Healthy targets? World Bank projects and targeted health programmes and policies in Costa Rica, Argentina, and Peru, 1980–2005

Shiri Noy
Department of Sociology, University of Wyoming, Laramie, WY, USA

ABSTRACT
Despite its central role in diffusing neoliberal policies and its status as an important external funder of health, the World Bank’s effect on health policies in developing countries has been little explored. I examine how the World Bank framed and funded targeting in healthcare in Costa Rica, Argentina, and Peru. Results indicate that the World Bank and national governments pursue targeting and justify its implementation differently across countries. While both national government and the World Bank cite efficiency and equity concerns as a rationale for targeting, the World Bank is more likely to invoke efficiency and cost-cutting measures. Targeting also happens against the backdrop of very different policies across these countries: coexisting with universalism in Costa Rica, growing public insurance in Peru, and a federally managed health system in Argentina. Domestic factors associated with countries’ existing health systems, in particular coverage and segmentation in the health sector, help account for variation in both the groups/areas targeted and the discourse and rationale in national and World Bank documents. I conclude by discussing the implications of these results for our understanding of the World Bank’s influence on health policies in developing countries.

Scholars are increasingly interested in how neoliberal policies espoused by international financial institutions affect social policies and safety nets in developing countries (Armada, Muntaner, & Navarro, 2001; Huber, 2005; Huber & Stephens, 2012; Kaufman & Nelson, 2004; McGuire, 2010). Powerful international financial institutions (IFIs), notably the World Bank and the International Monetary Fund (IMF), often work conditions into loans sought by developing countries. These loans and their accompanying conditions allow IFIs to dictate reductions in countries’ social spending and pressure countries into restructuring their social sectors. However, few studies have examined the content of IFI prescriptions and projects, especially in social sectors. In addition, while the World Bank is a highly centralised and bureaucratised institution, its staff varies across countries and the extent of the uniformity of programmes and loans across countries is little known. In this article I begin to fill this gap by examining World Bank health projects, focusing on targeting as a policy instrument, in Argentina, Costa Rica, and Peru between 1980 and 2005.
This study seeks to answer three related questions: first, how does the World Bank conceptualise the ideal role of the state in the health sector in Costa Rica, Argentina and Peru and how does this compare with national governments’ conceptions? Secondly, how does targeting as a policy instrument fit into broader health sector goals and strategies? Thirdly, how is targeting promoted and discussed differently by the World Bank and national governments, and why is it implemented differently across these three countries? Understanding how targeting in health has been framed and discussed by national governments vis-à-vis the World Bank, in a comparative perspective, provides important information about differences, commonalities, and ultimately, the implementation of this allegedly neoliberal policy instrument that is seen as directly challenging more inclusive, universal health systems in developing countries.

Theory and literature

Targeting in social and health policy

Rationale for targeting

Targeting involves the focusing of resources and service provision on a particular segment of the population in an effort to reduce poverty and promote social development. Beneficiaries may be defined by a particular status characteristic (e.g. mothers and children or those below a certain income), a location (e.g. a particular province or town) and/or a health intervention (e.g. HIV/AIDS or tuberculosis). While sometimes conflated with means-testing, whereby recipients of care must demonstrate that their income/wealth falls below some specified level, services, targeting and means-testing are related but distinct concepts. This distinction is important because some criticisms of targeting are actually criticisms of the strictness of enforcement in means-testing, utilized to ensure that only the intended recipients receive benefits.

Targeting social provision has been advanced as a tool for doing more with less, channelling resources to the ‘deserving poor’ – ensuring that assistance reaches the truly needy. Targeting has become an increasingly popular policy instrument given austerity: a tool by which the state can correct market inefficiencies in the provision of social services (Mkandawire, 2005). Targeting can then increase efficiency by generating greater output for the same input. In health this suggests better health outcomes (e.g. infant mortality rates) and/or more interventions (e.g. vaccinations) for similar levels of spending or investment. Targeting has also been cited as a way to achieve equity in that it reduces inequality by raising the standard of living of the poor and otherwise neglected groups. In this latter formulation, targeting is a way of ensuring that health services reach populations or areas that the market cannot, or will not, because of access constraints, inability to pay, or other reasons. Equity is then a post hoc health concern, where targeting may help ameliorate inequalities that are built into the existing system. Targeting has thus been identified as a neoliberal tool in social service provision, one which involves government intervention only to correct market inefficiencies. Targeting by definition segments and divides populations. Most notably, targeting stands in opposition to universalist policies and, as such, assigns public health interventions to a residual and selective interventionist rather than inclusive, universalist role – a tool especially advanced by the World Bank since the 1980s (Mkandawire, 2005). The debates about targeting and universalism point to important variation in ideas about what targeting aims to do as well as the very definitions of the policy challenges it seeks to address, such as equity and efficiency.

Critiques of targeting

Targeting has been critiqued on several fronts: ideologically, theoretically, and empirically. Critics of targeting advance several arguments. First, poorer countries that are most in need of targeting due to limited resources are the least able effectively to target needy populations due to institutional weakness and there may be error in targeting, for example, those who should be eligible are sometimes excluded
Secondly, targeting is often associated with stigma and other social costs. Even if they do not deter use, such policies make powerful statements about the equality of citizens and may disempower their beneficiaries. Thirdly, targeting creates dualism with a state-funded structure aimed at the poor while the wealthy often utilize a private-sector dominated structure, with consequent differences in quality, further exacerbating existing inequalities. In particular, targeted programmes are often buttressed by means-testing, in order to ensure that only the eligible benefit from these programmes. Such a dual system, in addition to the potential stigma imposed, also means that the lower-middle class and those not living in extreme poverty have no stake in these programmes, rendering the programmes politically vulnerable to cuts and cancellation. Fourthly, the emphasis on poverty reduction associated with targeting replaces the broader goal of development. Social policy is assigned the secondary role of taking care of poverty rather than advancing equal rights or redistribution and equity more broadly. Fifthly, and finally, because targeting is filtered via local institutions and politics, any existing institutional and social biases (for example gender or ethnic bias) and weaknesses are repeated and extended in these targeted programmes (Mkandawire, 2005).

The empirical evidence on targeting is mixed. Some studies have found it to be successful in reducing poverty while others point to issues and challenges in its planning and implementation (van Oorschot, 2002; Weiss, 2004). Despite these concerns the World Bank has continued to promote targeting across domains.

**The World Bank, neoliberalism, and social policy reform**

The World Bank, along with other financial institutions, has been identified as one of the main proponents of neoliberal reforms in social policy, among them targeting. Generally, neoliberalism is characterised by the idea that markets are the most efficient form of resource distribution, resulting in a healthier economy. Underlying this belief in the benefits of allowing the market to allocate resources is an emphasis on property and contracts as means to maximise efficiency. The state should only get involved in cases of extreme market inefficiencies, rather than promoting universal services. The original Washington Consensus indicates that at least some economists were aware that spending on health and education were important for poverty reduction and beneficial for economic growth, as it is investment in human capital (Williamson, 2002). Notably, in this formulation investing in education and health are no longer ends in themselves, but a means to economic development via an improved labour pool. Targeting may then be the ideal policy instrument by which to convert the poor into an important potential labour pool.

International financial institutions can use conditions associated with their loans and projects, especially through structural adjustment programmes, to mandate policy changes in borrower countries (though some have suggested local policymakers may use conditions to their advantage to effect change in their preferred direction, cf. Weyland [2005]; Vreeland [2003]). The debt crisis at the end of the 1970s and after rendered governments in developing countries especially vulnerable, and agreeing to implement IFI reforms became a precondition of receiving bailout funds (Babb, 2005). Latin America (along with sub-Saharan Africa) was especially susceptible, with the so-called ‘lost decade’ of the 1980s prompting increased borrowing from IFIs (Lloyd-Sherlock, 2000; McGuire, 2010). In addition, as the largest external funder of global health in the developing world, the World Bank also wields important normative power (Ruger, 2005).

While IFIs certainly pattern national thinking about social policy, diffusing these models via their loans and consultants, their influence is only one of a number of factors influencing government policy decisions. Public opinion and civil society, sometimes together with competition and disagreement among domestic elites, affect the trajectory of health systems’ reform (Berman, 1995). Targeting certain groups can change both the popularity and also the effects and outcomes of particular health programmes, rendering it an important facet of national policy.
**Case selection**

Case selection was guided by an effort to retain the commonalities of the Latin American context, since the World Bank has macro-regional offices, yet introduces variation in countries' health systems, in particular their structure and financing. The Latin American context provides important regional constancy as each global region office at the World Bank has its own Vice President, and we might expect its approach to be most similar within, rather than across, regions.

Argentina, Costa Rica and Peru represent different types of health models according to Mesa-Lago’s (2005, p. 33) typology: Argentina is characterised by low coordination between the three subsectors of public, social security, and private provision, each with its own financing; Costa Rica has unified, nearly universal, social security-run health system with some subcontracting to the private sector for provision of services; and Peru displays little coordination among the three subsectors of public, private, and social security, and has few separations of functions in terms of financing, purchasing, delivery, and regulation, within the health system. These differences are particularly important for a study seeking to examine targeting in the context of World Bank projects and loans and national health sector reform. Leveraging the comparative angle of Argentina, Costa Rica, and Peru, whose health sectors have all undergone some reform since 1980 which are characterised by different levels of state involvement in health, allows for a more complete understanding of the World Bank’s influence across contexts. These trends and findings are summarised in Table 1 which outlines the direction of reforms of the health systems against which targeted interventions operate in each country, further detailed in the analysis section.

**Empirical expectations**

The existing literature on the World Bank, neoliberalism, and targeting suggests several empirical expectations for the World Bank’s work in targeting in health in the three countries. Rica, and Peru. First, I expect that the World Bank will promote targeting uniformly, in the interest of efficiency and via the introduction of private providers and market mechanisms (such as means-testing) across the three countries. Secondly, I expect that Costa Rica, with its strong public system, will be least likely to implement targeted programmes. Thirdly, I expect that in Peru, where the health system has the least coverage of the three countries, that the World Bank will promote targeting most extensively – financing more and larger scope targeted projects. Fourthly, and finally, I expect that the World Bank will increasingly focus on equity together with efficiency given claimed shifts away from the Washington Consensus, particularly from the mid-1990s and after.

**Data and methods**

**Data**

I use national and World Bank policy documents to examine targeting in World Bank projects and health sector reform in Peru, Argentina and Costa Rica. First, I analyse documents from World Bank.

<table>
<thead>
<tr>
<th>Structure of the health system (1980s)</th>
<th>Direction of reforms (1980s–2000s)</th>
<th>Targeted programmes pursued (with World Bank involvement)</th>
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</thead>
<tbody>
<tr>
<td><strong>Argentina</strong></td>
<td>Obras Sociales (social security) holds largest share, public facilities free but concentrated in urban areas</td>
<td>Targeted programmes to complement the public system (Plan Nacer), cost-recovery by public hospitals and double-coverage elimination</td>
</tr>
<tr>
<td><strong>Costa Rica</strong></td>
<td>Caja Costarricense de Seguro Social (CCSS) near universal coverage</td>
<td>Deepening coverage in poor areas/for poor people, focus on primary health care</td>
</tr>
<tr>
<td><strong>Peru</strong></td>
<td>Segmented, EsSalud (formal sector), public and private facilities</td>
<td>Extension of coverage via the SIS (public insurance)</td>
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</tbody>
</table>
health-related projects and loans in the three countries that began between 1980 and 2005. These documents include technical reports, letters of intent and completion reports for all World Bank loans and projects related to health. Together, they represent different dimensions of the World Bank’s work in health as they vary in length, content, and substance. As such, these documents provide a comprehensive, official account of the World Bank’s promotion of targeting in these three countries. Secondly, I analyse health plans, documents related to health programmes, laws, and decrees published by governments (which contain sectoral goals), assessments of previous accomplishments, and future plans. The analysis of government documents allows me to identify governments’ goals as they relate to health policy and states’ discourse on targeting, and also examine the extent of alignment between government and World Bank discourses.

1980 was chosen as the starting point for the analysis as it marks the beginning of the debt crisis, a time when all Latin American countries were reconfiguring their public sectors and when the World Bank loans and advice were especially sought by governments of developing countries. It is also an ideal starting point because the World Bank’s 1980 ‘Health Sector Policy Paper’ formally committed the World Bank to direct lending in the health sector. The end point was selected because 2005 provides some retrospective distance, allowing me to examine largely completed projects. My data comprises the population (rather than a sample) of official documents related to health sector projects and loans from the World Bank in Argentina, Costa Rica and Peru. In order to identify relevant projects I examined all World Bank projects in Argentina, Costa Rica, and Peru from 1980 to 2005 via the World Bank indexed system, and looked up projects’ summaries and descriptions and included any project which had a health sector component. Figure 1 displays the starting and duration of health related World Bank projects in the three countries between 1980 and 2005.

I examine 281 World Bank documents related to these 58 projects across the three countries, accessed via the World Bank’s website. On average, each project had four documents associated with it, with documents ranging from one to 117 pages in length. These health projects lasted an average of five years in Argentina and Peru and four years in Costa Rica. It is important to note that many World Bank projects are multi-sectoral with the health component sometimes composing only a fraction of the monies allocated in the projects.

For the national policy documents I drew from health plans and other national documents, including laws and decrees. The Argentinean government has a myriad of documents associated with each of their national plans while Peru’s first official health sector plan was for 2002–2012, but the government has published several documents related to previous projects. In Costa Rica the Ministry of Planning publishes a development plan, including specific plans for each sector, every four years. I procured these documents as well as Argentinean and Peruvian health sector documents during archival research in 2011, supplemented by material available online via Ministries of Health, social security, and other government websites.

**Analytic strategy: policy paradigms and policy change**

IFIs influence national policies on several levels: outlining broad approaches and ideas (e.g. healthcare as the responsibility of the state or relegated to the market), identifying problems (e.g. overspending concerns or system fragmentation), and proposing solutions (e.g. targeted health programmes and interventions). While programmatic ideas such as targeting are concrete, precise and policy-specific solutions to policy problems, paradigmatic ideas (such as pursuit of equity and/or efficiency), are those that define the assumptions about overall objectives (Campbell, 2002). Epistemic communities, typically comprised of political elites, international organisation personnel, experts, and other policy practitioners are often instrumental in both establishing consensus and implementing corresponding reforms about best policy practices (Kay, 2000; Martinez Franzoni & Voorend, 2011). In particular, they may be important in diffusing policies within regions (Weyland, 2005, 2006). However, there is typically cross-national variation in implementation, often owing to disagreements between local political elites, and the historical and institutional national context.
Figure 1. World Bank health sector related projects in Argentina, Costa Rica, and Peru approved between 1980 and 2005.
Figure 1. (Continued).
<table>
<thead>
<tr>
<th>Country</th>
<th>Target group/area</th>
<th>Intervention</th>
<th>World Bank project</th>
<th>Project years</th>
<th>Project years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>Women and children</td>
<td>Infrastructure, supplies, training and information systems to reach women and children in poor neighbourhoods at the provincial and municipal level</td>
<td>Maternal and Child Health and Nutrition Project (PROMIN I)</td>
<td>Aug-1993</td>
<td>Mar-2000</td>
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<td></td>
<td></td>
<td>Continuation of PROMIN I, focus on prenatal services and paediatric services for children under 5, develop early childhood development centres, decentralise these social services</td>
<td>Maternal and Child Health and Nutrition (PROMIN II)</td>
<td>May-1997</td>
<td>Dec-2005</td>
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<td></td>
<td></td>
<td>Implementation of MCHIP/Plan Nacer in 9 provinces</td>
<td>Provincial Maternal-Child Health Investment Project</td>
<td>Apr-2004</td>
<td>Jul-2010</td>
</tr>
<tr>
<td></td>
<td>People with HIV/AIDS</td>
<td>Establishment of diagnostic centres, improvement of hospitals and other facilities, training of health personnel in diagnosis, treatment and counselling, prevention subprojects via NGOs</td>
<td>Aids and Sexually Transmitted Diseases Control Project</td>
<td>May-1997</td>
<td>Dec-2003</td>
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<tr>
<td></td>
<td>Poor provinces and people</td>
<td>Reduction in public sector positions (health and education sectors)</td>
<td>Provincial Reform Project II – Tucuman</td>
<td>Aug-1997</td>
<td>Dec-1999</td>
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<td></td>
<td></td>
<td>Reduction of health sector personnel, promote public hospital autonomy</td>
<td>Provincial Reform Project II – Salta</td>
<td>Aug-1997</td>
<td>Dec-1999</td>
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<tr>
<td></td>
<td></td>
<td>Restructuring the Obras Sociales Provinciales, extending provincial Health Insurance to the uninsured poor, promoting public hospital autonomy</td>
<td>Provincial Reform Project II – San Juan</td>
<td>Aug-1997</td>
<td>Jun-2000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gathering and systematising social sector specific information to enhance the government’s capacity to target social services, monitor and evaluate social service</td>
<td>Fourth Social Protection Project</td>
<td>Oct-1998</td>
<td>Dec-2005</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The project was cancelled because of governmental administrative delays but its original goal was to establish health insurance for the poor</td>
<td>Health Insurance for the Poor Project</td>
<td>Nov-1999</td>
<td>Dec-2002</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Update databases to ensure benefits are being appropriately awarded</td>
<td>Social and Fiscal National Identification System Project</td>
<td>Apr-1999</td>
<td>Dec-2005</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>Indigenous communities</td>
<td>Separating CCSS functions, performance-based financing, develop a management information system to identify the most disadvantaged CCSS users including incorporating indigenous areas</td>
<td>Health Sector Strengthening and Modernization II Project</td>
<td>Jul-2001</td>
<td>Dec-2009</td>
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<td></td>
<td>Poor regions and people</td>
<td>Redefined primary healthcare model via the creation of EBAIS (Equipos Básicos de Atención Integral de Salud), CCSS (social security agency) institutional reform and contracts with hospitals</td>
<td>Health Sector Reform Project</td>
<td>Oct-1993</td>
<td>Sep-2002</td>
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<tr>
<td>Country</td>
<td>Target group/area</td>
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<tr>
<td>Peru</td>
<td>Women and children</td>
<td>Separating CCSS functions, performance-based financing, develop a management information system to identify the most disadvantaged CCSS users.</td>
<td>Health Sector Strengthening and Modernization II Project</td>
<td>Dec-2001</td>
<td>Dec-2009</td>
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<td></td>
<td></td>
<td>Strengthening of public health programmes focusing on mother and child health programmes and support community-based projects via CLAS (Comités Locales de Administración de Salud), modernise hospitals.</td>
<td>First Phase Health Reform: Mother and Child Insurance and Decentralization of Health Services</td>
<td>Dec-1999</td>
<td>Jun-2006</td>
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<tr>
<td></td>
<td></td>
<td>Provision of supplies, equipment and training professional and community health workers focusing on maternal and child health and nutrition and tuberculosis treatment in four of the poorest provinces.</td>
<td>Basic Health &amp; Nutrition Project</td>
<td>Feb-1994</td>
<td>Dec-2000</td>
</tr>
<tr>
<td>Poor provinces and people</td>
<td>Provision of supplies, equipment and training professional and community health workers focusing on maternal and child health and nutrition and tuberculosis treatment in four of the poorest provinces.</td>
<td>Basic Health &amp; Nutrition Project</td>
<td>Feb-1994</td>
<td>Dec-2000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Investment in small scale infrastructure and public services and investment in productive projects to stimulate economic activities in poor communities.</td>
<td>Social Development and Compensation Fund II</td>
<td>Jul-1996</td>
<td>Jun-2000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Providing primary health care and basic health services to marginal communities.</td>
<td>Primary Health Project</td>
<td>Nov-1982</td>
<td>Jun-1989</td>
</tr>
<tr>
<td>Indigenous people</td>
<td>Promotion of community sub-projects and communication with state entities by indigenous and Afro-descendant population.</td>
<td>Indigenous and Afro-Peruvian Peoples Development Project</td>
<td>Feb-2000</td>
<td>Jun-2004</td>
<td></td>
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</tbody>
</table>
I use content and discourse analysis to examine targeting in these documents, utilizing the software ATLAS.ti. (2010) Broadly, I follow the process tracing approach which includes content (or textual) analysis where documents (in this case policy documents and reports) are seen as containing valuable information about actors (e.g. who is cited, government offices and individuals mentioned), prominent ideas (e.g. neoliberalism, efficiency), and reflecting temporally bound understandings, ideas and views on issues, topics and actors (George & Bennett, 2005). While I examined documents associated with all World Bank loans and projects in these countries (see Figure 1), my analysis is focussed on the subset of loans and projects that include a targeted intervention, listed in Table 2. These documents provide a ‘public transcript’ of World Bank involvement and the ways in which targeting is discussed, assessed, and promoted in these countries. National documents allow me to examine the extent to which World Bank projects shaped national agendas and discourse while leaving open the option for feedback and recursive processes.

Results

Targeting and health systems reform in Peru, Argentina and Costa Rica: historical perspectives and recent initiatives

Targeting as a policy instrument operates against very different policy backdrops and legacies across Peru, Argentina, and Costa Rica and is intended to fulfil different goals. I find that across each of the three countries efficiency is a main concern in both World Bank and national documents in the face of distinct but related pressures: worries about financial sustainability, financial crisis, and increased costs of medical technologies. However, targeting is also discussed as an important instrument to advance equity and expand access.

Peru is the poorest of the three countries; it is geographically segmented, and home to a sizeable indigenous population resulting in some particular health challenges, recognised by the World Bank in its projects there (P062932, 2007). In the 1990s the major reforms of Peru’s primary-level, public health system included fees for services, means-testing, a basic package of health services, and decentralisation of the administration of local health clinics (Ewig, 2006). In 1994 Salud Básica Para Todos was introduced: a basic package of health services with the focus on extending services to poverty stricken and remote areas (P062932, 1999, p. 2). This reform came in conjunction with an attempt to decentralise the administration of health services via the Comités Locales de Administración de Salud (CLAS) initiative which aimed to expand coverage and improve the efficiency via community participation.

In the late 1990s two different schemes, also run by the Peruvian Ministry of Health, the Seguro Materno Infantil (SMI) and the Seguro Escolar Gratuito (SEG) targeted pregnant women, mothers and children, and children in public schools, respectively who did not have other forms of public or private insurance though such means-testing was not typically enforced. While both were subsidised and financed with public monies, the SMI also received funding from the Inter-American Development Bank and the World Bank (Jaramillo & Parodi, 2004; P062932, 1999). In Peru targeting has therefore been utilized to extend access for certain groups of people, which because of its limited health system, by definition means increased coverage. Peruvian government documents, on the other hand, seem concerned with targeting as a way of righting historical wrongs including marginalisation, perhaps harkening back to the times of forced sterilisation in the 1990s. The health policy plan for 2002–2012 notes these historical inequalities:

"those most affected by poverty, marginalisation and exclusion, towards who we should direct increased efforts to alleviate their hazardous condition, [have] remained in the same plight, which affects their sense of the future and the hope of a dignified life. (Ministerio de Salud de Peru, 2002, p. 5, authors' translation)"

Targeting is then a way to extend access to those to whom access has been historically denied, working towards increased equity. For these two groups – mothers and children and the poor – state
intervention in the form of public insurance is seen as warranted, at least until unemployment decreases so that more people are absorbed into the social security system.

In 2001 the incoming government decided to unify these two programmes, creating the Seguro Integral de Salud (SIS) (Parodi, 2005; P078951, p. 2004). Partly, this was a response to an estimate that approximately 58% of the population did not have health insurance, and relied entirely on Ministry of Health posts. As of 2008 about 18% of the population was using SIS services (Alcalde-Rabanal, Lazo-González, & Nigenda, 2011, p. S248). In this context, the World Bank issued a loan in 2004 to implement targeting in order to expand coverage: ‘better targeting of resources, together with coverage expansion, are expected to improve the overall allocation of public resources for the social sectors, while increasing access and quality of services for the poor and vulnerable’ (P083968, 2004, p. 3). However, expansion of health services here is for mothers and infants and the poor, rather than a universalistic expansion of services.

A gendered approach has a long history in Latin American health systems, which developed around a male breadwinner model, and some have argued that this focus comes at the expense of gendered consideration of universalism (Gideon, 2014). That is, women and children are often assumed to be provided for via a husband/father’s insurance. The social security system in Peru, EsSALUD, serves approximately 20% of the population and services are highly concentrated in urban areas. Finally, members of the police and armed forces and their family members receive services from health establishments designated for their use. Approximately 2% have private insurance (‘prepagos’).

In contrast, Argentina is a highly decentralized country and provincial governments are largely responsible for their own health policies. Broadly, the Argentinean health system is composed of three sectors: public, private, and social security. The social security system is organised along broad occupational lines or industrial sectors, and is called Obras Sociales (Tobar, 2001). There are over 300 Obras Sociales, which have their root in health insurance funds for workers created by trade unions (Fleury, Belmartino, & Baris, 2000). There are 24 provincial Obras Sociales – one in each province – with which public employees in each province are affiliated, with a separate Obras Sociales for retirees, PAMI (Programa de Atención Médico Integral). PAMI and the Obras Sociales together cover slightly less than half of the Argentinean population (Belló & Becerril-Montekio, 2012).

In the context of the decentralized nature of the Argentinean health sector, equity is a concern both geographically but also because of the great inequalities in resources and services across the OS. However, efficiency is of greater concern, especially as a result of the various economic crises Argentina weathered between 1980 and 2005. Indeed, when equity is discussed, it is done briefly and always in tandem with efficiency concerns:

Multiplicity of social insurance and public and private health subsystems adding up to an intricate, inequitable and ineffective financing and delivery of health services; Need for institutional development in national and provincial Ministries of Health (MoHs) to reinforce their capacity to regulate and control health care system. (P043418, 1997, p. 4)

While equity is not directly defined it is treated as the more equal distribution of resources and, particularly, helping the poor or groups that are ‘vulnerable’. Indeed, the strategy is to help the deserving poor – those that are unable, but actively trying, to secure health insurance or healthcare for themselves. Targeting women and children in Argentina is justified on the grounds of both equity and efficiency: ‘In the short run, the highest priority on grounds of equity and efficiency is to address the health and nutritional needs of poor mothers and children’ (P006025, 1993, p. 14). The central goal, therefore, is to help the ‘deserving’ (as compared to the ‘non-deserving’ who may have multiple coverage) and minimise access of the non-deserving, especially for those who benefit from multiple social programmes, particularly in the context of financial crises and recessions:

by cross-checking against other programs, the likelihood of awarding these benefits to non-deserving persons is substantially reduced. Through cross-checking as well, an estimated 20,000 cases of double coverage (national vs. provincial social programs) will be detected in the first participating province alone. (P055461, 1999, p. 6)

The private sector consists of clinics and facilities that service individuals but also Obras Sociales affiliates and private insurance plans (called Empresas de Medicina Prepaga, EMP or ‘prepagas’) that
can be paid by individuals or companies with resources negotiated with the Obras Sociales. In addition, since 1993, hospitals can be legislatively and legally self-managed (Cavagnero, Carrin, Xu, & Aguilar-Rivera, 2006). In 1996, the Programa Medico Obligatorio (PMO) established a basic package of services that all providers, namely Obras Sociales, must provide with the goal of establishing minimum health services. The Superintendencia de Servicios de Salud (SSS) is the regulatory body which enforces this (replacing ANSSAL in 1996).

Costa Rica is hailed as a health success story of 'health without wealth'. Despite its status as a developing country it has achieved high life expectancy and low levels of infant mortality (P006952, 1996; Sáenz, Acosta, Muiser, & Bermúdez, 2011). In Costa Rican national development plans, published every four years, efficiency in health is discussed in the context of financing, but equity is also a primary focus. While World Bank documents do make mention of equity, their idea of equity is formulaic (basing resource allocation on regional inequality and poverty) and geographically bound. For the Costa Rican government the issue of equity is exemplified in a universal contributory social security system (whether people use it or not) which is based on solidarity: funds from those earning higher wages subsidise those with lower wages, with the government further subsidising the poor and indigent. Equity is therefore a matter not only of health outcomes but also of people's access to services, and is intricately tied to financing with subsidisation for the poor. While access is discussed by both the World Bank and the state, World Bank documents emphasise access as an outcome in the context of economic distortions (for example, externalities), whereas the Costa Rican government prioritizes access as it relates to issues of equity and quality of care.

In 1993 Costa Rica integrated its social security programme with the Ministry of Health, resulting in a single-payer model managed by the social security programme and financed by employers, employees and the government (with government subsidies for the poor). The main provider of health services is the Caja Costarricense de Seguro Social (CCSS), established in 1941, which originally provided health services to formal workers and then expanded to include their families in 1961, but has since expanded to encompass the whole population, and effectively covers over 85% of the Costa Rican population. The CCSS relies on tripartite financing, from employers, employees, and the state. Therefore 15% of the population, consisting largely of agricultural labourers, informal sector workers, self-employed professionals, and business owners, lives without public health insurance. Uninsured people however do use public health facilities despite not being officially insured, especially hospitals (Clark, 2002; Unger, De Paepe, Cantuarias, & Herrera, 2008).

Originally the CCSS managed both pensions and health insurance which were part of a single fund but in the 1990s pension and health funds were separated. The health system was further subdivided administratively into units responsible for health financing, purchasing, and pensions where the CCSS purchases health services from its operational units. In 1973, Ministry of Health hospitals were transferred to the control of the CCSS as well. Since 1995 basic health services have been provided via Equipos Básicos de Atención Integral de Salud (EBAIS) which took over all direct medical functions previously provided by the Ministry of Health (P006954, 2003). The World Bank and other international agencies were involved in this reform. Each EBAIS consists of a medical team, in urban areas these are typically clinics and in rural areas they are mobile (Rosero-Bixby, 2004).

The role of government in the health sector in Peru, Argentina and Costa Rica

Discussion of the ideal and actual role of government in the health sector in World Bank documents, as compared with national documents, provides information about the framing of neoliberal incentives to reduce state involvement and may illuminate how targeting fits into broader discussions about health across these three countries. In Peru, the concern since the 1980s has been developing rather than improving the health system because, unlike in Argentina and Costa Rica, the health system does not yet cover a majority of the population. The first World Bank health project in Peru was focused on extending coverage, especially to the poor and mothers and children via a primary health care
approach (P007982, 1982, p. 7). The goal of the government is to extend coverage via public facilities, especially in remote areas.

In Argentina, the role of the state in healthcare is more complex. Provincial governments are responsible for health in their jurisdictions and manage their own Obras Sociales Provinciales whereas the national (federal) government is seen as being an important regulatory agent rather than provider. The following quote from Provincial Maternal-Child Health Sector Adjustment Loan Program Document from 2003 demonstrates that the concern is mainly with efficiency, with the government needing to step in to correct market inefficiencies, especially during economic crisis:

Although the government is committed to consolidating the improvements in regulation of the Obras Sociales system introduced in the last decade, it is also a priority to ensure that the majority of the population receive health care in the public systems under effective, efficient, and decent care conditions... The efforts of the provincial public sector to increase the capacity of the supply of services to respond to the greater demand, resulting from the economic crisis, are not sufficient ... because the management model attempts to meet the growing demand without the creation of incentives to improve efficiency. (P072637, 2003, p. 44)

In this formulation the national government regulates and the provincial governments provide services directly, and while the system should strive for both universalism and increased coordination, in reality it is segmented by occupation and labour market status (e.g. formally employed or not). In Argentina, targeting is seen as a way to utilize resources more efficiently and therefore extend state capacity to cushion people against the vagaries of the market.

In Costa Rica, investing in education, health and infrastructure are described as a means for achieving social and political stability, a concern in the context of economic crisis and civil war and unrest among its Central American neighbours (P006927, 1988). While the focus on investment in social services for the goal of political stability is utilitarian, it suggests that the World Bank recognises that economic and social policies (and spending) are related to political stability, differing significantly from the critiques of neoliberalism as an approach which ignored (to its own detriment) the relationship between economic and political conditions. In the presidential memo for the second structural adjustment loan (SAL) in 1988, the World Bank stressed the importance of ‘improved management of the public sector’ as a method to ‘increase public savings, improve the cost-effectiveness of public investment, and reduce the size of the parastatal sector’ (P006952, 1996, p. 56). According to this SAL, investment in the health sector, among other types of social spending, is largely discussed in the context of the need to control government expenditure given balance of payments problems. The role of the state in the health sector is therefore one of management, always keeping in mind the importance of reducing public spending and increasing public savings. Overall, my analysis suggests significant variation in the World Bank's conceptualisation of the government's role in health: in Peru extended coverage via insurance, in Argentina regulation of the social security sector, and in Costa Rica management with high involvement in health reform via the CCSS, a parastatal agency.

World Bank projects and targeting in health

The above section demonstrates that there are differences in emphasis on efficiency and equity across countries and between national governments’ and World Bank documents, situating these differences in historical context and against the backdrop of existing health systems. In this section I turn my attention to analysing whether these differences can be accounted for by cross-national variation in the targeted groups. Table 2 summarises, by country, the targeted group, corresponding to World Bank project(s) and subsequent policy reform. Table 2 when considered together with Figure 1 indicates that not all World Bank projects in each of the three countries involved targeting. It also demonstrates that there is variation in the groups targeted across these three countries, but also some commonalities.

In all three countries the poor were targeted. However, in Peru the focus is on maternal and child needs, specifically poor mothers and children. Historically in Latin America, women's health concerns were primarily addressed in relation to their role as mothers (Gideon, 2014). Peru has been in the process of expanding and implementing the SIS: a health insurance which has its origins in the
maternal and child insurances that began with World Bank and Inter-American Development Bank funded programmes. However, the first World Bank health project in the country was intended to be quite comprehensive in that it sought to reform the health care model via the development of ‘Primary Health Care Modules’ consisting of medical teams serving ‘up to 15,000 scattered population or up to 40,000 cluttered population’ (P007982, 1993, p. 15), although it was to be implemented, at least initially, in only four areas. Means-testing featured in the World Bank’s plans for and discussion of the SIS: ‘Directly SIS targets the poor through geographical and means tested procedures. A benefit analysis of all the large social programs in Peru, found that in health SIS is the best targeted program’ (P062932, 2007, p. 20).

Argentina has also targeted women and children via its Plan Nacer programme, which provides health insurance for pregnant women and infants without other health insurance, partially funded by both the World Bank and the Inter-American Development Bank. The first loan for this project was issued in 1993 and as the staff appraisal report states, the World Bank believed that the best way for the government to proceed was by focusing on health outcomes via targeting in the interest of efficiency: ‘The overarching goal of health policy should be the improvement of health status, within the existing financial constraints, through better targeting and more efficient resource use’ (P006025, 1993, p. 14). This was regarded as particularly critical given that the Obras Sociales are employment based, and public hospitals, though freely accessible, are clustered in urban areas and provide curative but not preventative care. This was a central reason for the introduction of programmes that focused on prenatal care, as these fell during times of financial crisis with high unemployment rates.

In Argentina there is also discussion of buffering the effects of economic crises and structural adjustments, presumably felt by the entire population but in these cases the decision is to target the (hopefully) temporarily unemployed who may have fallen into poverty. Therefore, targeting in Argentina is aimed at four main groups: women and children, the poor including the large number of those unemployed due to economic crisis, those with HIV/AIDS, and indigenous people. Targeting these groups is seen as consistent with several interrelated goals the World Bank identifies for Argentina: poverty-reduction, efficiency and cost-cutting, social development, investment in human capital, and improving social services for vulnerable groups. As noted in the context of the HIV/AIDS program: ‘the project supported existing CAS [Country Assistance strategy] objectives of enhancing social development in Argentina and improving social services for the most vulnerable groups in society’ (P043418, 2004, p. 4). In Costa Rica World Bank projects promote targeting against the backdrop of a system that has been and remains universal, with nearly 90% of the population covered by the CCSS. Targeting is seen as a policy instrument in the pursuit of equity and increased access. For example, the Health Sector Strengthening and Modernisation II Project seeks to ‘introduce measures to increase the equitable distribution of resources, [and the] targeting of public subsidies’ (P073892, 2001, p. 11). It is not a question of the system not being universal or of ineligibility, but rather of utilization of available resources among those eligible.

Costa Rican development plans frequently refer to targeting underserved indigenous communities: ‘A special effort will be made to extend the coverage of health services to indigenous communities – many of which do not currently have access to basic services’ (MIDEPLAN Plan Nacional de Desarrollo, 1994–1998, ‘Francisco J. Orlich’, authors’ translation) – and areas that have historically been neglected: ‘the actions and policies adopted in the health sector should be oriented at addressing areas and sectors that have so far been less favoured, without neglecting the quality of services of the rest of the population’ (MIDEPLAN Plan Nacional de Desarrollo, 1986–1990, p. 30, author’s translation). The World Bank was involved in the planning and implementation of the EBAIS which was aimed at increasing utilization and the reach of the public system. However, the World Bank pushed for a weaker version of the current EBAIS implementation (for example, not including a physician in each EBAIS) (Clark, 2002). Ultimately targeting is implemented sparingly in Costa Rica and is an attempt to distribute spending more evenly and reach more people, particularly underserved communities, rather than to increase spending in a particular area in a quest for more efficient, strictly targeted spending.
**Targeting: challenges in implementation**

Beyond the critiques of targeting as a policy intervention, sometimes seen as intensifying inequality and weakening universalist approaches, targeting is also criticized for the challenges inherent in its implementation even when well designed. This seems to have been exacerbated, in several instances, by the fact that the World Bank is an external agency, perhaps not as sensitive to local conditions as necessary for successful programme implementation and characterised by high personnel turnover. This is discussed in the implementation report for Aids and Sexually Transmitted Diseases Control Project in Argentina:

> Aside from the generally good opinion about the Bank’s technical expertise provided during project implementation, the borrower pointed out one specific issue in which the Bank could have improved its performance, specifically related to the frequent changes in Bank staff and consultants participating in supervision missions…In addition, the borrower was left with the impression that missions too often based their judgments and advice on their own experience in different countries without taking into account the socioeconomic and legal framework prevailing in Argentina. (P043418, 2004, p. 18)

In Peru the trouble with the implementation of targeting was one of communication with disadvantaged groups, and also one of lack of demand for services: ‘the intercultural strategies utilized to increase the effective demand of poor vulnerable pregnant women are already institutionalised in the mainstream institutions’ (P062932, 2007, p. 24). Therefore, the World Bank did not bring much ‘value added’ in this sense and ‘by early 2003 it had become obvious that the SIS’s maternal and child programs were not adequately covering poor, mostly rural areas, which was considered critical for achieving of the Project’s developmental objectives’ (P062932, 2007, p. 36).

This emphasis on women, children and childbirth is closely tied to an international agenda, in addition to its historical legacy in Latin American health systems. Specifically, targeting women and children is linked to the achievement of the Millennium Development Goals in Peru: ‘the incoming administration [of President Alan Garcia] continues to adhere to the achievement of the Millennium Development Goals, one of which is reduction of maternal and child mortality rates’ (P062932, 2007, p. 23).

Another, earlier, project in Peru also encountered implementation challenges, not only because of political setbacks but also because it relied on coordination by the Ministry of Health, which was institutionally weak but also ill-situated in the larger political national context: ‘in the context of tight budgetary constraints, the Ministry of Health was unable to defend its requests for counterpart funding to the Ministry of Economy and Finance’ (Primary Health Project, Project Completion Report, 1993, p. 9). In short, this project, like many others ended up highlighting basic institutional challenges rather than providing important public health and other political and economic contextual information for health: ‘this project yields useful lessons on organisation’ (P007982, 1993, p. iv). Indeed, as discussed above, many of the challenges resulted from identifying the target groups, and convincing them to utilize the services available to them.

**Targeting, equity, and efficiency**

All three countries, and indeed all developing countries, are concerned with efficiency, given limited public budgets; however, in Costa Rica targeting is viewed as a means of more efficiently targeting disadvantaged groups in the context of universalism. Peru on the other hand is working towards segmented universalism, the SIS is intended to ultimately provide coverage to anyone that does not have private or social security coverage. However, it has not been as successful as the Costa Rican and Argentinean projects thus far. I argue that this is owing to a combination of factors. First, because the SIS (originally the children and maternal health insurance) is not as tightly linked with equity in discourse it is viewed as a more problematic intervention by both policymakers and the general population. Second, because the Ministry of Health is institutionally weak and marginalized, it is not allocated many resources or political power, which has thus hindered the progress of this programme.
Finally, this programme may serve to reinforce discourse about gender norms through its focus on maternal policies and a health system which still operates as it was developed, around the presumption of a male breadwinner (Gideon, 2014). The legacy of gendered health systems suggests that women and children’s health is a residual concern to be addressed post hoc with targeted programmes rather than integrated more fully into the country’s health system.

In Argentina there is also concern with efficiency and equity but targeting is not only geographically oriented or targeted towards particular social groups but also temporally situated, ramped up during economic crisis. Furthermore, the focus in Argentina is more category/group oriented – most particularly as regards women and children and those with HIV/AIDS – than in Peru, because almost half the population is covered via the Obras Sociales system while Peru is more inclusive in its targeting of the poor. In Costa Rica, while the development of EBAIS was a way to ensure a more complete and equitable coverage of the population it did not help only the poor, nor was it implemented solely in poor areas, but rather nationwide. That is, targeting serves to ameliorate some of the inequalities that exist in spite of there being a universal system. In Peru, on the other hand, targeting is part of an effort at extending access and promoting utilisation of available health services, breaking cross-cultural barrier and perhaps atoning for previous inequalities.

The Costa Rican health system and in particular the EBAIS primary healthcare model in Costa Rica stands as a model for emulation: it is universal, with excellent health outcomes relative to spending amounts per capita. To a certain extent, the same can be said of Plan Nacer in Argentina. While it is hard to determine what the precise impact of the programme is, it is generally considered a success story, both nationally and regionally. In these cases, targeting is seen as successful because it is commensurate with the overall goals of the government for the health sector, and fulfils both paradigmatic goals – equity and efficiency. In addition to the problem of making policy instruments propelled by international organisations such as the World Bank commensurate with policy paradigms of national governments, their actual implementation is also challenging.

**Conclusion**

The World Bank’s involvement in the neoliberal health reforms in Colombia and Chile in the 1990s, which pushed for increased privatisation, has received much scholarly attention (Noy, 2015; Unger, De Paepe, Buitrón, & Soors, 2008). However, the World Bank’s approach to health as embodied in reforms in those countries may not be representative of the World Bank’s overall work in the region. My analysis demonstrates that the World Bank does not always pursue a draconian, neoliberal agenda as evidenced by symmetry with government goals and the promotion of targeting in the quest for equity, together with universalism in some cases. I find evidence for three of the four empirical expectations described earlier in the paper. First, contrary to my first expectation I do not find that the World Bank has promoted targeting uniformly. As one example, while across all three cases, it has focused on efficiency it does not uniformly promote market mechanisms and means-testing.

My second expectation – that Costa Rica would be the least likely to employ targeting – was supported by my analysis. Though targeting was not entirely absent it was limited both in quantity and scope compared with programmes in Peru and Argentina as it operates there against a backdrop of universalism. Overall, existing domestic health arrangements in health limit the interest and ability of the World Bank to pursue targeted health programmes as demonstrated in the Costa Rican case.

My third expectation that the World Bank would most aggressively and successfully push targeted interventions in Peru, and that Peru would have the highest level of targeting both in terms of number of projects and people covered, was not confirmed. Argentina and Peru experience similar levels of targeting, both in the number of projects and the variety of groups as well as the duration of projects. Indeed, the results from Peru indicate that targeting is promoted in the interest of growing the recently introduced public insurance systems: the SIS.

My fourth expectation that the World Bank would shift from discussing targeting in the context of neoliberalism, prioritising efficiency, economic growth, and limited state involvement, towards
discussions of equity received mixed support. My analysis reveals that even in the early 1980s there was mention of equity, but that equity is mentioned but without much discussion of how targeting may fit into achieving it. While the World Bank invokes equity throughout this time period it is usually in tandem with efficiency, and how the World Bank conceptualises equity is not clarified. Interestingly, the World Bank has increasingly discussed efficiency in the context of social development, which represents a shift away from neoliberalism as focused solely on market outcomes and investment in labour, and towards a conceptualisation of the state's direct role (rather than solely the market's) in development. This discourse is apparent in relation to different populations targeted, both within and across countries. These trends and findings were summarised in Table 1 which outlined the direction of reforms of the health systems against which targeted interventions operate in each country.

Policy change is constrained and enabled by historical institutional arrangements and countries' broader political economies. International organisations such as the World Bank promote particular ideas and policies within this context. In this way IFIs and INGOs work as policy advisors: diffusing and promoting particular policy paths. While targeting is viewed as neoliberal in its focus on segmentation and limited state involvement in health, the level of stringency in its implementation (for example whether targeting is means-tested), and its framing (for example whether it is a policy instrument for the achievement of equity, efficiency and/or poverty-alleviation), varies widely across these three countries.

Much of the existing literature on IFIs has sought to examine the extent that they are able to impose their neoliberal mandates on domestic policies, largely via structural adjustment loans. My research demonstrates that IFIs' mandates themselves should be empirically examined rather than assumed. The World Bank's recommendations for health sector reform vary substantially across Peru, Argentina, and Costa Rica. While there is certainly evidence of a focus on efficiency and an economic logic there is also concern with equity and social development as ends in themselves. Leveraging the comparative angle of three cases, and paying close attention to the policy discourse and framing surrounding targeting, illuminates important ideational dynamics of the policy process. This article demonstrates that there is variation in World Bank strategies, in the alignment of these strategies with countries' priorities, and ultimately in policy change and implementation.

Beyond variation in the groups targeted, the paradigmatic goals that targeting aims to achieve across the three countries varies as well: in Costa Rica, efficiency, against a backdrop of universalism; in Peru, access and extended coverage in a quest for increased efficiency – that is, better outcomes in health for investments, and in the long-term, equity; and in Argentina, buffering during economic crisis, treating and reducing HIV/AIDS transmission, and efficiency. Means-testing of the poor, implemented in Peru in some instances, is not apparent in Costa Rica, while in Argentina there is an effort to determine need by eliminating double coverage. This makes sense given that these programmes in Peru were pursued in the midst of limited coverage and a fragmented and segmented health system. While Argentina’s health system is also fragmented, coverage is quite high by the Obras Sociales, whereas in Peru this segmentation is compounded by a lack of coverage and higher levels of poverty.

In an era of intensifying globalisation it is important to consider the ways in which countries’ goals and strategies towards development are shaped by external actors. This analysis demonstrates that the World Bank has served as an important policy advisor to developing countries, promoting particular policies, among them targeting. While targeting embodies several neoliberal imperatives with its focus on markets and efficiency and its contrast to a universal approach, I find that targeting has been neither homogeneously promoted by the World Bank nor uniformly implemented by national governments. The pursuit of targeting as a policy instrument interacts with national goals and existing institutions and can work in the service of equity, at least discursively.

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Notes on contributor

Shiri Noy is an assistant professor of Sociology at the University of Wyoming. Her research examines the role of international organizations in shaping global health priorities in developing countries. Her forthcoming book with Palgrave MacMillan entitled Banking on Health: The World Bank and Health Sector Reform in Latin America examines the role of World Bank in health sector reform in Latin America.

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