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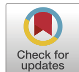

Fragmentation of Health Benefits Plans in Chile: Findings from a comparative policy analysis and implications for advancing Universal Health Coverage

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ABSTRACT

Background: Health Benefit Packages (HBPs) are essential for advancing universal health coverage (UHC) globally. In Chile, a fragmented and segmented health system includes multiple HBPs. Understanding their characteristics is crucial to inform policy debates on whether to maintain multiple HBPs or move toward a unified national plan.
Objective: To characterize Chile's HBPs by examining their foundations, mechanisms for defining and updating covered services, and their interactions with health system functions and outcomes.
Methods: We conducted a document review informed by methodological approaches from rapid reviews. Primary sources included laws, decrees, regulations, and technical norms governing HBPs in Chile, complemented by information from institutional websites and selected grey literature. Data were systematized using a conceptual matrix with three domains and twelve dimensions capturing the main elements of any HBP.
Results: **S**even HBPs were identified, including the "Explicit Health Guarantees Plan" and the "Ricarte Soto Law", the "High-Cost Oncological Drugs Fund", and the essential HBP for the public, private and the armed forces and security forces system. Significant variability was found across eight of the twelve dimensions, particularly regarding health technology assessment mechanism. Similarities were observed in principles, laws, healthcare provisions, and regulatory dimensions.
Conclusions: Maintaining multiple HBPs may hinder equitable access to health services. We recommend that Chile advance toward harmonizing or unifying the set of services into a universal HBP, supported by a robust HTA mechanism to ensure transparency and fairness. This approach could enhance the effectiveness of the health system and help achieve UHC.

Research in context box

What is already known about the topic?

The World Health Organization promotes UHC based on three key elements: population coverage, services coverage, and financial protection. HBPs are central mechanisms for organizing and expanding these components. Chile represents an interesting case study as its progress toward UHC has relied on creating multiple HBPs with distinct features—serving different beneficiary groups, following diverse policy approaches, and establishing varied pathways for patient access to services.

What does this study add to the literature?

This study provides a comparative analysis of the HBP operating in

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Chile, using an analytical framework designed specifically for this purpose. The results show that HBP share common characteristics but, more importantly, they present differences that can undermine equitable access to healthcare.

What are the policy implications?

Policymakers should consider advancing toward harmonizing HBPs to enable a unified and coherent set of services. This process requires defining a common structure and value framework across benefit packages, aligning HTA processes through a transparent institutional system, and incorporating patient perspectives to ensure that defined benefits effectively translate into equitable access to care.

1. Background

Universal health coverage (UHC) has been promoted by the World Health Organization (WHO) to foster equitable access to health services and financial risk protection for people worldwide [1]. A UHC requires financing a comprehensive mix of healthcare services for all people throughout their life course, including activities such as promotion, prevention, treatment and rehabilitation. These services must be chosen under considerations of efficiency, equity and affordability and delivered to meet quality standards to produce their expected outcomes [2]. The set of services made available to the population, often selected through a priority-setting process, can be organized as a health benefits package (HBP) [3], which constitutes one of the most important instruments for moving toward UHC in health systems across the globe [4].

The HBP can be defined as “the set of health services and products that can be feasibly financed and provided for everyone, given a particular country’s actual circumstances” [5]. Consequently, HBPs may differ across countries, reflecting differences in their epidemiological, socioeconomic and political conditions [2]. While some countries choose to adopt a single ‘universal’ HBP for all citizens, others have implemented two or more HBPs tailored to specific demographic groups or health priorities [4]. For example, while Colombia established a single universal HBP (Plan de Beneficios de Salud, PBS) [6], Australia has distinct programs customized to specific healthcare requirements [7], such as the Pharmaceutical Benefits Scheme (PBS) for medications [8], the Medicare Benefits Schedule (MBS) for professional services [9] and the Prostheses List for surgical implants and other medical devices [10].

Chile, a high-income country with a fragmented and segmented health system involving both public and private sectors in insurance and healthcare provision [11–13], has organized its coverage system to include multiple HBPs. These include universal plans that cover a wide spectrum of citizens, such as the HBP for prioritized health problems under the Regime of Explicit Health Guarantees (GES in Spanish) ([5,14,15]), an HBP for high-cost technologies [16], and a specific HBP for cancer drugs, available only to beneficiaries of the national public insurer [17]. In contrast, private insurers operate based on a market supply model, offering a variety of HBPs for individuals to choose from, and are funded primarily by obligatory contributions through a premium determined based on individual risk.

The current health policy debate in Chile is centred on two potential paths toward UHC: the first involves further developing new HBPs for services such as mental health or rare diseases [18], whereas the second entails implementing a single “Universal Health Plan” that would supersede the current multiple HBPs and provide coverage to all citizens [19]. This study aims to characterize healthcare HBPs in terms of their foundations, mechanisms for elaborating and updating services and interactions with other healthcare system functions and outcomes to support them. By analyzing the existing HBPs, this study provides insights into the strengths and weaknesses of the current approach, informing policymakers on the feasibility and impact of continuing with multiple HBPs or transitioning to a single universal health plan.

2. Methods

We conducted an analysis of the HBPs operating in Chile based on a de novo methodological framework.

First, we identified the HBPs active within the country, encompassing all coverage schemes defined by an explicit list of services and interventions recognized as entitlements for citizen healthcare access. Financing schemes that did not meet this definition, those related to private supplementary insurance, or those programs undertaken to build health delivery capacity, were excluded.

To describe and characterize how each HBP operates, we conducted a rapid documentary review, adapting the principles of rapid reviews [20]. The approach was intentionally restricted to primary legal and regulatory sources—laws, decrees, regulations, and technical norms—complemented with official institutional websites. In addition, we reviewed selected grey literature, such as technical reports, academic books, and publications from international organizations (e.g., the Inter-American Development Bank), to provide additional context and triangulation of findings.

The search strategy was applied to official repositories, including the “Diario Oficial”, the “Biblioteca del Congreso Nacional (BCN)”, and the websites of the Ministry of Health and other relevant public institutions. Key terms corresponded to the formal names of each HBP and their regulatory instruments, complemented by a snowballing strategy to identify legal modifications or related documents. The review was limited to documents published up to April 2024.

Document selection was conducted by one reviewer and subsequently validated by two additional researchers, who also supported the retrieval of grey literature. Data extraction was carried out by one reviewer and organized in Microsoft® Excel® for Microsoft 365 MSO (Version 2508, Build 16.0.19127.20192, 64-bit). The extracted information was then systematized using a de novo analytical framework specifically developed for this study, which is described in the following section. The extracted information was then systematized using a de novo analytical framework specifically developed for this study, which is described in the following section. The categorization of findings across domains was discussed and validated jointly with four other researchers.

To synthesize and analyze information on each HBP examined, we developed a conceptual matrix designed to encapsulate the main elements in setting up any HBP, from its creation to implementation Accordingly, we selected three “domains”: i) the foundation of the HBP, which represents the components that allow the construction of a well-established platform to institutionalize the HBP and provide guarantees of consistency over time to stakeholders and citizens; ii) elaboration and update of the HBP, which is used to describe the HTA mechanism, which is determined to define and periodically review and update the list of health services included in the HBP; and iii) The HBP’s influence on health system functions and outcomes examines how the HBP shapes and interacts with key components of the health system from both the patient’s and the system’s perspectives, and how these interactions ultimately impact the system’s outcomes.

The domains were disaggregated into elements called “dimensions” to further operationalize them, resulting in *the following: the foundation of the HBP*: principles, laws, scope, and value frame; *the elaboration and update of the HBP:* priority-setting methods, processes, and the health technology assessment (HTA) institutional arrangement; and the *HBP’s influence on health system functions and outcomes*: financing, healthcare provision, regulation, responsiveness, and financial protection. The selected dimensions are defined in Table A1. Additionally, we propose a diagram to represent the suitable interrelation among the three domains and their respective dimensions within the HBP framework (Fig. 1) to achieve the expected outcomes in terms of the ultimate objectives of the

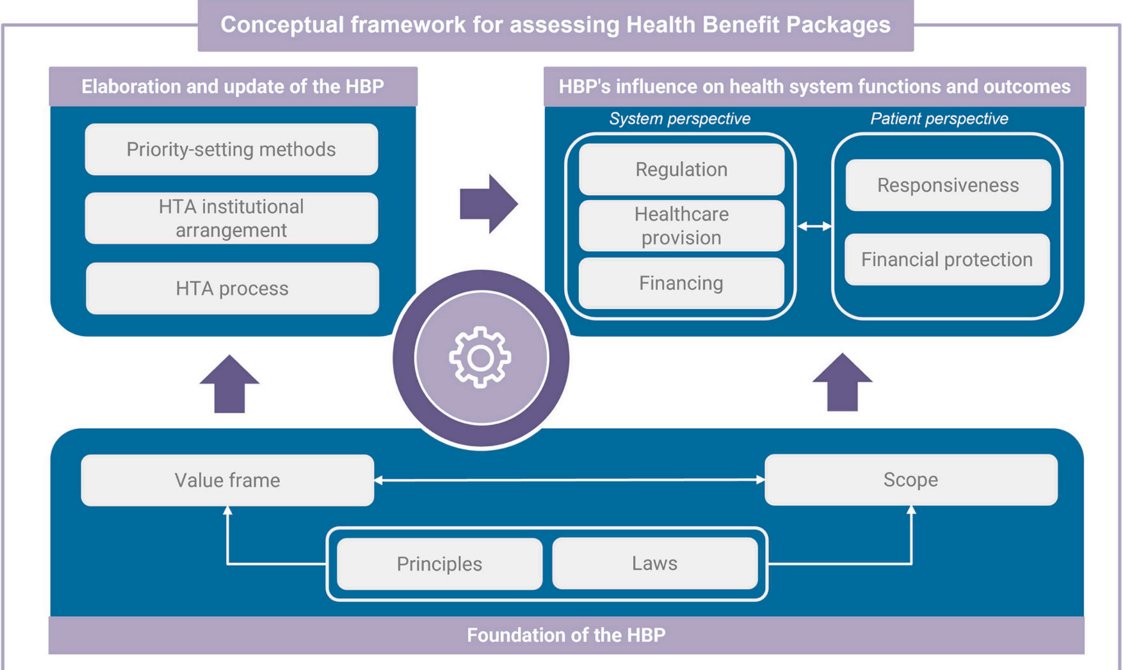

Fig. 1. Conceptual framework for health benefit packages: domain, dimensions, and their interrelations.
This figure illustrates the interconnected configuration of the divided into three macrodomains: the foundation of the HBP, the elaboration and update of the HBP, and the HBP's influence on health system functions and outcomes. The foundation of the HBP encompasses fundamental elements such as principles, laws, value frames, and scope, which establish the main pillars for the institutional architecture of the HBP. Elaboration and update of the HBP include priority-setting methods, HTA institutional arrangements, and processes, which dictate how services are selected and then reviewed, updated, and managed. The HBP's influence on health system functions and outcomes considers both the system perspective—comprising regulation, healthcare provisions, and financing—and the patient perspective, which focuses on responsiveness and financial protection. The arrows indicate the dynamic interactions and feedback loops among these components, aligning the HBP with health system goals and ensuring its effective implementation. HBP: Health Benefit Package. HTA: Health Technology Assessment. This figure was created by the authors.

WHO health system and the UHC. This structure allowed for systematic comparison across HBPs and identification of similarities and differences.

3. Results

Seven HBPs operating in Chile were found (Figure A1). The "Explicit Health Guarantees Plan" (GES) [21–25] ensures legally mandated services for a broad range of health conditions, offering guarantees for access, timeliness, financial protection, and quality from diagnostic tests through follow-up. The "Ricarte Soto Law" (LRS) ([16,26–31]) provides financial protection for high-cost diagnoses and treatments, with coverage guaranteed by the National Health Fund. The "High-Cost Oncological Drugs Fund" (DAC) ([17,32,33]) offers coverage for expensive oncological drugs for public healthcare patients lacking other coverage options. Additionally, the four remaining HBPs correspond to the basic health benefit package for beneficiaries from the public system (Fonasa) [34–37], the private system (Isapre) ([36,38–40]), the armed forces (FFAA) [41–46], and the security forces (FFOOs) [47–50], each of which administers unique benefit structures tailored to their respective populations [51]. Figure A2 in the supplementary material shows the position of the seven BHPs in the WHO universal health coverage cube, to better understand their role in Chile's health system.

In line with the framework established for characterizing HBPs, we categorized the data extraction into three domains: the foundation of the HBP, the elaboration and update of the HBP, and the interaction with health system functions and outcomes.

3.1. Foundation of the HPB

Table 1 presents a description of the dimensions included in the "Foundation of the HBP" for the seven HBPs. Common principles among these plans include "Equity", "Right to health", and "Efficiency". Notably, GES and LRS highlight the principles of "participation", which considers the HBP from a social perspective, whereas "freedom of choice in healthcare", which allows access to different types of healthcare providers, is considered by Fonasa and Isapre.

With respect to the Scope dimension, the set of services is organized primarily by technology/services, followed by technology-indication pairs and a basket of health services. Most HBPs offer a comprehensive range of services, covering at least from diagnosis to rehabilitation. In contrast, the LRS and DAC consider only treatment services. All the HBPs include a positive list of services with coverage, whereas Isapre, FFAA and FFOO also have negative lists. Most of the HBPs have restrictions on beneficiary eligibility based on the type of insurance; the Fonasa, Isapre, FFAA and FFOO plans are mutually exclusive. In contrast, LRS eligibility is unrestricted, providing meaningful universal access for the entire population.

In the Laws dimension, the HBPs present homogeneity, with six out of seven HBPs being established by the primary law. In contrast, the value frame dimension shows that the value attributes are explicitly stated in the law only for GES and LRS. we present the details of the relevant criteria considered in each HBP to prioritize and categorize services in terms of the value they bring to the health system (Table A2). It encompasses clinical, epidemiological, economic, supply capacity and social criteria. We incorporated the criteria found in normative documentation for the DAC and Fonasa, although it is not a clear declaration of the permanent and stable decision-making criteria used for reimbursement.

Table 1
Assessment of the domain “Foundation of HBP” and its dimensions: underlying principles, scope, legal basis, and value frameworks in Chile.

HBP/ Dim.	Principles	Scope	Law	Value frame
Explicit health guarantees (GES)	Right to health, Equity in health, Solidarity in health, Efficiency in the use of resources, social participation in health.	- Services are oriented to diagnosis, treatment, monitoring, rehabilitation and palliative care. - Services are organized in a basket of health services by disease. - The HBP is structured as a positive list - Eligibility of beneficiaries is restricted.	Established in primary law. Law No 19.966/ 2004, Establishes a system of health guarantees.	The value criteria **are explicitly stated** in the law
Ricarte Soto's Law (LRS)	Universality, Participation, Equity Transparency, Patient safety, Sustainability, Progressiveness, Financial risk protection.	- Services are oriented to diagnosis and treatment. - Services are organized in technology-indication pairs - The HBP is structured as a positive list. - Eligibility of beneficiaries is unrestricted, universal.	Established in primary law. Law N°20,850/ 2015, Creates a system of financial protection for high-cost diagnoses and treatments.	The value criteria **are explicitly stated** in the law.
High-Cost Oncological Drugs (DAC)	Right to health, Efficiency, Equity, Access to new oncological technologies.	- Services are oriented toward treatment and palliative care. - Services are organized in technology-indication pair. - Positive list is contemplated. A technical committee reviews and approves the coverage. - Eligibility of beneficiaries is restricted.	Established in secondary law[2].	The value criteria are not legally stated.
Health benefits plan for public system (Fonasa)	Right to health protection, Equal access to health care, Freedom of choice in healthcare (public or private health subsystem).	- Services are oriented to health promotion, disease prevention, diagnosis, treatment, rehabilitation and palliative care. - Services are organized by technology/ service and grouped in two tariffs: MAI and MLE[1]. - The HBP is structured as a positive list. - Eligibility is formally restricted, but effectively open to the entire population,	Established in primary law. DFL No 1/2005, Fixes the consolidated, coordinated and systematized text of Decree Law No 2.763/1979 and Laws No 18.933 and No 18.469.	The value criteria are not legally stated.
Health benefits plan for private system (Isapre)	Right to health, protection, Equal access to health care, Freedom of choice in healthcare (public or private health subsystem).	- Services are oriented to health promotion, disease prevention, diagnosis, treatment, rehabilitation and palliative care. - Services are organized by technology/ service and grouped by type of intervention, according to the level of care (outpatient, inpatient). - The HBP is structured as positive and negative lists, variable among plans. - Eligibility of beneficiaries is restricted.	Established in primary law. DFL No 1/2005, fixes the consolidated, coordinated and systematized text of Decree Law No 2.763/1979 and Laws No 18.933 and No 18.469.	The value criteria are not legally stated.
Health benefits plan for armed forces (FFAA)	Solidarity, Continuity, Efficiency, right to free and equal access to curative medicine.	- Services are oriented to disease prevention (only in active personnel), diagnosis, treatment, and rehabilitation. - Services are organized by technology/ service and grouped by type of intervention, according to the level of care (outpatient, inpatient). - The HBP is structured as positive and negative lists. - Eligibility of beneficiaries is restricted.	Established in primary law. Law No 18.948/ 1990, Constitutional Organic Law of the Armed Forces of the Ministry of National Defense and Law No 19.465/1996, Establishes the health system of the Armed Forces.	The value criteria are not legally stated.
Health benefits plan for security forces (FFOO)	Efficiency Health for wellness.	- Services are oriented to disease prevention (only in active personnel), diagnosis, treatment, and rehabilitation. - Services are organized by technology/ service and grouped by type of intervention, according to the level of care (outpatient, inpatient). - The HBP is structured as positive and negative lists. - Eligibility of beneficiaries is restricted.	Established in primary law. Law No 18.961/ 1990 Constitutional Organic Law of Carabineros. Decree Law N°844/1975, Creates the Carabineros Welfare Department.	The value criteria are not legally stated.

HBP: Health Benefit Packages. DFL: Decree with Force of Law. Dim.: Dimensions. [1] Fonasa negotiate the purchase of services with both public and private providers and reports the total service cost and patient co-payment under the Institutional Assistance Modality (MAI) and Free Choice Modality (MLE), respectively. [2] In Chile, secondary law refers to ministerial decrees issued by the Ministry of Health. See Methods and Table A1 in the supplementary material for operational definitions of each dimension.

3.2. Elaboration and update the HBP

The second domain analyzed was *Elaboration and update of the HBP,* which examines how the set of services are defined and updated periodically (Table 2). One HBP has only an HTA system with structure, systematization and transparency standards for priority-setting methods (LRS). Three HBPs (GES, DAC, and Fonasa) have publicly stated some information about the design and adjustment mechanism, process or institutions involved. However, this information was not available for Isapre, FFAA or FFOO.

In most HBPs that specify the institutional arrangement, the Ministry of Health leads the evaluation and decision-making process, and they have an Advisory Council as a recommender (GES, LRS, DAC, and Fonasa). Citizen participation is considered only in LRS, involving patient groups and representatives from academia and scientific societies. The HTA process is fully detailed in two HBPs, GES and LRS, and partially informed in DAC and Fonasa. Additionally, only the LRS has monitoring and evaluation steps in its process.

3.3. Interaction of HBPs with health system functions and outcomes

The third domain, presented in Table 3, involves the interaction of HBPs with health system functions and outcomes and is analyzed from both the health system perspective and the patient perspective. From the system perspective, HBPs are predominantly financed through taxes and/or compulsory contributions, with three HBPs (Isapre, FFAA, FFOO) accepting voluntary contributions to enhance coverage scope or level. Quality standards for providers are required for three HBPs (GES, LRS and Fonasa). With respect to the Regulation dimension, all the HBPs are supervised by the Superintendency of Health (SH), which oversees the proper provision of services included in the HBPs. However, its competencies depend on how explicit the entitlements in the HBP are.

From the patient perspective (Table 3), the HBPs show variability in their arrangements to empower citizens to effectively utilize their health insurance entitlements. Patient enrollment is automatic for Fonasa, FFAA, and FFOO beneficiaries, whereas it is voluntary for GES and subject to approval by the insurance company for Isapre (individual risk selection) or a technical committee for LRS and DAC. Information about services included in the HBP is publicly available in all the HBPs, and in

Table 2
Assessment of the domain “Elaboration and update of the HBP” and its dimensions: Priority-setting methods, HTA institutional arrangement, HTA process.

HBP/Dim.	Priority-setting methods	HTA institutional arrangement	HTA process
Explicit health guarantees (GES)	The methods are generally established, and it lacks a HTA system with structure, systematization and transparency.	The main stakeholders institutionally participating are identified as: Evaluators: leading by Ministry of health Recommenders: Advisory council (representatives from academia and scientific societies) Decision-makers: Ministry of Health and the Ministry of Finance. Citizen participation: Not contemplated.	The HBP has a process of reviewing and updating every three years. The main steps are defined by law and includes determination of the economic resources available, technical and economic analysis, prioritization process, consultation with advisory council and final decision. The process does not include a monitoring and evaluation of the HBP.
Ricarte Soto’s Law (LRS)	The methods are established in detail. Furthermore, the HBP has a system of HTA with coherent structure, systematization and transparency.	The main stakeholders institutionally participating are identified as: Evaluators: leading by Ministry of health Recommenders: Advisory council (Prioritized Recommendation Commission comprising qualified professionals and patient groups representatives). Decision-makers: Ministry of Health and the Ministry of Finance. Citizen participation: Contemplated through the Citizen Surveillance and Control Commission, which is made up of patient groups registered with the Ministry of Health, representatives of scientific societies and academia. Its function is to advise the ministers by monitoring the functioning of the system and making recommendations.	The HBP has a process of reviewing and updating every three years. The process is defined by law and included steps as: technical and economic analysis along with make reports public, prioritization and recommendation process by an advisory council and final decision. The process includes a monitoring and evaluation of the HBP.
High-Cost Oncological Drugs (DAC)	The methods are not clearly established, and it lacks a HTA system with structure, systematization and transparency.	The main stakeholders institutionally participating are identified as: Evaluators: leading by Ministry of Health Recommenders: Advisory council (The High-Cost Drugs Committee comprising oncology experts and Ministry of Health representatives). Decision-makers: Ministry of Health. Citizen participation: not contemplated.	Details of the process are unknown, but consider at least: technical and economic analysis, prioritization and recommendation process by an advisory council and final decision. The process does not include a monitoring and evaluation of the HBP.
Health benefits plan for public system (Fonasa)	The methods are not clearly established, and it lacks a HTA system with structure, systematization and transparency.	The main stakeholders institutionally participating are identified as: Evaluators: Fonasa Recommenders: Fonasa Decision-makers: Ministry of Health and the Ministry of Finance. Citizen participation: not contemplated.	Details of the process are unknown, but consider at least: technical analysis, prioritization process and final decision. The process does not include a monitoring and evaluation of the HBP.
Health benefits plans for private system (Isapres)	N/A	N/A	N/A
Health benefits plan for armed forces (FFAA)	N/A	N/A	N/A
Health benefits plan for security forces (FFOO)	N/A	N/A	N/A

HBP: Health Benefit Package. Dim.: dimension. HTA: Health Technology Assessment. N/A: Not available. See Methods and Table A1 in the supplementary material for operational definitions of each dimension.

Table 3
Assessment of the domain "Interactions with health systems' functions and outcomes" and its dimensions: Financing, Healthcare provision, Regulation, Responsiveness, and Financial protection.

HBP/ dim.	Financing	Healthcare provision	Regulation	Responsiveness	Financial protection
Explicit health guarantees (GES)	**Collection**: variable[1] **Pooling**: variable. **Purchasing**: Purchase Organization and payment methods not established.	- Quality-related accreditation standards requested. - Clinical guidelines to orientate de clinical practice contemplated. - Closed network to provide benefits contemplated.	The SH has the function of supervising and mediating disputes.	- Patients with suspected/ confirmed HBP diseases may enroll and activate coverage. - Information on benefits is public, understandable, and includes explicit guarantees of access, quality, timeliness, and financial protection. - Patient navigation is publicly available and understandable.	Cost-sharing with monthly deductible by basket. Mechanism to reduce the amount of cost-sharing not contemplated.
Ricarte Soto's Law (LRS)	**Collection**: Taxes. **Pooling**: Single **Purchasing**: Purchase organization and payment methods established.	- Quality-related accreditation standards requested. - Clinical guidelines to orientate clinical practice contemplated. - Closed network to provide benefits.	The SH has the function of supervising and mediating disputes. The "Citizen Oversight and Control Commission" is responsible for monitoring and making recommendations about the HBP operation.	- Patients with an HBP-eligible disease/technology can enroll only after technical committee approval. - Coverage and benefits information is publicly accessible and understandable. - Patient navigation process is publicly accessible and understandable.	Without cost-sharing, the HBP assures 100 % of coverage.
High-Cost Oncological Drugs (DAC)	**Collection**: Taxes. **Pooling**: Single. **Purchasing**: Purchase organization and payment methods not established.	- Quality-related accreditation standards not requested. - Clinical guidelines to orientate clinical practice contemplated. - Closed network to provide benefits.	Supervising institution has not been established.	- Patients with an HBP-eligible disease/technology can enroll only after technical committee approval. - Coverage and benefits information is publicly accessible and understandable. - Patient navigation process is publicly accessible and understandable.	Without cost-sharing, the HBP assures 100 % of coverage.
Health benefits plan for public system (Fonasa)	**Collection**: Taxes, compulsory insurance contribution. **Pooling**: Single **Purchasing**: Purchase organization and payment methods established.	- Quality-related accreditation standards requested. - Clinical guidelines to orientate clinical practice contemplated. - Closed network to provide benefits: one public and one private network.	The SH has the function of supervising and mediating disputes	- The enrollment is automatic while patient is Fonasa beneficiary. - Information about coverage and benefits is publicly accessible and understandable. - Patient navigation process is publicly accessible and understandable.	Cost-sharing with copayments, variable by insurance contribution. Includes a mechanism to reduce the amount or exclude the copayment.
Health benefits plans for Private system (Isapre)	**Collection**: Compulsory insurance contribution, voluntary insurance contribution. **Pooling**: Multiple **Purchasing**: Purchase organization and payment methods, not established.	- Quality-related accreditation standards not requested. - Clinical guidelines to orientate clinical practice not contemplated. - Open or closed network depending on the plan.	The SH has the function of supervising and mediating disputes	- Eligibility depends on institution criteria. Automatic enrollment while patient is Isapre beneficiary. - The services included are stated in the contract between the beneficiary and the insurer (with minimum thresholds of coverage). - Patient navigation is stated in the contract.	Cost-sharing with copayments and maximum threshold, variable by plan contracted. Mechanism to reduce the amount of cost-sharing contemplated, mainly in high-cost hospital diseases.
Health benefits plan for armed forces (FFAA)	**Collection**: Compulsory insurance contribution, voluntary insurance contribution, taxes. **Pooling**: Multiple. **Purchasing**: Purchase organization established, and payment methods not established.	- Quality-related accreditation standards not requested. - Clinical guidelines to orientate clinical practice not contemplated. - Institutional network with option to agreement with out-of-network providers.	The SH has the function of supervising and mediating disputes	- Automatic enrollment while patient is an Armed force health beneficiary. - Information about coverage and benefits is publicly accessible. - Patient navigation is stated by each branch.	Cost-sharing with copayments, variable by active service or retire Mechanism to reduce the amount of cost-sharing contemplated, through voluntary insurance fund.
Health benefits plan for security forces (FFOO)	**Collection**: Compulsory insurance contribution, voluntary insurance contribution, taxes. **Pooling**: Single **Purchasing**: Purchase organization established, and payment methods not established.	- Quality-related accreditation standards not requested. - Clinical guidelines to orientate clinical practice not contemplated.	The SH has the function of supervising and mediating disputes	- Automatic enrollment while patient is a law enforcement and security forces health beneficiary. - Information about coverage and benefits is publicly accessible and understandable. - Patient navigation is stated by each branch	Cost-sharing with copayments, variable by active service or retire Mechanism to reduce the amount of cost-sharing contemplated, through voluntary insurance fund.

(*continued on next page*)

Table 3 (*continued*)

HBP/ dim.	Financing	Healthcare provision	Regulation	Responsiveness	Financial protection
		- Institutional network with option to agreement with out-of-network providers.			

HBP: Health Benefit Package. Dim: Dimension. [1]It is a mandatory plan for both Fonasa and Isapre and is financed through taxes or as part of the compulsory insurance contributions, respectively. See Methods and Table A1 in the supplementary material for operational definitions of each dimension.

three HBPs, the overall patient trajectory is defined and explained in understandable terms.

Financial protection is robust in GES, LRS and DAC due to limited or non-existent copayments. The Isapre, FFAA, and FFOO plans include mechanisms to reduce or exclude copayment through voluntary supplementary insurance funds. Notably, the GES stands out for offering explicit guarantees in terms of access, quality, timeliness, and financial protection.

4. Discussion

This study aimed to characterize healthcare HBPs operating in Chile. We analyzed the legal and public documentation of the structure and organization of seven HBPs, using a framework specifically developed for this purpose. This allowed us to systematize the collected data and make comparisons between the HBPs. Overall, the results indicated that there is variability in the configuration of the HBPs studied. We found similarities among the HBP in the following dimensions: principles, laws, healthcare provisions, and regulation. However, we found discrepancies in the scope, value frame, priority-setting, HTA institutional arrangement, HTA process, financing, responsiveness and financial protection dimensions.

The observed similarities in these dimensions, despite the fragmentation of the Chilean health system, can be attributed to the development of the system in the last 20 years, which achieved a significant degree of social and political consensus ([18,52]). The most recent major reform began in 2005 with the implementation of the GES HBP, which introduced explicit rights concerning access, timeliness, financial protection, and quality standards for prioritized health problems. This reform led to significant reorganization within the Ministry of Health and the creation of the Superintendence of Health to oversee compliance [53], impacting beyond GES to the entire healthcare system.

Regarding the differences in the dimensions mentioned above, in terms of achieving UHC, the variability across the HBP would be acceptable as long as, given the same need, patients receive the same services, and no equity problems are generated [54]. Yet, our analysis shows that scope dimension differs markedly: some HBPs, such as Fonasa and Isapre (that shares certain common minimum standards [51]), ensure broad services across prevention, treatment, and rehabilitation, while others, like LRS or DAC, focus narrowly on treatment or high-cost interventions. Additionally, GES was initially designed with the intention of expanding over time into a universal health plan, its full development has not been achieved [52]. This fragmented approach risks generating inequities and inefficiencies, particularly when patients navigate multiple packages simultaneously.

A critical weakness lies in the absence of institutionalized HTA processes across HBPs. Our results reveal differences among the HBPs in the dimension related to the HTA mechanisms (related to the *elaboration and update the HBP* domain), with fragmented or ad hoc arrangements. This situation undermines transparency and continuity, while also opening the door to exceptional mechanisms such as judicialization for high-cost intervention coverage or priority setting through legislative action driven by civil society [18], allocating resources outside the institutionalized process. Strengthening the HTA system in Chile, which is linked to coverage decisions, is a highly desirable political aim, not only to improve the quality and legitimacy of current decisions but also to support a potential future unified national plan [56]. According to the WHO, HTA plays a critical role in supporting health authorities in their decision-making processes for reimbursement, ensuring fairness for citizens and maintaining broad legitimacy [55].

In addition, fragmentation is evident in financing and pooling. Most HBPs have their own pool of risk, resulting in insufficient risk distribution and inefficiencies such as adverse selection and risk selection, particularly in the Isapre plan [52]. From the patient perspective, we observed that the financial protection dimension reflects different proportions of coverage, highlighting that it varies depending on the type of beneficiary (either active service or retired) in FFAA or FFOO. Additionally, because a patient could be included in more than one HBP, the use of the benefits of each plan becomes difficult. For example, one patient with a cancer diagnosis is entitled to the services included in the HBP corresponding to his insurer (Fonasa, Isapre, FFAA or FFOO) and could also be eligible to receive interventions from GES, LRS and DAC, each with its own enrollment criteria and patient navigation.

Overall, HBPs in Chile have contributed to UHC within a mixed system where both public and private actors play a central role, sometimes collaboratively. Similar dynamics has been documented in other context suggesting that hybrids governance models can contribute to expanding coverage, though often at the cost of greater complexity [57–60]. Using the UHC cube, our results indicate that population coverage is nearly universal, and over time, HBPs have been designed to complement one another, gradually expanding both the range of services covered and the degree of financial protection beyond the basic schemes (Figure A2).

However, despite these contributions, our findings highlight the heterogeneity among HBPs, and provide relevant inputs for the discussion of health policy in the coming years: whether Chile should continue developing and improving multiple HBPs or move toward a single universal HBP. Our work presents undesirable differences between HBPs, which suggests that progress in harmonizing or unifying the set of services and programs available is more consistent with an equitable health system from the perspective of UHC.

We argue that one of the most relevant contributions of this work is the framework developed to characterize the HBP. Although other frameworks are available for analyzing HBPs, they describe only specific components of HBPs, such as the HTA mechanism [61], financing or administration [62], or presenting their components without the relationships among them [63]. The added value of our framework is that we integrate all the relevant components for an HBP. Furthermore, to our knowledge, this is the first framework that includes the patient perspective through capturing responsiveness and financial protection effects [54]. Consequently, we strongly believe that our framework can be used in future studies to analyze and compare HBPs in different contexts and jurisdictions.

We acknowledge as a limitation of this study, performing our analysis on normative basis only because the documented norms may differ from the actual operation and implementation of the HBPs. Nevertheless, HBPs governed by highly regulated public and private entities in Chile should operate in a manner highly consistent with the normative. Regardless, further research may be performed to understand whether HBPs are fully consistent with the laws and bylaws. In addition, our analysis focused specifically on the entitlements defined through HBPs—namely, the services to which citizens are formally

entitled—without addressing demand-side aspects such as the organization of healthcare networks, the essential contribution of the health workforce, or the role of community participation and broader societal engagement in making benefits effective in practice. Future studies should therefore integrate both normative and operational perspectives to provide a more comprehensive understanding of how HBPs contribute to UHC.

5. Conclusions

The HBP is essential for advancing UHC as it defines the entitlements guaranteed by the health system. In our study, we characterized seven HBPs operating in Chile and identified significant differences in eight of the twelve dimensions analyzed. When interpreted through our framework, this heterogeneity reflects key challenges in the foundation domain (e.g., fragmented and overlapping benefit definitions), the elaboration and update domain (lack of a uniform institutionalized HTA process), and the functions and outcomes domain (fragmented financing and inequities in financial protection). These differences highlight opportunities for improvement, particularly regarding the equity goal of UHC. Given the ongoing debate about whether Chile should continue developing new HBPs or establish a unique and universal HBP for all citizens, our findings suggest that multiple HBPs risk compromising fair access to services. Since equity is paramount for achieving UHC, we recommend that Chile pursue to harmonizing or unifying the set of service in a universal HBP, at least for an essential set of services. Additionally, we observed that Chile has performance gaps in the implementation of a robust HTA mechanism to legitimize health policy decision-making and ensure transparency and fairness. This approach will likely enhance the effectiveness of the health system and support the goal of achieving UHC.

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Availability of data and materials

All data generated or analyzed during this study are included in this published article.

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CRediT authorship contribution statement

Pilar Contreras-Montiel: Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Conceptualization. **Nicolás Armijo:** Writing – original draft, Methodology, Conceptualization. **Macarena Vera:** Writing – review & editing, Visualization, Methodology. **Oscar Arteaga:** Writing – review & editing, Validation. **Pamela Góngora-Salazar:** Writing – review & editing, Validation. **Carlos Balmaceda:** Writing – review & editing, Methodology. **Manuel A. Espinoza:** Writing – original draft, Methodology, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare that they have no competing interests.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.healthpol.2025.105507.

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