Public health impact of Covid-19: Chile

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Agenda

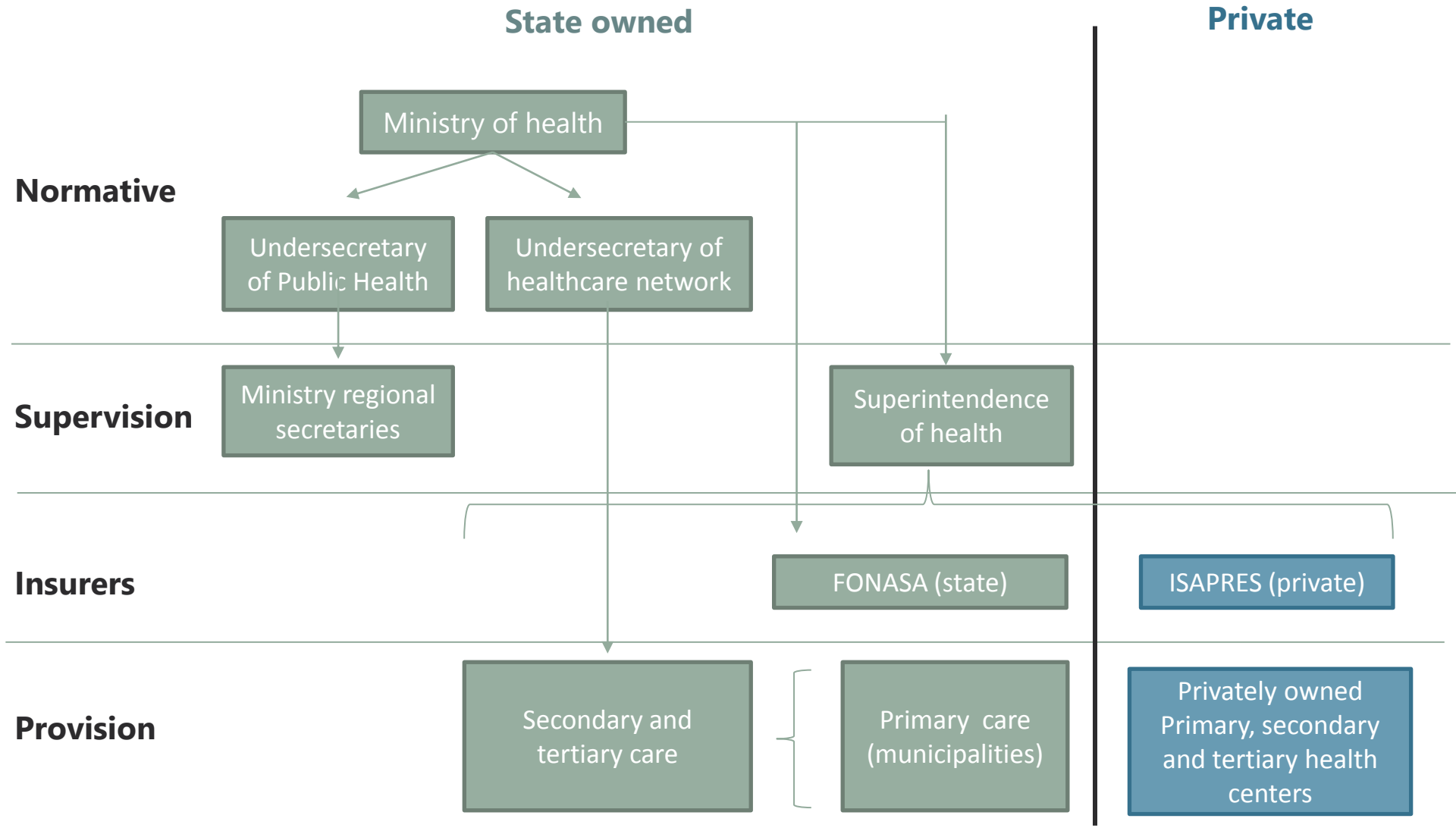
01 Organization of health system in Chile

02 Evolution of Covid-19 and actions taken in Chile

03 Lessons and final comments

1. Organization of health system in Chile

Institutions that integrate the healthcare system



Source: adapted from Benavides et al. 2013

Health insurance

- Current structure and organization of health insurance dates back to late 1970′. Changes in the middle of 2000′.
- Mix of public and private initiatives.

Layers	Description
Layer 1	**Mandatory insurance** • Executed by Fonasa (1 public insurer) and Isapres (12 private insurers - 6 compete). • Coverage: in general hospital and outpatient care, inpatient pharmaceuticals and a group of services associated to 80 health conditions, which are guaranteed (GES services) in access, opportunity (timely access), financial coverage, quality. • Regulated by the government. • Supervised by Superintendence of Health.
Layer 2	**Voluntary insurances** • Executed by private insurance companies. • Coverage: copayments of mandatory insurance, catastrophic expenses (after a deductible), assistance in medical facilities, other benefits. • Regulated as any other insurance company. • Supervised by Superintendence of Securities and Financial Services.

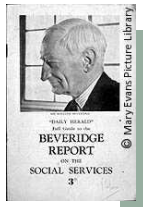
Source: own elaboration.

Two components with different rationales at the insurance level

	Public component	Private Component
Insurers	1 (Fonasa). 78% population.	12 (Isapres). 14.4% population.
Funding	Salary contribution (7%), state subsidy, co-payments.	Salary contribution (7%), voluntary contributions (> 3%), co-payments.
Premium determinants	Income level (7%).	Plan content, age, number of dependents.
Health plan	Unique: contents (benefits). Varies: financial coverage (decreases with income) and providers (exception of people with no income –Fonasa A).	Varies: benefits, financial coverage and providers.
Providers	Mainly State providers, but also privately owned providers in agreement.	Privately owned (State owned in special cases).
Cost of medical care	Determined by State.	Determined by market.
Providers payment	Hospitals: historical budget, fee for service, salaries, DRG. Primary care: per capita, salaries.	Fee for service (retrospective and prospective). Some innovations.

Source: Own elaboration, CASEN 2017.

Thus: Chile combines different types of health insurance systems



National health service and insurance (Beveridge).

State centralizes planning, collection and financing (mainly through taxes). Provision can differ (public / private).

Fonasa

Private insurances.

Insurance market. Risk rated premiums, freely set by the insurer.

Social health insurance (von Bismark).

Health insurance is mandatory. There are many (regulated) third party payers (insurers) and payment is not related to risk.

Isapres (private insurers, with many regulations, that intend to assimilate them to a SHI system, i.e. GES services)

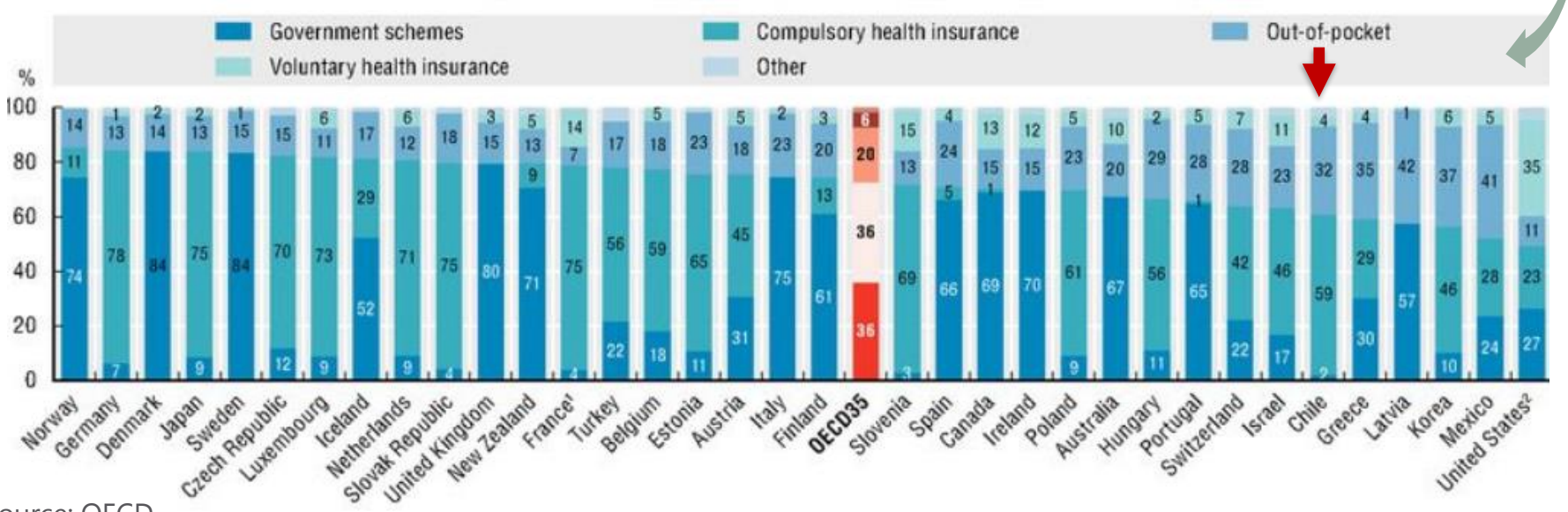
And then, we experienced the problems documented for those systems, as well as others that emerge from the interaction of them

- Signs of a two-tier system where the elderly, sick and poor stay in Fonasa.
- Low levels of competition because of proliferation of plans and non-transparent private health insurance market.
- Low levels of choice and affordability for low-income and high-risk individuals.
- High levels of risk selection due to no open enrollment and poor RE scheme.
- Fonasa and Isapres face different regulations and thus cannot compete in equal terms.
- Quality of care gap between Fonasa and Isapres (i.e. longer waiting times in Fonasa).
- Low incentives to control costs → High premiums in Isapres have led to an increase in people suing their Isapres.

Universal coverage still not achieved

- (i) Who is covered: 92,4% with insurance
- (ii) What services are covered: excludes outpatient pharmaceuticals and other services (more expensive treatments and drugs).
- (iii) How much is covered: there are co-payments, that can be important.
- (iv) Quality of the covered services: for those who get the services quality is quite good, but there are important waiting lists.

OOP / THE



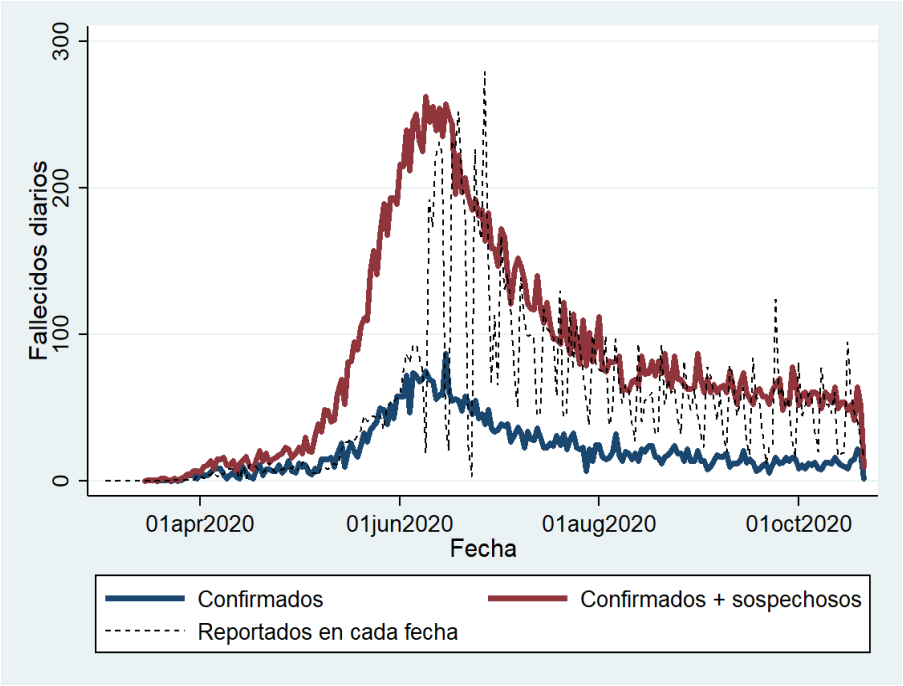
Source: OECD

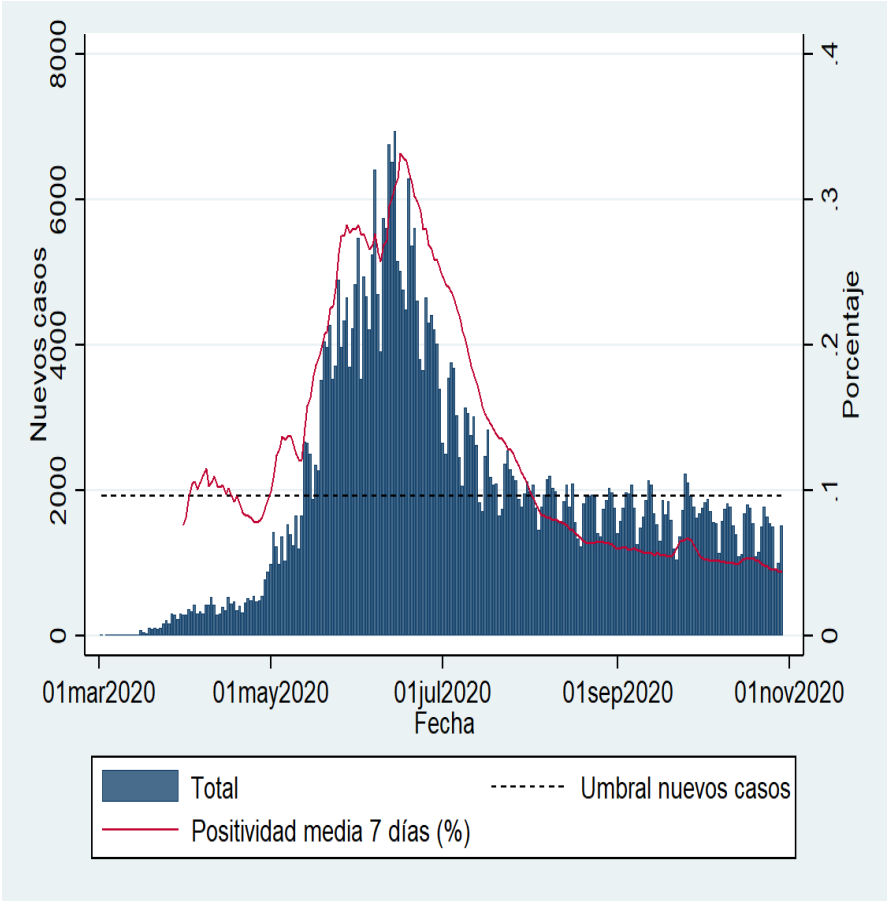
2. Evolution of Covid-19 and actions taken in Chile

The strategy

- There was not a defined previous plan.
- Health:
  - Strong effort to strengthen health system capacities.
  - Late implementation of TTI strategy.
  - Innovation in the modalities of attention.
- Mitigation and containment:
  - Early closures.
  - Moving and selective local quarantines.
  - Active search of Covid-19 cases after peak.
- Economic:
  - Gradual economic support for workers and families.
- Pandemic management:
  - Gradual increase and improvement in the delivery of information and communication of risk to the population.
  - Lack of intra and extra governmental coordination.

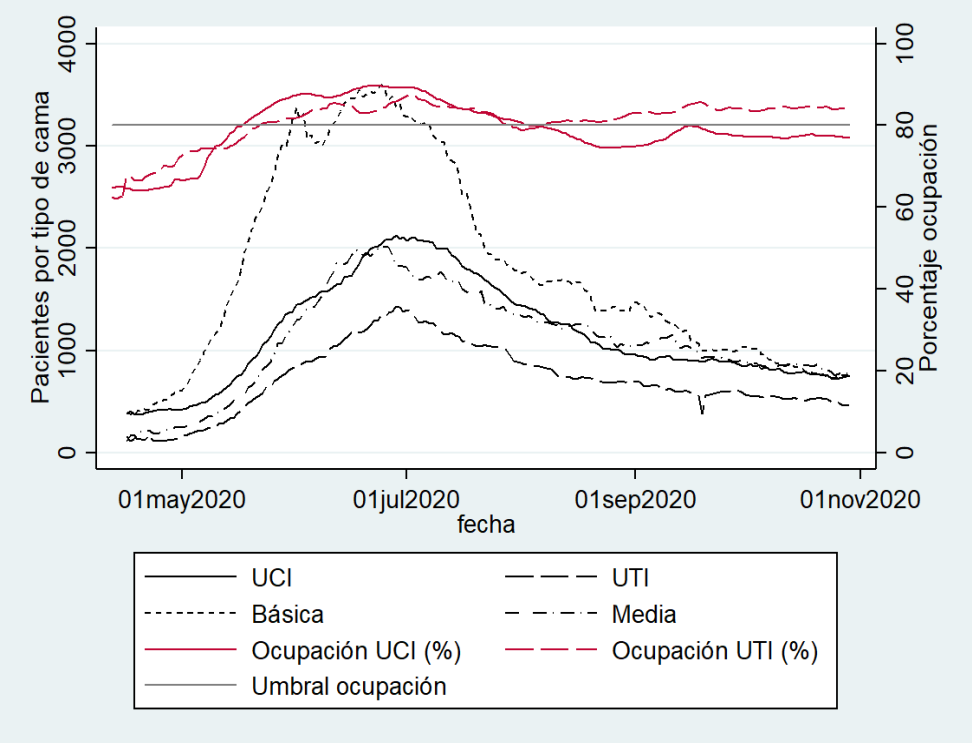
Evolution of Covid-19 cases and deaths



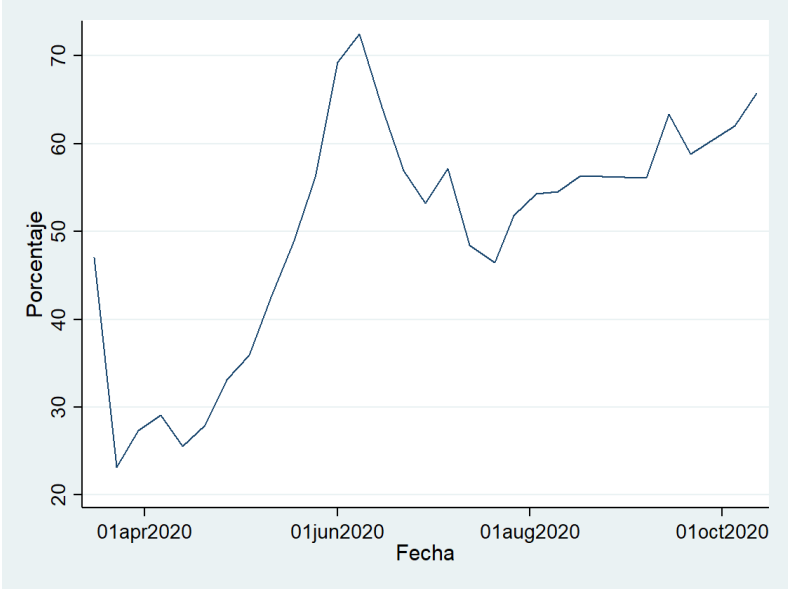


- Rapid increase from may onwards with a peak in June
- Uniform behave from september onwards (low downward trend)

Evolution of Covid-19 beds occupation rates



Proportion of deaths to Covid-19 hospital discharges per week



- In June and July occupation rates were high, as well as proportion of deaths related to hospital discharges.
- Probably related to lower quality of care when ICU and ITU where full.

Measures taken in the 4 recommended aspects

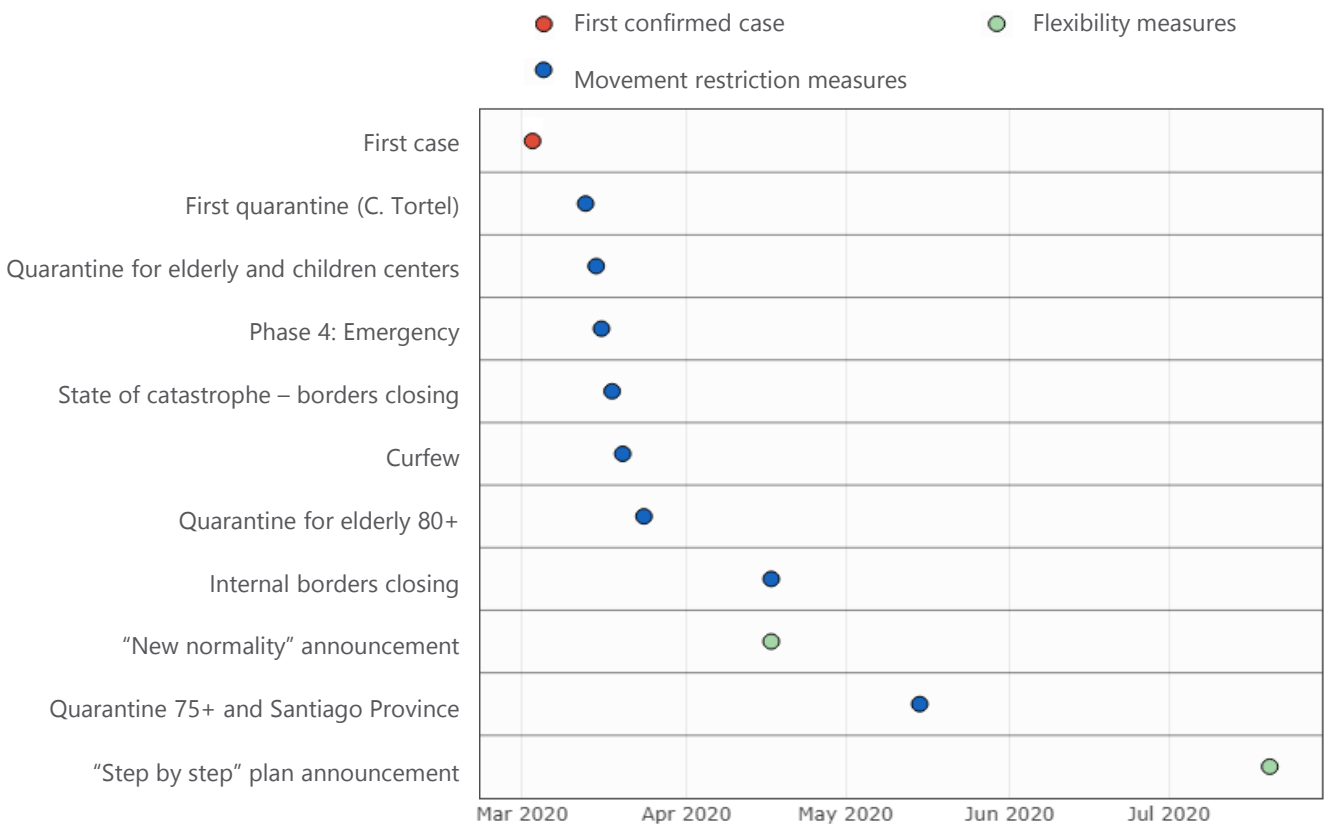
1) Mitigation and containment

2) Economic support

3) Pandemic management

4) Health related

- Early adopter, except for massive quarantines



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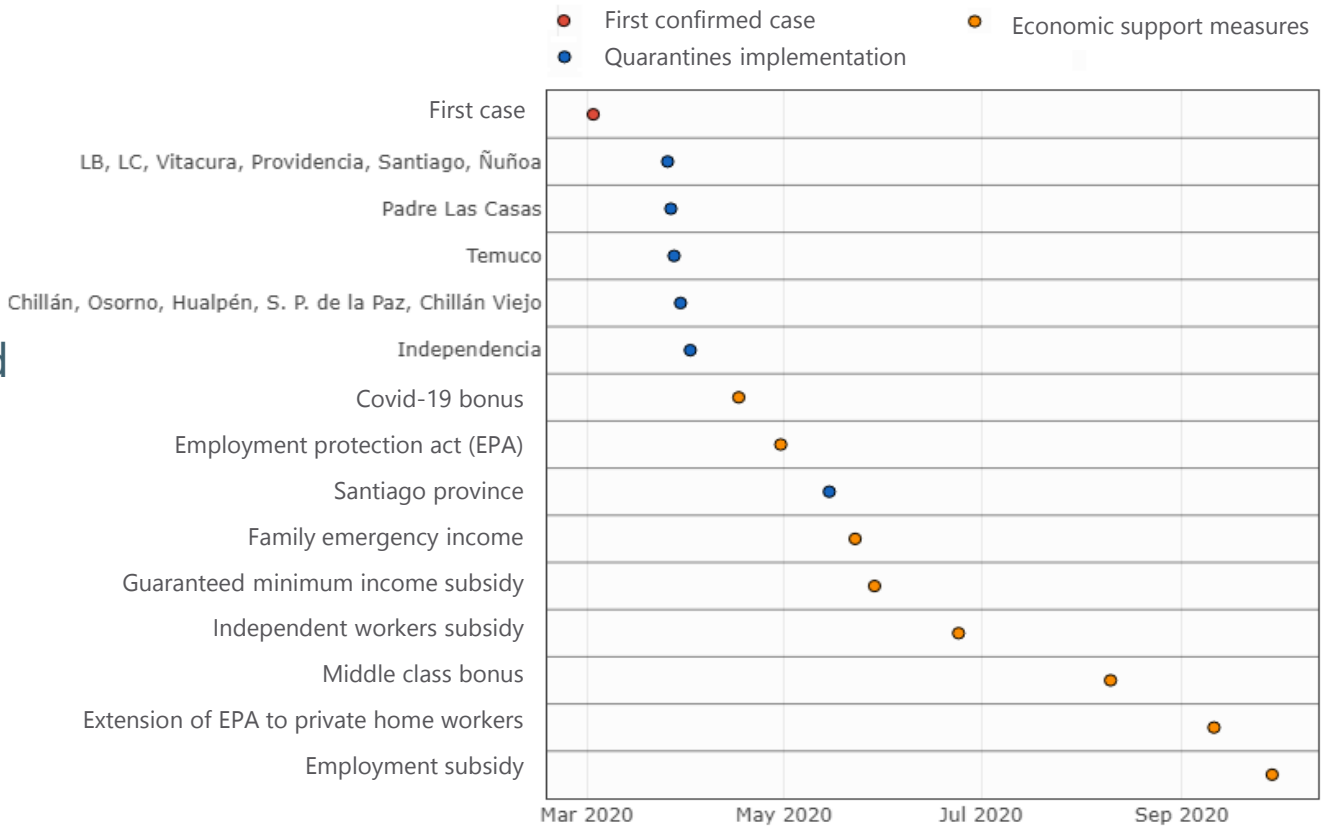
- Not timely, particularly to informal workers and the most vulnerable.
- Undermied compliance.
- Size of support.



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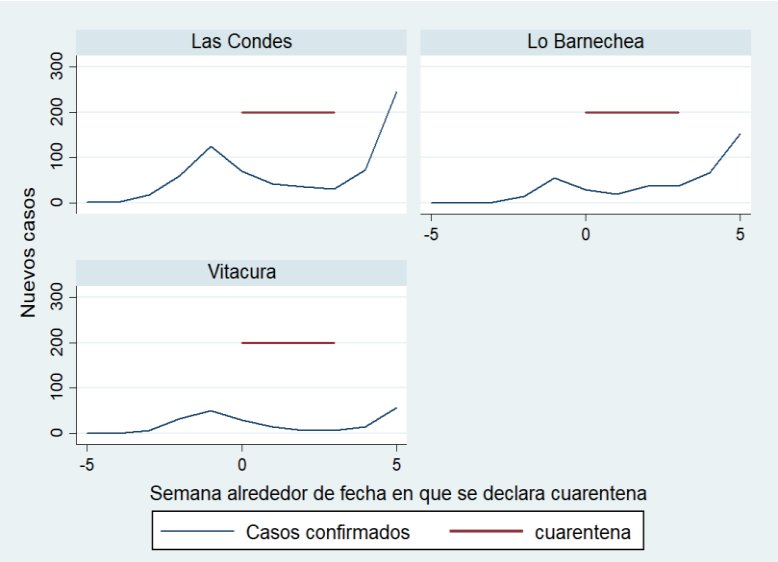
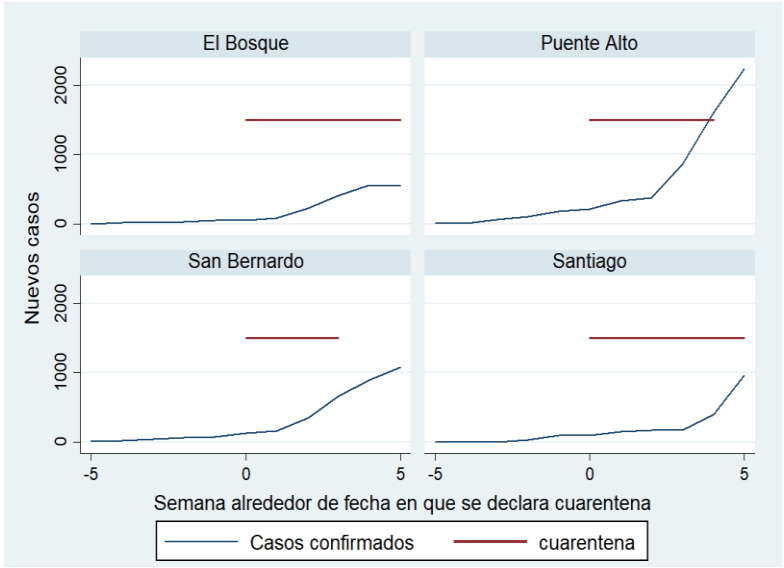
- Impact of quarantines was different according to socioeconomic level of neighborhoods

High SE level



Low SE level



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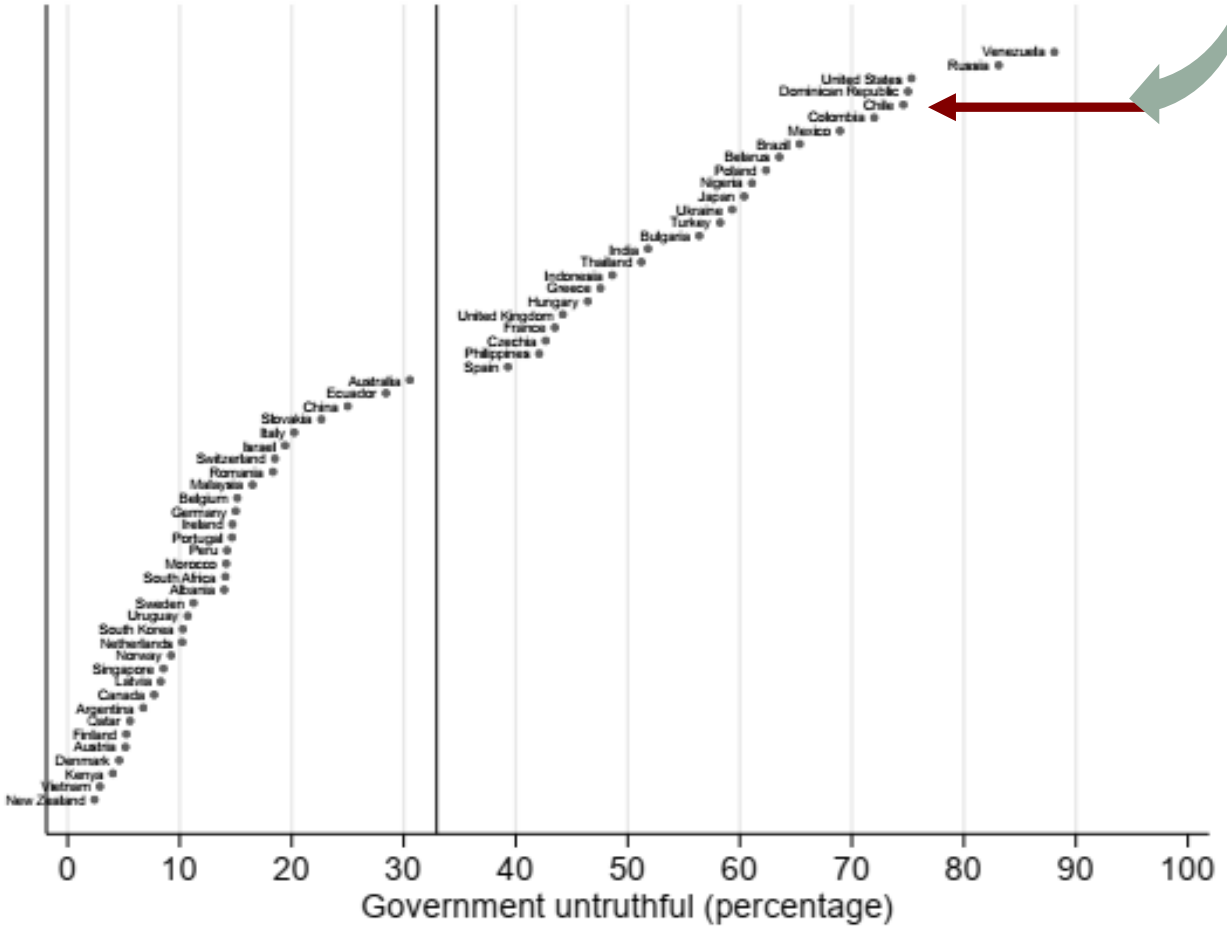
- Impact of communication on behavior



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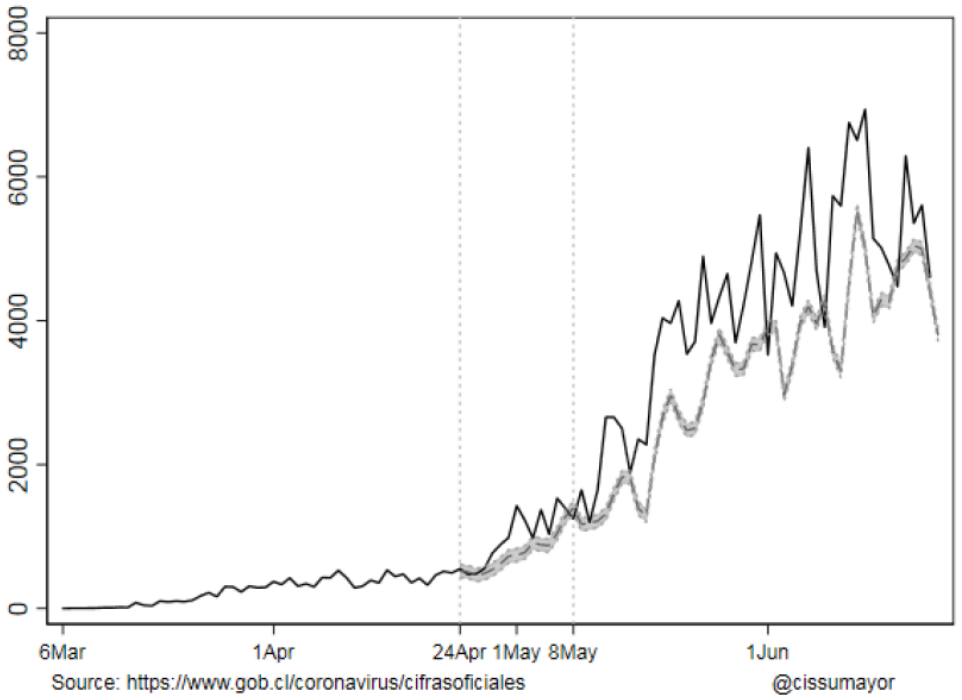
- Impact of "new normality" announcement in April

Figure 4: Explaining "the new normal"



Measures taken in the 4 recommended aspects

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2) Economic support

3) Pandemic management

4) Health related

- Initial low capacities.

Country	Doctors (per 1,000 hb)	Nurses (per 1,000 hb)	Beds (per 1,000 hb)	Intensive (100,000 p)	Ventilators (100,000 p)
Chile	2.59	2.96	2.11	7.3	6.8
OCDE	3.4	8.8***	4.7	12	NA
Brazil	2.1	1.5	2.3 (2012)	20.6	29.6
Colombia	2.1	1.3**	1.7	10.5	10.8
Ecuador	2.03 (2016)	2.5**	1.3 (2013)	6.9	10.5
Peru	1.3 (2016)	2.4**	1.6 (2012)	2.9	0.9
Argentina	3.9	2.5**	5 (2014)	18.7	19.3
Uruguay	5.07	1.9**	2.8 (2014)	19.9	NA

Source: (OCDE Health Data; OCDE, 2020a; Global Health Observatory Data Repository (Banco Mundial), 2020)

Measures taken in the 4 recommended aspects

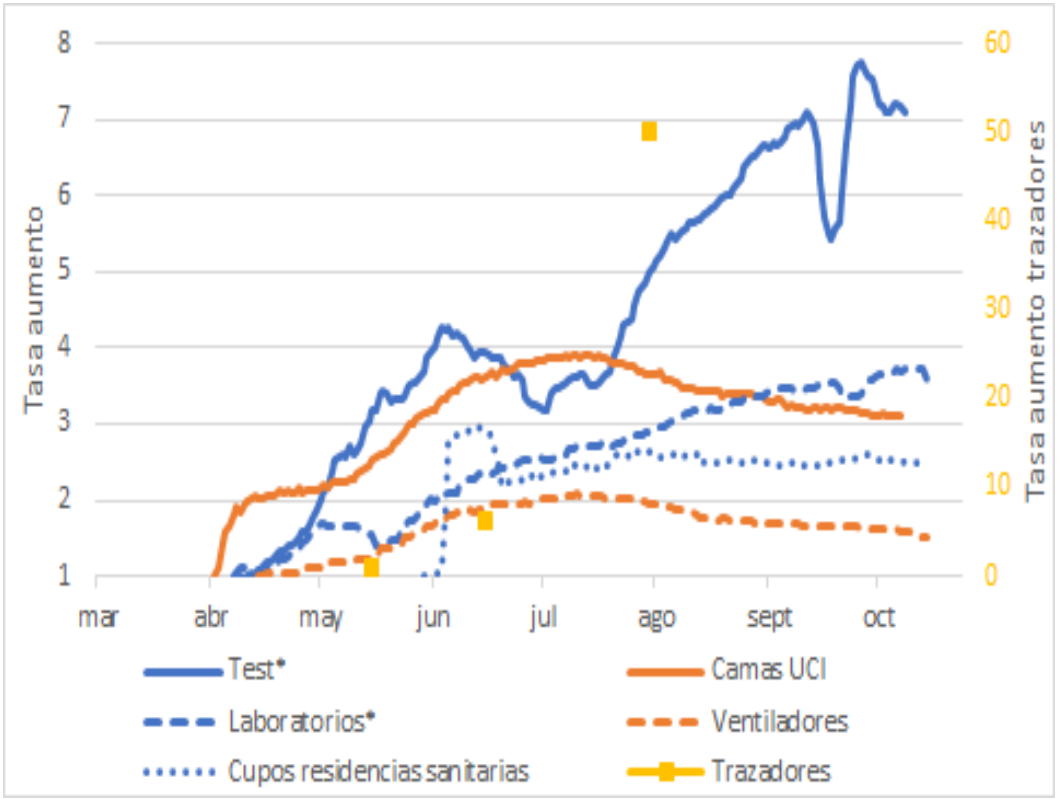
1) Mitigation and containment

2) Economic support

3) Pandemic management

4) Health related

- Increase in testing, labs., beds, ventilators, tracers.



Measures taken in the 4 recommended aspects

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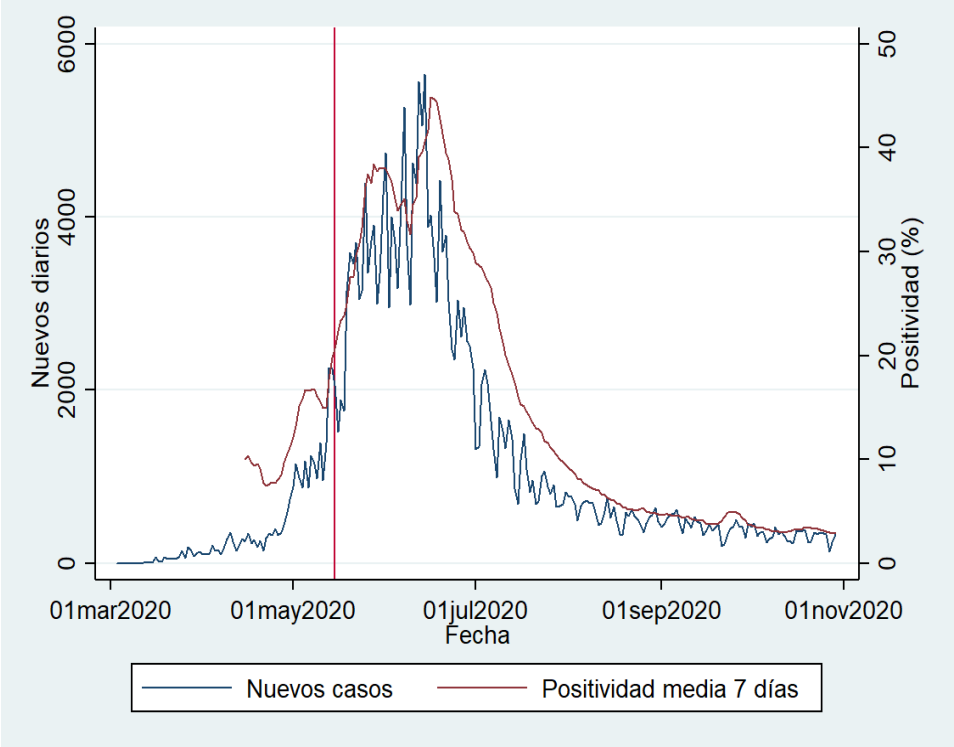
- Sustained decrease in cases coincide with implementation and strengthen of TTI measures.



3. Lessons and final comments

Lessons from a sanitary point of view

- To address a pandemic like this one the focus needs to be integral, considering sanitary, economic and management aspects.
- Early and enough economic support:
  - Specially for the informal sector and the most vulnerable to help compliance.
- Health response:
  - Testing, tracking and isolation was late. Incorporation of primary care and private providers in tracking.
  - Better use of sanitary residences (for people unable to self isolate).
  - Innovation in the delivery of healthcare (telemendicine, mobile clinics, home deliver of medicines).
- Management:
  - The pandemic answer needs to be coordinated.
  - Communication must be improved. Integrating and involving all stakeholders and health related “actors”.
- Mitigation and containment:
  - Keep active surveillance (testing riskier groups and places, pool testing).
  - Massive routine testing to address second wave.

Future challenges

- Chile needs a plan to face emergencies like this one.
- Health resources must be incremented (beds, healthcare workers).
- Chile needs to address risk factors (obesity, smoking).
- Information must be integrated and online.
- Innovation in the delivery of healthcare (telemedicine, mobile clinics, home deliver of medicines).

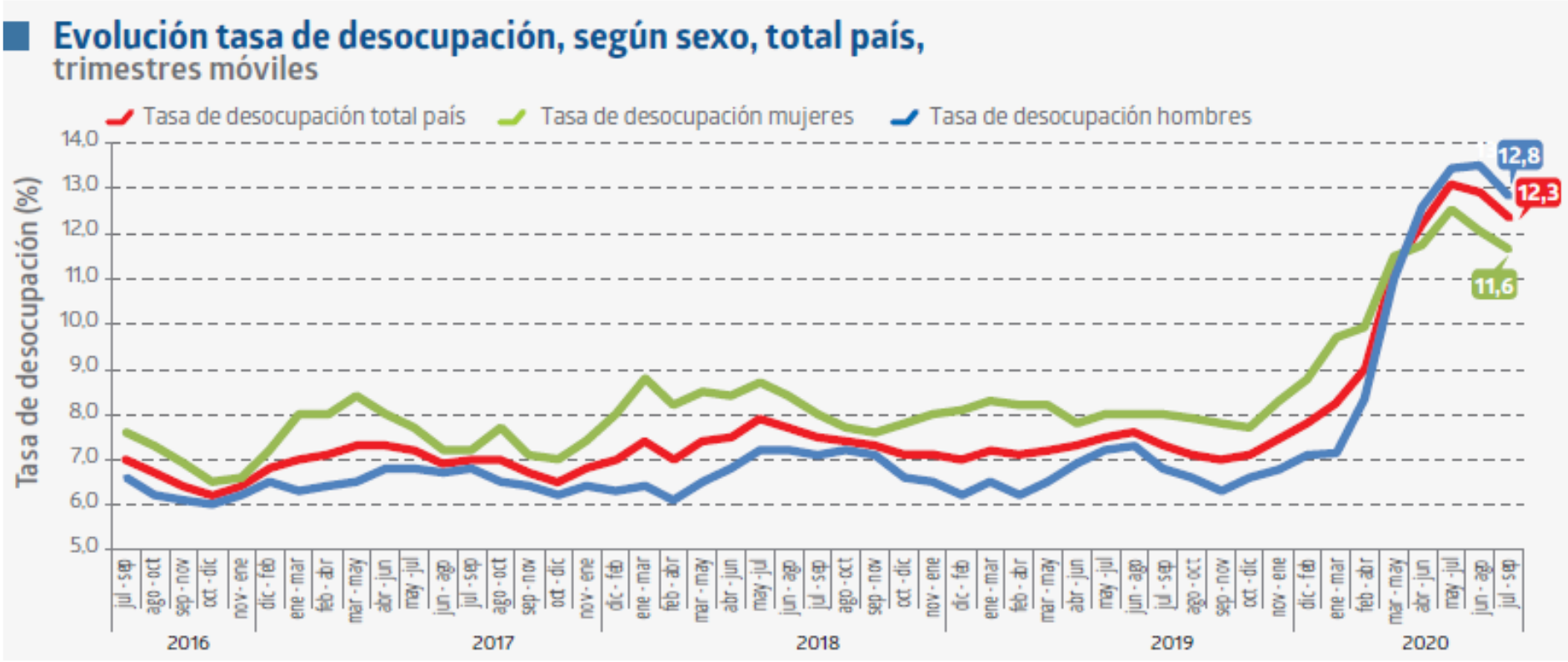
1. Risk factors

Indicador (año 2016 o más cercano)	Chile	OCDE
Esperanza de vida al nacer (años)	80,2	80,6
Proporción de adultos mayores (65+)	10,9%	17,4%
Consumo de alcohol (litros per cápita, mayores de 15 años)	7,9	8,9
Consumo de tabaco diario (población mayor de 15 años)	24,5%	18,0%
Prevalencia estimada de la diabetes (adultos de entre 20 y 79 años)	8,6%	6,4%
Población con sobrepeso y obesidad (mayores de 15 años)	74,2%	58,2%
Sobrepeso (incluye obesidad) en niños de 5-9 años	38,3%	31,4%

Source: OECD.

Economic and social impact

Unemployment



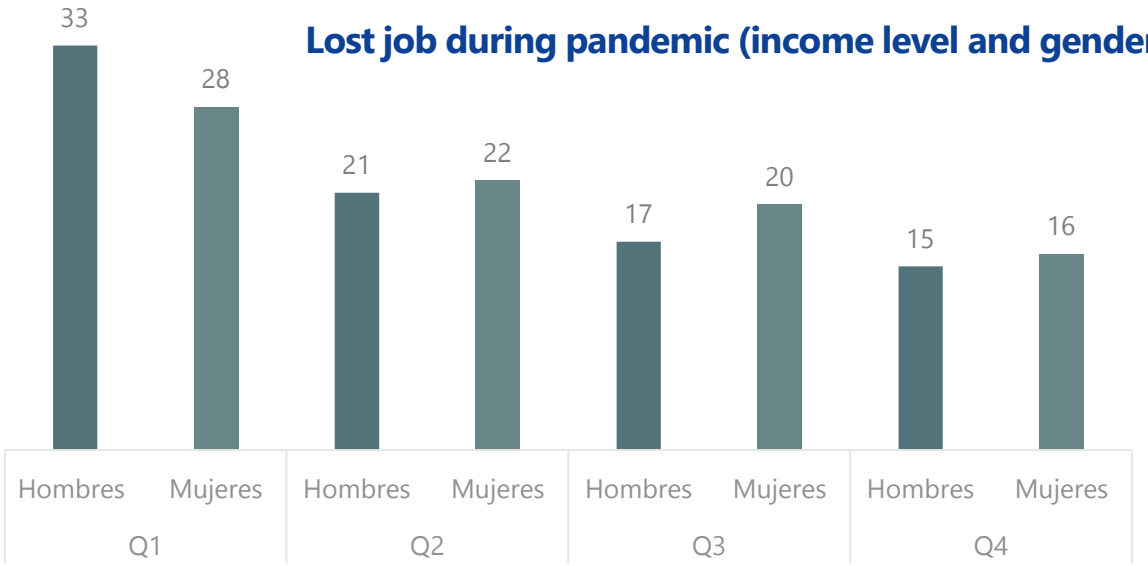
Source: INE (2020).

Economic and social impact

Employment and income losses

	Total	Alto	Medio	Bajo
Perdió todo o casi todo, o más de la mitad del ingreso	33	19	28	41

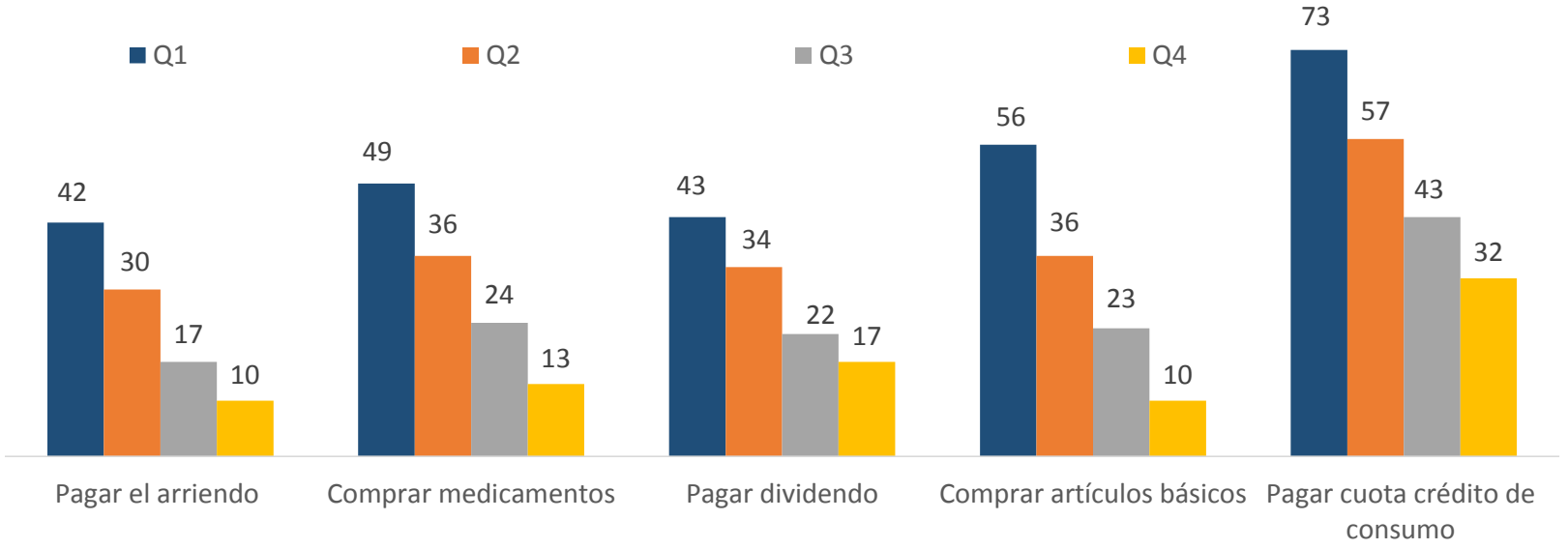
Source: Bicentenario 2020 julio



VIDA en Pandemia

Economic and social impact

Difficultes to pay bills, mental health



Source : FEN (Vida en Pandemia)

	Total			18-34 años	35-64 años	65+ años	Alto	Medio	Bajo
% de la población con estrés psicológico serio	15	9	21	12	17	18	2	15	19

Source: Bicentenario 2020 julio

Public health impact of Covid-19 Chile

Carolina Velasco

November 2020

Proposals on the table

Official proposals

- 2010 Presidential committees (2).
- 2011 Bill (SHI for Isapres).
- 2014 Presidential committee (Single payer and SHI).
- 2019 2 bills for Isapres and 2 for Fonasa)
- 2020 (today) Bill for Fonasa

Academic / research center´s proposals

- Saving accounts (2008).
- Health-status insurances (2010).
- SHI (2014-2017).
- NHS (2018 and 2019).
- Modernization of Fonasa (2019-2020)

Isapres´ bills (2019-2)

- 2019:
  - Universal health plan (UHP): content areas (current + ?), copayments, stop loss, open enrolment but less coverage for preexistences for 18 months, preferred provider network (80% out of network), indefinite, same premium for 3 age groups.
  - Risk compensation scheme: age, sex and in a second stage health status. Funded by a fix amount per person.
  - Panel of experts calculates referential premium indexes.
  - Advisory Council for risk adjustment mechanism.

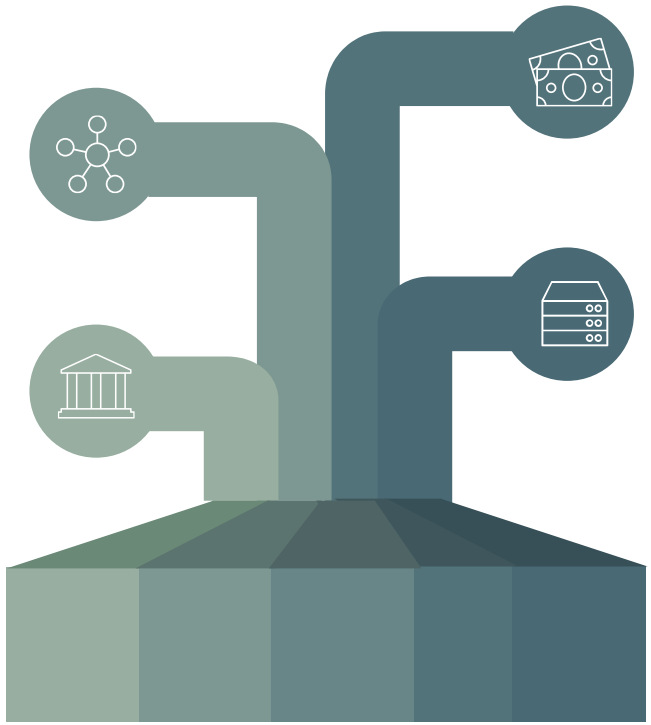
Fonasa´s bill (2020)

- Fonasa:
  - New attributions (e.g. provider payment, out of network purchases, requirements for and supervision of providers)
  - New governance (board integrated by state officers - weak)
  - New definition: public insurer that guarantees universal health plan deliver.
  - Drugs insurance: generic bioequivalent (not covered by UHP).
- Universal health plan: Determined by Ministry and Fonasa, with standards for waiting times to be guaranteed.
- Superintendent of Health supervises Fonasa.

Reforms proposed

Maintains 2 components (2 pools).

Maintains incentives for risk selection and self selection (community rating).



Maintains copayments.

No real open enrolment and access to all.

Next steps…

- Integration of both components:
  - One pool (contributions and taxes).
  - One risk compensation scheme to all insurers.
  - New regulatory framework that allows competition and choice
    - Same playing field for all insurers (Isapres and Fonasa) and providers .
    - Open enrolment.
    - Pricing rules?
  - Same (and bigger) standardized package (no copayments but deductibles).
  - Information.

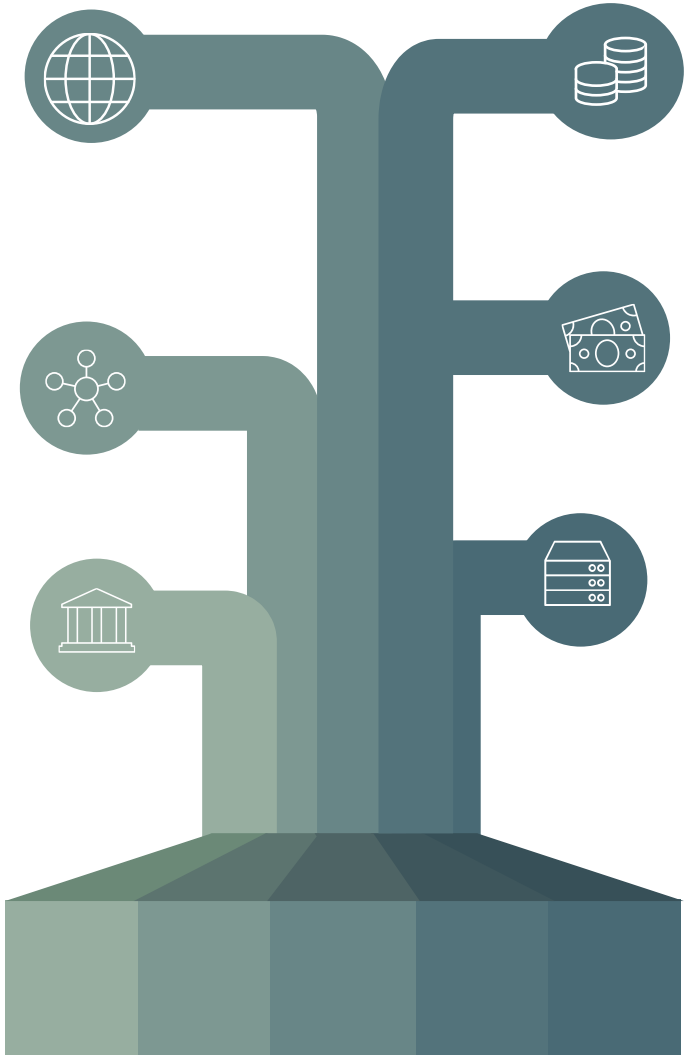
- Alternative: eliminate isapres and move to a single payer scheme.

Fonasa: problems of (state) single payers schemes

Vulnerable to political changes and captured by interest groups (providers).

Inefficiencies:
- Bureaucracy.
- Monopoly.
- Lack of powers and incompatibles ones.

Low levels of transparency:
- Results.
- Resources.
- Processes.



Increasing costs:
- Rising hospital debts.
- Rising State contribution.
- Waiting lists / times.

Under statement of income.

Less access for vulnerable groups:
- Old age.
- Migrants.
- Low income.

Isapres: problems of health insurance markets + deficient regulation

Risk selection and captivity.

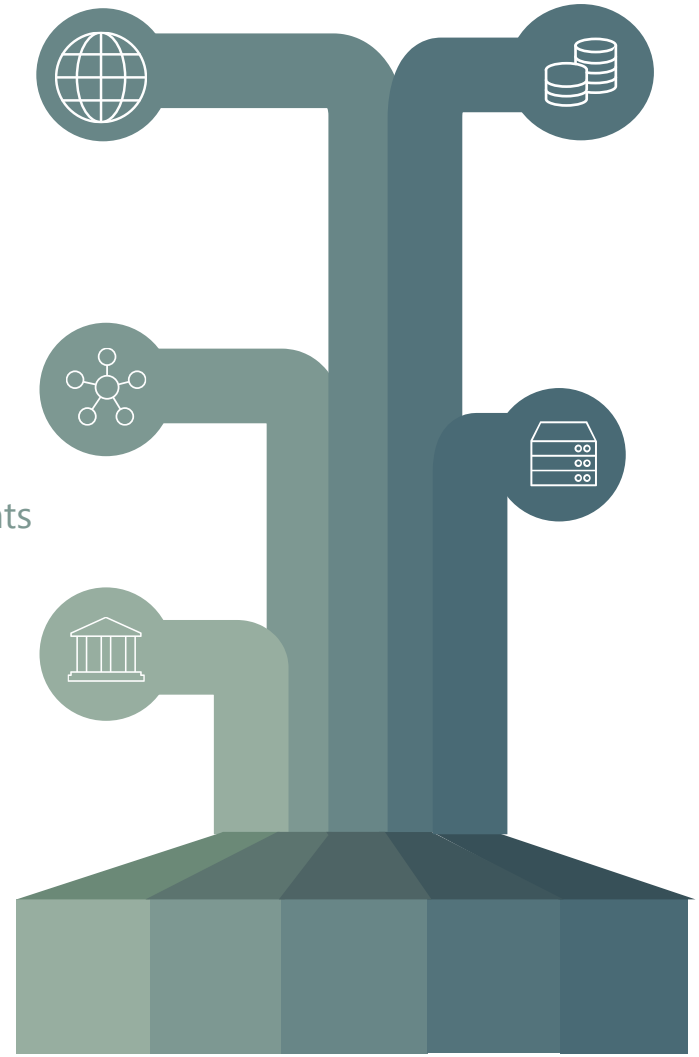
- Adverse selection.
- (Bad) regulation: premiums, no open enrollment.

Low transparency and no price competition.

- Product (health plan) differentiation.
- Uncertainty on final payments

Inefficiencies.

- Duplication of coverage (i.e. GES and catastrophic).
- Deficient regulation (i.e. permanent contracts).



Low levels of cost containment.

- Moral hazard.
- Voluntary insurances.
- Fee for service.
- Fonasa as a last resort insurer.

High prices / premiums and exclusion:

- High premiums for high risks.
- Low access for low income.
- No state subsidies.