

Universal health coverage: The strange romance of The Lancet, MEDICC, and Cuba

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Abstract

As a key supporter of universal health coverage (UHC), *The Lancet* recently partnered with Medical Education Cooperation with Cuba (MEDICC), a non-governmental organization based in the United States, to produce a Spanish-language translation of *The Lancet's* series on UHC in Latin America. This translation was launched as part of CubaSalud 2015, an international health conference held during April 2015 in Havana, Cuba. Despite its often ambiguous definition, UHC usually refers to a *financial* reform extending *insurance* coverage in varying degrees to a larger part of a country's population. UHC does not mean "healthcare for all" (HCA) – a healthcare delivery system that provides equal services for the entire population regardless of an individual's or family's financial resources.

UHC has received wide criticism because it does not necessarily create a unified, accessible system; because it usually encourages a role for private, for-profit insurance corporations; and because it involves tiered benefits packages with differing benefits for the poor and non-poor. Although the UHC orientation has become "hegemonic" in global health policy circles, its ideological assumptions

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have not been confirmed empirically. The editors of *The Lancet* and *MEDICC Review* should explain more fully the decisions to translate the UHC series and to launch the translation in Havana, and they should provide "equal time" for critiques of UHC and presentations of endeavors to achieve HCA.

Introduction

The Lancet has emerged as a key supporter of universal health coverage (UHC).¹ Recently *The Lancet* partnered with Medical Education Cooperation with Cuba (MEDICC), a non-governmental organization based in the United States, to produce a Spanish-language translation of *The Lancet's* series on UHC in Latin America. Editors of *The Lancet* and of *MEDICC Review*, a journal published by MEDICC, launched the Spanish translation on April 22, 2015, in Havana, Cuba. The launch took place as part of CubaSalud 2015, a large international health conference, and included Cuban participants as well as officials of the World Health Organization (WHO), Pan American Health Organization (PAHO), and World Bank. Funding for the publication came from the Rockefeller Foundation, WHO/PAHO, and the Economic Commission for Latin America and the Caribbean (ECLAC/-CEPAL, a regional commission of the United Nations).

What is UHC?

Although its definition often remains imprecisely stated, UHC usually refers to a *financial* reform extending *insurance* coverage in varying degrees to a larger part of a country's population. UHC does not mean "healthcare for all" (HCA) – a healthcare delivery system that provides equal services for the entire population regardless of an individual's or family's financial resources.

UHC has received wide criticism from progressive organizations and individuals such as the Association of Latin American Social Medicine (ALAMES), the globally-based People's Health Movement (PHM), Global Health Watch (GHW), and various researchers including myself. Only one article in *The Lancet's* series (representing ALAMES) conveys criticism of the UHC approach and favors a unified, public sector approach to HCA.²

On the surface, UHC conveys the symbolism of universal access to health services. UHC proposals usually describe ways to extend services to populations that face barriers to access, particularly poor people, ethnic/racial minorities, and otherwise marginalized groups. The use of the term "universal" conveys concern about the severe access barriers affecting people around the world.

However, the UHC approach does not necessarily entail a unified, accessible healthcare delivery system. In fact, most UHC proposals actually disfavor such unified systems. Instead, the proposals argue for a multifaceted *financing* reform that would extend some services, but not necessarily all needed services, to those who currently lack health insurance.

In such proposals, the public sector enters into a competitive relationship with an expanded private sector, in which private, usually for-profit insurance corporations play an increasingly important role. Through UHC, these insurance corporations gain access to public trust funds dedicated to health and social security benefits. Corporations are then paid from these funds for providing "managed care" services on a prepaid, capitated basis. As shown in prior research, corporations use much of the capitation payments for investment in the global financial marketplace.^{3,4}

A reduced role for the state and privatization of public services therefore make UHC consistent with other neoliberal policies. Under UHC schemes implemented in countries such as Colombia and Mexico, the state gathers funds through a combination of mandatory taxes and premiums and disburses the funds to corporations that contract for delivering services to insured individuals and families.^{5,6} In addition, the state directly delivers services for the remaining uninsured poor through public sector hospitals and clinics, which become increasingly stressed due to budgetary cutbacks.^{4,7}

UHC almost always involves tiered benefits packages, with differing benefits for the poor and non-poor. A national reform provides a minimum package of benefits that experts view as essential. The poor and previously uninsured receive basic insurance with little or no out of pocket copayments. The non-poor or their employers can purchase additional benefits.

Under minimum packages, for instance, all women would be entitled to periodic pap smear screening for cervical cancer. But treatment of cervical cancer if revealed by pap smear screening would not necessarily be covered under the benefits packages, leaving women vulnerable to variability in local government funding and policies. In Mexico's UHC program (*Seguro Popular*) benefits available for treatment of cervical cancer for poor women with positive pap smears have varied according to the financial resources and policies of different Mexican states.^{4,8} [and unpublished data] Surely there must be something terribly wrong with a system that offers cervical cancer screening to all women and then selectively denies treatment to those who are poor.

As the ALAMES authors point out, the concept of UHC has become "hegemonic" in global health policy circles.² Its promotion involves several ideological assumptions:^{4,9}

- Efficiency increases if financing is separated from service delivery, and if competition is generalized among all subsectors (state, social security, and private).
- The market in health is the best regulator of costs.
- Demand rather than supply is to be subsidized.
- Private administration is more efficient and less corrupt than public administration.
- Deregulation of health and social security trust funds allows the user freedom of choice and an ability to opt for the best administrator of his or her funds.
- Quality is assured by fostering the client's satisfaction through competition of providers in the marketplace.

There are only a limited number of data-driven studies of UHC outcomes. These studies, in countries like Colombia, Chile, and Mexico – based on evidence – have not confirmed the above assumptions regarding managed care, competition in markets, efficiency, cost reduction, or quality. Under

UHC, access barriers remain or worsen as costs increase and corporate profit making expands.^{4,7,10,11} In many countries, regressive taxes structures impede the expansion of insurance coverage, and prioritization of clinical services under UHC can impede the achievement of broader public health goals.^{12,13}

What is HCA?

HCA sees healthcare as a human right, provided in a national system where access does not differ according to income, wealth, occupation, gender, racial/ethnic characteristics, age, or other criteria. Usually the vision of HCA involves a single public system that provides outpatient, inpatient, and preventive services; that is the model of Cuba. In some countries as diverse of Brazil and Canada, HCA is based on public sector funding for services provided in either the public sector or by private practitioners, hospitals, and clinics; however, participation by for-profit corporations is either prohibited or tightly regulated.

The unifying principle in HCA is that the national health system should not include tiers with differing benefit packages for rich and poor. For instance, because Canada prohibits private insurance for services provided in its national health program, Canada's wealthy must participate in the publicly financed system. The presence of the entire population in a unitary system assures a high quality national program. The ALAMES article in *The Lancet* series succinctly expresses the HCA vision: "ALAMES argues for the right to health for all citizens, without distinction, with the state as the guarantor of finance and administration."² In Latin America, countries trying to advance the HCA model include Cuba and Brazil, as well as Bolivia, Ecuador, Uruguay, and Venezuela, all of which have moved in the direction of HCA after rejecting the prior neoliberal models.

Why Cuba for a Launch of UHC?

In light of Cuba's unified public system embodying HCA, the launch of *The Lancet's* UHC series seems ominous. Does UHC figure in the future of Cuban healthcare? Is HCA in Cuba entering a trajectory of decline? How was a decision reached to launch the UHC translation in Havana?

The editors of *The Lancet* and *MEDICC Review* should become more transparent about the process leading to UHC's debut in Havana. "The usual sus-

pects" may have orchestrated this momentous event, mainly by financing the original *Lancet* series, the translation, and the launch. Rockefeller, ECLAC/CEPAL, WHO/PAHO, and the World Bank (which, along with the Gates Foundation, provides substantial funding for WHO) have acted collaboratively to foster UHC in Latin America. Now, with a detente emerging between Cuba and the United States, has the Cuban health system become a target for transformation in the direction of UHC?

In this context, it is worthwhile remembering WHO's *World Health Report* 2000, which ranked the world's health systems with a conceptual orientation and methodology that received scathing criticism worldwide.^{14,15} Briefly, "choice" was a major criterion in evaluating health system performance. From this perspective, unified public health systems that did not encourage choice among private providers ranked lower than those that did. As a result, Colombia (ranked 22nd in the world and 1st in Latin America), Chile (33rd), Costa Rica (36th), and even the United States (37th) ranked higher than Cuba (39th), despite Cuba's much admired, accessible health system and outstanding health indicators. Brazil ranked very low, 125th, again due to its attempt to achieve HCA through a unified public sector health system, codified in the Brazilian constitution of 1988.

The co-director of WHO's ranking project, Dr. Julio Frenk, later became an architect of UHC reform as Mexico's minister of health. He and his colleagues described Mexico's reform in *The Lancet*,⁶ an article which generated criticism for unsubstantiated claims of success.^{4,7} Despite wide criticism of the WHO ranking project and of UHC in Mexico, Frenk and his coworkers became leading proponents of UHC, partly through a key article in *The Lancet's* series.¹⁶ Because they have not disavowed the low rank of Cuba's health system, Frenk and colleagues may still believe that Cuba would benefit from a reformed health system, reorganized as UHC with private insurance corporations in competition with Cuba's public sector.

Is a subtext for the Havana launch a hope to privatize Cuba's health system, or to open it up to private insurance corporations? Although this scenario may seem farfetched given Cuba's accomplishments, the Cuban government has been moving swiftly to reduce its public sector expenditures by eliminating jobs and expanding private sector economic activities. Is healthcare soon to follow? This

scenario should worry those who have admired and supported Cuba's public health endeavors. Such changes do worry Cuba's activists in ALAMES, whose coordinator wrote just after the Havana launch of UHC: "ALAMES-Cuba supports and works in accord with the process of social and economic transformations that are developed in the country in the consolidation of SOCIALISM, prosperous and sustainable, which conceives health as a human right for all, that never will be an object for profit or commodification."¹⁷

Where from Here?

The editors of *The Lancet* and *MEDICC Review* should explain their decisions to translate the UHC series and to launch the translation in Havana. Several issues in particular warrant transparency and clarification:

- What role did funding agencies play and how were the funds used?
- What conflicts of interest affect the authors and editors? Particularly troubling is the lack of clear disclosures in the translated articles about major funding from the same international financial institutions and foundations.
- Why was the editorial board of *MEDICC Review* not consulted before the decisions to translate the UHC series and to launch it in Havana?
- Do *The Lancet*, *MEDICC*, and *MEDICC Review* support UHC or HCA?

The Lancet and *MEDICC Review* should provide "equal time" for critiques of UHC and presentations of endeavors to achieve HCA. Future articles should address such topics as:

- implementations of UHC and HCA
- "hegemonic" versus "counter-hegemonic" public health policies
- "philanthro-capitalism," including the positions of key foundations (Rockefeller, Gates) and non-governmental organizations
- Global Health Watch, the People's Health Movement, ALAMES, and popular movements favoring HCA

Financing for this effort should come from the same funders who supported the translation of *The Lancet's* UHC articles, or from others if the original funders do not agree.

Conclusion

The translation and launch of the UHC series have generated concerns that warrant attention. Clarification of the rationale and process of decision-making should occur with transparency that resolves the mysteries discussed above. *The Lancet* and *MEDICC Review* should clarify whether they support UHC or HCA, and why. Additional publications and translations should present a balanced picture of UHC and HCA, including critiques of the hegemonic principles associated with UHC.¹

Author's contributions

The author conceived the effort, conducted the literature review, wrote the article, and edited it.

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¹ After this article was accepted for publication, the editors of *MEDICC Review* provided a brief explanation of their decision making process in response to my letter to the editors that they published; this is available at <http://tinyurl.com/hhgz3hd> (Cited August 6, 2015).

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