

Can Insurance Guarantee Universal Access to Health Services?

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Insurance programs stand at the center of health policy debates in many parts of the world. Obama's recent health care reform, designed to make health insurance compulsory in the US, has highlighted the role of insurance schemes as a way of guaranteeing universal access to health services. Nevertheless, it should be kept in mind that this proposal was an attempt to limit the excesses of the most inefficient and expensive health system in the world. It was not simply a matter of social justice; the cost of providing health care is a major economic problem in the US.

Yet, the emphasis on insurance programs presents us with a scientific and logical paradox. Obama's initial reforms highlight the urgent need to regulate the health care market, specifically the insurance and medical care industries. Yet the international debate over health insurance plans frames them as a response to popular demands that governments guarantee universal access to health services.

The debate over the role of the market is almost entirely absent in most European countries which have some form of (public or quasi-public) national health service. Historically, these national services have (rather successfully) guaranteed all their citizens timely access to needed health services. International interest in health insurance involves primarily the so-called middle income countries or the (formerly socialist) transition economies. These countries are now dealing with the failures of 1990's health reforms which introduced market mechanisms to improve health care quality and reduce costs.

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The World Bank, the International Monetary Fund, and even to some extent the World Health Organization have all proposed and promoted health insurance schemes. Based on their faith in market solutions, they put principles of neo-classical economics ahead of the satisfaction of human needs.

An attentive reading of their recommendations highlights several important facts. In order to guarantee financial sustainability, universal insurance is invariably limited to a "right" to a restricted package of services. In reality, these insurance schemes are designed neither to open access to needed health services nor to provide universal health coverage. Instead, everyone gets an insurance policy, even if it doesn't guarantee comprehensive health care services.

"Universal" insurance financing mechanisms pave the way for a second generation of health reform by solving two problems ignored in the 1994 World Bank reforms. First, they provide an effective demand (i.e. purchasing power) for the health care industry in settings where most people live in extreme poverty. Second, they open up a new and lucrative private market: the administration of health insurance funds.

Although more public funds and tax dollars are earmarked for health, this is done through demand subsidization (putting money in the hands of the users) rather than subsidizing supply by increasing the budget of public institutions. As a result, a new layer of competition is added to the system. Not only do public and private service providers compete, we also see competition between public and private insurance plans. Furthermore, private companies are offered a series of advantages in order to break the "monopoly" of public institutions. A new ideological discourse has been created to present this new institutional scheme as

“democratic” in contrast to the “bureaucratic model” of public services. In order to avoid the well documented failures of the health market, the State is supposed to assume the role of regulator. This solution was promoted by Enthoven in his theory of the “managed competition” and has been questioned for some time because of its meager results in practice.

Although universal insurance schemes claim to be evidence-based, they ignore multiple experiences in Latin American countries. At least three countries – Chile, Colombia, and Mexico – have tried universal insurance with very disappointing results. While each of these countries adopted different insurance mechanisms, they all shared certain common results. None has achieved universal coverage; at least 10% of the population has remained uninsured. A second common feature is an increase in national health care expenditures, both public and private. This increase has not meant greater access to health services, at least not in Colombia or Mexico. A third commonality is that market logic – centered on “individual care” conceived as a “private” good – has destroyed the institutional scaffolding of public and collective health. The result is the re-emergence of previously controlled diseases and the reduction of preventive interventions.

By contrast, the private sector has seen very high profits. In countries with a mature private health care sector (Chile since 1979/1980 and Colombia since 1993) health care firms have strengthened their position not only vis-à-vis the public sector but also with respect to other private firms. Prior to the recent election of a conservative president, the

Chilean government tried to regulate the corrupt practices of risk selection (cherry-picking) and avoidance of moral hazard. But the insurance industry had acquired such political strength that these efforts were unsuccessful. The Colombian case is even more dramatic. The public-private system is virtually bankrupt and the result – despite vigorous protests – will probably be a major cut in covered services.

All three countries have seen insufficient investment in infrastructure; services which are supposedly covered are simply not available to those who have insurance. It goes without saying that social inequities in health have increased. Economic barriers to health remain important and the (in)ability to pay constitutes an important determinant of access to services.

The Chilean and Colombian experiences with “universal” insurance show that their only undeniable achievement is to turn health into a lucrative private business (particularly for the administrators of the insurance funds). However, from the viewpoint of satisfying health needs, “universal” insurance offers no advantages and many disadvantages over the option of a single public health system with universal and free access and financed with tax funds. This latter is the most humane option, because it values the lives of all equally; it is the most fair, because those in need receive proportionally more; it is the most equitable because all have equal access to the available services when faced with the same need; and it is the most affordable because it does not have to generate a profit and its administrative expenses are lower.



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