

Equity in Health Care and Public Health Policy: The Search for Social Justice in Chile's Plan AUGE

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After a remarkable experiment with social medicine since 1990, infrastructural problems forced the Chilean state to reform its health system. In 2005, they passed Plan AUGE, a comprehensive health care reform meant to provide equitable, universal health care for specific ailments. The reform explicitly guaranteed that patients have access to care, financial coverage, and an assured quality of care for the AUGE illnesses. This paper explores the implementation and immediate effects of Plan AUGE from 2005 to 2010, arguing that while the legislation has improved some health care indicators, the legislation cannot be considered equitable. I base this conclusion on the Chilean construction of health care equity found in both health care policy in the 1980's, and Chilean scholarly discourse. My paper examines the legislation in relation to its political infrastructure and regional disparities of care, using publications from the World Bank, the Chilean Ministry of Health, and various medical ethics and public health policy journals. My investigation indicates serious infrastructural woes created by AUGE in response to the elevated demand for treatment for AUGE illnesses. The paper also examines how AUGE resources became concentrated in the urbanized areas, leaving the remote regions in the far north and south of Chile unable to handle the AUGE-related demand for treatment. My research suggests that Plan AUGE threatens to exacerbate the exact conditions it seeks to eliminate. In doing so, my paper engages pressing issues in health care and the improvement of care in marginalized areas of the country, in an attempt to find a practical and effective model of health care for the region.

Chile is consistently at the forefront of Latin American development in health care. One might presume that the cause of its achievement in health care is its overall high standard of development, however, there are explicit reasons for Chile's consistent success in health care. Primarily, Chile's health insurance system is among the most sophisticated in the region. The elaborate organization of the system into private and public interests allows for physicians to efficiently handle the bulk of health claims. Chile has also enjoyed considerable quality of care, most evident in the power and political respect the nation has for the *Colegio Médico de Chile*, the professional organization of Chilean physicians. Despite its sophistication, the Chilean health system has persisting problems regarding access to care in rural areas, health care costs, and the quality of care in remote areas. In an effort to alleviate some of these concerns, the Chilean government passed *Acceso Universal con Garantías Explícitas*, also known as Plan AUGE in 2005. A comprehensive health care reform, AUGE guarantees government coverage and treatment for a list of fifty-six explicit ailments. While AUGE has improved Chile's health indicators, the reforms have left several problems unaddressed and as such, it is the subject of heavy criticism from physicians and patrons alike. Physicians contend that the universal nature of the reform has restricted their medical-professional liberty in diagnosing patients and providing appropriate treatments. Patrons have voiced ongoing concerns regarding the continuing regional disparity in access to care and the quality of rural care, as well as the infrastructural weaknesses within the system. Plan AUGE, despite its obvious benefits, is not a significant step towards equity in health care as illustrated by the persisting health care problems in Chile, and in widespread criticism from doctors and patients.

This paper will offer evidence that Plan AUGE is not as influential and holistic as Chilean politics and health care experts claim it is. The paper's analysis will be focused on investigating Plan AUGE with the legislation's purpose in mind: to provide fair and equitable health for all Chileans. The significance of this reform lies in the fact that AUGE theoretically is a sound alternative model for health care in Latin America. Where AUGE fails, however, is in its lack of infrastructural accountability and its tendency to exacerbate pre-existing problems in health care. The paper itself is an investigation employing terminology and methods from medicine, public health, sociology, and political science, suggesting that the most effective way of analyzing a comprehensive health care reform such as AUGE is through an interdisciplinary lens. The first part of this paper will define equity in health, and explain how the theory can be applied to the Chilean case. Part two will shed light on the evolution of the Chilean health care system since its establishment in the Pinochet era. Part three will discuss the implementation of Plan AUGE and its reception in recent literature. Part four will examine my evidence from the various Chilean government agencies with a focus on the problems created by the implementation of AUGE and possible methods to alleviate them.

I. Constructions of Equity in Health Care

Before discussing the evolution of the Chilean health care system, one must first consider what it means to have equity in health, and how nations can further advance along the path to equity. When talking about Plan AUGE or any health care provision,

one must be able to reasonably evaluate whether this legislation is equitable or inequitable. We must also consider both domestic and international constructions of what equity in health looks like. Health care expert Jaime Burrows empirically labels equity in health as conditions referring to equal access to and utilization of health services for those who require the care and equal health results, i.e. hospitalization rates, life expectancy, etc.¹ The caveat to this over-arching theory on health care equity is that achieving equity in this fashion has the potential to be undesirable because of the restrictions citizens may place on their lives to obtain the label of “health equity” e.g. excessive dietary and lifestyle restrictions. While the conscious decision to live a healthy lifestyle is important, it should bare no consequence as to whether a state’s policy can be considered equitable. Additionally, Burrows responds to this criticism by asserting that even when health care access is deemed equitable, there are inevitable inequalities that will persist.² The fact remains that in this construction of equity, the definition is applied on an individual basis and is not applicable to a heterogeneous population. We must look at equity in health care through a lens applicable at the state level in order to access whether or not legislation is equitable.

As opposed to the international approach to defining equity in health care, the Chilean construction of equity can be more easily applied. At its most elementary level, equity (and justice in health) must distribute resources equally, implying that each citizen has the same rights and must receive the same health attention.³ Chilean discourse has

¹ Jaime Burrows, “Inequalities and healthcare reform in Chile: equity of what?” *Journal of Medical Ethics* 34:9 (September 2008), 2.

² *Ibid*, 2.

³ Claudio Lavados Montes and Alejandra Gajardo Ugás, “El principio de justicia y la salud en Chile,” *Acta Bioethica* 14:2 (Winter 2008) 207.

leaned towards a construction of population equity that has a strong ethical, philosophical, and economic grounding i.e. to tackle equity in health care from an interdisciplinary approach. Like Burrows, Montes and Ugás acknowledge that there will be an inevitable presence of inequality due to the classic economic constraint of scarce resources. They point out that as long as the health care rights of Chileans are recognized, there is equity present to some degree.

This political grounding to health care justice has defined Chile's strides towards equity as its system has evolved. The first manifestation of health care protection in the law appears in the 1980 Constitution. This document legally protected citizens' free and equal access to health care services, as well as identifying a citizen's right to choose between the private and public sectors.⁴ The Constitution additionally outlined the state's responsibility to coordinate and control "the actions related to health...and to guarantee the execution of health actions fits with the norms and laws," regardless of the nature of the provider.⁵ In other words, the Constitution of 1980 formally holds the state responsible for providing health care and recognizes citizens' rights to access to care. It should be noted that such a political approach to defining equity in health care leaves ample room for interpretation, i.e. policy makers can use this politicized definition to exploit loopholes. A solid understanding of the Chilean construction of health care equity is essential in evaluating the social justice implications of Plan AUGE explicitly through a Chilean lens.

⁴ Burrows, "Inequalities and healthcare reform," 1.

⁵ Ibid, 1.

II. The Chilean Health Care System and its Antecedents

In this section, I will examine the evolution of the Chilean Health Care System in order to provide some context behind why AUGE was implemented. This system, in its current manifestation, can trace its establishment back to the late 1970's under the rule of Augusto Pinochet. Under the Pinochet neoliberal model, Chile experienced a large European influence both through immigration and commerce, fostering support for a stronger public sector in health care. In order to more efficiently enact policy and eliminate possible opposition, Pinochet banned the Colegio Médico from contributing to policy making in 1979.⁶ Pinochet dissolved the previously debilitated *Servicio Nacional de Salud* and in 1979, enacted Law Decree 2763 which established the *Fondo Nacional de Salud* (FONASA), whose primary purpose was to provide a higher quality of health care through state-sponsored avenues to Chileans.⁷ FONASA was to be financed through a monthly paycheck deduction of 4%, eventually inflating to 7% for all patrons.⁸ In addition, FONASA only required co-payments for the highest two income quartiles of its clientele, meaning that the bulk of its patrons could receive health care without paying the provider when the service was administered. Pinochet lastly established the *Institutos de Salud Previsional* (ISAPRE's) for Chileans who wanted to opt out of state coverage and invest in an HMO plan.⁹ The ISAPRE's allowed Chileans to obtain a higher quality of care depending on the amount they paid monthly, whereas the FONASA care structure had a ceiling that did not allow for care costs to exceed the 7% deduction. The private

⁶ Joseph L Scarpaci, "HMO Promotion and the Privatization of Health Care in Chile," *Journal of Health Politics, Policy and Law*, 12:3 (Fall 1987), 559.

⁷ Ibid, 559.

⁸ Ibid, 562.

⁹ Ibid, 559.

sector took off, controlling nearly 40% of Chilean health capital while only covering 18% of the population in 1990.¹⁰

While the system established by Pinochet was innovative for its time, the Chilean health system began to deteriorate by the end of the 1980's. The military government subjected the health sector to severe budget cuts, falling by \$714 million in the period 1975-1985.¹¹ The budget cuts affected all areas of health care; hospital beds were eliminated, physician salaries dropped drastically, and medical schools experienced a sharp reduction in personnel. Perhaps the hardest hit area of health care was primary care, a sector that did not possess the finances to maintain their facilities or pay their physicians well before the budget cuts. These effects were not limited to FONASA; while ISAPRE's continued to turn a profit, the private sector was not providing sustainable and equitable care for even its most premium plans.¹² As Pinochet left office, it was clear that the health system needed reform.

The transition to democracy brought about some much needed restructuring of the health care system. The responsibility of rescuing the ailing health care system fell on the first Concertación President Patricio Aylwin but he did not go about this task alone. The Western powers were extremely receptive towards Chile's transition back to democracy and as such, were willing to invest directly in the Chilean economy. The World Bank floated FONASA a \$200 million loan to restructure the public sector that included a stipulation that FONASA would rehire 2,000 physicians previously blacklisted

¹⁰ Stephen Reichard. "Ideology Drives Health Care Reforms in Chile," *Journal of Public Health Policy* 17:1 (Spring 1996) 88.

¹¹ *Ibid*, 89.

¹² Jorge Jimenez de la Jara and Thomas Bossert, "Chile's health sector reform: lessons from four reform periods," *Health Policy*, 32:1-3 (April-June 1995) 163.

under Pinochet to staff the hospitals.¹³ The Concertación government pumped more U.S. money into the primary care system, creating a new Division of Primary Care and pledging to expand its budget by 50% over the next four years.¹⁴ Aylwin also fought for more state control of the ISAPRE's, enforcing a service-oriented agenda in lieu of the profit-first mantra of the 1980's under the neoliberal Pinochet model.

Along the same lines, the Chilean government sought to make the choice between the private and public sectors more competitive vis-à-vis closing the gap between patron income and quality of care. The establishment of free choice modality in FONASA allowed upper-income patrons to obtain secondary and tertiary care in either sector at a reduced price, incentivizing loyalty to the public sector.¹⁵ FONASA also mandated that its indigent beneficiaries become exempt from payroll deductions as well as co-payments in its facilities.¹⁶ ISAPRE reform entailed expanding its appeal to a wider socioeconomic base. It accomplished this by creating cheaper plans and increasing its health care expenditure per beneficiary 18% between 1990 and 1996.¹⁷ The empirical restructuring of both public and private sectors helped Chile reestablish its reputation as an innovator in health care.

By the early 2000's, a new wave of problems threatened the integrity of the Chilean Health Care System. As Stephen Reichard points out, the success of Chile's

¹³ Reichard, "Ideology reform," 91.

¹⁴ De la Jara and Bossert, "Chile's health sector reforms," 163.

¹⁵ Ricardo Bitrán et. al. "Equity in the financing of social security for health in Chile," *Health Policy* 50:3 (January 2000), 176.

¹⁶ *Ibid*, 176.

¹⁷ Claudio Sapelli and Arístides Torche, "The Mandatory Health Insurance System in Chile: Explaining the Choice between Public and Private Insurance," *International Journal of Health Care Finance and Economics*, 1:2 (June 2001) 98.

health care system relative to the region has left the nation with a substantially older population to care for.¹⁸ Although physicians had a more central role in policy making, many physicians remained staunchly opposed to ISAPRE discrimination of high-risk patients and the elderly, forcing those subsets of the population to gamble with public quality care.¹⁹ Even though it provided care to only 61.8% of the population, FONASA became inundated with the poorest and highest-risk population subsets. Although the creation of the Catastrophic Care Program in 1999 initially helped FONASA cope with their high-risk patrons, the twenty health benefits the program covered were extremely costly.²⁰ The care required to sustain the program entailed employing highly specialized doctors and technology and often resulted in lengthy waiting lists for the treatments while the public hospitals scrambled to fund the program.²¹ Perhaps the most persistent problem throughout this time period had been the regional disparity in resource distribution. When FONASA financing was restructured, it allowed for funds to be allocated to public hospitals based on historic budgets; the rural hospitals simply could not compete with the urban demand and as such, their hospitals, physicians, and patrons bore the consequences. The government did not incentivize physicians to practice in rural areas and as a result, the doctor population remained extremely low and quality of care suffered. ISAPRE's were not even available in rural areas. Focusing the bulk of their resources on Santiago in the 1990's did not allow for the private sector to get a

¹⁸ Reichard, "Ideology reforms," 94.

¹⁹ *Ibid*, 99.

²⁰ Verónica Vargas and Sergio Poblete, "Health Prioritization: The Case of Chile," *Health Affairs* 27:3 (May-June 2008), 783.

²¹ *Ibid*, 783.

foothold in the far northern or southern regions of Chile.²² The background information presented in this survey of the Chilean Health Care System provides a concrete basis for understanding the sophistication of the system that allowed Chile to implement a comprehensive reform, as well as the conditions that necessitated the reform.

III. The Implementation of Plan AUGE

Now that the theoretical and historical contexts have been provided, this section of the paper will explore the steps leading up to the creation of AUGE and its implementation. Early during his presidency, Ricardo Lagos established a committee to examine and propose changes to the health system. The committee was made up of representatives from the Colegio Médico, health workers unions, and private health providers.²³ The committee identified four challenges for reform: the aging of the population, the increasing cost of health care services, the gap between the socioeconomic strata with regard to benefits received, and the health gap between social groups.²⁴ After months of failed negotiations between the committee and Colegio Médico and a resulting strike in 2002, President Lagos stepped in to expedite the reform's approval.²⁵ The Chilean government wanted to craft a reform in which public and private providers could coordinate and serve their patrons under a common law. According to the World Bank report, Lagos was directly involved in using communication campaigns to counteract his opposition, discussing the reform in the lens

²² Reichard, "Ideology reforms," 92.

²³ World Bank, *Chile Regime of Explicit Health Guarantees (Plan AUGE)*, 2008, 3.

²⁴ *Ibid*, 3.

²⁵ *Ibid*, 4.

of human rights, confronting health care professionals with citizens' demands, and providing a forum for the civil society groups to come together and unite under the banner of reform.²⁶ By late 2003-2004, the Chilean legislature was on board with the reform so long as it remained a bill that was created from a social justice lens.

The legal framework, at this point known as the Regime of Explicit Health Guarantees, worked to establish new mechanisms for health funding and a comprehensive list of health problems to be included in the legislation. To oversee the administration and implementation of the bill, the state established the Office for the Superintendent for Health, a ministerial sub-secretariat, and numerous other smaller local councils.²⁷ In late 2003, Chile passed a law stipulating that the funding for the legislation would come from a temporary increase in the consumer tax, the tobacco tax, customs revenues, and the liquidation of the state's shares in FONASA.²⁸ This essentially means the state was placing its faith in the health care providers to work out the details of financing this massive legal undertaking without intervention. Lagos went on record in 2004 saying he would rework the national budget if the bill could not operate without more revenue.²⁹

Unlike the previously stated political initiatives, the state could not form a comprehensive list of health conditions to cover without the assistance of the Colegio Médico. Health professionals surveyed all of the major health problems that plagued Chile with a focus on their frequency, seriousness, and the cost of treatment. The most

²⁶ World Bank, "Plan AUGE," 4.

²⁷ Ibid.

²⁸ Ibid, 5.

²⁹ Ibid.

telling criterion was the number of years of healthy life lost, a statistic found by examining the early mortality with the disability that the disease can cause to those who survive it.³⁰ Commonly known as a DALY (disease-adjusted-life-years), this statistic was compiled primarily by reviewing the 2000 Quality of Life Survey and the 2003 National Health Survey.³¹ Attention was also given to mental health ailments, as well as conditions that generate only partial disability due to the fact that both branches of disease result in significant loss of quality of life. When the prioritization process terminated, the committee had a list of fifty-six ailments to include in the new reform.

After years of collaboration between the executive branch, legislative branch, Colegio Médico, and various other civil society groups, Plan AUGE was implemented in 2005. The legislation itself, Acceso Universal con Garantías Explícitas, is comprised of four explicit guarantees: Access, Opportunity, Quality and Financial Protection.³² The access guarantee stipulates universal access for the list of ailments without discrimination based on gender, sex, age, ethnicity, race, or socioeconomic status. The opportunity guarantee defines a maximum waiting period and guarantees an alternate provider if service is unavailable in the same time period.³³ The quality guarantee requires all physicians and hospitals to abide by the standards of accreditation, certification, and evaluation set forth by the Ministry of Health.³⁴ Each of the Chilean sectors of care has different regulations to abide by, ensuring that specialized attention is given to physicians engaged in different subspecialties. The guarantee of financial protection sets a

³⁰ World Bank, “Plan AUGE,” 5.

³¹ Vargas and Poblete, “Health Prioritization,” 784.

³² Vicente Valdivieso D and Joaquín Montero L, “El Plan AUGE: 2005 al 2009,” *Revista Médica de Chile* 138:8 (August 2010), 1040.

³³ *Ibid*, 1042.

³⁴ *Ibid*, 1043.

reasonable price ceiling for each covered ailment's diagnosis, treatment, and rehabilitation and pledges the government cover the costs that exceed the ceiling,³⁵

Plan AUGE also includes several concrete mechanisms for ensuring that its mandates are systematically carried out and its content continually edited. AUGE regulations fall under the responsibility of both the Ministry of Health and the Superintendent for Health. Chileans file claims e.g. waiting time grievances with the Superintendent regardless of with which provider (FONASA or ISAPRE) the citizen sought care.³⁶ Primary care providers issue periodic public surveys to their patrons, ensuring accountability on a practice-by-practice basis.³⁷ With an understanding of the policy-forming process and implementation of AUGE, one can approach the effects of the legislation from a more practical mindset, with the knowledge that each component of the law was aimed to alleviate a specific problem identified in the years leading up to AUGE.

IV. Critical Analysis of Plan AUGE

This section will cover analysis and evidence as to why AUGE cannot be considered a step towards equity in health care based on the context provided regarding equity and the Chilean Health Care System. Before I enter into my analysis, it would be dishonest to operate under the assumption that AUGE did nothing to benefit the Chilean Health Care System. AUGE is considered the chief cause for the Chilean government's

³⁵ World Bank, "Plan AUGE," 7.

³⁶ *Ibid*, 7.

³⁷ *Ibid*, 8.

increase in total health spending over the course of its implementation, rising from 6.9% of Chile's GDP in 2005 to 8.3% in 2009.³⁸ AUGE's treatments of more serious forms of cancer have led to drops in mortality rates over the first two years of its implementation, specifically in testicular, gall bladder, and breast cancer.³⁹ A Ministry of Health study showed that in the years following AUGE's execution, there has been a monumental increase in the early detection of cervical and breast cancer, indicating that AUGE is taking effect at both the primary and secondary levels of health care.⁴⁰ Bitrán and his associates also found that there have been massive drops in case-fatality rates for hypertension, type 1 diabetes, epilepsy, depression, and HIV/AIDS over the first year of AUGE (11%, 48%, 98%, 98.6%, and 56% respectively).⁴¹

Despite its documented and well-studied benefits, AUGE cannot be considered a step towards equity in health. With respect to infrastructure, AUGE is still a plan that is coming into full fruition and as such, AUGE has numerous problems with its administration. There appears to be an apparent lack of knowledge among AUGE's lower socioeconomic strata; according to the Superintendent, only 40% of the AUGE beneficiaries in the public sector are aware they have entered the system, suggesting an even smaller percentage are aware of the explicit guarantees laid out by AUGE.⁴²

Although the guarantee implies universal access, the Ministry of Health to date has not

³⁸ Global Health Expenditure Database, "Chile- National Expenditure on Health," World Health Organization, Accessed September 15th, 2011.

<http://apps.who.int/nha/database/StandardReport.aspx?ID=REP_WEB_MINI_TEMPLATE_WEB_VERSION&COUNTRYKEY=84010>

³⁹ Bitrán, et al. "After Chile's Health Reform: Increase in Coverage in Access, Decline in Hospitalization and Death Rates," *Health Affairs* 29:12 (December 2010), 2163.

⁴⁰ Ibid, 2164.

⁴¹ Ibid, 2167.

⁴² Charles Dannreuther and Jasmine Gideon, "Entitled to Health? Social Protection in Chile's Plan AUGE," *Development and Change* 39:5 (September 2008) 858.

developed procedures for monitoring access. This raises question marks regarding hospitals that previously had trouble securing health resources, especially in rural, remote areas of the country. Patients also have a difficult time voicing their opinions regarding AUGE; the Superintendent mainly considers the views of health professionals since professional opinions have been focused on specific clinical encounters.⁴³ This suggests that even in the scenario a patient had a problem with AUGE, the patient could do very little to affect change.

With respect to the guarantee of quality, there is a marked shortage of doctors, namely family medicine doctors, internists, pediatricians, OB/GYN's and psychiatrists across the country.⁴⁴ While highly urbanized centers have the means to recruit physicians, less densely populated areas often do not. Given the average physician density across Chile is one per 559, the central region (home to Santiago, Concepción, and Valparaíso) has a physician density of one per 471.⁴⁵ While this figure seems unexceptional, both the northern and southern regions have rates well below one per 800.⁴⁶ As mentioned above, the disparity of physician distribution is best understood when examining the statistics pertaining to medical specialists. Some of the most unequal distributions occur within the specialties of medical oncology and cardiovascular/cardiothoracic surgery, where the central and south central zones are

⁴³ Tomas Pantoja, Marcela Beltrán, and Gladys Moreno, "Patients' perspective in Chilean primary care: a questionnaire validation study," *International Journal for Quality in Health Care* 21:1 (February 2009), 51.

⁴⁴ Valdivieso and Montero, "El plan AUGE," 1043.

⁴⁵ Michele Guillou, Jorge Carabantes C, and Verónica Bustos F. "Disponibilidad de médicos y especialistas en Chile," *Revista Médica de Chile*, 139:5 (May 2011). 559

⁴⁶ *Ibid*, 559.

home to 98.4% and 97.9% of the specialists, respectively.⁴⁷ The shortage of physicians is especially present in FONASA; as of 2008, there are 920 beneficiaries per physician in the public sector, compared to a rate of 276 per physician with ISAPRE's.⁴⁸ This indicates that even with the implementation of AUGE, public-sector physicians are still far more saturated than ISAPRE doctors, perhaps even worse than before. While the majority of the population resides in the urbanized areas of the central regions, AUGE guarantees access and quality of care across the country, not just its major cities. Put simply, the Ministry of Health cannot guarantee quality of care if the distribution of physicians remains concentrated in the private sector and in the central regions of the country.

AUGE also creates problems specific to the patient-physician relationship. If an ailment is not covered in AUGE, the patron must find appropriate care in their FONASA or ISAPRE plan. This does not pose a huge issue for private-sector patrons however; the FONASA may not be able to cover the treatment. In this respect, AUGE does not do anything to alleviate the inequality between the two sectors. Additionally, this poses a problem for doctors' diagnoses distinguishing between AUGE and non-AUGE sicknesses. One physician noted the difference between oesophageal cancer (not covered by AUGE) and stomach cancer (AUGE-guaranteed) is about one millimeter.⁴⁹ This conflict is not uncommon with AUGE illnesses and continues to alienate physicians aspiring to remain professional and honest with their patients but who understand the problems of financing health care out of pocket.

⁴⁷ Guillou, Carabantes, and Bustos, "Disponibilidad de medicos," 567.

⁴⁸ Ibid, 563.

⁴⁹ Dannreuther and Gideon, "Entitled to Health?" 858.

Additionally, there remains a substantial subset of the population who opt not to receive care for AUGE-covered ailments within the system. In a recent study conducted by Amanda Dawes and Felipe Gonzalez, out of a sample of 9,127 AUGE-eligible individuals belonging to both private and public sectors, only 72% of the sample opted to receive AUGE treatment.⁵⁰ Within this sample, 94% of the subjects identified as FONASA patrons. The choice for FONASA patrons to opt out of AUGE was surprisingly competitive; only 73.7% of the FONASA patients chose AUGE over alternative treatment. Out of the 526 ISAPRE patrons in the study, only 193 of them opted to receive treatment through AUGE.⁵¹ This study demonstrates that there is a large group of patients, both in the private and public sectors, who believe that their best option to pursuing treatment for AUGE-illnesses is outside of the AUGE system. One can reasonably infer that the cause of this trend is that the quality of care is better outside of the AUGE system. The data presented in this section indicate the multitude of problems related to the implementation of Plan AUGE and as such, demonstrate why AUGE cannot be considered a step towards equity in health in its current form.

V. Discussion and Conclusion

A superficial review of the current problems in Chilean Health Care might lead to the conclusion that these issues are inevitable and based on Chile's global indicators, the government should simply stay the course. The fact remains that the Chilean government

⁵⁰ Amanda Dawes and Felipe Gonzalez, "On the Importance of Hospital Supply in Health Reforms: the AUGE Plan in Chile," Presented at Pontificia Universidad Católica de Chile (November 2010), 1.

⁵¹ *Ibid*, 9.

has a constitutional and a legal obligation to tackle these problems. In order to alleviate some of the strain caused by AUGE, the Ministry of Health has to circulate information regarding AUGE more effectively. Ignorance regarding the policies of AUGE cannot remain as an excuse as to why patients are not receiving AUGE benefits. Additionally, Chile must find a way to appease Colegio Médico or face the possible consequence of a physician brain drain. Physicians are well aware of the scarcity of some AUGE (and non-AUGE) resources and technology, creating a situation where frustrated Chilean doctors may seek an education, residency, or permanent work abroad. This appeasement must start with allowing the Colegio Médico more power within the Superintendent, so that doctors have a direct way of influencing the direction in which AUGE is revised.

Physicians aside, the most pressing issue in Chilean Health Care is finding a solution to the disparity in care, particularly along regional demographics. Although AUGE stipulates universal access and guarantees quality of care, it lacks the infrastructural mechanisms to ensure that the remote areas of Chile have the capital and medical staff to honor the government's guarantee. One possible solution to this conundrum is to incentivize physicians to practice in rural areas through entities such as the Chilean Rural Practitioners Programme. Programs like these across Chile provide doctors a number of forms of monetary and non-monetary compensation to pledge a predetermined amount of years in a rural area. While the Rural Practitioners Programme is concerned with permanent settlement of rural areas for its physicians, surveys have indicated that patrons, both public and private, are extremely satisfied with the quality of

care provided by doctors in the program.⁵² Incentive-based programs like these require minimal government funding considering the benefits to its participants are primarily non-monetary. Whether through this program or another, the Chilean government must find a way to improve the quality and access to care in the remote regions of the country in order to advance closer to equity in health care.

In addition to incentivizing rural health, the Chilean government should look into abolishing the private sector of care altogether. When the ISAPRE's were first created, Chilean physicians opposed their establishment because they were worried the quality of care in the public sector would suffer. Pinochet knew this but was more concerned about the profits the private sector could generate and as such, ignored the physicians' complaints. Now that the Chilean economy has some leverage, the government's abolishment of the ISAPRE's would bring about favorable consequences for health care in Chile. First and most importantly, the Ministry of Health (and by extension, FONASA and Plan AUGE) would assume control of ISAPRE assets and could use the revenue ISAPRE has generated to improve the quality of care in the public sector. FONASA would hire the private sector physicians and manage ISAPRE facilities. The government could compensate for its expenses to ISAPRE executives by temporarily raising the monthly contribution rate to 9%. Although this is a radical step given the revenue generated by the private sector, making the state-run public sector the only health provider in Chile would reduce the inequality gap in health care benefits, generate more

⁵² Sebastian Peña et. al, "The Chilean Rural Practitioner Programme" a multidimensional strategy to attract and retain doctors in rural areas," *Bulletin of the World Health Organization*, 88:5 (May 2010), 374.

health care revenue for the Ministry of Health, and provide a uniform improvement in quality of care.

While Plan AUGE has shown some benefit, it cannot be considered a step towards equity in health because of the problems the legislation has not addressed in its first six years of implementation. AUGE's importance lies in the fact that theoretically, the legislation is a sound alternative to health reform and a model that other nations in the region can follow. Its downfall is the Chilean government's inability to hold the Ministry of Health and the Superintendent accountable for the unfulfilled guarantees made by AUGE. The sophisticated health system, as well as a solid understanding of equity in Chile, made the creation of AUGE possible. Literature has demonstrated the marked areas that AUGE has benefited such as hospitalization rates for AUGE's diseases and mortality rates across the board. As the analysis shows, these benefits are not uniform across the population, as there is an ongoing disparity along socioeconomic and regional boundaries. The disparity can be attributed to a lack of AUGE infrastructural organization and enforcement, and a regional scarcity of resources and physicians. In summary, the Chilean government must find a way to alleviate the regional and socioeconomic strain facilitated by AUGE or face the consequences of further infrastructural debilitation, physician brain drain, or an ever-widening inequality gap.

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