Health Systems

Health sector reform: priorities and packages
Alberto Infante

Measures of health sector reform have been adopted in Chile, Colombia and Mexico. The extent to which they promote equitable access to appropriate health services is considered below.

In Latin America the only countries in which the implementation of health sector reform has been in progress for a substantial period are Chile, where it has been evaluated and partially reoriented, and Colombia; in Mexico it was launched comparatively recently. The situation in each of these countries is examined below, with particular reference to the introduction of basic packages of preventive and clinical interventions.

Chile
Health sector reform began in Chile during 1980 against a background of drastic reductions in public expenditure, public sector contraction and privatization. Part of a social security reform, it involved:

- decentralization of public health resources and management to 26 regional services, and municipalization of primary care, a process completed in 1988;
- giving people a choice of either paying a compulsory premium to the established state system of insurance or to one of the health insurance institutions (ISAPRES) created in accordance with the 1980 Constitution.

The health insurance institutions are private independent bodies that can be “open”, with affiliates of any type, or “closed”, with affiliates belonging to only one company. By the end of 1994 there were 23 of the “open” kind and 14 of the “closed” kind in operation, and about 26% of the population had become members. Only very few of these institutions manage their own facilities.

The workers who became members had relatively high incomes, and per capita expenditure was 2.3 times higher than in the state system. The principle of “who pays most receives most” holds sway in ISAPRES: risk selection is such that the
Reform of the health and social security systems in Chile, 1993-95

Reorientation and prioritization of health programmes:
- readjustment for demographic and epidemiological transition.

Financing reform for better management:
- analysis and control of beneficiaries' contributions (fighting fraud);
- resource allocation based on regional priorities and local projects, with definition of prospective budgets.

Fostering the regulatory role of the state:
- in respect of hospitals, clinics, doctors, laboratories, technical requirements, safety, quality of clinical process, information given by private insurance companies to users, and accessibility.

Improvement of the health insurance system:
- the superintendency has been strengthened in order to tackle misuse of public facilities and other problems, and efforts are being made to correct shortcomings in the health insurance institutions (ISAPRES) related, for instance, to chronic and catastrophic pathologies.

Structure and operation of the new health sector:
- modification of the legal framework;
- increasing the public health budget in order to improve and restructure facilities, modify systems of remuneration, modernize management, and meet the needs of the population.

elderly, the chronically ill and some original members who cannot afford increasing premiums are forced to remain in or to return to the public system (1). Furthermore, because there is no coverage of catastrophic risk, complementary private insurance schemes have emerged.

In 1990 the following major problems were confronted:

- the underfunding of public hospitals was affecting quality;
- the municipalization of primary health care facilities was creating financial problems and a shortage of qualified personnel;
- the relationships between the public system and the subsystems of ISAPRES, and between these institutions and their clients required regulation.

During 1991 and 1992 it was decided to increase the health budget by 50% over four years, using national funds and international loans. A superintendency was created for ISAPRES, and two laws were proposed, one to regulate these bodies and another to reorganize the primary care financial system on a capitation basis. Both laws were eventually passed as part of a cautious approach to reorienting the health system.

The law on health insurance institutions came into force in 1995, empowering the superintendency to clarify their functions. This resulted in a reduction in per capita expenditure by the institutions, although it was still 1.6 times higher than that in the public system.

A package was drawn up on the basis of Oregon's Medicaid Managed Care programme, with adaptations to the Chilean
Health sector reform in Chile: superintendency strategies, 1995

- Increasing fees and number of reasons to cancel activity of health insurance institutions (ISAPRES).
- Suppressing "not covered" periods for certain benefits.
- Limiting possibility of risk selection.
- Regulating clients' use of financial surpluses of ISAPRES.
- Facilitating clients' voluntary exit from ISAPRES.

epidemiological profile. It included curative and preventive services, and was to be totally or partly subsidized by the state. Health services that were not included were to be financed from additional fees that were not exempt from taxes.

In order to limit risk selection and promote equity the suggestion was made that a compulsory package of benefits, financially accessible to lower-income groups, should be offered to members of ISAPRES. However, no such provision materialized and the issue remains to be considered.

Colombia

In 1991 the new Constitution defined social security as a public service to be offered under state control, following principles of effectiveness, universality and solidarity. Health was declared to be a right of all citizens; the participation of the private sector in health care was confirmed; services were to be decentralized in accordance with their complexity; community participation was encouraged; and basic health care was to be free of charge. The health system was reformed in 1993, taking into account the following circumstances.

- A third of the population lacked regular access to health services.
- Expenditure on health was about what could be expected in view of the country's level of development.
- Inadequate coverage reflected inequity and ineffectiveness deriving from institutional fragmentation; there were, for instance, over 1000 entities with different benefits schemes.

Health-promoting entities are required to provide, either themselves or by arrangement with provider entities, a benefits package in exchange for a guaranteed per capita contribution, and to offer their members more than one option for provision. Complementary plans, financed by additional voluntary premiums, can also be offered.

For members of the contributory subsystem the package has to be at least equal to the benefits provided by the Social Security Institute. In 1994 the per capita unit cost in the subsidized subsystem was US$59, roughly half that in the contributory subsystem, and its basic package content was therefore defined in a more restrictive way (2).

The contents of both packages were determined in accordance with the disease burden calculated in terms of disability-adjusted life years (DALYs). This resulted in the designation of 33 groups of treatments for diseases that had similar risk factors, were present in the same population, and were treated in similar ways or at the same level of care. By 2001 it is intended that the subsidized package will have been improved to the level of the contributory one.
Objectives of health sector reform in Colombia

- Universal coverage to be achieved within a reasonable period, with compulsory affiliation to the social security system.
- Increased solidarity and a compulsory health plan with a contributory subsystem and a subsidized one for the poor and most vulnerable groups, financed by a solidarity fund.
- Increased efficiency, with competition and free choice between public and private insurers (health-promoting entities).
- Fostering public health through a basic care plan defined by the Ministry, implemented by municipalities and financed by a mixture of central and local funds.

- Decentralizing the implementation of the basic health plan is a risky long-term strategy, and the Territorial Councils for Social Security in Health are still inadequately developed.
- It is unclear whether the new model will substantially improve matters in respect of the fragmented nature of the public insurance system. The creation of health-promoting entities is largely unrestricted since the minimum conditions for affiliation are weakly applied. The law raises the possibility that health-promoting entities may not diversify supply in places where there are insufficient providers, and contains no financial mechanisms for channelling providers towards underserved areas. Thus the risk remains that geographical inequities in coverage will continue.

Mexico

Mexico’s Health Sector Reform Programme was released in 1996 (3). The basic package for the rural poor includes 12 interventions, comprising 60 actions and 220 activities, addressing eight of the ten main causes of mortality. A basic list of 40 essential drugs and pharmaceutical products is associated with these interventions. At the beginning of 1997 the basic package was introduced in 380 municipalities inhabited by over 4 million people, 30% of them without regular access to care. There is also a more comprehensive list of essential actions aimed at populations not covered by social security, conceived as a performance agreement to be fulfilled by the 17 states in which services for these populations are not yet decentralized.

The following concerns have emerged.
As the criteria for assigning federal resources to the states are unclear, the possibility exists that interterritorial disputes will arise, even in the short term.

As limits for opting out were not initially mentioned, there could be financial problems in the social security system. Furthermore, there is a need for a national body to regulate private health insurance companies from the very beginning.

Because of a lack of data on the cost of and budgetary provisions for the basic package there are questions about sustainability and financial equity.

There is insufficient clarity about whether the basic package will be delivered through the primary care system as it currently exists or through new units.

International financial institutions play an important role in all three countries. Thus, for example, of the $63 million Colombia is investing in health sector reform, $38 million have been made available as a loan from the World Bank. Problems may arise when such funds go to political and strategic designs and studies associated with health sector reform rather than to the development of the health service infrastructure, the acquisition of equipment or the training of personnel. It is important to maintain a balance between national and international approaches.

Chile's health sector reform has had considerable influence in Latin America. One should bear in mind, however, that it began after seven years of drastic cuts in public expenditure on health (4). It has been evaluated since the beginning of the 1990s and is now subject to reorientation involving more regulation of public and private providers, more financial solidarity, and more equity.

Although the great diversity of circumstances in different countries makes it advisable to proceed cautiously with
health sector reform, a consideration of one country’s experience may be of value when reform is being contemplated in another. In Colombia, some criticisms of the Chilean model have been taken into account, particularly regarding basic packages, risk selection and government control of health-promoting entities. It remains to be seen how Mexico will profit from the experience of Chile and Colombia, especially in the areas of health insurance skimming, cost evaluation, timetables for extension coverage programmes, incorporation of public administrative levels and private providers into coverage efforts, and elimination of overlapping in the public network.

There are ethical, political, methodological and implementation problems associated with the establishment of basic packages. In Latin American countries this strategy has been promoted with two purposes:

- either to regulate an emerging private health insurance sector and enhance efficiency, as in Chile;
- or to increase regular access, as in Colombia and Mexico.

The establishment of basic packages in Chile was promoted as part of a strategy to redirect public health funds to the most needy and to open the middle-class private health insurance market to financial opera-

tors. Unfortunately, the financial sector was not particularly happy with the strategy, which, furthermore, was not defended by certain parts in the government.

The costs of the Chilean scheme and the Colombian subsidized package greatly exceed the World Bank’s basic package proposal for middle-income countries and the proposal made at the Summit of the Americas held in Miami in 1994. The same may also be true of the Mexican programme. This may be related to a proportionately low public expenditure on health, although there are suggestions of a similar state of affairs in countries with higher levels of such expenditure.

Some concerns remain about the “basic package of benefits” approach as a way of providing equitable access to basic health services. Focusing efforts on the most needy can be justified as a way of incorporating them into a general health system of good quality. However, if this perspective is lost there is a possibility of promoting a dual system in which there is public finance for the poor and private finance for everybody else, with indirectly reinforced marginalization. This might be politically useful in the short term but there is a risk of duplication and, in the medium term, of a failure to achieve equity. In order to avoid this it is necessary to assess the relationship between problem analysis, strategies and action, and to have clear plans for guaranteeing coverage according to health needs, including those associated with catastrophic risk.

Health sector reform should promote equitable access to appropriate health services. It should not merely present big companies with health insurance markets comprising upper-income groups, while
maintaining inferior cover for the poor. In this connection it is important to remember that, in many Latin American countries, per capita incomes for 1993 were lower than they had been a decade earlier. The number of people living in poverty in these countries is estimated at 210 million, which is higher than ever before.

**Acknowledgements**

The author thanks Daniel López-Acuña, Matilde Pinto, Pablo Isaza and Charles Godou, Division of Health Systems and Services Development, PAHO, Guillermo Frías, Resident in International Health, and Marcos Vergara, Chilean Ministry of Health, for their valuable contributions and comments.


---

**Health care provision in Latin America**

The most important provider within the public sector is the ministry of health, which is charged with two major functions: prevention and sanitation (e.g., immunization, environmental sanitation, control of endemic and epidemic diseases, health education, supervision of all health care, etc.) and curative services. ... Social insurance has become the second major provider of health care in the Region (basically curative services), mainly through the sickness-maternity program and, to a lesser extent, through employment-injury and family-allowance programs. ... The private sector is essentially devoted to for-profit or nonprofit curative medicine. It constitutes the smallest of the three sectors, with the possible exceptions of Brazil’s, although it is rapidly expanding in many countries.