Supplementary File 3 – Health System summary, by country

Country	Health system summary
Brazil[1]	• **Health expenditure per capita (in Purchasing Power Parity [PPP], international dollars [int$])**: 1,472.2 (out-of-pocket expenditure per capita: 404.2);[3] • **Delivery structure:** complex network of public and private providers, ranging from single doctors to specialty and multispecialty tertiary care hospitals; • **Physicians per 1,000 population in 2018**: 2.1;[4] • **Nursing and midwifery per 1,000 population**: 9.7;[4] • **Government role:** the Brazilian public health system, the Unified Health System (SUS), is managed, financed, and provided by all levels of government; • **Private insurance role**: complementary role; • **Healthcare Access and Quality (HAQ) Index†**: 63.8;[5] • **Primary care**: primary health care (PHC) facilities offer both curative and preventive services; PHC facilities are mainly public; Family Health Care teams and the Basic Health Units are the first point of contact between the community and a health provider; • **Primary care team**: doctor, nurse, nurse assistant, and community health workers; Each the team is responsible for providing primary care to 3–4000 people in a defined geographic area, and each community health worker looks after 750 people in the community; The team can also incorporate oral health teams (dentists and dental technicians); • **Primary care service fee**: services at government facilities, including preventive and primary care, diagnostic services, and outpatient and inpatient hospital care, are delivered free of charge; Medications on the essential drug list are free, while other prescription drugs are purchased from private pharmacies.
India[1]	• **Health expenditure per capita (in PPP, int$)**: 253.3 (out-of-pocket expenditure per capita: 158.1);[3] • **Delivery structure:** complex network of public and private providers, ranging from single doctors to specialty and multispecialty tertiary care hospitals; • **Physicians per 1,000 population in 2017**: 0.8;[4] • **Nursing and midwifery per 1,000 population**: 2.1;[4] • **Government role:** financing, legislation, and regulation by central government; financing, regulation, and direct provision of services by state governments; • **Private insurance role**: limited role providing substitutive coverage for the upper class urban population; • **Healthcare Access and Quality (HAQ) Index†**: 41.2;[5] • **Primary care**: PHC facilities offer both curative and public health programmes, with a strong focus on maternal and child health; PHC facilities are mainly public; Some private, especially in urban areas; The primary health center is the first point of contact between a village community and a medical officer and provides curative and preventive services to 20,000 to 30,000 people; • **Primary care team**: primary care physician, mid-level provider, auxiliary nurse midwife (ANMs), multipurpose worker (MPWs), and accredited social health activists (ASHAs); • **Primary care service fee**: services at government facilities, including preventive and primary care, diagnostic services, and outpatient and inpatient hospital care, are delivered free of charge; Primary care services within the private sector are covered by private insurances or out-of-pocket payments; Medications on the essential drug list are free, while other prescription drugs are purchased from private pharmacies.

South Africa[2]	• **Health expenditure per capita (in PPP, int$)**: 1,097.8 (out-of-pocket expenditure per capita: 85.3);[3] • **Delivery structure**: complex network of public and private providers, ranging from single doctors to specialty and multispecialty tertiary care hospitals; • **Physicians per 1,000 population in 2017**: 0.9;[4] • **Nursing and midwifery per 1,000 population**: 3.5;[4] • **Government role**: government-funded healthcare is available to all citizens regardless of their income or employment status; • **Private insurance role**: limited role providing substitutive coverage for the upper class urban population; • **Primary care**: PHC facilities are mainly public; Some private; Public services are provided through a nurse-based, doctor-supported infrastructure of clinics and community health centers, available within 5kms to more than 90% of the population, and free at the point of use; Ward-based outreach teams and the community health centers are the first point of contact between the community and a health provider; • **Healthcare Access and Quality (HAQ) Index**†: 49.7;[5] • **Primary care team**: clinical nurse practitioners might be supported by doctors, and in larger clinics, a broader multi-professional team consisting typically of nurses, doctor(s), pharmacist, allied health professionals and lay counsellors can support the staff. Care is supported by an emerging system of community-based outreach teams consisting of community health workers. • **Primary care service fee**: services at public facilities are free of charge; Fee-for-service for care provided by private general practitioners.
The United States[1]	• **Health expenditure per capita (in PPP, int$)**: 10,246.1 (out-of-pocket expenditure per capita: 1,126.3);[3] • **Delivery structure:** network of private providers, ranging from primary care to outpatient specialist care and tertiary care hospitals; • **Physicians per 1,000 population in 2016**: 2.6;[4] • **Nursing and midwifery per 1,000 population**: 8.5;[4] • **Government role:** shared responsibility; Medicare: age 65+, some disabled; Medicaid: some low-income; for those without employer coverage, state-level insurance exchanges with income-based subsidies; • **Private insurance role**: primary private voluntary insurance covers most population; Supplementary for Medicare; • **Primary care**: PHC facilities are private; • **Healthcare Access and Quality (HAQ) Index**†: 88.7;[5] • **Primary care team**: primary care physician; Practices – particularly large ones – often include nurses and other clinical staff; • **Primary care service fee**: fee-for-service.

†HAQ Index Provides a summary measure of personal healthcare access and quality for a given location. This measure is based on risk-standardized mortality rates or mortality-to-incidence ratios from causes that, in the presence of quality healthcare, should not result in death – also known as amenable mortality. HAQ Index performance is shown on a scale of 0 to 100, with 0 reflecting the worst observed levels across countries from 1990 to 2016 and 100 being the best observed during this time.

[1] The Commonwealth Fund. International Health Care System Profiles. Available from https://international.commonwealthfund.org/countries. (Accessed March 14th, 2020).
[2] World Health Organization. Primary health care systems (PRIMASYS): case study from South Africa, abridged version. Geneva: World Health Organization; 2017. Available from: https://www.who.int/alliance-hpsr/projects/primasys/en/. (Accessed March 14th, 2020).
[3] World Health Organization. Global Health Observatory data repository. Geneva: World Health Organization. Available from: https://apps.who.int/gho/data/node.home. (Accessed March 20th 2020).
[4] World Health Organization. The 2018 update, Global Health Workforce Statistics. Geneva: World Health Organization, 2018. Available from: http://www.who.int/hrh/statistics/hwfstats/. (Accessed March 22th 2020).
[5] Fullman N, Murray CJ, Lozano R, et al. Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016. The Lancet 2018; 391:2236–2271. doi: 10.1016/S0140-6736(18)30994-2.