

Latin America: priorities for universal health coverage



To achieve universal health coverage, a definition of what coverage everybody is guaranteed is needed. In view of the gap between what is medically possible and what is financially feasible, some type of rationing is inevitable in all societies. So the decision is not about whether to prioritise, but how best to achieve this.¹ However, this issue is often neglected or is an afterthought in the debate about universal health coverage. This situation arises because explicit priority setting is contentious, politically charged, and technically challenging, and it is rarely studied and poorly understood.² Thus, lessons from Latin America are especially relevant. More than any other part of the world, countries in this region have introduced explicit priority setting to define their health benefit plans.^{3,4} Advocates argue that the results are potentially more effective, equitable, transparent, and efficient than are implicit rationing practices, which include waiting lists, quality adjustments, or user fees.⁴

The first lesson is that benefit plans take different shapes and sizes, and are not restricted to a list of essential services for societies with severe resource constraints. Giedion and colleagues⁴ highlight the heterogeneity of approaches used by Latin American countries to establish priorities and to design and deliver benefit plans. The scope ranges from broad to narrow, in terms of types of technologies used, disease control priorities, and eligible populations. For example, Uruguay's *Plan Integral de Atención en Salud* (PIAS) is comprehensive for everybody and provides integral universal care for health disorders throughout the life cycle, mainly at primary care level, and an extensive catalogue of more complex diagnostic and therapeutic services, independent of provider.⁵ Chile's *Acceso Universal con Garantías Explícitas* (AUGE) plan includes legally enforceable entitlements to a comprehensive set of services for a prioritised group of diseases, but does not deny health care for other disorders, which remain subject to waiting lists.⁶ Thus, AUGE is comprehensive for some diseases. Colombia's *Plan Obligatorio de Salud Subsidiado* (POSS) selects interventions across disease groups to establish a set of health-care services guaranteed by the state, which means that all people can receive a limited set of services.⁷

Other plans are designed for eligible subpopulations. The Mexican *Seguro Popular* benefit plans for people outside the social security system prioritise catastrophic

coverage for complex benefits (*Fondo de Protección contra Gastos Catastróficos* [FPGC]) coupled with groups of interventions in *Catálogo Universal de Servicios Esenciales de Salud* (CAUSES).⁸ Peru's *Plan Essential de Aseguramiento en Salud* (PEAS) prioritises health disorders, but provides more limited essential health-care services for specific groups.⁹ *Plan Nacer* in Argentina and *Paquete Básico de Salud* (PBS) in Honduras focus on health care for poor mothers and children.^{10,11} All of these programmes are examples of coverage of specific population groups with some interventions, rather than universal plans.

A second lesson relates to the large institutional capacities needed to define and regularly update benefit plans. Institutions find fulfilling their promise very resource intensive; sustained political and technical leadership backed by legal underpinnings are required. Good technical processes are a *sine qua non*, encompassing health needs assessment and appraisal of new technologies and intervention alternatives, and planning and service delivery organisation. Politically, balancing various, at times conflicting, interests is needed. Robust regulatory measures need to be in place to keep vested interests from serving narrow parochial interests of industry, specific groups, or organisations, and consequently distorting national health goals. For example, by law in Chile the definition of AUGE requires the use of epidemiological, burden of disease, and cost-effectiveness studies and must consider social preferences and feasibility. Mandatory consultative

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procedures are led by an independent, technical consultative council.¹² Despite the transparency of the Chilean process, questions remain about fairness and the level of public participation.¹³ Furthermore, benefit plans that enhance universal health coverage must be backed by adequate resources to transform a list of priorities into the reality of available, accessible, and acceptable quality services. Thus, mobilisation of financial resources and investment in human resources and infrastructure are fundamental to universal health coverage.¹⁴

Third, although benefit plans and their definition processes continue to evolve in Latin American countries, improved monitoring and assessment at national level are urgently needed to establish whether plans have effectively translated into improved health and health equity and more satisfied citizens. In Mexico, there is evidence that *Seguro Popular* has contributed to closing gaps between service coverage, financial protection, and treatment of people with health disorders.¹⁵ In Chile, after the inclusion of breast cancer in AUGE in 2005, biopsies nearly doubled and surgery rates with breast reconstruction more than tripled. More importantly, early detection of all breast cancer cases diagnosed at stage 1 improved from 68% to 75%, and late diagnosis (stage 4) decreased from 9% to 4%.¹⁶ Nevertheless, the potential for displacement of people whose disorders are not covered by plans remains an equity concern.¹³

Worldwide, a forward-looking research and competency development agenda on priority setting is needed to disseminate what is known more widely, investigate what is not known, and support capacity building to do what has to be done to accelerate action on universal health coverage. Learning more from Latin America is a starting point.

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Conditional cash transfers and health in Latin America

In the 1990s, several Latin American countries started implementing a social policy innovation, conditional cash transfer (CCT) programmes, which have been replicated elsewhere. In poverty reduction policies, CCT programmes have two goals: to increase the resources available for consumption, to meet basic needs of low-income families; and to foster human development, to interrupt the intergenerational transmission of poverty. In CCTs,

monetary and non-monetary resources and a range of social services are provided to families living in poverty on the condition that they adhere to commitments in the areas of education, health, and nutrition.

So far, these programmes have been implemented in 16 countries in Latin America and reached a fifth of the population. CCTs address poverty in a holistic manner by implementing cross-sector interventions

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