

HEALTHCARE FINANCING AND REIMBURSEMENT: A GLOBAL REVIEW OF MAJOR TOPICS AND TRENDS
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LAWS AND REGULATIONS ON HEALTHCARE FINANCING AND REIMBURSEMENT
<p>1. Please provide a bird's eye view on the healthcare economy, indicating, in general terms, the role of the government (public healthcare) and private actors (private healthcare).</p>
<p>In practice, the health system in Bolivia is a mixed system that combines both public services (mandatory short-term social security system and free healthcare system for those not covered by the social security system) and private services (voluntary through private companies). In economic terms, this structure seeks to balance universal access to health with the participation of the private sector in the financing and provision of services.</p> <p>Public healthcare</p> <p><i>Unified Health System</i></p> <p>The state, through the Unified Health System (Seguro Único de Salud or SUS), guarantees free care to the most vulnerable sectors of the population: those not covered by the social security system. However, despite the intentions of universality and free care, there are several economic challenges that limit the effectiveness of the SUS.</p> <p>From a legal perspective, the SUS financing is a state obligation, as established in the Political Constitution of the State (the 'Constitution'), which recognises health as a fundamental right. Article 35 of the Constitution establishes that the state must guarantee access to quality health services without discrimination, which implies a direct responsibility in terms of financial resources. The resources to finance the public system come mainly from the National General Treasury (Tesoro General de la Nación or TGN), but also from contributions from subnational governments (departmental and municipal governments), which contribute with direct transfers for the implementation of health projects at the local level.</p> <p><i>Formal and informal workers</i></p> <p>From the point of view of labour regulations, the existence of a mixed healthcare system has significant implications for formal and informal workers. Formal workers must affiliate to health insurers through their employer, which implies a financial contribution from both the worker and the employer. However, informal workers, who constitute a considerable part of the Bolivian population, do not have access to this type of coverage and, therefore, must resort to the public health system, which is not always prepared to adequately care for this population.</p> <p>Private healthcare</p>

The mixed model, however, is not free of contradictions. The private sector, composed of hospitals and insurers, provides an alternative for those who can afford services outside the public system. In this context, direct voluntary payments and private insurance are the main mechanisms through which services are financed in the private sector.

The problem lies in the fact that, although public services have a legal framework of free services, limitations in terms of infrastructure, personnel and availability of resources generate a growing dependence on the private sector to meet specific health needs. This creates a division that, in many cases, goes against the constitutional principle of equal access to healthcare.

2. Please provide a high-level overview of the legal framework regarding healthcare financing and reimbursement.

The legal framework governing healthcare financing and reimbursement in Bolivia is primarily based on the Political Constitution of the State, which recognises the universal right to health. The most relevant regulations are the following:

Law 1152 of 30 December 2013

This law established the SUS, ensuring free healthcare for individuals not covered by social security.

Social Security Code of 14 December 1956

This code regulates short and long-term benefits, including health insurance, pensions, maternity, work-related risks and disability, establishing contributions, financing mechanisms and the rights of insured individuals.

Law 1883 of 25 June 1998

This law regulates private insurance, setting basic principles for coverage and reimbursements. The reimbursement of private healthcare services is primarily governed within the framework of social security and contractual agreements between private insurers and their policyholders. Reimbursements depend on contractual terms established by insurers, under the supervision of the Pension, Securities, and Insurance Authority (Superintendencia de Pensiones, Valores y Seguros or SPVS). This entity ensures transparency in setting premiums and coverage conditions.

3. What are the key regulators and supervisory bodies regarding healthcare financing and reimbursement?

Healthcare financing and reimbursement in Bolivia are subject to oversight by several key regulators and supervisory bodies:

- Ministry of Health and Sports: the highest authority in public health policy, responsible for designing, implementing and monitoring national health programmes, including the SUS.
- TGN: provides the main financial resources for the public healthcare system, ensuring its sustainability.
- SPVS: supervises and regulates private health insurers, ensuring compliance with financial and contractual obligations.

- National Health Fund (Caja Nacional de Salud or CNS) and other social security funds: manage the financing and provision of healthcare services to formal sector workers and their dependents through tripartite contributions.
- Municipal and departmental governments: complement funding for healthcare services under the SUS framework.
- Supervisory and Control Authority for the National Health System (ASUSS): responsible for overseeing and regulating the SUS and ensuring the effective operation of public health services.

These regulatory and supervisory entities work together to balance the financing and reimbursement of healthcare services, aiming to ensure equitable access and financial sustainability within a mixed public-private healthcare system.

4. Has there been a change to healthcare financing and reimbursement as a consequence of the Covid-19 pandemic?

Increased direct involvement/spending of the government

There were no major changes to the reimbursement model, but the SUS faced financial pressure due to the higher demand for Covid-19 services. Funding for the SUS was increased due to the rising demand for Covid-19-related healthcare. The government allocated additional resources for purchasing medical equipment and strengthening hospitals.

Shifts in budgets

The government reallocated funds within the health sector, prioritising Covid-19 response efforts, including purchasing medical supplies, strengthening healthcare infrastructure and financing the SUS to accommodate increased demand.

Fast-track funding

The government accelerated the disbursement of funds for urgent healthcare needs, particularly for Covid-19 treatments, medical equipment and vaccines, ensuring quicker access to essential resources.

5. Who has access to the healthcare system as a patient on the one side and as a medical service provider/supplier of medical goods on the other side? What are the conditions of admission?

In Bolivia, access to the healthcare system is regulated by both public and private frameworks, with specific conditions for patients and healthcare providers:

Patients

Access to public healthcare is universal and guaranteed by the Constitution. Through the SUS, Bolivian citizens and legal residents can receive free healthcare services without requiring prior enrolment, provided they are not covered by public social security systems. Workers formally affiliated with social security institutions, such as the CNS, receive services based on mandatory contributions.

Healthcare providers and suppliers

Permission to provide medical services or supply medical goods requires authorisation and registration with the Ministry of Health and Sports. Providers must meet specific licensing

requirements, maintain professional qualifications and comply with quality standards established by sectoral regulations. Suppliers of pharmaceuticals and medical devices must also register with the National Medicines and Health Technology Agency (Agencia Estatal de Medicamentos y. Tecnologías de Salud or AGEMED) to operate legally.

Health funds and private insurance companies

In addition to the CNS and other social security funds, recognised entities, such as health funds and private insurance companies, may provide healthcare services. These entities must be authorised by the SPVS and ASUSS to comply with regulations to ensure financial sustainability and service quality.

This dual access system aims to ensure comprehensive healthcare coverage while maintaining regulatory control over service providers and suppliers, thereby promoting efficiency and quality in health services.

HEALTH INSURANCE FINANCING AND COVERAGE

6. How are health insurance carriers financed? How are premiums determined?

Mandatory or optional insurance

In Bolivia, public health insurance carriers are financed through both mandatory and optional insurance according to the following:

Mandatory insurance

The social security system mandates health insurance coverage through the SUS for all citizens and legal residents. Additionally, employers are required to contribute to health insurance for employees under the CNS and other social security schemes (the employee's direct family members may also be registered and receive healthcare services).

Optional insurance

Private health insurance is optional and available to individuals or companies that wish to access additional services beyond what is provided by the public system. These policies are offered by private insurance companies. The premiums are determined between the parties and under the supervision of a public entity called Autoridad de Pensiones y Seguros (APS)

Governmental involvement in the determination of premiums

For mandatory insurance, the government plays a role in defining the contribution rates for social security and the SUS, but premiums for private health insurance are determined by private insurers.

7. How is the coverage of medical services by health insurance carriers regulated? Are there differences in coverage for in-person medical appointments and telemedicine appointments?

Freedom of insurance carriers to define coverage

Private insurers have the flexibility to design coverage plans, offering various options based on different service categories. Coverage varies depending on the insurer and the chosen plan.

Involvement of the government in defining coverage

The government plays a key role in defining coverage for mandatory insurance through the SUS and social security systems, ensuring access to a basic set of healthcare services, which include medical care, hospitalisation and surgery. It also sets minimum coverage standards for private insurers.

Special cases (telemedicine, orphan drugs, off-label use etc)

The use of telemedicine consultations was promoted by the government; however, Bolivia doesn't have a specific regulation for telemedicine. Notwithstanding, some insurers and the public sector apply these services to facilitate access.

HOSPITAL SECTOR

8. How are services provided by hospitals in the stationary (inpatient) and ambulatory (outpatient) settings financed and reimbursed?

Fixed/flat pricing per treatment category/indication (bundle payment)

In the public healthcare system of Bolivia, hospitalisation services and some outpatient procedures are financed by the National Health Service, which covers treatment costs through predefined budgets. In this model, financing is based on resource allocation for a specific treatment or procedure, which can be considered a form of bundle payment.

Individualised/specified pricing/fee-for-service

In the private sector and for certain outpatient consultations in public hospitals, the fee-for-service model is used. This means patients pay for each consultation, exam or treatment provided, with prices set for each type of service. This model is common in private clinics or when patients are not covered by public health insurance.

Contribution/financing by the government

The public healthcare system in Bolivia is primarily financed by the government through tax revenue and social contributions. National Health Insurance and public insurers cover most of the costs for hospitalisation and outpatient consultations. Patients may need to make co-payments for certain services or medications.

In the private sector, health insurance or direct patient payments cover service costs, with prices set according to the type of treatment or consultation.

Reimbursement model

In public healthcare, reimbursement follows predefined government-approved budget or financing frameworks. Health funds and social security systems handle reimbursements to hospitals and clinics based on agreed upon treatment categories. In the private sector, reimbursement is more direct, often involving private health insurers refunding patients or paying providers directly based on negotiated rates or patient policies.

9. How are the prices of such services determined? How is economic efficiency controlled?

Free pricing, price setting by government, and negotiation between the government/insurer and hospital

Prices of hospital services in Bolivia are determined through two mechanisms:

- Free pricing: In the private sector, hospitals set their own prices based on market

demand and operational costs.

- Price setting by the government: In the public sector, the government sets standardised pricing lists for most services, especially those covered by National Health Insurance

Role of associations (insurers and hospitals)

- Insurance companies: Private insurers negotiate prices with hospitals for the services covered under insurance plans.
- Hospital associations: Private hospitals may belong to associations that help to standardise pricing and negotiate with insurers.

Definition of pricing lists

Government: Sets pricing lists for public healthcare services (eg, surgery and consultations) to ensure affordability.

- Private sector: Pricing lists are determined by hospitals or through negotiations with insurers.

However, the government controls and supervises the prices and correct services provided by private health entities.

HEALTHCARE PROVIDERS IN PRIVATE PRACTICE

10. How are services provided by physicians, therapists, laboratories and other service providers financed and reimbursed?

Fixed/flat pricing per treatment category/indication

In the public sector, the government sets fixed prices for specific treatments or procedures, ensuring affordability for those covered by National Health Insurance. Some private providers also use fixed pricing for common services.

Individualised/specified pricing

In the private sector, providers set individual prices for each service (eg, consultations, laboratory tests and therapies), with variations based on complexity. Public services may have specified pricing for specialised treatments.

Contribution/financing by the government

The government finances services for those covered by National Health Insurance, including reimbursement for physicians, therapists and laboratories. Low-income patients may receive subsidies, with co-payments for some services. Private health insurers reimburse providers based on negotiated rates.

Reimbursement model

In the public healthcare system, providers are reimbursed based on government-approved tariffs or treatment bundles. Health professionals, laboratories and therapists receive reimbursement through predefined payment structures managed by social security systems or national health funds. In the private sector, reimbursement is either direct from patients or through negotiated agreements with private health insurers, who compensate providers

according to service contracts.
11. How are the prices of such services determined? How is economic efficiency controlled?
Free pricing, price setting by government, and negotiation between the government/insurer and service provider <ul style="list-style-type: none">• Free pricing: In the private sector, providers set their own prices based on market conditions and the cost of services.• Price setting by the government: The government sets standardised pricing lists for most public sector services, ensuring that healthcare remains affordable for those covered by National Health Insurance.• Negotiation: In the private sector, insurance companies and service providers negotiate reimbursement rates, establishing the prices for insured patients.
Role of associations (insurers and service providers) <p>Insurance companies: Private insurers negotiate with service providers to set prices for treatments and procedures covered by insurance.</p> <p>Service provider associations: Associations of healthcare providers may help standardise pricing, advocate for fair compensation and negotiate with insurers.</p>
Definition of prices <p>Government-defined prices: The government defines prices for public health services to ensure uniform pricing and affordability. These prices apply to services like consultations, treatments and diagnostic tests.</p> <p>Private sector: Prices in the private sector are defined by individual service providers or negotiated between insurers and providers.</p> <p>However, the government controls and supervises the prices and correct services provided by private health entities.</p>
PHARMACEUTICALS AND MEDICAL DEVICES
12. How are pharmaceuticals and medical devices financed and reimbursed?
Coverage by public/mandatory health insurance and/or funding by the government <p>National Health Insurance covers medicines and medical devices for insured patients, primarily funded by the government. Also, the government finances the acquisition of medicines and devices for public health services, ensuring access for the general population.</p>
Coverage by private/optional health insurance and/or self-payment by patients <p>Private health insurance covers medications and devices based on the insurance plan, though not all products may be reimbursed. Uninsured patients or those seeking non-covered treatments often pay out-of-pocket for pharmaceuticals and medical devices.</p>
13. How are the prices of pharmaceuticals and medical devices determined? How is economic efficiency controlled?
Free pricing and price setting by the government

In the private sector, prices are set by the market based on demand and competition. In the public sector, the government regulates the prices of essential medicines through the public entity that controls and establishes the list prices of medicaments called AGEMED, which was created under Supreme Decree No 2905 of 21 September 2016.

Criteria for pricing: health technology assessments, international price comparison and pay-for-performance

The government does not always use formal health technology assessments (HTA) or international price comparison for pricing. However, cost-effectiveness evaluations may be considered for some medicines. Pay-for-performance models are not widely applied in Bolivia for pharmaceuticals and devices.

LITIGATION INVOLVING HEALTHCARE FINANCING AND REIMBURSEMENT

14. Please provide a high-level overview of major litigation topics and landmark cases regarding healthcare financing and reimbursement.

Cases on limits to public/mandatory health insurance funding in individual cases (eg, maximum spending per additional life year)

In Bolivia, legal disputes often arise when patients challenge coverage limitations for high-cost treatments under the SUS. These cases may involve arguments about the fairness of cost-effectiveness decisions and the availability of expensive therapies, like cancer treatments, highlighting tensions between limited resources and patient needs.

Cases on emergency financing of hospitals and other service providers in financial distress

Bolivian hospitals, particularly public ones, often face financial difficulties due to insufficient reimbursement from the SUS, leading to potential lawsuits when they seek additional funding or demand payment for services rendered.

RECENT DEVELOPMENTS AND TRENDS

15. What are the recent developments and trends for the next few years? Please outline any unresolved issues, proposed changes or trends for healthcare financing and reimbursement, and briefly indicate how these may foreseeably affect the medical sector in the near future.

Upcoming changes in legislation/regulation

Reforms to Universal Health Insurance are expected to improve coverage and sustainability, and control medication costs. These changes will aim to address gaps in access and quality of care, especially in rural areas, but all of them are subject to the political landscape in the coming years.

Ongoing litigation regarding fundamental issue(s) and expected judgments

Legal challenges are likely to arise concerning access to expensive medications and the availability of specialised treatments within the public healthcare system as patients seek greater coverage for high-cost therapies.

Factual shifts regarding financing (total spend and distribution among payors)

The increase in public health spending and the focus on primary care and prevention will largely depend on Bolivia's political situation in the coming years. The government's ability to allocate more funds to healthcare will be influenced by the political landscape, including decisions on economic priorities and the role of the private sector in public-private partnerships. These factors will shape the future of healthcare financing in Bolivia.