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Universal health system and universal health coverage: assumptions and strategies

Ligia Giovanella [1]
Adriana Mendoza-Ruiz [1]
Aline de Carvalho Amand Pilar [1]
Matheus Cantanhêde da Rosa [1]
Gabrieli Branco Martins [1]
Isabela Soares Santos [1]
Danielle Barata Silva [1]
Jean Mendes de Lucena Vieira [1]
Valeria Cristina Gomes de Castro [1]
Priscilla Oliveira da Silva [1]
Cristiani Vieira Machado [1]

Abstract *In recent years the international debate about universality in health has been marked by a polarization between ideas based on a universal system, and notions proposing universal health coverage. The concept of universal coverage has been disseminated by international organizations and has been incorporated into health system reforms in several developing countries, including some in Latin America. This article explores the assumptions and strategies related to the proposal of universal health coverage. Firstly, a comparison is provided of the models of universal health coverage and universal health systems. This is followed by a contextualization of the international debate, including examples of different health systems. Finally, the implications of the proposal of universal coverage for the right to health in Brazil are discussed. The analysis of different concepts of universality and the experiences of different countries shows that health insurance-based models, either social or private, are not as satisfactory as public, universal health systems. Greater understanding about ongoing international projects is essential in order to identify the possibilities represented by the consolidation of the Unified Health System (SUS) in Brazil, as well as the risks of dismantling the SUS.*

Key words *Universal health systems, Universal health coverage, Health reforms, Right to health, Unified Health System (SUS)*

[1] Escola Nacional de Saúde Pública, Fiocruz. R. Leopoldo Bulhões 1480, Manguinhos. 21041-210 Rio de Janeiro RJ Brasil. giovanel@ensp.fiocruz.br

Introduction

In recent years, the international debate about different conceptions of universality in health has become polarized around proposals based on a universal health system (UHS) and ideas of universal health coverage (UHC).

The concept of universal health coverage has been disseminated by international organizations such as the World Bank (WB) and the World Health Organization (WHO)[1-3] as well as being incorporated into United Nations resolutions[4].

There is uncertainty regarding the meaning of "universality" in the UHC proposals. In European countries, universality generally refers to the public coverage of national systems, under names like universal healthcare or universal health systems (UHS). In developing countries, the term universal health coverage (UHC) is used to refer to basic services coverage[5], or to public or private health insurance coverage[6-8], indicating an emphasis on the subsidy of demand, to the detriment of the development of universal public health systems.

In Latin America there have been disputes regarding plans to achieve universality in health; these are centered on different conceptions about the right to health and the role of the state in social protection. Brazil is the only capitalist country in the region that has adopted a universal, public system since 1988. Although the implementation of the Unified Health System (SUS) has suffered from constraints and contradictions, the recognition of health as a right of citizenship and the expansion of services has resulted in important advances. Other Latin American countries have followed different paths towards health reforms, some of which have incorporated principles that are consistent with the proposal for universal health coverage, in various forms.

This article explores the assumptions and strategies related to the idea of universal health coverage and its possible consequences for Brazil. Initially, the concept of universality is contrasted within the UHC and UHS models. This is followed by a contextualization of the international debate, including examples of different health systems. Finally, the implications of the concept of universal coverage for the right to health in Brazil are discussed. It is argued that greater understanding about different projects in the international are essential to identify the possibilities and threats for the consolidation of the SUS in Brazil.

The concept of universal coverage in the international context

Universal health coverage (UHC) is an ambiguous term that has led to different interpretations and approaches by national health authorities, and governmental and non-governmental organizations, especially in developing countries. The implications of this ambiguity and the assumption of the principles of universal coverage for the right to health have been analyzed in the literature[6,7,9,10].

At the international level, the concept of universal coverage was shaped in the period 2004-2010 through relationships between the WHO, the Rockefeller Foundation and the WB, bringing together a number of pro-market reform guidelines such as the reduction of state intervention and an emphasis selective and focalized health policies[10]. In 2005 the WHO Assembly adopted resolution No. 58.33, "Sustainable health financing: universal coverage and social health insurance"[11]. However, the global debate around this issue became more prominent with the publication in 2010 of a report on financing[1]. Based on this report, in 2011 the WHO Assembly adopted a resolution on sustainable financing and UHC[12], which urged countries to ensure that health financing prevented direct payments from households on an out-of-pocket (OOP) basis, recommending early financial contributions as a form of risk-sharing in order to prevent "catastrophic expenditure" in health resulting in impoverishment[12].

The issue of funding is central to the idea of UHC, which encourages increased private participation in sector financing and the expansion of the private health market, as seen in the Rockefeller Foundation's arguments in the defense of UHC: "A large proportion of the population is willing to pay for private sector health services", and "strong market players such as pharmaceutical manufacturers, hospital organizations, provider associations and insurance companies, are likely to increase pressure to attract public and private financing, particularly as LMICs [low and middle-income countries] adopt policies to finance health insurance as a means to Universal Health Coverage (UHC)"[13]. It is plausible to suppose that the economic interest behind the saturation of the private health insurance market in Europe and the USA, together with the financial crisis of 2008, have influenced the concept of UHC, in search for clientele for this market in countries with large economies such as Brazil, India and South Africa.

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The ambiguities regarding the conception of universality in the UHC proposal can be perceived in the changing of concepts and approaches related to health financing in official WHO documents. The 2008 World Health Report suggested that the level of universality was related to the proportion of expenditure covered by public funds, and the path to universality would be to reduce users' participation in expenditure by increasing public expenditure[14]. In subsequent documents the key indicator "proportion of public expenditure on health"[14] was replaced by expressions such as "shared funds", "current pooled funds"[1], "funds raised to date", and "coverage mechanisms"[2]. The role of public funding is reduced in importance and the strategy becomes reducing direct spending through the purchase of private health insurance or subsidized insurance for the poor[1,2] (demand subsidy). In other words, the way to move towards universal coverage is no longer the extension of public funding[14] corresponding to a universal health system (supply subsidy).

In the Americas, the emphasis on health insurance coverage and the indistinction between coverage and access proposed by the WHO was questioned by some countries which are attempting to build universal health systems (including Brazil). The Pan American Health Organization (PAHO) consulted its member states and adopted a resolution in 2014 which broadened the conception by incorporating the guarantee of access to health services and mentioning the right to health[15], as well as disseminating "universal health" as a strategy to be implemented in the region.

With the expansion of the international debate, in 2015 universal coverage was incorporated into Agenda 2030 as one of the Sustainable Development Goals (SDGs). Target indicator 3.8 of SDG 3 "health and well-being" is to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all"[4].

The indicators defined in 2017 by the WB and the WHO to monitor target 3.8 of SDG 3 and to monitor the evolution of coverage focus on out-of-pocket expenditure (the proportion of the population that incurs catastrophic expenditures, defined as high expenditure on health *at the time of use* as a percentage of domestic income) and suggest a minimum basket of services included in the proposed "essential services index" [3].

This choice of indicators disregards the fact that payments for private health plans can also be catastrophic, and that in a situation of poverty there is little or no available finance for health spending. Furthermore, scientific evidence shows that the greater the investment in the public health system, the lower the percentage of catastrophic private spending in sector financing.

The essential services index focuses on the maternal-child and infectious-contagious diseases group and, although it includes the prevalence of diabetes and hypertension, it does not incorporate any prognostic indicator for cancer treatment[3]. In addition to presenting the same problems as any composite index regarding the weighting of components, in the absence of data the calculation of indicators is probably based on estimative models, with methodological limitations and results that are far from reality.

The incorporation of universal coverage among the SDGs has medium-term repercussions for all countries that are obliged to comply with these indicators by 2030. Thus, it is relevant to unveil the assumptions and strategies involved in the universal coverage proposal.

The proposals for universal health coverage (UHC) and universal health systems (UHS), which characterize projects under discussion, are characterized and contrasted here as polar (ideal) types. Nonetheless, both conceptions can be implemented in different ways[16], which do not always correspond to all the highlighted characteristics.

The main objective of the UHC proposal is to promote financial health protection, i.e. that everyone can access health services without experiencing financial difficulties, reducing direct payments at the time of use (OOP), and avoiding catastrophic expenditure. The use of the word "coverage" refers to financial coverage due to an insurance affiliation. In other words, it means that everyone should be affiliated to some type of insurance. However, the latter does not guarantee access to and the use of healthcare whenever necessary. This concept differs from health coverage that associates health provision with access and effective use[6]. Health insurance contracts cover specific interventions, and the supply is unevenly distributed geographically, which harms disadvantaged regions and social groups[17].

The UHC proposal contains three central components: a focus on financing by pooling; affiliation by insurance modality; and the definition of a limited package of services. This proposal reduces the role of the state, restricting it to

regulating the health system. It is intended that the state should promote insurance or contract out private services to offer to people who are unable to buy them in the market. The separation of functions between financing and provision implies the pricing of health services, which turns them into a commodity. For private sector actors health is a good or a product; those who are unable to pay for the merchandise or service are not entitled to receive their benefits.

The key element of UHC is the combination of public and private funding (insurance premiums, social contributions, philanthropy, general taxes) in funds managed by private or public insurers to finance the health expenditures of plan holders in accordance with their package. Eligibility is conditional upon affiliation to some form of health insurance (private or public). Individuals are eligible, or not, depending on the rules of each insurance policy, or their ability to pay.

UHS is financed by public funds from general tax revenues and social contributions, which provides greater solidarity, redistribution and equity. The degree of redistribution depends on the progressivity of the tax burden, i.e. a greater proportion of taxation on rents and property than on consumption. The UHS model aims to ensure that all people have their needs met without restrictions on access; it enshrines the guarantee of universal access as a condition of citizenship.

Thus, the different financing models have different effects in relation to solidarity. In the UHC model the effects are restricted because the coverage is segmented by insurances that are differentiated by social groups and according to income, which corresponds to different packages of services. In private insurance, risk pooling can be achieved; however, the price of premiums is calculated on the basis of risk, irrespective of an individual's ability to pay, and therefore failing to promote equity. The public nature of the UHS model has broad effects: it absorbs and divides costs within society, promoting redistribution and ensuring to the most under privileged access under equal conditions. In this system the richest pay for the poorest, thereby reducing social inequity[9].

Because the affiliation in the UHC concept is performed by an insurance contract, it presupposes the definition of an explicit and, in general, limited package of services. The basket is defined in the insurance contract and is differentiated according to purchasing power. Minimum packages for marginalized population groups generate "classes" of citizens, resulting in "poor services for poor people". In universal systems there is no definition of a limited basket: health services should be offered according to population needs. The comprehensive nature of healthcare is one of the principles of universal systems; everyone should receive healthcare according to their needs, not based on merit or income.

In the UHC concept it is understood that the public sector is unable to meet the health demands of the population. The privatization of health insurance and health services is advocated, based on the argument that private provision is more efficient; an assertion that lacks evidence. Private providers respond to demands and not the health needs of the population; they are based in areas of greater socioeconomic development; they offer more profitable services; they provide more unnecessary services and violate standards of good medical practice more often; they are less efficient and have worse health outcomes than public services. However, they also provide more timely attention and more personalized care[18,19].

The myriad and diverse contracts between insurers and service providers in the UHC concept increase operational and administrative costs, reducing the efficiency of the system. Service provision is fragmented in UHC because it does not include design components related to the health system, such as territorial and network organization, which prevents the continuity of care and coordination both between and within services[9]. Furthermore, the focus of insurance protection is on individual medical attention because the contracts are individual, with premiums calculated according to the characteristics of individuals and the scope of the contracted package, regardless of population needs.

In universal systems, the guarantee of comprehensive care (individual and collective) requires coordination between services which are organized in networks, integrated and territorialized, distributed according to economies of scale, and focused on primary healthcare (PHC); there is a predominance of public administration and provision, resulting in better quality, lower costs and greater efficiency[20,21]. Universal systems integrate individual care, as well as collective health prevention and promotion actions. A population-based approach calls for transversal, cross-sectoral policies to address the social determinants of health[8].

PHC is advocated as a strategy for universal coverage[14]; however, it can have very different meanings. In the UHC agenda[4], PHC refers to a

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basic package of essential services and medicines which are defined in each country, corresponding to a selective approach designed to reach a basic universalism in developing countries. It distinguishes itself from the comprehensive approach of the universal public systems, where PHC corresponds to the basis of the system and refers patients to other levels of care whenever needed.

The two aforementioned proposals are aligned to different conceptions of citizenship: residual citizenship in UHC and full citizenship in the universal systems. Universal health coverage is aligned with a liberal vision; a government residual social intervention, that is focalized and based on selected health interventions. It is deemed that the state should intervene and assume social responsibility when individuals, their families, or community networks are unable to guarantee the satisfaction of minimum necessities in the market, in a conception of inverted citizenship, in which individuals enter into a relationship with the state when they recognize themselves to be non-citizens[22]. The state should subsidize insurance and guarantee a restricted package of benefits for poor groups that have "failed" to secure their basic needs in the market.

Chart 1 summarizes and contrasts the main characteristics of the conceptions of universal health coverage and of the universal health system.

The universalization of social protection in health in advanced industrialized countries

A striking feature in European countries is the universal guarantee of access to health services through publicly-funded national health systems that are one of the pillars of welfare regimes. The classic European models for universal healthcare are Bismarckian-type social insurance, which is funded on the basis of mandatory social contributions from employees and employers, and membership depending on participation in the labor market; and the Beveridgian model of a national health service, with universal access based on citizenship and financed by fiscal resources with a predominance of public providers.

The process of universalizing European health systems in most Western and Nordic countries was completed in the 1960s and 1970s with the expansion of social insurance for all workers and their dependents, in full employment, or via the creation of national health services such as in the United Kingdom (1948), Portugal (1974), Italy (1978) and Spain (1986).

The pioneering National Health Service (NHS) in the UK is an international reference for the universal access system; it is fiscally financed, with a centralized structure and regionalized coverage. It guarantees comprehensive care at all levels through robust PHC, with mandatory registration of citizens at a general practitioner's office; this is a pathway and filter for access to specialists who are situated at a second level in hospital outpatient clinics, most of which are public (Chart 2)[23].

The Bismarckian model of social insurance, which began in 1883 in Germany, had an important international impact after it was implemented during the first decades of the twentieth century in many countries, including some in Latin America, where, due to the high informality of the labor market, it reached restricted sections of the population. However, in European countries there was a progressive inclusion of population groups, with a broadening and standardization of benefits and universal coverage.

Social insurance differs from private insurance because it is compulsory and because it comprises contributions regardless of the risks of becoming ill. By combining contributions proportional to income and access according to necessity, it is based on principles of solidarity and promotes redistribution between those who are insured from higher to lower incomes, from young people to the elderly, from the healthy to the sick.

In general, national health services are more efficient and have similar or better health outcomes than social insurance models. Both systems have more positive results than market-centered modalities, such as in the United States of America (Table 1)[20,21].

The US health system exemplifies the restrictive consequences for the right to health of a model based on different types of insurance, with a strong emphasis on the private sector. In a survey of the systems in eleven developed countries, it was evaluated as the worst due to higher health spending, reduced administrative efficiency, and worse results in terms of equity, access, quality, life expectancy and infant mortality[21].

The USA differs from other advanced, industrialized countries because of the residual nature and predominance of the private market in health insurance and healthcare, with a significant portion of the population uncovered (Table 1). The system is segmented and fragmented in its organization (insurance companies are the main purchasers of services), supply (the impor-

Chart 1. Contrasting characteristics of the universal health coverage (UHC) and universal health system (SUS) models.

Characteristics	UHC	Universal System
Conception of health	Health as a commodity.	Health as a universal right.
Role of the state	Minimal. Restricted to the regulation of the health system. Explicit separation of financing/purchasing and service functions.	Social welfare. Responsible for the funding, management and delivery of health services.
Funding	Pooling of public and private funds (insurance premiums, social contributions, philanthropy, taxes).	Publicly funded via tax revenues (general taxes and contributions for social insurance).
Emphasis of reforms	Subsidy of demand for health insurance purchase. Packages of services›selectivity and focalization on the poorest	Subsidy of supply to guarantee equitable access.
Eligibility/ Entitlement	Segmented access depending on affiliation to some form of insurance (private or public).	Universal access as a condition of citizenship.
Efficiency of system	Increased operational and administrative costs. Higher total expenditure on health.	Lower operating and administrative costs. Reduced unit costs due to economies of scale. Lower total expenses due to greater regulation of supply.
Design of service system	Fragmented services without territorialization.	Networked, territorialized, PHC-orientated services.
PHC approach	Selective	Comprehensive
Service provision	Services provided mainly by the private sector.	Services provided mainly by the public sector.
Package of services	Restricted (basic/minimum packages). Explicit	Comprehensive (comprehensive care). Implicit
Integrality	Focused on individual care and biomedical services. Dichotomy between individual and collective care.	Integration between individual care and public health actions. Integration of health promotion, prevention and care.
Social determinants of health (SDH)	Does not incorporate the SDH approach. Restricted possibility of intersectoral action.	Incorporates the SDH approach. Facilitated possibility of intersectoral action.
Role of citizen	Consumer/object	Protagonist/individual
Citizenship	Residual	Full
Solidarity effects	Restricted	Comprehensive
Equity	Crystallizes inequalities of access and use according to income and social insertion. Access dependent on individual's ability to pay.	Guaranteed access to, and use of, health services between social groups for equal needs, regardless of ability to pay
Ideology	Liberal	Social-democrat
Target countries	Low and middle-income countries	All countries

Source: the authors.

tance of private, for-profit hospitals), financing, eligibility rules and basket of covered services[24].

In 2010, intense discussions culminated in the passing of The Affordable Care Act (so-called "Obamacare"), which expanded coverage through subsidies for private insurance and inclusion in publicly segmented schemes, but without achieving universality.

The interests of US healthcare companies are in favor of universal coverage through insurance.

Chart 2. Characteristics of universality in health in Germany, the UK and the USA.

Characteristics	Germany	UK	USA
Denomination	Social Security for Illness *Gesetzliche Krankenversicherung* (GKV)	National Health Service (NHS)	Private healthcare
Founded	1883	1948	1965 (Medicaid and Medicare)
Entitlement	Compulsory social insurance traditionally linked to the labor market; progressive inclusion of populational groups.	Universal access as a condition of citizenship.	Targeted coverage based on ability to pay. Workers in the formal labor market contractprivate health insurance. Medicaid: population below the poverty line. Medicare: people aged 65 and over.
Scope of universality	1970s	1948	No. Obamacare (2010) aimed to expand coverage, but did not achieve universality.
Insurance institutions	Institutions controlled by public legislation with autonomous administration. The *Krankenkassen* (Disease Boxes), managed by representatives of workers and employers (113 Boxes in 2017), regulated by the state.	Not applicable	Private insurers of various types (from insurance to managed care companies). Medicaid: managed by states. Medicare: operated by private insurers hired by the federal government.
Funding	Predominantly public via compulsory social contributions proportional to salary (15%) paritary between employers and workers (70% social contributions, 7% fiscal resources).	Predominantly fiscal and public (68% fiscal resources, 15% social contributions).	Predominantly private (51%). Private insurance premiums. Medicaid: state fiscal resources and federal subsidies. Medicare: Compulsory social contributions during active life.
Basket of services	Implicit. Comprehensive and uniform. Guaranteed outpatient and hospital care at all levels of care; pharmaceutical assistance.	Implicit. Comprehensive and uniform. Guaranteed outpatient and hospital care at all levels of care; pharmaceutical assistance.	Differentiated according to ability to pay and insurance contract. Medicare does not cover all services and most beneficiaries need to pay for private insurance to supplement the basket.
Populational coverage	GKV social security: 90%*. Private insurance: 10% substitute (4.4% civil servants).	100% Citizens and permanent residents.	Medicaid: 19% Medicare: 17% Private insurance: 68% Uninsured: 11%
Service providers	Wide range of services supplied by public and private providers accredited to the GKV at all levels.	Public supply** 84% public beds. Specialized outpatient care in public hospitals. PHC: national contract with general practitioners exclusively working for the NHS.	Wide-ranging service provision by predominantly private, profit-making and non-profit providers.

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Chart 2. Characteristics of universality in health in Germany, the UK and the USA.

Characteristics	Germany	UK	USA
Design of system	System is not territorialized or organized in networks.	Integrated, centralized structure. Regionalized organization of services and resource allocation based on populational health needs and regional specificities.	System is not territorialized or organized in networks. Some insurers organize their own networks.
PHC	Weak PHC. Tradition of care by general practitioners who do not exercise gatekeeper function.	Robust PHC. Obligatory registration of citizens in a general practitioner's surgery with gatekeeper function.	Weak PHC. Managed care organizations require a first consultation with generalist with gatekeeper function as a method of reducing costs. Community health centers cover less than 10% of population.

Source: the authors, using[23,25,26]
* Social insurance coverage is not 100% because since its foundation civil servants do not participate and high-income workers can opt for private insurance. A total of 1-2% of the population are covered by social assistance, which pays for the services used by beneficiaries or their contribution to the GKV. ** From the 1990s onwards, new forms of management in public hospitals, as well as the separation of the functions of funding and supply with the internal market, have resulted in commodification.

Financial capital holds sway as the administrator of health insurance and of service provider companies; those interests are linked to those of the pharmaceutical and medical equipment industries through increased share of the global insurance and health services market[25].

Reform models for UHC in Latin America

In Latin America, two countries (Colombia and Mexico) implemented health reforms consistent with the proposal for universal coverage, at different times and in different ways.

In Colombia, the radical reform of 1993 adopted the model of structured pluralism[28], which is characterized by the separation of the functions of financing, assurance and the provision of services, under the respective responsibility of the state, financial intermediation organizations (insurers) and a variety of providers. Different schemes were created such as a Contributory Regime which was compulsory for formal workers and those with a contributory capacity, and a Subsidized Regime which focused on the poor, with inequalities in its benefit plans and per capita values[28].

Some of the results of the reform were an increase in public spending and health coverage (Charts 3 and 4), although there was still inequality between the regimes. There was an expansion of health insurance and service delivery in the private sector, which accentuated segmentation and led to problems such as refusal of services, high administrative expenses, and a focus on profit generation and corruption[28-30]. The incremental changes from 2004-2015, which were the result of social mobilization and the work of the judiciary, were not sufficient to overcome the failures inherent to the model. In the face of the power of private agents, market dynamics remained, with persistent distortions and inequalities[31].

In Mexico, social health insurance reforms began in the 1990s in the context of neoliberal adjustment policies. These reforms met with resistance but were not dismantled; however, they were financially constrained by reduced employer contributions[7,32].

The most radical reform occurred in 2003 with the creation of Popular Health Insurance (SPS). The SPS was intended to provide universal health coverage by 2010, covering the poorest sectors of society and providing them financial protection by offering a restricted package of actions (90 in 2004, and 287 in 2016) (Chart 3). Adherence to SPS is voluntary and it receives tripartite funding from the federal government, the states and families, with exemption by quota for lower income groups[7,33].

Despite the expansion of coverage to the poor, the main criticisms of the SPS are as fol-

Table 1. Socioeconomic and health-funding indicators for selected countries.

Indicators	Year	Brazil	Colombia	Mexico	USA	Germany	UK
Population (millions)[a]	2015	205.962	48.229	125.891	319.929	81.708	65.397
GNI per capita ppp	1990	[b]6,510	[b]4,620	[b]5,840	[b]23,730	[b]19,740	[b]16,800
	2014	[c]15,570	[c]12,910	[c]16,840	[c]56,116	[d]47,500	[d]43,350
Population coverage %[e*]	2002	100.0	65.4	48.3	84.8	99.8	100.0
	2014	100.0	96.6	83.0	88.5	100.0	100.0
Population without coverage % (millions)[e]	2002	0.0	34.6 (14,229,772)	51.7 (53,467,054)	15.2 (43,719,030)	0.2 (164,977,000)	0.0
	2014	0.0	[a]3.4 (1,625,000)	17.0 (21,000,000)	[a]11.5 (36,538,000)	0.0	0.0
Total health expenditure as % of GDP[e]	2002	7.1	5.7	5.4	14.0	10.1	6.6
	2014	8.3	7.2	5.7	16.5	1.1	9.9
Public expenditure on health as% of GDP	2002	[e]3.2	[e]4.6	[e]2.3	[e]6.3	[d]8.2	[d]6.0
	2014	[c]3.8	[c]5.4	[c]3.3	[c]8.3	[d]8.7	[d]7.6
Public expenditure on health as % of total health expenditure[e]	2000	40.3	79.3	42.7	44.2	79.4	79.3
	2014	55.2 (2013)	76.3	51.8	49.3	84.3	79.6
Public expenditure on health per capita in US $ ppp[e]	2002	307	317	238	2.403	[d]2.328	[d]1.757
	2014	549 (2013)	724	532	4.457	[d]3.990	[d]2.808
Out-of-Pocket (OOP) expenditure as % of total health expenditure	2002	[e]38.8	[e]12.2	[e]54.4	[e]14.3	[d]12.1	[d]10.8
	2014	[c]25.5	[c]15.4	[c]44.0	[c]11.0	[d]13.2	[d]9.7

* There are inconsistencies in the information regarding coverage in Colombia and Mexico due to the political interests involved. The population surveys show lower levels of coverage.

Sources: the following databases: a.United Nations DESA/Population Division. World Population Prospects 2017. Available at: https://esa.un.org/unpd/wpp/Download/Standard/Population/. Accessed: 26/12/2017. b. The World Bank. GNI per capita, PPP (current international $). Available at: https://data.worldbank.org/indicator/NY.GNP.PCAP.PP.CD?name_desc=false. Accessed: 26/12/2017. c.PAHO. Health Information Platform for the Americas-PILSA. Available at: http://www.paho.org/data/index.php/es/?option=com_content&view=article&id=515:indicadoresviz&Itemid=0. Accessed: 21/12/2017. d.European Health Information. European Health for All database (HFA-DB). Available at:https://gateway.euro.who.int/en/datasets/european-health-for-all-database/. Accessed: 23/12/2017. e.OECD. Stat. Available at: http://stats.oecd.org. Accessed: 21/12/2017.

lows: failure to achieve universal coverage (there are still 21 million people without insurance); the restricted nature of the service package and inequalities of access; the inadequacy of the care model; and the persistence of high out-of-pocket expenses, including those who are affiliated to the SPS. The reforms did not result in improvements in the health of the population, a significant reduction in inequalities, greater efficiency or quality. On the contrary, segmentation was accentuated and funding limits persisted[7,8,32,33].

Universality in the Brazilian Unified Health System (SUS): advances and challenges

In Brazil, an eventual implementation of the UHC proposal would generate many deleterious effects. On the one hand, the universal right to health was constitutionally established in Brazil in 1988 and since then the SUS has expanded access to the entire population, favoring the improvement of health conditions and even the country's economy. The system is based on a comprehensive notion of universality, which provides coverage and comprehensive healthcare for the entire population: UHC would break with that right.

On the other hand, the Brazilian health sector has characteristics that make the SUS more vulnerable to the private interests that underpin the UHC proposal. It is worth emphasizing the legacy of the Brazilian health system, which, since the 1970s, has had a strong private supply of healthcare services, of which the SUS is the main buyer.

Chart 3. Proposed reforms for the UHC model in the light of the experiences of the systems in Mexico and Colombia.

Characteristics	Colombia General System of Social Security in Health (SGSSS) 1993 – present	Mexico Popular Health Insurance (SPS) 2003 - present
Emphasis of reforms	Subsidy on demand. Radical reform of the health sector with the creation of health provision and health insurance markets. Total separation of the functions of funding, intermediation and provision of services by specialized agents. Social security was transformed by the reforms.	Subsidy on demand. Reforms aim to create a market for healthcare provision and health insurance but the separation of the funding and provision has not materialized. Co-exists with social insurance.
Elegibility/ entitlement	Those who are unable to pay and who are not part of the formal labor sector are affiliated to the Subsidized Regime (RS) depending on the availability of resources. Workers in the formal labor sector, or who are able to pay, are obliged to join the Contributory Regime (RC).	People who are not part of the formal work sector (open or uninsured population). Voluntary affiliation.
Funding	RS: combination of national and sub-national fiscal sources, with solidarity contributions equivalent to 1.5% of the mandatory contributions of the RC and of the Armed Forces model, (Ecopetrol). RC: mandatory contributions from workers (4%) and employers (8.5%) in terms of salaries; 12.5% of income of self-employed or those who are able to pay. In 2014 the employer's contribution for employees earning up to ten minimum wages was replaced by a tax on profits. Co-payments for RC and RS users by income ranges, with exemption for vulnerable groups.	Combination of fiscal sources from the national government (83%) and states (16%), with mandatory contribution per affiliated family (1%) according to socioeconomic conditions, except for deciles I to IV. No co-payment for services included in the basket.
Buying function	Insurance companies (Health Promotion Enterprises – EPSs) perform financial intermediation and manage risks. In 2014, in the RC there were 17 ICs (15 private and two public), and in the RS there were 35 ICs (24 private, two mixed and nine public). Unit of payment by capitation (UPC), differentiated by RC and RS with gradual equalization. In 1994 the UPC-RS was equivalent to 60% of the UPC-RC, which reached 89% in 2017.	No insurance providers were established. The intermediation/purchase function is performed by government agencies.

it continues

Since then, Brazilian governments have favored the private sector through various incentives and subsidies[11]. Recently, there has been a progressive reduction of the state's managerial capacity resulting from contracts with private organizations to manage and provide services in public health units. Whilst the private sector is privileged, the SUS is insufficiently funded, at levels below that provided for by the Brazilian Constitution, with resources less than 4% of GDP (Table 1), which is insufficient to guarantee the universal right to comprehensive healthcare.

Since the passing of the Brazilian Constitution (1988), the SUS and the private sector have grown significantly. Currently, 24.5% of the population have double health coverage (private and

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Chart 3. Proposed reforms for the UHC model in the light of the experiences of the systems in Mexico and Colombia.

Characteristics	Colombia General System of Social Security in Health (SGSSS) 1993 – present	Mexico Popular Health Insurance (SPS) 2003 - present
Segmentation of social protection (% of populational cover)	Contributory regime: 46% Subsidized regime: 45% Special schemes: 5% Total population covered: 96% (2016)	Popular insurance: 49.9%, Social insurance: 46.9% 17% remain without health coverage (2015)*
Basket of services	Obligatory Health Plan (POS): explicit baskets of benefits differentiated for RC and RS. POS-S basket with restricted content and differentiated costing. From 1995-2013 the average RS per capita expenditure corresponded to 33% of the RC expenditure. From 2008-2012 there was gradual equalization of the explicit baskets of RS and RC benefits; however, differences in use and costing persist. From 2015 the service basket became implicit, with a list of exclusions.	Universal Catalog of Health Services (CAUSES): restricted, explicit basket with 287 interventions (2016); 91% individual and 9% collective. Of the individual interventions 50% were hospital and 40% outpatient. Protection Fund for Catastrophic Spending (FPGC): 61 interventions included only eight types of cancer, HIV/AIDS treatment, treatment for acute myocardial infarction for those aged under 60, and hepatitis C treatment for patients aged 20-50. Complete coverage for care for children up to five years ("Medical insurance for a new generation"). Services not included in the baskets are only accessible through direct payment.
Design of the service system	Does not include a proposal to organize service network; provides for competition between providers. Fragmented services, without territorialization as a result of IC contracts with public and private providers. The supply from public providers is the only one available to the population in dispersed areas	Does not include a proposal to organize service network. Segmentation and fragmentation of provision of services. Population in dispersed areas with difficulty in accessing services.
Health service providers	Private and public service providers. Transformation of hospitals and public health centers into state-run social enterprises, aiming at revenues from billing services to insured individuals (subsidized demand) and elimination of public on-lending (subsidized supply) with closing of public providers.	Mainly public service providers from the Health Department (autonomous hospitals and health centers). Contracts are allowed with social and private insurance providers.

* The total exceeds 100% because there are workers with double coverage in social insurance.
Sources:[7,28,30,32-35].

public coverage) and these are mainly workers in the formal market, which in practice reflects a segmented health system.

Nonetheless, the SUS organizes healthcare in more than 5,500 municipalities for 200 million Brazilians. The SUS broke with the previous model by establishing new institutional, managerial and care bases. It is a universal health system with a territorial design and foreseeing a hierarchical network at comprehensive levels of care. In keeping with the guidelines for decentralization and the participation of society, the SUS's institutional and decision-making framework incorporated instruments for democratization and the sharing of health system management between different government entities and civil society. Guided by the importance of a comprehensive approach, the system's design considers integra-

tion between public health actions and individual care, with guarantee of care at all levels of complexity, according to necessity, and without defining a restricted basket of services.

The expansion of PHC services in Brazil, including remote and disadvantaged areas, has increased access to collective and individual care, producing positive impacts on the health of the population. The strategy for PHC within UHC refers to a basic package of services and medicines, corresponding to a selective approach, which would represent a step backwards from the comprehensive concept of PHC within the SUS. The characteristics of the private sector (a fragmented nature, a procedural approach to healthcare, and payment for services) are incompatible with comprehensive PHC. When the private sector incorporates family doctors it seeks to reduce costs and barriers to access to comprehensive care.

Although the SUS is one of the largest universal health systems in the world, since its inception it has suffered from private sector competition and constraints which affect the capacity of the state to guarantee the universal right to health. One of these constraints is the Divestment of Union Revenue (DRU), which has reduced the federal budget by 20% since 1994 (a percentage recently increased to reach 30% by 2023), in addition to the creation of a mechanism for divesting state and municipal budgets.

Most recently, Constitutional Amendment 95/2016 froze government expenditure for the next twenty years and nullified the constitutional foundations of social security. The long period of time provided by this amendment is indisputably sufficient to change the basis of the SUS and other social policies, confirming that the Brazilian state will no longer guarantee social rights.

Other threats to the precept of the universal right to health in Brazil are contained in Law No. 13,097/2015, which allows direct or indirect participation and the control of foreign capital in the health field, and PEC 451, which is being drafted in Congress and which aims to oblige employers to offer workers a private health plan.

The economic crisis in Brazil has affected the private health sector, especially the insurance market, which is mainly supported by clientele linked to employment. Due to unemployment, insurers have lost two million customers since 2014. In 2016 the Minister of Health proposed an accessibility plan to "review the size of the SUS" because it was considered that it would not be possible to "sustain the level of rights determined by the Constitution"[36]. Affordable plans would have coverage that was exclusively limited to outpatient care and a low monthly cost, with the expectation of expanding the private market. This proposal coincides with the UHC idea of promoting the provision of health coverage through private insurance.

The UHC proposal would meet the demands of Brazilian insurers and, possibly, those of financial capital and international insurers by increasing participation in the "health market"[13]. The further strengthening of the private sector represents the greatest threat to the SUS and to the universal right to health.

Conclusion

The universal health coverage (UHC) proposal is unclear in terms of its assumptions and strategies. The use of concepts and terms similar to those used for universal health systems makes it difficult to understand the changes in progress. The analyzed characteristics demonstrate the contradictory and deleterious aspects of insurance-based models of expansion of coverage; this results in the segmentation, selectivity, focalizationand crystallization of inequalities, which violates the universal right to health.

As Noronha[6] has observed, there has been a semiotic shift from the right to health and from universal and equal access to healthcare, to the concept of "universal coverage", specified as "the protection of financial risk" and the search for alternative mechanisms of sector financing.

In advanced industrialized countries, universalization was achieved by the 1970s through the introduction of Bismarckian social insurance or Beveridgiannational health services, resulting in greater efficiency and equity in national universal access services based on full citizenship. On the contrary, the case of the USA, where health coverage has been provided by the market, has been marked by inefficiencies due to high expenses, low effectiveness, poor health outcomes and a high proportion of the population without health coverage.

In Latin America, classical European models have influenced health policies, but have not been fully implemented. The two paradigmatic experiences of reforms in the Latin American region disseminated as models for UHC show the failure to achieve universal access through insurance. The goals of universal coverage were not met, service baskets remained unequal, and the segmen-

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tation and fragmentation characteristic of Latin American health systems were intensified.

In summary, the promises of the models based on UHC have not materialized and there is no evidence that they have produced more effective results than the universal systems (Chart 4).

In Brazil, the SUS was established as a response to a conception of full citizenship, providing access to healthcare for the vast majority of Brazilians as a human right. Organizational changes have made it possible to reorient the system towards integrality and equity, with a reduction in inequalities in access to services, although it is still far from its egalitarian ideology[37].

The experiences of the analyzed countries demonstrate that any insurance arrangements - social, private or subsidized - do not outweigh the strengths of the design of the national public health system adopted in Brazil, even though the results achieved by SUS have not yet reached their full potential. It is crucial to resist the current conjuncture of attacks on the SUS and the risks of that it may be dismantled by fiscal adjustment policies. The challenge is to overcome the storm while maintaining the central objective image: health is not a commodity. It is the right of all and the duty of the state.

Chart 4. Summary of the results of the expansion of coverage in the UHC proposal.

- Insurance has not been an effective way to provide the universal right to health .
- Being insured does not mean guaranteed access to health services.
- Insurance does not guarantee comprehensive coverage according to necessity; it is limited to a restricted package of services.
- In individual insurance models, the focus is on individual healthcare coverage, to the detriment of populational/public health interventions.
- Subsidizing demand, and competition between public and private operators and services, does not make systems more effective or efficient.
- The UHC model increases segmentation and crystallizes social stratification and inequities in access to health and health conditions.

Source: the authors.

Collaborations

L Giovanella, IS Santos, Mendoza-Ruiz contributed with the conception, the analysis and the writing; ACA Pilar, MC Rosa, GB Martins, D Barata, JML Vieira, VCG Castro, POS Faria contributed to the analysis and writing; CV Machado contributed to the critical review.

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