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# Analysis of Health Budget Practices in 8 Latin American countries: Current Practices, Systemic Challenges, and the Road Ahead for Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, Mexico, and Peru

Ipchita Bharali, Ernesto J. Ortiz, Clara Marin Carballo, Wenhui Mao, Lisa Bourget

- Strategies to align financial planning with health priorities
- The impact of fostering intersectional collaboration
- Ways to use fiscal policy to shape healthier populations

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# EXECUTIVE SUMMARY

## Purpose of the report

This report examines the health budgeting practices in Latin America, with a focus on how countries plan, prioritize, allocate, manage, and utilize resources to improve health outcomes across eight Latin American countries – Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, Mexico and Peru. The analysis aims to understand the process and management of health budgets allocation and execution, identify gaps between population health and budget allocations and provide actionable recommendations to policymakers and health system stakeholders for improving budgetary practices in health across these countries.

## Methodology

We conducted a mixed methods study which included a desk review, secondary data analysis and interviews and consultations with key stakeholders and experts from Latin America. We analyzed government budget reports and policy documents to extract information and document the budgeting processes, key legislations, institutional mechanisms and roles and responsibilities of various entities in the budgeting process across the eight countries. We conducted secondary data analysis on health financing trends and budget allocations based on data from latest budget reports, and international databases. We also conducted interviews with 25 key informants across the eight countries, as well as multilateral health organizations that support health budgeting in Latin America. Additionally, two consultations with the FIFARMA program managers and country representatives, and the Andean Committee on Health and Economy at ORAS-CONHU were done to refine and validate the study findings.

## Key Findings

The following key findings have emerged from the study:

- While there is high level of commitment to UHC across countries, there is **chronic underfunding of UHC**. Most countries fall short of the WHO-recommended 6% of GDP public investment to health, leading to reliance on out-of-pocket spending, shortages, and inequities—particularly in Argentina, Mexico, Peru, and Ecuador. Even stronger systems like Brazil's SUS and Costa Rica's CCSS face fiscal pressures from rising costs, aging populations, and rigid expenditure caps.
- Ongoing macro-fiscal issues inflation, debt burdens, and rigid fiscal rules have created a **constrained fiscal space and economic volatility** across the countries. This has eroded health budgets and limit governments' flexibility to allocate or execute

resources effectively, with particularly acute challenges in Argentina, Brazil, Colombia, Mexico, and Peru.

- **Budget practices are mostly outdated and there is weak use of evidence in budgeting.** Historical, line-item budgeting is common which undermines responsiveness to epidemiological needs. Limited integration of health data and performance metrics into budgeting reduces efficiency and accountability, despite some movement toward results-based approaches (Eg. Costa Rica, Argentina Plan SUMAR, Peru).
- Overlapping roles of ministries, social security funds, and subnational governments result in duplication, inefficiencies, and inequities leading to **fragmentation and poor coordination**. Weak coordination between health, finance, and planning authorities limits the alignment of resources with national health priorities.
- Many subnational governments lack the technical and managerial ability to plan, execute, and monitor health budgets. **Decentralization without adequate capacity** has led to under-execution of funds, inefficiencies, and inequities in service delivery—especially in rural and underserved areas.
- There is **disconnect between planning and budgeting** where national or sectoral health plans are often weakly linked to budget allocations, resulting in gaps between strategic priorities and the actual resources available to deliver them.

Despite the challenges, some good practices have emerged in the studied Latin American countries that offer valuable lessons in health budgeting that can inform more effective, equitable, and resilient health systems.

- Experiences from Peru, Argentina, and Costa Rica show that **results-based budgeting approaches** that link budgets to outcomes (e.g., maternal and child health, nutrition, primary care coverage) improves both funding flows and service delivery, while also promoting accountability across levels of government.
- Use of **tools that optimize efficiency and equity through strategic allocation**, such as Costa Rica's EBAIS model (using primary-care data to guide local budgeting), centralized procurement, and pooled financing via payroll and sin taxes help reduce fragmentation, improve equity in allocations, and enhance financial sustainability.
- Judicialization of health in countries like Colombia, Costa Rica, and Ecuador has expanded access and ensured rights-based accountability but **judicialization of health requires reforms to maintain budgetary flexibility and long-term sustainability**.
- There are successful ways to **leverage fiscal policies and intersectoral financing** through innovative mechanisms—including taxes on soda, alcohol, tobacco, and junk

food, as well as intersectoral "Health in All Policies" approaches—to generate revenues for health while also addressing risk factors for noncommunicable diseases.

- Latin America's diverse experiences demonstrate that **context-specific reforms—adapted from regional peers and global lessons**—can support more effective, equitable, and resilient health systems.

## Recommendations

Based on the issues emerging from this study and discussions with key informants, we propose the following recommendations to improve health budgeting in the studied Latin American countries. These recommendations underscore the importance of aligning financial planning with health priorities, fostering intersectoral collaboration, and using fiscal policy not only to raise revenue but also to shape healthier populations.

1. There is **need to increase public health spending and financial sustainability** to address the growing healthcare costs and explore alternative financing mechanisms to ensure adequate funding.
2. Health budgeting should aim for **more equitable distribution of resources** to address inequities in access across income groups and geographies.
3. **Governance and coordination** should be improved to enhance decision-making and accountability.
4. To improve prioritization, efficiency and cost-effectiveness, there should be **greater use of evidence informed health budgeting and prioritization practices.**
5. **Capacity building, especially at the sub-national level is needed** to improve technical and administrative capacity for budget execution and service delivery.
6. Need to **consolidate health financing and reduce fragmentation** to reduce redundancy and improve coordination.

## Table of Contents

## ABBREVIATIONS

| | |
|---|---|
| ADRES | Administrator of the Resources of the General System of Social Security in Health |
| ASF | Superior Audit Office of the Federation |
| AUGE | Acceso Universal con Garantías Explícitas |
| CCSS | Caja Costarricense de Seguro Social |
| DIPRES | Budget Directorate within Ministry of Finance |
| EBAIS | Equipos Básicos de Atención Integral de Salud |
| EPS | Health Promotion Entities |
| FNS | Fundo Nacional de Saúde |
| FONASA | Fondo Nacional de Salud |
| FUS | Fondo Universal de Salud |
| GES | Explicit Health Guarantees |
| GGHE-D | Domestic general government expenditure on health |
| GHED | Global Health Ependiture Database |
| HTA | Health technology assessment |
| HTC | Honorable Tribunal de Cuentas |
| IESS | Instituto Ecuatoriano de Seguridad Social |
| IMSS | Instituto Mexicano del Seguro Social |
| INSABI | Instituto de Salud para el Bienestar |
| ISAPRE | Instituciones de Salud Previsional |
| ISSSTE | Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado |
| KII | Key informant interview |
| LAC | Latin America and the Caribbean |
| MBP | Multi-Year Budget Programming |
| MEF | Ministry of Economy and Finance |
| MINSA | Ministerio de Salud |
| MoF | Ministry of Finance |
| MoH | Ministry of Health |
| MPH | Ministry of Public Health |
| NCDs | Non-communicable diseases |
| NGOs | Non-government organizations |
| ONP | Oficina Nacional de Presupuesto |
| PAMI | Programa de Asistencia Médica Integral |
| PBS | Plan de Beneficios en Salud |
| PEFA | Public Expenditure and Financial Accountability |
| PFM | Public financial management |
| PforR | Program for results |
| PMO | Programa Médico Obligatorio |
| PNS | Plano Nacional de Saúde |
| PPA | Plano Plurianual |

| | |
|---|---|
| PpR | Presupuestos por Resultados |
| RBF | Results-based financing |
| SCHP | Secretaría de Hacienda y Crédito Público |
| SCI | Service Coverage Index |
| SGSSS | Sistema General de Seguridad Social en Salud |
| SHCP | Secretaría de Hacienda y CréditoPúblico |
| SIAFI | Sistema integrado de Administração Financeira do Governo Federal |
| SIDIF | Integrated Financial Information System |
| SIGEN | General Syndicate of the Nation |
| SIOPS | Sistema de Informações sobre Orçamentos Públicos em Saúde |
| SIS | Seguro Integral de Salud |
| SSA | Secretaría de Salud |
| SUS | Sistema Único de Saúde |
| UPC | Per Capita payment unit |
| UHC | Universal health coverage |

## BACKGROUND

Health budgeting is a critical component of public financial management (PFM), shaping how governments allocate, prioritize, and use resources to improve population health.[1,2] In Latin America, the issue has gained increasing relevance due to a combination of persistent health inequities, economic volatility, and the region's ambitious move toward universal health coverage (UHC).[3]

Over the past two decades, countries in Latin America have made notable progress in expanding health coverage, improving service delivery, and increasing public investment in health. Most health systems in Latin America are publicly funded. Donor support, while limited in comparison to other regions, has also played a role in influencing budgeting practices, particularly in lower-income countries or in specific health areas such as HIV, maternal health, and immunization.[4] Countries in the region have demonstrated leadership and innovation in public financial management for health. Brazil has implemented performance-based transfers to subnational entities; Chile and Mexico have introduced program budgeting linked to health outcomes; and Colombia and Peru are working to align health financing with primary care priorities. Costa Rica stands out for its relatively unified and results-driven health system funding model. Despite these achievements, health systems in the region continue to face persistent challenges in how resources are allocated and managed. Budget rigidities, fragmentation of health financing, limited integration between planning and budgeting processes, and underuse of performance and equity data often constrain the effectiveness of health spending. These challenges are especially pronounced in decentralized systems or where multiple financing schemes operate in parallel.[5–7] However, these gains have not always been matched by improvements in the efficiency, equity, and transparency of health budgeting processes. Many health systems in the region continue to face challenges such as underfunding, fragmented financing, rigid budget structures, and limited alignment between health plans and budgets.[8,9]

The COVID-19 pandemic exposed and exacerbated existing weaknesses in health financing systems, underscoring the need for more resilient, responsive, and equitable budgeting practices. At the same time, it has created momentum for reform and innovation in public financial management—ranging from the introduction of program-based and results-based budgeting to improved use of health information systems and fiscal space analyses. It has also reinforced the importance of prioritizing equity in health budgeting, as vulnerable populations were disproportionately affected by service disruptions and under-resourced primary care. Additionally, disparities in health outcomes and access—often shaped by geography, socioeconomic status, ethnicity, and gender—highlight the importance of budgeting processes that incorporate equity considerations and ensure resources are directed to where they are most needed.[10,11,12]

This report examines current practices, systemic challenges and the road ahead for health budgeting across selected countries in Latin America: Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, Mexico, and Peru, with the goal of identifying opportunities to strengthen the effectiveness and equity of public health expenditure.

### Study objectives

The key objectives of the study are to:

- Understand the process and management of health budgets allocation and execution
- Identify gaps between population health and budget allocations
- Provide actionable recommendations for improving budgetary practices in health

## METHODS

### Country selection

Eight Latin American countries were selected for this study: Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, Mexico, and Peru. The countries were chosen in consultation with our funder, Federación Latinoamericana de la Industria Farmacéutica (FIFARMA), the Latin American Federation of the Pharmaceutical Industry. These countries account for the highest levels of GDP and/or GDP per capita in Latin America. Some key economic, governance and health financing characteristics of the selected countries are shown in Table 1. All countries, except Chile, are upper middle-income countries, with GDP per capita ranging from US$ 14,472 in Ecuador to US$ 29,465 in Chile.[13] Four countries (Chile, Colombia, Costa Rica and Mexico) are OECD member states, while Argentina, Brazil, and Peru are in-accession process to receive membership.[14] Although the countries represent higher income levels compared to other countries in the region, they also suffer from high levels of disparities and inequities, which impacts health access. In terms of domestic public investments in health, countries like Argentina (5.8%) and Colombia (5.3%) are performing much better than Peru (4%) and Mexico (3%).[15] WHO/PAHO recommends public health investments of 6% of GDP in health.[16]

There are some common characteristics, but also important distinctions in the health systems, and how governments finance and allocate resources to health across these countries. Most of the health systems across these countries are publicly financed, although there is a mix of public and private financing in countries like Brazil and Chile. There are efforts to improve transparency, equity and results-based budgeting across all countries, with varying degrees of implementation and success. The organizational and institutional structures across the selected countries vary widely from highly centralized like Costa Rica, to highly decentralized countries like Brazil, Mexico and Colombia, where subnational and

even municipalities play a key role in health sector planning, budgeting and implementation. The differences in government structures also significantly shape the budgeting practices across these countries. Federal and decentralized countries like Brazil, Argentina, and Mexico exhibit more complex, decentralized budgeting processes, where subnational governments play a critical role in health planning, budgeting and service delivery. In contrast, unitary systems like Chile, Costa Rica, and Ecuador maintain more centralized control, allowing for more uniform implementation of health policies. In terms of financing models, countries like Costa Rica and Colombia rely on social health insurance systems, while Brazil and Mexico depend more heavily on general tax revenues. Budgeting approaches also vary: some countries have successfully adopted advanced program-based and performance-oriented systems, while other countries still rely heavily on historical and line-item budgeting. We dive more deeply in to how the specific similarities and differences in the countries in Findings section of the report. This report aims to provide actionable insights for policymakers across the region by analyzing across these varied health systems and budgeting practices, identifying bottlenecks, and highlighting emerging good practices and opportunities for reform.

**Table 1: Countries included in the study and their characteristics across key dimensions**

| Country/ Region | Income status | OECD status | GDP per capita (constant 2021 US$, PPP) 2023 | Population (millions) 2023 | GINI Index 2022 | Current health spending per capita US$ 2022 | Government health spending % GDP (GGHE-D % GDP), 2022 | Government structure |
|---|---|---|---|---|---|---|---|---|
| **Argentina** | Upper middle income | Accession in-process | $ 27,105 | 45.5 | 40.7 | $ 1,371 | 5.8% | Decentralized |
| **Brazil** | Upper middle income | Accession in-process | $ 19,080 | 211.1 | 52 | $ 849 | 4.1% | Decentralized |
| **Chile** | High income | Member since 2010 | $ 29,465 | 19.7 | 43 | $ 1,547 | 5.1% | Centralized |
| **Colombia** | Upper middle income | Member since 2020 | $ 18,358 | 52.3 | 54.8 | $ 506 | 5.3% | Unitary states with decentralization |
| **Costa Rica** | Upper middle income | Member since 2021 | $ 25,980 | 5.1 | 47.2 | $ 979 | 5.0% | Centralized |
| **Ecuador** | Upper middle income | No | $ 14,472 | 17.9 | 45.5 | $ 493 | 4.6% | Unitary states with decentralization |
| **Mexico** | Upper middle income | Member since 1994 | $ 21,880 | 130.0 | 43.5 | $ 651 | 3.0% | Centralized |
| **Peru** | Upper middle income | Accession in-process | $ 15,294 | 33.9 | 40.3 | $ 446 | 4.0% | Unitary states with decentralization |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **OECD average** | | | **$ 52, 705** | | | **$ 5,552** | **8.3%** | |

Source: OECD, World Bank World Development Indicators, World Health Organization Global Health Expenditure Database, Inter-American Development Bank

Notes:
For purposes of uniformity and comparability across countries, we have used international data sources such as the World Banks's World Development Indicators and World Health Organization's Global Health Expenditure Database in this table. The year for which latest data is reported across all countries in these databases has been used for comparability.

Government health spending % GDP in the table is the domestic government health spending as a percentage of GDP (GGHE-D%GDP) from the WHO Global Health Expenditure database shows the level of public health expenditure from domestic sources as a share of the country's GDP.

## Data analysis

We conducted a mixed methods study which included a desk review, secondary data analysis and interviews with key stakeholders and experts from Latin America (Figure 1).

**Figure 1: Methodology**


We analyzed government budget reports and policy documents to extract information and document the budgeting processes, key legislations, institutional mechanisms and roles and responsibilities of various entities in the budgeting process across the eight countries. We conducted secondary data analysis on health financing trends and budget allocations based on data from latest budget reports, and international databases like the WHO Global Health Expenditure database, World Bank, and Institute for Health Metrics and Evaluation. For purposes of uniformity and comparability across countries, we have used international data sources and the year for which latest data is reported across all countries in these databases in the data tables.

We conducted in-depth interviews of key stakeholders with deep knowledge of the budgeting and health financing issues in each country. We interviewed government officials, researchers, and stakeholders at NGOs/CSOs and private sectors with relevant expertise in the developing, implementing, or operating of health financing and budget/expenditure reports to help us understand the policy and implementation issues of health budgets in our focus countries. A total of 25 key informant interviews (KIIs) were conducted for the study. Table 2 provides information of the interviewed key informants by country. Although we aimed to maintain uniformity in terms of KII representation across government, academia, private sector and non-government organizations (NGOs), there is wide variation in the number of interviews and sectoral representation across countries – Argentina (2), Brazil (1), Chile (2), Colombia (2), Costa Rica (1), Ecuador (7), Mexico (2), Peru (5), and multilateral health organization (3). Many key informants from the private sector are former officials at the ministry of health (MoH) of their respective countries with extensive experience and knowledge about the health budgeting practices, and have active government engagements in their current positions. All interviews were conducted via Zoom, and the interview data was analyzed to explore the perspectives, experiences, and insights using the framework described in the next section on the process, challenges and successes of the health budgeting process in each country. Additionally, we had consultations with two groups to refine and validate the findings of our study – program managers and country representatives of FIFARMA across our focus countries, and the Andean Committee on Health and Economy at ORAS-CONHU.

**Table 2: Basic information about key-informants (anonymized to protect confidentiality)**

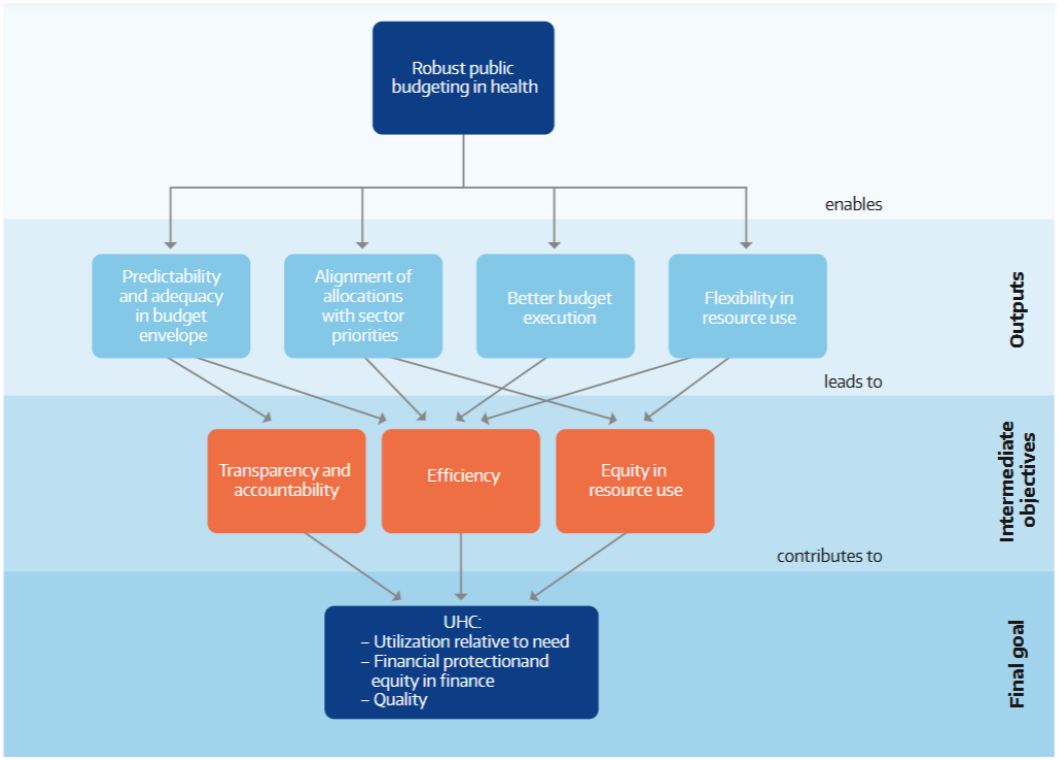
| Country | Current position | Organization type | Sector |
|---|---|---|---|
| **Argentina** | Director | Pharmaceutical research organization | Private sector |
| **Argentina** | Manager | Pharmaceutical research organization | Private sector |
| **Brazil** | Director | Non-profit pharmaceutical research | Private sector |
| **Chile** | Director | Pharmaceutical organization | Private sector |
| **Chile** | Director | Budgeting institution | Government |
| **Colombia** | Director/ Former MoH official | Pharmaceutical company | Private sector |
| **Colombia** | Consultant/ Former MoH official | Health institution | NGO |
| **Costa Rica** | Director | Pharmaceutical research organization | Private sector |
| **Ecuador** | Dean/ Former MoH official | University | Academia |
| **Ecuador** | Director | Health/social institution | Government |

| | | | |
|---|---|---|---|
| **Ecuador** | Executive director | Pharmaceutical research organization | Private sector |
| **Ecuador** | Manager | Pharmaceutical research organization | Private sector |
| **Ecuador** | Manager | Pharmaceutical research organization | Private sector |
| **Ecuador** | Manager | Pharmaceutical research organization | Private sector |
| **Ecuador** | Consultant | Multilateral health organization | Multilateral |
| **Mexico** | Director | Pharmaceutical research organization | Private sector |
| **Mexico** | Director | Research organization | NGO |
| **Peru** | University professor/ Former MoH official | University | Academia |
| **Peru** | Executive director | Pharmaceutical organization | Private sector |
| **Peru** | Regional Head | Pharmaceutical company | Private sector |
| **Peru** | University professor | University | Academia |
| **Peru** | Consultant | Consulting company | Private sector |
| **Multilateral organization** | Advisor | Multilateral health organization | Multilateral |
| **Multilateral organization** | Health system specialist | Multilateral health organization | Multilateral |
| **Multilateral organization** | Financing specialist | Multilateral health organization | Multilateral |

## Framework of analysis

We have referred to the budgeting framework developed by the World Health Organization to guide the analysis (Figure 2).[17] The framework disentangles the key outputs that can come from strengthened budgeting systems in health (i.e. predictability, alignment, execution, flexibility), which can then lead or contribute to the intermediate goals of UHC (i.e. transparency and accountability, efficiency and equity in resource use). The framework offers a structured way of assessing public sector health budgets and it was selected for its alignment with the objectives of this report. We used the framework to inform the design of desk-based review as well as interview questions with key informants. The framework also provides good practices for health budget and facilitates us to identity the gaps and areas for improvements in health budgeting in the selected Latin American countries.

**Figure 2: Robust budgeting as an enabler of UHC**




Source: WHO Budget matters for health: key formulation and classification issues

## FINDINGS

### 1. Overview of health status and health financing

Health systems across Latin America face a dual challenge of addressing both persistent infectious diseases and a growing burden of chronic non-communicable diseases (NCDs), while public spending on health remains relatively low. Table 3 below provides an overview of health outcomes and health financing trends across the studied countries. Overall domestic government health spending in LAC region was approximately 4.1 % of GDP in 2022, but countries like Costa Rica, Chile, Colombia, and Argentina are approaching the WHO-recommended target of spending 6% of GDP on health.[3] Most countries spend about 4% of GDP in health from domestic sources, only half of the OECD average.[13,15] There were notable increases in domestic health spending during the COVID-19 pandemic, however, there are noticeable drops in the share of GDP and domestic resources spent on health in 2021 as the pandemic slowly subsided as seen in Figure 3.[15]

**Table 3: Overview of health outcomes, disease burden and health spending in Latin America**

| Country/ Region | Current health spending per capita US$ | Government health spending % GDP (GGHE-D % GDP) | Domestic government health spending % general government spending (GGHE-D % GGE) | Out of pocket spending % current health spending | Life expectancy at birth (years) | Under 5 mortality (per 1,000 live births) | Non-communicable disease deaths % total deaths | Diabetes mortality (per 100,000) |
|---|---|---|---|---|---|---|---|---|
| **Year** | **2022** | **2022** | **2022** | **2022** | **2022** | **2022** | **2019** | **2019** |
| **Argentina** | $ 1,371 | 5.8% | 15.2% | 26.4% | 75.8 | 9.8 | 76.7% | 12 |
| **Brazil** | $ 849 | 4.1% | 9.0% | 27.4% | 74.9 | 14.6 | 74.7% | 25 |
| **Chile** | $ 1,547 | 5.1% | 19.0% | 35.5% | 79.2 | 6.8 | 85.1% | 11 |
| **Colombia** | $ 506 | 5.3% | 15.7% | 14.4% | 76.5 | 12.4 | 75.6% | 9 |
| **Costa Rica** | $ 979 | 5.0% | 25.8% | 22.4% | 79.3 | 10.1 | 82.0% | 15 |
| **Ecuador** | $ 493 | 4.6% | 11.9% | 32.5% | 76.6 | 13.2 | 76.2% | 27 |
| **Mexico** | $ 651 | 3.0% | 10.4% | 39.1% | 74.0 | 12.9 | 80.4% | 72 |
| **Peru** | $ 446 | 4.0% | 16.7% | 27.0% | 76.8 | 16.1 | 72.6% | 13 |
| **LAC region** | **$ 722** | **4.1%** | **11.7%** | **30.0%** | **74.6** | **16.2** | **75.5%** | **21** |
| **OECD average** | **$ 5,552** | **8.3%** | **19.7%** | **13.1%** | **81.0** | **6.7** | **87.0%** | **23** |

Source: WHO, World Bank

Notes:

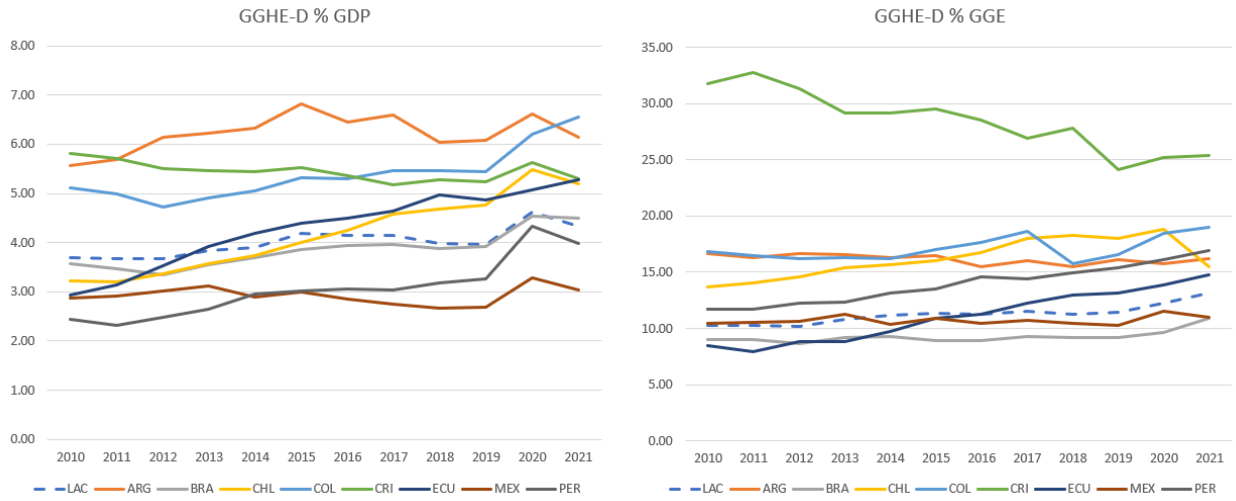
For purposes of uniformity and comparability across countries, we have used international data sources such as the World Banks's World Development Indicators and World Health Organization's Global Health Expenditure Database in this table. The year for which latest data is reported across all countries in these databases has been used for comparability.

Government health % GDP in the table is the domestic government health spending as a percentage of GDP (GGHE-D%GDP) from the WHO Global Health Expenditure database shows the level of public health expenditure from domestic sources as a share of the country's GDP.

Domestic government health spending % general government spending (GGHE-D%GGE) from the WHO Global Health Expenditure database shows the level of public health expenditure from domestic sources as a share

overall public expenditure. It is an indicator of the country's commitment to prioritizing health within its budget from its own domestic sources.

**Figure 3: Domestic government health spending as a percentage of GDP over the years**




Source: WHO Global Health Expenditure Database

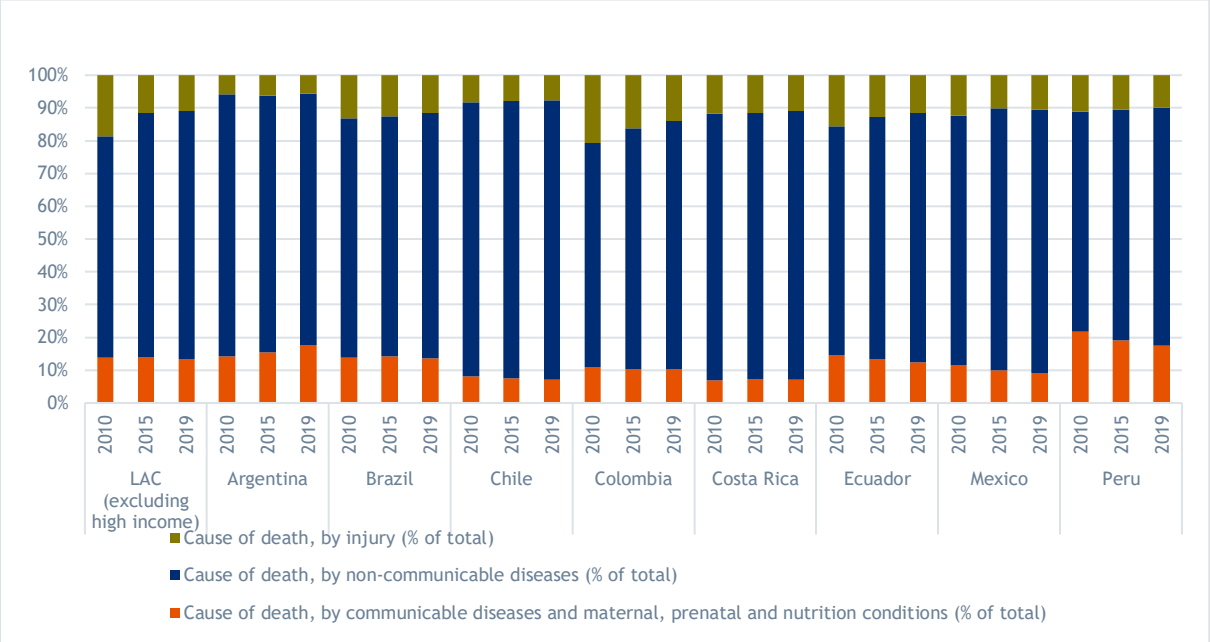
Notes:

- GGHE-D % GDP is the domestic government health spending % of GDP
- GGHE-D % GGE is the domestic government health spending % of overall government expenditures

Healthcare costs in Latin America are on the rise, driven by the significant burden of NCDs. Deaths due to NCDs comprises more than 70% of total deaths in all the countries (Figure 4).

The high NCD burden in Latin America is not only a huge driver of health costs, but also has economic implications in the form of loss of productivity. A study conducted in 2022 found that that diseases have a large economic cost to Latin America's economy. Driven mostly by NCDs like cardiovascular conditions, neoplasms, type 2 diabetes, cancer, and ischemic heart disease, there is substantial productivity losses to the tune of approximately 2.5% to 6.4% of GDP across the eight studied countries.[18] Another study focused on Costa Rica and Peru found that productivity losses from NCDs and mental health conditions amount to US$ 81.96 billion (2015 US$) for Costa Rica, and US$ 477.33 billion for Peru for the period 2015-2030. New analysis by PAHO found that NCDs, along with mental health conditions will cost the region over US$ 7.3 trillion in lost productivity and healthcare spending between 2020 and 2050.[19] There is an urgent need to boost investments in chronic diseases in Latin America to reduce prevalence and also due to the high cost-benefits of averting these productivity losses.[19,20]

**Figure 4: Causes of death by diseases (% of total)**




Source: World Health Organization Mortality and Global Health Estimates

## 2. Status of universal health coverage and role of public financing

UHC in Latin America has made notable progress over the past two decades, with many countries expanding access to essential health services and reducing financial barriers. And having reliable public budgets, clearly defined health sector priorities and output targets, and flexibility in budget execution are key to strengthening the financial systems needed to effectively implement and sustain UHC.[3]

The WHO's Service Coverage Index (SCI) scores countries on a scale of 0 to 100**,** where higher scores indicate greater access to essential health services. The SCI covers 14 different essential health services which can be clubbed under four main categories: (i) reproductive, maternal newborn and child health, (ii) infectious diseases (iii) NCDs, and (iv) service capacity and access. As of 2021, the range of the SCI ranges between 59 and 82, revealing a great inequality among the countries of the region indicating disparities in service quality, access for marginalized populations, and financial protection (Figure 5a).[21] The most advanced countries in terms of coverage include Chile (80), Brazil (80), Colombia (80) and Costa Rica (80) with scores equal to or above 80. Although these four countries have the same overall SCI score, as seen from Figure 5b below, there are variations in service coverage for the four main categories. Peru (71), Mexico (75), Ecuador (77), Argentina (79).[22] The changes in essential health service coverage have varied widely, especially due to the COVID-19

pandemic. Countries like Peru and Brazil have seen stagnation or decline since before the COVID-19 pandemic.[1]

**Figure 5a: Evolution of UHC service coverage index in Latin America**

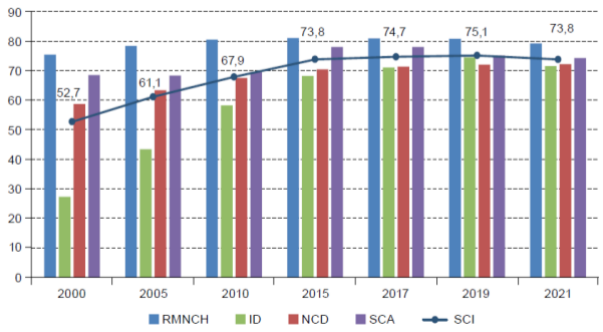
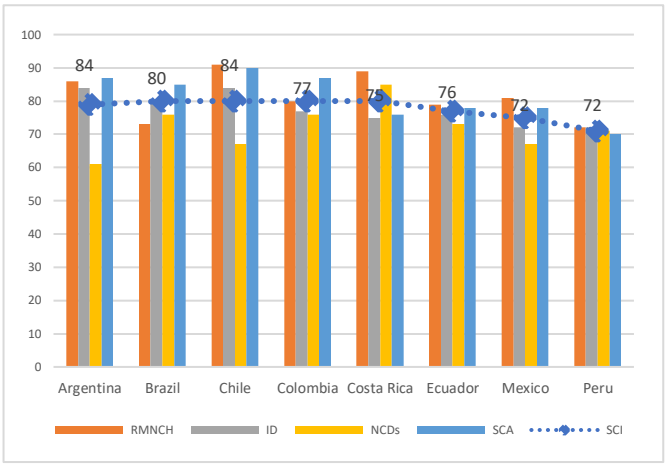



**Figure 5b. UHC service coverage index across countries, 2021**




Source: Figure 5a extracted from CEPAL report on La sostenibilidad financiera de los sistemas de salud de América Latina y el Caribe: desafíos para avanzarhacia la cobertura sanitaria universal. Figure 5b based on data extracted from the WHO Global Health Obesevatory https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage

Notes:

- RMNCH: Reproductive, maternal, newborn and child health; ID: infectious diseases; NCD: noncommunicable diseases; SCA: access and care services; SCI: health services coverage index.
- Latin America average score based on data from Argentina, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Uruguay, and Venezuela
- WHO reports SCO scores over 80 as ≥80 without presenting the actual score to make country comparisons more realistic. Chile, Brazil, Colombia and Costa Rica are all reported to have scores ≥80 https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage

The provision of UHC in the selected LACs is done through various key schemes that are primarily funded by general taxation and social security contributions. There is a great variation in the provision of UHC across the countries based on their health system, financing architecture and socio-economic and political characteristics (Table 4). In Argentina, UHC efforts are fragmented across public, social security (Obras sociales), and private sectors. The public system, financed through general taxes, serves the uninsured population, while the social security system, ObraSociales, is financed by employer and employee contributions in the formal sector.[23–25] Despite relatively high government spending on health (approx. 5.8% of GDP), budget fragmentation and inefficiencies have led to issues with equitable distribution and service quality. One study looked at the socioeconomic disparities in healthcare utilization within Argentina's fragmented and decentralized health system and

found that there is a pro-rich bias in healthcare utilization where individuals with higher socioeconomic status are more likely to utilize healthcare services compared to those with lower socioeconomic status. The study found that Argentina's health budget allocation may not be effectively addressing existing socioeconomic disparities in healthcare access.[23]

In Brazil, there is a dual health system, where the National Health Fund (Fundo Nacional de Saúde, FNS) finances public provision, while private health insurers serve higher-income populations.[26] Brazil's Sistema Único de Saúde (SUS) is the largest public health system in the region, providing free services to the entire population. Funded through federal, state, and municipal taxes, SUS has achieved significant improvements in maternal and child health, but faces challenges related to funding adequacy and service quality.[8] Chile's Fondo Nacional de Salud (FONASA) covers about 78% of the population and is funded by a mandatory 7% payroll tax. The wealthier population can opt out to purchase private insurance through Instituciones de Salud Previsional (ISAPREs). Chile's health provision is characterized by fragmentation due to this public and private provision.[27,28] Colombia's Plan de Beneficios en Salud (PBS) under the Sistema General de Seguridad Social en Salud (SGSSS) is financed through payroll taxes and general revenues. It offers a unified benefits package for both contributory and subsidized populations and has significantly expanded access since the 1993 reforms.[29,30] Providers under the PBS scheme are paid based on a per capita payment unit (UPC) for the covered services. Colombia also has a Maximum Budgets funding mechanism called the Presupuestos Maimos en Salud that funds health services and technologies not included under the PBS. This Maximum Budgets mechanism has aimed to improve the comprehensiveness of services by covering services beyond the scope of the UPC benefits package.[31,32] In Ecuador, the Instituto Ecuatoriano de Seguridad Social (IESS) covers formal sector workers; and the armed forces and the national police through payroll contributions, while the Ministry of Public Health uses tax revenues to provide health services for those not covered under any scheme. Together, these entities for the Public Network of Comprehensive Health Care.[33,34] The presence of multiple health schemes has resulted in duplication and fragmentation, with access and quality issues. In recent years, Mexico's health insurance landscape has undergone a great transformation.

Until 2020, Seguro Popular was Mexico's largest publicly funded insurance program for over 15 years and had over 50 million beneficiaries. With a change in government, the Instituto Mexicano del Seguro Social (IMSS) which covers the general public and private sector, and Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE) which covers government employees, were put in place. Additionally, Seguro Popular has been replaced by the Instituto de Salud para el Bienestar (INSABI), which covers individuals that are ineligible for IMSS or ISSSTE. Recent studies have shown that the transition from Seguro Popular to the current system has led to service gaps, lower health coverage, and reduced

financial protection, with a drop in insurance enrollment by 16.8%.[35–37] Peru's key UHC schemes include the non-contributory and subsidized Seguro Integral de Salud (SIS) that covers the poor and informal populations, and the Seguro Social de Salud (EsSalud) contributory scheme funded through a 9% payroll contribution, that covers formal sector employees and dependents. The SIS is funded through the government budget and includes the essential UHC package called the Plan Esencial de Aseguramiento en Salud. SIS provides other complementary services that include preventative, curative and rehabilitative health services through a network of 8,000 public health establishments.[38,39,40] Recent UHC legislations have expanded health service benefits to the population, with increased benefits and coverage in recent years.[41,42] However, the presence of multiple schemes and providers have led to duplication and fragmentation, as well as large variations in service provision, access and resource allocation between the SIS and EsSalud.[40] Costa Rica's Caja Costarricense de Seguro Social (CCSS) has long been lauded as a successful model for UHC, which is funded by payroll contributions and government taxes (Box 1). Through pooling, cross-subsidization and pro-poor distribution, the CCSS has ensured nearly universal health access to a full range of health services for its population.

**Box 1: Costa Rica's UHC model: the Caja Costarricense de Seguro Social (CCSS)**

**Overview:**
- Established in 1941, the CCSS administers nearly all public health services for citizens and legal residents

- Transitioned service delivery from the Ministry of Health to CCSS by the mid-1990s, integrating primary, secondary, and tertiary care

**Financing of the CCSS:**
- Funded through payroll contributions and taxes:
  - 15% payroll tax, split among employers (9.25%), employees (5.5%), and the government (0.25%)
  - Other tax revenues and earmarked taxes such as excise taxes on luxury goods to subsidize the poor

**Coverage:**
- Universal and compulsory coverage achieved through decades of expansion

**Key innovations for efficiency, quality and equity:**
- Central pooling of revenues and redistribution based on need
- Very low administrative costs (3-4%) burden on the budget[43]
- Donor supported reforms to implement expansion of primary care (EquiposBásicos de Atención Integral de Salud - EBAIS primary care network), digitalization of health records (EDUS digital health record system nationwide by 2019), and strategic resource allocation (World bank "Program for Results" to integrate care networks, capitation-based financing, digitalization, and performance-based resource allocation)[44,45]
- 'Contracting in' strategy, whereby performance targets are negotiated with regional health officials based on available resources, population characteristics, and past performance to monitor health performance[43]
- Starting from 2024, the CCSS is adopting strategic purchasing moving away from historical budget towards a capitation model[46]

**Health and financing outcomes:**

- **High levels of investments in health** compared to other LACs that even surpasses many OECD countries**. Domestic government spending on health was 5.2% of its GDP in 2022**, which is above the average Latin America and Caribbean region (4.1%), but below that OECD average (8.3%) or other LAC countries like Cuba (10.5%), Uruguay (6.3%) and Argentina (5.6%)[15]
- **Health constituted 25.8% of the general government expenditures in 2022**, which is above the LAC average of 11.7%, and other OECD peers like Chile (19%)[15]
- ***Universal access to full range of health services with very good health indicators*** (life expectancy exceeds many OECD countries) with one of the highest levels of life expectancy in the LAC region at 80 years.[13]
- **Free point of care health access,** with no formal co-payments, out of pocket expenses are mostly non-catastrophic.[45,45]
- **Equitable financing of UHC** - Lowest 20% income quintiles receive nearly 30% of CCSS resources compared to 11% spent on the top richest 20% income quintile, similar rates of healthcare utilization across socio-economic groups and rural-urban areas.[43,47]

Sources: Author compilation based on multiple sources

Public financing of UHC is key to mitigate high out-of-pocket expenditures and ensure access for the most vulnerable. While the public provision of UHC financed through general taxes and social health insurance is quite advanced in the Latin American region, there are wide variations in coverage and progress based on the country's unique systems and structures. In later sections we describe the issues of fragmentation, duplication, and, inefficiency which has led to inequities and access issues across these countries.

**Table 4: Major UHC financing schemes across Latin America**

| Country | Scheme Name | Financing | Population health coverage by sub-systems (As of 2019) | | | |
|---|---|---|---|---|---|---|
| | | | Public (%) | Social security (%) | Private (%) | Others (%) |
| **Argentina** | Obras Sociales and Programa de Asistencia Médica Integral (PAMI) | Mandatory contributions from employers (3%) and employees (6%) and federal and municipal contributions | Universal | 51.0 | 7.9% | 3.2 |
| | Compulsory Medical Plan, Programa Médico Obligatorio (PMO) | Financed through contributions of Obras Sociales and private insurance | | | | |
| **Brazil** | Sistema Único de Saúde (SUS) | Tax revenues and social contributions from federal, state, and municipal governments | Universal (SUS) | 0.0 | 19.6 | 0.0 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Chile** | Fondo Nacional de Salud (FONASA) and Instituciones de Salud Previsional (ISAPRE) | Mandatory payroll contributions (7% of income) and general taxation | Universal (Explicit Health Guaranteed) | 73.5 | 16.3 | 6.7 |
| **Colombia** | Sistema General de Seguridad Social en Salud (SGSSS) | Payroll contributions (contributory regime) and general taxation (subsidized regime) | Universal (Basic health care plan under SGSSS) | 91.1 | N/A | 3.9 |
| **Costa Rica** | Caja Costarricense de Seguro Social (CCSS) | Payroll contributions and general taxation | Universal (Under CCSS) | 0.0 | 0.0 | 0.0 |
| **Ecuador** | Instituto Ecuatoriano de Seguridad Social (IESS) and ISSFA and ISSPOL for armed forces and pólice personnel | Payroll contributions and general taxation | Universal | 29.1 | | |
| **Mexico** | Instituto Mexicano del Seguro Social (IMSS) - Ordinary and Bienestar | General taxation; federal government subsidies | | | | |
| **Peru** | Seguro Integral de Salud (SIS) and EsSalud | General taxation (SIS) and payroll contributions (EsSalud) | Universal (Under SIS) | 24.0 | 5.5 | N/A |

Source: Authors' compilation based on various reports and published articles.

Note: Population health-coverage data (except Ecuador and Mexico) extracted from Pan American Health Organization. "Universal Health in the 21st Century: 40 Years of AlmaAta." Report of the High-Level Commission. Revised edition. Washington, D.C.: PAHO; 2019. Population data on Ecuador is based on data from Lucio R, López R, Leines N, Terán JA. El financiamiento de la salud en Ecuador. revistapuce. 2019 May 3(108) available from https://www.revistapuce.edu.ec/index.php/revpuce/article/view/215

## 3. Health budgeting

In this section, we will describe the key features, challenges and successes of different aspects of the health budgeting system across the studied countries.

### 3.1 Legislation

Across Latin America, health financing is shaped by national budgetary legislation and institutional frameworks that vary by country (Table 5). The legislative frameworks across the different countries reflect diverse pathways toward health financing, with varying degrees of centralization, fiscal protections, and institutional coherence influencing how health budgets are allocated and managed across the region.

In Argentina, the health budget is embedded in the national budget and governed by the National Budget Law. The system is highly decentralized, with provincial governments responsible for health service delivery.[48,49] Law 24.193/1992 established Obras Sociales – the mandatory social health insurance mechanism in the country.[50] Brazil operates under a constitutionally guaranteed right to health, established in the 1988 Constitution. Brazil's SUS is financed through federal, state, and municipal funds, and guided by Law 8.080/1990. However, fiscal restrictions under Constitutional Amendment 95 (PEC 95/2016) have capped health spending growth for 20 years, straining the public system[51–53]. In Chile, the health budget is allocated annually through the national budget and regulated by the Budgetary Law, with its constitutional framework ensuring public health responsibilities. While the system is more centralized, the government has proposed reforms such as the Fondo Universal de Salud (FUS) to unify health funding streams.[54]

A key piece of legislation that has shaped Colombia's healthcare system is Law 100 of 1993. This was a major reform to establish the current health insurance mechanism which comprises of two regimes - the subsidized and contributory regimes under the General System of Social Security in Health (SGSSS), which aimed to provide universal health coverage and improve access, efficiency, and quality of health care in the country.[29] In 2011, Law 1438 unified the health package under these two schemes to guarantee equal benefits regardless of the regime to all Colombians.[55] As one key informant noted: *"Statutory law obligates the government to equalize the contributory and subsidized regimes and now everyone has the same benefit package."* Previous to this law, the health budget of Colombia was small and the country had to progressively work for 20 years to increase the budget allocation for this program and cover the entire population. A key constitutional mechanism in Colombia's health sector is the 'tutela mechanism' which was introduced under Article 86 of the 1991 Colombian Constitution to protect the rights to healthcare access for citizens. Under the provision of the tutela, if a health service is not provided by the insurer, Colombians can approach a judge who can direct the insurer to provide the service within 15 days. While it has helped to keep health providers accountable, tutelas have an impact on the health budget to ensure that all services and drugs covered under the comprehensive package are funded and made available to citizens in a timely manner.[56,57] While the "tutela" mechanism enables citizens to claim their right to health through the courts on one hand, on the other hand, it has increased pressure on fiscal allocations and implementation efficiency, also contributing to unpredictability in budget execution. Colombia is undergoing significant health reforms under the current President Gustavo Petro's administration to respond to issues around significant financial challenges related to the SGSSS. In recent years, insurers also known as health promotion entities (EPS), have been spending more than they receive, leading to a huge financial deficit. Additionally, key informants noted that the UPC has been adjusted over the years to account for general inflation rather than actuarial studies that reflect the true cost of care. As health care costs evolve differently and often outpace

inflation, this has jeopardized the sustainability of the health system and impacted the quality of health care. The proposed reform (*Bill 339 of 2023)* seeks to shift control of healthcare system funding from private companies to the government, moving towards a single-payer public healthcare system. The proposal is to eliminate the existing EPS and replace them with Health and Life Managers. These entities would not manage funds or act as insurers but would instead administer and coordinate health services, receiving a percentage of the state budget based on their performance.[58] Additionally, healthcare funding and management will be centralized under a single public entity, Administrator of the Resources of the General System of Social Security in Health (ADRES). ADRES is responsible for reimbursements and payments for both UPC and Maximum Budgets.[59]

Costa Rica funds its universal health coverage primarily through the CCSS, whose budget is part of the national budget governed by Article 176 of the Constitution.[60] Similar to the tutela mechanism in Colombia, Costa Ricans have been able to access improved health services due to the judicialization of health. If access to a certain medication is immediately unavailable, Costa Ricans can file legal protection claims in the Constitutional Chamber, and key informant mentioned that *"Social Security Fund is obligated, while the case is being resolved, to provide a substitute/medication immediately."* This legal mechanism is being increasingly used to get access to high-cost innovative therapies, which also impacts the health budget and creates uncertainties depending on the number of legal protection claims filed. Article 12 of Ecuador's 2018 constitution has declared health as a fundamental human right.[61,62] Ecuador, while decentralized in theory, sees strong central government control over health policy. The budget follows constitutional guidelines and the National Development Plan.[63,64] However, considering the presence of multiple health schemes and institutional arrangements, the health system is fragmented.[61,62]

In Mexico, a federal country, the health budget is governed by the Federal Budget and Fiscal Responsibility Act and the Constitution, with funds distributed among various decentralized entities. Recent reforms created IMSS-Bienestar to unify service provision for the uninsured.[65,66] Peru allocates funds through the national budget law with line items for the Ministry of Health (MoH) and the SIS, its public insurance scheme, though the system remains fragmented across regions and institutions.[67,68]

**Table 5: Key health budgeting legislations and laws**

| Country | Key legislations for health budgets |
|---|---|
| **Argentina** | The health budget is **part of the national budget**, governed by the National Budget Law.<br>**Decentralized** structure<br>The budgetary system is primarily determined by **Law No. 24.156** on Financial Administration and the National Public Sector Control Systems and its regulations<br>**Law 23.660** is the Health Insurance Act that established the social health insurance (Obras Sociales) for employees and their families and mandated the basic health services, PMO |

| | |
|---|---|
| **Brazil** | **1988 Constitutional law** established guaranteed right to health<br>**Annual Budget Law**, or LOA and the dget Guidelines Law, or LDO governs the general budget<br>**Organic Health Law 8080 of 1990** established the SUS and defined the responsibilities for public health provision<br>**Constitutional Amendment 29 of 2000 (CA29)** established minimum percentages of tax revenue that Federal, State, and Municipal governments are required to allocate to public health |
| **Chile** | **Article 19 of the Constitution** guarantees a right to health protection and established the state's duty to ensure free and equal access to health<br>The Constitution and Budgetary Law The health budget is **part of the annual national budget,** regulated by the Budgetary Law and defined in the Constitution<br>**Health Guarantee Law 19.966 of 2005 (*Acceso Universal con GarantíasExplícitas* [AUGE])** established the Explicit Health Guarantees (GES) system, guaranteeing access, quality, financial protection, and timeliness for a specified set of health conditions |
| **Colombia** | **Law 38 of 1989** states that the health budget is part of the national budget<br>**Law 100 of 1993** established the Social Security System in Health, SGSSS, creating contributory and subsidized health insurance schemes and defining roles for EPS and IPS<br>**Law 1438 of 2011** introduced comprehensive care models for chronic non-communicable diseases and mental health into the SGSSS and strengthens primary care networks<br>**Law 715 of 2001** regulates resource allocation to departments and municipalities for health, education, and other social services<br>**Law 1955 of 2019** introduced Maximum Budgets funding mechanism to fund services and technologies not covered by the per capita payment unit, UPC |
| **Costa Rica** | **Article 176 of the Constitution** states that the health budget is part of the national budget<br>**Law 17 of 1941** created the CCSS, which administers healthcare and social security<br>**Law 7772 of 1998** updated the health service administration under the CCSS and regulates patient rights |
| **Ecuador** | **The Constitution** states that the health budget is part of the national budget<br>**General National Budget (Article 292)** is the key instrument for managing the State's revenues and expenditures<br>**Health Reform Law of 1997** initiated health system restructuring at provincial and district levels, focusing on primary healthcare and decentralization<br>**Organic Health Code (COES) of 2006** consolidated public health regulations, defines health system structure, and established rights & duties of users and providers<br>**Constitutional reforms in 2008** to establish mandatory health insurance, Seguro Universal Obligatorio |
| **Mexico** | Health budget is part of the national budget. The budget follows the Federal Budget and Fiscal Responsibility Law and the Constitution. Decentralized (federal) country<br>**Seguro Popular Law of 2003 e**stablished the *Seguro Popular* program to provide health coverage for the uninsured before its integration into the *Instituto de Salud para el Bienestar (INSABI)* in 2020<br>**INSABI Law of 2020** replaced Seguro Popular to offer free, universal coverage for basic health services and medications for those without social security<br>**Ley General de Salud of 1984** updated in 2014 governs the health system structure, rights, and regulation of public health<br>**General Health Law Decree 2023** dissolved the INSABI and transferred responsibilities to provide free health services to those without insurance through the IMSS-Bienestar |

| | |
|---|---|
| **Peru** | **Law No. 28411**, General Law of the National Public Budget System governs the national budget<br>**Law 26842 of 1997** established the right to health and outlined the government's responsibilities to ensure the same<br>**Law 27657 of 2002**created comprehensive health insurance, SIS to subsidize health insurance for low-income individuals through MINSA |

Source: Author compilation from multiple sources

Several key issues related to the legislation of budgets were highlighted by key informants. In Chile, there is a lack of programmatic budgeting in legal frameworks - health budgets are defined at the facility level rather than by program. This limits the ability to track and align spending with national health priorities such as primary care or disease-specific interventions. Countries like Mexico, Ecuador, Costa Rica, and Peru have multiple co-existing subsystems (e.g., social security, ministry-run services, and private insurance), often with distinct funding rules enshrined in various legal instruments. The fragmentation across subsystems leads to inefficiencies and coordination challenges. Key informants noted that Ecuador's Constitution mandates periodic increases in the health budget, but this legal obligation is often not financially feasible as this legal mandate is unfunded. As a result, there is fiscal stress and reliance on debt to meet legal spending targets. Ecuador and Peru have laws specifying how the health budget should be elaborated. Peru stands out for legally incorporating evidence-based budgeting, a positive innovation. But there is a disconnect between legislative intent and practical implementation, making its effectiveness unclear. In Colombia and Costa Rica, legislation defines health financing through taxes and social security contributions. However, legal reliance on formal-sector contributions is misaligned with economic realities as high rates of informality dilute the revenue base and challenges the sustainability of health financing systems.

Overall, health sector legislation in Latin America suffers from a combination of insufficient specificity**,** fragmentation**,** and ambitious legal mandates without fiscal backing**.** While some countries are introducing more evidence-informed budget laws, most still struggle to create legislative coherence that supports integrated and sustainable financing of health systems.

## 3.2 Institutional settings

A key element of effective PFM in the health sector is the clear delineation of institutional responsibilities across the budget cycle—covering preparation, approval, execution, reporting, and audit. In Latin America, these functions are typically shared across ministries of finance, health authorities, and oversight bodies, with varying levels of centralization or decentralization.

The institutional settings for health budgeting in Latin America as shown in Table 6 below reflects a complex interplay between central and subnational governments, with significant variation in the degree of decentralization and institutional coordination. The differences in

government structures also significantly shape the budgeting practices across these countries. Federal and decentralized countries like Brazil, Argentina, and Mexico exhibit more complex, decentralized budgeting processes, where subnational governments play a critical role in planning, spending and service delivery. In contrast, unitary systems like Chile, Costa Rica, and Ecuador maintain more centralized control, allowing for more uniform implementation of health policies.

**Table 6: Institutional features affecting health budgeting across countries**

| Country | Separation of budget making and execution | Health budget proposal | Review and approval of health budget | Health budget execution | Reporting | Audit |
|---|---|---|---|---|---|---|
| **Argentina** | Budget made centrally by Ministry of Finance (MoF) executed by Ministry of Health (MoH) and subnational governments | MoH prepares and submits to MoF | MoF sets the budget ceilings, the Cabinet finalizes the budget and the Congress Commission of Budget and Finance reviews and amends the budget before final approval by Congress | MoH at federal level; provinces/municipalities via provincial treasuries and SIDIF | MoF publishes monthly and quarterly cash-based reports; Pre-Budget Statement and other transparency docs | Federal: SIGEN (Audit Office); subnational: provincial courts (e.g., HTC in Buenos Aires audits execution accounts) |
| **Brazil** | Central budget by Ministry of Planning; execution decentralized via SUS across federal, states, municipalities | MoH along with the Ministry of Planning and the Presidency | Ministry of Planning/MoF reviews the budget, which is sent to the Cabinet for further review. Congress approves via annual Budget Law | Federal level via SIAFI/FNS; subnational via states & municipalities using SIOP | SIAFI Brasil tracks federal execution; SIOPS provides bi-monthly subnational health financial data | Federal: Tribunal de Contas da União (TCU); subnational: state/municipal courts of accounts |
| **Chile** | Unified approach: DIPRES (Budget Directorate within Ministry of Finance) prepares budget; while MoH executes | MoH drafts; submits to DIPRES | DIPRES negotiates ceilings, Parliament Budget Committee reviews the budget, approved budget is passed by Congress | MoH manages execution across regions and municipalities | DIPRES publishes annual execution reports; MoH conducts efficiency audits; applies selective spending reviews | Contraloría General de la República performs legal and ex-ante review ("toma de razón") and audits |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Colombia** | MoF sets budgets; MoH and Territorial Entities execute | MoH drafts proposals and sends to MoF | MoF integrates the health budget into the medium-term fiscal framework. Once Cabinet approves the budget, Congress passes it via budget law | Central: MoH executes federal health spending. Subnational: Departments & municipalities execute deep-funded health budgets | MoF & Finance Directorate publish budget execution & fiscal framework; Health Ministry shares fiscal impact of reforms | Contraloría General de la República audits national & territorial execution; local comptrollers audit subnational entities. |
| **Costa Rica** | MoF defines ceilings and MoH executes | MoH drafts the budget and submits to MoF | MoF and the Executive Council reviews and approves, then Legislative Assembly passes via annual budget law | Central Ministry at national level; regional Health Areas (Áreas de Salud) implement services locally | MoF publishes execution via annual reports; MoH monitors by health area | Contraloría General de la República audits central and regional execution |
| **Ecuador** | MoF sets national budgets; M of Public Health (MPH) + IESS execute | MoH drafts, submits to Finance Secretariat; IESS proposes separately for its network | Finance Office negotiates ceilings; Cabinet approves; National Assembly enacts laws | Ministries: MPH central execution through provincial health directorates & public hospitals; IESS: separately runs its hospitals and staff | Finance publishes annual budget and execution; MPH implements tools for cost tracking and efficiency (MGPSS/PERC) | Contraloría General del Estado audits central, MPH, and IESS; provincial audit divisions oversee at subnational levels. |
| **Mexico** | SHCP (MoF) sets budget; MoH executes, alongside IMSS/ISSSTE/INSABI/IMSS Bienestar | MoH and social security agencies draft proposals; MoF integrates into annual expenditure plan | MoF and Office of Public Administration negotiate; Cabinet approves; Congress authorizes via annual "Presupuesto de Egresos" | Central: Secretaría de Salud (SSA) for uninsured services; Subnational: IMSS, ISSSTE, INSABI branch; States/municipalities via IMSS Bienestar & local clinics | MoF provides quarterly and annual cash-based execution data; SSA & MoF report on service delivery; IMSS Bienestar publishes program execution metrics. | Auditoría Superior de la Federación audits federal health spending; state auditors and ASF audit subnational agencies. |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | Agency for Budget Transparency also publishes quarterly reports on budget execution | |
| **Peru** | Ministry of Economy and Finance (MEF) sets ceilings; MoH (MINSA) and EsSalud execute | MoH drafts budget request; submits to MEF; EsSalud proposes separately via Ministry of Labor & Social; other service providers likewise | MEF evaluates and sets ceilings; Cabinet approves; Congress enacts expenditure law annually | MoH: executes at central + regional level; EsSalud through social security model | MEF publishes execution rates; MoH reports on use of funds | Contraloría General de la República audits MoH, EsSalud, and subnational regional health administrations. |

Source: Author compilation based on review of various country policy documents and published reports

In Argentina, the MoF is responsible for budget formulation and reporting, while the MoH develops national health programs, which are executed is shared between the Ministry of Health and subnational governments. The MoH drafts the health budget proposal, which is submitted to MoF. Budget ceilings are defined by ONP, finalized by the Cabinet, and approved by Congress through annual legislation. Execution responsibilities are divided between federal and provincial entities, coordinated through the Integrated Financial Information System (SIDIF). Budget audit is conducted by the General Syndicate of the Nation (SIGEN) at the federal level, with provincial audit courts, such as the Honorable Tribunal de Cuentas (HTC) in Buenos Aires, covering subnational execution. In Brazil, the federal budget is prepared by the Ministry of Planning in consultation with the MoH and MoF, which is then submitted to the Cabinet and approved by Congress through the annual Budget Law.

In Brazil's highly decentralized system, state governments also contribute to developing the state-level health budgets that inform the federal budget and budget execution is also highly decentralized. The budget is executed by federal, state and municipal governments through the SUS. Budget oversight is done through the Federal Court of Accounts and subnational courts.

Chile centralizes budgetary planning through DIPRES (Budget Directorate of the Ministry of Finance), which develops and monitors budget execution. The Ministry of Health defines

policies and service priorities, while and also executes the budget at the federal and subnational levels. The audit and legal reviews of the budget are conducted by the Office of the Comptroller General.

Colombia combines centralized budget formulation—led by the MoF —with budget execution managed by both the MoH at the national level, and the subnational and municipal governments at the local level. The MoH drafts the health budget, which is integrated into the medium-term fiscal framework. The Comptroller General audits both national and subnational budgets with support from local audit offices.

In Costa Rica, MoF defines budget ceilings, while the MoH formulates and executes the budget. Budget execution is overseen by the MoH, while regional health agencies and local Equipos Básicos de Atención Integral de Salud (EBAIS) clinics deliver the health services. The CCSS, which manages health service delivery, operates largely independently with its own financing mechanisms (payroll contributions and earmarked taxes). This centralized and vertically integrated structure has been key to Costa Rica's strong health outcomes and financial sustainability. The Comptroller General of the Republic audits spending at both the central and regional levels.

In Ecuador, the MoF sets the budget ceiling, but budget formulation and execution is split between the Ministry of Public Health (MPH) and the Social Security Institute (IESS) who draft and execute their respective budgets. As one key informant elaborated, *"The Ministry of Economy and Finance assigns a global ceiling… then the Ministry of Health is responsible for organizing resources needed by each province, district, and hospital."* – *KI, Ecuador*. MPH operates through the provincial health directorates and public hospitals, while the IESS has its own health delivery system. MPH is tasked with accountability and performance reporting, while the Comptroller General of the State, along with provincial audit offices, is responsible for oversight.

Mexico's budgeting system is complex and comprises of multiple agencies – the MoF called Secretaría de Hacienda y Crédito Público (SHCP), sets the overall budget, while the MoH and social security agencies like IMSS, ISSSTE and INSABI draft sector specific proposals. SHCP and the Office of Public Administration consolidate and review proposals, which are approved by the Cabinet and enacted by Congress via the annual Presupuesto de Egresos. Budget execution is shared across federal and subnational entities, while the Superior Audit Office of the Federation (ASF) conducts federal audits, while subnational auditing is handled by state-level bodies.

In Peru, the Ministry of Economy and Finance (MEF) determines budget ceilings and evaluates budget proposals. Both the MoH (MINSA) that finances free or subsidized health insurance for the uninsured and EsSalud that provides mandatory social health insurance to

formal sector employees, prepare separate budgets which are reviewed by the MEF, and sent to the Cabinet and Congress for approval and enactment. Like most countries, Comptroller General audits the health budget. While clarifying the role of the different agencies, one key informant from Peru mentioned, *"Congress approves the budget… [but] the negotiation is intense and focused on infrastructure. They don't get involved in technical aspects like medication budgets."* – *KI,* Peru

There are key similarities and differences in the institutional settings for health budgets across these countries highlighted by both the desk review and interviews. Firstly, in nearly all countries, the Ministries of Finance and National Planning or Economy play a dominant role in determining budget ceilings and allocations. These institutions often hold a lot of power and play a critical role in shaping the health budget by setting budget ceilings, evaluating budget proposals and negotiating allocations. In Colombia for instance, key informants said that the shift toward tax-based funding due to high informality strengthened the Ministry of Finance's role. *"As a result of discussions with multilateral banks on labor informality, a significant share of health contributions is replaced by general taxes. That makes national co-financing more important, and it increases the role that the Ministry of Finance plays in budget decision-making."- KI, Colombia.*

Secondly, in each country, the MoH is the key authority responsible for drafting the overall health budget and coordinating across key institutions involved in health delivery.

Thirdly, legislative approval of the finalized budget involving the Congress, National Assembly and the Cabinet is common across all countries. Based on key informants' interviews, the influence of Congress in shaping health-specific allocations in the budget can vary significantly from country to country. In Peru for example, Congress negotiates public works, while the MoH handles technical components of the health budget. On the other hand, in Argentina, Congress has significant influence due to broader political instability, which can shift power dynamics in the budget process.

Fourth, all countries have a key agency in place for budget audit, which is usually the Comptroller General, which is supported by local audit agencies for subnational audits. Key informants noted that most oversight responsibilities are focused on spending execution than outcomes or service delivery impact. As one key informant from Peru noted, *"It's a control of execution, not of results or achievement of objectives."* – *KI, Peru*

While there are some similarities, there are also substantial differences in the institutional settings and roles based on country context. The degree of budget centralization varies greatly, with countries like Chile and Costa Rica, being highly centralized and following unified budget formulation through a financial agency within the MoF; while Brazil, Colombia and Mexico have a highly decentralized system that actively involves subnational and municipal

governments. Decentralized countries also tend to involve multiple agencies in drafting and executing the health budget (Eg. Mexico, Peru, Ecuador), while these functions are more centralized at the MoF in centralized countries. Interviews with key informants also highlighted that many countries operate fragmented systems involving multiple subsystems with different funding rules, governance structures, and legal mandates. This complexity undermines efficiency, coordination, and accountability. Argentina and Mexico face high fragmentation, with overlapping roles across levels of government and diverse health financing mechanisms. Costa Rica, Ecuador, and Peru also illustrate legal and structural division between social security systems and MoH services. The reporting and transparency mechanisms also vary across countries. Some countries have more developed reporting systems with greater frequency of reporting and detailed data reporting, such as SIAFI and SIOPS in Brazil, and SCHP dashboards in Mexico, compared to the other countries. Peru uses a dashboard to publish daily updates on budget execution with a high level of detailed breakdowns.[69] In terms of linkages between planning and budgeting, Argentina, Colombia and Peru utilize the integrated medium term fiscal framework for their health budgets, while other countries follow annual budget cycles with varying linkages to annual and multi-year planning, which is discussed in more detail in the next section. Additionally, key informants also noted that macroeconomic crises, fiscal pressures, and political transitions directly affect how legal budget mandates are enforced or interpreted. For instance, Ecuador has constitutional mandates for health budget increases, but has been relying on loans due to fiscal limitations. In Colombia, economic informality reshaped funding models, increasing the weight of public taxation in health budgets.

Our analysis found that the studied Latin American countries have established formal legislative and institutional frameworks for health budgeting, yet practical implementation is hampered by fragmentation, informality, and weak enforcement mechanisms**.** Ministries of Finance and Planning dominate the process, while Ministries of Health who are in-charge of setting health sector priorities often lack fiscal authority. Legislatures, although responsible for budget approval, typically have limited influence on technical budget content and institutional frameworks, and responsibilities for monitoring of performance-based budgeting remains underdeveloped. A stronger alignment between legal mandates, technical planning, and implementation capacity is essential to improve the impact of health budgets on UHC and health equity.

## 3.3 Health sector planning, prioritization and linkages to budgeting

The health planning and prioritization processes across the studied LACs are carried out through diverse institutional mechanisms—ranging from annual programming to long-term health strategies—with varying degrees of integration into the health budget. Across most countries, annual plans with line item and program budgets are used with priorities based

on previous year's execution and emergent priorities. Countries like Brazil and Mexico used medium term plans such as Brazil's Plano Nacional de Saúde (PNS) and Mexico's Sector Plan to guide health priorities within the budget ceilings.

Table 7 below provides an overview of the different types of health plans that guide health priorities and health budgets across countries.

**Table 7: Key health plans and health sector priorities by country**

| Country | Strategic planning | Strategic priorities in the health sector | National plan vs subnational plans | Budget alignment with plan priorities |
|---|---|---|---|---|
| **Argentina** | **Strategic health planning with decentralized approach** Plan Nacional de Calidad en Salud guides the budget. | Improved access and health equity, comprehensive health approach, improved coordination, information and resource management, improved access to medicines, maternal and child health | National plans with supporting provincial plans under Plan SUMAR | Partial alignment between strategic priorities and funds. Alignment is strongest for result-driven programs like Plan SUMAR which aligns provincial targets and national priorities. Recent budget cuts have led to underfunded priorities |
| **Brazil** | **Medium term planning approach** Plano Nacional de Saúde (PNS) – currently implementing PNS covers 2024-2027 | Expansion of universal health care and specialized care and health services, reduction of health inequities, control of preventable diseases, increased access to medicines, strategic supplies, and pharmaceutical services, scientific and technological development | National strategic plans supported by local health plans under SUS | Partial alignment, with a strong medium-term outlook. Planning and funding strategies make it easy to link budgets to strategic priorities, however, there are regional disparities, implementation and fiscal constraints |
| **Chile** | **Strategic medium and long-term planning approach** Current health strategy 2023-2026 is closely linked to the decennial strategy Estrategia Nacional de Salud para el Cumplimiento de los Objetivos Sanitarios de la Década 2021–2030 | Primary health care strengthening, comprehensive UHC reforms including creation of a universal health fund, health risk management and resilience, improved and timely access to quality medicines, reduce wait times, promotion of health technology | Nationally driven strategic plans with operational plans for health districts and municipalities | Moderate alignment. There are clear strategic goals and funding allocations, however, there is fragmented financing, legal bottlenecks and low budget transparency |

| | | | | |
|---|---|---|---|---|
| | | assessments (HTAs), improved health leadership and oversight | | |
| **Colombia** | **Strategic long-term planning approach** Ten-Year Public Health Plan supported by annual Institutional Action Plan and the National Development Plan | Eradication of preventable diseases and control of NCDs, strengthening health surveillance and risk management, improved access to essential services, improved palliative care | National strategic plans supported by local district health plans | Good alignment of planning and financing, along with legislative support. However, there is underfunding and ongoing legislative efforts by the current administration threatens institutional alignment |
| **Costa Rica** | **Strategic medium- and long-term planning approach** The National Health Plan 2023-2033 is supported by various medium term and annual plans | Access to comprehensive care, health promotion, improved health information management and digital systems, emergencies response, and governance | National health strategies supported by local health plans under the CCSS | Strong alignment of strategic priorities and funding. Resources are tied to strategic priorities through various operational plans and newly introduced strategic purchasing mechanisms |
| **Ecuador** | **Strategic medium-term health planning approach** The Decennial Health Plan (2022-2031) supported by medium-term Health Strategic Plan (2021-2025) and annual operational plans | Reducing health inequalities, digital transformation, health system strengthening, reduce disease prevalence, including malnutrition, child and maternal mortality | National strategic plans supported by local health plans of provincial governments | Good alignment of planning and budgeting with a focus on digital integration. However, there are regional variations due to implementation and resource constraints |
| **Mexico** | **Strategic medium-term planning approach** The sectoral plan, Plan Nacional de Salud 2024–2030 is supported by annual programmatic strategy | Prioritize health promotion and prevention, enhance the quality of health care, strengthen and expand IMSS-Bienestar program to provide services to the uninsured, improve availability of medications, supplies, and equipment, upgrade and integrate the health sector into a unified system | National health plans supported by state and local health plans | Moderate alignment of plan strategies and funding due to severe fiscal constraints, regional variations, structural fragmentation and new reforms |

| | | | | |
|---|---|---|---|---|
| **Peru** | **Medium term planning approach** Ministry of Health's 2025–2030 Strategic Plan is supported by annual operational plans | Improved UHC, prevention and control of communicable diseases and NCDs, primary health care expansion, improved health infrastructure and access in remote areas | National plan supported by regional and local health plans | Partial alignment between strategic priorities and the budget. While there are efforts to integrate performance, monitoring and budget oversight, there is severe fragmentation and underfunding |

Source: Author compilation based on review of various country health plans, strategy documents and published articles

Argentina's strategic health priorities are driven my multi-year national strategies which are supported by provincial plans.[70] The national strategic plan, Plan Nacional de Calidad en Salud outlines some key priorities such as improved access and health equity, comprehensive health approach, improved coordination, information and resource management, improved access to medicines, maternal and child health.[71] The provinces play a key role in annual planning and budgeting, and Plan SUMAR is central to the budgeting process. The pay for results Plan SUMAR model makes it easy to link strategic targets to budgeting. However, this alignment is not as strong for the entire health sector due to fragmented health structures and influence of provincial governments on budget implementation.[72,73] Budget execution data illustrates some of these gaps in budget execution.[74]

Brazil uses a medium-term framework covering a four-year period, and the national health plan, Plano Plurianual (PNS) aligns with the medium-term framework cycle. The 2024-27 PNS focuses on strengthening primary and specialized care, local production of medicines and vaccines, integration across federal units, and health equity.[75,76] Through the FNS, funds for supporting the national health plan are transferred to sub-national governments, creating linkages between budget flows and policy priorities.[26] However, the linkages between priorities and budgets are not always clear due to implementation and fiscal constraints. For instance, the 20-year constitutional fiscal ceiling introduced in 2016 through the Constitutional Amendment 95/2016, has severely constrained funding allocations impacting not only strategic plan priorities, but also the achievement of key global targets like the Sustainable Development Goals.[77,78] Similarly, certain parliamentary amendments can redirect resources away from plan priorities derailing alignment with budgets.[79] While Brazil is still navigating underfunding and budget re-allocation issues, there are ongoing efforts to improve linkages between planning and budgeting through various tools like the strategic map.[80]

In Chile, strategic plans are structured around sectoral priorities communicated through budget notes from DIPRES. The current strategic plan 2023-26 prioritizes UHC, primary health care, health risk management, improved health leadership and reduction of long wait times.[81] Chile is grappling with legal bottlenecks that affects the alignment of plan priorities and financing. While planning frameworks and use of evidence-based planning and financing through use of health technology assessments (HTAs) have aimed to improve decision-making in aligning funds to priorities, the growing surge in civil-society led 'disease laws' are causing inefficiencies and fragmentation. For example, the Cancer Law allows for creation of separate plans for cancer, creation of a Cancer Fund with resources allocated for research and infrastructure of cancer. Several other similar laws have emerged undermining national health planning and prioritization in Chile.[82,83]

Colombia's Ten-Year Public Health Plan outlines key strategic priorities such as the promotion of health, reduction of NCD risk factors, integrated management of NCD care and enhanced surveillance and research systems.[84] The country also uses a medium-term plan, currently Plan Nacional de Desarrollo (2022–2026) to set priorities for the health sector.[85] While Colombia has achieved high levels of UHC and has a relatively high level of public health spending on the region, alignment between priorities and funding is jeopardized by underfunding and inefficiency issues related to macro-fiscal stress and overspending by EPS under its insurance program. For instance, the health insurance premium UPC, which is a significant share of the health budget, was increased by only 5.36% for 2025, which does not keep up with inflation and jeopardizes adequate support for strategic goals.[86] As one key informant said, *"Colombia needs to do something … a more medium-term vision, a medium- and long-term financing vision. Why? Because health decisions are almost always made on an annual basis. We're very constrained by the fiscal situation." – KI, Colombia*

Costa Rica's multi-year planning for health is done through the National Development Plan (2023–2026) and the National Health Plan 2023-2033.[87] Apart from workforce optimization, service coverage expansion and maintaining health spending, key informants mentioned that Costa Rica has 6 key priority areas - vaccine preventable diseases, NCDs and chronic disease management, and high cost-diseases. One key informant mentioned, *"I believe they focus on four main areas: prevention through vaccination; treatment of non-communicable and chronic diseases; and high-cost diseases. Those are the four pillars where they currently have a strategic focus, aiming to optimize budget issues, budget planning, and to improve negotiations in order to expand coverage for more patients."* – *KI, Costa Rica.* Health planning and budgeting are aligned through a performance-based and integrated health system. Budgets are pro-poor, with a need-based allocation system that focuses on primary healthcare provision, and is well-supported by the recently adopted strategic purchasing reforms that tie resource flows to population needs.[46] Annual budgets are linked to performance through

performance agreements (10% performance-linked budgets for hospitals) and through the World Bank supported Program-for-Results (PforR) which ties disbursements with program results.[43,47]

Ecuador has both Health Strategic Plan (2021-2025) and Decennial Health Plan (2022-2031), and current priorities include improved universal and free health care provision, improved primary care provision, and lowering the burden of preventable diseases.[88,33] There are efforts to align budgets with priorities through a focus on institutional plans and digitalization, along with annual operational plans.[89,90]

Mexico's health sector priorities are guided by the sector strategy, Plan Sectorial de Salud 2024–2030, which is integrated into the annual federal budget and annual programmatic strategy. The current priorities of the current are health system extension via IMSS-Bienestar, medication availability, reducing wait times, digital health, rural workforce retention.[91] The country's budget shortfalls, recent health reforms and shift away from Seguro Popular, have created constraints to align funding to health priorities.[92–94]

Peru has a multi-year strategic plan that is supported by operational plans based on inputs from local and regional governments.[95] The current strategic priorities include improving UHC, prevention and control of communicable diseases and NCDs, primary health care expansion, improved health infrastructure and access in remote areas. Although there are efforts to improve operationalization of the strategic plans and also efforts to improve monitoring, alignment between plan priorities and funding is negatively impacted by a largely fragmented health system.[40]

Based on the review of strategic planning and prioritization across the studied countries, expansion of UHC and primary health care, health emergency preparedness, reduction of long wait times, disease prevention and financial and digital health reforms emerge are the key priorities across countries. Although countries have strategic health plans and medium-term frameworks to guide health sector planning and budgeting, key informants have pointed out the weak linkage between planning and budget allocation. While some countries have national health strategies or benefit packages, these plans often lack financial backing or formal linkage to budget formulation. Key informants from Chile and Peru mentioned that national health plans exist but are not binding for the budgeting process. *"The problem is that the National Health Strategy is not guaranteed a dedicated budget."* – *KI, Chile.* In Peru, the National Health Plan is used more as a reference than a planning tool. *"There is a national plan through 2030, but it serves more as a reference point, like a guideline. No one is actually required to budget according to that plan."* – *KI, Peru.* Key informants also talked about the limited use of disease burden and evidence in priority setting.

There is also fragmentation in planning structures, especially in decentralized countries. Key informants mentioned that countries have institutional fragmentation where each subsystem or agency plans in isolation, reducing coordination and coherence in national health budget priorities. Key informants especially discussed Peru, Mexico and Argentina's cases, where parallel agencies develop separate budgets that are not well-aligned at the central level. This fragmentation affects the Ministry of Health's role in influencing allocations. Key informants also talked about the influence of political stakeholders, civil society and patient groups in budgeting and priority setting. Budget priorities are often influenced more by political leadership, interest groups, or institutional lobbying than by public health data or systematic needs assessments. *"Pressures from the government and patient associations shape the budget."* – *KI, Chile. "Who has requested something, and for what purpose? Who's making the most noise? Many times, that's how it works…. I never saw a process that had any clear objective or any sort of criterion for prioritization based on results or actual needs."* – *KI, Ecuador.*

The key informants did highlight country efforts to improve the process of strategic budgeting for health through positive innovations and practices. For example, Colombia uses actuarial modeling and benefit package updates based on health risk. Key informants mentioned "*The most important process in the budgetary definition in Colombia is the actuarial analysis of the risk of the people. That is performed every year. What premium we pay is very important, because the system integrates private and public. – KI, Colombia.* Costa Rica segments medicines by financial impact to improve forecasting. Key informants also highlighted that emerging new therapies and high costs treatments have led to difficulties in formulating the budget. For instance, in Costa Rica, medications are usually divided in to two categories - those on the Official List of Medications and those not on the list. Future needs can be easily forecasted for those in the official list based on historical data, however, the budget for those not on the official medication list leads to uncertainties, especially as this list includes high cost therapies. They quoted, "Products with high financial impact are those that consume more than $600,000 per year…. there is an annual planning process within the Social Security Fund to define that procurement plan. And the second category is NO-LOM medications, which are basically those not included in the official list of medications. And that's where uncertainty comes in, because that's where most of the innovative therapies fall." – *KI, Costa Rica.* Despite advancements like Colombia's actuarial analysis and Costa Rica's medication classification, most countries do not use burden of disease data, cost-effectiveness analysis, or outcome indicators in setting budget priorities. Key informants mentioned that Mexico lacks metrics and cross-disease budget analysis. "*The government does not publish its priorities in health."* – *KI, Mexico.* In Peru, key informants observed that indicators are focused on inputs rather than outcomes; health priorities are often politically driven. *"Indicators used are not adequate. The disease burden is not included."* – KI, Peru.

Overall, planning and priority setting for health budgeting in the studied countries in Latin America remains largely fragmented, disconnected and weakly linked to population health needs. HTAs can play a key role in improving health planning and budgeting by ensuring that public spending is directed toward interventions that offer the greatest value for money. By systematically evaluating the clinical effectiveness, cost-effectiveness, and broader impact of medical technologies—such as drugs, procedures, and equipment—HTAs help governments make informed decisions about which treatments to include in public coverage. Box 2 below summarizes the status of HTAs across the studied LACs. Although in practice, countries use HTAs, their findings are not legally binding and so the impact on health budgeting is weak.[96–99]

**Box 2: Status of health technology assessments (HTAs) and uses in studied countries to improve decision-making and optimize resource allocation in budgeting**

When HTAs are integrated into budgeting processes, they contribute to more efficient, equitable, and evidence-based health systems. HTAs not only prevents the adoption of low-value or unnecessary technologies, but also supports the rational allocation of limited resources, enhances transparency in decision-making, and can reduce long-term healthcare costs. Most of the studied countries use HTAs in the health budgeting system, with varying degrees of success which is summarized in the table below:

| Country | Institution leading HTAs | Where it is used? | Used in planning and budgeting? |
|---|---|---|---|
| **Argentina** | **CONETEC** (National Commission for HTA) under the Ministry of Health | Supports national drug reimbursement decisions; more recently emphasized under universal health coverage reforms. | Yes, but low receives low financial support and human resources for assessments [97,100–102] |
| **Brazil** | **CONITEC** (National Committee for Health Technology Incorporation) | Mandatory for technology incorporation into the Unified Health System (SUS). | Yes. Advanced HTA use with legal provisions[102–104] |
| **Chile** | **Department of Health Technology Assessment and Evidence-Based Health** | Supports prioritization of interventions under the Ricarto Soto law; Proposals to expand to universal health benefits plan | Yes. Moderate HTA use but growing policy integration[83,98,105] |
| **Colombia** | **IETS** (Institute of Health Technology Assessment) | Informs design of benefits package and coverage under the PBS (Health Benefits Plan) | Yes, IETS has strong technical capacity, but HTAs are not mandatory or systematic[99,106,107] |
| **Costa Rica** | **HTA Commission** at CCSS | Some use of HTA in technology acquisition and formulary decisions | Yes, but inconsistent use and low policy integration[99,108] |

| | | | |
|---|---|---|---|
| **Ecuador** | **HTA Unit** within the Ministry of Public Health | Influences some policy decisions, especially related to public procurement and financing of essential medicines and medical devices | Yes, but HTAs are in nascent stages, with low policy integration[109,110] |
| **Mexico** | **CENETEC (National Center for Health Technology Excellence)** | Informs procurement and basic health sector decisions under IMSS Bienestar | Yes, but not mandatory, considered as recommendations[99,111] |
| **Peru** | **Instituto de Evaluación de Tecnología en Salud e Investigación (IETSI); Instituto Nacional de Salud (INS)** under the Ministry of Health | Growing influence on coverage decisions and clinical practice guidelines | Yes, but HTA use is mostly informative and underfunded with low policy integration[40,112] |

Source: Author compilation from different reports

## 3.4 Budget practices

Health budgeting practices play a pivotal role in shaping the efficiency, equity, and effectiveness of health systems, particularly in resource-constrained settings like those in Latin America. According to WHO, robust budgeting practices—those that align spending with policy priorities, performance indicators, and service delivery targets—are essential to achieving UHC. Transparent and performance-oriented health budgets contribute to better fiscal discipline, reduce inefficiencies, and help ensure that public health expenditures respond to the actual needs of the population.[113,114] With respect to the health sector, the WHO has highlighted four key types of budget classifications: economic, administrative, functional, and programme budgets, with each serving key functions in improving the public financing of health (Table 8). While economic budgets focus on input control, administrative budgets focus on accountability, functional budgets on international comparability and policy relevance, and programme budgets on strategic outcomes and results. When used together, they strengthen transparency, planning, and effectiveness in health budgeting.[17]

Our focus countries use a mixed approach to health budgeting using economic, i.e. line-item, administrative, functional, and programmatic budget classifications in health planning (Table 8). However, the exact structure and emphasis vary across countries. The use of historic line-item budgets is most common across all the countries, where the annual budgets are increased every year, based on previous year's budget. Most times this approach reflects a lack of linkage between planning and budgeting in the health sector. The functional classification of budgets is seen most commonly in Brazil where funding is allocated based on six key functional areas: primary care; medium- and high-complexity outpatient and

inpatient care; health surveillance; pharmaceutical assistance; SUS management; and health service network investment.[115,116] Brazil's SUS also has some features of a functional budget through the National Health Fund to ensure accountable and decentralized fiscal flows between the federal, state and municipal governments. Programme budgeting that helps to track expenditures under major health programs is used across various countries – e.g. Argentina's Plan Nacer/Programa Sumar (Box 3)[117,118], Brazil's Programa Saúde da Família for primary-care delivery[119,120], Mexico's IMSS-Bienestar[37,121], Chile's universal primary healthcare reforms funded by the World Bank.[122]

**Table 8: Budget classifications and applications in the health sector**

| Budget type | Features | Benefits | Country implementation examples |
|---|---|---|---|
| **Economic classification** | Organizes expenditures by the type of economic transaction, such as salaries, goods, and services. Follows international standards like the *Government Finance Statistics Manual (GFSM) 2001* | Facilitates control over inputs and costs<br><br>Enables consistency and comparability in financial reporting across sectors and countries<br><br>Useful for monitoring resource allocation by input categories, though less effective for tracking outputs or outcomes | Used across all the focus countries in the form of line item budgets |
| **Administrative classification** | Breaks down the budget by the institutions or entities (e.g., ministries, departments, hospitals) responsible for implementing and managing funds | Clarifies accountability by identifying who controls and spends public funds<br><br>Helps in decentralization efforts and resource tracking at subnational levels<br><br>Enables alignment with organizational structures and facilitates internal audits | Brazil's SUS |
| **Functional classification** | Categorizes spending by the purpose or function, such as health or education, and further into sub-functions like outpatient services or public health | Allows comparison across countries using internationally defined categories<br><br>Supports planning and evaluation by showing how funds are allocated to different health services<br><br>Facilitates policy analysis, including efficiency and equity assessments | Brazil |

| | | | |
|---|---|---|---|
| **Programme classification** | Groups expenditures according to specific policy objectives or outputs (e.g., maternal health, immunization). Can include activity-based classifications | Links budgets to results and policy goals<br><br>Encourages performance-based budgeting and strategic planning<br><br>Offers flexibility and country-specific tailoring to address national health priorities | Argentina's Plan Nacer/Programa Sumar, Brazil's Programa Saúde da Família, Mexico's IMSS Bienestar |

Source: Adapted from Barroy H, Dale E, Sparkes S, Kutzin J: Budget matters for universal health coverage: key formulation and classification issues. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.

Health budgeting reforms in the studied Latin American countries have been instrumental in promoting accountability and decentralization, especially when functional and administrative classifications are well-integrated.[123] Countries like Brazil, Chile and Mexico, that have implemented programmatic and results-based budgeting have been able to improve linkages between health spending, improved service coverage and health outcomes, resulting in reduced maternal and child mortality and expanded access to primary care (Table 9). For instance, Brazil's decentralized financing through the SUS, supported by earmarked transfers and programmatic allocations, has enabled targeted investment in primary care and preventive services. Similarly, Colombia's results-based budgeting for subsidized insurance schemes has helped improve health service access for lower-income populations. While challenges remain—such as fragmentation, inefficiencies in subnational allocations, and limited fiscal space—countries with more coherent and transparent health budgeting practices have generally experienced better health system performance and progress toward UHC goals. Continued institutional strengthening, better expenditure tracking, and alignment with national health strategies are therefore crucial for sustaining and improving health outcomes in the region.

**Table 9: Successful results-based financing and budgeting approaches adopted by countries**

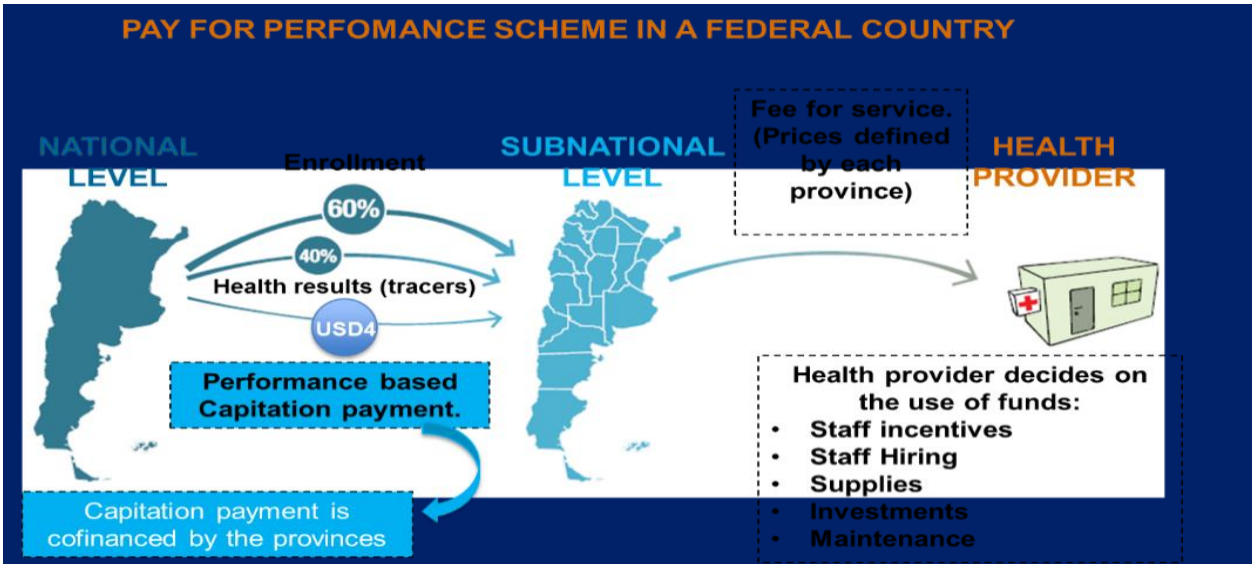
| | |
|---|---|
| **Argentina** | Successful performance-based financing through Plan Nacer/Sumar where funds are allocated to provinces based on enrollment and achievement of health indicators |
| **Brazil** | Constitutionally mandated minimum spending levels for health at federal (15% of net current revenue), state (12% of total revenue), and municipal (15% of total revenue) levels. |
| **Chile** | Program for results (PfoR) approach for universal primary healthcare (PHC) reforms funded by the World Bank whereby a per-capita payment per service model will be used to pay providers based on the cost of delivery of the PHC benefit package |
| **Colombia** | Capitation payments where government allocates funds to EPS based on a per capita payment (UPC) to cover a defined benefits package. |

| | |
|---|---|
| **Costa Rica** | Use of program for results through prospective budgeting and capitation models to align resources with health outcomes. Additionally, strategic purchasing introduced in 2024 to move away from historical budget towards a capitation model |
| **Ecuador** | Budgeting process includes multi-year planning and programmatic budgeting. |
| **Mexico** | Programmatic budgeting: funds allocated based on specific programs and objectives |
| **Peru** | Results-based budgeting implemented since 2008 across several key health programs |

**Box 3: Results-based budgeting under Argentina's Plan SUMAR**

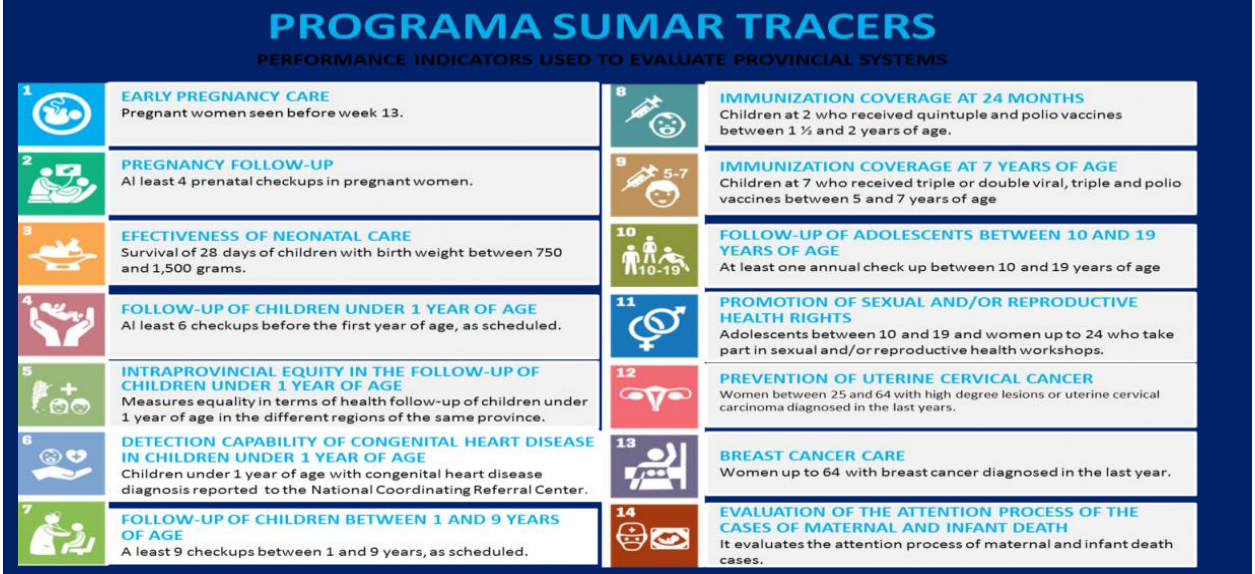
Argentina was the first low-or middle-income country to use incentives to simultaneously expand health coverage and improve birth outcomes through a results-based financing (RBF) program called Plan Nacer. Plan Nacer, now known as Plan SUMAR, was introduced in 2004 through funding support from the World Bank to improve maternal and child health outcomes in the country. Under this program, funds are transferred to provinces and municipalities via capitation payments based on: 1) the enrollment of eligible population who effectively received a preventive service in the last 12 months; and, 2) provincial performance on health output indicators (such as prenatal care, vaccine coverage, healthy child and adolescent visits, adequate care for patients with diabetes and hypertension and cancer prevention)[124]. The program is still active and is used as a mechanism to provide a supplemental health budget to provinces using a performance-based transfer mechanism. It is considered a good example of reformed performance monitoring of health within a regular PFM system. Under this program, 60% of the budget is allocated from the centre to the provinces based on the number of people enrolled to the program. Provinces must co-finance 15% of the transfers from the center. Annually, this co-financing amounts to less than 1% of provincial health budgets. The centre allocates a fixed amount per person for the enrollees while the remaining 40% is based on the performance of certain maternal and child health care tracer indicators [117,125].

**Figure: RBF in the intergovernmental financing mechanisms of Programa Sumar**




As of 2024, Plan Sumar covers more than 700 health services organized in 50 care pathways within its benefit package. The program has led to significant health improvements, including a 9% reduction in low birth weight among clinic users and a 23% reduction among beneficiaries. Additionally, there was a 22% decrease in in-hospital neonatal deaths for clinic users and a 74% reduction for beneficiaries [118].

**Figure: Performance indicators used in Plan Sumar**



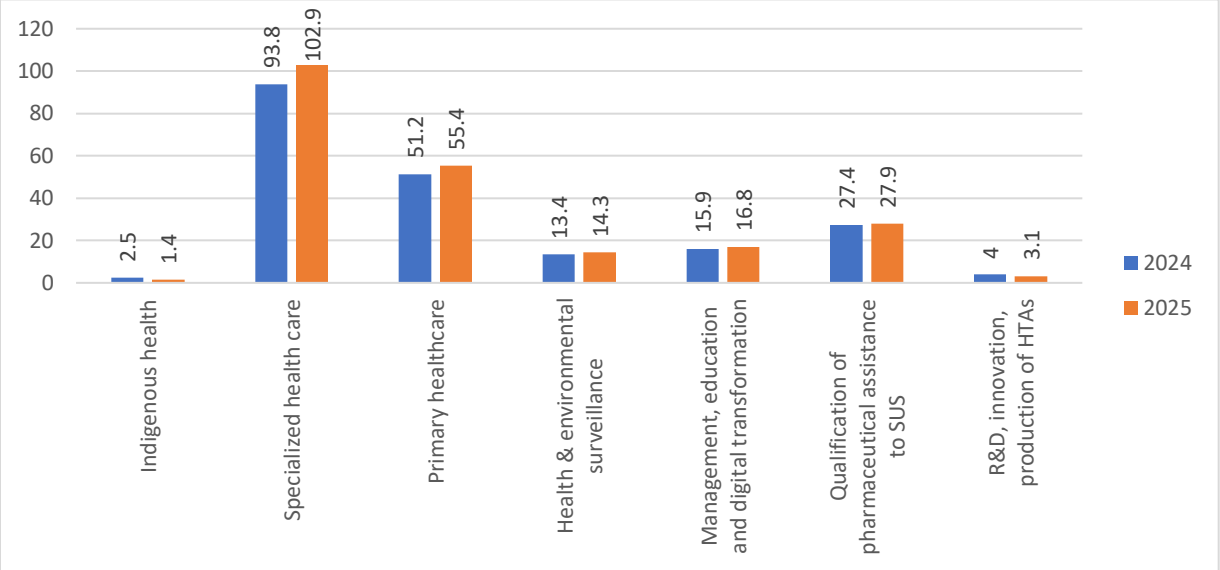

Figures source: Extracted from https://www.improvingphc.org/argentina-purchasing-payment-systems-0

## 3.5 Budget allocations and priorities

When it comes to health budget allocations, the prioritization of health programs and sub-sectors within health budgets in the studied countries in Latin America varies significantly by country, reflecting different health system structures, policy goals, and population needs.

In Argentina, the largest share of the health budget is allocated to transfers, with communicable diseases and vaccine-preventable programs ranking second (117 billion ARS). While programs addressing HIV, hepatitis, TB, and leprosy receive moderate funding (21 billion ARS), non-communicable NCDs rank low in priority, with only 7 billion ARS allocated.[126] Brazil, on the other hand, directs nearly half its health budget to primary and specialized care, particularly to hospital, ambulatory, and primary services, followed by support and administrative functions. It also maintains a significant commitment to health research and innovation, investing around 4 billion BRL annually (Figure 6).[127]

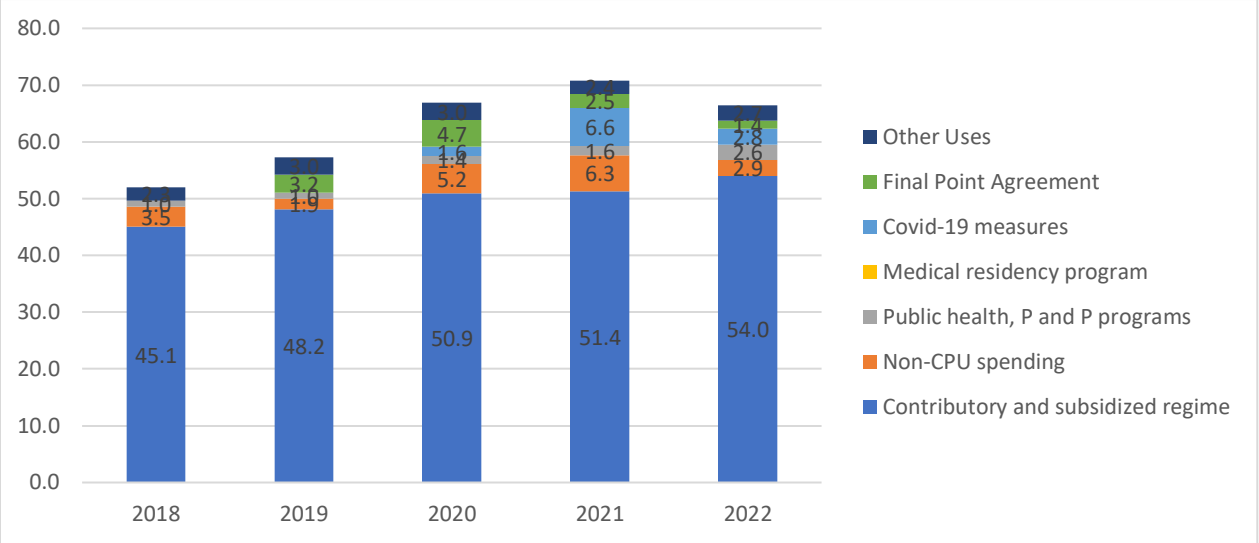
**Figure 6: Brazil's budget allocations in 2024 vs 2025 (in R$, billions)**




Source: Kroll R. Orçamento da saúde: com R$246 bilhões, financiamento do SUS cresce 6,2%. Futuro da Saúde. https://futurodasaude.com.br/orcamento-da-saude/

Chile emphasizes universal access to primary care, with a projected 47 billion CLP allocated in 2025, supported by ongoing UHC and primary healthcare reforms.[128] Colombia's capitation-based payments to insurers (UPC) under a defined benefits package takes up the largest share of the budget, indicating a focus on insurance-based service provision (Figure 7).[129–131]

**Figure 7: Colombia's health budget allocations over the years**



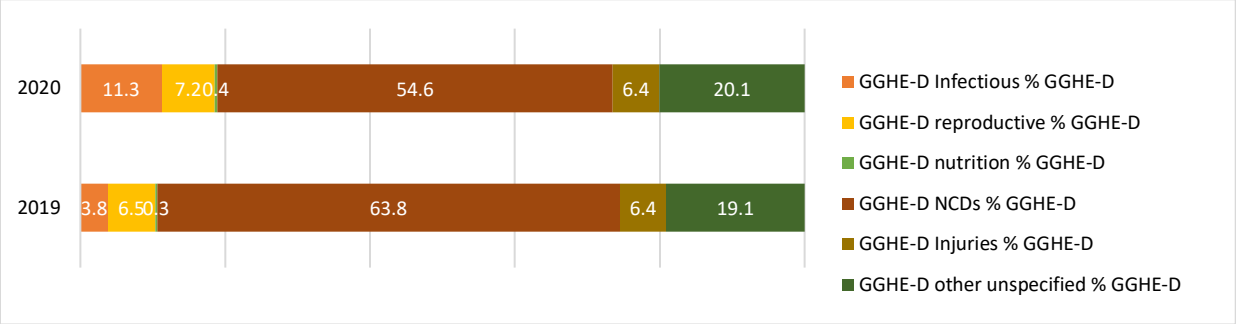

Source: Adapted from Aspectos financieros y fiscales del sistema de salud en Colombia [Internet]. Banrep.gov.co. Banco de la República; 2023. Available from: https://repositorio.banrep.gov.co/items/5319ce1f-f2f3-470e-ac8e-5090d387b7bf

Additionally, Colombia's Maximum Budgets mechanism introduced in 2020 is a funding system that is integrated in the annual health budget by an explicit budget line. It is complimentary to the UPC and is used to improve coverage to high cost drugs, technologies and services outside the UPC. This system was introduced to avoid retrospective reimbursement issues with the EPS which are unpredictable and not transparent, and create a more predictable funding mechanism.[31,32] Costa Rica's budget shows heavy emphasis on service delivery through CEN-CINAI and non-allocable expenditures, which together make up over 75% of its health budget for 2025.[132] In Mexico, despite a 25% increase in funding for IMSS-Bienestar (serving those without social security), the overall health budget has been cut by 11% in 2025. Allocations for programs supporting informal workers have declined, and administrative expenses remain high, at nearly 10% of the budget. NCD funding has also seen a marginal decrease.[133] Peru has prioritized early childhood development and maternal/neonatal health, allocating 2.6 billion PEN each in 2025. Cancer control ranks next, while NCDs are much lower, at only 802 million PEN, reflecting a focus on maternal and child health over chronic disease management.[134]

Although NCDs contribute excessively to the disease and mortality burden across the studied countries, domestic spending on NCDs is not well-documented. For instance, in the WHO Global Health Expenditure Database (GHED) that captures spending by disease categories, disease spending from domestic resources data was only available for Costa Rica.

NCDs account for more than 80% of total deaths in Costa Rica, with heart diseases, chronic kidney disease, and stroke being the main causes of deaths.[135] Based on the GHED data, Costa Rica's domestic spending on NCDs is 55% of total domestic spending by disease categories (Figure 8).

**Figure 8: Costa Rica's domestic general government health expenditures by disease categories**



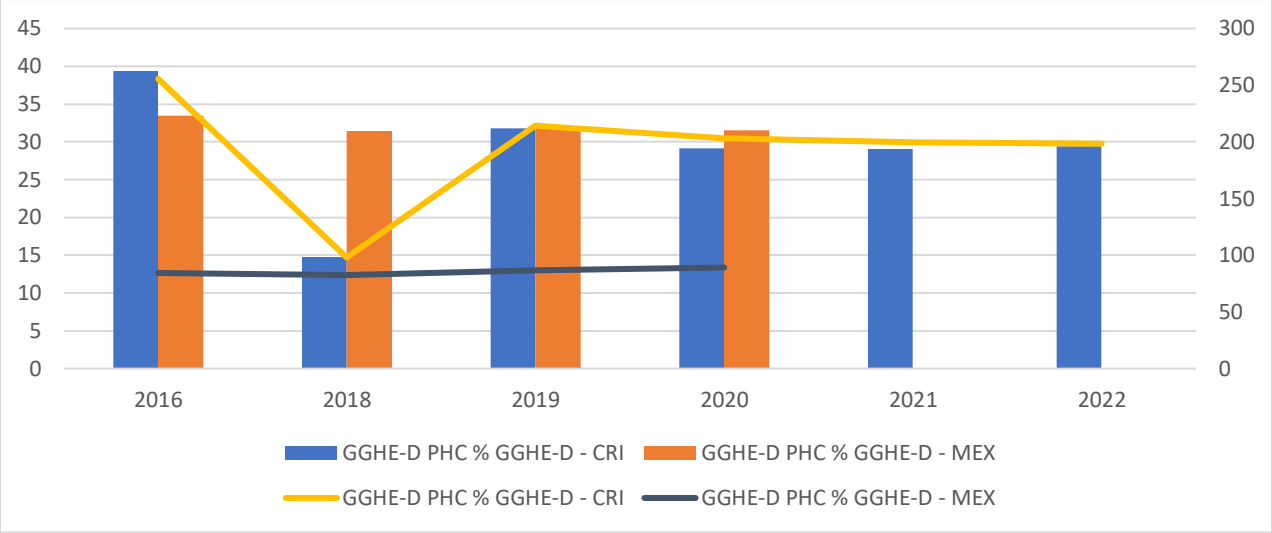

Source: WHO GHED

Based on available data on domestic government primary health care spending data from the WHO GHED database, both Mexico and Costa Rica spend around 30% of its domestic government spending on primary health care (GGHE-D PHC % GGHE-D), meeting the WHO recommended guideline to allocate 30% of government expenditures on health to primary healthcare (Figure 9). Per capita domestic government spending on PHC in Costa Rica (US$ 203 in 2021) is more than double of what is spent by Mexico (US$ 89 in 2021), although data for recent years is not available for comparison.[15] Brazil's budget allocations in recent years also points towards a prioritization of primary health care which has received the second largest allocation after the SUS in 2024 and 2025 (Figure 7).[136]

Costa Rica's focus on a strong primary health system is one of the key success factors for its health progress. Costa Rica's Equipos Básicos de Atención Integral de Salud (EBAIS) model, launched in 1995, marked a pivotal shift in the country's primary health care delivery. Implemented by the CCSS, the EBAIS model provide almost 80% of all health care services in the country through one budget driven by a set of goals and priorities. The CCSS is the sole public health care provider in the country, which helped to integrate both preventative and curative services under the EBAIS model.[137,138] Multidisciplinary teams—comprising physicians, nurses, technical aides, medical clerks, and sometimes pharmacists—are assigned to serve geographically empaneled communities, with approximately 4,000 people per team. Supported by strong political will and funding from the World Bank, IDB, and PAHO, EBAIS clinics prioritized prevention, health promotion, monitoring, and accountability via data-driven performance feedback.[139,45] This community-centric, proactive approach rapidly expanded access—coverage rose from 25% pre-reform to over 93% by 2017—and significantly improved health indicators, including a notable reduction in communicable

disease incidence and long-term reductions in adult and infant mortality. The model's success extended beyond health outcomes; it also generated positive socio-economic impacts. A 2021 study found that increased primary care access through EBAIS clinics was associated with an approximate 4% increase in household income**,** suggesting that healthier populations were better able to pursue economic opportunities.[45,138,140] Robust investments in workforce training, use of existing infrastructure, and community engagement ensured sustainability and equity, especially in underserved rural areas. Today, Costa Rica's experience is highlighted by WHO and PAHO as a model for integrated, people-centered primary healthcare—a system that delivers broad population coverage, reduces health inequalities, and supports long-term economic development.

**Figure 9: Costa Rica and Mexico's domestic general government health expenditures on primary healthcare**




Source: WHO GHED

These budget trends illustrate the variation in sectoral priorities: while countries like Brazil, Chile, and Peru invest significantly in primary care and maternal-child health, others like Mexico and Argentina show mixed commitment to NCDs and informal sector coverage, and Colombia emphasizes insurance mechanisms over direct service delivery.[131]

Interviews with key informants highlighted some key features and also underlying issues with health budget allocation systems across the countries. Interviews highlighted the mixed resource allocation mechanisms used across the countries, ranging from centralized to decentralized allocations, and the use of capitation, earmarked transfers and direct subsidies. Chile uses per capita transfers for primary care to municipalities, but funding is widely viewed as insufficient. The country uses specialized programs like GES for allocations to priority conditions, and Ricarte Soto for high-cost conditions. Colombia has a flexible

public health budget in addition to the main benefits package, allowing regions to address their own public health priorities. Despite Colombia's universal right to health and budgetary provisions, there are large budget deficits and growing financial strains on the health sector. Resources to both the UPC and Maximum Budgets is insufficient, with growing demands for high cost drugs. There is increasing debt to the tune of COP 4.3 trillion as of 2024 due to delayed reimbursements to providers, with average reimbursement time increasing from 125 days in 2023 to 154 days as of early 2025. This threatens the financial sustainability of key health programs in Colombia.[141] In Peru, health budgets are split between regional and central governments, which create inefficiencies and coordination problems. Key informants pointed out that health allocations have also been impacted by chronic underfunding in some countries and broader macro-fiscal environments. Additionally, rigid budget ceilings further limit flexibility in regional budget allocations and execution. The tight ceilings or inflexible line items used by some countries restricts the ability to adapt to changing health demands or emergencies. In Peru, budget rigidity prevents adaptation and undermines service delivery. As one key informant noted, *"budget allocation is absolutely biased, completely rigid, if you will, due to the fiscal target."- KI, Peru.* Similarly, fiscal austerity policies in Mexico have led to reduced flexibility and funding, especially for populations without social security. In Chile, weak macro-fiscal conditions and falling tax revenues have led to stagnation of budgets allocated to hospitals. Hospitals are running budget deficits and have to negotiate mid-year additions to meet the rising health care costs. This has in-turn resulted in informal practices like delayed provider payments or prioritization of procedures that bring in additional revenue. One key informant noted, *"The resources for hospitals, specifically for surgeries and general hospital operations, typically start at about 70% of what was actually executed the previous year. Hospitals begin the year with that partial funding, and the Ministry of Finance is aware of this. For example, if a hospital spent 100 million dollars last year, it might begin the new year with only 70 million. This leads to an issue, every year there's a conflict or negotiation with the Ministry of Finance to secure the additional 20% needed to reach previous levels… the spending pressure that the hospitals have during the year in terms of there not being enough resources to do the job…So you call the provider, you call a company, and you say, Well, I can't pay you right now, but maybe in 6 months I will pay you. So let's make this deal, informally" – KI, Chile.*

Overall, health budget practices and allocations in the studied countries reflect a mix of technical, political, and fiscal dynamics. Some systems offer flexibility for regional adaptation (e.g., Colombia), while others suffer from rigid and fragmented funding models (e.g., Peru, Mexico). There are common challenges include underfunding, urban–rural inequalities, and ad hoc allocation methods that prioritize negotiation strengths over needs. Reforming these practices will require not just more funding, but improved planning, flexibility, and transparency in budget execution.

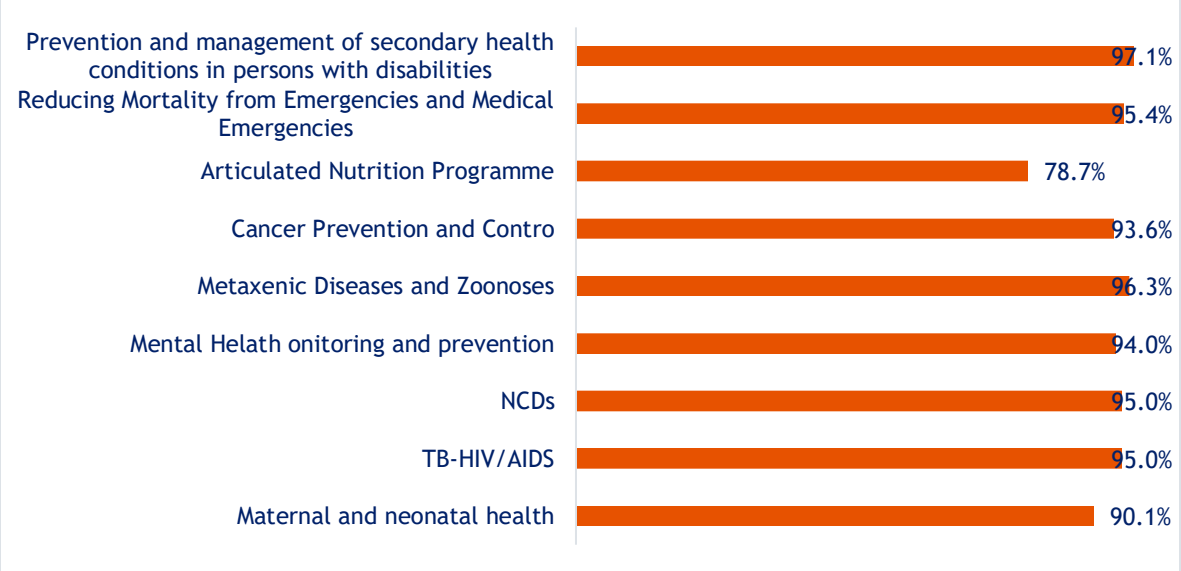
## 3.6 Budget implementation

Health budget implementation refers to the process through which allocated public funds for health are disbursed, managed, and spent to deliver services and achieve policy goals. In Latin America, the effectiveness of this process varies widely across countries due to differences in institutional capacity, fiscal discipline, and PFM systems. While many countries have made progress in linking budget execution to health outcomes through performance-based approaches and digital tracking systems, challenges such as procurement delays, under-execution of funds, and fragmented governance continue to hinder the alignment between spending and service delivery. This section examines how health budgets have been implemented in Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, Mexico, and Peru, drawing from academic literature and government reports to assess how effectively public funds have supported national health policy goals.

Argentina's federal health budget has recently experienced significant shifts. Under the 2024 austerity measures led by President Milei, federal health spending was cut by nearly 48% in real terms, affecting programs like cancer treatment, immunization, and infectious disease control—triggering drug shortages and staff layoffs in public hospitals. These reductions have seriously disrupted implementation, causing reversed health gains and overwhelming service delivery. Brazil's SUS boasts robust PFM systems, but challenges linger in translating budget into outcomes. The unified health account system allows allocation by function and subnational execution, but granular linking of funds to health programs remains limited. While budget reliability is high, procurement delays and variation across states can undermine targeted public health interventions, requiring improved monitoring by the Ministry of Health. Chile has successfully implemented major reforms like the AUGE/GES guarantee system, which ensures financing and access for 80+ priority health conditions. This policy relies on well-executed health budgets and strong fiscal discipline under DIPRES. Budgets are efficiently transferred to regional and municipal levels, supporting delivery of guaranteed services, though performance-based budgeting remains evolving. Colombia's health expenditures are primarily executed via the contributory and subsidized systems under ADRES, covering around 50 million people. Most of the general budget (57%) provides vital funding for monthly capitation payments to insurers and extensive health technologies. Outcomes suggest effective coverage—OOP expenses stayed low during COVID. However, misalignment persists where procurement lags and oversight issues occasionally emerge. Costa Rica leveraged a World Bank PforR instrument (2016–2022) to implement health system reforms, including primary care network integration, digital health record rollout (EDUS), and strategic resource allocation. Performance-based disbursement drove improvements: major outpatient surgeries rose substantially, waitlists fell, and quality data systems enhanced accountability—signifying a high-performing budget implementation

aligned with policy goals. Ecuador's health system suffered from underinvestment before and during the COVID-19 pandemic when austerity led to layoffs and infrastructure decline—particularly in Guayaquil—impairing emergency response capacity. While health in all policies and HiAP principles have been institutionalized, affirmative budgetary follow-through remains uneven, undermining alignment between allocations and health sector goals. Mexico has established an advanced performance-informed budgeting framework: over 5,000 performance indicators—including hundreds for health—are embedded in annual and quarterly reports via SHCP and CONEVAL. Despite these systems, budgetary pressures for fiscal consolidation risk constraining health funding, potentially diluting gains from performance tracking. A strong health policy focus is needed to sustain goals under broader fiscal reforms. Peru has moved toward results-based budgeting in health since 2007, achieving improvements in child nutrition and maternal health, along with improved levels of budget execution and transparency across key disease programs. The results-based budgeting, Presupuestos por Resultados (PpR) covered almost 40% of the total health budget in 2024. The PrR has helped to track performance and outcome indicators. However, the line-item rigid structure still predominates, limiting flexibility and performance integration. Moreover, complex budgetary regulations, and planning and management issues at the regional levels have led to lower levels of budget execution. Between 2000–2020, overall health budget execution averaged 88% (Figure 10), with municipal execution as low as 66%, contributing to delays in infrastructure, staffing, and pandemic response.[40]

**Figure 10: Execution of results-based budgeting, PpR in Peru**




Source: OECD Reviews of Health Systems: Peru 2025
https://www.oecd.org/content/dam/oecd/en/publications/reports/2025/04/oecd-reviews-of-health-systems-peru-2025_3f7c00aa/f3ddb6a4-en.pdf

Beyond, budget execution and expenditure reports, Public Expenditure and Financial Accountability (PEFA) assessments are very useful in revealing key patterns in how public financial management (PFM) systems affect health budget implementation. PEFA is a PFM assessment framework established in 2001 by international donors like the World Bank and IMF with an objective to improve PFM systems to enhance transparency, accountability, and service delivery. It evaluates the PFM system under 7 key pillars – (i) budget reliability, (ii) transparency of public finances, (iii) management of assets &liabilities, (iv) policy-based fiscal strategy, (v) predictability &control in budget execution, (vi) accounting &reporting, and (vii) external scrutiny and audit.[142] Figure 11 below provides an overview of the PEFA framework and the scoring system.

**Figure 11: Overview of the PEFA framework**


Source: Author compilation from Public Expenditure and Financial Accountability website https://www.pefa.org/

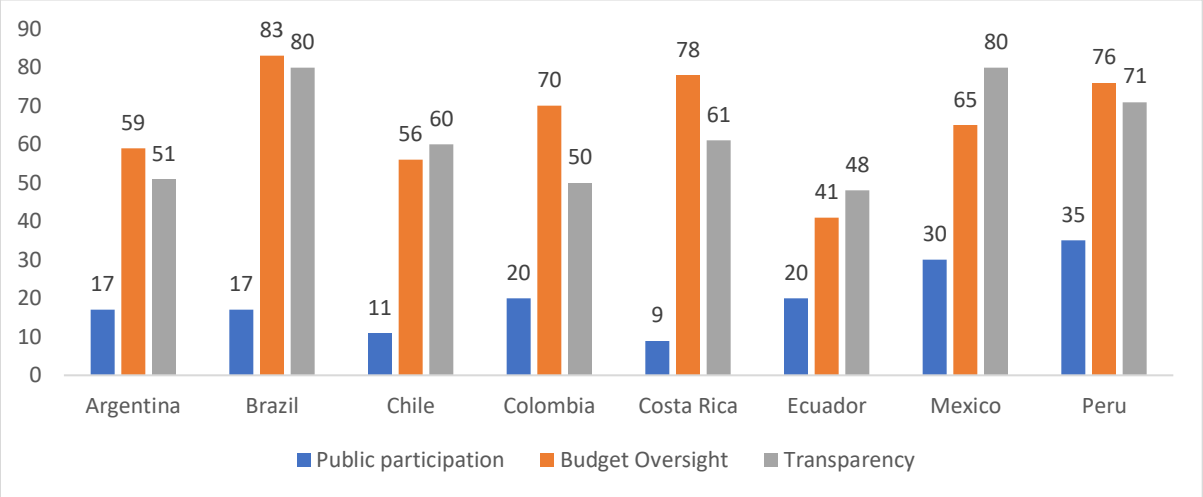
Although most PEFA assessments are national and not sector-specific, their findings have direct implications for health sector performance. The PEFA developed a self-guided Public Financial Management Performance (PFMP-SA) for the Health Sector in collaboration with USAID, but information on the adoption of this tool is unclear especially after the dismantling of USAID.[143] PEFA assessments have been conducted and are publicly available in some of the studied countries - Argentina, Colombia, Costa Rica, Mexico, Peru (reviews conducted for 9 subnational regions in Peru). Ecuador's PEFA reports are not publicly available.

Based on the publicly available and recent PEFA assessments, Argentina, Colombia and Costa Rica show relative strengths in budget reliability and treasury systems, which contribute to stable health financing and more predictable resource flows. Argentina's 2019 national PEFA

assessment found high budget reliability based on strong alignment between approved and executed budgets leading to dependable funding flows for health services, and strong systems for treasury and cash management help ensure timely release of health funds. However, there were key weaknesses such as weak coordination with the decentralized public health system hindering unified performance tracking and accountability, weak performance-informed budgeting that limits the ability to link health funding to service delivery outcome, and prevalence of accounting transparency and external scrutiny that are below international best practices, weakening external oversight of health expenditure credibility and weak provincial health audits.[144] Colombia scored high in budget reliability and medium term planning, which are key for stable, predictable financing and health policy continuity. Additionally, an assessment of the COVID response reveals PFM flexibilities that allows swift reallocations to health during emergencies. However, the assessments show weaknesses in performance budgeting of tying outcomes to health allocations, transparency issues in procurement, and weak external audit capacity to scrutinize health spending. Additionally, delays in accreditation of health insurers and fragmentation across insurance schemes have limited the efficiency of health spending and affected implementation.[145,146] Costa Rica has reliable budgets and transparency at both the national and subnational levels. Costa Rica's stable treasury and subnational budgeting systems support its strong primary care delivery model, but more efforts are needed to link health allocations to community-level service quality and performance.[147] Peru's subnational PEFA reviews found clear and logically structured economic and functional budget classifications, transparent allocation of resources - including for health, and high predictability of intergovernmental transfers. Evaluations show good predictability in recurring transfers. Despite these, procurement issues, limited transparency and audit follow-up, and variations in subnational capacity were pointed out by the reviews.[148]

Apart from PEFA, the International Budget Partnership conducts an Open Budget Survey to assess transparency, public participation and oversight across government budget practices in countries. Figure 12 shows the country scores, out of 100, across the three domains for the year 2023. A score above 61 is considered adequate, while any score below 40 is considered weak. While Chile, Ecuador and Argentina have lower than adequate scores in budget oversight, transparency scores are also lower than adequate score well in these countries, along with Colombia. The local participation scores are quite weak with each country scoring below 40 highlighting the need for more meaningful engagements of the public in budgeting processes.[149]

**Figure 12: Comparison of country scores from the Open Budget Survey, 2023**




Source: Open Budget Survey rankings 2023 https://internationalbudget.org/wp-content/uploads/rankings-charts-OBS-2023.pdf

Key informants also discussed several issues that impact budget implementation and transparency in the respective countries. Informants from each country talked about the geographic and institutional inequities in budget allocation. Despite equal benefits packages used by some countries, budget allocation often reinforces inequalities, especially between urban and rural areas. In Colombia, key informant highlighted regional disparities in infrastructure and technical capacity as key drivers of health inequities, despite universal insurance coverage. *"we have problems in the utilization in the public health portion. Incredibly, it's 5%. But some of it goes to localities, to small towns. The mayors of small towns have an amount of this money. And if you think, maybe we have in Colombia 1,100 different municipalities. Some of them don't use the money. "* – *KI, Colombia.* Similarly, in Mexico, key informant noted that budget execution is significantly lower than the initial budget and this gap is increasing. Key informants from Peru noted that budget execution is in the hangs of the Ministry of Finance, and there is flexibility to move budget from different programs or even sectors that are executing less to areas that need more budget. While on one hand, budget execution is usually low for categories like procurement, infrastructure, equipment and medications, key informants noted that the budget is inadequate to meet the health needs of the population.

Overall, implementation of health budgets in the studied countries in the LAC region varies greatly. Implementation of health budgets across Latin America varies widely. Examples of successful budget execution include Costa Rica's PforR-driven, performance-linked health reforms. While Chile and Mexico have robust frameworks, links between spending and outcomes are missing. Colombia's strong capitation model ensures coverage, yet occasional oversight and procurement lags point to areas needing improvement. In countries like

Argentina, Ecuador and Peru, broader systemic and macro-economic issues have also impacted budget implementation in the region, such as political shifts, austerity measures, and structural rigidity can degrade implementation and derail health objectives.

## KEY CHALLENGES AND LESSONS

### Challenges

As noted across the previous sections of the report, health budgeting in Latin America faces persistent challenges that hinder the efficiency, equity, and sustainability of health systems across the region. Countries such as Argentina, Colombia, and Ecuador struggle with fragmented financing, lack of coordination across levels of government, and limited fiscal space, which constrain their ability to deliver comprehensive services. Judicialization—where patients resort to legal action to access treatments—adds unpredictability and financial strain, particularly in Colombia and Ecuador. In many cases, rigid budget structures and weak monitoring mechanisms impede the ability to adapt to changing health needs or ensure results-oriented spending. These challenges are compounded by economic volatility and political shifts, which often disrupt long-term planning and compromise the continuity of health investments. Below we list some of the key challenges in health budgeting that emerged from this study.

**Unfavorable financing environment**

- **Committed but underfunded UHC:** Most of the studied Latin American countries have made strong commitments to UHC, but chronic underfunding undermines progress. Despite the WHO's recommendation to allocate at least 6% of GDP to health, Argentina, Mexico, Peru, and Ecuador spend far less, leaving their public systems unprepared to meet the changing and rising healthcare needs. Mexico and Peru, in particular, have some of the lowest levels of public spending in the region, resulting in heavy reliance on out-of-pocket payments. Chile also struggles with high household spending due to inequities between its well-resourced private system and underfunded public sector. Argentina's economic instability and inflation erode the real value of budgets, while Ecuador faces fiscal volatility linked to oil revenues. These financial constraints translate into shortages, inefficiencies, and inequities in access, especially for poor and informal workers. Even stronger systems face pressures. Brazil's constitutionally mandated SUS has advanced UHC, but federal spending caps and coordination challenges across levels of government strain resources. Colombia's insurance-based model suffers financial deficits as costs outpace per-capita transfers, threatening sustainability. Costa Rica stands out for its CCSS, which delivers relatively equitable access, but it too faces rising costs from aging populations and noncommunicable diseases. Across the region,

underfunding, fragmentation, and reliance on out-of-pocket spending continue to undermine financial protection and equity, leaving UHC goals only partially realized.

- **Chronic fiscal constraints:** The macro-fiscal environment—marked by economic volatility, inflationary pressures, and rigid public financial management laws—further constrains governments' ability to allocate and execute health budgets effectively. This underfunding translates into service shortages, inefficiencies, and persistent inequities in access, while also increasing reliance on out-of-pocket payments, which disproportionately affect poorer households. Argentina's economic instability and high inflation erode the real value of health budgets, limiting the capacity of public hospitals and primary care services. In Brazil, despite the constitutional guarantee of the SUS, federal health funding has stagnated under fiscal expenditure caps, pushing patients toward higher out-of-pocket expenditures and straining coordination across federal, state, and municipal levels.
  Colombia's subsidized health insurance scheme suffers from chronic underfunding, with financial deficits in health insurers (EPS) driven by underestimated per capita payments and rising care costs.
  In Mexico, low public health spending and fragmentation of coverage have left the system highly reliant on out-of-pocket spending, particularly affecting informal workers and the uninsured. Peru, with one of the lowest public health spending in the region, faces structural underfunding that undermines service delivery, with households shouldering a significant share of costs directly. Across these countries, rigid fiscal rules, chronic underinvestment, and fragmented financing structures limit the ability of health systems to meet growing demands, underscoring the urgent need for reforms that strengthen fiscal space, improve budget flexibility, and enhance equity in financing.

**Budgeting approaches**

- **Budgets based on historic trends rather than health needs:** The studied countries frequently rely on historic, line-item-based budgeting**,** which locks funding into categories like personnel or infrastructure rather than outcomes or epidemiological priorities. This limits flexibility and responsiveness, as observed in Peru, where outdated budgets and rigid public financial management discourage strategic adaptation to shifting needs. The lack of public health leadership, insufficient technical staff, and poor data systems exacerbate this rigidity, undermining efforts to align resources with disease burden or performance metrics. There is widespread underuse of evidence-based approaches **in** health budgeting. While there are attempts by countries like Chile, Costa Rica Peru, Mexico, to use more evidence-based budgeting approaches, these need to be further strengthened and used more broadly in the region.

- **Lack of data or use of data to inform budgets:** The limited use of routine data and analytic evidence in health budgeting remains a major bottleneck to smarter, needs-driven resource allocation across most of the countries. Many countries still depend heavily on historical, line-item budgets and face weak institutional links between epidemiological/disease-burden data and budget formulae — for example, Colombia and Peru have good data but lack an institutionalized strategy to monitor indicators and act on inefficiencies, constraining reallocation toward high-burden areas. Key root causes include fragmented financing pools, weak health accounts and incomplete digital systems that limit real-time use of cost, utilization and outcomes data when setting annual envelopes and priorities. There are some reforms to address this, such as the adoption of results- and performance-based that combine data and monitoring systems with institutional incentives to align funding with disease burden and health needs; use of more evidence-based strategic purchasing, and adoption of expenditure tracking systems across countries.

**Governance**

- **Coordination issues between the ministries of health, finance and planning:** A major challenge for health budgeting across Latin America is the fragmented coordination between ministries of health, finance, and subnational governments**,** as well as across public insurance schemes and social security funds. This fragmentation often leads to duplication of spending, inefficiencies, and inequities in service delivery. In Argentina, overlapping responsibilities between the Ministry of Health, provincial authorities, and social security funds create misaligned incentives, with weak coordination mechanisms preventing efficient pooling of resources. Brazil's SUS, while constitutionally guaranteed, faces persistent coordination issues between federal, state, and municipal levels—compounded by fiscal decentralization—leading to uneven service quality and gaps in implementation of national priorities. In Colombia, the coexistence of contributory and subsidized health insurance regimes has created coordination deficits, with financial transfers often delayed or misaligned with real population needs. In Chile, the public FONASA system and private ISAPRE insurers operate in silos, resulting in inequities and inefficiencies in how resources are budgeted and allocated. Costa Rica, despite strong primary care, experiences institutional rigidity between the Ministry of Health and the CCSS, complicating joint planning and financing. In Mexico, the dismantling of Seguro Popular and creation of INSABI revealed institutional fragmentation and coordination issues, while Peru's mix of MoH, EsSalud, and regional health directorates has hampered budget coordination, particularly in aligning national priorities with subnational execution. Collectively, these coordination failures weaken the

translation of strategic health plans into coherent budgets, perpetuating inefficiencies and limiting progress toward universal health coverage.

- **Decentralization without adequate capacity:** A persistent obstacle to effective health budgeting in Latin America is the limited local administrative capacity to plan, execute, and monitor health resources, which undermines equity and efficiency. Many countries have decentralized health responsibilities to subnational levels without providing the technical and managerial resources required to manage them. In Argentina, provincial and municipal authorities often lack the expertise and tools to translate national health priorities into local budgets, resulting in fragmented service delivery and inefficiencies. Brazil's highly decentralized SUS relies heavily on states and municipalities for budget execution, but uneven technical capacity and weak fiscal management at the local level contribute to disparities in service quality and significant under-execution of allocated funds. In Colombia and Peru, subnational governments frequently struggle with weak institutional capacity, leading to delays in budget disbursement and execution, particularly in rural areas where oversight is limited. In Mexico, states often underspend allocated health resources, with low execution rates reflecting administrative bottlenecks and, in some cases, corruption linked to inadequate monitoring systems. Chile and Costa Rica have comparatively stronger institutional frameworks, but local health facilities still face resource shortages and administrative rigidity that constrain effective use of budgets. Ecuador highlights the risks of decentralization without sufficient oversight, as municipalities have shown both low absorption of funds and exposure to misuse. Across the region, these local capacity gaps not only reduce efficiency but also deepen disparities in access and service quality, particularly affecting marginalized and rural populations.

**Institutional mandates and settings**

- **Fragmented health system leading to inefficiencies:** Several of the studied countries face severe fragmentation across its health system, including programs, institutions, and levels of government. This has led to duplication of staff, infrastructure, and financing streams. In Argentina, provinces are constitutionally responsible for delivering public health services, which gives them significant autonomy in planning and spending but creates wide disparities in access and quality between regions. Brazil's SUS, while universal in principle, suffers from coordination and financing gaps across federal, state, and municipal levels, with decentralization amplifying inequalities in service provision. Similarly, Peru and Mexico face highly decentralized but fragmented systems, with the Ministry of Health and social security institutions operating in silos. In Mexico, overlapping entities such as SSA, IMSS, and ISSSTE maintain parallel financing and

delivery networks, hindering resource pooling and creating inefficiencies. Other countries face subtler forms of fragmentation. In Chile, strong fiscal oversight and performance-based budgeting exist, but deep inequities remain between users of the public FONASA system and private ISAPRE insurers, producing a two-tiered system. Ecuador struggles with duplication between Ministry of Health facilities and social security institutions, resulting in redundant infrastructure and uneven service delivery. Costa Rica is comparatively less fragmented due to the dominant role of the CCSS in financing and provision, though some institutional overlaps still occur with the Ministry of Health's regulatory functions. Across the region, this fragmentation weakens the ability to link budgets to strategic priorities, reduces economies of scale, and perpetuates inequities in access and quality of care.

- **Weak linkages between health planning, prioritization and budgeting:** In many countries, health plans—whether national, medium-term, or annual—exist independently of the budget process, resulting in gaps between stated priorities and the funds actually available. In Argentina, provincial autonomy in health service delivery and fragmented planning structures often mean that national strategies are poorly reflected in provincial budgets. Brazil's SUS faces similar difficulties, with federal health plans not always fully synchronized with state and municipal budget execution, leading to uneven implementation and gaps in service coverage. Although Colombia's Ten-Year Public Health Plan outlines national priorities, financing flows to EPS and local health authorities are often misaligned with disease burden and strategic objectives. Mexico's multiple institutions—SSA, IMSS, ISSSTE—operate largely independent budgeting cycles, making it difficult to ensure that national health goals translate into coordinated funding. In Chile, Ecuador, Costa Rica, and Peru, although planning documents exist, weak integration with the budget process, rigid line-item structures, and limited use of evidence hinder alignment of resources with health needs. Across the region, these disconnects reduce efficiency, limit responsiveness to epidemiological shifts, and perpetuate inequities in access and quality of care.

## Lessons

Beyond the challenges, diverse experiences of the studied Latin American countries offer valuable lessons in health budgeting that can inform more effective, equitable, and resilient health systems. Despite varying institutional arrangements and fiscal capacities, countries like Peru, Argentina, Costa Rica, and Mexico have demonstrated how strategic budgeting reforms—such as results-based financing, centralized procurement, equitable taxation, and investment in primary care—can drive improvements in access, efficiency, and health outcomes.

Countries like Costa Rica, Peru and Argentina have adopted various models of results-based budgeting approaches that have contributed to improved funding of health as well as improved health outcomes. Costa Rica's EBAIS model uses primary-care data to target resources to high-risk areas and inform budgeting at the local level, improving equity in allocations. Peru's PforR budgeting approaches align resource allocation with health outcomes, and has contributed to notable improvements in maternal/child mortality and nutrition, though challenges remain around flexibility and systemic coordination. Argentina's Plan Nacer/SUMAR**,** supported by World Bank funding, exemplifies long-standing results-based financing—tying incentives to provincial governments and providers, which enabled targeted service delivery reaching millions of uninsured individuals. Costa Rica achieves budget optimization through centralized procurement, improving efficiency in acquiring medical products. This is complemented by broader health system investment and universal health coverage, contributing to overall financial sustainability. The CCSS pools funds centrally—via payroll and sin taxes—to provide universal coverage and avoid social stratification of health benefits (Box 1). Although the judicialization of health has put immense pressure on health budgets across these countries, they have also been very effective in improving health access for citizens. In Colombia, judicialization—the legal right of citizens to demand access to approved treatments—ensures accountability and expands access to essential services. Costa Rica and Ecuador also face judicialization pressures, where citizens sue the state for access to therapies. Lastly, intersectoral and innovative health financing sources can help to increase resources for health budgets. PAHO has reported efforts in Argentina, Chile, Costa Rica, and Mexico to use "Health-in-All-Policies" and intersectoral budgeting mechanisms to promote equity. Fiscal policies—such as Mexico's 2013 soda and junk-food tax—generated revenue for school drinking water and reduced sugar intake by almost 8% over two years. Similar taxes on tobacco, alcohol, and sugary beverages have been piloted in Brazil, Colombia, Mexico, and Chile to both raise funds and curb noncommunicable diseases. Latin American countries can benefit from learning through these success stories of their peers and also from key lessons around the world.

## CONCLUSION AND RECOMMENDATIONS

Improving health budgeting in Latin America requires a multifaceted approach to address systemic inefficiencies, promote transparency, and align financial planning with population health needs. Discussion with key informants highlighted the need for comprehensive reform of budgeting processes. In countries like Argentina, interviewees emphasized the need to reduce fragmentation in the financing system and to develop accurate, updated national health accounts and price indices for health services and medications. These reforms would help establish performance-based budgeting, enhance resource allocation, and enable tracking of key performance indicators. Similarly, budget structures should be

aligned with the level of care, as recommended in Mexico and by the OECD, to ensure that spending reflects the different needs of primary, secondary, and tertiary care systems.

Key informants also called for greater transparency and accountability across the region must be prioritized. Peru, Mexico, and Ecuador have called for publicly accessible budget information and improved monitoring systems to combat widespread corruption and inefficiency. This includes digital transformation of procurement and financial management systems, as suggested in Ecuador, to enable better traceability and reduce leakages. In Colombia and Peru, where corruption in both the public and private sectors undermines efficiency, robust surveillance systems, standardized procedures, and enforcement mechanisms are critical to safeguarding public funds.

Interviews also emphasized that budgeting should be more adaptive and results-oriented. Countries like Ecuador and Costa Rica highlighted the need for flexible planning tools to respond to emerging needs, such as the growing demand for high-cost therapies. In Costa Rica, judicialization creates unpredictability in budgeting, underscoring the importance of better forecasting and inclusion of cost-effectiveness frameworks that consider societal impacts—not just drug costs. Across countries, there is a need to incorporate long-term planning, particularly in Colombia, where short-term decisions have led to inefficiencies. Finally, enhancing primary care investment and population outreach, as emphasized in Chile and Costa Rica, is crucial to achieving universal coverage and addressing health inequalities, especially for underserved populations like informal workers or younger men. These recommendations, drawn from firsthand insights, point toward the urgent need for governance, institutional coordination, and evidence-based policy in building more resilient health financing systems.

Based on the issues emerging from this study and discussions with key informants, we propose the following recommendations to improve health budgeting in the studied Latin American countries. These recommendations underscore the importance of aligning financial planning with health priorities, fostering intersectoral collaboration, and using fiscal policy not only to raise revenue but also to shape healthier populations. Collectively, they reveal that well-designed budgeting mechanisms are foundational to achieving universal health coverage and responding sustainably to both routine and crisis health needs.

1. **Increasing public health spending and financial sustainability**. Most countries face growing NCD burdens, and there is underspending and budget deficits (Brazil, Colombia). There is a need to increase public investment in health and explore alternative financing mechanisms to ensure adequate funding.
2. **More equitable distribution of resources**: Per capita spending on all groups of population should be equitable (currently a problem in Mexico, Chile). There is need

for reforms towards a unified health system to ensure equitable access and resource distribution.

3. **Improved governance and coordination:** Improve coordination between different levels of government and health institutions to enhance decision-making and accountability.
4. **Promoting evidence informed health budgeting and prioritization:** Disease burden and economic evaluation evidence have not been available or widely used to aid the allocation of budget and priority setting. Most countries will benefit from better use of evidence to design the benefit package and allocate adequate budget to improve efficiency and population health.
5. **Capacity building:** Decentralized countries (Mexico, Brazil, Argentina) and countries with local institutional capacity (Ecuador) have reported varying capacities that impact budget execution and service delivery. There is a need to develop the administrative and technical capacities of health institutions, especially at the subnational level, to manage services effectively.
6. **Better integrated health system to streamline services and reduce inefficiencies.** This is an important opportunity in countries like Mexico and Peru with high fragmentation between federal and state levels. There is a need to consolidate health financing and service delivery structures to reduce redundancy and improve coordination.

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