Differences in social health protection between wage earners and the self-employed: Comparative analysis in European and Latin American countries

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Introduction

The idea of a comparative analysis of Latin American and European social health protection for the self-employed responds to a desire to learn more about the implementation of universal health care in Latin American countries.

Latin American countries are currently interested in the reform of health care systems. In recent years, different measures to achieve universal health care coverage have been discussed in Argentina, Brazil, Colombia, Chile, Mexico, Peru and Uruguay.

Historically, access to social health protection in Latin American countries has been offered only to wage earners and their families. As a result, health care systems, in general, are segmented and the access to health protection is unequal. Many countries have tried to face this problems, trying to offer universal coverage to the whole population, including self-employed persons, who are more likely to remain uninsured because they are not compulsory insured through their employers.

However, some difficulties have arisen during the implementation of universal health care in these countries. In this regard, It is important to analyze if there are differences of treatment in social health protection between wage earners and the self-employed in European and Latin American countries, taking into account that, because of the historic development of social health protection in Latin American countries, the self-employed population is more likely to be in a vulnerable situation.

For this reason, it will be useful to analyze if the level of health coverage that is being offered to the self-employed is really attractive, in comparison to the health benefits that a wage earner receives.

European countries have been recognized for developing social security systems that give wide coverage to its citizens under the Welfare State. It is therefore important to compare Latin American policy efforts with the experiences developed in European countries to get ideas about how to guide and strengthen Latin American reforms.

The comparative analysis of European countries will make use of a previous research carried out by the Mutual Information System on Social Protection (MISSOC): Social protection of the self-employed in the Member States of the European Union, of the European Economic Area and in Switzerland. Situation on 1 January 2012. In this document differences of treatment in social health protection of the self-employed have been analyzed. The conclusions of this contribution will be presented in this paper.

Regarding Latin American countries, there is not reliable comparative data available on which to base comparisons about social health protection of the self-employed. We tried to use American Social Security Administration website, which provides comparative information about social security programs throughout the world; however, it is not possible to find the specific differences in social health protection between wage earners and self-employed persons there. For this reason, it was necessary to search on National Social Security Administrations websites, as well as to identify local doctrine that addresses topics such as the evolution of health care reforms; the challenges of health care systems; among others.

Precisely, it is important to mention that we have selected to study only Latin American countries that have made efforts to extend health care coverage to the whole population, namely, Argentina, Brazil, Colombia, Chile, Mexico, Peru and Uruguay. The focus of this research on these seven countries obeys to the fact that it is at time of reforms that government authorities and policy-makers are open to look at comparative experiences to find ideas and solutions to the problems they are facing during the implementation of health care reforms.

Now, it is time to clarify the way the information will be presented. This paper is divided into five sections. This research takes the concept of the self-employed and the definition of social health protection as its starting point in order to understand the object of this study. In the second part, differences of treatment in social health protection between wage earners and self-employed persons are going to be identified. Firstly, this analysis will be presented in relation to European countries. Then, the situation in Latin American countries will be described. The third part of this research presents a comparative analysis about the social health protection for the self-employed in both regions. In this chapter, we will introduce an explanation about the differences of treatment that have been identified and we will analyze if they can be justified. Finally, this paper concludes with a general comment about the necessary arrangements that should be made to fully extend health care coverage to self-employed persons.

1. Working definitions

It is important to start defining the object of this study. This research deals with the differences of treatment between wage earners and self-employed people, regarding social health protection in European and Latin American countries. In this sense, attention will be paid to the concept of self-employed, as well as the social health protection definition.

1.1 Who are self-employed persons?

In this part, we will deal with the legal definition of self-employed persons in the field of social security. Professor Paul Schoukens has explained that, in European countries, the concept of self-employed is not easy to define. In this section, his contribution on this topic will be presented. Then, it will be analyzed

how Latin American countries deal with the concept of self-employed in the field of social security.

The definition of self-employed in social security systems can be positive (when the concept is given within the social security legislation or by referring to other legislation) or negative (when it is defined as a residual category in contrast with an employment and civil servant status). Most European countries follow the negative approach: "a self-employed person is a person practicing a professional activity for the purpose of gain without being a worker or a civil servant. The essence of the definition lies mostly in the second part: the fact of not being a worker (nor a civil servant)".[1] Self-employment "is a leftover category that is delimited against the concept of worker. The professionally active persons that are not workers are, for purposes of social security, usually considered as self-employed".[2]

In Latin American countries, social security legislation does not refer to the definition of the self-employed. Historically, access to social protection was offered only to wage earners and their families. In this regard, when these countries have tried to extend social health protection to the whole population, they have offered voluntary health plans for the uninsured population, including the self-employed.

From this perspective, it has not been really relevant to define the self-employed in social security legislation. People who do not have access to any social health protection scheme (probably, because they are neither wage earners, nor civil servants, nor poor) can hire health plans that are offered by social security institutions. We can find, however, one difference in the relative importance of the need to identify an applicant as a self-employed. In a number of countries, like Argentina or Uruguay, social security administrations take into

[1] Paul Schoukens. *"Comparison of the Social Security Law for Self-Employed Persons in the Member-States of the European Union"*. In Danny Pieters (ed.). Changing work patterns and Social Security, Kluwer International, 2000, p. 63.

[2] Ibidem, p. 64.

account the incomes of the self-employed to define the amount of the contributions that must be paid. In these countries, the social security administration checks the annual tax declaration for this purpose. Although there is no definition of the self-employed in social security law, we can find an indirect relation with tax regulations. In contrast, in other countries, like Peru, self-employed persons are supposed to pay flat contributions, becoming not relevant at all the definition of self-employment in social security.

Notwithstanding this difference, the term “self-employed” in Latin American countries will refer mainly to the following sectors of the economy:

- Independent professionals, who frequently work as doctors, lawyers, architects, engineers, photographers, journalists, writers, artists, web designers, etcetera.

- Entrepreneurs of small business, positioned in a variety of sectors, such as services to buildings, consulting services, machine shops, farming, groceries, textile manufacturing, etcetera.

In spite of the heterogeneity of the self-employed population, taking into account the access to social health protection, two general groups can be identified. On one hand, qualified self-employed workers who can afford their enrollment into a health insurance scheme, either private or public; therefore, there is no lack in social health protection in this sector. On the other hand, low-skilled self-employed workers (most of whom are self-employed just because they do not have other possibility to obtain employment). This sector usually do not get enough incomes to enroll into a health insurance scheme. Even some of them work on the informal economy, which is characterized by evasion of tax law, social security regulations and labour law. In this precarious environment, this part of the self-employed workers do not benefit from any social health protection.

1.2 What is social health protection?

The second component of the object of this research refers to the "social health protection".

In principle, social protection is a means of increasing the income security of an individual. However, the topic of social protection is linked with the need for protection of society itself against the so-called social risks. The effect of a social risk is not confined to the individual but to the society in general. It is the society itself that tries to protect itself against the occurrence of some social risks.

Professor Jos Berghman emphasizes this perspective when he argues that "the effect of income loss associated with the core risk of incapacity for wok is in fact not confined to the person that is directly hit by it. It will reflect on others, even the broader society: from cultural and motivational effects on the children of the unemployed up to political instability and social upheaval".[3]

Then, social protection in the health sector can be called social health protection.

As Professor Danny Pieters mentions, "people can be taken ill or be victim of an accident, they can be born ill or disabled and so on. In all of these cases they will need health care to restore and maintain their health in the best possible way, to relieve their pain and to make their health disorder more bearable by any other means".[4]

In this context, social health protection refers to the need of society to protect itself against the specific risk that face people when they become ill and medical

[3] Jos Berghman. *"Chapter 17: Social protection and social quality in Europe"*. In Beck, W. van der Maesen, L. and Walker A. (eds.), The Social Quality of Europe, Kluwer Law International, The Hague, 1997, p. 225.

[4] Danny Pieters. *Social Security: An Introduction to the Basic Principles*. Second Edition. Kluwer Law International, The Netherlands, 2006, p. 85.

care is required. In such a situation, health services must be available to everyone who needs it. Access to health care must not threaten income sufficiency of individuals.

As “the need for health care is often highly unpredictable and very costly for the individual, although it is predictable and affordable for large groups”,[5] social protection can help to spread the financial burden of health care services so that they become available to all people who need them.

In this sense, social health protection refers to the income protection that should be guaranteed to citizens when medical care is required. Finally, this research addresses social health protection from the point of view of certain segment of society: the self-employed workers.

Now, Professor Kieke Okma and Mister Theodore Marmor have pointed out that usually policy-makers do not pay attention to the income protection goal of health policy: “The attention of policy-makers and commentators alike has shifted away from protecting the incomes of vulnerable groups, focusing instead on disputes about the organization and efficiency of medical care, cost controls and payment modes”.[6] For this reason, it is important to mention that we are not going to deal with the governmental action to improve health care of the self-employed population.

[5] OECD. 1992. *The Reform of Health Care. A comparative Analysis of Seven OECD Countries.* Health Policy Studies Nº 2. Paris: Organization for Economic Development and Co-operation, p. 15.

[6] Kieke Okma and Theodore R Marmor. *Understanding Health Care Reform in Western Europe and the United States* (book chapter, forthcoming. October 15, 2010), p. 2. Even, it has been emphasized that the worlds of health care and welfare state have been separated: “By shifting the emphasis of health policy away from income protection to separate health care administration and issues of protection and promotion of health, Health Ministers have created a separated world. Health policy documents nowadays hardly even mention income protection as a major policy goal, and some even argue that such a function should be seen as separate from health policies altogether”. In: Kieke Okma. “*Health care and the Welfare State: Two worlds of welfare drifting apart?”* Jos Berghman et.al. (eds). Social Security in transition. Kluwer Law International: Netherlands, 2002, p. 237.

2. What are the differences of treatment between self-employed persons and wage earners regarding health care benefits?

In this chapter we will make a country-comparative summary of the differences in social health protection between self-employed persons and wage earners. It is important to mention that this paper will not deal with the challenges that arise from the different way to assess the income of self-employed persons.[7] This research is only focused on the provision of health care benefits.

In general, all European countries provide their citizens with universal coverage for social health protection. Health care benefits are available to all citizens on the same basis. On the other hand, although Latin American countries have tried to reform health care systems to offer universal coverage to the whole population, including the self-employed; there are still differences of treatment in social health protection between wage earners and the self-employed.

2.1 In European countries

Disregarding differences on the way social health protection is organized,[8] all European countries agree on the importance to provide health care benefits based on the residence principle; therefore, they are meant to cover the whole population, not taking into account if the beneficiaries are wage earners or self-employed persons.

This conclusion follows from the information provided by the Mutual Information System on Social Protection-MISSOC document: Social protection of the self-

[7] Brendam Whelam has provided a relevant analysis on the different issues that arise in the assessment of income for self-employed workers. "*Assessing the incomes of the self-employed"*. Danny Pieters (ed.), Changing work patterns and social security, Kluwer International, 2000, pp. 149-160.

[8] In 2002, Professor Paul Schoukens identified three models on social health protection in European countries. Some countries organized social health protection of the self-employed through universal social security schemes; others did it through a general scheme for self-employed; and in others countries, different schemes for different categories of self-employed persons could be found. In: Paul Schoukens. *The social security systems for self-employed people in the applicant EU countries of Central and Eastern Europe*, Intersentia, Antwerpen-Oxford-New York, 2002, p. 218-219.

employed in the Member States of the European Union, of the European Economic Area and in Switzerland. Situation on 1 January 2012.

In accordance with this report, the self-employed enjoy the same entitlements to health care benefits as wage earners in Austria, Belgium, Bulgaria, Czech Republic, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Norway, Poland, Portugal, Romania, Slovenia, Slovakia, Spain, Switzerland, Sweden, The Netherlands and United Kingdom.

2.2 In Latin American countries

Virtually all Latin American countries studied in this research have the same objective regarding health care, namely, the desire to achieve equity and combat social exclusion by extending health coverage to all citizens. There have been plans to move towards universal health rights in Argentina, Brazil, Colombia, Chile, Mexico, Peru and Uruguay.

Despite this policy goal, we have identified differences of treatment in social health protection between wage earners and the self-employed. As a consequence, the self-employed population enjoys a lower degree of social health protection in comparison with wage earners.

This fact is completely in conflict with the objective of achieving equity and combating social exclusion, as long as “social protection system is only an instrument that may contribute to safeguarding the overall objective of social integration”.[9]

[9] Jos Berghman. *Social protection and social quality in Europe*, in Beck, W., van der Maesen, L. and Walker A. (eds.), The Social Quality of Europe, Kluwer Law International, The Hague, 1997, p. 231.

2.2.1 Argentina

In Argentina, wage earners are compulsory insured into the social health insurance fund they choose. There are more than 300 social insurance funds (Obras sociales), which are required by law to offer a basic package of health benefits to all insured population (Programa Médico Obligatorio). On the other hand, self-employed persons can enroll into this system with two specificities; depending on the subsystem they are affiliated:

- As a *monotributista* (subsystem applicable for the self-employed persons whose earnings do not exceed certain amount per year), the beneficiary will have access to some complex health services (transplant, prosthesis, drugs for HIV/AIDS and drug treatment) only after six months of contributions.[10] In this way, unlike wage earners, low income self-employed persons will only be able to hire health plans that include waiting periods for some medical treatments.

- In second place, a self-employed person can apply for a voluntary affiliation (subsystem applicable for any uninsured person who wants to participate into one social health insurance fund). However, social insurances funds are allowed to refuse voluntary health plan applications.[11] In this way, unlike wage earners who are compulsory enrolled into a health insurance fund, some self-employed persons will be denied health insurance enrollment.

[10] Superintendencia de Servicios de Salud. *Manual del Beneficiario de Obras Sociales*, Buenos Aries, 2011. Document downloaded from Argentinean Superintendence of Health Services website (www.sssalud.gob.ar), Monday, June 03, 2013, 21:00, p. 23.

[11] Ibidem, p. 29.

2.2.2 Brazil

The Unified Health System of Brazil (Sistema Único de Saúde do Brazil) was created to cover the whole population, based on the residence principle. This unified scheme tried to eliminate differences between workers, who were obliged to be part of the social security system, and the rest of the population who were mostly uninsured.

Brazilians have the possibility to buy private health care protection and get a tax rebate. In this regard, "because the quality of care under the new publicly financed system did not satisfy middle and upper-class Brazilians, they moved, in massive numbers, to the private sector".[12]

As a consequence, the unified health system does not really allow people with inadequate incomes to select receiving higher quality services provided by the private sector. This situation has an impact mainly on the self-employed group, who is more likely to be covered by the public system (with very basic or poor quality of services) in comparison with wage earners. In this way, most of the self-employed population will only have access to a lower quality of social health protection.

2.2.3 Colombia

In Colombia, there are two health insurance schemes: the contributory and non-contributory regimen. Dependent workers and self-employed persons are obliged to participate in the contributory scheme if their incomes surpass certain amount defined by the law. On the other hand, the non-contributory or subsidized scheme covers the poor population.

[12] William Savedoff, Jens Holst. "Implications of Enrolment Criteria for Social Health Insurance". In: Extending Social Protection in Health. Developing Countries' Experiences, Lessons Learnt and Recommendations, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GMBH. Germany, 2007, p. 98.

All persons who participate in the contributory scheme have a right to receive the same package of health benefits, known as the Compulsory Health Plan (Plan Obligatorio de Salud). Then, in principle, there is no difference of treatment in social health protection between the self-employed and wage earners.

Nevertheless, as Mister Gallego mentions, Social Security Administration has difficulties to assess the real incomes of self-employed workers and to control that they are indeed affiliated to the contributory scheme. Actually, part of the self-employed population would prefer not to pay contributions but to use subsidized health services for free in case they get sick.[13]

This situation originates that low income self-employed workers do not enjoy any social health protection. They will prefer to remain uninsured. Unlike wage earners, who are affiliated into the social security system through their employers, self-employed persons are in a higher risk of lacking social health protection.

2.2.4 Chile

In Chile, wage earners can choose to protect their health through private health insurance institutions (Instituciones de Salud Previsional) or through the National Health Fund (Fondo Nacional de Salud). Wage earners are obliged to be affiliated to one of these systems. Conversely, self-employed persons are not required to participate in a social health protection scheme, but they can join voluntarily to any of them.

The National Health Fund offers health plans to wage earners and self-employed people on the same basis. However, self-employed persons can only

[13] Juan Miguel Gallego. *"Demanda por seguro de salud y uso de servicios médicos en Colombia: diferencias entre trabajadores dependientes e independientes".* In: Lecturas de Economía N° 68, Universidad de Antoquia, 2008, p. 104.

access to health care benefits once they have made six contributions, continuous or discontinuous, during the last twelve months.[14] This waiting period does not apply to dependent workers and constitute a difference of treatment in social health protection.

On the other hand, as Mister Carmelo Mesa-Lago has mentioned, "although coverage is near-universal, there is significant inequality with regards to income, employment status, region, ethnic origin, access and gender (…)".[15] In this sense, "persons who had money [and were affiliated to private health insurance institutions] enjoyed timely access to services, but the poor or those on low incomes [who were affiliated to the national health fund] had to wait a long time for care".[16]

Although in theory, wage earners and self-employed persons are equally free to choose between the private and public system, most of the self-employed do not really have a choice and were affiliated to the national health fund: "although the self-employed workers represent 20 per cent of the economically active, they represent only 9 per cent of all directly insured persons in the ISAPREs [private health insurance institutions], most of whom are high-earnings professionals".[17]

Therefore, regarding private health insurance institutions, a second difference of treatment can be identified. Unlike wage earners, most of the self-employed population will only have the possibility to enroll into the National health fund, which offers lower quality of services.

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[14] Fondo Nacional de Salud de Chile. *Fonasa en 100 preguntas. Guía práctica para los asegurados.* Document downloaded from Chilean National Health Fund website (www.fonasa.cl), Sunday, June 02, 2013, 11:00, p.19.

[15] Carmelo Mesa-Lago. "*Social protection in Chile: Reforms to improve equity".* In: International Labour Review, vol. 147, Nº 4, 2008, p. 379.

[16] Ibidem, p. 380.

[17] Ibidem, p. 380.

2.2.5 Mexico

The Mexican Social Security Institute (Instituto Mexicano de la Seguridad Social) is a compulsory social insurance scheme for workers. This public Entity also provides health services to those people who want to become insured on a voluntary basis. This type of health plan is particularly important for the self-employed population. However, the following differences of treatment can be found on voluntary health plans:

- A voluntary insured will not receive treatment for some pre-existing conditions that are defined by the law: cancer; chronic kidney, heart or neurologic disease; HIV / AIDS; among others.
- Some medical care services will not be available during a certain period after affiliation (for example, in the first two years, no surgery for orthopedic conditions; in the first year, no surgical procedures for lithotripsy for kidney stones; in the first six months, no treatment for benign breast tumors, etcetera).

Self-employed workers also have the possibility to hire insurance plan from the Health Institute of the Mexican State (Instituto de Salud del Estado de México). The Popular Health Insurance (Seguro Popular) is at the disposal of all uninsured population, including the self-employed, but with some limitations and exclusions. This health insurance does not cover "cardiovascular problems, diagnosis and treatment of cancer, transplantation, dialysis, cerebrovascular diseases and serious injuries."[18]

[18] Televisa. Redacción de Noticias. *¿Qué es el seguro popular?* Mexico City, January 17, 2005. Published on line at: http://www.esmas.com/noticierostelevisa/mexico/419064.html, Monday, June 03, 2013, 11:00.

2.2.6 Peru

Peruvian Social Security Health Insurance (Seguro Social de Salud - Essalud) is the scheme that provides health protection to wage earners. The Comprehensive Health Insurance (Seguro Integral de Salud - SIS) provides health care to poor population (non-contributory scheme) and low income persons (semy-contributory scheme).

Before Peruvian government published universal health insurance law in 2010, self-employed persons could purchase health insurance plans offered by Essalud.[19] However, after the effective date of this law, Essalud does not offer voluntary health plans anymore. Nowadays, a self-employed person can only protect himself trough SIS semy-contributory scheme or private health insurances.

Now, the scheme that covers wage earners is better financed than the scheme that covers the poor population, and so the former has better consumer satisfaction than the later. In this sense, self-employed workers only have the possibility to enroll into a social health scheme that provides lower quality care.[20] This situation constitutes a difference of treatment in social health protection between wage earners and the self-employed.

2.2.7 Uruguay

In Uruguay, mutual associations, called as Collective Health Care Institutions (Instituciones de Asistencia Médica Colectiva), provide coverage for workers that are obliged to contribute to this social security system. Self-employed

[19] These voluntary health plans available to the self-employed population incorporated exclusions based on preexisting conditions, as well as limitations (waiting periods) that did not apply to health plans for wage earners.

[20] It is important to point out that this difference of treatment does not apply to high income self-employed persons who can afford private health insurance.

persons can enroll into this private system. In this case, they would be entitled to the same health benefits as wage earners.

Self-employed persons can also select receiving health coverage through the Administration of State Health Services (Administración de Servicios de Salud del Estado), public Entity which provides health care to citizens, especially those with low incomes.

As in other Latin American countries, low income self-employed persons will only have the posibility to enroll into the public insurance system, while most of the wage earners will receive better quality services provided by private collective health care institutions. This situation constitutes a difference in the social health protection of the self-employed.

3. Comparative analysis

3.1 A human rights-based approach: No differences of treatment in European countries

All European countries have achieved universal access to health care. Medical services are provided on the same basis for the whole population. No differences of treatment in social health protection for self-employed are certainly attributable to a common understanding of a human rights-based approach.

The Universal Declaration of Human Rights recognizes that "everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services" (article 25.1). In this regard, everyone should have an equal opportunity to enjoy an adequate level of health, particularly because “the social

right to care for health is indispensable for the effective exercise of individual human rights".[21]

Access to health is a pre-requisite for the exercise of other human rights (economic, social and cultural rights) and, ultimately, is fundamental for the achievement of equity in society: "All human beings have an equal right to health; this is the fundamental principle of social policy that inspired the health for all movement and this is very close to the goal of equal opportunity and full participation [in society]".[22]

All in all, it is clear that access to health care is a matter of universality. It should be linked to citizenship. No differences of treatment between wage earners and the self-employed population are acceptable from a human rights-based approach.

3.2 Differences of treatment in Latin American countries

Reforms efforts made in Latin American countries have tried to guarantee some minimum of health care services available to the whole population. Disregarding labour situation, it is desirable that some minimum of services are available for all. "A growing global movement for universal coverage is advocating for the transformation of health care into a universal right, which entails a transition from traditional social insurance as employment benefit to universal social protection of health, a right of citizenship."[23]

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[21] Henriette D.C. Roscam. *"Right to Care for Health: The Contribution of the European Social Charter"*. European Journal of Health Law Nº 12, 2005 p. 183.

[22] Geneviève Pinet. *Is the law fair to the disabled? A European survey*. WHO Regional Publications, European Series, Nº 29, p. 2.

[23] Felicia Marie Knaul, Eduardo González-Pier, Octavio Gómez-Dantés, David García Junco, Héctor Arreola-Ornelas, Mariana Barraza-Lloréns, Rosa Sandoval, Francisco Caballero, Mauricio Hernández-Avila, Mercedes Juan, David Kershenobich, Gustavo Nigenda, Enrique Ruelas, Jaime Sepúlveda, Roberto Tapia, Guillermo Soberón, Salomón Chertorivski, Julio Frenk. *"The quest for universal health coverage: achieving social protection for all in Mexico"*. Published online on www.thelancet.com. Editorial Lancet, vol. 380, 2012, p. 1260.

From this perspective, the self-employed population should enjoy the same level of social health protection than wage earners. However, this objective has not been accomplished. Even when law guarantees basic health benefits for the whole population (including self-employed workers), differences of treatment indeed exist.

In the following pages, we will analyze each of the differences in the social health protection for the self-employed, previously identified.

3.2.1 Waiting periods in health plans

Some Latin American countries have tried to include self-employed persons into the coverage of health insurance schemes that were initially conceived for wage earners and their families. However, by doing this, they have offered optional health plans with an application of specific waiting periods for some medical conditions(for instance, Argentina, Chile and Mexico).

Waiting periods are characteristics of private insurance market. Private health insurers can opt not to cover some medical conditions during certain period after the suscription of health´s plans, because it is reasonable to think that these medical conditions are preexisting to the date of affiliation.

Waiting periods for the self-employed have been usually justified in believing on the importance of avoiding free raider practices, because “each individual is tempted to leave the burden of giving [contributions for medical care] to others”.[24] So, it is necessary to avoid that an individual participate in a health insurance scheme just during a short period, with the objective of receiving the required medical treatment and, then, cancel his membership.

[24] OECD, op.cit. p. 15

Nevertheless, we must consider that as a consequence of waiting periods, self-employed persons are proposed to receive health services in a more restrictive basis than wage earners. They do not really benefit from risk polling and solidarity if they cannot access to health services from the beginning of their enrollment. Trying to deny the provision of the medical treatment that requires a person is unacceptable from a human right-based perspective.

3.2.2 Health insurance denial

In Argentina, health insurers have the right to deny a health application submitted by someone who wants to obtain insurance on a voluntary basis. Right of admission allows health funds to practice adverse selection, focusing on persons with high incomes and lower risk, while denying the enrollment of low income persons and higher risk. Health funds have the possibility to create barriers to people who are at higher risks to become ill.

There is no valid reason at all to allow this practice. Again, right of admission is completely against the principle of solidarity in social health protection. It is unacceptable that someone with disabilities or preexisting medical conditions cannot enroll into a social health scheme. Medical treatment must be available to all citizens who need it.

3.2.3 Access to a health scheme with lower quality services

In some Latin American countries (for instance, Brazil, Chile, Peru and Uruguay), most of the self-employed persons will only have the possibility to enroll into a health care scheme that provides lower quality services, in comparison with the scheme for wage earners. This difference of treatment stimulates that part of the population is professionally active under an inferior

social health protection, creating a dual system that is completely in conflict with the objective of social integration.

Typically, the number of protected persons as a percentage of the population is the measure used to analyze the coverage of health care systems in Latin American countries. However, universality should not be measured merely in quantitative terms. Ultimately, universality means that all people should have access to health care services of similar quality.

It is not acceptable that health services provided to most of the self-employed population are not adequate in comparison with the services provided to wage earners.

3.2.4 Part of the self-employed people remain uninsured

In some Latin American countries (for instance, Colombia and Peru), an important part of the self-employed population prefers to remain uninsured. This situation obeys to the fact that health care schemes affordable to the self-employed, offer low quality services. Even if health plans are provided in the same basis for wage earners and self-employed people (because law has established a set of mandatory essential health benefits), bad quality of services provided by health schemes for the self- employed discourages them from enrolling and contributing for their health protection.

As a result, part of the self-employed lacks basic social health protection, especially, those low-skilled self-employed persons. Logically, qualified self-employed workers will be able to hire private health insurance. Nevertheless, large part of the self-employed population is far from falling into this category.

Therefore, part of the self-employed population in Latin American countries does not have any institutional form of financial protection concerning health.

Wage earners instead are typically compulsory insured to a health care insurance scheme. This difference of treatment is unacceptable and represents a weakening of the situation of self-employed persons.

4. Final comment

I hope this research will be helpful to get a general orientation of the current implementation of Universal health care in Peru and other Latin American countries. Reform efforts in these countries must continue focused on extending equal access to health care for all citizens. As a means of achieving equal rights to all, it is necessary to eliminate the difference of treatment in social health protection between wage earners and the self-employed.

If there is any lesson here, it seems to be clear that efforts to extend coverage must be made in such a way that they really contribute to address inequalities in Latin American countries. Citizens must be entitled to the same social health protection, irrespective of their labour situation. The differences of treatment identified in this research cannot be justified and must be eliminated.

5. References

Brendam Whelam. *"Assessing the incomes of the self-employed"*. Danny Pieters (ed.), Changing work patterns and social security, Kluwer International, 2000, pp. 149-160.

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