

Challenges in Health in Latin America **Philip Musgrove; Deputy Editor, Health Affairs**

Background

The first Copenhagen Consensus panel in 2004 rated three health-related solutions - control of malaria, control of HIV/AIDS and reduction of micronutrient deficiencies - in the top four overall. Other more general proposals, such as strengthening basic health services, were given a lower priority. There seem to be two reasons for this: the detailed estimates of cost-effectiveness were difficult to provide for the broader interventions and, on a global scale, the greatest burden of ill health lies with sub-Saharan Africa, ravaged by both malaria and AIDS.

There are problems with an approach based on cost-effectiveness. In particular, the ratio takes no account of the scale of the challenge, so that a purely economic ranking does not necessarily prioritize programs which could do the most overall good, just those which invest the money most effectively. Valuing years of life gained by reference to income does not change that ranking. Secondly, valuations based instead on increased productivity fail to take account of the all-important improved happiness and welfare benefits of better health.

It is also interesting to see that, when presented with the same set of challenges as the first Copenhagen Consensus academic panel, two groups of UN ambassadors and senior diplomats in 2006 rated scaled-up basic health care as top of their lists. This suggests that policymakers are more concerned with the overall scale of problems, whereas academics tend to favor projects for which the most detailed evidence and rigorous analysis is available.

For the next global Copenhagen Consensus event, scheduled for May 2008, a paper has been prepared by Jamison. It differs from the papers presented in 2004 in taking account of non-communicable diseases and injuries and in concentrating on sub-Saharan Africa and South Asia, the world's poorest regions but otherwise uses the same methods. It draws on the second edition of *Disease Prevention Priorities in Developing Countries* (Jamieson et al, 2006 - referred to as DCP2, which) provides much useful information, in particular the importance of non-communicable diseases (NCDs), which present greater challenges in Latin America than some poorer regions. NCDs account for fully two thirds of deaths and 65% of all DALYs (Disability Adjusted Life Years), 13-16 percentage points higher than in other developing regions. Cardio-metabolic conditions, particularly diabetes, are increasing in importance and one of the major risk factors, obesity, is now more common than underweight in the region.

A different approach to the challenges

For the *Consulta de San José*, health is the subject of this single solution paper. Looking again at the challenges reviewed in 2004 and 2006 does not seem the best approach, as there remains the problem of properly valuing the benefits of interventions, and even the new cost-effectiveness estimates would not much change rankings among diseases.

An important issue in Latin America, beyond specific diseases, is uneven access to quality healthcare. This, argues for defining health challenges in a systemic way rather than relative to particular diseases. The downside of this is that there is little quantitative data

on costs and benefits available. Nevertheless, studies on the effect of expanding primary health care on childhood mortality suggest benefit-cost ratios in the range of 2-3.

This paper takes the disease-specific challenges as given and looks at how overall health systems can be improved to deliver specific interventions more effectively.

Unfortunately, because of the necessary lack of quantitative analysis possible for this approach, it is not possible to compare the recommendations directly with other solutions.

Definition of the challenges

There is a real need for better access to high-quality healthcare, but fulfilling this has to be balanced against other priorities such as education and food security. The overall health challenge can then best be expressed as *Of a given set of interventions that society can afford, people do not always get those that they need.* This overall challenge has four component causes:

- People don't realize they need care (demand is lacking)
- They lack access to care for physical, financial and cultural reasons (supply deficiencies)
- When care is accessible, it is provided inefficiently
- Even when care is accessible, its quality is substandard

The first two problems arise at the community and household level, while the third and fourth are characteristics of health service delivery. All are affected by failings in health policy and strategic management. All the problems are considered below in more detail.

Ignorance of need means lack of demand

Health statistics can only be collected by counting disease cases treated by the healthcare system or by population surveys. Although acute illness cannot be ignored by the sufferer, there are many people in the early stages of chronic conditions such as diabetes or cardiovascular disease who are unaware of any problem. Equally, people may be unaware of risk factors such as smoking or obesity.

Some risk factors can be tackled on a population-wide basis quite cost effectively. For example, shifting 2% of total fat consumption from trans fatty acids to polyunsaturates can be accomplished at quite low cost, without consumers even being aware of the risk, if done at source by food processors. If the alternative approach of a media campaign and product labeling is taken, the costs are much higher and effectiveness lower. In the case of early stage disease, earlier treatment may be more cost-effective as well as having a better outcome.

Although there are no direct estimates of the number of people who are unaware they have a disease, they can be detected by screening. A modeling exercise in Australia on diabetes screening showed that the benefits in terms of avoidance (or at least postponement) of death or complications made this cost-effective compared to other interventions, and it even produced savings within a decade (that is, the incremental costs were negative).

No similar results are available for Latin America, but it is reasonable to assume that there will be even more undiagnosed cases of disease. Diabetes incidence is estimated as 6% of the population, affecting 19 million people, lifestyle factors such as obesity are as common as in richer countries, and screening costs should be lower. Surveys in a number

of countries in the region show that self-reported health improves with income, and it seems that the poor are less aware of chronic disease. Ignorance of need for preventive care may be even greater. This is the motivation for demand-side incentives in the form of conditional cash transfers for poor people, to increase their use of preventive and health-promotion services.

Time and distance as barriers to care

Distance from a provider and, more particularly, the cost of reaching it, are important factors in care not being sought among poorer sections of the community. This is far more of a problem for the rural population, which in any case is often poorer than average. Colombian data shows that the urban-rural difference in the probability of seeing a doctor for a health problem is about 12% for households with insurance and only 7-8% for the uninsured. This is consistent with cost being the dominant reason for not getting care.

Cultural barriers to effective care

In addition to simple ignorance of health needs, there can be cultural misconceptions, such as the belief that avoiding sugar alone (rather than controlling overall carbohydrate intake) is sufficient to avoid diabetes. The other cultural barrier occurs when the patient and doctor do not have a common mother tongue or understanding of medical treatment. This is mainly a problem for indigenous populations.

The household burden of financing healthcare

As countries become richer, prepayment for healthcare via insurance or taxes becomes more common, but in poorer countries, treatment is more often paid for out-of-pocket (OOP) and this increases the chance of unaffordable levels of expenditure and financial catastrophe.

A WHO analysis of surveys in 89 countries, including 13 in the LAC region, showed OOP healthcare spending, normally at less than 5% of total expenditure, was not burdensome on average. Even as a percentage of disposable (non-subsistence) income it seems bearable, but “catastrophic” healthcare spending – 40% or more of the non-subsistence budget – can affect as many as 10% of households in countries with poor public provision such as Brazil and Nicaragua.

Out-of-pocket medical expenditure is highly concentrated among a minority of households. Even so, a study in Mexico found that between two and four million families each year either spent more than 30% of disposable income on healthcare or crossed the poverty line because of it.

Such studies undoubtedly understate the problem, because they take no account of treatment foregone because it is unaffordable. They also do not include the longer term costs of financing care – selling land or taking children out of school, for example – neither do they do more than probe the most recent medical history of respondents.

The relatively small proportion of households affected by catastrophic OOP costs should, in principle, mean a modest increase in funding of healthcare should ease the problem significantly. However, the price reductions necessary to tackle the problem would also increase the demand for care from all sectors of the population, worsening overall access problems.

Finally, we should note that even improving access to immediate care loses much of its value if impoverished families are unable to pay for drugs to treat their condition in the longer term.

Inefficient provision

Four primary sources of inefficiency can be identified:

- Health services deliver the wrong interventions, in particular providing less cost-effective care when more cost-effective alternatives exist.
- Inputs are provided in the wrong proportions, so that output is limited by the scarcest input and others are idle or underutilized.
- Facilities, especially hospitals, operate with diseconomies of scale or scope. This arises partly from poor investment decisions and partly from poor distribution of responsibilities and capacities.
- The health system is dynamically inefficient because public spending is pro-cyclical and exacerbates rather than offsets fluctuations in private employment insurance cover and health expenditure. In an unstable economy, public spending may be cut just when there is the greatest need for it, so assuring macroeconomic stability is arguably the most important single way to improve health.

Substandard quality

There are more than 30 million admissions to hospitals in the region each year. Based on US statistics, medical errors might be expected to result in between 41,000 and 92,000 preventable deaths. Although no such figures exist for out-patient care, errors are considered to be so common that WHO has devised a set of nine easily-followed guidelines to assure patient safety. Implementing these must surely result in an overall cost saving.

For patients presenting specific symptoms (fever, diarrhea, etc), or for prenatal care, protocols exist which can form a basis for evaluation of actual practice. From such a study in Mexico, the particular variations among providers and patients which stand out are that public providers perform better than private ones, fully qualified doctors perform better than those without a degree, and poorer patients and indigenous women receive notably worse care in the private sector. This is despite public perception favoring the private sector. In contrast, a similar study in Paraguay actually showed *more* effort devoted to poorer patients.

Defining the solutions

Defining challenges systemically means that the solutions which have to be considered are reforms of the entire health sector. Assessing costs and potential outcomes is more problematic than for specific disease-related interventions. Four solutions are proposed, which would have a synergistic impact if implemented together. They are ranked subjectively in order of importance:

- Increase access to care
- Raise quality
- Improve efficiency of delivery
- Reduce ignorance or misperception of needs

Improving access to care

Providing better access requires some kind of universal insurance coverage, with services delivered on a competitive basis by both the public and private sectors. This can be achieved in several ways, as illustrated by three examples.

In Chile, all employees must contribute 7% of their pay to either the National Health Fund or a private insurer of their choice. The better-off are free to contribute more, but provision to the poor is subsidized via general taxation. The approach in Mexico is the *Seguro Popular*, introduced in 2003 to provide insurance for the half of the population not covered by either social security or the scheme for public employees. Enrolment is voluntary, but the poorest families are fully subsidized. These families are also required to participate in health promotion activities. In Colombia, the government introduced a legal framework for a new class of insurers and new finance mechanisms. There are contributory and subsidized regimes, and there is competition between both providers and insurers. Explicit insurance cover has been much expanded in both Colombia and Mexico.

No one model is obviously preferable, and the appropriate degree of competition is open to debate, but any of these schemes is preferable to creating narrowly defined insurance for specific groups or conditions. It is clear that a serious attempt to enroll the uninsured can rapidly expand coverage. All the schemes aim to finance demand for rather than supply of care, in contrast to the normal public service model. It is clear that the guarantee of cover must be transparent and explicit.

Raising quality of care

Once care is available, its quality becomes important. The Institute of Medicine defines six aspects of quality: safety, effectiveness, patient-centeredness, timeliness, efficiency and equity.

There are many different ways to improve quality, either on an organizational or practitioner basis. Coupled with different initial quality standards, it is difficult to specify solutions for individual countries or the region. Training providers on specific protocols for diagnosing and treating childhood illnesses has been shown to be very cost effective when initial quality is low. This suggests strongly that, for the LAC region, the most important intervention would be training with peer review for primary care, for all common conditions for which there are sound guidelines.

Improving efficiency

Universal insurance coverage and improved quality will go some way to improve the efficiency of care delivery, and competition may also help. However, the outcome depends upon how quality is measured and rewarded: costs may rise if more is done for patients.

Efficiency in the sense of minimizing the resources needed for a particular output is often addressed via the concept of *new public management*, which includes greater flexibility, more local autonomy and separation of finance from provision of services. The examples of Chile, Mexico and Colombia all draw on this approach. Improving efficiency is a technical problem, for which better management often helps, but there is also a political dimension and change is often opposed by providers.

While better management can improve the way care is provided, there is also the question of allocation: what care and services to provide. The best recommendation here

is to use cost-effectiveness as a criterion for choice, to get the largest possible health gains for a given expenditure. Chile has used this approach very effectively, adding 56 treatments to the list of those guaranteed to patients by both the Ministry of Health and private insurers.

Although less urgent today than 20 years ago, reducing the volatility of public spending on health would make an important contribution towards consistent efficiency. This is essentially a political issue of ensuring macroeconomic stability and better long-term planning.

Increasing public knowledge

Increasing people's understanding of diseases, symptoms and risk factors can help to deliver cost-effective treatments at an early stage. This can be done most cheaply via print and electronic media but, if the cost is justified, there may be face-to-face counseling or health screening. Screening may be justified for more serious or prevalent conditions such as HIV/AIDS, diabetes or breast cancer.

Universal access to healthcare and improved quality of care can themselves both improve rates of diagnoses, but there are usually further opportunities to improve knowledge. If surveys are done to gauge the level of knowledge on particular diseases, rational decisions can be made about offering screening services to all or part of the population.

The costs of improving utilization of good quality care

Of the solutions discussed, the extension of insurance cover is by far the most costly, and also the only one for which even approximate estimates are possible. However, because costs are redistributed, the net cost to society is less than that to the public sector.

The most complete and recent data is available for the Colombian scheme. The premium for the contributory part of the scheme in 2002 was 300,684 Colombian pesos (\$120 at market exchange rates), and half that for the subsidized regime. The average premium for the 5.3 million contributors and 8 million subsidized beneficiaries was \$84. The fund took in 4.74 billion pesos and paid out 4.59 billion. In fact, there is also still substantial supply-side financing, which inflates the real costs to \$164 for the full package and \$83 for fully subsidized cover. Per capita total health expenditure in the country is \$136.

About 8 million out of the total 22 million people eligible for subsidized insurance are currently covered. Extending this to the remaining 14 million would cost \$1.16 billion. However, since not all of these would need the full subsidy, the cost would fall to around \$1 billion. Costs of other interventions to improve healthcare would be small by comparison.

Benefits from the proposed solutions

From 1993 to 2003, the value of healthcare delivered in Colombia rose by 11% in real terms, although high administrative costs mean this is only a fraction of the 50% increase in public spending over the period. For the beneficiaries, previously uninsured, the improvement is much greater than 11%. Real benefit-cost ratios are difficult to estimate, but must surely be greater than 1.

The Colombian reforms have, in particular, shifted the burden of payment from households to government. The benefits have reached the poorest households

preferentially: insurance coverage in the lowest income quintile rose from 9 to 48%. Their welfare gain is significant, for only a small additional cost to the more prosperous.

Conclusions: what to do

The key reform which would increase access to healthcare is to extend subsidized, affordable insurance to the whole population. While not guaranteeing higher quality or efficiency, this probably facilitates the needed reforms in these areas.

Although this approach is different from that of the previous Copenhagen Consensus exercises, which target interventions for particular conditions, the two are complementary. Without a well-functioning healthcare system, specific efforts will be less effective than they could be.