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A Case Study on Ecuador's Health Reform towards Universal Health Coverage: Challenges and Achievements

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ABSTRACT

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Universal Health Coverage (UHC) is a global health goal that does not only translate into good health outcomes but also drives economic growth and development. After a period of deep political, economic and social crisis, the Ecuadorian government identified the need to improve the National Health System (NHS) through a series of institutional reforms with the goal of achieving UHC for the Ecuadorian population. With the recognition of the right to health in the Constitution, UHC has become a fundamental health goal for Ecuador.

This study aims to explore the trajectory of the NHS reforms in Ecuador.

The reforms are analyzed using a descriptive approach and referencing a selection of indicators utilized by the WHO for monitoring UHC. Four dimensions of UHC are analyzed: the right to health, population coverage, health financing systems and access to services. Moreover, the achievements and challenges of the reforms are discussed from the perspective of institutional change using the New Institutionalism theory. Findings show that there have been noteworthy advancements towards the attainment of UHC; however, this goal is still on the far side considering the institutional limitations, as well as the ability of the government to sustain health funding. The study describes the government's attempt to improve the institutional architecture of the NHS through the adoption of the Integral Health Model and the Integral Public Health Network, aimed at fixing the historic fragmentation of the public health system. However, findings show these attempts have only been incremental despite the significant increase in health budget. Other key challenges for the government include the low coverage rate under the public insurance scheme as well as the high rate of out-of-pocket expenses incurred by households. Tackling some of the challenges presented in this study represents an opportunity for future governments to move closer towards the attainment of UHC and reduce poverty and the deep-grounded inequalities characteristic of Ecuador.

Keywords: Universal Health Coverage, Health Care Reform, National Health System, New Institutionalism

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Table of Contents

List of Tables and Figures

List of Abbreviations and Acronyms

CONASA	National Health Council
FONSE	Ecuadorian National Health Fund
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IESS	Ecuadorian Social Security Institute
IMF	International Monetary Fund
INEC	National Institute of Statistics and Censuses
ISSFA	Armed Forces Social Security Institute
ISPOL	National Police Social Security Institute
LAC	Latin America and the Caribbean
MAIS	Comprehensive Family and Community Health Care Model
MDG	Millennium Development Goals
MERCOSUR	Southern Market
MF	Ministry of Finance
MPH	Ministry of Public Health
NCD	Noncommunicable Disease
NHS	National Health System
NI	New Institutionalism
OOP	Out-of-pocket (expense)
PAHO	Pan-American Health Organization
PHC	Primary Health Care

SDG	Sustainable Development Goals
RPIS	Integral Public Health Network
SENPLADES	National Secretariat of Planning and Development
SOLCA	Society for the Fight Against Cancer
SSC	Rural Social Security
SHI	Social Health Insurance
SHC	South American Health Council
TB	Tuberculosis
TSSE	Sectorial Transformation of Health in Ecuador
UHC	Universal Health Coverage
UN	United Nations
UNASUR	South American Union of Nations
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

According to the World Health Organization (WHO) the enjoyment of "*the highest attainable standard of health is one of the fundamental rights of every human being without a distinction of race, religion, political belief, economic or social condition*" (WHO, 1946). In its Constitution, the WHO defines health as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" (WHO, 1946). Universal health is also the 3rd Sustainable Development Goal (SDG) (United Nations General Assembly, 2015) and can help the world progress towards achieving all Millennium Development Goals (MDGs) related to health. The SDGs put health as a priority in reducing not just income inequalities but also the gender gap and improving access to services. In 2012, in a special declaration, United Nations (UN) Member States agreed to take the necessary steps towards achieving universal health coverage (UHC) by 2030, reaffirming the international community commitment towards UHC. This includes financial risk protection, access to quality health-care services, medicines and vaccines for all (United Nations General Assembly, 2013). The push for UHC is pressing given that the WHO estimates that every year about 100 million people fall into poverty because of health expenditures.

The first time the international community urged governments to attain UHC was on September 1978 during the International Conference of Primary Health Care which resulted in the Declaration of Alma Ata. The conference expressed the need for urgent action by all governments, all

health and development workers, and the world community to protect and promote the health of all the people of the world, asserting the notion of health as a fundamental human right and recognizing the inequality in the health status of people, particularly in developing countries. Furthermore, the Conference set the year 2000 as the target for governments, international organizations and the whole world community to attain a level of health that will permit the world's populations to lead a socially and economically productive life. The declaration asserted "*Primary health care (PHC) is the key to attaining this target as part of development in the spirit of social justice*" (International Conference of Primary Health Carre, Alma-Ata, 1978).

UHC continues to be the main public health objective worldwide. However, in many countries, it has not been given the political priority that it merits. The WHO has identified that there are at least 400 million people in the world that have no access to basic health services, and estimates that 40% of the world's population lack social protection. Additionally, the WHO affirms that countries that have less developed health systems can benefit greatly from improvements, noting that efficient health systems promote economic growth (WHO, 2017).

UHC consists on several principles, values and components, which countries apply differently, yet seeking the same goal. In the case of Ecuador, the government of Rafael Correa (2007-2017) pushed forward a series of necessary reforms to be able to meet the goal of UHC. Correa's government, socialist and democratic, moved away from the privatization

and commercialization of health systems that was predominant in the 1990s and focused on strengthening the role of the State. The consolidation of the Ecuadorian public health system and the guarantee of the right to health were a priority for the government of Correa who made a call to "reinstitutionalize" the State and hence, health provision. In this context, this paper aims to examine the Ecuadorian government reform process using the new institutionalism and its variants as the theoretical approaches that seek to explain whether the Correa Administration was able to generate institutional change for the attainment of UHC. It highlights UHC' global policy making process and explores the main factors driving UHC in Ecuador. Finally, in order to support the theoretical analysis of this study, the researcher includes a longitudinal analysis and assessment of Ecuador's health care reform during the period comprised between 2007 and 2014.

This paper will examine key lessons of Ecuador's implementation of UHC and will conclude with a series of recommendations for policy-makers in the health sector, to assist the sector's continuous reform process for the attainment of this goal. This study is relevant in the Ecuadorian context as the country strives to reduce social inequalities and meet national and international health targets.

1.1 Problem Statement and Objectives

Ecuador like other Latin American countries faces the country's deeply engrained poverty and inequality. In the study of public policy, Latin America and the Caribbean (LAC) has been often characterized as being the

region in the world with the most inequality which can be traced back to its colonial period. Since the 1960s, inequality has been higher than any other region of the world, including Sub-Saharan Africa (Deninger & Squire, 1996). Furthermore, during the region's transition into democracy which began in the late 1970's, inequality increased. The Gini coefficient per capita for the region increased from 48.4 in the 1970s, during an era of economic growth and authoritarian regimes, to 52.2 during the 1990s transition into democracy. (World Bank, 2003). During this transition, the region experienced highly volatile and modest economic growth with 44% of the population living below the poverty line in 2002 (CEPAL, 2003). For many scholars, the slow economic growth, and increasing inequality in the region were largely influenced by economic and social policies inspired by neoliberalism and the so-called Washington Consensus. International financial organizations prescribed market-driven policies and privatization of services. However, these market driven policies resulted in lower growth rates compared to the region's authoritarian developmental state era of the 60s and 70s. Asian countries, on the other hand, were more resistant to the neoliberal politics and continued to present high rates of growth with financial stability (Bresser-Pereira & Theuer, 2012).

Ecuador was the last country in the Americas to constitute a health Ministry (Guevara, 2011) with the creation of the Ministry of Public Health (MPH) in 1967. According to Guevara, since the MPH's inception, the public health system had been weak and characterized by its inequality. The 1990s was the peak of the neoliberal era in LAC, when the IMF and the World

Bank took advantage of the region's financial instability to provide loans under health reforms conditionalities (Guevara, 2011). These neo-liberal reforms included the privatization of health services, the encouragement of user fees, performance related pay, separation of the provider and purchaser functions, determination of a service package that privileges cost-effective medical interventions, and a stronger role for the private sector in health (Patrick & Dor, 2003). These neoliberal reforms did not improve quality of care, equity and efficiency (Homedes & Ugalde, 2009). They contributed to an increase in distrust and fear of impoverishment due to high health fees. This is evidenced by the percentage of people that were sick but decided not to seek medical care which accounted for 35% of the population in 1995 and 72% in 1999 (INEC, 2006).

After the neoliberal policies increased the inequality gap in the region, many Latin American countries opted to elect left-wing rulers. These included, Hugo Chaves in Venezuela, Evo Morales in Bolivia, Lula da Silva in Brazil, Ernesto Kirchner in Argentina, Rafael Correa in Ecuador, to name a few. These governments tried to build up a new developmental state based on the renationalization of oil and mining companies and the expansion of welfare programs including the adoption of UHC.

UHC has been adopted as a national goal by many countries worldwide under the notion that a healthy life for all is essential for human and economic development. Many literary works have sought to explain the path countries follow to attain UHC and have highlighted the beneficial outcomes associated to this goal. Achieving UHC does not only translate to

good health outcomes, but can drive economic development since it can drive people's productivity, educational performance and reduce poverty (Frenk & de Ferranti, 2012). For example, the report "Macroeconomics and Health: Investing in Health for Economic Development" finds a strong relationship between health and economic growth were an improvement in life expectancy at birth or longevity of a population is associated with an annual economic growth increase (WHO Comission of Macroeconomics and Health, 2001). Likewise, a study by the Lancet Commission on Investing in Health estimates a return of about $10 USD for every dollar invested in health services across the life course (Jamison, et al., 2013). Hence, achieving UHC is one of the bases for countries development and well-being.

This paper will discuss the conditions that prompted the Ecuadorian government's decision to adopt UHC and will review the main health reforms of the Correa Administration. The core of this paper concentrates on an assessment of the reform, based on analysis of all published and publically available scientific literature and data. The challenge is to assess if these ongoing reforms have created impactful change and the institutionalization of the National Health System.

Therefore, the main objective of this study is to analyze if the government of Rafael Correa was able to transform the health sector for the attainment of UHC. The secondary objectives of this study include:

1. To briefly describe the regional and global policy process towards UHC;

2. To assess the common challenges in the attainment of UHC, and provide recommendations of strategies to overcome the challenges faced in the case of Ecuador's health system;
3. To explore UHC in the Ecuadorian context and identify the main achievements and challenges;

This study is relevant to both Public Administration and Public Policy Studies as it aims to identify possible gaps in the Ecuadorian health system and identify possible challenges for policy makers. Literature about health reform, health systems and UHC in Ecuador is limited. Therefore, this thesis aims to contribute to literature on the topic. For example, a 2012 paper by DePaepe et al titled "Ecuador's Silent Health Reform" described the neoliberal reforms of the 1990s onward and conducted an in-depth review of the Ecuadorian health system. The authors noted "*President Correa progressive government intended to reverse [neoliberal reforms] by increasing public budgets for health, but hesitated to introduce needed radical changes*". However, the paper lacks an assessment of the Correa era reforms and the rationale behind the decision-making process and institutions, which this paper seeks to explore. Another piece of literature related to health care in Ecuador is an investigation conducted by the Center for Economic and Social Rights that shows evidence that during the government of Rafael Correa the public healthcare system has been weakened, while the private healthcare system has been strengthened. The study looks at the alliances, agreements and contracts between the public and private sectors in which a vast amount of public resources have gone

into the hands of the groups of private healthcare providers (Iturralde, 2015). According to the report, the need to satisfy the social right to healthcare is not being met by the State because of its lack of capacity. According to the report, despite the enormous investment of the Ecuadorian government in strengthening the public health system, out of pocket costs are above the average of South America.

With this in mind, my paper seeks to explore whether the reforms led by the Correa Administration have truly strengthened the public sector and move the country closer to achieving UHC. Analyzing health system performance across countries can highlight good practices, leads to innovation and sharing, and inspire policy makers to consider approaches and strategies. In terms of generalizability, this case study serves as an analysis of the successes and failures of Ecuadorian institutions towards the attainment of UHC so that other countries with similar characteristics can accelerate their quest towards this goal. The findings of this research should contribute to other literature that seeks to understand similar reforms taken by other countries in the transition towards UHC, from the stand point of coverage, access, financing and sustainability of health systems. The study will provide important insights to other developing countries and it will provide recommendations to the Ecuadorian government to enhance the effectiveness of health reforms.

1.2 Methodology

The methodology utilized for this research is based on deductive reasoning to explain the successes and challenges of the Ecuadorian health system in the attainment of universal health care in Ecuador. Deduction is a logical model in which specific expectations of hypothesis are developed on the basis of general principles (Babbie, 2013). A literature will be conducted including scholarly articles from ProQuest, JSTOR, the SNU library and Google Scholar, focusing on key words such as universal health care, universal health systems, health care reform, health systems, among others. To ensure a comprehensive literature review, no date restrictions will be specified. To compliment the literature review, publications, country reports and evaluations and presentations from organizations including The World Bank, WHO, PAHO, among other public health think tanks and leading organizations.

Once the literary review has been completed, a thorough review of primary and secondary sources related to the Ecuadorian health system will be reviewed. These include official government statistics, documents, legislation, regulations, evaluation reports, news articles, among others. An interview schedule will be designed by the researcher based on the findings encountered during the literature review. The interview schedule will be administered to key stakeholders in the Ecuadorian health system. The results of these interviews alongside the findings from the document review will be used to answer the research questions.

CHAPTER 2: LITERARY REVIEW

2.1 Theoretical Framework

Scholars recognize that all governments have similar challenges and meet these challenges differently (Miller & Yang, 2008). Public policy can be defined as the way government directly or indirectly responds to these challenges and influence the lives of citizens (Peters, American Public Policy: Promise and Performance, 1982). How we solve public policy problems depends on many factors, one of the most important factors being the capacity of institutions through which policy decisions are framed and implemented (Weaver & Rockman, 1993). It is important to understand why certain actors make certain public decisions, the factors that influence their decisions, the role of institutions in the policy process and why certain governments create institutional change or fail to create any change at all. To comprehend institutional change there a series of theories that seek to explain this complicated process. For the purpose of this study, the approach used for this analysis will be new institutionalism (NI). The variants of NI that will be considered for this study are historical institutionalism and rational choice institutionalism, given that these concepts are appropriate in the analysis of institutional change.

The analysis of institutional change is crucial in the study of Public Administration and Public Policy. Institutionalism is a popular tool in political analysis, as it seeks to explain how norms, rules, identity and culture shaping behavior. To understand the concept of institutionalism it is

important to define institutions. Institutions are systems of established and prevalent social rules that structure the way society interacts (Hodgson, 2006). Institutions can also be defined as the formal and informal rules and norms that organize social, political and economic relations, and are not to be confused with organizations (North, 1990). The basis of any institutional analysis is the notion that institutions, in the long term, will matter more than individuals (Yang & Miller, 2008).

Institutionalism is one of the central pillars of political science that focuses on the rules, procedures and formal organizations of a system of government (Floretos, Falleti, & Sheingsate, 2016). Formal and informal institutions can be "complementary, competing or overlapping" (Leftwich & Sen, 2010). For Leftwich and Sen, understanding when, how and why institutions work therefore involves understanding their decision-making process, their evolution, and the conditions for their effective implementation. Peters describes classical institutionalism as the process of observations made by political philosophers to analyze the success of institutions and make recommendations for creation of new institutions based on those observations. These institutions, he describes, are created because of the tendency of individual behavior towards collective purposes. For Peters, these observations are formulated almost entirely in legal terms and constitute the beginning of political science were institutions and their impacts on society are analyzed in a systematic manner (Peters, Institutional Theory in Political Science: The New Institutionalism, 2012).

The new institutionalism (NI) gives a new approach to classical institutionalism. The NI tries to understand the relations between institutions and actors, how they affect and influence each other. For March and Olsen, political institutions are "*interrelated sets of rules and sequences that define connected actions in terms of relationships between roles and situations*" (March & Olsen, 1984). The NI includes 3 main variants including rational choice institutionalism, historical institutionalism and sociological institutionalism. NI emerges because of the reemergence of traditional political institutions, such as legislature, legal systems and the state as the subject of interest (March & Olsen, 1984). It retakes the state as a fundamental variable, independent for the analysis and study of political processes or phenomena. In this sense, this theory leads to the study of the state and its effect on society. NI emerges as a need to explain the new political changes and interactions that include informal institutions such as social movements and civil society, which are new protagonists in the political sphere (Floretos, Falleti, & Sheingsate, 2016). In the following section the author will describe the analytical approaches of NI that will be used for this study: historical and rational choice institutionalism (Hall and Taylor).

2.1.1 Historical Institutionalism

Historical institutionalists explain incremental change through path dependency which explains how the institutional context, which was inherited from the past, influences developments and pushes these along certain paths (Hall & Taylor, 1996). Historical institutionalists define

institutions as "formal or informal procedures, routines, norms, and conventions embedded in the organizational structure of the polity or political economy" (Hall & Taylor, 1996). The notion that institutions will prevail over time is the basis of historical institutionalism. Path dependency is a useful concept that explicates why institutional structures persist; however, it also explains the occurrence of incremental change and inefficiencies that may arise from such changes. Historical institutionalism is based on the assumption that a historically constructed set of institutional constraints structure the behavior of political actors and interest groups during the policy-making process (Immergut E. M., 1998).

In order to explain how institutions shape the behavior of individuals, Hall and Taylor explain two approaches of historical institutionalism: the calculus approach and the cultural approach. The calculus approach focus is on aspects of human behavior that are "*instrumental and based on strategic calculation*", that is, individuals try to attainment of goals by a specific preference which they select based on the option that provides the maximum benefit. On the other hand, the calculus approach asserts that institutions affect individual behavior by altering the preconceived notions that an actor has regarding the actions taken by others. The cultural approach seeks to explain the behavior of individuals, not as strategic but tied to his or her worldviews. This approach sees individuals as rational, however, as "satisficers" rather than utility maximizing. From the cultural approach, institutions provide "*moral or cognitive templates for interpretation and action*" that affect the "*identities, self-images and*

preferences of actors". On the one hand, the calculus approach explains that institutions persist because individuals adopt patterns of behavior because the alternative is less beneficial than the status quo. The cultural approach, on the other hand, explains that institutions are resistant to change because they structure the actual choices of the reform that the individual will choose from.

Historical institutionalism explains the persistence of institutional structures through power relations. That is, new institutionalists believe that institutions give some groups unequal access to decision-making, which results in there being winners and losers. Historical institutionalists argue that these power inequalities can influence policy-making and the path that institutions follow. Furthermore, the concept of path dependency used by historical institutionalists seeks to explain why inefficient structures are institutionalized arguing that staying on the path is in the actors' interest, because changing the path is more costly (Lowndes & Roberts, 2013). Moreover, for historical institutionalists, the concept of "*critical junctures*" seeks to explain historical continuity punctuated by periods of substantial institutional change (Hall & Taylor, 1996).

There are two conceptual frameworks in historical institutionalism that seek to explain change, these are incremental models and punctuated equilibrium models. Incremental models describe change as an accumulation of small adjustments over time, describing institutions as stable and enduring over time. However, in this context, historical institutionalism seeks to explain change through the occurrence of "*critical junctures*" external to institutions

(Da Cunha Rezende, 2005). Punctuated equilibrium models, on the other hand, conceive the option of there being a radical change. Both incrementalism and punctuated equilibrium are based on two key causal mechanisms: diffusion process and path dependency (Da Cunha Rezende, 2005). When referring to institutional change, Douglas North explains that change in deeply rooted institutions is "*fundamentally gradual and incremental*". He explains that the informal institution rooted in believes and conventions are slow to change even though formal institutions can rapidly adapt to change (North, 1990). In this context, changes require institutionalizing new rules and behaviors. Furthermore, he explains that external shocks or internal political or economic processes can present opportunities for changing institutions were citizens sometimes mobilize to defend existing inclusive institutions or to demand new ones.

Moreover, Hall and Taylor explain that historical institutionalism is deeply grounded in that institutional paths are closely linked to historical development. Therefore, institutions are subject to the decisions that were taken by actors of the past. As a result, historical institutionalism has attempted to explain how these path dependent institutions respond to new challenges. Hall and Taylor explain that existing "*state capacities*" and "*inherited policies*" structure subsequent decisions. Another explanation that "*policies adopted in the past condition subsequent policies, by encouraging social forces to organize themselves according to certain orientations rather than to others, to adopt particular identities, or to develop interests in policies whose abandonment would involve an electoral*

risk" (Hall & Taylor, 1996). In the context of historical institutionalism some scholars have described historical developments in periods of continuity and "*critical situations*." These are critical moments in which important institutional changes occur that take institutions into an alternative path. The main problem with this approach is how to explain what triggers critical situations.

2.1.2 Rational choice institutionalism

For authors Hall and Taylor rational choice institutionalists focus on the operation of institutions concentrating on the importance of transaction costs. Rational choice institutionalism also explains actors behavior through the calculus approach which sees actors behavior as being rational and strategic, maximizing the attainment of what they perceive to be their own interests (Schmidt, 2010). The way that rational institutionalism views the creation of institutions and the occurrence of incremental institutional changes as highly purposive, being a product of the choices of actors who think that these actions will maximize their interests (Hall & Taylor, 1996). For Hall and Taylor, rational choice institutionalism views institutions based on their functions and efficiency, this is a more operational view of institutions. Because of this functional approach, rational choice institutionalism can help explain why some institutions are inefficient in structure by providing a framework for the analysis of structural deficiencies. For example, due to insufficient institutional structures, actors might lack information to make informed decisions about the optimal outcome of their actions, which is referred to as the collective action

dilemma. Because of the collective action dilemma, actors think they are maximizing the attainment of their preference but in reality, because of the lack of sufficient institutional structures, they end up making decisions that leads to an outcome that neither represents actors' individual preferences, nor the collectively optimal outcome (Hall & Taylor, 1996).

Therefore, rational choice institutionalism views actors' interests in maximizing their own returns, as the central concept in this approach. Furthermore, Hall and Taylor explain that, rational choice institutionalism, explains why institutions are created, and why they persist over time as a result of the actions of rational, return maximizing actors. The authors explain that rational choice institutionalism seeks to explain the survival of institutions by the fact that they fulfil important functions that serve the interests of individual actors more than alternative institutional forms. Therefore, rational choice institutionalism explains institutional continuity because institutional changes only occur when actors feel that such change will maximize their preferences. Furthermore, these rational actors may be reluctant to change because of they fear the consequences and high costs that may arise from such changes. Rational choice institutionalists therefore argue that institutions are created to satisfy the social and economic needs and the same actors that create these institutions are subject to this system.

Within rational choice institutionalism, principal agent theory can be used to explain how information asymmetry can produce change or the lack of it. Principal agent theory which is also referred to as agency theory explains the relationship between two parties, in which one party or the principal

engages another party which is designated as the agent, to perform some tasks on behalf of the principal. The theory assumes that the principal delegates his theory to the agent to perform a given task. However the problem of information asymmetry arises when the agent becomes more knowledgeable about the work than the principal himself. Furthermore, because of this information asymmetry the agent might have different interests or goals than the principal, which is also referred to as conflict of interest.

The distributional approach to gradual change is a theory within historical and rational choice institutional which emerges as a way to explain gradual institutional change through interrupted equilibrium. One of the critiques of both rational and historical institutionalism is that they have not been able to analyze or explain institutional change. The distributional approach tries to resolve these limitations for the analysis of change by incorporating concepts of critical junctures taken from historical institutionalism and key concepts and methods from rational choice institutionalism. This approach incorporates the concept that the normal condition of any institution is change, understood as a gradual process resulting from the interweaving of diverse dynamics and moving away from the notion that institutions are stable. Therefore, the distributional approach moves away from the perspective that views institutions as being in permanent balance and only interrupted during brief crisis situations. Under this approach, gradual change is derived from three basic factors: "*ambiguity which is the product of gaps and cracks in the rules, the role of the agency as the one that*

interprets and executes these rules, and power which is present in every institution and a key ingredient that the agency detonates" (Mahoney & Thelen, 2010).

Common areas of critique of the new NI framework maintain that institutions are not change resistance as new institutionalists claim. They claim that "*when institutional change does take place, new institutionalists draw on exogenous factors as explanations*" (Lecours, 2005). Furthermore, they criticize NI's notion that institutional change is unlikely to happen because it's too costly. Critics claim that institutional change does take place despite these presumed costs (Lecours, 2005).

Health systems are the institutional basis and expression of health policies, since the structure of health systems, their organization and governance, have fundamental implications on policy implementation (Mackintosh & Koivusalo, 2005). Health systems values include equity in the distribution of health, fairness in financing systems as well as being able to protect households from incurring the cost of catastrophic diseases. Other values include responsiveness to the expectations and needs of the population; and respect for the dignity of all people. In the other hand, health systems seek to support resource redistribution and build strategies to include marginalized populations in all decision-making activities (WHO, 2012). However these values are not always shared by all actors in health policy-making.

There are several pieces of literature that describe the influence actors and institutions in health policy. Ellen Immergut, in her book Health Politics, describes how health actors' interests and institutions in Western Europe have shaped health care politics, focusing on three case studies: France, Switzerland and Sweden. In her book, Immergut seeks to explain how key actors in the health sector, such as medical professionals, influence government's health policy and choice of health system. For Immergut, the Swiss referendum, the French parliament, and the Swedish executive bureaucracy emerged as key elements in explaining why national health insurance was adopted in these countries (Immergut E. M., 1992). Immergut seeks to explain why nations with similar levels of economic development produce different outcomes when it comes to the role of government in health.

Defining social programs such as a country's National Health System (NHS), is a highly controversial and politicized topic in which a series of actors and interest groups voice their opinion. Immergut describes the interaction between actors as an ideological divide between liberalism and socialism ad between free market and planned economy. The author then adds that political parties use this dichotomy to build their agenda and garner votes. On the other hand, she identifies the emergence of doctors, unions, employers and other interest groups in national health insurance discussion. For Immergut, "*this political context is an institutional context*" were different nations have developed different institutions, formal and informal, for making political decisions. The author describes the formal

institutions of government as defined by constitutions and the informal practices that have developed around these institutions as interest groups, political parties, individual politicians, and bureaucrats who have struggled to influence these formal institutions (Immergut E. M., 1992).

The model that Ecuador followed for a long time determined a reduction of the state apparatus since that was the direction of economic policy, and this meant that there was no oversight of the institutional aspect. In this context, the Correa Administration reincorporates the importance of institutions to generate stability and change. The health reform of the Correa Administration can be analyzed through a wide variety of theoretical lenses. This paper focuses on the actors and institutions of Ecuador's health sector and their role in policy-making and implementation. The study seeks to analyze whether there was an incremental institutional change as opposed to significant reform in the form of the attainment of UHC, analyzing the way in which the NHS is perceived. Second, the study seeks to explain the persistence of the NHS institutional structure, pointing out factors that impede substantial reform towards the attainment of UHC.

2.2 Theoretical Background

This section serves to present a series of theoretical concepts and conduct a theoretical review of the frameworks to assess the progress towards the attainment of UHC. These concepts and analytical tools will be the base for the analysis and interpretation of the data that will complement the

interview findings thereafter. As the basis of this study, the "WHO cube" framework based on the asessment model developed by Busse, Schreyogg, & Gericke (2007) will be described in this section, as well as other literature regarding UHC. Universalism and UHC will be described in depth. Moreover, this section will review previous literature about the commonalities of countries that have achieved UHC.

2.2.1 Universalism

Following the principle of solidarity, the universalistic system promotes fairness and equality: all citizens are guaranteed similar rights regardless of their class or social status. In line with Esping-Andersen's three worlds of the welfare state, Mkandawire describes policy behind the welfare state as choice between "*universalism*" and "*targeting*". Under universalism, social benefits, such as health, are a right of the population, while under targeting, eligibility to certain social benefits consists of choosing certain parameters to determine the "*truly deserving*" (Mkandawire, 2005).

For Mkandawire, universalism is at stake because countries have come to the realization that there are fiscal limits to universal provision. Ideology plays a key role in the selection of the policy instrument and although there is a focus on efficient resource allocation to meet the needs of the state, the real focus should be on government values and their responsibility to its citizens (Mkandawire, 2005). For Skocpol, the most successful social policy for the reduction of poverty has been universalistic, and targeting has been used as an additional instrument for making universalism effective,

which she calls "*targeting within universalism*", in which extra benefits are directed to low-income groups (Skocpol, 1991).

For Esping-Andersen, universalism turns into a dual system with the success of the working-class and the rise of the middle class, the better-off turn into private providers to supplement the modest quality of universalist standards of welfare, therefore creating a system similar to that of the social-assistance state: the poor rely on the state, and the remainder on the market (Esping-Andersen, 1990). For this reason, some of the most successful universalist states have been those that have promoted a "*stratified universalism*" specifying the eligibility criteria for different strata groups. Therefore, most scholars agree that a somewhat "*modified*" or "*mixed*" version of universalism must be present to ensure the success of this policy tool and its sustainability.

Ecuador's Development Plan is based on Universalist policies that have aimed at eliminating barriers to education and public health care in order to achieve universal coverage. Within healthcare, some of the major reforms include the costs for doctors' visits has been eliminated, access to essential free medicines has been expanded, and the workday has been standardized to include eight hours open to the public. For these two sectors, operating budgets have increased, as well as investment in basic infrastructure (SENPLADES, 2014).

2.2.2 Universal health coverage

The WHO defines UHC as "*access to key promotive, preventive, curative*

and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access". For the WHO, the principle of financial-risk protection is at the center of UHC, ensuring that the cost of care does not put people at risk of financial catastrophe. The WHO also recommends that UHC is based on primary health care. Another definitions sees UHC is "*a system in which everyone in a society can get the health services they need without incurring financial hardship…whether or not a country has achieved universal health coverage therefore depends on three related factors: who is covered, for which services are they covered and with what level of financial contribution*" (Savendoff, Ferranti, Smith, & Fan, 2012). Although there is a broad definition which has been widely accepted, there has been no clarification of conceptual and practical issues to help countries achieve UHC. "*The discussion of how countries should pursue UHC has been run almost exclusively on financing mechanisms*" (Bump, 2015). Even though defining UHC has created heated debates among scholars, there is no agreement about the definition (Frenz & Vega, 2010). However, the WHO's definition and most definitions embrace the following components of UHC: access to health care and/or an insurance scheme, coverage, rights, and both social and financial protection (McKee, Balabanova, Basu, Ricciardi, & Stuckler, 2013).

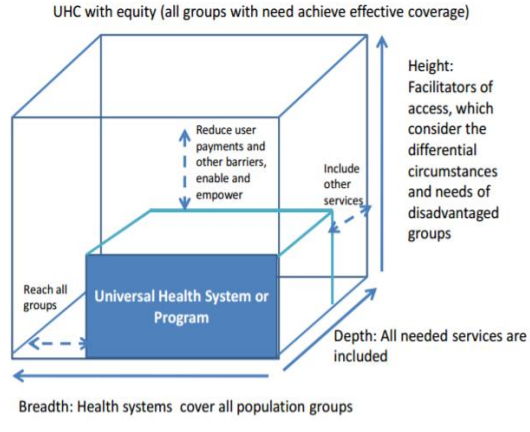
2.2.3 The dimensions of UHC

Busse et al, propose a three dimensional model for measuring coverage which includes breadth, depth, and height of coverage (Figure 1) and resemble the founding principles of the British NHS, "*universal,*

comprehensive, and free at the point of delivery". For the authors, these dimensions help determine the quantity needed of prepaid financial resources vs. OOP payments. "Breadth is defined as the extent of the covered population and depth as the number and character of services covered; height specifies the extent to which costs of the defined services are either prepaid or financed through cost-sharing" (Busse, Schreyogg, & Gericke, 2007). The 2010 World Health Report by the WHO suggests Busse et al's three broader dimensions for UHC (Figure 1), which they describe as follows:

1. Service coverage (the list of services that are covered under UHC)
2. Financial coverage (the proportion of total costs covered through insurance or other pooling mechanisms; and,
3. Population coverage (the proportion of the population covered)

Figure 1: Dimensions of universal health coverage with equity



Source: WHO

Going one step forward, based on the WHO framework for accomplishing UHC. Abotisem and Allegri synthetize several literatures on this topic and denote that in order to achieve UHC, there are 4 core elements that must be considered (adding one more element to the definition): 1) the acknowledgement of health as a human right, 2) the need for population coverage, 3) financial protection, 4) access to health services (Abotisem & De Allegri, 2015).

1. The right to health

The first perspective regarding universal health care is grounded on the premise that health is a human right and requires the existence of a legal framework to ensure health for all (Stuckler, Feigl, Basy, & McKee, 2010). This also implies that the government has a legal entitlement to health care of all the population (Barcena, 2014). However, to guarantee a comprehensive right to health, the state must not only focus on health service provision but also on social determinants of health (WHO, 2012). Savendoff et al make an important distinction, by explaining that a constitutional rights provision "*distinguishes countries whose political systems have reached consensus on aims but not necessarily on implementation*" and furthermore, adds that there are many countries that have adopted these provisions, however do not have policies or resources in place to guarantee this right (Savendoff, Ferranti, Smith, & Fan, 2012). In LAC, for example, 19 countries have acknowledged the right to health guaranteed by the state in their constitutions.

The Universal Declaration of Human Rights (1948) states that "*everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services*". According to Harrington and Stuttaford, health as a human right was relegated to secondary status and for many years (Harrington & Stuttaford, 2010) due to the fact that idea of health as a fundamental human right has suffered from vagueness and inarticulateness, especially, when compared to other civil and political rights (Evans, 2003). Based on the recognition that health is a human right, according to the WHO Constitution, governments have a responsibility for the health of their peoples which can be fully attained only by providing adequate health and social programs. Another perspective on the right to health argues that undocumented immigrants are excluded from accessing health services due to the legal connotation of citizenship as a right to health (Kingston, Cohen, & & Morley, 2010). From this point of view, scholars suggest that there needs to be a shift from the view of health as a form of assistance, to a view that health is a humanitarian responsibility that trespasses the boundaries of the state (Lencucha, 2013).

2. Population coverage

The second dimension of UHC is the need for population coverage, which refers to the proportion of the population that is covered. This dimension of UHC denotes "*equal or same entitlements*" to the benefits of a health system with no one left behind (Oxfam, 2013). Universal population coverage, although it's the ultimate goals, must be carefully planned for to

avoid offering services, creating false expectations among the population, and not being able to respond for lack of capacity (Hickey & Du Toit, 2001). The criteria for entitlement to coverage vary between tax-financed countries, social health insurance (SHI) countries, and countries where a large part of health care is financed through private health insurance or medical savings accounts (Busse, Schreyogg, & Gericke, 2007). SHI countries use different frameworks to define the group of persons that are insured. However, most SHI systems such as Korea or Japan, these are work-related insurance programs that were gradually expanded to nonworking segments of the population. On the other hand, Tax-Financed Systems such as New Zealand, the United Kingdom and Australia, UHC has been a central feature of these models. Under these systems entitlement to health services is based on residence, independent from citizenship, undocumented immigrants being the only ones left behind.

3. Health financing systems

The third dimension and perhaps one of the most important is financial protection to achieve UHC. UHC is a mechanism that protects populations from falling into poverty due to the devastating economic consequences of ill health in their family (Xu, et al., 2003). With this said, in order to attain sustainable UHC, governments must implement health care financing mechanisms with the ultimate goal of eliminating OOP expenses. Health systems financing is the process by which revenues are collected from primary and secondary sources, accumulated in fund pools and allocated to specific activities of particular providers which can be divided into three

categories: revenue collection, fund pooling and purchasing (Murray & Frenk, 2006). Revenue collection refers to financial contributions that are collected with equity and efficiency. Pooling refers to contributions that are pulled so that the costs of health care are shared by all and not borne by individuals at the time get ill under the principle of solidarity. Purchasing refers to the contributions that are used to buy or provide appropriate and effective health interventions. The international community has endorsed financing health care from pooled mechanisms such as tax revenue, and funds from SHI, private health insurance, as essential requirements for moving towards universal financial protection (Carrin, James, & Evans, 2005). Although there is no consensus, a mixed pooling system is recommended, based on the premise that it is very difficult to sustain coverage, relying only on one financing strategy (Kutzin, Health financing for universal health coverage and health system performance: concepts and implications for policy, 2013).

Countries that have achieved UHC have developed systems that are prepaid which are also referred to as a tax-based or social health insurance-based (SHI). These two common financing models have been labeled as the "Beveridge Model or Tax Based System" and the "Bismarck Model or SHI" (Kutzin, Bismarck vs. Beveridge: is there increasing convergance between health financing systems?, 2011). In a tax-based system, general tax revenue is the main financing source, and the available funds are used by the state to provide public health services or purchase those services offered by a private system. In an SHI system, contributions come from workers,

the self-employed, enterprises and the government. In both, the contributions made by all contributors are pooled and services are provided (Carrin, James, & Evans, 2005). In the discussion between general tax revenues versus insurance, there is no evidence that one system is better than another, however many cases have suggested that whatever heritage exists in a country should be the basis for further progress toward UHC. (Bump, 2015). UHC rests on the strength of the state to facilitate the collection and redistribution of resources and regulate the subsequent provision of care. Weaknesses in the state, if it does not respond to the demands of all citizens, or if it does not have reliable or fair revenue generation mechanisms—are likely to limit its ability to move toward UHC (Bump, 2015). Moreover, a study conducted by Mackintosh and Koivusalo demonstrate that countries with better health outcomes have lower commercialization of health expenditure and that countries that spend more of their GDP on private health expenditure do not display better health outcomes. The authors find that publicly managed health finance can only play a role in the achievement of UHC if their principle of operation is non-commercial (Mackintosh & Koivusalo, 2005).

4. Access to services

The fourth component of UHC is the need for access to services. This means that a country's health coverage must include a package of services that according to the WHO should include promotive, preventive, curative and rehabilitative health interventions (WHO, 2005) Some scholars argue that UHC should include a minimum basic package of services or

interventions that is disease-oriented (Sachs, 2012). Another school of thought and the preferred and recommended strategy by the WHO recommend a service provision package focused on PHC.

In a review of high-income countries that have achieved UHC, Busse et al found that, in SHI system countries, the contents of the benefits packages and the processes applied to define them vary between countries and range from a list of benefits prescribed by law via decree to negotiations between insurance funds and providers. Among the notable difference in the contents of benefit packages is the inclusion of benefits regarding acute curative care and ambulatory long-term care. On the other hand, Busse et al, observed that in Tax-Financed systems benefit packages are not explicitly defined, however, countries have begun to incorporate the notion of cost-effectiveness to govern their health-care decisions.

In summary, the attainment of UHC is the primary goal of every health system (WHO, 2010) and it encourages states to implement prepaid health care financing systems, access to quality health care and provides the population with the protection from excessive OOP health related expenses (WHO, 2005).

2.2.4 Factors giving rise to UHC

According to McKee et al, the first system of organized health care appeared in Germany in the late 19th century. "*European governments played an increasing role as investments in health and welfare became a means of addressing social problems of industrialization (alcoholism,*

tuberculosis, and overcrowding), forging political alliances as well as transferring resources from the rich to the poor, from working ages to children and old people, and from healthy to ill" (McKee, Balabanova, Basu, Ricciardi, & Stuckler, 2013). Therefore, the expansion of health care has long been a political process and one often bound up with the growth of social welfare generally (De Ceukelaire & De Vos, 2009).

According to McKee et al, there are multiple factors giving rise to a country's decision to pursue UHC. These include the strength of progressive parties and organized labor, economic availability, opportunities to create cohesive systems, path dependency and windows of opportunity. These factors can be best understood in a unified framework when viewed together as part of a social movement towards UHC (McKee, Balabanova, Basu, Ricciardi, & Stuckler, 2013). A study carried out by Jesse Bump concluded that UHC is intensely political and is characterized by a domestic political debate. For example, he states that an approach based on solidarity is required when expanding care beyond formal employment groups, which requires thinking about redistribution. He suggests that the attainment of UHC is a lengthy process and countries should adopt small, incremental reforms of any size, and not necessarily look to make fast and dramatic changes to their health system. He then suggests that UHC rests on the strength of the government to enable the collection and redistribution of resources and regulate the consequent provision of care. "*Weaknesses in the state if it does not respond to the demands of all citizens, or if it does not have reliable or fair revenue generation mechanisms, are likely to limit its*

ability to move toward UHC" (Bump, 2015).

For Greer and Mendez, academics tend to discuss UHC as though it were an end goal that only requires technical follow-up. This approach contradicts literature that proposes that UHC is a transformative and political goal, dependent on the characteristics and actors that make part of a country's governance. For the authors, when there are conflicting views regarding health care and lack of adequate political support a redistributive policy such as UHC is unlikely to happen (Greer & Mendez, 2015). For UHC advocates, this means that they must ultimately engage in political conflicts within countries. The author believes that the commitment to UHC by WHO Member States is often a resource for political argument rather than a binding obligation.

There are several examples of countries that have successfully reached UHC implementing different health systems and following different paths to attain this goal. These examples are best described by a study conducted by Savendoff et al that found three common features in these countries successful attainment of UHC:

1. a political process triggered by a series of factors to push forward public policies and programs with the objective of expanding health coverage, improving equity and avoiding possible financial risks;
2. an increase in income and health spending;
3. A decline in out-of-pocket (OOP) expenses and an increase in the share of health spending that is pooled into unique fund;

Savendoff et al, draw conclusions from countries that have achieved UHC, such as UK, France, Germany and Sweden (Savendoff, Ferranti, Smith, & Fan, 2012). Furthermore in a preliminary study, titled "Achieving Universal Health Coverage: Learning from Chile, Japan, Malaysia and Sweden", Savendoff and Smith find additional commonalities in the path towards the attainment of UHC. First, they conclude that UHC is "*accompanied by a large role for the government*". A second commonality they describe is that "*the path to UHC is contingent, emerging from negotiation rather than design*", and their final finding is that UHC is attained incrementally and over long periods of time. Moreover, in their finding, Savendoff et al describe the historical path that countries follow towards the achievement to UHC which they describe in three main phases: early phase, expansion phase and universal phase which I summarize as follows:

1. The early phase is characterized "*voluntary actions through multiple efforts*" by efforts from interest groups that vary from local groups to larger movements at a national level and charitable organizations organized to provide health services for the most vulnerable populations. Furthermore, in this early stage, health insurance provided by job affiliation is predominant, usually born from industry led initiatives. During this initial phase, the authors note that the government does not have a prominent role in the provision of health services but subsidize external aid groups that run health facilities.
2. This phase is characterized by an increase in the role of the government in the provision of health services. National governments pushed

forward the mandatory participation of the population in social insurance schemes.

3. The third phase which the authors refer to as the universal phase refers to the attainment of UHC in which governments establish a coherent national all-inclusive insurance scheme. During this phase the government is seen as the sanitary authority for the promotion of UHC and institutions are more established than in earlier phases.

Finally, the authors point out that the universal phase is not a final phase because institutions will continue to change and factors such as emerging medical technologies, social inequalities and increasing costs will continue.

CHAPTER 3: RESEARCH METHODS

The following Chapter describes the choice of methods and study design of this research. The proposed research will be descriptive in nature, analyzing the major institutional and policy changes proposed for the NHS of Ecuador and will analyze whether these reforms have contributed to the attainment of UHC. The case study will analyze the health systems reforms between 2007 and 2014.

The research will be supported through a descriptive analysis of health statistical data from Survey Data from the National Statistics Institute of Ecuador (INEC), including the National Life Conditions Survey and Health Services Satellite Account. Data from National Health Accounts is produced by the Central Bank of Ecuador which manages all economic statistics in the country, and will also be used in this study. This information will be complimented with data from the WHO, World Bank, as well as other national data resources from the Ministries of Health. Furthermore, the study will be complemented with an analysis of legal documents, historical events, information about key actors and interviews to be conducted with important actors from the Ecuadorian health system and academia.

The author will analyze Ecuador's health reform using a descriptive approach and referencing the framework and a selection of indicators for UHC provided by the WHO. In examining Ecuador's reforms towards UHC, the author will perform a thorough assessment of Ecuador's health systems

and explore whether the government of Rafael Correa was able to bring about institutional change in the health sector for the attainment of UHC. Furthermore, the paper seeks to highlight some of the challenges of the Ecuadorian health sector as well as the challenges shared by other developing countries. The research will conclude with recommendations that will allow policy makers to continue to strengthen of Ecuador's health system.

The primary objective of the study is to analyze how institutional reforms that initiated in 2007 under the Correa administration have contributed to the attainment to UHC. In this context, the researcher will identify institutional and policy gaps for the further improvement of the health system. Furthermore, the study aims to answer the following questions:

1. Did the Correa era healthcare reforms contribute to the attainment of UHC in Ecuador after the neo-liberal era?
2. What is the global policy process for the attainment of UHC?
3. What are the main challenges that Ecuador faces in the attainment of UHC? What are the common challenges in other developing countries?
4. What role do formal and informal institutions play in the health policy-making process in Ecuador?

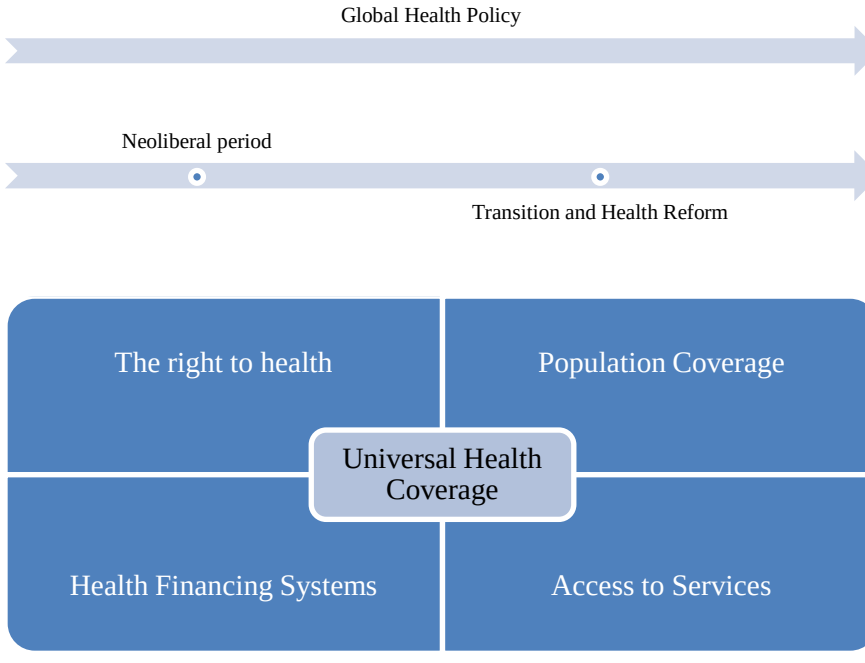
According to Babbie, an exploratory cross-sectional study "*involves observations of a sample, or cross-section, of a population or phenomenon that are made at one point in time*". In this context, this study will be describing the health reform process from 2007 to 2014, after the election

of Rafael Correa as President of Ecuador, focused on the National Health System institutional reforms.

At an international level, governments have been encouraged to set up national surveillance mechanisms to measure the progress of health systems, with an emphasis on social determinants of health (WHO, 2008). The WHO and PAHO have developed a set of strategies and indicators to help countries push the necessary reforms forward, for the attainment of UHC. Other international organizations such as the OECD have also pushed forward a series of indicators that provide an overview of the health status of the population, determinants of health, health care resources and utilization, health expenditure and financing, and quality of care. Reliable measures of health and health care enable policy makers to make informed decisions that allow them to improve the health systems in each of their countries and regions. With this in mind, to analyze the Ecuador's health reforms and measure progress toward UHC, the author will utilize the WHO monitoring framework which stems from the "WHO cube" proposed by Busse, Schreyögg, and Gericke (2007) which was described earlier in this study and includes three basic dimensions: population coverage, service coverage, and financial protection. Furthermore, an additional dimension will be analyzed which is the guarantee of health as a human right.

The evaluation will be qualitative and will focus on an explanatory cross-sectional analysis of each of the dimensions described as follows:

Analytical framework



Graph elaborated by the author

From the literary review, the study will adopt a series of indicators that have been referenced to the WHO's Framework, Measures and Targets for WHO, the WHO's Strategy for Universal Health and key indicators included in the PAHO's Strategic Plan 2014-2019. However, not all indicators will be covered, given the limitation of data for some of the indicators.

Dimensions of UHC	WHO Indicators
Right to health	- Constitutional and normative provisions guaranteeing the population's right to health
Financial coverage / Financial Risk Protection ***This includes sufficient and sustainable revenue collection, financial accessibility for health services and efficiency and equity in provision of services***	Resource Collection 1. Level of Funding - public expenditure for health as a % of GDP - Health budget as a % of total government budget 2. Level of Population Coverage 3. Level of Financial Risk Protection - % of HH with Catastrophic Payments - OOP Expenditures - OOP expenditures as a percentage of total health expenditures Revenue Sustainability 1. Ratio of external funding and government funding as share on total health expenditure 2. Tax Revenue Collection Purchasing 1. Level of Equity in Health Financing - Equity in service utilization
Coverage of Essential Health Services ***Includes health coverage through social protection***	1. Promotion and Prevention - Births delivered in a health facility - Births assisted by a skilled provider - Women receiving any antenatal care (ANC) from a skilled provider - Married women in reproductive age using modern family planning methods - Received 3 doses of DPT vaccine

mechanisms. Increased utilization of first-level care services after implementation of new people-centered model of care	- Prevalence of no Tabaco smoking - Maternal mortality 2. Treatment Indicators - Access to antiretroviral (ART) drugs - TB treatment success rate
Health systems capacity (*Infrastructure and Human Resources*)	1. Service Utilization Levels - Number of consultations provided - Number of outpatient consultations by nationality - Number of health facilities by sector - 2. Diminished workforce shortages and health workforce distribution - Number of doctors and health workers by sector - Reduction of distribution gap of health personnel between urban and rural 3. Increased regulatory capacity 4. Improved quality of their national health information system. 5. Implementation of functioning mechanism for governance of health research.

CHAPTER 4: EMPIRICAL ANALYSIS

3.1 The Regional and Global policy process towards UHC

The 1978 International Conference of Primary Health Care was the first multilateral space where the concept of UHC was discussed. From this point on there have been a series of international statements, resolutions, reports and recommendations that have further supported the urgent call for the adoption of UHC at an international level, which I summarize in Table 1.

Table 1: Main International and Regional Statements Supporting UHC

International Statements Supporting UHC		
Document	Year	Statement
International Conference of Primary Health Care	1978	• Health is a fundamental human right and the attainment of the highest possible level of health is a most important world-wide social goal, sets year 2000 as a target. • PHC is key to attaining this target.
Mexico Ministerial Statement for the Promotion of Health	2000	• Recognizes the contribution of health promotion strategies to the sustainability of local, national and international actions in health.
Report of the Commission of Macroeconomics and Health, WHO	2001	• Urges middle-income countries to undertake fiscal and organizational reforms to ensure universal coverage (WHO, 2001).
Extension of Social Protection in Health: Joint Initiative of The PAHO and the International Labor Organization, CSP26.R19	2002	• Urges member states to identify, monitor, and evaluate potential causes of social exclusion in health. • Urges countries to define and implement national strategies to extend social protection in health from an intersectoral approach (PAHO, 2002).
Sustainable health financing, universal coverage and social health insurance, WHA58.33	2005	• Urges members to ensure health financing systems that include a method for prepayment to avoid risks of impoverishment. • Calls for countries to ensure adequate and

		equitable distribution of good-quality health care infrastructures and human resources for health. • Urges countries to plan the transition to UHC as a way to attain internationally agreed development goals
Regional Declaration to the New Orientations for Primary Health Care (Declaration of Montevideo)	2005	• Advocates for the integration of the principles of PHC in the development of NHSs, health management, organization, financing, and care.
The South American Health Council Five-Year Plan is Approved	2010	• The document identifies its five lines of action which prioritize the development of Universal Health Systems and Universal Access to medicines.
Sustainable Development Goals (SDGs) Transforming our world: the 2030 Agenda for Sustainable Development, UN Resolution A/RES/70/1	2015	• Goal 3: To ensure healthy lives and promote wellbeing for all at all ages. • Target 3.8 Achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all (United Nations General Assembly, 2015) • Multiple goals also have linkages health.
Sustainable Health Financing structures and UHC, World Health Assembly Resolution 64.9	2011	• Urges countries to attain affordable universal coverage, strengthen their financial systems.
Rio Political Declaration on Social Determinants of Health	2011	• Recognizes the need to combat unequal access to health systems and pledges to support social protection levels as defined by countries to address their specific needs.
Mexico City Political Declaration on Universal Health Coverage	2012	• Calls for governments to work together on the development and use of transparent financial mechanisms, accountability and reporting, and monitoring and measuring of health system performance and outcomes, in the realization of UHC. • Work to promote the inclusion of UHC as an important element in the international development agenda, and promote international cooperation.
Bangkok Statement on Universal Health Coverage	2012	• Agrees to make UHC a reality and to ensure better health for all and makes a call to promote its inclusion as a priority in the global development agenda.

United Nations Conference on Sustainable Development (Rio+20)	2012	• Emphasis on the importance of UHC to enhance health, social cohesion and sustainable human and economic development. • Calls for the full realization of the right to the enjoyment of the highest attainable standard of physical and mental health.
Global Health and Foreign Policy, 6^{7th} Session of the United Nations General Assembly, A/RES/67/81	2012	• Recognizes the importance of universal coverage in NHSs, especially through PHC and social protection mechanisms. • Invites Member States to adopt an intersectoral, health-in-all policies approach. • Urges countries to accelerate the transition towards affordable and quality health-care services. • Recommends the inclusion of UHC in the post-2015 dev. Agenda.
World Health Assembly Resolution WHA67.14 on Health in the Post-2015 Development Agenda	2014	• Urges member states to promote UHC, defined as universal access to quality prevention, promotion, treatment, rehabilitation and palliation services and financial risk protection as fundamental to the health component in the post-2015 development agenda.
PAHO Strategy for Universal Access to Health and UHC CD53.R14	2014	• Outlines key regional strategies for the implementation of UHC in the Americas.
World Bank Strategy to end poverty by 2030	2015	• Sets the year 2030 for ending poverty by helping governments achieve UHC by this date, with the potential to transform the health and well-being of individuals and societies.

Table elaborated by the author

According to World Bank, over the next 20 years, changes in population size and structure alone will increase total health spending needs by 47 percent in LAC (Saad, 2011). LAC is one of the regions that has predominantly included the right to health as a Constitutional right and in a series of legislations, and are actively promoting an equitable path to UHC

(Yamin & Ariel, 2014). In the region of the Americas, PAHO has been the main health multilateral organization pushing forward the pursue of UHC. At the regional level, in the Americas, the Pan-American Health Organization 53rd Directing Council approved resolution CD53.R14 "Strategy for Universal Access to Health and Universal Health Coverage" includes four strategic lines for the strengthening of health systems and a push forward towards UHC (PAHO, 2014). These four lines are as follows:

- Strategic Line 1: Expanding equitable access to comprehensive, quality, people-and-community-centered health services
- Strategic Line 2: Strengthening stewardship and governance
- Strategic line 3: Increasing and improving financing, with equity and efficiency, and advancing toward the elimination of direct payment that constitutes a barrier to access at the point of service.
- Strategic line 4: Strengthening intersectoral coordination to address social determinants of health.

A push for UHC is also reflected in the Pan American Health Organization 2014-2019 Strategic Plan in which several indicators have been identified to measure the progress of the countries of the Americas towards the attainment of UHC. Furthermore, for developing countries, a major influence in the attainment of UHC and the expansion of health services and the strengthening of public institutions was the adoption of Millennium Developing Goals that included a series of health-related goals.

In Ecuador, an important driver that has supported the country's push

towards universal health has been the region's path towards economic and social integration. Article 423 of the Ecuadorian Constitution establishes "*Integration, especially with LAC countries, shall be the strategic objective of the State*" (Constitution of the Republic of Ecuador, 2008). In South America, there have been a series of integration efforts at a sub-regional level from organizations such as The Southern Common Market (MERCOSUR), the Andean Health Agency (ORAS-CONHU), the Amazonic Cooperation Treaty Organization (OTCA), and the Union of South American Nations (UNASUR). The South American Health Council (SHC) is the health arm of the UNASUR which proposed to "to consolidate South America as a health integration space that contributes to health for all and to development, incorporating and integrating the efforts and sub regional achievements of MERCOSUR, ORAS-CONHU, and OTCA." UNASUR's SHC proposed in 2009 a 5-year plan that includes 5 lines of work: (i) Epidemiological Shield, (ii) Development of Universal Health Systems, (iii) Universal access to medicines, (iv) Health promotion and action on health determinants, and (v) Development and management of human resources in health. Furthermore, in 2011, the South American Institute of Government in Health (ISAGS) was created, whose objectives are leadership training, knowledge management and technical support to health systems.

The region as a whole is moving towards the attainment of UHC in compliance with global and regional mandates and recommendations, and is doing so with the support of regional organizations. However, it is

important to point out that the health reforms for the attainment of UHC in Ecuador are not only tied to the compliance with international commitments with the PAHO, WHO, UNASUR, among other regional organizations. These efforts are also part of the Ecuadorian government on-going efforts to reform the public sector and rebuild state institutions in accordance to the Constitutional Mandates and the National Plan of Good Living.

3.2 Common Challenges for the Attainment UHC

A document review was performed for regarding the key challenges hindering implementation of UHC in developing countries. It is important to mention that each country has a different health system structure and therefore each country has taken different approaches to the transformation of their health systems for the attainment of UHC. Specifically, in the case of LAC, given that the region in its entirety was vastly influenced by neoliberal policies in the 1990s, presents common challenges which I briefly describe as follows:

1. **Responsiveness of health systems to health needs upon demographic changes in the population and the rise of NCDs.** According to the WHO, the decline of deaths due to common transmittable diseases as a result of vaccination and improvement in health conditions has led to populations living longer lives contributing to the population aging, which will increase the burden on governments' capacity to strengthen current health systems. LAC, in echo with the rest of the world, is experiencing an increase in NCDs which brings

about two key challenges: 1) developing preventive, cost-effective policies and 2) increase access to quality health care. This means that health care expenditures will need to be increased and institutions will need to be reformed to conform to these changes. The leading causes of mortality and morbidity in the region are attributed to NCDs. The LAC region's population is "*equally likely to die prematurely from just one NCD than from all communicable diseases combined*" (Anauti, Galiani, & Weinschelbaum, 2015). The WHO has attributed the rise of NCDs to an increase in the incidence of obesity, attributed to poor eating habits and sedentary lifestyles. Another important factor driving the increase in NCDs is the prevalence of aging populations across the globe. A journal article by Hue et al, describes the case of Thailand which has the second speed of population aging of SE Asia. For Thailand, population aging implies 1) increasing medical cost per capita and 2) a decline in tax collection because the working-class population decreases, which increases the government's burden when it comes to managing Thailand's Universal Health Insurance Scheme (Hsu, Huang, & Yupho, 2015).

2. **Informal employment.** A common pattern in the adoption of UHC is the prevalence of an informal sector. Coverage of civil servants and those in the formal sector can be attained through payroll deductions (in the form of contributions to health insurance schemes or income tax) and complemented by the inclusion of the poor through government subsidies. This has been the pattern in countries such as Vietnam, Indonesia, and the Philippines. However, its main setback is that it has

typically resulted in a coverage gap for those in the middle. These are mainly informal workers and their families (Bredenkamp, Evans, Lagrada, Lagenbrunner, & Palu, 2015). One distinguishing characteristics of developing countries is their large informal labor sector. A case study regarding Thailand's impact of the informal sector on the Universal Health Insurance Scheme found that informal employment has a significant effect on the financing issue. If the informal labor sector is fully formalized, the government's ability to finance UHC in the aging economy can be largely improved, and the labor tax burden can be reduced by 40% (Hsu, Huang, & Yupho, 2015). A successful example of the extension of health insurance to self-employed or workers in the informal sector is that of the Republic of Korea which was able to achieve full coverage in 1989, after a 12-year effort by the government, which was done through mandatory enrolment which included subsidies for the poor and partial subsidies for informal workers.

3. **Inequalities in health, variability in benefit packages.** As it relates to health equity, LAC shows a huge gap in health risks and outcomes between the rich and poor (Belizan, Cafferata, Belizan, & Althabe, 2007). The study "Health Inequality in Latin America" evidenced that the region's health care systems are designed to favor those who needed the least. A recent study, that developed an index for measuring inequalities in the region between 2005 and 2010, found that Cuba has the most equity in healthcare, and that the least favorable was Haiti, and in general, found that LAC continues to struggle with inequality in

health despite governments' efforts to achieve UHC (Cardona, Acosta, & Bertone, 2013). The challenge of defining one benefit package that is adequate to the disease burden represents "*good value for money and is socially acceptable*", is a key challenge for UHC. Furthermore, there is a challenge in closing the gap between legal rights and citizens' ability to benefit from health services by ensuring the availability of quality health services within a close geographic proximity.

4. **Fragmentation of Health Systems** is one of LAC's greatest challenges towards the attainment of UHC. In 1978, the Alma Ata Declaration stated that PHC "*should be sustained by integrated, functional and mutually supportive referral systems*" (International Conference of Primary Health Carre, Alma-Ata, 1978). In 2005, during the III Montevideo Declaration, the document states "*Health care models should be based on effective PHC…and work for the establishment of health care networks and social coordination that ensures adequate continuity of care*" (PAHO, 2005). A fragmented health system presents a barrier towards integration in LAC were the health sector are characterized by the coexistence of several coverage schemes in which different socioeconomic groups are covered by different funding pools, each with particular benefits, financing sources, and rules for access and purchasing of services (Bossert, et al., 2014). For many years, countries of the LAC region have maintained a two-tiered system of health care: one for the formal sector and another, delivered through ministries of health, for the informal sector, poor and uninsured (Baeza & Packard, 2006). According to Barillas fragmented health systems

contribute to the existing inequalities in the population and increase the cost of services due to the creation of multiple administrative units (Barillas, 1997). “Fragmentation manifests itself as a lack of coordination between the different levels of and settings of care, duplication of services and infrastructure, unutilized productive capacity, and health care provided at the least appropriate location, especially hospitals. Furthermore, in fragmented health systems, users experience lack of access to services, loss of continuity of care and failure of health services to meet their needs” (Montenegro, et al., 2011). There is also a loss opportunity for procurement of medical devices, medicines and other inputs, in large quantities, through economies of scale (Barillas, 1997). A report of the PAHO summarized some of the causes of fragmentation in the region of the Americas (Box 1).

Box 1: Leading Causes of Fragmentation in the Region of the Americas

Leading Causes of Fragmentation in the Region of the Americas

- Institutional segmentation of the health system, i.e., the coexistence of subsystems with different modalities of financing, affiliation and health care delivery, each of them 'specializing' in different strata of the population according to type of employment, income level, ability to pay, and social status;
- Health facilities of various levels of care under different decentralized administrative entities (provinces, states, municipalities, health districts, ministry of health, etc.);
- Predominance, within health services, of programs targeting specific diseases, risks and populations (vertical programs) with no coordination or integration into the health system;
- Extreme separation of public health services from the provision of personal care;
- Model of care centered on acute episodic care of disease, and hospital-based treatment;
- Weak steering role capacity of the health authority;
- Problems with quantity, quality and allocation of resources;
- Deficiencies in definition of roles, competencies and contracting mechanisms, as well as disparities in health workers' wages;
- Multiplicity of payer institutions and service payment mechanisms;
- Legal and administrative obstacles; and
- Financing practices of some international cooperation agencies/donors that promote vertical programs.

Source: Adapted from PAHO/WHO 2011

The case of Uruguay is an example of health integration which was the result of a sector reform through the implementation of the Integrated National Health System (SNIS) (Sollazo & Berterretche, 2011). However, Sollazo and Berterretche explain that this attempt of integration has shown that although there has been a structural change,

there is still a lack of coordination at an operational level which hinders integration of the Uruguayan health system.

5. **Financing health systems:** In line with fragmentation of health systems in the provision of health services, there is also fragmentation in financing systems. The demographic and epidemiological changes described below will continue to boost the cost of health care. Although public funding for health has increased in regions like LAC, the financing arrangements are still lacking. One of the key challenges in LAC has been the separation of financing and provision, as a way to incentivize quality efficiency and accountability (Almeida & Dmytraczenko, 2015). The separation of these functions offers providers greater autonomy in managing inputs to achieve efficiency gains. The LAC region has been characterized by tax-financed public systems coupled with SHI financed from payroll taxes, as well as private insurance financed by OOP expenses. According to Almeida and Dmytraczenko, the OECD countries experience has shown that pooling arrangements in health systems are optimal because they reduce segmentation and foster equality and efficiency in the management of health funds. The authors explain that pooling arrangements facilitate cross-subsidies from the rich the poor and spread risks from younger to older populations and from the healthy to the ill. Two successful cases of health financing reforms include Chile and Uruguay that were able to create a pooling fund, making health financing more sustainable.

6. **Deficit in human resources in health and health systems capacity.** Nearly all countries are challenged by worker shortage, skill mix imbalance, maldistribution, negative work environment, and weak knowledge base. The 2006 World Health Report, Working Together for Health, issued by the World Health Organization (WHO), analyzed the worldwide crisis in human resources for health. In developing countries, inequities persist in the availability, distribution, and quality of the health workforce. The situation in the Region is contextualized by poor retention rates in rural and/or underserved areas, high mobility and migration, precarious working conditions, low productivity, and poor performance, all hindering the progressive expansion of services, particularly at the first level of care.

These are a few of the challenges that countries present in the attainment of UHC. On the other hand, political stability, committed leadership, sustained economic growth, and strong health systems are crucial factors that contribute for achieving UHC (WHO, 2014).

3.3 Health Care Models in Latin America

Latin America is one of the regions that proposed a path towards UHC, and in fact, many Latin American countries recognize the right to health and have adopted healthcare models that will allow them to achieve UHC (PAHO, 2017). Chile has a Bismarckanian social security system based on a health insurance for workers funded by a salary tax and, on the other hand, a state-led National Health System, based on the British National Health

Service, which is funded by general tax revenue headed by an institution called the National Health Fund (FONASA) (Becerril-Montekio, Reyes, & Manuel, 2011). Different from Ecuador, Chile's social security system did not set up a separate social security delivery system with its own hospitals and services apparatus. Instead, the social security system served to fund public services and allowed for the use of a complimentary private system through public funding. During the military dictatorship of the 1980s people were given the option to opt out of the public insurance system and choose a private health insurance which created a fragmented health system in which the private health sector had an important role in service delivery (Unger, De Paepe, Cantuarias, Girogio, & Arteaga Herrera, 2008). In recent years, just like Ecuador, Chile has been working to strengthen its public health care.

In countries like Colombia, Peru and Mexico, the healthcare system is based on a national health insurance for the entire population based on mandatory payroll tax contributions and a subsidized regime financed by local and state tax revenues (Escobar, Giedion, Giuffrida, & Glassman, 2016). In all of these countries the health care system is based on scheme that involves the participation of three agents: insurers, users, providers and pension fund administrators. The insurer can contract health services from both the private and public providers (Gomez-Camelo, 2005).

On the other hand, Uruguay's health system consists of public and private health institutions. The public sector, administered by the Ministry of Public Health through an institution called the State Health Services

Administration (ASSE) and several other related agencies such as the Police and Military. Public medical services are free for primary health care services. Other types of medical treatment are given based on established fees (Aran & Laca, 2011). These are a few of the health care models being implemented in Latin America. All models are very different; however serve as the platform for the achievement of UHC, within the institutional possibilities that have shaped each country's health policy making.

3.4 Background on Ecuador

4.3.1 Geographical Location

Located in the north-western corner of the South American continent, Ecuador is one of the smallest countries in the region with only 283,560 square kilometers. The country borders with Colombia in the North, Peru in the South and the Pacific Ocean on the West (Figure 2). The Equator crosses through the country giving it its distinctive name. Ecuador is known as the country of four worlds: the Pacific Coast, the mountainous Andes, the Amazonian Jungle and the Galapagos Islands. However, Ecuador is also located in a seismic area which is prone to earthquakes, volcanic eruptions and tsunamis. The country is divided into 24 provinces with Quito as its capital city and Guayaquil as the main port and most populated city in the country.

Figure 2: Map of Ecuador

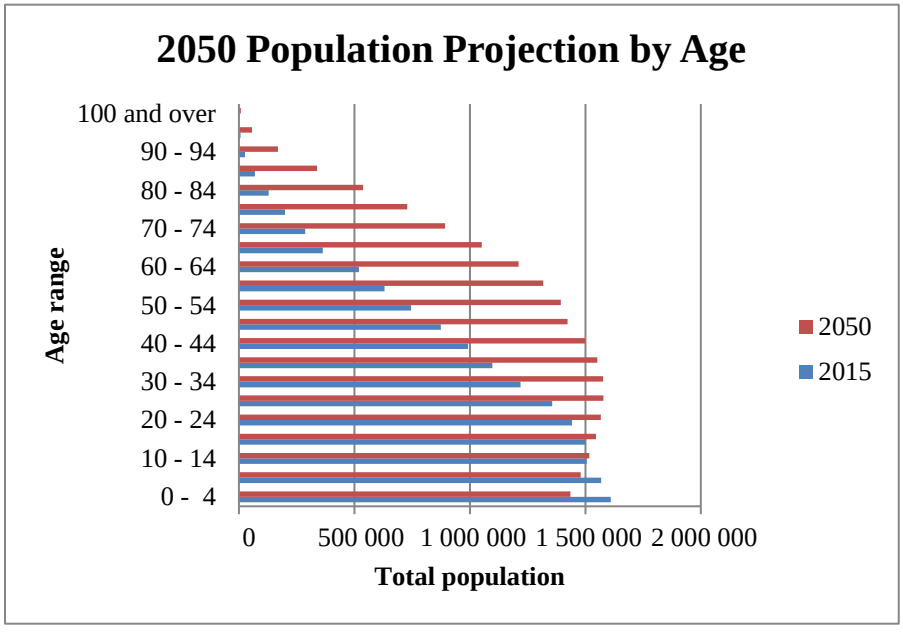
Source: Bruce Jones Designs 2009, http://www.freeusandworldmaps.com/

4.3.2 Demographic Profile

As most of Latin American countries, Ecuador was colonized by Spain and gained independence on August 10, 1809. Ecuador has a population of 16,144,000 (2015 estimate). Similarly to other Latin American countries, Ecuador has an urban population concentration. In 2015 64.4% of the population lived in urban areas and this segment of the population is expected to increase to 75.1% by year 2050. Although, the demographic structure of the country currently shows a predominant young population, projections indicate that by year 2030, Ecuador will have an aging population with women having 2 or less children which is depicted in Figure 3. Furthermore, life expectancy is projected to grow from 75 years of age in 2010 to 80,5 years of age by year 2050 (INEC, 2010). Ecuador is a

multiethnic and pluricultural state composed of ethnically diverse populations. As per the 2010 Census, the largest ethnic group is the mestizos who constitute 71% of the population. White Ecuadorians represent 6.1% of the population, Amerindians account for 7% of the population, the Montubio population for 7.4% and the afro-Ecuadorian population accounts for 7,2% (INEC, 2010).

Figure 3: Ecuador's Population Projection by Age



Source: CELADE - Population Division of ECLAC. 2017 Revision

4.3.3 Economic Profile

The Ecuadorian transition into democracy which started in the 1979 was not an easy task for the state. To synthetize, Ecuador went from a development

model focused on strong state intervention and coordination in the 1980s to a neoliberal model in the 1990s in which the state's regulatory, redistributive, and planning capacities were dismantled (SENPLADES, 2009). The 1990's were characterized by "Washington Consensus" type reforms, management of external debt and subordination to the neo-liberal policies imposed by the World Bank and IMF. This was also a decade of political turmoil and institutional instability – between 1992 and 2006 there were a total of 8 governments in power. Furthermore, in 1999 Ecuador underwent an acute economic crises which was triggered by the adoption of liberalization policies, unsuccessful macroeconomic stabilization policies, external shocks including low price of oil, and moreover, the flooding caused by el Nino which affected the country's coastal provinces (Ponce & Vos, 2012). As a result, in the year 2000, after undergoing an economic and financial crisis, the country abandoned its own currency and became a dollarized economy. In summary, Ecuador's turn into the new millemium was characterized by a crisis of governance, increased corruption, administrative instability and lack of continuity in public management.

Between 2006 and 2014, Ecuador's economic growth accounted for an average 4.3%. According to the World Bank, this growth can be explained by the high oil prices coupled with significant external investment in the country's public apparatus which allowed for an increase in public expenses, especially in the social, energy and transportation sectors (The World Bank, 2017). As a result of this economic growth, in 2011 Ecuador transitioned from being a low-median income country to a high-median income country,

with a gross national income per capita of $6,150 in 2014 (The World Bank, 2014). However, in 2015 the country was drastically affected by a dependency in oil revenues coupled with plummeting prices of oil which drastically slowed economic growth in 2015. In 2015 the country's GDP growth plummeted to 0.16%. Furthermore, in 2016 the country suffered a catastrophic earthquake which continued to affect economic growth and in this year the economy contracted by 1.47%. Likewise, countries like Brazil and Venezuela were also affected by low oil prices that translated into an economic recession which has affected the region as a whole and will continue to affect the region's economic performance for the next few years.

Table 2: Global Economic Indicators, Ecuador

Global Economic Indicators for Ecuador						
	2006	2012	2013	2014	2015	2016
Population	13,967,480	15,419,666	15,661,547	15,903,112	16,144,368	16,385,068
Population Growth (Annual %)	1.68	1.58	1.56	1.53	1.51	1.48
GDP Per Capita (USD)	3,350.79	5,702.10	6,074.09	6,432.22	6,205.06	5,968.98
GDP Growth Rate (Annual %)	4.40	5.64	4.95	3.99	0.16	(1.47)
GDP (Billion USD)	46.8	87.9	95.1	102.3	100.2	97.8
Inflation, Consumer Prices (Annual %)	3.03	5.10	2.74	3.57	3.97	1.72
Total Debt Service (%)	33.25	10.76	12.16	14.60	24.40	
Total External Debt Stock (Billion USD)	18.3	17.1	19.1	24.4	27.3	16.8
Net ODA Received (% GNI)	0.42	0.17	0.16	0.16	0.32	

Source: World Bank Data

4.3.4 Social Profile

Ecuador's Human Development Index ranking has been categorized as High Human Development by the UNDP with a ranking of 89 points (United Nations Development Programme, 2016). Moreover, Ecuador achieved 20 of the 21 Millennium Development Goals adopted in 2005 and which deadline was 2015 (SENDPLADES, 2014). The only unmet goal was that of reducing maternal mortality by the 75% target established by the UN. Ecuador reduced maternal mortality by 68% and has established a series of strategies and programs to progress towards the attainment of this goal. Ecuador's National Development Plans aimed to attaining national goals were key to the attainment of the Millemium Development Goals.

In the context of the National Development Plan, Ecuador was able to decrease the national percentage of people living under poverty from 36.7% in 2007 to 23.1% in June 2017. Moreover, the reduction of poverty for the rural population is more significant from 61.3% in 2007 to 41% in June 2017. There was also a reduction for the segment of the population living under extreme poverty. National levels were reduced from 16.5% in 2007 to 8.4% in June 2017. Extreme poverty for the rural segments was consistently reduced from 33.3% in 2007 to 17.8% in June 2017 (INEC, 2017). The reduction in poverty was also reflected in the Gini coefficient that fell from 0.54 to 0.47 between 2006 and 2014.

Although Ecuador's unemployment rate had been characterized as one of the lowest in the region, with a low 3.5% in 2013, the most recent

international financial crises and negative economic growth of the region resulted in an increase in unemployment at the end of 2016. The national unemployment rate reached 4.5% (INEC, 2017). Furthermore, after a decade of economic growth and reduced unemployment, informal employment is a persistent problem in Ecuador and makes up 39.31% of the working population (INEC, 2017). This percentage of the population is exposed to lack of access to social protection, benefits, and among others, job security and labor rights. The problem of informal labor is exacerbated by the flow of Colombian refugees and the flow of unauthorized immigration from countries with political and economic turmoil such as Venezuela. Ecuador is the host to the second-largest number of refugees and asylum seekers in Latin America. Just in 2016, the number of recognized Colombian refugees in Ecuador had increased to 57,325 from a total of 60,253 refugees (95.2% of the total). Furthermore, a total of 233,049 refugee requests had been received by the Ecuadorian authorities in 2015 (ACNUR, 2017).

4.3.5 Development Model

Ecuador's developmental model of "Good Living" or "Sumak Kawsay", pushed forward by the government of Rafael Correa, has been characterized as a paradigm shift to traditional development models (Villalba, 2013). The concept of Good Living is constructed on the concept and worldview of the "Sumak Kawsay" which is a concept borrowed from ancient Andean societies which is based on human, economic, social, cultural and environmental rights. Furthermore, "Sumak Kawsay" is based on the notion

of social cohesion and community values encouraging civil participation in decision making. In Ecuador, the government of Rafael Correa made the concept of Good Living the defining purpose of public policy (SENPLADES, 2014).

Ecuador's development plan is the foundation of institutional change and is conceived as an instrument for social change. The first version of the National Plan of Good Living states that the determining factor for the "reinstitutionalization" of the State is grounded in the social and economic crises that the country experienced but also the profound political crises, in which institutions showed their deep grounded inefficiency. Furthermore, the development plan clearly states that the model that Ecuador followed for a long time determined a reduction of the state apparatus since that was the direction of economic policy, and they meant that the new government needed to pay special attention to institutions. In this context, the National Plan for Good Living is the instrument that puts institutions at the center of development as these generate stability and change, because without them it is difficult to have an efficient administration on the one hand, and on the other hand, institutions provide the linkage with citizens.

The plan was created through the Constitutional reform of 2008. Article 280 outlines the National Development Plan as the main instrument guiding public policies, programs and budgets. Furthermore, the plan mandates the execution of the State Budget, the allocation of public resources, and helps guide the coordination of competences between the central government and the decentralized autonomous governments. The National Plan is a 5-year

that has included 12 objectives (Table 3) and it's coordinated by the National Secretariat for Planning and Development (SENPLADES from its acronym in Spanish). The Plan has its own separate budget and governing structure – The National Planning Council, an intersectoral technical secretariat for the Development Plan. Across the board, Correa's administration development plans have been focused on reducing inequality through an intersectoral approach that is built into the design and implementation of programs at the state and local levels of government. In the health sector, this translated into health goals that tackle social determinants of health from an intersectoral perspective. Furthermore, public participation is a cornerstone of the plan as well as public oversight mechanisms at the central and local governments to ensure consensus building and representation from local and traditionally marginalized communities.

Table 3: 12 Objectives of the National Plan of Good Living 2013-2017

Objective 1:	"Consolidate the democratic state and the construction of popular power"
Objective 2:	"To foster social and territorial equity, cohesion, inclusion and equality in diversity".
Objective 3:	"To improve people's quality of life".
Objective 4:	"To strengthen citizen capacities and potential".
Objective 5:	"To build spaces for social interaction and strengthen national identity, diverse identities, pluri-nationality and interculturality".
Objective 6:	"To consolidate the transformation of the judicial system and reinforce comprehensive security, with strict respect for human rights".
Objective 7:	"To guarantee the rights of Nature and promote environmental sustainability globally".
Objective 8:	"To consolidate the social and solidary economic system, sustainably".

Objective 9:	"To guarantee dignified work in all forms".
Objective 10:	"To promote transformation of the productive structure".
Objective 11:	"To ensure the sovereignty and efficiency of strategic sectors for industrial and technological transformation".
Objective 12:	"To ensure sovereignty and peace, deepen the strategic insertion in the world and Latin American integration".

Source: SENPLADES.

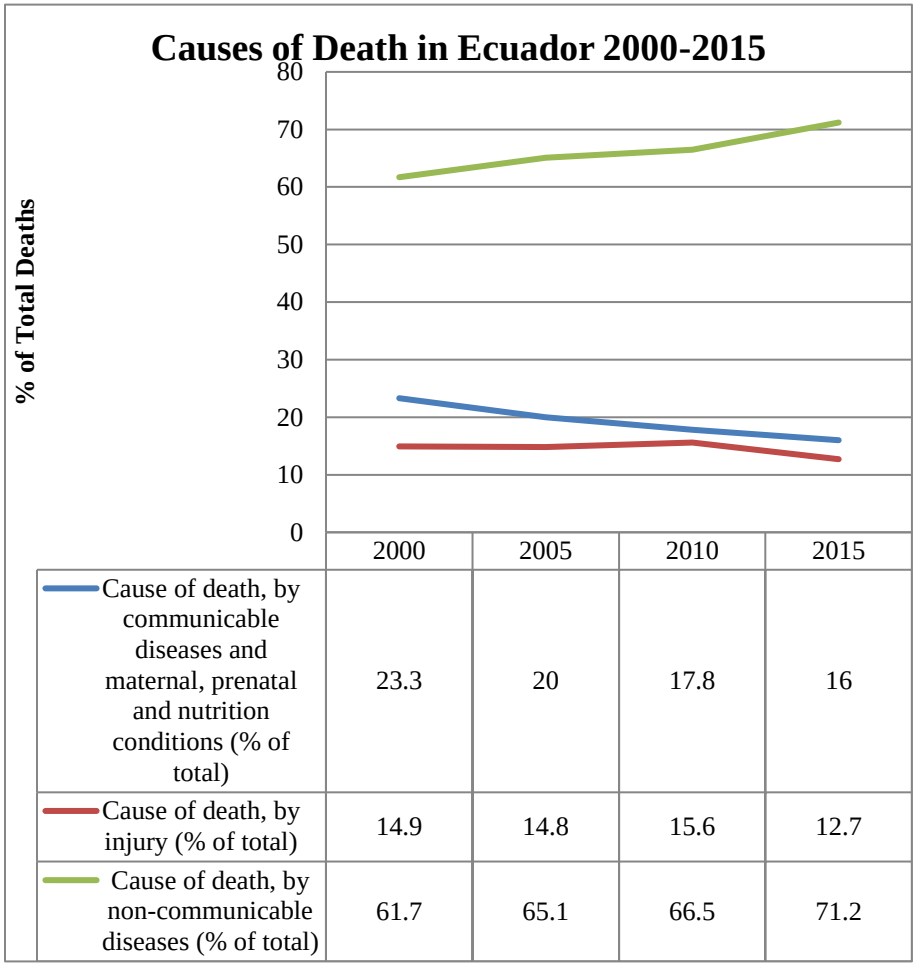
4.3.6 Health Profile

Since 2006, the main causes of death of the Ecuadorian population consist in the five main causes which include ischemic heart disease, diabetes mellitus, cerebrovascular diseases, influenza and pneumonia and ground transportation accidents. According to the WHO the prevalence of these diseases is mainly related to bad nutrition habits and sedentary behavior (WHO, 2002). These statistics are consistent with the global trend were the prevalence of NCDs is increasing due to factors including population growth, population ageing, as well as changes in behavioral, occupational and environmental risks tied to the world's economic transition (WHO, 2011). These trends are depicted in Figure 4.

Ecuador, following global patterns has seen an increase in the prevalence of non-communicable diseases in the population. As it relates to nutrition, there has been a reduction of chronic malnutrition in children less than 5 years of age. The prevalence of stunting in children less than 5 decreased from 33.5% to 25.3% in the period between 2004 and 2012. However, the prevalence of overweight and obesity in children under 5 years of age increased from 6.6% to 8.6% in the period between 2004 and 2012 (INEC,

2012). In regards to the prevalence of overweight and obesity, ENSANUT 2011-2013 found that a total of 6 of every 10 Ecuadorians ages 19-59 are overweight or obese (INEC, 2013).

Figure 4: Causes of Death in Ecuador 2000-2015



	2000	2005	2010	2015
Cause of death, by communicable diseases and maternal, prenatal and nutrition conditions (% of total)	23.3	20	17.8	16
Cause of death, by injury (% of total)	14.9	14.8	15.6	12.7
Cause of death, by non-communicable diseases (% of total)	61.7	65.1	66.5	71.2

Source: National Institute of Statistics and Censuses of Ecuador (INEC)

4.3.7 National Health System Profile

According to a WHO 2000 report that aimed to assess the overall efficiency a health system for 191 countries through a composite index of 5 indicators (health, health inequality, responsiveness-level, responsiveness distribution, and fair-financing), using 1997 estimates, Ecuador was ranked 111 out of 190 countries in terms of its health system performance (Tandon, Murray, Lauer, & Evans, 2000). In contrast, Ecuador's neighboring country, Colombia, was ranked 22 in the world and 1 among the Latin American countries. In respect to the responsiveness distribution or equality, the index positioned Ecuador in ranking 133 out of 190 countries this is the lowest ranking for this category in LAC, just over Haiti putting in evidence the profound inequality that existed in Ecuador in terms of access to health services.

Ecuador currently maintains a two-tiered system of public health care: one for those affiliated to a public social security scheme, and another delivered directly by the MPH for those who are uninsured. The Social Security Institute (IESS from its acronym in Spanish) is the second national health provider, based on a system of insurance coverage based on job affiliation. IESS administers four types of insurance, as well as other benefits for its affiliates:

1. The General Individual and Family Health Insurance Benefits
2. The General Disability, Old Age, Pension Pawnshop and Funeral Aid Benefits

3. The General Work Risk Insurance Benefits
4. The Rural Social Security (SSC) Benefits (a special insurance scheme that protects the population from the rural sector and artisanal fisherman of Ecuador).

Other public institutions in the public health sector include the Armed Forces Social Security Institute (ISSFA from its acronym in Spanish) and the National Police Social Security Institute (ISPOL from its acronym in Spanish), and some Health Services provided by some municipalities. Furthermore, the Ministry of Defense, Ministry of Interior and the Ministry of Social and Economic Inclusion (MIES from its acronym in Spanish) also manage some health provision facilities (i.e. health provision in penitentiaries). The private sector includes nonprofit and for profit health providers. The private nonprofit health sector is also represented by large organizations including the Guayaquil Welfare Board (Junta de Beneficiencia de Guayaquil), The Society for the Fight against Cancer (Sociedad Protectora de Lucha contra el Cancer- SOLCA), the Ecuadorian Red Cross and many other smaller scale foundations. As it relates to private insurance and prepaid medical practitioners, these accounted for approximately 3% of the population in 2011. In addition to an approximate 10,000 private medical offices with basic infrastructure, located in major cities and where the population usually makes OOP payments (Lucio, Villacres, & Henriquez, 2011).

In accordance with the Ecuadorian Constitution in its Article 360, the NHS consists of an Integrated Public Health Network (RPIS from its acronym in

Spanish) that consists of the articulated set of institutions, social security and other providers that belong to the state from a legal, operational or complementary basis". The MPH, as the sanitary authority, is responsible for steering and ensuring the improvement of the NHS. The mission of the MPH is to exercise the rectory, regulation, planning, coordination, control and management of the Ecuadorian Public Health through the governance and health surveillance and control and guarantee the right to Health through the provision of individual care services, disease prevention, health promotion and equality, health governance, research and development of science and technology; articulation of the actors of the system, in order to guarantee the right to Health (MPH, 2012). The National Health Council (CONASA for its Acronym in Spanish) is the entity under the MPH designed to promote the construction and organization of the NHS, whose mission is to establish the National Health Policy, a Comprehensive Health Plan, coordinate with its members its implementation, and promote social participation and the exercise of health rights. The National Health Council consists of all members of the NHS including, both public and private and is the space were all sectorial reform negotiations take place.

4.4 Brief Summary of the Health Reform

The following section provides an overview of the history of Ecuador's health reforms, from the neoliberal era to the new era of the "Citizens Revolution under the mandate of Rafael Correa. However, this section will

only highlight the main health reforms of the Correa Administration based on the review of a series of governmental documents and complimented with information provided by interviewees.

4.4.1 The Neoliberal Phase

Since the creation of the MPH there are a number of political forces that have characterized the sector which include a predominant influence of the medical profession and the elites, the influence of several regional influences and the need to comply with some international commitments assumed by the Ecuadorian State (Public health expert). The neoliberal era which started in the 1990s influenced the health sector in many ways, including a decrease in infrastructure spending, policies encouraging direct payment of services, and the elimination of subsidies and poverty alleviation mechanisms (Malo, Reform of the Ecuadorian Health System: towards universal coverage [Reforma del Sistema de Salud de Ecuador: hacia la cobertura universal], 2014). Finally, in terms of service delivery, neoliberalism policies pushed forward restrictive service packages in which catastrophic diseases like cancer were not considered for treatment. In 1993 the World Bank published the "World Development Report: Health Investment" in which countries are recommended to define a package of essential health services as a way to improve the allocation of efficient and equitable distribution of resources of the health sector. In the case of Ecuador, technical assistance for determining the country's health services package was provided by the United States Agency of International Development (USAID) in 1996 (USAID, 1996). In this package, preventive

public health such as vaccination services and epidemic control were free of charge, however curative health services were not. During this period the WHO and PAHO stopped being the primary international advising organizations on health matters in Ecuador. The World Bank occupied this role as a way to decrease government spending and minimize the role of the state in health matters (Guevara, 2011). For example, in 1991, the Interamerican Development Bank prepared a special report in which it proposed that Ecuador's health insurance and pension funds be managed privately. This proposal was part of a National Referendum in 1995 in which the population rejected the participation of the private sector in the management of social security. In summary, during the 15-year neoliberal era which started in the 1990s in Ecuador, the for-profit private sector increased, focusing its services on curative medicine linked to the provision of private health insurance, causing a further fragmentation of the Ecuadorian public health system (Guevara, 2011). Furthermore, the increasing health demands of the population were not being met by the MPH because of a systematic decrease in the public health budget. This signified that the private health sector was growing at faster rates than the public sector. Moreover, the Ecuadorian population almost totally lacked health insurance – an approximate 85% were uninsured being the richest quintiles of the population the ones that benefited the most (INEC, 2017). The political and institutional instability experienced by the country during these years, did not allow the development of public policy as each government in office (8 governments in 10 years) had new issues in agenda which did not allow for improvements of the health sector, not to mention

the many demands of the ruling elites and health professionals. The system of provision of health services was characterized by the fragmentation and segmentation, since there was no coordination between actors or separation with between subsystems, and each of them had a population attached or beneficiary with access to differentiated services. This led to duplications of activities with low impact on the population's health. The minimum role of the state together with growing social demands, aggravated by the financial crisis in 1999, provoked Constitutional rights to be breached and evidenced that the state guarantees were ineffective.

4.4.2 The Citizens Revolution

The overall dissatisfaction of the population, rooted from the instability during the neoliberal period, became an important factor that lead to Correa's successful regime and system reforms (Public health expert). Correa's regime became known as the "Citizens' Revolution", and echoed the population's urge for a different alternative form of governance. The Citizens Revolution of the Correa Government is considered as an alternative for the State to recover from the institutional weakness. To do so, the government relied on the conformation of the National Constituent Assembly, the approval of a new Constitution, and the introduction of a National Development Plan which guides all public policy in the country.

Correa's first reform consisted in rewriting its Constitution. Correa called for a National Referendum in Abril 2007, which resulted in an approval by 81.72% of voters for the dissolution of the National Congress and the

election of new representatives to conform the Constitutional Assembly of Montecristi. The Constitutional Assembly was integrated by important political leaders and academics. Correa's party, Alianza PAIS, had majority seats, 70% of total sits, which secured a smooth process for writing the Constitution and achieving consensus among members. The National Constitutional Assembly, in approximately a year of work, drafted a new Constitution which created a basis for an institutional shift in Ecuador. The former Constitution of 1998 had been written and implemented without the Ecuadorian people's consent, it was approved by the National Assembly of a government ruled by elites and approved in a military base (Avila Santamaria, 2012). Although the Constitution of 1998 achieved great development in the recognition of human rights, the Constitution was based on an economic model that was liberal and had been influenced by the Washington Consensus, harmonizing Ecuador's economic model with globalization as a means to attract foreign investment (Avila Santamaria, 2012).

A month after the new government came into power; the Ministry of Public Health created the "Advisory Council for Health Sector Transformation in Ecuador - TSSE". This became the space for negotiation and elaboration of different sectoral initiatives with the participation of different organizations related to the health sector, including the participation of all members of CONASA (Donoso Puertas, 2009). It was in this space that began to process the main initiatives of reform, and where the government could form alliances while for the elites which included health providers and

doctors, this space allowed them to put pressure on their interests (Public health expert).

The first step for the Sectorial Transformation of Health in Ecuador was the inclusion in the Constitution of 2008 the articles corresponding to health gathering many of the proposals of the sector which were articulated under the TSSE (Ministry of Public Health of Ecuador, 2008). The main proposal was that of an integral model of care that would guarantee equitable and universal health coverage. The proposal consisted on a two-teared model of care in which 1) An exchange of services among the public health network at the second and third levels of care were each public actor (MSP, IESS, ISSFA, ISPOL) maintained its autonomy and 2) a unitary system of basic health provision which integrates all public health institution at the primary health level and implements a pooling fund (Donoso Puertas, 2009). For the implementation of this new integral model of health, there were several reforms that had to be implemented thereafter which are described below:

1. **The Institutionalization of the Integral Public Health Network – RPIS**. The conformation of the RPIS is established in article 360 of the Constitution and is the fundamental axis for the functioning of the NHS. The MPH as the national sanitary authority leads the network and established the National Technical Commission which is made up of representatives of each of the public subsystems (IESS, ISSFA, and ISPOL). This commission operates on a permanent basis coordinating and making decisions regarding the NHS. The network of health services under the RPIS is structured regionally with two levels of

decentralization by zones and districts. Under the umbrella of the MPH and coordination of the CONASA, the RPIS aimed to tackle the inefficiencies and barriers to access caused by a fragmented public health sector so that the Ecuadorian population can access any of institutions' services regardless of their affiliation. One of the most important accomplishments of the RPIS was defining the benefits package for the Network which satisfies 90% of the current burden of disease in the country.

2. **The Establishment of the Complimentary Health Network** which allows for the participation of the private sector in the implementation of the health care model through the purchase of services that the public sector buys from the private sector to meet the demand that cannot be covered. In the System, if health services cannot be met by the RPIS, the patient may be referred to the Private Complimentary Health Network, and the associated costs will be covered by the public sector. Usually, patient referrals occur because lack of accessibility due to geographical circumstances, lack of physical space, based on resolute capacity, insufficiency of health professionals, infrastructure problems and equipment or supply problems (IESS, 2016). The Complimentary Health Network consists of private clinics that have been accredited or approved by the MPH and other organizations of the RPIS, to provide medical care to the Ecuadorian population.
3. **The Strengthening of the Stewardship Role of the MPH** as the national health authority leading the NHS. This gives the MPH the ability to dictate norms and exercise control over the system. However,

the necessity to strengthen the MSP's structure in the conduction, standardization, coordination, regulation and control of health activities, was a key aspect of the reform (Expert, academia). This translated into the need to establish a new structure of the MSP. The new structure implemented for the MPH of Ecuador consists of two Viceministries under the Minister of Health. First, the Viceminister of Governance and Health Surveillance which defines public policies, models, norms, strategies and other tools to ensure the governance of the NHS, as well as the public health surveillance, promotion and protection of public health. On the other hand, the Viceminister of Integral Health Care mission is to ensure the implementation of public sector policies for disease prevention and health promotion, and ensure individual, family and community health care according to the principles of universality and quality all levels of care of the MPH.

4. **The Establishment and Implementation of the Integral Health Care Model – MAIS.** The Model of Integral Health Care with a Family, Community and Intercultural Approach (MAIS-FCI) is the set of strategies, rules, procedures, tools and resources that, when complemented, organizes the NHS to respond to the health needs of the people, the families and the community, allowing the integrality in the levels of care in the health network. The model proposed by the MSP seeks to consolidate primary health care as a strategy that prioritizes disease prevention and health promotion. The model modifies the focus and practice of care towards a more integral model. In Ecuador, vertical health programs had prevailed over comprehensive PHC (Tejerina, et

al., 2009). Furthermore, as a way to strengthen PHC, the Ministry of Health reorganized health provision into three levels. The I Level is the closest to the population; it facilitates and coordinates the flow of the patient within the system, guarantees an adequate reference and counter-reference, and ensures continuity of care. It is outpatient and resolves short-term health problems. It is the obligatory entrance door to the NHS. The II Level of Care includes all the actions and services of specialized outpatient care and those that require hospitalization. Level III corresponds to the establishments that provide specialized and specialized ambulatory and hospital services (Malo, La Salud en el Ecuador: Modelo de Atencion Integral de Salud con Enfoque Familiar, Comunitario e Intercultural, 2013).

5. **Implementation of a new Management Model, Decentralization and Deconcentration of the NHS**. The Management Model responds to the recovery of the planning capacity of the State, instrumented in the National Plan for Good Living (PNBV) to which public policies, programs and projects are subject; the programming and execution of the State budget; investment and allocation of public resources; allowing to coordinate the exclusive competences between the Central Government and the Decentralized Autonomous Governments. The new management model proposes the financial, functional and administrative deconcentration towards the new territorial structures, defined as zones and districts, which will allow an adequate separation of functions between the central level, responsible for the institutional policy and the exercise of the faculty of rectory, and the local level

(Chang, 2009).

6. **Human Resources Reforms.** These were directed at the establishment of fair wages for health professionals, and the retention of health personnel with a policy of increasing salaries by 80% the fairness in the distribution of working hours to 40 hours a week for all staff. The lack of fair wages caused the migration of the personnel to other countries in search of better remunerations, because the disincentives were significant. One of the biggest problems facing the health sector is the brain drain, especially to countries like Spain, Italy, Chile and Argentina among others. According to the MPH, about 40% of doctors graduated in the country are abroad (Ministry of Public Health).
7. **Increase in Health Spending and Improvement of Financing Mechanisms.** At the basis of the reform were an increase in public health expenditure and a progressive increase in funding for the attainment of UHC (Chang, 2009).

4.5 Analysis and Interpretation using the WHO Framework

In this section, the author will analyze Ecuador's health reforms using WHO indicators as measures of progress toward UHC between 2007 and 2014. Key health statistical data will be used to assess Ecuador's progress towards the attainment of UHC which will be based on each of the indicators selected during the literary review. The study analyzes how the Ecuadorian health systems could be enhanced to expand health coverage.

4.5.1 The right to health

The first of UHC is the guarantee of the right to health by the State from a normative perspective. Based on the recognition that health is a human right, it is important to analyze the right to health in Ecuador from a normative perspective. With this in mind, this section will analyze the new Constitution of 2008 and the National Plan of Good Living as the basis for the attainment of UHC in Ecuador. In this analysis, it is important to note Correa's government focus on the re-institutionalization of the State where the efficiency and function of State institutions is widely discussed.

The 2008 Constitution sets the stage for Ecuador's innovative developmental model based on the concept of the "Sumak Kawsay" or Good Living which proposes a paradigm shift for Ecuador. (Avila Santamaria, 2012). The overarching goal of the Ecuadorian Constitution is Good Living and all of the government's policies and programs are derived from this goal. As it relates to health, the Ecuadorian Constitution of 2008, in its Article 3, delineates the State's duty to guarantee, without discrimination, the rights established in the Constitution, in particular, the right to health, alongside the rights to education, food, social security and water. Article 30 of the Constitution states "*Health is a right guaranteed by the State and whose fulfillment is linked to the exercise of other rights, among which the right to water, food, education, sports, work, social security, healthy environments and others that support the good way of living*". The key principles outlined in the Constitution that govern the provision of health services include equity, universality, solidarity,

interculturalism, quality, efficiency, effectiveness, prevention, and bioethics, with a gender and generational approach (Constitution of the Republic of Ecuador, 2008).

The Ecuadorian Constitution of 2008 derives from the Constitution of 1998 which had already recognized the right to health. The recognition inclusion of rights in the 1998 Constitution, as well as provisions recognizing Ecuador's, were considered a significant advance in the country's history. However, the 1998 Constitution did not have its institutional counterpart (Avila Santamaria, 2012) and did not define the mechanisms to guarantee these rights. (Echeverria, 2008). As opposed to the Constitution of 1998, the new Ecuadorian Constitution of 2008 clearly describes how these rights will be guaranteed by the State through the Good Way of Living System. As it regards to the guarantee of the right to health by the State, the Constitution establishes the creation of a NHS comprised of institutions, programs, policies, resources, actions, and players in health. Furthermore, it establishes the Comprehensive Public Healthcare Network (RPIS for its acronym in Spanish), comprised of the state institutions, social security and other suppliers on the basis of legal, operational and complementary ties. The 2008 Constitution also reclaims the stewardship role of the MPH, establishing that "*the State shall exercise leadership of the system through the national health authorities, shall be responsible for national health policymaking, and shall set standards for, regulate and monitor all health-related activities, as well as the functioning of sector entities*". Furthermore, the Ecuadorian Constitution of 2008 establishes that the State Budget is

intended to finance the national healthcare and education systems, and it will increase each year by a percentage no less the 0.5 % of the GDP, until it reaches at least 4% (Constitution of the Republic of Ecuador, 2008). It is important to mention that the New Constitution also includes new rights, tied to determinants of health, such as the right to water, food and a healthy environment.

Another important aspect of the 2008 Constitution for the achievement of UHC is the recognition of the right to social security and the responsibility bestowed specifically to the State to guarantee and ensure the effective exercise of this right. The 1998 Constitution also recognized the right to social security. However, stated that social security will be provided with the participation of the public and private sectors. Furthermore, the 1998 Constitution, in accordance to the right to social security, states that compulsory general insurance will be progressively extended to the entire urban and rural population, with or without employment dependence, as permitted by the general conditions of the system. In the 2008 Constitution, these rights are explicitly extended to traditionally excluded sections of the population, including persons who carry out unpaid work in households, livelihood activities in the rural sector, all forms of self-employed, and lastly, those who are unemployed (Constitution of the Republic of Ecuador, 2008). Therefore, the new Constitution of 2008 extended the social security coverage benefit to the population regardless of employment status to those who wish to join voluntarily. In summary, the social security system enjoys special Constitutional protection that defines it as public and universal,

prohibits its privatization and forces it to meet the needs of the population through compulsory universal insurance.

In essence, the 2008 Constitution has a redistributive approach that strengthens the public sector role in the operationalization of its mandates. In relation to priority groups, the 1998 Constitution states that, in public and private areas, priority attention, preferential and specialized will be given to children, adolescents, pregnant women, people with disabilities, those with complex catastrophic diseases, people in a situation of risk, victims of domestic violence, child abuse and natural disasters. However, the new Constitution of 2008 goes a step forward in guaranteeing the rights of citizens, especially those that had been traditionally marginalized, including imprisoned persons. For example, as it relates to pregnant women, as described in Section 4 of the Constitution, "*the State shall guarantee the rights of pregnant and breast-feeding women*" which include their right to not be discriminated, free maternal health care services, priority protection and care of their integral health and life during pregnancy, during childbirth and postpartum, and the right to facilities needed for their recovery after pregnancy and during breast-feeding. The protection of pregnant women in the Constitution is a key factor in the reduction of maternal mortality. Furthermore, the 2008 Constitution also guarantees the rights of persons with disabilities, taking the rights established in the Constitution of 1998, a step further, by prohibiting their discrimination as it relates to employment, education, air travel, transportation, access to healthcare. This sets the stage for the passage of the National Law of Disability in August of 2013 in

which, among other important policies, requires that 4% of employees in all public and private companies with more than 25 employees be persons with disabilities. Under this law persons with disabilities have certain benefits from several public and private entities, these include utilities, transportation, and taxes. The law stipulates rights to health facilities and insurance coverage, increased access and inclusion in education. Moreover, the 2008 Constitution in Chapter 1 advocates for "*the principle of universal citizenship, the free movement of all inhabitants of the planet, and the progressive extinction of the status of alien or foreigner as an element to transform the unequal relations between countries, especially those between North and South*". In this context, Article 11 establishes that no one should be discriminated against for reasons of ethnic belonging, place of birth, migratory status. Article 40 establishes that the right to migrate of persons is recognized. "*No human being shall be identified or considered as illegal because of his/her migration status*". In the health context, this translates into health provision through the mandatory health insurance to all people regardless of their citizenship.

In summary the Constitution is the document that provides the basis for institutional change during Correa's administration.

4.5.2 Financing

Improving financing, in an equitable and efficient way, with the purpose of eliminating direct payment is one of the strategic lines pushed forward by PAHO in its Strategy for the attainment of UHC. In Ecuador,

sustainability of the health budget is a big concern, especially due to Ecuador's dependency on oil revenue. Like any other health system, the Ecuadorian health system cannot efficiently achieve UHC, without ensuring equitable financial protection for all households, and this requires a coordinated effort from all the institutions involved. This section's analysis describes the health financing structure of the Ecuadorian government and will focus on a description of three aspects of health financing: resource collection, revenue sustainability and purchasing, and aims to assess the sector's overall improvement towards the attainment of UHC.

4.5.2.1 Resource Collection

Resource collection is the basis of health financing within the UHC framework. An increase in revenue collection is a key UHC determinant, especially as it relates to populations that are uninsured and not covered by any of the social insurance schemes of IESS, ISSFA, ISSPOL or private insurance. Sustained resource collection guarantees that uninsured populations receive health care provision through government funds and do not have to incur OOP payments. In Ecuador, the Central Government is in charge of establishing the criteria for distribution of resources among the different sectors. Article 366 of the Ecuadorian Constitution establishes that "*public funding for health shall be timely, regular and sufficient and m ust come from ongoing sources of the General Budget of the State. Gov ernment resources shall be distributed on the basis of population criteri a and health needs*" (Constitution of the Republic of Ecuador, 2008). The allocation of state resources is done according to the political priorities

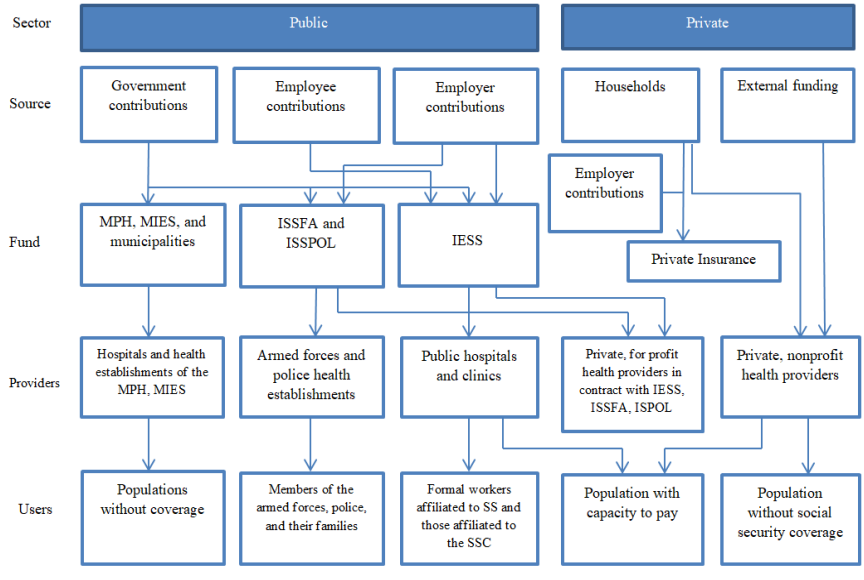
in the National Plan of Good Living as the document that guides the social agenda of the government. The executing agency is the Ministry of Finance (MF), responsible for collecting and distributing fiscal resources, i.e., taxes, oil revenues, loans and grants from multilateral organizations and non-governmental organizations.

The institutions that make up the public health system include the MPH, IESS, ISPOL, Ministry of Interior (MoI), ISSFA and the Ministry of Defense (MoD), the MPH being at the head of the National Public Health Network. These are all the public entities that have health establishments under their domain. The MF is in charge of the final budget approval for all Ministries in the health network (MPH, MoD and MoI). The MPH is in charge of purchasing goods and services for the establishments under its domain and relies on funding from the National Budget. The MoD and MoI partially fund the institutions under their domain through government subsidies and the established contributions that complement the private contributions of the affiliates of ISSFA and ISPOL respectively. Furthermore, they fund health establishments under their domain, including, for example, in the case of MoD, penitentiary health establishments.

The IESS has three financing mechanisms which include the contributions of its affiliates, the contribution of private or public employees, and the State's contribution determined by the Executive (Republica del Ecuador, 2001). The Law of Social Security, Article 49, determines the separation of funds of the accumulated contributions by the insurance type and their purpose, and these are managed separately from the assets of the IESS.

Both ISSPOL and ISFFA are both funded by contributions from its beneficiaries, employer's contributions (the State) and the funding that derives from the State Budget. For ISPOL and ISFFA the beneficiary and employer contributions are calculated differently (Policia Nacional del Ecuador, 1995) (Fuerzas Armadas Ecuatorianas, 1993). Figure 5 depicts the financial structure of the Ecuadorian health sector. In 2014, the National Health Budget for Health of $4,191.33 million dollars was distributed historically as follows: 52% allocated to the MPH, 44% to the IESS, and the remainder 4% to ISPOL and IESS.

Figure 5: Financing structure of Ecuador's health sector



Source: Adapted from (Lucio, Villacres, & Henriquez, 2011)

Ecuador's fragmented financing structure stems from a disjointed health

system characterized by multiple sources of financing, fundraising mechanisms, differences in coverage and provision of health services (Villacres & Mena, 2017). These challenges are evident in the RPIS in that each institution has its own resources, distribution mechanisms, management and evaluation. Furthermore, the fragmentation translates into limitation of cross-subsidies among the different population groups, duplication of effort and administrative costs, lack of integrated planning (Villacres & Mena, 2017).

Table 4 summarizes the evolution of resource collection indicators in three periods of 2007 and 2014. As stated previously, these indicators are recommended by the WHO as measures of UHC financing. The analysis of each indicator will follow in detail.

Table 4: Summary of Key UHC Financial Indicators 2007 and 2014

Indicator	2007	2014	Difference
Total health expenditure per capita as a percentage of GDP	$204.4 million	$325.2 million*	59
Public expenditure for health as a % of GDP	1.4%	4.5%	3.1
Health budget as a % of total government budget	17.76%	23.19%	5.43
% of HH with Catastrophic Payments	-	45.4%	-
OOP expenditures as a percentage of total health expenditures	63.82%	55.10%*	8.72
Ratio of external funding and government funding as share on total health expenditure	0.96%	0.30%	0.66
Government tax revenue as a % of GDP	10.51%	13.47%	2.96

**2013 data used for comparison*

Source: Table elaborated by the author with data from the World Bank and INEC

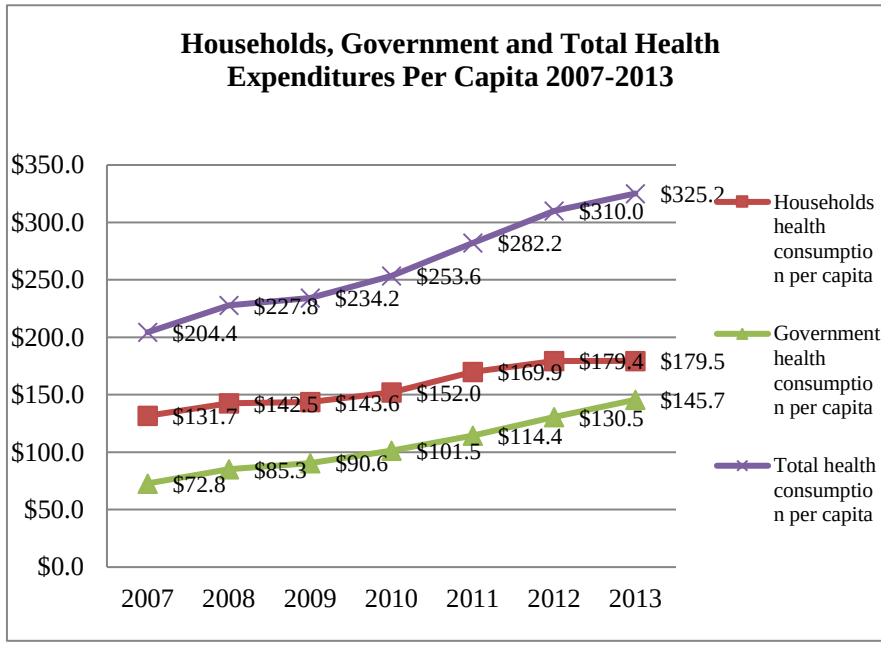
4.5.2.1.1 Level of Funding

4.5.2.1.1.1 Total health expenditure

At a global level, health expenditure is increasing as countries are becoming richer. Data from the National Health Accounts of Ecuador shows that total health expenditure increased from $204.4 million in 2007 to $325.2 million in 2013, which accounts for an increase of approximately 60% within this 7 year period. Along the same lines, there has also been a significant increase of total health expenditure as percentage of GDP from 5.5% in 2007 to 7.39% in 2013 during a period of economic growth, consistent with the notion that health expenditure generally increases when GDP increases (Xu, Saksena, & Holly, 2011). This data is evidence that there has been a significant increase in healthcare spending which has been steadily increasing during the government of Rafael Correa in order to meet the national health goals set forward under the National Development Plan. In particular, there has been an increase in total government health expenditure, which has doubled in the period between 2007 and 2013 from $72.8 to $145.7 million following the constitutional provisions regarding the government's health budget. On the other hand, households' health expenditures per capita have also increased from $131.7 million in 2007 to $179.5 million which represents a 36% increase. These numbers indicate that household health expenditures continue to be higher than the government's expenditures which indicate that OOP expenses from households continue to be a

significant share of health expenditure nationwide. Figure 6 depicts the trend for households, government and total health expenditures.

Figure 6: HHs, Govt and Total Health Expenditures Per Capita 2007-2013



Source: National Health Accounts

When analyzing a country's increase in total health expenditure, it is important to note that this upward trend is related to the country's economic growth. However, an increase in government spending does not translate to a reduction of OOP expenditure for households (Xu, Saksena, & Holly, 2011). For Xu et al, although there is a direct relationship between an increase in government spending and an increase in the available health services, if governments do not change the structure of total health expenditure, this will result in people paying more OOP in order to obtain

these services. Therefore, improving financial risk protection to eliminate OOP health expenditure in most low income countries, like Ecuador, requires a major increase in government spending and the adequate health financing mechanisms (Xu, Saksena, & Holly, 2011).

4.5.2.1.1.2 Public expenditure in health

Since 2006, when Rafael Correa took power, social investment became a priority for the new government. The Constitution dictates that "public resources should be oriented towards the guarantee of rights for good living, thus promoting the guarantee of social rights to allow meeting the basic needs of the population". During the Correa Administration, public health expenditure has increased consistently over the last 10 years, from 1.4% of GDP in 2006 to 4.5% in 2014 (The World Bank, 2017), which represents an increase from 17.76% to 23.19% of total government expenditure. In the year 2000 the health budget accounted for 115.5 million dollars, in 2010 it accounted for 1,244 million dollars. The increase is appropriate given the State's guarantee of UHC in the constitutional mandate of universal health insurance for the population.

Member countries of the Organization for Economic Cooperation and Development (OECD) had an average public expenditure on health of 7.8% of GDP in 2014. During the same period, the average for the LAC region was 3.8% of GDP. Ecuador was able to surpass the region's average with 4.5% of public spending as a percentage of GDP. Furthermore, taking into account that a lack of adequate financing mechanisms and inefficient use of

resources as factors hindering the attainment of UHC, PAHO's Resolution CD53.R14 "Strategy for Universal Access to Health and Universal Health Coverage" proposes a benchmark target for the region for public expenditure as a percentage of GDP of 6%. Ecuador is in the right path towards meeting this regional goal. This increase in social investment is due to a series of factors, perhaps two of the most important ones being the renegotiation of the country's external debt, especially the debt that was deemed illegitimate; and the second factor is the increase in revenue from taxes. However, for authors such as Iturralde, the Correa administration prioritized other sectors such as energy, education and housing over social welfare and health, and therefore, although there was a significant growth in public spending in health, this sector grew less rapidly than the others (Iturralde, 2015).

4.5.2.1.2 Level of population coverage

Full population coverage is the primary goal of UHC and it is fundamental in assessing health systems financing. An upward trend in population coverage should indicate whether the Ecuadorian health reforms towards the attainment of UHC have been effective and have provided further financial protections to households as it relates to health. In Ecuador, in the year 2007 19.8% of the economically active population was insured under the social security scheme. An additional 9.7% of the economically active population was covered by other insurance schemes including the SSC, ISSFA, ISPOL and private insurance. In total, only 29.7% of the economically active population had insurance coverage, which means there

was a significant percentage of the population that was uninsured and was at risk of financial hardship due to illness (INEC, 2016). By year 2014, coverage of the economically active segment of the population increased by 16.0 percentage points, from 29.7% to 45.9%. This represents a 55% increase. According to the most recent Life Conditions Survey of Ecuador's Statistics Institute, the most significant increase is in the urban area, where it can be observed that coverage increased by 21.3 percentage points, from 22.2% to 43.5% (INEC, 2014). This coverage includes all national public and private insurance. As it relates to the SSC which covers the rural and vulnerable populations of Ecuador, there has been a significant increase in beneficiaries of this insurance scheme. In 2006, the SSC scheme had members reaching 670,000 beneficiaries. In April 2017, the beneficiaries increased by 393,640 affiliates that with their families total 1'212,662 beneficiaries throughout the country, more than double the number of beneficiaries (IESS, 2016). Table 5 depicts the evolution in the number of affiliates for the public sector insurance schemes. If we take the population for the year 2014 as a reference, we can calculate the total number of population with coverage as it relates to the total population, as follows:

4,277,415/ 15,903,112 = 26.8% of the population with coverage in 2014

Hence, there has been a vast increase in coverage; however, those who are covered are still a small percentage of the total Ecuadorian population. This also means that the MPH is covering close to 70% of the population who does not have coverage elsewhere under the guarantee of universal health insurance.

Table 5: Evolution of Population Coverage by the IESS and SSC

Year	Affiliates to the IESS General insurance	Active Affiliates to the SSC	Total Number of Affiliates
2007	1,518,164	717,657	2,216,479
2008	1,734,498	786,761	2,492,771
2009	1,884,337	864,217	2,709,039
2010	2,137,451	938,642	3,018,985
2011	2,510,018	1,028,634	3,538,652
2012	2,762,794	1,106,083	3,868,877
2013	2,944,250	1,142,416	4,086,666
2014	3,113,163	1,164,252	4,277,415

Source: Anuarios Estadísticos, IESS, ISSFA, ISPOL

In 2008, the Government of Rafael Correa, proposed to criminalize the non-affiliation to social security by employers, with the expectation that this would pressure employers to formalize labor relations. The Organic Comprehensive Criminal Code of 2014 required the employer to pay personal and employer contributions. The criminalization for lack of affiliation aimed to ensure that all formal sector workers are covered which should account for a steady increase in coverage. To summarize, data shows that there has been a significant increase in coverage in the formal sector. However, and approximate 70% of the population continues to be uninsured. This percentage of the population must be covered by the MPH, in accordance to the constitutional mandate of universal health insurance for all the population.

4.5.2.1.3 Level of financial risk protection

According to the WHO, the two most common used indicators for the measure of financial protection in health are 1) the incidence of catastrophic health expenditures and 2) the prevalence of impoverishment due to out of pocket health payments (World Health Organization and The World Bank, 2014). The low percentage of coverage of the Ecuadorian labor force translates into a higher risk of informal and non-traditional workers incurring in catastrophic expenses given that health costs must be paid OOP if the MPH is not able to meet their demands. This can represent a high burden, especially for low-income families.

4.5.2.1.3.1 Out of Pocket Payment and Catastrophic Expenditure

According to a 2014 report from the Lancet Commission on Global Surgery, 45.4% of Ecuadorians are at risk of catastrophic expenditure for surgical care (Shrime, Dare, Alkire, O'Neil, & Meara, 2015). OOP expenses as a percentage of total consumption expenditure in health services, although it decreased from 63.82% in 2007 to 55.10% in 2013, are still high, reflecting the low coverage in the population. According to the report "Privatization of Health in Ecuador" by Iturralde, Ecuador ranks third in the region in terms of OOP expenditures, after Venezuela (66%) and Paraguay (57%) (Iturralde, 2015). This translates into a large burden to users of healthcare facilities, particularly those in the poorest quintiles of the population. OOP expenses as an indicator is a critical measure of UHC and currently, the Ecuadorian health system still relies on direct payments. According to the National Health Accounts data, 95% of private health expenditure was direct households expenditure. In particular, out of pocket expenditures in

medicines have a significant burden for households which represent 38.2% (2013) of total household health expenses. In general, rural households continue to spend a higher amount of resources in health expenses, as compared to urban households. In 2014, rural households spent 8.1% of their monthly expenses in health related expenses, compared to urban households which spend 7.3%. However, the gap has shortened, as compared to 2004 where health expenses from the poorest quintile of the population, which predominantly lives in rural areas, accounted for 4%, compared to 9% of the richest quintile. In summary, although the health sector still relies heavily in OOP expenses, during the Correa administration there was some progress in decreasing this prevalence by 13 percentage points.

4.5.2.2 Revenue Sustainability

4.5.2.2.1 Government tax revenue

As for the tax regime, it is worth noting that the Constitution conceives it as an important element of social equity and reform. The Constitution explicitly identifies direct taxes as a priority tool to fund the State's budget and emphasizes the redistribution of wealth, as well as the principles that guide tax collection. Article 285 of the Ecuadorian Constitution of 2008 states three clear objectives for the country's fiscal policies:

1. The financing of services, investment and public goods.
2. The redistribution of revenues through appropriate transfers, taxes and subsidies.

3. The creation of incentives for investment in different sectors of the economy and for the production of goods and services that are socially desirable and environmentally acceptable.

Art 300 of the Constitution states that the tax system must be governed by a series of principles including "generality, progressivity, efficiency, administrative simplicity, nonretroactiveness, equity, transparency and revenue collection adequacy". It also states that "Priority shall be given to direct and progressive taxes" and that "tax policy shall promote redistribution and shall stimulate employment, the production of goods and services, as well as ecologically, socially and economically responsible conduct" (Constitution of the Republic of Ecuador, 2008).

During the Correa Administration, government tax revenue as a percentage of GDP has had a huge increase (Table 6). Between 2006 and 2015, tax collection grew by $ 9,170.8 million which represents a 92% growth. It is important to note that the Correa Administration made a pledge to not increase VAT. In this sense, since 2007, when Correa was elected, VAT remained at 12% and it was only increased in 2016 when the country suffered a devastated earthquake. A that time, VAT was increased from 12 to 14% on a temporary basis. However, there has been an upward trend as it relates to direct taxes, for example, income tax increased from 25% to 35% during Correa's administration (Paz y Mino Cepeda, 2015). In general, tax revenue has increased consistently which explains an improvement in the capacity of the Internal Revenue Service of Ecuador to collect taxes to fund the different social programs that have been prioritized by the government

of Correa, health being a priority sector. It is important to note, however, that a vast percentage of the government's budget comes from oil revenue which has dropped dramatically since 2014 given the worldwide decrease in oil prices. This has driven the Correa Administration to propose new types of direct taxation including inheritance taxes and capital gains tax. These legislations are still in debate today.

Table 6: Tax collection as a percentage of GDP 2006-2014

Year	Revenue Collection IRS	GDP	Tax Revenue as a % of GDP
2006	$4,672.28	$46,802.04	9.98%
2007	$5,361.87	$51,007.78	10.51%
2008	$6,508.52	$61,762.64	10.54%
2009	$6,849.79	$62,519.69	10.96%
2010	$8,357.20	$69,555.37	12.02%
2011	$9,560.99	$79,276.66	12.06%
2012	$11,263.89	$87,623.41	12.85%
2013	$12,757.72	$94,472.68	13.50%
2014	$13,616.82	$101,094.16	13.47%

Source: Adapted from Ecuador's Central Bank

The WHO encourages countries to develop more extensive and equitable tax-based systems, or SHI-based systems or a hybrid between these two models. With this in mind, it is evident that Ecuador is in the right path to provide financial protection for the attainment of UHC, through an increase in tax-based collection, as well as an increase of contributions of affiliates to the social security insurance scheme. However, it is important to know that the MPH which covers 70% of the population is entirely dependent on

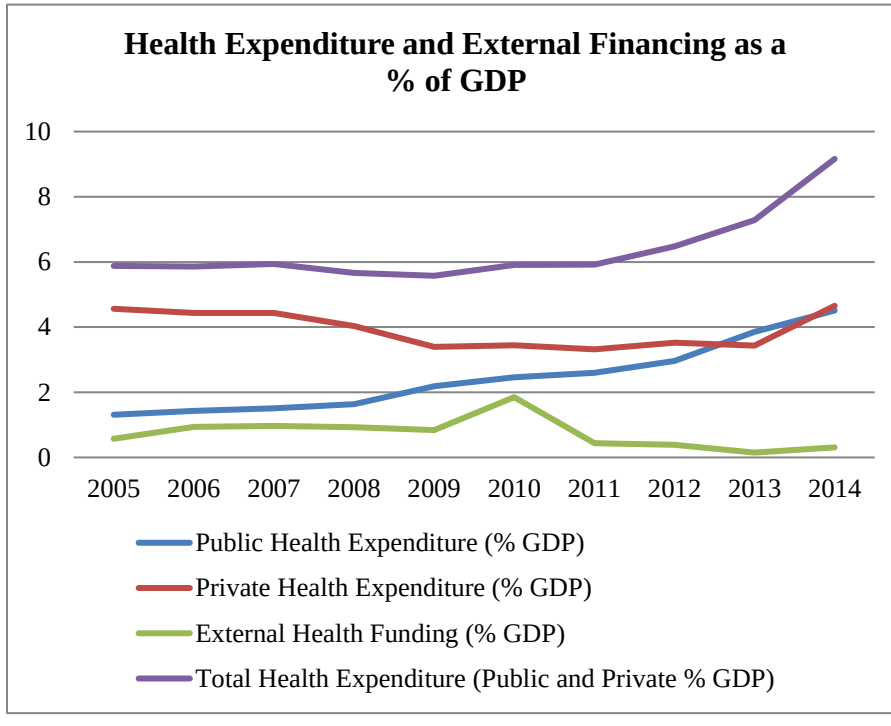
government funds. Therefore, UHC in Ecuador is highly dependent on the government's capacity to allocate funds to the health sector. The reliance on a budget that is highly volatile due to changing prices in oil and economic ups and downs makes us reflect on the need for the State to look for more stable and diverse sources of funding for health.

4.5.2.2.2 External funding

Ecuador is not a country dependent on international cooperation. The multi-annual amount of disbursements of cooperation between 2007-2014 amounted to $ 2,786.99 million, which corresponds to approximately 0.48% of GDP per year and 1.7% of the general budget per year (SETECI, 2015). In particular, data from the World Bank shows that in 2007 total external funding for health as a percentage of total expenditures on health for Ecuador accounted for a low 0.96% which further decreased to 0.30% in 2014 (The World Bank, 2017). The decrease in external funding for health can be explained by Ecuador's transition in 2011 from being a low-median income country to a high-median income country, with a gross national income per capita of $6,150 in 2014 (The World Bank, 2014), which restricted the country's legibility for some streams of funding. In this context, as part of the International Cooperation Strategy, one of Ecuador's International Cooperation Pillars is to strengthen South-South Cooperation. In summary, the NHS of Ecuador is not reliant in external funding; however, this analysis serves to support the notion that sufficient funding for the Ecuadorian health system must come from the government and the beneficiaries and that national Health Financing mechanisms shall be given

priority. Figure 7 summarizes health expenditure trends by sector as a % of GDP were the country's low reliance on external financing is clearly depicted.

Figure 7: Health Expenditure and External Financing as a % of GDP



Source: World Bank Data

4.5.2.3 Purchasing

Purchasing refers to the process by which funds are allocated to health providers to obtain services on behalf of a segment of the population or the population as a whole. It allows us to determine whether the money spent

results in the most cost-effective and most equitable provision of services possible. Purchasing includes 1) identifying the products or services to be purchased according to the populations needs, priorities and cost-effectiveness, 2) choosing service providers, giving consideration to quality, efficiency and equity, 3) determining purchasing mechanisms including payment mechanisms and contractual details (Figueras, Robinson, & Jakubowski, 2005).

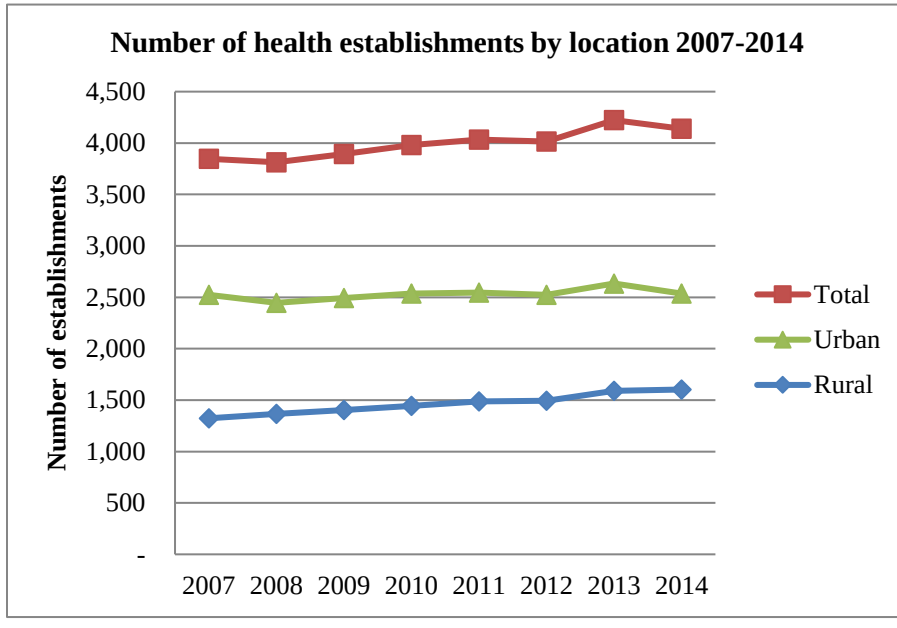
In line with other Latin American countries, one of the key challenges of the Ecuadorian government is the separation of financing and provision, as a way to incentivize quality efficiency and accountability (Almeida & Dmytraczenko, 2015). The separation of these two functions has been a key recommendation of the WHO. However, in Ecuador, budget allocation is based on historical budgeting information which creates inefficiencies because it incentivizes providers to increase costs, there are no incentives tied to meeting health goals or improving the quality of services or its efficiency, furthermore, budget allocations not always meet the needs of the population. Under the National Health Network, there are four healthcare providers: the MPH, IESS, ISSFA and ISPOL and each of these institutions has its own resources, distribution mechanisms, management, and evaluation. As there are four administrators of resources, there are also different bureaucratic processes and information systems, as well as different ways apply the regulations for the management and purchase of health benefits. In terms of purchasing with equity, this means there are differences in services provided, waiting times, and OOP payments. For

health providers this also translates into delayed payments. In 2013, the MPH carried along an improvement in norms and processes to regulate purchasing. In negotiation with the RPIS and Complimentary Health Network, an important regulatory document was adopted, the List of Rates for Health Services (Tarifario de Servicios), which provides a maximum amount for services provided between providers and financiers of the public and private health networks.

4.5.2.3.1 Equity in Health Services

The concept of health equity is rooted in the notion that accessing and receiving health care should depend on the needs of the population and not on factors like ability to pay, location, social status, race or other distinctions (Le Grand, 1991). In measuring equitable provision of health services for the Ecuadorian population, it is important to point out that Ecuador is a country with huge income disparities, where 23% of the population continued to live under poverty, especially in rural populations were an approximate 40% of the population lived under poverty. Taken the existing inequalities under consideration, the government of Rafael Correa emphasized the construction of health facilities in rural areas to guarantee the provision of health services to the poorest segments of the population. Figure 8 shows the increase in the number of health facilities in the rural area, which increased from 1,323 facilities in 2007 to 1,603. In the urban areas, on the other hand, the number of health facilities has remained constant with very small variations. This portrays the Correa administration's emphasis on health provision with equity.

Figure 8: Number of health establishments by location 2007-2014



Source: INEC.

As it relates to health equity, Table 7 and 8 depict the evolution of population coverage by quintiles and also by urban and rural segments of the population. There is a great increase observed in coverage in the urban area, where coverage increases 21.3 percentage points, from 22.2% to 43.5%. When analyzing the access to health insurance according to quintiles the increase is relatively homogeneous, with exception of the poorest quintile, where coverage reaches only 23% compared to 65.9% in the richest quintile. This means that although there has been an increase in the overall coverage of the population, the poorest sectors and rural areas

are still lagging behind, and the richest, urban populations are accessing more health services.

Table 7: Health coverage urban and rural

Years	Total	Urban	Rural
2006	21.40%	22.20%	19.80%
2014	41.40%	43.50%	37.20%
Difference	20.00	21.30	17.40

Source: INEC

Table 8: Health coverage by population quintiles

Years	Q1	Q2	Q3	Q4	Q5
2006	13.40%	14.00%	16.60%	26.40%	47.40%
2014	23.30%	32.30%	38.20%	47.60%	65.90%
Difference	9.90	18.30	21.60	21.20	18.50

Source: INEC

Consistent with the findings of a series of studies regarding health equity, there is a high degree of "pro-rich horizontal inequity" (Glorioso, 2013) in countries around the world (Van Doorslaer, Xander, & Puffer, 2003) which is also evidenced in Ecuador's coverage statistics.

Although the government of Ecuador, during the Correa Administration was able to designate a larger budget to the health sector, the financing structure of the NHS continues to be fragmented and limits the possibility to improve funding mechanisms. Therefore, although the reform pushed forward by the Correa Administration has in many ways, made great strides to

consolidate and strengthen the NHS, the financing mechanism has been left behind. In this context, the MPH has been working on a proposal to structure the Ecuadorian National Health Fund (FONSE from its acronym in Spanish) which consist of an entity, dependent of the MPH, responsible for the administration of public resources for the RPIS, with the exception of those funds belonging to social security due to constraints in the Constitution that grant autonomy to the IESS. However, the optimal solution would be a Constitutional amendment to allow pooling of public resources from all sources (Villacres & Mena, 2017). The creation of the FONSE has been included in the new Organic Health Code proposal which is currently under debate in the National Assembly. Ecuador seeks to emulate Uruguay's creation of the FONSE which has deemed successful in the Uruguayan context. This approach is optimal, given the WHO recommendations for a pooling mechanism as a way to spread the risk so that no individual has to carry the burden to pay for health care. From the experience of OECD countries, pooling arrangements in the Ecuadorian health systems would be optimal because it helps reduce segmentation and foster equality and efficiency in the management of health funds (Almeida & Dmytraczenko, 2015).

4.5.3 Health Systems

Health Systems are the backbone of health institutions and key in the attainment of UHC. For the WHO, health care systems are one of the most important determinants of health and recommends that health systems be designed and financed to ensure fairness, UHC with suitable human

resources. Furthermore, the WHO's recommendation specifies that health systems should be based on a PHC Model, combining grassroots level action on the social determinants of health as well as a strong primary level of care, and focusing equally on prevention and promotion (WHO, 2008). This section describes the improvement of health systems for the attainment of UHC during the Correa Administration.

4.5.3.1 Service Utilization Levels

An important part of the Correa era reform was the increase in public funds destined to the health sector for the improvement of public infrastructure, human resource development and capacity building. The deficit in medical professionals in Ecuador is significant which was a driver for a series of reforms that included significant salary increases for health professionals in the public sector, scholarship and incentives for students in the medical field, and the employment of thousands of professionals to meet the populations demands, especially in rural areas where new medical facilities were constructed.

4.5.3.1.1 Number of consultations provided

Perhaps the most important reform related to the strengthening of health systems and provision of services is the adoption of the MAIS based on the concept of PHC. The model organizes the NHS as a way to respond to the health needs of individuals, families and the community, allowing the integrality in the levels of care in the health network, and health establishments to be categorized based on their level of complexity. Special

attention has been given to the primary level of care in Level I health facilities. Table 9 shows the evolution of the number of consultations provided by the MPH by level which clearly indicates the duplication of consultations at the primary level from 2007 to 2014.

Table 9: Number of consultations by level of provision 2007-2014

Levels	2007	2009	2011	2013	2014
First Level	13,539,546	20,515,220	23,588,288	29,378,694	29,548,513
II and III Levels	6,786,819	10,450,193	11,486,039	9,894,311	9,659,806
Total consults	20,326,365	30,965,413	35,074,327	39,273,005	39,208,319

Source: MPH Statistical Report 2006-2014

4.5.3.1.2 Number of outpatient consultations by nationality

Furthermore, in accordance to the Constitutional mandates, the provision of health must be guaranteed by the state regardless of citizenship status, from an understanding that the right to health trespasses borders. Under this notion, since 2008 the MPH has increased the provision of health to citizens of neighboring countries like Colombia and Peru, especially in facilities located close to the borderline, as well as to refugees from and immigrants from other countries. Table 10 shows the number of outpatient consultation provided to Ecuadorian patients as well as patients from other nationalities in 2014.

Table 10: Total outpatient consultations according to nationality 2014

	Ecuadorian	Colombian	Peruvian	Cuban	Others	Total
Levels	27,957,505	128,764	20,961	6,046	22,671	28,135,947
First Level	3,670,239	15,325	3,370	652	3,624	3,693,210
Second and Third Levels	973,127	3,203	362	520	1,261	978,473
Total consults	32,600,871	147,292	24,693	7,218	27,556	32,807,630

Source: MPH Statistical Report 2006-2014

It is important to note that the different insurance schemes offer different benefit packages and provision of services. However, based on the guarantee of the right to universal health insurance, the State, through the MPH is obligated to seek medical resolution through the institutions in the RPIS or the Private Complimentary Network. The government has made an emphasis on the universality of coverage, the number of impatient and outpatient consultations have increased however there is no data that will allow analyzing the efficiency and quality of these consultations.

4.5.3.1.3 Number of Health Facilities by Sector and Distribution

In the period of 2007-2014, the Ecuadorian government emphasized the construction of new health facilities, especially in the rural areas and poor urban areas that did not have access to health services. Table 4 depicts the increase in public health establishments during this period. During the 2007-2014 period the number of public health establishments increased from 3,080 to 3,418, with 338 new health facilities, a majority of these being primary level facilities. It is important to note that and approximate

55% of primary public health establishments are under jurisdiction of the MPH, followed by IESS with approximately 30% of primary level health establishments. As it related to second and third level establishments, the MPH also has a majority of this type of establishment under its jurisdiction. These numbers show that the MPH is the main health provider at a national level and that the State has expanded its role as a health provider nationwide, thus reversing the trend to eliminate state provision during the neoliberal era. Table 4 shows that in the case of the private nonprofit sector the number of health facilities has considerably decreased from 231 to 162 facilities which could be interpreted as the MPH and public sector, filling the gap or void that had previously been filled by the nonprofit sector during the neoliberal period in Ecuador. The private for profit sector, on the other hand, has had a consistent increase in the number of health facilities during this period.

However, it is important to note that as of 2014 75% of hospitals with impatient care belong to the private sector. On the other hand, 95% of outpatient health units belong to the public sector and only 5% to the private sector. This indicates that the public sector, although it has strengthened its PHC infrastructure and provision of services, there is still a lack of infrastructure as it relates to second and third level, specialty health establishments with inpatient care. This means that there are fewer beds available to respond to more complicated pathologies, and therefore, the gap for these services must be filled by the private sector.

Table 11: Number of Health Establishments by sector 2006-2014

Number of Health Establishments by sector and type 2006-2014						
Years	Total number of establishments	Establishments by sector			Establishments by type	
		Public Sector	**Private for profit sector**	**Private nonprofit sector**	**With admission**	**Without admission**
2007	3,847	3,080	536	231	729	3,118
2008	3,813	3,085	542	186	714	3,099
2009	3,894	3,140	560	194	728	3,166
2010	3,981	3,203	576	202	743	3,238
2011	4,032	3,261	583	188	753	3,279
2012	4,015	3,269	565	181	735	3,280
2013	4,223	3,443	607	173	765	3,458
2014	4,139	3,380	597	162	742	3,397

Source: Instituto Ecuatoriano de Estadística y Censos

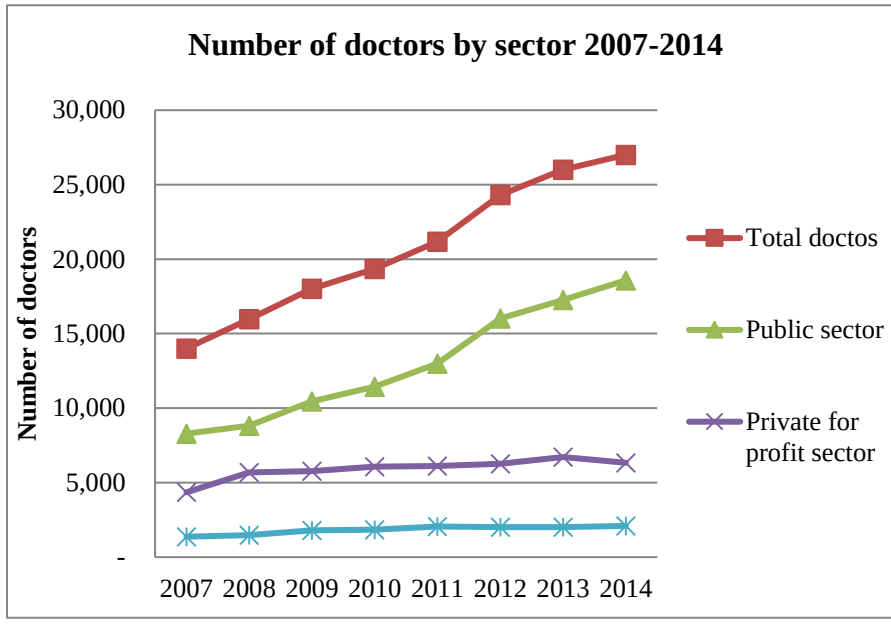
4.5.3.2 Health workforce and distribution

4.5.3.2.1 Number of doctors and health personnel by sector

One of the biggest issues related to health workforce shortages in the public health sector in Ecuador was related to the irregular working hours of doctors who did not meet a regular, 40-hour workweek and were dedicating only a few hours to public service and the rest to their private practice. In this regard, one of the most important reforms that were implemented during the Correa Administration was the regularization of the workweek schedule to meet 40 hours, coupled with a salary increase of up to 70% and an acknowledgment of overtime hours. In total between 2007 and 2014

10,295 doctors were hired, almost triplicating the number of health professionals in the MPH (Figure 9).

Figure 9: Number of doctors by sector 2006-2015



Source: National Institute of Statistics and Censuses of Ecuador (INEC)

Although the number of medical professionals increased by approximately 21% between 2007 and 2014, Ecuador still has a huge gap between supply and demand of services due to the deficit of doctors and nurses. The WHO calculates the threshold of 4.45 skilled health professionals per 1,000 population which represents a shortage of 17.4 million health workers, 2.6 million being doctors and 9 billion being nurses (WHO, 2016). In 2007, Ecuador had a ratio of physicians per 1000 population of 0.9 which, as a result of the human resources reforms, was able to increase to 1.6 per 1000

habitants. This rate is much lower than the LAC average for 2014 of 2 physicians per 1,000 and even lower when compared to countries like Uruguay and Argentina who have 3 plus physicians per 1,000 habitants. As it relates to nurses, the rate increased from 0.8 in 2007 to 1 nurse per 1,000 people.

4.5.3.2.2 Reduction of distribution gap of health personnel

As it relates to distribution of health personnel between urban and rural, the total number of health personnel in urban areas in 2014 was of 103,437 while in rural areas it accounts for 14,058 health workers. Although there have been improvements as it relates to workforce distribution, doctors tend to focus on urban areas.

4.5.3.3 Regulatory capacity

One of the key indicators for health system improvement is increased regulatory capacity toward achieving the status of functional regulatory authority of medicines and other health technologies. In Ecuador, the reform process focused on creating two regulatory agencies: one for the control of products for human consumption, the Agency for Health Regulation and Control (ARCSA from its acronym in Spanish) and the other one for the quality of the provision of health services, the Agency of Quality Control of Health Establishments (ACCES from its acronym in Spanish). Furthermore, in the period between 2006 and 2014, a series of regulations have been implemented. Perhaps the most innovative, regulatory policy that Ecuador implemented in 2012, in line with the Global

Action Plan for the Prevention and Control of NCDs, is the Food Labeling Regulation for Processed Foods which aims to inform consumers about the nutritional content in processed foods, as a preventive measure for obesity in the country. Furthermore, during the period, the Viceministry of Governance has developed a series of clinical practice guidelines, among other important regulatory documents that did not exist before.

4.5.3.4 Health Systems

Another key indicator for health systems is improved quality of their national health information system. In Ecuador, most of the statistical information is generated by the INEC, The Central Bank of Ecuador, as responsible for generating the figures corresponding to the National Health Accounts. Because the Ecuadorian health system is fragmented, health information usually stems from different sources. For this reason, in 2012 the MPH implemented a new information system called GeoSalud which began with the geo-referencing of all health units of that institution and was gradually incorporated on a national scale in pharmacies.

4.5.3.5 Governance of health research

Implementation of functioning mechanism for governance of health research is another important indicator of health systems improvement. One of the Correa Administration's strides in the strengthening of health research was the creation of the National Institute of Public Health Research (INSPI from its acronym in Spanish) in 2010. A standard reference on the state of scientific research is the number of postgraduate

degrees offered nationally, which in Ecuador is only 397 masters programs and specialties, which is much lower than the region's average.

4.5.4 Coverage of Essential Health Services

The WHO groups coverage of essential health services indicators into two broad categories to cover the spectrum of interventions: prevention (which includes services for health promotion and prevention) and treatment (which includes services such as treatment, rehabilitation and palliation). The WHO found that these indicators are relevant, good-quality, available indicators of service coverage with prevention interventions. Table 12 summarizes these indicators for Ecuador. Unfortunately data for several years was not available; therefore only data from the last available year is displayed.

Table 12: Coverage of Essential Health Services Indicators

Indicator	
Promotion/prevention	
Family planning coverage with modern methods	The use of modern contraceptive methods increases, from 58.7% to 71.7% between 2004 and 2012.
Antenatal care coverage	The provision of antenatal control increased between 2004 and 2012, from 84% to 95% of women who received at least one antenatal control.
Skilled birth attendance	Births assisted by a skilled provider as a percentage of total births increased between 2006 and 2014, from 82.6 to 96.3%.

Diphtheria, tetanus and pertussis (DTP3) immunization coverage among 1-year-olds	In 2013 the immunization coverage among 1-year olds reached 99%
Prevalence of no tobacco smoking in the past 30 days among adults age ≥ 15 years	Current Adult Prevalence: Percentage of the population 15 years or older who smoked any tobacco product at the time the survey was conducted the survey, including daily and occasional smokers represented 36,3% of the male population and 8.2% of the female population.
Treatment indicators	
Antiretroviral therapy coverage	In 2013, the anti-retroviral coverage among people living with HIV (%) was of 31%.
Tuberculosis treatment coverage	In 2013 treatment-success rate for new tuberculosis cases (%) was 75%

Source: INEC and WB data

The data displayed below shows that there is a gap in public available data regarding previous years for some of the indicators. However, we can see that indicators such as family planning coverage, antenatal health coverage and skilled birth attendance have improved. However, Ecuador experienced an increase in maternal mortality between 2007 and 2011 which contradicts these indicators. Furthermore, treatment indicators remain low compared to regional averages.

4.6 Interviews

To explore the Ecuadorian health reforms of the Correa Administration toward the attainment of UHC, an interview schedule was prepared with three key stakeholders from different sectors that were invited to provide their views about this pressing topic. The interviewees included an expert from the public health sector, an expert from academia and a high-level doctor from the private sector. An important finding of the interview is that there are divergent perspectives about the issue of institutional change in the health sector which will be analyzed hereafter.

Among the interviewees there are two divergent points as it relates to the changes generated by the Correa Administration for the pursue of UHC. On the one hand, the interviewee from the public health sector viewed the changes in the health sector positively. On the other hand, the interviewees from the private sector and academia were skeptical about the real impact of the reforms. As it relates to the goal of UHC, most interviewees agreed that the Correa Administration cannot be given credit for the incorporation of this concept in health policy-making, therefore UHC is not paradigmatic in the Ecuadorian context. For one of the interview from the private health sector, UHC has been pursued for many years by other governments, however, past attempts to reform the system towards this goal were not prosperous in that they did not reach legislative or sectorial consensus.

Most interviewees identified key factors for the pursue of UHC in Ecuador including Rafael Correa's promise of resource redistribution and some

mentioned that is a political/ideological issue, and lastly the necessity to comply with global and regional commitments as this is a concept that been discussed in high-level forums and recommended by organizations like the UN, WHO and PAHO.

The most recurring issue brought up by all interviewees was the fragmentation of the NHS. They all agreed that the integration of the health network presented a series of issues rooted in the fear that certain institutions would lose their autonomy and be absorbed by the MPH. Furthermore, everyone agreed that the MPH needs to strengthen its leadership role as the National Health Authority and the sustainability of UHC is contingent on the ability of the MPH to exercise its authority and lead the public health sector in the right direction. The interviewees from the public sector and academia agreed that the adoption of the Integral Model of Health Care was the most fundamental change, as well as an increase in the portfolio of services and the number of health professionals to meet the needs of the population. However, the interviewee from the private sector and the interviewee from academia also pointed out their skepticism regarding the real impact of these reforms in the population's health. They agree in that the health indicators did not show a significant impact. Furthermore, they all agreed that a fundamental change of Correa's health reform was normative in the guarantee of the right to health as stated in the Constitution.

There were many concerns raised in terms of sustainability and financing mechanisms. For example, the interviewees from the public and private

sectors mentioned the sector's dependence on the National Budget and the ability of the state to generate funding. Furthermore, all interviews mentioned negatively the issue of the current debt that the public sector holds with the private sector.

In regards to recommendations for the improvement of the health system towards the attainment of UHC, they all pointed out to the need to solve the NHS fragmentation, institutionalize the Integral Health Model from a normative to an operational level, and the need to emphasize the PHC. The interviewee from academia also mentioned the need to exercise good governance among all health and social actors.

CHAPTER 5: DISCUSSION AND FINDINGS

Health policy making in Ecuador in the 1990s and early 2000s was influenced by neoliberalism and changes towards market-driven health systems. This was a period of economic and political instability that increased the inequality gap in the country. The Correa Administration 2007-2017 brought a period of stability characterized by the rebuilding of institutions, strengthening the public sector and introducing new paradigm for the development of the country, focused on the concept of well-being which could only be achieved by increasing public spending in the social sectors, health institutions being a priority. However, the central question of this study is: did the government of Rafael Correa generate institutional changes in the NHS towards the attainment of UHC?

The importance of institutions for the exercise of public action is great, since it is the space where public policies are channeled. From the empirical evidence gathered in the previous chapter, it can be implied that the institutional changes introduced by the government of Rafael Correa respond to a new institutionalist approach in which public decision making consists of a set of interactions between institutions and its actors (social and international actors). There is a strong relationship between formal and informal institutions. One the one hand, there are important normative documents such as the new Constitution of 2008 which guide policy-making and on the other hand, informal institutions such as lack of coordination and integrality, lack of authority and supervision of the MPH, and social expectations which play an important role in the NHS.

In Ecuador, like in many countries, defining social programs such as the NHS is a highly controversial and politicized topic in which a series of actors and interest groups voice their opinion. From the empirical data gathered we can observe that the government of Correa proposed a radical redefinition of the role of the State reflected in the guarantee of rights to health. There were great advances at a normative level with the new Constitution of 2008 and the National Plan for Good Living. The national referendum, on the one hand, provided the general population a voice to decide on policy issues and deciding on the need to rewrite the Ecuadorian Constitution. Thereby, the Constitutional Assembly and the enactment of a new Constitution is at the core of the Ecuadorian political system providing policy makers with an opportunity to have a direct impact on the course of health policy making. Policy makers were able to include the right to health as a Constitutional provision and mandate that this right be guaranteed through the creation of the NHS. At the time Correa was elected, he had a high approval rating amongst the population, and thereafter majority support in the Constitutional Assembly and later in the National Assembly. Therefore, the electorate, the National Assembly and the Executive were all articulated, there being no restrains in the passage of the New Constitution and further legislation and reforms in the pursuit of UHC. The Ecuadorian political system is shaped by decisions made by the National Assembly and being pushed by the Executive Branch. Interest groups have the ability to block legislation when there is great division amongst congressional majorities. However, in the case of the Correa Administration, the executive dominated the National Assembly and the Constitutional Assembly, making

it easier for health policy decisions to be imposed by the Executive Government.

Furthermore, the country's positive economic performance allowed the government to increase the health budget exponentially, focused on strengthening the sector's capacity and improving infrastructure. Finally, we see an attempt to improve the institutional architecture of the NHS through the adoption of the Integral Health Model that looked to fix the historic fragmentation of the public health system. However, on the other hand, we see that these attempts to reform the public health sector, despite the increase in investment, continue to face the same problems of the past: the Integral Health Model has not been fully institutionalized and the autonomous characteristics of public organizations persist, therefore fragmentation of the NHS perseveres. There continues to be an enormous coverage gap with only 30% of the population reporting coverage under a public or private scheme. Another important indicator that shows the persistence of old structures is the high rate of OPP expenses incurred by households. And finally, health indicators such as maternal mortality have not positively improved, and as one of the interviewees points out, there are indicators that remain unchanged such as the prevalence of NCDs and teen pregnancy rates. Furthermore, Ecuador seems to be the scenario in which institutions are built without a linkage between the institutional means and objectives. For example, hospitals are built without having a sufficient number of doctors or the necessary capacity and services are provided to those who do not need them the most. This points to the need for the

government to increase the institutionalism, understood as "the coherence between means and objectives" which can allow the Ecuadorian government to improve the NHS but also "generate trust and legitimacy of the system at the level of citizenship" (Expert from academia).

One of the issues that has been highlighted by all interviewees is the absence of a consolidated institutional structure in the health sector, which is a main factor hindering the attainment of UHC. One of the interviewees pointed out that the institutional structure of the NHS has not been resolved because although there are constitutional frameworks whose objective is to provide political stability, the health sector has been characterized by permanent political conflicts and fragmentation which has hampered the development of an integrated and competent NHS (Public health expert). There are fundamental problems related to informal institutional constrains which prevent the cohesiveness of the NHS which include a lack of coordination among actors, egoistic behaviors from actors, and the lack of authority and stewardship of the MPH, to name a few. Furthermore, the continued absence of solid institutions has at the same time provoked the existence of a political culture characterized by citizen's apathy and conformity with a poor health care system (Doctor, private sector).

To recap the theoretical approaches of this study, these are historical institutionalism which explains institutions in the contexts of time and their historical context where path dependency and change play an important role; and the new institutionalism of rational choice which envisions change as a series of decisions These two frameworks will be used to understand the

challenges hindering institutional change, understood as the full realization of the reforms of the NHS. The findings of this study will be discussed for each of these frameworks.

1. Historical Institutionalism: path dependency

In order to explain institutional change through the lens of historical institutionalism in the case of the Ecuadorian health reform, it is important to understand how history has shaped these institutions and pushed them towards a certain path. Peters establishes that "*There will be change and evolution, but the range of possibilities for that development will have been constrained by the formative period of that institution*" (Peters, Institutional Theory in Political Science: The New Institutionalism, 2012). In the case of the Ecuadorian NHS, the path dependency that characterizes its institutions is linked to its historical structures characterized by a fragmented public health system and a weak health authority, which was identified by all of the interviewees. For example, one of the interviewees mentioned:

> *"We are on the road to ensuring that Ecuadorians have access to health and have a better quality of life, however, we are still scattered…everyone is doing it separately. We still don't have good governance, with participation of all actors in health and each of the institutions in the network still handles separate processes and separate goals."*

The fragmented characteristic of well-rooted health institutions and lack of authority of the MPH can be seen as a veto point because clearly conditioned the reform options and alternatives of the Correa

Administration, and therefore conditioned the attainment of UHC. One alternative would have been to consider a Unitary Health System which would be the ideal model to follow considering the constitutional provision on the guarantee of the right to health. However, institutions such as the ISPOL, ISSFA and the IESS, that have an affiliation scheme, could not be dismantled and unified. For example, The IESS has functioned as an autonomous entity funded by personal contributions of the Ecuadorian workforce, and to an extent, has an established source of revenue collection, well-institutionalized administrative and practical systems. It runs well as an institution and has worked to serve its affiliates. Therefore, a Unitary Health System, based on a Beveridge Model, was not an alternative for the Administration given the possible setback from interest groups, affiliates and workers. A second alternative would have been to emulate the Bismarcknian Model that the IESS follows as an institution and move towards Universal Insurance (Public health expert) that would require a subsidy to cover those who do not work or belong to the informal sector. However affiliates to the IESS might resist the implementation of a Universal Insurance System because of the perception that the cost of universal access through universal insurance is prohibitive and would require to create a subsidized fund for those who cannot contribute, whose administrative management would not be easy given the size of informal sector (Public health expert). By creating a Network System based on the MAIS with service delivery by the RPIS, the Correa Administration has aimed to expand coverage to the entire population, choosing the alternative that would create lesser friction amongst workers, affiliates and retirees.

Given these alternatives, in the Ecuadorian health context, "*a series of incremental changes can lead to even greater change along the path than if there was a critical juncture*". Thus from a historical institutionalism perspective incremental changes in the Ecuadorian health system were more viable than changing or deinstinstitutionalizing previous structures. This is the case in the introduction of the Integral Health model and reorganization of the NHS under the RPIS which is based in the notion that previous structures could not be changed but could be reorganized. Thus, the Correa Administration opted to incorporate incremental changes that reinforced the current structures, because "*a radical change in structure would signify greater costs, and could translate into political conflicts with health professionals or among public institutions*" (Public health expert).

In this analysis it is important to note that the Ecuadorian health sector is composed of institutions that have a certain degree of autonomy that they want to maintain as a means of survival. The IESS, ISSFA, ISPOL were all conceived as autonomous and semi-autonomous institutions that function on the basis of work affiliation. Therefore, the Integral Model proposed under the Administration of Correa has not been institutionalized at an operational level because the autonomous characteristics of these institutions and egoistic behavior of actors still prevails. In the case of IESS for example, there is a constitutional provision that characterizes it as an autonomous institution. Therefore, this is a sector were actors, such as affiliates and unions are highly resistant to change and radical changes would create conflicts that could halt any reform process.

There are bottlenecks when it comes to the implementation of the Integral Health Model, especially when it comes to the role of the IESS. On the first hand, the ambiguous definition of the IESS, almost since its creation, has led to different interpretations of its nature and autonomy, not only for policy makers but also for the insured. The IESS is a public institution that is administratively and financially autonomous and can make its own investments and decisions related to its funds, reserves and acquisitions (El Universo, 2015). However, historically, the government has favored their own agenda and even allocating the IESS funds to fund to government's general budget.

In 2010, a reform was approved to increase health coverage benefiting children less than eighteen years of age (Ley de Seguridad Social). According to the INEC, this caused a greater gap between those who are insured and those who are covered by the IESS services, posing greater financial burden on the IESS Fund (INEC, 2016). Furthermore, in 2016 an unemployment subsidy benefit was approved under the Employment Promotion Law allowing people to receive a 5-month unemployment subsidy. Another important reform to the IESS during the Correa administration was that of voluntary affiliation to the IESS by those people who work in the home and do not receive remuneration from a public or private employer (IESS, 2014). All of these policy-decisions which aimed to increase health coverage for the Ecuadorian population have impacted IESS financial ability to cope with an increasing pool of patients. Finally, the most important reform of the Correa Administration that affected the

IESS was the government's decision to stop contributing to the IESS Fund. By executive decree in April 2015 the fixed contribution of 40% to the Pension Fund was abolished and it was replaced by a guarantee of delivery of resources in the case that is needed. This has pushed the IESS to cover the expenses of the Pension Fund by using its own reserves; generating uncertainty of the economic situation of the institution, its sustainability and its ability to fund retirement pensions in the future. For interest groups and the insured, the expansion of the population covered by social security would apparently constitute an advance as a state policy, however, due to the lack of adequate planning; this situation represents a financial and actuarial deterioration for the IESS due to the decrease in State contributions and an increase in coverage, without providing the accurate financing model to support this scheme (Revista Lideres, 2017). This issue has been controversial as the government alleges that the IESS has the economic capacity to face the payment of pensions in the long run, interests groups and international organizations such as the International Labor Organization (Gonzalez, Sabando-Vera, Amaya Peso, & Noboa Panchana, 2017) say that the institution will have the need to take their reserves with the risk of not being able to pay retirement pensions in the medium or long term.

Actors such as workers unions and associations such as the Frente Unitaro de Trabajadores has voiced their complete rejection of the Correa's government decision to use IESS financial reserves to fund the government's budget and activities, including those funds dedicated to

sustain universal health coverage. For these workers' associations, the government is violating the IESS autonomy making decisions about the IESS patrimony and its financial future (Diario Correo, 2018). The medical profession through its diverse associations has also voiced its rejection stating "*for the [Correa Administration] the IESS autonomy only served as philanthropy to public resources for the benefit of the current government*" and to restrict the rights of members and retirees. It is evident that while the government pushes forward its agenda to increase the population's coverage and achieve UHC, there are no solutions when it comes to the financial sustainability of this policy choice which continues to create friction amongst those who have contributed to the IESS Funds. This friction also translates to the delivery of services where medical practitioners at the IESS tend to favor IESS affiliates over those covered by Compulsory Health Insurance. This scenario might also be replicated in the private sector were private hospitals may turn away patients that were derived from public hospitals because payment from the public sector is often delayed or there is the notion that the IESS doesn't have enough funds to meet its demands (private sector interviewee).

Another conflict when it comes to policymaking has to do with the informal employment sector and how to provide health coverage to this group of people that in Ecuador constitutes an important percentage of the population. These groups are often given health coverage through the implementation of some kind of subsidy which also has an important implication on health funding. This precise policy decision is often a

conflicting issue in Ecuador as interest groups, unions and affiliates do not want to IESS funding to be spent in health coverage of those informal workers and unaffiliated to the IESS insurance scheme.

Another theoretical perspective of historical institutionalism notes that not all reforms or improvements, seen as institutional change, are in fact efficient, since not all path dependent trajectories necessarily lead to progress. In the case of the Ecuadorian reform, this is evidenced in the analysis of indicators which was done in the previous section of this study which evidences that the reforms of the Correa Administration did not necessarily bring about significant change as it relates to the populations health or coverage. The increase in maternal mortality is an example of this. In this respect, one of the interviewees added:

> *"In general, the most evident institutional changes were directed towards the increase of infrastructure and provision of services. Although there was a breakthrough in these two aspects of the Health System, health indicators do not show a positive impact. For example, we see that teenage pregnancy rates have increased, and the incidence of chronic diseases has remained unchanged, and in some cases has increased. There is no substantial change or at least, it could not be reflected in impact indicators*."

One of the interviewees argues that incremental changes have been worse off than taking no action at all, because the reforms and changes that were implemented by the government of Correa do not aim at benefiting the Ecuadorian people but the bureaucrats behind the health system, whose

primary interest is for the bureaucratic apparatus to grow (Doctor, private sector). This is the case of public doctors and nurses who, with the human resources reform pushed forward by the MPH, were able to double and even triple their salary. However, without a proper result-driven performance evaluation.

This interviewee also views incremental changes as "*rearranging and reorganizing a set of issues without really resolving the root of the problem*". He adds:

> *"The integration of health systems under the RPIS does not necessarily improve coverage, but brings organizational and bureaucratic problems. UHC can be perfectly achieved with several healthy entities where autonomous private and public sectors cohabit perfectly. This is completely contrary to what is happening in our country. Here, universal means that the State handles everything. What we are seeing is a socialist system, centralized, bureaucratized and de-financed with a tremendous burden in terms of semi-functional hospitals, and public care posts that often do not have enough medical personnel or supplies."*

Moreover, in the case of health financing structures, it is evident that although there have been improvements in tax collection, and the introduction of some regulatory frameworks for pricing of services. However, the health financing structures inherited from the past which mirror the system's structural fragmentation, have also conditioned the subsequent reforms of financial mechanisms such as a common pooling

fund. This was a dimension of the NHS that all interviewees criticized. One of the interviewees added:

> *"The government of Rafael Correa invested resources in projects that people can see, infrastructure, state of the art hospitals that are well equipped, however, some hospitals and machinery is being underutilized. It is clear that we are lacking good information systems to improve purchasing and allocation of resources.*

Another interviewee mentioned:

> *"If the State is taking care of the universal provision, then it also has to provide the necessary resources and in countries like Ecuador we encounter a series of drawbacks, from the infinite corruption, to preferential million-dollar contracts to purchase Cuban generics, to the poor handling of debt".*

The occurrence of institutional change in the Ecuadorian context can also be explained through the concept of "critical junctures" external to institutions (Da Cunha Rezende, 2005). In particular, punctuated equilibrium models conceive the option of there being a radical change. For example, an external crisis or internal political or economic processes can cause institutions to change. In the case of Ecuador, the Government of Rafael Correa was able to reform health institutions because of the financial crises of the decade of the 1990s which proved that the state guarantees of health had been breached and could not be met. Undoubtedly, the crisis situation experienced in Ecuador was a determining factor in the electoral

victory of Rafael Correa. Therefore, the Ecuadorian case seems aligned with the concept of the formation of punctuated or strong equilibria periods of crisis as catalysts of any kind of institutional reform (Steinmo, 2008, Pierson & Skocpol, 2008). The crisis prompted the need to opt for a reform of public institutions. In relation to the transformation and strengthening of the NHS, it is important to highlight that the government had a huge window of opportunity as it relates to the health sector reform. In general terms, all the conditions were met to push forward a sectorial reform. To name a few, the reforms stemmed from crises and there was a legislative majority in the assembly, as well as high approval rates by the population, and the introduction of the TSSE Consultative Body with participation of all sectors, which became the space were all alternatives were discussed and policies were made.

2. Historical Institutionalism: persistence of institutional structures due to power inequalities

The empirical data analyzed in previous chapters, as well as the information collected from interviewees, all display the same conclusion, and that is that the Integral Model needs to be institutionalized at an operational level, the role of the MPH as the sanitary authority needs to be strengthened, and the efficiency and coordination between health network institutions needs to be enhanced. Self-preserved institutions can explain the tendency to resist to integration or to the alternative of a Unitary Health System which prevents substantial change in the institutional structure of the Ecuadorian Health System. "*Inefficient structures are institutionalized because staying on path*

is in the actor's interest, because changing is more costly" (Lowndes & Roberts, 2013). Therefore, one possible scenario would point to the fact that the Integral Health Model has not been institutionalized because it is not in the best interests of institutions like the IESS, who want to preserve its autonomy and resist the possibility of merging into a Unitary Health System. As one of the interviewees pointed out:

> *"Affiliates to the IESS have wanted to maintain it autonomous because many of them have been contributing to this scheme for many years. Therefore, for them, it wouldn't be fair to redistribute the funds of the IESS to other groups that have not contributed in the past. There is great fear on the side of the affiliates that the State will use up all of their funds".*

Power struggles among institutions also helps to explain why the institutionalization of the Integral Health Model and coordination of the RPIS has been difficult. Many of the institutions that make up the RPIS are not prepared to give up some of their autonomy and authority to the MPH.

In short, it seems useful to observe the notion presented above that actors will tend to favor events in their own interest. This is for example the case of the governments push towards horizontal health care models based on primary health care and moving away from vertical programs were it may be difficult to reform these structures due to strong institutional structures which are suported by the medical professionals who are resistant to change and prefer to stick to vertical programs as a means of self-preservation..

Historical institutionalism tries to explain how power relations shape the emergence of institutions or institutional change. This draws attention to one clear determinant factor in Ecuador's health reform, and that is, that the government of Rafael Correa had a high approval rate amongst the population, not to mention that it had a legislative majority and a growing bureaucratic apparatus of technocrats (Doctor, private sector) that supported his paradigmatic reforms. The election of Rafael Correa brought a change in power relations in the country which was shifted away from the traditional elites. This is evidenced in the Constitutional reforms, as well as in the National Plan of Good Living, were social investment is prioritized and power and resources are given back to the people. Therefore, when talking about power relationships, the Correa Administration gave the people of Ecuador rights and guarantees that previous governments had not provided, and these gave the people more power in the game. Therefore opposition groups that were skeptical to some of the health reforms, such as private doctors, providers, and private for profit hospitals, were for the first time in history at loss from a power relation perspective. This is clear in the way that the Consultative Body of the TSSE operated and reached consensus, were traditional opposition by health professional and elites did not veto the possibility of a reform. However, from this perspective, an alternative scenario for the support of health reforms by these groups would have been that they did not perceive that the reforms would hinder the continuity of their commercial transactions with the State. To this point, it is important to note that the public sector has profound dependence on the private sector to resolve complicated pathologies and provide the high-level care they are

incapacitated to provide to the population.

Another scenario where power structures play a significant role, is at a regional level. As one of the interviewees pointed out:

> "*Socialism of the 21st century plays a role in the Correa government determination to pursue Universalist policies. The wave of new democratic and socialist states in the region were trying to prove that socialism was the best alternative for our countries*"

Therefore, the new wave of socialist governments that dominated the region pursued a paradigmatic shift from neoliberalism were also interested in self-preservation of their ideology and political power. For example, this can be seen from Ecuador's decision to purchase generic medications and other health supplies from Cuba, as a way of regional cooperation and self-preservation of this new ideology that emerged called socialism of the 21st century which embraces Universalist policies and the concept of UHC. Thus, the regional environment also has an influence on the national direction of policies.

3. Rational Institutionalism: Incremental institutional change: collective action dilemmas

Stemming from the calculus approach, rational choice institutionalism states that actors will only change or set up a new institution if this fulfils certain interests and helps them maximize their returns. Therefore, in simple terms, rational choice institutionalism believes that institutional change only

occurs when actors perceive it will benefit them in some way. Applying the rational institutionalist approach one could imply that a suboptimal outcome such as an inefficient and weak NHS is in the interest of some of the actors and institutions. For example, an inefficient NHS would be in the interest of the private sector, which includes doctors and providers. As one of the interviewees points out, "*the private sector was overpricing the state for services provided to the RPIS*". The interviewee further explains:

> "*Price caps were established as a means to regulate prices for both the public network and the private network. The problem is that the private sector was taking advantage of the lack of competence of the public sector administration and increased certain prices above the established cap. Now the IESS maintains a debt, which they deem illegitimate, with the private sector and has not been able to deliver payments on time. And why is this? Because there was no supervision, regulation or auditing processes for contracts that would allow these institutions to identify overprices".*

Therefore, a well-functioning NHS is not always a priority concern of private actors. This could also, be said about the IESS. A scenario would indicate that it's not in the IESS best interests to have an integrated health system because that would mean that they would need to take on more patients outside the social security scheme which represents a high burden, not to mention that this would mean that they would lose some of their autonomy. Another perspective of rational choice institutionalists is that institutional change is costly and creates uncertainties which make actors

reluctant to such changes. In the health sector it is clear that the different set of actors, collective and individual, will tend to resist certain changes because they would need to invest a great deal of time and resources in adapting to these institutions . This could be the scenario for the institutions like IESS that want to maintain their autonomy for fear of losing their budget or staff if reform if the structural reform system entails elimination of duplication among organizations. As a result, there is a general unwillingness among the institutions that are part of the NHS to be coordinated. This is a critical veto point which explains resistance to change and further reforms in the Ecuadorian context. As one of the interviewees explains:

> *The government wanted to implement a single insurance and a single health agency; however, Ecuador still does not have a very clear concept of solidarity. So when all actors realize that people need equity and exercise solidarity, we will improve out health system. It will take several years to have an integrated set of actors in health. Right now, we have an integral health network only by name and not at an operational level."*

On the other hand, however, rational choice institutionalists may also view the Ecuadorian health system as a collective action dilemma. The weak structure of the NHS may cause actors to face insufficient information to judge which actions produce an optimal outcome for them. By trying to pursue their individual interests (such as autonomy) actors act in a way that produces an outcome that is collectively suboptimal or inefficient; which can translate to less desirable health outcomes. Therefore, this presumes

that the actors of the NHS have not fully realized the advantages of a fully integrated, well operated health system.

4. Explaining the persistence of institutional structures: calculus approach

A rational institutionalist perspective would suggest that a collective action dilemma may be overcome by improving the institutional architecture of Ecuador's NHS (e.g. by establishing the integral model of care). However, from the calculus approach, rational choice institutionalists believe that institutional structures are only changed or established by means of voluntary agreements between involved actors. Therefore, improving health governance and establishing a well-integrated RPIS, requires the strong political will of all the actors involved. This would point out to the fact that the Consultative Body of the TSSE provided the space for such voluntary agreement by all actors to reform the NHS structure. However a more negative picture would point at the fact that this was not a "voluntary agreement" but processes of long negotiations were each institution had to make compromises, for example, give away some of their autonomy. In this later view, an efficient NHS will not be possible, as there is no political will among actors to create an efficient institution.

To summarize this discussion, there is some empirical evidence to show that the reforms of the NHS posed a solution to the problem evidenced by the "old" system; however we can deduce that the NHS is going through a face of consolidation and institutional strengthening, as stated by Peters (1999).

There are key challenges to the institutionalization of the new structure and coordination proposed under the new Integral Health Model. Although the NHS has been reorganized under this model, many of the characteristic principles and institutional values of these institutions have not been relatively affected.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Summary of Findings

For the WHO, strong institutions are needed to keep the public and private sectors accountable and tackle the inequitable distribution of power, money and resources. “High income inequalities create barriers to UHC, whereas political stability, committed leadership, sustained economic growth and a comprehensive health system reform that improves governance, financing and healthcare services are critical for achieving UHC.” (WHO, 2013).

The Correa Administration made health a right that is guaranteed by the State. The Constitution of 2008 describes health as a human right, which is guaranteed to the Ecuadorian population through the NHS which is comprised by a series of public institutions. The Constitution sets precedence to a series of reforms of the public health systems which included strengthening the role of the Ministry of Health as the national sanitary authority, integrating a very fragmented public health system, increasing the state’s infrastructure and human resource capacity, to name a few. The Correa Administration political commitment to the improvement of the Ecuadorian health system, to meet the demands of the population, has been an essential factor that has contributed to the country’s advancement towards UHC. However, Ecuador’s health system still has a long way to go to be able to cover the health demands of the population. This study finds that Ecuador faces similar obstacles to other developing countries in the

attainment of UHC: fragmented health systems, the change in the epidemiological characteristics of the population, aging populations, to name a few. Table 13 summarizes the empirical information gathered in previous sections delineating the main achievements and challenges of the health reform of the Correa Administration.

Table 13: Summary of Findings

Summary of Findings: Achievements and Challenges of the Ecuadorian health reform towards the achievement of UHC		
Dimension of UHC	Achievements	Challenges
Right to health	*New Constitution of 2008 guarantees the right to health, which will be guaranteed by the NHS, under the leadership of the MPH*	*Difficulty in establishing a system that would guarantee universal health to all the population*
Coverage	*Some indicators show improvements*	*Some key indicators like maternal mortality did not show improvements* *Growing incidence of NCDs, aging populations*

Health Systems Capacity	*Introduction of Integral Health Model focused on PHC* *Conformation of the RPIS and Complimentary Health Network* *Definition of basic healthcare package covering 90% of pathologies* *Increase in equity of health services and distribution of health personnel between urban and rural areas*	*The NHS continues to be fragmented and institutions continue to grasp to their autonomy.* *Mismatch between institutional means and objectives, lack of planning, reliable information systems* *Dependence of the public sector in the private sector for second and third level care, and treatment of complicated pathologies.*
Financing Mechanisms	*Increase in public health spending allowing investment in infrastructure and capacity building.* *Increase in income generated from tax collection* *Introduction of price caps for public and private services* *Insurance coverage for the formal sector increased.* *Out of pocket expenses in health decreased*	*Fragmentation of financing mechanisms doesn't allow for the implementation of a pooling fund* *The MPH, which is in charge of health provision for 70% of the population relies entirely in the State Budget which is highly volatile* *Insurance coverage (public or private) covers only 30% of the population, informal sector* *Out of pocket expenses continue to be considerably high*

Table elaborated by the author

This data shows that Ecuador is moving in the right direction to attain UHC. However, the transformation of the health system has been pursued

incrementally, as this was the best option within the set of alternatives, given that a radical change in direction of the NHS would most probably be repelled by the set of institutions and actors that make up the NHS. Therefore, the progression towards UHC is slow as it has been demonstrated by some of the indicators reviewed in previous sections. Furthermore, this study finds that the health reform that was led by the government of Rafael Correa in Ecuador is still at a normative phase of institutionalism. The Integral Health Model is not yet institutionalized at an operational level due to critical factors that have to do with the lack of stewardship and authority of the MPH, egoistic behavior of public health institutions that want to maintain their autonomy, interest groups opposing views, as well as institutional constraints embedded in the ritual and norms that dictated how these institutions operated in the past, and now represent a clear veto point to the full realization of the reform.

6.2 Recommendations

It is undeniable that the attainment of UHC requires the convergence of a series of dimensions including normative recognition of the right to health, population coverage, sufficient health systems capacity and well-established financial mechanisms to sustain the Ecuadorian health system. However, the achievement of UHC is not only technical and must also be accompanied by healthy institutions, an encouraging political environment and a favorable economic climate. In Ecuador, the 15-year neoliberal period that was characterized by a profound economic crisis which weakened

public administration institutions and did not allow improvements or a systematic progression of the health sector. Whereas, the Correa Administration, which was in power for 10 years brought a period of relative stability which has allowed important reforms to occur. This brings about another point to consider, and it is that the health sector, especially in the Ecuadorian context is very sensitive to the economic and political environment. Thus, policy-makers at the Ministry level must take all of these factors into consideration when monitoring, formulating and reformulating strategies towards the attainment of UHC. Furthermore, policy-makers should be informed of the recommendations, and findings of relevant studies regarding universal health coverage as a way to improve policy-making and strengthen the Ecuadorian health system. For this, it is important for policy-makers to be engaged with relevant health organizations that are leading the international debates about UHC, such as PAHO and the WHO. Also, there must be an engagement with health partners and counterparts in Ministries in other countries as a way to promote information sharing and the diffusion of best practices as a way to tackle and resolve common challenges in the attainment of UHC.

Well-functioning financial mechanisms and resource collection are at the core of UHC. The positive economic climate that accompanied the Correa Administration was a determining factor in the expansion of the National Health Budget, and thus the increase in government spending in the area of health. However, Ecuador's economy is highly volatile in that the country is dependent on oil revenues. This points out to the conclusion that the

Ecuadorian government must diversify its sources of funding and look into innovative funding mechanisms. For example, the need for a pooling fund, which has already been established by the MPH, seems like a viable solution that would provide for a more sustainable source of funding for the NHS. Furthermore, the MPH must continue to work with the institutions that make up the NHS (IESS, ISSFA, and ISPOL) to resolve the issues concerning a full operational integration of the NHS. For this, the incremental approach seems appropriate given the complicated political climate and segmented characteristics of the NHS. Thus, it is important that all actors continue to engage in conversations and exercise good governance as a way to reach consensus and progress towards the attainment of UHC.

Furthermore, monitoring the reform process towards the attainment of UHC is critical for policy-makers to make sure they are achieving national health goals, shortening the inequality gap and protecting Ecuadorian households from impoverishment. Currently the MPH of Ecuador does not utilize a particular framework to assess the country's progress towards UHC. Instead, the MPH conducts progress assessment and performance reviews, however, not within the frame of UHC. In this sense, PAHO's UHC strategy and indicators are helpful tools to guide policy-making and assessing the Ecuadorian health system's progress. Also, for the sake monitoring, a fundamental recommendation for policy-makers in the health sector is for the improvement of information systems that can produce accountable information. Finally it would be important for future administrations to

perform a comprehensive evaluation of the outcomes of the implementation of the reform once the reform has been fully completed. In this context it would also be important to reevaluate the alternatives to an Integral Health Model. Perhaps an integrated model would allow the Ecuadorian NHS to progress into a Unitary Health System, which could be a second phase reform.

6.3 Limitations of this study

This research shows the importance of public policy applied to health by describing the health reform process carried out by the Correa Administration and conducting a longitudinal assessment of the Ecuadorian health sector before and after the reforms, using the WHO UHC monitoring framework. This study has been an explanatory and descriptive in nature, utilizing qualitative methods and analyzing primary and secondary data. Therefore, a main limitation of the study relates to constraints in time and accessibility of data for some of the indicators. The time constraints of this study did not allow the researcher to make an official request to the MPH for the disclosure of more accurate data. When primary data was not available, the researcher had to rely on secondary data including scientific journals, empirical data from sources such as the WHO and World Bank, government publications, among others. The significant gaps in the availability of public data about some indicators required to measure progress towards UHC evidences that Ecuador's need for improved health information systems. Moreover, the researcher completed three interviews with experts from different health sectors to be able analyze the reform

process. Although the interviews provided some insight regarding the Correa administration health reforms and their views of UHC in the Ecuadorian context, more interviews would have allowed having more detailed insights on this topic. Furthermore, formal requests for interviews with high-level decision makers and policy makers were made, however given the time constrains and the distance factor, it was difficult to schedule these interviews. Furthermore, while the WHO monitoring framework is a useful construct for reviewing progress toward UHC, however, it is not a good framework for analyzing health system performance. Nonetheless, it was is useful tool in reviewing key policies and programs aimed at advancing UHC in Ecuador.

6.4 Theoretical Implications

There is an array of theoretical literature that aims to assess the path taken by countries towards the attainment of UHC. Some literary works focus on the main components of UHC and others focus on the process toward the attainment of UHC. This study aims to contribute to existing literature on the topic, from an institutional perspective. The theoretical framework introduced for this study was NI. This framework is useful in explaining the policy implications as the policy-making process towards the attainment of UHC in Ecuador. The analysis of this research was developed evaluating the public policy two periods, and points out a notorious change in some areas, but also identifies challenges and resistance of certain actors and institutions to the attainment of a fully integrated NHS.

Furthermore, the assessment of the NHS of Ecuador through the lens of UHC, has helped reflect on the fact that most literature on the subject corresponds to monitoring reports and yearly publications developed by global health organizations like the WHO, however, there is still a gap as it relates to literature about UHC from the perspective of governments, as well as the sharing of best practices, particularly in the context of developing countries. This study has been qualitative in nature. On this basis, a recommendation for further studies would include quantitative methods, for example, to demonstrate whether an increase in government spending in health, has in fact impacted the populations health. Furthermore, it is evident that the UHC monitoring framework puts more emphasis on the financing aspects of UHC. In that sense, a future study could render recommendations for Ecuador's government implementation of a unified pooling system such as a Health Fund.

The study contributed to the theoretical understandings regarding the importance of strengthening financial mechanisms and the improvement of health systems to reach UHC, and pinpointed the main challenges in reaching this goal. Through this descriptive assessment, policy-makers can learn about the characteristics of UHC and direct public policy towards this goal. Furthermore, it is important to note that President Rafael Correa was in office until May 2017. Therefore, a new study could analyze the policy implications for the new government of Lenin Moreno, as it relates to reaching UHC.

6.5 Policy Implications

This study served to examine the effectiveness of UHC within the Ecuadorian context with the purpose of (a) informing strategic decision-makers about the key challenges in the attainment of UHC (b) assist the Ministry of Public Health (MPH) in its strategy towards health sector reforms for the attainment of UHC. The government of Ecuador, during the Correa Administration aimed to achieve a paradigmatic change in policy-making that represented a change of direction from past administrations. At the center of these changes, the government of Correa increased the government's spending in the health sector and sought to reform National Health Institutions. This study sought to analyze the set of indicators provided by the WHO which in summary provided insights regarding key challenges of Ecuador's public health system such as the low coverage rates from social security schemes, which only cover an approximate 30% of the population, as well as an alarming high percentage of OOP expenses for health among Ecuadorian households. Other findings included the government's failed attempts to integrate public health systems under the RPIS and a lack of stewardship of the MPH as it related to all public health matters. These findings are timely, as they can contribute to further improvements of the NHS from the perspective of UHC.

The findings of this study are centered on the fact that the NHS is moving in incremental transition towards universal health coverage. However, there are persistent veto points hindering further change such as prevailing health structures and institutions that have slowed down the transition into UHC.

Furthermore, the assessment of UHC evidenced that at the center of UHC are health financing systems which need to be given more attention to. Therefore, the government must focus on how to institutionalize financing mechanisms within the current structures to allow for effective mobilization of government funding that will provide sustainability of the health system within the limits of the current system. These could be for example, policies that ensure efficiency of resource allocation and purchasing, to allow for better health performance at all levels. Finally, it is important to note that the reform of the NHS through an integrative approach is an innovative solution that resolves the issues of fragmentation of health systems in the Ecuadorian context. The reform process is still ongoing and could render positive results in the future and thus, could be used as a best practice and a model for other developing countries to incorporate under similar conditions.

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APPENDIX

QUESTIONAIRE

1. Why was universal health coverage (UHC) contemplated by the Correa administration? Please describe the conditions that prompted the reform.
2. Please describe the political process that enabled the health sector reforms pushed forward by the Correa Administration. Why didn't previous governments pursue a reform?
3. How did the health reforms of the Correa administration contribute to the attainment of UHC in Ecuador? From your perspective, what have been the most important reforms?
4. Is Ecuador in the right path towards UHC? From your perspective, what are the main challenges that Ecuador faces towards the attainment of UHC?
5. How is Ecuador's progress compared to other Latin American countries, as it refers to UHC? What lessons can Ecuador learn from other countries and what best-practices can Ecuador highlight/share with other countries?
6. How would you describe the Ecuadorian health system today? Please suggest ways in which the Ecuadorian Health System can be improved.
7. Has the health system integration (i.e. integration of health services through the RPIS) contributed to the attainment of UHC? Are all

public institutions fully integrated?

8. How should Ecuador be financing healthcare? Please suggest ways in which Ecuador's health care financing mechanisms can be improved.
9. In the light of the country's current financial situation, how can the country progress towards UHC? Can UHC be sustainable?
10. Has governance of the health sector improved? What has been the role of the private sector, academia and civil society in the health reform process?
11. Has the Ministry of Health's stewardship capacity improved?

ABSTRACT IN KOREAN LANGUAGE

국문초록

보편적 의료보장을 위한 에콰도르 개혁사례연구 : 도전과 성과

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글로벌행정전공

보편적 의료보장(Universal Health Coverage: UHC)은 건강증진뿐만 아니라 경제성장과 발전을 이끄는 세계 보건 목표이다. 정치적, 경제적, 사회적 위기를 거친 후 에콰도르 정부는 국민의 UHC를 달성하기 위하여 일련의 제도개혁을 실시하였다. 헌법상의 권리에 기반하여 UHC는 에콰도르의 기본 보건 목표가 되었다.

본 연구에서는 에콰도르의 국립보건시스템 개혁 사례를 검토하고자 한다. 제도개혁은 기술적 분석과 WHO의 UHC 지표를 활용한 변수를 바탕으로 분석하였다. UHC는 건강권, 인구보장범위, 건강재정시스템, 의료접근성의 네 가지 차원에서 분석하였다. 또한, 개혁의 성과와 도전은 신제도주의 이론에 기반하여 제도적 변화의 관점에서 논의하였다. 연구 결과, UHC 성과목표 달성에 주목할만한 발전이 있었지만, 정부의 보건기금 지원능력과 제도적 한계를

감안할 때 여전히 목표 달성 정도가 낮음을 확인할 수 있었다.

이 연구는 공공보건시스템의 역사적 분절화 현상을 바로잡는 것을 (분절화 된 공공보건시스템의 개선을) 목표로 하는 통합건강모형 (Integral Health Model)과 통합건강네트워크(Integral Public Health Network)의 채택을 통해 NHS의 제도적 구조를 개선하려는 정부의 시도를 기술하고 있다. 연구 결과, 유의미한 예산 증대에도 불구하고 이러한 시도가 점증적인 지표 개선으로만 이어졌음을 알 수 있었다. 정부가 직면한 또 다른 과제는 공적 보험제도하에서 낮은 보험적용비율과 높은 가계지출비용이다. 본 연구에서 제시된 과제들을 해결한다면, 향후 에콰도르 정부가 UHC의 성취도를 높이고 빈곤과 악화된 빈부격차를 해소하는 기회가 될 것이다.

주제어: 보편적 건강보장, 보건개혁, 국립건강제도, 신제도주의

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