



Universal health

Access and coverage for all

Fiscal space for increasing health priority in public spending in the Americas Region

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Contents

I.	Introduction	4
II.	Fiscal space for health in Latin America and the Caribbean: analytical framework ...	7
1.	Introduction	7
2.	Analytical and conceptual framework of the policy options	7
2.1	<i>Creating conducive macroeconomic conditions.....</i>	<i>8</i>
2.2	<i>Greater prioritization for health.....</i>	<i>8</i>
2.3	<i>Creating new tax revenues through a greater tax burden.....</i>	<i>8</i>
2.4	<i>Increasing the efficiency of tax collection</i>	<i>9</i>
2.5	<i>External aid with loans and specific donations for the health sector</i>	<i>9</i>
2.6	<i>Increased efficiency in existing health expenditures.....</i>	<i>10</i>
3.	Implementation considerations.....	10
III.	Fiscal space and expanded social dialogue	12
1.	Introduction	12
2.	Theoretical framework	12
2.1	<i>Increasing fiscal resources</i>	<i>13</i>
2.2	<i>Prioritizing public health expenditure (PHE)</i>	<i>13</i>
2.3	<i>Greater efficiency and equity in insurance and social inclusion policies to fight poverty.</i>	<i>14</i>
2.4	<i>Improving purchasing capacity.....</i>	<i>14</i>
2.5	<i>Developing structured systems in IHSDNs/PHC</i>	<i>14</i>
3.	Policy recommendations	15
IV.	Economic growth and fiscal priority as sources of fiscal space for Universal Health	17
1.	Introduction	17
2.	Problem and underlying causes.....	17
3.	Analytical framework.....	18
4.	Study and grouping of countries.....	19
5.	Analysis methodology.....	19
6.	Results and analysis	19
7.	Analysis and policy recommendations	22
V.	Changes in the taxation structure and formalization of the economy as sources of fiscal space for universal health	24
1.	Situation in Latin America and the Caribbean	24
2.	Analytical framework (Methodology).....	25

3.	Policy options	25
4.	Conclusions	27
VI.	External financing for the health sector in Latin America and the Caribbean	29
1.	External financing as a source of fiscal space	29
2.	External financial aid in Latin America and the Caribbean	29
3.	Thoughts on external aid as a source of fiscal space	31

Tables and graphs

Table IV.1:	Effects of growth on PHE and TPE and TSPE levels.....	21
Table VI.1:	Nonreimbursable external health funding. Impact on reducing gap toward the 6% GDP threshold. Average values (unweighted) 1995-2013	30
Graph IV.1:	PHE and GDP evolution per country during 1995-2014 period.....	20
Graph VI.1:	Nonreimbursable external resources for health, as percentage of total health expenditure	30

I. Introduction

Fiscal Space (FS) refers to the availability of resources to finance an increase in public spending without compromising the sustainability of the government's financial position or the stability of the economy (Heller 2005). It is also defined as the gap between the current level of spending and the level of maximum expenditure that a government can take on (IMF and World Bank 2006). The concept has been heavily applied to health and the World Health Organization (WHO, 2010) and the Pan American Health Organization (PAHO, 2014), have pointed out that to achieve the goal of attaining universal health coverage, it is necessary to look at new sources of financing. The PAHO Member States agreed to reach 6% of GDP spending on health, setting it as a useful reference in most cases, and a necessary condition to reduce inequities and improve financial protection in the framework of universal access to health care and universal health coverage (PAHO 2014).

The development of FS depends on specific aspects of each country (Heller 2006) and this specificity goes beyond value judgments to identify targets and mechanisms to advance economic and social development (Bauer et al. 2010). In turn, the generation of FS aims to fill an important need, as is the extension of coverage and access to health, as well as the need to face the added expense that comes from the aging of the population, the implementation of new health programs, reduced out-of-pocket spending and improving the quality of care, among others.

A central concept of the definition of FS is the generation of new resources. It is not about finding ways to increase the budget surplus but to evaluate new sources from which to obtain financing. Heller (2006) refers to the ability of governments to generate additional resources to existing ones. This characteristic differentiates FS from other merely budgetary concepts. Tandon and Cashin (2010) confirmed that FS focuses on ways to generate a volume of fiscal resources that are not available at the time and that are not expected to be generated in a state of status quo.

Political will and democracy play an essential role in the creation of FS (Durán-Valverde and Pacheco 2012). The channel between social need, political decisions, and the generation of FS through the amount of transparency and justification in the use of resources (Marcel 2014). This is demonstrated by Stucker et al. (2010), where the depth of the democratic

system of tax collection is correlated to the increased public spending on health. In the same vein Clements et al. (2012) concluded that political consensus is a common characteristic of successful countries in terms of improving the conditions and public spending on health. The evidence confirms what Gupta and Mondal (2013) point to, regarding the fact that universal health coverage is more of a political issue than a technical one. FS is the way to achieve this goal, but the initial justification of it passes through a political decision, which in turn is determined by the depth of democracy in each country.

This document presents a summary of a series of policy briefs on the need to create fiscal space for health in the region of the Americas. Thus, each chapter summarizes one of them. Five themes inspired by the overall analysis of 14 countries selected from Latin America and the Caribbean are discussed. The first presents the analytical framework for discussion of the issue of fiscal space and their sources. The second summons and advocates for the implementation of a social dialogue, extended to help facilitate decision-making toward increased public health financing. The third deals with the analysis of economic growth and fiscal priority as resources for the creation of fiscal space, with concrete data from a set of selected countries. The fourth policy brief outlined here discusses the tax structure and the formalization of the economy, as sources for creating fiscal space. Finally, Chapter 5 summarizes the document dedicated to external financing as a source of fiscal space in the selected countries.

International evidence and the series of analysis presented here show that there it is technically possible to generate fiscal space, and therefore the responsibility is on the political will to do so. It also appears favorable to diversify the sources of their creation to ensure sustainability, since diversified measures allow maintaining the conditions of sustainability of the economy and preserving the fiscal balance. Moreover, it seems advisable to mobilize endogenous rather than exogenous sources and to rely on domestic resources, tax and non-tax, rather than external resources such as grants and loans, because external flows generally suffer from high volatility and the additional debt may destabilize the fiscal balance and not be sustainable in the long term. There are some mechanisms that are repeated in almost all the conclusions of the studies and also in the following: the tax increase, the review of tax expenditures, the increase or creation of taxes on products harmful to health, the greater efficiency of spending public and better administration of tax.

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II. Fiscal space for health in Latin America and the Caribbean: Analytical Framework

1. Introduction

The advances achieved in health over the last two decades in Latin America and the Caribbean (LAC) require specific and coordinated actions aimed at improving health systems within the framework of the country's social policies. Economic growth in itself does not guarantee the social rights of the most vulnerable populations, nor the reduction of the inequities that still persist.

In this regard, the regional Strategy for Universal Access to Health and Universal Health Coverage (hereinafter Universal Health) achieves an integrating approach that considers the different dimensions related to the health system. In particular, increased and improved funding is crucial and impinges on the other strategic lines of the resolution. This document seeks to take a closer look at the potential sources available to create fiscal space for health that may be considered among the policy options as a means of sustaining the advances made in the Region.

2. Analytical and conceptual framework of the policy options

Over the past decade, the need to address the insufficiently low public spending on health has been recognized and debated, highlighting the urgent need to increase governments' fiscal undertaking to allocate resources to the health sector, under what is known as "fiscal space." To overcome the limitations of the health system in order to respond to population needs, various papers (Durairaj and Evans, 2010; PAHO, 2010) call for the exploring of possible sources to generate new income for the health sector and for improvements to the efficiency of the system.

With a view to developing an analytical framework, the potential sources for the creation of fiscal space described in the specialized literature are presented.

2.1 Creating conducive macroeconomic conditions

Economic growth can result in increased revenue for governments. However, a direct relationship between the gross domestic product (GDP) and tax revenue is an oversimplification: different growth and development models offer different opportunities for the generation of fiscal space for health. Hence the need to explore the most relevant dimensions that mediate between economic growth and the capability of countries to increase their public expenditure on health.

2.2 Greater prioritization for health

There are several concepts regarding how to measure the fiscal priority for health. One perspective emphasizes prioritization in competitive terms within public spending or social spending. In this case, greater prioritization of health represents increased expenditure in the sector relative to social spending or total public spending. Another perspective positions health expenditure as part of public social spending on the grounds that it also represents an effort toward social inclusion, and that positioning health expenditure as competing with other social sectors undermines the need for an intersectoral approach to Universal Health.

2.3 Creating new tax revenues through a greater tax burden

The low tax burden in LAC countries can be regarded as a window of opportunity. Strategies include various modalities with and without specific allocations for the health sector.

Changes to general taxation: this is one of the principal sources for LAC countries and involves reviewing the administration of existing taxes (VAT, income tax, corporate taxes, etc.), with a view to levying new taxes and a general overhaul of tax collection.

Generating new taxes on a specific group of companies or certain activities: the high economic concentration in many countries of the region facilitates the option of levying special taxes on large companies. Another option would be to tax specific activities—such as tourism or financial activity—which would represent a major source of revenue.

Taxes on specific goods: the tax in LAC countries on “harmful goods”, such as alcohol, saturated fats, or tobacco, is much lower than the average in Organization for Economic Cooperation and Development (OECD) countries. Even if revenue from this is not earmarked

for the health sector, the reduced consumption of these products would lower the demand on the health services.

Resources relating to use of natural resources: the wealth of natural resources places countries in a strategic position economically, and this greatly affects their fiscal capacity. This type of tax can provide an opportunity to acquire exceptionally large amounts when prices are high, but also represents a challenge to sustainability in unfavorable international contexts.

Social security contributions to the health sector: in some countries social security is a consolidated subsector with a long history within the health system, while in others with low public spending on health, this source for the generation of fiscal space is lacking. Furthermore, the potential risks associated with the segmentation of the health system, according to different types of coverage, must also be recognized (Titelman et al., 2014; Cotlear et al., 2014).

2.4 Increasing the efficiency of tax collection

Reducing corruption and tax evasion or avoidance is an important source of fiscal space. However, efficient tax collection is associated with the level of formality of the economy. The size of the informal economy affects not only the amount collected, but also the breakdown of the different types of taxes. In difficult-to-control contexts, levying taxes that are easy to collect (sales taxes) will prevail to the detriment of those that are more difficult to control (personal income tax).

2.5 External aid with loans and specific donations for the health sector

One of the external aid mechanisms is foreign loans. Although these represent an essential support for investment projects in infrastructure, the sustainability of the future operational costs to service these with internal fiscal resources must be considered. Furthermore, a country's foreign debt has macroeconomic implications.

Another mechanism is donations, the effects of which can be complex and even contradictory, with regard to progress toward Universal Health. Firstly, these payments can be very volatile which compromises the continuity of many projects financed in this way. Secondly, management of these funds tends to be arbitrary, involving many institutions in a

process that is often inefficient, and also generating coordination issues among the health authorities and these agencies. Thirdly, sometimes these funds actually displace internal financing meaning that total expenditure remains unaltered—or even competing for the same resources.

2.6 Increased efficiency in existing health expenditures

The *World Health Report 2010* (WHO, 2010) recognizes that reducing inefficiency in health systems is a fundamental and unavoidable strategy in the road toward universal coverage and the creation of fiscal space in a country. The main inefficiencies identified in the report include human resources, drugs, and health services. For LAC countries, within a demographic and epidemiological transition framework, the medical care model, organized based on curative and hospital care, is a key source of inefficiency. Improving the efficiency of health systems requires a framework for the strengthening of the health authority's leadership function.

With regard to financing, the high prevalence of insurance segmentation, the use of payment mechanisms based on historical budgets, as well as the fragmentation of services also increase inefficiency. Advancing toward more integrated forms of collective association of funds for health and toward strategic payment mechanisms constitutes an important potential source of generation of fiscal space.

3. Implementation considerations

Advances are made only with political and institutional efforts. Promoting these changes will imply, in many cases, some conflict of interests between the different actors, so the analysis of the political economy underlying these will be needed. Managing the conflicts and tensions that may emerge via an expanded social dialogue will make it possible to coordinate an array of actors with the technical skills to produce new organizational and institutional mechanisms, and with the political capacity with sufficient social, professional, and technical support.

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III. Fiscal space and expanded social dialogue

1. Introduction

The purpose of this chapter is to promote the development of a strategy of "expanded social dialogue" to generate fiscal space in a move toward greater health access and coverage in Latin American and Caribbean countries. The main contribution of this type of initiative is to promote the necessary social participation and interactive processes with (and between) different actors engaged in developing new institutional agreements.

Within the framework of the regional Strategy for Universal Access to Health and Universal Health Coverage (hereinafter Universal Health) (PAHO-WHO, 2014), the aim is to strengthen the role of the health authority and to combat the country's impotence in defining the "rules of game;" to change the organization and care model (Integrated Health Services Delivery Networks, IHSDNs) with the principal aim of breaking down access barriers; to address insufficient public financing and inequity in the resource allocation and insurance model, and to improve the coordination between health policies and other social policies.

2. Theoretical framework

An analytical framework for the development of an expanded social dialogue should consider the following:

Innovation in institutional arrangements: different ways of creating fiscal space with a view toward Universal Health involve new approaches to institutional arrangements and include those relating to the organization of service production, to insurance modalities, or the transfer of resources, as well as those relating to the source, collection, and generation of resources for health.

Actors: a distinction should be made between actors in the health, financial, and other sectors or social areas, identifying the various interests, conceptions, and positions. An analysis of their technical and political capabilities is essential.

Disputes and conflicts: advancing toward Universal Health is both conflictive and political by nature, where some sectors may feel threatened in the defense of their interests. The

political economy of these processes must be analyzed, as well as the possible tensions that could arise. As inputs to be considered for an expanded social dialogue on the creation of fiscal space, different activities could be undertaken, such as evaluation studies, debates, forums and work agenda, and dissemination.

Each source for the creation of fiscal space should be positioned within the institutional field of the health sector, to provide a context for the type of institutional arrangements, actors, and disputes that form part of the political economy.

2.1 Increasing fiscal resources

This is one of the principal sources for the creation of fiscal space, and includes changing the taxation structure, acquiring more resources from social security, and improving tax collection. Sometimes these changes imply legislative decisions and there will, undoubtedly, be pressures from various sides. The possibility of implementing tax reforms depends greatly on how the political system administers the relative influence of the different groups. In cases in which the improvements only involve decisions of the executive branch, the governance and legitimacy of governments must be considered.

2.2 Prioritizing public health expenditure (PHE)

After evaluating the scope and parameters of this source of fiscal space, different criteria can be used. The first criterion entails increasing PHE relative to total health expenditure (THE). According to another criterion, greater priority for PHE is conceived within the context of increasing THE, on the understanding that countries that experience greater THE growth relative to the gross domestic product (GDP) and total public spending are in a better position to achieve increased PHE.

As decision-making processes associated with the generation of greater resources are generally limited to actors linked with public finances, it is essential to change the approach so that a broader community is included. In this regard, greater social interaction and integration are required between the health sector and areas such as housing, food, education, safety, employment, and the environment. The collective leadership of social policies is a key component.

2.3 Greater efficiency and equity in insurance and social inclusion policies to fight poverty

Combating segmentation and fragmentation offers another source of fiscal space. The number of insurance providers operating without a regulatory framework for risk compensation and resource distribution raises issues of efficiency and equity. As a result, social security systems that foment segmentation must be reformed, while their integration or coordination with other public schemes calls for the creation of regulatory mechanisms, standardization of coverage, and integration of financial resources.

The positioning of professionals, private corporations, or for-profit providers is another element to be considered, as these may be resistant to change. However, it should be stressed that reducing segmentation improves not only equity, but also the efficiency of the financing system and these positive effects affect the entire civil society, nonprofit and for-profit.

2.4 Improving purchasing capacity

Strengthening the regulation and the incentive structure for providers helps increase the efficiency of the health services, and thus represents another source of fiscal space. The array of instruments includes modifications to payment mechanisms designed to transfer resources associated with improvements in the performance of services, and the introduction of case-mix measurement systems, which introduces standards of services in payment modalities by case or result.

Political difficulties with this type of innovation are related to the State's leadership capacity. A critical conflict involves the latent tension between regulation and professional autonomy. In this regard, the expanded social dialogue tool can help attain greater transparency in performance dimensions and their indicators.

2.5 Developing structured systems in IHSDNs/PHC

Developing structured systems not only implies strengthening of primary health care, but also modifying the coordination mechanisms between the different organizations and care levels. If improvements in efficiency are sought, greater fiscal resources associated with the incorporation and/or strengthening of necessary services are needed.

In many countries these changes will lead to disputes between professionals groups, and between professionals and political actors. In such cases, an expanded social dialogue would be a strategy to conduct a constructive and innovative debate, incorporating an analysis of international experiences, the systematization of alternatives, and pilot schemes of varying magnitude in regions or nations.

3. Policy recommendations

Regarding the scope of the dialogue, this should stretch beyond health sector actors to include other social sectors influencing social determinants of health, as well as civil society sectors and economic-financing areas associated with the collection and allocation of resources for health.

In turn, the arguments for the creation of fiscal space should be coherent, so that they may be integrated with the other dimensions of the regional Strategy for Universal Health. Interventions with a limited vision are bound to fail.

Strategies should be flexible and appropriate for the economic and institutional trajectory of each scenario. Measures will vary depending on the health system, the productive structure, and the fiscal capacity available in each country. Few countries of the region are in a position to increase their fiscal resources in the short term.

Resources and institutional production processes should be sustainable. Some financing sources are less sustainable, including foreign aid or taxes on natural resources. Furthermore, the sustainability of the “process” transcends the analysis of the funding capacity or the service needs.

Advancing towards Universal Health is very time-consuming. This analysis is based on data from a decade that has been especially positive in economic terms for most countries in Latin America and the Caribbean. However, the challenges to be faced in creating fiscal space require continuous efforts and must be continuously explored and scrutinized with the relevant prospective studies.

The concept of health as a social right should be strengthened, and health policy must be treated as a social policy designed to reduce inequalities and inequities. We must take into

account that almost all the countries studied present regressive collection systems, and do not reach the minimum threshold of public spending on health of 6% the GDP earmarked in the regional Strategy.

Concerning the efficiency of health systems, in the study of non-communicable diseases, a weak correlation was drawn between health coverage and outcomes. This relation is most likely conditioned by the efficiency in the organization of the system (its performance), by the existence of access barriers, and by lifestyle habits. The incorporation of new ways to improve the effectiveness and efficiency of the health services, as part of the expanded social dialogue agenda, will also make it possible to include evaluation criteria that would, in turn, serve as an accountability mechanism.

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IV. Economic growth and fiscal priority as sources of fiscal space for Universal Health

1. Introduction

The relationship between economic conditions, fiscal priority for social policies, and public health expenditure (PHE) has varied over the decades and depending on the political leanings of the particular governments in Latin America and the Caribbean (LAC).

In LAC during the 1980s, there was a generalized deterioration in social spending both in absolute terms and in relation to total public expenditure (TPE), which was reflected in its use as a fiscal adjustment tool (Almeida, 2002). In the 1990s, spending on health services continued along the same lines as the previous decade, with further entrenchment. In the two decades after 1980, private financing was always higher than public. In European Union countries, on the other hand, during the 1990s the trend in health funding was the reverse to that in LAC, with the growing importance of public financing reaching almost 80% in the second half of the decade (Almeida, 2002).

The decade commencing in 2000 offered favorable economic conditions for LAC countries, with great progress in the mobilization of resources by governments and a clear differentiation compared to the political leanings of the previous decade. In most countries of the region, this reversion favored the sustained growth of total health expenditure (THE), as well as the public financing of this sector (GHED-WHO, 2015). Nevertheless, fiscal efforts are still insufficient to make significant advances toward the Strategy for Universal Access to Health and Universal Health Coverage (hereinafter Universal Health) (PAHO/WHO, 2014).

2. Problem and underlying causes

The distance between PHE levels and some benchmarks associated with public financing needs allows us to gauge the challenges still pending in efforts to improve the fiscal space for health. In general, two types of thresholds are used to calculate this gap in the resources needed: the PHE value as a percentage of the gross domestic product (GDP), as that promoted by PAHO, and a per capita PHE value.

Regarding the PHE as a percentage of GDP of each country, this indicator has been seen to improve in all countries selected for the present study. However, the only country that exceeds the reference 6% GDP threshold indicated in the regional Strategy for Universal Health (PAHO/WHO, 2014) is Costa Rica—for all other countries, the PHE increase as a percentage of GDP required to exceed this threshold is between 16% and 92%.

Looking at the per capita PHE value at two different time points (1995 and 2013), increases are also observed in the indicator in all countries. Nevertheless, if the benchmark taken is the average per capita PHE of countries that have reached indicators of results and resources invested, compatible with those expected for the implementation of a Universal Health strategy, none of the countries would reach the average, with an increasing gap during this period.

3. Analytical framework

Aimed at the creation of fiscal space in favor of Universal Health strategies, this paper seeks to determine to what extent economic growth and the political priority of governments toward social policies impact the expansion of PHE. The dimensions considered in this analysis include the evolution of public financing as a variable dependent on the general economic growth of countries and on the fiscal priority assigned by governments to social spending.

Public financing is analyzed using the per capita PHE, with funds from compulsory tax revenues and social security contributions. Economic growth is evaluated through per capita GDP growth. Fiscal priority for social spending is measured as changes in total social public expenditure (TSPE) and total public expenditure (TPE).

The analysis of the impact of changes in the per capita GDP on the per capita PHE is measured through the elasticity of both variables. The impact of fiscal priority on PHE entails two elasticity measurements: elasticity between per capita GDP growth on the evolution of TPE and TSPE, and the elasticity between both variables and per capita PHE.

4. Study and grouping of countries

This paper is based on a study of 14 countries: Argentina, Barbados, Brazil, Bolivia, Chile, Colombia, Costa Rica, Ecuador, Guyana, Honduras, Jamaica, Nicaragua, Paraguay, and Peru. Although each country is analyzed separately, given their heterogeneity, it was decided that the procedure would benefit from the grouping of countries according to economic criteria.

With this in mind, four groups of countries were formed. The first group includes upper-middle-income countries: Argentina, Brazil, Chile, and Costa Rica. The second group is the low-income countries: Bolivia, Honduras, Nicaragua, and Paraguay. The third group comprises countries of the Andean Region: Colombia, Ecuador, and Peru—although they have different GDP, their level lies between upper-middle-income and low-income countries. Finally, the only criterion grouping Barbados, Guyana (South America), and Jamaica is that they are in the Caribbean.

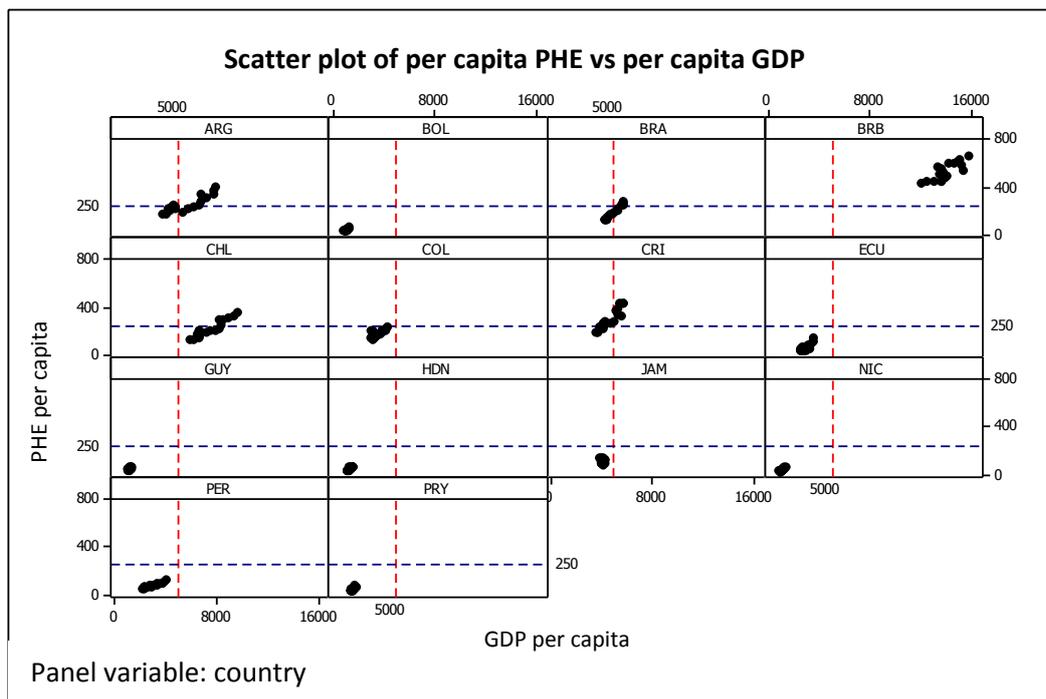
5. Analysis methodology

Scatter plots are used to visualize the evolution of the variables and their functional relationship. The growth rate is calculated through log-linear models, considering each variable as a regression over time. To analyze the relationship between dimensions, the elasticities between the variables being studied and the significance of their parameters are measured, using log-linear models. The models are applied to each country individually, to the overall measurement, and to each group of countries.

6. Results and analysis

Although there is a clear relationship between per capita GDP and per capita PHE, different trajectories are also recognized, with GDP fluctuations impacting on PHE to varying degrees. Graph IV.1 traces the trajectories of each case, including their location in quadrants, which makes it possible to identify and locate the countries in relation to different GDP and PHE levels.

Graph IV.1: PHE and GDP evolution per country during 1995-2014 period



Source: Authors

For the group of upper-middle-income countries, the final point of the series attains levels in the fourth quadrant (high GDP and PHE levels). The scope of the changes is very substantial, considering that the starting point in almost all the cases (except for Chile) is the first quadrant (lower GDP and PHE levels). The group of countries with low GDP levels has a limited trajectory: in all cases they are located and remain in the first quadrant. The evolution of the Andean group starts from the first quadrant and has a greater trajectory than the previous group. Finally, the group of Caribbean countries is characterized by its heterogeneity. Barbados has GDP and PHE values in the fourth quadrant during the entire period studied. Jamaica shows a limited trajectory in the first quadrant, and Guyana remains in the lower part of the first quadrant, with low GDP and PHE levels.

Table IV.1: Effects of growth on PHE and TPE and TSPE levels

Country	Elasticity				
	Economic growth and public health expenditure	Economic growth and fiscal priority		Fiscal priority and public health expenditure	
	PHE pc vs GDP pc	TPE pc vs GDP pc	TSPE pc vs GDP pc	PHE pc vs TPE pc	PHE pc vs TSPE pc
Argentina	0.872	1.47	1.3	0.885	0.588
Barbados	0.414	1.71	No data	0.77	No data
Bolivia	1.71	1.79	1.60	0.945	0.638
Brazil	2.45	1.13	2.03	1.93	1.11
Chile	2.03	1.14	1.11	1.65	1.68
Colombia	1.01	1.28	1.7	0.834	0.721
Costa Rica	1.73	1.14	1.60	1.44	1.04
Ecuador	3.28	3.39	4.03	0.947	0.707
Guyana	1.04	1.21	No data	0.169	No data
Honduras	2.15	1.19	3.38	0.944	0.71
Jamaica	-1.71	0.376	-0.345	0.111	No data
Nicaragua	1.93	0.595	3.35	2.16	0.489
Paraguay	2.51	1.66	3.46	1.44	1.03
Peru	1.13	1.03	1.02	1.05	0.913
<i>Group indicator</i>	1.03	1.06	1.32	0.893	0.771

Source: Authors

On analyzing the elasticities of economic growth and fiscal priority for increased PHE, we may conclude that in the group of countries with higher per capita GDP, the evolution of per capita GDP has been an important source of fiscal space for health, with elasticity of per capita PHE relative to per capita GDP close to two—with the only exception being Argentina (Table IV.1). On the other hand, both TPE and TSPE had elasticities over one with respect to the GDP during the period analyzed.

In the group of countries with lower per capita GDP, GDP growth has also been an important source of fiscal space for health, with an elasticity of per capita PHE relative to per capita GDP close to two. The elasticity of the per capita TPE relative to the per capita GDP was over one—with the exception of Nicaragua.

Within the group of countries with mid-range per capita GDP, both Colombia and Peru have unitary elasticities, or slightly over one on analyzing the evolution of per capita PHE, TPE and TSPE relative to per capita GDP. This indicates that spending levels on each of these were closely determined by GDP changes. Ecuador was the exception, with elasticities over 3 in each case (over 4 in the case of TSPE).

The countries of the Caribbean followed a dissimilar pattern. In Guyana, the per capita PHE and the per capita TPE had a slightly positive evolution, although with limited correlation between them. In Jamaica, the per capita TPE showed low elasticity relative to the per capita GDP, while the per capita PHE showed (as well as the per capita TSPE) a negative elasticity. In Barbados, the per capita PHE had low elasticity compared to the per capita GDP as well as to the TPE. However, and unlike the per capita PHE, the per capita TPE had an elasticity of 1.7 during the period analyzed, materializing in a strongly positive behavior.

7. Analysis and policy recommendations

With regard to economic growth with fiscal priorities in favor of social policies to support advances toward Universal Health, this proposal replaces a fiscal priority conceived in terms of competitive crowding out of other social policies with one in which health sector efforts are driven by the development of social protection systems. A fiscal priority toward the development of social protection systems is a component that characterizes the type of growth, and will serve as a factor that contributes to the creation of fiscal space for health.

Observing the influence of the contextualization of each particular case, the analysis of the group of countries reveals that a country's level of wealth is a relevant factor when describing its ability to increase its fiscal space for health. Poorer countries will experience greater difficulty in bridging the gap between public spending and the reference values. Furthermore, forecasts for new economic and political scenarios in the region should be included as essential data when analyzing the country's ability to sustain efforts toward increased public health expenditure. The financing model can include particular features, in different institutional dimensions, that should be considered, including the financing decentralization levels in subnational states, the level of segmentation with various insurance funds and service coverage; the make-up, integration, and dynamics of social security, or the regulation and coordination between public financing and private health insurance.

Finally, the analysis of the time spans studied reveals that the process of increasing PHE and reducing the gap in reaching international references is extremely slow. Firstly, the productive matrix of health systems is increasingly and constantly dependent on

technology. The increasing impact of changes in international prices of imported technology and consumables will depend greatly on differences in domestic prices, the country's foreign trade conditions, and its foreign exchange capacity. Secondly, the political and institutional capabilities necessary to sustain increased public spending in the long term must be carefully considered. These conditions will be affected by the State's capacity to produce non-cyclic policies that defend continuous and increased public financing, with sufficient flexibility and adaptability to address any potential economic, social, and political contingency.

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V. Changes in the taxation structure and formalization of the economy as sources of fiscal space for universal health

1. Situation in Latin America and the Caribbean

The decade commencing in 2000 offered favorable economic conditions for countries in Latin America and the Caribbean (LAC), seen primarily in their high per capita gross domestic product (GDP) growth rates. However, the taxation structure varies greatly from one country to another: while public debt is low in Latin America, it is high in the Caribbean, and low tax burdens still persist, with tax structures being essentially regressive.

In 2010, LAC continued to be the region where average government revenue as a percentage of the GDP was lowest, despite the considerable increase (4 percentage points of GDP) seen in this indicator during the 2000-2010 period. If countries of the Organization for Economic Cooperation and Development (OECD) are taken as reference, the difference in tax revenues exceeds 15 points of GDP. This “fiscal gap” is further aggravated by the extensive informal sector in the region, which means that state social policies are hampered by insufficient public resources that states are capable of mobilizing.

Aside from the low tax collection, the taxation structure in the region tends to be more regressive than countries with higher wealth and development levels (OCDE, 2014). In the latter, direct taxes (on income and profits) represent on average 39% the total tax collection, while in LAC they represent 29.5%. On the other hand, despite the high specific taxes on consumption in LAC, tax on certain products prejudicial to health (tobacco, alcohol) is much lower than in OECD countries (WHS, 2014).

Finally, regarding the breakdown of government revenue in LAC and its evolution during the 2000-2010 period, the most dynamic component was revenue from natural resources. In this regard, we cannot fail to ignore that the high dependency on natural resources as a source of income for the national treasury involves certain risks due to the high volatility of this type of revenue. Also, the prospects of generating fiscal space from this source would appear limited in the light of forecasts of a downward trend in the price of basic goods or energy and mineral commodities (Gómez Sabaíni et al., 2015).

2. Analytical framework (Methodology)

The methodology used to explore the possibilities of creating fiscal space combines a retrospective analysis (2002-2012), to evaluate the conditionalities of the tax burden, with a prospective analysis based on the comparison of local and international conditions. A sensitivity analysis is conducted on the rates of certain taxes and on the size of the informal economy in 14 LAC countries.

This involves two stages: firstly, an individual evaluation of increases in government income that may be generated in each country from each alternative source, and then analyzing the impact on the creation of fiscal space for the health sector from the increases estimated in government income, assuming that such increases are destined to general income and that public health expenditure will increase depending on the level of priority that governments assign to it.

Increased revenue from increasing tax rates

The general methodology used to estimate increased tax revenue from increasing the rates of value-added tax (VAT), corporate income tax, and personal income tax, as well as reducing the informal economy, was defined in three steps:

- a) Assign the rate increase probability for each tax, as well as the relative loss of revenue due to the informal sector.
- b) Determine the magnitude of the tax increase and reduction of informal economy in each country in terms of reducing the gap between LAC and OECD averages.
- c) Calculate the revenue increase resulting from increased tax rates and reduced informal economy.

3. Policy options

The gaps in tax rates and levels of informality are analyzed in terms of LAC and OECD averages. Depending on the probability of reducing informality and increasing tax rates detected, variations in forecasted tax revenue are estimated according to the specially constructed scenarios. Finally, based on previously forecasted revenue increases, the estimated increases in public health expenditure (PHE) are compared in two alternative

fiscal priority scenarios: the current fiscal priority is maintained or a PHE of 15% the total public spending is assumed.

Fiscal expansion and increasing public health expenditure

In the case of the countries with low GDP (Bolivia, Honduras, Nicaragua, and Paraguay), the potential changes to their taxation structures could generate increased tax revenue that would allow a PHE increase, as a percentage of the GDP, of up to 27% on average, and which would reach 43% if combined with a fiscal priority for health of 15%. Furthermore, the distance from the benchmark of 6% the GDP for PHE would be cut by 60% and 98%, respectively.

On the other hand, in countries with medium GDP (Colombia, Ecuador, and Peru), unequal increases in the PHE would be obtained, with an average PHE increase as the GDP percentage of 19% and 34% in each case (maintaining the current fiscal health priority and increasing it to 15%, respectively). The gap from a PHE of 6% the GDP would be reduced by 63% and 95%, respectively.

Looking at countries with upper-middle GDP (Argentina, Brazil, Chile, and Costa Rica), the size of the results is reduced—PHE as a percentage of the GDP would increase on average by 14%. In this case, increasing the fiscal health priority to 15% does not significantly change the results, since the PHE in these countries is close to this value, as the percentage of total public spending.

For Caribbean countries (Barbados, Guyana [in South America], and Jamaica), the gaps in the tax rates studied relative to average OECD tax rates are lower. In this case, with a fiscal priority of 15% the total public spending, these countries would generate an average potential increase of PHE relative to the GDP of 16% depending on the possibilities of creating the projected fiscal space. This PHE increase in these countries would imply an average reduction in the gap from the benchmark (6% the GDP) of over 28% (considering a fiscal PHE priority of 15% the total public spending).

It should be pointed out that, in all cases, the formalization of the economy is the source that could, potentially, create the most fiscal space, followed by VAT changes.

4. Conclusions

The concept of creating fiscal space to advance toward Universal Health by changing the taxation structure and reducing the informal economy has been shown to be a major potentiality in the majority of countries studied. However, the values differ substantially depending on income levels, taxation structures, the size of the informal economy, or the fiscal priority given to the health sector, as well as the idiosyncratic uniqueness of the institutional makeup of health systems in each country and group of countries studied.

Low-income countries will only make progress if they boost their fiscal capacity as a short- and medium-term objective. In upper-middle-income countries, on the other hand, changes must be introduced to promote greater integration of total health expenditure, reducing segmentation, and improving the equity and efficiency of health systems. The panorama for middle-income countries implies challenges on both fronts.

In the Caribbean countries, the situations are very diverse due to varying productive structures, income levels, and public debt. Although the analysis of the potential impact of changes to the taxation structure and improvements toward a formal economy would herald significant progress, this group of countries has fewer opportunities to create fiscal space due to their low income level.

Regarding contributions to fiscal space by tax type, while VAT is the tax with greater contributory importance in the creation of fiscal space, the contribution of personal income tax (IRPF) is relativized due to the low level of productivity. The possibility of this tax becoming an important source of fiscal space for health depends on the capacity of governments of the region to increase the effective rates that the richest decile of the population pays, by reducing “tax evasion and avoidance, tax exemptions and deductions, or and preferential treatment toward capital income that in some countries is untaxed and in others the tax rate is lower than that on earned income” (Hanni et al., 2015).

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VI. External financing for the health sector in Latin America and the Caribbean

1. External financing as a source of fiscal space

According to the World Health Organization (WHO), there are broadly three ways of raising additional funds or to diversify sources of health funding: making health expenditure a higher priority, finding new or diversified sources of domestic funding, and increasing external financial support (WHO, 2010).

In turn, there are two types of external aid: loans and donations. Loans are considered essential for infrastructure investment projects, but the sustainability of the associated future repayments should be weighed up. Furthermore, the resulting foreign debt has macroeconomic implications for countries.

This paper focuses on donations, which have been a major source in the creation of fiscal space, primarily in low-income countries (Tandon and Cashin, 2010). For this reason, Bolivia, Guyana, Honduras, and Nicaragua are specifically analyzed as case studies.

2. External financial aid in Latin America and the Caribbean

The aim in this section is to determine to what extent nonreimbursable external health financing (EHF) has bridged the gap to attaining a public health funding of 6% the gross domestic product (GDP) in the four countries mentioned above during the 1995-2013 period. This threshold is specified as a “useful benchmark” and a necessary condition in the regional Strategy of Universal Access to Health and Universal Health Coverage (hereinafter Universal Health) (PAHO, 2014).

All four countries have failed to meet this benchmark in public health expenditure (PHE), although an increasing trend of PHE as percentage of the GDP was observed during the period studied in all cases. Working under the assumption that the entire nonreimbursable EHF was allocated to public health financing, the contribution of this funding source to bridge the gap toward reaching 6% the GDP was unequal. The high volatility and lack of stability of EHF are largely due to factors beyond the health systems of the countries studied (Table VI.1).

Table VI.1: Nonreimbursable external health funding. Impact on reducing gap toward the 6% GDP threshold. Average values (unweighted) 1995-2013

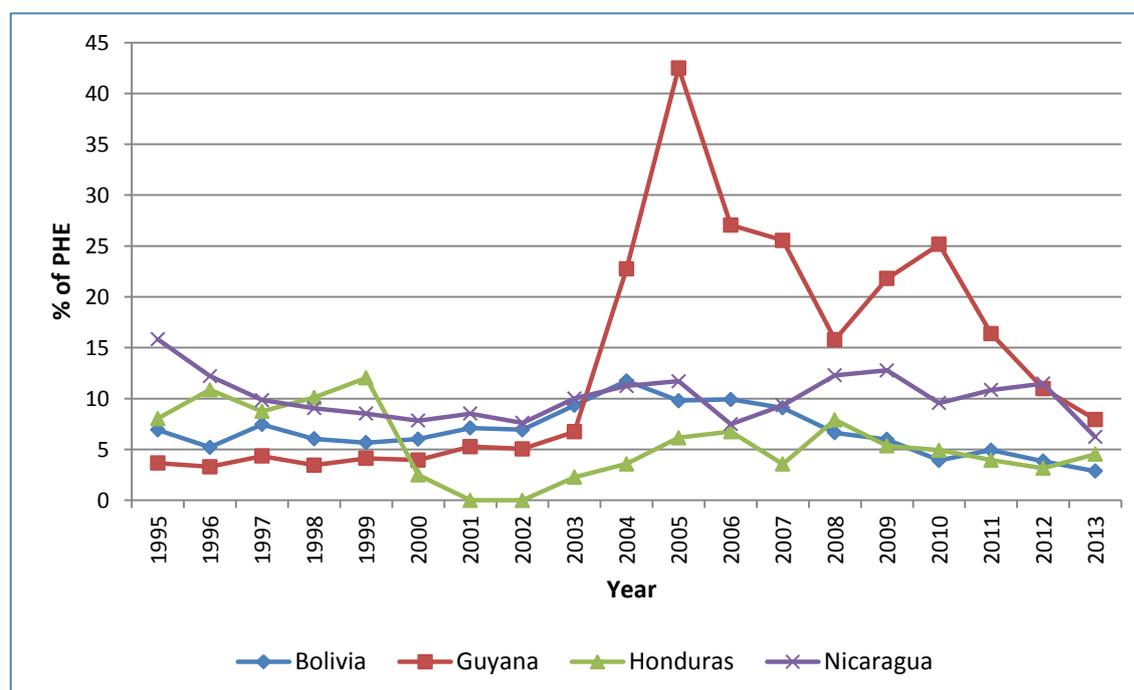
Country	PHE % GDP	Gap threshold (6% GDP)	EHF % GDP	CV (EHF GDP) %	Gap reduction with EHF
Bolivia	3.52	2.48	0.36	33.93%	14.72%
Guyana	4.43	1.57	0.81	83.28%	51.81%
Honduras	3.64	2.36	0.42	37.31%	17.95%
Nicaragua	3.54	2.46	0.66	29.34%	26.75%

EHF: External health financing; **CV**: Coefficient of variation: calculated as the relationship between standard deviation and mean EHF values as percentage of GDP between 1995 and 2013.

Source: National health accounts (NHA) indicators (WHO, 2015).

Furthermore, one of the most important issues regarding foreign aid for health is the marked decrease of these funds. This is the dominant trend in recent years in low-income countries of the region with available data (**Graph VI.1**).

Graph VI.1: Nonreimbursable external resources for health, as percentage of total health expenditure



Source: National health accounts (NHA) indicators (WHO, 2015).

3. Thoughts on external aid as a source of fiscal space

The volatile nature of nonreimbursable external aid, its fragmented management regarding the role of the health authorities, and the potential displacement of public health expenditure are problems that need to be considered with caution.

Regarding this volatility, when the flow of aid is cut, governments may be unable to continue with the envisaged health programs. Given the political price of interrupting an aid program, rejecting the aid altogether may well be preferable in many cases (Williams and Hay, 2005). Furthermore, evidence suggests that the volatility relative to primary health care spending tends to be higher (Gottret and Schieber, 2006).

Fragmentation in the management of resources is reflected in the large number of donor institutions which leads to only the partial integration of the aid into the budgets of governments receiving the aid. Such uncertainties prevent the use of the funds in a standardized national health plan, hampering effective coordination between the health authorities and donor agencies. Additionally, the more projects there are, the greater the inefficiency.

Finally, it is key to determine if the nonreimbursable external aid increases the availability of resources or if, conversely, it displaces internal financing, with no changes to total expenditure. A study of the health financing sources of 144 countries between 1995 and 2006 showed that a 1% increase in donor funds was associated with a 0.14% reduction in public health expenditure in low-income countries (Farag et al., 2009).

The priority given to health in the plans of governments receiving nonreimbursable external funds is vital so that the aid contributes substantially to the creation of fiscal space for health. Although external aid is a valuable contribution to improve health service financing, this contribution must be framed within an overall fiscal plan in favor of universal coverage and access.

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