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Global Health in the Grip of Neoliberalism: A Combined Retrospective Comparative Stages Heuristic Policy Analysis

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ABSTRACT

Background: The COVID-19 pandemic revealed critical weaknesses in global health systems, many of which have roots in the neoliberal policies that have dominated global health governance since the 1980s. Neoliberalism, characterized by market-driven policies, privatization, and reduced government intervention, has profoundly impacted healthcare access, equity, and quality worldwide.

Objective: This study aims to analyze the impact of neoliberal reforms on health systems in various countries, focusing on the interplay between governance, policy formulation, and stewardship in the health sector. By examining the outcomes of these reforms, the study seeks to understand how different approaches to neoliberalism have shaped health system performance and equity.

Methods: The study employs the Stages Heuristic Model (SHM) to conduct a retrospective comparative analysis of health policy reforms in ten countries, including the United States, Chile, New Zealand, Ecuador, and China. The research synthesizes data from peer-reviewed articles to assess the outcomes of neoliberal policies on healthcare systems.

Results: The analysis reveals that in countries such as the United States and Chile, neoliberal reforms led to increased health inequities and a tiered healthcare system, where access to quality care became increasingly dependent on socioeconomic status. In contrast, countries like Taiwan, which balanced neoliberal reforms with strong public health initiatives, managed to maintain more equitable health systems. China and Venezuela, both of which initially adopted more interventionist healthcare policies, made notable early strides in improving access to healthcare and addressing inequities, particularly for underserved populations. However, Venezuela's progress was undermined by economic challenges and insufficient support for higher-level care, leading to a decline in health outcomes over time.

Conclusion: The study underscores the need for governance models that prioritize equity and public health in healthcare systems. It suggests that while neoliberal policies can drive economic efficiency, they often do so at the cost of health equity, necessitating a re-evaluation of global health governance and policy approaches.

Keywords: Neoliberalism, health reform, economic reform, health inequity, social safety net, austerity measures, privatization.

Introduction

During the COVID-19 pandemic, health systems were criticized for their inadequate performance. Health systems' lack of preparedness, overwhelmed infrastructure, and healthcare access inequities opened many discussions concerning the underlying reasons for these shortcomings [1]. Issues were raised, mainly that current health systems are the result of the long trend of concentrating on efficiency [2], underinvestment in the public health sector [3], and pushing for the privatization of health services [4]. These trends are directly related to neoliberalism and its proliferation as a dominant reform paradigm in the last decades.

"Neoliberalism" is an economic and political approach that advocates for limited government intervention in the economy, free-market capitalism, deregulation, and reducing social safety nets. In many places of the world, it has been a prominent economic and political doctrine [5]. Originating in the late 20th century, neoliberalism gained prominence as a reaction to the perceived failures of Keynesian economics and state-led welfare models. Initially, after World War II, many newly independent and developing nations adopted state-led development and nation-building strategies, with governments heavily involved in managing demand, stabilizing markets, and promoting social welfare. However, the economic challenges of the 1970s, particularly the stagflation crises characterized by economic stagnation, high inflation, and high unemployment, led many countries to seek alternative economic approaches. Key principles of neoliberalism include prioritizing economic efficiency, privatization of public services, and fostering competition. Adopting a neoliberal ideology does not only affect the economy of a country but also its social aspects including health, education, and even the social structure [6]. Neoliberalism has reshaped policies across various sectors, including health. Governments called for privatization, marketization, deregulation, and austerity measures, which gave rise to deep implications for healthcare access, equity, and quality [7].

This study examines how neoliberal reforms in healthcare have been applied across various national contexts and integrated into institutional frameworks. Through case studies from different countries, it provides a comparative overview of these policies' socioeconomic and public health impacts on healthcare services. The analysis spans from the 1980s to the COVID-19 pandemic, exploring how long-term neoliberal reforms have shaped healthcare systems' effectiveness and equity. The pandemic response is an example of these policies' cumulative effects. The study also addresses the complexities of implementing neoliberal reforms in distinct socio-political environments and their long-term implications for healthcare delivery and public health outcomes.

Methods

DATA SOURCE AND COLLECTION

This study's data collection was conducted in two steps to ensure a rigorous and comprehensive analysis of the impact of neoliberalism on healthcare reforms. The first step involved a systematic search in the Scopus database using the keywords "neoliberalism" and "health reform." The primary goal was to identify relevant cases for analysis. Collected studies were organized using Zotero, a citation management tool, to eliminate duplicates. Each study's title and abstract were reviewed for eligibility, focusing on studies written in English and relevant to neoliberalism and health reforms. Studies meeting these criteria were included a full-text review, aiding in selecting the most pertinent cases.

- **Search Term:** (TITLE-ABS-KEY ("neoliberalism" AND "health reform")) AND (LIMIT-TO(LANGUAGE, "english"))

The initial search provided a foundational set of cases, but the information available was sometimes limited. To supplement the initial data, a second step was done where a search was conducted using Google Scholar. This supplementary search aimed to gather more detailed information on each identified case, including aspects related to healthcare systems, equity, and responses to the COVID-19 pandemic. Keywords such as country names, healthcare, equity, and COVID-19 were used to expand the scope of data collection, providing a more comprehensive understanding of the contextual factors influencing health outcomes.

POLICY ANALYSIS METHODS

This study employs an analytical framework of two steps. The Stages Heuristic Model (SHM) to understand the policy process and healthcare system and health equity changes in different countries. And, a comparative analysis to compare the experiences of different countries in adopting neoliberal reforms and their effects on health. Policy implications and recommendations for better more equitable health future outcomes in the context of neoliberalism were drawn from the results of the analysis.

The Stages Heuristic Model (SHM), as proposed by Lasswell [8] and further developed by Brewer and DeLeon [9] is known as the policy cycle framework. SHM is a multipurpose framework that has been used in political science, policy analysis, and public administration. It is a widely used policy analysis tool as it allows for understanding the policy process and analyzing policy accompanying changes and their implications. The SHM has five main steps (Figure 1): *problem identification:* This stage involves identifying the issues that led to the adoption of neoliberal reforms, considering all relevant factors such as economic challenges (e.g., high inflation and low growth rates), social tensions, and inefficiencies in the healthcare system. It also accounts for the broader context, including the dominance of neoliberalism as a hegemonic ideology influencing policy decisions and shaping the understanding of these issues as problems requiring intervention. *Agenda setting*, where policy options including neoliberal reforms are considered. It involves assessing these options within the context of the hegemonic influence of neoliberalism, which often prioritizes market-oriented solutions. The agenda-setting process considers the political and economic environment, stakeholders' influence, and the extent to which neoliberal ideology has permeated policy discourse and decision-making processes. *Policy formulation* is where a decision is made and a policy is chosen often reflecting the neoliberal emphasis on privatization, deregulation,

and reducing public sector involvement. *Policy implementation* to assess how neoliberal reforms were implemented in healthcare delivery. And *policy evaluation* which is an analysis of the outcomes of neoliberal reforms in terms of their impact on health including equity among socio-economic groups. [10].

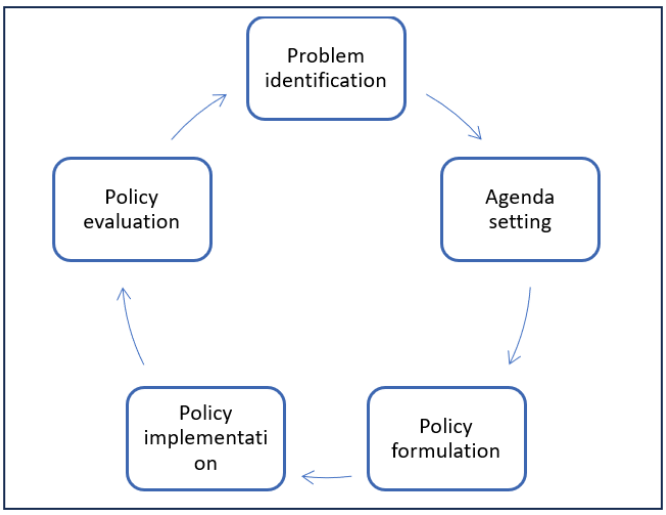

Figure 1: Stages Heuristic Model -Policy cycle

Comparative analysis is a powerful methodology within political science that allows for political systems, institutions, or processes comparison [11,12]. Comparative analysis in this case deepens the understanding of the patterns, trends, commonalities and differences in the adoption of neoliberal reform and its impact on health outcomes in different countries giving valuable insight into the effectiveness of neoliberal reforms and their implication in a country's healthcare system. For this study, the comparative analysis was done through cross-case synthesis where stages of the policy process were compared among country cases followed by a thematic analysis where overarching themes related to the impact of the adoption of neoliberal ideology on healthcare systems are discussed taking into consideration the trade-offs between economic liberalization and its immediate and long-term impact on health access, equity and outcomes.

The combination of the SHM and comparative analysis not only provides a comprehensive framework for examining the intricacies of policy development but also enables the identification of unique national responses to neoliberal reforms. This dual approach is crucial in uncovering the underlying factors that influence the variation in healthcare system transformations and their subsequent impacts on equity and access.

Results

SEARCH RESULTS

The systematic search in the Scopus database resulted in 29 studies within which there are 2 books and 27 peer-reviewed articles within which there were 11 studies covering specific countries (Senegal(1), Chile (4), New Zealand (2), Colombia(1), Turkey(1), Ecuador(2), Taiwan(1), China (2), Venezuela(1), Guyana (1), USA (2)), three studies covered specific areas (Latin America (2), Latin America and Africa (1)) and five of them are general (not country-specific).

STAGES HEURISTIC MODEL

The second part of the results is divided by countries where each country's neoliberal reform and its effect on health are analyzed using the SHM and its five steps.

Chili

Problem identification: Before the 1970s, Chile faced social and political tension due to unequal land distribution, where land ownership was concentrated in the hands of the wealthiest portion of the population, leading to stagnation of a highly potential agricultural sector. Chile faced economic challenges, including high inflation, low growth rates, and fiscal deficits. Moreover, the government perceived inefficiencies in the healthcare system, characterized by inequities in access and quality of care, and rising healthcare costs [13].

Agenda setting: To face the economic problems, Pinochet, in the 1970s brought a group of economists "Chicago Boys" from Chicago University to implement economic reform. They called mainly for the privatization of state-owned companies, trade Liberalization opening of the Chilean economy for foreign competition, and export-oriented growth where the industrial focus shifted toward productivity for export.

Policy formulation: Under the leadership of Augusto Pinochet, in the 1980s Chile adopted an economic reform highly influenced by the neoliberal doctrine. The reform encompassed the healthcare system. The 1981 Health Sector Reform aimed to increase efficiency, competition, and consumer choice in healthcare provision.

Policy implementation: The implementation of the healthcare reform led to the privatization of healthcare services, the introduction of a private health insurance system and user fees and decreased public spending on health.

Policy evaluation: Although Pinochet's reforms led to economic growth, they came at the expense of social aspects, particularly in the public sector. The austerity measures and reduction of state intervention resulted in a tiered healthcare system characterized by user fees, with a higher quality private healthcare sector and a lower quality public sector. This system disproportionately benefited wealthier individuals who could afford private care, while the public sector, burdened by limited resources, offered lower quality services.

Additionally, the reforms decentralized healthcare responsibilities, shifting them to localities. This shift meant that areas rich in resources could provide better quality healthcare services, while poorer regions suffered from fewer and lower-quality provision points. As a result, there were significant socioeconomic inequalities in access to services based on wealth, gender, and place of residence. Key social aspects, such as equitable access to healthcare and strong public health infrastructure, were neglected.

Following Pinochet's era, from the 1990s to the present, Chile's policy focus shifted towards maintaining economic growth while also addressing social disparities. This period saw an increase in social spending aimed at

poverty reduction and improving healthcare accessibility. Specific policies included investments in public healthcare infrastructure and targeted social programs to enhance service delivery in underserved areas. [14–17].

Ecuador

Problem Identification: In Ecuador, the adoption of neoliberal policies manifested as a hegemonic shift towards a market-oriented economy, which affected various sectors, including health. This shift was characterized by a reduction in state intervention, an emphasis on privatization, and an increased reliance on market mechanisms. The country's economic trajectory was significantly influenced by its dependence on oil revenue, particularly after the discovery of oil in the 1960s. This dependence became problematic when falling oil prices led to economic crises marked by high inflation, unsustainable public debt, currency devaluation, and stagnant growth.

These broader economic challenges, driven by neoliberal economic policies, had direct repercussions on the healthcare system. The market-oriented approach resulted in significant fragmentation within the healthcare system, inequitable access to services, and financial barriers for the population. Specifically, out-of-pocket payments for healthcare reached as high as 61%, imposing a heavy financial burden on many citizens [18].This environment fostered a healthcare landscape where access and quality of care were increasingly determined by market forces rather than equitable public provision.

Agenda setting: These economic challenges along with other factors including the pressure to adopt the International Monetary Fund (IMF) suggested solution which concentrated on privatization, trade liberalization and austerity measures created pressures to adopt a more neoliberal approach to stabilize the economy and promote growth. In the period (2007-2017) during Rafael Correa's presidency, the government recognized the presence of these problems in the healthcare system and considered the National Plan for Good Living and healthcare reform.

Policy formulation: the Ecuadorian government enacted the Organic Law of Health, and implemented various initiatives to operationalize the reform. The declared objective was to concentrate on the social determinants of health, equity and inclusion.

Policy implementation: Correa's government started a centralized state approach to health reform. The reform included an increase in the budget for the Ministry of Health (MoH), increased investment in infrastructure, equipment and human resources for health and extended the social protection scheme making it tax-based financed and supported by oil revenue.

Policy evaluation: although the healthcare reform implemented before Correa has never been declared to be neoliberal reforms, they were criticized to be a "silent" neoliberal reform as it was accompanied by limited public spending, increased government engagement with private health service providers, the limited access to certain healthcare services such as access to specialists and the high out-of-pocket expenses. Correa's government transformation plan intended to reverse these effects however, the transformation was criticized to be slow. Fragmentation persisted and It appeared far-fetched that an effective taxation system would ever be implemented [19,20].

Colombia

Problem identification: several challenges were identified in the Colombian healthcare system mainly: accessibility, quality, and equity which needed to be addressed.

Agenda setting: in the 1990s under the guidance of IMF and the World Bank, Colombia was one of the countries that were forced to adopt a more neoliberal approach limiting their interventionist role. This approach was extended to reach the healthcare sector and a neoliberal reform for health reached the agenda.

Policy formulation: the neoliberal reform was introduced through Law 100/93 which emphasized market competition and privatization in Colombia's healthcare system with the aim of improved efficiency and expanded access.

Policy implementation: the reform implementation resulted in the proliferation of private health providers, increased competition between insurers and increased workload on health professionals leading to dissatisfaction.

Policy evaluation: the reform increased the concentration on profit over care resulting in a dehumanized and fragmented healthcare system with unequal access to healthcare services as patients with limited resources might have difficulty accessing quality care under this system. Moreover, the focus shifted towards tasks rather than holistic care coordination limiting the health workforce's ability to utilize their full skill set.[74]

Venezuela

Problem identification: Before Chávez's administration, Venezuela's healthcare system faced significant challenges, including inequitable access to services and resource shortages. High proportion of the population lacked access to high-quality care, although the country was regionally recognized for advancements in specialized fields like heart surgery and infectious diseases such as polio were largely controlled. Neoliberal policies in the 1980s and 1990s, emphasizing privatization and reduced public spending, led to a weakening of public healthcare infrastructure, contributing to growing inequalities in access to services.

Agenda setting: In contrast to the prevailing neoliberal trend in other Latin American countries, President Hugo Chávez advocated for a reform model centered on social justice, equity, and universal access to healthcare. His administration sought to address the shortcomings of the previous neoliberal policies by increasing state involvement in the healthcare sector and ensuring that all citizens, regardless of socioeconomic status, could access quality healthcare services.

Policy adoption: Barrio Adentro was introduced as a cornerstone healthcare reform, designed to address inequities in access by deploying Cuban health workers

to underserved areas. The program established a network of primary care clinics (*Consultorios Médicos Populares*) and Comprehensive Diagnostic Centers (CDIs) to provide free, community-level care. Despite its focus on accessibility, concerns about the qualifications of the foreign professionals and the sustainability of the program arose, with some arguing that strengthening the existing health infrastructure would have been a more effective strategy.

Policy implementation: Barrio Adentro was successful in expanding access to primary care, especially in marginalized areas, but the focus on basic services left higher-level care underfunded. The program did not invest sufficiently in hospitals and specialized services, which led to a collapse of tertiary care infrastructure. Consequently, while primary care services expanded, the system struggled to manage more complex health needs. [21,22].

Policy evaluation: Initially, *Barrio Adentro* helped improve access to healthcare in underserved communities, but long-term outcomes revealed a deterioration of the public healthcare system. Key health indicators, such as child growth parameters, declined, and shortages of medical staff and supplies became pervasive. Despite the government's commitment to a state-led model, economic mismanagement and underfunding of healthcare during periods of high oil revenues weakened the system.

Guyana

Problem identification: Throughout the post-independence period, the Guyanese government has had relatively low resources, leaving it with little to spend on health. Guyana's healthcare system has significant constraints, including limited access to healthcare services, inadequate infrastructure, and inequities in health outcomes, all of which required government intervention.

Agenda setting: in 1970s, the socialist government decided to act upon the healthcare system limitations making health a primary issue on the agenda. The government had a strong dedication of resources to public health

Policy adoption: accordingly, the government introduced a clause into the development of the new Republican constitution that would guarantee "the right to free medical attention". Emphasizing the provision of free healthcare as a fundamental principle of the new Republic.

Policy implementation: while implementing "the right to free medical attention" the government declared its inability to provide complete coverage of health service and advocated for the nation's central principle of self-help through preventative care and the use of local resources in order to decrease the load on the health system and increase efficiency.

Policy evaluation: national economic difficulties continued and insufficient spending on the healthcare system continued leading to health workforce understaffing, and frozen salaries. The discussion of underspending and efficiency continued in the 1980s, reinforced by the World Bank structural adjustment loan introduced as a new vehicle to promptly transfer funds to numerous postcolonial countries, including Guyana [23–25].

New Zealand

Problem identification: New Zealand had a Universal taxpayer-funded health system that was supposed to cover the whole population. However, this system did not provide equitable access to healthcare services, especially for the indigenous Maori people. Furthermore, within this system, the government was supposed to cover two-thirds to three-quarters of the cost of healthcare services within this system. With time the government contribution value to the system eroded and patients covered most of the cost in the 1970s.

Agenda setting: Efforts to improve equity in access, particularly for the Maori, began in the 1970s when the Treaty of Waitangi was incorporated into legislation as a measure to affirm Maori rights. However, significant changes to the healthcare system were not observed until the 1980s and 1990s, when neoliberal policies were introduced by the elected market-driven government. During this period, the Treasury was strongly influenced by American ideas regarding the role of competition in the healthcare system, advising the government to adopt these policies.

Policy formulation: in the early 1990s significant changes were introduced to the healthcare system through the Green and White paper and the Youth Health and Public Health paper. Mainly, New Zealand embraced elements of corporatization as a solution for the healthcare system challenges.

Policy implementation: the adoption of these policy changes resulted in the increased role of the private sector, individuals became more financially responsible for their healthcare, and charges were introduced in secondary care in public hospitals. As for the Maori population, there was an increase in Maori health providers.

Policy evaluation: the reforms did not acknowledge the social determinants of health and cultural diversity in New Zealand. The neoliberal approach in New Zealand increased income and health inequities among the population. Despite the Maori increased access to health services through increased providers, Maori population health deteriorated due to the sever economic effects of neoliberal reforms on Maori families' economic situation resulting in persisting health inequities. Since 1997, there has been a retreat from neoliberal free-market approach towards a more in between neoliberal social approach in healthcare system policies.[26,27]

China

Problem identification: in 2003, The fourth-generation government of China acknowledged several healthcare system issues, including inequities in the distribution of health resources among different geographical areas, inadequate government spending on health, rising overall health expenditures resulting in a high rate of households experiencing catastrophic health expenses, and the lack

of insurance coverage for around 45% of urban residents and 80% of rural residents[28].

Agenda setting: Although some scholars link China's health reforms to the 2003 SARS outbreak, evidence suggests that the reform process had already begun earlier, notably with the issuance of the 'Decision on the Further Improvement of Rural Health Work' in October 2002. The government was facing increasing social discontent due to the implementation of neoliberal policies before the early 2000s and saw health reform as a way to address this tension.

Policy formulation: the government decided to expand several urban and rural government-administered health insurance programs.

Policy implementation: between 2003 and 2009 several modifications took place, namely: the establishment of the New Rural Cooperative Medical Insurance (NRCMI) for China's rural population, the expansion of the Urban Employees Basic Medical Insurance (U-Employee) for urban employees, the establishment of the 'rural medical assistance' for rural residents in poverty, the 'urban medical assistance' for urban residents in poverty, and the Urban Residents Basic Medical Insurance (U-Resident) for urban residents. Finally, the development of a national essential drug list, reform of the primary health care system, and reform of public hospitals.

Policy evaluation: Although the uninsured proportion of the population fell from more than 70% to 5%, significant inequalities in the distribution of health resources between geographical areas persisted. Additionally, out-of-pocket spending increased, and the proportion of households experiencing catastrophic health expenses did not decline. These mixed outcomes indicate that while coverage expanded, issues related to equitable access and financial protection remained unresolved. In response, the Chinese government continued to refine its policies, seeking a balance between neoliberal market-driven approaches and the need for broader social protection.[28,29].

United States

Problem Identification: The United States has faced persistent issues with increasing healthcare costs and limited access to healthcare services. Despite being a wealthy nation, a significant portion of the population remains uninsured or underinsured, limiting their ability to access necessary healthcare services. This lack of coverage has led to negative health outcomes, as individuals often forgo care due to cost, resulting in preventable illnesses and more severe health conditions.

Agenda Setting: The U.S. healthcare system has historically been influenced by neoliberal values, emphasizing market efficiency and individual responsibility over collective social responsibility. This ideology has made comprehensive healthcare reform challenging, as powerful stakeholders, including the insurance and pharmaceutical industries, have significant influence in shaping policy. The absence of strong social solidarity movements further complicates efforts to prioritize healthcare as a public good. However, despite these challenges, Barack Obama successfully brought healthcare reform to the forefront of the national agenda during his 2008 presidential campaign, culminating in the passage of the Affordable Care Act. This marked a significant, though contested, shift towards expanding healthcare access within a predominantly market-driven system.

Policy formulation: The Affordable Care Act (ACA) was enacted in 2010. ACA aimed to expand health insurance coverage to millions of Americans. ACA mandated American citizens to have health insurance or pay a penalty. ACA also aimed to improve healthcare outcomes and reduce costs through promoting preventive care and improving healthcare quality.

Policy implementation: The ACA implementation was in the form of a tiered system of health insurance plans. Four main health insurance plans "metal tiers" were offered through the state and federal exchanges: Bronze, Silver, Gold, and Platinum. They differ in the average percentage of total healthcare expenses that the plan will cover.

Policy evaluation: ACA did not increase access to healthcare services. ACA was not based on a single-payer healthcare system, where the government acts as the sole insurer. Instead, ACA expanded health insurance coverage by creating marketplaces (exchanges) where individuals and small businesses can shop for private health insurance plans. Thus, having a tiered system with access that depends on the individual job status and his ability to pay premiums. [30,31].

Senegal

Problem identification: Senegal experienced social, economic, and political disparities, which resulted in health inequities based on factors such as place of residence, gender, and age.

Agenda setting: Senegal government which represented itself as the protective caretaker of its citizens recognized these disparities and decided to act upon its healthcare system deficiencies. The government was backed up by international organizations mainly the WHO and UNICEF who conducted a meeting in 1987 to increase the availability of essential medicines and to improve drug procurement systems through resale of pharmaceuticals at health centers.

Policy formulation: In the 1990s, the Senegalese government initiated the Bamako Initiative, which encompassed health reforms, including the implementation of a new financing plan.

Policy implementation: the implementation of the health reform had three cornerstones: decentralization where responsibilities including managing health spending and budgeting were transferred to regional and municipal officials. The introduction of minimal user fees for primary care services at government health structures and higher fees for care at secondary and tertiary care were introduced. Community involvement in the health sector was ensured through the establishment of health committees. And "responsibilization" which claims that the healthcare system would be of limited effect on health

outcomes as long as citizens do not know how to take care of their health shifting the health responsibility from the state to the individuals.

Policy evaluation: the health reform resulted in increased access to healthcare systems where primary care services were available in rural and urban areas, and generic pharmaceuticals were available for patients in these structures at a wholesale price. Although healthcare services were provided at minimal fees these fees constituted a financial barrier for rural areas citizens causing them to delay healthcare services. Also, primary care services were limited leading to referrals to secondary care units which had higher fees. Community involvement resulted in the creation of a new political arena dominated by senior politically affiliated men leading to the further marginalization of women and children as stakeholders in decision-making. Decentralizing the health system aimed at increasing accountability and responsiveness created problems in money disbursement from central to local levels [32].

Taiwan

Problem identification: Before fully embracing neoliberal reforms, Taiwan's National Health Insurance (NHI) system aimed to provide universal healthcare coverage. However, the NHI faced financial challenges, raising concerns about its sustainability and efficiency.

Agenda setting: Unlike many nations, Taiwan was not directly influenced by the World Bank or IMF but was instead shaped by global economic trends and its trade relationship with the United States. The push towards neoliberal reforms was driven by internal aspirations for economic growth, democratization, and the privatization of public sector enterprises. Despite these pressures, there was significant resistance from the public health liberation movement, which prioritized maintaining robust public health services. This resistance helped limit the extent of neoliberal influence on Taiwan's healthcare system.

Policy formulation: Policies were formulated to promote market openness, fiscal austerity, and privatization, aligning with neoliberal principles.

Policy implementation: The implementation of these neoliberal policies introduced increased market mechanisms in healthcare. However, Taiwan's National Health Insurance (NHI) system played a crucial role in counteracting potential inequities, focusing on both equity and efficiency.

Policy evaluation: The neoliberal reforms in Taiwan emphasized privatization and market efficiency, which posed challenges to prioritizing public health. Despite these, Taiwan's commitment to universal coverage and the active efforts of the Public Health Liberation Movement successfully mitigated the negative impacts, ensuring that public health priorities remained above purely capitalist interests [33–35].

COMPARATIVE ANALYSIS

To facilitate the comparison among cases, the results of the first step of analysis are summarized in Table 1 where each column (except for the first column) provides a comparison criterion among cases. Starting with problem identification which is mainly the driver behind the adoption of a health reform be it based on a neoliberal ideology or not, all the countries included faced some kind of healthcare system challenge. The common healthcare system challenge among all cases was the presence of one or more of the socioeconomic inequitable access to healthcare services (financial, geographic, gender, etc.) which resulted in disparities in health outcomes. Other healthcare system challenges found in these cases and which are related to access inequity were; the rising cost of healthcare services (USA), the high percentage of uninsured population (USA, China), and the catastrophic health expenditure (China). Moreover, healthcare systems deficits were accompanied by financial challenges in the health sector in Taiwan and reduced governmental expenditure in New Zealand, China and Guyana.

Policy adoption in healthcare reform during the neoliberal era is deeply intertwined with agenda setting, contextual factors, stakeholder influence, and prevailing ideologies. In many cases, policies reflect the vision of the dominant agenda setter, resulting in manifestations of neoliberal ideology such as privatization, market competition, and individual responsibility towards health.

During the period from the 1970s onwards, marked by the rise of neoliberal doctrine, countries globally faced economic challenges, notably the stagflation crises of economic stagnation, high inflation, and high unemployment. This crisis was one of the drivers for countries to seek change in their economic approaches from interventionism to a more neoliberal approach. After WWII, western countries went to adopt a more interventionist approach to the economy and the welfare of their countries. Governments were deeply involved in managing demands, stabilizing markets and promoting social welfare in their countries. However, the stagflation crises made governments look for ways out of the crises, and the neoliberal doctrine was on the rise. At the time, many scholars criticized the interventionism approach to be ineffective and recommended the neoliberal approach to face the stagflation. They argued that limited government intervention, free markets and individual freedom would end the crises and lead to economic prosperity [36].

The United States was the pioneer in adopting the neoliberal doctrine and advocating for it, had already incorporated the neoliberal philosophy into its policymaking approach. So, when the government was faced with challenges in the healthcare sector, the neoliberal and individual responsibility model was already on the agenda as an approach to address whatever challenge rise to the government agenda including the challenges in the healthcare sector. Another neoliberal country was New Zealand. A neoliberal government was elected to power. This government embraced the advice of its treasury and pursued neoliberal approaches to healthcare reform.

Non-neoliberal countries were pushed to adopt neoliberalism through the influence of the US as in the case of Chile or under the pressure of certain international financial organizations mainly the IMF and World Bank such as Ecuador and Colombia. The rest of

the cases were more resilient to the neoliberal doctrine. They tried either to balance its effects such as the case of Taiwan or adopted an interventionalist non-neoliberal approach such as Venezuela, Guyana, China and Senegal.

In most cases, the policies adopted mirror the vision of the winner in setting the agenda thus for the USA the ACA essentially created private health insurance schemes allowing the private sector to expand and emphasizing the individual responsibility towards health which are basically neoliberal manifestations. For New Zealand, the corporatization of the healthcare sector, the increased number of private providers and the introduction of secondary healthcare fees were also manifestations of the neoliberal ideology of the neoliberal government elected. Chili's policies of decreased public spending on health, privatization of healthcare services and the introduction of a private health insurance system and user fees were also the result of the interest of Pinochet in the neoliberal economy and the effect of the Chicago boys who came from the US university. Ecuador's and Colombia's policies were similarly a result of an influential stakeholder, the IMF and World Bank. However, Colombia's policy was through a law (100/93) that emphasized market competition and privatization while Ecuador's policies were through a national plan (National Plan for Good Living). Taiwan's policy adopted increased market mechanisms while sticking to universal coverage as a result of both external neoliberal pressure and internal interventionalist pressure. Venezuela, Guyana, Senegal and China's policies were more affected by their governments' social interests. Venezuela's adopted policy was the introduction of a decentralized community-based healthcare system. Guyana's policy was through the right to free medical attention. Senegal's adopted policy was through the Bamako initiative and the new financing plan and finally, China's adopted policy was through a governmental decision to expand health insurance coverage.

Table 1 Intercountry Comparative Health Reform Policy Analysis

Country	Problem identification	Agenda setting	Policy adoption	Policy implementation	Policy evaluation
Chili	• Inefficiencies in the healthcare system: inequities in access and quality of care, and rising healthcare costs	• Economic challenges: high inflation, low growth rates, and fiscal deficits. • Discussion of economic reform with economists from Chicago University who called for a neoliberal reform	• Adoption of a neoliberal-influenced reform to increase efficiency, competition, and consumer choice in healthcare provision	• Decreased public spending on health Privatization of healthcare services. • Introduction of a private health insurance system and user fees	• A tiered healthcare system with user fees. • Low-quality public sector vs. higher quality private healthcare sector • Socioeconomic inequality in access to services according to wealth, gender and place of residence
Ecuador	• Fragmented healthcare system • Financial barriers- high out-of-pocket payments • Inequitable access to services	• Economic crises, high inflation, unsustainable levels of public debt, currency devaluation, and stagnant growth. • Pressure by the IMF for privatization, trade liberalization and austerity	• National Plan for Good Living including healthcare reform with a concentration on the social determinants of health, equity and inclusion	• increase in the budget for the MoH, investment in infrastructure, equipment and human resources for health and extension of the social protection scheme	• Fragmentation persists and It appeared far-fetched that an effective taxation system will ever be implemented.
Colombia	• Inequity in accessibility and quality, were the main problems in the healthcare system	• The IMF and the World Bank pushed for the adoption of a neoliberal reform	• Law 100/93 was introduced emphasizing market competition and privatization in Colombia's healthcare to improve efficiency and expand access	• Increased number of private health providers • Increased workload on health professionals	• Dehumanized and fragmented healthcare system. • Unequal access to healthcare services
Venezuela	• Inequitable access to healthcare services, poor health outcomes, and a lack of resources.	• a reform model that emphasized social justice, equity, and universal access to	• A decentralized community-based healthcare system was introduced	• prioritized preventative healthcare.	• Access to healthcare services was increased. • Health outcomes ameliorated

Country	Problem identification	Agenda setting	Policy adoption	Policy implementation	Policy evaluation
		healthcare was advocated for by President Hugo Chávez		• CDIs were established in marginalized areas	
Guyana	• limited resources for the healthcare system resulting in limited access to healthcare services, inadequate infrastructure, and disparities in health outcomes	• Socialist government pushed towards investing in public health	• The new Republic constitution encompassed "the right to free medical attention" which emphasized the provision of free healthcare	• The government could not provide full coverage and called for self-help through preventative care and the use of local resources	• Overloaded health workforce. • Frozen salaries • self-help through preventative care and the use of local resources • The World Bank pushed for further cuts in governmental spending worsening the situation
New Zealand	• Inequitable access to healthcare services. • Decreased public spending on health	• Legislation changed to protect the rights of minorities. • A neoliberal government was elected • Treasury advice to adopt a market-driven approach	• the Green and White paper and the Youth Health and Public Health paper were produced. • Both embraced corporatization as a solution for the healthcare system challenges	• Increased number of private providers • Introduction of secondary care charges	• Increased inequalities
China	• High percentage of uninsured population • Geographical health inequities • insufficient government spending on health • catastrophic health expenditure	• 2003 SARS outbreak • increased social discontent	• expansion of several urban and rural government-administered health insurance programs	• Expansion of insurance coverage • Reform of public hospitals • Reform of PHC system	• Reduced geographical inequities • Increased out-of-pocket expenditure
United States	• increased healthcare costs • Large percentage of the uninsured population • limited access to healthcare service	• neoliberal model and individual responsibility • presidential campaign for health reform	• Affordable Care Act (ACA) was enacted	• a tiered system of health insurance plans	• Inequitable access to healthcare system. Access depended on individual's ability to pay premiums
Senegal	• Place of residence, gender and age-based health inequities	• The government wanted to address these disparities • WHO and UNICEF supported	• Bamako Initiative; health reform with a new financing plan	• decentralization to regional and municipal levels • Minimal user fees for primary care services at government health structures and higher fees for care at secondary and tertiary levels were introduced. • Establishment of health committees	• Increased access to PHCs and generic pharmaceuticals. Financial barriers remained due to high user fees in secondary care • Marginalization of women in decision-making • Central to peripheral money transfer problems
Taiwan	• Financial challenges in healthcare system	• external pressure to adopt neoliberal reforms	• Market openness, fiscal austerity and privatization policies	• Increased market mechanisms in healthcare	• The negative effects of the neoliberal reforms were balanced by the commitment to

Country	Problem identification	Agenda setting	Policy adoption	Policy implementation	Policy evaluation
		• economic growth aspiration • Public health liberation movement			universal coverage and the collective efforts

Policy implementation followed suit; the US implemented the ACA through tiered system of health insurance plans. New Zealand reform policy was implemented through the increasing number of private providers and the introduction of secondary care charges. Chile's implementation was through decreasing public spending, privatization of health services and the introduction of user fees. Ecuador's implementation was through investing in healthcare sector infrastructure and resources and through extending the social protection schemes. Colombia's implementation was through increasing private providers, increasing efficiency and reducing expenditure on health. Taiwan's implementation was a struggle between two perspectives: increased market mechanisms in the healthcare sector and focusing on public goods and prioritizing public health goals. Taiwan managed to do so through expanding healthcare coverage, and financial stability [37,38]. Venezuela's implementation was through prioritizing preventative healthcare and the establishment of CDIs. Guyana's implementation fell behind its adopted policy, although Guyana's government for free medical care it couldn't provide full coverage and resorted to preventive health calling people to take care of their health and capitalize on local resources. China's implementation was in line with its reform where the government expanded government-administered health insurance coverage and reformed the PHCs. Lastly, Senegal implemented the Bamako initiative through decentralization and the introduction of minimal user fees for primary care and higher user fees for secondary care. Overall, while neoliberal principles guided many of these implementations, variations in context, resources, and political priorities led to diverse approaches to healthcare reform.

Policy evaluation is the final step in the comparative analysis and the one that explores the effects of certain adopted doctrines and approaches on health care systems in these countries. Countries can be grouped into three groups according to the approach adopted: a neoliberal approach, a more interventionist approach and a balanced approach. For countries that adopted the neoliberal approach (US, Chili, Colombia, Ecuador, and New Zealand the common impact of the policies adopted was increased health inequities which were mainly according to the financial capacity along with the persistence of healthcare system problems such as in Ecuador and the dehumanization of healthcare sector in Colombia. Countries that leaned more towards the interventionalist approach were more towards increasing access to healthcare services such as the case of Guyana, Venezuela, China and Senegal. Taiwan which tried a balanced approach managed to achieve double gain through boosting the economy while progressing towards universal health coverage.

A comparative analysis of healthcare reforms in many countries indicates the powerful influence of neoliberal ideology on policy formulation and implementation. Nations subscribing to neoliberal ideas, such as the USA, Chile, Colombia, Ecuador, and New Zealand, witnessed policies characterized by privatization, market competition, and individual responsibility, often resulting in growing health inequities and persisting healthcare system challenges. On the other hand, interventionist nations such as China, Taiwan, Guyana, Senegal, and Venezuela placed a higher priority on providing equal access to healthcare services in order to reduce inequalities and improve population health outcomes. Although neoliberalism shaped health reforms in certain countries, the diverse contexts, resource allocations, and political agendas yielded in different approaches to healthcare reform in other countries. This highlights the complex relationship between ideology, policy formulation, and healthcare outcomes on a global scale.

Discussion

This study concentrated on the effect of neoliberalism on healthcare systems and health equity. Neoliberalism has been a dominant doctrine shaping economic and social policies in many countries since the 1980s. This ideology aims to foster economic growth and improve GDP by promoting free markets, encouraging private sector growth, and limiting government spending. However, it often neglects critical social dimensions, such as social welfare, safety nets, healthcare accessibility, and equity. The long-term impact of these neoliberal policies has significantly influenced health outcomes and healthcare systems globally, particularly during crises like the COVID-19 pandemic.

Countries' capacities and strategies for managing the COVID-19 pandemic varied widely, reflecting the influence of neoliberal policies over time. Scholars have even referred to COVID-19 as a "neoliberal disease," highlighting how these policies have shaped healthcare systems' preparedness and response [39]. The ability of countries to respond effectively to health crises is often linked to their healthcare systems' structure, funding, and accessibility [1,40,40,41], which are, in turn, shaped by the adoption of neoliberal or more interventionist approaches.

Countries that adopt neoliberal approaches tend to depend on the private sector for service delivery, limit expenditure on health and shy away from UHC resulting in persistent healthcare challenges and pronounced health inequities leading to challenges in managing health emergencies [42,43]. In our study, neoliberal countries (i.e., the USA, Chile, Ecuador, Colombia, and New Zealand) had these challenges and exhibited inadequate responses during the COVID-19 pandemic.

The USA healthcare system has its own strengths such as having well-trained workforce and high-quality medical specialists. Nonetheless, it is frequently criticized for

inadequate healthcare coverage leaving citizens without protection with high health cost resulting in poor health outcomes and increased health inequities [44–46]. Apparently, these US healthcare systems deficiencies attributed to the US response to the pandemic and its outcomes. USA response to COVID-19 and the resultant COVID-19 morbidity and mortality were severe compared to other countries. In 2021, US COVID-19 attributable cumulative mortality was 15% of that of the global total [47]. COVID-19 has also highlighted the inequalities in the US healthcare system [48]. These inequalities have their roots in neoliberalism. The neoliberal governance of the healthcare system concentrated on market-based policies leading to these inequities [49]. The neoliberal US healthcare system failed to concentrate on public health and prioritized corporate profit resulting in poor preparedness for the pandemic and protection of the health workforce [50]. Scholars indicated the need for government intervention and adequate social services to overcome these widened inequities [51].

New Zealand's case is somewhat different. Although neoliberal principles, such as privatization and deregulation [7,52] affected the healthcare system in New Zealand and resulted in social inequalities, the government of New Zealand responded to the pandemic with great acclaim, enacting a "go hard, go early" policy and offering assistance to both individuals and businesses [53,54] which helped in mitigating the effects of neoliberal policies.

The other three countries in this category: Chile, Ecuador and Colombia response to COVID-19 did not have better outcomes. According to our Worldmeter data on COVID-19, the percentage of death cases in these countries was relatively high (Table 1) especially in Chile where the percentage of death cases can be compared to that of the US. Chile's neoliberal policies resulted in social inequities that have been made worse by the COVID-19 [15,55], especially in the capital, where lower-class communities have seen greater rates of infection and mortality as a result of comorbidities and restricted access to healthcare [56,57]. Ecuador's response to COVID-19 was also marked by high inequalities [58], where the government prioritized the private sector leading to the exacerbation of existing inequalities that are rooted in neoliberalism [59]. COVID-19 had similarly exposed and exacerbated health inequalities in Colombia, a consequence of neoliberal policies. The neoliberal governance model in Colombia which is characterized by decreased governmental expenditure on social services was a main obstacle for the implementation of Universal Health coverage which led to health inequities in access to healthcare services [51]. In Colombia, health inequity was observed in the lower socioeconomic groups and indigenous people through greater rates of COVID-19 mortality [60]. The epidemic has caused an additional 3.5 million people to live in poverty, making the residents of lower-income neighborhoods to have a ten-fold higher risk of hospitalization or COVID-19-related death than residents of wealthy neighborhoods [61].

Table 2: COVID-19 mortality [62]

Country	Population	Deaths	%D
US	334805269	1219487	0.364237697
New Zealand	4898203	5697	0.11630796
Chile	19250195	64497	0.335045957
Colombia	51512762	143200	0.277989365
Ecuador	18113361	36043	0.19898571
Venezuela	29266991	5856	0.02000889
Senegal	17653671	1971	0.011164817
Guyana	794045	1300	0.163718681
China	1448471400	5272	0.00036397
Taiwan	23888595	19005	0.079556793

On the other hand, there are the more interventionalist countries, including China, Guyana, Senegal, and Venezuela. During COVID-19, although their responses varied, some were praised while others were criticized. China, although, was criticized for implementing strict control measures such as complete lockdowns, which were considered unsuitable for other nations [63] was praised for its socialist economic and political system which prioritized saving millions of lives over protecting economic growth [64]. And responded to the COVID-19 pandemic by putting in place a robust social safety net that combined welfare, support, and social insurance [65].

Guyana had originally planned to take an interventionist stance, but it finally gave in to external pressure to cut back on government health spending. Major disparity in access and insufficient healthcare coverage were the outcomes of this choice. These flaws were exposed during the COVID-19 pandemic, which made it necessary for foreign agencies like the World Bank, GAVI, and the Pan American Health Organisation (PAHO) to provide support in order to obtain necessary COVID-19 medical supplies and rectify uneven access to healthcare [66,67].

In Senegal, the government pursued a multi-sectoral approach to managing the pandemic while maintaining healthcare services. The Ministry of Health collaborated with the private sector to enhance access to testing services, including establishing partnerships for manufacturing COVID-19 rapid diagnostic tests, which were crucial for timely detection and patient isolation [68]. However, underlying socio-economic factors continued to significantly impact Senegal's healthcare system, leading to unequal health outcomes among certain communities during COVID-19 due to limited access to healthcare services [69].

Venezuela's already fragile healthcare system has been made even more vulnerable by the COVID-19 outbreak and socioeconomic unrest. Medicine is being practiced in a precarious manner due to healthcare workers leaving the industry due to unfavorable working conditions, low pay, as well as shortages of supplies, equipment, and necessities like water and electricity. These problems are exacerbated by the pandemic, highlighting the country's struggle to provide adequate healthcare services amid ongoing crises[70].

Finally, Taiwan where the neoliberal approach was adopted but balanced through commitment to social values and adopting universal coverage schemes. Taiwan's response to COVID-19 was recognized as proactive and effective [71]. During the COVID-19 pandemic, Taiwan's National Health Insurance NHI system played a crucial role in disease prevention efforts by facilitating easy tracking and access to potential patients. This demonstrated the effectiveness of a well-designed, universal, and equitable healthcare system in responding to public health challenges like COVID-19. Taiwan's NHI system is a single-payer approach that has achieved universal coverage, equity, and cost-effectiveness since its implementation in 1995. This government-run social health insurance program covers all residents, providing equitable medical and health care services based on principles of access, benefits, cost control, and administrative simplicity [72,73].

The negative effects of neoliberalism on health originate from the fact that within neoliberalism, health is treated as a normal service or commodity. Health is a human right, healthcare services should not and cannot be treated as a commodity. Regular commodities and services follow normal market rules such as elasticity and externality meaning that demand for a good or service changes in response to price fluctuations and that cost or benefit caused by one party is incurred or received by another. Health does not follow these rules. Healthcare services are not elastic, the demand for healthcare services is not sensitive to their price meaning that people will seek health regardless of the price as much as they can with their available resources. On the other hand, externalities are highly significant in health. Pollution is a negative externality that highly affects health while vaccination is a positive externality as it indirectly benefits individuals by reducing the likelihood of contagious illnesses.

Within a neoliberal approach healthcare sector characteristics are ignored. Neoliberal policies call for market- driven approaches for healthcare sector such as privatization where individuals are to pay for healthcare services. This is where access to care becomes significantly influenced by the price elasticity of demand for healthcare services. High costs may discourage people from getting essential medical care, especially those with little financial means leading to increased health inequities.

Neoliberal emphasis on market mechanisms, limited government intervention and deregulation give rise to health-related negative externalities. The deregulation and decreased governmental oversight in industry often result in water and air pollution, these are negative externalities with adverse effects on public health.

To counteract the negative effects of neoliberalism, healthcare should not be subjected to the same principles and dynamics as a typical market. Governmental intervention through regulations and expenditure are needed to ensure availability and equitable access to healthcare services. Moreover, health needs to be treated as a common good. A good that is neither rivalrous nor excludable is referred to be a common good. Non-rivalrous indicates that the use of the good by one person does not reduce its availability to others, and non-excludable means that people cannot be successfully prevented from enjoying the good. Health is non-rivalrous, meaning that one individual maintains good health does not diminish another individual to enjoy good health. Health, particularly public health measures such as disease prevention, sanitation, and vaccination programs, is non-excludable. Individuals cannot be prevented from enjoying the benefits of a vaccination program which prevents the spread of a contagious disease.

Lastly, it is crucial to acknowledge that although neoliberal policies frequently worsen disparities in healthcare outcomes and access, other important factors also come into play. Each country's response to neoliberal reforms and their healthcare system's performance during the pandemic cannot be fully understood without considering the varying levels of economic resources, political will, and socio-economic structures.

Study limitations

This study has several limitations related to the methodology used. The study depends on qualitative data from specific published cases. Although the cases for this study were selected based on a systematic search in one of the biggest databases for published literature, the included cases may introduce selection and publication bias. The study is a comparative study, despite using a comparative approach based on the stages heuristic model that was used in the first step of the analysis, each country's context is different challenging the ability to account for contextual specificities of countries, such as varying income levels, government capacities, and levels of development. These factors can influence the adoption and outcomes of neoliberal reforms, making direct comparisons methodologically complex. The study tries to relate neoliberal ideology adoption to healthcare system reform outcomes. However, causality is very complex to prove where various factors including neoliberalism may influence healthcare reforms. The stages heuristic model although recognized in policy analysis, has its limitations. The model assumes that the policy process is a linear process when it is an iterative process with feedback loops. SHM also do not concentrate on stakeholders' influence, power dynamics, and contextual variations which in our study the variations among countries in terms of institutional structures, legal frameworks and historical background.

Conclusion

In conclusion, the influence of neoliberalism on healthcare systems is profound, often deepening existing disparities

in access and outcomes. Countries embracing neoliberal policies typically face heightened healthcare challenges and inequities due to their emphasis on market-driven solutions and limited expenditure. While interventionist countries like China and Taiwan demonstrate more effective crisis management through their prioritization of universal healthcare, economic instability, as observed in Venezuela, can hinder such efforts. To mitigate neoliberalism's adverse impact on health, healthcare must be treated as a common good, necessitating robust governmental intervention and regulation to ensure equitable access and address negative externalities. While neoliberalism has long-term effects and is a significant factor, it's essential to recognize that countries' responses to health crises like COVID-19 are multifaceted, influenced by factors beyond neoliberal ideology alone, including strong leadership, prior experience, and economic resources. Therefore, a comprehensive understanding of healthcare systems must consider a diverse range of influences, recognizing both the role of neoliberalism and the broader contextual factors at play.

Conflicts of Interest

The authors declare no conflict of interest.

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