THE POST MILITARY GOVERNMENT REFORMS TO THE CHILEAN HEALTH SYSTEM

A case study commissioned by the Health Systems Knowledge Network

Antonio Infante

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1 Paper presented in the Health Services Knowledge Network Meeting; London, October 2006. The article contents are based in the author’s experience and selected bibliography.
**Background to the Health Systems Knowledge Network**

The Health Systems Knowledge Network was appointed by the WHO Commission on the Social Determinants of Health from September 2005 to March 2007. It was made up of 14 policy-makers, academics and members of civil society from all around the world, each with his or her own area of expertise. The network engaged with other components of the Commission (see [http://www.who.int/social_determinants/map/en](http://www.who.int/social_determinants/map/en)) and also commissioned a number of systematic reviews and case studies (see [www.wits.ac.za/chp/](http://www.wits.ac.za/chp/)).

The Centre for Health Policy led the consortium appointed as the organisational hub of the network. The other consortium partners were EQUINET, a Southern and Eastern African network devoted to promoting health equity ([www.equinetafrica.org](http://www.equinetafrica.org)), and the Health Policy Unit of the London School of Hygiene in the United Kingdom ([www.lshtm.ac.uk/hpu](http://www.lshtm.ac.uk/hpu)). The Commission itself is a global strategic mechanism to improve equity in health and health care through action on the social determinants of health at global, regional and country level.
Acknowledgments

This paper was reviewed by at least one reviewer from within the Health Systems Knowledge Network and one external reviewer. Thanks are due to these reviewers for their advice on additional sources of information, different analytical perspectives and assistance in clarifying key messages.

This paper was written as part of the work of the Health Systems Knowledge Network established as part of the WHO Commission on the Social Determinants of Health. The work of the network was funded by a grant from the International Development Research Centre, Ottawa, Canada. The views presented in this paper are those of the authors and do not necessarily represent the decisions, policy or views of IRDC, WHO, Commissioners, the Health Systems Knowledge Network or the reviewers.
This article will expose the different situations, financial, political and organisational that stressed the Chilean Health System in the last 30 years. Probably because of the historical strength of its organisation and the good performance in health indicators, it maintains a structure with national coverage that gives access to health care to all the population.

The state managed National Health Service created during the fifties was reformed by the military government by introducing private health insurance. The privatisation efforts were undermined by the economic crisis in the early 80’s, and after 1990 limited by the commitment of the democratic governments to strengthen the public health sector.

With the democratic governments the principal efforts have been centered in strengthening the public health services in a national policy of equity; regulating the private health insurance and provision system developed during military rule; and improving the quality and opportunity of care given to the most needed population, the beneficiaries of the public sector.

1. The Chilean National Health Service a proequity tool

High social inequalities are found in Chile. Pinochet's government deepened that reality (Graphic N°1\(^3\)). Democratic governments improved those differences through public policies, mainly in education and health. However the family income in the richest quintile is 8.6 times more than the income of a family in the lowest one. Differences are less in the health area\(^4\) probably, and this is the hypothesis, because the good access and high coverage of the chilean health system.

The Chilean health care organisation was developed step by step during the 1900th. As in many Latin-American countries the first organisation was closely related with social security, with separated health provision to the formal workers under social insurance and to the informal workers and the neediest population in a social welfare organisation.

The National Health Service was created in 1952 with the fusion of all the previous health care institutions. The advantages of the unification were visible soon. The health coverage improved with the investment in rural hospitals and primary health care clinics surrounding a general hospital in a limited territorial zone. Professional delivery and neonatal attendance grew rapidly. In the mid sixties, massive plans of family planning, new schemes of vaccines including measles prevention and maternal and infant supplementary feeding programmes increased the impact of a wide net of primary care facilities.

Also in the sixties and early seventies there was important investment in areas related with positive human development\(^5\). Inversions in public education, water and sanitation and the National Health Service consolidation could explain the progressive descent of the infant mortality rate (Graphic N°2). During this period a very strong sanitary discipline was developed. In this period there are also two laws that enhance health protection. The first one gave wide coverage to workers in job-related accidents and diseases. The second was the beginning of a different health care system to blue and white-collar workers, giving to the latter a voucher with

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\(^2\) Paper presented in the Health Services Knowledge Network Meeting; London, october 2006. The article contents are based in the author's experience and selected bibliography.

\(^3\) Ruiz Tagle J.; Chile 40 years of income inequality. Esc Economía U de Chile; 2000. (http://econ.facea.uchile.cl/academic/jruiz/papers/desigualdad_40_anos.pdf)

\(^4\) National Health Survey 2003 (http://epi.minsal.cl/epi/html/frames/frame3.htm)

\(^5\) Ranis G; Stewart F; Economic growth and human development in latin america; ECLAC Journal; Dec 2002.
public subsidy to go to private doctors clinics, something that increased during the military regime.

In Allende’s government (70-73) community participation in health increased and also did the public investment focused in the mother and child area. Training and infrastructure (maternities, neonatal care units) strengthened the National Health Service performance.

**Graphic Nº 1**

*Per capita income inequality in presidential periods*
*Chile 1957 - 1997*

![Graph showing per capita income inequality in presidential periods in Chile from 1957 to 1997.](image)

Source: Ref 2

**Graphic Nº 2**

*Infant Mortality Rate and Per capita Income*
*Chile 1960 – 2003 (US$ 1993)*

![Graph showing infant mortality rate and per capita income in Chile from 1960 to 2003.](image)

Source: ECLAC

MOH
Initially the military government didn’t modify too much the NHS’s programmes, however there was a rigorous targeting of activities, focused in child growth monitoring. Nutritionists were included in the primary health care team and the supplementary feeding programme was reinforced including pregnant and infant population at risk of undernutrition. An undernutrition treatment community centres net was also developed. This could explain the descent of infant mortality rate till 1984\(^6\), with a 4 years plateau and since 1990 a continuity in the secular trend, in this occasion related with increased per capita income.

In this scenario, IMR became a propaganda tool to the regime, as an example of good social policy. Probably this argument, the economic crisis of 83 and the democratic victory in the referendum explains that the National Health Service was not totally privatized. The actual structure, with more fragmentation than is desirable, is similar to the initial one and responsible of the health care of 70% of the Chilean population.

2. The Military Government’s health reforms

The health reforms during the military rule were oriented basically by two doctrines: the subsidiary role of the State and national security.

a. The subsidiary role of the State: this principle is pro private initiative and gives to the state the responsibility of public goods provision and a minimum of welfare conditions to the neediest population\(^7\).

This had consequences in different areas. In social security the elimination of the state and owners financing, leaving to the employee the whole responsibility of his social protection. In the health area the figure was the same, the employee contributes with a compulsory 7% of his monthly income to his family health insurance. In both situations private agencies took control of the administration of those funds. In the health area the private administration focused mainly in managing funds of the high-income population (ISAPRE). For the low-income population and also collecting the public financing for the poorer population the government creates a public health insurance agency (FONASA) that depends from the Ministry of Health. Consequently, population covered by ISAPRE went to private clinics and the FONASA’s to the public hospitals and facilities. Graphic Nº 2 shows the current distribution of chilean population in both insurances.

<table>
<thead>
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<th>Graphic Nº 2</th>
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<tr>
<td>Distribution of Public and Private Health Insurance</td>
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<tr>
<td>Income quintiles</td>
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Source: National socio economic survey (CASEN) \(^6\)MIDEPLAN 2003

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\(^6\) Castañeda T.; Socioeconomic context and infant mortality rate descent in Chile. Rev CEP Nº 16; June 1984

\(^7\) Larroulet C; Working paper; Centre of Public Affairs; 1984.
ISAPRE’s are the best example of the military’s regime ideology. Deregulated since the beginning, with direct public subsidies (employer could add an extra 2% to the employee’s contribution, discounting it from his tributes. That did possible that more population became ISAPRE users) or cross subsidies because a number of ISAPRE users also use the public health care system particularly in emergency care\(^8\). Also until 1995, year in which it was regulated, part of the utilities of the ISAPRE came from excedents in the annual contribution to health, particularly of the younger population. People needed preconditions to be an ISAPRE affiliated. If he or she did have chronic illness; or she did have the risk of being pregnant, the cost of the health plan increased so the contribution was considerably higher. The skimming policy was the rule. The other population must go to the public health care system.

A second consequence of the subsidiary role was the permanent search of private administration alternatives to the public health system. Different kind of corporations were developed looking for more flexibility, particularly in the human resources administration. With that perspective in mind is easy to explain the absence of an investment policy with it’s consequences in the deterioration of equipment, and in human resources training. This deepened the difference between public and private health sector increasing the inequity in access to health care.

b. The doctrine of national security: the principal teaching of this policy is that the State is constantly under attack of external and internal enemies, obedient to foreign ideologies, mostly of totalitarian sign, that pretend the defeat of the democratic order.

The meaning of this in the health sector was the fragmentation of the National Health Service for better control. It was divided in 25 provincial services and more than 300 local primary health care units under municipal administration. All of the civil authorities were under military control and the Health Minister was from the army. In these scenario the probability of unions or social organisations activities was remote.

The government presented this strategy as decentralisation. But the control of financing and programmes remained in the headquarters. What grew up was bureaucracy, each new unit needed administrative support.

3. The Post dictatorship Reforms

The first democratic government after the military regime found a dual health system. A private, well provisioned one to the ISAPRE’s wealthy people and an agonic public one to give care to the majorities. Public hospitals with deteriorated heating power and ambulances; very basic xray systems; beds without sheets and mattresses; a very badly paid and unmotivated personnel; therapeutic arsenal only with basic goods. However the working routines and high coverage programmes were still in operation.

Two additional elements became present and unattended during the 17 years of military government. Inequity and epidemiologic transition. The first because of the public policy implemented in those years and the other as a consequence of the wide coverage of the family planning programmes of the 60’s. This reality requiered a drastic intervention of public health policies.

A Strengthening of the public health system

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\(^8\) A survey done by the national consumers agency in 1994 estimated that 15% of primary health care visits; 10% of emergency room visits and a number of hospitalizations were from ISAPRE users that didn’t pay. In: Del Canto C; Parada M; Incentives for the development of the private insurance market 1980-1998; ARCIS University Thesis; 2000.
Health Investments

The first priority was the investment in health infrastructure, hospital goods and equipment. Also in health personnel salaries and new positions.

The public health sector wage was quadruplicated in 1990-2004. The media of investment in infrastructure and equipment in the 90’s was US$ 86.5 millions a year in comparison with the US$ 15 million that was the media in the 80’s. In the first years of democracy about a 30% of the money came from multilateral credit agencies. Currently the investment is only with national resources. Public hospitals do have modern equipment and in several areas they took again technical leadership as it was in the past.

There are some critics from the management side that point out that a significant amount of the wage growth has been in salaries not related with a productivity increase. On the other hand in the medical area the argument is that there are important gains in the current safer clinic procedures. The discussion is actually open.

Primary Health Care

This area is a priority. The decision of the democratic government was that primary health care would continue under municipal administration now with elected authorities. The evaluations done by the ministry of health didn’t show differences between municipal and central government’s administration.

Protocols for the reference of patients were implemented and the barriers between primary care level and hospitals decreased. The primary care prestige has increased among users and clinicians and PHC is considered a key factor in the health sector’s performance. Nevertheless there still remain difficulties in the patients flux through the health net but it is not clear if that is attributable only to the kind of administration.

Currently 30% of the health budget goes to PHC. Specific programmes has been developed for infant and adult acute respiratory diseases with remarkable impact in lethality. Diabetes, hipertension, epilepsy and depresion do have guaranteed access to integral care. Psicologists, kinesiologists and specialists counselling are included in the PHC team increasing the local resolutivity. The therapeutic arsenal includes more medicines; ecography, basic laboratory and cardiovascular tests are also in the local clinic. Primary care emergency rooms (SAPU) replace a great number of hospital emergency room visits. In addition to the all previous measures, a family oriented health care strategy is under implementation, giving priority to prevention in medical and psicosocial problems.

B Private health care regulation

In 1992 a ISAPRE’s Superintendency was created to regulate the private administration of the compulsory 7% monthly income contribution. In the recent years this regulation has increased. Since 1995 the employee is the owner of his non used annual contribution and in 1998 the 2% subsidy was eliminated. In 2004 in the last reform, the unilateral increase of the health plan cost was regulated and also the skimming practice, reducing the possibility of dropping out risky affiliates. Since 1998 the number of ISAPRE’s affiliates is decreasing probably as a result of stronger regulations , at the same time their average income has increased so the ISAPRE’S profit increased. In 2005 the Superintendency role widened including the public insurance fiscalisation.

C Looking for equity in health reforms

The most ambitious reform began after 10 years of democratic governments. In the first decade all the energies were concentrated in the management area following World Bank’s
recommendations. However in the analysis of some mortality rates between 1985 and 1999 a widening of the gap between poor and rich population was found\(^9\). Also a national study of disease burden among counties confirmed the gap\(^10\). The previous reform projects centered mainly in management didn’t decrease the equity gap. An other scope of analysis was needed to impact in equity.

The 2000’s reform became law in 2004 and was centered in national health objectives with the first goal in equity gap. The chosen intervention were to guarantee access, opportunity of care and financial protection in a group of the most prevalent health problems, representing the 70% of the disease burden and priority to the chilean population (Figure N° 1)\(^11\).

The deepest strategy twist, in addition to the sanitary objectives centered reform, was the empowering of people giving them health care legal rights. Universal health care access, well defined waiting times and a maximum spending of money is guaranteed by law (Plan AUGE). Public and private insurance must deliver this Plan and the Superintendency of Health’s duty is to control people’s rights. The reform is willing to give equal opportunity of access to health care solutions, with independence of socioeconomic conditions, to all the chilean population.

![Figure N° 1](image)

The priority setting in AUGE

<table>
<thead>
<tr>
<th>HEALTH PROBLEMS</th>
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<tr>
<td>People’s priorities</td>
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<tr>
<td>Frequency</td>
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<td>Health System’s Priorities</td>
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<tr>
<td>¿Do we have an effective treatment?</td>
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<tr>
<td>¿Can we deliver it in the whole country?</td>
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| DEBATE AND SOCIAL CONSENSUS |

| GUARANTEES |

As an example a newborn with a suspected congenital heart disease must be diagnosed in 48 hours and if there is a surgical solution, surgery must be done in the other 48 hours. A patient with a probability of cataracts must be diagnosed in 6 month and operated 6 month after the diagnostic confirmation\(^12\).

The AUGE began a gradual implementation in July 2005 with 25 problems; an additional fifteen were guaranteed in July 2006, and in July 2007 the implementation will be completed with sixteen other. The current President’s goal is to implement another 24 in her four years period, completing 80. Today more than 2 million people have been beneficiaries of AUGE and FONASA, the public health insurance agency, is one of the chilean more confident institutions.

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\(^9\) Vega J; Enfermo de pobre; University Journal N° 73, 2001  
\(^10\) Concha M; Aguilera X; Burden of disease in Chile; MINSAL 1996.  
\(^11\) 19.966 law (www.minsal.cl)  
\(^12\) For a detailed description of guarantees see www.minsal.cl
D Public health policy strengthening.

An other relevant policy measure was the separation in the Ministry of Health organisation between the health provision area and the health policy and regulation area. The objective was to strengthen the policy area looking to develop public health population interventions in living styles and social determinants of health as the priority, in a scenario of chronic illness high prevalence.

The new organisation of the Ministry of Health has two viceministers, one in public health and the other in health care; a public insurance giving protection to the majority of the population and the Health Superintendency with a fiscalisation role also to the private health insurances.

4. Summary

The chilean health system did have several changes in the last 30 years. The main modifications occurred during the dictatorship regime with a privatisation purpose. Nevertheless, the National Health Service strength; financial (1983 crisis) and political problems (referendum defeat in 1988) prevented the completion of this design.

The arrival of democracy in 1990 did mean a sustained effort in the public health care strengthening; a private health care regulation and a deep will in the equity gap reduction. The most relevant change has been the empowerment of population’s rights and the guarantee that there are health care solutions to more than 70% of the disease burden.

There is not enough time to show evidence of health impact. But AUGE is working as designed with a good evaluation of public and private beneficiaries. A recent cigarette and smoking regulation law is also a good sign of the development of a public health preventive policy.