



## **COUNTRY CASE STUDY**

### **HEALTH INSURANCE**

#### **IN CHILE**

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### **1. OVERVIEW OF POLITICAL, SOCIO-ECONOMIC AND HEALTH CONTEXT**

Chile gained independence from Spain in the 19<sup>th</sup> Century. It has had a volatile political history, moving between governments with very different ideological views. For example, in 1970 Salvador Allende became President and implemented a range of socialist policies including the nationalisation of many industries and land redistribution. In 1973, there was a coup and a military government headed by Augusto Pinochet took control. Under Pinochet, who ruled until late 1989, there were widespread human rights abuses and a move towards 'free market' economic policies. More recently, Chile has been led by elected Presidents from the Christian Democrat and Socialist Parties.

Chile is classified by the World Bank as an upper middle income country. In 2005, it had a GNI per capita of US\$5,870, and an annual inflation rate of 4.8%. Chile is highly dependent on foreign trade, with copper being the most important export, with wood products, fresh fruit, processed food, seafood and wine also being important exports. Poverty levels have reduced dramatically in recent years, declining from 45% of the population being below the poverty line in 1987 to 18.8% in 2003. However, income inequalities are still considerable.

Statistics on the health status of the population and the delivery of health care in Chile are notable. Child immunisation rates for measles and DPT3 are high with approximately 94% of all children between the ages of 12-23 months having been immunized in 2004. Almost all births (99.8% in 2003) are attended by skilled health staff. In 2003, there was 1.1 physicians per 1000 people, and in 2002, there were 2.6 hospital beds per 1000 people.

Chile exhibits some of the best health status indicators among countries in its income classification and among other Latin American countries (see table below). Child malnutrition was low, with 1% of all the children under 5 being underweight. The leading causes of death are diseases of the circulatory system, malignant neoplasms, injuries and diseases of the respiratory system.

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<b>Macro- &amp; socio-economic and demographic indicators</b>	
GDP (USD 2005 Billions)	115.3
GNI per capita (USD 2005)	5,870
Gini coefficient (2000)	57
Urbanisation (% total population)	87%
Literacy (% population aged 15+)	96%
Population (Millions 2005)	16.3
Unemployment rate (1997)	6.4%

<b>Labour Force Structure by sector (% of labour force) (2004)</b>	
Services sector	25%
Commerce	18%
Industry and manufacturing	16%

<b>Health Sector Financing/Expenditure Statistics (2003)</b>	
Health expenditure, total (as a percentage of GDP)	6.1
Health expenditure, public (as a percentage of GDP)	3.0
Health expenditure, public (% of total health expenditure)	48.8
Health expenditure per capita (\$)(2002)	642

<b>Health Status Indicators</b>	
Infant mortality rate (per 1000 live births)(2003)	8
Under 5 mortality rate (per 1000 live births)(2004)	8
Maternal mortality (per 100, 000 live births)(2000)	31
Life expectancy at birth (years)(2003)	77.9

**Sources:** WHO National Health Accounts website for health care financing statistics;  
World Bank website for all other data

## **2. DEVELOPMENT OF CHILE'S HEALTH SYSTEM**

Chile's health system development has been influenced by its economic development and the different political ideologies that have been dominant in the country's history. The organised health system began during the 1920s with the establishment of the Sanitary Law in 1918, which established that the state was responsible for sanitation and preventative health programs. The establishment of this law reinforced the expectation that the state was deemed responsible for actively ensuring a good public health system.

The Social Security Law of 1924 was then established which was aimed at ensuring coverage for health services for workers and their families; this was the first formal health insurance system. The Ministry of Health was created in the same year and its mandate was to conduct research on health conditions and to extend public health programs.

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The National Health Service was then established in 1952. This health service was funded through social security contributions and general tax revenues and provided nationally organised public hospitals and clinics as well as basic health and sanitation services. This National Health Service which came about under a socialist/communist regime was the major health provider in the country for 40 years. Under this system, there was universal, tax funded coverage, which was regarded as one of the most comprehensive and best organised health systems in the Latin American region.

In 1979, the financing of the public health system was reorganised into one National Health Fund, thus creating the Fondo Nacional de Salud (FONASA) for collecting health-related payroll taxes and allocating national budget subsidies. This was closely followed by the creation of Instituciones de Salud Provisional (ISAPREs) – i.e. private insurance, by allowing the social insurance tax to be transferred to private insurance companies. Earlier reforms in 1968 allowed the social security service, SEREMA, to have private preferred providers, and allowed SEREMA's white collar workers to opt out of the public service and use private providers for basic ambulatory care and to have this care partially covered by payroll tax insurance benefits. This paved the way for the development of the ISAPREs. This happened during a military regime favouring decentralisation and privatisation as major policy reforms. Since 1981 workers have been able to choose between public and private insurance creating two very distinctive sections of the health system.

For decades it was mandatory for formally employed workers to contribute a specified percentage of their wages to health insurance, which was provided only by the public insurer. However, since 1981, workers have been able to choose between public insurance and several private insurers, and as a result, about half of the country's active dependent workers opted out of the public and into the private insurance system.

### **3. CURRENT STRUCTURE AND FUNCTIONING OF THE HEALTH SYSTEM**

The health system is a mixed system with the public system being financed from general taxes, a dedicated health tax, and co-payments for some income groups. The private system is mainly financed by contributions in the form of a dedicated health tax and some additional premia and co-payments. All formal sector workers are required to contribute a 7% payroll health tax up to a ceiling of US\$2,000<sup>1</sup>.

Delivery of care is also divided between the public and private sectors. The public sector provides primary and preventive care through health centres owned by municipalities, and secondary and tertiary care is provided through public hospitals owned by the National Health Services System (NHSS). The private sector consists of for-profit and non-profit clinics, diagnostic centres, specialised private hospitals, and private health professional offices.

Up until 1981, 90% of all hospital beds in the country were owned by the NHSS, but the private sector's infrastructure grew to such an extent thereafter that private sector beds accounted for 25% of all hospital beds in the country by 1992.

### **4. STRUCTURE AND FUNCTIONING OF THE HEALTH INSURANCE SYSTEM**

The Chilean health insurance system consists of public insurance and private insurance. As indicated above, the public insurance component is managed through the National Health Fund (FONASA), and private health insurance is provided through the ISAPREs.

At present, FONASA covers 69.5% of the country's population, over a third of these being indigents and half being contributing members and their dependants. The ISAPREs cover about 16.5% of the population. The other 14.2% of the population include those who used smaller insurance or welfare systems such as the Armed

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<sup>1</sup> This is the approximate amount of the ceiling which varies in pesos with the exchange rate with the dollar.

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Forces, and other groups who did not have any insurance cover at all like some very high income brackets. In the mid-1990s there were about 20 open ISAPREs in existence, i.e. ISAPREs which any member of the public could join. Closed ISAPREs, i.e. those restricted to the employees of certain large companies, only covered 5% of those who are members of private insurance schemes. In 2006, this had reduced to 8 open and 7 closed ISAPREs.

### **4.1. FONASA – PUBLIC HEALTH INSURANCE**

#### **4.1.1. Contributions and funding**

The funding for the public insurer comes from four main sources: subsidies from the national treasury i.e. general taxes revenues; a 7% dedicated payroll tax; co-payments by users of the public health system; and co-payments made by FONASA beneficiaries who wish to obtain care from either public and private providers (this is called the ‘free choice’ option under FONASA). A large proportion of FONASA’s budget, at least 50%, is funded by general tax revenues. Being a public insurer, FONASA caters for a range of different income groups within the general population.

Premiums or contributions are proportional. People who are employed and choose to use the FONASA must pay 7% of their income towards health insurance, irrespective of their age, number of dependants or health status. The FONASA categorises members into 4 groups A-D. The legally indigent are in Group A, and as they have no income are exempt from contributing to FONASA. Members from Groups B-D are required to pay the 7% dedicated health tax.

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<b>FONASA Groups as a percentage of Chile's population</b>		
<b>FONASA GROUP</b>	<b>Income category Monthly income<sup>2</sup> (2006)</b>	<b>Proportion of country's population (%)</b>
Group A	Legally indigent	24
Group B	<US\$254	22
Group C	US\$254-370	12
Group D	>US\$370	12

Source: <http://fon.fonasa.cl>.

### **4.1.2. Benefit structure**

All FONASA members are entitled to the same benefit coverage. The only difference is that members from Groups C and D, pay co-payments of 10% and 20% of the cost of the service respectively. Members in Groups A and B therefore have access to unlimited cover with no co-payments. Benefits are comprehensive and include consultations and treatment with specialists, laboratory tests and other diagnostics, and hospitalisation.

### **4.1.3. Co-payments and limits**

In the public system co-payments are applicable only to middle and high income members for secondary and tertiary care. Therefore those members with higher incomes are required to pay co-payments on top of the dedicated health tax. The co-payment is related to the service provided and is a percentage of the cost of the service rendered at secondary and tertiary facilities. The co-payment differs for each income category but is never more than 20% of the cost of the intervention delivered by the facility. There are no co-payments for primary care as primary care is provided free for everyone.

### **4.1.4. Cross subsidies and risk pooling within the system**

FONASA has members from across the income spectrum, although 72.7% of its members are in the lowest two income quintiles. FONASA is financed from general tax revenue which is progressively structured. In terms of financing, the FONASA structurally allows for income cross-subsidies, even though the FONASA is partly financed through a proportional payroll tax. Low income earners do not pay co-

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<sup>2</sup> Using the Peso/Dollar exchange rate as at 31/12/06 source: <http://www.oanda.com>

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payments and most importantly the indigent do not pay any contributions to FONASA. There are clear health risk cross-subsidies in the public insurer, as everyone receives the same comprehensive benefits.

### **4.2. ISAPREs – PRIVATE HEALTH INSURANCE**

#### **4.2.1 Contributions and funding**

The ISAPREs are funded from the dedicated payroll tax of 7% of the people who have chosen to enrol with them. The members tend to be middle and high income earners. Those who have cover through the ISAPREs are required to pay out-of-pocket for services which are not covered in their contract with the ISAPRE. The health insurance benefits that a member receives are in line with the size of benefits that 7% of their salary can purchase. ‘Top-up’ insurance can be purchased from ISAPREs (i.e. members can pay contribute over and above the 7% payroll deduction to ensure a more comprehensive benefit package).

#### **4.2.2. Benefit structure**

The ISAPREs benefits are linked to the level of a member’s contributions. Benefit structures are individualised, so a member receives a benefit structure based on their income and risk profile. Members with high incomes can therefore purchase more health cover with 7% of their incomes than those earning less. Members can also choose to pay additional premiums on top of the 7% of their income and have access to additional benefits.

#### **4.2.3. Co-payments and limits**

All primary care is provided without any co-payments and limits. For secondary and tertiary care, the ISAPREs function on a system of preferred providers, co-payments and limits. If members use preferred providers, co-payments tend to be low or non-existent. Limits are set for specific members for specific interventions, and high cost interventions tend to have limits attached to them. There is no coverage of health care once the limits have been reached.

#### **4.2.4. Cross subsidies and risk pooling**

The ISAPREs receive funding equivalent to 7% of their members' salaries, and additional premia based on 'top-up' cover that a member often has to pay in order to have comprehensive cover. There are many different private insurers and they all function independently. Therefore as a system, ISAPREs do not have any income cross-subsidies. Within a private insurer there may be minimal income cross-subsidies between the middle and high income earners. This however is limited by the fact that contributions are capped at a certain level, i.e. the highest income earners pay the lesser of the contribution ceiling and 7% of their income.

Health risk cross subsidies are virtually non-existent in the ISAPREs as each individual member is covered with a specific benefit package in line with their risk profile and contributions, and there is the option of paying an additional amount for extra benefits.

## **5. KEY ISSUES**

Chile's health system has been criticised for being inequitable as it divides the health system, with a public system catering for the indigent, low and low to middle income groups and a private system providing health care for the middle and high income groups. All workers are required to contribute 7% of their income to the health insurance scheme of their choice. However, if a worker belongs to a private ISAPRE scheme and is regarded as a high risk enrollee, he or she either has to contribute more than 7% or accept a reduced benefit package, whereas if the worker is in FONASA, he or she receives the same benefit package for the 7% contribution, whatever the level of risk. The result is that the healthier and wealthier are heavily concentrated in the ISAPRE schemes and the less healthy and less wealthy are concentrated in FONASA.

The Chilean government introduced reforms in mid 2005 to address these inequities, called the AUGE Plan or "Universal Access with Explicit Guarantees". Under this plan, specified diseases (56 diseases that are major causes of ill health in Chile, many of which are regarded as 'catastrophic' such as cancer and AIDS) have to be covered by FONASA and ISAPRE, with maximum co-payments specified. It is a form of

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prescribed benefit package that all insurance schemes must cover and a mechanism for ensuring some financial protection for the entire population. The number of diseases included are being gradually increased so that all 56 diseases are covered by 2007.

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