or discretionary. They are to be maintained whether specific individuals can pay for them or not. The Constitution of El Salvador identifies health care as a plank in this floor. Health care services should therefore be accessible, independent of ability to pay.

The market-oriented doctrine of the multilateral development banks assumes that the high cost of certain treatments will lead to the bankruptcy of health systems, and, as a result, patients will be provided with these services only to the extent that they can pay for them. The population apparently has only a right to certain minimal services, identified by the World Bank and the ANSAL study, and these services must cost less than the per capita payment calculated by the IDB, if the private



providers are to receive a return. The policies promoted by the IDB, the World Bank, and the Executive Branch of the Government of El Salvador are designed to establish a stratified health care system that excludes those who cannot pay from all but the most basic services.

<p style="text-align: center;"><b>BASIC HEALTH SERVICES ANSAL</b></p>	<p style="text-align: center;"><b>ADDITIONAL HEALTH SERVICES ANSAL</b></p>
<ul style="list-style-type: none"> <li>• Vaccination</li> <li>• Prevention and treatment of acute intestinal and respiratory disorders</li> <li>• Nutritional education</li> <li>• Education about hygiene</li> <li>• Prevention and treatment of parasites</li> <li>• Prevention and control of STDs</li> <li>• Family planning</li> <li>• Pap smear and mammogram</li> <li>• Prenatal care and normal birth services</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment for acute infectious diseases referred by primary care facilities</li> <li>• Births requiring special attention</li> <li>• Acute abdominal surgery</li> <li>• Emergency treatment for trauma and poisoning</li> <li>• Treatment for malaria and tuberculosis.</li> </ul>

Source: ANSAL: *La Reforma de Salud: Hacia su Equidad y Eficiencia*. USAID, PAHO/WHO, World Bank, IDB, San Salvador, May, 1994.

### **C. A reform based on confrontation**

The Government of El Salvador, the IDB and the World Bank have embarked on a restructuring process in which no meaningful social participation takes place. The Governing Council for Health has played, to date, only a superficial role. While it analyzes large volumes of information attached to the reform proposals presented by CONASA, FUSADES, ANSAL, and civil society organizations, the Government takes steps to advance privatization. The Government has delayed and hindered the Council's work while refusing to grant it the authority to evaluate the implications of pilot project 1092/OC-ES and disregarding it when awarding concessions for medical services, surgery and consultations.

Further, the Government, facing a labor dispute in the health care sector that began in November of 1999, used the situation to avoid mediation efforts until March of 2000. The STISSS and the SIMETRISSS membership struck the public health system to protest the ISSS' violation of agreements between the union and the Government signed in May of 1998, according to which the Government would not privatize the public health care system. In November 1999, however, after renovating and reconstructing the Zacamil Hospital, the Government prepared to turn it over to a consortium of concessionaires. The STISSS struck to prevent this, and the Government fired 221 workers in response - principally workers employed

in pharmaceutical units, which the Government was interested in privatizing first. Although the strike was lifted, the dispute over the 221 fired employees remained unresolved until August 2000. The Executive Director of ISSS initially proposed that the dismissed workers form cooperatives to provide privately the services they had formerly been employed to provide as government workers. In other words, the Director proposed to privatize the Institute using the workers she had fired when they struck to prevent privatization.

#### **D. Reform proposals put forth by civil society ignored**

Finally, the civil society proposals that attempt to reconcile private and public interests as well as the interests of the workers in the sector, doctors, and the public in general have been tacitly ignored. Although the proposal put forth by the Citizens' Health Initiative is among those to be analyzed by the Governing Council, the measures implemented *de facto* by the Government are completely at odds with the spirit of the reforms proposed by broad sectors of society. Consequently, it is clear that no serious, systematic attention has been given to them.

#### **V. PROPOSALS FROM CIVIL SOCIETY INSTITUTIONS**

This disregard of civil society organizations occurred even though, beginning in April 1999, they established a broad-based consultation process for the purpose of incorporating the views of all social sectors into a reform proposal. Thirteen different types of institutions participated: midwives and health promoters, churches with health programs, humanitarian institutions, community leaders, unions of health technicians, unions of health administrators, universities, municipalities, NGOs, journalists, private health care enterprises, autonomous and government institutions with health care programs, and special patient groups. This consortium made a concerted effort to formulate a proposed policy and strategy in health care, which was then synthesized by a selected group of recognized national specialists.

The principles of the health care proposal from civil society are the following:

- Design and implementation of an integrated health care model with an emphasis on primary care.
- Primary care that includes a focus on social participation, health care promotion and education, nutrition and hygiene, mental health, care for patients with special needs, prevention and mitigation of emergencies and disasters, respect for existing international conventions and national laws in matters of health.
- Geographically accessible information and cultural communication.
- Direct bilateral communication between the users of the system and the workers in the system.<sup>9</sup>

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<sup>9</sup> "Propuesta de Política y Estrategia de Salud," San Salvador, February 1999 (mimeo).

The STISSS, in particular, proposed a new financing method, in which all employees and independent workers would contribute to a new health care system and all employers would finance a proportional part of the cost of health insurance. The new system would have auditing controls that measure the effectiveness and efficiency of the use of all resources. The ISSS would be responsible for producing an estimate of annual costs in order to secure the necessary financing. Potential sources of funding would include new taxes on tobacco, alcohol and gun and ammunition sales. and on the producers and promoters of products or habits detrimental to public health.<sup>10</sup>

## VI. GUIDELINES FOR A DEMOCRATIC REFORM

It is urgent that the reform process be redirected. Operation 1092 of the IDB includes under its second component a number of activities that could be reoriented to support a broad social discussion at the national level of the proposals to restructure the public health system. The Operation includes USD 1 million in unprogrammed funds that could be used to support an effective national consultation process, managed on a tripartite basis by the Government of El Salvador, the Inter-American Development Bank, and civil society organizations that submitted proposals to the Governing Council for Health. As guidelines to reorient the reform process based on the proposals of the ANSAL study and the IDB, the Citizens' Health Initiative proposes the following:<sup>11</sup>

1. The solution of continuing labor disputes in the sector through broad-based negotiations that examine the assumptions of the proposals and allow a democratic discussion of the issues.
2. Strengthening and broadening the jurisdiction of the Council to allow participatory consultative exercises that will include all the sectors of civil society involved in the issue. The participation of health workers is fundamental to the composition of the Council, and respect for their right to participate must be the basis of sustainable labor relations in the sector.
3. Discussion and approval by the Council of all measures that imply the transformation of structure, management, and financing in the health sector either promoted or financed by the IDB. It is clearly disingenuous to take measures to transform the sector, while the Council is still debating these same measures.
4. The IDB must demonstrate its commitment to democracy and self-determination in El Salvador by (a) complying with the national laws in formulating its projects, (b) respecting the decision of the National Assembly with respect to its loans and projects, and (c) submitting its loans and projects to democratic discussion and open deliberation.

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<sup>10</sup> *Modelo de Protección Social para El Salvador*, Sindicatos de Trabajadores del Instituto Salvadoreño del Seguro Social, San Salvador, n.d.

<sup>11</sup> For more detailed information about the needs assessments performed to develop the proposals for the Citizens' Health Initiative, see Appendix.



## APPENDIX

From June 1998 until June 1999, a broad-based coalition of thirteen grassroots organizations and NGOs worked to formulate a popularly supported proposal for health sector reform. This effort culminated in a national symposium of more than 150 organizations that produced the document "*Propuesta de Política y Estrategia de Salud.*" The final document was the product of a series of workshops held during the symposium. The symposium also created the Civil Society Initiative and instructed it to promote the implementation of the "*Propuesta.*" The details of this document are described below.

### **Training Needs in the Public Health Care System**

The national crisis in the quality and the quantity of training provided health care workers, together with the lack of appropriate policies, is reflected in the sector as a whole. Among professionals, training is offered more or less indiscriminately according to ability to pay, not according to the country's needs. Therefore, issues of oversupply in certain professions (doctors) exist side-by-side with undersupply (nurses). Further, few employment possibilities exist in the public sector, despite the unmet health needs of much of the population.

Virtually all technical training is in the hands of private enterprise, with few mechanisms for regulation, and occupational training in health care is not articulated with national needs. Recently, scandals have come to light regarding private training, casting doubt upon the axiom that the private sector performs better than the public.

Just as at the technical level, university level training is given in response to demand rather than to the country's health needs. Attention is devoted almost exclusively to the physical aspects of medicine.

For all levels of training and education, demand consists not of a spectrum but of two extremes: personal initiatives on the one hand, and objectives of the international cooperation agencies and banks on the other. The former have provided the country with specialists who respond to the market. The latter offer funds for training – especially through MSPAS – but only in the areas prescribed by the international agencies. Cronyism, the lack of relation between training and public health needs, and the random nature of training are the major difficulties with this approach.

### **Distribution in Health Care Occupations**

The table below shows the disproportionate ratio of doctors to support staff (nurses and nurses' aides). It also illustrates the scarcity of dental care. Such a distribution shows the strictly medical model of health, as opposed to a more integral approach, which would include physical, mental, and social services. The table also shows the

disproportionate resources available to the ISSS, bearing in mind that the population covered by the Institute is about one quarter of that covered by the MSPAS.

### Distribution of Human Resources in MSPAS and ISSS, 1998\*

Resources	MSPAS	ISSS
Doctors	3,120	1,651
Dentists	334	176
Nurses	1,753	574
Nurses' aides	3,118	1,399
Other Workers	Not Available	2,541

\* Source: Pan American Health Organization/World Health Organization, *Perfil del Sistema de Servicios de Salud*. December 1998.

### Problems with Equipment

The following problems affect biomedical equipment in the public sector:

- 30% of the equipment is defective.
- 70% of high tech equipment is located in hospitals in the capital.
- The highest quality equipment is found in the ISSS and in the private sector.

### Investment in Health

It is estimated that in 1996 58.8% of expenditures on health were made directly by households, and 39% of this amount was spent by the poor.<sup>12</sup> Medication absorbed the largest proportion of funds (41.5%), and doctors fees came next (25.9%). In total, households spent 4.2% of GDP on health services, the Government spent 1.7%, ISSS 1.2%, and insurance companies 0.2%. Together, all sources spent more than 7% of GDP, a sum that requires careful planning and investment.

<sup>12</sup> MSPAS and others, *Estimación del Gasto Nacional en Salud durante 1996*. San Salvador, 1997.

This situation has been interpreted by the international lenders as evidence that the poor and near-poor can, in fact, pay for at least a part of the health services they need. The Banks have therefore proposed cost recovery programs for the population attended by the MSPAS. Such programs do not recognize the cruel tradeoff confronted by the poor, who, when faced with a medical bill, forgo other basic needs in order to pay it.



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# **RESTRUCTURING PUBLIC HEALTH CARE IN TRINIDAD AND TOBAGO: THE CONDITIONS IMPOSED BY INTERNATIONAL FINANCIAL INSTITUTIONS**

## **I. INTRODUCTION: THE WORLD BANK, THE INTER-AMERICAN DEVELOPMENT BANK AND PUBLIC HEALTH CARE IN TRINIDAD AND TOBAGO**

### **A. Background**

For the past five decades, the twin-island economy of the Republic of Trinidad and Tobago has depended heavily on the production of gas and oil for the international market. As a result, the population has experienced the classic boom and bust cycles of an oil economy. During the 1970s, when oil prices rose suddenly and dramatically, the Government collected windfall revenues and made extensive investments in infrastructure, not all of them warranted or sustainable. When oil prices fell in the 1980s, the country had few economic reserves to fall back on. Although the World Bank had graduated Trinidad and Tobago from concessionary lending in 1984, the continuing economic contractions of the 1980s reduced per capita income so fast that the country soon became eligible once again. In 1986, the Government approached the International Monetary Fund (IMF) for macroeconomic assistance, and by 1988 Trinidad and Tobago was back in the hands of the World Bank and the Inter-American Development Bank (IDB) for the restructuring of its debt and its economy. The World Bank approved a structural adjustment loan in 1990 and continued lending through a series of economic and social projects.

The austerity agreements the Government signed with the World Bank, the IDB, and the IMF—together referred to as the International Financial Institutions (IFIs)—have resulted in a substantial reduction in the standard of living of the population. Between 1988 and 1994, at the request of the IFIs, the Government cut spending, introduced a stiff value-added tax, devalued the country's currency, minimized capital controls, removed price controls on consumer staples, privatized about 50 percent of state-owned enterprises, and began a comprehensive retrenchment program in the Civil Service. The net effect of these measures was increasing job loss, reduction of household income, and poverty. During this period, unemployment soared, together with emigration, and there was a significant change in the composition of the poor population. Whereas formerly “the poor” was made up primarily of vulnerable groups such as the elderly, the unemployed, and the disabled, by the late 1980s the poor population of Trinidad and Tobago also included active members of the labor

force who were subsisting on low wages—the “new poor.” By 1994, 21 percent of the population fell below the poverty line, and nearly half of this group was classified as extremely poor, that is, without their own resources to buy the minimum amount of low-cost food needed daily. Unemployment was 14 percent, with much higher figures for women and youth.<sup>13</sup>

### ***B. Public Health Achievements in Trinidad and Tobago***

Despite the economic catastrophe of the 1980s, the health statistics of Trinidad and Tobago remained fairly impressive. Average life expectancy held steady at 72 years, infant mortality stayed low at 13 deaths per 1,000 births, and child malnutrition remained minimal to nonexistent. The Pan American Health Organization described Trinidad and Tobago as well into the demographic and epidemiological transition represented by low birth rates and death rates and a shift toward mortality caused by chronic and degenerative diseases rather than widespread deprivation and communicable diseases.<sup>14</sup>

This profile can be attributed to the comprehensive public health care system and the long-standing public commitment to social safety nets. In 1996, the Government’s expenditures on health care were equivalent to about 3 percent of the gross domestic product (GDP). Public health services were delivered through a network of 13 hospitals, 106 health care centers, and a range of targeted programs and support services. Public hospitals provided virtually all of the country’s emergency and inpatient care. With the exception of the Eric Williams Medical Science Center, all health services were provided free of charge and financed out of general tax revenues.

### ***C. The Health Sector Restructuring Problem***

From the beginning of their macroeconomic restructuring interventions in Trinidad and Tobago, the IFIs targeted social sector spending for the deepest cuts. Analyses published by the World Bank show that the IFIs intended to return the Government to solvency by eliminating many subsidies and social services and by imposing significant wage cuts on public workers. Both of these tactics attracted the attention and concern of the Public Services Association (PSA), an affiliate of Public Services International (PSI) representing health care workers in Trinidad and Tobago. For the past ten years, the PSA, together with other progressive labor unions, has resisted the ill-conceived, one-size-fits-all strategies of the IFIs. This paper documents the economic interventions implemented by the IFIs, the negative consequences of these actions, and the undemocratic and potentially harmful policies the IFIs seek to implement in the

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<sup>13</sup> “Memorandum of the President of the International Bank for Reconstruction and Development to the Executive Directors on a Country Assistance Strategy of the World Bank Group for the Republic of Trinidad and Tobago,” the World Bank, Washington, D.C., March 24, 1999, p. 4.

<sup>14</sup> Trinidad and Tobago: Basic Country Health Profiles, Summaries 1999, PAHO, Washington, D.C. 2000.

future. It is the hope of both PSA and PSI that information in this report will contribute to an understanding of the important health and social issues at stake in the restructuring process and lead to a national campaign to resist this sophisticated and coordinated assault on the rights of public workers and the general population. At the same time, PSI and PSA hope that the IFIs will come to understand the negative consequences of their economic strategies in Trinidad and Tobago and in many Caribbean countries.

## II. IFI POLICIES FOR PUBLIC SECTOR MODERNIZATION IN THE CARIBBEAN

### A. IFI Blueprint for Reform

The World Bank has never made a secret of its blueprint for effecting reforms in the Caribbean: public sector “modernization” has always been a priority. In the World Bank view of modernization economic growth should be driven primarily by the private sector while the public sector is limited to maintaining public security, providing infrastructure in areas deemed unprofitable by the private sector, and administering temporary social services for the destitute.

In the Caribbean, the results of the State’s reduced scope of activities are substantial: the Civil Service is downsized, jobs are reclassified, information systems are established to monitor productivity, budget allocations are made based on productivity measures, and user fees are imposed for services previously financed through taxes.<sup>15</sup>

From past experience, the IFIs are aware that their interventions will be received unfavorably. For this reason, they describe them in neutral and reassuring terms.

*The partnership of public and private sectors can take many forms along the dimensions of financing, management and ownership. For instance, many recent reforms have introduced cost-recovery for publicly provided services and introduced contracts and subsidies as ways to have public sector support for private production of services that benefit the wider society.*<sup>16</sup>

The World Bank analysis of the economic picture in Trinidad and Tobago went farther, and its intentions were harder to obscure. Bank economists identified two principal sources of the Government’s fiscal deficits: i) public sector wages, and ii) income transfers and subsidies. According to the World Bank, rising public sector wages had not only bankrupted the Government but had also driven up private sector wages, making the country unattractive to foreign investment and limiting the possibilities of economic recovery. At the same time, the burden of extensive subsidies left the public sector in debt and drove away private foreign capital. The availability of public income support programs made it necessary for private companies to pay living wages in order to attract workers. In the view of the World Bank, programs such as unemployment insurance, national health insurance, and welfare constituted “disincentives to work.” The main obstacle to the process of development in the country, according to the

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<sup>15</sup> *Public Sector Modernization in the Caribbean*, Report No. 15185 CRG, World Bank, Washington, D.C. April 1996.

<sup>16</sup> *Ibid.*, p. iii.

World Bank, was that working class incomes were too high and profits therefore were not high enough.

### ***B. Changes in the 1990s***

The “problem” presented by high wages has been a continuing theme of the IFIs in the Caribbean, but until the 1990s, governments in the region had been able to play the Cold War card with the U.S. dominated multilateral banks. Thus they had maintained the flow of international financing without deliberately and overtly attacking labor’s acquired rights and wage levels in order to increase national “competitiveness.” Because of their strategic geographical position, the long-standing U.S./Cuba feud, and occasional flirtations with socialism in islands such as Jamaica and Grenada, the Caribbean countries and territories had not been obliged to lower pay scales to the levels in Central and South America. This geopolitical advantage disappeared in the 1990s, and the IFIs adopted a tougher stand with Caribbean borrowers. The drive to restructure the health sector in Trinidad and Tobago typified this policy shift.

The economy of Trinidad and Tobago is one of the largest in the Caribbean, and the country is a producer of oil and gas. Historically, it has had an important role in the political leadership of the region, and it has a well-established and progressive, organized labor movement. Health care workers constitute a significant part of both unionized labor and public sector labor. Moreover, the protections enjoyed by health care workers are guaranteed by the Constitution. In the view of the IFIs, if they could implement a restructuring program in Trinidad and Tobago that lowered wages, limited pension rights, and reduced job security in the health sector, the program might be transferable to other territories/countries where the IFIs plan to privatize state enterprises and social services.

As the fiscal crisis brought on by the slump in oil prices worsened for the Government of Trinidad and Tobago in the late 1980s and early 1990s, there was an intensified assault on wages. Public sector wages were more or less frozen after 1989, at the request of the IFIs, and after the Government signed its first agreement on health sector reform with the IDB in 1991 wages began to fall. Between 1984 and 1996 income transfers and subsidies declined from 50 percent of Government spending to 28 percent.<sup>17</sup> This shift from budget cuts in economic services, which had been the Government’s first line of defense in the 1980s, to social spending cuts in the 1990s was the initiative and the directive of the IFIs. The policy came from Washington and not from Port of Spain, which can be seen from the critical position taken by the World Bank in its analysis of the Government’s early attempts to resolve the fiscal crisis.

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<sup>17</sup> *Trinidad and Tobago. Macroeconomic Assessment and Review of the Public Sector Reform and Expenditures: The Changing Role of the State.* Report No. 15187-TR. The World Bank, Washington, D.C., June 28, 1996, pp. 12-13.

*A notable feature of the adjustment in Government expenditures since 1989, is that while real expenditure has fallen by around 7 percent over the period (though large decreases occurred before then due to the fall in oil revenues) spending on education, housing, health, social security and welfare has remained more or less constant in real terms and has increased as a proportion of total expenditure. The major burden of adjustment has therefore been borne by 'economic services' which includes much physical infrastructure investment (roads, communications) and maintenance.<sup>18</sup>*

In 1995, when a new Government came to power, the IFIs' bias toward spending on infrastructure while cutting wages and subsidies became more pronounced. In that year, the United National Congress (UNC) party formed an alliance with the two successful parliamentarians belonging to the National Alliance for Reconstruction Party elected from Tobago and formed a narrow majority in Parliament. The Government then forged a broad agreement on the need to make the economy of Trinidad and Tobago more competitive. Making the economy more competitive (in terms of the IFIs) meant reducing labor costs. The Government, the IDB, and the World Bank collaborated on a 10-year economic program that would serve as a long-term policy framework for this purpose. Among the features of the new policy framework were:

- Facilitating private-sector-led employment generation and entrepreneurship in non-oil sectors;
- Eliminating social subsidies and social programs that might serve as disincentives to work.<sup>19</sup>

### ***C. Realigning Government Spending***

The Country Assistance Strategy (CAS) of the World Bank made it clear that the IFIs viewed social safety nets and tax-supported public services such as health care as potential causes of low productivity and, to the extent that they sheltered people from the worst consequences of poverty, as policies that promoted idleness and discouraged work.

To implement the strategy of realigning government spending from social services to infrastructure investment and promotion of privatization, the IDB approved a loan of USD 134 million for the Health Sector Reform Program (937/OC-TT) for Trinidad and Tobago in July 1996. Although the Government had actually adopted a program of health sector reform five years earlier, with technical assistance from the IDB, after the Bank became involved as a lender, the commercialized, anti-worker features of the program grew increasingly significant. Externally driven policies that imposed user fees, restricted services,

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<sup>18</sup> Ibid., p. 14.

<sup>19</sup> Country Assistance Strategy of the World Bank Group, p.ii.

and limited the acquired rights of workers in the sector led directly to anti-democratic and illegal procedures in the implementation of the program. Because many aspects of health care reform were inevitably unpopular, public debate was soon eliminated, and policy decisions were made behind closed doors by groups with narrow interests.



### III. THE POLITICS OF HEALTH SECTOR REFORM

The Government of Trinidad and Tobago introduced the Health Sector Reform Program in 1991 to “improve the health status of the population by promoting wellness and providing affordable quality care in an efficient and equitable manner.”<sup>20</sup> The Ministry of Health identified the major components of the program at that time as:

- Reform of the Ministry of Health into a skeleton facility limited to the planning and regulatory functions necessary to manage extensive contracting and outsourcing;
- Establishment of five Regional Health Authorities (RHAs) as independent statutory authorities accountable to the Minister of Health;
- Devolution of service delivery and management to the five RHAs;
- Reduction of public sector expenditures, employment, and wages in health care through a new strategy for funding the pension plan of RHA staff, an employment policy focused on fewer, more highly skilled personnel, reduced overall staffing levels, and changes in organizational structures to accommodate outsourcing of services;
- Reduction of curative and hospital services and infrastructure to focus on less expensive mass interventions, emphasizing low-cost services, and restricting health care to the primary level as much as justifiably possible;
- Design of broader financing mechanisms focused on user charges and increased social security payroll deductions.

The actual legal instrument effecting the incorporation of the statutory bodies under whose jurisdiction the decentralized health care delivery system would fall was the Regional Health Authorities Act No. 5 of 1994. The goals set forth by the Government during the early stages of the reform appeared fair and progressive. Because its membership would be immediately affected by the reform, the PSA insisted on inclusion at every phase of program design, implementation, adjustment, and audit. The response of policymakers, though unwritten, can only be described as adversarial and confrontational. The first serious conflicts between the Government and the PSA developed in 1993 and 1994 regarding four provisions of the RHA bill.

- Security of tenure of health care personnel;
- Erosion of protections guaranteed by the Constitution related to financial entitlements and other benefits for Civil Servants;
- Union recognition via respect for the convention governing successorship;<sup>21</sup>

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<sup>20</sup> Trinidad and Tobago, Technical Assistance Program ATN/SF/CD/(PP)/JF-3650-TT, IDB, Washington, D.C., 1991.

<sup>21</sup> The provisions extending existing contractual coverage to employees shifted from one agency to another.

- Access to and affordability of health care services for the working class and the poor.

Ultimately, the larger question of the constitutionality of the Act itself arose when the bill became law without receiving the support of a “special majority” in Parliament. Because the legislation contemplated modifying the terms and conditions of employment of health care workers in the Civil Service, a special majority rather than a simple majority was required in order to pass. This question remains unresolved.

When the UNC party came to power in 1995, it began negotiations with the IDB to finance and implement a health sector reform program that represented an even greater departure from popular consensus on i) the health care responsibilities of the Government, and ii) the civil service protections and regulations that apply to health care workers.

## IV. THE HEALTH SECTOR REFORM PROGRAM OF THE IDB: 937/OC-TT

### A. The IDB Loan Document

As the IDB became more directly involved in the reform of the health sector in Trinidad and Tobago, its analysts hoped for a relatively smooth transition from a publicly funded system to one largely funded through user fees. The IDB loan document (937/OC-TT) noted optimistically that a favorable policy environment existed for this shift. It identified three encouraging features of the political climate with respect to implementing health sector changes. First, restructuring the health sector was part of a broader public sector plan to transfer services from the Government to private providers and enterprises. Second, the Government had already defined a restructuring strategy for health care; and third, the Cabinet of the new Government in 1995 had already created the RHAs, which paved the way for privatization. Still, the IDB anticipated problems: It recognized that the plans for provision of health care in Trinidad and Tobago represented policies, institutional structures, and resource allocation priorities that would be “radically different” from the existing system.<sup>22</sup>

The loan document identified specific components of the strategy that might generate opposition from labor and community groups.

- The closing of smaller hospitals, the consolidation of certain services, and the transformation of small hospitals into district health facilities, which was perceived as downgrading;
- The introduction of user charges;
- The introduction of a new pension plan for health workers who leave the public service for RHA employment.<sup>23</sup>

The loan document outlined in euphemistic detail how the IDB and the Government intended to deal with the anticipated opposition.

*The implementation of the human resources strategy could be hampered by delays in negotiations with the various unions and associations. The main issues, specifically the transferring of authority and the rationalization of the workforce have been the subject of informal comments by the different stakeholders. The strategy includes a communications program that will address all related issues. In anticipation of negotiations, the MOH (Ministry of Health) has begun a series of workshops with the main employee groups and associations. Professional assistance in industrial relations and communications will be provided throughout the program.<sup>24</sup>*

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<sup>22</sup> Trinidad and Tobago. Health Sector Reform Program, 937/OC-TT, IDB, Washington, D.C. July 10, 1996, p. 13.

<sup>23</sup> Ibid., p. 43.

<sup>24</sup> Ibid., p. 44.

In other words, the IDB did not intend to hold formal consultations with the affected workers or adapt policy to meet their needs and concerns. Instead, employing a method of dealing with unions that PSI has documented in a number of countries, the IDB indicated it would inform the workers about what was to occur rather than consult with them and retain consultants and industrial relations specialists. These latter were brought in to make the program more palatable to health workers and, if needed, to apply more coercive tactics to carry out health sector reform.

### ***B. The IDB Reforms Appeal to Private Providers***

It is apparent that neither the IDB nor the Government intended to negotiate seriously with the PSA or with the general public because the main features of the health sector reform had little to do with *health*. Instead, they focused on *cost and profit*; the Government, having already entered into a financial agreement with the IDB, was no longer in a position to negotiate. Reviewing the loan document that was approved in 1996, it is clear that the main elements of the reform were economic rather than social. In the 44-page document, only two paragraphs are substantively devoted to a discussion of the health status of the population or the health issues of the country. The rest of the document addresses issues of financing, administration, and organizational structure. It is apparent that the IDB plans to operate the health sector in a manner that will appeal to private providers.

### **C. Coercive Efforts to Reduce Health Care Personnel**

As mentioned earlier, the loan document of the IDB and the Country Assistance Strategy of the World Bank for Trinidad and Tobago clearly show the eagerness of the IFIs to transfer public expenditure from social services and salaries to infrastructural investment. The IDB has identified cost savings in health care personnel as a fundamental objective of health sector reform. In order to free up Government revenues to buy equipment and fund construction, the IDB has proposed decentralizing authority and introducing individual output measures as a basis for personalized pay scales that would be calibrated by some form of health care productivity rating system. Confounding the plans of the IDB and the Government are protections provided to the Civil Service in the Constitution that fix wages and working conditions of public health personnel.

For the IDB, civil service status was an obstacle to implementing changes to the economy it deemed necessary.

*While personnel absorbs almost three-quarters of total expenditures, responsibility for appointment, promotion, discipline, and dismissal of staff lies with the Public Service Commission, whose power is enshrined in the Constitution. There is overstaffing in many grades and shortages in*

*others because managers cannot reallocate spending to achieve the right skill mix. The highly centralized and aggregated accounting and procurement system also provides no incentive to know, or system to measure the costs of services. This overcentralized and difficult to manage structure results in a lack of accountability and responsiveness to changing health needs.*<sup>25</sup>

#### **D. Sidestepping Constitutional Protections**

The solution to this legal roadblock is a tactic the IDB has employed throughout Central America and the Caribbean in countries where civil service protections are legally guaranteed. In the context of the loan agreement the IDB takes steps to remove direct responsibility for health care from the Ministry of Health. This action renders public health workers redundant, and they can be separated voluntarily or compulsorily, according to the degree of political resistance they can muster. Responsibility for public health is then vested in the newly constituted (RHAs), such as those established in Trinidad and Tobago in 1994. These institutions then rehire the former Civil Servants at lower wages, with less job security, and under individual rather than collective contracts.

*This maneuver is a version of the old “runaway shop,” although in this case the shop has not run far. In fact, the hospital or health care facility where the new contract employee comes to work is often the same facility he or she left as a Civil Servant. The IDB describes the scheme this way:*

*The cornerstone of institutional changes within the Health Sector Reform Program is the separation of regulatory and provider functions, which to date have been exercised by the MOH in a centralized manner. By transferring the provider function to the Regional Health Authorities, a reorganized and strengthened MOH will be able to assume a leadership role, focusing on policymaking, planning, monitoring, and regulation. It will set national health priorities based on needs assessment, and will influence the provision of care by a combination of sponsorship and regulation of public and private providers.*<sup>26</sup>

The institutional changes targeted by the IDB typify the commercialization of health care delivery that is taking place through the RHAs. The prescribed shift in job responsibilities would result in a reduction of MOH personnel from 400 to less than 100. Because the RHAs were established as autonomous bodies, they would be directed by boards made up of representatives from commerce, industry, health care, and the community, according to the IDB. The RHAs would be run by a chief operating officer and a senior management team. Noticeably

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<sup>25</sup> Ibid., p. 5.

<sup>26</sup> Ibid., p. 5.

absent from the list of groups and stakeholders represented on the RHA boards was the PSA.

*E. Coercion of Workers to Leave the Civil Service*

The progressive-sounding Regional Health Authorities (RHA) Act of 1994 will ultimately eliminate civil service protections for 11,000 medical workers in hospitals and clinics and do away with the positions of all but about 100 public health workers, who would remain as administrators at the MOH. The loan document explained exactly how the transformation would be accomplished.

*The strategy calls for the use of financial and nonfinancial incentives to entice current staff to transfer, within the parameters set by the RHA Act and as soon as possible, to full employment under the regions. The establishment of a fully funded, contributory pension plan for RHA employees, the use of discretionary voluntary separation and early retirement 'packages,' and the abolition of public service positions as soon as they become vacant or as the staff are transferred to the RHAs are meant to be the backbone of the human resources strategy.<sup>27</sup>*

Documentation and testimony from the public health workers affected, however, show that the transfer of personnel has not been carried out in the benevolent terms described by the IDB.<sup>28</sup>

First, in the workshops held to communicate the new terms of employment to public health workers, discussion leaders and facilitators did not reveal that under the new arrangement, skilled and administrative workers would no longer be represented by the PSA. The union would represent only unskilled daily-rate workers, in violation of the RHA Act of 1994 itself. Nor were workshop participants told that job security would be virtually eliminated, that the pension system would be less generous, or that their own contributions to the pension system would be much higher.

Health care workers reported that they were systematically pressured by the Government to accept voluntary separation settlements or early retirement packages and resign. If they did, they were told, they would be rehired by the RHAs. If they did not, they would lose their jobs anyway, but without compensation and without the option of retraining and employment at the RHAs under any terms. The loan agreement sums up the personnel shift: "This strategy includes measures to achieve a complete transition from the current public service status of the majority of the nearly 11,000 health sector workers, to RHA employment under new service conditions."<sup>29</sup> The document then refers

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<sup>27</sup> Ibid., p. 7.

<sup>28</sup> Interviews with public health workers, conducted by PSA, September–December 2000.

<sup>29</sup> Ibid., p. 7.

the reader to Annex I for details on the new service conditions. Annex I, however, was not included in the version of the agreement released to PSI.

#### ***F. Defaming Public Health Workers***

The IDB loan document repeatedly refers to the inefficiency of public health workers and the inadequacies of their services. Nowhere, however, does the document substantiate or quantify these charges. Nonetheless, the Health Sector Reform Program is predicated upon reduction of staff, redeployment of personnel, the need for a new skills mix, and a change in investment that shifts resources from salaries to equipment. Although these conclusions allegedly derive from extensive diagnostic studies carried out by the IDB, neither the PSA nor the public was informed about or consulted regarding the studies. The public does not know how the studies were conducted, who conducted them, or how such derogatory and prejudicial conclusions were reached about public health workers.

In contrast, the PSA has extensively documented the shortage of nursing staff, low pay for nurses, the lack of resources public health nurses have at their disposal, and the excessively long shifts that put patient care at risk. The reform program does not address these pressing issues, and the Government has allowed them to reach intolerable levels. In fact, the PSA has data indicating that because of poor working conditions, low pay, stress, and overwork, trained nurses and semi-skilled assistants have been steadily emigrating from Trinidad and Tobago for the past ten years.<sup>30</sup>

#### ***G. IDB Tunnel Vision***

The IDB analysts behind the sector reform strategies appear to purposefully ignore the obvious connection between the lack of investment in infrastructure and the poor quality health services. In Trinidad and Tobago, a major cause of job dissatisfaction, difficulty recruiting, and difficulty retaining public health nurses has been the working conditions to which nurses are subject. When the Government does not invest in the physical plant, in materials and equipment, staff are limited in what they can accomplish. When these problems are compounded by understaffing, the quality of service is certain to decline. Instead of consulting the PSA on the design of an integrated program of investment, training, and staffing that addresses real and urgent problems, the IDB simply prescribes the same boilerplate remedies it has imposed on other countries in the past. Typically, these remedies include:

- Diagnostic studies that are in fact market analyses rather than health needs assessments;

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<sup>30</sup> Critical Problem Areas in Health Institutions Requiring Serious Immediate, Short Term, Medium Term and Long Term Action, Public Services Association, Port of Spain, 2000.

- Transfer of public service workers to lower-paying positions with quasi-private or private employers;
- Separation of administrative and provider functions in hospitals and health posts;
- Cost-cutting measures across the board to finance the purchase of information technology, for the purpose of measuring staff productivity and tracking patient payments.

In its policy document, *Public Sector Modernization in the Caribbean*, the World Bank emphasized:

The wage bill is the largest non-interest expenditure object in government budgets, and its share has been rising in most Caribbean countries . . .

The accompanying table indicated that in Trinidad and Tobago the wage bill, as a ratio of current government expenditures, had only increased from 40.6 percent in 1980 to 41.9 percent in 1994. Nevertheless, the Bank stated that:

*This rise typically has crowded out operation and maintenance and even investment spending to the point of seriously reducing the efficiency of the public service and the effectiveness of programs.*<sup>31</sup>

The table in question showed an increase in proportionate expenditures of as much as 32 percent in some countries during the period, but Trinidad and Tobago showed virtually no change. Nonetheless, the IFIs prescribe the same restructuring of expenditure between salaries and capital investment for Trinidad and Tobago, for Barbados with an 11 percent increase. and for Antigua and Barbuda, with a 32 percent increase in spending on wages relative to investment. The World Bank continues:

*Spending by most health ministries also suffers because salary expenses crowd out non-wage recurrent spending. Doctors, nurses, and public health workers are important, but their effectiveness is limited by dilapidated buildings and the scarcity of medications and functioning equipment.*<sup>32</sup>

The World Bank document is clear about where salaries will be cut when it argues, with no data presented, that the Caribbean tradition of turning to the Government as an employer of last resort has left a “legacy of overstaffing at lower levels.”<sup>33</sup>

## ***H. Problems with Generalized Notions of Development***

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<sup>31</sup> *Public Sector Modernization in the Caribbean*, p. 21.

<sup>32</sup> *Ibid.*, 27.

<sup>33</sup> *Ibid.*, p. 21.



This approach to reform by the World Bank and the IDB embodies everything that is wrong with generalized notions of development and globalization. Trinidad and Tobago, like all countries, is unique in many ways. Unlike other Caribbean countries, it witnessed an oil boom in the 1970s and 1980s. Unlike North, South, or Central America, it is an island state, which limits its potential for economies of scale and raises the cost of basic goods, such as food, much of which must be imported. Trinidad and Tobago has a history of colonization, slavery and indentured servitude, forced immigration, and economic emigration. The population is well educated at the primary level, but has inadequate secondary schooling and suffers from very high unemployment and underemployment (somewhat relieved by emigration). There is a high level of poverty. Because of social patterns that developed during the colonial period and were reinforced during the prosperity of the oil boom, the State has traditionally served as a major employer. The centralized public health service has performed well throughout a long period of declining resources, maintaining preventive care programs, vaccination campaigns, rural clinics and curative facilities. The effects are visible in Trinidad and Tobago's health statistics, which show the country assuming a morbidity profile that resembles that of developed countries.

Into this context, the IFIs have introduced a new health system, decentralized to RHAs and private providers, who have limited performance history in Trinidad and Tobago; a regulatory system that is similarly untested and unprecedented and, in fact, does not yet exist; and a technology-intensive administration, although there is a shortage of university and secondary school graduates. The IFIs would also establish a technology-intensive overall care system, although there is a shortage of jobs on the one hand and of highly skilled health care personnel on the other. The IDB loan places a heavy emphasis on primary care, although statistics show an increasing shift toward health problems involving degenerative and chronic diseases, such as hypertension and certain cancers. The documentation that justifies this approach is based almost exclusively on orthodox economics and cost-benefit analysis. Consultations with the PSA and with independent community groups that might have revealed the unsuitability of these policies were deliberately not held in violation of, or through manipulation of the IFIs own mandates.

## **I. Reforms at the Expense of Patients and Workers**

All remedies prescribed by the IDB are described in an abstract manner to avoid publishing the details of unpopular measures and to obscure the fact that IDB economists lack familiarity with the day-to-day operation of the Trinidad and Tobago public health system. The policy descriptions are further distorted by deceptively benign language about the implications of the health reform policy for workers and the public, for example:

*The Health Sector Reform Program (HSRP) is at the forefront of the public sector reform effort, encompassing actions and programs aimed at greater efficiency, improved allocation of resources and better organization and management of sector institutions.*<sup>34</sup>

Only later in this IDB document are we told about the new and intense pressures for cost containment that will be placed on the RHAs at the heart of the reform:

- Service agreements between the RHAs and the Ministry of Health are hard and fast, and the RHAs must absorb any additional costs incurred over and above those the Ministry agreed to pay for when the agreement was signed. This type of financial arrangement builds in every incentive to limit services;
- RHAs must shift from in-patient to ambulatory care as much as possible;
- Bed numbers in the hospitals administered by RHAs are to be reduced;
- Specialties are to be geographically concentrated;
- Referrals for more advanced and costly care should be strictly controlled;
- The number of health care centers nationally will be reduced from 106 to 44.

To achieve projected savings, the RHAs will need increased autonomy. This will enable them to reduce workers' wages and limit health care provided to the public. These practices are repeatedly referred to by the IDB as "increasing efficiency."<sup>35</sup>

The IDB and in fact all of the IFI lenders in the Caribbean believe that these measures must be implemented to bring about health sector reform. Their belief is based on two assumptions:

- 1) Wage protections for public workers serve as disincentives to work.
- 2) Patients prefer to use hospitals and doctors rather than the less costly clinics and nurses.

While there may be some truth to the second assumption, it is far from established and requires empirical research to determine its scope and cause.

The entire sector reform project is predicated on these ideas, which are expressed by the IFIs implicitly and explicitly.<sup>36</sup> Unfortunately, these biased views and misconceptions are presented in IDB's analyses as inherently objective and the product of the Government of Trinidad and Tobago.

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<sup>34</sup> Ibid., p. 5.

<sup>35</sup> Ibid., passim.

<sup>36</sup> Health Sector Reform Program, 937/OC-TT, p. 7; Country Assistance Strategy of the World Bank Group, p. ii.

*The strategies of the GORTT (Government of the Republic of Trinidad and Tobago) for the reform of the health sector are based on outcomes and recommendations of the sector studies conducted with the technical assistance of the Bank and the ensuing policy dialogue.<sup>37</sup>*

Although the IFIs state that these policies were developed in Trinidad and Tobago, they bear an uncanny resemblance to the health reforms recently undertaken in El Salvador, Belize, the Bahamas, Nicaragua, and Guatemala, among others, all with the same technical assistance and financing from the IDB. Moreover, no meaningful policy dialogue ever took place with the unions immediately affected by the restructuring in any of these countries, any more than it did in Trinidad and Tobago. In every case, however, the IDB asserted that it had followed the same open and consultative procedures.

## **J. Evaluation of the IDB Loan**

Because of the lack of consultation and the unpopular content of IDB loan 937/OC-TT, it is not surprising that implementation has not gone well, despite the optimistic assessment of the political climate surrounding the loan's initial execution period in 1996. The Northwest RHA presented an analysis of the health reform situation in August 1998. It identified such difficulties as i) the slow progress of reform, ii) the flight of manpower overseas, iii) a community dissatisfied with health care, and iv) the private sector becoming the only health care alternative, at a time when it is adopting a higher-level of technology than patients or the country can afford.<sup>38</sup>

The author of this study of the IDB loan implementation points out that if the Northwest RHA (NWRHA) has documented failure of the health reform program, then for all practical purposes health reform has failed from the perspective of the union and the public. The NWRHA includes the capital of Trinidad and Tobago and has jurisdiction over the largest, most commercially viable and densely populated region in the country.

The IDB representative in Trinidad and Tobago substantively agreed with this evaluation, although for different and less socially responsible reasons. He wrote to the Minister of Health in July 1998 with dissatisfaction that: i) the Ministry had been unable to oblige most RHA staff to resign from the Civil Service, ii) workers continued successfully to resist payments and rewards based on quotas, piecework and other individual performance measures, and iii) information about the system was inadequate from the Bank's perspective.<sup>39</sup> The IDB representative complained about the inordinate amount of time required to recruit

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<sup>37</sup> Public Sector Modernization, , p. 5

<sup>38</sup> Stephen Thomas, Health Sector Reform in Trinidad and Tobago. Perspective 2001. Public Services Association, Port of Spain, February 2001. p. 21.

<sup>39</sup> Correspondence between Frank J. Moresca, IDB Resident Representative, Port of Spain, and Hamza Raffeek, Minister of Health, Republic of Trinidad and Tobago, July 1998.

for long-term consultant positions in the MOH, in the Project Administration Unit, and at the RHAs. Nor did “adjustments to the staff skill mix or the development of improved service-delivery attitudes move forward.” The IDB was generally unhappy with the 1997 Annual Review which, it said, did not systematically assess and document the program or policy targets achieved and did not set 1998 milestones or document corrective actions to be taken.<sup>40</sup> The IDB went so far as to advise the Ministry that “the success of the reform agenda depends on the enthusiastic support of significant interest groups.”<sup>41</sup> This seems to suggest that the IDB and its representatives in the member states are unable to understand that when the Bank approves a loan designed to cut salaries, eliminate benefits, impose user fees, privatize basic services, and restrict secondary services that no one can do without, its policies will be received with less than enthusiastic support from interested groups. And, in the absence of consultation with these groups, the IDB may never come to understand this.

### ***K. Plans for Revising Health Sector Reform***

By 1999, both the IDB and the Government recognized that the Health Sector Reform Program was badly bogged down. Under the umbrella of the National Trade Union Center, the Prime Minister met with the leadership of the PSA to discuss the urgent needs of nursing personnel who, during the implementation period of the reform, had suffered salary losses due to inflation, continuing problems of understaffing—sometimes forced to work double and triple shifts—and frequent emergencies due to lack of medications. At the meeting, the Government agreed to a three-point protocol.

- The Chief Personnel Officer of Government would place the 25 percent pay increase incentive offered to nurses before the PSA, and would stop undermining the union by bypassing its leadership and offering the negotiated incentive directly to nurses as individuals.
- The RHA Act would be amended to grant the PSA full recognized status for the purposes of collective bargaining.
- The Government would transfer all Constitutional protections for public officers to the RHAs.

### ***The Government’s Response***

The Government never honored any of these agreements. Although the Prime Minister appointed a Task Force to investigate problems of staffing, overcrowding, shortage of pharmaceuticals, waiting time in clinics, and the care environment, as he had agreed, the PSA was excluded from it. Even so, the

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<sup>40</sup> Stephen Thomas, p. 23.

<sup>41</sup> Correspondence between Mr. Moresca and Mr. Raffeeek.

report the Task Force issued reiterated the position of the union, i.e., the health care system showed serious problems in budget allocations, operated according to unidentified and arbitrarily determined priorities, and suffered alarming levels of discontent and disaffection among all categories of personnel.<sup>42</sup>

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<sup>42</sup> Performance Review of the Northwest Regional Health Authority, August 30, 1998, cited in Thomas, p. 37.

## V. PENSION REFORM: THE NEXT STEP

Despite the failure of existing health reform policy in Trinidad and Tobago, the IDB continues to operate in the same unilateral, nonconsultative manner, designing and approving loans that ultimately will harm the interests of working people and violate national law. One of the major cost-cutting measures to be achieved by the transfer of Civil Servants from the employ of the Ministry of Health to unprotected jobs at the RHAs is the loss of pension fund benefits. Civil servants, including public health workers, are entitled by law to old age benefits through the noncontributory civil service pension scheme for public employees. Employees actually contribute to the system, but they do it indirectly through income taxes rather than through a payroll deduction earmarked for the fund. Employees transferring from the Civil Service to the RHAs will lose this benefit, although the workshops and seminars held by the IDB and the Ministry of Health have not explicitly or adequately informed public health workers about this loss. When questioned, IDB representatives say that this omission occurs because the terms of the new pension fund are not yet finalized.

In reality, this information has not been released because the IDB cannot construct a convincing actuarial argument for changing the terms of funding civil service pensions. Payroll deductions will increase and benefits will decrease not so much because the solvency of the pension fund is at risk, but because the Government needs to free up funds for the purchase of extensive management information technology. This advanced administrative technology will become necessary should the IDB privatize the pension fund, a policy the IDB continually promotes.<sup>43</sup>

### **The World Bank Assessment of the Civil Service System**

In its assessment of the solvency of the civil service pension system, the World Bank reported: "The liability of the Government due to the civil service pension scheme has not been quantified."<sup>44</sup> The study goes on to reveal the arbitrary policy decision that will require larger pension fund contributions from new civil service employees or current Civil Servants transferred to the RHAs. The World Bank says that no study of the system has been done in recent years, although deductions from general revenues to pay these pension obligations were constant between 1986 and 1988, and then declined because of the stagnation of public sector salaries. Costs, in other words, are constant or declining as a percentage of public expenditure.

Nonetheless, the World Bank claims to be alarmed by the lack of information about the pension fund. It strongly implies that there is apt to be some

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<sup>43</sup> Cristián Aedo and Osvaldo Larrañaga, *Social Service Delivery Systems: An Agenda for Reform*, Center for Research in Applied Economics, Inter-American Development Bank, Washington, D.C., 1994, passim.

<sup>44</sup> *Trinidad and Tobago. Macroeconomic Assessment and Review*, p. 36.

underlying problem in the fund's actuarial balances, but must concede that there is no "immediate crisis." This wording, of course, implies that current problems exist although they are not yet critical, and that in the near future, urgent pension-threatening financial shortfalls will materialize. Once again, the World Bank makes these charges on the basis of virtually no data, by its own admission.

Having extrapolated a potential fiscal emergency to occur at some unspecified date in the future, the World Bank then goes on to recommend possible remedies that negatively affect the incomes of public workers. The Bank comments that:

*A contributory scheme<sup>45</sup> for new employees is one way to deal with these issues. It would help to clarify the Government's pension liability, accumulate a fund and ease the transfer of Civil Servants to the private sector. There are precedents for introducing new conditions for new Civil Servants. For example, the travel allowance that existed for Civil Servants was eliminated for new entrants.<sup>46</sup>*

This remedy involves the introduction of a two-tiered framework for pension benefits: one for older workers already in the system and a second, restricted and less expensive one for new public workers. Unions have always resisted this tactic because it allows the erosion of benefits over time and destroys solidarity. Nevertheless, this is what is planned. The World Bank, encouraged by the fact that travel allowances have been eliminated for newer public workers, is likely to pressure the Government to restrict pension benefits as well.

### **The World Bank Suggests A Way to Fund Pensions**

The World Bank's assessment of the Civil Service system provides a glimpse of what is in store for public workers in Trinidad and Tobago. It refers to the defunct Industrial Development Corporation, a former statutory board with a pension fund based on payroll deductions of 5 percent. The Bank suggests that such a deduction might be adequate to fund pensions for Civil Servants. Needless to say, none of this speculation has been transmitted to the PSA, whose members will essentially suffer a 5 percent wage/benefit loss, should the program be approved.

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<sup>45</sup> The World Bank and the IDB typically refer to payroll deductions as "contributions," so that a contributory scheme means a pension fund based on additional taxes, usually taxes that place a much higher relative burden on low income wage earners.

<sup>46</sup> *Trinidad and Tobago. Macroeconomic Assessment and Review*, p. 47.

## VI. HEALTH SECTOR PROBLEMS DOCUMENTED BY THE PSA

The World Bank assessments and IDB loan documents leave the impression that public health workers in Trinidad and Tobago are comfortably well off, although at the same time they lack the skills appropriate to their jobs and do not have enough to do at work. Because the specialists and consultants employed by the IFIs write only in the abstract and do not deal with the realities of day-to-day health care, their diagnostics and policy recommendations are consistently off the mark. In contrast, the PSA outlines in detail the specific issues that a serious health reform must address. For example, the union described the tasks that must be performed by a registered nurse (RN) and an enrolled nursing assistant (ENA) in a day shift at Port of Spain General Hospital.

1. Receive a briefing on each patient's status from the previous shift
2. Take diet requests and deliver them to the dietary department
3. Serve breakfast
4. Assist with patients going to surgery, which should begin by 8:00 a.m. and continue throughout the shift
5. Administer pre-medication if ordered for patients going to surgery
6. Supervise medications that are controlled substances
7. Clear breakfast
8. Bathe patients
9. Change bed linens
10. Collect physicians' reports
11. Collect specimens and deliver them to the laboratory
12. Inventory ward supplies
13. Continue taking patients to and from surgery
14. Monitor patients returned from surgery for hemorrhaging, asphyxiation, or restlessness
15. Serve and clean up lunch
16. Track new admissions
17. Prepare patients' reports for the next shift
18. Brief the incoming shift<sup>47</sup>

In addition to documentation of staff duties, the PSA has extensive information about combined equipment, infrastructure, and training needs. The union compiled information by hospital in June 2000 that specifies immediate problems affecting patient care and the health of personnel. Four years into the Health Sector Reform Program, for example, the staff at Caura Hospital documented the following problems:

- There are no special facial masks for nursing personnel on the wards since the new strains of hospital-acquired infections became apparent, e.g., multi-drug resistant tuberculosis;

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<sup>47</sup> Cited by PSA from the duty roster of Port of Spain General Hospital, Wednesday, November 3, 1999.



- Drug-resistant TB patients are not isolated as the public was led to believe. They walk about the institution using all the facilities, e.g., pay telephones;
- The supply of disinfectants is inadequate;
- The supply of hand-washing materials is inadequate;
- Nursing personnel frequently contract throat infections, “pseudomonas” (hospital-acquired infection);
- Severe staff shortages exist, especially on evening and night shifts;
- The plumbing throughout the hospital is faulty;
  - There is no doctor to see the staff, and no annual x-rays are provided despite continuing exposure to tuberculosis;
- Mentally ill patients from St. Ann’s are sent to Caura Hospital, but the nursing staff is not trained to handle these types of patients;
- The staff dining room is not equipped with cutlery, glasses, or plates;
  - TB and HIV patients are housed together;
  - The pharmacy is open only one or two days a week;
  - Caura Hospital is a fire hazard;
  - Security at the institution is inadequate.

These problems are not abstract; they represent immediate concerns that could be effectively addressed through consultation with the union, flexibility, good faith, and political will, none of which has been part of the multi-year, multi-million-dollar IDB Health Sector Reform Program. The PSA, the public, and the patients have good reason to view the health reform program as a failure.

## **VII. PSA PROPOSED HEALTH SECTOR REFORMS**

Although it has not been consulted as part of the Health Sector Reform Program, PSA has developed an initial set of recommendations for addressing the critical health care problems faced by its members. As a set of operating principles, the union proposes the following:

1. Honest, transparent collaboration among all stakeholders, possibly through the establishment of a formal decision-making forum;
2. Expeditious recognition of workers' representative organizations;
3. A guarantee of patients' rights and remedies through the enactment of appropriate legislation, including the establishment of independent enforcement mechanisms;
4. Development of protocols governing:
  - The conduct of medical and other health care professionals
  - The quality of drugs and pharmaceuticals
  - Performance audits
5. Availability of free health care to the economically disadvantaged;
6. Assignment of high budgetary priority to essential services and essential services personnel.

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# THE INTER-AMERICAN DEVELOPMENT BANK AND HEALTH SECTOR REFORM IN BELIZE\*

## I. INTRODUCTION

On October 18, 2000, the Board of Directors of the Inter-American Development Bank (IDB) approved a Health Sector Reform Program Loan (1271/OC-BL) for Belize. The loan provides USD 9.8 million in financing from the IDB and anticipates approximately USD 8 million in counterpart funding from the Government of Belize, the European Union, and the Caribbean Development Bank. Because of the rapidly growing population of Belize, increasing ethnic diversity, and expanding health care needs, popular organizations hoped for an opportunity to debate the alternatives of health sector reform publicly. The Public Service Union (PSU), an affiliate of Public Services International (PSI) and the umbrella National Trade Union Congress of Belize (NTUCB), representing over 300 health care workers directly affected by the terms and conditions of the new loan, had both the political and legal right to be consulted. Modern trade unionism requires union leaders and members to take a more proactive role in national affairs. Unfortunately, such activity is often viewed with suspicion by governments rather than welcomed as a sincere attempt to contribute to the process of national development.

The study presented here documents workers' dissatisfaction with particular aspects of the Health Sector Reform program. The PSU was not included in any meaningful way in the discussions and debates surrounding the health reform issue. The terms of the reform and the loan were presented to the public and to the PSU as a *fait accompli*. Despite many statements on the part of the IDB and the Government of Belize concerning their willingness to consult with and include the PSU, no specific steps were taken to bring this about. On the contrary, a "show committee" was established that was never intended to produce any genuine health policy initiatives.<sup>48</sup> This pattern of operations is not new in Belize or in other countries. In fact, the IDB has been operating in this manner since 1994 when a previous health loan was implemented in Belize.<sup>49</sup>

PSI, in cooperation with the PSU, prepared this study to examine the IDB's involvement in the proposed program to restructure health care in Belize. The study

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\* Prepared with assistance from Eduardo Melendez of the Belize Institute of Executive Professionals.

<sup>48</sup> Before the committee met, draft legislation had already been introduced. It was subsequently finalized and published by the Government Printing Office at the end of December 2000. The increase in Social Security contributions became effective January 1, 2001.

<sup>49</sup> Project Design and Implementation of Health Policy Reforms, ATN/SF-4686-BL, IDB, Washington, D.C., October 1994.

identifies the provisions of the program that do not comply with the national laws of Belize, the international labor standards recognized by the Government, the terms of existing collective bargaining agreements between public health workers and the Ministry of Health, and the disclosure mandates of the IDB itself. The study will show the extent to which the Bank has inappropriately intervened in the internal affairs of the Government, neglected to secure the appropriate level of labor agreement in proposed reforms, and introduced measures that compromise the interests of the population as more people seek better health care.

These violations of national law, institutional mandates, and international conventions continue to occur despite restraints placed on the U.S. Executive Director at the IDB by the United States Congress in 1994. Congress directed the U.S. Executive Directors at all international financial institutions to use their voice and vote to oppose loans that break laws and retreat from internationally-recognized labor rights. Although nearly seven years have elapsed, this law has yet to be enforced. PSI hopes that the present study will contribute to the growing pressure on the IDB to respect the laws of its largest donor, to respect the rule of law in its borrowing countries, and to adopt policies that support and strengthen the limited public services that exist.

## **II. THE PUBLIC HEALTH AND SOCIAL SECURITY SYSTEM OF BELIZE**

As structured, the Government of Belize is the principal provider of health services: the Ministry of Health has been providing health care as a public service through a network of facilities. The network includes the Karl Heusner Memorial Hospital, a referral hospital that serves all districts, 6 district hospitals, about 40 health centers, 30 health posts, and a mental health facility. Direct services are provided by these centers and extension services are provided through outreach programs that address maternal and child health, public health and water safety inspection, health education and nutrition, disease control, and control of sexually transmitted diseases (STDs) and HIV/AIDS. The system also includes a nursing school, a national laboratory, a national equipment maintenance center, and a series of other medical support services. The facilities are operated by nurses and other staff stationed at the health centers and health posts to provide primary care. Secondary care is provided by medical specialists and general practitioners, supported by nurses and other staff. All personnel are public employees, although non-public community nursing aides provide services in small villages in exchange for a minimal stipend.

### **A. Record of Achievement**

The Public Health System has achieved steady and meaningful advances in health care and coverage in the past two decades. The total fertility rate declined and life expectancy at birth increased from 68.4 years in 1980 to 71.8 years in 1991. Infant mortality declined sharply from 31.5 deaths per 1000 live births in 1993 to 26.0 per 1000 in 1996. Much of the improvement in infant and child survival was due to the

Expanded Program on Immunization (EPI) implemented by the Ministry of Health in 1993 and carried out by Public Health Service personnel. The EPI program achieved the elimination of measles and introduced vaccine to eliminate mumps and rubella. During this same period, the vector control program of the Ministry of Public Health carried out systematic spraying of houses and identification and treatment of mosquito infested areas, particularly in the countryside. The Public Health Bureau conducted rabies vaccination and health education campaigns to promote the vaccination of animals. The system also implemented 100 percent screening of blood donations to eliminate the transmission of HIV (the virus that causes AIDS) through blood transfusions. According to information from the Pan American Health Organization (PAHO), the Public Health System undertook training, monitoring, and mobile clinic outreach to ensure coverage (PAHO, 1998). Much of the work was done through the 75 public facilities functioning as health centers and rural health posts. The centers provide prenatal and postnatal care, immunizations, growth monitoring for children under five years of age, treatment for diarrhea and minor illness, and health education. Selected specialized clinics also offer treatment for hypertension, diabetes, tuberculosis, sexually transmitted infections, and HIV/AIDS. Each of the centers serves 2,000 to 4,000 people, and most provide a mobile clinic that visits the more remote villages at least every six weeks.

## **B. Pressures to Change**

While improvements in health have taken place throughout Belize, the Public Health System has come under increasing pressure from two converging trends: immigration and relatively decreasing budget allocations. The country became a destination for refugees from the civil wars in El Salvador and Guatemala during the 1980s and early 1990s. Thousands of impoverished and traumatized people fled the violence in those countries and sought refuge in Belize. In 1991, according to the UN High Commissioner for Refugees, the migrant population of Belize was approximately 30,000, or 14 percent of the total population. In the following five years, this number nearly doubled, largely due to the continued influx of refugees.<sup>50</sup> This new segment of the population tended to be poor and sick as the result of sudden flight and exposure to war.

At the same time, the Government of Belize experienced increasing pressure from the international financial institutions to cut the national budget deficit. As a result, the public health system suffered serial cuts in available resources and was left to struggle with the expanding needs and demands of a rapidly growing and increasingly diverse population. Between 1992 and 1995, the share of the national budget allocated to the public health system declined from 9 percent to 8 percent despite significant growth in the population.<sup>51</sup>

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<sup>50</sup> *Health in the Americas*, 1998 Edition, Vol. II. PAHO, Washington, D.C., 1997, p. 77.

<sup>51</sup> In 1995, the Ministry of Public Health unilaterally changed an agreement and reduced anticipated wage increases from 6.5 percent to 5 percent. That same year annual increments were frozen by the Ministry, which cited lack of financial resources.

### **C. The PAHO Study**

Information collected by PAHO documents increasing breakdown of the health system during the 1990s due to poor administration and poorly implemented “reforms.” The PAHO study reports that the services provided by mobile clinics suffered from deficient equipment maintenance, presumably for lack of financial resources.<sup>52</sup> The Ministry concentrated physicians and nurses in metropolitan Belize City and gave little support to the outlying infrastructure of district hospitals. In 1995, the Government eliminated the Rural Water Supply and Sanitation Unit, “to streamline the public service and improve efficiency,” but this step adversely affected the monitoring of rural water systems and maintenance.<sup>53</sup> Nor has the Government assigned appropriate priority to food safety. Laboratories were limited in number and staffing and poorly maintained, while food testing has been done outside the country, if at all.

Health care management and finances were decentralized in 1997, but without guidelines for budget distribution or administrative procedures. Public health officers reported some progress in coordination between community-based programs and hospital referrals, but problems occurred as a result of lack of management training at the community level. During this period successive Ministers of Health gave verbal support to primary health care. The Ministry recently created district health teams to “promote intersectoral and community participation in health development.” However, these teams are composed mainly of public health service personnel who have been given neither the legal authority nor the budget necessary to operate. Existing health care legislation is more than 30 years old and no effective regulatory mechanisms, norms, or standards exist to enforce it.<sup>54</sup>

### **D. Implications for Belize**

With little administrative, financial, management, or political support, the staff of the Public Health System has had to operate in a climate of growing demand. An update of the Poverty Assessment Report by the Caribbean Development Bank, the Ministry of Economic Development, and the Central Statistics Office of Belize shows that 33 percent of Belizeans are poor, and 13 percent are extremely poor (unable to meet expenses for basic food items). In the Toledo District where the majority of the indigenous Maya live, the poverty rate is nearly 60 percent. Unemployment in the district has increased since 1995, and a large percentage of the labor force is unskilled. Only 39 percent of the population has access to adequate sanitation facilities, and solid waste management is a serious problem throughout Belize. Thirty-six percent of children do not complete primary school, and roughly 30 percent of the population is illiterate. Women are especially disadvantaged. Over half of pregnant women treated at the public health clinics suffer from iron deficiency anemia, and incidents of domestic battering are widespread. For women in the age

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<sup>52</sup> *Health in the Americas*, p.84.

<sup>53</sup> *Ibid.* p. 85.

<sup>54</sup> *Ibid.* p. 84.

group between 20 to 49, complications of pregnancy were the leading cause of hospital admission (29 percent) between 1993 and 1996. Complications of pregnancy accounted for 42 percent of female hospital admissions at all ages. Of these, 37 percent were cases related to abortion, indicating a lack of access to family planning and birth control.<sup>55</sup> Overall, the picture is one of an impoverished and rapidly growing population, served by the poorly equipped and overworked staff of the Ministry of Public Health. Neither the population nor the public health workers have been well supported by the Ministry and the Government, which have provided insufficient resources to maintain the health care system and have continued to operate in a context of misguided decentralization efforts.

### **III. THE HEALTH SECTOR REFORM PROGRAM - IDB LOAN 1271/OC-BL**

The health situation in Belize is about to worsen. In October 2000, the Board of Directors of the IDB approved the Health Sector Reform Program for Belize, which will fund the privatization of health care services and the restructuring of the Social Security System. The loan had been the subject of discussions and studies carried out by the Government of Belize and the Inter-American Development Bank since 1994. At no time during that period, however, was PSU, the union representing public health workers, adequately informed or meaningfully consulted about the content of the reforms, despite both the Bank's and the Government's legal obligation to do so. On the contrary, events suggest that the Government actually staged consultations with the union while the real discussions were carried on elsewhere by IDB economists. The IDB economists had no legal authority to set public health policy for the people of Belize and no day-to-day experience with the delivery of health care services.

In the absence of meaningful discussion about health care reform with the Government and negotiation of certain elements of that reform, both the PSU and the NTUCB object to the current process on behalf of the population. First, the changes in health care will require the creation of a completely new network of private providers that will replace much of the existing system rather than strengthening and amplifying the infrastructure and personnel already in place. Second, although public health workers have a range of rights under the national labor laws of Belize and the conventions of the International Labor Organization (ILO) signed by the Government, these rights have been systematically violated during the formulation of the loan and will be further violated during implementation. Third, the studies carried out and the analyses applied to the health situation in Belize are primarily market-based, focused on financing, administration, costs, and user fees. The IDB loan document devotes only five paragraphs to a description of the country's health needs. Fourth, the loan includes a component that finances an advertising campaign to promote the terms of the loan after it has been approved, rather than using these funds to conduct meaningful consultations about the needs of the population with groups directly involved in the provision of health care.

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<sup>55</sup> Basic Country Health Profiles, Summaries 1999, [www.paho.org/project.asp](http://www.paho.org/project.asp)



Finally, the changes to Social Security inflict real hardship on workers paying into the system. The increases in Social Security taxes were unilaterally imposed in January 2001, before the results of the pilot study were available. In good faith, the unions withheld comment on the planned increases pending the results of the study, but then found that payroll deductions had been summarily implemented.

#### **IV. VIOLATION OF NATIONAL LAWS AND IDB POLICY**

The biggest problem with loan 1271/OC-BL is its objective. The loan was conceived as part of an economic package to address the question of reducing the public external debt and restructuring the health sector in Belize. The loan document emphasizes that the additional capital spending necessary to promote economic growth and reduce the debt will be financed at least in part by the sale of the public enterprises still remaining in state hands. While the public hospitals are not, strictly speaking, public enterprises, the IDB and the World Bank increasingly view health services as tradable commercial activities with cost-recovery potential.<sup>56</sup> In order to support the argument that public health care must be completely reorganized and privatized, therefore, the analysis done by the IDB begins with a chronicle of the system's shortcomings and deficiencies. The IDB describes "inefficiency and poor quality in public and private health service provision," "organizational and strategic weakness," and "inefficiency and inequity in health spending patterns."<sup>57</sup> The loan document does not mention the significant improvements in life expectancy and mortality rates cited earlier, nor does it identify those aspects of the public health system that made them possible. Also omitted is any mention of the budget cutting, much of it imposed by the international development banks over the past twenty years, that has weakened the public health service. Judging from similar health sector reform programs in neighboring countries, where the IFIs also employed its "defund and defame" strategy, neither the analysis nor the conclusions drawn from it are surprising.<sup>58</sup>

##### **A. Privatization without Consultation**

Although the IDB grants or loans funds for diagnostic studies in preparation for each large-scale loan program, the conclusions of the different studies of public enterprises and services are almost always the same: privatize. No serious study is devoted by the Bank to the existing health care system in a borrowing country because that system is inevitably to be dismantled and replaced. For example, the IDB proposes the same formula for health care reforms in El Salvador, with nearly 6 million people and an annual per capita income of under USD 1,500, as it does in

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<sup>56</sup> Hector Sánchez and Gustavo Zulata, *La Hora de los usuarios. Reflexiones sobre la economía política de las reformas de salud*. IDB, Washington, D.C., 2000.

<sup>57</sup> Belize: Health Sector Reform Program, Operation No. 1271/OC-BL, IDB, Washington, D.C., October 18, 2000, pp. 4 - 5.

<sup>58</sup> See *The IDB, the World Bank, Labor Rights and Privatization in Central America*, PSI, Washington, 2001.

Belize, with a population of less than 300,000 people and a per capita income of USD 2,555. In Belize, therefore, the predetermined conclusions concerning the breadth and the type of reform render consultation with the PSU a moot point. Bank consultants do not need information about the current system or the ideas of day-to-day line workers about potential changes because the model for health sector reform has already been established in Washington. The PSU objects to this process as a violation of the right of public workers to be consulted and informed about changes in their terms of employment. Moreover, the NTUCB objects to the terms of the loan on behalf of the people of Belize, who have long supported publicly provided basic health care.

The Constitution of Belize grants citizens the right to receive information without interference.<sup>59</sup> When the Executive Branch of the Government signed the loan agreement, however, the Public Service Union, which represents public service workers in the Ministry of Health, was not consulted. Interviews conducted for this study indicated that workers in the Ministry of Health were completely unaware of the effects the reform would have on their employment and the livelihood of their families.<sup>60</sup>

## **B. IDB Strategy for Health Sector Reform**

Like similar programs implemented in other countries, the IDB reforms are designed to stimulate private involvement in the provision of health care and to transform hospitals from public facilities to autonomous regional authorities operated by independent boards authorized to impose user fees. The projected reforms will reduce the number of health care clinics, health care posts, and district hospitals; reduce primary care to minimal, standardized fee-based packages; and severely restrict access to secondary care. The system will be partially financed by a National Health Insurance Fund (NHIF).

Although no precedent for this approach to health care exists in Belize, and no candidate for public office ever proposed it, the plan was implemented through a pilot program prior to any legislative action authorizing it. According to the loan document:

*An initial step to establishing the NHIF will be to set up a pilot project to build the technical and financial skills to fully implement the National Health Insurance Fund. By the time the pilot has been completed, legislation creating the NHIF will have been enacted, the NHIF organizational structure established, skills developed and systems implemented.*<sup>61</sup>

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<sup>59</sup> Constitution of Belize, Chapter 2, Section 12, Subsection 1.

<sup>60</sup> As of January 31, 2001, workers in the Ministry of Health had no information about their employment status in the context of the health sector reform.

<sup>61</sup> Belize: Health Sector Reform Program, p. 7. This is standard operating practice for the IDB in implementing health care “innovations.” A pilot project is established *before* any consultations take place, or in fact, before enabling legislation is debated. Ensuing discussions then are confined to minor adjustments in the pilot project before it is scaled up, and the larger questions,

The loan document goes on to describe the prescriptions for improved health care in Belize within the context of the standard macroeconomic and social sector prescriptions of the IDB.

The Bank's Country Paper identifies support to the country in preparing the economy for globalization. In productive sectors, initiatives will focus on improving the legislative, regulatory, and incentive structures necessary to promote private sector investment.<sup>62</sup>

The Bank's strategy for health sector reforms includes large-scale layoffs of personnel, user fees, reduction of the number of rural and in-patient facilities, packaged care, and the use of newly-established non-governmental organizations (many of them politically connected) to provide the services. The IDB describes these policies as: institution strengthening, cost recovery, infrastructure rationalization and improvement, emphasis on reproductive health services and community participation.

At the same time, however, that Bank documents discuss the proposed reforms, government officials and IDB representatives avoid consultation or discussion with the affected workers, despite the legal risks of ignoring consultation mandates and violating the terms of civil service employment, as well as acquired labor rights.

### **C. Violation of the Belize Labour Code of Conduct**

In Belize, consultation mandates are quite explicit. The Belize Labour Code of Conduct, specifies that trade unions and employers are responsible for making available to workers information pertaining to policies affecting them. The code has been interpreted to instruct both the Government of Belize and the umbrella NTUCB to consider the trends in industrial relations in order to help workers anticipate and keep abreast of change.<sup>63</sup>

The Code additionally stipulates that the Government is to provide reasonable facilities to the NTUCB and the PSU so that the unions may adequately represent their members.<sup>64</sup> As an employer, the Government is obliged to consult with organizations representing workers, such as the PSU, and three separate sections of the Code specifically detail what is intended by the term "consultation." Consultation is the "joint examination and discussion of problems and matters affecting employers and workers. It involves *seeking mutually acceptable solutions* (emphasis added) through a genuine exchange of views and information. Employers

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such as the extent of private sector involvement, the appropriateness of charging user fees of the poor, or the effectiveness of treatment, are never debated.

<sup>62</sup> Ibid., p. 7

<sup>63</sup> Sections 15 and 16 of the Belize Labour Code of Conduct

<sup>64</sup> Ibid. Section 22.

should take the initiative with the cooperation of workers and their representatives to establish appropriate arrangements for effective consultation.<sup>65</sup>

None of this ever took place regarding the issue of health sector reform despite the provisions in the Labour Laws of Belize explicitly governing disclosure of information. The law asserts that information disclosure is fundamental to an effective working relationship and requires social partners to adhere to the collective bargaining principles of fair play, close communication, and mutual respect.<sup>66</sup>

#### **D. Violation of IDB Disclosure Policies**

The procedures used to formulate the loan do not comply with the IDB's own disclosure policies.

*Information concerning the Bank's operational activities will be made available to the public in the absence of a compelling reason for confidentiality.*

*This policy is based on the premise that: a) the effectiveness of projects supported by the Bank will be strengthened by public access to information and consultation with affected populations; and b) broad availability to the public of information about the Bank's projects will increase understanding and support of the Bank's mission and increase transparency and accountability.*

The Bank claims that its disclosure policy is oriented by the following principles:

- Access to all public Bank information should be available in any of the Bank's member countries.
- Information provided to the public for the purpose of *permitting and encouraging dialogue should be made available in a form and at a time which permits substantive assessment of the project and affords adequate time for comment.* (emphasis added).<sup>67</sup>

The actions of the Government of Belize and the IDB in this regard strongly suggest that both the Social Security Board and the Task Manager for the Health Sector loan were well aware of these laws and mandates regarding disclosure, communication, and consultation, and made deliberate efforts to evade them. The loan document itself explains the Bank's misgivings about the possible reception of its proposed health care reforms.

*Political and social pressures may prevent the rationalization of services. To the general public and some of their political leaders, the more hospitals and health centers the better. There is limited understanding of the need to concentrate skilled staff and services to improve quality...Organizational reforms may*

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<sup>65</sup> Ibid., Section 42.

<sup>66</sup> The Laws of Belize, Chapter 234 , Section 6, Subsection 4.

<sup>67</sup> OP-102 Disclosure of Information, Inter-American Development Bank, Washington, D.C.

*encounter opposition from interest groups, including civil servants and medical practitioners. Not all public service workers (and their union) may agree that services should become more autonomous or that management within the public service should be transferred and tightened.*<sup>68</sup>

The IDB's technical experts thus attributed an intransigent position to the union and then acted accordingly. Curiously, interviews with the leadership of the NTUCB, the PSU, and numerous grassroots organizations showed that neither the unions nor the public was disposed to assume that "the more hospitals the better." But neither were popular organizations prepared to assume that the fewer and more autonomous the facilities the better, as the Bank's technical people seemed to do. All interviews with union officials and documents printed by PSU show a concern for health care deficits and a willingness to explore a range of possible solutions.<sup>69</sup>

### **E. The NTUCB Position**

At a workshop convened by the NTUCB, 36 participants representing the eight affiliated trade unions of the Congress made clear their specific objections to the *terms* of the reform.

- Implementation of the NHI at this time, or within the immediate future is premature due to a lack of proper consultation and information, especially with stakeholders.
- Proposed contribution fees to be paid are too high and beyond the ability of working people to pay, especially coming on the heels of the large increases for Social Security (600 percent), implemented on January 1, 2001.
- NHI in its present draft form, limits a person's freedom to choose his/her service providers.
- NHI as proposed, even under the present registration process for its south-side pilot project, *is creating another bureaucracy* (emphasis original).
- Stakeholders, especially the workers' and employers' representatives, are absent from the decision-making and selection process (including selection of service providers).

The NTUCB also made clear its willingness to debate and negotiate a more equitable reform process.

*Consequently, the NTUCB calls on the Government of Belize to desist from the implementation of this NHI Scheme, without proper consultation and prior approval by the social partners. The NCUTB stands ready to dialogue and participate in the decision-making process.*<sup>70</sup>

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<sup>68</sup> Belize: Health Sector Reform Program, p. 28.

<sup>69</sup> *Assessment of the Impact of the Health Sector Reform on Employment and Working Conditions of Public Sector Workers, mimeo, Public Services Union, Belmopan, 2001.*

<sup>70</sup> Press release of the National Trade Union Congress of Belize, February 21, 2001.

The observations of the Bank's technical experts, however, show clearly a conviction that they know best how to improve public health services in Belize and that the medical practitioners and staff employed by the system are both unaware of service deficiencies and ignorant of the steps necessary to address them. The document suggests that opposition from the NTUCB and the PSU stems from ignorance and self-interest rather than from a legitimate political stance that should receive serious formal consideration. Given this perspective on the part of the Bank, the steps that were subsequently taken could have been anticipated.

## **F. Effects of the IDB Proposed Reforms**

In the absence of meaningful consultation, the IDB had good reason to believe that its proposed reforms would be widely rejected and politically unpopular. First, based on undisclosed diagnostic studies, the six established health districts would be reduced to four, and three district hospitals would be converted to primary care facilities only.<sup>71</sup> Total hospital beds would be reduced from 384 to 271 and hospital productivity (discharges) would increase 40 percent. Secondly, IDB consultants would instruct hospital and central authorities on the structure and enforcement of performance agreements to govern the functioning of the reorganized facilities, and within four years 80 percent of facilities would be transferred from public control to contracts between the health facility and its autonomous regional manager. Third, productivity and output targets would be a negotiated part of the agreements, so that effectively, national-level collective bargaining agreements with organized workers in the sector would disappear, in violation of public service protections.

## **G. Role of the IDB Multilateral Investment Fund**

Complementary funding from the IDB's Multilateral Investment Fund (MIF) in the amount of USD 1.2 million would become available to promote the development of small businesses and micro-enterprises in the health sector. These businesses, promoted and supported by the IDB, would serve as outsourcing facilities for the public health system, gradually replacing the career Civil Service with contract personnel. These enterprises have to be established from the ground up, as no infrastructure, expertise, regulatory framework or precedent for them exists in Belize. Public workers have reason to believe that the businesses are designed to replace them with low-wage, standardized services, while the public worries that inexperienced, profit-seeking enterprises will become the only source of subsidized health care. Both workers and patients have cause for concern. The description of the MIF project reads:

*The MIF program creates a policy, regulatory and purchasing environment that facilitates expansion of the domestic private sector in publicly and privately funded health services. The components are: (a) developing a regulatory framework within the Ministry of Public Health for the private sector; (b) improving private sector standards and market organization*

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<sup>71</sup> Assessment of the Impact of the Health Sector Reform, p. 13.

*through group practices, franchises, and other forms of competitive organization including corporate and organizational development of private providers as contractors; and (c) developing and institutionalizing private sector purchasing and contracting.*<sup>72</sup>

This funding source will provide technical support for at least five private provider contracts with the public sector. The agreement finances technical assistance to develop and implement purchasing and contracting functions within the Ministry of Public Health, to enable the Government to procure more services from the private sector. A temporary fund will outsource “innovative” contracts with the private sector in “high priority” service areas. In plain language, the project brief describes how low-wage unregulated enterprises will operate for profit what have heretofore been tightly supervised services such as the disposal of toxic waste and procurement of pharmaceuticals.

For the population at large, then, as well as for public health workers, important aspects of the reform are not appealing. Nor are the terms of the NHIF proposed to finance the reforms likely to enjoy broad support. A letter from the General Secretary of PSI to Enrique Iglesias, the President of the IDB, pointed out that the reforms mandate a jump of up to 600 percent in employees’ contributions to the new system, although workers in Belize have received no corresponding salary increases that might mitigate the impact of such summary increases in health care costs.<sup>73</sup>

## **V. VIOLATIONS OF INTERNATIONAL LABOUR ORGANIZATION CONVENTIONS**

The Government of Belize has ratified the eight core internationally recognized labor standards that guarantee the fundamental rights and freedoms of the Belizean worker. These include: ILO Convention 29 on Forced Labor, ILO Convention 87 on Freedom of Association and Protection of the Right to Organize, ILO Convention 100 on Equal Remuneration, ILO Convention 98 on the Right to Organize and Collective Bargaining, ILO Convention 105 on the Abolition of Forced Labor, ILO Convention 111 on Discrimination in Employment and Occupation, ILO Convention 138 on the Minimum Age for Entering Employment, and ILO Convention 182 on the Complete Elimination of the Worst Forms of Child Labor. The Government has also ratified an additional 42 ILO Conventions and has

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<sup>72</sup> Support for Health Sector Reform TC9811945, MIF/AT-310, ATN/MT-6805-BL, IDB, Washington, D.C., December 1999.

<sup>73</sup> Correspondence dated December 20, 2000 from the PSI to Enrique Iglesias, President of the IDB.

pledged to promote social dialogue and social partnership, including communication and consultation. Despite these international commitments, however, the PSU is not part of the governance structure of the health sector reform.

#### **A. ILO Convention 144: Tripartite Consultation**

One of the most important conventions ratified by Belize in the context of the labor rights of the PSU is ILO Convention 144. This convention specifies that workers and employers should exchange views and conduct discussions within tripartite bodies before government makes its final decision regarding policies affecting labor. Most importantly, workers and employers who participate in the consultative procedures must be freely chosen by their respective organizations and enjoy freedom of association. Nevertheless, no respondent interviewed for this study indicated that he or she was supplied with adequate information about the health sector reform before the various bills to implement the program were drafted. It should be emphasized that the mere communication of information and reports transmitted to employers and workers after the fact does not in itself meet the obligation to ensure effective consultation since, by that stage, the government's position is already final.

During extensive interviews, it became clear, for example, that public officers in Orange Walk and Belize City were completely unaware of the effects of the health sector reform and its implications for them. In their view, the PSU was responsible for the protection of their rights; they believed that the union had been consulted regarding changes in their terms of employment.

Under the labor code of Belize and according to Convention 144, this should have taken place but did not. No information has been forthcoming from the Government or its respective representatives to date. Nor is information available about the conditionalities of the loan agreement between the IDB and the Government of Belize.

#### **B. ILO Convention 151: The Right to Organize in the Public Sector**

Section 7 of this convention directs that measures appropriate to national conditions shall be taken, where necessary, to encourage and promote the full development and use of mechanisms for the negotiation of terms and conditions of employment between public authorities concerned and public employees' organizations. A reasonable interpretation of this convention would require the Government to supply the PSU with information about the conditions of the loan agreement and the health sector reform process in order to enable the union to represent the interests of its members. Health workers who will be affected by the reform need proper and sufficient information about their status if they are to consider and contribute to the negotiating process effectively. This convention specifically pertains to the



protection of public sector employees because these employees are not adequately covered by ILO Conventions 87 and 98. Protection of the right to organize, protection from acts of anti-union discrimination in employment, protection from interference by public authorities in the establishment, functioning and administration of unions, and the civil and political rights of public employees are all covered by this convention and violated by the Bank and the Government in the reform process.

### C. ILO Convention 154: The Promotion of Collective Bargaining

With respect to existing international standards,<sup>74</sup> appropriate measures should be taken by the Government to promote free and voluntary collective bargaining. This convention applies to all branches of economic activity, although with respect to the public service, national laws or regulations or national practice may fix special modalities of application of this Convention. Article 2 of the convention specifies that the term “collective bargaining” extends to all negotiations that take place between an employer, a group of employers or one or more employers’ organizations, on the one hand, and one or more workers’ organizations, on the other, for the purpose of a) determining working conditions and terms of employment and/or b) regulating relations between employers and workers. Article 7 states that: Measures taken by public authorities to encourage and promote the development of collective bargaining shall be the subject of prior consultation and, whenever possible, agreement between public authorities and employers and workers. The Article emphasizes that collective bargaining is one of the main pillars of the relations between employers and workers. Special emphasis is placed on prior consultation before implementation of any agreement or policy. The terms of this convention have been violated by the health sector reform process, although the Article explicitly identifies the benefits to all parties of respecting the right of prior consultation.<sup>75</sup>

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<sup>74</sup> These standards are set forth in: the Freedom of Association and Protection of the Right to Organize (ILO Con. 87), the Right to Organize and Collective Bargaining (ILO Con, 98), The Collective Bargaining Agreements Recommendations, the Voluntary Conciliation and Arbitration Recommendation, the Labor Relation for the Public Service (ILO Con.151) and the Labor Administration Convention and Recommendation (ILO Con. 150 and recommendation 158).

<sup>75</sup> ILO Convention 154: The Promotion of Collective Bargaining, Article 7.

#### ***D. Lack of Consideration for the Fundamental Rights and Freedoms of Health Sector Workers***

In negotiating the loan agreement with the IDB, the Government did not provide health sector workers with the information necessary for them to make informed judgments about the reform process. Moreover, the terms and conditions of international agreements tend to be available only to Government officials. Although the livelihoods of their members will be immediately affected, PSU representatives were not included in the consultative processes before the agreement was finalized. As a result, they knew little about the specific conditionalities attached to the loan and had difficulty representing their members' interests.

Similarly, workers were excluded from the negotiation of transitional periods, as well as from the Governance Structures established to ensure compliance with the loan agreement. As a consequence, health sector workers are concerned about the protection of their acquired rights, compliance with international labor standards ratified by Belize, and the effects of a unilateral restructuring of the public health service regarding the terms of their employment.

#### **VI. “SHOW COMMITTEES,” OBFUSCATION, AND PROPAGANDA**

Recognizing the probability of popular rejection of its proposed reforms, the IDB developed a multidimensional strategy to promote its policies. Aspects of this approach have been documented in other Central American countries, but the campaign in Belize represents a full-court press. The strategy includes:

- Consultation committees without adequate information and with no real authority for decision-making.
- Pilot projects that implement proposed changes before appropriate legislation is passed and before public debate takes place.
- A sophisticated, intensive propaganda campaign, described by the Bank as an information or an education initiative, financed with borrowed money, which the population targeted by the campaign must then repay.

##### **A. “Show Committees”**

In July 2000, the Social Security Board established a Working Group to advise the Ministry of Health on the sector reform proposed by the Bank. The Group included six representatives of employers and the Government and four union representatives from the NTUCB and from PSU. The minutes of a meeting on July 25 of the Group show that the General Manager of the Social Security System was anxious to secure approval for the proposed increases in employees' payroll deductions and the date to impose them before the Working Group had the relevant information about financing the system. She admitted that Social Security financing could not be divorced from the NHIF, that service provision methods and legislation

were already in preparation but that funding was still being discussed by the Government and the IDB. Her comments throughout the meeting suggested that the Social Security Board was still uncertain about financing requirements for the new insurance system. Nevertheless, the General Manager pressed the Working Group to approve the increase in workers' and employers' contributions to Social Security, and falsely recorded that the PSU approved increased payroll deductions, although its representative was not present.<sup>76</sup> The minutes of the meeting were then released to the press. The PSU leadership protested the erroneous recording of its approval, citing specific objections to the reforms. In a letter to the General Manager of the Social Security Board, the union President wrote: "I find it completely unacceptable for anyone to speak on my behalf at meetings for which I had given no prior authority; further, it is inappropriate to attribute comments to any member of the committee who is absent." The letter then reiterated PSU's objections to the reforms.

- Public officers cannot agree to the dramatic increase in Social Security contributions the new fund would require from low income contributors.
- The PSU is not convinced that the increase is justified.
- Serious questions have been raised about the propriety of the use of Social Security Funds in the past, and the PSU prefers that these issues be investigated before agreeing to increase contributions to the Fund.
- Should increased contributions be necessary, the PSU objects to the immediate imposition of the entire increase rather than a more manageable phased-in approach.<sup>77</sup>

## **B. Obfuscation**

The Social Security Board did not release these objections to the press, and no steps were taken to correct the impression that the PSU accepted the increase. Through PSI these objections were transmitted to Enrique Iglesias, the President of the IDB, but the Bank never responded.

During the final months of 2000, the Social Security Board became quite adept at marketing the reform to the public. In a series of confusing and misleading statements, one press release read:

Social Security is modernizing. Improvements to the Benefits are necessary to bring them up to date. The expansion of the contributions schedule is also essential for higher income earners to be adequately covered in the event of sickness, employment injury or other contingencies. Increases in pensions to a realistic level are vital in the modernization

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<sup>76</sup> Belize Social Security Board, Reform 2000, Minutes of the Working Group Meeting, Belmopan, July 25, 2000.

<sup>77</sup> Correspondence between the PSU and the Social Security Board, 27 November, 2000.

process. Generally, the Social Security will continue to modernize all other aspects of its operations to ensure Excellence in Customer Service.<sup>78</sup>

Subsequent paragraphs describe new benefits in glowing terms but never mention the abrupt, steep increases planned for payroll deductions. Similarly, another press release reads: “Caring for You, our Customer, Means Positively Modernizing Social Security,” with additionally unclear statements about increased deductions. Finally, in a media release labeled “Protection Against Economic Insecurity,” the Social Security Board claimed:

*The Government of Belize today announced that the proposed package of improvements to the Social Security Scheme will be effected starting January 1, 2001. The improvements to be implemented were presented to and discussed with the general public and the media, in meetings held countrywide in June. Further consultations were carried out with the Belize Chamber of Commerce, the Belize Business Bureau, and the National Trade Union Congress, representatives of employers and insured persons in Belize... The improvements in January will greatly modernize Belize's Social Security Scheme by providing an up-date and more realistic social safety net for all Belizeans. Social Security Cares About You!*<sup>79</sup>

The December 18 press release repeats almost *verbatim* the only phrase to refer directly to increased deductions in any of the announcements: “An expanded Contributions Schedule will also be effected in order for higher-income earners to be adequately covered in the event of sickness and other contingencies.” In all statements, the phrasing about payroll deductions is deceptively and elaborately worded, and although the press releases emphasize the so-called consultative role of the Working Group, they make no mention of the fact that the unions opposed the sudden unilateral increases in payroll deductions during these discussions and repeatedly requested more information and more time to study the proposal.

Nevertheless, increased quotas are a striking feature of the plan for working class taxpayers (see tables 1 and 2). The figures in the table demonstrate that national health insurance is now to be financed by exponentially increased Social Security taxes on lower middle income workers.

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<sup>78</sup> Social Security Board press release, n.d. Like the IDB, the Social Security Board always refers to these mandatory payroll deductions as ‘contributions.’

<sup>79</sup> Media Release, Social Security Board, December 18, 2000.

**TABLE 1**  
**SOCIAL SECURITY – SCHEDULE OF CONTRIBUTIONS**  
**FOR 2000**

Weekly Earnings	Insurable Earnings	Employees Contributions	Employers Contributions	Total Contributions
Under \$40	25	0.12	1.63	1.75
\$40 - \$69	55	0.55	3.30	3.85
\$70 - \$109	90	0.90	5.40	6.30
\$110 and over	130	1.30	7.80	9.10

**TABLE 2**  
**SOCIAL SECURITY – PROPOSED SCHEDULE OF**  
**CONTRIBUTIONS FOR 2001**

Weekly Earnings	Insurable Earnings	Employees Contributions	Employers Contributions	Total Contributions
Under \$70	55	0.65	3.30	3.95
\$70 - \$109	90	0.90	5.40	6.30
\$110 - \$139	130	1.30	7.80	9.10
\$140 - \$179	160	2.35	8.85	11.20
\$180 - \$219	200	3.75	10.25	14.00
\$220 - \$259	240	5.15	11.65	16.80
\$260 - \$299	280	6.55	13.05	19.60
\$300 and over	320	7.95	14.45	22.40

Source: Social Security Board, Belmopan, 2000.

### C. Propaganda

While the PSU has not been able to obtain detailed information about the source of the financing for the public information campaign promoting proposed health sector reforms, the budget allocations for 1271/OC-BL give some indications. A loan component identifies “Public Information Strategy” as a specific objective and specifies a budget of USD 105,000. The loan document frankly describes what would—in any objective context—be recognized as a propaganda campaign.

The Program will support the designing, implementation, and evaluation of a communication strategy aimed to ensure the success of all three components of the Program and specially inform the population on the progress and success of the pilots contemplated in component 3 (Support to the National Health Insurance Fund). *A key task will be to find the most influential supporting groups and to forge solid and well-informed coalitions. The communications strategy will be based on relevant information gathered by the program about the attitude and expectations of different social groups* (emphasis added). Hence the program will finance: (i) technical assistance for gathering relevant baseline information, finding the supporting parties and developing the strategy for the formation of coalitions; (ii) workshops for strengthening of coalitions; and (iii) design, implementation and evaluation of communications strategy.<sup>80</sup>

The IDB has manipulated and misconstrued its mandate to *consult*, transforming it into a directive to *selectively inform*, and therefore use the funds borrowed by the country to promote borrowing for such purposes as the Bank itself determines. Thus, national and international political pressure to make the Bank’s procedures more transparent and the Bank’s policymakers more accountable has been deflected. Unpopular boilerplate policies continue to be unilaterally imposed from abroad, but now they are accompanied by a costly public relations campaign, despite the fact that the meaning of “consultation” is explicitly spelled out in the laws of Belize regarding the responsibilities of the Government, as an employer, to the union, as the representative of public employees.

## VII. RECOMMENDATIONS FOR EQUITABLE REFORM

*In contrast to the views imputed to the unions by the IDB, the NTUCB and the PSU identify and support the need for the reform of the Public Health Service as a whole. The unions represent a position, however, which advocates consultation between the IDB, the Government, the NTUCB and the PSU. The National Trade Union Congress of Belize represents more than 80,000 workers, and neither the Bank nor the Government can expect that working people will finance a health care system*

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<sup>80</sup> 1271/OC-BL, p. 12.

*according to specifications that they have never been either informed or consulted about.*

*The Government and the Bank cannot justify their unilateral actions by arguing that the unions are uninvolved or uninterested. On the contrary, the PSU, specifically, has articulated a series of principles about health care reform and for a number of years has emphasized an integrated sectoral approach that might include related aspects of: education, financial management, land, health, and records management. Moreover, several reviews of particular areas of the Public Service have been conducted and the following conclusions were reached:*

- The system is outdated and inefficient.
- Organizational and strategic weaknesses exist.
- The system is too cumbersome, bureaucratic and highly centralized.
- Reform must consider present and future demand on services and decentralize where necessary.

**With respect to health care reform in particular, the PSU has raised specific questions.**

- Has the government conducted an objective survey of financing alternatives for health care? For example, have financing sources other than additional taxes on low-income wage earners been explored, such as property or capital gains taxes?
- Is it necessary or fair for low-income working people alone to pay a significant increase in contributions to the National Health Insurance Fund and to pay user fees for services? Is this double taxing or overtaxing the low-income employed?
- Are alternative sources of financing available to pay for health care services for the indigent and the unemployed?
- Under the proposed plan, won't private medical services be prohibitively expensive for the low-income employed and the unemployed?
- What will NHI cover and what will it cost? Why have representative organizations had no say in the decision-making process?
- Financial estimates of the cost of the system made by the PSU indicate that if the Government falls short on its 30 percent

commitment to the Fund, the NHI will be bankrupt in less than five years. Are contingency plans in place?

In addition, PSU has a number of stated positions on health care reform.

- NHI must provide a comprehensive package that satisfies the health care needs of the working population.
- Low-income and unemployed people must have equity in and access to general health care.
- Reform should build on existing Social Security arrangements and provide more bargaining power to the user of the service relative to the provider of services.

Public officers are also concerned about equity and fairness in salaries for health care workers. The last negotiated salary increase was in 1993, and payment was completed in 1997. Since that time the cost of living has increased significantly. Male public officers now pay 2 ¼ percent of their salary to a pension fund for widows and children. All public officers pay Social Security, and a large majority pays income tax, plus domestic expenditures such as utilities, mortgages, education costs, and medical bills. In recent years, all benefits to public officers have been withdrawn due to economic instability, and in 1995-96 over 1,000 persons were retrenched.

Taking into account this decrease in the purchasing power of public employees, the PSU would like to see health care reform that:

- Is affordable.
- Provides comprehensive coverage.
- Includes curative secondary care based on a clear referral policy and not just primary care services.
- Upgrades the medical system.
- Articulates appropriate standards and guidelines for service providers.



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# **EVALUATION OF THE IMPACT OF HEALTH SECTOR REFORMS IMPLEMENTED BY THE WORLD BANK AND THE IDB IN NICARAGUA\***

## **I. INTRODUCTION**

Since 1987, successive Nicaraguan Governments have been subjected to intense internal and external pressure to transform the national health care system and the retirement and pension system, as part of a larger process of increasing deregulation and privatization. At the outset, the state was solely responsible for both the pension system and the financing, administration and delivery of health services, but during the 1990s the private sector assumed a growing role in the direct provision of health services, equipment and supplies. This paper argues that this transition has been accomplished under the tutelage and pressure of the IFIs based in Washington, and that the ideological zeal of these institutions has allowed corruption and caused disorganization in the health sector. Public health care workers, together with the population that depends on the public system for medical attention have, suffered the consequences. We argue, too, that the impending transition to a private pension system can be expected to produce similarly negative consequences for the same population.

In support of its affiliates in Nicaragua, the Health Workers' Central (*Central de Trabajadores de la Salud, FETSALUD*) and the General Confederation and National Union of Employees (*Confederación General Unión Nacional de Empleados, UNE*), PSI began to research the institutions and the financing behind this public/private transition. The research is part of an ongoing effort to monitor the policies and the loans of the IFIs, which, together with the Government of Nicaragua, systematically formulate and implement projects that violate labor rights and national law while deepening poverty in the country.

The introduction of market incentives into the provision of health services has been heavily underwritten and promoted by the World Bank and the IDB. Both enumerate their objectives in Nicaragua as (1) the promotion of economic growth and poverty alleviation, (2) the restructuring of the public sector, and (3) the promotion of private sector investment. In this context, the privatization of health care implies the imposition of larger and more frequent user fees, the dramatic downsizing of the public health service, and the subsidizing of profit-seeking private enterprises in the sector.

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\* Prepared in cooperation with the *Central de Trabajadores de la Salud* and the *Confederación General Unión Nacional de Empleados*, Managua, September 2000.

From the point of view of workers and patients, this approach has not worked well in other Latin American countries where it has been tried. It faces even greater complications in the Nicaraguan setting.<sup>81</sup> Here, the rapid privatization promoted by the IFIs is explicitly prohibited by the national Constitution. Nonetheless, rather than strengthen already established mechanisms and build on public sector experience to amplify the coverage provided by the existing system, the IFIs have chosen to build a parallel system with no history, no capacity and no legal foundation in the country. In Nicaragua, neither the current political leaders nor the institutions they manage enjoy long-term legitimacy, the private sector lacks financial experience and resources, and regulatory structures for private health care enterprises do not exist.<sup>82</sup>

Even so, the World Bank with loan No. 12393 and the IDB, with loan No. 1027/SF-NI, allocated USD 63.6 million to privatize health care in Nicaragua, working through both the Ministry of Public Health (MINSa) and the National Institute of Social Security (INSS). The process began and continues in an opportunistic, unmonitored economic climate in violation of existing law. As a consequence, the implementation of both loans violates the labor rights of Nicaraguan public health workers, and the mandates of the IFIs themselves, and allows the abuse of the general public in basic matters of sickness and health.

## II. THE SOCIOECONOMIC CRISIS AND THE HEALTH CARE SYSTEM

As of September 2000, Nicaragua was suffering a period of multidimensional crisis. More than 50% of the economically active population lacked permanent work, 41 percent were chronically underemployed, and 14.3 percent were openly unemployed. A 2000 survey conducted by the Socioeconomic Research and Advisory Center (*Centro de Investigación y Asesoría Socioeconómica, CINASE*) in Managua showed that 82.8 percent of Nicaraguans live in poverty, 37.4 percent of them in extreme poverty.<sup>83</sup> The latest available figures show that 36.3 percent of adults are illiterate, and only 46 percent of children reach the fifth grade.<sup>84</sup> Respondents' perceptions of the Government's intentions and abilities to remedy the situation are dismal: 70.7 percent said that the Government had

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<sup>81</sup> See Angelina González Rosetti and Thomas Bossert, *Enhancing the Political Feasibility of Health Reform: A Comparative Analysis of Chile, Colombia and Mexico*, USAID, Washington, D.C., June 2000 (Health Sector Reform Initiative).

<sup>82</sup> The 1998 Project Identification Document for the Health Sector Modernization Project in Nicaragua (NI PID 35753) stated, "At this point there exists no legal framework to sustain the health reforms initiated up to now. The law that introduced the *Sistema Unico de Salud* effectively merges the activities of the MINSa (Ministry of Health) and INSS (National Institute of Social Security), but fails to acknowledge the existence of a private sector. Reforms introduced by the past Government are mostly based on ministerial decrees."

<sup>83</sup> For purposes of the study, those with annual incomes between USD 218 and USD 462. Those with incomes below USD 218 were classified as extremely poor. *La Situación de la Pobreza en Nicaragua. Un Análisis desde la Sociedad Civil*. CINASE, Managua, June, 2000.

<sup>84</sup> *Human Development Report 1999*. United Nations Development Program, New York, 1999.

done nothing to reduce poverty, and 15.7 percent said it only promoted the private sector for this purpose. As a result, when asked about their expectations for the following year, 46.6 percent of respondents told CINASE interviewers that they believed the situation would be about the same, or worse. Thirty percent would not even speculate. Nor is the perception of international projects and assistance favorable: 40.6 percent of respondents said they did not know that international institutions were active in the country, and 22.2 percent said the assistance received was less than expected.

The health status of the population reflects the high incidence of poverty. Despite improvements, infant mortality is the highest in Central America, and UNICEF reports widespread infant, child, and maternal malnutrition. Preventable and treatable diseases, such as malaria, dengue, diarrhea, and respiratory infection, affect large proportions of the population and complications in childbirth are often fatal. The overall epidemiological picture is one of poverty-related illness and premature death.<sup>85</sup>

### **III. PRIVATIZATION, THE WORLD BANK, AND THE IDB**

Between 1980 and 1987, the Sandinista Government maintained free medical care, including diagnostic services, laboratory work, and medication, through a public health system that covered 70 percent of the population. Because of the war in the late 1980s, however, substantial resources from the sector were spent addressing health problems related to generalized and violent conflict. In 1987, the Government began to experiment with limited forms of privatization, but only in the areas of pharmaceutical purchases and user fees for some outpatient services. As a result, neither the infrastructure nor a legal framework for privatization was in place when the World Bank and the IDB began to restructure the public health system during the 1990s. Only the national Constitution of 1987, as amended in 1995, governed the provision of health care, and it clearly asserts the responsibility of the State.

**ARTICLE 59.** – Nicaraguans have the right to health. The State will establish the basic conditions for its promotion, protection, recovery and rehabilitation. It is the State's responsibility to direct and organize health programs, services and activities and to promote popular participation in their defense.

**ARTICLE 105.-** Educational, health, and social security services are the permanent responsibilities of the State, which is obligated to provide them without exception and to improve and broaden them. The infrastructure and the installations pertinent to these services are the property of the State and cannot be alienated in any form.

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<sup>85</sup> World Bank, "Staff Appraisal Report, Republic of Nicaragua Health Sector Reform Project," 12393 NI, Washington, D.C., November 1993, p. 9. (mimeo).

Free health care for vulnerable sectors of the population is guaranteed, with priority assigned to maternal and infant programs. State services of health and education should be broadened and strengthened. The right to establish private services in the areas of health and education is guaranteed.<sup>86</sup>

All the same, the Government of Violeta Chamorro cut the health care budget by 50 percent, from USD 135 million in 1989 to USD 67 million just after she was elected in 1990. Annual per capita health expenditure ultimately fell by more than 50 percent in the 1990s relative to the '80s: from USD 35 to USD 16. Additionally, in 1990 the Government opened the pharmaceutical market and commercial drugs were once again imported, but because of budget shortfalls, quality control was not effective. At the same time, then, the quality of medications deteriorated, inventory fell dramatically and prices increased.<sup>87</sup> The budget cuts, together with the Chamorro Government's "Occupational Conversion Plan," forced more than 1,000 public health workers from the Ministry, and outpatient services diminished abruptly. Those who left the public service tended to be members of the paramedics' and doctors' unions, support and anti-epidemic personnel, and statistical technicians. In their wake, they left an overburdened and increasingly underpaid staff.

During this period, the Government imposed user fees more or less indiscriminately on all sectors of the population, including the poorest, in order to cover sudden deficits. By cutting public health expenditure in half, the Chamorro Government *de facto* privatized a large portion of health services that had previously been funded through tax revenue. The practice of allocating funds for public health on the basis of macroeconomic considerations, rather than need was established. The World Bank and the IDB have continued this practice, subordinating public health to ideology and relentlessly opening a market for medical services to newly created, inexperienced, profit seeking and publicly subsidized entrepreneurs, many with close ties to the ruling political party.

#### **IV. THE LOANS**

##### **A. World Bank, 12393 NI November 1993**

Into a socioeconomic context of broad-based poverty, prevalent transmissible disease due to inadequate sanitation, lack of education, and widespread malnutrition - and a political context of nonexistent regulation and large-scale, high-level corruption, the World Bank and the IDB introduced a series of projects designed to privatize health care, beginning in 1992. In that year, the Minister of Health (MINSA) created the Local Systems of Integrated Health Care (SILAIS) by decree. No other legislation defined the status or function of these units. The SILAIS were responsible, at the local level, for coordinating primary health care

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<sup>86</sup> National Constitution of Nicaragua, Managua, 1995.

<sup>87</sup> FETSALUD "Evaluación del Impacto de las Reformas en el Sector Salud del Banco Mundial y el BID en Nicaragua," Managua, 1999, (mimeo).

with more sophisticated curative measures, including hospital stays, but they lacked resources to fulfill their mission after the budget reduction and the loss of personnel of the previous two years. The Government proposed to address the deficits by establishing user fees, a policy promoted by USAID and by the World Bank. The SILAIS then began to charge patients about 50 percent of the cost of their services in order to make up for the budget shortfall. By 1993, when the World Bank Health Sector Reform Project was approved, the financing for the Ministry of Health had become much more complex, at the same time that it diminished. The Ministry received a public appropriation, financing from international loans, support from INSS for the contracting of public and private services, and the fees paid by the general population for medical attention.<sup>88</sup>

With the implementation of World Bank loan (12393 NI), it became clear that two principal objectives were to be achieved. First, the loan would consolidate the practice of paying for basic health services. Secondly, the entire structure of State-managed, nationally subsidized health care operations would be transformed into a “demand-driven,” self-supporting, stratified system based on imported management techniques and technologies.

The project included six objectives, with the weaknesses described below.

- *Decentralization* (“institution strengthening”) would assign block budget allocations to local governments to be managed by untrained personnel, reassign staff without consulting either staff members themselves or local supervisors, establish outsourcing mechanisms at the SILAIS with no provision for oversight, purchase standardized information technology without local infrastructure or staff capability assessments, identify training needs after the fact, and impose user fees based on abstract macroeconomic calculations.<sup>89</sup>
- *Primary Health Care (PHC)* measures would design and test a standardized package of basic services nationwide, using cost as the primary consideration. Standardized training to deliver the package would be given to newly assigned (or contracted) personnel. Borrowed funds would be spent on an advertising campaign to sell the

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<sup>88</sup> As in other Central American countries, the National Institute for Social Security (INSS) provides pension fund management and health care services to the employed, and the Ministry of Health (MINSa) is responsible for the broader public health care system.

<sup>89</sup> The terms of reference for Institution Strengthening Technical Assistance include the following method for arriving at the per capita budget calculation: i) establish a comprehensive basket of curative, preventive and rehabilitation benefits corresponding to the primary care level and compatible with the Nicaraguan health care model. . . ii) value the basket defined above to cover the costs of an average provider of the first and second care levels; evaluate the alternative per capita differentiation through corrective factors for populations in distinct bio-medical risk situations, poverty levels or eventual differences of urban-rural costs; iii) carry out simulations of the financial impact on the MOH budget to determine the effect of setting the per capita at different levels.” Report No. 12393-NI, Annex 5. These calculations establish what the Ministry would insure. The patient must pay for any treatment not included in the basket designated by the Bank as “compatible with the Nicaraguan health care model,” regardless of his or her medical condition or ability to pay.

project to the population paying for it, and evaluations would be prepared on the basis of assessments reported by the project's own consultants.

- *Pharmaceutical Supply and Distribution System* would conduct feasibility studies to determine the most expedient means of privatizing the pharmaceutical branch of the health care system, operate a showcase private pilot pharmacy, and increase private participation in the sector with no legal framework for oversight or regulation.
- *Rehabilitation and Maintenance of Hospitals* component would renovate hospitals on an emergency basis and conduct a feasibility study of the cost of maintaining them based on assumed user fees for which no legal precedent existed and which was prohibited by the prevailing interpretation of the Constitution.
- *Financing for Feasibility Studies for Privatizing the Social Security Institute*. See above.
- *Project Administration*. The consultants responsible for the financial studies would be funded as described above.

At that date (1993), the Bank was not receptive to the suggestion that populations and social groups affected by its loans ought to be involved in both the formulation and the implementation of these reforms, and neither the unions organized in the sector nor community groups were consulted about the impact of the activities planned and financed. Health care workers' unions, in fact, were referred to in the Staff Appraisal Report for the Project only as "project risks":

*The main risks are a) the feasibility of accomplishing a reform program given Nicaragua's weak institutional base; b) possible delays by the (Ministry of Health) to [sic] implement policy reforms because of likely opposition from affected interest groups (such as unions, medical associations, pharmaceutical suppliers). . .*<sup>90</sup>

We argue that this attitude of suspicion and distrust on the part of project managers at the Bank led to exclusionary implementation procedures that violated both national civil service law and collective bargaining agreements in force between the FETSALUD, the UNE, and the Government of Nicaragua.

Interestingly, when the World Bank loan document refers to the benefits to be derived from the project, the preponderance of the identified payoffs refer to cost savings for the Government, rather than health improvements for the public or increased resources and support for workers.

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<sup>90</sup> Staff Appraisal Report (SAR), Republic of Nicaragua Health Sector Reform Project, 12393 NI, November, 1993, Washington, D.C. mimeo., p. 51.



*The project would have a significant impact on the financial equilibrium of the health sector by reducing the cost of providing services and introducing mechanisms to recover a share of these costs.*<sup>91</sup>

The document also identifies the reduction of unit costs for primary health care due to standardization, reduced capital investments and operating costs, and again, increased revenue through illegal fee charging of patients at hospital centers. If the savings materialized as expected, the document suggested that PHC might extend from the current 70 percent coverage of the population to 90 percent. In other words, if costs could be reduced and patients could pay, then coverage might be extended.

To date, we cannot know whether the project did, in fact, increase coverage. Project evaluation documents are not public and repeated efforts to obtain information concerning project results from World Bank officials were unsuccessful.

## **B. World Bank NI 35743 and IDB 1027/SF-NI: Lack of Consultation**

In 1998, the IFIs undertook the implementation of two new loans for the Health Sector: the Health Sector Modernization Project at the World Bank and the Support for MINSA Hospital Modernization at the IDB. By this time, considerable pressure had built on both multilateral banks to incorporate public consultations with interested parties in the final approval of projects. Both projects, however, proceeded along the lines of the earlier World Bank initiative in the continuing attempt to privatize health care and lower costs, and in viewing the workers in the sector as “Project Risks.”

The IDB project specifically identified “Opposition from organized health workers as a risk to the successful implementation of the project,” and the World Bank Project Identification Document stated bluntly that “The system is overstaffed with 23,000 workers who often have the wrong skills mix, are underpaid and demotivated.” Neither document cites any specific evidence to substantiate these conclusions.

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<sup>91</sup> Staff Appraisal Report, Republic of Nicaragua, Health Sector Reform Project, Nov. 24, 1993, Latin American and Caribbean regional Office, Report No. 12393, Washington, mimeo.

As justification for privatizing the system, the IFIs and the Government then promoted a campaign that maligned both the qualifications of public health workers and the services provided by the system.

*The publicly-financed health care system that covers 70 percent of the population is institutionally weak, plagued by low service quality and inefficiencies. Effective policy-making, planning and management is (sic) hampered by the lack of useful process indicators linked to a viable financial and accounting information system. Planning and management is (sic) characterized by ad-hoc decisions without taking into consideration long-term effects.*<sup>92</sup>

For all the Banks' insistence on process indicators and accounting information, however, they do not reveal the data that led them to conclude that institutional structures and unmotivated staff are the cause of inefficiencies rather than lack of resources and political will. In fact, process indicators would suggest that the public health institutions are achieving significant advances with the scarce resources available in Nicaragua, and that rather than restructure them, the Banks might consider reinforcing them.

The indices of human development with respect to health dramatically improved in Nicaragua between 1970 and 1997. During that period, life expectancy at birth increased from 53.6 years to 67.9 years. Infant mortality fell from 107 per 1,000 live births in 1970 to 42 in 1997, and the under-5 mortality rate fell from 168 per 1,000 live births to 57.<sup>93</sup> These improvements were not due to better nutrition: the daily per capita supply of protein fell nearly 30 percent during this same time frame. These types of improvements tend to result from better pre- and post-natal care and more comprehensive vaccination programs; in other words, medical attention provided by the public health service. It should be pointed out that the services were provided despite an increasingly generalized civil war in the 1980s and the continuing budget cuts in public health during the 1990s.

Even the World Bank grudgingly admits that for the period between 1979 and 1993, when the budget cuts clearly began to hurt, health services improved substantially.

*Between 1979 and 1993, total health facilities, including health and medical posts, health centers, and hospitals increased from 172 to 850. Coverage was extended from 30 percent to 70 percent of the population, and quality of care improved somewhat during the early 1980s, especially at the primary level.*<sup>94</sup>

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<sup>92</sup> Nicaragua-Health Sector Modernization Project, PID NIPA35753, April 29, 1998.

<sup>93</sup> *Human Development Report 1999*, United Nations Development Program, New York, 1999, Table 8, p. 170.

<sup>94</sup> Staff Appraisal Report (SAR), Republic of Nicaragua Health Sector Reform Project, p.1.

In light of these gains, the fact that the Banks did not consult with the public health workers unions or attempt to shore up the struggling system is baffling if the loans were intended to provide means for urgently needed health care and for repair of deteriorated infrastructure. Information from both the *Central de Trabajadores de la Salud (FETSALUD)* and the *Union Nacional de Empleados (UNE)* however, confirms that they did not. According to FETSALUD: "A systematic shutdown has occurred of spaces for discussion and presentation of health policies by social sectors, institutions and communities. We do not ask for official events, but rather real opportunities for participation."<sup>95</sup> Similarly, UNE asserts that the Executive Director of the INSS concluded agreements with the World Bank and the IDB in June and July, 1999, and recognizing the requirement to hold consultations with the unions, told the press that he had initiated these discussions with associations, unions and civil society. UNE disputes the Director's claim, arguing that he consulted only with those unions allied to the Government that do not represent the majority of workers, with the American/Nicaraguan Chamber of Commerce, the Nicaraguan Association of Private Banks, the Chamber of Industry, and the Nicaraguan Chamber of Commerce. This selection of associations and organizations, together with the Director's statement about consulting civil society, reveals the deliberate manipulation and misrepresentation of efforts by grassroots and representative organizations to democratize discussions with the IFIs.

Lack of consultation is of concern to PSI and its affiliates in Nicaragua for two reasons. First, FETSALUD and UNE have collective bargaining agreements in force with INSS and MINSA, and the exclusion of the unions from negotiations related to future staffing, salaries, performance evaluations and job descriptions constitutes a broad violation of these agreements.<sup>96</sup> Non-consultative and secretive discussions with governments are, however, characteristic of the operations of both IFIs in matters involving personnel of the public sector. It is a profoundly undemocratic practice that undermines civil service institutions and politicizes government functions, even as the IFIs assert their commitment to "good governance" and democratic institutions.

Secondly, the exclusion of the unions from formulation of the project results in costly mistakes due to a lack of on-the-ground experience, inadequate planning

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<sup>95</sup> *Evaluación del Impacto de las Reformas.* P. 5.

<sup>96</sup> "The subcomponent would finance training and consulting services for the implementation of the key recommendations of the study (financed by World Bank Project 12393 NI, 1993), in particular: (a) to simplify present job categories and staffing structures, to review staffing numbers per level of service, to prepare job descriptions and operational directives; (b) to adapt salary and incentive levels and streamline promotion criteria; (c) to implement a personnel planning system to improve labor market distortions such as the current highly skewed physician:nurse ratio; and (d) to adapt the legal and regulatory framework for a modern personnel policy." Project Appraisal Document on a Proposed Adaptable Program Credit in the Amount of SDR 17.9 million to the Republic of Nicaragua for a Health Sector Modernization Project, World Bank, Washington, D.C. May 11, 1998, mimeo., p.46.

and superficial, formulaic analyses. For this, the public ultimately suffers. If the funds spent were simply grants for technical cooperation, wasting them would be bad enough in a national setting with such compelling health needs. But financing for these activities is *borrowed* from the IFIs, and must be repaid to them – with interest – by the population of Nicaragua.

Documents from the World Bank and the IDB suggest that task managers have ample evidence demonstrating that their closed-door, exclusionary practices of project implementation simply do not work. They overburden imported consultants and experts, and the project becomes dependent on the continued employment of a few individuals, who may or may not remain from year to year. Analysis by the Banks of the political context in which the reform ultimately takes place is poor to non-existent.

In 1993, when the World Bank undertook Project 12393, the Staff Appraisal Report said the following:

*Planning capability is weak, particularly in regard to multi-year planning that responds to national policies, and norms and local conditions are hardly taken into consideration. There is also limited capability for harmonizing short-term investment and operational needs with long-term investment requirements. This is aggravated by the shortage of staff with training and experience in strategic planning and budgeting.*<sup>97</sup>

Accordingly, this project spent USD 2.4 million on institutional strengthening of the Ministry, USD 900,000 for technical assistance to the management of the INSS, and USD 1 million for project administration. All told, the project invested USD 4.3 million and took five years to address problems of planning and administration in the Ministry and at the INSS. In 1998, however, the Project Appraisal Document (PAD) for a follow-up effort in health sector reform found:

***Executing capacity at MINSA:*** *At the central level, MINSA has acquired extensive experience in executing projects with external financing, but weak institutional capacity continues to be a problem*

***Project Management:*** *A recent assessment carried out during project preparation found administrative and financial management of the ongoing project unsatisfactory, due mostly to the appointment of new and inexperienced weak staff at the PCU (Project Coordinating Unit) after the 1997 change in government.*<sup>98</sup>

In other words, the project was being run by imported consultants and political appointments. The PAD goes on to describe in veiled language problems of corruption and lack of progress.

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<sup>97</sup> Staff Appraisal Report, Republic of Nicaragua, Health Sector Reform Project, NO. 12393 NI, SAR, The World Bank, Washington, D.C. 1993, mimeo. P.5

<sup>98</sup> Project Appraisal Report, May, 1998, p. 15.

*However, this rating (unsatisfactory) was upgraded in January 1998, after MINSA and the PCU had focused on problem areas, re-establishing financial systems and controls, and standardizing financial and administrative data bases. As a result, it was agreed to strengthen the financial system under the second project and carry out additional auditing and regular progress reports in order to ensure adequate control and supervision of all PCU operations.<sup>99</sup>*

At the same time that the PAD virtually admits malfeasance at the political level, it continues to force cutbacks in technical personnel and eliminate jobs at the Ministry, in violation of civil service law.<sup>100</sup> This does not constitute “institution strengthening.” On the contrary, it constitutes institution *weakening*. We would argue that if the union leadership and membership had a greater role in formulating and implementing the project, problems of the type described in the PAD would be greatly reduced because those employed long-term by the Ministry have a stake in expanding its scope and improving its services, while short-term, contracted personnel may not.

Neither the World Bank nor the IDB will adopt this more inclusive approach, however. Both Banks concentrate decision-making and implementation at the highest levels, or in separate units of short-term, high-paid consultants specifically hired for the purpose. They do this repeatedly. After discussing political and auditing problems at MINSA associated with the first World Bank loan, the second project proposes Project Coordinating Units at both MINSA and INSS, to be staffed by three senior consultants hired prior to negotiating the final form of the loan. In fact, it is often the practice at the IFIs for consultants such as these to actually write the loan documents, in which they include their own ideal job descriptions and salaries.

While the task managers at the Banks are fully aware of the risks inherent in this type of administration,<sup>101</sup> the ideological drive of their own institutions toward privatization, staff cuts, user fees, and service curtailment will not allow them to involve the truly technical people in project formulation because that would also involve the unions.<sup>102</sup>

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<sup>99</sup> Ibid., p. 15.

<sup>100</sup> Ibid., p.17.

<sup>101</sup> For example, a document evaluating an IDB water project in El Salvador, reported, “With respect to the Project Coordinating Unit, only one of five technicians included in the unit during the period was capable of executing his duties. The rest of the personnel were primarily political appointees, unable to carry out assigned tasks. *Informe Parcial de Terminación de Operaciones, El Salvador, Programa de Emergencia Obras Acueducto/Alcantrillado, Administración Nacional de Acueductos y Alcantrillados ANDA*. IDB. Washington, D.C. 898/SF-ES, Mayo de 1999, p.14.

<sup>102</sup> To minimize the difficulties associated with using political staff to implement the project, the World Bank resolved in its second loan (NIPA35753) to “Ensure government commitment to the continuity of the reform.” The Project will agree with the government to protect the reform process in the future by maintaining core teams intact for at least the length of the administration. The government will also agree to retain staff who have been trained with project resources.” PID NIPA35753, April 29, 1998, mimeo.

The institutional imperative of the IFIs themselves then, causes them to violate the national Constitution, sabotage democratic institutions, and subvert collective bargaining agreements, while undermining their own reforms by placing project formulation and implementation almost exclusively in the hands of external consultants and political appointees.

#### **IV.B. Legal Framework for Restructuring**

The health sector reforms designed by the Banks are also a matter of concern to PSI and its affiliates because at the same time that they violate the Constitution, they operate in a vacuum of contractual law. Because the Constitution assigns responsibility for health services to the State, existing law does not provide for regulation of private enterprise in the sector. In their haste to privatize the public health system, the IFIs began to grant concessions to small private health care enterprises without an enforceable legal framework to set forth obligations and compensation. In both World Bank and IDB documents pertaining to the two 1998 loans, concerns about this lack of enforceability are evident.

Beginning in 1994, the World Bank provided advisory services to the INSS for the purpose of creating private providers of primary health care, paid on a per capita basis: *Empresas Medicas Previsionales* (EMPs). The EMPs have a short and checkered history in Nicaragua. They were established by Presidential decree 127-94, separating INSS from MINSA and allowing INSS to purchase medical services from MINSA or from private providers. But the decree conflicts with Law 8 governing national health care, which established the *Sistema Nacional Unico de Salud*, (SNUS) passed in 1979. Under the law, MINSA and INSS were essentially merged, and INSS was mandated to transmit all health insurance revenue derived from the payroll tax to MINSA for the purpose of providing all services free of charge.

Based only on the 1994 decree and in violation of the more-comprehensive and longer-standing Law 8, INSS contracted two public firms with access to MINSA facilities and nine private companies to provide medical services based on a capitated payment of USUSD 9.30 per month. Between 1994 and 1999, enrollment with the EMPs increased dramatically and the number of EMPs grew from 11 to 41 (34 private and 7 public), still without any additional legal foundation.

At the same time, the package of services provided through the EMPs specified the treatments covered and drastically cut back on services insured. Any disorder not named in the EMP agreement would not be covered. The scheme maintained a long list of exclusions: dialysis, chemotherapy, and vascular surgery, for example. Chronic diseases or catastrophic conditions like cancer or renal disease or severe burns were not insured. With the exception of immunizations and pre-natal care, preventive services, such as check-ups, were not covered, either. This component of health insurance reform undertaken by

the INSS was then folded into the World Bank Health Sector Modernization Program in 1998, together with all of the corresponding legal problems.

FETSALUD and UNE object to this Bank intervention on two counts. First, the loan finances and promotes a practice that is illegal in Nicaragua under both the Constitution and Law 8: charging for basic health services. Secondly, because the World Bank and the IDB are aware of this, they have been actively promoting legislation that would legalize their *de facto* scheme of imposing user fees, thus directly interfering in the legislative process of the country – and using loan funds to do it.

World Bank documents recognized this: “ The work on the legal and regulatory framework may cause some politically-motivated maneuvering,” the Bank wrote in 1998. Apparently, in the view of the project managers and consultants, activities undertaken by national political actors such as unions or community organizations, constituted “maneuvering” and was somehow illegitimate, in contrast to their own activities restructuring the country’s national health insurance, which is undertaken by non-nationals and accountable only to a supernational financial institution representing no one.

The politically motivated maneuvering, the IFIs wrote, could be neutralized through: (i) building consensus in the political arena, including the Assembly; (ii) including major stakeholders in the revision and discussion of laws thus fostering ownership; (iii) developing support within the donor community; and (iv) implementing communication campaigns to inform the public at large.”<sup>103</sup>

Ultimately, the Bank chose to lobby the Assembly, close ranks with other donors, and use public relations and advertising to promote the program. This active lobbying was necessary because, on its own, the IFI plan for INSS reform did not appeal to the public and could not withstand legal scrutiny.

The drive to privatize did not allow the INSS to consider other reform options seriously or to establish the precautions necessary to test and evaluate a new system. INSS contracted all EMPs that met minimal standards for providing services. They did not use a competitive bidding process because of the “immaturity of the EMP market.”<sup>104</sup> The standards applied to EMPs for certification by the INSS involved financial criteria alone: was the enterprise financially viable, did it have evidence of incorporation and did it meet a minimum capital requirement? According to the Bank, “Performance (i.e., quality monitoring and utilization control) and organizational requirements (data collection and reporting) were not major elements of the certification process...No clear performance or quality assurance requirements were stated

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<sup>103</sup> PAD 17609 – NI, p. 19.

<sup>104</sup> Gerard M. La Forgia et al, “Growing Pains, the Nicaraguan Social Insurance Health Model in Transition,” paper presented at the World Bank Conference “The Challenge of Health Reform: Reaching the Poor. San Jose, Cost Rica, May, 2000, p. 8.

(or regularly monitored).<sup>105</sup> While the norms stated that the EMPs were “to provide appropriate, efficient and safe services based on scientific principles,” actual reporting requirements consisted only of presenting service production statistics.<sup>106</sup> In most cases, not even these were verified.

The steps taken show the ideology behind the putative reforms; while the IFIs rhetorically supported the establishment of process indicators and management information systems, they actually threw together an unmonitored and fragmented system of minimal and haphazard private coverage. The results were predictable. Even without systematic monitoring, by May 2000, the INSS had been forced to sanction 30 of 41 EMPs (nearly 75% of them) for minor or moderate infractions, three for serious infractions and seven had their contracts terminated. Because of a lack of legal jurisdiction, however, the INSS cannot recover funds from any of the enterprises.<sup>107</sup>

The IFIs frequently justify their approach to reforms by arguing that the new measures will eliminate the loss of funds due to mismanagement or corruption. In health, the Banks said that they meant to establish subsidized private providers and, by encouraging them to compete with one another, provide better services for greater numbers of people at a lower cost. In theory, such a system might function in some settings, although even in the U.S., with its sophisticated monitoring capability and truly competitive marketing of HMOs, this approach to health care is unpopular. In Nicaragua, however, the theory is inapplicable because the multilateral banks set up the privatization of health services without either competition or regulation. One or the other of these constraints might have kept the EMPs honest, but without either one of them, the EMPs were under no pressure to be efficient or effective.

In privatizing public services, including health services, the IFIs have taken advantage of well-intentioned pressure to incorporate civil society, in the form of community organizations and non-governmental organizations (NGOs), into their projects. This popular pressure is meant to democratize the formulation and implementation of projects and to make the IFIs themselves more accountable to grassroots organizations. The World Bank and the IDB, however, use the request that they include NGOs in consultations and project implementation to include private enterprises instead. In a project like health sector reform in Nicaragua (as well as in Guatemala, El Salvador, and Trinidad and Tobago), these particular NGOs” are often recently constituted and their most significant feature is the close link between a one of their officers and the governing political party. The corruption and confusion that resulted in Nicaragua as a consequence of the two World Bank and the IDB projects illustrate the fact that private profit-seeking companies can be easily disguised as NGOs and that consequently, not all NGOs are ideal.

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<sup>105</sup> Ibid., p. 9.

<sup>106</sup> Ibid., p. 9.

<sup>107</sup> Ibid., p. 9



The experience in Nicaragua shows that effective services should be provided systematically, with concern for need as well as cost, with reasonable and carefully considered regulatory structures.

## **V. THE PROPOSED PENSION REFORM: IDB PROFILE NI 0101**

In July, 2000, the IDB prepared a project profile entitled “Support for the Pension System Reform,” in response to a request from the Government of Nicaragua for a USD 30 million loan for this purpose. Nicaragua currently has a pay-as-you-go system, but the basic structure and strategy of the project conforms to the outlines of the plan to restructure health services. The new system will create small-scale, subsidized private enterprises to manage pension funds. Funds will be provided by all salaried employees, employers and the self-employed. Contributions to the system will be mandatory for all public workers (salaried employees) and voluntary for the self-employed.

According to the IDB project profile, this transition from a public to a private pension scheme is necessary to finance impending deficits in the existing pension scheme. Nonetheless, data demonstrating the problem are neither presented nor cited. If these future deficits materialize, however, it would not be due to demographic trends. Data from the US Census Bureau show that in 2000, 4.3 percent of the Nicaraguan population is over 60 years of age (the retirement age under the current system), and the average life expectancy is only 67.<sup>108</sup> The project profile makes clear, however, that the primary objectives of privatization are to deepen and stabilize financial and capital markets rather than to provide an income for retirees.<sup>109</sup>

The new system will be based on individualized capitalization accounts to be managed by private pension fund administrators (AFPs). The retirement scheme will change from a defined benefit system to a defined contribution system. In other words, no benefit level is guaranteed, although public workers are all obliged to contribute. Further, the new pension scheme is already partially implemented. Although the IDB loan had neither been proposed to nor approved by the National Assembly, the INSS unilaterally decreed an increase in contributions in June, 2000, and the higher payroll tax rate went into effect in August. As a result of the proposed changes, workers will be assessed a higher payroll contribution to fund their retirement, yet no benefit level will be guaranteed. Moreover, in an economy plagued with widespread corruption in the finance sector at the highest levels, obligatory contributions will be managed by newly-established, inexperienced and poorly monitored private firms. If the

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<sup>108</sup> If deficits should develop, they would most likely result from employers’ failure to deposit contributions in the fund, contribution evasion by employers, or corruption among individuals with access to the fund. See for example, the recent scandals involving privatized banks in Nicaragua, Interbank and BANIC.

<sup>109</sup> “Support of the Pension System Reform, Profile 1, July 7, 2000, p. 1.

success rate of the EMPs established to provide health care services is any indication, prospects for retirement are increasingly bleak for working Nicaraguans.

The Table below lays out a comparison of benefits under existing law and benefits under the proposed “reforms.”

**COMPARATIVE ANALYSIS OF PROPOSED REFORMS TO  
SOCIAL SECURITY  
AND CURRENT BENEFITS UNDER EXISTING LAW**

<b>PROPOSED REFORMS</b>	<b>SOCIAL SECURITY LAW 1982</b>	<b>IMPACT</b>
<p><b>Financing for Social Security</b></p> <p>The employer and the employee will pay 21.75 percent of the wage as a social security tax</p>	<p>The tripartite tax is made up of a 12.5 percent contribution from the employer, a 4 percent contribution from the employee, and a .5 percent contribution from the State, for a total tax of 17 percent.</p>	<p>The reform will impose a substantial tax increase upon implementation. The employer's contribution will increase to 15.5 percent, the employee's to 6.25 percent, and the State's will remain the same at .5 percent for a total of 21.75 percent.</p>
<p><b>Eligibility</b></p> <p>65 years of age</p>	<p><b>Eligibility</b></p> <p>60 years of age</p>	<p>Given the average life expectancy of 67 years, the proposal results in a worker paying a 4 percent tax on his or her wages over 25 years minimum of paid work, in return for a pension for the few remaining years of life.</p>
<p>25 years of paid work minimum</p>	<p>750 weeks of paid work</p>	<p>Increase in required contribution period of approximately 10 years.</p>
<p>Provides 12 monthly payments annually</p>	<p>Includes 13 monthly payments annually</p>	<p>Loss of one months income each year.</p>
<p>Does not include health insurance</p>	<p>Includes health insurance</p>	<p>Loss of health insurance for the retired.</p>
<p>Not indexed for inflation</p>	<p>Indexed for inflation</p>	<p>Gradual decline in value of benefits</p>
<p>Duration of pension undefined</p>	<p>Lifetime pension</p>	<p>Potential loss of benefits over time.</p>

Source: *Informe Ejecutivo, Confederación de Trabajadores de la Administración Pública*, Managua, September, 1999, p. 18.

The new pension scheme proposes similar restrictions and cuts in disability insurance. To qualify, one must be sicker, and one receives less.

## **VI. AN ALTERNATIVE PROPOSAL**

FETSALUD and UNE therefore oppose the World Bank and IDB proposals to privatize health care and the public pension system. It should be reiterated that the contributions in the Social Security Fund are inalienable and may not be dispersed for investment to private companies. In addition FETSALUD and UNE propose:

1. Changes in the current administration of the Fund for the purpose of restoring the integrity of the Fund and the acquired rights of contributors provided for under the valid Social Security Law.
2. Modernization of data collection in both the public health and the pension systems in order to improve information gathering and services and impede malfeasance and misuse of funds.
3. True autonomy for the Institute of Social Security in order that the INSS may guarantee benefits for all of the insured.
4. Participation of workers in the proposal of candidates for the presidency of the INSS. Selection of the INSS president by the National Assembly rather than the Executive branch of Government.
5. Participation by retirees and contributors to the health insurance and pension funds in investment decisions regarding these funds, in order to guarantee that investments contribute to improvement of the standard of living in Nicaragua.
6. Creation of a body, with participation of workers, retirees, employers and civil society, for the purpose of establishing a board charged with insuring that the Reserve Funds are prudently administered.
7. Withdrawal from the market of the Vacation Center "El Velero," one of the most important sources of income for the Reserve Funds.

## **VII. CONCLUSION: SOCIOECONOMIC CONSEQUENCES OF THE IFI REFORMS**

A report recently released by ECLAC demonstrates at the regional level the validity of what we are arguing in Nicaragua. The report, *Panorama Social de América Latina, 1999-2000*, quantitatively demonstrates that the IFI reforms of the past two decades have had a negative socioeconomic impact on living standards in the region because they have caused increasing labor market instability, they have privatized social services and they have forcibly minimized union influence in politics.<sup>110</sup>

ECLAC points out that respondents to their surveys reported increased vulnerability in the social services area, especially in education and health care.

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<sup>110</sup> *Panorama Social de América Latina. 1999-2000*. CEPAL, Santiago de Chile, 2000.

*Panorama Social* concludes that IFI policies have obliged many middle and lower income households to pay directly for all or part of service costs, at the same time that they face greater employment instability and falling incomes.<sup>111</sup> The ECLAC study also found “a decline in workers’ benefits, not only in terms of income, but also in terms of social security, whose impact on living conditions is very direct.”<sup>112</sup>

In countries where stable, rapid economic growth has not occurred, declining coverage and quality of social services have had a substantial impact. Nicaragua is such a country. The report goes on to say that the poorest groups in these countries are, of course, the ones who suffer most, but that in the past two decades, non-indigenous, poor and middle-class sectors have also experienced growing income instability.

The World Bank promoted this deterioration in living standards in Nicaragua quite openly:

*A major challenge ahead for the Government (of Nicaragua) is to maintain the recent stabilization gains in the face of lower external resource inflows while simultaneously improving the conditions for resuming growth with equity. At the same time a drastic reduction in total consumption will be needed to increase domestic savings and release resources for investment. This poses another challenge, i.e., to prevent the anticipated consumption decline from adversely affecting the living standards of the poorest and most vulnerable members of the population (emphasis added).*<sup>113</sup>

For the working class, the implications of this economic prescription were clear. Certainly, by 1993, there were no longer any “savings” to be squeezed out of the poor. Nor would the wealthy voluntarily contribute a “consumption decline” of their own to the stabilization effort. The resources to be released for investment would come out of the already-eroded incomes of the working class. The health sector loan, according to the Bank, was part of this initiative. It would “enhance the viability of the adjustment process.”

So it happened that between 1994 and 1997, social spending per capita fell by nearly 20 percent.<sup>114</sup> And by 1997, according to the same source, 66 percent of households fell beneath the poverty line.

Despite the irregularities, the illegalities, the funds spent, and the autonomy enjoyed by both Banks as they pursued their policies, they admitted in 1995 that the policies were a failure in Nicaragua: “Although the adjustment program included significant downsizing of the public sector, the liberalization of domestic

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<sup>111</sup> Ibid.

<sup>112</sup> Ibid.

<sup>113</sup> Health Sector Reform Project, SAR, November 24, 1993, mimeo., p. 1.

<sup>114</sup> *Panorama Social*, p. 230.

and foreign trade, and the liberalization of the financial sector, its measures were not sufficient to trigger the resumption of growth.<sup>115</sup> And yet these policies continue:

*Reducing poverty will depend on sustaining and deepening the economic reform program and further refining policies that will promote growth. To this end, the Government must increase its focus on strengthening the institutional structures that are needed for markets to function efficiently so as to generate growth. This will involve rebuilding the state apparatus to support the private sector and to assist the poor by providing essential infrastructure and strengthening the human capital base.*<sup>116</sup>

By “deepening the economic reform program,” the World Bank means expanding the scope of privatization and deregulation. Rather than conclude that the policies have failed and adopting a new approach, the Banks argue that their reforms have not had the desired effects because “they have not gone far enough.”<sup>117</sup>

The alleged reforms have been formulated behind closed doors, without consultation and therefore without practical experience in either the health care or the public pension system of Nicaragua. The ideological basis of these reforms includes two principles, imported from the IFIs that are highly questionable, and yet they orient all reforms in the social sectors (a) that economic growth is the means to poverty reduction, and (b) that private sector production of goods and services is necessary for growth.

After the publication of the UNDP data, these principles are even more difficult to sustain. FETSALUD and UNE therefore propose:

- An immediate end to the illegal implementation of the payroll tax increase;
- Re-examination of the health care and pension reform proposals prepared by the IFIs;
- The establishment of meaningful consultation processes with unions and other civil society organizations for the purpose of developing equitable and effective reforms.

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<sup>115</sup> Poverty Assessment, Nicaragua, FY95, World Bank, Washington, D.C.

<sup>116</sup> Ibid.

<sup>117</sup> Wm. Savedoff, Organization Matters.

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