ELSEVIER

Archives of Medical Research ■ (2018) ■

Archives of Medical Research

Health Systems in Latin America: The Search for Universal Health Coverage

Julio Frenk[a,b] and Octavio Gómez-Dantés[c]

[a]*President of the University of Miami, Miami, USA*
[b]*Ex Ministro de Salud de México (2000–2006), Ciudad de Mexico, Mexico*
[c]*Centro de Investigación de Sistemas de Salud, Instituto Nacional de Salud Pública, Cuernavaca, Morelos, Mexico*

Received for publication June 4, 2018; accepted June 19, 2018 (ARCMED_2018_122).

This paper discusses the health challenges faced by countries in Latin America. These challenges have two dimensions: those related to the health needs of populations and those related to the way in which health systems are responding to these needs. The main conclusion is that in order to improve health conditions and move towards universal health coverage, Latin American countries need to design a new generation of policy innovations based on the separation of the three main functions of health systems: financing, delivery and stewardship. © 2018 IMSS. Published by Elsevier Inc.

Key Words: Universal coverage, Latin America, Health systems, Policy.

Universal health coverage (UHC) is one of the targets of the Sustainable Development Goals (1). It was also adopted as the top priority of the new Director General of the World Health Organization (2). It has been likewise one of the main objectives of the Pan American Health Organization in the past years (3). Physicians and other health professionals in Latin America can play a crucial role in the search for UHC, but for this to happen it is essential they understand the challenges faced by health systems. The complexity of challenges and solutions is such that physicians today need to master not only the *content* but also the *context* of their practice. This means that, in addition to mastering the clinical and technical dimensions of their practice, doctors and other health professionals must also understand the administrative and financial arrangements that shape the organizations where they work.

The purpose of this paper is to discuss the health challenges faced by countries in Latin America. These challenges have two dimensions: those related to the health needs of populations and those related to the way in which health systems are responding to these needs. The main conclusion is that in order to improve health conditions and move towards UHC, Latin American countries need to design a new generation of health system innovations.

Health Conditions in Latin America

In the final decades of the past century Latin America started witnessing a major transformation in its health profile characterized by rapid population ageing and rising prevalence of chronic diseases. Increasing access to water and sanitation facilities, improvements in nutrition, and extended access to vaccines and other preventive interventions produced a decline in the burden of undernutrition and common infections, which translated into an unparalleled reduction in child mortality and an increase in life expectancy. Infant mortality in Latin America declined from 82 deaths per 1000 births in 1970 to 32 deaths per 1000 live births in 2000, while life expectancy increased from 63 years in the mid-1970s to over 70 years in 2000 (4,5). People in the region began to live long enough to manifest the effects of the chronic exposure to health risks linked to modern life, such as physical inactivity, unhealthy diets, environmental pollutants, smoking, and social isolation. The result was a dramatic rise in the prevalence of chronic, non-communicable diseases (NCDs) which by 2011 were responsible for over 70% of all deaths in Latin America (6).

However, this epidemiological transition did not follow the clear-cut replacement of old for new causes of disease, disability, and death experienced by developed countries. Instead, Latin America is facing a protracted and polarized

Address reprint requests to: Octavio Gómez-Dantés, Avenida Universidad 655, Colonia Santa María, Cuernavaca 62100, Morelos, México; Phone/FAX: (+52) (77) 7241-1474; E-mail: ocogomez@yahoo.com

0188-4409/$ - see front matter.
https://doi.org/10.1016/j.arcmed.2018.06.002

health transition that has created a complex burden of ill-health (7,8). The term 'protracted' refers to the coexistence of different types of disease, those of the pre-transitional era and those associated to urban, modern societies. The term 'polarized', in turn, refers to the presence of different rates of disease in the extremely unequal Latin American societies, much higher in the poorer sectors of the population. To this we should add the health challenges imposed by globalization. Together these challenges have created a triple burden of disease.

The first component of this triple burden is the unfinished agenda of undernutrition, common infections, and reproductive health problems. The prevalence of stunting in children under 5 in Latin America is still high, varying from only 5% in Costa Rica to almost 50% in Guatemala (9). The second component includes the challenges represented by NCDs, mental disorders, and injuries. Cardiovascular diseases, the main cause of death in the region, produce one million deaths a year in Latin America, and it is estimated that the number of deaths will keep growing (10). The third component involves the health risks directly associated with globalization, including pandemics such as AIDS, influenza and zika, and the health consequences of climate change. Zika cases have been detected in all countries of Latin America, and recent projections indicate that there could be millions of cases of this disease every year in this region, leading to thousands of cases of Guillain-Barré syndrome and microcephaly (11).

Another type of transition was also taking place in the two final decades of the past century in Latin America, generating additional pressures on the overburdened health systems of the region: the democratization of societies (12,13). This wave, which advanced steadily in almost all Latin American countries, expanded the claim for social rights, including the right to health care, which implies regular access to comprehensive and effective health services with financial protection for all.

Health Systems in Latin America

Modern health systems were created to meet the health needs of populations. In Latin America they were established in the first half of the past century. They followed a common pattern, which led to what have been called segmented health systems, namely systems that have several organizational niches serving, with dissimilar rules and unequal benefit packages, different population groups, mostly segregated by socio-economic level and labor status (14). Social security institutions [for example, Chile's Compulsory Insurance Fund (*Caja de Seguro Obligatorio de Chile*), Mexican Social Security Institute (*Instituto Mexicano del Seguro Social*), Costa Rican Social Security Fund (*Caja Costarricense de Seguridad Social*), Colombian Social Insurance Institute (*Instituto Colombiano de Seguros Sociales*)] were, in general, well financed and served the needs of the salaried population offering broad health benefit packages. These institutions had their own financial sources (contributions from employers, employees, and government), and most of them built their own health care networks for the exclusive use of their affiliates. Ministries of health [for example, Chile's Ministry of Hygiene, Social Assistance and Welfare (*Ministerio de Higiene, Asistencia y Bienestar Social*), Costa Rica's Ministry of Public Health and Social Protection (*Ministerio de Salud Pública y Protección Social*), Mexico's Ministry of Public Health and Assistance (*Secretaría de Salubridad y Asistencia*), Peru's Ministry of Public Health and Social Assistance (*Ministerio de Salud Pública y Asistencia Social*)], in contrast, were poorly financed, mostly from general taxes, and served the poor, non-salaried population offering public health and basic maternal and child services. These ministries provided health care in their own clinics and hospitals and hired health workers as civil servants. Finally, the private sector developed along two paths: one offering high quality services for the wealthier population, and the other one offering services of heterogeneous quality to the poor population, which frequently generated excessive expenditures in health.

Cuba and Costa Rica initially followed this same path, but in the 1960s and 1970s, respectively, they both adopted a different health system model, the unified public model. In Cuba, all public health institutions were merged to create the National Health System, which is financed with public resources and operates under the full control of the Ministry of Public Health. This ministry provides public health services and health care to all the population through a network of facilities owned by the national government (15). The private provision of services is illegal. In Costa Rica, the service delivery component of the Ministry of Health was transferred to the Costa Rican Social Security Fund (CRSSF) in 1973 (16). The Ministry of Health is now in charge of strategic planning and regulation, while the CRSSF controls the financing (through contributions and fiscal transfers) and delivery of personal health services through its own health network. It also has contracts with a few private providers.

In the late 1980s Brazil also followed a distinct model. All public institutions devoted to health were merged under the Single Health System (*Sistema Único de Saúde* or SUS) (17). SUS is financed with public resources but, in contrast with the Cuban and Costa Rican systems, it contracts services with a wide variety of federal, state, and municipal public providers, as well as private providers. The Brazilian health system also has a strong private sector that offers services financed either through out-of-pocket payments or private health insurance.

These developments can be systematically analyzed through a typology of health systems in Latin America. As shown in Table 1, the classification is based on two key dimensions: first, the type of population access to