Chile

Health systems

Economic classification: **High Income**

Health systems summary

Chile has a mixed public/private health insurance system that together provides universal health coverage. All workers must use 7% of their income to pay for health insurance but individuals can choose to contribute to the public insurance provided by Fondo Nacional de Salud or to private insurance provided by Instituciones de Salud Previsional. Coverage under the two types of insurance are not identical, there are differences between and within them and this is often based on contribution (and therefore an individual's income). Approximately 78% of the population is covered by public insurance, including most of the rural and urban poor and retirees. On the other hand, private insurers covers a smaller but wealthier segment of the population, creating inequality in risk pooling between the two insurance types.

General taxation and out of pocket expenditure are used to supplement the insurances. Out of pocket expenditure remains high (at approximately 38% of total health expenditure), so financial protection in Chile is considered to be poor.

Indicators

Where is the country's government in the journey towards defining 'Obesity as a disease'?	Some progress
Where is the country's healthcare provider in the journey towards defining 'Obesity as a disease'?	No
Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity?	No
Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity?	Yes
Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas?	Some progress
Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas?	No
Are there any obesity-specific recommendations or guidelines published for adults?	No
Are there any obesity-specific recommendations or guidelines published for children?	No
In practice, how is obesity treatment largely funded?	Out of pocket

Perceived barriers to treatment

Lack of political will, interest and action	Poor health literacy and behaviour	Social determinants of health	Food cost and availability
Lack of financial investment and funding for coverage	Lack of opportunity for physical activity	Lack of training for healthcare professionals	High cost of out of pocket payments
Obesity not recognised as a disease	Lack of evidence, monitoring and research		

Summary of stakeholder feedback

Stakeholders acknowledged that Chile has adopted and implemented a handful of initiatives and laws to address obesity, including regulations on the advertisement and labelling of foods and restricted access to unhealthy products in schools. Despite this, it was considered that efforts were insufficient and inefficient, with improved investment and a more intersectoral approach needed. In short, it was felt that although the government talked about obesity as an epidemic, it did not yet treat obesity as a disease.

Similarly, it was judged that healthcare providers too do not treatment obesity as a disease. Availability and coverage of obesity treatment was reported to be poor in both the public and private system as obesity is believed to be an aesthetic issue rather than a medical one. However, obesity treatment was considered to be better provided for in the private system as other ailments took priority in the public system and there were better trained professionals in the private system.

It was suggested that those with obesity would become eligible for treatment when their BMI was 30 kg/m² or above, with people entering the system via primary care in the public system and by going straight to a specialist in the private system. However, the few options in the public system, poor insurance coverage and long waiting lists mean that many fall out the system without receiving adequate treatment. The result is mass undertreatment of obesity in Chile.

Stakeholders noted that there are no guidelines or recommendations for obesity treatment for adults nor children, and obesity did not feature heavily in any non-communicable disease strategies. They also highlighted that there is limited to no specialist obesity training available for health professionals, with SCOPE seemingly the only notable option. The availability of suitably trained, qualified professionals was therefore considered limited in urban areas but worse in rural areas.

Based on interviews/survey returns from 8 stakeholders

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