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COMMENTARY

From the right to health to the healthcare market: the progressive dismantling of the public system in Ecuador

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Over the last two decades, Ecuador's healthcare system has undergone profound changes. From significant expansion of access during Rafael Correa's administration in 2007 to the current privatization's focus promoted by President Daniel Noboa. The overall picture shows that this journey has been marked by advances, setbacks, and growing institutional uncertainty.

This commentary seeks to briefly analyse this journey, its structural implications, the challenges, and what is at stake for the right to health in Ecuador. We define health not only as the absence of disease, but, within the framework of Latin American social medicine or collective health, as the relationship between the health-disease process of individuals, groups, and societies and social determination and the conditions of social reproduction [1].

Healthcare reform and contradictions in the healthcare model during the Citizen Revolution

State spending on health rose from 1.1% of GDP in 2007 to 4.2% in 2018, and per capita spending rose from $209.52 to $516.25 [5]. However, this expansion was accompanied by corruption cases, persistent shortages of medicines and medical devices, and territorial planning disconnected from local needs. Those needs were not taken into consideration, for example, the marginalization of health promoters at the national level and the elimination of local health councils that included municipal participation in health decision-making [6,7]. In addition, free healthcare and increased referrals to private clinics drove the accumulation of capital in pharmaceutical companies, insurance companies, and private providers, thereby promoting a new neoliberal market dynamic in the health sector [8,9].

Despite the rhetoric of universalization, this period saw the dismantling of social security. Thus, based on the guarantee of continuity of health care established in the formation of the Health Integrated Public Network (Red Publica Integral de Salud in Spanish, RPIS), public funds were transferred to private clinics for patient referrals from public hospitals, neglecting improvements in the social security infrastructure itself. In addition, the State failed to comply with its obligations under the social security law with the IESS (Social Security Ecuadorean Institute). The Peasant Social Security was weakened by allowing individual affiliations since 2016 to replace the collective affiliation of peasant organizations, which was a central element of the innovative community health model of that social security scheme [10]. At the same time, while legal frameworks on the right to health were strengthened, social participation was further restricted and critical organizations were persecuted, with nearly 700 social leaders prosecuted [11]. Furthermore, persecution was enabled with the application of mechanisms for the "purchase of mandatory resignations" from public officials, including health professionals [12]. In the name of efficiency, the health administration prioritized the international accreditation of hospitals and replaced health professionals with administrators, resulting in a reduction in epidemiological surveillance [13,14]. In addition, a logic of productivity was imposed on health personnel, evaluating their performance based on indicators and transforming the patient-doctor relationship into a "customer" and "provider" transaction dynamic [15].

In terms of health care, the reforms promoted the Comprehensive Health Care Model (MAIS), based on Primary Health Care (PHC), and the State resumed a strong guiding role, regaining leadership in the national health system [16]. However, this concentration limited local autonomy and made it difficult to adapt to diverse contexts. The reforms progressed rapidly but lacked sufficient planning in terms of financial sustainability, staff training, and supply of inputs. Despite this, sustained social investment improved some indicators, such as a decrease in maternal mortality and increased access to basic services [17-19].

The government's disconnect with medical organizations and federations, as well as with indigenous organizations, women's organizations, and health workers'

unions, limited the effective implementation of PHC in different territories. There were setbacks in the area of sexual and reproductive health. One of those was the abolition of the Free Maternity Law Enforcement Unit, which allowed monitoring the implementation of this law through the independent oversight by women's organizations in health services. Another one was the elimination of the specific budget allocated to the care of women and children under five, under the argument of universal health care. Added to this was the criminalization of abortion in the Comprehensive Organic Criminal Code, which led to the prosecution of 503 women for this crime between 2014 and 2021 [20], as well as the imposition of the Family Plan, which promoted abstinence and replaced a more comprehensive approach previously developed in the National Intersectoral Strategy for Family Planning and Prevention of Adolescent Pregnancy (ENIPLA) [21].

During this period, health policy functioned as a tool of partisan hegemony, meaning that strategies to expand access to and free public health services were mechanisms for garnering electoral support [14]. The expansion of public services without infrastructure proportional to demand weakened the public system and favored a model closer to the privatization of health services. Between 2008 and 2014, transfers to private hospitals totaled USD 2.201 billion [22]. In short, although between 2007 and 2017 there was an unprecedented expansion of health spending and access to services, a technocratic, centralized model dependent on the private sector also took hold, where the promise of universalization coexisted with a high concentration of political and economic power.

The lost decade of leadership in health

After Correa's term ended in 2017, the successive governments of Lenín Moreno (2017-2020) and Guillermo Lasso (2021-2023) adopted a regressive stance on public health policies. During this period, adjustments were made to the state's role in health care. There were varying levels of efficiency in the management of public health resources. While it is true that Moreno inherited an Ecuador with a debt of US$42 billion, corresponding to 42% of gross domestic product (GDP) and exceeding the 40% limit established by the Constitution [23]; in the name of "austerity" and "efficiency," budgets were frozen, health personnel were laid off, and numerous community health programs were paralyzed, directly affecting access to health services.

Improvisation replaced planning. During Lenín Moreno's administration, there were at least six health ministers, while Guillermo Lasso's administration appointed two ministers in a period of just a year and a half. This high turnover is evidence not only of the country's political instability, but also of the institutional fragility of the health sector in particular. In this context, public health became increasingly marginalized on the government's agenda. Meanwhile, the IESS, which is crucial for providing health care to millions of its members, continued to suffer from mismanagement and chronic corruption [24].

The present: moving towards the dismantling of the public health system

The government of Daniel Noboa (2023–present) has strongly revived a technocratic narrative focused on the "modernization" of the state through the privatization of key services. In health, this orientation has been reflected in a progressive dismantling of the public system, beginning with a drastic reduction in funding for the MSP: more than $1.3 billion was cut, severely affecting the operational capacity of health facilities at all levels of care [25].

Added to this is the reversal of the decentralized management model—based on health zones and districts—toward a centralist, slow, and inefficient scheme already seen prior to the 2008 constitution [26]. In response to shortages of medicines and medical devices, the executive branch created a new National Public Health Committee, whose strategy of centralized bulk purchasing has exacerbated the shortage of essential supplies and favored large private suppliers [26,27].

Staff cuts and the loss of institutional capacity cannot be explained solely by the demands of the International Monetary Fund (IMF), but also by the inefficiency and lack of technical leadership within the MSP itself: five health ministers in less than two years in office. The result is a weakened public system that is dependent on and increasingly subordinate to private interests.

Recently, actions and attention have focused on the IESS. President Noboa recently stated: "Inconsistencies and gray areas must be eliminated. Social security should not be a health provider; that should be the responsibility of the MSP" [28]. The initiative to "outsource" or even modify the current IESS health model, possibly transferring its management to private entities, proposes a profound structural change with potentially serious repercussions. It is not just a matter of streamlining processes: what is at stake is the guarantee of universal access to health care as a fundamental right. This door was already opened with the proposal for the Sectoral Transformation of the Health Sector presented at the beginning of Health Minister C. Chang's term in 2008 and is currently being further developed.

Regional experiences, such as those in Chile and Colombia, have shown that private insurance-based systems deepen inequalities and further fragment health care [29,30]. Instead of resolving the structural problems that the IESS had been facing since the decade of the Citizen Revolution, the Noboa administration has chosen to push members (more than 3 million contributors) toward systems that prioritize profitability over coverage. Added to this is a discourse that criminalizes public inefficiency without offering real alternatives for institutional strengthening. The "private solution" appears to be a magic formula, when in reality it could become a costly trap for the state and a death sentence for those

who cannot afford insurance or co-payments.

What future do we want for health in Ecuador?

What is at stake today is not only a model of management and care, but also the public and universal nature of healthcare in Ecuador. The reforms promoted by Correa, with their ups and downs, demonstrated that with political will and constant investment, it is possible to move toward a more inclusive healthcare system that seeks access for all [19]. Now, the shift toward the privatization of health care threatens to consolidate an exclusionary model in which the quality of care depends on the out-of-pocket expenditures of each individual or family. To reverse this trend, the state must regain its role as guarantor of rights, strengthen the IESS through structural reforms and, above all, develop a health policy based on long-term financing and provision of health services, with social participation and social justice criteria as established in the constitution. By 2026, Ecuador faces enormous challenges: how can a health system be built in a context where illicit drug-related economies move nearly US$3.5 billion and employ approximately 50,000 people? [31,32]; how should health services adapt to territorial scenarios affected by social violence? And, above all, how can the health system recover resiliently in the face of this reality? Building health for all requires addressing the restoration of a society frayed by violence, in which health services are not excluded from that reality [33].

The debate on the health system requires a national, democratic, and transparent discussion that goes beyond technocratic or business sectors. It is essential to reactivate the participation of social organizations, including those linked to health that have managed to survive despite processes of demobilization and institutional weakening. Health is not a commodity; it is a fundamental right, and defending it is everyone's responsibility.

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