Downloaded from jme.bmj.com on 3 September 2008

Inequalities and healthcare reform in Chile: equity of what?

J Burrows

J. Med. Ethics 2008;34;e13
doi:10.1136/jme.2007.022715

Updated information and services can be found at:
http://jme.bmj.com/cgi/content/full/34/9/e13

These include:

References This article cites 12 articles, 5 of which can be accessed free at:
http://jme.bmj.com/cgi/content/full/34/9/e13#BIBL

Rapid responses You can respond to this article at:
http://jme.bmj.com/cgi/eletter-submit/34/9/e13

Email alerting service Receive free email alerts when new articles cite this article - sign up in the box at the top right corner of the article

Notes

To order reprints of this article go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to *Journal of Medical Ethics* go to:
http://journals.bmj.com/subscriptions/

Downloaded from jme.bmj.com on 3 September 2008

Inequalities and healthcare reform in Chile: equity of what?

J Burrows

Correspondence to: Dr Jaime Burrows, Centre for Professional Ethics, Research Institute for Law, Politics and Justice, Keele University, Keele ST5 5BG, UK; j.e.burrows.oyarzun@ilpj.keele.ac.uk

A previous version of this paper was awarded the Chilean Medical Association, Bioethics Prize. Unpublished Category. December, 2005. Original title "Desigualdades y Reforma de la Salud ¿De qué Equidad hablamos?"

Received 17 August 2007
Revised 20 March 2008
Accepted 3 April 2008

ABSTRACT

Chile has achieved great success in terms of growth and development. However, growing inequalities exist in relation to income and health status. The previous Chilean government began to reform the healthcare system with the aim of reducing health inequities. What is meant by "equity" in this context? What is the extent of the equity aimed for? A normative framework is required for public policy-makers to consider ideas about fairness in their decisions about healthcare reform. This paper aims to discuss the main features of the Chilean healthcare reform and their implications for such a normative framework.

Over the last decades Chile has made important progress in terms of development. It is "widely seen as one of the most stable emerging market economies and has a record of high growth".[1] Thanks to this sustained growth, owing to its political and economical stability, Chile has reached a GDP of $10 874 per capita, and a human development index equal to 0.859, ranking 37th among 177 countries.[2 3] The percentage of the population living below the national poverty line fell from 45% to 17.0% between 1987 and 2004.[1] In the health field, similar progress can be observed, with a life expectancy at birth of 77.9 years, an infant mortality rate around 8 per 1000 live births, less than 1% of children under age 5 underweight, and 100% of births attended by skilled health personnel.[3]

Nevertheless, these successes are shadowed by an increasingly unequal social structure. For example, Chile is ranked ninth from the worst in terms of income distribution.[4] In 2000 the wealthiest 10% of the population received 42.3% of combined national income, while the poorest 10% received 1.1%.[1] Health status measures also suggest alarming levels of inequality: childhood mortality rates in 1998 were six times greater in children whose mothers had no education than the mortality of children whose mothers had the highest level of education.[5] In 2000 the birth rate in the group of women aged 15–19 years was almost 20 times greater in the poorest communities than the richest.[6]

During President Ricardo Lagos's term of office (2000–6), Chile carried out a healthcare system reform that aimed, among other objectives, "To reduce health inequities by improving health status of worst-off social groups".[5] Such an objective, to reduce health inequities, requires a normative framework to understand what equity means in terms of health, and specifically to know what should be the focus and extent of the policy changes aimed at reducing health inequities in a healthcare reform context. This paper aims to discuss the main features of Chilean healthcare reform and their implications for such a normative framework.

CHILEAN HEALTHCARE SYSTEM

We must start by explaining the main features of the healthcare system in Chile and outline the most important reforms introduced recently. Since the beginning of the 1980s, when the former dictator Augusto Pinochet ruled the country (1973–89), the Chilean healthcare system turned from a universal national health service, created in 1952 and very similar to the United Kingdom's NHS, to a mixed public-private system. This followed a series of reforms established under the libertarian mainstream that dominated the governments of many Western countries, then headed by Margaret Thatcher in the United Kingdom and Ronald Reagan in the United States. Pinochet's reforms aimed at reducing the role of public institutions, allowing for-profit healthcare services and health insurances to work under market rules. It is possible to track the starting point of such a reform to the Chilean constitution of 1980:

> "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 coordinate and to control the 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 the health system to use, either the private or the public system."[7]

The healthcare reform performed during the 1980s was based on the following principles: "individual freedom, justice, property right, and subsidiarity".[8] Individual freedom means freedom to choose the health insurance and the healthcare service, and freedom to decide how much each person spends on other goods. Justice means "to give each one according to his contribution", based on the pre-eminence of the property right, which implies that each one receives health care proportionally to what he or she pays directly or through a freely agreed insurance scheme. Property right is the right to decide the destiny of what is owned, in this case, one's own health as well as other goods. Subsidiarity means that the state does not interfere in activities that individuals can afford themselves as far as possible, but it should intervene if

Downloaded from jme.bmj.com on 3 September 2008

individuals cannot do so. In the Chilean context, the state allows the private sector to organise, administer and finance healthcare services and insurance; but the state also organises, administers and finances public healthcare services and a public health insurance (FONASA National Health Fund), because of the number of people unable to afford private sector costs.

After merging the private sector into the healthcare system, health progressively became understood as a commodity. The new system became a market of health service institutions where the private offering (doctors' offices, private hospitals) compete with the public healthcare offering (primary care institutions, public hospitals). There is also a market for health insurance, where private institutions (ISAPRE, private health insurance) compete with a public institution (FONASA).

The recent healthcare reform

In his first inaugural speech before the National Congress, President Lagos stated "that a central objective of his government was to contribute to guarantee the right to health for all the Chilean people according to their needs, without discrimination by ethnic origin, sex, religious beliefs, socioeconomic condition, age or the place where he or she lives. One of the main tasks of my administration will be to carry out a deep healthcare reform, focused on the rights and guarantees of the people and a solidarity-based financial system".[9]

To strengthen the right to health protection, the government proposed and successfully obtained the approval for a law that institutes a "system of health guarantees", which is the core of the reform. Through this system, for any group of health problems that has been prioritised by the health authority, the government can make explicit what is to be guaranteed by the Chilean state in terms of access, opportunity, quality and financial protection.

The justification preceding the proposal of the law that institutes a system of health guarantees stated that the intended healthcare reform has its foundations on five principles—namely, the right to health, equity, solidarity, efficiency and social participation. The right to health means that every person within the country has the right to a mechanism of social protection with universal and opportune access to health care when they are ill, and the right to healthy conditions in the place where they live and work, within the resources and possibilities of the nation. Equity is the consequence of an intentioned action aimed at identifying and reducing the factors and conditions that determine "avoidable inequalities in health". Solidarity is the effort of Chilean society aimed at obtaining for the most vulnerable the guarantees the wealthier have. Efficiency is a principle ruling the use of resources in the sector aimed at improving the health outcomes for the money spent. Social participation means the recognition of the people as customers and citizens, so they can express their preferences and expectations to improve the health policy through transparent mechanisms of information and involvement.[10]

What is to be guaranteed through this system is the access to certain health interventions determined by the health authorities, aimed at extending life expectancy and the quality of life, based on their cost-effectiveness and the priority given by the authority to the health problems those interventions are intended to solve. According to the System of Health Guarantees' Law, health authorities should consider previous economic evaluation and the potential demand for the interventions and the offering capacity of the Chilean health system, either public or private. Then, what is to be spent on the system depends on a limit set annually by the economic authorities according to the growth of gross domestic product (GDP).

Additional features of the healthcare reform were aimed at strengthening the health authorities' capacity to oversee the correct functioning of the "market in health" because it has important limitations—that is, information asymmetry; monopolies in areas of low population density; or the "prisoner's dilemma"; etc. Each of these failings creates groups that do not have access to health care, contributing to the production of health inequities.[11–15]

EQUITY IN HEALTH

In recent years, a large amount of literature has been published trying to define justice and equity in health, or at least trying to define when health inequalities are unjust or inequitable. We can classify such definitions, referring to:

- Equal access to and utilisation of health care for those in equal need of health care, or
- Equal health outcomes (as measured by, for example, life expectancy).

Authors, like Culyer, who emphasise equal access to and utilisation of health care propose that: "Equity in health care requires that patients who are alike in relevant respects be treated in like fashion and that patients who are unlike in relevant respects be treated in appropriately unlike fashion".[16] Some people think that "the principle of achieving equal health outcomes is potentially highly undesirable because it would require too many restrictions on the ways in which people may choose to live their lives".[17]

But the fact is, even when the access to the health system is equitable, there are remaining health inequalities that are hardly acceptable.[18] It has not been possible to eliminate health inequalities by simply removing the difficulties in accessing medical services, as can be seen in developed societies with significant social asymmetries. Over a certain level of development, health status is determined by an individual's place on the socioeconomic scale.

Supporting the emphasis on health outcomes, the most popular definition for health inequities is Whitehead's definition: "it refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust".[19] Braveman and Gruskin propose that equity in health could be defined as "the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage". Explaining this concept, they add "Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic or religious group) at further disadvantage with respect to their health".[20] Situations of vulnerability such as the lower income, greater material withdrawal, lower educational level or reduced access to health benefits are all associated with worse levels of health in certain groups of the society, and are all considered to be important "health determinants".[21]

Health inequalities and social determinants of health

There is growing evidence and scientific consensus to support the hypothesis that health inequalities are derived from social

 J Med Ethics 2008;34:e13 (http://jme.bmj.com/cgi/content/full/34/9/e13). doi:10.1136/jme.2007.022715

Downloaded from jme.bmj.com on 3 September 2008

inequalities that systematically disadvantage the poorer sections of society.[22–27] Those social inequalities in socioeconomic status (usually measured by occupation, education, income or ownership of assets such as homes or cars), gender, race or ethnicity, migration history, degree of urbanisation and religion or caste are recognised as social determinants of health.[28]

When greater inequalities in social determinants exist, such as income level, population health status shows a larger level of inequality. It occurs not only for the poorest people in relation to the richest, but is verifiable through the entire socioeconomic gradient. The slope of social inequalities is also reflected in the gradient of health inequalities. The steeper the socioeconomic slope, the greater the inequalities in health status between different classes. Fast growing developing countries are increasing the gap between wealthy and poor people and, consequently, the health gap is also enlarging.[25] In the middle-income developing countries, like Chile, there is a paradox: when poor people are ill, they receive better health care than ever before, and maybe the treatment will be the same as that provided to wealthy people. However, the risk of disease or premature death for wealthy people has reduced faster than the risk for worst-off people.[29] Developed countries and developing ones, which have greater inequitable levels of per capita income, have a lower health state than societies with smaller per capita income but a more equitable distribution of income.[21]

Equity in the Chilean healthcare reform

According to the "Health objectives for 2000–2010" statement of the Chilean secretary of state for health, to reach equity through health interventions it is necessary to diminish the risks and improve the health of those more vulnerable, those who belong to lower socioeconomic classes. This statement declares that the concept of equity should be based on the principles of distributive justice developed from John Rawls's *A Theory of Justice*. "Those principles [says the statement] have important implications in defining those inequalities in health that correspond to unfairness".[5]

Rawls goes beyond the classic liberal meaning of justice as "procedural justice". According to him, the social agreement is designed to ensure fairness between free and equal individuals, but it must allow those underprivileged groups to reach the best achievable situation, allowing them to participate effectively in social and political life.[30] Even though Rawls did not consider health in the list of primary social good, the Chilean government assumed that social and political involvement is seriously restricted when people lack the chance of attaining a suitable health status. The "system of health guarantees" is supposed to intend actions aimed at identifying and reducing the factors and conditions that determine avoidable inequalities in health.

DISCUSSION

How far does the Chilean healthcare reform make concrete changes to the healthcare system? What are the implications for a theoretical framework on health equity?

The Chilean healthcare reform started by President Lagos was aimed at switching the healthcare paradigm, departing from a libertarian account about health to arrive at an egalitarian one. For the libertarian account, the right to property principle goes before the principle of equity; therefore, the role of the state is limited to guarantee the functioning of the "market in health" and to supply the health care to disadvantaged people who are unable to afford it. From the egalitarian point of view, the goal is to reduce health inequities by improving the health status of the worst-off.

First, the Chilean healthcare system is still working under market rules. The reform did not eliminate the market as a mechanism to distribute resources in health, even though some mechanisms changed to control its correct functioning. Chilean people can still decide which system to choose, either the private or the public; and this decision depends on the individual's preferences, but mainly lies in economic capacity. The distortion produced by private competition, because the wealthier are offered additional health-related commodities (for example, use of individual rooms in private hospitals that are out of the reach for public institutions), leads to a breach in people's expectations about health care. Even if access to guaranteed interventions is equal across the socioeconomic scale, healthcare services are not equal for rich and poor people.

The second point to consider is how the universal access to health care is financed. The poorest receive support from the state through public insurance and public healthcare services, but those who have some income are forced to pay for insurance in either public or private institutions (7% of their salaries). So the use of public services does not mean that these services are completely paid for by public budget; instead, people whose income is only moderate have to partially pay as their income is not enough to pay for private insurance.

Third, all the guarantees are healthcare actions related to some important health problem, but the system of explicit guarantees does not allow for interventions related to social determinants of health. Interventions aimed at promoting health and preventing illness through public health actions still lack a robust system to guarantee them. Interventions eventually oriented to social determinants depend on the enthusiasm of the authorities in charge at the time.

Lastly, the mechanism to decide what is to be guaranteed depends on research on burden of disease and cost-effectiveness. These methodologies hardly help the worst-off people if their problems do not add up to as many quality adjusted life years (QALY) as other problems that may be more prevalent in wealthier people. Those interventions that improve health for worst-off people do not get priority if alternative interventions improve the health of a larger number of people. Similarly, economic studies performed to add new guarantees to the system are not intended to be redistributed to worst-off people, but to calculate the average potential demand costs, including private and public sectors, to set the limits for social expenditure in health.

Implications for the theoretical framework

The Chilean healthcare reform opted to maintain a market system that treats health as a commodity. This may reinforce the theory that health is an individual property that should not be equally distributed, but distributed according to market rules, where only those who are not able to participate receive the subsidiary support from the state. For the theoretical framework supporting the healthcare reform this is a major challenge, as it reduces the importance of health as a special good and puts it at the same level as other goods. Other consequences are a reinforcement of the question about what should count as a currency for egalitarian justice,[31] and what is the status of health before individual freedom or the property right.

The Chilean government states it aims at going upstream to the social determinants of health because of a concern about

Downloaded from jme.bmj.com on 3 September 2008

health outcomes being unequally distributed. Nevertheless, the new system emphasises the equal access to and utilisation of health care for those in equal need of health care. This could mean that the equal access to health care outweighs the importance of equal outcomes in health, or that it is not possible to give priority to social determinants of health. The difficulties in giving priority to such determinants through a system that guarantees equal health outcomes could range from the obstacles set by political opposition to any change in distribution of socioeconomic determinants, to the intrinsic difficulties in the design and the performance of effective interventions in this field. However, if we concede that the Chilean healthcare reforms fulfil the four conditions of the "accountability for reasonableness"[32]—namely, publicity, relevance, revision and appeals, and regulation, the main theoretical implication should be that the resulting outcome of such a process is that social determinants of health are not as much a priority as having a guaranteed access to health care.

The healthcare system recently reformed in Chile, as in any other country, deals with resource limitation. The system of guarantees arranges a method to set up an economic limitation to health expenditure. This challenges the other supporter of the egalitarian account, Amartya Sen, who proposes that a significant impact upon the health status of a country will require the efficient redistribution of income and an expansion in public expenditure, especially in the educational and health sectors.[33] His proposal suggests an additional dilemma for equity in health—the trade-off between equity and economic growth. The latter can diminish poverty by increasing the income of the poorest and improve their health status by improving elements associated with poverty (access to potable water, food and housing); but economic growth, in turn, requires macroeconomic stability, built upon the need to avoid possible inflationary pressures derived from measures such as the excessive expansion of public expenditure. The additional cost that would be required for reform that sought to tackle unequal health determinants could become a threat to economic growth in a developing country where there are still many people who fall below the poverty line.

CONCLUSIONS

The Chilean government stated its vision on health as a need to satisfy democratic equality. The intended objective of the healthcare reform is to set up a system that guarantees the constitutional right to protection of health and ensures equal opportunities to citizens. This objective rests on an egalitarian account developed under Rawls's theory of justice, but considering health as a primary good. In this account, interventions in the social determinants of health should be considered a main objective to obtain an egalitarian distribution of health outcomes.

However, the reform of the healthcare system has been unable to abandon some traits of a libertarian account—namely, the importance of individual freedom and the property right that justifies the persistence of a healthcare market.

The system does not guarantee interventions over social determinants. Instead, it gives priority to an egalitarian access to health care. If we agree that this was the result of an accountable and reasonable process, we can suppose that even with the empirical importance of social determinants of health and health outcomes, they do not have the same moral importance for those who decide the health policy.

Finally, the weight given to the efficiency in the trade-off between health equity and efficiency, challenges the importance of health equity when a country like Chile is still concerned about poverty. The overall efficient use of resources allows developing countries to reduce poverty and, therefore, improve the health status of worst-off people faster that when redistributive measures or excessive public spending slows growth. Thus, it seems to be a more appealing objective for the governments of developing countries.

Acknowledgements: I would like to thank Dr Angus Dawson who helped me with the translation into English and made supportive comments on the manuscript.

Competing interests: None.

REFERENCES

1. **Foreign and Commonwealth Office**. *Country profiles*. London: FCO (accessed 12 July 2007). Available from: http://www.fco.gov.uk/servlet/Front?pagename = OpenMarket/Xcelerate/ShowPage&c = Page&cid = 1007029394365&a = KCountryProfile&aid = 1019744942580.
2. **Ross-Larson B,** De Coquereaumont M, Trott C. *Human development report 2006*. New York: United Nations Development Programme. 2006 (accessed 12 July 2007). Available from: http://hdr.undp.org/hdr2006/report.cfm.
3. **Denny C.** *Human development report 2005*. New York: United Nations Development Programme. 2005. (accessed 5 July 2007). Available from: http://hdr.undp.org/reports/global/2005/.
4. **Dikhanov Y.** *Trends in global income distribution, 1970–2000, and scenarios for 2015*. New York: United Nations Development Programme. 2005 (accessed 5 July 2007). Available from: http://hdr.undp.org/docs/publications/background_papers/2005/HDR2005_Dikhanov_Yuri_8.pdf.
5. **Ministerio de Salud, Chile**. [*Health objectives for decade 2000–2010*. 2nd ed.] Santiago: Ministerio de Salud. 2005. [Spanish]
6. **Secretaría Regional Ministerial de Salud, Región Metropolitana**. [*Diagnosis of health in the metropolitan area*]. Santiago: SEREMI de Salud RM, 2005. [Spanish]
7. **Gobierno de Chile [Chilean constitution]**. Santiago: Ministerio Secretaría General de la Presidencia, 2005. [Spanish]
8. **Caviedes R.** [*Governing principles of the health systems*]. In: Giaconi J, ed. [*Health in XXI century, the necessary changes*.] Santiago, Chile: Centro de Estudios Públicos, 1995:19–39. [Spanish]
9. **Lagos R.** [Speech before the National Congress.] Valparaiso, Chile: 2000 (accessed 10 July 2007). [Spanish] Available from: http://www.camara.cl/hist/archivo/discurs/21m2000.pdf.
10. **Lagos R,** Artaza O, Eyzaguirre N. [Message from the President of the Republic to propose a new law that establishes a system of guarantees in Health]. Santiago: 2002 (accessed 10 July 2007). [Spanish] Available from: http://sil.congreso.cl/docsil/proy3244.doc.
11. **Murray CJL,** Gakidou EE, Frenk J. Health inequalities and social group differences: what should we measure?. *Bull World Health Organ* 1999;**77**:537–44.
12. **Jack W.** *Health insurance reform in four Latin American countries. Theory and practice*. Washington, DC: World Bank Development Research Group, 2000 (accessed 10 July 2007). Available from: http://www-wds.worldbank.org/external/default/WDSContentServer/IW3P/IB/2000/12/22/000094946_≥00121302021464/Rendered/PDF/multi_page.pdf.
13. **Wagstaff A.** *Measuring equity in health care financing: reflections on (and alternatives to) the World Health Organization's Fairness of Financing Index*. Washington, DC: World Bank Development Research Group, 2001 (accessed 10 July 2007). Available from: http://www-wds.worldbank.org/external/default/WDSContentServer/IW3P/IB/2001/03/20/000094946_01030305572311/Rendered/PDF/multi_page.pdf.
14. **Puig-Junoy J,** Jané E, Castells X, *et al*. [Recent Changes in the health systems of Latin America and perspective of future.] *Gac Sanit* 2002;16:2–4. [Spanish]
15. **Ortún Rubio V,** Del Llano Señarís JE. [State and market in health]. In: Del Llano JE, Ortún V, Martín JM, *et al*, eds. [*Health management: innovations and challenges*.] Barcelona: Masson, 1998. [Spanish]
16. **Culyer AJ.** Equity—some theory and its policy implications. *J Med Ethics* 2001;**27**:275–83.
17. **Oliver A,** Mossialos E. Equity of access to health care: outlining the foundations for action. *J Epidemiol Community Health* 2004;**58**:655–8.
18. **Evans T,** Whitehead M, Diderichsen F, *et al*, eds. *Challenging inequities in health: from ethics to action*. New York: Oxford University Press, 2001.
19. **Whitehead M.** *The concepts and principles of equity and health*. Copenhagen: World Health Organization, 1990. (Also in: *Int J Health Serv* 1992;**22**:429–45.)
20. **Braveman P,** Gruskin S. Defining equity in health. *J Epidemiol Community Health* 2003;**57**:254–8.
21. **Daniels N,** Kennedy B, Kawachi I. Justice, health, and health policy. In: Danis M, Clancy C, eds. *Integrating ethics and health policy*. New York: Oxford University Press, 2002.
22. **Marmot M.** The influence of income on health: views of an epidemiologist. *Health Aff* 2002;**21**:31–46.

Downloaded from jme.bmj.com on 3 September 2008

23. **Graham H.** Social determinants and their unequal distribution: clarifying policy understandings. *Milbank Q* 2004;**82**:101–24.
24. **Marmot M.** *Health in an unequal world. The Harveian Oration*. London: Royal College of Physicians of London, 2006 (accessed 5 July 2007). Available from: http://www.who.int/social_determinants/resources/health_in_an_unequal_world.pdf.
25. **Braveman PA,** Egerter SA, Cubbin C, *et al*. An approach to studying social disparities in health and health care. *Am J Public Health* 2004;**94**:2139–48.
26. **Contoyannis P,** Forster M. The distribution of health and income: a theoretical framework. *J Health Econ* 1999;**18**:603–20.
27. **Acheson D.** *Independent inquiry into inequalities in health*. London: Stationery Office), 1998 (accessed 5 July 2007). Available from: http://www.archive.official-documents.co.uk/document/doh/ih/ih.htm.
28. **Nuffield Council on Bioethics**. *Public health: ethical issues*. London: Cambridge Publishers, 2007.
29. **Gwatkin DR.** Health inequalities and the health of the poor: what do we know? what can we do? *Bull World Health Organ* 2000;**78**:3–18.
30. **Rawls J.** *A theory of justice*. Cambridge: Belknap Press of Harvard University Press, 1971.
31. **Cohen G.** On the currency of egalitarian justice. *Ethics* 1989;**99**:906–44.
32. **Daniels N.** *Just health*. Cambridge: Cambridge University Press, 2007.
33. **Sen A.** Health in development. *Bull World Health Organ* 1999;**77**:619–23.