

Changing Health Care Provider Incentives to Promote Prevention: The Chilean Case

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Due to the efforts of former President Ricardo Lagos's administration and the recent election of socialist President Michelle Bachelet, the former Minister of Health, the theme of health care reform resonates strongly in the political landscape of Chile. The Chilean government recently implemented a series of reforms in the health sector targeting inequity in health care, termed AUGE. AUGE explicitly guarantees all Chileans access, timeliness, quality and financial protection when seeking treatment for the most common illnesses in the country. The next set of health care reforms will most likely move past this direct impact on Chilean health care consumers and target one of the more deeply-rooted causes of health care inequity in Chile: provider incentives. In a developing country with enough resources to maintain a sufficient health care infrastructure but where the payment system has yet to drive health care spending to large scale inefficiencies, reform-

ing the role of preventive services in health care provision becomes particularly important to consider in the context of reform. Creating feasible health policy options in Chile necessitates analysis of provider incentives with respect to prevention in health care.

This paper examines the impact of different payment mechanisms on incentives for the provision of preventive services in the Chilean health care system. After providing a brief overview of the Chilean health care system, this paper examines the reasons underlying the need for the government to increase preventive services. It then details the preventive services already present in Chile and analyzes health care providers' current incentives for offering such services. Afterwards, it focuses on how to change provider incentives to encourage prevention in the Chilean health care system. Finally, this paper proposes a theoretical model to change these incentives and demonstrates how such changes could be implemented through the development of a pilot program.

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The Chilean Health Care System

The Chilean health care system enjoys high rankings in many of the World Health Organization's (WHO) health indicators, ranking thirty-second in the world for overall health system performance and twenty-third in the world for the overall level of population health.¹ However, this severely fragmented system is plagued with inequities, ranking 168th in terms of financial equity.² Examining these averaged statistics reveals large disparities in health care. For instance, Chile ranked first in the world in health for children under the age of five in 2000, but the infant mortality rate in the poorer municipalities was sixteen times as high as that of the affluent suburbs.³ This disparity arises, in part, from the differences between the major components of the health care system: private providers, public providers, private insurers (ISAPRES) and the public insurer (FONASA). By examining each of these elements, one can determine which providers and insurers the government must target with health policy to produce the maximum desired effect.

Chilean private health care providers are predominantly for-profit, privately owned practices, specialized clinics and hospitals. This highly lucrative sector is abundant in resources and draws many health care professionals away from the public providers, as many physicians split their time working between the private and public sectors. Public health care providers, on the other hand, form the network that serves the vast majority of the Chilean people. The Ministry of Health manages this network of providers through twenty-eight regional entities (Servicios de Salud) that receive money directly from FONASA and then determine the budgets for all of the public health care

providers in their jurisdiction. Public health care facilities consist of municipality-funded primary care centers, complex ambulatory secondary-care centers and tertiary-care hospitals varying in their resources and levels of specialization. While the public health care provider network spans all regions of Chile, the private health care providers are concentrated primarily in urban areas.

ISAPRES, the private for-profit health insurance companies regulated by Superintendencia of Health, offer coverage to roughly 17% of the Chilean population. While the government has defined a minimum package of services for the ISAPRES, they can offer a great variety of health care plans with respect to different prices and services offered in the private sector. In contrast, the public health insurer, FONASA, funded by the federal government's tax revenue and by premiums and out of pocket expenses from its beneficiaries, extends its universal health care plan to all those who wish to enroll, covering 69% of the population, including 83% of the elderly. FONASA classifies its beneficiaries into four groups according to income and number of dependents in order to determine co-payments for secondary and tertiary care in the public sector. The classification also determines access to the private health care providers at prices subsidized by FONASA. The disparity between the private and the public insurance sectors extends beyond the distinct socioeconomic profiles of their beneficiary populations (stemming from the ISAPRES' freedom to risk select) to the level of care provided by each insurer. Thus, in order to most effectively address the needs of the majority of the Chilean population, the government must target either the public health care provider network directly or use FONASA to effect this change indirectly.

Need for Prevention

After familiarizing oneself with the major elements and themes characteristic of the Chilean health care system, one can begin to recognize the Chilean government's immediate need to increase preventive services. In order to assess objectively whether the level of prevention in Chile is at its optimum, one must invoke tools of general economic analysis with respect to prevention and apply them to the Chilean situation.

Several unusual effects may confound the market for preventive services with negative consumption externalities, resulting in a less than optimal quantity of preventive services.⁴ Major information asymmetries abound among providers, consumers and insurers in the health care market, with consumers often lacking access to information about prevention and, even when given this information, not being able to translate it into preventive health decisions.⁵ Furthermore, the presence of health insurance as an intermediary between consumers and providers in a health care market effectively shifts much of the incentive for receiving preventive services to the insurer because of moral hazard. That is, as a significant fraction of the cost of curative medical care shifts from direct out-of-pocket payments to the health insurer, the consumer has less incentive to take preventive measures to reduce those costs. While available empirical evidence tends to suggest that moral hazard does not have as significant of an impact on under-consumption of prevention as once assumed, these studies are far from conclusive.⁶ Nevertheless, the Chilean government, as the major source of funding for FONASA, has much incentive to increase levels of prevention to compensate for this externality, which has gone unaddressed in Chilean health policy.

Preventive services can also lead to another type of externality by their very preventive nature. Measures to become vaccinated or to prevent other communicable disease taken by one consumer can benefit other free riding consumers, who do not receive the preventive services, yet do not catch the disease due to its decreased prevalence in the population. The overall benefit of prevention in a country is greater than the sum of the utility of each individual person receiving preventive services. While such analysis furthermore suggests major government intervention for the provision of more preventive services, the Chilean government must take into account the cost-effectiveness of increasing such prevention.

The government must examine which preventive services will be most cost-effective relative to curative treatment if the illnesses are not prevented. Additionally, it needs to determine whether increasing prevention now will be cost-effective compared to increasing prevention later. In the selection of which preventive services to emphasize, Chile must consider epidemiology in addition to the nature of certain preventive services. While increasing some preventive services (such as awareness campaigns) will not require major capital, other preventive services (such as vaccinations, laboratory testing, etc) require more resources. In order to analyze this second, temporal issue with respect to cost effectiveness for increasing prevention, one can justify this increase in the Chilean case with economic models regarding prevention as a dynamic externality⁷ to future generations or an investment in health.⁸ However, in the case of the strong Chilean economy, whose proportional health care costs have yet to inflate as rapidly as that of other similarly developing countries, the need to change health policy to correct this externality and increase the provision of preventive services stems primarily from

regional experience.

Preventive Health Care Services in Chile

The Chilean government has only recently begun to recognize the dearth of preventive services among its citizens. A significant part of the recent health care reforms passed by the administration of former President Lagos deals with increasing the curative services for the Chilean population. However, Chile has also begun to launch public health campaigns to promote awareness for vaccination, HIV/AIDS and communicable diseases and to make preventive services more accessible through primary care services financed with capitation. For instance, the primary care spending on immunizations increased 62% between 2000 and 2005⁹ and the number of preventive health examinations for adults nearly doubled between 2002 and 2005.¹⁰

While the public sector in Chile has always provided free preventive health evaluations for adults upon their first visit to a primary care center, a new health law targeting all citizens details a series of completely free and voluntary preventive medical tests, regardless of whether one is insured by FONASA or ISAPRES. One will receive these free preventive services from specified primary care providers, with the exception of three services offered in secondary and tertiary care centers.

These examinations are administered to asymptomatic people or those with high risk periodically throughout their life, in hopes of detecting preventable or controllable sicknesses or conditions and reducing the morbidity and mortality associated with them. The Ministry of Health decides which preventive exams to include and to what extent by first consulting

with the National Health Goal outlines for 2010, then judging whether the benefits of a test will outweigh its risks and, finally, seeing if adequate therapy is available to resolve a health problem if detected.¹¹ For instance, all adults currently have access to free diabetes, obesity and hypertension monitoring, whereas tests for tuberculosis and syphilis are available only to those at high risk. This reform also currently guarantees free tests for congenital diabetes, HIV/AIDS and syphilis for pregnant women high at risk and phenylketonuria and congenital hypothyroidism tests within a month following birth. For detecting the most widespread killers, free preventive examinations, such as Pap smears, mammograms and cholesterol monitoring, also become available as citizens reach the age of high risk. The spectrum of preventive examinations ranges from tobacco and alcoholism questionnaires for adolescents to comprehensive functional evaluations for those over sixty-five years.¹²

However, this new reform in prevention is only the first step in the right direction. While the increased access to these preventive services increases demand, the Chilean government must also target the supply side of this equation in order to assure that providers will truly offer these services. The Chilean government must address the root of the problem behind the provision of preventive services: provider incentives.

Current Provider Incentives for Prevention

The different mechanisms of payment in Chile create diverse provider incentives for prevention. Both FONASA and ISAPRES, as the country's public and private health insurers, respectively, currently transfer money

to private providers on a retrospective fee-for-service basis. FONASA also transfers funds to the public health care sector based on fee-for-service mechanisms, but these only cover certain services or groups of services assigned a fixed value. Payment for the provision of the rest of these health care services and facility maintenance costs comes from prospective historical budgets, which are often antiquated and thus undervalued. FONASA does not pay each public health care provider separately; funds are transferred to the public provider's corresponding regional health entity (*Servicio de Salud*) under the Ministry of Health, which then pools funds from all public health care providers in its area and determines budgets for each provider. FONASA also transfers money to these regional health entities for primary care facilities based on capitation, a means of allocating health care financing prospectively based on the region's specific health care needs and disease burden. It should be noted that the presence of this separate entity managing the budget of public health care providers does not eliminate any incentives based on payment mechanisms, but rather softens the impact of changes in these methods of fund transfer.

Each type of health care provider has different incentives for the provision of preventive services depending on methods of payment. Private providers always receive money on a fee-for-service basis with no ceiling on income, regardless of whether the source is a private insurer or FONASA. This retrospective payment system creates an incentive for the overproduction of health care services because health care professionals and providers have an incentive to induce demand, sometimes when it is not necessary.¹³ Furthermore, due to the new AUGE laws, Chileans are guaranteed waiting times, beyond which the government has to

buy services in the private sector if the public sector does not have enough resources. Subsequently, health care professionals who work in the public sector as well as the private sector can now transfer demand from the public sector, where they operate on salary, to their own private practices. This results in a decreased emphasis on prevention among private health care providers and nearly all health care professionals because preventive services, if administered effectively, will decrease the net flow of patients and overall demand for health care services.

Secondary and tertiary public providers as institutions in the Chilean health care system also have very little incentive to provide preventive services, but not for the same reasons as private health care providers. Since budgets of public providers comprise of both historical budget and fee-for-service payment mechanisms, each individual public provider will have incentive to provide more services, which have specific retrospective payments associated with them instead of those grouped together in the historical budget. The vast majority of preventive services offered by secondary and tertiary public health care providers do not have specific values attached to them, resulting in their underproduction because provision of these services does not change the amount of funding received from FONASA for each individual health care provider.

Although the mechanisms of payment in the Chilean health care system provide very little incentive for the efficient provision of preventive services for the vast majority of health care providers, incentive for prevention does exist at the most basic level: public sector primary care. The public primary care centers are funded, in part, by individual municipalities, but also by the federal government through capitation.

Each primary care center in the public sector will receive a set amount of money according to how many beneficiaries live in its catchment area. While this amount is partially adjusted for variables such as the proportions that are urban/rural, elderly and impoverished, it remains insufficient for the prediction of future health care costs. Nevertheless, this mechanism based on capitation creates an incentive to reduce the demand for services, such that the volume of patients is not as great. The ideal policy for achieving this is a focus on prevention. Using capitation as a method of fund transfer for primary care centers appears to function well with respect to the provision of prevention in Chile, as these centers serve as a gatekeeper to the upper levels of care in the Chilean health care system and already offer the majority of preventive services anyways.

However, the current payment mechanism creates tension between the primary health care providers and the secondary and tertiary providers, due to these dramatic differences in focus and approach to providing health care. This discourages efficiency in the provision of preventive services when they are actually administered, as the greatest results usually manifest themselves in the long term when prevention is carried out on a large scale. Although funding for each public health care provider comes and goes to the same Servicio de Salud in a region, the partially retrospective payment system does not encourage these providers to work together for the same long-term preventive goal. Instead, it creates a global inefficiency in the provision of preventive services by encouraging each public health care provider to work individually in looking for the short-term retrospective payment.

New Model for Provider Incentives

In order to create a new model for changing provider incentives to increase prevention and efficiency in its provision, one must first examine the different types of payment mechanisms possible. Table 1 provides a brief overview of the characteristics of several common payment mechanisms.¹⁴ The most logical place to start in designing a payment system that creates increased incentive for prevention is with a capitation model, such as the existing method of per capita fund transfer in the public primary care sector in Chile, which has already proven to be a successful payment system in promoting prevention. However, one must build a more sophisticated model beyond this simple capitation to ensure that equity in provision is maintained.

The generally accepted view of equity as an objective for health care systems consists of providing equality in opportunity and access to health care for the same health care need. In other words, an equitable health care system will ensure that the allocation of resources among persons or populations depends on each person or population's specific health care needs. Capitation represents one example of a framework for allocating health care financing by estimating individual consumption for a service at issue over a certain period and subject to a global budgetary restriction.¹⁵ By using the relative health care costs of each person based on his or her characteristics, models of risk-adjusted capitation are able to calculate a price for each person and maintain an equitable distribution of resources based on each individual's specific health care needs.¹⁶

Characteristics usually taken into consideration when adjusting for risk reflect the great-

System of Payment	Concept	Economic Incentive	Distribution of Risk	Predicted Effects	Efficiency	Quality	Public Intervention
Payment by Medical Service	One is paid for each individual service	Maximize the number of economic acts	It usually falls on the financier	i. Lack of prevention ii. High technology and quality iii. Induction of demand iv. "Corruption" v. Rate discrimination vi. Inequality	Incentive for activity and over utilization	+	Maximum rates
Payment by Salary	One is paid for time at work	Minimize the effort in work	i. Pure salary: Risk falls on the provider ii. Adjusted for productivity: Risk falls on the financier	i. Importance of promotions ii. Growth of staff iii. Cooperation among doctors	i. Can create incentive for activity and over-utilization ii. Over-importance of the role of doctors	+	i. Weaken business ii. Guarantee quality iii. Design of mixed systems
Payment per Capita	One is paid according to the affiliation with individuals to which one provides treatment.	Maximize affiliation and minimize costs of treatment	i. Per capita without correction: Risk falls on the provider ii. Adjusted per capita: Risk falls on the financier	i. Prevention ii. Diversion iii. Risk Selection	Promotes integration of preventive services when it is efficient	-	Control of quality through standards and promotion of competition
Payment for hospital stay	One is paid according for each patient and night	Maximize the length of stay and minimize average cost of stay	i. If not adjusted by payment: Risk falls on provider for expensive stays ii. If adjusted for rates according to expected costs: Risk falls on the financier	i. Increased average hospital stay ii. Unnecessary hospital income iii. Cost of stays minimized and on the ball iv. Sacking of ambulatory surgery	Promotes hospital activity	- +	Limit length of average hospital stay
Payment by hospital admission	A hospital is paid for each patient admitted, independent of duration of stay	Maximize the number of admissions and minimize average cost of each patient	i. If not adjusted by payment: Risk falls on provider for expensive stays ii. If adjusted for rates according to expected costs: Risk falls on financier	i. Increase hospital admissions ii. Reduce average stay iii. Re-admission of patients iv. Unnecessary hospitalization	Promotes hospital activity	-	i. Penalization for re-admissions ii. Exclusion of extreme cases iii. Adjust for rates
Payment by budget	One is paid according to concrete activity in a period	Maximize costs	It usually falls on the provider if there is no bill for individual services	i. Costly application ii. Compatible planning iii. Maneuverable margin for provider	Promotes efficiency, unless there is too much information asymmetry	-	Requires great effort not to fall into inertia

Source: B. Alvarez L. Pellisé y F. Lobos "Sistemas de pago a prestadores de servicios de salud en países de América Latina y de la OECD", Revista Panamericana de Salud Pública, vol 8, N°1/2, 2000. tr. Neel Butala

Table 1. Common Payment Mechanisms

est variation in health care expenditure. Diverse models of risk adjustment exist, ranging from strictly demographic models (based on sex, age, etc.) to socioeconomic models (based on mortality, morbidity, education, unemployment, standard of living, social class, rural/urban, etc.) to models based on diagnostics. The most prominent of these models based on diagnostics include the Ambulatory Care Group (ACG) developed at Johns Hopkins University and Diagnostic Cost Groups (DxCg) developed at Boston University and the Bureau of Health Economic Research.¹⁷ Payment systems using risk-adjusted capitation attempt to reflect the health care needs of an integrated population of heterogeneous individuals when assigning global budgetary ceilings.

The addition of risk-adjusted capitation ensures efficiency in the allocation of resources for the provision of health care on both population (macro) and individual (micro) levels. A capitation ceiling prevents population-level

inefficiencies associated with retrospective payment systems such as costs spiraling out of control. Furthermore, maintaining a retrospective payment system until this ceiling is reached and adjusting for risk solves many of the micro-inefficiencies otherwise caused by simple capitation, such as decreased effort and quality (skimping) or risk selection (selecting the most easily treatable conditions and dumping the more expensive procedures onto other providers).¹⁸ By reducing the variability between the expected cost of treating an individual and the financing that health care providers receive, risk-adjusted capitation reduces the incentives to risk select and improves health care quality.¹⁹ For instance, providers will be less likely to "cream skim," as their budgets already reflect the health care needs of the population.

At the core of this new model of risk-adjusted payment mechanism lie inherent incentives for increasing prevention. A capitation ceiling drives health care providers to decrease

the demand for their services and target the long-term health of their population. Providers have an incentive not to provide as many health care services as before because they are limited by a global budget. The most effective manner to approach this new ceiling is through increasing prevention because the primary goal of preventative services is to reduce the need for more care in the future, thereby reducing demand for future health care consumption. This overarching capitation ceiling also encourages efficiency in the provision of prevention; risk-adjusted capitation breaks down any previous individual incentives for health care providers in favor of a territorial prevention-based focus. Furthermore, as each patient will be treated in the most appropriate health care facility, this will eventually lead to greater efficiency of the health care system overall. The implementation of this model of risk-adjusted capitation will result in collaboration between health care providers in different levels to maximize the quantity and efficiency of preventive services offered.

Implementing Risk-Adjusted Capitation in Chile

This new model for changing provider incentives to encourage prevention has much potential as a viable health policy option in Chile. A feasible way to manage the trade-off between selection resulting from prospective payment mechanisms and inefficiency resulting from retrospective payment mechanisms is to use a mixed payment system containing aspects of both components. For instance, in the Chilean case this could entail the present retrospective fee-for-service and structural cost payments and the current partially prospective payment

for the rest of the hospitals' case mix and in-hospital ambulatory care units. This could also include a retrospective payment for preventive services. The operation of this system can be subject to incentives for good performance based on comparison among groups of hospitals through yardstick competition. Morbidity from hospital discharges, pharmaceutical prescriptions and ambulatory health care now become fundamental considerations. In addition to these current direct payment mechanisms, a risk-adjusted capitation payment mechanism to allocate resources to territories for their associated populations should manage the global budget.

In order to implement a risk-adjusted capitation payment mechanism, Chile must first determine which variables to consider when adjusting capitation by risk, as empirical studies have shown that many variables commonly used in this process do not predict future health care expenditure very accurately.²⁰ Capitation adjusted for risk using only age and sex as variables has shown only a 2% correlation with future health care expenditure in the United States in the context of payment from Medicare to HMOs.²¹ When one also includes previous hospital information, such as data on primary diagnoses, secondary diagnoses and procedure, the predictive power of this model increases to roughly 12% of future health care expenditure. However, when one additionally includes pharmaceutical expenses in this equation, the correlation between the predicted expenditure for a person and actual future health care cost increases sharply to upwards of 30%.

Chile can successfully implement this new model for risk-adjusted capitation, which accurately adjusts for 30% of risk, through use of extensive new data sets and powerful software. While it maintains an accurate census of the population, Chile needs data for individual

hospital and ambulatory consumption as well as individual pharmaceutical consumption codified according to standard specifications (International Codification of Diagnostics 9 or 10 and ATC, respectively). It will also be necessary to create a system of classification of patients in order to measure the complexity of hospital cases. Diagnosis Related Group (DRG) software will first measure the casuistry (case mix) of each hospital through analyzing current hospital data sets to determine information such as principal diagnoses, secondary diagnoses and specific procedures used. This will differentiate payment for the variable case mix from the payment used to cover expenses related to maintaining installed infrastructure. Once this mechanism of variable hospital payment is computed, one can then use Diagnostic Cost Group (DxCg) software to calculate diagnostics, procedures and pharmaceutical costs for each individual in order to determine a credible risk-adjusted capitation ceiling for each region or Servicio de Salud. However, this will only adjust for risk according to health care needs expressed in a hospital setting. Individuals without access to such health care facilities will be excluded from this data set. By using data from national health surveys, econometric software can determine this unexpressed health care need and create a more accurate model for risk-adjusted capitation according to the Chilean reality.

Exceptions to this model for determining risk-adjusted capitation do exist, given the unique geographic distribution of Chile and the consequent dispersion of the Servicios de Salud. For instance, regions and zones with very few inhabitants spread far between may necessitate allocation of additional resources in order to maintain certain levels of upkeep for installed infrastructure. Furthermore, national hospitals to which other health care providers

refer patients from all over the country may require exceptional allocation of resources for reasons regarding equity in access to health care.

This new model, when implemented in the context of Chile's unique health care system, can allow the inclusion of a special incentive for all health care providers under the jurisdiction of a single Servicio de Salud or region to sit down and work together to orient themselves towards the same long-term health goal for its population. If a region stays under its predetermined risk-adjusted capitation ceiling, such a surplus in funding can then be distributed partially among the different health care providers grouped under the same Servicio de Salud or region as an incentive to work together. This resulting integration between health care provider levels can mitigate the present lack of continuity between primary attention and secondary and tertiary attention in Chile and improve the efficiency of the system as a whole.²²


This new reform, creating a macro-efficient territorial allocation of health care resources among the different regions, will serve as a perfect complement to the other health reforms, which guarantee care regarding certain illnesses (AUGE), recently undertaken in Chile. AUGE assures micro-efficiency in the provision of health care services by guaranteeing individuals rights to timeliness, access, quality, financial protection and opportunity by law. In order to facilitate health care providers' response to meeting this law, each of these guaranteed health care services also has a specific value associated with it, effectively creating a retrospective fee-for-service payment system for providers. However, this micro-efficient retrospective payment system will now have a payment cap, which will prevent overproduction and inefficiency. With the gradual increase of AUGE

and the inclusion of methods to monitor the quality of those health care services not covered under AUGE so as not to discriminate among any health care needs, it becomes possible to achieve both micro and macro efficiency in health care with these new reforms.

While the incorporation of this new risk-adjusted capitation payment mechanism will drastically change the current provider incentives for prevention, it will not radically alter the overall progression of mechanisms for fund transfer in Chile. In fact, the Interagency National Commission currently developing this idea feels that implementation of this new payment mechanism will need only two years. This ceiling will accommodate the recent trend in the Chilean government to increase the number of health care services or groups of health care services with specific values attached to them in an effort to reduce the proportion of funding allocated to health care providers based on antiquated historical budgets. This movement forces health care providers to make their cost structures explicit, separating costs dependent on the case mix of each health care provider from the fixed costs resulting from installed capacity. With the implementation of this new change, the result will be a comprehensive mixed direct payment mechanism until providers reach their regional risk-adjusted capitation ceiling. In addition to inherently promoting prevention through incentives, this new payment system will have substantial benefits for improving health care quality, integrating different health care levels, containing costs and promoting equity in Chile.

While the Chilean government has already responded to the need to increase preventive health services by increasing demand for health care through the recently implemented AUGE program, the Chilean government must continue to increase the prevention activities

throughout the country. By analyzing the impact of changing payment mechanisms on prevention in Chile, one can determine that the most effective method of increasing this supply of preventive services is through implementing a new, risk-adjusted, capitation ceiling for macro resource allocation to each region or Servicio de Salud in context of a micro mixed payment system. A fundamental characteristic of this model of resource allocation is the integration of the different levels of health attention in order to generate greater coordination among networks of providers and increase efficiency and equity. Models similar to this are currently being developed in Cataluña, Spain, and harbor many similarities to the form of resource allocation of Kaiser Permanente in California. Many countries use these tools of territorial resource allocation through risk-adjusted capitation ceilings with different levels of sophistication or at least use the DRG case mix for resource allocation to hospitals. However, one should note how use of these tools does not guarantee the vision of health care integration that we propose, given the diversity of institutional scenarios in these distinct countries.

Once implemented in Chile, one can expect the empirical results to show that the resultant payment mechanism will harmonize with the other elements of the Chilean health care system to create correct incentives for the more efficient provision and greater amount of preventive services. 

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