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Chile

Pablo Villalobos Dintrans

The Health Care System in Chile

Global Dynamics of Social Policy CRC 1342

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Content

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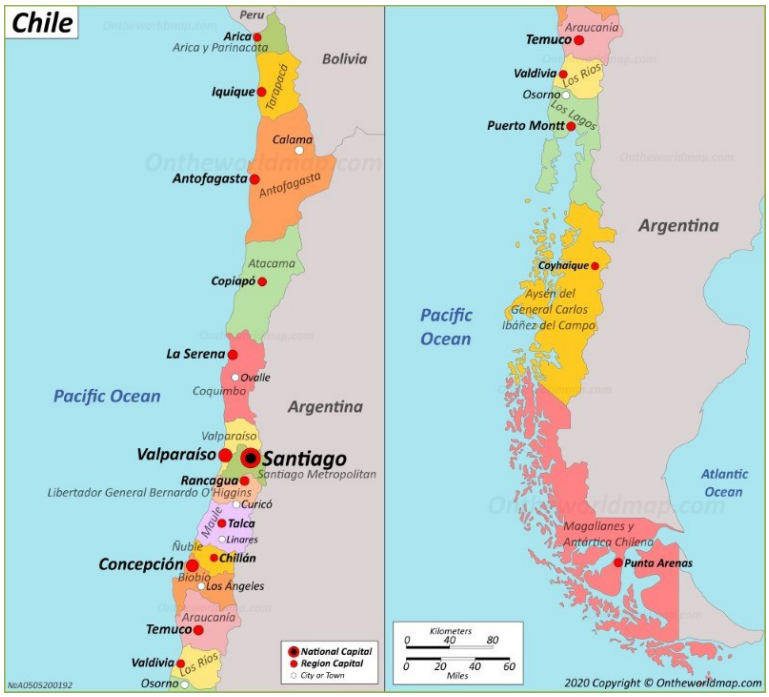
1. Country Overview



Source: https://ontheworldmap.com/chile/ (Accessed: May 17, 2021)

- Sub-Region: South America
- Capital: Santiago
- Official Language: Spanish
- Population size: 19,116,201 (UN data 2021; 2020 value)
- Share of rural population: 12.4% (UN data 2021; 2020 value)
- GDP: 282.32 billion USD (World Bank 2021, 2019 value)
- Income group: High Income
- Gini Index: 44.4 (World Bank 2021; 2017 value)
- Colonial period: Mid-16th century-1810 (Spanish colony) (CoW 2021)
- Independence: 1818 (declaration of independence) (CoW 2021)

2. Selected Health Indicators

Indicator	Country	Global Average
Male life expectancy	77.6 (2018)	70.4 (2018)
Female life expectancy	82.4 (2018)	74.9 (2018)
Under-5 mortality rate*	7.0 (2019)	37.7 (2019)
Maternal mortality rate**	13.0 (2017)	211.0 (2017)
HIV prevalence***	0.5 (2019)	0.7 (2019)
Tuberculosis prevalence****	18.0 (2019)	130 (2019)

Source: World Bank 2021

* Mortality rate, under-5 (per 1,000 live births)
** Maternal mortality ratio (modelled estimate, per 100,000 live births)
*** Prevalence of HIV, total (% of population ages 15-49)
**** Incidence of tuberculosis (per 100,000 people)

3. Legal beginning of the system

Name and type of legal act	Organisational Regulation of the Charity Board [*Reglamento Orgánico de la Junta de Beneficencia*]
Date the law was passed	1886
Date of *de jure* implementation	1886
Brief summary of content	Its main goal was to regulate health centres, including local hospitals and other health organisations, to meet the rising population's health needs.
Socio-political context of introduction	At the time, Chile needed to organise and establish its national institutions by, e.g., creating national-level regulations for hospitals that had mostly been established by local initiatives and were under local administration (usually charities). This was a strategy to avoid political inactivity and strengthen centralism (Tapia 2015).

4. Characteristics of the system at introduction

a. Organisational structure

- The system was composed of health centres (hospitals and other institutions), established by local authorities, based on regional requirements. This law sought to establish a national-level regulation for these organisations; transferred the ‚hospitals' administration to local boards which, in turn, was headed/supervised/controlled by the National Board.
- Local governments were responsible for the provision of services. Under the 1886 regulation, a centralised authority was put in charge of overseeing the functioning of hospitals and other healthcare institutions.
- There is no information on eligibility, entitlement, and coverage at the time of the introduction.

b. Provision

At the time of its introduction, the Charity Board was constituted by (Tapia 2015):

- Mental health asylums [*casas de orates*]: 1
- Orphanages [*asilos y casas de expósitos*]: 14
- Hospices [*hospicios*]: 9
- Facilities for people with infectious diseases [*lazaretos*]: 16
- Hospitals: 49
- Dispensaries [*dispensarios*]: 39

Table 1. Service Provision: Health infrastructure and services 1900-1997

Year	Hospitals	Beds	Physicians	Vaccinations
1900	83	13,143	ND	182,440
1910	97	ND	ND	312,465
1930	145	15,697	963	493,849
1940	198	22,284	1,428	633,574
1950	224	27,832	2,205	ND
1960	242	28,119	3,724	3,725,570
1970	ND	35,932	4,462	3,888,396
1980	219	37,967	11,671	4,000,351
1990	ND	32,932	14,334	4,614,449
1997	226	42,223	17,467	4,558,395

Source: Tapia (2015)
ND: no data.

c. Financing

Financing of healthcare was basically provided by charity institutions (mostly the Catholic church) and direct payments.

Table 2. Financing: Government health expenditure by percentage of GDP

Year	Government health expenditure/ GDP
1885	0.00%
1895	0.00%
1907	0.00%
1920	0.00%
1930	0.45%
1940	0.91%
1950	0.93%
1952	1.57%
1955	1.13%
1960	1.32%
1965	1.92%
1970	1.63%
1975	1.78%
1980	2.79%
1985	2.75%
1990	1.89%
1995	2.17%

Source: 'Author's own elaboration based on Díaz et al. 2016).

d. Regulation

The organisations mainly responsible for the regulation of the system at introduction were:

a) Charity Board: the board was in charge of the 'country's hospitals until the creation of the National Health System in 1952.
b) Ministry of Internal Affairs (Hygiene and Charity branch): at the national level, it constituted the only health authority in the country (within the government apparatus).

Additionally, the Regulation of the Charity Board [*Reglamento Orgánico de la Junta de Beneficencia*] regulated providers through local boards overseen by the National Board. In terms of benefits, health services were limited to those that people could get at the hospitals and other health institutions listed above.

5. Subsequent historical development of public policy on healthcare

a. Major reform I

Name and type of legal act	First Health Regulation [*Código Sanitario*]. and the Health Department [*Dirección General de Sanidad*] (Law 3,385)
Date the law was passed	1918
Date of *de jure* implementation	1918
Brief summary of content	Establishes a centralised health authority in the country. Establishes an executive position and health organisations at the local level.
Socio-political context of introduction	Endeavour to resolve a dispute over whether healthcare should be privately or publicly funded in the light of general poverty and issues such as the cholera pandemic of 1918.

b. Major reform II

Name and type of legal act	Creates the Ministry of Hygiene, Assistance and Social Welfare (Law Decree 44) and the 'Workers' Insurance [*Seguro Obrero*] (Law 4,054), a social health insurance that covered employees for work-related injuries and diseases.
Date the law was passed	1924
Date of *de jure* implementation	1924
Brief summary of content	The State assumes responsibility for protecting worker's health. The Ministry's aim was to bring together and coordinate all the health-related institutions such as the Health Department, Charity Board, Worker's Insurance, and other health-related work benefits.
Socio-political context of introduction	Political tensions and awareness of worker's rights, including the creation of unions (after the Russian Revolution in 1917) and the creation of welfare states in Europe. These laws were enacted amid a tense political environment, including the intervention of the armed forces in the discussion of the nation's budget and the President's resignation (and change of the Constitution).

c. Major reform III

Name and type of legal act	Establishment of the National Health Service (Law 10,389) and the Social Insurance Office[1].
Date the law was passed	1952
Date of *de jure* implementation	1952
Brief summary of content	It consolidated a series of health-related institutions under a single authority.
Socio-political context of introduction	Influence of the social medicine movement and the National Health System (NHS) in England.

d. Major reform IV

Name and type of legal act	Local health services were created, as well as the National Health Fund (Fonasa), the National Supply Center (Cenabast) and the Institute of Public Health (ISP) (Law Decree 27,603)
Date the law was passed	1979
Date of *de jure* implementation	1979
Brief summary of content	The Ministry of Health becomes solely responsible for the governance of the system. It consolidates the National Health System and the system for employees (Sermena) into a decentralised system with 27 health services along the national territory[2]. 'FONASA's goal is to collect contributions and finance healthcare services.
Socio-political context of introduction	Neoliberal reforms post-coup d'état in 1973 and an increasing role of the private sector in health.

1 According to González et al. (2019), the National Health Service offered healthcare services to all residents of the country, although preventive and curative treatments were only intended for poor people as well as employees and their families (70% of the total population).

2 Tapia (2015) states that, by the time of this reform, the Chilean health system coverage was: 20% Sermena; 50% employees covered by the National Health Service; 7% of independent workers who contributed to one of the previously named schemes; between 18% and 20% of non-contributive beneficiaries (self-employed) who received services by paying out-of-pocket, and the rest of the population covered by an armed forces scheme.

e. Major reform V

Name and type of legal act	Creation of the Municipal Primary Health System (DFL 1-3063)
Date the law was passed	1980
Date of *de jure* implementation	1980
Brief summary of the content	Decentralisation of the primary health and increasing the 'system's efficiency and coverage.
The socio-political context of introduction	Neoliberal reforms post-coup d'état in 1973 and an increasing role of the private sector in health.

f. Major reform VI

Name and type of legal act	Creation of private health insurers (ISAPRE) (Law Decree 3,500)
Date the law was passed	1980
Date of *de jure* implementation	1981
Brief summary of content	Freedom to choose between public and private insurers; market-oriented reforms via competition. Healthcare resources increased by allowing private initiatives to insure and provide healthcare.[3] Subsidiary role of the State.
Socio-political context of introduction	Neoliberal reforms post-coup d'état in 1973 and an increasing role of the private sector in health.

g. Major reform VII

Name and type of legal act	Ministry's structural change separating the MoH into two under-secretaries: Public Health and Health Providers' Network (Law 19,937)
Date the law was passed	2004
Date of *de jure* implementation	2005
Brief summary of content	The objective is to meet the people's needs in a changing environment and resolve some systemic problems (ageing, inequality, etc.). Goals/principles: Health as a right, reducing inequalities, more solidarity, efficiency, and social participation. It creates two undersecretaries and positions the MoH as the institution in charge of regulating and coordinating the health sector. Creates the Superintendency of Health.
Socio-political context of introduction	Changing the legacy of the military regime.

h. Major reform VIII

Name and type of legal act	AUGE/GES initiative (Law 19,966)
Date the law was passed	2004
Date of *de jure* implementation	2006
Brief summary of content	The objective is to meet the people's needs in a changing environment and solve some system's problems (ageing, inequality, etc.). Goals/ principles: Health as a right, reducing inequalities, more solidarity, efficiency, and social participation. All repetition of preceding legislation introduces a series of services guaranteed by law (access, quality, and financial protection). Originally included 40 health conditions. Meanwhile, there are 85 conditions.
Socio-political context of introduction	Changing the legacy of the military regime.

Source: López 2019; González et al. 2019; Ministerio de Salud de Chile 2021.

3 By this time (1979) the public health expenditure had decreased considerably compared with the previous decade.

6. Description of the current healthcare system[4]

a. Organisational structure

- Currently, the Health Services are decentralised institutions under the supervision of the Undersecretary of the Providers' Network. At present, there are 29 of these services in the country, one for each of the 16 administrative regions except in the most populated regions: Valparaíso (divided into three services), Metropolitan (divided into six services), Biobío (divided into four services), Araucanía (divided into two services), and Los Lagos (divided into three services).
- In terms of regional allocations of responsibilities of healthcare, the Health Services are responsible for coordinating and managing the health providers in their geographical area. Regarding financing, health resources come from different sources. The health insurers are in charge of collecting health insurance contributions. The national health budget is defined at a central level between the Ministry of Health and the Ministry of Finance. Ultimately, the system's governance is the responsibility of the Ministry of Health at the national level. The Superintendency of Health regulates public and private providers.
- The country has a mixed system (public/ private) in both provision and insurance. People can opt between insurers and providers. Although the freedom to choose is one of the main principles of the system, the current regulations and incentives allow selection in private insurance; consequently, this scheme tends to cluster younger (primarily males) and wealthier people (Villalobos Dintrans 2018).
- As for provision, people can choose to use their health insurance coverage with public or private providers. Except for FONASA A beneficiaries (see below), people in the public insurance (FONASA) can opt for getting healthcare from private providers using the free-to-choose scheme (*Modalidad Libre Elección*, MLE).
- All residents are entitled to health insurance. The health insurance system offers two main options:
  - Public insurance (FONASA)
  - Private insurers (ISAPRE)

Each person can opt between one of the (compulsory) schemes. In both cases, the minimum contribution is 7% of the salary. FONASA's beneficiaries are divided into four groups, based on income:

Beneficiary type	Income group	Benefits (for providers of the public network)
FONASA A	No income/ extremely poor	No compulsory contribution No payments for healthcare services
FONASA B	i. Monthly wage lower than CLP $280,000 [roughly US $380] ii. Public health sector workers	i. Contribution but no payment ii. 100% coverage, 0% co-payment
FONASA C	Monthly wage between CLP $280,001 and CLP $ 420.480 [roughly US $560]	90% coverage, 10% co-payment
FONASA D	Monthly wage larger than CLP $ 420,481	80% coverage, 10% co-payment is the 10% gap intentional

Source: González et al. 2019.

4 Based on González et al. 2019.

b. Coverage

ISAPRE beneficiaries sign an individual contract with the insurer that sets the services, coverages, and premiums.

Table 3. Coverage: Percentage of population coverage by different schemes.

Percentage of population covered by government schemes (other)[5]	2%
Percentage of population covered by social insurance schemes * Public (FONASA) * Private (ISAPRE) * Armed Forces (CAPREDENA)	 78% 14% 3%
Percentage of population covered by private schemes	–
Percentage of population uncovered	3%[6]

Source: González et al. 2019

c. Provision

Indicator	Value
Physician density (per 1,000 inhabitants)	2.6 (2018)
Nurses and midwives density (per 1,000 inhabitants)	13.3 (2018)
Hospital beds density (per 1,000 inhabitants)	2.1
Hospital beds in public institutions (number)	25,991
Hospital beds in public institutions (share of total hospital beds)	70%

Source: World Bank Indicators 2021; González et al. 2019

» Importance of inpatient and outpatient sectors: In 2016, 37% of all the healthcare services were delivered by private providers; out of these services, most are outpatient services such as exams (45%), medical visits (24.5%), and other outpatient procedures (23.2%).

d. Financing (percentage of GDP)

Indicator	Value
Total expenditure for health	9.1% (2018)
Domestic general government health expenditure	50.8%[7](2018)
Private Expenditure on health » Out-of-pocket expenditure » Other	49.2% (2018) 33.2% (2018) 16% (2018)

Source: World Bank Indicators 2021.

5 For example, the PRAIS scheme, a health benefit for people who suffered violation of human rights during the military government.

6 Although not formally enrolled, all residents are entitled to health coverage by FONASA.

7 In 2013, this expenditure was financed by government expenditure (54.4%) and contributions to compulsory health insurance schemes (45.6%).

e. Regulation of dominant system

- The main bodies responsible for regulating and organising the system are:
  - Ministry of Health: national health authority, in charge of designing the national health policies.
  - Regional authorities (SEREMI): regulation of the national health planning—including implementation of policies and programs—at the local level.
  - Institute of Public Health: regulation of drugs and medicines.
  - Superintendency of Health: regulation of healthcare providers.
- Superintendency of health is in charge of regulating providers (public and private). The institution is responsible for the registry and accreditation of individual and institutional providers. Every three years, the accreditation and certification process are carried out by institutions authorised by the Superintendency of Health (acreditadores). Its goal is to ensure that providers meet the norms and standards defined by the Ministry of Health. (González et al. 2019).
- In terms of the benefit package, the beneficiaries of the public insurance (FONASA) are entitled to two types of benefits schemes: institutional scheme (*Modalidad de Atención Institucional*, MAI) and free-to-choose scheme (*Modalidad Libre Elección*, MLE), which offer different coverages depending on the type of provider (public and private) and the type of service. The MAI scheme is for people getting healthcare from public providers, with benefits varying according to the type of FONASA beneficiary (A, B, C or D). Co-payments in this scheme are defined using a reference value of each service covered, set by FONASA, and approved by the Ministry of Health and the Ministry of Finance. The benefit package includes preventive services (primary health), healthcare at secondary and tertiary levels (both inpatient and outpatient), and oral health services. Maternity and sick leave are also covered by the health insurance. The MLE scheme is designed as a complementary coverage for the MAI. Here, people can access healthcare through private providers, with the co-payments varying by the healthcare provider (not the 'beneficiary's income group) (González et al. 2019).

7. Co-existing systems

Besides FONASA, the main alternative scheme is private insurance, ISAPRE. As previously described, people self-select into one or another system, with ISAPRE providing health insurance for 14% of the population. Service provision for this group uses the same network of providers (public and private) as FONASA and is subject to the same regulations, although there are differences in their governance (Bitrán Dicowski and Villalobos Dintrans 2020).

8. Role of global actors

The role of global actors in terms of provision and financing is negligible. The main role of global actors is the one played by global health institutions such as the World Health Organization, the Pan American Health Organization, and others, in terms of providing information and guidelines for different health topics.

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