Policy tools for achieving more equitable financing of and access to health care services in Latin America and the Caribbean

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This paper reviews policy tools or instruments for achieving more equitable financing of and access to health care services. The paper summarizes the economic rationale for public policies and the types of tools that governments can use in addressing resource allocation efficiency issues and equity objectives in order to reduce inequalities in the financing of national health systems and to improve equity in the access to health care services. Estimates are presented on the patterns of government expenditures and financing in countries of Latin American and the Caribbean. Estimates are also included on the level of government expenditures, the composition of revenues, the importance of government social and health expenditures, and the distribution of the benefits of government expenditures on health for different income groups. The last section of the paper presents policy challenges faced by the governments of Latin American and the Caribbean as they try to achieve more equitable financing of and access to health care services.

Key words: equity, public policy, economics, health services accessibility, health expenditures.

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RATIONALE AND TOOLS FOR GOVERNMENT INTERVENTIONS

Efficiency and equity considerations

Market failures and distributional or equity considerations are the two main reasons for government intervention in the market's resource-allocation outcomes. In the presence of market failures, government intervention is justified in terms of social efficiency. Interventions based on equity considerations are justified based on society's principles of equity and social justice. Summaries of government intervention alternatives in the presence of failures in the health care markets have been presented by Hemmings (1) and by Kochhar (2). Government interventions to address equity concerns are of a different nature than those aimed at addressing efficiency or market failure issues.

Equity in the financing of and access to health care services are distributional objectives. Equity or distributional objectives are based on societal perceptions about the fairness of distribution of income and of welfare resulting from the initial distribution of endowments and abilities. However, there are several market-failure conditions that call for government interventions that may have important implications for equity.

In general, the arguments for organizing national health care systems to provide universal access to health care services are based on equity considerations, that is, as an equity objective. However, the case for social insurance or direct government involvement in the provision of health care services may also be based on efficiency considerations. The advocacy of social insurance (government-mandated health care insurance systems or programs), for example, is based on arguments of market failures due to imperfect information among contracting parties. Something similar occurs with merit goods, which are the type of goods for which individual decisions about levels of consumption may not be the best. The existence of merit goods calls for direct government involvement in providing particular types of services where individual uncertainty about the benefits of these services or lack of foresight about the amount of services that will be needed in the future may result in levels of consumption that are not the best.

Social insurance

The argument for government intervention in the insurance markets as well as in the presence of merit goods is based on efficiency arguments. With social insurance, the justification is based on market failures due to the lack of perfect information among contracting parties, which is a basic condition for an optimal competitive solution. The fact that insured individuals have more relevant information about their risk than insurers have gives rise to adverse selection and moral hazard. Adverse selection arises because low-risk (or healthy or younger) individuals will have less incentive to buy health insurance, and high-risk (less healthy) persons will tend to buy health insurance. On the other hand, insurers will prefer to insure low-risk individuals and to avoid high-risk persons. When they exist, market health-insurance solutions will tend to discriminate against high-risk individuals, that is, those who have the greatest need. Moral hazard in the health insurance markets arises from the fact that insured consumers will tend to demand too much medical care. Once they are insured, for individuals the cost of consuming additional quantities of health care services is zero. For their part, insurers will tend to impose either nonmonetary barriers to access or deductions and coinsurance fees.

In the case of merit goods the argument is made that individuals may not act in their own self-interest. Government interventions are needed to encourage the consumption of optimal levels of health care services and the purchasing of insurance to protect against catastrophic losses due to illness or accidents.

Institutional organization, expenditures, revenue collection, and regulations

Governments may intervene in the health care markets in a number of ways. Among these are: spending on particular health care programs or health care services, funding a national health care services system of universal coverage, and organizing and funding mandatory universal social health-insurance schemes. These approaches can be used singly or in combination. Decisions about interventions will have implications for the institutional configuration of national health systems, the level and composition of government expenditures, and the relative importance of taxes or other revenue sources for national health systems.

Government regulation is another policy tool that can be used indirectly to achieve some distributional objectives. Such regulation can include consumer protection measures, antimonopoly legislation, guarantees on the quality of goods and services, minimum standards for the quality of health care goods and services, and periodic certification or recertification of health care service providers. These policies may provide more benefits for the poor and others with less access to information.

The scope and coverage of these broad types of government interventions in the health care markets will shape the range and depth of private health care markets and will give rise to different types of national public health systems. Table 1 summarizes the different types of institutional organization and/or expenditure mechanisms that governments can use to intervene in the provision of health care services. The table also shows the revenue collection instruments that can be used to fund these health care services. The first column of Table 1 summarizes the different mechanisms or institutional sectors of the economy through which governments can intervene, directly or indirectly, to achieve efficiency or distributional objectives. The other columns of the table show the different revenue collection instruments that institutional sectors of the economy, including governments, can use to finance their activities. Governments may use: 1) direct tax revenues (individual, corporate, and property taxes), 2) indirect taxes (sales taxes or value-added taxes, trade taxes, and turnover and excise taxes on real and financial transactions), 3) social contributions (social security and payroll taxes), 4) grants, and 5) other revenues, including fees for services. The character of a specific national health system will depend on the types of institutions used as mechanisms to channel government intervention in the health care markets, the relative importance of the amount of resources spent by these institutions, and the revenue collection instruments used to finance the system.

TABLE 1. Health care systems, institutional sectors, and financing or sources of revenue[a]

Health care system/Institutional sector of the economy	Financing/Sources of revenue					
	Taxes		Social contributions	Grants	Other revenues	
	Direct	Indirect			Fees	Premiums
National health care service system/Public sector (statutory)	XXX	XXX				
Central government (ministry of health and other public institutions[b])						
Local governments (states/provincial, municipal)[c]						
National health care insurance system/Social insurance institutions (mandatory)			XXX			
Single (national)						
Multiple (provincial, departmental, occupational)						
Mix-managed sickness funds (competitive, occupational)						
Mixed national health care systems/Private sector (voluntary)					XXX	XXX
Nonfinancial: Institutional and individual providers[d]						
Financial: Health insurance and prepayment schemes						
Nonprofit institutions serving households						
Households						

Source: Reference 3.
[a] The marked cells (XXX) indicate the use of the particular type of financing (revenue collection) for the indicated type of health system.
[b] "Other public institutions" includes other institutions receiving transfers from the central government but operating with their own budgets.
[c] This local governments grouping refers to countries with federal systems with an effective role for local governments in deciding on resource allocation and revenue collection.
[d] These providers are ones involved in the financing, production, or provision of health care services.

Institutional configuration

There are two main public policy tools to achieve equitable financing and access. The first is the organization of national health insurance schemes of universal coverage, and the second is the use of direct government expenditures in health. The two can also be used in combination.

National health systems can be divided into three general categories: 1) national health care service systems ("statutory"), 2) national health insurance systems ("mandatory"), and 3) mixed or segmented national health care systems. In public- or government-dominated systems (statutory and mandatory health care systems) public expenditures represent the largest component of national health care expenditures. In market-oriented systems (mixed or segmented health care systems) the private components of expenditures will account for the largest share of the overall national health care expenditures.

Another level of differentiation of national health systems is whether the universal access to health care services is directly through government institutions or is through universal health insurance schemes. These two systems may be either centralized or decentralized. Similarly, with market-oriented systems the distinction can be made between: a) those in which most of the health care services are transacted between producers and consumers directly and b) those in which access to health care services is through private health insurance schemes.

Within the framework presented above, the national health systems of most of the countries of Latin America and the Caribbean (LAC) would be classified as mixed or segmented national health systems. The LAC national health systems are rather heterogeneous. Most of them are characterized by a relatively weak predominance of a "main" institution or source of finance. Only two of the LAC countries can be said to have a national health system with universal access. One is Costa Rica, which has national health insurance that covers around 85% of the population. The other is Cuba, which has a national health care service system with universal coverage. The national health systems in the rest of the LAC countries can be characterized as mixed systems, with varying degrees of coverage by government programs, and with substantial differences in instruments of finance and in the absolute and relative levels of expenditures.

Expenditures and financing: fiscal revenues

The level of public expenditures as a percentage of the gross domestic product (GDP) or of the gross national income (GNI) can be used as an indicator of government involvement in addressing distributional or equity objectives, in a narrow sense. In a broader sense, that expenditure level is the fiscal policy component of the country's economic and social development strategy. From a technical point of view the economics literature provides no definitive answer concerning the optimal level of government

expenditures as a proportion of gross domestic product or national income. In part this is due to the fact that optimal expenditure decisions may not be consistent with the optimal level and composition of tax revenue collections. Much of the discussion about the level of public expenditures and the level of GDP lies in the realm of politics.

Wagner's Law, which the German economist Adolf Wagner developed based on his empirical observations, suggests that public expenditures, as a percentage of GDP, will increase constantly with the level of economic and social development. The main reason for this is the complexity of institutions and regulations in more advanced societies. There is also a "ratchet effect" with entitlements that prevents a decline in the share of government expenditures over time or as income increases. Increased government expenditures can also result from social unrest, famines, war, natural disasters, and the political process itself, and it can be hard to later reduce these higher expenditures. Also important are demographic changes, the aging of the population, and the burden of social security and pension programs.

FINANCING AND EXPENDITURES PATTERNS IN LATIN AMERICA AND THE CARIBBEAN

Government expenditures and sources of revenue

Table 2 summarizes the evolution of the total central-government expenditures as a percentage of GDP in different regions and countries of the world as well as for the world as a whole. These data show that there are large differences in the relative importance of government expenditures in different parts of the world.

Taken together, the LAC countries have the most unequal distribution of income and wealth of any world region. While government interventions may be more needed in countries with greater inequalities and more poverty, the data from Table 2 show that the level of government expenditures in the LAC countries lags behind that of more-advanced countries. This is especially true for the nations of the European Monetary Union, which have extensive social welfare programs, as indicated by Tanzi and Zee (7).

For countries with large inequalities in the distribution of income and wealth, the optimal tax structure would be a progressive one, with the rich paying proportionally more in income and property taxes than the poor. However, the tax structures of the LAC countries are far from that ideal. In comparison with the developed countries of the world in terms of the main sources of government revenues, in the LAC countries income taxes and property taxes play a smaller role (8, 9). In the LAC countries, revenues from taxes on income and property represent less than one-third of what is being collected in the developed economies. Similarly, mandatory contributions for health insurance and other social insurance are one of the main mechanisms for financing social programs in developed countries. In the developed countries these social security and payroll taxes represent around 8.2% of the GDP, versus just 4.8% in the LAC countries.

Total government social expenditures and health expenditures

The governments of the LAC countries vary greatly in the commitments that they have made to social and health programs (Table 3). Middle- and high-income LAC countries spend more on social and health programs, in both relative and absolute terms. The relative share of social expenditures as a percentage of GDP in the countries with an annual per capita income higher than US$ 5 000 is around 15.5%. In contrast, that figure is about half that amount, just 7.9%, for the LAC countries with an an-

TABLE 2. Total central-government expenditures as a proportion of gross domestic product (GDP) and in US$ per capita

Area/Country	Govt. expend. as % of GDP				Per capita govt. expenditure, 1998[a] (US$)
	1973	1980	1990	1998	
World	24.0%	30.2%	25.8%	27.9%	$2 051
European countries[b]	25.5%	31.1%	38.6%	40.1%	$9 420
Latin America and the Caribbean	16.6%	19.2%	25.5%	21.0%	$1 476
Canada	19.5%	23.6%	26.2%	21.5%	$5 876
United States of America	20.8%	20.7%	22.7%	19.9%	$6 878

Sources: References 4–6.

[a] Per capita government expenditure is given in US$ of the year 2000 in terms of purchasing power parity, which equalizes the purchasing power of different currencies by eliminating the differences in price levels between countries.

[b] European countries = countries of the European Monetary Union.

TABLE 3. Public expenditures on social programs and on health programs as a percentage of gross domestic product (GDP) and in US$ per capita, countries of Latin America and the Caribbean (LAC)

Country	Total social expenditure/GDP		Health expenditure/GDP		Per-capita expenditure in 1996–1997[a]	
	1990–1991 (%)	1996–1997 (%)	1990–1991 (%)	1996–1997 (%)	Social (US$)	Health (US$)
Argentina	17.7	17.9	4.0	4.1	2 164	496
Bolivia	6.0	12.0	1.2	1.4	286	33
Brazil	19.0	19.8	3.6	2.9	1 449	212
Chile	13.0	14.1	2.1	2.5	1 285	228
Colombia	8.1	15.3	1.2	3.7	901	218
Costa Rica	18.2	20.8	7.1	7.3	1 716	602
Dominican Republic	4.5	6.0	1.0	1.4	343	80
El Salvador	5.4	7.7	1.8	2.8	330	120
Guatemala	3.3	4.2	0.9	0.9	158	34
Honduras	7.8	7.2	. . .[b]	. . .	172	. . .
Mexico	6.5	8.5	. . .	. . .	749	. . .
Nicaragua	10.3	10.7	4.2	4.4	225	92
Panama	18.6	21.9	6.1	6.8	1 248	388
Paraguay	3.0	7.9	0.3	1.2	352	54
Peru	2.3	5.8	. . .	...	274	...
Uruguay	18.7	22.5	3.2	3.7	1 818	299
Venezuela	9.0	8.4	1.1	1.1	483	63
Low-income LAC countries[c]	. . .	7.9	. . .	2.1	257	47
Middle-income LAC countries[d]	. . .	15.5	. . .	3.7	. . .	259
LAC regional average[e]	10.1	12.4	2.7	3.2	821	172
Maximum	19.0	22.5	7.1	7.3	2 164	602
Minimum	2.3	4.2	0.3	0.9	172	33
Canada	. . .	. . .	. . .	6.6	1 216	1 803
United States of America	. . .	. . .	. . .	5.9	. . .	1 966

Source: References 10 and 11.

[a] Per-capita expenditure is in US$ of the year 2000 in terms of purchasing power parity, which equalizes the purchasing power of different currencies by eliminating the differences in price levels between countries.

[b] The ellipsis symbol (. . .) indicates that data were not available.

[c] Low-income countries = countries where the annual per capita income is less than US$ 5 000 in terms of purchasing power parity.

[d] Middle-income countries = countries where the annual per capita income is more than US$ 5 000 in terms of purchasing power parity.

[e] LAC regional average = arithmetic average for the countries of Latin America and the Caribbean that are included in this table.

nual per capita income lower than US$ 5 000. The differences in the absolute amounts of expenditures on social and health programs are even greater, with the amounts in low-income countries being around one-fifth the levels in middle-income LAC countries.

Government expenditure in health as a percentage of GDP is an indicator of political commitments to address social concerns about health issues. Distribution of those expenditures by income groups is an indicator of the use of health expenditure as a tool to address equity issues.

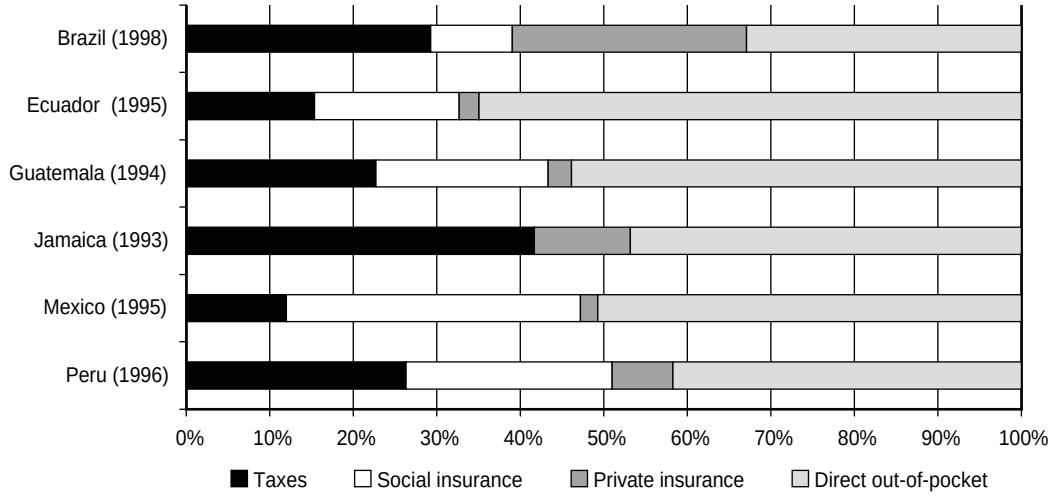
Assessing equity

As one way of looking at the issue of equity, Figure 1 summarizes the sources of funding for national health care expenditures in six LAC countries. As can be seen, these countries vary greatly in the relative importance of taxes, social insurance contributions, private insurance, and direct out-of-pocket spending.

The variations among the other LAC countries are similar to the ones for the six countries of Figure 1. Overall, in the LAC countries around 56% of total health care expenditures are private expenditures, specifically direct out-of-pocket expenditures and contributions to private health insurance schemes and prepaid health plans. For the remaining 44% of health care expenditures, there are large variations in the relative importance of the different revenue collection instruments used.

Inequities in access to health care services can be assessed by comparing the actual utilization of health care services with estimates of the distribution of the need for these services. Studies on inequalities in access to health care services in the LAC countries have found major inequities in access to different type of health care services. Inequities in access to preventive health care services are more pronounced than inequities for curative services. Inequities in access to hospitalization are less pronounced than inequities for curative care services (3).

FIGURE 1. Health financing mix in six countries of Latin America and the Caribbean



Source: Reference 3.

TABLE 4. Distribution of benefits (%) of government expenditures on health in selected countries of Latin America and the Caribbean by income quintiles

Country/Year	Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)
Argentina[a]	31.0	18.0	26.0	18.0	7.0
Argentina, 1991[b, c]	38.7	16.6	25.5	14.8	4.5
Bolivia, 1990[c]	15.2	14.7	24.4	24.4	21.3
Brazil, 1994[c, d]	31.5	26.5	19.5	14.2	8.3
Colombia, 1970[a]	21.4	26.9	19.0	25.9	6.8
Colombia, 1974[a]	28.0	22.0	20.1	17.7	12.2
Colombia, 1993[a]	27.4	25.6	18.7	15.9	12.5
Colombia, 1997[c]	17.5	19.7	22.2	20.7	19.7
Costa Rica, 1986[c]	27.7	23.6	24.1	13.9	10.7
Chile[a]	31.0	25.0	22.0	14.0	8.0
Chile, 1996[c]	30.9	23.2	22.2	16.5	7.2
Ecuador, 1995[a]	12.5	15.0	19.4	22.5	30.5
Ecuador, 1994[c]	18.8	41.9	16.0	16.3	7.0
Guatemala, 1998/99[a]	12.8	12.7	16.9	26.3	31.3
Jamaica, 1993[a]	25.3	23.9	19.4	16.2	15.2
Peru, 1997[a]	20.1	20.7	21.0	20.7	17.5
Uruguay, 1993[c]	34.9	19.9	22.1	13.2	10.0
Average[e]	26.9	23.3	22.0	16.7	11.1

Sources: References 3 and 10.
[a] Estimates reported in Suárez-Berenguela (3).
[b] Distribution of households is according to earned income, less social security contributions, income taxes, and government subsidies.
[c] Estimates are from CEPAL (10). Quintiles are by level of income per capita. These estimates include government expenditures on both health and nutrition.
[d] Data for Brazil are for São Paulo only.
[e] Unweighted average from CEPAL (10).

Distributive impact of government health expenditures

Most of the studies on the distributive impact of government expenditures assess the distribution of the benefits of government expenditures on health care services according to income group. The concepts and methods used are similar to those used in the analytical and empirical work on fiscal incidence analysis sponsored by the World Bank and the International Monetary Fund (12–14). Table 4 shows estimates of the distributive impact of government expenditures on health in LAC countries, by income quintiles. There are large variations in the figures, both among countries and within the same country over time. These findings suggest there is a large degree of variability in the effectiveness of health expenditures as a distributive tool. Paradoxically, there seems to be an inverse relationship between the income level for the countries

and the distributive impact of government expenditures on health. The distributive impact of government expenditures is progressive in higher-income countries, including Argentina, Chile, Costa Rica, and Uruguay. Conversely, the impact is regressive in lower-income countries, including Bolivia, Ecuador, and Guatemala. The distributive impact is neutral in the case of Peru.

Colombia is the only country for which we have estimates for the 1970s and the 1990s (Table 4). Those figures show that policy decisions may have a noticeable effect on the distributive impact of health expenditures. The progressivity of government expenditures in health was higher in 1974 and 1993 than it had been in 1970, but that progressivity had been lost by the end of the 1990s.

POLICY CHALLENGES FOR LATIN AMERICA AND THE CARIBBEAN

Public expenditures and fiscal revenues are the main tools that governments can to use to achieve more equitable financing of and access to health care services. However, most of these fiscal instruments are not fully utilized in developing countries, including the countries of Latin America and the Caribbean. Higher levels of taxation are needed if the LAC nations are going to provide the same levels of government services as the more-developed countries do.

The levels of public expenditures on social programs are the results of public policy choices. In the LAC countries there are large variations in the distributive impact of government expenditures on health care services and public health programs. That suggests that in most of these nations that there is ample room for improving the use of government financing and expenditure tools in order to achieve more equitable financing and access.

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SINOPSIS

Herramientas políticas para lograr una financiación y un acceso más equitativos a los servicios de atención sanitaria en América Latina y el Caribe

En este trabajo se revisan las herramientas e instrumentos políticos para lograr una financiación y un acceso más equitativos a los servicios de atención sanitaria de los países de América Latina y el Caribe. Se resumen los fundamentos de la intervención de los gobiernos para abordar los objetivos de eficiencia y equidad, y se presentan datos empíricos sobre la importancia de los diferentes instrumentos políticos de los gobiernos para lograr una financiación y un acceso más equitativos a los servicios de atención sanitaria. También se proporcionan estimaciones de la importancia relativa, magnitud y composición de los ingresos de los gobiernos, así como de sus gastos en salud y del impacto redistributivo de los mismos. El artículo concluye con un resumen de los retos políticos a los que se enfrentan los gobiernos de América Latina y el Caribe para intentar lograr una financiación y un acceso más equitativos a los servicios de atención sanitaria.

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