Health Financing and Financial Protection in the Americas

Working Paper prepared by the WHO Regional Office for the Americas
This paper is a summary of the Chapter 1, Section 6, of Health in the Americas 2017, with some updates and modifications. The new contribution is focused in financial protection and the analysis of new information about this issue.
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Acknowledgements

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1. Introduction

Despite the progress in addressing health in the Americas, exclusion and lack of access to quality services persist for large sectors of the population. An estimated 30% of the population has no access to health care for financial reasons, and 21% is kept from seeking by geographic barriers (1). At the global level, in 2010 an estimated 103 million people incurred out-of-pocket payments exceeding 10% of households total consumption or income (11.1% of the population in the region) and 17.5 million incurred it at the 25% threshold (1.9% of the population). (2)

The prevailing models of care, based more on hospital care for episodes of acute illness than on comprehensive health care, including disease prevention and health promotion, often with excessive use of technologies, weak primary care services, and poor distribution of human resources (physicians, nurses, and others), do not necessarily meet the health needs of people and communities. As an example, data shows sustained high rates of total hospitalizations for ambulatory care-sensitive conditions in some countries of the Region like Argentina (18%) and Colombia (22%) (3). Investments to reform and improve health systems have not always been designed to deal with new challenges related largely to the demographic and epidemiological transition, social and economic changes, or the evolving expectations of the population.

Lack of universality and equity in access to quality services and appropriate coverage, entails a substantial social cost and increases the risk of impoverishment of population groups in highest conditions of vulnerability. The evidence shows that when there are access barriers to services (whether economic, geographic, cultural, demographic, gender, ethnic or age related, or other), deterioration in health implies not only greater expenditure but a loss of income as well. The absence of mechanisms to protect against the financial risk of ill health creates and perpetuates a vicious cycle of disease and poverty.

Insufficient financing and inefficient allocation and use of the available resources for health are major obstacles to progress toward equity and financial protection. For example, if we take life expectancy as an overall indicator of health status and take public expenditure in health as one of its determinants, as seen in other studies (4) in the Region of the Americas two countries like Chile and the United States can reach similar levels of life expectancy (79.5 years) with very different levels of public expenditure in health as a percentage of the GDP (3.9 and 8.3 respectively) indicating potential sources of inefficiencies in public expenditure (3). Indeed, average public health expenditure in the Region of the Americas is very low compared with the countries of the Organisation for Economic Co-operation and Development (OECD) (5, 6). Still, the largest share of available resources is highly concentrated in hospital curative and specialized care rather than in preventive and promotion activities at the first level of care.

Direct payment or out-of-pocket expenditure (OOP) at the point of service, the most inefficient and regressive form of financing, yields an unstable flow of financial resources and constitutes an access barrier that impedes or delays care and makes it more expensive for both users and the health system (7, 8). Furthermore, it has a relatively greater impact on the poor, as even the smallest payment can represent a substantial portion of their budget, making it highly regressive and inequitable. (12)

The strategy for universal access to health and universal health coverage (1) of the Pan American Health Organization (PAHO) redefined the concept of coverage and access to health and stressed the values of the right to health, equity and solidarity; it also recognized financing as a necessary, though insufficient, factor in reducing inequities and increasing financial protection for the population.
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The core value in the strategy's definition of “access,” embraced as a priority for society as a whole, is “the right to health,” which requires adequate, allocated, and efficiently managed financing.

This vision stands in sharp contrast to the traditional view, in which access to certain services depended on an individual’s and household’s ability to pay and went hand in hand with the proposals to adopt direct payments and the promotion of policies that had led to the fragmentation of health systems in previous decades. At least part of these policies stemmed from recommendations found in reports from multilateral agencies (9). At the same time, the strategy acknowledges the need to foster the necessary changes through political and social action that puts health squarely at the center of the policy agenda.

Strategic Line 3 of the strategy calls for “Increasing and improving financing, with equity and efficiency, and advancing toward the elimination of direct payment that constitutes a barrier to access at the point of service.” Three interrelated lines of action flow from this:

- Increase financial protection by eliminating direct payment, which constitutes an access barrier, thus preventing exposure to catastrophic expenditures or those that lead to or exacerbate poverty. The replacement of direct payment as a financial mechanism should be planned and progressively achieved through prepaid pooling mechanisms, using sources of funding that guarantee their stability and sustainability.
- Increase public health expenditure to the benchmark of 6% of GDP, which implies a commitment by society as a whole to increase the fiscal space for health in terms of new public sources of financing, with the search for equity as the main objective.
- Boost efficiency in the health system by adopting a series of measures that specifically impact its financing and organization, such as aligning payment mechanisms with health system objectives, deploying human resources accordingly and with the right skills-mix and rationalizing the introduction of new medicines and other health technologies that contribute significantly to rising health expenditures.

Countries in the Region of the Americas have not remained indifferent to the challenges they face and have adopted different policies to address them. The commitments made in 2015 with the launching of the UN Sustainable Development Goals, among which the goal of universal access and the measure of financial protection as one of its indicators, reinforce these efforts.

This paper shows an overview of the health system financing situation in the Region and the advances and challenges they still face under the lens of Universal health objectives. Following this introduction, health financing in the Region will be examined in a conceptual and descriptive section, with special attention to financial protection. The third and final section discusses the immediate challenges facing the countries in terms of the need to equitably and efficiently increase financing with financial protection.
2. Financing health in the Americas

The financing of health systems in the Americas rely on a variety of revenue sources linked to the nature of the different arrangements to cover and improve access to health services for the overall population. In general, there is a clear predominance of public funding sources mirroring the prevailing mix of models linked to employment (e.g. social health insurance) and entitlement based on legal residence (e.g. national health services) along with specific schemes put in place to cover and financially protect the most vulnerable, the unemployed and the informally employed.

General government and social security funds prevail as the main financing agents through both specific budget-line allocations and transfers out of general revenues, and social (employer/employees) contributions respectively, with some exceptions where external and direct payments at the time of service play the biggest role.

Figure 1: Segmented health systems reflected in the financing

Sources: PAHO/WHO 2017, Health in the Americas. (13)
External funding (from international agencies, donors, foundations, etc.) and other private sources are only relevant in few countries and mainly linked to the funding of priority programs (i.e. HIV/AIDS, Tuberculosis, malaria and vaccination), whose long-term financial sustainability is at stake.

Pooled resource arrangements, in turn, are usually long-term and have also taken shape during the historical development of the systems. The Region is largely characterized separate sub-systems built around specific population groups with little or no solidarity across these.

On the other hand, the purchase of services as a resource allocation mechanism takes many forms, with historical budgets in the public sector and fee-for-service payments in the private sector predominating (10).

In the majority of the countries, operational financing decisions are made year-to-year by the ministries of finance and health as part of a planning process in which the democratic political system is involved, since in most cases, the main source of funding (or a significant part of it) – the budget – is approved by the parliament or congress. Other sources of financing are determined by the market through private expenditure.

Total per capita health expenditure in the Region averages 1,320 international dollars (Intl$) per year (adjusted by purchasing power parity) and ranges from Intl$ 160 in Haiti to Intl$ 9,145 in the United States. Factoring out the United States and Canada, the value falls to Intl$ 1,113. This absolute level of expenditure can be compared with the average for the OECD countries, which is three times that of the Region and far less scattered. Furthermore, in each country the different segments present very different per capita expenditures, one of the most relevant signs of inequity and segmentation. For example, in El Salvador, per capita health expenditure in affiliates to the Institute of Magisterial Welfare ² was four times that of users of general public health services through the Ministry of Health, with per capita expenditure in the general regime of social security standing almost exactly in the middle of both extremes, at least until 2011 (11). However, in the last years the country is advancing towards closing these gaps in an effort to reduce inequities. Other countries are also making efforts in the same direction, but slowly, as seen in Colombia and Chile. With the reform of 2008, Uruguay’s transition was faster in closing this gap, leading to a drop in the difference between the per capita expenditure of mutual private providers and the main public provider from 2.3 times greater in 2007 to just 25% greater in 2012.

2.1 Public expenditure in health
Considering the universal health strategy’s public health expenditure benchmark of at least 6% of GDP ³, Figure 2 shows that only 5 of the 34 countries that provided information are above that threshold: Canada, Costa Rica, Cuba, the United States, and Uruguay. The countries below the threshold include three with public health expenditure above 5% of GDP: Colombia (5.4%), Nicaragua (5.1%), and Panama (5.9%).

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² Translation from Spanish “Instituto Salvadoreño de Bienestar Magisterial”
³ While this indicator is very important because it is a significant measurement of country efforts in health and because of its acceptance as a prerequisite and useful benchmark in the regional strategy for universal health, it cannot be interpreted in isolation, since individual variations can reflect movements within a country’s economic cycle (variations in GDP), for example, regardless of the resources allocated to the health sector.
Observing what happens with total health expenditure and its public-private mix, we discover that in countries that exceed the 6% benchmark, public health expenditure accounts for more than 70% of total health expenditure, except in the United States.

Furthermore, in the case of Bolivia, Canada, Colombia, Costa Rica, Panama, and Uruguay, this balance is similar to the average for the OECD member countries (73%). At 17%, total health expenditure in relation to GDP in the United States is known to be the highest in the world, without proportionally better health outcomes (14). This indicates the need not only for more resources but greater efficiency in their use.

At the opposite extreme, countries with lower public health expenditure are also those in which the composition of total health expenditure is more skewed toward the private component: Guatemala (private expenditure of 62%), Haiti (79%), Saint Kitts and Nevis (58%), and Venezuela (71%).

However, Peru and the Dominican Republic are examples of the opposite, with low public health expenditure (3.3% and 2.9% of GDP, respectively) and a high share of public health expenditure in total health expenditure (61% and 67%, respectively). Added to this is the case of the United States, with high public health expenditure (8.3%), but health expenditure that is predominantly private (52%).

Figure 2. Health expenditure as a percentage of GDP and composition public-private, as a percentage of total expenditure, 2014

Figure 3 presents data on fiscal capacity in the Americas, and the average for EU countries. The median for the Region, around 30% of GDP, stands in marked contrast to the average of 48% of GDP for total public expenditure in the EU countries. Fiscal capacity (understood as total public-sector resource mobilization) should be a potential source of fiscal space for health in the Region. Furthermore, the combination of a low tax burden and weaknesses in tax collection—manifested, for example, in tax evasion, elusion and tax fraud—create a scenario not uncommon in the Region that must be considered in the specific analyses.
When analyzing the fiscal priority of health in the Region (Figure 4), the variability of the indicator is even greater. While public expenditure in health in the EU member countries averages 14% of total public expenditure, almost half the countries in the Region of the Americas give higher priority to the health sector. In the case of Costa Rica and Nicaragua, for example, public expenditure in health accounts for almost one quarter of total public expenditure (23% and 24%, respectively).

At the opposite extreme, however, nine countries allocate less than 10% of their total budget to the health sector: Haiti (5%), Venezuela (5.8%), Brazil (6.8%), Saint Kitts and Nevis (6.9%), Argentina (6.9%), Trinidad and Tobago (7.6%), Jamaica (8.1%), Grenada (9.2%), and Guyana (9.4%).
Painting a more complete picture of the countries’ health financing efforts requires at least this dual perspective in order to see how countries that prioritize health in their budget may be spending little due to their excessively low level of total public expenditure, while countries with a high level of total public expenditure may not be prioritizing the health sector, even though health expenditure figures are relatively high in absolute terms.

Combining the data on fiscal capacity and fiscal priority reveals very unequal country performance. For example, despite its relatively low fiscal capacity (25% of GDP), public health expenditure in Nicaragua is relatively high for the Region (5.1% of GDP), thanks to the high priority of health in the national budget (24% of total public expenditure). However, in Guatemala, where the fiscal priority of health is relatively high for the Region (17.8% of total public expenditure), public health expenditure is low (2.3% of GDP), due to the country’s excessively low fiscal capacity (13.4% of GDP, the lowest in the Region).

In Brazil, public health expenditure stands at 3.8% of GDP, despite a high fiscal capacity (almost 40% of GDP), since health has a low fiscal priority (6.8%). In general, the data show that in the eight countries where public health expenditure exceeds 5% of GDP (Canada, Colombia, Costa Rica, Cuba, the United States, Nicaragua, Panama, and Uruguay) the fiscal priority of health is more than 14% of public expenditure.

### 2.2 Out-of-pocket health expenditure

When examining the impact of health expenditure on household well-being and access and use of health services, out-of-pocket health expenditure merits special attention. This type of payment is required at the moment of use of services and generally at the point of service and includes any kind of cost-sharing (in the presence of insurance), full payment (if no insurance), formal or informal. It should be measured net of ex-post reimbursements and excludes any form of prepayment such as insurance premiums.

The fact that this type of payment may be required to receive care or access the necessary health services makes them a health care access barrier. Even among people who can cover these expenses, incurring them may adversely affect their household’s well being and the consumption of other goods and services or may even be harmful to health if the alternative is avoiding medical care.

It also has implications for the efficiency of the health system, since by discouraging the use of the health services, it deters care seeking to more advanced stages of an illness, requiring more complex and expensive services at later more expensive stages of illness.

Thus, out of pocket expenditure can result in access barriers to households and higher costs to the health system in the medium and long term, together with worse health outcomes, poorer health system response capacity, and lower efficiency and effectiveness.
Figure 4 shows the value of the indicator OOP as a percentage of total health expenditure for the countries of the Region and, as a reference, the average for the countries of the European Union (EU). First, it shows that while out-of-pocket health expenditure in the EU countries averages 21% of total health expenditure, 29 countries in the Region (83%) exceed that value.

Furthermore, countries with a lower proportion of out of pocket health expenditure are also those with higher public health expenditure (as a percentage of GDP) (Figure 1): Canada, Colombia, Cuba, the United States, and Uruguay. Some exceptions are conspicuous: Suriname has low public health expenditure (2.9% of GDP) and also a low proportion of out-of-pocket expenditure (11% of total health expenditure); and Costa Rica, with very high public health expenditure for the Region (6.8% of GDP), has a moderate proportion of out of pocket expenditure (25% of total health expenditure).

Low out-of-pocket expenditure is not always an indication of equitable access, since it may also be due to lack of access to the services. Also, it can sometimes increase with the desired increase in access, although the ratio with coinsurance rates or unit values of copayment remains constant. For example, Colombia and the United States show relatively high levels of population coverage for the period 2010-2015 (around 95 and 90% respectively) but with still relatively high levels of people reporting monetary barriers to access care (29 and 37% respectively) and even increasing in the period for Colombia (3).

Figure 5. Proportion of out-of-pocket health expenditure as a % of total health expenditures in the Region of the Americas, 2014

Source: PAHO/WHO 2017, Health in the Americas.

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4 European Union parameters are used as representative of the more advanced countries, even though development levels in some EU countries are considered similar to those of several countries in the Americas.
The weight of direct payment (out-of-pocket expenditure) by households in total health expenditure is trending downward in certain countries in the Region, among them Chile, Colombia, El Salvador, and Mexico (Figure 6).

Here, the case of El Salvador is worth examining (Figure 6). In 1995, more than 60% of its health expenditure was financed through direct payments; today, the figure is less than 30% and though still high, represents a significant decline. In Colombia, the indicator fell from 38% to 15% in that same period, and the country currently has one of the lowest percentages of out-of-pocket expenditure in the Region. Other countries show certain stability in the indicator and remain at very high levels, as in Guatemala (above 52% throughout the period), or low levels, as in Costa Rica, although with a certain upward trend (from 21% to 25% during the period) (Figure 6).

In Ecuador, a marked increase in the indicator was observed between 1995 and 2000 (moving from 32% to 62%), subsequently shifting downward, but nevertheless remaining at very high levels (48% in 2014).

Figure 6. Trends in out-of-pocket health expenditure in the Americas, 1995–2014 (selected countries)

Sources: PAHO/WHO 2017, Health in the Americas.
2.3 Financial protection

Out-of-pocket expenditure is generally more of a direct barrier to care for households with lower purchasing power, but it can also be one for the middle class (15). Thus, having access to health services does not prevent out-of-pocket payments from undermining health equity, since “overcoming” the barrier can significantly jeopardize a household’s well-being, driving it into poverty (impoverishing expenditure) or exceeding a given proportion of its total expenditure or ability to pay (catastrophic expenditure).

Expenditure is considered impoverishing for a household when it represents the difference between being above or below the poverty line (16). Different poverty lines can be used. Expenditure is considered catastrophic when out-of-pocket health expenditure represents a substantial percentage of household expenditure—usually 30% or 40%\(^5\) of its ability to pay (12, 13), or 10% or 25% of total expenditure or income (17, 2), with “ability to pay” understood as total household income (measured as total household expenditure) minus the expenditure necessary for meeting basic subsistence needs (20, 21). The incidence of catastrophic and impoverishing expenditure indicators vary with the methodology used, as different poverty lines can be used to assess the extent of impoverishment in each country and regionally.

However, a recent PAHO study with data within the period 2004-2015 (22) for 11 countries in the region shows that in 7 of them, 2.5% of households have catastrophic expenditures, regardless of the methodology used. These methodologies use different catastrophe thresholds, based on the measure of ability to pay. Hence, some use a threshold of 30% or 40% of a household’s ability to pay because they discount basic needs. More recently, within the SDG monitoring framework two thresholds are used to define catastrophic expenditures (10% and 25% of total household expenditure).

Regardless of the methodological differences of the primary sources of data and considering the 25% threshold, 6 of the 11 countries face catastrophic expenditures in over 2% of households, while only Costa Rica and Uruguay have an incidence below 1% (Table 1). Over 1% of households in Guatemala and Nicaragua incur in impoverishing health expenditures when considering the USD1.90 per day poverty threshold, while in Bolivia and Peru it is above 0.5%.

Countries can be classified into three groups (Table 1). In one group, Uruguay, Panama, Mexico, Costa Rica and Bolivia have an incidence of catastrophic health expenditure in less than 2% of households (less than 8% for the 10% threshold), but Mexico and Bolivia have an impoverishing expenditure above 0.5%. In another group, Chile, Argentina, Peru, and Nicaragua show an incidence of catastrophic expenditures between 2% and 4%, (10-15% for the 10% threshold) but with high variance in the incidence of impoverishing expenditures: Chile and Argentina face a negligible incidence of impoverishing expenditures, while Peru and Nicaragua show an incidence above 0.5% (Nicaragua reaches 1.2%). Finally, in the third group, Guatemala and Ecuador have a high incidence of catastrophic and impoverishing expenditure.

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\(^5\) There is no absolute consensus regarding a threshold. For example, Wagstaff and van Doorslaer (18) examine threshold differences in the case of Vietnam. Knaul et al. (19) define a threshold of 30% of the non subsistence expenditure or the total expenditure of a household once the international poverty line of US$ 1 per day is discounted.
### Table 1: Catastrophic Health Expenditure and Impoverishing Health Expenditure* (% of households). Preliminary data

<table>
<thead>
<tr>
<th>Country</th>
<th>Catastrophic Health Expenditure (SDG indicator 3.8.2, 25% threshold) In %</th>
<th>Catastrophic Health Expenditure (SDG indicator 3.8.2, 10% threshold) In %</th>
<th>Impoverishing Health Expenditure (USD1,90 per day in 2011 PPPs) In %</th>
<th>Survey year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>2.518</td>
<td>10.890</td>
<td>0.007</td>
<td>2012-2013</td>
</tr>
<tr>
<td>Bolivia</td>
<td>1.403</td>
<td>6.612</td>
<td>0.616</td>
<td>2014</td>
</tr>
<tr>
<td>Chile</td>
<td>2.31</td>
<td>12.230</td>
<td>0.000</td>
<td>2012</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>0.833</td>
<td>5.182</td>
<td>0.021</td>
<td>2013</td>
</tr>
<tr>
<td>Ecuador</td>
<td>4.453</td>
<td>20.430</td>
<td>0.453</td>
<td>2011-2012</td>
</tr>
<tr>
<td>Guatemala</td>
<td>4.149</td>
<td>11.781</td>
<td>1.076</td>
<td>2014</td>
</tr>
<tr>
<td>Mexico</td>
<td>1.324</td>
<td>4.658</td>
<td>0.230</td>
<td>2014</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>3.239</td>
<td>14.982</td>
<td>1.218</td>
<td>2014</td>
</tr>
<tr>
<td>Panama</td>
<td>1.301</td>
<td>6.280</td>
<td>0.018</td>
<td>2007-2008</td>
</tr>
<tr>
<td>Peru</td>
<td>2.564</td>
<td>12.974</td>
<td>0.536</td>
<td>2015</td>
</tr>
<tr>
<td>Uruguay</td>
<td>0.638</td>
<td>7.177</td>
<td>0.009</td>
<td>2005-2006</td>
</tr>
</tbody>
</table>


*: considering monetary expenditures including imputed rent
According to Figures 7 and 8, the poorest households have a greater risk of impoverishment, while wealthier households have a greater possibility of facing financial catastrophe due to health events.

**Figure 7: Distribution of catastrophic health expenditure in % (SDG indicator 3.8.2, 25% threshold) by household consumption/income quintiles, in 11 countries. Preliminary data**

2. FINANCING HEALTH IN THE AMERICAS

Figure 8: Distribution of impoverishment due to out-of-pocket health spending in % (USD1.90 poverty line) by household consumption/expenditure quintiles, in 11 countries. Preliminary data

Figure 9 also shows that rural households have a higher incidence of impoverishment and the distribution of catastrophic health expenditures similar between rural and urban households.

Figure 9: Impoverishing out-of-pocket health expenditures (left) and catastrophic expenditure (SDG indicator 3.8.2, 25% threshold) (right) by area of residence in 7 countries* in % of households. Preliminary data

In the case of Chile, there is a lower incidence in Santiago than in the Regions for both indicators. In Ecuador, households in rural areas present a higher catastrophic expenditure incidence than those in urban areas. In Guatemala, this is reversed and urban households have a higher incidence of catastrophic spending.

Bolivia shows several exceptions. First, it is the only country where the poorest face a greater proportion of catastrophic health expenditure and spending is impoverishing also for the non-poor, although not at the level of Guatemala and Nicaragua. Households in rural areas are twice as likely to face catastrophic expenditures than those in urban areas.

In Costa Rica, households in urban areas show higher catastrophic spending, while in Uruguay and Mexico, households in rural areas have a higher incidence of catastrophic health expenditures. For Mexico, rural areas are the ones that incur catastrophic expenses the most, as in Nicaragua and Peru.
3. Discussion and Challenges

3.1 Increasing public investment: a priority need
Health financing in the Region is far from meeting the objectives set by the countries in 2014 when they adopted the strategy for universal health. In fact, as mentioned, only a small group of countries have achieved a public expenditure in health of 6% of GDP (Figure 10), and direct expenditure in the Region accounts for 33% of total health expenditure.

Figure 10: Public health expenditure as % GDP and out-of-pocket health expenditure as %THE in the Americas, 2014

Increase in per capita public expenditure has historically been moderate, with relatively low elasticities in health expenditure with respect to economic growth (below 1 in many countries).

Even the peak public health expenditure of 2009 was due to the impact of the economic crisis on the GDP of the countries of the Region and not to an absolute increase in public expenditure. However, although the average GDP growth rate would recover by 2010 and continue until 2014 (23), the particular situations in the Region in response to the global crisis caused the decline in public health expenditure as a percentage of GDP to continue in several countries, as seen in Figure 11.
Several studies show that countercyclical government spending has been essential for meeting long term economic and human development targets (17–21) and will surely be today to meet the United Nations Sustainable Development Goals adopted in 2015 with a 2030 horizon.
3.2 More efficiency: necessary, but not enough

Efficiency in the organization of services implies the adoption of people- and community-centered models of care and the delivery of quality services by strengthening the first level of care and building integrated networks.

Resource allocation in a health system is efficient when it achieves an optimal combination of morbidity and mortality reduction and greater financial protection for households that permits equitable access to health services with given resources. In this case, the efforts are designed to yield what society needs and expects in terms of health and well-being—a task that involves both the State and society.

The degree of productive and technical efficiency achieved will depend on how the health services are managed—or to put it another way, on obtaining the best response capacity through better coordination and linkage between levels of care and care networks.

To enhance efficiency in the health system, resources need to be allocated towards generating those health goods and services that society values the most (allocative efficiency) and in the least costly way, or using the least possible amount of resources (technical efficiency). Dynamic efficiency, in turn, implies guaranteeing conditions and efficiency levels over time through innovation in the health systems in the broadest sense of the word (29).

Payment mechanisms must be aligned with system objectives. Thus, it is important to note that territorial and population-based payment systems—keeping in mind morbidity levels and combined with mixed-level payment mechanisms—are potentially effective regulatory mechanisms for meeting these objectives (30, 31).

Aligning incentives with health system objectives to promote integrated care and comprehensive services, and putting emphasis on the first level of care are initiatives that can boost the efficiency of the system as a whole. Studies coincide in recommending the adoption of payment mechanisms with circumstantial margins of flexibility and empirically contrasted macro- and micro-allocation instruments. Territorial capitation and episode-based payment (also called bundled payment or case rates, as in diagnosis-related groups) are two examples of tools that can boost the efficiency of expenditure (32).

There are known mechanisms for boosting efficiency in resource utilization, among them protocols for reducing clinical variability, centralized drug procurement systems, economic evaluation, and the evaluation of other aspects, such as safety and quality in the introduction of new technologies, programs to boost workforce efficiency and productivity, and the strengthening of disease prevention and health promotion. In this context, the measures with the greatest short-term impact are related to resource allocation mechanisms, including those involving drug procurement.

From 2010 to 2015, several countries in the Region, among them Brazil, El Salvador, and Ecuador, made progress in this regard, channeling most of the growth in expenditure to the first level of care to broaden access to these services and improve their quality. For cases like those of Chile, Mexico, Peru, and Uruguay, results based payment systems were
also established (33). The 2008 reform in Uruguay involved the expansion of coverage and pooling of social security and State funds to finance services to the beneficiaries of FONASA, the national health insurance program that currently covers more than 70% of the population. The risk-adjusted capitation payment system used in this fund also considers four targeted areas associated with preventive measures for pregnant women and older persons and the allocation of human resources.

During this period, Peru launched a results-based payment system through a project implemented at the more general level of results-based budgets. Chile, in turn, introduced targets in the per capita transfer system in primary health care and is developing a hospital payment system based on diagnosis-related groups, aspiring to be the first country in LAC to employ this tool. Suriname currently uses a capitation system for first-level providers and payment per day and bed in the hospital setting.

3.3 Improving financial protection through pooled funding
Increasing financial protection requires greater public expenditure, adopting efficient interventions primarily at the first level of care to boost response capacity and increase linkage among service networks. Increasing financial protection will reduce inequity in access. However, the replacement of direct payments should be done gradually through collective prepayment mechanisms involving different sources of financing, such as contributions to social security, taxes, and fiscal revenues. Thus, the main components of a financing system designed to guarantee financial protection to the population are the elimination or minimization of direct payments by households and the pooling of funds.

Pooled funds, in which the risk of disease and the need for health services are shared by a group of people through collectively financed prepayment mechanisms, is therefore key to financial protection. Sharing risk under any institutional arrangement implies the transfer of resources or a subsidy from healthy people to patients, as well as from young people to older people – basically, from people who are not using the health services at a particular moment to those who are. Moreover, these arrangements need to be mandatory, as opposed to voluntary, to advance in the direction of universal health.

Moreover, for this financing to be solidarity-based, there should also be a subsidy, grounded in redistributive policies, from households with greater contributory capacity (the wealthiest) to those with fewer resources (the poorest), whose contributions are limited but whose health care needs tend to be greater.
The existence of numerous small and fragmented funds hinders the cross subsidies mentioned above, since it provides an incentive for risk selection: each fund will attempt to capture people who are better off economically and in better health (the less risky) and exclude those with limited resources and more health problems (the higher risks). Smaller funds are more vulnerable to specific risks, such as illnesses that require more expensive treatment. Therefore, funds that cover a small number of people tend not to be economically viable in the long term (7).

Furthermore, when the members of a fund share similar characteristics in terms of the social and environmental determinants of health to which they are exposed, the risk of health problems tends to be inefficiently diluted, implying a higher cost per person to treat episodes of illness than in funds that cover people with different characteristics. This is a powerful reason for advising against segmented funds for communities with limited resources.

The existence of numerous funds with their respective mechanisms for collecting and pooling resources and contracting services compromises the efficiency of the entire health system due to the administrative costs that it entails, as well as the cumulative superimposed transaction costs. Single large funds tend to be a more efficient type of organization than competing funds, as long as organizational and institutional incentives are adequate (34). Economies of scale in the operation of these funds can generally be expected—not only in the collection and pooling of resources, but in the contracting of services for large numbers of people.

In addition to increasing access to quality health services, financial protection is an important tool for fighting inequity and poverty, as it converges with policies for development and the social and economic protection of societies. In other words, it represents a specific contribution from the health sector to human development strategies.
4. Conclusion

By instituting reforms, changes, or transformations grounded in the values of health as a right, equity, and solidarity, PAHO’s Member States have committed to moving toward the elimination of direct payment or out-of-pocket expenditure, the creation of the largest possible pooled funds, and more efficient public financing as the way of promoting greater individual and community access to comprehensive quality services in integrated health systems, with strengthening of the first level of care.

Advances in general are oriented in the right direction but are slow and are reflected in the slow increase in public spending and the consequent slow decrease in out-of-pocket expenses. The efforts to expand the government’s role in financing health using public financing have been insufficient so far to replace direct payments at the point of service (including cost-sharing in government funded and private insurance schemes) as source of funding. In consequence, financial barriers to access are still in place, and households continue bearing an important share of the financial burden to access health services and remain at risk of falling into financial catastrophe or impoverishment.

It is necessary to accelerate the speed of changes towards universal health, so that financing is no longer a barrier and a factor of catastrophe and impoverishment and allows access to quality health services, in an equitable and timely manner.
References


