The Meanings of Universal Health Care in Latin America

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Abstract In Latin America, competing definitions of universal health care are found. Variants include traditional universalism, basic universalism, and minimal or residual universalism. These definitions are informed by European traditions, a renewed emphasis on equity among Latin American social policy experts, and World Bank strategy. This essay explores these definitions as well as areas of overlap and points of difference between and among them using examples from several Latin American countries. The most important difference concerns the preventive and curative services not covered by the benefits packages of minimal universal programs, a gap expected to grow increasingly costly for patients.

Keywords universalization, Costa Rica, Chile, Latin America

In December 2012, the United Nations General Assembly passed a resolution asking all countries to implement universal health care systems. Indeed, a trend toward framing access to health care as a right of citizenship and recognition that healthy populations are the foundation of productive workforces had already made universal coverage a hot topic in Latin America. Nevertheless, we are confronted with competing definitions of universal health care. Variants of universal coverage include traditional universalism, basic universalism, and minimal or residual universalism. These definitions are informed by European traditions, a renewed emphasis on equity among Latin American social policy experts, and World Bank strategy. Some overlap is found among the varieties of universalism, but crucial differences exist. The most important difference concerns the

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curative services not covered by the benefits packages of minimal universal programs, a gap expected to grow increasingly costly for patients. The varieties of universalism described here are all represented in Latin America, a region of twenty countries ranging from lower-income to upper-income economies.

In Latin America, traditional universalism was founded on the International Labor Organization's (ILO) model for social security programs. The principles of the ILO model, as disseminated from its European origins to the rest of the world through international conventions, included universal coverage, equal treatment, solidarity, comprehensiveness and sufficiency of benefits, unification of program administration, and financial sustainability (Mesa-Lago 2008a: 5). Social security systems first enrolled salaried workers. Benefits, including health care, were extended to these workers and then to their dependents. The idea was that as economies developed (i.e., industrialized), a growing number of people would leave agricultural and informal-sector jobs for salaried positions, and health care coverage would gradually become universal (Mesa-Lago 2008a: 6). Only it did not work this way in many Latin American countries where some people became members of social security institutes but large numbers remained uninsured because dependent development failed to offer adequate formal-sector employment. Instead, ministries of health became responsible for using sparse government revenue to provide medical services to popular sectors. Ministries of health often lack sufficient resources to provide enough care. For example, while El Salvador's Ministry of Health is responsible for providing health care services to 77 percent of the population, its funding is equivalent to only 1.5 percent of the country's gross domestic product (World Bank 2011: 4).

Exceptions to this trend exist. Among them, Costa Rica, where a single institution oversees social insurance (pension and health), best exemplifies the extension of the ILO model to the maximum possible. Officers of the ILO delivered important assistance to Costa Rican officials after the social security law was passed in 1941 (Rosenberg 1983: 75). Since then, Costa Rica has gradually expanded public pension and health programs to the vast majority of the population, including informal-sector workers and immigrants. The social security institute covers indigenous populations and the indigent through noncontributory regimes. All persons enrolled in the health insurance program obtain the same rights to benefits. Medical benefits run the range from preventive to curative to rehabilitative care. Expensive and complex procedures like organ transplants are provided as dictated by individual physicians' decisions about medical need, not income or employment status.

Like traditional universalism, the concept of basic universalism seeks to enhance solidarity and equality by guaranteeing coverage for all. What separates basic from traditional universalism in health care is that the former defines explicitly and a priori what conditions must be covered while the latter tends to leave coverage up to physician discretion and system availability. Basic universalism is not much needed under a traditionally universal system like Costa Rica's where health care is reasonably well funded and a single institution decides how to ration medical resources for the entire population. But in countries where fragmented insurance and delivery systems result in uneven coverage, incentives to avoid sicker enrollees, and significant resource shortages, rules to ensure that everyone with the same diagnosis will be treated equally can be quite useful. Basic universalism focuses on the equal and proper treatment of selected pathologies chosen for their impact on the country's morbidity and mortality rates and the availability of treatment protocols (Tobar 2006: 289).

Chile's Universal Plan of Explicit Guarantees in Health (Plan Acceso Universal con Garantías Explicítas en Salud, or Plan AUGE) is the best example of this concept. Conceived of largely to reduce inequalities in access and funding across the public and private health insurance systems, the Plan AUGE was passed into law in 2004 (Urriola Urbina 2005; Mesa-Lago 2008b). The program defines a set of diseases (pathologies) for which coverage is automatically and mandatorily provided for all citizens, no matter their income or insurance status. The coverage is affordable because co-pays are limited to 10–20 percent of the treatment cost and are subject to annual caps. The coverage guarantees quality because providers must follow treatment protocols. And the coverage is timely because the law establishes maximum waiting times. The Plan AUGE applied to seventeen conditions in its first year and has been increased to eighty at this writing. To determine the list of covered pathologies, the Ministry of Health considers a disease's prevalence in Chile, the mortality and morbidity it causes, whether significant gaps in access to care for it exist in the country, and the existence of evidence-based treatment protocols (Urriola Urbina 2005: 72).

Basic universalism focuses on delivering equal treatment for pathologies that are prevalent, costly to society, and responsive to tested interventions. In some ways, the concept of minimal universalism overlaps with this approach. In its *World Development Report 1993: Investing in Health*, the World Bank (1993) introduced the idea that governments should guarantee their populations a minimal package of cost-effective essential health benefits and has continued to refine this approach through its most recent strategy paper for the health sector, *Healthy Development: The World*

Bank Strategy for Health, Nutrition, and Population Results (2007). The policy of ensuring that the entire population can access a package of essential benefits shares with basic universalism the concept that all citizens are entitled to a certain set of interventions, the desire to reduce inequalities driven by the fragmentation of a country's health care system, and a focus on addressing prevalent pathologies for which there are effective protocols. In general, both approaches seek to secure a healthy and therefore productive society and to alleviate hardship by shielding families from catastrophic medical expenses.

The two main differences between these approaches are that the minimal essential benefits packages are targeted to the poor and that the services offered consist almost entirely of preventive and primary care interventions. Countries adopting essential benefits packages tend to be motivated by the overlapping purposes of reaching the rural poor and informal sectors as well as meeting Millennium Development Goals 1, 4, 5, and 6 by alleviating extreme poverty, reducing child mortality, improving maternal health, and combating infectious disease. Ministries of health often use means-testing methodologies to target the packages. The services contained in the packages are often preventive, aimed at the root causes of poor health outcomes and meant to shield families from catastrophic medical expenditures. In particular, the packages share a focus on maternal, reproductive, and child health; major infectious diseases such as HIV/AIDS, malaria, and tuberculosis; and tobacco control. The focus on preventive medicine is laudable, and the targeting of maternal, child, and reproductive health may be particularly helpful in correcting gender bias within a country's social services. For instance, the World Bank (2007:60) finances a program in Argentina, Plan Nacer, that provides over five hundred thousand uninsured women and children with a package of services aimed at reducing maternal and under-five mortality.

Yet a contradiction lurks within this approach. The World Bank (2007: 13) recognizes that noncommunicable diseases (NCDs) will be the leading cause of death in low-income countries by 2015 and that catastrophic costs for medical care related to these conditions will put an enormous burden on health systems as well as poor households. But the essential benefit packages it promotes consist almost entirely of primary and preventive care, not medical services for the chronic, complex conditions of aging urban populations. Costa Rica's and Chile's universal plans cover specialty and subspecialty treatments for cancers, cardiovascular disease, and psychiatric conditions not included in essential benefit packages. Because of these gaps, essential benefits packages may perpetuate inequalities in

access to affordable medical services and reflect a retreat from universalism toward a more residual notion of public health care benefits.

Latin American countries have vastly different capacities to universalize coverage (by any definition) and respond to the growing challenge of NCDs. Strategies to attack the root causes of many NCDs with preventive interventions and surveillance programs, not to mention curative medicine, chronic disease management protocols, and palliative care, will require new resources and organizational upgrades. Many countries in the region will need to rely on assistance from international organizations for the funding and technology transfers to meet these challenges.

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