Maria S Martinez-Gutierrez

*Arrival*

I arrived in Santiago, Chile on July 4th with my two children and was immediately overwhelmed by a sense of urgency. I needed to set up a series of interviews with healthcare providers and patients of primary care facilities in the municipality of Estación Central, but I also needed to put my affairs in order (get a new visa, talk to my employers in Chile to let them know what were my plans for the next two years, and celebrate my son’s birthday with his extended family among other things). The purpose of my trip was to develop contacts with the Office of the Health Superintendent and to conduct a pilot qualitative study of public and private provision of primary health care in Chile for low and middle-income populations in Santiago.

*The Chilean Health System*

The health system in Chile can be described as a two-tier system with two major types of **health insurance** — public and private. Although, health insurance is partially tied to employment (every employed worker is required to contribute 7% of his or her salary towards health insurance), it can be said that Chile has “effectively reached universal health insurance enrollment” (Savedoff, 2009). Even within each type of insurance the population has access to different health plans depending on their income level.

Within Chile’s health system, low-income people are publicly insured in plans enabling them to get primary care services in public primary healthcare facilities (Bitrán, Escobar, & Gassibe, 2010). Primary care in the public healthcare network is largely delivered through primary healthcare centers (PHC) where a variety of services are offered on-site. Delivery of healthcare services is organized around standardized procedures and payment is capitated (Vargas & Wasem, 2006), with built-in incentives to provide preventive services. PHCs, even though decentralized at the local level, are an integral part of the national public healthcare network; consequently, national vertical programs such as immunization programs (Vargas & Wasem, 2006) operate through PHCs that standardize and make accountable the provision of primary healthcare services in each municipality or locality.

On the other end of the spectrum, privately insured high-income people generally choose to go to private providers for primary care services (Bitrán, Escobar, & Gassibe, 2010), some of them with high standards of care (for example, the U.S. Joint Commission has accredited a few private hospitals in Chile). High-income people tend to obtain their full set of healthcare services in integrated healthcare facilities housed in hospitals.

Middle-income people can choose to go either to public or private primary healthcare providers[[1]](#footnote-1). This decision could partly be influenced by their affiliation with public or private insurance since privately insured people have better coverage for private providers than publicly insured groups. Additionally, for this group, income could be an important predictor of choice of provider since out-of-pocket expenses in this group tend to be higher than for high-income groups that are able to buy health plans with better benefit packages (Holst, Laaser, & Hohmann, 2004). Primary care private providers serving this population constitute a heterogeneous group ranging from stand-alone practitioners, small practices, medical centers and private hospitals. Generally, they are not accredited by any agency and work under fee-for-service arrangements so they generally do not have incentives to provide preventive services. As a result, the Chilean health system, much like the education system, is extremely segregated; the more money you are willing to pay the better access to remedial health services you get. In terms of quality of services, there is no evidence that private primary care is better than publicly delivered services.

*The gap between the plan and the reality*

For the pilot study I wanted to interview healthcare providers to ask them about the characteristics and features of the systems they worked in such as continuity of care, coordination with other levels of care and comprehensiveness of care. I also wanted to ask low and middle-income users of the system how they chose which type of facility to attend and what characteristics of their healthcare delivery system they value the most. The first week of scheduling was hectic, trying to contact the municipality’s officials and getting their authorization to do my research. The week ended with a polite refusal; municipal elections would take place in the next few months and the political atmosphere was turbulent to say the least. Quickly I started looking for another municipality. After considering every municipality in Santiago that had a mixed low and middle-income population and a large enough number of private primary healthcare providers, I selected the municipality with the smaller population in order to be able to interview a large portion of the providers’ population in that area. After a fair amount of bureaucratic procedures I was able to get the authorization to contact public primary healthcare centers. In the meantime, I had secured the services of a research assistant who helped me set up interviews with private providers and patients. In the end I managed to interview twelve primary healthcare managers and physicians (four from the public sector) and to conduct two focus groups with patients of a public healthcare facility. My research assistant is continuing to conduct focus groups and interviews with patients on both the public and the private system.

Concurrently, I wanted to contact the Office of the Health Superintendent to find out about the data they had on primary care providers (any data beginning with a list of providers and basic information such as number of visits per year) and the ongoing efforts the Office was making to regulate providers’ quality of care. Although I e-mailed the Office incessantly, and called almost daily I was not able to get an appointment with the Providers Commissioner. However, I was able to interview the Chief of the Research Department of the Chilean Medical Association who had been a Providers Commissioner during the last administration. He told me about the regulatory scene: the Healthcare Guarantees plan[[2]](#footnote-2) (GES) included a quality guarantee, but the implementation of this requirement has been slow. Before the plan was put in place, private healthcare facilities have been required to get an authorization from the state to operate but once they were authorized they generally were not subjected to any supervision thereafter. This information is, to this day, not centralized and is housed in each region’s public health department. In 2005, things changed, mainly for hospitals. Both private and public hospitals had to be authorized to operate and they started an accreditation process that will eventually become mandatory in 2013. Facilities providing outpatient services have started the process at a much slower pace; not only that but they will be accredited using standards for curative service provision. Bottom line, the Office of the Superintendent did not have a lot of data on ambulatory care providers.

*What did I find?*

Both public and private providers agreed that the main challenge PHCs face is the lack of resources (especially a lack of primary care doctors). No surprises there. What I found interesting was that private providers saw themselves as a “necessary evil.” Some of them even told me that they should not be providing primary care services for low-income populations. They do think they should play a role in the provision of services for middle-income populations but explained to me the problem they encounter when providing care to low-income people. With much sacrifice, poor people raise money to attend a private healthcare facility only to realize they don’t have enough to take them to the next level of care. They will need more money to pay for medications and lab tests and that is only if their problem is not serious enough to merit inpatient treatment.

Private doctors and managers were also very candid in their assessment of the comprehensiveness of care they provide. They explicitly recognized that they do not provide as much preventive services as the population needs, and they blame this on the way health financing works in the private sector; preventive services such as home visits are not reimbursed by health insurance plans (either private or public). They also recognized that their approach is eminently individualistic, without any consideration for the patient’s context, either their family or their community. In contrast, almost every public provider mentioned with pride the fact that a health team regularly visited the community, especially patients that were confined to bed and could not go to the PHC to receive care. Patients also spontaneously mentioned this program.

Another thing PHC patients valued was getting care for free and the fact that the PHC they regularly used had been improving in terms of accessibility and comfort.

Finally, public managers and doctors highlighted the fact that in public centers care is provided by a multidisciplinary team that has been assigned a portion of the center’s families, operating in practice as a “medical home” for those families. In this way, the population is divided in sectors (groups of people) that effectively have a regular source of care (as long as health workers in the team stay in that PHC).

*Why do I care?*

A few months ago, President Piñera announced the expansion of the public health insurance voucher system to some low-income groups[[3]](#footnote-3) allowing them to have access to the same type of private providers I studied in Santiago. At a first glance this decision may seem beneficial; Chile would be improving access to primary care services for low-income people with the added benefit of freedom of choice. But, looking at the big picture, we do not know if the money spent in these vouchers would yield a bigger return on investment — better health for the Chilean people — than spending this money in the public primary care system. My research describes how public primary healthcare services are inherently different than services provided in a private setting. More evidence about the quality of services provided, not only in terms of patient satisfaction but also in terms of effectiveness, is needed. It’s time we stop assuming uncritically that, in Chile, private care is better than public care, especially in terms of primary health care.

References

Bitrán, R., Escobar, L., & Gassibe, P. (2010). After Chile's health reform: increase in coverage and access, decline in hospitalization and death rates. Health Affairs , 29 (12), 2161-2170.

Holst, J., Laaser, U., & Hohmann, J. (2004). Chilean health insurance system: a source of inequity and selective social insecurity. Journal of Public Health , 12 (4), 271-282.

Letelier, L., & Bedregal, P. (2006). Health reform in Chile. Lancet , 368 (9554), 2197-8.

Savedoff, W. (2009). A moving target: universal access to healthcare services in Latin America and the Caribbean. Inter-American Development Bank Working paper (667).

Vargas, V., & Wasem, J. (2006). Risk adjustment and primary health care in Chile. Croatian medical journal.

1. “Actividad”, FONASA statistics, Excel document. www.fonasa.cl [↑](#footnote-ref-1)
2. The implementation of healthcare reform in Chile started in 2000 with a new program known as the General Guarantees in Health Bill (GGH) which “…creates a system of explicit guarantees [for both private and public sectors] in predefined health conditions for access, opportunity, quality …[of] services, and financial protection” (Letelier & Bedregal, 2006). [↑](#footnote-ref-2)
3. http://www.latercera.com/noticia/nacional/2012/07/680-470987-9-pinera-anuncia-que-pensionados-vulnerables-de-fonasa-podran-acceder-a-bonos-de.shtml [↑](#footnote-ref-3)