3 Primary health care for resilient health systems in Latin America

Over the past two decades, LAC-7 countries have had important improvements in terms of population health. These health improvements are linked both to Latin America's socio-economic progress and people's increasing access to better preventive and curative care. Currently, LAC-7 countries face new health challenges related to an ageing population and an increasing prevalence of risk factors for health and non-communicable diseases. In addition, LAC-7 countries have been one of the most affected regions of the world in terms of COVID-19 mortality, revealing health system bottlenecks that prevented a more effective response to the pandemic. These include highly fragmented health systems, lack of financial and human resources and an unfinished agenda towards strengthening primary health care. Increasing preparedness and resilience of LAC-7 health systems to face future high impact shocks will be critical not to reverse many of the well-being and health gains achieved during the last two decades.

Introduction

Health care systems in Latin America have had important improvements in the last two decades (OECD/The World Bank, 2020[1]). Aiming at universal health, policies have been implemented to improve access to care, coverage and care quality. Argentina, Brazil, Chile, Colombia, Costa Rica, Mexico and Peru (LAC-7) have implemented policies to strengthen primary health care (PHC) and place it at the centre of their health care strategy. However, there is significant variation in the effective implementation of these policies across countries. While in most other OECD health systems primary health care covers the entire population, the quality, range of services, and coverage of PHC in LAC-7 countries still has room for improvement. System fragmentation, and bottlenecks of human and physical resources are common denominators to most LAC-7 health systems, preventing an effective response to evolving health care needs. In addition, the LAC-7 region is confronted, as many other OECD countries, to an ageing population and increasing prevalence of long-term, chronic non-communicable diseases. This epidemiological transition calls for strong PHC to improve population health by carrying out health promotion and immunisation activities, providing regular exams and screening to identify diseases, and providing routine care for underlying health conditions.

This chapter provides an overview of the organisation of health systems and primary health care systems in LAC-7 countries. It starts by giving an overview of LAC-7 socio-economic characteristics, highlighting several gains achieved over the past two decades. Then, the chapter explores the organisational structure and the main stakeholders of each country's health system, with a special focus on the primary health care system. Finally, the chapter concludes with an overview of the main health challenges faced by each country's population, focusing on the evolution of health outcomes, causes of death and health risks in the region.

Socio-economic characteristics of LAC-7 countries: A brief snapshot

The section gives a brief snapshot of LAC-7 gross domestic product (GDP), ageing projections, income distribution and the prevalence of poverty to understand the social context in the region when the COVID-19 pandemic hit. The indicators presented in the section are related to the social determinants of health, and as such, they have significant impact on population's health but also in country's response capacity to health shocks.

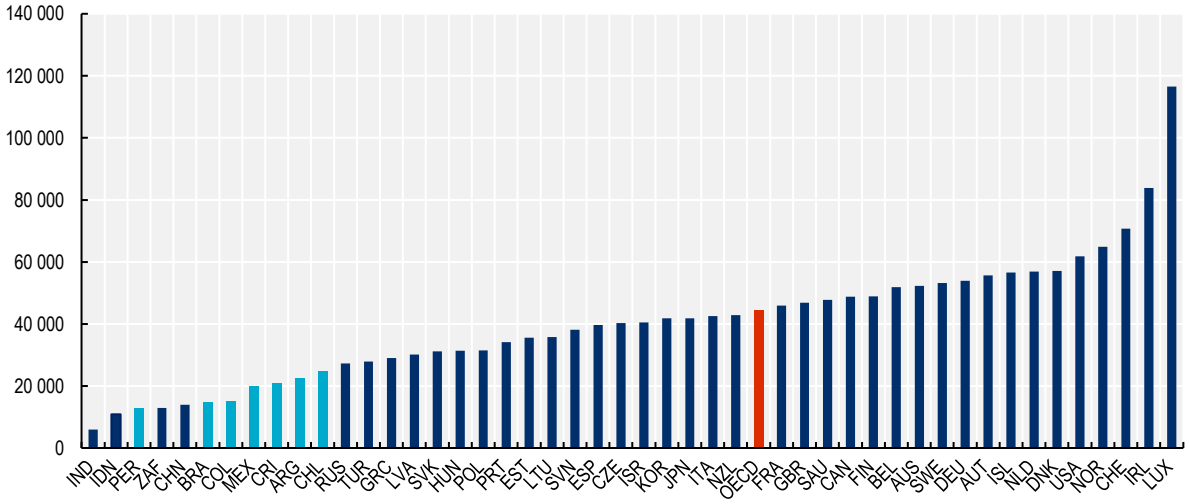
The Gross Domestic Product of LAC-7 countries indicates important differences in available resources

The GDP per capita in LAC-7 countries (at USD 18 576 on average across LAC-7) is lower than the OECD average (at USD 44 416 per capita). Among LAC-7 countries, there are important disparities. Peru has the lowest GDP per capita at USD 12 577, while Chile has the highest at USD 24 588 (Figure 3.1). Except for Peru (third lowest GDP per capita after India and Indonesia among OECD, LAC-7 and G20), other LAC-7 countries have higher GDP per capita than G20 countries including India, Indonesia, China and South Africa.

Considering that in 2019 the world per capita GDP was USD 17 630 (World Bank, 2021[2]), we can place the cluster of LAC-7 countries at the lower and higher end of countries around the world's average. This goes in line with the World Bank classification of countries by income, where all but Chile (lower end of high income countries) are classified as upper middle income. Countries in the series have had important GDP growth in the past two decades, increasing substantially the available resources in the health and social sectors, with direct impact on people's health. However, the more limited resources in LAC-7 when compared to other OECD countries amplify the challenge of fighting the COVID-19 pandemic.

Figure 3.1. GDP per capita in OECD, LAC-7 and G20 countries

GDP per capita, PPP (USD), 2015-20 average



Source: OECD (2021[3]) Gross Domestic Product (GDP) (indicator), https://doi.org/10.1787/dc2f7aec-en. For Peru, World Bank Database (2021[2])

The LAC-7 region is characterised by high income inequality

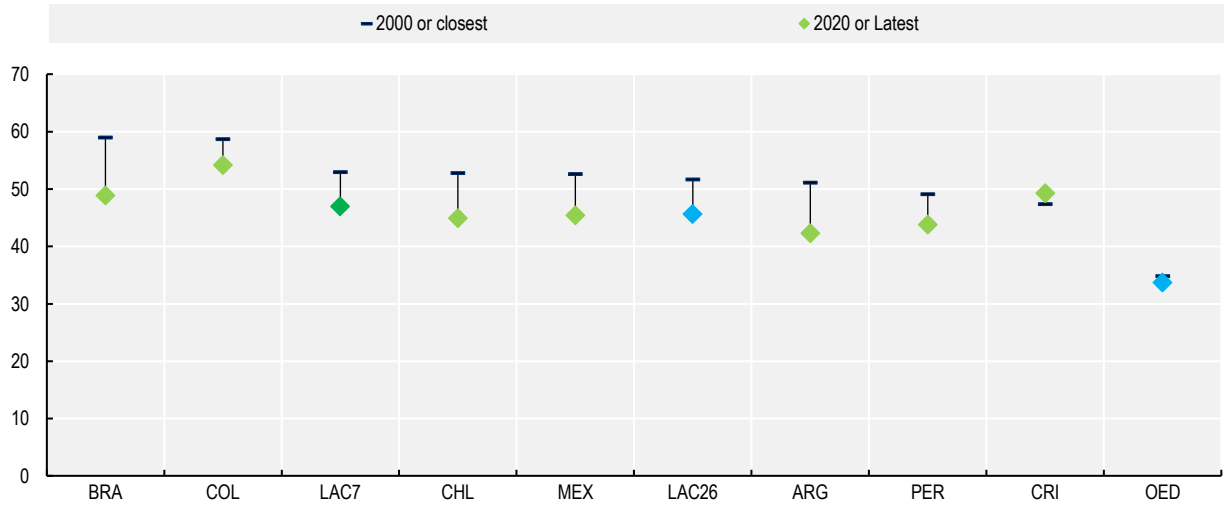
The changes in GINI index (The Concise Encyclopedia of Statistics, 2008[4]) from 2000 to 2020 in LAC-7 countries shows some progress towards reducing income inequality (Figure 3.2). However, progress in income inequality has slowed down and even reverted in the past years, having small net changes when analysing the past two decades. The biggest reductions are shown in Brazil (with a reduction of 17% between 1999 and 2020), and Argentina (with a reduction of 18% between 2000 and 2020). Colombia saw the smallest reduction in income inequality over the past 20 years (at 9%), and Chile and Mexico saw similar level of reduction of 15% in the past two decades. Costa Rica is the only country in LAC-7 where income inequality increased, which took the country from being the least unequal in 2000 among the LAC-7, to the second most unequal country (after Colombia) in 2020.

The GINI index in the LAC-7 countries is consistently higher than 40 points (the threshold of high income inequality), above the OECD average of 34 points and the LAC-26 average. The high GINI index in LAC-7 countries means a high concentration of income at the very top of the population distribution. Moreover, the COVID-19 pandemic has deepened the deprivation level of already disadvantaged population, with income inequality projected to have increased by 3% in Argentina, Brazil and Mexico between 2019 and 2020 (OECD, 2021[5]).

In addition, high-income inequality resonates with health system fragmentation. The connection is embedded in the fact that high income population can afford and will seek for better quality than the standard of care. This generates incentives to create several sub-systems: some of high quality for a small part of the population, while the rest is treated with much fewer resources.

Figure 3.2. Evolution of the GINI Index between 2000 and 2020

0 to 100 scale



Note: Brazil uses data from 1999 for baseline year. A GINI of 0 represents perfect income distribution, while 100 says that 1% of the population has 100% of the resources.
Source: World Bank (2021[2]), World Development Indicators.

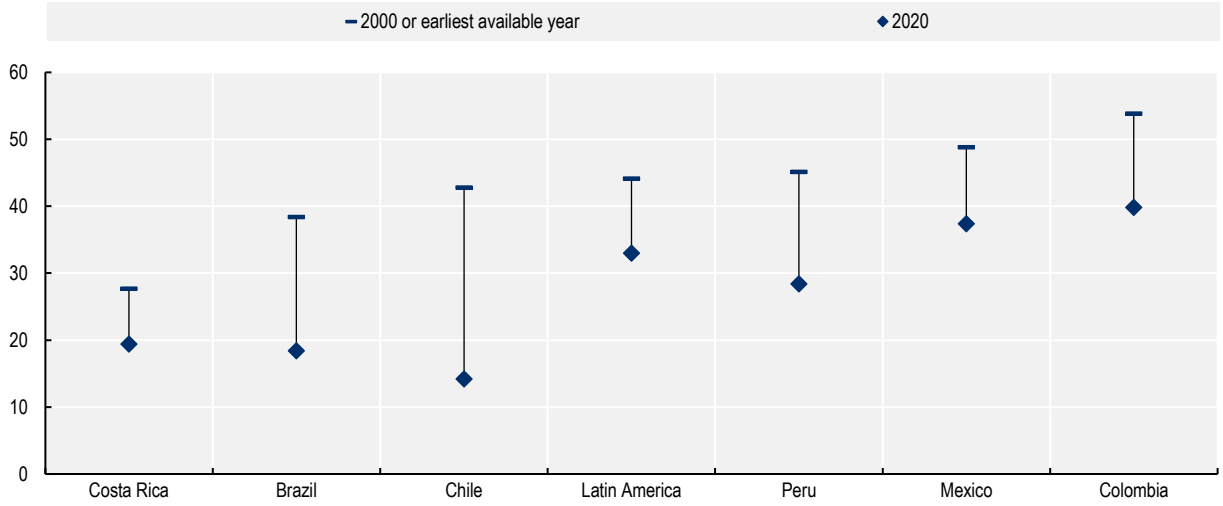
In addition to high levels of income inequality, corruption is an important problem in Latin American health systems, and experts say it has been enhanced during the COVID-19 crisis (Gedan et al., 2020[6]). In 2013 transparency international exposed that in LAC, 42% of the population on average considers the health sector to be corrupt or very corrupt (8 percentage points higher than in OECD countries). In LAC-7, the country with highest perceived corruption in the health system was Colombia, with 63% of the population considering the Colombian system corrupt or very corrupt. Argentina was the lowest with only 26% of the population reporting perceived corruption. Corruption is a determinant of wasteful spending, and has an important impact on the performance and efficiency of health systems (OECD/The World Bank, 2020[1]). Because of the emergency generated by the pandemic, countries activated fast-track protocols for procurement and distribution deals, consequently with less controls, time to investigate and public awareness, which may have exacerbated the problem (Gedan et al., 2020[6]).

From 2000 to 2020, LAC-7 countries made progress towards eradicating poverty

Defined as people without sufficient income to buy a basic food basket and other necessary goods and services, poverty in LAC-7 was reduced from 42.8% of the population in the year 2000 to 26.3% 20 years later. Over the same time period, poverty in the whole Latin American region decreased from 44% to 33% of the population. This important decrease is led by Chile (from 42.8% to 14.2%) and Brazil (from 38.4% to 18.4%), followed closely by Costa Rica (27.7% to 19.4%). Comparing the cases of Colombia and Brazil is interesting, as these two countries have similar GDP per capita and GINI index. However, Brazil was very successful in reducing poverty since the implementation of the Bolsa Familia programme (currently known as the Auxílio Brasil programme) (Ferreira de Souza, Osorio and Paiva e Sergei Soares, 2019[7]), while Colombia in 2020 is still the country in the series with the higher percentage of the population living in poverty (Figure 3.3). It is important to highlight that Colombia was reducing poverty at a positive pace until 2019 only reverting the trend in 2020, as other countries in the LAC region. The relation between the increase in poverty and the COVID-19 pandemic is hard to miss, and has been further explored in the OECD report “How’s Life in Latin America?” (OECD, 2021[5]).

Figure 3.3. Share of people without sufficient income to buy a basic food basket and other necessary goods and services

Percentage of the population



Note: Brazil, Peru use data from 2001 and Colombia from 2002 for earliest available year.
Source: ECLAC (2022[8]), CEPALSTAT database, based on data from Household Surveys Database.

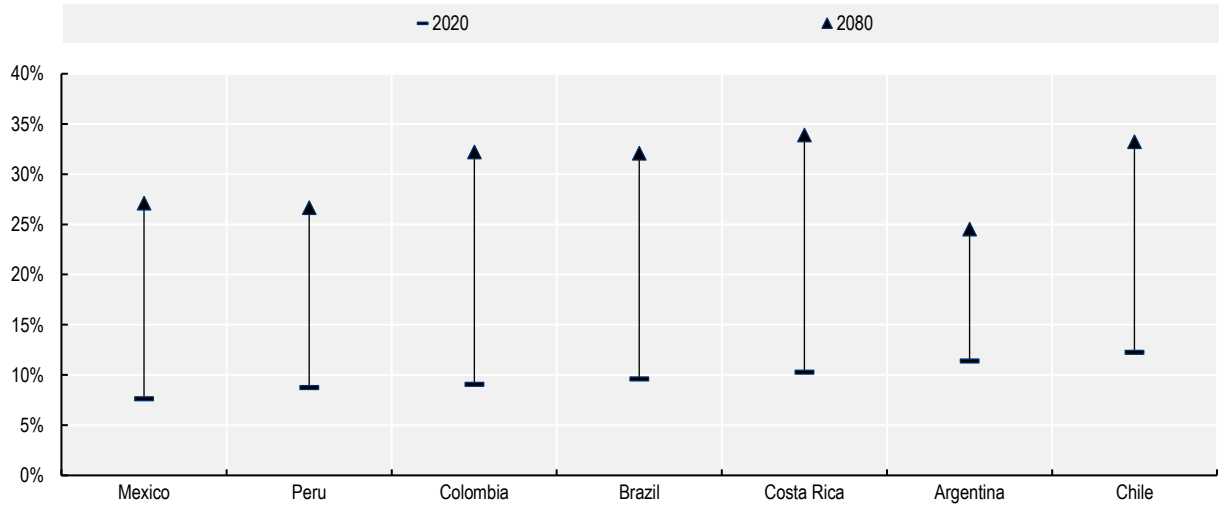
LAC-7 countries are projected to experience a rapid population ageing

The proportion of the population aged 65 years and older is expected to increase substantially in all LAC-7 countries. As countries improve its socio-economic conditions and life expectancy increases, the composition of the population changes with a rising share of older people, increasing the burden on the health system due to growing burden of chronic non-communicable conditions among this population.

According to UN's projections, by 2080, the share of population aged 65 years or more will increase on average by 20 percentage points, reaching 25% in Argentina, 27% in Mexico and Peru, and more than 30% in Colombia, Brazil, Costa Rica, and Chile (Figure 3.4). The shift in the population demographic will have important implications for health needs, putting pressure on both the health care systems and the economy. Countries will have to invest in long-term care and strong primary health care system to manage chronic non communicable conditions. The demographic changes will add pressure to existing health systems unless appropriate measures are put in place for the systems to cope with increased demand linked to the ageing phenomenon.

Figure 3.4. Ageing projections in LAC-7 countries

Share of the population aged 65 years or more, 2020-80



Source: United Nations, Department of Economic and Social Affairs, Population Division (2019) (2019[9]), World Population Prospects 2019, Online Edition. Rev. 1.

The health care systems in selected LAC countries

This section summarises the main characteristics of health care systems in LAC-7 countries. This includes the health system governance, insurance schemes and key institutions for health care delivery. A special section present the organisation of primary health care system in each LAC-7 country, highlighting common and different features between systems.

Health insurance models

Most health care systems fall under one of two broad categories, either National Health Systems (NHS) or Social Health Insurance models (SHI). In other cases, countries combine elements of the two into a hybrid model. There is no one ideal model for the organisation of health services, and no model category has evidenced better performance than the other consistently in all health system objectives. The classification of LAC-7 countries health systems into these categories can be found in Table 3.1.

The National Health System model and the Social Health Insurance model

In a National Health System model, health care is primarily financed through governmental schemes. As such, funding comes from general and specific taxation such as tobacco and alcohol excise taxes. In Brazil, the National Health System (called the Sistema Único de Saúde) has universal health coverage, where people is automatically entitled to care based on their residency (Massuda et al., 2020[10]).

In social health insurance models, the purchasing and providing functions of the system are responsibility of separate entities. Health care is organised through compulsory health insurance schemes, through either public or private insurance entities. Usually, there is a universal coverage scheme that insurance entities need to follow, over which they can provide additional services (e.g. "*Plan de Acceso Universal a Garantías Explícitas*" (AUGE) in Chile, "*Plan Esencial de Aseguramiento en Salud*" (PEAS) in Peru or "*Programa Médico Obligatorio* (PMO)" in Argentina). Health provision is purchased by insurance entities

to comply with their coverage schemes. Funding comes from the payment of social contributions or health insurance premiums. People that are unable to pay social contributions or insurance premiums is covered by the state. Chile, Colombia and Costa Rica follow this model.

Some countries have a hybrid model, financed with a mix of compulsory social contributions and governmental schemes. Coverage is then provided by several fragmented insurers. Argentina, Mexico and Peru follow this model.

Table 3.1. Health insurance models in LAC-7

LAC-7 countries by type of health insurance model

National Health System	Hybrid insurance system	Social Health Insurance
Brazil	Argentina	Costa Rica
	Mexico	Chile
	Peru	Colombia

Three insurance schemes

The insurance scheme depends on the affiliate contributory status and can be related to the insurance coverage plan and the range of available insurance institutions for affiliation. We can distinguish three types of affiliates:

- **Non-contributory scheme**, including people not employed in the formal sector and not able to pay insurance premiums, usually poor and/or vulnerable groups e.g. children, disabled population or pregnant women. The state subsidises health coverage for this group of population in the existing insurance institutions.
- **Contributory scheme**, including people employed in the formal sector that pay health care as percentage of their salary. In some cases e.g. Chile, they can affiliate to a public or private insurer depending on the annual income of the employee.
- **Private voluntary scheme**. These are people that seek private insurance as either an alternative or a complement to the National Health System or Social Health Insurance plans. They provide payment through insurance premiums.

Health care system governance and model of care

The ministries of health (MoH) are the highest responsible authorities within the health care systems of all LAC-7 countries. The role of the MoH varies between countries, resulting in different levels of centralisation. The common standard capacities of the MoH are to act as the regulating body, having quality surveillance responsibilities and guiding health policy, research and technological development. In more centralised systems, the MoH adds to these capacities the responsibility of providing and delivering health care services. At the same time, the health insurance model shapes the landscape of the model of care. National Health System models are predominantly public in terms of governance, funding and provision, while in countries that follow a social health insurance model, social security institutions are responsible for administrating resources and organising care provision contracting public or private providers. The main institutions composing LAC-7 health systems are summarised in Table 3.2.

In Brazil, the MoH, puts special focus on co-ordinating the health care system. Given the National Health System model, governance, funding and provision is organised through the unified health system ("*Sistema Único de Saúde*" (SUS) (OECD, 2021[11]). Private health insurance qualifies for tax reductions, and provide complementary coverage to about 25% of the population that purchases this alternative to deal with deficiencies in care quality and access (Tikkanen et al., 2020[12]). Private health care provision

can be purchased by both private insurers and the SUS. Health care service delivery is decentralised to municipalities. Municipalities, through the municipal secretary of health, manage the financing, co-ordination of health programmes, and both direct delivery and contracting of health care services, including primary health care services.

Costa Rica's health care system is centralised. However, the MoH is only responsible for stewarding the system (standard capacities) and does not deliver health care services. The MoH organise its responsibilities through a network of regional and local offices, each of them is in charge of enforcing national health policies in their jurisdictions. The provision of universal health care services is the responsibility of an autonomous entity that also act as the system main public insurer, the "*Caja Costarricense del Seguro Social*" (Costa Rican Social Insurance Fund – CCSS). CCSS is an autonomous institution that independently organises the financing, purchasing and the provision of most health care services in Costa Rica through both their own and external providers (both public and private). The *Instituto Nacional de Seguros* (National Insurance Institute – INS), another public and autonomous institution, operates in both the private and public sector and covers labour and road accidents providing insurance, inpatient and rehabilitation care. The private sector is composed by insurance companies, co-operatives, self-management enterprises and private clinics and hospitals. Available estimates suggests that complementary private insurance is purchased by approximately 30% of the population (Columbia Public Health, 2019[13]). MoH oversee private health care services through a public entity called the Superintendencia General de Seguros (General Superintendence for Insurances – SUGESE).

In Chile the MoH, represented by two undersecretaries ("*Salud Pública*" and "*Redes Asistenciales*"), is responsible for ensuring care supply, providing public health guidelines and financing health services. Health care provision is decentralised, and overseen by local governments at a regional or municipal level. A network of hospitals, walking-in clinics and outpatient services ("*Sistema Nacional de Servicios de Salud*" – SNSS) provides public health services within a specific geographic area. The network is related to the "*Redes Asistenciales*" undersecretary with decentralised governance into the regional health services and is headed by a regional directorate ("*Dirección de Servicio*"). Private providers can also be part of the network if they have standing contracts with the public insurance scheme. Health care coverage is provided primarily either by the state-owned National Health Fund – "*Fondo Nacional de Salud*" (FONASA), or by privately owned social security institutions, "*Instituciones de Salud Previsional*" (ISAPREs). FONASA covers around 78% of the population, ISAPRES cover around 17-18% of the population, while a further 3-4% are covered under the armed forces insurance scheme (OECD, 2019[14]). Private health care providers can be contracted by both private and state owned social security. There is a market of complementary private insurance, which in 2007 was estimated to cover 24% of the population, mainly through collective insurance linked to co-operatives and labour unions (Departamento de Estudios y Desarrollo, 2008[15]).

The health system in Colombia is organised as a competition model. The MoH (and Social Protection) is responsible for overall stewardship and gives special attention to formulating, monitoring and enforcing regulations aimed at minimising market failures and guaranteeing equitable access to health services. Long-term objectives and responsibilities to deal with health challenges are defined in ten-year national public health plans (Second version 2022-31 in implementation phase). Purchase, provision of health care services and managing population health risk are the responsibility of the system's insurers, "*Empresas Promotoras de Salud*" (EPS). Health care provision happens through direct contracts between insurers and health care providers ("*Instituciones Prestadoras de Salud*-IPS"). EPS are public or private entities that act as intermediaries and managers of the resources provided by the state. They are responsible for implementing the objectives set by the MoH, developing the guidelines and their protocols, and supervising the performance of health care. IPS are constituted by both public and private outpatient and inpatients services with different service complexity levels. Complementary private insurances exists, known as "*Medicina Prepagada*" that act as both insurers and providers of some elements of health care (estimated to cover around 9% of the population (Fasecolda, 2020[16]). People are affiliated with the social security system through either the contributory or the subsidised regime (in 2021 48% vs 47% respectively)

(Ministerio de Salud y Protección Social Colombia, 2022[17]). The latter includes people outside of formal employment and a special benefit regime for armed forces, teachers and other selected services.

Argentina's health system is one of the most fragmented and segmented in the LAC-7 region, where each of the provinces have independent responsibility for leadership, financing and delivery of health services. Provinces can transfer this responsibility to the municipalities depending on their capacities and resources. The role of the federal government is limited to oversight and funding of the health care system for people without coverage. The Argentinian health system has elements of a National Health System model, reflected in the public coverage and provision scheme available for everyone in the country. At the same time, as in the social health insurance model, contributory affiliates (and family) have the possibility of entering the compulsory social security scheme, managed by insurance institutions called "*Obras Sociales*". There are more than 200 of such entities at the national level, regulated by the Superintendence of Health Services (SSS). These institutions finance health care services of their affiliates in both the public network and private providers. Finally, there are private insurers that can complement or replace other insurance schemes. As in Colombia, they are known as "*Medicina Prepagada*" and cover 15.7% of the population (either by association with their *Obra Social* or by voluntary enrolment) (Instituto Nacional de Estadísticas y Censos. República Argentina, 2010[18]). Private insurance is reserved for private voluntary affiliates and typically covers for private providers.

In Mexico, the delivery of health care services and federal and local health programmes is responsibility of each autonomous state. The central government, through the MoH, provides public health programmes and has responsibility over national health information, data, and statistics. The health system is currently undergoing a major reform that started in December 2018, with the removal of "*Seguro Popular"* and the creation of a new system under the Health Institute for Wellbeing ("*Instituto de Salud Para el Bienestar"* – INSABI) as the universal health programme. Under INSABI, the federal government has now recentralised procurement, personnel (health workers have been hired as federal employees) and health service delivery (Reich, 2020[19]). Alongside the public universal health programme, health coverage in Mexico can be provided through a variety of sub-systems – multiple insurers with individual's affiliation usually determined by their employer. The largest of these is the "*Instituto Mexicano del Seguro Social*" (IMSS), which provides health coverage alongside other services to contributory affiliates. Likewise, the Institute for Social Security and Services for State Workers (ISSSTE) provides coverage for federal workers. Health service providers are different for the multiple insurers. The fragmentation of the health system can generate care continuity problems when the situation of an affiliate changes. The system relies heavily on private providers, where up to 67% hospitals and 54.5% registered outpatient clinics are private (DGIS, 2019[20])

In Peru, the health system is fragmented into public and private subsystems, each replicating fundamental health care system activities with separated governance structures. Each system has separated financing, service delivery mechanisms and works with their own health care providers. The MoH is responsible for electing the head of the regional health directorates ("*Direccion regional de Salud* – DIRESA") and local hospitals. Further, the "*Superintendencia de Salud*", a governing body part of the MoH, is responsible for authorising, controlling and supervising the good performance of the health system. The "*Seguro Social de Salud*", more commonly known as EsSalud, covers all salaried formal workers and their families as contributory affiliates (24.8% of the population). The "*Seguro Integral de Salud*" (SIS) provides coverage for Peruvians who do not have other health insurance (44.4% of the population). SIS manages two coverage regimes; the subsidised regime and the semi-contributory regime where households contribute with health premiums (Instituto Nacional de Estadística e Informática, 2018[21]). Private or public health provider entities ("*Entidades Prestadoras de Salud*" – EPS) exist as complementary insurance and purchasing entities. Private health insurance covers only a small proportion of the Peruvian population (5.1%) and complement or replace the other insurance schemes (Instituto Nacional de Estadística e Informática, 2018[21]). Similar to Mexico, independent public or private providers ("Instituciones prestadoras de servicios de salud- IPRESS") deliver health care, and either belong, or are directly linked, with the different insurance schemes.

Table 3.2. Summary of main institutions in health care system

Health care systems' main institutions by country and function

Country	Governance model	Health care provision	Public insurance	Private insurance
Argentina	Decentralised	Network of public providers Private providers	National and provincial health ministries Obras Sociales	Private insurance companies ("Medicina Prepagada")
Brazil	Decentralised	SUS	SUS	Complementary insurance companies
Chile	Decentralised	SNSS Private providers	FONASA Separate system for armed forces	ISAPREs Complementary insurance companies
Colombia	Decentralised	IPS	EPS	EPS Complementary insurance companies ("Medicina Prepagada")
Costa Rica	Centralised	MoH CCSS Hospitals & primary care teams Private providers	CCSS	Private insurance companies
Mexico	Re-centralised (before 2018, the health system was decentralised)	INSABI	IMSS, ISSSTE	Private insurance companies
Peru	Decentralised	IPRESS	SIS EsSalud EPS	EPS

Vertical integration versus horizontal integration

Vertical integration refers to a system where the purchasers of health care services (insurers) and the providers of health care services are the same institution or are directly linked (e.g. owned by the same economic group). Horizontal integration has, in general, a more flexible definition. When stakeholders at the same level (providers or purchasers) belong to the same institution or have agreements to co-ordinate care, incentives, information, accountability and/or responsibilities, we understand the system to be horizontally integrated.

Costa Rica, Mexico and Peru have vertically integrated health services, where insurers have their own care providers. Colombia is partially vertically integrated as their integration is limited by a legal ceiling to a 30% of the total activity. Argentina, Brazil and Chile are vertically fragmented. Even though there are public insurers and public providers working directly with each other in these three countries, the institutions are independent of each other. Horizontal integration is more common among public insurers and providers. The CCSS in Costa Rica has an horizontally integrated network of financial and administrative organisation of services, while in Brazil's SUS, Chile's public insurer (FONASA) and the subsidised regime in Mexico (INSABI) are horizontally integrated at purchasing level. Peru, Argentina (Novick, 2017[22]) and Colombia are horizontally fragmented at both purchasing (between institutions and/or geographical governance structures) and provider level.

Working towards integrated care, functions are increasingly horizontally organised in most OECD health systems. Vertical integration has advantages, like lower transaction costs, and disadvantages, including losing the market competition to incentivise the optimisation of quality and prices (OECD, 2015[23]). However, in vertically integrated systems each subsystem has little incentive to integrate horizontally. The problem is enhanced when there is a lack of sectoral leadership that co-ordinates and articulates the country's public and private providers. Important weaknesses can arise, for example, in the setup of centralised information systems for monitoring and evaluating care quality and other key strategic issues

(as in the case of Colombia). Having identified fragmentation issues, Colombia created Integrated Health Care Pathways or Routes (Rutas Integrales de Atención en Salud), designed to organise the necessary arrangements, actions and responsibilities to co-ordinate and provide integrated care.

In health systems with various vertically integrated sub-systems, there are no incentives to share information, guidelines or to co-ordinate care between parallel subsystems. This is the case of Peru and Mexico, where the different sub-systems have little co-ordination and no integration between them (OECD, 2017[24]).

Fragmented health insurance systems often lead to coverage gaps and service inequalities

Countries with a social health insurance model allow insurance companies to provide more comprehensive benefit packages in addition to the standard of care, usually financed by premiums and co-payments, thus creating care disparities according to the payment capacities of the population (Box 3.1 for definition of standard of care). In Argentina, a heavily fragmented system both horizontally and vertically, health inequalities are rooted both in the different coverage packages offered on top of the standard of care and in the inequalities between municipalities. Inequalities are enhanced in systems that are vertically integrated but heavily fragmented at care provision level, as in Mexico and Peru. In these systems, insurers and providers replicate functions in parallel subsystems according to the population contributory status, thus introducing structural inequalities. Moreover, 24.5% of the population in Peru in 2018 and 26.5% of the Mexican population in 2020 had no insurance coverage (Quispe Duran, 2019[25]; Durand Carrión, 2018[26]; Velázquez, 2021[27]).

Box 3.1. Standard of care

What do we mean by standard of care?

LAC-7 countries have defined a basic care coverage plan that is compulsory for all insurers and, hence, works as the standard of care for the health system. These care plans are usually called “universal”, but the term universal is used to signal that they are available for all the population, not necessarily covering all health care needs. In Brazil, that follows a National Health System model, the standard of care covers all diseases and health conditions of all the population (OECD, 2021[11]) effectively fitting the definition of WHO for a universal health insurance (WHO, 2022[28]). In the other countries in the region, the standard of care covers a set of diseases chosen because of the burden of disease they represent. In Chile, the plan for universal access for explicit guaranties (AUGE) ensures access, financial protection and quality for 80 health problems. In Argentina, the compulsory medical plan (PMO) defines the standard of care for all the system insurers, independently of their governance structure, and focuses on the coverage of a comprehensive set of health services. Peru has the essential plan of health coverage (PEAS) that aims at providing the minimal care plan for all the population and ensures access and coverage in terms of opportunity, service and quality.

Expanding the standard of care to reduce health care inequalities

Inequalities that are rooted in the coverage, access, range of services and some elements of care quality will be directly reduced by expanding the standard of care, so that a larger portion of the population and a larger portion of health issues is included. However, inequalities that are rooted in the differences between care providers caring for population according to their affiliation status will have limited improvement with the expansion of the standard of care. Prompt access to care (with limited waiting lists) for example, depends both in the standard of care and in the service capacity of the providers to care for patient’s needs. Other aspects of care quality, such as hotel service in inpatient care and access to the latest health technology and pharmacology, are other aspects that are commonly unaffected by the standard of care.

Even in Brazil, the only country in the region with a National Health System model, there are disparities in care services. The quality and/or coverage of the public system pushes people (>25%) to use complementary private health insurers and seek quicker and better quality care in private providers (Fontenelle et al., 2019[29]). This is accentuated by the fact that there is very little communication or data exchange between providers (or schemes) when patients move between treatment under SUS and private coverage (OECD, 2021[30]).

System fragmentation can also lead to differences in health spending. Cotlear et al. (Cotlear et al., 2015[31]) describes how per capita spending by the government on the non-contributory system was typically narrower (it covered less benefits, for example, no access to breast cancer treatment) than spending on the contributory system and voluntary private sector system.

Universal health insurance schemes are being pushed across LAC-7 countries to reduce health care inequalities. Challenges of these programmes can be partially linked to system fragmentation. SUS in Brazil covers all diseases and health conditions of all the population, making the standard of care part of the universal health insurance. SHI systems in Costa Rica, Chile and Colombia have universal insurance plans covering 91%, 78% and 50% of the population respectively (Cotlear et al., 2015[31]). Argentina's universal health coverage programme (The Health Benefits package of plan "*NACER"*) started caring only for maternal and child health, therefore covering only around 4% of their population, but has then been expanded to cover for the population with public coverage (around 44% of the population). The new range of covered services guarantees access to over 800 comprehensive health care services, and is financed by transferring funds to the provinces based on equity and performance criteria (the new programme is called SUMAR).

Primary health care in LAC-7 countries

Primary health care governance and model of care

Not only do the selected LAC-7 countries present different levels of centralisation at both governance structure and PHC core functions, but they also have a different level of PHC comprehensiveness. These characteristics determine the strength of primary health care and its importance in the health care system of LAC-7 countries. Overall, Brazil, Chile and Costa Rica have a relatively more developed PHC system, followed by Argentina, Colombia, Mexico and Peru.

PHC is governed by local and/or regional governments in all countries except Costa Rica, and more recently Mexico. Argentina, Brazil and Chile's primary health care system is decentralised to municipalities. There is a degree of co-ordination and shared accountability within the municipal primary care services in all countries, which avoids larger fragmentation of PHC services. However, in decentralised systems, municipalities provide supplementary funding to the primary health care sector which leads to disparities in health care quality across municipalities (OECD, 2021[11]).

PHC is also decentralised to regional governments in Colombia and Peru, with Peru being double decentralised because of several insurance scheme subsystems. System fragmentation is determined by little to no co-ordination between providers at the same level of care and no shared accountability or responsibilities, leading to overlapping functions between providers and target populations. It is important to mention that policies have been created to attend this issue, such as the Integral Health Service Policy (Política de Atención Integral en Salud) that Colombia launched in 2016.

All LAC-7 countries rely upon a network of primary health care composed of multi-disciplinary teams (except Mexico which also relies on solo-practices of primary care practitioners) to act as the first-point of care for non-emergency affections and routine care (Table 3.3). The reliance on multi-disciplinary PHC teams to be the first-point of care is an effort to encourage appropriate use of health services, as it enables the possibility to provide proactive, preventive and co-ordinated care. The 2004 Federal Health Plan in

Argentina, the Integral model for health delivery (Modelo de Atención Integral en Salud-MIAS) in Colombia the biopsychosocial model implemented by the Ministry of Health in Chile since 2013, and the introduction of mobile PHC units in Peru are examples of policies to improve access to high quality PHC in LAC-7.

However, there is a circular causality between the ability of PHC to comply with its core functions and being the first-point of care. On the one hand, the benefits of having quality and comprehensive PHC are only achievable with effective provision and use of PHC as the first-point of care. On the other hand, the effectiveness of PHC delivery as first-point of care is determined by the access, quality and comprehensiveness of PHC services. In Mexico for example, the establishment of PHC as an integral part of the health system is not optimal, with limited opening hours. Therefore, people commonly seek first-contact care in hospital emergency departments or pharmacies that provide physician consultations. In a similar vein, because of the small number of primary health care facilities in Peru; 40% of EsSalud users are ascribed to a hospital as their first point of care. In Brazil, as of August 2022, 27% of the population are not covered by family health teams (FHTs) and too many patients bypass primary health care and directly seek care in outpatient specialties and hospitals. This means that opportunities for proactive, preventive and co-ordinated care are lost.

Models of care with mandatory PHC registration and gate-keeping nudge first-point of care and increase the opportunity to deliver comprehensive health care services ranging from health promotion, diseases detection to managing chronic conditions. Unlike many other OECD countries (Box 3.2), there is no direct incentive and no obligation to register with a primary health care physician in Brazil, Colombia or Mexico. Only in Chile, patients with public insurance scheme are required to register with a primary health care physician while in Argentina and Costa Rica patients have financial or quality incentives to do so. For example, Costa Ricans are required to register to a local PHC centre in other to access all benefits provided by the social insurance of CCSS, including receiving sick leave payment when this is prescribed by a private doctor. PHC gatekeeping exists for most specialist care services either by compulsory referral or financial incentives in Chile, Colombia, Costa Rica and Mexico, while there is no formal referral system in Argentina, Peru or Brazil.

PHC facilities have both common and different functions across countries. Common functions relate to early detection and disease management, while responsibility for public health is shared between the PHC delivery network and several specific institutions. On the other hand, functions that are different between countries relate to the more comprehensive range of responsibilities found in well-developed PHC systems, such as co-ordinating care delivery, addressing health risk factors, and identifying at risk or target population.

In Argentina, PHC facilities (“Centro de Atención Primaria”- CAPS) are formed by inter-disciplinary teams made up of a wide range of primary care practitioners (PCP). These include: general practitioners, clinicians, paediatricians, gynaecologist, nurses, social workers, psychologists and obstetricians, nutritionists, speech therapists, sociologists and dentists. The PHC units are also responsible for health promotion and protection actions, delivered in the form of targeted programmes by population groups and health areas e.g. maternal and child health, nutrition or tuberculosis. Public health functions are shared with the Directorate for Health Research, but the Ministry of Health also has a National Directorate of Epidemiology and Health Situation Analysis, in charge of Epidemiological Surveillance.

In Brazil, primary health care is delivered through family health teams (FHTs) that follow a community-based approach. The teams are composed of a physician, nurse, nurse assistant and community health agents, and cover a defined population of between 2000 and 3 500 people. Community health agents provide an essential part of public health services by visiting families, identifying issues or risk factors, and supporting their access to preventive care or treatment (OECD, 2021[11]). The National Health Council is a permanent body of SUS with the mission to oversee, monitor and supervise public health policies. It is composed of health professionals, the scientific community, service providers and the private sector and in its membership includes representatives of users, workers, SUS managers and health service providers. Moreover, the constitution guarantees community participation in the public health system at all levels of

governance. This is done through health councils and health conferences, composed of 50% community members, 25% providers, and 25% health system managers.

A defined basic primary health care package is provided by a multi-disciplinary team in Chilean PHC. There are several types of primary health care centres with varied levels of services complexity, denominated "Centros de Atención Primaria de Salud" (APS). These include ambulatory care, family medicine, rural health posts, community care, rehab centres, primary emergency care, among others. There are also few specialty clinics providing primary health care, which are part of the hospital network and more directly dependent on the regional health administration. As in other countries, PHC in Chile provides all three core functions, as explicitly stated in the Integral Model for Family and Community Health (Ministry of Health, 2013[32]). Public health functions are shared with the National Institute of Public Health, responsible for health promotion and prevention through quality surveillance, accreditation, health research, and health technology assessment (Instituto de Salud Pública de Chile, 2022[33]). At a higher level, these responsibilities are shared with the undersecretary of public health. Infectious disease surveillance, including disease outbreaks, is undertaken by the Department of Epidemiology in co-ordination with the Departments of Public Health of Regional Ministerial Secretariats (SEREMIs).

In Colombia, the PHC network of service delivery is constituted by four types of primary health care units: health posts (in charge of promotion and prevention); health centres (for outpatient consultation); health centre with beds (which conduct deliveries without complications and minor emergencies) and; local hospitals (which provides hospital care of low complexity). At the same time, complementary private insurers can provide primary health care through contracted PCPs. Several elements of public health are external to the PHC network of service delivery. The MoH has health promotion responsibilities and in exceptional cases, as for the COVID-19 pandemic, can organise primary health care independently from the PHC network. In parallel, EPS has responsibilities over, and organises activities of health promotion and disease prevention. Epidemiologic surveillance is responsibility of the National Health Institute and Public Health Observatory, while the National Health Observatory (department in the National Health Institute) is responsible for the surveillance of public health information and provision of policy recommendations.

Primary health care units in Costa Rica are called "Equipos Básicos de Atención Integral en Salud" (Basic Teams for Comprehensive Health Care – EBAIS), and are formed by multi-disciplinary teams delivering PHC in all its core functions, health promotion, early detection and disease management. Further, referrals or direct transfers to secondary care are also co-ordinated by EBAIS. The MoH delegates care delivery responsibilities to the CCSS and, instead, focuses primarily on steward the health system and public health functions. The MoH is responsible and accountable for public health targets, creating an incentive to collaborate actively with other Ministries (e.g. Finance, Education, Sport and Recreation), national trade and industry bodies (e.g. in the pharmaceutical sector) and with civil society organisations. The CCSS public health involvement considers the participation in health promotion and prevention activities.

In Mexico, the undersecretary of Public Health manages national disease prevention and health promotion programmes, which are a mix of disease-focused public health initiatives (e.g. HIV, breast cancer, diabetes or mental health) and person-based preventive health care initiatives (related to ageing, cardiovascular risk or healthy schools). These programmes include vaccinations and control of vector-borne diseases. Further, PHC in Mexico is undergoing an important reform. In 2020 the Comprehensive and Integrated Primary Health Care Model (Atención Primaria de Salud Integral e Integrada) was created, however, the implementation of the new model has been inconsistent because of financial and organisational constraints. Historically, there were four subsystems, governed by the MoH, IMSS, ISSSTE and private providers. The subsystems were vertically integrated with their own PHC providers, composed of outpatient health centres, generalists and nurses, family medicine units and pharmacies. But also general hospitals, hospital clinics and physicians (included specialists) offices, bypassing the opportunity to optimise health care pathways. Each subsystem had departments for attending public health functions, such as epidemiological surveillance and health promotion (WHO, 2017[34]).

The Peruvian health system fragmentation extends to PHC, posing issues for health care quality and continuity (Cuba-Fuentes et al., 2018[35]). A wide variety of primary health care providers exists. The MoH has four types of primary health care providers and EsSalud another four categories. Private health schemes also have an array of providers that provide PHC, from physician offices to all-levels-of-care clinics. Importantly, the government has started to promote exchange and co-ordination between provider networks, which is a step towards better integration within the primary health care system. The largest network of public PHC centres belongs to the Regional Governments and to the Ministry of Health. Around 50% of these do not have a doctor, are located in very remote areas and there is a lack of incentives and human resources policies to attract physicians or other health care professionals. Moreover the "Diagnosis of gaps of infrastructure and equipment of the health sector" report by the MoH shows that 90% of health centres presents inadequate installed capacity. PHC sensitive conditions are regularly referred to hospitals because of the lack of adequate infrastructure or care network (GOPBM – MINSA, 2021[36]). Under these circumstances, PHC functions in Peru are de facto shared with other levels of care, while both the central and regional governments support the public health function in all its capacities. On a more positive note, the report monitoring gaps in infrastructure is a key tool to understand the determinants of PHC performance and implement policies for improvement.

Box 3.2. Primary health care in Denmark

The Danish primary health care governance and model of care

Denmark is a high-income country and has a National Health System with universal coverage funded largely through taxation. Since 2007, the primary care sector in Denmark is decentralised into three political and administrative levels, with the purpose of responding more closely to the needs of the people. In the first level, the state formulates overall national health policy and legislation, co-ordinating and guiding policies implementation at a general level. In the second level, each of the five regions are responsible for the provision of hospital care, services of outpatient specialists, and parts of primary care, including services of General Practitioners, physiotherapy, and dental services for adults. Finally, there are 98 municipalities to act as local administrative bodies responsible for home nursing, care homes for elderly, rehabilitation, general disease prevention, and child dental care.

General practitioners (GPs) play a central role in the Danish health care system. Nearly all Danish GPs are self-employed professionals working on a contractual basis with the regional authorities. Danish GPs are represented by the Organisation of General Practitioners, whose main function is to conduct collective negotiations of the conditions for provision of GP services. GPs practices are subject to far-reaching regulation stating the permitted number of practices, their geographical distribution, remuneration, number of patients listed with a given practice, and conditions under which patients are accepted by the practice. The system of patient lists is a central characteristic of the system. The regulation sets a limit of 1 600 patients per GP.

Danish GPs are the first point of contact within the health care system and are responsible for providing continued care management including acute, chronic and preventive health care. GPs are also responsible for integrating physical, psychological, social, cultural and existential dimensions relevant to the patient health. As of 2016, a special focus has been given to improving the quality of long-term care and reducing hospital admissions among elderly. These functions don't exclusively fall under the responsibilities of GPs. Hospital care costs (up to 20% of total health services) are financed by municipalities, creating a direct incentive for municipalities to invest in preventing hospitalisations. The other 80% of health care costs are financed through a block grant and an activity-related subsidy from the state. The effectiveness of primary care is demonstrated by the relatively infrequent need for hospitalisation for many chronic conditions such an asthma and heart failure and the good performance on management and prescribing for elderly patients with diabetes.

Source: OECD (2017[37]), *Primary Care in Denmark*, https://doi.org/10.1787/9789264269453-en.

Primary health care financing

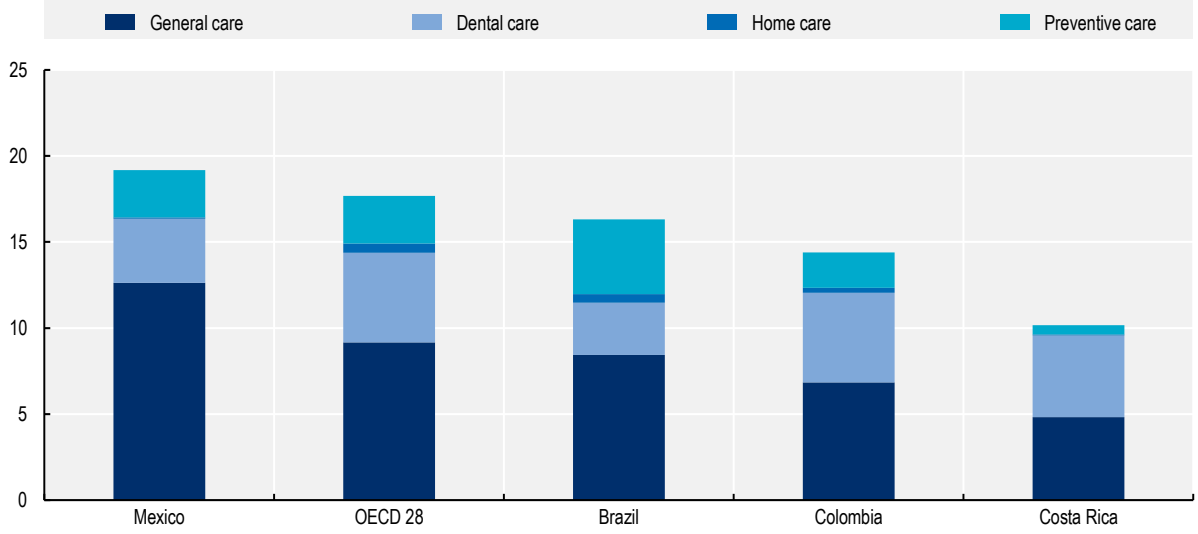
Primary health care expenditure

Throughout the report we define primary health care in terms of its core functions. This definition presents a challenge for calculating expenditure because the responsibility over core functions is usually disaggregated into different governing bodies within health systems. At the same time, categories of expenditure data are not feasibly convertible into PHC core functions. The OECD estimates PHC expenditure by classifying data by health service type and by service provider. However, given data limitations for the LAC-7 countries, PHC expenditure is estimated using the "expenditure on basic services" definition. This definition considers PHC by the type of health service, including outpatient care, outpatient dental care, home-based curative care and preventive services (OECD, 2021[38]).

Using the "expenditure on basic services" definition, Mexico, Brazil and Costa Rica spent respectively 19.2%, 16.3% and 10.2% of their health expenditure to primary health care in 2019 (Figure 3.5). Using the same definition, Colombia spent 14.4% of current health expenditure in PHC in 2017. In Chile (using another methodology for calculation), PHC corresponded to 21% of the public health spending, that in time represented 50.4% of the total health expenditure (World Bank, 2021[2]). The share of PHC expenditure in Chile has been relatively stable from 2011 onwards (Moraga-Cortés, Bahia and Prada, 2021[39]). Even though the different calculation methods and years of analysis make regional assessments unfeasible, we can notice that besides Mexico, all other LAC-7 countries spent less on PHC than other OECD countries (for which the average is 17% of the total health spending). However, the larger percentage seen for Mexico may be explained by a suboptimal use of resources, which relates to its fragmented health system. Adding to the underfunding of PHC, there are differences between investments in private and public systems (Aiken et al., 2021[40]), resulting in quality differences between types of users.

Figure 3.5. Estimated expenditure on PHC

Spending on primary health care services as a share of current health expenditure, 2019 or latest available year



Note: Data from 2019 unless otherwise specified. 2018 data for Australia and Japan, 2017 data for Colombia. It includes 29 OECD countries. Countries with no representative data for general outpatient care have been excluded to avoid misinterpretation. Countries excluded are Chile France, Greece, Ireland, Israel, Italy, New Zealand, Portugal, Türkiye and the United States. Data is not available for Argentina and Peru. Data from Brazil was prepared in the context of the OECD health review.
Source: OECD (2022[41]), OECD Health Statistics.

While out-of-pocket spending is a source of inequalities and prevents universal access to health care, it constitutes an important part of LAC health financing strategies. Out-of-pocket payments put households at tangible risk of catastrophic expenditures and discourages accessing primary and other types of care (Laokri, Soelaeman and Hotchkiss, 2018[42]). Amongst LAC-7 countries, out-of-pocket spending represented on average 28.1% of total health expenditure, a much higher average than on average across other OECD countries in 2019 (at 19.8%).

Payment systems and incentives in LAC-7 countries

As other OECD countries, LAC-7 countries uses a variety of payment systems to finance PHC (Table 3.3). Most systems combine either capitation or global budget with fee for services, and some countries add pay for performance methods. Capitation and global budget schemes imply some degree of territorial organisation for the delivery of services. To optimise the use of resources, health authorities should avoid double financing of providers that overlap in target population and services. Countries with better organised PHC will be in a better position to optimise their funding strategy. An optimal global budget needs an accurate understanding of the health services needed by the population a priori, while the capitation system is more flexible as it can be accompanied by risk adjustment to make the payments according to the characteristics of the population, as is the case in Colombia, Peru, Chile and more recently in Brazil. As of 2018, Colombia, Costa Rica and Mexico were not using pay for performance methods in PHC, limiting incentives to increase health care quality.

Countries vary in the mechanisms to determine the amounts paid with each payment method. The fees payed for services in Chile are set unilaterally by the central government, while in Argentina and Colombia they are negotiated between individual purchasers and providers. A similar situation happens for capitations, while in Argentina and Colombia capitation levels are negotiated between purchaser and providers, in Peru and Chile it is unilaterally set by a central authority. Global Budgets on the other hand are set by allocation principles at the central level in all countries that use them. Similarly, salaries for employed PHC workers are negotiated between purchasers and providers in Argentina, while in Peru they are unilaterally defined by central government (Lorenzoni et al., 2019[43]).

Because of system fragmentation, PHC might be paid differently in the same country. This leads to different incentives within the system, making it harder for authorities to introduce interventions. For example, Peru and Colombia list both capitation and global budget to pay providers, methods that are usually mutually replaceable, giving the idea that some providers might have a global budget while others are paid by capitation. Similarly, in Chile, fee for service is used to pay private group practices only (Lorenzoni et al., 2019[43]). Less common payment methods also exist, like the prospective amount payed for a set of expected services in Chile (“Programas de pago prospectivo por prestación”) (Eduardo Goldstein, 2018[44]).

Policy innovations are also taking place to provide economic incentives for the primary health care providers to deliver good care quality. In 2018, 11 OECD countries, including Mexico, reported using specific add-on payments to incentivise care co-ordination, prevention activities or active management of chronic disease, and 15 countries reported using pay-for-performance (P4P) mechanisms in primary health care. The overarching objective is to improve care quality and the performance of PHC. Such incentive schemes have been introduced in Argentina, Brazil, Chile and Peru.

The Sumar programme in Argentina

Argentina started using P4P schemes in 2004 through the Sumar Programme (the expansion of Plan Nacer). The MOH allocates additional resources to the provinces through a financing mechanism based on results. The Sumar Programme intends to create in all provinces the function of “strategic purchase” transferring additional resources that complement the provincial budgets to progressively guarantee the provision of the Health Services Plan. The P4P is instrumented through a system of capitated transfers to

the provinces adjusted for performance. The 60% (monthly transfer) of the amount is linked to enrolment and provision of an essential health service in the last year. The remaining 40% (quarterly transfer) is linked to the level of performance achieved according to 14 indicators.

The Ministry of Provincial Health cannot use transferred resources directly but has to transfer them to health centres paying a fee for each health service provided to a beneficiary of the Programme in order to incentivise preventives services, home visits or co-ordination between establishments. Health centres have autonomy on spending respecting the investment rules and categories framework authorised by the Provinces and/or the Municipalities.

The Programme created a tool for production planning and investment of resources that allows to health centres to define coverage goals of the Health Service Plan, to estimate the funds to be received and prioritise investments. The Sumar Programme demonstrates that improvements in health outcomes can be achieved with modest additional resources. Important health outcomes have been achieved between its inceptions in 2004 with less than 1% of the average of the annual provincial budget. The fact that the Health Services Plan is part of the P4P provides incentives to stimulate the provision of covered services and monitoring its delivery (Sabignoso, 2018[45])

The Previne programme in Brazil

Brazil uses a combination of payment systems in primary health care. In 2019, the country introduced a P4P scheme called '*Previne*' programme. Before '*Previne*', there was a voluntary pay-for-performance bonus based on the *National Programme for Improving Primary Care Access and Quality* (PMAQ) with a fixed and variable capitation component to transfer funds to municipalities (OECD, 2021[11]).

'*Previne*' has modified the capitation payments to account better for differences in health care needs across municipalities, streamlined the pay-for-performance indicators and revisited the strategic actions to be financed by the federation. As part of the new Previne pay-for-performance programme, the country monitors several indicators on access to PHC, risk factors and quality covering maternal health, child immunisation, breast cancer screening, and management of hypertension and diabetes. While this programme has the potential to improve access to PHC, its introduction is very recent so it is still early to assess its effectiveness. Another important change is that capitation payments are only made for people registered with Family Health Teams (adjusting for socio-economic, demographic and geographical factors). This will most likely incentivise FHTs to further engage with households. So far, the programme has led to a large increase of people registered with Family Health Teams. From the 2020 federal budget for PHC (BRL 20.4 billion), 52% are allocated based on weighted capitation, 24% are salaries for community health workers (a subcomponent of the strategic actions), 15% incentive payments for strategic action and priority areas, and 9% are performance bonuses (OECD, 2021[11]).

The P4P programme in Chile combines two components

In Chile, public clinics controlled by the municipalities with financing from the central government (with complement from the municipalities) deliver PHC services. Transfers from the Ministry of Health are distributed as follows: 70% capitation, 25% payments for priority areas defined by the Ministry of Health (including mental health) and 15% performance bonuses and other payments. There are two different types of capitation. The first one is based on average cost per person to deliver 96 key services defined in the *Plan de Salud Familiar* (Family Health Plan). It is adjusted by the economic capacity of the municipalities, the rurality of the population, and the accessibility. The second one is based on age of patient. For each enrolled patient over 64 years old, municipalities receive an additional monthly payment, the same amount in all municipalities.

Moreover, Chile has a P4P scheme that combines two payment schemes:

- Health Goals: defines eight goals with ten indicators. It targets frontline workers in primary health care, who have the opportunity to receive bonus wages every three months, which can add up to two months of potential extra bonus salary per year. The goals were developed to target the main burdens of disease in the country and areas with low-compliance to set standards.
- Primary care activity Indicators, which determine the monthly payment from the Ministry of Health to municipalities. Three categories of activity are included: general activity (such as coverage of preventive medical examinations), continuity of care (such as around the clock availability) and compliance with care standards. Evaluations are conducted quarterly, and if the annually set goals for each of the indicators are not met, monthly rates are lowered accordingly.

Performance budgeting in Peru

Peru uses performance budgeting as a public management strategy to introduce incentives to public entities towards the achievement of results, improving the quality of public spending. It involves entities in the three levels of government (national, regional and local).

The Budgeting Programme is a programming unit that allows the operationalisation of the budget strategy by result in the Public Sector Budget. The Budgeting Programme can be Results Oriented Budgeting (PPoR), and Institutional Budgeting Programs (PPI). The PPoRs are intended to achieve results on the population and their environment, and are multisectoral and intergovernmental in nature, while the PPIs are intended to achieve sectoral results and institutional strategic objectives.

The Ministry of Health is responsible for conducting nine PPIs on topics such as nutrition, maternal-neonatal health, tuberculosis, HIV, prevention and control of cancer. It also participates in the management of products related to the health function through three PpoR: vulnerability reduction and emergency care due to disasters, early childhood development and reduction of violence against women.

Table 3.3. Organisation and provision of primary health care in LAC countries

	Governance of primary health care	Primary health care providers	Population per PHC unit according to national guidelines	Form of organisation	Payment mechanisms (capitation, fee-for-service, P4P)	Is referral required to access to secondary care	Are patients required or encouraged to register with PHC?
Argentina	Municipalities	Centro de Atención Primaria" (CAPS), composed of inter-disciplinary teams.	3 200 ([46])	Team practice	Fee-for-services/P4P, global budget	No need and no incentive to obtain referral	No obligation to register but incentives to do so
Brazil	Municipalities	Family Health Teams (FHTs), which are multidisciplinary	2 000-3 500	Team practice	Global budget/fee-for-services/P4P	No need and no incentive to obtain referral	No incentive and no obligation to register
Chile	Municipalities (92.6% of centres)	Centros de Atención Primaria de Salud" (APS)	Urban*: 20 000 – 40 000 Rural: 500 – 4 500 ([47])	Team practice	Capitation/fee-for-service/P4P	Referral is required for the population in public scheme for most services**	Patients in public scheme are required to register (87% registered)

	Governance of primary health care	Primary health care providers	Population per PHC unit according to national guidelines	Form of organisation	Payment mechanisms (capitation, fee-for-service, P4P)	Is referral required to access to secondary care	Are patients required or encouraged to register with PHC?
Colombia	MoH (MIAS)	Health posts, Health centres, Health centres with beds, local hospitals	Not available	Team practice	Capitation/FFS/Global budget	Referral is required to access most secondary services	No incentive and no obligation to register
Costa Rica	MoH	CCSS through EBAIS	3 500-4 000 ([48])	Team practice	Global budget	PCP referral is required	Incentive to register
Mexico	MoH (No different gov. body for PHC) Undersecretary. Public Heath (MoH)	Multiple primary health care providers	Not available	Solo practice and team practice	NR	Primary health care physician referral is required	No incentive and no obligation to register
Peru	MoH EsSalud Private insurance	Multiple primary health care providers	2 000-3 200	Team practice	Capitation/FFS/P4P/Global budget	No need and no incentive to obtain referral	No incentive and no obligation to register

Note: * Not including emergency primary health care centres. ** Or incentivised depending on care plan. NR: No Response.
Source: Authors based on Lorenzoni et al. (2019[43]), "Health systems characteristics: A survey of 21 Latin American and Caribbean countries", https://doi.org/10.1787/0e8da4bd-en, and based on consultations with experts.

Main health challenges in the LAC-7 countries

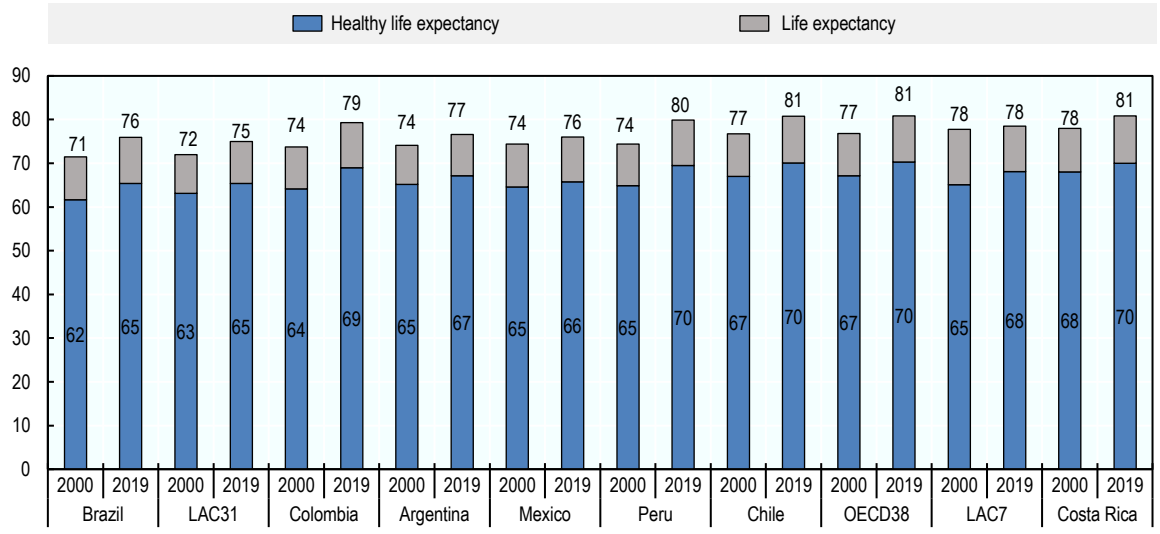
Evolution of health outcomes

Despite progress, life expectancy in LAC-7 is still falling behind other OECD countries

Life expectancy at birth continues to rise in LAC, reaching 75 years on average in 2019, a gain of 3 years since 2000. While LAC-7 countries saw smaller improvements in the period, from 77.8 years in 2000 to 78.5 in 2019, they are considerably above the regional average. In comparison, other OECD countries gained 3.6 years during the same period and reached 80.9 years on average in 2019. The countries with the longest life expectancy in LAC-7 countries in 2019 were Costa Rica and Chile with over 80 years old, closely followed by Peru.

Costa Rica, Chile, and Peru have also the highest healthy life expectancy among LAC-7 countries, around 70 years in 2019. In contrast, Mexico and Brazil have both low life expectancies at birth (around 75 years old) and low healthy life expectancy (at 66 years old) (Figure 3.6). LAC-7 countries on average lag behind other OECD countries with regards to the number of activity limitations due to health problems (OECD average of 70 years for healthy life expectancy).

Figure 3.6. Life expectancy at birth and healthy life expectancy at birth, 2000 and 2019



Source: The global health observatory WHO (2019[49]).

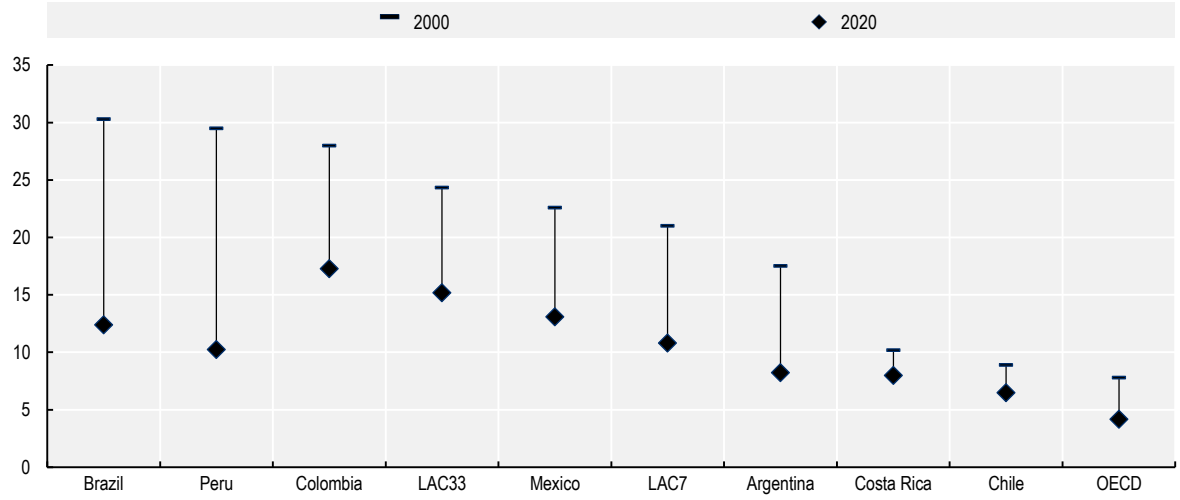
Infant mortality in LAC-7 region has been halved over the past two decades

Infant mortality average in LAC-7 countries has decreased from 21 deaths per 1 000 live births in 2000 to 10.8 deaths per 1 000 live births in 2020. Infant mortality is lower in Chile, Costa Rica and Argentina (under 8 deaths per 1 000 live births), while higher in Colombia, Mexico and Brazil (17.3, 13.1 and 12.4 per 1 000 live births respectively) in 2020. Peru and Brazil saw the highest declines of around 60% between 2000 and 2020, higher than among other OECD countries (Figure 3.7).

In LAC-7 countries, maternal mortality ratio (MMR) averaged 44.6 deaths per 100 000 live births in 2020, substantially higher than the 9.2 deaths per 100 000 live births in other OECD countries but lower than LAC-31 countries with an average of 83.5 deaths per 100 000 live births in 2020. Estimates show that Chile as the lowest MMR among LAC-7 countries with 10.9 deaths per 100 000 live births and followed by Costa Rica with 29.4 deaths per 100 000 live births. At the other end of the scale, Peru and Brazil have the highest MMR over 60 deaths per 100 000 live births (OECD/The World Bank, 2020[1]).

Figure 3.7. Infant mortality in LAC-7 countries

Mortality rates per 1 000 live births



Source: All review countries (except ARG and PER) from OECD.stat. ARG, PER and other LAC countries from WHO (2019[49]), The global health observatory.

LAC-7 countries experience an epidemiological transition towards increasing prevalence of chronic non-communicable diseases

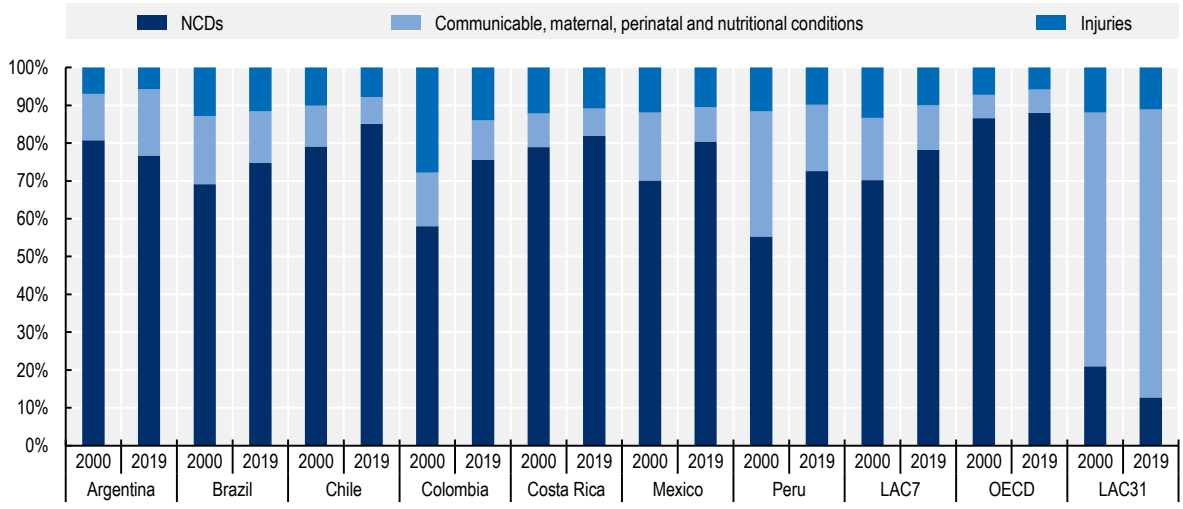
In LAC-7 countries, the burden from non-communicable diseases (NCDs) is increasing and substituting deaths caused by communicable diseases. NCDs are the most common causes of death, being responsible for almost 80% of all deaths across LAC-7 countries, close to the OECD average of 88% in 2019. Cardiovascular diseases and cancers are the most prevalent NCDs in LAC-7 countries, accounting for 46% of all deaths in 2019 (Figure 3.8).

However, communicable diseases, maternal, perinatal and nutritional conditions, still remained major causes of death among LAC-7 countries, accounting for 12% of deaths in 2019. Deaths attributed to injuries, violence have decreased from 13% in 2000 to 10% in 2019. In the case of HIV, the overall prevalence in adults between 15 and 49 years old in the region of LAC-7 is not very high, but it has increased from 0.26% in 2000 to 0.44% in 2020. In LAC-7 countries, it ranges from 0.30% in Peru to 0.60% in Brazil and Chile. The incidence of tuberculosis (per 100 000 population per year) has decreased in all LAC-7 countries, with an average incidence of 53.1 in 2000 to 39.7 cases per 100 000 population in 2020. The highest incidence rate was seen in Peru, Brazil and Colombia, with 116, 45 and 37 cases per 100 000 population in 2020 respectively. The lowest incidence rates were reported in Costa Rica and Chile (below 15 cases per 100 000 population.

In addition, the prevalence of diabetes in adults (20-79 years old) has slightly decreased in LAC-7 countries from 9.4% in 2011 to 9.1% in 2021 but it remains higher than across other OECD countries (7% on average in 2021) (Figure 3.9). This prevalence ranged from under 6% in Peru and Argentina to 16.9% in Mexico. In Chile and Mexico, the prevalence of diabetes is rising while it decreased in Brazil, Costa Rica, Colombia, Argentina and Peru.

Figure 3.8. Evolution of causes of death, 2000 and 2019

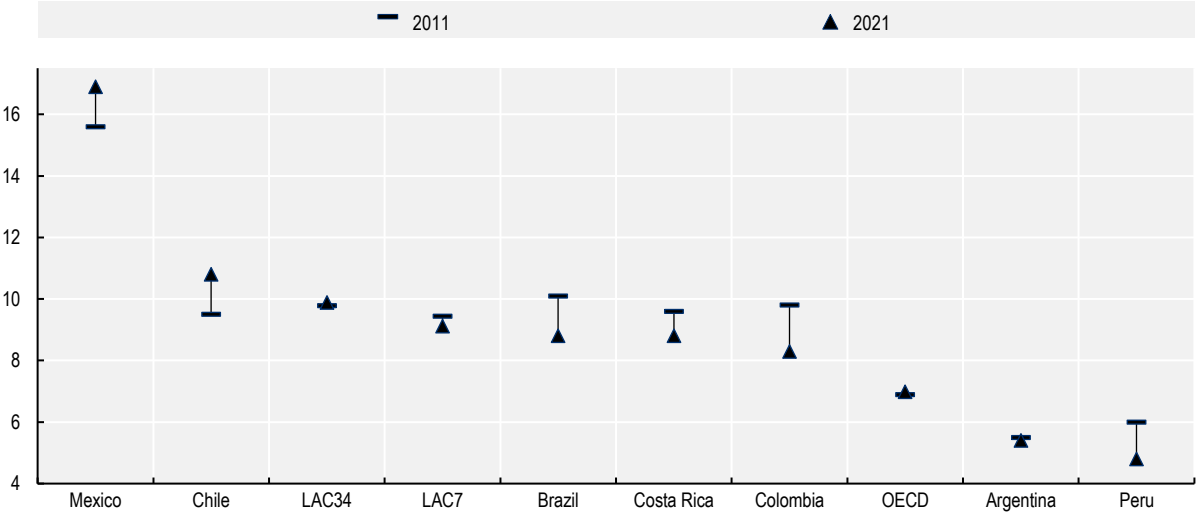
Percentage out of total deaths



Note: WHO methods and data sources for global causes of death 2000-19. Global Health Estimates Technical Paper WHO/DDI/DNA/GHE/2020.2. Geneva: World Health Organization; 2020.
Source: WHO (2019[49]), The global health observatory.

Figure 3.9. Prevalence of diabetes in LAC-7 countries

Age-adjusted diabetes prevalence, percentage of 20-79 years old



Source: International Diabetes Federation (2021), Diabetes Atlas 2021.

Increasing risk factors for health

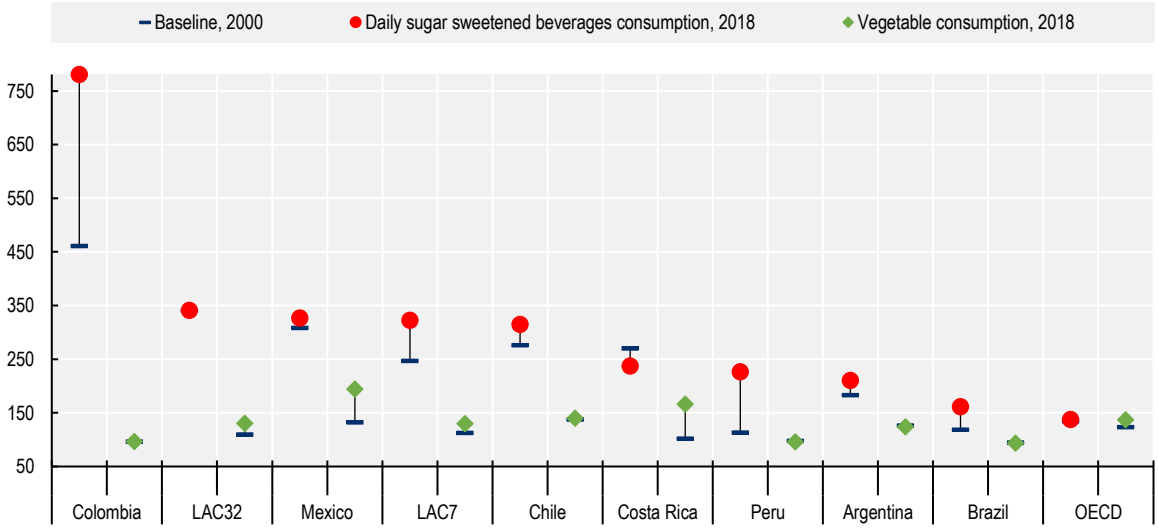
Several risk factors for health raise some concerns in LAC-7 countries as they go hand in hand with an increased prevalence of chronic non-communicable diseases. This calls for more effective health promotion and disease prevention at primary health care level.

Physical activity, along with adequate and healthy nutrition are some of the key determinants contributing to health and well-being. People having a diet rich in fruits and vegetables and low in fat, sugars and sodium, are at a lesser risk of developing one or more cardiovascular diseases and certain types of cancer (Graf and Cecchini, 2017[50]). Daily consumption of fruit and vegetables in the LAC region is estimated to be under the recommended 400 grammes per person per day (OECD/The World Bank, 2020[1]) and the latest data (Figure 3.10) shows that the consumption of vegetables has not improved substantially in LAC-7 between 2000 and 2018.

In addition, the estimations of the Global Dietary Database show that LAC-7 countries increased their intake of sweetened beverages between 2000 and 2018. Brazil is the only country in the series with levels comparable to OECD countries. Colombia is an outlier reaching 780 grammes of daily intake per person, more than twice the LAC-7 average (Figure 3.10). Calculations for Colombia are consistent with other countries and were based on the Survey of Nutritional Situation in Colombia 2005 and 2010, by the Colombian Family Welfare Institute (Colombian Family Welfare Institute, 2010[51]).

Figure 3.10. Healthy diet in LAC-7 countries between 2000 and 2018

Daily grammes of sugar beverages and vegetables per person



Note: Data is estimated by GDB with a consistent methodology based on Bayesian models.
Source: Global Dietary Database, extracted on 15 December 2021.

Unhealthy diet is a major risk factor for overweight and obesity reducing life expectancy, increasing health care costs and the burden on the economy (OECD, 2019[52]). Only recently countries in the region have introduced policies to improve healthy food intakes, such as labelling unhealthy foods and controlling products sold in and around schools.

The latest data show an important increase in LAC-7 countries in both male and female overweight and obesity between 2000 and 2020 (Figure 3.11). Moreover, the share of the population being obese or overweight in all LAC-7 countries is larger than across other OECD countries. While overweight rates are similar between women and men, obesity rates are systematically higher among women (Figure 3.11).

Children overweight rates are also worrying across LAC-7 countries: over 38% of both male and female adolescents were overweight or obese in 2016 on average. Argentina and Chile are the countries in the region with the highest share of adolescent being overweight or obese (above 50%) (OECD/The World

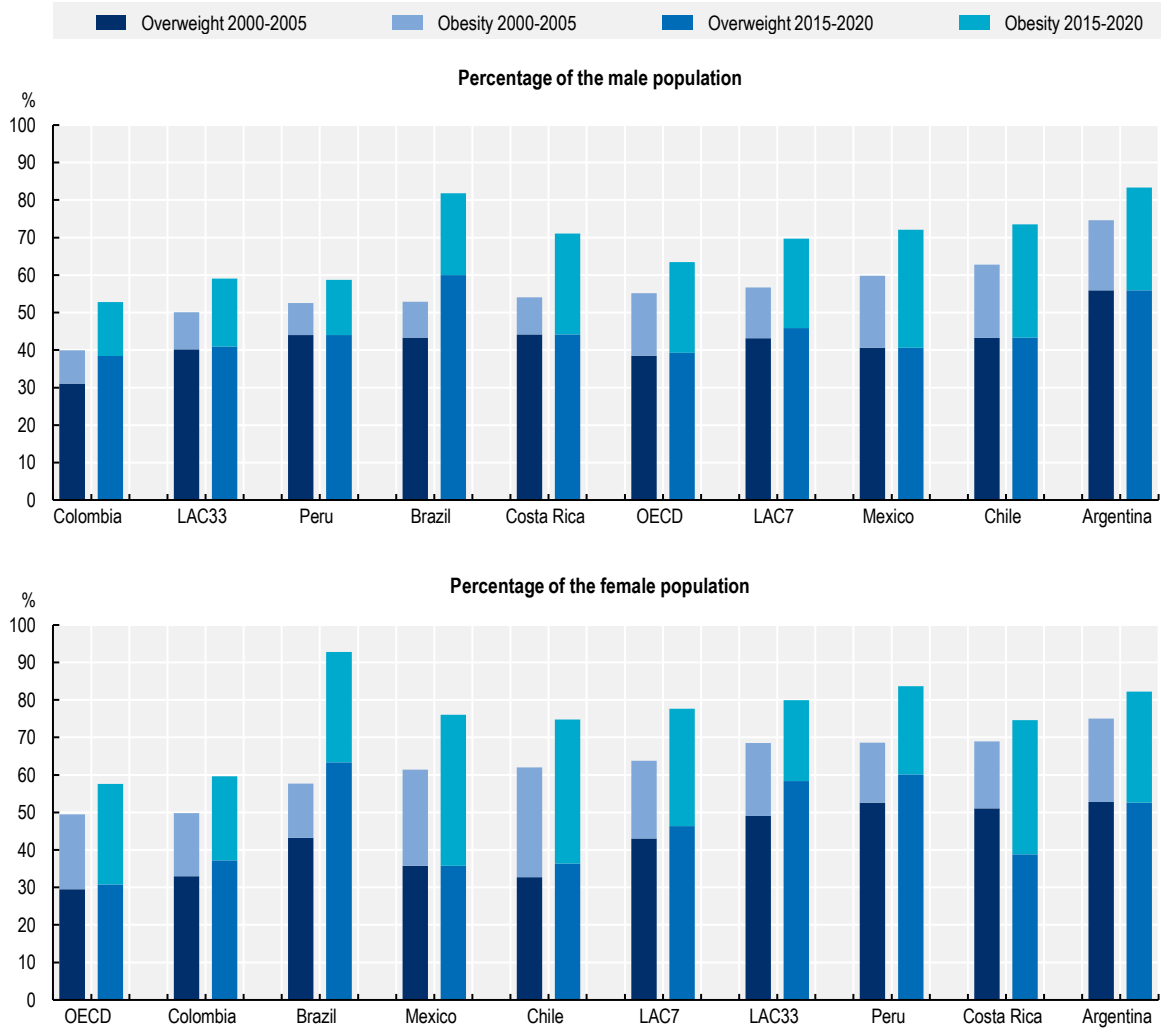
Bank, 2020[1]). High children overweight rates means higher risk of cardiovascular diseases or diabetes during adult age, putting pressure on the primary health care sector.

An important factor explaining high overweight and obesity rates in LAC-7 countries is the lack of physical activity. Available evidence suggests that in 2016 over 40% of adults in Argentina, Colombia, Brazil and Costa Rica had insufficient physical activity (OECD/The World Bank, 2020[1]). Among adolescents aged 11-17, this proportion reaches 84% in Latin America, higher than the world average of 81% of adolescents who reported insufficient physical activity (OECD/The World Bank, 2020[1]).

On a more positive note, smoking rates have been falling in all LAC-7 countries between 2000 and 2018 (Figure 3.12) signalling the effectiveness of tobacco control measures in the region. In 2018, only Chile (45%) had a higher percentage of their population smoking daily than the OECD average (24%), while Argentina smoking rates is close to the OECD average. Colombia reported the lowest share of daily smokers (at 8%).

Figure 3.11. Overweight and obesity rates in LAC countries give cause of concern

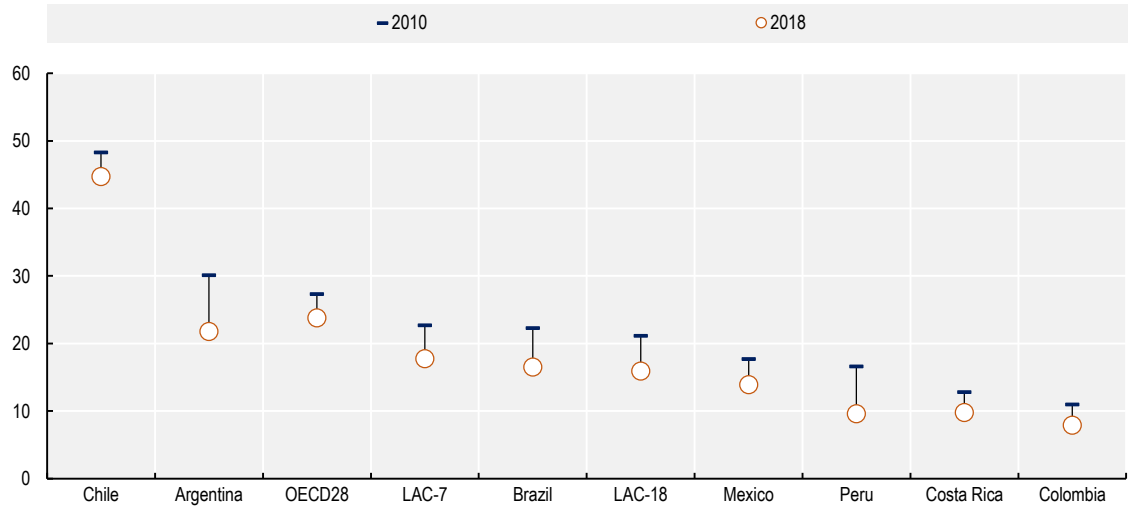
Earliest year between 2000-05 versus latest year between 2015-20



Note: Overweight (BMI >= 25 and < 30); Obesity (BMI >= 30) (Brazil presents differences in methodology). OECD data used is measured data. GHO data are crude estimates. OECD averages for 2000-05 comprises only 12 countries and for 2015-20, 19 countries.
Source: For BRA, CHL, COL, CRI(2015-20), ARG(Obese) and MEX OECD (2022[41]), OECD Health Statistics 2022. Others from WHO (2019[49]), The global health observatory.

Figure 3.12. Evolution of tobacco consumption in 2010 and 2018

Share of the population aged 15 years or older who smokes tobacco daily



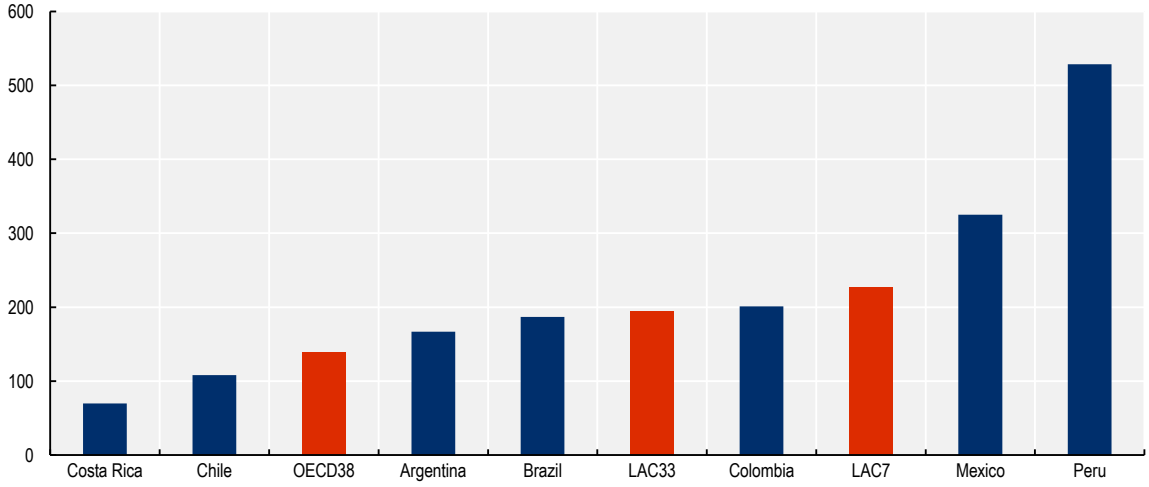
Source: World Bank, World Development Indicators, data updated on 28 October 2021.

The direct health impacts of COVID-19 have been dramatic in LAC-7 countries

LAC countries has been one of the most affected regions of the world in terms of COVID-19 mortality (OECD, 2021[38]). When observing estimated rates of excess mortality as an indicator of the direct health impact of the pandemic in the LAC-7 countries, Peru and Mexico stand above the LAC-7, LAC-33 and OECD-38 averages, highlighting the high death toll that COVID-19 has had in the region. On the other hand, this indicator also highlights how Costa Rica and Chile have been less severely impacted by the pandemic than other OECD countries on average (see Figure 3.13).

Figure 3.13. Estimated excess mortality rates among LAC-7 and OECD countries, 2020-21

Estimated excess mortality rate per 100 000 population



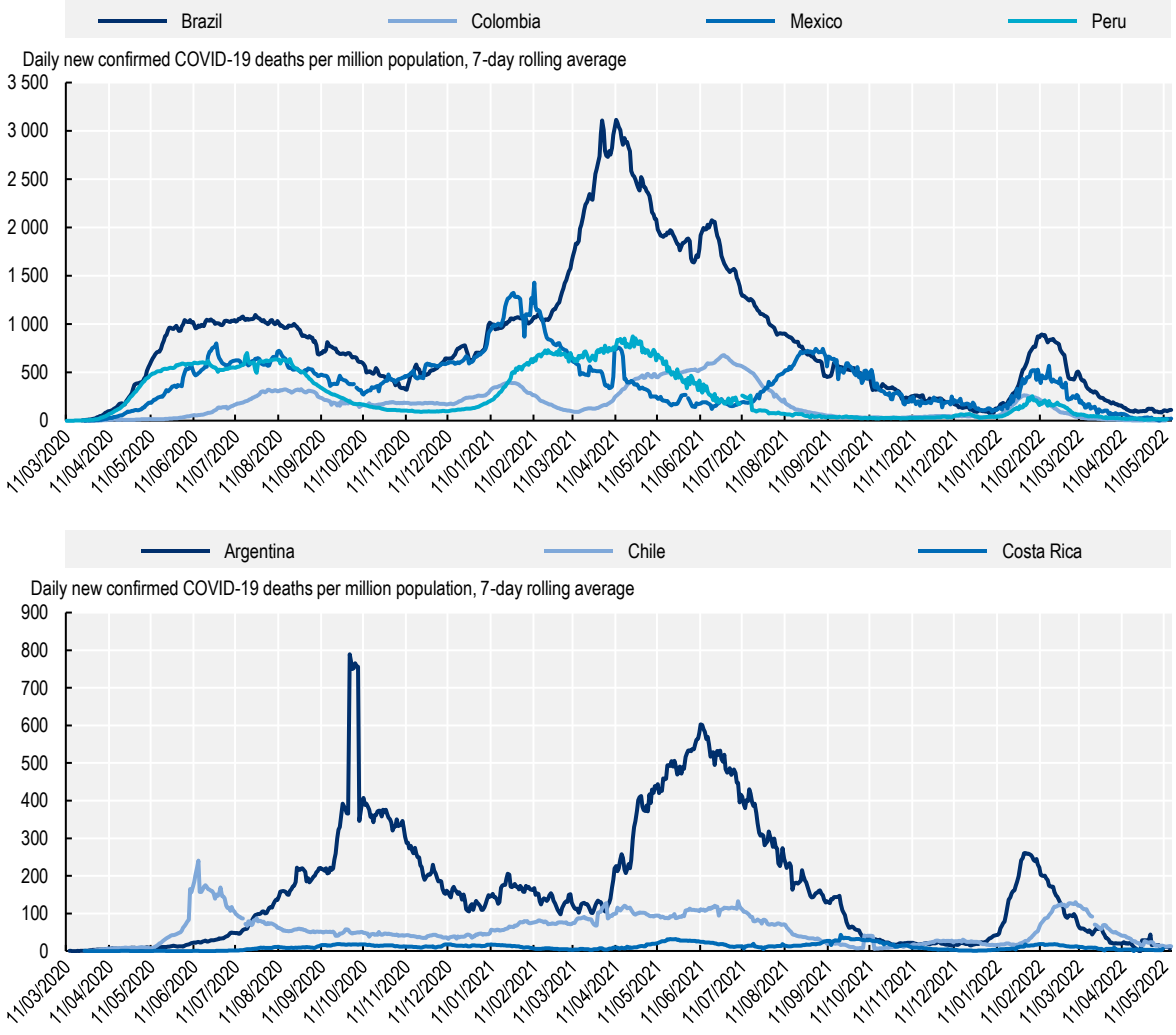
Source: Wang et al. (2022[53]), "Estimating excess mortality due to the COVID-19 pandemic: a systematic analysis of COVID-19-related mortality, 2020-21", https://doi.org/10.1016/s0140-6736(21)02796-3.

Excess mortality is deemed to be a more accurate indicator of the direct health impact of COVID-19 in LAC countries due to the underestimation of COVID-19 mortality that exists in certain countries of the region. The underestimation of crude mortality is clearly observed in the reported COVID-19 deaths per million people. Countries such as Peru and Mexico, which exhibited the highest estimated excess mortality amongst LAC-7 countries, report lower rates of COVID-19 deaths than Brazil all along the pandemic years (2020-21), and also lower rates than Argentina and Peru during some of the different waves (see Figure 3.14).

The COVID-19 pandemic also had an important indirect impact on health, particularly deteriorating mental health and disrupting access to care. This effect is derived from both the indirect effects of the disease (fear of catching the disease) and the direct impacts of measures countries took to absorb the crisis and meet COVID-19 needs. The topic is further addressed in Chapter 4, Chapter 5 and Chapter 6 of this report.

Figure 3.14. COVID-19 deaths per million population, LAC-7 countries

Grouped by levels of excess mortality rates



Source: COVID-19 Data Repository by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University; Dong, Du and Gardner (2020[54]), available at Our World in Data 2022.

Conclusions

The LAC-7 region has been one of the most affected regions in the world in terms of COVID-19 mortality. Excess mortality rates in LAC-7 countries are considerably larger than in other OECD countries. The socio-economic context, the limited infrastructure and capacity of health systems and its organisation are all important determinants explaining the health and socio-economic consequences of the COVID-19 pandemic.

Over the past two decades, LAC-7 countries have made measurable improvements in economic and social conditions. Life expectancy in LAC-7 countries reached 77.9 years on average in 2020 (a gain of almost 3 years since 2000) and infant mortality in LAC-7 region has been halved over the past two decades. However, improvements have been unequal across and within countries, and too limited to close the gap with higher income countries. Despite significant reduction, income inequality is still an important issue in LAC-7 countries, well above the level in other OECD countries. At the same time, the fragmentation of health care in LAC-7 countries generates inequalities in health care coverage and inefficiency in the use of limited health care resources.

In a step towards the right direction, insurance coverage has improved substantially (reaching almost universal coverage in several countries) and primary health care systems have been strengthened. In most LAC-7 countries (for example Chile, Costa Rica and Brazil) primary health care has a community-based approach delivered by multidisciplinary teams. However, opportunities to provide proactive, preventive and co-ordinated care are too often being lost because primary health care do not act as the first point of care (as in Mexico, Peru, Brazil or Argentina). The growing burden of non-communicable chronic diseases associated with the expansion in exposure to risk factors and rapid population ageing in LAC-7 countries call for stronger primary health care systems, notably to encourage greater health promotion, early detection of diseases, and providing routine care for underlying health conditions in primary and community settings. As explored in Chapters 4, 5 and 6 of the report, this will help increasing preparedness and resilience of LAC-7 health systems to face future high impact shocks. Assigning clear responsibilities for primary health care and making stakeholders accountable for the health care of the population will help in this process. Such a push needs also to be accompanied by capacity building and payment schemes that incentivise quality improvements.

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