Editorial

Challenges of the Chilean health system: towards a universal, equitable, and efficient model

Abstract

Chile's health system faces persistent structural challenges despite progress in coverage and professional training. This essay critically examines key issues affecting the quality and equity of care, including inefficient hospital and administrative management, extensive waiting lists, and the shortage and migration of medical specialists from the public to private sector. It highlights how the dual public-private model deepens socioeconomic segmentation, resulting in unequal access to services. The consequences of these shortcomings- especially for vulnerable populations- are far-reaching, leading to frustration, inequality, and declining public trust. The essay concludes by advocating for a universal, equitable, and non-discriminatory health system centered on social justice, sustainable investment, and political will.

Keywords: Chilean health system, healthcare equity, health management, public-private healthcare, health reform, universal healthcare

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Planck Barahona Urbina
Department of Industry and Business, University of Atacama, Chile

Correspondence: Planck Barahona Urbina, Department of Industry and Business, University of Atacama, Atacama, Chile

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Introduction

The Chilean health system faces a series of structural challenges that have raised concerns over recent decades. Despite progress in coverage, technology, and professional training, significant shortcomings persist that affect the quality and equity of care. Waiting lists, inefficient hospital management, the migration of specialists from the public to the private sector, and socioeconomic segmentation in access to services are just a few of the issues that negatively impact population health.[1]

This essay critically addresses the main shortcomings of the Chilean health system, focusing on three key areas: hospital and administrative management, waiting lists for medical services and procedures, and the availability of specialists in the public sector. It also explores the causes of professional migration to the private sector and reflects on the feasibility and urgency of implementing a truly universal, equitable, and non-discriminatory health model.

Fragmentation of the Chilean health system

Chile's mixed health system comprises a public subsystem (FONASA) and a private one (ISAPREs). This dual structure has created a deep socioeconomic segmentation in access to services. While approximately 78% of the population is affiliated with FONASA, only about 15% use private insurance.[2] This disparity reflects not only income gaps but also significant differences in waiting times, specialist availability, and perceived quality of care.

The coexistence of two parallel systems has consolidated an inequitable model in which access and service quality are closely tied to purchasing power. Individuals with greater resources can opt for faster, more comfortable private services, while those dependent on the public system face bureaucratic hurdles and long delays.

Inefficient management and its impact on care quality

A key issue in Chile's public health system is inefficient hospital and administrative management. Its centralized, hierarchical structure hinders agile, locally-tailored decision-making. Procurement, staffing, and surgical scheduling often follow rigid protocols that slow operations and create bottlenecks.[3]

Reports from the Comptroller General and Ministry of Health highlight poor resource use, lack of performance indicators, and weak oversight. This results in unused beds, underutilized operating rooms, and medical staff burdened with administrative tasks that could be delegated.

Moreover, the lack of integrated health information systems impedes patient tracking, coordination across care levels, and clinical outcome evaluation. The absence of a unified digital system increases costs, duplicates tests, and delays diagnoses, directly affecting patients.

Waiting lists as a symptom of structural crisis

Waiting lists are among the most visible expressions of the public system's crisis. As of 2025, more than 2 million people await specialist consultations, and around 400,000 need non-urgent surgery. In some cases, waits exceed 400 days, jeopardizing health and sometimes even lives.[3]

Although policies like GES (Explicit Health Guarantees) and special programs aimed to reduce wait times have helped certain prioritized conditions, many others remain neglected. Overemphasis on quantitative goals can lead to prioritizing easier cases to meet targets while delaying complex ones.

Core causes include the lack of specialists in the public sector, limited availability of medical appointments, and inefficient appointment management. Geographic centralization of services also creates inequalities, forcing many to travel long distances for care.

Lack of specialists and migration to the private sector

The shortage of specialists severely affects care quality and wait times in the public system. Chile's physician-to-population ratio is below the OECD average, and distribution is uneven, with Santiago and private providers having the highest concentrations. Over 60% of specialists work exclusively or partly in the private sector.

Migration is driven by multiple factors: better pay, lighter workloads, better infrastructure, and more professional autonomy in private practice. In contrast, public hospitals offer lower salaries, insufficient resources, and poor infrastructure, deterring long-term commitment.

The state-sponsored "Scholarships for Placement and Training" program has produced mixed results. While it has increased the number of trained specialists, retention after mandatory service is low, showing that improving working conditions is essential.

Impact on the population: inequality, frustration, and erosion of trust

Health system deficiencies directly affect millions. Long waits, financial barriers to private care, and treatment uncertainty cause frustration, stress, and preventable suffering.

Inequities disproportionately impact women, rural residents, older adults, and trans individuals who face additional social and institutional barriers. The result is growing mistrust in the public system, leading to indebtedness, self-medication, or treatment abandonment.

In the long run, these deficiencies worsen public health outcomes and increase emergency service demand.

Toward a universal, equitable, and non-discriminatory system

Structural reform is essential. A truly universal system must guarantee access and quality regardless of income, gender, identity, or geography. This implies integrating public and private funding, eliminating fragmentation, and organizing care around need rather than market logic.

International models—like the NHS (UK), Canada's system, or Costa Rica's—offer valuable insights, though local adaptation is needed. Chile must invest in its public health network, improve working conditions, and commit to sustained infrastructure and technology improvements.

Such reform requires political will, greater public funding, and confronting private interests. While challenging, it is the only way to ensure that health is a right and not a commodity.

Conclusion

Chile's health system is at a crossroads. Endless waiting lists, specialist migration, poor management, and inequitable access have eroded public trust. Vulnerable populations suffer most. The challenge of building a universal, equitable, and non-discriminatory health system is urgent. It requires deep changes in financing, service delivery, and workforce development. It also demands an ethical and political commitment to social justice. Health must no longer depend on wealth, gender, or geography. It's time to put people at the center of the system.

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Conflicts of interest

The author declares that there are no conflicts of interest.

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