Access to Innovative Medicines in Latin America: What is the Solution?
ISPOR 4th Latin America Conference
14 September 2013

Cancer is an increasing issue in Latin America

- The number of cases is estimated to increase by 35% in South America and 42% in Central America and Mexico\(^1\)
- Overall incidence estimated at 1.6 million by 2030\(^2\)
- Mortality rates in the region are increased compared to the US and Europe\(^1\)
  - 0.59 mortality to incidence ratio vs. 0.43 for EU and 0.35 for US

---

2. PAHO. Cancer in the Region of the Americas.
Access to cancer care remains a concern, particularly access to new oncology medications

- Cases are frequently diagnosed at later stages of disease, contributing to increased mortality

- Inequalities in distribution of cancer centers in urban settings vs. rural settings

- Cost of cancer care estimated at 0.12% of GNI per person in LatAm vs. 0.51% in the UK and 1.02% in the US.¹

- According to analysis by Goss et al., use of cancer drugs approved in the US since 2004 would increase costs of cancer drugs in Latin America by 15% each year¹

¹. Lancet Oncology 2013; 14(5): 391-486

---

Agenda

<table>
<thead>
<tr>
<th>Topic</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differential access to oncology products in private and public systems in Brazil</td>
<td>Otávio Clark, MD, Director, Evidencias Consultoria, Campinas, Brazil</td>
</tr>
<tr>
<td>Mexico and the inclusion of products in the Basic Formulary process and access to oncology medications</td>
<td>Q. F. León Zapata S., General Director, Guia Mark, S.A. de C.V.</td>
</tr>
<tr>
<td>Access to innovative medicines in Chile</td>
<td>Thomas Leisewitz, PhD, Professor, Pontificia Universidad Católica de Chile</td>
</tr>
<tr>
<td>Discussion: What is the solution?</td>
<td>Michelle Sotak, Associate Director, Optum Life Sciences</td>
</tr>
</tbody>
</table>
ACCESS TO INNOVATIVE MEDICINES IN LATIN AMERICA: WHAT IS THE SOLUTION?

otavio.clark@evidencias.com.br
@otavioclark
Otávio Clark
The solution is pretty obvious

As money is limited...

CORRELATION BETWEEN EXPENDITURE ON HEALTH AND OUTCOMES 2003

Life Expectancy (number of years)

0 10 20 30 40 50 60

Total Expenditure on Health (THE) per capita, US$
Solution is TRANSPARENCY

Brazilian HTA agency
CONITEC: submission process

- Very clear PROCESS for submission
  - "NICE like"
  - Requirements:
    - Systematic review
    - Pharmacoeconomic analysis
    - Submission in a specific form
Brazilian HTA agency

**CONITEC: analyses process**

- Very OBSCURE criteria
- We do not know which criteria are used to approve or deny a requirement for a drug or technology incorporation

- Decisions VERY contradictory
  - “...results not important clinically”
  - “...SUS already offers a broad range of options to treat...”
  - “...data not robust enough..”

- ALL of these analysis are made for drugs already approved for use in the market by ANVISA
  - Some have received the status of “innovative, with substantial gains” from CMED (price regulator)

- Many of the technologies considered “not good enough” are largely accepted as effective
O plenário da CONITEC discutiu sobre a incerteza no cenário atual das evidências científicas de eficácia e segurança do geftinibe, pois tanto ensaios clínicos quanto revisões sistemáticas não mostram resultados significativos de magnitude clínica importante. Além disso, alguns dos artigos científicos considerados divergiram em seus resultados e conclusões. De maneira geral, ponderou-se sobre não haver diferença clinicamente significativa entre acrescentar ou não o geftinibe ao esquema terapêutico com quimioterapia dupla padrão, no que se refere à sobrevida geral.

Erlotinibe para câncer de pulmão de células não pequenas em primeira linha

O plenário da CONITEC discutiu sobre a incerteza no cenário atual das evidências científicas de eficácia e segurança do erlotinibe, pois tanto ensaios clínicos quanto revisões sistemáticas não mostram resultados significativos de magnitude clínica importante. Além disso, alguns dos artigos científicos considerados divergiram em seus resultados e conclusões. De maneira geral, ponderou-se sobre não haver diferença clinicamente significativa entre acrescentar ou não o erlotinibe ao esquema terapêutico com quimioterapia dupla padrão, no que se refere à sobrevida geral.
10/17/2013

NICE

TA258  Erlotinib for the first-line treatment of locally advanced or metastatic EGFR-TK mutation-positive non-small-cell lung cancer

View the summary and implementation tools

1 Guidance

1.1 Erlotinib is recommended as an option for the first-line treatment of people with locally advanced or metastatic non-small-cell lung cancer (NSCLC) if:

- they test positive for the epidermal growth factor receptor tyrosine kinase (EGFR-TK) mutation and

NICE

TA192  Gefitinib for the first-line treatment of locally advanced or metastatic non-small-cell lung cancer

View the summary and implementation tools

1 Guidance

1.1 Gefitinib is recommended as an option for the first-line treatment of people with locally advanced or metastatic non-small-cell lung cancer (NSCLC) if:

- they test positive for the epidermal growth factor receptor tyrosine kinase (EGFR-TK) mutation and
One month before the SAME commission had issued a recommendation AGAINST this, saying rituximab IS NOT EFFECTIVE in this indication (there was NO new publication in the period)

CONITEC

- Most denials are based NOT on economical issues
  - "clinical data not good enough"
- Is it an excuse to hide the real problem?
CONITEC

- “Dossiers submitted by industry are of low quality”
  - Usually, the CLINICAL information is global,
  - The clinical information is publicly available
  - After all, is CONITEC evaluating a DOSSIER or a TECHNOLOGY?
Transparency

- Budget
  - How much can our society expend in health?
- Efficacy
  - How much is a benefit of "substantial magnitude"
- What are the priorities?
  - Does our society WANT innovative treatments or should we treat poverty first?
- Which are the thresholds for VALUE?
  - Imatinib?
  - 3X GDP/capita?
  - US$ 50,000/QALY

Decision

- We, the people…
- NEED AN AGENDA!
Obrigado!

@otavioclark
Otávio clark
@otavioclark
19 8149 5375

ACCESS TO INNOVATIVE MEDICINES IN LATIN AMERICA – WHAT IS THE SOLUTION?
ACCESS TO MEDICATIONS: A GLOBAL PROBLEM

Leon Zapata
Ximena Burbano-Levy
Access debate

- Public-health policy debates have largely focused on patents on medicines as the main barrier to patients’ access to treatment. Advocates of this view blame patents for the high prices of essential medicines, putting them out of reach of many people who need them.¹
- Less focus on availability of drugs for noncommunicable diseases, although this group of illnesses including cardiovascular disease, cancer, chronic lung diseases and diabetes represents the leading causes of death worldwide.², ³

Medicines Policies ⁴

- Improving access of patients in developing countries to currently available drug therapies.
- Improving the prospects for the development of new medicines for diseases endemic in developing countries.
- Developing the industrial base in developing countries.
The World Trade Organization (WTO) is the international organization dealing with the rules of trade between nations.

- 148 countries
- 18 agreements
- TRIPS is the agreement with a higher impact on the pharmaceutical sector and access to medicines.

The Agreement on Trade Related Aspects of Intellectual Property Rights

- Minimum standards for many forms of intellectual property (IP) regulation including patents.
- Doha declaration: WTO statement that clarifies the scope of TRIPS.
  - The TRIPS Agreement does not and should not prevent Members from taking measures to protect public health, (i.e.: HIV. Tuberculosis, malaria)
TRIPS AGREEMENT

- Includes provisions that allow a degree of flexibility for countries to accommodate their own patent and intellectual property systems and developmental needs.
- Allows the use of compulsory licenses (CL): 6
  - Enables a competent government authority to license the use of a patented invention to a third party or government agency without the consent of the patent-holder.

TRIPS AGREEMENT

- Article 31 conditions for CL: 6
  - Case-by-case determination of compulsory license applications,
  - Need to demonstrate prior (unsuccessful) negotiations with the patent owner for a voluntary license
  - Payment of adequate remuneration to the patent holder.
Private sector conditions

- If companies are to invest in new patented medicines for which the market in developing countries would not currently justify the investment, then an effective alternative funding mechanism is needed.
- Even if there were an effective funding mechanism, widespread copying or compulsory licensing due to lack of IPP would substantially reduce the incentive to invest in new medicines.
- If significantly lower prices are to be charged for patented medicines in developing countries than elsewhere then the markets must be effectively segmented.

Innovative medications in Mexico

- Mexico is the 12th largest pharmaceutical market in the world - the second largest in Latin America after Brazil.
- There are 2.5 billion unit sales of medication annually in Mexico.
- Between 1999 and 2006, the industry grew more than 200%, and by a further 14% between 2007 and 2009.
- Currently accounts for 37% of all pharmaceutical sales in Latin America.
Innovative medications in Mexico

- 12 FTAs with 33 countries, including Japan, the European Union, the United States (US), Canada and Israel.
- As a member of the North American Free Trade Agreement (NAFTA), Mexico has access to the most well-established and emerging pharmaceutical markets in North and Latin America.

The manufacturing operations in a free trade zone, “the maquiladora programme”, resulted in exports from Mexico to the US rising by 135% between 1994 and 1999, and also allowed US companies to establish manufacturing plants in Mexico.
India has invested millions of pounds in Mexico.

Ranbaxy Laboratories and Wockhardt Limited lead the expansion of generic drugs in Mexico.

India has the largest portion of generic drug manufacturing in Mexico along with the export of Ayurvedic medicines.

Mexican Government's approval of the production of innovative drugs by pharmaceutical companies, as well as increasing patient access to anti-cancer drugs.

In 2011, Mexico's Ministry of Health and the Mexican Association of Industrial and Pharmaceutical Research introduce 31 types of innovative drugs for cancer, hepatitis C and rare genetic syndromes, among others.

In February 2012, the Mexican Federal Commission for Protection against Health Risks (COFEPRIS) agreed to the introduction of three active drug substances that are present in medicines used in treating cancer, osteoporosis and degenerative disease.
In 1991, the Mexican Government established laws protecting intellectual property rights, giving pharmaceutical companies an incentive to produce high-quality and affordable medications in Mexico.

The protections also gave well-established companies exclusive rights to manufacture products in and out of Mexico.

**Potential Solutions**

- **Policy objectives:** Notably, policies which might improve affordable access to patented medicines in the short term through copying or licensing would discourage future investment in R&D for new medicines. ³

- **A high quality, sustained strategy** is required to improve healthcare infrastructure; and to increase R&D expenditure and convert it into effective new products. ³
Innovative medications in Mexico into public sector

- Cuadro Básico y Catálogo de Insumos del Sector Salud (CBCISS) (Basic formulary) tool for inclusion of health technologies.
- Consejo de Salubridad General: authority based on:
  - Scientific evidency
  - Standards
  - Transparency

Population needs


Innovative medications in Mexico

- 2008: Guidelines for health economic evaluations.
- 2011: Devices
- No consensus on WTP
- Considered for approval if RCEI ≤ 1 GPD per capita
- Reviewers Committee’ freedom of concepts.

Sample of last year’s CSG decisions

- **Approvals (May 2012-July 2013):**
  - Panitumumab,
  - Pazopanib,
  - Everolimus,
  - Fluvestrant, (in process)

- **Modifications:**
  - Capecitabine
  - Lapatinib
  - Erlotinib

- **Rejections or need for re-submissions:**
  - April 2013
    - Bevacizumab
    - Vemurafenib
    - Ipilimumab
    - Denosumab
    - Cabazitaxel
    - Gefitinib
  - November 2012
    - Alemtuzumab
  - October 2012
    - Crizotinib
    - Temsirolimus
    - Degarelix

After first approval...

- A new submission is requested at every Institution:
  - IMSS
  - ISSSTE
  - Pemex
  - others
Potential Solutions

- To develop an effective healthcare delivery system, comprising trained nurses, doctors and well equipped clinics and hospitals.
- The IP system is the fundamental arrangement through which private sector R&D into new and improved medicines is financed and incentives are provided for new research.
- It depends on a) the prevention of copying - i.e. the effective protection of the intellectual property which results from successful research, and b) on the medicines that are successfully patented finding a market.

Potential Solutions

- Currently, despite the lack in many countries of effective national IPP, because there is no international patent exhaustion, companies are generally willing to make patented products available at much lower prices in developing countries than in developed markets; this is economically efficient.
- At government institutions, less barriers, clear rules and transparency in health technology assessments, is advisable.


Thanks
Access to Innovative Medicines in Chile

Thomas Leisewitz
Pontificia Universidad Católica de Chile
HEORT Chile
14 September 2013
Health insurance | Mandatory insurance

- All dependent workers, and from 2018 almost all independent workers, must choose one private (ISAPRE) or public insurance (FONASA, National Health Fund).
- Financing: mandatory contribution for workers (7% wages); + fiscal subsidy (equivalent to 55% of the budget) for the public insurer (FONASA).
- Almost 17 million insured people: 13.6 million in FONASA, 3.1 million in 7 open private insurers (ISAPRE).
- Mandatory insurance is compound by two elements:
  - The AUGE Plan
  - Complementary Plan

Mandatory insurance | AUGE Plan

- Enacted in 2005, is also known as GES (Explicit Guarantees in Health).
- From 2013, considers 80 health problems, targeting 55% of the burden of disease
- The plan explicitly defines how patients should be addressed, in terms of timely access to care, maximal copayments, and quality standard, for diagnosis, medical and surgical treatment, and follow-up
- Based on evidence-based practice guidelines, they may consider: consultations, inpatient treatment, surgeries, lab exams and images, procedures, ambulatory drugs, etc.
Mandatory insurance | Complementary Plan

- Covers a set of non-prioritized health services.

- **FONASA:**
  - Institutional modality (MAI): within the public network of health providers, beneficiaries have access to wide array of services, though limited by waiting lists
  - Free-choice modality (MLE): they may buy services from private providers, facing significant copayments (over 50%). There is a list of covered services (aka FONASA MLE).

- **ISAPRE:**
  - Private insurers must sell a plan covering at least FONASA MLE
  - These plans have an average real coverage of 80% of inpatient care and 70% for ambulatory services.
  - Beneficiaries can increase the paid premium over 7% of their income, in order to buy better coverage for the listed services.

Mandatory insurance | Benefits definition

1. **AUGE Plan:**
   - The Ministry of Health every three years may update the set of diseases by law, after hearing the opinion of an Advisory Council, within the financial constraint set by the Ministry of Finance.
   - The prioritization process considers cost-effectiveness analyses
   - The final set of guaranties are enforced by law as a Presidential decree

2. **Complementary Plan:**
   - Annually, FONASA will define the benefit package for its insured population, after negotiating it with the Ministry of Finance.
   - The definition rarely involves cost-effectiveness analyses; it usually relies on evidence of effectiveness, financial considerations and social pressure.
   - After that, ISAPREs will have to match the coverage for their affiliates, but since they usually have better coverage before, this is not a big problem.
   - ISAPREs themselves also do not decide to cover services through formal HTA process.
**Health insurance | Voluntary insurance**

Voluntary coverage comes from two sides:

1. **ISAPRE:**
   - Supplementary health benefits: Affiliates may pay over the mandated 7% of wages, to buy additional coverage (sometimes they consider drug reimbursement).
   - Additional Coverage for Catastrophic Diseases (CAEC): a stop-loss ceiling, above which beneficiaries may receive inpatient care without co-payment (within a preferred provider network). This benefit also covers some ambulatory drugs (as anti-neoplastic drugs).

2. **General Insurance Companies:**
   - In 2012, 3.7 million people have a supplementary insurance policy for prescription drug reimbursement

---

**Health providers | Two worlds**

Two sub-systems, working in parallel.
Health providers & type of insurance

Although not closed, there is some restriction for private insured to use public network. FONASA patients receive little or no coverage if they use private providers.

Drug Coverage | Simplified scheme (mandatory insurance)

- Kind of drug covered and (level of reimbursement)
**Drug Coverage | Additional coverage**

- Kind of drug covered and (level of reimbursement)

**Access to Chilean market | Drug authorization process**

- Main actors:
  - The Institute of Public Health (ISP) is in charge of regulating through the authorization of imports, production and commercialization of drugs. The National Agency for Medicines (ANAMED) is a Department of the Public Health Institute of Chile (ISP).
  - ANAMED is in charge of drug registration in Chile as set out in the regulation of the National System for Pharmaceutical Control, called Decreto Supremo N°3/2010. All pharmaceutical products marketed in the country must have a current health register or market authorization.

- Drug approval in Chile is done for all the regions in the country (national level). There are no requirements at regional or hospital level. It is an unexpensive, quick process.

- Health economic data could be classified as helpful, but it is not defined which HE data should be submitted.

- There is not price regulation for prescription drugs or medical care services in the private health providers, with the exception of the AUGE coverage which only sets the maximum copayment.
Pharmaceutical market | Health Technology Assessments

• National health authorities are becoming more conscious about the economic data to take decisions.
  – Methodological Guidelines for HE analyses published recently (March 2013)

• However, today:
  – FONASA: If they want to cover a new diagnostic intervention or treatment, they usually focus on budget impact.
  – ISAPRES: Private insurers are not worried about health economic information, they seldom ask for it.
  – AUGE Plan:
    • It is required by law that before any change, there should formally analyze the impact on the public health budget and the health benefit on the population.
    • AUGE treatments: Only 59% of the prioritized interventions had enough evidence of their cost effectiveness.
    • HE data could improve the chances for being prioritized, though it is not considered essential for the decision process.

Non-reimbursed drugs | Decision making in public hospitals

• Patients in public hospitals still may receive drugs not considered in the AUGE Plan, or in official clinical guidelines. Each hospital autonomously decide the allowed set of drugs, with great variance in the followed methodology, and total expenditure.

• Key decision makers:
  • For the drug to be available in the hospital => ISP (ANAMED), FONASA, CENABAST or Hospital administration
  • For the patients to be informed that the drug is a treatment option => Ministry of Health (official guidelines) or medical doctors in the public sector.

• Factors influencing the decision:
  • For the drug to be available in the hospital => safety and effectiveness data
  • For the patients to be informed that the drug is a treatment option? => physicians knowledge and preference
Ambulatory care | Non-reimbursed drugs

- The covered set of ambulatory drugs is more restricted.
- Patients may have access through the market paying out-of-pocket to receive medicines not covered under AUGE or Complementary Plan.
- For this purpose, they might use supplementary coverage if they have contracted one.
- In particular, for Cancer treatments and some immunosuppresser drugs, ISAPRE affiliates may be eligible for the Additional Coverage for Catastrophic Diseases (CAEC). The coverage could be as high as 100%.

Summary

- Access to pharmaceuticals in Chile is determined by two variables: (i) health authority definition of minimum drug provision; and (ii) private consumption under free market conditions.
- Registration of drugs is an easy, cheap, and rather quick process. Innovative medicines do not receive a special treatment.
- A specific set of diagnostic and treatment interventions for 80 prioritized diseases (the "AUGE Plan", responsible for 55% of the country burden of disease) receive explicit guarantees according to clinical guidelines, including drug coverage for private and public insured patients.
- Besides AUGE Plan, access to ambulatory drugs is granted for public insured population (FONASA) through the provision of a limited set of prescription drugs available at public primary health centers, and in smaller proportion at specialty clinics. Patients do not pay for them. Public hospitals autonomously decide the set of drugs they will use, without a uniform, formal HTA process.
- Under private insurance, in addition to AUGE Plan, drug coverage is considered for inpatient care and for extraordinary outpatient cases under catastrophic coverage (called CAEC).
Epidemiological profile | Cardiovascular Diseases & Cancer

- Major cause of death, Chile, 1970 versus 2004

Oncology Care in Chile | Overview

- In the public sector, patients go to primary care and then they must be derived to an oncologist. In the private sector, there is no formal primary care, and patient self-referral is widely accepted.

- For children under 15 years, the AUGE covers almost all kind of cancers and offers warranties in terms of waiting time to be attended, and clinical guidelines.

- For adults, some cancers are in the AUGE (cervical, breast, testicular, prostate, gallbladder and gastric cancers, lymphomas and leukemia).

- There are specialty hospitals (Instituto del Cáncer), department within hospitals and free-standing clinic (Fundación Arturo López Pérez).

- Oncologists are compensated by a salary in the public sector and fee for service in the private.
Oncology Care in Chile | Budget Holders

• The primary payer for oncology care is mainly FONASA. As most cancer are in the AUGE, this program guarantee maximum copayments of 20% for the richer members. In the private sector, ISAPREs cover in average terms around 72% of hospital costs and 58% of outpatient services, not considering drugs.

• The primary payer for new patented biologic/pharmaceutical products for oncology care are patients. Generally new drugs are firstly used in the private sector and they may be reimbursed by ISAPREs under the additional catastrophic coverage if the patient choose to (although may be also covered by supplementary insurance).

• The budget for oncology drugs is set at the payer level FONASA (national level) in negotiation with the Ministry of Finance.

Oncology Care in Chile | Decision Making

• Treatment decision to use a new patented biologic/pharmaceutical product is made by physicians, who press insurers to cover it.

• Oncologists and also patients (that will pay for it until coverage is possible) are the key decision makers.

• Safety and effectiveness are the key evidence required to consider or recommend use of new biologic/pharmaceutical products. Besides clinical data, the approval of agencies like FDA or EMA is not required.

• Cost effectiveness analyses would be helpful in the treatment decision making process but not essential.
Improving access | Four ways

- Volume-price agreements
- Cap on budget impact
- Coverage with evidence development
- Risk-sharing agreements

Source: OECD, 2010.

Improving access | Volume-price agreements

- Public and private insurance have developed mechanisms.
- For innovative drugs, given the size of Chilean market, achieving the target volume could be a barrier.

Source: OECD, 2010.
Improving access | **Cap on budget impact**

**Volume-price agreements**

**Cap on budget impact**

**Coverage with evidence development**

**Risk-sharing agreements**

• "Dose capping": payer pays up to a defined number of treatment cycles. Then the pharma company must pay the rest.

• Interesting mechanism for diseases with small incidence.

Source: OECD, 2010.

---

Improving access | **Coverage with evidence development**

**Volume-price agreements**

**Cap on budget impact**

**Coverage with evidence development**

**Risk-sharing agreements**

• Done very limitedly, as pilot programs.

• Considering there is no reimbursement for ambulatory free-choice, FONASA could set up agreements with drug manufacturers.

• It would require ISP authorization anyway.

Source: OECD, 2010.
Improving access | Risk-sharing agreements

- Volume-price agreements
- Cap on budget impact
- Coverage with evidence development
- Risk-sharing agreements

Source: OECD, 2010.

The way forward | Some recommendations

- Rationalize access to new drugs, introducing formal HTA process, at least for public affiliates. That way could at the same time improve the value-for-money achieved, and improve access to better treatments.

- FONASA should avoid decentralized buying definition at public hospitals, but could introduce new mechanisms for covering innovative drugs. I would suggest at least two: Coverage with evidence development, and Risk-sharing agreements.

- Private insurance may be spending too much in innovative medicines. They should be beneficiated also with formal HTA introduction.
Thank You

Additional information
Acronyms

- **AUGE** (aka **GES**): Explicit Health Guaranties
- **CAEC**: Additional Coverage for Catastrophic Diseases
- **CENABAST**: Pharmaceutical Supply Clearinghouse for the public health providers net
- **FONASA**: Fondo Nacional de Salud, Health National Fund, health public insurer
- **ISAPRE**: Institución de Salud Previsional, Previsional Health Institution, health private insurer
- **ISP**: The Institute of Public Health
- **MINSAL**: Ministry of Health

General Background of the Chilean Healthcare System

- **POPULATION:**
  - 17 million inhabitants, 12.7% are over 60 years.
  - 40% of the population lives in the Metropolitan Region of Santiago (estimate June 2010). There are 15 administrative regions.

- **GDP (WB, 2010):**

- **HEALTH EXPENDITURE (WB, 2010):**
  - 8.0% of GDP. Per-capita spending on health US$ 947.

- **LIFE EXPECTANCY AT BIRTH (WB, 2010):**
  - 79 years (76 years for men 82 years for women).

- **INFANT MORTALITY RATE (WB, 2010):**
  - 7.0 infants/ 1,000 live births.

Source: Health Superintendence
Public and Private Health Spending as a Percentage of GDP (Latin America and the Caribbean, 2010)


Public and Private Health Spending as a Percentage of GDP (OECD countries, 2010)

Source: World Databank, WB.
Life Expectancy and Health Per Capita Expenditure
(Latin America and the Caribbean, 2010)

Source: World Bank data.

Life Expectancy and Health Per Capita Expenditure
(OECD Countries, 2010)

Source: World Bank data.
Epidemiological Profile

Major cause of death
Chile 1970 and 2004

% of total causes

- Circulatory System
- Tumors
- Respiratory System
- External Causes
- Gastrointestinal System
- Endocrine, Nutritional and metabolic Causes
- Undefined
- Infectious and parasitic diseases

1970 vs 2004

Source: Department of Statistics and Health Information, Ministry of Health, Chile.

Scheme of Financial Flows

Financial sources
- Taxes
- Contributions to social security (quotes)
- Private insurance (prepaid premiums)
- Out of pocket expenditures (copayments)

Health Insurances
- Line item budgets
- Global budgets
- Capitation
- Fee for service
- DRG’s
- Payment related to the assigned population health

Healthcare Providers

Payment Systems

Financial Mechanisms

Source: Health Superintendence.
The Chilean Health System

The System Actors

**Financial Sources**
- State
  - Fiscal Contribution
- People
  - 7% of income
- Companies
  - 0.9% of income

**Insurances**
- Armed Forces
- FONASA
- ISAPRES
- MUTUALS

**Healthcare Providers**
- Their Own Providers
- Public Providers Network
- Private Clinics and Medical Centers

**Public Sector**

**Private Sector**

Source: Health Superintendence.

The Chilean Health System

Currently Funding Model

- Premiums according to risk and income (legal mandate = 7%; mean = 10%)
- 7% of income premiums and subsidies
- Payments per event
- Voluntary supplementary premiums

Source: Health Superintendence.
The Chilean Health System
Evolution of per capita health expenditure

Source: World Databank, WB.

In 9 years, an increase of 218%.

Source: Health Superintendence, based on FONASA available information.

Income Distribution in the Health Sector
FONASA and ISAPREs, 2010 (1/2)

Note: Figures are expressed in pesos of December 2010, $ 500 / dollar.
The Funding of Health
The Public Insurance: FONASA

Standard plan funded with 7% of taxable income

- **Group D**
  - Contributors with income exceeding $265.720 (US$ 571), if 3 dependents or more, they go to Group C
  - 20% copayment using MAI

- **Group C**
  - Contributors with income between $265.720 and $182.000, if 3 dependents or more, they go to group B
  - 10% copayment MA

- **Group B**
  - Contributors with incomes below $182.000 (US$ 391)
  - Free Care in MAI

- **Group A**
  - Lacking resources people or Indigents
  - Free Care in MAI, denied access to MLE

---

The table below shows the distribution of healthcare expenditure, sick leave expenditure, and total expenditure for Isapres and Fonasa in 2010.

<table>
<thead>
<tr>
<th>Source</th>
<th>Population</th>
<th>Healthcare Expenditure</th>
<th>Sick Leave Expenditure</th>
<th>Total Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isapres</td>
<td>82%</td>
<td>62%</td>
<td>73%</td>
<td>73%</td>
</tr>
<tr>
<td>Fonasa</td>
<td>18%</td>
<td>38%</td>
<td>27%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Note: Figures are expressed in pesos of December 2010, $ 500 / dollar.
Source: Health Superintendence, based on FONASA available information.
The Funding of Health
Private Health Insurances: ISAPREs

More than 12,727 different plans being mainly marketed by 7 open ISAPREs

- **Price 1**
  - Explicit Health Guaranties (GES)
  - Each ISAPRE sets one single price independent of individual risk (community premium)

- **Price 2**
  - Complementary Health Plan
  - Price depends on individual risk (Base Price x Risk Factors)

- **Price 3**
  - Supplementary Benefits from ISAPREs
  - Price depends on the type of benefit provided

8.9% of the operational revenue in 2010.

Source: Health Superintendence.

Explicit Health Guaranties Plan (1/2)

- **Universal Access**: it benefits the entire population covered by ISAPREs and FONASA
- **Explicit Guaranties**: they are published and may be demanded

¿Which are they?

- **Access**
  - The ISAPREs and FONASA are obliged to ensure delivery of guaranteed benefits to all its beneficiaries.

- **Opportunity**
  - Deadline for the delivery of guaranteed health benefits. Deadline set in hours, days or months, depending on each specific healthcare.

- **Quality**
  - Guaranteed benefits shall be delivered by a health care provider registered and accredited by the Health Superintendence.

- **Financial Protection**
  - Payment for guaranteed benefits are indexed to a tariff fixed on a decree (from 0% to 20%).
Explicit Health Guaranties Plan (2/2)

Prioritising System

PRIORITIZED HEALTH PROBLEMS
- The most frequent
- The most serious
- The most expensive
- What hurts more the quality of life

GUARANTEED INTERVENTIONS
- Effectiveness
- Promotion
- Prevention
- Healing
- Rehabilitation

FEASIBILITY OF THE PLAN
- Country's supply capacity.
- Available resources

PHASED IMPLEMENTATION
- DS 170 July 2005
- GES - 25
- GES - 40
- GES - 56
- GES - 69

Disclaimer

The author is exclusively responsible for all the information and opinions included in the presentation, which may not be considered done in the name of the affiliated institutions.
Thank You