Towards Universal Health Coverage: the Chilean experience

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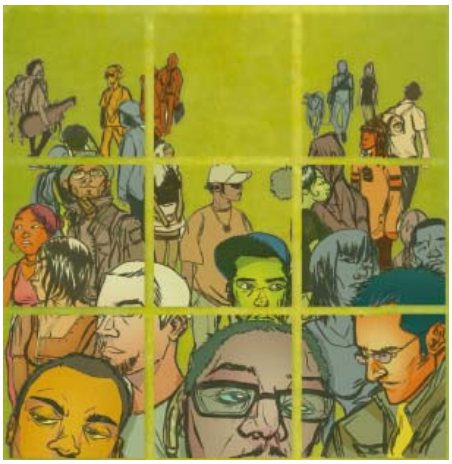
HEALTH SYSTEMS FINANCING
The path to universal coverage

World Health Organization



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World Health Report (2010) Background Paper, No 4

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Abstract

Notwithstanding good average health indicators, Chile has a poor ranking in terms of economic equality. In the last decades the epidemiological profile has changed substantially posing new challenges to the health-care system. As a result of reforms introduced during the military regime, the Chilean healthcare system is structurally segmented with low-income, high-risk populations being served mainly by the public sector and high-income, low-risk populations generally being treated in the private sector. A drastic intervention of public health policies was required. With the return to democracy, initial interventions were directed to capital investments in the health sector, improvement of primary care and tighter regulation of the private sector.

Beginning in 2000, a new set of reforms was proposed focussing on patients' rights and guarantees and increased equity in the financing system. The main result of the new legislation was the introduction of the AUGE Plan, a regime of explicit guarantees (access to treatment, opportunity, quality and financial protection) applied to a list of prioritized conditions progressively increased from 25 to 66. The identification of pathologies to be included was done through an *ad hoc* defined algorithm including criteria such as magnitude of the problem, effectiveness of available medical treatment, capacity of the healthcare system, costs and social consensus. The AUGE plan benefited both the subscribers of the public as well as the private systems. To cover the cost of the reform additional resources were identified, mainly in the form of a temporary increase in the consumer tax. The reform had to face numerous challenges during the parliamentary debate and was finally approved with some significant compromises. Several unresolved issues have been identified by scholars and social actors, and represent future challenges from ethical, methodological, organizational, quality-related, financial, as well as social and political perspectives. Solutions, however, may now lead away from the solidarity perspective at a moment in which Chile is facing a significant political transition led by a centre-right coalition.

Introduction

Health conditions in Chile improved considerably over the last decades. Life expectancy at birth is eighty years for women and seventy-three years for men, and the infant mortality rate is 8.6 per 1,000 live births. This success largely stems from improved living conditions resulting from socio-economic development and strong efforts in preventive care. The epidemiological profile has changed significantly, evolving from the preponderance of communicable diseases to a significant increase in non-communicable and chronic diseases. This advanced transition is associated with the ageing of the population, urbanisation, deterioration of the environment, and lifestyle factors. Notwithstanding good average health indicators, morbidity and mortality vary greatly across socio-economic groups and residency suggesting that programs and policies have not been effective in benefiting Chile's disadvantaged populations (Vargas and Poblete, 2008). This also reflects Chile's very low ranking in terms of economic equality[1].

The structural segmentation of Chile's health-care system has resulted in low-income, high-risk populations being served mainly by the public sector, while high-income, low-risk populations are generally treated in the private sector.

1 Health policies and reform in the transition to democracy (1990-2000)

1.1 The legacy of the military regime

In 1979, the military regime that came into power after the 1973 coup against socialist president Salvador Allende embarked on a sweeping health sector reform based on neoliberal doctrines (Unger J.P. et al., 2008).

As part of a broader process of reform, aiming at reducing the role of public institutions, social policy was oriented towards replacing the Welfare State (*Estado de Bienestar*) with a Subsidiary State (*Estado Subsidiario*) governed by the dictates of the market; in this context, the health sector underwent a process of privatisation, inspired by principles such as: individual freedom, justice, property rights and subsidization. In this system, justice meant receiving health care according to individual contribution through direct payment or through freely agreed insurance schemes (Dannreuther and Gideon, 2008; Burrows, 2008).

Burrows (2008) identifies the Chilean 1980 Constitution, passed under the Pinochet regime, as the starting point of that process:

[1] According to UNDP's 2005 Human Development Report, Chile ranked 9th to the last among all the countries of the world in terms of income equality.

> The Right to Health Protection
>
> The State protects the free and equal access to the actions of promotion, protection and recovering of health and rehabilitation of the individual. It falls to the State to co-ordinate and to control those actions related to health. The preferred role of the State is to guarantee that the execution of health actions fits with the norms and laws, even if actions are performed by public or private institutions. The law may enforce mandatory insurance premiums. Each person has the right to choose which health system to use, either the private or the public one.

A private health insurance system, ISAPRES (Instituciones de Salud Previsional), was developed and coexisted with the public system, but was intended to be the predominant choice (Unger J.P. et al., 2008).

The National Health Fund (FONASA) was created in 1979 as a public agency to collect and manage the resources coming from the compulsory contributions of employees who chose to remain in the public system (or who could not afford an adequate plan with an ISAPRES company), and from the national government's health budget (Unger J.P. et al., 2008).

Within FONASA, entitlements depended upon earnings-related contributions. Coverage within FONASA was stratified into four groups, A through D: A, indigent; B, very low income; C, lower-middle income; and D, higher-middle income. Users of categories A and B were entitled only to services provided by public hospitals and clinics. The lowest income groups were entitled to free care directly from FONASA but were only eligible for certain services and important exclusions existed. Groups C and D could opt to use private providers within their FONASA agreement, but users had to make co-payments since FONASA only covered up to 50 per cent of private provider charges (Dannreuther and Gideon, 2008; Unger J.P. et al., 2008).

The private health system, ISAPRES, was created in 1981 to manage the payroll contributions of those opting out of the public system. The private companies purchased most health care from the private sector, which received a significant boost. The ISAPRES market offered no fewer than 8,000 different individual plans, designed according to sex, age, health risk, supplementary premiums, and co-payments (Unger J.P. et al., 2008).

Users signed contracts which established the degree of coverage and type of benefits for individuals and their dependants. The benefits offered varied according to the premium paid and the health risk of the insured person(s). Contracts lasted one year, after which time the ISAPRES insurees were entitled to change their coverage and cost. There was no minimum standard and health plans were legally allowed to exclude pre-existing health conditions (Dannreuther and Gideon, 2008).

Within the public sector pre-existing divisions between blue- and white-collar workers were completely eliminated in 1986 with the establishment of a uniform compulsory health insurance contribution of 7% of the salary (Dannreuther and Gideon, 2008).

The market concentrated on the affluent and young clients with lower health risks: the mean income of ISAPRES members in 2003 was more than four times higher than FONASA members and the profits of ISAPRES exceeded 20% (Unger J.P. et al., 2008).

Bias in Accessing Entitlements

With the dual system some relevant bias in accessing entitlement became evident, whereby in such a two-tiered system, the public sector was seen as the provider of last resort.

With no mechanisms in place to take into account changes in the demographic and epidemiological profile of the population, health conditions related to the changing lifestyles and ageing of the population were left out, whereby the improvement rates of health outcomes were greater and faster among the top quintiles, while the poorer sections of the population had higher rates of infectious diseases such as tuberculosis (World Bank, 2007).

Gender biases were also observed, because, within FONASA, women could be either covered in their own right or included as dependants of their husbands if they were not formally employed, whereas men could not be included as dependants of their wives. This was not the case in ISAPRES where both men and women could access the system as individual beneficiaries or as dependants. Due to the well documented gender gap in wages, a key factor limiting women's access to the ISAPRES, the majority of ISAPRES members were men aged between twenty-five and forty-nine (females represented only 32% of ISAPRES members in 2001).

In addition, women of reproductive age were required to pay higher premiums within the ISAPRES (at least two or three times greater than those paid by men of similar age) and would lose any entitlement to services associated with labour or maternity if these higher premiums were not paid.

Co-payments required for additional services represented a serious barrier for certain economic groups, forcing about one-quarter of ISAPRES users to use public services. The notorious gender gap in wages also reduced women's ability to make additional co-payments compared to men.

Lack of health provision was highlighted as an issue by Chilean home-workers and represents an important concern for informal workers in general (Dannreuther and Gideon, 2008).

Elderly people had lower benefits and coverage unless they paid higher premiums while expenses related to HIV/AIDS treatment were also not covered by the private system (World Bank, 2007).

Organizational issues

From an organizational point of view, the National Health Service was transformed into the National Health System, which included, at that time, 26 autonomous territorial health services (currently there are 29). These entities took over the responsibility for hospital care, while the oversight for more than 300 primary health-care facilities was transferred to municipalities. The funding of public health services was drastically reduced and as a consequence, the supply of health care in public facilities was restricted. (Unger J.P. et al., 2008).

The government presented this strategy as decentralization, however the control of financing and programmes remained in the headquarters. Thus, from this arrangement, grew a complex bureaucracy as each new unit needed administrative support. In addition, with all of the civil authorities under military control and the Health Minister himself appointed by the army, the existence of unions or social organization activities was severely restricted (Infante, 2008).

Two parallel systems of financing and service provision now existed. The financing function was separated from service delivery, resulting in a deeply segmented health-care system which generated even greater inequities and inefficiencies characterized by clear differences in the quality of care and access to services across different income groups. Thus, resources were disproportionately allocated to healthy and young individuals in the private system (Dannreuther and Gideon, 2008; Zuñiga Fajuri, 2007). In addition, preventive measures and health promotion were highly under funded.

Referrals were also a problem in the public sector (from the primary health-care network into hospitals), as well as between the public and private sectors (lack of entry mechanisms that would allow an individual from the public sector to receive services in the private network). The public hospitals and health centres lacked personnel and equipment, thus generating long delays to services. In addition, inadequate working conditions resulted in frequent strikes by health workers (World Bank, 2007).

According to some authors, rather than health service users, the main beneficiaries of the reforms have been the private health insurance companies, some of which are owned by transnational corporations. The longstanding role of economic institutions based in the United States of America in the Chilean economy, especially since the ‘Chicago Boys’ became the main advisers, has also sustained the technocratic nature of policymaking in Chile (Dannreuther and Gideon, 2008).

The first democratic government after the military regime found a dual health system. A private, well-provisioned network to serve the ISAPRE´s wealthy people and an agonic public system to provide care to

the majority of the population. The public system was characterized by public hospitals with deteriorated heating power and ambulances, very basic x-ray systems, beds without sheets and mattresses, a very poorly paid and unmotivated work force, and a therapeutic arsenal stuffed only with basic drugs. However, most public health programs continued to be operational. After 17 years of military government, the country was experiencing growing inequity and while facing a deep epidemiological transition, a drastic intervention of public health policies was required (Infante, 2008).

1.2. Back to democracy. Health policies and interventions in the 1990s

In March 1990, a coalition of centre-left wing parties came to power and captured all the elections until the most recent presidential contest (January 2010) that brought a right wing coalition back to government power after 20 years,[2] most of which have been characterized by a social policy that has been broadly defined as "social democratic" and seeking to attach a Western-style welfare state to a dynamic emerging market economy (Unger J.P. et al., 2008).

Health sector investments

During this period, the priorities were to invest in health infrastructure, hospital goods and equipment, increase of personnel salaries and the creation of new positions.

Public expenditure on health increased dramatically from 1990 to almost three times more in constant *pesos* in less than a decade. While the proportion of public expenditure on health remained fairly stable at around 3% of the gross domestic product, up from a low of 2% in 1976, economic growth explains the increase in absolute numbers. Private expenditure remained stable as a proportion of gross domestic product, but increased sharply in absolute numbers. To fund the increase in public expenditure a tax reform was approved that reversed the tax reductions of the Pinochet years (Unger J.P. et al., 2008).

The average investment in infrastructure and equipment in the 1990s was US$ 86.5 millions per year in comparison with the US$ 15 million per year in the 1980s. In the first years of democracy about 30% of the investment money came from multilateral financial institutions. Currently, the investment is entirely based on national resources. Public hospitals have modern equipment and in several areas they regained the scientific and technical leadership they held in the past.

Some would argue that a significant amount of increased public spending went into salaries without an increase in productivity. In contrast, clinicians argue that clinical procedures improved considerably in terms of safety (Infante, 2008).

2 The new President will take office on March 11, 2010.

Primary Health Care (PHC)

The democratic government maintained the first level of health care under municipal administration, but the authorities were now elected instead of appointed by the central government as it was during the military regime.

Procedures to refer patients were introduced, facilitating the flow between different levels of care, and Primary Health Care became a key element for the performance of the health sector.

Currently, 30% of the health budget goes towards PHC. Specific programmes have been introduced for child and adult acute respiratory diseases and have already demonstrated a remarkable impact on mortality. Similarly, guarantees were introduced to ensure access to care for people suffering diabetes, hypertension, epilepsy and depression.

Resolutive capacity was increased by including psychological support, kinesiology and specialized counselling as a part of the services offered at the primary level, as well as by increasing the availability of both drugs and diagnostic technology. Primary care emergency rooms (SAPU) absorbed a great number of the emergency care cases previously delegated to hospitals, whereas priority was given to family health and preventive programs (Infante, 2008).

Between 1999 and 2003, the public insurer (FONASA) implemented a Catastrophic Care Program. It included about twenty health benefits that were costly because they required highly specialized professionals and technology, negatively affected public hospitals' financial standing, and increased patient waiting lists (Vargas and Poblete, 2008).

Governance

Among the first regulatory interventions instituted by the new democratic government in March 1990, was the creation of the ISAPRES Superintendence which was designed to regulate the administration by the private sector of the compulsory 7% monthly income contribution. In 1995, it was ruled that the employee would be the owner of his unused annual contribution and, in 1998, the 2% public subsidy of the ISAPREs system was eliminated (Infante, 2008).

2. Pursuing Universal Access. Health Reforms 2000-2009

During the first decade of democratic government most efforts concentrated on the management of the sector. It was only under President Lagos' government (2000–2006) that a new comprehensive health reform plan was initiated. Prior to that time, reform projects had followed the World Bank's recommendations, mainly focusing on management issues and budget control without facing the long-lasting inequities.

In his inaugural speech before the National Congress, President Lagos indicated that one of the main goals of his administration would be: "*to carry out a deep healthcare reform, focused on the rights and guarantees of the patients and a solidarity-based financing system*" (Lagos, 2000).

2.1. Explicit guarantees and solidarity-based financing system

A reform process, centred on the National Health Objectives for the decade 2000-2010 and aiming to reduce the equity gap, was initiated in 2000 by drafting a set of laws that President Lagos' Administration (2000–2006) submitted to the Parliament in 2002. The reform aimed to ensure universal access, opportunity of care and financial protection for the most prevalent health problems that represented 60 to 70% of the disease burden of the Chilean population.

The deepest strategy twist, however, would lie in empowering people to recognize their legal right to health care and equal opportunity to access it, regardless of socioeconomic conditions (Infante, 2008; Paho, 2007).

By the year 2005, the Chilean Parliament had approved the four following health-reform laws (Letelier and Bedregal, 2006).

1. The Law N. 19,888 of 2003. Provide the funding necessary to ensure priority social objectives of the government.

- The law guarantees financial resources for the Plan AUGE based mainly on an increase of V.A.T by 1% (Chile, 2003).

2. The Law N. 20,015 of 2005. Modifies law N. 18,933 on Heath Insurance Institutions.

- Known as the private health insurances law, it ensures stability of the private system and protects affiliates. The law regulated the unilateral increase by the ISAPREs of the health plan cost, as well as the "skimming practice", reducing the possibility of the insurance companies to drop out risky affiliates (Chile, 2005).
- Since 1998, the number of ISAPREs' affiliates is decreasing, most likely as a result of stronger regulations, while, at the same time, their average income has increased so that the ISAPRE´S profit

has also increased. In 2005, the Superintendent role widened to include the supervision of public insurance (Infante, 2008).

3. Law N. 19,937 of 2004. Establishes a new concept of Health authority and management and strengthened civic participation.

- The law reviews different aspects of the Health Authority and establishes a network of Autonomous Hospitals. It sets the structure of the health sector according to different functions (care, regulation, finance), strengthens the health authority and establishes conditions for greater flexibility in managing hospitals. It splits the former Under Secretariat of Health into two under secretariats: the Under Secretariat of Public Health and the Under Secretariat of Health Care Networks. It also reorganized the former ISAPREs' Superintendence into the Health Superintendence, responsible for overseeing ISAPREs, the National Health Fund (FONASA), as well as public and private health-care providers (Chile, 2004).

4. Law N. 19,966 or AUGE law of 2004. Establishes a System of Universal Access and Explicit Guarantees in Health.

- This law established the Universal Access Plan with Explicit Guarantees with predefined health conditions for access, opportunity, quality of services and financial protection. The so called AUGE Plan (Chile, 2004a).

Due to its relevance for universal coverage, we will focus on the changes introduced by Law No. 19,966.

2.1.1. The AUGE Plan

The key elements defined by the Regime of Explicit Guarantees in Health, Law 19,966, are:

- A medical benefits package consisting of a prioritized list of diagnoses and treatments “with Explicit Guarantees” for 56 health conditions;
- Universal coverage for all citizens;
- A set of Explicit Guarantees specific to the universal health plan and enforced by law (Bastías et al. 2008).

The prioritized list

The departure point for the design of the prioritization plan included all interventions that were provided by the system at that time and that constituted the default health plan. An algorithm to provide analytical support to the discussion on priorities was constructed based on: magnitude, effectiveness, capacity of the health-care system, costs and social consensus.

Magnitude

- Epidemiological indicators measuring the burden of disease for different conditions: incidence, prevalence, and mortality rate with the main ranking criterion as the DALY[3]. Mental health conditions, and conditions that generate partial disability and, therefore, a significant decline in the quality of life, were also considered priorities.

Effectiveness

- The possibility of affecting the outcomes of the condition through medical treatment was assessed; health conditions were stratified into high, medium, and low treatment effectiveness, and those conditions with high or medium treatment effectiveness were pre-selected.

Capacity of the health-care system

- The feasibility of guaranteeing treatment to all citizens, regardless of their place of residence and socio-economic status, introduced an equity element in order to reduce the existing gaps in mortality across socio-economic groups;
- A comprehensive analysis of the existing public and private health infrastructure and the evaluation of their capacity to deliver the services; the group of conditions for which it was deemed enough available resources existed was pre-selected.

Costs

- Estimation of cost per case and total cost per condition based on treatment protocols suggested by experts and national scientific associations.
- High-cost conditions were identified as those with annual treatment costs greater than or equal to the annual minimum wage (US$ 2,697).

Social consensus

- People's preferences were elicited so that reformers could use the gathered information to prevent special-interest groups from defining the health plan (Bastías and Valdivia, 2007; Vargas and Poblete, 2008).

3 The Disability Adjusted Life Years (in Spanish: *Años de Vida Saludable Perdidos, AVISA)* is a time-based measure that combines years of life lost due to premature mortality and years of life lost due to time lived in states of less than full health.

Health conditions prioritized under Chile's universal health care plan				
2005		**2006**	**2007**	**2010**
1. Delivery care with analgesia	17. Chronic renal insufficiency	26. Refractive errors	41. Arterial hypertension	57. Epilepsy in patients over 15 y.
2. All childhood cancers	18. HIV/AIDS	27. Tooth loss in older adults	42. Encephalitic vascular accident	58. Bronchial Asthma in patients over 15 y.
3. Cervicouterine cancer	19. Cataracts	28. Surgery requiring prosthesis	43. Diabetes mellitus, types 1 and 2	59. Parkinson
4. Breast cancer	20. Major burns	29. Hypoacusis	44. Prematurity	60. Juvenile idiopathic arthritis
5. Leukaemia (adults)	21. Polytrauma with or without medullary lesion	30. Benign hypertrophy of the prostate	45. Retinopathy of prematurity	61. Hip dysplasia
6. Lymphoma (adults)	22. Hernia of the nucleus pulposus	31. Pneumonias in older adults	46. Difficult breathing of new-born	62. Integral Oral health in pregnant women
7. Testicular cancer	23. Tumours and cysts of the substantia nigra pars compacta	32. Orthotics for older adults (canes, wheelchairs, others)	47. Accidents requiring Critical Patient Unit care	63. Multiple Sclerosis
8. Prostate cancer	24. Aneurysms	33. Haemophilia	48. Rheumatoid arthritis	64. Hepatitis B
9. Stomach cancer	25. Diabetic retinopathy (children under 9 years)	34. Cystic fibrosis	49. Degenerative osteoarthritis	65. Hepatitis C
10. Cancer of the gallbladder and bile duct		35. Scoliosis	50. Epilepsy (program to improve management in children)	66. Prevention of renal chronic disease
11. Terminal cancers (palliative care)		36. Depression	51. Eye trauma	
12. Ischemic disease (myocardial infarction)		37. Alcohol/drug dependence	52. Detached retina	
13. Behavioural disorders		38. Psychosis (severe psychiatric disorders)	53. Strabismus (children under 9 years)	
14. Congenital heart disease (operable)		39. Bronchial asthma	54. Acute respiratory infections (children under 15 years old)	
15. Neural tube defects		40. Chronic obstructive pulmonary disease	55. Comprehensive oral health	
16. Cleft lip/palate			56. Dental emergencies	

Universal Coverage

The Plan committed public funding for health care of people without an income and established compulsory contributions for independent workers. Execution of the AUGE Plan began gradually, and since 2007 all health problems covered under the plan are now included (Paho, 2007).

The law introduced the adoption of a Verification Study, with a defined methodology and implementation procedures, which would ensure that the costs derived from the inclusion of health conditions benefiting from Explicit Guarantees would be defined in a specific amount of resources that is defined by the Ministry of Finance (*Ministerio de Hacienda*).

To that end the Finance Ministry defines a Universal Premium (*Prima Universal*), which is a value defined in UF (*Unidades de Fomento*)[4] that represents the average economic cost of ensuring, to all subscribers of both ISAPRES and FONASA, access to the full list of prioritized health conditions during 12 months. In this way, each time that the Government decides to increase the number of conditions in the list, the proposal must undergo the same Verification Study and resultant costs will not be allowed to exceed the Universal Premium.

To allow for the gradual introduction of prioritized health conditions, in 2005, it was established that Explicit Guarantees would be applied to a maximum of 25 pathologies, for which the total expected individual cost could not exceed the Universal Premium of 1.02 UF. Starting in 2006, Explicit Guarantees would be applied to maximum of 40 pathologies, with a Universal Premium equivalent to 2.04 UF; and from July 1st 2007 the number of conditions will be brought to a maximum of 56 and the Universal Premium to 3.06 UF (Chile, 2007).
Afterwards, the value of the Universal Premium will be readjusted according to the real variation of the General Index of Hourly Remuneration (*Indice General de Remuneraciones por Hora*) calculated by the National Institute of Statistics (*Instituto Nacional de Estadísticas - INE*).

In its last adjustment, which created the list of health conditions under the Plan AUGE 66, the expected costs per capita were calculated to be 3.13 UF and, thus, below the adjusted reference Universal Premium of 3.47 UF[5] (Chile, 2009).
The Ministry of Health estimated that since 2002, when only three pathologies were covered under the Pilot AUGE Plan, 4.2 million Chileans have benefited from the Explicit Guarantees, 74% of which belong to the poorest sector of the population (Chile, 2009).

The health policy framework and plans slated for the current Administration's term (2006–2010) call for increasing the number of health problems covered by the AUGE Plan from 56 to 80 by 2010 (Paho, 2007). The decision to bring the total of granted care conditions to 66 and the improvement of a number of previously introduced "guarantees", was taken before the end of the year 2009 by the AUGE's Consultative Committee, and should become effective by July 2010, after the signature of the President and the approval of the Controller (Chile, 2009).

Explicit Guarantees

Explicit guarantees foreseen by the law include: access, timeliness (opportunity), quality and financial protection.

4 The Unidades de Fomento are inflation-linked currency units inroduced in Chile since 1967; its value is calculated by the country's Central Bank on the basis of the Consumer Prices Index provided by INE.
5 Equivalent to aprox. 38 USD on January 1st 2010

Access is related to the fact that the prioritized set of services is guaranteed to all; the plan enforces, by law, the legislation that both private insurers and public health services offer the mandatory benefit package.

Opportunity defines a maximum waiting period for receiving services at each stage. This time is variable depending on diagnosis and settings defined for the condition. *Ex*. Renal terminal chronic insufficiency: initiation of haemodialysis: 7 days from confirming the diagnosis. Hip surgery: 240 days from confirming diagnosis.

Quality is defined through the set of activities, procedures, and technologies necessary for treating the medical condition that can be provided only by registered and accredited health providers; standards and accreditation mechanisms are defined by the Ministry of Finance (*Ministerio de Hacienda*).

Financial protection is defined by the maximum that a family can spend on health per year. Indigent and very low-income people (FONASA groups A and B) are exempt from any payment. For the rest, the co-payment charged to the beneficiaries cannot exceed 20% of the reference price defined by the health authority. Maximums differ depending on the family's income, thus protecting the principles of equity, inclusion, and redistribution (Bastias et al., 2008; World Bank, 2007).

Financing the Plan AUGE

The financial commitment to cover costs was calculated based on foreseen demand. (Bastías and Valdivia, 2007)

Law 19,888 stipulated that resources will be derived from:

- a temporary increase in the consumer tax from 18 to 19% between October 1, 2003 and October 1, 2007 (although President Bachelet has extended the tax increase for a longer period);
- the tobacco tax;
- customs revenues;
- sale of the state's minority shares in public health enterprises.

As additional sources of funding, the reform also considered pre-existing FONASA funds, potential increases in co-payments, budget increases from economic growth, and potential reallocations of resources from other sectors.

To mitigate fiscal pressure, the reform was implemented in stages and considered the progressive addition of medical conditions to the list of priority diseases.

The new Health Superintendence took over the functions of the previous Superintendence of ISAPRES, and was also placed in charge of the FONASA budget regarding the treatment and services of the guaranteed list of conditions. Thus, this new institution is the first body to supervise public and private funds together (World Bank, 2007).

Between 2002, year when the reform was presented to Parliament, and 2007, two years after the approval of the full reform package, the Public health expenditure more than doubled, passing from US$ 2.018 millions to US$ 4.417 millions (current value)(Fig. 1)

Per capita health expenditure, both total and public, did not sow substantial changes with respect to the steady increase observed since the 1990s (Fig. 2). A more substantial change can be observed in terms of the proportion of public versus private health expenditure, whereby in 2002 the former becomes prevalent reaching 52.7% by 2006. It is also interesting to note that, parallel to the decreased private expenditure, the out-of-pocket component represented 54.8% of this increase by 2006 (Fig. 3). Altogether, in the same period, the total health expenditure (public and private) as percentage of the GDP progressively decreased from 6.2% in 2002 to 5.3% in 2006 (WHOISIS, 2010).

Fig. 1
Chile - Public health expenditure 1987-2007

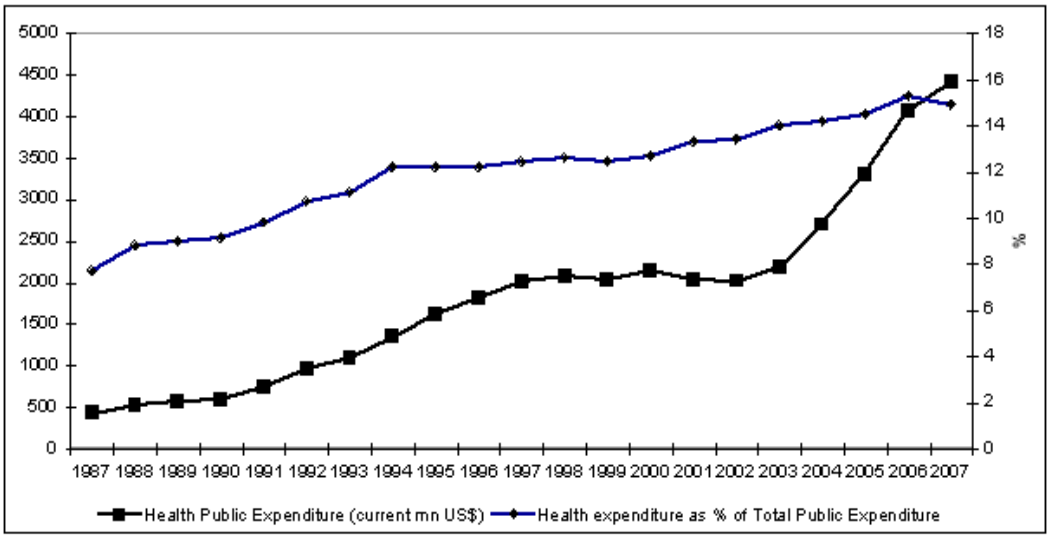
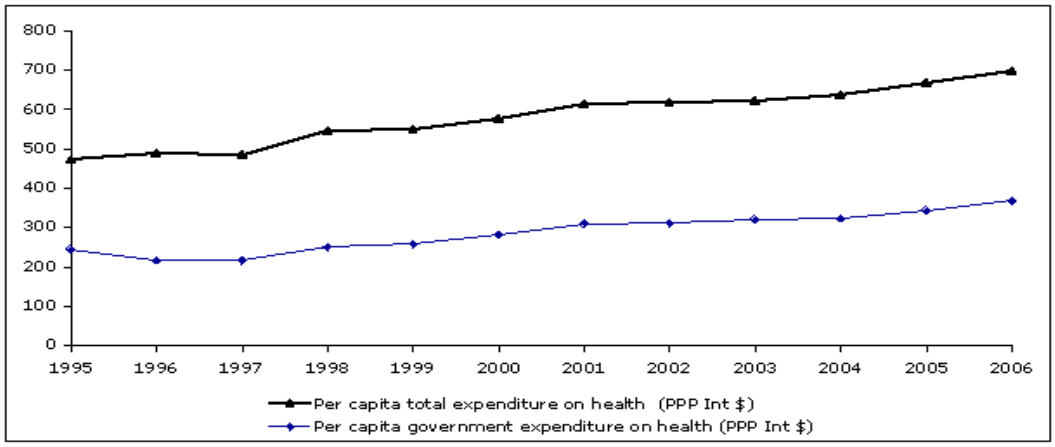
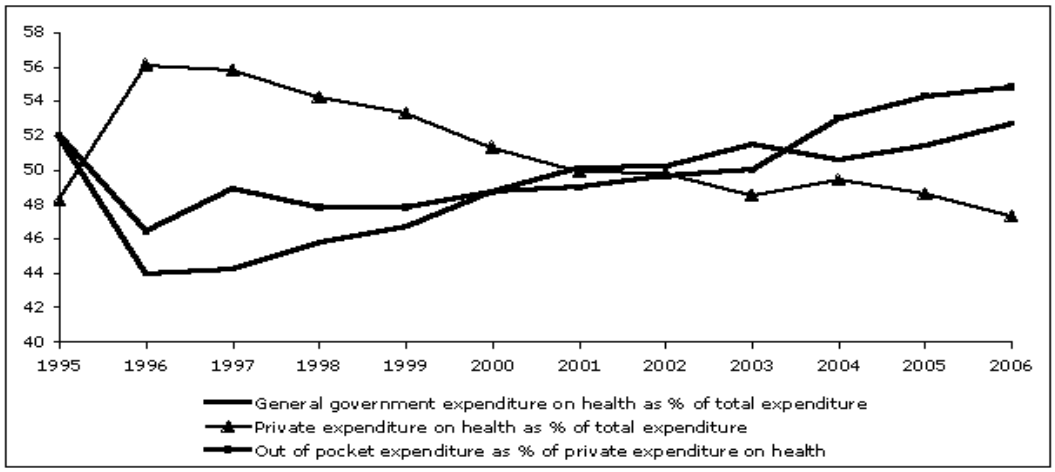


Fig. 2
Chile - Per capita total and public health expenditure 1995-2006



Source: WHOSIS, 2010

Fig. 3
Chile - Public and private health expenditure as percentage of total expenditure 1995-2006



Source: WHOSIS. 2010

Delivering the Plan AUGE

The universal health plan is delivered by prearranged provider networks which established by both the public and private sectors. (Bastías et al., 2008)

2.2. The Reform process and its challenges

Debating the Reforms

Ricardo Lagos took over the Presidency of Chile in 2000 as the first Socialist President since Allende held office in 1971. Early on, he expressed his decision to implement a wide-reaching health sector reform and to

overcome important inequities present in the system.

The Reform had to be based on principles such as: a) the right to health, including mechanisms of social protection, universal access to appropriate and opportune care, in accordance with national capacities and resources; b) equity; c) solidarity; d) efficient use of resources; and e) social participation in health. (Román and Muñoz, 2008).

An Inter-ministerial Committee on Health Sector Reform was created to design and propose changes to the health system. The committee included representatives of the Ministry of Health, the Chilean Medical Association, health workers unions, and private health providers.

Four main challenges were identified: the progressive ageing of the population, the increasing cost of health services, the inequalities in the health status of different socio-economic groups, and a gap in the health conditions of different socioeconomic groups. To effectively deal with these issues, both the type and quality of services and the mechanisms of delivery needed to be changed.

Thus, the inter-ministerial committee identified four objectives for the 2000-2010 decade: (a) improving existing health indicators; (b) addressing the new demands derived from the ageing and the changing health profile of the population; (c) closing health gaps and inequalities across socioeconomic groups; and (d) improving the scope, access to, and quality of services according to the expectations of the population (World Bank, 2007).

Four working groups were established, including trade union members, academics, physicians and service providers, the private health insurance companies, the ISAPRES and a ‘Citizenship and Health Group” made up of NGOs and civil society representatives, including grassroots women’s groups and neighbourhood associations. Lack of participation in the debate and design of the reforms could and would have affected its responsiveness in terms of meeting people’s health rights. In fact, Lagos did attempt to bring new actors into the debate and different groups of civil society actors were invited to participate. Nevertheless, the decision-making process reflected a longstanding bias towards technocratic decision making and entrenched interests. This was reflected in the break down of the Working Groups in October 2001 as many participants felt they were excluded from any real decision-making processes (Dannreuther and Gideon, 2008).

The above described set of bills was ready to be send to the Parliament in 2002, although conflicting positions emerged early in the debate.

The Chilean Medical Association (*Colegio Médico*) opposed the reforms, which they considered an attack on their right to autonomy to practice and a first step towards a USAstyle, managed health-care system. In 2002,

opposition to the reforms was manifested through a series of strikes held by doctors and other health workers (Dannreuther and Gideon, 2008). President Lagos stepped in to support the reform and his involvement resulted in various agreements with health workers, including projects on a "new institutional structure" and "status of public employees." The new vision was based on the belief that the public and private health sectors could be co-ordinated and could operate under a common system of rules, to achieve an optimal allocation of existing resources (World Bank, 2007).

The reforms in the public system easily found support in Parliament; however, in the last instance, due to resistance from the ISAPRES (and the private sector more broadly as well as conservative elements of the Government), Lagos was forced to sacrifice the proposed Solidarity Fund that would require the ISAPRES to redistribute funds to the public sector in order to secure the AUGE. Proposed tax increases to fund the new measures, in particular tax increases on alcohol, tobacco and petrol were also opposed (Dannreuther and Gideon, 2008).

Finally, the reformed set of laws was approved in both the Senate and the Chamber of Deputies by large majorities, with the exception of the bill on the "Rights of the Person in the Health System," which included the rights to information, respectful treatment, and other similar provisions. This bill was initially supported in Parliament but has not been approved until now. This bill was controversial because included euthanasia as a living will and the possibility of refusing therapeutic treatment (World Bank, 2007).

As referred to by Bastias and co-authors (2008), these reforms progressed due to the consistent and firm support of the executive power, including: the counteraction of the political opposition, the use of human rights rhetoric in the discussion of the reform, the role of the Senate in mediating between conflicting interests of stakeholders, a move on the part of the government to mitigate the opposition of health professionals, and the emergence of mediating parties, such as civil society organizations, which managed to involve all political actors in a broader and less politicised discussion.

2.3. Results and open issues

Issues related to universality of coverage

The Chilean healthcare reform initiated by President Lagos was aimed at switching the healthcare paradigm; that is, departing from a libertarian approach to health – the right to property principle goes before the principle of equity - to reach an egalitarian one, whereby the goal is to reduce health inequities by improving the health status of the worst-off. However, the reform did not eliminate the market as a mechanism to distribute resources in health and only introduced mechanisms to control its adequate functioning (Burrows, 2008).

Besides presenting budgetary constraints, the purpose of the Plan AUGE is to attempt to introduce an element of solidarity into the system and to move away from the concept of an “essential package” of services that had been associated with the privatisation of health services. The prioritized list of conditions with universal coverage aims at guaranteeing a level of coverage that is enforceable and in principle, the same for all. The aim of the Plan AUGE is to remove any inequalities in provision and ensure equity in access to health-care services, regardless of the type of provider used by people or their income levels (Dannreuther and Gideon, 2008). The prioritization process explicitly identified guarantees the “rights” that the beneficiaries can claim through an ad hoc administrative and legal procedure introduced by law (Drago, 2006).

However, equal access to treatment is attained only by the population group included in the pre-defined health conditions and leaves out patients who have disorders not listed under GGH Law. From a socio-political standpoint, some argue that restricting demand for care to a set of conditions, AUGE, and thus limiting access to care to a defined group of patients, affects the right to integral health of the whole population, a part of the principle of the common good. According to those authors, this represents an ethical violation of the principles of solidarity and equity (Román and Muñoz, 2008).

Although access is defined as universal, no specific mechanisms are in place to ensure non-discrimination. In addition, illegal immigrants and undocumented people cannot access available services (World Bank, 2007).

Issues related to financing of the AUGE Plan

The system of guarantees introduced with the reform established a method to set up economic limitations to health expenditure. Burrows (2008) argues that this approach challenges Amartya Sen's egalitarian suggestion that a significant impact on the health status of a country will require the efficient redistribution of income and an expansion in public expenditure, especially in the education and health sectors.

The funding of AUGE through a 1% increase on consumer tax, from 18 to 19%, intended as a temporary increase, but later extended, represents a regressive mechanism of funding and raises serious equity questions as it means an increase in food costs and costs of other basic goods (World Bank, 2007).

There are also gender dimensions that are impacted because this type of tax increase is more likely to affect women who are primarily responsible, particularly in Chile, for buying household goods (Dannreuther and Gideon, 2008).

Services offered under the AUGE list of guaranteed conditions require co-payment. Financial protection is ensured by explicitly defining maximum required payments for each of the guaranteed conditions and by

making services accessible to those who cannot afford the costs. It has been estimated that savings from using AUGE reached up to 500,000 *pesos* per year for diabetic patients and up to one million *pesos* for patients with severe depression (World Bank, 2007).

However, some argue that guaranteeing care in a public sector that suffers serious limitations, induces a patient to look frequently for care in the private sector. As a result this mechanism would favour the capitalization of the private system; in fact, the State besides funding the public sector, is enforced by law to cover guaranteed services beyond its capacity (Román and Muñoz, 2008).

Issues related to implementation

Some limitations have been identified in the development of procedures to monitor access (World Bank, 2007).

Maximum waiting period is specified for all guaranteed conditions and if service is unavailable within that period, an alternative provider is assigned. A maximum pre-established time limit is set in terms of an initial consultation and follow-up treatment after the diagnosis for the time needed to re-establish health. However there is no guarantee for continuous provision, with the exception of a few conditions where treatment duration is defined with more precision (Dannreuther and Gideon, 2008).

The AUGE process has emphasized the implementation and evaluation of all of the health plan's guarantees except those related to quality. Current discussions have stressed the need for accreditation of health-care organizations that deliver services under the plan, an action which seems more related to the issue of safety than to guaranteeing quality. On the other hand, a number of clinical guidelines aimed at directing and improving the clinical decision-making process have been issued, which instead seems to be a step closer to a guarantee for quality of care (Bastías et al., 2008).
At least for some conditions better use of evidence-based medicine under AUGE was successful in reducing in-hospital mortality (Nazzal et al., 2008).

After the initial implementation of the AUGE in 2005, demand for many of the services far outstripped expectations and generated additional budgetary pressures, possibly overloading the system (Román and Muñoz, 2008). One explanation for the unexpected demand (in addition to an undetected potential demand) was that people waited until the start of the new system before seeking medical attention. The guarantees laid out in Law 19,966 were only applicable to health conditions declared after 1 July 2005; for example, schizophrenia was only covered by the Plan AUGE if symptoms were detected after that date, so people delayed seeking a diagnosis (Dannreuther and Gideon, 2008).

A 2005 study reported by the World Bank (2007) found that AUGE had been beneficial to all socio-economic groups, and had been used by more than 3.2 million people (19.6% of the population). Lower-income groups (A and B in FONASA) used the system more (75%) than higher-income groups (24.2%). ISAPRE subscribers used AUGE mostly for high-cost treatments while the most frequent users (53.3%) occupied the middle-income stratum (with incomes between 300,000 and one million *pesos*); 24.5% of subscribers had incomes higher than one million while only 22.2% of subscribers had incomes less than 300,000 *pesos*.

Correct implementation depends on the support of health professionals. Due to the complexity of the reform, most patients, at best, are not fully aware of their current rights or, at worst, are misinformed about them. Thus, already busy clinicians are left with the burden of explaining these unfair situations to patients. (Letelier and Bedregal, 2006). In one survey, 45% of the people interviewed said that their physicians did not recommend the use guarantees regime, even if they are obliged to do so by law (World Bank, 2007).

The reform, in fact, did not take into account management options tailored to the new setting and lacked a human resources strategy to respond to new needs of health-care workers and gain their consensus (Méndez, 2009). Some authors considered the assumption that health professionals would immediately comply with the laws rather naïve. As an example, they reference the huge administrative burden of recording information each time a general practitioner makes a presumptive diagnosis of conditions covered under the health plan. Doctors' distrust of the system has been fuelled by the lack of transparency in the initial priority-setting process and by unsolved problems with the central information system where data are still manually codified. This is a situation that may induce many health professionals not to recommend the use of guarantees, even though they are obliged to do so by law (Bastías et al., 2008).

In agreement with a recently passed law on transparency, the Minister of Health is pursuing the adoption of a system to regularly monitor and evaluate the implementation and development of the reform concerning equity, access and participation. To this end, a specific project was recently developed, resulting in the design of a prototype system. Among the obstacles to be overcome in the implementation of the evaluation process, the project noted the weakness of baseline data and the insufficient co-ordination among interested public institutions (Infante and Orellana, 2009).

Issues related to the Prioritization method

The centrepiece of the Reform was the Plan AUGE which includes a number of conditions benefiting from explicit guarantees.

Vargas and Poblete (2008) identified four weaknesses throughout the AUGE process. First, the selection of the conditions was a multi-criterion decision-making process that included apparently contradictory criteria: burden of disease and social preferences, cost-effectiveness and high costs, and rule of rescue. Second, not all criteria were equally important as two dominant criteria - high burden of disease and social preferences - captured 88% of the selected conditions. Third, if reducing inequality through prioritization is a main policy goal, the criteria should be included explicitly because burden of disease and social preferences cannot readily capture socioeconomic inequality and, to an even lesser extent, gender inequality. Fourth, in contrast to recommendations found in the literature, the criterion of cost-effectiveness was introduced in a limited number of conditions in a first phase and at the last stage when identifying an effective treatment for the selected conditions within the limits of the national health budget (Vargas and Poblete, 2008).

Others have questioned the process of setting limits and priorities for its legitimacy and fairness. Elements, such as transparency, appeals, and procedures for revising decisions, seem to be absent from the debates about the Chilean reform process. Although there are institutions, mechanisms and procedures to revise those conditions and interventions that are guaranteed, the program lacks clearly established mechanisms for social accountability (Bastías et al., 2008).

Access and opportunity guarantees were established mainly on the basis of experts' opinions for each condition and the decision-making around the list of guaranteed health conditions in the AUGE was considered very technocratic (Dannreuther and Gideon, 2008).

The algorithm of prioritization has been criticized for not incorporating gender inequality, which appeared subsequently in the discussion (Vargas and Poblete, 2008).

In terms of gender discrimination, the AUGE Plan put an end to the commercialisation of health plans without coverage for maternity ("plans without uterus") (Zuñiga, 2007).

Nevertheless, the Women's Health Movement argued that the choice of health conditions did not acknowledge gender differences in women and men's vulnerability to ill health at different stages of the life cycle. They also maintained that many of the selected health conditions do not reflect women's health priorities and several major causes of morbidity among women are excluded, like for osteoporosis, which affects more women than men and is a growing cause of morbidity among women in Chile. Furthermore, health problems related to women's sexual and reproductive health rights were ignored by the AUGE, particularly the issue of abortion, which remains illegal in Chile.

Health problems related to intra-familial and sexual violence and sexually transmitted diseases were also not included in the AUGE, although these issues were first raised by the Women's Health Movement in 2002 at the beginning of the reform process (Dannreuther and Gideon, 2008).

It has also been noted that the Plan AUGE introduces for some conditions significant segmentation by age, sex or seriousness of the morbid event, especially in the area of emergency (myocardial infarction), diseases with very bad prognosis (AIDS), or high social consequences (alcoholism, drug addiction, dental health in

pregnant women, etc.). This segmentation would disregard the need for integral health care. In addition, there are conditions which are not included, such as accidents and injuries due to violence, that are only considered for emergency care, thus limiting care to 2-4 days despite the fact that these categories represent the fourth highest cause of death in the country (Román and Muñoz, 2008).

Studies conducted in 2006 by the Initiative for Equity in Health and the Ministry of Health show that despite achievements in maternal and infant health, there have been alarming increases in smoking, obesity, and suicide. While AUGE can be expected to have some impact on reducing these problems, it has yet to have a discernible impact on the mortality rate (World Bank, 2007).

Similarly, in the case of chronic diseases, care of the acute phase may be guaranteed while the subsequent evolution for treatment of the chronic phases escapes care enforced by law. This may imply that a number of complications, often requiring surgical intervention or complex treatments remain excluded. Also preventive measures implemented in the early, often asymptomatic phase of these diseases, is overlooked. In general, the missing attention of the Reform towards prevention is criticized (Román and Muñoz, 2008).

The focus on a limited set of conditions to be dealt with clinically also leaves out the eventual rehabilitation phase and the unsolved burden it poses on households. For example, the emphasis in many of the protocols on reducing the time patients will spend in hospital and increasing home care for those with chronic or terminal illnesses contains an implicit assumption that once transferred back home patients will have someone available to look after them, not to mention the gendered assumptions about women's capacity to undertake unpaid care (Dannreuther and Gideon, 2008).

Patients have guaranteed access to treatment as established in the protocol related to the health condition, with which clinicians are required, by law, to comply. However, some of the standard diagnostic and therapeutic procedures do not find consensus among practitioners (Román and Muñoz, 2008).

Users requiring a different type of treatment than the one defined in the protocols for a particular health condition or those with a health problem not covered in the guaranteed list will not be covered by the AUGE. Instead, they must continue to use the pre-existing system and decide between FONASA and the ISAPRES. In this instance, those in the ISAPRES are privileged since they can often use their health insurance plans to pay for alternative treatment while those in FONASA may not be covered. In this respect, the AUGE does not resolve the issue of inequality between the public and private systems. For some users the difference between being diagnosed with a condition that is covered by the AUGE and one that is not may feel quite unfair. As one cancer specialist noted, this presents serious ethical problems as 'the boundary between an oesophagus and a stomach cancer can be measured in millimetres. So we're going to have to tell a patient, 'If your cancer had been a millimetre lower your treatment would have been guaranteed'" (Dannreuther and

Gideon, 2008).

Patients with a condition listed under the GGH Law will have expedited access to treatments explicitly included in the disorder's protocol and these are conditions with which clinicians are compelled, by law, to comply. This situation might lead to difficult access to technologies not included in the protocol. For example, the protocol for adult patients with terminal-stage renal disease guarantees access to haemodialysis, but not peritoneal dialysis, so even if the patient and clinician agree on peritoneal dialysis, the GGH Law will not cover it. Although the protocols for GGH disorders are the same for public and private health systems, patients in the private system usually have additional health insurance which allows them to choose between treatment by GGH protocols or by their usual private health care that does not restrict access to therapies not included in the protocols. This scenario again leaves the inequities in different social groups unresolved. Patients with community-acquired pneumonia might receive different access to treatment if they are aged 63 years rather than 67 years (Letelier and Bedregal, 2006).

Due to the priority setting, the "non AUGE" conditions, estimated at 52% of the total demand at any given time, may suffer delays in care, both in terms of access and time needed for diagnosis and initiating treatment, as well as lack of financial support (Román and Muñoz, 2008).
However, protocols are reviewed regularly to add new disorders to the list and incorporate new evidence for the treatment of every GGH condition, leaving space for continuous improvement (Letelier and Bedregal, 2006).

Finally, all the guarantees are related to healthcare actions. The system of explicit guarantees does not allow for interventions on social determinants of health and preventing illness through public health interventions still lacks the robust system needed to guarantee them (Burrows, 2008).

Public information and claiming rights

The need to persuade health-care consumers has been a major concern during the implementation of Chile's health plan. The Ministry of Health has invested in several marketing strategies aimed at generating more active participation of the public by encouraging people to demand their rights.
However, it is probably too soon to evaluate the impact on this area and will only show measurable effects on consumer preferences some decades after being implemented (Bastías et al., 2008).

Mechanisms of social accountability and social monitoring of the AUGE were not clearly established from the beginning, nor is there any law to guarantee or regulate citizen's involvement. At the request of the Superintendent of Health periodic opinion polls have been conducted.

Early evidence collected suggested that only 40% of AUGE beneficiaries in the public system were aware of the fact that they belonged to the system and an even a smaller number knew about the specific enforceable guarantees and their option to file claims when guarantees are not fulfilled. In contrast, 98% of the AUGE patients in the ISAPRES knew that they had entered the system and were aware of their rights. Dannreuther and Gideon (2008) argue that there are clear class and gender implications of this, given that low-income women are one of the least likely sectors of society to be in an ISAPRES, and claim that this lack of knowledge about health rights as a major obstacle to increased community participation on issues of health reform.

More recent surveys (2007) interviewing individuals in their households, both FONASA and ISAPRE subscribers, confirmed a relatively low knowledge of the reform. Only 48% of respondents were aware of at least one of the explicit guarantees, and only 29% of the existence of all of guarantees. 80% did not know which diseases were listed in the guarantees regime. Despite this lack of awareness however, there was a general feeling (69%) that health care had improved in the country since AUGE with access being the most valued guarantee, ranking first in each socio-economic group. 64% of those who were eligible for guaranteed treatment, but did not take advantage of the new regime, identified lack of information as the reason. Among those who did use AUGE, 42% acknowledged a noticeable difference between the quality of services covered by AUGE and those that are not. Both FONASA (60%) and ISAPRE (59%) subscribers indicate that the new regime resulted in faster and higher-quality services; ISAPRE clients also mentioned the reduction in costs (World Bank, 2007).

Explicit guarantees enforced by law imply that when the expected right is not fulfilled, the patient may go to court to claim enforcement of their rights. This possibility may involve not only health professionals, but also the whole administration being considered responsible for potential malpractice suits that ultimately increase the judicial burden of medicine (“judicialización de la medicina”) (Román and Muñoz, 2008).

3. What next? What could be done that has not been done: expectations and future challenges

Currently, the Chilean health system, in financial terms, remains quite regressive due to the persistence of enormous differences in the type and quality of care between those with and those without resources.
To solve the equity problems, the reform must be extended to create a “Health Solidarity Fund” to allow the transfer of funds from the private to the public system (Zuñiga, 2007). As mentioned above, this solidarity component, which would have allowed to create a model that privileged the common good eliminating the most visible signs of discrimination, was rejected by right wing legislators when the law proposal was discussed in Congress.

The changes introduced by the Chilean reform are not exempt from technical and operational complexities. Among them, in order to improve the management in the public institution, especially hospitals, it is necessary to have a) an adequately trained workforce, with sufficient numbers of professionals, including physicians, specialized in the diagnosis and treatment of the AUGE explicit guarantees and b) a policy sufficiently implemented to date and agreed upon with the universities that train these professionals. A stronger and planned focus on the existing and new human capital required, would both ensure higher technical compliance and a positive involvement and commitment of all cadres of health workers (Méndez, 2009).

Another management requirement, easy to implement in a country like Chile, is the effective functioning of the network of services within a geographical area for an assigned population, which in addition to generating a more organized demand for services, will facilitate the processes of reference and counter reference as well as the follow-up of patients between different levels of health care.

It is also necessary to again stress the potentially negative effects of providing insufficient and inadequate care to the non-AUGE health problems, an aspect for which there is no valid information to date and which could generate some form of rationing. This aspect is closely related with the need, as many have pointed from the beginning of the reform process, of effective and accessible preventive interventions, the promotion of healthy life styles and a stronger capacity to effectively solve a greater number of problems at the primary and secondary level of care.

It is accepted that Chile's universal health care plan has been of great significance from both a social policy and a legal and institutional perspective, nevertheless a number of issues call for further and urgent analysis such as: the legitimacy and fairness of the priority-setting process at the policy making level, the implementation of the explicit guarantees related to quality of care and the need for processes and strategies to consolidate the health plan at the organizational level. On the other hand, the pre-defined economic limits to the expansion of the list of conditions under the Plan AUGE, directly links the possibility to expand the benefits of the reform to the economic growth of the country (Galleguillos, 2007; Bastías et al., 2008, Vergara 2007).

The new political situation raises many questions about the future of the Chilean health system, however the reform process is well advanced and was approved by a large majority of the country's political forces.

4. What can be learnt from the Chilean experience that could be useful to other countries

The new legal framework was of great significance from both a social policy and a legal perspective, as it was the first example in the country and the entire Latin American region of the legal instalment of a rights-based social guarantee that incorporates the principles of access, quality, opportunity and financial protection (World Bank, 2007).

While it is still too early to evaluate the success of the Plan AUGE, it does represent an important shift in social policy within the Latin-American region, as many reformers search for an effective way of providing universal social protection. Although transforming social exclusion in the region requires more than just a progressive health program, the Plan AUGE does offer an important starting point of discussion for promoting more inclusive forms of rights (Dannreuther and Gideon, 2008).

Bastías and co-authors (2008) have compared Chile's reform process with that of several other relevant countries based on 5 core characteristics: organization, financing, payment, regulation and persuasion. Organisationally, Chile's health care reform strengthened decentralization, which not only empowered local decision-makers but also made them more responsible for the health outcomes, a reform analogous to the 1993 reform in Burkina Faso. As in Canada, the adequate funding for the Chilean reform was secured by the government through an increase in taxation. Nonetheless, these resources accounted for only the public sector; private sector institutions had to raise their premiums to cover the costs of the health plan. Financially, payment methods between insurers and providers did not change significantly because of the reform. However, some modifications have been observed in the private system, as providers now compete to offer the cheapest alternatives using a scheme similar to preferred provider organizations in the United States. The supervision of quality standards and financial oversight is performed by an independent government agency called the Superintendence of Health. Similar agencies exist in Colombia and other Latin American countries.

Few countries have conducted a prioritization process as thorough as Chile's, and there is very little empirical evidence documenting such cases. Vargas and Poblete (2008) thoroughly analysed the Chilean prioritization process. Their findings raise important issues for policy-makers. Highlighting the importance of introducing the criterion of social preference in the prioritization process, in addition to the widely used burden of disease, and the use *a posteriori* of the cost-effectiveness criterion when selecting alternative treatments.

From an economic point of view, the approach adopted by Chile in defining health-care demand would not be easily applied in countries with less developed information systems. With the exception of the Mexican case, the majority of the studies made in less developed countries are indirect econometric estimates based on assumptions related to determinants of consulting behaviour and antecedents about service utilization. In other words, in less developed countries, studies are not based on specific epidemiological data as that information is not available. In the Chilean case, compared with other Latin-American countries, up-to-date epidemiological information is widely available and of relatively good quality, including information related to service utilization. This provides a situation which enables countries to adopt studies based on a demand model that uses local indicators and not only indirect econometric indicators (Chile, 2007).

Changing notions of citizenship have been central to the development of the Chilean health system and the ability of people to make use of their right to health. An understanding of the socio-economic and political contexts in which the system developed is critical to understanding why certain forms of citizenship have been promoted over others. The high levels of social polarisation that have been evident in the Chilean health sector suggest that for many the right to health has been relatively meaningless. Dannreuther and Gideon (2008) have extensively examined this issue from a gender equity perspective, identifying an inherent male bias in the conceptualisation of social and economic rights. Women are often unable to access those rights independently and their entitlements are defined by their marital status. Gender has political and economic dimensions, such as the fundamental division between the paid and the unpaid economy which generates gender specific modes of exploitation, marginalisation and deprivation. If citizens are to genuinely claim their rights under the Plan AUGE, other support networks must be available to them which includes, for example, helping marginalised sectors of society to effectively access the judicial mechanisms available to them to support their claims.

The issue that benefits are only available to citizens rather than residents, leaving out important groups such as migrant workers, may be a vital issue when aiming at universal health-care coverage. This is not only relevant in relation to increasing migration, but also in terms of access to trans-national care for populations living in border areas.

Chile has developed a comprehensive rights-based system (with both access/quality and redress/enforcement dimensions) that avoids solely judicial protections of health rights. Rather than introducing more services for the poor, this system integrates the poor into a universal system; i.e., those who require the most support are enabled to access goods and services on equal terms as the rest of the population (World Bank, 2007)

Annex - The current organization of the Health System in Chile

The Ministry of Health is the lead agency in the sector. It formulates and establishes health policies and issues general standards and plans, as well as supervising, monitoring, and evaluating compliance with them.

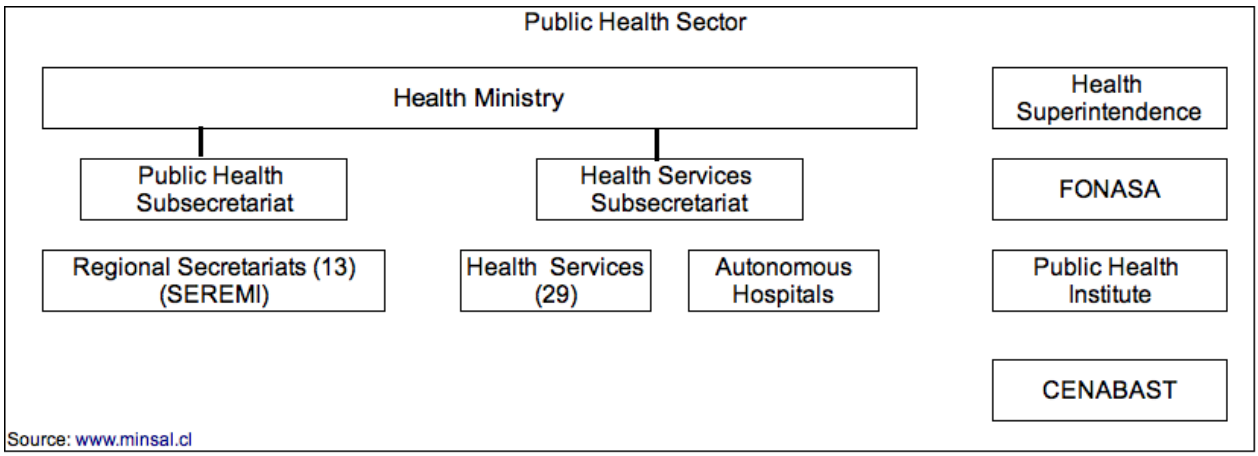
These regulations constitute the mandatory frameworks for care at public and private health facilities, in agreement with the public sector, and represent a frame of reference for the organization of private health-care institutions.

The following five areas/entities report to the Ministry:

1. Health Services;
2. National Health Fund (FONASA),
3. Health Superintendence,
4. Public Health Institute (ISP), responsible for regulating drugs and medical inputs,
5. Central Supply Clearinghouse (CENABAST).

With Law No. 19,937 (on *Health Authority and Network of Autonomous Hospitals)* health authority functions were transferred to the Ministry of Health's Regional Secretariats in each of the 13 regions of the country, and the responsibility for managing the health-care network was delegated to the 29 health service bureaux.

Fig. 4
Organigram of the Chilean Public Health Sector



Financing, pooling and service delivery

In Chile the health system is dual in terms of financing, health insurance, and service delivery.

Financing

By law, all workers are required to pay 7% of their monthly wages into public (FONASA) or private (ISAPREs) health insurance.
In addition to contributions from its members, FONASA receives transfers from the Ministry of Finance to cover indigents and to carry out public health programs.
The private insurance sector is represented by the ISAPREs, private health insurers that administer the obligatory contributions from wage earners; their members can pay additional premiums to improve their insurance plan coverage (Paho, 2007).

Because of this arrangement, the public and private health subsystems in Chile have existed almost completely separately rather than in a co-ordinated manner to achieve common health objectives. In the public sector, primary care services exist everywhere in the country and are relatively well-organized, delivering free medical, dental, nursing and midwifery services at local health centres administered and owned by local municipalities. Secondary and tertiary care is provided by a network of public outpatient and hospital facilities with different levels of complexity. By contrast, the private sector has neglected the development of primary care networks, focusing mainly on the delivery of secondary and tertiary care (Bastías et al., 2008).

The ISAPREs and FONASA are both overseen by the Office of the Health Superintendent. Implementation of the AUGE Plan has consolidated the role of his authority. There are also employers' mutual insurance plans that specifically administer insurance for on-the-job accidents and occupational diseases financed by the employers.

Although FONASA and the Office of the Health Superintendent are autonomous, they are subject to oversight by the Ministry of Health, which bears responsibility for sector policy. The Public Health Institute control drugs and medical inputs and acts as the national reference laboratory. CENABAST procures products for the public sector.

Service delivery

The delivery of services also is mixed. The administration for a vast majority of primary care facilities is carried out by the municipalities while hospitals fall under the responsibility of the Health Services.
Law No. 19,937 authorized a network of autonomous hospitals, which should provide greater flexibility in the management of the country's 56 highly complex hospitals. In 2005, autonomy authorization was granted to five hospitals; by 2009, it was expected that all 56 of the country's highly complex hospitals will be granted this authorization, which did not happen. In addition, there are numerous clinics, medical centres, laboratories, and pharmacies managed by private individuals or companies.

There are only a few not-for-profit non-governmental organizations, and their work is limited to some rural health centres and hospitals operated by religious organizations.
FONASA covers 68.3% of the population and the ISAPREs 17.6%. The remaining 14.1% is covered by other private plans (such as the armed forces plan) or has no insurance at all (Chile, 2003).

ISAPREs can be “closed” or “open”. In closed institutions, membership is limited to individuals working in a given company or sector of the economy, such as large public copper mining companies. Open institutions allow anyone to become affiliated. Most ISAPREs (15 nationwide) work through private providers, but may also sign contracts with public health institutions for specific services (e.g., hospitalization in private wings of public hospitals, emergency care, and care in intensive care units). Some ISAPREs have their own networks of clinics to provide care for their subscribers, a trend that has been increasing as the AUGE Plan has been progressively implemented. The insurance contract is negotiated individually between the ISAPRE and the client, who is required to make a co-payment, which varies considerably. The guaranteed financial protection specified under the AUGE Plan sets the maximum co payment amounts for FONASA and ISAPRE beneficiaries (guaranteed financial protection) for health conditions covered by the plan. Public health services must meet all demands for emergency services. Moreover, the public health programs (such as immunization and tuberculosis control) cover the entire population, without discrimination. Peak coverage under ISAPREs was reached in 1995 reaching 26.3% of the population. Since 1997, there has been a migration to FONASA, which is attributed to the effects of the Asian financial crisis at the end of the 1990s, to improved public health services, and to the recent implementation of the AUGE Plan (Inostroza et al., 2005).

FONASA is responsible for supervision and control of public health sector financing, but all public sector institutions are controlled by, the Office of the Controller General.(Paho,2007).

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