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HEALTH SECTOR REFORM, FINANCING, AND THE POOR **
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When the Heads of State met in Miami in 1994 for the I Summit of the Americas, they addressed the issue of health from several angles, but devoted considerable attention to the reform of the health sector, and mandated the Pan American Health Organization (PAHO) to coordinate efforts for monitoring the progress of such reforms in the hemisphere. This has proven to be one of the most challenging tasks that have been assigned to us, and I have been constantly amazed by the multiplicity of issues that are involved. Most of the interest has been in the reform of the health care systems, and little attention has been given to reform that addresses the other determinants of health. In addition, the focus has been mainly on the personal care systems and less on the health systems that address the population-based needs that have traditionally fallen within the purview of the public health systems. Although I am coming more and more to the belief that there is too sharp a distinction made between the two systems, for the purpose of this afternoon's discussion I will pay more attention to the personal care systems.

My remarks will draw on the information being collected through the Latin America and Caribbean Health Sector Reform Initiative of the United States Agency for International Development (USAID) that has been supported by us. I will confine myself to the countries of the Americas, and most of the data I will cite are taken from the 1998 edition of Health in the Americas. I should note that while there are good data on the health care systems and how they are financed, as well as numerous studies on equity in health, there is very little work on the impact of the reform process on the poor, and the precautions that should be taken to ensure that any impact is not negative in terms of health status or access to services.

The interest in health sector or health care reform has stemmed from several general concerns. There is no doubt that the indicators of population health in the Americas are improving steadily, but there is dissatisfaction that there are still gross inequalities in health outcomes and in access to basic health services. We estimate that at least 25% of the population of Latin America and the Caribbean lacks access to basic health services and, almost by definition, this group is the poorest in the society. The average national health expenditure is approximately 7.3% of the GDP, and the steady increase in this figure is also a source of concern. In addition, whereas in the decade of the eighties, when the Region suffered from a

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severe economic crisis and the fraction of the national health expenditure that came from the public purse fell, we now see that at least in the first part of this decade —when there was evidence of economic recovery— the public share began to rise again. The interest in reform in health has also been a part of the general thrust to reform the state apparatus as a whole. In addition, the changing health profile in the Region has called into question the capacity of the systems to deal with the new health realities that stem from changes in demography and forms of social organization.

There is general agreement that the major objectives of the reform processes that are occurring in one form or another in all countries are to increase efficiency, effectiveness, quality, financial sustainability, and equity. This concern for equity has many different connotations. There is the issue of equity regarding social groups, particularly the poor; equity in health services and outcomes; and equity in relation to how the services are organized and financed to ensure certain outcomes. There is often ambivalence as to whether the efforts should be directed or targeted towards the deprived or whether there should be efforts to raise the general standards such that they benefit as a consequence. This is not an abstract philosophical point, as one or other approach determines such basic steps as the forms of collecting and analyzing data. My own bent is towards the egalitarian position and, therefore, I have no difficulty in emphasizing in PAHO the imperative need to have data so disaggregated that we are able to detect the groups that are disadvantaged and that, therefore, need special attention. In the case of health care reform, there is no doubt that the poor represent the group that needs special attention.

There is substantial variation in the health systems in the Region, but I would venture to say that the dominant forms of organization are not particularly pro-poor. Traditionally, there has been segmentation of the health care systems into three subsystems —the ministries of health; the social security institutions; and the private, for-profit sector. I must note that this does not apply to the Caribbean where the social security systems have concerned themselves with social benefits that do not include health care, and the ministries of health and the private sector deliver the health care. In Cuba, the Ministry of Health is the single provider. In countries where the triad of subsystems functions, the general rule has been that it has fallen to the lot of the ministries of health to fund and provide the services for the poor. I always fear that health services uniquely for the poor will be poor services. The approach must be to provide a basic set of services to everyone without specifically targeting the poor.

We have found growing acceptance of the view that the segmentation of the sector is not the most efficient and certainly not the most equitable. There is also agreement that the reform has to address the form of organizing the services that includes the removal of this segmentation, as well as the form of financing health care, and equally important the role of regulation or guiding the system that must lie with the ministry of health.

The countries of the Americas spent about $1.2 trillion on health in 1995, which represents about half of the world's expenditure and 12.8% of the hemisphere's GDP. In Latin America and the Caribbean the expenditure was $114 billion and represented 7.3% of that Region's GDP. While the weighted average expenditure per caput was $240, there was a wide disparity among the countries, with Haiti and Nicaragua spending $9 and $38, respectively. Argentina and Uruguay were among those who had the highest expenditure –$800 and $500,

respectively. The majority of the expenditure is in the private sector, with a ratio of 51:49, private to public spending. The poorer the country, the greater share of health expenditure that comes from the individual. This runs counter to the common idea that the public expenditure is more important in poor countries. Thus, in Haiti 63% of expenditure is private, and the figures for El Salvador, Colombia, and Ecuador are 73%, 70%, and 68%, respectively. Approximately two-thirds of this private expenditure is in the form of direct payment to providers of health care services. Our data show that the fraction of the private health expenditure that does not go for direct payment is largely devoted to purchasing insurance of one form or another. The number of persons in private insurance schemes has increased from $48 million in 1991 to $70 million in 1996, and there is every indication that this figure is growing. Given the vagaries of income generation in the poorest of the countries there must be considerable variation in the capacity of the poor to access private services even when they are available. Also, in view of the difficulty in regulating the quality of services in the majority of countries, especially the poorest ones, there is doubt as to whether the expenditure on care by the poor is indeed buying them an optimal product.

Public spending is concentrated mainly in public social security institutions, and represents about 40% of total public spending. Central government accounts for 37% and local government for 23% of public spending. The expenditure on social security, although it occupies such a large fraction of the public spending, covers only about one quarter of the total population. In general, where there is a high level of spending in the social health insurance scheme, there is a high level of coverage. The converse is true. In the Dominican Republic, which has the lowest spending by social security, only 7% of the population is covered. In those poor countries with low levels of coverage, and with limited economic possibilities, it will be the poor who will again have difficulty in accessing services.

As we have seen, in the poorest countries private expenditure forms a higher proportion of national health outlays. This does not run counter to the generally accepted positive relationship between per caput income and spending on health.

The increase in health expenditure in Latin America and the Caribbean over the past 15 years has been greater than the increase in economic growth and has awakened the same kind of concerns that we have seen in this country. Also, the fact that much of this increase was financed with public resources made countries look with even more concern at the fact that there was not an accompanying increase in equitable access to health services. It is possible that the poor were even more disadvantaged, in spite of the increased spending. There has been reflection that in spite of the increased spending, there is a considerable health gap, and inequity in health has at the best not been improved. For the level of expenditure in the Region, both coverage and health indicators should be better.

There is increasing enthusiasm for systems of reform that seek to expand social protection in health and in desegmenting the system such that all parts assume the functions necessary to ensure that expansion. Thus we see in Costa Rica the Ministry of Health divesting itself of primary responsibility for the actual delivery of health care services which are being financed by a pool of resources that come from government as well as social insurance sources. The Ministry is assuring universal coverage to poor and non-poor alike, without actually

delivering the services and is carrying out the monitoring and regulatory functions through decentralized mechanisms. Its decentralized, or regionalized, systems are converted from the executing role that they played formerly to the new guiding or steering functions. This does not imply the absence of the private sector as occurs in Cuba, but has the same end of ensuring universal access and, by definition, addressing the health needs of the poor.

One of the major problems in ensuring a stable or single pool of funding such that there can be a single insurer has been the rapid growth of the informal sector in Latin America and the Caribbean. In Venezuela, for example, the percentage of the informal urban employment was approximately 37% in 1990, but this had risen to about 50% by 1996. It is not inevitable that the informal sector is made up only of the poor, but it is true that the poor and poor women do dominate this sector. The lack of access to health care by this group is shared to a large extent by the rural population and very specifically the rural poor, although this class has not increased significantly over the last decade. In contrast, the numbers of the urban poor are increasing steadily and now number some 125 million persons. Several factors are involved in the lack of access to and use of services by the poor, and they include geographical isolation of services and in many instances other transactional costs that are excessive.

One approach that has been considered for providing health care to the informal sector that embraces the poor is that of micro-insurance schemes. These are conceived as autonomous, with voluntary affiliation and adapted to the social and work conditions of the group. It is believed that many poor have not been included in social insurance schemes not only because of lack of material resources, but because poverty itself leads to a disengagement from society and consequent lack of empowerment or perhaps disempowerment. We are currently discussing with ILO how to explore the nature of such schemes in Latin America and the possibility of expanding them.

Micro–insurance is only one of the means of financing the health services, and indeed is not the most common. The other accepted means include general revenue from taxes, user fees, private insurance, and social insurance contributions. I have already alluded to the growth of private insurance and the presence of the social insurance contributions. Taxes have been used and are being used in almost every one of our countries to finance health care and, prior to recent changes in the organization of the economies, the welfare model predicated that the major funding for healthcare would come from taxes. One of the advantages was that equity in the delivery of services was almost assured, and there were no financial barriers that prevented the poor from accessing the services. However, in recent times, as health has had to compete with other sectors for allocations from a budget that has not expanded to keep pace with societal demands, there have been problems in financing the sector. Tax reform in Latin America has resulted in modest increases in revenue, and the average tax burden is now 14.1% of GDP. I know of no instance, however, in which the government has been able to designate and maintain a specific tax for health or a specific portion of the tax for the health of the poor. There are numerous examples, however, of specific health programs that provide subsidies to the poor in areas such as nutrition.

I refer, lastly, to user fees that are collected at point of service and are very likely to have the effect of reducing the demand for service. My experience of this means of supplementing the

financing of services is that the difficulty in collecting the fees, and the complications that arise in establishing the criteria for exemption such that the poor are not disadvantaged, make them of marginal benefit and sometimes positively damaging to the poor.

The models of health sector reform and financing in Latin America and the Caribbean are becoming of considerable interest to the managed-care organizations in this country, and the interest may indeed have an impact on the Region's ability to incorporate the poor into the systems that are being designed. As the rate of profit in managed care organizations here begins to fall, it is natural to look at the potential markets in the south. There are already significant managed-care markets in Latin America. One source quotes revenues from managed-care in Brazil as being $2.99 billion in 1995, and the market is growing. A recent article in *The Economist* claims that "over 45 million Brazilians were covered by private health plans in 1998, four times the 1988 figure." The funds that are already being managed by social security schemes are considerable, and the example of the ISAPREs in Chile shows the possible success of the privately managed social insurance schemes. One concern that has been expressed is the extent to which these schemes will contribute to more inequity in health care and the possibility of even further marginalization of the poor. The answer must lie of course in the capacity of the ministry of health to exercise the regulatory or guiding role to which I have referred so often.

In summary, I believe that the best approach to a health care system that pays attention to the health needs of the poor is one in which inputs from various sources such as general tax revenue and social security create a single fund for financing a specifically determined set of services that will be universally available. The reform of the current systems will also have to focus not only on the mechanisms for financing and ensuring provision of the needed services, but of equal if not greater importance is ensuring that the State through the ministry of health has the tools to guide and regulate the system. There is still a great deal of empirical work to be done. As I said at the beginning, even now no one can say for sure that one or other scheme of financing will produce an improvement in the health status of the population we most wish to benefit —the poor. I hope that some of you here will be motivated to produce or stimulate the production of the data needed to answer that question.

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