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Health Systems Characteristics: A Survey of 21 Latin American and Caribbean Countries

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Abstract

In 2018, the Inter-American Development Bank and the OECD launched a survey to collect information on key health systems characteristics in Latin American and Caribbean (LAC) countries. This paper presents the information provided by 21 of these countries. It describes country-specific arrangements to organise the population coverage against health risks and the financing of health spending. It depicts the organisation of health care delivery, focusing on the public/private mix of health care provision, provider payment schemes, user choice and competition among providers, as well as the regulation of health care supply and prices. Finally, this document provides information on governance and resource allocation in health systems (decentralisation in decision-making, nature of budget constraints and priority setting).

The main findings of this survey are the following:

- Where most OECD health systems provide basic primary health care coverage to the entire population, there is more variation in the range and level of coverage across LAC countries. About half of the responding LAC countries already provide or are making considerable movements towards providing residence-based coverage to their population, with the remainder countries providing a set of different insurance coverage schemes. Private health insurance plays an important role when it comes to secondary coverage.
- Primary care is predominantly delivered in public clinics, which is similar to what is reported for the majority of OECD countries. By contrast to OECD, a large part of LAC countries reports that there is no need for people to register with a primary care physician.
- In contrast to OECD countries, activity-based hospital payments are used only in a few countries and there is a limited use of financial incentives to providers linked to quality of care delivered.
- Health Technology Assessment (HTA) is carried out in half of the responding countries, and its scope and coverage varies significantly across countries. Only a few LAC countries use HTA systematically to make coverage decisions and no country reported to use HTA to determine reimbursement level.

Résumé

En 2018, la Banque interaméricaine de développement et l'OCDE ont lancé une enquête pour recueillir des informations sur les principales caractéristiques des systèmes de santé dans les pays d'Amérique Latine et des Caraïbes. Cette publication présente les informations fournies par 21 de ces pays. Elle détaille les dispositifs des pays pour organiser la couverture de la population contre les risques de santé et le financement des dépenses de santé. Cette publication décrit l'organisation des prestations de soins de santé, en mettant l'accent sur le mixte public / privé des prestations de soins de santé, les systèmes de paiement des prestataires, le choix des utilisateurs et la concurrence entre prestataires, ainsi que sur la réglementation de l'offre et des prix des soins de santé. Enfin, ce document fournit des informations sur la gouvernance et l'allocation des ressources des systèmes de santé (décentralisation de la prise de décision, nature des contraintes budgétaires et établissement des priorités).

Les principales conclusions de cette enquête sont les suivantes:

- Là où la plupart des systèmes de santé des pays de l'OCDE fournissent une couverture de base à l'ensemble de la population, la gamme et le niveau de couverture varient davantage d'un pays à l'autre. Environ la moitié des pays d'Amérique latine et des Caraïbes qui ont répondu fournissent déjà ou sont en train de s'orienter considérablement vers une couverture basée sur le lieu de résidence de leur population, les autres pays fournissant un ensemble de régimes de couverture différents. L'assurance maladie privée joue un rôle important dans la couverture secondaire.
- Les soins primaires sont principalement dispensés dans des cliniques publiques, ce qui est similaire à ce qui est rapporté pour la majorité des pays de l'OCDE. Contrairement à l'OCDE, une grande partie des pays d'Amérique latine et des Caraïbes signalent que les personnes n'ont pas besoin de s'inscrire auprès d'un médecin généraliste.
- Contrairement aux pays de l'OCDE, les paiements d'hospitalisation basés sur l'activité ne sont utilisés que dans quelques pays et les incitations financières accordées aux prestataires liées à la qualité des soins, sont limitées.
- Une évaluation des technologies de la santé (*Health Technology Assessment*, HTA) est réalisée dans la moitié des pays ayant répondu, et sa portée et sa couverture varient considérablement d'un pays à l'autre. Seuls quelques pays d'Amérique latine et des Caraïbes utilisent systématiquement l'HTA pour prendre des décisions en matière de couverture et aucun pays n'a signalé avoir fait recours à l'HTA pour déterminer le niveau de remboursement.

Table of contents

Tables

Figures

1. Why a health systems characteristics survey for Latin American and Caribbean countries?

1. Most Latin American and Caribbean (LAC) countries consider health as a fundamental human right and entitlement, but they use different approaches to health system organisation, governance and service delivery aiming to fulfil such rights (Atun *et al.* 2014). Particularly, health financing systems vary greatly in Latin America and the Caribbean. While some countries rely more on a public system funded through government revenues, others depend on social or mandatory health insurance schemes with private or public administrators. Voluntary private insurers have a strong presence in the region, but the population covered through this system is very small and generally has high-income levels.

2. Fragmentation is one of the key characteristics of health systems in LAC countries, both in terms of financing and in terms of service delivery (Bosssert *et al.* 2014). Most LAC countries have at least two and up to four health financing schemes, which creates challenges to coordinate, monitor and enhance efficiency in health systems. The population covered by each of these schemes and the package of goods and services covered differ from country to country, and is usually not as comprehensive as in the majority of OECD member countries (OECD 2016a).

3. A key concern in many LAC countries is that as they reach the middle-income development stage, with substantial progress in the maternal and child health and infectious diseases agendas, they face new challenges associated with growing burden of chronic diseases, providing care for an ageing population, and meeting increased citizen's expectations. Moreover, as citizens increasingly begin to demand new and better health care services, new and expensive technologies are presented to the market at a rapid pace, adding pressure onto already constrained budgets. In the context of low economic growth, there is little room for increasing health spending to meet these challenges and demands; instead, governments need to do more with the same resources (Izquierdo *et al.* 2018). Thus, the increase of value for money in health care becomes a priority to promote the financial sustainability of health systems, in particular as countries move further along the demographic transition and face challenges of gradually rising dependency ratios and shrinking tax base (Dmytraczenko and Almeida 2015). In this context, overcoming fragmentation and improving coordination is a key challenge to increase health expenditure efficiency and achieving more equitable health systems in the LAC region.

4. The incentive structures produced by different institutional arrangements are important determinants of the performance of health care systems and can help understanding variations in cross-country performance patterns (Oxley and MacFarlan, 1994; Dormont *et al.* 2006; Chernew and May 2011). Thus, health system characteristics are suitable for assessing the effect of health policy and institutions on increasing value for money in health care (OECD 2009; OECD 2010).

5. The OECD survey on Health Systems Characteristics (HSC) aims to collect key policy and institutional characteristics by which heath care systems can be meaningfully differentiated from one another in the approach taken to finance health care, organise health care delivery, allocate resources and govern the behaviour of actors. The survey aims also to develop knowledge and indicators that can be used to inform policy-oriented studies of

health systems performance and identifying the critical policy and institutional characteristics that underlie good performance.

6. The HSC survey provides a structured snapshot of the key policies and institutions that underpin health care insurance and health care delivery in a given country. This survey describes arrangements to organise population coverage; the financing of health care insurance and delivery; the organisation of health care delivery, focusing on the public/private mix of health care provision, provider payment schemes, user choice and competition among providers, as well as the regulation of health care supply and prices. The survey also describes key aspects of governance and resource allocation in health systems, such as decentralisation in decision-making and the nature of budget constraints.

7. No such survey has been undertaken, yet, in the LAC region. There, health systems are typically described in simplistic terms based mainly on financing and delivery arrangements. In the past, the distinction between "Public Integrated", "Public Contract" and "Private Insurance/Provider" models adequately reflected a larger set of consistent institutions and incentives (Londoño and Frenk 1997). Increasingly, however, with the rapid development of systems of health and social care in the LAC region, these distinctions are being blurred. For example, systems based on social health insurance have increased the role of taxes in financing, and national health systems use new contracts and payment schemes for the provision of care. As a result, health systems with similar financing mechanisms may have indeed very different incentive structures.

8. Hence, there is a need to collect information on institutional arrangements and policies in a systematic way to progress analyses both within and outside the LAC region to inform policy. A limited set of quantitative indicators that capture the main characteristics of health systems can then be used to assess the role of health institutions and policies on health systems efficiency (Lorenzoni *et al.* 2018).

2. The survey

9. The survey on HSC is based on a conceptual framework grounded in concrete structural or organisational characteristics of health systems (Paris *et al.* 2010). This framework comprises three domains:

- health financing and coverage arrangements;
- health care delivery systems; and
- governance and resource allocation.

10. The first domain describes health financing and health coverage arrangements. These arrangements determine the degree to which health-related risks are pooled and also affect the incentives faced by third-party payers or insurers (if any) and individuals with respect to their health-care decisions. A first consideration relates to the characterisation of basic (primary) coverage. There may be a single scheme that provides basic or primary coverage to all or nearly all of the population (through a national health service or a social insurance scheme operating as a single payer) or multiple coverage schemes serving different parts of the population. Basic coverage for health and financial risks associated with health care needs may be automatic (e.g., based on residency), compulsory (for the whole population or for some population segments) or voluntary. The questionnaire then investigates the level of regulation of health insurance markets in countries in which several health insurance companies/funds offer basic primary coverage to citizens, compulsory or not. Moreover, it looks at how governments intervene to guarantee health coverage for high-risk or economically disadvantaged people in countries where health coverage is not automatically provided to all residents. Furthermore, the survey assesses the comprehensiveness of coverage by basic (primary) health insurance according to three dimensions: the share of the population covered by the system; the scope of benefits and types of services covered and the level of coverage for these benefits and services. Finally, the role of private health insurance as a "secondary source" of coverage is described.

11. Health systems show a high diversity in the organisation of the delivery of care, in providers' status and in payment arrangements, factors that affect the incentives they face. To characterise health systems, the second domain depicts the type of institutions delivering services (e.g. physicians in solo practice, in group practice, clinics or health care centres), the public/private mix for physicians and acute hospital care and providers payments schemes. The degree of user choice among providers is then assessed using information on the existence of gate-keeping and how primary care is co-ordinated with other levels of care including incentives and/or restrictions for accessing specialised care. Then, different aspects of regulation are considered, including what kind of incentives exist to improve the accessibility, efficiency and quality of health care services.

12. The third domain focuses on issues of governance and resource allocation in health care systems. High-level authorities are generally responsible for the achievement of policy goals (provision of effective and high-quality services, responsiveness and allocative efficiency). To achieve these goals, policy makers rely both on market incentives and on regulatory tools. The relative importance of these two sets of instrument varies significantly across countries. In each, policy-makers define the scope of their intervention in health systems' governance and set rules for the allocation of public resources devoted to health systems. Information is gathered on the role of health technology assessment and

quality of care policies and on the responsibilities and authorities of health system stakeholders. A final section provides some additional material on patient's rights, representation and public involvement in the health care system as well as budgeting practices for health.

13. The LAC HSC survey draws heavily on the OECD survey. In particular, the Inter-American Development Bank (IDB) and OECD reviewed questions and responses of the 2016 OECD survey to tailor the questionnaire to regional priorities. A pilot test by two LAC countries then helped assessing the feasibility of the survey in the LAC region. The LAC HSC questionnaire comprises three domains, 19 sections and 78 questions[1] (see Table 2.1).

Table 2.1. Number of questions by domain/section

Domain/section	Number of questions
PART I - Health care financing and coverage arrangements	
Section 1. Characterisation of basic health care coverage	2
Section 2. Regulation of health insurance markets for basic health care coverage	6
Section 3. Other interventions of the public sector in the health insurance market	2
Section 4. Comprehensiveness of basic health care coverage	2
Section 5. Protection against excessive out-of-pocket expenditure	5
Section 6. Competition between health insurers offering basic health care coverage and consumer choice	4
Section 7. Private health insurance acting as a secondary source of coverage	2
PART II - Health care delivery systems	
Section 8: Provision of health care and payment of health services	5
Section 9: Employment status and remuneration of health care professionals	4
Section 10: Pay-for-performance and other financial incentives for providers	3
Section 11: Patients' choice and competition among providers	7
Section 12: Workforce training and regulation	7
Section 13: Infrastructure and service delivery planning	1
Section 14: Price regulation for health care services	6
Section 15: Coordination and continuity of care	4
PART III - Governance and resource allocation	
Section 16. Health Technology Assessment	4
Section 17. Quality of care	7
Section 18. Patients' rights and citizens' involvement	2
Section 19. Budgeting practices for health	5

14. To help country experts fill in the questionnaire, a *survey data tool* to gather responses was prepared. This tool consists of an Excel file that contains several sheet, each corresponding to one section of the survey. Drop-down multiple-choice menus facilitate the task of providing responses to questions. Guidelines for data collection and a glossary were prepared too. The data survey tool was made available to countries in English and Spanish. Countries could choose the questionnaire language onto the cover page (see Figure 2.1).

[1] Of note that a question may comprise several sub-questions.

Figure 2.1. Cover page of the 2018 LAC survey (Spanish version)

15. An online platform known as the *Health System Characteristics Community* (Figure 2.2) was set up to support countries in responding to the HSC survey. This online platform allowed countries to download the survey data tool, a PDF version of the survey and submit the completed survey. The platform also served as a point of communication with IDB and OECD, providing countries with updated information on the survey.

Figure 2.2. Cover page of the online community

16. Between June-November 2018, the questionnaire was compiled by the following organisations in 21 (out of 26) LAC countries:

Country	Organisation
Argentina	Ministry of Health
Belize	Ministry of Health
Bolivia	Ministry of Health
Brazil	Ministry of Health
Chile	MINSAL
Colombia	Ministry of Health
Costa Rica	Ministry of Health
Dominican Republic	Ministry of Health
Ecuador	Ministry of Health
El Salvador	Ministry of Health
Guatemala	Ministry of Health
Guyana	Ministry of Health
Honduras	Ministry of Health and Health Secretariat
Jamaica	Ministry of Health
Mexico	*Secreteria de Salud*
Panama	Ministry of Health
Paraguay	Ministry of Health
Peru	Ministry of Health
Suriname	Ministry of Health
Trinidad and Tobago	Ministry of Health
Uruguay	Ministry of Health

17. Country responses[2] were reviewed by IDB and OECD, and then validated by countries. The following part of this paper reports the main results of the 2018 LAC HSC survey by domain. When appropriate and sound, results for LAC countries are compared against results for OECD countries. Additional overview tales are shown in the Annex.

[2] No responses to questions on "Other interventions of the public sector in the health insurance market" (section 3), "Comprehensiveness of basic health care coverage" (section 4), "Workforce training and education" (section 12), "Infrastructure and service delivery planning" (section 13), "Price regulation for health care services" (section 14), "Coordination and continuity of care" (section 15), "Quality of care" (section 17) and "Budgeting practices" (section 19) were available from the questionnaire for Brazil, reflecting the complexity and variety of the Brazilian health care system.

3. Results

3.1. Health care financing and coverage arrangements

18. Health care financing and coverage arrangements determine the degree to which health-related risks are pooled. They generate financial transfers, generally promoting horizontal equity (via transfers from healthier to sicker people), as well as vertical equity (via transfers from higher-income to lower-income people). These arrangements also affect the incentives faced by third-party payers or insurers (if any) and individuals with respect to their health-care decisions.

19. Due to the fragmentation of health systems in LAC, providing a clear typology for health coverage is a complex task. In some countries, there are coexisting models and overlapping coverage. For this reason, the coverage part of the survey focused on a basic package of services for a "typical" adult employed in the formal sector.

20. Countries differ in the organisation of the supply of basic (primary) coverage (Table 3.1). Basic health coverage is provided by a national health system in ten countries (Belize, Brazil, Ecuador, El Salvador, Guyana, Honduras, Jamaica, Panama, Paraguay and Trinidad and Tobago), by multiple insurers in eight countries (Bolivia, Dominican Republic, Mexico, Peru, Chile, Colombia, Guatemala and Suriname) and by a single health insurance scheme in Costa Rica and Uruguay. In countries with multiple insurance schemes, affiliation to a specific insurer is not a matter of choice in Bolivia, Dominican Republic, Mexico and Peru, whereas in Chile, Colombia, Guatemala and Suriname people can choose their insurer. In Argentina, all residents have access to the public system. However, all formal employees must also enrol in a health insurance plan (*obra social*) with choice of insurer.

Table 3.1. Provision of basic (primary) coverage for the "typical" employed adult

Main source of basic health coverage		List of countries
Residence-based health coverage		Argentina, Belize, Brazil, Ecuador, El Salvador, Guyana, Honduras, Jamaica, Paraguay and Trinidad and Tobago
Contributory health coverage	Single payer	Costa Rica and Uruguay
	Multiple insurers, with automatic affiliation	Bolivia, Dominican Republic, Mexico, Panama and Peru
	Multiple insurers, with choice of insurer	Argentina (formal employees), Chile, Colombia, Guatemala and Suriname

21. In contrast, a lower proportion of OECD countries (11 out of 34) provides residence-based coverage, whereas a higher proportion on OECD countries (8 out of 34) provides contributory health coverage through a single payer.

22. Countries with multiple insurance funds have adopted different mechanisms to regulate private insurance markets. These are done either to ensure uniform contribution rates and benefits to the whole population or to allow insurance funds to differentiate their products. The extent to which LAC countries require health insurers and funds to offer the same coverage or benefit package to their insured population varies considerably (Table 3.2).

23. Most of the responding countries allow insurers to freely define the range (which goods and services) and the level (what portion of the cost) of benefits covered. By contrast, Colombia, Dominican Republic and Peru have implement policies requiring insurers to offer the same level of coverage/co-payment. In Bolivia, Chile and Uruguay, health insurers are required to offer the same benefit package, but could differentiate the level of coverage. Lastly, in Argentina and Brazil insurance schemes are required to cover a minimum benefit package. In two-thirds of reporting countries, contributions and premiums are fully regulated, whereas in the remaining countries there are no regulatory constraints in place. In most countries, there is no risk-equalisation between insurers/funds.

Table 3.2. Regulation of health insurance markets in countries with multiple insurers

Country	Are insurers/funds required to offer the same coverage?	Are premiums/contributions regulated by the government or the parliament?	Premiums are modulated according to:	Is there any system of risk-equalisation between health insurers/funds?	If yes, what risk factors are used?
Argentina	Differentiate benefits with defined minimum package	Contributions/ premiums are fully defined by regulation		Yes	Age, gender
Belize		Not relevant		No	
Bolivia	Same benefit package / differentiate level of coverage	Contributions/ premiums are fully defined by regulation		No	
Brazil	Differentiate benefits with defined minimum package	Contributions/ premiums are fully defined by regulation	Age	Yes	
Chile	Same benefit package / differentiate level of coverage	Contributions/ premiums are fully defined by regulation	Income	No	
Colombia	Same level of coverage / co-payment	Contributions/ premiums are fully defined by regulation		Yes	Age, gender, geographical area
Costa Rica					
Dominican Republic	Same level of coverage / co-payment	Schemes/funds can define contributions/premiums without any regulatory constraint.		No	
Ecuador					
El Salvador	Freely determine benefits and level of coverage	Contributions/ premiums are fully defined by regulation		No	
Guatemala	Freely determine benefits and level of coverage	Not relevant		No	
Guyana	Freely determine benefits and level of coverage	Schemes/funds can define contributions/premiums without any regulatory constraint.	Age, gender, health status, benefit design, income	No	

Country	Are insurers/funds required to offer the same coverage?	Are premiums/contributions regulated by the government or the parliament?	Premiums are modulated according to:	Is there any system of risk-equalisation between health insurers/funds?	If yes, what risk factors are used?
Honduras					
Jamaica	Freely determine benefits and level of coverage	Schemes/funds can define contributions/premiums without any regulatory constraint.		No	
Mexico	No	No		No	
Panama	Freely determine benefits and level of coverage	Schemes/funds can define contributions/premiums without any regulatory constraint.	Age, gender, health status, benefit design, geographical area	No	
Paraguay	Freely determine benefits and level of coverage	Contributions/ premiums are fully defined by regulation		No	
Peru	Same level of coverage / co-payment	Schemes/funds can define contributions/premiums within regulatory constraint.	Age, gender, health status, benefit design, geographical area	No	
Suriname	Freely determine benefits and level of coverage	Contributions/ premiums are fully defined by regulation		No	
Trinidad and Tobago	Freely determine benefits and level of coverage	Contributions/ premiums are fully defined by regulation		No	
Uruguay	Same benefit package / differentiate level of coverage	Contributions/ premiums are fully defined by regulation		Yes	Age, gender

24. When coverage is not automatically provided to all residents through national or local health systems, policies have been implemented to guarantee access to coverage or care for people with low-income or high-health risks. The majority of responding countries have implemented dedicated public insurance programmes to ensure coverage to low-income and high-risk groups (Table 3.3).

Table 3.3. Complementary interventions of the public sector in health coverage

Country	Does the government intervene to ensure access for low-income or economically disadvantaged groups?	If yes, how? Public subsidies for the purchase of basic health insurance	Share of the population eligible for such subsidies?	Share of the population with effective take-up of subsidies?	If yes, how? People are entitled to health coverage through dedicated public insurance programmes	Share of the population entitled through dedicated insurance programmes?	Does the government intervene to ensure access to high-risk groups (seniors, disabled, people with chronic disease, etc.)?	If yes, how? The government regulates premiums to promote access to insurance for high-risk groups	If yes, how? The government subsidises the purchase of basic health insurance	If yes, how? High-risk groups are entitled to public coverage through dedicated programmes	If yes, how? The public sector directly provides free health care services to high-risk groups
Argentina	Yes	Not relevant			Yes	38	Yes	Yes	Yes	Yes	Yes
Belize	Yes	Not relevant			Yes		Yes				Yes
Bolivia	Yes	Not relevant			Yes	14.1	Yes			Yes	Yes
Brazil											
Chile	Yes	Flat (same level)			Yes	18.4	Yes	Yes	Yes	Yes	Yes
Colombia (*)	Yes	Not relevant			Yes	45.7	Yes	Yes	Yes	Yes	
Costa Rica											
Dominican Republic	Yes	Flat (same level)			Yes	32.9	Yes		Yes	Yes	
Ecuador	Yes	Flat (the same for all beneficiaries)	100	60.6			Yes		Yes		Yes

Country	Does the government intervene to ensure access for low-income or economically disadvantaged groups?	If yes, how? Public subsidies for the purchase of basic health insurance	Share of the population eligible for such subsidies?	Share of the population with effective take-up of subsidies?	If yes, how? People are entitled to health coverage through dedicated public insurance programmes	Share of the population entitled through dedicated insurance programmes?	Does the government intervene to ensure access to high-risk groups (seniors, disabled, people with chronic disease, etc.)?	If yes, how? The government regulates premiums to promote access to insurance for high-risk groups	If yes, how? The government subsidises the purchase of basic health insurance	If yes, how? High-risk groups are entitled to public coverage through dedicated programmes	If yes, how? The public sector directly provides free health care services to high-risk groups
El Salvador	Yes	Flat (the same for all beneficiaries)			No		Yes			Yes	Yes
Guatemala	No										
Guyana	Yes	Not relevant			Yes	60	Yes		Yes	Yes	Yes
Honduras											
Jamaica	No						Yes			Yes	Yes
Mexico	Yes				Yes	37	No				
Panama	Yes	Flat (the same for all beneficiaries)			Yes		Yes	Yes	Yes	Yes	Yes
Paraguay	No										
Peru	Yes	Means-tested	53			56.3	Yes		Yes		Yes
Suriname	Yes	Flat (same level)			Yes		Yes			Yes	
Trinidad and Tobago	No						Yes			Yes	Yes
Uruguay	Yes				Yes	24.3	Yes	Yes	Yes	Yes	Yes

Note: (*) In Colombia, low-income or economically disadvantaged groups choose their insurer and the government pays the cost of insurance.

25. In most LAC countries (17 out of 21 reporting countries), basic (primary) coverage is complemented by a secondary source of coverage (Table 3.4). This secondary source of coverage allows additional risk-pooling for benefits not covered by basic (primary) health insurance – its role is "supplementary" - in Belize, Ecuador, Guyana, Peru, Suriname and Uruguay. It allows additional risk pooling for costs not covered by basic (primary) health insurance – its role its "complementary" – in Argentina, Brazil, Chile, Honduras and Peru. It is "duplicative" in Argentina, Brazil, Colombia, Dominican Republic, Guatemala, Guyana, Honduras, Peru, Suriname and Trinidad and Tobago.

26. This proportion is similar to the one found for OECD countries where only five countries (out of 34) reported that private health insurance does not provide a secondary source of coverage for health.

Table 3.4. Private health insurance as a secondary source of coverage

				Duplicative	
Country	**Is private health insurance a secondary source of coverage for some of the population?**	**Supplementary (it covers health goods and services not covered in the basic benefit package)**	**Complementary (it covers cost-sharing for health goods and services covered in the basic benefit package)**	**Only when delivered by providers whose services are not eligible for funding by basic coverage**	**Including when delivered by providers whose services are eligible for funding by basic coverage**
Argentina	Yes	Not generally	Significant	Significant	Not generally
Belize	Yes	Significant			
Bolivia	No		Not allowed		
Brazil	Yes		Significant	Significant	Significant
Chile	Yes	Marginal	Significant	Not allowed	Not allowed

				Duplicative	
Country	**Is private health insurance a secondary source of coverage for some of the population?**	**Supplementary (it covers health goods and services not covered in the basic benefit package)**	**Complementary (it covers cost-sharing for health goods and services covered in the basic benefit package)**	**Only when delivered by providers whose services are not eligible for funding by basic coverage**	**Including when delivered by providers whose services are eligible for funding by basic coverage**
Colombia	Yes	Not generally	Not generally	Significant	Marginal
Costa Rica	No				
Dominican Republic	Yes	Marginal	Marginal	Marginal	Significant
Ecuador	Yes	Significant	Not generally	Marginal	Marginal
El Salvador	Yes				
Guatemala	Yes	Not allowed	Marginal	Not allowed	Significant
Guyana	Yes	Significant	Marginal	Significant	Marginal
Honduras	Yes	Not allowed	Significant	Not allowed	Significant
Jamaica	Yes				
Mexico	No				
Panama	No				
Paraguay	Yes	Not generally	Not allowed		
Peru	Yes	Significant	Significant		Significant
Suriname	Yes	Significant		Significant	

				Duplicative	
Country	**Is private health insurance a secondary source of coverage for some of the population?**	**Supplementary (it covers health goods and services not covered in the basic benefit package)**	**Complementary (it covers cost-sharing for health goods and services covered in the basic benefit package)**	**Only when delivered by providers whose services are not eligible for funding by basic coverage**	**Including when delivered by providers whose services are eligible for funding by basic coverage**
Trinidad and Tobago	Yes			Significant	
Uruguay	Yes	Significant	Not allowed		

3.2. Health care delivery systems

27. Health systems show a high diversity in the organisation of the delivery of care, in providers' status and in payment arrangements, factors that will affect the incentives they face.

28. The organisation and public/private mix of provision of outpatient physicians' services is shown in Table 3.5. In most LAC countries, primary care services are primarily provided by public primary care clinics staffed by physicians and other health professionals. In Colombia and Uruguay, those services are provided by public and private primary care clinics, whereas in Guatemala those services are provided by nurses in health centres.

29. Private group practices represent a second form of primary care service provision in Brazil, Chile, Costa Rica, Panama and Trinidad and Tobago, while hospital outpatient departments represent a second form of provision in Argentina (public hospitals), Brazil (public), Belize (public and private), Colombia (public), El Salvador (public), Guyana (private) and Peru (public).

Table 3.5. Predominant modes for the provision of primary care services and outpatient specialists' services

Country	Are primary care services provided predominantly in:	If other	Is there a second significant form of service provision?	If yes, please indicate the form	How do key purchasers pay these providers?
Argentina	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		Yes	Outpatient departments of public hospitals	FFS
Belize	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		Yes	Outpatient departments of public and private hospitals	FFS
Bolivia	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		No		
Brazil	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		Yes	Outpatient departments of public hospitals Private group practices	
Chile	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		Yes	Private group practices	FFS
Colombia	Public and private primary care clinics staffed by physicians and other health professionals (e.g., nurses)		Yes	Outpatient departments of public hospitals	FFS, global budget
Costa Rica	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		Yes	Private group practices	FFS
Dominican Republic	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)				
Ecuador	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		No		
El Salvador	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		Yes	Outpatient departments of public hospitals	

Country	Are primary care services provided predominantly in:	If other	Is there a second significant form of service provision?	If yes, please indicate the form	How do key purchasers pay these providers?
Guatemala	Other, please specify	Health centres staffed by nurses	No		
Guyana	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		Yes	Outpatient departments of private hospitals	FFS
Honduras	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		No		
Jamaica	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)				
Mexico	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		No		
Panama	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		Yes	Private group practices	FFS
Paraguay	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		Yes		
Peru	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		Yes	Outpatient departments on public hospitals	FFS and global budget
Suriname	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		No		
Trinidad and Tobago	Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)		Yes	Private group practices	FFS
Uruguay	Other, please specify	Public and private primary care clinics staffed by physicians and other health professionals (e.g., nurses). Outpatient departments of public and private hospitals			

30. Predominant modes of physicians' payment vary across LAC countries. Global budget is the predominant mode of payments for primary care physicians in Costa Rica, Ecuador, El Salvador, Guatemala, Jamaica, Mexico, Panama, Paraguay and Trinidad and Tobago (Table 3.6). Primary care physicians are predominantly remunerated by fee-for-service in Bolivia and Suriname, whereas in Guyana they are remunerated by salary. The other nine countries use a mix of mode of payments, including capitation and FFS. If capitation is one components of payments, it is normally adjusted by age and gender.

31. Global budget is the predominant mode of payment for outpatient specialists in Brazil, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico and Panama. Specialists are predominantly remunerated by fee-for-service in Suriname, whereas in Guyana they are remunerated by salary. The other seven countries use a mix of mode of payments, mainly a mix of fee-for-service and global budget.

Table 3.6. Predominant modes of physicians' payment

Country	How are primary care physicians paid?	If capitation is one component of payment, is it adjusted?	If yes, what are the main risk factors used?	How do key purchasers pay outpatient specialists service providers?
Argentina	FFS, pay-for-performance, global budget			FFS, global budget, pay-for-performance
Belize	Capitation, FFS, pay-for-performance, global budget	Yes	Geographical location	FFS, pay-for-performance
Bolivia	FFS			
Brazil	FFS, global budget			Global budget
Chile	Capitation, FFS	Yes	Age, economic level of municipality, rurality and difficult to deliver the health services	FFS, global budget
Colombia	Capitation, FFS, prospective global budget	Yes		FFS, prospective global budget
Costa Rica	Global budget			Global budget

Country	How are primary care physicians paid?	If capitation is one component of payment, is it adjusted?	If yes, what are the main risk factors used?	How do key purchasers pay outpatient specialists service providers?
Dominican Republic	Capitation, pay-for-performance, global budget			FFS, global budget
Ecuador	Global budget			Global budget
El Salvador	Global budget			Global budget
Guatemala	Global budget	Yes	Age, gender, health status, geographical location	Global budget
Guyana	Fixed government salaries			Monthly fixed salaries
Honduras	Capitation, global budget	Yes	Age, gender, health status, geographical location	Global budget
Jamaica	Global budget			
Mexico	Global budget			Global budget
Panama	Global budget			Global budget
Paraguay	Global budget			
Peru	Capitation, FFS, pay-for-performance, global budget	Yes	Age, gender, prior utilisation of services, geographical location	FFS, global budget
Suriname	FFS			FFS
Trinidad and Tobago	Global budget			FFS, global budget
Uruguay	Capitation, FFS, global budget	Yes	Age, gender	FFS, global budget, per capita

32. Different hospital payment methods are used across LAC countries (Table 3.7). Public hospitals are mainly remunerated by global budget (13 countries). In Bolivia and Colombia payment is based on procedures or services provided, whereas in Argentina, Belize, Costa Rica and Jamaica remuneration is based on line-items budgets. In ten countries, capital funding is covered by these payments, whereas in 12 countries teaching and research are funded separately.

33. Non-for profit hospitals are mainly remunerated based on procedures or services provided (eight countries). Only in Chile, a DRG-like system is use as a basis for payment. In seven countries, capital funding is covered by these payments, whereas in six countries teaching and research are funded separately.

34. For profit hospitals are mainly remunerated based on procedures or services provided (14 countries). Only in Guatemala, a DRG-like system is use as a basis for payment. In 11 countries capital funding is covered by these payments, whereas in ten countries teaching and research are funded separately.

Table 3.7. Hospital payment schemes

	Publically owned hospitals			Not-for-profit privately owned hospitals			For-profit privately owned hospitals		
Country	**Main payment method**	**Is capital funding covered in these payments?**	**Are teaching, training and research funded separately?**	**Main payment method**	**Is capital funding covered in these payments?**	**Are teaching, training and research funded separately?**	**Main payment method**	**Is capital funding covered in these payments?**	**Are teaching, training and research funded separately?**
Argentina	Line-item budgets	Yes	No	Payment based on procedure or service	Yes	No	Payment based on procedure or service	Yes	No
Belize	Line-item budgets	No	Yes	Payment based on procedure or service	Yes	Yes	Payment based on procedure or service	Yes	Yes
Bolivia	Payment based on procedure or service	No	Yes	Payment based on procedure or service	No	Yes	Payment based on procedure or service	Yes	Yes
Brazil	Prospective global budget	No	Yes				Prospective global budget	No	Yes
Chile	Prospective global budget	No	Yes	Payment per case (DRG-like)	No	Yes	Payment based on procedure or service	No	Yes
Colombia	Payment based on procedure or service	Yes	No	Payment based on procedure or service	Yes	No	Payment based on procedure or service	Yes	

	Publically owned hospitals			Not-for-profit privately owned hospitals			For-profit privately owned hospitals		
Country	**Main payment method**	**Is capital funding covered in these payments?**	**Are teaching, training and research funded separately?**	**Main payment method**	**Is capital funding covered in these payments?**	**Are teaching, training and research funded separately?**	**Main payment method**	**Is capital funding covered in these payments?**	**Are teaching, training and research funded separately?**
Costa Rica	Line-item budgets	Yes	No						
Dominican Republic	Prospective global budget	No	No	Payment based on procedure or service	Yes	No	Payment based on procedure or service	Yes	No
Ecuador	Prospective global budget	No	No	Payment based on procedure or service	Yes	Yes	Payment based on procedure or service	Yes	Yes
El Salvador	Prospective global budget	Yes	Yes				Payment based on procedure or service		
Guatemala	Prospective global budget	Yes	Yes	Payment based on procedure or service	Yes	Yes	Payment per case (DRG-like)	Yes	Yes
Guyana	Prospective global budget	No	No				Payment based on procedure or service	Yes	Yes
Honduras	Prospective global budget	Yes	Yes						
Jamaica	Line-item budgets	Yes	Yes				Payment based on procedure or service	Yes	
Mexico	Prospective global budget	No	Yes	Payment based on procedure or service	No	Yes	Payment based on procedure or service	Yes	Yes
Panama	Prospective global budget						Payment based on procedure or service		
Paraguay	Prospective global budget	Yes	Yes	Prospective global budget		Yes	Prospective global budget	Yes	Yes
Peru	Prospective global budget and payment based on procedure or service						Payment based on procedure or service		
Suriname									
Trinidad and Tobago	Prospective global budget	Yes	No	Line-item budgets	Yes	No	Payment based on procedure or service	Yes	No
Uruguay	Line-item budgets	Yes	Yes						

35. In contrast, 16 out of 34 OECD countries use case-based funding such as DRG payments as the main method to pay public hospitals. Payment per case is typically associated with hospitals, mainly for inpatient curative treatment but increasingly for day cases, outpatient or rehabilitative treatment. It can be considered as a bundled payment as it combines in a single tariff the payment of a range of services provided during the patient's stay. In about a dozen OECD countries, global budgets are the predominant mode of payment for hospital services. Less common is the use of line-item budgets and payment by procedure as the main form to pay public hospitals (OECD 2016b).

36. Some differences in the use of payment mechanisms can be observed across OECD countries between health systems with residence-based health coverage and those where coverage is based on contributory payments. There appears to be a stronger tendency towards DRG-type payments in countries with contributory coverage, while in residence-based coverage systems, there is a tendency towards broader forms of payment for inpatient services in public hospitals (e.g. global budget), though DRG-type payments are also used. Even in systems that predominantly use global budgets to pay public hospitals, DRGs may still exist. In some cases, countries use DRGs as a patient classification tool to allocate budgets rather than explicitly for payment.

37. The existence and scope of bonuses paid to primary care providers for achieving targets related to quality of care is shown in Table 3.8. Seven countries – Argentina, Belize, Chile, Dominican Republic, Paraguay, Peru and Uruguay – reported that primary care providers could get a bonus linked to quality of care mainly for targets relating to preventive care and management of chronic diseases. Participation is mandatory in five countries, and voluntary and open to all providers in Peru. Six countries use an absolute measure to assess performance. Bonuses are paid to individual physicians (three countries) and to the organisation (four countries).

Table 3.8. Performance-related payment incentives. Primary care providers

Country	Can primary care providers get a bonus payment for achieving targets related to the quality of care?	If yes, for those providers participating in the programme(s), do targets typically relate to:	If yes, is participation:	If yes, is performance against quality objectives defined in terms of:	If yes, is the bonus payment normally paid to:
Argentina	Yes	Preventive care, management of chronic diseases, referral rates, efficiency	Voluntary but subject to some conditions	Change over time, relative ranking	Directly to individual physicians
Belize	Yes	Preventive care, management of chronic diseases, patient satisfaction, efficiency, maternal and child health	Mandatory for all primary care providers in a target category	Absolute measure	The organisation
Bolivia	No				
Brazil	No				
Chile	Yes	Preventive care, management of chronic diseases, referral rates, patient satisfaction, efficiency, Coverage of dental services in targets groups	Mandatory for all primary care providers nationwide	Absolute measure, relative ranking	The organisation
Colombia	No				
Costa Rica	No				
Dominican Republic	Yes	Preventive care, management of chronic diseases	Mandatory for all primary care providers in a target category	Absolute measure	The organisation

Country	Can primary care providers get a bonus payment for achieving targets related to the quality of care?	If yes, for those providers participating in the programme(s), do targets typically relate to:	If yes, is participation:	If yes, is performance against quality objectives defined in terms of:	If yes, is the bonus payment normally paid to:
Ecuador	No				
El Salvador	No				
Guatemala	No				
Guyana	No				
Honduras	No				
Jamaica	No				
Mexico	No				
Panama	No				
Paraguay	Yes	Preventive care, management of chronic diseases, referral rates, uptake of IT services, patient satisfaction, efficiency	Mandatory for all primary care providers nationwide	Absolute measure, change over time, relative ranking	Directly to individual physicians

Country	Can primary care providers get a bonus payment for achieving targets related to the quality of care?	If yes, for those providers participating in the programme(s), do targets typically relate to:	If yes, is participation:	If yes, is performance against quality objectives defined in terms of:	If yes, is the bonus payment normally paid to:
Peru	Yes	Preventive care	Voluntary and open to all primary care providers	Absolute measure	The organisation
Suriname	No				
Trinidad and Tobago	No				
Uruguay	Yes		Mandatory for all primary care providers in a target category	Absolute measure	Directly to individual physicians

38. The existence and scope of bonuses paid to specialists for achieving targets related to quality of care are reported in Table 3.9. Only five countries – Argentina, Chile, Paraguay, Peru and Uruguay – reported that specialists could get a bonus linked to quality of care mainly for targets relating mainly to preventive care, management of chronic diseases and uptake of IT. Participation is mandatory in three countries, and voluntary but subject to some conditions in two countries. Four countries use an absolute measure to assess performance. Bonuses are paid to the individual specialists (three countries) and to the organisation (two countries).

Table 3.9. Performance-related payment incentives. Specialists

Country	Can specialists get a bonus payment for achieving targets related to the quality of care?	If yes, for those providers participating in the programme(s), do targets typically relate to:	If yes, is participation:	If yes, is performance against quality objectives defined in terms of:	If yes, is the bonus payment normally paid to:
Argentina	Yes	Preventive care, management of chronic diseases, uptake of IT services	Voluntary but subject to some conditions	Change over time, relative ranking	Directly to individual physicians
Belize	No				
Bolivia	No				
Brazil	No				
Chile	Yes	Management of chronic diseases, patient satisfaction, hospital acquired pathologies	Mandatory for all specialists nationwide	Absolute measure, relative ranking	The organisation
Colombia	No				
Costa Rica	No				
Dominican Republic	No				
Ecuador	No				
El Salvador	No				
Guatemala	No				
Guyana	No				
Honduras	No				

Country	Can specialists get a bonus payment for achieving targets related to the quality of care?	If yes, for those providers participating in the programme(s), do targets typically relate to:	If yes, is participation:	If yes, is performance against quality objectives defined in terms of:	If yes, is the bonus payment normally paid to:
Jamaica	No				
Mexico	No				
Panama	No				
Paraguay	Yes	Preventive care, management of chronic diseases, uptake of IT services, patient satisfaction	Mandatory for all specialists nationwide	Absolute measure, change over time, relative ranking	Directly to individual physicians
Peru	Yes	Preventive care, management of chronic diseases, uptake of IT services	Voluntary but subject to some conditions	Absolute measure	The organisation
Suriname	No				
Trinidad and Tobago	No				
Uruguay	Yes		Mandatory for all specialists in a target category	Absolute measure, relative ranking	Directly to individual physicians

39. The existence and scope of bonuses paid to hospitals for achieving targets related to quality of care are reported in Table 3.10. Only two countries – Chile and Paraguay – use bonuses to provide incentives to hospitals linked to quality of care. Patient satisfaction and patient experience are the main target of these incentives. Participation is mandatory and performance is assessed against an absolute measure and change over time.

Table 3.10. Performance-related payment incentives. Hospitals

Country	Do some acute care hospitals get a bonus payment for achieving targets related to the quality of care?	If yes, for those providers participating in the programme(s), do targets typically relate to:	If yes, is participation:	If yes, is performance against quality objectives defined in terms of:	Is the bonus payment normally paid to - % of total hospitals providing acute inpatient care	Is the bonus payment normally paid to - % of hospitals providing acute inpatient care and eligible for the programme
Argentina	No					
Belize	No					
Bolivia	No					
Brazil	No					
Chile	Yes	Clinical outcome of care, patient satisfaction, patient experience	Mandatory for all providers nationwide	Absolute measure, change over time	100	100
Colombia	No					
Costa Rica	No					
Dominican Republic	No					
Ecuador	No					
El Salvador	No					
Guatemala	No					
Guyana	No					
Honduras	No					

Country	Do some acute care hospitals get a bonus payment for achieving targets related to the quality of care?	If yes, for those providers participating in the programme(s), do targets typically relate to:	If yes, is participation:	If yes, is performance against quality objectives defined in terms of:	Is the bonus payment normally paid to - % of total hospitals providing acute inpatient care	Is the bonus payment normally paid to - % of hospitals providing acute inpatient care and eligible for the programme
Jamaica	No					
Mexico	No					
Panama	No					
Paraguay	Yes	Clinical outcome of care, the use of appropriate processes, patient satisfaction, patient experience	Mandatory for all providers nationwide	Absolute measure, change over time, relative ranking		
Peru	No					
Suriname	No					
Trinidad and Tobago	No					
Uruguay	No					

40. To encourage appropriate use of health services, countries have been relying on primary care physicians to guarantee good follow-up of patients and serve as gate-keepers. In a large part of LAC countries, there is no incentive and no obligation to register with a primary care physician (see Table 3.11). Only in Brazil, Chile and Suriname patients are obliged to register, while in Argentina, El Salvador and Panama patients have financial incentives to register. In 13 countries – Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, Guyana, Jamaica, Mexico, Panama, Suriname, Trinidad and Tobago - primary care physician referral is compulsory to access specialist care, whereas in the remaining countries there is no need to obtain primary care physician referral.

Table 3.11. Gate-keeping

Country	Are patients required or encourage to register with a primary care physician or practice?	Do primary care physicians control access to specialist care?
Argentina	Patients are not obliged to register with a primary care physician (or practice) but have financial incentives to do so (e.g., reduced co-payments)	There is no need and no incentive to obtain primary care physician referral
Belize	There is no incentive and no obligation to register with a primary care physician (or practice)	Primary care physician referral is compulsory to access most types of specialist care (except in case of emergency)
Bolivia	There is no incentive and no obligation to register with a primary care physician (or practice)	Primary care physician referral is compulsory to access most types of specialist care (except in case of emergency)
Brazil	Patients are obliged to register	Primary care physician referral is compulsory to access most types of specialist care (except in case of emergency)
Chile	Patients are obliged to register	Primary care physician referral is compulsory to access most types of specialist care (except in case of emergency)
Colombia	There is no incentive and no obligation to register with a primary care physician (or practice)	Primary care physician referral is compulsory to access most types of specialist care (except in case of emergency)
Costa Rica	There is no incentive and no obligation to register with a primary care physician (or practice)	Primary care physician referral is compulsory to access most types of specialist care (except in case of emergency)
Dominican Republic	There is no incentive and no obligation to register with a primary care physician (or practice)	There is no need and no incentive to obtain primary care physician referral
Ecuador	There is no incentive and no obligation to register with a primary care physician (or practice)	Primary care physician referral is compulsory to access most types of specialist care (except in case of emergency)
El Salvador	Patients are not obliged to register with a primary care physician (or practice) but have financial incentives to do so (e.g., reduced co-payments)	There is no need and no incentive to obtain primary care physician referral
Guatemala	There is no incentive and no obligation to register with a primary care physician (or practice)	There is no need and no incentive to obtain primary care physician referral
Guyana	There is no incentive and no obligation to register with a primary care physician (or practice)	Primary care physician referral is compulsory to access most types of specialist care (except in case of emergency)
Honduras	There is no incentive and no obligation to register with a primary care physician (or practice)	There is no need and no incentive to obtain primary care physician referral
Jamaica	There is no incentive and no obligation to register with a primary care physician (or practice)	Primary care physician referral is compulsory to access most types of specialist care (except in case of emergency)
Mexico	There is no incentive and no obligation to register with a primary care physician (or practice)	Primary care physician referral is compulsory to access most types of specialist care (except in case of emergency)

Country	Are patients required or encourage to register with a primary care physician or practice?	Do primary care physicians control access to specialist care?
Panama	Patients are not obliged to register with a primary care physician (or practice) but have financial incentives to do so (e.g., reduced co-payments)	Primary care physician referral is compulsory to access most types of specialist care (except in case of emergency)
Paraguay	There is no incentive and no obligation to register with a primary care physician (or practice)	There is no need and no incentive to obtain primary care physician referral
Peru	There is no incentive and no obligation to register with a primary care physician (or practice)	There is no need and no incentive to obtain primary care physician referral
Suriname	Patients are obliged to register	Primary care physician referral is compulsory to access most types of specialist care (except in case of emergency)
Trinidad and Tobago	There is no incentive and no obligation to register with a primary care physician (or practice)	Primary care physician referral is compulsory to access most types of specialist care (except in case of emergency)
Uruguay	There is no incentive and no obligation to register with a primary care physician (or practice)	

41. A national legislation on quality of care is available in almost two thirds of LAC countries (see Table 3.12). In most countries (16 out of 19), there is an organisation at national level responsible for quality of care policies.

Table 3.12. National legislations and organisations responsible for quality of care

Country	Is there national legislation on health care quality in your country?	If yes, please provide the name of the legislation and website link	Is there an organisation with responsibility for national policy on health care quality in your country?	If yes, please provide the name and website link
Argentina	Yes	El Programa Nacional de Garantía de Calidad en la Atención Médica, coordinado operativamente desde la Dirección Nacional de Calidad en Servicios de Salud y Regulación Sanitaria tiene como objetivo la promoción de la cultura de la calidad de los servicios de salud. El Decreto N°178 del año 2017 ratificó la vigencia del Programa Nacional de Garantía de Calidad de la Atención Médica: www.argentina.gob.ar/salud/calidadatencionmedica	Yes	La Dirección Nacional de Calidad en Servicios de Salud y Regulación Sanitaria de la Secretaría de Gobierno de Salud del Ministerio de Salud y Desarrollo Social. https://www.argentina.gob.ar/salud/calidadatencionmedica

Country	Is there national legislation on health care quality in your country?	If yes, please provide the name of the legislation and website link	Is there an organisation with responsibility for national policy on health care quality in your country?	If yes, please provide the name and website link
Belize	No		Yes	The Ministry of Health is the regulatory authority and therefore sets national policies and legislations. This is done through the Policy, Planning and Project Management Unit
Bolivia	Yes	Manual para la implementacion de los ciclos de mejoramiento de la calidad de atencion en servicios de segundo y tercer nivel de atencion. Bases para la organizacion y funcionamientno del proyecto nacional de calidad en salud (PRONACS) https://www.minsalud.gob.bo/images/Documentacion/dgss/Area_de_Calidad/56%20Pronacs.pdf https://www.minsalud.gob.bo/35-libros-y-normas/2477-mauales-1-de-la-ursc	Yes	Ministry of Health www.minsalud.gob.bo
Brazil				
Chile	Yes	http://www.supersalud.gob.cl/observatorio/575/w3-propertyvalue-4738.html	Yes	1. Ministerio de Salud: http://www.minsal.cl. 2. Superintendencia de Salud www.supersalud.cl: http://www.supersalud.gob.cl/observatorio/575/w3-propertyvalue-2459.html
Colombia	Yes	https://www.minsalud.gov.co/salud/PServicios/Paginas/sistema-obligatorio-garantia-calidad-SOGC.aspx	Yes	https://www.minsalud.gov.co/salud/PServicios/Paginas/sistema-obligatorio-garantia-calidad-SOGC.aspx
Costa Rica	No		Yes	The Ministry of Health has the responsibility for national policy on health, but there is no specific policy on health care quality: https://www.ministeriodesalud.go.cr/index.php/sobre-ministerio/estrategias-politicas-planes
Dominican Republic	No		Yes	Ministry of Health [http://www.msp.gob.do/oai/documentos/Politicas/POLI_PropuestaNacionalCalidadSalud_20120713.pdf]
Ecuador	Yes	Ley Orgánica de Salud; Ley Orgánica del Sistema Nacional de Salud; Decreto Ejecutivo No. 703 Web: https://www.salud.gob.ec/catalogo-	Yes	Agencia de Aseguramiento de la Calidad de los Servicios de Salud y Medicina Prepagada - ACESS http://www.calidadsalud.gob.ec/#

Country	Is there national legislation on health care quality in your country?	If yes, please provide the name of the legislation and website link	Is there an organisation with responsibility for national policy on health care quality in your country?	If yes, please provide the name and website link
		de-normas-politicas-reglamentos-protocolosmanuales-		
El Salvador	Yes	Se cuenta con lineamientos tecnicos, guias , protocolos, manuales de atencion, las cuales son diferentes por cada institucion (MINSAL, ISSS, Privados, Bienestar magisterial entre otros, No contamos con una Politica de calidad en salud. www.salud.gob.sv , Centro Virtual de Documentacion Regulatoria	No	
Guatemala	No		No	
Guyana	No		Yes	Ministry of Public Health
Honduras	Yes	Sistema Nacional de calidad en salud, politica de calidad en salud. Acuerdo No. 251 del 11 de marzo del 2011	Yes	La Secretaria de Salud de Honduras, a traves de la Direccion General de Normalizacion y la Direccion General de vigilancia del marco normativo en salud. www.salud.gob.hn
Jamaica	No			Health Services Planning and Integration, Ministry of Health
Mexico	Yes	http://www.calidad.salud.gob.mx/	Yes	Direccion general de cualidad y educacion en salud : http://www.calidad.salud.gob.mx/
Panama	Yes	www.minsa.gob.pa	Yes	minsa.gob.pa
Paraguay	Yes	www.mspbs.gov.py - Codigo Sanitaria y leyes vigentes	Yes	www.mspbs.gov.py - Ministerio de Salud Pública y Bienestar Social
Peru	Yes		Yes	SUSALUD - Superintendencia Nacional de Salud (http://portal.susalud.gob.pe)
Suriname	No		No	
Trinidad and Tobago	No		Yes	Department of Technical Medical Services, Ministry of Health
Uruguay	Yes	https://www.colegiomedico.org.uy/etica-medica/#codigo	Yes	https://www.colegiomedico.org.uy/

42. In half of LAC reporting countries, there are arrangements in place to guarantee continuity of care, mainly through primary care centres (Table 3.13). Nine countries – Argentina, Belize, Bolivia, Chile, Colombia, Costa Rica, Ecuador, Panama and

Uruguay- reported that a large majority of primary care physicians use a computer for several purposes, including making appointments, ordering laboratory tests and issuing drug prescriptions,. Only Costa Rica reports that a majority of health care physicians offer patients the option to view online, download or transmit information from their medical record.

43. In all reporting countries, a large majority of nurses provide at least immunisation services.

Table 3.13. Coordination of care

Country	Are there any arrangement in place to see a primary care physician or nurse when the practices are closed?	If yes, individual primary care physicians available for their own patients	If yes, group of primary care physicians available on a rota basis	If yes, primary care centres (minor injury units, urgent care centres)	If yes, general practitioner cooperatives	If yes, other arrangements are available	Do a large majority (>75%) of primary care physicians use a computer?	If yes, they use a computer for:	A majority (>50%) of primary care physicians offer patients the option to:	Do a large majority (>75%) of nurses or assistants independently provide:
Argentina	Yes		Yes	Yes			Yes	Sending referral letters to medical specialists, storing diagnostic test results, receiving alerts or prompts about a potential problem with drug dose or drug interaction		Immunisation, health promotion, routine checks of chronically ill patients, minor procedures, home visits
Belize	Yes					Polyclinics are opened in some locations until 8 pm and in rural communities the model is one where the nurse resides on the first floor of the clinic or within the village to be able to provide	Yes	Ordering laboratory tests, issuing drug prescriptions, keeping records of consultations, sending referral letters to medical specialists, receiving alerts or prompts about a potential problem with drug dose or drug interaction, sending prescriptions to the pharmacy		Immunisation, health promotion, routine checks of chronically ill patients, minor procedures, health check-ups, home visits

Country	Are there any arrangement in place to see a primary care physician or nurse when the practices are closed?	If yes, individual primary care physicians available for their own patients	If yes, group of primary care physicians available on a rota basis	If yes, primary care centres (minor injury units, urgent care centres)	If yes, general practitioner cooperatives	If yes, other arrangements are available	Do a large majority (>75%) of primary care physicians use a computer?	If yes, they use a computer for:	A majority (>50%) of primary care physicians offer patients the option to:	Do a large majority (>75%) of nurses or assistants independently provide:
						care when the clinic is closed				
Bolivia	No						Yes	Making appointments, keeping records of consultations, sending referral letters to medical specialists, storing diagnostic test results, sending prescriptions to the pharmacy		Immunisation, health promotion, routine checks of chronically ill patients, minor procedures
Brazil										
Chile	Yes			Yes			Yes	Making appointments, ordering laboratory tests, issuing drug prescriptions, keeping records of consultations, sending referral letters to medical specialists, storing diagnostic test results, sending prescriptions to the pharmacy		Immunisation, health promotion, routine checks of chronically ill patients, minor procedures

Country	Are there any arrangement in place to see a primary care physician or nurse when the practices are closed?	If yes, individual primary care physicians available for their own patients	If yes, group of primary care physicians available on a rota basis	If yes, primary care centres (minor injury units, urgent care centres)	If yes, general practitioner cooperatives	If yes, other arrangements are available	Do a large majority (>75%) of primary care physicians use a computer?	If yes, they use a computer for:	A majority (>50%) of primary care physicians offer patients the option to:	Do a large majority (>75%) of nurses or assistants independently provide:
Colombia	Yes			Yes			Yes	Keeping records of consultations		Immunisation, health promotion, minor procedures, health check-ups
Costa Rica	Yes			Yes			Yes	Making appointments, ordering laboratory tests, issuing drug prescriptions, keeping records of consultations, sending referral letters to medical specialists, storing diagnostic test results, receiving alerts or prompts about a potential problem with drug dose or drug interaction, sending prescriptions to the pharmacy	View online, download, or transmit information from their medical record	Immunisation, health promotion, routine checks of chronically ill patients, minor procedures, home visits
Dominican Republic	No						No			Immunisation, health promotion, routine checks of chronically ill patients, minor procedures, health check-ups

Country	Are there any arrangement in place to see a primary care physician or nurse when the practices are closed?	If yes, individual primary care physicians available for their own patients	If yes, group of primary care physicians available on a rota basis	If yes, primary care centres (minor injury units, urgent care centres)	If yes, general practitioner cooperatives	If yes, other arrangements are available	Do a large majority (>75%) of primary care physicians use a computer?	If yes, they use a computer for:	A majority (>50%) of primary care physicians offer patients the option to:	Do a large majority (>75%) of nurses or assistants independently provide:
Ecuador	Yes			Yes			Yes	Ordering laboratory tests, issuing drug prescriptions, keeping records of consultations, receiving alerts or prompts about a potential problem with drug dose or drug interaction, sending prescriptions to the pharmacy		Immunisation, routine checks of chronically ill patients, minor procedures
El Salvador	Yes			Yes			No			Immunisation, health promotion, routine checks of chronically ill patients, minor procedures
Guatemala	No						No			Immunisation, health promotion, routine checks of chronically ill patients, minor procedures, home visits
Guyana	Yes	Yes	Yes		Yes		No			Immunisation, health promotion, minor procedures, home visits
Honduras	No						No			Immunisation, health promotion, minor procedures
Jamaica	No									Immunisation, health promotion, routine checks of chronically ill patients, home visits

Country	Are there any arrangement in place to see a primary care physician or nurse when the practices are closed?	If yes, individual primary care physicians available for their own patients	If yes, group of primary care physicians available on a rota basis	If yes, primary care centres (minor injury units, urgent care centres)	If yes, general practitioner cooperatives	If yes, other arrangements are available	Do a large majority (>75%) of primary care physicians use a computer?	If yes, they use a computer for:	A majority (>50%) of primary care physicians offer patients the option to:	Do a large majority (>75%) of nurses or assistants independently provide:
Mexico	No						No			Immunisation, health promotion
Panama	Yes		Yes	Yes			Yes	Making appointments, issuing drug prescriptions, keeping records of consultations, sending referral letters to medical specialists, sending prescriptions to the pharmacy		Immunisation, health promotion, routine checks of chronically ill patients, minor procedures, home visits
Paraguay	No						No			Immunisation, health promotion, minor procedures
Peru	No						No			Immunisation, health promotion, minor procedures, home visits
Suriname	Yes	Yes	Yes	Yes			No			Immunisation, health promotion, routine checks of chronically ill patients, minor procedures, health check-ups, home visits
Trinidad and Tobago	Yes			Yes	Yes	yes, solo type arrangements	No			Immunisation, health promotion, routine checks of chronically ill patients, minor procedures, health check-ups

Country	Are there any arrangement in place to see a primary care physician or nurse when the practices are closed?	If yes, individual primary care physicians available for their own patients	If yes, group of primary care physicians available on a rota basis	If yes, primary care centres (minor injury units, urgent care centres)	If yes, general practitioner cooperatives	If yes, other arrangements are available	Do a large majority (>75%) of primary care physicians use a computer?	If yes, they use a computer for:	A majority (>50%) of primary care physicians offer patients the option to:	Do a large majority (>75%) of nurses or assistants independently provide:
Uruguay	Yes			Yes			Yes	Making appointments, ordering laboratory tests, issuing drug prescriptions, storing diagnostic test results		Immunisation

3.3. Governance and resource allocation

44. This section will focus on aspects of governance, which pertain to more "general" features of health systems, i.e. overarching responsibilities over health systems, including public participation and patients' rights as well as the role of health technology assessment and quality of care policies and on the responsibilities and authorities of health system stakeholders.

45. The survey intended to collect a minimum set of information on the effective use of health technology assessment in decision making. Thirteen countries – Argentina, Belize, Brazil, Chile, Costa Rica, Ecuador, El Salvador, Guyana, Jamaica, Mexico, Peru, Trinidad and Tobago and Uruguay - reported to carry out HTA, mainly in the public sector (Table 3.14). The main purchaser performs HTA at central level in eleven countries, while only in four country an independent body is responsible to carry out HTA at central level.

Table 3.14. Use of HTA

Who performs HTA						
Country	**Is HTA carried out in your country?**	**If HTAs are carried out, in what sectors do they take place?**	**An independent body is responsible for HTA in the health sector at central level**	**Main purchasers (health insurance, government) perform HTA at central level**	**Main purchasers (health insurers, governments) perform HTA at local level to inform their decisions**	**Several independent bodies perform HTA at the request of purchasers' or providers' groups**
Argentina	Yes	Public sector, universities - research institutions, private sector		Yes		Yes
Belize	Yes	Public sector		Yes		
Bolivia	No					

Who performs HTA						
Country	**Is HTA carried out in your country?**	**If HTAs are carried out, in what sectors do they take place?**	**An independent body is responsible for HTA in the health sector at central level**	**Main purchasers (health insurance, government) perform HTA at central level**	**Main purchasers (health insurers, governments) perform HTA at local level to inform their decisions**	**Several independent bodies perform HTA at the request of purchasers' or providers' groups**
Brazil	Yes	Public sector	Yes			
Chile	Yes			Yes		
Colombia	Yes	Public sector, universities - research institutions, private sector	Yes			
Costa Rica	Yes			Yes		
Dominican Republic	No	No				
Ecuador	Yes	Public sector		Yes		
El Salvador	Yes	Public sector		Yes		

Who performs HTA						
Country	**Is HTA carried out in your country?**	**If HTAs are carried out, in what sectors do they take place?**	**An independent body is responsible for HTA in the health sector at central level**	**Main purchasers (health insurance, government) perform HTA at central level**	**Main purchasers (health insurers, governments) perform HTA at local level to inform their decisions**	**Several independent bodies perform HTA at the request of purchasers' or providers' groups**
Guatemala	No					
Guyana	Yes	Public sector, universities - research institutions, private sector	Yes			
Honduras	No					
Jamaica	Yes	Public sector			Yes	
Mexico	Yes	Public sector, private sector		Yes		
Panama	No					
Paraguay	Yes	Universities - research institutions, private sector	Yes	Yes		

Who performs HTA						
Country	**Is HTA carried out in your country?**	**If HTAs are carried out, in what sectors do they take place?**	**An independent body is responsible for HTA in the health sector at central level**	**Main purchasers (health insurance, government) perform HTA at central level**	**Main purchasers (health insurers, governments) perform HTA at local level to inform their decisions**	**Several independent bodies perform HTA at the request of purchasers' or providers' groups**
Peru	Yes	Public sector, private sector		Yes		
Suriname	No					
Trinidad and Tobago	Yes	Public sector, private sector		Yes		
Uruguay	Yes	Public sector		Yes		

46. A few LAC countries use HTA systematically to make coverage decisions and no country reported to use HTA to determine reimbursement level (i.e. price) (Table 3.15). Contrary to this picture, an increasing number of OECD countries use HTA to provide scientific and technical evidence related to new medical technologies during assessment and decision-making processes. However, its use and systematic application varies across countries and technologies. While 19 OECD countries reported a systematic use of HTA in order to decide whether a new medicine should be covered, only nine OECD countries did so for decisions pertaining to new medical procedures, and eight for new medical devices. Only 10 countries use HTA to inform coverage for all technologies, either systematically or only in some circumstances (Auraaen *et al.* 2016).

Table 3.15. Countries using HTA systematically or occasionally to make coverage decisions or set reimbursement level

Type of technology	Use of HTA to make decisions	Countries
Medical procedures	Systematically used to make coverage decisions	Brazil, Trinidad and Tobago, Uruguay
	Used in some circumstances to make coverage decisions	Argentina, Belize, Chile, Colombia, Guyana, Mexico, Paraguay
	Used to determine reimbursement level	
Pharmaceuticals	Systematically used to make coverage decisions	Belize, Jamaica, Mexico, Paraguay, Uruguay
	Used in some circumstances to make coverage decisions	Argentina, Brazil, Chile, Costa Rica, El Salvador, Guyana, Peru
	Used to determine reimbursement level	
Implantable medical devices	Systematically used to make coverage decisions	Brazil, Trinidad and Tobago, Uruguay
	Used in some circumstances to make coverage decisions	Argentina, Chile, Colombia, Costa Rica, Mexico, Paraguay
	Used to determine reimbursement level	

47. One third of LAC countries use HTA to establish practice guidelines, whereas only Argentina and Peru reported the use of HTA to determine the objectives of P4P schemes. Around half of the countries use HTA to support the design of public health policies (Table 3.16).

Table 3.16. Circumstances in which HTA is used

Circumstances	Countries
To establish practice guidelines for health professionals	Argentina, Belize, Brazil, Chile, Mexico, Paraguay, Peru, Uruguay
To determine objectives for pay-for-performance schemes	Argentina, Peru
To support the design of public health policies	Argentina, Belize, Brazil, Colombia, El Salvador, Mexico, Paraguay, Peru, Trinidad and Tobago, Uruguay

48. The survey intended to collect a minimum set of information on patient rights and citizens' or patient representatives' involvement in the decision making process. In a large part of reporting countries (16 of 21), there is a formal definition of patients' rights at the national level (Table 3.17).

Table 3.17. Patient rights and involvement

Country	Is there a formal definition of patients' rights at the national level?	If yes, please provide a web link to the charter	If yes, which institution(s) is responsible for handling reported violations against the patient's charter?
Argentina	Yes	http://servicios.infoleg.gob.ar/infolegInternet/anexos/160000-164999/160432/norma.htm y	En la jurisdicción Nacional el Ministerio de Salud y Desarrollo Social y en cada una de las jurisdicciones provinciales y Ciudad Autónoma de Buenos Aires, la máxima autoridad sanitaria local.

Country	Is there a formal definition of patients' rights at the national level?	If yes, please provide a web link to the charter	If yes, which institution(s) is responsible for handling reported violations against the patient's charter?
		http://servicios.infoleg.gob.ar/infolegInternet/anexos/195000-199999/199296/norma.htm	
Belize	Yes		Ministry of Health
Bolivia	No		
Brazil	Yes	http://conselho.saude.gov.br/biblioteca/livros/carta5.pdf	The Judiciary Branch
Chile	Yes	http://www.bcn.cl/guias/derechos-deberes-pacientes	Superintendencia de Salud
Colombia	Yes	https://www.minsalud.gov.co/salud/CAS/Paginas/Carta-de-derechos-y-deberes-y-carta-de-desempe%C3%B1o-del-afiliado-al-sistema-de-salud.aspx	Superintendencia Nacional de Salud
Costa Rica	Yes	Ley Nº 8239 Derechos y deberes de las personas usuarias de los servicios de salud públicos y privados. (Law N° 8239. Act for Rights and Duties of users of public and private health services): http://www.pgrweb.go.cr/scij/Busqueda/Normativa/Normas/nrm_texto_completo.aspx?param1=NRTC&nValor1=1&nValor2=48278&nValor3=51401&strTipM=TC	The national legislation states that all health services must have a "Services Comptroller" which must give assistance and investigate any complaint of patients. http://www.ccss.sa.cr/contraloria. A "General Audit of Health Services Office" was created within the MoH responsible for monitoring and supervising the work of "Comptrollers". Patients may also turn to the Office of the Ombudsman to report any violation of their basic human rights: www.dhr.go.cr/ The Constitutional Court has also responsibilities to ensure the right to health. http://sitios.poder-judicial.go.cr/salaconstitucional/historia.htm.
Dominican Republic	No		
Ecuador	Yes		
El Salvador	Yes	http://www.salud.gob.sv/cartas-de-derechos/	La Oficina por el Drecho a la Salud, del Ministerio de Salud y el Consejo Superior de Salud Pública de El Salvador
Guatemala	No		
Guyana	Yes		
Honduras	No		

Country	Is there a formal definition of patients' rights at the national level?	If yes, please provide a web link to the charter	If yes, which institution(s) is responsible for handling reported violations against the patient's charter?
Jamaica	Yes	Not uploaded on the MoH website	
Mexico	Yes	http://www.conamed.gob.mx/comisiones_estatales/coesamed_nayarit/publicaciones/pdf/carta_derechos.pdf	CONAMED
Panama	Yes		
Paraguay	Yes	www.mspbs.gov.py - Ministerio de Salud Pública y Bienestar Social	Ministerio de Salud Pública y Bienestar Social en forma conjunta con el Ministerio Público y la Defensoria del Pueblo
Peru	Yes		
Suriname	No		
Trinidad and Tobago	Yes		Department of Technical Medical Services, Ministry of Health
Uruguay	Yes	http://www.msp.gub.uy/sites/default/files/18.335.pdf	Ministerio de Salud Pública

4. Discussion

49. This paper provides a snapshot of an important set of information on health systems characteristics as reported by 21 Latin American and Caribbean countries in 2018. The information is collected through the OECD Health System Characteristics Survey. This OECD survey has collected similar institutional characteristics of OECD health systems in three waves, 2008, 2012 and 2016. Based on these survey responses, the OECD also developed a methodology to map changes in institutional characteristics and measure their impact on health system efficiency over time (Lorenzoni *et al.* 2018).

50. In collaboration with the IDB, the OECD collected descriptive information on the characteristics of LAC health systems' financing and coverage arrangements, care delivery, governance and resource allocation. To our knowledge, this set of information is unique in scope. Though this information does not allow all specificities of complex health systems to be addressed, it helps identifying similarities and differences in their institutional setting and forms the basis for future analytic work.

51. While responses to this survey confirm the considerable level of fragmentation of coverage and financing structures that exists across LAC health systems, they also provide a level of descriptive detail that was previously unavailable in the region. Where most OECD health systems provide basic primary health care coverage to the entire population, few LAC countries do the same. About half of the responding countries already provide or are making considerable movements towards providing residence-based coverage to their population, with the remainder countries providing a set of different insurance coverage schemes. Private health insurance plays an important role when it comes to secondary coverage. All responding countries except Bolivia, Costa Rica, Mexico and Panama report that private health insurance serves as a secondary source of coverage for their population.

52. When coverage is not provided automatically, all responding countries with the exception of Guatemala and Paraguay, report having policies in place ensuring access to care for disadvantaged groups or people with specific health needs. Similar to the OECD, most LAC countries have mechanisms protecting vulnerable populations from excessive out-of-pocket payments and catastrophic health spending. Most often, these mechanisms include total or partial exemption from out-of-pocket payments for people of low-income. In contrast to many OECD countries, only a few responding countries have financial protection policies in place for other population groups, for example seniors, pregnant women and children. As a result, the lack of policies in place protecting households with young children and elderly may represent a barrier to accessing health services.

53. Primary care is predominantly delivered in public clinics, which is similar to what is reported for the majority of OECD countries. By contrast, large part responding LAC countries report that there is no need/incentive for patients to register with a primary care physician. Nevertheless, in 13 out of 20 responding countries, primary care physicians control the access to specialist care. People are therefore obliged to consult a primary care physician to obtain a referral to access specialist care in most of the responding LAC

countries. This fragmentation across levels of care and providers may also result in an inappropriate use of hospital emergency department for conditions treatable in a primary care setting (Macinko *et al.* 2016).

54. Nearly all LAC countries have a combination of private for –profit, non-profit and public hospital providing acute care to the population. Publicly owned hospitals are remunerated by global, prospective budgets, while non-for-profit and for-profit hospitals are remunerated based on procedures provided. In contrast to OECD countries, hospital DRG-based payments are used only in two countries: Chile for non-for-profit hospitals and Guatemala for for-profit hospitals.

55. Contrary to common practice in OECD countries, there is a limited use of incentives linked to quality of care delivered within the LAC health systems. Seven countries report using bonuses linked to primary care physicians' participation in care programmes or reaching specific targets. Among those countries, most programmes are related to preventive care and chronic disease management. It is less common for countries to have quality programmes targeting specialist care. Five countries report the use of incentives for specialists, mainly linked to preventive care, management of chronic diseases and uptake of IT. Only Chile and Paraguay reported incentives to hospitals linked to patient satisfaction and patient experiences with care.

56. In OECD countries, the range of benefits publicly covered is usually defined following a two-step process. First, a body assesses the technology in terms of a set of criteria including clinical and economic and, in some cases, societal factors. In some cases, the body in charge of conducting the health technology assessment issues a recommendation, upon which a second body funds a coverage decision (Auraaen *et al.* 2016). Based on the survey responses, the definition of the range of benefits publicly covered appear to be less clear in the LAC countries. HTA is carried out in half of the responding countries, and its scope and coverage of assessment varies significantly across countries. Similar to the majority of OECD countries, HTAs are most often centralised in LAC countries. However, contrary to OECD countries, only a few LAC countries use HTA systematically to make coverage decisions and no country reported to use HTA to determine reimbursement level.

57. There is an OECD move towards making health systems more people-centred. Although this move is mainly targeting the people's experience when encountering the health system as patients, it may also include the extent to which people are consulted in decision processes related to health system governance. In a large part of LAC reporting countries, there is a formal definition of patients' rights at the national level. When it comes to patient's participation in decision concerning health system governance, the picture is more fragmented. For the most part, patients' opinion weighs in health technology assessments, but also decisions related to service planning and definition of public health objectives. As outlined above, the role of patients in making decision around coverage or reimbursement arrangements is less common in LAC countries.

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Annex A. Additional summary tables

58. Basic (primary) health coverage is available to the vast majority of residents of LAC countries (Table 5.1). Only Costa Rica, Mexico and Panama reported that 5.3% of the population is not insured. In Argentina, Belize, Panama and Trinidad and Tobago all the population is covered by a national health system, whereas in Suriname all the population is covered by compulsory health insurance. Voluntary health insurance coverage plays a major role in Peru, Mexico, Uruguay and Brazil.

Table 5.1. Characteristics of basic primary health coverage

Country	Automatic coverage	Compulsory Insurance coverage	Voluntary coverage	Not insured
Argentina	100	56.9	5.1	
Belize	100	33		
Bolivia	14.1	38.2	1.4	
Brazil	70		23	
Chile	18.4	56.8		
Colombia	45.7	48.7		
Costa Rica		94.7		5.3
Dominican Republic	26.3	70	3.3	
Ecuador	60.6	40.3	9.4	
El Salvador	72	27	1	
Guatemala	47.2	12.7	2	
Guyana	90		10	
Honduras	60	18.3	10	
Jamaica	50			
Mexico		46	37	17
Panama		70		30
Paraguay				
Peru		30.6	69.3	
Suriname		100		
Trinidad and Tobago	100			
Uruguay		73.2	26.8	

59. There is a large body of literature on the respective advantages of competing health insurance schemes versus single payer systems. For example, regulated competition in health insurance markets has the potential of producing efficiency gains and improve the quality of care provided if insurers have the ability to differentiate their products and consumers have adequate information on the price and quality of these products. Half of the countries - Dominican Republic, El Salvador, Guatemala, Guyana, Jamaica, Paraguay, Peru, Trinidad and Tobago - report that health insurer are not required to enrol any applicant. People are generally allowed to switch insurer at any time, except for Argentina, Dominican Republic and Uruguay. Further details on consumer choice and competition between health insurers offering basic (primary) health care coverage are reported in Table 5.2 below.

Table 5.2. Further regulation of health insurance markets with competing providers

Country	Are health insurers/funds required to enrol any applicant?	Are health insurers/funds required to accept contract renewal for people they cover?	Are there limits to premium increases in the case of contract renewal?	Are there restrictions on switching?	What kind of information is available to individuals who are choosing among alternative health insurers/funds? Information on premiums	Is this information disclosed by:
Argentina	Yes			People are allowed to switch at set times/frequencies		Individual funds, private organisations, public authorities
Belize						
Bolivia	Yes				Benefits covered	Individual funds, public authorities
Brazil	Yes	Yes	Yes	People are allowed to switch insurers at any time	Premiums, benefits covered, performance	Private organisations, public authorities
Chile	Yes			People are allowed to switch insurers at any time	Premiums, benefits covered, performance	Individual funds, private organisations, public authorities
Colombia	Yes			People are allowed to switch insurers at any time	Performance	Public authorities
Costa Rica						
Dominican Republic	No	No	No	People are allowed to switch at set times/frequencies	Premiums, benefits covered	Individual funds, public authorities
Ecuador						

Country	Are health insurers/funds required to enrol any applicant?	Are health insurers/funds required to accept contract renewal for people they cover?	Are there limits to premium increases in the case of contract renewal?	Are there restrictions on switching?	What kind of information is available to individuals who are choosing among alternative health insurers/funds? Information on premiums	Is this information disclosed by:
El Salvador	No	Yes	Yes	People are allowed to switch insurers at any time	Premiums, benefits covered, performance	Private organisations, public authorities
Guatemala	No	No	No	People are allowed to switch at set times/frequencies	Premiums	Individual funds
Guyana	No	No	No	People are allowed to switch insurers at any time	Premiums, benefits covered, performance	Individual funds, private organisations
Honduras						
Jamaica	No	No	No		Premiums, benefits covered	Private organisations
Mexico						
Panama	Yes	Yes	Yes	People are allowed to switch insurers at any time	Premiums, benefits covered, performance	Private organisations
Paraguay	No	No	No	People are allowed to switch insurers at any time	Premiums, benefits covered, performance	Private organisations
Peru	No	No	No	People are allowed to switch insurers at any time	Premiums, benefits covered	Individual funds
Suriname	Yes	Yes	Yes	People are allowed to switch insurers at any time	Premiums, benefits covered	Individual funds
Trinidad and Tobago	No	No	No	People are allowed to switch insurers at any time	Benefits covered	
Uruguay	Yes	Yes		People are allowed to switch at set times/frequencies	Performance	Public authorities

60. Market structure is another important feature for competition among health insurance plans. As already mentioned in the introduction, the LAC countries differ considerably in the number of insurance plans a consumer typically faces. While six countries, including Argentina, Bolivia and Colombia, report having 1-2 plans, another seven countries, including Brazil, Chile and Peru, report that the average consumer can choose among more than five plans (Table 5.3). The

health insurance market appears to be not concentrated – that is competitive - in all reporting countries except Chile and Suriname where the top insurance company covers three fourth of the population.

Table 5.3. Share of the primary health insurance market by number of insurance companies

		Share of the basic health insurance market covered by:							
Country	A customer has how many choices of health insurance plans?	Top insurance company - % market	Top insurance company - % population	Top 3 insurance companies - % market	Top 3 insurance companies - % population	Top 5 insurance companies - % market	Top 5 insurance companies - % population	Top 10 insurance companies - % market	Top 10 insurance companies - % population
Argentina	1-2	16.3	10.4	29.9	19.1	35.4	22.6		
Belize	3-5			25	15				
Bolivia	1-2	9.1	28.6	27.2	34.4	45.4	36.3	90.9	38.1
Brazil	More than 5	7.4	1.7	19	4.4	27	6.23	37	8.5
Chile	More than 5	69.9	75.2	81.4	82.6	91.6	89.4	99.8	93.5
Colombia	1-2	11.2	7.3	24	20.4	35.1	31.6	56.2	52.2
Costa Rica									
Dominican Republic	More than 5	31.1	39.2	73.9	57.2	86.9	62.8	94.8	6.5
Ecuador									
El Salvador	More than 5								
Guatemala	1-2	18.3	13			22	15		
Guyana	3-5	5	5			20	20		
Honduras	More than 5								
Jamaica		85	16.1						
Mexico									
Panama	More than 5	17.4		38		55		63	
Paraguay									

		Share of the basic health insurance market covered by:							
Country	A customer has how many choices of health insurance plans?	Top insurance company - % market	Top insurance company - % population	Top 3 insurance companies - % market	Top 3 insurance companies - % population	Top 5 insurance companies - % market	Top 5 insurance companies - % population	Top 10 insurance companies - % market	Top 10 insurance companies - % population
Peru	More than 5							100	8
Suriname	1-2		75						
Trinidad and Tobago	3-5					10	15		
Uruguay	1-2								

61. The share of the market owned by private for profit health insurers is significant (> 90 %) in Colombia, Jamaica and Peru (**Table 5.4**). In 14 of 16 reporting countries, health insurers require prior authorisation to seek care and offer plans with restricted network of providers. In 10 of 14 countries, insurers offer plans that mandate care coordination, whereas in 11 of 15 countries plans offer several options for cost sharing. Financial rewards are not common among health insurance plans in LAC countries.

Table 5.4. Structure of the primary health insurance market

	Share of the market insured by:				Are health insurers allowed to:				
Country	Not-for-profit insurers (public or private) - % market	Not-for-profit insurers (public or private) - % population	Private for-profit insurers - % market	Private for-profit insurers - % population	Require prior authorisation	Offer plans with restricted network of providers	Offer plans requiring specific care pathways	Offer several options of cost sharing	Offer financial rewards
Argentina	46.4	72.6	15.7	24.5	yes	yes	yes	yes	no
Belize		33		15	yes	yes	yes	yes	no
Bolivia	90.9	38.1	9.1	1.4	no	no	no	no	no
Brazil	77.3	77.3	22.3	22.3	yes	no	no	yes	no
Chile	69.9	75.2				yes		yes	

	Share of the market insured by:				Are health insurers allowed to:				
Country	Not-for-profit insurers (public or private) - % market	Not-for-profit insurers (public or private) - % population	Private for-profit insurers - % market	Private for-profit insurers - % population	Require prior authorisation	Offer plans with restricted network of providers	Offer plans requiring specific care pathways	Offer several options of cost sharing	Offer financial rewards
Colombia	6.4	6.6	93.5	93.4	no	yes	no	no	no
Costa Rica									
Dominican Republic	36.6	41.7	63.3	27.5	yes	yes	no	no	no
Ecuador									
El Salvador				1	yes	yes	yes	yes	yes
Guatemala	18.3	13	4	2	yes	yes	yes	yes	no
Guyana	60	60	20	20	yes	yes	yes	yes	yes
Honduras		18.3		10	yes	yes	yes	yes	no
Jamaica			100	18.9	yes	yes			
Mexico									
Panama			21	50	yes	yes	yes	yes	no
Paraguay					yes	yes	yes	yes	yes
Peru			100	8	yes	yes	yes	yes	
Suriname	37		22		yes				
Trinidad and Tobago			10	15	yes	yes	yes	yes	
Uruguay									

62. Coverage of functions of care by basic primary health coverage can be found in Table 5.5 below. There is no general deductible – the lump sum threshold below which an insured person must pay out-of-pocket for health care before insurance coverage begins - in all reporting countries except Guatemala and Guyana. In Bolivia, Costa Rica, Honduras, Mexico and Paraguay there is no cost sharing for acute inpatient care, primary care physicians and specialists contacts, clinical laboratory tests and diagnostic imaging, pharmaceuticals and dental care, whereas in Guyana cost sharing is required only for health goods and services provided by the private sector.

63. Generally, in LAC countries inpatient acute and outpatient primary and specialist care are covered or reimbursed at a higher level than pharmaceuticals, dental care or laboratory tests and diagnostic imagining.

Table 5.5. Coverage of functions of care by basic primary health coverage

Country	Is there a general deductible that must be met?	If yes, amount of the deductible that must be met before basic primary health coverage pays/reimburses? (national currency units)	If yes, period in which the deductible applies	Are patients required to share the costs of acute inpatient care	Are patients required to share the costs of outpatient primary care physician contacts	Are patients required to share the costs of outpatient specialist contacts	Are patients required to share the costs of clinical laboratory tests	Are patients required to share the costs of diagnostic imaging	Are patients required to share the costs of pharmaceuticals	Are patients required to share the costs of dental care	Are patients required to share the costs of dental prostheses	For outpatient primary care physician contacts, do people usually:
Argentina	No			Depends on health insurer and plan	Depends on health insurer and plan	Depends on health insurer and plan	Depends on health insurer and plan	Depends on health insurer and plan	Depends on health insurer and plan	Depends on health insurer and plan		Receive free services at the point of care (public hospitals and health centers)
Belize	No			Yes	No	Yes	Yes	Yes	No	Yes		Receive free services at the point of care
Bolivia	No			No	No	No	No	No	No	No		Receive free services at the point of care
Brazil												Receive free services at the point of care

Country	Is there a general deductible that must be met?	If yes, amount of the deductible that must be met before basic primary health coverage pays/reimburses? (national currency units)	If yes, period in which the deductible applies	Are patients required to share the costs of acute inpatient care	Are patients required to share the costs of outpatient primary care physician contacts	Are patients required to share the costs of outpatient specialist contacts	Are patients required to share the costs of clinical laboratory tests	Are patients required to share the costs of diagnostic imaging	Are patients required to share the costs of pharmaceuticals	Are patients required to share the costs of dental care	Are patients required to share the costs of dental prostheses	For outpatient primary care physician contacts, do people usually:
Chile	No			Cost sharing ranges from 10% to 50%, depending on health insurer and chosen coverage plan.	Depending on health insurer, visits are either free of charge, or cost sharing is around 39% (average in 2010).	Depending on health insurer and chosen coverage plan, cost sharing ranges from 10% to 50%.	Patients publicly insured with a restricted access to public provides have a maximum co-insurance of 20% while patients publicly insured with free choice of provider and privately insured have a maximum co-insurance of 50%.	Patients publicly insured with a restricted access to public provides have a maximum co-insurance of 20% while patients publicly insured with free choice of provider and privately insured have a maximum co-insurance of 50%.	Publicly insured patients with a plan with access restricted to public providers have no cost-sharing. Publicly insured with free choice of provider and privately insured have no coverage for medicines cost unless the medicine is included in the Explicit Guarantee program, in which case cost-sharing is limited to 50%.	Depends on insurance fund Fonasa public/ free choice and Isapres.	Depends on insurance fund Fonasa public/ free choice and Isapres.	Receive free services at the point of care
Colombia	No			Cost sharing varies depending on income	Ticket for low complexity and non-emergency services	Ticket for low complexity and non-emergency services	Ticket for low complexity and non-emergency services	Ticket for low complexity and non-emergency services	Ticket for low complexity and non-emergency services	Ticket for low complexity and non-emergency services		Pay only user fees or co-payments (where applicable)
Costa Rica	No			No	No	No	No	No	No	Not covered		Receive free services at the point of care

Country	Is there a general deductible that must be met?	If yes, amount of the deductible that must be met before basic primary health coverage pays/reimburses? (national currency units)	If yes, period in which the deductible applies	Are patients required to share the costs of acute inpatient care	Are patients required to share the costs of outpatient primary care physician contacts	Are patients required to share the costs of outpatient specialist contacts	Are patients required to share the costs of clinical laboratory tests	Are patients required to share the costs of diagnostic imaging	Are patients required to share the costs of pharmaceuticals	Are patients required to share the costs of dental care	Are patients required to share the costs of dental prostheses	For outpatient primary care physician contacts, do people usually:
Dominican Republic	No			Unlimited consumption of services; 15% of the service price is covered by the patient. There are no shared costs for affiliates of the Subsidized Regime of Family Health Insurance.	Only patients of the subsidize regime of the Family Health insurance have access to primary care physician contacts and there are no shared costs. People with affiliation to other regimes have to get attention of specialists.	The health insurance pays a fixed amount of DOP$300 since 2007. The rest of the costs of consults shall be paid by the patient. There are no shared costs for affiliates of the Subsidize Regime of Family Health Insurance.	Unlimited consumption of services; 20% of shared costs. There are no shared costs for affiliates of the Subsidize Regime of Family Health Insurance.	Unlimited consumption of services; 20% of shared costs. Fixed amount of DOP$8,000 yearly; 30% of shared costs. There are no shared costs for affiliates of the Subsidize Regime of Family Health Insurance.	Fixed amount of DOP$8,000 yearly; 30% of shared costs. There are no shared costs for affiliates of the Subsidize Regime of Family Health Insurance.	Unlimited consumption of services; 20% of shared costs.		Receive free services at the point of care
Ecuador	No											Receive free services at the point of care
El Salvador	No			No	No	No	No	No	No	No	No	Receive free services at the point of care
Guatemala	Yes	5	Episode of illness	No cost-sharing	No cost-sharing	No cost-sharing	Yes	Yes	Yes	No cost-sharing		Receive free services at the point of care
Guyana	Yes			In private sector	In private sector	In private sector	In private sector	In private sector	In private sector	In private sector		Receive free services at the point of care

Country	Is there a general deductible that must be met?	If yes, amount of the deductible that must be met before basic primary health coverage pays/reimburses? (national currency units)	If yes, period in which the deductible applies	Are patients required to share the costs of acute inpatient care	Are patients required to share the costs of outpatient primary care physician contacts	Are patients required to share the costs of outpatient specialist contacts	Are patients required to share the costs of clinical laboratory tests	Are patients required to share the costs of diagnostic imaging	Are patients required to share the costs of pharmaceuticals	Are patients required to share the costs of dental care	Are patients required to share the costs of dental prostheses	For outpatient primary care physician contacts, do people usually:
Honduras	No			No cost-sharing	No cost-sharing	No cost-sharing	No cost-sharing	No cost-sharing	No cost-sharing	No cost-sharing		Receive free services at the point of care
Jamaica	No											Receive free services at the point of care
Mexico	No			No	No	No	No	No	No	No		Receive free services at the point of care
Panama	No											Pay only user fees or co-payments (where applicable)
Paraguay	No			No	No	No	No	No	No	No		Receive free services at the point of care
Peru	No						Yes	Yes	Yes	Yes		Receive free services at the point of care
Suriname	No											Pay only user fees or co-payments

Country	Is there a general deductible that must be met?	If yes, amount of the deductible that must be met before basic primary health coverage pays/reimburses? (national currency units)	If yes, period in which the deductible applies	Are patients required to share the costs of acute inpatient care	Are patients required to share the costs of outpatient primary care physician contacts	Are patients required to share the costs of outpatient specialist contacts	Are patients required to share the costs of clinical laboratory tests	Are patients required to share the costs of diagnostic imaging	Are patients required to share the costs of pharmaceuticals	Are patients required to share the costs of dental care	Are patients required to share the costs of dental prostheses	For outpatient primary care physician contacts, do people usually:
												(where applicable)
Trinidad and Tobago	No		No	No	No	No	No	No	No	No		Receive free services at the point of care
Uruguay	No			No	Yes	Yes	Yes	Yes	Yes	Yes		Pay only user fees or co-payments (where applicable)

64. Most LAC countries have introduced policies to protect patients from excessive co-payments and catastrophic expenditure for health, to guarantee access to care to some disadvantaged categories or to promote public health objectives (Table 5.6). Mechanisms to facilitate health care access for selected categories though co-payment reductions or exemptions are shown in the tables below. People with income under a designated threshold are the target of protective policies in a large part on LAC countries, whereas only a few countries report policies aimed at protecting seniors and children.

65. Many OECD countries have introduced mechanisms to facilitate health care access for low-income patients though co-payment reductions or exemptions. In nearly all OECD countries, children have no or reduced co-payments, as do pregnant women (Paris *et al.* 2016).

Table 5.6. Exemption from co-payments

A. Those with certain medical conditions or disabilities

Country	Are there exemptions?	Acute inpatient care	Outpatient primary care physician contacts	Outpatient specialist contacts	Clinical laboratory tests	Diagnostic imaging	Pharmaceuticals	Dental care	Dental prostheses
Argentina	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Belize	Yes		Total exemption	Partial exemption	Partial exemption	Total exemption	Total exemption	Total exemption	
Bolivia									
Brazil	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Chile	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	
Colombia	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Costa Rica									
Dominican Republic	No								
Ecuador									
El Salvador									

Country	Are there exemptions?	Acute inpatient care	Outpatient primary care physician contacts	Outpatient specialist contacts	Clinical laboratory tests	Diagnostic imaging	Pharmaceuticals	Dental care	Dental prostheses
Guatemala	No								
Guyana	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Partial exemption	Total exemption	Partial exemption	Partial exemption
Honduras									
Jamaica									
Mexico	No								
Panama	Yes								
Paraguay									
Peru	Yes				Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Suriname									
Trinidad and Tobago	Yes								
Uruguay	Yes	Total exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption		

B. Those with income under a designated threshold

Country	Are there exemptions?	Acute inpatient care	Outpatient primary care physician contacts	Outpatient specialist contacts	Clinical laboratory tests	Diagnostic imaging	Pharmaceuticals	Dental care	Dental prostheses
Argentina	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Partial exemption	Total exemption	
Belize	Yes	Partial exemption	Total exemption	Partial exemption	Total exemption	Partial exemption	Total exemption	Total exemption	
Bolivia									
Brazil	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Chile	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	
Colombia	Yes	Total exemption	Total exemption	Not relevant	Total exemption	Total exemption	Total exemption	Total exemption	
Costa Rica									
Dominican Republic	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Ecuador									
El Salvador									
Guatemala	No								

Country	Are there exemptions?	Acute inpatient care	Outpatient primary care physician contacts	Outpatient specialist contacts	Clinical laboratory tests	Diagnostic imaging	Pharmaceuticals	Dental care	Dental prostheses
Guyana	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Partial exemption	Total exemption	Partial exemption	Partial exemption
Honduras									
Jamaica									
Mexico	No								
Panama	Yes								
Paraguay									
Peru	Yes				Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Suriname									
Trinidad and Tobago	Yes								
Uruguay	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption		

C. Beneficiaries of social benefits

Country	Are there exemptions?	Acute inpatient care	Outpatient primary care physician contacts	Outpatient specialist contacts	Clinical laboratory tests	Diagnostic imaging	Pharmaceuticals	Dental care	Dental prostheses
Argentina	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Partial exemption	Total exemption	
Belize	No								
Bolivia									
Brazil	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Chile	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	
Colombia	Yes	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption
Costa Rica									
Dominican Republic	No								
Ecuador									
El Salvador									

Country	Are there exemptions?	Acute inpatient care	Outpatient primary care physician contacts	Outpatient specialist contacts	Clinical laboratory tests	Diagnostic imaging	Pharmaceuticals	Dental care	Dental prostheses
Guatemala	No								
Guyana	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Partial exemption	Total exemption	Partial exemption	Partial exemption
Honduras									
Jamaica									
Mexico	No								
Panama	Yes								
Paraguay									
Peru	Yes				Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Suriname									
Trinidad and Tobago	Yes								
Uruguay	No								

D. Seniors

Country	Are there exemptions?	Acute inpatient care	Outpatient primary care physician contacts	Outpatient specialist contacts	Clinical laboratory tests	Diagnostic imaging	Pharmaceuticals	Dental care	Dental prostheses
Argentina	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Belize	Yes	Partial exemption	Total exemption	Partial exemption					
Bolivia									
Brazil	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Chile	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	
Colombia	Yes	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption
Costa Rica									
Dominican Republic	No								
Ecuador									
El Salvador									
Guatemala	No								

Country	Are there exemptions?	Acute inpatient care	Outpatient primary care physician contacts	Outpatient specialist contacts	Clinical laboratory tests	Diagnostic imaging	Pharmaceuticals	Dental care	Dental prostheses
Guyana	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Partial exemption	Total exemption	Partial exemption	Partial exemption
Honduras									
Jamaica									
Mexico	No								
Panama	No								
Paraguay									
Peru	Yes				Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Suriname									
Trinidad and Tobago	Yes								
Uruguay	Yes	Total exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Not relevant

E. Children

Country	Are there exemptions?	Acute inpatient care	Outpatient primary care physician contacts	Outpatient specialist contacts	Clinical laboratory tests	Diagnostic imaging	Pharmaceuticals	Dental care	Dental prostheses
Argentina	Yes								
Belize	Yes	Partial exemption	Total exemption	Partial exemption	Partial exemption	Partial exemption	Total exemption	Total exemption	
Bolivia									
Brazil	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Chile	Yes		Total exemption					Total exemption	
Colombia	Yes	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption
Costa Rica									
Dominican Republic	No								
Ecuador									
El Salvador									
Guatemala	No								

Country	Are there exemptions?	Acute inpatient care	Outpatient primary care physician contacts	Outpatient specialist contacts	Clinical laboratory tests	Diagnostic imaging	Pharmaceuticals	Dental care	Dental prostheses
Guyana	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Partial exemption	Total exemption	Partial exemption	Partial exemption
Honduras									
Jamaica									
Mexico	No								
Panama	Yes								
Paraguay									
Peru	Yes				Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Suriname									
Trinidad and Tobago	Yes								
Uruguay	Yes	Total exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	

F. Pregnant women

Country	Are there exemptions?	Acute inpatient care	Outpatient primary care physician contacts	Outpatient specialist contacts	Clinical laboratory tests	Diagnostic imaging	Pharmaceuticals	Dental care	Dental prostheses
Argentina	Yes								
Belize	Yes		Total exemption	Partial exemption	Total exemption	Total exemption	Total exemption	Total exemption	
Bolivia									
Brazil	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Chile	Yes		Total exemption					Total exemption	
Colombia	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption		
Costa Rica									
Dominican Republic	Yes								
Ecuador									
El Salvador									
Guatemala	No								

Country	Are there exemptions?	Acute inpatient care	Outpatient primary care physician contacts	Outpatient specialist contacts	Clinical laboratory tests	Diagnostic imaging	Pharmaceuticals	Dental care	Dental prostheses
Guyana	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Partial exemption	Total exemption	Partial exemption	Partial exemption
Honduras									
Jamaica									
Mexico	No								
Panama	Yes								
Paraguay									
Peru	Yes				Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Suriname									
Trinidad and Tobago	Yes								
Uruguay	Yes	Total exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	Partial exemption	

G. Those who have reached an upper limit (or cap) for out-of-pocket payments

Country	Are there exemptions?	Acute inpatient care	Outpatient primary care physician contacts	Outpatient specialist contacts	Clinical laboratory tests	Diagnostic imaging	Pharmaceuticals	Dental care	Dental prostheses
Argentina									
Belize	No								
Bolivia									
Brazil	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Chile	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Colombia	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Costa Rica									
Dominican Republic	Yes	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption	Total exemption
Ecuador									
El Salvador									
Guatemala	No								

Country	Are there exemptions?	Acute inpatient care	Outpatient primary care physician contacts	Outpatient specialist contacts	Clinical laboratory tests	Diagnostic imaging	Pharmaceuticals	Dental care	Dental prostheses
Guyana	Yes	Not relevant	Not relevant	Not relevant	Total exemption	Partial exemption	Total exemption	Partial exemption	Partial exemption
Honduras									
Jamaica									
Mexico	No								
Panama	No								
Paraguay									
Peru	No								
Suriname	Yes	Partial exemption			Partial exemption	Partial exemption		Partial exemption	Partial exemption
Trinidad and Tobago	No								
Uruguay	No								

66. Similarly to OECD countries, when the role of secondary source of insurance is “duplicative”, it is mainly for quicker access, expanded choice and choice of doctor (Table 5.7).

Table 5.7. Services covered in countries where duplicative coverage plays a significant role in primary health insurance

Country	Expanded coverage of non-medical services	Expanded choice	Quicker access	Choice of doctor	Lower co-payments	Financial benefits
Argentina	Yes	Yes	Yes			Yes
Belize				Yes	Yes	
Bolivia						
Brazil	Yes	Yes	Yes	Yes		
Chile						
Colombia		Yes	Yes	Yes		
Costa Rica						
Dominican Republic					Yes	
Ecuador		Yes	Yes			
El Salvador	Yes	Yes	Yes	Yes		
Guatemala						Yes
Guyana						
Honduras						
Jamaica		Yes	Yes	Yes		
Mexico						
Panama						
Paraguay	Yes	Yes	Yes	Yes		
Peru	Yes	Yes	Yes	Yes		
Suriname						
Trinidad and Tobago		Yes	Yes			
Uruguay	Yes		Yes	Yes		

67. The public/private mix in the provision of acute hospital care is reported in Table 5.8. In all LAC countries (except Costa Rica and Ecuador), care is provided by public owned and for-profit privately owned hospitals. Half of the LAC countries report that also non-for-profit hospitals provide acute care. Public hospitals are owned by the central government in fourteen countries, by the regional government in four countries and by the municipal government in two countries. In Costa Rica, public hospitals are owned by the social health insurance fund.

Table 5.8. Public/private mix in the provision of hospital acute care

	What is the status of hospitals delivering acute inpatient care?			
Country	**Publically owned hospitals**	**Not-for-profit privately owned hospitals**	**For-profit privately owned hospitals**	**Are public hospitals mainly owned by:**
Argentina	Yes	Yes	Yes	Regional government
Belize	Yes		Yes	Central government
Bolivia	Yes	Yes	Yes	Municipal government
Brazil	Yes	Yes	Yes	Municipal government
Chile	Yes	Yes	Yes	Central government
Colombia	Yes	Yes	Yes	Regional government
Costa Rica	Yes			Social health insurance funds
Dominican Republic	Yes	Yes	Yes	Central government
Ecuador	Yes			Central government
El Salvador	Yes	Yes	Yes	Central government
Guatemala	Yes	Yes	Yes	Central government
Guyana	Yes		Yes	Regional government
Honduras	Yes		Yes	Central government
Jamaica	Yes		Yes	Central government
Mexico	Yes		Yes	Regional government
Panama	Yes		Yes	Central government
Paraguay	Yes	Yes	Yes	Central government
Peru	Yes		Yes	Central and regional government
Suriname	Yes		Yes	Central government
Trinidad and Tobago	Yes		Yes	Central government
Uruguay	Yes	Yes	Yes	Central government

68. Patient choice among providers is a feature of competitive markets, usually considered to put downward pressure on prices and/or increase the quality of services provided. In ten countries – Chile, El Salvador, Guatemala, Guyana, Honduras, Jamaica, Panama, Paraguay, Suriname, Trinidad and Tobago - patients are not given any incentive to choose one primary care provider over another, while in seven countries – Brazil, Costa Rica, Dominican Republic, Mexico, Peru and Uruguay - the patient is assigned to a specific providers (Table 5.9). In Bolivia, Colombia and Ecuador the patient's choice is limited, whereas in Argentina patients have financial incentives to choose certain providers. In seven countries – Argentina, Colombia, Guatemala, Panama, Paraguay, Suriname and Uruguay - patients can choose the individual doctor within the practice.

69. In eight countries – Belize, Brazil, Chile, Costa Rica, Guyana, Mexico, Trinidad and Tobago and Uruguay - patients are assigned to a specific outpatient specialist, while in seven countries – Dominican Republic, El Salvador, Guatemala, Honduras, Jamaica, Panama and Paraguay - the patient do not face any incentive to choose one provider over another. In Bolivia, Colombia, Ecuador, Peru and Suriname the patient's choice is limited, whereas in Argentina patients have financial incentives to choose certain providers. In four countries – Argentina, Dominican Republic, Paraguay and Uruguay - patients can choose the individual specialist within the facility.

70. In eight countries – Dominican Republic, Guatemala, Guyana, Honduras, Jamaica, Panama, Paraguay and Trinidad and Tobago- patients can choose any hospital to seek care, while in the remaining countries patient's choice is limited..

Table 5.9. Patient choice among providers

Country	Are patients generally free to choose a primary care practice for primary care services?	Can the patient choose the individual doctor within the practice chosen or assigned to?	Are patients usually free to choose providers for outpatient specialist services?	Can the patient choose the individual doctor within the outpatient specialist service institution chosen or assigned to?	Are patient usually free to choose hospitals for in-patient care?	Can patients choose their individual doctor within the hospital?
Argentina	Patients can choose any primary care provider but have financial incentives to choose certain providers	Yes	Patients can choose any physician providing outpatient specialist services but have financial incentives to choose certain providers	Yes	The patient's choice is theoretically limited but may be expanded in certain circumstances	
Belize	The patient is assigned to a specific provider	No	The patient is assigned to a specific provider	No	The patient's choice is strictly limited with no exception	
Bolivia	The patient's choice is limited	Not relevant	The patient's choice is limited	Not relevant	The patient's choice is strictly limited with no exception	
Brazil	The patient is assigned to a specific provider	No	The patient is assigned to a specific provider	No	The patient's choice is theoretically limited but may be expanded in certain circumstances	
Chile	Patients are not given any incentive to choose one provider over another	No	The patient is assigned to a specific provider	No	The patient's choice is theoretically limited but may be expanded in certain circumstances	Usually not

Country	Are patients generally free to choose a primary care practice for primary care services?	Can the patient choose the individual doctor within the practice chosen or assigned to?	Are patients usually free to choose providers for outpatient specialist services?	Can the patient choose the individual doctor within the outpatient specialist service institution chosen or assigned to?	Are patient usually free to choose hospitals for in-patient care?	Can patients choose their individual doctor within the hospital?
Colombia	The patient's choice is limited	Yes	The patient's choice is limited	Not relevant	The patient's choice is strictly limited with no exception	
Costa Rica	The patient is assigned to a specific provider	Not relevant	The patient is assigned to a specific provider	No	The patient's choice is strictly limited with no exception	Usually not
Dominican Republic	The patient is assigned to a specific provider	No	Patients do not face any incentives to choose one provider over another	Yes	Patients can choose any hospital without any consequence for the level of coverage	
Ecuador	The patient's choice is limited	No	The patient's choice is limited	No	The patient's choice is strictly limited with no exception	
El Salvador	Patients are not given any incentive to choose one provider over another	No	Patients do not face any incentives to choose one provider over another	No	The patient's choice is theoretically limited but may be expanded in certain circumstances	
Guatemala	Patients are not given any incentive to choose one provider over another	Yes	Patients do not face any incentives to choose one provider over another	No	Patients can choose any hospital without any consequence for the level of coverage	
Guyana	Patients are not given any incentive to choose one provider over another	No	The patient is assigned to a specific provider	No	Patients can choose any hospital without any consequence for the level of coverage	
Honduras	Patients are not given any incentive to choose one provider over another	No	Patients do not face any incentives to choose one provider over another	No	Patients can choose any hospital without any consequence for the level of coverage	
Jamaica	Patients are not given any incentive to choose one provider over another	Not relevant	Patients do not face any incentives to choose one provider over another		Patients can choose any hospital without any consequence for the level of coverage	
Mexico	The patient is assigned to a specific provider	No	The patient is assigned to a specific provider	No	The patient's choice is theoretically limited but may be expanded in certain circumstances	

Country	Are patients generally free to choose a primary care practice for primary care services?	Can the patient choose the individual doctor within the practice chosen or assigned to?	Are patients usually free to choose providers for outpatient specialist services?	Can the patient choose the individual doctor within the outpatient specialist service institution chosen or assigned to?	Are patient usually free to choose hospitals for in-patient care?	Can patients choose their individual doctor within the hospital?
Panama	Patients are not given any incentive to choose one provider over another	Yes	Patients do not face any incentives to choose one provider over another	No	Patients can choose any hospital without any consequence for the level of coverage	
Paraguay	Patients are not given any incentive to choose one provider over another	Yes	Patients do not face any incentives to choose one provider over another	Yes	Patients can choose any hospital without any consequence for the level of coverage	
Peru	The patient is assigned to a specific provider	No	The patient's choice is limited	No	The patient's choice is strictly limited with no exception	
Suriname	Patients are not given any incentive to choose one provider over another	Yes	The patient's choice is limited	Not relevant	The patient's choice is theoretically limited but may be expanded in certain circumstances	
Trinidad and Tobago	Patients are not given any incentive to choose one provider over another	No	The patient is assigned to a specific provider	No	Patients can choose any hospital without any consequence for the level of coverage	
Uruguay	The patient is assigned to a specific provider	Yes	The patient is assigned to a specific provider	Yes	The patient's choice is strictly limited with no exception. Please specify limitations	

71. The availability of information on prices for users or purchasers has the potential to enhance the quality and efficiency of services provided (Table 5.10). In Bolivia, Guyana and Peru prices charged to patients can vary across primary care providers, whereas in Suriname and Uruguay all providers charge the same price to patients (see the table below). In nine LAC countries – Argentina, Colombia, Ecuador, Guatemala, Guyana, Honduras, Mexico, Suriname and Trinidad and Tobago - patients do not know the price, while in Argentina, Bolivia, Dominican Republic, Panama, Paraguay, Peru and Uruguay information on prices is available.

72. In Belize, Bolivia, Dominican Republic, Guyana Panama, Peru, Trinidad and Tobago and Uruguay prices charged to patients can vary across specialists, whereas in Chile and Suriname all providers charge the same price to patients. In nine LAC countries – Colombia, Ecuador, Guatemala, Guyana, Honduras, Mexico, Suriname and Trinidad and Tobago - patients do not know the price, while in Argentina, Belize, Bolivia, Chile, Dominican Republic, Panama, Paraguay, Peru and Uruguay information on prices is available.

Table 5.10. Information on prices of providers' services

Country	Are prices of primary care services the same or different between providers?	How information on prices of physicians' consultations/visits is made available?	Are prices of outpatient specialist services the same or different between providers?	How information on prices of physicians' consultations/visits is made available?
Argentina	Health care services are free at the point of care (public sector)	Information on prices charged by providers is in practice most often readily available (posted, communicated in advance)	Outpatient specialist services are free at the point of care (public sector)	Information on prices charged by providers is required to be readily available (posted, communicated in advance)
Belize	Health care services are free at the point of care		Prices charged to patients can vary across providers with possible consequences for the patient's own expenses	Information on prices charged by providers is required to be readily available (posted, communicated in advance)
Bolivia	Prices charged to patients can vary across providers with possible consequences for the patient's own expenses	Information on prices charged by providers is in practice most often readily available (posted, communicated in advance)	Prices charged to patients can vary across providers with possible consequences for the patient's own expenses	Information for prices charged by providers is in practice most often readily available (posted, communicated in advance)
Brazil	Health care services are free at the point of care		Outpatient specialist services are free at the point of care	
Chile	Health care services are free at the point of care		All providers charge the same price to patients (partly or fully refunded by coverage schemes)	Information on prices charged by providers is required to be readily available (posted, communicated in advance)
Colombia	Health care services are free at the point of care	Patients generally do not know the price they will pay before the encounter	Outpatient specialist services are free at the point of care	Patients generally do not know the price they will pay before the encounter
Costa Rica	Health care services are free at the point of care		Outpatient specialist services are free at the point of care	
Dominican Republic	Health care services are free at the point of care	Information on prices charged by providers is required to be readily available (posted, communicated in advance)	Prices charged to patients can vary across providers with possible consequences for the patient's own expenses	Information for prices charged by providers is in practice most often readily available (posted, communicated in advance)
Ecuador	Health care services are free at the point of care	Patients generally do not know the price they will pay before the encounter	Outpatient specialist services are free at the point of care	Patients generally do not know the price they will pay before the encounter

Country	Are prices of primary care services the same or different between providers?	How information on prices of physicians' consultations/visits is made available?	Are prices of outpatient specialist services the same or different between providers?	How information on prices of physicians' consultations/visits is made available?
El Salvador	Health care services are free at the point of care		Outpatient specialist services are free at the point of care	
Guatemala	Health care services are free at the point of care	Patients generally do not know the price they will pay before the encounter	Outpatient specialist services are free at the point of care	Patients generally do not know the price they will pay before the encounter
Guyana	Prices charged to patients can vary across providers with possible consequences for the patient's own expenses	Patients generally do not know the price they will pay before the encounter	Prices charged to patients can vary across providers with possible consequences for the patient's own expenses	Patients generally do not know the price they will pay before the encounter
Honduras	Health care services are free at the point of care	Patients generally do not know the price they will pay before the encounter	Outpatient specialist services are free at the point of care	Patients generally do not know the price they will pay before the encounter
Jamaica	Health care services are free at the point of care		Outpatient specialist services are free at the point of care	
Mexico	Health care services are free at the point of care	Patients generally do not know the price they will pay before the encounter	Outpatient specialist services are free at the point of care	Patients generally do not know the price they will pay before the encounter
Panama		Information on prices charged by providers is in practice most often readily available (posted, communicated in advance)	Prices charged to patients can vary across providers with possible consequences for the patient's own expenses	Information on prices charged by providers is in practice most often readily available (posted, communicated in advance)
Paraguay	Health care services are free at the point of care	Information on prices charged by providers is required to be readily available (posted, communicated in advance)	Outpatient specialist services are free at the point of care	Information on prices charged by providers is required to be readily available (posted, communicated in advance)
Peru	Prices charged to patients can vary across providers with possible consequences for the patient's own expenses	Information on prices charged by providers is required to be readily available (posted, communicated in advance)	Prices charged to patients can vary across providers with possible consequences for the patient's own expenses	Information on prices charged by providers is in practice most often readily available (posted, communicated in advance)

Country	Are prices of primary care services the same or different between providers?	How information on prices of physicians' consultations/visits is made available?	Are prices of outpatient specialist services the same or different between providers?	How information on prices of physicians' consultations/visits is made available?
Suriname	All providers charge the same price to patients (partly of fully refunded by coverage schemes)	Patients generally do not know the price they will pay before the encounter	All providers charge the same price to patients (partly or fully refunded by coverage schemes)	Patients generally do not know the price they will pay before the encounter
Trinidad and Tobago	Health care services are free at the point of care	Patients generally do not know the price they will pay before the encounter	Prices charged to patients can vary across providers with possible consequences for the patient's own expenses	Patients generally do not know the price they will pay before the encounter
Uruguay	All providers charge the same price to patients (partly of fully refunded by coverage schemes)	Information on prices charged by providers is required to be readily available (posted, communicated in advance)	Prices charged to patients can vary across providers with possible consequences for the patient's own expenses	Information on prices charged by providers is required to be readily available (posted, communicated in advance)

73. Sixteen LAC countries reported the availability of national standards for quality of care (Table 5.11). In a large part of countries, those standard concern primary care, hospital care and technologies. In two thirds of countries reporting the use of standards, those standards apply equally to public and private providers.

Table 5.11. National standards for quality of care

Country	Are there national standards for health care quality for:	Name of the organisation responsible for administering the standards and website link	Do these standards apply equally to public and private providers in your country?	Specifications	How is compliance with these standards assessed in your country?
Argentina	Primary care, hospital care, technologies	En relación a éste punto en el Programa Nacional de Garantía de Calidad en la Atención Médica se desarrollan: • Estándares de Calidad de Estructura • Estándares de Calidad de los Procesos • Manual de Mejora de la Calidad de Atención para establecimientos del Primer Nivel de Atención (alcance ambulatorio)	Yes		Accreditation scheme, inspectorate function, clinical audit

Country	Are there national standards for health care quality for:	Name of the organisation responsible for administering the standards and website link	Do these standards apply equally to public and private providers in your country?	Specifications	How is compliance with these standards assessed in your country?
Belize	Primary care, hospital care, technologies	Ministry of Health different units or departments	Yes		Monthly Audits and supervision visits to public health care facilities and through re- licensure for private facilities
Bolivia	Primary care, hospital care, technologies	Ministry of Health www.minsalud.gob.bo	Yes		Accreditation scheme, inspectorate function, clinical audit
Brazil					
Chile	Primary care, hospital care, technologies	1. Ministerio de Salud: www.minsal.cl; 2. Instituto de Salud Pública: www.ispch.cl	Yes		Accreditation scheme, inspectorate function
Colombia	Primary care, hospital care, technologies	https://www.minsalud.gov.co/salud/PServicios/Paginas/sistema-obligatorio-garantia-calidad-SOGC.aspx; https://www.invima.gov.co/	Yes		Accreditation scheme, inspectorate function, clinical audit
Costa Rica	Primary care, hospital care, technologies	The Minister of Health establishes the national regulations that all health services (public and private, ambulatory and hospitals) must comply to obtain a license to operate https://www.ministeriodesalud.go.cr/images/stories/docs/DTIC/2016/DTIC_legislacion_especifica_establecimientos_salud.pdf Regarding technologies, every product that is used on health care (drugs, pieces of equipment, devices) must have a Registry Number issued by the Ministry of Health before it can be released on the national market. https://registrelo.go.cr/cfmx/plantillas/ms/index.cfm?uri=/cfmx/home/index.cfm&errormsg=	Yes		Inspectorate function
Dominican Republic	Primary care, hospital care, technologies	Dirección de Habiitación (DHA) for primary and hospital care; Dirección	Yes	It doesn't apply for primary care	Inspectorate function, clinical audit

Country	Are there national standards for health care quality for:	Name of the organisation responsible for administering the standards and website link	Do these standards apply equally to public and private providers in your country?	Specifications	How is compliance with these standards assessed in your country?
		General de Medicamentos, Alimentos y Producots Sanitarios (DIGEMAPS) for technologies; Unidad de Guías y Protocols for guidance and assesment in the formulations of standards and Public Health Programmes.			
Ecuador	Primary care, hospital care		Yes		Clinical audit
El Salvador	Primary care, hospital care, technologies	El Ministerio de Salud cuenta con estandares de calidad de la atencion medica, a predominio en la atencion materno infantil en hospitales y Unidades de Salud e indicadores de proceso , resultado www.salud.gob.sv	No		
Guatemala					
Guyana	Primary care, technologies	Ministry of Public Health	No	No system for monitoring the quality of health care in the private sector	Inspectorate function
Honduras	Primary care, hospital care	La Secretaria de Salud de Honduras, a traves de la Direccion General de Normalizacion. www.salud.gob.hn	Yes		
Jamaica	Hospital care	Ministry of Health		The standards are only compulsory for public facilities	Inspectorate function, clinical audit
Mexico	Primary care, hospital care, technologies	Direccion general de cualidad y educacion en salud : http://www.calidad.salud.gob.mx/	No	The standards apply only to Servicios Estatales de Salud and to hospitals of the Secretaría de Salud. They neither apply to the medical units of the Seguridad Social nor to private facilities	Accreditation scheme, inspectorate function
Panama	Primary care	Ministry of Public Health	Yes		
Paraguay	Primary care, hospital care, technologies	www.mspbs.gov.py - Ministerio de Salud Pública y Bienestar Social	Yes		Accreditation scheme, inspectorate function, clinical audit
Peru			Yes	Standards refer to to certification and accomplishment of patients' rights.	Accreditation scheme, inspectorate function
Suriname					
Trinidad and Tobago	Primary care, hospital care, technologies		Yes		Inspectorate function

Country	Are there national standards for health care quality for:	Name of the organisation responsible for administering the standards and website link	Do these standards apply equally to public and private providers in your country?	Specifications	How is compliance with these standards assessed in your country?
Uruguay					

74. Eleven LAC countries reported the availability of a set of national metrics to monitor compliance with the quality of care standards (Table 5.12). In a large part of countries with national metrics, those metrics are publically reported at the provider level at least annually.

Table 5.12. National metrics for quality of care

Country	Is there a set of national metrics available to monitor compliance with the standards in your country?	If yes, please provide a list of metrics and website link to the administering organisation	Are these metrics publicly reported at the provider level at least annually?	Specifications
Argentina	Yes	Recientemente se ha desarrollado un tablero de control para monitorear el desempeño de la atención primaria de la cobertura universal de salud que lleva adelante ésta Secretaría de Gobierno de Salud. Los primeros resultados se encuentran en fase de producción. El panel será publicado en breve.	Yes	
Belize	No		No	
Bolivia	No		No	
Brazil				
Chile	Yes	Both hospitals and primary care centres have a list of metrics of quality indicators. We will attach them to this survey.	Yes	
Colombia	Yes	http://oncalidadsalud.minsalud.gov.co/Paginas/Inicio.aspx	Yes	
Costa Rica	No		No	
Dominican Republic	Yes	Porcentaje de: Infecciones Asociadas a la Atención en Salud Cirugías en el que se aplica correctamente la Lista de Verificación para la Seguridad de la Cirugía. Expedientes clínicos que cumplen con la Norma	Yes	

Country	Is there a set of national metrics available to monitor compliance with the standards in your country?	If yes, please provide a list of metrics and website link to the administering organisation	Are these metrics publicly reported at the provider level at least annually?	Specifications
		Nacional de Expediente en cuanto a su (organización y contenido) Eventos adversos relacionados a la cirugía. Nacimientos por cesáreas. Salas de recién nacido que al ser inspeccionados cumplen con los estándares mínimos de habilitación Servicios de laboratorio que al ser inspeccionados cumplen con los estándares mínimos de habilitación Servicios de emergencia que al ser inspeccionados cumplen con los estándares mínimos de habilitación Salas de partos que al ser inspeccionados cumplen con los estándares mínimos de habilitación Salas de cirugías que al ser inspeccionados cumplen con los estándares mínimos de habilitación		
Ecuador	Yes		Yes	
El Salvador	Yes	Lineamientos tecnicos para la evaluacion de resultados en Salud en las Redes Integradas e Integrales en Salud , Ficha tecnica de indicadores hospitalarios priorizados, estos documentos estan en prceso de oficializacion por lo que no se encuentran en estos momentos en la pagina Web de MINSAL.	No	Se publican un aserie de indicdores y logros en salud a traves de la memoria de labores que se realiza cada año
Guatemala	No		No	No se han desarrollado estos indicadores
Guyana	Yes	Standards and technical services. Metrics may not be available electronically	No	Providera re either licensed or not. If not they are made aware of where they fell short and they are given a period of time to correct their short comings
Honduras	No		No	No se han desarrollado estos indicadores
Jamaica	Yes	Some of the standards are monitored as part of the indicators in the service level agreement between the Ministry of Health and the four regional health authorities	Yes	

Country	Is there a set of national metrics available to monitor compliance with the standards in your country?	If yes, please provide a list of metrics and website link to the administering organisation	Are these metrics publicly reported at the provider level at least annually?	Specifications
Mexico	Yes	http://dgces.salud.gob.mx/INDICASII/resultados.php	Yes	
Panama	Yes	Department of monitoring and evaluation, audit of quality of care and standard of hospital services	Yes	
Paraguay	Yes	www.mspbs.gov.py - Ministerio de Salud Pública y Bienestar Social	No	
Peru	No		Yes	SUSALUD publica encuestas de servicios de salud
Suriname				
Trinidad and Tobago	No		No	
Uruguay	No		No	

75. Regulation of medical education varies across LAC countries (Table 5.13). In 12 countries – Belize, Bolivia, Chile, Colombia, Ecuador, Guyana, Jamaica, Mexico, Panama, Peru, Suriname and Trinidad and Tobago - there are limits to students accessing medical education mainly in the form of budgetary or capacity constraints. Those limits are normally set by universities. Fifteen countries – Belize, Bolivia, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, Guyana, Honduras, Jamaica, Mexico, Panama, Peru, Trinidad and Tobago and Uruguay- reported limits in accessing medical post-graduate training mainly in the form of budgetary or capacity constraints. Those limits are usually set by universities. Eleven countries reported an increase in the number of students accessing medical education during the past four years. Eleven countries reported also an increase in the number of students accessing general medicine.

Table 5.13. Regulation of medical education

Country	Are limits set for the number of students accessing medical education?	If yes, please indicate who sets these limits:	Are limits set for the number of students accessing medical post-graduate training?	If yes, please indicate who sets these limits:	Have any major changes occurred during the past 4 years in the number of students accessing medical education?	If yes, please indicate if they	Have any major changes occurred during the past 4 years in the number of students accessing general medicine?	If yes, please indicate if they
Argentina	No, there are no limits		No, there are no limits		Yes	increased	No	
Belize	Yes, budget or capacity constraints	National government	Yes, budget or capacity constraints	National government	Yes	increased	Yes	increased
Bolivia	Yes, quotas on the number of students admitted	Universities	Yes, quotas on the number of students admitted	Universities	Yes	increased	Yes	increased
Brazil								
Chile	Yes, budget or capacity constraints	Universities	Yes, budget or capacity constraints	National government, universities	No		Yes	increased
Colombia	Yes, quotas on the number of students admitted	Universities	Yes, quotas on the number of students admitted	Universities	No		Yes	increased
Costa Rica	No, there are no limits		Yes, budget or capacity constraints		Yes	increased	Yes	increased

Country	Are limits set for the number of students accessing medical education?	If yes, please indicate who sets these limits:	Are limits set for the number of students accessing medical post-graduate training?	If yes, please indicate who sets these limits:	Have any major changes occurred during the past 4 years in the number of students accessing medical education?	If yes, please indicate if they	Have any major changes occurred during the past 4 years in the number of students accessing general medicine?	If yes, please indicate if they
Dominican Republic	No, there are no limits		Yes, quotas and of budget or capacity constraints	National government	No		No	
Ecuador	Yes, budget or capacity constraints	Universities, hospitals	Yes, quotas on the number of students admitted	Universities, hospitals	No		No	
El Salvador	No, there are no limits		No, there are no limits		No		No	
Guatemala	No, there are no limits		No, there are no limits		No		No	
Guyana	Yes, budget or capacity constraints	National government, sub-national levels of government, universities	Yes, budget or capacity constraints	National government, sub-national levels of government, universities	No		Yes	increased
Honduras	No, there are no limits		Yes, quotas on the number of students admitted	National government, universities	Yes	increased	Yes	increased
Jamaica	Yes, budget or capacity constraints	Universities	Yes, budget or capacity constraints	Universities	Yes	increased		

Country	Are limits set for the number of students accessing medical education?	If yes, please indicate who sets these limits:	Are limits set for the number of students accessing medical post-graduate training?	If yes, please indicate who sets these limits:	Have any major changes occurred during the past 4 years in the number of students accessing medical education?	If yes, please indicate if they	Have any major changes occurred during the past 4 years in the number of students accessing general medicine?	If yes, please indicate if they
Mexico	Yes, budget or capacity constraints	Universities	Yes, budget or capacity constraints	National government	Yes	increased	No	
Panama	Yes, quotas on the number of students admitted	Universities	Yes, quotas on the number of students admitted	Universities	Yes	increased	Yes	increased
Paraguay	No, there are no limits		No, there are no limits		Yes	increased	Yes	increased
Peru	Yes, budget or capacity constraints	National government, universities	Yes, budget or capacity constraints	National government, universities	Yes	increased	Yes	increased
Suriname	Yes, quotas and budget or capacity constraints	National government	No, there are no limits		No		Yes	increased
Trinidad and Tobago	Yes, quotas and budget or capacity constraints	National government, universities	Yes, quotas and budget or capacity constraints	National government, universities	No			
Uruguay	No, there are no limits		Yes, budget or capacity constraints	Ministry of health, universities	Yes	increased		

76. A formal system of continuous medical education (CME) is reported to be in place in half of reporting countries (Table 5.14, Panel A): Belize, Bolivia, Costa Rica, Ecuador, Guyana, Honduras, Jamaica, Mexico, Panama and Paraguay, and applies to all specialties in two thirds of those countries. In five countries – Belize, Guyana, Jamaica, Panama and Paraguay -, CME is mandatory for all physicians.

77. Nine countries – Belize, Bolivia, Ecuador, El Salvador, Guyana, Panama, Paraguay, Peru and Uruguay – report that formal requirements exist for physicians to practice primary care. A large part of LAC countries (16 of 19) report also that formal requirements exist for facilities to provide primary care.

78. Fifteen countries report that formal mandatory requirement exist for facilities to provide primary care, whereas for Trinidad and Tobago those requirement are on a voluntary basis (Panel B). Increase in training capacity is the most often used policy to address physicians supply problems. Ten countries say that there is no regulation in place for physician to choose location of care. Among the nine countries reporting the existence of a regulation, four say that it is linked to density.

Table 5.14. Regulation of the supply of physicians

Panel A

Country	Is a formal system of continuous medical education (CME) in place for physicians?	If yes, does it apply to all specialities?	If yes, is the system mandatory for all physicians?	Do formal requirements exist for physicians to practise primary care?	If mandatory, please briefly describe the requirements
Argentina	No		No, participation in CME is voluntary	No	
Belize	Yes	Yes	Yes, CME is mandatory and linked to recertification or relicensing of physicians	Yes, mandatory	Must obtain a licensure and registered by the Belize Medical council
Bolivia	Yes	No	No, participation in CME is voluntary	Yes, mandatory	Medical students must complete the province year before graduating and working
Brazil					
Chile	No			No	
Colombia	No			No	
Costa Rica	Yes	Yes	No, participation in CME is voluntary	No	
Dominican Republic	No			No	
Ecuador	Yes	No		Yes, mandatory	

Country	Is a formal system of continuous medical education (CME) in place for physicians?	If yes, does it apply to all specialities?	If yes, is the system mandatory for all physicians?	Do formal requirements exist for physicians to practise primary care?	If mandatory, please briefly describe the requirements
El Salvador	No			Yes, mandatory	Se debe contar con el título de la especialidad alcanzada rconocido por una entida univeristaria acreditada y estar registrado en la Junta de Vigilancia de la Profesión Médica
Guatemala	No			No	
Guyana	Yes	Yes	Yes, CME is mandatory and linked to recertification or relicensing of physicians	Yes, mandatory	Must be qualified and have full registration
Honduras	Yes	Yes	No, participation in CME is voluntary	No	
Jamaica	Yes	Yes	Yes, CME is mandatory and linked to recertification or relicensing of physicians	No	
Mexico	Yes	Yes	No, participation in CME is voluntary		As a one year social service in more deprived areas required to graduate, although currently there are other options, including research.
Panama	Yes		Yes, CME is mandatory and linked to recertification or relicensing of physicians	Yes, mandatory	trabajar en el área que otorgó la licencia
Paraguay	Yes	Yes	Yes, CME is mandatory and linked to recertification or relicensing of physicians	Yes, mandatory	Especialidad, formacion, area a la que apunta
Peru	No			Yes, mandatory	
Suriname	No			No	
Trinidad and Tobago	No			No	
Uruguay	No			Yes, mandatory	Para poder ejercer como especialista deben tener el título habilitante registrado en el MSP. El registro de los títulos es obligatorio para el ejercicio. Asimismo, los médicos que egresan del pregrado pueden ejercer (con el registro del título correspondiente) como médicos generales.

Panel B

Country	Do formal requirements exist for facilities to provide primary care?	If mandatory, please briefly describe the requirements	What are the policies in place to address the identified physician supply problems?	Is there any regulation concerning physicians choosing the location of their practices?
Argentina	No		Increase in training capacity, incentive for take-up of GP, financial incentives to correct perceived geographic misdistribution	No
Belize	Yes, mandatory	Certification from the Ministry of Health to be eligible for trade licensure to operate a business which is a trade and commerce legislation	Increase in training capacity, prolong working time, introduction or expansion of non-physician practitioner roles	No
Bolivia	Yes, mandatory	Doctors, nurses and others must have a professional title	Increase in training capacity	Yes, relating to geographical proximity
Brazil				
Chile	Yes, mandatory	Autorización sanitaria por parte de las SEREMIs	Increase in training capacity, incentive for take-up of GP, incentives for take-up of specialities, introduction or expansion of non-physician practitioner roles, financial incentives to correct perceived geographic misdistribution	Yes, relating to other factors
Colombia	Yes, mandatory		No	Yes, relating to density
Costa Rica	Yes, mandatory	The general requirements are defined in Articles 9 and 10 of the Executive Decree No. 39728-S: "General Regulation of Health Services" http://www.pgrweb.go.cr/scij/Busqueda/Normativa/Normas/nrm_texto_completo.aspx?param1=NRTC&nValor1=1&nValor2=81752&nValor3=104395&param2=1&strTipM=TC&lResultado=1&strSim=simp The specific requirements are those to be met by the establishment for health services, according to the type of service they provide. In the case of primary health care services, these are defined by the Executive Decree No. 30698-S: "Standard for Enabling Headquarters Establishments of Basic Comprehensive Health Care (EBAIS)". http://www.pgrweb.go.cr/scij/Busqueda/Normativa/Normas/nrm_texto_completo.aspx?param1=NRTC&nValor1=1&nValor2=49292&nValor3=52698&param2=1&strTipM=TC&lResultado=10&strSim=simp		Yes, relating to other factors

Country	Do formal requirements exist for facilities to provide primary care?	If mandatory, please briefly describe the requirements	What are the policies in place to address the identified physician supply problems?	Is there any regulation concerning physicians choosing the location of their practices?
Dominican Republic	Yes, mandatory		Financial incentives to correct perceived geographic misdistribution	Yes, relating to other factors
Ecuador			Incentives for take-up of GP	Yes, relating to density
El Salvador	No			No
Guatemala	Yes, mandatory	Existen licencias para funcionar según reglamento	No	Yes, relating to density
Guyana	Yes, mandatory	Facilities should be certified or licensed but this is not enforced	Prolong working time, introduction or expansion of non-physician practitioner roles	No
Honduras	Yes, mandatory	Todo establecimiento prestador de servicios de salud debe cumplir con los requerimientos rectores de cumplimiento de normas que se hace de a traves d e una licencia sanitaria para poder ejercer en el sistema nacional de salud	Increase in training capacity, target immigration policy, introduction or expansion of non-physician practitioner roles	No
Jamaica	No		Increase in training capacity	No
Mexico	Yes, mandatory	Ver http://www.calidad.salud.gob.mx/site/calidad/acreditacion.html	Increase in training capacity, introduction or expansion of non-physician practitioner roles	
Panama	Yes, mandatory		Increase in training capacity, financial incentives to correct perceived geographic misdistribution	No
Paraguay	Yes, mandatory	Infraestructura, exigencias y standares establecidos	Increase in training capacity, prolong working time, target immigration policy, incentives for take-up of GP, incentives for take-up of specialities, introduction or expansion of non-physician practitioner roles, financial incentives to correct perceived geographic misdistribution	No
Peru	Yes, mandatory	Registro en la Superintendencia de Salud	Incentives for take-up of specialities	No
Suriname	Yes, mandatory			Yes, relating to density
Trinidad and Tobago	Yes, voluntary		Increase in training capacity, prolong working time, incentives for take-up of specialities, introduction or expansion of non-physician practitioner roles	Yes, relating to geographical proximity
Uruguay	Yes, mandatory	lo que se necesita es habilitar el servicio ante el MSP.	Increase in training capacity, incentives for take-up of specialities, financial incentives to correct perceived geographic misdistribution	No

79. Regulation of nursing education varies across LAC countries (see Table 5.15). Nine countries –Bolivia, Chile, Colombia, Guyana, Jamaica, Mexico, Panama, Peru and Trinidad and Tobago - reported limits for entry based on quotas and/or budget and capacity constraints. These limits are usually set by universities. In thirteen countries there was an increase in the nursing student intake over the past four years.

Table 5.15. Regulation of nursing education

Country	Is there any limit for entry into nursing education?	If yes, please indicate who sets these limits:	Have any major changes in nursing student intake occurred during the past 4 years?	If yes, please indicate if they
Argentina	No, there are no limits		Yes	increased
Belize	No, there are no limits		Yes	increased
Bolivia	Yes, quotas on the number of students admitted	Universities	Yes	increased
Brazil				
Chile	Yes, budget or capacity constraints	Universities	Yes	increased
Colombia	Yes, quotas on the number of students admitted	Universities	Yes	increased
Costa Rica	No, there are no limits		Yes	increased
Dominican Republic	No, there are no limits		No	
Ecuador	No, there are no limits	Universities	No	
El Salvador	No, there are no limits			
Guatemala	No, there are no limits		No	
Guyana	Yes, budget or capacity constraints	National government, sub-national levels of government, universities	Yes	
Honduras	No, there are no limits		No	
Jamaica	Yes, budget or capacity constraints	National government, universities	Yes	increased

Country	Is there any limit for entry into nursing education?	If yes, please indicate who sets these limits:	Have any major changes in nursing student intake occurred during the past 4 years?	If yes, please indicate if they
Mexico	Yes, budget or capacity constraints	Universities		
Panama	Yes, quotas on the number of students admitted	Universities	Yes	increased
Paraguay	No, there are no limits		Yes	increased
Peru	Yes, quotas and budget or capacity constraints	National government, universities	Yes	increased
Suriname	No, there are no limits		Yes	
Trinidad and Tobago	Yes, quotas and budget or capacity constraints	National government, universities	Yes	increased
Uruguay	No, there are no limits		Yes	increased

80. The regulation of hospital supply and of the diffusion of high-cost medical technology is common in LAC countries though not systematic (Table 5.16). In eight countries – Belize, Bolivia, Costa Rica, Honduras, Paraguay, Peru, Suriname and Uruguay – regulation applies to all hospitals, while in four countries – Chile, Colombia, Jamaica and Mexico – it applies only to public hospitals. In Argentina, Dominican Republic, Guatemala, Panama and Trinidad and Tobago providers are free to establish and expand capacity.

81. Certificate of needs and formal hospital infrastructure and master plan are the main regulatory tools used sat national level; their implementation is mainly driven by administrative and regulatory procedures.

Table 5.16. Regulation of hospital activities and high-technologies

Country	Is there any regulation regarding the capacity and service mix provided by hospitals?	If yes, does it apply to:	What is the main regulatory tool used?	If formal hospital and infrastructure master plan is used, it is designed at:	If formal health services plan is used, it is designed at:	Is the implementation of the regulation on capacity driven by:
Argentina	No, providers are free to establish and expand capacities		Formal health services plan		Sub-national level	Administrative and regulatory procedures, negotiations and agreements between stakeholders

Country	Is there any regulation regarding the capacity and service mix provided by hospitals?	If yes, does it apply to:	What is the main regulatory tool used?	If formal hospital and infrastructure master plan is used, it is designed at:	If formal health services plan is used, it is designed at:	Is the implementation of the regulation on capacity driven by:
Belize	Yes	To all hospitals that operate on the territory	Certificate of needs			
Bolivia	Yes	To all hospitals that operate on the territory	Formal hospital and infrastructure master plan	National level		Administrative and regulatory procedures
Brazil						
Chile	Yes	Public hospitals		National level, sub-national level		
Colombia	Yes	Public hospitals	Formal hospital and infrastructure master plan	National level		Administrative and regulatory procedures
Costa Rica	Yes	To all hospitals that operate on the territory	Formal hospital and infrastructure master plan	National level	National level	Negotiations and agreements between stakeholders
Dominican Republic	No, providers are free to establish and expand capacities		Certificate of needs			
Ecuador	Yes		Formal health services plan			Administrative and regulatory procedures
El Salvador	Yes	Public hospitals, private non-for-profit hospitals	Formal hospital and infrastructure master plan	National level		Administrative and regulatory procedures
Guatemala	No, providers are free to establish and expand capacities		Other tool			Administrative and regulatory procedures

Country	Is there any regulation regarding the capacity and service mix provided by hospitals?	If yes, does it apply to:	What is the main regulatory tool used?	If formal hospital and infrastructure master plan is used, it is designed at:	If formal health services plan is used, it is designed at:	Is the implementation of the regulation on capacity driven by:
Guyana	Yes	Public hospitals, private for-profit hospitals	Certificate of needs			Administrative and regulatory procedures
Honduras	Yes	To all hospitals that operate on the territory	Certificate of needs			Administrative and regulatory procedures
Jamaica	Yes	Public hospitals	Other tool	National level		
Mexico	Yes	Public hospitals	Certificate of needs	National level		Administrative and regulatory procedures
Panama	No, providers are free to establish and expand capacities					
Paraguay	Yes	To all hospitals that operate on the territory	Formal health services plan		National level, sub-national level	Administrative and regulatory procedures, economic incentives, negotiations and agreements between stakeholders
Peru	Yes	To all hospitals that operate on the territory		National level		Administrative and regulatory procedures
Suriname	Yes	To all hospitals that operate on the territory	Formal health services plan		National level	Administrative and regulatory procedures
Trinidad and Tobago	No, providers are free to establish and expand capacities		Certificate of needs			Administrative and regulatory procedures, economic incentives, negotiations and agreements between stakeholders
Uruguay	Yes	To all hospitals that operate on the territory	Other tool			Administrative and regulatory procedures

82. Primary care physicians are public employees remunerated by salary in all LAC countries except Jamaica (Table 5.17). Specialists providing services on an outpatient basis are public employees remunerated by salary in all LAC countries except Dominican Republic and Suriname. In thirteen countries, dual practice is allowed at least in some circumstances.

Table 5.17. Employment status and remuneration of physicians supplying primary care and outpatient specialists' services

Country	Are physicians supplying primary care services predominantly:	Are these physicians remunerated by:	Are physicians supplying outpatient specialist services predominantly:	Are these physicians remunerated by:	Is dual practice allowed for these physicians?	If yes, what is the share of specialists with dual practice?
Argentina	Publically employed	Salary	Publically employed	Mix of salary and fee for services	Yes, in some circumstances only	
Belize	Publically employed	Salary	Publically employed	Salary	Yes, always	85
Bolivia	Publically employed	Salary	Publically employed	Salary	Yes, in some circumstances only	
Brazil	Publically employed	Salary	Publically employed	Salary	Yes, always	75
Chile	Publically employed	Salary	Publically employed	Salary	Yes, always	
Colombia	Publically employed	Salary	Privately employed	Mix of salary and fee for services	Yes, always	
Costa Rica	Publically employed	Salary	Publically employed	Salary	Yes, in some circumstances only	
Dominican Republic	Publically employed	Mix of salary and capitation	Self-employed	Fee for Services	Yes, always	
Ecuador	Publically employed	Salary	Publically employed	Salary	Yes, always	

Country	Are physicians supplying primary care services predominantly:	Are these physicians remunerated by:	Are physicians supplying outpatient specialist services predominantly:	Are these physicians remunerated by:	Is dual practice allowed for these physicians?	If yes, what is the share of specialists with dual practice?
El Salvador	Publically employed	Salary				
Guatemala	Publically employed	Salary	Publically employed	Salary	Yes, always	26
Guyana	Publically employed	Salary	Publically employed	Salary	Yes, always	90
Honduras	Publically employed	Salary	Publically employed	Salary	Yes, always	
Jamaica	Self-employed	Fee for Services	Publically employed	Salary		
Mexico	Publically employed	Salary	Publically employed	Salary		
Panama	Publically employed	Salary				
Paraguay	Publically employed	Salary				
Peru	Publically employed	Salary				
Suriname	Publically employed	Mix of salary and fee for services	Self-employed	Fee for Services		
Trinidad and Tobago	Publically employed	Salary	Publically employed	Salary	Yes, always	90
Uruguay		Salary				

83. Specialists providing services on an inpatient basis are public employees remunerated by salary in all LAC countries except Dominican Republic and Peru (Table 5.18). Among reporting countries, dual practice is not allowed only in Guyana.

84. In most countries, government decides on the recruitment of medical staff. Only in Colombia and Guatemala hospital mangers have complete autonomy, while in Suriname hospital managers need to negotiate with local authorities. A pay scale is negotiated at central level in all reporting countries except Colombia

Table 5.18. Employment status and remuneration of physicians supplying inpatient specialists' services and methods of recruitment of medical staff

Country	Are physicians supplying in-patient specialist services predominantly:	Are these physicians remunerated by:	Is dual practice allowed for these physicians?	If yes, what is the share of specialists with dual practice?	Recruitment of medical staff:	Remuneration level of medical staff:	Are work contracts of the salaried medical staff officially with:
Argentina							
Belize	Publically employed	Salary	Yes, always	85	Central or local level of government decides	A pay scale is set or negotiated at the central level	Central government
Bolivia	Publically employed	Salary	Yes, always		Central or local level of government decides	A pay scale is set or negotiated at the central level	Central government
Brazil	Publically employed	Salary	Yes, always	80	Central or local level of government decides	A pay scale is set or negotiated at a local level	Local government
Chile	Publically employed	Salary	Yes, always		Central or local level of government decides	A pay scale is set or negotiated at the central level	Local government
Colombia	Privately employed	Salary	Yes, in some circumstances only		Hospital managers have complete autonomy	Hospital managers have complete autonomy	The hospital
Costa Rica	Publically employed	Salary	Yes, in some circumstances only		Central or local level of government decides	A pay scale is set or negotiated at the central level	Central government
Dominican Republic	Self-employed	Mix of salary and fee for services	Yes, always		Central or local level of government decides	A pay scale is set or negotiated at the central level	Central government
Ecuador	Publically employed	Salary	Yes, always		Central or local level of government decides	A pay scale is set or negotiated at the central level	The hospital

Country	Are physicians supplying in-patient specialist services predominantly:	Are these physicians remunerated by:	Is dual practice allowed for these physicians?	If yes, what is the share of specialists with dual practice?	Recruitment of medical staff:	Remuneration level of medical staff:	Are work contracts of the salaried medical staff officially with:
El Salvador	Publically employed	Salary	Yes, always	100	Central or local level of government decides	A pay scale is set or negotiated at the central level	Central government
Guatemala	Publically employed	Salary	Yes, always	100	Hospital managers have complete autonomy	A pay scale is set or negotiated at the central level	The hospital
Guyana	Publically employed	Salary	No	70-90	Central or local level of government decides	A pay scale is set or negotiated at the central level	Central government
Honduras	Publically employed	Salary	Yes, always		Central or local level of government decides	A pay scale is set or negotiated at the central level	Central government
Jamaica	Publically employed	Salary			Central or local level of government decides	A pay scale is set or negotiated at the central level	
Mexico	Publically employed	Salary			Central or local level of government decides	A pay scale is set or negotiated at the local level	Local government
Panama	Publically employed	Salary					
Paraguay							
Peru	Self-employed	Salary	Yes, always		Hospitals must negotiate with local authorities. Central or local level of government decides	A pay scale is set or negotiated at the central level	Central government. Local government
Suriname							
Trinidad and Tobago	Publically employed	Salary	Yes, always		Hospitals must negotiate with local authorities	A pay scale is set or negotiated at the central level	The hospital
Uruguay	Publically employed	Salary	Yes, always	60	Central or local level of government decides	A pay scale is set or negotiated at the central level	Central government

85. The payment method of primary care services varies significantly across LAC countries (Table 5.19). FFS are determined by negotiation between purchasers and providers both at individual (two countries) and collective (three countries) level as well as unilaterally set by central government (three countries). Capitation is determined by negotiation between purchasers and providers both at individual (two countries) and collective (three countries) level as well as unilaterally set by central government (four countries). In all fourteen reporting countries, global budget for primary care services is allocated by principles defined at central level, while in five of seven reporting countries salary is set unilaterally at central level by government.

86. For specialists' services (Table 5.20), FFS is determined by negotiation between purchasers and providers both at individual (two countries) and collective (three countries) level as well as unilaterally set by central government (five countries). In ten of thirteen reporting countries, global budget for specialists' services is allocated by principles defined at central level.

Table 5.19. Payment method for primary care services

Country	If fee-for-service is a component or single mode of payment, are fees based on a common Resource-Based Relative Value Scale (RBRVS) (or equivalent)?	If fee-for-service is a component or single mode of payment, are fees (or point values of the RBRVS)	If capitation is a component or main payment method, how is the capitation determined?	If global budget is a component or main payment method, how is the budget determined?	If salary is a component or main payment method, how is the salary determined?	Who defines the price billed to patients for primary care services (if any)?
Argentina	No	Negotiated between individual purchasers and providers	Negotiated between purchasers and providers	By allocation principles defined at central level	Negotiated between individual purchasers and providers	Not applicable, health care services are free at the point of care
Belize			Negotiated between key purchasers' and providers' associations at central level	By allocation principles defined at central level		Not applicable, health care services are free at the point of care
Bolivia	Yes, there are several RBRVSs set at local level or by different payers	Negotiated at local level between key purchasers' and providers' associations		By allocation principles defined at central level	Other	Providers cannot charge patients beyond the rate defined for third-party payers (which may include statutory co-payments)
Brazil						

Country	If fee-for-service is a component or single mode of payment, are fees based on a common Resource-Based Relative Value Scale (RBRVS) (or equivalent)?	If fee-for-service is a component or single mode of payment, are fees (or point values of the RBRVS)	If capitation is a component or main payment method, how is the capitation determined?	If global budget is a component or main payment method, how is the budget determined?	If salary is a component or main payment method, how is the salary determined?	Who defines the price billed to patients for primary care services (if any)?
Chile	No	Unilaterally set by central governments	Unilaterally set by key purchasers or government at central level	By allocation principles defined at central level		Not applicable, health care services are free at the point of care
Colombia	No	Negotiated between individual purchasers and providers	Negotiated between purchasers and providers	By allocation principles defined at central level	Other	The price billed to patients may be partially or fully covered by any type of health insurance
Costa Rica						Not applicable, health care services are free at the point of care
Dominican Republic	No		Negotiated between key purchasers' and providers' associations at central level	By allocation principles defined at central level		The price billed to patients may be partially or fully covered by any type of health insurance
Ecuador	Yes, there is one RBRVS for the whole country	Unilaterally set by central governments	Unilaterally set by key purchasers or government at central level	By allocation principles defined at central level	Unilaterally set by central governments	Not applicable, health care services are free at the point of care
El Salvador				By allocation principles defined at central level		
Guatemala	No	Other	Negotiated between purchasers and providers	By allocation principles defined at central level	Negotiated at local level between key purchasers' and providers' associations	Providers can charge any price without any guidance
Guyana	Yes, there is one RBRVS for the whole country					Not applicable, health care services are free at the point of care
Honduras	No	Other	Unilaterally set by key purchasers or government at central level	By allocation principles defined at central level	Unilaterally set by central governments	Not applicable, health care services are free at the point of care

Country	If fee-for-service is a component or single mode of payment, are fees based on a common Resource-Based Relative Value Scale (RBRVS) (or equivalent)?	If fee-for-service is a component or single mode of payment, are fees (or point values of the RBRVS)	If capitation is a component or main payment method, how is the capitation determined?	If global budget is a component or main payment method, how is the budget determined?	If salary is a component or main payment method, how is the salary determined?	Who defines the price billed to patients for primary care services (if any)?
Jamaica	No	Unilaterally set by key purchasers				Not applicable, health care services are free at the point of care
Mexico	No					Not applicable, health care services are free at the point of care
Panama	Yes, there are several RBRVSs set at local level or by different payers					The price billed to patients may be partially or fully covered by any type of health insurance
Paraguay				By allocation principles defined at central level	Unilaterally set by central governments	Not applicable, health care services are free at the point of care
Peru	No		Unilaterally set by key purchasers or government at central level	By allocation principles defined at central level	Unilaterally set by central governments	Not applicable, health care services are free at the point of care
Suriname	No	Negotiated at central level between key purchasers' and providers' associations				The price billed to patients may be partially or fully covered by any type of health insurance
Trinidad and Tobago	No	Negotiated at central level between key purchasers' and providers' associations		By allocation principles defined at central level	Unilaterally set by central governments	Not applicable, health care services are free at the point of care
Uruguay			Other (please specify)	By allocation principles defined at central level		

Table 5.20. Payment methods for outpatient specialists' services

Country	If fee-for-service is a component or the main payment method, are fees based on a common RBRVS (or equivalent)?	If fee-for-service is a component or single mode of payment, are fees (or point values of the RBRVS)	If global budget is a component or main payment method, how is the budget determined?	Who defines the price billed to patients for outpatient specialist services (if any)?
Argentina	No		By allocation principles defined at central level	Not applicable, health care services are free at the point of care
Belize				Providers cannot charge patients beyond the rate defined for third-party payers (which may include statutory co-payments)
Bolivia	Yes, there are several RBRVSs set at local level or by different payers	Negotiated at local level between key purchasers' and providers' associations	By allocation principles defined at local level	Providers cannot charge patients beyond the rate defined for third-party payers (which may include statutory co-payments)
Brazil				
Chile	No	Negotiated at central level between key purchasers' and providers' associations	By allocation principles defined at central level	Providers cannot charge patients beyond the rate defined for third-party payers (which may include statutory co-payments)
Colombia	No	Negotiated between individual purchasers and providers	Negotiated between purchasers and providers	The price billed to patients may be partially or fully covered by any type of health insurance
Costa Rica				Not applicable, health care services are free at the point of care
Dominican Republic	Yes, there are several RBRVSs set at local level or by different payers	Negotiated between individual purchasers and providers	By allocation principles defined at central level	Providers can charge any price without any guidance
Ecuador	Yes, there is one RBRVS for the whole country	Negotiated at local level between key purchasers' and providers' associations	By allocation principles defined at central level	Not applicable, health care services are free at the point of care
El Salvador			By allocation principles defined at central level	

Country	If fee-for-service is a component or the main payment method, are fees based on a common RBRVS (or equivalent)?	If fee-for-service is a component or single mode of payment, are fees (or point values of the RBRVS)	If global budget is a component or main payment method, how is the budget determined?	Who defines the price billed to patients for outpatient specialist services (if any)?
Guatemala	No	Other	Negotiated with key purchasers	Providers can charge any price in some circumstances (depending on their status, or on patients' status), please specify
Guyana	Yes, there are several RBRVSs set at local level or by different payers	Unilaterally set by key purchasers		The price billed to patients may be partially or fully covered by any type of health insurance
Honduras	No	Other	By allocation principles defined at central level	Not applicable, health care services are free at the point of care
Jamaica	No	Unilaterally set by central governments	By allocation principles defined at central level	Providers cannot charge patients beyond the rate defined for third-party payers (which may include statutory co-payments)
Mexico	No			Not applicable, health care services are free at the point of care
Panama	Yes, there are several RBRVSs set at local level or by different payers			The price billed to patients may be partially or fully covered by any type of health insurance
Paraguay				Not applicable, health care services are free at the point of care
Peru	No	Unilaterally set by key purchasers	By allocation principles defined at central level	Not applicable, health care services are free at the point of care
Suriname	No	Unilaterally set by central governments		The price billed to patients may be partially or fully covered by any type of health insurance
Trinidad and Tobago	No	Unilaterally set by central governments	By allocation principles defined at central level	Not applicable, health care services are free at the point of care
Uruguay				

87. The methods of determining prices paid to public and private hospitals vary importantly across LAC countries (Table 5.21). For public hospitals, rates are mainly unilaterally set by government for all the different bases for payment, whereas for private hospitals prices are mainly set through negotiations between health insurance schemes and providers.

Table 5.21. Regulation of prices for covered hospital services

	Public hospitals				Private hospitals				
Country	**If DRG is the payment mechanism, how are DRG "point values" determined?**	**If fee-for-service is the payment mechanism, how are fees determined?**	**If global budget is the payment mechanism, how is the budget determined?**	**If per diem is the payment mechanism, how is the payment determined?**	**If DRG is the payment mechanism, how are DRG "point values" determined?**	**If fee-for-service is the payment mechanism, how are fees determined?**	**If global budget is the payment mechanism, how is the budget determined?**	**If per diem is the payment mechanism, how is the payment determined?**	**Who defines the price billed by hospital to patients for in-patient acute care services (if any)?**
Argentina									Hospitals can charge any price in some circumstances (depending on providers', physicians' or patients' status)
Belize			By allocation principles defined at central level			Set by providers			The Hospital under the Authority and private can set price but public hospitals have one set price by central government (MOH)
Bolivia	Unilaterally set by local government or key purchasers and identical for all hospitals in the locality (e.g. region)	Negotiated at local level between key purchasers and providers	By allocation principles defined at local level	Unilaterally set by local government or key purchasers and identical for all hospitals in the locality (e.g. region)	Unilaterally set by individual key purchasers	Negotiated between individual key purchasers and providers	By allocation principles defined at local level	Negotiated between individual key purchasers and individual hospitals	Providers always freely determine their prices
Brazil									

	Public hospitals				Private hospitals				
Country	**If DRG is the payment mechanism, how are DRG "point values" determined?**	**If fee-for-service is the payment mechanism, how are fees determined?**	**If global budget is the payment mechanism, how is the budget determined?**	**If per diem is the payment mechanism, how is the payment determined?**	**If DRG is the payment mechanism, how are DRG "point values" determined?**	**If fee-for-service is the payment mechanism, how are fees determined?**	**If global budget is the payment mechanism, how is the budget determined?**	**If per diem is the payment mechanism, how is the payment determined?**	**Who defines the price billed by hospital to patients for in-patient acute care services (if any)?**
Chile	Negotiated at central level between key purchasers and providers	By allocation principles defined at central level				Negotiated at central level between key purchasers and providers			Hospitals cannot charge patients beyond the rate defined for third-party payers (which may include statutory co-payments)
Colombia	Negotiated between individual key purchasers and individual hospitals	Negotiated between individual key purchasers and providers	Negotiated with financing authorities	Negotiated between individual key purchasers and individual hospitals	Negotiated between individual key purchasers and individual hospitals	Negotiated between purchasers and providers	Negotiated between purchasers and providers	Negotiated between individual key purchasers and individual hospitals	
Costa Rica									Not applicable, health care services are free at the point of care (or only entail a small co-payment)
Dominican Republic	Unilaterally set by government or key purchasers at central level and identical for all hospitals in the country	Set unilaterally by key purchasers (or government) at central level	By allocation principles defined at central level	Unilaterally set by government or key purchasers at central level and identical for all hospitals in the country	Negotiated between individual key purchasers and individual hospitals	Negotiated between individual key purchasers and providers	Negotiated with financing authorities	Negotiated between individual key purchasers and individual hospitals	Providers always freely determine their prices
Ecuador			By allocation principles defined at central level				By allocation principles defined at local level		

	Public hospitals				Private hospitals				
Country	**If DRG is the payment mechanism, how are DRG "point values" determined?**	**If fee-for-service is the payment mechanism, how are fees determined?**	**If global budget is the payment mechanism, how is the budget determined?**	**If per diem is the payment mechanism, how is the payment determined?**	**If DRG is the payment mechanism, how are DRG "point values" determined?**	**If fee-for-service is the payment mechanism, how are fees determined?**	**If global budget is the payment mechanism, how is the budget determined?**	**If per diem is the payment mechanism, how is the payment determined?**	**Who defines the price billed by hospital to patients for in-patient acute care services (if any)?**
El Salvador			By allocation principles defined at central level						
Guatemala	Unilaterally set by government or key purchasers at central level and identical for all hospitals in the country	Set unilaterally by key purchasers (or government) at central level	By allocation principles defined at central level	Unilaterally set by government or key purchasers at central level and identical for all hospitals in the country		Negotiated at local level between key purchasers and providers	Negotiated with financing authorities		Hospitals can charge any price in some circumstances (depending on providers', physicians' or patients' status), please specify
Guyana		Negotiated between individual key purchasers and providers				Negotiated between individual key purchasers and providers			
Honduras			By allocation principles defined at central level			Set unilaterally by key purchasers (or government) at central level	By allocation principles defined at central level		
Jamaica		Set unilaterally by key purchasers (or government) at central level	Negotiated with financing authorities						
Mexico		Negotiated at central level between key purchasers and providers	Based on previous year's budget and eventually negotiated with financing authorities						

	Public hospitals				Private hospitals				
Country	**If DRG is the payment mechanism, how are DRG "point values" determined?**	**If fee-for-service is the payment mechanism, how are fees determined?**	**If global budget is the payment mechanism, how is the budget determined?**	**If per diem is the payment mechanism, how is the payment determined?**	**If DRG is the payment mechanism, how are DRG "point values" determined?**	**If fee-for-service is the payment mechanism, how are fees determined?**	**If global budget is the payment mechanism, how is the budget determined?**	**If per diem is the payment mechanism, how is the payment determined?**	**Who defines the price billed by hospital to patients for in-patient acute care services (if any)?**
Panama	Unilaterally set by government or key purchasers at central level and different for all hospitals in the country								
Paraguay									
Peru	Unilaterally set by individual key purchasers	Set unilaterally by key purchasers (or government) at central level	By allocation principles defined at central level	Unilaterally set by government or key purchasers at central level and identical for all hospitals in the country		Set unilaterally by key purchasers (or government) at central level	By allocation principles defined at central level		
Suriname		Negotiated at central level between key purchasers and providers							.
Trinidad and Tobago			By allocation principles defined at central level			Negotiated between individual key purchasers and providers			Not applicable, health care services are free at the point of care (or only entail a small co-payment)
Uruguay									

88. Most countries central authorities set specific ceilings for public health spending (Table 5.22). Thirteen countries have an early warning system that provides an alert when health budget overruns. Moreover, fourteen countries have a cost containment strategy in place for public health spending.

Table 5.22. Nature and stringency of the budget constraints

Country	Does your country set specific ceilings for public health expenditure?	If yes, for which agents?	If targets are set, please indicate which institution sets the budgetary ceilings for health expenditure?	Specifications	Is there an early warning system to provide an alert that public health expenditures may exceed targets or legally binding levels, i.e. health budget overruns?	Is there an overall cost containment strategy to ensure that publicly-funded health expenditure stays within the initially allocated amounts?	If yes, who has the main responsibility for proposing cost containment measures?
Argentina	Yes, it sets public health expenditure targets for specific health financing agents (or schemes). Please specify for which agents	Ministry of Health / Central government / Local government	Central Budget Authority (e.g. Ministry of Finance)	En Primera instancia, y luego la aprobación definitiva por Honorable Congreso de la Nación Argentina	Yes, but an alert does not legally require action	Yes	Cabinet of Ministers, ministry of Finance, ministry of Health
Belize	Yes, it sets an expenditure ceiling for overall public health expenditure	Ministry of Health / Hospital under the Authority/ National Health Insurance fund	Central Budget Authority (e.g. Ministry of Finance)	Ministry of Finance sets the budget ceilings and the Ministry of Health sets the allocations within the ceiling. The budget must be approved by the parliament according to the Finance and Audit Reform Act of 2000	Yes, and sets in motion required action for the current year	Yes	Cabinet of Ministers, ministry of Finance, ministry of Health
Bolivia	Yes, it sets public health expenditure targets for specific health financing agents (or schemes). Please specify for which agents	Local government	Central Budget Authority (e.g. Ministry of Finance)	Law No. 475 and D.S. 1984 establish that municipal governments can spend up to 15.5% on health Ministry of Economy and Public Finance establishes the annual budget	Yes, and sets in motion required action for the current year	No	
Brazil	Yes, it sets an expenditure ceiling for overall public health expenditure		Other (please specify)	GDP % growth as defined by the Federal Constitution	Yes, and sets in motion required action for the current year	Yes	Parliament
Chile	Yes, it sets an expenditure ceiling for overall public health expenditure	Ministry of Health / Central government, local government, health insurance fund(s) or schemes	Central Budget Authority (e.g. Ministry of Finance)	The Ministry of Finance sets the budget and afterwards is approved (or modified in some points) by the National Parliament. At the local level (municipalities administer primary care in the vast part of the country) can define their own budget in addition to the resources provided by the central level.	Yes, and sets in motion required action for the current year		Ministry of Finance, ministry of Health, health insurance funds, local governments

Country	Does your country set specific ceilings for public health expenditure?	If yes, for which agents?	If targets are set, please indicate which institution sets the budgetary ceilings for health expenditure?	Specifications	Is there an early warning system to provide an alert that public health expenditures may exceed targets or legally binding levels, i.e. health budget overruns?	Is there an overall cost containment strategy to ensure that publicly-funded health expenditure stays within the initially allocated amounts?	If yes, who has the main responsibility for proposing cost containment measures?
Colombia	Yes, it sets public health expenditure targets for specific health financing agents (or schemes). Please specify for which agents	Ministry of Health / Central government	National Parliament	National Budget Law	Yes, and sets in motion required action for the current year	Yes	Ministry of Finance, ministry of Health
Costa Rica	No				No, there is no such a system	Yes	Health insurance funds
Dominican Republic	Yes, it sets public health expenditure targets for specific health financing agents (or schemes). Please specify for which agents	Ministry of Health / Central government, local government	Central Budget Authority (e.g. Ministry of Finance)		No, there is no such a system	No	
Ecuador	Yes, it sets an expenditure ceiling for overall public health expenditure	Ministry of Health / Central government, local government	Central Budget Authority (e.g. Ministry of Finance)		Yes, but an alert does not legally require action	Yes	Cabinet of Ministers, ministry of Finance, ministry of Health
El Salvador	Yes, it sets an expenditure ceiling for overall public health expenditure	Ministry of Health / Central government	Central Budget Authority (e.g. Ministry of Finance)	En general, previa negociación con el Ministerio de Salud, es el Ministerio de Hacienda quien establece los limites o techos presupuestarios anuales del gasto en salud de dicha entidad. En el caso de los esquemas de aseguramiento público, dado que manejan recursos propios (cotizaciones de empleadores y empleados), su techo de ingresos y gastos son definidos por cada entidad, según sus proyecciones financieras anuales	No, there is no such a system	No	
Guatemala	Yes, it sets an expenditure ceiling for overall public health expenditure		Central Budget Authority (e.g. Ministry of Finance)	El Ministerio de Finanzas establece los techos del financiamiento y luego lo aprueba el Congreso de la República	Yes, and sets in motion required action for the current year	Yes	Ministry of Finance, Ministry of Health, Health Insurance funds

Country	Does your country set specific ceilings for public health expenditure?	If yes, for which agents?	If targets are set, please indicate which institution sets the budgetary ceilings for health expenditure?	Specifications	Is there an early warning system to provide an alert that public health expenditures may exceed targets or legally binding levels, i.e. health budget overruns?	Is there an overall cost containment strategy to ensure that publicly-funded health expenditure stays within the initially allocated amounts?	If yes, who has the main responsibility for proposing cost containment measures?
Guyana	Yes, it sets an expenditure ceiling for overall public health expenditure	Ministry of Health / Central government, local government, health insurance fund(s) or schemes	Central Budget Authority (e.g. Ministry of Finance)		Yes, and sets in motion required action for the current year	Yes	Parliament, cabinet of Ministers, ministry of Finance, ministry of Health, health insurance funds, local governments
Honduras	Yes, it sets an expenditure ceiling for overall public health expenditure		Central Budget Authority (e.g. Ministry of Finance)	La Secretaria de Salud y todas las instituciones del estado elaboran y presentan sus planes operativos anuales y presupuestos (POAP), por medio del cual se financia la salud publica y la Secretaria de Finanzas conduce este proceso	No, there is no such a system	Yes	Ministry of Finance
Jamaica	No				No, there is no such a system	No	
Mexico	No		Central Budget Authority (e.g. Ministry of Finance)		Yes, but an alert does not legally require action	Yes	Parliament, Ministry of Finance, Ministry of Health, Health Insurance funds, local governments
Panama	Yes, it sets an expenditure ceiling for overall public health expenditure		Central Budget Authority (e.g. Ministry of Finance)		No, there is no such a system	Yes	

Country	Does your country set specific ceilings for public health expenditure?	If yes, for which agents?	If targets are set, please indicate which institution sets the budgetary ceilings for health expenditure?	Specifications	Is there an early warning system to provide an alert that public health expenditures may exceed targets or legally binding levels, i.e. health budget overruns?	Is there an overall cost containment strategy to ensure that publicly-funded health expenditure stays within the initially allocated amounts?	If yes, who has the main responsibility for proposing cost containment measures?
Paraguay	Yes, it sets an expenditure ceiling for overall public health expenditure		Central Budget Authority (e.g. Ministry of Finance)	El presupeusto para el Ministerio de Salud es propuesto por la misma entidad (como parte del poder ejecutivo) pero es analizado desde el punto de vista de las perspectivas de realizaciones fiscales y ajustado en base a estas perspectivas por el Ministerio de Hacienda, esto es presentado al Congreso de la Nacion quien lo aprueba via Ley de la Nacion y lo entrega al Poder Ejecutivo nuevamente para su ejecucion.	Yes, and sets in motion required action for the current year	Yes	Parliament, cabinet of Ministers, ministry of Finance, ministry of Health
Peru	Yes, it sets public health expenditure targets for specific health financing agents (or schemes). Please specify for which agents	Ministry of Health / Central government, local government, health insurance fund(s) or schemes	Ministry of Health, Ministry of Finance, National Parliament		Yes, and sets in motion required action for the current year	Yes	Ministry of Health, Ministry of Finance, Health Insurance funds
Suriname	No		National Parliament		No, there is no such a system	No	
Trinidad and Tobago	Yes, it sets public health expenditure targets for specific health financing agents (or schemes). Please specify for which agents	Ministry of Health / Central government	National Parliament	The Standard Finance Committee of Parliament approves the health budget	Yes, and sets in motion required action for the current year	Yes	Parliament, cabinet of Ministers, ministry of Finance, ministry of Health
Uruguay	No		Central Budget Authority (e.g. Ministry of Finance)		No, there is no such a system	No	

89. There are several measures regularly undertaken in response to budgets exceeding initially targeted levels (Table 5.23). All countries except Brazil, Costa Rica and Panama make supplemental budget appropriations. Other measures legally possible include deficit increase by sub-national levels of government and providers. Cut in procurement of medicines is the most used cost containment tool.

Table 5.23. Consequences of reaching health expenditure targets

A Legally possible

Country	Supplemental budget appropriations are made	Health insurance fund deficits increase	Sub-national government budget deficits increase	Providers (e.g. hospitals) accumulate deficits	Cuts in payment rates to hospitals	Cuts in health personnel wage bill	Cuts in physicians' fees	Cuts in procurement of medicines	Cuts in pharmaceutical prices	Cuts in pharmaceutical reimbursement	Cuts in the benefit package (delisting of services)	Increase in patients fees/co-payments/deductibles	Rationing of health services (strict budgets for providers)	Claw-back requested from providers
Argentina	Yes			Yes										
Belize	Yes							Yes	Yes				Yes	
Bolivia	Yes		Yes											
Brazil			Yes											
Chile	Yes		Yes	Yes	Yes		Yes	Yes		Yes	Yes		Yes	
Colombia	Yes	Yes	Yes	Yes										
Costa Rica														
Dominican Republic	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ecuador	Yes	Yes						Yes						

Country	Supplemental budget appropriations are made	Health insurance fund deficits increase	Sub-national government budget deficits increase	Providers (e.g. hospitals) accumulate deficits	Cuts in payment rates to hospitals	Cuts in health personnel wage bill	Cuts in physicians' fees	Cuts in procurement of medicines	Cuts in pharmaceutical prices	Cuts in pharmaceutical reimbursement	Cuts in the benefit package (delisting of services)	Increase in patients fees/co-payments/deductibles	Rationing of health services (strict budgets for providers)	Claw-back requested from providers
El Salvador	Yes		Yes	Yes		Yes		Yes					Yes	
Guatemala	Yes													
Guyana	Yes							Yes	Yes	Yes	Yes	Yes	Yes	
Honduras	Yes													
Jamaica	Yes													
Mexico	Yes	Yes	Yes		Yes			Yes		Yes			Yes	
Panama														
Paraguay	Yes		Yes	Yes	Yes			Yes			Yes		Yes	Yes
Peru	Yes			Yes							Yes		Yes	
Suriname	Yes	Yes	Yes											
Trinidad and Tobago	Yes		Yes	Yes	Yes								Yes	Yes
Uruguay	Yes	Yes		Yes	Yes			Yes	Yes		Yes	Yes	Yes	

90. In the past four budget years, fourteen countries made supplemental budget allocations, whereas seven reported deficit increase at sub-national and provider level as well as measures of rationing health care services (panel B).

B Used in the past four budget years

Country	Supplemental budget appropriations are made	Health insurance fund deficits increase	Sub-national government budget deficits increase	Providers (e.g. hospitals) accumulate deficits	Cuts in payment rates to hospitals	Cuts in health personnel wage bill	Cuts in physicians' fees	Cuts in procurement of medicines	Cuts in pharmaceutical prices	Cuts in pharmaceutical reimbursement	Cuts in the benefit package (delisting of services)	Increase in patients fees/co-payments/deductibles	Rationing of health services (strict budgets for providers)	Claw-back requested from providers
Argentina	Yes			Yes										
Belize	Yes							Yes	Yes			Yes (only at the hospitals under the Authority)	Yes	
Bolivia	Yes		Yes											
Brazil			Yes											
Chile	Yes			Yes									Yes	
Colombia	Yes	Yes	Yes	Yes										
Costa Rica														
Dominican Republic	Yes			Yes									Yes	
Ecuador														
El Salvador	Yes		Yes	Yes		Yes		Yes					Yes	

Country	Supplemental budget appropriations are made	Health insurance fund deficits increase	Sub-national government budget deficits increase	Providers (e.g. hospitals) accumulate deficits	Cuts in payment rates to hospitals	Cuts in health personnel wage bill	Cuts in physicians' fees	Cuts in procurement of medicines	Cuts in pharmaceutical prices	Cuts in pharmaceutical reimbursement	Cuts in the benefit package (delisting of services)	Increase in patients fees/co-payments/deductibles	Rationing of health services (strict budgets for providers)	Claw-back requested from providers
Guatemala	Yes													
Guyana	Yes												Yes	
Honduras	Yes													
Jamaica	Yes													
Mexico		Yes	Yes		Yes			Yes		Yes			Yes	
Panama														
Paraguay	Yes		Yes	Yes	Yes			Yes			Yes		Yes	Yes
Peru														
Suriname														
Trinidad and Tobago	Yes		Yes	Yes										
Uruguay	Yes	Yes		Yes										

91. The scope and coverage of assessment varies significantly across countries. A positive list is established at central level for the coverage of medical procedures (ten countries), pharmaceuticals (11 countries) and implantable medical devices (eight countries), whereas only Colombia establishes a negative list of non-covered technologies (Table 5.24). Other mechanisms to define the range of technologies covered are less used across LAC countries.

Table 5.24. How the range of technologies covered by primary health insurance is defined

A. Medical procedures

Country	A positive list is established at the central level	A negative list (of non-covered technologies) is established at the central level	Individual third-party payers establish their own positive lists	Individual third-party payers establish their own negative lists	Providers under budget constraints establish their own positive lists at the local level	The range of benefits covered is not defined, every technology performed by a clinician is covered by basic primary coverage schemes
Argentina	Yes		Yes			
Belize						
Bolivia						
Brazil	Yes					
Chile	Yes		Yes			
Colombia		Yes				
Costa Rica						
Dominican Republic						
Ecuador	Yes					

Country	A positive list is established at the central level	A negative list (of non-covered technologies) is established at the central level	Individual third-party payers establish their own positive lists	Individual third-party payers establish their own negative lists	Providers under budget constraints establish their own positive lists at the local level	The range of benefits covered is not defined, every technology performed by a clinician is covered by basic primary coverage schemes
El Salvador	Yes				Yes	
Guatemala						
Guyana	Yes		Yes	Yes	Yes	
Honduras						
Jamaica	Yes		Yes			Yes
Mexico	Yes					
Panama						
Paraguay						
Peru	Yes					
Suriname						
Trinidad and Tobago	Yes				Yes	
Uruguay	Yes					

B. Pharmaceuticals

Country	A positive list is established at the central level	A negative list (of non-covered technologies) is established at the central level	Individual third-party payers establish their own positive lists	Individual third-party payers establish their own negative lists	Providers under budget constraints establish their own positive lists at the local level	The range of benefits covered is not defined, every technology performed by a clinician is covered by basic primary coverage schemes
Argentina	Yes		Yes			
Belize	Yes					Yes
Bolivia						
Brazil	Yes					
Chile	Yes		Yes			
Colombia		Yes				
Costa Rica						
Dominican Republic						
Ecuador	Yes					
El Salvador	Yes				Yes	

Country	A positive list is established at the central level	A negative list (of non-covered technologies) is established at the central level	Individual third-party payers establish their own positive lists	Individual third-party payers establish their own negative lists	Providers under budget constraints establish their own positive lists at the local level	The range of benefits covered is not defined, every technology performed by a clinician is covered by basic primary coverage schemes
Guatemala						
Guyana	Yes		Yes	Yes	Yes	
Honduras						
Jamaica	Yes					
Mexico	Yes					
Panama						
Paraguay						
Peru	Yes					
Suriname						
Trinidad and Tobago	Yes					
Uruguay	Yes					

C. Implantable medical devices

Country	A positive list is established at the central level	A negative list (of non-covered technologies) is established at the central level	Individual third-party payers establish their own positive lists	Individual third-party payers establish their own negative lists	Providers under budget constraints establish their own positive lists at the local level	The range of benefits covered is not defined, every technology performed by a clinician is covered by basic primary coverage schemes
Argentina						
Belize						
Bolivia						
Brazil	Yes					
Chile	Yes					
Colombia		Yes				
Costa Rica						
Dominican Republic						
Ecuador	Yes					
El Salvador	Yes				Yes	

Country	A positive list is established at the central level	A negative list (of non-covered technologies) is established at the central level	Individual third-party payers establish their own positive lists	Individual third-party payers establish their own negative lists	Providers under budget constraints establish their own positive lists at the local level	The range of benefits covered is not defined, every technology performed by a clinician is covered by basic primary coverage schemes
Guatemala						
Guyana	Yes		Yes	Yes	Yes	
Honduras						
Jamaica						
Mexico	Yes					
Panama						
Paraguay						
Peru						
Suriname						
Trinidad and Tobago	Yes				Yes	
Uruguay						

92. Economic evaluation includes a wide range of different perspectives and methods, which are designed to compare two or more alternatives in terms of costs and outcomes. Thirteen LAC countries reported performing economic evaluation – at least in some circumstances - when assessing health technologies. LAC countries adopt different perspectives for economic evaluation (Table 5.25). The perspective adopted for economic assessment (public payer, health system or societal) determines the types of costs (and savings) taken into account in analyses. The public payer perspective is adopted in eight LAC countries and generally takes into account direct medical costs (the cost of the product itself and associated medical acts, including costs of adverse effects) and potential savings for public payers. The health system perspective is less often used (by six countries); it generally takes into account direct medical costs and savings for all payers including patients and private insurers, where relevant. The societal perspective is accepted by only two LAC countries. It considers a wide range of costs and benefits beyond the health systems: direct medical costs, indirect medical costs, direct non-medical costs, indirect non-medical costs and savings such as productivity gains.

93. Twenty-seven OECD countries reported performing economic evaluation when assessing health technologies, particularly for pharmaceuticals. Most HTA agencies accept or require cost-effectiveness and/or cost-utility analyses, and prefer cost-minimisation analysis when the new technology is no more effective than existing ones. The public payer perspective is adopted by more than half of OECD countries, whereas the health system perspective is less often used (by 12 OECD countries). The societal perspective is also common and accepted by 13 OECD countries (Auraaen *et al.* 2016).

94. Similarly to OECD countries, in a majority of LAC countries economic evaluation includes affordability or budget impact analysis (BIA). Although different specifications may be used, BIA generally refers to an analysis of the financial impact of funding a new medical technology for a finite period.

Table 5.25. Features of economic evaluation used in HTA

		Perspective			
Country	**Economic evaluation**	**Public payer**	**Health system**	**Societal**	**Affordability or budget impact**
Argentina	No				Yes
Belize	In some cases		Yes		Yes
Bolivia					
Brazil	Yes	Yes	Yes	Yes	Yes
Chile	Yes	Yes			Yes

		Perspective			
Country	**Economic evaluation**	**Public payer**	**Health system**	**Societal**	**Affordability or budget impact**
Colombia	In some cases	Yes			Yes
Costa Rica	Yes	Yes			Yes
Dominican Republic	No				
Ecuador	In some cases		Yes		Yes
El Salvador	No				
Guatemala					
Guyana	In some cases	Yes			Yes
Honduras					
Jamaica	In some cases				Yes
Mexico	In some cases	Yes			Yes
Panama					
Paraguay	In some cases				Yes
Peru	In some cases	Yes	Yes		Yes
Suriname					
Trinidad and Tobago	In some cases		Yes	Yes	Yes
Uruguay	In some cases	Yes	Yes		Yes

95. Citizen or patient representatives have a formal role mainly in the definitions of public health objectives (ten countries) and in the decisions relating to service planning (seven countries) (Table 5.26). The picture is similar across OECD as only a few countries involve patients directly in the process leading to coverage decision of specific technologies (Auraaen *et al.* 2016).

Table 5.26. Areas of formal role for citizens or patients' representatives

	Area				
Country	**Coverage or reimbursement**	**Licensing of pharmaceuticals**	**Health Technology Assessment**	**Decisions relating to service planning**	**Definitions of public health objectives**
Argentina	No	Yes	Yes	No	No
Belize	No	No	No	Yes	Yes
Bolivia	No	No	No	Yes	Yes
Brazil	Yes	No	Yes	Yes	Yes
Chile	Yes	No	Yes	Yes	No
Colombia	Yes	No	No	No	No
Costa Rica	No	No	No	Yes	Yes
Dominican Republic	Yes	No	No	No	Yes
Ecuador					
El Salvador	No	No	No	No	No
Guatemala	No	No	No	No	No
Guyana	No	No	Yes	Yes	Yes

	Area				
Country	**Coverage or reimbursement**	**Licensing of pharmaceuticals**	**Health Technology Assessment**	**Decisions relating to service planning**	**Definitions of public health objectives**
Honduras	No	No	No	No	No
Jamaica	No	No	No		
Mexico	No	No	No	Yes	Yes
Panama	No	No	No	Yes	Yes
Paraguay	No	No	No		Yes
Peru					Yes
Suriname					
Trinidad and Tobago		Yes	Yes	Yes	Yes
Uruguay	Yes	Yes	Yes	Yes	Yes

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