As reported in the previous section on private and external expenditure, high levels of out-of-pocket (OOP) spending in the region present a challenge not only for governments looking to improve access but also to individuals, household and communities. High OOP means that the population is directly financing a substantial part of care when they need it, which in turn can push them into poverty or financial hardship. The global incidence of catastrophic spending at 10% or more of OOP relative to household income or consumption has been estimated at 9.7% in 2000, 11.4% in 2005, and 11.7% in 2010. This means that globally 808 million people in 2010 incurred catastrophic health spending (Flores et al., 2018[2]). In addition, high OOP can have very negative consequences for the financial and social wellbeing of households, in some cases leading them into poverty. It has been estimated that at the USD 1.90 per day poverty line, the worldwide incidence of impoverishment decreased between 2000 and 2010, from 131 million people (2.1% of the world's population) to 97 million people (1.4%) (Wagstaff et al., 2018[3]).

Figure 6.11 shows the proportion of households spending over 10% of income or consumption (depending on the proxy chosen to estimate wealth) on OOP health care expenditures in 16 LAC countries. This excludes private pre-paid payments. On average, almost 8% of the population spends more than 10% of their household consumption or income. The proportion is low in a number of countries such as El Salvador, Mexico and Guatemala (under 2%), but it is almost 17% in Barbados followed by Nicaragua and Chile around 15%. In addition, most countries have a low proportion of households spending over 25% of their income or consumption on OOP, but Haiti is much higher than the rest with 4% of the population spending a quarter of their household income in OOP for health care.

As high OOP expenditure on health can take people into financial ruin, Figure 6.12 shows the proportion of households that have been pushed below the poverty line. In 15 LAC countries, 1.7% of the population was pushed by OOP health care expenditure below the societal poverty line compared with the 1.2% in OECD countries. Consistent with the high proportion of households making OOP payments over 10% and 25% of the income or consumption, over 5% of Nicaraguan households have been driven below the poverty line, followed by Haiti (3.3%), Chile (2.6%) and Ecuador (2.4%). On the other hand, the proportion is lower in several countries such as Bahamas, Honduras or El Salvador where less than 0.5% of the population falls into poverty because of OOP health care expenditures.

To ensure adequate access and coverage for all groups, governments must implement efforts to protect households against excessive OOP expenditures that can drive people into poverty. Some common aspects of successful reforms include pooled or coordinated use of different revenue sources; progressively increasing the size of compulsory prepaid funds; redistribution of money form prepaid funds; and new organisations and institutional arrangements to support and enable change (WHO, 2018[4]).

As discussed in Chapter 2, wasteful spending in LAC health systems is taking resources that could be spent in more and better health care. For instance, fragmentation of LAC health systems is not only a relevant source of waste but also contributes to create barriers for expanding access and financial protection, and therefore improving health outcomes. Fragmentation limits the pooling of funds and the existence of more effective insurance mechanisms, components that lead to better access to necessary care and improved population health, with the largest gains accruing to poorer people (Moreno-Serra and Smith, 2012[5]).

Definition and comparability

Data on financial protection indicators was taken from the World Bank Health Equity and Financial Protection dataset. The dataset has grown over time from the first dataset published in 2000 which pulled data from 42 surveys and one type of survey, covered just 42 countries, and included just 34 indicators, which all concerned maternal and child health. In 2013, for the first time, the database included household out-of-pocket health expenditures, noncommunicable disease indicators (NCD), and data from high-income countries. The 2018 database follows this trend by employing over 1 600 surveys, covering 183 countries, and encompassing multiple years of data, richer NCD data, and more extensive data on household out-of-pocket expenditures.

The poverty line is defined here as the higher of the USD 1.90 (USD 2011 PPP) poverty line and a 50% of median consumption poverty line (%).

References

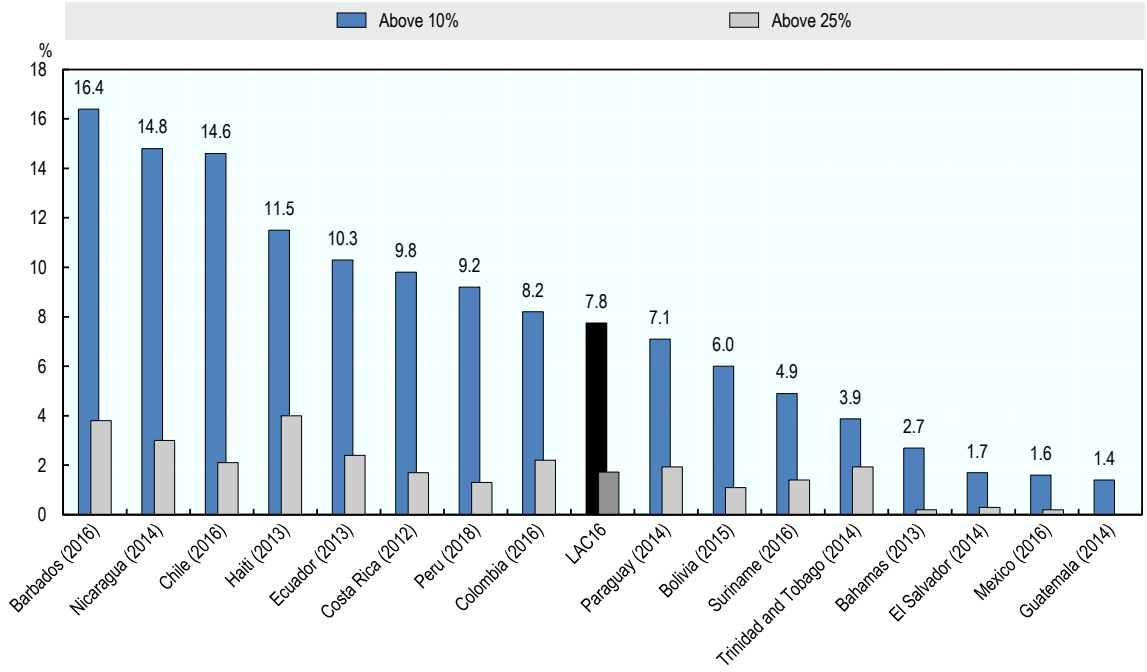
[2] Flores, G. et al. (2018), "Progress on catastrophic health spending in 133 countries: a retrospective observational study", *Articles Lancet Glob Health*, Vol. 6, pp. 169-79, *http://dx.doi.org/10.1016/S2214-109X(17)30429-1*.

[5] Moreno-Serra, R. and P. Smith (2012), *Does progress towards universal health coverage improve population health?*, Lancet Publishing Group, *http://dx.doi.org/10.1016/S0140-6736(12)61039-3*.

[3] Wagstaff, A. et al. (2018), "Progress on impoverishing health spending in 122 countries: a retrospective observational study", *The Lancet Global Health*, Vol. 6, pp. e180-e192, *http://dx.doi.org/10.1016/S2214-109X(17)30486-2*.

[4] WHO (2018), *Health financing*, World Health Organization, *https://www.who.int/health-topics/health-financing*.

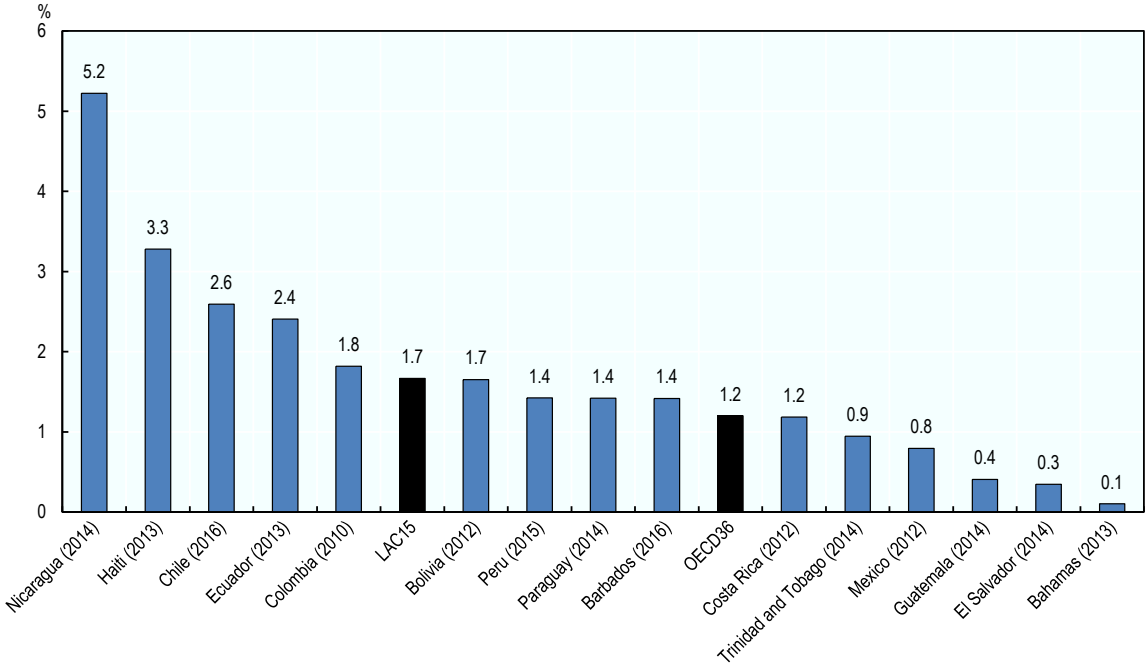
Figure 6.11. **Proportion of population spending more than 25% and 10% of household consumption or income through out-of-pocket health care expenditure**



Note: Countries with data older than 2010 were excluded.
Source: World Bank Health Equity and Financial Protection 2020.

StatLink https://stat.link/48ae7c

Figure 6.12. **Proportion of population pushed by out-of-pocket health care expenditure below the societal poverty line**



Note: Countries with data older than 2010 were excluded.
Source: World Bank Health Equity and Financial Protection 2019.

StatLink https://stat.link/e9y2ix