

SESSION V – Discussant:

Cristian Baeza. [to be revised by the author].

Thank you, very much for the invitation. I think it is a tremendous seminary and discussion. Don't worry, I am not going to comment on every one of the numbers we just saw and I have like one minute, so I am going to make a very brief discussion.

I want to take the policy-maker perspective in Latin America rather than population statistics discussion on the details of the methodology although I am going to discuss a little bit of that. From the policy making perspective, I think what we are discussing in Latin America is the need for a policy instrument that would allow us to predict who will be exposed to health expenditures that will throw him or her or the family into poverty and even worse will maintain them in poverty because of damage to their capacity to produce human capital. So the perspective that most of the Latin American countries are taking here is that we need an instrument to be proactive in preventing through public subsidy policy the effects of health shocks and the contribution to poverty. As I will discuss later on, my perception of the papers I had the opportunity to review is that we are still and most likely we need to be in that phase. In the phase were we are looking at population statistics and looking at no work in the aggregate the impact of health expenditures is on poverty rather than having an instrument that will allow us family by family to intervene early on in the process of them falling into poverty.

My perception from that respect, I agree with one of the papers that the NAS approach is probably a little bit sort of an autopsy of what has happened with poverty and health rather than an instrument to be proactive and have a cut ex-ante in the discussion.

Therefore, I agree with the approach of having a cut at the expenditures somehow including it into the poverty line as an ex-ante. Having said that, however, I would say that although the method of including the health expenditures into the poverty line is certainly an improvement in perspective to policy makings been able to anticipate an predict the impact on household, I would argue that is still far in terms of been effective and efficient and I will discuss why. The reason why I say that is that using the average, although better than using the median, probably in terms of getting closer to

identifying the amount of expenditures that would throw people into poverty and using those indicators for subgroups of the population divided by age or gender or whatever, is still a bad predictor of what is going to happen with specific family in the future and is, I would say a very bad predictor in terms of been able to capture the variance and predict the variance and been able to get close on what the actual expenditures will be.

As I said the position I am taking in the discussion is of policy making been able to intervene early in the process of people falling into poverty with public subsidy so you need to be able to distinguish there is who is going to follow into poverty. It is certainly a good measure to make audiences, particularly in the US apparently, aware of the importance of health expenditures as a contributor to poverty. My perception is that we already take it for granted. That is of a very significant importance and that's why we are willing to subsidize and that's why we are asking the question of how we identify those specific families. Here is where I think the direct and indirect method might shake hands together. I come from the insurance field and I have been working a lot on risk adjustments and the possibility of predicting the variance through models that will use the past year's consumptions in health and expenditures it's something that might significantly increase the capacity of capturing the predictable variance for the purpose of identifying families in a better way.

The second thing that really strike me a little bit I think is that at the core of the discussion is the issue of what is the necessary expenditures in health, what is the adequate level of expenditure, what is the consumption that we would respect. The position taken by both methods, the direct and the indirect, used by the authors basically assume that the necessary expenditures in health are a function of the actual expenditures of the subgroups. Both use a measure of the average of the median of the categories that are studying but it doesn't tell us anything about what the necessary consumption is; because it assumes that the necessary consumption is a function of the *actual* expenditure or is a function of the *actual* consumption of the groups.

My perception is that that is a little bit complex, particularly for Latin America as consumption may not necessarily be what people need and people might be consuming heroine and spending a huge amount of money in heroin but doesn't mean that we will

use a measure of the consumption of heroin assuming what is the necessary consumption and it means even less that we are willing a society to subsidize that consumption. What is happening in Latin America for good or worse, there is an increasing trend to a normative decision proposal in what the necessary consumption should be through what is called the guaranteed health packages now; saying the consumption that a society's willing to subsidize is this level.

I think some of the results in terms of comparing the consumption of the poor and the rich and the high level of expenditures by the rich and the low levels of expenditures by the poor and subsequently adjusted by both, the Peruvian case and the U.S. case, somehow illustrate the issue. I mean no wonder if we do not standardize or adjust by a level of decide conception by the society or standardized package, we will witness exactly that; we will witness that the rich spends more and the poor spends less and if we don't adjust the expenditures to this level, it is very difficult to interpret what the levels of expenditures by the poor are. Both papers do adjustments to the level of consumption of the uninsured. I have to confess that I didn't understand quite well how the adjustment was done and how the numbers came up the 1.115 but you can explain it later, I am sure.

Some specific comments on the presentations by WHO. I didn't have the papers but I know Chris worked very well, so the issue of the 40% of capacity to pay and using capacity to pay only with caloric consumption at a very basic level I think calls for the discussion again in what are we protecting when we want to protect people from falling into poverty: are we protecting basic caloric consumption or are there other inputs to the human capital formation, a function of the household that we want to protect. My perception, although food is very important for me, as you can see I think is not the only parameter we want to protect in this discussion so I am a little bit worried about that approach.

The second which is common, I think to the three papers is the issue of including only out-of-pocket expenditures. I am not sure it is in the case of the US where out-of-pocket also includes premium rates. In the case of the discussion in Latin America we tend to separate those two discussions and the only thing I want to emphasize is the

need to include premiums and out-of-pocket not pure out-of-pocket. Otherwise I don't know if Ruben wants to give me all his income and I will protect him from his co-payments, which I don't think he will.

The third issue is and with this I am going to close the comments. The last issue is the findings on the role of accidents in Peru and the probability of becoming poor. This is something that the people who have been working in social protection in health in protecting people from health strokes, the financial aspects of health strokes. I have been telling all the way you have events that really can crush your disposable income and consumption and so on but it really poses key questions on the role of the public subsidy policy: whether we should concentrate on protecting people from these accidents, rather than low frequency-low cost preventive and primary health care and so if we take the perspective of the poverty connection. That's basically all so we are having some time. Thank you.