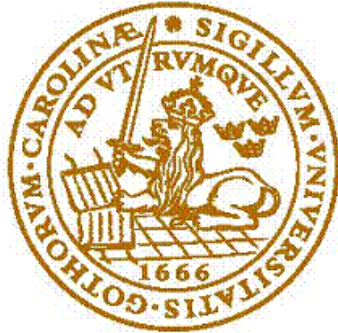


Lund University
Department of Political Science

STVK12
Spring 2012
Supervisor: Catia Gregoratti



LUND
UNIVERSITY

NEOLIBERAL HEALTH REFORMS
IN LATIN AMERICA:
THE PUBLIC PRIVATE MODEL IN URUGUAY

A Bachelor's Thesis

Zarah Backlund

Acknowledgements

This study has been completed at the Department of Political science and based on a field study carried out in Uruguay January until March 2012. It has been an opportunity to put in to practice knowledge and tools provided at the Bachelor Programme in Development Studies, Lund University. However the most significant insights that have been inspiring and motivating this work were probably gained during the field study. It included challenging moments as well as unforgettable memories and experiences.

A special thanks is given to:

Yonhatan Rodriguez, Guillermo Fuentes, Carmen Midaglia, all interviewees that participated in the study and the staff and colleges at Lund's University that has been an inspiration sources as well a helping hand.

Abstract

For the last decades Latin America has been the target for several neoliberal health system reforms. Public Private Partnership models in health care provision are increasingly advocated on both national and global scales. Foremost the public private partnerships are suppose to enhance is equity in health system regarding distribution of resources and reaching out to poorer parts of populations. In this study the concept of equity is defined in three different streams¹, namely equity through participation, equity in resources equity in access to health care. The analytical framework for this study will be based upon these three streams. A recent health reform in Uruguay is an example of a public private model. It attempts to enhance equity in an integrated health care system. This paper seeks to provide an insight on how the reform is evolving. The empirical material collected during a field study in Uruguay (6th January – 12th March, 2012) constitute for the data to be analysed. Utilizing a qualitative case study research approach, important features of the experiences of the reform are revealed.

Keywords: *Public Private Partnerships, Equity, Health care reforms, Uruguay*

¹ Discussion and definitions on these three streams will be provided in section 3.5.1

Abbreviations

MSP – Ministerio de Salud Publica (Ministry of Public Health, Uy)

WB – World Bank

IMF – International Monetary Found

USAID – United States Agency for International Development

WHO – World Health Organization

UNDP – United Nations Development Programme

PNUD – Programmas de las Naciones Unidas para el Desarrollo

SNIS – Sistema Naccional Integrado de Salud

HDI – Human Development Index

Table of Content

Acknowledgements.....	2
Abstract.....	3
Abbreviations.....	4
1 Introduction.....	6
1.1 Research problem	6
1.2 Research question and aims of study	7
2. Background	8
2.1 Health care reforms in Latin America	8
2.2 Uruguay ‘The welfare state of Latin America’	9
2.3 A segmented health care system	10
2.4 The health care reform, SNIS	11
3 Theoretical discussion – A conceptual framework	12
3.1 The neoliberal agenda	12
3.2 The notion of Public Private Partnerships	13
3.3 The debate on Public Private Partnerships	14
3.4 The concept of equity	15
3.5 PPPs and equity	16
3.5.1 Analytical framework	17
4 Methodology	18
4.1 Constructing a case study	18
4.2 Reflexivity	19
4.3 Translation	21
4.4 Empirical Material	22
4.4.1 Interviews.....	22
4.4.2 Observations	23
5 Analysis.....	23
5.1 The public private model in Uruguay	24
5.2 Equity through participation	26
5.3 Equity in resources.....	28
5.4 Equity in health care access	31
5.5.Concluding Analysis.....	35
6 Conclusion	37
Appendix - Interviews	38
Bibliography	39

1 Introduction

1.1 Research problem

In development politics on both global and national dimensions the neoliberal agenda has been widely accepted, from ideological to practical manners. The trend of neoliberal promotion of the private sector role in what before was considered as a state domain, is in recent discourse known as *public private partnership* (PPPs). According to Barr (2007:19), there has recently been enthusiasm for using public private partnerships to improve the delivery of health and welfare services, especially in developing countries. The success of public private partnerships in this context appears to be mixed, and few data are available to evaluate their effectiveness. There are various experiences of neoliberal agenda in Latin America, where health care reforms have been implemented enhancing the private sector's role in providing public health care, aiming to reduce inequalities and improve health care for the poorer parts of populations (Homedes and Ugalde 2005, Pribble 2010, Wallace and Gutiérrez 2005).

With considerable successful delivery of state services and institutional strength, Uruguay could be seen as the welfare state of Latin America. Despite the country's fairly high level of development, the population is notably stratified. According to UNDP the greatest challenges for the country are poverty and inequalities. Uruguay had until recently a health care system that significantly segmented the population, where private providers were almost entirely engaged with the wealthier part of the population and the rest of the population were attained in public health care. The health care reform SNIS, Sistema Nacional Integrado de Salud, *The Integrated National Health care System*² in 2008, included the ambition to create an integrated health care system which would decrease the gap between rich and poor. Considering available definitions of public private partnerships (Weintaub, 1997:8), the defining of SNIS as a public

² SNIS consists of certain mechanisms that will be described more explicitly throughout this paper.

private partnership³ is evidently supported. The private entities in the Urugayan health system now are engaged in providing subsidized health care to a low income group of the population. These new costumers of the private sector come from a part the population previously could not benefit from health care, other than the public health care, as this is free of charge.

1.2 Research question and aims of study

Recognising SNIS as a case of a neo-liberal PPP model for health care provision, the aim of this study is to provide insight on how the health care reform in Uruguay is evolving. The evaluations made on the health care reform in Uruguay are so far mainly quantitative. For instance results show a significant increase of low income takers are now affiliated at the private health providers. However, quantitative evaluations can only provide a limited account of the effects of the reform. The aim of this study is to look beyond what quantitative evaluations can provide. By utilizing a qualitative approach, this research will seek to grasp the experiences of the reform on different levels within the policy process, namely: formulation level, implementation, and micro level

Acknowledging the limitations involved in the research design, the aim of this study is not to provide a generalization, rather a significant insight on the case in concern.

Thus the following research question is stated:

- From an Equity⁴ perspective: What are the main potentials and risks of the public and private health care model in Uruguay?

³ The notion of Public Private Partnerships will be discussed more into dept later on in chapter 3.

⁴ A discussion and definition of the concept of equity will be provided in section 3.4.

2. Background

In this chapter the case of the Uruguayan health reform will be positioned within a broader context. A background presentation of the old- and new health care system in Uruguay will thereafter be provided.

2.1 Health care reforms in Latin America

The inefficiencies and inequities of the Latin American health systems have been acknowledged for several decades. By the late 1970s and early 1980s Latin American political leaders, users, providers, and researchers were all aware that some changes were needed to reverse to revert the increasing users' dissatisfaction and decreasing quality of care, and improve the equity and efficiency of the systems (Homedes and Ugalde 2005:83). As mentioned earlier, various attempts are to be found in the previous literature, that Latin America, since the 1980s have been the target for actors [e.g World Bank and IMF] for imposing health reforms. According to Homedes and Ugalde (2005:84) The World Banks attempts to increase the role of the private sector in management and delivery of health services has had limited success in Latin America. In Colombia, the health care reform indicates that the assumed gain through a neo-liberal model is not to rely on. The country has explicitly followed the WB reform blueprints, despite of a very substantial increase in health care expenditures, a large percentage of the population continues to be uncovered, the poor parts of population continue to experience obstacles in accessing services because of high co-payments. Moreover there is seemingly no measurable improvement in efficiency and medical care quality, however public health care has deteriorated, and health equity has suffered (Homedes and Ugalde 2005:91).

Recent reports show how the neoliberal trend of public private partnerships in health sector are encouraged in developing countries, mainly aiming at employing the private sector in attempt to reach out for the poor and vulnerable groups of populations. In a report from 2010 of USAID on the potential of PPPs in Peru to

reduce health inequalities, the significant role of the private sector health provision is stressed. The state can according to the report foster PPPs in various ways, including public sector providing financial support to the private sector entities that are willing to target the poorer and vulnerable. It is suggested that the barriers, created to ensure customer protection, should be eliminated to avoid adverse impact on private sector expansion. Goals of policies and regulations should enhance rather than contain commercial sector ability to respond to market conditions (Karra, Sharma and Vargas, 2010:13).

2.2 Uruguay ‘The welfare state of Latin America’

Uruguay can be seen to constitute the welfare state of Latin America. With a regime that has been historically characterized by relatively high levels present coverage of the various goods and services, social security, health and education. However the quality and quantity of services are argued to vary. Even though Uruguay presents some of the lowest levels of inequality in Latin America, it is one of the most unequal countries in the ranking of more developed countries. In March 2005 the current government was installed, a leftist coalition: *Frente Amplio* (Broad Front). With mechanism for the distribution of wealth, social inclusion and participation, the state in this sense is given an active role (Borgia, 2008:112). Strengthening the role of the state in the economy is one of the current government’s clearest policy lines. In parallel to that, it is also seeking to involve the private sector in some of its initiatives linked to public services. The striving for a greater welfare state and ambition to decrease the stratification within the population is clearly visible in the government’s programs and policies. Despite the country’s fairly high level of development, the population of Uruguay is notably stratified, regardless of its HDI ranking, the country has several developmental challenges including inequality/social exclusion (UNDP, 2011:2). However there has been considerable progress in providing evidence on the level and trends of poverty and inequality in Uruguay. The increase of poverty and inequality in the within the country, began before the dramatic economical crisis that Uruguay experienced in 2002. Despite a relatively well-developed social

protection system, poverty in the country has doubled in recent years (EC, 2007:8). In Uruguay, the high levels of social exclusion have raised the need for a development with policies that promote a democratic system in which citizens are full participants (UNDP, 2011:2).

2.3 A segmented health care system

Before the health care reform in 2008 the Uruguayan population had variant access to different forms of health coverage, according to their income level. The system was recognized as highly segmented where the private sector provided health care to the rich and the public sector to the poorer parts of the population, there were moreover a heavy fragmentation in the supply of health services (MSP, 2010:19). The cooperation between the two sectors were almost no existing, consequently the absence of coherence between the two. The private sector was superior in an aspect of resources and quality, while the public health care was characterized by low quality care and an overpopulated system. Acknowledging the importance of equality within healthcare together with the universalistic ambitions of the recent government Frente Amplio, the reformation of the health system started to emerge. The effects of the economical crisis in 2002, with high indicators of unemployment and poverty, generated a situation of a precendented social dislocation. The private sector barely managed to overcome this critical juncture, however the results were complicated. The public sector, with an insufficient budget, weakening of infrastructures and inadequate human resources, was facing an overload of demands of the population without social security coverage. The private sector, on the other hand, continued to draw on a very high debt, which were challenging the continuity of its role within the health system (MSP, 2010:18) The sustainability of a mutual system were at crisis at financial and assistance perspective as well as the crisis regarding declining trust among users of the health system.

2.4 The health care reform, SNIS

Article 264 specifies that The Integrated National Health System would provide comprehensive care to all people residing in the country, guaranteeing equitable and universal coverage. According to the law, The Integrated National Health System will be guided by several general principles. Health promotion will focus on environmental factors and population lifestyles. Health policy will coordinate various social sectors with an impact on health. Coverage will be universal. Health services will be accessible and sustainable. Service provision will be equitable and continuous (Borgia, 2008:118). The current health reform is at the heart of Uruguay's social, economic and political transformations, changes which also have a moral ethical and social justice dimension. The model incorporates the public and private sectors in new ways than the old system. Through subsidised health care the private entities are supposed be engaged with 'new' part of the population. Before the reform the ones that could afford health care at the private providers were a very small portion of the population. Under the coordination of MSP (The Ministry of Public Health) the private and public sector are engaged under completely new terms to provide health to the Uruguayan population. In official documents concerning the construction of the new health system it is stated that the rectory needs to incorporate mechanisms to enable the complementing and integrating of the public and private providers to ensure equity in access for all citizens to quality services with an effective and efficient use of resources at the disposition of the health care system as a whole. Along with the reform el Fondo Nacional de Salud, FONASA (the national health fond) was created in 2007 (MSP, 2010:56). Through FONASA individuals with formal employment are allowed to affiliate for subsidised health care at private health care providers.

3 Theoretical discussion

– A conceptual framework

In this chapter the start point constitute of a broad presentation of the neoliberal agenda. Continuing, the discussion will stream down to the notion of public private partnerships and the current debate regarding these partnerships. Further the equity concept will be given space and definition of the concept will be provided. Thereafter the equity concept will be linked to the notion of public private partnerships and how these are argued to relate will be discussed. The final part of this chapter constitute of a description of the analytical framework employed in this study.

3.1 The neoliberal agenda

Neo-liberalism is the defining political economic paradigm of our time, it refers to the policies and processes whereby a relative handful of private interests are permitted to control as much as possible of social life in order to maximize their personal profit (McChesney, 1999). However to consider the notion of neo-liberalism as a unified ideology seems immensely difficult. As stated by Larner (2000:12)

“We are alerted to the possibility that there are different configurations of neo-liberalism and that close inspection of particular neoliberal projects is more likely to reveal a complex and hybrid political imaginary rather than the straight forward implementation of a unified and coherent philosophy”

In development politics both on global and national scales the neoliberal agenda has been widely accepted, from ideological to practical manners. Multinational organs, primary IMF and the World Bank are argued to play critical roles in pushing on the neoliberal agenda on to a wide group of developing countries. According to Larner (2000:6) the most common conceptualization of neo liberalism is as a policy framework – marked by a shift from a Keynesian welfarism towards a political agenda favouring the relatively unfettered operation

of markets. One consequence is the ‘rolling back’ of welfare state activities, and new emphasis on market provision of formerly ‘public’ goods and services. Analysts tend to attribute this shift in policy agendas to the capture of key institutions and political actors by a particular ideology, a body of ideas or worldview. This is understood to be based on five values: The individual: freedom of choice, market security, laissez faire and minimal government (Larner, 2000:7).

3.2 The notion of Public Private Partnerships

The neoliberal promotion of the private sector role in what before was considered as a state domain, is in recent discourse known as *public private partnership* (PPPs) The notion of PPPs can be found on the global, region and national scale. On these scale, PPPs are found in several areas of service delivery, however within health care PPPs have gained great grounds. The distinction between public and private sector usually means the distinction between governmental and non-governmental (Weintaub, 1997:8). According to Weintraub (1997:8) Private sectors regards two set of structures: ‘non-profit’ for instance non-governmental organisations and ‘for-profit’ organisations, enterprises that seek profit. The notion of Public Private Partnerships has a vast amount of definitions and indicators, however there has been no consistent definition of what, precisely, constitutes a public private partnership (Barr, 2007:20) According to Jütting (1999:2) PPPs is defined as:

“institutional relationships between the state and the private for-profit and/or the private not for-profit sector, where the different public and private actors jointly participate in defining the objectives, the methods and the implementation of an agreement of cooperation”.

Stated by Ruckert (2011: 3) Public private partnership can neither be understood as a privatized form of advanced liberal governance nor as a novel practice in the public domain. Rather PPPs should be conceived as the re-arranging of the boundaries between the public and private sphere and as a political effort to further entrench private interest with an ever shrinking public sphere. Goel and Galhotra (2007) stresses that PPPs seek to complement rather than substitute for

public health services. According to Jütting (1999:4) the growing interest of the potentials of a public private partnerships to provide social protection in developed and in developing countries can partly be explained through financial pressures, governments have to reallocate resources with the highest effectiveness.

3.3 The debate on Public Private Partnerships

Public Private Partnerships are at the top of many agendas in international public health these days. When the market fails to distribute health benefits to people who need them, especially to poor people in developing countries, partnerships between public and private organizations are often considered offering an innovative method with a good chance of producing the desired outcomes (Reich, 2001:1). Accordingly public private partnerships have become a common approach to health care problems worldwide. During the late 1990s, several public– private partnerships emerged, however most were focused on specific diseases such as HIV/AIDS, tuberculosis, and malaria. However the emerging trend is PPPs as mechanism for health care delivery (Barr, 2007:19). While public-private partnerships are conceptually appealing, many concerns exist. In literature on private sectors involvement in providing public health, two sides could seemly be fund. The advocators stress the potential of PPPs in public health delivery. On the other hand there are critique raised, concerning power structures, conflicting interests and the risks with PPPs. The private sectors with its superior resources and efficiency is argued to be an unavoidable actor in what before was considered to be public domain activities. The notion of Public Private Partnership as being inevitable, is criticized from several point of views. According to Buse and Harmer (2004:55), dominant discourse has emerged constructing a paradigm of public private collaboration that may inhibit mainstream analysis of alternatives. Acknowledging that most literature on PPPs are provided by the advocates, the mechanism could be argued to be of a promoting fashion, enhancing the potential of these partnership while avoiding possible alternative solutions to emerge.

At a national level, urban studies and discourse analyses have begun to consider partnership in terms of power (Hastings, 1999). The question of power within public private partnership regards several dimensions. The concept of power could be argued to constitute a significant part of the discussion regarding PPPs. However due to space limitation this will not be dealt with in this paper. Nevertheless what is seemingly touched upon in this paper is the trend of considerable powerful actors involved in promoting these partnerships. Accordingly the World Bank has announced that it will encourage partnerships as part of its comprehensive development framework (Reich, 2000:617). Enthusiasts of public-private partnership such as the World Bank believe these partnerships could help address specific cost and investment challenges faced by governments and improve efficiency and quality of health services (Asante and Zwi, 2007)⁵. Expressions such as “stewardship” and “steering rather than rowing,” used in policy documents on the global agenda for health sector reform from the World Bank and the World Health Organization (WHO). Not so much debate, however, exists on how public private partnerships improve or undermine global health equity and moreover evidence of how public private partnerships in the health sector have affected global health equity is scarce. (Asante and Zwi, 2007).

3.4 The concept of equity

Equity is a value laden concept which has no uniquely correct definition (Mooney, 1987). However, the concept of equity is seemly employed in various contexts. There is an enormous literature on equity in health and health care, written from every conceivable disciplinary perspective, and several principles of equity are commonly discussed (Oliver and Mossialos, 2004:655). According to WHO (1998:72) equity is considered to be

“fairness in the allocation or treatments among different individuals or groups”.

For this paper, the concept of equity will be defined as equity through participation, equity in resources and equity in access to health care. These three streams will be more explicitly discussed in the analytical framework.

⁵Page numbers were missing and therefore not part of reference.

The analytical framework is constructed while acknowledging the vast range of definitions, accumulations or separations of the concepts involved. However for this research this dissection seemed appropriate considering the following. Some definitions available, separate the concepts of equity and access, seemly in technical sense, where concept of equity is more of a mechanism (e.g juridical). However in this research the concept of equity is defined through a ideological point of view rather than technical, aiming at grasping the equity pursuit of PPPs in terms of improvement in health for most vulnerable groups and the SNIS objective to integrate a segmented population. According to Raman and Björkman equity is separate from accountability (2006:77).

3.5 PPPs and equity

Partnerships with the private sector has emerged as a new avenue of reforms, in part due to resource constraints in the public sector of governments across the world, however these partnerships within the health sector can however be for various purposes. Underlying the bulk of global partnerships for health is the desire to bridge the inequity gap in healthcare access between rich and poor countries. In particular, partnerships involving the UN agencies consider equity a primary goal (Asante and Zwi, 2007). Through increasing competition, delegation of power to the local level, the active participation of the concerned population and synergetical effects positive impacts on the efficiency, equity and quality of health care provision can be observed. Consequently, cases of public private partnerships in the health sector indicate the potential positive effects (Jütting, 1999:2). Recent documents from USAID assert a relationship between PPPs and equity in health systems. In *EQUITY framework for Health*, there is clear call for yielding for public partnerships for equity (USAID, 2010:1). The possibility of a PPP in the health sector can be explored to meet the growing health care needs of the population.

3.5.1 Analytical framework

The WHO's definition of public private partnership as the "means to bring together a set of actors for the common goal of improving the health of a population through mutually agreed roles and principles" (Asant and Zwi, 2007) appears appropriate to be employed in this study. The analytical framework will be based on a conceptualization of equity, along with how public private partnerships in health system are expected to improve equity. As earlier mentioned three different streams are to constitute the conceptualization of equity in this study, namely, equity through *participation*, equity in *resources* and equity in *access to health care*. Firstly equity through participation (*i*) will in this paper regard the participation of health system users. As playing costumers, the poor are deemed to be more inclined to complain about bad service and hold service providers accountable (Ruckert, 2011:14). As Seen in Venezuelan case the personal involvement of the users of services helped to provide an efficient and equitable service provision (Jütting, 1999:8). Equity in resources (*ii*) refers to public and private sectors potentially gain from one another in the form of resources, technology, knowledge and skills, management practices and cost efficiency (ADBI, 2000 in Raman and Björkman, 2006:77). PPPs are argued to have a positive indicator for the distribution resources in health systems especially gaining the most vulnerable groups of populations (Karra et.al, 2010:4). Equity in access to health care (*iii*) concerns the geographical and socioeconomic context. PPPs are as earlier mentioned PPPs are expected to improve accessibility in health care systems. However, in order to access health care services, several factors need to be considered. According to Homedes and Ugalde (2005:90), the neoliberal health reform in Colombia, indicates that expanded affiliation does not imply higher coverage. Subsidies do not always reach the neediest (Homedes and Ugalde, 2005:91). Acknowledging that socio-economical as well as geographical constrains can hinder some groups of a populations access to health services, equity in access is seemly of complex matter.

Consequently the concept of equity is turned into thematic headings in this analytical framework. According to Holiday (2007:94) the formation of themes represent the necessary dialogue between data and researcher. In order to provide a comprehensive yet succinct analysis, thematic headings seemed appropriate for this study.

4 Methodology

This chapter will provide overview of the field study carried out 6th of January until 12th of March 2012. Firstly the research design will be explained and discussed. Thereafter some considerations regarding the researcher's position will be given space. Empirical material will be touch upon when translation of material and also different type of material is presented.

4.1 Constructing a case study

The intention of this study is to generate insight on a single case. The material conducted only concerns the health care reform, SNIS. Experiences of the health care reform are conducted on three different levels namely formulation level, implementation and micro level.

Uruguay as stated before is considered as the welfare state of Latin America. Acknowledging this title, the Uruguayan health care reform constitutes an interesting case. The reform is of neoliberal character, thus could be interpreted as a contradiction to what seemingly is a state of other than neoliberal structure. Engaging the private sector with improving the health care service for a low-income subpart of the population through a partnership with the public sector is seemly a complex challenges that requires considerations beyond institutional mechanisms.

The field work was carried out in Toledo, hence constitute for the principal data collected. Toledo is to be a proper sample for this case study based on following

considerations; firstly it is of great importance to verify the implementation of the health care reform outside Montevideo recognizing the spatial inequalities found in the state services. Secondly Toledo hold for a low income population and is positioned within the department in Uruguay that constitute for the highest numbers of rural poverty in the country. Since the principal aim of the reform is to decrease the gap between rich and poor within the health care system, it seemed highly important to focus on a poorer part of the population.

Within the context of the research topic the qualitative sets of methods seems to have significant strengths considering the following: firstly qualitative methods can be used for testing theories (Bryman, 2008:373). Meanwhile it is more common in the process of qualitative research that theories generates or emerge rather than testing those selected in the outset of the research. Secondly a qualitative set of research methods can provide deeper understanding of complex issues. When it comes to complexity of the policy process which this research concerns it could seemly be utilise these depth providing strengths of qualitative methods. Since the research questions regards both experiences and practical matters, utilize interviews of semi-structured character were apparent appropriate (Bryman, 2008:438) Thus, this type of interviewing follows a structure while allowing the emergences of new approaches to view the topic. Due to the time limitation and the focus of this research, interviews are based upon purposive sampling (Bryman, 2008:458).The selected persons for the interviews was choose on basis of their position within the policy process of the health care reform, thus on definition of who are relevant to the research question.

4.2 Reflexivity

The notion of reflexivity contains various significant parts. However reflexivity in research involves, according to Sultana (2007:376) reflection on self, process and critically examining power relations and politics in the research process, and researcher accountability in data collection and interpretation. Sultana

acknowledges that reflexivity is not something that should be added on in the final phase of the research hence argues that it is of great importance that reflexivity occurs from the beginning until the end of the research (Sultana, 2007:376). For this field work the notion of positionality and insider/ outsider status of the researcher has been a present element throughout the research process. This paper will provide some of the reflections made regarding my field study in Toledo, Uruguay.

The country is divided into departments, where the department of Canelones is part of Metropolitan Montevideo. The municipality Toledo is part of the Canelones department and consists of a low class and working class population. The field work in concern is carried out in Toledo hence constitute the principal data collected. The roads are mainly dirt roads, the characteristic houses are made of concrete material with tin roof and the main transportation is walking or motorbike. I was familiar with this neighborhood before the field work began. During my University studies in Montevideo a year earlier I got to know a family in this area. However being accepted as part of this family has been crucial for my integration with the people in Toledo. The culture in the area holds for strong family values, thus daily life is commonly shared in large families. As stated by Sultana (2007:378), the important thing for me was to be as faithful to the relations in that space and time, and to the stories that we shared and the knowledge that was produced through the research. In everyday life, I took every opportunity to gain more understanding for my research topic. Relaxed conversations in waiting-lines, or at the buss-stop opened up for an improvement in the understanding of the different issues involved in the topic for my research, which inspired and supported the formulation of the interview guides. As for communalities, discussed by Sultana (2007:378); my nationality, gender, ethnicity, attire, I focused on staying true to these communalities, while putting effort into integrating in the rural and social context, being careful in not proceed to far and risks to be perceived as an outsider pretending to be an insider. Furthermore, the notion of insider or outsider status is complex thus should be carefully used. Mullings (1999:340) argues that the binary implied in the

'insider/outsider' debates, however, is less than real because it seeks to freeze positionalities in place, and assumes that being an 'insider' or 'outsider' is a fixed attribute. The insider/outsider binary in reality is a boundary that is not only highly unstable but also one that ignores the dynamism of positionalities in time and through space. No individual can consistently remain an insider and few ever remain complete outsiders. Endeavors to be either one or the other reflect elements of the dualistic thinking that structures much of Western thought (Mullings, 1999:340).

Acknowledging the discussion by England (1994) on the increasing wary surrounding positionality and 'objective research', these are highly complex matters. However analyzing ones role as a social researcher also involves making statements regarding the value and definitions encapsulated in the concepts. Are there value-free research? Could a researcher be truly aware of all the biases that social research comprise? Greenbank (2003:792) argues that the researcher values are embedded in the choice of research methods. The choice of methods will thus be influenced by the researchers underlying epistemological and ontological position. According to Greenbank (2003) the inclusion of reflexive accounts and the acknowledgement that educational research cannot be value-free should be included in all forms of research.

4.3 Translation

The spanish spoken in Uruguay can vary diminutive depending on area. In Toledo the language includes some slang that is slightly different from the common vocabulary in Montevideo⁶. While interviewing the health system users in Toledo, what vocabulary to employ, was carefully considerate, since the insider status might be affected. The two other groups of interviewees were met with the same strategy, hence considering the context for the interview to determine vocabulary (e.g ministry or health clinic), however in these cases not aiming at gaining insider status. All interviews were conducted while videotaping, the assistant for

⁶ Observations from the field study carried out in January until March 2012, in Uruguay supports that certain areas seemingly differ in vocabulary used in daily life conversations.

this job was a native Uruguayan from Toledo, Yonhatan Rodriguez. It was beneficial to be accompanied by a known person from the area, when constructing the interview guides for interviewing the health care system users in Toledo. The assistant was not employed with translation, thus the material was directly interpreted by the researcher. The transcription included the translation of all material from spanish to english. For the transcription (hence the translation) part of the research, video recordings were significantly helpful, since video recording provides the body language and expression of the person speaking, however some argue that audio tape is for almost all research purposes fully sufficient (Glesne, 1999:79). Hence for this research video were employed due to the challenge of language and translation. The transcribed and translated material was subsequently coded in accordance with the previously presented analytical framework⁷

4.4 Empirical Material

4.4.1 Interviews

For this study the semi-structured interviews were conducted from three different groups: five interviewees on micro level (health system users), three implementers (doctors, employed in either public or private health sector). Finally two health ministry workers (who took part in formulating the reform) were interviewed. In the analysis these three groups will be presented as:

- Group T: Health system users in Toledo. Referred to as: T1-T5
- Group D: Doctors employed at clinics in Toledo. Referred to as: D1-D3
- Group M: Health Ministry Workers, employed at MSP. Referred to as: M1 and M2.

⁷ Codes included three categories namely: participation, resources and access to health care. The material were cautiously categorised, however not all material was considered as relevant and therefore not presented in this paper. Note: Video recordings from all interviews conducted are available.

The material, since collected from different stages of the policy process of the health reform, allows a broad analysis on various aspects that could be found within these different stages. The vast limitations for what the material could count for is however explicitly acknowledged hence recognizing the issues of generalizations. The approach in the analysis will be considering the material collected regarding the health reform in Uruguay as a case of a public private partnership in health provision thus continuously draw on connections to the broader discussion.

4.4.2 Observations

While being in, several participatory observations were conducted, many times without intention. Living in Toledo, under more or less the general standard in that neighbourhood, provided crucial situations and experiences. These revealed important features of the health care system which hardly could be discovered in an interview situation. From the amount of observations from the field study, one of these is to be a part of this paper. The reasons for choosing this observation in particular is based on the consideration that it capture the vulnerability⁸ that tend to be reality for many health system users in Toledo.

5 Analysis

This chapter will firstly provide a placement of SNIS within the analytical framework. Thereafter some general considerations and empirical regarding the implementation of the health reform will be presented and discussed. The main body of this chapter however constitute of an analysis based on the earlier described analytical framework. Finally a concluding analysis will be given, where all parts of the analysis will be reflected upon.

⁸ The majority of people [health system users] that I got in contact with in Toledo during the field study lived under conditions where no possibility of savings, insecure employments (where contracts for salary payment were often broken or unfulfilled). The location of residence was seemly a factor that increased the challenge to manage household economy since much of public services mainly are located in Montevideo.

5.1 The public private model in Uruguay

When evaluating public private partnerships, one issue to confront is the difficulty to establish a clear, consistent division between which organizations should be considered ‘public sector’ and which organizations should be placed in the ‘private sector’ (Barr, 2007:22). In the Uruguayan health care model, the public sector consists of ASSE, which is the public health institution, decentralized from the Ministry of public health (MSP). The private sector engaged in the health care system constitute of various non-profit entities (MSP, 2010:21). Acknowledging the absence of uniformed definitions of PPPs, SNIS, created upon common objectives and responsibilities, stated and shared by both public and private sector, consequently follows the commonly accepted definition on such partnerships (Jütting, 1999:5). In 2008, Uruguay’s parliament approved a bill (no:18.211) to reform the health care component of the social security system, the creation of SNIS, geared to:

“extending comprehensive care to all residents and to guarantee equitable and universal coverage through a coordination of the public and private health sector” (Bergolo, 2011:7).

Stated in the official documents by the public health ministry, one of the principal objectives of the health care reform in Uruguay is to improve the equity within the health care system (MSP, 2010). Recognizing PPPs claimed capacity to enhance equity in health care system, this would imply that the public private model for health care delivery in Uruguay would improve the equity within the health care system in the country.

According to Mirafteb (2004:98) the details of the partnership contact, though extremely important, cannot alone ensure equitable process and outcome. Particular attention must be paid to a programs social, economical and political environment. As for the case of Uruguay the healthcare system was highly segmented before the reform. The private providers had only clients that could pay the relatively costly fees, hence as well as a very small group of health insured workers. Consequently the reform brought a crucial change in what type of clients that could access the care provided by private entities. The affiliation through FONASA opened up for a low income part of the population that never

before had been affiliated for the private health entities. The context of the old health system, both social and economical, was significantly separating rich from poor, thus the environment where the health reform was to be implemented could seemly be challenging an equitable process and outcome.

Indicated in by the empirical data collected, the shift in health provision due the reform was a brutal change. As an interviewee, Shirely Ramirez Melian, a single mom in Toledo explained:

“It was implemented one day to another, it didn’t have a process”

(Interview nr:T3).

The institutions involved experience a vast change. The context in which the reform was implemented consequently not only regards the political or administrative sphere but the environment in which the health system users are to be attained. According to Dr Delferro, who works at a private clinic in Toledo, some great changes have come with the reform. The interviewee states:

“It is more equal in every way, now we are attending people with very low income”.

(Interview nr: D1)

However several times the interviewee Dr Delferro indicates concern towards this new group of clients. With the document in hand, which through FONASA allows you to affiliate for private health providers, the interviewee expresses:

“People come here with this paper, because they do not want to work”

(Interview nr: D1).

Thereafter the interviewee declare, what could seemingly be an alarming differentiation:

“You have to look a little closer at what type of people that can enter, the other type will have to stay with public health care”

(Interview nr: D1).

Nishtar (2004:3) stresses that if PPPs are not carefully designed, there is a danger that they may reorient the mission of the public sector, interference with organizational priorities, and weaken their capacity to uphold norms and regulations. Such shift is likely to displace the focus from the marginalized and may therefore be in conflict with fundamental concept of equity in health. As earlier mentioned, one of the main features of the old health system was the segmentation between poorer and richer parts of population. One of the main objectives of the reform was to decrease this segmentation through the creation of an integrated system (MSP, 2010). The segmentation consequently, required significant consideration when implementing the health care reform. The director of SNIS, Elena Clavell, explains in an interview the issue of segmentation within the health care system, which is seemingly of a complex matter:

“A group of the population emigrated to private providers. It starting to become a mix within the system, in public and private. It is not that elitist as before, it began to change. There are privates that are aiming at capturing this [affiliated through FONASA] part of the population and now the start having similar problems that before was characteristic for ASSE. The work with a vulnerable part of the population requires another type of attention. It starts to show. We are far from breaking the segmentation. We learned how to live with this gap, and now step by step begin to work on it, but still far from considerer that the system has solved this problem”.

(Interview nr: M2).

This statement indicates that there is still an existing gap, which might challenge the improvement of equity in the health care system. In the following analysis the earlier discussed streams of equity will separately be analysed.

5.2 Equity through participation

Participation is considered to be imperative as it potentially contributes to a better governance practices by improving accountability. Accountability in PPPs could be defined as players held accountable for the delivery of efficient and equitable services in a partnership arrangement (Nishtar, 2004:5). As playing costumers, the poor are deemed to be more inclined to complain about bad service and hold service providers accountable (Ruckert, 2011:14). In SNIS, participation of health

system users is a key object (MSP, 2010), however according to empirical material there are seemingly difficulties in achieving this objective. Material from interviews with doctors in Toledo indicates that the assumed participation is not to be found. As Dr Paleo, who works at a clinic in Toledo states:

“Here there is no participation”

(Interview nr: D2).

The idea of participation, as a mechanism for the health system users, means improve the likelihood of requiring accountability from the health care providers. Though, as seemingly found in the empirical material, it could be difficult to enhance the participation in a contexts where never practiced before. Otilia Silvia, a retired woman in Toledo explains :

“They [the people in the village] think that you are out of your mind if you try to organize any complains ”

(Interview nr: T5).

Not only the social context but geographical context might determine participation, the sense of exclusion due to residential location, according to Otilia Silvia there is no one to turn to in this area (Interview nr:T5). The lack of institutions to turn to (or lack of information on where these are) might be a serious obstacle when considering Jütting (1999:9) “Without the active participation of the communities and the municipalities it is difficult to build a functioning and sustainable health care system”.

Moreover participation in terms of litigation is of a costly nature. (Corduneanu-Huci and Hamilton and Masses-Ferrer, 2011:6) To hold a health care provider accountable by law would mean a financial situation which the main part of the health system users interviewed could not afford. This could possibly create obstacles in holding health care providers accountable. According to Jütting (1999:8) there must be interest and a commitment of some individuals to make a

PPP happen. As seen from the Venezuelan case the personal involvement of the users of services helped to provide an efficient and equitable service provision. Following this view there might be significant improvements to achieve in additionally encouraged through more extensively geographical coverage in institutions to turn to and improved information regarding affordable suggestions on how to hold providers accountable.

5.3 Equity in resources

As previously discussed PPPs are argued to have a positive indicator for the distribution resources in health systems especially gaining the most vulnerable groups of populations. Presumed benefits of partnerships are improvements in quality of services, reduced cost of care either due to competition or through economies of scale, redirecting the public resources to other areas, reduction in the duplication of services, adoption of best practices, targeted services to the poor and better self-regulation and accountability (Raman and Björkman, 2006:8). According to Karra et.al (2010:4) PPPs provide opportunities to capitalize on strengths, maximize the use of existing capacity, create competition, achieve economies of scale, extend service delivery networks, target the poor, and mobilize additional resources. Before the reform the resources within the health system were highly imbalanced between the public and private sector where the latter held for more advanced and better resources than the former. One of the attempts of the reform was to establish a resource network between the sectors, to overcome the mentioned imbalance.

The empirical material collected in Toledo is as earlier mentioned collected from both health system users and doctors (implementers of the reform). The interviewees that were attained or worked at the public clinics (Policlinica Casarino and Policlinica Toledo) had very similar experiences concerning the resources that these clinics hold for. In various ways indicators reveal that public sector in Toledo has scarce resources to fulfil the objectives⁹ of the

⁹Universal health care to the entire population, in levels of accessibility and homogeneous quality (MSP, 2010)

reform.(Interview nr T2, T4, T5, D2, D3). For instance few doctors are supposed to attain overpopulated clinics. Dr Paleo, one of the two doctors working at Policlinica Casarino, in Toledo describes the improvements of model of attending the clients, however he explains:

“We are working with less resources than what we would need to improve the quality of the services”

(Interview nr: D2).¹⁰

The empirical material indicates that this problem of resources mainly regards the public health sector, the quality and quantity of medicine is not of the same as at the private providers, and deficiency of certain medicines are common (Interview nr: T5, D2, D3).

Partnership between public and private sector are most likely controlled by regulations or frameworks for responsibility. In SNIS there are certain mechanisms employed to enhance the responsibility regarding the implementation of the reform. Consequently the doctors are required to follow and achieve goals stated. These, *Las metas* (The goals) concerns both private and public sector health providers and constitute for a quantitative approach to evaluate the persons attained at the health clinics. Marcelo Setaro, health ministry worker describes in interview that covering evaluations are unfortunately very costly, he explains:

“The goals are quantitative”

(Interview nr: M1).

The empirical material indicates a difference in how public and private sector interpret these goals. As states by Dr Delferro, working at a private clinic (Medica Uruguay) in Toledo:

¹⁰ Observation: Meanwhile interviewing this doctor, the nurse at the clinic, interrupts the interview, asking the doctor [interviewee] for advice on how to solve a deficient a certain medicine. The patient in concern needs a medicine that is according to the nurse not to find at any public clinic or pharmacy in the area.

“I fulfil a hundred percent of the goals”

(Interview nr: D1).

Seemingly satisfied with what the goals captures. Though Dr Virginia Cozzolino, doctor at a public clinic in Toledo, has a seemingly a different view. When asked during the interview if she experienced that the evaluation [las metas] are enough to understand how the situation for the patients really are, the interviewee responds by asking:

“Do you want the lie or the truth? Because in reality, this form is the most visible, there are high expectations and not enough resources”.

(Interview nr: D3).

During the interview she explains that the goals are not enough to ensure that people really get attended. Dr Cozzolino states:

“I can just fill in this paper and say that every patient was attained and it will look perfect”¹¹

(Interview nr:D3).

Some empirical material point towards that the public sector has resources of good quality, even resources of equal quality as those in the private sector. However the empirical material indicates an important issue, namely several of interviewed health system users in Toledo supports that there is a difference in resource distribution within the public sector (Interview nr: T2, T4, T5.). The director for SNIS, also indicates the differences of resources within the public sector. Meaning that in n some parts of the country the public health sector is superior to the private sector entities in resource quality (Interview nr: M2). When interviewing Otilia Silvia, a retired woman in Toledo she explains:

¹¹ In the following text more attention will be given to what the doctors at this clinic experiences as challenges in provision of health care in Toledo.

“Public health has perfectly equipped hospitals and the best specialists, but it is all in Montevideo. In this area, there is nothing. What is lacking in public health is here, in this area, in Montevideo it is totally different, nobody cares about improving this area. If someone actually cared to improve here, we would already be better off”.

(Interview nr: T5).

Seemly equity in distribution of resources between the public and private sector has improved due to the health care reform, however the distribution within each sector requires further consideration. In the following section some part of this issue will be given space, when discussing equity in access to health care.

5.4 Equity in health care access

Considering geographical aspect [location of services], the empirical material collected in Toledo indicates that the private sector clinics have not reached out sufficiently to this area. Dr Paleo, working at a public health clinic, in Toledo explains:

“Here there are not many privates providers”.

(Interview nr: D2).

Consequently those who live in Toledo and are affiliated for private providers, most likely has to go to Montevideo to get attained. As seen in the case of the Colombian health reform health increased affiliation does not have to indicate higher coverage (Homedes and Ugalde, 2005:90). Technically, the health care system allows all citizens of Uruguay to health care through universal coverage. However this study reveals experiences that universal coverage does not guarantee access. Indicators of this can be found in both public and private sector.

An important aspect in accessing health care is seemingly affordability. The attendance for an affiliated person at a private health provider includes co-payments for the client. These co-payment, according to the empirical material, effects decisions of which health provider to chose. Those affiliated through FONASA are allowed to a free choice¹² between public or private providers (MSP, 2010). Doctors as well as health system users describes that at first many, that were allowed, changed from public to the private providers. As stated by Dr Paleo, working at a public clinic in Toledo:

“They could sign up and get membership at the private providers, but when the moment came to access the services, they couldn’t maintain it economically”

(Interview nr: D2).

This would imply that subsidised health care through FONASA was not enough to give health system users access to the services of the private providers. Homedes and Ugalde (2005:91) stresses the fact that subsidised does not always reach the neediest. These co-payments constitute a hinder for accessing health services at the private providers. Moreover there is evidently an economical aspect on how to *get to* the services. As already discussed the private providers are scarce in Toledo, consequently accessing services at private provider does in most cases include the cost of transportation. This cost could make the difference of accessing health service or no. According to Virginia, a doctor working at a public clinic in Toledo, the costs for the bus ticket can be determining if some patients are able to access health services or no. The clients that are attained at this public clinic in Toledo are those who are not allowed through FONASA. This would imply that this group has no other choice than attain themselves at this clinic. As discussed earlier, obstacles to distribute resources within the public sector are seemingly affecting the health system user’s possibility to get access to services. As the interviewee Dr Cozzolino, doctor at a clinic in Toledo explains:

¹² In official documents provided by the MSP it is stated that every health system users who is allowed through FONASA, has the free choice of health care provider (both private or public).

“If we need to give money to the patients to make them go to Montevideo, we do that here. There are things that you have to do”

(Interview nr: D3).

There is seemingly an existing vulnerability for a subgroup in the health care system. Recognizing that some suffer economical obstacles to access close by health providers, meanwhile living far from where good quality health care is economically affordable. The issue of emergency care within the health care system can be found in the material from several of interviews conducted. There are evidently vast deficiencies in the geographical coverage of emergency assistance, for instance ambulances (Interview nr: T1, T2, T3, T4, T5, D2, D3). Otilia Silvia, a retired woman in Toledo describes:

“If something happens at night [emergency], there is no way to get out from this area, if you don't have money”

(Interview nr: T5).

The discussion concerning emergency care could accordingly be placed in the earlier considered *equity in resources*, however it is a matter that also regards access. In Toledo it is according to most interviewed health system users almost impossible to access a public ambulance. As Shirley Pirez, a housewife in Toledo, explains:

“There is only one ambulance in the area and if you call they would never send it, because it is occupied with another person or because that it is broken. If you call the police they will drive you, but only if they have a car available. They do not have any medical devices, only the car. We don't bother to call the ambulance, because if you call SAPP (private health care provider) they charge you, if you are not affiliated to them, around 2000 pesos, but it could be more now. Instead you go out in the street and beg passing cars to drive you”.

(Interview nr:T2).

Considering the cost for the private entity ambulance in the neighbourhood that the interviewee mentions, it is seemingly an impossible amount to pay for an individual such as herself, that does not have an income, or for earlier mentioned interviewee Otilia Silvia, that earns 2900 pesos per month¹³. The deficiency of public emergency care is an acknowledge problem in the area, there is an ongoing struggle to get one or two more public ambulances to attain the area (Interview nr: T1). Interviewee Walter Lacuesta explains that if you call for a public ambulance, they will not come. He is affiliated at a private provider that does not have a clinic in the area. The interviewee states:

“If you call to Montevideo [to his private health care provider] for an ambulance, they tell you that they do not cross the border” [which separates the departments of Montevideo and Canelones]

(Interview nr:T1).

Equity in access to health care from this point of view is seemly not fulfilled in this area, since location of residence or economic situation determines if an individual can access for instance emergency health care.

As previously mentioned, an observation made during field study embodies a vulnerability that seemingly exists within a group of heath care system users in Toledo. The observation highly regards accessibility of health care.

Observation No:I

Maria Mabel Alvez – When health is not an option.

In Toledo, positioned within the department of Canelones, works fifty-seven year old Mabel Alvez, in a child-care centre. She works double shifts, being also the security guard for the child centre six nights a week. Despite the amount of hours working, she barely manages her household economy. Her blood pressure is due to stress dangerously high, she tells me that the doctors time after time requires her to come to the hospital in Montevideo do examinations to get the right treatment. Through the changes due to the health reform, she is allowed to affiliate for private health care providers. Her service is through a private entity

¹³ See in Appendix: Interview nr:2 and Interview nr:5.

that does not have any clinics or hospitals in Toledo or close by. Not affording car or motorbike, leaves Mabel depending on the local busses to take her to the hospital in Montevideo to do her exams. The price for the buss-ticket is constantly increasing, small changes which in these neighbourhoods can have vast effects on families' household economies. The challenges for Mabel are firstly that the visit at the doctor comes with copayments. You need to pay for meeting the doctor, for every exam the doctor will make and for every recipe you will get for medication, even what Mabel would need to pay is subsidised to a much lower prices that before the reform, this price in not low according to Mabel. Secondly she needs to leave a day from work to go to Montevideo, since the busses are highly irregular and the waiting at the doctors can be long. Thus she will lose a day at work and all income for that day. Consequently the costs for attaining her health are too high and Mabel did therefore not follow up the doctor's requirements concerning her high blood pressure. One day in my field study I get interrupted in my work by one of the daughters of Mabel storming into my house, Mabel is hospitalized for a stroke. I accompanied Mabel the two weeks at the hospital and through the complicated surgery she went through to return to her normal life. The doctors said that she was very lucky.

The observation portrays a health care system user's apparent *priority*, that the empirical material from interviews support (Interview nr: T1, T4, T5, D3). With low income and no possibility to savings, maintaining good health tends to not be prioritized. Consequently this could have vast effects on an individual, hence also entire families' health.

5.5. Concluding Analysis

(i) Equity through participation

The potentials that increased participation holds are apparently great. The participation of health system users might significantly improve the understanding for what is needed to achieve the objectives of the health care reform. As seen in this paper there are experienced for instance disclose deficiencies in access to health care, thus the participation of health care users could supply aspects that reveal important features of these issues. Participation to hold health care providers accountable are according to the finding of this study not fully achieved. As earlier discussed the experienced lack of participation is most likely due to several factors. Lack of (or lack of information about) someone to turn to with complains creates obstacles in holding health providers accountable. Moreover the

presumed effect of health system users as ‘customers’ are expected to require accountability of health system providers visibly includes hinder. As the empirical material indicates, being attained at the private health providers is despite the health reform costly. Difficulties in prioritizing health have been indicated in both interviews and observations. Thus the economic spending for holding a health care provider accountable might not be prioritized. A potential risk would be that affordability would distinguish which of the health system users that mainly can participate in requiring accountability.

(ii) Equity in resources.

There is a visible improvement in the resource distribution between the public and private sector. Potentials could be found in the increasing competition between public and private sector. However risks involved could be seen in distribution of resources within each sector. The empirical material concerning this risk, primary regards public sector. In public sector an imbalance in resource distribution can be seen. This results in areas where public sector has vast deficiencies in resources. Moreover the empirical material reveals a tendency of lack of resources hindering the provision of good services.

(iii) Equity in access to health care.

The empirical material reveals a tendency of health coverage without access to health care. This tendency could be explained through several factors. For the health care system users affiliated to private providers, co-payments are one obstacle. The location of health care services is evidently affecting the health system users in Toledo. Living far from where health care is provided is costly, in terms of transport and loss of income. Moreover the location can increase a risk and vulnerability for the health system users. For instance a vast deficiency in access to emergency health care can be found in the empirical material.

6 Conclusion

The aim of this study was to provide and insight on how the health care reform in Uruguay is evolving. Utilizing a qualitative approach this study seek to answer: *From an equity perspective: What are the main potentials and risks of the public and private health care model in Uruguay?*

All in all, enhance equity in health systems apparently requires multiple considerations. A Methodological conclusion to be drawn is that the qualitative approach of this study was allowing the revealing of issues that most likely would have been missing if utilized a quantitative approach.

The empirical conclusion to be drawn from this study regards both risk and potentials to enhance equity by using a public private model for delivering health care in the case of Uruguay. Affiliation at private health care providers, visibly do not guarantee access to health services within these entities. Moreover health system coverage does not imply guaranteed access to health care services needed. Confusing affiliation or health system coverage with actual access to health care can be seen as the main risk revealed in this study. The risk of not affording to prioritize health care is seemingly a fact. The visible potentials are mainly that enhanced participation of health system users could improve the understanding of why the revealed risks occur. Moreover the potentials of qualitative evaluations of the health reform are visibly vast.

Future research is advocated to examine if certain risks mentioned in this study might point at issues to be found on a theoretical level. PPPs in health provision are, as previously stated, strongly advocated. In the case of Uruguay, future research is suggested to examine the potential inherent restraint in the public private model, in overcoming mentioned risks. The complexity of enhancing equity through a public private partnership requires considerations if the model as such is applicable.

Appendix - Interviews

Group: (T) Health system users, Toledo.

Interview nr	Name	Personal data	Income /month ¹⁴	Date of interview
Nr: T1	Walter La Cuesta	51 year old, Construction worker	18 000p	2012-01-23
Nr: T2	Shirley Pirez	38 year old, Housewife	No income	2012-01-23
Nr: T3	Shirley Natalia Ramirez Melian	28 year old, School worker	9000p	2012-01-27
Nr: T4	Javier Cabrera	38 year old, Brick builer	20 000p	2012-01-28
Nr: T5	Otilia Silvia	57 year old, Retired	2900p	2012-01-31

Group: (D) Doctors at Public Private clinics, Toledo

Interview nr	Name	Type of clinic	Income/month	Date of interview
Nr: D1	Dr Alvaluz Delferro	Private clinic, "Medica Uruguay", Toledo	120 000p	2012-02-10
Nr: D2	Dr Gonsalo Paleo	Public clinic, "Policlinica Casariono", Toledo	32 000p	2012-02-14
Nr: D3	Dr Virginia Cozzolino	Public clinic, "Policlinica Toledo", Toledo	41 000p	2012-02-14

Group: (M) Health Ministry Workers, MSP Uruguay

Interview nr	Name	Position at the Ministry of Public Health, Uy	Date of Interview
Nr: M1	Marcelo Setaro	Strategic Planning Manager at the MSP	2012-02-23
Nr: M2	Elena Clavell	Director of the Integrated National Health care System, SNIS	2012-03-02

¹⁴The Uruguayan currency *pesos*. (1000 p = 50 US dollar). <http://www.preciodolar.com/dolar-hoy>

Bibliography

Asante, Augustine D and Zwi, Anthony B (2002) "Public-private partnerships and global health equity: prospects and challenges" *Indian Journal of Medical Ethics*, 4(4)

Barr, Donald A (2007) "A research protocol to evaluate the effectiveness of public-private partnerships as a means to improve health and welfare system worldwide". *American Journal of Public Health*, 97(1):19-25.

Bergolo, Marcelo and Cruces, Guillermo (2011) "Labor informality and the incentive effects of social security: Evidence from a health reform in Uruguay". *CEDLAS. Centro de Estudios Distributivos, Laborales y Sociales*. Universidad Nacional de La Plata.

Borgia, Fernando (2008) "Health in Uruguay: Progress and challenges in the right to health care three years after the first progressive government". *Social Medicine* .3(2).

Bryman, Alan (2008) *Social research methods*. Oxford University Press. Oxford.

Buse, Kent and Harmer, Andrew (2004) "Power to the partners?: The politics of public-private health partnerships". *Society for International Development*. 47(2):49-56.

Corduneanu-Huci, Cristina and Hamilton, Alexander and Masses-Ferrer, Issel (2011) "The political economy of healthcare litigation, Model and empirical application to Uruguay". TheWorld Bank. *Policy Reseach Paper*, No.5821.

De Grote, Tony and De Paepe, Pierre and Unger, Jean-Pierre (2005) "The Consequences of Neoliberalism: Colombia: In vivo test of health sector privatization in the developing world". *International Journal of Health Services*, 35 (1):125–141.

England, K (1994) "Getting Personal: Reflexivity, Positionality and Feminist Research" *The Professional Geographer*, 46 (1):80-89.

European Commission (2007) *Uruguay Country Strategy Paper* No. 613
http://eeas.europa.eu/uruguay/csp/07_13_en.pdf

Glesne, C. (1999). *Becoming qualitative researchers: An introduction* .2nd ed.. New York: Longman.

Goel, Naveen K and Galhotra, Bhiruchi and Swami, Hari M (2007) "Public private partnerships in the health Sector". *The Internet Journal of Health*, 6 (2).

- Greenbank, Paul (2003) "The role of values in educational research: The case for reflexivity", *British Educational Research Journal*, 29(6).
- Hastings (1999) "Analysing Power Relations in Partnerships: Is There a Role for Discourse Analysis?". *Urban Stud January*, 36(1):91-106
- Holiday, Adrian (2007) *Doing and writing qualitative research*. London: Sage. 2nd edition
- Homedes, Núria and Ugalde, Antonio (2005) "Why neoliberal reforms have failed in Latin America". *Science Direct, Health Policy* 71:83-96.
- Jütting, Johannes (1999) "Public-private partnership and social protection in developing countries: the care of the health sector". *Centre for Development Research (ZEF)*
- Karra, Mahesh and Sharma, Suneeta, and Vargas, Manuel (2010) "Fostering public-private partnership to reduce health inequalities in Peru". USAID.
- Larner, Wendy (2000) "Neo-liberalism: Policy, Ideology, Governmentality". *Studies in Political Economy*, 63:5-25.
- Marsch, David and Stoker, Gerry (2002) *Theory and methods in political science*. New York: Palgrave.
- McChesney, Robert W (1999) "Noam Chomsky and the struggle against neoliberalism". *Monthly Review*, 50(11).
- Miraftab, Faranak (2004) "Public-Private Partnerships: The Trojan Horse of Neoliberal Development". *Journal of Planning Education and Research*, 24(89):88-101.
- Mooney, Gavin (1987) "What does equity in health mean?". *Institute of Social Medicine*, 40(4):296-303.
- MSP (2010) *La Construcción del Sistema Nacional Integrado de Salud*. Uruguay: Ministerio de Salud Pública.
- Mullings, Beverly (1999) "Insider or Outsider, Both or Neither: Some Dilemmas of Interviewing in a Cross-cultural Setting". *Geoforum*, 30(4):337-350.
- Nishtar, Sania (2004) "Public-private 'partnerships' in health – A global call to action". *Health Research Policy and Systems*. 2(5).
- Oliver, Adam and Mossialos, Elias (2004) "Equity of access to health care: outlining the foundations for actions". *J Epidemiol Community Health*, 58:655-658.

- Pribble, Jennifer E (2010) "Universalizing Healthcare Policy in Chile and Uruguay". Paper Prepared for delivery at Annual Meeting of the American Political Science Association, Washington DC.
- Raman A, Venkat and Björkman, JW (2006) "Public-private partnership in health care services in india", *Health Administrator*, 21:62-77.
- Reich, Michael R (2000) "Public-private partnership for public health". *Nature Medicine*, 6(6):617-62.
- Reich, Michael R (2001) *Public-private partnership for public health*. Harvard Center for Population and Development Studies. Cambridge, US.
- Ruckert, Arne (2011) "The World Bank and Public Private Partnerships: Redrawing the Boundaries of Public and Private in Global Governance". Paper presented at the ISA Annual Convention 2011, Montreal, 16-19 March 2011.
- Sultana, Farhana (2007) "Reflexivity, Positionality and Participatory Ethics: Negotiating Field Work Dilemmas in International Research". *ACME: An International E-journal for Critical Geographies*, 6 (3):374-385.
- Wallace, Steven P and Gutiérrez, Verónica F (2005) "Equity of access to health care for older adults in four major Latin American cities". *Rev Panam Salud Publica*.17(5/6):394-409.
- Weintraub, Jeff (1997) *Public and Private in Thought and Practice: Perspectives on a Grand Dichotomy*. The University Chicago Press, US.
- UNDP (2011) *Report of the field visits of the Executive Boards of UNDP/UNFPA/UNOPS to Uruguay 26 February – 4 March 2011*. New York.
- USAID (2010) "EQUITY framework for Health". *Health Policy Initiative*. United States Agency for International Development.

