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Premature birth and Chilean public health coverage system: where are we?

Abstract

In Chile operates a national system to prevent premature birth supported by a universal scheme of guarantees aimed to provide access, timely treatment and financial protection to every woman under risk of premature birth. The aim of this article is to provide a short view on the strategies implemented in the country and the insurance organization towards the condition. It is possible to observe a strong sanitary organization designed to provide timely and evidence-based treatment no matter what insurance systems women possess. Nevertheless, it is possible to conclude that premature birth responds to many factors, and even when a health policy aims at its reduction, there are many others factors to take into account when it comes to its prevention.

Keywords: premature birth, health coverage, health guarantees

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Introduction

In Chile the premature birth is considered a public health issue. Its rate is about a 5-6% and has increased significantly in recent years.[1] Given that birth before 32weeks of gestation leads to a high risk of morbi-mortality in newborns and severe future health consequences, and because premature birth is responsible of the a 75% of perinatal deaths, since 2010 Chile has developed a national health protection system to face this issue.[2] In particular, as part of this system, a clinical guide was developed as a way to provide physicians and midwives scientific guidelines to prevent the premature birth. Also as part of this system, in Chile operates a scheme of explicit guarantees in medical conditions predefined by the Ministry of Health. One of these problems is premature birth, for which three different universal guarantees are considered. The first one is an Access Guarantee which is activated if there is a suspicion of premature birth risk. Every woman who is considered at risk will have access to a diagnosis confirmation. If the risk is confirmed, she will have access to treatment and future monitoring in special units.[3] On the other hand it also operates an Opportunity Guarantee. In case the woman is screened at risk, she will receive a prompt evaluation within 14days. In case of real risk of premature birth, defined as the presence of symptoms of premature birth, the guarantee assures an immediate medical evaluation before 6 hours. In case of imminent risk, the treatment cannot be delayed beyond 2hours.[3] Finally, the third guarantee regards the Financial Coverage as a way to prevent out of pocket and catastrophic expenditure.

These three guarantees operate both in public or private health system, which means that any woman at risk will have no matter her insurance system, a qualified attendance and evidence-based treatments. In the case of public system, women are admitted and treated in public facilities in special high-risk obstetric units where are permanently evaluated by obstetricians and midwives. In national statistics, during 2014 n=7,905 women were admitted in hospitals because of Disorders related to the condition, which represents the 20,8% of hospital admissions due to pathologies initiated in the perinatal period. Out of them, n=5,571 women were hospitalized for disorders related to short duration of gestation. This represents an increase in 100 women per/year in average. In the same year, n=656 newborns were registered as extreme premature (under 32weeks of gestation).[4] On the other hand, Chile counts with a mixed insurance system. If the insurance of women who delivered premature newborns is examined, almost a 60% of them are insured by the public insurance (National Health Fond), and only an 11% are insured by private institutions. The rest of women have different types of financing (e.g. out of pocket only).[4] The trend observed between the public and private system is repeated in other health problems, where the public system absorbs strongly higher risk cases, and receives the more economically vulnerable population.

The public insurance covers the 76,5% of population (estimation of 2012). As part of its management, the fond divides population into four groups according to their salaries from group A to D, being the group A the one with worst salary or homeless people, and group D the one with highest income. In average, one cycle of treatment/prevention of premature birth, costs about U$440 dollars in the case of woman. If the woman is classified in group A or B, the co-payment is 0%, but in the case of group C and D, the co-payment is 10% and 20% respectively.[3] This co-payment distribution allows a progressive expenditure. Unfortunately, no data is available regarding the direct or indirect costs of the premature child care, but they are presumed to be high. Even when the approach proposed in the guarantees scheme articulates three levels of care (primary, secondary and tertiary level), it is important to wonder why despite this complex articulation, a decrease in premature birth rates is not produced yet. Perhaps, what is missing is to consider the sociodemographic context of women and the health effects of a national post-transitional phase setting.

Conclusion

Given the importance and severe consequences of premature birth, Chile counts upon an articulated system to prevent it. This system articulates both public and private sectors in order to display evidence-based treatments. In a huge effort, premature birth was included as the 24th medical condition in a list of diseases prioritized by health authority. The public system has developed a strong financial protection scheme and an expedite access to specialized care in order to prevent the occurrence of premature birth. However, it is important

to highlight the great economic burden that premature birth and its future consequences provoke in health systems and maintain efforts to decrease its rates. Finally, it is important to remark that premature birth is classified as a syndrome, and as a result of a complex interaction of different types of factors. In the Chilean case it would be important to take into account not only sanitary factors as the unique answer, but also sociodemographic aspects (e.g. post transition phase) when it comes to premature birth prevention.

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Conflict of interest

The author declares no conflicto of interest.

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