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The Washington Consensus and the Push for Neoliberal Social Policies in Latin America: The Impact of International Organisations on Colombian Healthcare Reform

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1 Introduction

In 1993, Colombia introduced a major reform to its healthcare system to address severe deficits that translated into poor access and coverage for large parts of the population (Esteves 2012). Extant scholarship points to the significance of international influences and pressures at the time arising from what would come to be referred to as the "Washington

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Consensus" (WC) (see e.g. Restrepo and Valencia 2002; Esteves 2012; Prada and Chaves 2018). First coined by economist John Williamson in 1989, the term refers to a set of neoliberal policies advanced by Washington D.C.-based organisations, such as the World Bank (WB) and International Monetary Fund (IMF), but also the United States' (US) Department of the Treasury, and designed to help Latin American countries recover from the economic and financial tumult of the 1980s (Williamson 1993). The present chapter analyses the impact of this paradigm on the healthcare reform subsequently adopted in Colombia, asking *How do the policy ideas of international organisations (IOs) become co-opted into domestic social policy?* This question speaks to the complex relationship between international and national policy arenas, which, in line with *global social policy theory* (see e.g. Deacon 2007) and the *transnational interdependency approach* (CRC 2018), are increasingly in contact, contest, and in concert with one another, even in hallmark areas of domestic policy such as healthcare.

In what follows, we begin by addressing the relevance of Colombia as a case for observing the role of IOs in social policy. We argue that the country stands out as being both atypical and representative of the region at once. In the same section, we also provide a brief background on the healthcare system prior to the 1993 reform. Then, we outline the main policy principles and recommendations put forth by the WC, exploring key policy documents of the time, followed by a brief description of the reform process in Colombia. The aim of our analysis is to evaluate the degree of overlap between the policy aims expressed in the legislative acts introducing the Colombian healthcare reform and that of the WC paradigm. Our findings provide strong evidence for an alignment in the language and measures adopted by Colombia with the latter. We conclude by reflecting on the nature of interdependency between IOs and national constellations of political and economic factors, as they come together to impact social policy.

2 Background: What Colombia Can Teach Us

Colombia of the 1970s to the early 1990s stands out amongst its regional neighbours in some important ways, both economically and politically: whereas foreign credit plagued Latin American economies since the late 1970s, during the same period the Colombian government reduced reliance on external financing and contained inflation (Urrutia 1991). Moreover, while most countries in the region were grappling with waves of economic populism and re-democratisation (Alesina 2005), Colombia had succeeded at having a democratic political system in place for much of its history, keeping populist politicians at bay, and maintaining a stable economic policy marked by strong regulation of markets. Still, the country was neither immune to the fiscal crisis felt throughout the region, nor exempt from other severe problems that rendered it subject to international pressures, particularly by the United States. These problems comprised, amongst other things, terror by guerrilla and paramilitary groups, as well as drug cartels, rampant political corruption, and failing public services including those pertaining to health (Alesina 2005).

Prior to the 1993 reform, the Colombian healthcare system was characterised by high segmentation with public, private and social insurance schemes existing in parallel. While the National Health System (*Sistema Nacional de Salud*—SNS) had expanded considerably in the decades before the reform, with the addition of new hospitals and personnel, the 1980s saw a halt to progress: public spending decreased by 50 percent, resulting in an underfinanced, resource-scarce and geographically concentrated system (Esteves 2012). Both the Social Security Institute of Colombia and the Public Provision Funds, which provided services for formal workers, suffered from perennial deficits (Uribe 2004), as half of those required to contribute to the schemes failed to do so (Gómez-Camelo 2005; Esteves 2012). Additionally, the private system only targeted the wealthy and was affordable to just a small portion of the population (17 percent), the remainder of which was covered by the

public system (40 percent); social insurance (18 percent)[1]; minor schemes (5 percent); or else had no coverage or access to services whatsoever (20 percent) (Hernandez 2002; Esteves 2012).

Crucially, the underperformance or even worsening of the Colombian healthcare system at this time would soon become subject to much attention from both national politicians and IOs promulgating the WC paradigm (González-Rossetti and Bossert 2000). Indeed, healthcare professional groups and unions maintained that the 1993 reform was an illustration of the central government's neoliberal mindset, imported from abroad with the support of IOs for the purpose of privatising healthcare (Uribe 2004). Similar claims about the role of the WC have been made by other authors (Restrepo and Valencia 2002; Esteves 2012; Prada and Chaves 2018). Thus far, to our knowledge, research provides a limited a structured account of how the recommendations of the WC were reflected in the actual language and measures taken up in healthcare reform legislation. That is, *to what extent does the 1993 reform align itself with the policy goals put forth by IOs?* To answer this question, we begin by taking a closer look at the principles of the WC.

3 The Principles of the Washington Consensus

Extant scholarship maintains that over the last decades of the twentieth century there was a general agreement among international financial institutions and the US Treasury as to the policy agenda that needed to be pursued by Latin American governments in order to stabilise their fragile economies (Stiglitz 2004; Williamson 1990). The main recommendations set by the WC revolved around liberalisation, privatisation and macro-stability in order to boost private markets and, accordingly, minimise the role of the state (Stiglitz 2004). In line with Williamson (1990, 1993), these translated into ten general prescriptions provided to low-to-middle-income (LMI) countries. Six recommendations focused

[1] By public system, we refer to the arrangements financed through taxation, whereas social insurance refers to mandatory employment-based health insurance financed through contributions.

on economic policy (fiscal discipline, tax reform, competitive exchange rate, interest rates, property rights and trade), whereas four had direct implications for healthcare policy:

1. *Reordering public expenditure priorities*: public spending should move away from politically popular but economically unwarranted projects and towards neglected fields with high economic returns and the potential to improve economic distribution (e.g., primary healthcare);
2. *Liberalisation of inward foreign direct investment*: abolition of barriers impeding the entry of foreign direct investment (FDI) and foreign firms. International and domestic companies should compete on equal terms;
3. *Privatisation*: state-owned enterprises and responsibilities should be privatised;
4. *Deregulation*: governments should ease barriers and abolish regulations that impede the entry of new firms into the market or which limit competition.

This agenda, supported by all major IOs, was disseminated globally, especially by the WB which pushed for the adoption of the principles through loan conditions (Almeida 2015). Further, in 1987, the WB published the *Financing Health Services in Developing Countries* report, setting an agenda for health sector reforms. In it, four policy-specific recommendations were put forth:

1. *Charging users of publicly provided health services*, increasing or establishing user-fees for services and goods within public health facilities;
2. Encouraging *risk-coverage programmes* (introduction or expansion of programmes in which the population participates in some form of risk-sharing arrangement);
3. Strengthening the *non-government provision of health services* for which households are willing to pay through the incentivising of community-run and private sources of health services;
4. *Decentralising* the public health system, offering greater autonomy to local units of the system.

Although IOs often published country-specific documents of this kind, the policy prescriptions advanced in the 1987 WB report represented a one-to-one translation of WC principles into the policy (Williamson 1990, 1993). It, therefore, serves as an illustrative example and point of reference in the analysis of Colombian healthcare reform that follows.

4 Setting the Stage: The 1993 Colombian Healthcare Reform

As previously mentioned, the 1993 Colombian healthcare system reform is said to have been heavily influenced by IOs. Its basis was formulated and prescribed by a group of neoliberal technocrats under the leadership of Juan Luis Londoño, Health Minister at the time and who later assumed prominent positions at the WB and the Inter-American Development Bank (González-Rossetti and Bossert 2000; de Vos et al. 2006). According to Esteves (2012, 6), this group was mainly composed of foreign-trained economists who closely followed ideas promoted by leading IOs at the time, such as "changing the role of the State in the social sector from provider of services to regulator; promoting the role of the private sector; increasing efficiency, and using mechanisms other than those historically used in the delivery of social services, such as targeting and demand subsidies".

What is referred to as the 1993 Colombian healthcare reform is the result of the enactment of numerous legislative acts, particularly *Decree Number 77/87*, which laid the foundation for healthcare system decentralisation, transferring authority from the central to local governments; *Law Number 10/90*, which defined the basis for public provision of healthcare; and *Law Number 100/93*, the centrepiece of the reform, which framed all subsequent changes to the country's social security system. Similar to the 1979 Chilean reform, the Colombian government created health insurance institutions with access to health services based on individual income, in an attempt to achieve universal health coverage (Rotarou and Sakellariou 2017). More specifically, the country introduced mandatory health insurance, in which formal sector employees

and their families were insured by one scheme (Contributory Insurance), and self-employed and unemployed persons by another (Subsidised Insurance) (Prada and Chaves 2018). However, the mandatory benefit package comprised basic services only, and citizens were forced to purchase supplemental insurance if they wanted to cover any gaps.

To analyse whether and how policy agendas set by IOs were adopted and translated into the aforementioned healthcare legislation in Colombia, we explored the content of key policy documents selected in line with secondary literature. We pursued documents especially for references to policy-field specific prescriptions and general WC recommendations according to Williamson (1990, 1993) and the WB (1987). We measured the ways in which policy recommendations translated into concrete measures adopted into domestic legislation.[2] In what follows, we present the findings of this analysis.

5 The Adoption of Washington Consensus' Principles in the Colombian Healthcare Reform Legislation

The analysed legislative acts featured a total of twenty-two measures that correspond with the principles of the WC (Table 17.1). Amongst these, references to *decentralisation*, *non-public provision*, and *deregulation* processes came to the fore. It bears noting that *decentralisation*—the most frequently cited principle (thirty-four references)—represented the main goal of one of the analysed laws, which aimed to decentralise public services in order to "encourage the proximity between citizens and public services, as well civil society's vigilance and control of the provision of services" (Decree Number 77/87, 2, own translation). Specific to healthcare, we identified six ways in which central government mandates

[2] To guide our analysis of Colombian healthcare legislation, we constructed a codebook based on policy-field specific prescriptions and general WC recommendations. Taken together, our approach comprised the following steps: (1) building a codebook; (2) coding legislation according to the codebook and using Spanish-language equivalents; (3) describing the quantitative data and (4) analysing and interpreting qualitatively the content of legislation. Altogether, 182 pages and 470 legal articles were coded using NVivo software. Coded documents are available upon request.

were transferred to the local level: by (1) increasing participation of regional government and municipalities in managing and receiving taxes; (2) granting greater autonomy to local governments to administrate fiscal resources; (3) eliminating dual functions between levels of government; (4) allowing for more regulation and management of healthcare resources by local governments; as well as the (5) formulation, management and control of healthcare programmes and institutions and the (6) transfer of

Table 17.1 Washington consensus principles and healthcare reform legislation

Principle	Measures
Decentralisation	(a) Increasing participation of local government in managing and receiving tax revenues (b) Greater autonomy for local government to administrate fiscal resources (c) Elimination of dual functions (d) Regulation, management of resources, formulation and control of programmes transferred to local government (e) Transfer of care responsibilities
Deregulation	(a) Elimination/reduction of state regulations for private and not-for-profit organisations (b) Equal rules for public and private institutions (c) Sanctioning of legal penalties that impede/restrict free competition
Liberalisation	(a) Free choice of providers (b) Relaxation of regulations for private companies (c) Equal competition
Non-public provision	(a) Free choice of providers (b) Outsourcing of public services (c) Transfer the administration of small facilities to private and not-for-profit organisations
Privatisation	(a) Individuals can pay for additional coverage to private firms (b) Private providers receive public funds (share of the contribution)
Public expenditure priorities	(a) Increasing the healthcare budget (b) Prioritisation of primary care and basic services
Risk-coverage programmes	(a) Expansion of coverage (b) Promotion of risk-sharing schemes
User-fees	(a) Introduction of co-payments and deductibles (b) Payment for high-cost health services (c) Payment for complementary schemes

care responsibilities. The latter assigned local governments the responsibility for providing primary, secondary and tertiary care, as well as regulating and managing hospitals and health centres.

As concerns references to *deregulation*, these manifested in a reduced role for the state and an opening up to private market actors in key areas of administrative regulation:

> Administrative regulations of the health system will only be mandatory for public entities of the health sector but may be adopted by private entities. (Law Number 10/90, 4, own translation)

> Institutions (of any nature) will have technical, financial and administrative autonomy that guarantees a more efficient service. (Law Number 100/93, 40, own translation)

Additionally, free competition, another aspect of *deregulation*, was reinforced by introducing the same rules and conditions for both public and private institutions ("the referred contracts will not demand different requirements than those requested to contract private firms", Law Number 10/90, 17, own translation), and by legally sanctioning penalties that impeded or restricted free competition in the healthcare market (Law Number 100/93, 41). In a similar vein, *liberalisation* translated into legislation in the form of the free choice of providers (Law Number 100/93, 30); relaxation of regulation on private companies (Law Number 100/93, 4; Law Number 10/90, 6); and the securing of fair competition (Law Number 10/90, 17). The documents, however, made no reference to opening the market to FDI or foreign companies.

With regard to *non-public provision*, the Colombian reform introduced the basis for participation by private companies and persons as well as not-for-profit institutions in the healthcare system. This was observed in the legislation regulating both the public and the social insurance systems. In fact, the Colombian government defined the social security system as a "harmonious set of public and private entities" (Law Number 100/93, 2, own translation). In order to boost non-public provision, the legislation secured beneficiaries' free choice of providers and the possibility of outsourcing public services to private and not-for-profit institutions.

Additionally, the mandate of small facilities was transferred to non-public institutions. The healthcare reform also reordered *public expenditure priorities*, increasing the healthcare budget from 7 to 8 percent of GDP (Law Number 100/93., 59) and prioritising primary healthcare services:

> Transfer payments will be assigned to the provision of health services, according to the following order of priorities:
>
> 1. Basic health services and public assistance services.
> 2. Infrastructure to provide primary healthcare services (Law Number 10/90, 24, own translation).

User-fees were also established in the legal framework of the reform, mainly for those in upper socio-economic groups and/or working in the formal sector. Fees were introduced in the form of co-payments and deductibles to cover high-cost services and complementary schemes. For instance, high-cost services were only available after contributing for a pre-established period, and access to any service before contributing for twenty-six weeks had to be paid out-of-pocket (Law Number 100/93, 34). In addition, insurers could offer privately financed complementary schemes (Law Number 100/93, 36). As concerns *risk-coverage programmes*, one of the main goals of the 1993 reform was to increase healthcare coverage through the gradual expansion of the social security system, and the promotion of risk-sharing schemes:

> Guarantee the expansion of coverage until all the population has access to the system, according to the constitutional principle of solidarity. (La Number 100/93, 2, own translation)

> Healthcare providers will seek risk grouping mechanisms among their affiliates, companies, unions or associations or by geographic settlements. (Law Number 100/93, 39, own translation)

Although the documents do not refer to the transfer of state-owned institutions to private enterprises, *privatisation* could be found in connection with healthcare financing and service provision, with increased spending channelled through private insurers and/or care organisations,

and the transfer of provision from public to private institutions. Altogether, all eight principles of the WC were adopted and translated into domestic legislation through the enactment of twenty-two measures. These are summarised in Table 17.1.

6 Lessons Learned: The Impact of IOs on Colombian Healthcare Reform

Global social policy and global governance scholarship emphasise the influence of IOs on national policymaking, including in key areas of the welfare state such as healthcare. Typically, IOs are said to provide policy models and prescriptions to national governments, whether acting as financial institutions, champions of rights and values, guideposts for ideas and normative standards, or as facilitators of policy exchange and the implementation of best practices (Kaasch 2013). In the case of LMI countries, where dependency on international development aid, as well as knowledge and technical expertise can be substantial, the role of IOs may be even more pronounced. Indeed, the neoliberal agenda of IOs such as the WB and IMF, with backing by the US government, came to permeate Latin America during the fiscal crisis of the 1980s.

Although Colombia was not subject to the same kind of financial disarray as that of its regional neighbours, other problems—both political and economic—rendered the country a subject of international attention and source for concern. This, in turn, likely generated substantial pressure on national policymakers to incorporate the WC paradigm into their own thinking when it came time to reform the resource-deprived and highly segmented healthcare system. Indeed, as the findings of our analysis demonstrate, the ideas promulgated by IOs under the banner of the WC can be found in both the language and measures co-opted into Colombia's reform. Eight neoliberal principles and twenty-two policy measures featured prominently across three legislative acts.

Whether this was the result of international pressures tied to financial incentives or a genuine paradigmatic shift towards neoliberal thinking

embraced by like-minded national politicians cannot be determined by the present study. The findings of our analysis, however, provide robust evidence of an *alignment* of domestic policy with international ideas that were already widely in circulation in the region in the lead-up to the Colombian healthcare reform. The timing and content of the latter therefore suggest that the WC did indeed have an impact. However, the adoption of WC principles and the overall healthcare reform have been the subject of much criticism. Although there was an increase in public spending on health, reaching 75.1 percent of total health expenditure in 2014, access to and quality of services remained low (Prada and Chaves 2018), health inequalities persisted, and there was no impact on the health status of the population, (e.g., mortality rate, life expectancy) (Esteves 2012). Many experts claim that these failures seem to be related to the design and implementation of the reform, and new measures have been introduced to correct these flaws (Esteves 2021). Nonetheless, a paradigmatic shift away from WC principles has not yet taken place, and national legislation passed then continues to be the main legal framework for the Colombian healthcare system.

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