

FINANCING FOR DEVELOPMENT

Right to health in Latin America: beyond universalization

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This document has been prepared by Sonia Fleury, consultant of the Financing for Development Division of ECLAC, and Mariana Faria, Juanita Durán, Hernán Sandoval, Pablo Yanes, Víctor Penchaszadeh and Víctor Abramovich, in the framework of the activities of the project “Right to health in Latin America: beyond universalization” executed by ECLAC jointly with The Rockefeller Foundation (RFK/13/001).

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United Nations Publication

ISSN 1564-4197

LC/L.3647

ORIGINAL: ENGLISH

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Printed at United Nations, Santiago, Chile

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Introduction

Recently, Latin American countries have had to face the challenges of improving social inclusion and economic redistribution while consolidating democratic institutions after long periods of authoritarian regimes in many of them. Addressing pressure for social inclusion was all the more difficult, since these societies are characterized by some of the worst income disparities in the world and high degrees of labor market informality.

After the 70's, the massive explosion of social demands in the transition to democracy transformed the region into a social laboratory aiming to promote social inclusion. So, many different projects were designed and implemented in order to prevail over the main features of the stratified (Mesa-Lago, 1978) and segregated (Filgueira C.; Filgueira F., 2002) Latin-American pattern of social policies. This has been the recent challenge for these societies, requiring the development of new values, institutions and policy designs. However, the movement to universalize social rights took off in a juncture of macroeconomic adjustment and pressure to reduce public spending, engendering new social policies designs with the double aim of universalizing coverage and targeting the poor. The main dilemma of public policy decision-makers has been how to increase pluralism and competition without increasing inequality in the system of social protection.

The reform efforts—in health care and in social security systems—were part of the evolving context brought about by democratization of the region's political systems, the modernization of productive models in a globalized economy, and the redesign of the state's role. On one hand, the democratic governance in the Region depends on the countries' capacity for integrating the poor population into the political community, building up active citizenship and eliminating discriminatory barriers in the market. On the other hand, the widespread dissemination of the human rights principles and legal instruments in recent years may contribute to enforce the governments' commitment to universalize the right to health.

In this article we discuss the right to health considering its judicial or enforcement component as well as the health systems responsible for transforming rights-in-principle into rights-in-practice. We highlight the synergies and stressors between these two dimensions of the right to health—juridical and institutional—, by examining some experiences of health care reform in Latin American countries. These experiences used different approaches and mechanisms in order to overcome exclusion and

achieve the coverage of the poorest groups in the population and/or to achieve an egalitarian status for all citizens. The differences are based in prevalent values in each society and governmental orientations, and expressed in different strategies and arrangements regarding entitlement, financing, organizing and services' deliver. Although we've been assisting an expansion of health coverage in the region, so far this dynamics does not seem to thoroughly fulfill the universal right to health, and in this way overcome the prevalence of beneficiaries' segmentation in the region.

We present different trends in this general movement towards universal health coverage: (a) universal health care systems with constrained by the shortage of economic resources; (b) systems with stratified health coverage by designs; (c) targeted programs in segmented systems; and (d) newer multicultural approaches to health care.

Beyond the general tendency towards universalization we highlight the importance of surmounting the political and economic constraints that can jeopardize the leveler treatment inherent to the right to health as a human right, denying access and services' utilization. This way, reformed health care systems may increase coverage, but not citizenship.

I. Right to health: are normative principles sufficient?

Health is a fundamental human right affirmed by the United Nations and recognized in regional treaties and numerous national constitutions. WHO Constitution (Constitution of the World Health Organization, 1946) states that “*the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being...*”.

According to the United Nations Office of the High Commissioner for Human Rights “*human rights are rights inherent to all human beings (...). We are all equally entitled to our human rights without discrimination. These rights are all interrelated, interdependent and* indivisible. (...) International human rights law lays down obligations of Governments to act in certain ways or to refrain from certain acts, in order to promote and protect human rights and fundamental freedoms of individuals or groups. They are universal and inalienable. The principle of universality of human rights is the cornerstone of international human rights law*”.

Consequently, civil and political rights denial is a serious threat to health, as illustrated not only by examples of genocide and torture, but also as a consequence of other regimes in which particular groups have been systematically disenfranchised (Braveman, 2010). This way, genetic was frequently associated with politics since it gave the pseudo scientific basis for practices of group segregation, massive sterilization and genocide. However, one of the outstanding uses of health knowledge in the defense of civil rights has happened in the region with the use of genetic identification in of abducted children in Argentina, restoring their right to live with their true identity.

The UN Committee of Economic, Social and Cultural Rights has established that Article 12 of the Pact defines fundamental obligations to ensure, at the very least, the satisfaction of essential levels of the right to health, guaranteeing: (a) the right of access to health centers’, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; (b) access to essential nutrition so that nobody starves; (c) access to a home, a shelter and basic sanitary conditions, including an adequate supply to clean potable water; (d) provision of essential drugs, according to the periodic definitions present on WHO's Programme of Action on Essential Drugs; (e) an equitable distribution of all health facilities, goods and services; and, (f) the adoption and implementation of a national strategy and

implementation of a public health plan based on epidemiological evidence that face the health issues of the entire population (UN, 2000; Parra Vera, 2006).

BOX 1 USE OF GENETIC IDENTIFICATION TO REDRESS HUMAN RIGHTS VIOLATIONS IN ARGENTINA

During the dictatorship that ruled Argentina between 1976 and 1983 the military engaged in savage repression and egregious violations of human rights, including the forced disappearance of 30,000 political dissidents. The disappeared included babies and small children abducted with their parents, as well as several hundred pregnant women. Hundreds of these babies were appropriated by individuals linked to the military, who raised them under forged identity (Penchaszadeh, 1992). After the return of democracy in 1984, the search for these children began and procedures were implemented for proper legal, ethical and psychological handling as they were localized and identified. A National Genetic Database was created by law to analyze and store genetic markers of putative grandparents and other relatives (most parents were dead), to be matched with genetic markers of children and young adults as they were localized (Penchaszadeh, 1997). By law, identified persons were informed of their true identity and family ancestry, put in touch with their biological families and their true legal identity restored. When these persons were still minors, DNA testing by court order was mandatory. As they became adults, the Supreme Court, while accepting that a competent adult could decline submitting to a blood test, it ruled that DNA could legally be obtained and tested, even without consent, non-invasively (Penchaszadeh, 2011).

Over a span of 28 years (1984-2012) 107 individuals were identified at ages that ranged from 6 years to 36 years old, the latest thus far in 2012 (Penchaszadeh, 2012). The factors that made these developments possible were the actions of human rights organizations, the political will of decision makers and the advances in DNA identification technology. The latter, coupled with the development of a national genetic database to identify disappeared persons, was a key factor to the success of this program, which illustrates the importance of public investment in science and technology and its application to address human rights (Doretto; Fondebrider, 2012).

Source: Own elaboration.

These international normative principles when embodied in national constitutional support are indispensable to guarantee the role of the judiciary to assure that any citizen can claim the right to health in a universal and no-discriminatory basis. Nevertheless, the right can only become effective through social policies, encompassing the establishment of proper institutions in charge of the health system functions of stewardship including entitlement, design, funding, financing, provision and regulation. Therefore, the constitutional framework is indispensable but not sufficient to assure the right to health. Normative principles must be translated into institutions, norms and resources.

The right to health can be analyzed according to human rights normative framework selecting some key principles: equity, equality, no-discrimination and respect for cultural differences. However, the selected dimensions have a social justice component that can bring divergence regarding its operational conversion (Backman, Hunt, Khosla, Jaramillo-Strouss, Fikre, Rumble, Pevalin, Páez, Pineda, Frisancho, Tarco, Motlagh, Farcasanu, Vladescu, 2008). For example, equity can be translated either as equal treatment in the same circumstances (horizontal equity) or as treating differently according the level of needs (vertical equity). Social equality means equal rights under the law and equal access to social goods and services, what requires the absence of any kind of discrimination that can reproduces or enforces unjustifiably opportunities and treatments. However, singularities must be taken into account since the individual and groups' needs are embedded into social and cultural roots.

The challenge is how to transform rights in principle into rights in practices, particularly in contexts of prevailing economic austerity and elitist political traditions. The framework for analyzing country cases must not to be limited to jurisdictional and normative perspective, but must to focus on the institutional underpinnings as well. The concept of citizenship offers a comprehensive perspective, which connects normative social justice with the institutional basis of universal health coverage. Moreover, it provides an analytical framework that permits to differentiate among health reforms designs and implementation processes, identifying whether the coverage extension is correlated or not to the citizenship expansion.

Citizenship comprises several dimensions or components. The civic component of citizenship supposes the existence of a national political community where the individual is included and shares with others a system of beliefs and attitudes towards public powers and rules. It also includes the feeling

of belonging to a community and the public responsibilities of each individual as a member of the civil society towards the political system and the state. As a public dimension of the individual, citizenship postulates a model of integration and sociability. The legal component of citizenship entitles individuals to a set of rights and moral or legal obligations. The institutional component is responsible for translating values such as, equity and equality, into legal norms and social policies (Fleury, 2003).

Citizenship provides a framework for right to health analysis under the principles of equality, equity and non-discrimination as manifested through health care system institutional features, encircling design and organizations, financial sources, decision-making processes and public-private relations. Accordingly, the egalitarian political principle underlying citizenship status provides the criteria to analyze UHC strategies considering their outcomes in terms of recognition, redistribution and participation in the community of citizens.

Right to health recognition implies the universal attribution of the same legal status for all individuals, as well as taking into account singularities and cultural differences among groups. Redistribution implies fairness in terms of health care access and utilization. This does not mean ignoring existing disparities in other aspects, but to ensure that none determines all of the others (Walzer, 1984), neither differentiated the access to health services. Participation is a requirement of an active citizenship but not involved when universalization is basically translated into consumption. Regarded as a public value, participation is a way to increase awareness of rights, empower individuals, increase health knowledge, and exchange information.

However equity may express different moral perspectives. The dominant outlook builds on the idea that utilization of services should reflect actual need for care, yet a prominent competing view focuses on the availability of a decent basic minimum of care with a space for health market (Norman, 2013). These different moral perspectives will turn into diverse designs of health care systems give raises to specific universalization strategies. Thus, the response to the question about what kind of health care we owe each other in a society is different according to each equity perspective: a fair equality of opportunities to universal access; universal access to prudentially defined care or access to a decent minimum of health care (*idem*).

Even though both are ways to achieve health care universalization, they have dissimilar values according to citizenship status, because universal coverage does not always imply the same rights to health. While the fair equality of perspectives is attached to the equalitarian principle of universal citizenship it can fail to transform rights in law into rights in practice without adequate resources and political commitment. On the other hand, universal access to prudentially defined care maintains stratification and exclusion beyond the defined list of what is covered, while the decent minimum is a targeted policy that is far from a universal legal status.

Adopting both analytical perspectives of citizenship, normative and institutional, allows combining the legal status with the efficacy of the health care policy. Nevertheless, health goes beyond access to care and must be considered from the social and economic determinants perspective. The lack of economic and social rights assurance greatly affects health. In Latin America inequalities in the distribution of public goods is even worse than the income distribution. For instance, it is the richest region in the world in terms of freshwater availability per person, and yet across the continent inequalities in the water supply and sanitation services has led to populations being underserved. According to the World Bank at a regional level 100 million Latin Americans lack access to adequate sanitation” (World Bank, 2012).

While authorities and the population are increasing aware of health as human right, neglected needs such as water and sanitation are hardly translated into the language of rights, which reveals the mammoth gap between discourse and the practice regarding policies to implement thorough and trustfully the right to health in the region.

II. Rights and benefits: synergies and stresses

A. Widespread constitutional commitment

In the past three decades, Latin America has experienced an intense period of constitutional change, as nearly all the countries either adopted new texts or introduced profound reforms. A review of the constitutional reforms shows that a considerable extension of constitutionally recognized rights has occurred in the region. The movement towards consolidating UHC has spread across the region since the end of last and the beginning of this century, in spite of the differences that still persist regarding health expenditure, population coverage and constitutional and legal framework. (Table 1: Health Expenditure, Population Coverage and Constitutional and Legal Framework (annex 1).

The recent positive results regarding the right to health expansion are due to a synergic conjugation of legal protection, bottom-up pressure from civil society organizations, and the government's drive and concrete action. One outstanding example of this synergy leading to UHC is seen in the Brazilian antiretroviral policy. This case highlights the combined effects of civil society engagement for the right to health and government responsiveness within the framework of a universal health care system.

B. Judicialization

Even though most Latin American Constitutions are aligned with the philosophy of social constitutionalism, the prevailing rationale for concrete norms establishing social rights is programmatic. According to the institutional design of Latin American democracies, the Executive and Legislative powers are in charge of complying with the majority of the rights' demands, while the Judiciary plays a subsidiary role acting when the other powers fail to comply with their duties.

BOX 2 THE BRAZILIAN EXPERIENCE OF PATENT RELEASE FOR ANTIRETROVIRAL DRUGS

The lawsuits for the provision of antiretroviral drugs are part of the history of the fight against AIDS in Brazil. Based mainly on ensuring the right to health, guaranteed by Brazilian law, the claims to the Courts were crucial to enhance implementation of a policy for universal access. The first lawsuits began in 1996, with Courts deciding in favor of patients, with the main arguments based on Brazil's Constitution (1988) and the Organic Health Law (8080/90), which recognizes the right to universal healthcare. Also in 1996, Law 9313 was approved. This law strengthens the existing legal framework guaranteeing free access to antiretroviral drugs and assertively improved the National AIDS Program's structure for purchasing medicines (Ministério da Saúde, 2005).

While it would be an exaggeration to claim that the lawsuits about entitlements to medicine were a decisive factor behind the approval of Law 9313/96, it is fair to say that social mobilization and pressure from the legal battles waged by AIDS-specific-non-governmental organizations (NGOs) helped to shape a favorable environment for the approval of the law. Significantly, the exercise of the right to social participation, guaranteed by the Organic Health Law (8080/90) contributed to a more structured and better organized response from the government (Le Loup; Fleury; Camargo; Larouzé, 2010).

It was also in 1996 that Brazil incorporated the compulsory license into its national legislation. The Doha Declaration (2001) recognized the right of countries that have signed the TRIPS Agreement (2009) to take measures to protect public health and the access to medicines through compulsory licenses. The Compulsory License is a permission to use a patented product without previous authorisation from the patent owner. As a result to the success of the AIDS programme, and the need to provide free access to antiretroviral drugs, in 2007 the Brazilian government decreed its first compulsory license, that of antiretroviral Efavirenz (Hoirisch, 2010). The national production of the medicine began in 2009. This Compulsory License led to an approximately 72% reduction in the price of the antiretroviral. This tool can and must be used to guarantee access for the population to high-cost medicines that are strategic to health systems objectives if negotiations with transnational pharmaceutical labs for price reduction come to an impasse in an environment of limited resources.

Source: Own elaboration.

The presence of the right to health in the reformed Constitutions is important to reinforce the government's commitment as well as rallying social mobilization, but does not necessarily determine the role of Courts. While the role of the judicial system in the enforcement of the right to health increased in many countries after the Constitutional reforms, in some cases the legal decisions were based on adherence of international treaties on human rights (as in Argentina and Costa Rica) and in others to specific constitutional statements of health as citizens' right and the state's duty (such as in Brazil and Colombia). Accordingly, more important than the legal instrument is the autonomy of the Justice in the intergovernmental arrangement.

Most of the legal instruments aim to guarantee that fundamental rights have concrete effects instead of being simply rhetorical. To actively protect those rights, forms of direct judicial protection were created or reinforced, such as the writ for the legal protection of fundamental rights. In this scenario, the existence of judicial mechanisms in conjunction with the lack of effective realization of citizenship rights has led to a new kind of judicial activism, prompting ordinary citizens to press their claims and secure their rights through the courts. A substantial growth in the number of health rights cases focusing on issues such as access to health services and essential medicines is observed in Latin American countries. This health rights litigation is referred to as the judicialization of health. Analyzing the intensity of judicialization across countries, as well as the influence of the court's decision, it is possible to identify three countries with the highest policy impact in the region: Colombia, Costa Rica and Brazil.

TABLE 1
NUMBER OF HEALTH RIGHTS CASES PER CAPITA
(Tentative figures)

Country	Lawsuits <i>(annual figures)</i>	Populatio <i>(millions)</i>	Health litigation per capita <i>(lawsuits per 1,000,000)</i>
Colombia	150 00	45.6	3 289
Brazil	40 000	193.7	406
Costa Rica	500	4.6	109

Source: In Yammin and Gloppen *Litigating health rights: can courts bring more justice to health 2011*. (adapted by the authors).

Even though this phenomenon is increasingly observed in contemporary Latin American countries, considerable diversity of health judicialization can be found across countries. This process depends on an array of factors such as access and utilization of health services; access to courts; existence of contractual definitions of benefits; citizens' awareness of their rights and the existence of consumers' organizations; the role of pharmaceutical industry; as well as the creation of dialogic channels for consensus building among stakeholders.

Regarding the legal basis for litigation, in the Brazilian case the right to health is universally assured by the Constitution of 1988; in Costa Rica, although health rights are not in the Constitution, the 1989 constitutional amendment created a new Constitutional court —Sala IV—granting the opportunity for successful health rights litigation; and, Colombia guaranteed right to health as a universal un-renounceable right in the 1991 Constitution, while the Law 100 of 1993 established an health insurance system. In the Brazilian case the growth of litigation is credited to the universalization of the right to health in the public health system and civil society support organizations whereas in Colombia and Costa Rica the phenomenon is rather ascribed to institutional rules than to the civil society mobilization. Thus, the role of Supreme Court in adopting a broad definition of standing as well as eliminating many of the barriers to access justice is considered the main explanatory factor (Wilson, 2009).

Although the three countries deliver health care through a mixture of private and public health provision, Costa Rica and Brazil have unified public health systems, while Colombia has managed competition between public and private health-care in a health insurance scheme. In Colombia and Costa Rica there is a standardized benefits package, which circumscribes what is covered. In contrast, in Brazil this doesn't exist, since the SUS¹ is responsible for providing integral health care. In all of the three countries the legal claims are prominently based on the individual cases, in which the decisions refer to individual's right to access health care services and medicines. Since individual's access to justice is unequally distributed and highly conditioned by education and economic factors, litigation reinforces or even deepens unequal access to health resources (Yamin; Gloppen, 2011).

By reinterpreting existing law, or more effectively applying and enforcing existing rights, courts have a significant effect on policy choices and governance. These effects can be positive not only from an individual perspective, bur also collectively since the governmental authorities are compelled to be accountable for their decisions. However, in many cases courts decisions have had negative and problematic effects on health public policies, due to the impact on the public budget, which generates inequality in the health care system. Moreover, the right to health cannot be reduced to treatments for complex diseases and the use of costly medicines, at the expense of the implementation of mechanisms for health promotion and diseases prevention.

An underlying consideration is medicalization, a process that de-politicizes health problems, even those with complex social causes, by framing them as objectively resolvable thorough the intervention of doctors and the medical system (Conrad, 1992). As we complete the first decade of the twenty-first century it is clear that the pharmaceutical industry is playing an increasing important role in the process

¹ Sistema Único de Saúde.

of placing aspects of normal life that used to be managed without medical intervention, into the medical care paradigm.

The role of the Court in Colombia highlights not only the problems of an individual approach to judicial protection and its unequal bias in favor of upper and middle class demands, but also the role of the Judiciary in promoting equity by reducing gaps in benefits packages due to different entitlements based on income differences.

BOX 3 HEALTH LITIGATION: THE ROLE OF THE COURT IN COLOMBIA

The legal and institutional transformation of the protection of the right to health in Colombia generated tension. On the one hand, the 1991 Constitution created a bill of rights and provided an informal and expeditious mechanism for their protection called 'tutela'. The right to health was established as a universal non-renounceable right and with a public service in charge of the State. On the other hand, Law 100 of 1993 provided a universal insurance system based on a model of regulated competence, grounded in the approach promoted by the Inter-American Development Bank in the region (López, 2008; Lamprea, 2001).

The new health insurance system rather than developing the right to health, focused on the financial and administrative arrangements to supply services. It established two regimes for affiliation. For those with economic capacity Law 100 created the Contributory Regime, in which a monthly contribution based in the income ('cotización') gives entitlement to a package of services determined by the government ('Plan Obligatorio de Salud'). Additionally, the Subsidized Regime was created for those without economic capacity, in which government, partially with solidarity resources, finances the premium.

The consequences of the tension between the constitution right and legal entitlement are evident in the increase in litigation around the right to health subsequent to the reforms. Starting with the early 'tutelas', judges have empathetically protected plaintiffs based on the constitutional right to health. In 2011 for instance, 8 out of 10 cases were granted (*idem*). The magnitude of the escalation in constitutional health litigation can be dimensioned by the comparison with that of other rights: in 1993 the right to health was ranked 11th among the most invoked rights in 'tutelas', while by 1999 it was in first one (Cepeda Espinosa, 2007).

Apart from the massive numbers, health rights litigation is prominently focused on individual claims brought by middle and upper class plaintiffs (Yamin; Parra-Vera; Gianella, 2011; Procuraduría General de la Nación and DEJUSTICIA, 2008). This has led to ineffective and inequitable allocation of resources, putting financial strain on the system. However, it has also radically transformed the conception and the role of stakeholders in the health care system. Particularly, during the course of these cases judges have established that the responsibility of insurers and the state is not exhausted or limited by providing the coverage mandated in the insurance contract, but also includes a continuous commitment to achieve the effective fulfillment of the right.

In addition, litigation for the right to health has triggered forms of protection beyond the individual case. For example, in ruling T-760/08 the Constitutional Court ordered health authorities to address the structural problems that were causing massive litigation and to comply with the legal obligations. The ruling brought widespread benefits, including the order to update coverage – which had not been integrally reviewed after 14 years–, and the order to adopt a plan for unification of coverage for the Subsidized Regime mentioned beforehand, that was totally neglected by 2008, eventually leading to unification in 2012.

Source: Own elaboration.

Based on Latin American experience, one can come to the conclusion that the larger the gap between rights in law and rights in practice, the greater the increase in litigation will be, but not in equity. In addition, this critical situation increases the lack of confidence in authorities and threatens democratic governability, manifestations that go beyond the health system.

However, new tendencies of overcoming some tensions related to the right to health issues are also present. A significant obstacle to enforcing social rights is the inappropriateness of traditional procedural means for their safeguard. But, new perspectives on individual or collective rights' assurance are in course in several countries, such as, the recent developments of precautionary measures, the possibilities of use unconstitutionality petitions, and the advancements of certainty statements, the public civil action. This constitutional and legislative evolution in the past years is to be noted in countries like Argentina, Colombia and Brazil (Arcidiácono; Espejo; Garavito, 2010; Abramovich; Pautassi, 2009; Gauri; Brinks, 2008).

Examples of this trend are the Brazilian writs of mandamus of injunction, the legitimization of the Public Prosecutor and Defender to represent public interests, which are legal remedies that act as referral systems among the judicial and the legislative and executive powers. In Brazil, a consensus building approach between executive and judicial powers has been developed, creating synergies in the elaboration of alternative remedies, which help diminish the tribunals' workload and, at the same time, increase compliance of judicial decisions. From the executive view, this arrangement addresses issues that many times compromise substantial portions of budgets and may end up with the incarceration of health managers that disregard judicial decisions. Therefore, a number of proposals on covenants, committees and systems involving the justice system—including the Public Defender's Office, the Public Prosecutor and the executive power—is being experimented (Teixeira, 2011).

Another outcome of the recent incursion of the Judiciary in health issues in Brazil is growing intersectional interaction, which has engendered a new field of knowledge, health law. In 1988—the same year that the Brazilian constitution recognized health as a universal right—an academic publication called attention to the need to create a new academic discipline, health law (Dallari; Fortes, 1997). After two decades, the progress of the field of Health Law has been remarkable: post graduation degrees from health and law disciplines have been established in important Brazilian universities, two scientific journals were created and many books have been published; and numerous conferences, seminars and workshops were organized with the participation of assorted stakeholders.

III. Different paths to UHC: distinct patterns of citizenship

Social protection systems are considered to be arrangements for consensus building and for conveying conflicts to the redistributive arena, where they can meet a negotiated solution. The differences in social protection regimes are ascribed to variety of variables —from the ideological, political and institutional features to managerial and financial issues— clustered in different ways that are accountable for the systems' structure and its outcomes in terms of citizenship. Previous studies have demonstrated that the consequences of each pattern of social protection in shaping different modalities of citizenship are rather remarkable (Fleury, 1994).

The traditional Latin American social protection pattern that prevailed throughout the 20th century adopted the social security model, with benefits dependent on past contributions, establishing dissimilar contractual rights-relationships with occupational groups. The population was segmented, as well as the social protection systems. Since social rights were dependent on the insertion of individuals in the productive structure citizenship (Santos, 1980) was regulated by the working conditions.

This pattern combined a mix of stratified inclusion with different degrees of social exclusion since informality prevailed in the labor market. Hence, the majority of the population was either excluded from social protection or received social assistance through programs and actions – public or private – designated to alleviate the conditions for the most vulnerable groups of the poor. Although they provided access to certain goods and services, they did not establish social rights (Fleury, 1997).

Latin America is undergoing an intense process of social reform in recent decades. These reforms are moving Latin America societies towards a more inclusive system of social protection resulting in a remarkable increase in coverage and poverty reduction. Governmental commitment to poverty reduction gave rise to new social institutions and policy strategies for targeted cash transfer programs.

Concerning the universalization of health care systems there was a first generation of reforms beginning in the last quarter of the 20th century, to address problems of exclusion, stratification, and inefficiency. The diagnostic was that the existent social protection systems were non-egalitarian and a mean for reproducing social injustice. The reforming proclivity faced the resistances from powerful actors such as unions and central bureaucracy with vested interests in maintaining the old stratified and

exclusive social protection system. But, at the time of the reforms, the societies' complexity evolution revealed a new political scenario with others social actors pushing for reforms in order to assure the universal right to health. At the same time, business interests had increased their presence in the health care systems and tried to profit from the context of fiscal austerity that imposed severe political and economic constraints to the expansion of state participation in social protection.

Among the different approaches to achieving UHC, we can identify (Fleury, 2001) some paradigmatic health reform models in the region. The designs of these reforms reflect the strength of the contradictory forces at play. They were framed in a context of inflation and economic crisis and, the political change from authoritarian to democratic regimes. The timing of the reforms in relation to the economic and political transformations —whether they were previous, concurrent or subsequent—, partially explain their different design and implementation conditions (Fleury, 2000) Chile under the military dictatorship and pressed by economic crisis adopted a market oriented health insurance model with a subsidiary public system for the poorest, following international advisers. The grassroots mobilization in the transition to democracy in Brazil built a public national system that was later implemented in adverse economic context. In Colombia was facing a permanent civil insurgency while experienced a growing economic phase, which provided an opportunity for international and national technocrats approved their option for an insurance model of managed competition, that include public and private institutions.

The Chilean dual system was based on the consumer's purchasing power, with the individualization of risks and the absence of solidarity ties among the beneficiaries. Segmentation of the population into two systems forged a duality of citizens, without solidarity. The Brazilian experience aimed to create a universal public system of integral health-care attention charged with assuring social rights through a democratic, equitable, decentralized and participatory system of social policies. Nevertheless, it was — from the beginning —, underfunded and highly dependent on private facilities. At the same time, the business supplementary health insurance system grew. Thus, problems of access and quality contradict the universal right to health and defy the capacity of authorities to assure the right-in-practice in Brazil. The Colombian reform created a competitive insurance system administered by the government in a pluralistic managed competition model, encompassing private and public resources. Mechanisms to avoid adverse selection and cream skimming were introduced, as well as others to promote solidarity, such as the establishment of a basket of benefits with a fixed per capita for each insured person and a solidarity fund. Since the benefits were different in the contributive and non-contributive systems, and part of the population was not included in either system, at least three different citizens' statuses with different rights to health-care resulted.

Therefore, the reduction of excluded populations in all of these three countries was achieved with through the expansion of health coverage, but the segmentation of the population in different regimes, packages and opportunities to access still persists. This situation continues to drive and pushes for new piecemeal or structural reforms to cope with the problems of equity, equality and discrimination in the search for universal health coverage.

Accordingly, one can distinguish some general trends towards universal health coverage and their different impacts on the process of citizenship building, by examining case countries examples.

A. Universal health systems in a context of austerity

In Latin America we can find three different experiences of building up and maintain universal health systems in Cuba, Brazil and Costa Rica. In all the three cases the universal right to health was based on a public system: exclusively public in Cuba; dependent on private facilities in Brazil, and a social insurance system in Costa Rica. In Cuba and Brazil the support for universalize the right to health arose from the political process, with strong social mobilization. Differently, in Costa Rica, societal pressures and preferences played a relatively minor role while governmental leadership and technocrats pushed the reform.

However, in a context of increasing economic austerity, the sustainability of these reforms depends on maintaining social support and government commitment to reform as well as to the reduction

of the power of veto players' actors that can move away from the reform proposal, either because of scarcity of resources or because the course is deviated to fulfill particular interests.

The Cuban experience of building an outstanding universal health system is unique in the region. It was part of a revolutionary process, which began in the early 1960s with different measures that ended with the creation of the National Health Care System. The single public system encompasses all functions in health sector. The political commitment to assure the right to health can be illustrated with some examples, such as the fact that the health budget in 1978 increased 20 times fold from 1958 (CEBES, 1984) and the extension of the services to rural areas expanded hospital facilities from 1 to 53 rural hospitals in 1970, in a span of 10 years.

The system is organized according the following principles: (i) Health care is a right, available to all equally and free of charge; (ii) Health care is the responsibility of the state; (iii) Preventive and curative services are integrated; (iv) Public participation in the health system's development and functioning; (v) Health care activities are integrated with economic and social development, and (vi) Global health cooperation is a fundamental obligation of the health system and its personnel (Keck; MPH; Gail, Reed, 2012).

Its centralized supervision with flexible and decentralized operative structure permitted the achievement of high standards in the development of science and technology, human resources formation, and an effective and efficient strategy and plan of family doctors and nurse. It is also reflected in the exceptional outcomes in the health indicators, despite in the economic crisis that started with the collapse of Soviet Union. The Cuban health system has powerful political support from government and the population, since its history is intertwined with the success of the revolutionary regime and institutional stickiness. However, the current context of rigorous economic austerity imposes severe investments restrictions that can, in the future, jeopardize this political support.

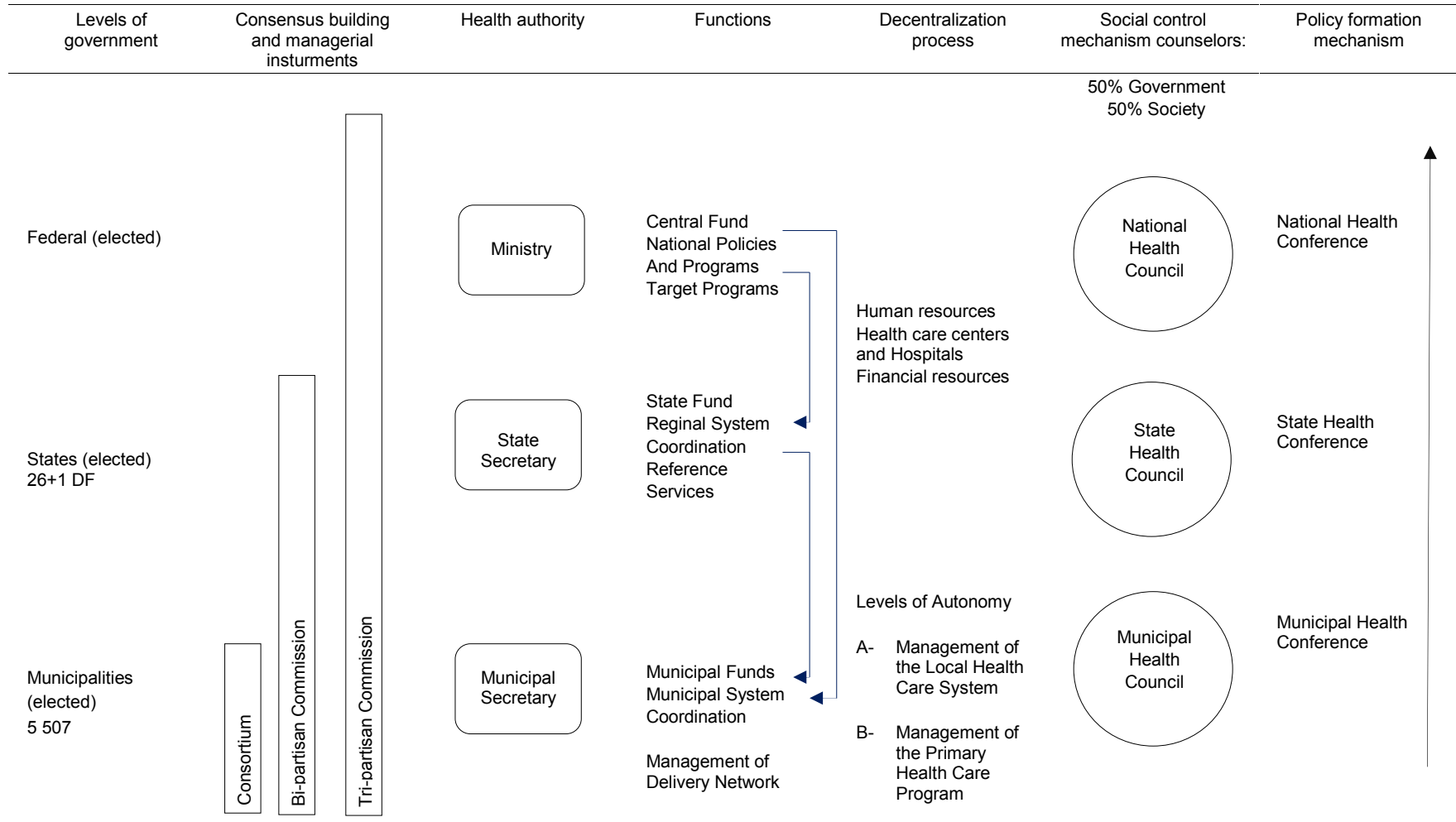
At the root of the Brazilian experience in building a national health system was a strong political coalition that pushed for the expansion of social rights as part of the transition to democracy. In this case, the singularity was a social protection system designed by civil society movements and its strong association with the transformation of the state and society into a democracy. This hallmark added some important characteristics to this reform, such as the combination of a highly decentralized health care system with a decision-making process that incorporates cooperation among federative bodies and organized society in participatory arenas. The existence of political spheres for negotiation and instruments for consensus-building were important innovations in the intergovernmental relationships, and in the relationship between the state and social actors.

The Constitution of 1988 established the Social Security arrangement as the core of the social protection system that was destined to ensure rights related to health, social insurance and social assistance as universal rights of citizenship. The new constitutional social policy model is characterized by the universality of coverage, the recognition of social rights, under the guarantee and duty of the state, and the subordination of the private sector to regulation based on the public relevance of actions and services in these areas. The new public arrangement is a decentralized public network cooperatively managed by participatory mechanisms, such as Councils and Conferences (Fleury, 2011).

The participatory mechanisms are composed from deliberative instances that guarantee the equal participation of organized society in each sphere of government that also includes health authorities (see table 2). The Councils are mechanisms of social control and budget approval, evaluating executive proposals and performance, and the Conferences form the polity through discussing a set of subjects in order to convey different interests to a common platform.

Social participation is also evaluated as an important component of sustainable health programs. Nevertheless, as the main hallmark of the Brazilian society is the unequal distribution of power and resources, this trait is also present in health field, expressed by the absence of pressure to include neglected diseases in the government priorities or in the appropriation of the participatory mechanisms by more organized groups.

**TABLE 2
SUB-BRAZILIAN POLICY FORMATION PROCESS AND DECISION-MAKING STRUCTURE**



Source: Own elaboration.

Besides, after two decades, the subdued public share of health spending (41%), the predominance of private hospitals (69.1%) and beds (61.3%) are sufficient to demonstrate how economic and political constraints made possible the dissonance between the legal status of universal right to health and the present difficult to access services and improve health conditions. However, the equality of rights does makes it possible to fight for its achievement (as demonstrated in the AIDS policy).

The case of Costa Rica demonstrates how a country, which up to the 1930s was classified as underdeveloped in social policies, attained with the strongest human development indicators in the region by the 1970s. The trajectory to universalize social protection in Costa Rica started in the early 1940s with the creation of an inclusive social insurance system, which differed from the regional pattern since it was focused on lower income groups, instead of covering occupational groups. The bottom-up expansion from poor to the lower and, only then, to upper middle-income groups is considered a milestone for establishing a basic floor of benefits.

The starting point in the 1940s was common to other countries in the region and was explained as a consequence of the ideas spread by international agencies based on the new social security paradigm. Nevertheless, this external variable does not explain the singularity of the Cost Rican political option and its sustainability. In confluence with the international scenario, internal factors included: a) the role of the political leadership, b) the absence of social veto actors with enough power to stop the new program or modify it to conform with particularistic interests; and (c) the central role of technocrats who brought the international debates to Costa Rica putting the ideas of political leadership into practice, and building a technical consensus around the new program (Martínez; Sánchez-Ancochea, 2012).

The Costa Rican Social Insurance System (CCSS)² is an autonomous entity that absorbed the Health Ministry network and is responsible for providing integral health care for different types of beneficiaries, according to their insurance condition. The primary care network - EBAIS³ - covers the population throughout the country. The social security regimes administered by the CCSS distinguish the following types of beneficiaries: (i) direct (maintains a conventional employer-employee relationship), (ii) self-insured (voluntary insured independent workers), (iii) pensioner, (iv) family insured (indirectly-insured relatives of direct beneficiaries: wage-earners, pensioners, or self-insured beneficiaries, and (v) insured by the State, in which case financing is the sole responsibility of the State.

Health insurance in Costa Rica is integrated; that is, there is no separation of service packages depending upon different types of insurance. Every insured is entitled to integrated health-care. But, since universal coverage to health-care was gradually achieved, some limits were fixed, reducing the scope of drugs prescriptions and disease treatments. Notwithstanding, the fact that the Costa Rican health-care system shows important indicators of successful performance, the system is also facing significant challenges regarding its sustainability, growth, and level of equity. These challenges arise from the dependency on a tripartite funding mechanism, typical of social insurance, and increasing offering of private and international healthcare and insurance services considered warning indicator about the loyalty of the insured population towards the system (Rocío Sáenz; Bermúdez; Acosta, 2010).

The Health Insurance deficit reached 7.6% of the total health expenses by 2010 (Veja, 2012). As a universal insurance, right to health in Costa Rica is funded by tripartite contributions. Although presenting one of the lowest unemployment rates in the region, health inflation, economic crisis and migrations endanger the financial balance. The actuarial perspective in a social insurance model puts strict limits on expenditures, which leads to the definition of a maximum value for treatments and drugs covered. In spite of this difference, the State must guarantee the universal right and compliance depends on strong political will.

² Caja Costarricense de Seguro Social.

³ Equipos Básicos de Atención Integral en Salud.

The three country experiences show that economic austerity imposes severe restrictions on universal health systems. Their sustainability depends on the political support from government and social actors. Nevertheless, social mobilization can decrease as a consequence of the incapacity to turn rights in law into rights in practice. The constraints are accentuated by the restricted fiscal basis for funding health systems and the dependency on private providers for different health inputs and services. Hence, it contradicts the equity requirements of universal citizenship, either by the consumers' differentiation or by the permanent stress between profit interests and public policies based on solidarity. Solidarity and social cohesion are expected outcomes of the universal systems, but, when they become ineffective, the result can lead to high levels of judicialization, increasing inequity, putting in danger the health system design and threatening democratic governability.

B. Reducing the gap among insurance plans

Some countries in the region have chosen UHC based on the existence of different insurance plans, including Chile, Colombia, and Mexico. The reforms towards universalization in insurance systems — dual, multiple or managed — were rooted in neoliberal ideology where the market is considered the best solution for the inefficiency of the state, avoiding in this way the prevalence of monopolistic interest groups, such as bureaucracy and corporative unions. The “New Public Management” current provides the tools for managing the reformed system, based on separating financing and provision functions with the introduction of competitive markets and quasi-markets in the health provision and insurance.

As the earliest experience, the Chilean was a radical structural reform that resulted in a dual health care system. Notwithstanding, a design that attributed to the public health system FONASA⁴ only an insurance function, it did not completely succeed. Hence, the public sector maintained other functions in provision and stewardship and progressively moved towards a regulation of the private insurance sector.

With the restoration of democracy, the elected governments sought alternatives to overcome the inequities of the dual system through piecemeal strategies: steadily increasing public health expenditure; eliminating subsidies to the private sector; and restoring state regulation. This process culminated in the creation of a plan of explicit guarantees for health care, called AUGE, to be implemented in both systems: public and private.

This new regulation aimed to reduce the gap between the two systems, approaching in this way the Chilean situation to that in Costa Rica, where health care procedures are guaranteed. But it still differs in a core issue, by maintaining a dual system with a public system in parallel to a profitable private insurance industry. While the exclusion of some previous coverage in Costa Rica has led to litigation the plan AUGE has, on the contrary, only implemented guarantees after 2005. This can explain the relative inexistence of litigations in Chile at this moment.

Although the recent efforts are addressing the reduction of gaps between the two system —private and public— relating to citizenship, the maintenance of dual regulated systems, although assuring guarantees that improve health conditions, does not provide the requirements to achieve cohesion and equal citizenship.

⁴ Fondo Nacional de Salud.

BOX 4 GUARANTEES: THE AUGÉ PLAN IN CHILE

The plan of guarantees in health care access (AUGE – Universal Access with Explicit Guarantees) was conceived as a system of progressive implementation that generated enforceable rights for the comprehensive care of the incorporated diseases. It was argued that it was not enough to proclaim the right to health-care, but that conditions (legal, functional and material) had to be created for its exercise. This is why the guarantees were proposed as a way to empower people to obtain the services they needed, because despite being formal holders of public or private health insurance coverage, there was a clear social gradient in terms of access to the detriment of the poor and less educated.

A group of experts were commissioned to design a major reform (Fundación Democracia y Desarrollo, 2000) in order to tackle the inequality, which was identified as the biggest problem of the Chilean healthcare system, despite the strong injection of resources in the public health sector during the 90s. Regardless of the good countries health indicators, many studies showed large differences in life expectancy, disability, access and out-of-pocket expenses related to income levels and education.

Equity must be achieved by public policies designed to mitigate the unequal distribution of wealth, power and education in society (Ministerio de Salud de Chile, 2010). In this respect, regarding access to health services, the Commission considered the need to prioritize diseases for which cost-effective treatments were available (Vargas; Poblete, 2008). Therefore, proposed a guaranteed plan established by law, which would cover diseases with the highest incidence in generating disability and premature death. The bill was sent to Congress in May 2002 and passed in August 2004 (Barrera, 2004). It was strongly criticized in the healthcare sector, both by the unions and private providers, but very well received by the population.

Since the plan applied to both the public and private sectors, it has resulted in increased state regulation, imposing health care guarantees for a list of pathologies with maximum waiting times, limited co-payments and in accordance with clinical guidelines established by the Ministry of Health.

Starting in 2002, the plan was implemented in the public health system throughout the country, starting with guarantees for three conditions. The plan came into full effect in June 2006, with 56 medical conditions. Since then, it has been revised twice: in 2009, when 13 additional pathologies were covered; and in 2012, when 11 more were added. With these additional conditions coming into force in July 2013, the plan reached a total of 80 guaranteed diseases (Ministerio de Salud de Chile, 2013). Therefore, demonstrably, it was not a "basic benefits package", but incorporates comprehensive care, with the complexity required for each case, based on enforceable guarantees of access, opportunity, quality and financial protection.

Up to 2012, 11.864.093 people benefited from these guarantees (70% of the population) (Departamento de Estudios y Desarrollo, 2011), which led to a greater awareness of health rights, improvements in access for the most vulnerable sectors and a reduction in mortality and disability (World Bank, 2013) in diseases such as heart attack and cervical cancer, among other guaranteed diseases (Bitrán; Escobar; Gassibe, 2010).

Source: Own elaboration.

In the Colombian case, the managed completion model has been threatened by limitations to coverage expansion, due to the restrictions of solidarity, based on formal workers contributions and the critical intermediary⁵ role of for-profit insurance companies, EPS.⁶ A new project is now in the Congress, assuring the role of the State in guaranteeing the right to health and put forward the creation of a Single Health System,⁷ responsible for a universal social insurance with equal conditions and benefits.

This project redirects the Colombian health system to a national public insurance. However, powerful vested interest linked to the present system still can veto the projected reform or approved another conciliatory proposal.

Mexico is also adopting the insurance strategy to universalize health coverage. It is a singular case of a highly segmented public system. Mexico's health-care system is essentially public, but available data reveals significant out of pocket expenses by families in order to cover health-care costs. Even though people predominantly depend on public services, they still often utilize private services, especially at the first level of medical attention and purchase medicine.

The national health services are highly fragmented and adhere to a strict hierarchy. Health services are provided through five different social security entities. According to data from 2011, the

⁵ As collecting contributions, enrolling and assuring health plans, and paying providers.

⁶ EPS – Empresas Promotoras de Salud.

⁷ Sistema Único de Salud.

Mexican Social Security Institute (IMSS) has 52.8 million beneficiaries, of which 10.8 million would fall under the IMSS-Oportunidades System that covers a lower range of services than the 47.4 million beneficiaries under Social Security. On the other hand, the Social Security Institute for State Workers (ISSSTE) is responsible for 12.2 million people and the social security institutions for the Mexican Oil Company, Army and Navy have 1.1 million beneficiaries.⁸ The “Seguro Popular” or National Healthcare Protection System has seen the most dynamic growth in the last decade and in 2011 it reported having 51.8 million beneficiaries. Other public systems cover 0.9 million people, while 2.0 million people are covered by private systems.

This paints a picture regarding of widespread inequality in access to health-care. However, in juxtaposition with the presented segmentation and stratification there was room for an interesting experience of building consensus in favor of a universal social coverage for a target population, regarding non-contributive pensions in Mexico City. It illustrates the importance of government responsiveness to social demands, although it also demonstrates its constriction to a local government policy.

All of these countries experiences aimed to eliminate exclusion and some of them also sought to close gaps among different insurance plans. The insurance path to universalization can minimize stratification but cannot eliminate discriminations, since the existence of a plurality of rights to health is inherent to this pattern. Universalization, in this path, is a governmental and technocratic project that does not requires social participation.

C. Targeted programs in segmented systems

In several countries in the region one can observe a trend to create National Health Systems, starting with the introduction of targeted programs covering the most vulnerable groups. In those cases, the National Health System designates a comprehensive number of different conditions of insurance with public and private providers, considered as complementary. The aim is to achieve universality in fragmented systems with high levels of exclusion, in predominantly multicultural societies where indigenous and rural groups have been excluded from coverage. This type of universal insurance, like the scheme adopted in Peru, encompasses three regimes according to the contributive capacity of the insured person. The segmentation of the system and the differentiation of entitlement conditions reproduce the traditional Latin American pattern of citizens’ stratification, although trying to reduce the level of exclusion.

Targeted programs focus on alleviating poverty and protecting more vulnerable groups, aiming to achieve universal insurance coverage, but far from a universal healthcare system blueprint. The public insurance of the poor may conciliate the combat of poverty in democratic regimes with the possibility to enlarging the health care market, although even in the richest countries in the region have no more than 25% of the population has voluntary private insurance (table 1, annex 1) those programs are listed for each country).

⁸ Informe al ejecutivo federal y al Congreso de la Unión sobre la situación financiera y los riesgos del Instituto Mexicano del Seguro Social 2011-2012, available at: <http://www.imss.gob.mx/estadisticas/Documents/20112012/informecompleto.pdf>.

BOX 5
THE EX POST CONSENSUS IN FAVOUR OF A UNIVERSAL
NON-CONTRIBUTIVE PENSION IN MEXICO CITY

In 1997 the Mexican Federal Government enacted a cash transfer program called Progresa which changed its name to Oportunidades in 2002. It is a means-tested, targeted and conditional program. As it has been established, its main impact on poverty has resulted in the reduction of its intensity rather than in its incidence (Banegas, 2011). In this context in 2001, not with the intention of replacing Oportunidades, but opening a new perspective, the Mexico City government innovated in the design of income support and healthcare policies through a universal, unconditional and non-contributive pension, just for the habitants of Mexico City, which amounted to at least half a minimum wage for those over 70 years of age (later lowered to 68 years of age in 2008) and the establishment of free access to all available treatments and medications in the health-care program for the segment of the population without social security. Both programs were elevated to the status of law (in 2003 and 2006 respectively) as demandable rights (Martínez, 2011). However, one of the relevant differences is that Oportunidades is a national program and the non-contributive pension works only for the Mexico City elderly population (Lo Vuolo, 2013). The universal pension was criticized by forces across the entire political spectrum, as being populist and having a handout mentality, in addition to being catastrophic for local finances. The program's opponents highlighted the fact that it should rather be limited to "those who needed it" and that it could not be in exchange for nothing.

The program was born as not only an innovative and daring initiative, but also a controversial one. As the program was implemented, however, the controversy began to fade and the construction of an ex post consensus, clearly expressed in its status as a right, began after a brief span of time. In a span of five years, from 2003 to 2008, the program was firstly rejected by the Legislative Assembly, secondly, a few months later, with a different political composition it was approved only with the votes of the party in the government, and, by 2008 a reform initiative was approved unanimously, reducing the age to 68 years (Yanes, 2011). Universality and financial feasibility were no longer questioned, rather the debate centered on how much to lower the age. An ex post consensus had formed, not necessarily based on a change in the convictions and values of legislators, but rather in the strong social legitimacy that the pension had acquired in the streets and homes of the city, which later became political legitimacy and legal institutionalization.

The citizen's pension is in fact a modest monetary transfer (around 70 dollars a month), not enough even for a complete basic food basket, but whose impact on the incomes of senior citizens cannot be underestimated, particularly for older women who report it as their only or main source of income. It has also had a very important impact on the reorganization of social relations and the subjectivity of people. Pool (Instituto De Atención de Los Adultos Mayores del Distrito Federal, 2009) results assert that the entitled persons assessed the pension in very favorable terms and even the economic impact of the pension resulted to be very significant for the majority. However it is acknowledged by all the recipients that the benefits go far beyond the monetary contribution, especially in aspects related with self-esteem, safety and independence. Also relevant is the feeling of acting as social actors within the family, the community and the society (Duhau, 2009), as well as in the use of public spaces (Asamblea Legislativa Del Distrito Federal, 2008). This pertains to a perspective of dignity, broadened autonomy and a larger sense of independence in the last stage of life.

Source: Own elaboration.

ECLAC⁹ makes a reasonable argument that the gradual implementation of rights does not make them any less obligatory (Machinea, 2007). However, this argument can fulfill equity, but not the equality principle. Accordingly, it is only acceptable when progressivity does not signify the coexistence of distinct protection regimes. As citizens' rights are not dividable, they can only be increased within a universal basis. Otherwise, universalization could be a veil to hide the pervasive stratification and exclusion from high levels of health care.

In some countries in the region —Ecuador, Bolivia, Venezuela— one can also observe efforts to assure the health to right as part of the consolidation of a new social and political arrangement in pluralist and multicultural societies, in an emancipation of colonial and oligarchic power. The challenge is to conciliate the democratic regime in a capitalist economy with the communitarian traditions, in situations of popular mobilization and conflictive rule.

⁹ Economic Commission for Latin America and the Caribbean.

BOX 6

RIGHT TO HEALTH AS PART OF THE SUMAK SAWSAY

Far from the western tradition where human rights are individualized and considered in a fragmented way —civil, politic, social and environmental— the concept of Sumak Kawsay⁷ assumed in the new Constitutions of Ecuador and Bolivia comes from the holistic and communitarian indigenous tradition. The requirement of an intercultural approach for people's rights brought this principle of promoting balance and harmony between the person and the surrounding context as a key value articulating other communitarian and individual rights.

Another assumption underlying this principle is the de-colonization of Latin American societies, inaugurating a new political pact to replace old oligarchic arrangements that ruled in favor of the elites with the exclusion of the poor, mostly the rural indigenous populations. A new ethics is required regarding power exercises, mobilizing the citizenship in closet connection with authorities, as basic to assure legitimacy. This is also reflected in the health sector, where principles such as compassionate care and intercultural health practices are added to participation, equity, and, universality as guidelines for healthcare system.

This conception can represent a powerful impulse towards universal health care rights, and may influence other countries in the region. However, the right in practice for all citizens under equalitarian conditions is dependent on overcoming the highly segmented health coverage schemes, and goes further than a program of primary attention.

It is still unpredictable whether this holist view will prevail over predominant fragmented policies and the medical model, concentrated in illness, reshaping in health field the relations among state, society and citizens. However, this perspective is the only one that explicitly connects universalization of health care with the perspective of shifting from curative to preventive care in a holistic basis. In this sense, it places the social determinants of health as the core of a multicultural model.

Source: Own elaboration.

IV. Conclusions: towards a community of citizens

In this article we analyzed different national experiences towards health-care universalization. Although they share the same goal to expand coverage, they take different paths, according to the strategy adopted and differ regarding citizens right to health entitlement.

Universality is expressed not only regarding entitlements to access health facilities, but also in terms of the differences in systems and health care networks; packages of benefits with differentiated levels of attention; requirement of co-payments; feasibility and quality of the services. Each of these variables can introduce deep stratification inside a universal health coverage situation.

In addition, there is a crescent interest of profitable international and national companies in the insurance, drug and hospital branches, in the new market represented by Latin-American consumers. We should be aware of universalization as a market demand and the consequences of social protection insertion into the circle of accumulation, since it provokes a re-stratification of the consumers. This perspective contradicts the egalitarian principle of the right to health and impedes the creation of social cohesion among citizens.

Using citizenship as an analytical framework allows us to differentiate the common attempt to provide healthcare in the region, since paths to universal coverage does not always signify the extension of the right to health to all citizens in equalitarian basis.

Beyond analyzing the presence of specific features to indicate the realization of the right to health in the region, we must consider the existence of clusters where some aspects that are crucial to define a pattern of universalization with different social projects of sociability coexist.

In all the three patterns we identified efforts to overcome the exclusion to health care are observed, although the equalitarian right to health is not common to all of them, nor is the capacity to transform the right in law into a right in practice. Moreover, some new tendencies towards a multicultural approach to health dispute whether the universalization of health care means the consolidation of the hegemony of the curative model with high technology consumption in the health sector, which is far from the social determinants perspective. Therefore, the trend to universalization is not unavoidably a path to build a community of citizens.

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Annex

TABLE A.1
HEALTH EXPENDITURE, POPULATION COVERAGE AND CONSTITUTIONAL AND LEGAL FRAMEWORK

	Health expenditure	Health coverage	Health constitutional and legal framework	Universalization through programs
Argentina	2009	Total expenditure on health: 8.6 – 9.4% of GDP	Public expenditure: 70%	2012 Social security: 55%
Bolivia (Plurinational State of)	2008	Total expenditure on health: 4.62% of GDP	Public expenditure: 42%	Social Security: 28%
Brazil	2008 Total expenditure on health: 8.4% of GDP 2007 Public expenditure: 41,6%	2012 SUS: 100% Private 25% (double coverage)	Health is a right of everybody and duty of the State, ensured by social and economic policies aimed at reducing the risk of diseases and of other damages and the universal and equal access to the efforts and services for its promotion, protection and recovery. (Federal Constitution of Brazil Art. 196 to 200 and Act 8080/90).	
Chile	2008 Total expenditure on health: 6.56% of GDP 2006 Public expenditure: 56%	2012 Public Subsystem (FONASA): 74% ISAPRE: 17%	The State shall ensure the execution of the health efforts, be them provided through public or private institutions. Each person shall have the right to choose the health system from which he/she wishes to benefit, being it a public or private one. (National Constitution of 1980, Art. 19)	Chile

Table A.1 (continued)

	Health expenditure	Health coverage	Health constitutional and legal framework	Universalization through programs
Chile	<p>2008 Total expenditure on health: 6.56% of GDP</p> <p>2006 Public expenditure: 56%</p>	<p>2012 Public Subsystem (FONASA): 74% ISAPRE: 17%</p>	<p>The State shall ensure the execution of the health efforts, be them provided through public or private institutions. Each person shall have the right to choose the health system from which he/she wishes to benefit, being it a public or private one. (National Constitution of 1980, Art. 19)</p>	
Colombia	<p>2009 Total expenditure on health: 6.4% of GDP Public expenditure: 84%</p>	<p>2011 Contributory system: 42.6% Subsidized system: 48.4% Special systems: 4.8%</p>	<p>The 1991 Constitution assured the health to right as a universal non-renounceable right, meanwhile the Law 100 of 1993 provided an insurance system for health, for those with economic capacity, that gives the right to a package of services.</p>	
Costa Rica	<p>2011 Total expenditure on health: 10.9% GDP Public expenditure: 70%</p>	<p>2009 Caja Costarricense de Seguro Social (CCSS): 75% Indigentes por cuenta del Estado: 12% Privado: 30% Público (salud pública colectiva): 100% Hay doble cobertura.</p>	<p>Consumers and users are entitled to the protection of health, to freedom of choice and to equal treatment. (National Constitution of 1949, Art. 46) The new constitutional chamber of the Supreme Court (Sala Constitucional or Sala IV) has declared health as right based on international instruments ratified by the country and in the Article 21 of the Constitution, which states "life is inviolable."</p>	

Table A.1 (continued)

	Health expenditure	Health coverage	Health constitutional and legal framework	Universalization through programs
Cuba	2009 Total expenditure on health: 11.9% GDP Public expenditure: 96%	2009 Social security: 100%	Everyone has the right to treat and protect their health. The State guarantees this right. (National Constitution of 1976, Art. 50)	
Ecuador	2008 Total expenditure on health: 8.5% of GDP Public expenditure: 52%	2012 MSP: 70% Public Insurance: 21.2% Private Insurance: 8.2%	Health was explicitly recognized as a right to every person by the new 2008 Constitution. Health public services shall be universal and free in all service levels. The health system is based on the principles of equality, universality, solidarity, interculturality, precaution and bioethics with focus on gender and generational. (National Constitution of 2008, Art. 32 and 362)	
Mexico	2011 Total expenditure on health: 6.2% of GDP Public expenditure: 49%	2010 Público (Secretaría Federal y Secretarías Estatales de Salud): 42% Seguro popular: 15%: IMSS: 45% ISSSTE: 7% PEMEX y Fuerzas Armadas: 6% Privado: 3% Sin cobertura: 1% Hay doble cobertura.	National Constitution in Force: 1917 Article 2-B: "To reduce deficiencies and shortcomings affecting indigenous peoples and communities, such authorities are obliged to: (...)" III. Ensure the effective access to health services by means of the broadening of the national system coverage, properly availing of the traditional medicine, as well as support the nutrition of indigenous peoples by means of food programs, especially for children (...)".	Oportunidades Program (cash transfer - senior citizen's pension).

Table A.1 (continued)

	Health expenditure	Health coverage	Health constitutional and legal framework	Universalization through programs
Peru	2010 Total expenditure on health: 5.2% of GDP Public expenditure: 55,8%	2010 Total coverage: 64.7% Comprehensive insurance on health: 39.3% Social security: 20.7% Other insurances: 4.7%	Article 4: "Man and woman are equal before the law (...). Every person has the right to the health protection. The Law shall define the terms and conditions for accessing health services and shall determine the assistance to be provided by the Federation and federal organisms in matters of general health (...)". The State ensures free access to health provisions and pensions through public, private or mixed organisms. The Constitution specifies the right to health to the person with disabilities. (National Constitution of 1993, Art. 46 and 7).	Plan Esperanza (comprehensive cancer care to the poor people, who are in the Integral Health Insurance (SIS).
Uruguay	2008 Total Health expenditure: 7.5% of GDP Public expenditure: 63,8%	2012 National Health Insurance: 53% ASSE: 30% Military or Police health plan: 7% Pre-paid IAMC: 12% Private Insurance: 1.2% Double coverage is considered.	The Constitution of 1967 (latest reform in 2004) declares that the State shall supply for free the prevention and assistance means to indigent or poor people lacking resources. The Act 18211 of 2007 Creates the National Integrated Health System (SNIS) and declares health as a right of all inhabitants residing in the country.	Oral Health Program (focused on children, pregnant women and elderly). Previniedo Program (prevention of risk factors associated with NCDs).

Table A.1 (concluded)

	Health expenditure	Health coverage	Health constitutional and legal framework	Universalization through programs
Venezuela (Bolivarian Republic of)	2003 Public expenditure: 3.4% of GDP MPPS: 61% Health Fund: 21% Contributions to health services and public insurance: 18%	2012 SNPS: 100% 2005 IVSS: 17.5% Private Insurance: 11.7% Double coverage (IVSS and private): 2.4%	Health is an essential social right that should be assured by the State as part of the right to life. Creation of a National Public Health System (SPNS) of intersectorial character, de-centralized and participative, multi-ethnic, multicultural and multilingual pertinence, by the principles of gratuity, universality, integrity, equality, social integration and solidarity. (National Constitution of 1999, Art. 83 and 84).	Mission Barrio Adentro (comprehensive publicly funded health care, dental care, and sports training to poor and marginalized communities). Mission Milagro (recovery of vision). (Both programs are in cooperation with Cuba).

Source: Health Systems in South America: Challenges to the universality, integrality and equity. South American Institute of Government in Health, Ligia Giovanella, Oscar Feo, Mariana Faria, Sebastián Tobar (orgs.). Río de Janeiro: ISAGS, 2012. 836 P.



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