

The Washington Consensus and Social Policy: World Bank Projects and Health Sector Reform in Costa Rica

Shiri Noy

International financial institutions—namely the International Monetary Fund and the World Bank—have been central in diffusing neoliberal ideas. However, little is known about the World Bank’s involvement in health policy reform in Latin American countries, and even less about governments’ responses to these recommendations and directives. I use World Bank project and loan documents together with national policy documents to examine health sector reform in Costa Rica between 1980 and 2005. I trace World Bank involvement in and discourse surrounding Costa Rican health sector reform, including the ideal role of government in health, the shifting relationship between the Costa Rican social security system and the Ministry of Health, and the focus on primary care. Using the policy paradigm approach, I identify two paradigmatic goals apparent in World Bank and national documents: efficiency and equity. I find that, although the government and the World Bank are consistent in their approach to these goals, they do not emphasize them in the same way, and they describe them in the context of differing logics. I conclude by assessing the implications of this study for our understanding of the relationship between neoliberalism, international financial institutions, and health sector reform in Latin America.

Las instituciones financieras internacionales, en particular el Fondo Monetario Internacional y el Banco Mundial, han sido centrales en la difusión de ideas y prácticas neoliberales, pero poco se conoce de la participación del Banco Mundial en las reformas de los sectores de salud en los países latinoamericanos y menos aún sobre la respuesta de los gobiernos a estas recomendaciones y directivas. Basada en documentos de los proyectos y los préstamos del Banco Mundial y en documentos de política nacional, esta investigación examina la reforma del sector de salud en Costa Rica. Se examina la participación del Banco Mundial en el discurso que rodea la reforma de salud costarricense, incluyendo las discusiones del papel ideal del gobierno en la salud, la relación cambiante entre la CCSS (seguridad social) y el Ministerio de Salud y un énfasis en la atención primaria. Al utilizar el enfoque del paradigma político, se identifican dos objetivos paradigmáticos aparentes del discurso del Banco Mundial y en los documentos nacionales, la eficiencia y la equidad. Mientras que el gobierno y el Banco Mundial son consistentes en su acercamiento a estos objetivos, las instituciones los enfatizan de manera distinta y los describen en el contexto de lógicas diferentes. Se concluye con una evaluación de la importancia de este estudio con

respecto a un entendimiento de las consecuencias del neoliberalismo y las instituciones financieras internacionales para la reforma de los sectores de salud en América Latina.

Key words: globalization, health sector reform, health policy, Costa Rica, Washington Consensus, neoliberalism, World Bank

Introduction

Globalization scholars have argued that neoliberal pressures have had detrimental effects on social spending and governmental safety nets in developing countries. One mechanism identified for the spread of neoliberalism in the developing world is the involvement of international financial institutions (IFIs) in the domestic policies of governments via projects, loans, and structural adjustment programs. The effect of IFIs on social policy in developing countries has not been sufficiently theorized or empirically explored, especially when compared with the wealth of research on the implications of neoliberalism for trade, monetary, and fiscal policy (Babb, 2005; Fourcade-Gourinchas & Babb, 2002; Murillo, 2002; Portes & Hoffman, 2003; Teichman, 2004; Weyland, 2005, 2007). Powerful IFIs, most notably the World Bank, may steer social policy change in their preferred direction via conditions on loans and projects, but empirical analyses of the content of these projects across countries and sectors are scant. These loans and projects are not an event; they are a process involving national actors, often from varying agencies and ministries and with different interests and priorities, which requires a temporal analysis and merits additional attention.

Costa Rica has historically emphasized social spending, particularly on health and education (as the military was abolished in 1949) and has been referred to as “the Switzerland of Central America” for its strong welfare regime (Franzoni, 2008). Like other welfare regimes, Costa Rica has not been immune to economic recession and retrenchment pressures, and like the rest of Latin America and the developing world, it has been subject to neoliberal pressure from powerful international institutions. Costa Rica provides a particularly interesting context in which to examine how World Bank projects and discourse on health align with national priorities, given its strong emphasis on universal healthcare coupled with rising costs and a serious debt crisis in the 1980s.

I examine World Bank loans to and projects in Costa Rica related to health sector reform and development from 1980 to 2005. A discursive analysis of loan documents supplemented by national documents related to health goals allows me to examine how the Costa Rican government defines health priorities as compared with the World Bank, and the extent that these priorities are aligned (or mismatched); second, I examine how the World Bank frames and justifies its particular strategies for health sector reform in Costa Rica and whether and how these have changed over time; finally, I examine how project proposals were actually carried out. I use several documents to compare the government’s and the World Bank’s assessments of the success or failure and contributions of the projects and to examine the causes (and consequences) of deviating from original project plans.

Neoliberalism and the Washington Consensus

Neoliberalism has been considered an economic approach, an ideology, or a philosophy; it is generally characterized by the idea that markets are the most efficient form of resource distribution, resulting in a healthier economy (Huber & Solt, 2004; Stiglitz, 1999). Underlying this belief in the benefits of allowing the market to allocate resources is an emphasis on property and contracts. Neoliberalism prizes the market and aims to restrict government intervention in the economy.

The economist Williamson coined the term “Washington Consensus” in 1989 to describe the typical reform package promoted by IFIs and the United States for developing countries. These packages recommended trade and financial liberalization, privatization of state enterprises, and legal protection for property rights. According to Williamson (2002), the Washington Consensus advocated “pro-poor and pro-growth” public expenditure, spending on basic health, education, and infrastructure (rather than defense or administration, for example). Naim (2000, p. 506) argues that there was never a consensus, with economists disagreeing not only on the content but also the pace and sequence of reforms, and notes that “Washington Confusion” might be a better descriptor than “Washington Consensus.” Despite these differences of opinion, the Washington Consensus has proved to have important implications for developing countries in the form of structural adjustment loans (SALs) and other projects.

The term Post-Washington Consensus emerged in the late 1990s and emphasizes the need to move beyond the Washington Consensus by considering seriously the importance of governance institutions in any reform effort (Burki & Perry, 1998; Clift, 2003; Öniş & Şenses, 2005; Radin, 2008; Stiglitz, 1999, 2003). Some have also argued that, contrary to the Washington Consensus, the Post-Washington Consensus framework promotes investment in human capital as an end rather than only as a means to economic development. For example, in the late 1990s, the World Bank began to consider the Human Development Index (a measure developed by the United Nations Development Programme in 1990, which measures nutritional status, educational attainment, and health status) an important indicator of poverty (Bonai, 2002). Compared with the previous indicator, gross domestic product per capita, this measure clearly incorporates the social dimensions of development, but much like its predecessor, the Post-Washington Consensus “remains imbued with confusion and theoretical grey areas” (Santiso, 2004, p. 829). Some argue that talks of moving beyond the Washington Consensus are overemphasized, as state intervention is still discouraged and the state is largely seen as being driven by rent-seeking agents, prone to corruption (Bonai, 2002; Fine, 2001).

The World Bank and Health Sector Reform

Despite repeated assertions in both popular media and in scholarly research that World Bank involvement via loans—especially SALs—has had detrimental effects on welfare states and social policy (e.g., Birn & Dmitrienko, 2005; Huber & Solt, 2004; Hunter & Brown, 2000; Navarro, 2007), there are few empirical studies on the mechanisms, channels, and effects of World Bank and other IFI involvement in health policy. Several notable studies, although not focused on the role of

the World Bank, include information about the World Bank's involvement in specific health policy change. Ewig (2006) examines health sector reform and gender in Peru, and Lloyd-Sherlock (2005) discusses health sector reform in Argentina. Noy (2013b) provides an overview of the World Bank's changing approach to health. For a brief discussion of World Bank involvement in health sector reform in El Salvador in 1998, see Homedes and Ugalde (2005).¹

Evidence on the effects of IFI projects and involvement in national social policy, specifically health policy, remains inconclusive. Empirically, the detrimental effect of IMF and World Bank borrowing across domains has been documented (Bonaf, 2002; Easterly, 2001; Hunter & Brown, 2000; Ilon, 1996; Mesa-Lago, 2006, 2008; Mesa-Lago & Müller, 2002), but there is no indication that IFI involvement in public health has yielded reduced government expenditure. Existing accounts of health sector reform in Latin America have noted that there is increased privatization, which furthers the interests of foreign corporations and insurance agencies (Armada, Muntaner, & Navarro, 2001; Barrientos & Lloyd-Sherlock, 2000; De Vos, De Ceukelaire, & Van der Stuyft, 2006; Homedes & Ugalde, 2005). When directly studied, the effects of neoliberal pressures on health policy and spending have been mixed. Hunter and Brown (2000) find no correlation between World Bank lending in a given country and the resources devoted to education and health. Recent quantitative research by Huber and Stephens (2012) and Noy (2011, 2013a) do not find an association between IFI presence and lower levels of public health spending in Latin America.

In Latin America, research on the effect of IFIs on health systems has focused on two cases where reform was arguably most neoliberal in its approach, Colombia and Chile. Under the rule of Pinochet in Chile in the 1980s, medical care delivery was opened to the private sector and decentralized to the municipal level, largely aggravating existing inequalities (Unger, De Paepe, Cantuarias, & Herrera, 2008). In Colombia, health care reform influenced by neoliberal ideas was launched in 1993, replacing the public sector with one in which private and public providers compete for clients, insurance premiums are paid by employers, and government covers the poor (Mesa-Lago, 2008; Stocker, Waitzkin, & Iriart, 2008). The analysis of the involvement and effects of the World Bank on health sector reform in these two countries is informative, but may overstate the World Bank's ability to influence a country's health policies and its neoliberal approach to health sector reform across countries.

Data and Analytic Approach

To examine the effect of the World Bank on health sector reform in Costa Rica, I analyzed World Bank and national government documents in Costa Rica between 1980 and 2005. To identify relevant projects, I examined all World Bank projects in Costa Rica from 1980 to 2005 via the World Bank indexed system. I looked up project summaries and descriptions, and the analysis included any project that had a health sector component. I confirmed that I had identified all relevant documents by conducting a keyword search of "health" (and variants thereof, such as "healthcare") and "Costa Rica." To capture government goals and discourse surrounding health sector reform, I examined national development plans published by the Costa Rican government every four years, which

contain sectoral goals, assessment of previous accomplishments, and future plans. These government plans were accessed at two locations during fieldwork in Costa Rica in 2011, the archival holdings at the Ministerio de Planificación Nacional y Política Económica (MIDEPLAN) office in San José, and the library at the Instituto de Investigaciones Sociales, at the Universidad de Costa Rica.

My analysis begins in 1980 for two reasons. First, this year marks the beginning of the debt crisis, a time when all Latin American countries were reconfiguring their public sectors and when governments of developing countries especially sought World Bank loans and advice. Second, 1980 marks the World Bank's formal commitment to direct lending in the health sector, in its "Health Sector Policy Paper" published the same year. I analyze the population (rather than a sample) of documents related to health sector projects and loans from the World Bank in Costa Rica. I end my analysis in 2005 as it provides retrospective distance and omits uncompleted (still in progress) projects.

I focus on the World Bank for three reasons. First, substantively it is one of the most important actors in diffusing and implementing neoliberal ideas in health in the developing world in general, and Latin America in particular. Second, it is the largest funder of health in developing countries, contributing to its normative position, but also in terms of monetary power in global health (Ruger, 2005). Although there were also other agencies (e.g., United States Agency for International Development [USAID] and the Inter-American Development Bank) involved in health sector reform in Costa Rica, the World Bank was an important funder of health projects in Costa Rica during this time period. More to the point, my research examines World Bank projects in the country during this time period and how they corresponded (or not) to government goals for the health sector. This comparative, discursive analysis provides a focus on World Bank priorities, discourse, and funding in Costa Rica and whether and how this corresponds to government priorities, discourse, and engagement with the World Bank on health issues. An important benefit of focusing on the World Bank is that it offers the greatest methodological access to loan-related documents, technical reports, letters of intent, and completion reports for all projects, a rarity among financial institutions.

Tables 1 and 2 provide a list of the documents used in the analysis. The World Bank documents used in the analysis are indexed in Table 1 by project and note accompanying documents, loan amounts, and start and end date. There were eight projects related to the health sector in Costa Rica between 1985 and 2005 (and a total of 21 projects in Costa Rica across all sectors). I use 33 documents related to these eight projects; the average World Bank contribution to these projects was approximately US\$46.81 million per project, and approximately 58% of total World Bank spending in Costa Rica at the time was invested in these eight projects, although some of these projects are multi-sectoral, with health comprising anywhere from a minor portion to the entirety of any single project's focus. Documents related to World Bank loans range from 2 to 170 pages in length. Table 2 contains an index of the national policy documents used in the analysis. I draw from health plans published every 4 years by Costa Rica's Ministry of Planning, procured during archival research in 2011—except for the two most recent plans that are available online—and from national laws and decrees to examine official national health discourse and policy.

Table 1. World Bank Loans to Support Health Care Reforms in Costa Rica, 1980–2005

Project name/Project ID	Accompanying Documents	Cost in U.S. \$Millions	Implementing Agency	Date of Approval	Date of Completion
P006921 San Jose Metropolitan Area Water Supply Project	<ol style="list-style-type: none"> 1980, Report and Recommendation of the President of the IBRD to Executive Directors, 39 p. 1980, Staff Appraisal Report, 101 p. 1990, Project Completion Report, 33 p. 	26 (IBRD:26)	Costa Rican Water and Sanitation Institute	December 23, 1980	June 30, 1988
P006923 Structural Adjustment Loan Project I	<ol style="list-style-type: none"> 1985, Recommendation of the President of the IBRD to Executive Directors, 88 p. 1994, Project Completion Report, 76 p. (joint completion report for SALI and SALII) 	80 (IBRD:80)	Ministry of Planning	April 16, 1985	June 30, 1986
P006927 Structural Adjustment Loan Project II	<ol style="list-style-type: none"> 1988, Recommendation of the President of the IBRD to Executive Directors, 75 p. 1988, Loan Agreement, 11 p. 1988, Loan Agreement Amendment, 1 p. 1989, Loan Agreement Amendment, 2 p. 1992, Loan Agreement Amendment, 2 p. 1994, Project Completion Report, 76 p. (joint completion report for SALI and SALII) 	100 (IBRD:100)	Ministry of Planning	December 13, 1988	July 31, 1992
P006933 Technical Assistance Loan Project	<ol style="list-style-type: none"> 1985, Recommendation of the President of the IBRD to Executive Directors, 66 p. 1993, Project Completion Report, 76 p. 	4.6 (IBRD:3.5; Local:1.1)	Ministry of Planning	April 16, 1985	April 1, 1991
P006941 Water Supply and Sewerage Project II	<ol style="list-style-type: none"> 1993, Loan Agreement, 20 p. 1993, Guarantee Agreement, 4 p. 1993, Staff Appraisal Report, 123 p. 1996, Amendment 1, 4 p. 1997, Amendment 2, 5 p. 2005, Implementation Completion Report, 59 p. 	27.1 (IBRD:26) Estimated:23.5; Actual:20.1 (IBRD Commitment:26; Disbursed:26 ; Government Estimate:6.5; Actual:6.8)	Costa Rican Water and Sanitation Institute	June 17, 1993	December 31, 2003
P006952 Structural Adjustment Loan Project III	<ol style="list-style-type: none"> 1993, Loan Agreement, 14 p. 1996, Project Completion Note, 12p 	100 (IBRD:100)	Ministry Of Finance	April 15, 1993	April 30, 1995
P006954 Health Sector Reform Project	<ol style="list-style-type: none"> 1992, Grant Agreement 10 p. 1993, Loan Agreement 18 p. 1993, Project Agreement 6 p. 1993, Staff Appraisal Report, 170 p. 1996, Amendment 3p. 2003, Implementation Completion Report, 66 p. 	32 (IBRD:22; Government:10)	Costa Rican Social Security Agency	October 21, 1993	September 30, 2002
P073892 Health Sector Strengthening and Modernization II Project	<ol style="list-style-type: none"> 2001, Project Agreement, 8 p. (P284) 2001, Loan Agreement, 12 p. (P288) 2001, Project Information Document, 9 p. (P291) 2001, Project Appraisal Document, 95 p. (P290) 2002, Integrated Safeguards Data Sheet, 4 p. (P287) 2010, Implementation, Completion and Results Report, 94 p. (P286) 	Estimated:23.5; Actual:20.1 (IBRD Commitment:17; Disbursed:13.3 ; Government Estimate:6.5; Actual:6.8)	Costa Rican Social Security Agency	July 12, 2001	December 31, 2009

Source: Author's analysis based on World Bank (n.d.), IBRD, International Bank for Reconstruction and Development (an arm of the World Bank); SAL, structural adjustment loan.

Table 2. Costa Rican National Documents

Document	Source	Date
Plan Nacional de Desarrollo, 1978–1982 “Gregorio Jose Ramirez”	OFIPLAN	
Plan Nacional de Desarrollo, 1982–1986 “Volvamos a la Tierra”	MIDEPLAN	
Plan Nacional de Desarrollo, 1986–1990	MIDEPLAN	
Plan Nacional de Desarrollo, 1990–1994 “Desarrollo Sostenido Con Justicia Social”	MIDEPLAN	
Plan Nacional de Desarrollo, 1994–1998 “Francisco J. Orlich”	MIDEPLAN	
Plan Nacional de Desarrollo Humano, 1998–2002 “Soluciones Siglo XXI”	MIDEPLAN	
Plan Nacional de Desarrollo, 2002–2006 “Monsenor Victor Manuel Sanabria Martinez”	MIDEPLAN	
Ley Constitutiva Caja Costarricense de Seguro Social (Ley 17) (Constitutive Law of the Costa Rican Social Security Agency)	Asamblea Legislativa	October 22, 1943
Ley General De Asistencia Medico-Social (Ley 1153) (General Law Of Medical-Social Assistance)	Asamblea Legislativa	April 14, 1950
Ley Para Reorganizar Los Servicios Medicos Preventivos Con Base a la C.C.S.S.(Ley 5349) (Law to Reorganize Preventative Medical Services Based at the CCSS)	Asamblea Legislativa	October 3, 1973
Ley General de Salud (Ley 5395) (General Health Law)	Asamblea Legislativa	October 30, 1973
Ley Orgánica del Ministerio de Salud (Ley 5412) (Organic Law of the Ministry of Health)	Asamblea Legislativa	November 8, 1973
Ley de Desconcentración de Clínicas y Hospitales de la Caja Costarricense del Seguro Social (Ley 7852) (Law of Deconcentration of Clinics and Hospitals of the Costa Rican Social Security Agency)	Asamblea Legislativa	November 30, 1998
Derechos y Deberes De Las Personas Usuaris de Los Servicios De Salud Públicos y Privados (Ley 8239) (Rights and Responsibilities of Users of Public and Private Health Services)	Asamblea Legislativa	April 2, 2002

Source: Author's research at the archival holdings at the MIDEPLAN (n.d.-a, b, c, d, e) office in San José, in 2011.

OFIPLAN, Oficina de Planificación Nacional (National Planning Office); MIDEPLAN, Ministerio de Planificación Nacional y Política Económica (Ministry of National Planning and Economic Policy); CCSS, Caja Costarricense de Seguro Social; Asamblea Legislativa, Legislative Assembly.

In analyzing World Bank and government discourse on health policy and reform, I follow the policy paradigm approach. An examination of the involvement of the World Bank in national policy reforms must consider the different levels at which its influence can operate: ideas, problem definition, and proposed solutions. Most scholarship on IFIs has focused on outcomes of projects and loans, but I argue that it is also important to understand the ideational influence of the World Bank as it proposes ideas about health, identifies which health issues deserve attention, and may circumscribe the universe of possible solutions and tools to address these issues.

I draw from Campbell's (1998) work, which argues that, whereas programmatic ideas are concrete, precise, and policy-specific solutions to policy problems, paradigmatic ideas define assumptions about how the world works more generally, operating at the cognitive background of policymaking. This distinction echoes Hall's (1993) comments that first-order policy change involves changes in the overarching goals that guide policy in a particular field, akin to paradigmatic ideas. By analyzing official World Bank and government documents, I examine how IFIs—widely seen in globalization literature as institutionalizing neoliberal policies in developing countries—have promoted health care reform in Costa Rica. I employ process tracing—a method that helps analyze in detail policy and other documents to determine how principles are translated into practice and change over time (Campbell, 2002). I use 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) and prominent ideas (e.g., privatization, social justice), and reflect temporally bound understandings, ideas, and views on issues, topics, and actors (George & Bennett, 2005).

The World Bank documents provide a “public transcript” of its agenda for and work in health sector reform in Costa Rica. With these data, I examine changes in policy approaches over time, which is particularly valuable given the debate about whether neoliberal pressures began to be applied in developing countries in the 1980s or 1990s and questions about a possible Post-Washington Consensus. The national documents allow me to examine the extent to which World Bank projects reflect national agendas and discourse. The temporal nature of the data allows for an examination of feedback and recursive processes of World Bank learning and its possible responsiveness national discourses, priorities, and initiatives in ongoing and new projects. As indicated in Figure 1 and Table 1, three of the eight loans are SALs, and two of the eight are water-supply related and are therefore largely infrastructural.

Health Sector Reform in Costa Rica: Historical Perspective

Until the 1950s, the health care systems in most Latin American countries were quite similar, typically with a specific structure. Public health insurance plans were offered to employees in the formal labor market (financed via employer, employee, and sometimes government contributions), the poor had access to public services, and the wealthy had access to private services. Charity organizations, largely religious, provided supplementary care, so the legacy was one of segmented and fragmented systems. Many paths have since been followed in

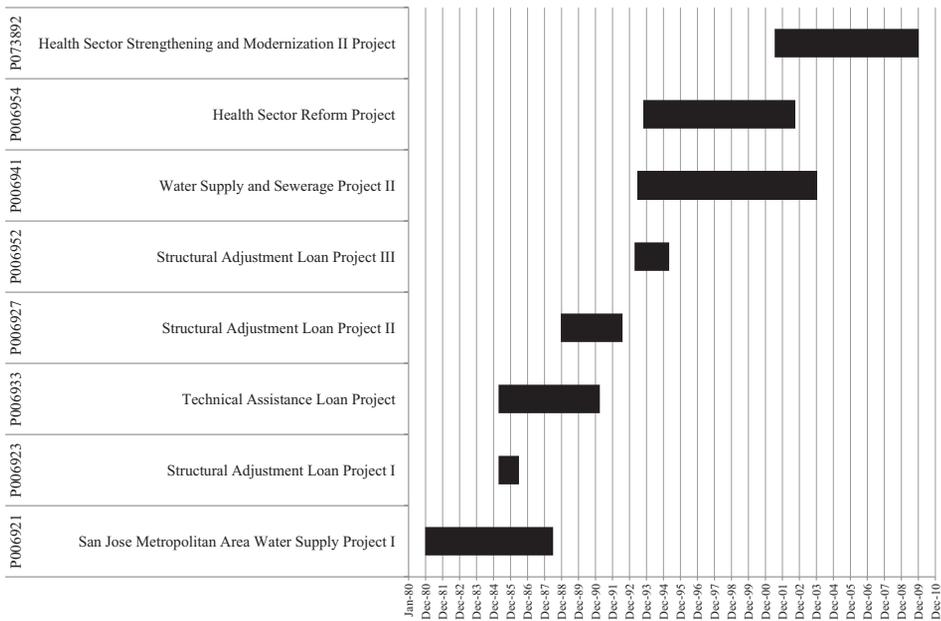


Figure 1. Duration of Approved World Bank Health Sector Reform-Related Projects in Costa Rica Approved between 1980 and 2005

Source. Author’s analysis based on World Bank (n.d.).

health sector reform. The Costa Rican model is different from all other Latin American countries; in 1993, Costa Rica integrated its social security program with the Ministry of Health (MOH), resulting in a single-payer model managed by the social security program and financed by employers, employees, and the government (with government subsidies for the poor). Costa Rica is hailed as a health success story, one of “health without wealth.” Despite its status as a developing country, it has achieved a high life expectancy—79.4 years—and low levels of infant mortality—8.8 per 1000 births in 2009 (Sáenz, Acosta, Muiser, & Bermúdez, 2011, p. S158).

Structure and Restructuring of the Costa Rican Health System

The main provider of health services is Costa Rica’s social security agency, the *Caja Costarricense de Seguro Social* (CCSS), established in 1941, which originally provided health services only to formal workers. The CCSS began including workers’ families in 1961, and has since expanded to encompass more than 85% of the Costa Rican population. Originally, the CCSS managed both pensions and health insurance which were part of a single fund, but in the 1990s, the funds were separated. The health system was further subdivided administratively into units responsible for health financing, purchasing, and pensions, and the CCSS purchases health services from its operational units.

The CCSS insurance consists of three health social security regimes, Sickness and Maternity Insurance (*Seguro de Enfermedad y Maternidad*); Disability, Old Age,

and Death Insurance (*Invalidez, Vejez y Muerte*); and a non-contributive insurance for those living in poverty or unable to work due to disability. The CCSS relies on tripartite financing, from employers, employees, and the state. The employer pays 14.16% of the employee's salary, the employee contributes 8.92%, and the state contributes 0.50%. The self-employed contribute on a voluntary basis, between 10.5% and 13.5% depending on income. Only 2% of users rely on private insurance, either through private insurers or the National Insurance Institute (*Instituto Nacional de Seguros*, INS). Fifteen percent of the population, consisting largely of agricultural laborers, informal sector workers, self-employed professionals, and business owners, lives without public health insurance. Even though these people are uninsured, they use public health facilities, especially hospitals (Clark, 2002; Unger et al., 2008).

The CCSS health system is divided into three levels; the highest level consists of high-complexity hospitals that allow for hospitalization and have equipment and surgeons for highly complex surgeries. The second level consists of a network of regional hospitals that provide emergency care and specialist consultations. Small clinics where patients can seek primary care make up the first level (Sáenz et al., 2011).

Perennial Financial Concerns and Neoliberal Propositions

As early as in its 1978–1982 development plan, the Costa Rican government began discussing the importance of considering privatization and downsizing the public sector. This is a somewhat surprising fact given its historic and continued emphasis on state-owned enterprise and social services. Although it recognizes that this public investment has been necessary, the report questions its sustainability and suitability on grounds of efficiency and sees it as contributing to the economic debt crisis:

In sum, [although] it is true that historically state intervention was the means of promoting economic development and resolving social problems, its growth has surpassed the original necessity. The public sector has grown and has taken shape in a way that makes it difficult to discover a rationale and justification for its growth. This has generated negative effects for both its efficiency and other variables that affect the rest of the economic-social system, and is probably the principal cause of the crisis of values that has immersed the country. (OFIPLAN, n.d., Tomo 1, p. 57, author's translation)

Early on, the Costa Rican government emphasized cutting back spending and focused on increasing efficiency. This provides compelling evidence that these movements were not only outwardly imposed (as has been argued to be the case with the influence of the “Chicago Boys” in Chile's reform), but also emerged domestically because of limited budgets, even in one of the most generous welfare regimes in the region. This development plan also discusses the challenges of institutionalizing development goals. “The most difficult task to achieve is that, although integrated development programs are institutionalized, development be at the service of man [sic] and not man at the service of development” (OFIPLAN, n.d., Tomo 3, p. 1, author's translation). As early as this period, there was also discussion of the problem of centralized decision making in the capital, San José, which is

prejudicial to a more dynamic and creative leadership on the part of regional agencies of the ministries and decentralized entities. Most of the decisions are made in San José, and consequently, the solutions are paternalistic and do not generate a truly active and committed participation on the part of public office, nor of the communities. (OFIPLAN, n.d., Tomo 2, p. 72, author's translation)

This focus on decentralization is echoed in later development reports and is one of the main foci of the first standalone World Bank health project in Costa Rica in 1993. The Health Sector Reform Project of 1993 was “the first free-standing Bank-supported health sector project for Costa Rica” (P006954, 1993, p. 16), which makes it of particular importance for examining parallels between government and World Bank priorities as well as the dynamics of implementation. The project involves the creation of the Teams of Integrated Health Care (*Equipos Básicos de Atención Integral de Salud*, EBAIS) and the transfer of all responsibilities from the MOH to the CCSS (although hospitals were transferred to the CCSS in the 1970s, the MOH retained responsibility for providing primary care services, especially to rural areas; Asamblea Legislativa, 1973).

Separation of Functions and the Diminishing Role of the MOH

Until 1973, the MOH indirectly controlled almost all public hospitals, which (except for four CCSS hospitals) were administered by *juntas de protección social* (social protection committees), quasi-public bodies overseen by the MOH and funded by proceeds from the national lottery and various taxes and transfers from the central government (Asamblea Legislativa, 1950). Legislation passed in 1973 transferred all public hospitals to the CCSS. The goal was to further separate functions; the MOH would become responsible for stewardship of the health sector while maintaining responsibility for preventative care and the CCSS would be responsible for all health facilities and health services.

Besides the CCSS and the MOH, the other main agency involved in the health sector is the Costa Rican Water and Sanitation Institute (AyA), a centralized public institution reporting to the MOH. AyA is in charge of directly administering and operating water and sanitation systems serving most of the Costa Rican population, although technically these services fall under the purview of municipalities (*cantones*). AyA oversees and operates the potable water, sewerage, and sanitation systems in urban and rural areas. It also works on the conservation of water basins and on reducing water pollution.

An Emphasis on Primary Care and Reaching the Population

In its 1982–1986 national development plan, the Costa Rican government recognized the success of the country in advancing health, and noted that the country's disease profile was then characteristic of the developed rather than the developing world. It also noted that, despite these notable advances, there “are certain social groups and geographic areas whose health indicators are worrisome and who do not have sufficient access to services” (MIDEPLAN, n.d.-a, p. 34). The report describes that in the 1970s there was much progress made in the quality and quantity of health establishments, and that the challenge at that time was to use them more efficiently, further extending services to rural areas and

focusing on preventative health—at this point still under the responsibility of the MOH (Morgan, 1990). The summary of this plan also emphasized important achievements in community participation in health and the development of primary health care (MIDEPLAN, n.d.-a, p. 120).

The focus on reaching the entire population was reiterated in the 1986–1990 plan, which set the goals for the health sector as maintaining existing health achievements and levels of health indicators in Costa Rica, emphasizing the most vulnerable groups in the population—mothers, children, and teenagers. The 1990–1994 national development plan focused on primary health care, but also noted that the health sector and its institutions needed to “modernize and develop, guided by the principles of integration, decentralization, and democratization, so that they may assume their roles efficiently and without duplication” (MIDEPLAN, n.d.-c, p. 13). These same goals appeared in the 1993 World Bank staff appraisal report (written before the loan was signed, and containing the World Bank staff’s appraisal of the possible contribution of the project) for the Health Sector Reform Project. The Health Sector Reform Project of 1993 was involved in the creation of the EBAIS, which signals the importance of World Bank involvement in some of the most significant (and successful) reforms in the Costa Rican health system and indicates that the priorities raised by the government were addressed in this World Bank project (P006954, n.d.).

Since 1995, basic health services have been provided via EBAIS, which took over all direct medical functions previously provided by the MOH. Each EBAIS consists of a medical team; in urban areas, there are typically clinics, some are CCSS-owned, but a few are sub-contracted (Rosero-Bixby, 2004). In rural areas, EBAIS are mobile and travel. Each “health area” has at least one EBAIS, based on population—one per approximately 4,000 people. There are more than 100 health areas in the country, some with multiple EBAIS (Bustelo & Rodríguez Herrera, 2008; Clark, 2002).

Paradigmatic Goals, Parallels, and Divergence in Government and World Bank Discourses

The previous section described health policy reforms in Costa Rica since 1980 and covered the World Bank and the government’s discussions of health problems and priorities. The World Bank documents also provide important information about broader themes and concerns. This section focuses on how the World Bank views the ideal level and type of government involvement in the Costa Rican health sector.

Health in Context: The Role of Government in the Health Sector

Structural adjustment programs provide an excellent source of information about the World Bank’s view of problems, concerns, and areas of future focus for the Costa Rican health sector. Although they focus on macroeconomic issues, in particular trade and export promotion, there are several mentions of the public sector and, more germane to this study, the social sector. They provide information about how the World Bank has viewed Costa Rica’s health sector in the context of other macroeconomic, political, and regional considerations.

Although the first structural adjustment program, begun in 1988, specified a reduction in public sector employment, results were “uneven.” According to the World Bank, the outcomes reflected “both the long-standing emphasis on public sector programs, especially in the social sectors, as well as the difficulties of curtailing public employment in the year preceding the 1986 elections” (P006927, 1988 p. 6). The memo by the president of the World Bank that accompanied the first SAL identified Costa Rica’s investment in social services and infrastructure as positive and vital for continued political stability:

Economic growth was accompanied by substantial progress in the health and social sectors; for example, waterborne diseases were controlled and extensive social welfare programs and medical care facilities were established, with widespread social security coverage . . . These social and economic achievements, coupled with Costa Rica’s strong democratic tradition, have been key factors in the country’s ability to maintain social and political stability, despite the serious deterioration in the economy and in the overall standard of living that has taken place since 1980. (P006923, 1985, p. 2)

Investing in education, health, and infrastructure are seen as a means for achieving social and political stability, a real concern in the context of Central American countries plagued by civil war and political instability. The utilitarian bent on investment in social services for the goal of political stability suggests that the World Bank is interested in focusing on economic and social policies (and spending), because of their effect on political stability rather than their centrality in the context human rights or wellbeing. This idea is in contrast to the common understanding of neoliberalism as focused on reducing government intervention in markets, and which recommends economic policy reform with little attention to social and political stability. The World Bank presidential memo for the second SAL stressed the importance of “improved management of the public sector” as a method to increase savings. “The present administration is committed to increase public savings, improve the cost-effectiveness of public investment, and reduce the size of the parastatal sector” (P006927, 1988, p. 56). The World Bank appears concerned, beyond what a more purely neoliberal approach might suggest, with social and political stability in the face of economic problems; social spending is a means to achieve and maintain stability.

The third structural adjustment program supported several reforms, among them “public sector reform, including privatization of government services and enterprises, reduction of public employment, budgetary reform, institutional restructuring, and tax reform” (P006952, 1996, p. 2). The project completion report indicates that, although originally the passage of a law to allow private insurance companies to compete with the national insurance institute (INS) was a second tranche (payment) condition, this was amended so that the passage of another law² was largely accepted as a condition for effectiveness (P006952, 1996, p. 3). Such negotiations signal at least some flexibility on the part of the World Bank, where conditions, even after they are set, are more negotiated with rather than imposed on the national government.

According to these SALs, the goals for the public sector are generally consistent with the neoliberal approach, embodied by the Washington Consensus, of privatization, reduction of the statecraft in the form of reduction of public employment, and a focus on higher levels of efficiency, but recommendations for the

social sector are less clear cut. The World Bank recognizes that social services are tied to Costa Rica's political and social stability, especially following the debt crisis of the 1980s. In addition, although some conditions were related to the social sector, the World Bank seemed to be more interested in state-owned enterprises and their privatization rather than social expenditures.

An implementation report for the first standalone health project by the World Bank in Costa Rica, begun in 1993, outlines the World Bank's general strategy in Costa Rica, which is to

ensure macroeconomic stability, reform the public sector, integrate the economy with world markets, strengthen infrastructure, enhance competitiveness and efficiency of the financial system, improve coverage and efficiency of social programs to further reduce poverty and improve environmental management. The loan was the first Bank operation to Costa Rica in the health sector and was seen as an important vehicle to strengthen the social sector policy dialogue with the Government. (P006954, 2003, p. 3)

Although health is viewed as important, it is promoted in the context of broader public sector reform and international economic integration. In addition, the earlier quote indicates that, because of the centrality of the CCSS and health in Costa Rica, health is seen as an important domain in which the World Bank can become involved, as a means for broader engagement with the government on social policy.

Costa Rica–World Bank Relations: Cooperation and Flexibility

The World Bank and the Costa Rican government were largely in agreement about the main problems the health sector faced during this time period. There were concerns about access, particularly in remote and rural areas, the promotion of equity, and the financial sustainability of the system given increasing health costs and a concern with (in)efficiency. Despite some assertions that the World Bank was more likely to focus on infrastructural loans in the 1980s, it appears that, at least for health sector projects in Costa Rica, this was not the case; the SALs and the accompanying technical assistance loan accompanying SAL I, which involved consultants who were working on possible strategies to strengthen the CCSS (P006933, 1993, p. 3), were initiated as early as 1985, whereas a major infrastructural program related to the water supply, the Water Supply and Sewerage Project, began later—in 1993.

The World Bank is also more sensitive to national policies than might be expected given evidence from other (non-health) domains and the literature on the Washington Consensus. The World Bank frequently makes reference to national plans and priorities as defined by governments. For example, for the San Jose Metropolitan Area Water Supply project, an associated memo and recommendation states, "The 1979–82 national development plan indicated a national goal of providing water supply through house connections to 95 percent of the urban and concentrated rural population and to 47 percent of the population in dispersed rural areas" (P006921, 1980, p. 9). Still, reference to national plans does not indicate agreement with them or a belief that they are feasible, as this same paragraph continues, "It is unlikely that these goals will be met by the target date

of 1982 . . . AyA has yet to develop a systematic approach to planning and programming its capital activities, taking into account its capacity to implement investment projects" (P006921, 1980, p. 9). Although the World Bank was aware that Costa Rica had set its own national priorities, it was not universally supportive of these goals and sometimes doubted their feasibility.

The conditions outlined in the loan agreements from this period are broad, and loan documents indicate that the Costa Rican government retained flexibility and that the World Bank was willing to make concessions and adapt projects to national conditions (for example, a change of government that resulted in changes to the program). Overall, such changes did not seem to affect negatively World Bank–country relations or the World Bank's overall assessment of projects.

During the first change of administration, in 1998, there was a short period during which the project was rated as "unsatisfactory" as the new administration froze implementation to reconsider the depth and pace of reform. Once the new administration affirmed the positive direction of the reforms, project execution was resumed and the "satisfactory" rating was once again obtained. (P006954, 2003, p. 18)

In addition, the CCSS, the most important national actor in health in Costa Rica, seemingly maintained autonomy across reforms and input from the World Bank. For example, one World Bank document notes that, "the CCSS made a strategic decision to combine the studies and implementation of reforms regarding the separation of functions and the introduction of performance-based payment mechanisms" (P006954, 2003, p. 12).

In the SALs, investment in the health sector is largely discussed in the context of balance of payments, along with other types of social spending. Here health sector reform was a specific tool for achieving financial and economic as well as political stability. In the context of its general approach in Costa Rica, the World Bank recognized as early as the 1980s that social services were tied to political stability and allowed the government significant autonomy in determining project specifics. This finding provides nuance to discussions of neoliberal pressures and the Washington Consensus, indicating that there is perhaps more variation in World Bank–country relations and strategies than previously discussed.

Efficiency and Equity: Disparate Emphases on Paradigmatic Goals

My analysis of these policy documents follows Campbell's (1998) approach and reveals two main paradigmatic goals for the health sector as they appear in national, World Bank, and other documents—equity and efficiency. Generally, equity and efficiency are as seen as competing goals, and a focus on cost-effectiveness is viewed as central to neoliberalism, which prizes efficiency and cost concerns over equity, including distributional and inequality issues. In these official documents, both goals are often identified in the same sentence or passage. This fact is particularly prevalent in World Bank documents, where equity is almost always discussed in tandem with efficiency. When equity is discussed alone, it is largely in descriptions of the government's historical and current emphasis and strategy. For example, "the present Government which

assumed office in May 1990 is aware that while important progress has been achieved, the reform process must be deepened and consolidated if it is to provide a solid base for sustained and equitable development into the next century" (P006941, 1993, p. 1), and "the functional changes in the national health system count on strong support from across the political spectrum, and also from the beneficiaries who count on more equitable, quality health care since health service delivery is seen as a key pillar of Costa Rica's public social services" (P073892, 2010, p. 30).

When equity is discussed independently of efficiency and not in the context of describing government priorities, it appears that the World Bank's interpretation is narrower than the national, sectoral definition. For example, according to the World Bank, achievement of increased equity would be apparent via a reduction in differences in CCSS per capita health spending across designated national health areas (P073892, 2001, p. 26), and "the vast majority of sub-projects and activities carried out under the Project incorporated the country's indigenous areas. In such areas, equity was interpreted as ease of access" (P073892, 2010, p. 18). In some instances, equity is synonymous with more equitable spending and access across geographic regions, and in others, contradictorily, with higher spending and targeting of particular regions, largely those with high levels of poverty, a high proportion of indigenous people, or both.

In contrast, national documents discuss equity together with broader concepts and terms such as solidarity, social justice, and the distribution of "the benefits of development" (OFIPLAN, n.d., p. 93, author's translation) as well as community participation in an integrated health system (MIDEPLAN, n.d.-b, p. 32). Furthermore, in government documents discussions of equity are frequently coupled with mentions of universal access "... improve coverage, access, opportunity and quality, in addition to the operations of health services in line with the population's needs and the country's economic conditions" (MIDEPLAN, n.d.-e, author's translation). Quality of services is also mentioned as being an important component of adequate access.

The challenge in this area is to resituate social development in the center of state action, with the goal of assuring the context of a framework of equity, solidarity, and equality of opportunity, that the entire population has access to fundamental social services, without sacrificing the quality of these same services. (MIDEPLAN, n.d.-d, author's translation)

On the other hand, the World Bank discusses access using economic logic in the context of (in)efficiency as a way to correct distortions in demand (P006954, 1993, p. 3). Although there is also mention of quality in access, it is in tandem with efficiency. For example, the World Bank notes that one project "played an instrumental role in achieving the project's overall objective of extending access, increasing efficiency, and improving quality" (P006954, 2003, p. 13).

The government and the World Bank are both concerned with issues of cost and efficiency in the health system. For the World Bank the concern is largely related to financing and evasion of payment, and its solution is increased rationalization (and bureaucratization) in the form of separation of functions between providers, financing, and purchasing. Besides the separation of functions, efficiency is to be achieved through the use of subcontracting to private providers or

cooperatives, which may also be viewed as neoliberal via the promotion of market mechanisms. This is not wholesale privatization; services remain under the CCSS, an autonomous agency of the government, but there is an effort to introduce private firms into the market and to open up the insurance market (private firms can now provide insurance).

Official documents indicate that the World Bank and the Costa Rican government seemed to be largely in agreement about the main problems the health sector faced. The problem areas were centered on issues of access, particularly in remote and rural areas, and the financial sustainability of the system, given increasing health costs. The difference lies in the framing of these priorities. The ways in which equity and efficiency are discussed in conjunction with values, other ends, means, and strategies for achievement are different for the government and for the World Bank.

To summarize, the national development plans discuss efficiency and issues in financing, but equity concerns are also a primary focus. The World Bank documents mention equity, but its idea of equity is mathematical (a formula based on regional inequality and poverty in resource allocation) and geographically bound. For the Costa Rican government, the issue of equity is exemplified in a universally contributive social security system (whether people use it or not) based on solidarity; funds from those earning higher wages subsidize those with lower wages, with the government subsidizing the poor and indigent. Equity is therefore not only a matter of outcomes (health environments, sewerage systems in rural areas, and more), but also of access, and is intricately tied to financing and redistribution. Although both discuss access issues, the World Bank documents emphasize access as an outcome in the context of economic distortions, whereas the Costa Rican government prioritizes access as it relates to issues of equity and emphasizes that it is important that increased access does not happen at the expense of quality of care. There is therefore a contradiction between a neoliberal directive to reduce the size and role of the state in the market and a call for the state to regulate a growing, increasingly complex private sector (Jordana & Levi-Faur, 2005) apparent in the World Bank's policy prescriptions for the Costa Rican health sector.

Discussion and Conclusion

Drawing from Campbell's (1998) and Hall's (1993) policy paradigms approach, I use World Bank loan and project documents to examine how it conceptualizes Costa Rica's health priorities, problems, and solutions between 1980 and 2005 and its involvement in Costa Rican health sector reform. I contrast them with data from Costa Rican national plans to examine parallels and differences in policy goals. This analysis allows me to trace areas of agreement and contention as well as changes over time across national priorities and agendas and prescriptions by the World Bank. Although the neoliberal focus of IFIs and their detrimental influence has been extensively decried, the implications of neoliberalism for health policy in developing countries are far from articulated, theoretically and empirically, beyond a discussion of pushes toward privatization and resultant inequality.

By moving beyond examining health spending and outcomes, my analysis traces the ideational and discursive shifts in the World Bank's approach to health in Costa Rica and how it is mirrored (or not) in the Costa Rican government's approach. The use of World Bank documents and national documents provides a rich source of data that allows me to examine variation in the World Bank and the government's emphasis on two important goals in health policy—equity and efficiency. The documents also provide information about the ways in which logics, justifications, and framing vary across the Costa Rican government's position and the World Bank's. In this way I am able to trace the process of reform and examine changing priorities and framing over time and across these two data sources, supplemented by other primary documents.

This study also contributes to our understanding of health policy reform in the context of other national concerns. My analysis demonstrates how national priorities for health are related to other national concerns (e.g., political stability, economic growth, and social development) in Costa Rica and how plans and priorities are funded, implemented, and negotiated vis-à-vis the World Bank. Although there are differences in the discussion of policy goals and paradigms, there is also much commonality. As suggested by studies on neoliberalism, the World Bank is more focused on efficiency, discussing it in largely economic terms, whereas the Costa Rican government is fundamentally concerned with user satisfaction and equity in the context of concerns about cost, but there is much overlap in the discussion of problems and diagnoses of solutions.

Some scholars question the power of IFIs, including the World Bank and the IMF, to affect the content of national policies, but there is evidence that these IFIs have been important for national policy reform, especially but not limited to the case of pensions and monetary policy (Babb, 2009; Cruz-Saco & Mesa-Lago, 1999; Lora, 2001; Teichman, 2004). The World Bank is the largest external funder of global health, so understanding its priorities, foci, and suggestions in health is especially important (Ruger, 2005). An examination of where and how its priorities align with those of national governments is crucial because its financial sway has translated into its status as an authority in global health. What the World Bank has to say about health makes a difference, not only because of its influence via loans, but because it has normative power. It helps frame the universe of possible and desirable reforms in the developing world.

My analysis provides compelling evidence that, although the World Bank is espousing some policies that may fall under the umbrella of neoliberalism—separation of functions, a focus on efficiency (more so than equity), and recommendations to the CCSS to subcontract some health services to private providers—some of these concerns can be predated to the Costa Rican government. It has not always been the case that because the World Bank is advocating a neoliberal policy the Costa Rican government adopts it. I find some evidence to the contrary. The Costa Rican government was concerned with the bloat of its public health apparatus long before the World Bank had anything to say about it. This study provides evidence that national governments have more agency and flexibility in their dealings with IFIs than may have been previously thought, at least in health, and that the World Bank is not strictly neoliberal and market-oriented in its approach, as suggested by the literature on the Washington Consensus.

By examining all available World Bank health project and loan records, more general World Bank health documents, and all Costa Rican government plans, I have access to the population of official documentation of health plans, priorities, and activities in the country between 1980 and 2005. These public records are just that—they are the official word of the World Bank and the government in regards to the health sector. They do not contain “behind the scenes” opinions and records, but they are valuable because they represent the official goals and priorities for health sector reform, those that are shared with the public and those that are pointed to by the media and other sources and often followed in reforms.

Some may argue that the World Bank did not play a large role in health sector reform in Costa Rica during this time period, so examining its projects, loans, and the discourse therein is of little utility. In reality, there is significant evidence that the World Bank had an important hand in some of the most extensive reforms in Costa Rica’s health sector. As Clark (2002) documents, the World Bank was instrumental in supporting the creation of the EBAIS (along with USAID and other aid agencies) and has supported several other central administrative changes in the structure of health financing and provision.

Finally, I recognize that the Costa Rican government and the World Bank are not unitary institutions, and they have changed over time. The World Bank changed presidencies and Costa Rican office staff during the time period under observation, as did the Costa Rican government. The development plans were written under different presidents from different parties, but they still represent the official government position for the health sector at any given time and the variation of these approaches. This study focuses on the parallels and divergence between the government and World Bank’s emphases on paradigmatic goals and health policies and projects and recognizes that they represent temporally bound and politically contingent stances on these issues. These movements toward privatization are not solely the result of World Bank projects. These documents indicate that Costa Rican discussions of cost cutting in health predate those of the World Bank. My analysis presents evidence on the World Bank’s involvement in health sector reform in Costa Rica and how its projects, emphases, and goals compared with those of the national government during this time period.

Like any other institution, the World Bank is characterized by a myriad of contradictions, such as the imposition of conditionality but the granting of loans despite their non-fulfillment; and the broad neoliberal promotion of increased private sector involvement and less state involvement in markets, including the health market, together with a call for increased government involvement in the form of regulation of the private sector. Although the World Bank is a centralized, bureaucratic institution, its personnel vary by country; it is these people who deal directly with governments most of the time. In addition, governments are not helpless actors; during times of economic crisis (such as the debt crisis in Costa Rica in the 1980s), they are in less-powerful negotiating positions, but some research has suggested that governments may blame IFIs and other international organizations for policy changes that they wish to implement but are popularly undesirable (Vreeland, 2003; Weyland, 2007).

Arguments about the World Bank's influence on national policies center on its ability to condition its loans and monies granted, asking governments to carry out particular neoliberal reforms, but the World Bank's policies have changed over time, as is evidenced in debates about the Washington and post-Washington Consensus. There is little information about the contents of its policies for health, and even less about changes over time. The two cases that have received the most attention, Chile and Colombia, may provide a skewed understanding of the role that the World Bank has played and seeks to play in health sector reform in developing countries. My analysis indicates that the extent of its neoliberal emphasis—especially on privatization—is not uniform across countries. The Costa Rican case demonstrates that the World Bank is interested in supporting policies that promote equity (albeit narrowly defined) as well as efficiency, and has allowed the government flexibility in reform. Focusing on extreme cases may distort our understanding of the World Bank's health priorities and its involvement in health sector reform in Latin America and developing countries more generally. This study extends the available evidence about the World Bank's approach to health sector reform in Latin America, enriching and expanding our understanding of the relationship between neoliberalism and social policy.

About the Author

Shiri Noy is an assistant professor of Sociology at the University of Wyoming. Her research is primarily in political sociology and is centered on globalization, political culture, institutions, and development. She has published research on the dynamics of globalization and health policy reform in Latin America in the *International Journal of Comparative Sociology*, *Revista de Ciencias Sociales*, and *Sociology of Development*.

This research was supported by a National Science Foundation grant SES-1029564. I thank Patricia A. McManus, Brian Steensland, Bernice A. Pescosolido, Koen Voorend, Jelena Radovic Fanta, and the editors and anonymous reviewers for useful comments and suggestions.

Notes

¹This is not to say that there is no research on neoliberalism and health sector reform, but this research is largely focused on outcomes. Even to the extent that it tracks the process of health sector reform, the pressures exerted by the World Bank are stated and assumed without being unpacked. Often the specifics of World Bank prescriptions are not discussed, and authors instead focus on the reforms ultimately implemented (see for example Barrientos & Lloyd-Sherlock, 2000; Buse & Gwin, 1998; De Beyer, Preker, & Feachem, 2000; De Vos et al., 2006; Homedes & Ugalde, 2005). This research is valuable for examining the outcomes of health sector reform, but it does not focus on the particulars of World Bank policy prescriptions and their possible changes over time and across countries. I argue that it is important to move beyond declaring neoliberal pressures on the part of the World Bank in broad strokes to examining these prescriptions empirically as they relate to health sector reform across contexts.

²The Law of Economic Democratization was meant to encourage Employee Share Ownership Plans, involving employee and consumer shareholder associations in Costa Rica in the private sector and the privatization of state-owned companies in the late 1980s and 1990s. Largely because of lack of political will, this law did not ultimately pass. The Law for the Promotion of Competition and Effective Consumer Defense (Asamblea Legislativa, 1995) passed in 1995 and contains various exceptions protecting public sector monopolies; it was seen as fulfilling some of the effectiveness conditions of the loan.

References

- Armada, F., Muntaner, C., & Navarro, V. (2001). Health and social security reforms in Latin America: The convergence of the World Health Organization, the World Bank, and transnational corporations. *International Journal of Health Services, 31*(4), 729–768.
- Asamblea Legislativa. (1950). *Ley General de Asistencia Medico-Social*. San Jose: Author.
- Asamblea Legislativa. (1973). *Ley Para Reorganizar Los Servicios Medicos Preventivos Con Base a la C.C.S.S.* San Jose: Author.
- Asamblea Legislativa. (1995). *Ley de Promocion de la Competencia y Defensa Efectiva del Consumidor*. San Jose: Author.
- Babb, S. (2005). The social consequences of structural adjustment: Recent evidence and current debates. *Annual Review of Sociology, 31*, 199–222.
- Babb, S. (2009). *Behind the development banks: Washington politics, world poverty, and the wealth of nations*. Chicago, IL: University of Chicago.
- Barrientos, A., & Lloyd-Sherlock, P. (2000). Reforming health insurance in Argentina and Chile. *Health Policy and Planning, 15*(4), 417–423.
- Birn, A.-E., & Dmitrienko, K. (2005). The World Bank: Global health or global harm? *American Journal of Public Health, 95*(7), 1091–1092.
- Bonal, X. (2002). Plus ça change . . . The World Bank global education policy and the Post-Washington Consensus. *International Studies in Sociology of Education, 12*(1), 3–22.
- Burki, S. J., & Perry, G. (1998). *Beyond the Washington consensus: Institutions matter*. Washington, DC: World Bank Publications.
- Buse, K., & Gwin, C. (1998). The World Bank and global cooperation in health: The case of Bangladesh. *The Lancet, 351*(9103), 665–669.
- Bustelo, C., & Rodríguez Herrera, A. (2008). *La compra de servicios de salud en Costa Rica*. Santiago: CEPAL.
- Campbell, J. L. (1998). Institutional analysis and the role of ideas in political economy. *Theory and Society, 27*(3), 377–409.
- Campbell, J. L. (2002). Ideas, politics, and public policy. *Annual Review of Sociology, 28*, 21–38.
- Clark, M. A. (2002). Proceedings from the Woodrow Wilson Center Workshops on the Politics of Education and Health Reforms: *Health sector reform in Costa Rica: Reinforcing a public system*. Washington, DC. April 18–19, 2002.
- Clift, J. (2003). Beyond the Washington consensus. *Finance and Development, 40*(3), 9.
- Cruz-Saco, M. A., & Mesa-Lago, C. (1999). *Do options exist?: The reform of pension and health care systems in Latin America*. Pittsburgh, PA: University of Pittsburgh.
- De Beyer, J. A., Preker, A. S., & Feachem, R. G. (2000). The role of the World Bank in international health: Renewed commitment and partnership. *Social Science & Medicine, 50*(2), 169–176.
- De Vos, P., De Cuckelaire, W., & Van der Stuyft, P. (2006). Colombia and Cuba, contrasting models in Latin America's health sector reform. *Tropical Medicine & International Health, 11*(10), 1604–1612.
- Easterly, W. (2001). *The effect of IMF and World Bank programmes on poverty*. WIDER Discussion Papers. World Institute for Development Economics (UNU-WIDER). Retrieved from <http://www.imf.org/external/pubs/ft/staffp/2000/00-00/e.pdf>
- Ewig, C. (2006). Global processes, local consequences: Gender equity and health sector reform in Peru. *Social Politics: International Studies in Gender, State & Society, 13*(3), 427–455.
- Fine, B. (2001). *Social capital versus social theory: Political economy and social science at the turn of the millennium*. London: Routledge.
- Fourcade-Gourinchas, M., & Babb, S. L. (2002). The rebirth of the liberal creed: Paths to neoliberalism in four countries. *American Journal of Sociology, 108*(3), 533–579.
- Franzoni, J. M. (2008). Welfare regimes in Latin America: Capturing constellations of markets, families, and policies. *Latin American Politics and Society, 50*(2), 67–100.
- George, A. L., & Bennett, A. (2005). *Case studies and theory development in the social sciences*. Cambridge, MA: MIT.
- Hall, P. A. (1993). Policy paradigms, social learning, and the state: The case of economic policymaking in Britain. *Comparative Politics, 25*(3), 275–296.
- Homedes, N., & Ugalde, A. (2005). Why neoliberal health reforms have failed in Latin America. *Health Policy, 71*(1), 83–96.
- Huber, E., & Solt, F. (2004). Successes and failures of neoliberalism. *Latin American Research Review, 39*(3), 150–164.
- Huber, E., & Stephens, J. D. (2012). *Democracy and the left: Social policy and inequality in Latin America*. Chicago, IL: University of Chicago.
- Hunter, W., & Brown, D. S. (2000). World Bank directives, domestic interests, and the politics of human capital investment in Latin America. *Comparative Political Studies, 33*(1), 113–143.
- Ilon, L. (1996). The changing role of the World Bank: Education policy as global welfare. *Policy & Politics, 24*(4), 413–424.

- Jordana, J., & Levi-Faur, D. (2005). The diffusion of regulatory capitalism in Latin America: Sectoral and national channels in the making of a new order. *The Annals of the American Academy of Political and Social Science*, 598(1), 102–124.
- Lloyd-Sherlock, P. (2005). Health sector reform in Argentina: A cautionary tale. *Social Science & Medicine*, 60(8), 1893–1903.
- Lora, E. (2001). Structural reforms in Latin America: What has been reformed and how to measure it. Working Paper IDB-WP-346. Washington, DC: Inter-American Development Bank, Research Department.
- Mesa-Lago, C. (2006). Private and public pension systems compared: An evaluation of the Latin American experience. *Review of Political Economy*, 18(3), 317–334.
- Mesa-Lago, C. (2008). *Reassembling social security: A survey of pensions and health care reforms in Latin America*. New York: Oxford University.
- Mesa-Lago, C., & Müller, K. (2002). The politics of pension reform in Latin America. *Journal of Latin American Studies*, 34(3), 687–715.
- Ministerio de Planificación Nacional y Política Económica (MIDEPLAN). (n.d.-a). *Plan Nacional de Desarrollo, 1982–1986, Volvamos a la Tierra*. San Jose: Author.
- Ministerio de Planificación Nacional y Política Económica (MIDEPLAN). (n.d.-b). *Plan Nacional de Desarrollo, 1986–1990*. San Jose: Author.
- Ministerio de Planificación Nacional y Política Económica (MIDEPLAN). (n.d.-c). *Plan Nacional de Desarrollo, 1990–1994, Desarrollo Sostenido Con Justicia Social*. San Jose: Author.
- Ministerio de Planificación Nacional y Política Económica (MIDEPLAN). (n.d.-d). *Plan Nacional de Desarrollo, 1994–1998, “Francisco J. Orlich”*. San Jose: Author.
- Ministerio de Planificación Nacional y Política Económica (MIDEPLAN). (n.d.-e). *Plan Nacional de Desarrollo, 2002–2006 “Monsenor Victor Manuel Sanabria Martinez”*. San Jose: Author.
- Morgan, L. M. (1990). International politics and primary health care in Costa Rica. *Social Science & Medicine*, 30(2), 211–219.
- Murillo, M. (2002). Political bias in policy convergence: Privatization choices in Latin America. *World Politics*, 54(04), 462–493.
- Naim, M. (2000). Fads and fashion in economic reforms: Washington Consensus or Washington Confusion? *Third World Quarterly*, 21(3), 505–528.
- Navarro, V. (Ed.) (2007). *Neoliberalism, globalization, and inequalities: Consequences for health and quality of life*. Amityville, NY: Baywood Publishing Company.
- Noy, S. (2011). New contexts, different patterns? A comparative analysis of social spending and government health expenditure in Latin America and the OECD. *International Journal of Comparative Sociology*, 52(3), 215–244.
- Noy, S. (2013a). *Globalization, international financial institutions, and health policy reform in Latin America*. Bloomington, IN: Indiana University.
- Noy, S. (2013b). Las Políticas de Salud del Banco Mundial. *Revista de Ciencias Sociales*, 142(5), 75–85.
- Oficina de Planificación Nacional (OFIPLAN). (n.d.). *Plan Nacional de Desarrollo, 1978–1982 Gregorio José Ramírez*. San Jose: Author.
- Öniş, Z., & Senses, F. (2005). Rethinking the emerging Post-Washington consensus. *Development and Change*, 36(2), 263–290.
- P006921. (1980). Report and recommendation of the president of the IBRD from San Jose metropolitan area water supply. World Bank. Retrieved from <http://www.bancomundial.org/projects/P006921/san-jose-metropolitan-area-water-supply-project?lang=es>
- P006923. (1985). Recommendation of the president of the IBRD to executive directors for structural adjustment loan project I. World Bank. Retrieved from <http://www.worldbank.org/projects/P006923/structural-adjustment-loan-sal-project?lang=pt>
- P006927. (1988). Recommendation of the president of the IBRD to executive directors for structural adjustment loan project II. World Bank. Retrieved from <http://www.bancomundial.org/projects/P006927/structural-adjustment-loan-project-02?lang=es&tab=overview>
- P006933. (1993). Project completion report from technical assistance loan project. World Bank. Retrieved from <http://www.bancomundial.org/projects/P006933/technical-assistance-loan-project?lang=es>
- P006941. (1993). Staff appraisal report from water supply and sewerage project II. World Bank. Retrieved from <http://www.bancomundial.org/projects/P006941/water-supply-sewerage-project-02?lang=es>
- P006952. (1996). Project completion note for structural adjustment loan III. World Bank. Retrieved from <http://www.bancomundial.org/projects/P006952/structural-adjustment-loan-project-03?lang=es>
- P006954. (n.d.). Health sector reform project. World Bank. Retrieved from <http://www.bancomundial.org/projects/P006954/health-sector-reform-project?lang=es>

- P006954. (1993). Staff appraisal report from health sector reform project. World Bank. Retrieved from <http://www.bancomundial.org/projects/P006954/health-sector-reform-project?lang=es>
- P006954. (2003). Implementation completion report from health sector reform project. World Bank. Retrieved from <http://www.bancomundial.org/projects/P006954/health-sector-reform-project?lang=es>
- P073892. (2001). Project appraisal document from health sector strengthening and modernization II project. World Bank. Retrieved from <http://www.bancomundial.org/projects/P073892/health-sector-strengthening-modernization-ii-project?lang=es>
- P073892. (2010). Implementation, completion and results report from health sector strengthening and modernization II project. World Bank. Retrieved from <http://www.bancomundial.org/projects/P073892/health-sector-strengthening-modernization-ii-project?lang=es>
- Portes, A., & Hoffman, K. (2003). Latin American class structures: Their composition and change during the neoliberal era. *Latin American Research Review*, 38(1), 41–82.
- Radin, D. (2008). World Bank funding and health care sector performance in Central and Eastern Europe. *International Political Science Review*, 29(3), 325–347.
- Rosero-Bixby, L. (2004). Spatial access to health care in Costa Rica and its equity: A GIS-based study. *Social Science & Medicine*, 58(7), 1271–1284.
- Ruger, J. P. (2005). The changing role of the World Bank in global health. *American Journal of Public Health*, 95(1), 60–70.
- Sáenz, M. R., Acosta, M., Muiser, J., & Bermúdez, J. L. (2011). Sistema de salud de Costa Rica. *Salud pública de México*, 53, s156–s167.
- Santiso, C. (2004). The contentious Washington Consensus: Reforming the reforms in emerging markets. *Review of International Political Economy*, 11(4), 828–844.
- Stiglitz, J. E. (1999). More instruments and broader goals: Moving toward the Post-Washington consensus. *Revista de Economía Política*, 19(1), 94–120.
- Stiglitz, J. E. (2003). Democratizing the International Monetary Fund and the World Bank: Governance and accountability. *Governance*, 16(1), 111–139.
- Stocker, K., Waitzkin, H., & Iriart, C. (2008). The exportation of managed care to Latin America. *New England Journal of Medicine*, 340(14), 1131–1136.
- Teichman, J. (2004). The World Bank and policy reform in Mexico and Argentina. *Latin American Politics and Society*, 46(1), 39–74. doi: 10.2307/3177081
- Unger, J.-P., De Paepe, P., Cantuarias, G. S., & Herrera, O. A. (2008). Chile's neoliberal health reform: An assessment and a critique. *PLoS Medicine*, 5(4), 542–547.
- Vreeland, J. R. (2003). *The IMF and economic development*. Cambridge: Cambridge University.
- Weyland, K. (2005). Theories of policy diffusion lessons from Latin American Pension Reform. *World Politics*, 57(02), 262–295.
- Weyland, K. (2007). *Bounded rationality and policy diffusion: Social sector reform in Latin America*. Princeton: Princeton University.
- Williamson, J. (2002). *Did the Washington consensus fail?* Washington, DC: Institute for International Economics.
- World Bank. (n.d.) *Projects and operations*. World Bank. Retrieved from <http://www.worldbank.org/projects>