Mas Alla de los Promedios:
Understanding Why Inequity Persists and
What It Means for Health Policy in Latin America

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September 16, 2015
The Story

1. On average, economy and health are doing well, medical markets are growing too, but massive inequities exist within (and between) countries
   1. And also: demographic and epidemiological transition

2. Why does inequity persist?
   – Public spending flat in real terms, increasingly rapidly in others
   – More spend does not translate into greater effectiveness, concern about efficiency
   – Private spending still significant, with many families lacking a safety net, even in wealthiest countries
   – Reforms have expanded access, but scope of health benefits still narrow, and under threat from law suits
   – Coverage of key interventions highly inequitable, in part due to highly heterogeneous state-level capacity in mostly federal systems
   – Quality of care improving on some measures but still dismal overall

3. What does it means for policy?
Two decades of steady economic growth with big country commodity-driven booms

GDP per Capita (constant 2005 US$), 1995-2013

Source: WHOSIS, 2015
Health has also improved in Latin America – Life expectancy

Life Expectancy at Birth, Total (years), 1995-2013

Health has also improved in Latin America – Under-5 mortality

Under-5 Mortality (per 1,000 live births), 1995-2013

Markets and demand growing too

Sales growth in Avastin in 2010

<table>
<thead>
<tr>
<th>Region</th>
<th>Overall Pharmaceutical Growth</th>
<th>Avastin (Bevacizumab)</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Europe</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Latin America and the Caribbean</td>
<td>25</td>
<td>42</td>
</tr>
</tbody>
</table>

Source: Giedion (2011), from IMS, Overall growth pharma markets 2010.
Health gains were shared, but the poorest still lag

Under-5 Morality Rates: Averages and Quintile Distribution, 1995-2012 (or nearest year)

In Central America, inequalities in health access and outcomes persist

**Health Indicators for General vs. Salud Mesoamérica Population (poorest 20%)**

<table>
<thead>
<tr>
<th></th>
<th>General Population</th>
<th>Poorest Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality</td>
<td>85</td>
<td>110</td>
</tr>
<tr>
<td>(per 100,000 births)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child mortality</td>
<td>64</td>
<td>33</td>
</tr>
<tr>
<td>(per 1,000 births)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: A. Mokdad, IHME, “Inequalities in health outcomes and expenditures in Mesoamerica,” presented at IHEA Milan, 2015
Among poorest 20% - high anemia and stunting

Child Health Metrics, Salud Mesoamérica Population (poorest 20%)

Chiapas  El Salvador  Guatemala  Honduras  Nicaragua  Panama

- Complete vaccination for age (opportunity), according to vaccine card
- Anemia, children 6-23 months
- Stunting, children 0-59 months

WHY DOES INEQUITY PERSIST?
Public spending on health has grown alongside economic growth, slightly increasing over time in some countries and dramatically increasing in others.

For the highest spenders, consistent growth began around 2003.
But as a proportion of GDP, health spend has remained relatively flat in most Latin American countries with one exception – Costa Rica.
Within a certain threshold, greater public health spend does not directly translate into health gains, such as life expectancy.

Life Expectancy (Years) vs. Per Capita Public Spending on Health (constant 2005 US$), 2013

Note: Dotted lines = average
Sources: World Bank, 2015; WHOSIS, 2015
Other public social spending has grown faster than public spending on health and education in Latin America

**Public Spending on Health, Education, and Social Protection (% GDP), 1995-2010**

<table>
<thead>
<tr>
<th>Year</th>
<th>LAC</th>
<th>OECD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>13.5</td>
<td>19.5</td>
</tr>
<tr>
<td>2000</td>
<td>14.5</td>
<td>18.9</td>
</tr>
<tr>
<td>2005</td>
<td>15.3</td>
<td>19.7</td>
</tr>
<tr>
<td>2010*</td>
<td>18.8</td>
<td>22.1</td>
</tr>
</tbody>
</table>

*Or most recent year

Sources: WHOSIS, 2013; World Bank, 2013; Economic Commission for Latin America and the Caribbean, 2013; OECD Stats Extract, 2013
Private health spend as a proportion of total health expenditure ranges from 22% to nearly 75%
As a result, many people are still at risk for financial catastrophe related to out-of-pocket spending on health.
Countries have implemented policies and programs to expand access and use of health care

<table>
<thead>
<tr>
<th>Country</th>
<th>Reforms</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>Plan Nacer</td>
<td>2004</td>
</tr>
<tr>
<td></td>
<td>Plan Sumar</td>
<td>2012</td>
</tr>
<tr>
<td>Brazil</td>
<td>Unified Health System (SUS)</td>
<td>1988</td>
</tr>
<tr>
<td></td>
<td>Scale-up of Family Health Program (FHP)</td>
<td>1998</td>
</tr>
<tr>
<td>Chile</td>
<td>FONASA</td>
<td>1981</td>
</tr>
<tr>
<td></td>
<td>Universal Access with Explicit Guarantees (AUGE)</td>
<td>2005</td>
</tr>
<tr>
<td>Colombia</td>
<td>National Health Insurance System</td>
<td>1993</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>Special regime for the indigent</td>
<td>1984</td>
</tr>
<tr>
<td></td>
<td>Transfer of health services from MoH to CCSS</td>
<td>1993</td>
</tr>
<tr>
<td></td>
<td>Mandatory enrollment of the self-employed</td>
<td>2006</td>
</tr>
<tr>
<td>Guatemala</td>
<td>Program of Expansion of Coverage (PEC)</td>
<td>1997</td>
</tr>
<tr>
<td>Jamaica</td>
<td>National Health Fund (NHF)</td>
<td>2003</td>
</tr>
<tr>
<td></td>
<td>User fees abolished</td>
<td>2008</td>
</tr>
<tr>
<td>Mexico</td>
<td>Social Protection System in Health (SPSS)/Seguro Popular</td>
<td>2003</td>
</tr>
<tr>
<td>Peru</td>
<td>Maternal and Child Health Insurance</td>
<td>1999</td>
</tr>
<tr>
<td></td>
<td>Comprehensive Health Insurance (SIS)</td>
<td>2002</td>
</tr>
<tr>
<td></td>
<td>Universal Health Insurance (AUS)</td>
<td>2009</td>
</tr>
<tr>
<td>Uruguay</td>
<td>FONASA</td>
<td>2007</td>
</tr>
<tr>
<td></td>
<td>Integrated National Health System (SNIS)</td>
<td>2007</td>
</tr>
</tbody>
</table>
Coverage of essential services falls short of what is considered ‘universal’

Notes:

a) Prevention services: mammogram; Pap smear; antenatal care (more than four visits); measles vaccination; improved water source; adequate sanitation; and non-use of tobacco;
b) Treatment services: skilled birth attendance; antiretroviral treatment; tuberculosis treatment; diabetes treatment; dental care; and eye surgery

Source: WHO & World Bank, “Monitoring progress towards UHC at country and global levels,” 2014
There is variety in the scope of benefits covered by public funds

**COSTA RICA**
CCSS/Expansion of coverage and integration of primary care
Open-ended with formulary
Comprehensive benefits from primary to complex care

**BRAZIL**
SUS/Family Health Program
Open-ended
Comprehensive benefits from primary to complex care

**COLOMBIA**
National Health Insurance System/Régimen Subsidiado
Open-ended with a few exclusions
Comprehensive benefits from primary to complex care

**ARGENTINA**
Plan Nacer/Plan Sumar
Positive list
Primary care for pregnant women, children, adolescents

**PERU**
SIS
Positive list
MCH, childhood cancers, other basic health services
Benefits plan example: Colombia

2013-presente: unify plans
1993-2013: below
Pre1993: implicit rationing

Source: Ursula Giedion
Legal suits for access to certain medicines—frequently expensive, with equity and health trade-offs—further complicates the picture.

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**Number of Total Tutelas and Health Tutelas in Colombia, 1999-2014**

Data: Defensoría del Pueblo – La tutela y los derechos a la salud y a la seguridad social 2013

In Colombia, the rate of health-related judicial cases has exploded.

### Number of Judicial Cases Related to the Right to Health (per million inhabitants)

<table>
<thead>
<tr>
<th>Country</th>
<th>Cases per Million Inhabitants</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>0.2</td>
</tr>
<tr>
<td>South Africa</td>
<td>0.3</td>
</tr>
<tr>
<td>Argentina</td>
<td>29</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>109</td>
</tr>
<tr>
<td>Brazil</td>
<td>206</td>
</tr>
<tr>
<td>Colombia</td>
<td>3289</td>
</tr>
</tbody>
</table>

*Data: Ottar Moestad, et al.*

Yet cost-effectiveness and affordability are local

Cost-utility of Trastuzumab expressed as number of GDP per QALY

- USA
- UK
- Finland
- Canada
- Uruguay
- Chile
- Colombia
- Argentina
- Peru
- Brasil
- Bolivia

Bolivia is a middle-income country, but it would cost more than 38 times their annual GDP per capita to purchase a QALY with Trastuzumab

Source: Andrés Pichon-Riviere, 2013. La aplicación de la evaluación de Tecnologías de Salud y las evaluaciones económicas en la definición de los Planes de Beneficios en Latinoamérica
Most countries are highly decentralized, federal systems with large inequalities between states in terms of spend, capacity, coverage.

Coverage of the Family Health Strategy in Brazil by State, 2008

### Mexico-Chiapas: Measles Immunization Coverage *

<table>
<thead>
<tr>
<th>Method</th>
<th>Coverage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child health card or caregiver recall</td>
<td>83%</td>
</tr>
<tr>
<td>Child health card only</td>
<td>73%</td>
</tr>
<tr>
<td>Caregiver recall only</td>
<td>73%</td>
</tr>
<tr>
<td>Dried blood spot analysis (DBS)</td>
<td>68%</td>
</tr>
</tbody>
</table>

Note: * Values omit ranges
In poor communities, quality of care measured by availability of treatment and equipment is very low.

Quality of Care Metrics, Salud Mesoamérica Population (poorest 20%)

- **Nicaragua**: 10.8
  - Health units with permanent availability of equipment and inputs for emergency neonatal and obstetric care

- **Chiapas**: 3.6
  - Neonates with complications (low birth weight, prematurity, asphyxia, sepsis) treated according to the norms

- **Honduras**: 13.1
  - Women with complications (pre-eclampsia, eclampsia, sepsis, hemorrhage) treated according to the norms

- **Guatemala**: 4.4

- **Belice**: 2.9

Note: * Information on equipment and inputs are not available

Avoidable deaths related to infectious disease have declined but remain high.

Share of Total Deaths Related to Preventable Infectious Causes, 0-14 Years, 1985 and 2010

Note: * Amenable mortality = extent of mortality that could have been avoided through effective health care.


Data: World Bank estimates with data from WHO Mortality Database, modified.
Women with breast cancer are diagnosed at a later stage in Latin America compared to those in the US with a Hispanic background.

**Initial Diagnosis of Breast Cancer by Stage, Various Years**

<table>
<thead>
<tr>
<th>Country/Region</th>
<th>Stage I</th>
<th>Stage III-IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mexico</td>
<td>14%</td>
<td>48%</td>
</tr>
<tr>
<td>Peru (Lima)</td>
<td>9%</td>
<td>49%</td>
</tr>
<tr>
<td>Brazil (Sao Paulo)</td>
<td>10%</td>
<td>67%</td>
</tr>
<tr>
<td>Brazil (Puerto Alegre)</td>
<td>16%</td>
<td>30%</td>
</tr>
<tr>
<td>US, Non-Hispanic White</td>
<td>51%</td>
<td>16%</td>
</tr>
<tr>
<td>US, Hispanic White</td>
<td>40%</td>
<td>21%</td>
</tr>
</tbody>
</table>

See notes section for years

Sources: Iqbal et al., 2015; Shulman et al., 2010
What does it mean for policy?

- Strong case—with attention to equity, efficiency and effectiveness—to spend more public monies on health
  - Several innovative, well-evaluated reforms and schemes inside and outside the health sector

- Keep working to adjust reforms to enhance impact on the full set of health system goals
  - Coverage but also costs, scope of benefits, quality, financial protection
  - Incentives, incentives, incentives (de-fragment funding; clearer accountability for results; etc.)

- Build better priority-setting systems and agencies
  - Defensible, ethical, equitable and cost-effective public spending choices

- Don’t forget public health!
THANK YOU

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Distribution of Social Health Insurance Coverage across Income Groups

- **a. Chile**
- **b. Colombia**
- **c. Mexico**
- **d. Peru**

What is SM2015 Operating Model?

• Focus on the poorest 20%

• Evidence Based Health Interventions
  – Systemic Approaches
  – Context specific
  – Demand and supply interventions

• Results Based Financing Model
  – Establishing outcome level indicators and targets
  – Incentive at national level
  – All or nothing score

• Policy Dialogue

• Monitoring and Evaluation of Performance
Salud Mesoamérica uses a results-based financing model to improve the health outcomes of the poorest populations.

Argentina’s Plan Nacer uses a results-based financing scheme based on enrollment and health outcomes.

Impact: Reduced in-hospital neonatal mortality: 74% reduction for Plan Nacer beneficiaries, 22% reduction for all users of Plan Nacer clinics.