T20 POLICY BRIEF

G20 BRASIL 2024

T20 Brasil 2024 Let's rethink the world

Task Force 01

FIGHTING INEQUALITIES, POVERTY, AND HUNGER

Healthcare Expenditures: The Balance Between Families and the State

Ana Luíza Matos de Oliveira, Associate Economic Affairs Officer, ECLAC (Mexico)

Arthur Welle, Postdoctoral Researcher, Unicamp (Brazil)

Roberto Carlos Orozco Morales, Statistics Assistant, ECLAC (Mexico)

Luisa Cardoso, Inclusive Development Assistant, UN DESA (United States)

TF01

Abstract

Brazil and Mexico have economies marked by high informality and income disparities, waves of austerity policies from time to time, a rural-urban divide, and a high overall inequality, which also materializes itself into precarious access to healthcare. In this policy brief, we discuss in which sense private expenditures with this service are a burden to the household budget. We analyze the share of household expenditures that is allocated to healthcare, considering income, gender, ethnicity/race, rural/urban areas and the presence of elderly in households and its change over time. Over time, the share of private expenditures on healthcare is increasing, which leads to issues regarding financial constraints, disenfranchised groups, and the demographic transition, as the increase in private expenditures is not neutral regarding income, gender, race/ethnicity, rural/urban settings and the presence of elderly. Although focusing on Brazil and Mexico, we discuss the fine balance between households and the State in a more general manner when it comes to accessing key services. Increasing public expenditures on healthcare has the potential of equalizing conditions and avoiding overburdening the household budget.

Keywords: Public expenditures, social policy, health, equality, gender, social classes, ethnic and racial groups, poverty, Brazil, Mexico.

Diagnosis

Public health spending is positively associated with life expectancy, level of education, and per capita income, and consequently with human development (Miranda-Lescano et al. 2023). Moreover, access to healthcare is a human right according to the Universal Declaration of Human Rights (1948) and the International Covenant on Economic, Social and Cultural Rights (1966). However, the standards of human rights do not require a specific model of health financing: they only require that services be accessible to the entire community under conditions of equality and quality (Iniciativa por los Principios de Derechos Humanos en la Política Fiscal 2023).

Also, health expenditures are closely linked to the achievement of the United Nations Sustainable Development Goals (SDGs), particularly Goal 3 (Good Health and Well-being). Goal 3 seeks to reduce health inequalities within and among countries by addressing disparities in access to healthcare services, health outcomes, and health determinants. Health is a cross-cutting issue that intersects with various other SDGs, including poverty eradication (Goal 1), quality education (Goal 4), gender equality (Goal 5), and decent work (Goal 8). Goal 3 includes Target 3.8, which aims to achieve universal health coverage, including access to quality essential healthcare services and access to safe, effective, quality, and affordable essential medicines and vaccines for all. Target 3.8 also emphasizes the importance of financial risk protection, which involves shielding individuals and families from catastrophic health expenditures and ensuring that healthcare costs do not push them into poverty or exacerbate existing socioeconomic inequalities. However, the estimations of Dieleman et al. (2016) show that many low-income and lower-middle-income countries will not meet internationally set health

spending targets by 2030 and that spending gaps between low-income and high-income countries are not going to be narrower soon.

Health expenditures can have harsh financial consequences and may push households into debt or bankruptcy. The reliance on private expenses for healthcare can have intergenerational impacts, as children and future generations may experience adverse health outcomes and limited opportunities for socio-economic advancement if access to healthcare remains inadequate or unaffordable.

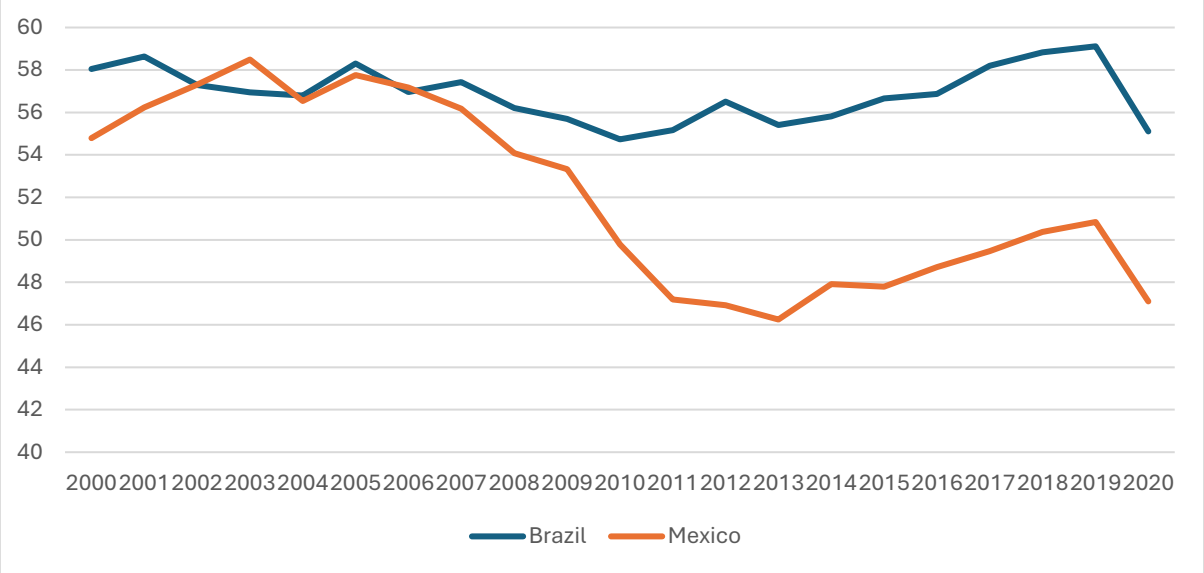
In this sense, the reliance on private expenses for healthcare poses significant social problems. Relative high costs can act as barriers to healthcare access, particularly for preventive and non-urgent services. Individuals may avoid seeking care, "opt-out" of recommended treatments or seek precarious alternatives due to cost concerns (Welle and Matos de Oliveira 2024), leading to undiagnosed or untreated health conditions and increased healthcare costs in the long run.

Furthermore, reliance on private expenses can contribute to inefficiencies within healthcare systems, as it incentivizes providers to prioritize services that yield higher profits rather than those that are most medically necessary. This can lead to overutilization of certain services, inappropriate care practices, and resource misallocation.

There are some indications about how much public spending in healthcare is optimal: around 6% of GDP has traditionally been suggested by the World Health Organization. However, not only the amount spent is important, but also how it is spent (if the public system tends to assist workers in the formal sector and leave aside those in informality or unemployment, for example) and financed (if through progressive or regressive taxes, for example). For the case of Mexico and Brazil, graph 1 shows that from around 2010/2011 until 2019, the share of domestic private health expenditure expanded in both countries:

private sources (including households) were increasing their expenditures at a faster rate than the government (see Graph 2). In 2020, with the COVID-19 pandemic and considerable public disbursements to face this healthcare challenge, the trend changed; however, 2020 seems to be an outlier.

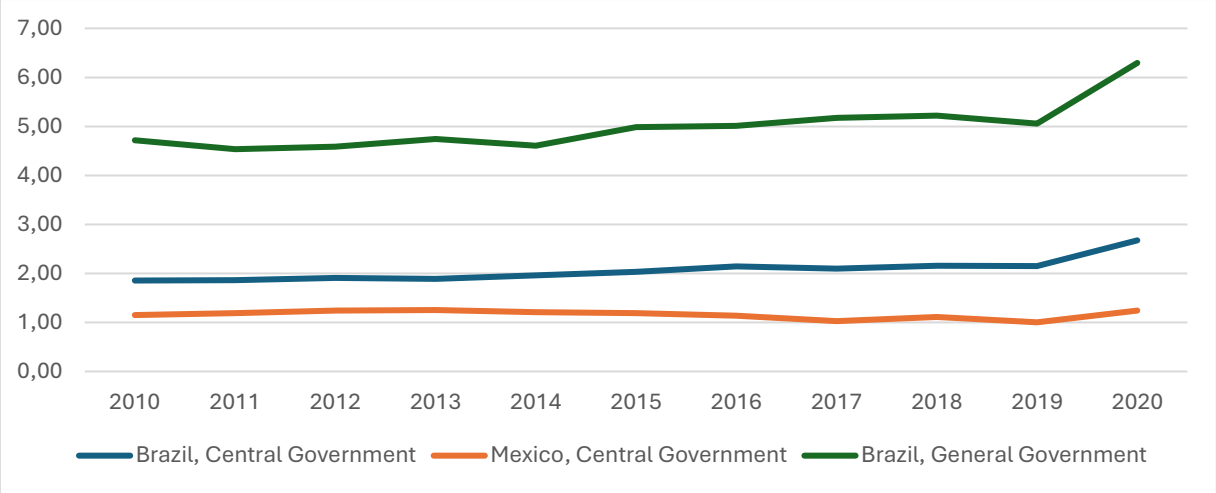
Graph 1 - Domestic private health expenditure (% of current health expenditure) (Brazil and Mexico, 2000 - 2020)



Source: World Bank Data

Note: Share of current health expenditures funded from domestic private sources (funds from households, corporations, and non-profit organizations). Expenditures can be either prepaid to health insurance or paid directly to healthcare providers.

Graph 2 - Public Healthcare Expenditures, as a percentage of GDP (Mexico and Brazil) (2000-2020)



Source: CEPALSTAT

The G20 can act as a platform for coordinating efforts to address shared health challenges and mobilize resources to support global health priorities. Moreover, health expenditures can enable countries to contribute to global health initiatives, partnerships, and funding mechanisms. Addressing high private healthcare expenses requires comprehensive policy interventions aimed at expanding health coverage, reducing financial barriers to care, improving healthcare affordability, and promoting equitable access to quality healthcare services for all.

Addressing health inequalities is also part of broader efforts to achieve inclusive growth and reduce disparities within and between countries. Health expenditures are essential for promoting social inclusion and ensuring access to quality healthcare services for all, regardless of socio-economic characteristics. In this policy brief, we analyze which groups (regarding income, gender, race and ethnicity, urban and rural settings and the

presence of elderly) are more affected by the increase in private healthcare expenditures, only interrupted by the pandemic, when unforeseen public expenditures were made.

Recommendations

Mexico and Brazil have public healthcare systems, and their coverage is reflected in the percentage spent on public healthcare, as seen in Graph 2. Mexico´s public sector includes: i) institutions which provide services to formal workers.[1] Its financing comes from three sources: government contributions, employer contributions[2], and employee contributions; ii) institutions that provide services to those without social security[3]. The private healthcare sector is financed by payments that users make when receiving care and with private health insurance premiums and offers services in private offices, clinics, and hospitals. In 2022, according to ENSANUT (2022), 48,8% of the need for healthcare assistance received care in the private sector, and 51,2% in the public sector (Shamah-

[1] Such as *Instituto Mexicano del Seguro Social* (IMSS), *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado* (ISSSTE), *Petróleos Mexicanos* (PEMEX), *Secretaría de la Defensa Nacional* (SEDENA), *Secretaría de Marina* (SEMAR) and others.

[2] Which in the case of ISSSTE, PEMEX, SEDENA and SEMAR is the same government.

[3] Such as *Seguro Popular de Salud* (SPS), *Secretaría de Salud* (SSa), *Servicios Estatales de Salud* (SESA) and *IMSS-Oportunidades* (IMSS-O). SPS, SSa and SESA are financed with resources from the federal government and state governments, in addition to contributions from users (Gómez-Dántes et al 2011).

Levy, 2023). Regarding Brazil, a Unified Health Care System (*Sistema Único de Saúde - SUS*) was established in 1988. The system is decentralized between the federal union, the 26 states, the Federal District, and the municipalities. This public system is not connected to employment or social security status. However, Brazil's private healthcare system covers 51.1 million Brazilians (25.1% of the total population) (ANS 2023)[4].

Now looking at private household expenditures, Brazil's *Pesquisa de Orçamentos Familiares* and Mexico's Encuesta *Nacional de Ingresos y Gastos de los Hogares* highlight how different characteristics of households lead to different patterns in healthcare expenditure. Here we outline three policy recommendations.

I) EQUITABLE DISTRIBUTION OF HEALTHCARE RESOURCES TO ENSURE EVERYONE HAS THE POSSIBILITY OF ADDRESSING HEALTHCARE NEEDS WITHOUT FINANCIAL CONSTRAINTS

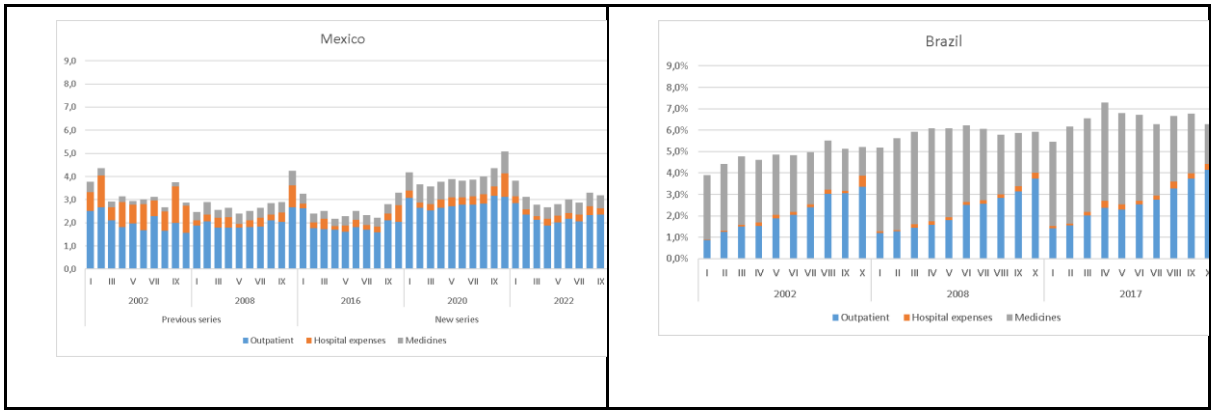
Spending a high proportion of income on healthcare represents a significant financial risk that can jeopardize individuals' financial stability, access to care, and overall well-being.

Addressing the underlying drivers of high healthcare costs and improving its affordability and accessibility mitigate financial risks, promote health equity and financial security.

[4] Users of private healthcare are also users of the Unified Health Care System, as it provides health monitoring, medication, vaccines, and high-complexity procedures such as transplants, for example, including for those covered by private health insurance.

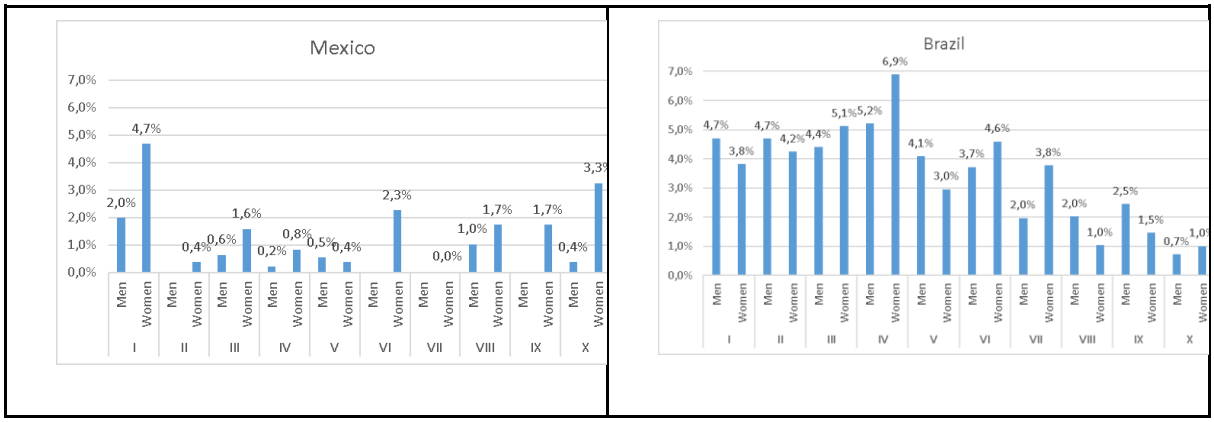
Graph 3 addresses how the first and last deciles in Mexico spend a higher proportion of household income on healthcare. For Brazil, over time, the amount spent on healthcare has increased more for those in the first deciles (see Graph 4). For Mexico, Graph 4 also showcases a higher increase for those in the first decile, especially when women are the head of the household.

Graph 3 - Private household healthcare expenditures, income decile, and type of expenditures (Mexico and Brazil)



Source: Brazil´s *Pesquisa de Orçamentos Familiares* and Mexico's Encuesta *Nacional de Ingresos y Gastos de los Hogares*.

Graph 4 - Mean real annual growth rate of health spending, by income decile and sex of head of household (Mexico, 2018-2020; Brazil, 2002-2017)



Source: Brazil´s *Pesquisa de Orçamentos Familiares* and Mexico's Encuesta *Nacional de Ingresos y Gastos de los Hogares*.

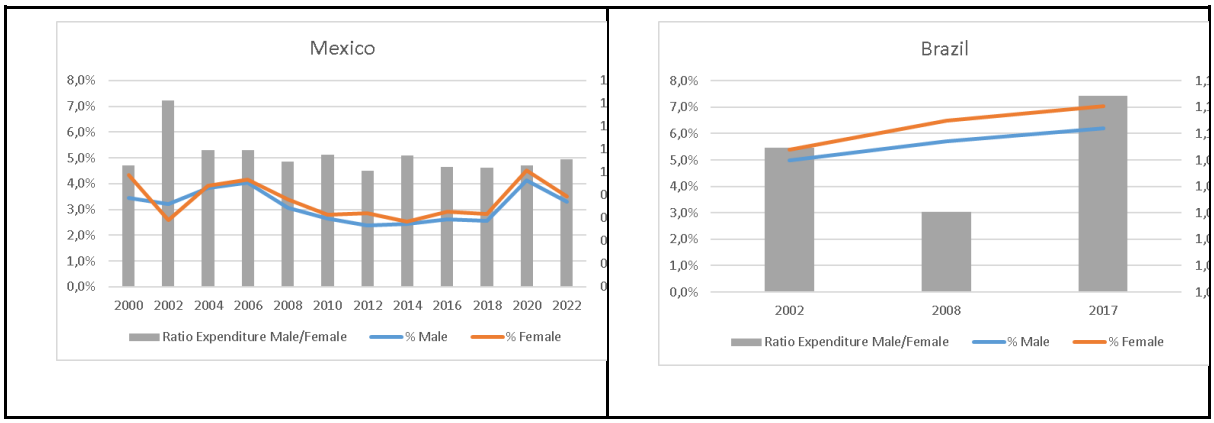
The first deciles in both countries allocate more resources to healthcare, which is a sign of alertness. The increase in expenditures could be due to a higher income or a perceived need to increase spending (and thus compromise the household budget) to access healthcare. In any case, increasing public investment in this area has the potential to increase imputed income, especially for the lower deciles.

II) REDUCTION OF HEALTH DISPARITIES BY PRIORITIZING INVESTMENTS IN HEALTHCARE INFRASTRUCTURE AND SERVICES FOR THOSE DISENFRANCHISED

Beyond income inequalities, disenfranchised groups, including low-income women, racial and ethnic vulnerable groups and rural communities, often face significant barriers to accessing quality healthcare.

Graph 5 highlights how, for both countries, women-led households usually allocate more resources to healthcare, even though the amount spent by men-led households is higher, due to a higher income.

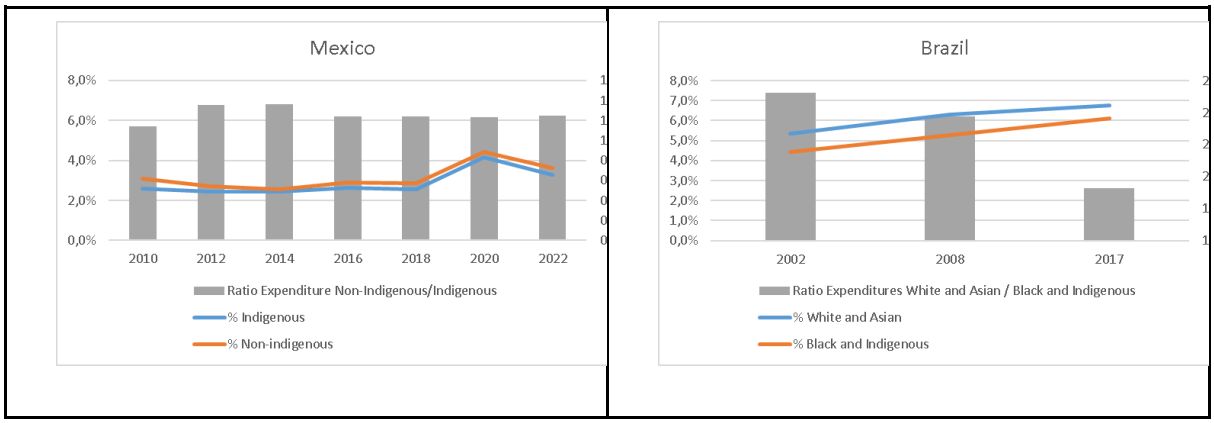
Graph 5 - Private household healthcare expenditures per gender of head of household (Mexico and Brazil)



Source: Brazil´s *Pesquisa de Orçamentos Familiares* and Mexico's Encuesta *Nacional de Ingresos y Gastos de los Hogares*.

Regarding race and ethnicity[5], in Mexico, Graph 6 shows that households led by Indigenous allocate fewer resources to healthcare in percentage, and, as their average income is lower than that of non-Indigenous-led households, non-Indigenous led households usually spend 1,25 times the amount allocated for healthcare in comparison to Indigenous-led households. In Brazil, White and Asian-led households spend consistently more on healthcare than those led by Black and Indigenous (in percentage), and also, the absolute amount they spend is consistently higher over time.

Graph 6 - Private household healthcare expenditures, per race/ethnicity of head of household (Mexico and Brazil)

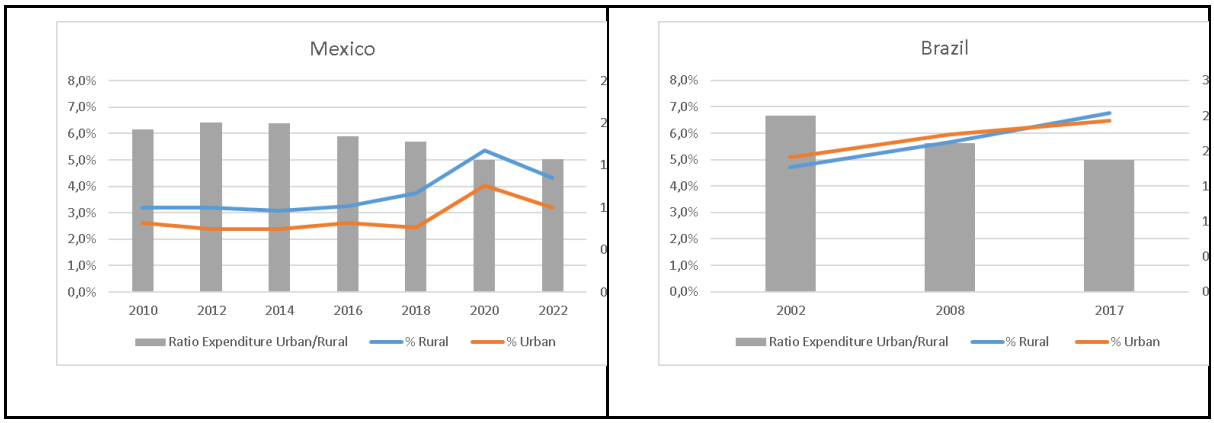


Source: Brazil´s *Pesquisa de Orçamentos Familiares* and Mexico's Encuesta *Nacional de Ingresos y Gastos de los Hogares*.

[5] Categories were chosen to reflect social and historical inequalities regarding race and ethnicity in both countries and according to the availability of data. For example, it was not possible to describe the situation of Black Mexicans, as the data did not allow for it.

The distinction between healthcare expenditures in urban and rural settings is particularly interesting because, as they are geographically separated areas, the consumption basket is also somewhat different. Graph 7 highlights how, for Mexico, households in rural areas consistently spend a higher percentage of their budget on healthcare, even though households in urban areas spend more in absolute terms. For Brazil, in 2002 and 2008, the percentage of the household budget allocated to healthcare in urban households was larger; however, in 2017, rural households´ was larger. As in the Mexican case, households in urban areas spend more in absolute terms.

Graph 7 - Private household healthcare expenditures, rural/urban area (Mexico and Brazil)



Source: Brazil´s *Pesquisa de Orçamentos Familiares* and Mexico's Encuesta *Nacional de Ingresos y Gastos de los Hogares*.

By targeting resources to disenfranchised groups, public healthcare investments can help build a more inclusive healthcare system. Also, diminishing the income gap between groups could increase the amount of resources they allocate to healthcare: graph 5, 6, and

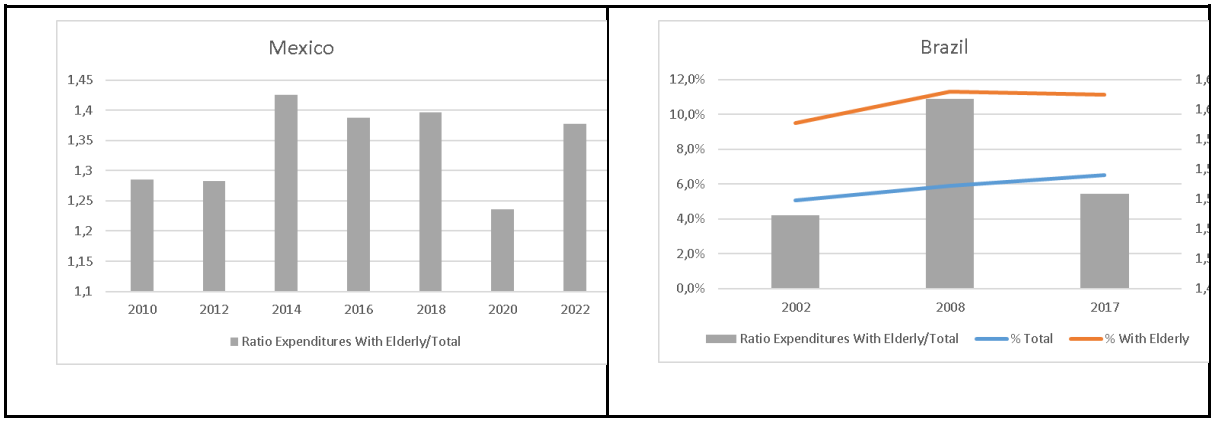
7 show that women, Indigenous (in the case of Mexico and Brazil), Black (in the case of Brazil) and rural households spend consistently less on healthcare in absolute terms, while the difference is not so large regarding other groups when it comes to the percentage of budget allocated to healthcare. If these groups were to maintain the percentage of household budget allocated to healthcare should their income increase, their healthcare expenditures would also expand in absolute terms.

III) DEVELOPMENT OF COMPREHENSIVE LONG-TERM CARE SERVICES TAILORED TO THE NEEDS OF OLDER ADULTS, INCLUDING PREVENTIVE CARE, GERIATRIC HEALTHCARE, REHABILITATION SERVICES, AND PALLIATIVE CARE

Many countries are experiencing demographic shifts characterized by an aging population. Health public policies aimed at the elderly are essential for addressing the unique healthcare needs and challenges associated with aging.

Graph 8 highlights how, for both countries, households where elderly are present spend consistently more in absolute terms regarding the average expenditure of all households. In Brazil, households where elderly are present also consistently spend more on healthcare than the average household.

Graph 8 - Private household healthcare expenditures and presence of elderly in the household area (Mexico and Brazil)



Source: Brazil´s *Pesquisa de Orçamentos Familiares* and Mexico's Encuesta *Nacional de Ingresos y Gastos de los Hogares*.

Note: Elderly is defined as over 65 years old.

Population ageing is more than just a collection of individual issues affecting a specific demographic group. It affects every aspect of societies and economies, and each phase of life has the potential to either enhance or diminish well-being in later years (UN DESA, 2023). Therefore, promoting healthy aging and enhancing the quality of life of the elderly is crucial for supporting aging populations and their families.

The provision of long-term care services tailored to the needs of older adults ensures age-appropriate medical interventions and support to maintain their health and well-being. That eases the difficulties caretakers face and helps to reduce healthcare costs associated with avoidable hospitalizations and complications. By prioritizing their healthcare needs and ensuring access to high-quality care and support, the State can alleviate the financial difficulties of households.

Outcomes

As technology evolves, treatments become more complex and the population ages, it is ever more important to increase public healthcare expenditures, to avoid overburdening households. The case of Mexico and Brazil highlights that the share of private expenditures on healthcare is increasing (and especially that of the household) and that this increase is not neutral regarding income, gender, race/ethnicity, rural/urban settings and the presence of elderly.

When countries promote equitable distribution of healthcare resources and the reduction of gaps, there is improved access to healthcare services for all, regardless of income level, race, ethnicity, or location. This scenario makes it easier to prevent diseases and manage chronic ones in specific groups. Public policies aimed at the elderly, for instance, play a crucial role in promoting the health, well-being, and quality of life of older adults while also addressing the broader social, economic, and demographic challenges associated with an aging population. Moreover, equitable distribution of healthcare resources contributes to social cohesion and solidarity. This fosters a sense of fairness that relates to the broader goal of promoting global health equity, which is central to achieving the SDGs.

It is ever more important to view economic (especially fiscal) policy from the standpoint of human rights: increasing public expenditures on healthcare can equalize conditions and avoid overburdening the household budget with healthcare costs. G20 countries can influence global health agendas, mobilize resources, and coordinate efforts to address health challenges on a global scale. By prioritizing the recommendations discussed in this policy brief, such as recognizing the need for the State to act as an

equalizer when it comes to accessing healthcare, the G20 can contribute to reducing health disparities both domestically and globally.

References

ANS. “Dados e Indicadores do Setor”. Accessed March 26th 2024. https://www.gov.br/ans/pt-br/acesso-a-informacao/perfil-do-setor/dados-e-indicadores-do-setor.

Dieleman, Joseph L., Tara Templin, Nafis Sadat, Patrick Reidy, Abigail Chapin, Kyle Foreman, Annie Haakenstad, Tim Evans, Christopher J L Murray and Christoph Kurowski. 2016. "National spending on health by source for 184 countries between 2013 and 2040." *The Lancet* 387, no. 10037 (2016): 2521-2535.

Gómez-Dantés, Octavio, Sergio Sesma, Victor M. Becerril, Felicia M. Knaul, Héctor Arreola, Julio Frenk. 2011. “Sistema de salud en Mexico”. Salud Pública de México, Vol 53., Supl. 2.

Iniciativa por los Principios de Derechos Humanos en la Política Fiscal. 2023. “Principios de derechos humanos en la política fiscal y derecho a la salud”. Accessed March 28th 2024.https://www.derechosypoliticafiscal.org/es/recursos/documentos-complementarios-y-fuentes/176-principios-de-derechos-humanos-en-la-pol%C3%ADtica-fiscal-y-derecho-a-la-salud-1.html

Miranda-Lescano, Ronald, Leonel Muinelo-Gallo and Oriol Roca-Sagalés. 2023. "Human Development and Decentralization: The Importance of Public Health Expenditure." *Annals of Public and Cooperative Economics* 94, no. 1 (2023): 191-219.

Shamah-Levy, Teresa. 2023. Resultados de la Encuesta Nacional de Salud y Nutrición - ENSANUT Continua, 2022. Accessed March 26th 2024. http://www.pued.unam.mx/export/sites/default/archivos/SUCS/2023/TSL2308.pdf

UN DESA. World Social Report 2023: Leaving no one behind in an aging world. Accessed March 27th 2024. Available at:

https://desapublications.un.org/publications/world-social-report-2023-leaving-no-one-behind-ageing-world

Welle, Arthur and Ana Luíza Matos de Oliveira. 2024. “The shrinking State: exploring the links between public spending and class, race and gender vulnerability in Brazil”. Revista CEPAL. Forthcoming.

World Bank. “Domestic private health expenditure (% of current health expenditure).” Accessed March 26th 2024. https://data.worldbank.org/indicator/SH.XPD.PVTD.CH.ZS?locations=BR.

G20 BRASIL 2024
BUILDING A JUST WORLD AND A SUSTAINABLE PLANET

T20 Brasil 2024
Let's rethink the world

Let's rethink the world

CEBRI
Rethink Tank

FUNDAÇÃO ALEXANDRE DE GUSMÃO

ipea
Instituto de Pesquisa Econômica Aplicada