Fiscal Space for Health: Conceptual framework and assessment for selected LAC countries

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Health Economics and Financing
(PAHO/WHO)
Motivation: Why fiscal space for health?

Outlook of recent PAHO book on the topic

Conceptual and analytical framework
  Definition and properties
  Components of a fiscal space study
  Sources of fiscal space

Assessment results: quantification of sources for selected countries

Discussion
Why Fiscal space for health?
Prioritize the first level of care

Evidence-based, correlation %GDP with absolute per capita

Regional Strategy for Universal health

1. Eliminate direct payment, barrier to access
2. Increase Public financing to 6% of GDP
3. Pooling mechanisms based on solidarity
4. Increase efficiency of the health system
5. Rationalize incorporation of health technologies
6. Prioritize the first level of care

- Expanding equitable access to comprehensive, quality, people-and community-centered health services
- Strengthening stewardship and governance
- Increasing and improving financing, with equity and efficiency, and advancing toward the elimination of direct payment
- Strengthening intersectoral coordination to address social determinants of health
Expenditure in health by sources of funds (LAC, 2016)

% GDP

Public  Private  External

Haiti  Venezuela  Guatemala  Grenada  Guyana  Saint Lucia  Dominican Republic  Honduras  Mexico  Antigua and Barbuda  Trinidad and Tobago  Peru  Suriname  Barbados  Jamaica  Bahamas  Dominica  Brazil  Belize  Colombia  Paraguay  Ecuador  Panama  Bolivia  Nicaragua  El Salvador  Argentina  Chile  Costa Rica  Uruguay
Matter of time?

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Source: Fiscal space for Health in the Americas: is economic growth sufficient? Camilo Cid Pedraza, Mauricio Matus-López and Ernesto Báscolo
Original research | PDF: https://doi.org/10.26633/RPSP.2018.86 | Published 10 August 2018
Compilation of PAHO’s work
Stand alone PAHO book (2017)


English version available from: www.paho.org/hss

Content of book

Compilation of several PAHO studies over the years, specifically:

- Regional Study for 13 countries
- 3 individual country assessments (*)

1. Theoretical framework
2. Economic context and health systems
3. Sources of fiscal space
4. Political and social analysis

Content of Series in PAHO journal

Adds two studies for the Caribbean:
- Grenada and Suriname
- Article on health accounts: as a way to keep track of investments in health and policies to increase fiscal space
Conceptual and analytical framework
Definitions (*)

Fiscal space

*Fiscal space* is defined as “the availability of budgetary room to provide resources for a desired purpose without any prejudice to the sustainability of a government’s financial position” (Heller, 2005a, 3).

Fiscal space for health

“*Fiscal space specifically for health* refers to the ability of governments to increase spending for the sector without jeopardizing the government’s long-term solvency or crowding out expenditure in other sectors needed to achieve other development objectives (such as some of the other other non-health MDGs)” (Tandon and Cashin, 2010, 11).

(*) Latest conceptual developments can be found in:

Therefore….any study on fiscal space for health must cover these aspects
Components of a study on fiscal space

1. **Justification:** factors that drive the need for increased fiscal space and quantification:
   - implicit (e.g.: health situation analysis)
   - explicit (either bottom-up or top-down like the 6%)

2. **Sources and quantification:** technical assessment and analysis of sustainable options that can provide additional resources *(next slide)*

3. **Feasibility of options:**
   - Analysis of documents and interviews and surveys
   - Complete political economy (institutional framework, stakeholder analysis and winners and losers)
2. Sources of fiscal space

1. Economic growth
2. Reprioritization of health
3. Increased revenue collection
4. External assistance and borrowing (it doesn’t count for the 6%GDP goal)
5. Increased efficiency (spending and collecting)
<table>
<thead>
<tr>
<th>Source of fiscal space</th>
<th>Study (reference)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regional (2)</td>
</tr>
<tr>
<td></td>
<td>Bolivia (4)</td>
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<tr>
<td></td>
<td>Granada (9)</td>
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<tr>
<td></td>
<td>Honduras (5)</td>
</tr>
<tr>
<td></td>
<td>Peru (3)</td>
</tr>
<tr>
<td></td>
<td>Suriname (6)</td>
</tr>
<tr>
<td>Economic growth/favorable macroeconomic conditions</td>
<td>•</td>
</tr>
<tr>
<td>Reprivitization of health expenditure</td>
<td>•</td>
</tr>
<tr>
<td>New tax revenues and social contributions for health</td>
<td>•</td>
</tr>
<tr>
<td>Tax increases</td>
<td>•</td>
</tr>
<tr>
<td>General taxes</td>
<td>•</td>
</tr>
<tr>
<td>Direct taxes</td>
<td>•</td>
</tr>
<tr>
<td>Indirect taxes</td>
<td>•</td>
</tr>
<tr>
<td>Public health excise taxesa</td>
<td>•</td>
</tr>
<tr>
<td>Tobacco</td>
<td>•</td>
</tr>
<tr>
<td>Social contributions to health</td>
<td>•</td>
</tr>
<tr>
<td>Reduction of tax expenditures</td>
<td>•</td>
</tr>
<tr>
<td>Taxes on natural resources</td>
<td>•</td>
</tr>
<tr>
<td>External assistance and loans</td>
<td>•</td>
</tr>
<tr>
<td>Improvements in efficiency</td>
<td>•</td>
</tr>
</tbody>
</table>

*Only the six articles that measure fiscal space are included
*a Earmarked taxes on harmful products

Source: the author. Adapted by PAHO, 2018 (10).
<table>
<thead>
<tr>
<th>Source of fiscal space</th>
<th>Technical feasibility</th>
<th>Political feasibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic growth and favorable economic conditions</td>
<td>This is business as usual. However, basing fiscal space on current and future periods of higher growth has not been enough.</td>
<td>There is almost universal agreement to increase government expenditure on health by at least the current rate of economic growth.</td>
</tr>
<tr>
<td>Reprioritization of the budget for health</td>
<td>Simply increasing the budget is feasible inasmuch as health accounts for a small part of it. From a technical standpoint, we must consider the effect of other sectors on health determinants and be aware that reducing the budget of sectors associated with health can be counterproductive.</td>
<td>The government budget has significant rigidity between sectors.</td>
</tr>
<tr>
<td>New revenue from general taxes</td>
<td>The VAT tends to be a quick and easy resource, but regressive. Income taxes tend to require fiscal reform.</td>
<td>VAT is problematic because it is regressive. Income tax is difficult because of lobbying by those who would have to pay more.</td>
</tr>
<tr>
<td>Excise taxes and earmarked taxes</td>
<td>Taxes on tobacco, alcohol, sugary beverages, and processed food are easy to calculate and operate</td>
<td>Very feasible and easily understood by the public, but not possible in light of recent reforms in some countries</td>
</tr>
<tr>
<td>Tax expenditures</td>
<td>Quite easy to identify, according to the context</td>
<td>Requires political decision and possible dialogue among the stakeholders, since there will be resistance from those affected</td>
</tr>
<tr>
<td>Social security contributions earmarked for health (formal sector)</td>
<td>Of limited efficacy; given how much of the labor market is in the informal sector, and the segmentation of the systems, this tends to benefit only formal workers.</td>
<td>Depends on variables associated with the economy and policies to improve the labor market</td>
</tr>
<tr>
<td>External assistance</td>
<td>There are few countries left that qualify for the most basic assistance. Loans are simple, but tend to cause problems of segmentation and vertical programming.</td>
<td>This is not considered possible, in light of volatility and long-term sustainability</td>
</tr>
<tr>
<td>Efficiency</td>
<td>In tandem with transformation processes, it is possible to identify opportunities for efficiency, such as moving toward IHSNs with PHC resolution and taking advantage of efficiencies with pooled funding, which tends to be singular and thus mitigates segmentation.</td>
<td>This is universally accepted. However, there may be resistance when measures are applied, unless prior agreements are reached among actors in the sector.</td>
</tr>
</tbody>
</table>

VAT, value-added tax; IHSN, integrated health services networks; PHC, primary health care.

Source: The author.
Quantification of sources: selected results
1. Economic growth

- Either as a prerequisite or as a source *per se*, is the most studied source because of the correlation (though not linear) between government revenue and GDP growth.
- Key measure: elasticity (of PHE with respect to GDP)
- Regional results: residual source for most countries

![Graph 4: Average annual variation in public health expenditure and GDP, both per capita, in selected countries. 2002-2012 (international dollars, PPP)](image-url)
1. Economic growth (cont.)

Specific countries: 3 scenarios (optimistic, neutral, pessimistic)

Bolivia (5.3, 4.9, 4.8 % GDP )

Peru (4.23, 3.73 , 1.9%GDP)

Only through the current social security system?
Redistributive capacity?
2. Reprioritization of health

Fiscal priority for health: public expenditure in health as % of total public expenditure

2. Reprioritization of health

Bolivia: aiming at 15% (immediately, linear, no change)

Graph 11. Trend in public health expenditure as a percentage of GDP in Bolivia according to several re prioritization scenarios, 2015-2021

If growth projections are met, public health expenditure could increase by 0.6 or 0.3 points of GDP by 2021.
3. Increased tax revenue

LAC Region: low tax revenue in general

*Graph 12. Tax revenues as a percentage of GDP in Latin America and the Caribbean, 1990-2015*
3. Increased tax revenue (cont.)

LAC Region: regressive tax structure

Graph 13. Distribution of tax revenues (percentage) in LAC and OECD countries, 2015

VAT is the most regressive tax
3. Increased tax revenue (cont.)

Regional study assessment: increase VAT, corporate and personal income

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Probability of an increase in tax rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High</td>
</tr>
<tr>
<td>1</td>
<td>100% of the gap between the current value of the tax rate and the average for LAC countries</td>
</tr>
<tr>
<td>2</td>
<td>50% of the gap between the current value of the tax rate and the average for LAC countries</td>
</tr>
<tr>
<td>3*</td>
<td>100% of the gap between the current value of the tax rate and the average for OECD countries</td>
</tr>
<tr>
<td>4*</td>
<td>50% of the gap between the current value of the tax rate and the average for OECD countries</td>
</tr>
</tbody>
</table>
3. Increased tax revenue (cont.)

Reduce tax expenditures

**Table 9. Tax expenditures in Latin America as a percentage of GDP, 2005-2013**

<table>
<thead>
<tr>
<th>Country</th>
<th>2005</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>2.21</td>
<td>2.46</td>
<td>2.59</td>
<td>2.45</td>
</tr>
<tr>
<td>Bolivia</td>
<td>2.70</td>
<td>1.00</td>
<td>1.20</td>
<td>1.30</td>
</tr>
<tr>
<td>Brazil</td>
<td>1.69</td>
<td>2.80</td>
<td>3.32</td>
<td>-</td>
</tr>
<tr>
<td>Chile</td>
<td>4.38</td>
<td>5.04</td>
<td>4.46</td>
<td>4.71</td>
</tr>
<tr>
<td>Colombia</td>
<td>3.70</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Guatemala</td>
<td>8.40</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mexico</td>
<td>6.32</td>
<td>3.87</td>
<td>3.82</td>
<td>-</td>
</tr>
<tr>
<td>Peru</td>
<td>2.07</td>
<td>2.04</td>
<td>1.94</td>
<td>-</td>
</tr>
</tbody>
</table>

**Sources:** Based on official country data and Villena, Lemgruber, and Jorratt (2010); MEFP (2014); Trigueros (2014); SIICL (2014); MECON (2016).

Gradual reduction by ¼ in Peru over 5 years: 0.48 pp GDP
3. Increased tax revenue (cont.)

Reduction of the informal economy: estimated at over 40% of GDP in LAC, with countries over 60%

Social security contributions: main channel when reducing informality, may not be conducive towards universal health

*Honduras: changing contributions ceilings could create fiscal space for health of 2.7 pp of GDP, while just formalization only 0.24pp*
3. Increased tax revenue (cont.)

Specific health taxes: “sin taxes”

- Limited use in the Region
- Little revenue gathering impact
- However: high public health impact, high impact in health expenditure and usually well received by the public

In Grenada, consumption can be reduced alongside growth in government revenues, making available additional resources for health:

“A 17% to 117% excise tax increase on the cost, insurance, and freight (CIF) value would achieve a 5% consumption decrease. Total government revenues would grow 8.7% and excise tax revenues would increase 11%.”
4. External assistance and borrowing**

(**it doesn’t count for the measurement of 6%GDP)

Depending on the situation of each country, but only recommended (to some extent) for capital formation.

External assistance: plan for transition (GAVI, GF)
5. Increased efficiency

Difficult to measure; it can liberate resources for other uses

Graph 16. Global public health expenditure per capita and mortality in children under 5, 2014

Source: WHO (2017a)
5. Increased efficiency

Uneven performance across the Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Resources</th>
<th>Coverage</th>
<th>Health Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolivia</td>
<td>--</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Guyana</td>
<td>-</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Honduras</td>
<td>--</td>
<td>-</td>
<td>/</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>--</td>
<td>/</td>
<td>+</td>
</tr>
<tr>
<td>Ecuador</td>
<td>-</td>
<td>-</td>
<td>/</td>
</tr>
<tr>
<td>Paraguay</td>
<td>-</td>
<td>/</td>
<td>-</td>
</tr>
<tr>
<td>Peru</td>
<td>-</td>
<td>/</td>
<td>-</td>
</tr>
<tr>
<td>Barbados</td>
<td>++</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>++</td>
<td>/</td>
<td>+</td>
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<tr>
<td>Jamaica</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Brazil</td>
<td>+</td>
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<td>+</td>
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<tr>
<td>Chile</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Colombia</td>
<td>+</td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

Table 10. Efficiency: resources and performance by health category by country, 2014

Performance categories: good, far above average (++); good (+); low (-); low, far below average (--). Source: Báscolo et al. (2015).
*Remember, at the end of the day…

It is useful to express the indicator of public expenditure in health as a %GDP as the product of two factors:

1. Fiscal capacity (source 3)
2. Fiscal priority for Health (source 2)
Political economy and conclusions

• Fiscal space for health focuses on the capacity and viability of sources of financing but does not answer all the questions and issues related to health expenditure

• In general, there is room or fiscal space for health in the majority of countries and room for more efficient expenditure

• Economic growth is not sufficient, we need to accelerate the pace

• More fiscal resources must be collected and in a better way

• Tax expenditures should be reviewed to identify unfair exemptions or exemptions no longer beneficial to the countries.

• There are arguments and room for increasing specific health taxes (mainly, on alcohol and tobacco).
From a policy standpoint, external loans and grants are not a viable source for governments in the medium and long term (plus, external funding doesn’t count for the 6% GDP goal).

Moving towards Universal Health is more a political decision than an exclusive technical discussion.

However, decisions should be guided by sound technical evidence.

A research agenda should include:
- More country specific studies (so far, Belize and Suriname)
- Efficiency in collection to fight evasion and elusion; re-evaluation of tax spending
- Specific analysis of effective tax rates for specific industries across countries
- Optimizing social efficiency in alignment with broad development goals such as Universal health and SDGs

....but don’t forget that collection of revenues is not all
Guiding principles for comprehensive health financing policy

- **Revenue**
  - Move towards a predominant reliance on public revenue sources (compulsory, prepaid, and pooled). Predictable, stable flow of funds. Efficiency gains as important as new sources.

- **Pooling**
  - Reduce segmentation (e.g. number of coverage schemes); increases risk-sharing; improves equity in spending across the population; simplifies flow of funds to service providers.

- **Purchasing**
  - Direct funds towards priority health services/ programmes; link (at least part) of funding with performance; incentives for greater efficiency and quality.

- **Benefits**
  - Universal entitlement around progressively expanded services (e.g. cost-effective, high financial burden, equity).

- **Governance**
  - Unified and/or coherent with a perspective across entire system, goal-driven, evidence-informed; concerned with the entire population. Need good information at national level across regions and schemes.
Thank you!
HERE GOES A TITLE IN ALL CAPS AND YOU CAN USE AN ACCENT COLOR TO HIGHLIGHT WORDS
HERE IS A TITLE ALL IN CAPS
HERE GOES A TITLE IN ALL CAPS
HERE GOES A TITLE IN ALL CAPS AND YOU CAN USE AN ACCENT COLOR TO HIGHLIGHT WORDS
HERE GOES A TITLE IN ALL CAPS AND YOU CAN USE AN ACCENT COLOR TO HIGHLIGHT WORDS
HERE GOES YOUR TITLE
HERE GOES A TITLE IN ALL CAPS AND YOU CAN USE AN ACCENT COLOR TO HIGHLIGHT WORDS

A NICE TITLE IN ORANGE A NICE TITLE IN BLUE
THANK YOU!