FINANCING ACCELERATOR NETWORK for NCDs

Financing NCDs in Latin America and the Caribbean: A Regional Landscape Analysis

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This report—led by FAN's Latin America and the Caribbean (LAC) NCD Financing Accelerator, Instituto de Efectividad Clínica y Sanitaria (IECS), and supported by Network Manager, Results for Development (R4D)—provides a regional landscape analysis of how financing for noncommunicable diseases (NCD) is mobilized, pooled, and allocated across LAC. By identifying current practices, structural constraints, and opportunities to strengthen health financing for chronic conditions, this work establishes a foundational roadmap to inform priorities for country-led support under the next phase of FAN in LAC.

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Abbreviations

AUGE-GES — Universal Access with Explicit Guarantees (Chile)
CAF — Development Bank of Latin America and the Caribbean
CENABAST — Central de Abastecimiento del Sistema Nacional de Servicios de Salud (National Supply Center, Chile)
CIIPS — Center for Implementation and Innovation in Health Policy (CIIPS)
CVD — Cardiovascular Disease
DRG — Diagnosis-Related Group
FAN — Financing Accelerator Network for NCDs
FONASA — Fondo Nacional de Salud (Uruguay's National Health Fund)
FNR — Fondo Nacional de Recursos, National Resources Fund, Uruguay
GDP — Gross Domestic Product
GES — Explicit Health Guarantees (Chile)
HEARTS — Healthy-lifestyle counselling, Evidence-based treatment protocols, Access to essential medicines and technology, Risk-based CVD management, Team-based care and Systems for monitoring
HTA — Health Technology Assessment
IADB — Inter-American Development Bank
IECS — Instituto de Efectividad Clínica y Sanitaria
KIIs — Key Informant Interviews
LAC — Latin America and the Caribbean
MIDO Initiative — Integrated Measurement for Timely Detection, Mexico
MEAs — Managed Entry Agreements
NCDs — Noncommunicable Diseases
OOP — Out-of-pocket
PAHO — Pan American Health Organization
PIAS — Plan Integral de Atención en Salud (Comprehensive Health Care Plan)
PBF — Performance-Based Financing
PMO — Compulsory Medical Program (Argentina)
SSB — Sugar-Sweetened Beverage
USD — United States Dollars
WHO — World Health Organization

Executive Summary

Noncommunicable diseases (NCDs) account for approximately 65% of all deaths in Latin America and the Caribbean (LAC) and represent a growing burden for health systems, households, and national economies. In the region, approximately 38% of NCD-related deaths occur before the age of 70, with substantial disparities across countries—NCD mortality rates range from 307 per 100,000 population in Costa Rica to 825 per 100,000 in Haiti. The economic costs are significant: smoking alone is attributed to an estimated USD 26.9 billion in annual direct medical costs across 12 LAC countries—approximately 6.9% of total health expenditure—while sugar-sweetened beverage (SSB) consumption is attributed to approximately USD 2 billion in annual healthcare costs in four countries studied. More broadly, the macroeconomic burden of NCDs is estimated to reduce annual economic growth by 0.5% to 2.0% in several countries in the region. Despite this, the flow of funding for NCDs remains insufficient, fragmented, and poorly traceable, limiting countries' ability to respond effectively to the growing demand for chronic care. Challenges are not uniform across the region. For example, some Caribbean countries rely more heavily on external support than those outside the Caribbean. Meanwhile, Southern Cone countries have institutionalized strategic purchasing practices more often than countries in other sub-regions.

OBJECTIVES AND METHODS

This report provides a regional landscape analysis of how financing for NCDs is mobilized, pooled, and allocated across LAC, with the objective of identifying current practices, structural constraints, and opportunities to strengthen health financing for chronic conditions in the region. The analysis focuses on four major NCD groups—cardiovascular diseases (CVDs), cancer, diabetes, and chronic respiratory diseases, while also incorporating relevant evidence on mental health conditions and chronic kidney disease. It uses a mixed-methods approach combining: i) a structured desk review of 157 documents published between 2020 and 2025; and ii) 21 semi-structured key informant interviews (KIIs) with 22 stakeholders across ten countries: Argentina, Brazil, Chile, Colombia, The Dominican Republic, Ecuador, Mexico, Peru, Trinidad and Tobago, and Uruguay; and iii) a regional validation dialogue held in Buenos Aires in April 2026, which convened 45 participants from ten countries, including government representatives, international organizations, civil society, and technical actors, to discuss preliminary findings, validate their relevance, and identify priorities for country support under the next phase of the Financing Accelerator Network for NCDs (FAN) next phase in LAC. The analysis is guided by the World Health Organization (WHO) health financing framework, which examines three core functions: resource mobilization, pooling, and strategic purchasing. By triangulating these sources, the report provides a comprehensive and policy-relevant perspective on current practices, constraints, and opportunities.

KEY FINDINGS

Resource mobilization: Health financing for NCDs is predominantly domestic, relying mainly on general taxation and social security contributions. External financing plays a complementary role without being systematic or institutional. In 2023, almost half of LAC countries spent below Pan American Health Organization (PAHO)'s recommended benchmark of 6% of GDP on public expenditure on health. Health taxes on tobacco, alcohol, and SSBs are widely implemented across the region, but their revenues are rarely channeled clearly to health programs. Even where earmarking mechanisms exist, the link between revenue generation and allocation to health services depends on country-specific institutional and budgetary arrangements and is often difficult to trace.

Risk pooling occurs primarily through public insurance and statutory coverage schemes —such as Chile's "Plan de Garantías Explícitas de Salud" (AUGE-GES) and social security systems. However, fragmentation across multiple insurance schemes, parallel subsystems, and segmented financing structures limits effective risk redistribution and contributes to persistently high out-of-pocket (OOP) spending, particularly for low-income and underserved populations.

Strategic purchasing approaches are increasingly common, with countries adopting explicit benefit packages, performance-linked provider payment mechanisms, and centralized or pooled procurement of medicines and products, including through the PAHO Revolving Funds. However, implementation remains partial and uneven, and often insufficiently aligned with long-term outcomes. More advanced instruments, such as managed entry agreements, remain at an early stage of development in the region.

INTERPRETATION OF FINDINGS

Health financing for NCDs within government budgets has limited traceability across prevention, treatment, and long-term care, while information on NCD expenditure remains largely unavailable. The WHO Global Health Expenditure Database (2023) does not report NCD expenditure as a share of current health expenditure for LAC countries, and only a few country-specific estimates from previous years are available. Information systems are fragmented and underutilized, limiting their role in expenditure tracking, decision-making and accountability.

There is a structural mismatch between the growing burden of NCDs and the way health financing systems are organized in LAC. Although NCDs are widely recognized as a policy priority, this recognition does not consistently translate into sustained political commitment, effective implementation, or dedicated financing. Health systems in the region remain largely organized around acute care, while NCDs require continuous, long-term, and integrated care. Primary prevention remains underfunded relative to curative and high-cost interventions.

This imbalance is particularly evident in mental health, which, despite gaining visibility in policy frameworks, continues to receive limited financial investment, accounting for only around 2% of total health expenditure on average across LAC. This misalignment between health financing systems and service delivery results in fragmented financing arrangements, weak coordination across levels of care, and persistent gaps in financial protection. This gap is reflected in high out-of-pocket spending, which accounts for 30–40% of total health expenditure in several countries and is often concentrated in medicines for chronic conditions. The central challenge is not only the magnitude of available resources, but how financing is structured, coordinated, and translated into effective service delivery.

Innovative approaches for financing, pooling and strategic purchasing of NCD services exist—including earmarked fiscal instruments such as Jamaica's National Health Fund (which receives 20% of the Special Consumption Tax on tobacco to subsidize essential medicines for chronic conditions), performance-linked payment models such as Programa SUMAR in Argentina and Previne Brazil, integrated care approaches such as "one-stop-shop" models for diabetes management in Mexico, and data-driven performance monitoring systems such as Colombia's High-Cost Account—but they remain project-based, fragmented, and difficult to scale.

Potential entry points for interventions to strengthen health financing for NCDs

Importantly, many of the key instruments needed to strengthen health financing for NCDs are already present in the region, including health taxes, strategic purchasing mechanisms, integrated care approaches, and information systems. However, these remain isolated, unevenly implemented, and insufficiently institutionalized, limiting their ability to generate system-wide transformation. Within the core entry points, we identified the following entry points for intervention to advance financing for NCDs:

1. Expanding the fiscal space for NCDs and more effective use of health taxes.
2. Strengthening and integrating information systems to improve the traceability and comparability of NCD expenditure; and developing regional indicators to support decision-making and accountability.
3. Investing in prevention and health promotion; reinforcing financial protection for chronic conditions.
4. Aligning provider payment mechanisms with benefits / entitlements and focusing on long-term outcomes, price negotiation and regional planning for medicines, supplies, and high-cost technologies.
5. Supporting existing programs with potential for scale by documenting promising country experiences; strengthening and integrating health information systems; and scaling successful innovations beyond pilot stages to survive political transitions.

Through FAN's three interconnected programmatic areas—FAN Foresight, FAN Forum, and FAN Fund—the initiative can help connect evidence generation, regional learning, and catalytic support to strengthen more integrated and sustainable financing for NCDs in the LAC region. Together, these functions can bridge the gap between identifying financing challenges, sharing practical solutions, and supporting the implementation and scaling of promising approaches.

Key Messages

- **NCDs are a major health and financing challenge in LAC. Smoking alone is estimated to generate USD 26.9 billion in annual direct medical costs across 12 Latin American countries, equivalent to 6.9% of total health expenditure in those countries.**

  NCDs account for approximately 65% of all deaths in the region, are a leading cause of disability, and place sustained financial pressure on health systems, households, and national economies.

- **Evidence across financing functions is uneven.**

  Pooling is least documented and the evidence base is comparatively underdeveloped as compared to resource mobilization and strategic purchasing. The evidence shows that resource mobilization remains constrained by limited fiscal space. Pooling mechanisms are largely concentrated in public insurance and statutory coverage schemes, while strategic purchasing shows the most visible progress.

- **The core challenge is not only the magnitude of resources, but how financing is organized.**

  Nearly half of LAC countries spent below PAHO's recommended benchmark of 6% of GDP for public expenditure on health in 2023. The low public spending is compounded by fragmentation, weak coordination, and limited traceability of funding flows which emerge as central barriers to financing continuous, integrated care for chronic conditions. The lack of systematic, comparable, and interoperable data limits the ability to assess health financing for NCD gaps, link resources to outcomes, and develop evidence-informed national and regional policies.

- **Positive experiences of financing have been identified in the region, but they remain fragmented and difficult to scale up.**

  Examples of instruments that provide lessons that could be considered for adaptation by peers include Chile's AUGE-GES, Argentina's SUMAR, Jamaica's National Health Fund, and Colombia's High-Cost Account.

- **The opportunity is to move from isolated initiatives toward more integrated and sustainable financing strategies.**

  Strengthening traceability, financial protection, primary healthcare systems, information systems, and implementation capacity can help translate existing experience into broader system-level transformation.

Introduction and NCD Regional Context

NCDs are the leading cause of mortality and disability in LAC, accounting for approximately 65% of all deaths in the region, with approximately 38% of NCD-related deaths occurring before the age of 70 (1). Although some progress has been made in reducing premature mortality, current trends remain insufficient to meet global targets. Significant disparities persist across countries, with NCD mortality rates ranging from 307 per 100,000 population in Costa Rica to 825 per 100,000 in Haiti (2).

The epidemiological transition has consolidated NCDs as the dominant health challenge in LAC, with CVDs and cancer as the main causes of mortality, and diabetes and chronic kidney disease contributing substantially to long-term disease burden. Population aging and the growing need for prevention, treatment continuity, and integrated chronic care are placing increasing pressure on health systems and financing arrangements (3). Mental health conditions, although less visible in mortality statistics, represent a major and growing share of disability and frequently coexist with other chronic diseases, increasing clinical complexity and service demand. This burden is further amplified by the high prevalence of key risk factors: tobacco use affects 16.6% of adults, physical inactivity 35.6%, and overweight or obesity 67.5%—with 33.8% of adults living with obesity. Harmful use of alcohol, at 7.5 liters of pure alcohol per capita per year, further contributes to the NCD burden (4).

Table 1 summarizes deaths and prevalent cases for the four major NCD categories in LAC in 2023. As shown, CVDs remain the leading cause of NCD-related mortality (nearly 25% of all deaths from NCDs). Neoplasms represent the second largest contributor to NCD mortality, followed by diabetes, chronic kidney disease, and chronic respiratory diseases. In contrast, diabetes and chronic kidney disease account for the largest number of prevalent cases, reflecting the sustained demand they place on health systems over time.

Table 1. NCDs Profile in LAC (2023)

NCD category	Deaths (%)	Prevalent cases
CVDs	1,159,700 (26.40)	51,088,300
Neoplasms	813,659 (18.52)	17,454,070
Diabetes and chronic kidney disease	471,475 (10.73)	106,497,600
Chronic respiratory diseases	207,596 (4.73)	61,438,190
Total (selected NCDs)	**2,652,430 (60.38)**	**263,478,160**

Notes: estimates correspond to both sexes, all ages, year 2023. Region: Latin America and the Caribbean (World Bank classification). Reference: Global Burden of Disease Collaborative Network. Global Burden of Disease Results Tool, 2023 (4)(5).

Health systems in LAC face important structural challenges in responding to the growing burden of NCDs (6). Fragmentation and segmentation remain defining features of many health systems in the region. Multiple insurance schemes, disease-oriented models of care centered on acute and hospital-based services, non-integrated vertical programs, and fragmented financing arrangements contribute to inefficiencies, duplication of services, and unequal access to care (7).

In this context, Universal Health Coverage (UHC), defined as ensuring that all individuals can access the quality health services they need without experiencing financial hardship, provides a comprehensive framework for assessing health system performance and progress. Globally, the growing burden of NCDs and mental health disorders has been identified as one of the major challenges to sustaining progress toward UHC, particularly in settings characterized by fiscal constraints, aging populations, and increasing demand for long-term care (6).

LAC presents a distinctive situation within the global UHC landscape. Although the region started from relatively high levels of health service coverage, quality is heterogeneous, progress has stagnated in recent years, and financial protection remains insufficient: approximately 15% of households experience financial hardship (impoverishing and/or catastrophic OOP spending) due to OOP health expenditures. Significant disparities also persist across countries and socioeconomic groups, reflected in substantial gaps in unmet healthcare needs between higher- and lower-income populations. The region performs relatively well on the NCD service coverage sub-index, one of the core metrics used by the WHO and World Bank to monitor global progress toward UHC. However, much of this progress appears to be driven by improvements in risk-factor control, particularly reductions in tobacco use, whereas progress in the detection, treatment, and control of major NCDs has been more limited (6).

The challenges associated with achieving UHC for NCDs are amplified by the economic burden these conditions impose on individuals, health systems, and societies. Their chronic nature increases demand for long-term care, medicines, follow-up, and specialized services, including high-cost treatments, contributing to rising healthcare expenditures. A modelling study conducted in 12 Latin American countries estimated that smoking generates approximately USD 26.9 billion in direct medical costs annually, representing about 6.9% of total health expenditures across these countries (8). Similarly, a modelling study assessing the impact of SSB consumption in Argentina, Brazil, El Salvador, and Trinidad and Tobago estimated that SSB consumption is associated with approximately USD 2 billion in annual direct healthcare costs linked to related diseases (9). When NCD-related expenditures are paid OOP, these rising costs can deepen household financial hardship and further constrain the health system's capacity to expand and sustain coverage for chronic care. More broadly, the macroeconomic burden of NCDs—including productivity losses and premature mortality—is estimated to reduce annual economic growth by 0.5% to 2.0% in several countries in the region (10), a finding consistent-

with a macroeconomic analysis showing that each 10-percentage-point rise in NCD prevalence is associated with a 0.5% reduction in annual economic growth (11). These challenges are further compounded in many countries by limited public resources and competing public spending priorities, narrowing the fiscal space available to expand service coverage and strengthen financial protection mechanisms for NCDs — and these constraints are rarely distributed evenly, often falling hardest on lower-income households and reinforcing existing equity gaps.

Despite their magnitude, NCDs remain insufficiently prioritized within health financing systems in the region. NCD spending, which is often embedded within general health budgets, is difficult to trace and may not align with population needs. (12) This structural underfunding is not limited to treatment strategies. Evidence from Chile shows that only 0.7% of total public expenditure is allocated to NCD prevention and health promotion activities, representing just 0.2% of the country's GDP while for example the cost of treating smoking-attributable disease alone — just one NCD risk factor — is estimated at 0.8% of GDP, four times the resources allocated to prevention (8,11).

These challenges are closely linked to persistent inequities across and within countries. People in low-income groups, informal employment, and rural or underserved areas face greater barriers to prevention, timely diagnosis, and continuous care, and are more exposed to financial hardship (12,13). As a result, NCDs not only reflect but also reinforce existing social and health inequalities in the region.

Together, these dynamics highlight a persistent gap between the scale of the NCD burden and the organization of health financing systems in LAC. Addressing this gap requires not only increasing resources, but also improving how financing is structured, governed, and translated into effective and equitable service delivery for chronic conditions.

Health Financing for NCDs in LAC

Despite important progress toward UHC, health financing systems in LAC continue to face structural constraints that limit their ability to respond effectively to the growing burden of NCDs.(14) Public spending on health remains insufficient in much of the region. PAHO identifies public expenditure equivalent to at least 6% of GDP as a necessary, though not sufficient, condition to reduce inequities and strengthen financial protection.(15) However, in 2023 nearly half of the countries were below this (Figure 1).

Beyond the level of spending, the organization of financing remains a central challenge. Health systems are highly fragmented across multiple financing and service delivery arrangements, including public services, social security schemes, and private insurance. This fragmentation contributes to inefficiencies, duplication of services, and unequal access across population groups.

Country experiences illustrate that external financing arrangements for NCDs vary across subregions. Most countries rely predominantly on domestic resources. Fiscal space is constrained by broader macroeconomic conditions and competing public spending priorities in other sectors such as education, infrastructure, and social protection. The economic implications of NCDs extend beyond the health sector, and should influence broader fiscal and development priorities. In Mesoamerica and the Andean region, countries such as Costa Rica, Guatemala, Panama, Colombia, and Peru tend to integrate external financing within public budgets or align it with broader health system priorities. In contrast, El Salvador, Honduras, Paraguay, and Saint Lucia rely more heavily on externally financed interventions, suggesting greater dependence on project-based funding. Caribbean countries such as Jamaica and the Dominican Republic show mixed models, combining external and domestic resources, while the Caribbean subregion more broadly appears to have greater dependence on external financing than the Southern Cone and Andean region, where funding structures are more diversified (18). These differences reflect variations in fiscal space, institutional capacity, and the integration of external financing within national systems.

In 2023, OOP payments accounted for approximately one third of total health expenditure, while public spending represents a relatively limited share (Figure 2). When OOP represents such a large share of total expenditure, the system as a whole offers weaker financial protection, which helps explain why a significant proportion of households experience financial hardship when seeking care. This is particularly problematic for chronic conditions, which require continuous treatment, long-term medication, and regular follow-up, increasing the risk of financial hardship and unmet needs for patients and their families. Evidence from LMICs indicates that NCDs impose a heavy financial burden on affected households, with medicines representing the largest component of costs and limited insurance coverage reflected in low reimbursement rates overall. (16)

Uninsured patients with NCDs face 2–7 times higher odds of incurring catastrophic levels of OOP expenditure, with lower-income households bearing a disproportionate share of this burden. (17)

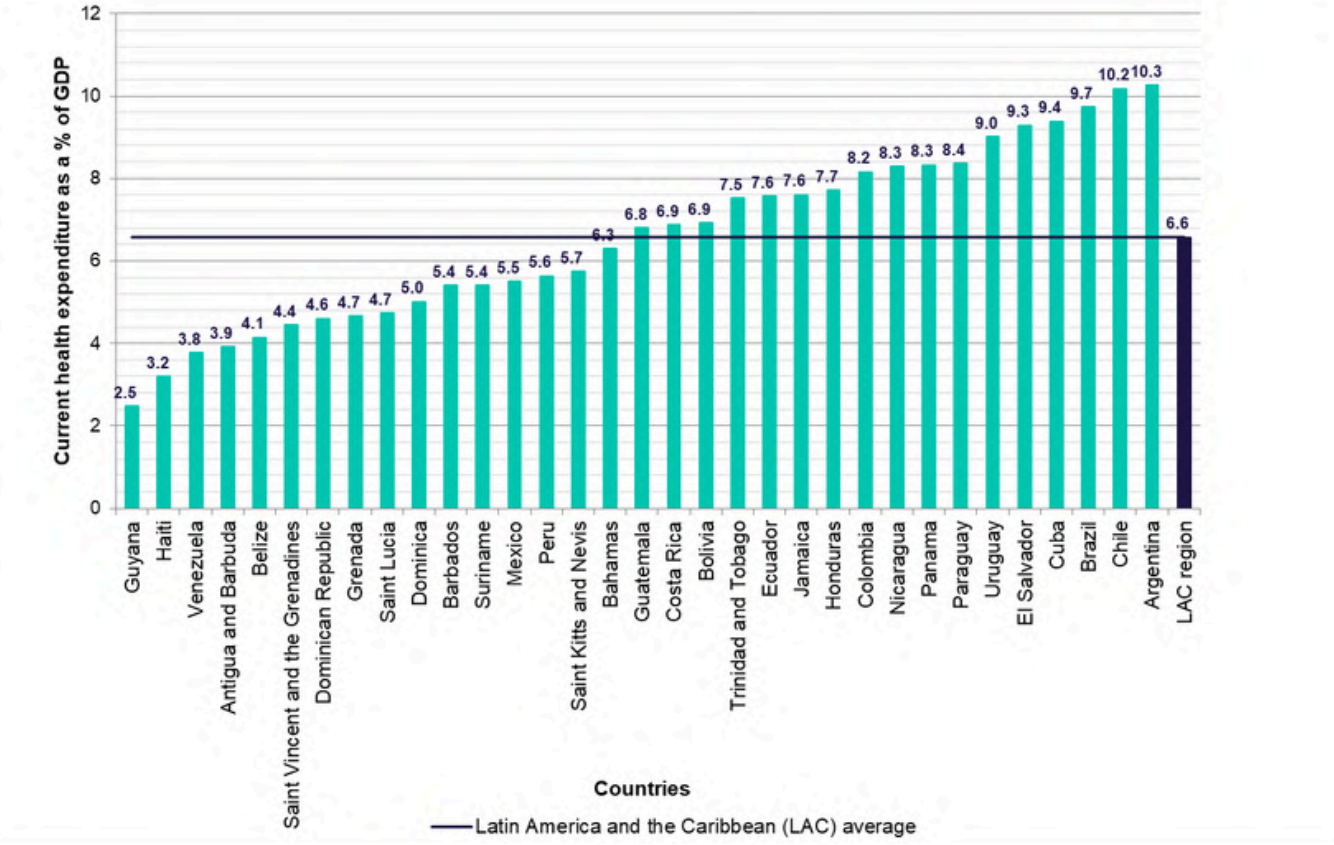
External financing plays a relatively minor and non-structural role, representing on average around 2% of total health expenditure and often concentrated in short-term or project-based initiatives (Figure 2) (18). This external support may also include technical assistance linked to specific programs, concessional loans, or reform processes, including support for policy design, institutional capacity development, information systems, and service delivery models.

NCD-specific spending remains difficult to trace across prevention, treatment, and long-term care. The most recent WHO Global Health Expenditure database (2023) does not report NCD expenditure as a share of current health expenditure for LAC-

countries; country-specific estimates are available only for Costa Rica (52.1% in 2020), Guyana (43.1% in 2019), and Haiti (13.2% in 2016). This absence of systematic and comparable data limits policymakers' ability to assess adequacy, identify financing gaps, and make evidence-informed decisions.(18)

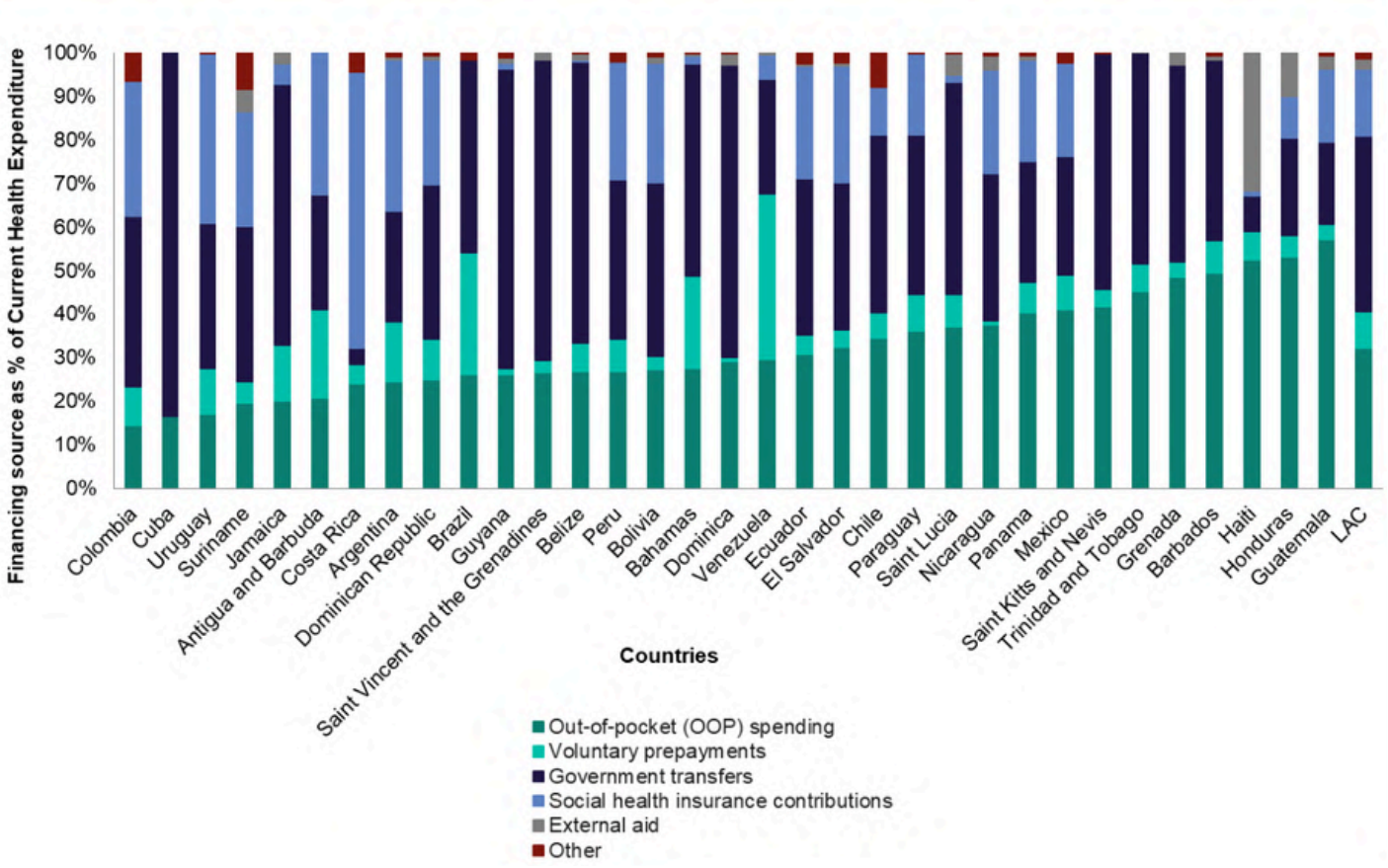
Together, these features show that the main financial challenge is not only the availability of resources, but also improving the way funds are pooled, allocated, tracked and used to support prevention, continuity of care, and long-term NCD management.

Figure 1. Current health expenditure as a percentage (%) of GDP in LAC countries



Source: World Health Organization (2023) Global Health Expenditure database.

Figure 2. Financing source as % of Current Health Expenditure in LAC countries



LAC Region
Source: World Health Organization (2023) Global Health Expenditure database.

LAC Landscape Study Methodology

This report was developed using a mixed-methods approach, integrating evidence from a desk review, KIIs interviews, and a regional validation workshop. Together these sources provide a comprehensive perspective on how financing for NCDs is mobilized, pooled, and allocated across the LAC region. The analysis focuses on four major NCD groups (CVDs, cancer, diabetes, and chronic respiratory diseases) while also incorporating relevant evidence on mental health conditions and chronic kidney disease.

For geographic analysis, countries were grouped as follows:

- **Southern Cone:** Argentina, Chile, Uruguay, Paraguay, Brazil;
- **Andean Region:** Colombia, Ecuador, Peru, Bolivia, Venezuela;
- **Mesoamerica:** Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica, Panama, and Mexico;
- **The Caribbean:** Cuba, Dominican Republic, Haiti, Jamaica, Trinidad and Tobago, Barbados, Bahamas, Eastern Caribbean States, Guyana, Suriname.

First, a structured desk review was conducted to identify NCD-related financing policies, programs, and initiatives implemented between 2020 and 2025. In total, 157 documents were analyzed, including peer-reviewed publications, grey literature, and reports from international, regional, and institutional sources.

Second, 21 semi-structured KIIs were conducted with 22 stakeholders involved in health financing for NCDs and policy across ten countries in the region: Argentina, Brazil, Chile, Colombia, Dominican Republic, Ecuador, Mexico, Peru, Trinidad and Tobago, and Uruguay. Participants were selected through purposive sampling to ensure diversity across sectors, institutions, geographic areas, and gender. All interview participants provided informed consent prior to participation.

Third, preliminary findings from the desk review and KIIs were presented and discussed at the Regional Dialogue on Needs and Priorities for Financing NCDs in LAC, held in Buenos Aires, Argentina, on April 23–24, 2026. The hybrid workshop, organized and led by IECS convened 45 participants from ministries of health, multilateral organizations, civil society and academic and technical institutions. Feedback from the workshop was used to validate the relevance of the findings, identify suggested adjustments to the report, and define priority areas for advancing FAN implementation in LAC.

The analysis was guided by a taxonomy of health financing mechanisms based on the WHO framework (19) (See Appendix 1), which distinguishes three core functions: resource mobilization, pooling, and strategic purchasing. Evidence from the desk review and KIIs was analyzed jointly to identify patterns, divergences, and cross-cutting challenges, while workshop feedback was used to validate and refine the-

interpretation of findings and inform the report's conclusions and proposed entry points for action.

Findings are presented through a set of thematic domains, including governance and organization, resource mobilization, pooling, strategic purchasing. The analysis adopts a narrative approach that combines evidence from the literature and KIIs with selected verbatims in italics, as well as some key regional examples to provide a comprehensive and policy-relevant perspective.

The study protocol was approved by the Central Ethics Committee of the Province of Buenos Aires (Act No. ACTA-2026-04234198-GDEBA-CECMSALGP, February 5, 2026).

LIMITATIONS

This landscape analysis has the following limitations that should be acknowledged. Although the methodology was designed to capture a broad range of evidence through a structured document review and KIIs, the availability and depth of information varied across countries. In particular, representation from the Caribbean was more limited than from other subregions, which may have constrained the extent to which the findings reflect the diversity of financing experiences in those settings. In addition, differences in data availability and documentation across countries may have influenced the level of detail and comparability of the evidence reviewed. Finally, given the considerable heterogeneity of health system organization and financing arrangements across LAC, the regional conclusions should be interpreted in light of this diversity, recognizing that they may not fully capture important country-specific contexts and circumstances.

Results

A. Governance and organization

Weak prioritization of NCDs in policy and financing. All countries have developed some formal strategies, plans, and policy instruments to address NCDs, often aligned with international frameworks. These include national plans, clinical guidelines, integrated care pathways, and selected financing and service delivery initiatives identified and highlighted in this report, reflecting broad policy recognition of chronic conditions. However, this recognition does not consistently translate into effective prioritization in policy or financing. Across the region, such innovations remain largely concentrated in specific instruments, pilot initiatives, or externally supported programs rather than in system-wide transformations.

> ***"We have gone from not even understanding the problem to understanding it. But a serious issue is that this does not mean we have increased health sector financing enough to truly address these challenges."***
>
> – Academic representative

The regional validation workshop reinforced the need to broaden health financing for NCDs agenda to issues that shape the long-term system responses, including mental health, digital interoperability, demographic transition and population aging, continuity of care, human capital, and sustainability. Participants particularly emphasized that population aging and the growing burden of NCDs require financing models that better account for long-term care needs and fiscal sustainability.

KIIs identified political turnover, institutional instability, and fiscal constraints as key barriers to long-term planning and continuity of NCD policies. In some cases, recent reforms or administrative restructuring weakened prior governance arrangements and disrupted implementation processes.

> ***"Each change of government means having to restart many discussions. Technical teams are lost, and priorities shift."***
>
> – Multilateral organization representative

The regional validation workshop further emphasized that NCDs often remain a "silent" and insufficiently perceived crisis, making it difficult to sustain political attention and financing over time. Participants noted that health financing for NCDs needs to be framed beyond annual budget cycles and short-term government horizons, given the growing costs of chronic care and the need for sustained prevention, care coordination, and system efficiency.

Persistence of vertical programs and approaches. In terms of programmatic focus, evidence from the literature and KIIs indicates that countries tend to concentrate on a limited set of high-burden conditions, particularly CVDs, diabetes, and cancer.

These are typically addressed through national strategies, benefit packages, and targeted programs, often supported by primary care strengthening initiatives such as the WHO-PAHO HEARTS program. However, while the literature documents a broad range of initiatives and policy frameworks, interviews suggest that their implementation remain uneven across territories and subsystems.

> *"There are national programs, but they do not reach all parts of the territory in the same way;" "Each subsystem has its own pathways and priorities, so national strategies are ultimately implemented very unevenly."*
>
> – Government representative

A recurrent finding across interviews is the persistence of vertical approaches and programs, more common in the low-income countries, that mostly depend on external financing from banks and donors, with limited coordination across levels of care and between prevention, treatment, and long-term management. This fragmentation is less visible in formal policy documents but emerges clearly in stakeholder interviews. In addition, financing for NCDs is typically embedded within general health budgets, without clearly identifiable budget envelopes, limiting visibility and accountability in resource allocation.

Low prioritization of prevention and health promotion. Another consistent pattern, highlighted in the KIIs and reinforced during the regional validation workshop, was the low prioritization of primary prevention. While preventive services are often formally included in benefit packages —typically covering basic screening and early detection activities such as blood pressure measurement, diabetes testing, cervical and breast cancer screening, and brief lifestyle counselling — interviewees reported that actual spending and policy attention remain concentrated on curative care and high-cost interventions. Preventive coverage therefore appears frequently partial rather than comprehensive, with more limited investment in sustained risk-factor management, nutritional counselling, smoking cessation support, and population-based prevention strategies.

> *"Most countries do not treat noncommunicable diseases as a real priority. In prevention, the data are poor and the agenda is underprioritized across almost the entire region."*
>
> – Civil society representative

> *"Blood pressure or blood glucose is checked during routine visits, but sustained follow-up is not always available afterward;"*
>
> – Civil society representative

> *"In primary care, there is often no real time to work on nutrition, physical activity, or behaviour change"*
>
> – Civil society representative

Mental health has limited coherence between policy, financing, and service delivery. The median share of total government health expenditure allocated to mental health is 2.1% globally and 2.1% in LAC. Both the literature and KIIs point to increasing visibility in policy frameworks, yet the incorporation of mental health into NCD financing and service delivery remains limited. As with other NCDs, mental health funding in most LAC countries is often embedded within general government health budgets and lacks identifiable budget envelopes. Although integrated budgets may help avoid vertical programming, interviewees highlighted gaps in dedicated funding, service availability, and specialized workforce. During the regional validation workshop, participants also emphasized the need to increase the visibility of mental health within the agenda of health financing for NCDs.

> *"In very few cases did we identify specific financing strategies for mental health. Mental health also represents important components of expenditure, although to a lesser extent. There is a recent law that expanded coverage, and now you can have more consultations and access psychology services directly without going through a physician first... however, there are large areas of the country without psychologists or psychiatrists."*
>
> – Colombia representative

Finally, civil society participation in the NCD agenda is recognized as relevant but remains limited in formal governance processes. While patient organizations, professional associations, and advocacy groups contribute to awareness and access in specific areas, interviews suggest that their involvement in policy formulation, priority-setting, implementation, improvement, and monitoring and evaluation is generally weak, fragmented, or dependent on ad hoc initiatives.

> *"Organizations are convened when there is a specific issue, but not as a stable part of the decision-making process."*
>
> – Academic, former health official representative

> *"I believe civil society is key to increasing pressure on countries regarding patients' needs. But strong associations do not exist everywhere."*
>
> – Regional multilateral organization representative

> *"Sometimes there are international organizations, but they do not always have enough strength at the local level to influence ministries."*
>
> – Multilateral institution representative

During the regional validation workshop, participants emphasized that advancing financing policies and integrated care requires not only technically sound proposals but also stronger conditions for implementation. A demand-oriented approach should be accompanied by stronger social participation, so that policies can be implemented, improved, and monitored over time. Experiences such as Brazil's health councils and greater social involvement in childhood cancer were highlighted as examples that could inform broader participation strategies.

Participants also noted that policies may be conceptually sound, but still fail to connect with the actual circuits of care, management, referrals, and service networks. In this regard, effective integration at the primary care level requires prior articulation at central levels of government, planning, and system stewardship. Together, these findings point to a governance model characterized by formal policy development but limited operational integration, where fragmentation, weak coordination, and constrained institutional capacity reduce the effectiveness and sustainability of NCD responses.

B. Institutional arrangements

Institutional leadership for NCD policies is typically located within ministries of health, through directorates of chronic diseases, public health units, or technical teams responsible for defining policies, benefits, and programmatic priorities. In some contexts, this leadership is supported by specialized institutions such as regulatory agencies, health technology assessment bodies, or information systems for high-cost conditions. International organizations, including WHO/PAHO and multilateral development banks, also play a key role in supporting policy development and system strengthening. Despite this institutional architecture, the findings point to important limitations in effective leadership, coordination, implementation, and institutional capacity.

KIIs highlighted several constraints affecting institutional leadership for health financing for NCDs and implementation. First, health ministries often have constrained decision-making power, particularly regarding stewardship, financing and system-wide organization, and face challenges in coordinating with ministries of economy or finance. While ministries of health are responsible for policy design, ministries of economy and finance play a decisive role in defining fiscal space, budget allocation, and spending priorities.

> ***"The Vice Ministry of Health Governance is responsible for everything related to public policies, and within that structure, there is a Directorate for Noncommunicable Diseases. However, it has no influence at any level over financing, so to speak. And there are no specific budget allocations for chronic diseases."***
>
> – Chile representative

> ***"The Minister of Finance tends to see health as a spending ministry that consumes resources. Those of us in health need to be better at showing that health is an investment."***
>
> – Multilateral organization representative

Second, KIIs pointed to fragmentation across institutional responsibilities and levels of the system. Responsibilities for promotion, prevention, and care are distributed across different units and levels of the system, with limited coordination mechanisms. This weakens the alignment between policy priorities, financing arrangements, service delivery, and disease burden.

"Fragmentation between the public sector, social security, and the private sector makes any common strategy very difficult."

– Academia representative (Argentina)

"Health promotion goes one way, healthcare delivery another, and disease burden another. Coordination is very difficult."

– Trinidad and Tobago representative

Third, KIIs emphasized that, while national authorities define policies and frameworks, implementation is often decentralized to subnational governments or other actors, resulting in heterogeneous execution across territories and population groups.

"It depends greatly on the province or municipality where you live."

– Argentina representative

Finally, interviews suggest that civil society participation in the NCD agenda is recognized as relevant but remains limited in formal governance processes. While patient organizations, professional associations, and advocacy groups contribute to awareness and access in specific areas, interviews suggest that their involvement in policy formulation, priority-setting, implementation, improvement, and monitoring and evaluation is generally weak, fragmented, or dependent on ad hoc initiatives:

"Organizations are convened when there is a specific issue, but not as a stable part of the decision-making process. I believe civil society is key to increasing pressure on countries regarding patients' needs. But strong associations do not exist everywhere. Sometimes there are international organizations, but they do not always have enough strength at the local level to influence ministries"

– Multilateral institution representative

Information systems are a critical component of governance but remain a major constraint. Although multiple systems exist—such as disease registries, service utilization databases, and platforms for high-cost conditions— most of the interviews point to persistent challenges related to data quality, interoperability, and limited analytical capacity. This was also reinforced during the regional validation workshop, where participants emphasized that limited data availability and weak interoperability constrain expenditure traceability and make it difficult to link resource allocation with service delivery, efficiency, and health outcomes. In practice, these systems often function as data repositories rather than tools for decision-making, although some initiatives have incorporated digital tools, dashboards, and performance monitoring mechanisms to support implementation and resource allocation.

Technical assistance also emerged in KIIs as an important source of support for institutional strengthening, particularly in areas such as policy and program design, digital transformation, equipment and supplies, health technology assessment, information systems, and service delivery models.

This support is primarily provided by multilateral and international organizations, including WHO/PAHO, the World Bank, regional development banks such as the Inter-American Development Bank and, in some cases, the Development Bank of Latin America and the Caribbean (CAF). However, KIIs suggest that technical assistance is often linked to specific programs, concessional loans, reform processes, or pilot initiatives, with varying degrees of integration into long-term institutional strengthening.

Across interviews, persistent gaps were identified in health financing for NCDs and in NCD governance. These include implementation capacity, economic evaluation, the integration and effective use of information systems, and the design of sustainable financing mechanisms and integrated care networks. In some countries, political transitions or system reforms were reported to weaken technical teams and institutional capacity, further limiting the ability to absorb, sustain, and institutionalize external technical support.

Some country experiences, such as Colombia's High-Cost Account[1], illustrate how integrated information systems can support monitoring, resource allocation, and performance management, although such approaches are not yet widely replicated across the region.

In Colombia, the High-Cost Account provides a long-standing disease registry that supports cohort follow-up through standardized annual reporting at the individual level. It contains extensive information on conditions such as hypertension and diabetes but has more limited coverage of cardiovascular events, including myocardial infarction and heart failure. Although it represents a valuable source of longitudinal data, it operates largely as a standalone information system with limited integration into the broader health information infrastructure.

The RIPS (Individual Registry of Health Service Provision) captures service utilization data at the encounter level, with patient identifiers that enable longitudinal follow-up across healthcare contacts. While it constitutes an important source of routine health information, it does not systematically incorporate cost data for preventive care and remains underutilized for decision-making.

The regional validation workshop reinforced several of these findings. Participants emphasized that advancing financing policies and integrated care requires not only technically sound proposals but also stronger conditions for implementation. A demand-oriented approach should be accompanied by stronger social participation, so that policies can be implemented, improved, and monitored over time.

[1] The High-Cost Account (Cuenta de Alto Costo, CAC) is a technical entity within the Colombian health system that collects, consolidates, analyzes, and disseminates information on high-cost diseases defined by the Ministry of Health and Social Protection. Its purpose is to generate high-quality statistical evidence to support disease monitoring, risk management, health decision-making, and public policy formulation.

Experiences such as Brazil's health councils and greater social involvement in childhood cancer were highlighted as examples that could inform broader participation strategies. Participants also noted that policies may be conceptually sound, but still fail to connect with the actual circuits of care, management, referrals, and service networks. In this regard, effective integration at the primary care level requires prior articulation at central levels of government, planning, and system stewardship. Together, these findings point to a governance model characterized by formal policy development but limited operational integration, where fragmentation, weak coordination, and constrained institutional capacity reduce the effectiveness and sustainability of NCD responses.

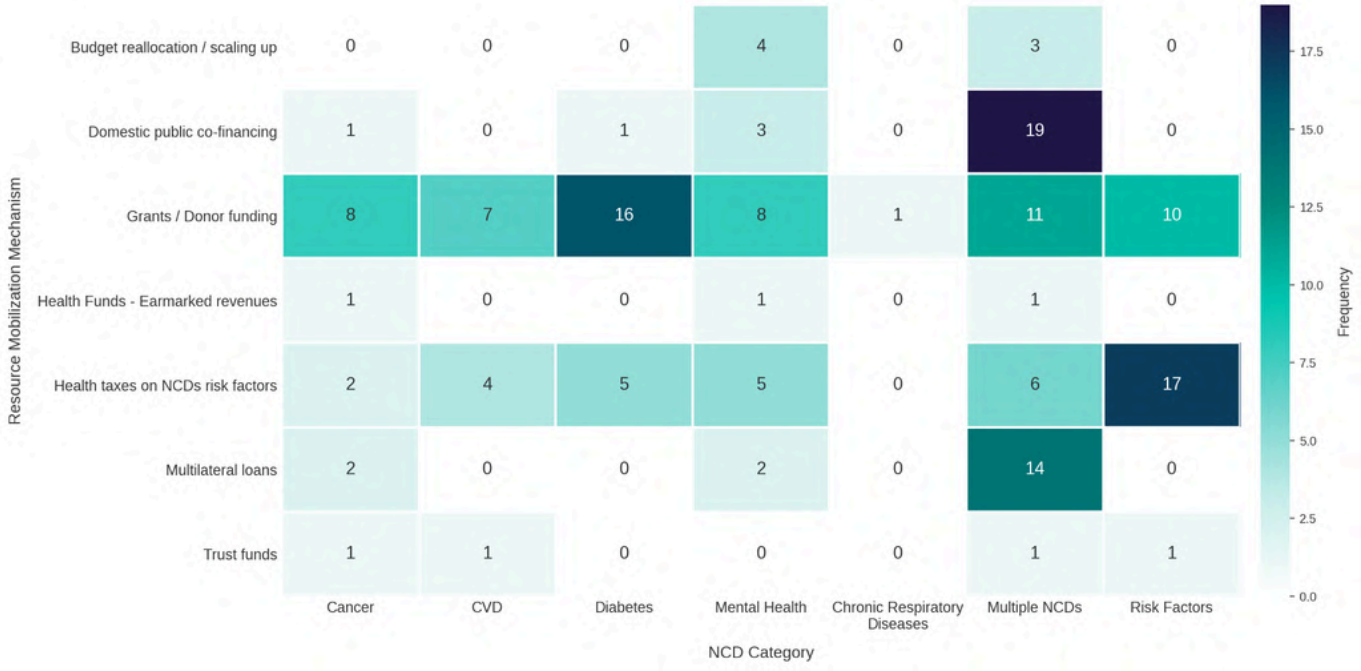
C. Resource mobilization

Resource mobilization refers to the mechanisms through which financial resources are generated to support NCD prevention, treatment, and long-term management, including domestic public funding, domestic private spending, external financing, and fiscal instruments.

Domestic financing and NCD focus

Health financing for NCDs is predominantly from domestic sources, relying on general taxation and social security contributions (Figure 2). Resource mobilization efforts tend to focus on integrated NCD programs and high-burden conditions — particularly CVDs, diabetes, and cancer— often linked to primary care strengthening and service delivery improvements (Figure 3). In contrast, areas such as mental health remain comparatively underrepresented within financing flows.

Figure 3. Source of health financing for NCDs by category



Source: IECS elaboration based on the analyzed data of the desk review.
Note: Cell values represent the frequency of occurrence across reviewed documents. A single document may contribute to multiple NCD categories and mechanisms simultaneously. "Multiple NCDs" refers to financing mechanisms that target NCDs broadly or jointly, without specifying a single disease category.

Health taxes and earmarking

Health taxes are rarely earmarked for health or NCDs. According to the documents reviewed, all countries in the region have implemented at least one health tax on tobacco, alcohol, and SSBs, however, their design and implementation level remains heterogeneous, and revenues are rarely earmarked for health or NCDs (21–24). Nine countries in LAC have legal frameworks regulating the allocation of these revenues to health, and only a subset—such as Paraguay, Jamaica, and Panama—have documented their use for specific NCD-related programs (24,25).

This highlights a significant gap between revenue generation and its targeted use for NCD prevention and control. Even where earmarking mechanisms exist, interviews suggest that the link between revenue generation and actual allocation to NCD services is often weak. Participants of the regional validation workshop also emphasized that health taxes should be considered not only as revenue-generating instruments, but also as public health tools to reduce harmful consumption due to their price elasticity, improve health, and help offset future NCD-related health system costs associated with major NCD risk factors. At the same time, participants noted two important limitations: first, revenues from these taxes do not always flow back to health or NCD programs, even when their primary rationale is health-related; and second, the scale of revenue generated may be insufficient to address the health and economic consequences of harmful consumption, regardless of whether funds are earmarked.

> ***"Often, those funds remain within ministries of finance and are not directly reallocated to health."***
>
> – NGO representative

As a result, their potential as a sustainable financing source remains underutilized and not widely institutionalized across the region, except for a few examples, such as Jamaica's National Health Fund (NHF) (see Box 1).

Box 1. Jamaica's National Health Fund: financing NCDs through earmarked taxes

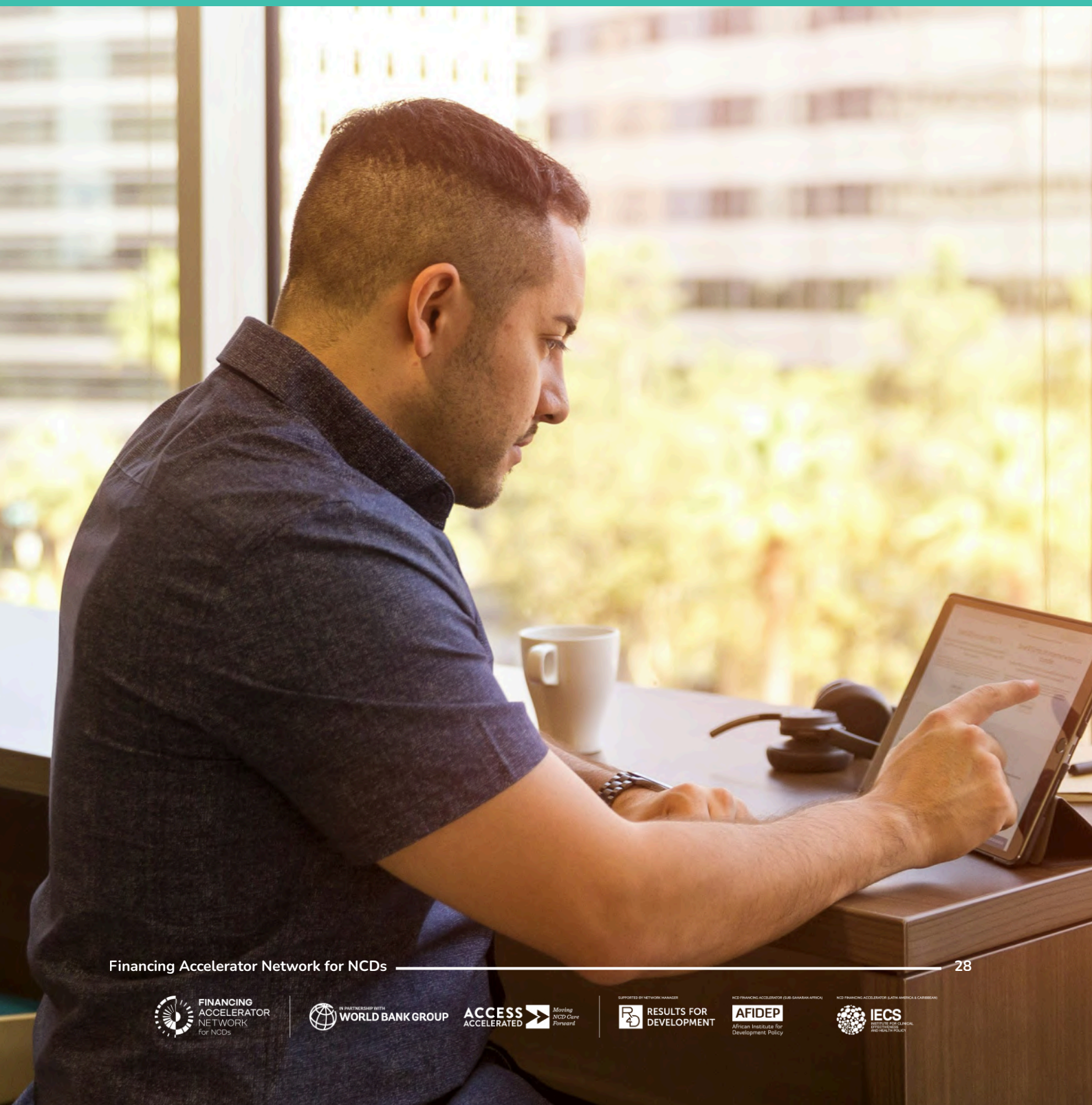
Jamaica's NHF is a public financing mechanism established in 2003 to improve access to care and financial protection for NCDs (26,27). It is financed through a combination of earmarked and general revenue sources. Notably, 20% of the Special Consumption Tax on tobacco products is allocated to the Fund, complemented by revenues from alcohol taxes and payroll-based contributions (28). These resources support the procurement and subsidization of essential medicines for chronic conditions, as also noted by one civil society stakeholder: *"The National Health Fund, financed in part by tobacco taxes, supports the procurement of essential medicines."*

Resources are primarily allocated to subsidizing prescription medicines for a defined set of chronic conditions—including CVDs, diabetes, and cancer—significantly reducing OOP expenditures and improving access to treatment (26,27). The Fund also supports health promotion activities, public health programs, and investments in service delivery (26).

The NHF illustrates how fiscal instruments can be linked to health financing, channeling revenues from health risk factors toward NCD services. Its impact depends on sustained institutionalization and integration within broader health system arrangements.

Dedicated funds and earmarked mechanisms

Dedicated health funds and earmarked revenues remain relatively uncommon, although existing experiences —such as cancer funds or earmarked tax revenues in Chile (20) and Mexico (24) — illustrate their potential to channel resources toward specific interventions, with effectiveness depending on the degree of institutionalization and sustained allocation of resources.



External financing and concessional loans

External financing largely plays a complementary role. Donor funding and concessional loans emerge as the most frequently documented external financing mechanisms, particularly in the Caribbean, including Barbados, Jamaica, Suriname, Dominican Republic, Saint Kitts and Nevis, Saint Lucia, Trinidad and Tobago, Antigua and Barbuda, Anguilla, Belize, Guyana, Saint Vincent and the Grenadines, where reliance on international cooperation is greater (17–22). The main external financiers identified include the IADB, the World Bank, regional development banks, United Nations agencies, philanthropic organizations, bilateral cooperation agencies, and specialized global partners.

Even when concessional loans from multilateral organizations—such as the World Bank or the IADB - are present, they are typically integrated into national budgets and directed toward specific investments—such as infrastructure, service delivery networks, or information systems—rather than recurrent expenditures.

> *"Especially for chronic diseases, virtually all funding comes from the national government. For information systems and strengthening primary care, there have been loans from development banks. Often, external financing from these banks is primarily related to infrastructure improvement."*
>
> – Academic representative

Overall, resource mobilization for NCDs in LAC is characterized by reliance on domestic funding and limited use and weak earmarking of fiscal instruments. These structural features limit the capacity of countries to scale up and sustain comprehensive responses to NCDs. Participants of the regional validation workshop emphasized that strengthening the financing traceability and coordination of international financing architecture can be pathways to improve efficiency, service delivery, and health outcomes along with monitoring of country-level initiatives.

D. Risk and Fund Pooling

Risk and fund pooling refers to the mechanisms through which financial resources are aggregated and redistributed across the population to spread financial risk and improve financial protection.

Pooling is frequently characterized by fragmentation. Multiple insurance schemes, parallel subsystems, devolution, and segmented financing structures limit the ability to consolidate resources into unified risk pools. This fragmentation cuts across multiple dimensions — between public and private sectors, between social security and subsidized schemes, and across subnational levels of government — and limits effective risk pooling, meaning that formal coverage does not always translate into real financial protection. As highlighted in the regional validation workshop, the concrete cost of this fragmentation includes duplication of efforts, inefficiency, and weakened financial protection, in addition to reducing cross-subsidization and the system's capacity to provide equitable financial protection across population groups.

A point raised during the regional validation workshop was that fragmentation is not uniform across countries. Participants distinguished between deregulated fragmentation, characterized by multiple pools with limited coordination or risk compensation, and more regulated forms of fragmentation. This distinction is important because the problem is not only the number of pools, but whether mechanisms exist to coordinate them, compensate risks, and protect people financially.

> ***"Our country has such a high level of fragmentation that, no matter how much effort you put into funding a government or a national program that supports provinces, you will only impact a portion of that 40%. The other 60% is within social security schemes that lack a public health perspective. What this system is missing is integration. As it stands, it's impossible."***
>
> – Academic representative

As a result, the existence of formal coverage does not necessarily translate into effective financial protection. A substantial share of NCD-related costs continues to be borne by individuals, particularly for medicines and timely access to care. This reflects gaps in service availability, supply chains, and the effective implementation of coverage guarantees.

Across the region, pooling experiences are frequently organized around a defined benefit package, with risk pools structured to finance integrated coverage for multiple NCDs rather than single conditions. Chile's AUGE scheme illustrates this approach, pooling resources to cover a broad set of conditions ranging from hypertension and depression to bone marrow transplantation, while Uruguay's National Health Fund (Fondo Nacional de Salud, FONASA) pools resources to finance the Comprehensive Health Care Plan (Plan Integral de Atención en Salud, PIAS) covering prevention, control, and broader health activities. Other pooling arrangements are organized around more targeted benefit packages for high-cost conditions, such as Uruguay's National Resources Fund (Fondo Nacional de Recursos, FNR) for high-cost low-prevalence treatments, Ecuador's dedicated cancer fund, and renal care coverage schemes. However, the scope of these pooled arrangements appears limited, which may contribute to high OOP spending in several countries.

Insurance was a common pooling mechanism present in most countries, typically through public insurance schemes, social security systems, or mixed models. These arrangements define coverage entitlements and benefit packages for NCDs, contributing to the expansion of formal access to care. However, the desk review, the regional validation workshop, and KIIs indicate that pooling remains the least developed and documented health financing function in the region. The pooling arrangements documented in the review were limited to a relatively narrow set of institutional mechanisms. More broadly, fragmentation across schemes, institutions, and levels of government limits effective risk redistribution and weakens financial protection, particularly for low-income and underserved populations.

The extent to which pooling arrangements can effectively redistribute risk and strengthen financial protection depends on the regulatory framework, institutional capacity, information systems, and coordination mechanisms available within each health system.

The available evidence from reviewed documents, KIIs, and the regional validation workshop suggests that more consolidated experiences are observed in countries such as Chile (see Box 2) and Argentina, where pooling is embedded within broader health system structures. In contrast, in other contexts such as Santa Lucia, pooling mechanisms appear to be more limited in scope or linked to specific programs such as the health system strengthening program focused on improving accessibility and responsiveness of key health services, reflecting differences in institutional capacity and system organization.(29)

Box 2. Guaranteed benefit packages and financial protection: Chile's AUGE-GES system

Chile's Explicit Health Guarantees system (AUGE-GES) is a statutory benefits scheme that secures **access, quality, timeliness, and financial protection** for a defined set of prioritized conditions across both public and private insurance schemes. Under AUGE-GES, all Chileans, regardless of type of insurance coverage, are guaranteed access to services for 90 priority health conditions, including all NCDs considered in this report.(30)

GES represents a shift from **nominal coverage to enforceable guarantees,** improving access and financial protection while strengthening the role of **primary care and referral systems.** It illustrates how **pooling arrangements, when combined with explicit entitlements,** can support more equitable and coordinated care. Evidence suggests a pro-poor pattern in utilization, with higher use of services among lower-income groups after the AUGE-GES reform.(31) However, remaining gaps for services not covered under AUGE-GES—such as coverage limitations for certain populations or conditions—highlight the challenges of **extending these guarantees more broadly.**

E. Strategic Purchasing of Essential Services

Strategic Purchasing refers to the decisions and mechanisms through which pooled resources are allocated to providers to maximize efficiency, equity, quality of care, and health outcomes. It involves defining what services are financed, from whom they are purchased, and how providers are contracted, paid, monitored, and held accountable (32).

In this context, fragmentation in purchasing refers to the distribution of purchasing responsibilities across multiple institutions. In fragmented health systems, ministries of health, social security institutions, public insurers, subnational governments, and other schemes may define benefits, contract providers, procure medicines, or set payment arrangements through partially coordinated or parallel mechanisms. This institutional dispersion can limit alignment across benefit design, provider payment, procurement, monitoring, and accountability.

There is evidence of a gradual shift from passive, input-based financing toward more explicit and performance-oriented purchasing arrangements. However, this transition remains uneven, fragmented, and constrained by broader systemic factors.

A central feature of this shift is the growing adoption of explicit benefit packages and prioritization mechanisms, which define what services should be purchased and delivered. Systems such as Chile's AUGE-GES establish legally guaranteed access to priority conditions, linking financing to service provision. Similarly, Colombia's High-Cost Account supports the management of chronic conditions through systematic data collection, monitoring, and benchmarking, strengthening accountability in resource allocation.

Despite these positive examples, the existence of formal entitlements does not necessarily translate into effective access. KIIs and workshop discussions pointed to persistent challenges in translating legal guarantees, benefit packages, and other formal coverage arrangements into actual service delivery, particularly where access conditions, provider capacities, information systems, monitoring arrangements, and accountability mechanisms remain weak or fragmented. As highlighted by one key informant, "in practice, for most spending, there remains a disconnect with outcomes" (Government representative). Participants of the regional validation workshop emphasized that this disconnect is reinforced by fragmented information systems, low-quality records, limited trained personnel for monitoring, weak accountability mechanisms, and the absence of adequate agreements or legal frameworks to support outcome-oriented purchasing.

Countries are introducing provider payment mechanisms aimed at aligning incentives with service delivery goals. Capitation is used in some countries such as Argentina and Colombia, for primary health care (PHC) to promote continuity and risk

management, often combined with other payment methods—such as fee-for-service, bundled payments, or Diagnostic Related Group (DRG)—at higher levels of care. While this reflects attempts to adapt financing to different service needs, it can also create misaligned incentives across levels of care, particularly for chronic conditions that require coordinated, long-term management.

During the regional validation workshop, participants suggested expanding the analysis of capitation in primary health care (PHC) and evidence-based benefit package design at the first level of care, given their relevance for aligning financing with continuity, coordination, and prevention in chronic care. They also suggested considering disease-specific legal frameworks, such as Chile's cancer law, to assess whether and how such instruments can contribute to more predictable financing and coverage for NCDs.

International and regional actors have also supported the design of NCD policy frameworks, national strategies, and implementation tools in the region. HEARTS in the Americas illustrates this role in relation to PHC-based CVD prevention and hypertension control. The initiative currently supports implementation in 34 countries and territories[2] across the region by promoting standardized treatment protocols, improving access to essential medicines and devices, and strengthening PHC systems, although implementation remains uneven across the region (36)(18).

> ***"We began to observe that in 2019 the country had signed on to the HEARTS strategy as an important strategy to implement. With the pandemic, nothing had been done. In 2021, we took up the HEARTS strategy and began to see it as an important approach at the primary care level for the two main conditions: hypertension and diabetes. We started to identify opportunities through primary care, entering through the prevention pathway. We designed a programme with free medication delivery, adapting the HEARTS strategy to our reality and our context."***
>
> – Dominican Republic key informant

Performance-based financing (PBF) mechanisms are present but generally limited in scope and scale (See Box 3), often implemented through specific programs or pilots rather than embedded within system-wide purchasing strategies.

> ***"Pay-for-performance is often seen as the solution to these issues; however, it is almost always fragmented, and in the end, you pay by program rather than for system performance. What you don't want are disease-oriented systems—you want health systems."***
>
> – NGO staff member

[2] Angulla, Antigua y Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Bermuda, British Virgin Islands, Chile, Colombia, Costa Rica, Cuba, Dominica, República Dominicana, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Mexico, Monserrat, Panamá, Perú, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, Venezuela.

For example, reforms in countries such as Mexico, Brazil, and Argentina have introduced performance-linked payments in specific contexts; these mechanisms can link financing to service delivery outputs and coverage expansion but these experiences remain fragmented and have not yet been consolidated into system-wide approaches.

Box 3. Blended payment models and performance incentives: Argentina's SUMAR Program

Argentina's SUMAR Program (originally launched as Plan Nacer in 2004) is a national initiative sponsored by the World Bank that combines **capitation-based financing with performance-linked incentives** tied to the delivery of prioritized health services and predefined indicators. The financing model combines a monthly capitation payment (60%) with a performance-based component (40%) linked to tracer results paid directly to the national network of 8,000 PHC centers. Over more than 20 years, the program has expanded to all 24 provinces, originally targeting mothers and children, the program evolved to cover the whole uninsured population, incorporating six new indicators for tracer conditions related to NCDs, including cancer screening and hypertension and diabetes follow-up.(33)

More than 17 million people with exclusive public coverage have been registered (40% of the Argentine population), and around 8 million receive at least one quality health service each year. In 2024, the program was renamed SUMAR+, integrating the Proteger and Redes de Salud programs, oriented to NCD prevention and control in provincial public health systems.

The program illustrates how strategic purchasing mechanisms can link financing to service delivery within a federal health system. However, sustaining and scaling performance-linked approaches across fragmented health systems still remains an ongoing challenge.

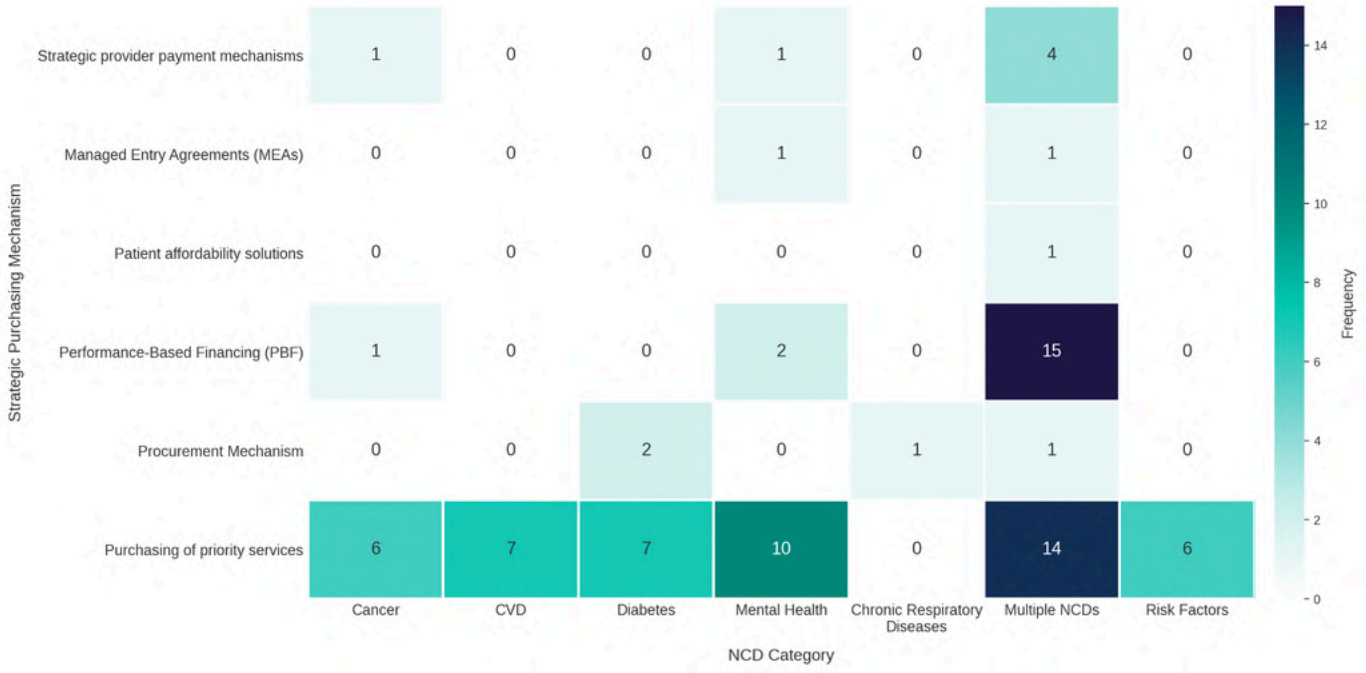
Centralized or pooled procurement mechanisms—such as the PAHO Revolving and Strategic Funds—enable countries to aggregate demand and negotiate lower prices, improving affordability and supply stability for chronic disease management. However, their effectiveness depends on institutional and regulatory frameworks, as well as coordination across levels of government. At the country level, Chile's Central de Abastecimiento (Cenabast) (34) provides an example of a centralized public procurement agency responsible for supplying medicines and clinical supplies to the national health services network and other public-sector institutions.

Participants of the regional validation workshop suggested that experiences such as Cenabast, as well as maximum prices and other price-setting or negotiation tools, should be further considered within insurance and procurement systems, particularly for high-cost medicines and technologies, which were highlighted as a growing challenge. In this context, Chile's Ley Ricarte Soto (35) provides an example of a dedicated national mechanism to expand financial protection for selected high-cost diagnoses and treatments, although it is not limited to NCDs. They also raised concerns about the budgetary pressure associated with new high-cost medicines, and emphasized the need to negotiate more effectively with manufacturers and use public purchasing power more strategically, especially where procurement remains fragmented across municipalities, states, or other subnational levels. Participants also called for stronger evidence on the implications of these technologies for health expenditure, financial protection, and population health.

Based on the overall analyzed data, strategic purchasing mechanisms appear unevenly distributed across NCD areas. The mapped examples and qualitative findings suggest that most documented efforts relate to CVDs, diabetes, and cancer, while mental health appears less developed in terms of strategic purchasing, with fewer identified financing mechanisms and continued reliance on input-based arrangements (Figure 4).

Compared with revenue mobilization and pooling, strategic purchasing was the financing function for which the analysis identified the most concrete mechanisms and country examples in LAC. According to the literature revision and the workshop discussions, these mechanisms remain unevenly implemented and are not consistently linked to monitoring, accountability, and long-term outcomes. Strengthening the role of purchasing will require better integration across financing functions, stronger information systems, greater monitoring and follow-up capacity, and clearer accountability arrangements. As noted by key informants, a persistent disconnect between purchasing decisions and health outcomes remains a central challenge, underscoring the need to move beyond process indicators toward outcome-oriented purchasing arrangements.

Figure 4. Frequency of Strategic Purchasing by NCD Category



Source: own elaboration based on the analyzed data of the desk review.
Note: Cell values represent the frequency of co-occurrence across reviewed documents. A single document may contribute to multiple NCD categories and mechanisms simultaneously.

Conclusions

The findings of this report point to a structural mismatch between the growing burden of NCDs and the way health financing systems are organized in LAC. Across the desk review, KIIs, and regional validation workshop, NCDs are widely recognized as a health and financial challenge and as a policy priority, yet this recognition does not consistently translate into sustained financing, effective implementation, or long-term system alignment. In addition, financing flows related to NCDs are difficult to trace within broader budget envelopes. The central challenge identified is therefore not only the magnitude of available resources, but how financing is structured, coordinated, tracked, and translated into effective service delivery.

Across financing functions, progress is uneven. Resource mobilization is predominantly domestic and constrained by limited fiscal space, while there are promising strategic purchasing practices, particularly through explicit benefit packages, performance-linked payment mechanisms, and some centralized procurement strategies. By contrast, pooling mechanisms remain the least documented and are frequently affected by fragmentation across schemes, institutions, and levels of government. These constraints are especially problematic for chronic conditions that require continuous, long-term, and integrated care.

Importantly, many of the key instruments and enabling mechanisms needed to strengthen NCD financing are already in place across the region, including health taxes, strategic purchasing mechanisms, PHC-based integrated care approaches such as HEARTS, and health information systems.

However, these efforts remain fragmented, unevenly implemented, and insufficiently institutionalized, limiting their potential to drive system-wide transformation. This suggests that the core challenge is not the absence of promising tools or experiences, but rather the lack of integration, continuity, and scale.

Gaps

Based on the triangulation of findings from the desk review, KIIs, and regional validation workshop, the analysis identifies a set of cross-cutting structural and operational gaps that continue to limit the ability of health financing systems to respond effectively to NCDs:

- **Uneven development across financing functions**, with more visible progress in strategic purchasing than in pooling, and persistent weaknesses in implementation capacity and institutional continuity
- **Fragmented pooling arrangements**, limiting effective risk redistribution and financial protection
- **Limited traceability of health financing for NCDs**, constraining visibility, accountability, and strategic planning
- **Misalignment between financing and service delivery**, particularly for chronic care pathways that require continuity and coordination
- **Underinvestment in prevention**, with spending and policy attention concentrated on curative and high-cost interventions
- **Weak and underutilized information systems**, limiting monitoring, decision-making, and accountability.

Entry points for action

Given the structural and systemic nature of the challenges identified, progress is unlikely to result from comprehensive reform alone. Instead, countries and relevant stakeholders may benefit from identifying practical and context-specific entry points that allow for incremental but sustained improvements in how resources are raised, pooled, and allocated for NCDs.

Potential entry points include:

- **Improving the traceability of NCD expenditure** within existing budgets, including evidence on financing gaps by condition and the costs of fragmentation, to strengthen planning, prioritization, and accountability
- **Making better use of fiscal instruments linked to health objectives,** including opportunities to better connect mechanisms of funding, disbursement, and payment with NCD priorities such as health taxes, results-based schemes, or pay-for-performance.
- **Documenting government-led management case studies** to support learning and scale-up of successful health financing for NCDs initiatives.
- **Reinforcing financial protection for chronic conditions,** especially where fragmentation and out-of-pocket spending continue to undermine access.
- Strengthening selected components of strategic purchasing, particularly where benefit design, provider payment, or procurement mechanisms can be better aligned with chronic care needs
- Investing in PHC and primordial, primary, and secondary prevention, shifting attention from reactive and high-cost responses toward more proactive and continuous integrated models of chronic care prevention and control, including health promotion and civic education.
- Enhancing the use of information systems and technical capacity for decision-making, including electronic health records, interoperability, and a regional set of health financing for NCDs indicators covering financial, epidemiological, disease burden, and outcome dimensions.
- Reviewing, documenting, and strengthening existing regional and country-level initiatives with potential for scale, including mechanisms already supported by PAHO/WHO or other regional partners, rather than creating parallel structures. This should include government-led case studies and lessons on how successful initiatives were implemented, adapted, sustained beyond political transitions, and integrated into routine health system financing.
- Strengthening regional planning for procurement, regulation, price negotiation, and technology transfer, particularly for medicines, supplies, and high-cost technologies including tools to support price negotiation, shared information, and regional mapping of production capacity and priority needs.
- Strengthening sustainability mechanisms so that successful initiatives can survive political transitions and be integrated into routine health system financing.

In highly fragmented settings, such targeted actions may offer a more feasible path toward broader system strengthening than pursuing comprehensive reforms from the outset.

Looking ahead, the evolution of health financing for NCDs in LAC will depend less on the introduction of entirely new instruments than on countries' ability to better integrate, institutionalize, and scale those that already exist. The findings of this report suggest that future progress will depend not only on mobilizing additional resources, but also on strengthening coordination across financing functions, improving institutional continuity, and aligning financing decisions more closely with long-term health outcomes and impact. In this sense, the challenge ahead is not simply to do more, but to organize existing efforts in ways that are more coherent, sustainable, and responsive to the long-term nature of chronic conditions.

Role of FAN

In light of these findings, FAN is well positioned to support countries and relevant stakeholders in addressing several priority challenges identified in this report, particularly weak traceability of health financing for NCDs, fragmented financial protection arrangements, uneven implementation of strategic purchasing, underused information systems, and promising initiatives that remain difficult to scale. FAN's value is likely to lie in connecting country-led problem identification, targeted analytical work, peer learning, catalytic funding, and regional partnerships to support more sustainable health financing for NCDs responses.

This contribution could be articulated through three complementary functions:

- FAN Foresight: supports countries in identifying and understanding financing bottlenecks, expenditure patterns, fiscal space opportunities, implementation barriers, and financing gaps for NCDs. It could also help strengthen sustainable health financing planning and budgeting, develop performance monitoring systems, improve expenditure traceability, and use data to inform financing decisions.
- FAN Forum: facilitates exchange across countries facing similar challenges, with a focus on practical lessons related to revenue mobilization, pooling, purchasing, financial protection, and the use of data for decision-making. This could include documenting and sharing country experiences with NCD prevention financing, pooled procurement, regulated pooling arrangements, performance-linked payment mechanisms, and implementation lessons from initiatives such as AUGE-GES, SUMAR, HEARTS, and Jamaica's National Health Fund.
- FAN Fund: provides catalytic financial support for country-led selected initiatives that test, adapt, evaluate, or scale promising health financing for NCDs mechanisms, including strategic purchasing, information systems, expenditure tracking, financial protection, and performance monitoring approaches.

Together, these interconnected functions can help bridge a gap repeatedly identified in this report: the distance between recognizing health financing for NCDs challenges and implementing more integrated and scalable responses.

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Appendix 1

Taxonomy

Taxonomy of NCD Financing Mechanisms

Resource Mobilization

*Mechanisms to generate resources for health | **Objective:** Generate additional resources for NCD programs*

Mechanism	Definition
Multilateral loans	Loans from multilateral development banks used to finance health programs or system investments.
Grants / Donor funding	Non-repayable funding from international organizations, governments, or foundations supporting health programs.
Trust funds	Dedicated funds created by multiple contributors to finance specific health priorities.
Domestic co-financing of externally funded initiatives	Domestic public contributions mobilized alongside external financing to support health or NCD programs and investments.
Blended finance	Financing that combines public, philanthropic, and private capital to mobilize additional investment for health initiatives.
Debt-based instruments	Mechanisms that convert or restructure public debt into investments in health programs.
Health taxes on NCD risk factors	Excise taxes on products linked to NCD risk factors such as tobacco, alcohol, or sugary drinks.
Dedicated health funds / earmarked revenues	Public revenues allocated specifically to health programs through earmarked taxes or funds.
Budget reallocation / scaling-up	Policy decisions to increase financing for health or NCD priorities through the expansion or reallocation of domestic public budgets.

Risk and Fund Pooling

Mechanisms that aggregate resources and distribute financial risk | ***Objective:*** *Expand financial protection and coverage*

Mechanism	Definition
Public insurance / statutory coverage	Public insurance programs that pool resources to provide health coverage to the population.
Complementary insurance	Insurance that covers services not fully included in the main public system.
Community-based insurance	Voluntary insurance schemes organized at the community level to share healthcare costs.
Digital insurance innovation (Insurtech)	Insurance mechanisms using digital platforms for enrollment, payments, or claims.
Financial protection schemes	Programs designed to reduce out-of-pocket spending for healthcare.

Strategic Purchasing of Essential Services

Mechanisms that determine how resources are allocated to services and providers | ***Objective:*** *Improve efficiency and access to NCD services*

Mechanism	Definition
Performance-Based Financing (PBF)	Payments to providers linked to achieving predefined health indicators or results.
Procurement Mechanism	Mechanisms used by governments or health systems to purchase medicines, medical devices, or health technologies more efficiently, such as pooled procurement, centralized purchasing, or joint purchasing arrangements.
Managed Entry Agreements (MEAs)	Agreements between payers and pharmaceutical companies linking payment to outcomes or financial conditions.
Strategic provider payment mechanisms	Reforms in provider payment systems to improve efficiency or quality.
Patient affordability solutions	Financial mechanisms designed to reduce costs faced directly by patients.
Purchasing of priority services	Targeted purchasing of health services based on public health priorities.

FINANCING ACCELERATOR NETWORK for NCDs

The Financing Accelerator Network for NCDs (FAN) is a transformative initiative established via a technical partnership between Access Accelerated and the World Bank, in close cooperation with Results for Development, to build a growing coalition of global and local organizations in support of improving sustainable financing for NCDs in LMICs.

FAN operates through regionally based NCD Financing Accelerators that support governments and local stakeholders with technical support, cross-country learning, and catalytic seed funding to advance local NCD financing programs, with the African Institute for Development Policy as host of the inaugural accelerator in SSA.

This initiative aligns with and will support the World Bank's goal to provide quality health services to 1.5 billion people by 2030 as well as Access Accelerated's mission to drive scalable, sustainable progress on NCDs as part of UHC.

Learn more at: www.ncdfinancing.org

FINANCING ACCELERATOR NETWORK for NCDs

IN PARTNERSHIP WITH WORLD BANK GROUP

ACCESS ACCELERATED Moving NCD Care Forward

SUPPORTED BY NETWORK MANAGER RESULTS FOR DEVELOPMENT

NCD FINANCING ACCELERATOR (SUB-SAHARAN AFRICA) AFIDEP African Institute for Development Policy

NCD FINANCING ACCELERATOR (LATIN AMERICA & CARIBBEAN) IECS INSTITUTE FOR CLINICAL EFFECTIVENESS AND HEALTH POLICY