Financing Primary Health Care in Chile

An assessment of the Capitation Payment Mechanism for Primary Health Care

The Lancet Global Health Commission on Financing Primary Health Care

SYNOPSIS

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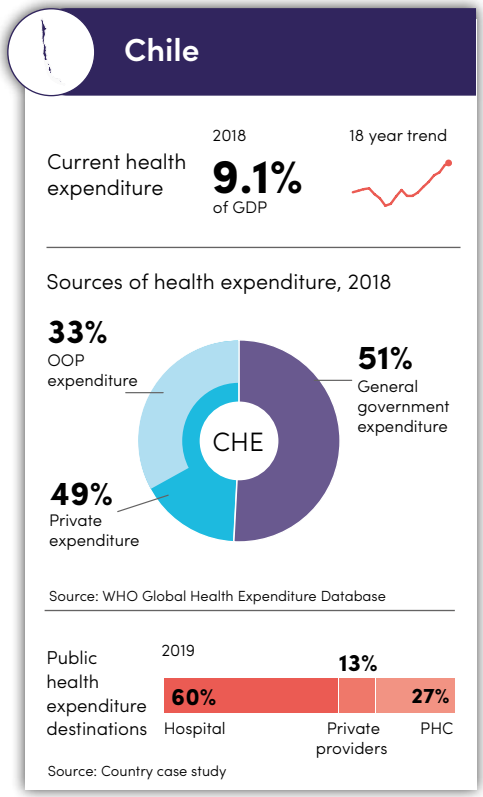
Chile has an established public primary health care (PHC) system comprising a range of facilities from Health Posts in rural areas to General Urban/Rural Centres and Community Hospitals, covering approximately 80% of the population. PHC has undergone a series of reforms including changes in the payment mechanism from fee-for-service to capitation in the 1990s, with the aim of obtaining greater equity in the allocation of resources, improved efficiency and quality of services. This paper examines the key aspects of the development, design, implementation and impact of the capitation system for PHC in Chile.



DEVELOPMENT AND DESIGN OF THE CAPITATION SYSTEM

During General Pinochet's dictatorship (1973-1990), municipalities received funding for PHC through a FFS mechanism, resulting in high levels of expenditure from the overuse of high-priced services. With the return to democracy in the 1990s, the new government sought to undo these inefficiencies by introducing a capitation system, allowing PHC providers to benefit from stable and secure funding and focus on providing preventative healthcare. Between 2003 and 2005, the government introduced further system-wide reforms aiming to guarantee access to quality, affordable, health care for the whole population and the introduction of a comprehensive Family Health model for primary care. These reforms both increased the role of, and funding required for PHC.

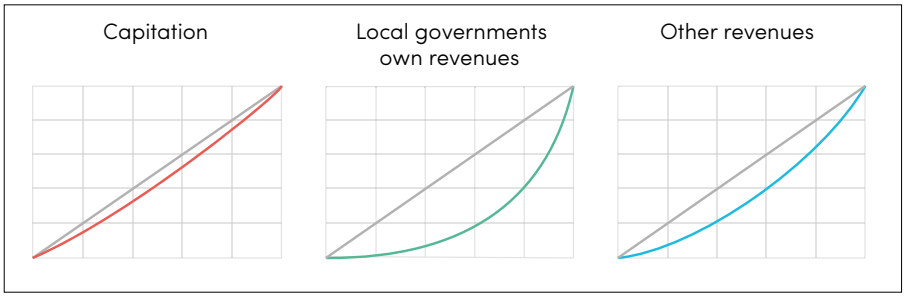
Under the new capitation system, prospective payments were transferred to local governments according to the size of their population, who then allocated resources to PHC providers to cover the cost of salaries and services in accordance with the government's Family Health Plan. The amount of funding per enrolled person was adjusted to take into consideration several factors including age, poverty and rurality. Between 2001-2019, the per capita amount for capitation increased steadily, and by 2019, capitation represented nearly 65% of the overall financing transfers to PHC.

IMPACT OF THE CAPITATION MECHANISM ON EFFICIENCY, QUALITY OF SERVICES AND EQUITY

Capitation has been used as a mechanism to allocate PHC resources from central to local governments in Chile rather than to generate improvements in services, and there is a lack of evidence to show its effects on the delivery of services in terms of efficiency, quality or equity. However, among key-informants, there is a general opinion that the change from FFS to capitation has corrected pernicious incentives to provide costly services, and a stable financing base has allowed the management and planning of health actions. Capitation has also favoured the development of a people-centred care model and led to a better coordinated PHC network, the maintenance of adequate equipment and infrastructure, and an expansion of PHC services. In addition, capitation has had a positive impact on the equity of resource allocation among local governments through the provision of more resources to poorer municipalities (see Lorenz curves in Figure 1 comparing equity impacts of different financing sources). Thus, the expansion of capitation during the last two decades (in absolute terms and relative to funding from local governments own revenue) increased the total revenue and made the Chilean PHC financing more egalitarian.

Figure 1: Lorenz curves for capitation, local government own revenues and other revenues, 2018

The closer the curve to the 45° line, the more equitable the financing source



Source: Country case study

STRENGTHS AND WEAKNESSES OF THE CAPITATION SYSTEM

Capitation has several advantages over other payment mechanisms including its ability to contain costs and to incentivize providers to focus on health promotion rather than disease management. Its successful implementation in Chile has been facilitated by strong administrative information systems that have ensured accuracy in numbers of enrollees and funding levels.

There are, however, several weaknesses associated with capitation. One notable limitation is the lack of financial integration between PHC and other levels of health care, which use different payment mechanisms such as diagnosis-related groups (DRG) for hospital care, making clinical coordination and integration of care difficult. Even within PHC, the use of complementary financing mechanisms, such as block payments to fund specific programmes, has reduced the ability of per capita funding to incentivise providers to treat patients in a holistic manner. Another weakness is in the crude nature of the risk-adjustment mechanisms that alter payments to municipalities according to their different needs. The poverty measure, for example, is based on the poverty of municipalities rather than of their populations. Further, there is no consideration for socio-cultural factors (such as serving first nation communities or diverse migrant populations) or differing disease burdens between municipalities.

Although Chile is a high-income country that has invested substantially in health in recent decades, ensuring adequate and equitable funding for PHC remains a particular challenge. A significant proportion of the capitation payment is allocated to paying salaries, as directed by the central government, leaving local municipalities with limited opportunity to invest or incentivise providers to prioritise their individual needs and goals.

LESSONS LEARNED

Lessons for other countries considering a capitation system for PHC.

1. **Ensure adequate funding for PHC.** Sufficient funds are required to cover the actual costs of providing a health plan or benefit package as well as a multidisciplinary team to deliver it. Costs should be updated regularly and include administrative costs.
2. **Consider how the potential benefits of capitation might be affected by existing payment mechanisms.** Policymakers should analyse other funding flows, regulations and payment mechanisms within the health system and consider how they might distort or nullify the positive effects of capitation, both at the PHC level and also across the continuum of care including at higher levels.
3. **For the benefits of capitation to be fully realised, it must be implemented in a way that incentivises PHC providers to improve services.** The Chilean system employs capitation as a resource allocation function from the central to local government, not as a means of incentivising PHC providers, e.g., by enabling them to retain and use surpluses. This limits the scope for capitation to improve the equity, efficiency, and quality of services.
4. **Consider the role of local governments in allocating funds to PHC providers.** If primary care is decentralized or deconcentrated, policymakers will have to reflect on whether to transfer funds to the municipal level (or the corresponding local government unit) or directly to PHC providers.
5. **Ensure all levels of government have sufficient technical capacity to implement capitation systems.** It is crucial to consider the technical capacities and management skills of the decentralized units to which per capita transfers are to be made and ensure these are sufficient to manage the PHC network.

This synopsis is based on one of 10 country case-studies written for the Lancet Global Health Commission on Financing Primary Health Care:

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