

Health Policies in Argentina, Brazil and Mexico: different paths, many challenges

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Abstract *Over recent decades, several Latin American health systems have undergone reforms. This paper analyzes health policies in Argentina, Brazil and Mexico from 1990 to 2014. It explores the reform strategies, explanatory factors and effects on the configuration of each health system. The analytical framework was based on the historical-comparative approach and considered the following aspects: political and economic context; health reform agendas, processes and strategies; changes in the health system configuration in terms of social stratification and de-commodification. The research methods involved literature review, document and data analysis and interviews. In the period, Argentina maintained an employment-based and fragmented healthcare system, expanded specific public programs and private health plans. Brazil created a public and universal health system, which coexists with a dynamic and growing private sector. Mexico maintained the employment-based health care and created a popular health insurance. Although the reform influences and strategies varied between the countries, social stratification and commodification persisted in the three health systems, under different arrangements. The transformation of these characteristics is essential to build universal health systems in Latin America.*

Key Words *Health policies, Health systems, Latin America, Public-private relations in health*

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Introduction

During the 20th century, segmented health systems were formed in Latin American countries, reflecting the structural inequalities of those societies. Private healthcare groups were formed in some countries, under state incentives. As from the 1980s, economic crises, market-oriented reforms and democratization processes led to transformations in Latin-American nation states, with repercussions on social and health policies^{1,2}.

Argentina, Brazil and Mexico are large, economically-relevant federative states, that in 2014 accounted for 60.8% of the population and 69.1% of the GDP of Latin America³. Between the 1930s and 1980s, each of these countries underwent developmental processes involving industrialization and labor regulation. Against this backdrop, social insurance institutions were created to provide pensions and health care for formal workers. Public health care systems were also established to control specific infectious diseases. The health system reforms implemented over the last three decades have differed in each of these countries, influenced by different institutional legacies, political agendas and governmental leanings.

This paper reviews the health policies in Argentina, Brazil and Mexico from 1990 to 2014. It investigates the strategies adopted by these nations to make health care reforms and the factors that influenced their different political choices and paths. Moreover, it attempts to explore *if, how* and *to what extent* the reforms have changed the structural configuration of each health care system. Once each case has been described, all three are then compared, with the aim of contributing toward a better understanding of the limits and challenges involved in building universal health systems in Latin America.

Methodology

The study was based on a comparative historical analysis⁴, focusing on the similarities and differences between the countries in terms of the timing and influences over the policies and also of the State-market relations in health. The lines of the analysis were: trajectory of the health policy; political and economic context; health reform agendas, processes and strategies; changes in the health system configuration, in terms of social stratification and de-commodification (expanded right to health care, which reduces individuals'

market dependency)⁵. Figure 1 summarizes the analytical framework.

The research techniques employed were bibliographic review, document analysis, secondary data analysis and approximately forty semi-structured interviews with experts and key health policy actors from the countries under study.

Paths of the national policies

Argentina: fragmented social security, expanded private sector and public programs

In early 20th century Argentina, State-led public health action was expanded and the first "mutual aid associations" were created, organized according to nationality or labor identification. The Peron government (1946-1955) strengthened the "mutuals", which became precursors of the *obras sociales* through which the unions administered health coverage and amplified public services. However, in the decades to follow, the health system suffered from underfunding and became fragmented according to people's ability to pay⁶.

In the following decades, the corporative pact established around *obras sociales*, funded by employers and employees, was crucial to the governability of union leaders and national governments⁷. As private service providers were hired this arrangement expanded exempt of state regulation⁸. Social security coverage was extended to workers by employment sector and a fragmented health care model was institutionalized, consisting of three subsectors: public, *obras sociales* and private⁶.

The return of democracy in Argentina was marked by the election of Alfonsín in 1983, who proposed to reorganize the union *obras sociales*, unify the system financing and universalize coverage for the population. However, resistance from the unions, economic crisis and the anticipated handover of power to president Menem in 1989 prevented the implementation of such changes⁹.

In the 1990s, the Menem administration adopted neoliberal reforms that involved trade liberalization and privatization, in coalition with members of the private sector, the World Bank and the International Monetary Fund¹⁰. In social insurance, the logic of capitalization prevailed and private pension funds began to administrate worker contributions in individual accounts¹¹.

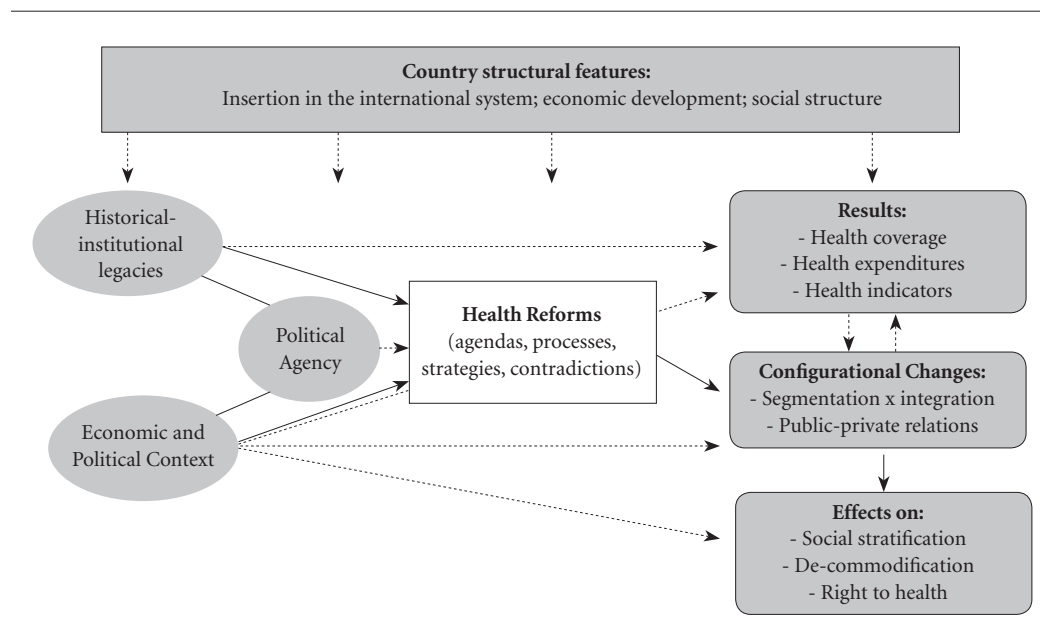


Figure 1. Analytical framework of the study.

Source: Prepared by the author.

Note: All the arrows indicate relations between conditioning factors of the policies and their effects. The solid arrows clarify the focus of the study.

Despite union opposition to radical reforms to the health system⁹, gradual changes affected the public sector, the *obras sociales* and the private sector⁸.

In the public subsystem, a significant portion of the health care services were already decentralized to the provinces. In 1993, a legislative framework enabling hospitals to convert to self-managed status was enacted. By 1999 more than one thousand hospitals had made the change, with varying degrees of autonomy and dependence on public funds. In several provinces, public services continued to suffer from underfunding and access-related problems⁸.

The *obras sociales* were adversely affected by the economic crisis, changes in employment relations and increased unemployment. In 1995 the Ministry of Finance, supported by the World Bank, proposed the introduction of market competition into the health insurance sector, by offering workers the right to choose between adhering to any *obra social* or using private health insurance. Although the unions blocked the private insurers from competing in the sector, new legislation recognized workers' freedom of choice

among *obras sociales*, eliminating the compulsory adhesion according to professional category⁷⁻⁹.

As a strategy to attract members, several *obras sociales* made agreements with companies to offer special plans. Market logic thus penetrated the *obras sociales* subsystem and modified the traditional corporative pact^{6,7}, favoring the expansion of prepaid health care companies¹².

The reforms of the 1990s failed in terms of health results and costs⁶. From 1999 to 2002, the economic crisis led to a public health emergency, which brought to light the low response capacity of the economy-dependent *obras sociales* and private segments¹³.

In the 2000s, the center-left administrations of Nestor (2003-2007) and Cristina Kirchner (2007-2015) made adjustments to the mixed public-private pensions system. In 2008, the system was renationalized and unified, enhancing its coverage to 90% of the population¹¹.

In health, the period was marked by the extension of specific public programs and debates on the regulation of the *obras sociales* and private sector. The Federal Health Council gained prominence as an intergovernmental body and

defined priorities included in the 2004-2007 Federal Health Plan¹⁴: national pharmaceutical policy; maternal and infant health; public health insurance; specific programs and Primary Health Care.

The international financing prior to the 2001-2002 crisis was redirected into implementing these priorities. The medicines policy involved the creation of the REMEDIAR program, aimed at access to a list of essential drugs, and the development of the Generic Drugs Act. The list of drugs included in the Mandatory Medical Program (*Programa Médico Obligatorio-PMO*), which was binding to the *obras sociales* and prepaid health care companies, was enlarged.

Regarding maternal and infant health, in 2004 the Nascer Plan was undertaken by the federal government and provinces to reduce infant and maternal mortality rates in the regions with the worst indices. In 2007, this was extended to the whole country, aimed at providing public coverage for pregnant women and children up to the age of 5 without social insurance. The plan acted like a provincial public insurance to bolster Primary Health Care¹⁵.

The period from 2008 to 2014 was characterized by the continuation of programs and focus on public health actions. The RemediAR and Nascer programs were reviewed and expanded. In 2009 the former incorporated an element to strengthen the health service networks in the provinces. In 2014 it was renamed RemediAR + Redes, and comprised of three strategies: the provision of essential drugs; strengthening of the health service networks; and training primary health care professionals¹⁶.

In 2012, the Nascer Plan was extended to cover children up to the age of 10, teenagers up to the age of 19, and women up to the age of 64, without formal health coverage. In 2014 it was renamed the Sumar Program, and had a distinctive federative arrangement, decentralizing decisions and providing incentives for the provinces and health teams¹⁶.

As far as the *obras sociales* are concerned, in the early 2000s, the Mandatory Medical Program (PMO) was regulated and would later be updated. However, regulation of the segment remained fragile. The *obras* continued to compete by affiliates and to expand contracts with private prepaid health care companies and health service providers.

As regards regulation of the private sector, in 2011 the Prepaid Medicine Act was enacted, allowing^{7,13}, for the existence of users whose rela-

tionship is mediated by *obras sociales*, and did not change the segmented structure and inequalities of the health system¹².

By 2011 there were approximately 280 national *obras sociales*, covering 39% of the population; the National Institute of Social Services for retirees and pensioners covered 8%; the 24 provincial *obras*, 14%. The private sector was formed by roughly 350 companies, covering 9% of the population. Finally, around 30% of the population depended on public services.

The Argentinian health care system is notoriously segmented, fragmented, with low levels of efficiency and equality. The public system is comprised of national, provincial and municipal services. The *obras sociales* are national and provincial organizations of varying nature and size. The private segment involves corporate services, medical offices and prepaid health care companies. There are also connections between such segments^{6,13}.

Brazil: universal public system and strong private sector

In the 20th century, the trajectory of health policy in Brazil developed in two areas: public health and social insurance healthcare. Coverage of the latter field expanded in terms of professional categories until 1966, when it was unified as a single institute responsible for social insurance and health care of formal, urban workers. In the subsequent decades, limitations persisted in the coverage, funding and state incentives for private health care provision, which increased by means of: the hiring of private care providers; state support for the construction of private hospitals; subsidies for companies to contract corporate private health plans; private clinics and the pharmaceutical and medicinal trade¹⁷.

In the 1980s, amidst economic crisis and democratization, the public health movement proposed a reform agenda, the guidelines of which were included in the Federal Constitution of 1988, which recognized health as a citizens' right and created the universal and public Unified Health System (SUS). Health was incorporated, along with social insurance and social assistance, under a broad concept of Social Security, to be financed by taxes and social contributions^{18,19}.

The 1990s were marked by democratization and economic liberalization, which featured: monetary stabilization, open market economics, restricted public spending, privatization of state companies, fragile industrial policies, State

downsizing, decentralization and new public-private relations²⁰. This agenda was introduced by the Collor administration (1990-1992) and maintained, with some variations, throughout the governments led by presidents Itamar Franco (1992-1994) and Fernando Henrique Cardoso (1995-1998 and 1999-2002). Notwithstanding external influences, the national elites – the Presidency and economic authorities – played the key roles in State reforms that imposed restrictions on Social Security, limiting spending and the expansion of public services.

The implementation of the SUS in the 1990s expressed tensions between the public health reform agenda and the State reform agenda. The significant changes included: unification of the control over national policy; the creation of intergovernmental commissions and participative councils, which increased the number of actors in the policy-making process and the support for the SUS; national expansion of public health services of various kinds, with particular focus on primary health care²¹.

However, the State reform agenda imposed restrictions on health policy in terms of financing, decentralization, the production of supplies and labor management. Market-oriented reforms, associated to the strength of the private sector in the country, affected public-private relations in health. Despite the expanded public services, the SUS remained dependent on private hospital beds, laboratories and other private services. Health insurance and health care plan companies continued to thrive, subsidized by tax breaks. The National Health Agency, created in 2000, regulated contracts and organized the private health plan market, but did not contain its growth.

During the first Lula administration (2003-2006), there was a continued emphasis on economic stability, associated to measures to improve the State's regulatory capacity. In his second term of office (2007-2010), a neo-developmental arrangement came to the fore, with emphasis on investments in infrastructure and innovation, strengthening public banks and national companies²². The commodities boom favored economic growth some years, and during the international crisis of 2008-2009, countercyclical policies were adopted.

In the social area, the government prioritized strategies for combatting poverty and the inclusion of vulnerable groups. Measures such as increases to the minimum salary and the expansion of income transfer programs helped curb pover-

ty and reduce income inequalities, with increased domestic consumption²³.

National health policy between 2003 and 2010 was marked by: new government priorities; gradual changes in the fields of health care, labor management and consumables for health; limited tackling of structural issues²¹.

The Family Health Program and health promotion policies were enlarged, incorporating incremental changes. Government flagship programs, such as *Brasil Sorridente* (Smiling Brazil), the Mobile Emergency Medical Service – SAMU, and the Popular Pharmacy introduced innovations in areas where there were gaps²¹. Changes to labor and health care supplies management were implemented, and during Lula's second term in office, health was prioritized as a strategic industry for development, with focus on qualified jobs, technological innovations and industrial dynamism²⁴.

The first Dilma Rousseff administration (2011-2014) was conducted against an unfavorable economic and political backdrop. In health, the programs in place were maintained and incremental changes made. New priorities were also established, such as the More Doctors program and the Emergency Care Units²¹.

Throughout the period under review, limitations persisted in funding and in public-private relations in health. The health budget remained dependent on negotiations with economic authorities and conditioned to growth. Investments in infrastructure remained low and the federal government's share in public spending on health fell²⁵.

The coverage of private health plans and insurance continued to grow. As the subsidies for the private sector and fragile state regulation persisted, health care companies extended both their political and market strategies²⁶. Following Dilma's reelection, a new law was enacted authorizing the entry of foreign capital into health, including in service provision.

In brief, the Brazilian health policies in the period showed both advances and contradictions²¹. Brazil has a universal public system which covers more than 200 million people, but remains limited by financial difficulties and inequalities. The country also has a dynamic private sector, which includes private providers to the SUS and a significant health plan and insurance segment, which serves roughly 50 million people, that is 25% of the Brazilian population, who also use the SUS.

Mexico: corporative system with public provision and health insurance for the poor

Public health actions in Mexico began to be implemented in the early 20th century. The employment-based health social insurance began to be developed in the 1940s, with the creation of the Mexican Institute for Social Security (IMSS) in 1943, and the Institute of Social Security and Services for Civil Servants (ISSSTE) in 1959. Until the 1970s formal workers were covered by corporative social insurance. Most of the population, however, depended on limited public care actions.

In the mid-1970s, the IMSS began to provide services to the poor rural population, who could not afford to contribute. In 1979, the program was renamed IMSS-Coplamar and, in the following decades underwent several expansions and name changes²⁷.

In the 1980s and 1990s, pushed by economic crises and under PRI (Institutional Revolutionary Party) governments, Mexico underwent market-oriented reforms characterized by trade liberalization, privatization and reduced public spending¹⁰, which affected social policies. The transition to democracy combined regular elections with frauds, repression and the appropriation of State resources by the PRI²⁸. Successive governments sought to reform the IMSS and ISSSTE – either by retrenchment or privatization – but they faced opposition²⁹.

The 1983 Constitution recognized the right to social protection in health. The La Madrid administration (PRI - 1982-1988) proposed a reform focused on rationalization, decentralization and diversification of service providers. The proposal was opposed by the IMSS bureaucracy, unions and governors³⁰. The first cycle of federal service decentralization affected 14 states, under adverse funding conditions, poorly defined responsibilities of the spheres of government and maintenance of federal power²⁷. Furthermore, limited results were achieved in terms of efficiency, quality and reduction of inequalities³¹.

Two entities were created which influenced health reforms in the following decades: the Mexican Health Foundation (FUNSALUD), a think tank backed by national and international enterprises; and the National Institute of Public Health (INSP), to train staff and propose policies. These structures were guided by the “New Public Health” thinking, aimed at organizing the health system and implementing evidence-based public funding, within the available limits³⁰.

In the 1990s, the Gortari (1988-1994) and Zedillo (1994-2000) PRI governments intensified the economic and social reforms, prioritizing poverty alleviation policies. In 1995, Congress passed a reform to the IMSS that established a shift from a pay-as-you-go, collective public pension system to a defined-contribution, individual account system, to be managed by private pension fund administrators. This reform, which came into effect in 1997, also increased the eligibility requirements and made pension benefits less secure²⁹.

The health system was affected by changes, despite resistance to any radical reform. The privatization of social insurance compromised the IMSS budget, limiting funding for health. From 1995 a second wave of decentralization began, in order to broaden the states’ participation in the funding, management and provision of services. Decentralized health bodies and federal funding mechanisms were established in the states, resulting in the formation of 32 state health systems that depended on federal resources²⁷. In a climate of economic austerity and under the influence of the World Bank, the federal agenda focused on basic health care actions.

In the early 2000s, the election of Fox, of the conservative National Action Party (PAN), interrupted the PRI’s hold on presidential power which had lasted for more than 70 years. Fox’s new Secretary of Health was Julio Frenk, who had worked at the INSP and the FUNSALUD and had been one of those responsible for formulating the structured pluralist model implemented in Colombia in 1993, characterized by: separation between funding and service provision; private participation in the purchase and provision of services; adoption of cost-effective intervention-packages³².

A reform was proposed with the aim of extending financial protection in health by means of voluntary insurance for those not covered by social insurance. In 2003 the National Congress, with a government majority, approved the creation of the System of Social Protection in Health (SSPH), including the Popular Health Insurance or *Seguro Popular* (SP). The SP was funded from three sources: federal government, states and a quota paid by enrollees, which low-income people were exempt from paying. Federal funds are transferred to the states according to the number of registered members, to cover the costs of a basic explicit service package (*Catálogo Universal de Servicios de Salud* – CAUSES). The program also included a limited group of high cost in-

terventions, aiming to reduce out-of-pocket expenditures. In 2013, the number of interventions included was 285 basic treatments and 59 high-cost treatments, provided by public or private providers³³.

The states quickly adhered in order to receive the federal funds. In 2001 the program began in 5 pilot states; in 2002, it covered 14; by 2003, 21; by 2004, 24; and by January 2005, 31 states³⁴. The Federal District, under the left-wing government of Obrador, of the Democratic Revolutionary Party (PRD), was the last to join.

The proportion of the population who signed up to the program varied from state to state, as did the availability of services, which depended on state investments and infrastructure. As from 2011 the IMSS-Oportunidades services in the states were made available to SPbeneficiaries²⁷. Despite the growing trend of private provision³¹, public providers still dominated in the IMSS and SP in 2014.

According to supporters of the 2003 reform, the positive outcomes would include: Increased public spending; significant enrollment of poor people to the SP; reach of “universal coverage” (insofar as being insured); expanded access to a basic package of interventions; increased financial protection in health³⁵.

On the other hand, limitations to the reforms have been pointed out: millions of Mexicans remain uninsured; public spending is still be limited as a proportion of the GDP; out-of-pocket expenditures remains high; affiliates’ access to the SP is limited to a restricted package of actions; the services and investments are unequal between states; and the reforms have further fragmented the health system, neither reducing inequalities nor increasing its efficiency or quality^{27,32,36,37}.

At the end of the period, the Mexican health system maintained a segmented structure. The estimated number of SP affiliates varies from source to source. In 2013, it was between 40 and 52 million^{27,36}. According to a 2012 survey, SP covered 38% of the population; IMSS, 32%; and ISSSTE, 6%, while 20% of the population remained uninsured by these programs³³.

In 2012, with the return of the PRI to the presidency, the government proposed a reform that would integrate the social insurance institutes and SP in a single universal health system. By 2014 the proposal was yet to be implemented and its guidelines were controversial in terms of the definition of the interventions package, the separation of functions and the introduction of private service purchasers^{27,33}.

Chart 1 summarizes the trajectory of the health policies in the three countries.

Conditioning factors and implications of the policies for configuration of the systems

All three countries display common structural characteristics, such as: colonial past; peripheral participation in global capitalism; partial industrialization and economy dependent on the tertiary sector; susceptibility to crises; highly concentrated income and social inequalities; young democracies with long history of authoritarian regimes, *coups d'état* and political instability. They have each suffered effects of the shift toward financial market economics and neoliberal policy in capitalism over recent decades.

The social protection and health systems of these countries reiterate the social stratification by segmenting clientele and benefits based on their association to labor markets or private segments. The social insurance programs led to the inclusion of formal workers and their families, while other citizens were left to rely on public health services. The existence of dynamic economies and higher income groups, associated to state support, has favored the growth of private segments: service providers to the social insurance system or to the public, health care plan companies, and the pharmaceutical trade. This process, and the limits of the public services, explain the significance of the private markets and spending on health in the three countries.

Similarities and differences are found in how the systems developed up to the 1980s, in terms of the corporative arrangement and configuration of health markets, which generated institutional legacies that were difficult to reshape in the decades to follow.

Argentina and Brazil were pioneers in Latin America in establishing social insurance health-care, reaching a reasonable level of coverage among formal workers by the 1980s¹. Initially organized according to employment sector, the systems of these countries differed in terms of their evolution, institutional arrangements and market dynamics, which conditioned the possibilities of their universalization.

In Brazil, in 1966, during the military dictatorship, the health and social insurance institutes organized according to professional category were unified into a single national institute. The following years were marked by the expansion of social insurance contracting out of private health care providers and state subsidies for private care

Chart 1. Health Policies in Argentina, Brazil and Mexico: prior trajectory, context and political agenda from 1990 to 2014.

Country	Prior Trajectory	1990-1999	2000-2014
Argentina	<p><i>Throughout the 20th century:</i></p> <ul style="list-style-type: none"> -Public health actions, public health services for uninsured population; - <i>Obras Sociales</i>: origin in the mutual aid associations; corporative-based (generally by unions) health services; distinct sizes and nature; coverage of more than 60% of the population; private providers often hired. - Private sector: private providers offer services to the <i>obrassociales</i> or individual clients; prepaid health care companies. <p><i>1980s:</i></p> <ul style="list-style-type: none"> - Return to democracy; election of Raul Alfonsín in 1983; - Proposals to unify the health system opposed, especially by the unions. - Economic and political crisis: anticipated handover of the government to Carlos Menem in 1989. 	<p>1989-1999- Menem Government</p> <p><i>Economic policy</i>: neoliberal reforms: structural adjustment, trade liberalization, privatizations, containment of public spending.</p> <p><i>Pensions</i>: creation of mixed (public-private) system; incentive to choose private system, based on individual contributions and administrated by private pension funds.</p> <p><i>Social Assistance</i>: start of income transfer programs to combat poverty.</p> <p><i>Health policy</i>:</p> <ul style="list-style-type: none"> - Public system suffers effect of limited funding and low investment; emphasis on the responsibility of the provinces; - Legislation encourages hospitals to become independent; varying adhesion among the provinces. - <i>Obras Sociales</i>: freedom of choice between <i>obrassociales</i> approved, but unions veto direct private insurance competition in the system; increased competition between the <i>obras</i>, which start to subcontract private companies to offer better plans and attract clients; corporative pact replaced by market logic. - Private sector: increase in private providers and prepaid health care companies. 	<p>2000-2002 – Economic crisis; 2003 to 2014 – Nestor Kirchner (2003-2007) and Cristina Kirchner (2003-2007) governments:</p> <p><i>Economic policy</i>: attempt to recover growth, formal employment and public investments; international loans.</p> <p><i>Pensions</i>: 2003-2007: corrections and free choice between systems; inclusion in the public system; 2008-2014: system renationalized; creation of unified and integrated public system (SIPA); 90% of population covered.</p> <p><i>Social Assistance</i>: expansion of income transfer policies and creation of <i>Asignación Universal por Hijo</i> program.</p> <p><i>Health policy</i>:</p> <ul style="list-style-type: none"> - Amplification of specific public programs, with international financial support; - Pharmaceutical Policy: <i>Remediar</i> program (later <i>Remediar-Redes</i>); generic drugs; increase of medicines on the PMO list; - <i>Nacer/SUMAR</i> Plan – provincial public insurance; covered pregnant women and children; in 2012 extended to teenagers and women up to 64. - Community Doctor Program (PHS); - Investments in hospital infrastructure; - <i>Obras Sociales</i>: persistent competition to attract clients, contracting out of private providers and of prepaid health care companies. - Prepaid Medicine Act (in 2011)

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plans¹⁷. Although the public health reform of the 1980s broke the traditional corporative arrangement, with the creation of the public and universal SUS, the existing social stratification was reasserted through the public-private relations, and the use of private health care plans by the

middle class and groups of workers. The strength of private segments would shape a situation of path dependence during the implementation of the SUS, fueled by state incentives and the imbricated relations between the public and private sectors³⁸.

Chart 1. Health Policies in Argentina, Brazil and Mexico: prior trajectory, context and political agenda from 1990 to 2014.

Country	Prior Trajectory	1990-1999	2000-2014
Brazil	<p><i>Throughout the 20th century:</i></p> <ul style="list-style-type: none"> - Public health actions focused on controlling specific diseases; - Social Insurance health care for formal urban workers provided by Pensions Institutes, unified in 1966 as the National Social Insurance Institute (INSS). Hospital services largely provided by private contractors. - 1960s: start of state subsidies to the private sector. - 1970s: social insurance health care extended to cover rural workers and some services for the entire population (e.g. emergencies); local experiments of service reorganization. <i>1980s:</i> - Redemocratization and broad social mobilization; public health reform movement; - 1988 Constitution: Extended Social Security; health as a right for all and State duty; creation of the Unified Health System: public, universal, free of charge, comprehensive, oriented by decentralization and social control. - Institutional reforms and decentralization in health. 	<p>Collor-PRN government (1990-1992); impeachment; Itamar Franco-PMDB government (1993-1994); Fernando Henrique Cardoso – PSDB government (1995-2002)</p> <p><i>Economic policy:</i> Neoliberal reforms: trade liberalization, privatizations, State reform and public spending containment.</p> <p><i>Pensions:</i> Social Insurance Organic Law in 1991; opposition to privatization proposals; from 1998 incremental reforms reinforce the contributive component and change rules for benefits access; public nature maintained;</p> <p><i>Social Assistance:</i> institutional changes (Social Assistance Organic Law); increase in income transfer policies at the end of the decade.</p> <p><i>Health policy:</i></p> <ul style="list-style-type: none"> - Influenced by the public health reform and State reform agendas. - SUS implementation begins under financial difficulties. - Emphasis on decentralization; expansion of decentralized public services; - Adoption of intergovernmental coordination and social control mechanisms; Especially from 1995-2002: - Expansion of the Family Health Program - Advances in mental health policies, HIV/AIDS control; tobacco control. - Health plan and insurance companies: regulatory law in 1998 and creation of regulatory agency in 2000; regulation limited and growth of the sector. 	<p>PT Governments - Lula (2003 to 2010) and Dilma Rousseff (2011-2014).</p> <p><i>Economic policies:</i> monetary stability; however developmentalist policies resumed, emphasis on creation of formal employment, increase in minimum wage and in population's purchasing power;</p> <p><i>Pensions:</i> incremental reforms in the arrangements for the general public and for civil servants reinforce the contributive character and alter the access criteria; public nature of the system maintained.</p> <p><i>Social Assistance:</i> expansion of income transfer policies; extension of the Continuous Cash Benefit (BPC) and creation of the Family Allowance Program (PBF); emphasis on strengthening the rights of vulnerable groups (black population, LGBT population, women).</p> <p><i>Health policy:</i></p> <ul style="list-style-type: none"> - Policies to reinforce PHC/Family Health Strategy: inclusion of new professionals in the More Doctors program (doctors hired for remote areas and more places offered to study Medicine). - Priority programs for critical areas: oral health, emergency care and pharmaceutical assistance. - Health promotion strategies, - Strategies to strengthen domestic production of strategic health supplies; - Strategies aimed at education and work management in health. - Supplementary private sector (health plan and insurance companies) - limited regulation by the national agency; sector continues to grow. - End of 2014: Provisional Measure (passed into Law in 2015) authorizes the health sector to be open to foreign capital, including health care.

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Chart 1. Health Policies in Argentina, Brazil and Mexico: prior trajectory, context and political agenda from 1990 to 2014.

Country	Prior Trajectory	1990-1999	2000-2014
Mexico	<p><i>Throughout the 20th century:</i></p> <ul style="list-style-type: none"> - 1917 Constitution – broad social pact; however 70 years of domination by a single party in power (PRI). - Limited public health actions; - In 1943: creation of the IMSS (formal workers); - In 1959: creation of the ISSSTE (civil servants); - 1970s: IMSS starts to offer health services to uninsured poor population in rural locations. <p><i>1980s:</i></p> <ul style="list-style-type: none"> - Miguel de la Madrid-PRI government (1982-1988) - Economic crises: austerity reforms, public spending containment; - Restricted democracy; - Constitutional reform of 1983 – people’s right to health protection. - Budget restraints on the IMSS, ISSSTE and Health Secretary; - 1983-1984 – Health services decentralized, under adverse financial conditions, involving 14 states 	<ul style="list-style-type: none"> - PRI governments of Carlos Salinas de Gortari (1988-1994) and Ernesto Zedillo (1994-2000) <p><i>Economic policy:</i> Economic crises and neoliberal reforms;</p> <p><i>Pensions:</i> successive proposals for privatization of social insurance;</p> <p>In 1995: privatization of the pension system (IMSS);</p> <p>opposition to privatization of health and the ISSSTE.</p> <p><i>Social Assistance:</i> expansion of anti-poverty policies (income transfer).</p> <p><i>Health policy:</i></p> <ul style="list-style-type: none"> - Health Sector Reform 1995-2000 – decentralization involves 32 states; creation of “decentralized public bodies” and public fund for federal transfers. - IMSS - Following privatization of pensions, growing financial difficulties for health care. - Low investment in public services and incentive to contract out to private providers (still limited). 	<ul style="list-style-type: none"> - PAN governments of Vicente Fox (2000-2006) and Felipe Calderón (2006-2012) – put an end to more than 70 years of PRI rule in national government. - Election of Peña Nieto – PRI returns to power in 2012. <p><i>Economic policy:</i> continued neoliberal policies; private sector growth incentivized.</p> <p><i>Pensions:</i> proposals to increase private participation in ISSSTE (complementary plans for civil servants);</p> <p><i>Social Assistance:</i> income transfer policies extended; <i>Progresa</i> become the <i>Oportunidades</i> program;</p> <p><i>Health policy:</i></p> <ul style="list-style-type: none"> - Social Protection for Health Act and Popular Health Insurance created (2003) - voluntary and for the poor - covers limited number of low and medium complexity health interventions (285 by the end of 2013) and list of complex interventions by means of the Catastrophic Health Care Fund; services generally provided by state departments; in some states public services expanded or outsourced to private services. - IMSS–Solidarieda renamed IMSS–Oportunidades; services made available to beneficiaries of the People’s Health Insurance in 2011. - IMSS and ISSSTE – financial difficulties; slow expansion of contracting out of private services. - Growth of medical offices; small growth of the private plan segment.

Source: Prepared by the author based on several bibliographic and documental sources.

Note: Acronyms: PHS – Primary Health Care; PMO – Mandatory Medical Program (*Programa Medico Obligatorio*); SIPA – Argentinian Integrated Social Insurance System.

In Argentina, while in 1967 the social insurance restructuring resulted in the formation of three national institutions, health remained under the administration of the unions by means of the *obras sociales*, the fragmentation of which was exacerbated in the subsequent decades¹². The pact between the State and the unions regarding

health care would preserve the corporative nature of the system, hindering the development of a universal system. However, it would not prevent the growth of private care provision within the *obras* from the 1990s onwards, encouraged by arrangements between the *obras* and pre-paid health care companies¹².

Mexico began to form its corporative subsystem with the creation of the IMSS in the 1940s, and the ISSSTE in the 1950s, which were consolidated as public social insurance and health care institutions for formal workers, primarily composed of public providers. From the 1980s onwards, the technical and political power of these institutes would hinder any break from the corporative pact in view of pressures for neoliberal reforms. The market presence, limited as regards service providers and health care plan companies, is expressed by the high out-of-pocket spending by families and the recent growing trend of private services³¹.

Another group of factors relates to the political context and the relationships between democracy, neoliberalism and the government profiles.

In Brazil, the fact that democratization preceded trade liberalization favored social mobilization and the enactment of a Constitution in 1988 that was progressive in terms of citizenship, and provided some protection against the neoliberal reforms of the 1990s. The center-left governments of Lula and Dilma from 2003 to 2014 implemented redistributive policies and preserved the SUS, with incremental advances. However, structural issues were not tackled, such as the dynamism of the private sector. Following Dilma Rousseff's impeachment in 2016, the new president, Michel Temer demonstrated the power of an unelected, neoliberal-leaning government, allied to national and international economic interests, in removing social rights.

In Argentina, following the crisis of the 1980s, trade liberalization was radicalized in the 1990s over the course of the democratically-elected Menem government¹⁰. From 2003 onwards, the center-left Kirchner administrations implemented renationalization measures and sought to expand social rights. This favored the extension of public health care programs without facing the segmentation of the *obras sociales* system, or containing the expansion of the health care markets within the *obras*.

In Mexico, meanwhile, rapid neoliberal reforms triggered in the 1980s affected the health system. Throughout the period there were no left-wing national governments and no proposals put forward to universalize health care. Social policy was focused on alleviating poverty, in keeping with the guidelines of the international agencies and of the economic reforms. The social insurance bureaucracy and the union movement sought to defend worker rights and

expand non-contributory coverage, through the existing institutes and public service provision. In the face of opposition against the reforms to social insurance, the governments focused on decentralization, fragilization of the institutes and, in the 2000s, on insuring the poor to offer a restricted package of actions. The whole period was marked by a dispute between projects to expand health service coverage based on neoliberal logics (pro-market, highly focalized) or corporative logic (defense of public institutions and of the rights acquired by part of the population). As from 2014, the proposal of a universal system was retrieved by a right-win government, associated to the risk of a restrictive homogenization of the services, under adverse funding conditions and unattached to the debate on rights and the health care model.

Table 1 summarizes the indicators from the countries in 1990 and 2014. In 1990 Brazil had the worst indicators for poverty, inequalities and health, but advanced significantly. Argentina, with the best initial outlook, also enjoyed positive results. As far as Mexico is concerned, despite the improved health indicators, limited poverty reduction results were reported, suggesting deficiencies in the focalized policies that have prevailed.

In health funding, increased public spending per capita is observed in Brazil and in Mexico, with the highest spending in the former (Figure 2). Argentina, despite higher initial levels, reported oscillations, with an increase between 2004 and 2009 and then reduction from 2010 onwards in spending per capita and public spending as a share of GDP.

Regarding the composition of public spending, in Brazil 100% was spent on the SUS, whereas in the other countries more than 50% was channeled into health care linked to social insurance for workers. In Mexico, the share corresponding to social insurance fell between 1995 and 2014. In Argentina, that share increased between 2009 and 2014, suggesting that social insurance health expenditures were more resistant against retrenchment than public health expenditures.

Private expenditures remained high in all three countries, although with differences in composition. Of particular note is the significance of health care plans in Brazil and of out-of-pocket expenditures in Mexico, which remained high throughout the period, as well as their growth in Argentina in recent years (Figure 3).

Table 1. Selected demographic, economic, social and health indicators. Argentina, Brazil and Mexico, around 1990 and 2014.

Indicador	Argentina			Brazil			México		
	1990	2014	% Var.	1990	2014	% Var.	1990	2014	% Var.
Population (total)*	32,688,966	42,874,155	31.2	150,310,243	205,960,069	37.0	85,380,637	122,978,018	44.0
Population (% Latin America)*	7.5	7.0	- 6.6	34.5	33.7	- 2.5	19.6	20.1	2.5
GDP per capita (current US\$)* ¹	4302.9	13225.9	207.4	2838.6	11732.6	313.3	3435.9	10532.4	206.5
GDP (% Latin America)* ¹	12.4	9.2	- 26.3	37.7	39.0	3.6	25.9	20.9	- 19.3
Agricultur, value added (% of GDP)** ¹	8.1	8.0	- 1.5	8.1	5.0	- 37.9	7.8	3.5	- 54.9
Industry, value added (% of GDP)** ¹	36.0	28.9	- 19.7	38.7	23.8	- 38.5	28.4	34.3	20.8
Services, value added (% of GDP)** ¹	55.9	63.1	12.9	53.2	71.2	33.8	63.7	62.1	- 2.5
Degree of openness of economy (% current US\$)*	15.6	28.4	81.8	14.1	25.1	77.6	34.3	65.8	92.0
Poverty (% population)* ²	16.1	4.3	- 73.3	48.0	16.5	- 65.6	44.2	41.2	- 6.8
Extreme povrty (% population)* ²	3.4	1.7	- 50.0	23.4	4.6	- 80.3	16.0	16.3	1.9
Gini coefficient* ³	0.501	0.470	- 6.2	0.627	0.548	-12.6	0.542	0.491	- 9.4
Improved water source (% of population with access)**	93.8	98.9	5.4	88.5	98.1	10.8	82.3	96.1	16.8
Improved sanitation facilities (% of population with access)**	87.4	96.1	10.0	66.6	82.7	24.2	66.2	85.1	28.5
Life expectancy at birth, total (years)**	71.5	76.2	6.5	65.3	74.4	13.9	70.8	76.7	8.4
Fertility rate , total (births per woman)**	3.0	2.3	- 22.3	2.8	1.8	- 36.3	3.5	2.2	- 35.5
Under 5 years mortality rate (per 1,000 live births)***	27.6	12.9	- 53.3	60.8	16.2	- 73.4	46.6	13.8	- 70.4
Infant mortality rate (per 1,000 live births)***	24.4	11.5	- 52.9	50.9	14.4	- 71.7	37.1	11.9	- 67.9
Neonatal mortality rate (per 1,000 live births)***	15.4	6.5	- 57.8	24.3	9.6	- 60.5	20.6	7.4	- 64.1

Sources: * ECLAC, 2017; ** World Bank, 2017; *** World Health Organization, 2017

Notes: 1 GDP - Gross Domestic Product. 2 Poverty and Extreme Poverty - in Argentina, data refers only to urban population, and to the years 1994 and 2012; in Mexico, data refers to national population and to the years 1992 and 2014. 3 Gini Coefficient - in Argentina, data refers only to urban population, and to the years 1990 and 2014; in Mexico, data refers to national population and to the years 1992 and 2014.

Final considerations

The health policies in the countries investigated have followed different paths in recent decades. However, all three display elements of path dependence, perpetuating social stratification and commodification in health, under distinct char-

acteristics. In Brazil, the SUS guarantees citizens' right to health care, but part of the population have private plans or access private services directly. In Argentina and Mexico, the segmentation is expressed in the coexistence of social insurance, specific public programs, prepaid private health plans and private services. The cre-

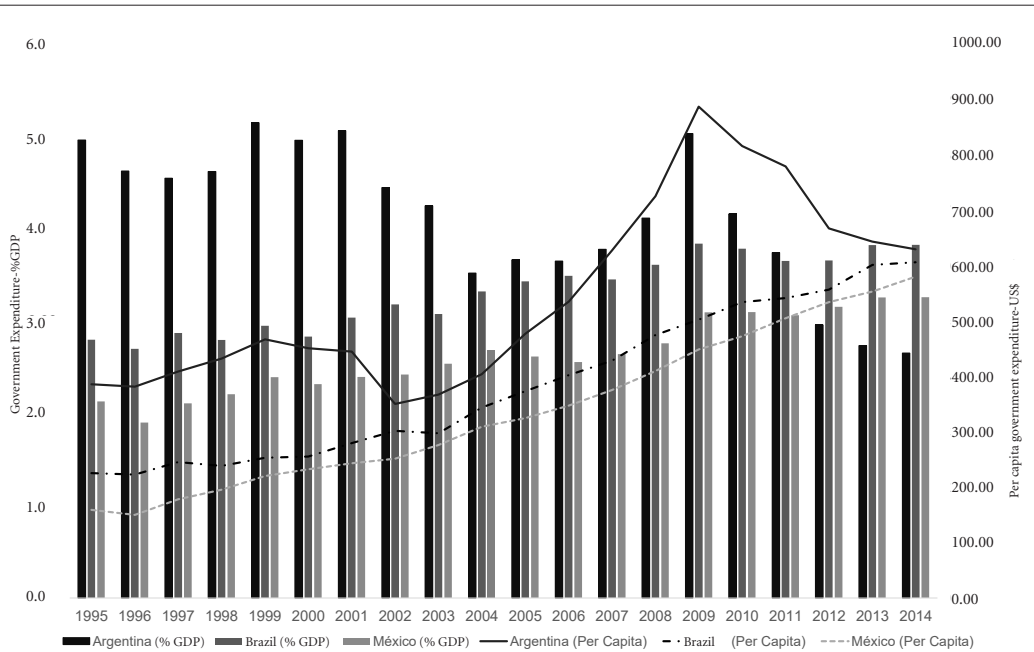


Figure 2. Government Expenditure in Health as a proportion (%) of the Gross Domestic Product and Per Capita Government Expenditure on Health (US\$ PPP). Argentina, Mexico and Brazil, 1995 to 2014.

Source: World Health Organization (Data Repository), 2017. <http://apps.who.int/gho/data/node.home>.

Notas: 1GDP–Gross Domestic Product; 2US\$ PPP: Purchasing Power Parity international dollar.

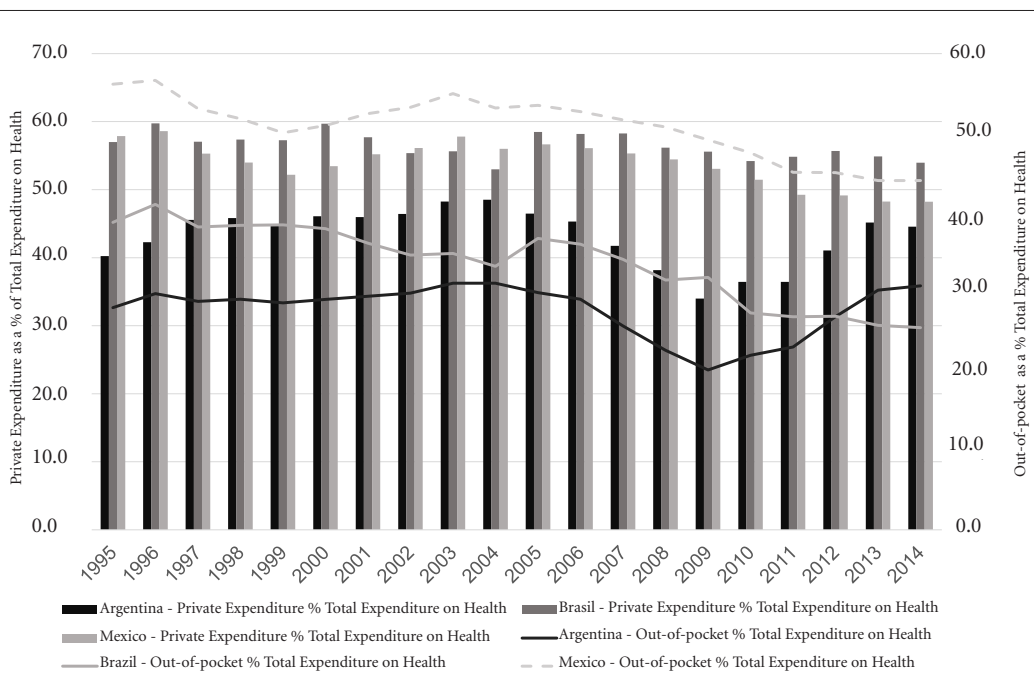


Figure 3. Private Expenditure on Health and Out-of-Pocket Expenditure on Health as a proportion of Total Expenditure on Health. Argentina, Brazil and Mexico, 1995 to 2014.

Source: World Health Organization (Data Repository), 2017. <http://apps.who.int/gho/data/node.home>.

ation of the *Seguro Popular* in Mexico exacerbated the segmentation and reaffirmed the health system as an element of social stratification.

In all three the corporative basis of social protection has played a major role in the expansion of rights and resistance against pro-market reforms. However, it has tended to maintain the segmented characteristics and hindered projects to universalize health care. Amid the tension between corporatism and neoliberalism, the idea of the universal right to health loses ground to the proposal of 'universal health coverage', which is coherent with the reforms in Mexico and the strategy launched in Argentina in 2016.

In Brazil, the breakaway from social insurance and the establishment of the SUS were fundamental for the consolidation of the right, but not sufficient to overcome stratification and the market forces in health. The central contradiction is the coexistence of a strong public system, which favored access and changes in the health care model, with a dynamic and growing private system, which remains intrinsically related to the public system and threatens its feasibility, disputing for funds from both the State and society.

The character of democracy and the political orientation of the governments have also been important. In Mexico, there were no progressive governments over the course of the three decades and the country was subjected to neoliberal reforms, with effects on pensions and health systems. In Argentina and Brazil, the rise

of center-left governments from 2003 to 2014 helped contain neoliberal reforms and pushed the implementation of redistributive policies, with expanded social and health programs. However, this did not suffice to tackle the structural problems in the health systems, which manifested contradictions and projects in dispute. The recent return to power of right-wing governments – in Argentina, by election; in Brazil via presidential impeachment – has led to setbacks in social rights. The fragile nature of democracy is demonstrated by institutional instability and policy discontinuity, media manipulation and the persecution of the left-wing leaders.

In all three countries, obstacles to the public health system transcend the boundaries of the public sector, relating to their identification as attractive markets for foreign and domestic health companies. Private interests and disputes over funding impairs the public services. However, health systems with a strong private component are fragmented, expensive, vulnerable to economic cycles and exclusionary, especially in unequal societies.

The challenge for the Latin American countries is to build a pact around a sovereign and democratic development project, aimed at guaranteeing social rights. From this perspective, the role of the State, in dialogue with different societal groups, would be to contain the market forces, promote social redistribution, reduce inequalities and expand universal citizenship.

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References

- Mesa-Lago C. *Reassembling Social Security: A Survey of Pensions and Health Care Reforms in Latin America*. New York: Oxford University Press; 2008.
- Huber E, Stephens JD. *Democracy and the Left: Social Policy and Inequality in Latin America*. Chicago: University of Chicago Press; 2012.
- Comisión Económica para América Latina, 2017. *CEPALSTAT*. [acessado 2017 Jul 1]. Disponível em: <http://www.eclac.org/estadisticas/>
- Mahoney J, Rueschemeyer D, editors. *Comparative historical analysis in the social sciences*. Cambridge: Cambridge University Press; 2003.
- Esping-Andersen G. *The Three Worlds of Welfare Capitalism*. Princeton: Princeton University Press; 1990.
- Belmartino S. *La atención médica argentina en el siglo XX, instituciones y procesos*. Buenos Aires: Siglo veintiuno editores; 2005.
- De Fazio FL. The relationship between the State and workers' unions and its impacts in the union-based health coverage regime in Argentina: an historical and political analysis. *Salud Colectiva* 2013; 9(3):301-315.
- Lloyd-Sherlock P. Health sector reform in Argentina: a cautionary tale. *Soc Sci Med* 2005; 60(8):1893-1903.
- Alonso GV. *Política y Seguridad Social en la Argentina de los '90*. Buenos Aires: Miño y Dávila Editores; 2000.
- Teichman JA. *The Politics of Freeing Markets in Latin America: Chile, Argentina and Mexico*. Chapel Hill: The University of North Carolina Press; 2001.
- Arza C. *Back to State: Pension fund nationalization in Argentina*. Buenos Aires: Centro Interdisciplinario para el estudio de políticas públicas; 2009. [Documento de Trabajo n.73]
- Clérico L, Ronconi L, Scioscioli S, Aldao M. Notas y preguntas sobre el marco regulatorio de la medicina prepaga. *Jurisprudencia Argentina* 2011; (8):3-35.
- Rovere M. El Sistema de Salud de la Argentina como Campo; Tensiones, Estratagemas y Opacidades. *Rev Debate Público* 2016; 6(12):23-42.
- Argentina. Ministerio de Salud (MS). *Bases para el Plan Federal de Salud 2004-2007*. Buenos Aires: MS; 2004.
- Garriga S. *Impacto del Plan Nacer sobre la Mortalidad Infantil en Argentina*. CEDLAS. Documento de Trabajo n° 168.2014. [acessado 2017 Jul 1]. Disponível em: http://www.cedlas.econo.unlp.edu.ar/wp/wp-content/uploads/doc_cedlas168.pdf
- Vilosio JO. *Oportunidades perdidas. Notas sobre política y reforma sanitaria en Argentina*. Buenos Aires: Del Hospital Ediciones; 2014.
- Oliveira JAA, Teixeira SF. *(Im)Previdência Social: 60 anos de história da previdência no Brasil*. 2ª ed. Petrópolis: Vozes; 1989.
- Escorel S. *Reviravolta na Saúde. Origem e articulação do movimento sanitário*. Rio de Janeiro: Editora Fiocruz; 1999.
- Paim JS. *Reforma Sanitária Brasileira: contribuição e crítica*. Salvador, Rio de Janeiro: Edufba, Editora Fiocruz; 2008.
- Sallum Junior B. Crise, democratização e liberalização no Brasil. In: Sallum Junior B, editor. *Brasil e Argentina hoje: política e economia*. Bauru: EDUSC; 2004. p. 47-77.
- Machado CV, Lima LD, Baptista TWF. Políticas de saúde no Brasil em tempos contraditórios: caminhos e tropeços na construção de um sistema universal. *Cad Saude Publica* 2017; 33(Supl. 2):e00129616.
- Erber FS. As convenções de desenvolvimento no governo Lula: um ensaio de economia política. *Rev. Econ. Polit.* 2011; 31(1):31-55.
- Arretche M, organizadora. *Trajetórias da desigualdade: como o Brasil mudou nos últimos 50 anos*. São Paulo: Editora da Unesp; 2015.
- Gadelha CAG, Costa L. Saúde e desenvolvimento nacional: a gestão federal entre 2003 e 2010. In: Machado CV, Baptista TWF, Lima LD, organizadoras. *Políticas de saúde no Brasil: continuidades e mudanças*. Rio de Janeiro: Editora Fiocruz; 2012. p. 61-90.
- Machado CV, Lima LD, Andrade CLT. Federal funding of health policy in Brazil: trends and challenges. *Cad Saude Publica* 2014; 30(1):187-200.
- Bahia L, Scheffer M, Tavares LR, Braga IF. From health plan companies to international insurance companies: changes in the accumulation regime and repercussions on the healthcare system in Brazil. *Cad Saude Publica* 2016; 32(Supl. 2):e00154015.
- Flamand L, Jaimes CM. *Seguro popular y federalismo em México*. Cidade do México: Centro de Investigación y Docencia Economicas; 2014.
- Levitsky S, Way LA. *Competitive authoritarianism: hybrid regimes after the Cold War*. Cambridge: Cambridge University Press; 2010.
- Dion M. Retrenchment, Expansion and the Transformation of Mexican Social Protection Policies. *Social Policy & Administration* 2008; 42(4):434-450.
- Pêgo RA, Almeida CM. Teoría y práctica de las reformas en los sistemas de salud: los casos de Brasil y México. *Cad Saude Publica* 2002; 18(4):971-989.
- Homedes N, Ugalde A. Twenty-Five Years of Convolutioned Health Reforms in Mexico. *PLoS Med* 2009; 6(8):e1000124.
- Uribe-Goméz M. Nuevos Cambios, Viejos Esquemas: Las Políticas de Salud en México y Colombia en los Años 2000. *Cad Saude Publica* 2017; 33(Supl2):e00112616.
- López-Arellano O, Soto ECJ. La reforma neoliberal de un sistema de salud. Evidencia del caso mexicano. *Cad Saude Publica* 2017; 33(Supl. 2):e00087416.
- Nigenda G. *El seguro popular de salud en México Desarrollo y retos para el futuro*. Nota Técnica de Salud n 2/2005. Banco Interamericano de Desarrollo. [acessado 2017 Jul 1]. Disponível em: <http://www.iadb.org/wms-files/products/publications/documents/1485608.pdf>
- Knaul FM, González-Pier E, Gómez-Dantés O, García-Junco D, Arreola-Ornelas H, Barraza-Lloréns M, Sandoval R, Caballero F, Hernández-Avila M, Juan M, Kershenobich D, Nigenda G, Ruelas E, Sepúlveda J, Tapia R, Soberón G, Chertorivski S, Frenk J. The quest for universal health coverage: achieving social protection for all in Mexico. *Lancet* 2012; 380(9849):1259-1279.
- Laurell AC. The Mexican Popular Health Insurance: Myths and Realities. *Int J Health Serv* 2015; 45(1):105-125.

37. Uribe-Gómez M, Pêgo R. Las reformas a la protección social en salud en México: ¿rupturas o continuidades? *Perfiles Latinoamericanos* 2013; 21(42):135-162.
38. Menicucci TMG. *Público e privado na política de assistência à saúde no Brasil: atores, processos e trajetórias*. Rio de Janeiro: Editora Fiocruz; 2007.

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