Rebuilding the broken health contract in Chile

Article *in* The Lancet · April 2020

DOI: 10.1016/S0140-6736(20)30228-2

4 authors, including:

Francisca Crispi
The London School of Economics and Political Science
15 PUBLICATIONS **14** CITATIONS
SEE PROFILE

Avi Cherla
The London School of Economics and Political Science
4 PUBLICATIONS **1** CITATION
SEE PROFILE

Elias Mossialos
The London School of Economics and Political Science
373 PUBLICATIONS **8,427** CITATIONS
SEE PROFILE

*Pablo Cox, Rodrigo Riveros, Camila Leiva, Yuri Carvajal, Pablo Fuentes, Jaime Recasens, Alvaro Covarrubias, Francisco Torres, Daniel Ramírez, Marcelo Verdugo, Pablo Muñoz
pablo.cox@gmail.com

Unidad de Imagenología, Hospital Carlos Van Buren, Valparaíso 2341131, Chile (PC, RR, CL, PF, JR, AC, FT); Centro de Neurología Traslacional (PC, PM) and Centro de Investigación Biomédica (PM), Universidad de Valparaíso, Valparaíso, Chile; Escuela de Salud Pública, Universidad de Chile, Santiago, Chile (YC); and Instituto de Química y Bioquímica, Facultad de Ciencias, Universidad de Valparaíso, Valparaíso, Chile (DR, MV)

Rebuilding the broken health contract in Chile

Many Chileans think that their country has lost its way. Massive protests highlight the need for a political reform to prioritise universal health care. The uncritical worship of the most extreme version of the free market by the Pinochet dictatorship led to the dismantling of the social contract and privatisation of the social security system. A system of personal retirement accounts was mandatory for new workers whereas the current workforce could opt out from the existing government-managed schemes. The disability insurance system was also privatised. Insurees could opt out of government-managed health insurance systems (Fondo Nacional de Salud [FONASA]) and join private health insurance plans (Instituciones de Salud Previsional [ISAPRE]). The creation of a two-tier system was the end of the national health-care system created in the early 1950s.

In Chile, 17–18% of the population opts for private coverage.[1] FONASA has open enrolment policies and is funded by mandatory contributions. ISAPRE charges risk-rated premiums and can reject applicants with pre-existing medical conditions.[2] Premiums are highly restrictive for people who earn a low income. In 2015, the average premium was equivalent to 45% of the minimum wage. The health system institutional design leads to population risk and income segmentation: FONASA covers women and those who are poorer, older, and sicker; whereas ISAPRE covers those who are richer, younger, and healthier. ISAPRE spends 1·35 times more per insuree than FONASA, although they cover people with a favourable risk profile.[3] ISAPRE administrative spending is large, 12·67 times higher per insuree than FONASA,[4] with most of it being spent on marketing to attract insurees at low risk.

In addition, most Chilean doctors work in the private health-care sector and provide care to the small proportion of the population who are privately insured, for greater financial incentives. Only 44% of physicians have contracts (several on a part-time basis) with public providers.[5] The public sector is underfunded and ill-equipped to provide care for most of the population. As a result, inequality for those who are chronically ill, older, and poor is of alarming concern. Waiting lists for specialist consultations and surgery are common in public hospitals[6] and emergency rooms are crowded.

The legacy of the dictatorship is pervasive. The result of the broken neoliberal social contract is an unfair distribution of resources and a 40-year period of social disintegration and inequality. Chile must decide if the time has come for a profound structural change, based on a different set of political and ethical principles.

We declare no competing interests.

*Francisca Crispi, Avi Cherla, Ennio A Vivaldi, *Elias Mossialos*
e.a.mossialos@lse.ac.uk

School of Public Health (FC), University of Chile, Santiago, Chile (EAV); and Department of Health Policy, London School of Economics and Political Science, London WC2A 2AE, UK (AC, EM)

1 Organisation for Economic Co-operation and Development. OECD reviews of public health. Chile: a healthier tomorrow. Paris: OECD, 2019.
2 Roman-Urrestarazu A, Yang JC, Ettelt S, Thalmann I, Seguel Ravest V, Brayne C. Private health insurance in Germany and Chile: two stories of co-existence, segmentation and conflict. *Int J Equity Health* 2018; **17:** 112.
3 Castillo-Laborde C, Aguilera-Sanhueza X, Hirmas-Adauy M, et al. Health insurance scheme performance and effects on health and health inequalities in Chile. *MEDICC Rev* 2017; **19:** 57–64.
4 Gallegos Castillo EA, Muñoz Vergara A. Eficiencia de los seguros de salud en Chile un análisis desde la perspectiva de la protección financiera. Santiago: Universidad de Chile, 2016.
5 Ministerio de Salud. Informe sobre brechas de personal de salud por servicio de salud. Santiago. 2017. https://www.minsal.cl/wp-content/uploads/2015/08/Informe-Brechas-RHS-en-Sector-P%C3%BAblico_Abril2017.pdf (accessed Nov 1, 2019).
6 Bossert TJ, Leisewitz T. Innovation and change in the Chilean health system. *N Engl J Med* 2016; **374:** 1–5.

Malnutrition needs prioritisation and public resources

Malnutrition is indeed a global emergency, and courageous and timely actions are needed from governments, media outlets, non-governmental organisations, and civil society.[1] Nevertheless, I believe that a reduction in malnutrition is only possible if there is political will, economic stability, and a prioritisation of malnutrition as public policy and a developmental issue by governments, especially in developing countries. In Pakistan, public health is a conundrum as the country is facing challenges such as high rates of teenage pregnancies, early child marriages, undernourished mothers, and less-spaced pregnancies (<24 months between pregnancies). These challenges lead to a vicious cycle of high morbidity and high mortality and, thus, adverse child health outcomes.[2]

Unfortunately, malnutrition is not a public priority in many developing countries including Pakistan due to the lack of essential resources (eg, low tax-to-gross domestic product ratio or adverse balance of payment situation) and expertise (eg, human resources, technology, and a general understanding of the issue). Furthermore, in most developing countries, obesity is not a topic of public debate. For example, in Pakistan, it was only in 2012 that data