Chile

The Commonwealth Fund

International Health Care System Profiles

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Overview

Chile operates parallel public and private health insurance. About eight in 10 residents are covered by the public National Health Fund (Fonasa).[1] Workers and pensioners contribute a mandatory 7 percent of taxable income to health insurance, which they may direct to Fonasa or to a state-regulated private insurer.[2] People without contributory income and legal dependents are covered by Fonasa, which is financed largely from general revenues.

The Ministry of Health sets policy and regulates the system. Care is delivered through a public network organized by regional health services and municipal primary care, alongside private providers. Minimum entitlements (covering access, timeliness, quality, and financial protection) are defined by Explicit Health Guarantees. The system is financed by general revenues, wage-based contributions, and out-of-pocket payments.[3]

Out-of-pocket health spending remains high, indicating limited financial protection. On average, per capita health spending in privately insured households is about four times that of households covered by the public system.[4] Life expectancy is higher than the regional average, and infant mortality is lower.[5] However, Chile lacks a formal long-term care system, and persistent inequities in outcomes and access continue to burden lower-income and Indigenous groups disproportionately.[6]

HEALTH SYSTEM
BY THE NUMBERS

10.1%
Health care spending as a percent of GDP

80.8 years
Life expectancy at birth

83.4%
Public insurance coverage

Coverage and Access

Background and History

Chile's health care system has undergone significant change over the past century as a result of socioeconomic and political reform. The 1886 Public Relief Commission (*Junta Central de Beneficencia y Asistencia Pública*) was one of the state's earliest organized efforts to centralize health and welfare services. In 1924, in response to the growing needs of industrial workers, the state introduced its first statutory health insurance system, the Social Security Funds (*Cajas de Provisión*). This system provided coverage in three tiers, with separate funds (*cajas*) for manual workers and skilled laborers, administrative staff and professional employees, and civil servants.[7]

However, this coverage system excluded significant sections of the population, particularly informal and rural workers.[8] To address this, in 1952, the government merged multiple health care providers to form the National Health Service (*Servicio Nacional de Salud*, or SNS), financed by general taxation and wage-based contributions. White-collar workers received additional benefits through the National Medical Service for Employees (*Servicio Medico Nacional de Empleados*, or Sermena), introduced in 1953.[9]

Chile's health care system was restructured under the military regime of General Augusto Pinochet (1973–90). In 1975, the SNS was decentralized, and primary care responsibilities were transferred to the municipalities.[10] Currently, there are 345 municipalities in Chile.[11]

In 1979, the National Health Fund (*Fondo Nacional de Salud*, or Fonasa) was established as the country's public insurance fund, and in 1980, private health providers (*Instituciones de Salud Previsional*, or Isapres) were legalized, giving individuals the opportunity to opt out of Fonasa and purchase private coverage.[12] The two-tiered system led to widespread inequities, with a growing gap in access to quality health care between wealthy and poor Chileans.

Following the return to democracy in 1990, health care reform became a top priority.[13] In 2005, Universal Access with Explicit Guarantees (*Acceso Universal con Garantías Explícitas*, or AUGE), was established to guarantee access to health care for a set of 56 conditions, regardless of insurance type or income. Upon its implementation, AUGE was renamed Explicit Health Guarantees (*Garantías Explícitas en Salud*, or GES). In 2022, the list was expanded to include 87 conditions.[14]

The Role of Public Health Insurance

Employed citizens must contribute 7 percent of their income (up to a legal ceiling of CLP 3.4 million [USD 3,693]) toward mandatory health insurance, with the option to choose between Fonasa or a private provider under Isapres.[15] Low-income or unemployed citizens are also eligible for Fonasa, with contributions covered by the state.[16] Members of the armed forces and the police are covered under separate programs.[17]

Fonasa members are categorized into four income-based groups. Tier A and B members (on low or no income) can get care only through public providers, which are organized under 29 local health authorities.[18] Tier C and D members (on higher incomes) may opt for Fonasa's Free Choice Modality (*Modalidad de Libre Elección*, or MLE), which allows them to use accredited private providers through copayments or pay-as-you-go vouchers.[19]

In 2024, 83.4 percent of the population was covered by Fonasa.[20] In addition to wage-based contributions, general government revenues and out-of-pocket payments help fund the system.[21]

The Ministry of Health (*Ministerio de Salud*, or MINSAL) plays a central role not only in financing but also in service delivery, operating through the Health Service Network (*Red Asistencial*), communal directorates, and partnerships with private providers.[22]

There can be crossover between the Fonasa and Isapres systems, with wealthier Fonasa members often paying for private outpatient care.[23]

Insurance Coverage (Percentage of Population), 2024

Source: OECD Data Explorer, Healthcare coverage, distributed by OECD, accessed December 6, 2025 ("public" insurance refers to Fonasa exclusively).

In 2022, the government introduced Zero Copayment (*Copago Cero*), which eliminated out-of-pocket costs for everyone insured under the public system, regardless of their income (*see Cost Sharing and Out-of-Pocket Spending*).[24]

Services Covered by Public Health Insurance

- Preventive care[25]
- Inpatient care
- Outpatient care
- Maternity care (including analgesia in labor, prematurity care, and oral health for pregnant women)[26]
- Primary care
- Dental care
- Eye care
- Mental health care
- Palliative care
- Long-term care (technical aids, hearing loss, and oral health)[27]
- Rehabilitative care
- Home visits.

Safety Nets

The safety net for people who are unemployed and on low incomes, retirees, children under age 6, and pregnant women is robust, with each group entitled to free health care through Fonasa.[28]

Under the GES system, MINSAL caps copayments for the treatment of certain conditions. Under Zero Copayment, Fonasa beneficiaries in all income groups have no copayments when treated in the public provider network. Copayments are capped at 10 percent for Group C and 20 percent for Group D for GES care received through accredited private providers.[29]

In Chile, the government introduced the Pharmacy Fund (*Fondo de Farmacias*, or FOFAR) for beneficiaries under Fonasa. The program is designed to strengthen access to essential medicines by ensuring their availability and free delivery through primary health care facilities[30] (*see Pharmaceutical Spending*).

In 2015, the Ricarte Soto Law established a universal financial protection mechanism for individuals suffering from high-cost medical conditions not covered under the standard benefits system. The law provides coverage for specific diagnoses and treatments — including oncological and immunological treatment and diagnoses of rare or infrequent diseases — regardless of a person's socioeconomic status or insurance status.[31]

Indigenous populations in Chile are largely left out of existing health and social safety nets.[32] Even when they are eligible for a program, these communities often face cultural barriers to accessing care, such as medical practitioners' limited awareness of how Indigenous communities conceptualize illness.[33]

The Role of Private Health Insurance

Private health insurance is provided through Isapres, which operate as individual insurance plans financed directly by enrollees.[34] By 2023, consolidation efforts had created a more streamlined system made up of 10 Isapres, with the top three covering over 60 percent of beneficiaries.[35]

Coverage varies according to a plan's premium and the insured individual's risk profile.[36] Isapres beneficiaries can choose between a free option, which allows access to any public or private provider, and a preferential modality, which lets the user choose from a predefined list of private institutions.[37]

Some people supplement their Isapres or Fonasa plans with complementary health insurance, which typically covers high-cost conditions and outpatient care.[38]

The Role of Government

The government plays a central and multitiered role in organizing, regulating, and delivering health care services across the country.[39] MINSAL is the highest authority. The Undersecretariat of Public Health (*Subsecretaria de Salud Pública*) focuses on population health, regulatory oversight, and the promotion of public health initiatives, while the Undersecretariat of Assistance Networks (*Subsecretaria de Redes Asistenciales*) supervises the health service networks that deliver care.[40]

MINSAL also oversees both Fonasa and Isapres, as well as public and private providers. It's supported by the Superintendency of Health (*Superindendencia de Salud*), the Institute of Public Health (*Instituto de Salud Pública*, or ISP), and the National Health Supply Center (*Central Nacional de Abastecimiento*, or CENABAST), which manages the procurement and availability of medicines.[41]

At the regional and local levels, the health care system is decentralized through 29 health districts coordinated under the National Health Service System (*Sistema Nacional de Servicios de Salud*, or SSNS) and 345 municipal primary health care networks.[42] These entities are responsible for operating public hospitals, clinics, and primary health care services.[43]

Integration and Care Coordination

Primary care services are well coordinated because all public primary health care facilities within a municipality fall under the same local health department.[44] All public services in a geographic area are legally part of a unified health care network overseen by the health district and coordinated by the Undersecretariat of Assistance Networks.[45]

As of 2005, primary health care has been implemented through the Comprehensive Family and Community Health Care Model (*Modelo de Atención Integral de Salud familiar y comunitaria*, or MAIS), which promotes person-centered care that not only addresses physical and mental health needs but also considers the cultural, familial, and community context.[46] Building on this, the Multimorbidity Patient-Centered Care Model (*Modelo de Atención Centrada en la Persona con Multimorbilidad*, or MACEP) was launched in 2017 to improve the treatment of high-risk patients within primary care. The model introduced case management, risk stratification, and self-management education, with patients receiving frequent, coordinated care tailored to their conditions.[47]

Mental health care integration is also a focus. The 2017–25 National Mental Health Plan (*Plan Nacional de Salud Mental*), for example, aims to integrate services within the community care model and treatment within the general health network (*see Mental Health Care*).[48]

Outside the primary care system, operational integration is more challenging, as secondary and tertiary care are managed by regional health districts.[49]

Operations and Resources

Overview of the Delivery System

The health care system operates across three levels of care:[50]

- Primary care offers preventive and curative services, typically provided by Family Health Centers (*Centros de Salud Familiar*, or CESFAM), rural health posts, and medical stations. These form the main entry point to the public system.
- Secondary care involves specialized services provided either by general hospitals or by standalone facilities, such as diagnostic and treatment centers.
- Tertiary care entails complex medical care, which is provided in advanced public hospitals.

Payment mechanisms for providers differ significantly between the public and private sectors. Fonasa pays public providers using centrally defined fee schedules and capitation payments for primary care that are lower than those in the private sector. Isapres mainly use a fee-for-service model, paying providers market rates. These insurers often negotiate fees either individually or through a network of preferred providers, offering discounted prices to those who use providers within that network.[51]

For services under the GES, fees are agreed collectively.[52] However, the fee-for-service structure incentivizes the preferential treatment of privately insured patients and the overuse of profitable services.[53]

Primary Care

The primary health care system is built on MAIS (*see Integration and Care Coordination*). Services are delivered by multidisciplinary teams made up of doctors, nurses, dentists, midwives, and social workers. The teams provide prevention, early diagnosis, chronic disease management, rehabilitation, and referral services.[54]

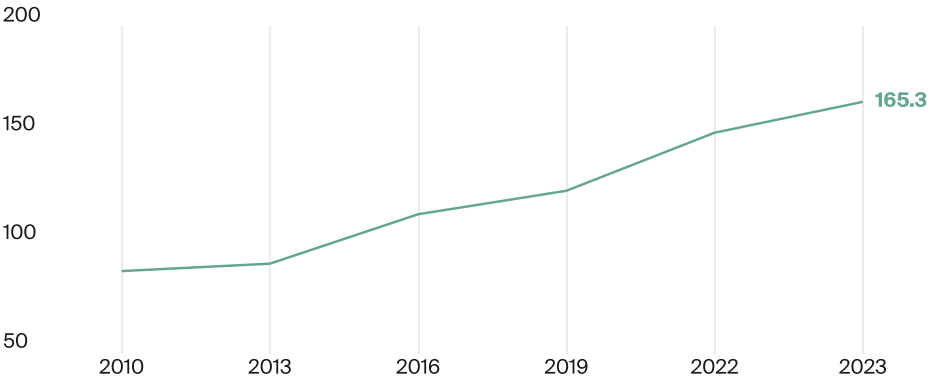
Primary health care is financed by the central government, and there are no copayments for public services. Municipalities primarily manage health services, with oversight and technical support provided by MINSAL and the regional health service.[55] CESFAM serve larger urban populations and coordinate the smaller Community Family Health Centers (*Centros Comunitarios de Salud Familiar*, or CECOSF) and Primary Care Urgent Health Services (*Servicio de Atención Primaria de Urgencia*, or SAPU).[56] Rural health posts serve widely scattered rural areas, offering basic health services and referral capabilities through resident paramedics.[57]

Under Fonasa, registration with a municipal primary health care network is mandatory, so primary care is the official gatekeeper of higher levels of care.[58]

To improve care quality and efficiency, the blended provider payment system combines capitation, pay-for-performance incentives (through the Program to Strengthen Primary Health Care Services [*Programa de Reforzamiento de la Atención Primaria de Salud*, or PRAPS]), and municipal budget allocations.[59]

There are no data for the number of GPs practicing publicly versus privately.

Number of GPs per 100,000 People, 2010–23



Source: The Global Health Observatory, Medical doctor: generalist medical practitioners (number), distributed by World Health Organization, accessed November 26, 2025; figures calculated using population data from World Bank Open Data, Population, total — Chile, distributed by World Bank Group, accessed November 26, 2025.

Outpatient/Specialist Care

Unlike in the private sector, where patients can consult specialists directly, patients in the public system must first obtain a referral from a primary care physician, after which they are placed on a wait list.[60] Follow-up communication from specialists is limited, with a considerable number of referrals not receiving responses.[61]

As of 2023, there were about 178 specialist medical practitioners for every 100,000 people.[62]

In 2024, half of working doctors were specialists in at least one area of care.[63] In 2023, the density of specialists was similar across the country, with the south registering slightly higher rates. Certain medical disciplines, including infectious diseases, emergency medicine, and adult intensive care, are underrepresented outside metropolitan areas. However, there is no substantial regional variation in most medical fields.[64]

No data are available for the number of specialist medical practitioners working publicly versus privately.

Physician Education and the Workforce

It typically takes seven years to earn a medical degree.[65] After five years, students receive a Bachelor of Medicine, which grants access to graduate academic programs but not clinical practice or medical specialization.[66] The final two years consist of intensive internships and clinical rotations and lead to the title of medical surgeon, which is required to practice medicine.[67] In 2024, Chile had 12.1 medical graduates for every 100,000 people.[68]

Annual tuition fees range from USD 5,000 to USD 10,000. Government and university scholarships are available to both domestic and international students.[69] The number of medical schools has grown dramatically over the past few decades, rising from six schools in 1990 to 29 in 2024.[70]

Offering practical training and public health exposure, the University of Chile's Rural Internship Program (*Internado Rural*) places seventh-year medical students in full-time rural assignments for three to four weeks.[71]

In 2020, Chile faced an estimated shortage of 1.13 physicians, nurses, and midwives for every 1,000 people, illustrating the country's health workforce gaps.[72] Within primary health care, the situation is particularly acute: a 40 percent shortage of doctors and just 40 percent coverage in some areas.[73]

The number of physicians has increased significantly, from 24,455 in 2010 to 65,737 in 2023.[74] International recruitment fills workforce gaps: A quarter of physicians are trained abroad.[75] The National Single Examination of Medical Knowledge (*Examen Único Nacional de Conocimientos de Medicina*, or Eunacom) is a national exam assessing theoretical and clinical competencies. Passing it is mandatory for any internally trained doctor who wants to legally practice medicine.[76] Pass rates for foreign doctors are about 30 percent lower than for Chilean graduates.[77]

Most foreign-trained physicians come from Venezuela, Ecuador, Colombia, and Cuba;[78] they often fill shortages in geographically remote or resource-constrained regions.[79]

Number of Medical Graduates per 100,000 People, 2021

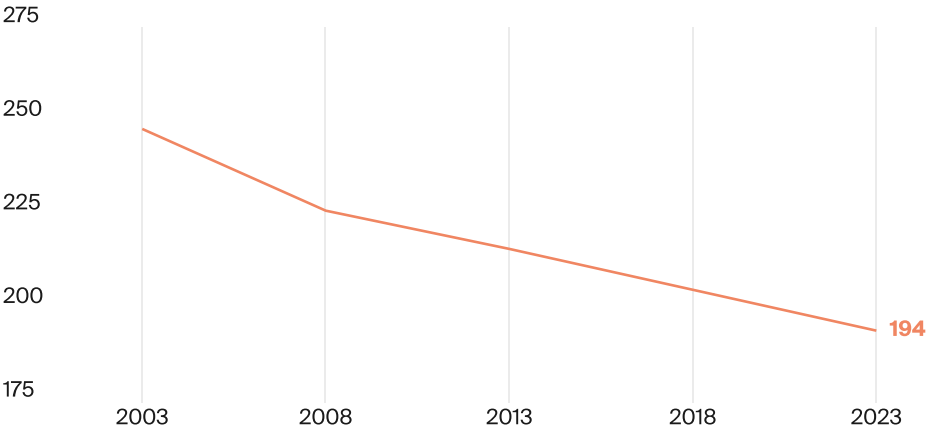
Source: Health at a Glance (Organisation for Economic Co-operation and Development, November 7, 2023).

Hospitals

Of Chile's 425 hospitals, 46 percent are publicly owned, and 54 percent are operated by private owners, who typically call these services "clinics."[82] Public hospitals serve a significantly larger portion of the population, and higher patient volumes and heavier workloads in public hospitals can, at times, overburden both staff and infrastructure.[83] Challenges in public facilities include nurse shortages, high patient-to-nurse ratios, and insufficient time for specialized care tasks.[84]

Public hospitals are predominantly financed by Fonasa, using a mixed payment system that combines prospective payment per case (whereby hospitals receive a predetermined, fixed fee for treating a patient), fee for service, and capitation for outpatient and chronic disease management.[85] In contrast, Isapres primarily pay for private ambulatory care on a fee-for-service basis and use a combination of case-based and fee-for-service payments for hospital services.[86]

Number of Hospital Beds per 100,000 People, 2003–23



Source: The Global Health Observatory, Beds, hospital beds (per 10,000 population), distributed by World Health Organization, accessed November 26, 2025.

Mental Health Care

Mental health care in Chile emphasizes patient-centered treatment, which is mostly delivered at community mental health centers. Care is fully covered under the public health system. Functioning as both primary and secondary care facilities, community mental health centers accept referrals from other primary care centers but can also be accessed directly.[88]

The objectives of the 2017–25 National Mental Health Plan include the integration of services throughout the health care system, increased investment in resources and initiatives, and an even greater focus on community-based care.[89]

HOSPITALS BY THE NUMBERS

In 2023, there were **191 hospital beds per 100,000 people**.[80]

In 2023, there were **545 nurses and midwives per 100,000 people** (compared with 671 across the Americas in 2022).[81]

MENTAL HEALTH CARE BY THE NUMBERS

In 2020, there were **6 mental hospital beds per 100,000 people** (compared with 29 beds on average in high-income countries).

There were **9 psychiatrists per 100,000 people** in 2020 (the same as the average for high-income countries).

The total number of mental health professionals was **20 per 100,000 people** in 2020 (compared with 62 on average in high-income countries).[87]

The High Impact Coalition for Mental Health (*Coalición de Alto Impacto para la Salud Mental*), is an initiative, launched in 2022, designed to scale community-based intervention in mental health. Its focus is on women, children, and Indigenous communities.[90] That year, the government also launched Building Mental Health (*Construyendo Salud Mental*), a long-term strategy to strengthen mental health support through suicide prevention and better emergency response and service provision.[91]

Number of Mental Hospital Beds per 100,000 People, 2020

Source: World Health Organization, Mental Health Atlas 2020 (WHO, 2021); World Health Organization, Mental Health Atlas 2020 — Chile Member State Profile (WHO, 2022).

Despite these initiatives, long wait times and a lack of capacity have led to largely negative public perceptions of the mental health care system.[92]

Long-Term Care and Social Support

With no formal long-term care system, such services are provided mainly by unpaid family members. An estimated 470,000 informal family caregivers take on this responsibility.[93] In 2021, just 4 percent of older adults with care requirements had access to state-supported benefits.[94] Basic services are delivered through municipalities and nonprofit entities under the supervision of the National Service for the Elderly (*Servicio Nacional del Adulto Mayor*, or Senama).[95]

In 2020, the National Comprehensive Health Plan for the Elderly and 2020–30 Action Plan (*Plan Nacional de Salud Integral para Personas Mayores y el Plan Acción 2020–2030*) was introduced to enhance the quality of life for older people, promote autonomy, and integrate health and social care services to provide more comprehensive support.[96]

In 2022, the Ministry of Social Development and Family (*Ministerio de Desarrollo Social y Familia*, or MDSF) created "Chile Cares" (*Chile Cuida*), a national support and care system offering dependents and their caregivers coordinated public services. Under this system, community care centers provide home visits, caregiver training, mental health support, and relief services. In addition, municipal local support and care networks coordinate services at the local level, with the aim being to bring care closer to households and ease family burdens.[97]

Cost and Affordability

Health Care Spending Overview

In 2022, health care spending accounted for 10.1 percent of gross domestic product (GDP), higher than the average for high-income countries (8.2%) and the regional average for the Americas (7.3%).[98]

Health Care Spending as a Percentage of GDP, 2022

Source: The Global Health Observatory, Current health expenditure (CHE) as percentage of gross domestic product (GDP) (%), distributed by World Health Organization, accessed November 26, 2025.

In 2022, total health care spending reached USD 33.5 billion, with the government contributing USD 16.9 billion and out-of-pocket payments totaling USD 11.9 billion.[99] On a per capita basis, health care spending was USD 1,770, well below the average for high-income countries (USD 5,930).[100]

Pharmaceutical Spending

In 2023, pharmaceuticals accounted for 13.4 percent of health care spending.[101]

Access to medication differs significantly between public and private insurance systems.[102] Fonasa beneficiaries receive most chronic disease medications free of charge through public health center pharmacies, supported by initiatives such as MINSAL's primary care program and FOFAR, which makes essential treatments for diabetes, hypertension, and dyslipidemia available.[103] These programs also help to address supply shortages by providing centralized procurement and additional funding.[104] However, shortages of non-covered or legacy medicines — drugs still in use but excluded from public coverage — mean that some Fonasa patients must make purchases at private pharmacies.[105]

Isapres patients primarily purchase medications directly from community pharmacies, with partial reimbursement for medication covered under GES policies. Typically, such reimbursement is 15 to 35 percent for branded drugs and over 80 percent for generics.[106]

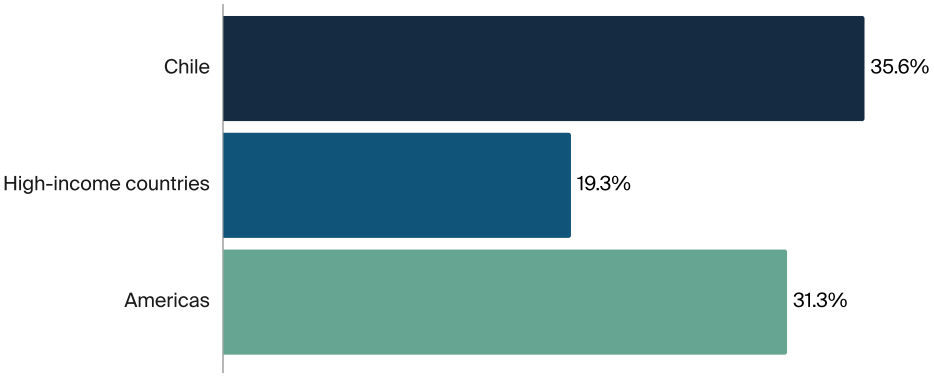
Municipal pharmacies were introduced in 2015 to reduce out-of-pocket spending. Operated by local governments on a nonprofit basis, these pharmacies provide medications at close to cost — often at least 50 percent cheaper than the prices charged by private pharmacies. As of 2020, there were more than 160 such pharmacies in operation.[107]

Cost Sharing and Out-of-Pocket Spending

In 2023, out-of-pocket spending accounted for 34.6 percent of total health spending, compared with an average of 31.3 percent across the Americas.[108]

"The persistence of out-of-pocket spending is a big problem," explains Cristian Herrera, senior health specialist in the Latin America and Caribbean region at the World Bank Group. "It's having a direct impact on households."

Percentage of Health Care Spending That Is Out of Pocket, 2023



Source: The Global Health Observatory, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/out-of-pocket-expenditure-as-percentage-of-current-health-expenditure-%28che%29-%28-%29, distributed by World Health Organization, accessed December 19, 2025.

The introduction of Zero Copayment in 2022 removed out-of-pocket costs for anyone receiving treatment in public hospitals and clinics. This benefit applies to everyone insured under Fonasa, regardless of their income.[109]

Copayments still apply to treatment by private providers. Under the GES system, these are capped according to the patient's beneficiary group and the number of illnesses being treated. For Fonasa tier C patients, the cap is 10 percent of the reference price. For those in tier D and for Isapres beneficiaries, the cap rises to 20 percent of the reference price.[110] For those in Fonasa tier C, there's a maximum of 21 monthly contributions for a single illness and 31 for two or more illnesses. For tier D patients, the monthly contribution caps are 29 and 43, while those for Isapres members are 29 and 41.[111]

How Are Costs Contained?

Reforms in public procurement and pharmaceutical pricing are significantly reducing health care costs.[112]

For example, the 2020 CENEBAST law gave private pharmacies the right to purchase medicines at government-negotiated prices through CENABAST, leading to a price reduction of as much as 70 percent.[113]

The Drugs II Bill (Ley de Fármacos 2), which is still pending approval, aims to reduce out-of-pocket spending and improve equitable access to medication with mandatory drug prescription, international price referencing, and limits on pharmacy profit margins.[114]

Quality and Outcomes

Health Outcomes

In 2023, life expectancy was 80.8 years — higher than the regional average for the Americas (74.1 in 2021) but below the average for high-income countries (81.1 in 2023). There's a significant gender gap, with women living an average of 83.3 years and men 78.2 years.[124]

In 2021, the leading cause of mortality was noncommunicable disease, which accounted for 73.3 percent of all deaths. This was followed by communicable, maternal, perinatal, and nutritional conditions (21.3%) and then by injuries (5.4%).[125]

Addressing Health Inequities

In 2024, 11.5 percent of Chile's population identified as Indigenous.[126] This percentage has remained relatively stable since 2017.[127] While historically concentrated in rural areas, nearly 88 percent of Indigenous people now live in urban centers, reflecting broader demographic shifts.[128] There has also been rapid growth in the migrant population; Chile has 1.6 million foreign-born residents (8.8% of the population — a share that has doubled since 2017).[129]

Health disparities are deeply rooted in socioeconomic and ethnic inequities. Chile is the only Latin American country that does not recognize its Indigenous population in its constitution, and Indigenous Chileans face significantly worse outcomes, with a life expectancy of 76.2 years, seven years shorter than that of non-Indigenous populations.[130] Health care access is also highly uneven: Low-income and rural districts often lack adequate facilities, as most services are concentrated in urban centers.[131]

While the government has undertaken a range of measures to provide more equitable access to care, targeted support for Indigenous groups is limited. Many programs fail to address language and cultural barriers, geographic isolation, higher poverty levels, and lack of integration, all of which restrict effective access.[132]

Rural residents in Chile face poorer access to timely, specialized care than those in major cities. Specialists are heavily concentrated in Santiago's Metropolitan Region,[133] while sparsely populated regions have far fewer clinicians per capita and longer travel times to advanced services. Rural communities rely on primary-level rural health posts (postas rurales); more than 2.1 million people receive care through 1,170 rural health posts nationwide. The government's Rural Digital Hospital (Hospital Digital Rural) initiative extends telemedicine to these areas.[134]

Gender-based disparities persist across Chile's health system. Within the public insurance system, women face substantially longer wait times for treatment than men.[135] In the private system, women pay higher premiums but receive less coverage.[136] Overall, women report poorer self-perceived health (35.1% versus 19.9% in men), with the widest gap seen among those with lower levels of education.[137]

HEALTH OUTCOMES **BY THE NUMBERS**

In 2023, average life expectancy was **80.8 years** (compared with 81.1 in high-income countries). **Men** lived an average of **78.2 years** (compared with 78.5 in high-income countries), and **women** lived an average of **83.3 years** (compared with 83.7 in high-income countries).[115]

The top three causes of death in 2021 were:

- COVID-19: **125 deaths per 100,000 people**
- Ischemic heart disease: **69 deaths per 100,000 people**
- Stroke: **61 deaths per 100,000 people**.[116]

The avoidable mortality rate was **229 deaths per 100,000 people** in 2022.[117]

The maternal mortality rate was **17 deaths per 100,000 live births** in 2024 (compared with 59 on average in the Americas in 2023).[118]

The infant mortality rate was **6.2 deaths per 1,000 live births** in 2024 (compared with 11 on average across the Americas in 2023).[119]

In 2021, the share of the population with mental health disorders was **17 percent** (compared with 16% on average in high-income countries).[120]

The suicide rate was **10.8 per 100,000 people** in 2023 (compared with an average of 12 in high-income countries).[121]

The gun death rate was **three deaths per 100,000 people** in 2023.[122]

In 2022, **39 percent** of adults were affected by obesity.[123]

Migrants — particularly migrant women — are also disproportionately marginalized. Many remain uninsured; 15.8 percent of migrants lack coverage, compared with 2.2 percent of locals. Similarly, 9.2 percent of migrants report unmet health care needs after illness or injury versus 6 percent of Chilean-born residents.[138] Pregnant migrants also use fewer prenatal health services.[139] Children and young migrants are exposed to additional risks linked to insecure environments, while experiences of discrimination and abuse exacerbate stress and worsen overall well-being.[140]

Despite these inequities, the World Bank Group's Cristian Herrera has seen improvements: "Chile has managed to generate at least a baseline for more equitable access and financial protection," he explains. "The Explicit Health Guarantees reform has increased access, improved outcomes for patients, reduced inequalities, and provided financial protection."

Innovation and Reform

Health Care Innovation

Chile has undertaken multiple reforms designed to expand public coverage, modernize care delivery, and provide more equitable access to health care services across the country.

The Program for Universal Primary Health Care Coverage and Resilience was launched in 2023, backed by a World Bank loan of USD 200 million.[141] It expands access to free, high-quality services, including telemedicine and new rural clinics, regardless of insurance status.[142] It also aims to increase climate resilience and preparedness for public health emergencies, as well as to improve efficiency through artificial intelligence–powered virtual health management.[143]

In 2024, the Isapres Short Law (Ley Corta de Isapres) introduced reforms to modernize and strengthen Fonasa. At its center is the Complementary Coverage Model (Modalidad de Contratación Complementaria, or MCC). The MCC allows Fonasa patients to purchase voluntary insurance that offers expanded access to private health care providers and reduced copayments. This model is designed to promote equity and financial protection and pool risk.[144]

Health Care Technology

Chile has made notable strides in digitizing its health care system, particularly since the COVID-19 pandemic.[145] "Chile is a frontrunner in the region for digital health, and — for instance — telemedicine is widely used," says the World Bank's Cristian Herrera. "The introduction of digital health has been strong, and there is a good environment for innovation in that sense."

The journey has been uneven, however, especially in primary health care, where the lack of a national financing policy for digital technologies has led to fragmented implementation.[146] Multiple electronic medical records coexist without interoperability, even within the same referral network.[147]

Initiatives such as Digital Hospital (Hospital Digital), which focuses on specialist care and reducing wait times, have limited primary health care applications, such as appointment scheduling.[148] Barriers include low digital literacy among older adults, insufficient out-of-hours telehealth availability, and a lack of robust reimbursement processes for remote services.[149]

Despite these challenges, there have been some promising developments. For instance, in 2020, during the COVID-19 pandemic, MINSAL launched EPIVIGILA, a real-time digital surveillance system that has transformed infectious disease tracking and has enabled data-driven public health responses.[150] In 2022, MINSAL implemented DHIS2, an open-source data platform for specialized registries such as the National Childhood Cancer Registry (Registro Nacional de Cáncer Infantil, or RENCI), and for the delivery of COVID-19 medications to certain patients.[151]

This profile reflects data as of January 2026. New or updated information may have become available since its release.

Notes

1. OECD Data Explorer, Healthcare coverage, distributed by OECD, accessed December 6, 2025, https://data-viewer.oecd.org/?chartId=ded33310-2176-469a-890f-b579846f0128.

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