NO LESS THAN 5!

ALAMES Ecuador

The Covid-19 pandemic exposed the structural weaknesses of health systems in Ecuador and most Latin American countries. Decades of consolidation of the private health sector made a joint and effective response to the worst health threat in our history impossible.

The progressive dismantling of public, state and community health systems in favour of the market has elements in common throughout the region. In some cases, services were directly privatized; in others, the State and social security were used as levers to transfer resources to private companies, through the scheme of outsourcing[1]. The truth is that, after four decades of applying neoliberal policies, alternating with populist and progressive nuances, the private health sector has a decisive weight in the definition and/or application of public policies.

The high out-of-pocket spending of the population is one of the most harmful consequences of this process and one of the causes for increasing social inequalities. By 2016, average out-of-pocket spending in Latin America and the Caribbean was 39.5%, three times the average spending of the populations of rich countries (13.8%)[2]. If we take into account that this spending is equivalent, on average, to 80% of all private spending, the population is assuming a disproportionate burden on its family economy.

Out-of-Pocket Health Care Spending in Latin America as a percentage of total health expenditure, 2016

Country	Expenditure of pocket
Argentina	14,8
Bolivia	28,1
Brazil	43,9
Chile	34,7
Colombia	20,6
Costa Rica	22,1
Cuba	9,3
Ecuador	41,4
El Salvador	27,6
Guatemala	54,8
Honduras	47,3
Mexico	40,0
Nicaragua	32,7
Panama	28,6

[1] Dávalos, 2016; Iturralde, 2014; Iturralde, 2015.
[2] Chang, Cowling, Micah et al., 2019.

Peru	29,1
Paraguay	37,0
Dominican Republic	44,1
Uruguay	17,2
Venezuela	33,8

This distortion has additional facets. For example, the inverse relationship between per capita GDP and private health expenditure,[3]which accentuates social inequalities: the poorer the population, the more it has to spend on health from its meagre income. From a capitalist logic, the scarcity of state resources translates into a decrease in budgets for the social area. The health sector is usually the most affected

Latin America faces a chronic deficit in health spending. Most countries have public spending that does not exceed 50% of total health spending. This means that private spending remains an excessive burden on society.

Public expenditure on health is composed of the general state budget (or the central government, depending on the lexicon used in each country) and social security. This relationship varies greatly, depending on the systems in each country. However, given the progressive crisis in the social security systems, caused by several factors (ageing population, change in the structure of work, growth of labour informality, reduction in the mass of affiliates, privatization of social security as in Chile or Colombia), the general State budget is becoming the most important pillar of public expenditure.

The table below shows this constant, with the exception of Cuba and Costa Rica, which have universal and unified health systems. In the case of Argentina, because of its decentralized financing scheme, State spending is divided between the central government budget (0.9%) and the provincial governments (1.8%). The other countries base public spending on a significant contribution from the central government budget. In the case of Chile, for example, this represents 86% of total public spending, as a result of the dismantling and privatization of the social security system operated in recent decades.

In Latin America, average health spending by central governments in 17 countries of the region has reached 2.2% of GDP as of 2015, and has remained stable until 2018. In the case of five Caribbean countries (Bahamas, Trinidad and Tobago, Guyana, Barbados and Jamaica), this average reached 3.3% of GDP in 2018 (this information is not included in the overall analysis because it generates too many statistical deviations).

Public and government expenditure on health in Latin America

[3] ILO/PAHO, 1999.

Country	central government expenditure/GDP*	Year	% public expenditure /GDP**	Year
Argentina	2,7	2016	6,61	2017
Bolivia	1,9	2016	4,42	2017
Brazil	2,0	2016	3,96	2017
Chile	4,5	2018	5,20	2018
Colombia	2,8	2017	5,31	2017
Costa Rica	0,8	2016	5,39	2017
Cuba	n/i	2016	10,47	2017
Ecuador	2,5	2016	4,36	2017
El Salvador	2,5	2016	4,61	2017
Guatemala	1,1	2016	2,08	2017
Honduras	2,8	2016	3,15	2017
Mexico	1,1	2018	2,81	2018
Nicaragua	3,4	2016	5,02	2017
Panama	1,7	2016	4,39	2017
Peru	n/i	2016	3,16	2017
Paraguay	1,9	2016	3,03	2017
Dominican Republic	1,7	2016	2,82	2017
Uruguay	3,4	2016	6,58	2017
Venezuela	n/i	2016	0,19	2017

Sources: * ECLAC, based on official country information.
** datosmacro.com

In Ecuador, the weight of the private sector remains enormous. For the period 2015-2016, the structure of income measured by the accrued budget of the MOH, by assets of the IESS health fund and by the sale of the entire private sector reflects a serious imbalance from the perspective of universal access. The MOH budget reached US$ 2.492 billion, the IESS health fund US$ 4.404 billion, and private revenues reached US$ 6.524 billion[4]. The ratio was 51.39% for the public sector and 48.61% for the private sector. If we see that in European countries this ratio ranges between 80-20% and even 90-10%, we can conclude that a profound injustice persists in our country.

The situation is even more serious when we analyse coverage: the MSP served 9 million people, the IESS 4.5 million and the private sector 1 million. In other words, the State's per capita expenditure was 276 dollars, the IESS was 979 dollars and the private sector was approximately 6,524 dollars, which shows absolute social inequality: there is health for wealthy sectors that can pay for it, health for middle sectors protected by social security and health for poor people who must share the scarce resources of the State. If one takes into account that the private health sector is governed by a strictly profit-making and monopolistic logic, one concludes that a good portion of the national wealth goes into the coffers of large companies, economic groups and multinational corporations that offer services of all kinds. The case of private insurance companies, which cover both patients and professionals threatened by the law of medical malpractice, is paradigmatic[5].

[4] Give them up, 2016.
[5] Give them up, 2016.

Under these conditions, the State budget for financing health becomes fundamental - but not sufficient - to close this gap.

Although the Constitution states that the State budget for the health sector should be equivalent to no less than 4% of GDP, this figure does not exceed 2.8% by 2020[6]. This figure represents the approximate average of recent years, despite the enormous availability of resources during the second oil boom (2002-2014). Total public spending is close to 4.5% of GDP, still far from the 6% recommended by the WHO. These financial limitations explain, in part, the failure of the National Health System to deal with the Covid-19 pandemic.

The impact of the health crisis has brought back to the fore the importance of strong state, public and community systems. During the pandemic, private health care services maintained a cost structure that made them inaccessible to the majority of the Ecuadorian population. Moreover, they did not even undergo a unified plan led by the authorities, as is appropriate during a health disaster.

The possibility of similar situations in the future cannot be ruled out, and the cost in human lives resulting from the inability and ineffectiveness of the health system is unacceptable. Strengthening health systems based on solidarity and universality is the only option for ensuring optimal health conditions for the population, not only in the face of certain eventualities, but also as a guarantee of the permanent right to decent living conditions. In addition, it is the best strategy for limiting and reducing the private health business by expanding public coverage with quality services.

But increasing the state budget does not solve the problem alone, because optimizing state funding depends on the quality of spending. In this sense, it is essential to apply a model that prioritizes primary care, intercultural health and community and neighbourhood organization around a collective health agenda. Increased public spending should be prioritized according to the epidemiological profile of the country's different territories and regions and the specific needs of the population. The budget that is best invested is that which prevents disease.

That is why it is incoherent that, in the areas of the Amazon where mining and oil extraction are being promoted, state investment in health is being applauded with a budget obtained from the destruction of nature and the life of the communities. The increase in the state budget cannot be made on the basis of an extractive industry that classifies some communities and some human beings as disposable.

On the other hand, an institutional redesign is required to optimize the State budget. Bureaucratic clientelism and corruption in the MSP prevent an efficient use of resources and increase their waste. However, this risk should not be a pretext for restricting budget increases.

As ALAMES Ecuador, we consider that the 4% established in the Constitution is still insufficient to recover and strengthen the public health sector in Ecuador. The pandemic brought to the fore the urgent need to have a system capable of responding not only to an emergency, but also to the country's strategic requirements. The universal right to health, as part of social protection, is a prerequisite for achieving Sumak Kawsay. In that regard, we propose that the State budget for the health sector cannot be less than 5 per cent of GDP.

References

[6] The twenty-second transitional provision of the 2008 Constitution, according to which the health budget was to be increased each year by no less than 0.5 per cent of GDP to 4 per cent, was never fulfilled.

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