

Strengthening health systems to achieve Universal Health Coverage: Lessons from four Latin American countries.

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Abstract

Background: During the 1990s, health systems within several Latin American countries changed to expand service coverage and reach more people. These changes are considered the antecedent of the Universal Health Coverage (UHC). Seven years after the United Nations' call for UHC, healthcare services in Argentina, Brazil, Colombia, Mexico are generally accessible and affordable. However, these countries increasingly struggle to meet their populations' growing health needs while also addressing rising health care costs. This research aims to describe measures taken by these four countries to commit by UHC, addressing their barriers and challenges.

Methods: This study examined literature review data, supplemented with survey data collected from regional stakeholders. Data were analyzed within an ad-hoc matrix.

Results: These four countries increased healthcare services coverage by strengthening their primary healthcare systems. They also expanded coverage for non-communicable diseases, provided community outreach, and increased the number of skilled healthcare workers. New pharmaceutical support programs provided access to treatments for chronic conditions at zero cost, while high-costs drugs and cancer treatments were partially guaranteed. However, these measures did not achieve full financial protection to all, leaving citizens exposed to possible catastrophic expenditures, despite increased service coverage. UHC is funded primarily through taxes and pooling resources, and these four countries still struggle to find mechanisms that could increase pooling mechanisms capable of increasing service coverage, while reducing financial inequities among people.

Conclusions: Argentina, Brazil, Colombia, and Mexico have made progress towards UHC. Nevertheless, additional mechanisms to sustain financial protection are urgently required. The decentralization of the primary healthcare system, the development of public-private partnerships, and the implementation of progressive financing mechanisms like conditional cash transfers are potential manners to improve service delivery and financial protection contributing to effective UHC.

Introduction

According to the World Health Organization (WHO), comprehensive universal health coverage (UHC) strategies aim to guarantee "universal access to a strong and resilient people-centered health system, with primary care as its foundation." [1] Currently, 1.3 billion people lack access to effective, affordable healthcare, while an additional 1.7 billion spend at least 40% of their household income on healthcare. [2]. By expanding access to health services, covering prevention, health promotion, treatment, and rehabilitation, UHC aims to protect citizens from the potentially catastrophic financial impact associated with high-cost health care. [3]

As stated in the Sustainable Development Goals (SDG) 3.8,[3] the WHO seeks to expand UHC to one billion additional people by 2030. [4–6] To meet this goal, governments must commit to increasing public healthcare financing, while progressively increase access to essential medicines. Also, they must

guarantee coverage to vulnerable groups, especially women and girls from the poorest wealth quintile.[7] UHC must also include financial protection initiatives to protect patients from the potentially catastrophic impact of large medical bills. WHO notes that policies that improve access to health services have had greater impact on expanding UHC than those that improve financial protection. [8]

During the 1990s, several countries throughout Latin America (LAC) began reforming their healthcare systems by creating frameworks to monitor improvements in quality of care[4], enhancing primary healthcare (PHC) networks[9], decentralizing health governance, strengthening regulatory measures, and improving efficiency.[3] They also addressed the structural fragmentation that prevented health providers from making purchasing decisions. Yet these efforts have been challenged by inequitable funding and employment-based contributions that sometimes create parallel payment schemes that can lead to tiered and fragmented care. [10] As countries allocate financial resources differently, many developing economies are still debating which UHC financing mechanism may best serve their country. [11]

The purpose of this paper is to examine the approaches and potentials of implementing UHC in LAC. It examines four countries (Argentina, Brazil, Colombia, Mexico) where health services are generally accessible and affordable. However, these countries' governments increasingly struggle to meet their populations' growing health needs while also addressing rising health care costs.

This research identifies and describes measures taken to implement UHC, and discuss their barriers (political, economic, social). It concludes by making recommendations to help other LAC strengthen their health systems to fully commit to UHC.

Results

Study Selection Results

Abstracts from 411 peer-reviewed and grey literature articles were screened, with 73 undergoing full-text assessment, those who did not contain information to fill the evidence matrix were excluded. A total of 40 articles were selected for qualitative synthesis. Of these 40 articles, four focused solely on Argentina, 14 on Brazil, one on Colombia, and 13 on Mexico. The remaining eight articles examined health system processes in multiple countries (one article focused on Argentina, Brazil and Mexico; one on Brazil and Mexico; and three examined Colombia and Mexico). The three final articles reviewed processes from across Latin America. Figure 2 summarizes the study selection process.

Country-specific Evidence Assessment Results

Using the evidence assessment matrix, data were analyzed and correlated to identify UHC achievements and challenges faced by these countries during UHC implementation. Table 1 summarizes the findings from the country analysis.

I. Healthcare service delivery

Nearly all articles described strengthening delivery of primary care services, either by creating new care delivery models or by enhancing already functioning primary care services. [13, 14] Evidence suggests that some approaches reduced health inequities. [15– 18]

Argentina

The Argentine healthcare system ensures all citizens have access to basic healthcare services through its tripartite of public, *Obras Sociales* [Social Security], and private insurance. The public health system, covers nearly 16 million people who lack any other form of coverage,[31] operates at three levels (federal, provincial, municipal) and is financed through general taxes.

After introducing *Plan Federal de Salud* [Federal Health Plan] in 2004, the Argentinean MOH launched *Plan Nacer* [Plan to Born] in 2007, providing coverage to pregnant women and children up to five years of age. [25] In 2013, the program changed its name to *Plan Sumar* [Plan to Add] expanding coverage to at-risk and low-income citizens through financial aid programs, such as *Asignación Universal por Hijo* [Universal Child Allowance] and *Asignación Universal por Nacimiento* [Universal Birth Allowance]. Since inception of *Plan Nacer*, the low birth weight mortality rates have dropped 9%, while neonatal mortality has fallen 22%. [18, 19]

Table 1- Country- specific measures to commit with UHC

	Argentina	Brazil	Colombia	Mexico
healthcare service delivery	<i>SUMAR</i> provided comprehensive PHC oriented to maternal and child health; <i>REDES</i> was expanded to provide coverage to all chronic conditions for all ages at PHC [19]. Implementation of community primary care physicians strengthening PHC with qualified staff.	Primary care network covering 62% of the population <i>ESF</i> introduced community health workers in primary care teams, increasing coverage in underserved areas. Improvement of pre-natal care and sexual and reproductive health programs [15-17, 20, 21] Reduction in health inequalities among racial groups by the implementation of PHC. (10)	Law 100 (1993) reformed established the Mandatory Health Benefit Package (POS) Private insurance (EPS) under managed competition are in charge of healthcare provision, contracting its own providers (IPS)[22-24] 2015 <i>Statutory Law</i> tend to strengthen and unify POS (based on World Bank UHC model), increasing its breadth and reducing <i>Tutelas</i> [22]	Social Security institutions (IMSS, ISSTE, PEMEX) covers more than 70% of population. <i>Seguro Popular (2004)</i> and <i>Seguro Medico para la nueva generacion</i> " (2007) created to cover those in informal sector. . Improvement in the integral coverage of hypertension, diabetes; Also birth control and integral pregnancy management for 90% of the population under <i>Seguro Popular</i> .
Access to medicines and Health products	<i>REMEDIAR</i> provided pharmaceutical assistance at PHC level covering 85% of drugs for chronic conditions [19, 25] Comprehensive care programs for HIV and cancer guarantee treatments for patients w/o coverage [18, 26] Colorectal Cancer, Cervical and Uterine Cancer, Diabetes, Smoke cessation programs provide free of charge treatments [26]	<i>Farmacia Popular</i> and <i>Dose Certa</i> programs which subsidized costs and reduced out of pocket health expenditure in treatments for diabetes, hypertension, asthma, and cardiovascular diseases. Other diseases like nutritional and bleeding disorders, cholera, Chagas disease, dengue, schistosomiasis, filariasis, leprosy, HIV/AIDS, influenza, leishmaniasis, malaria, meningitis, systemic mycoses, multiple myeloma, human rabies, trachoma, and tuberculosis have expanded coverage. National Immunization program providing free vaccination (11,23,36)	Medicines and health products are included in the POS lists managed by the EPS; Large proportion in out of pocket expenditure on essential medicines were seen. <i>Statutory law</i> mandated the creating of a list of medicines and health products that should be removed from POS due to the lack of clinical benefit and value for the people.	Subsidization for medicines to control chronic diseases. Vaccination cards are available for Mexican Children's independently of socioeconomic status and health insurance Government established centralized purchasing and price control to guarantee the fair pricing and access to high cost treatments.
governance, financing, oversight and HIS	The country lack of decentralization policies that regulate health provision from central to subnational levels with lower primary care orientation in the provinces due to	Decentralization of healthcare services and budget management responsibility at municipal level. [15] NGOs were contracted to to provide support to public health services [29] Lower development of unified HIS in the public healthcare services [17]	<i>Law 100 established the Capitation payment unit a fixed amount that government pay to EPS per insured.</i> [22] High amount of people avoid enrolling in POS contributive level	Implementation of PPP to increase coverage to NCD has been cost-effective. Healthcare facilities in SP are under accreditation program

<p>poor institutional capacities [18, 19] Central government transferred more than USD 234 million to provinces to fund primary health strategy over SUMAR [19] HIS is still in development and the country lacks of connectivity across the entire health [18][19]</p>	<p><i>Strong criticisms about underfunding of SUS [30] Federal spending on healthcare unchanged over 15 year period, slight increase of 0,7% GDP in public health expenditure over 5 year period [21]</i></p>	<p>and still under subsidized causing effect inequalities [24] Labor contributions are based on fixed proportion of the income collected by the government under FOSYGA [24]</p>	<p>SP move towards accreditation of facilities, investments in technology and qualified human resources. Federal and State funds are granted to SP, coming from tax revenue and household' contributions</p>
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Enhancing the primary care network in Argentina, they introduced preventive health programs, such as those addressing sexually transmitted infections, cardiovascular disease, diabetes, and other chronic conditions. It also increased the number of deliveries attended by skilled healthcare workers, especially for those living below the poverty level. [15, 16, 18, 21] Other programs strengthened primary care by targeting public sector coverage.[26] For instance, Argentina implemented the *Programa de Medicos Comunitarios* [Community Doctors Program] (2004 to 2007), which applied differential payments to family medicine and general practice physicians working within primary care centers.[19]

Brazil

Brazil has a dual public/private healthcare system. The public subsector, *Sistema Único de Saúde* [Unified Health System] or SUS, provides free healthcare coverage for nearly 80% of citizens. Brazilian health system operations are managed primarily at the state and municipal levels, while the MOH oversees the health sector at the federal level by developing national policies and providing technical and financial assistance.

Guided by five core principles (universality, integrality, equity, decentralization, and social participation), the creation of the SUS in 1988 has been cited as “the most influential movement toward social inclusion and democratization in health.” [32, 33] SUS provides access to free health services through programs, such as *Estrategia de Saúde Familiar* [Family Health Strategy] (ESF), a community-based, multidisciplinary program that assists vulnerable populations, by engaging community healthcare workers within the PHC delivery chain. [15, 17, 33] ESF is one of the biggest community-based PHC programs in the world[15], achieving higher quality of care and user-satisfaction than traditional primary or private health care. [17] After expanding coverage of marginalized populations[15], ESF reduced mortality from both non-communicable and infectious diseases, especially infant mortality due to diarrhea and respiratory infections, while improving health outcomes for people living in remote areas. [15, 17]

Brazil broadened access to PHC primarily by increasing the number of primary care physicians and nurses. [34] The *Mais Médicos* [More Doctors] program, established in 2013, recruited and deployed physicians to work in priority areas (e.g., remote regions with low density of healthcare workers, communities with at least 20% poverty). Due to Brazilian physicians' low interest in these roles, foreign physicians filled 500 of these positions. Later, with support from the Pan American Health Organization (PAHO), Brazil signed an agreement with the Cuban government whereby Cuba would provide the primary care doctors, increasing primary health coverage index by 12% and decreasing avoidable hospitalizations within the participating communities by 3%. [35] Due to several concerns around this program by opposition parties, its future became unclear after President Rousseff's impeachment; however, Cuba agreed to keep providing physicians through a direct agreement with PAHO. Nonetheless, in November 2018, Cuba decided to discontinue the program soon after President Bolsonaro took office, questioning the quality of care provided by Cuban physicians.[1]

Colombia

Colombia enacted its goal for creating UHC in 1993 by initiating managed competition through large-scale participation of the private sector, while also separating the purchasing functions from care provision. The *Ley de Salud Universal Nro. 100* [Universal Health Law 100] also stopped federal provision of health services, transferring these operations to the municipalities. Today, the majority of the population is covered through *Plan Obligatorio de Salud* [Mandatory Health Plan] (POS), which covers health services, medical procedures, and medicines. POS has two components: the subsidized component for those not formally employed, and the contributive component for all others.[22] As enrollment in the subsidized component grew by 24% between 2000 and 2011, access to health services expanded to more people living at the poverty level.[23, 24, 36] In 2015, both components were unified under the *Ley Estatutaria de Salud* [Statutory Health Law], which standardized health benefits, controlled resources, and limited the number of *Tutelas* [lawsuits] pursuing coverage for technologies not included in the insurer's benefit packages. [22]

Mexico

Mexico's healthcare is provided through the social security system, the public health sector, and private health plans. These sectors function in parallel with little coordination between them. The public health sector is composed of the social security institutions, which cover those formally employed, and *Seguro Popular* [Popular Insurance], which provides coverage to those under the informal sector or at the poverty level (self-employed, unemployed, informal sector workers, those working outside the labor market, and their families), thereby achieving the main goal of UHC [14, 22, 23, 36, 37]. Established in 2004, *Seguro Popular* expanded its breadth of coverage when, under the 2007-2012 health reform, introduced *Seguro Medico para la Nueva Generación* [Health Insurance for the New Generation], providing UHC to all children born after December 2006 and those under-five-year-old who lack formal health coverage. [38] Additionally, *Catálogo Universal de Servicios de Salud* [Universal Catalog of Health Services] (CAUSES)

expanded covered services to include 1,807 ICD 10 diagnostic categories, 294 surgical procedures, and treatments for 65 different catastrophic diseases. [37]

II. Access to medicines and health products

All four of these countries created programs to expand coverage of essential medicines, which, when paired with other interventions, [19, 25, 27, 28, 39] strengthened PHC [16, 19, 27] and thereby improved treatment of non-communicable diseases. Although comprehensive oncology care and access to high cost drugs are provided in Argentina, Brazil, Colombia and Mexico, inequities still exist for people treated under the public healthcare system. [18, 27, 37, 39]

Argentina

In 2002, Argentina launched *Programa Remediar* [Remedy Program] (REMEDIAR) as part of its national strategy to improve access to generic medicines, providing essential medicines free of charge for those enrolled in PHC [19], eventually expanding coverage to all citizens. The MOH provide essential drugs, such as those to treat diabetes, hypertension, asthma, and other chronic conditions, free of charge.[16, 25, 27] In 2008, REMEDIAR was integrated into different health service networks (REMEDIAR + REDES) aimed at controlling non-communicable diseases through early detection, while expanding vaccination programs for at-risk populations.[18] This program has changed its name to *CUS Medicamentos* [UHC Medicines], [19] and recently was revamped as REMEDIAR. [40] Argentina also established *Comisión Nacional de Evaluación de Tecnologías de Salud* [National Commission on Health Technology Assessment (HTA) in Argentina], or CONETEC, to provide evidence-based mechanisms to support the inclusion of new medical technologies in the national formularies. [18] ***Brazil***

In Brazil, expanding coverage for high-cost drugs is a contentious issue, as indicated by increased lawsuits demanding coverage of high-cost drugs to treat cancer and certain rare or low prevalence diseases over the last 20 years. [28] Yet, Brazil acknowledges that drug prices constitute a significant barrier to care. SUS provides access to medicines through several programs: *Programa Farmacia Popular do Brazil* [Popular Pharmacy Program of Brazil], *Dose Certa* [Certain Dose], and *Remedio em Casa* [Home Remedy]. These programs have increased access to essential medicines by 20% under the SUS. [28] Brazil also provides free immunizations. [16] Finally, in 2011, Brazil established their national HTA agency, *Comissão Nacional de Incorporação de Tecnologias No Sistema Único de Saúde* [National Commission for the Incorporation of Technologies in the Unified Health System] (CONITEC)[2]. CONITEC advises MOH about technologies that demonstrated an additional benefit and could be incorporated in the SUS. However, the health secretary must approve all changes.

Colombia

The Statutory Law determined that the POS should establish which services are considered essential and which should be excluded from the benefits package. In 2017, resolution 330 established the procedure involving different stakeholders (including the public), to decide which technologies should be

disinvested. Then, the MOH underwent a deliberative process to prioritize and create a negative POS list. [41]

In 2011, Colombia created the *Instituto de Evaluación Tecnológica en Salud* [Institute of Health Technology Assessment], or IETS, as a separate public organization in charge of development of clinical guidelines and technology assessment advising the MOH.

Mexico

Mexico's *Seguro Popular* provides access to low-cost medicines for chronic conditions, but on a smaller scale when compared to Argentina's *Programa Remediar* or Brazil's *Farmacia Popular*. Their enrollees also have limited access to certain high-cost treatments[14].

The Mexican government established a national commission that negotiates with the manufacturers the price of the drugs included on its "essential medicine list" [42]. These negotiation not only benefited *Seguro Popular* enrollees, they benefited other programs, as well, providing access to a differential price, while avoiding extensive government drugs expenditures.[43] In the case of Mexico, the price negotiation is not related to an HTA itself, it is a mechanism created by the General Health Council.

III. Financing, Governance, Stewardship and HIS

It is worth to remark that health expenditures vary across the four LAC as do their financing mechanisms, according to the type of fiscal policies with most using a mix of federal and state taxes. [14, 18, 21, 22, 25, 36, 37, 44, 45] As other elements like Public-Private Partnerships (PPP), governance and HIS also do. .

Argentina

In 2015, Argentina spent 10.2% of its GDP on healthcare, yet only 3% on public health expenditure with a per-capita health expenditure of \$1390; Although, Argentina is on top of LAC in health expenditures.[18, 25]

Due to its Federal constitution, each province owns the healthcare delivery. The government funds national programs like SUMAR by cash transfer; however, each MOH allocates them according to their local needs and capacities. As the country lacks regulation policies, this process is not equitable in some provinces. [21]

Argentina's HIS implementation is part of the ongoing proposal of quality implementation. [4, 18]

Brazil

While Brazil's total healthcare spending is similar to other countries of the Organization for Economic Cooperation and Development (OECD) (roughly 9% of GDP), less than half this amount comes from public sources.[17] During the last two decades, Brazil's public health expenditure remains between 3.3% to 4.5% of its GDP. [18,25] Brazil's SUS is funded through the central government, states, and municipal

budgets, as well as tax revenue. [17] Previous articles have described how cash transfers from the central government to the states or provinces are used to implement social protection measures. [15, 25] One such program, *Bolsa de Família* [Family Grant], unifies multiple social initiatives to provide extra cash to the poorest, conditional upon school attendance and use of PHC services. [16, 29]

In Brazil, both public and private providers may deliver primary care, vaccination, pharmaceutical coverage, dental care, and tertiary care, while private organizations provide the most advanced medical care. [28, 33] PPP improves access to primary services at many municipalities. [46] However, significant controversy surrounding the recent introduction of foreign insurance companies and healthcare providers [33] to the market and the indiscriminate, not outcome-based payments for these organizations. [29, 30] Brazil has long sought societal representation in policymaking at different levels (federal, state and municipalities) through its health councils. [32] However, the lack of continuity in political will and policies to legitimize citizen involvement have contributed to structural and financial hurdles. [17, 28]

Although the *DATASUS* [SUS data network] helps tracking disease registries and public expenditure to guide public health intervention, the implementation of electronic health record is delayed. [17]

Colombia

Healthcare financing is made mainly through government contributions, as well as district or municipal taxes, including gambling taxes. Also, relies on cross-subsidization across its two POS components, whereby 1.5% of payroll tax funds are transferred from the contributive regime to the subsidized one. [36] The *Fondo de Solidaridad y Garantía* [Solidarity and Guarantee Fund] or FOSYGA, uses a similar form of cross-subsidy, receiving funds from the insurance companies and uses it to subsidize the non-contributory system. [23] Healthcare provision is run by EPS, private insurance organizations contracted under managed competition rules to manage both POS components. However, in a country where health is considered an "economic asset", this strategy of managed competition would be considered as an "open market initiative" rather than a PPP. [23] Statutory Law mitigated asymmetries among POS components, a long-standing issue after Constitutional court passed the *Sentencia T-760* [Rule T-760] Although the increasing social participation promoted by the statutory law, decision-makers perceive that citizens are not ready to be involved in these deliberative processes, as they lack understanding of health as a public good. [41]

Mexico

Mexico's public health expenses range from 2.2% to 3.0% of its GDP.[37] *Seguro Popular* is highly-subsidized mainly through federal and state taxes;[23] the federal government contributes with 83% of the annual cost per person, while the states provide the remaining 17%.[44] The program saw a 13-fold increase in Federal investment from 11 million Mexican pesos in 2004 to 146 million Mexican pesos in 2013. [14] During 2017, its financial management changed to the *Comision Nacional de Proteccion Social en Salud* [National Commission of Social Protection in Health] and the *Regimenes estatales de proteccion social en Salud* [State Regimes for Social Protection in Health], two pooling mechanisms for the strategic

purchases in the system. [14] This change led to a 9% decrease (from 52.2% to 41.4%) in out-of-pocket health expenditures, as well as improvement in the quality of care, and a 43% increase in coverage, adding an additional 53.5 million people in 2018. [37]

PHC is highly fragmented at the Mexican federal level, whereby of the 32 *Regimenes Estatales de Protection de Salud* [state regimens for health protection] (REPS) that direct the PHC implementation managing its resources and funding, yet only 23 are partly owned by the state. [45] The Mexican government has collaborated agreements with private providers to strengthen the quality of care provided through *Seguro Popular*, ensuring delivery of cost-effective treatments for chronic conditions. [47]

Mexico developed an ad-hoc electronic tool to assess its health system performance, pointing out the hurdles in access to effective health coverage.[48]

Survey Findings - Qualitative Assessment

Semi-structured surveys were sent to policymakers who were involved or have a deep understanding of the UHC development in LAC. Candidates were selected according to their professional background and experience within local health system. However, the response rate was 33% (two from Argentina, one from Brazil). Table 2 summarizes data contrasting the findings from both methods.

Table 2 - Survey findings from regional stakeholders

Element for Analysis	Evidence in Literature Review	Framing the Stakeholder surveys
<i>Healthcare service delivery</i>		
Strengthening of first level of care	Available	<i>Most Frequent</i>
Are standards or guidelines for improving the quality of health services delivery?	Available	Frequent
Monitoring quality of care by indicators	Available	Frequent
Community participation in the first level of care	Available	Frequent
<i>Access to Medicines and Health Products</i>		
Processes for improving the availability and regulation of medicines and other health technologies (medical devices, diagnostic tests)	Not Available	Some frequent
Essential drugs provision at the first level of care	Available	<i>Most Frequent</i>
Promotion of the development of generic essential medicines	Not Available	Frequent
Monitoring the Per capita public and private spending on pharmaceutical products	Available	Frequent
Development of a national program for Blood donation / access to safer blood products	Not Available	Frequent
<i>Governance, Finance, Stewardship and HIS</i>		
Funding mechanisms promoting resource mobilization from the central level	Available	Some Frequent
Availability of PPP to support core elements of UHC / PHC	Available	Not Assessed
Tracking the average public health expenditure (expressed in % of Gross Domestic Product)	Available	<i>Most Frequent</i>
Policies to ensure the availability, equitable distribution, and quality of human resources for health	Not Available	Frequent
Use of health information systems to support decision making / UHC allocation	Available	Frequent

“*some frequent*” (10-30% of responses), “*frequent*” (31-65% of responses) and “*most frequent*” (66%–100% of responses).

Discussion

Although numerous publications analyze both the evolution of healthcare systems and adoption of UHC across Latin America, this review utilizes elements from the WHO 13th program of work Framework to examine how UHC has been incorporated into regional and country-level health systems. The information covered in this report supports the assessment, planning, and execution of those measures that enhance both service provision and financial protection mechanisms in an aim to improve access to comprehensive care, reflecting the UHC purpose. Each of the four countries have strengthened their health services coverage through UHC by establishing patient-oriented health systems that expand access to health services, especially primary care, increasing the perceived quality of care [4, 27, 37] These LACs developed numerous country-specific measures to develop UHC through either expanded coverage of health services or through strengthened financial protections.

- Argentina achieved “nominal” UHC, meaning that people enrolled in the healthcare systems have the right to access them. [18] Currently, the country is striving towards more effective UHC, especially by improving access to quality healthcare services by introducing capitated payments transferred to the provinces that would enable expanded coverage for services included in their health benefits packages. [4, 18]
- Brazil increased social investment due in part to *Bolsa Familia*. [16] In the last ten years, Brazil also expanded coverage to 62% of citizens by quadrupling the number of people covered by the ESF program.[17] To guarantee and maintain UHC targets, such as infant mortality and access to ESF, recent models of the Brazilian health system have shown that the country must *increase its annual contribution by the central government to the municipalities by 3%*. [49]
- Statutory Law allowed to uniform the services covered by the POS, expanding the services ranges for those under the subsidized scheme, strengthening the health coverage and reducing the number of *Tutelas*.
- In 2012, Mexico also claimed to have achieved UHC, standing as another example of “nominal” UHC. [22]

UHC initiatives in these four LAC have been faced with challenges surrounding the lack of strong financial protection measures and inadequate governance mechanisms which continue to put many people at risk of catastrophic health expenditures. There is still debate surrounding the ideal financing mechanisms for UHC in low to middle-income countries (LMICs). These countries face challenges stemming from uneven tax collections and the increase in out-of-pocket expenditure [11]. Also, they operate without clear guide regarding tax funding apart from the recommendation to allocate 5% of the gross domestic product to healthcare. Challenges faced by these countries include:

- Argentina metrics showed that even with strong financial incentives and an increase in the pooling of funds, unmet healthcare needs persist, mainly in provinces that suffer a lack of health providers, outdated health information systems, and low institutional capacity. The fragmentation in healthcare funding has led to ineffective funding policies at both the state and sub-national level. Most of these health coverage initiatives rely on the external funding, meaning these are controlled by the MOH or the Ministry of Finance rather than each Argentinian province. [18, 19, 46] Health governance issues must be resolved in order to ensure access to quality health systems; financial readjustments are insufficient, as emphasized by Uribe-Gomez. [22]
- Brazil's SUS continues to be underfunded as federal health funding stagnate with public health spending increasing only 3.2% over the last 10 years.[21] SUS receives only 46% of the available funds slated for public health. [30] This has led to an increase in patient cost-sharing (e.g., out-of-pocket expenditures) for persons in the lower economic strata, as well as nearly 400,000 lawsuits related to insufficient health coverage. [50]. Two studies found that out-of-pocket health spending was higher in the groups covered by this program, even when compared to higher-income populations with private medical insurance. [50]
- Colombia has also been plagued by underfunding of its subsidized POS component, as well as high rates of informal workers evading their health contributions. Insufficient funding has furthered health inequities [24]. This research has shown that, under these conditions, even with FOSYGA cross-subsidization it does not guarantee the adequate funding. [22]
- Mexico currently faces a 25% deficit in health spending. Appropriate funding for *Seguro Popular* would require resource pooling and cooperation between the states and central government. [14] Because of this deficit, Mexican President Lopez Obrador stressed the need for its transformation resembling *the Instituto Mexicano de Seguros Sociales* [the Social Security Institute]. Hence, in July 2019, *Seguro Popular* moved into the *Instituto de Salud para el Bienestar* [Institute of Social Welfare], which will have its structure and governance mechanism funded by central mechanisms and provide coverage against catastrophic health expenditures. [51, 52].

UHC remains an important policy agenda for many LACs, where achieving UHC requires more than health system reforms and financial protection.[7, 53, 54] Given that LMICs cannot subsidize all of their healthcare expenditures, financial protection measures are needed to achieve UHC. These could be achieved by improving tax policies, such as including a mandatory contribution or by involving the private sector to support structural inefficiencies in healthcare, or through the provision of funds by external donors, if required.

Many LAC continue to develop new initiatives in their quest for UHC. Prioritized health services baskets (benefits packages), selects healthcare interventions that demonstrate cost-effectiveness and might improve the UHC index by expanding access to high-value health services, while reducing the patient's financial burden. This methodology could be applied to prioritize essential services for other countries, as the *Regimen de Garantias Explicitas en Salud* [Regime of Specific Guarantees in Health] program, or AUGE, in Chile did, and as it has been done in other LMICs. [6, 55, 56] Chile's AUGE is a worthy example for

LAC. AUGE offers both an extended benefits package and financial protection measures funded mainly through VAT taxes [57]. Moreover, in 2015, the Senate approved Ricarte Sotto bill, which created a fund to guarantee comprehensive care, including drugs, devices, and procedures for certain diseases not included in AUGE program.

Finally, strengthening PHC is a turnaround in health systems to commit to UHC and SDGs, as well as to include challenges posed by non-communicable diseases (cardiovascular disease, diabetes), as well as injuries, and emerging diseases with pandemic potential. [4, 6, 53, 58] This is an example of Argentina, that is expanding their PHC network at a wider scale allowing to maintain a continuum between the different levels of care.

In keeping with UHC aims, these following measures could be considered to enhance the health service delivery, while minimizing financial risk to patients:

- First, decentralize the PHC and transition their management to each region (community, municipality). To guarantee access to specialized healthcare services (i.e. surgical services or diagnostic tests) while avoiding excessive wait times, a referral program between the PHC and specialty care, usually run by the MOH, should be available. Co-payments for the use of these centers need to be avoided.
- Second, find an efficient mechanism for the healthcare system financing, especially for the primary care. Channeling of funds from the central government to autonomous regions, conditional cash transfers, and implementation of “progressive” mechanisms for health expenditure have all been shown to be an efficient way to finance the PHC.[18] However, as the PAHO recommends allocating 30% of healthcare expenditure to PHC, coordination between finance and health authorities is required since political and economic instability faced by many countries in LAC might challenge the implementation of this recommendation.[59]
- Third, involving private organizations could be considered in countries with healthcare system structural or technical issues that may conflict the UHC. In the case of Southern Africa where private organizations were contracted to deliver PHC [60], or in Brazil where established agreements with NGOs to provide human resources for the first level of care, are such examples. [29] This requires that MOH controls the private sector performance with an outcomes-based approach. Healthcare governance with clear roles and responsibilities is required to guarantee that healthcare is being delivered equitably.

LIMITATIONS

The qualitative analysis of this project includes semi-structured surveys and policymakers from the region, supplements elements gathered from the literature synthesis. Semi-structured self-surveys are a direct way to collect information easily, but are plagued by low response rates. [61] Due to the extensive nature of these surveys, which could limit response rates, only three stakeholders per country were included in this analysis, making the data analysis more descriptive rather than quantitative; the low

response rate was a primary limitation with this approach. Also, as a qualitative method, interview responses should not be extrapolated or compared with the level of certainty of other methods (i.e. quantitative analysis). An alternative to collect data more directly would have been to interview these stakeholders by phone. Although this is a straightforward approach, the institutional written consent required would increase the time required to conduct and analyze these surveys.

Conclusions

This review presents the current situation of UHC implementation in Argentina, Brazil, Colombia, and Mexico, using different elements from the WHO in their 13th Program of Work to compare service coverage and financial protection. The four countries have made progress in the service coverage by implementing primary care reforms, and by incorporating of certain elements into their national health programs, such as subsidized essential medicines. However, these countries lag in providing strong financial protections from high medical bills based on WHO's global figures. While no country has achieved true UHC for all its citizens, UN member countries must develop the capabilities and strategies to achieve UHC if they are to meet WHO's goal of covering two billion people by 2030.

Future targets for health system development in LAC include developing a sustainable PHC network (integrated health services networks) that would be capable of reaching more than 85% of the population at need.[59] Comprehensive health services includes family physicians and community healthcare workers as cornerstones of care, complemented with the provision of essential medicines, and access to childhood immunization programs. Non-communicable diseases prevention programs and the enhancement of social protection mechanisms are examples of strengthening PHC while providing financial protection.

List Of Abbreviations

AUGE: *Acceso Universal con Garantias Explicitas (Chile)*

CNPSS: *Comision Nacional de Proteccion Social en Salud (Mexico)*

EPS: *Empresa Prestadora de Salud (Colombia)*

ESF: *Estrategia Saúde Familiar (Brazil)*

FOSYGA: *Fondo Solidario y de Garantias (Colombia)*

GDP: *Gross Domestic Product*

HIS: *Health Information Systems*

HIV/AIDS: *Human Immunodeficiency Virus*

IPS: *Instituciones Prestadoras de Salud (Colombia)*

ISB: *Instituto de salud para el bienestar (Mexico)*

LAC: *Latin America and the Caribbean*

LMICs: *Low to middle-income countries*

LSHTM: *London School of Hygiene and Tropical Medicine*

MoH: *Ministry of Health*

NCD: *Non-Communicable Diseases*

NGOs: *Non-Government Organizations*

PAHO: *Pan American Health Organization*

PCCs: *Primary Care Centers*

PHC: *Primary Health Care*

POS: *Plan Obligatorio de Salud (Colombia)*

PPP: *Public-Private Partnerships*

REPS: *Regimenes de proteccion en salud (Mexico)*

SDG: *Sustainable Development Goals*

SESA: *Servicios Estatales en Salud (Mexico)*

SHS: *Suplementar Health Subsector (Brazil)*

SMNG: *Seguro Medico para la Nueva Generacion (Mexico)*

SP: *Seguro Popular (Mexico)*

SUS: *Sistema Único de Saúde (BRAZIL)*

UHC: *Universal health coverage*

WHO: *The World Health organization*

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Figures

Health Service Delivery



- Primary Healthcare implementation
- Sexual and Reproductive programs in place?
- Diseases management program (NCD / CD)
- Quality of care programs implementation

Access to medicine and Health Products



- Implementation of extended vaccination programs
- Access to generic medicines tackling most relevant health issues
- Implementation of Health Technology Assessment
- Regulations for safer access to blood products
- Provide extended coverage for TB, Malaria and zoonoses

Governance, Finance, stewardship and HIS



- Provide a legal framework for HC service implementation
- Provide a framework for cooperation beyond borders
- Provide a framework for cooperation within other state members
- Public Private partnerships implementation to support UHC
- Disease registries implementations
- National statistics in place
- Evidence based healthcare programs
- Implementation of telemedicine to support access to healthcare

Figure 1

Characteristics of the evidence assessment matrix

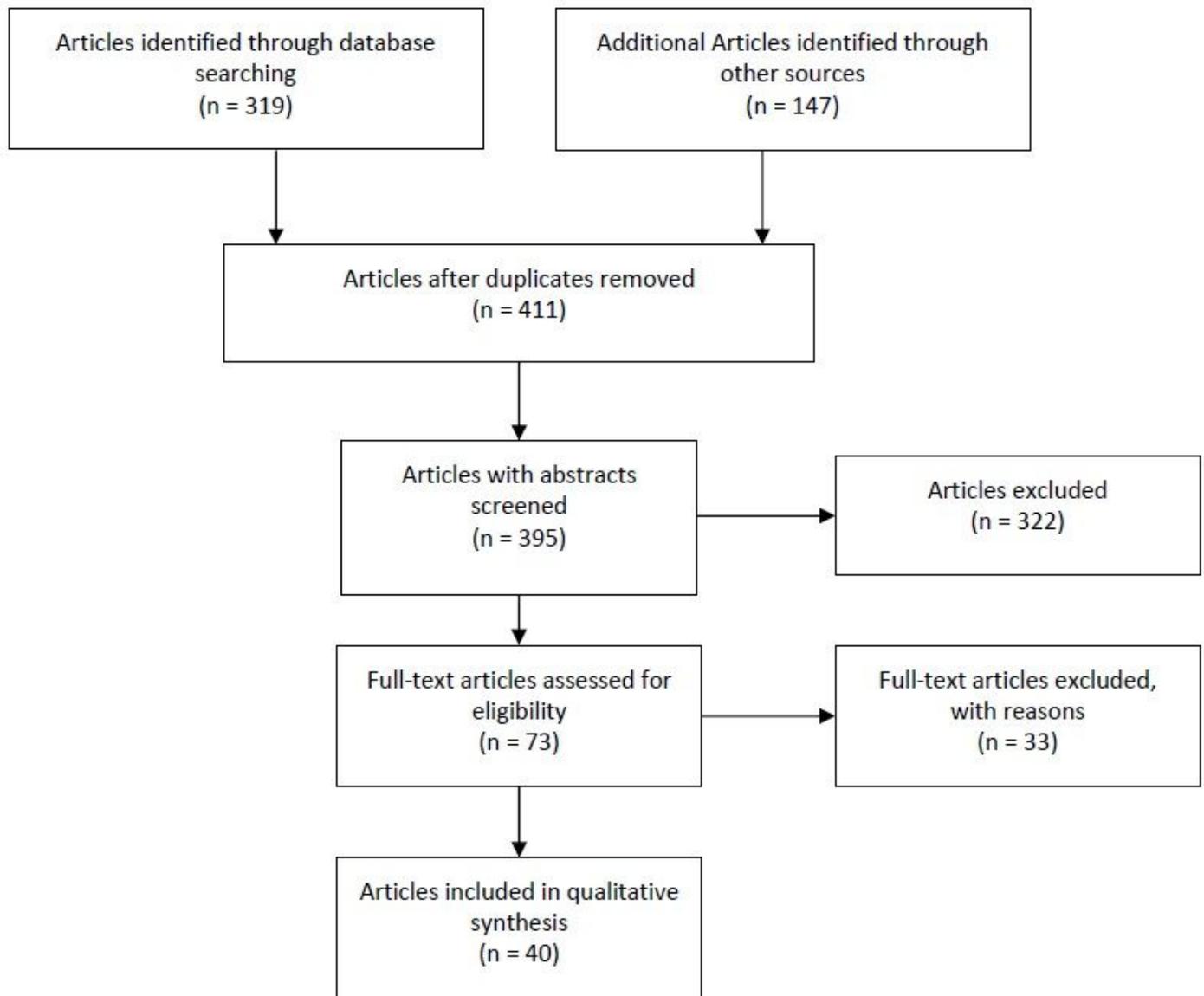


Figure 2

Prisma Flow diagram from literature search

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