

The financial sustainability of health systems in Latin America and the Caribbean

Challenges in moving towards
universal health coverage

María Luisa Marinho
Daniela Sugg
Consuelo Farías



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Abstract

Health is a fundamental human right and an essential pillar of inclusive and sustainable social development. Target 3.8 of the Sustainable Development Goals (SDGs) is to achieve universal health coverage, ensuring access to essential health services, including financial risk protection. However, health systems in Latin America and the Caribbean face multiple structural challenges, backdropped by a development crisis involving three development traps that hinder its progress. The Economic Commission for Latin America and the Caribbean (ECLAC) stresses the need to transform the region's development models and strengthen health systems through a sustained and efficient increase in public funding. Although the World Health Organization (WHO) recommends that countries should invest at least 6% of GDP in public health, in order to achieve a significant impact on financial protection and reduce out-of-pocket spending to below 20% of total health expenditure, the exercise undertaken in this document suggests that investment of 6.7% of GDP is needed. Ensuring the financial sustainability of health systems is key to successful implementation of the investments needed to reduce inequalities, move towards universal health coverage (UHC) and guarantee the right to health for all, leaving no one behind.

Introduction

Health is recognized internationally as a fundamental human right, which means that all people have the right to the highest attainable standard of physical and mental health (WHO, 2023a). As is true of all human rights, the right to health is interdependent with others: it is a prerequisite for other rights, such as education and work, and exercising the right to health in turn depends on other rights being guaranteed. This interdependence is also reflected in the social determinants of health identified in the 2030 Agenda for Sustainable Development, in which health plays a central role in achieving inclusive social development, economic development and environmental sustainability (Marinho *et al.*, 2023).

Sustainable Development Goal 3 focuses on people's health and well-being, aiming to ensure healthy lives and promote well-being for all at all ages. To this end, the countries agreed on various targets, one of which is to achieve universal health coverage (UHC) (SDG target 3.8). This entails guaranteeing access to quality essential health services for all, including access to safe, effective, affordable and quality medicines and vaccines, and protecting households from financial risks.

In a development crisis scenario characterized by three traps —low capacity for growth; high inequality and low social mobility and cohesion; and weak institutional capacity and ineffective governance to meet development challenges (Salazar-Xirinachs, 2023; Economic Commission for Latin America and the Caribbean [ECLAC], 2024a)—the countries of the region have made multiple efforts to advance towards UHC. This is unfolding in a context in which health systems have structural weaknesses that undermine the results of their efforts, such as chronic underfunding, fragmented service provision and segmentation of the population by ability to pay (ECLAC, 2022). These elements converge with the social determinants of health, impacting people's well-being directly and accentuating health inequalities and the vulnerability of certain population groups (ECLAC, 2022; Marinho *et al.*, 2023; Organisation for Economic Co-operation and Development and World Bank [OECD and World Bank], 2020).

Given this challenging scenario, there is an urgent need to increase the efforts being made in the region to guarantee universal health (Economic Commission for Latin America and the Caribbean and Pan American Health Organization [ECLAC and PAHO], 2024). In the context of the Commission's call for countries to transform their development models, including the expansion of social protection and the welfare state (ECLAC, 2024a), the need to move towards universal, comprehensive, sustainable and resilient health systems has been recognized (ECLAC, 2022). This means health systems that ensure

financial protection, coverage and access under a universal approach that is sensitive to differences. Health systems must also be capable of responding to the different demands of the population in coordination with other sectors; they need the capacity to fulfil commitments in terms of coverage, adequacy (quality) and financial sustainability, for both current and future generations; and they must have capacity to adapt swiftly to changes and respond efficiently to crises (Arenas de Mesa, 2023).

Achieving UHC in the region requires health systems to be optimized and transformed. This involves both increasing investment in health, and allocating and executing the available resources efficiently and strategically. Sustained investment in health generates social, economic and environmental benefits, thus reaffirming the intrinsic connection between health and sustainable development. Five years from the deadline for fulfilling the 2030 Agenda for Sustainable Development, and ahead of the Second World Summit on Social Development to be held in 2025, it is urgent that the region's countries prioritize strengthening their health systems, increasing investment to reduce inequalities and reallocating resources from lower priority expenditures (Savedoff *et al.*, 2023), in order to achieve the Sustainable Development Goals (SDGs) and improve people's general well-being (ECLAC and PAHO, 2024).

It is crucial that investment in health be sustainable, with a balance struck between universal coverage and access, adequate benefits and the financial sustainability of the system, so that stable policies are implemented over time and commitments to current and future generations are met (ECLAC, 2018; Arenas de Mesa, 2019, 2023). The Pan American Health Organization (PAHO) and the World Health Organization (WHO), along with other international organizations, have insisted on the need for increased investment to achieve UHC in the countries of Latin America and the Caribbean. Specifically, it is argued that public spending on health needs to be equivalent to at least 6% of gross domestic product (GDP), in order to guarantee the coverage of essential health services and financial protection for households (Pan American Health Organization and World Health Organization [PAHO and WHO], 2019). Advancing towards the proposed objectives requires additional resources to be allocated efficiently to the health sector. In this scenario, fiscal constraints and fiscal space for health will need to be analysed.

As a contribution to this endeavour, this document includes an analysis from the standpoint of financial sustainability, with a view to defining the amount of economic resources that would be needed to achieve the goal of UHC and how quickly this could be implemented, together with an assessment of the fiscal space available to the countries to increase health spending. It also addresses the central importance of considering efficiency in health expenditure management.

Following this introduction, the document is organized in five sections. Section I provides a brief conceptual discussion of the relationship between health and sustainable development—in particular the impact of health on the 2030 Agenda for Sustainable Development and the importance of the UHC goal. Section II includes an analysis of UHC in the countries of the region, addressing both the coverage of essential health services and the proportion of households facing high health expenditures, and revealing trends and progress. Section III focuses on estimating both the investment and the time needed to achieve UHC in Latin America and the Caribbean, using different metrics, while section IV outlines the fiscal space for health and funding sources, in particular the importance of efficient financial management in the sector. Lastly, section V offers final observations on the importance of consolidating health systems that achieve the UHC goal, in terms of both access to the services and financial protection for households, guaranteeing the financial sustainability of health systems.

I. Health in the 2030 Agenda for Sustainable Development: universal health coverage

Without health, sustainable development will not be achievable, because health has a major impact on the three constituent dimensions: inclusive social development, economic development and environmental sustainability. This is reflected in the interdependence of Goal 3 with the other Goals, and also in the fundamental role it plays in fulfilment of the 2030 Agenda for Sustainable Development. These arguments are developed below, together with an explanation of how target 3.8 of the 2030 Agenda for Sustainable Development is measured.

A. Health and sustainable development

Health, which is recognized as a basic human right and a constituent element of physical, mental and social well-being (WHO, 1946), has evolved from a focus on the absence of disease to a comprehensive and multidimensional vision that encompasses well-being in all of its dimensions and people's interactions with their sociocultural, economic and environmental contexts. This paradigm shift consolidates health as a key pillar for achieving sustainable development and, thus, the 2030 Agenda for Sustainable Development, by influencing its three components: inclusive social development, economic development and environmental sustainability (Marinho *et al.*, 2023).

Sustainable development is defined as a development model that meets the needs of present generations without compromising the needs and possibilities of future generations (United Nations, 1987). To achieve this, in 2015, the Member States of the United Nations adopted the 2030 Agenda for Sustainable Development, consisting of 17 Sustainable Development Goals (SDGs). This agenda is rights-based and guided by various principles, including universality, leave no one behind, interconnectedness, indivisibility and inclusion (United Nations, 2018b). Specifically, Goal 3 advocates for ensuring healthy lives and promoting well-being for all at all ages, and it consists of nine specific targets ranging from reducing maternal and child mortality to achieving UHC, among others.

The principle of interdependence between the different Sustainable Development Goals is clearly visible in Goal 3. Numerous studies have demonstrated the relationship between Goal 3 and Goal 1 (no poverty), Goal 2 (zero hunger) and Goal 8 (decent work and economic growth) (Hughes *et al.*, 2021; Viana *et al.*, 2022; Nilsson *et al.*, 2018). A healthy population also fosters inclusive social development by strengthening the conditions for people to participate effectively in teaching and learning processes, by improving educational performance and reducing school absenteeism, and by promoting labour inclusion through higher rates of labour participation and less absence from the labour market, and participation in the various domains of society. Health also contributes to reducing poverty and the different inequalities, which serve as fundamental barriers to inclusive social development. It also boosts economic development by increasing people's productivity and promoting environmentally sustainable practices, food security and access to healthy foods, which contribute to the sustainability of ecosystems (Marinho *et al.*, 2023).

Violation of the right to health undermines other social rights. This was seen during the coronavirus disease (COVID-19) pandemic, when the health crisis triggered a prolonged social and economic crisis in the region. This period saw the steepest decline in economic activity in 120 years, with a 7% contraction in GDP, an employment crisis involving a reduction in the pace of new job creation and a deterioration in working conditions, major setbacks in poverty and extreme poverty levels, and an exacerbation of educational inequalities in terms of access and quality, among other factors (ECLAC, 2022; ECLAC and PAHO, 2021). This was also reflected in the 2030 Agenda as a whole, with a regression seen in 27% of the SDG targets in Latin America and the Caribbean (ECLAC, 2023) in areas such as health, poverty, inequality, education, labour and nutrition.

This confirms the key role of health as a necessary condition for achieving sustainable development, and also that the right to health affects the fulfilment of other fundamental rights, since people's lives and well-being ultimately depend on it (ECLAC and PAHO, 2020). These considerations highlight the importance of investing in health systems in a financially sustainable manner, to thus achieve sustainable development (ECLAC and PAHO, 2024).

B. Universal health coverage (UHC): a key target for guaranteeing the right to health

The Economic Commission for Latin America and the Caribbean has reaffirmed the need for the region's countries to strengthen their commitment to universal health, and thus boost their efforts to build universal, comprehensive, sustainable and resilient health systems (ECLAC, 2022). According to the Sustainable Development Goals Report 2023, the adverse effects of the pandemic on Goal 3 at the global level persisted in 2023, with slippage in health indicators such as declining childhood vaccination rates and stagnating progress in reducing maternal mortality (United Nations, 2023). In Latin America and the Caribbean, these trends are explained largely by the deterioration of the social determinants of health, stemming from the economic and social crises triggered by the pandemic, and by the high levels of structural inequality that characterize the region's health systems (ECLAC and PAHO, 2024).

In this context, it is imperative to address the chronic underfunding of health systems in Latin American and Caribbean countries, along with the various barriers to accessing healthcare and the high level of out-of-pocket expenses incurred by households. These factors directly affect the capacity to meet target 3.8 of the 2030 Agenda, on achieving universal health coverage,¹ which refers to ensuring timely access to quality services for the entire population, regardless of their ability to pay and with financial protection, covering a wide range of essential health services, including health promotion, disease prevention, treatment, rehabilitation and palliative care (World Health Organization and International Bank for Reconstruction and Development [WHO and IBRD], 2023).

¹ See <https://www.un.org/sustainabledevelopment/es/health/>.

The Pan American Health Organization argues that primary healthcare (PHC) is the most effective and cost-efficient strategy to achieve universal health coverage, as it ensures that people's needs are prioritized and addressed in a comprehensive manner (see box 1).

Box 1

The primary care strategy: a necessary approach for advancing towards universal health

The primary healthcare (PHC) strategy is essential for promoting people's well-being and combating inequality. Its importance stems from the fact that it facilitates greater access to, and contact with, health services, and it recognizes the impact of social and material conditions as determinants of health. Primary healthcare focuses on individuals and communities throughout the life cycle, tackling access barriers and obstacles while promoting active participation. A development strategy based on PHC is thus more inclusive and sustainable.

In 1978, the Declaration of Alma-Ata recognized PHC as a fundamental element in achieving adequate levels of health for the entire population, and it emphasized the need to coordinate health with other sectors, in order to respond satisfactorily to people's health needs (World Health Organization and United Nations Children's Fund [WHO and UNICEF], 1978). Forty years after that declaration, in 2018, the countries met in Astana at the Global Conference on Primary Health Care. This conference adopted a renewed approach that stresses the right to integrated, quality primary care, with health understood as a multisectoral construct, and recognizing the importance of community engagement and empowerment with respect to health services (WHO and UNICEF, 2018). Based on this, PHC was defined as:

"... a whole-of-society approach to health that aims equitably to maximize the level and distribution of health and well-being by focusing on people's needs and preferences (both as individuals and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment" (WHO and UNICEF, 2018, p. 8).

The Declaration of Astana highlights the central role of PHC in achieving both universal health coverage and the Sustainable Development Goals (SDGs). As a comprehensive, multisectoral strategy with a focus on the social determinants of health, PHC contributes directly to inclusive and sustainable social development. Thus, in Compact 30.30.30 proposed by PAHO in 2019 (PAHO and WHO, 2019), the countries committed to eliminating barriers to health access by at least 30%, increasing public health spending to 6% of GDP by 2030 and investing at least 30% of those resources in PHC. This would contribute to progress towards universal health and the fulfilment of SDGs.

Source: World Health Organization and United Nations Children's Fund. (1978). Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, URSS, 6-12 September; World Health Organization and United Nations Children's Fund. (2018). *A Vision for Primary Health Care in the 21st Century: Towards Universal Health Coverage and the Sustainable Development Goals*. World Health Organization. <https://apps.who.int/iris/handle/10665/328065>; Pan American Health Organization and World Health Organization. (2019). *Compact 30*30*30 PHC for Universal Health*.

Globally, progress towards universal health coverage faces significant challenges. The coverage of essential services has stagnated and, since 2000, the proportion of people facing catastrophic health expenditures has been rising steadily² in all regions of the world (WHO and IBRD, 2023).

The Universal Health Coverage Global Monitoring Report is the official tool used to monitor UHC. It is prepared every two years by WHO and IBRD, with the aim of measuring progress in health and thereby transforming public health services. In 2018, as part of its Thirteenth General Programme of Work (GPW 13) for the five-year period 2019–2023, WHO established the *triple billion target* strategy, which has the following objectives:³

- One billion more people benefitting from universal health coverage.
- One billion more people better protected from health emergencies.
- One billion more people enjoying better health and well-being.

² The World Health Organization defines catastrophic spending as "relatively large out-of-pocket health spending, in effect those exceeding 10% and 25% of the household's total consumption or income (budget)" (WHO and IBRD, 2021, p. 2).

³ For further information see https://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-sp.pdf?ua=1.

The World Health Organization's updated Fourteenth General Programme of Work (GPW14) for 2025–2028, still in draft form, has recalibrated the objectives from relative to absolute terms. The preliminary objectives that have been set are as follows:⁴

- Six billion people with better health and well-being.
- Five billion people who benefit from universal health coverage without financial hardship.
- Seven billion people better protected from health emergencies.

Universal health coverage is monitored by measuring the following SDG indicators (WHO and IBRD, 2023):

3.8.1 Coverage of essential health services, which refers to people's access to the health services they need, regardless of their economic capacity.

3.8.2 Financial protection measured by the proportion of the population with large household expenditures on health as a share of total household expenditure or income.

To measure progress towards universal health coverage, WHO has developed the service coverage index (SCI), which specifically measures SDG indicator 3.8.1. This is calculated as the geometric mean of 14 indicators, as detailed in table 1.⁵

Table 1
Indicators for constructing the service coverage index (SCI)

Category	Indicators	Calculation
Reproductive, maternal, newborn and child health (RMNCH)	1. Family planning (FP) 2. Antenatal care, 4+ visits (ANC) 3. DTP3 immunization (DTP3) 4. Care seeking for suspected ARI (ARI)	$RMNCH = (FP * ANC * DTP3 * ARI)^{1/4}$
Infectious diseases (ID)	5. TB treatment (TB) 6. HIV therapy (ART) 7. Insecticide-treated nets (ITN) 8. Basic sanitation (WASH)	If high malaria risk: $ID = (TB * ART * ITN * WASH)^{1/4}$ If low malaria risk: $ID = (TB * ART * WASH)^{1/3}$
Noncommunicable diseases (NCD)	9. Hypertension treatment (HP) 10. Diabetes prevalence (Diab) 11. Tobacco non-use (Tobacco)	$NCD = (HP * Diab * Tobacco)^{1/3}$
Service capacity and access (SCA)	12. Hospital bed density (Hospital) 13. Health worker density (HWF) 14. IHR core capacity index(IHR)	$SCA = (Hospital * HWF * IHR)^{1/3}$
Universal health service coverage Index (SCI)		Universal health service coverage index (SCI) = $(RMNCH * ID * NCD * SCA)^{1/4}$

Source: World Health Organization and International Bank for Reconstruction and Development. (2023), *Tracking universal health coverage 2023 global monitoring report*, p. 4.

Note: DTP3 refers to three doses of the combined diphtheria, tetanus and pertussis vaccine; ARI stands for acute respiratory infection; HIV is the acronym for human immunodeficiency virus; TB tuberculosis; IHR International Health Regulations.

The index is obtained from a combination of administrative data reported by the countries, estimations derived from surveys (such as demographic and health surveys and multiple indicator surveys conducted by countries and agencies) and estimates modelled by WHO. Estimations are available for the following reference years: 2000, 2005, 2010, 2015, 2017, 2019 and 2021 (WHO, 2023b).

⁴ Available at https://apps.who.int/gb/ebwha/pdf_files/WHA77/A77_16-en.pdf.

⁵ For countries that are not endemic for malaria (n=154), the insecticide-treated net (ITN) coverage indicator is excluded, and the geometric mean is calculated using just 13 indicators (WHO and IBRD, 2023).

The measurement of each indicator is not publicly available, but is reported by component and total. Moreover, the health service coverage index cannot be interpreted directly as the proportion of the population covered by a set of essential services. Only if it is deemed to represent average coverage within the population could it be converted into a percentage indicating how many people receive essential health services.

One of the shortcomings of SCI, under review by WHO in 2024, is that it only measures the proportion of the target populations that are subject to healthcare actions, without assessing whether these were of sufficient quality and quantity to achieve the expected outcomes. Accordingly, it does not provide a comprehensive view of the established target. However, until it is reformulated, it remains the best measure available for analysing UHC, which is why it was used in this analysis.

Measurement of target 3.8.2 of the 2030 Agenda for Sustainable Development, which refers to the proportion of the population with large household health expenditures as a proportion of total household income, refers mainly to out-of-pocket health expenses incurred by households when accessing and receiving health services. These include payments for medicines and health products, outpatient and inpatient care services, including dental care, diagnostic and laboratory services and emergency transport and rescue services (United Nations, 2018a).

Catastrophic health expenditure, a key indicator for monitoring SDG 3.8.2, refers to the proportion of the population that spends between 10% and 25% of family income on health. Other complementary measures have also been designed, such as impoverishment owing to health expenditure. This aims to identify how many people fall into poverty as a result of their spending on this item, using various poverty lines (such as the global poverty line), the extreme poverty line and a relative poverty line⁶ (WHO and IBRD, 2021).

Progressing towards UHC requires improving service coverage and financial protection. Accordingly, WHO defined a composite indicator of service coverage and financial protection to measure the goal of “1 billion more people benefiting from UHC” by the end of 2023 (WHO, 2018). The estimation, which is global for all countries, in other words without a component breakdown, is generated from the percentage of services received without incurring financial hardship. This corresponds, firstly, to the estimation of the average service coverage index, which groups the index of the four SCI categories. The average service coverage (average SCI) is multiplied by the population not suffering financial hardship, and then this percentage is multiplied by the world population of a given year (number of people), to obtain the number of people receiving universal coverage, as shown in equation 1.

Calculation of the population with UHC

$$\text{Population with UHC} = \text{SCI} * \left(1 - \frac{\text{Population with catastrophic health expenditure}}{\text{Total population}} \right) * \text{Population} \quad (1)$$

This creates a single aggregate UHC indicator measured in absolute terms, which corresponds to the number of people with health coverage. Thus, the difference between two time periods in this estimation makes it possible to assess progress made in terms of the number of people who access health services without incurring catastrophic expenses.⁷

⁶ For further information see <https://www.who.int/data/gho/data/major-themes/universal-health-coverage-major>. In addition, the absolute poverty line corresponds to a threshold of US\$ 2.15 per person per day (2017 PPP dollars), and the relative poverty line corresponds to 60% of the population's average consumption.

⁷ See <https://www.who.int/data/stories/the-triple-billion-targets-a-visual-summary-of-methods-to-deliver-impact>.

II. Analysis of universal health coverage in Latin America and the Caribbean

Any estimation of the efforts that the countries of the region need to make to advance towards UHC while keeping their health systems financially sustainable, requires an overview of the current situation of UHC in Latin America and the Caribbean. Accordingly, this section analyses progress towards UHC in the region, through an analysis of 20 countries. SDG indicator 3.8.1, which monitors health service coverage, is addressed first, followed by indicator 3.8.2, which measures the population exposed to financial risks owing to the large out-of-pocket expenses they must incur to access healthcare. Monitoring the trends, evolution and patterns of UHC in the region's countries aims to provide evidence that contributes to effective access to universal healthcare for all, leaving no one behind.

A. Coverage of essential health services: uneven progress interrupted by the coronavirus disease (COVID-19) pandemic

WHO defines essential health services coverage as “the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access, among the general and the most disadvantaged population” (WHO, n.d.). These are tracked by the WHO service coverage index (SCI), which establishes a scoring system that ranges from 1 to 100, consisting of four subcomponents: (i) reproductive, maternal, newborn and child health (RMNCH); (ii) infectious diseases (ID); (iii) noncommunicable diseases (NCD); and (iv) service capacity and access (SCA).

The analysis in this document is based on the most recent SCI data for 2021, reported in 2023, using the ranges defined by WHO. In addition, progress over time is assessed using annualized and inter-period growth rates. The World Health Organization has defined five ranges, based on the health service coverage index, to characterize progress in UHC, which are applied in this analysis.⁸

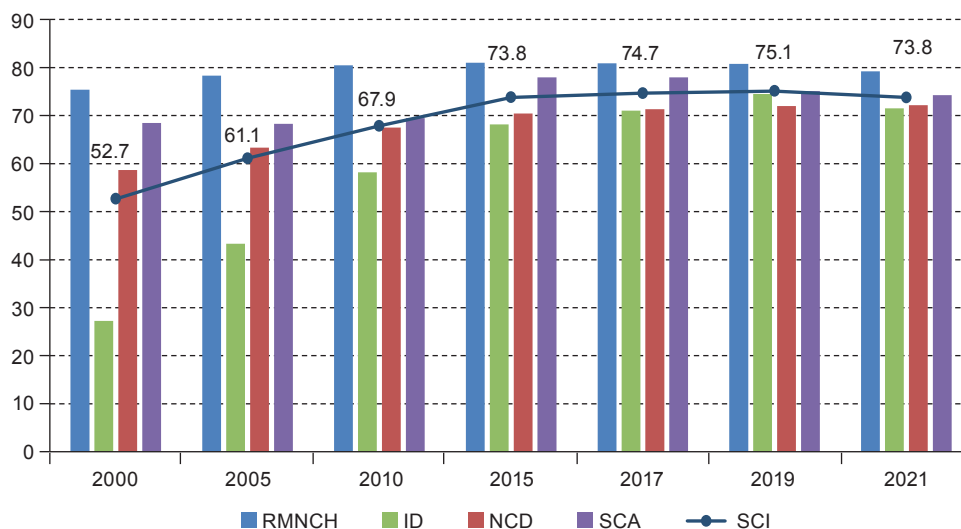
⁸ The essential health services coverage index uses a measurement scale from 0 to 100 (WHO, 2024a).

- **Very high** (SCI score of 80 or more)
- **High** (SCI between 60 and 79)
- **Medium** (SCI between 40 and 59)
- **Low** (SCI between 20 and 39)
- **Very low** (SCI below 20)

The available records make it possible to analyse 20 countries in Latin America and the Caribbean,⁹ with information for 2000, 2005, 2010, 2015, 2017, 2019 and 2021. Considering that there are no SCI data disaggregated by gender, age, socioeconomic status, disability or other structural axes of the region's social inequality matrix (ECLAC, 2016), this document does not analyse the distribution of the index within the countries.

Between 2000 and 2021 the health service coverage index rose from 52.7 points to 73.8, as shown in figure 1. Following a sharp increase between 2000 and 2015, the indicator has since remained relatively stable, albeit retreating by 1.5 points between 2019 and 2021 in the wake of the COVID-19 pandemic and its adverse impact on health systems. During this period, the steepest decline occurred in the infectious diseases subcomponent, followed by reproductive, maternal, newborn and child health and access to care services. This reduction in coverage is closely related to the displacement effect that occurred during the pandemic, a phenomenon that led to the postponement of health-care needs other than those associated with COVID-19 (ECLAC and PAHO, 2020).

Figure 1
Latin America and the Caribbean (20 countries):^a evolution of the service coverage index, by subcomponent, 2000, 2005, 2010, 2015, 2017, 2019 and 2021
(Indices)



Source: Prepared by the authors, on the basis of data from the World Health Organization.

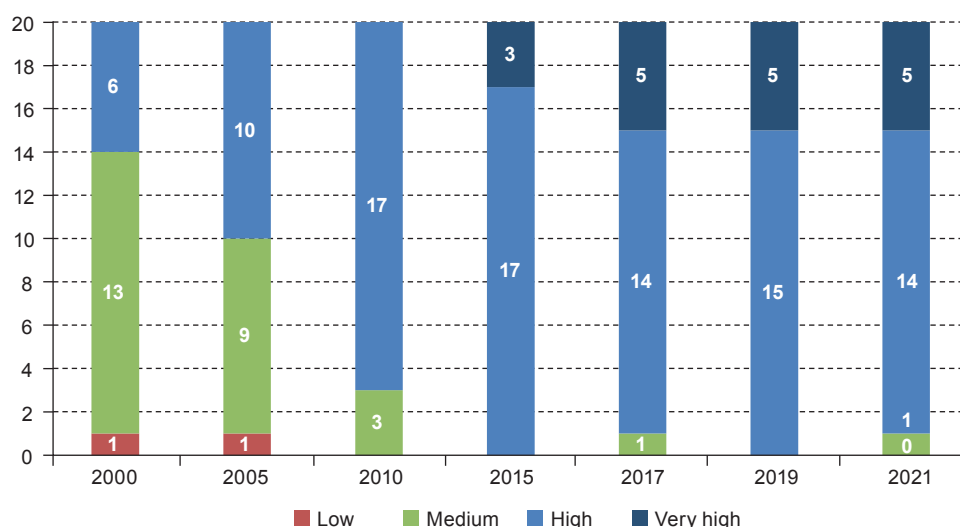
Note: RMNCH: Reproductive, maternal, newborn and child health; ID: Infectious diseases; NCD: Noncommunicable diseases; SCA: Service capacity and access; SCI: Health service coverage index.

^a Argentina, Belize, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia, Suriname and Uruguay.

⁹ Data for the following countries are available for analysis: Argentina, Belize, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia Suriname and Uruguay.

According to the ranges defined by WHO, the countries made significant progress towards universal coverage between 2000 and 2021.¹⁰ As shown in figure 2, in 2021, five countries attained the “very high” SCI range (Brazil, Chile, Colombia, Costa Rica and Uruguay), whereas no country had been in this category before 2015. In addition, some countries transitioned from the “low” to “medium” and from “medium” to “high” ranges. The latest records for 2021 indicate that 14 countries attained the “high” range (Argentina, Belize, the Bolivarian Republic of Venezuela, Ecuador, El Salvador, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia and Suriname). In addition, one country had a “low” level of coverage (Guatemala), and no country had “very low” coverage (SCI between 0 and 20) between 2000 and 2021.

Figure 2
Latin America and the Caribbean (20 countries):^a number of countries by range of progress in the service coverage index, 2000, 2005, 2010, 2015, 2017, 2019 and 2021



Source: Prepared by the authors, on the basis of data from the World Health Organization.

Note: No country reported a “very low” health service coverage index (SCI less than 20).

^a Argentina, Belize, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia, Suriname and Uruguay.

In 2021, the countries’ health service coverage indices ranged from 59 to 82, thus revealing significant inequality across the region. Chile, Uruguay, Brazil, Colombia and Costa Rica are the most advanced in terms of essential health service coverage, with scores of than 80 or more (see map 1). In contrast, Belize, Honduras, the Plurinational State of Bolivia and Suriname, face greater challenges, with index scores below 70. Guatemala is the country with the lowest index in 2021, at 59.

Significant and rapid progress was made towards UHC between 2000 and 2010, with an annual growth rate of 3.1%. However, although growth continued thereafter, it did so more slowly and actually retreated between 2019 and 2021 (by 1.9% per year) as a result of the COVID-19 pandemic, as shown in figure 3. The four subcomponents of SCI followed a similar trend to that of the general indicator, with slackening growth. However, the indicator for the access and care services subcomponent increased rapidly until 2015, before slowing and then retreating from until 2019 (see figure 3). This is relevant, because it indicates a loss of productive capacity in the health-care network prior to the COVID-19 pandemic.

¹⁰ For details on the countries in each category, see annex A1.

Map 1
Latin America and the Caribbean (20 countries):^a health service coverage index by country, 2021

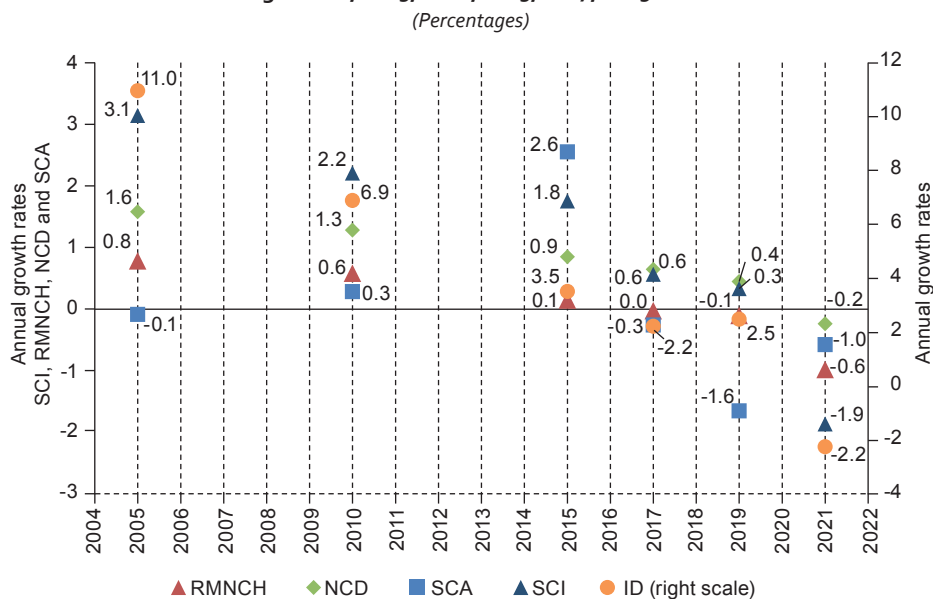


Source: Prepared by the authors, on the basis of data from the World Health Organization.

^a Argentina, Belize, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia, Suriname and Uruguay.

Changes in essential health service coverage have not been uniform across Latin American and Caribbean countries. In some, there has been considerable dispersion or variability over the years, while other countries, such as Peru, Honduras and Brazil, have experienced decline or stagnation since the two years prior to the COVID-19 pandemic (see figure 4). The coverage of essential health services also declined generally during the pandemic period, between 2019 and 2021. Specifically, 85% of the 20 countries analysed saw health service coverage retreat, the exceptions being Chile, Colombia, El Salvador and the Plurinational State of Bolivia, which saw no change in this dimension. Although a more in-depth analysis by country is needed to understand what happened during this period, the stability of the indicator in these countries could reflect greater resilience in their health systems.

Figure 3
Latin America and the Caribbean (20 countries):^a annual growth rate of the service coverage index, 2005, 2010, 2015, 2017, 2019 and 2021

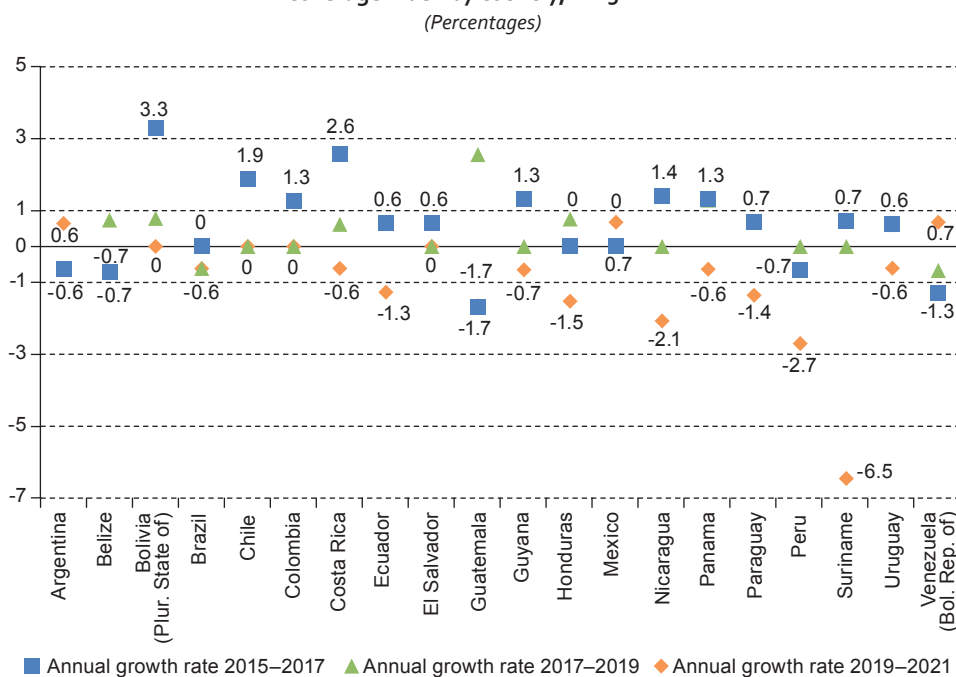


Source: Prepared by the authors, on the basis of data from the World Health Organization.

Note: RMNCH: Reproductive, maternal, newborn and child health; ID: Infectious diseases; NCD: Noncommunicable diseases; SCA: Service capacity and access; SCI: Health service coverage index. The right scale shows the values for SCI and the subcomponents RMNCH, NCD and SCA, while the left scale shows the values for the subcomponent ID, since these are outside the range of the other subcomponents.

^a Argentina, Belize, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia, Suriname and Uruguay.

Figure 4
Latin America and the Caribbean (20 countries): growth rate of the health services coverage index by country, 2015–2021



Source: Prepared by the authors, on the basis of data from the World Health Organization.

The general setback in the progress of health service coverage during the pandemic underscores the need to review the subcomponents and the situation in each country between 2019 and 2021. On average, the steepest decline in the region occurred in the infectious diseases (ID) subcomponent (4.19%), followed by reproductive, maternal, newborn and child health (RMNCH) (1.93%) and service capacity and access (SCA) (1.10%). In contrast, there was a slight increase in the noncommunicable diseases (NCD) subcomponent (0.22%). However, there is considerable heterogeneity among countries, in terms of both the magnitude of variations and the subcomponents, as shown in table 2.

Table 2
Latin America and the Caribbean (20 countries): annual growth rate of
the health services coverage index and its subcomponents, 2019–2021
(Percentages)

Country	Total SCI		Subcomponents			
		RMNCH	ID	NCD	SCA	
Suriname	-12.50	-1.35	-37.68	...	-7.69	
Peru	-5.33	-5.26	-7.69	1.43	-6.67	
Nicaragua	-4.11	-2.56	-8.96	...	-1.52	
Guatemala	-3.28	-1.39	-5.48	...	-7.14	
Honduras	-3.03	-2.47	-5.71	...	2.44	
Paraguay	-2.70	-5.88	...	...	-1.56	
Ecuador	-2.53	-3.66	-3.80	...	-7.14	
Belize	-1.45	-3.70	-9.86	...	5.36	
Guyana	-1.30	-2.47	-7.79	...	2.30	
Panama	-1.27	-3.61	...	...	...
Brazil	-1.23	...	-2.44	...	...
Costa Rica	-1.22	1.14	-2.60	...	-2.56	
Uruguay	-1.20	-1.08	3.66	1.54	-7.45	
Bolivia (Plurinational State of)	...	-1.37	3.51	...	-3.33	
Chile	...	...	...	1.52	-1.10	
Colombia	...	-1.23	2.67	...	...
El Salvador	...	1.27	-5.48	...	4.94	
Argentina	1.28	-1.15	2.44	...	2.35	
Mexico	1.35	-1.22	-1.37	...	2.63	
Venezuela (Bolivarian Republic of)	1.35	-2.67	2.82	...	4.23	
Latin America and the Caribbean	-1.86	-1.93	-4.19	0.22	-1.10	



Source: Prepared by the authors, on the basis of data from the World Health Organization.

Note: RMNCH: Reproductive, maternal, newborn and child health; ID: Infectious diseases; NCD: Noncommunicable diseases; SCA: Service capacity and access; SCI: Service coverage index.

In the infectious diseases and the reproductive, maternal, newborn and child health subcomponents, 80% of the countries analysed experienced coverage setbacks, compared with 50% in the case of access to healthcare services, while no country recorded a setback in the coverage of noncommunicable diseases. Suriname suffered its greatest setbacks in the ID subcomponent (37.68%) and in service capacity and access (7.69%).

Although the situation in Suriname is an extreme case, the SCA subcomponent is also retreating significantly in Uruguay, Guatemala and Ecuador. In the ID subcomponent, the countries regressing the most are far from the extreme, but Peru, Nicaragua, Belize and Guyana record setbacks of over 7%.

This background information is essential, because it highlights the inequality that exists between countries in the region. It also underscores the importance of analysing each country's specific situation in order to develop its roadmap, since the status of each subcomponent will define the baseline for projecting the future.

A regionwide analysis of service coverage shows that, although the average index for the region is positive, the trend from 2015 to 2021 flatlined, with almost no progress, before being interrupted by the COVID-19 pandemic. There are also persistent inequalities between countries in the region, with some still lagging far behind in this dimension. This highlights the coverage disparities that exist between countries in the region, which is also replicated in terms of access and health outcomes (Marinho *et al.*, 2023; OECD and World Bank, 2020). Although it is impossible to conduct an analysis within countries, previous research provides evidence that vulnerable groups have the greatest difficulty accessing health services (WHO and IBRD, 2023). In this context, the countries will need to make a significant financial effort to achieve universal coverage with no one left behind, while keeping their health systems financially stable.

B. Financial protection in health: a dimension with setbacks in the region

The second domain of UHC measurement corresponds to SDG indicator 3.8.2, which measures the proportion of the population exposed to financial risks owing to the large out-of-pocket expenses they have to incur to access healthcare. The financial-protection subdimension of UHC is fulfilled when there are no financial barriers to accessing necessary health services, and direct health expenditure or out-of-pocket expense is not a source of financial hardship (WHO and IBRD, 2023).

The World Health Organization considers health spending to be catastrophic when out-of-pocket expenses absorb more than 10% or 25% of the household budget, and it monitors how the proportion of households in that situation varies through time. According to the WHO definition, financial protection in terms of health expenditure is classified in three categories: (i) improving; (ii) no change; and (iii) worsening. The measure is based on the average annual variation in the percentage of the population affected, with variations of less than 0.1 of a percentage point being considered as no change (WHO and IBRD, 2023).

For this analysis, the indicator of catastrophic health expenditure in Latin American and Caribbean countries presents records for a total of 17 countries.¹¹ Following the methodology used by WHO and developed by Wagstaff *et al.* (2018), the analysis drew on the most recent data available for each country, and those with at least two measurements in 2000–2022 were used to evaluate the variation over time.¹² As some of the records are more than a decade old, the corresponding results and trends should be analysed with caution.

¹¹ The following countries have data available for analysis: Argentina, Belize, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, and Uruguay.

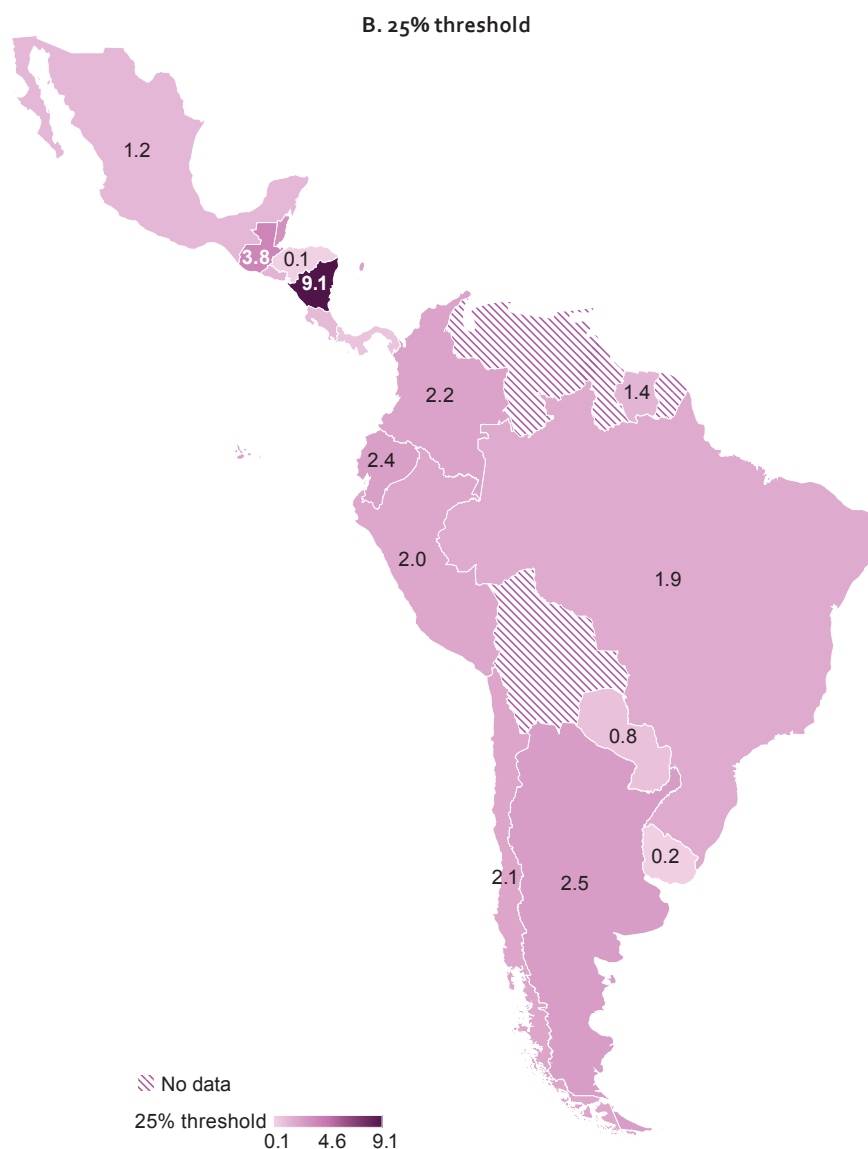
¹² The database used corresponds to World Health Organization, Global Health Observatory (<https://www.who.int/data/gho>).

The regional picture shows that in seven of the 17 countries, over 12% of households face catastrophic health expenditure, with more than 10% of their budget being absorbed by this item.³³ Map 2 illustrates catastrophic health expenditure in Latin America and the Caribbean (at both the 10% and the 25% thresholds), using the latest record available for each country.

Map 2
Latin America and the Caribbean (17 countries):^a catastrophic health expenditure, by threshold
(Percentages)



³³ The countries in question are Brazil, Chile, Ecuador, Guatemala, Nicaragua, Paraguay, and Peru.



Source: Prepared by the authors, on the basis of data from the World Health Organization (WHO).

^a Based on the latest available records, as follows: Argentina, 2017; Belize, 2018; Brazil, 2017; Chile, 2016; Colombia, 2016; Costa Rica, 2018; Ecuador, 2013; El Salvador, 2019; Guatemala, 2014; Honduras, 2004; Mexico, 2020; Nicaragua, 2014, Panama, 2017; Paraguay, 2011; Peru, 2021; Suriname, 2016; and Uruguay, 2016. The Bolivarian Republic of Venezuela, Guyana and the Plurinational State of Bolivia are not included.

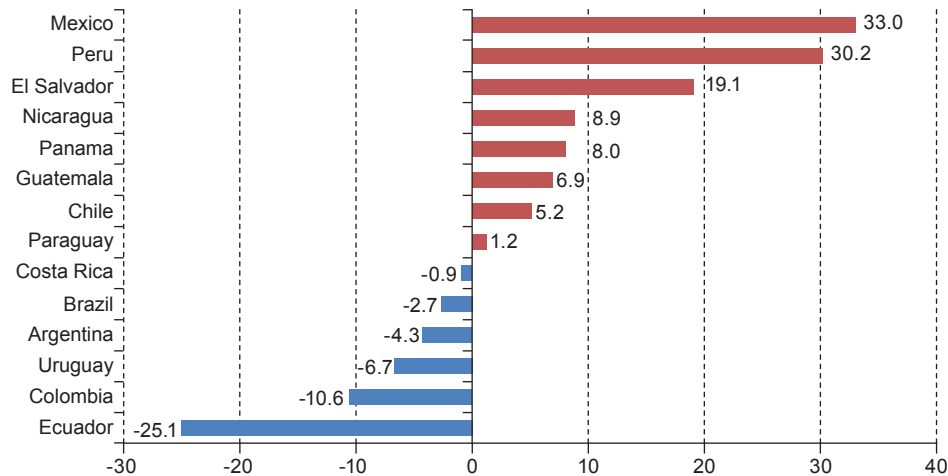
Applying the higher threshold, more than 3% of households in Belize, Guatemala and Nicaragua spend over 25% of their budget on healthcare. Nicaragua is the country with the highest catastrophic health expenditure at both the 10% and the 25% thresholds. However, this record corresponds to 2014, when 27.7% of Nicaraguan households spent more than 10%, and 9.1% spent more than 25% of their budget on health.

The variation in the catastrophic expenditure indicator was analysed in 14 countries.¹⁴ This requires at least two records, for which the interval 2000–2021 was established, and the two most recent records available for each country were selected. Based on the 10% threshold, six countries show improvement,

¹⁴ The following countries are considered: Argentina, 2017 and 2004; Brazil, 2017 and 2008; Chile, 2016 and 2011; Colombia, 2016 and 2008; Costa Rica, 2018 and 2012; Ecuador, 2013 and 2011; El Salvador, 2019 and 2018; Guatemala, 2014 and 2011; Mexico, 2020 and 2018; Nicaragua, 2014, and 2009; Panama, 2017 and 2008; Paraguay, 2011 and 2000; Peru, 2021 and 2020; and Uruguay, 2016 and 2005.

while the rest have deteriorated (see figure 5). The most rapid progress was made in Ecuador (between 2011 and 2013) and in Colombia (between 2008 and 2016, where the population with catastrophic health expenses absorbing more than 10% of the household budget, decreased annually by 25% and 11%, respectively). In contrast the steepest slippages occurred in Mexico (between 2016 and 2018) and in Peru (between 2020 and 2021), where the proportion of the population with catastrophic expenses grew by over 30% per year. On average, the proportion of the population with health expenditures exceeding 10% of the household budget increased by 4.5% per year.

Figure 5
Latin America (14 countries): annual increase in the proportion of the population with health expenditure exceeding 10% of the household budget
(Percentages)



Source: Prepared by the authors, on the basis of data from the World Health Organization.

Note: The years considered for each country are as follows: Argentina, 2017 and 2004; Brazil, 2017 and 2008; Chile, 2016 and 2011; Colombia, 2016 and 2008; Costa Rica, 2018 and 2012; Ecuador, 2013 and 2011; El Salvador, 2019 and 2018; Guatemala, 2014 and 2011; Mexico, 2020 and 2018; Nicaragua, 2014 and 2009; Panama, 2017 and 2008; Paraguay, 2011 and 2000; Peru, 2021 and 2020; and Uruguay, 2016 and 2005.

Analysing catastrophic health expenditure at the 25% threshold, 8 of the 14 countries recorded an improvement in terms of financial protection in health, while the situation worsened in the others (see figure 6). However, in those eight countries, the indicator improved by less than at the 10% threshold. In countries where the situation worsened, the rates of deterioration were greater, with catastrophic expenditure increasing by more than 40% per year in Mexico and Peru. On average, annual growth of 8.7% was reported.

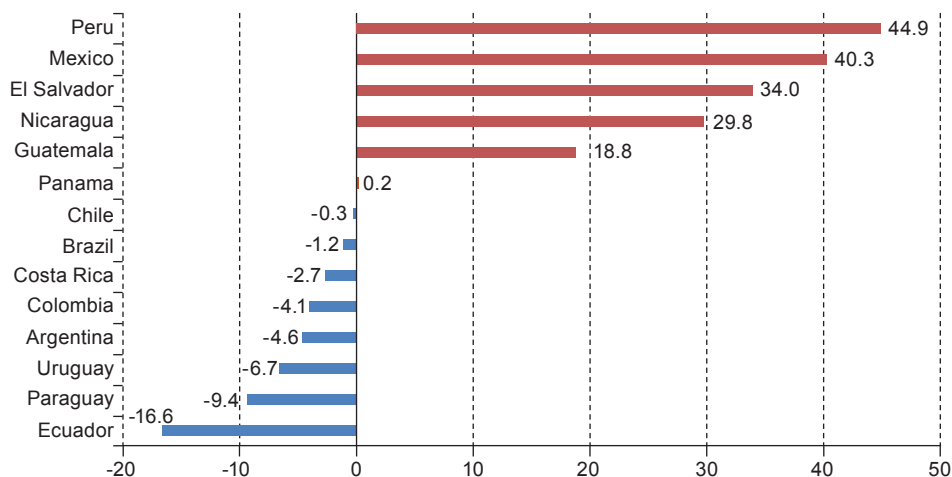
In general, catastrophic expenditure indicators display a similar trend in relation to both thresholds, except in the cases of Paraguay and Chile, where the indicators worsened at the 10% threshold, but improved at 25%.

The trends described above show that the capacity of health systems in Latin American and Caribbean countries to provide sufficient financial protection for their populations has deteriorated.¹⁵ As a result, access to health services continues largely to be financed directly by households through out-of-pocket spending. This can create economic barriers that prevent households from accessing quality health services in a timely manner, while also interfering with their capacity to access other essential services, such as education, housing and food (WHO and IBRD, 2023). Financial vulnerability owing to healthcare varies according to household sociodemographic characteristics. It is more common among poor households,

¹⁵ As the data for each country refer to different years that are far apart, it is impossible to estimate a regional average.

which have to cut back their consumption of basic products in order to finance out-of-pocket healthcare expenses, which can then perpetuate a vicious cycle of poor health and poverty (WHO and IBRD, 2023). Nonetheless, some countries in the region have adopted laws and reforms that seek precisely to reduce household out-of-pocket health spending and increase financial protection (see box 2).

Figure 6
Latin America (14 countries): annual increase in the proportion of the population with health expenditure exceeding 25% of the household budget
(Percentages)



Source: Prepared by the authors, on the basis of data from the World Health Organization.

Note: The years considered for each country are as follows: Argentina, 2017 and 2004; Brazil, 2017 and 2008; Chile, 2016 and 2011; Colombia, 2016 and 2008; Costa Rica, 2018 and 2012; Ecuador, 2013 and 2011; El Salvador, 2019 and 2018; Guatemala, 2014 and 2011; Mexico, 2020 and 2018; Nicaragua, 2014 and 2009; Panama, 2017 and 2008; Paraguay, 2011 and 2000; Peru, 2021 and 2020; and Uruguay, 2016 and 2005.

Box 2
Regional experiences in reducing high levels of out-of-pocket expenses and providing financial protection for households in Latin America

Latin American countries have adopted reforms and policies that have transformed their health systems with a view to reducing high household out-of-pocket expenses. A prime example is the health system reform in Uruguay, which began in 2005 and established the National Integrated Health System (SNIS) through Act No. 18.211. This model unified public and private providers under financing based on the pooling of resources through the National Health Fund (Fonasa), a single, public and mandatory fund, with the aim of expanding nominal coverage of financial protection for the population (PAHO and WHO, 2021).

One of the key achievements of this reform has been the improvement in financial protection for households in Uruguay. By significantly reducing out-of-pocket expenses through solidarity-based financing, the economic burden of illness and treatment has been reduced, particularly for the most vulnerable families (PAHO and WHO, 2021). In addition, the system has also promoted more equitable access to quality services, preventing health problems from leading to impoverishment or catastrophic debt for households. According to data from the Ministry of Health, out-of-pocket spending decreased from 23% to 15% between 2005 and 2019, and public health expenditure grew from 3.81% to 6.58% of GDP between 2005 and 2017 (Centre for Studies into Economic and Social Reality [CERES], 2024). These advances place Uruguay within the parameters recommended by WHO: public expenditure on health above 6% of GDP and out-of-pocket expenses below 20% of total health spending. It should be noted that out-of-pocket spending has remained constant in recent years, at around Ur\$ 10,000 per person (equivalent to US\$ 220) per year, mainly in direct payments (such as for products or private appointments) and co-payment vouchers (known as *órdenes* and *tickets*).

Chile has also made significant efforts to move in this direction, notably through policies to provide financial protection in health. These include the 2004 Law on Explicit Health Guarantees (GES) (Act No. 19,966), which establishes a benefits plan with guarantees of access, timeliness, quality and financial coverage for the public and private systems (excluding those of the armed forces and police). Subsequently, in 2015, Act No. 20,850, known as the “Ricarte Soto Law”, was adopted, granting 100% universal financial protection (regardless of the individual’s insurance system) for treatments, diagnoses, food and high-cost devices. As of 2024, this law has benefited more than 65,000 people (Fonasa, 2024). In 2022, the “zero co-payment” initiative was added, ensuring completely free healthcare for users in Fonasa brackets C and D, in addition to those in brackets A and B, who already received free healthcare. This measure eliminates out-of-pocket payments for services in the public health system, benefiting more than 16 million people, targeting, in particular, low- and middle-income households in tiers C and D, which represent 1,601,800 people (Government of Chile, 2024). Although its real impact has yet to be assessed, the policy aims to strengthen financial protection for households and foster more equal access to healthcare.

Source: Centre for Studies into Economic and Social Reality. (2024). *Situación actual y propuestas para mejorar el Sistema de Salud de Uruguay*. Informe especial; Government of Chile. (2024). *Copago Cero cumple dos años: 1,6 mill ones de personas yam hen silo beneficia as*. <https://www.gob.cl/noticias/copago-cero-cumple-dos-anos-16-millones-personas-han-sido-beneficiadas/>; Pan American Health Organization and World Health Organization. (2021), *Funcionamiento del sistema de salud en Uruguay: principios, modelo de financiamiento, gestión y atención*; National Health Fund. (2024). *Datos abiertos FONASA*. <https://datosabiertos.fonasa.cl/>.

III. The importance of financial sustainability in health systems, to increase investment in health and move towards universal health coverage by 2030

Universal health coverage in Latin America and the Caribbean can only be achieved by transforming the health systems, which, among other factors, entails increasing investment in this area. This poses a major challenge for countries in the region, given the chronic underfunding of their health systems in a context of high uncertainty (ECLAC and PAHO, 2024). It is therefore essential to maintain investment in health through time, while safeguarding universal access and coverage, as well as the sufficiency of the benefits and the financial sustainability of the system (Arenas de Mesa, 2019).

Efforts to move towards universal health must consider health system sustainability. This means simultaneously addressing coverage, adequacy of benefits (coverage quality) and financial sustainability, striking a balance between these three dimensions so as to meet commitments to current and future generations (ECLAC, 2018; Arenas de Mesa, 2019, 2023). Ensuring one of these dimensions alone cannot guarantee the sustainability of the systems; if any dimension is insufficient to meet the population's needs, then system sustainability is threatened.

Estimation of the investment in health needed by Latin American and Caribbean countries to move towards UHC must constantly take into account, not only the financial sustainability of their health systems, but also their general sustainability. Thus, while this section focuses on estimating the investment needed to increase service coverage rates and implement financial protection, the next section analyses the fiscal space for health available to the countries, in order to consider the financial sustainability of these endeavours.

Quantifying the resources needed to achieve UHC is a topic that has hardly been explored and therefore has a sparse evidence base. This reflects the inherent complexity of the issue, how it is measured and the multiplicity of factors that affect progress towards UHC.

The Pan American Health Organization has set a target of public health expenditure representing at least 6% of GDP by 2030. This forms part of the PAHO/WHO Compact 30-30-30, which proposes reducing access barriers to health by 30% and allocating 30% of public health expenditure to primary care (PAHO

and WHO, 2020). McIntyre *et al.* (2017) developed a methodology to calculate the public resources needed to move towards UHC. Analysing the correlation between public health expenditure (as a percentage of GDP) and various indicators that, according to the literature reviewed by these authors, are correlated with universal health, the study suggests that countries should allocate at least 5% of GDP to health. They also propose that very low-income countries should consider an additional target that includes a minimum per capita contribution of US\$ 86 per year.

Another important contribution to quantifying and projecting the public resources needed to advance towards UHC is the study carried out by the Global Burden of Disease Health Financing Collaborator Network (2018). This makes a projection of public expenditure on health in 188 countries and sets up a stochastic frontier model,¹⁶ with a view to analysing the effect of public expenditure on health coverage outcomes. The study projects health expenditure to 2040, but does not set a specific target for UHC; it finds that public resources and efficiency gains in health expenditure are the key factors explaining progress towards universal coverage.

These approaches thus concur that financing should focus on reducing out-of-pocket and private spending and on prioritizing public resources, adopting a shared vision of health funding. The following section describes the calculation of the health service coverage index and the financial protection needed to move towards UHC.

A. Estimating the investment needed to increase the health service coverage index and move towards universal health coverage

The investment needed to achieve UHC can be determined through various methodological routes, according to the information that is available. Any method involves defining a target, benefit or outcome to be achieved. In this case, the first question was what level of coverage each country should achieve, and then at what cost.

The first approach discussed in this section, comparative analysis (or benchmarking), is a useful tool for evaluating and comparing the performance of different entities or countries in specific domains, with the aim of identifying best practices and areas for improvement. A direct way to apply this analysis in the health sector is through the relationship that exists between total health expenditure, as a percentage of each country's GDP, and its health service coverage index (SCI), and then defining, for example, a benchmark average cost with results for the region or for groups of countries. This is the first method for estimating the required investment. By establishing a measurement rule, or predefined standard, to evaluate the performance of an organization, country, or system, yardstick benchmarking can be applied as a methodological strategy. This is a type of comparative analysis that uses a metric rather than focusing solely on the best practices of sector leaders.

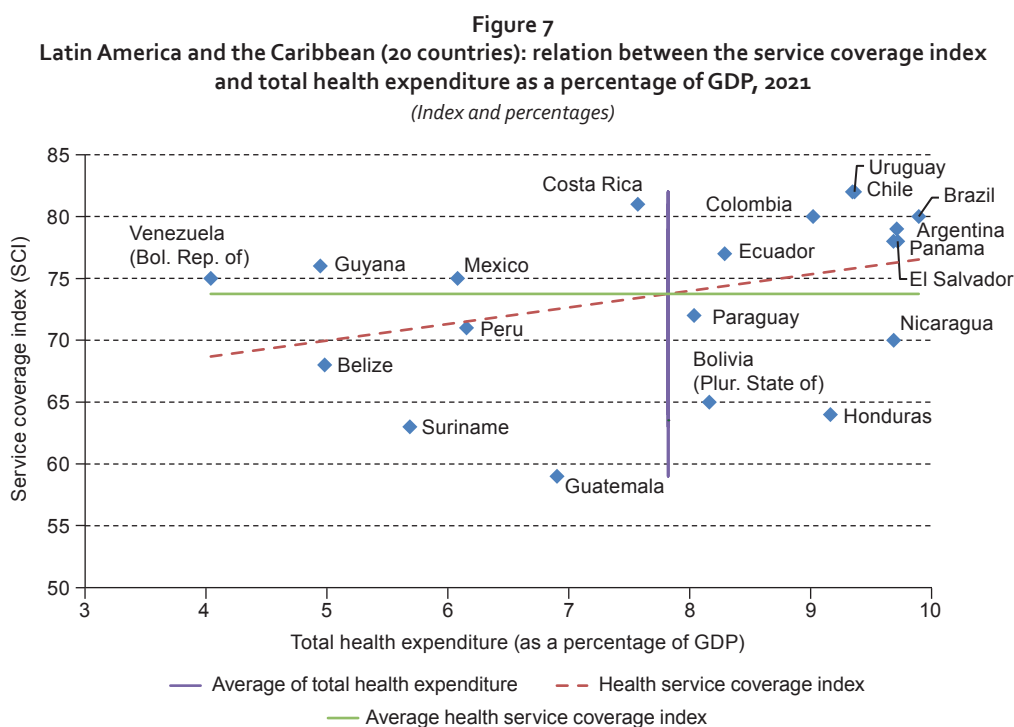
The second approach considered in this study analyses the relationship that exists between the investment, represented by public health expenditure, and the results achieved in terms of coverage. This makes it possible to estimate an elasticity which, depending on the model specification used, can reflect the relationship of change at both the regional and local levels. By not requiring a predefined coverage target, this methodology affords greater flexibility to the estimation and makes it possible to identify the marginal or gradual contributions and impacts of the health investments.

¹⁶ This is a parametric method that uses an econometric approach to estimate efficiency. It assumes that production has two error components: one associated with inefficiency and the other with random factors beyond the control of the units. A production function is specified, and inefficiencies are separated from random disturbances, thus making it possible to take uncertainty into account (Global Burden of Disease Health Financing Collaborator Network, 2018).

1. Application of benchmarking analysis

(a) Relationship between service coverage and health expenditure

Figure 7 shows the average of total health expenditure (vertical line),³⁷ including both the public and the private sectors, along with the average health service coverage index (SCI) (horizontal line). This generates four quadrants that can be classified as follows: high SCI and high expenditure (quadrant 1); high SCI and low expenditure (quadrant 2); low SCI and low expenditure (quadrant 3); and low SCI and high expenditure (quadrant 4). This grouping enables comparative analysis both between and within the groups, thus revealing the differences and similarities between the countries.



Source: Prepared by the authors, on the basis of data from the World Health Organization.

An initial observation is the heterogeneity that exists among the countries of Latin America and the Caribbean, as shown by the dispersion of countries relative to the two scales of figure 7. The figure also shows that, although additional resources are needed for health, this is necessary but not sufficient to increase health service coverage rates. For example, countries in quadrant 4 (lower right) have higher total health expenditure as a percentage of GDP than the regional average, but a lower service coverage index.

The total health expenditure of the 20 countries analysed averages 7.8% of GDP, with public health spending equivalent to 4.8% of GDP and an average SCI score of 73.8, which is in the high coverage category. Among the group of countries with the highest levels of essential service coverage, namely Brazil, Chile, Colombia, Costa Rica and Uruguay, quadrant 1 (upper right) of figure 7, shows that their total health expenditure averages 9% of GDP and, as shown in table 3B, their public expenditure on health is equivalent to 6% of GDP.

³⁷ Public expenditure on health consists of general government health expenditure in the national health accounts nomenclature and refers to general government, State or provincial government, local or municipal government, and social security funds (see Organisation for Economic Cooperation and Development [OECD], World Health Organization [WHO] and Eurostat, (2011)). This differs from the public health expenditure figures reported in the different versions of Social Panorama of Latin America and the Caribbean published by ECLAC, which refer to health expenditure by central government.

Table 3
Latin America and the Caribbean (20 countries):^a total health expenditure, service coverage index (SCI) and public expenditure on health, 2021
(Percentages of GDP and indices)

A. Latin America and the Caribbean (20 countries)			
Total	Total health expenditure (Percentages of GDP)	Service coverage index (SCI)	Public health expenditure (Percentages of GDP)
Median	8.2	75.5	4.9
Mean	7.8	73.8	4.8
Maximum	9.0	82.0	7.1
Minimum	4.0	59.0	1.4
B. Very high service coverage index (SCI>80) (5 countries): Brazil, Chile, Colombia, Costa Rica and Uruguay			
Total	Total health expenditure (Percentages of GDP)	Service coverage index (SCI)	Public health expenditure (Percentages of GDP)
Median	9.3	81.0	5.9
Mean	9.0	81.0	6.0
Maximum	10.0	82.0	7.1
Minimum	7.6	80.0	4.5

Source: Prepared by the authors, on the basis of data from the World Health Organization.

^a Argentina, Belize, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia, Suriname and Uruguay.

Considering figure 7 and the information in table 3, which shows total expenditure (public plus private), public expenditure, and the service coverage index, it is clear that there are exceptions to the rule in terms of high public expenditure and poor performance. These include Honduras and the Plurinational State of Bolivia, or the opposite case represented by the Bolivarian Republic of Venezuela, Guyana and Mexico. However, given that a service coverage index above 80 is needed to attain the high rating, this requires public health expenditure averaging 6% of GDP. Based on this benchmarking, it can be concluded that the target is an SCI of at least 80 and public expenditure on health equivalent to 6% of GDP.

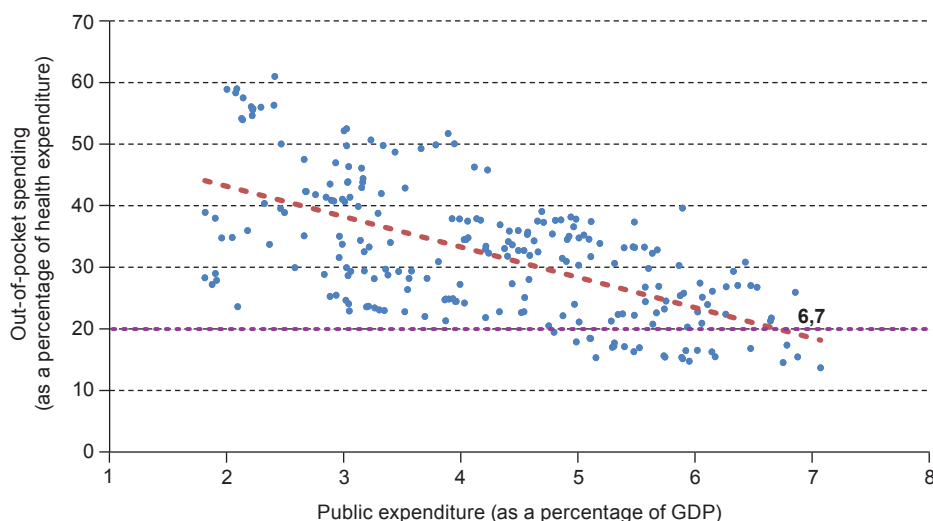
(b) Relationship between catastrophic expense and expenditure on health

The 2010 World Health Report noted that the incidence of catastrophic expenditure and impoverishment declines sharply when direct payments (out-of-pocket expenses) represent between 15% and 20% of total health expenditure (WHO, 2010).

Applying the benchmarking methodology for out-of-pocket expenses (as a percentage of total health spending) and public health expenditure (as a percentage of GDP), figure 8 shows the relationship for the 20 countries in the years for which data are available.¹⁸ Firstly, there is a negative correlation between public health expenditure and out-of-pocket spending, with the latter diminishing as public expenditure on health increases. Moreover, a horizontal line, drawn at the point at which out-of-pocket spending represents 20% of total health expenditure, intersects the vertical axis above 6% of GDP (specifically at 6.7% of GDP). This suggests that enhancing financial protection would require even greater financial effort than that needed to increase UHC.

¹⁸ Corresponding to 2000, 2005, 2010, 2015, 2017, 2019 and 2021.

Figure 8
Latin America and the Caribbean (20 countries):^a correlation between public health expenditure and out-of-pocket spending, 2000, 2005, 2010, 2015, 2017, 2019 and 2021
(Percentage of GDP and percentage of total health expenditure)



Source: Prepared by the authors, on the basis of data from the World Health Organization.

^a Argentina, Belize, the Bolivarian Republic of Venezuela, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, the Plurinational State of Bolivia, Suriname and Uruguay.

As noted above, higher public expenditure on health is necessary but not sufficient to guarantee a higher level of health service coverage. Nonetheless, evidence provided by the comparative analysis of spending on the two dimensions of universal coverage indicates that public health spending should be equivalent to at least 6% of GDP (PAHO and WHO, 2020). This minimum level of public health expenditure contributes not only to increasing service coverage but also to improving financial protection for households.

2. Methodologies for estimating the investment needed to advance towards UHC

(a) Benchmarking against a standard reference

After briefly reviewing the situation in each country and presenting the estimation of resources needed to advance towards UHC according to the benchmarking, it is essential to establish targets. Accordingly, this document proposes and analyses two thresholds derived from the benchmarking performed above.

The first consists of attaining an SCI of at least 80 points, to achieve a very high level of progress, regardless of the source of financing, with expenditure estimated as a percentage of each country's GDP. The second metric involves achieving public health expenditure of at least 6% of GDP.

The first estimation starts by estimating the average cost of each point in the service coverage index (SCI) for each country (j) (see equation 2). Based on the remaining points that each country needs to achieve the target, the resources needed are calculated using equations 3 and 4 below. If the country has already attained 80 SCI points, it is not included in the calculation.

$$\text{Average costSCI}_j = \frac{\text{Total health expenditure}_j (\% \text{GDP})}{\text{SCI}_j} \quad (2)$$

$$\text{PointsSCI}_j = (80 - \text{SCI}_j) \quad (3)$$

$$\text{Health expenditure}_j = \text{PointsSCI}_j * \text{Average costSCI}_j \quad (4)$$

The second step is to determine the additional resources, in terms of percentage points of GDP, needed to reach the 6% target (see equation 5), which is applicable only to countries that are currently below that threshold.

$$\text{Additional resources}_j = 6\% - \text{Public health expenditure}_j (\% \text{GDP}) \quad (5)$$

The necessary investment is then determined as the higher of the contributions reported by the two measures (see equation 6).

$$\text{Contribution}_j = \text{Max}\{\text{Health expenditure}_j ; \text{Additional resources}_j\} \quad (6)$$

The first phase of the estimation in this exercise (equation 5) found that Brazil, Chile, Colombia, Costa Rica and Uruguay do not require additional resources, since they attain the benchmark target of an SCI of 80 or above. In contrast, the remaining 15 countries analysed need to allocate an additional 1% of GDP to the health sector, on average, to improve health service coverage.

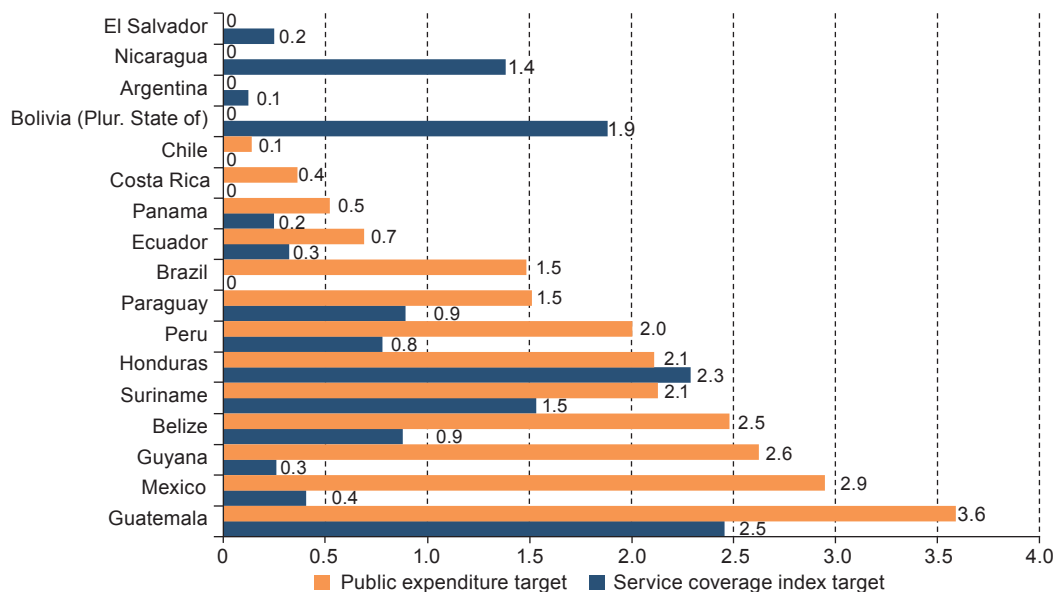
In the second phase (equation 6), which estimates the additional resources needed to achieve a public financial contribution of at least 6% of GDP, of the 20 countries analysed only six (Argentina, Colombia, El Salvador, Nicaragua, the Plurinational State of Bolivia and Uruguay) would not require additional resources. The remaining 12 countries would need an estimated additional contribution averaging 1.7% of GDP.

Figure 9 shows the results of this estimation (equations 5 and 6) and distinguishes between the estimated contribution needed to attain the SCI level (blue bars) and the public health expenditure needed to attain at least 6% of GDP (orange bars). For example, in the cases of Brazil and Colombia, no additional resources are required to achieve the essential service coverage index target (high level corresponding to a score of 80). In contrast, Mexico needs additional resources equivalent to 0.4% of GDP to attain an SCI of at least 80, and an additional 3% of GDP to achieve the target public contribution of 6% of GDP.

Figure 10 shows the results considering the higher of the contributions reported by the two measures (as calculated in equation 6). Under this methodological approach, to advance towards UHC, Latin America and the Caribbean would need to increase public health spending by an average of 1.6% of GDP. Of the region's countries, Guatemala needs to add the most resources to its health system, equivalent to 3.6% of GDP, while Argentina requires the smallest increase, at 0.1% of GDP. Most countries need to prioritize additional public investment in health, in order to make sustained progress towards UHC. In some cases, this would mean more than doubling the resources they currently allocate to the health sector, which poses a significant challenge in terms of financial sustainability.

Estimating the average costs by country makes it possible to proxy the cost function and, thus, ascertain each country's health production function. The data on the average cost of the service coverage index vary widely between the region's countries (see figure 11). In some cases, the average cost decreases for each additional point of the service coverage index, indicating the presence of economies of scale. In other cases, a rising average cost suggests that the system is in a phase of diminishing returns. In this case, each additional SCI point becomes progressively more expensive than the previous one, unless, among other factors, the health system adopts more efficient production technologies. Thus, for Argentina, Chile, Colombia, Nicaragua, Panama, Paraguay, Suriname and Uruguay, it could be more complex and challenging to make progress on UHC, as these countries' average costs currently increase with each additional unit of SCI.

Figure 9
Latin America and the Caribbean (17 countries):^a estimation of the additional spending needed to attain the very high level of the service coverage index^b and public health expenditure of at least 6% of GDP
(Percentage points of GDP)

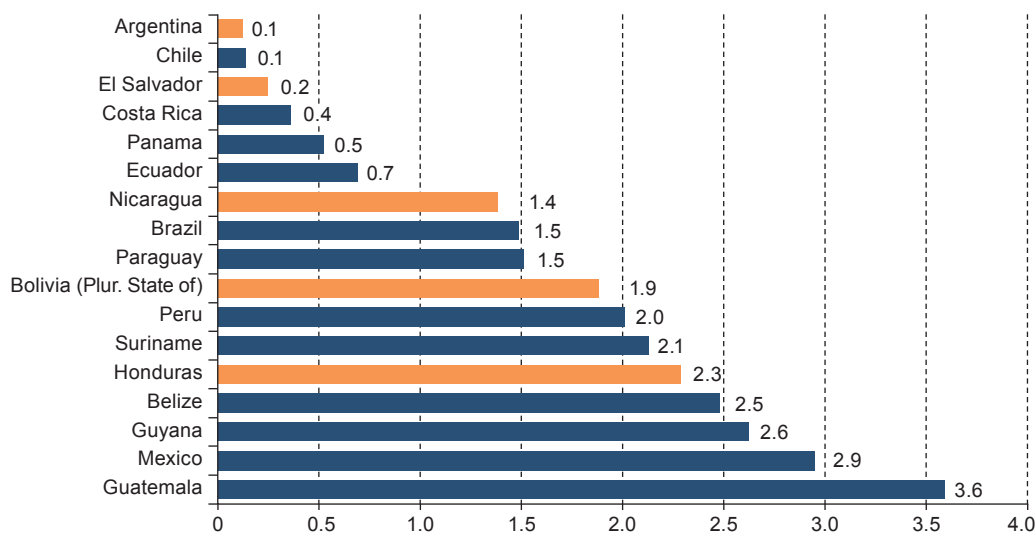


Source: Prepared by the authors, on the basis of data from the World Health Organization and the Economic Commission for Latin America and the Caribbean.

^a The Bolivarian Republic of Venezuela is not included, as the sources consulted do not give an up-to-date value for its GDP.

^b The very high level of the service coverage index corresponds to a score of 80 or above (for further information, see section II.A).

Figure 10
Latin America and the Caribbean (17 countries):^a estimated public expenditure needed to move towards UHC^b
(Percentages of GDP)

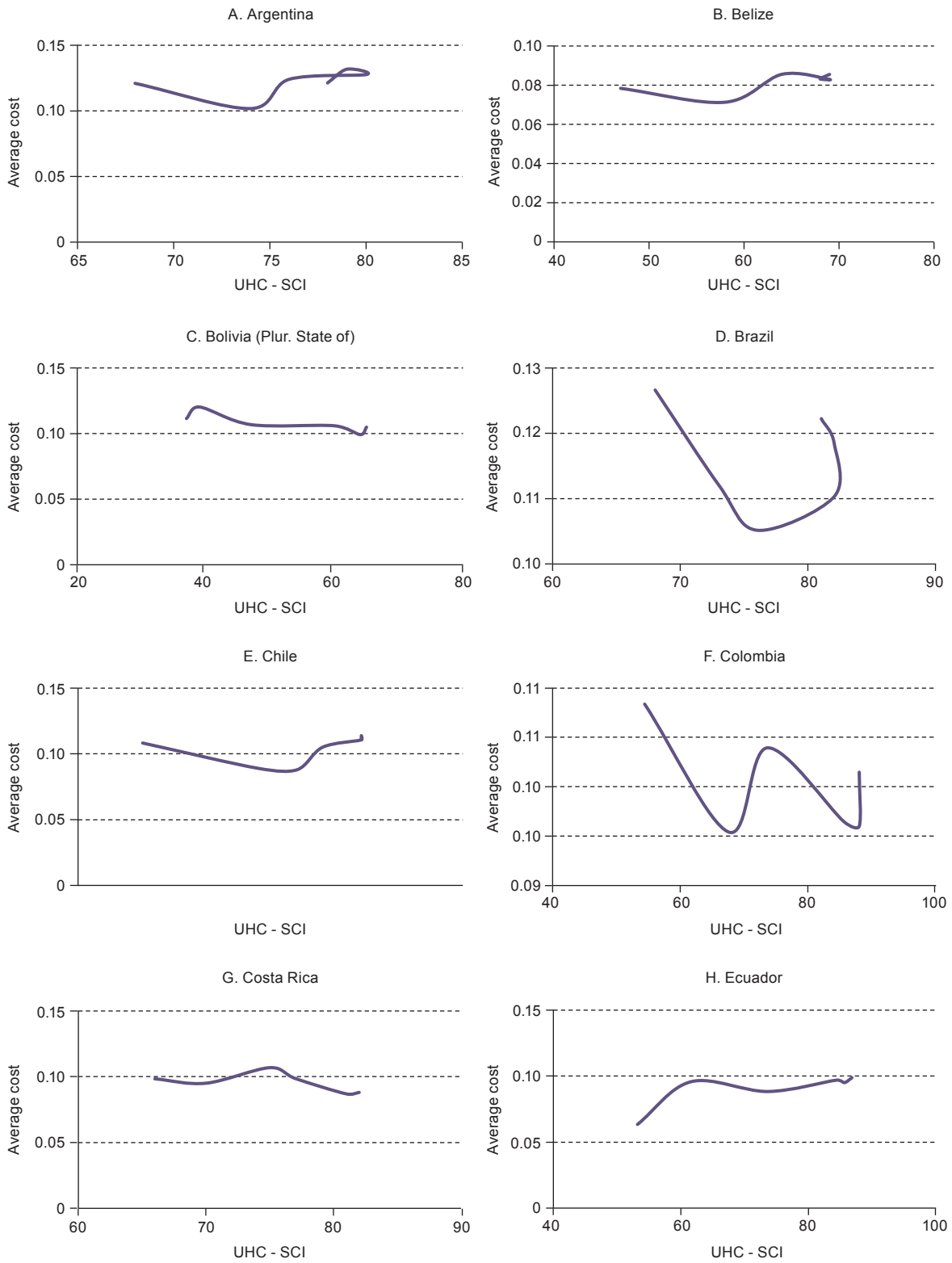


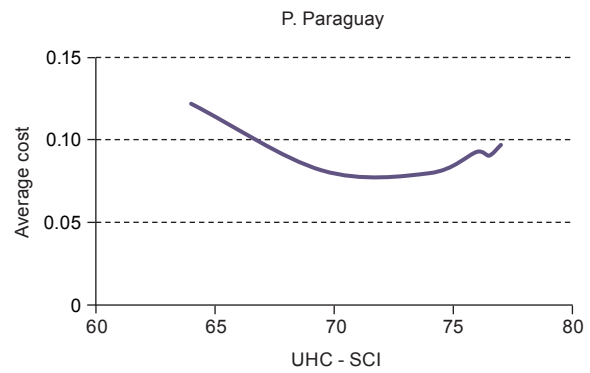
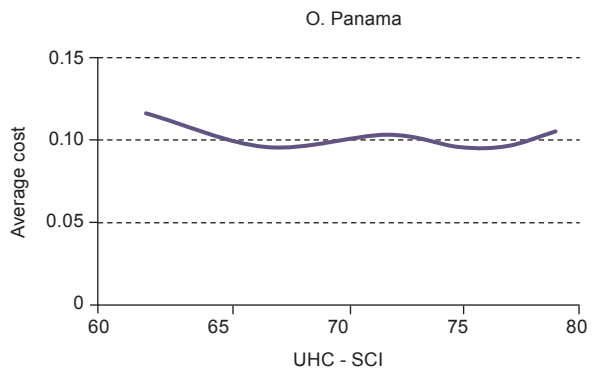
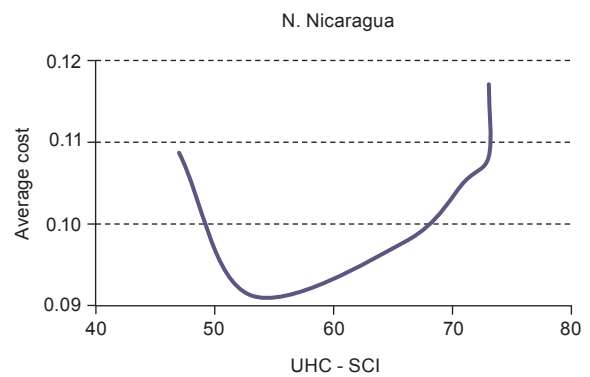
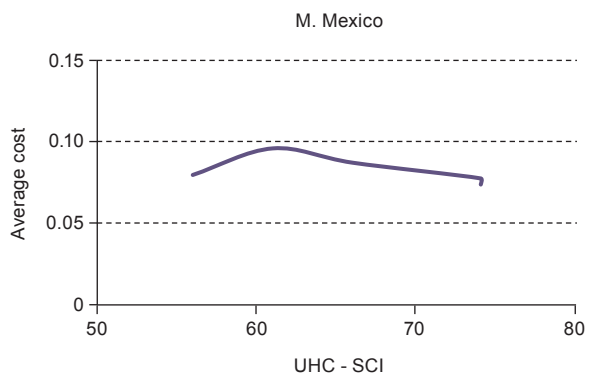
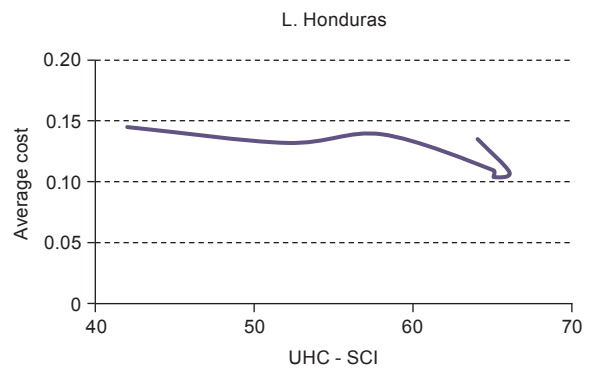
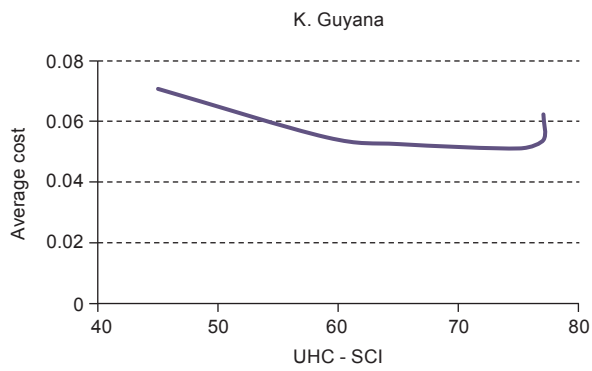
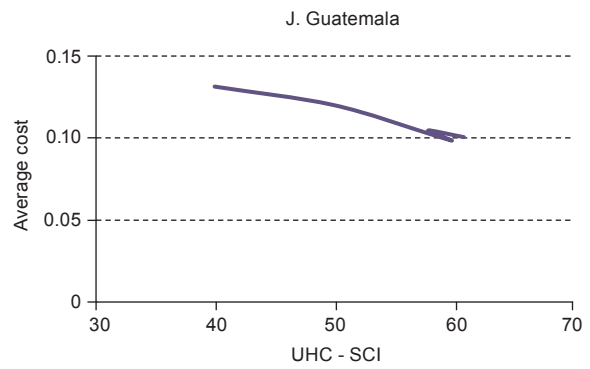
Source: Prepared by the authors, on the basis of data from the World Health Organization and the Economic Commission for Latin America and the Caribbean.

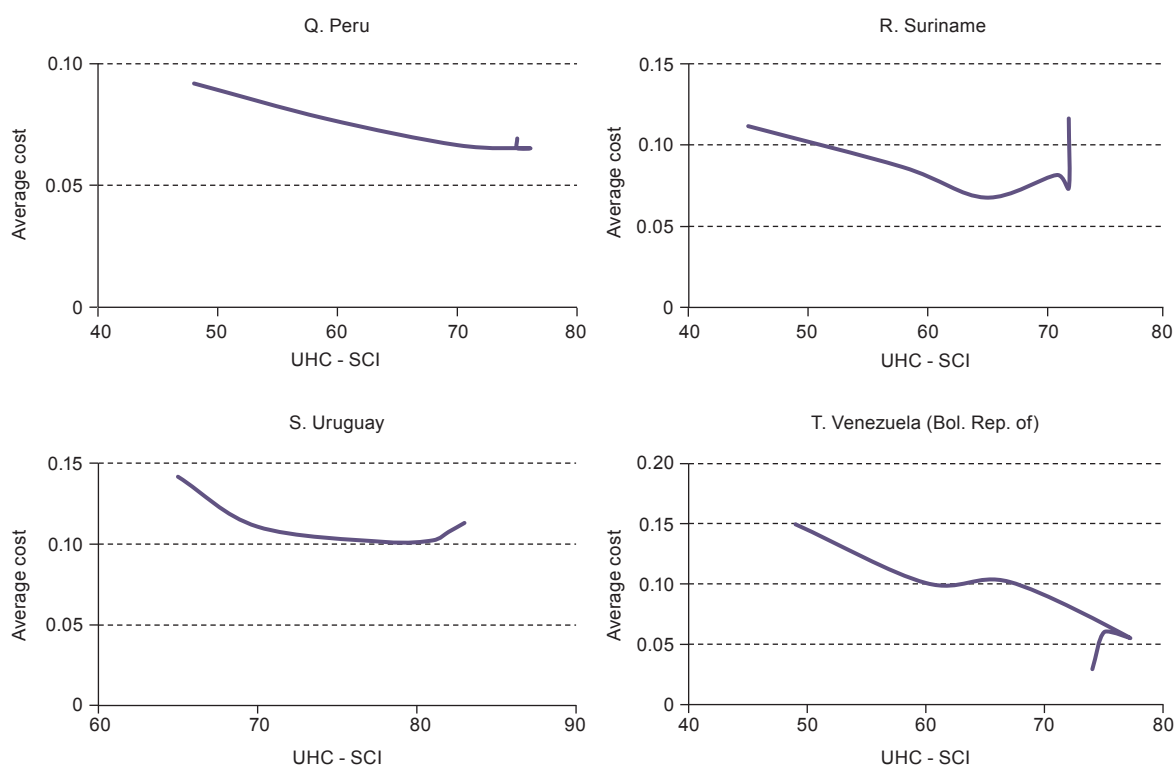
^a Colombia and Uruguay are not included in this figure, because both countries already meet the two targets defined in this study.

^b The orange bars correspond to countries whose maximum estimated contribution relates to the SCI gap; the blue bars correspond to the estimated contribution needed to attain public health expenditure of 6% of GDP.

Figure 11
Latin America and the Caribbean (20 countries):^a average cost curve of the service coverage index, by country
(Indices)







Source: Prepared by the authors, on the basis of data from the World Health Organization.

^a The countries report information available for the following years: 2005, 2010, 2015, 2017, 2019 and 2021.

The valuation using average costs and the SCI score is an analytical simplification of reality. To obtain a more accurate calculation, specific models need to be developed for each country, considering both their health production technology and the relative prices of their factors of production. In addition, the levels of efficiency (and inefficiency) associated with each monetary unit invested also need to be incorporated.

(b) Panel data fixed-effects model

The second approach applied to Latin American and Caribbean countries in estimating the investment needed to move towards UHC aims to identify the relation between total health expenditure (X) and the service coverage index (y), using a panel data model that makes it possible to analyse both time series and cross-sectional data.

The available information allows observations for 20 countries (i) corresponding to seven time periods (t),¹⁹ while controlling for the structural characteristics of each country (fixed effect, α). The specification is represented in equation 7.

$$y_{it} = \alpha_i + \beta X_{it} + e_{it} \quad (7)$$

For the coefficient of interest (β) to be interpreted as elasticity, the specification above was defined in natural logarithmic terms. Thus, the coefficient β will represent the percentage change in the service coverage index associated with a 1 percentage point of GDP increase in health expenditure. Given the model specification, the measure corresponds to an estimation for the region, but using the equation in its entirety makes it possible to project for each country how much the service coverage index would increase in response to a 1% increase in health expenditure (by evaluating each country's values and estimating the constant α). Each country's per capita GDP was also considered as an additional control variable.

¹⁹ The years available for the 20 countries are 2000, 2005, 2010, 2015, 2017, 2019 and 2021.

The results shown in table 4 indicate that for every GDP percentage point increase in total health expenditure, the service coverage index will increase by 0.256%. This suggests that the increase in public health spending is weakly correlated with the projected increase in SCI, so larger financial contributions would likely generate modest increases in coverage, consistent with the region's already high average SCI (73.8 percentage points in 2021). This finding reinforces the notion that additional resources must be supported by efficient expenditure management, which underscores the need to achieve financial sustainability.

Table 4
Results of the fixed-effects panel data model

Variables	Coefficient
Ln(Total health expenditure)	0.256*** (0.0629)
Ln(GDP per capita)	0.221*** (0.0196)
Constant	1.842*** (0.130)
Observations	119
Number of countries	20
R-squared	0.776
Prob >F	0

Source: Prepared by the authors, on the basis of data from the World Health Organization and the Economic Commission for Latin America and the Caribbean.
Note: Standard errors in parentheses; *** p<0.001; **p<0.05; *p<0.1.

The model results indicate that the estimated coefficients are statistically significant at the 99% confidence level, and that it is necessary to control for each country's per capita GDP to avoid overestimating the contribution of health expenditure to the SCI result. The model as a whole is also significant, as shown by its high degree of fit through R-squared,²⁰ and the F-test (Prob > F = 0.0000) indicates that the model is statistically significant and suggests that it has good general explanatory power, which supports its validity for analysis and prediction.

B. Estimation of the financial effort needed to move towards universal health coverage with financial sustainability

The speed of progress towards financially sustainable UHC depends on each country's priorities and how these are balanced with other key social and public concerns. For illustrative purposes, the additional annual contribution is determined below as the percentage points of GDP that the countries need to allocate to achieve universal coverage with financial protection within 10, 15 and 20 years.

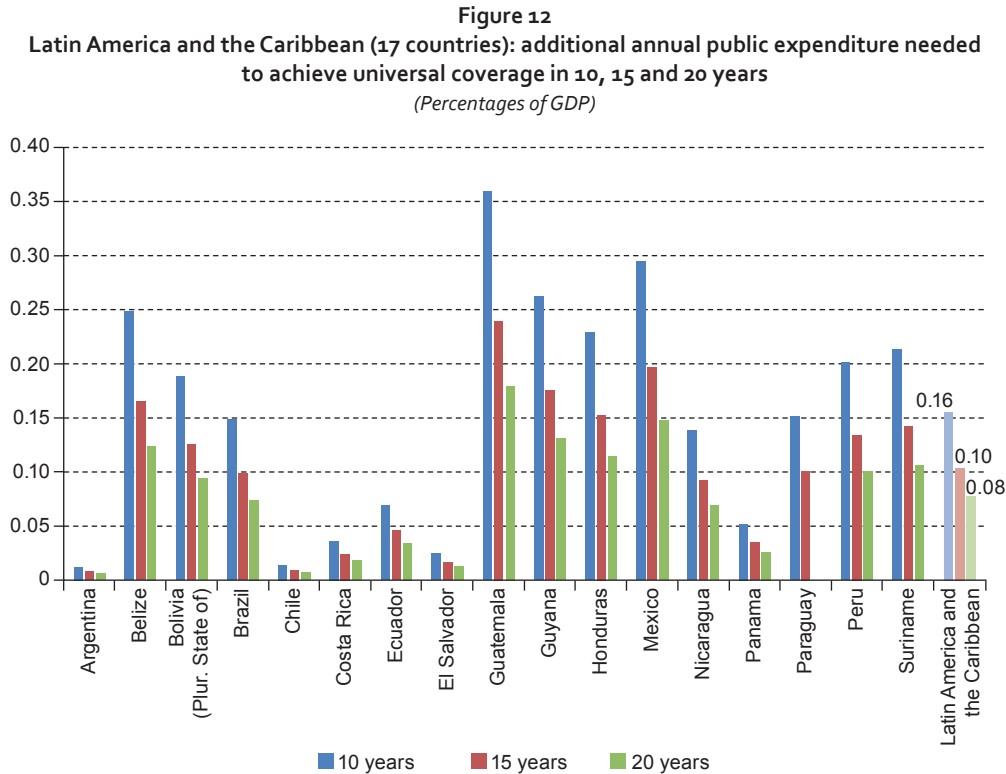
Considering the estimated contribution in equation (8) and the specified time frames, the annual increase in public health expenditure required to achieve a service coverage index of at least 80 and public health spending of 6% of GDP, is estimated as a percentage of GDP. In simple terms, this corresponds to an average annual contribution according to the defined time frame.

$$\text{Estimated annual contribution}_j = \frac{\text{Contribution}_j}{N} \quad (8)$$

Where: N takes the values 10, 15 and 20.

²⁰ R-squared (R^2), or coefficient of determination, is a statistical measure that indicates how well a regression model fits the observed data. In simple terms, R-squared represents the proportion of the variation in the dependent variable (to the variable to be predicted or explained) that is explained by the independent (predictor) variables included in the model.

The results indicate that, with the exception of Colombia and Uruguay, the countries need to increase their public health expenditure annually by an average of 0.15%, 0.10% and 0.07% of GDP in the scenarios projected for 10, 15 and 20 years, respectively. However, countries such as Guatemala, Guyana and Mexico would need to make almost double the regional average effort to attain the established coverage levels within the specified deadlines. Figure 12 presents the estimated rates for the 17 countries analysed.



Source: Prepared by the authors, on the basis of data from the World Health Organization and the Economic Commission for Latin America and the Caribbean.

Comparing the annual growth rates of total health spending and public expenditure on health (both as a percentage of GDP), over the last 5 and 10 years, with the previously estimated additional annual contributions, and using equation (9) below, makes it possible to determine a reference rate. This is defined as the maximum annual growth rate of total health spending and public health expenditure in the countries of the region (j). The analysis includes four rate measurements, based on two key criteria: the time horizon (5 or 10 years) and the type of health expenditure (public or total).

Where:

$$\text{Effective growth rate}_j = \max \{ \text{RateGTS}_{j,10}; \text{RateGPS}_{j,10}; \text{RateGTS}_{j,5}; \text{RateGPS}_{j,5} \}$$

Rate GTS₁₀: annual rate of total health expenditure 2010–2021

Rate GTS₅: annual rate of total health expenditure 2015–2021

Rate GPS₁₀: annual rate of public health expenditure 2010–2021

Rate GPS₅: annual rate of public health expenditure 2015–2021

Table 5 reports estimations of the historical trend and the annual contribution over a 10-year period, together with the gap identified between the two figures. Only in the cases of Chile, El Salvador and Panama is the estimated pace of contribution less than the maximum estimated rates of expenditure growth; in all other countries, the opposite is true.

Table 5
Latin America and the Caribbean (19 countries): estimated contribution compared
with historical contribution to achieve SDG indicator 3.8.2
(Percentages of GDP)

Country	Maximum annual variation <i>(Percentages of GDP)</i>	Estimated annual variation to achieve target in 10 years <i>(Percentages of GDP)</i>	Gap <i>(Percentages of GDP)</i>
Argentina	0.0117	0.0123	0.001
Belize	0.0186	0.2481	0.230
Bolivia (Plurinational State of)	0.0647	0.1883	0.124
Brazil	0.0318	0.1485	0.117
Chile	0.0383	0.0139	-0.024
Colombia	0.0425	0	0
Costa Rica	-0.0006	0.0363	0.037
Ecuador	0.0613	0.0690	0.008
El Salvador	0.0527	0.0249	-0.028
Guatemala	0.0282	0.3590	0.331
Guyana	0.0738	0.2625	0.189
Honduras	0.0413	0.2290	0.188
Mexico	0.0121	0.2948	0.283
Nicaragua	0.0610	0.1383	0.077
Panama	0.0613	0.0522	-0.009
Paraguay	0.0771	0.1512	0.074
Peru	0.0572	0.2010	0.144
Suriname	0.0634	0.2130	0.150
Uruguay	0.0447	0	0

Source: Prepared by the authors, on the basis of data from the World Health Organization and the Economic Commission for Latin America and the Caribbean.

This analysis shows that, although the region's countries face a major financial challenge in achieving the proposed targets, the amounts in question are manageable. However, they must be backed by efficient management to make it possible to invest fiscal resources strategically in the health sector, to achieve their objectives within a reasonable time frame.

The region's health systems need to be financially sustainable for progress to be made towards UHC. While increased investment in health is essential, it is also crucial to optimize its allocation and make expenditure more efficient, in order to achieve a sustainable balance. The results show that public health expenditure targets (6% of GDP) and a high SCI level of 80 or more can be achieved, and that the corresponding fiscal efforts must be accompanied by financial sustainability and efficient management of health system expenditure.

The analytical tools used in this document, such as cross-country benchmarking and the panel data model, make it possible to identify clear targets and quantify specific projections for each country. They underscore the need for public health spending of at least 6% of GDP, and they draw attention to the inherent differences between countries in the region, which makes it necessary to study each case individually to generate policy recommendations.

IV. Financial sustainability and alternatives for expanding fiscal space for health

This section analyses the financial sustainability and fiscal space for health available to the region's countries. Firstly, it analyses the countries' fiscal capacity for public action. Next, it presents the concept of fiscal space for health and explores the different sources of health sector financing. Lastly, it proposes financial management as one of the fundamental tools for advancing towards UHC and making the health systems financially sustainable.

A. Fiscal space

Fiscal space is closely related to a country's economic capacity and its ability to collect and generate (or borrow) the resources needed for various purposes, including social and productive ones.

Fiscal space refers not only to the availability of resources, which is closely related to a country's productive and revenue-raising capacity, among other factors, but also to its capacity to mobilize resources efficiently and effectively. Sufficient fiscal space enables a country to implement countercyclical policies during periods of recession, invest in critical infrastructure, improve public services, expand social protection and respond promptly to emergencies, crises and disasters.

Heller (2005, 2006) defines fiscal space as the capacity of a country to provide additional budgetary resources for a specific purpose without jeopardizing the sustainability of its financial position. This definition underscores the importance of balancing short-term spending needs with the capacity to finance them in the medium and long terms without incurring unsustainable debt. This is consistent with the ECLAC (2018) definition of financial sustainability.

Fiscal space, and, hence, the spaces available for progress, can be measured using different methodologies (Arenas de Mesa, 2016; OECD, 2016). Aside from the methodologies used, there is consensus that fiscal space depends on policies to promote economic growth, as well as fiscal and macroeconomic policies.

A country's fiscal space can be affected by multiple factors, including interest rates, potential growth, fiscal trajectory, external macroeconomic shocks, future spending projections and structural reforms (Heller, 2005 and 2006; Arenas de Mesa, 2016). Although an in-depth analysis of the fiscal space of Latin American and Caribbean countries is beyond the scope of this document, an introduction to the debate on fiscal space for health is developed below.

B. Fiscal space for health: alternatives for expansion

There is no universally accepted definition of the concept of fiscal space for health, and discussion of it has evolved over time. WHO (2018, p. 2) states that the study of fiscal space for health is wide-ranging. It addresses the economic, institutional, health and political analysis of different countries, which poses a major challenge for researchers, given the need to incorporate a multidisciplinary approach in each of the dimensions considered. Moreover, the evaluation of fiscal space must be adapted to each country, considering its initial fiscal position, its revenue and expenditure structure, the characteristics of its debt, the structure of its economy, and the prospects for foreign inflows and the external conditions it faces (Heller, 2006).

In the decade of 2000, it was projected that, for most low-income countries, much of the fiscal space needed to increase health spending in the short and medium terms would depend on external financing in the form of grants (Heller, 2006). However, this view has evolved towards the idea that countries should be self-sufficient in raising resources. WHO (2018) describes this phenomenon as the transition from cash transfers and grants to sustainable public financing that is organically adapted to the characteristics and needs of each health system. The Economic Commission for Latin America and the Caribbean and PAHO argue that it is urgent to invest in health systems to reduce inequality and achieve the Sustainable Development Goals of the 2030 Agenda for Sustainable Development, and that this process needs to be financially sustainable to enhance coverage and access to quality care (ECLAC and PAHO, 2024).

Fiscal space for health has also been defined as 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 non-health SDGs (Tandon and Cashin, 2010, p. 11). This implies increasing health financing without reducing or cutting back on areas that are equally essential for well-being and economic development, such as education, infrastructure or security. Tandon and Cashin (2010) stress the importance of assessing fiscal space for health through a detailed analysis of the factors driving the need for increased health resources and potential sources of additional financing. This approach makes it possible to identify areas for improvement and optimization, and thus maximize the impact of the available resources. In global terms, four areas can be identified to increase fiscal space for health:²¹

1. Tax reforms that increase public revenues

- Tax policies, such as reducing tax evasion and avoidance: ECLAC (2024) has estimated that regional tax evasion and avoidance absorbed 6.7% of GDP (equivalent to US\$ 433 billion) in 2023. If part of the reduction in tax evasion and avoidance were allocated to health, the target of public health spending equivalent to 6% of GDP would be achieved more easily.
- Fiscal rules, efficiency in revenue collection and execution of public expenditure.
- Specific taxes on consumer products that are harmful to the population (tobacco, alcohol, sugar, vaporizers, among other products considered "bad goods").

²¹ Similar exercises are undertaken in Tandon and Cashin (2010); Tandon *et al.* (2014).

2. Alternatives for public spending on health

- Encourage the flow of resources from voluntary to general-mandatory insurance.
- Prioritize resource allocation to the health structure.

3. Improvements in health expenditure management

- Ensure efficient resource allocation, especially in projects associated with the SCI indicators.
- Establish evaluation processes to monitor essential UHC indicators.
- Study the budgetary impact and cost-benefit ratio of including new health technologies.
- Encourage a culture of evaluation in health policies and projects.
- Establish strategic purchasing mechanisms that make it possible to distribute risk.
- Strengthen public financial management in health, for example by aligning procurement mechanisms more closely with financial management standards.

4. Use of external financing for investments in a strategic and sustainable manner²²

- Invest in local capacities to ensure services are sustainable.
- Invest in critical local health infrastructure.

C. Sources of health financing²³

When analysing fiscal space for health, whether understood as additional resources available or as a reallocation of resources to the health sector, it is essential to identify the countries' priorities in this sector. One way to measure different health priorities is through expenditure measures and the various sources of financing. Between 2000 and 2021, Latin American and Caribbean countries have been increasing their public expenditure efforts in the health sector. On average during this period, the region allocated 14.7% of total public spending to health, spearheaded by Costa Rica (25.4%) and Uruguay (22.4%).

The analysis made by ECLAC of the composition and distribution of public social spending in Latin America and the Caribbean for 2023 shows that the countries prioritize social protection—the payment of pensions and conditional transfer programmes, followed by education and health, and then other dimensions of social spending (ECLAC, 2024c; Podestá, 2023).

In 2021, the last year for which information is available, total health spending by 20 of the region's countries averaged 7.8% of GDP. Of these countries, 12 exceeded the regional average, with Brazil recording the largest total health expenditure share at 9.9% of GDP. In contrast, eight were below the average, with the Bolivarian Republic of Venezuela lowest at 4%. In the same year, total health expenditure in OECD countries averaged 9.7% of GDP (OECD, 2023).

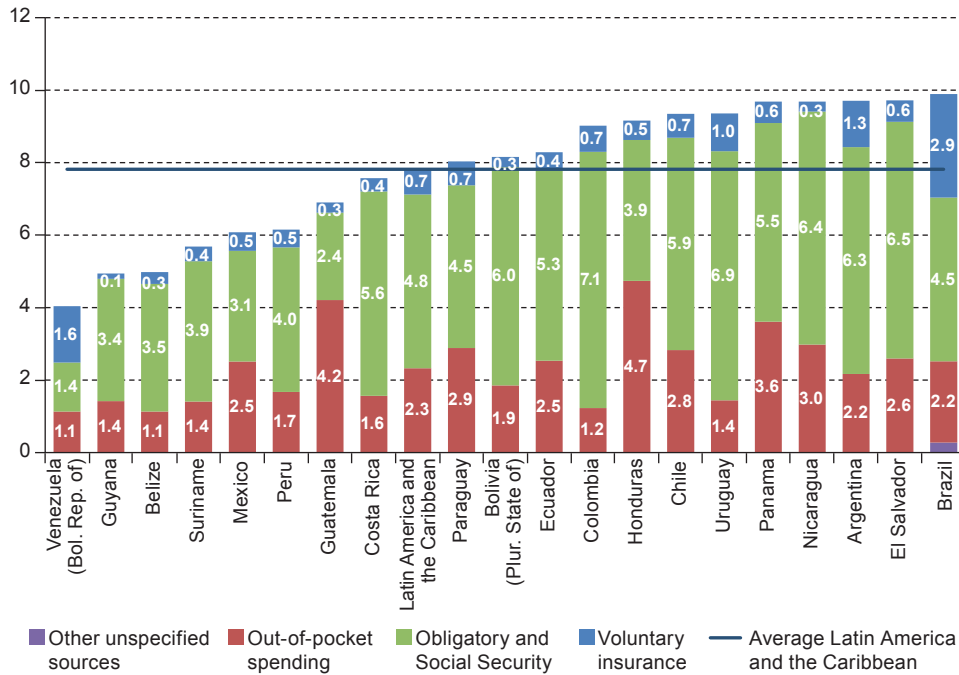
Consideration of financing sources is central to the discussion of UHC, as additional efforts are required from general resources or mandatory health insurance to expand the expenditure base and thus reduce the financial risk faced by households in the region. According to the classification of national health accounts compiled by WHO, in 2021, 60.8% of health expenditure in Latin America and the Caribbean was financed by the government and social security, 29.7% by out-of-pocket spending,²⁴ 9.3% through voluntary insurance, and the rest by other unspecified items (see figure 13).

²² Grants in the health sector are a scarcely evaluated and underutilized mechanism. Nonetheless, the analyses conducted by OECD (2012) and WHO (2018) on the effectiveness of these grants, and their recommendations, remain valid.

²³ The data presented on health expenditure were obtained from the WHO database, Global Health Expenditure Database. <https://apps.who.int/nha/database/Select/Indicators/en>.

²⁴ In 2021, out-of-pocket health spending averaged 18.4% in OECD countries (OECD, 2023).

Figure 13
Latin America and the Caribbean (20 countries): total health expenditure by source of financing, 2021
(Percentages)



Source: Prepared by the authors, on the basis of data from the World Health Organization.

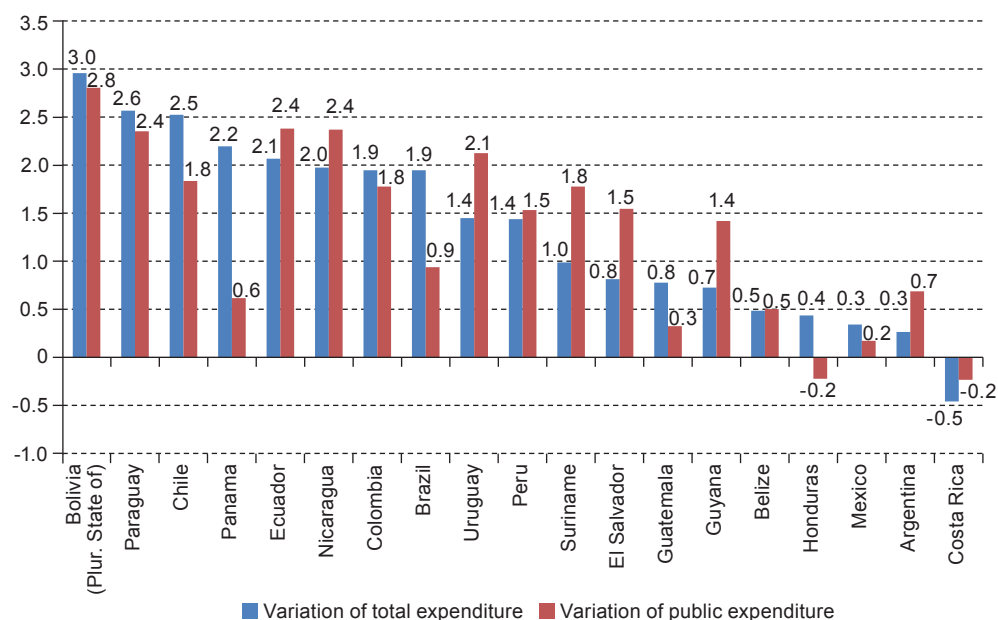
Here too, the composition of health expenditure in Latin America and the Caribbean varies greatly. In 2021, Colombia reported the largest share of health expenditure financed by social security and government, at 78.4%, followed by the Plurinational State of Bolivia (73.7%) and Uruguay (73.4%). In contrast, direct out-of-pocket spending by households finances more than 60% of health expenditure in Guatemala, 51.7% in Honduras and 41.3% in Mexico. The countries with the smallest shares of out-of-pocket spending were Colombia (13.6%) and Uruguay (15.4%). Lastly, the countries in which voluntary insurance accounted for the largest shares of total health expenditure were the Bolivarian Republic of Venezuela (38.4%), Brazil (28.8%) and Argentina (13.2%).

A review of total health spending and public expenditure on health between 2010 and 2021 shows that total health spending increased throughout the region except in Costa Rica²⁵ (see figure 14).²⁶ In the Plurinational State of Bolivia and in Paraguay, Chile and Panama, total health expenditure increased by between 2.2 and 3 percentage points of GDP, and public spending on health grew by less than total health expenditure, which may suggest an increase in out-of-pocket and other sources of financing. In contrast, in Argentina, Ecuador, El Salvador, Guyana, Nicaragua, Peru, Suriname and Uruguay, public expenditure on health increased in absolute terms by more than total health expenditure, indicating a significant effort to channel public resources into the sector.

²⁵ The data for Costa Rica can be explained by a fiscal consolidation policy.

²⁶ As the PAHO/WHO data source does not contain health expenditure records for the Bolivarian Republic of Venezuela in 2010, that country is excluded from the analysis of variations in total and public health spending.

Figure 14
Latin America and the Caribbean (19 countries): variations in total health expenditure and public expenditure on health between 2010 and 2021
(Percentage points of GDP)



Source: Prepared by the authors, on the basis of data from the World Health Organization.

The same analysis performed between 2015 and 2021 shows that the increase in health expenditure (both total and public) was less than in 2010–2021 in absolute terms, which is to be expected since the period in question is shorter. Uruguay, El Salvador, Ecuador and Suriname increased their public health spending significantly between 2015 and 2021 (see figure 15). In the other countries, the increase in health expenditure comes mainly from direct household out-of-pocket spending.

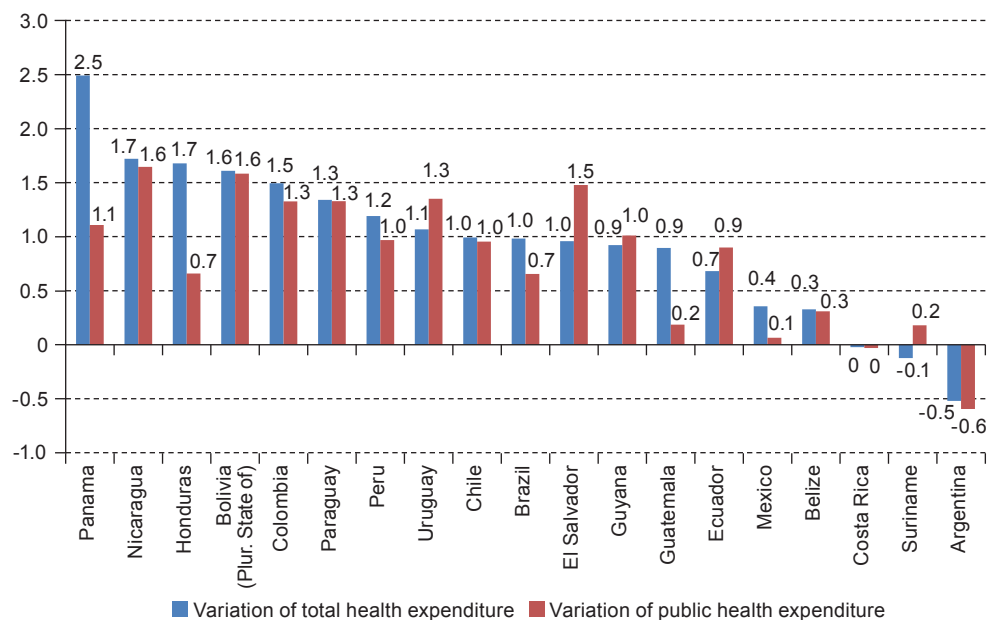
This time-series analysis shows that the pace of public health spending by the region's countries has slackened, and that it is financed mainly from private sources, either through household out-of-pocket spending or through private insurance.

Consideration of public health expenditure targeted towards PHC, which PAHO and WHO recommend should account for at least 30% of total public health expenditure (PAHO and WHO, 2020), shows that seven of the 20 countries analysed report this information in a disaggregated manner. This makes it challenging to use these statistics to strengthen the design of PHC policy, among other dimensions.

Table 6 shows that, in six of the seven countries with information available in the WHO database, the share of PHC spending total public health expenditure declined, on average from 49% in 2016 to 41.7% in 2021. Uruguay is the only country in this group with information available that bucks the trend, with its PHC share of spending expanding from 40.6% in 2016 to 45.4% in 2021. In Costa Rica the PHC expenditure share fell by nearly 10 percentage points from 43.4% in 2016 to 34.5% in 2021. Nonetheless all countries allocated more than 30% of their public health expenditure to PHC.

Figure 15
Latin America and the Caribbean (19 countries): changes in total health expenditure
and public spending on health between 2015 and 2021

(Percentage points of GDP)



Source: Prepared by the authors, on the basis of data from the World Health Organization.

Table 6
Latin America and the Caribbean (7 countries):
share of primary healthcare in public spending on health, 2016–2021
(Percentages)

Country	2016	2017	2018	2019	2020	2021	Average
Brazil	42.0	47.8	40.9	40.0	-	-	41.1
Costa Rica	43.4	25.2	26.2	38.2	36.1	34.5	33.9
Guyana	76.1	76.1	75.8	75.7	-	-	76.0
Brazil	42.0	47.8	40.9	40.0	-	-	41.1
Costa Rica	43.4	25.2	26.2	38.2	36.1	34.5	33.9
Guyana	76.1	76.1	75.8	75.7	-	-	76.0
Mexico	45.0	44.2	44.0	44.3	42.3	44.4	44.1
Latin America and the Caribbean (7 countries)	49.0	45.4	45.8	46.4	41.1	41.7	45.4

Source: Prepared by the authors, on the basis of data from the World Health Organization.

As information is only available for seven countries, this situation cannot be considered representative of the region as a whole. In addition, a more thorough evaluation of the efforts of health systems to promote PHC would entail analysing contribution not only in relative, but also in absolute and per capita terms. Although a large share of public health spending is targeted towards PHC, in some cases this represents less than 6% of GDP, resulting in insufficient expenditure in absolute terms (Marinho *et al.*, 2023).

PAHO/WHO classifies health expenditure in different categories or functions, aligned with the national accounts. For a total of 67 countries for which PAHO/WHO has information, the distribution of health expenditure was as follows: 54.6% was allocated to curative care; 17.3% to supplies; 10.5% to long-term care; 5.3% to prevention; 4.5% to administrative expenses; and 2.1% to rehabilitation.

Table 7 shows the distribution of public health expenditure by function, considering that only nine countries in the region have information available for 2019 or a more recent year. As is the case internationally, the countries analysed place a heavy emphasis on curative healthcare (58.0%),²⁷ with a meagre and almost minimal share allocated to rehabilitation (0.8%) and long-term care (0.5%). Spending on prevention is also limited (6.4%), except in Guyana (14.4%) and Uruguay (8.2%). Meanwhile, administrative expenses absorb a large share in Chile (11.5%) and Paraguay (10.9%), especially compared with Uruguay, which allocates the smallest share to this function (0.5%).

Table 7
Latin America and the Caribbean (9 countries):
distribution of public health expenditure by function, 2019 or latest year available
(Percentages of total)

Country	Administration	Curative	Examinations	Supplies	Long-term care	Other	Prevention	Rehabilitation
Brazil	6.4	50.2	11.3	20.4	1.8	4.4	4.3	1.1
Chile	11.5	46.3	5.0	12.7	0.2	20.7	3.3	0.2
Costa Rica	8.3	75.2	1.4	12.4	0.6	0.0	0.8	1.3
Guatemala	7.0	41.1	0.2	26.1	0.0	20.0	5.4	0.2
Guyana	5.3	57.4	1.3	21.0	0.0	0.0	14.4	0.5
Mexico	5.0	60.6	2.7	26.6	-	2.0	3.0	0.2
Paraguay	10.9	55.0	9.8	19.1	0.0	1.0	4.0	0.3
Suriname	5.9	69.4	6.7	12.2	0.0	0.2	5.5	0.0
Uruguay	0.5	69.2	0.5	7.2	1.4	9.6	8.2	3.5
Latin America (9 countries)	6.8	58.0	4.3	17.5	0.5	6.4	6.4	0.8

Source: Prepared by the authors, on the basis of data from the World Health Organization.

On a preliminary basis, this information suggests that the nine countries of the region for which data are available target their health spending on curative care, in other words hospital care and management of the population who are ill. This poses a challenge for strengthening efforts to increase health spending on PHC, targeting health promotion and disease prevention, considering the social determinants of health and their impact on accentuating health inequalities. Formulating more precise recommendations and suggestions for each of the region's countries, especially given the limited information available on PHC spending, will require a more detailed analysis of the focus of health expenditure on PHC, by care activity and relative productivity.

D. The central role of financial management in making health systems financially sustainable

As discussed in this document, achieving UHC requires additional resources, which can be obtained by increasing the fiscal space for health, for example by expanding the national budget on the back of stronger economic growth. This scenario could either generate additional resources for health, or else it could lead to the creation of mandatory insurance systems in situations where they do not exist. What is important is that the various sources of financing guarantee the financial sustainability of the health systems, to be able to meet commitments to both present and future generations.

²⁷ The analysis of health spending on curative care needs to be treated with caution, because it includes both hospital and outpatient care. Its classification also depends on how each administrative system accounts for expenditure on tests and supplies, which is related closely to payment mechanisms. In systems with broader benefit packages for curative care, a large proportion of supplies and tests is likely to be included in such expenditure.

In this context, efficient management of health expenditure is a priority and an objective in itself. In 2010, WHO estimated that from 20% to 40% of all health spending is currently wasted through inefficiency (WHO, 2010). The issue of efficiency has been debated widely not only in the health sector but in all areas of public spending. It can be measured both globally, using econometric models, and from a specific perspective, analysing the relation between inputs outputs of specific actions, programmes and policies.

The management of health expenditure has opportunities for improvement, both in technical aspects and in resource allocation. Examples include exploiting economies of scale in the procurement of supplies and services, and investing in management evaluation and control systems and information systems to support health system financial management.

At the international level, financial management as a fundamental tool for achieving UHC has gained traction in recent decades. It enables more efficient design, allocation and use of health budgets and makes it easier to implement financing reforms. Barroy and Gupta (2021) argue that financial management should be included systematically in assessments of budgetary space, to inform more effective dialogues between the finance and health sectors. This is essential since fiscal space for health, and in particular for UHC, is closely related not only to a country's economic capacity, but also to the ability of states to collect, manage and generate (or borrow) the resources needed for social, productive and other purposes.

Financial management provides an opportunity for countries to administer public resources efficiently and make progress in terms of both financial sustainability and inclusive social development strategies (ECLAC and PAHO, 2024; Andrews *et al.*, 2014). Financial management encompasses the planning, execution and evaluation of public budgets as well as management of the public debt and accountability (Pimenta *et al.*, 2014; Arenas de Mesa and Berner, 2010).

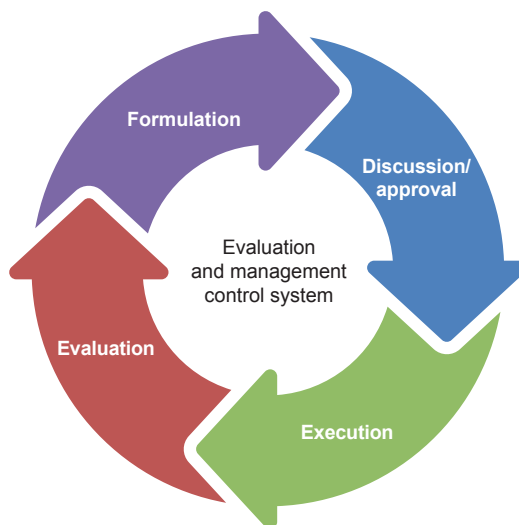
Various studies have shown that strengthening financial management systems in the health sector can facilitate the implementation of financing reforms geared towards UHC, mainly through three key areas: (i) reliable public budgets; (ii) budgets with more clearly defined sectoral priorities, production targets and implementation capacity; and (iii) flexibility in health budget spending.

Diagram 1 illustrates how the financial management model is applied to health. The financial management cycle reflects the process of constructing public budgets, starting with formulation, discussion and approval by the different branches of government, and followed by execution and evaluation of effectiveness and efficiency in the use of resources, thereby providing feedback for the formulation of a new fiscal cycle. Each stage is essential for the efficient allocation and use of resources, and it is here that the key topics of planning, strategic payment mechanisms, timely and proper budget execution, accountability and continuous evaluation come into play (Cashin *et al.*, 2017). Payment mechanisms are very important in this process, as they represent the specific mode of procurement in the health sector, generating an alignment of incentives and distribution of risks, which is included in the execution dimension.

Cammack *et al.* (2020) introduce the concept of financial bottlenecks, which they define as "any systemic budgetary weakness which adversely affects the delivery of services through its impact on efficiency, equity or execution and which can be remedied primarily through budgetary means" (Cammack *et al.*, 2020 p. 5). Thus, a problem is considered a financial bottleneck if it satisfies two criteria: (i) it is critical to the achievement of sector objectives; and (ii) it can be resolved through improvements in financial management.

The World Health Organization stressed the need for further research and additional support for countries to address specific health sector challenges, especially in defining budget programmes and aligning effective expenditure management with the budget (WHO, 2018). Budgetary approaches need to be aligned with the financing mechanisms. Financial management in the health sector is essential for promoting the financial sustainability of health systems, since the latter will depend not only on the amount of resources allocated to health but also on their administration and management in the sector.

Diagram 1
Financial management in health



Source: Prepared by the authors, on the basis of Arenas de Mesa, A. and Berner, H. (2010). *Presupuesto por resultados y la consolidación del sistema, evaluación y control de gestión del gobierno central*. Budget Office of the Ministry of Finance of Chile.

V. Final reflections

The world is five years out from the date agreed upon for fulfilling the commitments made in the 2030 Agenda for Sustainable Development, and the countries and regions face multiple challenges in achieving the SDG targets. One of the greatest challenges has been the COVID-19 pandemic, which triggered crises of various kinds that hindered the achievement of SDGs, with Latin America and the Caribbean seeing a 32% setback in progress towards the goals generally, not just in the health domain (ECLAC, 2024a). This has been compounded by structural challenges linked to the development crisis unfolding in the region (Salazar-Xirinachs, 2023; ECLAC, 2024a) and a social risk structure that is undergoing a process of reconfiguration and is making the Latin American population more vulnerable (Robles, 2023; ECLAC, 2024c).

In this context, ECLAC has called on the countries to transform their development model, with one of the essential measures being the expansion of social protection and the welfare state (ECLAC, 2024b). A fundamental element in this dimension consists of health systems which, as noted previously (ECLAC, 2022; ECLAC and PAHO, 2021), have major structural weaknesses, including chronic underfunding, that hinder progress towards universal health. As analysed in this document, although total health expenditure in the region averaged 7.8% of GDP in 2021, public health spending represented just 4.8% of GDP, which is below the 6% recommended by WHO.

According to the analysis presented in this document, a public contribution of at least 6% of GDP is needed to guarantee access to a range of health services, but at least 6.7% of GDP is needed to have an impact on financial protection and keep out-of-pocket expenses below 20% of total health spending. Moreover, the countries of the region need to increase public health expenditure by an average of 1.6% of GDP to make progress in universal health coverage.

Considering the projected scenarios for achieving UHC within 10, 15 and 20 years, the region's countries need to increase their public health spending annually by 0.15%, 0.10% and 0.07% of GDP, respectively. Moreover, the results estimate that achieving the very high SCI level (index above 80 points) requires public health expenditure equivalent to 6% of GDP.

The pace of total health expenditure growth in the region between 2010 and 2021 has slackened since 2015, with growth mostly being financed privately, either through household out-of-pocket spending or private insurance, which is detrimental to the financial protection of households. This trend should be addressed as a priority for the region's countries, since financial protection is a necessary condition for progress towards UHC.

The data analysed in this document show that the countries that have made constant progress towards SDG target 3.8 over time, achieving a very high level of health service coverage and a high degree of financial protection for the population, maintain high levels of public expenditure on health. In other cases, even though some countries have a high level of coverage, the challenge remains of providing greater financial protection to households, which requires additional resources to be allocated to the health sector. Nonetheless, nearly half of the countries analysed still have major shortcomings in terms of coverage and financial protection. This creates a demand for financial sustainability in the region's health systems, and underscores the need to redouble efforts to reduce household out-of-pocket spending in this area.

Between 2000 and 2021, the region made significant progress in terms of the health services coverage index (SCI), which rose from 52.7 to 73.8 points. Since 2015, however, progress has slackened, with the pandemic causing a major setback, especially in the capacity of the health-care system. This will increase demand for financial sustainability in health systems, among other factors, in order to advance towards UHC.

The high level of out-of-pocket spending in several countries exposes families to financial risks, thereby perpetuating inequalities in access to health services. Reforms in countries such as Chile and Uruguay have proven effective in reducing out-of-pocket spending and strengthening financial protection. Nonetheless the region, on average, needs to make public financing more robust. The countries are thus challenged not only to increase resources for the health sector, but also to develop efficient expenditure management mechanisms, to make the region's health systems sustainable.

The analysis of financial protection, such as the percentage of households that spend more than a certain proportion of their budget on health, is based on measurements taken at different points in time, which makes it hard to assess progress accurately. In this context, to manage such expenditure and its consequences, it will be essential to measure household contributions more effectively, for example through household budget surveys and complementary instruments.

To consolidate health systems that achieve the UHC target, in terms of both access to services and financial protection for households, it is essential to enhance financial sustainability to thus increase investment in health, while also improving the efficient management of health expenditure and financial management. To this end, mechanisms and public policies need to be developed that expand the fiscal space for health. This will depend on the fiscal space and fiscal sustainability of the region's countries, among other factors (Arenas de Mesa, 2016); and on managing investments efficiently, promoting economies of scale and developing comprehensive systems that function as interconnected health service networks that are capable of meeting the population's expectations adequately. This must be done within a framework of financial sustainability that underpins the coverage and adequacy of benefits for both current and future generations.

The possibilities available to the countries to make their health systems financially more sustainable will depend on their individual characteristics, the organization of their health systems and the fiscal space available for health. While some countries will be able to maintain their current speed of progress, others will need an additional boost, higher prioritization of health on the public agenda and increased fiscal space for health.

Investing in health means investing in development strategies that foster inclusive and sustainable social development. Accordingly, ensuring the financial sustainability of health systems must be a priority, to thus fulfil the ethical imperative of the right to health for all, leaving no one behind, as well as a strategic action to boost economic growth and inclusive social development and to contribute to environmental sustainability in the region.

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Annex A1

Table A1.1
Latin America and the Caribbean (20 countries): service coverage index,
2000, 2005, 2010, 2015, 2017, 2019 and 2021

Country	2000	2005	2010	2015	2017	2019	2021
Argentina	68	74	76	80	79	78	79
Belize	47	58	64	69	68	69	68
Bolivia (Plurinational State of)	37	39	47	60	64	65	65
Brazil	68	73	76	82	82	81	80
Chile	65	74	77	79	82	82	82
Colombia	52	63	68	78	80	80	80
Costa Rica	66	70	75	77	81	82	81
Ecuador	51	58	68	77	78	79	77
El Salvador	52	65	73	77	78	78	78
Guatemala	40	50	58	60	58	61	59
Guyana	45	59	65	75	77	77	76
Honduras	42	52	58	65	65	66	64
Mexico	56	61	66	74	74	74	75
Nicaragua	47	53	66	71	73	73	70
Panama	62	67	72	75	77	79	78
Paraguay	48	59	68	72	73	74	72
Peru	48	59	70	76	75	75	71
Suriname	45	58	65	71	72	72	63
Uruguay	65	70	78	81	82	83	82
Venezuela (Bolivarian Republic of)	49	60	67	77	75	74	75
Latin America and the Caribbean^a	53	61	68	74	75	75	74

Source: Prepared by the authors, on the basis of data from the World Health Organization.

^a The figures for Latin America and the Caribbean represent the simple average of the selected countries.



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