CHILE CASE

Dr. Jorge Jiménez – Dr. Pedro Pérez Cruz

PANAMERICAN HEALTH ORGANIZATION

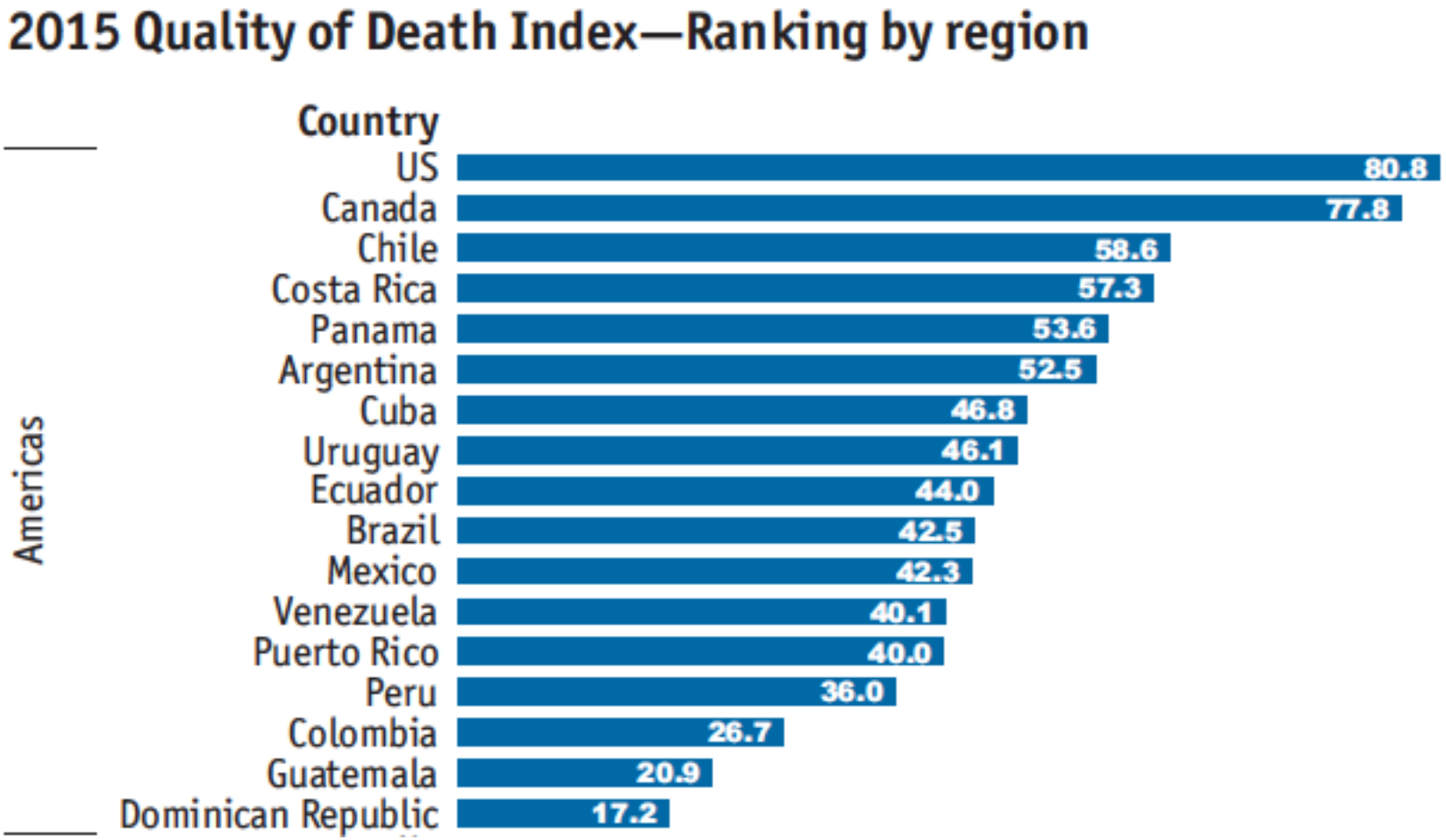
Washington DC, USA.

December 8, 9 – 2016

INTRODUCTION

POPULATION	17,948,141 habs
% URBAN POPULATION	89.53 %
SURFACE AREA	13,383 sq km
GDP PER CAPITA	13,383 USD
HDI	RANK 42; 0.832
POVERTY	14.4%
EXTREME POVERTY	2.8%
GINI INDEX	50.45
LIFE EXPECTANCY	81.7 years
FERTILITY RATE	1.76
CHILD MORTALITY	7 x 1000 live births
HEALTH EXPENDITURES (%GDP)	7.786 %
HEALTH EXPENDITURES (% PUBLIC)	49.47%

INTRODUCTION



METHODS

- We followed the proposed structures to prepare the Case.
- Our sources:
  - Literature Review about Chile Health Sector
  - Interview with stakeholders and HCP
  - Field experience during 2015
  - Personal experience of the authors
- We will not get into the details of the Chilean Health Care System → Key ideas
- We will focus on PC situation.

CHILEAN HEALTH CARE SYSTEM

- MOH defines health policies for the whole country.
- High % population is insured: 80% publicly insured and 17% privately insured.
- HC reform 2004 created a strategy to guarantee the delivery of a minimum set of services to all the population.

CHILEAN HEALTH CARE SYSTEM

GES REFORM (Health Explicit Guarantees)

- 80 prioritized health conditions
- All patients with insurance, have guaranteed:
  - Access
  - Time to obtain the services
  - Financial protection
  - Quality of care
- Publicly insured obtain care through Public HS
- Privately insured obtain care through private non-articulated providers.

PALLIATIVE CARE IN CHILE

STEWARDSHIP AND GOVERNANCE

- PC and Pain Control for patients with advanced cancer was one of the first 4 conditions included in the GES reform
- Guarantees:
  - Access: all patients with advanced cancer
  - Time to obtain services: 5 days after notification
  - Financial prot.: 26 USD per month max co-pay
  - QOC: not in place yet***

PALLIATIVE CARE IN CHILE

- MOH provides norms and guidelines to make recommendations for HCP. These documents do not provide standards of care.

FINANCING

- Every person pays an extra premium over the mandatory insurance for the coverage of the GES conditions.
- No financing to patients without cancer

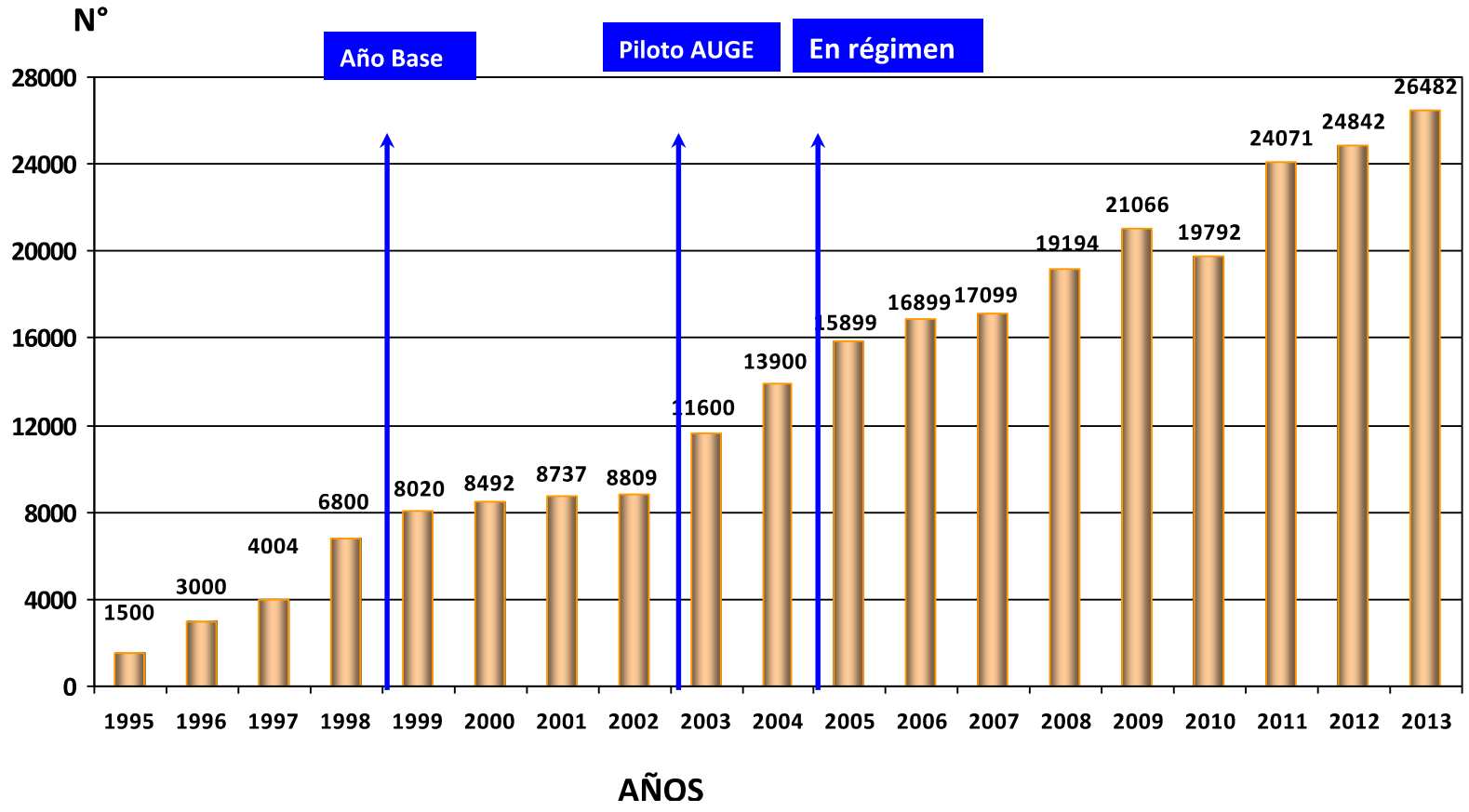
PALLIATIVE CARE IN CHILE

SERVICE DELIVERY

- 208 PC units throughout the country.
  - Little information about what happens in the private sector.
- Mainly structured as outpatient services. Little inpatient services and heterogeneous home based services.
- No coverage outside business hours.

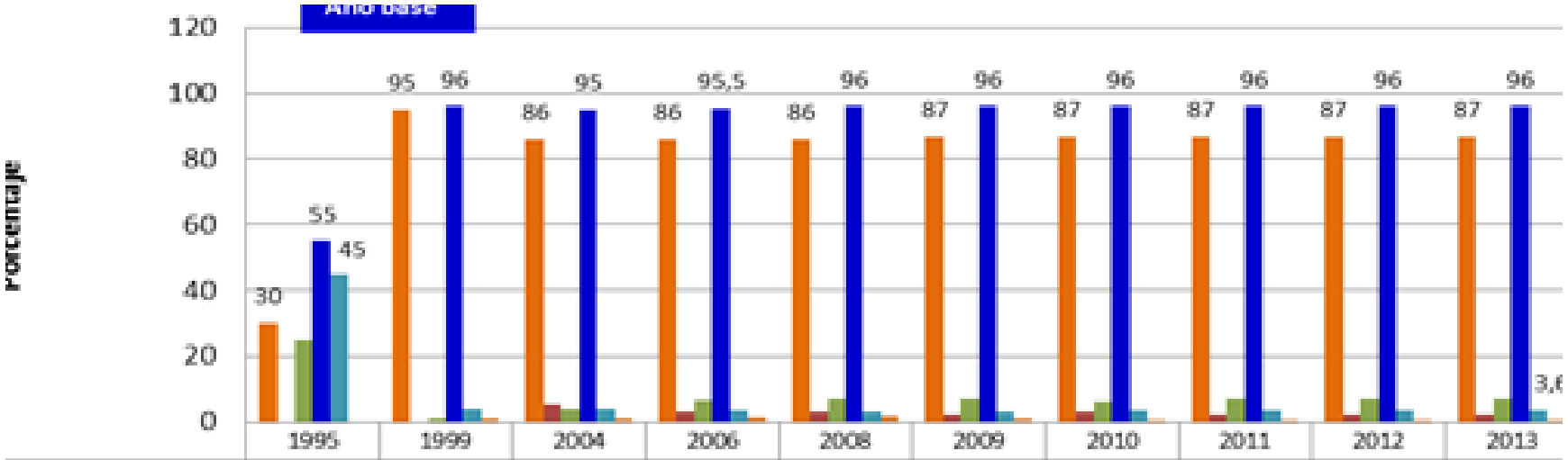
PALLIATIVE CARE IN CHILE

Number of patients covered by the PCPC GES benefit



PALLIATIVE CARE IN CHILE

Place of death in the public sector %



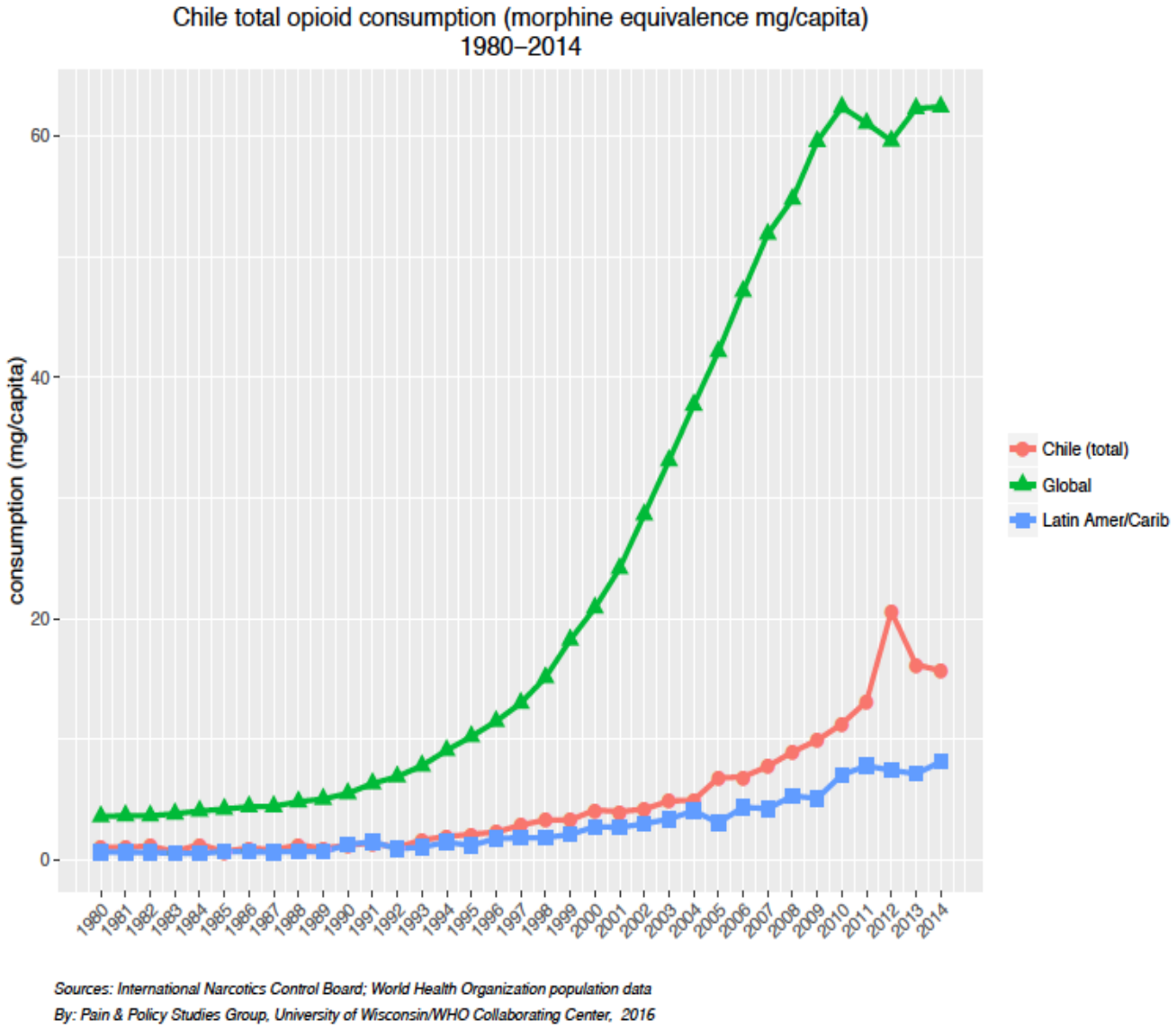
	1995	1999	2004	2006	2008	2009	2010	2011	2012	2013
Domicilio	30	95	86	86	86	87	87	87	87	87
Hogar de Cristo	0	0	5	3	3	2	3	2	2	2
Hogar de Ancianos	25	1	4	6,5	7	7	6	7	7	7
Residencia habitual	55	96	95	95,5	96	96	96	96	96	96
Hospital	45	4	4	3,3	3,2	3,1	3,5	3,5	3,5	3,6
Otros	0	1	1	1,2	1,8	0,9	0,5	0,5	0,5	0,4

PALLIATIVE CARE IN CHILE

SERVICE DELIVERY

- Heterogeneity in the way local services are organized.
- Great access to opioids, due to the work of civil society, scientific associations and international NGOs.
- Lack of measures to assess the impact of the program, just indirect measurements: number of PC units, opioid consumption, coverage, number of patients dying at home.

PALLIATIVE CARE IN CHILE



PALLIATIVE CARE IN CHILE

RESOURCE PRODUCTION AND MANAGEMENT

- Limited inclusion of PC in undergraduate programs.
- No specialty training in PC.
- Current providers are self taught, or completed a theoretical training.
- Lack of career paths and adequate remuneration

MAIN CONCLUSIONS

- There is no UHC for Pain Control and Palliative Care in Chile.
  - Good coverage of HC to PC and PC for cancer patients
  - No coverage for non-cancer patient.
- A preexisting strong Public Health System facilitated making PCPC available for patients with advanced cancer.
- Civil Society, Medical Scientific Associations and International NGOs, were essential in promoting awareness of the problem of Pain Control and were able to influence government.

MAIN CONCLUSIONS

- Given this important development under the framework of cancer programs the much needed expansion to other conditions has failed and is a pending task.
  - The institutional support system could be helpful and also a barrier to the development of PC
- The outcomes used to assess impact are indirect and may have undesired effects.
  - We don´t know what is the experience of patients and caregivers. We are doing research to answer these questions

MAIN CONCLUSIONS

- There is no clear policy regarding training in PC, and this might be a problem in order to use the available resources.

- The main tasks ahead to improve the expansion and quality of the Chilean palliative care program are:
  - Human resource training at the best possible level.
  - Expand community participation
  - Research and evaluation in palliative care