

Social policy and health policy in Latin America: a field of political struggle

La política social y de salud en América Latina: un campo de lucha política

Política social e de saúde na América Latina: um campo de luta política

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Social policy and health policy are integral parts of society's projects, but their place in societies differs. Rightist or neoliberal governments view such policies as an area they cannot overlook without losing legitimacy, and as a terrain for patronage and corporate population control. The main objective of such governments is to make social and health policies another field for commodification and generation of profit for capital.

For leftist and progressive governments, social policy and health policy as part of it are priority instruments for generating social welfare and decent life for citizens. Nevertheless, when such policies are insufficiently or incorrectly implemented, they not only fail to serve their purpose, but can become an important source of de-legitimation and popular discontent.

The two major health policy standards, so-called Universal Health Coverage (CUS, acronym in Spanish) and what is known as the Unified Health System (SUS), express two distinct ways of conceiving and (re)building the state. Thus, CUS or "structured pluralism" ¹ as it is known in Latin America is the model promoted by the neoliberal state, while SUS pertains to the social state.

Strictly speaking, CUS refers to insurance coverage and not universal access to the required services, since it only supports an explicit and financed package of services for individuals, leaving aside public health actions ². Its objective is to introduce the market and competition, both in the administration of funds and purchase of services and in the provision of medical services, in both cases including both private and public agents. The content of the packages of services varies according to the premium, and public funds are often used to subsidize the market. The three most well-known national cases of this model are Chile, Colombia, and Mexico, which nevertheless have some differences ³.

SUS is intended to guarantee the universal right to health as a duty of the state. It is based on the original English model of the National Health Service: free of cost, with solidarity, redistribution, universality with comprehensive, integrated coverage of services for the entire population, and funded by general taxation. In the Latin American countries with this model, it is written into the respective Constitutions in some form ⁴.

Nevertheless, not only the neoliberal governments or states, minimal or modernized, but also social welfare, leftist, or progressive governments have experienced problems in implementing their

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respective health policies that apparently would correspond to their political ideology. The reasons are varied and complex, of an economic, political, institutional, and ideological order, or rather a mixture of the above.

The notion by García Linera ⁵, of “institutional materiality” as a dimension of the state, allows addressing this problem. The existence of institutions with their own history and structures cannot be overlooked particularly when moving from one form of the state to another, as is the case both in the construction of the neoliberal state and that of the social democratic state of law.

In the former, it has proven impossible to replace the preexisting public institutionality with another, market-centered and private system without encountering serious problems. In the case of Colombia, where the CUS model was implemented through *Law n. 100* in 1993, in time it led to the system’s economic bankruptcy in 2009, despite several partial reforms. This not only debunked the model’s “success case”, but also revealed serious problems involving denial of services and corruption ⁶. The solution proposed by the Colombian government, to condition the right to health on sufficient budget resources, was defeated through a broad mobilization of different sectors of the population in which health workers played an important role ⁷.

Another attempt to implement CUS, in Mexico, has failed to reorganize the highly segmented health system according to the central concepts of regulation, financing, administration of funds/purchase of services, and provision. The reason is that the private sector cannot replace the country’s public social insurance, which is the main provider of services with its own installations and human resources, without causing a nationwide collapse in healthcare services. Thus, the policy to create a “Universal National Health System” is at a standstill, despite strong pressure by the private insurance industry, part of the power block currently in government. This is explained not only by the impossibility of financing such a system, but also because it would drastically reduce health services to the 40% of the population covered by the public social insurance, leading to a profound political conflict for a government already suffering serious lack of legitimacy ⁸.

As for the SUS, only Cuba has built one entirely. The majority of the leftist governments have written into their constitutions the SUS as a duty of the state, but they have also experienced institutional problems in its construction. The various obstacles include a weakened public institutional structure inherited from neoliberal governments and the private health sector’s weight and power.

Even the public social insurance institutions have frequently and successfully opposed joining the SUS. Paradoxically, the large trade unions have also maintained or negotiated private medical insurance and/or services as a labor benefit, although one would expect them to adhere to the ideals of solidarity, equality, redistribution, and the right to health as a citizen’s right. Meanwhile, clean slate attempts have led to the parallel development of another health subsystem built as a further obstacle to construction of the SUS. The most well-known case is *Misión Barrio Adentro* in Venezuela ⁹.

The persistence and growth of the private sector in health insurance and/or provision of medical services are not an inertial phenomenon, since they involve economic interests and forces with the capacity to generate or take advantage of political conflicts, contributing actively to the de-legitimization of progressive governments. These forces have additionally helped underfinance the public system by capturing tax resources directly or via tax exemptions.

Despite these problems, the progressive governments that have opted for CUS have been much more successful than the neoliberal governments in expanding real access to health services. For example, the SUS provided access to health services for tens of millions of previously excluded citizens ¹⁰. In Venezuela, the Chavista government likewise expanded services to 17 million previously excluded Venezuelans ⁹. There is also a sustained effort at building a public system focused on comprehensive, integrated primary care.

The priority is an extensive social policy expressed as the inclusion of a number of diverse themes, especially featuring both public goods and services such as active generation of employment and an overall increase in income. Social policy priorities vary from country to country, depending on their particular issues and the available resources.

The scenario in countries with neoliberal governments is quite different. The Mexican government has been forced to acknowledge that 17% of the population lacks health insurance (Instituto Nacional de Estadística y Geografía. Encuesta intercensal México 2015. <http://www3.inegi.org.mx/sistemas/tabuladosbasicos/default.aspx?c=33725&s=est>, accessed on Mar/2016), although universal coverage was proclaimed in 2012. Besides, insurance coverage does not guarantee access to the required services, for two reasons. The first is that the CUS model only guarantees access to explicit, limited packages of services, and the second is that neither the private sector nor government has covered the huge deficit in services, especially in the country's poorest regions. Meanwhile, in Colombia the denial of services has led to hundreds of thousands of court cases, and the Constitutional Court has declared unconstitutional the existence of distinct packages of services according to the payment made.

Social policy in these countries is targeted and minimalist, generally conducted through income transfer programs conditioned on the adoption of prescribed behaviors. Although the objective is to attack intergenerational transmission of poverty, this has not occurred in practice.

In the ideological terrain, the persistence of the medical model carries great weight, as does the idea that "good medicine" use medical high-technology and fourth-generation patented medicines. This ideology is still hegemonic, accepted not only by physicians and other healthcare personnel but also by politicians and even the general population. It has various negative results, unnecessarily increasing the cost of medical care, destroying clinical procedures, alienating physicians, and causing iatrogenic outcomes. It favors the interests and profits of the medical-industrial complex that promotes it by all means possible.

This ideology becomes an obstacle to building a public health system focused on public health, with its conception of the social and historical determination of the health-disease process and the corresponding model of care with social participation, inter-sector collaboration, and health education and promotion at the center. The challenge is apparently to create another culture of health, built step by step and with sustained social participation. This also requires reflection on the health area's specificity within social policy as a whole.

The struggle for the right to health as a citizen's right is not consistent with a market-centered, limited conception. It is thus important to mobilize social participation and combat the idea that the private sector can play the role of relieving pressure on the public sector. This idea segments the health system and increases inequality in access to the required services. It also reinforces the notion of the public system as a poor system for the poor.

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