Universal Social Policy at the Crossroads in Latin America: Recent Developments in the Healthcare Systems of Cuba and Mexico

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Introduction

In recent times, the quest for universalism in social policy has occupied a relevant space in the public and political agendas of many countries around the globe (Martínez Franzoni and Sánchez-Ancochea 2016). Many actors inside and outside governments deem social policies that are able to reach the entire population a precondition to advance in the advancement towards equal and just societies. This article analyses recent developments in the construction of universalism in healthcare in Latin America, by comparing two contrasting cases. On the one hand, the case of Cuba, considered the oldest universal system in the Americas, and on the other hand, Mexico, where only recently the government has shown efforts to design a universal healthcare system. The aims are to compare current outputs in healthcare and to explain how they were generated. The article attempts to establish the degree in which both countries at the present time provide universal healthcare and to explain recent political economy developments that led to the current configuration of the systems.

Notions of universalism

The concept of universalism in social policy can be interpreted in different ways. One refers to a type of social programme that in contrast to a social assistance or social insurance programme, is offered as a citizen's right with no means test or contributions, financed by general taxes (Béland 2010, CISS 2002, Clasen 1997). The advantages of universal programmes have been abundantly discussed in the social policy literature (Sen 1999, Titmuss 1974, Ortiz and Cummnis 2013, Martínez Franzoni and Sánchez-Ancochea 2016). In Western Europe, social policy systems designed on universal principles have been found to generate better outcomes in terms of poverty and inequality reduction and of the promotion of social solidarity (Esping-Andersen 1990, Korpi

and Palme 1998). There is however, a recent complementary conceptualisation that can result especially relevant for Latin American countries.

The traditional notion may be defined as input in the design of social policy systems and programmes, but authors like Martínez Franzoni and Sánchez-Ancochea (2016) point to the need to adopt an alternative perspective, that views universalism as an output. These authors argue that an alternative conceptualisation should focus not so much on the supply of a service as a citizen's right, but more on the importance of the actual coverage of the population, on the generosity of the benefits offered and the equity in which those benefits are provided across the population. Hence, establishing eligibility to a programme as a right of citizenship may only be a first step towards universalism. What in fact would determine if a programme is universal is if the level of benefits is enough to provide comprehensive, not minimal protection, and if the programme design is not fragmented or stratified in a way that they it generates or reproduces social inequalities. Additionally, in Martínez Franzoni and Sánchez-Ancochea (2016) framework, the role of the private sector becomes a crucial factor, because if a programme's design offers implicit or explicit market options, people will not make use of it even if eligibility is granted as a social right (Bernales-Baksai and Velázquez Leyer 2018). In other words, stating that citizens have a right to a social benefit does not offer real social protection unless the government guarantees actual access in an equitable way to the entire population.

The Cuban and Mexican healthcare systems in the twenty-first centuries

Cuba is considered one of the social policy pioneer countries of Latin America. The first social security programmes were introduced in the 1910s, and grew gradually with a segmented and stratified logic, offering differentiated coverage and benefits for different categories of workers and their families (Viamontes 2017, Mesa Lago 1986). By the time of the socialist revolution that

set up a one-party political system and a centrally planned economy in 1959, the healthcare system consisted on three public segments: a mutualist segment for insured workers, a state run segment for the general population, and the private sector. In 1961, the National Health System was created with the unification of the three segments, organised upon universalist principles, with coverage for all citizens and funded with public resources (Delgado García 1998). Patients had to cover the costs prosthesis and medications prescribed in ambulatory services, but all primary, secondary medical attention and medicines for hospitalised patients was made free at the point of service (Domíngez-Alonso and Zacca 2011). The system was expanded rapidly, resulting in great improvements in the health conditions and positioning the country among the world leaders in several health indicators and innovations, until the 1990s, when the economic crisis that resulted from the dissolution of the Communist Block and the loss of the main export markets, began to affect healthcare provision (Delgado García 1996, Fuentes Reverón 2017).

Common problems include shortage of medicines, prosthesis and medical equipment; deficiencies in the infrastructure; delays in obtaining appointments with general practitioners and transfers to specialist attention; and a lack of doctors and nurses to meet demand of services. There have also been claims of corruption and cronyism to access services (Fuentes Reverón 2017). Data that can illustrate the dimension of problems in recent year does not seem have been produced, but in a 2003 government survey 62 percent of respondents claimed to be unsatisfied with the health services (Domíngez-Alonso and Zacca 2011).

The economic crisis and the demographic transition have been blamed as the causes of the problems of healthcare provision. Government revenue has fallen because of difficulties of gaining access to international markets for Cuban products and medicines and equipment have to be imported at higher prices because of the economic blockade of the United States (Domíngez-Alonso and Zacca 2011). International missions of Cuban doctors have become a source of income

for the system, but they have caused shortfalls in the supply of services; at the same time, doctors within the country have had to look for alternative sources of income due the fall in the value of government wages (Íñiguez Rojas 2012). On the other hand, in recent years the country has been aging rapidly; life expectancy has reached almost 80 years and the fertility rate has dropped to 1.5 children per women; in 2010 close to 20 percent of the population was 60 years old or older. The aging of the population has been accompanied by an epidemiological transition towards chronic degenerative diseases (Bayarre Vea et al. 2018). Economic and demographic pressures have opened and widened the gap between formal and real access to health services (Fuentes Reverón 2017), and have begun to create regional inequalities (Íñiguez Rojas 2012).

Economic and demographic factors have put great pressures on the health system, however in the midst of the economic crisis, health has been prioritised by the government and the population as well. After a problematic period in the worst years of the crisis of the 1990s and early 2000s, several indicators recovered (Hadad Hadad and Valdés Llanes 2010). In the mid-2010s public health spending represented 17.3 percent of total government spending and 9.6 percent of GDP, two of the highest percentages in the world (WHO 2019); total health spending amounted to 12.2 percent of GDP (WB 2019), above the European Union and Latin American averages. The causes behind the priorisation of healthcare may be found in social demands. Even in the authoritarian context of the one-party regime, citizens' complains of the deficiencies of the health system are published in the official newspaper (Fuentes Reverón 2017). It is perceived that the Cuban people conceive the provision high quality healthcare a right, so that when the government fails in guaranteeing that right, they look for ways to express their discontent (Acosta 2019).

The Mexican health system had a truncated coverage limited to formal sector workers and their families until the first years of the present century. Considering the country's social policy, Mexico was placed in the intermediate group among Latin American nations. The first national social

insurance programmes, including healthcare, were introduced in the 1940s. Large groups of the population were left uncovered because families' breadwinner did not have a formal employment relationship. Excluded groups included peasants and agricultural workers, the self-employed, urban informal employees and domestic workers, plus their economic dependents. Social insurance healthcare evolved in a fragmented and stratified way, with separate systems for private sector employees and different categories of public sector workers. Separate autonomous social insurance institutes with tripartite funding from employees, employers and the state were created to administer services for each segment of the labour force, the largest as the Mexican Social Insurance Institute (IMSS), which was meant provide coverage to private sector employees and their families. Social insurance coverage never reached half of the population.

The supply of public healthcare to the uncovered population remained extremely limited until 2002. The Secretariat for Health was meant to organise healthcare for the population not covered by social insurance, but in all the 20th century that never happened. The government organised universal vaccination programmes and public health campaigns, primary healthcare services were offered to poor beneficiaries of social assistance programmes, and some public hospitals were built in large urban areas, but quality and access remained poor, services were precarious, no records of beneficiaries or patients were kept and in many cases, and in many cases a co-payment was required.

A third segment was constituted by the private sector, which began to grow rapidly from the 1970s onwards. Private healthcare services expanded to cover not only high income groups, but because of poor quality and difficult access of public services, middle and low income families were also pushed to rely on them (Bernales-Baksai and Velázquez Leyer 2018).

The public system was reformed in the 2002, with the creation of a voluntary health insurance programme for families not covered by social insurance. The new programme was called Popular

Health Insurance, it offered medical insurance and services to any family without social insurance, utilising the infrastructure built by the Secretariat for Health. New clinics and hospitals were supposed to be developed to meet additional demand. Affiliation required the payment of a fee, but poor families were exempted and even for non-poor families fees were of low amount. The federal and state governments complemented family contributions with their own contributions. With Popular Health Insurance , the proportion of the population covered by a public insurance programme increased from 40 percent in 2000 to 82 percent in 2017, however, that expansion reproduced the fragmentation and inequality of previous years. Different segments were kept for different occupational categories. The original idea was to subsidise the integration of poor uncovered families to the IMSS, but it failed because the reform also included the proposal of creating a market where public and private hospitals and clinics competed among each other to attract beneficiaries, which the IMSS trade union opposed (Lakin 2010). Unlike the social insurance segments, PHI only covered 1,400 illnesses out of 12,500 classified by the World Health Organisation (WHO) (Ordóñez Barba and Ramírez 2018).

Spending on the PHI segment has increased, but has remained at lower levels than spending on the social insurance segment (Ordóñez Barba and Ramírez 2018), yet, total levels of public spending have not been raised: as a proportion of total government expenditure, health expenditure actually dropped from 10.7 percent in 2003 to 10.4 percent in 2016, and as a proportion of GDP, only a slight increase was registered from 2.5 percent in 2003 to 3.1 in 2015 (WHO 2019). Hence, the effort devoted to the new programme for population with no social insurance do not appear to be too significant.

The segment of private health services has continued to play a major role all through the expansion phase of PHI. Private spending as percentage of GDP has remained at around 2.5 percent; moreover, most private spending is out-pocket-spending, and whilst it fell from 54

percent of total spending in 2002 to 41 percent in 2015 (WB 2019), the latter figure still meant that close to half of all spending belonged to the type of spending considered more risky to families. Private medical services received a boost with the introduction of the deductibility of private health spending from personal income tax (Brachet Márquez 2007). Private spending is not restricted to upper-income families, in 2016 close to half of households of the poorest three income deciles reported private spending on health services (ENIGH 2016).

Throughout present century, different governments have presented the expansion in public healthcare as an achievement and have stated that the country has reached universal coverage (Martínez Franzoni and Sánchez-Ancochea 2016). However, they have referred exclusively to the growth in affiliation figures, which indeed have been increased by PHI's implementation, but with no real access to services being granted to many of the newly insured families (Ordóñez Barba and Ramírez 2018). Electoral motivations have triggered the increase in PHI's registrar (Lakin 2010). The process has been conducted at such a fast pace with duplicity and errors, that if actual numbers from official records are added, total affiliation of the all public segments would surpass 100 percent of the population (Ordóñez Barba and Ramírez 2018). In reality, according to the government's own official survey, a high percentage of families lack public health insurance, and even people that are a covered by a public segment, frequently use private services (ENESS 2017) due to poor access and quality (Ordóñez Barba and Ramírez 2018).

The demographic and epidemiological transitions are also placing strong pressures on the health system (Barba 2011, IMSS 2015). Fertility rates have decreased and life expectancy has risen, and although not as acute as in other Latin American countries (Di Cesare 2011), the epidemiological transition away from infectious diseases towards chronic degenerative diseases present new challenges that the current system does not seem to be ready to address. In fact, in 2016 the government declared a national epidemiological emergency for diabetes mellitus II (SS, 2016).

Depictions of recent developments: at the crossroads of universalism

Universalism faces strong challenges in Cuba and Mexico. In formal terms, both countries establish the right to healthcare of all citizens and have displayed public policies for that goal. Yet, economic and political pressures are mining their capacity to achieve an authentic universalism. Following Martínez Franzoni and Sánchez-Ancochea's notion of universalism (Martínez Franzoni and Sánchez-Ancochea 2016), in recent years massive coverage has been threatened in both cases, generosity measured as quality of medical attention has diminished in Cuba and not advanced in Mexico, and equity of coverage and benefits across population groups has been fractured in the former case and bumped into rigid obstacles in the latter.

Economic and demographic factors are putting strong pressures on both healthcare systems, factor which indeed have been identified as strong drivers of the development of social policy systems (Béland and Mahon 2016). Indeed those factors seem to be undermining efforts for universalism. Demographic and epidemiological transitions represent major risks for public healthcare provision in the two countries. In addition, social policies do not develop in a vacuum, and as noted for other cases (Myles and Quadagno 2002), economic globalization also seems to be a driving force for changes in Cuba and Mexico, although in different ways. In Cuba, the isolation of the economy, which can be described as an extreme case of (intentional or unintentional) protectionism that blocks participation in international markets, and in Mexico, the opposite, an extreme case of a liberalised economy and an export oriented strategy which blocks attempts at raising sufficient resources to advance towards universalisation. These cases suggest that what is needed is not a retreat to a protectionist glorious past of closed economies, which arguably never

existed, but instead of finding alternatives to make economic globalization work for the improvement of people's livelihoods.[1]

Under similar pressures of scarce resources and increasing demand for public spending, policy responses in each case have followed previously established paths, since existing institutions filter external factors, as commonly acknowledged in the social policy literature (Esping-Andersen 1990, Pierson 2004, Gingrich 2015). In Cuba, the unified system has been sustained, with healthcare being prioritised in the midst of continuous economic crisis. Demands for improvements are given a space in official media sources. It is possible to conclude that such positive feedback emanates from the perceived right that people have of the universal access to healthcare. Since the search for electoral gains cannot be a factor, ideational factors can be behind the positive response offered by the government to social demands. Considering that healthcare is precisely interpreted as one of the main achievements of the communist governments, officials and politicians have paid special attention to the area that grants the regime domestic and international legitimacy.

In Mexico, in spite of continuous recommendations of advancing towards the unification of all public segments (OECD 2018), no path-departing reforms have been undertaken. The social policy literature highlights the obstacles for the aggregation of political preferences that fragmented welfare systems raise. Since social demands for healthcare improvements have not occupied a relevant space in public or political agendas in recent years (Ferrero and Velázquez Leyer 2016), it may well be that the historical limited coverage of social insurance and the fragmented expansion with PHI have blocked the interpretation of health as a social right that the government has the obligation to fulfil. The central role of the private sector may be adding to the policy trajectory,

[1] The recent progressive labour reform approved in Mexico as part of the renegotiations of the North American Free Trade Agreement (REF) proves that it is possible.

since as has been noted by Béland (2010), ample private provision of social services may constitute a powerful source of positive feedback of the status quo.

Conclusions

The article presented preliminary arguments upon the recent development of healthcare systems in Cuba and Mexico. In both cases, economic and demographic changes are exerting pressures on public healthcare systems. However, this article argues that path dependencies generate different responses from the government. In Cuba, there are strong social demands for the improvement of health services and a positive response from the government prioritising public healthcare provision. In Mexico, in spite of poorer results, social demands are not evident and healthcare does not appear to be government priority. Evidence suggests that the cause of the different response lies in the feedback mechanism generated by the history of each healthcare system. In Cuba, universal provision generates the perception of healthcare as a social right, whilst in Mexico, a fragmented public system and a large role of private providers blocks the aggregation of preferences for a better public health services. Universalism is at risk in both countries, but in Cuba the existing architecture creates its own resistances against external pressures, in Mexico, on the other hand, the current architecture represents an obstacle for the advancement towards a universal health system.

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