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COUNTRY SPOTLIGHT

CHILE

BEST PRACTICES ON

Alternative Financing Models

CHILE'S RICARTE SOTO LAW: FROM AD HOC ACCESS TO A NATIONAL GUARANTEE

How a dedicated national fund turned ad hoc access into a guaranteed route to high-cost therapies

THE PROBLEM

High-cost therapies had no reliable route into Chile's health system

Chile entered the 2010s with broad coverage but **persistent gaps in financial protection**. Care ran through parallel public (**Fonasa**) and private (**Isapres**) insurers — a mix that widened coverage yet left uneven exposure to out-of-pocket costs, especially for therapies outside the standard benefits package.

The real gap was the **absence of a predictable route for high-cost interventions**. Guarantees like GES covered defined conditions, but many rare diseases, immunological conditions and select cancers sat at the edge of benefit design. For those patients, access could hinge on ability to pay, ad hoc administrative decisions, public campaigns, charitable fundraising, or the courts — an **equity problem** the system could not absorb.

Problem the system was trying to solve

NATIONAL ENTITLEMENT
Convert fragmented, ad hoc access into a defined national entitlement for selected high-cost diagnoses and treatments.

FINANCIAL PROTECTION
Reduce catastrophic household exposure for technologies outside routine benefits.

SOUND DECISIONS
Build a decision architecture balancing equity, evidence, affordability and fiscal discipline.

The question was no longer whether these therapies existed - it was how Chile could finance fair, predictable access to them.

Sources: 1. The Commonwealth Fund, 2026. International Health Care System Profiles: Chile; 2. Aguilera X, et al. Monitoring and evaluating progress towards universal health coverage in Chile. PLoS Med. 2014;11(9):e1001676; 3. Saldías-Fernández MA, et al. Ley Ricarte Soto, un particular estudio de caso para reflexionar. Rev Med Chile. 2025;153(4):279-293.

THE CATALYST & RESPONSE

A patient movement became a national law

The turning point was **social** and **political pressure** around patients who could not access high-cost treatments through existing coverage mechanisms. In 2013, journalist Luis Ricarte Soto, who was undergoing cancer treatment, highlighted the financial burden of high-cost medicines. He convened the **Marcha de los Enfermos (March of the Sick)**, bringing patients and families together to demand **state-backed financing** for treatments they could not afford. The mobilization helped turn individual access struggles into a **national policy priority**.

In response, Chile enacted **Law 20.850 (the Ricarte Soto Law) in 2015**, creating a national **Financial Protection System** for selected **high-cost diagnoses and treatments**. The Ministry of Health leads coverage policy and decision-making, Fonasa administers financial protection, and a dedicated Fund finances the approved benefits. To preserve sustainability, **the expected annual cost of covered treatments cannot exceed 80% of projected Fund resources**.

The solution combined three features

DEDICATED GOVERNMENT FUND
Ring-fenced financing separated from discretionary budgets - not simply add-on money.

NATIONAL-LEVEL ACCESS PATHWAY
Coverage tied to explicit decisions, defined protocols and approved provider networks.

FOCUS ON EQUITY IN ACCESS
Universal entitlement for covered diagnoses when criteria are met, regardless of ability to pay.

It did not simply add money to the system. It tied financing to explicit coverage decisions, clinical eligibility and monitored delivery.

Sources: 1. BCN, 2015. Ley N° 20.850. Crea un Sistema de Protección Financiera para Diagnósticos y Tratamientos de Alto Costo y rinde homenaje póstumo a don Luis Ricarte Soto Gallegos; 2. MINSAL, 2015. Ley Ricarte Soto – Preguntas Frecuentes; 3. Superintendencia de Salud, Gobierno de Chile. Ley Ricarte Soto – Orientación en Salud; 4. Armijo N, et al. Análisis del proceso de Evaluación de Tecnologías Sanitarias del Sistema de Protección Financiera Para Diagnósticos y Tratamientos de Alto Costo en Chile (Ley Ricarte Soto). Value Health Reg Issues. 2022;32:95-101; 5. Saldías-Fernández MA, et al. Ley Ricarte Soto, un particular estudio de caso para reflexionar. Rev Med Chile. 2025;153(4):279-293; 6. BCN, 2013. Tribute in memory of the journalist Mr. Ricarte Soto Gallegos, recently deceased.

HOW IT WORKS

One coordinated pathway, from evidence to treatment

The **Ricarte Soto Law** operates through a defined **national coverage** and **delivery pathway**: Technologies must be identified, evaluated and prioritized before a ministerial decree includes them.

1. IDENTIFY CANDIDATE TECHNOLOGY:
Requests go to MINSAL; technologies are screened against high-cost scope and available funding.

2. EVALUATE THE EVIDENCE:
The Ministry of Health's HTA function, ETESA-MINSAL, assesses clinical benefit and safety, economic and budget impact, pricing conditions, implementation feasibility, and ethical and social considerations.

3. PRIORITIZE AND DECIDE:
A prioritized recommendation informs the ministerial decree defining covered diagnoses, treatments and protocols.

4. CONFIRM ELIGIBLE PATIENTS:
Specialists submit cases via the Fonasa platform; confirmatory centers or expert committees validate eligibility.

5. PROCURE AND DELIVER:
Fonasa validates demand, and the National Health Services Supply Centre (CENABAST) purchases, imports where needed, to maintain treatment continuity.

6. MONITOR AND UPDATE:
Covered patients are tracked across eligibility, delivery and expenditure, while horizon scanning, periodic re-prioritization and price negotiation keep the benefit set current.

Inclusion of a treatment under the Law establishes a national coverage pathway, but **access remains tied to defined clinical rules**. Each patient must meet the **disease-specific eligibility criteria** set out in the relevant Ministry of Health (MINSAL) **protocol**, such as diagnosis, disease severity, treatment history or other clinical requirements.

The treating specialist submits the case through Fonasa for eligibility validation, after which treatment is provided at an approved center. This protocol-based process ensures that coverage reaches patients who meet the defined clinical requirements and that access remains consistent across the system.

WHY THE DESIGN MATTERS

HTA is particularly challenging for rare diseases and high-cost technologies, where the available evidence may be limited and the consequences of non-coverage can be significant. Once a treatment is guaranteed under the law, patients enter a traceable pathway linking eligibility, delivery and expenditure. Moreover, centralized procurement through CENABAST consolidates purchasing, supports price negotiation and enables coordinated supply through approved providers.

Protocol-based eligibility supports consistent access, while centralized procurement strengthens price negotiation and supply coordination.

Sources: 1. Armijo N, et al. Análisis del proceso de Evaluación de Tecnologías Sanitarias del Sistema de Protección Financiera Para Diagnósticos y Tratamientos de Alto Costo en Chile (Ley Ricarte Soto). Value Health Reg Issues. 2022;32:95-101; 2. MINSAL. Decreto Supremo N° 13 de 2017. Aprueba reglamento que establece el proceso destinado a determinar los diagnósticos y tratamientos de alto costo con sistema de protección financiera, según lo establecido en los artículos 7° y 8° de la ley N° 20.850; 3. Superintendencia de Salud, Subdepartamento de Fiscalización de Beneficios, 2025. Informe de Fiscalización FB N° 45: Análisis de la Trazabilidad de la Ley N° 20.850, cuarto trimestre de 2024; 4. CENABAST. Anuario 2021.

THE RESULTS

Access expanded into a guaranteed national entitlement

The law created a **national entitlement** to selected high-cost interventions for eligible patients. By Q4 2024, the Law had covered 73,629 users across all four insurance systems, Fonasa, Isapres, Capredena (military) and Dipreca (police), spanning 27 guaranteed health conditions.

Scale and reach of the Ricarte Soto Law

73,629	27	38,149	CLP 125.5bn	CLP 175.7bn
Cumulative users (Q4 2024)	Guaranteed diseases (Q4 2024)	Users in follow-up (51.8% of cumulative users, Q4 2024)	2021 CENABAST operational value	2025 Fund budget

Patients gain **100% coverage** for explicitly guaranteed high-cost medicines, devices or foods when protocol criteria are met, reducing their exposure to out-of-pocket costs. A 2025 decree adding therapies shows the model can expand when evidence, prioritization and fiscal rules align — while strengthening HTA-led decisions, transparency and centralized procurement.

Even at this scale, the Fund accounted for approximately **1.4% of FONASA's total expenditure** (2022), keeping high-cost coverage fiscally bounded even as access expanded. Pooled procurement through CENABAST enabled pooled purchasing, price management and coordinated national supply.

But the very features that impose discipline **create pressure over time**. A bounded fund improves predictability yet can lag behind innovation, inflation, new indications and demand. Staying effective means active updating, horizon scanning, price negotiation and — where uncertainty is high — **managed-entry** or **outcomes-based agreements**.

TRANSFERABLE INSIGHT

Chile's experience shows that **sustainable access** to high-cost therapies requires more than a dedicated fund. Financing must be linked to **HTA-led prioritization, protocol-based eligibility, centralized procurement and continuous monitoring**. These principles can help strengthen equitable access and financial protection in other health systems.

Countries do not need to replicate Chile's model exactly but can adapt its core principles to their own context. Establishing such a system requires **a sustainable financing base, strong institutions** and a **delivery network** capable of reaching eligible patients. Long-term success then depends on **regular reprioritization, price negotiation** and, where uncertainty is high, **managed-entry** or **outcomes-based agreements**. Access is secured by the complete pathway surrounding the fund, not by financing alone.

Sources: 1. Superintendencia de Salud, Subdepartamento de Fiscalización de Beneficios, 2025. Informe de Fiscalización FB N° 45: Análisis de la Trazabilidad de la Ley N° 20.850, cuarto trimestre de 2024; 2. CENABAST. Anuario 2021; 3. MINSAL, 2025. Decreto N° 36 de 2024. Modifica decreto N° 2, de 2019, que determina los diagnósticos y tratamientos de alto costo con sistema de protección financiera de la ley N° 20.850; 4. Superintendencia de Salud, Gobierno de Chile. Ley Ricarte Soto – Orientación en Salud; 5. Carlson JJ, et al. Linking payment to health outcomes: a taxonomy and examination of performance-based reimbursement schemes between healthcare payers and manufacturers. Health Policy. 2010;96(3):179-190; 6. Ferrario A, 2013. Managed Entry Agreements for Pharmaceuticals: The European Experience; 7. Armijo N, et al. Análisis del proceso de Evaluación de Tecnologías Sanitarias del Sistema de Protección Financiera Para Diagnósticos y Tratamientos de Alto Costo en Chile (Ley Ricarte Soto). Value Health Reg Issues. 2022;32:95-101.

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ANSEA ASIA OFFICE:

ANSEA CONSULTANTS PTE LTD
151 Chin Swee Road,
#07-12, Singapore 169876

Phone: +65 6956 6164
Website: www.anseaconsulting.com
Email: info@anseaconsulting.com

ANSEA EUROPE OFFICE:

ANSEA AG
Im Singeisenhof 9 ,
4125 Riehen, Switzerland

Phone: +41 61 5562114
Email: info@anseaconsulting.com

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