Universal health coverage in Latin America 2

Overcoming social segregation in health care in Latin America

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This is the second in a Series of four papers about universal health coverage in Latin America

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Latin America continues to segregate different social groups into separate health-system segments, including two separate public sector blocks: a well resourced social security for salaried workers and their families and a Ministry of Health serving poor and vulnerable people with low standards of quality and needing a frequently impoverishing payment at point of service. This segregation shows Latin America's longstanding economic and social inequality, cemented by an economic framework that predicted that economic growth would lead to rapid formalisation of the economy. Today, the institutional setup that organises the social segregation in health care is perceived, despite improved life expectancy and other advances, as a barrier to fulfilling the right to health, embodied in the legislation of many Latin American countries. This Series paper outlines four phases in the history of Latin American countries that explain the roots of segmentation in health care and describe three paths taken by countries seeking to overcome it: unification of the funds used to finance both social security and Ministry of Health services (one public payer); free choice of provider or insurer; and expansion of services to poor people and the non-salaried population by making explicit the health-care benefits to which all citizens are entitled.

Introduction

This Series paper underlines one distinctive feature of Latin America's efforts to move towards universal health coverage: the drive to overcome social segregation in health care and its concomitant health-system segmentation, as part of a broader effort to promote equality of opportunities and effective exercise of the, in many countries constitutional, right to health care.[1]

Key messages

- During the late 20th century, health-care coverage for poor people and health outcomes for most of the population in Latin America improved substantially; but despite this achievement, the simultaneous segmentation of health care created a perception of inequity and exclusion.
- Since the right to health care and the right to equality of opportunity have become mainstreamed, the gap between the two public sector blocks (Ministry of Health and Social Security) in quality of health care and financial protection for those needing it is increasingly unacceptable.
- A change in values has transformed health systems. Personal health care was once regarded as the work of charity. It then became the prerogative of one sector of the economy (a labour benefit), and now it is deemed by many as a social right. Public health was initially about mitigating risks to trade, then about the opening of new territories; today it is about investing in people.
- Countries in Latin America are converging in their desire to overcome health-care segregation, but not in the way to do it. Countries are following three different paths to reach this goal: single-payer, choice of payer, and explicit minimum benefits. Each of these paths has both merits and shortcomings, and can offer lessons to the rest of the world.

In our initial outline of developments in health systems in Latin America, the emphasis is on reform efforts that began in the late 20th century and intensified at the beginning of the 21st century. Our focus is on the background of the creation of two public sector blocks: a well endowed social security system and a poorly financed Ministry of Health. Insights by Juan Luis Londoño and Julio Frenk, at one time Ministers of Heath in Colombia and Mexico, respectively, show that in countries with a segmented model, different population groups are attended to by different institutions. Poor people tend to be served by the Ministry of Health, the formal sector workers by social security agencies, and the rest of the population by the private sector.[2] Social security agencies historically have had substantially higher amounts of funding per person, access to larger benefits packages, better quality of care, and no charges at the point of service compared with the lower quality and the limited financial protection provided by the services of the Ministry of Health. Additionally, each health institution is vertically integrated in the sense that it performs the financing, delivery, and governance functions, but does so only for the population with which it is associated.

In Latin America, the segregation of poor people from the formal sector populations is especially rigid because of the existence of separate hospitals and medical facilities for the exclusive use of social security enrollees. Frenk[3] even characterised this segregation as a "medical apartheid", even though there was no legal restriction on the use of social security health services strictly on the basis of racial or ethnic characteristics. Roemer[4] also stated that in Latin America "one could readily identify a person's social class by examining the way he obtained medical care".

Nowadays, social segregation in segmented health systems is perceived as a major obstacle to the reduction of gaps in health-care access.[5] To overcome this gap (the

	Phase 1: pre-national institutions	Phase 2: national institutions	Phase 3: primary health care and consolidation of segmentation	Phase 4: overcoming segregation
Milestone defining the beginning of each phase	Independence.	Creation of Ministry of Public Health.	Consolidation of social security institutions.	Implementation of one of the paths to integration.
Values and assumptions underpinning health care	Public health is acknowledged as a limited state responsibility, mostly linked with trade and economic use of territories. Personal care is initially an object of charity by religious orders and evolves to beneficencias (philanthropic elite-led organisations).	Public health is a state responsibility. Personal services for formal sector workers become a responsibility or right linked to labour status and financial contribution; for poor people, it becomes a form of social assistance.	Two views of public and primary health care: comprehensive (a social right) and selective (an instrument for individual and economic development linked to control of specific health problems and management of what was perceived as the population time-bomb). Personal services for the formal sector perceived as benefits from a truncated welfare state.	Increased consensus around the idea that health care is a social right—linked to general consolidation of democracy. Epidemiological change requires going beyond communicable, maternal, and child health. Recognition that economic growth might not lead to a fully formal economy. Economic growth facilitates expansion of public expenditures in health.
Public health	Public health and sanitation interventions initially aimed at facilitation of trade by focusing on ports and later on increasing the productivity of export-producing areas. Later in this period, all countries create offices in charge of sanitation linked to the ministries in charge of public activities, such as law enforcement.	Public health is the main responsibility of a sectoral ministry. Public health often includes responsibility for improved water and sanitation. Dissemination of scientific measures of control. Countries initiate vertical programmes against malaria, yellow fever, yaws, hookworm, and smallpox.	Expansion of primary health care combining public health with child, maternal, and population services. Immunisation and vertical programmes coexist with broader holistic programmes that aim to improve the living conditions of poor people. Rapid expansion of improved water and sanitation.	Governments slowly owning up to new behavioural risks, including by implementing multisectoral policies linked to tobacco, obesity, violence, and other social determinants of health. Epidemiological surveillance continues to be strengthened.
Institution building at the national level	In the 19th century, development of hospital beneficencias, which become autonomous from religious orders. In the 20th century, state participation in international public health coordinating events; 1924 PAHO conference defines health as a responsibility of the state. Reliance on family and community support, and practitioners of traditional medicine (mainly indigenous and African-American).	Creation of Ministry of Public Health in charge of public health interventions. Implementation of vertical campaigns against communicable diseases. In many countries, the ministry is also in charge of providing social assistance through public hospitals; charity hospitals become state-owned (often attached to medical schools) and health workers become public workers. Some building of public hospitals but provision of care is seen as a transitory responsibility of state, waiting for populations to become incorporated into the formal economy. Separately, social security institutions are created, initially created as financing institutions but gradually moving to the provision of personal health services.	Ministries evolve from the Ministry of Public Health and Assistance into the Ministry of Health. Massive efforts to expand essential child and reproductive services to previously underserved regions and populations through vertical programmes. Extended implementation of user fees for interventions not included in vertical programmes, especially at a hospital level. In many countries, health functions are decentralised, usually as part of a wider political process. Consolidation of social security institutions into fewer larger institutions. Social security benefits are extended to dependants of formal sector workers. Some countries launch market-oriented reforms. Initial development of private insurance. Rapid growth of private hospitals.	Countries that enter phase 4 (seeking equity) aim to reduce inequalities in access and in financial protection. They choose from one of three paths: integration of the financing of social security and public subsectors into a single-payer sector; allowing a choice of insurer to all populations; or maintaining segmentation of financing or provision, but making efforts to increase per person financing of the public sector and to mandate explicit benefits. In a few countries, expansion of comprehensive primary health care through family health strategy.

PAHO=Pan American Health Organization.

Table 1: **An institutional history of health systems in Latin America**

differences in social protection in health) between the two public sector blocks is a central feature of Latin American's attempts to move towards universal health care and is thus a key point on the universal health coverage agenda.

Here, we discuss in detail the various paths that countries in the Latin American region are taking to expand coverage and overcome segmentation. We also apply both recent and historical perspectives to identify lessons that might be useful worldwide.

Several provisos need mentioning. First, our analysis refers to the evolution of both personal and public health services; personal services are defined as preventive, diagnostic, therapeutic, and rehabilitative actions applied directly to individuals and the public services as actions applied by health-sector agencies either to collectivities (eg, mass health education) or to the non-human component of the environment (eg, basic sanitation).[6] Second, because of the paucity of information, we have not addressed the increasingly important topic of the private sector's role in the provision of social protection in health, but postponed this topic for future research. Third, we have not mentioned social determinants of health and their role in the quest for universal health coverage because one of the companion papers[7] in this Series is fully devoted to this important topic.

Key developments in the health systems of Latin America

Phases of health system development

Many factors have contributed to the transformation of health systems in Latin America. Objective factors include economic, health (demographic or epidemiological), political transitions, and the global availability

	Argentina	Brazil	Chile	Colombia	Costa Rica	Mexico	Peru
Start of phase 1: independence	1816	1822	1818	1810	1821	1810	1821
Start of phase 2: creation of Ministry of Public Health	1946	1930	1924	1938	1927	1943	1935
Start of phase 3: merger of social security agencies for the exclusive benefit of salaried workers and their families	1971 (compulsory affiliation to *Obras Sociales* and creation of PAMI)	1967 (creation of INPS)	..	1946 (creation of ISS)	1973 (integration of social security and Ministry of Health hospitals)	1982 (railroad workers join IMSS)	1973 (creation of IPSS)
Start of phase 4: either integration of social security and Ministry of Health or implementation of actions to equalise Ministry of Health with social security	..	1989 (creation of SUS)	1952 (creation of SNS; 1979 creation of Fonasa as one public payer; and 2005 [AUGE])	2012 (equal benefit plans mandated by constitutional court are implemented)	1984 (integrates informal workers to CCSS)	2004 (*Seguro Popular*)	2010 (legislated, not yet implemented)

PAMI=*Programa de Atención Médica Integral*. INPS=*Instituto Nacional de Previdência Social*. ISS=*Instituto de Seguridad Social*. IMSS=*Instituto Mexicano del Seguro Social*. IPSS=*Instituto Peruano de Seguridad Social*. SUS=*Sistema Único de Saúde*. SNS=*Servicio Nacional de Salud*. AUGE=*Acceso Universal con Garantías Explícitas*. CCSS=*Caja Costarricense de Seguridad Social*.

Table 2: **Historical milestones for four phases of health system history in selected Latin American countries**

of technological and institutional or organisational innovations.[8–10] Ideological factors include changes in values regarding the role of health-care services in society and in the prevailing development paradigm. However, and simplifying substantially for the sake of the bigger picture, we identify four distinctive, yet to some extent overlapping, phases in the history of health systems in Latin America (table 1).

The first two phases took place in the context of very inequitable societies, which fuelled the creation of health systems characterised by the institutional segmentation of the delivery of health-care services across different population groups on the basis of social class or employment status.[11] The milestones that marked the initial two phases were political independence and the creation of the first Ministry of Health, respectively (table 2). During the first phase and the first half of the second phase, attention to public health services dominated health systems. The milestone that marked the third phase in each country was the consolidation of segmentation of the health system through changes in social security legislation that created one block of the population that was included under the umbrella of welfare legislation and another block that was excluded. This phase was also characterised by the expansion of primary health care, which improved the provision of personal health services for poor people. Yet, the social segmentation of health-care services and the segregation of population groups was maintained and in many cases deepened. The fourth phase begins when countries attempt to equalise benefits, health-care quality, and financial protection across population groups, thus reducing the segmentation of their health systems in an effort to achieve universality. As opposed to the other three phases, which took place at similar periods of time in most Latin American countries, the fourth phase started at very different moments in each country. It began in 1952 in Chile, in 1960 in Cuba, in 1984 in Costa Rica, in 1989 in Brazil, in 1993 in Colombia, and in 2004 in Mexico.

Each country transitioned to the next phase at its own pace, so there are substantial lags between the date of achievement of a specific milestone in one country and that of the neighbouring countries. This lag implies that often the process of health-policy diffusion becomes apparent only after a sufficiently long historical perspective. We posit that policy convergence will happen in the transitions to phase 4. Although in several countries it has yet to begin, the spillover effects from countries that are striving to achieve universality of coverage are likely to stimulate most countries to move in this direction.

Phase 1: pre-national health institutions

The initial phase of health-system development in Latin America runs from the year of declaration of independence in each country to the creation of the first national-level health institutions (eg, the Ministry of Sanitation or Public Health, which, depending on the country, were mostly created in the 1930s and 1940s).

The main activity of health institutions was the provision of public health or community services, which by the early 20th century, with the consolidation of the germ theory of disease, was increasingly on the basis of scientific evidence.[12] In international trade-oriented economies, the initial focus was on the prevention and control of epidemics—mostly of cholera, plague, and yellow fever—through the sanitary management of ports, mainly through the establishment of quarantines.[13] This focus later expanded to the control, beyond ports and borders, of all those diseases that prevented the economic use of any region for the production of high-value exports.[14]

Public health services in Latin America achieved formal institutional status with the creation of national

specialised offices, often under the umbrella of the ministry in charge of policing law enforcement.[15] The development of these offices and the association between them was strengthened by the organisation of the General International Sanitary Conventions of the American Republics that started in 1902 and the establishment of the International Sanitary Bureau that same year, renamed Pan American Sanitary Bureau in 1923.[16,17]

The delivery of personal health services also underwent a slow but substantial transformation during this phase. In the colonial period, most personal health services were provided at the household level. Hospitals were mostly shelters for pilgrims and very poor and sick people and were managed not by doctors but by religious orders.[18] In the late 19th century, these hospitals were increasingly reorganised as autonomous philanthropic institutions managed by local elites, which expressed a change in the values associated with health care from religious to private or secular charities.

The Latin American countries with high 19th century and early 20th century European immigration (eg, Argentina, southern Brazil, Chile, Cuba, and Uruguay) also witnessed the initial development of social insurance in the form of sickness funds, mutual aid societies, and other self-help organisations.[19]

Phase 2: creation of modern national health institutions

Phase 2 includes the establishment of the modern national health institutions that continue to shape health systems in Latin America today: the Ministry of Public Health and the social security institutions. The milestone associated with the beginning of this second phase in each country is the creation of an independent ministry in charge of public health. For most countries, this creation of an independent ministry happened during the 1930s and 1940s, and the core function assigned to these institutions was the provision of public health services. The creation of these agencies allowed the channelling of financial and human resources to launch large-scale public health campaigns through vertical programmes, which took advantage of newly available technology for the management of a narrow range of common infections and parasitic diseases. As a result, mass campaigns against yaws, smallpox, polio, tuberculosis, trachoma, leprosy, onchocerciasis, brucellosis, and malaria were implemented throughout the region.[20]

Hunt,[21] the economic historian who has produced the most extended series of life expectancy data for Latin America covering the 20th century, points out that the launch of these campaigns coincided with the beginning of a period of rapid increase in life expectancy in Latin America. During the initial decades of the 20th century, average life expectancy in Latin America increased by only 1–2 years per decade and the gap in life expectancy between Latin America and the USA grew continuously, reaching a peak of 25 years in the 1940s

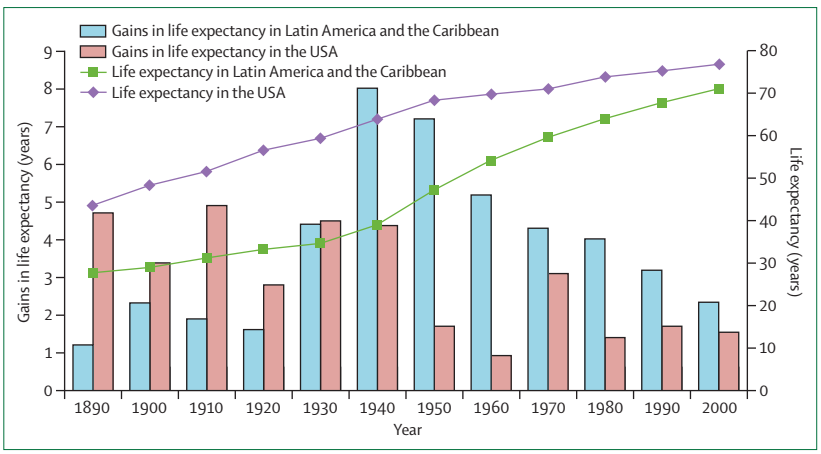

Figure 1: **Gains in life expectancy in Latin America, the Caribbean, and the USA from 1890 to 2000**
Data from Hunt.[21]

(figure 1). After that period, and coinciding with the public health campaigns, life expectancy in Latin America rose more quickly. The decades of fastest growth in this indicator were the 50s, 60s, and 70s, with gains of 8·0, 7·2, and 5·2 years, respectively. In this period, the life expectancy gap between Latin America and the USA decreased to less than half its peak of the 1940s.

During this second phase, ministries of public health were gradually given additional responsibilities: first to oversee the provision of personal services offered by charity hospitals, but then to provide personal health services themselves, mostly to poor people in urban and rural areas, a function perceived at the time as public assistance.[22] Many ministries in the region showed this new responsibility by adding this new function to their initial name: Ministry of Hygiene, Assistance and Social Welfare in Chile (1924), Ministry of Public Health and Social Protection in Costa Rica (1927), Ministry of Public Health and Assistance in Mexico (1943), and Ministry of Public Health and Social Assistance in Peru (1942).[15] At the same time, new public hospitals were built and charity hospitals were transformed into larger and, thanks to additional public resources, better endowed facilities, which hired health workers as civil servants.[23]

In most of Latin America, these decades also witnessed growing employment in manufacturing, extractive industries, government services, and professionalised armed forces. Influenced by the European social security tradition, most countries created social security institutions to serve the workers of these sectors, usually providing a combination of old-age and disability pensions and health-care benefits. These include the Retirement and Pension Fund (*Caixas de Aposentadorias e Pensões*) in Brazil in 1923, the Compulsory Insurance Fund (*Caja de Seguro Obligatorio*) in Chile in 1924; the Worker's National Insurance Fund (*Caja Nacional del Seguro Obrero*) in Peru in 1936; the Costa Rican Social Security System (*Caja Costarricense del Seguro Social*) in 1941; the National Medical Service for Employees

Panel 1: **Pioneering social desegregation of health care in Chile and Cuba**

In 1952, Chile took the unprecedented step in Latin America of integrating most of the government's major health services into one entity, including the facilities of the manual labourer social security system (*Caja de Seguro Obrero*) and the Ministry of Health facilities serving poor people, creating a National Health Service (*Servicio Nacional de Salud* [or SNS]). This new entity was inclusive of different populations and built on the initial attempts in 1939 by the then Minister of Health of Chile, Salvador Allende, to create national services.[39] The SNS strengthened the role of the government as a direct provider of personal health services and invested heavily in the training of health professionals. Further, by requiring doctors to undertake residencies in rural areas, SNS was able to effectively reach most of the population with basic health services by the end of the 1970s.[23]

After this achievement in health-care coverage, the Chilean health system suffered a major setback. In 1973, Augusto Pinochet overthrew the socialist government of Salvador Allende and established a dictatorship. In 1979, the Pinochet regime introduced reforms aimed at weakening the vigorous Chilean public health sector to make way for a greater role of the private sector. This included streamlining public institutions by creating one national health fund (*Fondo Nacional de Salud* [or FONASA]) and the National Health Service System (*Sistema Nacional de Servicios de Salud* [or SNSS]), decentralisation of the delivery of health services to 26 regional entities, and expansion of the role of municipalities in the management of public health-care facilities.[23,40] 2 years later, the Chileans were given the option of transferring their payroll contribution from FONASA to the newly created *Instituciones de Seguridad Previsional* (or ISAPRES) to purchase private health insurance. When democratically elected governments returned to power in the 1990s, they started rebuilding public financing and expanding health-care coverage by strengthening the financial support to FONASA and SNSS, and improving the scope and quality of public services, while enacting stronger rules to regulate ISAPRES. A major step towards the achievement of universal health coverage was taken with the establishment of the Universal Access with Explicit Guarantees Program (*Programs de Acceso Universal con Garantías Explícitas* [or AUGE]) in 2005.[41]

In Cuba, measures to reduce segmentation and expand health-care coverage were also implemented mid-century. In the 1950s, the country boasted one of the highest life expectancy figures in the world. Additionally, the infant mortality rate was the lowest in the Latin American region, 33·4 per 1000 livebirths in 1958, much below that of Argentina (61·1), Chile (126·8), Costa Rica (89·0), and Mexico (80·8).[42]

The Cuban revolution built on the achievements of the pre-revolutionary Cuban health system which, similarly to most health systems in Latin America, was segmented by social class.[43] After the revolution, the Ministry of Public Health was put in control of all resources for health and immediately started a programme of nationalisation and regionalisation of medical services. By 1970, the last mutualist hospital and clinic were collected into one public network, therefore placing all facilities under government control.[44] Major achievements in health conditions were reached in a short period of time, to the point that the Cuban experience has been regarded for several decades as one of the best examples of achieving good health care at a low cost.

(*Servicio Médico Nacional de Empleados*) in Chile in 1942; the Mexican Social Security Institute (*Instituto Mexicano del Seguro Social*) in 1943; and the Colombian National Welfare Fund (*Caja Nacional de Previsión*) in 1945 and the Colombian Institute for Social Security (*Instituto Colombiano de los Seguros de Salud*) in 1946.[15] These institutions were created in response to the mobilisation of various factors: unions demanding health care within a platform of labour rights, employers seeking to maintain a healthy workforce, political parties pursuing partisan objectives or health professionals looking to address public health challenges.[24] In most Latin American countries, the social security institutions developed hospital networks for the exclusive use of their affiliates.

In many of these countries, separate social security agencies were created to serve workers from different social groups (eg, manual labourers, office workers, and civil servants) and from different sectors (eg, oil workers, railroad workers, the armed forces, and the police). The health-care services offered by these agencies were typically for the benefit only of the workers (not their dependants), and initially focused on addressing occupational health and workplace injuries.[11] Poor people from rural and urban areas were almost uniformly excluded from social security facilities and could only meet their health needs through services offered by the ministries of health.[3]

Phase 3: providing increasing health benefits for the poor, non-salaried population while consolidating segmentation of the health system

Paradoxically, phase 3 included both an expansion of health-care services directed towards poor people and the simultaneous implementation of policies that deepened the segmentation between the two public sector blocks: the social security system providing health care to the workers of the formal sector of the economy and their families, and the ministries of health providing services for the non-salaried population, including poor people in urban and rural areas.

The first defining characteristic of this phase was the expansion of primary health care, which expressed the spirit of the 1978 Declaration of Alma-Ata and the adoption of the "Health for All in the Year 2000" strategy launched in 1979 by the World Health Assembly.[25,26] In most countries, this expansion had two features that gave it a strong pro-poor emphasis. First, it included an effort to reach underserved rural and peri-urban areas, which at the time covered most poor people. Second, it included adding child, maternal, and family planning services to the programmes fighting communicable diseases created during phase 2. The coverage of underserved areas was achieved through a rapid expansion of health posts and clinics, and the provision of services through the use of new and cost-effective medical technology, such as vaccines, oral rehydration therapy, and family planning methods. This expansion of primary health care took place, depending on the country, during the 1970s, 1980s, or 1990s. The rapid gains in life expectancy obtained in phase 2 continued during phase 3.

The second defining feature of this period was the creation of a truncated welfare state.[27] In earlier decades, individual firms or industries would decide what benefits to offer to their workers and whether these benefits would extend to their dependants. During this phase, these benefits become mandatory and more

homogeneous through legislation designed to create a welfare state. Jobs offered by formal sector firms had to offer the legal benefits. The theory was that all jobs should offer these benefits; in practice, it deepened the gap between a population with access to welfare state benefits and a population excluded from these benefits. There were two changes in the coverage and operation of social security agencies. First, the addition of the worker's family to the group of beneficiaries of social security, and second, the merger in many countries of social security institutions, which also included a merger of their health-care networks. In some countries, such as Brazil in 1967 and Peru in 1973, the institutions covering civil servants were merged with those covering office-based private sector employees and manual labour employees, creating a wide formal sector block. In others, private sector manual labourer and office-based worker social security agencies were integrated but remained separate from the civil service.

This third phase also included the implementation of decentralisation efforts in many of the ministries of health of the region, although not in social security institutions. The decentralisation process at this stage of health system development basically consisted in the transfer of responsibility for the provision of personal health services to provincial, state, or municipal health authorities.[28–30]

The 1980s were marked by severe macroeconomic instability and debt crisis, which affected most countries in the region. Governments reacted by imposing austerity plans, often with support of the international financial institutions. These austerity plans in turn had an effect on the design and implementation of health policy. Countries having authoritarian rule, and most notably Chile under military dictatorship, implemented macroeconomic stabilisation policies, which severely reduced public sector spending on health.

Governments in several countries also introduced or expanded user fees for health services, drugs, and other medical inputs, especially those provided in hospitals. The rationale behind the widespread introduction of user fees was to mobilise additional resources for public health-care facilities.[31,32] Research done in several developing regions eventually showed that user fees constitute major obstacles to the use of health care in poor communities, diminish adherence to long-term treatments, and can be impoverishing.[33–35]

In most parts of Latin America (and also within the major international financial institutions), there was resistance to the proposals to curtail investment in health. A cadre of international experts, including leading thinkers from Latin America, worked jointly to develop more innovative policies. As evidence of the disadvantages of user fees emerged, countries increasingly moved away from them and towards more effective options to finance health care that characterise the health reforms of phase 4.

Panel 2: Health care in Brazil, Costa Rica, Colombia, and Mexico

As part of the democratisation process witnessed in Brazil in the late 1980s, a broad social mobilisation known as Public Health Movement or *Movimiento Sanitarista* promoted the creation of the Unified Health System (SUS).[45,46] The 1988 Constitution formalised the creation of a public system that recognises health care as a citizen's right; the state's obligation to provide comprehensive, preventive, and curative care through decentralised public entities or third parties; and the need to promote community participation at all managerial levels, guaranteed through representation in the health boards. The implementation of SUS included a broad and ambitious reform that transformed many aspects of the health system, including governance, financing, health delivery, and social participation. In terms of financing, the creation of SUS involved the fusion of the contributory social security and the Ministry of Health.

A few years later, Costa Rica also launched a major policy initiative to integrate social security and the Ministry of Health and achieve universal health coverage. Through the National Plan for the Reform of the Health Sector, the Ministry of Health transferred its inpatient and primary health-care units to the Costa Rican Social Security System (*Caja Costarricense de Seguridad Social* [or CCSS]); expanded and strengthened its primary health-care teams (*Equipos Básicos de Atención Integral de Salud* [or EBAIS]) to reach poor and vulnerable populations; and assumed the stewardship role of the national health system.[47–50] The CCSS, which is financed with employee, employers, and government contributions, is now the one public provider of comprehensive health care that is made available to the entire population. Although private providers also offer health-care services which are paid mostly out-of-pocket, financial protection and coverage in Costa Rica are extremely well developed and substantial out-of-pocket health spending is rare.[51]

In Colombia, the 1991 Constitution established health care as a right and made the national government responsible for the provision of health services with the participation of public and private providers. To operationalise this constitutional mandate, Law 100 was passed in 1993 creating a compulsory health-insurance system with two regimes: the contributory regime, for the workers of the formal sector of the economy and the self-employed, and the subsidised regime, for poor people and those without health insurance.[52,53] Health insurance coverage is provided by several health plans known as Health Promoting Entities (*Empresas Promotoras de Salud* [or EPS]), which in turn organise the delivery of health services through various arrangements that include contracting with public and private health-care providers. The affiliates of the contributory regime should receive a set of benefits under the regular Mandatory Health Plan or POS. Those in the subsidised regime were meant to receive the same benefits. However, during a transition period, they had access to a reduced plan or POSS, which nonetheless included ambulatory care and treatment for several costly diseases such as HIV/AIDS, kidney failure, and cancer. This compulsory insurance system, although struggling with many different problems, has expanded health-care coverage of comprehensive services to more than 90% of the population. One area where the reform did not succeed was in closing the gap between the two regimes. The initial legislation mandated that the gap should be eliminated by 2001. However, as this provision was not implemented on time, the Constitutional Court of Columbia in 2008 ordered the equalisation of benefits in both regimes, which was finally achieved in 2012.[54]

A major reform to expand population and intervention coverage was also implemented in Mexico in 2004 with the creation of the People's Health Insurance or *Seguro Popular*, which includes the establishment of explicit entitlements through a well defined, ever-expanding and effective benefit package for the almost 50 million Mexicans who until then did not have access to publicly provided health insurance.[55]

The debate that emerged around macroeconomic stabilisation and health actually generated an environment for an exchange of ideas between policy makers from the Latin America region and those based

	Health system types (classified by sources of financing)	Integration of social security and public
Argentina	Tripartite: public, social insurance, and private	Segmented
Bolivia	Tripartite: public, social insurance, and private	Segmented
Brazil	Dual: public (three levels) and private (mainly supplementary)	Integrated
Chile	Dual: public or social insurance and private	Integrated
Colombia	Tripartite: public or subsidised social insurance, contributory social insurance, and private	Integration under implementation
Costa Rica	Dual: social insurance and private (small), public only direction-regulation	Integrated
Cuba	Single: public (there is no private)	Integrated
Dominican Republic	Tripartite: public, social insurance, and private	Integration under implementation
Ecuador	Tripartite: public, social insurance (with peasant insurance), and private	Segmented
El Salvador	Tripartite: public, social insurance, and private	Segmented
Guatemala	Tripartite: public, social insurance, and private (including NGOs)	Segmented
Haiti	Dual: public and private (three types)	Segmented
Honduras	Tripartite: public, social insurance, and private	Segmented
Mexico	Tripartite: public, social insurance, and private	Segmented
Nicaragua	Tripartite: public, social insurance (through private), and private	Segmented
Panama	Tripartite: social insurance, public, and private	Segmented
Paraguay	Tripartite: public, social insurance, and private	Segmented
Peru	Tripartite: public, social insurance, and private	Segmented
Uruguay	Dual: public or social insurance, and private (small)	Integrated
Venezuela	Tripartite: public, social insurance, and private	Segmented

NGOs=non-government organisations. Some data adapted from Mesa-Lago.[56]

Table 3: **Health system type and segmentation in Latin America**

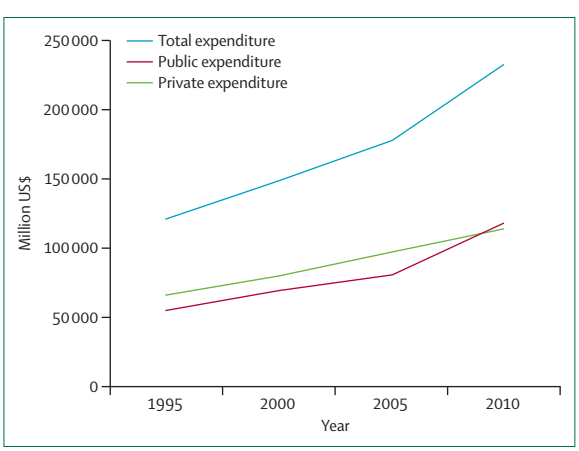

Figure 2: **Total, public, and private expenditure in health in Latin America from 1995 to 2010.**
Data from WHO Global Health Expenditure Database.[61]

at the International Monetary Fund, World Bank, and the Inter-American Development Bank. It also promoted a rich and innovative interaction between economists and health specialists that led to a plethora of research and tools to measure progress in health and health care.[36] One of the initial products of this exchange and of the growth of health economics was the 1993 World Development Report.[37,38]

Phase 4: the quest for equity

Phase 4 is characterised by the implementation of reforms designed to equalise the health-care benefits received by different population groups and offer financial protection that avoids catastrophic and impoverishing expenditures.

Two remarkable experiences signalled the start of this phase: the creation of the national health system in Chile in the early 1950s and the full integration of the Cuban health system in the 1960s (panel 1). These two pioneer experiences boosted efforts to achieve integration and equity in many parts of the region. They were eventually followed by the merging of the social security system and the Ministry of Health in Costa Rica in 1973, the creation of the Unified Health System (*Sistema Único de Saúde*) in Brazil in 1988, and the creation of a universal insurance system in Colombia in 1993 (panel 2).

Paths taken by Latin American countries to overcome segmentation

In 2008, Mesa-Lago[56] documented the state of health care and pension systems in Latin America. Table 3 is based on his work (updated by the authors of this Review) and describes the type of health system prevailing in 20 countries of the region. For each country, the table shows whether social security and public funds are segmented or integrated. Table 3 shows that 13 countries continue to have segmented systems.

Various contextual factors have affected the use of policies to reduce inequity through the expansion of health-care coverage in Latin American countries. Salient among them are the epidemiological transition, the democratic transition, the relatively high rates of economic growth, and the dissemination of values related to democracy and human rights.[57]

The proportion of the global burden of disease attributed to non-communicable diseases worldwide has been increasing in the past decades, whereas the proportion attributed to communicable ailments has decreased.[58] The pressure of this transition has affected the performance of health systems in the region, demanding additional financial resources, transformations in the prevailing models of care, originally designed to deal with common infections and reproductive events, and increasing intersectoral co-operation to address the social and behavioural risks associated with non-communicable diseases.[9]

Latin America has also witnessed an unprecedented trend toward democratisation that is part of what Huntington calls "democracy's third wave".[59] By the early 1990s, almost all the Latin American countries that had lived through decades of military rule or civilian-led authoritarian regimes had transitioned to democracy.[60]

	First path (one public payer)	Second path (freedom of choice of payer)	Third path	
			Makes explicit the entitlement of citizens to specific essential services	Includes coverage of severe illnesses
Argentina	No	Yes, within *Obras Sociales* and with limitations	Yes	Yes
Bolivia	No	Yes, within social insurance	Yes	No
Brazil	Yes	No	Yes	Yes
Chile	Yes	Yes (minimum income required)	Yes	Yes
Colombia	No	Yes, but separately for those in contributory system and (at lower level) for those in subsidised system	Yes	Yes
Costa Rica	Yes	No	No	Yes
Cuba	Yes	No	No	Yes
Dominican Republic	No	Under implementation	Yes	Partial
Ecuador	No	No	Yes	No
El Salvador	No	No	No	No
Guatemala	No	No	Yes	No
Honduras	No	No	No	No
Mexico	No	No	Yes	Yes
Nicaragua	No	Yes, in social insurance	Yes	No
Panama	No	No	Yes	Partial
Paraguay	No	No	Yes	No
Peru	No	Yes, but limited to social insurance beneficiaries and with restrictions	Yes	Under implementation
Uruguay	No	Yes, with temporary limitations for some lower income families	Yes	Yes
Venezuela	No	No	No	No

Data from Mesa-Lago.[56]

Table 4: **Paths to health system integration in Latin America**

Finally, economic growth rates in Latin America in the past two decades have had some effect on the health agenda by mobilising additional resources for social development, including health care (figure 2). The average economic growth rate in the period 1990–2010 reached 3·7% in Brazil, 5·1% in Chile, 3·5% in Colombia, 4·7% in Costa Rica, and 2·8% in Mexico.[62]

Ideology also affected the policies to reduce inequality in health. In view of the democratisation process in Latin America in the past few decades, the values and principles that guided the policies to expand coverage in this region were unsurprisingly those related to social rights: universality, equity, and participation in Brazil; equity, solidarity, and participation in Chile; universality and solidarity in Colombia; universality, equity, and solidarity in Costa Rica; and fairness, citizenship, and solidarity in Mexico.[63–68]

This context offered a window of opportunity to overcome social segregation in health care. The attempts to reduce inequities in health care in Latin American countries can be classified into three different paths, the first of which was followed mostly before 1990, the second mostly in the 1990s, and the third after 2000. Table 4 shows the paths followed by 19 Latin American countries.

The first path consisted of the unification of the funds used to finance both the services of the social security and the services of the Ministry of Health into one public payer. Within this path, two countries (Cuba and Costa Rica) retained the integration of the financing and delivery functions within the same institution, whereas two others (Brazil and Chile) separated the financing function from service delivery. Other countries also made attempts at unification of their social security and public institutions, but they proved to be politically difficult. Mexican health authorities considered this option in the 1980s and then again at the turn of the century, before the design and implementation of *Seguro Popular*, but they were opposed by strong vested interests.[69] Similar efforts took place in Peru, Ecuador, and the Dominican Republic, but with no success because of political opposition.

The second path was followed by countries mostly during the 1990s and aimed at establishment of free choice of the financing body. In some countries, financing bodies are both insurers and payers, and in others, they are simply payers of health-care providers. This type of reform was implemented in seven countries (Argentina, Bolivia, Chile, Colombia, Nicaragua, Peru, and Uruguay) (table 4).

Although overcoming of segmentation was often an explicit objective of these reforms, in practice, these initiatives were rolled out with a design that provided choice mostly to high-income groups. In Argentina, Bolivia, Chile, Nicaragua, and Peru, free choice of insurer, to the extent it exists, is limited to those insured by social security. In Colombia, following the legislation of 1993, poor people were also given a choice of insurer, but the choice was limited to a niche that offered a lower benefits package and had a partial need to use public hospitals, until the constitutional court ordered benefit packages be equalised in 2008.[70] In the past few years, only Uruguay has attempted to follow this path of integration; it remains in a transitional period during which some low-income families face limitations in their choice of provider or insurer.[71]

The third path was followed mostly after 2000, and consisted of the expansion of the health-care services available for poor people and the non-salaried population, and making the health-care benefits to which all citizens are entitled explicit. Table 4 shows that 14 Latin American countries have taken this route. 11 of the 14 countries have set up a special agency (often referred to as a public insurer or public payer) to channel funds earmarked for the list of essential services. In seven of these countries, a special fund has also been created to pay for the treatment of high-cost or severe illnesses.

Several countries are following more than one of the three paths to desegregation. Seven countries combined the use of the second and third paths (Argentina, Bolivia, Chile, Colombia, Nicaragua, Peru, and Uruguay). Chile uses elements of all three paths by having one public payer, providing a choice of payer, and legally mandating coverage of essential services for all citizens.

The three paths have achievements and shortcomings. The first path (one public payer) is praised by some specialists as the most effective route to establish the right to health care for all citizens through the provision of universal health coverage and the elimination of second class health care.[72] Critics of the first path, however, point out that although distinctions of quality are eliminated within the public sector, they remain or grow between urban and rural communities, wealthy and poor areas, and the public and the private sectors (and in the case of Cuba, through the provision of special services for very important people).[73] Critics of the one payer and provider path also argue that it creates monopoly powers that might lead to inefficiency, explosive cost increases, and unresponsiveness to the needs of users.[4]

The second path has been criticised for having focused on extension of choice for people who are well off, while providing few benefits for low-income families.[74] Additionally, regulation of the insurance market has often been difficult to do effectively, leading to problems of risk selection, which tend to imply that the more costly cases, together with the care of elderly people, end up as a government responsibility. Several countries have made substantial efforts to strengthen the capacity of their regulators, but regulation of insurance markets remains a major challenge in all countries of the region.

The third path has been effective in expanding benefits and improving the quality of the services provided to poor people, but has been criticised for two reasons. The first criticism is that the creation of a public insurer, separate from social security, reinforces segmentation and segregation.[75] The second criticism is about sustainability and states that equalisation of the benefits provided to poor people with those provided to the formal sector distorts incentives because workers lose the motivation to join the formal sector (where they have higher productivity and contribute to the financing of health care).[76] On the basis of the historical perspective used in this paper, however, we suggest that these criticisms miss the essential point that although these reforms are imperfect, they need to be understood as part of a dynamic strategy. They consist of efforts to raise the benefits and quality of health care provided to poor people and to the members of the informal sector up to the point where they are similar to those of social security institutions. Once the benefits and quality gaps are reduced, further reforms that are politically difficult at this moment will become feasible. Global history shows that many countries have gone through such a transition to later integrate their populations. In the past few decades, this path has been followed by Turkey, Korea, and Taiwan.[77–79]

Conclusions

Is Latin America making progress towards universal health coverage and equity in health? Two opposing views persist in this regard. One view emphasises the huge progress in health conditions and the contribution of investment in health to economic development; the other, the persistent feeling of injustice attached to social segregation that still characterises most health systems in the region. A group of analysts and historians stress the major improvements in health outcomes.[80] Life expectancy in Latin America almost tripled in the 20th century and is now close to that of high-income countries. Infant mortality and fertility have substantially decreased, even in the poorest countries. Much of this progress was achieved during the decades when countries of the region undertook ambitious interventions to control infectious diseases, expand water and sanitation, and provide mothers with better reproductive services and improved education. Others, by contrast, emphasise the differential care and financial protection received by various population groups in separate public health-care institutions and the insufficient access of a large proportion of the population to the improved-quality services provided by social security.[81] This segregation is becoming increasingly unacceptable as citizens' expectations associated with economic growth, consolidation of democracy, and the idea of health care as a social right have expanded.

The assessment of progress (or absence of it) also depends on the timeframe used for the analysis. Our historical paper shows that health systems change substantially and that countries in Latin America have periodically converged to similar policy solutions and reached what we could call a Latin American consensus several times in many areas. However, policy convergence and change take time, and might only become apparent when a long-term view is used in the analysis.

From this crucial paper, we can draw the following basic conclusions, which are associated with a set of global lessons presented in panel 3.

Segmentation of health systems in Latin America grew from the inequality prevailing in the region and has become a source of new forms of inequity. Health-system segmentation contributed to a process of social segregation separating a population that benefited from what became a truncated welfare state to a population excluded from its benefits. This segmentation has become an obstacle to the achievement of greater equity in a context of explicit government efforts to combat poverty and reduce inequality.

Our historical paper showed an apparent paradox: some of the decades of greatest improvement in life expectancy for the population as a whole were also the years when the segmentation of health systems became more entrenched. Much disagreement remains in Latin America about the instruments and institutions developed during that period. Much of the disagreement is about the use of one metric to assess progress; some analysts emphasise health outcomes, whereas others emphasise inequity and not enough social protection in health.

Changing values have been a catalyst for change throughout history. The evolution of health-care systems in Latin America has been associated with changes in values and in the rationale for investment in health. The rationale to invest in public health evolved from mitigation of risks to trade, to the opening of new economic territories, and then to the social returns of investments in human capital. A different set of values supported the evolution of personal health care, initially seen as an object of charity, turning into a labour benefit for the workers of the formal sector of the economy and their families, to finally reach the status of a social right.

Latin America has witnessed several waves of policy diffusion, where countries learned from each other and introduced institutional innovations benefiting from the experience of their neighbours. This policy diffusion process was affected or facilitated by multilateral organisations, development banks, donor agencies, academic centres, and philanthropic institutions, and had inconsistent results that depended on the policy idea being diffused, the agency pushing the policy, and the negotiation ability of the recipient country.

The boundaries of what is thought to be the health sector have changed over time, and so has the nature of intersectoral actions. The departments of public health were often first established as part of the law enforcement institutions. Later in the 20th century, they were established as independent ministries in charge of public health interventions, which often included the provision of water and sanitation. At a later phase, a responsibility for social assistance was added to these ministries, but it did not include the provision of personal health services for the workers of the formal economy, a responsibility that was given to social security agencies usually linked to a Ministry of Labour. Later still in the 20th century, ministries of public health added to their responsibilities the provision of population-based maternal and child care—only then did the ministries change their name to the Ministry of Health. At the same time, decentralisation and the growing role of the global government and of entities in charge of sanitation and environmental management have often reduced the role of the Ministry of Health to the management of public health interventions, increasing the need for intersectoral collaboration for the achievement of health outcomes.

Countries in Latin America are converging in their desire to overcome health-care segregation, but not in the best way to do it. They are following three different paths

***Panel 3:* Global lessons of Latin American efforts to desegment health systems**

- Left to their own inertia, health systems in unequal societies tend to develop in a segmented way, leading to new forms of inequality and social segregation. Countries at an early stage of development should avoid the creation of segmented health systems.
- The right to health transcends the idea of the right to an essential package of services. Although analysts continue to use the Millennium Development Goal indicators in the search for universal health coverage, developing countries should go beyond these indicators to incorporate outcome indicators related to non-communicable diseases, financial protection, and user satisfaction. Countries can expect a growing weight given to equity in judgments about the success of their health systems.
- Values matter. The strengthening of democracy together with rapid economic growth contribute to the establishment of a right to health and this, in turn, becomes a catalyst to health reform.
- Policy diffusion is a powerful catalyst of change. Institutions that support policy diffusion offer a public good (or a public bad). Importantly, learning that occurs across countries should be based on rigorous evidence. Developing countries should develop stronger channels of learning within and between regions, use mechanisms of diffusion that have transparent governance, and base their recommendations on rigorous evidence.
- Boundaries of the Ministry of Health change continually but never contain all the elements needed for health outcomes and social protection. Intersectoral cooperation to address health risks and the social determinants of health should be understood as part of the efforts needed for universal health care.
- The journey towards universal health care needs constant learning and adaptation. The rich experimentation in Latin America has not produced a consensus about the existence of the best model. Countries in Latin America have discovered the need to continually improve their own models. Often, improvements adapted by countries originate in lessons learned from countries following a different path than the adapting country.

to reach this goal. The single-payer path, which consists of the unification of public sector funds in one institution in an attempt to provide the same services to the whole population; the choice of payer path, which allows families to choose between various insurers or financing agents in an attempt to eliminate the segregation of populations by expanding choice; and the explicit benefit path, which is trying to equalise the benefits and the social protection afforded to the population groups covered by the different public-sector institutions by establishment of explicit health-care benefits for the population excluded from social security. No consensus exists about the superiority of any of these paths; however, there is a growing consensus that each of these paths has merits and that no country has arrived at a steady state. In fact, countries in each of the three paths are incorporating instruments and policies developed by countries in the other paths, and all are increasingly recognising that the aspirations implicit in universal health coverage will need constant adjustments to their models.

Contributors

DC and OGD drafted the paper with specialised contributions from FK. All authors conceived the structure of the paper and approved the final version. RA, MC, PFre, and RM contributed scientific literature. Authors contributed data and text about specific countries as follows: FK, RL (Mexico), ICHCB (Brazil), OC (Argentina), PFra (Peru), PFre (Chile), RG (Colombia), and RS (Costa Rica).

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OC was undersecretary of Finance for intergovernmental Relations in Argentina, 1999–2001. PFra was President of the Social Investment Fund of Peru. RG was Vice-Minister of Social Protection in Colombia, 2004–07. RS was Minister of Health in Costa Rica 2002–06. This Review is part of a series funded by the Rockefeller Foundation through a grant to the Economic Commission for Latin America and the Caribbean (ECLAC). DC, OGD, FK, RA, ICHCB, MC, PFre, RL, and RM declare no competing interests.

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