# HEALTH FINANCING PROFILE - CHILE



Chile's socio-economic development over recent decades has been accompanied by improving average health outcomes. Life expectancy at birth has risen from 55 years in 1955 to 78 years in 2012 and the infant mortality rate has fallen from 120 per 1,000 live births in 1955 to fewer than 8 in 2012, making its progress notable among upper-middle income Latin American countries.[1]

Socio-economic development has brought almost-universal access to piped-in water (93% of households) and improved sanitation facilities (96% of households).[2,3] The demographic and epidemiological transitions continue to advance as the population ages and non-communicable diseases eclipse infectious disease.[4]

Chile, however, exhibits high levels of economic inequality which are paralleled by stratified health access and outcomes with far greater gains seen among high-income groups. Though the nation has officially targeted the indigent and low-income population for free health coverage for over 100 years, this health divide between high and low income groups has persisted.

The government is addressing these equity issues with the "Universal Access with Explicit Guarantees" (AUGE) reform begun in 2005 which applies to all providers within the nation's Social Health Insurance (SHI).

## Health Finance Snapshot

**Total Health Expenditures (THE) per capita** (in USD at official exchange rate) have increased at an annualized rate of 9.3% from 2000 to 2011.

However, **THE** as a share of **gross domestic product (GDP)** has fallen by 1.1 percentage points (from 8.4% to 7.3%) during that same period.



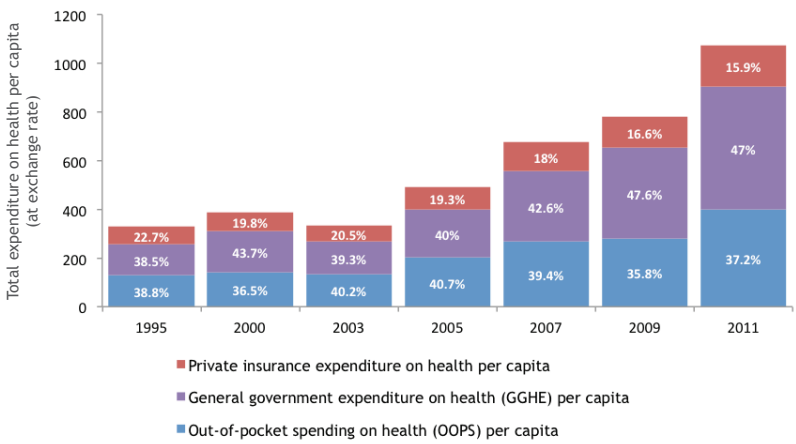
### Table 1. Health Finance Indicators: Chile

| | 1995 | 2000 | 2003 | 2005 | 2007 | 2009 | 2011 |
|---|---|---|---|---|---|---|---|
| Population (thousands) | 14,395 | 15,398 | 15,919 | 16,267 | 16,598 | 16,929 | 17,268 |
| Total health expenditure (THE, in million current US$) | 4,767 | 5,953 | 5,335 | 8,024 | 11,261 | 13,244 | 18,555 |
| THE as % of GDP | 6 | 8 | 7 | 7 | 7 | 8 | 7 |
| THE per capita at exchange rate | 331 | 387 | 335 | 493 | 678 | 782 | 1075 |
| General government expenditure on health (GGHE) as % of THE | 38.5 | 43.7 | 39.3 | 40.0 | 42.6 | 47.6 | 47.0 |
| Out of pocket expenditure as % of THE | 38.8 | 36.5 | 40.2 | 40.7 | 39.4 | 35.8 | 37.2 |
| Private insurance as % of THE | 22.7 | 19.8 | 20.5 | 19.3 | 18.0 | 16.6 | 15.9 |

Source: WHO, Global Health Expenditure Database; National Health Accounts, Chile

- **Out of pocket spending (OOPS)** makes up a substantial portion of **THE** (Table 1, Figure 1).
  - These costs are **point-of-service fees** (i.e.: provider co-payments, medications, etc.) and do not include private insurance premiums.
  - Within the private expenditure on health figures are health expenditures by **private insurers within Social Health Insurance (Isapres)** as well as private insurers not included in the SHI. The latter group accounts for a miniscule portion of THE, providing only supplemental insurance.

### Figure 1. Total Expenditures on Health per capita, Chile




Source: WHO, Global Health Expenditure Database; National Health Accounts, Chile

# Health Status and the Demographic Transition

Though Chile's health gains have typically been greater for wealthier segments of the population, increased usage of primary health services in recent years is expected to narrow the health gap between income groups. The advanced epidemiological and demographic transitions impact the nation's health costs as an aging population utilizes more health services with fewer young, healthy workers contributing to the system.

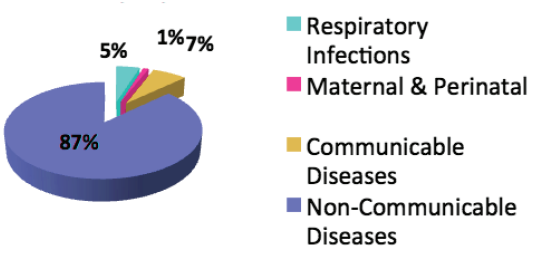
## Demographic Transition

- Birth and mortality rates are declining (figure 2)
- Life expectancy is increasing
- The 'bulge' in the population pyramid is moving upward (figure 3)
- The **total fertility rate (TFR)** has fallen from 2.6 in 1990 to 1.9 in 2012.

## Epidemiological transition

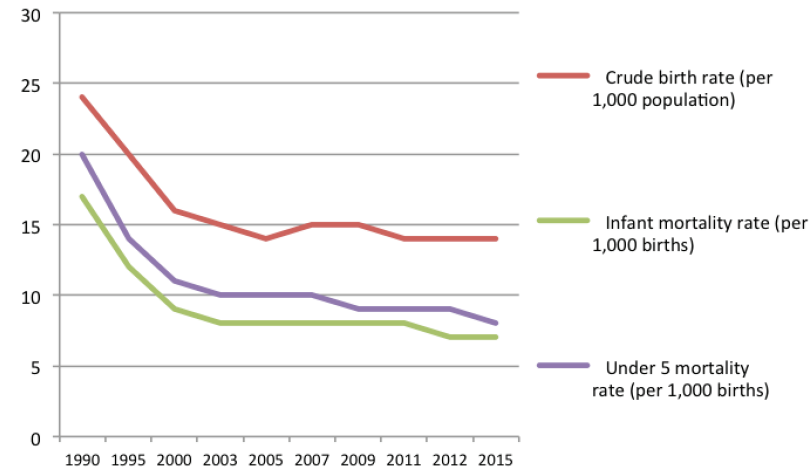
- Mortality from non-communicable (chronic) illnesses has far surpassed infectious disease mortality (Figures 4 and 5)

### Figure 4. Mortality by Cause, 2008. Chile.




Source: WHO, Global Burden of Disease Death Estimates (2011)

### Figure 2. Demographic Indicators. Chile



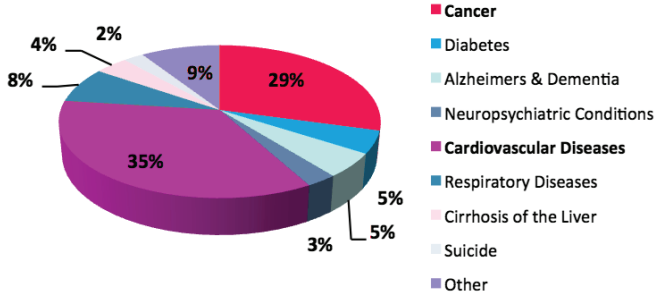

Source: United Nations Statistics Division and the Instituto Nacional de Estadísticas, Chile.

### Table 2. International Comparisons, health indicators.

| | Chile | Upper Middle Income Country Average | % Difference |
|---|---|---|---|
| GNI per capita (year 2000 US$) | 4,690.9 | 1,899.0 | 147% |
| Prenatal service coverage | 95.0 | 93.8 | 1.3% |
| Contraceptive coverage | 64.2 | 80.5 | -20.3% |
| Skilled birth coverage | 99.9 | 98.0 | 1.9% |
| Sanitation | 96 | 73 | 31.5% |
| TB Success | 72 | 86 | -16.3% |
| Infant Mortality Rate | 7.7 | 16.5 | -53.3% |
| <5 Mortality Rate | 8.8 | 19.6 | -55.2% |
| Maternal Mortality Rate | 25.0 | 53.2 | -53% |
| Life expectancy | 88.9 | 72.8 | 22.3% |
| THE % of GDP | 8.0 | 6.1 | 30.2% |
| GHE as % of THE | 54.0 | 54.3 | -.6% |
| Physician Density | 1.0 | 1.7 | -39.3% |
| Hospital Bed Density | 2.1 | 3.7 | -42.7% |

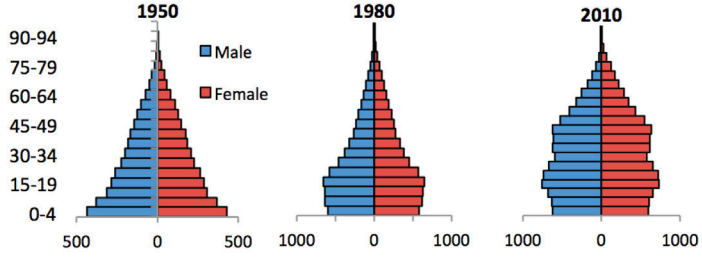
Source: Bitran, Ricardo. "Explicit Health Guarantees for Chileans: The AUGE Benefits Package", World Bank UNICO Series, No. 21, 2013

### Figure 5. Non-Communicable Disease Mortality. Chile.




Source: WHO, Global Burden of Disease Death Estimates (2011)

### Figure 3. Population Pyramids of Chile

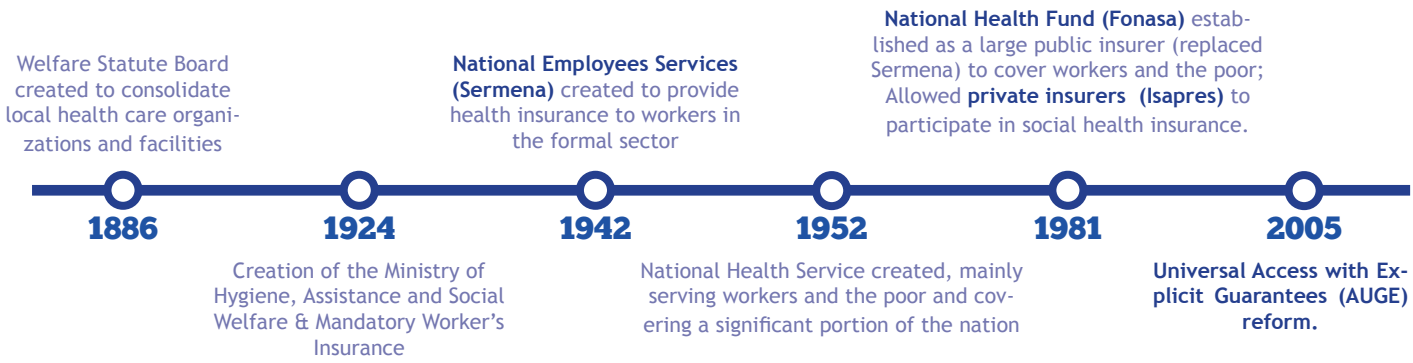



Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2010 Revision.

# Health System Financing and Coverage

**Chile's Social Health Insurance (SHI)** has undergone a series of transformations since the establishment of the Welfare Statute Board in 1886 culminating in the current **National Health Fund** (Fonasa). Setting it apart from many other SHI schemes in the region, Chile's system initially targeted the poor and reached nearly-universal coverage by the mid-20th century. However, a highly-profitable and **selective private insurance system ensconced in the SHI (Isapres)** has fostered marked health inequities between high income individuals and low-income or indigent populations. The **Universal Access with Explicit Guarantees (AUGE)** reform of 2005 has now established, for the first time, a mandatory minimum benefits package, waiting time limits and copayment caps for all SHI insurers (public & private).

**Figure 6. Timeline of Chile's Social Health Insurance (SHI)[5]**

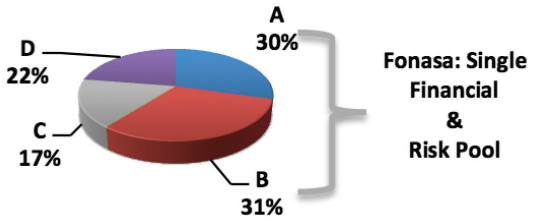



Chile's **SHI** includes:

- The National Health Fund (Fonasa). The large public insurer which covers four groups (A through D) and combines all Fonasa beneficiaries in the same financial and risk pool.

  A: Indigent
  B: Very low income
  C: Lower-middle income
  D: Higher-middle income

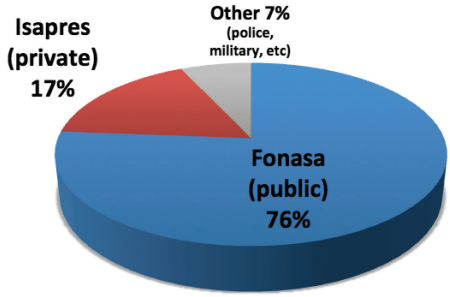
**Figure 7. Fonasa Beneficiaries 2011**




Source: Fonasa, Estadisticas Institucionales

  - Groups B, C and D make mandatory contributions to Fonasa through automatic payroll deductions (7% of earnings up to a maximum deduction of USD$140/month). They do not pay extra fees or premiums for AUGE.
  - Group A is completely covered by the State.
- **Private, for-profit insurers (Isapres)** with small and fragmented risk and financial pools. Since 1981, private insurers have been allowed to participate in the nation's **SHI** scheme provided they collect the same mandatory 7% payroll contribution paid by groups B,C and D (for Fonasa) plus an additional premium established by each Isapre. Isapres must also submit to government regulation of the SHI system.
  - With the AUGE reforms, Isapres may also now collect an additional **AUGE** premium which is determined by each insurer.

**Figure 8. SHI Beneficiaries, Chile, 2011.**




Source: Fonasa, Estadisticas Institucionales

The **AUGE** benefits expansion is supported on the public financing side by a 1 percentage point increase in the value-added tax (from 18 to 19%) which is generally thought to be progressive in the benefits it finances[5], tobacco taxes and customs revenues.

Group A (indigent) beneficiaries represent over one-quarter of Chile's population though Chile's official poverty is only 14.4%[5]

- A 2010 investigation by Fonasa found that most of the 400,000 individuals misclassified as Group A were independent and temporary workers who were not making contributions.
- As of mid-2012 these workers were to be re-classified and make the mandatory 7% payroll contribution to Fonasa or join an Isapre.

With the AUGE reform of 2005, a list of 56 (later growing to 69) priority health conditions was identified for legally-enforceable universal access to prevention, diagnosis and treatment (for Fonasa and Isapres beneficiaries) based on[4]:

- Magnitude as measured by epidemiological indicators such as incidence, prevalence, DALY and mortality;
- Treatment Effectiveness whereby treatments considered from medium to high on a pre-defined defined scale of effectiveness were chosen for coverage guarantees;
- Health System Capacity in terms of service provision feasibility for all geographic territories and for populations from all socio-economic strata;
- Cost was considered as cost per case and total cost per condition;
- Social Consensus involving surveying the population on their attitudes and opinions to counteract the ability of special interest groups to steer the health system reform process.

### Legal Guarantees for all SHI Beneficiaries via AUGE

- Prevention and diagnosis for 69 defined priority health conditions
- Establishment of explicit treatment protocols for the priority conditions
- Maximum wait times at health facilities defined and adopted
- Limits on out-of-pocket expenses for healthcare implemented

**Figure 9. Contributions and Coverage in Chile's SHI.**

| | Mandatory contribution | Additional Premiums | AUGE health services | Primary health services (non-AUGE) | Other medical and dental |
|---|---|---|---|---|---|
| **Fonasa** | | | | | |
| Group A | None | None | 100% covered with public providers | 100% covered with public providers | 100% covered with public providers |
| Group B | 7% up to a maximum contribution of US$140/month | | | 100% covered with public providers / Covered at 50-75% for private providers | Varying Co-payments with public providers / Covered at 50-75% for private providers |
| Group C | | | | | |
| Group D | | | | | |
| **Isapres** | | Private premium + AUGE premium | 100% covered with public providers | Varies by health plan | Varies by health plan |

Source: Fonasa, Health Plan Coverage. http://www.fonasa.cl/

## Challenges and Future Agenda

The **AUGE** reforms have greatly increased equity in access to care, particularly for the poorest individuals and households. 95% of the **AUGE** services delivered from 2005 through 2012 have gone to Fonasa beneficiaries. In a 2009 government analysis, mortality from some cancers, diabetes (type 1 and 2), hypertension, child epilepsy and HIV/AIDS were found to have dropped following the **AUGE** reforms.[5] Both **AUGE** and non-**AUGE** spending by Fonasa has increased by 35% from 2005 through 2009 as beneficiaries have begun to learn about and demand their newly guaranteed health services. Going forward, lawmakers are focusing on Fonasa's sustainability as well as regulating the Isapres to limit rampant price discrimination (based on age and gender), inadequate risk pooling and 'cherry picking' of young and healthy beneficiaries.[5]

**Figure 10. Future agenda for Chile's SHI**

| | |
|---|---|
| Sustainability | • MOF has set a maximum actuarial cost of **AUGE** per beneficiary<br>• This maximum cost must be balanced with the new legal guarantees for a growing list of services and health conditions |
| Accountability | • Improvements needed in the national health **information system (SIGGES)** which is meant to **track AUGE's** performance |
| Enforcement of Contributions & Proper Enrollment | • Introduction of a system to identify and track temporary and independent workers to ensure that they are making payroll contributions to either Fonasa or an Isapre<br>• Transfer of appropriate workers from Group A (indigent) to Group B in Fonasa |
| Regulation of Isapres | • Rein in 'cherry-picking' of young and healthy beneficiaries<br>• End price discrimination for women (who often pay 2-3 times what men pay in premiums during the female reproductive years)<br>• End unconstitutional premium hikes with age |

## References


1 World Health Organization. Global Health Observatory, Interagency estimates.
2 WHO / UNICEF. "Estimates for the use of Improved Drinking-Water Sources", Joint Monitoring Programme for Water Supply and Sanitation, Chile. March 2012.
3 WHO / UNICEF. "Estimates for the use of Improved Sanitation Facilities", Joint Monitoring Programme for Water Supply and Sanitation, Chile. March 2012.
4 Missoni,Eduardo and Solimano Giorgio. "Towards Universal Health Coverage: the Chilean experience", World Health Report, Background Paper, No. 4, 2010.
5 Bitran, Ricardo. "Explicit Health Guarantees for Chileans: The AUGE Benefits Package", World Bank Universal Health Coverage Studies Series (UNICO), No. 21, 2013.



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