

Addressing Systemic Challenges to Social Inclusion in Health Care:

Initiatives of the Private Sector

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Foreword

Latin America remains the most unequal region in the world, presenting significant challenges to overall regional development. A number of groups—among them the urban and rural poor (33.1 percent of the population), indigenous populations, Afro-Latinos, and women—continue to lack access to critical pillars of development, including quality health care services.

With this in mind, Americas Society (AS), with support from the Ford Foundation and leveraging the relationship with its sister organization Council of the Americas (COA), is working to strengthen the voice of these marginalized groups by presenting new research and promoting fresh debate on how the public and private sectors can address systemic challenges to social inclusion. In addition to health care, our efforts also focus on education and market access. The AS Social Inclusion Program involves in-country research, three white papers, dedicated issues of *Americas Quarterly*, and private roundtable meetings and public conferences with high-level public- and private-sector leaders on topics of inclusion.

This white paper presents the findings and conclusions of Americas Society's research on health care. The goal of this paper is to draw attention to a sample of new practices that increase access to quality health care for marginalized populations and spur businesses, governments and nonprofit organizations to commit more to address this issue. We are not seeking to evaluate individual programs but rather to present a variety of health care initiatives that all have the same goal: providing care for those that otherwise would not have access to it. It is essential that we consider these cases in their larger regional context and use the lessons learned to promote greater social inclusion.

To begin the research process, Americas Society formed a peer review committee that helped identify areas for research in this field. The next step included collecting information from corporations, nongovernmental organizations (NGOs) and foundations about existing initiatives. Preliminary findings were presented at a conference in December 2010 where diverse stakeholders provided feedback and direction for the drafting of this white paper. Researchers in Colombia and Mexico then set out to identify examples of private programs or public policy initiatives that have expanded health care access.

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Population, The World Bank; Thomas Bossert, director, International Health Systems Program, Harvard School of Public Health; Gabriel Carrasquilla, director, Center for Health Care Research Studies, *Fundación Santa Fé de Bogotá*; Donika Dimovska, senior program officer, Results for Development Institute; Amanda Glassman, director, Global Health Policy, Center for Global Development; Miguel Ángel González Block, executive director, Center for Health Systems Research, Mexico's National Institute of Public Health; Gina Lagomarsino, managing director, Results for Development Institute; and Bill Savedoff, senior fellow, Center for Global Development.

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Introduction

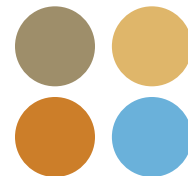
Universal health care has become an increasingly pressing—albeit elusive—goal in countries across the Americas. With transitions to democracy and the adoption of pro-market reforms sweeping the region in the 1980s and 1990s, many governments also began making efforts to improve equality and efficiency in their health care systems. Often, reform was shaped by national laws that modified the existing financing systems to increase insurance coverage for the poor. This was the case in Colombia and Mexico—the two countries of primary focus for this white paper. In other countries, for example Chile and Brazil, reforms centered on making use of the private sector within publicly-financed health systems. In Chile, this has meant strengthening the national public health insurer and establishing a strong regulatory regime that covers both private and public insurers; in Brazil, recent efforts have focused on establishing regulations for private insurers and experimenting with various state-level public administration models.

Regardless of the form change took, coverage has indeed expanded and progress has been made on key health indicators. In Colombia and Mexico, for example, ongoing national efforts have significantly increased health care access for those traditionally left out of the health care system. By the end of 2010, *Seguro Popular* had reached 42 million of Mexico's 50 million previously uninsured,¹ and by 2011, the subsidized regime of Colombia's *Ley 100* was providing health insurance to 11 million people who otherwise would have had no such insurance.²

Meanwhile, countries in Latin America have made notable advances in the areas of child mortality, maternal health and infectious diseases. By 2008, the regional average for the under-five mortality rate was 23 per 1,000 live births, down from 52 in 1990,³ while maternal mortality had decreased by nearly half over the same time period, from 140 deaths per 1,000 live births to 85.⁴ The incidence of both tuberculosis and HIV/AIDS has also decreased in most countries.⁵

In spite of these advances, there remain gross inefficiencies and disparities in care and health indicators across and within countries. For example, 20 percent of the population in rural areas lacks potable water—a number that is 10 times higher than in urban areas. Infant mortality rates are consistently highest among indigenous and Afro-descendent populations.⁶ This persistent lack of access to good health services directly and negatively affects labor

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productivity, household income level and a family’s potential for upward social mobility, impeding the development of a wide middle class and bearing consequences for macroeconomic growth.

Given the social, economic and political ramifications of inclusion, both the public and private sectors have reason to invest in combating exclusion. To some degree, this has been the case. Health reform legislation and private initiatives in recent decades are tackling the challenge of greater social inclusion. But more remains to be done. In particular, the private sector—in this paper taken to include for-profit health insurers, for-profit health providers, for-profit firms that operate outside the health industry, and nongovernmental nonprofit organizations—can play a more significant role in expanding health care access for those left out of the system. Specifically, the private sector can fill some of these health care gaps by investing in infrastructure and human resource capacity, especially in information and communications technology; educating the public; devising innovative financing and pricing models; and even providing affordable services directly. Most important, though, is that the design, implementation and evaluation of health policies and programs involve collaboration across sectors. By doing so, the private and public sectors can find new practices not only to provide care but to do so in a way that is financially sustainable.

The Americas Society set out to study select cases in which the private sector is expanding access to primary health care among marginalized groups. We focused specifically on the private sector because of the unique resources and perspectives it can contribute to expanding health coverage, and because of the economic ramifications of achieving universal health care. The cases were selected for their geographic, strategic and institutional diversity in order to provide a variety of examples to draw on for further discussion. In these instances we looked specifically at the ways in which public policy can facilitate and help to expand the private sector’s initiatives. Given that Colombia and Mexico both recently enacted national legislative reform to significantly expand health care access, we decided to focus on these two countries.

Preliminary in-country research and survey data from COA members provided initial insight into the areas of health care where the private sector is involved. This includes financing health care provision through grants or donations as a part of corporate social responsibility as well as insuring or treating patients at low cost as part of a firm's business model. The following matrix—by no means comprehensive—reflects this information (**SEE FIGURE 1**). Organized by country, it groups the initiatives included in the survey by more specific areas of operation: “health care financing,” paying for the provision of care through subsidies, vouchers or insurance; “direct service provision,” providing facilities where actual medical care is offered; “low-cost medical treatment,” facilitating access to discounted treatment, including services, pharmaceutical drugs and medical devices; “eHealth/mHealth,” leveraging information and communications technologies to expand access to care; “preventative measures/healthy lifestyles,” educating communities for better long-term health; and “health care policy advocacy,” collaborating with policymaking organizations and raising awareness about health care issues.

The firms surveyed are generally most active in providing direct services, expanding affordable access to treatment and promoting healthy lifestyles. This last area, which includes disease prevention, will assume increasing prominence in coming years as the burden of disease in Latin America shifts to chronic, non-communicable diseases.

Notably, only a few of these programs made use of information and communications technology or diversified financing streams. This was surprising. Many of the newest innovations in low-cost health care delivery that are gaining public attention utilize information and communications technology (ICT) or pro-poor health market models.⁷ With its enormous potential for expanding access to care and information in remote areas, connecting health professionals, tracking disease patterns, and monitoring patient follow-up, eHealth/mHealth is an area ripe for further investment. Greater attention should be paid to the successful eHealth/mHealth programs that exist.

One point worth bearing in mind is that health care is a field with numerous and diverse stakeholders. Rather than seeing one another as competitors, the private sector can work within the framework of public policy to reduce gaps in access—for example, by lowering the costs of health care, administering services more efficiently, subsidizing the treatment of poor patients with higher fees paid by wealthier patients, and reducing or overcoming physical barriers to health care.



Figure 1

HEALTH INTERVENTIONS, BY TYPE AND COUNTRY

Colombia	Health Care Financing	Direct Service Provision	Low-Cost Medical Treatment	eHealth/ mHealth	Preventative Measures/ Healthy Lifestyles	Health Care Policy Advocacy
Fundación SOMA		●	●			
Fundación Grupo Nacional de Chocolates			●		●	
Fundación Mayaguez		●	●		●	
Pfizer Inc.			●		●	
Cerrejón	●	●	●		●	●
Fundación Éxito		●	●		●	●
Colgate-Palmolive Colombia	●		●		●	
Fundación Siemens			●			
Cerromatoso					●	●
Mineros S.A.			●		●	
Fundación Alpina					●	
Fundación Corona					●	●
Fundación Pavco					●	
Fundación Sanitas	●		●			
Fundación Propal		●	●		●	
Sesame Workshop*					●	

Mexico	Health Care Financing	Direct Service Provision	Low-Cost Medical Treatment	eHealth/ mHealth	Preventative Measures/ Healthy Lifestyles	Health Care Policy Advocacy
Fundación Mexicana para la Planeación Familiar, A.C. (Mexfam)		●			●	
Farmacías Similares SA / Fundación Best, A.C.			●			
Fundación Adelaida Lafón		●	●			●
Fundación Comparte Vida					●	●
Sistemas Médicos Nacionales S.A. de C.V. (SIMNSA)	●					
Fundación Mexicana de Fomento para la Prevención Oportuna del Cáncer de Mama, A.C.		●	●		●	●
Fundación Gen, A.C.						
Centro de Investigación Materno Infantil Gen (CIMIGen)		●			●	●
Sesame Workshop*					●	
Johnson & Johnson*			●		●	●
Pfizer Inc.*			●	●	●	
Manpower Inc.*		●				●

Other Countries	Health Care Financing	Direct Service Provision	Low-Cost Medical Treatment	eHealth/ mHealth	Preventative Measures/ Healthy Lifestyles	Health Care Policy Advocacy
Telefónica*			●	●		
Pfizer Inc.*			●	●	●	●
Johnson & Johnson*			●		●	●
Microsoft Corporation*			●	●	●	●
Cisco Systems, Inc.*	●		●	●	●	
PepsiCo*					●	
Digicel*				●		
Manpower Inc.*	●		●		●	●
SwissRe Financial Services Corporation*	●					●

*Information acquired through a survey returned by the company.



Colombia's Health Care System

OPENING THE DOOR FOR THE PARTICIPATION OF FOR-PROFIT COMPANIES

Colombian society is characterized by profound social exclusion, in marked contrast to the guiding principles established in its Constitution of 1991. The availability and access to public services and standard of living vary substantially, both between urban and rural populations and between distinct regions. For example, while potable water is accessible to 90 percent of the population in municipal areas, it only reaches 60 percent in rural areas. On the Atlantic coast health services coverage barely reaches 43 percent, compared with a national average of 51 percent. In the department of Cauca, the percentage of the rural population that lives below the poverty line exceeds the national average by 33 percent.⁸

During the 1990s, the government undertook a process of social policy reform, including passage of *Ley 100* in 1993, which sought to enroll the population in one of two insurance regimes: a contributory regime for those able to pay and a subsidized regime for those that could not. Under these reforms, a guiding policy for the organization of the health system was promoting the inclusion of the most economically vulnerable sectors of the population by ensuring their access to health care through the government-subsidized insurance plan. Care not covered by the insurance—secondary-level care including some surgeries and diagnostic exams, for example—is offered at public hospitals. In spite of *Ley 100*'s focus on specifically insuring economically vulnerable sectors, experiences following the law's implementation have shown that being insured and actually accessing health services are not one and the same.

Due to the complexity of achieving universal coverage and the institutional, operational and financial fragility of Colombia's social protection systems, certain groups of the population remain excluded. The steps taken in the 1990s have proven insufficient in guaranteeing real access to health care, as geography continues to pose an obstacle and unequal service allocation persists. People in the lowest income quintiles living in semi-urban or rural areas—far from state capitals and metropolitan centers where the physical infrastructure and human and technological resources for health care are concentrated—are the most affected.

Ethnicity and race are factors that not only create disparities in different groups' standard of living but also impact their health and access to services. Evidence shows that, at equal levels of income, ethnic and racial minorities have less access to services and exhibit poorer health indicators—for example, high infant and mortality rates and low life expectancy—than their counterparts. Further complicating the issue is that these minorities are overly represented among the poor—presenting a double challenge for access.⁹ Both are true in Colombia. Additionally, the elderly poor in Colombia, who lack knowledge of available services and often work in the informal economy earning very low salaries, remain under covered in social security and excluded from social services as well.¹⁰

While Colombia's General System of Social Security in Health, implemented via *Ley 100*, has been successful in removing the economic barriers to health care access for populations in the lowest income quintiles, the system has yet to fully reach—and thereby reduce social exclusion for—marginalized groups such as ethnic and racial minorities and the elderly poor. Although these groups have government-subsidized social security, they still cannot access necessary health care services due to geographic isolation or simply a lack of coverage for certain procedures. Today, approximately 39 percent of Colombians are insured under a subsidized regime that covers a range of services greatly inferior to those provided by the contributory one. Given this reality, the case studies below describe how the private, for-profit sector can contribute to the government's efforts to improve social inclusion.

OVERVIEW OF EXAMPLES

Within this context, and with special attention paid to the existing and potential role of the private sector, we identified 15 health care initiatives undertaken by for-profit companies for the first phase of our research. Of the 15 initiatives, four focus on nutrition and food security, five on public health education campaigns, five on service provision, and one on technology utilization.

We chose three for further analysis based on their potential ability to improve care for underserved populations and to be sustainable over time. Each case study reflects the efforts of a for-profit company that is making important contributions to the communities where it operates and its workers reside. In doing so, they are improving the health and thus productivity of their current or future labor force while also contributing

to the overall well-being of those who may not otherwise be able to access health services.

The first, *De Todo Corazón*, is a program launched by Pfizer Colombia in strategic partnership with Mutual SER, a company managing federal health coverage for the elderly poor residing in municipalities of six states on the country's Caribbean coast. The second, *Unidad Móvil de Salud*, is run by the mining company Cerrejón in conjunction with public hospitals in three municipalities located in the department of La Guajira. It serves a majority indigenous population. The third, *Salud y Saneamiento Básico*, operated by the foundation of the Colombian paper manufacturer Propal and four municipal governments in the department of Cauca, serves a majority Afro-Colombian and indigenous population. Each is explained in more detail below.

All three initiatives either manage government health insurance or represent a partnership with state-sponsored public entities such as mayoral offices or public hospitals. They are models of how to integrate private-sector and government efforts.



● **THE THREE CASES—EXPANDING ACCESS**

Access to health care services can be defined and measured in distinct ways. Some definitions focus on use as a proxy for access. Others focus on insurance coverage or eligibility to receive health care services irrespective of whether they actually use it. Here, we use service utilization and the number of people receiving particular services to illustrate access.

PFIZER—MUTUAL SER: DE TODO CORAZÓN

A primary health challenge in a mountainous, geographically-challenging country like Colombia is the physical inability of certain segments of the population to travel in order to access certain types of care. *De Todo Corazón* seeks to reduce these geographical barriers for poor people over the age of 45 who reside far from cities. Those enrolled in the program can access specialized medical services such as cardiology in their local communities, along with critical follow-up care.

The program began in 2004 when Pfizer partnered with Mutual SER—a company that manages the federal insurance plan for people in the two lowest income quintiles—to develop a program to prevent and treat cardiovascular and cerebrovascular diseases. For Pfizer, this program is part of the company's effort to be a good corporate citizen. For Mutual SER, it is a means of pro-

viding coverage for additional services.

De Todo Corazón reduces the impact of catastrophic illnesses and provides health care for a segment of the population that would otherwise not have access to a specific set of services, due to suffering from diseases that are not covered by the subsidized regime of Colombia's *Ley 100*. The program was launched after findings from a study of nearly 70,000 Mutual SER patients showed that high blood pressure was the seventh leading cause of medical intervention and that cardiovascular and cerebrovascular illnesses were the leading causes of death.

The program includes four components: ongoing training for medical personnel; patient medical care; health education for patients and their families; and recreational activities. The training program is directed toward primary care doctors, specialists, community health promoters (*promotores de salud*), nurses, and bacteriologists, and provides instruction on cardiology and the treatment of high blood pressure, diabetes, dyslipidemias, and the use of health software. To date, *De Todo Corazón* is responsible for the training of 200 general practitioners, 20 specialists, 150 community health promoters, 180 nurses, and 50 bacteriologists.

The medical care component includes yearly checkups by a general practitioner, laboratory tests, prescriptions, and the necessary referrals to cardiologists or internists. Specialized doctors reassess any preliminary diagnoses, determine cardiovascular risk—in part with the help of medical software—and develop a monitoring and treatment plan.

Health education is a critical aspect of the program's prevention focus. Mutual SER community health promoters and sponsors (community leaders) accompany doctors during home visits to patients at high risk for heart disease or those who have suffered cardiovascular episodes. During these visits, the sponsors inform, train and educate patients and their families about healthy lifestyles, disease risk factors and the importance of following a disease management plan. The program's prevention strategy also includes organizing 40-person clubs that meet monthly for workshops, games and recreational activities that focus on the importance of diet and healthy habits.

The number of people served by the program increased from 4,000 people in 2004 to 21,982 in 2007. Additionally, 69 percent of patients adhere to the program's follow-up and educational regimens. *De Todo Corazón* clubs have also taken off in popularity. By the end of 2007, 322 of the 481 existing clubs (67 percent) were meeting regularly.

Similar improvements are documented in regard to the health of poor

patients at high risk for heart disease—a number that has fallen by 9 percentage points (from 55 to 46 percent) within target communities. At the end of 2008, 74 percent of patients had reached an acceptable diastolic blood pressure, compared to 32 percent in 2004. Likewise, the number of patients who met their target LDL cholesterol levels rose by 29 percentage points (from 25 to 54 percent).

CERREJÓN—PUBLIC HOSPITALS: UNIDAD MÓVIL DE SALUD (UMS)

The department of La Guajira contains the country's largest indigenous population. Many rural residents historically face barriers to medical access—a result of geographic isolation, language barriers and high costs, among other factors. Aware of these obstacles, the mining company Cerrejón acquired a mobile health and dental services unit to facilitate and improve health services for people residing in the municipalities of Barrancas, Hatonuevo and Albania.

The *Unidad Móvil de Salud* (UMS)—launched in July 2008—operates a mobile medical assistance program that provides individual, comprehensive diagnoses and develops activities for promoting health and the prevention of disease. Cerrejón coordinates the programs, maintains the UMS vehicle and provides medical supplies while regional hospitals are responsible for finding the necessary doctors, nurses, lab technicians, and community health promoters. By the end of 2008, UMS had launched services in 30 communities within the three target municipalities.

The UMS developed as a collaborative agreement among Cerrejón, municipal secretaries of health and public hospitals, including Nuestra Señora del Pilar in Barrancas, Nuestra Señora del Carmen in Hatonuevo and San Rafael in Albania. The support of the department-level Office of the Secretary of Health further supports the UMS mission.

The UMS vehicle functions as a mobile primary care center and offers general medicine, gynecological and dental services. Medical staff from public hospitals (doctors, nurses, and paramedics) provide basic health services in the areas of childhood care, adolescent medicine (10 to 29 years old), women's health (pregnancy and family planning), and adult medicine.

To guarantee that the neediest populations are being served, the UMS assesses its target communities on a monthly basis. A regional hospital then sends a health promoter to each community to identify patients, make appointments and set-up educational and other activities in anticipation of the arrival of the UMS.

Working-level discussions between the Ministry of Social Protection and groups involved in social responsibility could help promote greater knowledge among corporations about the health needs of marginalized communities and how to address them, spurring their involvement.



The UMS—relying on \$70,000 annually for upkeep—is growing quickly. It went from serving 239 patients at its launch to serving 11,459 children, adults and seniors by December 2009. In 2010, UMS services focused on primary care (32.0 percent of interventions), oral hygiene (22.5 percent), dental services (14.5 percent), nutrition, optometry (4.2 percent), child development (4.7 percent), and family planning (2.0 percent). In addition, 4.5 percent of the women received pap smears to screen for cervical cancer; 10.0 percent of these then received an additional ultrasound scan. Beyond that, the UMS provided 568 laboratory tests along with prenatal care for 40 women, high blood pressure and diabetes treatment for 82 people and vaccinations for 236 patients.

Besides strengthening ties to the community and its leaders, improving patient-doctor trust and building a collaborative relationship with the region's institutional hospitals, the UMS has yielded other impressive achievements. The training of hospital doctors and nurses resulted in effective and timely diagnoses, and educational campaigns taught people how to apply for government health coverage to obtain medication. Epidemiologic data show that illnesses relating to a lack of primary health care—such as poor maternal and child health—decreased.

Although on a lesser scale, specialized medical services such as gynecology, ophthalmology, pediatrics, orthopedics, and surgery (for 0.6 percent of patients) were also offered. The campaign for early detection of cervical cancer through pap smears stands out: it diagnosed 95 positive cases, representing 9.45 percent of the women tested, who were then offered additional treatment.

PROPAL—MUNICIPAL GOVERNMENTS: SALUD Y SANEAMIENTO BÁSICO

Recognizing the poor living conditions of the communities where its plants are located, Propal, a leading paper manufacturing company, launched a multi-pronged effort to promote social development and improve the standard of living. This included the creation of the *Fundación Propal* to administer social development projects. Fundamental to the Propal initiative is its belief that greater results can be achieved in collaboration. To that end it works through community participation and inter-institutional partnerships with the government of Cauca department, city governments, international agencies, and other local companies. Funding comes from this broad range of sources.

Launched in 1993, *Fundación Propal's Salud y Saneamiento Básico* program includes a medical center, community health projects and basic sanitation. This program expands social inclusion by offering otherwise scarce or non-existent quality care, including specialized medicine, to communities that are vulnerable due to socioeconomic conditions (in the bottom two-fifths of the income hierarchy), race and ethnicity (Afro-Colombians and indigenous populations), and/or social circumstances (mainly single, female-run households). In Cauca department, *Salud y Saneamiento Básico* focuses on the municipalities of Puerto Tejada, Gauchené, Villa Rica, and Caloto.

The medical center brings comprehensive general and specialized medicine—including diagnostic imaging, mammograms, fetal monitoring, and specialized lab work—to the communities. At the same time, the community health project focuses on education campaigns regarding basic public health and preventable illnesses. The basic sanitation component—designed and administered with support from Cementos Argos and Pavco—is dedicated to making drinking water widely available.

Although the program is fairly new, results are already available. From January to September 2010, the medical center recorded 113,800 health consultations. Services for most patients were paid for by the subsidized insurance regime, but 835 people who have yet to be affiliated to it received care completely free of cost. (By 2015, the subsidized regime is expected to include all those who cannot afford to enroll in the contributory regime.) In turn, the community health project completed an average of four days of service per month, offering medical attention in the form of pap smears, water fluoridation, deworming, and medication dispensation. Additionally, prevention and health promotion campaigns reached 4,962 people, including pregnant women, the disabled, older adults, and children under age two. An

additional 2,783 school-age children and adolescents also took part in the education program. The basic sanitation project has yielded improvements in 11 water systems (benefiting 180 families) and provided nine educational centers with sanitary kits.

● **THE THREE CASES—IMPACT AND SCALABILITY**

The experience of these joint ventures demonstrates the importance and power of collaborative action between the private, for-profit sector and government entities to improve health care for vulnerable communities. Over time, the three programs have expanded their coverage to new populations and geographic areas, thanks in large part to their strong working relationships with local governments. While focused on primary care, these programs venture as well into specialized medicine, mainly for illnesses of high incidence and high mortality rates in Colombia, such as heart disease and cervical cancer. They also serve remote locations with ongoing attention to health care needs, for example providing screening tests such as mammograms and laboratory tests—normally offered only in the largest cities—to populations marginalized by geographic isolation. In this sense, they respond to the non-communicable chronic illnesses increasingly affecting the Americas and overwhelming traditional basic care programs.

In spite of the successes achieved in making care available to vulnerable communities, obstacles to access remain. Even with these programs, geographic isolation remains one of the greatest impediments for indigenous groups, Afro-Colombians, the rural poor, and the elderly. Other challenges include communication difficulties due to linguistic and cultural differences (in the UMS case, 44 percent of the population served is indigenous) and limitations in the government-subsidized Mandatory Health Plan. Government-subsidized health insurance is restricted to primary-level interventions, excluding such secondary-level care as treatment for complications of chronic conditions like diabetes and hypertension or visual and mental health care, which disproportionately affect the elderly. While recently enacted laws (*Sentencia 760* from the Constitutional Court and *Ley 1438* of 2011) have mandated the unification of the benefits package for both regimes, it remains to be seen when the social security system will, in practice, begin to provide coverage for these diseases.

Further, if these programs are to bring about far-reaching changes in Colombia's health system, they must achieve scalability—understood here as

the capacity to expand a process without diminishing the quality of the service. Some have already begun to do so. Before *De Todo Corazón* was implemented, patients received only minimal health services in their local communities. Specialized medicine such as cardiology services was available only in cities, which meant that patients would have to travel to receive medical care. But follow-up care was often inaccessible as patients often lacked the financial means to travel for additional doctor visits. This program directly addressed that barrier. Patients could access cardiologists and nutritionists, specialized medical laboratories, electrocardiograms, and drug dispensation in their own communities.

Since starting with 4,000 patients in 2004, *De Todo Corazón* has gradually grown with annual increases of 50 percent. Without private funding or foundation support, the program's structure is one that can be replicated in both urban and rural areas, either in Colombia or elsewhere, where geographic and other barriers result in inadequate care for vulnerable populations. One lesson learned is the importance of enlisting the participation of community leaders who live in the same areas as the patients. Another key practice is to pool patients according to their place of residence, which facilitates the work of health professionals in providing follow-up medical attention.

Similarly, other companies or the government—either in Colombia or in countries with geographic and economic conditions similar to those of rural La Guajira—can replicate the *Unidad Móvil de Salud* program. In contrast to the *De Todo Corazón* program, the UMS provides health care services in dispersed communities where small population sizes often do not justify the construction of permanent health centers. The mobile clinic provides a means of taking health care straight to these residents' homes. What is needed, though, is an economic evaluation of the model to determine if it can be feasibly and justifiably implemented elsewhere in the country.

For *Fundación Propal*, *Salud y Saneamiento Básico* has expanded the reach of its community health projects in conjunction with municipal governments. But it is also exploring options to augment service delivery through a mobile clinic similar to the UMS model launched by Cerrejón.

In each of these cases, however, the programs depend on a corporation to cover essential operating expenses—a worthy expense given the positive community reaction to these initiatives. In the case of *De Todo Corazón* the necessary financial resources to run the program are wholly underwritten by Mutual SER and Pfizer, since the subsidized government insurance plan does not cover the targeted diseases. Cerrejón's *Unidad Móvil de Salud* began with a \$169,000 investment of corporate funds to buy the vehicle, supplies and

medical equipment, and each year Cerrejón invests an additional \$70,000 to pay for vehicle maintenance, supplies, health professional fees, a driver, security guards, and fuel. The financing mechanism for the *Salud y Saneamiento Básico* program is slightly more diversified, with funds being generated through a combination of company resources and reduced-rate services to patients, but *Fundación Propal* must still cover the expenses of a large staff of general practitioners, specialists and assistants.

If, in shifting priorities or for any other reason, these companies were to decide to focus on another area or reduce their budget, the operation of the programs would be jeopardized. Thus, broad-based financing is a major obstacle to scaling up interventions. Initiatives designed to expand access to marginalized populations must seek diverse and sustainable sources of funding. While for-profit companies like Cerrejón, Propal and Pfizer are making an impact, this is not common for Colombia. In general, the country's private sector shows a growing interest in social inclusion, but with a greater focus on education and the environment. Of the 15 health-related initiatives identified in Colombia as part of this study, only three companies (15 percent) are part of the health industry, despite health companies' rising importance for the national economy. An additional issue is how to design public-private partnerships so that activities extend beyond social responsibility. Working-level discussions between the Ministry of Social Protection and groups involved in social responsibility—including *Colombia Incluyente* and the Colombian Business Council for Sustainable Development—could help promote greater knowledge among corporations about the health needs of marginalized communities and how to address them, spurring their involvement.

None of these case studies utilizes telemedicine or other eHealth initiatives to improve access. But as seen in India and other emerging economies, the effective harnessing of existing technologies can overcome some of the geographical and financial obstacles to health care provision in remote communities. Wireless networks can reach much deeper into a country than any other technology to collect health data, support diagnoses and treatment, and advance education and research.¹¹ They make medical consultation, para-clinical analysis and interpretation of imaging data possible without requiring the physical presence of specialists. In so doing, they improve the local capacity for medical response and amplify the portfolio of services available to these populations. In turn, this reduces the need for referrals, cutting costs, eliminating the need for travel, and ultimately improving patients' quality of life.



Mexico:

A PUSH TOWARD UNIVERSAL COVERAGE, BUT WIDESPREAD ACCESS YET TO BE REACHED

Mexico's health care dynamics have changed dramatically in the last decade. Only 10 years ago, nearly 10 million Mexicans lacked any type of medical care, and more than 50 million people were not covered by social security. For those that did have insurance, coverage was regressive in that the poor faced the greatest health care costs in proportion to their income. Compared to its Latin American neighbors, Mexico spent below the regional average on health care in 2003—about 6.1 percent of GDP. Among other things these low levels of funding prevented Mexico from addressing the shifting burden of disease to chronic, long-term illnesses.¹²

But a far-reaching reform of the health care system—passed into law in April 2003 and implemented in January 2004—established a new System for Social Protection in Health (SSPH). The SSPH, which includes the *Seguro Popular* public health insurance program, sought to ensure that all had the right to health care as recognized in the Mexican Constitution. In the first half of 2011, nearly 50 percent of the Mexican population is expected to be affiliated to *Seguro Popular*. The SSPH has also improved public health centers and guaranteed quality services—through new accreditation methods and deployment of health quality indicators—to those that historically lacked access to health care.

Nonetheless, a lack of access to care and medication persists in highly marginalized urban and rural areas today. This gap in Mexican health care reinforces the exclusion of marginalized groups and thus the overall development of Mexican society. Here, the private sector—a significant, untapped resource in the delivery of care—can play an important role in the provision of outpatient and hospital care for those affiliated to *Seguro Popular* but who cannot access public health services.



OVERVIEW OF EXAMPLES

Given the impressive successes of *Seguro Popular* but also the challenges that exist in reaching certain marginalized segments of the population, our research looked at nine examples of private organizations seeking to fill the gaps that continue to exist today. Again, these are simply a representation of

efforts across geographic, thematic and industrial lines of private-sector initiatives to increase access for marginalized groups in Mexico. Of these nine cases, three were selected for further research based on geographic diversity, the method used to support access to health care and intended beneficiaries. Each program is described in greater detail below.

In all three examples—as is the case for private organizations overall—the strategies to expand health care access can be thought of as one part of a nationwide strategy. Each also responds to an unfortunate reality in Mexico: the unequal distribution of disease, determined by a population’s isolation and level of poverty. For example, in areas with a high concentration of marginalized groups, infectious diseases are the leading cause of infant mortality and a lack of medical services and trained personnel result in high rates of maternal mortality. This is not the case among middle- and high-income groups.

Each case study shares a common goal: facilitating access to care for groups who traditionally face barriers. Target communities are selected if they either fall outside of the social welfare system or the services offered by the Secretary of Health, or if they lack the means to pay for conventional health insurance. These examples were chosen because they facilitate access to health care services for clearly identified populations that would otherwise have great difficulty in obtaining such access.

The first case is *Sistemas Médicos Nacionales, S.A. de C.V. (SIMNSA)*, a profit-driven company established in 1992 that sells health insurance to persons living in Mexico but working in the United States. It is the first Mexican health insurance firm authorized to do business in California. The target clientele is Mexican workers in California who purchase HMO or PPO plans either directly (supplemented by their employers) or through unions in San Diego. These workers fall in the middle-income range (with earnings above the lowest-income levels in Mexico), but still cannot afford U.S. health insurance plans. With SIMNSA coverage, they gain access to medical services in Mexican cities.

The second case is the initiative of *Fundación Adelaida Lafón*, an NGO that runs a community clinic closely linked to Muguerza de Monterrey Hospital—now a part of the Christus Muguerza Group health care system—in the state of Nuevo León. Since its founding in the 1930s, the hospital has recognized the need to provide care for those of limited means and maintained a reserved area for such patients. At the end of the 1990s, administrators expanded on this service and began to offer care in a community clinic located in an inner-city neighborhood of Monterrey. The clinic is run by *Fundación Adelaida*

Lafón, which also serves an indigenous community in San Luis Potosí.

For both SIMNSA and *Fundación Adelaida Lafón*, only limited coordination is carried out with public services. At a national level, no official body exists at the Ministry of Health to regulate, coordinate or promote public-private collaboration. This means that it then falls on state-level Secretariats of Health to create any alliances with the private sector. But as discussed later in this section, many opportunities exist for greater collaboration.

The third case is *Fundación Mexicana para la Planeación Familiar* (Mexfam), a non-profit civil society organization founded in 1965 and dedicated to promoting comprehensive family planning. It provides information along with educational and clinical services in sexual and reproductive health to disadvantaged groups—mainly women and school-age adolescents and youth. Mexfam activities are carried out throughout the country but always in areas where approximately 25 percent of the population is considered marginalized.



THE THREE CASES—EXPANDING ACCESS

As in the case of Colombia, we define access to health care services based on utilization and the number of people receiving particular services. However, this data does not allow for an accurate assessment of the level of quality of each service.

SISTEMAS MÉDICOS NACIONALES, S.A. DE C.V. (SIMNSA)

Many low-wage documented Mexican workers who either reside in the U.S. or frequently travel between the two countries cannot afford to pay the high costs of U.S. health insurance. The result is often lack of access to preventative care or debt-burdening payments at times of immediate need to critical health care services. The *Sistemas Médicos Nacionales, S.A. de C.V. (SIMNSA)* sought to change this reality by offering discounted insurance policies to firms of 50 or more workers in the San Diego area.

The company or union can choose to buy an individual or family plan. According to SIMNSA, the company makes the decision and asks the worker to pay a portion of the cost. Commonly, the employer agrees to pay for the individual portion of coverage, while the worker assumes responsibility for the family portion. An individual plan costs \$1,400 per year, while a family plan costs \$3,900 annually. This rate—although still costly—is more affordable for the average plan participant whose income ranges from \$5 to \$7 per hour.

For these workers, the top health concerns are in the areas of reproductive health and work-related injuries, but chronic illnesses are a growing health need. In turn, the SIMNSA insurance plan covers services such as outpatient treatment, prescriptions, hospitalizations, surgeries, laboratory tests, mental health services, immunizations, cancer screenings, dental and optometry services, and prenatal, labor and neonatal care.

All services, with the exception of emergency medical attention, are provided in four cities on the Mexican side of the U.S.-Mexico border, relying on two main hospital units and a network of about 200 doctors. To stay competitive, SIMNSA partnered with Health Net, one of the largest publicly-traded health insurers in the United States, in an agreement where Health Net-affiliated providers offer emergency services in the United States.¹³ Plan participants can still enroll in *Seguro Popular* when living in Mexico but many remain with SIMNSA due to lack of knowledge about their eligibility or low confidence in the reliability or quality of services offered under *Seguro Popular*.

In 2000, SIMNSA received approval to operate as a licensed HMO in the state of California, although it had already been operating there for years (the relevant legislation, the Knox-Keene Health Care Service Plan Act of 1975, did not have provisions for licensing foreign health plans). At the time, it provided care to approximately 10,000 members from over 100 employer groups. In June 2004, SIMNSA had grown to 14,098 affiliates. By October 2007, the SIMNSA network had grown to about 20,000 members. Of these, 17,000 obtained coverage directly from SIMNSA or in California through its arrangement with Health Net. The remainder was covered through U.S. insurance companies that buy the service from SIMNSA.

FUNDACIÓN ADELAIDA LAFÓN—MUGUERZA DE MONTERREY HOSPITAL

In Monterrey, as is the case in many areas of Mexico, the poor population is often dependent on the informal economy. Many lack access to services offered by formal sector social welfare institutions, and while they may be eligible for *Seguro Popular*, the public insurance plan does not cover all of their needs.

This creates huge disparities in health care access and is the principal reason that the Muguerza de Monterrey Hospital in Nuevo León launched and backs *Fundación Adelaida Lafón*. The community clinic serves the residents of a poor Monterrey neighborhood, who often work in the informal economy

and can only access the minimal public services available. *Seguro Popular*, which has still yet to reach its nationwide coverage goal, remains unavailable for many in this zone.¹⁴

The *Fundación* also runs a second clinic in San Luis Potosí that serves an estimated 25,000 people from poor, indigenous rural communities where most of the heads of households work in subsistence farming and earn small, irregular incomes. Both clinics are dedicated to both improving health care as well as developing initiatives that support the communities' overall social and economic development.

The *Fundación's* health care centers are primary-level facilities that offer services 24 hours a day in family medicine, pediatrics and gynecology. Patients have access to the following: diagnostic testing through x-rays, ultrasound and laboratory tests; emergency services; general surgery; psychology; nutrition; and speech and physical therapy. The San Luis Potosí clinic serves clients whether or not they are affiliated to *Seguro Popular*. However, no relationship exists with the state Secretariat of Health since the public sector perceives the effort as competition rather than as a potential collaborator.

A primary care consultation costs about 50 pesos (about \$4), compared to 150 to 200 pesos at private institutions (\$12 to \$16). The cost of an x-ray or pap smear is about the same. The low fees at the clinic—which do not vary according to the patient's socioeconomic level—are structured to be affordable, while still covering about 75 percent of operating costs. Mugerza Hospital covers the remainder. Patients that cannot afford to pay are referred to the social service office and may be exempted from payment. In return, the patient must commit—either personally or through a family member—to volunteer at the health care center or in the community as a form of compensation. The Christus Mugerza group in turn benefits through increased brand recognition and positive brand association.

FUNDACIÓN MEXICANA PARA LA PLANEACIÓN FAMILIAR, A.C. (MEXFAM)

The founding of *Fundación Mexicana para la Planeación Familiar, A.C.* (Mexfam) in 1965 resulted from a need to create greater awareness of and access to family planning options in the most marginalized areas of the country. More than 40 years later it continues to offer new services designed to respond to Mexico's changing health needs.

Mexfam serves three primary constituencies: disadvantaged groups (low-income individuals, women, adolescents, and youth); marginalized people

The broad coverage provided by the System for Social Protection in Health (*Seguro Popular*) presents an opportunity for private organizations to provide access to services for marginalized populations in communities lacking health facilities.



without access to social welfare services; and professionals in the health and education fields (youth and community advocates, educators, doctors, nurses, social workers, and psychologists). It operates in 19 of Mexico's 32 states (including the Federal District), in which 25 percent of the country's most marginalized people reside.

Activities are concentrated on four programs. The *Programa Comunitario Rural* trains community advocates (*promotores comunitarios*) on issues of family planning, contraceptive use and other health issues. In turn, the *promotores* lead community discussions, participate in health fairs, conduct home visits, and distribute posters and brochures at strategic community locations. The *Programa Comunitario Urbano* is similar to the *Programa Comunitario Rural* and is implemented in outlying urban areas, poor inner-city neighborhoods and squatter settlements. The main difference between the two programs is that the urban *promotores* link up with existing initiatives, conduct the training sessions in schools and distribute contraception at medical clinics, whereas the rural *promotores* lead the initiatives and work in more community-based settings.

The other two initiatives incorporate service delivery at clinics. The *Programa Gente Joven* targets youth and carries out its activities through workshops and cultural and academic activities designed to improve their physical, emotional and social well-being. It includes *Centros de Servicios Médicos Gente Joven*, which are youth-focused facilities that serve the program objectives. The *Programa de Centros de Servicios Médicos* includes Mexfam clinics that provide general and specialized medical care in seven areas related to reproductive health: gynecology, pediatrics, urology, gastroenterology, dermatology, internal medicine, and surgery.

The number of services provided by Mexfam continues to rapidly expand. From 2006 to 2008, Mexfam saw a 34 percent increase in the number of its beneficiaries—from 3,278,900 to 4,394,135. These numbers include people who received medical services, participated in a contraceptive consultation or

distribution program or participated in a training or information session. In 2008, Mexfam provided contraceptive counseling to 467,000 individuals, screened 131,000 people for breast and cervical cancer, trained 157,000 youth through its *Programa Gente Joven*, offered 18,571 people services related to HIV/AIDS testing and prevention, performed 10,000 pediatric consultations, and delivered 2,392 babies.

Like its services, Mexfam's operating budget generally continues to grow, albeit at a slower pace than its increase in services. However, from 2006 to 2007, net revenue decreased by 12 percent—from \$11,587,516 to \$10,342,645. The majority of these funds came from foundation grants and philanthropic donations, subsidies, and interest earned on income. Mexfam also earns some revenue through the sale of contraceptives and other medications at its clinics and centers.

● ● **THE THREE CASES—IMPACT AND SCALABILITY**

Despite the implementation in recent years of a national health plan striving for universal coverage, major inadequacies and challenges persist. Isolated communities, highly marginalized sectors and/or indigenous communities continue to be excluded from social services. Even under *Seguro Popular*, coverage remains low in certain areas (for example, 39 percent in the state of Nuevo León in 2008). Furthermore, even under a policy of social inclusion, it will be a challenge to achieve and maintain universal coverage (public or private) that provides care for a broad number of illnesses while doing so with high-quality service delivery.

All three cases described in this paper have improved the health and overall quality of life of their program beneficiaries, although through distinct methods and with differing target populations. The successful experience of the *Fundación Adelaida Lafón* clinics is attributed to the support (financial, human, and technological) received from the Muguerza de Monterrey Hospital and its collaborative work with local communities. Similarly, Mexfam's success lies partly in its community advocates and education campaigns in local neighborhoods, as well as its ability to consistently update its methodologies in response to changing health needs. SIMNSA's success, in contrast, arose from its ability to identify and market to a specific market niche: documented Mexican workers employed in U.S. border communities who are unable to pay the high costs of U.S. health coverage.

While these programs have significantly expanded the health care options

for some of Mexico's neediest people, the true test for them and for Mexico's overall health care will be whether they can meet continued obstacles to access and expand their operations. As in Colombia, financing is precarious for these three programs. Lacking broad corporate support, Mexfam relies on grants and donations, but has recently broadened its focus to research and other activities in order to attract greater financing. In the case of SIMNSA and *Fundación Adelaida Lafón*, which combine high patient volumes with low costs, financing of operations largely comes from the beneficiaries themselves, showing how the private sector can serve marginalized groups in a self-sustaining business model. And unlike the programs in Colombia—two of which are administered by companies outside the health sector—the initiatives in Mexico are largely run by foundations or businesses that specifically operate in the health industry, meaning they may have a greater long-term stake in creating models to expand access to health services.

Beyond financing, both SIMNSA and *Fundación Adelaida Lafón* face distinct constraints to access. SIMNSA's activities and strategies are restricted to a specific geographical region and to only those who can afford to pay the reduced health insurance rates. Its principal challenge is in increasing coverage and finding ways to offer services to non-affiliated populations.

In the case of the *Fundación Adelaida Lafón* clinics, obstacles to access arise when individuals lack sufficient resources to pay even the nominal service fees and do not qualify for exemption through social service. Additionally, duplicating or expanding the *Fundación's* network of low-cost clinics to other areas with high concentrations of marginalized groups would require the support of large hospital firms, many of which are generally not receptive to such projects and partnerships. Nonetheless, the Christus Health Group may have an answer, as going forward it plans to establish a *Fundación* clinic in each municipality where the consortium opens a highly specialized hospital. In this way, as the for-profit hospital network grows, so will the number of low-cost *Fundación* clinics.

At the moment, plans to open highly specialized hospitals are concentrated in the northern states of Nuevo León, Coahuila, Chihuahua, and Tamaulipas with a project in the works to also open a hospital in the southern state of Chiapas. The model would appear to be replicable as long as patients can continue to fund the majority of operating costs and at the same time the clinics strengthen brand association of the new hospitals.

Collaborations between the *Fundación* and the public sector, especially municipal governments, do exist, but a stronger working relationship would

facilitate replication. In San Luis Potosí, for example, the clinic treats patients covered by *Seguro Popular*, but no formal agreement exists. There, as in the city of Monterrey, it would be conceivable to sign agreements where the private clinics would provide care to people covered by *Seguro Popular* for specific health issues and receive payment for that treatment through the System for Social Protection in Health.

For its part, SIMNSA's endeavor could be expanded—either by SIMNSA itself or another organization—into the main cities along the U.S.-Mexico border. Doing so would mean extending health care access to a sector of the population (and their families) that, while not the most indigent, cannot easily acquire private health insurance due to an inability to pay or an absent culture of being insured. Given the profile of workers enrolled in SIMNSA, the strategy seems to be feasible in the main border cities. What is more, growth in the medical tourism industry could trigger a spike in demand among workers in the United States. SIMNSA recently began to negotiate with other firms to promote the sale of its policies in the United States and to strengthen its capacity to respond to Mexico's health needs.

SIMNSA could also potentially engage in collaborative efforts with the public sector. Under the framework of the federal *Seguro Popular*, SIMNSA could work out an agreement by which its members receive care at health facilities run by border states' Secretariats of Health. These publicly-run medical centers would be able to compete with the private entities now under SIMNSA contract.

Mexfam, which is now active in more than half of Mexico and has long been recognized for its work with marginalized groups, has already demonstrated a notable capacity for expanding its strategy and services. It has also historically maintained a broad partnership with the public sector to develop programs and public health policies pertinent to reproductive health at the local, state and federal levels. When it was founded, Mexfam's services included family planning, maternal and child health, and sexual and reproductive education. Forty-five years later, its services have been expanded to include raising nutrition awareness, building latrines in marginal zones, treating parasites, organizing family vegetable gardens, and implementing sanitation projects. It could achieve even greater coverage and expand to state health care domains and medical facilities where operations do not currently exist—both by pursuing some of the strategies it has followed in the past and by creating new structures of collaboration with the government. This could entail joint efforts in administration of the health care system and expansion of

coverage by the System for Social Protection in Health.

All three of these entities face common challenges of access and scalability, providing valuable lessons for other organizations in Mexico and beyond, which seek to improve health care access and overall social inclusion. First, private entities should maintain regular contact with health officials and public institutions to coordinate similar or complementary efforts. Second, the public sector should view corporations and NGOs as a source of support and collaboration rather than as competitors for patients or clients. Third, the broad coverage provided by the System for Social Protection in Health (*Seguro Popular*) presents an opportunity for private organizations to provide access to services for marginalized populations in communities lacking health facilities. Legal and administrative opportunities exist for striking partnership agreements between the public and private sectors. Fourth, even with *Seguro Popular*, efforts are needed to provide access to care for people of limited resources. Finally, private organizations should conduct systematic evaluations to be able to then share successful experiences and lessons learned, as well as the causes of unsuccessful efforts. Such evaluations should also look at the quality of service both in terms of its technical aspects and of meeting the needs of those served.





Conclusions

Regionally, and specifically in Mexico and Colombia, it is clear that new practices are increasingly allowing marginalized populations—albeit through targeted interventions—to access primary health care services. But the case studies presented demonstrate that challenges remain for effectively addressing systemic challenges of society-wide health care inclusion. Here's what we found:

First, even in countries with health care models that seek to broadly expand access or even achieve universal access, significant gaps in access still exist for certain populations. The private sector can help to fill this void through health care financing, direct service provision, low-cost medical treatment, eHealth/mHealth, and prevention programs and education. The public system—whether through *Seguro Popular* in Mexico or *Ley 100* in Colombia—does not reach the entire population due to insufficient allocation of funds, the physical distribution of health care providers, lack of knowledge and awareness of the benefits available, and social stigma, among other reasons. In fact, for geographically isolated communities, the urban or rural poor, or indigenous and Afro-Latino populations, inclusive public policies can actually hamper their ability to receive quality health care services if such policies then yield an attitude of complacency from the health care industry.

Second, cross-sector collaboration increases an initiative's scalability and sustainability. Involvement of the public sector, hospitals and community leaders in the design and implementation of a targeted health program will lead to greater buy-in of the desired outcome and results. This is also true insofar as the need to bring together multiple stakeholders to provide the funding for a program to ensure its long-term sustainability and scalability. As seen in the case of the *Salud y Saneamiento Básico* program run by *Fundación Propal*, the effective engagement of local and regional government along with other businesses and even multilateral agencies will increase the potential longevity of an initiative. Much of the success of the *Fundación Adelaida Lafón* and Mexfam programs is a result of their community-wide collaboration both in terms of their financing and programming models. At the same time, broad-based collaboration also helps to ensure that an intervention is responding to some of the more pressing local health needs.

Third, the private sector has yet to fully appreciate the potential for profit when investing in health care initiatives that reach excluded groups. None of the examples involves for-profit service provision to marginalized populations. In Colombia, companies like Cerrejón and Propal launched their health care efforts to respond to the needs of the local population where corporate operations exist. But neither company is in the health care field. In fact, the majority of health investments come from businesses that traditionally have worked in isolated or vulnerable communities. More can be done by health care companies to better serve marginalized groups in a way that not only responds to corporate social responsibility goals but also directly or indirectly drives profits. The Pfizer–Mutual SER program is one example of a program that indirectly benefits the companies through positive brand association. Companies in the health industry can also expand their markets by finding ways to provide low-cost services to populations who have the potential to become part of their consumer base. A first step could be to conduct a broad search for services that the poor want and can be administered at low cost with potential financial returns for the firm.

Fourth, health outcomes are often measured in terms of access to care rather than access to quality care. But both indicators are critical to determining whether an intervention is in fact improving the overall care of the targeted population. Each program analyzed has shown great increases in the number of patients reached or number of services used. But the fundamental question of how these interventions have affected the overall health of the population remains. This is what matters for creating the opportunities that will lead to greater socioeconomic mobility and overall social inclusion.

Fifth, health delivery interventions have greater society-wide benefits when combined with public education efforts. While huge advances have been made in reducing infectious diseases and infant mortality, health care systems and providers are facing a growing burden of chronic, non-communicable diseases such as diabetes, cardiovascular and respiratory disease, and cancer. Education focused on improved diet and health practices is critical for increasing awareness about the risk factors for these diseases. Each of the case studies presented (with the exception of the SIMNSA insurance regime) incorporated education as a key component of the programs.





Recommendations

First, greater utilization of information and communications technology (ICT), through eHealth and mHealth initiatives, can expand access to quality care, reduce inefficiencies and cut costs. India is a prime example of how ICTs can expand health care access, but this approach has yet to catch on throughout Latin America. In this, partnership across sectors and providers is crucial to generate impact, sustainability and scalability. Companies are using video and mobile platforms to provide consumers with information; to connect clinics, physicians and patients otherwise separated from one another; and to track population migration and the spread of disease. Better optimization of ICTs will enhance access but will lead to even greater efficiency gains in the quality of care that is delivered, especially in remote areas. For example, eHealth and mHealth offer the ability for highly-skilled doctors located in urban areas to remotely diagnose and treat patients.

Second, a regional clearinghouse of for-profit models that serve marginalized populations can be an effective strategy for consolidating efforts. This study is not wholly comprehensive of the types of health interventions in the region, but it is representative of the efforts being carried out in Mexico and Colombia. Here, individual efforts are producing important lessons learned that could be good reference points for the larger health community. But a region-wide platform—both online and through working-level discussions—dedicated to for-profit models that address the primary health needs of excluded groups could lead to identification of a series of shared, cross-cutting best practices. One model for this is the Center for Health Market Innovations.

Third, regular dialogue between health ministries or local departments and the private sector is necessary to harmonize health care delivery efforts. As in the area of education, which is also studied in the Americas Society Social Inclusion Program, a certain level of distrust exists between the public and private sectors. Greater confidence in working together is seen at the local or state/department levels, but still, the two sectors could more effectively address the primary health care needs of excluded groups with better triangulation of: a) their service delivery efforts; b) the on-the-ground policy dynamics; and c) the actual health needs as shown by national health data. This can only be achieved through regular dialogue.

In the end, access to quality health care is a fundamental prerequisite for an individual's social mobility and labor productivity, and for society's ultimate economic growth and competitiveness. Put in a global context, this is precisely why three of the eight Millennium Development Goals—reduce child mortality, improve maternal health, and combat HIV/AIDS, malaria and other diseases—are focused on these critical health improvements.





ENDNOTES

- 1 Julio Frenk, "Assessing Mexico's Health System Reform" (Keynote Remarks, Health Care in the Americas: Public-Private Efforts to Increase Access, Americas Society, New York, NY, December 8, 2010).
- 2 Pol De Vos, Wim De Ceukelaire and Patrick Van der Stuyft, "Colombia and Cuba, Contrasting Models in Latin America's Health Sector Reform," *Tropical Medicine and International Health* 11 (10) (2006):1604-1612.
- 3 United Nations, *The Millennium Development Goals Report 2010* (New York: United Nations, 2010), 26.
- 4 World Health Organization, *Trends in Maternal Mortality:1990 to 2008* (Geneva, Switzerland: World Health Organization, 2010).
- 5 PAHO Health Information Platform, *Basic Health Indicators – Most Requested: Indicator Series*, http://ais.paho.org/phis/viz/mfr_indicatorserietable.asp (accessed February 17, 2011).
- 6 "Latin America's Bill of Health," *Americas Quarterly* 4 (3) (Fall 2010):55-59.
- 7 Joel Selanikio, "The Mobile Revolution in Health Care," *Americas Quarterly* 4 (3) (Summer 2010):64-65; Donika Dimovska, "Filling the Gap," *Americas Quarterly* 4 (3) (Summer 2010):66-71.
- 8 Luis Jorge Garay, "Crisis, exclusión social y democratización en Colombia" (working paper, *Universidad Nacional de Colombia*, 2003).
- 9 Cristina Torres, "Descendientes de africanos en la Región de las Américas y equidad en materia de salud," *Revista Panamericana de Salud Pública* 11 (5/6) (2002):471-479.
- 10 Luz Dary Salazar Álvarez, "El envejecimiento en Colombia: una construcción social 1970 – 2000," *Red Latinoamericana de Gerontología*, <http://www.gerontologia.org/portal/information/showInformation.php?idinfo=1649> (accessed February 17, 2011).
- 11 David Aylward, Beatriz Leão, Walter Curioso, and Fabiano Cruz. "Can You Heal Me Now?," *Americas Quarterly* 4 (3) (Summer 2010):90.
- 12 Felicia Marie Knaul and Julio Frenk, "Health Insurance in Mexico: Achieving Universal Coverage through Structural Reform," *Health Affairs* 24 (6) (2005):1467.
- 13 Health Net is the biggest health insurance company in the United States, offering its members a variety of plans. It offers many individual and family plans. It covers people working in small companies and people who are self-employed or temporarily out of work. There are ways for choosing different options for each family member. Health Net has a broad range of associates that in turn count on providers practically throughout the United States, especially in Arizona, California, New Jersey, and Oregon.
- 14 In 2008, the *Seguro Popular* coverage in select states reached 39 percent in Nuevo León, 50 percent in Baja California and 55 percent in San Luis Potosí. Even when *Seguro Popular* reaches its nationwide coverage goal, a clinic similar to that of *Fundación Adelaida Lafón* is likely to remain necessary since people may not affiliate themselves and all services may not be covered.