UNIVERSALIST REFORM OF THE HEALTH SYSTEMS IN MEXICO AND CHILE. A CHANGE OF TIME OR HISTORICAL INERTIA? *

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INTRODUCTION

Fernando Filgueira has recently noted (Filgueira, 2013) that in Latin America we are reaching the final stage of broad era of conservative modernization[1] that has included three phases: the exporter oligarchic capitalism of the 19th century, the industrialization by imports substitution (IIS) stage and the phase of economical liberalization that begun in the 1980's. According to him, in this last phase, it was proposed a new way for modernization that drastically limited the role of the State in the economy, promoted opening of markets and limited the range of social policies compatible with the new project, but it did not solve the inclusion deficit that characterized the previous stages (Filgueira, 2013: 19-20).

In his opinion, this long process is concluding due to the neoliberal project success in three aspects: the consolidation of an electoral democracy, the increase of population's educational qualifications and society's exposure to new and wide consumption patterns. These three factors, he says, have mined the political bases of conservative modernization because they generated a revolution of expectations that cannot be fulfilled, because the liberal reform did not get sustained economic growth nor wealth redistribution, nor a wide social access to different markets. Therefore, in today's current democratic context, political and economic elites would lack of sufficient tools to untie the region's stratified bondages. [2] (Filgueira, 2013: 18-25).

* This article contains several elements of a priorly published chapter in 2013 (Barba, 2013) and a lecture in 2015 (Barba y Valencia, 2015).

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1 Following Barrington Moore (1966), Filgueira notes that this kind of modernization´s characterized by the action of elites driving the modernization of their countries trying to keep stratified privileges untouched inherited from pre-industrial pre-modern stages. (Filgueira, 2013: 20).

2 Filgueira points out that "elites... will be part of the new process, but they will from positions of power that rely on competitive electoral alternatives in a mass democracy (Filgueira, 2013: 18)

As a corollary of this thesis, Filgueira assures that "a turn to the left" has been produced in our region, that in the social scope is expressed as a change in the orientation of its social policies and in the citizenship conception. All of it as a consequence of the extension of the State's fiscal capacities, the establishment of wide programs of conditioned cash transfers (CCTs), the appearance of care policies aimed at reducing gender inequalities and a solidary turn of insurance schemes in the fields of pensions and health[3] (Filgueira, 2013: 30-38).

In the scope of social policies, particularly in the field of health services we are interested in, the axis of this transformation in Latin America would be the emergence of a basic universalism in different versions4, that could crystallize into a universal benefits and basic transfers system, combined with an additional non-contributory pillar and/or a private assurance to access goods and non-essential services (Filgueira, 2013: 39-40).

With no doubt, Filgueira's proposal is highly controversial but serves in heuristic terms to analyze what is happening in different types of social protection systems in Latin America. In the specific case that concerns us here, our interest is to analyze the scope and limitations of reforms to health systems of Chile and Mexico, which could be framed on the aforementioned 'epochal change' hypothesis or could contradict it. The specific interest covered by these reforms is that both assume as a purpose to universalize some segments of the public health services in both countries.

To achieve this objective, the first segment of this article will examine traditional patterns of health systems in the region. The second will review the type of health systems prevailing in Latin America. The third will examine the general characteristics of health reforms in Latin America, political contexts and the main actors in the reforms. The fourth will review the three reformist waves that have been developing since the eighties. The fifth will analyze the health reforms in Chile and Mexico. We will conclude with a final reflection on the strength of the previously mentioned hypothesis brought to the light of the two reforms.

3 In another article, I have already done a critique of this thesis using the Mexican case to show that the '*left turn*' mentioned by that author does not apply to the Mexican case even though some of its requirements are met; it is recommended to look for Barba (2015).

4 *That deviate from an ideal model* as Filgueira, following Pribble (2013), define as "full universal coverage -examples: all families with children, all seniors, all the unemployed, the entire population with access to health- based on objective criteria and sustained by laws that support basic rights, adequate and homogeneous quality of services and low or no transfers stratification and general revenue financing -with a progressive tax base- or tax models whose architecture, combined with the benefits, generate progressive effects" (Filgueira, 2013: 39-40).

I. THE TRADITIONAL PATTERNS: FRAGMENTATION AND INEQUITY

A common tendency in Latin America is to institutionalize different protection mechanisms for formal wage sector (insured through contributory schemes), for higher-income sectors (insured through schemes of voluntary and private affiliation) and for vulnerable sectors without access to other systems (through the usage of public assistance for healthcare) (Tobar, 2006: 284).

The social security often provide care for middle-income strata, which appear as relatively privileged compared to the rest of the population (Abel and Lloyd-Sherlock, 2004: 808). The dominant pattern in Latin America has been denominated "fragmented pluralism," a term that emphasizes heterogeneity and inequity in the distribution of rights and the access to health services for different segments of the population. (Tobar, 2006: 284)

Therefore, while at one end of this model, some citizens have access to innovative medical technology; on the other, the poorer are doomed to low quality services. This segmentation has been generating fragmentation and social inequality and since the second half of the eighties it has worsened as a result of the crisis in the formal labor markets, which increased inequality within this model and severely limited its expansion during the last two decades. (Tobar, 2006: 284)

Furthermore, the segmental nature of these systems results in diminishing returns of health investments. In Latin America, traditional pluralist model is ineffective because the quality and responsiveness of each subsystem and each service are very heterogeneous.

As various authors highlight, this lack of efficacy is expressed by the actual increase of diseases that should have been eradicated[5], eradicated diseases that resurfaced[6] and emerging diseases that challenge the capacity of national health systems and reveal the limitations of Global health schemes[7] (Tobar, 2006: 285; Abel and Lloyd-Sherlock, 2004: 801, Franco and Alvarez, 2009).

5 Such as malaria.
6 Such as tuberculosis.
7 Such as AIDS or the H1N1 pandemic influenza.

However, although this structural trend has been deployed throughout the region, not all systems share the same characteristics, as indicated by the classification of health systems proposed by Mesa-Lago: unified systems, dual, tripartite and quadripartite (Mesa-Lago, 2007)

II. TYPES OF HEALTH SYSTEMS IN LATIN AMERICA

To paraphrase Mesa-Lago (2007), it could be said that there is a predominance of three major types of health systems in Latin America: unified, dual and tripartite[8]. The first type is characterized by having a unified public health system; the second has many variations but always includes a public segment and a private one; while the third differentiates between the public segment, the social security segment and the private one (Mesa-Lago, 2007: Table 7.1).

A unified public system only exists in Cuba, one quadripartite only in Colombia. Dual systems are infrequent these are the cases of Brazil, Chile, Costa Rica, Haiti and Panama. The most common type is the tripartite system, such as in Argentina, Bolivia, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Paraguay, Peru and Venezuela (Mesa-Lago, 2007: Table 7.1).

Mesa-Lago underlines that stratification does not determine the degree of integration and coordination between the various systems. In his opinion, there are only two cases where the degree of integration and coordination is very high: Cuba and Costa Rica, the first unified, the second a dual system. Two cases have achieved an average degree of integration: Chile (a dual system) and Colombia (a quadripartite system). In contrast, in the rest of Latin America, systems are neither integrated nor coordinated (Mesa-Lago, 2007: Table 7.1).

This point of view may be tempered a bit considering that Brazil, after the 1988 reform, managed to form a unified public health system, which significantly advanced their degree of integration (Barba and Valencia, 2015).

8 Some are even quadripartite, as in the case of Colombia.

Stratification is not determinant in the coverage levels that systems may achieve as Mesa-Lago (2007) draws attention to, there are seven cases that between 2001 and 2004 had reached very high levels of coverage: Cuba, which has an integrated system; Brazil, Chile, Costa Rica that are dual; Argentina and Mexico that are tripartite. In all those cases health systems covered between 97 and 100% of the population [9] (Mesa-Lago, 2007: Table 7.1).

Instead, coverage levels clearly appear to be close related with the types of regional welfare regimes. According to Barba (2003, 2007) and Filgueira (1998, 2004) ratings, all health systems with high levels of coverage belong to Dual and Universalist regimes (liberalized or not).

While virtually all health systems with medium or low levels of coverage or those that do not generate reliable information, belong to the "*exclusionary*" welfare regimes according to the ratings of Barba and Filgueira or "*informal family-orientated*" according to the classification of Martinez Franzoni (2008).

III. GENERAL CHARACTERISTICS, CONTEXTS AND ACTORS OF HEALTH REFORMS

Since the eighties in Latin America, there has been a recognition of the need to reform health systems in order to deal with enormous challenges derived from demographic and epidemiological changes, but also technical and financial problems. These reforms demand an approach that considers social, economic and political aspects profoundly intricately in this theme. In this task, the standpoint of social policy can be very useful.[10]

Health sector reforms have been defined by the Pan American Health Organization (PAHO) and the World Health Organization (WHO) as *"... a process that aims to make substantive changes in the different health institutions and the roles they play, to increase the equitable distribution of its benefits, the efficient management and meeting the health needs of the population. This pro-*

9 Colombia and Peru are two cases where reliable data indicates that coverage is medium and located in a range of 67 to 84 % of the population. The remaining cases are characterized by low coverage or lack of reliable indicators (Mesa -Lago, 2007: Table 7.1).

10 The operation of the health sector clearly influences economic growth, in developing the capacities of individuals to participate in the market, the levels of welfare of different social segments, the potential for reducing social disparity, addressing poverty or respond to social risks faced by vulnerable sectors of society .

cess is dynamic, complex and deliberate, is performed at a precise time frame and is based on conditions that make it necessary and viable"[11] (PAHO and WHO, 2004: 3)

The development of reforms includes several stages; it is slow and often involves the direction of governments across party lines. As we have seen, in some cases the reforms are structural in nature, involve legislative changes, affecting most of the functions of the health system, alter the relationship between public and private actors; in others they are very limited, concentrate on specific subsystems, or administrative changes such as management models (Infante et al., 2005: 15).

Types and paradigms of reforms

As noted in **Table 1,** these reforms can be classified as *partial and incremental* and as *structural or systemic*.

TABLE 1. TYPES OF REFORMS IN TERMS OF ITS REACH

Partial or Incremental	Structural or Systemic
• Do not require changes to existing institutions. • Neither the creation of new ones. • Its primary objective is to improve functions of health systems through relatively minor changes. • Additional complex changes.	• More complex. • Seek for a deep transformation of existing systems. • Try to reduce its segmentation. • Generate new institutions.

Sources: *Own elaboration from Lordoño and Frenk, 2000; World Bank, 2005 and La Forgia, 2006.*

According to these criteria, the reforms of the eighties decade tended to be partial or incremental while those in the nineties and the ones made since the year 2000 proposed structural changes.

According to Mesa-Lago (2007), the big difference between the reforms of the 90s and the most recent are paradigmatic. Latin-America have fluctuated between two opposing paradigms: reforms aimed to liberalize[12] health systems or seeking to universalize the right to health. **Table 2** describes these two extremes.

11 The translation is mine.
12 Liberalizing or *Downsizing* of Government, as shown in **Table 2,** is equivalent as to give to the market a central role in the provision of welfare.

TABLE 2. PARADIGMS OF REFORMS TO HEALTH SYSTEMS

The residual paradigm	The universalist paradigm
a) Emphasizes market mechanisms b) The expansion of the private sector c) The competition between institutions offering same services d) Freedom of choice of beneficiaries e) Cost reduction f) Efficiency g) Financial sustainability h) Separation of functions	a) Search for universal coverage b) Promotes equity c) Guarantees social rights d) Promotes community and social participation

Source: Own elaboration from *Mesa-Lago, 2007: 161-162.*

According to PAHO and WHO recent reforms in the Latin-American region have emphasized financial, structural, institutional and administrative aspects, but have paid little attention to improving the services provided by health systems or to the reduction of inequality in conditions or access to health or even to strengthen management functions or health authorities (PAHO and WHO, 2002 to 2004).

Another tendency has been to mix the two paradigmatic agendas. For example, the issue of equity, along with the issue of decentralization was crucial in Costa Rica and Brazil. While in Colombia there was a mix between a universalist approach (social security, equity, solidarity, social participation) with a markets approach (competitiveness, efficiency and freedom of choice) (Kaufman and Nelson, 2004).

CONTEXTS AND ACTORS

Moreover, reforms have been carried out in heterogeneous and complex contexts. In some cases, they have been part of general reforms processes of the State,[13] in others have been important elements of constitutional reforms.[14] They are often included in the State's processes of modernization[15] and at times they are the focus of the review of the health system itself [16] (Infante et. al., 2000: 14; PAHO and WHO, 2004).

Political contexts and the main actors have also been divergent. For example, the first applied reform in Chile was impulsed by a military gov-

13 As it happened, for example, in Argentina, Chile and Colombia (PAHO and WHO, 2004: **Table 3**).
14 As in Argentina, Colombia and Ecuador (Infante et. al., 2000: 14).
15 This has been argued in Argentina, Chile, El Salvador, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Dominican Republic, Trinidad and Tobago and Uruguay (Infante et. al., 2000: 14).
16 As it has happened in Brazil, Costa Rica, Cuba, Dominican Republic and Mexico (PAHO and WHO, 2004: **Table 3**).

ernment in an authoritarian manner, but when democracy was reestablished, an extensive debate led to the approval and the creation of a universal health access system with explicit guarantees (AUGE).

Overall, it can be stated that in the extreme part of the market, powerful actors such as the International World Bank (WB), the Inter-American Development Bank (IDB) and the Monetary Fund (IMF), have supported and funded reforms looking for a larger commodification of health systems.

For example, a clear indicator of its influence is that between 1990 and 2003, loans from the IDB and the World Bank to support reforms to health systems increased from approximately 700 million dollars to nearly 3,000 millions[17] (Mesa-Lago, 2007: 61; PAHO and WHO, 2004: Figure 1).

At the end of the universalization are located the non-financial multilateral international organizations such as WHO, PAHO and the International Labour Organization (ILO), as well as Health Ministries in some countries and non-governmental organizations (Ugalde and Homedes 2002; Lloyd-Sherlock 2004, PAHO and WHO, 2004: 7).

Among the actors that support Universalist reforms, those who oppose to liberal reforms and to the expansion of the private sector have gained relevance: health professionals, hospital administrators, social security employees and labor unions. This opposition was crucial, for example, to modify the focus of the reforms in Chile, which went from a commodification perspective to another one that emphasizes equity (Kaufman and Nelson, 2004).

THE CONTENTS OF THE REFORMS

The contents of the reforms are heterogeneous. They highlight the following issues: guaranteeing the right to health care in the Constitutions[18]; the creation of basic packages for vulnerable populations; strengthening the steering role of the Ministries of Health[19]; the separation of the provision of health services and the financing of the system; and the decentralization of health services (Infante et al., 2000: 15-16.).

17 Homedes and Ugalde argue that at the end of the 80s the World Bank had become the international leader and leading advocate of neoliberal reforms and became the main international player in the design and implementation of health policies (2005: 83, 94).

18 Often without this being translated into specific laws.

19 Although the results in this area appear to be poor.

THE IMPACT OF REFORMS

Health systems reforms in Latin America have been evaluated by the Pan-American Health Organization (PAHO) and the World Health Organization (WHO) in 2004, and by Carmelo Mesa-Lago (2007). In the first case, the results tend to be descriptive and it conforms to the information provided by the Ministries of Health; in the second case, it chooses to make a comparison that does not seek to evaluate the effectiveness of the reforms but its impact on social security principles[20] (Mesa-Lago, 2007: 165).

Two trends clearly identified by these evaluations are developments in the field of expanding the coverage of basic services but no substantial progress in the quality of services or the overall efficiency of health systems (Infante et. al. 2000 and 2005; Mesa-Lago 2005, 2007, PAHO and WHO, 2004).

However, there are a number of factors that hinder this task, including the great heterogeneity of health systems; the circumstances when reforms initiated; models followed; and the lack of comparable statistics (Mesa-Lago, 2005, 2007).

To address this complexity an alternative would be to make comparisons between two or three reforms in different countries. This strategy has allowed a proper analysis of various aspects of the reform process[21].

Precisely, this paper's purpose is to analyze the reforms to health systems of Chile and Mexico aimed to the extended universalization of the social right to health. In Chile, these reforms led to the creation of the program "*Universal Access with Explicit Guarantees in Health*" (AUGE) and in Mexico led to the establishment of the "*Seguro Popular*" (SP).

20 These principles are universal coverage; consistent quality of services for all citizens; solidarity, completeness and sufficiency of the benefits; unity, State responsibility, efficiency and social participation in management: financial sustainability, promotion of savings and capital markets. (Mesa-Lago, 2007:5-24)

21 These include comparisons of political factors involved in the feasibility of health reforms, the similarities and differences between reforms of social security and the ones of the health sector. Also the privatization and decentralization processes in different countries; the trans-nationalization processes arising from the application of management models and the impact of reforms in the social security principles (Gonzalez-Rossetti, 2005; Homedes and Ugalde, 2000, 2005, Granados and Gomez, 2000; Iriart, Merhy and Waitzkin, 2000; Mesa-Lago, 2005, 2007).

IV. TRAJECTORIES OF REFORMS DURING THE EIGHTIES AND NINETIES

Latin-American health system reforms started from the 1960s, however, there is an assumption that reforms of the eighties were the earliest in the cycle of stabilization and adjustment and their main objective is to attain economic liberalization. The next table shows that the bulk of the reforms will concentrate during the 1980s and 1990s decades **(Table 3)**.

TABLE 3. TRAJECTORIES OF HEALTH SYSTEMS REFORMS IN LATIN AMERICA (1960-2010)

	PIONEER 1960s-1970s	**EARLY 1980s (Decentralization)**	**INTERMEDIATE 1990s (Commodification)**	**DELAYED 2000 to present (Universal)**
Countries	Bolivia Cuba Trinidad and Tobago Jamaica	Brazil Chile Costa Rica Guatemala Mexico Venezuela	Argentina Chile (1) Paraguay Surinam The rest of the Caribbean Andean countries	Argentina Chile Ecuador Mexico Dominican Republic Peru Venezuela

Since the eighties
Source: Own elaboration from Azevedo, 1998; PAHO and WHO, 2004: Table 2; Mesa-Lago, 2007: Table 7.1

TABLE 4. KEY OBJECTIVES OF REFORMS TO HEALTH SYSTEMS IN LATIN AMERICA, 1980-2010

EARLY, 1980s (Decentralization)	**INTERMEDIATE, 1990s (Focus and commodification)**	**DELAYED, 2000-present (Universal)**
(1) Release central government funds to repay foreign debt (2) Increase the flexibility and proximity of health services to the population (3) promote community participation (4) In the case of Brazil: to combine decentralization and universalization	(1) Search for financial and administrative efficiency (2) Promotion of market strategies to improve services (3) Combination of public and private sectors (4) Achieve separation of the service delivery functions from the financing functions (5) Promote competition as mechanisms to seek efficient use of resources	(1) Expand coverage to those excluded from social security systems (2) Reforming the general health laws (3) To ensure the right to health (4) To establish minimum benefits for the entire population

Sources: Own elaboration from Ugalde and Homedes, 2002: 27; Vazquez, et. al., 2002: 30-31; Tobar, 2006: 285; Homedes and Ugalde, 2002; Mesa-Lago, 2007, Barba, 2013.

The main arguments wielded to justify reforms have been to improve efficiency, reduce the expense and facilitate privatization (Ugalde and Homedes, 2002: 22-23; Abel and Lloyd-Sherlock, 2004).

Table 4 shows that in the *early* reforms the key component was decentralization. Reforms were pragmatically induced to release funds from the central government to repay foreign debt[22]. A clear exception was the Brazilian reform aimed at guarantee the universal right to health. However, the main argument to justify decentralization was to increase the flexibility of health services and to bring them closer to the population. It was intended that the services would meet the local needs and favoring the cooperation of the community (Vazquez et. al., 2002: 31)

According to numerous authors, the results of the reforms that sought decentralization were poor, because of the increase of irrationality and inequality, the spending was not reduced, coordination did not improve and inefficiency grew by increasing unnecessary referrals to higher administrative levels (La Forgia and Gonzalez-Block 1995; Bossert: 1996; Holley: 1995; Larrañaga, 1999; Ugalde and Homedes, 2002)

During the nineties, there was a fundamental change in the orientation of reforms, which from that time were dominated by the search for efficiency and promoting marketing strategies to improve services **(Table 4)**. *Intermediate* reforms accentuated the combination of the public and private sectors in financing, developing new management strategies and in efficiency as the main objective[23] (Table 4).

To achieve greater efficiency, were promoted the separation of the service delivery functions from the financing functions and the competition between service providers[24] (Tobar, 2006: 285; Ugalde and Homedes, 2002).

The second-generation reforms pursued to focus actions and public services in the uninsured population and do more with less or the same resources. This eroded the principle of universality of coverage of public services and tended to weaken the control of transmissible diseases and vertical programs.

These reforms also wanted to consolidate markets or quasi markets (mechanisms of competition in the

22 This explains why international financial organizations promoted and financed these reform processes. In fact, the World Bank dedicated the World Development Report 1993 almost entirely to the change in health systems (World Bank, 1993).

23 Already in 1985, the Regional Committee of WHO for the Americas estimated that in this region about 30% of the spending was wasted on health. Besides, health systems were characterized by a healing and urban bias, inappropriate staffing structures and bad coordinated and fragmented administrations (quoted by Abel and Lloyd-Sherlock , 2004: 809)

24 It was thought that the State should guarantee stable financial flows for benefits and not necessarily to provide services directly, but through purchasing health services to private providers and private insurers to public hospitals (Tobar, 2006: 285; Ugalde and Homedes, 2002)

provision of social services) and to finance the health services demand as well, instead of ensuring public offering. WHO incorporated the concept of "*rectoría*" to refer to the role of government in health.

Since the 90s, the sign of the reforms changed, from the initial recognition that the two cycles of previous reforms had entered a deep paradigmatic crisis (Tovar, 2006: 285-286). Third generation reforms have had four main objectives: to extend coverage to excluded from social security systems, to reform general health laws, to guarantee the right to health and to establish minimum benefits for the entire population **(Table 5)**.

However, as noted by Carmelo Mesa-Lago (2007), the vast majority of the "*universalist*" reforms conducted in Latin America during the 90s and the 2000s did not come to fulfillment. Between 2003 and 2006, eight countries adopted or were debating about new health laws or changes to their health systems, but the overall scenario showed great failures **(Table 5)**.

TABLE 5. CHIAROSCURO OF REFORMS IN THE 2000S IN LATIN AMERICA

Clear (Pros)	Dark (Cons)
Chile had advanced into a third generation of reforms that originated the AUGE program Mexico had amended the General Health Law in 2004 and had created the "Popular Insurance" (SP)	In 2006, the reform started in Dominican Republic in 2001, paralyzed and started Counter-Reform discussion The Ecuadorian reform initiated in 2008 was declared partially unconstitutional in 2001 The 1997 Nicaraguan reform was void in 2005 The Venezuelan reform was completely paralyzed in 2006.

Source: Mesa-Lago, 2007: 159; Barba, 2010.

As shown in Table 5, the Chilean reform that led to the creation of *AUGE* and Mexican reform that established the *Seguro Popular* can be considered as relatively successful, hence the importance of examining them, especially in a context where the evaluation of the reforms are scarce.

V. REFORMS IN MEXICO AND CHILE
HEALTH SYSTEMS IN CHILE AND MEXICO

In 1952 Chile developed a State health system, centralized, with a high coverage and considered back then as one of the most universal, eq-

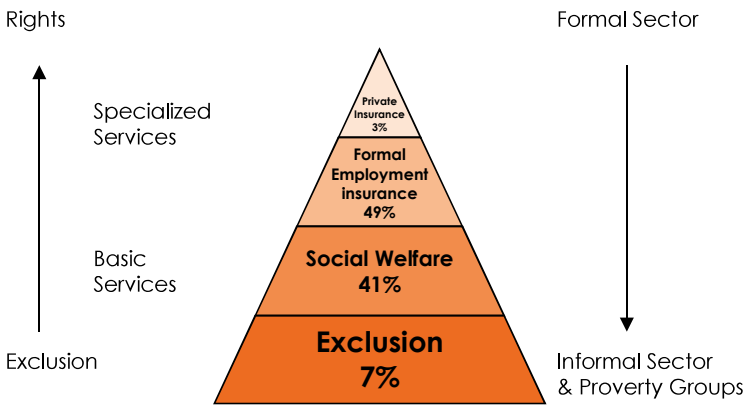
uitable and with better quality among Latin-American countries. However, during the eighties and the military dictatorship, a system of private financing was developed, which significantly increased the number of private clinics as a result of significant public subsidies (Azevedo, 1998: 194; Homedes and Ugalde, 2002: 58).

In Mexico, historically, the health system is highly segmented, further comprising of the Ministry of Health, private services and a broad segment of social insurance institutions for different sets of workers. Coverage of workers in the formal sector is mainly divided between the Mexican Institute of Social Security (*IMSS*) created in 1943 and the Institute for Social Security and Services for State Workers *(ISSSTE)* founded in 1959[25] (Barba, 2010).

While the Chilean system has achieved an average degree of integration, Mexico's health system is characterized by its disintegration (Mesa-Lago (2007). However, both systems have achieved a high degree of coverage. In Chile, in the late nineties, 69% of the population was covered by public services, 26% by private publicly funded institutions *(ISAPRES)*[26] and only 5% by private institutions.[27]

Historically, the Mexican case shows that the indigenous population has been excluded as the rest of the population is distributed among social security institutions, welfare state services and private health insurance. **Figure 1** shows the system's profile in 1998.

FIGURE 1. PAST STRATIFICATION OF SERVICES AND RIGHTS IN THE MEXICAN HEALT SYSTEM



Source: Own calculations based on OECD, 1998: 96

25 However, there are other institutions such as the Institute of Social Security for the Armed Forces of Mexico (ISSFAM), established in 1976; and social security for employees of Petroleos Mexicanos (PEMEX), included in the employees' contracts since the thirties decade of the last century (Barba, 2010).

26 Institutions of the Health Insurance System.

27 By the year 2000, Chilean population covered by the ISAPRES rised 30% (Granados and Gomez, 2000: 108)

Figure 1 also shows stratification in rights. At the base of the pyramid are the poorest, excluded by the health system. On the next floor, the assisted sector that belong to the uninsured. Then there are those insured through formal employment. Finally, at the top is located a minority with higher incomes, able to hire private insurance.

For policyholders who belong to the formal sector, whose were part of the 49% of the total population, the two most important institutions were the *IMSS* and the *ISSSTE*. The first had 80% of the beneficiaries, the second only 17% and well below we could find the *ISSFAM* and *PEMEX* workers, which both together attended 3% of the insured (OCDE, 1998: 96; Gutierrez, 2002: graphic 4.2)

Another large segment of the Mexican health system is conformed by the public health services for the uninsured, vulnerable population as a whole that includes 41% of the total population. The main institution responsible for providing health assistance was the Ministry of Health, accompanied by the *IMSS-Oportunidades* program (formerly known as *IMSS Coplamar* and *IMSS-Solidaridad*) and procurement programs to access basic health services[28](Barba, 2003 and 2010)

THE EARLY AND INTERMEDIATE REFORMS OF CHILEAN AND MEXICAN HEALTH SYSTEMS.

Both Mexico and Chile health systems have experienced early, intermediate and late reforms. In Chile, the reforms of the eighties had repercussions such as an incomplete municipalization of health services and a considerable deterioration of public services due to a drastic reduction in health investment. In addition, private insurance companies started to appear financed through the National Health Fund *(FONASA)*[29] which covers part of the cost of the service and the other part is paid by the user with the exception of the homeless population.[30] (Azevedo, 1998: 195; Homedes and Hugalde, 2002: 58)

28 The SSA was established in 1943, IMSS-Coplamar in 1979, named IMSS-Solidaridad in 1993 and changed its name afterwards to IMSS-Oportunidades in 1997. Simultaneously, the enforcement programs of access to basic health services were established in 1995 (Barba, 2003)

29 The only collection agency for health state imposes a funding fee equivalent to 7% of salary for workers.

30 This system has been very beneficial for the ISAPRE that have been operating with profit margins of 20% and administrative costs of 20% as well, precisely because to a very careful selection of customers; for example, the transference of retired workers and chronically ill patients to FONASA). Those percentages were reached thanks to a limited range of services offered to the users and increases in co-payments and deductibles (Homedes and Hugalde, 2002: 58).

During the nineties, efforts were made to recover the functions of the public sector by increasing investment, supporting decentralized local authority services, trying to improve the effectiveness of subsidies, making administrative improvements, actions to reduce inequality through focusing investments in the neediest communities articulated with a strategy for poverty reduction[31] (Azevedo, 1998; Homedes and Hugalde, 2002 Tobar, 2006).

In Mexico, decentralization has gone through two stages; the first one, between 1983 and 1988,[32] the second one began in 1994[33] and concluded with the creation of the *Seguro Popular* (SP) in 2004, which has an obvious centralizing inclination and provides benefits to exactly the same population served by the Mexican health services. Decentralization included only those services provided by the Ministry of Health, aimed at those who do not have social security or private insurance.[34] The evidence indicates that decentralization resulted in more inequality within and inter Mexican states and exacerbated the fragmentation of health policies increasing inequalities in mainly every health aspect (Gonzalez Pier, 2005; World Bank, 2004: 156).

The government of President Ernesto Zedillo *(1994-2000)*, tried to privatize the Mexican health system, through the Program of Health Sector Reform (HSRP), which intended to deregulate and dissociate some segments of social security to enable participation the private sector, not only in the field of pensions but of health. The target was to create a quasi-market[35]through the reversal of quotas[36] and opening up the possibility that the insured could chose doctors in primary care.

However, this reform failed because of the veto power of the union of the Mexican Institute of Social Service *(IMSS)*[37] and numerous *PRI* party congressional representatives. (Gonzalez-Rossetti, 2005: 28-29).

31 The diagnosis of the reform process was very negative, for a detailed description of this diagnosis see: Homedes and Hugalde (2002: Table 3).

32 During the first phase, which included only 14 of the 31 states, the balance of this process was very negative because decentralization did not imply the transfer of authority to each state's government so they could make decisions in three crucial areas: programing, human resources and financial. The net result was an intensification in inequality and reduced quality of services (Homedes and Hugalde, 2005: 216, Gonzalez Rossetti, 2005: 32).

33 This phase began in 1994 based on the signing of a Decentralization Agreement with each state, which had a lot of resistance but finally, the last agreement got signed in 1999. The programmatic authority system and decisions on staffing remained highly centralized. However, there was greater flexibility in the use of federal financial funds, from the creation of the Health Services Contributions Fund (FASSA). Since then, state services freely dispose of these funds transferred by the federal government, with the exception of those corresponding to the category of wages, which are the majority (Homedes and Hugalde, 2005: 216-217).

34 This particular group is known as "Open Population".

35 Separation of financing functions and services provision. Under a system of 'quasi-market,' providers can be private even using public funding as this same sample happened in the case of Chilean ISAPRES (Le Grand, 1991).

36 A company would have the possibility to avoid IMSS affiliation of their own workers if they prove to have a private social security service hired.

37 For the union, reform proposals represented an imminent beginning of the dismantling of the

THE THIRD GENERATION REFORMS IN MEXICO AND CHILE

MEXICO, CREATION OF THE SEGURO POPULAR (SP)

After the transition to democracy in 2000, the biggest change experienced by the Mexican social policy was the reform of the General Health Law in 2003 that gave rise to the Social Protection System in Health *(SPSS)*, designed to integrate health insurance *IMSS* and *ISSSTE* with a new insurance system, created in 2002: the "*Seguro Popular" (*Popular Insurance).

The reform in 2003 meant to address two long-standing problems of the Mexican system: the disintegration[38] and social inequality in health. Unequal access to health care in Mexico has multiple dimensions. The first one is the polarization in access to social security, as shown by the following data for 2004: while the coverage of social security for the elderly and indigenous native people is about 20%,[39] the richest decile in the income distribution had a 90% coverage, while the poorest decile barely reached 1.5% coverage (Scott, 2005: 60)

The second dimension is the unsatisfactory quality of the services offered, easily shown in the uneven per capita spending on health institutions. In 1995, taking the average per capita spending to the national level as an index 100, *PEMEX* exercised a per capita spending of 553.3, the *IMSS* 99.4, *ISSSTE* 63.0, *SSA* 52.8 and *IMSS-Solidaridad* 18.7. The per capita spending on top of the pyramid of public services was 10 times higher than in the base (OECD, 1998: Figure 17).

The third refers to the regional inequalities. In 1997 in the Northeast[39] region, the richest of Mexico, the 52% of the population were right holders to social security and were entitled to a health spending per capita of $1,277 pesos[41].

Comparatively, in the South Pacific Region[42], the poorest, only 16% had insurance and the per capita budget for health was over two times lower[43] (Gutierrez, 2002: Table 2).

IMSS through the introduction of private providers and a dangerous precedent in proposing amendments to the collective contract (Gonzalez-Rossetti, 2005: 34).

38 Mexican segmentation system can be seen in ***Figure 1*** presented in the previous section.

39 In rural areas, social security coverage for the elderly in 2004 was only 5% (Scott, 2005, 60).

40 Including the states of Nuevo Leon and Tamaulipas, with a population of 6.5 million, 89% of urban character, with the lowest birth rates and where the main industrial groups in the country are located (Gutierrez, 2002: 77).

41 Pesos from 1997.

42 Including the states of Chiapas, Guerrero and Oaxaca, with a population of 10 million , 53% of them have a rural origin, with high birth rates, predominant primary activities, where 25% of the population is indigenous and 24.5 % is illiterate (Gutierrez, 2002: 78).

43 $583 pesos.

These inequalities became more complex due to a prolonged and heterogeneous[44] epidemiological transition that led to the health system to face a double burden: an unfinished agenda in controlling infections, malnutrition and reproductive health problems[45]. Then followed by emerging challenges on account of diseases --as chronic diabetes or heart or liver disease[46], mental disorders-- and the growing problem of injuries and violence (Frenk, 2007: 16).

However, health financing did not increased to meet the new risks structure. In 2004, just after the 2003 reform, Mexico invested only 5.8% of GDP on health.[47]

The situation was aggravated because before the 2003 reform in Mexico, about 50% of health spending was private and almost entirely accounted to households expenses, which in 2004 were catastrophic or impoverishing[48] to 5 million people[49] (SSA, 2005; Scott, 2005: 68)

To cope with this critical situation, in 2003 the *Seguro Popular* was framed into the *SPSS*. The SP offers a basic health package that is accessed through a public and voluntary insurance, designed for those with a low income, jobless or self-employed people that are not right holders to any social security institution (National Commission for Social Protection in Health, 2011).

The package offered by the SP includes provision of medicines, financed through public subsidies and progressive contributions from households depending on income levels and household assets. Households in the first four deciles do not contribute financially (Ministry of Health, 2006: Table 1; CNPSS, 2011).

The SP is legitimized by affirming its own *Universalist* aspiration to exercise the constitutional right to the protection of guaranteed health care for all citizens. However, the 2003 reform did not change the dominant paradigm called "fragmented pluralism," which tries to extend coverage across different systems, which theoretically complement each other.

The SP focuses on first and second levels of medical care but aims to guarantees two types of services: the essentials and the high cost services. The first and second level of medical care absorb most of the assigned resources to the states and correspond to almost all

44 At the end of the last century, it was manifested as the addition of new aspects to the traditional patterns of disease, disability and death.

45 Problems related to poverty.

46 Associated with risk factors such as smoking, alcoholism and obesity.

47 This is equivalent to $357 USD per capita. This level of spending on health is significantly lower than the 14% of the GDP spent in the United States, equivalent to $4,500 US dollars per capita in 2000, and even less than 6.1% of GDP spent on average in Latin America (SSA, 2004).

48 *Catastrophic expenses* are defined as annual health disbursements of more than 30% of the available money intended for food in households; *impoverishing costs* represent expenses that reduce available resources below the poverty line.

49 The World Bank estimated that in 2002, 9% of insured households in Mexico faced impoverishing costs, while 40% of uninsured households fell below the poverty line as a result of health care costs. (World Bank, 2005)

expected interventions in the Universal Catalogue of Essential Health Services *(CAUSES)* and to the total of guaranteed medicines, which can be supplied in ambulatory care units and general hospitals.

The high cost services are provided in specialties hospitals and are financed through the "Fund for Protection against Catastrophic Expenses" *(FPGC)*. However, the SP does not clearly establish which services will be included. It simply clarifies that the provision is conditional upon the availability of resources that are not sufficiently guaranteed.

The package includes 283 first and second level interventions, the supply of 307 drugs and coverage of 1,500 diseases[50], besides 57 expensive and specialized interventions subject to coverage by the Fund for Protection against Catastrophic Expenses[51] and 131 operations covered by the *SMNG*, created in 2006 and articulated to the *Seguro Popular* (CNPSS, 2011; Knaul, et. al., 2013).

Grogger and colleagues (et. al.: 2011) confirm the limited impact of the *SP* on catastrophic expenses. They realized that the *SP* has only significant effects in reducing catastrophic health expenditures in rural areas, but only regarding to consultations and hospitalization, while in metropolitan zones it has little effect in that area, although it reduced average health spending, especially in the purchase of medicines and pregnancy care.

Cardenas (2011) founds that between 70 and 90% of those who required the services offered by the *SP* used care services but 5 out of 10 of those assisted affiliated people had to make other expenses not covered by the institution, demonstrating that personal expenses continue despite the reform[52].

Although regional gaps in the coverage of health services have been reduced, inequalities remain. This can be seen in **Table 6**, where it is clear that in the richest region there is a minor lack of health services, while in the poorest region there is an outweigh of these shortcomings.

50 100% served in first class units, 95% of second level and 60% of those that generate catastrophic expenditures and corresponding to actions of third level. (*CNPSS*, 2011).

51 In 2011, there were 57 interventions subject to coverage by the Fund for Protection against Catastrophic Expenses which is part of the People's Insurance *(Seguro Popular)*: including various types of cancer, corneal transplant, acute myocardial hearth attack in adults under 60 years old and congenital and acquired malformations subject to surgery. In 2011, spending billed 40% of its budget to pay for HIV antiretroviral (40%), breast cancer (25%) and neonatal intensive care (15%) (Knaul, et. al., 2013: Panel 2, p. 214).

52 According to the assessment made by *CONEVAL* to the *Seguro Popular* in 2010-2011, while the *SP* has significantly improved the scale and equity of health financing available for the population uninsured by contributory social security institutions, there is no clear evidence yet to verify and corroborate the program's impact on health. We need to demonstrate that the financial potential of the program will result in measurable progress on effective access to quality services and the health levels of the population (CONEVAL, 2011).

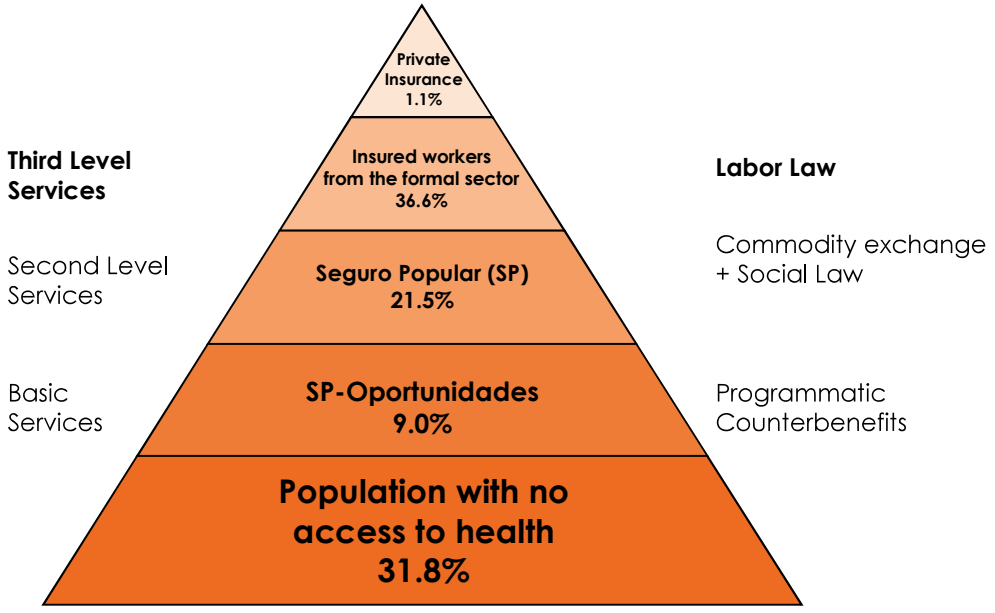
TABLE 6: PERCENTAGE OF PEOPLE WITHOUT ACCESS TO HEALTH SERVICES IN THREE STATES FROM THREE DIFFERENT REGIONS IN MEXICO (2008-2010)

Region	Location	Lack of Health Services 2008 2010	
Richest	Nuevo Leon (North region)	28.6	22.4
Middle	Jalisco (Pacific region)	37.2	35.2
Poorest	Chiapas (South region)	52.1	36.5
	National	40.8	31.8

Source: Compiled from *CONEVAL*, 2011: Table 5

Furthermore, the characteristic segmentation of the health system has not been overcome; it appears that it has added a new step to the Health Pyramid stated above. This significantly sets apart from the *Universalists* ideals and adds greater complexity to the system. **Figure 2** shows this new situation.

FIGURE 2. SEGMENTATION OF THE MEXICAN HEALTH SYSTEM IN THE LATE 2010S



Sources: Own calculation based on: CONEVAL, 2010; *INEGI* and *ISSSTE*, 2010; CNPSS, 2009

We can notice in **Table 7** that after the reform, the distribution of access to contributory security remains highly regressive as in 2010, 50% of the affiliated to these systems were concentrated in the three deciles higher incomes, while only 17.5% of the affiliated belonged to the poorest four deciles. On the contrary, the access distribution to the *Seguro Popular* is progressive since 63.8% of its members belong to the poorest deciles. These data reaffirm the dualistic nature of the Mexican health system.

TABLE 7. MEXICO: PERSONS AFFILIATED TO HEALTH INSTITUTIONS BY TYPE OF PUBLIC INSTITUTIONS IN 2010 *(PERCENTAGES)*

	Persons affiliated to social security institutions	**Persons affiliated to the *Seguro Popular***
Deciles 1 to 4	17.5	63.8
Deciles 7 to 10	50.0	10.3

Source: Compiled from Valencia, Foust and Tetreault (2013: Tables 9 and 11)

THE CHILEAN CASE

In Chile, during the government of President Ricardo Lagos, the Health Reform was developed to address five problems. First, inequality in access to health care between *ISAPRE* system (public/private) and *FONASA* (the public); second, deficiencies in public hospitals management. Third, the lack of regulation of plans and attentions in the private care subsystem; fourth, the unsuitability of the model that emphasized chronic diseases care and, as in the Mexican case, it had not been adapted to the changing epidemiological profile. Finally, the insufficient funding in the public sub-sector. This new reform intended to change the legal structure of the health system in order to promote greater equity and solidarity. The reform was estimated feasible because of the political changes at parliamentary level (Lenz, 2007: 8)

The National Public Health System provides all Chileans formal universality of access to health care. However, as Urriola (2006) notes, in reality the exclusion occurs in various ways such as waiting lists, lower quality of the benefits and financial requirements, especially to solve complex medical interventions affecting catastrophic expenses. Therefore, the timeliness, the quality and financing are the crucial variables that were considered in the 2004 reform (Urriola, 2006: 279-280).

The elaboration of the reform corresponded to an Interministerial Committee and what was sought was to carry out a number of principles, including: the universal right to health, to ensure an adequate

and timely care for all citizens, considering the capabilities and resources of the country; the equity of the system; social solidarity; the efficient use of resources and social participation in health. (Roman and Muñoz, 2008: 1600)

The reform crystallized a plan known as "Universal Access with Explicit Health Guarantees" ***(AUGE)***, later renamed as Explicit Guarantees in Health Regime **(GES)** which has resulted in a Plan of Public Health and Health Plan for People.

The latter, unlike the Mexican *SP* sets the type of beneficiary and guarantees diagnostic procedures, treatments and follow-ups in a limited number of specific and progressive diseases for patients. (Roman and Muñoz, 2008: 1600)

AUGE was created in 2004 similar purposes to those of the *SP*: improving the health care in terms of access, quality of care and ensuring funding for the most prevalent diseases and, financially, with more substantial burden on the patient and the Chilean State. Pathologies leading to catastrophic expenditures were included (2004, Ministry of Health).

The *package* attended by *AUGE* or GES is much smaller than the *SP*: initially 5, by 2005 25, by 2007 56 and, by 2013, it reached covering 80 diseases; the rest of the pathologies continue to be serviced by the public system *(FONASA)*, the *ISAPRES*[53] and by private medical services (Lenz, 2007: 24; Superintendence of Health, 2015).

However, *AUGE* offers four explicit guarantees *(GES)* for their beneficiaries: guaranteeing access, that implies to receive the precise attentions for each disease in the institutions of *FONASA* or *ISAPRES*. The second guarantee is quality assurance involving the granting of health benefits by registered or accredited operators to the Chilean Intendence of Providers. The third would be timeliness guarantee that sets maximum deadlines on service providers to meet established protocols on time. Finally, a guarantee of financial protection, which establishes the obligatory requirement for users to make the co-payment.[54] (Ministry of Health, 2002, Superintendence of Health, 2015)

As in the case of Mexico, *AUGE* has been criticized for the exclusion of diseases whose treatment is more

53 See note 17.
54 0% for A and B affiliates to *FONASA*, 10% Group C and 20% Group D and members of *ISAPRES* (Superintendence of Health, 2015).

expensive, resulting in the rejection of many patients, this gives this plan a relatively focused character. Regardless of this, unlike the *Seguro Popular*, *AUGE* offers explicit guarantees already mentioned and which are not present in the Mexican case. In addition, *AUGE* emphasizes on diverse high mortality and cost conditions. (Lenz, 2007; Roman and Muñoz, 2008).

Another distinctive *AUGE* feature is that it was conceived as a dynamic system that proposes to improve the services already offered and gradually add others. Nevertheless, the plan design tends to address the acute phase of chronic diseases, but the subsequent stages escape to the attention guaranteed by law, resulting in complications associated with the evolution of some non-considered diseases as well as the lack of preventive actions performed by the system.

Different authors consider that *AUGE* has not reduced the costs of the health system, when in fact covering *AUGE*'s guarantees has meant more funds than expected. Nonetheless, compared to the *SP*, a significant advance is that patients have the right to appeal to the judicial system when *AUGE* guarantees are not met, underscoring the prosecution of this social right. (Ipanza, 2007; Roman and Muñoz, 2008: 1601)

In terms of political economy, Lenz highlights the success experienced by the reform in its phase of political negotiations but the political capital has not been enough to pave the way and ensure its implementation. The author points out two unbeatable obstacles: the losers, during the negotiation phase, often block or slow the pace of the actual reform; the second is that political negotiation is moving in a relatively abstract field that has little to do with the operational complexities of the implementation phase. With no doubt, this is an important lesson to take into account in any reform process. (Lenz, 2007: 31)

FINAL WORDS

In the introductory part of this work, we wondered whether reforms to the health systems of Chile and Mexico could be framed on the assumption of a *change of time* marked by the emergence of a basic *universalism* in different versions in Latin America. Evidences show that the Chilean case is closer to this assumption even if *AUGE* program appears to be more focused than *Seguro Popular* (SP) program, since targeting occurs in a historical context of greater universality. *AUGE* tends to increase the integrity of the health system, equity in access, quality of services and financing, and even the gradual inclusion of medical conditions that generate catastrophic expenses as well as the judicial prosecution of the right to health. This does not happen in the Mexican case.

These Chilean achievements mark goals that should be considered for a new reform of the Mexican Health System with *universalist objectives*, because since the creation of the *Seguro Popular* in Mexico, even though it offers a broader package of services, tends to reinforce the segmentation of the health system. It does not solve the problem of "pocket expenses" made by the users, it focuses on basic and second level services and does not allow overcoming regional gaps regarding health coverage.

On the other hand, the Chilean reform exhibits important limitations, as it does not seem to influence enough to change the structure of the Chilean health system already segmented since the creation of *ISAPRES* with a strong preference in favor of private services.

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