Health at a Glance: Latin America and the Caribbean 2026



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Foreword

Latin America and the Caribbean has made important progress in expanding health coverage and improving population health over recent decades. The region now faces a more demanding phase: turning coverage into care that is effective, high-quality, equitable and financially sustainable. Countries across the region are confronting a more complex health landscape, shaped by non-communicable diseases, population ageing, persistent infectious threats, and environmental and climate-related risks. These pressures are hitting health systems still constrained by low spending, high out-of-pocket payments, fragmented coverage, workforce shortages, and uneven infrastructure and digital capacity. Countries need to spend more, but also spend better: improving quality and equity while preserving affordability and long-term sustainability. These challenges are not felt equally. Inequalities in income, geography, education, ethnicity and other social determinants continue to shape who becomes ill, who receives timely and good-quality care, and who faces financial hardship when seeking treatment. This publication shows that national averages often hide large gaps in risks, access, quality, financial protection and outcomes. Making these gaps visible is a necessary step towards making them actionable.

This third edition of *Health at a Glance: Latin America and the Caribbean* highlights this shift. It brings together comparable evidence on health status, determinants of health, health data and health system infrastructure, expenditure and financing, quality of care, the health workforce, and ageing across 33 countries. It also includes two thematic chapters on issues that are central to the region's current policy agenda: healthcare quality, and inequalities in health and healthcare. The value of the *Health at a Glance* series lies not only in assembling these data, but in presenting them in a consistent and accessible way, allowing countries to benchmark progress and learn from variation across health systems. A distinctive feature of this report is that it places Latin America and the Caribbean in dialogue with one another and with OECD health systems. These comparisons are not rankings or a single model to emulate; they are a structured way to identify gaps and draw lessons from systems facing similar pressures related to ageing, chronic disease, quality improvement, digital transformation and financial sustainability.

A common message emerges across these analyses: many countries in the region have built the foundations of broader access, but the next generation of reform must focus on quality. Quality is a system-wide agenda, spanning governance, regulation, patient safety, evidence-based care, workforce capability, data systems, financing incentives and integrated, people-centred services, with the needs of underserved populations in mind.

At a time of tight fiscal constraints and rising demand for care, better policy choices depend on better evidence. By combining robust indicators with policy analysis, this publication aims to support governments, practitioners and researchers in identifying priorities, benchmarking progress, and learning from experiences across the region. The evidence presented here can help countries ask not only how to mobilise more resources for health, but also how to use them better.

The OECD, the Inter-American Development Bank and the World Bank are pleased to collaborate on this third regional edition. Together, they aim to support countries in using data and policy dialogue to advance reforms that are technically sound, financially realistic and responsive to people's needs. We hope this report will contribute to informed policy dialogue and to the shared effort of building health systems in Latin America and the Caribbean that are not only broader in coverage, but stronger in quality, fairness and sustainable over time.

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Reader's guide

Health at a Glance: Latin America and the Caribbean 2026 is a joint publication by the Organisation for Economic Co-Operation and Development (OECD), the Inter-American Development Bank (IDB) and the World Bank (WB). This report was co-ordinated by Frederico Guanais and Nicolas Larrain from the OECD, Sebastian Bauhoff from the IDB and Cristian A. Herrera, Nicole Feune de Colombi and Jeremy Veillard from the WB. Chapter 1 was co-authored by Nicole Feune de Colombi, Cristian A. Herrera, Denizhan Duran, Renzo Calderon and Jeremy Veillard from the WB and Niek Klazinga and Nicolás Larraín from the OECD. Chapter 2 was co-authored by Sebastian Bauhoff, William Savedoff and Laura Goyeneche from the IDB and Ángel González from the OECD. Chapters 3 to 9 were co-authored by Ángel González, Frederico Guanais, Nicolas Larrain and Berta Piqué-Smith from the OECD. The authors would like to thank Mark Pearson, and Francesca Colombo from the OECD Directorate of Employment, Labour and Social Affairs, Javier Guzman and Ferdinando Regalia from the Inter-American Development Bank and Michele Gragnolati and Jaime Saavedra from the World Bank.

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Structure of the publication

Health at a Glance: Latin America and the Caribbean 2026 is divided into nine chapters:

Chapter 1 on ***Quality of care in Latin America and the Caribbean*** examines the policy and institutional arrangements that shape healthcare quality in 19 countries. It is structured around six domains: governance, external assurance, evidence-based care, workforce capability, patient safety, and integrated and people-centred care. Drawing on internationally comparable indicators and a dedicated OECD policy survey on quality of care, the chapter provides a detailed stocktake of regulatory, measurement and financing arrangements, and identifies policy options to support more resilient, equitable and high-performing health systems.

Chapter 2 on ***Inequalities in health and healthcare*** analyses persistent gaps across population groups in exposure to health risks, access to and quality of care, financial protection and health outcomes, by income, education, place of residence, ethnicity, gender, age, migration status, disability and health system affiliation. Drawing on regional evidence, a dedicated OECD policy survey, and additional country profiles compiled by the OECD Secretariat, it reviews how countries are responding through policies on governance, financing, service delivery, workforce, digital health, data systems and emergency preparedness.

Chapter 3 on ***Health status*** highlights variations across countries in life expectancy at birth and survival to age 65, infant and neonatal mortality, under-five and adolescent mortality, and all-cause mortality, as well as the leading specific causes of death and morbidity – including cardiovascular diseases, cancer, injuries, maternal mortality, mental health, tuberculosis, mosquito-borne diseases and diabetes.

Chapter 4 on ***Determinants of health*** focusses on non-medical determinants of health. It features family planning, child malnutrition, and adolescent health, together with lifestyle and behavioural indicators such as overweight and obesity in adults, diet and nutrition, and tobacco use. It also covers water and sanitation, road safety, and environmental and climate risks.

Chapter 5 on ***Health data and health system infrastructure*** reviews the availability, digitalisation and interoperability of patient care data, including the use of electronic health record systems and patient access to their own information, alongside countries' capacities for the secondary use of data. It then presents indicators on the infrastructure and provision of services for hospital care, pregnancy and birth, and child healthcare.

Chapter 6 on ***Health expenditure and financing*** examines trends in health spending across LAC countries. It looks at how health services and goods are paid for, and the mix between government and compulsory insurance schemes, voluntary private schemes, direct out-of-pocket payments by households and external resources. It also assesses financial protection, including the share of household consumption absorbed by out-of-pocket and voluntary health spending.

Chapter 7 on ***Quality of care*** builds on the OECD Health Care Quality and Outcomes (HCQO) framework to examine the performance of health systems across LAC. It covers avoidable mortality (preventable and treatable), childhood vaccination coverage, avoidable hospital admissions for chronic conditions, in-hospital case fatality after acute myocardial infarction and stroke, cancer care outcomes, and patient safety and safe prescribing, including antimicrobial consumption.

Chapter 8 on ***Health workforce*** examines the supply of doctors, nurses and midwives, as well as allied health professionals such as dentists, pharmacists and physiotherapists. It also covers community health workers and environmental and occupational health personnel, and reports on the output of medical and nursing graduates and the stock of LAC-trained doctors and nurses working in OECD countries.

Chapter 9 on ***Ageing*** exhibits the demographic trends in LAC, both current and projected, as well as life expectancy and healthy life expectancy at age 60. Long-term care is also highlighted, with indicators on the drivers of care needs and system response, paid and unpaid caregivers, caregiver training and time burden, and mortality due to Alzheimer's disease and other dementias.

Latin America and the Caribbean countries

For this third edition of *Health at a Glance: Latin America and the Caribbean 2026*, 33 regional countries were included as seen in Table 1. Countries were selected based on their geographical location to either Latin America or the Caribbean, and if they are sovereign states.

Table 1. Latin American and Caribbean countries included and their ISO codes

Country	ISO Code	Country	ISO Code
Antigua and Barbuda	ATG	Guyana	GUY
Argentina	ARG	Haiti	HTI
Bahamas	BHS	Honduras	HND
Barbados	BRB	Jamaica	JAM
Belize	BLZ	Mexico	MEX
Bolivia	BOL	Nicaragua	NIC
Brazil	BRA	Panama	PAN
Chile	CHL	Paraguay	PRY
Colombia	COL	Peru	PER
Costa Rica	CRI	Saint Kitts and Nevis	KNA
Cuba	CUB	Saint Lucia	LCA
Dominica	DMA	Saint Vincent and the Grenadines (St. Vincent and the Grenadines)	VCT
Dominican Republic	DOM	Suriname	SUR
Ecuador	ECU	Trinidad and Tobago	TTO
El Salvador	SLV	Uruguay	URY
Grenada	GRD	Venezuela	VEN
Guatemala	GTM		

Selection and presentation of indicators

The indicators have been selected based on being relevant to monitoring health systems performance, considering the availability and comparability of existing data in the LAC region. The publication takes advantage of the routine administrative and programme data collected by the World Health Organization, the World Bank Group, and the OECD, as well as special country population surveys collecting demographic and health information.

The indicators are presented in the form of easy-to-read figures and explanatory text. Each of the topics covered in this publication is presented over two pages. The first page defines the indicator, provides brief commentary highlighting the key findings conveyed by the data, and provides a few key references. On the facing page is a set of figures. These typically show current levels of the indicator and, where possible, trends over time. In some cases, an additional figure relating the indicator to another variable is included. Where an OECD or LAC average is included in a figure, it is the unweighted average of the countries presented, unless otherwise specified. The number of countries included in the regional averages is represented by the number accompanying "OECD" or "LAC" (e.g. LAC15 represents the average of 15 LAC countries with available data).

Limitations in data comparability are indicated both in the text (in the box related to “Definition and comparability”) as well as in footnotes to figures.

Health and health system’s situation can evolve rapidly, arguably even more so in low and middle-income countries than in high-income ones. Therefore, it is important to note that some indicators might not reflect the latest situation for some countries. The authors have collected the latest available data so the landscape depicted in each chapter and section of the publication shows the most updated scenario as possible.

For Chapter 3, on ***Health Status***, mortality data are drawn from two complementary sources: the *WHO Mortality Database*, which is based on measured data and is therefore prioritised, and the *Global Burden of Disease* (GBD) study by the Institute for Health Metrics and Evaluation (IHME), which provides modelled estimates. Where the classification of causes of death is readily comparable between ICD-10 and the GBD cause list, both sources are presented for completeness.

Building on these sources, population denominators used to calculate mortality rates come from the *UN World Population Prospects* (various editions), using mid-year estimates. Mortality rates by age interval are age-standardised for comparability, unless stated otherwise, using a standard population that reflects the 2022 age distribution of the four OECD LAC countries, a structure that is both demographically representative of Latin America and the Caribbean and consistent with OECD reporting. This standard population was also used for non-disease specific indicators in Chapter 7. For sex-specific analysis, age-specific mortality rates are calculated separately for men and women and standardised using the same set of weights.

Indicators from LAC countries that are OECD Member or partner countries

Four LAC countries are OECD Member states: Chile, Colombia, Costa Rica and Mexico. Argentina, Brazil and Peru are currently in the process of accession to the OECD. The OECD average is calculated as the unweighted average of all OECD Member countries with available data for the indicator (not only the four LAC OECD Members: Chile, Colombia, Costa Rica and Mexico), regardless of whether individual country values are displayed in the figure.

Policy surveys informing Chapters 1 and 2

Chapters 1 and 2 draw on two dedicated OECD policy surveys carried out for this edition of *Health at a Glance: Latin America and the Caribbean 2026*. These surveys were designed to complement internationally comparable quantitative indicators with structured information on policy, governance and institutional arrangements across countries.

Chapter 1 draws on the **OECD Health at a Glance Latin America and the Caribbean 2026 Survey of Quality of Care Policies**, administered online between October 2025 and February 2026 to ministry of health officials participating in the publication. Twelve countries responded directly: Argentina, Belize, Brazil, Chile, Colombia, Costa Rica, Ecuador, Grenada, Mexico, Paraguay, Peru and Saint Lucia. The survey covered institutional and policy arrangements to support quality of care, including governance, regulation, workforce certification, accreditation, clinical guidelines, health technology assessment, audit and performance review, financial incentives, patient safety, infection control, patient experience, and selected health data sources and indicators. Additional country profiles were compiled by the OECD Secretariat for the Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Nicaragua and Panama, using public sources and interviews with experts.

Chapter 2 draws on the **Health at a Glance Latin America and the Caribbean 2026 Survey of Inequality and Inequity in Healthcare Policies**, administered online between October 2025 and February 2026 to ministry of health officials participating in the publication. Six countries responded directly: Argentina, Colombia, Costa Rica, Ecuador, Paraguay and Peru. The survey covered how countries address health inequities through policy, governance and operational practice, including laws, strategies, financing arrangements, data collection and disaggregation, monitoring and evaluation, digital health capabilities, targeted interventions for disadvantaged populations, and intersectoral action. Additional country profiles were compiled by the OECD Secretariat for the Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Nicaragua and Panama using public sources and interviews with experts.

Executive summary

Health at a Glance: Latin America and the Caribbean 2026 provides a cross-country assessment of health and health system performance in 33 Latin American and Caribbean (LAC) countries, combining comparable indicators with thematic analysis of priority policy issues. This edition focusses on two connected challenges: improving quality of care and reducing inequalities in health and healthcare.

The first thematic chapter shows that while many LAC countries have quality strategies, regulations and indicators in place, few have the tools to turn them into better care. The second shows that inequalities remain a key barrier to further health gains. Disadvantaged groups face greater health risks, more barriers to timely care, lower quality, weaker financial protection and poorer outcomes.

The seven data chapters document the broader context in which these challenges are unfolding. Overall, the findings point to a clear policy message: LAC health systems need to shift from expanding coverage to improving performance. The region has built important foundations, but the next phase of reform will depend on making systems more effective, equitable and prepared for ageing, chronic disease and future shocks.

The move to achieve universal coverage generated historic gains, which now need to be matched by better quality and more equitable healthcare

- **Health outcomes in LAC continue to improve, but progress is no longer closing the gap with OECD countries.** Life expectancy reached 74.6 years in 2024, up 2.4 years since 2010, but remained below the OECD average of 81.3 years, ranging from around 81 years in Chile and Costa Rica to fewer than 70 in Haiti and Bolivia. Infant mortality fell by 34.4% between 2010 and 2024 to 14.4 deaths per 1 000 live births, compared with about 4 in the OECD, while under-5 mortality declined by 43% to 16.3 per 1 000, around three times the OECD level. Further gains will depend less on expanding service contact and more on improving effectiveness, safety and responsiveness of care.
- **High avoidable mortality rates show where coverage fails to translate into better outcomes.** In 2023, avoidable mortality reached 297 deaths per 100 000 population in LAC25, compared with 162 in the OECD. Vaccination remains a relative strength, but weaker acute care and cancer outcomes point to shortcomings in diagnosis, referral, emergency response, specialised treatment and continuity of care. Treatable cancer mortality averaged 19.3 deaths per 100 000 population in LAC26, around 30% above the OECD average, and worsened over the last decade, rising by 1.2 while the OECD average fell by 2.8.

Quality policies in LAC have established standards, but the tools to drive continuous improvement and better outcomes are still lacking

- **Most countries have built the foundations of quality governance, but implementation remains uneven.** Quality is included as a cross-cutting priority in health strategies in 14 of 19 countries, and provider licensing and medicines regulation are reported in 17 of 19. However, only Peru and Chile report fully costed quality implementation plans with monitoring frameworks, suggesting that quality is often recognised as a priority without the budgets and accountability mechanisms needed to change care delivery.
- **Quality measurement is expanding, but it is weakly linked to accountability and incentives.** Many countries report quality indicators, audit systems and clinical guidelines, but only six have comprehensive national quality indicator sets. Quality-linked payment reforms are not implemented nationally in 12 of 19 countries. Accreditation is reported in 9 countries, clinical decision support in 6, and performance-based financing in 4, pointing to a gap between setting standards and embedding continuous improvement into routine care. Underdeveloped data infrastructure is reported as a barrier by most countries, while standardised patient experience measurement is reported only in Ecuador, Chile and Colombia. Only four countries report standardised coding systems for safety incidents and near misses.

Equity gaps persist because access alone does not ensure effective, affordable and person-centred care

- **Equity means ensuring effective care, not only access to care.** Disadvantaged groups face higher health risks, more barriers to timely care, lower-quality and less continuous care, weaker financial protection and poorer outcomes. Unmet healthcare need averages 35% in the region, ranging from 3.2% in Costa Rica to 73% in Peru. Infant mortality is about three times higher among the poorest than the richest in Peru, around one fourth higher in Haiti, and rural-urban gaps exceed 40% in several countries.
- **Equity policies still focus more on expanding services than adapting them to underserved groups.** Infrastructure expansion is reported by 13 of 14 countries, outreach by 11 and telehealth by 9, but transport support by only 7, bilingual or community staff by 6, and digital inclusion policies by 4. Financial protection also remains incomplete: subsidised or free services are reported by 13 of 14 countries and copayment exemptions by 8, but catastrophic expenditure funds by only 4.
- **Equity data systems remain too narrow to guide action.** All surveyed countries collect disaggregated information on service access and health outcomes, but only 6 of 14 do so for quality of care and only 5 for financial protection. Data systems capture ethnicity in 7 countries, disability in only 1 and migration status in none. Without stronger disaggregation, some of the region's most vulnerable groups remain policy blind spots.

Closing quality and equity gaps also requires stronger health system capacity and prevention to prepare the region to face new health risks

- **Expanding health gains will require addressing the new epidemiological reality.** Non-communicable diseases, including cardiovascular diseases and cancers, accounted for 75.9% of all deaths across LAC33 in 2023. Yet progress in reducing major NCD mortality has been much slower than in OECD countries: cardiovascular disease mortality declined by only 4% in LAC25 between 2010 and 2023, compared with 28.4% in the OECD, while cancer mortality declined by 4%, compared with 18% in the OECD.
- **Infrastructure gaps in LAC extend to both physical and digital capacities:** In 2024, LAC countries had 22.6 hospital beds per 10 000 population, compared with 42.0 in the OECD, while hospital discharges in nine reporting countries averaged 5 543 per 100 000 population, against 13 797 in the OECD. Digital systems remain uneven: Costa Rica, Paraguay and Peru report near-comprehensive linkage across primary care, hospital, prescribing and mortality datasets, while other countries report more limited linkages, often restricted to hospital-mortality or hospital-prescribing data.

Health spending from public sources in LAC remains low, and too much care is paid directly by households

- **LAC spends much less on health than OECD countries, and a smaller share is financed through pooled public or compulsory schemes.** In 2024, current health spending per capita in OECD countries was almost four times that of LAC countries, at USD PPP 6 097 compared with USD PPP 1 518. Health expenditure represented 6.5% of GDP in LAC33, compared with 9.3% in the OECD. Government and compulsory insurance schemes financed 57% of current health expenditure in LAC, compared with around 75% in OECD countries.
- **High out-of-pocket spending exposes households to financial hardship when care is needed and can limit timely access, especially for poorer groups.** Out-of-pocket payments accounted for 32% of current health spending in LAC in 2024, compared with 20% in the OECD. OOP payments represented 3.4% of household final consumption in LAC, similar to the OECD average of 3.2%, and exceeded 4.5% in Honduras, Suriname, Paraguay, Saint Kitts and Nevis, Chile and Panama.

Low workforce availability is a key barrier for access to high-quality health while long-term care and healthcare needs continues to grow as population ages rapidly

- **LAC health systems face major workforce shortages and lack integration between training, deployment, retention and scope-of-practice.** LAC has 2.4 doctors per 1 000 population, compared with 3.6 in the OECD, with a range from 9.5 in Cuba to 0.3 in Haiti. Nurse and midwife density is much lower, at 3.9 per 1 000 population in LAC compared with 10.3 in the OECD. Further, the region is doctor-heavy, with only 1.6 nurses and midwives per doctor, compared with 2.9 in the OECD. Training pipelines also remain uneven: while the number of medical graduates is close to the OECD average, nurse graduate output is half the OECD average.
- **Population ageing will sharply increase demand for health and long-term care.** The share of people aged 65 and over in LAC is projected to almost double, from 9.3% in 2023 to 18.1% in 2050, while the share aged 80 and over is projected to rise from 1.8% to 4.9%. The region relies on ~25 million unpaid caregivers compared with about 3 million paid caregivers; maintaining current care ratios would require around 60.5 million unpaid caregivers by 2050.

1 Quality of care in Latin America and the Caribbean

Despite major gains in care coverage over the past decade, large quality gaps in Latin America and the Caribbean continue to drive avoidable mortality, inefficiency and inequality. This chapter examines policy and institutional arrangements for healthcare quality in 19 countries across six domains: governance, external assurance, evidence-based care, workforce capability, patient safety, and integrated and people-centred care. While many countries have established the basic foundations of quality governance, few have built the learning systems needed to turn compliance into better outcomes. Large cross-country differences suggest unevenly organised acute and chronic care, with prevention generally performing better than treatment. Measurement systems, patient safety tools and incentives are increasingly in place, but are not yet routinely used to guide protocols, payment or accountability. People-centred and integrated care remain the least developed areas. Priority actions include strengthening governance, workforce quality, patient safety, public reporting, quality-linked financing, equity monitoring and interoperable digital infrastructure.

Introduction

Universal health coverage (UHC) has advanced with giant steps in Latin America and the Caribbean, alongside historic expansions in health spending, although health gains have often remained uneven and modest (Dmytraczenko and Almeida, 2015[1]). The regional index of essential service coverage rising from 66 in 2000 to 80 in 2019, before falling back to 74 in 2021, reflecting both progress and persistent fragilities (WHO, 2021[2]).

However, expanding coverage alone is not enough to deliver better health outcomes. Translating nominal coverage into better outcomes requires high-quality care, defined by the World Health Organization and the OECD as care that is effective, safe, people-centred, timely, equitable, integrated, and efficient (OECD/WHO/World Bank Group, 2018[3]). Quality concerns not only whether people can access services, but whether those services are organised and delivered in ways that contribute to better outcomes.

Quality of care has become the central challenge for health systems in Latin America and the Caribbean (LAC). Persistent quality gaps continue to weaken the promise of universal health coverage, contributing to avoidable deaths, wasted resources, wider health inequalities and undermining trust (Kruk et al., 2018[4]). Many of these quality gaps reflect how care is organised across fragmented and segmented health systems, where differences in access and quality across income groups, territories and population groups, undermine both confidence in institutions and the fairness of care (Roberti et al., 2024[5]). Persistent weaknesses in care co-ordination and regulatory oversight, limited measurement of clinical outcomes and patient experience, and insufficient use of data for improvement further constrain the delivery of high-quality care (OECD/The World Bank, 2023[6]; Lorenzoni et al., 2019[7]). For chronic conditions, multimorbidity and acute episodes requiring transitions between levels of care, quality increasingly depends not only on what happens within individual facilities, but on continuity across the patient journey, supported by functioning referrals, shared information, multidisciplinary care and clear accountability.

High-quality care is also a lever for efficiency and value for money. In fiscally constrained environments, improving care quality increases the return on health spending by aligning practice with evidence, preventing complications, and reducing unwarranted variation that is unrelated to patient need. Improving quality is therefore both a health and a fiscal objective: by aligning care more closely with evidence and reducing avoidable harm, health systems can improve outcomes while increasing the value obtained from existing spending and freeing resources to address unmet needs (OECD, 2017[8]).

Many countries in the region have now established important foundations for quality assurance, including regulatory frameworks, standards, quality policies and institutional responsibilities. The next phase is more demanding: it requires connecting these elements more effectively so that measurement informs action, regulation supports implementation, and financing and accountability reinforce better care rather than operate as separate mechanisms. Countries are not starting from the same point, and their position may differ across policy areas. Some are still consolidating core governance and quality-assurance mechanisms, while others can increasingly focus on implementation, organisational learning, accountability and the more systematic use of quality information and incentives.

The chapter examines these issues by combining internationally comparable quality outcomes with a stock take of the policies, institutions and implementation mechanisms that shape delivery of high-quality care with the focus on implications for policy and improving system performance. The stock take considers governance, professional and service quality assurance, health technology assessment, measurement and patient safety, financial incentives, and people-centred and integrated care. By linking observed performance to the underlying policy architecture, the chapter identifies policy options to support the development of more resilient, equitable and high-performing health systems capable of responding to the region's evolving health needs and strengthening trust in public institutions.

The analysis asks not only which quality mechanisms countries have adopted, but how far these mechanisms form a coherent system capable of translating standards, measurement and oversight into better care and outcomes. Comparing countries at different starting points also creates opportunities for benchmarking and peer learning within the region, while drawing on OECD experience to identify how more established quality systems connect governance, implementation and continuous improvement.

Quality of care in Latin America and the Caribbean measured through internationally comparable indicators

Assessing the quality of care across countries has historically been difficult in Latin America and the Caribbean due to fragmented health information systems, uneven reporting practices and limited availability of comparable data. Earlier analyses of health system performance in the region often relied on mortality statistics, facility-level studies or country-specific administrative data, limiting the possibility of systematic cross-country benchmarking. Over the past two decades, however, important progress has been made. Many countries have strengthened routine health information systems, expanded digital health records and improved the reporting of hospital, mortality and service utilisation data. At the same time, growing investments in health intelligence capacities and the secondary use of health data have enabled more consistent monitoring of health system performance. These developments have significantly improved the availability of internationally comparable indicators on healthcare quality, making it increasingly possible to assess outcomes, care processes and patient experiences across countries. While these indicators provide valuable insights into the state of quality of care in the region, their interpretation must also consider differences in data systems, reporting practices and health system organisation across countries (Kruk et al., 2018[4]).

International efforts to measure and compare healthcare quality have been strengthened through the development of conceptual frameworks and standardised indicators. The OECD Health Care Quality and Outcomes (HCQO) framework provides a structured approach to assessing health system performance across countries, organising indicators across key dimensions of quality including effectiveness, safety and people-centredness, and across levels of care such as primary care, hospital care and public health (OECD, 2024[9]). The framework emphasises the use of internationally comparable indicators to monitor how well health systems prevent disease, deliver effective treatment and minimise harm to patients. Within this approach, indicators can capture different stages of care processes and outcomes, ranging from preventive interventions to treatment results and health outcomes. By providing a common measurement framework, the HCQO indicators support cross-country benchmarking and help identify areas where health systems perform well or where further improvement may be needed.

A multidimensional picture of healthcare quality in Latin America and the Caribbean

Building on the OECD HCQO framework, the quality of care data chapter in *Health at a Glance: Latin America and the Caribbean 2026* (Chapter 7) presents a set of indicators covering key dimensions of healthcare quality across the region. It starts with avoidable mortality indicators, an overall measure of the ability of the health system to minimise deaths from causes that should not occur with effective public health policies and timely healthcare, distinguishing between preventable causes that can be reduced through population-wide prevention and treatable causes that depend more directly on the performance and quality of healthcare services. Second, the chapter evidences health prevention performance through vaccination coverage indicators. These indicators assess the reach and effectiveness of childhood immunisation programmes, including coverage for diphtheria, tetanus and pertussis (DTP3), measles-containing vaccines, and hepatitis B, which together capture essential components of preventive care and population protection against communicable diseases. Avoidable hospital admissions for chronic conditions such as asthma, chronic obstructive pulmonary disease, congestive heart failure and diabetes provide insights into the effectiveness and accessibility of primary care in preventing complications that require hospital treatment. Indicators of in-hospital case fatality following acute myocardial infarction and stroke assess the quality and timeliness of acute hospital care for major cardiovascular emergencies. Complementing the performance assessment for acute care, the chapter presents indicators for cancer care, including treatable cancer mortality and 5-year survival for childhood cancers. In addition, indicators of patient safety and safe prescribing examining both the policy foundations for patient safety – including alignment with the WHO Global Patient Safety Action Plan – and patterns of antimicrobial consumption, which provide signals on prescribing practices and potential risks related to medication-related harm.

Table 1.1 and Table 1.2 present a summary of internationally comparable quality of care indicators for countries in Latin America and the Caribbean. The figures provide a synthetic overview of relative performance across countries and dimensions of care, allowing broad patterns to be identified across the region.

Table 1.1. Selected quality of care indicators in LAC countries

	Mortality from **avoidable** causes Age-standardised rate per 100 000 population		DTP3 immunisation coverage among 1-year-olds (%)	Measles-containing-vaccine first immunisation coverage among 1-year-olds	Measles-containing-vaccine second-dose by the locally recommended age (%)	Hepatitis B immunisation coverage among 1-year-olds (%)	Criteria Global Patient Safety Action Plan 2021-2030 (out of 10 total)
	Mortality from **treatable** causes	Mortality from **preventable** causes					
Antigua and Barbuda	117	166	99	97	82	99	
Argentina	108	100	75	82	46	75	4/10
Bahamas			90	86	60	90	
Barbados			94	88	76	94	
Belize	166	252	88	84	83	88	5/10
Bolivia			59	67	61	59	5/10
Brazil	111	155	91	93	68	90	4/10
Chile	62	94	95	93	73	95	4/10
Colombia	74	122	89	93	86	89	7/10
Costa Rica	77	119	99	93	87	99	7/10
Cuba	113	141	99	99	99	99	8/10
Dominica	163	173	90	80	75	90	
Dominican Republic	132	132	87	89	78	86	6/10
Ecuador	91	153	70	74	60	70	8/10
El Salvador			95	96	90	95	4/10
Grenada	169	174	93	83	67	86	
Guatemala	158	207	81	90	78	81	
Guyana	232	321	98	99	97	98	2/10
Haiti			60	77	54	60	1/10
Honduras			75	79	77	75	
Jamaica	176	246	99	94	93	99	5/10
Mexico	135	176	78	80	69	78	
Nicaragua	132	143					
Panama	87	106	72	93	82	72	4/10
Paraguay	140	183	80	90	69	80	1/10
Peru	78	121	80	89	76	80	6/10
Saint Kitts and Nevis	163	221	97	95	97	97	
Saint Lucia	115	156	99	83	67	99	
St. Vincent and Gren.	217	216	99	99	99	99	
Suriname			69	73	52	69	
Trinidad and Tobago	150	171	92	96	89	92	4/10
Uruguay	80	140	94	97	95	94	10/10
Venezuela			62	71	51	62	
LAC	**130**	**167**	**86**	**88**	**76**	**86**	**5/10**
OECD	**57**	**105**	**93**	**93**	**88**	**92**	

Note: All indicators show values for 2024 or the latest available year, except mortality from avoidable causes, for which the latest year is 2023. Indicator specifications, clarifications and notes for further interpretation can be found in their respective sections of Chapter 7. OECD and LAC averages are simple averages computed with a minimum of 7 available countries. The number of countries in the averages for each indicator may vary. For further specifications please visit the corresponding section of Chapter 7. The colour scale is constructed based on the LAC average. Darker grey cells indicate progressively worse performance relative to the LAC average, while darker green cells indicate progressively better performance.
Source: See Chapter 7.

While each of these indicators is examined in detail in Chapter 7, considering them together allows broader patterns and insights to be identified. Indicators reflecting health outcomes and acute care quality show considerably wider variation across countries. Mortality from treatable causes – deaths that should be avoided with timely and effective healthcare – varies markedly across the region, ranging from around 62 deaths per 100 000 population in Chile to more than 230 per 100 000 in Guyana. This nearly fourfold difference suggests substantial disparities in the capacity of health systems to diagnose, treat and manage conditions that should be amenable to medical care. Such variation may reflect differences in access to timely treatment, the availability of specialised services, and broader health system quality factors including workforce capacity, infrastructure and care co-ordination. In contrast, preventive services tend to perform relatively well in many countries in LAC. Average coverage of core childhood

immunisation programmes – including diphtheria, tetanus and pertussis (DTP3), measles-containing vaccines (MCV1 and MCV2) and hepatitis B – remains high in several countries, reflecting the long-standing priority given to vaccination programmes and the strong legacy of national immunisation initiatives across the region.

Indicators related to patient safety and safe prescribing suggest that many countries in the region are still strengthening the institutional foundations for safer care. The degree to which countries meet the policy and governance criteria outlined in the WHO Global Patient Safety Action Plan 2021-2030 varies considerably, indicating differences in the maturity of patient safety frameworks, reporting systems and national strategies aimed at reducing avoidable harm in healthcare. Strengthening patient safety governance, promoting learning health systems and improving the monitoring of medication use are increasingly recognised as central elements of high-quality health systems (WHO, 2024[10]).

Table 1.2. Quality indicators for acute and primary care, LAC countries with available data

Age-sex standardised rate per 100 admissions

	In-hospital case-fatality within 30 days after admission for AMI[1]	In-hospital case-fatality within 30 days after admission for ischemic stroke[1]	In-hospital case-fatality within 30 days after admission for haemorrhagic stroke[1]	Congestive heart failure hospital admissions[2]	Diabetes hospital admissions[2]	Asthma hospital admissions[2]	COPD hospital admissions[2]
Argentina				34	57	18	25
Chile	9	9	25	61	90	14	32
Colombia	6	6		40	45	12	46
Costa Rica	7	35	25	19	54	11	17
Ecuador	11	8	17	42	5	5	5
Mexico	23	17	31	36	149	5	20
Paraguay	24	12	26				
Peru	20	2	11	5	26	3	4
LAC	**13**	**12**	**23**	**40**	**64**	**12**	**27**
OECD	**7**	**9**	**23**	**89**	**93**	**25**	**76**

1. Patients 45 years old and over. 2. Patients 15 years old and over.

Note: All indicators present values for 2024 or the latest available. Indicator specifications, clarifications and notes for further interpretation can be found in their respective sections of Chapter 7. OECD and LAC averages are simple averages computed with a minimum of 7 available countries. The number of countries in the averages for each indicator may vary. For further specifications please visit the corresponding section of Chapter 7. The colour scale is constructed based on the LAC average. Darker grey cells indicate progressively worse performance relative to the LAC average, while darker green cells indicate progressively better performance.

Source: See Chapter 7.

Indicators of acute hospital care point to marked differences in the capacity of health systems across the region to deliver timely and effective treatment for major cardiovascular emergencies (Table 1.2). Variation in case-fatality rates following acute myocardial infarction and stroke suggests uneven performance in emergency response, clinical pathways and hospital management, including access to rapid diagnosis, specialised treatment and co-ordinated care. At the same time, they can also relate to internal discrepancies in diagnostic coding practices. Cross-country evidence indicates that stronger performance in these areas is often associated with organised service delivery models, such as integrated cardiac and stroke care networks, specialised units and systematic quality monitoring, highlighting the role of system organisation and governance in shaping outcomes (OECD, 2025[11]). These initiatives, together with efforts to standardise diagnostic coding, are currently being prioritised in countries such as Peru to strengthen clinical pathways and emergency response times. The indicators reflect both the quality of care within hospitals and the organisation of the patient pathway, including timely recognition, referral and transfer to the appropriate level of care.

Admission rates for ambulatory care sensitive conditions further illustrate differences in how health systems manage chronic disease outside hospital settings. Wide variation across countries reflects differences in the effectiveness, accessibility and continuity of primary care, particularly in the prevention and management of conditions such as congestive heart failure, diabetes, asthma and COPD. Lower admission rates can signal stronger primary care performance, including timely diagnosis, regular follow-up and appropriate treatment; however, they may also reflect constrained hospital capacity or access barriers in some contexts. Read alongside the acute-care results and broader system indicators, these patterns underscore that quality depends on both care within individual facilities and continuity as patients move between providers and levels of care. Interpretation should nevertheless account for differences in access, hospital capacity, coding and data completeness.

Interpreting these measures requires careful consideration of health system characteristics and data availability across countries

Observed differences often reflect not only the quality of care provided but also variation in access, reporting and data systems. Differences in diagnostic coding, admission practices, referral pathways, case severity at admission and the completeness of hospital reporting can all influence results across countries. For example, differences in case-fatality rates may be influenced not only by the quality of clinical care but also by patterns of referral, delays in accessing treatment and variations in case severity at admission. Understanding these contextual factors is therefore essential when comparing quality of care indicators across countries and when identifying priorities for policy action.

An important limitation remains the large number of missing values across countries and indicators. The set of countries included in Table 1.2 represents a subset of countries in the region with relatively stronger health information systems and available data for international comparison. In many countries, the routine collection and reporting of performance measures remain incomplete or fragmented across health system subsystems. As a result, the available indicators provide only a partial view of the quality of care delivered across the region.

Moreover, interpreting quality of care indicators in Latin America and the Caribbean requires particular caution because health system performance is often shaped by both access constraints and quality differences. For example, low hospital admission rates for chronic conditions may reflect effective disease management in primary care but may also signal limited access to hospital services. For these reasons, analysing outcomes and service utilisation indicators alone may not fully capture the underlying drivers of healthcare quality in the region.

To better understand patterns in this data, it is therefore necessary to complement quantitative indicators with information on health system policies, governance arrangements and quality improvement strategies. The next section draws on the results of a policy survey conducted across 19 countries in Latin America and the Caribbean to examine the institutional frameworks, monitoring systems and policy instruments that countries have adopted to strengthen quality of care. This deeper examination of quality of care policies provides important context for interpreting the indicators presented above and offers insights into the policy levers available to improve healthcare quality across the region.

Policy and institutional quality of care landscape

Policies to advance quality of care aim to ensure services are effective, safe, and person-centred. Quality remains a concern even in systems with broad coverage, since access alone does not guarantee that care is delivered in ways that consistently achieve the desired outcomes or meet acceptable standards. To improve health outcomes while making better use of limited resources, countries need clear national quality of care strategies that translate coverage and investment into safer, more effective and more responsive services (OECD/WHO/World Bank Group, 2018[3]).

The joint survey conducted in 2025 by the World Bank, the OECD, and the Inter-American Development Bank, described in Box 1.1, provides a current snapshot of national quality of care strategies, institutional arrangements and implementation approaches in the region. To do so, the survey examined 23 policy mechanisms that countries use to define standards, organise quality governance, set and enforce standards, support professional and organisational improvement, monitor and report performance, strengthen patient safety, and promote people-centred and integrated care. These mechanisms can be grouped into six broad policy areas:

- **Governance and accountability**, which establish leadership, oversight and system-wide direction for quality of care. This includes clinical governance; public reporting; performance-based financing.
- **Regulation and external assurance**, which set minimum requirements for safe and acceptable care and assess whether providers meet them. This includes licensing of healthcare providers; accreditation; inspection of institutions for minimum safety standards.
- **Evidence-based care and technology governance**, which promote more effective and consistent care by aligning decisions and practice with evidence. This includes clinical decision support; clinical standards, pathways and protocols; health technology assessment.
- **Workforce capability and service improvement**, which strengthen professional competence and support quality improvement in clinical teams and organisations. This includes training and supervision; clinical audit and feedback; morbidity and mortality reviews; collaborative and team-based improvement cycles.
- **Patient safety and safe clinical practice**, which aim to reduce preventable harm and embed safer care processes in routine service delivery. This includes medicines regulation; safety protocols; safety checklists; adverse event reporting.
- **People-centred and integrated care**, which seek to make care more responsive to people's needs, preferences and capabilities, while improving continuity across settings. This includes formalised community engagement and empowerment; health literacy; shared decision making; peer support and expert patient groups; patient feedback and experience of care; patient self-management tools.

Box 1.1. OECD Health at a Glance Latin America and the Caribbean 2026: Survey of quality of care policies

The OECD Health at a Glance Latin America and the Caribbean 2026 Survey of Quality of Care Policies was administered online between October 2025 and February 2026 to officials in Ministries of Health participating in Health at a Glance Latin America and the Caribbean 2026. Twelve countries responded directly to the survey: Argentina, Belize, Brazil, Chile, Colombia, Costa Rica, Ecuador, Grenada, Mexico, Paraguay, Peru and Saint Lucia.

The survey collected information on the main institutional and policy arrangements to support quality of care. It covered: the overall policy framework for quality of care; legal and regulatory arrangements; workforce planning and professional certification and recertification; accreditation and other external quality assessment mechanisms; clinical practice guidelines; health technology assessment and the regulation of medical devices, blood products and pharmaceuticals; audit and performance review; financial incentives to improve quality of care; patient safety, medical malpractice and infection control; and mechanisms for patients to influence healthcare quality, including the measurement of patient experience. A second section of the survey collected information on the availability of selected health data sources and indicators at national and/or subnational level.

Additional information was compiled for the Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Nicaragua and Panama. For these countries, the information was collected by the OECD using public sources and interviews with national officials, rather than through direct completion of the survey by Ministry of Health officials. As such, these country profiles have a different status from the direct survey responses. They reflect, to the best of the Secretariat's knowledge, the most recent publicly available information on the topics covered. The survey and the list of sources used for country profiles collected by the OECD are provided in the annex of the report.

Finally, an in-person workshop was held in Buenos Aires, Argentina, in November 2025, bringing together representatives from six Latin American Ministries of Health to validate survey responses and discuss their interpretation in depth.

Figure 1.1 maps the implementation status of quality of care mechanisms across 19 Latin American and Caribbean countries. It points to a pattern of relatively strong institutionalisation for regulatory and safety foundations. alongside more limited development of mechanisms that support learning- and patient-centred governance.

Across the six policy areas, the survey suggests that most countries in Latin America and the Caribbean have made consistent progress in the foundational functions of regulation and external assurance. Provider licensing and medicines regulation are reported as implemented in 17 of the 19 countries assessed, indicating that most systems have established the basic rules needed to authorise providers and regulate core inputs to care. By contrast, accreditation is reported to be in place in only 9 countries, demonstrating a potential disconnect between policies and implementation. A similar pattern emerges in patient safety and safe clinical practice. Several countries have moved beyond basic regulation to adopt concrete harm-reduction tools, but implementation is still uneven: surgical safety checklists are reported to be implemented, or in the process of implementation, in 12 of 19 countries; adverse event reporting systems are implemented in 11 countries; and safety protocols are in place in 9 countries, with a further 5 reporting that they are being implemented. This distribution is consistent with international experience, where national quality efforts often begin with regulatory controls and patient safety instruments before evolving into more mature systems of measurement, learning and continuous improvement (WHO, 2017[12]).

The picture is more mixed in the policy areas that depend on institutional learning, active use of evidence and stronger patient involvement. Under governance and accountability, public reporting is implemented in 13 countries, but remains planned in five – Brazil, Costa Rica, Haiti, Nicaragua and Saint Lucia – while performance-based financing is reported in only four, indicating that strategic use of incentives is still far from systematic. In workforce capability and service improvement, training and supervision are relatively common (14 of 19 countries), but mechanisms that rely on routine reflection and feedback are less consistently embedded: clinical audit and feedback are reported to be implemented in 11 countries, and collaborative improvement cycles in 9, suggesting that many systems still have limited capacity to convert information into continuous improvement. A similar gradient appears in evidence-based care and technology governance. Clinical standards, pathways and protocols and health technology assessment are each reported in 13 countries, but clinical decision support is implemented in only 6, with a further 10 still in process, pointing to an important gap between setting standards and embedding them in day-to-day practice. The least developed area remains people-centred and integrated care. While community engagement and empowerment mechanisms are present in 12 countries, more operational tools that bring patients directly into decisions and quality improvement remain limited.

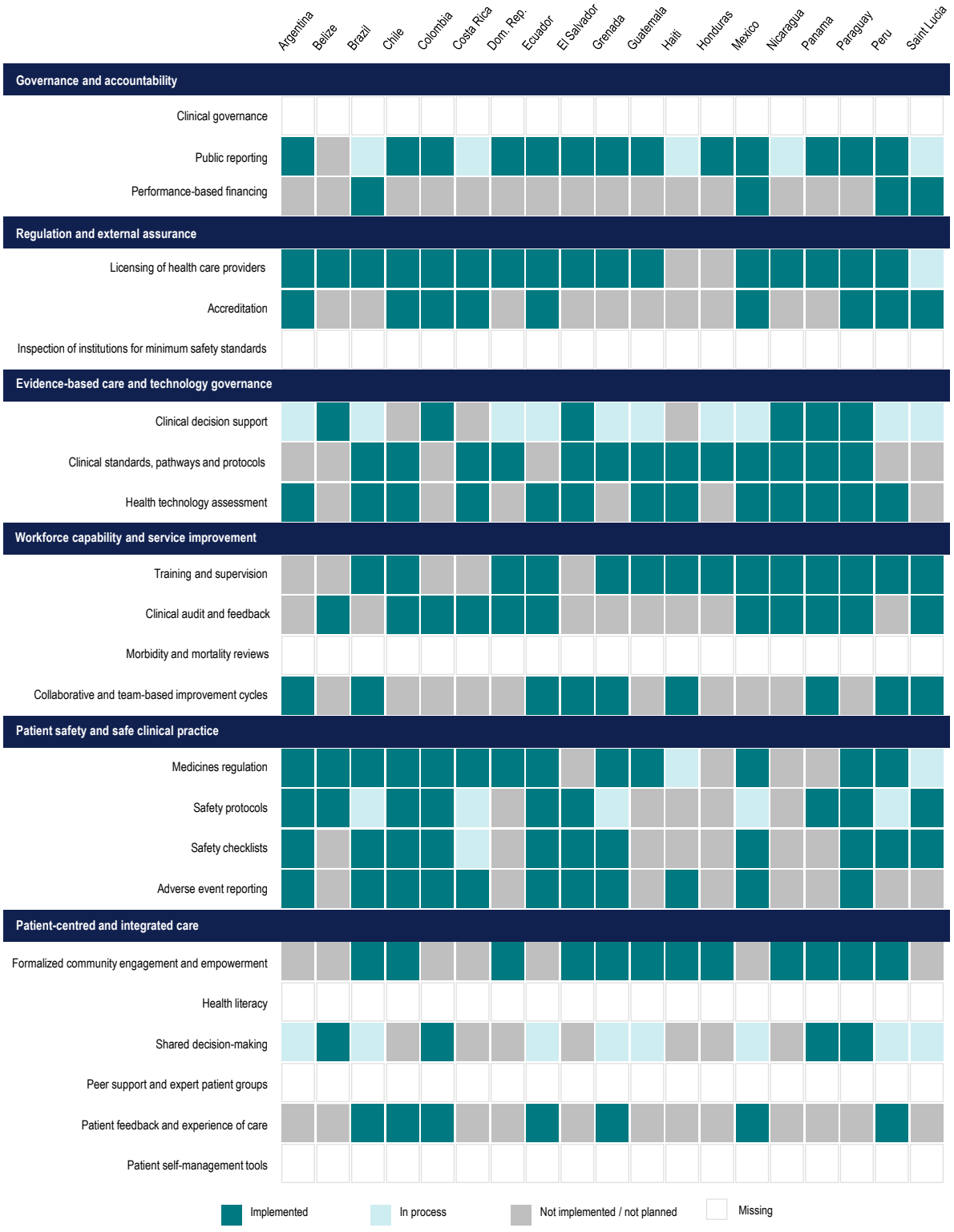
Looking across the 23 policy mechanisms in Figure 1.1 provides a simple indication of countries' different starting points. Argentina, Brazil, Chile, Colombia, Ecuador, Grenada, Mexico, Panama, Paraguay and Peru report full or partial implementation of at least 11 of the mechanisms assessed, suggesting a more established implementation base from which attention can increasingly turn towards consistent application, learning and accountability. Belize, the Dominican Republic, El Salvador, Guatemala, Haiti, Honduras, Nicaragua and Saint Lucia are still consolidating a broader set of these mechanisms, while Costa Rica, with 10 mechanisms implemented or under implementation, sits close to the boundary between these two broad groups. The distinction is particularly visible for mechanisms that move beyond basic system foundations towards external assurance, routine safety management and patient involvement: accreditation is in place in 7 of the 10 countries in the first group compared with 1 of 8 in the second, while safety protocols are reported in all 10 compared with 3 of 8, and patient feedback mechanisms in 7 compared with none. At the same time, variation within countries across individual policy areas, illustrated by Costa Rica's comparatively established accreditation and patient safety arrangements, reinforces the importance of treating these

as different starting points rather than as fixed categories of national quality systems. Among countries for which data are available, average treatable mortality is also lower in the first group, at around 106 deaths per 100 000 population, compared with 141 in the second, although this descriptive association should not be interpreted as evidence of a causal relationship.

The remainder of this chapter examines these six policy areas in greater depth, moving from the system-wide foundations and national policies for quality to the mechanisms used to improve care in practice and service-level policies. It begins with **governance and accountability**, including national policies, legal and regulatory frameworks, and the institutions responsible for quality of care. It then turns to **regulation and external assurance**, covering the quality assurance of health professionals and health services, as well as accreditation and related external assessment mechanisms. The chapter next examines **evidence-based care and technology governance**, including practice guidelines, health technology assessment, and the safety assurance of pharmaceuticals, blood products and medical devices, before addressing **workforce capability and service improvement** through indicators, audit, public reporting and other performance review mechanisms. This policy area is also complemented with **financial incentives and purchasing reforms** to support better care, an area that remains less developed in many countries in the region but are increasingly important for mature quality systems. As follows the chapter delves into patient safety and medical malpractice policies, and finalises with patient-centred and integrated care. Together, these sections trace the policy-to-implementation pathway for advancing care that is safe, effective and people-centred.

Figure 1.1. Implementation status of quality of care mechanisms across 19 Latin American and Caribbean countries

Policy mechanism implementation status



Source: Health at a Glance Latin America and the Caribbean 2026: Survey of quality of care policies.

Policies, legal and regulatory frameworks, and key organisations promoting quality of care

Across the 19 countries assessed, quality of care is increasingly being incorporated into the overall architecture of health policy, although many countries are still in the process of translating that recognition into formal governance arrangements, implementation plans and sustained institutional capacity.

The stock take indicates that most countries have national quality of care policies or strategies at varying stages of development, but these differ markedly in scope and maturity (Figure 1.2).Quality is treated as a cross-cutting element across sectoral strategies in a majority of surveyed countries (14 of 19), including Peru, Paraguay, Mexico, Grenada, Saint Lucia, Chile, Costa Rica, Brazil, El Salvador, Guatemala, Honduras, Nicaragua, Panama and the Dominican Republic. Within this group, only a smaller number appear to have moved towards a more operational model, demonstrating shortcomings in institutional structures: Peru and Chile have fully costed implementation plans with monitoring frameworks, whereas Grenada has formal mandates without dedicated budgets or costed plans. In the remaining countries: Ecuador, Argentina, Belize and Haiti quality is addressed through thematic policies-such as patient safety, surgical safety, medication safety, and hospital accreditation-rather than a single overarching national plan. Colombia occupies a somewhat different position: while quality-related policies are often organised around thematic areas, these sit within a broader regulatory quality architecture, notably the Mandatory Quality Assurance System for Healthcare (SOGCS) within the General System of Social Security in Health.

Figure 1.2. Positioning quality of care within overall health system strategy in 19 Latin American and Caribbean countries



Note: Answer to the question: How are the quality department and quality strategy positioned within your Ministry of Health?
Source: Health at a Glance Latin America and the Caribbean 2026: Survey of quality of care policies.

The regulatory landscape for quality of care in Latin America and the Caribbean remains centred on the traditional stewardship functions of the health system: health service and provider regulation, setting minimum standards through accreditation and establishing external assurance mechanisms such as licensing, and clinical governance mechanisms.

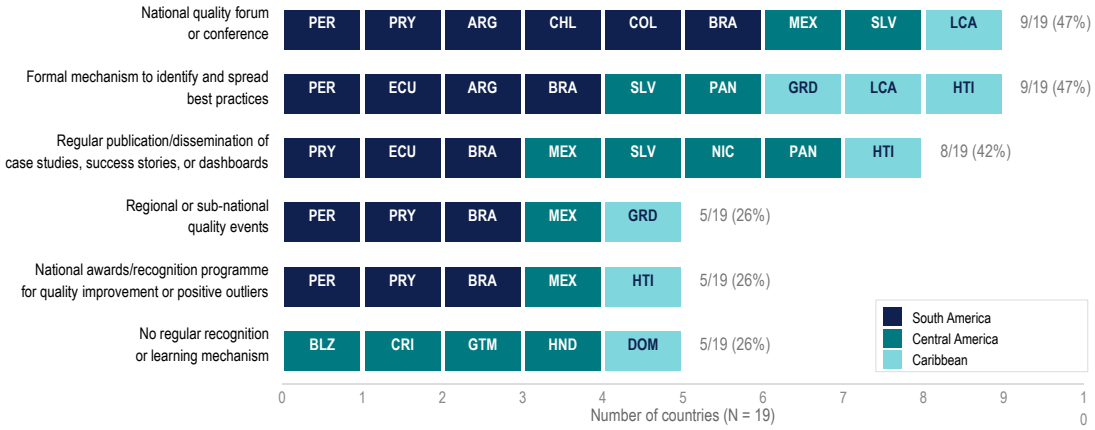
Across the region, most countries report having implemented core quality of care policies, including facility accreditation, clinical guidelines, infection prevention and control, and surgical safety indicating that the basic architecture for assuring acceptable standards of care is in place in most systems. However, more specialised domains associated with learning health systems (Institute of Medicine, 2013[13]) remain less consistently developed-such as patient safety incident reporting systems, digital health quality standards, and public performance reporting. Patient safety incident reporting systems, which are essential for moving from a culture of compliance to one of learning and prevention, are implemented in Paraguay, Ecuador, Saint Lucia, Chile, Belize, Colombia and El Salvador, but remains partial or planned in Peru, Mexico, Grenada, Costa Rica, Brazil and Panama, and is absent in several countries. A similar pattern is visible for digital health quality standards, which are implemented in Peru, Paraguay, Mexico, Saint Lucia, Belize, Colombia, Costa Rica, Brazil, El Salvador, Nicaragua and Panama, but remain planned in Ecuador, Grenada, Chile, Guatemala, Honduras and the Dominican Republic. These two aspects are sometimes directly linked, as we can see in the Peruvian plans to implement an interoperable digital health record system that includes the documentation of safety events.

Ministries of Health are the principal national actors

Typically operating through dedicated quality units (e.g. Mexico's *Dirección General de Calidad y Educación en Salud*) or specialised departments (Ecuador, Argentina, Saint Lucia, Chile, Colombia, Costa Rica, El Salvador, Haiti and the Dominican

Republic). Paraguay, Guatemala, Honduras, Nicaragua and Panama do not report dedicated quality units within the Ministry of Health but address quality through other ministerial structures. These structures co-ordinate national ministry programmes and priorities, supported by other national bodies including public health institutes (Peru, Mexico), independent quality agencies or superintendencies (Colombia, Ecuador), and social security payers (Peru, Colombia), which exert significant influence. Professional councils, such as medical and nursing colleges, also contribute to the regulatory landscape, particularly in Grenada and Chile. This institutional diversity reflects the organisation of health systems in the region, but also highlights a common challenge: quality improvement requires not only a nominal lead institution, but also effective co-ordination across regulators, purchasers, providers and professional bodies if policy is to translate into more consistent improvements in care.

Figure 1.3. Institutional mechanisms to learn from success in quality of care in 19 Latin American and Caribbean countries



Note: Answer to the question: "Does your country have regular, institutionalised mechanisms to recognize and spread success in healthcare quality improvement – including the identification of best practices and high performing positive outliers?"
Source: Health at a Glance Latin America and the Caribbean 2026: Survey of quality of care policies.

An important dimension of the stewardship role is its reach across public and private provision. Health services in LAC are commonly delivered through a mix of public, social security and private providers, but national quality arrangements do not always extend consistently across these sectors. As the sections below illustrate, gaps are particularly visible in workforce planning and patient safety. Effective national quality governance therefore requires standards, information and oversight mechanisms that apply across providers, while recognising differences in how public and private services are financed, regulated and organised.

Mechanisms to identify good performance exist, but learning systematically from success remains difficult

Figure 1.3 suggests that, beyond establishing rules and standards for quality, relatively few countries in the region have institutionalised mechanisms to learn systematically from success. While several countries report activities to showcase good practice, such as national quality forums or conferences, these are more common than formal systems to identify, document and spread effective approaches across the health system. National quality forums or conferences are reported in 9 countries: Peru, Paraguay, Mexico, Argentina, Saint Lucia, Chile, Colombia, Brazil and El Salvador. Likewise, 9 countries: Peru, Ecuador, Argentina, Grenada, Saint Lucia, Brazil, El Salvador, Haiti and Panama report formal mechanisms to identify positive outliers or high-performing teams. However, fewer countries appear to have more routine knowledge-sharing arrangements: the regular publication of quality improvement case studies is reported in 8 countries: Paraguay, Mexico, Ecuador, Brazil, El Salvador, Haiti, Nicaragua and Panama. Taken together, these findings suggest that, although some countries have begun to recognise and promote successful quality improvement efforts, the systematic diffusion and scaling of good practice remain uneven. This matters because mature quality systems depend not only on detecting poor performance, but also on identifying what works, rewarding improvement, and enabling effective practices to spread across organisations and levels of care.

From quality policies to implementation and learning

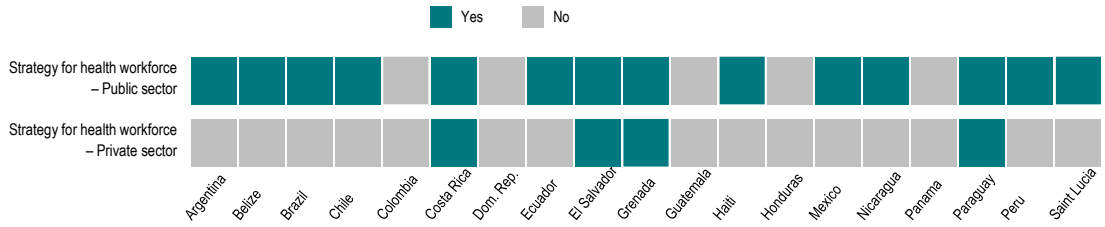
Considering both how quality of care is positioned within overall health system strategies and the institutional mechanisms available to learn from success, countries show different starting points in the governance of quality of care. Argentina, Brazil, Chile, Colombia, Ecuador, El Salvador, Mexico, Peru and Saint Lucia combine relatively established national quality structures with institutional mechanisms for implementation, co-ordination or learning, suggesting that attention can increasingly focus on strengthening accountability, ensuring consistent implementation and spreading effective practices across the health system. Belize, Costa Rica, the Dominican Republic, Grenada, Guatemala, Haiti, Honduras, Nicaragua, Panama and Paraguay have

important elements of this architecture in place but are still consolidating the links between policy commitments, institutional responsibilities, implementation capacity and systematic learning. The key distinction is therefore less whether countries have adopted quality policies than how far they have developed the full pathway from policy and institutional responsibility to implementation, learning and diffusion of effective practice. These distinctions are not absolute, as several countries in the latter group already have established arrangements in particular dimensions.

Strategic planning of health workforce as a crucial step for assuring professional quality

The quality of care that a health system can deliver depends heavily on how it develops and governs its health workforce. Countries need not only enough health professionals, but a workforce whose training matches population needs and whose competence is maintained throughout professional life. Assuring professional quality is therefore not simply a matter of controlling entry to practice; it requires a broader policy approach that links workforce planning, professional regulation and ongoing skills development to the delivery of safe, effective and people-centred care.

Figure 1.4. Implementation of a National Health Workforce Strategy by Sector in 19 Latin American and Caribbean countries



Note: Answer to the question: "Does your country have a comprehensive national health workforce strategy that addresses gaps in numbers, distribution, and retention of physicians and nurses in both the short and long term?"
Source: Health at a Glance Latin America and the Caribbean 2026: Survey of quality of care policies.

In several countries in the region, these priorities are now reflected in formal policy documents. Chile's *Estrategia Nacional de Salud 2021-2030* places workforce issues within a broader agenda of management, quality and innovation, while Colombia's Política Pública del Talento Humano en Salud 2025-2035 sets out a long-term framework for strengthening professional capability, continuous development and territorial capacity in service delivery. Yet, as Figure 1.4 shows, this strategic commitment is not matched by equally comprehensive planning across the health workforce. In many countries, workforce strategies do not cover both doctors and nurses consistently, and coverage is even less complete for other professional groups. Gaps are also more pronounced when both the public and private sectors are considered together. This matters not only for preparedness in periods of system stress, as highlighted during the COVID-19 pandemic, but also because healthcare in Latin America and the Caribbean is often delivered through a mix of public and private providers. In practice, this means that workforce policies focussed too narrowly on one part of the system may leave important gaps in quality assurance, continuity of care and effective service capacity.

Peru, Paraguay, Ecuador, Grenada, Saint Lucia, Chile, Belize, Brazil and Haiti all report plans that address the distribution and numbers of health workers in the public sector. Yet only Grenada, Belize and Costa Rica report a similarly comprehensive approach for the private sector. A second group has established forecasting and planning mechanisms, but with more limited sectoral coverage. Policies for workforce forecasting and planning in the public sector are reported in Peru, Paraguay, Mexico, Ecuador, Saint Lucia, Chile, Belize, Colombia, Brazil, Haiti, Nicaragua and Panama, while only Mexico and Grenada report such mechanisms for both the public and private sectors. By contrast, Argentina, El Salvador, Guatemala, Honduras and the Dominican Republic report no workforce forecasting and planning policies (OECD/IDB/The World Bank, 2026[14]). Given the mixed nature of health systems across the region, the gaps between public and private workforce strategies further demonstrates the need for a comprehensive and integrated model of stewardship to ensure equitable access to quality health services in both public and private sectors.

Certification, recertification and continuous professional development at the core of countries' regulatory approach for quality assurance in the health workforce

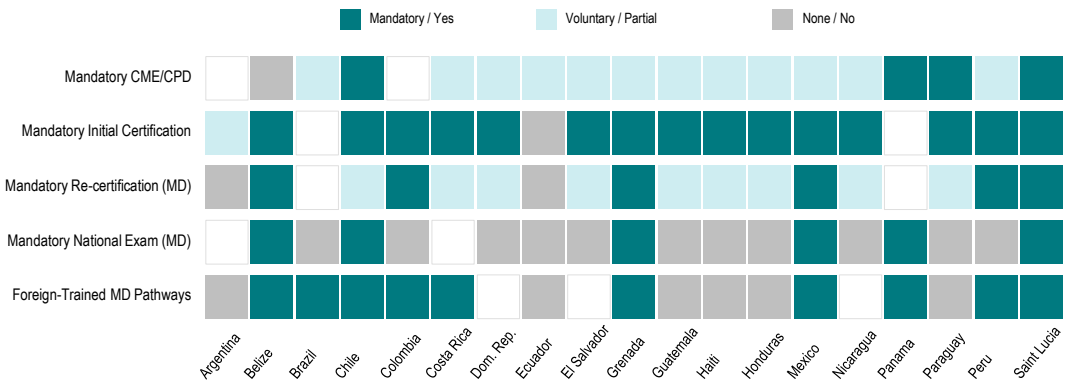
Continuous updating of knowledge and skills is essential for quality improvement and patient safety and should play a vital role in licensure maintenance. *Certification* is the formal process through which a competent authority confirms that a professional has met the education, training and assessment requirements needed to enter practice. *Recertification* is the periodic process through which that authority confirms that the professional continues to meet the required standards for practice, typically through continuing professional development and, in some systems, additional assessment. In turn, *continuing medical education (CME)*

and continuous professional development (CPD), together with quality improvement training, are essential and can be embedded in pre-service curricula or delivered through in-service training and recertification requirements.

In Latin America, regulatory approaches to professional certification and development vary (Figure 1.5);

- **Certification and recertification**: Initial certification for doctors is mandatory in most countries. Mandatory recertification for physicians is required in Peru (every 5 years), Mexico (every 5 years), Grenada (every 5 years), Panama (every 5 years), Saint Lucia (every 2 years), Belize (annually), and Colombia. In several countries: Paraguay, Chile, Costa Rica, El Salvador, Guatemala, Haiti, Honduras, Nicaragua and the Dominican Republic only initial certification is required, with no mandatory recertification. Argentina maintains a voluntary recertification system. Ecuador reports no formal certification requirement for physicians.
- **National certification exams:** Requirements vary widely. Mexico, Grenada, Saint Lucia, Belize and Panama mandate national certification exams for both public and private practice. Peru, Paraguay, Ecuador, Colombia, Brazil, El Salvador, Guatemala, Haiti, Honduras, Nicaragua and the Dominican Republic have no standardised national exam for initial certification. Despite these differences, certification pathways for foreign-trained physicians are reported in Peru, Mexico, Grenada, Saint Lucia, Chile, Belize, Colombia, Costa Rica, Brazil and Panama.
- **Continuous professional development (CME/CPD)**: Fully mandatory CME/CPD with quality improvement training integrated into curricula exists in Paraguay, Saint Lucia and Chile. Panama requires mandatory CME/CPD but without quality improvement integration. In most other countries: including Peru, Mexico, Ecuador, Grenada, Costa Rica, Brazil, El Salvador, Guatemala, Haiti, Honduras, Nicaragua and the Dominican Republic CME/CPD is encouraged but not legally required to continue practicing. Belize requires CME only.

Figure 1.5. Mandatory CME/CPD, certification, re-certification, and national exams in 19 Latin American and Caribbean countries



Note: Answer to the questions: "Which of the following best describes the policies for certifying, and re-certifying physicians and nurses in your country?" and "Are there national policies requiring continuous professional education (CME/CPD) and quality improvement training for physicians and nurses, and are these integrated into the training curricula?"
Source: Health at a Glance Latin America and the Caribbean 2026: Survey of quality of care policies.

These findings suggest that greater emphasis is still placed on controlling entry into medical practice than on assuring professional competence over time, but they also reveal different starting points in the development of professional quality-assurance systems. Belize, Chile, Colombia, Costa Rica, Grenada, Mexico, Panama, Paraguay, Peru and Saint Lucia have relatively more established arrangements, combining mandatory entry requirements with additional mechanisms such as recertification, CME/CPD, national examinations or pathways for foreign-trained physicians. Argentina, Brazil, the Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras and Nicaragua are still consolidating this broader architecture, with professional assurance relying more heavily on initial certification and voluntary or more limited mechanisms for maintaining competence over time. The distinction is therefore not simply whether certification exists, but how far countries have moved from a single entry-to-practice control towards a more comprehensive framework covering entry, continuing competence and professional mobility. For countries with more established arrangements, the challenge increasingly lies in ensuring that these mechanisms translate into meaningful updating of skills and improvements in clinical practice; for those still consolidating the foundations, strengthening the breadth and enforceability of professional quality-assurance mechanisms remains an important priority.

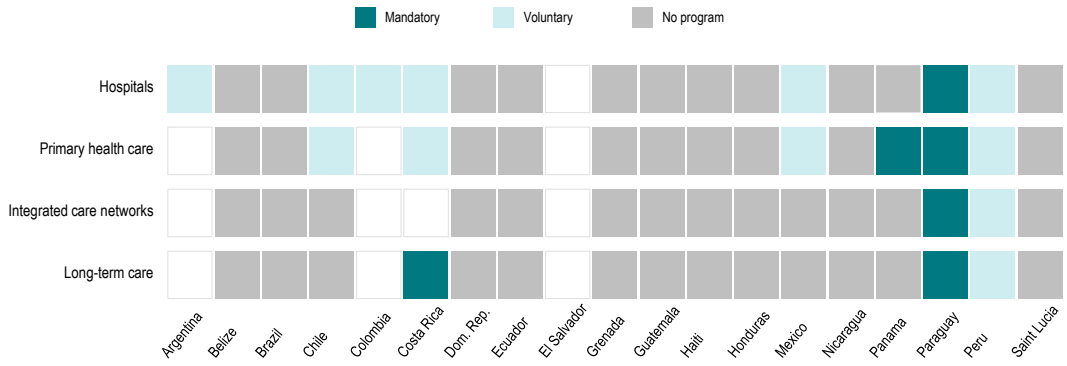
Accreditation and quality assurance of health services

Accreditation is a structured process of external quality assessment through which healthcare organisations are evaluated against defined quality and safety standards and formally recognised when those standards are met. Originating largely as a profession-led mechanism, accreditation has evolved with greater government involvement while generally remaining accountable to independent governing bodies. In practice, it relies on healthcare-specific standards and combines self-assessment, peer review and external reporting to promote continuous improvement. Its main contribution is to strengthen the conditions for better care through facilitating enforcement of nationally defined quality standards: it clarifies expected standards, reinforces internal governance and safety culture, and encourages organisations to monitor performance and address gaps systematically. Evidence suggests positive associations between hospital accreditation and safety culture, as well as with process and efficiency measures such as shorter length of stay though, although findings for other quality-of-care measures are mixed. Overall, accreditation appears most consistently to improve organisational processes and adherence to standards. Yet better patient outcomes do not follow automatically: these depend on whether accreditation is coupled with effective quality improvement, robust measurement systems and sustained organisational support to turn compliance into better clinical practice (Hussein et al., 2021[15]).

In LAC, accreditation processes are largely led by governments

Ministries of Health or specialised units are the sole authorities responsible for hospital accreditation in Peru, Paraguay, Ecuador and Saint Lucia. In contrast, Mexico, Colombia and Brazil use hybrid models involving government and private organisations. Notably, private organisations exclusively lead the process in some provinces of Argentina (Misiones, Chubut and Mendoza), while Chile and Costa Rica utilise specialised private or social security entities for specific oversight. Among the broader set of surveyed countries, Guatemala, Haiti, Honduras, Nicaragua, Panama and the Dominican Republic do not have formal hospital accreditation programmes.

Figure 1.6. Accreditation status by care setting in 19 Latin American and Caribbean countries



Note: Answer to the questions: "Are there national standards used in the accreditation process, and are these programs voluntary or mandatory?"
Source: Health at a Glance Latin America and the Caribbean 2026: Survey of quality of care policies.

Accreditation standards in the region are comprehensive, however, regulatory intensity of accreditation across care settings is mostly lacking or voluntary

Peru, Paraguay, Mexico, Ecuador and Chile evaluate clinical management, patient safety, infrastructure, equipment, and administrative processes. Patient satisfaction and staff competence are also high priorities. Emerging areas like the use of Information Technology (IT) are integrated into the standards of almost all countries except Chile and Belize.

Nevertheless, regulatory intensity of accreditation across care settings is mostly lacking or voluntary (Figure 1.6). For hospitals it is only mandatory in Paraguay; and voluntary in Peru, Mexico, Argentina, Chile, Colombia and Costa Rica; no formal national programme reported in Ecuador, Grenada, Saint Lucia, Brazil, Belize, Guatemala, Haiti, Honduras, Nicaragua, Panama and the Dominican Republic. In primary healthcare, accreditation is mandatory in Paraguay and Panama, while voluntary in Peru, Mexico and Chile; most other countries reported no formal programme. Long-term care remains the least regulated sector in terms of accreditation: Colombia reported the existence of mandatory requirements, while most other countries stated that they do not have a formal program.

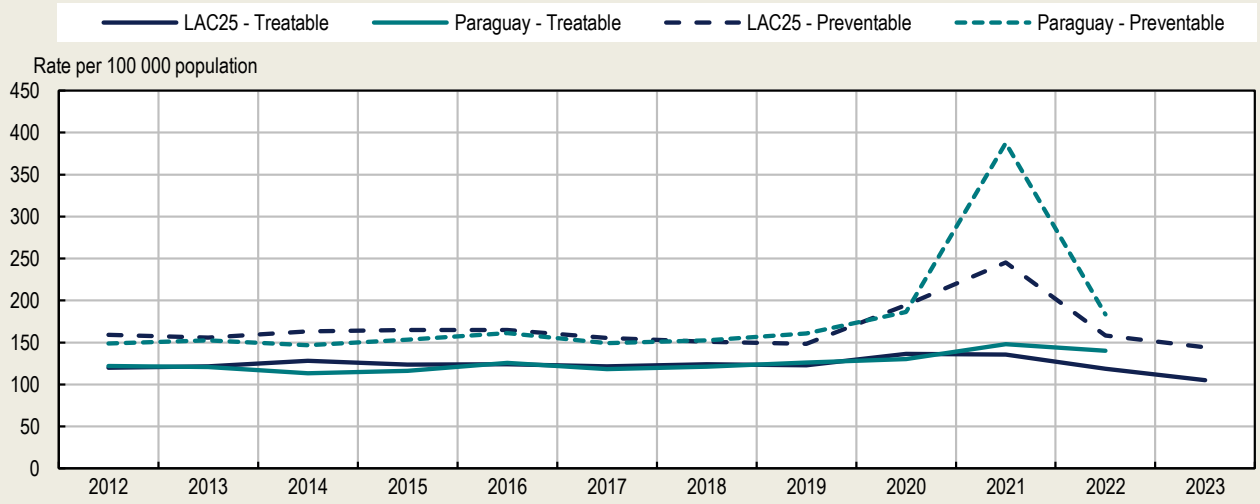
Box 1.2. Mandatory accreditation in Paraguay and care outcomes

In Paraguay, the legal basis for accreditation-related requirements dates back to Law No. 1032/1996, which created the National Health System and established accreditation and quality control as part of the organisation of services. The strongest whole-system policy push, however, came later with the National Quality Policy in Health 2017-2030, which made the policy mandatory for the entire National Health System, and with its subsequent operationalisation through the 2021 National Strategy for Quality Management in Health. Resolution S.G. No. 117/2021 assigned responsibility for implementation, monitoring and evaluation, and set out a more explicit governance structure for quality management at national, regional and hospital level.

This strong institutional framework contrasts with the country's more mixed performance on quality of care outcome indicators. Paraguay remains in the worst-performing quartile in the region for avoidable mortality in 2022 and also records high in-hospital case-fatality within 30 days after admission for acute myocardial infarction and for haemorrhagic stroke. At the same time, this contrast should be interpreted with caution: There has been an improvement in treatable mortality since 2021 when it was the highest rate in the region. Further, the National Quality Policy in Health only took effect from 2021, meaning that any effects on system performance may not yet be fully visible.

Figure 1.7. Treatable and preventable mortality in Paraguay are back to regional average levels

Evolution of treatable and preventable mortality in Paraguay and LAC average



Source: WHO mortality database (2026).

Different interpretations of accreditation requirements

The current Superintendence of Health defines accreditation as a voluntary and periodic process intended to verify compliance with quality levels above the minimum mandatory requirements. This helps explain why Paraguay may appear to have a "mandatory" accreditation approach in some policy mappings while the regulator's own public description presents accreditation as voluntary. In practice, the system appears to distinguish between mandatory categorisation and basic operating requirements, on the one hand, and voluntary accreditation to higher quality standards, on the other. This distinction is also reflected in the Superintendence's guidelines, where categorisation is obligatory whereas accreditation is voluntary. Paraguay illustrates that formal quality policies and accreditation-related requirements do not by themselves guarantee stronger outcomes. Implementation capacity, time lags and the effective use of quality information also matter, and outcome indicators should be interpreted with these limitations.

Source: Superintendencia de Salud de Paraguay (1996[16]), Ley N° 1032 que crea el Sistema Nacional de Salud; Ministerio de Salud de Paraguay (2021[17]) Resolución S.c. N 117 por la cual se aprueba la estrategia nacional de gestión de la calidad en salud, del Ministerto de Salud Púbiica y bienestar social, https://informacionpublica.paraguay.gov.py/public/3156632-RESOLUCIONSGN117DE2021ESTRATEGIADELACALIDADENSALUDpdf-RESOLUCIONSGN117DE2021ESTRATEGIADELACALIDADENSALUD.pdf; Superintendencia de Salud de Paraguay (2026[18]), Funciones – Superintendencia de Salud – Paraguay, https://superintendenciadesalud.gov.py/funciones/.

The region relies heavily on inspectorate models to establish baseline safety

In contrast to the independent, external assessment against voluntary standards encompassing accreditation, inspectorates enforce compliance with mandatory legal and regulatory requirements. Acting as a government-mandated oversight body, their primary role is to enforce minimum requirements. In this stocktake, 15 of the 19 countries confirmed the use of an inspectorate model to enforce mandatory minimum standards: Peru, Paraguay, Mexico, Ecuador, Argentina, Grenada, Chile, Costa Rica, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, Panama and the Dominican Republic.

Accreditation marks the shift from minimum regulatory compliance to continuous external quality assurance

Countries in the region occupy different starting points in external quality assurance. Argentina, Chile, Colombia, Costa Rica, Mexico, Panama, Paraguay and Peru have moved beyond baseline inspection by establishing formal accreditation arrangements in at least one care setting, although these differ in scope and whether participation is mandatory or voluntary. In these countries, the policy challenge increasingly lies in extending accreditation across care settings and ensuring that external assessment drives continuous improvement rather than compliance alone. Belize, Brazil, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Haiti, Honduras, Nicaragua and Saint Lucia still rely more heavily on inspectorates and minimum regulatory standards, making the development or consolidation of formal accreditation mechanisms a more immediate priority. The distinction is therefore between systems focussed primarily on assuring minimum standards and those beginning to layer continuous external quality assurance on top of those foundations.

Ensuring safety and quality of technologies

Institutionalizing Health Technology Assessment (HTA) is foundational to health system quality. When embedded in national decision-making, HTA prioritises high-value interventions and sets conditions for safe, appropriate adoption. Following market authorisation, robust post-market surveillance is required to ensure ongoing safe use of pharmaceuticals and technologies. In recent years, surveillance has expanded to include herbals, traditional and complementary medicines, blood products, biologicals, medical devices, and vaccines (WHO, 2002[19]).

In LAC, HTA responsibility is largely centralised within government

Dedicated government agencies conduct assessments to inform coverage decisions in 13 countries: Peru, Paraguay, Mexico, Ecuador, Argentina, Chile, Costa Rica, Brazil, El Salvador, Guatemala, Haiti, Nicaragua and Panama. Argentina has a mixed model where some provinces have incorporated the use of HTA through dedicated agencies and others such as Santiago del Estero and Buenos Aires do not have dedicated formal agencies. HTA is not formally organised in Grenada, Saint Lucia, Belize, Honduras and the Dominican Republic, indicating a key area for institutional development.

Box 1.3. HTA strengthens healthcare quality: Selected OECD country experiences

HTA helps determine not only whether a technology is safe and effective, but also whether it improves care relative to existing practice, is affordable, and can be integrated into routine service delivery.

- **Germany** combines federal regulation with statutory health insurance self-governance. BfArM, the federal authority under the Ministry of Health, oversees the regulation and post-market surveillance of medicines and medical devices, including vigilance and safety reporting. IQWiG, an independent scientific institute commissioned by the Ministry or the Federal Joint Committee, supports evidence assessment for reimbursement decisions. This links HTA directly to national coverage and pricing rules, helping ensure that adoption is driven by evidence. For digital health applications, assessment also covers usability and accessibility, including support for people with disabilities. The medicines pathway considers benefit for different patient groups, though broader equity considerations are less explicit.
- **Korea's** HTA model is vertically integrated. The Ministry of Food and Drug Safety (MFDS) regulates both medicines and medical devices and oversees market approval, quality and safety control, market compliance, and post-market surveillance and vigilance. The National Evidence-based Healthcare Collaborating Agency, founded by the Korean Government as an independent agency collaborating with the Ministry of Health and Welfare, leads HTA, while the Health Insurance Review and Assessment Service, under the ministry, reviews claims, manages benefit standards and conducts quality assessment. HTA is tied to national coverage and reimbursement decisions, helping steer adoption through system-wide review. Official guidelines are not explicit about a formal requirement to assess differential effects on vulnerable groups.
- **Spain's** HTA model is network-based rather than centred on a single national agency. RedETS (Spanish Network of Agencies for Health Technology Assessment and Services of the National Health System) brings together seven regional agencies and one state agency under the co-ordination of the Ministry of Health, with a permanent technical secretariat and a common methodology to support decisions on the incorporation, disinvestment and appropriate use of medical technologies in the National Health System. The state-level HTA unit is the Health Technology Assessment Agency within the *Instituto de Salud Carlos III.* Post-market surveillance sits mainly outside HTA and is led by the Spanish Agency of Medicines and Medical Devices, which is responsible for the evaluation, authorisation and continuous monitoring of medicines and for the control and surveillance of medical devices. On equity, RedETS' strategic framework support decisions that promote equity, cohesion and sustainability.

Although their institutional models differ, all three countries use HTA to make technology adoption more systematic, transparent and evidence-based. These arrangements illustrate the value of linking assessment to decisions about whether and under what conditions technologies are adopted, covered or reimbursed. They also incorporate equity considerations and post-market learning to varying degrees.

Source: Chapman (2025[20]), "Towards identifying good practices in the assessment of digital medical devices: Insights from several OECD countries", https://doi.org/10.1787/b485ee1f-en; OECD (2005[21]), *Health Technologies and Decision Making*, https://doi.org/10.1787/9789264016224-en; OECD (2022[22]), *Towards an Integrated Health Information System in Korea*, OECD Publishing, Paris, https://doi.org/10.1787/c4e6c88d-en; O'Rourke, Oortwijn and Schuller (2020[23]), "The new definition of health technology assessment: A milestone in international collaboration", https://doi.org/10.1017/S0266462320000215.

Post-market surveillance is standardised for pharmaceuticals and medical devices but varies for blood products

Peru, Paraguay, Mexico, Ecuador, Argentina, Chile, Costa Rica, Brazil, Guatemala and Panama consistently assess pharmaceuticals; medical device assessments are conducted in Peru, Paraguay, Mexico, Ecuador, Chile, Costa Rica, Brazil, Guatemala and Panama. Blood product assessments are less common, reported in Peru, Mexico, Argentina, Costa Rica, Guatemala and Panama. Nearly all countries conducting assessments have formal norms to evaluate compliance, ensuring technologies meet safety requirements in use. Direct links between HTA findings and reimbursement decisions are less common.

Peru is the only country that reports HTA results are linked to reimbursement decisions across three domains: medical devices, pharmaceuticals, and blood products. Chile and Paraguay connect HTA to reimbursement only for pharmaceuticals, while all other responding countries report no linkage at all.

Peru and Paraguay systematically require equity considerations in HTA

A key component of modern HTA is determining whether the differential impact on vulnerable populations is considered during the assessment process. Peru and Paraguay systematically require equity considerations, while Mexico, Ecuador, Argentina, Grenada, Chile and Brazil consider them only occasionally. Saint Lucia, Belize, Colombia, Costa Rica, Guatemala, Haiti, Honduras, Nicaragua and Panama report that equity is not yet integrated into formal HTA processes.

From establishing HTA to integrating assessment, surveillance and reimbursement

Countries also show different starting points in the governance of health technologies. Argentina, Brazil, Chile, Costa Rica, Ecuador, Guatemala, Mexico, Panama, Paraguay and Peru combine an institutionalised HTA function with routine post-market assessment of pharmaceuticals and, in most cases, medical devices, providing a more established basis for technology quality assurance. Belize, the Dominican Republic, El Salvador, Grenada, Haiti, Honduras, Nicaragua and Saint Lucia are still consolidating one or both of these foundations. For countries with more established arrangements, the next challenge is increasingly to connect assessment and surveillance more systematically to reimbursement, appropriate use and equity considerations; Peru, and to a lesser extent Chile and Paraguay, illustrate progress in this direction.

Quality indicators, national audit studies and practice guidelines

National audit studies

National audit studies are a critical tool for examining care quality in high-risk areas where clinical errors or adverse events are most likely to occur. By systematically reviewing care processes, outcomes and medical records, they can reveal preventable harm, identify departures from recommended practice and support corrective action at provider, facility and system level. They are particularly valuable for tracking major surgical complications, anaesthesia related mortality, and maternal deaths. Systematic review of medical records enables health systems to identify preventable harm and implement corrective actions (OECD/WHO/World Bank Group, 2018[3]).

> *Across Latin America and the Caribbean, countries are assembling the foundations of a national quality measurement infrastructure, but few have embedded these measures into routine accountability and governance*

Standardised national quality indicators are in use across the region to track structure, process, and outcomes. Six countries: Mexico, Saint Lucia, Colombia, Haiti, Nicaragua and Panama report comprehensive national indicator sets, while most others including Peru, Paraguay, Ecuador, Argentina, Grenada, Chile, Costa Rica, Brazil, El Salvador, Guatemala, Honduras and the Dominican Republic describe theirs as partial or still under development. Belize reports no national quality indicator set. The breadth of national indicator sets should not, on its own, be interpreted as a measure of measurement-system maturity. Countries may differ in how they assess whether their frameworks are comprehensive, and systems with narrower indicator sets may still use them effectively for reporting, benchmarking or accountability. What matters is not only the scope of measurement, but also data quality, coverage and its routine use for improvement.

Public reporting of provider performance is fully implemented in Peru, Chile and Colombia, and partially implemented in Paraguay, Ecuador, Grenada, Brazil, El Salvador, Panama and the Dominican Republic. Regular national quality performance reports are published in Peru, Mexico, Chile, El Salvador, Haiti and Panama. The mechanisms that convert indicators into action remain uneven: eight countries: Paraguay, Ecuador, Grenada, Colombia, Brazil, Nicaragua, Panama and the Dominican Republic use indicators for routine audit and feedback to providers; six (Paraguay, Grenada, Chile, Haiti, Honduras and Panama) use them for benchmarking across facilities; and only Peru and Paraguay tie them to pay-for-performance. The most common use reported by six countries (Paraguay, Mexico, Ecuador, Argentina, Costa Rica and Brazil) is to feed indicators into learning collaboratives, a softer approach that relies on voluntary engagement. Taken together, most countries have many of the building blocks for quality measurement, but measurement is not yet consistently linked to contracting, supervision, budgeting, or financial incentives.

To drive clinical improvement, several countries measure the impact of practice guidelines on patient outcomes. Eleven countries: Paraguay, Mexico, Argentina, Chile, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, Panama and the Dominican Republic maintain national monitoring systems for this purpose; Peru and Grenada use local or regional tracking. Ecuador, Saint Lucia, Belize, Costa Rica and Brazil report no formal monitoring systems. Despite these efforts, barriers to effective guideline implementation include limited resources (reported by 16 countries), inadequate dissemination mechanisms (15 countries), resistance to change in clinical practice (11 countries), lack of awareness (11 countries), and insufficient incentives (13 countries). To encourage adherence, countries are implementing monitoring and evaluation systems, although national coverage remains uneven and some rely on local or regional arrangements. Common barriers include limited resources and infrastructure, inadequate dissemination, resistance to changes in clinical practice, lack of awareness and insufficient incentives.

Evidence-based practice guidelines

Evidence-based clinical practice guidelines are central to strengthening quality and reducing adverse events. Drawing on the best available research, they support clinicians and patients in making appropriate, effective care decisions and standardise high-value interventions to reduce clinical inertia and unwarranted care variation.

In LAC, guideline development and implementation are largely institutionalised through expert groups under direct government co-ordination

In Peru, Paraguay, Mexico, Ecuador, Argentina, Costa Rica, Chile, Colombia, Belize and Brazil, Ministries of Health or delegated national authorities lead the technical groups that draft and update standards, aligning guidelines with national priorities and coverage policies.

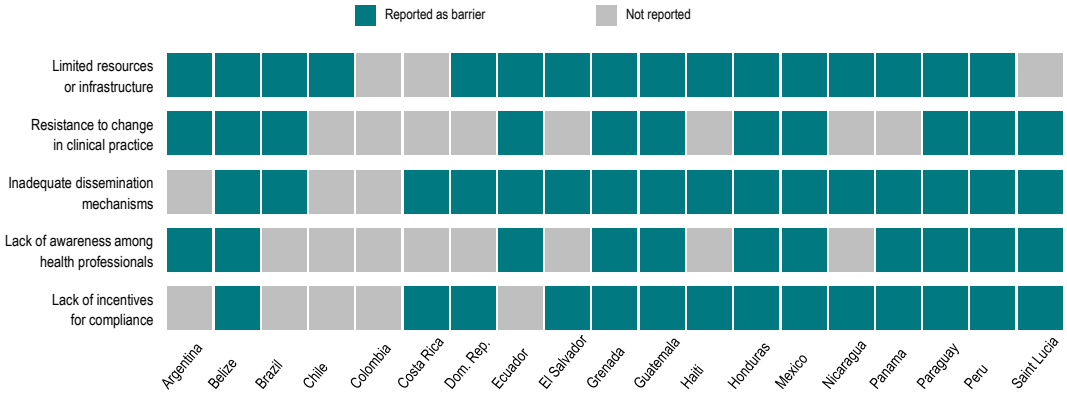
Most countries integrate equity considerations into guideline design. Eight countries: Peru, Paraguay, Mexico, Ecuador, Argentina, Saint Lucia, Costa Rica and Brazil systematically include recommendations to address disparities in diagnosis, treatment, and follow-up for disadvantaged groups. Nine countries: Grenada, Chile, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, Panama and the Dominican Republic occasionally include such considerations. Belize reports that equity is not included in guideline design.

Update cycles for major conditions, including cancer and cardiovascular disease (CVD), vary in frequency. Paraguay reports systematic updates of clinical practice guidelines every 2-3 years for both cancer and CVD; Chile updates cancer guidelines every 2-3 years but does not regularly update CVD guidelines. Peru, Mexico, Argentina and Colombia update guidelines approximately every 4-5 years. Ecuador, Costa Rica, Brazil and the Dominican Republic report that guidelines are not regularly updated. El Salvador, Guatemala, Honduras, Nicaragua and Panama update guidelines only when significant new evidence emerges. Grenada follows a similar evidence-driven approach. The scope of clinical practice guidelines varies across countries. For cancer, Peru, Ecuador, Argentina, Saint Lucia, El Salvador, Guatemala, Haiti, Nicaragua and the Dominican Republic report guidelines that incorporate a patient journey perspective, addressing co-ordination and integration of care across facilities and levels of the health system. Paraguay, Mexico, Grenada, Chile, Honduras and Panama report cancer guidelines that are primarily limited to facility-level clinical specifications. Belize, Costa Rica and Brazil similarly focus on facility-based clinical aspects. For cardiovascular disease, the patient journey perspective is more widespread: Peru, Paraguay, Ecuador, Argentina, Grenada, Saint Lucia, El Salvador, Guatemala, Haiti, Nicaragua and the Dominican Republic incorporate it, while Mexico, Chile, Honduras, Panama, Belize, Costa Rica and Brazil focus on facility-level specifications.

Despite high-quality guidelines, implementation faces barriers. To encourage adherence, countries are implementing monitoring and evaluation systems

Limited resources and infrastructure, resistance to changes in clinical practice, and inadequate dissemination are the most common barriers for implementation of guidelines (Figure 1.8). To encourage adherence, countries are implementing monitoring and evaluation systems: Paraguay, Mexico, Argentina and Chile have established national systems to track the impact of practice guidelines on patient outcomes. Others, like Peru and Grenada, rely on local or regional monitoring. These systems help identify gaps in compliance and prompt targeted training or resource allocation.

Figure 1.8. Reported barriers to the implementation of evidence-based clinical practice guidelines across 19 Latin American and Caribbean countries



Note: Answer to the questions: "What are the main barriers to the implementation of practice guidelines in your country? "
Source: Health at a Glance Latin America and the Caribbean 2026: Survey of quality of care policies.

Importance of health data and digital infrastructure

Health data and digital infrastructure are essential enablers of quality improvement, but their contribution depends not only on data availability, but also on interoperability, linkage capacity, routine use for performance assessment, and meaningful access for patients. As shown in Chapter 5, many countries in Latin America and the Caribbean have established digital health data systems and some capacity for governance and monitoring, yet important gaps remain in data integration across care settings, in

the routine use of data for quality improvement, and in patient access to their own information. These limitations weaken continuity of care, constrain performance measurement and reduce the ability of health systems to support safer, more efficient and more people-centred care. Further details are presented in Chapter 5, in the sections on Health data availability and Health data use and capacities.

Financial incentives to increase healthcare quality

Financial incentives and provider payment reforms can improve care quality and foster integration across levels of care when embedded in coherent, data-enabled, strategically purchased financing systems. Payment methods shape provider behaviour by influencing what is rewarded in practice: they can encourage better co-ordination, prevention and continuity of care, but can also reinforce volume and fragmentation if poorly designed. OECD work has emphasised that purchasing arrangements are most effective when financial incentives are linked to clear quality objectives, reliable measurement and accountability mechanisms, so that payment supports better outcomes and patient experience rather than activity alone (OECD/WHO, 2023[24]).

The degree to which quality is integrated into payment systems varies significantly across the region

Peru and Chile weight quality over 10% of payments for hospital services; Peru extends this to integrated care networks. Saint Lucia, Chile and Brazil apply major quality-linked payments primarily within primary healthcare (PHC). Paraguay, Mexico and Argentina weight quality under 10% of payments in hospital and PHC reimbursement. The remaining 12 countries: including Colombia, Ecuador, Grenada, Belize, Costa Rica, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, Panama and the Dominican Republic report no implementation of quality-linked payment reforms at the national level, though this does not preclude their use at the payer or subnational level.[1] In Colombia, for instance, insurance agencies (EPS) are known to apply performance-based contracting and quality-linked payment modalities unevenly across their provider networks, even in the absence of a nationally standardised policy.

Countries deploy several mechanisms to drive performance. Pay-for-performance (P4P) is used in Peru, Mexico, Saint Lucia, Chile (PHC) and Brazil, linking rewards to quality targets. Results-based financing (RBF) is used in Paraguay, Argentina and Brazil, tying funding to verified outputs and outcomes. Mixed models include Chile's diagnosis-related groups (DRGs) and mandatory contributions, and Grenada's block grants and procurement-based financing. It is worth noting that several of these mechanisms may also operate below the national level through individual insurers, subnational governments, or specific programmatic initiatives in ways that are not captured by a survey instrument focussed on national policy.

International experience suggests that payment reform is most effective when quality-linked incentives are introduced as part of a broader package rather than as a stand-alone lever. Financial incentives alone were generally insufficient to produce major changes in provider behaviour. More promising results were associated with accompanying measures such as training, non-financial incentives, better risk adjustment, clearer quality metrics and greater certainty over payment levels. This reinforces the message that purchasing for quality depends as much on design and implementation capacity as on the existence of incentives themselves (Barber et al., 2025[25]).

To determine these payments, health systems track a variety of performance metrics and indicators

Health outcomes, such as mortality or readmission rates, are utilised in Paraguay, Mexico, Saint Lucia, Chile, Costa Rica and Brazil to determine financial allocations. Success in preventive care measures is a priority for Paraguay, Grenada, Saint Lucia, Chile and Brazil. Furthermore, adherence to evidence-based clinical practice guidelines serves as a formal payment indicator in Paraguay, Chile and Brazil, ensuring that standardised protocols are followed in practice. While less common, patient experience and satisfaction measures are factored into the payment processes in Paraguay, Chile and Panama.

These patterns point to different starting points in quality-linked purchasing. Argentina, Brazil, Chile, Mexico, Paraguay, Peru and Saint Lucia have introduced quality-linked payment mechanisms at the national level, shifting the policy challenge towards improving their design, measurement and alignment with quality objectives. In the remaining countries, where national quality-linked payment reforms are not yet implemented, strengthening the measurement and strategic purchasing foundations needed to introduce such incentives remains a more immediate priority. These distinctions refer to national policy and do not exclude more advanced arrangements operated by individual payers, subnational authorities or specific programmes.

Box 1.4. How selected LAC countries embed quality in provider payment reforms

The following examples show how quality indicators can be incorporated into purchasing and payment decisions rather than collected separately from them.

- Paraguay has introduced results-based financing in seven health regions, establishing clear targets and linking resources to quality indicator compliance across maternal-child health, hypertension, diabetes, women's cancers, HIV/STIs, and tuberculosis.
- Chile employs a hybrid system that integrates diagnosis-related groups with performance elements, leveraging clinical guideline compliance and outcome data to drive hospital performance. Chile also operates a P4P scheme in primary healthcare that rewards PHC teams with bonuses for achieving pre-defined targets on quality of care indicators.
- Peru applies substantial quality weighting across hospitals and integrated networks through results-based budgeting, pilot pay-for-performance schemes targeting specific conditions, and capitation-based contracting at the primary care level, reflecting a progressive incorporation of financial incentives as opposed to a consolidated national system.
- Brazil concentrates payment reforms in primary care, using results-based financing to promote preventive care and community health outcomes.

Source: Health at a Glance Latin America and the Caribbean 2026: Survey of quality of care policies.

Patient safety and medical malpractice

Patient safety is a core principle of healthcare. While complications cannot be fully eliminated given clinical complexity, systematic safety measures can substantially reduce harm. High-quality systems adopt a "systems approach", treating errors as opportunities to address latent failures in processes, protocols, and organisational design (McNab et al., 2020[26]). By prioritizing prevention of avoidable harm, medication errors, surgical complications, and healthcare-associated infections (HAIs) systems protect patients and staff and reduce the financial and psychological burdens of unsafe care (WHO, 2024[10]).

Most countries have established national patient safety leadership, but formal programmes remain uneven

Ministries of Health lead patient safety in 18 of 19 countries, with regional and local health authorities playing a supporting role in 13. Only Panama reports a dedicated national patient safety agency, all other countries lack this institutional layer, which may limit the authority and technical depth available for sustained safety improvement.

National patient safety programmes are present in 12 of 19 countries. Seven countries: Argentina, El Salvador, Guatemala, Haiti, Honduras, Nicaragua and Panama report no formal program. Among countries with programmes, the most widely adopted elements are infection prevention and control, and safe use of medical devices (each reported by 12 countries), followed by surgical safety (11), medication safety and safe blood transfusion (11 each), reporting and learning from adverse events and patient identification (10 each). Prevention of falls, though less common, is addressed by 8 countries.

Adverse event reporting is stronger in the public sector but not yet used systematically for learning

Adverse event and medical error reporting is a key indicator of a maturing safety culture, though implementation differs markedly across sectors. In the public sector, six countries maintain mandatory reporting systems (Paraguay, Ecuador, Colombia, Brazil, El Salvador and Haiti), while eight operate voluntary systems (Mexico, Ecuador, Grenada, Saint Lucia, Chile, Belize, Costa Rica and Brazil with Ecuador and Brazil operating both mandatory and voluntary channels). Six countries report no national public-sector reporting procedure: Argentina, Guatemala, Honduras, Nicaragua, Panama and the Dominican Republic.

In the private sector, the picture is thinner: only Ecuador and El Salvador mandate adverse event reporting from private providers, and five countries offer voluntary systems (Paraguay, Mexico, Ecuador, Belize and Costa Rica). Seven countries report no national reporting procedures for the private sector: Peru, Saint Lucia, Guatemala, Honduras, Nicaragua, Panama and the Dominican Republic. However, subnational standards may exist within the oversight capacities of the regulatory agencies. When adverse event data are collected, their most common use is to inform quality improvement initiatives (9 countries: Peru, Paraguay, Mexico, Ecuador, Grenada, Chile, Colombia, Brazil and El Salvador), followed by professional education (5). However, only four countries use reported data for public reporting (Paraguay, Chile, Colombia and Brazil), and only Paraguay and Haiti apply regulatory measures or sanctions based on reported events. Three countries: Paraguay, Belize and Costa Rica report that collected data are not systematically used. More broadly, the use of adverse event information for learning, public reporting and regulatory action remains uneven.

Most countries have built infection prevention and control programmes, but reporting gaps remain

Robust Infection prevention and control (IPC) programmes are critical to reducing healthcare associated infections (HAIs) and are prioritised across the region. In the public sector, 18 of 19 countries report having IPC guidelines (Argentina is the exception due to missing data); dedicated infection control specialists are present in 16, surveillance systems for hospital-acquired infections in 15, mandatory infection control committees in 16, and regular staff training in 17. The private sector lags modestly: IPC guidelines are in place in 13 countries, surveillance in 12, and infection control specialists in 10, though two countries (Grenada and Panama) report no formal IPC policies for private facilities.

The use of standardised HAI indicators at the hospital level is widespread in the public sector. Surgical site infections (SSI) are tracked by 14 countries, while catheter-associated urinary tract infections (CAUTI) are monitored by 11. Central line-associated bloodstream infections (CLABSI) and ventilator-associated pneumonia (VAP) are each monitored by 12 countries. Hand hygiene compliance rates are tracked by 11 countries, and antibiotic stewardship indicators by 8, though this remains a gap worth noting given rising antimicrobial resistance in the region. Public transparency of these data varies across the region: seven countries report that HAI data in the public sector are nationally standardised and publicly reported (Paraguay, Mexico, Ecuador, Saint Lucia, Chile, Colombia and Brazil). Five countries: Peru, Grenada, Costa Rica, El Salvador and the Dominican Republic maintain nationally standardised data but do not report them publicly. Five countries report no standardised HAI data at all in the public sector (Belize, Guatemala, Haiti, Nicaragua and Panama). In the private sector, public reporting is less common: five countries publish nationally standardised data (Paraguay, Mexico, Ecuador, Colombia and Brazil), while four maintain nationally standardised but non-public data (Chile, Costa Rica, El Salvador and the Dominican Republic). Six countries report no standardised private-sector HAI data (Grenada, Belize, Guatemala, Haiti, Nicaragua and Panama).

Only four countries report having a standardised coding system for safety incidents and near misses

Only four countries (Peru, Argentina, Saint Lucia and Belize) report having a standardised coding system for safety incidents and near misses, such as SNOMED-CT or the WHO International Classification for Patient Safety. Peru notes that its Patient Safety Committees currently use a national framework for adverse event notification and analysis, with SNOMED-CT planned for the next phase. The limited adoption of standardised coding for near misses is significant: capturing events that almost caused harm (but did not) is widely recognised as one of the most effective tools for proactive risk management, and its absence in most LAC countries suggests that safety systems remain oriented toward reactive investigation rather than prospective learning (Alfayez et al., 2025[27]).

People-centred and integrated care

People-centred care is a defining feature of high-quality health systems, shifting from paternalism to partnership, providing care that is respectful of and responsive to individual preferences, needs and values. This approach empowers patients to participate in care decisions, strengthened by health literacy to enable informed choices and enhance safety. Beyond clinical encounters, well-designed systems create opportunities for patient participation in policymaking and systematically solicit consumer feedback, increasing accountability and revealing systemic gaps. Literature tells us that OECD elements of people-centred health systems improve accountability, reveal gaps that matter to users, and help align services more closely with what people need (OECD, 2021[28]). Recent evidence from the OECD PaRIS survey also shows that more people-centred care is associated with better patient-reported outcomes and experiences, particularly for people living with chronic conditions, underlining that patient partnership is not only a matter of responsiveness but also an important contributor to better care (OECD, 2025[29]).

National satisfaction surveys are implemented in 10 of 19 countries

LAC countries employ diverse mechanisms to capture the patient voice, with varying levels of institutionalisation. National satisfaction surveys are implemented in 10 of 19 countries (Paraguay, Mexico, Ecuador, Grenada, Saint Lucia, Chile, Belize, Colombia, Costa Rica and Brazil). Digital transformation has facilitated the rise of online platforms or hotlines for complaints and suggestions in 15 countries, providing a direct channel for user feedback. More formal structures like patient advisory councils or committees are less common but active in Paraguay, Mexico, Chile, Brazil and Haiti. Chile presents a particularly robust model through Law 20.500, which mandates Civil Society Councils and User Consultative Councils in hospitals and Local Development Councils in primary care. By contrast, Argentina, Saint Lucia, El Salvador, Guatemala, Honduras, Nicaragua and the Dominican Republic report limited or no formal national satisfaction survey mechanisms, indicating gaps in how patient opinions influence policy.

Patient organisations are essential advocates, though roles vary. Groups focussing on condition-specific advocacy exist in all surveyed countries except Belize. General patient defense organisations are more prominent in Mexico, Colombia and Brazil. Their influence on care quality is strongest where they are embedded in formal monitoring or policy cycles. For instance, organisations in Paraguay, Chile, Colombia and Costa Rica participate in monitoring and evaluation of services; groups in Paraguay, Ecuador, Argentina, Chile, Costa Rica, Brazil and Panama contribute directly to policy formulation. Belize reports no formal patient organisations, limiting structured representation of patient interests.

Systematic measurement of patient experience remains challenging

Nationwide standardised measurement is reported in Ecuador, Chile and Colombia. In Mexico, Grenada and Brazil, measurements are currently restricted to specific regions or health facilities rather than being a universal national requirement. Nine countries: Paraguay, Argentina, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, Panama, and the Dominican Republic report that measurement is not standardised, and Saint Lucia and Costa Rica report that patient experience is not measured at all. Peru employs the SERVQUAL methodology to evaluate user satisfaction, focussing on the alignment between patient expectations and perceptions.

Data collection is primarily led by Ministries of Health (9 countries) and individual health service providers (9 countries). In some contexts, specialised bodies such as SUSALUD in Peru or the Quality Assurance Agency in Ecuador take the lead. Independent research organisations and patient groups rarely collect or report experience data; Paraguay is the only country identifying independent researchers as key stakeholders in this process.

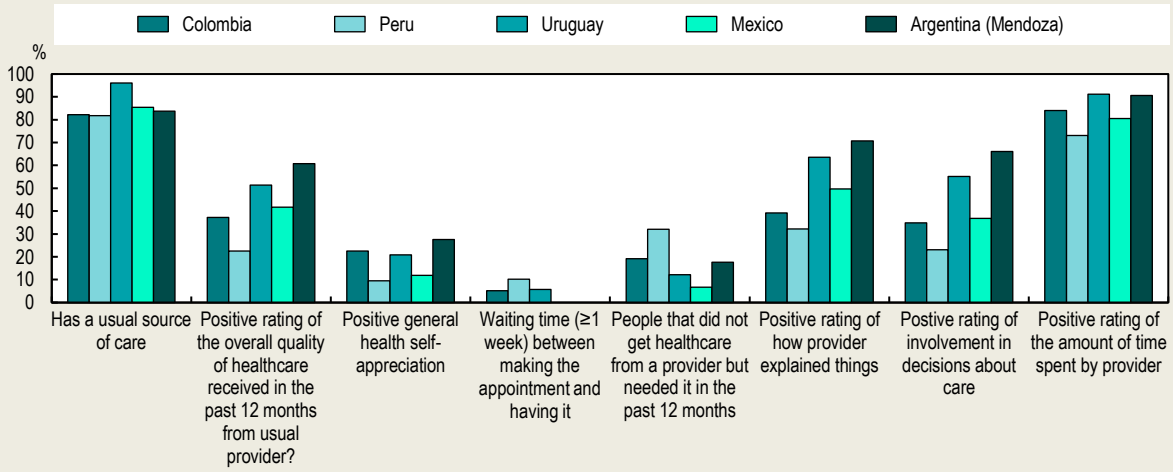
Box 1.5. Patient Reported Experiences: A key element in quality-of-care performance assessment

Patient-reported data complement conventional indicators by showing how people experience care and how health systems respond to their needs. However, their routine, standardised use remains limited across much of the region. In Latin America, five countries participate in the Quality Evidence for Health Systems Transformation (QuEST) Network, a global partnership that promotes high-quality, people-centred and equitable health systems through better measurement and evidence-based practice. A core instrument of this initiative is the People's Voice Survey (PVS), a population-based mixed-mode survey that captures what people value and experience in health systems.

Findings from 2025 in Argentina, Colombia, Mexico, Peru and Uruguay show that, while contact with health services is common, access to high-quality primary care remains limited. Only around 30-35% of adults report having a usual source of care that meets basic quality criteria, and fewer than half strongly believe they would receive high-quality or affordable care if seriously ill. About two-thirds received some preventive care in the past year, but delivery to at-risk groups lags: only around 42% of adults aged 50 and over report cardiovascular risk screening. Results also point to problems with waiting times and continuity, while mental healthcare stands out as a major gap, with only around one-quarter of those reporting need receiving appropriate care.

The OECD Patient-Reported Indicator Surveys (PaRIS) provide a different, more in-depth lens. PaRIS focusses on primary care users, especially people living with chronic conditions, and links patient responses to information from their primary care practices. Across PaRIS countries, 87% of respondents reported a positive overall experience of care and 66% reported good general health.

Figure 1.9. People's Voice Survey: Selected quality of care indicators in LAC countries, 2025



Note: Weighted estimates. Argentina (Mendoza) N=1 190, Colombia N=1 237, Mexico N=1002, Peru N=1 255; Uruguay N=1 237.
Source: People's Voice Survey Quest Network 2025.

E-cohorts: Extending people's voice through longitudinal follow-up

E-cohorts complement the cross-sectional People's Voice Survey by tracking experiences, care pathways and outcomes over time. Implemented in Peru and Uruguay, they combine repeated follow-up with patient-reported and clinical data to assess continuity, responsiveness and effectiveness of care. In Peru, results show this approach is feasible, with over 95% retention, and can improve blood pressure control while exposing persistent gaps in continuity of care.

Source: People's Voice Survey Quest Network 2025; OECD (2025[29]), *Does Healthcare Deliver?: Results from the Patient-Reported Indicator Surveys (PaRIS)*, https://doi.org/10.1787/c8af05a5-en.

Integrated care

Integrated care is central to improving quality in LAC. It organises services into a seamless continuum-from prevention and health promotion through treatment, rehabilitation, and palliative care across all levels and settings. As a strategy to elevate quality, integrated care reduces fragmentation, strengthens provider co-ordination and co-operation, and aligns services with patient needs and preferences, bridging primary, secondary, and tertiary care to avoid siloed delivery and ensure smooth transitions. PAHO has long framed integrated health services networks (RISS) as a key operational expression of primary healthcare, designed to improve access, efficiency and quality (PAHO, 2026[30]). The outcome indicators presented earlier are consistent with this concern: preventive services generally perform comparatively well, whereas acute and chronic-care indicators where co-ordination may be important, vary widely across countries. These patterns should be interpreted cautiously because of differences in access and data completeness.

The transition toward integrated care in LAC faces profound systemic barriers across hospital, primary healthcare, and long-term care settings. The most significant and widespread obstacle is underdeveloped health data infrastructure, limiting real-time exchange of patient information, reported by 17 countries for PHC and 18 for hospitals. There is widespread lack of systematic monitoring of integration's impact on quality and outcomes (noted in 15 countries in PHC; 14 in hospitals). Financial constraints are significant, with 16 countries in PHC and 15 in hospital settings citing insufficient funding and incentives for collaboration. Beyond these structural issues, Mexico highlights a specific gap in the development of management skills for medical unit leaders, while Grenada points to the fragmentation between public and private sectors and the limited integration of mental health and social services as major impediments to a sustainable continuum of care.

Despite these obstacles, countries are advancing policies to strengthen care co-ordination. Multidisciplinary teams are used in 15 of 19 countries: Paraguay, Mexico, Grenada, Saint Lucia, Chile, Colombia, Costa Rica, Brazil, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, Panama and the Dominican Republic. Eleven countries: Paraguay, Mexico, Grenada, Chile, Costa Rica, Brazil, El Salvador, Guatemala, Haiti, Honduras and the Dominican Republic have formal strategies and integrated care protocols. Shared electronic health records (EHRs) between providers operate in Paraguay, Mexico, Costa Rica, Brazil and Panama. Financial incentives and regular monitoring systems to promote and assess co-ordination are in place in Peru, Paraguay, Mexico, Chile and Brazil, with monitoring systems also reported in El Salvador, Guatemala, Haiti, Honduras, Panama and the Dominican Republic. Chile and Brazil also employ patient navigation programmes to support transitions across levels of care.

Countries are at different starting points in the transition from care co-ordination to system-level integration. Paraguay, Mexico, Chile, Costa Rica, Brazil and Panama have begun to complement organisational mechanisms with structural enablers such as shared electronic health records and/or financial incentives for co-ordination. In these countries, the challenge increasingly lies in extending these arrangements across providers and care settings and assessing whether they improve continuity and outcomes. Elsewhere, multidisciplinary teams, protocols and monitoring provide important foundations but strengthening the information and financing infrastructure needed to support integration across the system remains a more immediate priority.

Concluding remarks and actionable recommendations for the Region

The Latin American and Caribbean region stands at a critical juncture. As this chapter has detailed, a foundational infrastructure for quality of care is emerging, with most countries having established basic regulatory frameworks and quality policies. However, the journey from establishing structures to achieving high-quality outcomes is far from complete.

Quality of care policy in Latin America and the Caribbean has moved beyond isolated initiatives and now rests on a recognisable institutional base, but the transition from basic quality assurance to fully operational, learning and people-centred quality systems remains incomplete. Importantly, countries are not starting from the same point, nor do they occupy a single position across all dimensions of quality. A country may have relatively established accreditation or technology-governance arrangements while still consolidating measurement, integrated care or quality-linked purchasing. The next phase is more demanding. It requires stronger use of data, more systematic feedback and transparency, deeper organisational learning, and better alignment between regulation, financing and care delivery across care settings and schemes. This also requires quality to be addressed not only within individual facilities, but across the patient journey, where continuity, referrals, information exchange and accountability across providers increasingly determine whether high-quality care is actually delivered. How countries pursue these shifts, however, will depend on the foundations already in place in each policy area.

The cross-cutting challenges of inequity and weak digital infrastructure require focussed attention. Investing in interoperable data systems is not a technical afterthought but the core enabler for targeting interventions effectively, the identification of hidden disparities and the routine use of patient-reported measures. Closing the quality gaps in LAC depends on connecting robust governance, data systems and strategic incentives, while committing to equity in both public and private sectors. This direction is consistent with the international evidence on high-performing health systems, and it provides the clearest frame for interpreting both the progress already made and the gaps that remain.

Large performance gaps point to unevenly organised care

The region's quality profile is not uniformly weak, but uneven: some indicators show solid performance, while others reveal very large gaps in the delivery of timely and effective care.

- Cross-country differences are largest in indicators that depend on organised treatment pathways and timely clinical management, with nearly fourfold gaps in both treatable mortality and 30-day in-hospital case-fatality after acute myocardial infarction.
- Preventive services, particularly childhood immunisation, tend to perform more strongly than acute and chronic care pathways.
- These indicators remain essential for benchmarking, but they do not measure quality in isolation: differences in access, hospital capacity, coding, referrals and data completeness also shape observed results.

The institutional findings provide some hypothesis-generating patterns, but not a simple relationship between the presence of individual quality mechanisms and outcomes. In several policy areas, particularly quality governance, accreditation and technology governance, countries with more established arrangements also tend to record lower treatable mortality than countries still consolidating these foundations. However, this pattern is neither universal nor sufficient to infer causality. Paraguay illustrates the limitation particularly clearly: despite having comparatively extensive quality policies and institutional mechanisms, treatable mortality and several acute-care outcomes remain relatively poor. Conversely, favourable outcomes can coexist with less developed arrangements in particular policy domains.

Taken together, this suggests that better outcomes are unlikely to depend on any single quality mechanism. Rather, the chapter points towards the importance of combinations of effective governance, organised care pathways, reliable measurement, professional capability and the capacity to implement policies consistently. The next stage of quality improvement lies less in expanding the menu of indicators or policy instruments than in using them to identify where care pathways break down and ensuring that institutional arrangements translate into better care. International evidence points in the same direction: high-performing systems combine outcome measurement with stronger service organisation, transparent performance review and explicit mechanisms to translate results into improvement (OECD/WHO/World Bank Group, 2018[3]).

The region has built the foundations of quality governance, but not yet full learning systems

Progress across all other quality priorities depends on a clear institutional home for quality, with an explicit mandate, sufficient authority and stable implementation capacity across both public and private sectors. While many countries have established these building blocks, strengthening their scope and ability to translate policy into implementation remains a central priority.

Most countries in the region have already established a basic institutional architecture for quality of care. Quality is now widely recognised as a policy priority; Ministries of Health generally lead the agenda; and core regulatory functions are present in many systems. There is however an important distinction between establishing quality structures and developing the full pathway from policy and institutional responsibility to implementation, learning and accountability.

- Licensing, medicines regulation and other baseline stewardship functions are generally advanced, while accreditation, clinical audit, public reporting, decision support and patient-reported measurement are less consistently embedded in routine practice.
- Workforce quality assurance still places greater emphasis on entry into practice than on competence over time: Initial certification is common, but recertification, national examinations and mandatory CME/CPD are much less widespread.
- Health technology assessment and external quality assurance are becoming more institutionalised, but links to reimbursement, equity and broader quality-improvement cycles remain challenging.
- The reach of quality governance across public and private provision remains uneven. Workforce planning is substantially more developed for the public sector, while adverse event reporting and infection prevention and control are also less consistently institutionalised among private providers. In health systems where care is delivered through multiple public and private arrangements, national stewardship needs to ensure that core quality standards, measurement and accountability extend across sectors.

For countries still consolidating these foundations, priorities include clearer governance and accountability, more systematic external quality assurance, stronger mechanisms to maintain professional competence over time, and basic institutional capacity for measurement and patient safety. Countries with more established arrangements face a different challenge: ensuring that existing mechanisms are applied consistently, extend across public and private providers and care settings, and generate learning and accountability rather than compliance alone.

Across these different starting points, however, the broader policy direction is shared: moving beyond regulation and voluntary models towards more institutionalised quality assurance. Mature quality systems combine clear national stewardship with operational plans, regular feedback, professional development, external assessment and stronger use of evidence in decision making, ideally systematically implemented in both public and private sectors, and explicitly linked to financing and public reporting. OECD experience also suggests that professional quality improves when health systems modernise the role of health workers and move from one-off authorisation towards continuous development and accountability. Countries such as France (Haute Autorité de Santé, 2025[31]), where hospital certification is a mandatory external evaluation for all public and private hospitals, and Australia, where national safety and quality standards are embedded in a structured accreditation scheme, illustrate how standards and external assurance can be integrated more systematically with broader quality governance.

The missing bridge is the routine use of measurement, safety information and incentives for improvement

The region is advancing on measurement and safety. Many countries have introduced quality indicators, audit studies, practice guidelines, patient safety structures and, in a few cases, quality-linked payment reforms. The challenge is to organise these tools in an improvement system.

- National quality indicators, audit studies and guidelines are increasingly present, but in many countries they are not routinely linked to supervision, contracting, budgeting or payment. The progression is therefore from establishing reliable measurement and review mechanisms towards embedding their results in routine management, accountability and decision making.
- Patient safety systems are more advanced in infection prevention and control than in organisational learning from harm: adverse event reporting remains uneven, public reporting is limited, and standardised coding of incidents and near misses is rare. The progression is therefore from establishing safety rules and reporting mechanisms towards using information prospectively to prevent recurrence and spread effective practice.
- Argentina, Brazil, Chile, Mexico, Paraguay, Peru and Saint Lucia have introduced quality-linked payment mechanisms nationally, shifting their challenge towards improving design, measurement and alignment with quality objectives. In the remaining countries, stronger measurement and strategic purchasing foundations are generally needed before financial incentives can become a meaningful system-wide quality lever. In both cases, the evidence reinforces the same conclusion: data and incentives are most effective when embedded in broader systems of governance, feedback and implementation support.

The broader literature suggests that this pattern is typical of systems that have assembled the components of quality policy but not yet the feedback loops that make them effective (Institute of Medicine, 2013[13]). The logic of a learning health system is that indicators, audits, incident reports, clinical standards, digital tools and payment should reinforce each other through a continuous cycle of measurement, review and action. OECD work on payment reform similarly shows that financial incentives work best when they are part of a broader purchasing strategy based on reliable data, clear quality objectives and implementation support, rather than a stand-alone lever (Lindner and Lorenzoni, 2023[32]).

People-centred and integrated care remain the least institutionalised dimensions of quality

Countries increasingly recognise that quality must extend beyond individual facilities and episodes of care to the full patient journey. This is particularly important for chronic conditions, multimorbidity and ageing populations, where outcomes depend on continuity across providers and levels of care. People-centred and integrated care are central to this transition, although the institutional mechanisms needed to sustain them can still be strengthened across the region.

- Many countries have some way of capturing patient views, such as satisfaction surveys, complaints mechanisms or patient organisations, but fewer use standardised patient-reported measures or embed patient participation in routine policy and service improvement cycles. Stronger practice in the region is seen where patient voice moves beyond complaints and ad hoc surveys towards more institutionalised arrangements. Chile stands out for its formal participation structures, Peru for regular national measurement of user satisfaction, and Colombia for integrating people-centred information into broader quality observatories and monitoring systems.
- Integrated care shows a similar progression. Multidisciplinary teams, protocols and co-ordination arrangements are increasingly common, while shared records, aligned financing and systematic assessment of continuity remain less widespread. Brazil, Chile, Costa Rica, Mexico, Panama, Paraguay and Peru have begun to complement organisational mechanisms with structural enablers such as shared electronic health records and/or financial incentives for co-ordination. Elsewhere, strengthening the information and financing infrastructure needed to support integration remains a more immediate priority.
- Weak data infrastructure and fragmented financing continue to limit continuity of care across providers and levels of care.

OECD and PAHO emphasise that high-performing systems organise care around people, with patient voice, co-production, integration and continuity across the care pathway as core features; PaRIS further links more people-centred care with better patient-reported outcomes and experiences, particularly for people with chronic conditions (OECD, 2025[29]). The next step is to strengthen referrals, co-ordination, patient participation and information exchange where these foundations remain limited, while more established arrangements can be extended across providers and linked more systematically to patient-reported measurement. Across the region, interoperable data systems and better-aligned financing remain essential to overcoming fragmentation and sustaining continuity of care.

Actionable priorities for the region

The following strategic priorities offer a roadmap for institutionalising quality across LAC. They do not imply a single classification of countries: starting points differ across policy areas, and a country with relatively established arrangements in one dimension may offer opportunities for peer learning while still consolidating foundations in another. For each transition below, starting points are therefore defined by the specific mechanisms already in place, rather than by an overall assessment of the country's quality system.

From basic quality assurance to learning and accountability

For this transition, starting points depend on how far the mechanisms underpinning quality assurance have moved from establishing rules and institutional responsibilities towards implementation, external assurance and systematic learning. Where foundations are still being consolidated, quality responsibilities may remain dispersed, accreditation may be absent, HTA not formally institutionalised, and patient-safety arrangements centred mainly on basic standards. More established arrangements combine clearer national governance with mechanisms that go beyond minimum assurance: formal accreditation complements inspection, HTA operates alongside post-market surveillance, and systems increasingly identify good performance and learn from safety information. Different countries may be further along in some of these mechanisms than others. Examples include primary-care accreditation in Paraguay and Panama, Peru's links between HTA and reimbursement, and mandatory adverse event reporting across sectors in Ecuador and El Salvador.

- **Consolidate national quality governance arrangements.** Where quality responsibilities remain dispersed, formalise mandates, authority, resources and accountability, including oversight of private providers. For example, Guatemala and Honduras, where quality is addressed through broader ministerial structures without dedicated quality units, would benefit first from clearer mandates and co-ordination. Where governance structures are already established, as in Argentina or El Salvador among others, strengthen implementation, co-ordination, learning and accountability. These foundations are critical to the success of system-wide quality initiatives such as Salud Mesoamerica (Box 1.6).
- **Strengthen external quality assurance across care settings.** Countries with no formal or only limited accreditation arrangements should progressively institutionalise external quality assurance, particularly in primary healthcare, private provision and other under-regulated settings. This remains particularly relevant for countries such as Brazil and the Dominican Republic, where formal accreditation is still limited. Where accreditation arrangements are already established, as in Chile or Costa Rica, the priority shifts towards extending their reach across settings and ensuring that external assessment supports continuous improvement rather than compliance alone.
- **Embed health technology assessment in routine decision making.** Countries without formal HTA structures, such as Belize and Grenada, should focus first on institutionalising assessment capacity and linking it to national decision making. Where HTA is more established, as in Peru or Paraguay, the challenge increasingly lies in strengthening links between assessment, post-market surveillance, reimbursement, appropriate use and equity.
- **Develop stronger learning-based patient safety systems.** Where basic programmes and reporting mechanisms remain incomplete, as in Nicaragua or the Dominican Republic, establishing reliable mechanisms for reporting and learning from adverse events remains an immediate priority. Where reporting arrangements are more established, including in Ecuador and Colombia, systems should increasingly strengthen standardised coding, analysis of incidents and near misses, and the use of safety information for learning across public and private providers.

From facility-based quality to quality across the patient journey

Improving quality increasingly requires moving beyond the performance of individual facilities or episodes of care towards the experience and outcomes of people across the full care pathway. This means combining patient participation and patient-reported information with effective referrals, continuity across providers and levels of care, and the information and financing arrangements needed to support co-ordination.

Starting points in this aspect differ according to whether patient voice and care co-ordination remain mainly episodic and facility-based or are becoming embedded across the patient journey. In countries such as Haiti and Honduras, multidisciplinary teams, protocols and monitoring provide important foundations, but stronger information exchange and financing arrangements are still needed to support continuity across providers. Where structural enablers are more developed, as in Brazil or Mexico, the next step is to extend these arrangements across providers and care settings and strengthen accountability for continuity, outcomes and patient experience.

From collecting information to using it for improvement

For this transition, starting points depend on how far quality information has moved from collection and reporting towards routine use in management, accountability and purchasing decisions. In some systems, measurement and audit mechanisms are still being consolidated and quality information remains only loosely connected to decision making. In others, indicators and audit results are already used for feedback, benchmarking or public reporting, while more advanced purchasing arrangements also link provider payment to quality objectives. These dimensions do not necessarily progress together: relatively developed measurement systems may coexist with limited use of financial incentives, and quality-linked payment may operate only in selected services or schemes.

- **Make measurement more consequential.** This remains particularly relevant for countries such as Belize, which does not yet report a national quality indicator set, and Guatemala, where measurement arrangements remain more limited. Where these mechanisms are more established, as in Colombia or Panama, connect them more systematically to supervision, benchmarking, public reporting, contracting and other forms of accountability.
- **Align financing with quality and integration.** Where national quality-linked payment mechanisms are not yet established, as in Colombia or Costa Rica, priorities include strengthening measurement, provider feedback and strategic purchasing capacity. Where such mechanisms already operate, as in Chile or Argentina, the focus should increasingly shift towards improving their design, risk adjustment and alignment with broader quality and integration objectives.

Strengthen conditions for transitions towards better care quality

Workforce capability, interoperable digital infrastructure and equity are enabling conditions across all three transitions. For these conditions, starting points differ independently rather than forming a single progression. In workforce quality assurance, arrangements range from a predominant focus on entry to practice towards combinations of recertification and continuing professional development, while system-wide workforce planning across public and private sectors remains less developed. Digital foundations in the region range from fragmented information systems towards interoperability, linkage, standardised coding and patient access. Equity is also incorporated unevenly, ranging from limited consideration in quality mechanisms to more systematic integration into guidelines, HTA, measurement and performance monitoring.

- **Build continuous workforce quality assurance.** Where professional regulation remains focussed mainly on entry to practice, strengthen recertification and continuing professional development. This is particularly relevant in countries such as Ecuador or the Dominican Republic, where career-long assurance mechanisms remain more limited. Where arrangements are more established, as in Saint Lucia or Mexico, the emphasis can shift towards linking continuing competence more systematically to quality improvement and workforce planning across public and private sectors.
- **Strengthen equity-oriented quality monitoring.** Where equity considerations remain limited within quality mechanisms, build the capacity to disaggregate quality information and incorporate equity systematically into assessment and performance review. Belize and Panama, for example, have scope to strengthen the integration of equity considerations in guidelines or HTA. Countries with stronger measurement and governance foundations, such as Chile or Peru, can increasingly use those systems to identify and act on disparities in quality and outcomes.
- **Invest in interoperable digital infrastructure for quality.** Where digital foundations remain fragmented, prioritise common standards, connectivity and reliable exchange of information across providers, as remains important in countries such as Grenada or Honduras. Where stronger digital foundations are already in place, including Costa Rica or Panama, the next step is to expand data linkage, patient access and the use of digital information for continuity, measurement and quality improvement. Costa Rica's EDUS provides an example of patient-facing digital access, while Argentina, Belize, Peru and Saint Lucia report standardised coding arrangements for safety incidents and near misses.

Box 1.6. The "Salud Mesoamerica" Initiative: An equity-focussed model for quality improvement and results

The Salud Mesoamerica Initiative (SMI) shows how quality improvement and equity can be addressed together. Launched as a public-private partnership led by governments with support from the Inter-American Development Bank and other partners, the initiative targeted the poorest populations in Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama and Chiapas (Mexico). SMI operated through a results-based financing model in which performance awards were disbursed to Ministries of Health upon verified achievement of agreed targets, covering maternal and neonatal care standards, essential obstetric practices and service use, supported by independent measurement, common indicators and hands-on technical assistance to health facilities in the poorest areas for increasing access to quality indicators. Its aim was not only to expand access, but also to improve the quality of maternal and child healthcare in underserved areas through common standards, independent measurement, technical support and results-based financing.

SMI illustrates several of the quality levers discussed in the chapter: rigorous measurement and verification for accountability, learning and improvement, financial incentives tied to results, stronger co-ordination across levels of care, in-facility quality improvement teams and hands-on support for implementation and closing gaps. Reported improvements included better quality of neonatal and obstetric care, wider use of essential maternal care practices, and gains in respectful care and service use among indigenous women in Guatemala and Chiapas.

The key lesson is that equity-oriented policies can also be quality-improvement policies. SMI suggests that when reforms focus explicitly on poor and excluded populations, quality gains can be achieved alongside reductions in disparities in access and service performance. Addressing these disparities simultaneously can improve health outcomes. This provides a useful bridge to the next chapter on equity policies, which examines more broadly how health systems in the region can reduce gaps in care for disadvantaged groups.

Source: Eichler et al. (2017[33]), "The Initial Prize in the Salud Mesoamerica Initiative Results-Based Aid Initiative", https://doi.org/10.18235/0000854; Bancalari et al. (2024[34]), "Using subsidies to enhance access to maternal and newborn health care in remote villages", https://doi.org/10.18235/0013208.

References

Alfayez, A. et al. (2025), "Factors Affecting Patient Safety Near Miss Reporting: A Systematic Review", *Journal of Advanced Nursing*, Vol. 82/3, pp. 2022-2035, https://doi.org/10.1111/jan.70033. [27]

Bancalari, A. et al. (2024), "Using Subsidies to Enhance Access to Maternal and Newborn Health Care in Remote Villages", Inter-American Development Bank, https://doi.org/10.18235/0013208. [34]

Barber, S. et al. (2025), "Purchasing Primary Care Services for Quality Chronic Care: Capitation With Performance Payments in Four Countries", *The International Journal of Health Planning and Management*, Vol. 40/4, pp. 1007-1012, https://doi.org/10.1002/hpm.3929. [25]

Chapman, S. (2025), "Towards identifying good practices in the assessment of digital medical devices: Insights from several OECD countries", *OECD Health Working Papers*, No. 177, OECD Publishing, Paris, https://doi.org/10.1787/b485ee1f-en. [20]

Dmytraczenko, T. and G. Almeida (eds.) (2015), *Toward Universal Health Coverage and Equity in Latin America and the Caribbean: Evidence from Selected Countries*, The World Bank, https://doi.org/10.1596/978-1-4648-0454-0. [1]

Eichler, R. et al. (2017), "The Initial Prize in the Salud Mesoamerica Initiative Results-Based Aid Initiative", Inter-American Development Bank, https://doi.org/10.18235/0000854. [33]

Haute Autorité de Santé (2025), *Haute Autorité de Santé - Comprendre la certification pour la qualité des soins*, https://www.has-sante.fr/jcms/c_411173/fr/comprendre-la-certification-pour-la-qualite-des-soins (accessed on 26 March 2026). [31]

Hussein, M. et al. (2021), "The impact of hospital accreditation on the quality of healthcare: a systematic literature review", *BMC Health Services Research*, Vol. 21/1, https://doi.org/10.1186/s12913-021-07097-6. [15]

Institute of Medicine (2013), *Best Care at Lower Cost*, National Academies Press, Washington, D.C., https://doi.org/10.17226/13444. [13]

Kruk, M. et al. (2018), "High-quality health systems in the Sustainable Development Goals era: time for a revolution", *The Lancet Global Health*, Vol. 6/11, pp. e1196-e1252, https://doi.org/10.1016/S2214-109X(18)30386-3. [4]

Lindner, L. and L. Lorenzoni (2023), "Innovative providers' payment models for promoting value-based health systems: Start small, prove value, and scale up", *OECD Health Working Papers*, No. 154, OECD Publishing, Paris, https://doi.org/10.1787/627fe490-en. [32]

Lorenzoni, L. et al. (2019), "Health systems characteristics: A survey of 21 Latin American and Caribbean countries", *OECD Health Working Papers*, No. 111, OECD Publishing, Paris, https://doi.org/10.1787/0e8da4bd-en. [7]

McNab, D. et al. (2020), "Development and application of 'systems thinking' principles for quality improvement", *BMJ Open Quality*, Vol. 9/1, p. e000714, https://doi.org/10.1136/bmjoq-2019-000714. [26]

Ministerio de Salud de Paraguay (2021), *Resolución S.c. N 117 por la cual se aprueba la estrategia nacional de gestión de la calidad en salud, del Ministerio de Salud Pública y bienestar social*, Paraguay, https://informacionpublica.paraguay.gov.py/public/3156632-RESOLUCIONSGN117DE2021ESTRATEGIADELACALIDADENSALUDpdf-RESOLUCIONSGN117DE2021ESTRATEGIADELACALIDADENSALUD.pdf. [17]

OECD (2025), *Does Healthcare Deliver?: Results from the Patient-Reported Indicator Surveys (PaRIS)*, OECD Publishing, Paris, https://doi.org/10.1787/c8af05a5-en. [29]

OECD (2025), *The State of Cardiovascular Health in the European Union*, OECD Publishing, Paris, https://doi.org/10.1787/ea7a15f4-en. [11]

OECD (2024), *Rethinking Health System Performance Assessment: A Renewed Framework*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/107182c8-en. [9]

OECD (2022), *Towards an Integrated Health Information System in Korea*, OECD Publishing, Paris, https://doi.org/10.1787/c4e6c88d-en. [22]

OECD (2021), *Health for the People, by the People: Building People-centred Health Systems*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/c259e79a-en. [28]

OECD (2017), *Tackling Wasteful Spending on Health*, OECD Publishing, Paris, https://doi.org/10.1787/9789264266414-en. [8]

OECD (2005), *Health Technologies and Decision Making*, The OECD Health Project, OECD Publishing, Paris, https://doi.org/10.1787/9789264016224-en. [21]

OECD/IDB/The World Bank (2026), *Health at a Glance Latin America and the Caribbean: Survey of Quality of Care Policies, 2025*. [14]

OECD/The World Bank (2023), *Health at a Glance: Latin America and the Caribbean 2023*, OECD Publishing, Paris, https://doi.org/10.1787/532b0e2d-en. [6]

OECD/WHO (2023), *Purchasing for Quality Chronic Care: Summary Report*, WHO, Geneva/OECD Publishing, Paris, https://doi.org/10.1787/66dfc7e1-en. [24]

OECD/WHO/World Bank Group (2018), *Delivering quality health services: A global imperative for universal health coverage*, World Health Organization, https://iris.who.int/handle/10665/272465. [3]

O'Rourke, B., W. Oortwijn and T. Schuller (2020), "The new definition of health technology assessment: A milestone in international collaboration", *International Journal of Technology Assessment in Health Care*, Vol. 36/3, pp. 187-190, https://doi.org/10.1017/S0266462320000215. [23]

PAHO (2026), *Redes integradas de servicios de salud - OPS/OMS | Organización Panamericana de la Salud*, https://www.paho.org/es/temas/redes-integradas-servicios-salud (accessed on 10 April 2026). [30]

Roberti, J. et al. (2024), "Inequalities in health system coverage and quality: a cross-sectional survey of four Latin American countries", *The Lancet Global Health*, Vol. 12/1, pp. e145-e155, https://doi.org/10.1016/S2214-109X(23)00488-6. [5]

Superintendencia de Salud de Paraguay (2026), *Funciones – Superintendencia de Salud – Paraguay*, https://superintendenciadesalud.gov.py/funciones/. [18]

Superintendencia de Salud de Paraguay (1996), *Ley N° 1032 que crea el Sistema Nacional de Salud*, https://www.mspbs.gov.py/dependencias/dnvs/adjunto/975a86-LEYN10321996QUECREAELSISTEMANACIONALDESALUD.pdf. [16]

WHO (2024), *Global patient safety action plan 2021–2030: Towards eliminating avoidable harm in health care*, World Health Organization, https://iris.who.int/handle/10665/343477. [10]

WHO (2021), *UHC service coverage index*, https://data.who.int/indicators/i/3805B1E/9A706FD (accessed on 23 March 2026). [2]

WHO (2017), *National quality policy and strategy: WHO meeting report, Geneva, 14–16 June 2017*, World Health Organization, https://iris.who.int/handle/10665/258989. [12]

WHO (2002), *The importance of pharmacovigilance: Safety monitoring of medicinal products*, World Health Organization, https://iris.who.int/handle/10665/42493. [19]

Notes

[1] Survey responses are self-reported by Ministry of Health officials and primarily reflect the public sector. Payment reforms implemented by private insurers or subnational entities may not be fully captured.

2 Inequalities in health and healthcare in Latin America and the Caribbean

While countries in Latin America and the Caribbean have expanded coverage and improved health outcomes over recent decades, there are persistent and large gaps by income, education, place of residence, ethnicity and other population characteristics. These inequalities are reflected in exposure to health risks, access to services, quality of care, financial protection and health outcomes. This chapter examines the main patterns of health inequalities in the region and reviews how countries are responding through policies on governance, financing, service delivery, workforce, digital health, data systems and emergency preparedness. Drawing on regional evidence and a 2025 survey of 14 countries, it finds that policy efforts have advanced further in expanding the availability and affordability of services than in addressing the conditions needed to make care equitable in practice. Reducing inequalities will not only require extending coverage to address remaining gaps in access, but also improving the quality, continuity and responsiveness of care.

Introduction

Across Latin America and the Caribbean (LAC), progress in health coverage and outcomes over recent decades has been meaningful but uneven (OECD/The World Bank, 2023[1]). While many countries have expanded access to services and reduced mortality, large differences persist across population groups and territories. These inequalities are observed across multiple dimensions, including socio-economic status, geography, ethnicity, gender, age, migration status, disability, and health system affiliation, including segmented systems (Atun et al., 2015[2]; Cotlear et al., 2015[3]). As a result, national averages can obscure persistent gaps for specific groups and places.

These inequalities matter not only from a social perspective, but also for the performance of health systems. Where disadvantages accumulate, preventable illness and avoidable mortality remain concentrated, even when overall service contact is high, because effective coverage can remain unequal when service quality, continuity, or affordability differs across groups (Kruk et al., 2018[4]). Inequalities are often associated with delays in care, lower service quality, weaker financial protection, and higher downstream costs (Wagstaff et al., 2018[5]). They also reduce system resilience: shocks such as pandemics, economic crises, or climate-related events tend to widen existing gaps. (PAHO, 2022[6]; WHO, 2025[7]).

Inequalities and inequities

This chapter distinguishes between health inequalities and health inequities, terms that are sometimes used interchangeably but serve different analytical purposes. Health inequalities (or disparities) refer to measured differences in health outcomes, service use, quality, financial protection, or exposure to health risks across population groups. Health inequities are those inequalities that are considered unfair, avoidable, and amenable to policy action, arising from social conditions and from how health systems and other institutions are organised (WHO, 2013[8]). Governments act on inequities, but they rely on the measurement of inequalities to identify problems, monitor trends, and assess progress toward universal health coverage (UHC) and related goals.

Inequalities "in what" and "for whom"

To organise the analysis, the chapter distinguishes what aspects of health and health systems are unequal ("inequalities in what") and which population groups experience these differences ("inequalities for whom").

These aspects correspond to key dimensions commonly used in monitoring progress toward UHC (WHO/IBRD, 2023[9]). They are closely related. Inequalities in exposure to health risks and social determinants shape patterns of health need across populations. Inequalities in access to services, quality of care, and financial protection influence whether those needs are met in a timely and effective way. Inequalities in health outcomes reflect the cumulative effects of these differences. Taken together, they help explain why progress measured at the national level may not translate into comparable gains for all groups, and why persistent inequalities can undermine health system performance and resilience.

Population categories considered in the chapter include demographic and socio-cultural characteristics (such as gender, age, ethnicity, and migration status), socio-economic position (such as income and education), geographic location (including rural, remote, and subnational variation), and other relevant groupings, including disability and health system or insurance affiliation in segmented systems (Table 2.1). These groupings reflect distinct mechanisms through which disadvantage can shape exposure to risks, access to timely and effective care, and protection from financial hardship.

Table 2.1. Inequalities *in what* and *for whom*

Inequalities in what	Exposures and social determinants of health	Access and quality of care	Financial risk protection	Health outcomes
Inequalities for whom	Demographic and socio-cultural (such as gender, age, ethnicity, and migration status)			
	Socio-economic (such as income and education)			
	Geographic (including rural, remote, and subnational variation)			
	Other (such as disability and health system affiliation)			

This chapter first presents stylised facts on health inequalities in LAC across key domains, drawing on available international and regional evidence. It then examines how countries are addressing inequities through health system policies and interventions, highlighting common approaches, gaps, and opportunities. This analysis draws on information reported by countries through a regional survey, which documents the existence of policies, institutional arrangements, and mechanisms relevant to health equity, without assessing their effectiveness or the intensity of their implementation.

The ability to examine inequalities across these dimensions depends on the availability of disaggregated data, which remains uneven across the region. Many countries routinely report indicators by age, sex, and place of residence. However, disaggregation by ethnicity, migration or disability status, or health system affiliation is far less common and frequently reported in categories that are not comparable across countries. As a result, some inequalities are more visible than others, and gaps in data and reporting can limit both monitoring and policy action. These issues are taken up later in the chapter when examining countries' approaches to data, monitoring, and equity reporting.

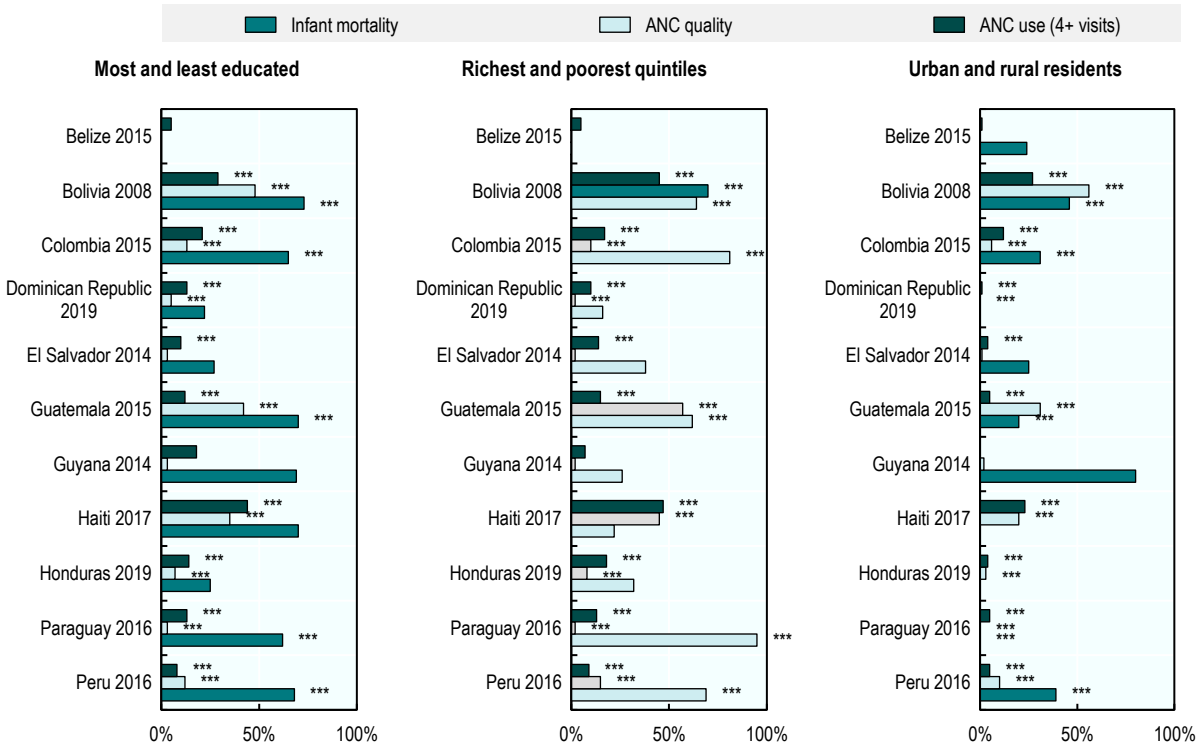
Stylised facts on Health Inequalities in LAC

This section draws on the literature and international data to provide a context for the primary focus of the chapter: the status of policies addressing inequality. Inequalities in health outcomes and healthcare have been a persistent concern in the region and remain observable across multiple domains, although the available evidence on within-country inequalities remains limited to a relatively narrow set of population groups.

Higher status households are more likely to benefit from government- or employer-sponsored health programmes or insurance that provide privileged access to better-quality services than those with lower status, particularly those who are unemployed, employed in informal jobs, or pertain to disadvantaged or marginalised groups. Such programmes sometimes provide higher status families with more financial protection but, in many countries, it is the richer households that have high shares of out-of-pocket spending while poorer ones have unmet health needs or resort to low-cost alternatives or self-treatment. Thus, the inequalities in health outcomes reflect more than differences in household income or assets. They are also transmitted or amplified by the associations between income and fewer health risks, greater access to good quality healthcare, and shares of out-of-pocket health spending relative to household income.

Figure 2.1 presents a picture of gaps in access to care, quality of care, and health outcomes, proxied by Antenatal Care (ANC) use, ANC quality, and the Infant Mortality Rate (IMR). Using data from (Bancalari et al., 2025[10]), these figures show gaps between better off and worse off groups. The gaps are normalised, which eliminates the mean difference between countries and emphasises relative inequality rather than absolute inequality. The value of measuring relative inequality is that it measures the condition of disadvantaged groups compared to what is achieved for the advantage in that same country. For example, in Peru the IMR for the richest was approximately 5.7 per 1 000 live births, compared to around 18.1 for the poorest, a relative gap of 69%. In Haiti, the richest faced an IMR of 45.1 per 1 000 live births, compared to around 58.2 for the poorest, a relative gap of 22%. Thus, while the gap in Peru demonstrates a larger relative gap between rich and poor within that country, overall Peruvians face much lower infant mortality than Haitians.

Figure 2.1. Inequality ratios in maternal and child health by education, wealth and place of residence



Notes: Values report within-country inequality ratios for education, wealth, and place of residence across antenatal care (ANC) use (4+ visits), ANC quality, and infant mortality. For ANC outcomes, gaps are calculated as one minus the ratios of the disadvantaged to the advantaged (i.e. 1 – least educated/most educated; 1- poorest/richest; 1 – rural/urban). Larger values indicate worse coverage or quality among disadvantaged groups and 0 indicates equality. For infant mortality, gaps are calculated as one minus the ratio of advantaged/disadvantaged (i.e. 1 – most educated/least educated; 1- richest/poorest; 1 – urban/rural). This retains the interpretation of larger values as indicating a larger gap between disadvantaged and advantaged groups, with 0 indicating no difference. Country years refer to the survey year; data sources include Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), and Peru's National Demographic and Family Health Survey (ENDES). Asterisks denote statistical significance as reported in the source (*** p<0.01).

Source: Inequalities ratios are based on estimates reported in Bancalari et al. (2025[10]), "Health inequalities in Latin America and the Caribbean: child, adolescent, reproductive, metabolic syndrome and mental health", https://doi.org/10.1093/ooec/odae028.

Health outcomes as measured by the IMR are much better for the richer and better educated than for the poorer and least educated in almost all countries. These gaps are also larger than the gaps in access to antenatal care and to the quality of care. This result is not surprising: infant mortality is affected by many factors beyond healthcare access and quality. The findings are somewhat like the proverbial glass that can be described as half full or half empty. Gaps in access to care and quality are not as bad as the health outcomes; but the gaps are still there. Thus, any factors associated with income or education that create higher risks for disadvantaged groups are not being offset by the healthcare system but, rather, amplified by them.

The urban and rural gaps in healthcare access, quality, and IMR are less well measured. Nevertheless, they present a similar story. For the most part, gaps in access to antenatal care appear to have been quite small in many of these countries, especially considering how dispersed their rural populations are. Bolivia, Colombia, Guatemala, Haiti and Honduras all have gaps in access that are less than 20%. Nevertheless, as with gaps by income and education, gaps in infant mortality remain large and significant between urban and rural areas. This appears to have been particularly true in Bolivia, Guyana and Peru, for which the IMR gap is more than 40%.

Coverage has expanded, but unmet need remains high and unequal

Despite improvements in service coverage in the 2000s, unmet healthcare needs – patients reporting they needed but did not seek appropriate care – remain widespread and highly unequal. Recent estimates suggest wide variation in unmet needs across the Americas, averaging 35%, with rates ranging from 3.2% in Costa Rica to 73% in Peru. Three countries report levels above 50%, and this rises to six countries when focussing on the lowest income quintile (PAHO, 2024[11]). These high rates are in part explained by the transition into successful universal coverage and higher health literacy. In Peru, for example, recent advances into the current 97% health coverage created new awareness of care needs that are still being optimized into the system (Bernal, Carpio and Klein, 2017[12]). Nevertheless, the sharp rise in unmet needs in the region during the COVID-19 pandemic suggests that aggregate gains – including progress in narrowing gaps across and within countries – remain fragile when systems are disrupted, and that disadvantaged groups are more likely to experience deferred or forgone care during shocks.

Within countries, unmet need and service coverage follow clear socio-economic gradients. For instance, coverage of reproductive, maternal, newborn, and child health (RMNCH) services is typically 15-20 percentage points (p.p.) higher among the richest quintile than the poorest. Women with secondary or higher education have markedly higher coverage than those with no formal schooling, and urban populations consistently report higher service coverage than rural residents (PAHO, 2024[11]).

Underlying this pattern there are differences in barriers to access, particularly regarding affordability. Across the region, about one in five individuals in the poorest quintile report unmet needs due to financial constraints, compared to roughly one in ten in the richest quintile (PAHO, 2024[11]).

Gaps in effective coverage and quality persist even where contact is high

As access has improved over time, gaps in quality of care have emerged as a major constraint to improving health outcomes in the region (Figure 1.2, see Chapter 1). A substantial share (an estimated 50-75%) of avoidable mortality in the region is attributable to poor-quality care rather than lack of access (Kruk et al., 2018[13]) (see indicator “Avoidable Mortality (preventable and treatable)” in Chapter 7). Thus, even where service contact is high, effective coverage remains uneven, reflecting shortcomings in continuity of care, diagnostic accuracy, treatment adherence, and system responsiveness.

These quality gaps are not evenly distributed within countries. In maternal health, women with low education and those in the poorest wealth quintile are not only less likely to complete four or more antenatal visits, but also less likely to receive the full package of recommended services compared to more advantaged women. For chronic conditions, socio-economic differences in prevalence are often moderate, yet inequalities widen substantially along the care cascade – particularly in diagnosis, treatment, and effective control (see section “Integrated Care” in Chapter 1). As a result, disadvantaged groups experience lower-quality and less continuous care even in settings where service utilisation is widespread (Bancalari et al., 2024[14]). Limited evidence also suggests that men experience higher levels of avoidable mortality than women, although poor quality likely accounts for most avoidable deaths for both sexes (Vargas, Rios-Zertuche and Bauhoff, 2025[15]).

Financial protection remains stratified

Financial risk protection has improved in parts of the region but remains uneven and often regressive. In 2019, nearly 8% of people in the Americas incurred catastrophic health expenditures, with double-digit catastrophic spending rates in some countries. Out-of-pocket (OOP) spending – often driven by spending on medicines – has declined as a share of total health expenditure since 2000 but still accounts for roughly one-third of health spending regionally, leaving households exposed to financial hardship when care is needed (see indicators “Financing of healthcare from households’ out-of-pocket” and “Financial protection” in Chapter 6).

Financial hardship is not evenly distributed. Rural households and lower-income groups face higher risks of catastrophic and impoverishing health spending; in some countries, the share of rural households pushed into poverty due to health costs is several times that of urban households.

Public policy regarding health financing strongly influences these patterns by affecting who benefits. Countries like Peru (see Box 2.1) and Mexico have retained segmented health systems that provide formal sector workers with better access to higher-quality care than those seeking care at government-run facilities. Countries like Brazil have implemented reforms to unify their

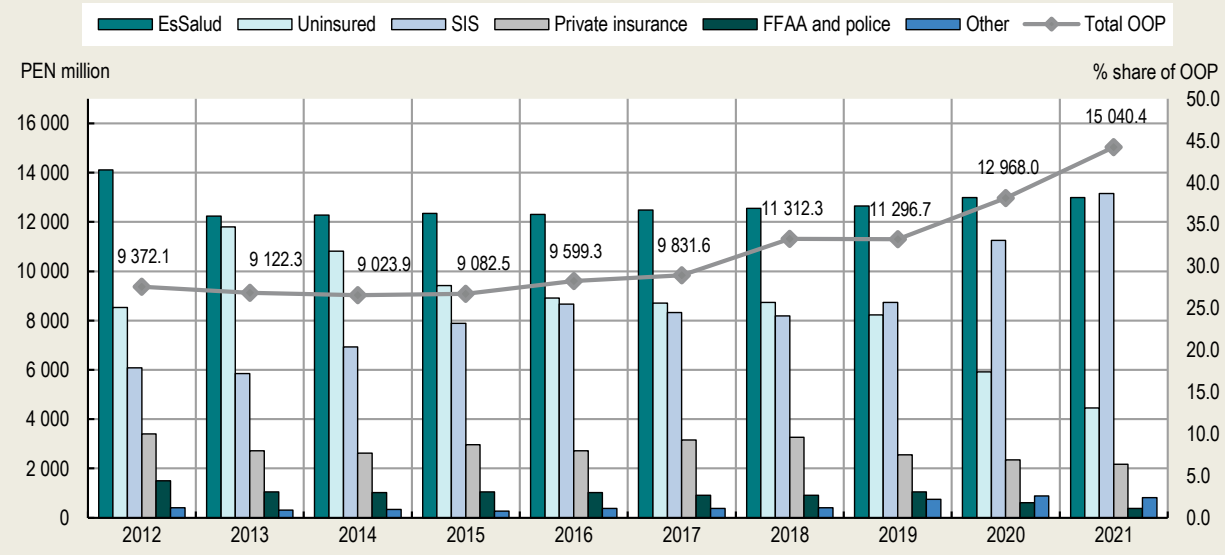
health system and incorporate everyone within the same common national pool; however, the country's upper income classes have opted into private health insurance to get better coverage and care, effectively segmenting the system (OECD, 2021[16]). Only a few countries, like Chile, Costa Rica, Colombia and Uruguay, have programmes which incorporate the whole population in a single system with cross-subsidies; although, even then, benefits and access vary between rural and urban areas and between people who contribute to the system and those who are fully subsidised (Roberti et al., 2024[17]). For Colombia, the system is indeed structured on cross-subsidies and relevant collection capacity. However, persistent inequities are not solely a matter of financial coverage: territorial barriers, particularly between urban, rural and dispersed rural areas, together with constraints in service supply, institutional organisation and differential access conditions, remain key drivers. Recent policy instruments are addressing these gaps, including the National Rural Health Plan, advances in interoperability, differential payment mechanisms, strengthening of national medicines production and public hospital infrastructure projects in rural areas.

Box 2.1. Health system segmentation and financial protection: The case of Peru

By 2023, insurance coverage in Peru had reached 97% of the population. Yet coverage does not translate into equal financial protection. The Seguro Social de Salud (EsSalud), a contributory scheme covering around 26% of the population, primarily formal sector workers, provides broader benefits than Seguro Integral de Salud (SIS), the non-contributory scheme covering around 62% of the population, mostly poor and vulnerable groups. EsSalud members access a full range of specialist and inpatient care, including costly interventions, without co-payments for medicines, while SIS has historically applied spending limits for higher-cost services beyond the basic package. The lack of infrastructure and an insufficient supply of health workers have further constrained what SIS affiliates can access in practice (OECD, 2025[18]).

In 2022, out-of-pocket (OOP) payments accounted for 27% of total health expenditure, 1.4 times the OECD average, despite declining by more than 20% over the preceding decade. Figure 2.2 shows that EsSalud affiliates account for the largest share of OOP, consistent with their higher utilisation of a more comprehensive scheme. By 2021, SIS affiliates had slightly surpassed them, a pattern that reflects direct payments for services covered under the benefit package but not available in SIS facilities. In other words, the increase in OOP among the poor signals a failure to provide care in public facilities along with inadequate mechanisms for financial protection. The trend in OOP spending among SIS affiliates serves as the baseline for Peru's ongoing fiscal reforms. The government is actively strengthening FISSAL (the high-cost fund) and improving the supply chain for essential medicines to ensure universal coverage for the most vulnerable.

Figure 2.2. Out-of-pocket expenditure by insurance scheme, share of total OOP (%), 2012-2021



Note: OOP data by insurance scheme from ENAHO survey.
Source: OECD (2025[18]), *OECD Reviews of Health Systems: Peru 2025*, https://doi.org/10.1787/f3ddb6a4-en.

Governments can offset the inequity inherent in segmented systems through appropriate direct- and cross-subsidies. Somewhat surprisingly, public funding often flows in the opposite direction, favouring privileged groups. Public insurance programmes for formal sector employees can run deficits which are ultimately repaid from general revenues. Governments sometimes respond to public pressures over the cost of healthcare to higher income groups by subsidising private insurance and private provision (OECD, 2021[16]). These patterns show how health financing structures can offset or amplify inequalities in access to services and financial protection.

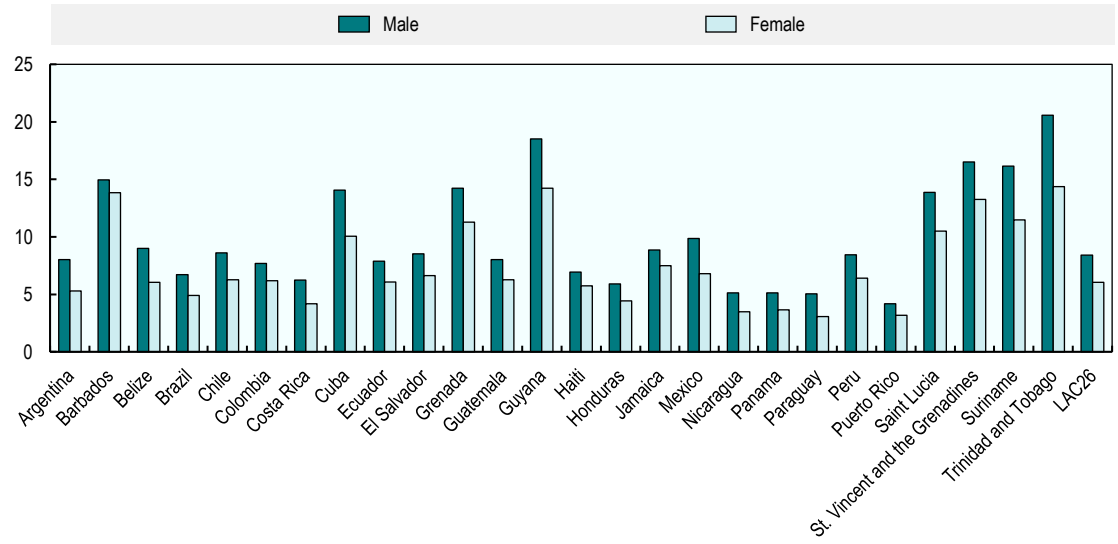
Exposure to health and climate risks follow strong socio-economic and territorial gradients

Across Latin America and the Caribbean, exposure to both health and climate risks is sharply stratified along socio-economic, territorial, and ethnic lines. Children in the poorest quintile face stunting rates that exceed those of the richest by 30 p.p. or more in Bolivia, Guatemala, Honduras and Peru, reflecting deep inequalities in nutrition, housing, food security, and access to safe water and sanitation (see indicators "Child malnutrition" and "Water and sanitation" in Chapter 4). Rural households consistently report lower access to electricity and basic infrastructure than urban households, and Indigenous populations often have systematically lower access to improved water and sanitation than non-Indigenous populations. A substantial share of urban residents lives in slum conditions, where overcrowding and inadequate services compound environmental, infectious, and climate-related risks (Libertun de Duren et al., 2022[19]; PAHO, 2019[20]). Behavioural and injury-related risks follow similar gradients: smoking prevalence and road traffic mortality are consistently higher among men than women, highlighting persistent gender divides in preventable mortality. Overweight and obesity are widespread across the region, but patterns vary by sex and country, often intersecting with socio-economic and territorial inequalities (Bancalari et al., 2024[14]; PAHO, 2019[20]).

Exposure and vulnerability to climate hazards interact with social inequality. Neighbourhoods of higher socio-economic vulnerability are systematically more likely to be at risk of high temperatures, for example in cities such as Barranquilla, Santiago and Mexico City (World Bank, 2025[21]). Flood exposure follows similarly steep social gradients: residents of neighbourhoods in the lowest quintile of educational attainment are several times more likely to experience flooding than those in the highest quintile (Kephart et al., 2025[22]).

The burden of ambient air pollution reflects the same territorial and demographic gradients (Figure 2.3 and Figure 2.4). In 2019, DALYs attributable to ambient particulate matter ranged from under 5 per 1 000 inhabitants in Paraguay and Nicaragua to above 15 per 1 000 in Trinidad and Tobago and Guyana, with males showing a consistently higher burden than females across all countries (Figure 2.3). Children under 15 faced a persistent and largely unchanged burden from ambient particulate matter over the decade, with several countries recording increases (Figure 2.4, left panel). Adults aged 65 and over experienced approximately seven times more DALYs per person from ambient particular matter than children at the regional level, with only modest improvement since 2010 in most countries (Figure 2.4, right panel; see also indicator "Environmental and climate risks" in Chapter 4).

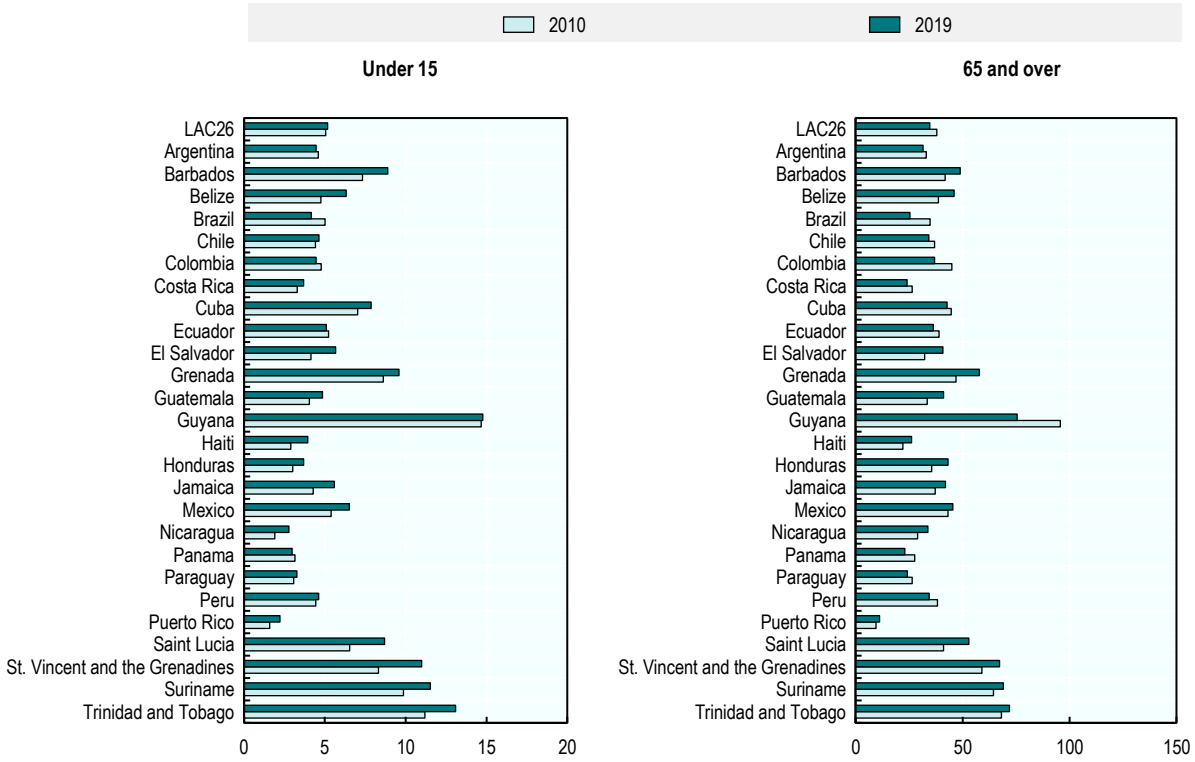
Figure 2.3. Disability-adjusted life years (DALYs) attributable to ambient particulate matter per 1000 inhabitants, by sex, 2019 (or latest year)



Notes: DALYs attributable to ambient particulate matter (PM2.5) per 1 000 inhabitants, all age groups combined. LAC = Latin America and Caribbean regional aggregate.
Source: OECD Environment Statistics, Mortality, morbidity and welfare cost from exposure to environment-related risks (2024).

Figure 2.4. Disability-adjusted life years (DALYs) attributable to ambient particulate matter per 1000 inhabitants, by age

Under 15 (left panel) and aged 65 and over (right panel), 2019 and 2010



Notes: DALYs attributable to ambient particulate matter (PM2.5) per 1 000 inhabitants aged under 15 (left panel) and 65 and over (right panel). LAC = Latin America and Caribbean regional aggregate.
Source: OECD Environment Statistics, Mortality, morbidity and welfare cost from exposure to environment-related risks (2024).

Health outcomes reflect cumulative disadvantage across groups

Differences in exposure, access, quality, and financial protection are reflected in unequal health outcomes. Adult mortality is consistently higher among individuals with lower education, with injuries contributing disproportionately to excess mortality among younger adults and noncommunicable diseases driving disparities among older cohorts (Buitrago et al., 2026[23]). Maternal mortality ratios vary dramatically across countries, from fewer than 20 to several hundred deaths per 100 000 live births. Infant and under-five mortality rates are consistently higher among Indigenous and Afro-descendant populations and among children in the poorest households; in several settings, under-five mortality among Indigenous children exceeds that of non-Indigenous children by 15-35 deaths per 1 000 live births – in some cases nearly double. Early-life disadvantages are further reflected in markedly higher child stunting and adolescent fertility rates among girls from the poorest households (see indicators “Maternal mortality”, “Infant and neonatal mortality”, and “Under age 5 mortality” in Chapter 3).

These inequalities widened during the pandemic. Mortality rates for healthcare-amenable conditions increased roughly twice as much in poorer states as in richer subnational units, underscoring how health shocks disproportionately affect already disadvantaged populations (Bernal Lara et al., 2023[24]; Pinto, Savedoff and Bauhoff, 2024[25]).

Disparities also deepen when considering the full cascade of care. Undiagnosed and untreated chronic conditions are disproportionately concentrated among lower income and lower education groups and in several countries among men. As a result, inequalities in health outcomes reflect not only differences in disease prevalence, but also gaps in detection, continuity of care and effective treatment – reinforcing socio-economic gradients across the life course.

How LAC countries respond to inequities: Insights from the 2025 equity survey

In the context of persistent inequalities, this section examines how countries in Latin America and the Caribbean are addressing health inequities through policy and system reforms, such as governance arrangements, financing choices, service delivery models, workforce policies, and information systems. It also considers countries’ capacity to identify, measure, and monitor inequalities in healthcare, which shapes whether inequities are visible and can be acted upon. We focus on the main functional

levers within the health system and at its interface with other sectors, and how they relate to the patterns of inequality described above. Through these levers, countries can influence whether existing disadvantages are mitigated or amplified. This analysis draws on a survey of health equity policies administered to Ministries of Health in 14 countries in the region: Argentina, Belize, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Nicaragua, Panama, Paraguay and Peru. The survey covered governance, financing, workforce, digital health, data systems, and emergency preparedness, and collected information on the existence and implementation status of policies and institutional arrangements, without assessing whether these legal frameworks and policies translate into effective action and impact for the populations facing the greatest barriers.

Box 2.2. Health at a Glance Latin America and the Caribbean 2026: Survey of Inequality and Inequity in Healthcare Policies

The Health at a Glance Latin America and the Caribbean 2026 Survey of Inequality and Inequity in Healthcare Policies was administered online between October 2025 and February 2026 to officials in Ministries of Health participating in Health at a Glance Latin America and the Caribbean 2026. Six countries responded directly to the survey: Argentina, Colombia, Costa Rica, Ecuador, Paraguay and Peru.

The survey documented how countries in LAC address health inequities through policy, governance, and operational practice. It consisted in three parts: Part I mapped the policy and governance context for equity, such as laws, strategies and financing arrangements. Part II examined the operational enablers of equity, such as data collection and disaggregation, monitoring and evaluation practices, and digital health capabilities. Part III explored cross-cutting and emerging areas, including targeted interventions for disadvantaged populations, and intersectoral action.

Additional information was compiled for the Dominican Republic, El Salvador, Guatemala, Haiti and Honduras. For these countries, the information was collected by the OECD using public sources and interviews with national researchers, rather than through direct completion of the survey by Ministry of Health officials. As such, these country profiles have a different status from the direct survey responses. They reflect, to the best of the Secretariat's knowledge, the most recent publicly available information on the topics covered. The survey and the list of sources used for country profiles collected by the OECD are provided in the annex of the report.

In addition, ad hoc information was gathered for a small number of countries that did not take part in the survey, to illustrate specific policy approaches and to place the chapter's comparative findings in context. This material was compiled from public sources and national authorities for illustrative purposes only. It does not form part of the survey dataset and is therefore not reflected in the survey-based figures and tables, which remain restricted to the 14 surveyed countries.

Source: Health at a Glance Latin America and the Caribbean 2026 Survey of Inequality and Inequity in Healthcare Policies.

Governance and legal frameworks for equity

Countries in the region have built equity commitments into their legal frameworks through two distinct instruments, which operate through different logics and reach different populations. The first establishes comprehensive rights to healthcare, typically anchored in constitutional provisions, giving individuals enforceable claims to services regardless of group membership. For example, in Colombia and Costa Rica, constitutional provisions have been cited in judicial proceedings to expand access to medicines and treatments that public systems had restricted. These judicial mechanisms are not necessarily neutral across socio-economic groups since they tend to be utilised by those who are able to navigate the legal system. The second instrument is group-specific, when governments create programmes to target particular populations such as Indigenous peoples, Afro-descendant communities, migrants, or people with disabilities. Such programmes operate through differentiated entitlements or adapted service obligations rather than universal claims, as in Paraguay's Law 5469 on indigenous peoples' health.

Table 2.2 shows that both instruments are used across the region. The specific instruments that operationalise these commitments include, for example, Colombia's 1991 Constitution (Art. 49), Law 100 (1993), and Decreto 858 (2025) as part of a people- and territory-centred model; Ecuador's 2008 Constitution (Art. 32) and the Ley Orgánica de Salud, alongside ministerial agreements; and Belize's Constitution and sector acts (e.g. Public Health Act) plus strategy documents (BHSSP 2025-2034). Several countries also have multiple instruments within the same category (e.g. more than one statutory or regulatory reference), which suggests that equity commitments are often anchored through layered legal and administrative frameworks rather than a single law. Chile's legal framework illustrates the same layered pattern. The right to health protection is anchored in the Constitution and operationalised through a range of statutory and regulatory instruments governing public and private health coverage.

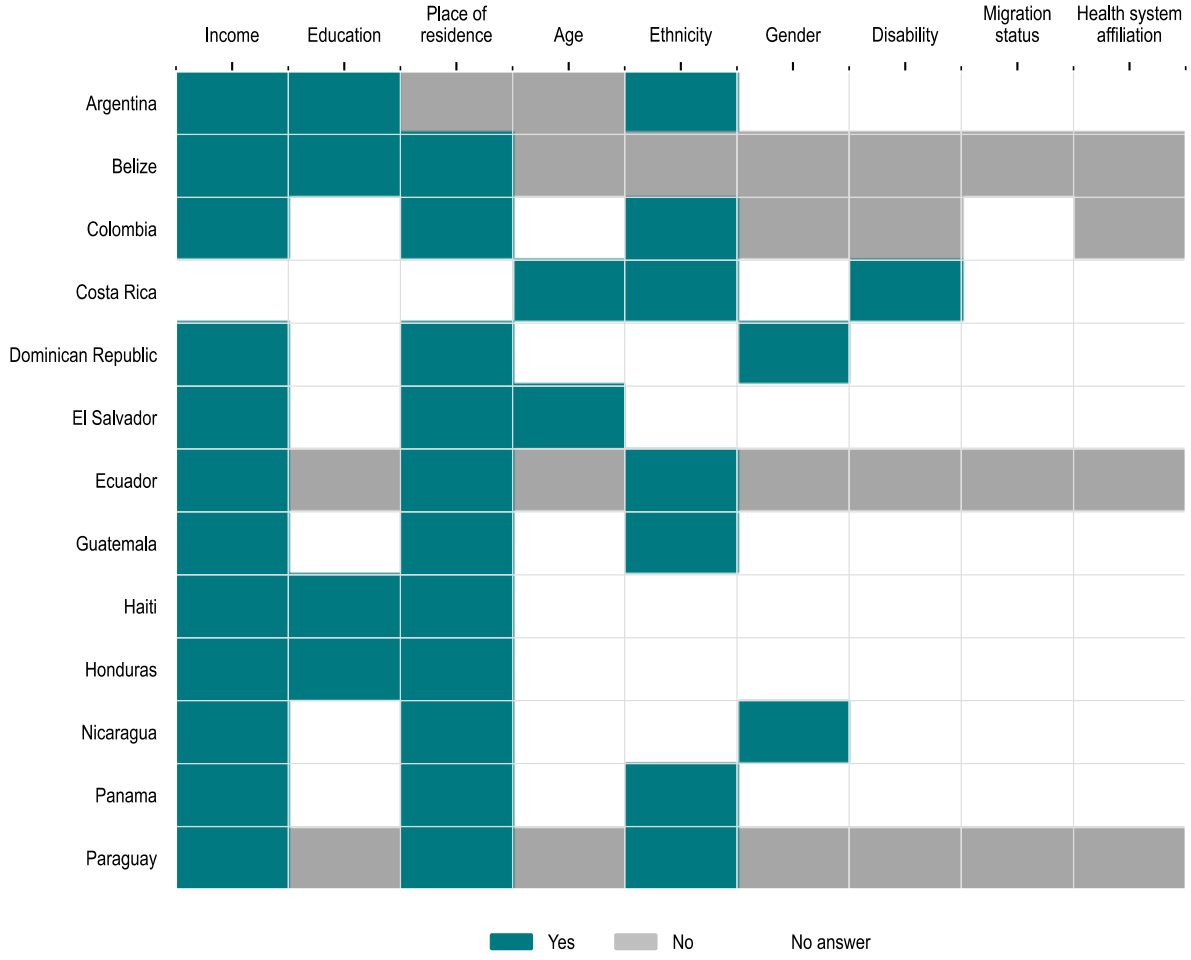
Table 2.2. Existence of national equity strategies and legal mandates

Country	Constitutional	Policy guideline	Regulation	Statutory law
Argentina	✓ (1994)	✓ (2015)	✓ (2023)	✓ (2009)
Belize	✓	✓	✓	✓
Colombia	✓ (1991)	✓ (2022)	✓ (2025)	✓ (1993)
Costa Rica	✓ (1949)	✓ (2023)	✓ (1973)	✓ (1973)
Dominican Republic	✓ (2010)	✓ (2023)	✓	✓ (2001)
El Salvador	✓ (1983)	✓ (2015)	✓ (2016)	✓ (2019)
Ecuador	✓ (2008)	✓ (2022)	✓ (2023)	✓ (2007)
Guatemala	✓ (1985)	✓ (2015)	✓ (2019)	✓ (1997)
Haiti	✓ (2012)	✓ (2021)	✓ (2005)	
Honduras	✓ (1982)	✓ (2013)	✓ (2014)	✓ (1991)
Nicaragua	✓ (1987)	✓ (2015)	✓ (2003)	✓ (2002)
Panama	✓ (2004)	✓ (2016)	✓ (1999)	✓ (1947)
Paraguay	✓ (1992)	✓ (2024)	✓ (1992)	✓ (2010)
Peru	✓ (1998)	✓ (2020)		✓ (2015)

Notes: Cells show a checkmark and, when available, the latest year reported for the legal instrument. Empty cells mean no answer was reported in the survey. Years come from the survey and may reflect updates or amendments rather than the first adoption year.

Figure 2.5 highlights which population groups countries identify as facing the greatest health inequities. Among the 13 countries that provided a ranking, income is the most consistently prioritised (12 countries), followed by place of residence (11 countries). Ethnicity is prioritised in about half of countries (7), while gender is rarely prioritised (2). Colombia, links inequities to persistent poverty and gaps in financial protection, alongside barriers for ethnic groups including weak articulation with traditional medicine and infrastructure and workforce constraints in dispersed rural areas. Belize highlights limited social protection and rural vulnerability to shocks. Paraguay points to financial protection barriers for lower-income groups; uneven service availability outside urban areas; and language and distance barriers affecting ethnic communities. Haiti and Honduras both identified education, linking it to health literacy and service use. Gender appears only in the Dominican Republic and Nicaragua, where it is framed through maternal and reproductive health and gender-based risks. Costa Rica is the only country that identifies disability among the top three inequities, related to structural barriers (e.g. transport and access constraints).

Figure 2.5. Population groups countries identified as facing the greatest inequities



Notes: Cells indicate whether each population group was ranked among the top three groups facing the greatest health inequities. "Yes" means the group appears in the country's Top 3. "No" means the country provided a Top 3 but did not rank that group in the Top 3, yet it may still be reported as facing inequities. "No answer" means no response was provided.
Source: Health at a Glance Latin America and the Caribbean 2026 Survey of Inequality and Inequity in Healthcare Policies.

Financing policies for equity

Figure 2.6 shows the financing mechanisms countries use to reduce inequities in access to care. Across the 14 countries, subsidised or free services are near-universal (13 of 14).

Figure 2.6. Equity-sensitive financing mechanisms



Notes: Cells indicate whether each financing mechanism was reported. "Yes" means the mechanism is in place; "No" means it was explicitly reported as not in place; "No answer" means it was not reported in the survey.
Source: Health at a Glance Latin America and the Caribbean 2026 Survey of Inequality and Inequity in Healthcare Policies.

Copayment exemptions are also common (8 of 14), while targeted insurance coverage is reported by six countries. By contrast, catastrophic expenditure funds are reported by four countries, and both income-based sliding-scale fees and cash transfers or vouchers are reported by only two countries each. The relatively limited use of these more targeted financial protection mechanisms across the 14-country sample is notable given broader OECD evidence that out-of-pocket spending remains an important source of financial hardship, particularly among poorer households (See Box 2.3).

Box 2.3. Out-of-pocket spending and financial hardship in OECD countries

Financial protection remains a major equity issue across OECD health systems. In 2023, households in OECD countries spent on average 3.2% of total household consumption on healthcare goods and services, but the burden varied widely: it was below 2% in Poland, Luxembourg, Colombia and Türkiye, and above 5% in Switzerland, Korea and Chile. Across the OECD, the largest component of out-of-pocket spending was pharmaceuticals and other medical goods (41%), followed by outpatient care (22%), dental care (16%) and long-term care (13%).

The incidence of catastrophic health spending also differs markedly across countries. It affects fewer than 2% of households in Sweden, Slovenia, the United Kingdom, Ireland and the Netherlands, but more than 10% in Lithuania, Latvia and Hungary. In all countries, poorer households are the most exposed. OECD evidence suggests that lower financial hardship depends not only on lower reliance on out-of-pocket payments, but also on how coverage is designed: countries with stronger protection tend to use copayment exemptions for low-income groups, annual caps on payments, and more comprehensive coverage of primary care. Portugal is cited as an example where removing flat-rate charges for primary care and publicly prescribed services may have helped reduce catastrophic spending in recent years.

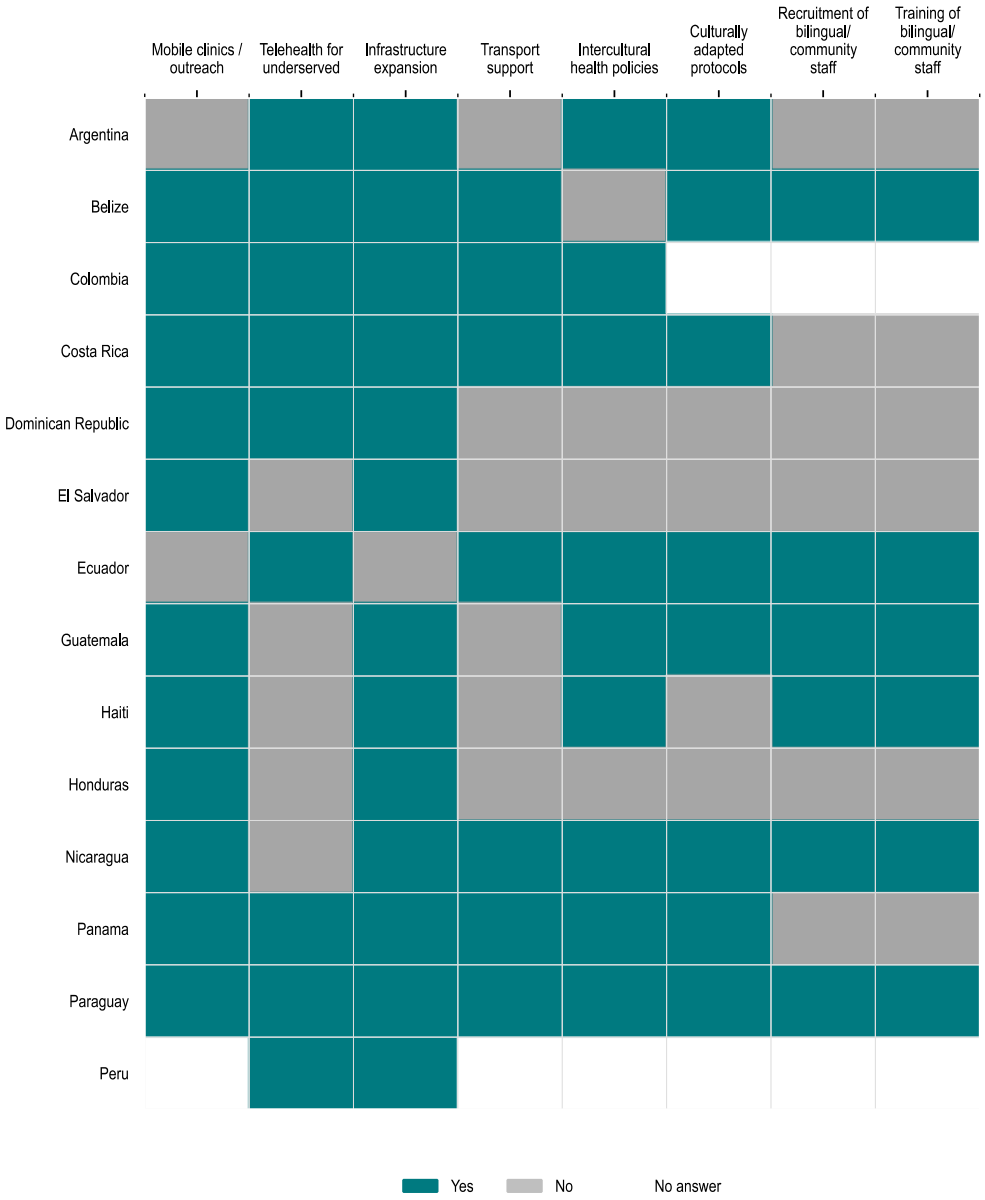
Source: Chapter 5 in OECD (2025[26]), *Health at a Glance 2025: OECD Indicators*, https://doi.org/10.1787/8f9e3f98-en.

Countries with subsidised care tend to implement this policy through a subsidised insurance regime or through free public provision that is intended to eliminate financial barriers for low-income groups. Costa Rica describes “Seguro por el Estado” (“Insurance from the State”) as the channel for insuring people who lack sufficient income, while Colombia offers a subsidised insurance package to people who meet a poverty-based eligibility standard (SISBEN). Copayment exemptions are typically provided as protections for specific vulnerable groups or priority services and appear to reduce point-of-service barriers within otherwise standard benefit structures. For example, Colombia reports exemptions in the subsidised regime, with additional exemptions for specific vulnerable groups (e.g. victims of internal conflict and people with disability certificates). Belize reports no direct user fees for covered services within the National Health Insurance programme in participating regions and reports that it also issues waivers for indigent patients and emergencies. When countries report mechanisms to reduce catastrophic health expenditures, they tend to refer to dedicated arrangements for high-cost conditions. Peru, for instance, notes it has a specialised fund for costly diseases (FISSAL) alongside subsidised insurance coverage. Finally, the few cases reporting transfers or vouchers (Argentina and Paraguay) indicate a complementary route for financial protection, using income support to facilitate access, rather than relying only on reducing user charges within the health system. In Paraguay, this is linked to Tekoporã (cash transfers for households in poverty), described as indirectly helping mitigate health-related spending. Chile, identified in Box 2.3 among the countries with comparatively high out-of-pocket spending, illustrates how such countries are nonetheless strengthening equity-sensitive financing: recent measures include the elimination of copayments in public provision (*Copago Cero*), the financial-protection guarantee embedded in the *Garantías Explícitas en Salud* regime, and schemes to lower the price of medicines.

Access and service delivery

Policies to reach underserved populations are widely reported, with the strongest emphasis on expanding service availability. Infrastructure expansion is nearly universal (13 of 14 countries) and mobile clinics or outreach are also common (11 of 14), while telehealth and intercultural health policies are each reported by 9 of 14 (Figure 2.7). By contrast, measures that strengthen culturally appropriate delivery capacity and reduce practical access barriers are less frequently reported. Transport support is reported by 7 of 14, and recruitment and training of bilingual or community staff are each reported by 6 of 14. Colombia links rural access and telehealth to recent national instruments, including the Plan Nacional de Salud Rural (Decreto 351 de 2025) and the national Telesalud framework (Ley 1 419 de 2010). Belize describes mobile clinics and outreach teams delivering primary care and vaccinations in hard-to-reach villages (including Mayan communities) and telemedicine initiatives in rural clinics. Paraguay provides concrete examples such as a mobile health clinic serving multiple Indigenous communities (Ley N.º 5469/2015 on Indigenous Peoples’ Health). Nicaragua frames outreach through the Modelo de Salud Familiar y Comunitario (MOSAFC), organised via territorial networks (SILAIS) and community brigades. The Dominican Republic emphasises territorial network strengthening and decentralisation under the SNS, and links digital transformation plans (PLANDES 2030) to reducing geographic access barriers.

Figure 2.7. Policies to reach underserved populations



Notes: Cells indicate whether each policy to reach underserved populations was reported. "Yes" means the policy is in place; "No" means it was explicitly reported as not in place; "No answer" means it was not reported in the survey", even though plans for future integration may exist.
Source: Health at a Glance Latin America and the Caribbean 2026 Survey of Inequality and Inequity in Healthcare Policies.

Workforce distribution and culturally appropriate care

A factor in ensuring effective access to healthcare is the location of medical professionals in relation to the population. To achieve an equitable distribution of the health workforce, countries report that they use geographic distribution strategies more often than rural retention strategies. The status of these efforts in terms of implementation also varies widely (Table 2.3). Among countries that reported policy status, geographic distribution is most often described as partially implemented (4 countries), followed by "under development" (2), "actively implemented" (2) and "no strategy" (2). For programmes to improve rural retention of the workforce, the dominant pattern is "no strategy" (6 countries), with fewer reporting "under development" (2) or "partial implementation" (2). Ecuador, Nicaragua and Haiti are among the few reporting an actively implemented geographic distribution strategy. Paraguay reports partial implementation for both distribution and rural retention, suggesting a more coherent workforce approach even if not fully implemented. By contrast, Guatemala and Panama report that they have neither of these strategies and

Colombia reports a distribution strategy under development without a rural retention strategy, reflecting a common gap between planning for distribution and retaining staff in rural areas.

Although few countries reported formal rural retention strategies in this survey, it may understate the range of measures actually in use. A separate review of six countries in the region found that Colombia, Costa Rica, Jamaica, Panama and Peru had introduced financial incentives for rural and remote service, local recruitment, and approaches that strengthen intercultural and community-oriented competencies among health workers (Carpio and Santiago Bench, 2015[27]). This suggests that some workforce measures may exist without being formalised or reported in the survey as explicit national equity strategies.

Table 2.3. Existence of distribution and rural retention strategies

Country	Geographic distribution strategy	Rural retention strategy
Argentina		
Belize	✓ Under development	✓ Under development
Colombia	✓ Under development	No strategy
Costa Rica	✓	No strategy
Dominican Republic	✓ Exists, partial implementation	✓ Under development
El Salvador	✓ Exists, partial implementation	No strategy
Ecuador	✓ Exists, actively implemented	✓ Under development
Guatemala	No strategy	No strategy
Haiti	✓ Actively implemented	✓ Under development
Honduras	✓ Exists, partial implementation	No strategy
Nicaragua	✓ Actively implemented	No strategy
Panama	No strategy	No strategy
Paraguay	✓ Exists, partial implementation	✓ Exists, partial implementation
Peru		

Notes: Cells indicate whether countries reported a national strategy on geographic distribution and rural retention of health professionals, and, when provided, the reported implementation status. “No strategy” indicates the country reported that no strategy is in place. A check mark (✓) without status indicates a strategy was reported but no status category was selected. Empty cells mean no answer was reported in the survey.
Source: Health at a Glance Latin America and the Caribbean 2026 Survey of Inequality and Inequity in Healthcare Policies.

Data systems, monitoring and equity reporting

Data production: digital infrastructure and health information systems

Figure 2.8 shows that digital inclusion policies to help vulnerable groups are not common. Only four countries report at least one inclusion measure (from among subsidised connectivity, devices/kiosks, community access points, or digital literacy). Peru reports using all of the mentioned digital inclusion measures through recent telecom regulations, delivery of kiosks and IT equipment to support electronic health records, expanding access through the National Telehealth Network, and integrating 29 Community Mental Health Centers (CSMC) into that telehealth network. Paraguay reported that it has community access efforts and targeted digital literacy for rural and indigenous women (e.g. programme “Nanum, mujeres conectadas”). Costa Rica created a Virtual Office within the Ministry of Health, conducted a pilot for kiosks in health areas, and developed a teleconsultation decree to regulate use for the population, alongside initial actions to support digital literacy.

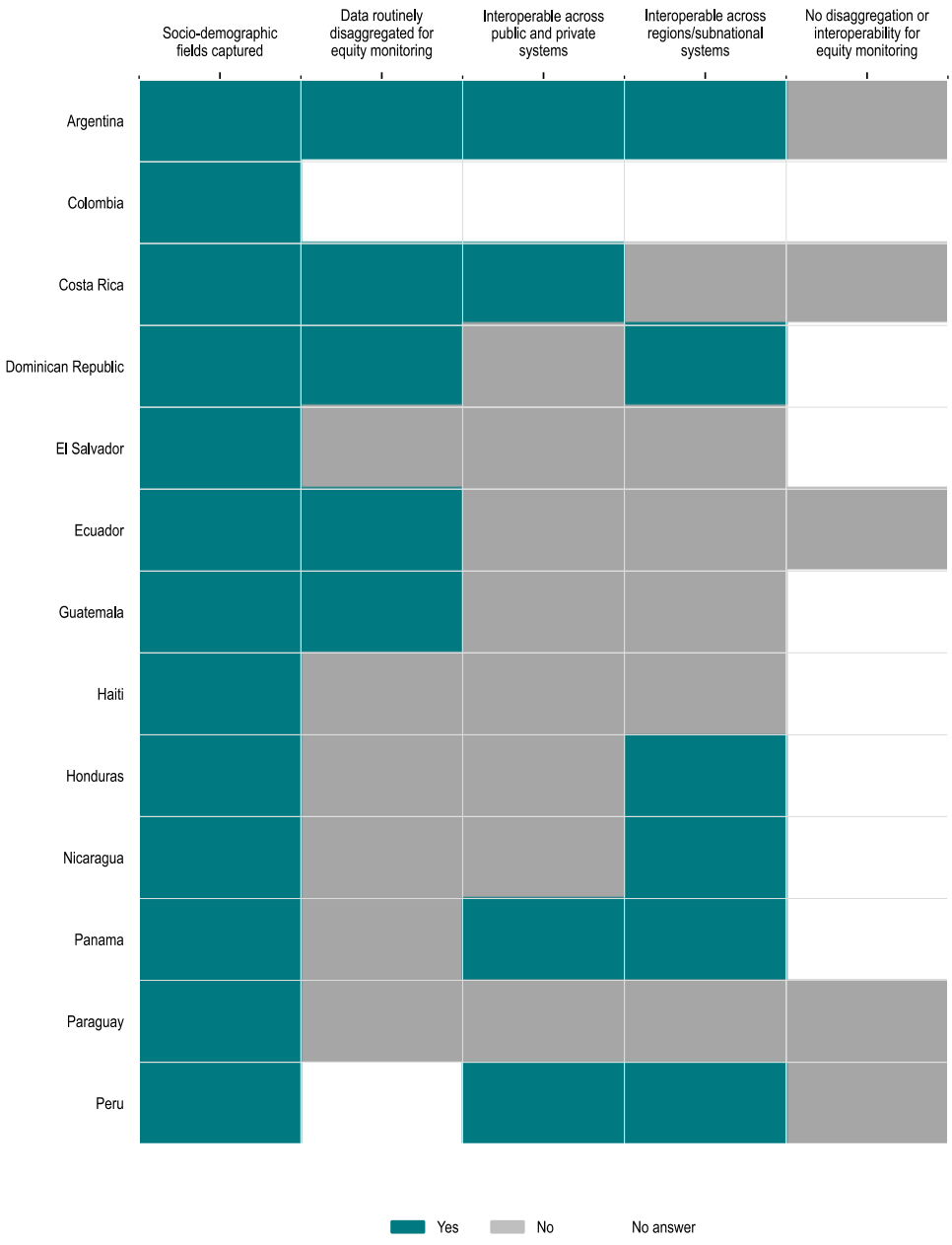
Figure 2.8. Digital inclusion policies for vulnerable groups



Notes: Cells indicate whether countries indicated specific digital inclusion measures for vulnerable groups in the survey. "Yes" lists countries reporting the measure; "No" indicates the measure was explicitly reported as not in place; "No answer" indicates it was not reported.
Source: Health at a Glance Latin America and the Caribbean 2026 Survey of Inequality and Inequity in Healthcare Policies.

While all countries report capturing socio-demographic data that is useful for measuring inequality, routine equity disaggregation is only reported for five countries (Argentina, Costa Rica, Dominican Republic, Ecuador, and Guatemala). Furthermore, interoperability of data systems across public – private or subnational systems is also uneven (Figure 2.9; see indicator "Health data availability" in Chapter 5). Costa Rica anchors its system in EDUS (Expediente Digital Único en Salud) and reports routine production of disaggregated outputs via the CCSS statistics unit. Paraguay describes its health information systems (HIS) as the backbone for routine service reporting but notes that it has incomplete geographic coverage and lacks interoperability. Ecuador reports it has more centralised data systems at the primary care level and more decentralised data arrangements for hospital care. Chile reports recent investments in its health information infrastructure that are relevant to equity-oriented monitoring, including the 2024 rollout of an open-source platform for the collection, analysis, and dissemination of health data, and the 2025 adoption of an interoperability standard to link records across systems and support a shared clinical history.

Figure 2.9. Electronic health record (EHR) and health information systems (HIS)

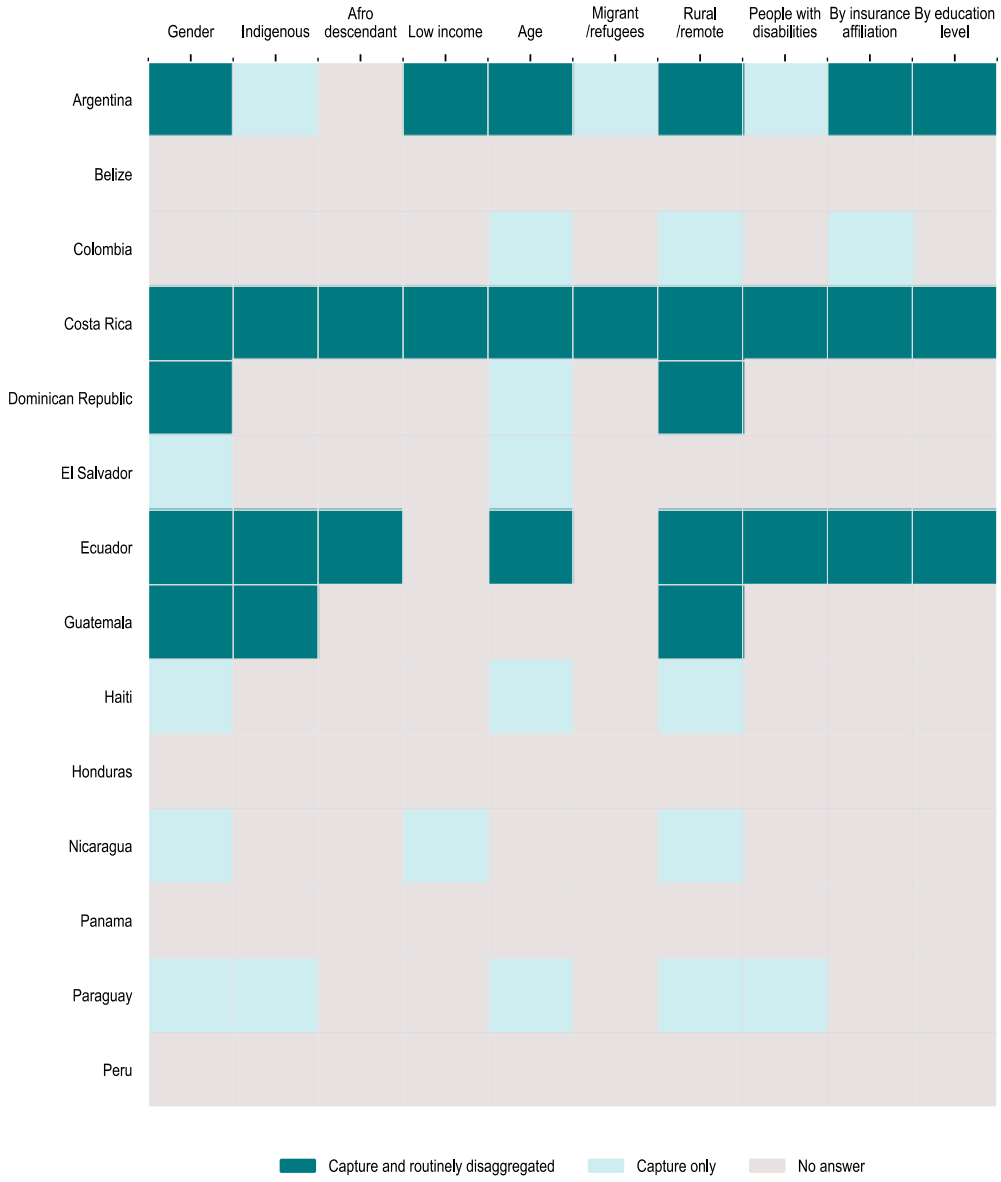


Notes: Cells indicate whether countries indicated selected EHR/HIS features in the survey. “Yes” lists countries reporting the feature; “No” indicates it was explicitly reported as not in place; “No answer” indicates it was not reported.
Source: Health at a Glance Latin America and the Caribbean 2026 Survey of Inequality and Inequity in Healthcare Policies.

When collecting data, only three countries report routinely gathering information across a wide range of categories: Costa Rica, Ecuador and Argentina (Figure 2.10). Among the other countries, Guatemala is the only one that explicitly collects information on ethnicity. Several countries reported that they only collect standard administrative fields (sex, age and place of residence) or include, in addition, one or two other equity-related categories.

Countries like Honduras and Haiti did not select specific population groups in the structured survey response but provided contextual information through open-ended responses. Honduras reported that its surveillance platforms (ESAVI/EVADIE) typically capture age and sex but notes limited documentation on broader socio-demographic fields or interoperability standards, and Haiti similarly describes routine capture of age, sex and geography for surveillance and reporting, but no routine capture of variables such as income, education, disability or insurance affiliation in the documents reviewed.

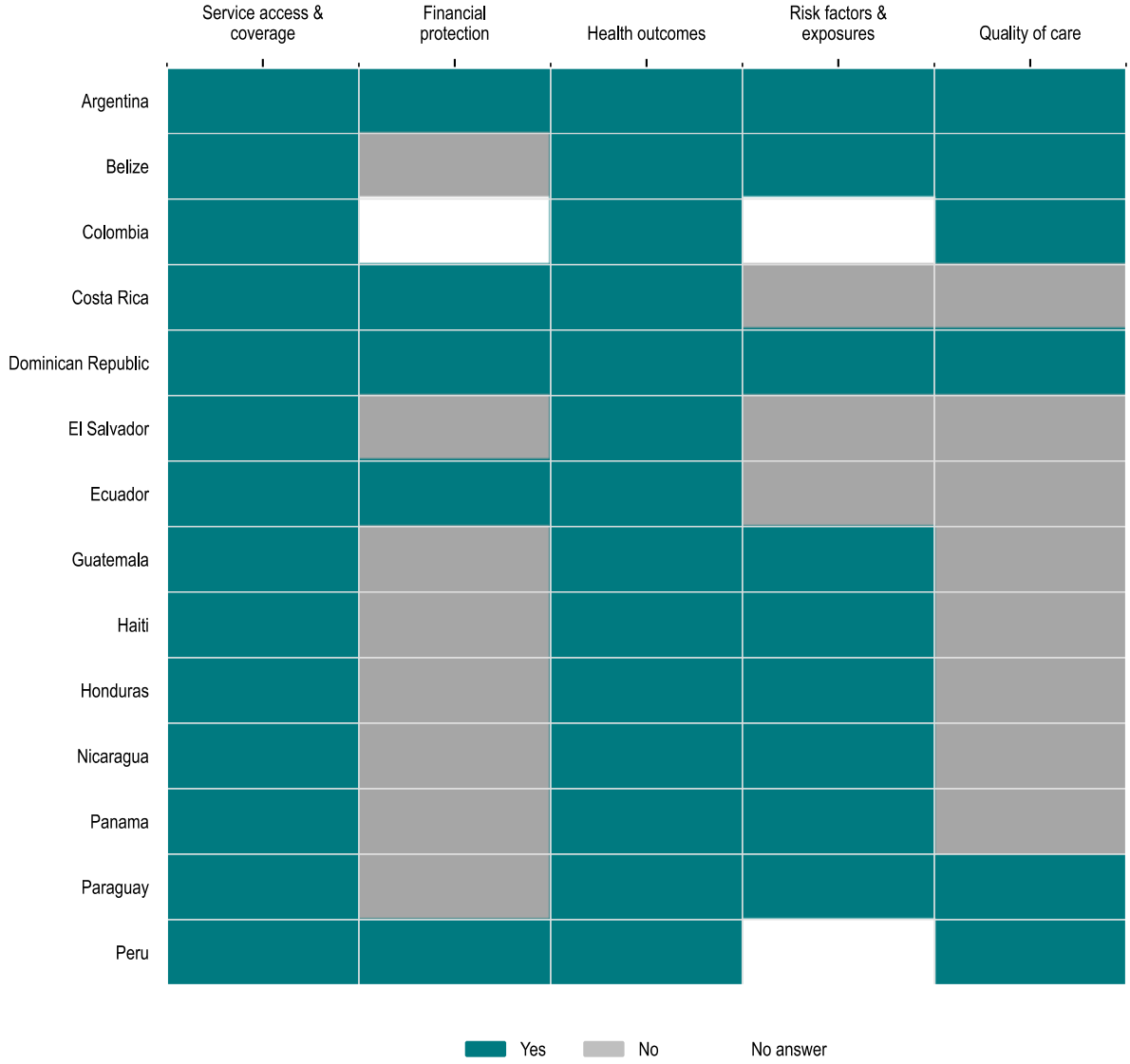
Figure 2.10. EHR / HIS systems capturing social stratification



Notes: Cells summarise which population groups are reported as captured in the EHR / HIS systems. Countries reported the population groups in the EHR/HIS features; grey cells indicate the information was not reported.
Source: Health at a Glance Latin America and the Caribbean 2026 Survey of Inequality and Inequity in Healthcare Policies.

Figure 2.11 shows that all surveyed countries collect disaggregated information for service access and coverage and health outcomes, while data gathering is more uneven for risk factors (10 countries), quality of care (6 countries), and financial protection (5 countries). Argentina links disaggregation to a mix of programme monitoring and sector information systems, including SITAM. Colombia describes national production of disaggregated indicators for access and outcomes, and notes that quality monitoring is closely tied to evaluations of EPS performance and related regulatory instruments rather than being systematically embedded in routine disaggregated indicator reporting across domains. Costa Rica highlights EDUS and the CCSS statistical function as the backbone for routine disaggregation, and notes that some equity metrics are derived from household data. Paraguay grounds disaggregated data in the national HIS, where indicators are generated mainly from facility service records (e.g. consultations), and notes that incomplete coverage and interoperability constrain broader routine disaggregation. The Dominican Republic references indicator production under PLANDES 2030, while Honduras and Haiti describe data collection that is largely organised around standard administrative breakdowns (age, sex, and territory), with more limited documentation of routine disaggregation for broader equity stratifiers (e.g. ethnicity, income, disability, or migration status).

Figure 2.11. Availability of disaggregated indicators by domain

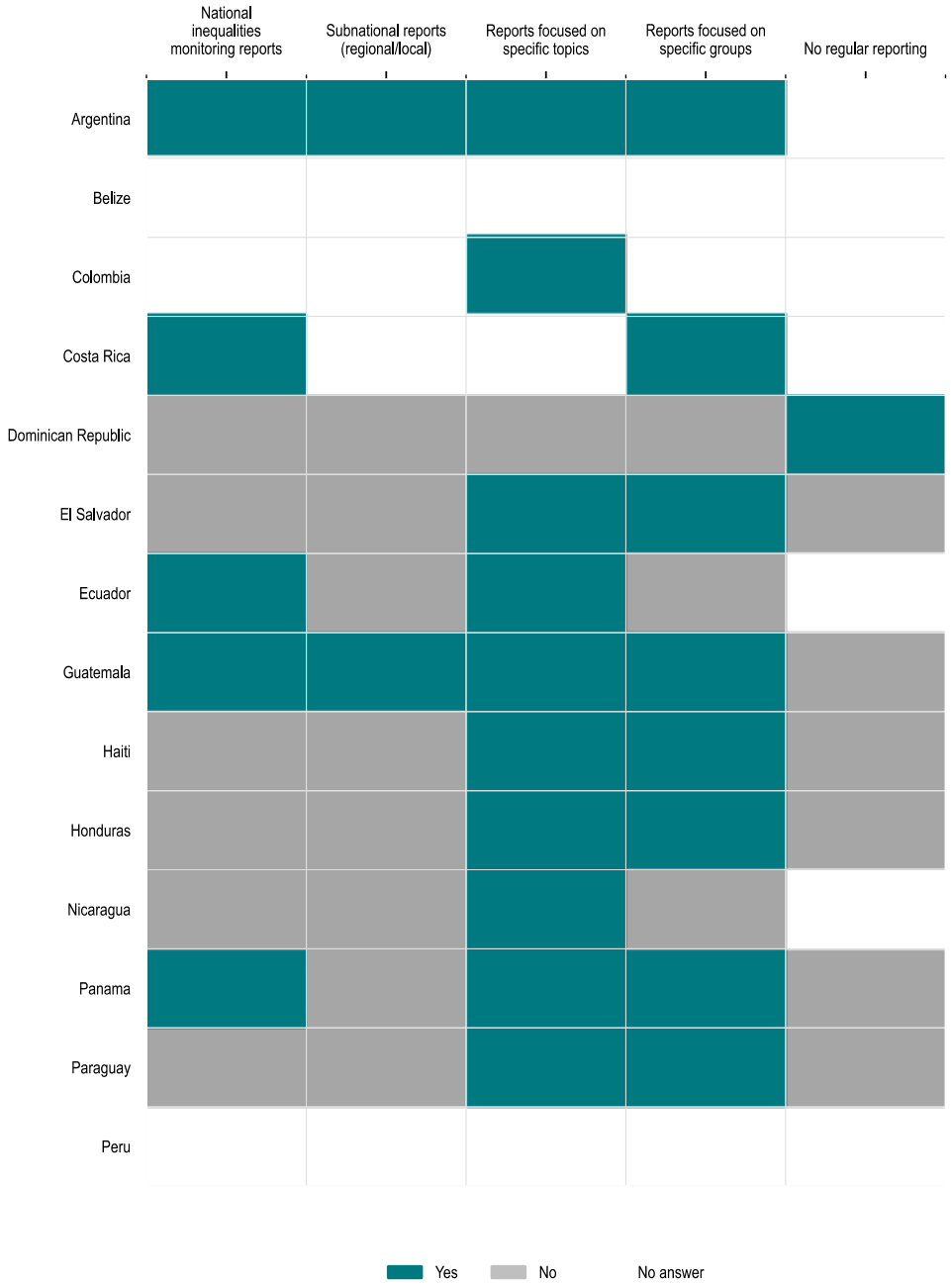


Notes: Cells indicate whether countries reported having disaggregated indicators available for each monitoring domain. "Yes" means the country reported disaggregation in that domain; "No" means the country reported not having it; "No answer" means it was not reported in the survey. "Yes" may reflect disaggregation produced from administrative systems and/or household surveys, depending on the country.
Source: Health at a Glance Latin America and the Caribbean 2026 Survey of Inequality and Inequity in Healthcare Policies.

Data use: Monitoring and reporting on inequalities

Figure 2.12 summarises whether countries report producing regular equity reports. In the survey, topic-focussed reporting is the most common format (10 of 12 countries), followed by group-focussed reporting (8 of 12). By contrast, fewer countries report a national inequality monitoring report (5 of 12), and subnational reporting is rare (2 of 12). Ecuador cites a national inequality report ("Informe país sobre desigualdades en salud", 2025) and uses it both as a national monitoring product and to inform topic-focussed reporting. Panama similarly references a national equity study ("Estudio Nacional de Equidad en Salud Sostenible") used for national monitoring and for reporting by topic and group. Argentina reports national and subnational reporting, noting that topic-focussed products are often produced on request and that group-focussed reporting is channeled through institutions such as DNAPSySC and PNSPI. Costa Rica reports group-focussed reporting and clarifies that INEC mainly publishes results rather than issuing dedicated technical reports, while several institutions (e.g. CONAPAM, CONAPDIS, INAMU) produce reports focussed on specific groups (e.g. gender, age, rural/urban, and disability). Paraguay reports topic- and group-focussed reporting and attributes regular reporting to the MSPBS, centred on routine reporting of health outcomes.

Figure 2.12. Availability of regular equity reports



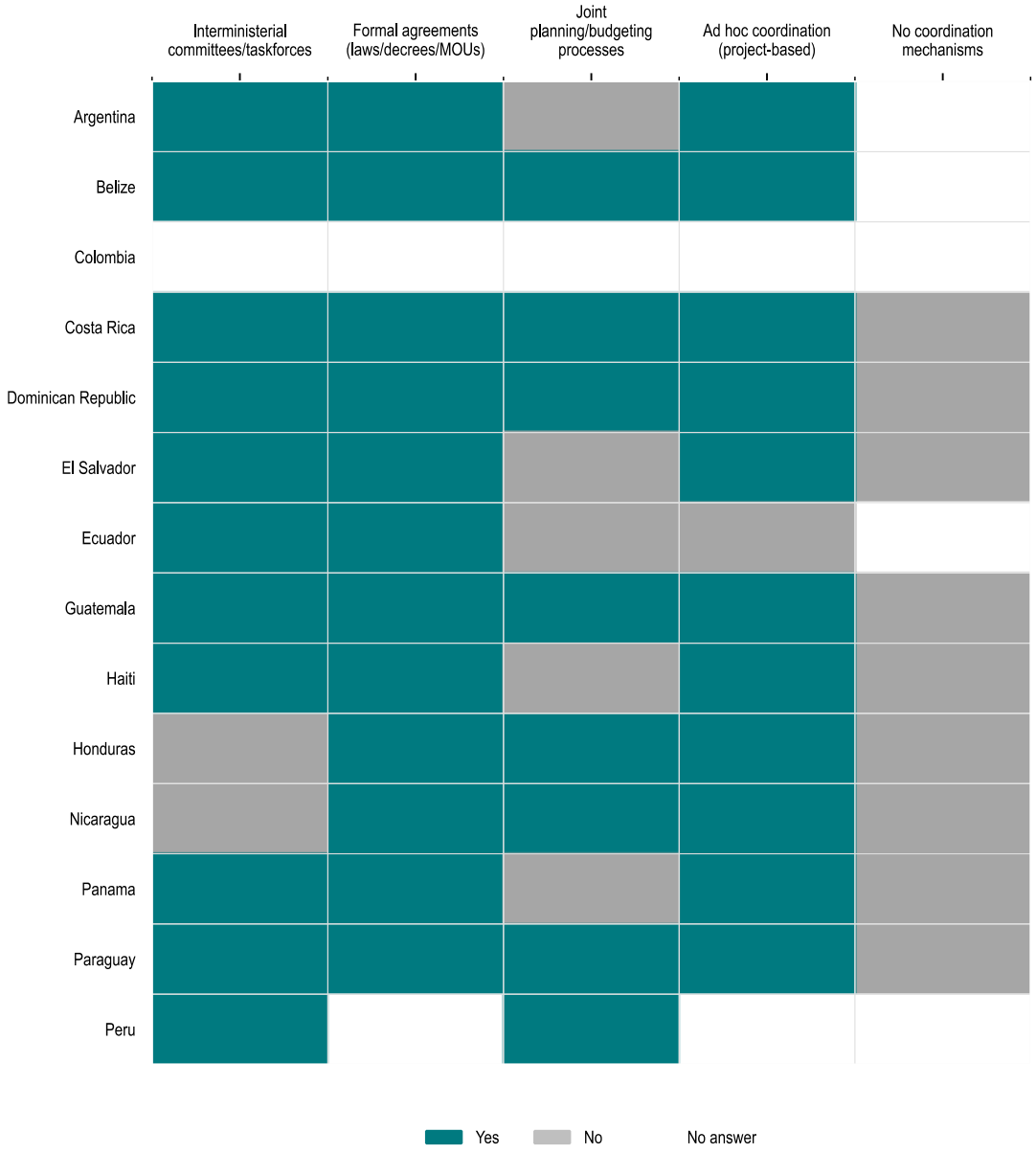
Notes: Cells indicate whether countries have national or subnational regularly reports on health inequalities; at least once every 2 years, rather than ad hoc or one-off publications.
Source: Health at a Glance Latin America and the Caribbean 2026 Survey of Inequality and Inequity in Healthcare Policies.

Intersectoral action and social determinants

All countries that responded to questions about intersectoral co-ordination reported at least two mechanisms for implementation. Across the 14 countries, formal agreements were reported by 12, interministerial committees or taskforces by 12, ad hoc co-ordination by 11, and joint planning/budgeting by 9 (Figure 2.13). In Ecuador, intersectoral action is linked to specific inter-institutional bodies, including committees on violence against women, maternal and neonatal health, and adolescent pregnancy prevention, and to national co-ordination around chronic child malnutrition ("Ecuador Crece sin Desnutrición Infantil"). Colombia did not report a specific mechanism for intersectoral co-ordination but highlighted intersectoral action in its National Development

Plan, explicitly framing health as being articulated with education, housing, safe water, basic sanitation, digital connectivity, and decent employment. In Argentina, the survey response highlighted active co-ordination between the national and subnational level and noted that formalisation often occurs through specific agreements and legal instruments (laws, resolutions, or administrative provisions); it also references co-ordination with Indigenous and civil registry agencies for territorial implementation. Costa Rica points to a single operational entry point, its Unidad de Planificación Sectorial, describing participation through commissions across multiple co-ordination modalities. Paraguay reports both interministerial groups and formal instruments, citing co-ordination around the Sistema de Protección Social and joint planning for large investments (e.g. between MOPC and MSPBS), while also noting that co-ordination can remain project-based rather than fully institutionalised. Peru highlights the Consejo Nacional de Salud as an articulation space across levels of government and civil society, noting the creation in September 2024 of a working commission on social determinants and the role of subnational councils and district committees in priority-setting. The Dominican Republic frames intersectoral action through formal legal and planning instruments, while Haiti links co-ordination primarily to emergency-oriented multisectoral planning (including RSI action planning and the health ministry's co-ordination role).

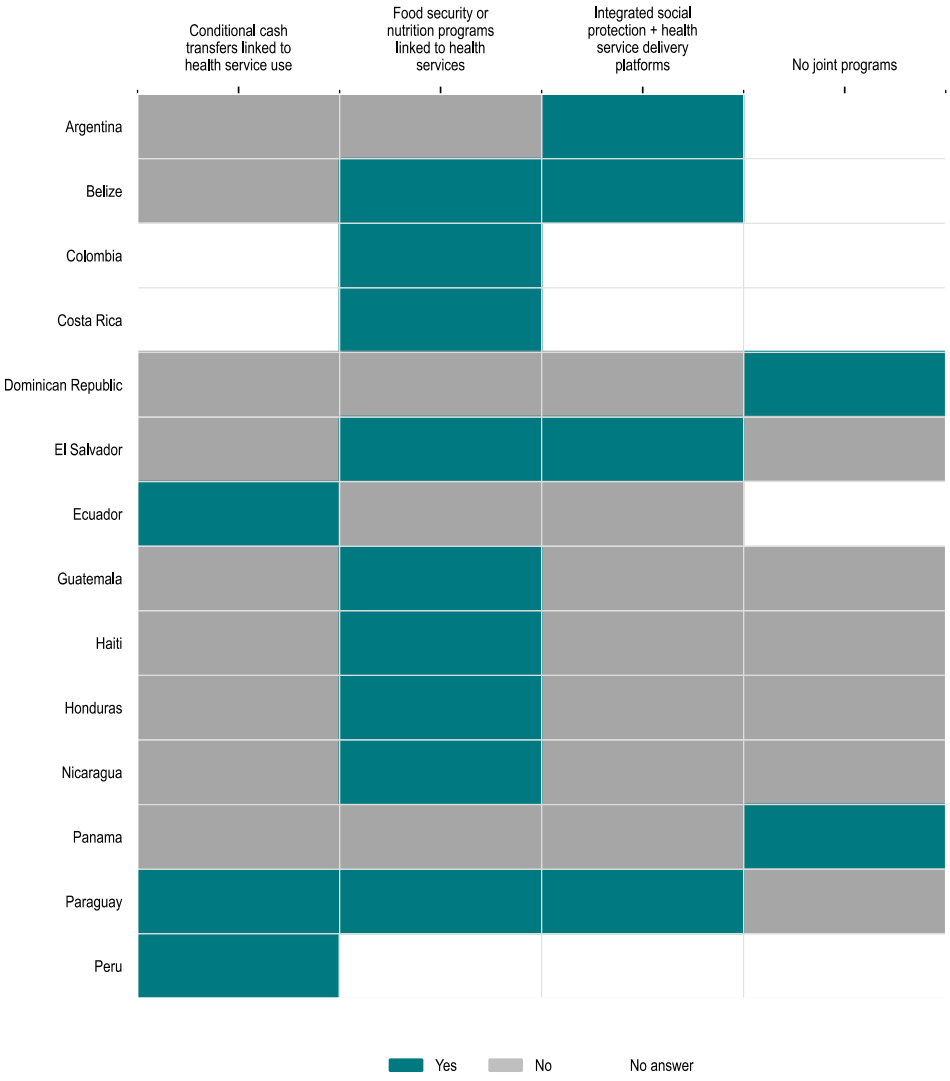
Figure 2.13. Mechanisms for intersectoral co-ordination



Notes: Cells indicate whether countries report each type of intersectoral co-ordination mechanism. "Yes" and "No" reflect the survey response for that item; "No answer" means it was not reported in the survey.
Source: Health at a Glance Latin America and the Caribbean 2026 Survey of Inequality and Inequity in Healthcare Policies.

Food security/nutrition linkages are the most frequently reported of joint programmes (9 of 14 countries) that connect social protection and other sectors with health objectives, followed by conditional cash transfers (5 of 14) and integrated delivery platforms (4 of 14) (Figure 2.14). Paraguay references Tekoporã (Ministry of Social Development), describing conditionalities linked to health actions such as vaccination and prenatal care, and situates these efforts within the Sistema de Protección Social (SPS); it also notes that joint work is not always present across all categories. Peru cites JUNTOS as a conditional transfer programme promoting access to health, education and nutrition for poor households, particularly those with pregnant women and children, and highlights Programa Nacional PAIS, described as delivering multisectoral “caravanas” and co-ordinated service packages that include health, food security and access to social programmes through service platforms. Ecuador points to the “Bono de los 1000 primeros días" as a mechanism linked to early-life nutrition and health. Colombia links joint action to Hambre Cero, described as coordinated implementation across institutions and regions, prioritising territories facing more severe food insecurity. Costa Rica and Belize frame the nutrition-health linkage more through service and guidance packages (e.g., dietary guidance and first-1,000-days materials in Costa Rica; and integrated nutrition and food support initiatives linked to service access in Belize), rather than through cash transfer instruments. Chile anchors intersectoral action in long-standing platforms such as the *Chile Crece Más* integrated early-childhood protection subsystem (formerly *Chile Crece Contigo*), together with cross-sectoral strategies linking health with education and social protection, as well as regulatory measures on risk factors, such as the marketing, labelling and advertising of alcoholic beverages.

Figure 2.14. Joint programs linking health services with social protection programs

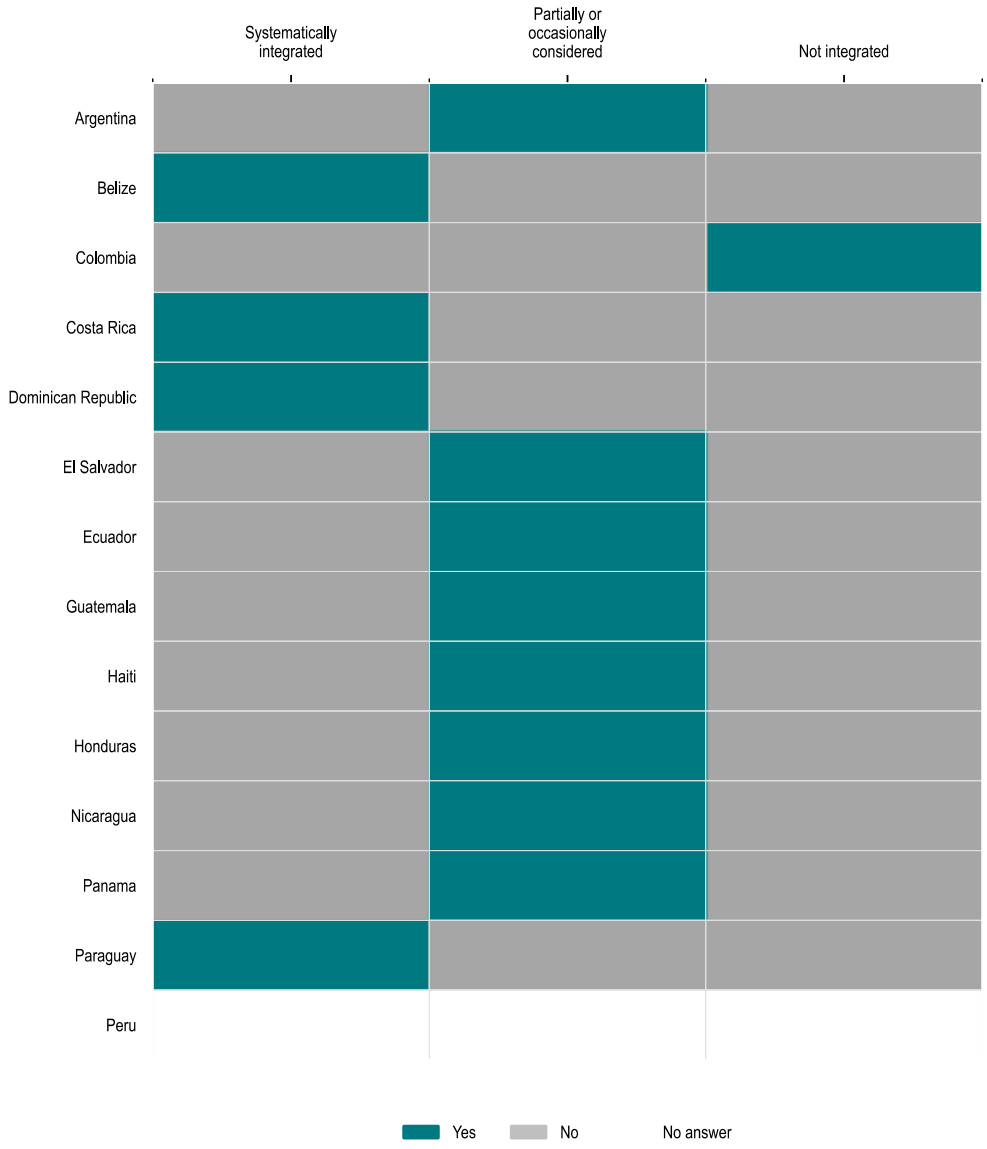


Notes: Cells indicate whether countries report joint intersectoral programs linked to health (e.g., social protection, nutrition/food security, or integrated platforms). “Yes” and “No” reflect the survey response for that item; “No answer” means it was not reported in the survey.
Source: Health at a Glance Latin America and the Caribbean 2026 Survey of Inequality and Inequity in Healthcare Policies.

Emergencies and disaster preparedness

Figure 2.15 indicates that four countries (Belize, Costa Rica, Dominican Republic and Paraguay) report equity as systematically integrated into preparedness planning, while eight countries (Argentina, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Nicaragua and Panama) report more partial integration. In Belize, emergency planning is described as combining vulnerability mapping, community-based preparedness, and targeted risk communication tailored to vulnerable groups. Paraguay anchors its approach in the Plan Nacional de Respuesta ante Emergencias con Enfoque Multiamenazas, which sets an operational model for health-sector response across multiple threats (including floods, epidemic outbreaks, heatwaves, droughts, wildfires and multi-casualty events). Costa Rica also reports systematic integration and explicitly points to the inclusion of specific vulnerable groups, such as people experiencing homelessness, people deprived of liberty, and populations in remote territories (e.g. Alto Telire). The Dominican Republic similarly reports systematic integration, describing risk-based and vulnerability-focussed preparedness frameworks. In contrast, Ecuador notes that its Plan de Respuesta Multiamenaza references equity in general terms but does not explicitly specify population groups. Among other countries reporting partial integration, Guatemala and Panama emphasise vulnerability and territorial inequities as planning considerations, while Honduras, Haiti and Nicaragua describe preparedness frameworks that recognise vulnerable populations but provide more limited detail on how equity is operationalised in routine preparedness instruments. Peru is currently updating its emergency preparedness framework to incorporate vulnerability mapping and to make equity a central pillar of its multihazard response plans, with the aim of prioritizing marginalized communities during national crises. Chile provides a related example through its Chilean Model of Mental Health in Disaster Risk Management, in place since 2019, which integrates mental health and psychosocial support into disaster preparedness and response. The model combines intersectoral coordination, community strengthening, support for response personnel, and targeted assistance for specific vulnerable groups within the national disaster-response system.

Figure 2.15. Equity considerations in emergency and disaster preparedness plans



Notes: Cells indicate equity is reported as integrated into emergency and disaster preparedness plans. “Systematically integrated” indicates equity is described as a routine element of preparedness planning; “Partially or occasionally considered” indicates equity is referenced but not consistently embedded across instruments or implementation. No answer means there was no survey response.
Source: Health at a Glance Latin America and the Caribbean 2026 Survey of Inequality and Inequity in Healthcare Policies.

Concluding remarks and actionable priorities

Countries in Latin America and the Caribbean have built recognisable equity policy frameworks, but the transition from commitment to consistent implementation remains the central challenge. The survey documents a region where legal mandates for equity are common, subsidised services are widespread, and countries are expanding outreach, telehealth, and intersectoral co-ordination. It also documents that the institutional conditions needed to make these commitments effective over time are frequently weak or absent: consistent monitoring of population groups and sustained territorial reach. Health inequalities in the region remain a direct expression of broader social inequality, and disadvantage accumulates across the care pathway, through prevention, diagnosis, treatment, and follow-up, producing wider gaps in outcomes than in access alone.

The survey points to a consistent pattern across policy domains: the strongest responses are those that expand the availability and affordability of services, while measures that address the deeper conditions needed to make services equitable in practice,

such as cultural adaptation, workforce retention, digital inclusion, and routine monitoring of key population groups, are systematically less developed. Equity attention is also narrower than the evidence warrants, focussed primarily on income and rural-urban gaps, with much less systematic attention to ethnicity, disability, migration status, and gender.

Access strategies prioritise expansion over depth. Infrastructure expansion is reported by 13 of 14 countries, outreach by 11, and telehealth by 9, yet transport support is available in only 7, bilingual or community staff recruitment in 6, and digital inclusion policies in just 4. Geographic distribution of the health workforce is more commonly reported than rural retention strategies, and for rural retention the dominant pattern is no strategy at all. Digital health is advancing more as a modernisation agenda than as an equity strategy: only four countries report at least one concrete measure to help vulnerable groups overcome barriers related to connectivity, devices, or digital literacy, and uneven interoperability further limits whether digital tools narrow or widen existing gaps.

Countries are building the basic architecture for monitoring access and coverage, but disaggregation for quality of care is reported by only 6 of 14 countries and for financial protection by only 5. Routine disaggregation by ethnicity, disability, and migration status are available in only a small number of countries. With an estimated 50-75% of avoidable mortality in the region linked to poor-quality care rather than lack of contact, reducing inequalities in health and healthcare now requires improving the content, continuity and performance of health systems, while tackling remaining deficits in access (Kruk et al., 2018[13]).

Actionable priorities for the region

Overall, the region has made important progress in bringing services closer and making them more affordable but has been less consistent in adapting delivery to the practical, cultural and organisational barriers faced by underserved groups. The common strengths are real: broad legal recognition, expanding service delivery for underserved populations, and growing intersectoral action. The recurring weaknesses are equally clear: incomplete monitoring of the population groups where inequalities are greatest, insufficient rural retention of health workforce and cultural adaptation of services, and shallow digital inclusion. Progress in the next phase depends less on adopting additional equity initiatives than on making existing ones more coherent, better targeted, and held to account.

The survey responses do not cover all dimensions of health equity; however, based on what countries reported, the most consistent gaps point to the following priorities:

- **Deepen access strategies to reach underserved groups effectively.** Countries have established broad infrastructure and outreach, but measures that address the practical, cultural, and organisational barriers that determine whether services are actually used by the most marginalised populations remain less consistently in place. The survey captures only a subset of such measures, yet even these show a systematic gap between availability and effective reach.
- **Extend monitoring to quality of care and financial protection, and key population groups.** Monitoring systems that capture access, but not quality or financial protection, cannot assess whether improvements are reaching those who need them most. Routine disaggregation by ethnicity, disability, and migration status remains the most actionable data gap across the region.
- **Strengthen rural workforce retention alongside geographic distribution.** Distribution strategies do not resolve workforce shortages in remote areas. Incentives, career pathways, and working conditions that make rural posts sustainable over time require dedicated investment.
- **Treat digital inclusion as an equity investment.** Digital health investments should be paired with concrete inclusion measures, such as connectivity, devices, and digital literacy, targeted at the populations least likely to benefit otherwise. Paraguay's Nanum programme and Peru's telehealth expansion illustrate that this is achievable.
- **Move intersectoral co-ordination from agreements to joint action.** Formal co-ordination structures are widespread, but joint planning and budgeting which are the mechanisms most likely to produce sustained action on social determinants, remain the exception.
- **Integrate equity into climate adaptation and emergency preparedness.** Only four of 14 countries embed equity systematically in preparedness planning. Given that health shocks consistently widen existing inequalities, vulnerability mapping and targeted response plans for marginalised groups should be standard, not exceptional.

References

Atun, R. et al. (2015), "Health-system reform and universal health coverage in Latin America", *The Lancet*, Vol. 385/9974, pp. 1230-1247, https://doi.org/10.1016/s0140-6736(14)61646-9. [2]

Bancalari, A. et al. (2025), "Health inequalities in Latin America and the Caribbean: child, adolescent, reproductive, metabolic syndrome and mental health", *Oxford Open Economics*, Vol. 4/Supplement_1, pp. i77-i121, https://doi.org/10.1093/ooec/odae028. [10]

Bancalari, A. et al. (2024), *Enhancing Maternal and Infant Healthcare in Remote Villages: Experimental Evidence on the Efficacy of Demandand Supply-Side Subsidies Publications*, https://publications.iadb.org/en/publications/english/viewer/Enhancing-Maternal-and-Infant-Healthcare-in-Remote-Villages-Experimental-Evidence-on-the-Efficacy-of-Demandand-Supply-Side-Subsidies.pdf. [14]

Bernal Lara, P. et al. (2023), "Disruption Of Non-COVID-19 Health Care In Latin America During The Pandemic: Effects On Health, Lessons For Policy", *Health Affairs*, Vol. 42/12, pp. 1657-1666, https://doi.org/10.1377/hlthaff.2023.00720. [24]

Bernal, N., M. Carpio and T. Klein (2017), "The effects of access to health insurance: Evidence from a regression discontinuity design in Peru", *Journal of Public Economics*, Vol. 154, pp. 122-136, https://doi.org/10.1016/j.jpubeco.2017.08.008. [12]

Buitrago, G. et al. (2026), "Socioeconomic disparities in adult mortality in Latin America", *BMJ Global Health*, Vol. 11/1, https://doi.org/10.1136/bmjgh-2024-018400. [23]

Carpio, C. and N. Santiago Bench (2015), *The Health Workforce in Latin America and the Caribbean: An Analysis of Colombia, Costa Rica, Jamaica, Panama, Peru, and Uruguay*, The World Bank, https://doi.org/10.1596/978-1-4648-0594-3. [27]

Cotlear, D. et al. (2015), "Overcoming social segregation in health care in Latin America", *The Lancet*, Vol. 385/9974, pp. 1248-1259, https://doi.org/10.1016/s0140-6736(14)61647-0. [3]

Kephart, J. et al. (2025), "Social disparities in neighborhood flood exposure in 44,698 urban neighborhoods in Latin America", *Nature Cities*, Vol. 2/3, pp. 246-253, https://doi.org/10.1038/s44284-025-00203-3. [22]

Kruk, M. et al. (2018), "High-quality health systems in the Sustainable Development Goals era: time for a revolution", *The Lancet Global Health*, Vol. 6/11, pp. e1196-e1252, https://doi.org/10.1016/s2214-109x(18)30386-3. [4]

Kruk, M. et al. (2018), "Mortality due to low-quality health systems in the universal health coverage era: A systematic analysis of amenable deaths in 137 countries", *The Lancet*, Vol. 392/10160, pp. 2203-2212, https://doi.org/10.1016/S0140-6736(18)31668-4. [13]

Libertun de Duren, N. (ed.) (2022), *Inclusive Cities: Healthy Cities for All*, Inter-American Development Bank, https://doi.org/10.18235/0004459. [19]

OECD (2025), *Health at a Glance 2025: OECD Indicators*, OECD Publishing, Paris, https://doi.org/10.1787/8f9e3f98-en. [26]

OECD (2025), *OECD Reviews of Health Systems: Peru 2025*, OECD Reviews of Health Systems, OECD Publishing, Paris, https://doi.org/10.1787/f3ddb6a4-en. [18]

OECD (2021), *OECD Reviews of Health Systems: Brazil 2021*, OECD Reviews of Health Systems, OECD Publishing, Paris, https://doi.org/10.1787/146d0dea-en. [16]

OECD/The World Bank (2023), *Health at a Glance: Latin America and the Caribbean 2023*, OECD Publishing, Paris, https://doi.org/10.1787/532b0e2d-en. [1]

PAHO (2024), *Progress in universal health in the Americas: Addressing unmet healthcare needs, gaps in coverage, and lack of financial protection through primary health care*, Pan American Health Organization, https://doi.org/10.37774/9789275129470. [11]

PAHO (2022), *Health overview. Health in the Americas 2022*, Pan American Health Organization, https://hia.paho.org/en/covid-2022/health. [6]

PAHO (2019), "Commission of the Pan American Health Organization on Equity and Health Inequalities in the Americas. Just Societies: Health Equity and Dignified Lives", in *Report of the Commission of the Pan American Health Organization on Equity and Health Inequalities in the Americas*, Pan American Health Organization. [20]

Pinto, D., W. Savedoff and S. Bauhoff (2024), "Social Determinants of Health: A Health-Centered Approach to Multi-Sectoral Action", *Inter-American Development Bank*, https://doi.org/10.18235/0013155. [25]

Roberti, J. et al. (2024), "Inequalities in health system coverage and quality: a cross-sectional survey of four Latin American countries", *The Lancet Global Health*, Vol. 12/1, pp. e145-e155, https://doi.org/10.1016/s2214-109x(23)00488-6. [17]

Vargas, S., D. Rios-Zertuche and S. Bauhoff (2025), "Changes and heterogeneity in quality-amenable excess mortality in Mexico: A systematic analysis for the years 2012, 2018, and 2021", *Lancet Regional Health. Americas*, Vol. 45, p. 101061, https://doi.org/10.1016/j.lana.2025.101061. [15]

Wagstaff, A. et al. (2018), "Progress on catastrophic health spending in 133 countries: a retrospective observational study", *The Lancet Global Health*, Vol. 6/2, pp. e169-e179, https://doi.org/10.1016/s2214-109x(17)30429-1. [5]

WHO (2025), *World report on social determinants of health equity*, World Health Organization, https://iris.who.int/handle/10665/381152. [7]

WHO (2013), *Handbook on health inequality monitoring: With a special focus on low- and middle-income countries*, World Health Organization, https://iris.who.int/handle/10665/85345. [8]

WHO/IBRD (2023), *Tracking universal health coverage: 2023 global monitoring report: Executive summary*, World Health Organization and International Bank for Reconstruction and Development / The World Bank, https://iris.who.int/handle/10665/374059. [9]

World Bank (2025), *Unlivable: Confronting Extreme Urban Heat in Latin America and the Caribbean*, World Bank, Washington, DC, https://doi.org/10.1596/43751. [21]

3 Health status

Life expectancy at birth

In the Latin American and Caribbean (LAC) region, life expectancy at birth continues to rise on average despite the onset of the COVID-19 crisis, driven by the steady reduction in mortality at all ages, and particularly of infant and child mortality in all countries (see indicators "Infant mortality" and "Under age 5 mortality" in the following sections). These gains in longevity can be attributed to several factors, including rising living standards, better nutrition, and improved drinking water and sanitation facilities (see indicator "Water and sanitation" in Chapter 4). Healthier lifestyles, increased education, and greater access to quality health services also play an important role (Raleigh, 2019[1]).

Life expectancy at birth for the whole population across the LAC region reached 74.6 years on average in 2024, a gain of 2.4 years since 2010. In comparison, OECD countries gained 2.0 years during the same period (Figure 3.1, left panel). However, a large regional divide persists in life expectancy at birth. The countries with the longest life expectancy in 2024 (or latest) were Chile and Costa Rica at around 81 years, closely followed by Panama at just below 80 years. In contrast, two countries in the LAC region had total life expectancies of less than 70 years (Haiti and Bolivia). In Haiti, a child born in 2024 can expect to live an average of 65 years.

Women tend to live longer than men do (Figure 3.1, right panel), but the degree of this disparity also varies across countries. The gender gap in life expectancy stood at 6 years on average across LAC33 countries in 2024, higher than the OECD countries average of 5.1 years. The gender difference was particularly large in El Salvador, with a more than 8.5 years gap, as well as in Venezuela, Saint Kitts and Nevis, Saint Lucia, Bahamas and Uruguay with gaps of seven years or more. Women also have greater rates of survival to age 65 (Figure 3.2), regardless of the economic status of the country. On average, across LAC countries, 84.1% of a cohort of new-born females would live to age 65, while only 74.1% of new-born males would live to age 65. Only in Costa Rica and Chile, more than 90% of new-born females are expected to live to age 65, still below the OECD average of 92%.

Higher national income – as measured by GDP per capita – is generally associated with higher life expectancy at birth (Figure 3.3). There were, however, some notable differences in life expectancy between countries with similar income per capita. For instance, Costa Rica and Chile had higher, and Guyana had lower life expectancies than predicted by their GDP per capita alone.

From a biological point of view, the male disadvantage in life expectancy may partly reflect biological mechanisms, including differences related to sex chromosomes and hormones, but these mechanisms remain insufficiently understood (Austad and Fischer, 2016[2]). Gender-based differences in life expectancy are also influenced by social mechanisms, such as reductions in maternal mortality over the past century, and by behavioural factors, as men face greater exposure to occupational hazards and engage more frequently in risky behaviours such as smoking and alcohol consumption (Hossin, 2021[3]).

Definition and comparability

Life expectancy at birth is the best-known measure of population health status and is often used to gauge a country's health development. It measures how long, on average, a newborn infant can expect to live if current death rates do not change. Since the factors affecting life expectancy often change slowly, variations are best assessed over long periods of time. Age-specific mortality rates are used to construct life tables from which life expectancies are derived. The methodologies that countries use to calculate life expectancy can vary slightly, leading to differences of fractions of a year. Some countries base their life expectancies on estimates derived from censuses and surveys, and not on accurate registration of deaths. Survival to age 65 refers to the percentage of a cohort of newborn infants that would survive to age 65, if subject to current age-specific mortality rates.

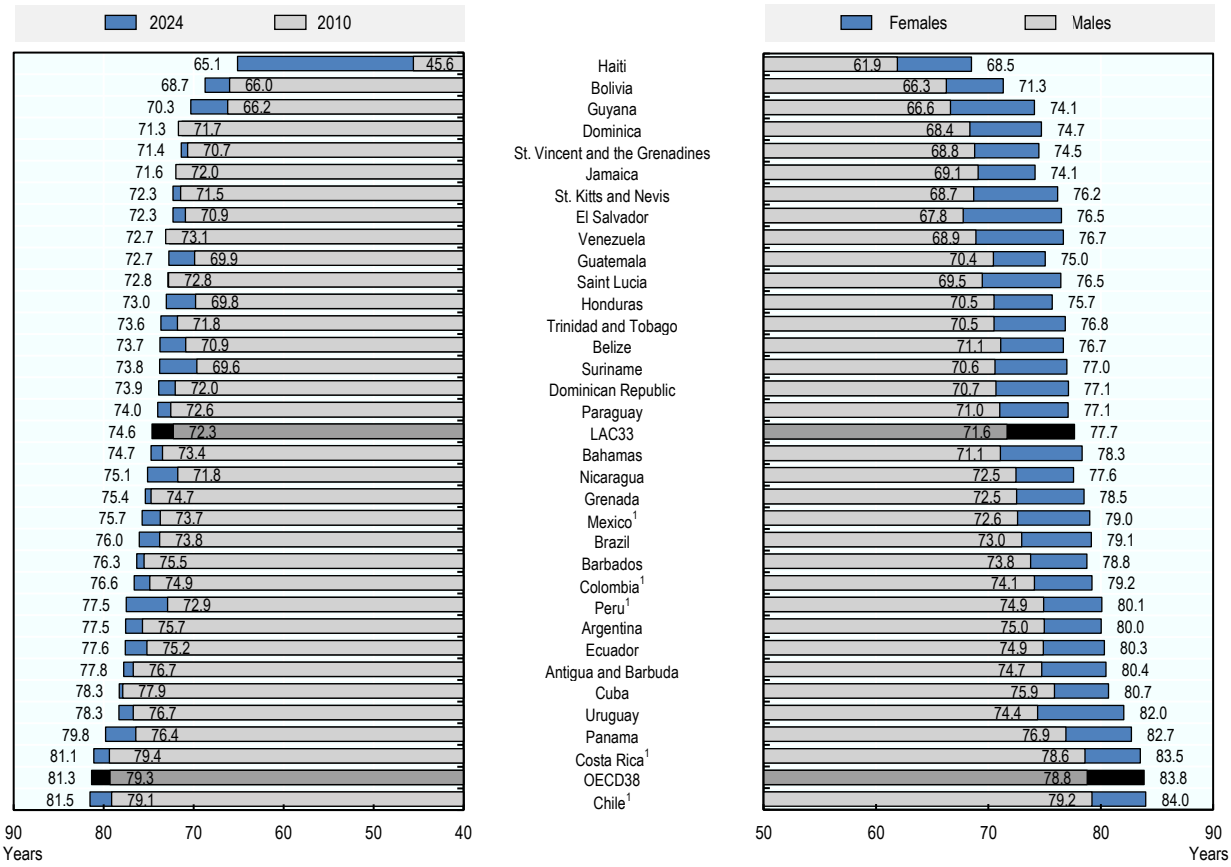
References

Austad, S. and K. Fischer (2016), "Sex Differences in Lifespan", *Cell Metabolism*, Vol. 23/6, pp. 1022-1033, https://doi.org/10.1016/j.cmet.2016.05.019. [2]

Hossin, M. (2021), "The male disadvantage in life expectancy: can we close the gender gap?", *International Health*, Vol. 13/5, pp. 482-484, https://doi.org/10.1093/inthealth/ihaa106. [3]

Raleigh, V. (2019), "Trends in life expectancy in EU and other OECD countries : Why are improvements slowing?", *OECD Health Working Papers*, No. 108, OECD Publishing, Paris, https://doi.org/10.1787/223159ab-en. [1]

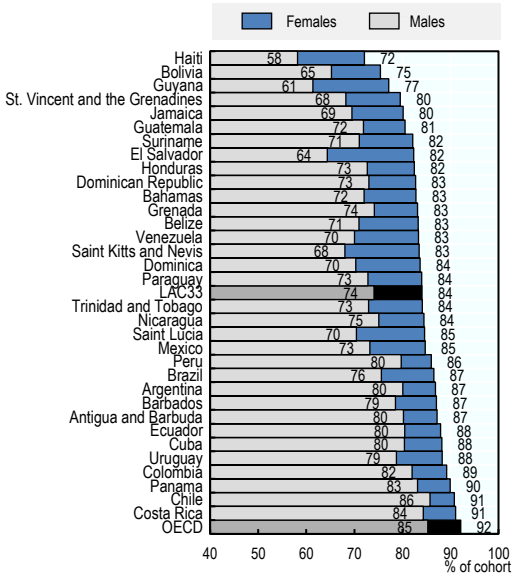
Figure 3.1. Life expectancy at birth, by sex, 2010 and 2024 (or latest year)



Notes: 1. Data from 2025. Source: World Bank and OECD Health Statistics 2026 for OECD, Peru and OECD LAC countries

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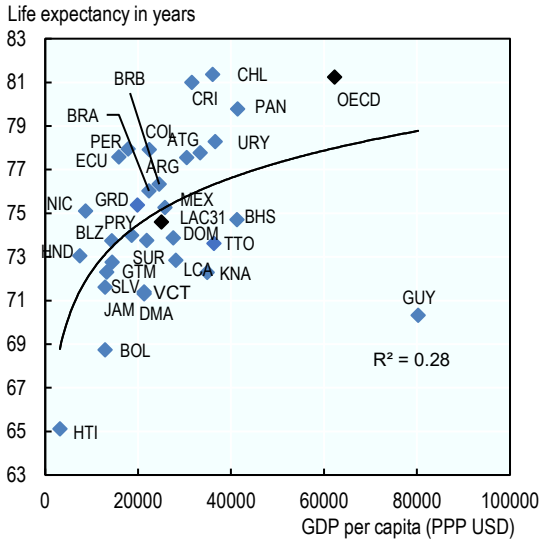
Figure 3.2. Survival rate to age 65, 2024



Source: The World Bank World Development Indicators Online 2026.

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Figure 3.3. Life expectancy at birth and GDP per capita, 2024



Source: The World Bank World Development Indicators Online 2026.

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Infant and neonatal mortality

Infant and neonatal mortality, reflect the impact of economic, social, and environmental conditions on the health of mothers and infants, as well as the effectiveness of health systems. Factors such as maternal education and immunisation, the quality and accessibility of antenatal and childbirth care, preterm birth and birth weight, immediate new-born care, and infant feeding practices are important determinants of infant mortality (see section "Infant and young child feeding" in Chapter 4). In addition, eliminating mother-to-child disease transmission is a priority in the LAC region to reduce infant mortality and morbidity (Debbag et al., 2023[1]).

In 2024, the infant mortality average in LAC was 14.4 deaths per 1 000 live births. Infant mortality was lower in countries such as Uruguay, Chile and Cuba (under 7 deaths per 1 000 live births), while higher in Dominican Republic, Dominica and particularly Haiti (at 28, 33, and 39 per 1 000 live births, respectively) (Figure 3.4). Between 2010 and 2024, the average infant mortality rate has fallen by 34.4% in the LAC region, with most countries experiencing declines between 20% and 50%. Haiti, Saint Vincent and the Grenadines, Nicaragua, El Salvador, and Bolivia saw declines of over 70%. However, countries like Dominica, Venezuela and Cuba experienced increases in infant mortality rate close to 30%.

Regarding neonatal mortality rates, the average in the LAC region was 10 deaths per 1 000 live births. Neonatal mortality rates were lower in countries such as Uruguay, Cuba, El Salvador and Chile (below 5 deaths per 1 000 live births), while Dominica, Haiti and Dominican Republic, recorded the highest levels, each exceeding 20 deaths per 1 000 live births (Figure 3.5). Between 2010 and 2023, neonatal mortality rate fell by 16.5% in the LAC region, with most countries showing reductions between 10% and 30%. Bolivia, Saint Vincent and the Grenadines and El Salvador saw declines of more than 40%. In contrast, Cuba, Grenada, Venezuela and Dominica experienced increases in neonatal mortality rates of over 35%.

Infant mortality can be reduced through cost-effective and appropriate interventions. Plans to improve newborn survival should be built on a strong foundation of essential newborn care and aligned with the Every Newborn Action Plan (ENAP) and Ending Preventable Maternal Mortality (EPMM) targets on antenatal care, postnatal care, skilled health personnel and emergency obstetric and newborn care. Increasing investment and directing resources toward two high-impact yet costly interventions, which are care for small and sick newborns and emergency obstetric care, is essential. These measures deliver multiple returns by reducing maternal deaths, stillbirths, newborn deaths, and both maternal and newborn morbidity. Key interventions essential for newborn care include skin-to-skin contact between mothers and newborns after delivery, hygienic umbilical cord and skin care, and early and exclusive breastfeeding for the first six months of life. Effective management and treatment of neonatal infections, pneumonia, diarrhoea, and malaria are also critical. Oral rehydration therapy is a low-cost and effective intervention to mitigate the debilitating effects of diarrhoea, and countries could also implement relatively inexpensive public health measures, including immunisation and providing clean water and sanitation (WHO, 2024[2]).

Definition and comparability

Infant mortality rate is defined as the number of children who die before reaching their first birthday in a given year, expressed per 1 000 live births. Some countries base their infant mortality rates on estimates derived from censuses, surveys, and sample registration systems, and not on accurate and complete registration of births and deaths. Infant mortality rates are generated by either applying a statistical model or transforming under age 5 mortality rates based on model life tables. Differences amongst countries in registering practices for premature infants may also contribute slightly to international variations in rates.

The neonatal mortality rate is the probability that a child born in a specific year or period will die during the first 28 completed days of life if subject to age-specific mortality rates of that period, expressed per 1000 live births. Neonatal mortality rates are estimates derived based on national data including civil registration data, censuses and surveys (UNICEF, 2025[3]).

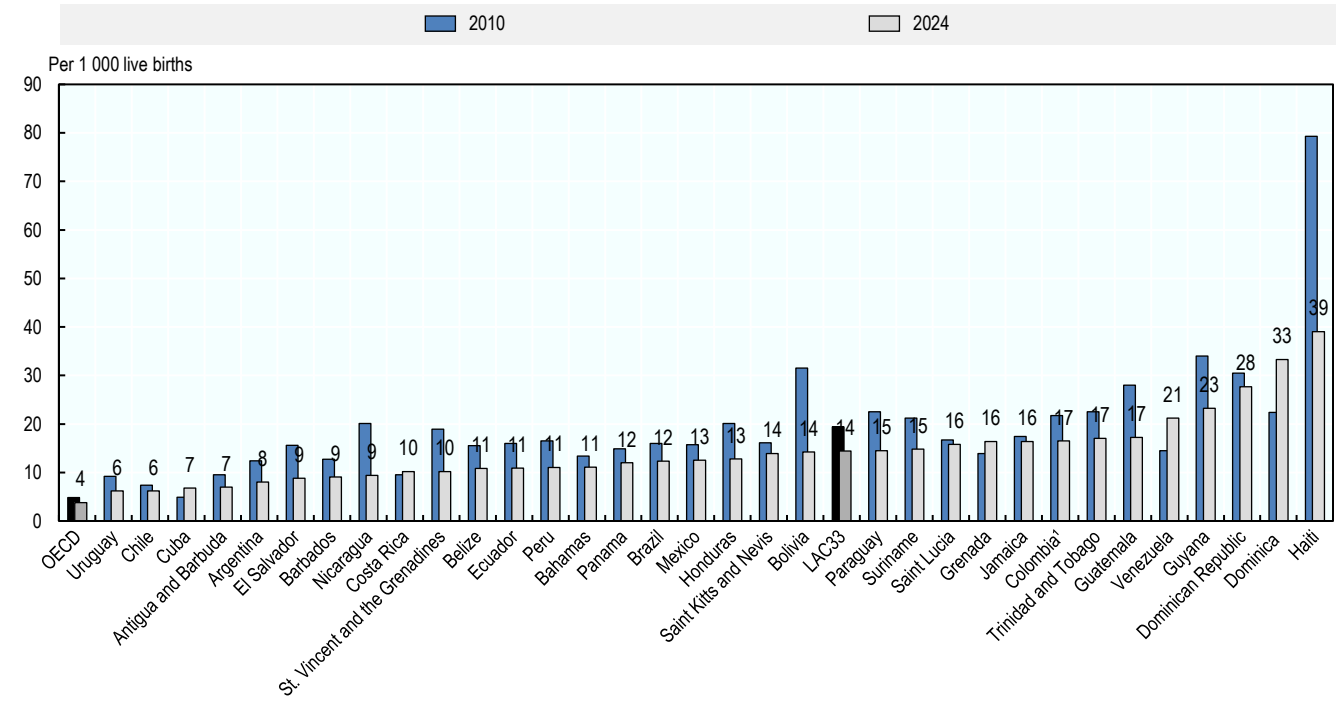
References

Debbag, R. et al. (2023), "Are the first 1,000 days of life a neglected vital period to prevent the impact on maternal and infant morbimortality of infectious diseases in Latin America? Proceedings of a workshop of experts from the Latin American Pediatric Infectious Diseases Society, SLIPE", *Frontiers in Pediatrics*, Vol. 11, https://doi.org/10.3389/fped.2023.1297177. [1]

UNICEF (2025), *Neonatal mortality rate*, https://data.unicef.org/topic/child-survival/neonatal-mortality/. [3]

WHO (2024), *Newborn mortality*, World Health Organization, https://www.who.int/news-room/fact-sheets/detail/newborn-mortality. [2]

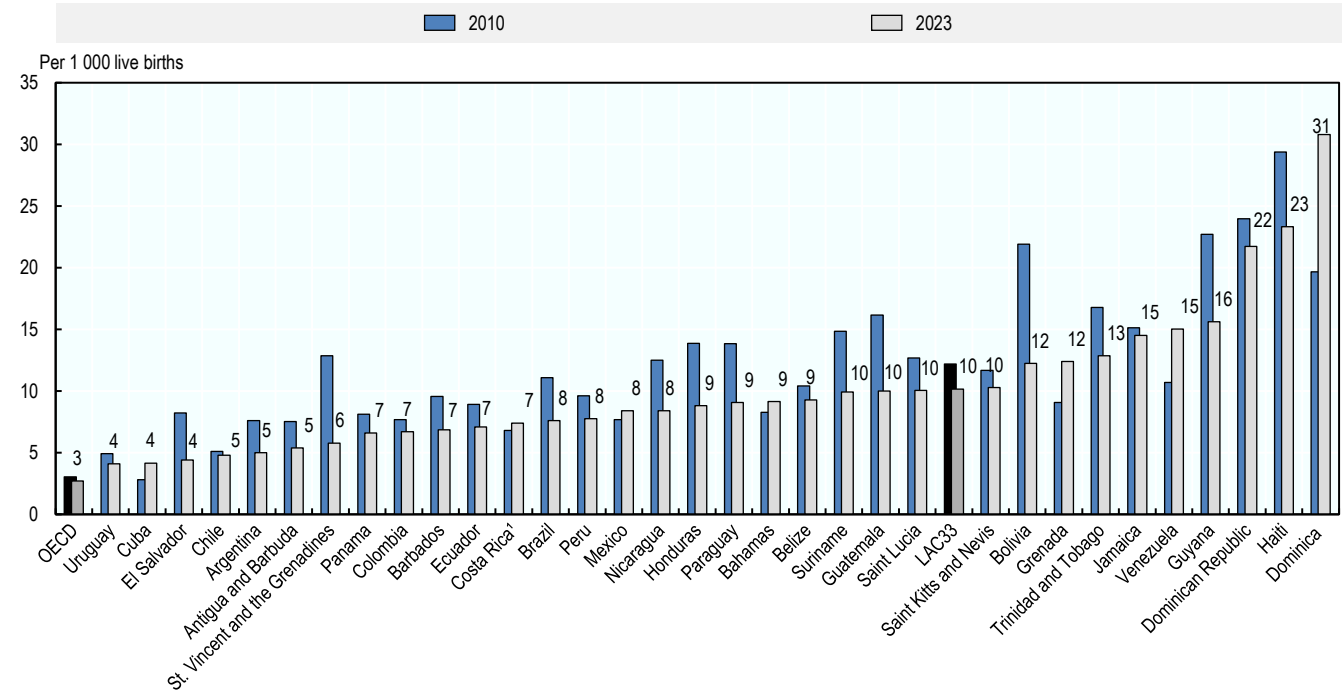
Figure 3.4. Infant mortality rates, 2010 and 2021-2024



Note: 1. Data from 2021. 2. Data from 2022. OECD LAC members data are extracted from OECD health data. Label corresponds to latest year available.
Source: OECD Health Statistics 2026 and The World Bank World Development Indicators Online 2026.

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Figure 3.5. Neonatal mortality rates, 2010 and 2020-2023



Note: 1. value from 2022. OECD LAC members data are extracted from OECD health data.
Source: OECD Health Statistics 2025 and UNICEF global databases 2025.

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Under age 5 mortality

The under age 5 mortality rate is an indicator of child health, as well as of the overall development and well-being of a population. The UN Sustainable Development Goals target reducing under age 5 mortality to below 25 per 1 000 live births by 2030. In 2023, 4.8 million children died worldwide before their fifth birthday (WHO, 2025[1]), with under-five mortality rate estimated at 36.7 per 1 000 live births.

The average under-five mortality rate across LAC33 countries was 16.3 deaths per 1 000 live births (Figure 3.6). Uruguay, Chile, Cuba, Antigua and Barbuda, Argentina and Barbados achieved rates of less than 10 deaths per 1 000 live births. Mortality rates in Guyana, the Dominican Republic and Dominica, were high, between 25 and 36 deaths per 1 000 live births, while rates in Haiti were very high, reaching 52.8 deaths per 1 000 live births. These countries also had the highest infant and neonatal mortality in the region, as seen in the previous section. While under age 5 mortality has declined by an average of 43% in LAC countries between 2010 and 2024, progress varies significantly amongst countries. Countries such as El Salvador, Saint Vincent and the Grenadines, Nicaragua, Bolivia and Haiti, reported a drop of over 80%, while the rate increased by 30% in Dominica, 29% in Venezuela, and 28% in Cuba. Haiti saw a reduction of 159% in the period, over the improvement average in the region.

Causes of under-5 mortality in the LAC region are very heterogeneous (Figure 3.7). The leading causes are presented using broad ICD-10 categories grouping multiple diseases. The category “other causes”, which includes conditions such as foetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery and necrotizing enterocolitis of foetus and newborn, accounts for the highest mortality rates overall, with 82 deaths per 10 000 live births in the LAC region. Among specific cause groups, under-5 mortality deaths rates reach 36.9 deaths per 10 000 live births for perinatal respiratory and cardiovascular disorders, 12.8 for congenital malformations, 10.4 for perinatal infections, 10.5 for disorders related to length of gestation and 6.3 for influenza and pneumonia. Dominica has the highest under-5 mortality rates for perinatal respiratory and cardiovascular disorders, while Guatemala shows the highest rates for perinatal infections and influenza and pneumonia.

Across LAC countries, under-5 mortality tends to be inversely related to the current health expenditure per capita (Figure 3.8). Chile and Uruguay have the lowest under-5 mortality rates, with fewer than 7.5 deaths per 1000 live births, less than half the LAC average, and are among the six countries with the highest health expenditures per capita (Chapter 6). However, Panama reports an under-5 mortality rate of 13 deaths per 1000 live births with similar expenditure. In contrast, Belize and Nicaragua have achieved the same under-5 mortality rate with much lower resources. This suggests a non-linear relationship, as health spending is strongly associated with mortality reductions at lower levels of spending, but these reductions diminish as countries approach a mortality floor, given that under-5 mortality cannot reach zero under real-world conditions. Peru is an example of successful public policies to enhance under-5 mortality. Interventions including expanding access to antenatal care and facility-based deliveries, ensuring high coverage of vaccines (pneumococcal, rotavirus and Hib), integrating culturally sensitive practices to improve service uptake, vitamin A supplementation and nutrition programmes, and improved safe water and improved sanitation have helped the country moving closer to their SDG goals (García et al., 2024[2]).

Definition and comparability

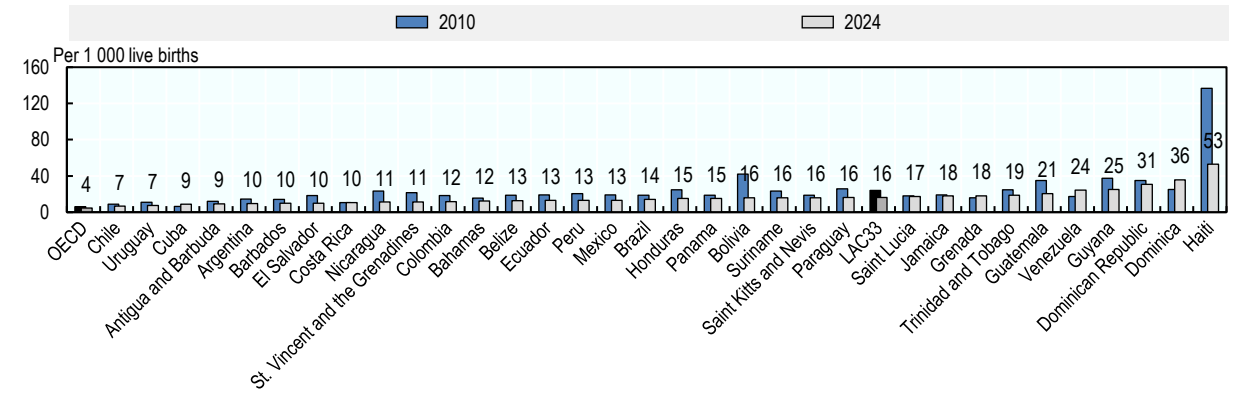
Under age 5 mortality is defined as the probability of a child born in a given year dying before reaching their fifth birthday and is expressed per 1 000 live births. Since under age 5 mortality is derived from a life table, it is, strictly speaking, not a rate but a probability of death. Age-specific mortality rates are used to construct life tables from which under age 5 mortality is derived. Some countries base their estimates on censuses, surveys, and sample registration systems, and not on accurate and complete registration of deaths. See indicator “Infant mortality” for definition of rate ratios. The five leading group of causes of under-5 mortality rates are perinatal infections (including bacterial sepsis), perinatal respiratory and cardiovascular disorders (notably respiratory distress of the newborn), congenital malformations (particularly congenital malformations of the heart), disorders related to the length of gestation, influenza and pneumonia and other causes, grouping the rest. However, given the heterogeneity of causes for under-5 mortality, the residual group labelled “other” accounts for the highest mortality rates overall.

References

García, P. et al. (2024), “Lessons from Peru to reduce under-5 mortality: understanding program implementation and context”, *BMC Pediatrics*, Vol. 23/S1, https://doi.org/10.1186/s12887-023-03890-w. [2]

WHO (2025), *Child mortality and causes of death*, World Health Organization, https://www.who.int/data/gho/data/themes/topics/topic-details/GHO/child-mortality-and-causes-of-death. [1]

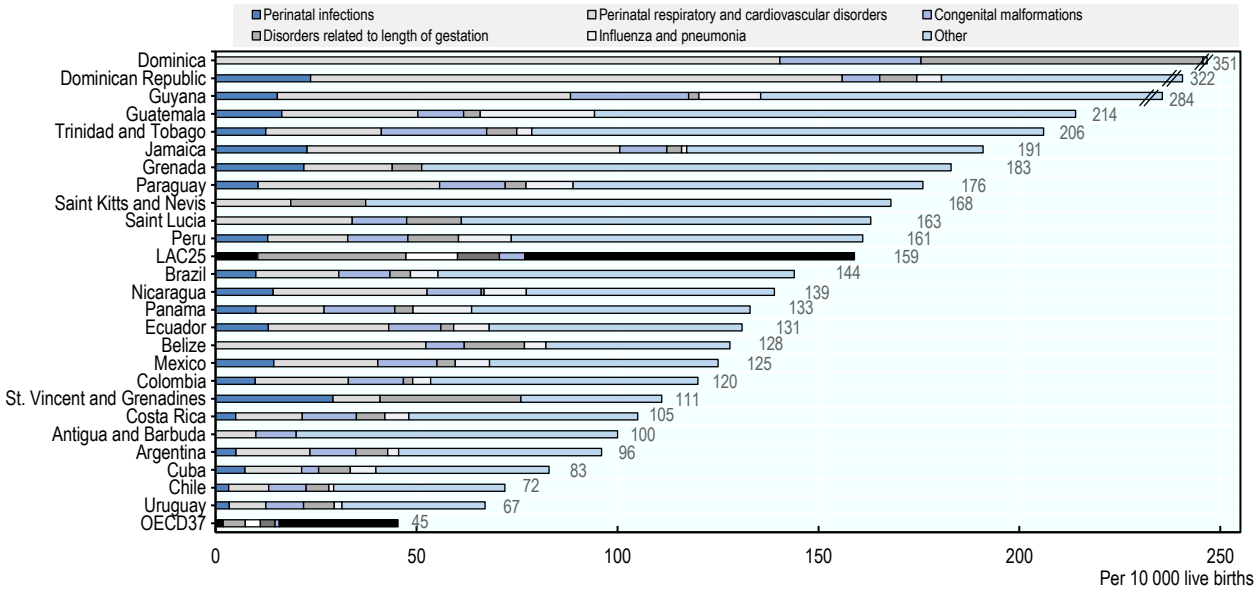
Figure 3.6. Under age 5 mortality rates, 2010 and 2024



Note: Label corresponds to latest year available.
Source: The World Bank World Development Indicators Online 2026.

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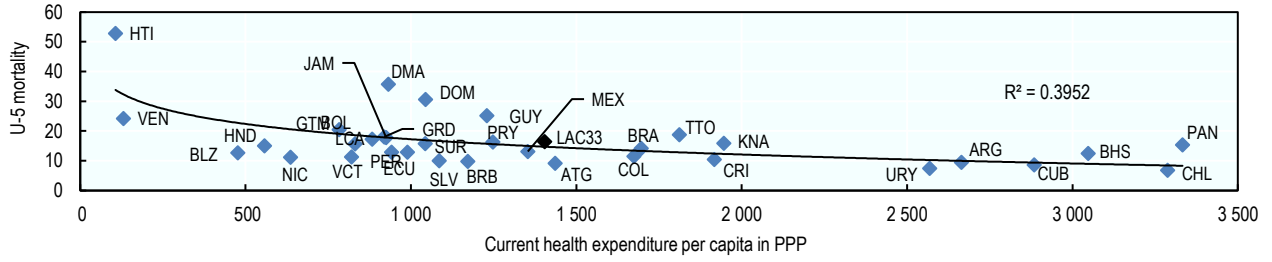
Figure 3.7. Cause-specific under-5 mortality per 10 000 live births, 2023 (or latest year)



Note: Total all-cause under-5 mortality rates shown in label
Source: WHO mortality database 2026 and The World Bank World Development Indicators Online 2026.

StatLink https://stat.link/3g978m

Figure 3.8. Under 5 age mortality per 1 000 live births and CHE PPP, 2024 (or latest available)



Source: The World Bank World Development Indicators Online 2026.

StatLink https://stat.link/023hna

Adolescent mortality

Adolescence is the phase of life between childhood and adulthood, from ages 10 to 19. Although adolescence is often considered a healthy stage of life, it is associated with significant mortality, morbidity and injuries, largely due to causes that are preventable or treatable. This period is particularly critical because it is when behavioural patterns are stablished, either protective or harmful, increasing health risks in the short and long term (WHO, 2025[1]). The LAC region has the second highest adolescent mortality rates in the world, with approximately 106 million adolescents living in the region in 2022 (The Lancet Child & Adolescent Health, 2022[2]).

In 2023, adolescence mortality rate was 2.3 deaths per 1 000 in the OECD, while the average across LAC countries was 5.8 (Figure 3.9). Chile, Antigua and Barbuda, Barbados, Cuba and Costa Rica achieved rates of less than 4 deaths per 1 000 people aged from 10 to 19 years old. In contrast, mortality rates in Venezuela and Haiti reached 10.4 and 10.7 deaths per 1 000. While the Dominican Republic had the third highest under-5 mortality rate, the country achieved adolescent mortality rates below the LAC average. While adolescent mortality has substantially declined by an average of 34.4% in LAC countries between 2010 and 2023, compared to the OECD reduction of 16.4%, progress has been unequal amongst countries. Countries such as Bahamas, El Salvador and Antigua and Barbuda reported a drop of over 35%, while in Saint Vincent and the Grenadines the rate increased by 30% and in Cuba by 16%.

There are wide gender disparities in adolescent mortality in the LAC region, with boys being 106% more likely to die than girls, compared with 73% in OECD countries in 2023. Across LAC countries, the average adolescent mortality rates were 1.4 per 1 000 amongst younger female adolescents, and 2.3 per 1 000 amongst older female adolescents (Figure 3.10). The highest rates for older adolescents were observed in Haiti, Guyana and Suriname with 4.7, 3.6 and 3.4 per 1 000, respectively. Haiti also has the highest rate of young adolescent mortality with 3.5 deaths per 1 000, followed by Honduras, Saint Vincent and the Grenadines, Grenada and El Salvador, with over 2 deaths per 1 000. Honduras, Grenada and El Salvador have older adolescent mortality rates below the LAC average of 2.3, but high young adolescent mortality. The differing mortality patterns between the two adolescent age groups suggest differentiated causes of death, where lower respiratory infections and congenital anomalies are more common in the first group, accidents and injuries, self-harm and interpersonal violence are leading causes in the second (WHO, 2024[3]).

Across LAC countries, older male adolescents are 193% more likely to die than younger male adolescents. Venezuela, Ecuador, Saint Kitts and Nevis, and Haiti have the highest mortality rates among older adolescents, exceeding 8 deaths per 1 000 (Figure 3.10). Among younger male adolescents, the highest mortality rates, over 3 per 1 000 are observed in Haiti, Saint Vincent and the Grenadines, Honduras and Grenada.

Adolescence represents a critical period for shaping health and well-being in adulthood; however, it remains under-represented in national policies. It is also during adolescence that sex differences emerge, with boys experiencing higher mortality from violence, drownings and road traffic injuries, and girls being more affected by suicide and maternal conditions caused by high adolescent birth rates. Interventions under the Global Accelerated Action for the Health of Adolescents (AA-HA!) include school-based violence prevention programmes aimed at reducing interpersonal violence. They also consider adolescent-responsive sexual health services that remove stigma around contraception and improve skilled antenatal and childbirth care to reduce maternal mortality among adolescent girls (UNCF, 2022[4]).

Definition and comparability

Younger adolescents refer to those aged 10 -14 years, and older adolescents to those aged 15 – 19 years. Younger adolescence mortality rate is defined as the probability of an adolescent aged 10 years in a specific year dying before reaching the age of 15 years. Older adolescence mortality rate is defined as the probability of an adolescent aged 15 years in a specific year dying before reaching the age of 20 years. Estimates come from civil registration, censuses and surveys. See indicator “Infant mortality” for definition of rate ratios.

References

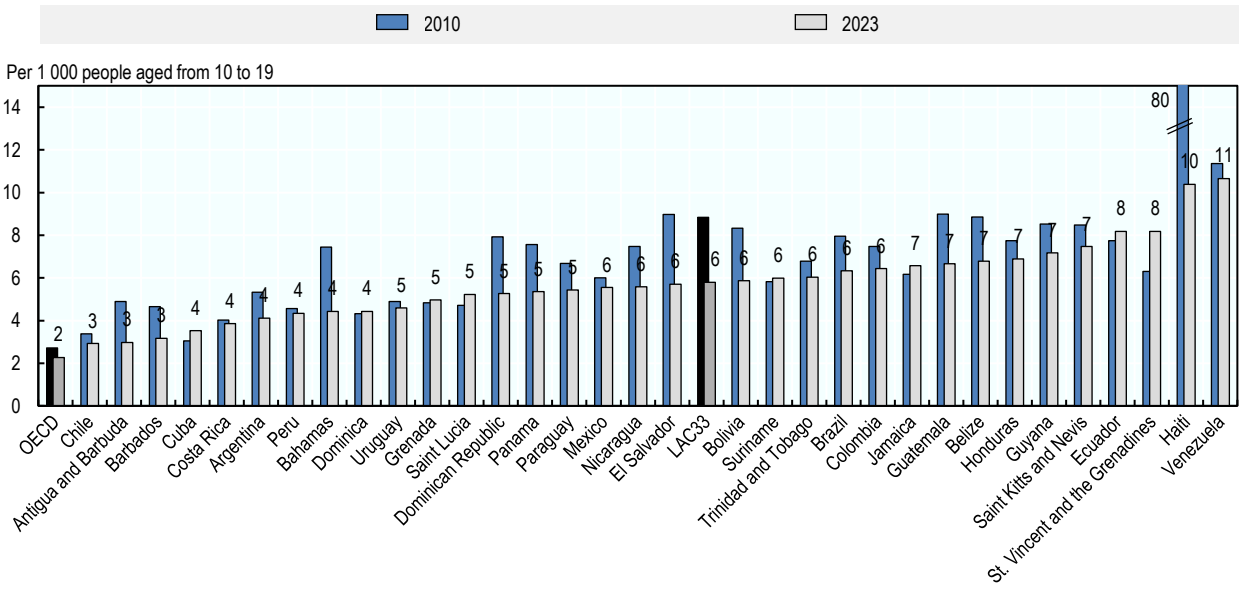
The Lancet Child & Adolescent Health (2022), *Adolescence in Latin America and the Caribbean*, https://doi.org/10.1016/S2352-4642(22)00282-6. [2]

UNCF, P. (2022), *No Time to Lose. Health Challenges for Adolescents in Latin America and the Caribbean*, IDB, PAHO, UNAIDS, UNICEF, UNWOMEN, USAID, World Bank, PMNCH, https://doi.org/10.37774/9789275126219. [4]

WHO (2025), *Adolescence Health*, World Health Organization, https://www.who.int/health-topics/adolescent-health. [1]

WHO (2024), *Adolescent and young adult health*, World Health Organization, https://www.who.int/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions (accessed on 19 December 2025). [3]

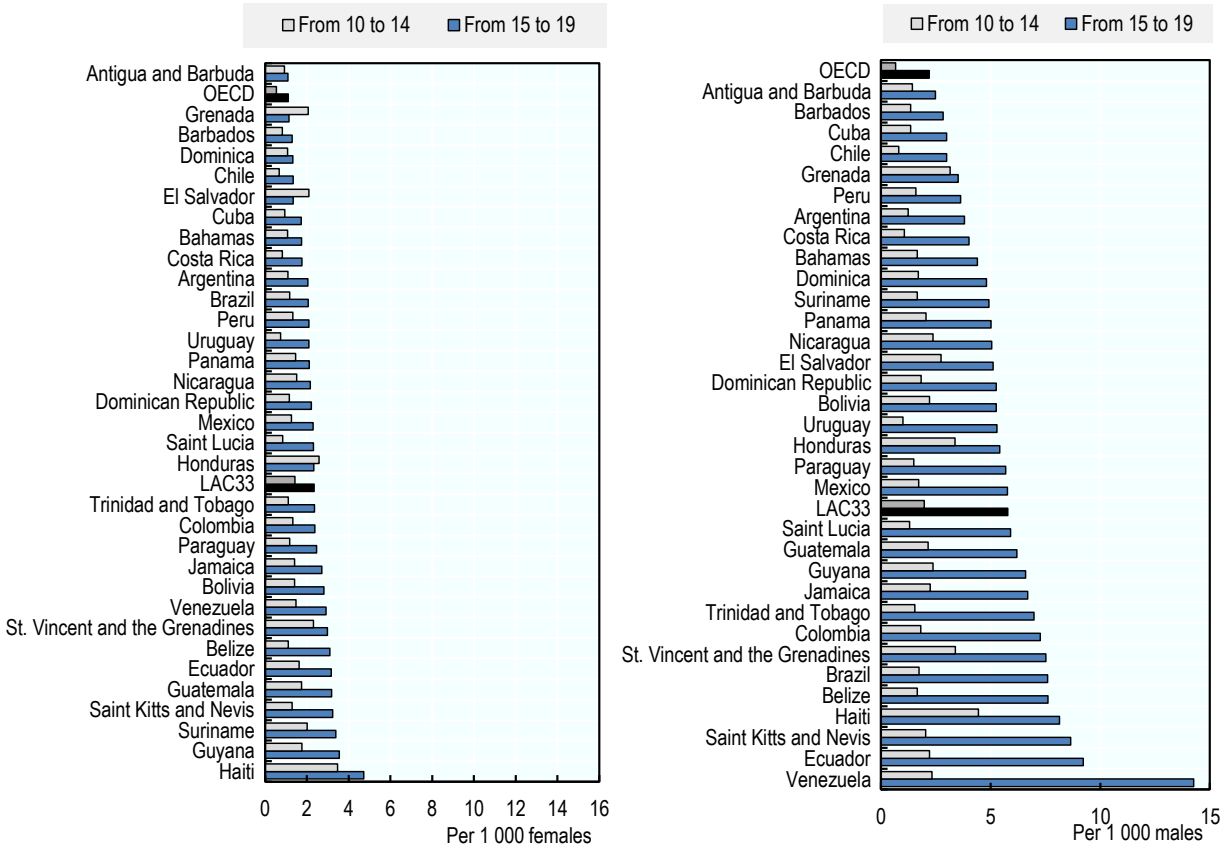
Figure 3.9. Adolescent mortality rates, 2010 and 2023



Source: WHO GHO 2025.

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Figure 3.10. Adolescent mortality rate, per 1 000 females and males aged 10-14 and 15-19, 2023



Source: WHO GHO 2025.

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Mortality from all causes

Cumulative development in countries is leading to an "epidemiological transition", whereby early deaths are replaced by late deaths, and communicable diseases are substituted by non-communicable diseases. This is also the case in LAC, where the burden from non-communicable diseases amongst adults – the most economically productive age group – is rapidly increasing. Over the last three decades, LAC countries have experienced major public health interventions that combined with the decline in infectious diseases and stable health trends, have contributed to rapid gains in life expectancies (Alvarez, Aburto and Canudas-Romo, 2019[1]). However, the COVID-19 pandemic has disrupted this progress, leading to a substantial increase in mortality, particularly in 2020 and 2021. Despite its delayed onset compared to other regions, estimates suggest that LAC accounted for 27% of global COVID-19 deaths by early 2022, although there was substantial heterogeneity within the region (OECD/The World Bank, 2023[2]).

There are wide disparities in adult mortality in the LAC region. For men in 2022, the probability of dying between ages 15 and 60 ranged from a low of 98 per 1 000 population in Chile to 281 per 1 000 in El Salvador and Haiti (Figure 3.11). It also exceeded 250 per 1 000 population in Guyana. Amongst women, the probability ranged from 57 per 1 000 population in Chile to 167 in Haiti. On average, 63.8% of deaths across LAC33 were among men, being approximately 1.76 times more likely to die than women. In most countries, mortality rates for men were one and a half times the rates for women or higher.

All-cause mortality for LAC25 using measured data from WHO mortality database ranged from less than 500 per 100 000 population in Chile, Costa Rica, Peru and Panama, to over 1 000 in Jamaica in 2023 (Figure 3.11). From estimated data, Haiti also had an all-cause mortality rate over 1000 per 100 000 population. For LAC25, mortality declined by an average of 5.2% between 2010 and 2019. The largest declines were in Chile, Panama, Brazil and Trinidad and Tobago (over 15% decrease). This overall declining trend in all-cause mortality is disrupted by mortality rise linked to the COVID-19 pandemic, particularly in countries where the most recent available data was from 2021 or 2020. The average all-cause mortality rate in LAC25 was more than 58% higher than the average amongst OECD Member countries in 2023. Amongst these countries, mortality increased by an average of 7.4% between 2019 and 2023, with Dominica, Jamaica and Saint Kitts and Nevis recording the steepest increases over this period (27.1% 25.9%, and 24.1% increase respectively). In comparison, all-cause mortality for the rest of LAC countries was captured with estimated data from IHME. In these countries, mortality decreased by an average of 1.5% from 2019 to 2023.

Non-communicable diseases such as cardiovascular diseases and cancers were the most common causes of death, being responsible for almost 75.9% of all deaths, on average, across all 33 LAC countries in 2023 (Figure 3.12; see also section "Mortality from cardiovascular diseases" and section "Mortality from cancer" in Chapter 3). In OECD Member countries, the average was higher at 85.3%. Communicable diseases such as respiratory infections, diarrhoeal diseases, and tuberculosis, along with maternal and perinatal conditions, also remained major causes of death amongst many countries in the LAC region, accounting for more than 14.1% of deaths in 2023 for the 33 LAC countries. The remaining 9.95% of deaths are attributed to injuries and violence.

Definition and comparability

Mortality rates are calculated by dividing annual numbers of deaths by mid-year population estimates. Rates have been age-standardised using population data from the four OECD LAC countries as standard population. The WHO mortality database uses country civil registration and vital statistics systems from each country, only accounting for medically certified deaths. However, complete vital registration systems do not exist in many developing countries, and about one-third of countries in the region do not have recent data. Misclassification of causes of death is also an issue. When WHO measurements are prior than 2020, IHME estimates are used. Estimates from IHME are derived from mortality data collected up to the year 2017. The World Bank Development Indicators for adult mortality, reported as the probability of dying between 15 and 60 years of age (adult mortality rate), derive from life tables of the Human Mortality (HMD, 2025[3]).

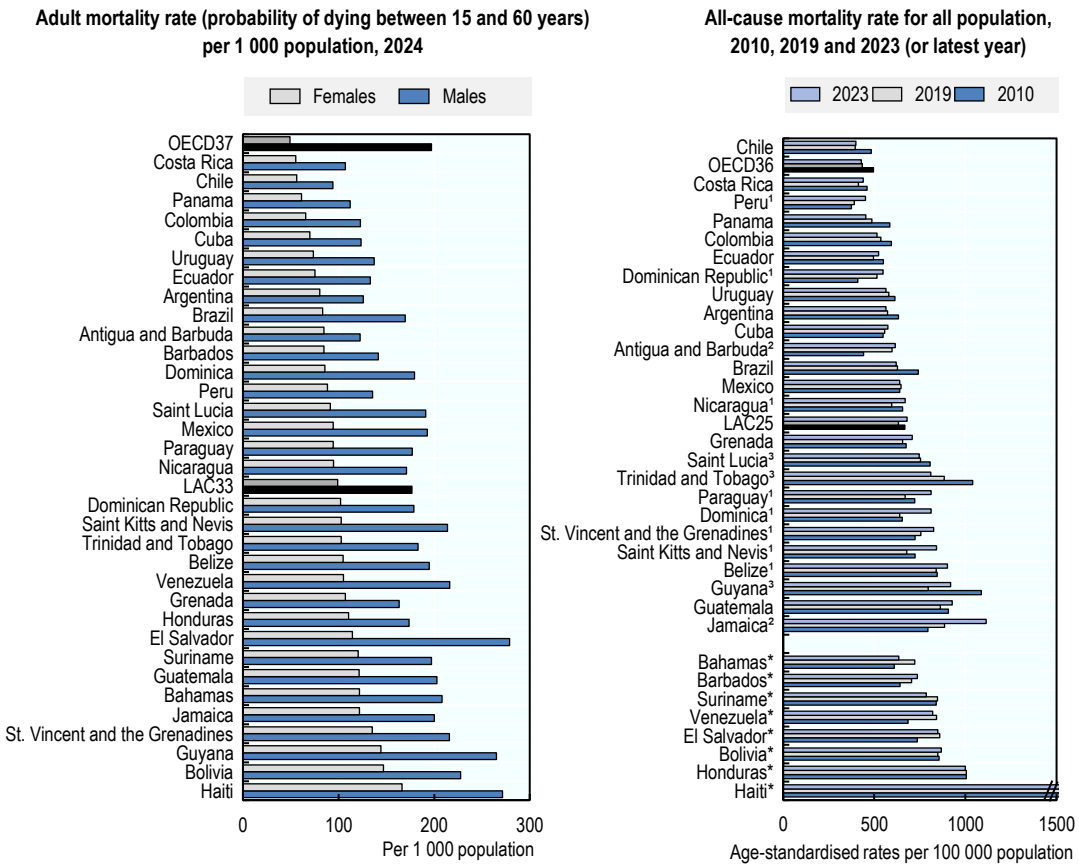
References

Alvarez, J., J. Aburto and V. Canudas-Romo (2019), "Latin American convergence and divergence towards the mortality profiles of developed countries", *Population Studies*, Vol. 74/1, pp. 75-92, https://doi.org/10.1080/00324728.2019.1614651. [1]

HMD (2025), *Human Mortality Database*, https://www.mortality.org/. [3]

OECD/The World Bank (2023), *Health at a Glance: Latin America and the Caribbean 2023*, OECD Publishing, Paris, https://doi.org/10.1787/532b0e2d-en. [2]

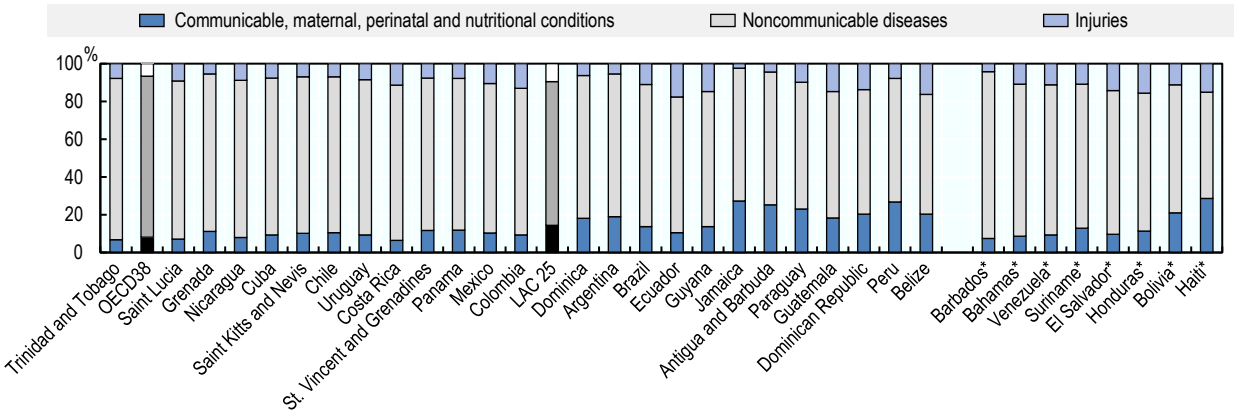
Figure 3.11. Adult mortality rate, 2024 and all-cause mortality rates, 2010, 2019 and 2023 (or latest year)



Note: Right panel: * IHME estimates. 1. Data from 2022. 2. Data from 2021. 3. Data from 2020.
Source: Left panel: The World Bank World Development Indicators Online 2026. Right Panel: WHO mortality database (2026) and Global Burden of Disease (2025), IHME.

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Figure 3.12. Proportions of all cause deaths, 2023 (or nearest year)



Note: *IHME estimates.
Source: WHO mortality database (2026) and Global Burden of Disease (2025), IHME.

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Mortality from cardiovascular diseases

Cardiovascular diseases (CVD) are the leading cause of death globally and caused over 2 million deaths in the WHO Region of the Americas in 2021, accounting for 28% of all deaths (WHO, 2025[1]). CVD includes diseases of the circulatory system, mainly ischaemic heart disease (IHD), cerebrovascular disease and other conditions such as hypertensive and arterial diseases. IHD results from plaque build-up in the coronary arteries, restricting blood flow to the heart, while cerebrovascular diseases affect blood vessels supplying the brain and include ischaemic and haemorrhagic stroke. Most CVD is linked to risk factors that can be controlled, treated or modified.

CVD is the leading cause of death in the LAC region. Based on the WHO mortality database, the average CVD mortality decreased in LAC25 (-4%) and decreased in OECD (-28.4%) between 2010 and 2023 (Figure 3.13). Among countries with WHO measured data, Dominica, Peru and Nicaragua have experienced the largest increases in CVD mortality rates of over +30% in the period. Notably, Guyana and Uruguay decreased their CVD mortality by an average of -40.7% and -36.5% respectively. Furthermore, COVID-19 may have contributed directly and indirectly to higher death rates from circulatory diseases in some countries, owing to disruptions to acute, primary and preventive care (OECD, 2023[2]). Mortality from CVD in eight LAC countries was based on estimated data from the IHME. These countries show an increase of 9.4% in average CVD mortality between 2010 and 2023, with Venezuela and El Salvador reporting the largest increases at 38.2% and 27.4%, respectively.

CVD mortality shows substantial gender disparities across all 33 LAC countries, with rates 52% higher among men than women. Among LAC25 countries, male mortality exceeded 300 deaths per 100 000 population in Jamaica, Trinidad and Tobago, Guyana, Nicaragua and Saint Vincent and the Grenadines in 2023 (Figure 3.13). Only Peru, Chile, Uruguay and Costa Rica were below the OECD average for men. Among women, rates were highest in Jamaica, Saint Kitts and Nevis, and Saint Vincent and the Grenadines, while Chile had the lowest rate, alongside Peru, Uruguay, Costa Rica and Panama below the OECD female average.

Together, IHD and stroke comprise 61% of all CVD deaths in the 25 LAC countries with measured data, similar to the 56% in OECD countries (Figure 3.14). IHD deaths represent over 55% of all CVD deaths in Nicaragua, Mexico and Ecuador compared to only 36% in OECD countries. This higher proportion may be primarily explained by delays in diagnosis and limited access to reperfusion therapies or other effective treatments. In contrast, in countries such as Antigua and Barbuda and Saint Lucia, IHD account for less than 15% of all CVD deaths. The lower shares may reflect differences in lifestyle-related factors, such as diet, population demographic, or possible underreporting. In Saint Lucia and Jamaica, cerebrovascular diseases deaths take 35% or more of all CVD deaths, while these represent 15% or less in Mexico, Nicaragua and Antigua and Barbuda. In contrast, in the 8 LAC countries with estimated data, IHD and cerebrovascular diseases deaths account for 79% of all CVD deaths, with the remaining 21% due to other cardiovascular diseases.

In LAC countries, deaths from cerebrovascular diseases are considerably lower than those from IHD, but their consequences for quality of life are often more severe. Many stroke patients report impaired quality of life due to pain and discomfort (Segerdahl et al., 2023[3]), while cardiac rehabilitation after myocardial infarction can improve both physical and mental health (Kolarczyk et al., 2024[4]). As populations age and multi-morbidity increases, timely access to cardiac care and rehabilitation will be essential to improve outcomes and quality of life for CVD patients (OECD, 2022[5]).

Definition and comparability

See indicator “Mortality from all causes” in Chapter 3 for definition, source, and methodology underlying mortality rates. Of all 33 LAC countries, LAC25 refers to the 25 countries with measured mortality data available from the WHO Mortality Database, while LAC8 refers to the countries whose mortality data are based on IHME estimates.

References

Kolarczyk, E. et al. (2024), “The factors of quality of life among patients after myocardial infarction in Poland: a cross-sectional study. The quality of life among patients after myocardial infarction”, *Scientific Reports*, Vol. 14/1, https://doi.org/10.1038/s41598-024-65525-z. [4]

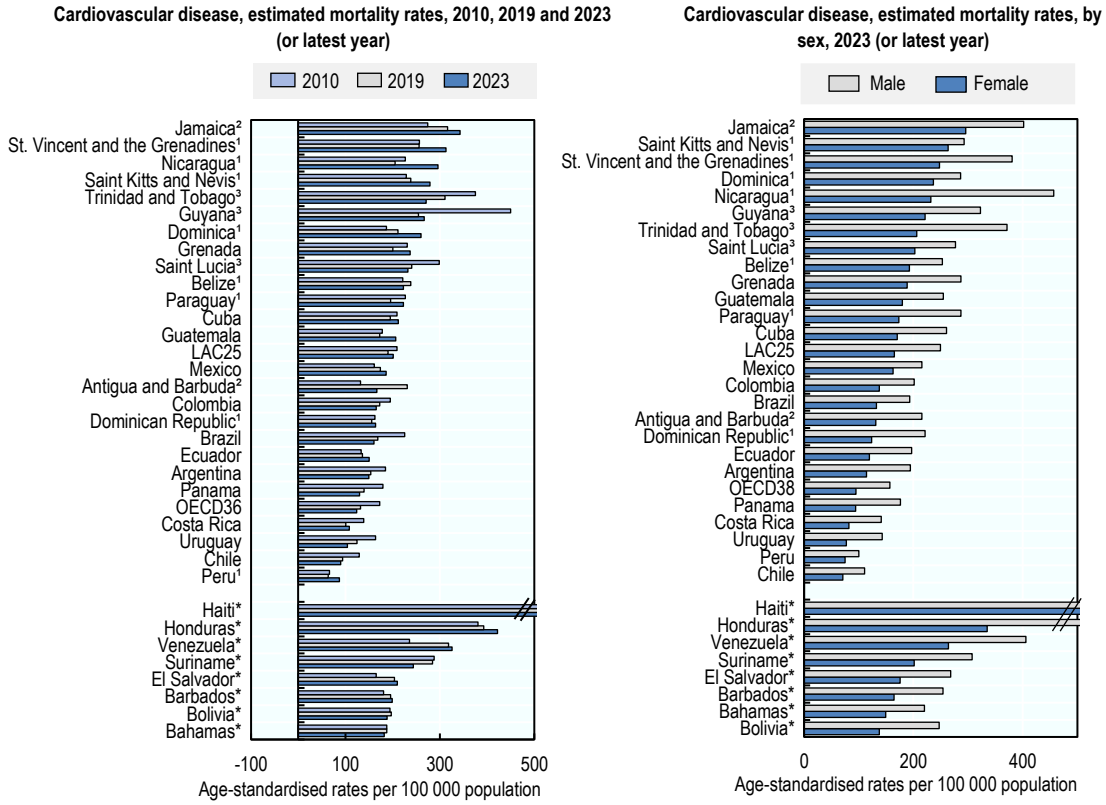
OECD (2023), *Health at a Glance 2023: OECD Indicators*, OECD Publishing, Paris, https://doi.org/10.1787/7a7afb35-en. [2]

OECD (2022), *Primary Health Care for Resilient Health Systems in Latin America*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/743e6228-en. [5]

Segerdahl, M. et al. (2023), “Health-related quality of life in stroke survivors: a 5-year follow-up of The Fall Study of Gothenburg (FallsGOT)”, *BMC Geriatrics*, Vol. 23/1, https://doi.org/10.1186/s12877-023-04308-z. [3]

WHO (2025), *Global health estimates: Leading causes of death*, https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/ghe-leading-causes-of-death (accessed on 1 December 2022). [1]

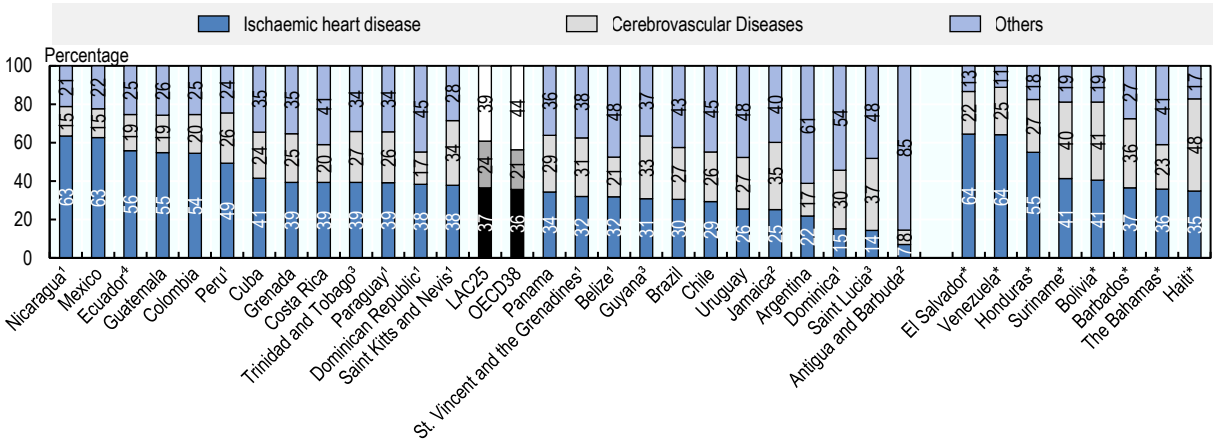
Figure 3.13. Mortality rate for cardiovascular diseases for 2010, 2019 and 2023 and by sex



Note: *IHME estimates. 1. Data from 2022. 2. Data from 2021. 3. Data from 2020.
Source: WHO mortality database (2026) and Global Burden of Disease (2025), IHME.

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Figure 3.14. Proportions of deaths per type of cardiovascular disease, 2023 (or nearest year)



Note: * IHME estimates. 1. Data from 2022. 2. Data from 2021. 3. Data from 2020. 4. Data from 2024.
Source: WHO mortality database (2026) and Global Burden of Disease (2025), IHME.

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Mortality from cancer

Cancer is the second leading cause of death after CVD amongst LAC countries, producing over 740 000 deaths in 2022 in the region (Ferlay J, 2024[1]). Only about 5% to 10% of all cancers are inherited, meaning that modifiable risk factors such as smoking, obesity, exercise, and environmental exposures, explain as much as 90-95% of all cancer cases (Whiteman and Wilson, 2016[2]). Prevention, early detection, and treatment remain at the forefront of the tools to reduce the burden of cancer.

The regional average cancer mortality rate in LAC33 was 116.2 per 100 000 population in 2023, considerably higher than the OECD average of 107 (Figure 3.15). Amongst the 25 LAC countries for which WHO mortality data were available, cancer deaths were less common in Dominican Republic, Nicaragua, Mexico, Guatemala, Ecuador and Panama, with rates below 80 deaths per 100 000 population, and highest in Saint Kitts and Nevis, Jamaica and Saint Vincent and the Grenadines, with over 145 deaths per 100 000 population. Overall cancer mortality has decreased in the LAC25 region by 4% since 2010, far below the 18% decrease observed in OECD countries. Saint Kitts and Nevis and Saint Vincent and the Grenadines, experienced the largest increases in the region, at 41.6% and 35.2%, respectively. Cancer mortality rates were higher in men than in women in all LAC33 countries, except Peru, in 2023 (Figure 3.15). While overall cancer mortality among females is similar between OECD and LAC25 countries, the male-to-female cancer mortality ratio is higher in OECD countries, at 1.50, compared to 1.40 in LAC25 countries. In LAC25, the highest male cancer mortality rates were observed in Saint Kitts and Nevis and Jamaica, at 247.9 and 208.6 deaths per 100 000 population, respectively. Among women, the highest rates were reported in Dominica and Saint Kitts and Nevis, both exceeding 120 deaths per 100 000 population.

In 2023, prostate, colorectal, and lung cancers, including also trachea and bronchus, were the leading causes of cancer mortality in the LAC25 region, accounting for 13.4%, 9.5%, and 9.3% of all cancer deaths, respectively (Figure 3.16). In OECD countries, the pattern was different with lung, colorectal and breast cancers leading cancer mortality, accounting for 18.3%, 11.1% and 6.9% of cancers deaths, respectively. Compared with OECD countries, colorectal and lung cancer accounted for a smaller share of cancer deaths in LAC25, while prostate and cervical cancers represented a larger share. This higher proportion of prostate and cervical cancer may be explained by limited early detection, lower HPV vaccination coverage, and delays in treatment. Prostate cancer accounted for over 25% of cancer deaths in Grenada, Dominica and Saint Kitts and Nevis. Colorectal cancer mortality is more prominent in some higher income countries such as Chile, Costa Rica, Argentina, Uruguay, and Trinidad and Tobago, representing more than 12% of cancer deaths. For lung cancer, the distribution varied considerably among LAC25 countries, from more than 15% of cancer deaths in Cuba and Uruguay to less than 5% in Dominica, Antigua and Barbuda and Saint Vincent and the Grenadines. Breast cancer represents a higher proportion of deaths in Grenada, Dominica, Jamaica, Trinidad and Tobago, and Antigua and Barbuda (more than 11%), and a lower share in Peru and Guatemala (below 6%). Stomach cancer deaths account for higher shares in Guatemala, Ecuador and Peru (over 13% of all cancer deaths) and the lowest in Antigua and Barbuda (below 2%). Liver cancer mortality accounted for less than 8% of cancer deaths in all LAC25 countries, except in Guatemala and Nicaragua, where it represented 20.9% and 11.6%, respectively. Finally, cervical cancer is responsible for over 11.6% of cancer deaths in Haiti, significantly higher than the LAC33 average of 5.3%.

To address the growing burden of cancer, targeted and equity-driven interventions are critically needed, including evidence-based treatments, early diagnosis and effective screening programmes (Piñeros et al., 2022[3]). Moreover, significant gaps in preventable cancer deaths with the OECD indicate that cancer control planning in the LAC region will be more effective and efficient by targeting risk factors such as smoking, physical activity and overweight/obesity.

Definition and comparability

See indicator “Mortality from all causes” in Chapter 3 for definition, source, and methodology underlying mortality rates. Of all 33 LAC countries, LAC25 refers to the 25 countries with measured mortality data available from the WHO Mortality Database, while LAC8 refers to the countries whose mortality data are based on IHME estimates.

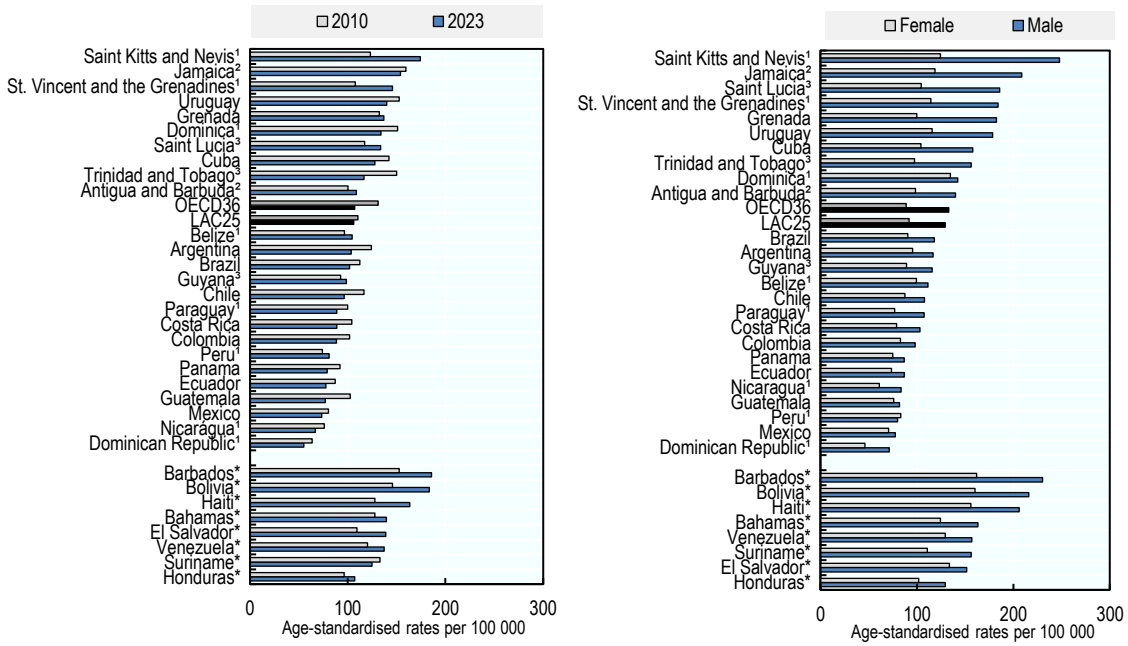
References

Ferlay J, E. (2024), *Global Cancer Observatory: Cancer Today*, International Agency for Research on Cancer, https://gco.iarc.who.int/today. [1]

Piñeros, M. et al. (2022), “An updated profile of the cancer burden, patterns and trends in Latin America and the Caribbean”, *The Lancet Regional Health - Americas*, Vol. 13, p. 100294, https://doi.org/10.1016/j.lana.2022.100294. [3]

Whiteman, D. and L. Wilson (2016), “The fractions of cancer attributable to modifiable factors: A global review”, *Cancer Epidemiology*, Vol. 44, pp. 203-221, https://doi.org/10.1016/j.canep.2016.06.013. [2]

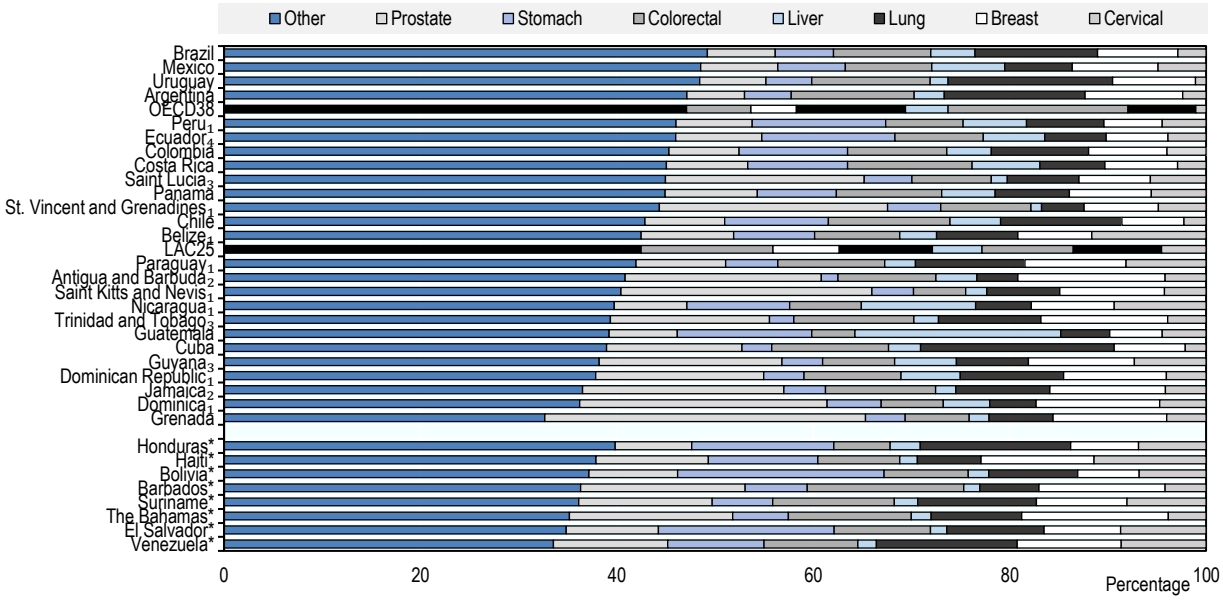
Figure 3.15. Cancer mortality rates in 2010 and 2023 (or latest year) and by sex



Note: * IHME estimates. 1. Data from 2022. 2. Data from 2021. 3. Data from 2020. 4. Data from 2024.
Source: WHO mortality database (2026) and Global Burden of Disease (2025), IHME.

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Figure 3.16. Proportions of cancer deaths, 2023 (or latest year)



Note: *IHME estimates. 1. Data from 2022. 2. Data from 2021. 3. Data from 2020. 4. Data from 2024. Lung cancers include trachea, bronchus, and lung cancers.
Source: WHO mortality database and Global Burden of Disease (2025), IHME.

StatLink https://stat.link/67ljid

Mortality from injuries

Injuries are a major yet largely preventable cause of death and disability across all age groups, causing over 650 000 deaths in the Americas in 2019 – around 9% of all deaths – with risks varying substantially by country, cause, age, sex and income group (WHO, 2025[1]).

Men had higher injury mortality rates than women in the LAC region in 2023, with 96.3 deaths per 100 000 men and 22.2 deaths per 100 000 women in LAC25, compared to 51.6 and 18.8 deaths per 100 000 respectively amongst OECD countries (Figure 3.17). Santa Lucia shows the largest gender difference with an injuries mortality rate more than nine times higher amongst men compared to women, followed by Saint Vincent and the Grenadines with rates more than eight times higher. Conversely, Cuba and Antigua and Barbuda show the lowest gender differences with injuries death gender ratios of 2.5 in both countries.

Violence accounted for 24.8% and road traffic for 19.8% of all injury deaths in LAC25 countries, adding up to more than 40% of injury deaths in 2023 (Figure 3.17). In OECD countries, the largest causes for injury death were 22.7% due to falls and 21% self-inflicted. More than 40% of all injury deaths could be attributed to interpersonal violence in Saint Vincent and the Grenadines, Trinidad and Tobago, Ecuador and Colombia while the lowest proportion was observed in Jamaica, Chile, Cuba and Argentina, all below 8% of all injury deaths. In Uruguay, Nicaragua, Guyana and Chile, self-inflicted deaths were over 20% of all injury deaths, and below 6% in Dominica, Guatemala, Peru, Jamaica and Saint Vincent and the Grenadines. Mortality from falls was highest in Cuba, accounting for 30.82% of all injury-related deaths, and lowest in Antigua and Barbuda, where no deaths were recorded. Drownings represented the largest share of injury mortality in Dominica, at 10.64%, and the lowest in Antigua and Barbuda, where no drowning deaths occurred.

Mortality from injuries due to violence shows an increase of 82.5% in LAC23 countries between 2000 and 2023, while the OECD had a decrease of -34.9% instead (Figure 3.18). The highest growth was observed in Dominica, Antigua and Barbuda, Saint Vincent and the Grenadines, and Costa Rica with more than 155%, while the largest decrease occurred in Colombia (-64.4%), Brazil (-59.1%) and Nicaragua (-54.2%). However, although Dominica appears as an outlier in terms of growth in mortality due to violence, in absolute terms the increase amounts to only 11 additional deaths per 100 000 between 2000 to 2022 (as this is the last year available). Mortality due to self-harm injuries in the period also increased in LAC23 by 9.5%, opposed to the reduction of -18.9% in the OECD. Paraguay shows the largest increase by 169.4% and Saint Lucia exhibits the most pronounced decrease of -69.9%. Road traffic injuries deaths in LAC23 experienced a decrease of –5.4% between 2000 and 2023, while the OECD showed a decrease of -52.4%.

OECD countries have widely adopted the “Safe System” approach to road safety, combining prevention, safer vehicles, stronger regulation and enforcement. In LAC, however, road traffic injuries have increased slightly over the past two decades, despite global road safety efforts that may have helped moderate the expected rise linked to growing vehicle ownership. Strengthening road safety governance, investing in safer infrastructure and adopting international vehicle safety standards remain critical to reducing injuries and fatalities, particularly among vulnerable road users (PAHO, 2024[2]).

Definition and comparability

See indicator “Mortality from all causes” in Chapter 3 for definition, source, and methodology underlying mortality rates. Of all 33 LAC countries, LAC18 or LAC15 refers to those with measured mortality data available from the WHO Mortality Database, while the remaining countries are based on IHME estimates.

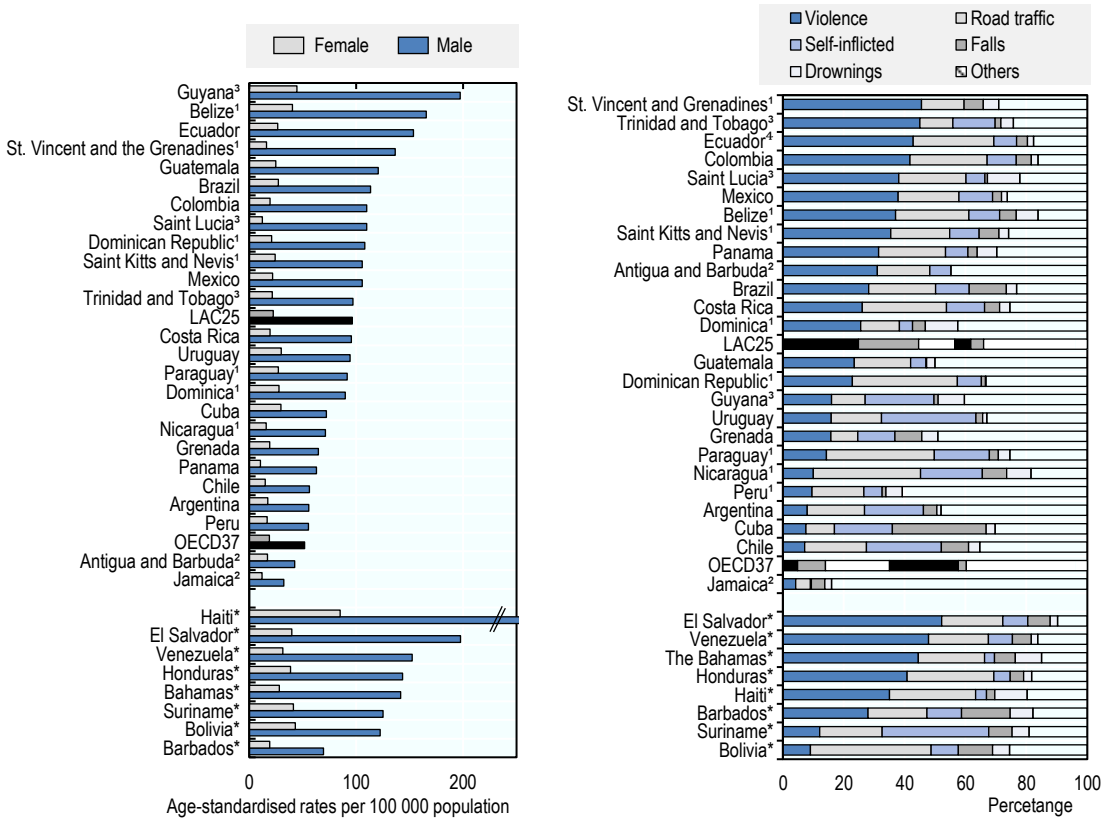
“Other” causes of deaths include accidental exposure to unspecified factors or accidental poisoning by and exposure to noxious substances, among others, and exclude deaths due to violence, falls, drownings, road traffic accidents and self-inflicted deaths. Injury deaths where the intent is not determined are distributed proportionately to all causes below the group level for injuries.

References

PAHO (2024), *Salvar vidas promoviendo un enfoque de sistemas de tránsito seguros en las Américas.*, Pan American Health Organization, https://www.paho.org/es/node/98195. [2]

WHO (2025), *Global health estimates: Leading causes of death*, https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/ghe-leading-causes-of-death (accessed on 1 December 2022). [1]

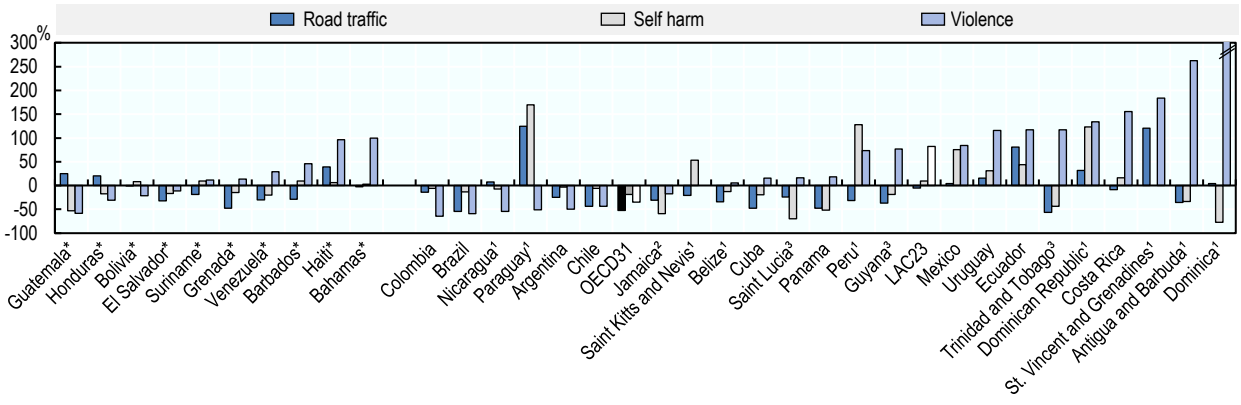
Figure 3.17. Mortality by injuries, male and female and by type, 2023 (or latest year)



Note: *IHME estimates. 1. Data from 2022. 2. Data from 2021. 3. Data from 2020. 4. Data from 2024.
Source: WHO mortality database (2026) and Global Burden of Disease (2025), IHME.

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Figure 3.18. Growth rates of road traffic accidents, self-harm and violence mortality, 2000-2023 (or latest year)



Note: * IHME estimates. 1. Data from 2022. 2. Data from 2021. 3. Data from 2020.
Source: WHO mortality database (2026) and Global Burden of Disease (2025), IHME.

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Maternal mortality

Maternal mortality is an important indicator of a woman's health status and of health system's performance. The Sustainable Development Goals set a target of global maternal mortality ratio to 70 per 100 000 live births by 2030.

In LAC, maternal mortality ratio (MMR) averaged 72 deaths per 100 000 live births in 2023, substantially higher than the average of 10 deaths per 100 000 live births in OECD countries (Figure 3.19, left panel). Estimates show Chile with one of the lowest MMRs at 10, while Haiti had one of the highest at 328, followed by Venezuela and Bolivia with 227 and 146, respectively. Despite high rates in certain countries, a reduction of -33.3% in maternal mortality has been achieved in the LAC region between 2000 and 2023, below the reduction in OECD countries of -37.6% in the same period. In Nicaragua, Paraguay, Suriname and Chile MMR decreased by around 70%. Nevertheless, during the same period MMR increased in 5 countries, with Venezuela (163%), Dominican Republic (64.7%), Jamaica (58.9%) and Bahamas (48.1%) experiencing increases of more than 40% (Figure 3.19, right panel).

Across 27 LAC countries, maternal mortality tends to be inversely related to the coverage of skilled birth attendance, however other factors might also influence MMR (Figure 3.20). Twelve countries had a higher coverage of skilled birth attendance than the LAC average and a lower maternal mortality ratio (top left quadrant). The converse was true in 4 countries (bottom right quadrant). However, in Cuba and Jamaica, skilled birth attendance coverage was the highest, at 100%, which is 3% above the LAC average but they also had a high MMR, over 170, meaning more than double the LAC average. This may suggest challenges with quality of care. Most countries (20) had more than 97% of births attended by skilled health professionals. However, substantial gaps in skilled birth coverage remain in Bolivia (72%), Mexico (88%) and Paraguay (91%), all bellow the LAC27 average.

Higher coverage of antenatal care (at least four visits) is slightly inversely correlated with MMRs (Figure 3.20). The top left quadrant of the graph, which represents higher than LAC average antenatal care coverage and lower than LAC average maternal mortality rates includes 9 of the LAC22 countries. Because maternal mortality rates have decreased significantly across the LAC region overall, they may no longer be as sensitive to variables that previously showed strong associations. Bolivia and Jamaica have the highest MMR, above 140 deaths per 100 000 live births and more than double the LAC22 average of 62, with antenatal care coverage below 85%. This suggest that these countries could reduce their MMR by increasing the number of antenatal care visits. However, it is important to consider the experience of countries such as Argentina, Antigua and Barbuda and Grenada, which have achieved low MMR despite comparatively lower antenatal coverage. This suggests that additional factors, such as ensuring maternal health access for all women, improving its quality, and empowering women and communities to exercise their sexual and reproductive rights, may have a positive impact on maternal health and the prevention of avoidable maternal mortality.

Risk of maternal death can be reduced through family planning, better access to high-quality antenatal care, and delivery and postnatal care by skilled health professionals. Addressing disparities in the provision of these essential reproductive health services to underserved populations must be included in any strategy. Furthermore, the broad health systems strengthening and universal health coverage agenda, along with multisectoral action (e.g. women's education, tackling violence) are crucial to reducing maternal deaths in the LAC region (WHO et al., 2018[1]).

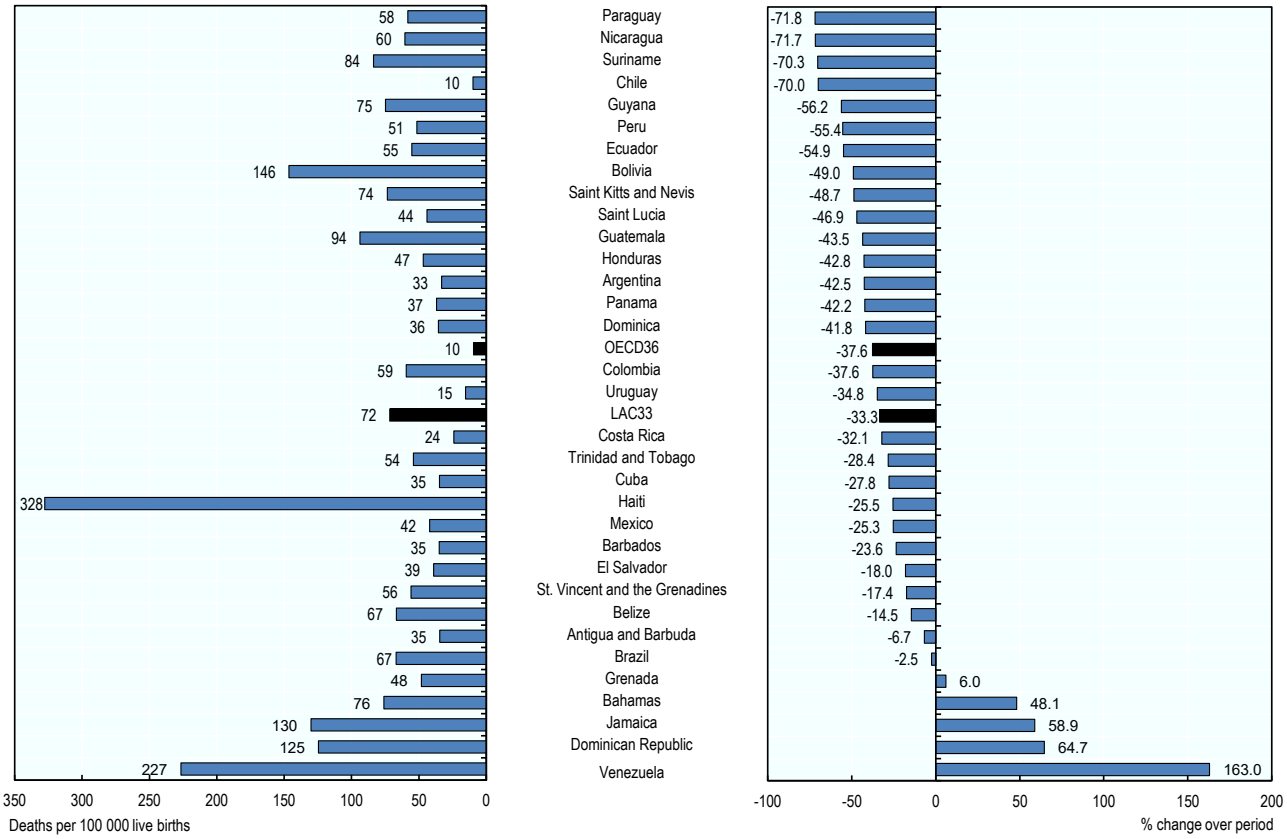
Definition and comparability

Maternal mortality is defined as the death of a woman while pregnant or during childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from unintentional or incidental causes. This includes direct deaths from obstetric complications of pregnancy, interventions, omissions, or incorrect treatment. It also includes indirect deaths due to previously existing diseases, or diseases that developed during pregnancy, where these were aggravated by the effects of pregnancy. Maternal mortality is here measured using the MMR. It is the number of maternal deaths during a given time per 100 000 live births during the same time. There are difficulties in identifying maternal deaths precisely. Many countries in the region do not have accurate or complete vital registration systems, and so the MMR is derived from other sources including censuses, household surveys, sibling histories, verbal autopsies, and statistical studies. Estimates should therefore be treated cautiously. Figure 20 uses X and Y ratios compared to the LAC average. They show the distance to the LAC average.

References

WHO et al. (2018), *Survive, Thrive, Transform. Global Strategy for Women's, Children's and Adolescents' Health: 2018 report on progress towards 2030 targets*, World Health Organisation, Geneva, https://www.everywomaneverychild.org/wp-content/uploads/2018/05/EWECGSMonitoringReport2018.pdf. [1]

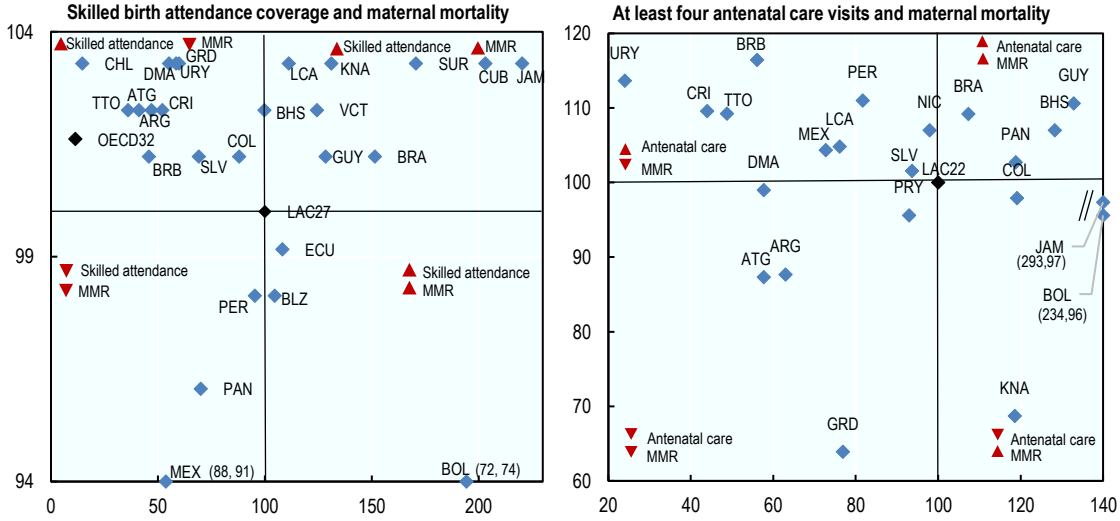
Figure 3.19. Estimated maternal mortality ratio, 2023, and percentage change since 2000



Note: Costa Rica values are from 2022.
Source: WHO GHO (2025), OECD data explorer for OECD Members and OECD average.

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Figure 3.20. Association between maternal mortality and skilled birth attendance coverage (left), antenatal care coverage (right), 2023 (or latest year)



Source: WHO GHO 2025.

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Mental health

For people to lead healthy and productive lives, good mental health is necessary. In the LAC region, about one in four individuals is expected to experience a mental health disorder during their lifetime. The COVID-19 pandemic had a substantial impact on the mental health of the population, adding to existing pressures such as constant digital connectivity, social isolation, and the climate crisis. Women are disproportionally affected by anxiety and depression, while the average male suicide rate in LAC remains considerably higher than that for women (UNDP, 2025[1]).

The average depression and depressive symptoms prevalence rate in LAC33 was 3 753 per 100 000 population in 2024, considerably lower than the OECD prevalence of 4 130 per 100 000 population (Figure 3.21). Within the LAC region, depression prevalence was the highest in Chile, Trinidad and Tobago and Cuba, with more than 4 200 cases per 100 000, and the lowest in Colombia, Nicaragua and Panama being lower than 2900 cases per 100 000 population. Although data for Colombia, Paraguay and Argentina were collected from health questionnaires sent to countries, substantial differences were found compared with IHME data, as all three reported a prevalence of fewer than 2 300 per 100 000 population. These differences could be explained by the fact that 2024 IHME estimates for depression prevalence are based on health survey data up to 2015 and scientific literature with data up to 2022.

People in LAC countries are now reporting higher levels of anxiety than before. In 2021, anxiety prevalence was 6 632.7 cases per 100 000 population, while in 2024 this rate increased to 7 173.7 cases per 100 000 in the LAC region based on IHME estimates. The average prevalence of anxiety and anxiety symptoms in LAC is higher than in OECD countries, where the prevalence stands at 6 659.4 cases per 100 000 population (Figure 3.22). Anxiety is not evenly distributed across LAC, and ranges from 4 820.0 cases per 100 000 in Panama to 11 376 per 100 000 in Brazil.

Regarding deaths by suicides, LAC25 experienced 7.1 deaths per 100 000 population on average in 2023, below the OECD37 average of 9.7 deaths per 100 000 population. Only Guyana, Uruguay, Cuba and Paraguay, had deaths rates by suicide above the OECD average, with 25.9, 21.2, 11.2 and 10.1 per 100 000 population respectively in 2023. Saint Vincent and the Grenadines and Jamaica had less than 2 deaths by suicide per 100 000 population in 2023 (Figure 3.23). Overall, self-inflicted mortality has increased in the LAC25 region by 11.7% since 2010, in contrast to the 16.7% decrease observed in OECD countries. Grenada and Paraguay experienced the largest increases in the region, at 451.5% and 135.9%, respectively. However, although Grenada appears as an outlier in terms of relative percentage change in mortality due to self-harm, in absolute terms the increase amounts to only 4 additional deaths per 100 000 between 2010 to 2023.

LAC countries could strengthen mental health outcomes by following the recommendations outlined by PAHO. These include increasing investment in community-based mental health services and promoting partnerships and collaboration among government ministries, agencies, academia and nongovernmental organisations in a “whole-of-government” approach. The Community Mental Health Centers (CSMC) model in Peru, which decentralizes psychiatric care to the primary level, is a good example. Additional interventions involve workplace programmes and suicide prevention strategies, and the incorporation of mental health and psychosocial support into emergency preparedness and response plans. Finally, improving data collection is highlighted as essential to support evidence-based policymaking (PAHO, 2023[2]).

Definition and comparability

Depression disorders category from the GBD disease classification includes major depressive disorder and dysthymia. Anxiety disorders are classified as a Level-3 cause and is not further subdivided into Level-4 subtypes. The GBD estimates were based on data on prevalence identified through systematic searches of published and unpublished documents, survey microdata, administrative records of health encounters, registries, and disease surveillance system that are catalogued in the Global Health Data Exchange website (Neufeld, 2022[3]).

The registration of suicide is a complex procedure, affected by factors such as how intent is ascertained; who is responsible for completing the death certificate; and cultural dimensions, including stigma. Caution is therefore needed when comparing rates between countries. Age-standardised mortality rates are based on numbers of deaths divided by the size of the corresponding population. The source is the WHO Mortality Database; suicides are classified as ICD-10 codes X60-X84 and Y870.

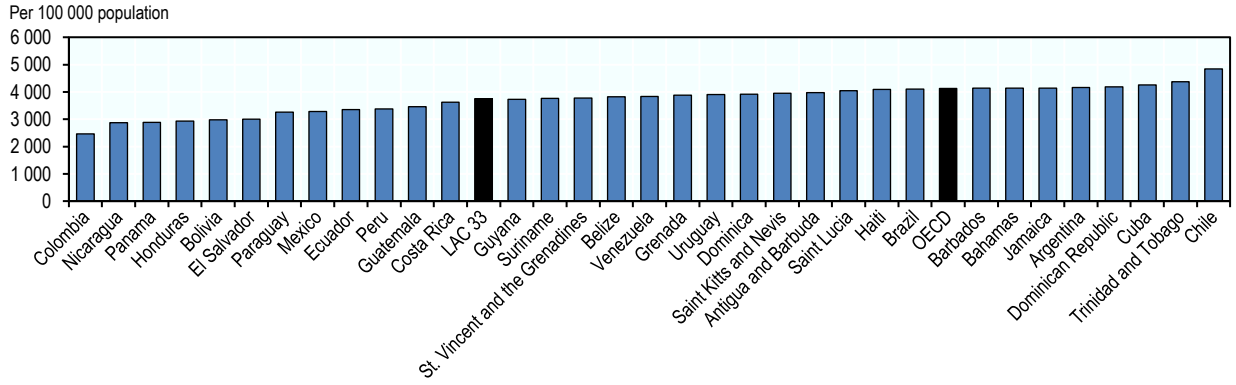
References

Neufeld, S. (2022), “The burden of young people’s mental health conditions in Europe: No cause for complacency”, *The Lancet Regional Health - Europe*, Vol. 16, p. 100364, https://doi.org/10.1016/j.lanepe.2022.100364. [3]

PAHO (2023), *Policy for Improving Mental Health*, Pan American Health Organization, https://www.paho.org/en/documents/policy-improving-mental-health. [2]

UNDP (2025), *Strong on the Outside, Struggling Within: A decline in Mental Health in LAC*, https://www.undp.org/latin-america/blog/strong-outside-struggling-within-decline-mental-health-lac#:~:text=Mental%20health%20struggles%20are%20not,3%25%20of%20men%2C%20respectively. [1]

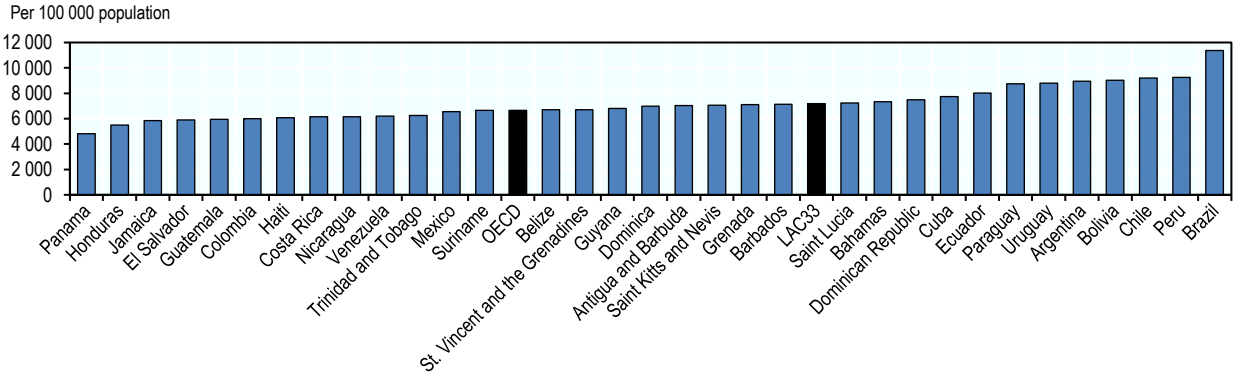
Figure 3.21. Estimates of prevalence of depression or symptoms of depression, 2024



Source: Global Burden of Disease (2025), IHME.

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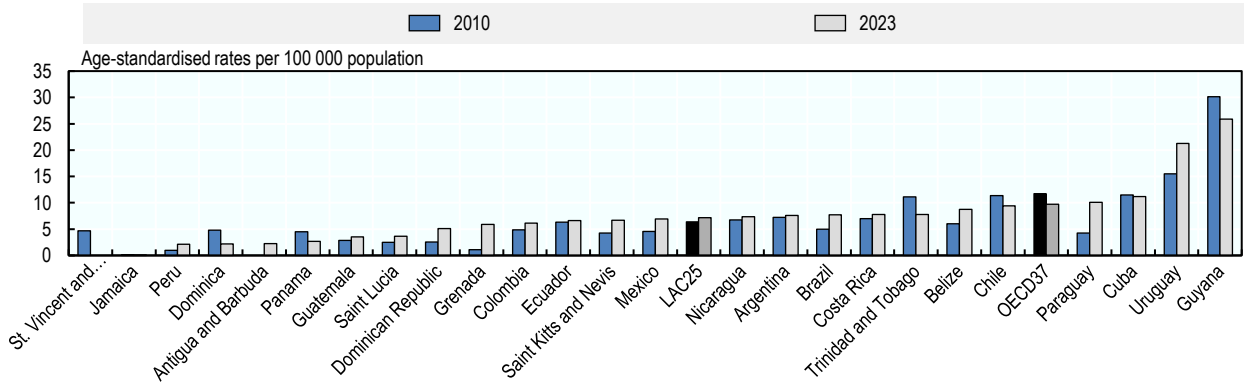
Figure 3.22. Estimates of prevalence of anxiety or symptoms of anxiety, 2024



Source: Global Burden of Disease (2025), IHME.

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Figure 3.23. Deaths by self-inflicted injuries, 2010 and 2023 (or latest year)



Source: WHO mortality database (2026).

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Tuberculosis

Globally in 2024 the total number of new cases of tuberculosis (TB) was estimated at 10.7 million, of which 3.3% were observed in the WHO region of the Americas. The number of TB deaths was estimated globally at 1.08 million, with the Americas experiencing a peak in 2022, followed by a decline in 2023 and a stabilisation in 2024 (WHO, 2025[1]). Most cases of TB are preventable if diagnosed early and appropriate treatment is provided. TB was declared a global health emergency by WHO in 1993 and the Sustainable Development Goals foresee the end of the epidemic by 2030.

The highest incidence rate was seen in Haiti, Peru and El Salvador, with 175, 139, and 116 cases per 100 000 population in 2024, respectively (Figure 3.24. left panel). Low incidence rates were reported particularly in the Caribbean region with below two cases per 100 000 population in Saint Lucia, Antigua and Barbuda, Barbados, Saint Kitts and Nevis, and Grenada. The highest numbers of confirmed cases of rifampicin-resistant TB (RR-TB) and multidrug-resistant TB (MDR-TB) in 2024 were found in Peru and Brazil with 2 379 and 1 417 cases, respectively (Figure 3.24, right panel). These levels are consistent with high-coverage active case-finding and molecular testing strategies in both countries. The lowest number of resistant cases were observed in Caribbean countries, including Antigua and Barbuda, Bahamas, Barbados and Dominica, among others.

High-quality TB services have expanded in LAC countries; however, great disparities are found in the region. The treatment success rates were excellent in Barbados, with 100% success and in El Salvador, Cuba, Nicaragua and Costa Rica with more than 85% success rate. In contrast, the treatment success rate is lowest in Jamaica with 38%, followed by Saint Lucia with 50%, well below the LAC30 average of 74% (Figure 3.25 – left panel).

In general, the LAC region is rising to the challenges presented by TB, with incidence and mortality declining steadily since 1990 despite regional disparities. The average reduction of incidence in the LAC region between 2000 and 2024 was 54%. The strongest decline in this period was observed in Saint Lucia, Honduras and Jamaica with more than 80% reduction, while in El Salvador incidence increased two-fold, moving from 58 to 116 cases per 100 000 population between 2000 and 2024 (Figure 3.25 – right panel).

In 2023, the Americas region reported a higher number of TB cases compared to pre-pandemic levels; however, 80% of cases were concentrated in eight countries (PAHO, 2025[2]). The fight against MDR-TB requires molecular techniques, including rapid molecular diagnostic tests, culture methods or sequencing technologies, which are often unavailable in countries that need them the most. The ShORRT (Short, all-Oral Regimens For Rifampicin-resistant Tuberculosis) initiative, aligned with WHO guidelines for DR-TB treatment, is currently being implemented in some LAC countries including Argentina, Dominican Republic, Peru, Brazil and Ecuador. These fully oral, modified short treatment regimens offer substantial benefits by shortening treatment duration compared to standard therapies, thereby improving patient adherence. Their effectiveness has already been evaluated in the Dominican Republic, where national guidelines have been updated accordingly (Rodríguez et al., 2025[3]). However, adoption of these regimens is still limited in the LAC region, and expanding their implementation could further improve regional MDR-TB control.

Definition and comparability

Tuberculosis (TB) is a contagious disease, caused by the *Mycobacterium tuberculosis* bacteria. It usually attacks the lungs but can also affect other parts of the body. TB spreads through the air when people with active disease cough, sneeze, talk or spit. Most infections in humans are latent and asymptomatic, with about one in ten latent infections eventually progressing to active disease. If left untreated, active TB kills between 20% and 70% of infected individuals within ten years depending on severity.

The TB incidence rate is the number of new cases of the disease estimated to occur in a year, per 100 000 population. The TB prevalence rate is the total number of persons with the disease at a particular time, per 100 000 population.

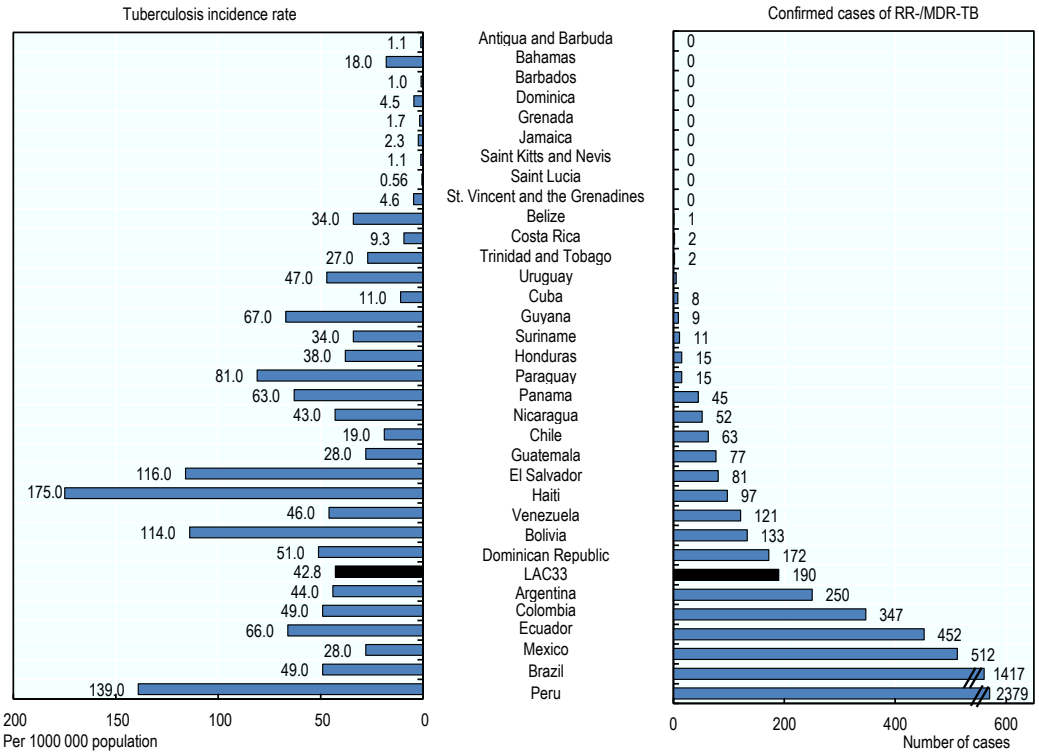
References

PAHO (2025), *Tuberculosis: Highlights*, Pan American Health Organization, https://www.paho.org/en/topics/tuberculosis (accessed on 5 December 2025). [2]

Rodríguez, M. et al. (2025), "Evaluation of a modified short all oral treatment regimen for rifampicin-multidrug resistant tuberculosis in Dominican Republic", *BMC Infectious Diseases*, Vol. 25/1, https://doi.org/10.1186/s12879-024-10417-w. [3]

WHO (2025), *The Global Health Observatory*, World Health Organization, Geneva, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/number-of-incident-tuberculosis-cases. [1]

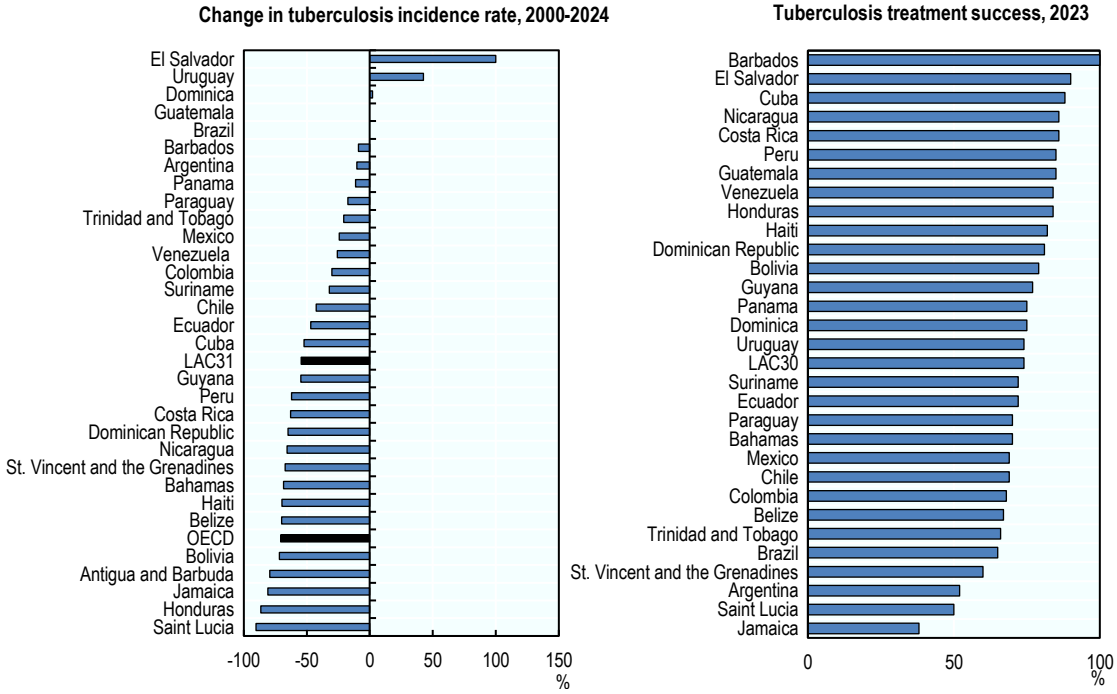
Figure 3.24. Tuberculosis incidence rate and confirmed cases of drug-resistant tuberculosis, 2024



Source: WHO GHO 2025.

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Figure 3.25. Change in tuberculosis incidence rate 2000-2024 and Tuberculosis treatment success for new cases, 2023 (or latest available)



Source: WHO GHO 2025.

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HIV/AIDS

HIV/AIDS has had a substantial impact on health in the LAC region since the early 1980s. The UN has set the goal of eliminating AIDS as a public threat under the SDGs by 2030, with a target defined as reducing the number of new HIV infections and AIDS-related deaths by 90% relative to 2010 (UNAIDS, 2014[1]).

In LAC26, the prevalence in adults aged between 15 and 49 ranged from 0.2% in Guatemala and Honduras to 1.6% in Haiti, Suriname and Guyana in 2024 (Figure 3.26, left panel). Although overall prevalence in the region is relatively low, the number of people living with HIV is over 2.1 million in reporting countries, most of which live in Brazil with 1 100 000 people, followed by Mexico with 400 000 and Colombia with 230 000 (Figure 3.26, left panel).

Expanded access to antiretroviral therapy (ART) has increased the survival rates of people living with HIV, but about half of those eligible for HIV treatment worldwide still do not receive it. In LAC25, the estimated coverage was particularly low (<50%) in Suriname and Saint Lucia, whereas it is 80% or over in Haiti, Peru and Ecuador (Figure 3.27). While some countries with high prevalence (e.g. Haiti) are addressing the issue of treatment coverage, the region remains substantially far from the goal of treating 90% of people living with HIV/AIDS.

The trend of new HIV infections in recent years in the LAC region has overall increased by 10% between 2010 and 2024. However, Caribbean countries show a differential trend as they have made substantial progress in reducing new HIV infections since 2010 (UNAIDS, 2024[2]). In 2024, more than 65% of new infections in the LAC region were in Brazil, Mexico and Venezuela, with Brazil alone accounting for more than one-third (42.3%) of new infections. Between 2010 and 2024, Haiti, Bahamas, Barbados and Ecuador reduced incidence rates by more than 20% (Figure 3.27). Among the countries reporting an increase in incidence, Venezuela experienced the highest growth at 179%, followed by Peru with 51%, and Guatemala and El Salvador with more than 40%. These increases are also partially explained by the expansion of diagnostic access and self-testing kits.

To meet the UNAIDS HIV targets, aligned with SDG target 3.3 on ending AIDS as a public health threat by 2030, the availability of post – exposure prophylaxis and HIV self – testing should be scaled-up while access to PrEP should be sustained (UNAIDS, 2024[2]). The rapid scale-up of antiretroviral therapy (ART) in LAC offers an unprecedented opportunity to successfully implement antiretroviral-based interventions for prevention and treatment, as well as to integrate ART with other key services related to sexual and reproductive health and rights, including addressing hepatitis B and C, tuberculosis, provision of clean needles and syringes, medication-assisted therapy, and non-communicable diseases. The benefits of ART and integrated services can only be fully realised if people living with HIV are diagnosed and successfully linked to care. This will require targeted efforts to remove barriers among populations disproportionately impacted by HIV/AIDS, including sex workers, their clients, men who have sex with men, transgender persons, and people who inject drugs, along with collaborations with stakeholders and civil society in at national and subnational levels (Bekker et al., 2018[3]).

Definition and comparability

Human immunodeficiency virus (HIV) is a retrovirus that destroys or impairs the cells of the immune system. As HIV infection progresses, a person becomes more susceptible to infections. The most advanced stage of HIV infection is the acquired immunodeficiency syndrome (AIDS). It can take 10-15 years for an HIV-infected person to develop AIDS, although antiretroviral drugs can slow down the process.

The HIV prevalence amongst adults aged 15 to 49 is calculated as the number of persons aged 15-49 estimated to be living with HIV divided by the total number of persons aged 15-49 in the country at this time.

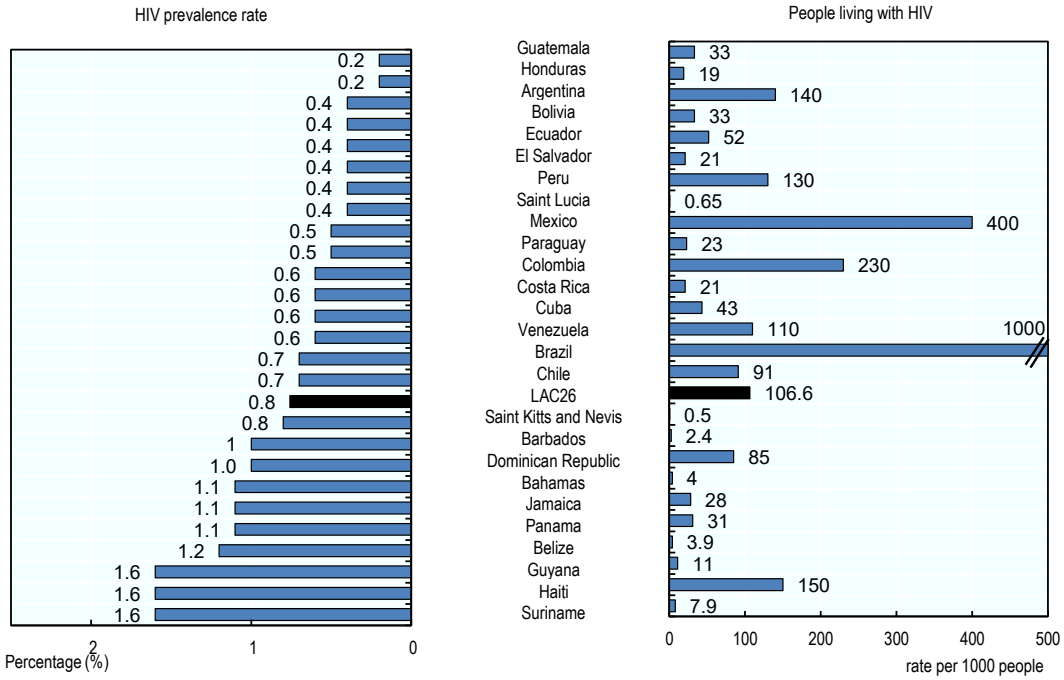
References

Bekker, L. et al. (2018), “Advancing global health and strengthening the HIV response in the era of the Sustainable Development Goals: the International AIDS Society-Lancet Commission.”, *Lancet (London, England)*, Vol. 392/10144, pp. 312-358, https://doi.org/10.1016/S0140-6736(18)31070-5. [3]

UNAIDS (2024), *AIDS info. Global data on HIV epidemiology and response*, https://aidsinfo.unaids.org/. [2]

UNAIDS (2014), *90–90–90: an ambitious treatment target to help end the AIDS epidemic*, Joint United Nations Programme on HIV/AIDS, Geneva, https://www.unaids.org/sites/default/files/media_asset/90-90-90_en.pdf (accessed on 1 October 2019). [1]

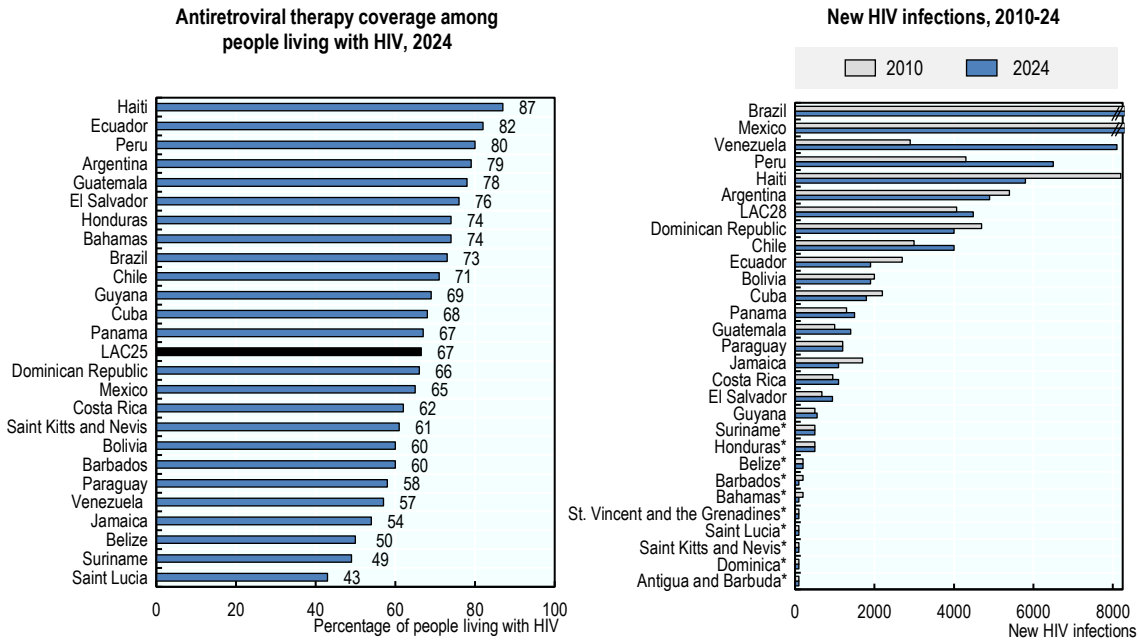
Figure 3.26. HIV prevalence rate, percentage of adults aged 15-19, and people living with HIV, absolute number in thousands, 2024



Source: WHO GHO 2025.

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Figure 3.27. Antiretroviral therapy coverage amongst people living with HIV (2024) and new HIV infections



Notes: In left panel, only values for 2024 are shown, * indicates the value is "less than" the number shown. Brazil (22 000, 18 000) and Mexico (55 000, 51 000) were truncated in the left panel for values of 2024 and 2010 respectively.
Source: WHO GHO 2025, UNAIDS 2025.

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Mosquito borne diseases

Malaria, dengue and Zika are three diseases that are transmittable by the bites of infected mosquitoes. They are present in LAC with varying degrees of incidence. Malaria is a tropical disease caused by a parasite in the mosquito and causes symptoms such as fever, headache, and vomiting. As part of the SDG targets, the UN set a goal to end the epidemic of malaria by 2030. Globally, malaria case incidence declined by 25.6% between 2000 and 2015, however, it increased by 8.5% between 2015 and 2024. In terms of mortality rates, it almost halved between 2000 and 2015, but progress has slowed since then, with only a further 7.4% reduction over the past 9 years (WHO, 2025[1]).

In the LAC region, country efforts have greatly reduced new cases of malaria, nearly or completely eradicating it in Argentina, Belize, El Salvador, Paraguay, Suriname, Mexico, Dominican Republic, Ecuador, Guatemala, Honduras and Costa Rica, plus several countries no longer report incidence data. However, the region remains vulnerable to outbreaks. The biggest incidence in the region can be found in Guyana with 43 cases per 1 000 risk population in 2023 (Figure 3.28, left panel). In 2023, Venezuela shows the largest number of estimated malaria deaths with 118 people dying in the country, followed by Brazil, Haiti, and Guyana with 73, 60, and 42 deaths, respectively (Figure 3.28, right panel).

Dengue is a viral infection caused by the mosquito Aedes aegypti and remains a public health problem in the Americas despite countries' efforts to prevent and mitigate it. Dengue causes a severe flu-like illness and sometimes can cause a potentially lethal complication called severe dengue. Incidence of dengue in the region is heterogeneous but has overall increased in the LAC region over the past four years. In some countries, such as Guyana, Brazil and Paraguay, the increase has been ten-fold or more. Guyana has the highest incidence, with 5 572 cases per 100 000 population, followed by Brazil with 4 843 and Paraguay with 4 269 (Figure 3.29 – left panel). Lethality of the disease also varies, ranging from no reported deaths in 16 LAC countries, including Bahamas, Chile and Cuba, among others, to 3.2% of cases resulting in deaths in Suriname, which is the country with the fourth lowest incidence (Figure 3.29 – right panel). This could suggest underreporting of cases or healthcare system limitations.

Zika fever is a viral disease caused by Zika virus transmitted by the mosquito Aedes aegypti, consisting of mild fever, rash, headaches, arthralgia, myalgia, asthenia, and non-purulent conjunctivitis. Incidence of Zika is very high in Brazil with 20.4 cases per 100 000 population in 2024. Belize and Bolivia follow with 7.43 and 2.15 cases per 100 00 population. Brazil's high reported incidence may partly reflect its comparatively strong surveillance and laboratory capacity for detecting Zika infections compared to other LAC countries that may underreport cases. Several countries in the region did not report any Zika cases in 2021 (Figure 3.30).

Mosquito borne diseases disproportionally affect economically disadvantaged communities, which lack adequate prevention methods and modern sanitation and infrastructure. It is essential that countries ensure equitable access to quality prevention and control services amongst these communities to protect them from communicable diseases like malaria, chikungunya, dengue, and zika. Outbreak preparedness and control are crucial for a proper prevention and response, for which countries should develop their capacities and resources. The use of insecticide-treated nets and indoor residual spraying with insecticides are important preventive measures for at-risk populations to avoid mosquito bites, and increasing education and awareness helps ensure that communities know how to protect themselves.

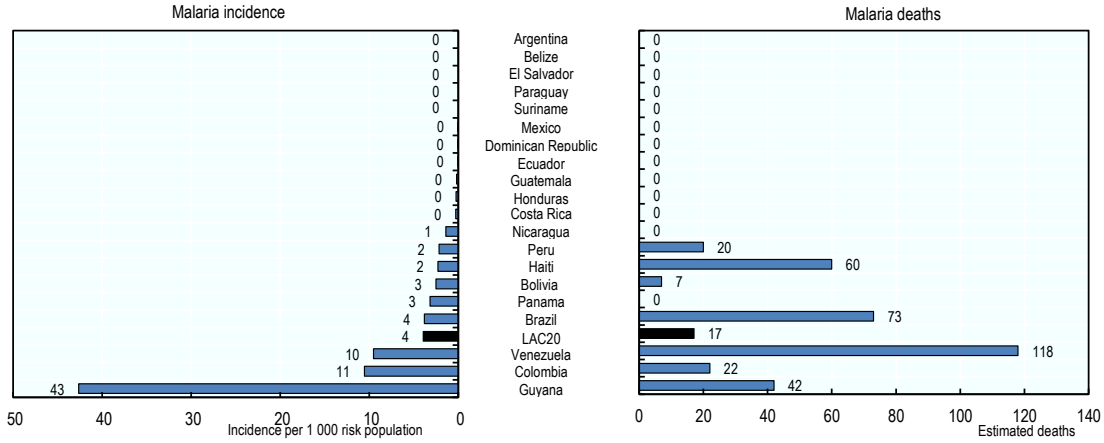
Definition and comparability

Underreporting of mosquito borne diseases cases and deaths remain a major challenge in countries with inadequate and limited access to health services and weak surveillance systems. The number of mosquito-borne diseases caused deaths were estimated by adjusting the number of reported cases for completeness of reporting, the likelihood that cases are parasite positive, and the extent of health service use. Population at risk is defined as population living in areas where malaria transmission occurs.

References

WHO (2025), *World malaria report 2025: addressing the threat of antimalarial drug resistance*, World Health Organization, https://iris.who.int/handle/10665/383951 (accessed on 8 December 2025). [1]

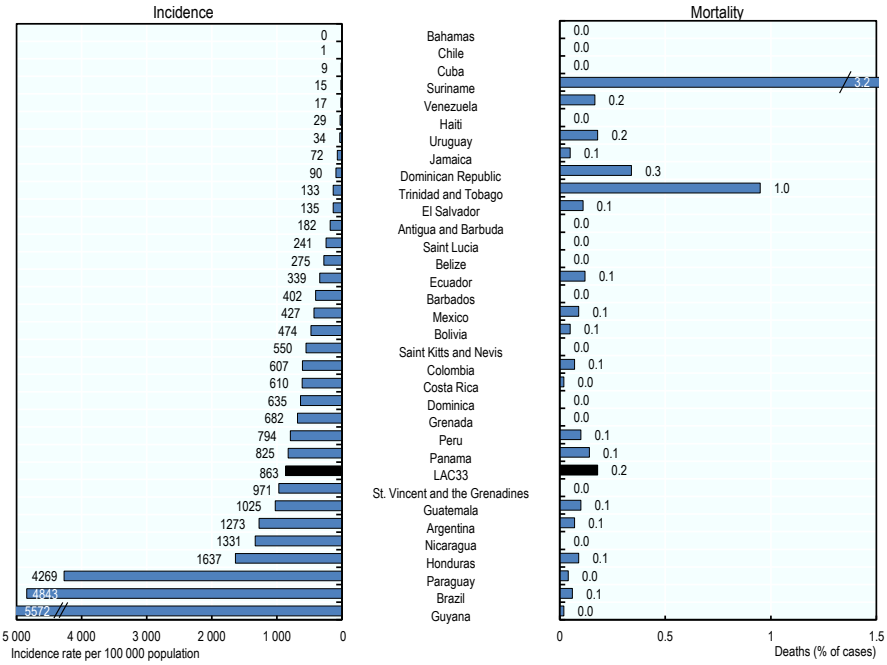
Figure 3.28. Malaria incidence and estimated deaths, 2022-2023



Source: WHO GHO 2025.

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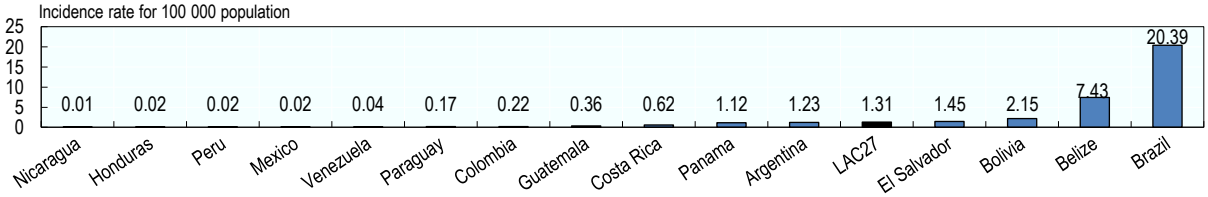
Figure 3.29. Dengue incidence and mortality, 2024 (or latest year)



Source: PAHO 2025.

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Figure 3.30. Zika incidence, 2023-2024



Note: Barbados; Chile; Ecuador, Jamaica, Uruguay, Suriname, Saint Lucia, Bahamas, Cuba, Dominican Republic, Haiti, Grenada report 0 incidence in 2024.and are omitted from the figure.
Source: PAHO 2025.

StatLink https://stat.link/dqcsfe

Diabetes

Diabetes is a chronic metabolic disease marked by high blood glucose, caused by insufficient insulin production or reduced response to insulin. People with diabetes are at a greater risk of developing cardiovascular diseases such as heart attack and stroke. They also have elevated risks for vision loss, foot and leg amputation due to damage to nerves and blood vessels, and renal failure requiring dialysis or transplantation. Globally, an estimated 589 million adults were living with diabetes in 2022, compared to 415 million in 2014 (IDF, 2025[1]). This estimate is much lower than the WHO/NCD-RisC estimate of 828 million people aged 18 years or older with diabetes in 2022 (Zhou et al., 2024[2]). However, these disparities may reflect variations in diagnostic methods and modelling approaches. Nevertheless, the global prevalence of diabetes has increased since 2014, and is projected to rise to 852.5 million by 2050 (IDF, 2025[1]). In LAC, more than 40 million adults (aged 20 years and over) live with diabetes and about half of them are undiagnosed and unaware of developing long-term complications.

Across all 33 LAC countries, the average prevalence of diabetes is 16.7% among men and 18.1% among women (Figure 3.31). The largest differences were observed in Caribbean countries such as Dominica and Barbados where women were 60.4% and 34.8% more likely to have diabetes, respectively. In contrast, in Argentina, Venezuela, Bolivia, Guatemala, Costa Rica, Uruguay diabetes was more prevalent among men, following the same trend observed in OECD countries. Evidence suggests that the Caribbean region has among the highest diabetes prevalence in LAC, reflecting both biological and social determinants of health, including higher levels of obesity and limited access to prevention services (Guariguata et al., 2018[3]).

The average diabetes prevalence percentage in LAC33 was 11% in 2024, considerably higher than the OECD prevalence of 8% (Figure 3.31). Within the LAC region, diabetes prevalence was the highest in the Dominican Republic, Mexico and Guyana, with diabetes prevalence above 16%, and the lowest in Bolivia, Ecuador and Honduras, at or below 5%. Overall, diabetes prevalence in LAC has increased by 11.74% since 2011, remaining below the 16.7% increase observed in OECD countries. The Dominican Republic has experienced the largest relative increase, at 117.28%, while prevalence in Bolivia has declined by approximately 48.5% over the 2011-2024 period.

Diabetes prevalence is highly correlated with diabetes-attributable mortality (Figure 3.32). However, countries such as Barbados and Dominica have diabetes-attributed mortality higher than 20% despite showing prevalence values lower than 14%. In contrast, the Dominican Republic has the highest prevalence of diabetes among LAC countries but attributable mortality its much lower than would be expected. This suggests that additional factors, such as modifiable risk behaviours (e.g. alcohol and tobacco use) and access to timely diagnosis, treatment, and glycaemic control may play a critical role in determining diabetes-related mortality beyond prevalence alone.

Policy efforts should address both diabetes prevalence and mortality by strengthening integrated NCD prevention and management, especially in primary care. Prevalence can be reduced through action on modifiable risk factors, including unhealthy diets, physical inactivity, tobacco and alcohol use, supported by population-level measures such as health taxes, nutrition labelling and screening for hypertension and other diabetes risks (WHO, 2024[4]). Most LAC countries have diabetes programmes in place, providing an important basis for stronger prevention and control.

Definition and comparability

Diabetes prevalence refers to the percentage of people aged 20-79 who have type 1 or type 2 diabetes. Accurate diabetes estimates at the national and global levels rely heavily on the quality and availability of data sources. Diabetes -attributable mortality rates were calculated by combining information on the number of annual deaths from all-causes stratified by age and sex, age- and sex-specific mortality relative risks separately for people with diabetes compared to those without diabetes. Relative risks attributable to diabetes are derived from cohort studies. Prevalence of diabetes and diabetes-attributable mortality were based on data from the Diabetes Atlas 2025 (IDF, 2025[1]).

References

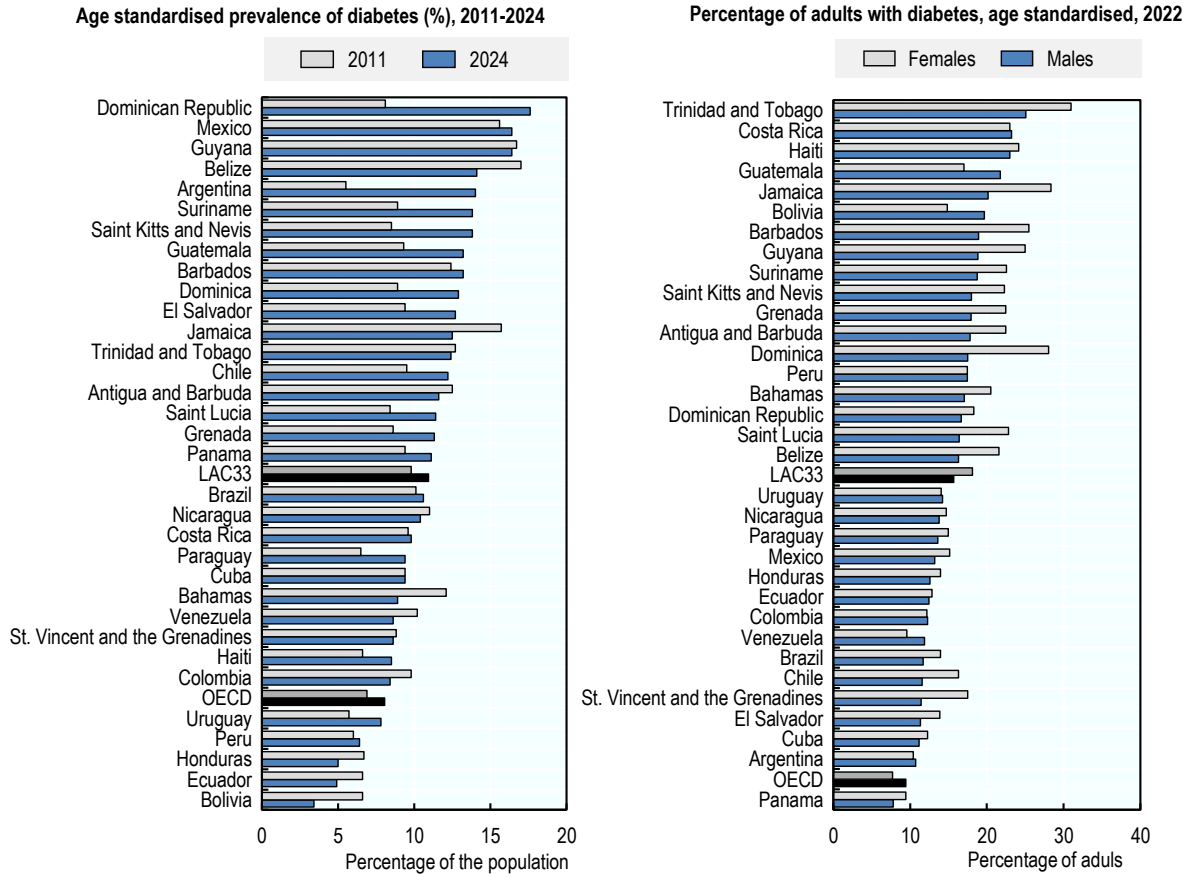
Guariguata, L. et al. (2018), “An updated systematic review and meta-analysis on the social determinants of diabetes and related risk factors in the Caribbean”, *Revista Panamericana de Salud Pública*, Vol. 42, pp. 1-11, https://doi.org/10.26633/rpsp.2018.171. [3]

IDF (2025), *Diabetes Atlas*, International Diabetes Federation, https://diabetesatlas.org. [1]

WHO (2024), *Guidance on global monitoring for diabetes prevention and control: framework, indicators and application*, World Health Organization, https://iris.who.int/handle/10665/379529. [4]

Zhou, B. et al. (2024), “Worldwide trends in diabetes prevalence and treatment from 1990 to 2022: a pooled analysis of 1108 population-representative studies with 141 million participants”, *The Lancet*, Vol. 404/10467, pp. 2077-2093, https://doi.org/10.1016/s0140-6736(24)02317-1. [2]

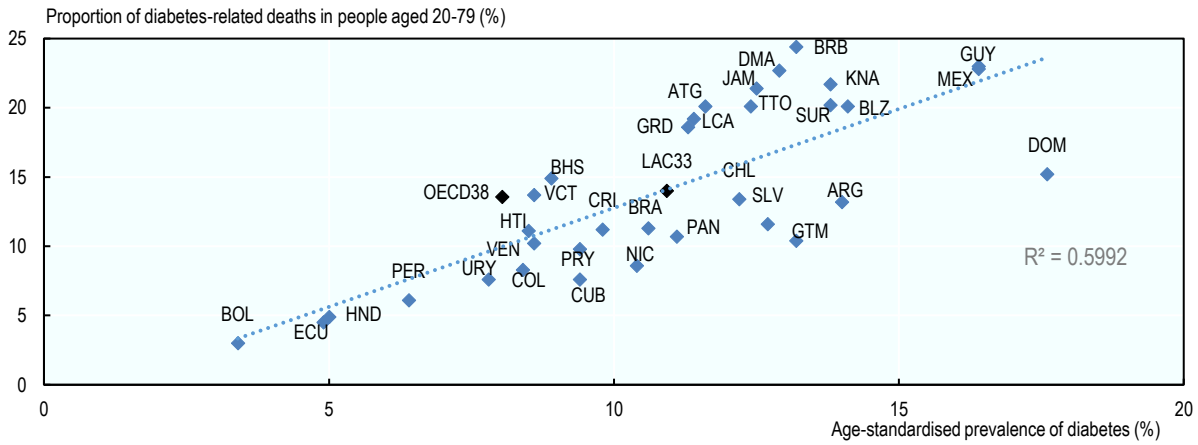
Figure 3.31. Prevalence of diabetes 2011 and 2024, and percentage of adults with diabetes 2022



Source: Left Panel: International Diabetes Federation, Diabetes Atlas, 2025. Right Panel: WHO GHO 2025.

StatLink https://stat.link/3stkio

Figure 3.32. Diabetes-attributable mortality, 2024



Source: International Diabetes Federation, Diabetes Atlas, 2025.

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4 Determinants of health

Family planning

Family planning is a core component of sexual and reproductive health and rights and an essential part of universal health coverage. Enabling women and couples to decide freely and responsibly whether and when to have children improves health, autonomy and broader social development, while access to effective contraception helps prevent unintended pregnancies and avoidable maternal deaths. Reflecting this importance, SDG target 3.7 calls for universal access to sexual and reproductive healthcare services, including family planning, information and education, and the broader evidence base continues to show that contraception is closely linked to better health and well-being outcomes for women and families (Starrs et al., 2018[1]).

Contraceptive use remains highly uneven across LAC, with a more than twofold gap between the countries at the top and bottom of the distribution (Figure 4.1). Nicaragua (79.3%), Brazil (78.1%) and Colombia (77.2%) report the highest prevalence, while Guyana (37.9%), Haiti (36.9%) and Trinidad and Tobago (36.5%) record the lowest levels. The LAC33 average stands at 62.1%, and most countries cluster between around 55% and 73%, suggesting that contraceptive use is widespread in much of the region but remains substantially lower in a smaller group of countries. This pattern is consistent with wider regional evidence showing that, despite important progress, inequalities in contraceptive coverage persist across and within countries (Ponce de Leon et al., 2019[2]).

Coverage of family planning with modern methods is high in much of the region, but important shortfalls persist (Figure 4.2). On average, 77.8% of women in need of contraception across LAC33 have their need satisfied with modern methods, with the highest levels in Nicaragua (90.0%), Uruguay (89.8%), Brazil (89.7%) and Colombia (87.3%). By contrast, Haiti (51.1%), Guyana (56.8%) and Trinidad and Tobago (57.1%) remain well below the regional average, and Bolivia also records a comparatively low value (60.9%). This indicator is particularly policy-relevant because it captures whether women who want to avoid pregnancy are actually protected by a modern method.

Adolescent birth rate remains a major challenge in several LAC countries, particularly among girls aged 15-19 years, and births among very young adolescents have not been eliminated (Figure 4.3). The birth rate among 15-19 year-olds reaches 71.3 per 1 000 in Nicaragua, 57.6 in Guatemala, 52.1 in Belize and 51.9 in Panama, compared with an LAC18 average of 38.6. Among girls aged 10-14, the regional average is 1.4 per 1 000, but rates are markedly higher in Nicaragua (4.69), Ecuador (2.45), Colombia (2.10), Guatemala (2.03) and Panama (2.03). By contrast, Chile records much lower rates in both age groups. WHO treats births among girls aged 10-14 and 15-19 as distinct indicators, and the broader literature shows that adolescent pregnancy is associated with higher risks for both mothers and newborns, especially at younger ages (Nove et al., 2014[3]).

The coexistence of lower contraceptive coverage and high adolescent fertility in other settings indicates that financial, geographic, informational and social barriers continue to limit reproductive autonomy, especially for adolescents and women in more disadvantaged circumstances. Recent evidence shows that inequalities in contraceptive coverage persist and that lower gender inequality is associated with better coverage of demand satisfied with modern methods; the literature also continues to link access to contraception with gains in maternal health and women's well-being (Moreira et al., 2023[4]).

Definition and comparability

Contraceptive prevalence measures the percentage of women of reproductive age (15-49 years) who are currently using a contraceptive modern method. Modern methods of contraception include combined oral contraceptives ("the pill"), progestogen-only pills ("the minipill"), implants, injectables, patches, vaginal ring, intrauterine device (copper and levonorgestrel), male and female condoms, vasectomy, tubal ligation, lactational amenorrhea method, emergency contraception pills, standard days method, basal body temperature method, two-day method, and symptom-thermal method. The share of women whose need for family planning is satisfied with modern methods measures the percentage of women of reproductive age (15-49 years) who want to avoid or postpone pregnancy and whose need for contraception is being met using a modern method. It therefore goes beyond contraceptive prevalence alone by capturing the extent to which women who need family planning are effectively covered by modern contraception.

The adolescent birth rate is defined as the annual number of live births to girls aged 10-14 or 15-19 per 1 000 girls in the respective age group. It is an age-specific fertility indicator that provides a measure of adolescent childbearing and is also an indirect marker of adolescents' access to sexual and reproductive health services, information and contraception.

References

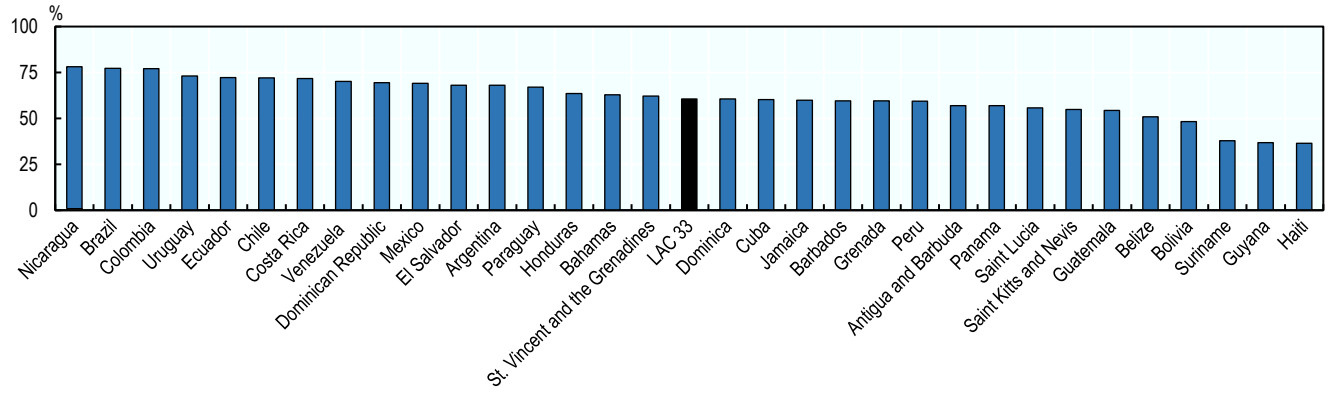
Moreira, L. et al. (2023), "The role of gender inequality and health expenditure on the coverage of demand for family planning satisfied by modern contraceptives: a multilevel analysis of cross-sectional studies in 14 LAC countries", *The Lancet Regional Health - Americas*, Vol. 19, p. 100435, https://doi.org/10.1016/j.lana.2023.100435. [4]

Nove, A. et al. (2014), "Maternal mortality in adolescents compared with women of other ages: evidence from 144 countries", *The Lancet Global Health*, Vol. 2/3, pp. e155-e164, https://doi.org/10.1016/s2214-109x(13)70179-7. [3]

Ponce de Leon, R. et al. (2019), "Contraceptive use in Latin America and the Caribbean with a focus on long-acting reversible contraceptives: prevalence and inequalities in 23 countries", *The Lancet Global Health*, Vol. 7/2, pp. e227-e235, https://doi.org/10.1016/s2214-109x(18)30481-9. [2]

Starrs, A. et al. (2018), "Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher– Lancet Commission", *The Lancet*, Vol. 391/10140, pp. 2642-2692, https://doi.org/10.1016/s0140-6736(18)30293-9. [1]

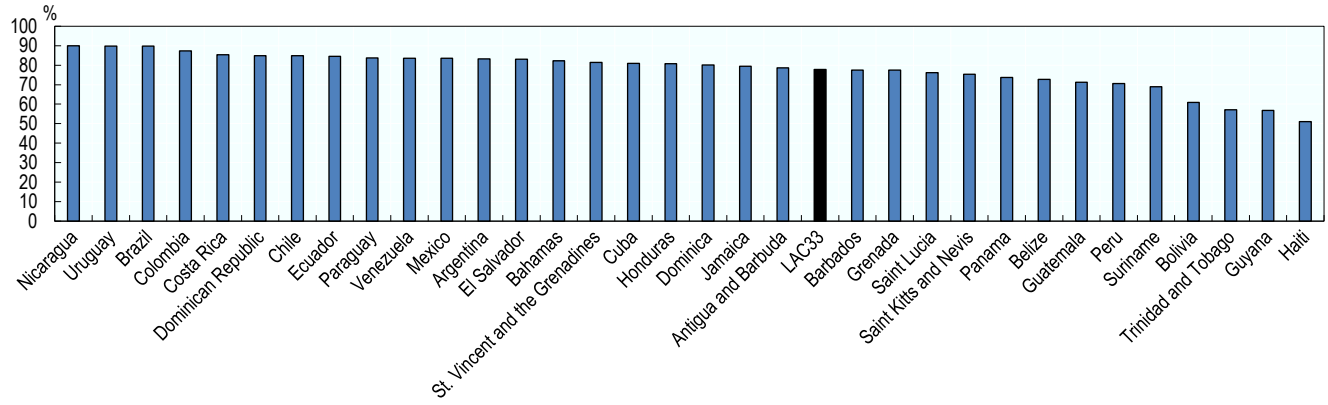
Figure 4.1. Contraceptive prevalence – any modern method (among women aged 15-49 years), 2025



Source: UNPD Family Planning Indicators 2025.

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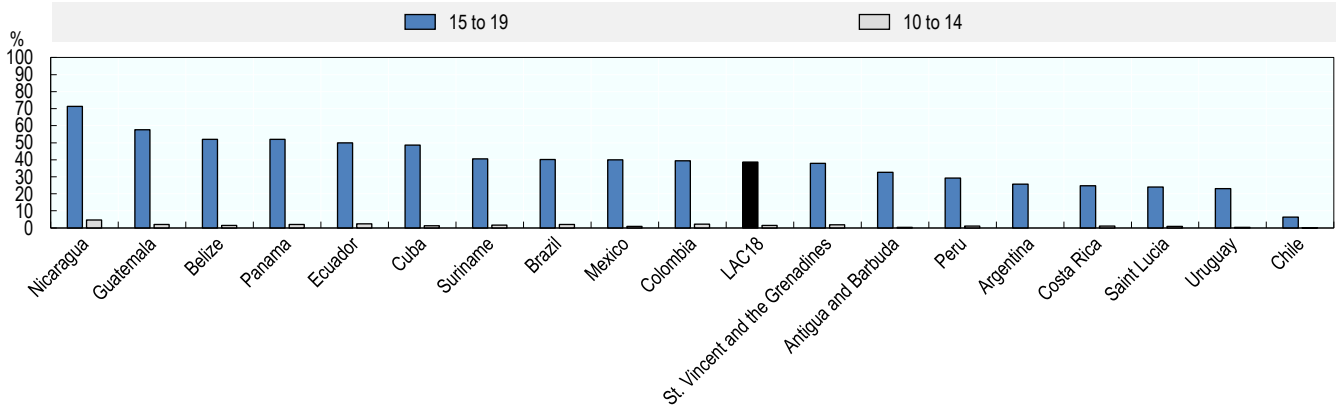
Figure 4.2. Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods



Source: UNPD Family Planning Indicators 2025.

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Figure 4.3. Adolescent birth rate per 1000 women, 2023 or latest year



Source: WHO Global Health Observatory 2025.

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Child malnutrition

A key component of human capital is healthy and well-nourished people throughout their lives, but many children cannot access sufficient, safe nutritious food and a balanced diet that meets their needs for optimal growth and development, to enable an active and healthy life. Globally, it is estimated that 150.2 million children are stunted, 42.8 million are wasted, and 35.5 million are overweight (The Global Health Observatory, 2024[1]). Hence, many countries are facing a double burden of malnutrition – characterised by the coexistence of undernutrition along with overweight, obesity or diet related NCDs – a health challenge on the rise in many LAC countries. Child malnutrition also contributes to poorer cognitive and educational outcomes in later childhood and adolescence, which in turn affect lifelong potential and heavily determines the socio-economic status of the individual.

The UN SDG target 2.2 aims to end all forms of malnutrition by 2030, including achieving, by 2025, the internationally agreed targets on stunting and wasting among children under five years of age, and includes an indicator on childhood overweight. Subsequently, in March 2025, the United Nations General Assembly adopted a resolution to extend the UN Decade of Action on Nutrition from its original period of 2016-2025 to 2030, in recognition that the world is off track to end hunger and malnutrition by the original target date (United Nations, 2025[2]). This initiative aims to eradicate hunger, and malnutrition in all its forms (undernutrition, micronutrient deficiencies, overweight, or obesity) and reduce the burden of diet-related NCDs in all age groups.

Stunting rates in LAC are generally lower than in other world regions but it is still a significant problem in several countries. In average, 11.2% of children below five years of age are stunted in LAC27 (Figure 4.4). The rate is nearly 45% in Guatemala, 22% in Haiti and around 18% in Ecuador and Honduras, while is lowest in Chile and Saint Lucia below 3%. Wasting rates are also lower than in other regions with an average of 2.7% amongst children below five years of age, but Barbados, Guyana and Trinidad and Tobago have significantly higher rates than average being over 6%. The lowest rates are observed in Chile, Peru, Ecuador and Guatemala all below 1%.

Countries with higher stunting prevalence tend to have higher than average under-5 mortality, reflecting the fact that about half of all deaths before the age of 5 can be attributed to malnutrition (Figure 4.5). Guatemala deviates significantly from the trend by having a stunting rate almost four times the LAC average and an under-5 mortality rate 4 points over the LAC average. This is mainly due to the high poverty rate and large inequality in the country, which causes that half the population cannot afford the cost of the basic food basket. This adds to the effects of natural disasters and climate change that damages food production and contribute to food insecurity and malnutrition by reducing agricultural productivity and disrupting food systems (WFP, 2024[3]).

Childhood overweight and obesity is shaping up to be one of the most significant challenges of the century. In LAC27, the average prevalence of overweight amongst children under age 5 is above 8% (Figure 4.6). The highest rates are observed in Argentina and Paraguay having 12% or more, followed by Barbados, Trinidad and Tobago, Panama, Uruguay, and Cuba, where more than one child out of ten is overweight. In turn, rates are lower than 5% in Haiti and Suriname.

Definition and comparability

The WHO definition of children overweight is weight for height greater than 2 standard deviations above WHO child growth standard median. The WHO definition of children obesity is weight for height greater than 3 standard deviations above the WHO child growth standard median.

Stunting (low height for age) reflects failure to reach linear growth potential because of long-term suboptimal health and/or nutritional conditions.

Wasting usually indicates recent and severe weight loss, often due to insufficient food intake and/or the presence of acute infectious disease, such as diarrhoea, which lead to loss of body weight.

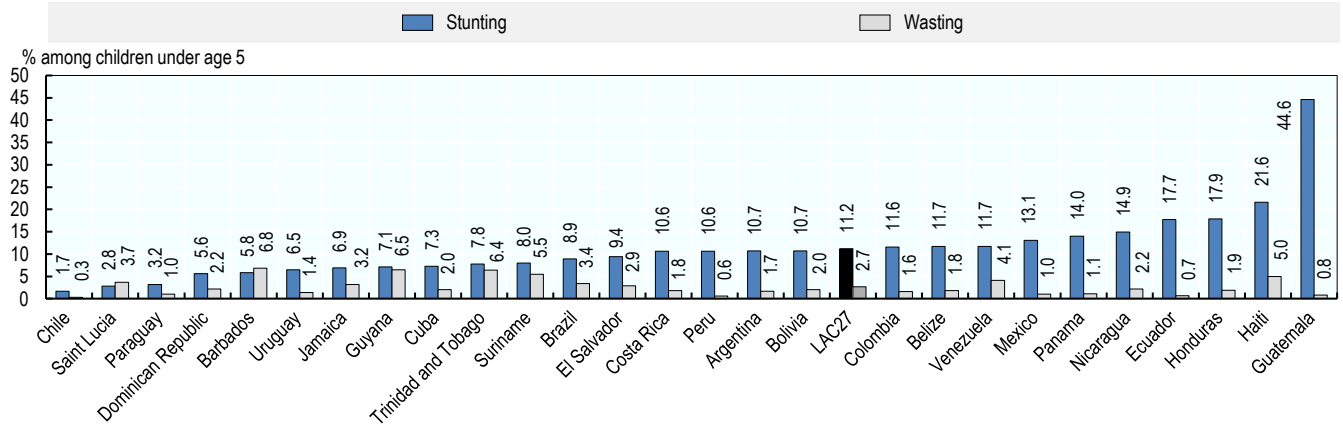
References

The Global Health Observatory (2024), *Joint child malnutrition estimates*. [1]

United Nations (2025), *Implementation of the United Nations Decade of Action on Nutrition (2016–2025)*. [2]

WFP (2024), *Climate Change Policy Update*, World Food Programme. [3]

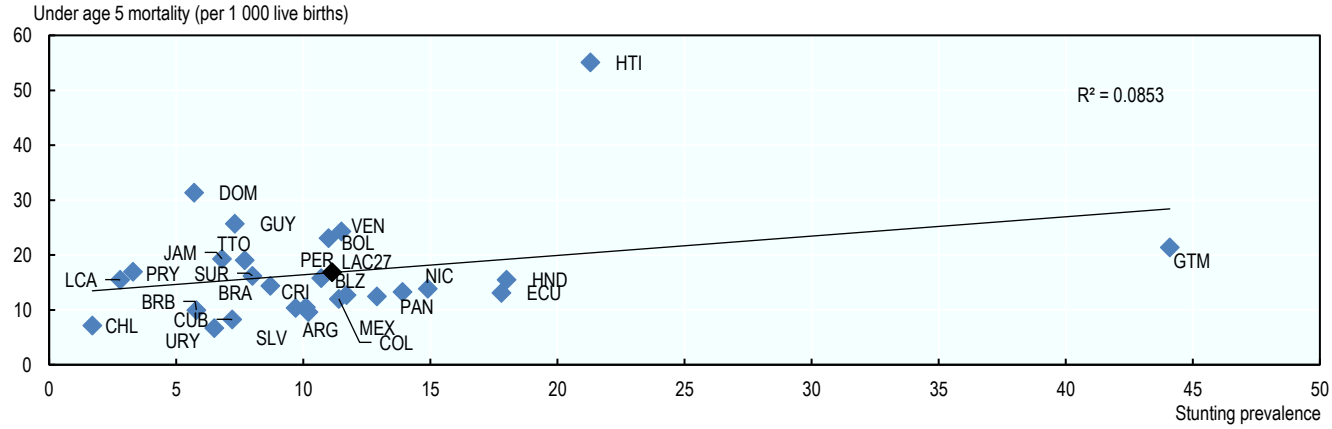
Figure 4.4. Prevalence of stunting and wasting amongst children under age 5, 2020 or latest year available



Source: WHO Global Health Observatory 2025.

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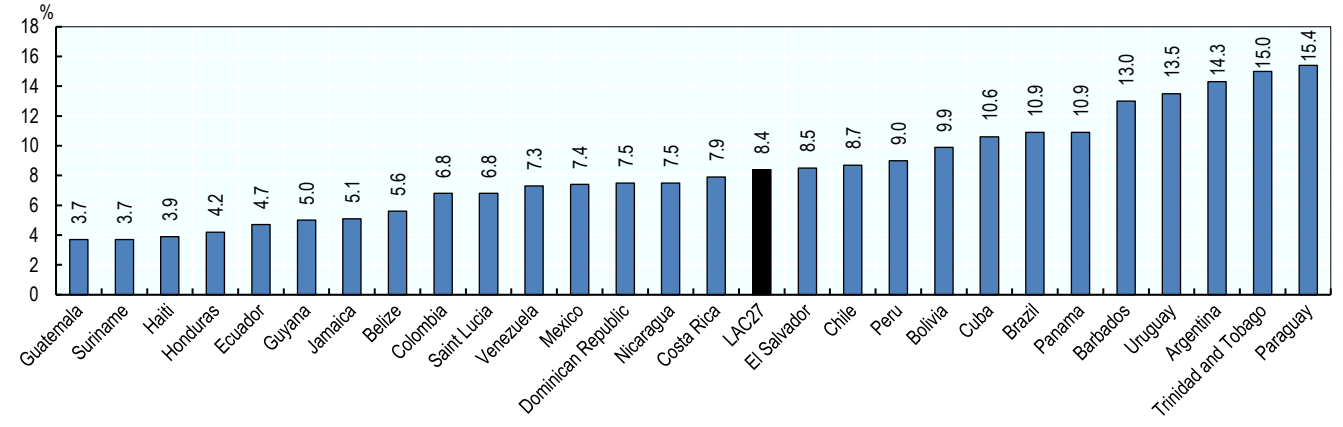
Figure 4.5. Under age 5 mortality and stunting prevalence, 2023 or latest year available



Source: WHO Global Health Observatory 2025, World Bank 2026.

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Figure 4.6. Prevalence of overweight amongst children under age 5, 2024 or latest available year



Source: WHO Global Health Observatory 2025.

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Adolescent health

Adolescence is a fundamental transitional phase in human development as it represents a change from childhood to physical, psychological, and social maturity. During this period, adolescents learn and develop knowledge and skills to deal with critical aspects of their health and development while their bodies mature. It is also a time when behavioural factors that may pose risks to future health become consolidated. Obesogenic environments, sociocultural influences and overexposure to harmful digital media have contributed to rising rates of overweight and obesity in LAC countries (UNICEF, 2025[1]). At the same time, although alcohol use is more prevalent among adults, adolescents may engage in riskier patterns such as binge drinking, sometimes higher rates than adults (Esposito et al., 2025[2]). Adolescent girls, especially early adolescents, are particularly vulnerable because they are particularly vulnerable to the consequences of pregnancy and delivery, as their bodies may not be physically prepared (UNICEF, 2024[3]).

Risk factors for NCDs, the leading cause of premature adult deaths, are often acquired in adolescence. Overweight and obesity are one these key risk factors. In LAC, obesity prevalence among adolescence is 15.1% for females, and 15.8% for males, both well above the OECD averages of 8.2% and 11.2%, respectively, in 2022 (Figure 4.7). Countries such as Bahamas, Antigua and Barbuda and Barbados exhibit obesity prevalence rates above 22% among females, while for males the highest rates, also above 22%, are observed in Chile, Trinidad and Tobago and Saint Kitts and Nevis. Guatemala is the only country in LAC where both male and female adolescent obesity prevalence rates are lower than the corresponding OECD averages. Interestingly, in Haiti, the prevalence of obesity is more than eight times higher in males (17.76%) than in females (2.11%).

In addition, alcohol and tobacco use are other important issues affecting adolescents in the region. Data for current tobacco smoking is from 2024, while the latest available data on heavy episodic drinking latest available data are from 2019 (Figure 4.8). The LAC average prevalence of current tobacco smoking is 9.8% in 2024 and the prevalence for binge drinking reaches 18% in 2019, both below the corresponding OECD averages for the same years (12.2% and 30.9%, respectively). Argentina, Mexico and Guatemala show the highest prevalence rates of current tobacco smoking (above 15%) among adolescents aged 13 to 15. For binge drinking, Peru, Chile and Argentina have the highest rates, all above 28%, with Peru being the only country above the OECD average, at 33.8%.

Another key issue for adolescents worldwide is the high prevalence of pregnancies during adolescence. LAC was the region with the second highest adolescence birth rates in 2022, with particularly high rates among girls with lower levels of educational attainment. In 18 LAC countries, the average adolescent birth rate is 38 births per 1 000 adolescent women aged 15 to 19, which is almost five times the rate observed in OECD countries, that stand in 8 births per 1 000 (Figure 4.9). Notably, all LAC countries except Chile, are situated above the OECD average. The highest adolescent birth rate is found in Nicaragua with 71 births per 1 000 adolescent women, followed by Guatemala with 58 births. In contrast, Chile with 6 births, followed well behind by Argentina, Uruguay and Costa Rica with 23, have the lowest adolescent birth rates in the region.

Definition and comparability

The most frequently used measure of underweight, overweight and obesity is the Body Mass Index (BMI). This is a single number that evaluates an individual's weight in relation to height and is defined as weight in kilograms divided by the square of height in metres. The WHO definition of children aged between 5-19 years obesity is BMI-for-age greater than 2 standard deviations above the WHO Growth Reference median.

Current tobacco smoking is expressed as the percentage of the youth population aged 13-15 who are current users of any tobacco product per 100 individuals in that age group. Data is obtained from the Global Youth Tobacco Survey. Heavy episodic alcohol drinking among adolescents is defined as the proportion of youth (15 -19 years) who have had at least 60 grammes or more of pure alcohol on at least one occasion in the past 30 days. A consumption of 60 grammes of pure alcohol corresponds approximately to 6 standard alcoholic drinks.

Adolescent birth rate is defined as the annual number of births to women aged 15-19 years per 1 000 women in that age group. It is also referred to as the age specific fertility rate for women aged 15-19 years.

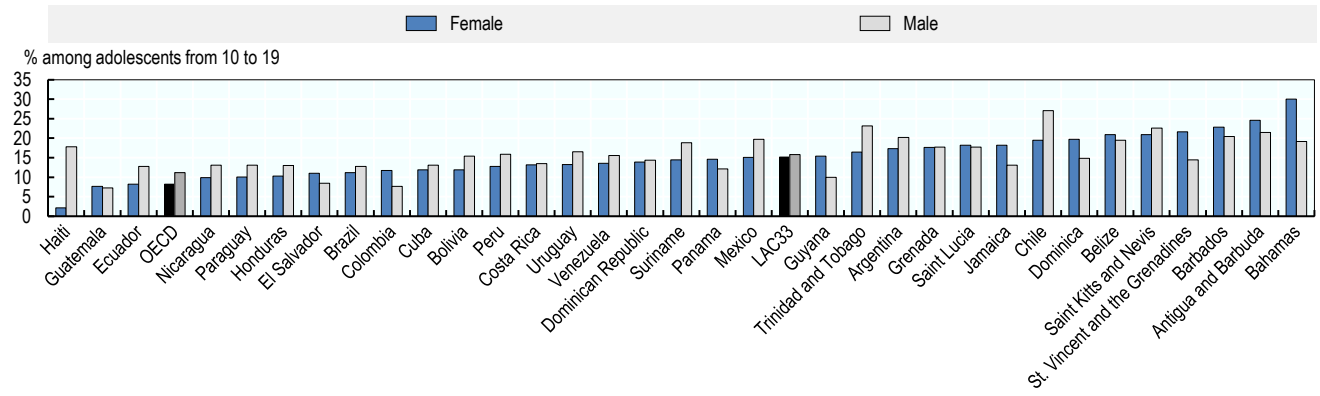
References

Esposito, S. et al. (2025), "Too young to pour: the global crisis of underage alcohol use", *Frontiers in Public Health*, Vol. 13, https://doi.org/10.3389/fpubh.2025.1598175. [2]

UNICEF (2025), *Protecting adolescent nutrition and mental health in Latin America and the Caribbean: Addressing obesogenic and sociocultural influences.*, https://www.unicef.org/lac/media/52926/file/Policy_Brief_Mental_Health_and_Nutrition.pdf.pdf (accessed on 12 February 2026). [1]

UNICEF (2024), *Early childbearing*, https://data.unicef.org/topic/child-health/early-childbearing/ (accessed on 12 February 2026). [3]

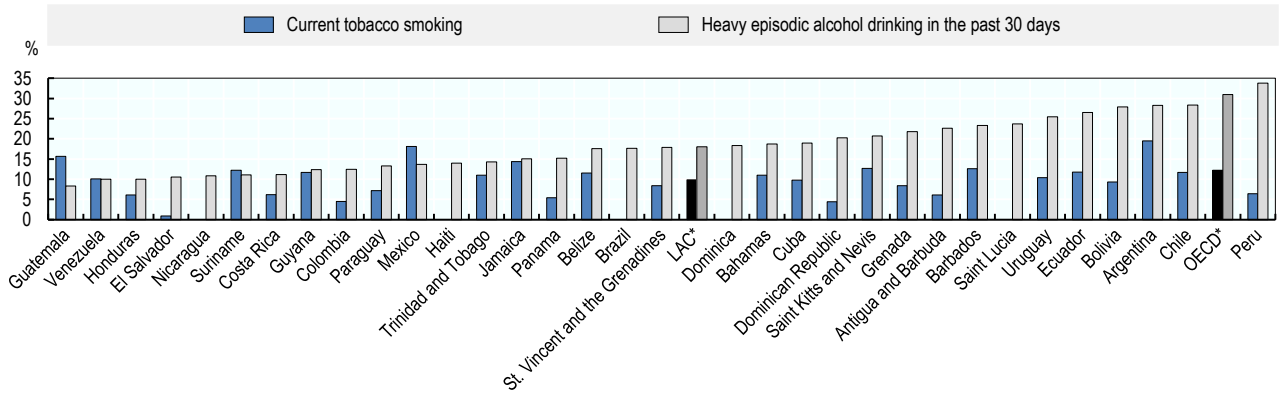
Figure 4.7. Prevalence of obesity among adolescents by sex, 2022



Source: WHO Global Health Observatory 2025.

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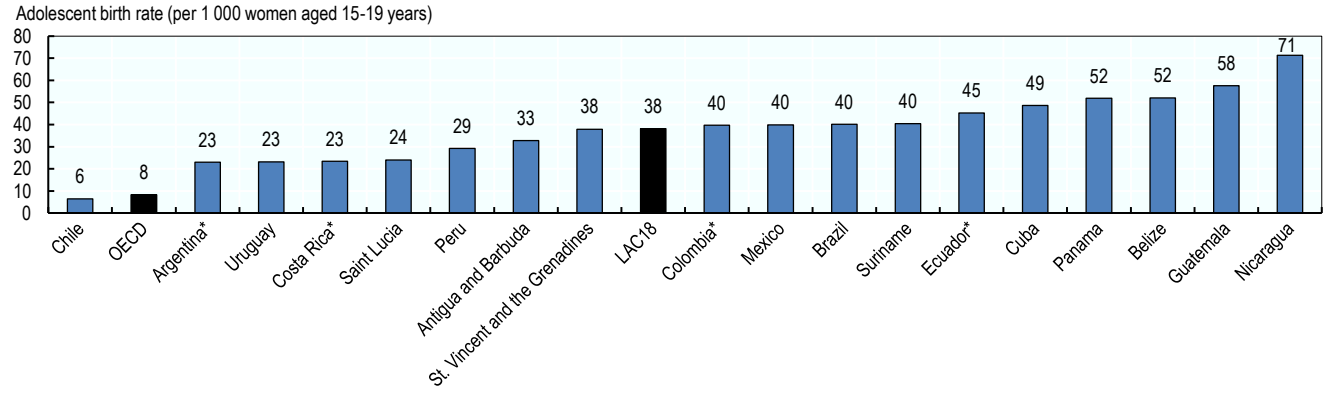
Figure 4.8. Prevalence of current tobacco smoking, 2024, and heavy episodic alcohol drinking in the past 30 days, 2019, among adolescents



Note: *LAC27, OECD16 and adolescents aged 13-15 for tobacco smoking and LAC33, OECD38 and adolescents aged 15-19 for alcohol drinking.
Source: WHO Global Health Observatory 2025.

StatLink https://stat.link/gvn3o1

Figure 4.9. Adolescent birth rate, 2023 (or latest year)



Note: * data coming from health questionnaires.
Source: WHO Global Health Observatory 2025.

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Overweight and obese adults

Overweight and obesity are major public health concerns as the global epidemic has far-reaching consequences for individuals, society, and the economy. Obesity is an established risk factor for numerous health conditions, including hypertension, high cholesterol, diabetes, cardiovascular disease, respiratory problems, skeletal diseases, and some forms of cancer, and mortality also increases progressively once the overweight threshold is crossed. Therefore, obesity and overweight reduce life expectancy, increase healthcare costs, decrease workers' productivity, and lower countries' GDP (OECD, 2019[1]).

In LAC, obesity prevalence among adults is 38.5% for females, and 24.28% for males, both well above the OECD averages of 25.3% and 6.24%, respectively in 2022 (Figure 4.10). Caribbean countries, including Bahamas, Saint Kitts and Nevis and Belize, are the LAC countries with the highest prevalence of female obesity, where more than 50% of adult women are obese (more than 1 out of 2 adult females are obese). Among men, the highest prevalence rates in males are also observed in Bahamas, Saint Kitts and Nevis and Argentina, with 39.2%, 37.4% and 34.8%, respectively. In contrast, Haiti is the only country in the region with obesity prevalence below the OECD average for both genders.

Obesity prevalence has increased from 2012 to 2022 in the LAC region, by 6.1 percentage points (p.p.) among males and 8.2 p.p. among females, much higher than the corresponding OECD increases of 3.9 and 2.8 p.p., respectively (Figure 4.11). Venezuela is the only LAC country below the OECD percentage point change for both females and males, and the only one with a decline over the decade, although this decrease is observed only for men. Some of the countries with the highest obesity prevalence in 2022, such as Saint Kitts and Nevis and Belize (see Figure 4.10.) are not among those with the highest changes in growth. This suggests that obesity may have plateaued at very high levels in several Caribbean countries where prevalence was already above 40% in 2012. In contrast, some countries experiencing the highest obesity growth, including Brazil, Argentina and Peru, are not among those with the highest obesity prevalence in 2022. However, their rapid growth trends indicate that they could reach similar obesity prevalences as Caribbean countries if effective policies are not implemented.

Overweight prevalence has also increased from 2012 to 2022 in the LAC region, rising by 8.1 p.p. among women and by 6.6 p.p. among men, both above the OECD increases of 2.6 and 3.1 p.p., respectively (Figure 4.12). In Ecuador, Bolivia and Guatemala, the overweight prevalence increase over the decade was more than 34% higher in men than in women.

In 2022, countries approved the WHO Acceleration Plan to Stop Obesity, that aims to halt globally rising obesity rates (WHO, 2023[2]). In the LAC region, nine countries are pioneering this initiative including Argentina, Barbados, Brazil, Chile, Mexico, Panama, Peru, Trinidad and Tobago and Uruguay. The Acceleration Plan recommends the application of front-of-package warning labels, restrictions on the marketing of unhealthy food products, regulation of foods offered in schools and the adoption of fiscal policies that promote healthy diets. This is complemented with surveillance policies such as Peru's "multi-layered nutritional surveillance system (SIEN)". However, the heterogeneity in obesity prevalence across the LAC region and the different country-specific contexts suggests that tailored policies are needed to achieve progress throughout the region (PAHO, 2025[3]). For countries experiencing very rapid growth in obesity over the last decade, there is a critical window for public health action, as evidence shows that without timely interventions, the burden of obesity is likely to continue rising as has occurred in other countries.

Definition and comparability

See indicator "Adolescents Health" in Chapter 4 for definition of Body Mass Index (BMI). Based on the WHO classification, adults with a BMI of 25 or over are overweight. Adults who have BMI between 20 and 30 are considered to have pre-obesity. A BMI of 30 or over is defined as obesity.

In many countries, self-reported estimates of height and weight are collected through population-based health surveys while other countries take measurements amongst the population. These differences limit data comparability. BMI estimates from health examinations are more reliable and generally result in higher values than those from self-reported surveys.

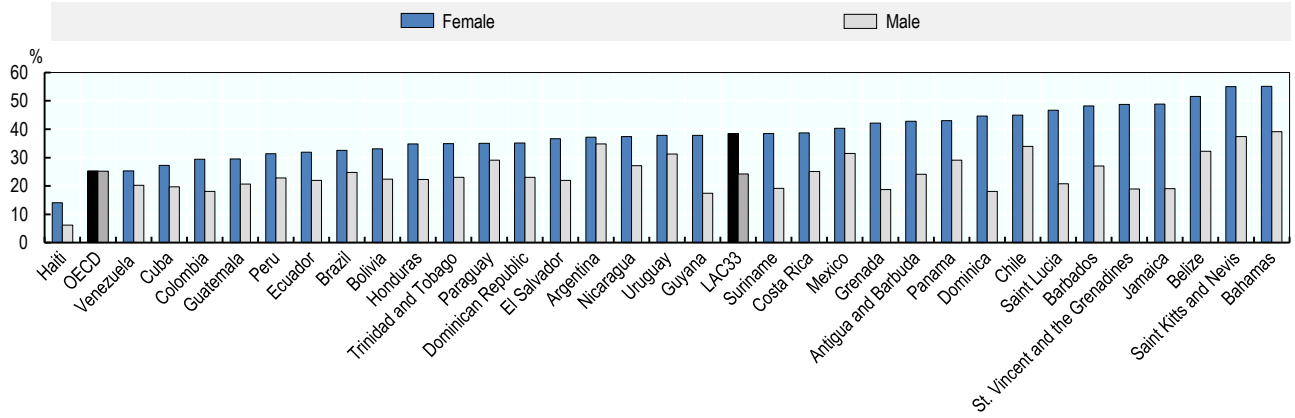
References

OECD (2019), *The Heavy Burden of Obesity: The Economics of Prevention*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/67450d67-en. [1]

PAHO (2025), *Nine Latin American and Caribbean countries intensify efforts to curb obesity with PAHO support*, https://www.paho.org/en/news/4-3-2025-nine-latin-american-and-caribbean-countries-intensify-efforts-curb-obesity-paho-0 (accessed on 13 February 2026). [3]

WHO (2023), *WHO acceleration plan to stop obesity*, World Health Organization, https://iris.who.int/handle/10665/370281. [2]

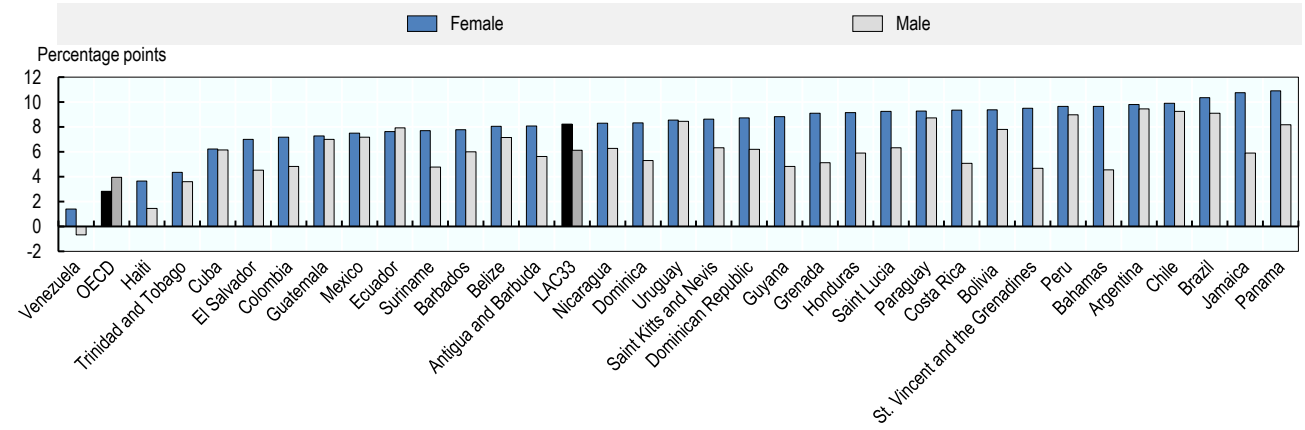
Figure 4.10. Prevalence of obesity among adults by sex, 2022 (crude estimates)



Source: WHO Global Health Observatory 2025.

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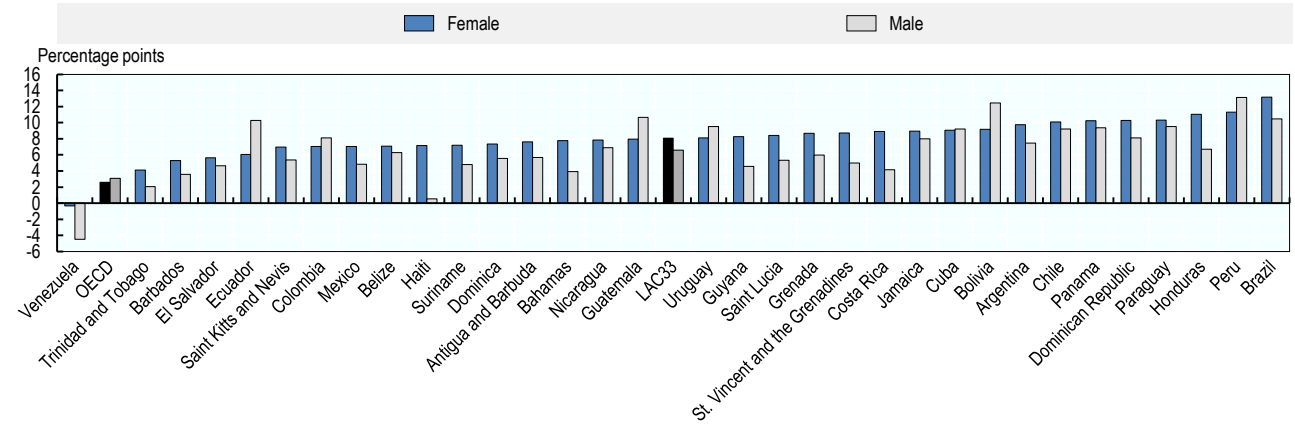
Figure 4.11. Obesity among adults, p.p. change 2012-2022, by sex (crude estimates)



Source: WHO Global Health Observatory 2025.

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Figure 4.12. Overweight among adults, p.p. change 2012-2022, by sex (crude estimates)



Source: WHO Global Health Observatory 2025.

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Diet and nutrition

A healthy and nutrient-balanced diet is essential to promoting health and well-being, supporting active lifestyles, preventing malnutrition and reducing the risk of non-communicable diseases (NCDs), such as CVD, diabetes and certain types of cancer. The principles of a healthy diet are adequacy, by providing enough essential nutrients; balance, by ensuring appropriate energy intake and limiting foods or beverages high in sugar, saturated and trans-fats; moderation, by reducing the consumption of foods with detrimental health effects; and diversity, by including a variety of vegetables, fruits, legumes, nuts and whole grains daily (WHO/FAO, 2024[1]). The LAC region faces the world's highest cost of a healthy diet while tackling the double burden of malnutrition, which contributes to an annual GDP loss of up to 16% (WFP, 2025[2]).

In 13 LAC countries, 19.9% of the population consumed more than one packaged ultra-processed salty snack in the previous day or night in 2023 (Figure 4.13). Differences exist between urban and rural areas, with urban areas reporting higher consumption of these food items (20.3%) compared to rural areas (18.3%). This pattern is observed in all 13 LAC countries except Ecuador, Nicaragua and Chile, where consumption in rural areas is 5, 3 and 1 p.p. higher than in urban areas, respectively. Regarding total population prevalence, Honduras, Guatemala and Costa Rica report the highest levels of salty snacks consumption, with 27%, 35.1% and 38.9% of people reporting eating these food items. In contrast, Peru, Brazil and Paraguay are the countries with the lowest consumption, all below 12%.

In addition, the WHO recommends that adults eat at least 400 grammes – or five or more portions – of fruit and vegetables per day. Across 13 LAC countries, 9.2% of the total population reports consuming no vegetables or fruits in the previous 24 hours (Figure 4.14). On average, this share is lower in urban areas at 8.2% than in rural areas at 10.4%, except in Bolivia, Chile, Mexico, Paraguay and the Dominican Republic. The largest urban-rural gaps are found in Honduras, Nicaragua and Ecuador, where zero consumption in rural areas exceeds urban levels by with 8.2, 7.7 and 5.2 p.p., respectively. This could be explained by the fact that rural residents often have less access to affordable healthy food and food diversity than urban area residents, combined with fewer years of education and lower income levels (Gonçalves et al., 2023[3]).

Excessive fast-food consumption is associated with higher levels of visceral adipose tissue, liver fat and odds of having metabolic-associated fatty liver disease (Odegaard et al., 2022[4]). In 2023, 5.6% of the population in 13 LAC countries report having consumed fast food during the previous day, or night is 5.6% in 2023 (Figure 4.15). Fast-food consumption is higher in urban (6.7%) than in rural areas (3.2%) across all analysed countries. The largest differences are observed in Chile, Costa Rica and Paraguay, where gaps exceed 5 p.p. between urban and rural populations.

The region's nutritional transition has been driven by rapid economic development in many LAC countries over the past decades, which has brought major lifestyle changes with direct implications for people's health. Diets have shifted toward more Westernised diets and increased access to ultra-processed products. At the same time, unplanned rural-to-urban migration and increased physical inactivity have resulted in increasing overweight and obesity along with persistent high rates of stunting and micronutrient deficiencies, a phenomenon described as the double burden of malnutrition (WFP, 2025[2]). Across the region in 2020, 131 million people could not afford a healthy diet, disproportionately affecting those living in the most vulnerable situations and low socio-economic status and limiting their access to more nutritious foods due to higher prices (FAO et al., 2023[5]).

Definition and comparability

Data on food consumption are collected using the Diet Quality Questionnaire (DQQ), a standardised, low-burden tool designed to measure dietary adequacy and diet-related NCD risk at the population level. Dietary adequacy includes both nutrient and food groups adequacy recommended in food-based dietary guidelines. The DQQ collects data about the consumption of 29 food groups, from 1 000 informants, and it has been implemented in over 100 nationally representative surveys (Global Diet Quality Project, 2024[6]).

All indicators refer to consumption during the previous day or night. Packaged ultra-processed salty snacks is defined as the proportion of the population who consumed salty packaged snacks (including crisps, chips and puffs); zero vegetable or fruit consumption is defined as the proportion of the population who consumed no vegetables or fruits; and fast-food consumption is defined as the proportion of the population who consumed fast food. The DQQ was built on the MDD-W questionnaire, aligned with the measurement guide published by FAO.

References

FAO et al. (2023), *Regional Overview of Food Security and Nutrition – Latin America and the Caribbean 2022*, FAO; IFAD; UNICEF; PAHO; WFP, https://doi.org/10.4060/cc3859en. [5]

Global Diet Quality Project (2024), *DQQ Results Dataset 2021-2024*, https://doi.org/doi:10.7910/DVN/KY3W8A (accessed on 10 March 2026). [6]

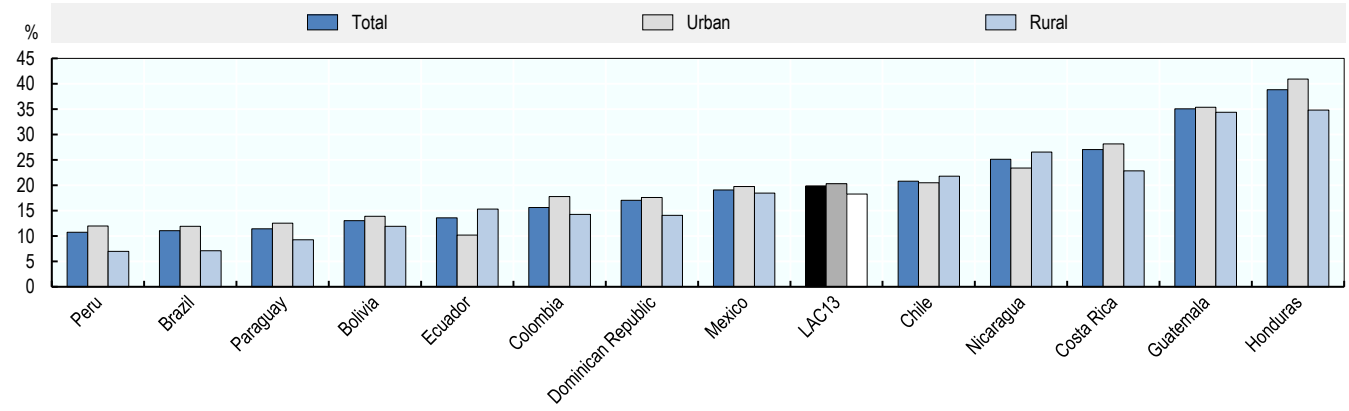
Gonçalves, N. et al. (2023), "Rural-urban disparities in fruit and vegetable consumption and cognitive performance in Brazil", *Brazilian Journal of Psychiatry*, https://doi.org/10.47626/1516-4446-2023-3316. [3]

Odegaard, A. et al. (2022), "Levels of abdominal adipose tissue and metabolic-associated fatty liver disease (MAFLD) in middle age according to average fast-food intake over the preceding 25 years: the CARDIA Study", *The American Journal of Clinical Nutrition*, Vol. 116/1, pp. 255-262, https://doi.org/10.1093/ajcn/nqac079. [4]

WFP (2025), *Fill the Nutrient Gap - Latin America and the Caribbean*, World Food Programme, https://www.wfp.org/publications/fng-latin-america-and-caribbean (accessed on 16 February 2026). [2]

WHO/FAO (2024), *What are healthy diets?*, WHO; FAO, https://doi.org/10.4060/cd2223en. [1]

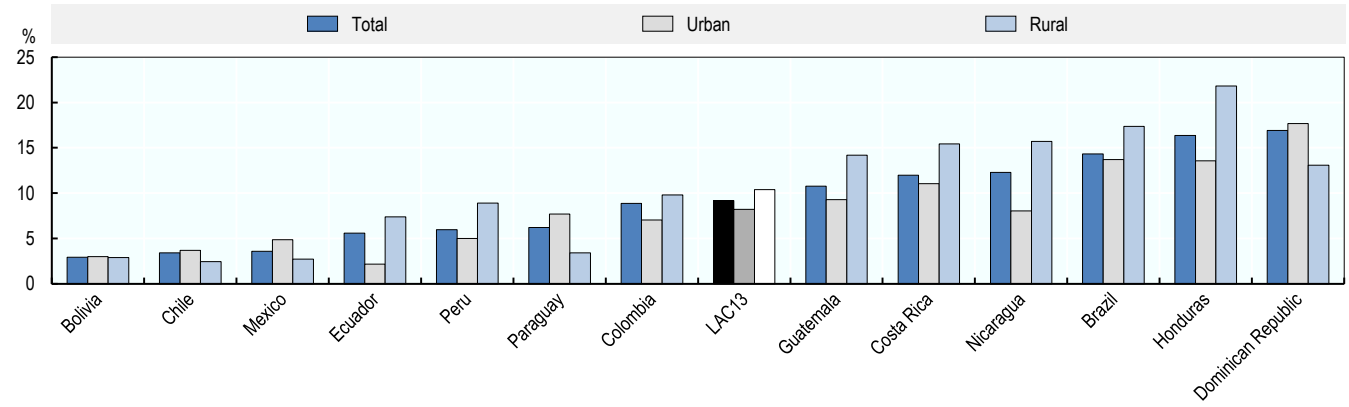
Figure 4.13. Consumption of packaged ultra-processed salty snacks, by urban and rural areas, 2023 (or latest year)



Source: Global Diet Quality Project.

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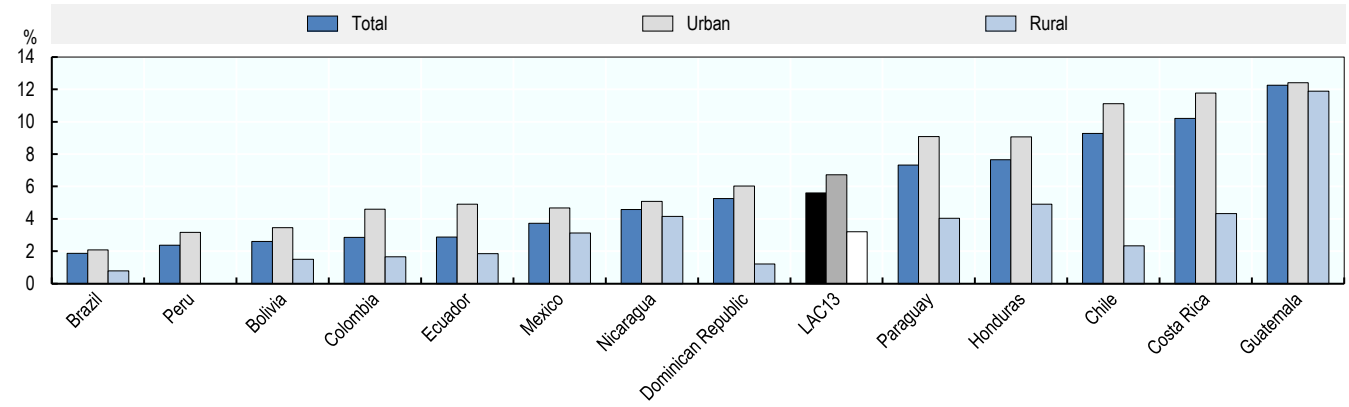
Figure 4.14. Zero vegetable or fruit consumption, by rural and urban areas, 2023 (or latest year)



Source: Global Diet Quality Project.

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Figure 4.15. Fast food consumption, by rural and urban areas, 2023 (or latest year)



Source: Global Diet Quality Project.

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Water and sanitation

Access to safe drinking-water, sanitation and hygiene (WASH) is fundamental to health, well-being and social development. Inadequate WASH remains a major cause of disease, contributing to diarrhoea, respiratory infections, undernutrition, schistosomiasis, soil-transmitted helminth infections and trachoma. In 132 low- and middle-income countries, an estimated 829 000 deaths and 49.8 million DALYs from diarrhoeal diseases were attributable to inadequate WASH in 2016, equivalent to 60% of all diarrhoeal deaths (Prüss-Ustün et al., 2019[1]). Recent evidence also shows that moving households up the WASH service ladder, including through improved water available on premises and higher-quality sanitation, can substantially reduce the risk of childhood diarrhoea (Wolf et al., 2023[2]). Expanding access to at least basic services therefore remains both a public health priority and an important component of more inclusive living standards.

Access to basic sanitation improved across LAC between 2014 and 2024, although rural areas continue to lag behind urban ones (Figure 4.16). On average across LAC24, urban coverage rose from 86.8% to 90.8%, while rural coverage increased from 73.0% to 81.0%, narrowing the urban-rural gap but not closing it. By 2024, Chile had reached universal access in both urban and rural areas, while Antigua and Barbuda, Costa Rica, Paraguay and Uruguay were also at or near universal coverage. At the other end of the distribution, Haiti remained the clear outlier, with only 32.4% of the urban population and 24.1% of the rural population having access to basic sanitation, and Bolivia also remained well below the regional average, especially in rural areas (53.3%). Progress was strongest where starting levels were lowest, particularly in rural Bolivia, Paraguay and Peru, and in urban Bolivia and Panama. Even so, wide territorial disparities persisted in several countries, notably Brazil, Panama, Bolivia, Peru and Guatemala.

Access to basic drinking water was consistently higher than access to sanitation and was close to universal in most urban areas (Figure 4.17). Across LAC26, urban coverage increased only marginally, from 97.0% in 2014 to 97.7% in 2024, suggesting that most gains in cities now come from reaching the last uncovered groups. In rural areas, progress was more substantial, with coverage rising from 85.3% to 90.6% over the same period. By 2024, a number of countries had already reached or nearly reached universal access for both urban and rural populations, including Brazil, Costa Rica, Paraguay, Trinidad and Tobago and Uruguay. Nonetheless, important rural deficits remained, particularly in Haiti (54.8%), Bolivia (78.7%), El Salvador (80.4%), Ecuador (81.4%) and Colombia (83.7%). The fastest rural improvements were observed in Peru, El Salvador, Paraguay, Brazil and Haiti, while Jamaica was the only country in the figure showing declines in both urban and rural drinking water coverage over the decade.

These indicators show steady progress in expanding basic WASH services across LAC over the past decade, with faster gains in rural areas helping to narrow longstanding territorial gaps. Yet sanitation still lags behind drinking water in many countries, and sizeable rural deficits persist. These gaps matter because health benefits rise as households reach higher service levels, while unsafe WASH remains a major source of preventable disease. Sustained investment in rural infrastructure, service quality, and targeted support for underserved communities will be essential to convert recent gains into universal, equitable access to both drinking water and sanitation (UNICEF/WHO, 2025[3]).

Definition and comparability

People that use an improved sanitation facility that was not shared with other households are classified as having at least basic sanitation services. Improved sanitation facilities hygienically separate excreta from human contact, using flushing to piped sewer systems, septic tanks, or pit latrines, along with improved pit latrines or composting toilets (UNICEF/WHO, 2025[3]).

People that use improved sources of drinking water that required no more than 30 minutes per trip to collect water are classified as having at least basic drinking water services. An improved drinking-water source is constructed so that is protected from outside contact, especially from faecal matter, improved sources include piped water, public taps, boreholes, and protected dug wells or springs (UNICEF/WHO, 2025[3]).

The WHO/UNICEF Joint Monitoring Program for Water Supply and Sanitation (JMP) database includes nationally representative household surveys and censuses that ask questions on water and sanitation, mostly conducted in developing countries. Generally, developed countries supply administrative data.

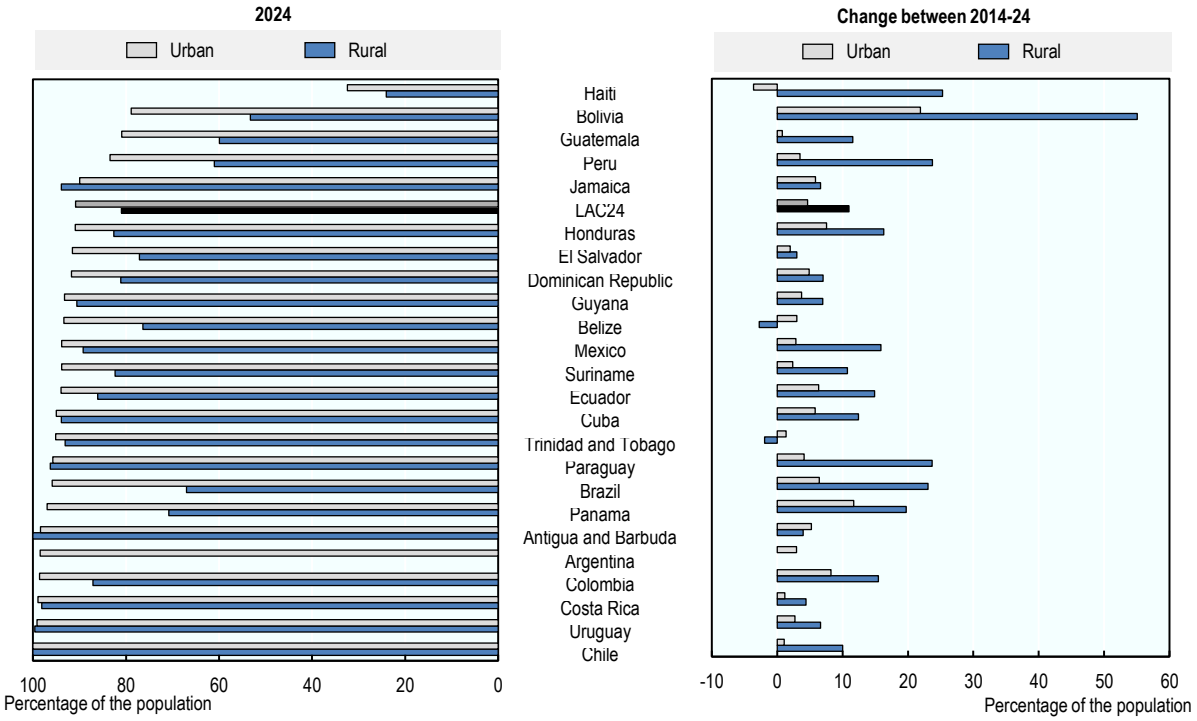
References

Prüss-Ustün, A. et al. (2019), "Burden of disease from inadequate water, sanitation and hygiene for selected adverse health outcomes: An updated analysis with a focus on low- and middle-income countries", *International Journal of Hygiene and Environmental Health*, Vol. 222/5, pp. 765-777, https://doi.org/10.1016/j.ijheh.2019.05.004. [1]

UNICEF/WHO (2025), *Progress on household drinking-water, sanitation and hygiene 2000-2024: Special focus on inequalities*, WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene, https://www.unicef.org/publications/index_96611.html. [3]

Wolf, J. et al. (2023), "Burden of disease attributable to unsafe drinking water, sanitation, and hygiene in domestic settings: a global analysis for selected adverse health outcomes", *The Lancet*, Vol. 401/10393, pp. 2060-2071, https://doi.org/10.1016/s0140-6736(23)00458-0. [2]

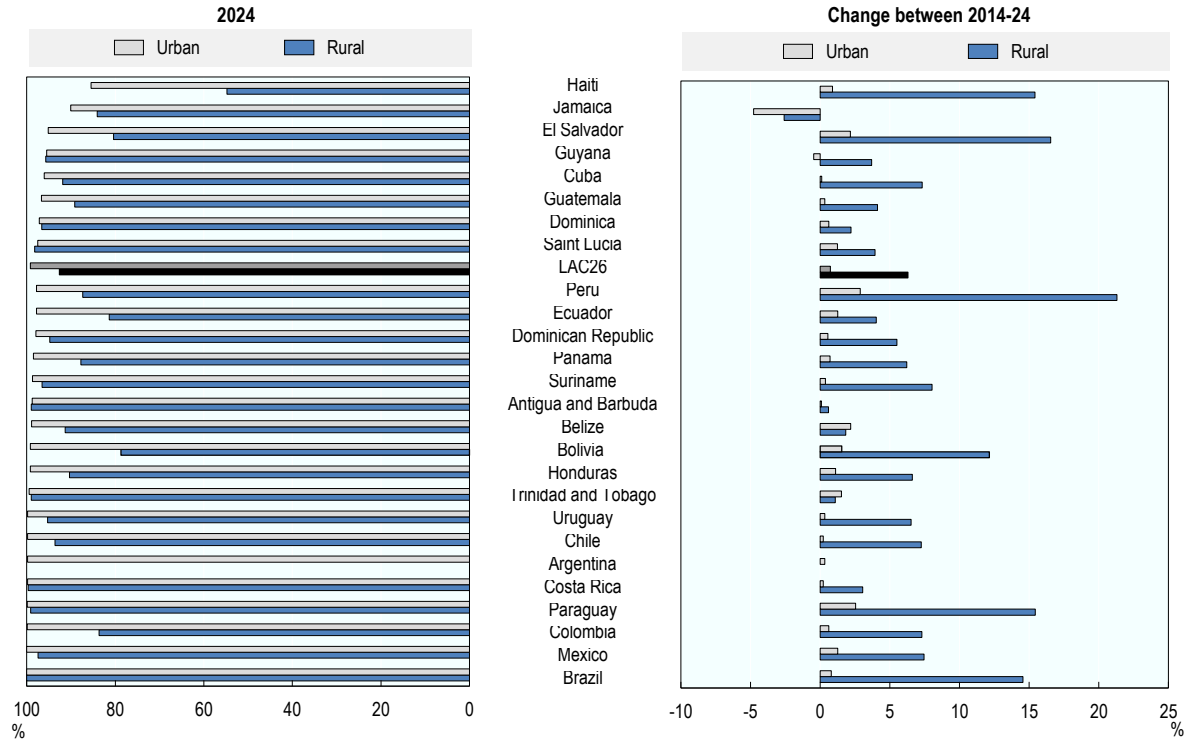
Figure 4.16. Access to basic sanitation, 2024 and change between 2014-2024



Source: WHO Global Health Observatory 2025.

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Figure 4.17. Share of the population with access to basic drinking water, 2024 and change between 2014-2024



Source: WHO GHO 2025.

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Tobacco

Tobacco use is the second leading risk factor for early death and disability worldwide, claiming more than 8 million lives every year, out of which about 1.2 million are the result of non-smokers exposure to second-hand smoke (WHO, 2023[1]). The negative effects of smoking spread out beyond individual and population health affecting the economy as well. Between 2007 and 2023, the global average smoking prevalence has reduced from 22.3% to 16.4%, a relative reduction of 26% over 16 years (WHO, 2025[2]).

The prevalence of current use of any tobacco product, whether on a daily or non-daily basis, varies greatly across the LAC region and also between sexes. In 2025, the LAC22 average prevalence among men is over 15 is 19%, well below the OECD average of 24.8% for men of the same age group (Figure 4.18). Prevalence among men is particularly high in Bahamas, Chile and Argentina, the only LAC countries above the OECD average, with more than 25% of men aged 15 and over reporting current tobacco use. The lowest prevalence amongst men is observed in Panama and Paraguay, both below 10%. Among women, the prevalence of current tobacco use is considerably lower than among men. For instance, Guatemalan women smoke around 12 times less than men. In 2025, the LAC22 average among women is 5.8%, well below the OECD average of 17%. Chile is at the top with prevalence over 23%, followed by Argentina and Uruguay. The lowest female prevalence is found in Honduras, Guatemala and Panama, all below 2%.

E-cigarette, a subset of electronic nicotine delivery systems, have rapidly gained popularity across the LAC region, becoming a key public health concern. These products have been promoted as “healthier alternatives” to conventional tobacco; however, they have failed to deliver the expected risk-reduction and now threaten the gains achieved in tobacco control through policy implementation (Izquierdo-Condoy, 2025[3]). In 2024, the prevalence of current e-cigarette use among adults in LAC15 is 1.6%, almost four times lower than the OECD average of 5.8%. Trinidad and Tobago and Paraguay show adult e-cigarette prevalence above 4%, while countries such as Uruguay, Panama and Saint Lucia report a prevalence below 0.5% (Figure 4.19.).

Increasing tobacco prices through higher taxes is one of the most effective interventions to reduce tobacco use, as it discourages young people from starting cigarette smoking and encourages current smokers to quit. A recent review of studies conducted in LAC countries found that tax increases effectively reduce cigarette use and can also be expected to increase cigarette tax revenue (Guindon, Paraje and Chaloupka, 2018[4]), which can then support complementary interventions. The average taxation on a pack of 20 cigarettes in LAC is 47.6%, well below the OECD average of 72.8% (Figure 4.20). The countries with the highest total tax shares on tobacco are Chile, Brazil and Argentina with 82.6%, 79.4% and 78.5% respectively, although these are not the countries with the highest retail prices. The most expensive cigarette pack can be found in the Bahamas with a price of USD 13, while the cheapest are sold in Paraguay with a price of USD 0.46.

LAC countries can strengthen its regulations to reduce tobacco use by fully implementing the WHO Framework Convention on Tobacco Control. For this, WHO’s strategy MPOWER can be followed to monitor tobacco use and prevention policies; protect people from tobacco use; offer help to quit tobacco use; warn about the dangers of tobacco; enforce bans on tobacco advertising, promotion and sponsorship; and raise taxes on tobacco (WHO, 2022[5]).

Definition and comparability

Current tobacco use prevalence is defined as the percentage of the population aged 15 years and over who currently use any tobacco product (smoked and/or smokeless tobacco) on a daily or non-daily basis. Tobacco products include cigarettes, pipes, cigars, cigarillos, waterpipes (hookah, shisha), bidis, kretek, heated tobacco products, and all forms of smokeless (oral and nasal) tobacco. Tobacco products exclude e-cigarettes (which do not contain tobacco), “e-cigars”, “e-hookahs”, JUUL and “e-pipes”. Estimates for 2025 were modelled using age-and-sex-specific prevalence rates from national surveys. Results were age-standardised to the WHO Standard Population.

Current e-cigarette use prevalence among adults is obtained from the most recent nationally representative survey.

Tobacco and nicotine products retail price data come from primary collection by surveying two types of retail outlets from the capital city: supermarkets or hypermarkets and kiosks, newsagent, tobacconist or independent food stores. Prices are collected from the most sold brand (pack of 20 sticks). Regarding tax data, countries are surveyed every two years and asked to report annual tax revenues at the national/federal level from all tobacco products for the most recent year available.

References

Guindon, G., G. Paraje and F. Chaloupka (2018), “The Impact of Prices and Taxes on the Use of Tobacco Products in Latin America and the Caribbean”, *American Journal of Public Health*, Vol. 108/S6, pp. S492-S502, https://doi.org/10.2105/ajph.2014.302396r. [4]

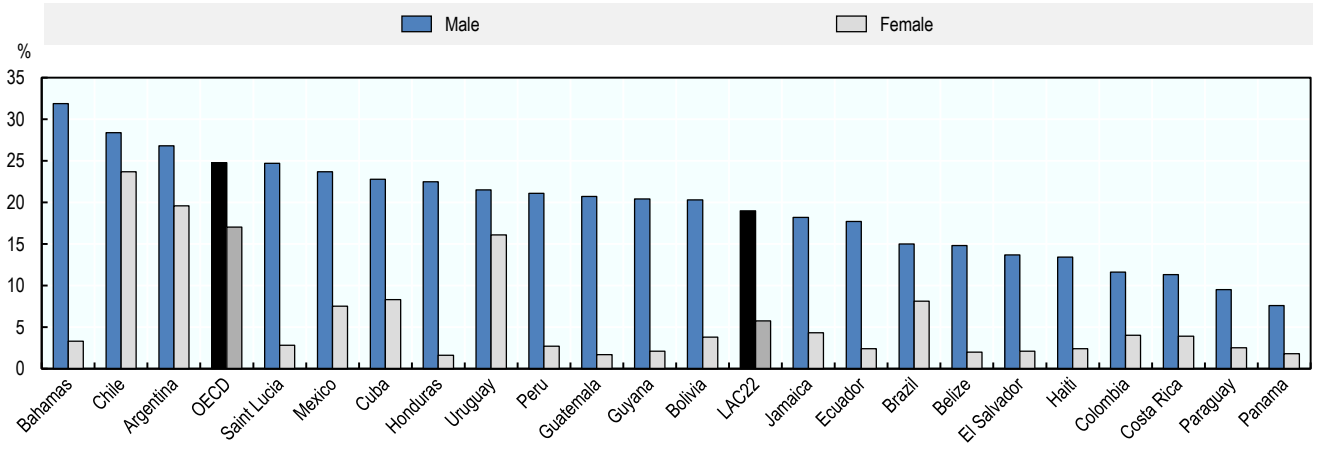
Izquierdo-Condoy, J. (2025), “Bridging the regulatory gap: a call for a regional, evidence-informed approach to e-cigarette control in Latin America”, *Frontiers in Public Health*, Vol. 13, https://doi.org/10.3389/fpubh.2025.1689171. [3]

WHO (2025), *WHO report on the global tobacco epidemic, 2025: Warning about the dangers of tobacco*, World Health Organization, https://iris.who.int/handle/10665/381685. [2]

WHO (2023), *Tobacco*, https://www.who.int/news-room/fact-sheets/detail/tobacco (accessed on 23 February 2023). [1]

WHO (2022), *Tobacco fact sheet*, https://www.who.int/news-room/fact-sheets/detail/tobacco. [5]

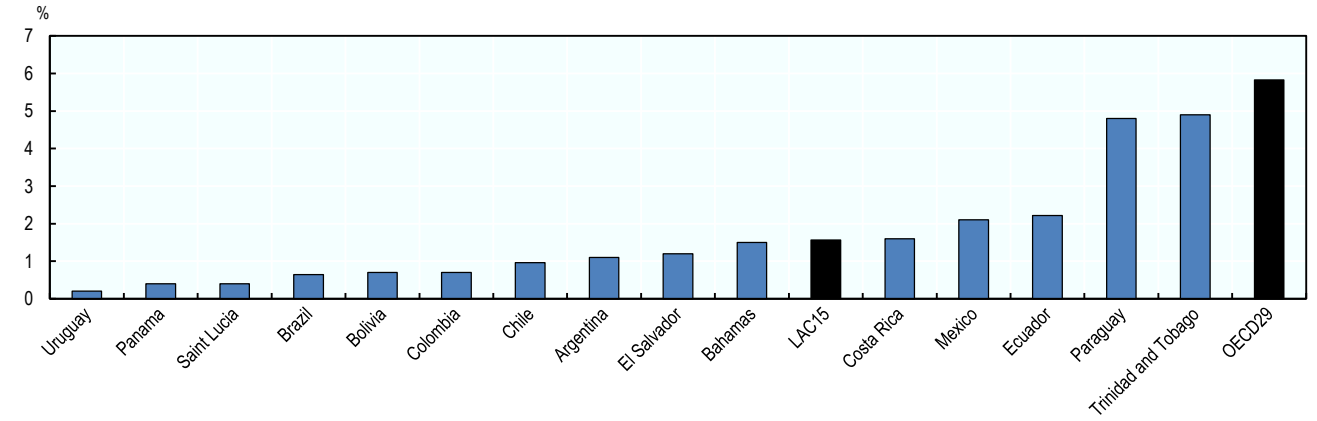
Figure 4.18. Current tobacco use prevalence (%), age-standardised, 2025, by sex



Source: WHO Global Health Observatory, 2025.

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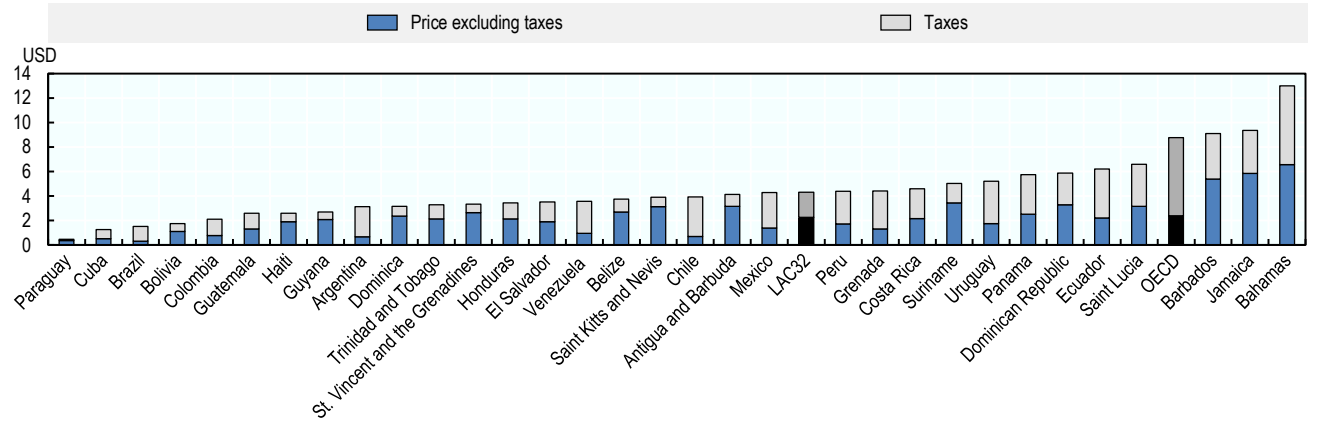
Figure 4.19. Prevalence of current e-cigarette among adults (%), 2024



Source: WHO Global Health Observatory, 2025.

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Figure 4.20. Retail price of a box of 20 cigarettes (most sold brand) in USD and national taxes, 2024



Source: WHO Global Health Observatory, 2025.

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Alcohol and drug use

Alcohol and psychoactive substance use continue to impose a substantial, yet largely preventable, burden on population health in Latin America and the Caribbean (LAC). Alcohol alone is causally linked to more than 200 diseases and health conditions, and WHO estimates that harmful alcohol use caused 2.6 million deaths globally in 2019. In the Americas, alcohol consumption remains around 40% higher than the global average and is characterised by particularly risky drinking patterns. At the same time, drug use disorders are an increasing public health concern in the Region, with PAHO estimating that 17.7 million people in the Americas were living with a drug use disorder in 2021, resulting in nearly 78 000 deaths directly attributable to these disorders (Martinez et al., 2025[1]).

In 2022, total alcohol consumption among people aged 15 and over averaged 5.6 litres of pure alcohol per capita across LAC33, substantially below the OECD average of 8.8 litres (Figure 4.21). Consumption ranged from 1.8 litres in Guatemala to 11.9 litres in Saint Lucia. Other countries with comparatively high levels of consumption included Antigua and Barbuda (9.9 litres), Barbados (9.8), Argentina (9.0) and Brazil (8.2), while Venezuela, Ecuador, Honduras and Haiti also remained below 3 litres per capita. Beer accounted for the largest share of alcohol consumption in LAC on average, followed by spirits, whereas wine consumption remained comparatively low. Beverage preferences nevertheless varied markedly across countries: wine represented a relatively large share of total consumption in Argentina and Uruguay, while spirits accounted for a large proportion of consumption in several Caribbean countries, notably Saint Lucia, Dominica and Saint Vincent and the Grenadines.

Drug poisoning mortality remains much lower in LAC than in OECD countries, although recent increases in some countries warrant attention (Figure 4.22). Across LAC25, the death rate from drug poisoning stood at 0.58 deaths per 100 000 population in 2023, compared with 5.21 in the OECD36. This regional average was slightly below the 2010 level of 0.61, but above the 2019 value of 0.42. In 2023, Grenada recorded the highest reported rate in the region, at 2.38 deaths per 100 000 population, followed by Costa Rica (1.83), Uruguay (1.81), Brazil (1.43) and Trinidad and Tobago (1.42). By contrast, several countries reported rates at or close to zero. Despite the comparatively low absolute levels, the upward movement observed in countries such as Brazil, Costa Rica, Mexico and Uruguay suggests that drug-related mortality is becoming a more visible public health issue in parts of the region.

Alcohol-specific mortality shows a different pattern. Rates are considerably higher than those observed for drug poisoning, and cross-country variation is wide (Figure 4.23). In LAC25, the alcohol-specific death rate was 6.72 per 100 000 population in 2023, below the OECD36 average of 9.45, but only slightly above the 2019 regional level of 6.65 and well below the 2010 level of 8.30. Guatemala reported the highest rate in 2023 (18.21 deaths per 100 000 population), followed by Saint Kitts and Nevis (17.57), Belize (12.81), Mexico (12.49) and Nicaragua (10.91). At the other end of the distribution, the lowest rates were observed in the Dominican Republic (0.90), Panama (1.50), Jamaica (1.69), Antigua and Barbuda (1.72) and Colombia (1.76). Over the longer term, several countries recorded sizeable declines, including Saint Vincent and the Grenadines, Chile, Dominica, Guyana and Nicaragua.

Harmful drinking patterns and high alcohol-specific mortality persist in several countries, despite average alcohol consumption remaining below OECD levels, while drug poisoning mortality, though still low by OECD standards, has increased in some countries. Addressing this burden will require stronger alcohol-control policies, better prevention and early intervention, and wider access to treatment and harm reduction services. Results should be interpreted with caution, especially in small countries, where year-to-year fluctuations may reflect population size, reporting completeness and coding changes.

Definition and comparability

Data on total alcohol per capita consumption were obtained from the WHO Global Health Observatory and represent the litres of pure alcohol consumed per person aged 15 and over during a calendar year, derived from production, import, export and sales data, often collected through taxation systems. The indicator is calculated by dividing this total recorded alcohol consumption (numerator) by the midyear resident population aged 15 and over for the same calendar year, as estimated by the UN WPP medium-variant projections (denominator).

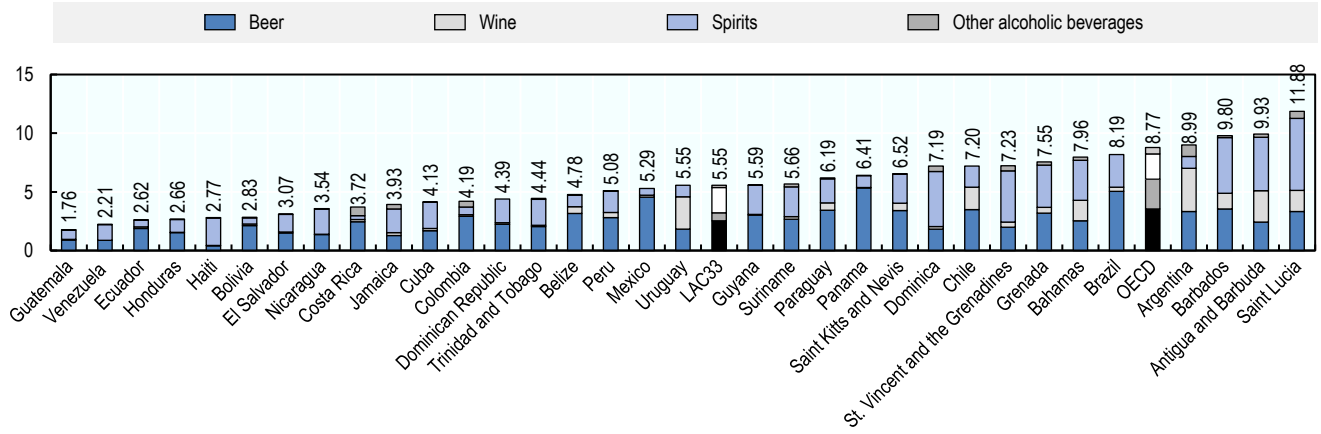
Data on drug poisoning and alcohol-specific deaths were extracted from the WHO mortality database. Mortality rates are calculated by dividing annual numbers of deaths by mid-year population estimates. Rates have been age standardised using population data from the four OECD LAC countries as standard population. The ICD-10 codes used to define underlying causes of death due to alcohol or drugs are based on the Office for National Statistics (Cornes et al., 2021[2]).

References

Cornes, M. et al. (2021), *Improving care transfers for homeless patients after hospital discharge: a realist evaluation*, NIHR Journals Library, Southampton. [2]

Martinez, R. et al. (2025), "The rising burden of drug use disorders in the Americas, 2000–2021", *Revista Panamericana de Salud Pública*, Vol. 49, p. 1, https://doi.org/10.26633/rpsp.2025.132. [1]

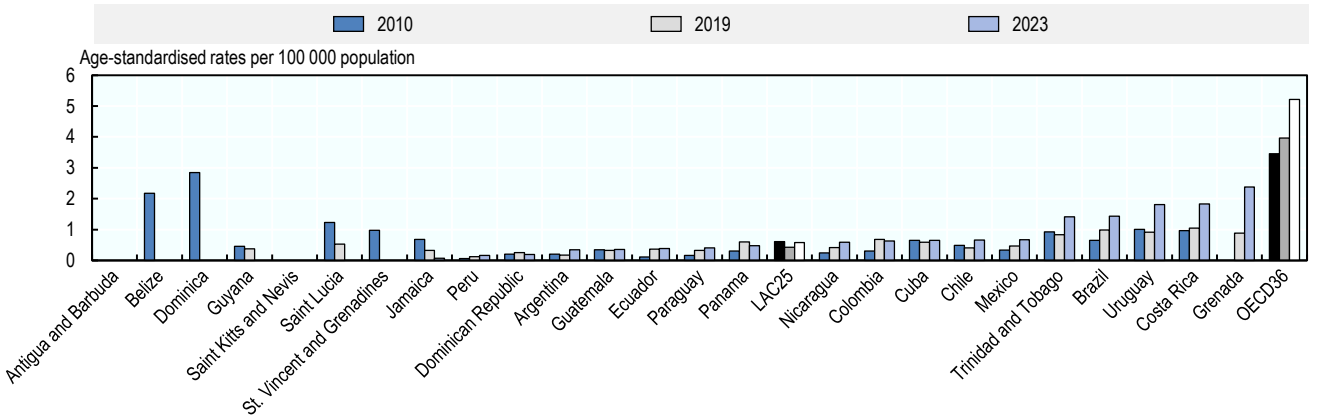
Figure 4.21. Total alcohol per capita (15+) consumption (in litres of pure alcohol), by beverage type, 2022



Source: WHO Global Health Observatory, 2025.

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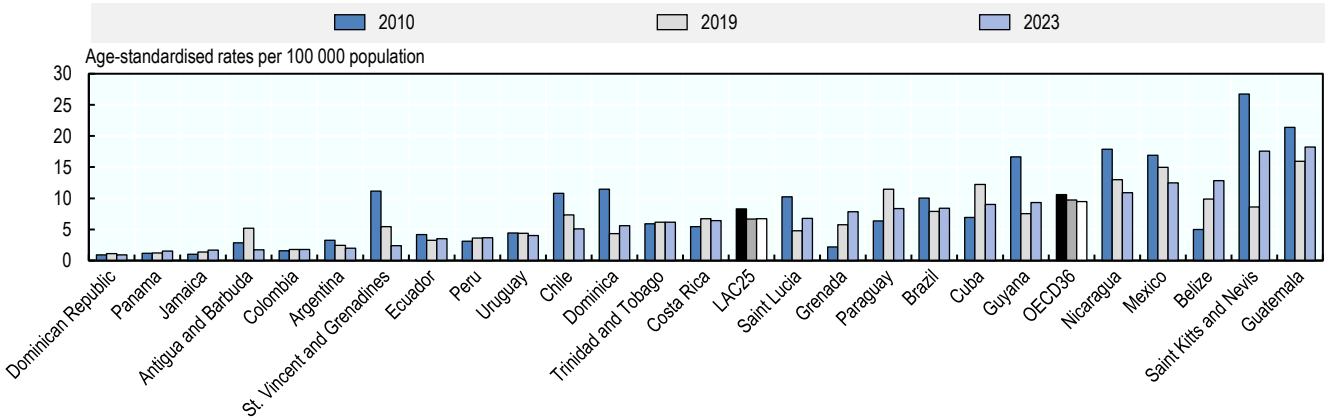
Figure 4.22. Drug poisoning deaths rates, 2010, 2019 and 2023 (or latest year)



Source: WHO mortality database (2026).

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Figure 4.23. Alcohol-specific death rates, 2010, 2019 and 2023 (or latest available)



Source: WHO mortality database (2026).

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Road safety

Approximately 1.9 million people die each year as a result of road traffic crashes, which are the leading cause of mortality amongst people aged 5-29 years. There is great disparity by income, with 92% of deaths resulting from road traffic happening in low- and middle-income countries (WHO, 2023[1]). The burden of road traffic injuries falls disproportionately on vulnerable road users – pedestrians, cyclists, and motorcyclists. Road injuries will cost the world economy USD 1.8 trillion (constant 2010 USD) in 2015-2030, which is equivalent to an annual tax of 0.12% on global gross domestic product (Chen et al., 2019[2]).

In 2023, the 25 LAC countries with available data from WHO mortality database reported an average of 20 deaths per 100 000 for men and 4.2 deaths per 100 000 for women due to road traffic accidents, both well above the OECD37 averages of 7.5 and 2.0 deaths per 100 000 population, respectively (Figure 4.24). For all other LAC countries, mortality data are obtained from IHME modelled estimates. Countries with the highest male death rates from road traffic accidents also tend to have the highest female deaths rates, although there are some exceptions. Overall, across LAC countries, men are 4.8 times more likely to die in a road traffic accident than women. Haiti, Bolivia and Honduras have the highest male road traffic mortality in the region, with death rates exceeding 45 deaths per 100 000 population. Among females, the highest rates are observed in Haiti, Bolivia, Saint Kitts and Nevis and El Salvador, all above 9 deaths per 100 000 population. At the opposite end, the lowest rates in the region are observed in Jamaica and Grenada, both below 4 deaths per 100 000 population and the only LAC countries below the OECD37 male average. Among women, Saint Vincent and the Grenadines is the only country reporting 0 deaths in 2022 (latest year available), followed by Jamaica, Saint Lucia and Antigua and Barbuda with 0.26, 0.98 and 1.60 deaths per 100 000 population, respectively.

The main risk factors for road traffic deaths and injuries are drinking and driving, speeding, and not using motorcycle helmets, seat belts and child restraints. Distracted driving is a growing threat to road safety, particularly due to the use of mobile phones and other in-vehicle technologies. Texting while driving causes cognitive, manual and visual distraction, and even hands-free phone use reduces driving performance (WHO, 2023[1]). As both handheld and hands-free devices create cognitive distraction, some national laws regulate both (Table 4.1). Driving with a blood alcohol concentration (BAC) above 0.05g/dl (grammes per decilitre) substantially increases crash risk and the likelihood of fatal or serious injuries. Enforcement through random breath-testing checkpoints is highly cost effective and can reduce alcohol-related crashes by approximately 20%. As of 2023, all 30 LAC countries with data available have implemented national laws against drinking while driving. Wearing a seat belt reduces fatalities amongst vehicle occupants by up to 50%. However, Antigua and Barbuda does not have a national seat-belt law, and several other countries do not require seat belt use for all the occupants. Child restraint systems, including infant seats and booster seats, reduce the risk of death in a crash by about 71% among infants (WHO, 2023[1]), yet mandatory national child restraint laws exist only in 19 LAC countries. Speed management remains one of the main challenges for road safety and calls for a long-term and multidisciplinary response. National speed limits legislation exists in 28 LAC countries, with the exception of Dominica and Venezuela. However, in several countries local authorities can modify speed limits. Wearing a motorcycle helmet correctly reduces the risk of death by more than 6 times and severe injury by up to 74%. Enforcement of helmet laws can increase helmet-wearing rates to over 90% (WHO, 2023[1]). However, Antigua and Barbuda and Dominica lack mandatory helmet regulations. In other LAC countries, motorcycle helmet wearing rates vary widely, being lower than 50% for both drivers and passengers in Ecuador and Paraguay, while six LAC countries report use rates over 90% for both.

In the LAC region, progress has been made over the past five years. For example, some countries have reduced their speed limits in rural and urban settings, including Colombia. New regulations on mobile phone use while driving have been introduced in Jamaica and Mexico. Mandatory motorcycle helmet legislation has been adopted in Guyana, and child restraint regulations have been introduced in Mexico. However, further policy action and investment are required to match the scale of the road traffic mortality burden in the region.

Definition and comparability

See indicator “Mortality from all causes” in Chapter 3 for definition, source, and methodology underlying mortality rates. Of all 33 LAC countries, LAC25 refers to the 25 countries with measured mortality data available from the WHO Mortality Database, while LAC8 refers to the countries whose mortality data are based on IHME estimates. For information about legislation on five main risk factors of road traffic deaths see the Road Safety country profiles.

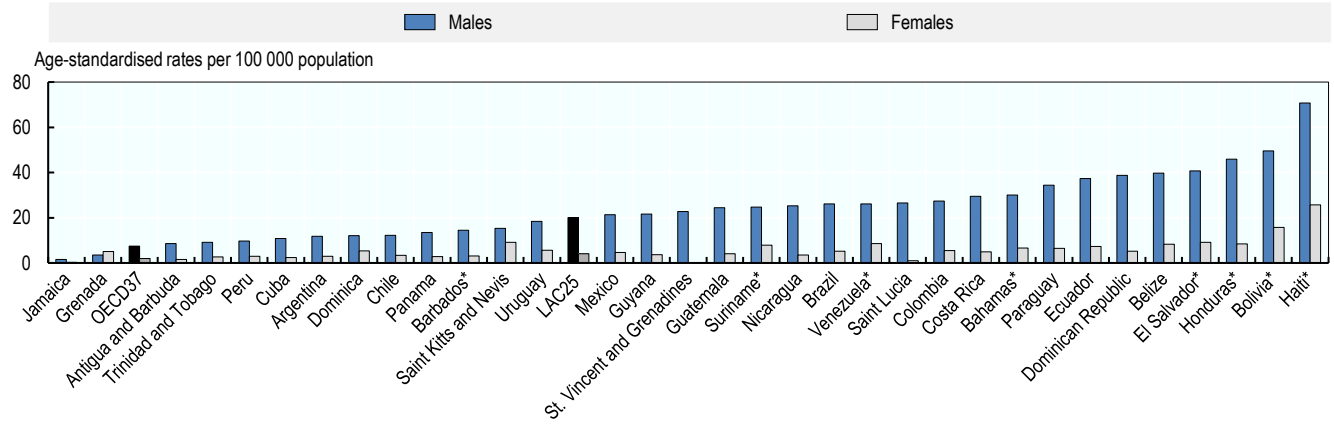
References

Chen, S. et al. (2019), “The global macroeconomic burden of road injuries: estimates and projections for 166 countries”, *The Lancet Planetary Health*, Vol. 3/9, pp. e390-e398, https://doi.org/10.1016/S2542-5196(19)30170-6. [2]

WHO (2023), *Road traffic injuries*, https://www.who.int/news-room/fact-sheets/detail/road-traffic-injuries (accessed on 20 February 2026). [1]

WHO (2023), *The Global Status Report on Road Safety*, World Health Organization, https://iris.who.int/handle/10665/375016. [3]

Figure 4.24. Road traffic death rates, by sex, 2023 (or latest year)



Note: * IHME estimates.
Source: WHO mortality database (2026) and Global Burden of Disease (2025), IHME.

StatLink https://stat.link/x04g27

Table 4.1. Existence of a national legislation on five main risk factors of road traffic deaths, latest year available

Country	Drink Diving	Seatbelt		Child restraint	Speed limit			Motorcycle helmet		Mobile phone use
	National law	National law	Applicability to all occupants	National law	National or local law	Rural (km/h)	Urban (km/h)	National law	Motorcycle helmet wearing rate (% driver / percentage passenger)	National law on hand-held/hand-free mobile phone use
Antigua and Barbuda	Yes	No	-	No	National	64	32	No	-	No
Argentina	Yes	Yes	Yes	Yes	Both	110	60	Yes	69/42	Yes
Bahamas	Yes	Yes	Yes	Yes	Both	48	40	Yes	-	No
Barbados	Yes	Yes	Yes	Yes	National	80	80	Yes	-	Yes
Belize	Yes	Yes	No	No	National	88	40	Yes	-	No
Bolivia	Yes	Yes	No	No	Both	80	40	Yes	-	No
Brazil	Yes	Yes	Yes	Yes	Both	100	80	Yes	100	Yes
Chile	Yes	Yes	Yes	Yes	Both	100	50	Yes	95/87	Yes
Colombia	Yes	Yes	Yes	No	Both	90	50	Yes	79/53	Yes
Costa Rica	Yes	Yes	Yes	Yes	National	60	50	Yes	97/90	Yes
Cuba	Yes	Yes	Yes	No	National	90	50	Yes	95/95	Yes
Dominica	Yes	Yes	Yes	No	None	-	-	No	-	No
Dominican Republic	Yes	Yes	Yes	Yes	National	60	60	Yes	-	Yes
Ecuador	Yes	Yes	Yes	Yes	Both	120	60	Yes	26/13	Yes
El Salvador	Yes	Yes	No	Yes	National	90	50	Yes	-	Yes
Guatemala	Yes	Yes	No	No	Both	80	60	Yes	-	Yes
Guyana	Yes	Yes	No	Yes	National	64	64	Yes	-	Yes
Haiti	Yes	Yes	Yes	No	National	-	50	Yes	-	Yes
Honduras	Yes	Yes	Yes	No	National	-	-	Yes	-	Yes
Jamaica	Yes	Yes	Yes	Yes	National	80	80	Yes	-	Yes
Mexico	Yes	Yes	No	Yes	Both	80	50	Yes	-	Yes
Nicaragua	Yes	Yes	No	Yes	National	100	45	Yes	95/95	Yes
Panama	Yes	Yes	Yes	No	National	100	80	Yes	95/95	Yes
Paraguay	Yes	Yes	Yes	Yes	Both	110	50	Yes	35/11	Yes
Peru	Yes	Yes	Yes	Yes	Both	60	50	Yes	-	Yes
Saint Lucia	Yes	Yes	No	No	National	-	-	Yes	-	Yes
Suriname	Yes	Yes	Yes	Yes	National	80	40	Yes	95/90	Yes
Trinidad and Tobago	Yes	Yes	No	Yes	National	80	50	Yes	98/98	Yes
Uruguay	Yes	Yes	Yes	Yes	Both	90	45	Yes	93/82	Yes
Venezuela	Yes	Yes	Yes	Yes	None	-	-	Yes	-	Yes

Source: WHO Global Status Report on Road Safety (2023[3]).

Environmental and climate risks

Climate change is one of the biggest challenges for humankind. It is linked to many different types of environment distress, such as extreme temperatures, spread of tropical diseases and their vectors, and air pollution. Air pollution is already the most significant environmental health risk and a major cause of death and disability, causing approximately 7 million premature deaths annually, and its future impact is likely to be even greater if adequate policy action is not developed. Moreover, 99% of the global population breathe air exceeding WHO air-quality guidelines, with low- and middle-income countries suffering from the highest exposures (WHO, 2026[1]).

While the economic cost of heat-related mortality varies widely across the LAC region, the overall burden has consistently increased over the last decades. In LAC27, the average annual monetised global losses due to heat related mortality for 2020-2024 were 244% higher than the 2000-2004 average, expressed as the equivalent number of average annual incomes (Figure 4.25). In 2024, this burden was the lowest in Bahamas, Saint Vincent and the Grenadines and Belize, where losses remain below 1000 average annual income equivalents. For instance, in Saint Vincent and the Grenadines the loss is equivalent to about 322 annual incomes. At the opposite end, Mexico and Brazil showed very high losses, reaching 409 384.8- and 498 325.9-income equivalents, respectively.

Dengue is a mosquito-borne viral disease transmitted by the *Aedes aegypti* and *Aedes albopictus* species. The basic reproduction number (R_0) for dengue has increased across LAC when comparing 2015-2024 with 1951-1960. On average, LAC25 had an increase of 0.23 for *Ae. aegypti* and of 0.25 for *Ae. albopictus* species, meaning that each case now leads, on average, roughly a quarter more secondary infections than in the 1951-1960 period (Figure 4.26). Colombia, Ecuador and Nicaragua exhibited the largest increases in aegypti-related R_0 (over 0.7), while Brazil, Bolivia and Colombia, showed the highest gains for albopictus-related R_0 (above 0.59). Only a few countries experienced declines in the dengue R_0, with Trinidad and Tobago, Haiti, Dominican Republic, Jamaica and Argentina experiencing reductions for *Ae. aegypti* (ranging from -0.20 to -0.04) and Cuba, Uruguay and Argentina for *Ae. albopictus* (from -0.30 to -0.03).

In LAC31 countries, mortality rates attributed to household and ambient air pollution in 2019 were on average 42.1 age-standardised deaths per 100 000 population for females and 53.7 for males. Mortality rates for men were higher than for women across all LAC countries with available data, except in Haiti. Haiti had the highest mortality rates for both women and men at 216 and 204 deaths per 100 000 population, respectively. Bahamas, Panama, Antigua and Barbuda, and Barbados had the lowest male mortality rates in the region, with less than 22 deaths per 100 000 population, while the lowest female mortality rates were in Bahamas and Uruguay with less than 12 deaths per 100 000 population (Figure 4.27).

Climate change is altering the ecology of dengue vector mosquitoes and expanding the geographic areas where species can live. While *Ae. aegypti* is adapted to warmer urban environments (24-34°), *Ae. albopictus* is more prevalent in cooler suburban and rural environments (15-30°), however, it is now expanding into temperate regions that were previously only populated by *Ae. Aegypti,* increasing projected dengue infection risk (Chacón and Santos-Vega, 2026[2]). PAHO recommends sustained dengue surveillance, targeted mosquito-control in high-risk areas, and strong clinical care to prevent severe cases and deaths. Communities play a key role in prevention actions supported by health education campaigns. Finally, improving diagnostics, increasing early detection and advancing research on vaccines is essential to strengthen dengue prevention (Anand et al., 2024[3]).

Definition and comparability

Data on costs of heat-related mortality combines estimates on heat-related mortality rates and the value of statistical life-year (VSLY) estimated for the member countries of the OECD. It uses a fixed ratio of the VSLY to gross domestic product per capita. The value of mortality is presented as number of peoples' incomes the loss would be equivalent to in a given country and region.

In viral diseases, R_0 represents the expected number of cases directly generated by one case in a population of individuals susceptible to infection. For both costs of heat-related mortality and absolute change in dengue associated R_0 data are extracted from the Lancet Countdown 2025 data explorer (Lancet Countdown, 2025[4]).

Ambient (outdoor) particulate matter pollution results from emissions from industrial activity, households and vehicles, which are complex mixtures of air pollutants, many of which are harmful to health. Of all these pollutants, fine particulate matter, even at low levels, has the greatest effect on human health.

References

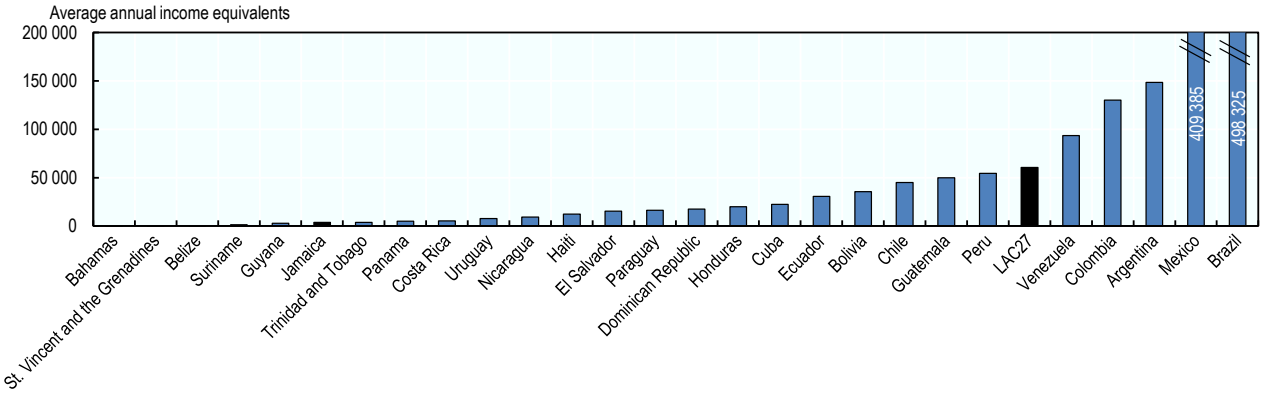
Anand, A. et al. (2024), "An urgent call for action: addressing the unprecedented rise in dengue cases in the Americas", *Annals of Medicine & Surgery*, Vol. 86/7, pp. 3814-3815, https://doi.org/10.1097/ms9.0000000000002186. [3]

Chacón, S. and M. Santos-Vega (2026), "Temperature and competition: drivers in the ecological dynamics of Aedes mosquitoes and dengue spread", *Parasites & Vectors*, https://doi.org/10.1186/s13071-025-07187-y. [2]

Lancet Countdown (2025), *Explore our data*, https://lancetcountdown.org/explore-our-data/ (accessed on 24 February 2026). [4]

WHO (2026), *Air pollution*, https://www.who.int/health-topics/air-pollution#tab=tab_1 (accessed on 24 February 2026). [1]

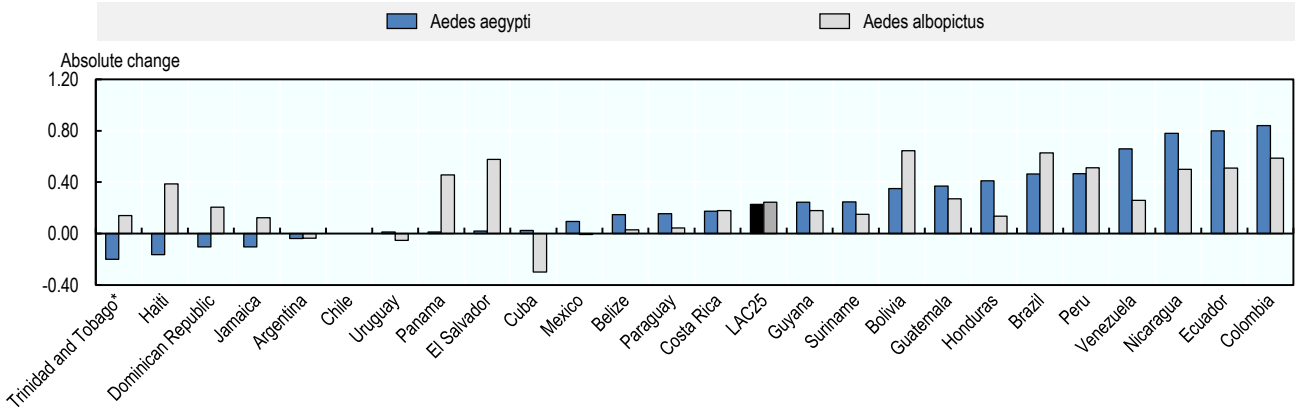
Figure 4.25. Costs of Heat-Related Mortality, 2024



Source: The Lancet Countdown report, 2025.

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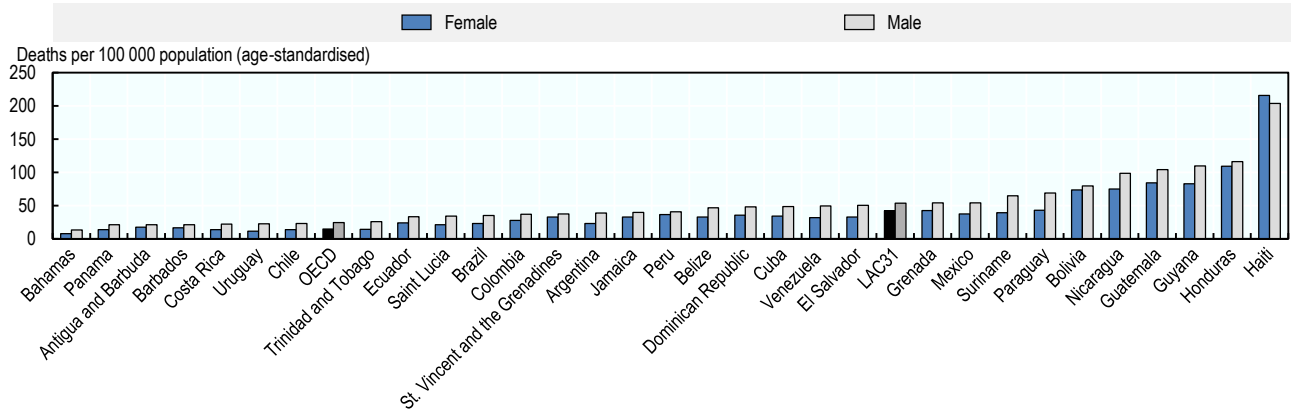
Figure 4.26. Absolute change in basic reproduction number (R0) for dengue transmission by *Aedes aegypti* and *Aedes albopictus* mosquitos in 2015-2024, compared to 1951-1960 baseline



Note: * Trinidad and Tobago has no available data for *Aedes aegypti* for 2024, interval calculated as the average from 2015 – 2023.
Source: The Lancet Countdown report, 2025.

StatLink https://stat.link/nsvqdj

Figure 4.27. Mortality rate attributed to household and ambient air pollution, by sex, 2019



Source: WHO Global Health Observatory, 2024.

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5 Health data and health system infrastructure

Health data availability

Health information systems are most effective when data flow seamlessly between the actors that generate, use and benefit from them. The wider use of high-quality, interoperable data underpins new digital health services and applications, making information easier to understand and usable across different settings and users (OECD, 2021[1]). In the 2025 OECD Health at a Glance Latin America Survey of Quality-of-Care Policies, countries were asked whether selected types of health data are available to national or subnational authorities, whether they are managed through electronic health record (EHR) systems, and whether patients can access their own data. The results show that, while many countries have established digital systems and use data for governance, quality assessment or performance purposes, patient access does not always follow.

Hospital data are available to national or subnational authorities in all participating countries, although in Argentina, Grenada and Colombia availability is limited to subnational authorities. Most countries report some form of EHR use; however, coverage varies. In Peru, EHR systems have nation-wide coverage, including across levels of care, with integration across parallel systems; while in Colombia they operate primarily at the level of individual institutions rather than as integrated national systems. Patient access remains very limited: only Costa Rica and Peru provides widespread digital access to data for patients in all levels of care, while others mainly provide access in physical form upon request.

Primary care data are generally available to public authorities across participating countries, though the level of centralisation varies. In Paraguay, information is compiled at the level of health regions rather than nationally. Several countries report nationwide administrative use of primary care data, including Argentina, Brazil, Chile, Costa Rica and Mexico. However, digital infrastructure remains uneven. In Colombia, EHR use in primary care was largely confined to Bogotá but has gradually expanded to other regions, improving interoperability. Resolution in 2025 establishes its mandatory implementation for providers. In Grenada it is available only in selected public clinics. In some countries, EHR systems operate in parallel across providers without full interoperability. This is the case for all Caribbean countries with available data. Despite the growing use of primary care data for governance and service monitoring, capacity for patient access remains limited.

Prescription medicines data show comparatively larger gaps. While a majority of countries report that authorities have access to prescribing data and that these are at least partly managed electronically, fewer countries integrate this information nationally with other levels of care or provide patients with direct access to their medication information. This represents a missed opportunity. Digital prescribing data can support pharmacovigilance, monitoring of antimicrobial use and cost control. When shared with patients, they can also reduce medication errors, improve adherence and facilitate safer transitions of care between settings.

Where hospital and primary care data are already digitally captured and used for governance and performance monitoring, extending secure digital access to patients would strengthen care continuity, support shared decision making and improve accountability. Current gaps in patient access weaken information continuity between authorities, providers and patients – particularly for people with chronic conditions. Strengthening this continuity remains an important opportunity to improve quality, efficiency and person-centred care.

Definition and comparability

Data on health data availability are drawn from the OECD Health at a Glance Latin America 2026 Survey of Quality-of-Care Policies (2025). The survey was administered online between October and December 2025 to officials of Ministries of Health in participating countries as part of the data collection for Health at a Glance Latin America and the Caribbean 2026. Twelve countries participated: Argentina, Belize, Brazil, Chile, Colombia, Costa Rica, Ecuador, Grenada, Mexico, Paraguay, Peru and Saint Lucia. Seven additional countries are included whose information was collected ad-hoc by the OECD from expert consultation and published literature. The survey collected information on the availability of selected health data sources and indicators at national and/or subnational level. For this publication, a subset of indicators was selected for reporting. Further information on the survey questionnaire, scope and methodological details is available in the readers' guide.

References

OECD (2021), *Health at a Glance 2021: OECD Indicators*, OECD Publishing, Paris, https://doi.org/10.1787/ae3016b9-en. [1]

Table 5.1. Availability of patient care information across settings 2025

Health data availability, digitalisation and patient access across hospital, primary care and prescribing settings

	Healthcare setting	Availability of health data to national or subnational authority	Are patient care data managed in an Electronic Health Record system?	Do patients have digital access to their own data?
Argentina	Hospital data	✓	✓	X
	Primary care data	X	✓	X
	Prescription medicines			X
Belize	Hospital data	✓	✓	X
	Primary care data	✓	X	X
	Prescription medicines	✓	✓	X
Brazil	Hospital data			X
	Primary care data	✓	X	X
	Prescription medicines			X
Chile	Hospital data	✓	X	X
	Primary care data	X	✓	X
	Prescription medicines	X	X	X
Colombia	Hospital data	✓	✓	X
	Primary care data	✓	✓	X
	Prescription medicines	✓	✓	X
Costa Rica	Hospital data	✓	✓	✓
	Primary care data	✓	✓	✓
	Prescription medicines	✓	✓	✓
Ecuador	Hospital data	✓	X	X
	Primary care data	✓	X	X
	Prescription medicines			X
Grenada	Hospital data	✓	✓	X
	Primary care data		✓	X
	Prescription medicines	X	X	X
México	Hospital data	✓	X	X
	Primary care data	✓	✓	X
	Prescription medicines	X	X	X
Paraguay	Hospital data	✓	✓	X
	Primary care data	✓	X	X
	Prescription medicines	✓	✓	X
Perú	Hospital data	✓	✓	✓[1]
	Primary care data	✓	✓	✓[1]
	Prescription medicines	✓	X	✓[1]
Saint Lucia	Hospital data	✓	✓	X
	Primary care data	✓	X	X
	Prescription medicines			X
Dominican Republic	Hospital data	✓		X
	Primary care data	✓		X
	Prescription medicines	✓		X
El Salvador	Hospital data	✓	✓	X
	Primary care data	✓	✓	X
	Prescription medicines	✓	✓	X
Guatemala	Hospital data	✓	✓	X
	Primary care data	✓	✓	X
	Prescription medicines	✓		X
Haiti	Hospital data	✓		X
	Primary care data	✓		X
	Prescription medicines	✓		X
Honduras	Hospital data	✓		X
	Primary care data	✓		X
	Prescription medicines	✓		X
Nicaragua	Hospital data	✓	X	X
	Primary care data	✓	X	X
	Prescription medicines	✓	X	X
Panama	Hospital data	✓	✓	X
	Primary care data	✓	✓	X
	Prescription medicines	✓	✓	X

Note: Data are based on the following questions: (i) Is patient care data available in digital form to a national authority? (ii) Is patient care data managed in a national or subnational electronic health record (EHR) system? (iii) Do patients have access to their own data, and if so, how is this access provided?. Responses cover the following care settings: all care settings, hospital data, primary care data, mortality data, prescription medicines, formal long-term care, cancer registry data and population health surveys. The figure presents a selection of these settings.[1]Peru is expanding digital citizenship in health, deploying platforms that allow patients to access their health information electronically.

Source: OECD Health at a Glance Latin America survey of quality-of-care policies, 2025.

Health data use and capacities

Robust health information systems are a cornerstone of high-performing health systems, enabling continuity of care, performance assessment and evidence-informed policymaking. The OECD has emphasised that the ability to link data across care settings and to support their secondary use is essential for monitoring quality, improving outcomes and strengthening accountability (OECD, 2023[1]). Similarly, the WHO highlights that integrated, interoperable health information systems are critical to advancing universal health coverage and driving system improvement (WHO, 2021[2]).

Figure 5.1 shows countries' ability to link patient-level data across care settings. Capacity varies widely across LAC countries. Costa Rica, Peru and Paraguay report near-comprehensive linkage across primary care, hospital, prescribing and mortality datasets, enabling tracking along the care pathway. By contrast, several other countries report only limited linkages, often restricted to hospital – mortality (Chile) or hospital – prescribing (Brazil) connections, reflecting more fragmented information systems.

Across the region, the most common linkages connect hospital data with mortality records and hospital data with prescribing data. In contrast, linkages involving primary care – particularly connections between primary care and prescribing or hospital data – are less consistently available. These gaps constrain the ability to assess continuity of care and long-term outcomes beyond the hospital setting and limit the production of accurate performance assessments that can effectively drive quality improvement.

Embedding secondary uses of health data within national legal and policy frameworks is another critical dimension of health data capacity. Figure 5.2 shows substantial cross-country variation in whether national plans, laws or strategies explicitly include secondary uses such as quality monitoring, system planning or research across different care settings. Some countries report broader formal recognition of secondary uses across multiple settings, while others indicate more limited or setting-specific provisions, often concentrated in hospital data. These differences reflect varying levels of policy development regarding the governance and strategic use of health data.

Regular use of health data for quality assessment and improvement remains uneven across the region. Eleven countries report routinely using hospital and nine countries mortality data to publish or monitor quality indicators, systematic reporting based on primary care, prescribing data, long term care or cancer registry is less common. In some cases, data may exist and even be linkable but are not yet routinely translated into publicly reported quality indicators. This suggests that data availability and linkage capacity do not automatically lead to systematic use for performance monitoring. Strengthening analytical capacity and institutional arrangements for health intelligence remains an important next step in many countries.

Definition and comparability

Data on health data availability are drawn from the OECD Health at a Glance Latin America 2026 Survey of Quality-of-Care Policies (2025). The survey was administered online between October and December 2025 to officials of Ministries of Health in participating countries as part of the data collection for Health at a Glance Latin America and the Caribbean 2026. Twelve countries participated: Argentina, Belize, Brazil, Chile, Colombia, Costa Rica, Ecuador, Grenada, Mexico, Paraguay, Peru and Saint Lucia. The survey collected information on the availability of selected health data sources and indicators at national and/or subnational level. It covered areas including cancer registry data, formal long-term care data, mortality data, population health surveys, and the methods through which patients can access their health data. For this publication, a subset of indicators was selected for reporting. Authorities form participating countries had the possibility to add well-documented additional information after the survey was completed.

Further information on the survey questionnaire, scope and methodological details is available in the readers' guide. Country responses are available upon request.

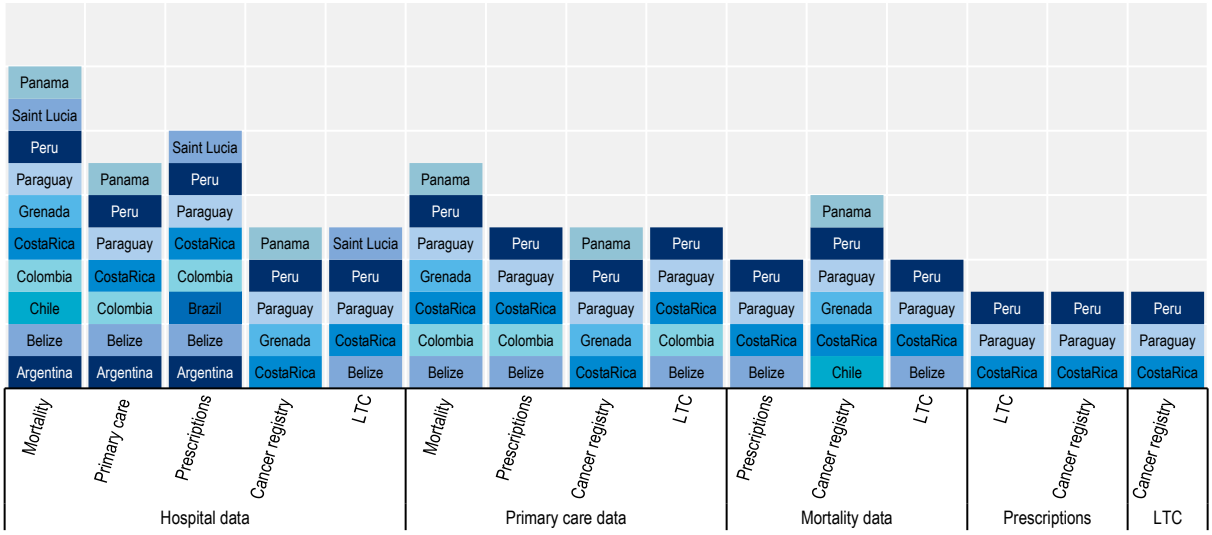
References

OECD (2023), *Health at a Glance 2023: OECD Indicators*, OECD Publishing, Paris, https://doi.org/10.1787/7a7afb35-en. [1]

WHO (2021), *Global strategy on digital health 2020-2025*, World Health Organization, https://iris.who.int/handle/10665/344249. [2]

Figure 5.1. Maturity in data linkages across care settings, 2025

Current capacity to link patient-level records across care settings for producing quality-of-care assessments

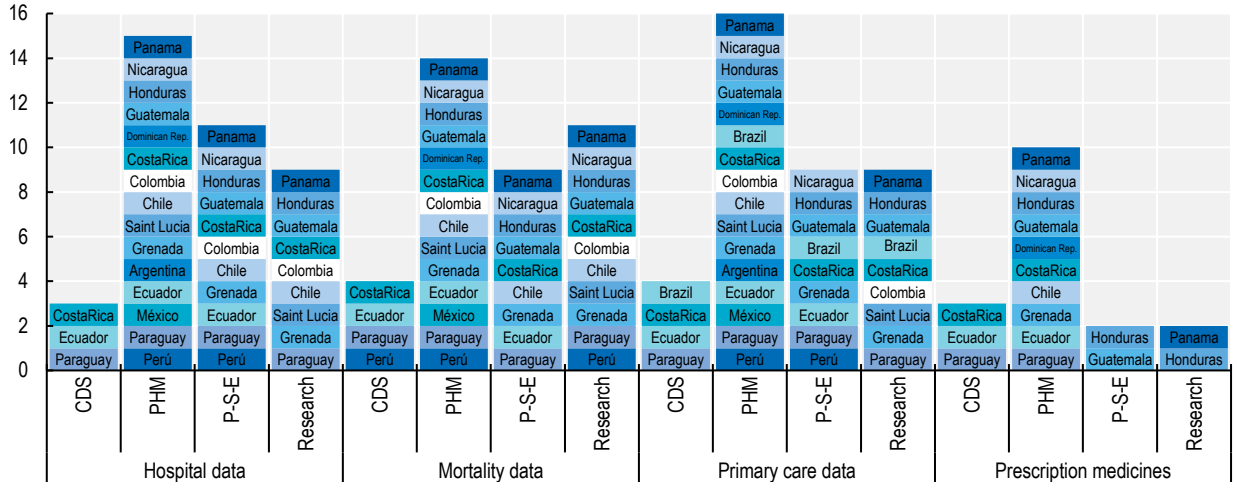


Note: The graphs maps countries' current capacity to link patient-level records across care settings for producing quality-of-care assessments.
Source: OECD Health at a Glance Latin America survey of quality-of-care policies, 2025.

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Figure 5.2. Secondary use of health data, 2025

Secondary uses of health data by care setting



Note: Responses to question <<*Does your national plan, legal framework, or policies include secondary uses of health data?*>> CDS: Clinical decision support. PHM: Population health monitoring. P-S-E: Performance, Safety and Efficiency.
Source: OECD Health at a Glance Latin America survey of quality-of-care policies, 2025.

StatLink https://stat.link/s0jgyx

Medical technologies: Radiotherapy equipment

Radiotherapy is a cornerstone of modern cancer care, used either as a curative treatment or to provide palliative relief for advanced disease. It relies on ionising radiation delivered through specialised equipment to destroy cancer cells while minimising damage to surrounding healthy tissue. Data from the International Atomic Energy Agency (IAEA) classify radiotherapy equipment into several categories reflecting different treatment technologies (WHO, 2021[1]). Photon and electron beam radiotherapy units – usually linear accelerators or cobalt-60 teletherapy machines – are the most common and form the backbone of external beam radiotherapy worldwide. Brachytherapy units deliver radiation internally through sealed radioactive sources placed inside or close to the tumour. X-ray generators provide lower-energy radiation typically used for superficial treatments, while proton and ion therapy systems represent highly specialised particle-beam technologies capable of delivering very precise radiation doses with reduced damage to surrounding tissues.

In Latin America and the Caribbean, radiotherapy infrastructure varies widely across countries, reflecting differences in health system resources (Elbanna et al., 2023[2]). Figure 5.3 shows the availability of radiotherapy equipment relative to cancer burden, measured as the number of radiotherapy units per 1 000 cancer cases. On average, LAC countries have about 1.38 radiotherapy units per 1 000 cancer cases, slightly below the OECD average of 1.45.

Availability varies widely across countries in the region. Some smaller countries report relatively high levels of equipment relative to cancer incidence, including Barbados (3.6 units per 1 000 cancer cases) and Suriname (2.7), while Uruguay (1.8) and Guyana (1.6) also exceed the OECD average. In contrast, several large countries have lower availability, including Cuba (0.66), Brazil (0.86) and Chile (0.89), while Colombia, Peru, Honduras and Nicaragua report around one unit per 1 000 cancer cases. The composition of radiotherapy equipment also differs across regions. In LAC, photon and electron beam units account for about 1.05 units per 1 000 cancer cases, compared with 1.17 in OECD countries, while brachytherapy availability is slightly higher in LAC (0.32) than in the OECD (0.24). Proton or ion therapy systems (0.01 per 1 000 cancer cases) are present in OECD countries but not reported in LAC, indicating more limited access to advanced radiotherapy technologies in the region (Figure 5.4).

While some countries have expanded access to modern external beam technologies, radiotherapy equipment remains highly concentrated in major cities in many LAC countries, creating geographical disparities in access to treatment. On average, about 62% of radiotherapy units are located in the capital city and 69% in the two largest cities, compared with 25% and 40% respectively in OECD countries (Figure 5.4).

Other medical technologies, including computed tomography (CT) scanners, magnetic resonance imaging (MRI) units and mammography equipment, are essential for diagnosing diseases and detecting conditions such as cancer at earlier stages. Internationally comparable and up-to-date data on their availability in LAC remain limited, with the most recent comprehensive source being the WHO Global Atlas of Medical Devices 2022, used in Health at a Glance: Latin America and the Caribbean 2023 (OECD/The World Bank, 2023[3]). Improving monitoring of these technologies is important as demand for diagnostic imaging grows and investment in capital-intensive equipment expands across the region.

Definition and comparability

The indicator measures the availability of radiotherapy equipment relative to cancer burden, expressed as the number of radiotherapy units per 1 000 new cancer cases. The denominator is based on estimated cancer incidence in 2022 from the Global Cancer Observatory (GLOBOCAN), produced by the International Agency for Research on Cancer (IARC). Data on radiotherapy equipment are drawn from the Directory of Radiotherapy Centres (DIRAC) maintained by the International Atomic Energy Agency (IAEA), which compiles information on radiotherapy facilities and equipment worldwide. Comparability across countries may be affected by differences in reporting completeness in the DIRAC database, as some facilities may not report their equipment or update their information regularly.

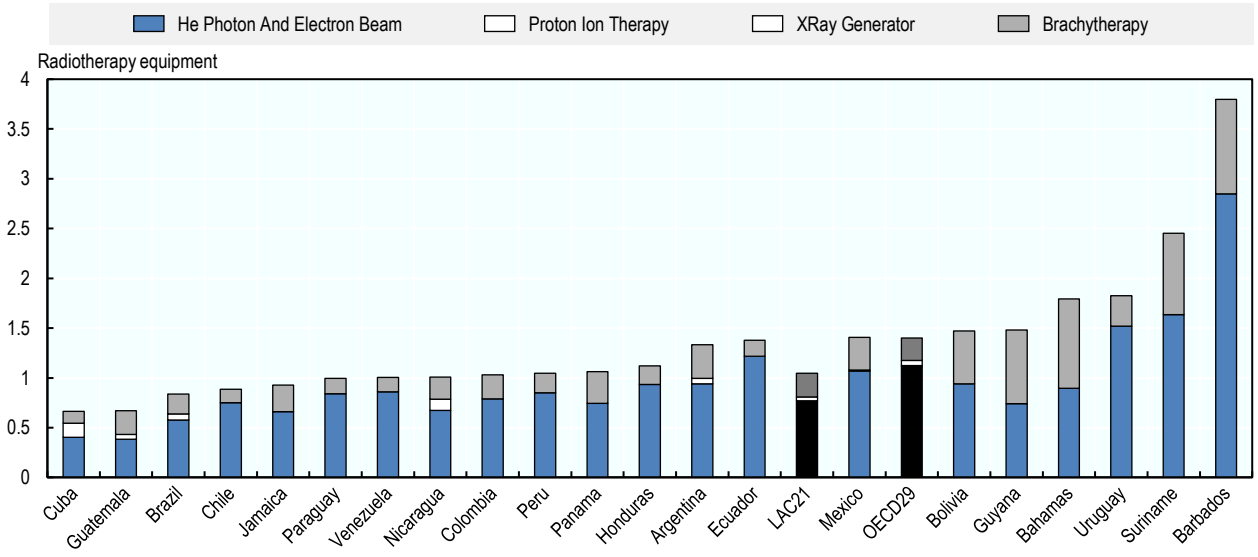
References

Elbanna, M. et al. (2023), “Radiotherapy resources in Latin America and the Caribbean: a review of current and projected needs based on International Atomic Energy Agency data”, *The Lancet Oncology*, Vol. 24/9, pp. e376-e384, https://doi.org/10.1016/s1470-2045(23)00299-1. [2]

OECD/The World Bank (2023), *Health at a Glance: Latin America and the Caribbean 2023*, OECD Publishing, Paris, https://doi.org/10.1787/532b0e2d-en. [3]

WHO (2021), *Technical specifications of radiotherapy equipment for cancer treatment*, World Health Organization, https://iris.who.int/handle/10665/339912. [1]

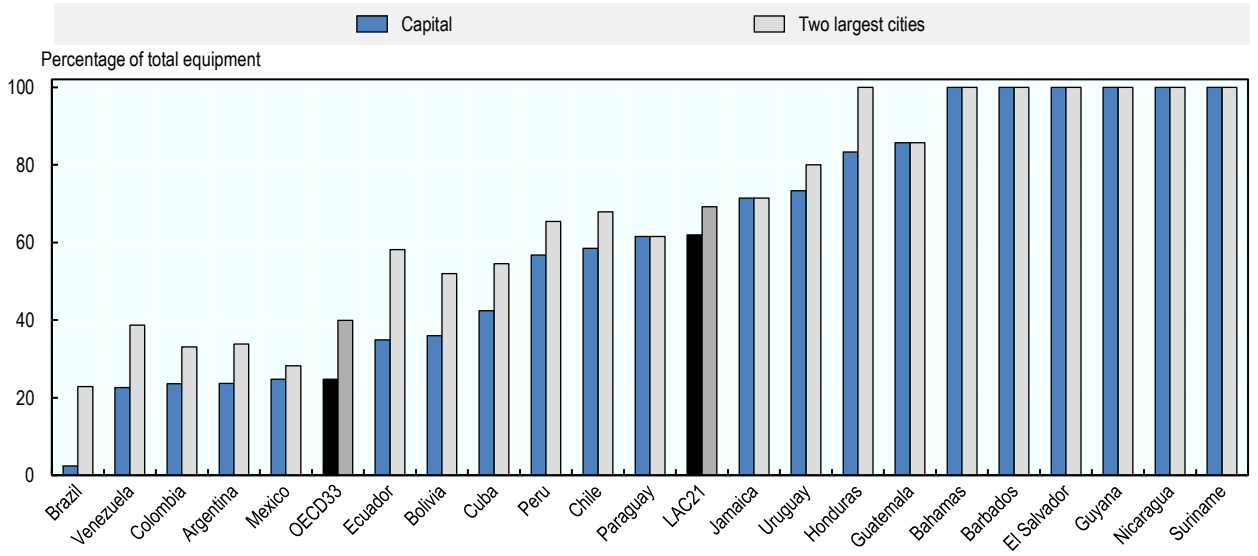
Figure 5.3. Radiotherapy equipment per 1000 cancer cases, 2024 or latest year available



Note: The latest available data on radiotherapy equipment for LAC and OECD countries refer to different years between 2021 and 2025. As a result, some distortion may arise due to mismatches between the year of equipment counts and the reference year for cancer incidence estimates (2024).
Source: Estimated cancer incidence in 2024 from the Global Cancer Observatory. Radiotherapy equipment from the Directory of Radiotherapy Centres (DIRAC) maintained by the International Atomic Energy Agency.

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Figure 5.4. Proportion of radiotherapy equipment located in the country's capital or two major cities. Latest available



Note: The latest available data on radiotherapy equipment for LAC and OECD countries refer to different years between 2021 and 2025.
Source: Radiotherapy equipment from the Directory of Radiotherapy Centres (DIRAC) maintained by the International Atomic Energy Agency.

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Hospital care

Hospitals represent a major component of health system infrastructure and account for a large share of capital investment in most countries. The availability of hospital beds provides an indication of the resources available to deliver inpatient care. However, higher bed supply is often associated with higher admission rates, a phenomenon known as Roemer's Law, which states that "a built bed is a filled bed". Ensuring that hospital resources are used efficiently and that access to inpatient care is well co-ordinated is therefore essential. Increasing the number of hospital beds or hospital stays does not necessarily improve population health outcomes and may lead to inefficiencies if hospital care substitutes for more appropriate outpatient or community-based services.

The availability of hospital beds provides an indication of the resources available to deliver inpatient services. Across LAC countries, the number of hospital beds remains well below the OECD average Figure 5.5. On average, LAC countries have 22.6 hospital beds per 10 000 population, compared with 42.0 beds per 10 000 population across OECD countries. However, bed availability varies widely across the region. Barbados reports the highest density, with about 64 beds per 10 000 population, followed by Haiti and Cuba with around 40-50 beds per 10 000 population. At the other end of the distribution, Guatemala has fewer than 5 beds per 10 000 population, while Honduras, Nicaragua and Mexico also report relatively low levels of hospital bed availability. These large disparities reflect differences in investment in hospital infrastructure, as well as variations in the organisation of care and the role hospitals play within national health systems. The availability of beds for psychiatric care is also substantially lower in LAC than in OECD countries. On average, OECD countries report about 6.2 psychiatric beds per 10 000 population (Figure 5.5). In contrast, the availability of psychiatric beds in the LAC countries with available data is much lower. Mexico reports around 0.3 beds per 10 000 population, while Ecuador, Costa Rica, Chile and Colombia report between 0.4 and 1.7 beds per 10 000 population. Argentina shows the highest availability among the countries with available data, with around 4.9 beds per 10 000 population. These figures highlight the relatively limited capacity for inpatient mental health care across much of the region.

Hospital discharge rates provide an indication of the use of inpatient services. Across nine LAC countries with available data, hospital discharge rates average about 5 543 discharges per 100 000 population, considerably lower than the OECD average of about 13 797 per 100 000 population (Figure 5.6). Within the region, discharge rates vary substantially. Uruguay and Chile report the highest levels, with around 9 300 and 8 300 discharges per 100 000 population, respectively, followed by Brazil with around 6 450 discharges per 100 000 population. At the lower end, Argentina and Mexico report fewer than 3 700 discharges per 100 000 population. In general, countries with greater hospital bed availability tend to have higher discharge rates and vice versa, although differences in admission practices, health system organisation and access to inpatient care also play an important role.

In eleven LAC countries with available data, the average length of stay (ALOS) in hospitals is about 5.7 days, shorter than the OECD average of 7.9 days (Figure 5.6). The longest stays are observed in Costa Rica, with about 7.1 days on average, followed by Panama (6.7 days) and Chile (6.1 days). The shortest stays are recorded in Ecuador (4.5 days) and Mexico (4.7 days). The ALOS reflects patterns of hospital use and efficiency, but it should be interpreted with caution. Shorter stays may indicate more efficient care and a shift towards outpatient or post-acute care settings, reducing the cost per discharge. However, excessively short stays may also indicate premature discharge, while longer stays may reflect delays in discharge due to limited availability of rehabilitation or long-term care services. Conversely, longer stays can sometimes reflect greater patient complexity or differences in clinical practice (Rojas-García et al., 2017[1]).

Definition and comparability

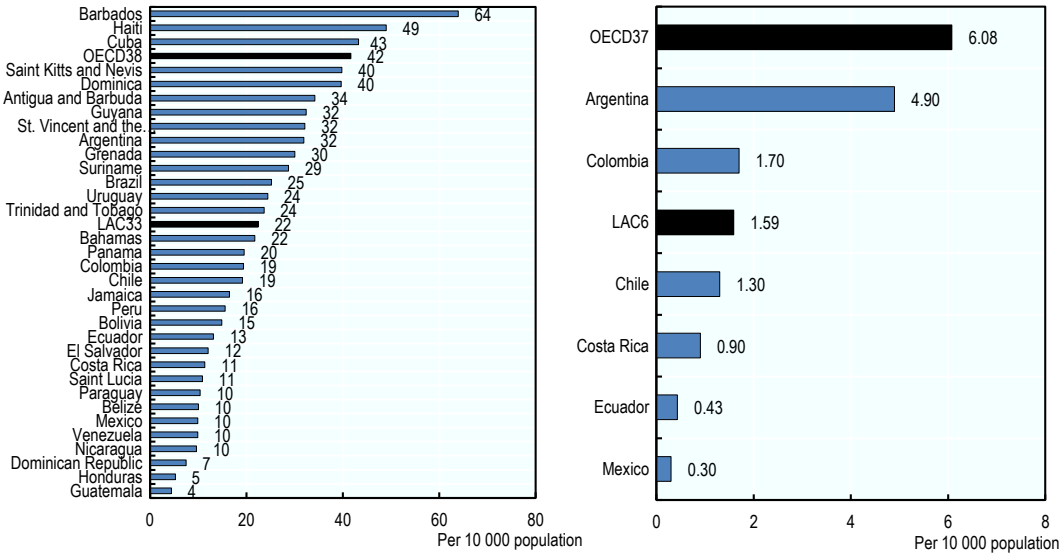
All hospital beds include those for acute care and chronic/long-term care, in both the public and private sectors. A discharge is defined as the release of a patient who has stayed at least one night in hospital. It includes deaths in hospital following inpatient care but usually excludes same-day separations. The discharge rates presented are not age-standardised, not considering differences in the age structure of the population across countries. The figures reported for ALOS refer to the number of days patients spend overnight in an acute-care inpatient institution. ALOS is generally measured by dividing the total number of days stayed by all patients in acute-care inpatient institutions during a year by the number of admissions or discharges. There are considerable variations in how countries define acute care, and what they include or exclude in reported statistics. For the most part, discharges and ALOS data in the LAC region cover only public sector institutions.

References

Rojas-García, A. et al. (2017), "Impact and experiences of delayed discharge: A mixed-studies systematic review", *Health Expectations*, Vol. 21/1, pp. 41-56, https://doi.org/10.1111/hex.12619. [1]

Figure 5.5. Total hospital beds and beds for psychiatric care

Total hospital beds (left panel) and beds for psychiatric care (right panel) per 10 000 population, 2024 or latest year available

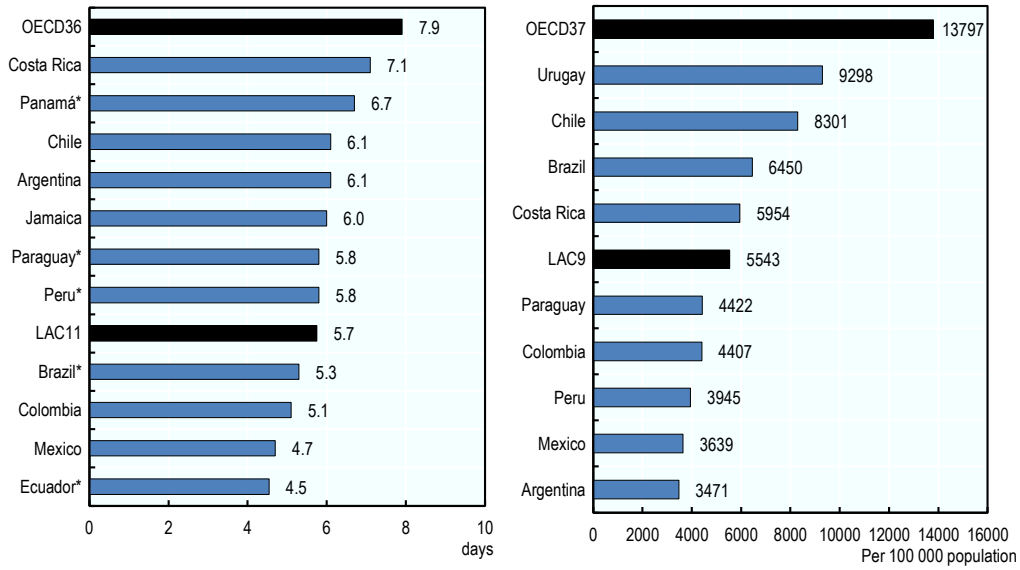


Note: Psychiatric beds in Costa Rica is an estimated value. For Argentina, the figure reflects only discharges from establishments of the official sector (national, provincial or municipal dependency); other sectors are not included.
Source: WHO GHO 2025, OECD Health Statistics 2026 and OECD Health at a Glance: Latin America and the Caribbean Questionnaire for psychiatric beds in Ecuador.

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Figure 5.6. Hospital discharges and average length of stay for acute care in hospitals, latest year available

Average length of in-patient stay (left panel) and hospital discharges per 100 000 population (right panel), 2024 or latest



Note: *Country can't discriminate between curative and other type of admission for the calculation of average length of in-patient stay. Panama only includes hospitals in the Caja de Seguro Social. Peru only includes hospital of EsSalud (22.6% of the population in 2023) for length of stay estimation. UN Population statistics for population counts. For hospital discharges, Paraguay data are derived from the Ministerio de Salud Pública y Bienestar Social hospital discharge form and cover only institutions directly dependent on the MSPBS, representing an estimated 59% of the population and not the entire national health system. Peru discharge data cover only hospitals directly dependent on the Ministry of Health, representing an estimated 65% of the population. Brazil reports hospitalisations rather than discharges. Data from Panama, Urugay, Peru and Brazil come from public national sources and their exact specifications could not be fully validated against OECD definitions and standards.
Source: OECD Health Statistics 2025, OECD Health at a Glance: Latin America and the Caribbean Questionnaire and national sources.

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Pregnancy and birth

Maternal and newborn health benefit from adequate antenatal care and safe delivery services, including care provided by skilled health professionals and access to health facilities for childbirth, which help reduce the risk of complications and infections (see also indicators on family planning and infant and young child feeding in Chapter 4) (Measure Evaluation, 2019[1]). Reflecting their importance, Sustainable Development Goal (SDG) 3.7 calls for universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes by 2030.

In LAC countries, most pregnant women receive the recommended minimum of four antenatal care visits, although coverage varies substantially across countries. On average, 86% of women in LAC receive at least four antenatal visits, compared with 93% across OECD countries. Coverage is particularly high in several countries including Uruguay and Puerto Rico (98%), Peru and Guyana (95%), and Brazil, Costa Rica and Trinidad and Tobago (94%), Mexico and Saint Lucia (90%), the Bahamas and Nicaragua (92%), and the Dominican Republic and Belize (93%). Moreover, some countries place low importance in collecting these indicators given that it has been high for many years and is considered a completed goal. This is the case for several OECD countries. However, coverage remains considerably lower in some parts of the region. Grenada (55%), Saint Kitts and Nevis (59%), Haiti (67%) and Suriname (68%) report the lowest levels, suggesting important gaps in access to maternal health services (Figure 5.7).

Most births in LAC are attended by skilled health professionals such as doctors, nurses or midwives, and the vast majority occur in health facilities, indicating that safe delivery care is now nearly universal across much of the region (Figure 5.8). Coverage of births attended by skilled personnel is close to 100% in many countries, including Chile, Cuba, Uruguay and several Caribbean countries, and reaches 98-99% in Argentina, Brazil, Colombia, Costa Rica and the Dominican Republic. Coverage remains somewhat lower in Ecuador (96%), Peru and Belize (95%), Honduras (94%) and Panama (93%), and particularly in Paraguay (91%), Mexico (88%) and Bolivia (72%) (Figure 5.8 – left panel). Similarly, most deliveries take place in health facilities, with levels around 99-100% in countries such as Chile, Cuba, Uruguay, Brazil and Costa Rica. Lower rates are observed in Panama, Honduras and Belize (around 92%), and especially in Guatemala (71%) and Haiti (67%), where a larger share of births still occur outside formal health facilities (Figure 5.8 – right panel).

In many OECD countries, the share of facility births is no longer systematically monitored because home births increasingly reflect parental choice rather than lack of access to care, often occurring with trained midwives and appropriate referral systems. By contrast, where facility delivery remains incomplete, births outside health facilities may still signal barriers to access to skilled care. Overall, the high coverage observed across most LAC countries suggests that access to professional delivery care has largely become a standard component of maternal services. As coverage approaches universality in many countries, the indicator becomes less informative for distinguishing health system performance. While it remains important to monitor to ensure continued access to safe delivery care, future assessments of maternal care quality in the region may increasingly rely on more nuanced indicators of quality and outcomes during childbirth.

Definition and comparability

Antenatal care coverage – at least four visits (%) measures the percentage of women aged 15-49 with a live birth who received antenatal care four or more times during pregnancy. Births attended by skilled health personnel measures the percentage of live births assisted by trained professionals such as doctors, nurses or midwives who can manage normal deliveries and recognise or refer complications. Births delivered in a health facility measures the percentage of live births occurring in recognised health facilities, including hospitals, clinics and maternity centres.

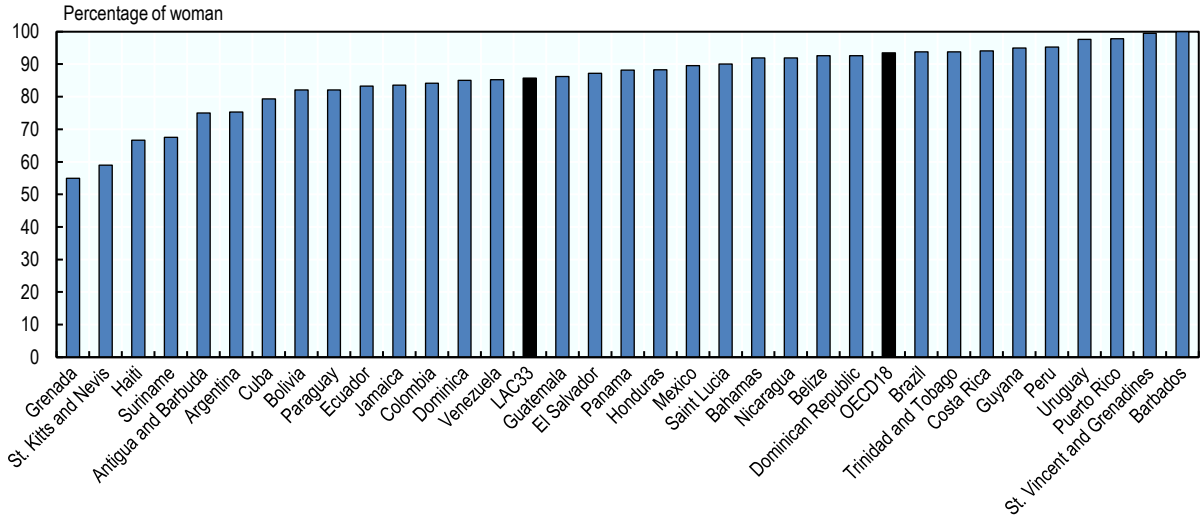
Estimates are primarily derived from nationally representative household surveys, such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), based on women's reports of recent births. In some countries, routine health information systems or civil registration data may also be used where reporting coverage is high. Cross-country comparability may be affected by differences in survey timing and methodology, the classification of health facilities or skilled personnel, and potential recall bias in survey responses.

References

Measure Evaluation (2019), *Indicator Compedium - Antenatal Care Coverage*, https://www.measureevaluation.org/rbf/indicator-collections/service-use-and-coverage-indicators/antenatal-care-coverage. [1]

Figure 5.7. Antenatal care coverage: at least four visits, 2024 or latest year available

Percentage of women aged 15-49 who had a live birth and received antenatal care four or more times during pregnancy

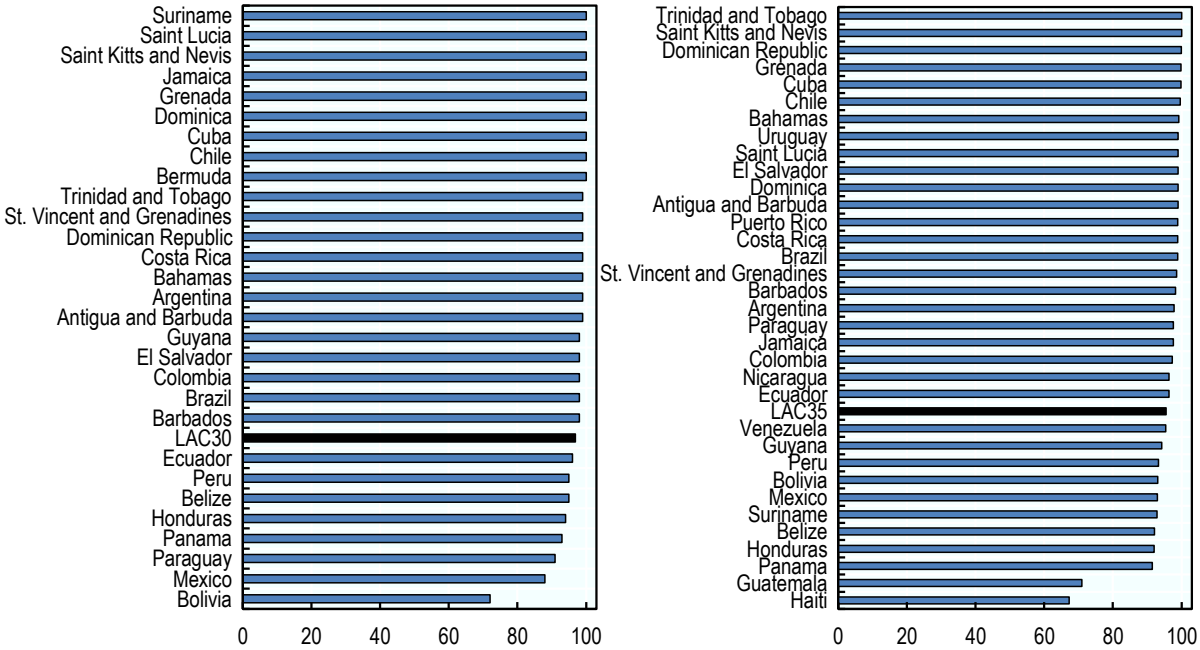


Source: WHO GHO 2025.

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Figure 5.8. Births attended by skilled health personnel and births delivered in a health facility, 2024 or latest year available

Percentage of births attended by skilled health personnel (left panel) and births delivered in a health facility (right panel), out of total live births



Source: WHO GHO 2025.

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Child healthcare

In the LAC region, infectious diseases such as diarrhoea and pneumonia remain important causes of illness and death among children under five, even though effective and widely recognised treatments are available (PAHO, 2017[1]) Health systems can greatly reduce these risks by ensuring timely access to basic child health services, including appropriate home management and care provided by trained health professionals. Recommended interventions – such as oral rehydration therapy (ORT) for diarrhoea, vaccination, zinc and vitamin A supplementation, and appropriate antibiotic treatment for acute respiratory infections – are low-cost, well established and widely promoted in primary healthcare. As a result, the extent to which children receive these treatments or caregivers seek professional advice when illness occurs provides an indication of access to and use of essential health services, as well as the availability of basic resources and information for caregivers.

ORT combined with continued feeding is a simple and effective treatment for childhood diarrhoea, helping prevent dehydration and reducing mortality among children under five. However, the use of this recommended treatment varies widely across LAC countries. On average, 46% of children with diarrhoea in LAC receive oral rehydration therapy and continued feeding, although coverage ranges from around one-third in Argentina and Cuba (33%) and Guyana (37%) to over half in the Dominican Republic (54%), Honduras and Trinidad and Tobago (52%), and 61% in Peru. In El Salvador, coverage (only ORT) is around 70-75% in rural and urban areas. Important differences between rural and urban areas are also observed in several countries, such as Cuba, Jamaica and Peru (Figure 5.9).

Seeking advice or treatment from a health facility or provider is an important step in the timely management of childhood diarrhoea, particularly when symptoms become severe. Across the LAC countries with available data, around 30% of caregivers receive care from a health provider when a child under five has diarrhoea. Rates vary substantially across countries, ranging from 25% in Trinidad and Tobago and 32% in Jamaica to 45% in Guyana and 51% in Honduras, and over half in Cuba, Argentina and the Dominican Republic (around 53-57%). In some countries, differences between boys and girls are observed, although these variations are generally small. The relatively low levels of care-seeking in several countries suggest that many cases of childhood diarrhoea are managed at home without professional guidance, underscoring the importance of caregiver knowledge and access to primary care services.

Care-seeking from a health facility or provider is essential for the timely diagnosis and treatment of acute respiratory infections (ARI), which remain a leading cause of illness and death among young children. Across LAC countries with available data, the share of children under five with ARI symptoms for whom advice or treatment was sought from a health professional varies widely. Care-seeking is very high in Argentina (94%) and Cuba (90%) and remains above 80% in the Dominican Republic (85%) and Guyana (84%). Lower levels are observed in Honduras (70%), and particularly in El Salvador (61%) and Peru (59%). In the case of Peru, this is by design, as their integrated care model encourages care resolution in the familiar and community setting with supervising support of the primary level. Differences between rural and urban areas are generally modest in the countries with available data, although rural levels are slightly higher in some cases such as Guyana and El Salvador (Figure 5.10). It is important to stress the relevance of rational antibiotic use, both due to the health implications of antimicrobial resistance development and as a source of waste in health systems (OECD/The World Bank, 2020[2]).

Definition and comparability

Three indicators are used to assess access to and use of essential services for the management of common childhood illnesses. Oral rehydration therapy (ORT) and continued feeding for diarrhoea measures the percentage of children under age five who had diarrhoea in the reference period and received oral rehydration salts (ORS), recommended home fluids or increased fluids, together with continued feeding. Care-seeking for diarrhoea measures the percentage of children under age five with diarrhoea for whom advice or treatment was sought from a health facility or health provider. Care-seeking for symptoms of acute respiratory infection (ARI) measures the percentage of children under age five with symptoms consistent with ARI (such as cough accompanied by rapid or difficult breathing) for whom advice or treatment was sought from a health facility or provider. Estimates are primarily derived from nationally representative household surveys, including Demographic and Health Surveys, Multiple Indicator Cluster Surveys and similar programmes, based on caregiver reports of illness episodes among children in the two weeks preceding the survey.

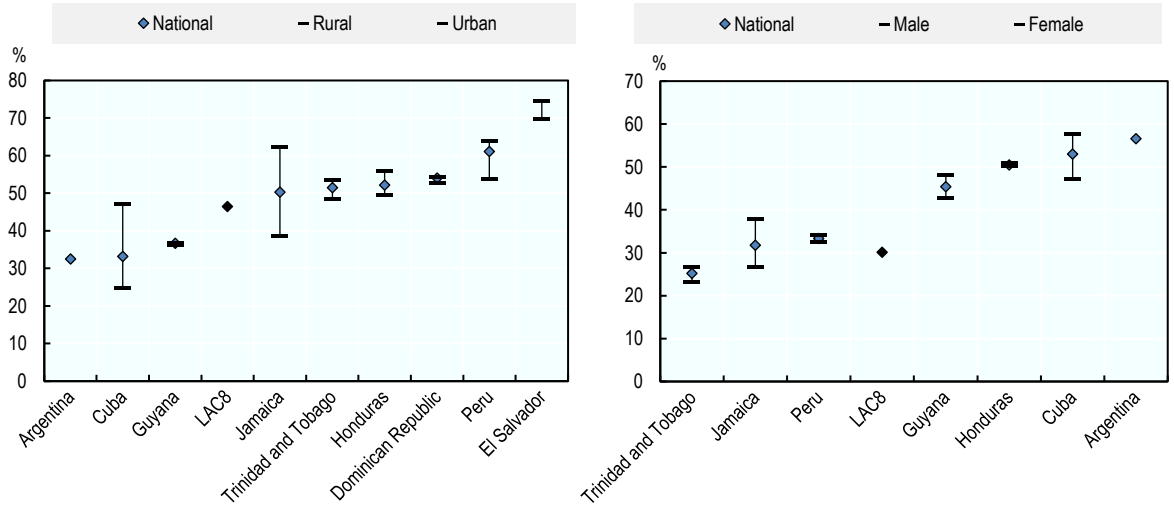
References

OECD/The World Bank (2020), *Health at a Glance: Latin America and the Caribbean 2020*, OECD Publishing, Paris, https://doi.org/10.1787/6089164f-en. [2]

PAHO (2017), *Health in the Americas+, 2017 Edition. Summary: Regional Outlook and Country Profiles*, Pan American Health Organization, Washington, D.C., https://www.paho.org/salud-en-las-americas-2017/wp-content/uploads/2017/09/Print-Version-English.pdf (accessed on 27 September 2019). [1]

Figure 5.9. Children (under age 5) who had diarrhoea and received oral rehydration therapy and those seen in a health facility, 2023 or latest year available

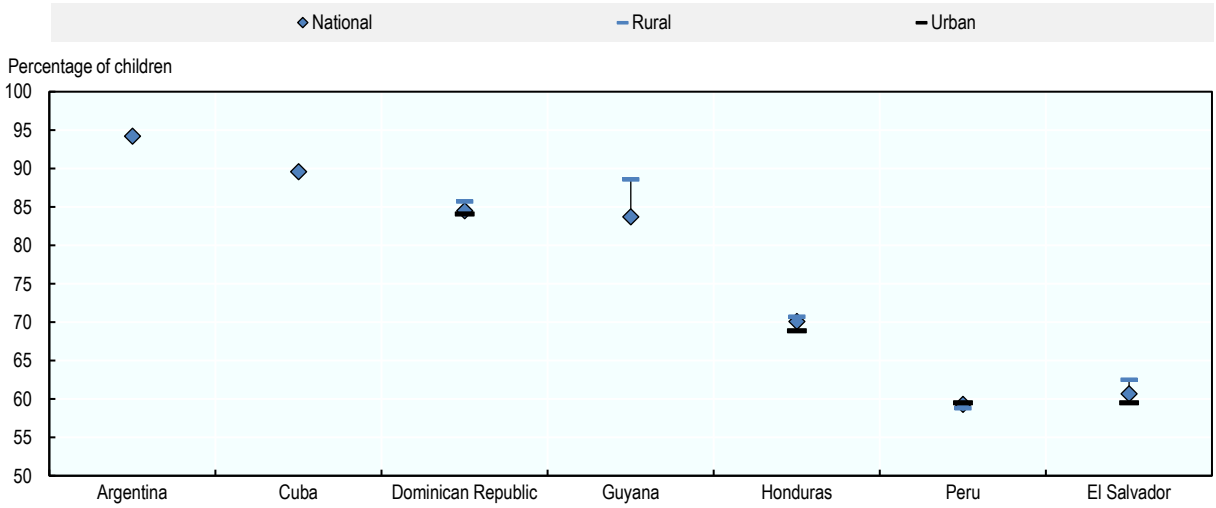
Left panel: Percentage of children (under age 5) who had diarrhoea and received oral rehydration therapy and continued feeding. Right Panel: Percentage of children (under age five) with diarrhoea for whom advice or treatment was sought from a health facility or provider



Note: Oral rehydration therapy corresponds to: Oral rehydration salts OR recommended homemade fluids OR increased fluids. El Salvador only considers children with diarrhoea who are given oral rehydration therapy.
Source: UNICEF Child Health Coverage Database 2025.

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Figure 5.10. Children under age 5 with acute respiratory infection symptoms whom advice or treatment was sought from a health facility or provider, 2023 or latest year available



Source: UNICEF Child Health Coverage Database 2025.

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6 Health expenditure and financing

Health expenditure per capita and in relation to GDP

The level and trend of health spending in a country can be explained by demographic, social and economic factors, as well as by the financing and organisational arrangements of the health system. In 2024, on average, current health spending per capita in OECD countries was almost four times that of LAC countries, at USD PPP 6 097 compared with USD PPP 1 518. In 2024, or the latest available year, per capita health expenditure ranged from about USD PPP 105 in Haiti to USD PPP 4 003 in Chile, with Panama, Uruguay and Argentina also spending above USD PPP 3 000 per person. Cuba, the Bahamas, Brazil and Trinidad and Tobago also reported spending above USD PPP 2 000 per person. On average across LAC33, government and compulsory insurance schemes accounted for about 60% of health spending, or USD PPP 905 per capita, while voluntary schemes and out-of-pocket payments accounted for the remaining 40%, or USD PPP 613 per capita. By contrast, government and compulsory insurance schemes financed around 77% of health spending in OECD countries (Figure 6.1 – left panel).

In 2024, current health expenditure accounted for 6.5% of GDP in LAC33, an increase of 0.33 percentage points (p.p.) since 2014, compared with an OECD average of 9.3% of GDP, up 0.60 p.p. (Figure 6.1 – right panel). The gap in health spending as a share of GDP between LAC and OECD countries has therefore widened slightly. Health spending exceeded 10% of GDP in Chile and Argentina, while Brazil, Cuba, El Salvador and Uruguay were also among the highest-spending countries in relative terms. At the other end of the range, health spending accounted for less than 4% of GDP in Guyana, Haiti, Venezuela and Antigua and Barbuda. Between 2014 and the latest available year, the health share of GDP fell most sharply in Cuba, Guyana, Antigua and Barbuda and Haiti, while it rose by more than 2 p.p. in Chile and Trinidad and Tobago, and by more than 1.5 p.p. in Paraguay.

Overall health spending growth and economic performance shape how much countries spend on healthcare over time. Between 2019 and 2024, real per capita health spending in LAC33 grew by 1.7% per year on average, broadly in line with real GDP per capita growth (Figure 6.2). This contrasts with OECD countries, where real health spending grew faster than GDP, at 2.7% versus 1.1% per year. In LAC, real health spending increased most rapidly in Guyana, Paraguay, Guatemala, the Dominican Republic and Panama, where average annual growth exceeded 5%. In Paraguay, health spending growth clearly outpaced economic growth, while in Panama and the Dominican Republic it accompanied relatively strong GDP growth. By contrast, Haiti, Suriname, Cuba, Dominica, Antigua and Barbuda and Venezuela recorded negative real health spending growth, indicating a contraction in the real purchasing power of health systems. Guyana remains a clear outlier, with very rapid growth in both health spending and GDP, reflecting the impact of recent oil-sector developments.

On average, health capital expenditure represented 0.3% of GDP across LAC29, compared with 0.4% across OECD countries (Figure 6.2). In 2023, Panama, Bolivia, Guyana and Nicaragua reported the highest levels of health capital expenditure, at between 0.6% and 0.9% of GDP. By contrast, capital spending was below 0.1% in eight countries.

Definition and comparability

Health expenditure is given by the sum of expenditure on total healthcare services, medical goods dispensed to outpatient, public health services, health administration, and health insurance, by nationals in the country or abroad. Imports for final use are included, and exports for final use are excluded.

Healthcare financing can be analysed from the point of view of financing schemes, financing agents, and types of revenues. Health financing schemes are defined in the System of Health Accounts (OECD/Eurostat/WHO, 2017[1]) and include government schemes, compulsory health insurance, voluntary health insurance, and private funds such as households' out-of-pocket payments, NGOs, and private corporations. Out-of-pocket payments are expenditures borne directly by patients and include cost-sharing arrangements and any informal payments to healthcare providers. The economy-wide (GDP) PPPs are used as the most available conversion rates.

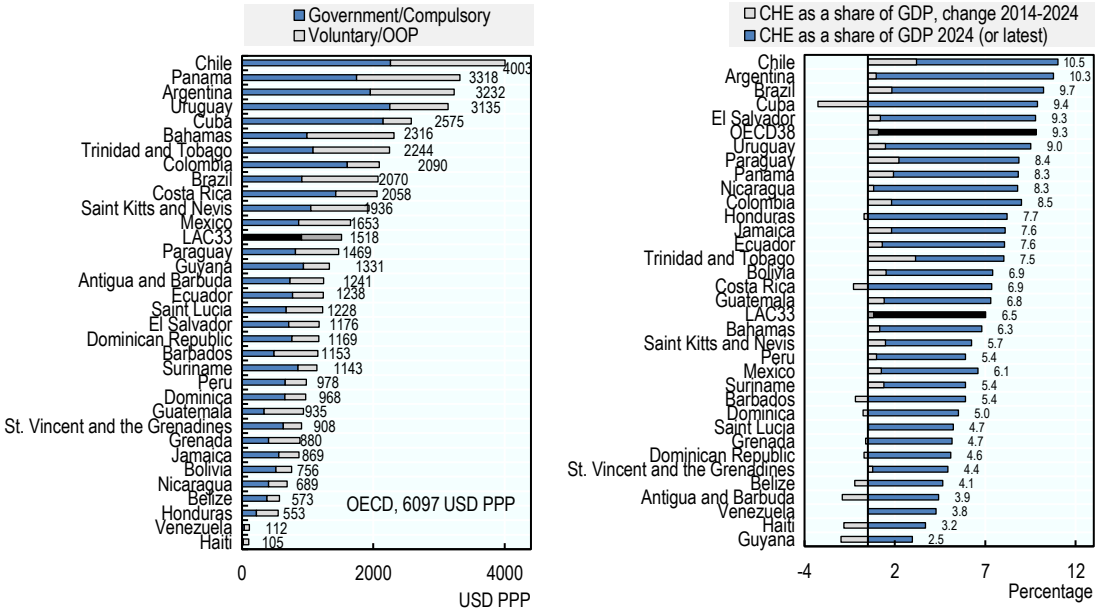
Gross fixed capital formation in the health sector is measured by the total value of the fixed assets that health providers have acquired during the accounting period (minus the value of the disposals of assets) and that are used repeatedly or continuously for more than one year in the production of health services. Gross fixed capital formation is reported by many countries under the System of Health Accounts.

References

OECD/Eurostat/WHO (2017), *A System of Health Accounts 2011: Revised edition*, OECD Publishing, Paris, https://doi.org/10.1787/9789264270985-en. [1]

Figure 6.1. Total expenditure on health per capita in 2024 and change in total expenditure on health as a share of GDP since 2014

Left panel: Total health expenditure per capita (current USD PPP), 2024. Right Panel: Change in total expenditure on health as a share of GDP, 2014-2024 (or latest available)

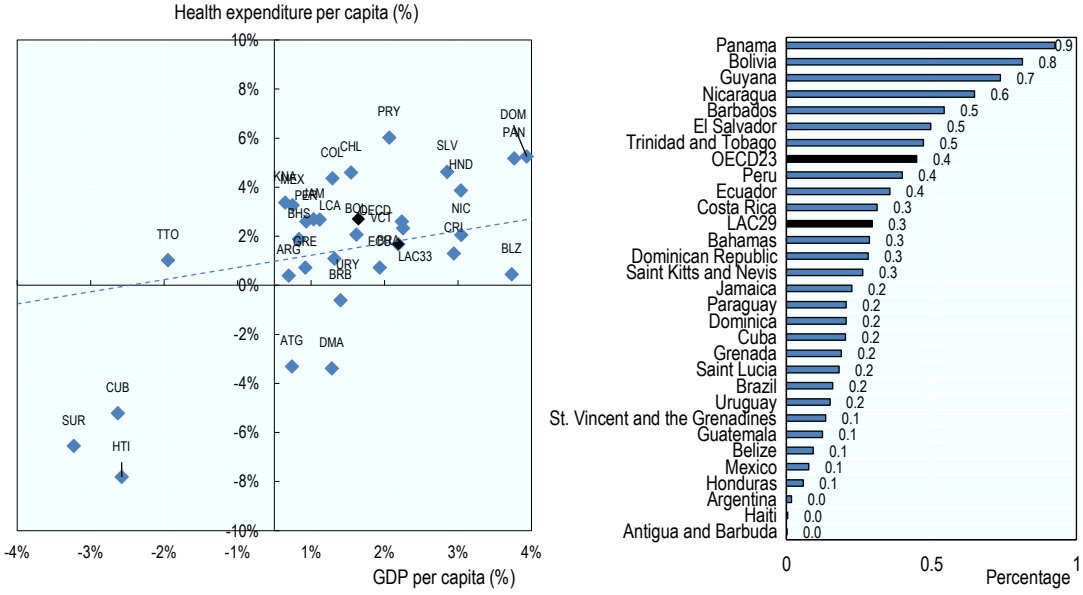


Note: Figures in 2024 international USD PPP. CHE as a share of GDP change 2014-2024 expressed in p.p.
Source: WHO Global Health Expenditure Database 2025; OECD Health Statistics 2025 for OECD countries.

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Figure 6.2. Figure 2 Growth rate in health spending and GDP per capita, and Health Capital Expenditure as percentage GDP

Left panel: Average growth rate (in real terms) in health spending and GDP per capita, 2019-2024 or latest 5-year span. Right panel: Health Capital Expenditure as percentage GDP, 2023



Note: Left Panel: Venezuela (-2.2%,-10.5%) and Guyana (14.8%,31.7%) were excluded from the graph for being outliers.
Source: WHO Global Health Expenditure Database 2025; OECD Data explorer for OECD countries.

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Financing of healthcare from government and compulsory health insurance schemes

Health system financing arrangements can be broadly classified according to their compulsory or voluntary nature. Countries that predominantly finance healthcare through government schemes provide care coverage to individuals based on their residency. In other cases, systems that are financed with compulsory health insurance schemes (either through public or private entities) linked to the payment of social contributions or health insurance premiums, provide care coverage based on affiliation. In addition to these, a varying proportion of healthcare spending consists of households' out-of-pocket payments – either as standalone payments or as part of co-payment arrangements – as well as various forms of voluntary payment schemes such as voluntary health insurance. In the LAC region, substantial fragmentation in health systems often leads to coexisting financing schemes and in some cases, overlap. There is substantial heterogeneity in financing arrangements in LAC, where most standard models of public financing exist in the region (Lorenzoni et al., 2019[1]).

Figure 6.3 reports health expenditure financed by government and compulsory health insurance schemes as a share of GDP in 2024 (or the latest available year), the COVID-19 peak in 2021 and in 2015. Cuba continued to allocate the highest share of GDP to public health spending, at 7.8%, despite a marked fall from 12.6% in 2021. Haiti remained at the bottom, at 0.6%, while Guyana and Venezuela were also below 2% of GDP. On average, public health expenditure in LAC was broadly unchanged between 2015 and 2024, at around 3.8% of GDP, after rising temporarily to 4.5% in 2021. By contrast, the OECD average increased from 6.5% of GDP in 2015 to 7.0% in 2024, implying a wider gap with LAC. Spending generally surged during the pandemic and then fell back, although in some countries – including Paraguay, Jamaica, Saint Kitts and Nevis, Uruguay and Chile – public health spending efforts remained clearly above pre-COVID levels.

Government and compulsory health insurance schemes remained the main source of health financing in 2024, accounting for 57% of current health expenditure on average in LAC (Figure 6.4). This remains well below the OECD average of 75%. Higher shares indicate that a larger part of health spending is financed through compulsory, pooled schemes rather than voluntary or out-of-pocket payments, and therefore signal broader baseline coverage of health needs. Between 2015 and 2024, the regional average increased only slightly, from 56% to 57%, leaving the gap with the OECD average virtually unchanged. In 2024, only Cuba and Colombia reached or exceeded the OECD average, while Suriname, Uruguay, Costa Rica and Guyana were also among the countries with the highest compulsory financing shares. At the other end of the range, Haiti, Venezuela, Guatemala and Honduras continued to rely much more heavily on voluntary and out-of-pocket spending. The largest increases since 2015 were observed in Saint Kitts and Nevis, Guyana, Saint Lucia, Jamaica and Suriname, while Panama, Cuba, Argentina and Barbados recorded the largest declines. In Colombia's case, relatively favourable indicators of financial protection in the region should not be interpreted as a comprehensive assessment of the health system's performance. Persistent challenges remain in financial sustainability, effective access, territorial inequalities, and the timeliness of service delivery.

Several factors – including the type of system in place, the available fiscal space, and the policy and political priority given to health – determine the size of public funds allocated to health. Relative budget priorities may also shift from year to year as a result of political decision making and economic conditions. In 2024, health expenditure by government and compulsory insurance schemes represented 13.2% of total government expenditure in LAC, compared with 15.5% in OECD countries (Figure 6.5). Costa Rica devoted the largest share of its public budget to health, at 24.9%, followed by Paraguay, Uruguay, Cuba and Panama, all close to or above 20%. At the other end of the spectrum, Venezuela, Haiti, Dominica, Saint Kitts and Nevis, Grenada, Guyana, Barbados and Saint Vincent and the Grenadines allocated less than 8% of government expenditure to health. Between 2015 and 2024, the regional average remained almost unchanged, while the OECD average increased modestly. The largest increases in the region were observed in Paraguay, Chile, Jamaica, Trinidad and Tobago, Peru and Bolivia, while the largest declines were recorded in Dominica, Costa Rica and Guyana (Figure 6.5).

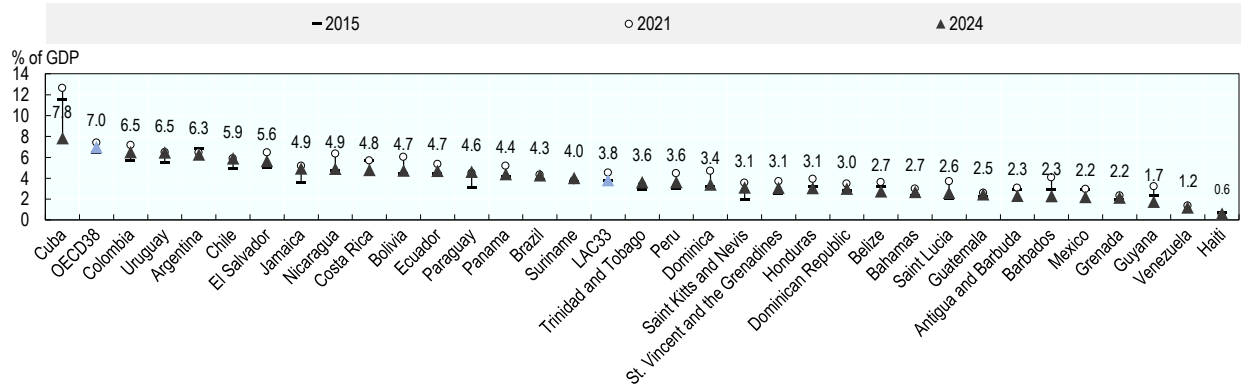
Definition and comparability

The financing classification used in the System of Health Accounts provides a complete breakdown of health expenditure into public and private units incurring expenditure on health. General government health expenditure includes government expenditure and public social security funds.

References

Lorenzoni, L. et al. (2019), "Health systems characteristics: A survey of 21 Latin American and Caribbean countries", *OECD Health Working Papers*, No. 111, OECD Publishing, Paris, https://doi.org/10.1787/0e8da4bd-en. [1]

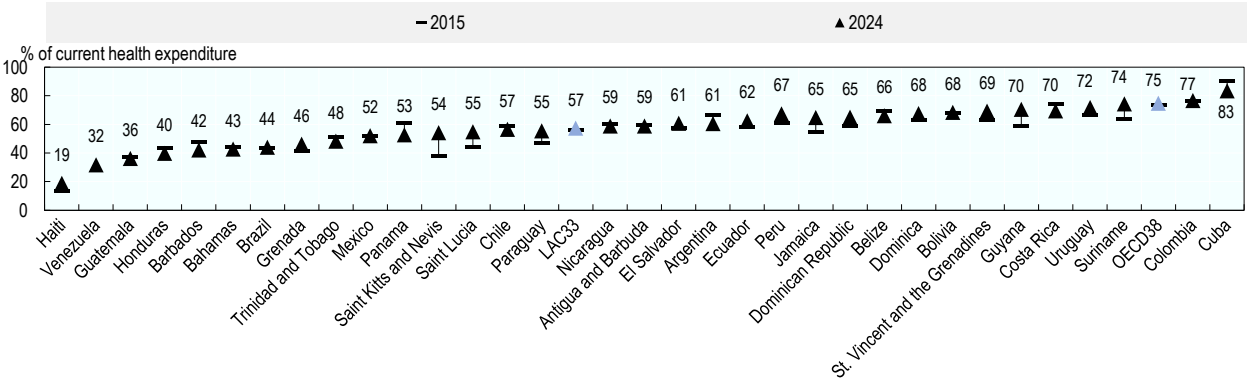
Figure 6.3. Change in government health expenditure as a share of GDP, 2015-2024



Note: Label corresponds to 2024 or latest year available.
Source: WHO Global Health Expenditure Database 2025, OECD Health Statistics 2025 for OECD countries.

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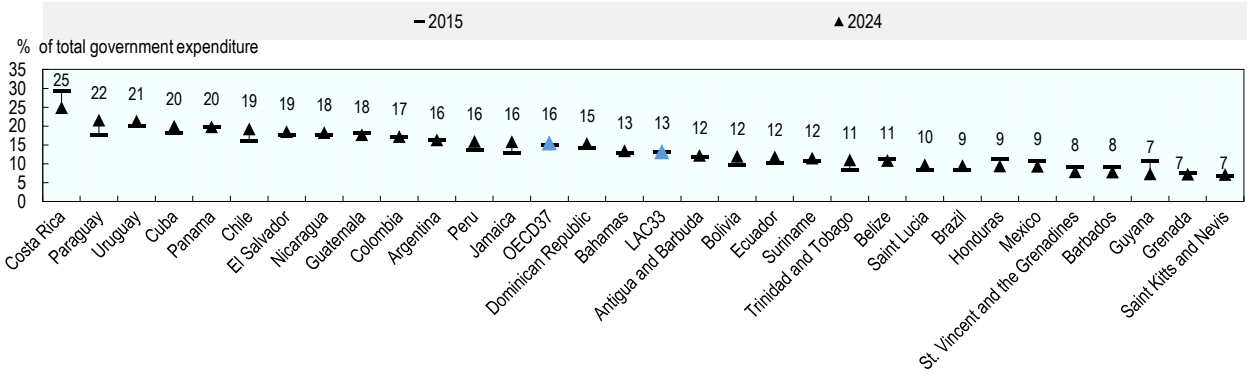
Figure 6.4. Change of government share in current expenditure on health, 2015-2024



Note: Label corresponds to 2024 or latest year available.
Source: WHO Global Health Expenditure Database 2025, OECD Health Statistics 2025 for OECD countries.

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Figure 6.5. Change in health expenditure by government and compulsory (public) insurance scheme as a share of government expenditure, 2015-2024



Note: Label corresponds to 2024 or latest year available.
Source: WHO Global Health Expenditure Database 2025.

StatLink https://stat.link/fngkrl

Financing of healthcare from households' out-of-pocket payments, voluntary payment schemes and external resources

Health spending outside government and compulsory schemes comprises out-of-pocket expenditure (OOP), voluntary payment schemes and external resources. OOP expenditure refers to direct payments by households for healthcare, while voluntary payment schemes include private insurance premiums and other voluntary prepayment arrangements. External resources refer to funds for health received from donors or similar sources.

On average in 2024, or the latest available year, 32% of current health spending in LAC was paid out-of-pocket, still well above the OECD average of 20% (Figure 6.6). The highest OOP shares were observed in Guatemala, Honduras and Haiti, where more than half of current health spending came directly from households. Barbados, Grenada and Trinidad and Tobago also reported shares above 45%. At the other end of the spectrum, Colombia, Cuba and Uruguay remained below 20%, while Jamaica and Suriname stood at around 20%. Between 2015 and 2024, the share of OOP payments in total health spending in LAC fell only slightly, from 33% to 32%, similar to the modest reduction observed across OECD countries. Some countries recorded substantial reductions, notably Saint Kitts and Nevis, Saint Lucia, Jamaica, Guyana and Grenada. However, OOP shares increased markedly in Haiti, and also rose in Panama, Cuba, Barbados, Chile, Belize and Trinidad and Tobago. Despite some progress, OOP expenditure still exceeds 20% of current health expenditure in most LAC countries, indicating continued vulnerability to catastrophic health spending in the event of illness or emergency.

Figure 6.7 shows that voluntary payment schemes represented 10.3% of current health expenditure in LAC in 2024, or the latest available year, almost twice the OECD average of 5.4%. The highest shares were reported in Venezuela, the Bahamas, Brazil and Haiti, where voluntary schemes accounted for close to 30% or more of current health spending. Antigua and Barbuda also reported a relatively high share, at 20%. By contrast, voluntary schemes accounted for less than 5% of current health spending in Cuba, Dominica, Guyana, Nicaragua, Saint Kitts and Nevis, St. Vincent and the Grenadines and Bolivia. Between 2015 and 2024, the regional average changed very little, rising from 10.1% to 10.3%, but country trends diverged. The largest increases were observed in Argentina, Mexico, Costa Rica, the Bahamas and Antigua and Barbuda, while Haiti, Suriname, Guyana, Uruguay and Chile recorded sizeable declines. Private health insurance remains an important source of secondary coverage in many countries, either supplementing benefits not included in the basic package, complementing public coverage by covering user charges, or duplicating coverage for those seeking faster access to private care.

In 2024, or the latest available year, external resources represented a negligible share of health spending in most LAC countries, but remained substantial in Haiti, at 31.6% of current health expenditure, and in Honduras, at 10.1% (Figure 6.8). External resources also accounted for around 5% of current health spending in Suriname and Saint Lucia. On average across LAC26, the share of external resources fell from 3.8% in 2015 to 3.0% in 2024, but remained well above the OECD26 average of 0.1%.

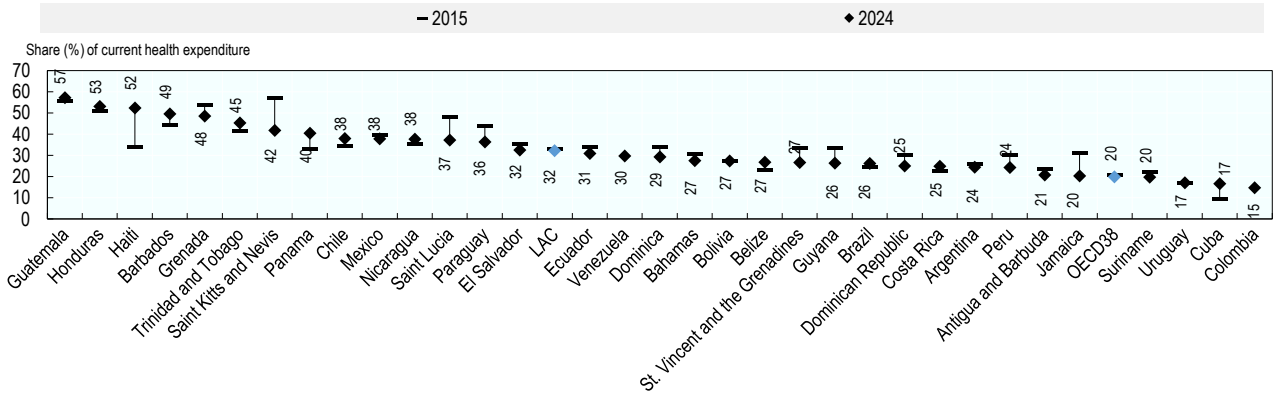
Definition and comparability

The financing classification used in the System of Health Accounts provides a complete breakdown of health expenditure into public and private units incurring expenditure on health. Private sector comprises pre-paid and risk pooling plans, household out-of-pocket expenditure and non-profit institutions serving households and corporations. Out-of-pocket payments are expenditures borne directly by the patient. They include cost-sharing and, in certain countries, estimations of informal payments to healthcare providers.

Voluntary healthcare payment schemes include voluntary health insurance, non-profit institutions serving households (NPISH), and enterprise financing schemes. Data on voluntary insurance coverage was taken from the responses provided by countries to the 2018 Health System Characteristics Survey in Latin America and the Caribbean.

External funding for health is measured as Official Development Assistance disbursements for health from all donors. Disbursements represent the actual international transfer of financial resources. Disbursements for health are identified by using the classification of the sector of destination codes 121 (health, general except 12 181, medical education/training and 12 182, medical research), 122 (basic health), and 130 (population policies/programmes and reproductive health except for 13 010 Population policy and administrative management), and 510 (general budget support) (http://www.oecd.org/dac/stats/aidtohealth.htm). General budget support for health is estimated by applying the share of government expenditure on health over total general government expenditures to the value reported in ODA. Given that disbursement money is spent over several years by countries, funds disbursed at year t are compared to total health expenditure in year t+1.

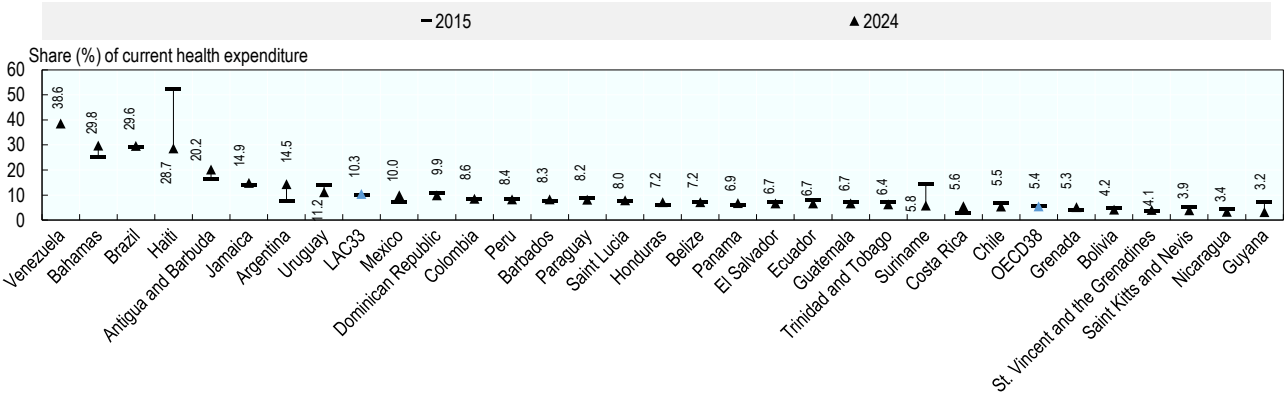
Figure 6.6. Change in out-of-pocket spending as a share of current expenditure on health, 2015-2024



Note: Label corresponds to 2024 or latest year available.
Source: WHO Global Health Expenditure Database 2025, OECD Health Statistics 2025 for OECD countries.

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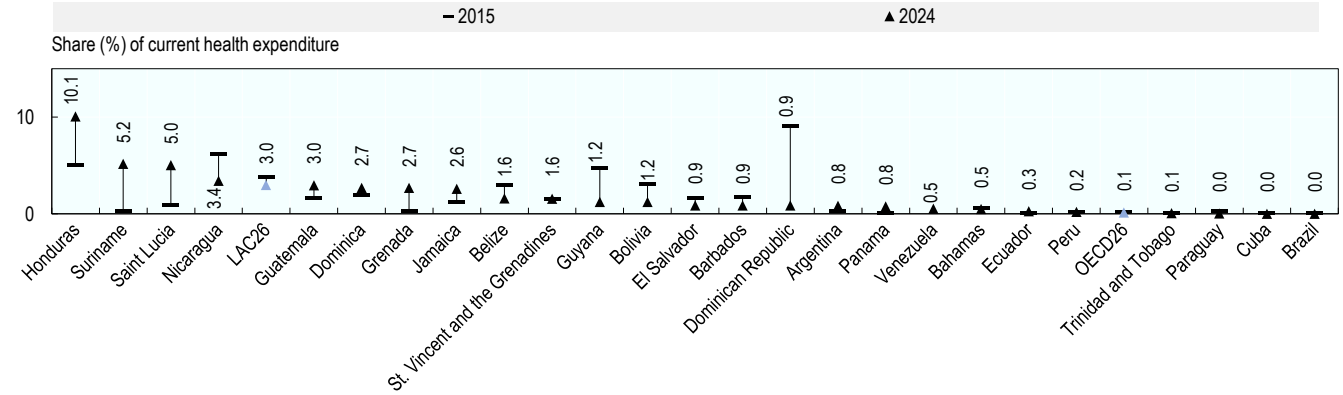
Figure 6.7. Change in voluntary healthcare payment schemes as a share of current expenditure on health, 2015-2024



Note: Label corresponds to 2024 or latest year available.
Source: WHO Global Health Expenditure Database 2025, OECD Health Statistics 2025 for OECD countries.

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Figure 6.8. Change in external resources as a share of current health expenditure, 2015-2024



Note: Label corresponds to 2024 or latest year available. 7 LAC countries (Colombia, Costa Rica, Antigua and Barbuda, Chile, Mexico, Saint Kitts and Nevis, Uruguay) are excluded for having external resources <=0.01% of CHE in 2015 and 2024. Haiti is an outlier with values of 50.9% for 2015 and 31.6 for 2024.
Source: WHO Global Health Expenditure Database 2025, OECD Health Statistics 2025 for OECD countries.

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Financial protection

As reported in the previous section, high levels of out-of-pocket (OOP) spending in the region present a challenge not only for governments seeking to improve access, but also for individuals, households and communities. High OOP spending means that households directly finance a substantial part of care when they need it, which can push them into poverty or financial hardship. Globally, the incidence of catastrophic health spending – defined as OOP payments equal to 10% or more of household income or consumption – has increased over time, reaching 11.7% in 2010, equivalent to 808 million people (Flores et al., 2018[1]).

Figure 6.9 shows OOP health payments as a share of household final consumption expenditure. On average, OOP accounted for 3.4% of household final consumption in LAC in 2024, or the latest available year, similar to the OECD average of 3.2%. However, there is substantial variation across countries. OOP represented less than 2% of household final consumption in Venezuela, Guyana, Colombia, Haiti, Antigua and Barbuda, the Dominican Republic, Belize and Saint Vincent and the Grenadines, but exceeded 4.5% in Honduras, Suriname, Paraguay, Saint Kitts and Nevis, Chile and Panama. Between 2015 and 2024, the burden of OOP relative to household consumption rose in several countries, including Panama, Chile, Brazil, Guatemala and Suriname, while it fell in others such as Antigua and Barbuda, the Dominican Republic, Saint Lucia, Ecuador and Haiti. These averages, however, are calculated at the national level and provide no information on how the burden is distributed within countries; a relatively moderate national share can mask substantial inequalities, with low-income households facing much higher OOP shares and greater risk of financial hardship than better-off households.

Figure 6.10 shows voluntary healthcare payment schemes as a share of household final consumption expenditure. On average in LAC, these schemes absorbed about 1.0% of household final consumption in 2024, or the latest available year, very close to the OECD average. The share was close to zero in Cuba and below 0.3% in Guyana, Dominica and Saint Vincent and the Grenadines, but exceeded 2% in Argentina and the Bahamas, reaching 4.6% in Brazil. Between 2015 and 2024, the burden of voluntary payments fell sharply in Haiti and Suriname, and also declined in Uruguay and Guyana, but increased notably in Argentina, the Bahamas, Jamaica, Panama and Brazil. As with OOP spending, these figures are national averages and do not show how the burden is distributed across income groups, which is important given that voluntary schemes are often concentrated among better-off households and may contribute to system segmentation.

Taken together, OOP payments and voluntary healthcare schemes absorbed around 5.7% of household final consumption expenditure in LAC in 2024, or the latest available year, above the OECD average of about 4.2%. The combined burden varies widely, from around 2% or less in Guyana and Venezuela to more than 8% in Brazil, Chile and Panama. In some countries, relatively moderate OOP shares coexist with high voluntary payments, as in Brazil, the Bahamas and Argentina, suggesting more prepayment but also greater segmentation. In others, high OOP with more limited voluntary cover, such as Panama, Chile, Guatemala and Honduras, signals heavier reliance on direct payments at the point of use. As with each indicator on its own, these figures are national averages and do not capture how the burden is distributed across income groups. To ensure adequate access and coverage for all groups, governments need to strengthen financial protection so that OOP payments and voluntary healthcare schemes do not absorb an excessive share of household resources (WHO, 2018[2]). High reliance on these payments schemes, together with fragmented funding arrangements, limits pooling and solidarity and often reinforces segmentation between population groups.

Definition and comparability

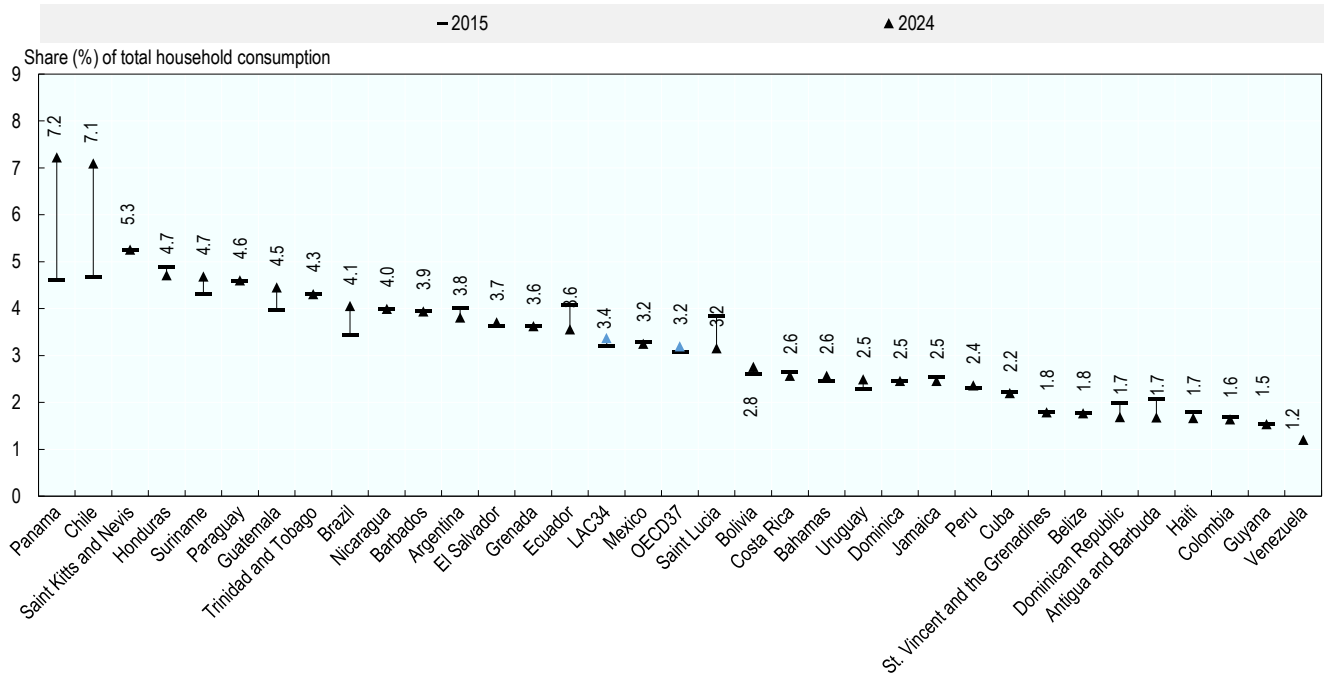
This section uses three standard aggregates to describe the burden of private health spending on households. Out-of-pocket (OOP) payments are direct payments by households for healthcare goods and services from their income or savings at the time of use, net of any reimbursements by third-party payers. They include co-payments, deductibles and other direct charges, and may also capture informal payments where these are reported. Voluntary schemes cover all non-compulsory pre-paid arrangements for healthcare, including voluntary health insurance schemes, financing schemes of non-profit institutions serving households (NPISH) and enterprise financing schemes. OOP and voluntary schemes are compiled under the System of Health Accounts (SHA 2011). Final consumption expenditure of households and non-profit institutions serving households is a national accounts aggregate, measuring the value of goods and services purchased or otherwise acquired for individual consumption by resident households and non-profit institutions serving households.

References

Flores, G. et al. (2018), “Progress on catastrophic health spending in 133 countries: a retrospective observational study”, *Articles Lancet Glob Health*, Vol. 6, pp. 169-79, https://doi.org/10.1016/S2214-109X(17)30429-1. [1]

WHO (2018), *Health financing*, World Health Organization, https://www.who.int/health-topics/health-financing. [2]

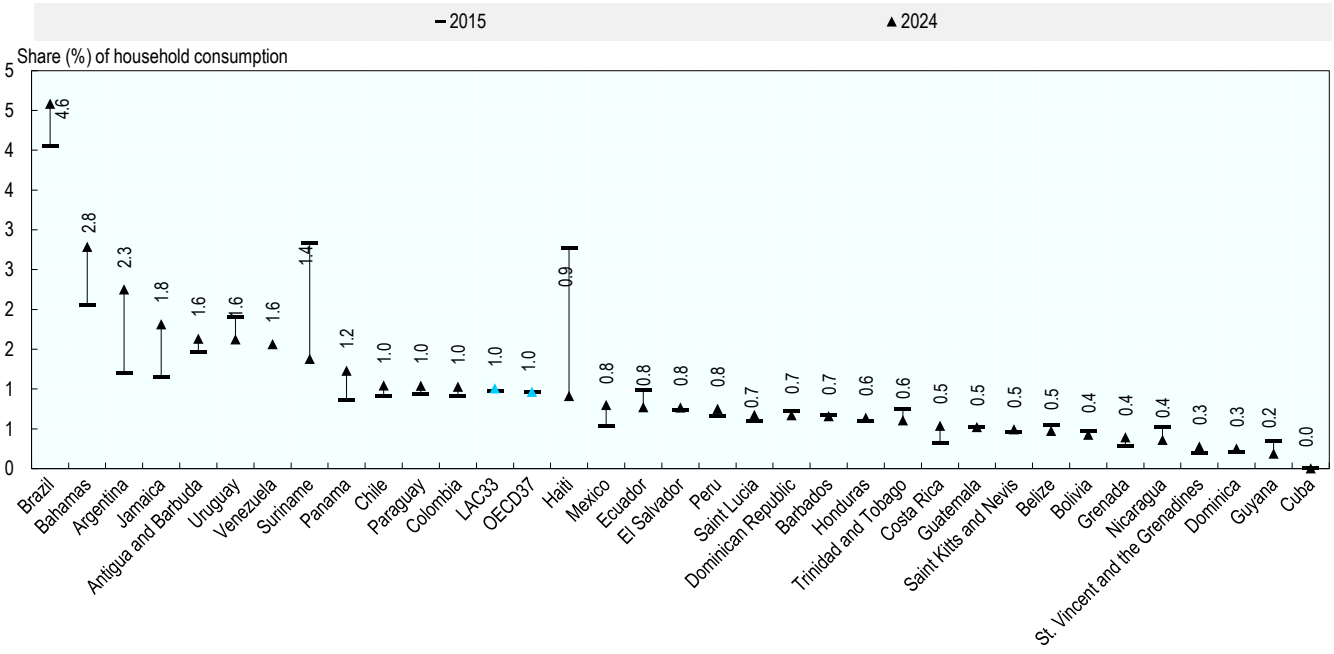
Figure 6.9. Out-of-pocket health expenditure as a share of final household consumption, 2015-2024



Note: Labels correspond to 2024 (or latest available year).
Source: WHO Global Health Expenditure Database 2024.

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Figure 6.10. Voluntary healthcare expenditure as a share of final household consumption, 2015-2024



Note: Labels correspond to 2024 (or latest available year).
Source: WHO Global Health Expenditure Database 2024.

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7 Quality of care

Avoidable mortality (preventable and treatable)

Avoidable mortality is a metric to assess how effectively public health and healthcare systems reduce deaths that should not occur in the presence of effective prevention and timely, high-quality care. It measures deaths from preventable causes, which can be addressed through population-wide public health and primary prevention policies, and treatable causes, for which appropriate and timely healthcare interventions can substantially reduce mortality risks.

Across the 25 Latin American and Caribbean (LAC25) countries included in this analysis, avoidable mortality was substantially higher than OECD average in 2023. Using the OECD – LAC standard population, total avoidable mortality in LAC reaches 297 deaths per 100 000 population, compared with 162 per 100 000 across the OECD (Figure 7.1). The gap is already large among men (378 versus 220 deaths per 100 000), while avoidable mortality among women is twice as high in LAC countries as in the OECD (222 versus 109 deaths per 100 000). Total avoidable mortality ranges from 155 deaths per 100 000 population in Chile to around 200 in Costa Rica and Panama to over 500 deaths per 100 000 in Guyana, pointing to large differences in both prevention and health system performance across countries.

Treatable mortality is also markedly higher across LAC countries, pointing to deficiencies in timely access to and quality of care. In the LAC19, treatable mortality reaches 274 deaths per 100 000 among men and 196 among women, versus 117 and 67 in the OECD. The lowest treatable mortality rates in the region are seen in Panama (163; 70), Argentina (171; 75) and Costa Rica (184; 66), while the highest are observed in Paraguay (513; 270), Peru (437; 194) and Brazil (393; 191). Across countries, treatable mortality is consistently higher among men than women – for example, LAC19 shows a gap of 78 deaths per 100 000 (274 vs. 196), and Paraguay a gap of 243 (513 vs. 270) –highlighting persistent gender differences in health risks and health-seeking, alongside system constraints affecting both sexes (Figure 7.2).

Preventable mortality contributes substantially to the avoidable mortality gap. In the LAC25, preventable mortality averages 237 deaths per 100 000 among men and 102 among women, compared with 153 and 61 in the OECD. The lowest rates in the region are observed in Chile (men 134, women 54 per 100 000), close to OECD levels, followed by Argentina (143; 59), Panama (151; 62) and Costa Rica (182; 59). At the other end, preventable mortality is highest in Guyana (458; 199), Belize (347; 158) and Jamaica (307; 194), signalling major gaps in prevention, risk-factor control and access to quality primary care (Figure 7.3).

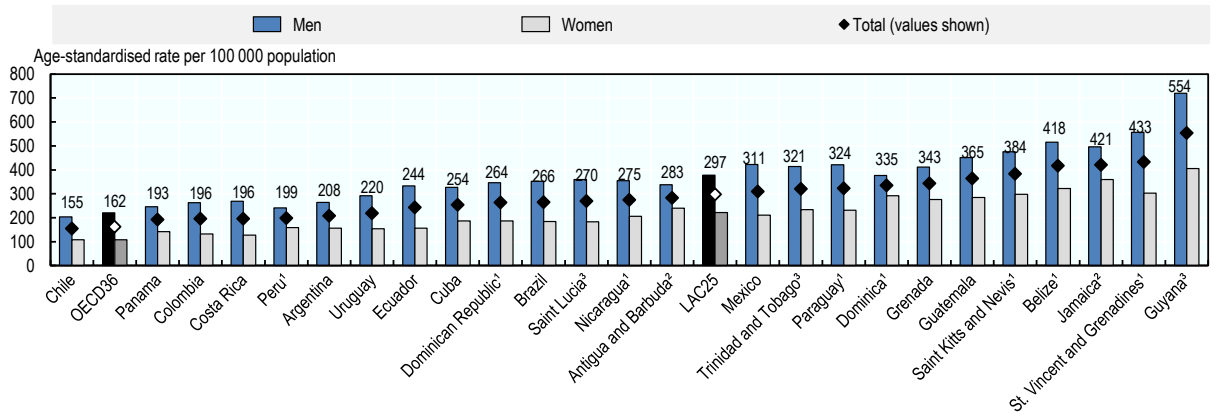
Definition and comparability

Based on the 2022 OECD/Eurostat definitions, preventable mortality is defined as causes of death among people aged under 75 that can be mainly avoided through effective public health and primary prevention interventions (i.e. before the onset of disease/injury, to reduce incidence). Treatable (or amenable) mortality is defined as causes of death that can be mainly avoided through timely and effective healthcare interventions, including secondary prevention and treatment (i.e. after the onset of disease, to reduce case fatality).

Avoidable mortality estimates are based on two current lists of preventable and treatable mortality adopted by the OECD and Eurostat in 2022. The attribution of each cause of death to the preventable or treatable mortality category was based on the criterion of whether it is predominantly prevention or healthcare interventions that can reduce it, with the rationale that a large part of these deaths can be avoided. Causes of death that can be both largely prevented and treated once they have occurred were attributed to the preventable category on the rationale that if these diseases are prevented, there would be no need for treatment. In cases when there was no strong evidence of predominance of preventability or treatability (as with ischaemic heart disease, stroke and diabetes), the causes were allocated on a 50:50 basis to the two categories to avoid double-counting of the same cause of death in both lists. The age threshold of premature mortality is set at 74 years for all causes as has been traditionally used in high income countries. COVID-19 was categorised as a preventable disease, as most deaths can be prevented through prophylaxis, such as vaccination or use of protective facemasks.

Data comes from the WHO Mortality Database, and the mortality rates are age-standardised to the 2022 OECD LAC population.

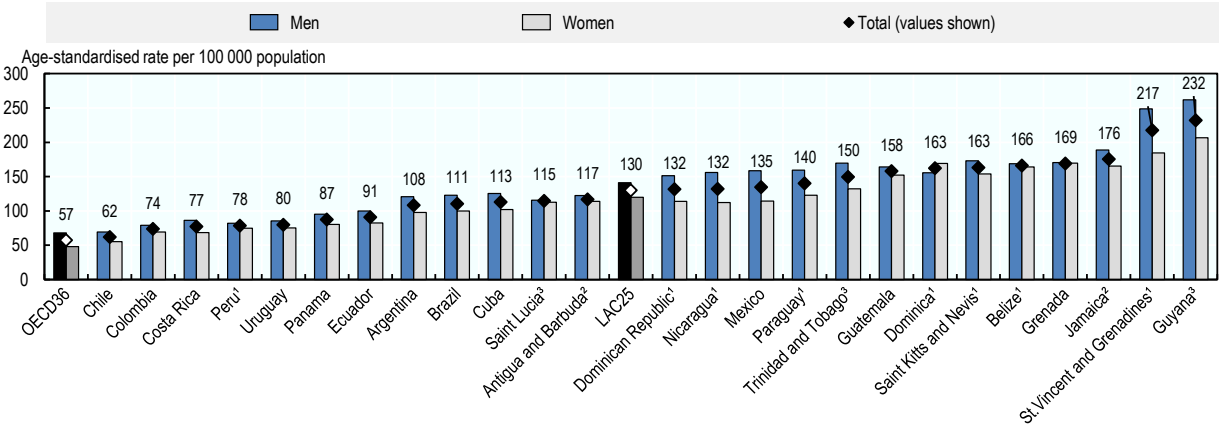
Figure 7.1. Mortality from avoidable causes, 2023 (or latest year)



1. Data from 2022, 2. Data from 2021, 3. Data from 2020.
Source: WHO mortality database (2026).

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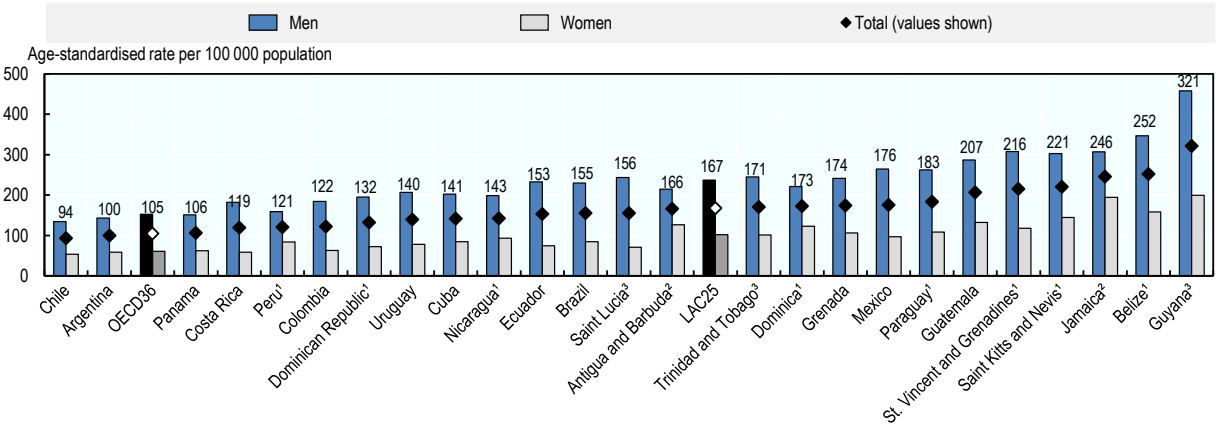
Figure 7.2. Mortality from treatable causes, 2023 (or latest year)



1. Data from 2022, 2. Data from 2021, 3. Data from 2020.
Source: WHO mortality database (2026).

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Figure 7.3. Mortality from preventable causes, 2023 (or latest year)



1. Data from 2022, 2. Data from 2021, 3. Data from 2020.
Source: WHO mortality database (2026).

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Childhood vaccination programmes

Childhood vaccination remains among the most effective and cost-effective health interventions and a core component of national disease-prevention strategies (Chan et al., 2017[1]). High and equitable coverage of childhood vaccination campaigns is essential to interrupt disease transmission and protect all communities from several communicable diseases. Hence, coverage is an important quality of healthcare indicator. The section presents the coverage of vaccination programmes for diphtheria, tetanus toxoid and pertussis (DTP3), measles (Measles-containing-vaccine first and second-dose, MCV1 and MCV2) and hepatitis B (HepB3). Because of their importance and schedule these vaccination programmes represent a full spectrum of challenges related to routine vaccination for children.

In 2024, average DTP3 coverage in LAC was 86% (LAC32), below the 90% level recommended by WHO for programme performance (Figure 7.4) and below the OECD average of 93%. Seventeen of 32 LAC countries reached ≥90% (for example Antigua and Barbuda, Costa Rica, Cuba, Jamaica, Saint Lucia, and Brazil), while four remained <70% (Suriname, Venezuela, Haiti and Bolivia). The LAC average is higher than 2021 (82%) but has not returned to the ~90% regional average observed in 2018 (pre-pandemic).

While the measles-containing-vaccine first dose (MCV1) averaged 88% in 2024 in the region, about 5-10% of children fail to develop immunity after the first dose, so the second dose is required to ensure immunity in those at risk (World Health Organization, 2019[2]). MCV2 was notably lower at 76% for LAC32 (Figure 7.5). The OECD averages were 93% (MCV1) and 88% (MCV2). Sixteen of 32 countries achieved ≥90% for MCV1, but only seven did so for MCV2 (Cuba, Guyana, St Vincent and the Grenadines, Uruguay, Saint Kitts and Nevis, El Salvador and Jamaica). Twelve countries had MCV2 <70% (including Brazil, Paraguay, Bahamas, Argentina, Mexico, Haiti, Ecuador, Suriname, Venezuela and Bolivia). WHO's elimination goal requires ≥95% coverage for both doses – few LAC countries currently sustain that level across MCV1 and MCV2. MCV1 has risen from 83% in 2021 but remains below the ~90% regional average seen in 2018; MCV2 at 76% highlights a persistent second-dose gap relative to pre-pandemic performance (90% in 2018).

WHO recommends three doses of the Hepatitis B vaccine for all children, with a timely birth dose as part of national immunisation schedules (WHO, 2017[3]). Coverage for this vaccine averaged 86% in LAC in 2024, versus 92% in the OECD (Figure 7.6). Sixteen LAC countries reached ≥90%, but four had <70% coverage (Suriname, Venezuela, Haiti and Bolivia). This represents an improvement from 81% in 2021 but remains short of pre-pandemic levels (≈90% in 2018 where comparable).

Persistent coverage gaps reflect both service-delivery and demand-side barriers. Beyond logistical issues, limited provider recommendation, misinformation, and socio-economic barriers continue to hinder vaccination uptake (Guzman-Holst et al., 2020[4]). Strengthening programme quality (appointment reminders/recall, outreach to under-served areas, continuous monitoring of drop-out from dose 1 to dose 2) and targeted community engagement to counter misinformation are priorities to close the MCV2 gap and lift DTP3 and HepB3 coverage above WHO benchmarks.

Definition and comparability

Vaccination rates measure the share of children receiving doses within the recommended timeframe, typically at age one (e.g. DTP3, HepB3, MCV1) or by the locally recommended age for later doses (MCV2). Some countries use combination vaccines (e.g. measles – rubella), others administer components separately. Coverage is derived from surveys in some countries and administrative records in others, which can affect results and comparability.

References

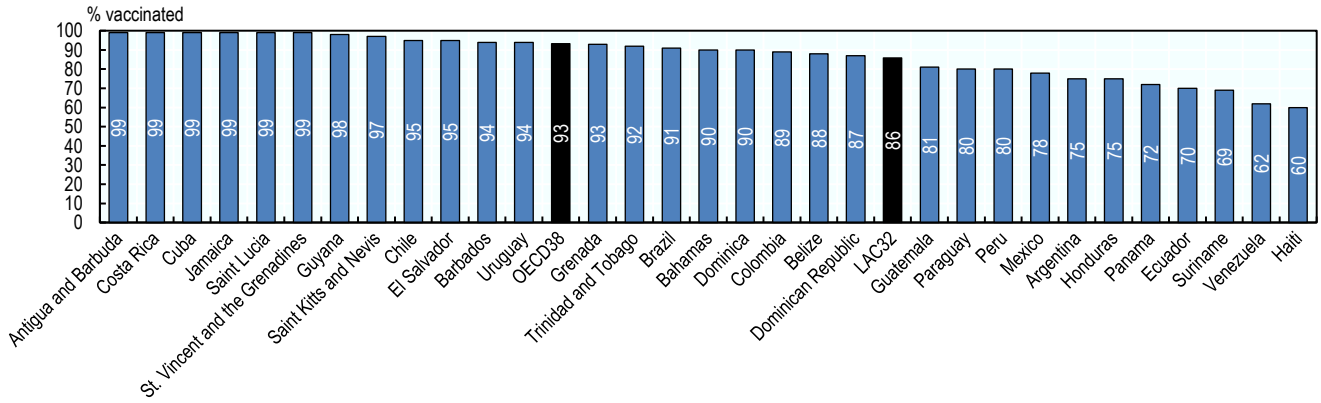
Chan, M. et al. (2017), "Reaching everyone, everywhere with life-saving vaccines", *The Lancet*, Vol. 389/10071, pp. 777-779, https://doi.org/10.1016/s0140-6736(17)30554-8. [1]

Guzman-Holst, A. et al. (2020), "Barriers to vaccination in Latin America: A systematic literature review", *Vaccine*, Vol. 38/3, pp. 470-481, https://doi.org/10.1016/j.vaccine.2019.10.088. [4]

WHO (2017), "Hepatitis B vaccines: WHO position paper", *WHO - Weekly epidemiological record*, Vol. No 27/92, 369-392, https://www.who.int/publications/i/item/WER9227. [3]

World Health Organization (2019), "Measles vaccines: WHO position paper, April 2017 – Recommendations", *Vaccine*, Vol. 37/2, pp. 219-222, https://doi.org/10.1016/j.vaccine.2017.07.066. [2]

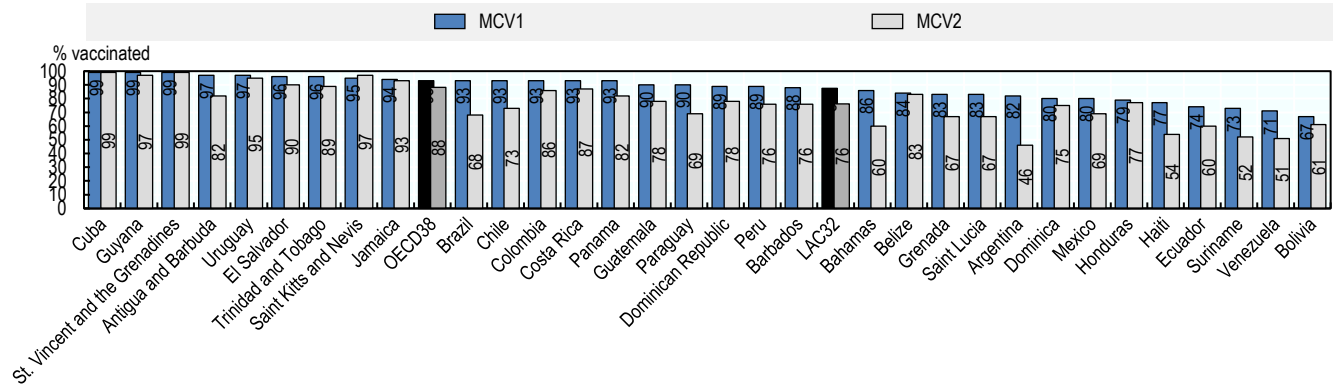
Figure 7.4. Vaccination rates for diphtheria, tetanus toxoid and pertussis children aged one, 2024



Source: WHO Global Health Observatory 2025.

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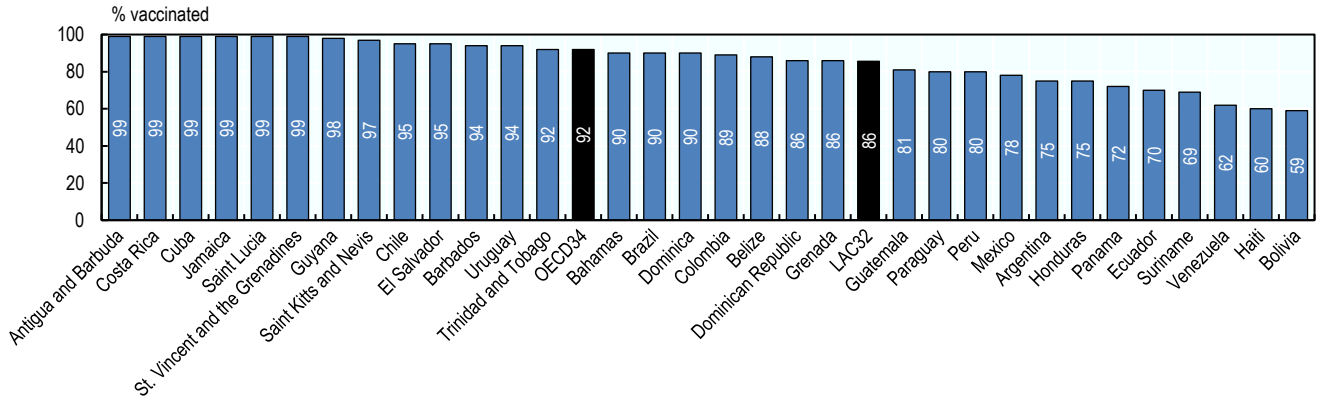
Figure 7.5. Measles-containing-vaccine first and second-dose immunisation coverage among 1-year-olds and by the locally recommended age, 2024



Source: WHO Global Health Observatory 2025.

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Figure 7.6. Hepatitis B immunisation coverage among 1-year-olds, 2024



Source: WHO, Global Health Observatory 2025.

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Avoidable hospital admissions

Strengthening primary healthcare is one of the most effective interventions for improving healthcare systems efficiency and population health. A high-performing primary care system that provides accessible and high-quality services can reduce acute deterioration in people living with four long-term conditions that are widely prevalent in LAC; asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and diabetes, and reduce unnecessary admissions to hospital. For this reason, measuring the number of hospitalisations due to these diagnoses is an indicator of the capacities of the healthcare system to appropriately manage conditions at the primary care level. However, LAC countries generally have lower hospital capacity and use than OECD countries, with fewer hospital beds (23 versus 42 per 10 000 population on average; see Chapter 5) and lower hospital discharge rates (fewer than 500 versus almost 1 400 per 10 000 population on average; see Chapter 5). As a result, low avoidable admission rates may reflect constraints in access to hospital care, rather than stronger primary care performance alone.

Figure 7.7 shows hospital admission rates per 100 000 population for asthma and COPD in eight LAC countries (LAC8) and the OECD average. On average, LAC8 countries report substantially lower admission rates than the OECD – around one-third of the OECD average for asthma (9.3 versus 25.3 per 100 000) and about one-quarter for COPD (20.8 versus 76.3). Patterns for the two conditions are broadly similar: countries with low asthma admission rates also tend to have low COPD admission rates. Peru and Ecuador record the lowest rates for both conditions (around 3-6 admissions per 100 000), followed by Paraguay and Mexico, while Argentina, Chile and Colombia display comparatively higher rates within the LAC group but still well below the OECD average. Part of the gap with the OECD may reflect more limited hospital capacity and lower overall discharge rates in many LAC health systems.

Figure 7.8 presents admission rates per 100 000 population for diabetes and CHF. For diabetes, LAC8 countries again show lower admission rates on average than the OECD (54 versus 93 per 100 000). However, Mexico stands out with a rate well above the OECD average (149), while Chile's rate (90) is close to the OECD level. Argentina, Costa Rica and Colombia have intermediate rates (around 45-57), and Ecuador, Paraguay and Peru report very low admission rates (5-26 per 100 000). For CHF, admission rates in all reporting LAC8 countries are below the OECD average of 89 per 100 000. The LAC8 average stands at 33 admissions, with Chile showing the highest rate in the region (61) and all other countries reporting markedly lower rates: around 34-42 in Argentina, Colombia, Ecuador and Mexico, and fewer than 25 admissions per 100 000 in Costa Rica, Paraguay and especially Peru (5).

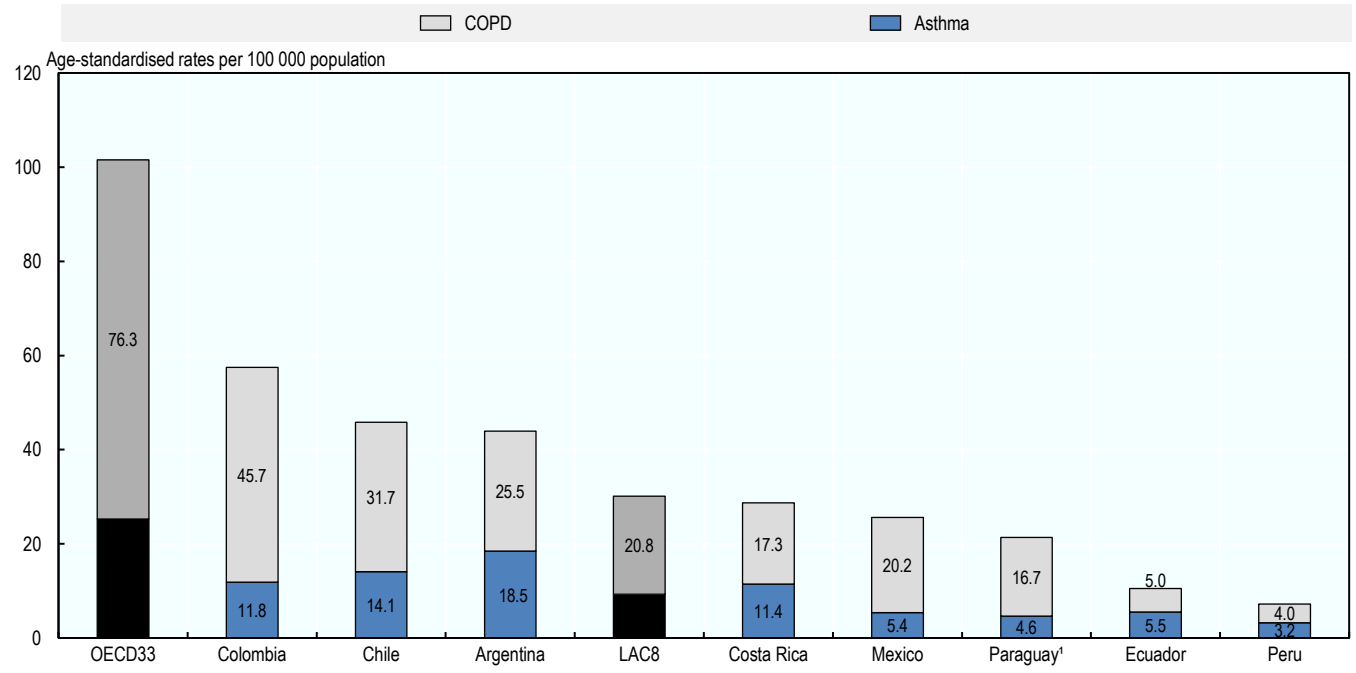
The low admission rates for diabetes, respiratory conditions and CHF must be interpreted against the backdrop of fewer hospital beds and lower hospital discharge rates in LAC than in other OECD countries. While they may partly reflect strong primary care and good management of chronic cardiovascular disease, they may also capture unmet need for hospital care, under-diagnosis, delays in seeking care or barriers to admission where hospital capacity is constrained.

Health systems must find an adequate balance to ensure the least wasteful level of hospital utilisation while ensuring adequate access across the entire population. LAC countries must continue to invest in building primary care capacity in order to minimise waste and prepare for a heavier burden caused by the increased prevalence of chronic conditions brought on by population ageing (see Chapter 9).

Definition and comparability

The indicators are defined as the number of hospital admissions with a primary diagnosis of asthma, COPD, CHF and diabetes among people aged 15 years and over to 85 years per 100 000 population. Rates are age-sex standardised to the 2022 OECD LAC population aged 15 and over to 85 years. Admissions resulting from a transfer from another hospital and where the patient dies during the admission are excluded from the calculation as these admissions are considered unlikely to be avoidable. Disease prevalence and availability of hospital care may explain some, not all, variations in cross-country rates. Differences in coding practices among countries may also affect the comparability of data. Differences in data coverage of the national hospital sector across countries may also influence indicator rates: Measures for Paraguay only cover public care services of the Ministry of Health.

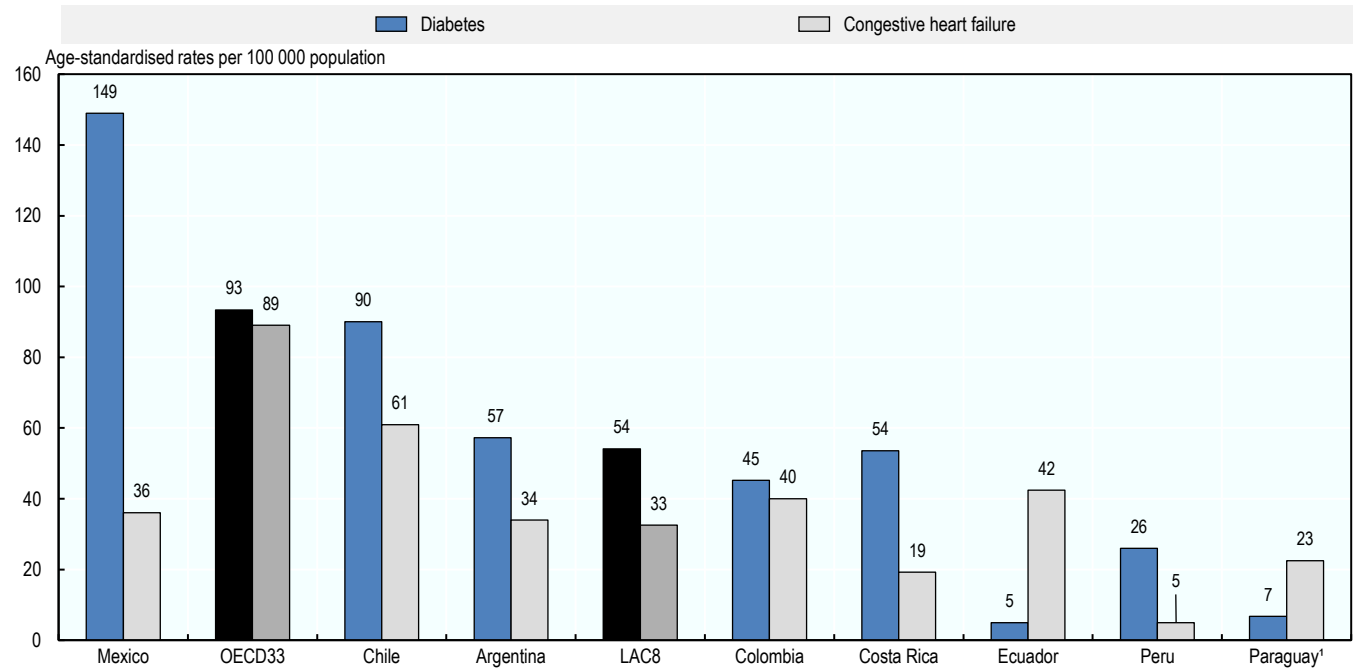
Figure 7.7. Asthma and COPD hospital admissions in adults, 2024 (or nearest year)



Note: Rates are age-sex standardised to the OECD LAC population of 15 to 85 years old. 1. Only for care services of the Ministry of Health.
Source: OECD Health Statistics 2025 for OECD countries; Ad-hoc data collection for non-OECD countries.

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Figure 7.8. Congestive heart failure and diabetes hospital admissions in adults, 2024 (or nearest year)



Note: Rates are age-sex standardised to the OECD LAC population of 15 to 85 years old. 1. Only for care services of the Ministry of Health.
Source: OECD Health Statistics 2025 for OECD countries; Ad-hoc data collection for non-OECD countries.

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In-hospital mortality following acute myocardial infarction and stroke

Ischaemic heart diseases and stroke are among the leading causes of death in Latin America (see Chapter 3). These diseases impose substantial health, economic and social costs, both through premature mortality and long-term disability among survivors. Over recent decades, outcomes following acute myocardial infarction (AMI) and stroke have improved in many countries, supported by advances in medical technologies and treatment protocols, including lipid- and blood-pressure-lowering therapies, thrombolysis and angioplasty (OECD, 2015[1]). Thirty-day in-hospital case fatality rates for AMI and stroke are widely used indicators of the quality of acute care. These measures reflect the effectiveness and timeliness of emergency responses and hospital treatment pathways, including rapid diagnosis, access to reperfusion therapies, and co-ordinated patient transport. At the same time, case fatality rates may also be influenced by patient characteristics, such as case severity, as well as differences in admission practices.

For AMI, age- and sex-standardised 30-day in-hospital mortality rates in Paraguay (24.2%), Mexico (22.6%) and Peru (19.9%) are substantially higher than the OECD average mortality (6.5%). Ecuador (10.9%) and Chile (8.8%) report higher mortality than OECD average but within the OECD range, while Costa Rica (6.8%) and Colombia (5.6%) are closer to, or below, the OECD average (Figure 7.9).

There are also important cross-country differences in fatality rates within 30 days after admission for ischemic stroke (Figure 7.10). Peru reports the lowest 30-day mortality rate (2.5%). Nevertheless, this measure is considerably below findings in published literature, were a 6.9 in-hospital case fatality rate was found in 2017 (Labán-Seminario, Carrillo-Larco and Bernabé-Ortiz, 2022[2]). While other factors such as a high incidence of first-ever strokes in Peruvian general population can also contribute to lower rates (Lazo-Porras et al., 2022[3]), this measure should be interpreted with caution because of quality and comparability of recording and reporting practices. Colombia (6.1%) and Ecuador (7.8%), sit close below the OECD average (8.7%). Chile's rate (8.8%) is close to the OECD average, while Paraguay (11.8%), Costa Rica (15.3%) and Mexico (17.0%) report markedly higher mortality.

Mortality following haemorrhagic stroke is, as expected, considerably higher than for ischaemic stroke across all countries (Figure 7.11). Mexico (30.6%), Paraguay (25.6%), Costa Rica (25.3%) and Chile (24.7%) all report rates above the OECD average (23.4%). In contrast, Ecuador (17.0%) and Peru (11.4%) show lower fatality rates.

While LAC countries have made progress in reducing the burden of cardiovascular disease, greater emphasis is needed on improving the quality and consistency of acute care. Improving cardiovascular and cerebrovascular outcomes requires a co-ordinated, people-centred approach spanning across prevention and early detection, strong and preventive primary care, timely referral to emergency services, and the consistent use of up-to-date, evidence-based clinical protocols (OECD, 2025[4]). Strengthening health information systems and analytical capacity is essential for routine monitoring and international comparability. Yet only seven LAC countries can currently report comparable quality-of-care indicators for AMI and stroke, and even measures miss important aspects of acute management and post-discharge care (see box below). Moreover, important indicators such as access to thrombolysis, haemodynamic services, and specialised stroke units are essential for accurate performance assessment of acute CVD conditions, but remain limited in the region. Interpretation of the presented indicators also requires caution: observed differences may reflect variation in access to emergency and hospital services and in admission, registration and coding practices. For example, very low case fatality rates in some countries (e.g. Peru) may partly signal access barriers or selective hospital admission rather than better care.

Definition and comparability

The in-hospital case-fatality rate following AMI, ischemic and haemorrhagic stroke is defined as the number of people who die within 30 days of being admitted to hospital out of 100 patients admitted to hospital with these conditions. This indicator is based on unique hospital admissions and restricted to mortality within the same hospital, differences in practices in discharging and transferring patients may influence the findings. Standardised rates adjust for differences in age (45+ years) and sex and facilitate more meaningful international comparisons. Standardization uses the 2015 OECD standard disease-specific population. Data presented here do not take account of patients that are transferred to other hospitals during their care or reflect patients who died outside of hospitals within 30 days.

References

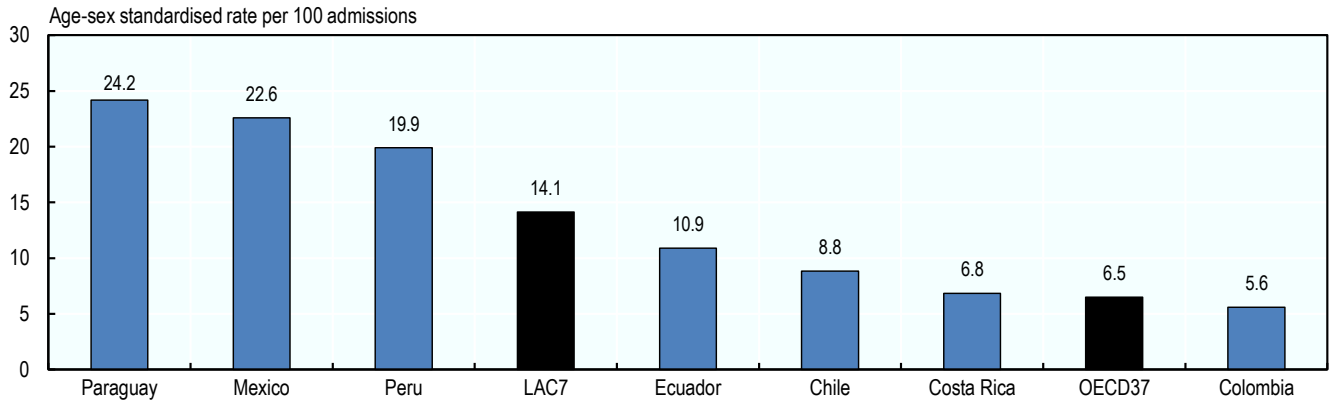
Labán-Seminario, L., R. Carrillo-Larco and A. Bernabé-Ortiz (2022), "Stroke-related length of hospitalization trends and in-hospital mortality in Peru", *PeerJ*, Vol. 10, p. e14467, https://doi.org/10.7717/PEERJ.14467/SUPP-1. [2]

Lazo-Porras, M. et al. (2022), "Population-based stroke incidence estimates in Peru: Exploratory results from the CRONICAS cohort study: Population-based stroke incidence estimates in Peru", *The Lancet Regional Health - Americas*, Vol. 5, p. 100083, https://doi.org/10.1016/j.lana.2021.100083. [3]

OECD (2025), *The State of Cardiovascular Health in the European Union*, OECD Publishing, Paris, https://doi.org/10.1787/ea7a15f4-en. [4]

OECD (2015), *Cardiovascular Disease and Diabetes: Policies for Better Health and Quality of Care*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/9789264233010-en. [1]

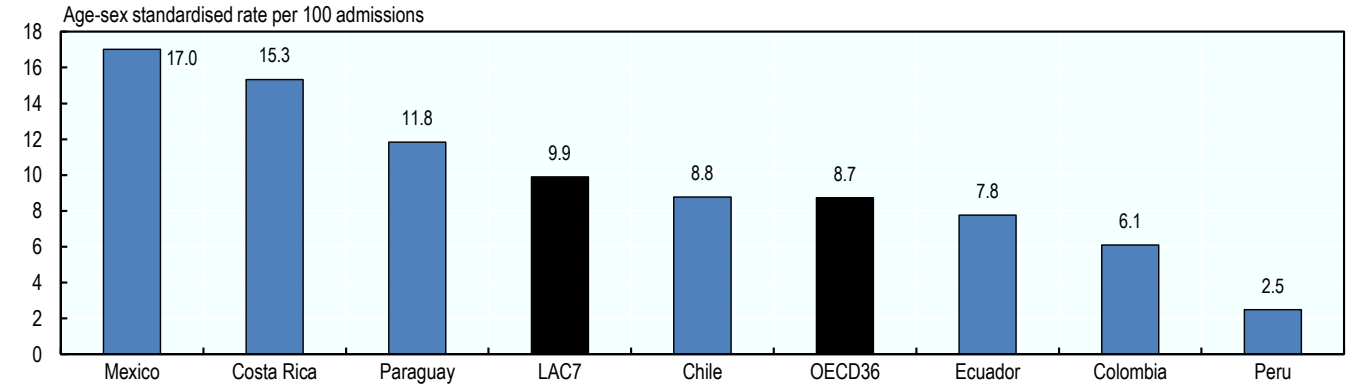
Figure 7.9. In-hospital case-fatality rates within 30 days after admission for AMI, patients 45 years old and over, 2024 (or latest year)



Source: OECD Health Statistics 2025; OECD questionnaires for HAG LAC 2026.

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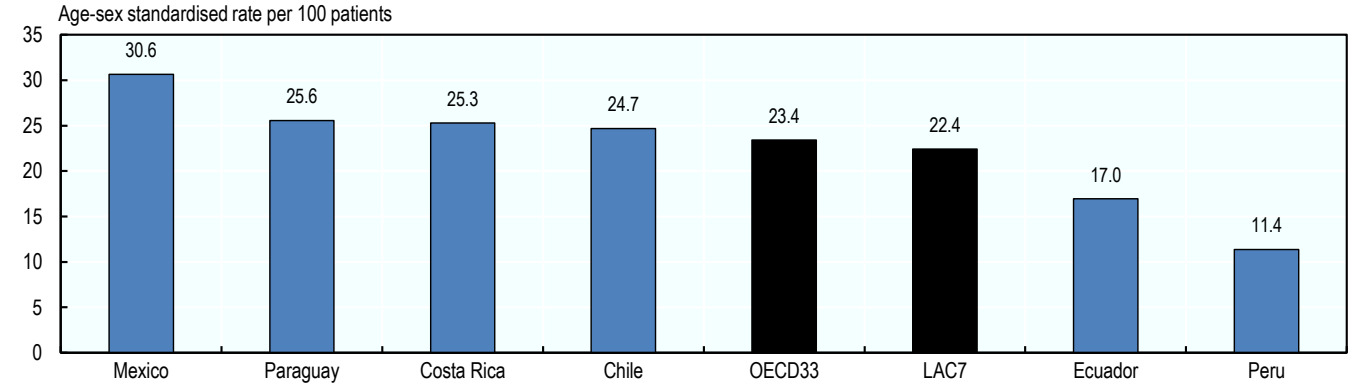
Figure 7.10. In-hospital case-fatality rates within 30 days after admission for ischemic stroke, patients 45 years old and over, 2024 (or nearest year)



Source: OECD Health Statistics 2025; OECD questionnaires for HAG LAC 2026.

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Figure 7.11. In-hospital case -fatality rates within 30 days after admission for haemorrhagic stroke, patients 45 years old and over, 2024 (or nearest year)



Source: OECD Health Statistics 2025; OECD questionnaires for HAG LAC 2026.

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Cancer care

After cardiovascular disease, cancer care is the second cause of death in LAC (see Chapter 3). In 2020 the region recorded around 1.5 million new cancer cases and 700 000 cancer deaths a year, making cancer care a major test of health system capacity to diagnose and deliver timely, effective treatment. Differences in the quality and timeliness of cancer care translate into marked differences in survival and treatable cancer mortality across countries (Piñeros et al., 2022[1]).

Treatable mortality captures deaths that should be avoidable through timely and effective healthcare. Several cancers have been included in this definition, the most prevalent being colorectal, breast and cervical cancers (OECD/Eurostat, 2022[2]). Figure 7.12 shows wide cross-country variation in mortality from treatable cancers. The LAC26 average was 19.3 deaths per 100 000 population in 2023, around 30% above the OECD36 average of 14.8. Rates ranged from 8.3 in El Salvador to 30.6 in Jamaica and 31.4 in Dominica, close to 300% difference. Only six countries were below the OECD average, while Mexico and Colombia were at the OECD level. Over the last decade, the LAC average worsened by 1.2 deaths per 100 000, whereas the OECD average improved by 2.8. Large increases were observed in Antigua and Barbuda (+5.6 deaths per 100 000), Saint Kitts and Nevis (+4.5), Belize (+3.7), Guyana (+3.6), Peru (+2.7) and Costa Rica (+2.6), while the clearest reductions were seen in Guatemala (-2.9) and El Salvador (-2.0).

Figure 7.13 shows the Childhood Cancer Survival Index for the six WHO tracer cancers combined. In the 13 LAC countries participating in CONCORD the average 5-year survival was 75%, 15 percentage points (p.p.) below the OECD27 average of 90%. Estimates ranged from 55% in Peru to 83% in Costa Rica and Uruguay and 85% in Trinidad and Tobago, a spread of 30 p.p. between the lowest and highest estimates. Eleven of the 13 LAC countries shown were already above the WHO Global Initiative for Childhood Cancer target of 60%, but only Trinidad and Tobago came close to the OECD average.

Countries with lower treatable cancer mortality and higher childhood cancer survival are more likely to have stronger pathways for early diagnosis, faster referral and treatment, better access to specialised care, and information systems that allow outcomes to be monitored and compared. Delays at any stage of the pathway, from first contact with the health system to diagnosis and treatment, can worsen outcomes and raise costs. Population-based cancer registries are essential to benchmark survival, reveal inequalities, and identify where improvements in care pathways are most needed (OECD/European Commission, 2026[3]). Strengthening these core functions, alongside sustained investment in oncology workforce and treatment capacity, is central to narrowing the gaps seen across the region.

Definition and comparability

The Cancer Survival Index is a single summary measure of 5-year net survival for the six WHO tracer childhood cancers combined. Net survival measures the probability of surviving five years after diagnosis after correcting for deaths from other causes, which vary across countries, over time, and by age and sex. In CONCORD-4, the index is calculated as a weighted average of survival estimates by age, sex and cancer type, using individual records from population-based cancer registries. Comparability is stronger where registries cover the full national population; where national data were not available, estimates may rely on regional registries, and less reliable estimates are flagged in the figure.

Treatable cancer mortality refers to deaths from cancers that can be mainly avoided through timely and effective healthcare, including secondary prevention and treatment after disease onset. The indicator follows the 2022 OECD/Eurostat list of treatable causes of death and is restricted to deaths occurring at ages 0-74. For cancer, it includes colorectal cancer, breast cancer (female only), cancer of the uterus, testicular cancer, thyroid cancer, Hodgkin's disease, lymphoid leukaemia and benign neoplasms, as well as the treatable share of cervical cancer, which is split equally between the preventable and treatable categories.

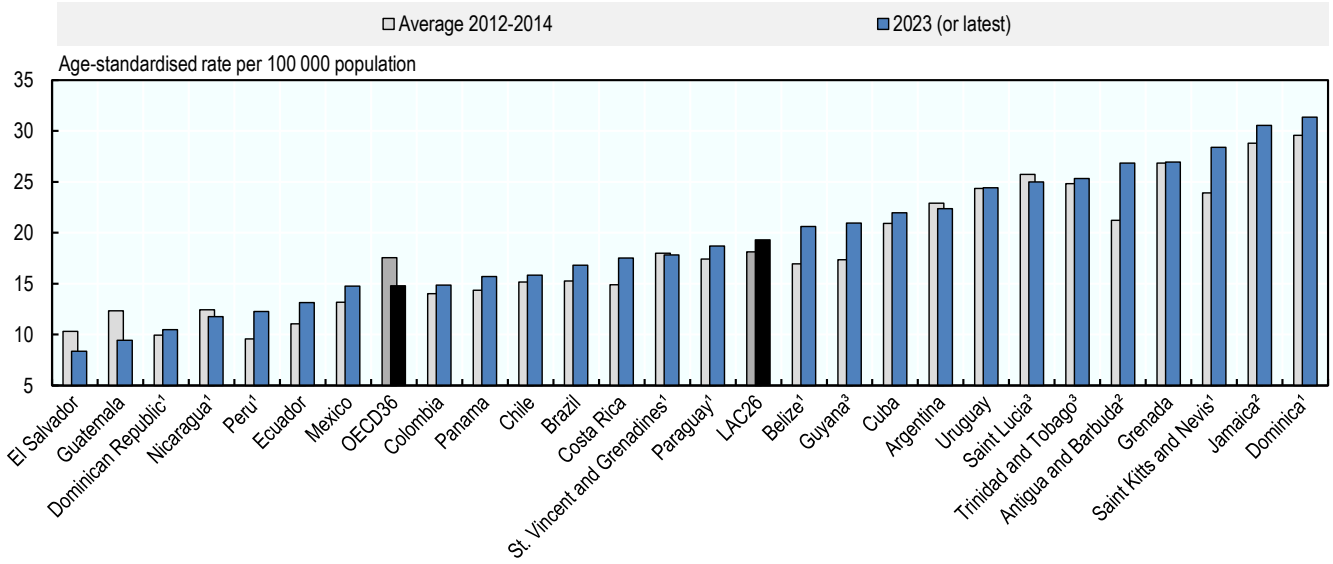
References

OECD/European Commission (2026), *Delivering High Value Cancer Care: European Cancer Inequalities Registry Analytical Report*, OECD Publishing, Paris, https://doi.org/10.1787/060869fe-en. [3]

OECD/Eurostat (2022), *Avoidable mortality: OECD/Eurostat lists of preventable and treatable causes of death (January 2022 version)*, https://www.oecd.org/content/dam/oecd/en/data/datasets/oecd-health-statistics/avoidable-mortality-2019-joint-oecd-eurostat-list-preventable-treatable-causes-of-death.pdf. [2]

Piñeros, M. et al. (2022), "An updated profile of the cancer burden, patterns and trends in Latin America and the Caribbean", *The Lancet Regional Health - Americas*, Vol. 13, p. 100294, https://doi.org/10.1016/j.lana.2022.100294. [1]

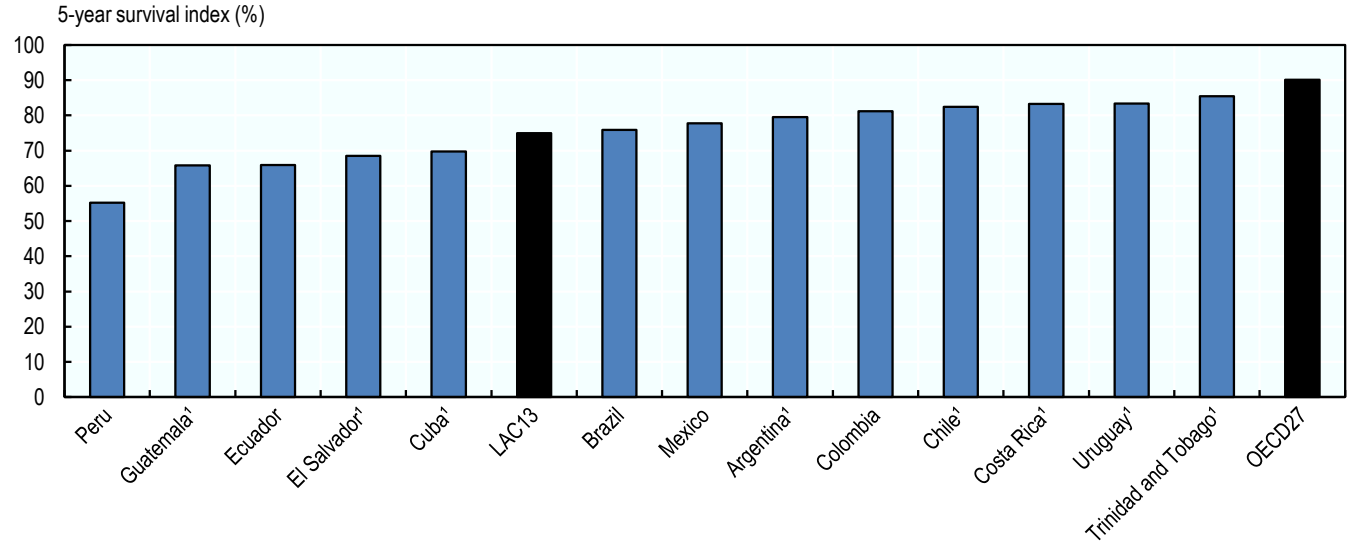
Figure 7.12. Mortality for treatable cancers, 2023 and 10-year difference



1. Data from 2022. 2. Data from 2021. 3. Data from 2020. Treatable cancers are identified with ICD-10:
Source: WHO mortality database (2026).

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Figure 7.13. 5-year Cancer Survival Index for six WHO tracer childhood cancers combined diagnosed 2015-2019



Note: Cancer Survival Index is a single summary measure of 5-year net survival cancers combined. It is calculated as a weighted average of survival estimates by age, sex, and cancer type. WHO's Global Initiative for Childhood Cancer identifies these six common tracer cancers: Acute lymphoblastic leukaemia, Burkitt lymphoma, Hodgkin lymphoma, Retinoblastoma, Wilms tumour and Low-grade glioma. 1. Data with 100% coverage of the national population. averages are unweighted averages of the component CSIs.
Source: Allemani et al. (2026), "Progress towards the WHO Global Initiative for Childhood Cancer target of 60% 5-year survival for all childhood cancers combined , 1990-2019 (CONCORD-4)", https://doi.org/10.1016/S0140-6736(26)00189-3.

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Patient safety and safe prescribing

Patient safety is a core dimension of quality of care and a key policy priority for health systems, given the substantial burden of preventable harm associated with unsafe care and inappropriate use of medicines. Medication-related harm, including the inappropriate use of antimicrobials, is among the most common and avoidable sources of patient safety incidents, contributing to adverse drug events and the growing threat of antimicrobial resistance. In response, the World Health Organization has articulated the Global Patient Safety Action Plan 2021-2030 (Astier-Peña et al., 2021[1]), which calls for stronger governance, learning systems and safer medication practices across countries. This section brings together two complementary indicators to assess progress in this area: the extent to which countries have established the system-level foundations for patient safety in line with the Action Plan, and patterns of antimicrobial consumption, which provide insight into prescribing practices and potential risks related to unsafe or inappropriate use. Together, these indicators highlight both the policy commitment to patient safety and how it translates into everyday prescribing behaviour, offering a more comprehensive picture of patient safety and safe prescribing in the region.

The Global Patient Safety Action Plan 2021-2030 sets out a comprehensive framework for strengthening patient safety through governance, learning systems, workforce training and patient engagement. Across Latin America and the Caribbean, progress in meeting these criteria remains uneven. No country in Latin America and the Caribbean fully meets all assessed requirements (Figure 7.14), while six countries meet most criteria and can be considered as having broadly aligned patient safety systems. Uruguay stands out with the highest level of alignment, meeting 10 of the assessed criteria, followed by Cuba and Ecuador (eight criteria each). A second group of countries – including Colombia and Costa Rica (seven criteria each), as well as the Dominican Republic and Peru (six criteria) – meet several core elements but still show gaps, particularly in national target-setting and public reporting. The majority of countries partially meet the Global Patient Safety Action Plan criteria, typically having foundational policies in place – such as reporting systems for never events or participation in international safety initiatives – but lacking comprehensive national action plans, regular publication of patient safety performance, or explicit targets to reduce medication-related harm. At the lower end of the distribution, Guyana, Haiti and Paraguay meet few criteria, indicating limited system-level patient safety infrastructure.

Average antimicrobial consumption in Latin America and the Caribbean varies widely across countries and therapeutic groups. During the period 2019-2022, total consumption ranged from 23.9 defined daily doses per 1 000 inhabitants per day (DID) in Argentina and 22.0 DID in Colombia, to below 6 DID in Chile (5.4 DID) and Trinidad and Tobago (5.9 DID), and 2.9 DID in Saint Kitts and Nevis (Figure 7.15). In all countries, consumption is dominated by beta-lactams, penicillins (J01C), which account for the largest share of use, reaching 11.8 DID in Argentina and 7.7 DID in Colombia, followed by macrolides (J01F) and quinolones (J01M) – two classes commonly associated with inappropriate prescribing when used outside guideline-recommended indications. Higher-consumption countries also tend to show broader use across multiple antimicrobial classes, whereas lower-consumption countries display more concentrated prescribing patterns. Colombia, for instance, is advancing the formulation of a policy document under the National Council for Economic and Social Policy (CONPES) to reduce the impact of antimicrobial resistance, covering both human and veterinary use. These large cross-country differences likely reflect a combination of variation in disease burden, access to medicines, prescribing practices and regulatory oversight, and underscore the importance of strengthening antimicrobial stewardship and safe prescribing policies to reduce unnecessary exposure and mitigate the risks of antimicrobial resistance and medication-related harm.

Definition and comparability

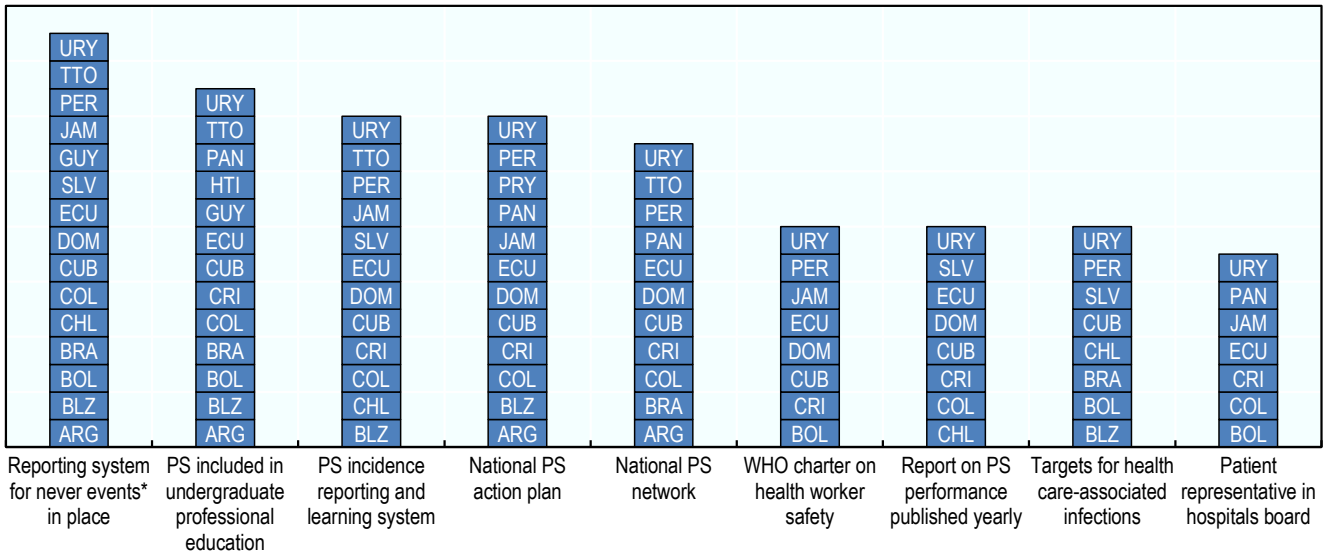
This indicator “Countries that met or partially met criteria of the Global Patient Safety Action Plan 2021-2030“ is based on official country responses to the Patient Safety Action Plan Core Indicator Survey, administered by the World Health Organization to assess implementation of the Global Patient Safety Action Plan 2021-2030. Nineteen countries in Latin America and the Caribbean participated in the survey. Countries are classified as having met or partially met the criteria depending on the number of elements in place. The survey is self-reported.

Antimicrobial consumption is measured as defined daily doses per 1 000 inhabitants per day (DID), averaged over the period 2019-2022, and classified according to the Anatomical Therapeutic Chemical (ATC) system. Data are based on national sales or reimbursement records and reflect outpatient antimicrobial use. Consumption levels are presented by major therapeutic groups. DID does not capture the appropriateness of individual prescriptions, treatment duration or adherence to clinical guidelines.

References

Astier-Peña, M. et al. (2021), “El Plan de acción mundial para la seguridad del paciente 2021-2030: identificando acciones para una atención primaria más segura”, *Atención Primaria*, Vol. 53, p. 102224, https://doi.org/10.1016/j.aprim.2021.102224. [1]

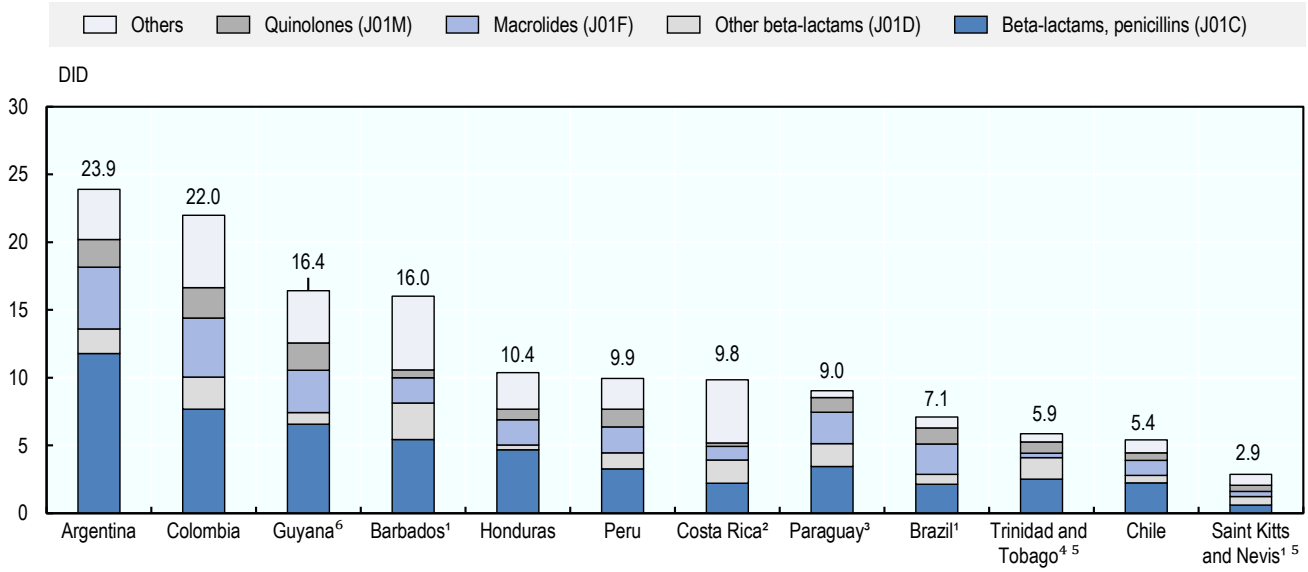
Figure 7.14. Countries that met or partially met criteria of the Global Patient Safety Action Plan 2021-2030



Note: *Sentinel events. PS: Patient Safety.
Source: WHO (2023), Patient safety action plan core indicator survey response.

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Figure 7.15. Country average AMC expressed in DiD, according to the therapeutical group, during the period 2019-2022



Note: Abbreviations: DiD: Defined Daily Dose (DDD) per 1 000 inhabitants per day. For St. Kitts and Nevis, data was presented separately between the islands. The graph shows a weighted average, even though estimates form St. Kitts are from 2021 and for Nevis 2022. For Trinidad and Tobago only the data collected by the Eastern Regional Health Authority is presented. 1. The data correspond to the only year evaluated so far. 2. There is a potential underestimation of AMC for Costa Rica during the year 2022, and therefore in the average consumption over the entire period, as the informatic systems of the CCSS were impacted by a cyberattack during that year. 3. The data correspond to the total average consumption (hospital + community) of the public sector, for two years, period 2020-2021. 4. The data corresponds to the total consumption (hospital + community).5. Average consumption includes data from three years, the period 2019-2021. (6) Region 2 – Pomeroon-Supenaam.
Source: Marin et al. (2025), "Implementing national antimicrobial consumption in Latin America and the Caribbean: opportunities and lessons learned" https://doi.org/10.1017/s0950268824001237.

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8 Health workforce

Doctors

An adequate and well-distributed medical workforce is a prerequisite for accessible, high-quality care, particularly as population ageing and multimorbidity increase demand for longitudinal management in primary care. Recent global reassessments also underline that persistent health-workforce shortages and maldistribution remain a material constraint on progress towards universal health coverage in many settings (Boniol et al., 2022[1]). Evidence from Brazil's *Programa Mais Médicos* shows that deployment policies can rapidly expand physician supply in underserved areas, but also that short-term provision alone cannot substitute for structural workforce planning. National analyses suggest that sustainability depends on alignment with training capacity, regulatory frameworks and retention policies; while health gains were greater where baseline physician density was lower, the overall evidence underlines the need to pair deployment initiatives with broader primary-care system strengthening (Hone et al., 2020[2]; Pinto Junior, Amorim and Aquino, 2020[3]).

Doctor density varies markedly across Latin America and the Caribbean, ranging from around 9.5 doctors per 1 000 population in Cuba to 0.3 in Haiti, a more than 30-fold difference (Figure 8.1). On average, the LAC33 has 2.4 doctors per 1 000 population, compared with 3.6 in the OECD. Several countries are at or above the OECD average (e.g. Argentina 5.1; Uruguay 4.7), whereas a number of countries report fewer than 1 doctor per 1 000 (e.g. Honduras 0.5; Jamaica 0.5; Nicaragua 0.7). While part of the cross-country variation reflects differences in education capacity and retention, it also reflects definitional differences in whether data capture practising doctors or all licensed physicians.

Women account for roughly half of physicians in the countries with available data, with an average of 50.9% in LAC18 compared with 49.5% in the OECD (Figure 8.2). The share is highest in the Dominican Republic (72.0%) and Peru (64.6%), while Mexico reports a lower share (43.9%). A more gender-balanced physician workforce has implications for training pathways and employment conditions, as specialty choice and working-time patterns may differ on average by gender, affecting full-time equivalent supply. However, a higher share of women in the workforce does not in itself ensure equity in career progression, leadership access or pay. Evidence from the broader health and care sector shows persistent gender pay gaps and occupational segregation, underlining the importance of pairing service-level workforce planning with policies that promote fair remuneration and equitable career development (WHO, 2022[4]).

The age profile of physicians suggests heterogeneous replacement pressures. Across 14 LAC countries, 25.1% of physicians are aged 55 years or over on average, below the OECD average of 32.1% (Figure 8.3). Guatemala stands out with 46.8% of physicians aged 55+, followed by the Dominican Republic at 36.3%, while Paraguay reports 10.9%. Countries with an older physician workforce may face a near-term risk of retirements unless training inflows, retention policies and productivity improvements are strengthened.

These indicators point to three simultaneous planning challenges; (i) closing large cross-country gaps in physician density, (ii) adapting training and workplace policies to a near-parity (or majority-female) workforce, and (iii) anticipating retirements where physician populations are older – while protecting retention and productivity. Evidence from recent physician surveys shows how quickly retirement intentions can shift with workload and working conditions reinforcing the importance of proactive retention and work-environment strategies alongside training-pipeline measures. (Walsh et al., 2024[5]).

Definition and comparability

Doctors per 1 000 population refers to the headcount of physicians. Depending on the country, this may measure practising physicians, professionally active physicians, or all licensed/registered physicians. Some countries include interns and residents, while others report only fully licensed physicians. Data are typically headcounts and do not capture part-time work (full-time equivalents). The indicators on the share of women and the share aged 55+ are calculated on the same underlying physician stock; therefore, differences in the underlying definition therefore carry over to these indicators.

References

Boniol, M. et al. (2022), "The global health workforce stock and distribution in 2020 and 2030: a threat to equity and 'universal' health coverage?", *BMJ Global Health*, Vol. 7/6, p. e009316, https://doi.org/10.1136/bmjgh-2022-009316. [1]

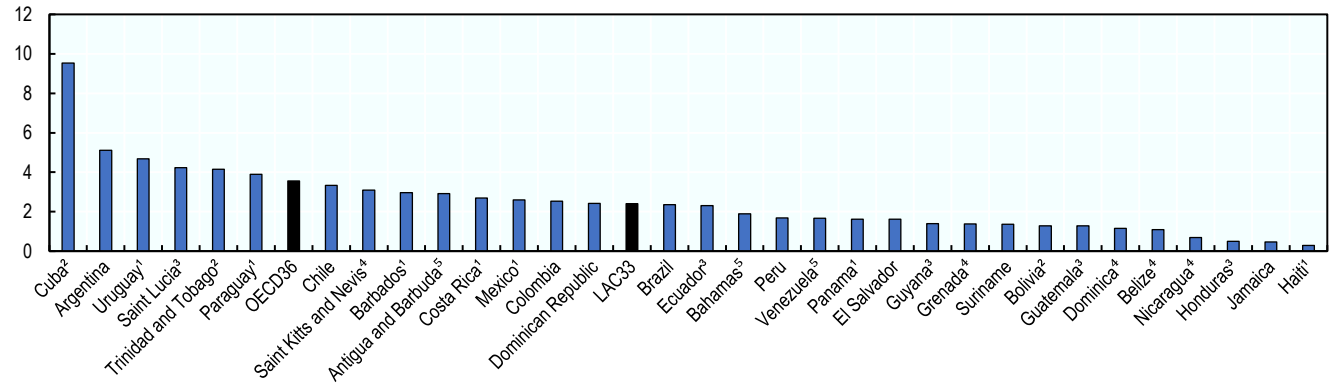
Hone, T. et al. (2020), "Impact of the Programa Mais médicos (more doctors Programme) on primary care doctor supply and amenable mortality: quasi-experimental study of 5565 Brazilian municipalities", *BMC Health Services Research*, Vol. 20/1, https://doi.org/10.1186/s12913-020-05716-2. [2]

Pinto Junior, E., L. Amorim and R. Aquino (2020), "Programa Mais Médicos: contexto de implantação e efeito no provimento de médicos na atenção primária à saúde no Brasil, 2008 a 2016", *Revista Panamericana de Salud Pública*, Vol. 44, pp. 1-9, https://doi.org/10.26633/rpsp.2020.23. [3]

Walsh, R. et al. (2024), "Factors associated with plans for early retirement among Ontario family physicians during the COVID-19 pandemic: a cross-sectional study", *BMC Primary Care*, Vol. 25/1, https://doi.org/10.1186/s12875-024-02374-9. [5]

WHO (2022), *The gender pay gap in the health and care sector: a global analysis in the time of COVID-19*, World Health Organization. [4]

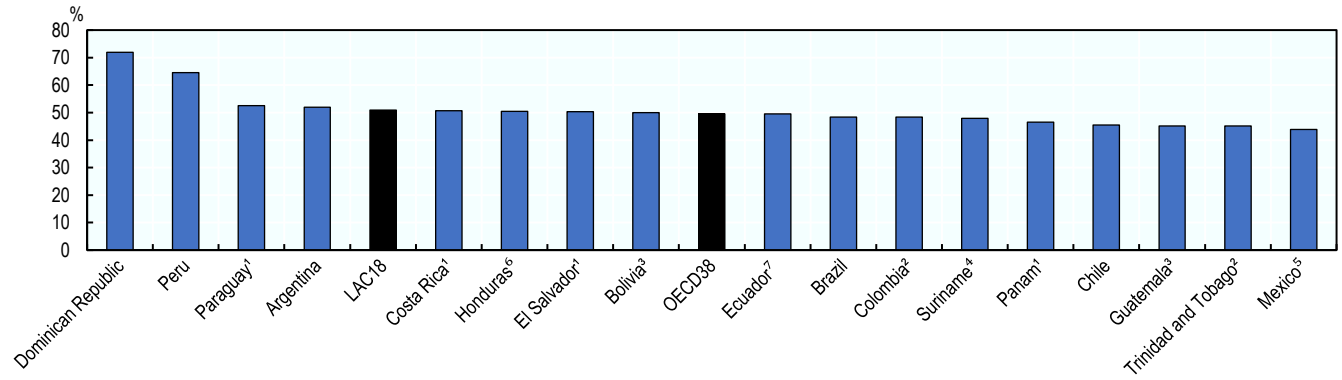
Figure 8.1. Doctors per 1 000 population, 2023 or latest year available



1. Data from 2022. 2. Data from 2021. 3. Data from 2020. 4. Data from 2018. 5. Data from 2017.
Sources: WHO Global Health Observatory 2025; OECD Health Statistics 2026 for OECD average.

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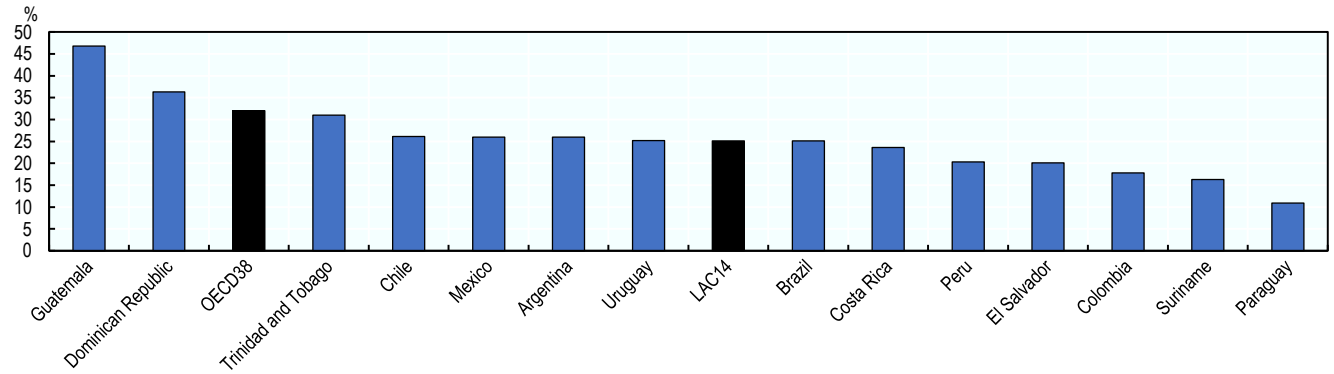
Figure 8.2. Share of female doctors, 2023 or latest year available



1. Data from 2022. 2. Data from 2021. 3. Data from 2020. 4. Data from 2019. 5. Data from 20176. Data from 2016. 7. Data from 2015.
Sources: WHO Global Health Observatory 2025; OECD Health Statistics 2026 for OECD average.

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Figure 8.3. Share of doctors aged 55 years or more, latest year available



Source: PAHO (2025), *The health workforce in the Americas: Regional data and indicators*, https://doi.org/10.37774/9789275129708; OECD Health Statistics 2026 for OECD average.

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Nurses and midwifes

Nurses and midwives are central to safe and effective service delivery across the care continuum – from hospital care to community-based prevention, chronic disease management and maternal and newborn health. Evidence from evaluations of nurse staffing policy reforms shows that improving registered-nurse staffing is associated with lower patient mortality and readmissions, underscoring that workforce availability is both a capacity and a quality/safety lever (Dall'Ora et al., 2022[1]; McHugh et al., 2021[2]).

Across the LAC33, the density of nurses and midwives averages 3.9 per 1 000 population, well below the OECD average of 10.3 (Figure 8.4). Values range from around 9.7 in Antigua and Barbuda and 9.4 in Paraguay to 0.7 in Haiti and 0.7 in Honduras. Several large countries cluster around 2-3 nurses and midwives per 1 000 (e.g. Mexico 3.0; Costa Rica 3.1; Panama 3.3), pointing to constraints on scaling team-based primary care and safe hospital staffing. As with doctors, cross-country comparability is influenced by whether countries report practising personnel or all registered/licensed nurses and midwives (see Definition and comparability box).

Midwifery personnel density averages 4.3 per 10 000 population across LAC19, broadly similar to the OECD average of 4.2, but dispersion is large (Figure 8.5). Antigua and Barbuda reports a very high value (29.5 per 10 000), which may reflect differences in how nurse-midwives are classified and small-population effects; Chile (8.2) and Paraguay (7.8) also stand above the regional average. Several countries report very low densities (≤0.3 per 10 000 in Brazil, Trinidad and Tobago and El Salvador), and Mexico reports a near-zero value. These differences should be interpreted cautiously because midwifery is not recognised as a distinct occupation in some countries, and midwifery functions may be performed by other cadres. Where implemented, continuity of midwife-led care is associated with lower caesarean and instrumental birth rates and more spontaneous vaginal births.

Skill-mix in LAC, proxied here by the number of nurses and midwives per doctor, is comparatively doctor-heavy in many LAC health systems, as Figure 8.6 shows by plotting the density of nurses and midwives against that of doctors. The figure also highlights overall workforce shortages in several countries. The LAC33 average is 1.6 nurses per doctor, far below the OECD average of 2.9. Several Caribbean countries exceed the OECD average (e.g. Dominica 5.8; Saint Vincent and the Grenadines 5.1; Jamaica 3.5), whereas ratios are notably low in Colombia (0.6), Cuba (0.8) and the Dominican Republic (0.8). Persistently low nurse-to-doctor ratios typically indicate constrained capacity for prevention, follow-up and care co-ordination in team-based models of care. The comparatively limited data available for countries like Colombia reflect the fragmentation of human resources for health information sources and inherent issues of comparability.

These indicators point to a dual agenda: (i) expanding and retaining nurses and midwives where densities remain very low, and (ii) improving skill-mix and deployment, so that workers can practise to the top of their competencies – particularly in primary care teams and maternal services. At the same time, cross-country variation in nurse-to-doctor ratios should be interpreted with caution, as national reporting does not always distinguish consistently between nursing professionals, nursing associate professionals and nurses not further defined. WHO's latest nursing report suggests that these classification issues remain material for international comparison, even though many observations can be reclassified ex post (WHO, 2025[3]). Evidence syntheses indicate that delegation or substitution of some primary care physician activities to nurses can maintain patient-relevant outcomes across multiple tasks and settings, supporting skill-mix reforms as a practical response to workforce constraints. (Paier-Abuzahra et al., 2024[4]).

Definition and comparability

WHO reports the density of nursing and midwifery personnel per population. This category may include professional and associate nursing/midwifery roles, while traditional birth attendants are excluded. Cross-country comparability is limited by whether countries report practising, professionally active, or all licensed-to-practise workers. The data for some countries only include nurses and midwives working in the public sectors. PAHO prioritises the reporting of practising workers, but when these data are unavailable, it uses professionally active or all licensed-to-practise nurses and midwives. Comparability is affected by the fact that midwifery is not a distinct occupation in some countries, with midwifery functions performed by nurses with midwifery training or non-formally trained birth attendants who are not captured in NHWA reporting. The nurse-to-doctor ratio combines two indicators and therefore compounds definitional and reporting differences.

References

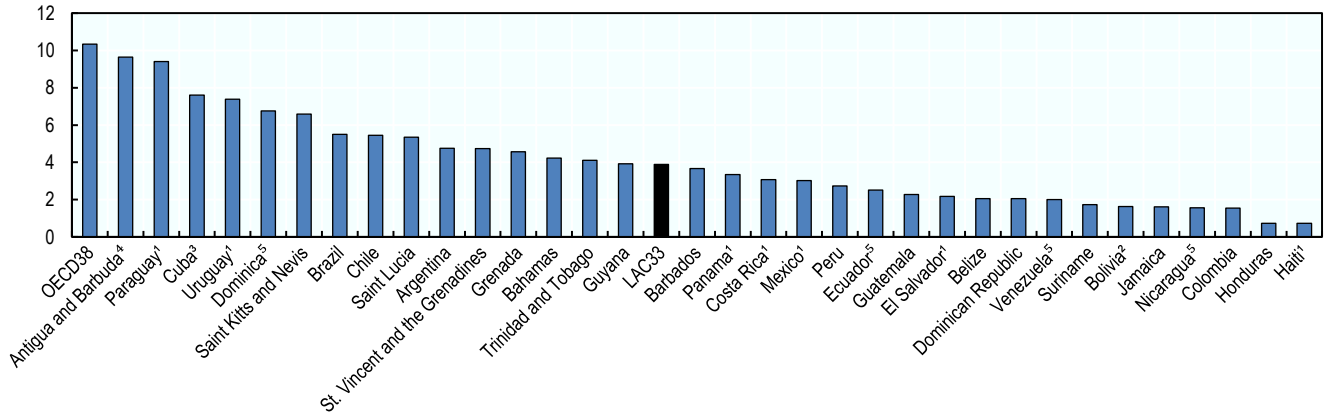
Dall'Ora, C. et al. (2022), "Nurse staffing levels and patient outcomes: A systematic review of longitudinal studies", *International Journal of Nursing Studies*, Vol. 134, p. 104311, https://doi.org/10.1016/j.ijnurstu.2022.104311. [1]

McHugh, M. et al. (2021), "Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: a prospective study in a panel of hospitals", *The Lancet*, Vol. 397/10288, pp. 1905-1913, https://doi.org/10.1016/s0140-6736(21)00768-6. [2]

Paier-Abuzahra, M. et al. (2024), "Effects of task-shifting from primary care physicians to nurses: an overview of systematic reviews", *Human Resources for Health*, Vol. 22/1, https://doi.org/10.1186/s12960-024-00956-3. [4]

WHO (2025), *State of the world's nursing 2025: Investing in education, jobs, leadership and service delivery*, World Health Organization. [3]

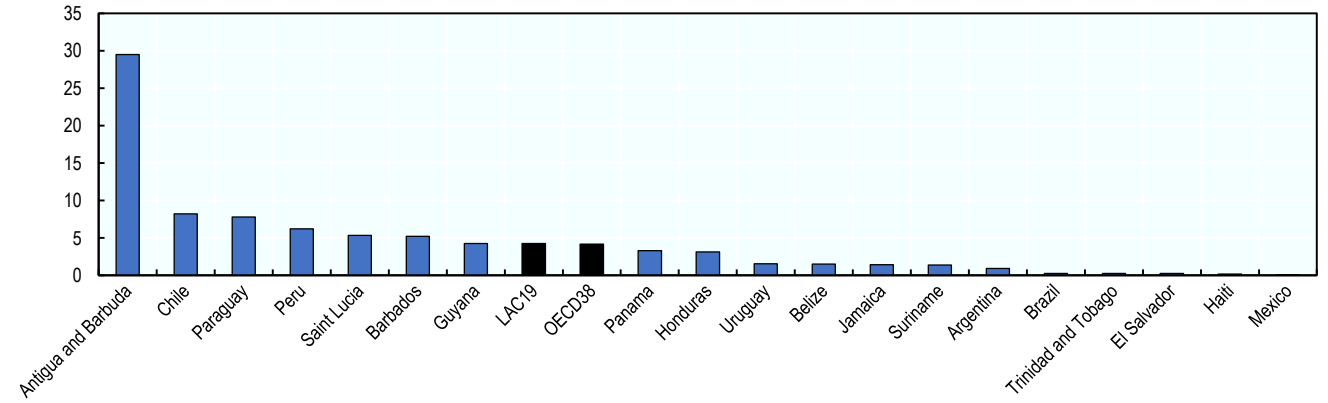
Figure 8.4. Nurses and midwives per 1 000 population, latest year available



1. Data from 2022. 2. Data from 2021. 3. Data from 2020. 4. Data from 2019. 5. Data from 2018.
Sources: WHO Global Health Observatory 2025; OECD Health Statistics 2026 for OECD average.

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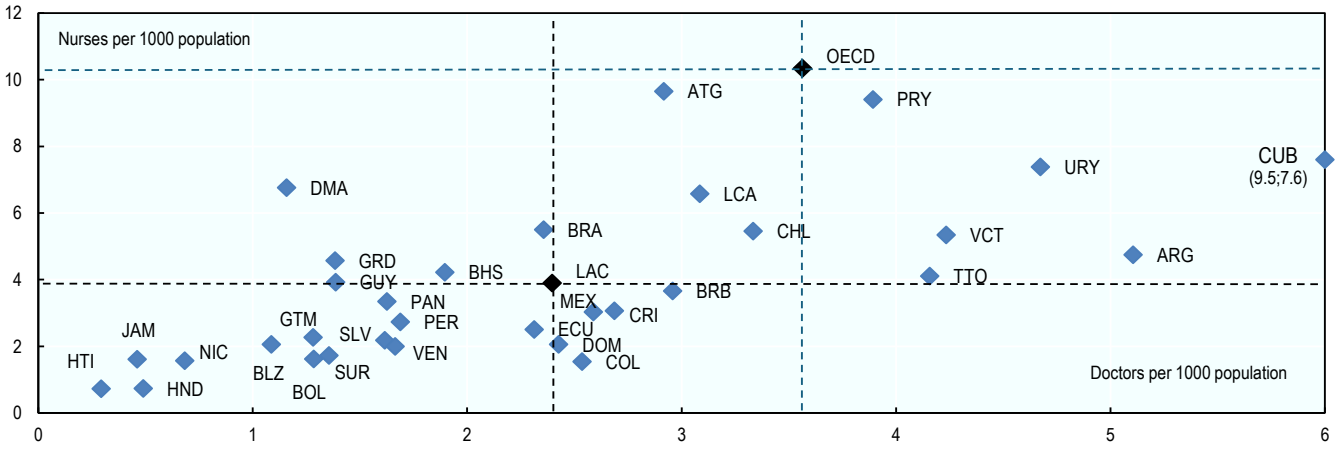
Figure 8.5. Midwives per 10 000 population



Source: PAHO (2025), *The health workforce in the Americas: Regional data and indicators*, https://doi.org/10.37774/9789275129708. OECD Health Statistics 2026 for OECD average.

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Figure 8.6. Ratio of nurses (incl. midwifes) to doctors, latest year available



Source: WHO GHO 2025; OECD Health Statistics 2026 for OECD average.

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Dentists, pharmacists, and physiotherapists

Dentists, pharmacists and physiotherapists complement primary care teams and are critical for integrated pathways. Oral diseases remain highly prevalent and socially patterned, demanding stronger prevention and access to care (Peres et al., 2019[1]). In parallel, rehabilitation needs are widespread and growing, with an estimated one in three people worldwide benefiting from rehabilitation at some point (Cieza et al., 2020[2]). Against this epidemiological backdrop, PAHO's NHWA-based indicators point to large cross-country variation and important data gaps for these professions in the Region of the Americas (PAHO, 2025[3]).

Dentist availability is highly uneven. Across the LAC32, there are 4.0 dentists per 10 000 population on average, compared with 7.3 in the OECD (Figure 8.7). Cuba (16.7) and Chile (14.8) report the highest densities, while Haiti (0.2), Honduras (0.3) and Nicaragua (0.4) report fewer than 0.5 dentists per 10 000. Such gaps are likely to translate into differences in timely access to preventive and restorative services, especially for lower-income groups, unless oral health is better integrated into primary healthcare and public coverage.

Pharmacist densities also vary widely, reflecting different roles in service delivery and regulation. Costa Rica reports 11.6 pharmacists per 10 000 population, above the OECD average of 8.7, while the LAC21 average is 3.6 (Figure 8.8). Several countries report fewer than 2 pharmacists per 10 000 (e.g. Guatemala 1.2; Dominican Republic 1.5; Peru 1.5), and Haiti reports 0.3. Limited pharmacist availability can constrain safe medicines use, adherence support and continuity of care for people living with chronic conditions.

Physiotherapist density is markedly lower in LAC than in the OECD. The LAC16 average is 3.7 physiotherapists per 10 000 population, compared with 12.1 in the OECD (Figure 8.9). Chile reports a high density (18.5), whereas several countries report fewer than 1 physiotherapist per 10 000 (e.g. Panama 1.0; Suriname 0.9; Jamaica 0.7) and some report near-zero availability. Low rehabilitation capacity may contribute to unmet needs and poorer functional outcomes following injury, chronic disease and ageing-related disability.

The indicators suggest a "triple gap": large inequalities in oral health service capacity, constrained pharmaceutical workforce availability in many countries, and limited rehabilitation capacity. Policy responses include strengthening training pipelines, expanding team-based primary care with appropriate scopes of practice, and improving deployment to underserved areas. Given the high burden of preventable oral disease and growing rehabilitation needs, scaling these workforces is increasingly relevant for health system performance. The evidence base supports this direction: pharmacist-delivered hypertension care has been synthesised in recent systematic reviews showing improvements in blood pressure outcomes, and broader reviews underline the expanding role of community pharmacists in cardiovascular risk prevention and management – highly relevant for LAC's NCD agenda (Motlohi et al., 2023[4]).

Definition and comparability

Indicators for dentists, pharmacists, and physiotherapists per 10 000 population are sourced from PAHO's *The health workforce in the Americas: Regional data and indicators* (2025) (PAHO, 2025[3]), based on Member State reporting to the National Health Workforce Accounts (NHWA), extracted in late 2023 and covering 2017-2021 (latest available by country).

PAHO classifies dentists and pharmacists as priority occupations and physiotherapists as an occupation of interest. A key comparability issue is the NHWA distinction between practising, professionally active, and licensed-to-practise workers: PAHO prioritises practising counts, followed by professionally active and then licensed-to-practise, though licensed registers may include individuals not currently providing services (e.g. inactive, retired, or emigrated). Each indicator is calculated as the number of workers in the occupation divided by the population, multiplied by 10 000. Cross-country comparability is further affected by differences in occupational boundaries (e.g. treatment of dental hygienists, pharmacy technicians, physiotherapy assistants), variation in public/private sector coverage, and inconsistent metadata or headcount concepts across years, with PAHO noting substantial heterogeneity in data sources and reporting practices.

References

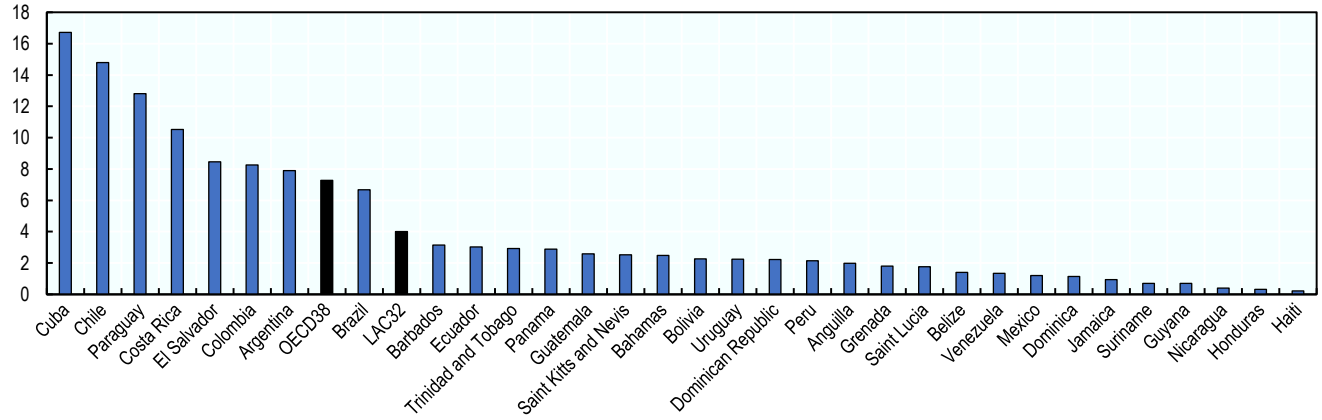
Cieza, A. et al. (2020), "Global estimates of the need for rehabilitation based on the Global Burden of Disease study 2019: a systematic analysis for the Global Burden of Disease Study 2019", *The Lancet*, Vol. 396/10267, pp. 2006-2017, https://doi.org/10.1016/s0140-6736(20)32340-0. [2]

Motlohi, N. et al. (2023), "A systematic review of the role of community pharmacists in the prevention and control of cardiovascular diseases: the perceptions of patients", *Systematic Reviews*, Vol. 12/1, https://doi.org/10.1186/s13643-023-02338-7. [4]

PAHO (2025), *The health workforce in the Americas: Regional data and indicators*, Pan American Health Organization, https://doi.org/10.37774/9789275129708. [3]

Peres, M. et al. (2019), "Oral diseases: a global public health challenge", *The Lancet*, Vol. 394/10194, pp. 249-260, https://doi.org/10.1016/s0140-6736(19)31146-8. [1]

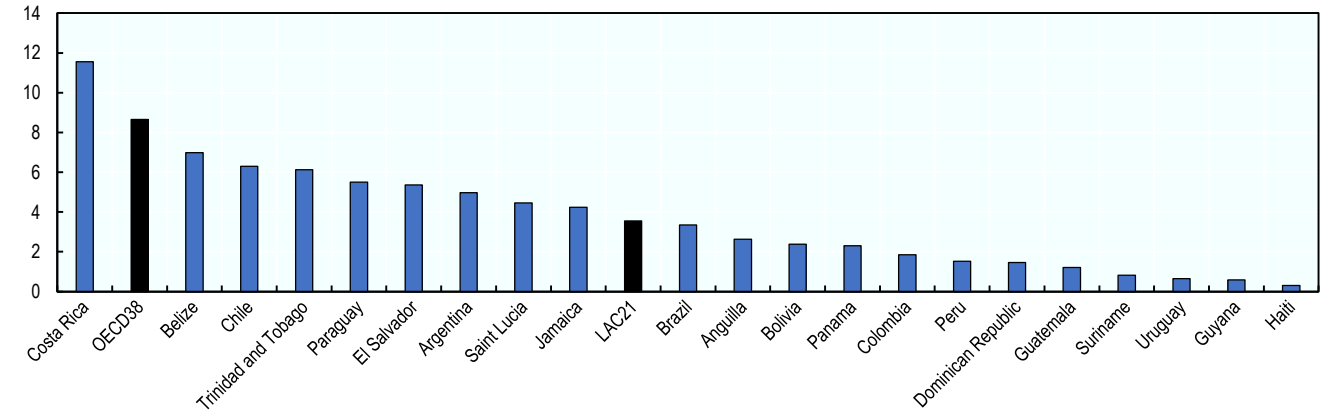
Figure 8.7. Dentists per 10 000 population, latest year available



Source: PAHO (2025), *The health workforce in the Americas: Regional data and indicators*, https://doi.org/10.37774/9789275129708. OECD Health Statistics 2026 for OECD average.

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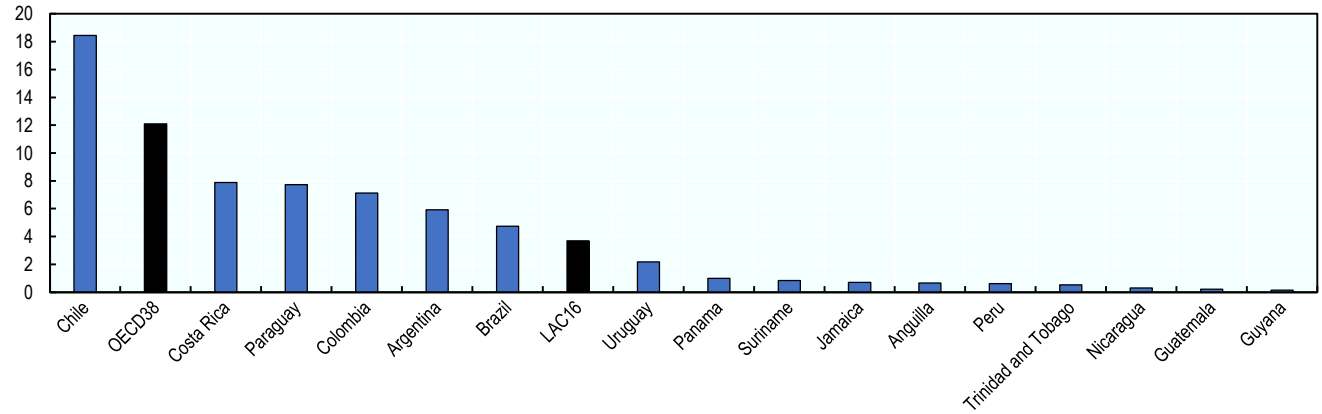
Figure 8.8. Pharmacists per 10 000 population, latest year available



Source: PAHO (2025), *The health workforce in the Americas: Regional data and indicators*, https://doi.org/10.37774/9789275129708. OECD Health Statistics 2026 for OECD average.

StatLink https://stat.link/giydxa

Figure 8.9. Physiotherapists per 10 000 population, latest year available



Source: PAHO (2025), *The health workforce in the Americas: Regional data and indicators*, https://doi.org/10.37774/9789275129708. OECD Health Statistics 2026 for OECD average.

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Community health workers and environmental and occupational health

Strengthening primary healthcare in LAC requires both people-centred service delivery and strong public health functions. Community health workers (CHWs) extend prevention, follow-up and navigation to underserved communities, while environmental and occupational health personnel support regulatory and surveillance functions (e.g. workplace risk control, sanitation and broader environmental health protection). Recent evidence synthesises that CHW interventions can be cost-effective in primary healthcare, but performance depends on programme design, including supervision, remuneration and integration with services (Van Iseghem et al., 2026[1]). More broadly, efforts to deliver essential public health functions require multidisciplinary workforce capacity across health and non-health sectors (WHO, 2022[2]). Cross-country differences in reported densities for CHWs and environmental and occupational health personnel should be interpreted with caution, as these functions are often regulated, employed and recorded by different ministries or agencies.

CHW availability varies sharply across reporting countries. Brazil reports 19.1 CHWs per 10 000 population, reflecting the scale of the Family Health Strategy and its community health agent cadre, while Honduras (7.6) and Guyana (6.6) also report higher densities (Figure 8.10). The LAC13 average is 4.7, but some countries report very low values, including Paraguay (1.6) and Panama (1.2), and Guatemala reports 0.1 per 10 000. Differences partly reflect the scope of CHW programmes (paid vs. volunteer, full-time vs. part-time) and whether CHWs are counted as a distinct cadre within health workforce statistics or absorbed into broader technical workforce categories.

Indicators for environmental and occupational health inspectors and associates suggest large differences in regulatory capacity (Figure 8.11). Brazil reports 81.4 inspectors per 100 000 population and Uruguay 51.2, well above the LAC12 average of 21.4, while several countries report fewer than 6 per 100 000 (e.g. El Salvador 5.8; Panama 4.0; Peru 4.0; Guatemala 2.3). Because these functions can be delivered by staff in different ministries and agencies, cross-country comparability is sensitive to institutional arrangements and occupational classification and the distinction between licensed and professionally active workers.

Reported densities of environmental and occupational health and hygiene professionals also vary widely (Figure 8.12). Nicaragua reports 67.5 professionals per 100 000 population, an extreme value compared with the LAC9 average of 11.5, while El Salvador reports 21.4 and Brazil 5.5 (around 2021). Several countries report fewer than 1 professional per 100 000 (e.g. Peru 0.7; Uruguay 0.5; Panama 0.4). Such dispersion likely reflects both real differences in workforce capacity and major differences in how countries define and record these occupations; it may also reflect variation in whether countries report licensed, professionally active or mixed categories of workers. Values should therefore be interpreted with caution.

These indicators point to a "dual capacity" challenge for LAC: (1) community-facing outreach (CHWs) and (2) public health protection functions (environmental/occupational health professionals) are both highly variable across countries. In *Health at a Glance: Latin America and the Caribbean* terms, this matters for the credibility of PHC-oriented reforms: CHWs can strengthen continuity and self-management support, with systematic review evidence showing measurable improvements in chronic disease outcomes in some settings (Evans, White and Ha, 2023[3]). In parallel, adequate inspection and environmental health capacity underpins safe food, water, workplaces and public environments – areas where cross-country analyses continue to emphasise the centrality (and complexity) of inspection practice (Barnes et al., 2024[4]).

Definition and comparability

Community health workers (CHWs) are health-related outreach workers providing community-based prevention, follow-up, navigation and health promotion. Countries differ in whether CHWs are paid or volunteer, formal or informal, and whether they are counted in national workforce statistics. Environmental and occupational health personnel include both inspectors/associates and professionals as classified in international occupational classifications. In practice, these functions may sit across multiple sectors (health, labour, environment), which affects coverage and comparability. Data for these occupations are particularly sparse and definitions less standardised; large outliers may reflect differences in reporting or occupational mapping.

References

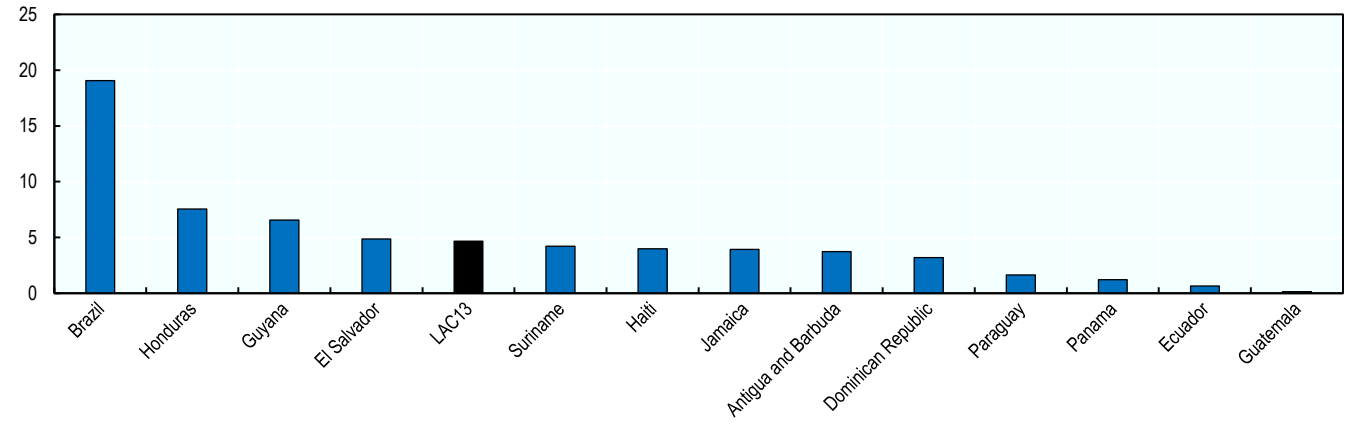
Barnes, J. et al. (2024), "Performing food safety inspections", *Food Control*, Vol. 160, p. 110329, https://doi.org/10.1016/j.foodcont.2024.110329. [4]

Evans, J., P. White and H. Ha (2023), "Evaluating the effectiveness of community health worker interventions on glycaemic control in type 2 diabetes: a systematic review and meta-analysis", *The Lancet*, Vol. 402, p. S40, https://doi.org/10.1016/s0140-6736(23)02140-2. [3]

Van Iseghem, T. et al. (2026), "The Cost-Effectiveness of Community Health Workers in Primary Health Care: A Systematic Review", *Value in Health*, Vol. 29/2, pp. 324-344, https://doi.org/10.1016/j.jval.2025.09.004. [1]

WHO (2022), *National workforce capacity to implement the essential public health functions including a focus on emergency preparedness and response: roadmap for aligning WHO and partner contributions*, World Health Organization. [2]

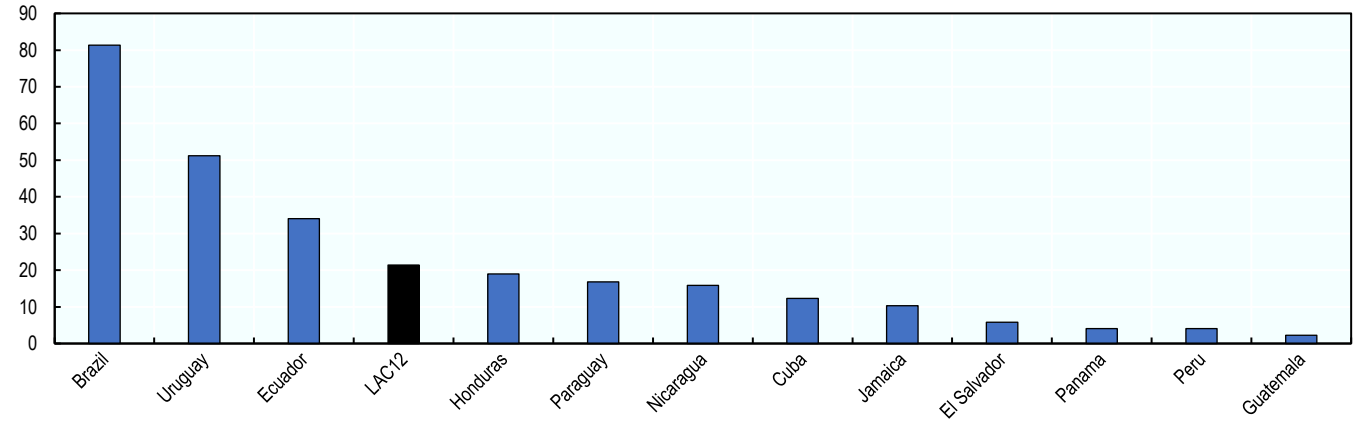
Figure 8.10. Community health workers per 10 000 population, latest year available



Source: WHO Global Health Observatory 2025.

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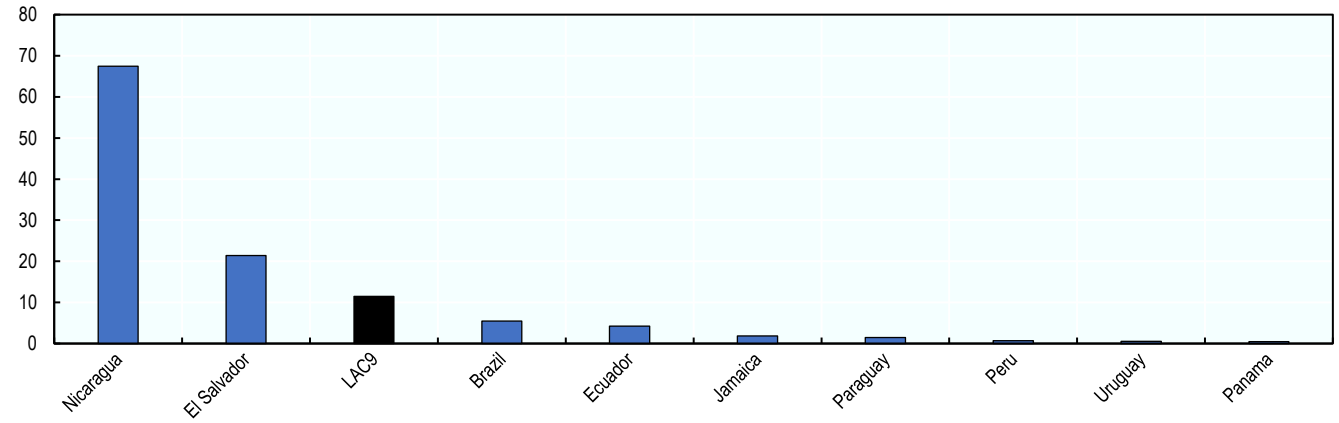
Figure 8.11. Environmental and occupational health inspectors and associates per 100 000 population, latest year available



Source: WHO Global Health Observatory 2025.

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Figure 8.12. Environmental and occupational health and hygiene professionals



Source: WHO Global Health Observatory 2025.

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Graduates

Graduate output is a leading indicator of future workforce supply, but it does not automatically translate into greater domestic availability if retention is weak, if graduates concentrate in certain locations or specialties, or if a sizeable share of training is provided to international students who subsequently leave. In several Caribbean settings, "offshore" medical schools cater largely to international students – often from North America – who typically leave after graduation, which can inflate national graduation rates relative to domestic health system needs (Halperin and Goldberg, 2016[1]; Morgan, Crooks and Snyder, 2017[2]). Since comparable data on admissions capacity, entrants and completion rates are limited, graduate output should be interpreted as only a partial proxy for training capacity. Differences across professions may also reflect variation in attractiveness, educational requirements and barriers to entry. Graduate indicators should therefore be interpreted alongside evidence on domestic labour market absorption and patterns of international student and worker mobility.

Medical graduate output ranges widely, from 33.9 graduates per 100 000 population in the Dominican Republic to 4.3 in Costa Rica (Figure 8.13). The LAC10 average is 12.8, close to the OECD average of 14.5, with Mexico (14.5), Colombia (14.7) and Uruguay (14.7) near the OECD average. The very high rate in the Dominican Republic may partly reflect the internationalisation of medical education in parts of the Caribbean, where a substantial share of enrolment can be foreign students who do not enter the domestic workforce (Halperin and Goldberg, 2016[1]; Morgan, Crooks and Snyder, 2017[2]).

Professional nurse graduate output generally exceeds medical graduate output but varies sharply across countries (Figure 8.14). The OECD average is 34.9 nurse graduates per 100 000 population, while the LAC19 average is 18.4. Saint Vincent and the Grenadines reports 44.6, and Chile reports 34.0 (close to the OECD average), whereas Guatemala reports 2.1 and Cuba 4.0. As with other indicators, small populations and differences in nursing education structures (e.g. professional vs. associate training routes) can affect comparability.

Pharmacist graduate output is highest in Brazil (8.2 per 100 000) and Costa Rica (5.6), above the OECD average of 4.2, while the LAC8 average is 3.4 (Figure 8.15). Mexico reports 3.4, whereas Panama reports 1.8 and Argentina and Colombia about 1.2. Given the expanding role of pharmacists in medicines management and continuity of care, sustained low graduation rates may constrain development of clinical pharmacy services.

Overall, the graduate indicators highlight substantial differences in training capacity across professions and countries, and they underscore that workforce planning needs to link education policy with retention, deployment, and differences in professional attractiveness and access to education. In countries with high graduate output, improving domestic absorption and working conditions can help translate training into service capacity. In countries with low graduate output, targeted expansion of education capacity may be needed, but should be paired with strategies to reduce emigration and address geographic maldistribution. Finally, where international student inflows are large, graduate output should be interpreted alongside evidence on the destination of graduates and domestic workforce needs (Lee et al., 2024[3]).

Definition and comparability

Graduates per 100 000 population count individuals completing pre-service education or training in the specified profession in a given year. Education structures differ (e.g. professional versus associate nursing; different pharmacy qualifications) and reporting may cover public and private institutions to varying degrees. Graduate output may include international students who do not enter the domestic workforce, and graduates may emigrate. Moreover, limited and sometimes missing data on admissions capacity, entrants, completion rates and faculty availability mean that graduate numbers are only a partial proxy for training capacity. Differences across professions may also reflect variation in attractiveness, entry requirements and access to training. Graduate indicators should therefore be interpreted alongside evidence on labour market absorption and retention.

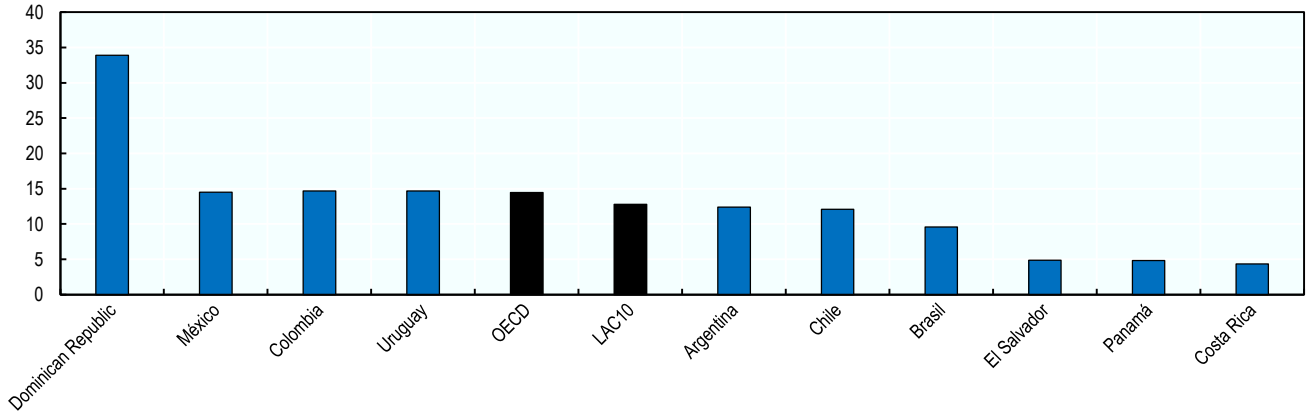
References

Halperin, E. and R. Goldberg (2016), "Offshore Medical Schools Are Buying Clinical Clerkships in U.S. Hospitals: The Problem and Potential Solutions", *Academic Medicine*, Vol. 91/5, pp. 639-644, https://doi.org/10.1097/acm.0000000000001128. [1]

Lee, J. et al. (2024), "Methods for health workforce projection model: systematic review and recommended good practice reporting guideline", *Human Resources for Health*, Vol. 22/1, https://doi.org/10.1186/s12960-024-00895-z. [3]

Morgan, J., V. Crooks and J. Snyder (2017), ""We have been forced to move away from home": print news coverage of Canadians studying abroad at Caribbean offshore medical schools", *BMC Medical Education*, Vol. 17/1, https://doi.org/10.1186/s12909-017-1071-4. [2]

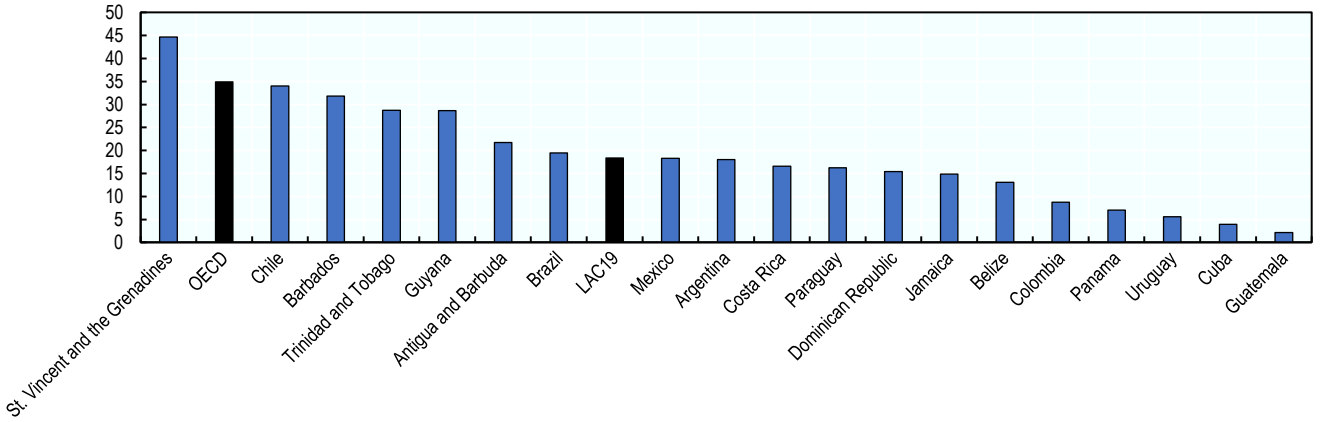
Figure 8.13. Medical graduates per 100 000 population, latest year available



Source: OECD Health Statistics 2026 for Argentina, Chile, Colombia, Mexico and OECD average. Rest of countries: PAHO (2025), *The health workforce in the Americas: Regional data and indicators*, https://doi.org/10.37774/9789275129708.

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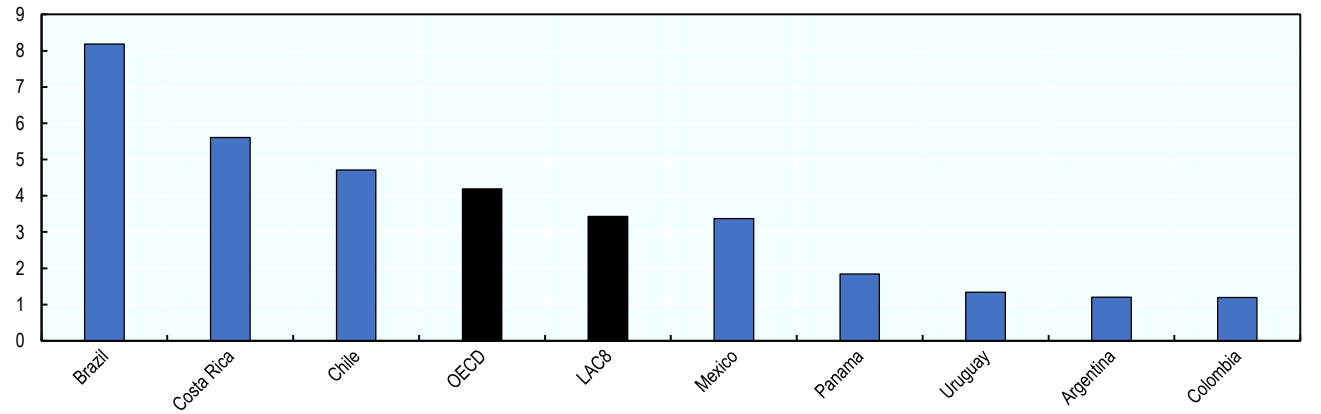
Figure 8.14. Nursing graduates per 100 000 population, latest year available



Source: OECD Health Statistics 2026 for Argentina, Chile, Colombia, Mexico and OECD average. Rest of countries: PAHO (2025), *The health workforce in the Americas: Regional data and indicators*, https://doi.org/10.37774/9789275129708.

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Figure 8.15. Pharmacy graduates per 100 000 population, latest year available



Source: OECD Health Statistics 2026 for Argentina, Chile, Colombia, Mexico and OECD average. Rest of countries: PAHO (2025), *The health workforce in the Americas: Regional data and indicators*, https://doi.org/10.37774/9789275129708.

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Stock of migrant doctors and nurses to OECD countries

International mobility of health professionals is shaped by a mix of "push" factors (e.g. pay, working conditions, career progression and security) and "pull" factors (e.g. demand, active recruitment and recognition of qualifications). Mobility can generate benefits (skills acquisition, remittances and diaspora links) but can also accelerate shortages, especially where training capacity is limited. OECD analyses therefore use expatriation rates to distinguish large origin countries with sizeable numbers abroad from smaller states where outward mobility represents a large share of the domestically born workforce (OECD, 2025[1]).

Doctor expatriation to OECD countries is higher for the LAC33 as a whole (20.1%) than for the OECD average (10.2%), with very high exposure concentrated in several Caribbean states (Figure 8.16). The highest rates are observed in Grenada (68.6%), Jamaica (57.7%), Saint Vincent and the Grenadines (56.2%) and Dominica (50.9%); rates remain elevated in Suriname (46.0%), Guyana (43.5%) and Haiti (40.1%). By contrast, most larger continental countries have single-digit rates – Cuba (8.6%), Panama (8.1%), Colombia (7.4%) and Ecuador (6.5%)–and very low rates in Mexico (2.2%) and Brazil (1.2%). This pattern implies that risks to domestic service capacity are driven less by where the largest stocks are, and more by where emigration constitutes a large fraction of the domestically born medical workforce.

The exposure profile is even more pronounced for nurses, with the LAC33 expatriation rate reaching 34.5%, compared with an OECD38 average of 8.7% (Figure 8.17). Several countries exhibit extremely high rates – Jamaica (89.9%), Haiti (85.2%), Guyana (78.4%), Grenada (74.5%) and Dominica (72.0%)–followed by Belize (65.8%), Saint Lucia (64.5%), Saint Vincent and the Grenadines (64.1%) and Trinidad and Tobago (61.6%). Rates are also high in Barbados (52.2%), Saint Kitts and Nevis (51.5%), Suriname (49.1%), Antigua and Barbuda (43.3%) and the Bahamas (43.0%). At the other end, several large countries have relatively low exposure – Brazil (1.0%), Paraguay (1.3%), Argentina (1.5%), Uruguay (3.5%) and Chile (4.6%)–with a group near the OECD average (Costa Rica 8.6%; Mexico 9.5%; Ecuador 9.6%). Overall, the nursing results indicate that outward mobility can represent a system-level supply shock for a subset of countries, particularly small island states.

Outward mobility to OECD countries is structurally different across the region: (1) large absolute stocks from major countries (driven largely by scale and long-standing corridors) and (2) very high expatriation rates in several Caribbean states – especially for nurses – where migration can exceed the domestically employed workforce. OECD analyses highlight, for example, that more nurses from Antigua and Barbuda, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica and Saint Vincent work in other countries than domestically. Workforce shortages are not "caused" by migration alone – investment in education, employment and working conditions remains the primary lever – but migration can meaningfully exacerbate shortages for specific origin countries and occupations (OECD, 2025[1]). This supports a dual policy response: strengthen domestic attraction and retention (pay, career pathways, workload and safety), while improving the governance of mobility (ethical recruitment, bilateral agreements and better data) to support sustainability in both origin and destination systems.

Definition and comparability

The expatriation rate is the percentage of doctors or nurses born in a given country who are working in OECD countries, out of the total number of doctors or nurses born in that country (those working at home plus those working in OECD countries). In this section, the companion "stock" measure reports the number of LAC-born doctors/nurses working in OECD countries (2000 and 2020).

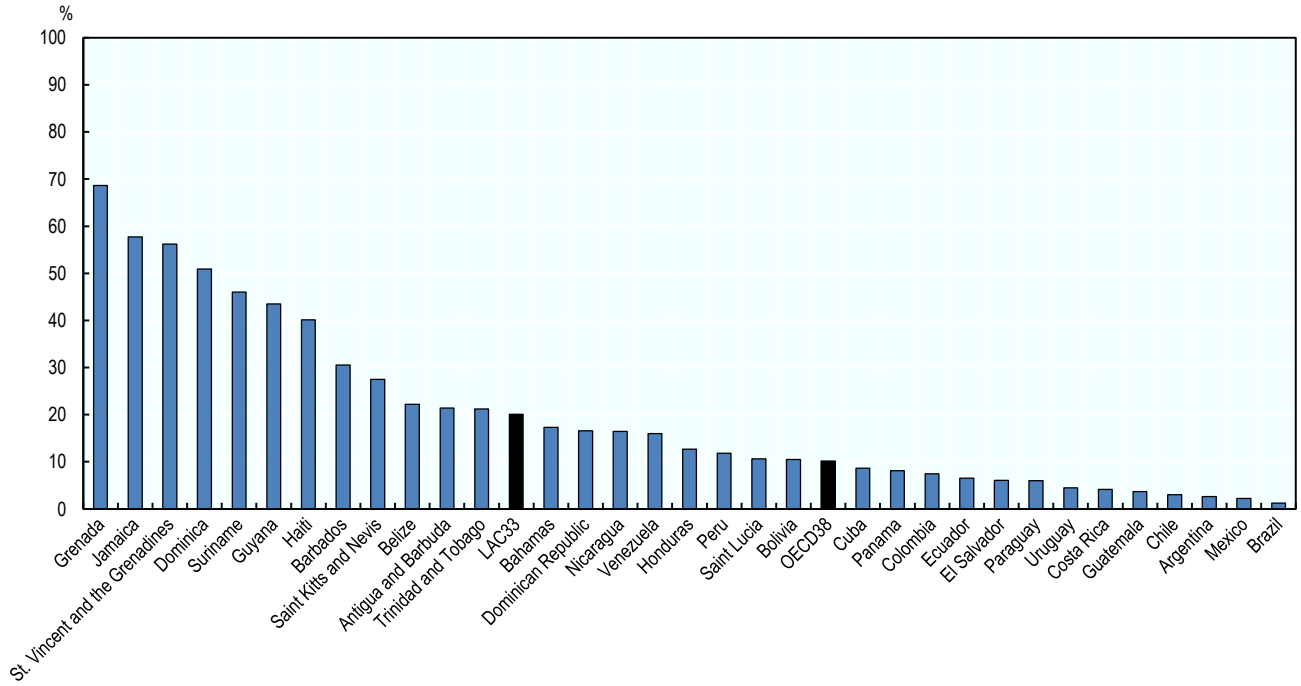
Stocks capture scale (how many professionals are abroad), while expatriation rates capture exposure (how large that outflow is relative to the origin workforce). This is particularly important for small states, where moderate absolute numbers can translate into very high rates.

The indicator captures migration to OECD destinations only (so it may understate total emigration where non-OECD destinations are important). Rates also depend on consistent occupational definitions and measurement of "working" across origin and destination sources and years, so time trends can partly reflect data improvements.

References

OECD (2025), *International Migration Outlook 2025*, OECD Publishing, Paris, https://doi.org/10.1787/ae26c893-en. [1]

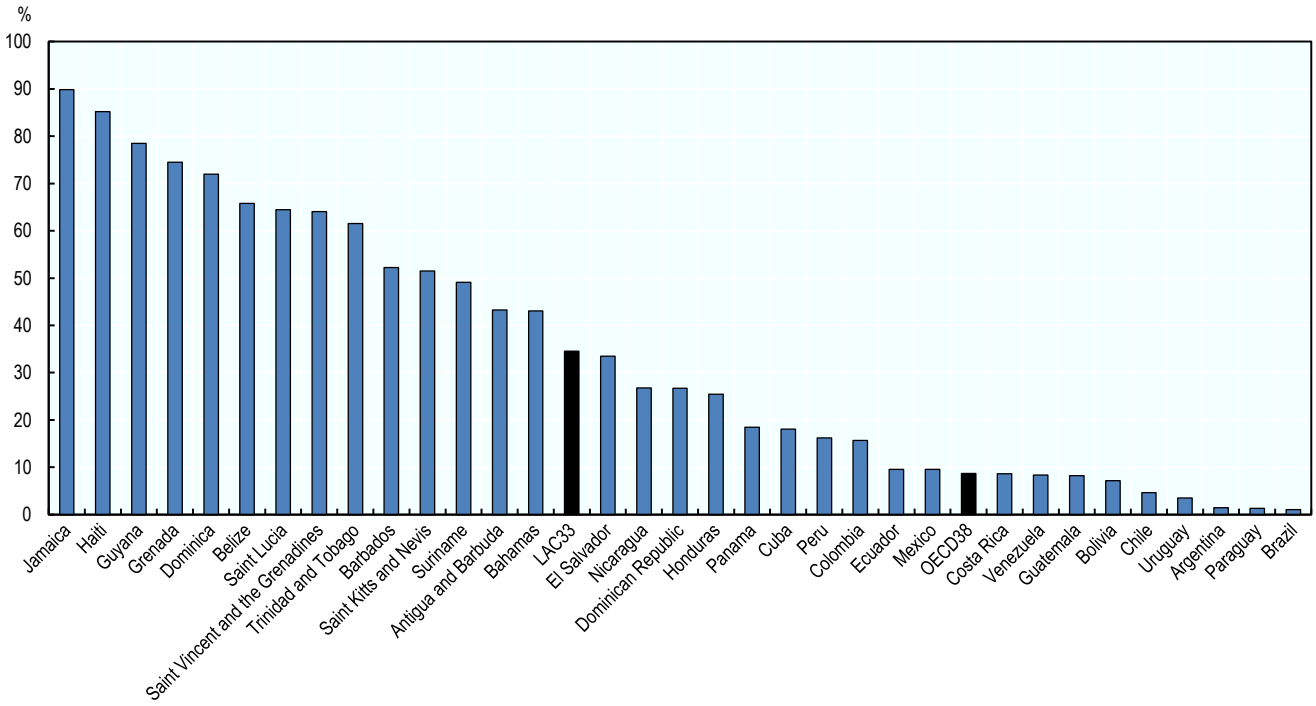
Figure 8.16. Stocks of migrant doctors to the OECD by country of origin and emigration rates



Source: OECD calculations based on the OECD Database on Immigrants in OECD Countries (DIOC) 2000/01 and 2020/21 (and EU-LFS 2021 where relevant), and WHO National Health Workforce Accounts (NHWA) for the size of the domestically born workforce in origin countries.

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Figure 8.17. Stocks of migrant nurses to the OECD by country of origin and emigration rates



Source: OECD calculations based on the OECD Database on Immigrants in OECD Countries (DIOC) 2000/01 and 2020/21 (and EU-LFS 2021 where relevant), and WHO National Health Workforce Accounts (NHWA) for the size of the domestically born workforce in origin countries.

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9 Ageing

Demographic trends

Population ageing is accelerating in Latin America and the Caribbean (LAC). While the region remains younger than OECD countries on average, it is ageing at a faster pace as fertility declines and survival at older ages improves. United Nations projections indicate that the share of people aged 65 and over will rise rapidly across LAC over the coming decades, increasing the old-age dependency ratio and the demand for health and long-term care services. The speed of this demographic transition matters for policy. Countries ageing faster have less time to adapt financing, service delivery and workforce capacity, particularly for long-term care (LTC) and chronic disease management. This makes early investment in age-friendly health systems and community-based care models critical to prevent avoidable hospital use and unmet care needs as dependency rises (Bloom, Canning and Fink, 2010[1]).

By 2050, the share of people aged 65 and over is projected to almost double in the LAC31 average, rising from 9.3% in 2023 to 18.1% (Figure 9.1, left panel). Even then, LAC will remain younger than the OECD average, where the share is projected to reach 26.4% in 2050 (from 18.5% in 2023). Ageing will be most advanced in Cuba (around 30.2% aged 65+ in 2050), Chile (26.7%) and Costa Rica (25.3%), while Haiti, Guatemala and Bolivia are projected to remain below 10%. In several countries that are still relatively young today (for example Belize and Honduras), the share aged 65+ increases rapidly in proportional terms but remains comparatively low in 2050 because it starts from a small base and fertility remains higher than in the fastest-ageing countries. As women live longer than men, the older population will increasingly be feminised, with implications for income security, care needs and living arrangements (Bilal et al., 2019[2]).

Growth will be even faster at the oldest ages. The share of people aged 80 and over in the LAC31 average is projected to rise from 1.8% in 2023 to 4.9% in 2050 while the OECD average is also set to increase substantially, from 4.9% to 9.6%. (Figure 9.1, right panel). Several countries are projected to see this share at least triple, with some Caribbean countries, such as Antigua and Barbuda, approaching 8% by 2050. This will increase demand for long-term care, complex chronic care in primary care, better care co-ordination, and rehabilitation and reablement services to prevent or delay dependency and support ageing in place (OECD, 2025[3]). However, ageing will vary within countries, often progressing faster in urban areas and potentially widening socio-economic disparities. Strengthening health systems and age-friendly environments can help ensure that longer lives do not necessarily translate into greater dependency (Beard et al., 2016[4]).

In parallel, as the share of older adults increases, the relative size of the working-age population declines – tightening fiscal and workforce constraints during the transition. The ratio of working-age adults to people aged 65 and over in LAC31 is projected to fall from about 7.2 in 2023 to 3.6 in 2050 (Figure 9.2), implying roughly half as many potential workers per older person. In OECD, the same ratio is projected to decrease from 3.6 in 2023 to 2.4 in 2050. The outlook is particularly challenging in Cuba (1.9 in 2050), Chile (2.3), Costa Rica (2.5) and Barbados (2.5), where the scope to finance age-related spending from a relatively large working-age base will diminish substantially.

Although non-LAC OECD countries are currently at a more advanced stage of population ageing, the speed of the transition in LAC makes early and integrated policy planning especially urgent. Health systems will need to adapt rapidly to evolving population needs, while reforms in pension systems, labour markets and health financing – particularly for long-term care (see section “Long-term care” in this chapter) – will be essential to safeguard financial sustainability (Álvarez, 2020[5]).

Definition and comparability

Population shares and dependency ratios are based on the United Nations World Population Prospects (WPP) 2024 Revision, using the medium-variant projections. Projections are internally consistent across countries, but uncertainty increases with the time horizon and depends on assumptions about future fertility, mortality and migration. Differences between countries reflect both current age structures and the pace of fertility decline, survival improvements and migration patterns.

References

Álvarez, F. (2020), *Los sistemas de pensiones y salud en América Latina: los desafíos del envejecimiento, el cambio tecnológico y la informalidad*, CAF, Caracas, http://scioteca.caf.com/handle/123456789/1652. [5]

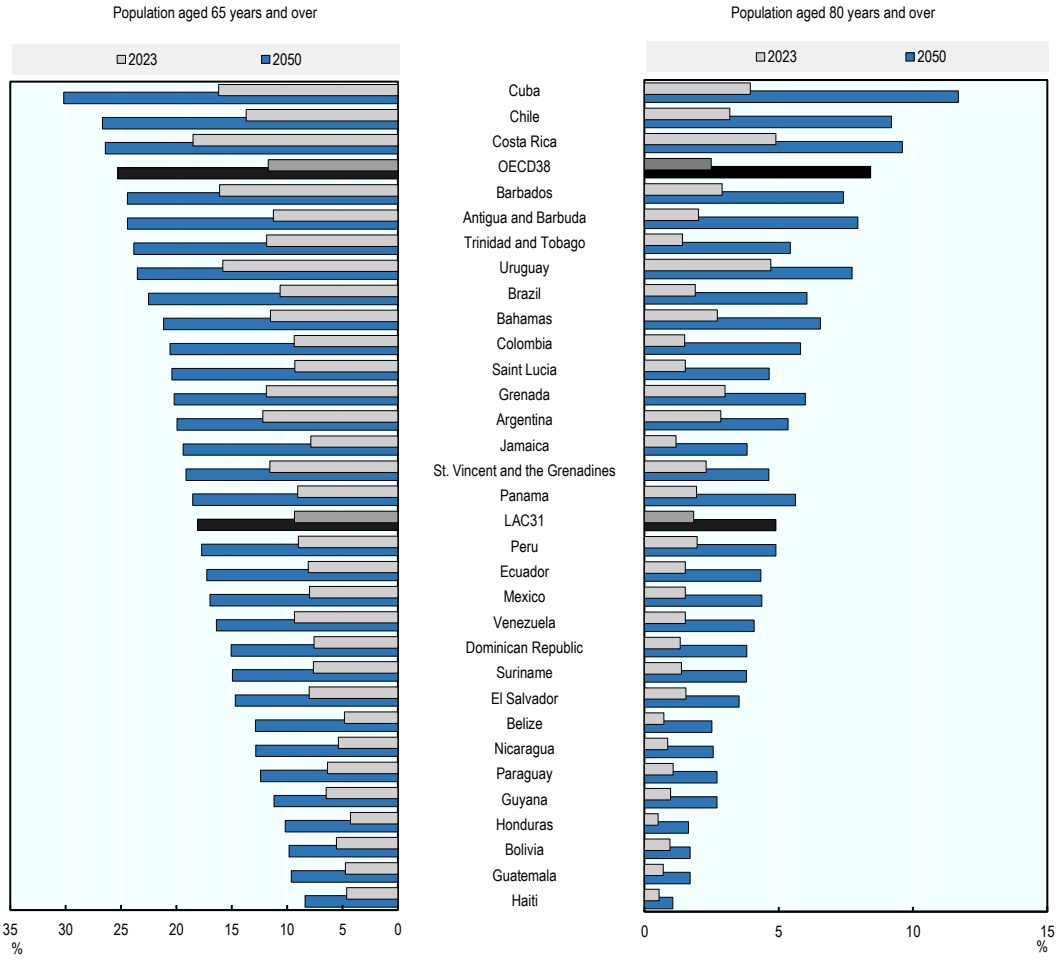
Beard, J. et al. (2016), “The World report on ageing and health: a policy framework for healthy ageing”, *The Lancet*, Vol. 387/10033, pp. 2145-2154, https://doi.org/10.1016/s0140-6736(15)00516-4. [4]

Bilal, U. et al. (2019), “Inequalities in life expectancy in six large Latin American cities from the SALURBAL study: an ecological analysis”, *The Lancet Planetary Health*, Vol. 3/12, pp. e503-e510, https://doi.org/10.1016/s2542-5196(19)30235-9. [2]

Bloom, D., D. Canning and G. Fink (2010), “Implications of population ageing for economic growth”, *Oxford Review of Economic Policy*, Vol. 26/4, pp. 583-612, https://doi.org/10.1093/oxrep/grq038. [1]

OECD (2025), *The Economic Benefit of Promoting Healthy Ageing and Community Care*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/0f7bc62b-en. [3]

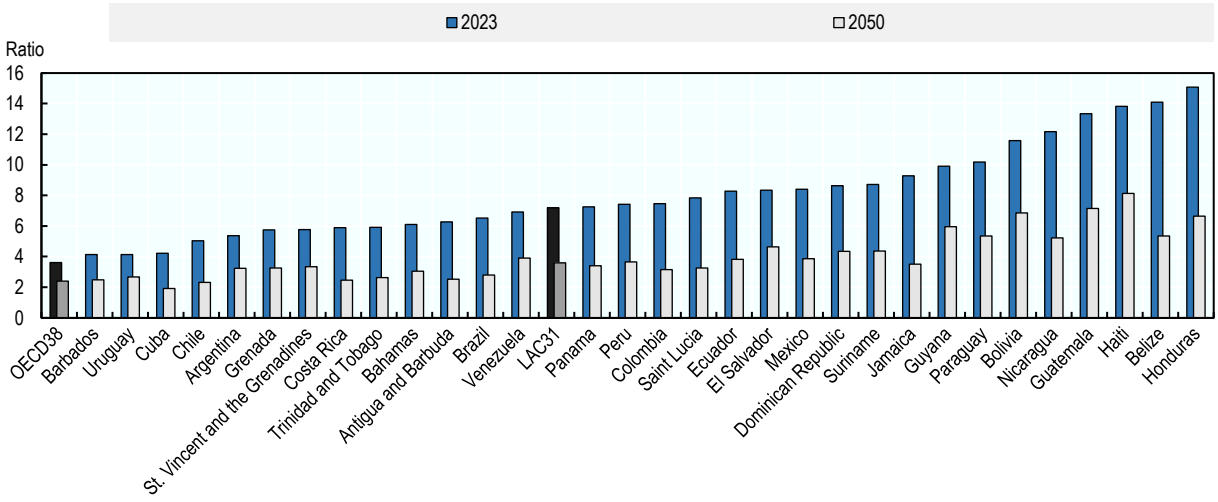
Figure 9.1. Current estimate and projected share of the population aged 65 and 80 years or older, 2023 and 2050



Source: United Nations World Population Prospects, 2024.

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Figure 9.2. Current estimate and projected rate of population aged 15-64 to population aged 65 or older, 2023 and 2050



Source: United Nations World Population Prospects, 2024.

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Life expectancy and healthy life expectancy at age 60

Life expectancy at age 60 summarises expected remaining years of life after age 60 based on period life tables, while healthy life expectancy (HALE) at age 60 adjusts these years for time spent in less than full health. Taken together, they provide a more complete picture of ageing than life expectancy alone, distinguishing gains in survival from gains in health. WHO estimates are produced using standardised methods to enhance comparability across countries and provide final age-sex mortality estimates through 2021, capturing the mortality shock during the COVID-19 pandemic.

Remaining life expectancy at age 60 is lower in LAC than in the OECD, and many LAC countries experienced a marked drop in 2021, coinciding with the COVID-19 mortality shock. On average in LAC31, a 60-year-old in 2021 could expect to live a further 20.7 years if female and 17.5 years if male (Figure 9.3) – about 4.6 and 4.0 years fewer than the OECD average, respectively. Between 2000 and 2021, life expectancy at age 60 in LAC31 declined overall (women: 21.6 to 20.7; men: 18.7 to 17.5), whereas the OECD average was broadly stable over the period, with slower gains in many countries even before the pandemic. Country patterns are heterogeneous: several countries recorded sizeable reductions by 2021 (especially among men), while others continued to post modest gains. In 2021, remaining life expectancy at age 60 was highest in Costa Rica and Chile and lowest in Bolivia for both women and men. These differences reflect a mix of long-term drivers (such as cardio-metabolic risk, health system performance and socio-economic conditions) and short-term shocks; updated Global Burden of Disease (GBD) 2021 estimates provide a consistent lens on cause-specific mortality changes and their impact on life expectancy during 2020-2021 (Naghavi et al., 2024[1]).

Longer life does not necessarily mean more years in good health. HALE at age 60 – from WHO GHO – captures expected years lived in full health, adjusting for disease and disability (see “Definition and comparability”). In the OECD, HALE at 60 is 18.3 years for women and 16.2 for men; in LAC31 it is about 2.8-2.9 years lower (15.5 and 13.4, respectively; Figure 9.4). Country estimates range from 11.5 healthy years for women in Haiti and 9.3 for men in Bolivia to 18.5 for women and 16.6 for men in Costa Rica, with similarly high values in Chile (17.8; 16.4) and Panama (18.1; 15.9). This gap translates into more years with functional limitations and higher demand for community-based and residential long-term care. While HALE is model-based, its value lies in integrating fatal and non-fatal health loss into a single, comparable metric; GBD 2021 results reinforce that HALE gains often lag life expectancy gains when morbidity is not reduced as much as mortality (Ferrari et al., 2024[2]).

The divergence between life expectancy and HALE at older ages has direct implications for health system design and long-term care. Lower HALE often reflects greater prevalence and severity of functional impairment and multimorbidity, which interact to accelerate declines in physical and cognitive function. This strengthens the case for integrated, person-centred primary care with prevention, medication review, rehabilitation and maintenance of function at its core (Calderón-Larrañaga et al., 2018[3]). Gender gaps also narrow when focussing on healthy years: in LAC31, women live about 3.2 more years than men at age 60 in total life expectancy (20.7 vs. 17.5) but only 2.1 more healthy years (15.5 vs. 13.4), with very small HALE gaps in some countries (e.g. Haiti) and larger ones in others (e.g. Uruguay). Consistent with evidence of partial decoupling between longevity and healthy longevity in LAC (Robledo, Cano-GutiéRrez and Garcia, 2022[4]), HALE series typically lag life expectancy updates and may not fully capture the COVID-19 period depending on the latest WHO GHO year used in this publication.

Definition and comparability

Life expectancy at age 60 is the average number of additional years a person aged 60 would live if exposed, over the rest of their life, to the age- and sex-specific mortality rates of a given year. Healthy life expectancy (HALE) at age 60 adjusts remaining years of life for time spent in less than full health, combining mortality and morbidity information.

Both indicators are produced by the WHO Global Health Observatory using standardised methods to support cross-country comparability. HALE is model-based and updated less frequently than life expectancy, so year-to-year changes should be interpreted cautiously, particularly around the COVID-19 period.

References

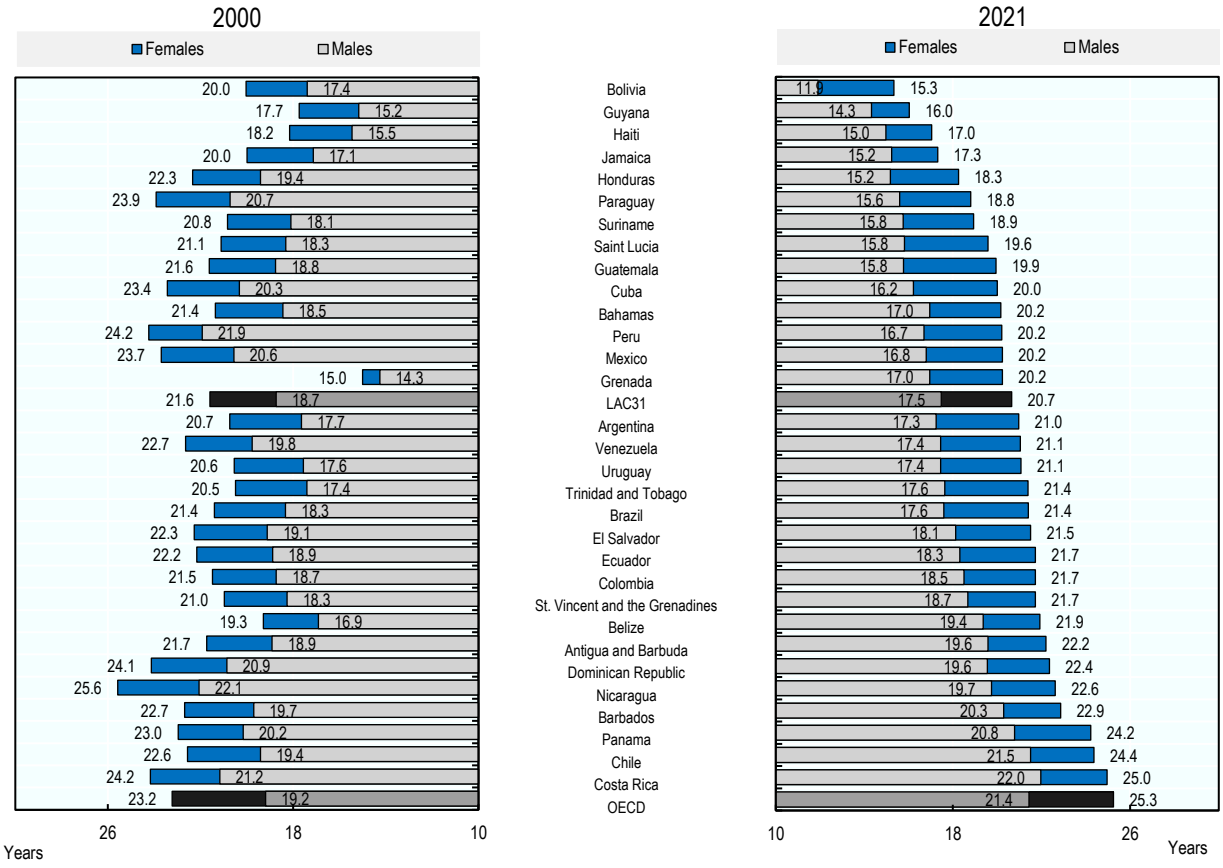
Calderón-Larrañaga, A. et al. (2018), “Multimorbidity and functional impairment–bidirectional interplay, synergistic effects and common pathways”, *Journal of Internal Medicine*, Vol. 285/3, pp. 255-271, https://doi.org/10.1111/joim.12843. [3]

Ferrari, A. et al. (2024), “Global incidence, prevalence, years lived with disability (YLDs), disability-adjusted life-years (DALYs), and healthy life expectancy (HALE) for 371 diseases and injuries in 204 countries and territories and 811 subnational locations, 1990–2021: a systematic analysis for the Global Burden of Disease Study 2021”, *The Lancet*, Vol. 403/10440, pp. 2133-2161, https://doi.org/10.1016/s0140-6736(24)00757-8. [2]

Naghavi, M. et al. (2024), “Global burden of 288 causes of death and life expectancy decomposition in 204 countries and territories and 811 subnational locations, 1990–2021: a systematic analysis for the Global Burden of Disease Study 2021”, *The Lancet*, Vol. 403/10440, pp. 2100-2132, https://doi.org/10.1016/s0140-6736(24)00367-2. [1]

Robledo, L., C. Cano-GutiéRrez and E. Garcia (2022), “Healthcare for older people in Central and South America”, *Age and Ageing*, Vol. 51/5, https://doi.org/10.1093/ageing/afac017. [4]

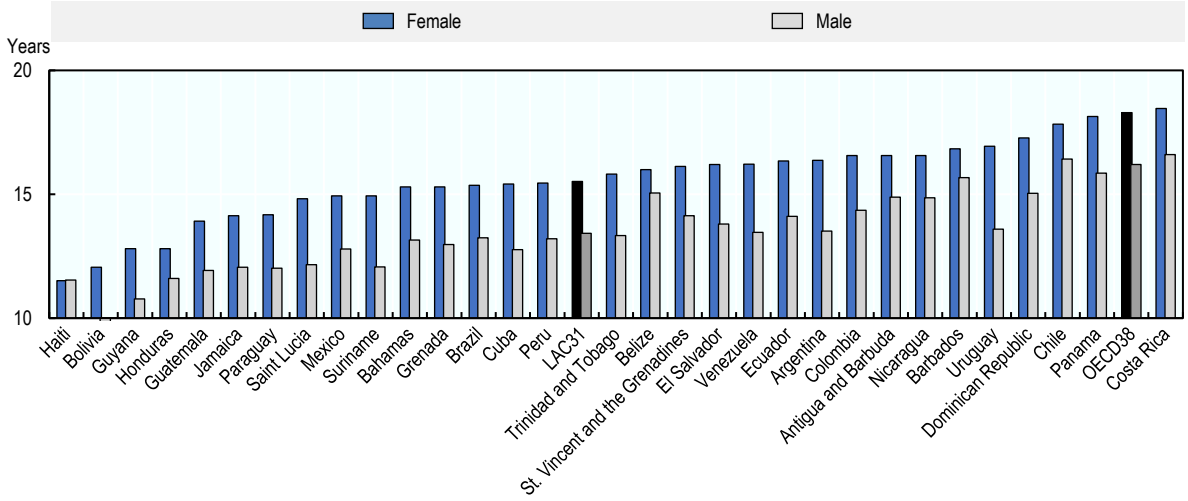
Figure 9.3. Life expectancy at age 60, by sex, 2000 and 2021



Source: WHO Global Health Observatory 2025.

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Figure 9.4. Healthy life years at age 60, by sex, 2021



Source: WHO Global Health Observatory 2025.

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Drivers of long-term care needs and system response

Population ageing in LAC is bringing rapid growth in LTC needs, driven by rising chronic conditions, functional limitations and cognitive impairment at older ages. While age alone does not determine dependency, the accumulation of conditions greatly increases the likelihood of needing help with daily activities. Demographic change, morbidity patterns and health system performance together shape LTC demand, and without effective prevention and co-ordinated care, longevity gains often translate into higher care needs rather than extended independence (Gianfredi et al., 2025[1]).

Older people with chronic conditions are much more likely to report needing help with activities of daily living than those without, underscoring how prevention and effective chronic disease management can delay dependency (Figure 9.5). Across LAC8, around 27% of older adults with at least one chronic condition report care needs, compared with 14% among those without. The gap is sizeable in many countries, reflecting how chronic disease contributes to functional limitations and the need for support.

Public spending on long-term care services is very limited in the LAC countries with available data (Figure 9.6). Reported spending represents less than 1% of current health expenditure in Paraguay and is close to zero in several other countries, compared with around 14% on average in the OECD. Some of this gap reflects genuine differences in coverage, but cross-country comparisons also require caution because long-term care may be recorded in either the health or social sector (e.g. Chile), and accounting practices differ. Low public spending is consistent with qualitative evidence that long-term care provision in LAC relies heavily on families and informal arrangements rather than organised services (PAHO/IDB, 2023[2]).

Dementia is becoming a growing driver of long-term care needs as populations age (Figure 9.7). Across LAC33, the mortality rate attributed to Alzheimer's disease and other dementias increased modestly between 2014 and 2024 (from 17.8 to 18.6 deaths per 100 000 population), with substantial cross-country variation. Rates are highest in Paraguay and lowest in Haiti. Differences partly reflect population age structure, but also variation in diagnosis and cause-of-death certification; in some countries, rising mortality may indicate better recognition and coding rather than faster underlying disease growth.

These indicators point to a widening gap between rising long-term care needs and the limited capacity of formal systems in LAC. With high burdens of chronic disease and dementia alongside very low public long-term care spending, much of the adjustment to population ageing is occurring within households rather than through organised services – reinforcing inequities, constraining women's labour-market participation, and disproportionately affecting lower-income families. Without a gradual expansion of accessible, needs-based services, these pressures will intensify. Closing the gap requires a dual strategy: (1) strengthen prevention, person-centred primary care, care co-ordination and rehabilitation/reablement to delay dependency, maintain function and reduce avoidable hospital use; and (2) progressively develop formal long-term care that complements family care – expanding home-based and community services and providing support for informal carers. Regular monitoring of chronic conditions, long-term care spending and dementia trends is essential to assess whether systems are adapting quickly enough to the realities of population ageing in LAC.

Definition and comparability

Functional dependence by chronic conditions: Share of older people who report needing help with basic activities of daily living among those with no chronic conditions versus those with at least one chronic condition. Comparability is limited by differences in survey questions, chronic-condition lists and the possible under-coverage of institutionalised populations.

LTC spending share of current health expenditure: Expenditure on long-term care services as a percentage of current health expenditure, reported using the System of Health Accounts framework. Cross-country differences in accounting practices and in the boundary between health and social spending can affect levels and trends.

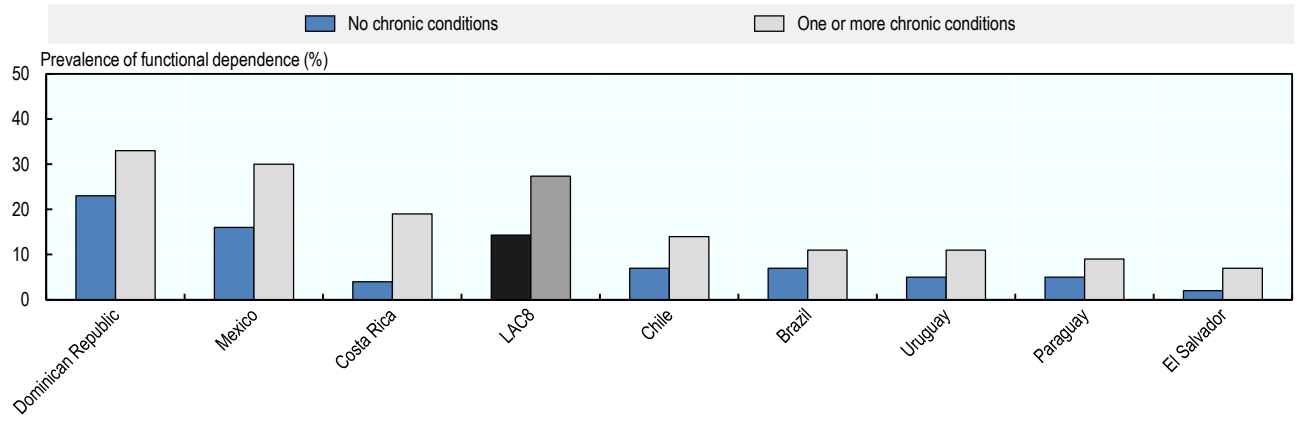
Deaths from Alzheimer's and other dementias: Deaths per 100 000 population attributed to Alzheimer's disease and other dementias (GBD cause definition). Comparability is affected by variation in diagnosis and cause-of-death certification/coding, and by changes in recording practices over time.

References

Gianfredi, V. et al. (2025), "Aging, longevity, and healthy aging: the public health approach", *Aging Clinical and Experimental Research*, Vol. 37/1, https://doi.org/10.1007/s40520-025-03021-8. [1]

PAHO/IDB (2023), *Long-term Care in Latin America and the Caribbean*, Pan American Health Organization and Inter-American Development Bank, https://doi.org/10.37774/9789275127155. [2]

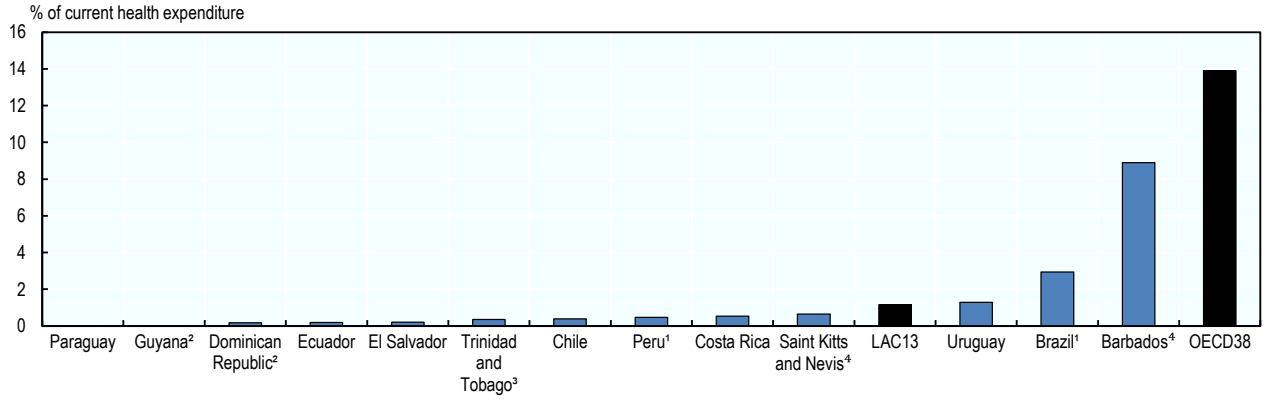
Figure 9.5. Prevalence of functional dependence by presence of chronic conditions



Source: IDB Dataset associated with Stampini et al. (2025), *Who Cares? How to Support and Ensure Recognition for Caregivers for Older People in Latin America and the Caribbean*, https://doi.org/10.18235/0013724.

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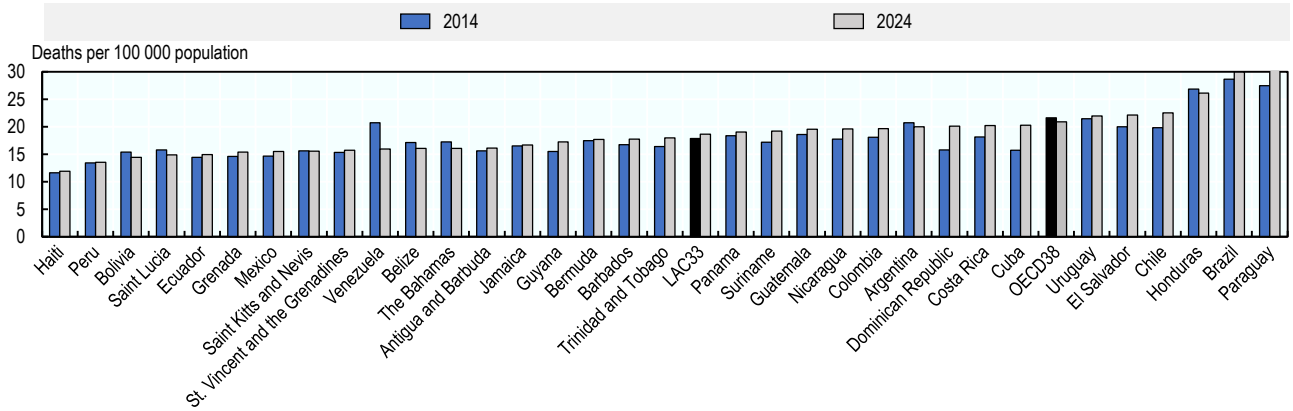
Figure 9.6. Expenditure in long-term care services as a share of current health expenditure, 2023 (or latest year)



1. Data from 2022, 2. data from 2019, 3. data from 2018, 4. data from 2016
Source: WHO Global Health Expenditure Database 2025.

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Figure 9.7. Deaths rate for Alzheimer and other dementias per 100 000 population, 2014 and 2024



Source: GBD 2025.

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Paid and unpaid caregivers

Family caregiving remains the backbone of long-term care in LAC. Around four in five older people who need help with daily activities receive support from an unpaid carer, usually a family member, highlighting both the centrality of households and the limited reach of formal services. At the same time, the report *Who Cares? How to Support and Ensure Recognition for Caregivers for Older People in Latin America and the Caribbean* (Stampini et al., 2025[1]) estimates roughly 25 million unpaid caregivers in the region, versus about 3 million paid caregivers, an imbalance that becomes more problematic as population ageing accelerates and family networks shrink. This reliance on unpaid caregiving reflects both limited public provision and strong social norms around family responsibility, but it also has significant implications for equity, labour market participation and caregiver well-being. Evidence from both high-income and middle-income settings shows that heavy dependence on informal care can mask unmet need and shift the costs of ageing from public systems to households (OECD, 2023[2]).

Paid care for older people in LAC is delivered mainly through home-based arrangements and domestic work, rather than through institutional services (Figure 9.8). Across the LAC17 average, only about one in ten paid caregivers work in institutions; around half are domestic workers with care responsibilities. This reflects both limited formal long-term care provision and the way care tasks are often embedded in broader household services, frequently in informal employment. In practice, domestic workers may gradually take on caring responsibilities as needs increase, yet they may not be declared as carers and may lack social protection. Several countries regulate household services as a whole (without a sharp distinction between domestic work and care), although a number are moving towards more specific occupational profiles and competency frameworks for carers to professionalise the workforce. Cross-country differences in the shares of institutional, home and domestic-work caregivers also reflect variation in long-term care system development, but measurement is challenging because domestic workers with care responsibilities are often estimated rather than directly identified in surveys (Bom et al., 2018[3]).

Unpaid family care remains the backbone of long-term care in LAC. The report *Who Cares?* estimates around 25 million unpaid caregivers in the region (about 60% women), providing an average of 7.5 hours per week of care for older people; to maintain current caregiver-to-older-person ratios, the number of unpaid caregivers would need to increase to around 60.5 million by 2050. Time-use surveys suggest that most unpaid care is provided within households (around 59% across the LAC9 sample; Figure 9.9), although patterns vary and some countries, such as Argentina, report a larger share of care provided to people outside the household. These estimates should be interpreted cautiously: care provided within households is often underreported, particularly when tasks for a spouse or parent are viewed as part of everyday family responsibilities rather than "care".

These two figures point to a consistent storyline: care for older people in LAC is organised primarily around households – through unpaid family care and, when paid, often through domestic work rather than a clearly professionalised care workforce or institutional sector. In a region where unpaid care is already widespread and demographic trends will increase needs, strengthening long-term care systems will require *both* expanding and professionalising the paid workforce and better supporting family caregivers (for example through training, information and policies that protect caregivers' well-being).

Definition and comparability

Paid caregivers by type: Shares of paid workers providing care for older people in (i) institutions, (ii) home care, or (iii) domestic work with care responsibilities, based on the IDB *Who Cares?* dataset. Domestic workers providing care are typically estimated rather than directly identified in labour/household surveys, which limits comparability across countries. The LAC17 value pools all paid caregivers observed across the 17 countries with data (not a simple average of national estimates).

Unpaid caregivers: Shares of unpaid caregivers providing care to older people within versus outside their household, based on time-use surveys. Comparability is affected by differences in survey design, coverage of care provided outside the household, and potential underreporting of care within households. The LAC9 value pools all observations across the nine countries with available time-use survey data.

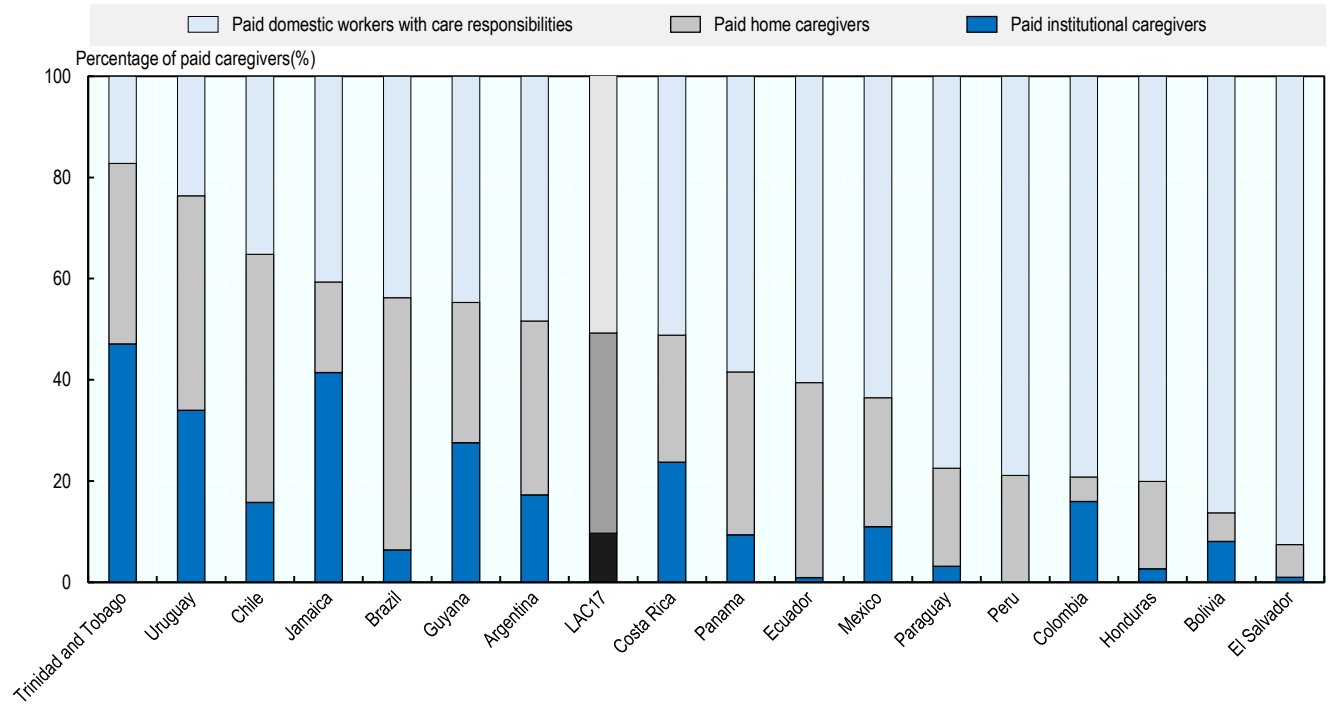
References

Heyn, P. (ed.) (2018), "The Impact of Informal Caregiving for Older Adults on the Health of Various Types of Caregivers: A Systematic Review", *The Gerontologist*, Vol. 59/5, pp. e629-e642, https://doi.org/10.1093/geront/gny137. [3]

OECD (2023), *Beyond Applause? Improving Working Conditions in Long-Term Care*, OECD Publishing, Paris, https://doi.org/10.1787/27d33ab3-en. [2]

Stampini, M. et al. (2025), *Who Cares? How to Support and Ensure Recognition for Caregivers for Older People in Latin America and the Caribbean*, Inter-American Development Bank, https://doi.org/10.18235/0013724. [1]

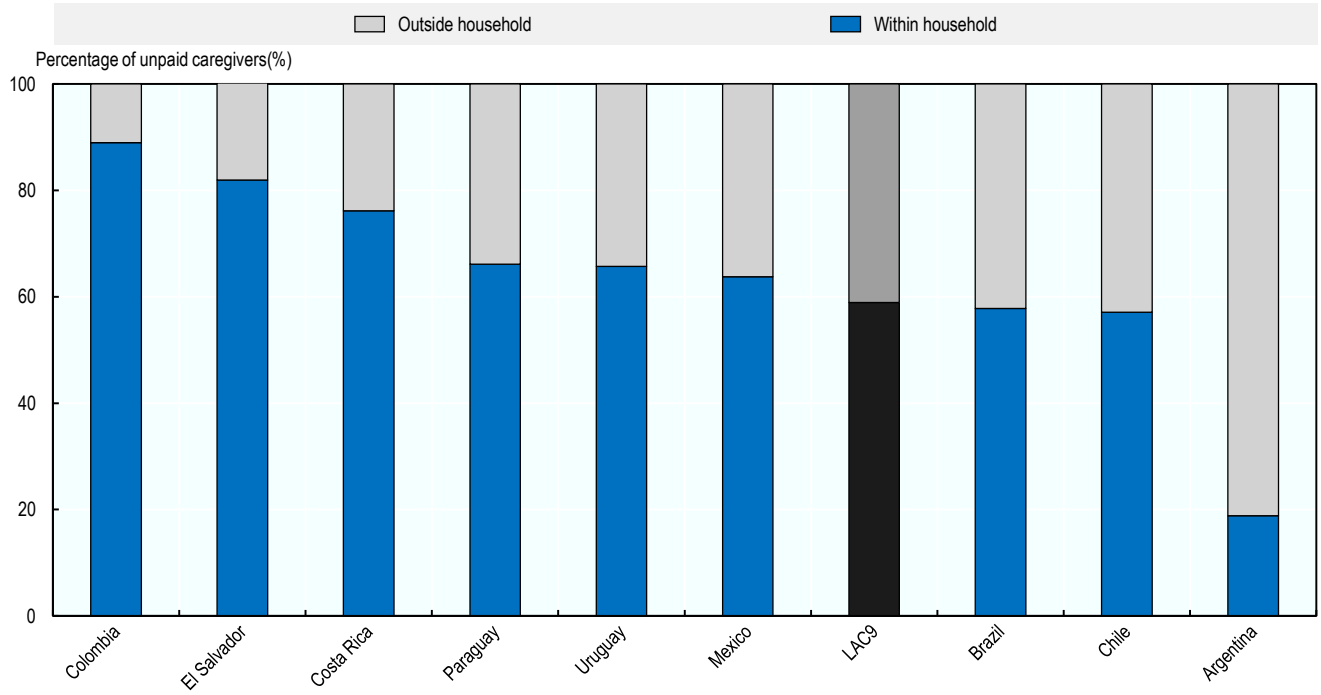
Figure 9.8. Percentage of paid caregivers for older people



Source: IADB Dataset associated with Stampini et al. (2025), *Who Cares? How to Support and Ensure Recognition for Caregivers for Older People in Latin America and the Caribbean*, https://doi.org/10.18235/0013724.

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Figure 9.9. Percentage of unpaid caregivers



Source: IADB Dataset associated with Stampini et al. (2025), *Who Cares? How to Support and Ensure Recognition for Caregivers for Older People in Latin America and the Caribbean*, https://doi.org/10.18235/0013724.

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Caregiver training and time burden

Training and time are two of the tightest constraints on the sustainability and quality of LTC in LAC. Care work is inherently complex – spanning personal care, household support, monitoring changes in condition, and emotional support – and the report *Who Cares? How to Support and Ensure Recognition for Caregivers for Older People in Latin America and the Caribbean* (Stampini et al., 2025[1]) stresses that weak skills development and poor support translate into lower-quality care and worse outcomes for caregivers themselves. Unpaid caregiving is strongly gendered: women constitute around 60% of unpaid caregivers and, driven by social norms, tend to spend more time on care and take on the least flexible tasks, with knock-on effects on paid work and well-being.

Large training gaps among paid caregivers are likely to undermine care quality and retention (Figure 9.10). Across LAC22, 37% of paid caregivers report no training, 16% rely on self-study and 47% report some course-based training – often shorter than the Ibero-American Protocol's 260-hour recommendation. Where training exists, it tends to emphasise technical tasks while giving less weight to communication, emotional resilience, caregiver self-care and person-centred approaches. Inadequate training can increase preventable complications (for example through unsafe mobility support, poor infection prevention or delayed recognition of deterioration) and can contribute to caregiver stress and turnover. Evidence from structured education and skills programmes for carers, particularly in dementia care, suggests such support can improve caregiver outcomes and be cost-effective, indicating a missed opportunity to strengthen long-term care systems (Livingston et al., 2020[2]).

Women spend more time providing unpaid care for older people than men in every country with data (Figure 9.11). Across the LAC8 average, women provide 8.8 hours per week compared with 6.0 hours for men. Gender gaps are particularly large in some Southern Cone countries, reflecting both labour market patterns and persistent gender norms. Most time-use surveys miss "passive care" (being on call) and, as noted above, may undercount care provided within households, so total hours – and gender gaps – are likely underestimated. High time burden without adequate preparation elevates stress, musculoskeletal injury and mental health risks, threatening the sustainability of care arrangements; prolonged high-intensity caregiving is linked to worse caregiver health, especially when responsibilities arise suddenly or with little support (Bom et al., 2018[3]). These pressures will intensify as dementia and multimorbidity increase with population ageing.

These two figures point to a dual challenge for LTC policy: professionalise and standardise skills in the paid workforce while reducing the time and intensity burden that falls disproportionately on women in unpaid care. The report's direction of travel is clear – expand accessible, higher-quality training pathways (including recognition of prior learning), and strengthen caregiver support policies (information, psychological support, respite, and flexible work/leave), alongside efforts to shift gender norms and increase men's participation in care.

Definition and comparability

Training of paid caregivers: Share of paid caregivers reporting no training, self-study, or any formal course (short/medium/extended combined), based on the IDB caregiver survey. Cross-country comparability may be affected by sampling and self-reported training categories. The LAC22 value pools all observations across the 22 countries with data.

Hours of unpaid care by sex: Average hours per week spent providing unpaid care to older people by women and men, from time-use surveys. Comparability is limited by differences in task lists, recall periods, definition of "older", and the omission of "on-call" time; reported hours likely underestimate total care time. The LAC8 value pools all observations across the eight countries with data.

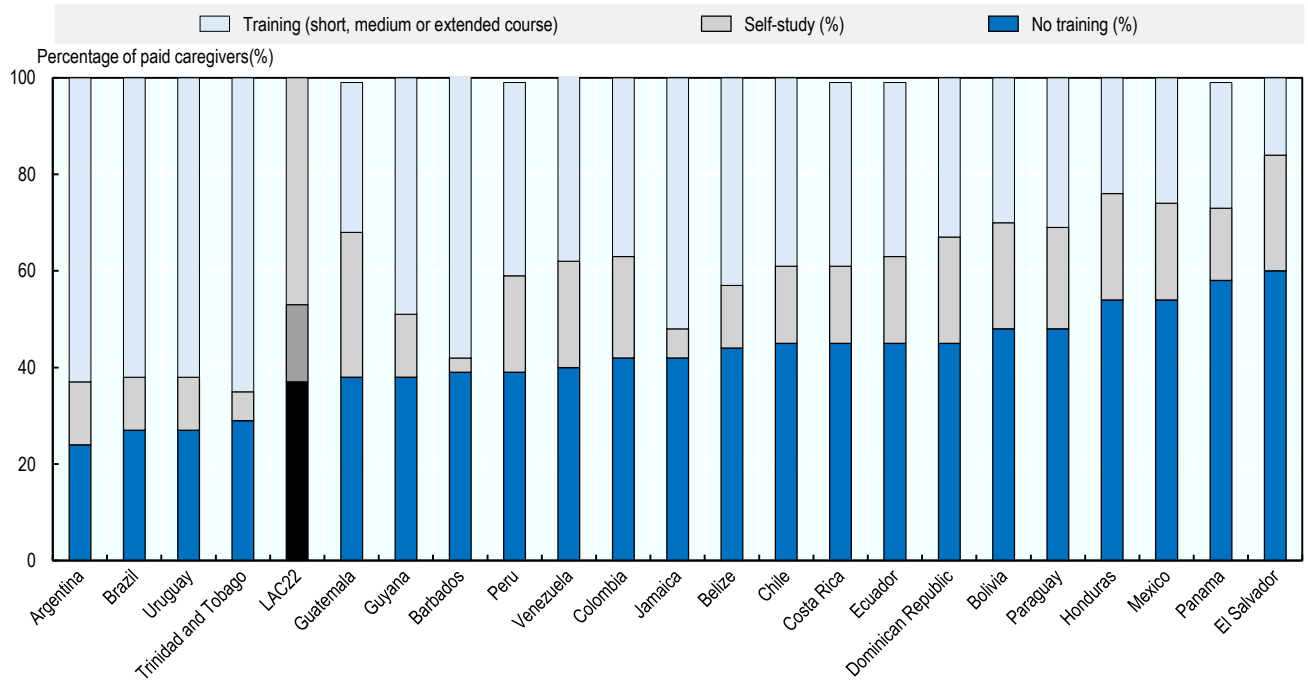
References

Heyn, P. (ed.) (2018), "The Impact of Informal Caregiving for Older Adults on the Health of Various Types of Caregivers: A Systematic Review", *The Gerontologist*, Vol. 59/5, pp. e629-e642, https://doi.org/10.1093/geront/gny137. [3]

Livingston, G. et al. (2020), "Dementia prevention, intervention, and care: 2020 report of the Lancet Commission", *The Lancet*, Vol. 396/10248, pp. 413-446, https://doi.org/10.1016/s0140-6736(20)30367-6. [2]

Stampini, M. et al. (2025), *Who Cares? How to Support and Ensure Recognition for Caregivers for Older People in Latin America and the Caribbean*, Inter-American Development Bank, https://doi.org/10.18235/0013724. [1]

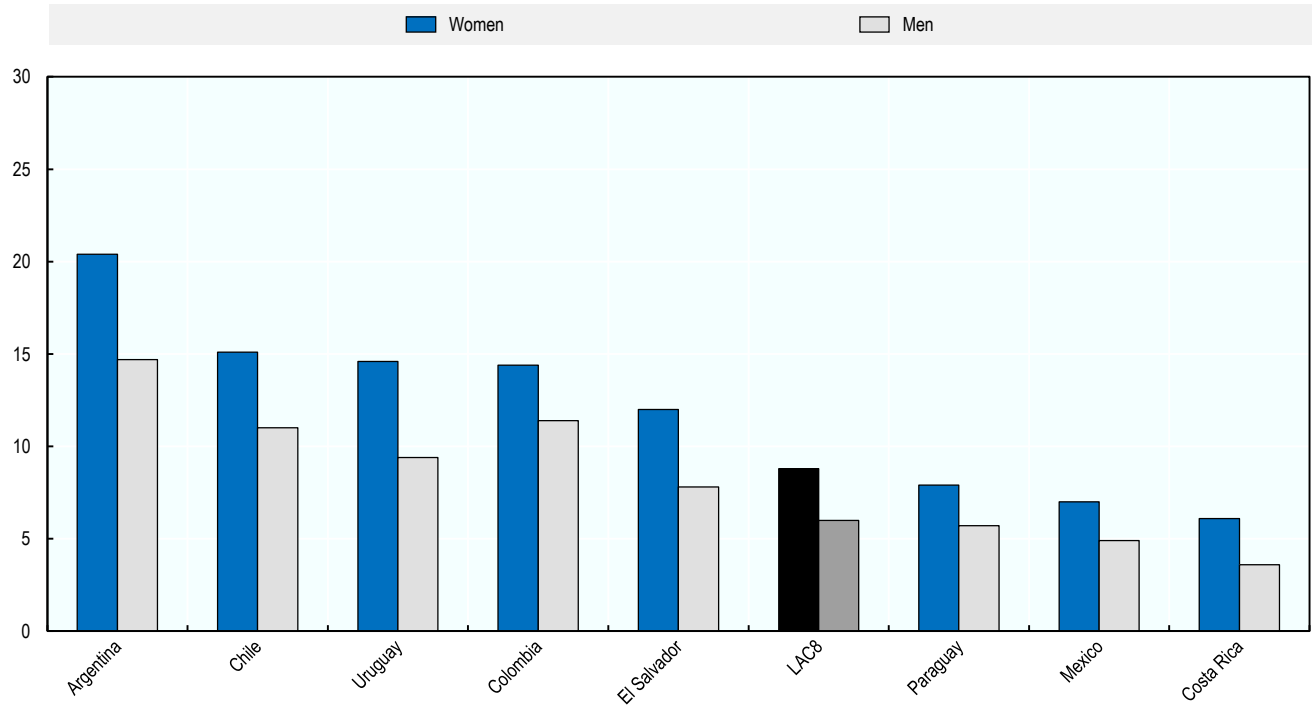
Figure 9.10. Percentage of Caregivers by level of training



Source: IADB dataset associated with Stampini et al. (2025), *Who Cares? How to Support and Ensure Recognition for Caregivers for Older People in Latin America and the Caribbean*, https://doi.org/10.18235/0013724.

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Figure 9.11. Time caregivers spend providing care for older people in hours/week, by sex



Source: IADB dataset associated with Stampini et al. (2025), *Who Cares? How to Support and Ensure Recognition for Caregivers for Older People in Latin America and the Caribbean*, https://doi.org/10.18235/0013724.

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Health at a Glance: Latin America and the Caribbean 2026

This third edition of *Health at a Glance: Latin America and the Caribbean*, prepared jointly by OECD, the Inter-American Development Bank and the World Bank, presents a set of key indicators of health status, determinants of health, health data and health system infrastructure, health expenditure and financing, quality of care, health workforce, and ageing across 33 Latin America and the Caribbean countries. Each of the indicators is presented in a user-friendly format, consisting of charts illustrating variations across countries and over time, concise descriptive analyses highlighting the main findings conveyed by the data, and methodological boxes defining the indicators and discussing limitations in data comparability. This edition also includes two thematic chapters focused on issues of particular importance for the region: quality of care, and inequalities in health and healthcare across Latin America and the Caribbean.

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