Journal of Healthcare and Prevention

Extended Abstract Open Access

# Health Policies and Services in Latin America and the Caribbean. In-Equalities in Coverage and Quality

**Cristina Gomes**

*Cristina Gomes, Professor, FLACSO México*

**Keywords:** Population, Health Care, Immunization

## Abstract

This study analyzes the fragmented health policies and services in Latin America, describing the historical social, economic and political contexts and pressures that frame the process of building fragmented health policies and services, analyzing the public expenses, coverage, generosity and quality of the health plans and services. The methodology integrates bibliographic review, statistical analysis and results of case studies.

In 2017, the Latin American and Caribbean (LAC) population reached 644 million people, representing 8.68% of the world's population. LAC is the region with the highest levels of socioeconomic inequality and also the greatest ethnic-racial diversity in the world. In 2010 the LAC's indigenous population corresponded to 42 million people or 7.8% of that of Latino Americans. Afro-descendants represent between 20% and 30% of the population of the region, or 133 million people (UNDP, 2010; World Bank, 2015).

Indigenous and Afro-descendants are likely to be poor, to live in rural areas with scarce access to social security, pensions, and health services and policies. They are under-represented in power and decision-making agencies, and in policies and services, due to stereotyping, prejudices and ethnic-social barriers, which result in higher mortality, morbidity (hypertension and diabetes), when compared to white people. As a result, they die earlier; have a lower life expectancy, a higher number of children and levels of poverty coupled with the highest fertility, mortality, when compared to their national and international counterparts (Gomes, 2007).

Between 1930 and 1940, most LAC countries had the same life expectancy as Europe – close to 35 years, but higher fertility rates (6 children per women) than those of the European populations in the old regime. Between 1950 and 1990, life expectancy rose to over 70 years, and fertility rates were cut in half, from six to less than three children per woman from 1960 to 1990 (Livi-Bacci, 1990).

These demographic and epidemiological transitions were due to improvements in sanitation and health, and to extensive access to modern vaccines, antibiotics, and contraceptive methods in the period, in addition to the development of health policies and services in the region, which started at the beginning of the 19th Century with charity institutions (Gomes, 1995).

Since the beginning of the 20th Century, bipartite social security funds for health care and pensions were created by categories of workers and, between 1940 and 1990, the States unified and assumed administrative control of these corporative systems, creating national security institutes which provided pensions and health services for only around 40% of the region's formal workforce. Protection covered diseases, maternity, accidents at work, occupational diseases, unemployment, disability, old age and death for formal workers and their relatives. However, most families depended on workers in informal jobs, excluded from formal and contributory social security. For this group and unemployed, the State offered access to mass vaccination, preventive and primary health care (financed by taxes), with lower coverage and quality. This fragmentation remains to this day (Mesa Lago, 1992).

In the 1960s the development of the market for health products and technologies took place, and the costs of and spending with health systems were multiplied. As in the Institutes of Social Security the budgets of health and pensions were managed together, the savings for pension systems were used to cover the growing health expenditure. In the 1980s, there were reforms in constitutions and health laws, regulation and monitoring of the sector, and the separation of health funds and savings for pensions (Mesa Lago, 1986 and 1992).

In the 1990s, the majority of the informal workers and their families had access to prevention programs, sanitation, immunization, and primary attention. However, the macro-economic stabilization programs and recurrent crises increased poverty and decreased investments in social policies, especially health, and the poorest population was excluded from health systems in the region.

Currently, the social security systems cover the majority of the population only in Brazil, Costa Rica, Ecuador and Panama. In Colombia, the state spends 38% of its resources in covering 82% of the population (served by the Ministry of Health), and invests 62% of health sector resources towards only the 18% of the population that is affiliated with Social Security. Farmers, unpaid workers, informal employees and the unemployed are not covered in Costa Rica, Uruguay and Peru (Fleury, 2005).

Laws and universal care for children and pregnant women were implemented in Ecuador, Bolivia and Peru. In Argentina, corporate systems were converted into a national mandatory plan and the decentralized provincial programs cover 50% of the population. The public subsystem covers 37% – mainly the poor – and the private subsystem covers only 10% of the population (Mesa Lago, 1986, 1992).

In Mexico, the coverage was extended since 1989, and in 2007, the Popular Health Insurance covered all groups and reached 600 thousand families with 800,000 contributors, 1.8 million in 2008, 3 million in 2009, and 4.3 million in 2010. However, today it has been reformed, since a monthly contribution was mandatory in order to have the right to join it (Almeida, 2005).

In Chile, the Ministry of Health and the National Health Fund (FONASA) have covered 67.5% of the population since 1982, and the new Provisional Health Institution (ISAPRES) covers 18.5% (Almeida, 2005).

Colombia had reform in 1993. Both the public and the private financial sectors participate in a mixed system that includes a contributory system –the old corporate system, a subsidized scheme for the poor, and a public system for people not affiliated with other schemes (Londoño and Frenk, 1997).

In Brazil, in 1988, the Unified Health System was created, with universal access; municipalities are the main providers of services, exacerbating regional differences. From 2005 to 2014, new programs were created – emergency transportation, popular pharmacies, dentists, and emergency units. However, after 2016 financing has decreased limiting coverage and quality (Paim et al, 2011).

Reforms in health systems have been relatively homogenous in the region. But most countries continue to have fragmented models to date, with different institutional and legal paths, with alternative forms of public-private partnership and management, in spite of all countries seeking the same goals (universal coverage and an increased quality of health care). The main limiting factor in most countries was the lack of resources to finance the system (Fleury, 2001; Cavangero, 2015).

Common tendencies in the Chilean, Brazilian and Colombian reforms consist of the decentralization of service, the transition to a pluralistic public-private network, and the development of a complex network of relationships and negotiations between funders and service providers (Cavangero, 2015).

Data from WHO (2012) and the World Bank (2019) were analyzed and show that government expenditures with social security systems are strongly correlated with the proportion of workers contributing to the system, with per capita GDP per employee (measured in PPP), with total spending, and with the proportion of retirees over 65 years of age. As expected, the more taxpayers and retirees, the greater the contribution of the government to maintain the system. However public expenditure within social security isn't related to health spending in any period, since health spending is more dependent on the health transnational market. In spite of a recent process of expansion in coverage, different forms and degrees of limited access, coverage, quality and scope in basic health reinforce the persistence of inequalities and discrimination of the poorest and more vulnerable groups; and it is necessary to reorient health policies in order to overcome the challenges of a globalized world, discrimination and market resistances.

**References**


1. Almeida, C.M. (2005) Reform of the State and of the Health Sector in Latin Ameri- ca. In: Minayo, M.C.S. and Coimbra, C.E.A.J., Eds., Acting Critiques: Human and Social Sciences in Health in Latin America, FIOCRUZ, Rìo de Janeiro, 6-60.

2. Cavangero, E., Almeida, G., Seely, E.S. and Marinho, F. (2015) Setting the Context for Universal Health Coverage Reforms in Latin America and the Caribbean.

3. Fleury, A.S. (2001) Universal, Plural or Dual? Models and Challenges in Health At- tention in Latin America. Interamerican Development Bank, Washington DC.

4. Londoño, J.L. and Frenk, J. (1997) Structural Pluralism: Towards an Innovative Model for Health System Reform in Latin America. Health Policy, 41, 1-36. https://doi.org/10.1016/S0168-8510(97)00010-9

5. Mesa Lago, C. (1986) Comparative Study of the Development of Social Security in Latin America. International Social Security Review, 39, 127-133. https://doi.org/10.1111/j.1468-246X.1986.tb00625.x

6. Mesa Lago, C. (1992) Health Care for the Poor in Latin America and the Caribbean. Inter-American Foundation and Pan American Health Organization, PAHO Scien- tific Publication, No. 539, Washington DC.

7. Paim, J., Travassos, C., Almeida, C., Bahia, L. and Macinko, J. (2011) The Brazilian Health System: History, Advances, and Challenges. The Lancet, 377, 1778-1797. https://doi.org/10.1016/S0140-6736(11)60054-8

8. WHO (2012) World Health Statistics. https://doi.org/10.22233/20412495.0819.1 https://www.who.int/whosis/whostat/EN_WHS09_Full.pdf?ua=1

9. World Bank (2019) Data Indicators. https://data.worldbank.org/indicator