

# The Politics of the AUGE Health Reform in Chile

## A Case Study prepared for the Results for Development Project

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### 1. Background

In 1994 President Frei pondered the need for social reform in Chile and considered the two sectors most in need of change: health and education. Upon consultation with his closest political advisors, he chose education; attempting to do anything in health, they said, would be politically very risky. During a previous government, a strike by emergency doctors had forced out the Minister of Health. Chile's Medical Association had a fearful reputation as a powerful political force, never before defeated. Thus, passing the responsibility of health reform to the following president seemed like a wise move.

Enter President Lagos in 2000. A lawyer and PhD economist from the University of Duke, he had been a member of Chile's Socialist Party and a political exile during the military regime of Augusto Pinochet. Early into his six-year term, he visited a rural health post in a remote southern location. There, villagers asked him if his government would be willing to co-finance a wood stove to heat up the facility during the cold and humid winter. Back in Santiago, and still struck by the modesty of the request, President Lagos mentioned the incident to his close friend and public health expert, Dr. Hernan Sandoval. "What kind of health system do we have where citizens have such modest expectations and feel so little empowerment?" (see Appendix A for an overview of Chile's health system and Appendix B for an overview of Chile in the Latin American context).

Figure 1 President Ricardo Lagos



President Lagos thus made the resolute decision to develop and implement a deep health reform under his term. He appointed Dr. Sandoval as head of the Health Reform Commission and informed the Minister of Health, Dr. Michelle Bachelet, of his commitment to reform. Dr. Bachelet, herself a former political exile and the daughter of a dissident general who had died during Pinochet's regime, was uncomfortable having in her cabinet a Health Reform Commission that she didn't direct. Further, she had a traditional view of health policy based on big government, and felt that the existing problems in the health sector could be solved through increased public financing.

### 2. The shaping up of the AUGE reform

President Lagos was concerned with the contents of the reform and with the political process that should lead to its approval in congress. He set up several technical reform committees including ones in the Ministry of Health (MOH), the Ministry of Finance, and the Secretariat of the Presidency. If these committees failed to reach a common view about the

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reform, differences would be bridged at a higher level through the Ministers Committee. Any remaining disagreements would be resolved by Lagos himself.

The head of the reform commission within the MOH, Dr. Sandoval, wanted to avoid the political problems that health reform initiatives had met elsewhere. In his mind, a prominent failure was that of Hillary Clinton's health reform initiative in the U.S. He thus engaged David Michaels, former advisor to Ms. Clinton now working at the U.S. Department of Energy, to learn from his failed experience. Michaels summarized Clinton's mistakes as follows:

- At the design stage the Clinton reform initiative involved only technicians but no politicians.
- The reform seemed more concerned with health insurance than with health care.
- The initiative was mainly focused on the problem of lack of health insurance for 30 to 40 million American while paying relatively less attention to the health system for the majority 200 million Americans with insurance.
- The Clintons and their collaborators did not anticipate the extent to which interest groups would oppose the reform (they spent US\$5 billion fighting it).

From this Dr. Sandoval concluded the following regarding the AUGÉ health reform:

- It should have at its base a clear long-term political view.
- It should focus on health care and health systems.
- The reform should not be formulated as one solely concerned with the health problems of the poor, but of all citizens.
- Reform strategists should be prepared to deal and defeat the huge opposition that would come from various interest groups.

### **3. The design**

In its early design, the AUGÉ reform, as submitted by Dr. Sandoval to President Lagos, contained the following key elements (see Appendix C):

*Patients' Guarantees.* The reform would grant the beneficiaries of Fonasa and Isapres explicit guarantees regarding:

- The kinds of medical problems that would be covered and the kinds of health interventions that would be offered to deal with those problems; they were referred to as *Access Guarantee*.
- The quality of those interventions, known as *Quality Guarantee*.
- The maximum time that the beneficiaries of Fonasa and Isapres should wait before receiving the guaranteed interventions (*Opportunity Guarantees*).
- The maximum copayment that beneficiaries would be expected to make when receiving care for the guaranteed interventions. A copayment table was defined stating upper limits to copayments in proportion to the beneficiaries' monthly income (*Financial Protection Guarantee*).

*Compensation Fund.* A fund would be set up with contributions by individual Isapres and Fonasa to compensate those insurers who had a higher-than-average actuarial risk, defined on the basis of the age and gender of its beneficiaries.

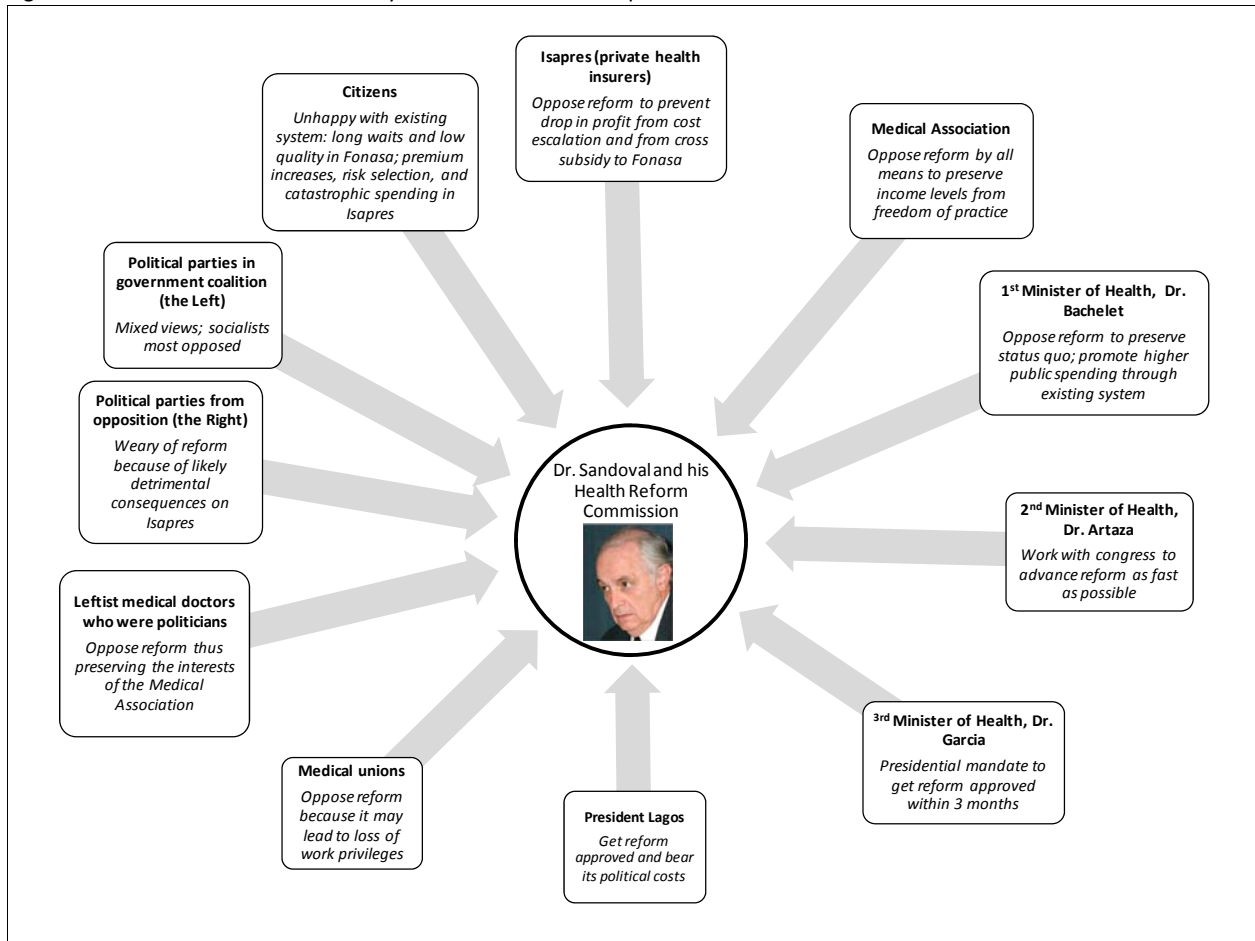
#### **4. The reform stakeholders**

Reform stakeholders quickly surfaced and expressed their views (see Figure 2, counter-clockwise, beginning from the top right):

1. The Minister of Health, Dr. Bachelet, wanted to avoid a major reform and instead was in favor in increased public financing for health. She promoted a draft law, known as Health Rights and Responsibilities of Citizens, and submitted it to the congress; to date it has not yet been approved. She managed to get political support to postpone the AUGE reform, as conceived by Sandoval.
2. The Medical Association was fiercely against the reform. It followed its usual strategy preserving the *status quo*.
3. The Isapres were concerned that the reform would result in increased spending and thus in a drop in their profits. They also were against a component of the reform which promoted the implementation of a Compensation Fund that would require the Isapres to provide a cross subsidy to Fonasa to compensate it for the greater medical risk of Fonasa's beneficiaries resulting from risk selection by the Isapres (show figure with beneficiaries' differences in age and gender between Isapres and Fonasa).
4. Citizens covered by Fonasa were very unhappy with it because they were often forced to wait for months or years for certain medical procedures and the quality of care in the public sector was low. Those covered by Isapres were unhappy about high annual increases in their premium, risk selection and exclusions, and insufficient financial coverage against catastrophic medical expenses.
5. Political parties belonging to the leftist ruling coalition (known as *Concertacion*) had mixed views about the reform. The Socialist Party most clearly opposed it.
6. Political parties in the rightist opposition disliked the reform because it threatened the profitability and long-term existence of Isapres.
7. Medical doctors who were professional politicians opposed the reform representing the interests of the Medical Association.
8. Medical unions, in particular the National Federation of Health Workers, historically controlled by the Communist party, were against the reform fearing a loss in work stability.
9. President Lagos was prepared to support the reform, face all political costs, and do what was required to get it approved by the congress in the shortest possible time.

#### **5. The Strategy of President Lagos and Dr. Sandoval**

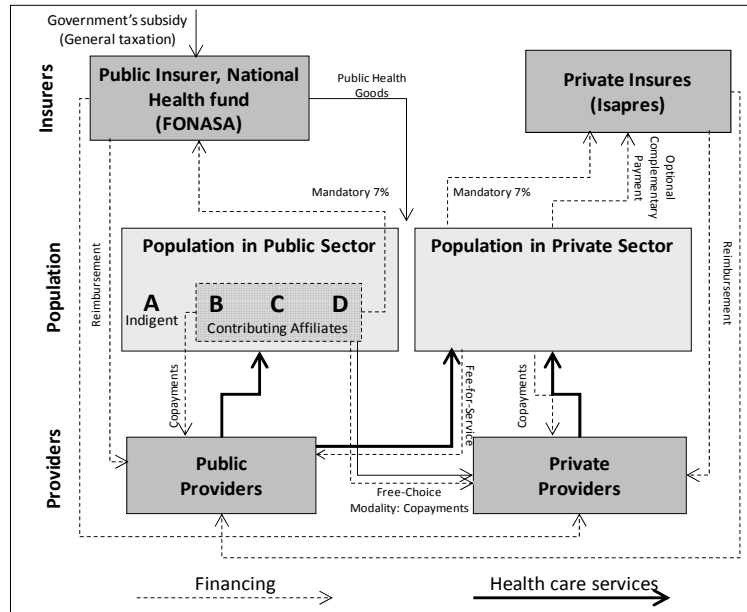
Figure 2 The AUGE health reform: Policy stakeholders and their positions



## Appendix A. Overview of Chile's Health System

Chile relies on Social Health Insurance (SHI) to provide near universal coverage to its population (**¡Error! No se encuentra el origen de la referencia.**). *Fonasa*, the single public insurer and by far the system's largest, covers over two-thirds of the population, including the nation's indigent (who are fully subsidized). Several private health insurers known as *Isapres* compete for coverage of about 17 percent of Chileans. Other systems, such as those of the Armed Forces, cover up to 5 percent of the remaining population, while another 10 percent is presumed to have commercial insurance coverage or no coverage (Figure 4). Isapre

Figure 3 Chile's health system

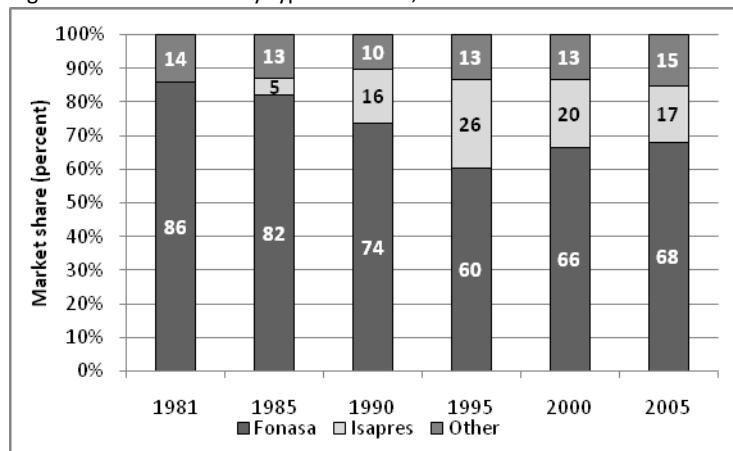


beneficiaries use mostly private health providers and Fonasa beneficiaries use mainly public health providers, although non-indigent Fonasa beneficiaries are entitled to modest co-financing from Fonasa for private health care.

Source: Bitran (2007).

SHI has both mandatory and voluntary components regarding the choice of insurer and the amount of the contribution. In principle, individuals can freely choose to enroll with Fonasa or an Isapre, but in practice income is the main determinant of the choice: upper middle- and higher-income individuals tend to choose an Isapre, to obtain better coverage for their money; lower-middle and lower-income ones choose Fonasa. The law requires that formal workers contribute a health insurance premium equal to 7 percent of their income up to a monthly income ceiling of about US\$ 1,500; it also allows Isapre affiliates to make voluntary premium contributions above the mandatory 7 percent in exchange for better coverage. Both Fonasa and Isapres have set copayments. Fonasa's copayments are rather small overall and increase with the affiliate's income.

Figure 4 SHI enrolment by type of insurer, 1981-2005



## Appendix B. Selected development indicators for the LAC region, Chile and other selected LAC countries

Table 1 Selected LAC countries: Development indicators, circa 2005

	Latin America and the Caribbean	Nicaragua	Colombia	Dominican Republic	Brazil	Costa Rica	Argentina	Chile	Mexico
<b>Demography and surface area (2005)</b>									
Population, total (million)	549,0	5,1	44,9	9,5	186,4	4,3	38,7	16,3	103,1
Population ages 0-14 (% of total)	30,0	38,0	31,0	32,0	28,0	28,0	26,0	24,0	30,0
Population growth (annual %)	1,3	0,5	1,4	1,6	1,3	1,7	1,0	1,1	1,0
Fertility (number of children per woman)	2,4	3,1	2,4	„	2,3	2,0	2,3	2,0	2,1
Rural population (% of total)	22,7	41,5	27,2	33,5	16,2	38,4	10,0	12,6	24,0
<b>Economy (2006)</b>									
GNI per capita, Atlas method (current US\$)	4.767	1.000	2.740	2.850	4.730	4.980	5.150	6.980	7.870
GDP growth (annual %)	5,5	3,7	6,8	10,7	3,7	7,9	8,5	4,0	4,8
Inflation (annual %)	6,5	10,7	5,3	4,2	4,3	10,0	13,4	11,7	4,5
<b>School enrolment</b>									
Primary (% gross)	117,6	103,2	112,4	117,8	150,7	108,0	98,8	100,3	108,7
Secondary (% gross)	87,6	66,3	78,1	70,7	104,2	79,2	96,7	90,8	80,2
Tertiary (% gross)	29,3	„	29,3	„	16,1	25,3	53,1	47,8	24,0
<b>Health status and health care</b>									
Life expectancy at birth (years)	72,5	70,4	72,8	„	71,2	78,9	74,8	78,2	75,4
Infant mortality rate (per 1,000 live births)	26,2	30,0	17,2	26,0	31,0	11,0	15,0	8,0	22,0
Prevalence HIV/AIDS (% of population)	0,6	0,2	0,6	1,1	0,5	0,3	0,6	0,3	0,3
Immunization, DPT (% of children 1-2 years)	91,0	86,0	87,0	77,0	96,0	91,0	92,0	91,0	98,0
<b>Health expenditure (HE, 2004)</b>									
Per capita (current US\$)	272	67	168	148	290	290	383	359	424
Total (% of GDP)	7	8	8	6	9	7	10	6	6
Public (% of total HE)	52	47	86	32	54	77	44	47	46
Private (% of total HE)	48	53	14	68	46	23	56	53	54
Out-of-pocket (% of private HE)	74	96	49	73	64	<89	49	46	94
Private prepaid (% of private HE)	n.a.	3,2	51,0	21,1	35,8	2,1	45,6	54,0	5,6
Social security (% of public HE)	n.a.	26,3	59,6	16,2	0,0	90,6	56,8	33,3	67,3

Source: Authors from [www.worldbank.org](http://www.worldbank.org) and [www.who.org](http://www.who.org).

## Appendix C. Priority health problems of the AUGE reform

### Box 2 Chile's Explicit Health Guarantees Reform

The Explicit Health Guarantees regime (GES, also known as AUGE) is a law that confers the following 4 Explicit Health Guarantees, to all SHI beneficiaries:

- **Access:** FONASA and ISAPREs are legally bound to cover an explicit set of guaranteed health interventions related to the 56 priority health problems.
- **Quality:** The health interventions must be delivered at a properly registered and certified provider.
- **Opportunity:** The health interventions must be delivered within explicit maximum time periods.
- **Financial protection:** FONASA and ISAPREs must reimburse an explicit amount for each guaranteed health interventions.

### GES priority health problems

- |   |  |
|---|--|
| 1. End-stage chronic renal failure  | 28. Prostate cancer  |
| 2. Operable congenital heart disease (under 15 years of age)  | 29. Adult leukemia   |
| 3. Cancer of the uterus or cervix   | 30. Strabismus (under 9 years of age)  |
| 4. Cancer pain relief and palliative care   | 31. Diabetic retinopathy   |
| 5. Acute Myocardial Infarction  | 32. Retinal detachment   |
| 6. Diabetes Mellitus Type I   | 33. Hemophilia   |
| 7. Diabetes Mellitus Type II  | 34. Depression (15 years of age or more)   |
| 8. Breast cancer (15 years of age or more)  | 35. Benign prostatic hyperplasia   |
| 9. Spinal Dysraphia   | 36. Acute stroke   |
| 10. Scoliosis surgery (under 25 years of age)   | 37. Chronic obstructive pulmonary disease  |
| 11. Cataract surgery  | 38. Bronchial asthma   |
| 12. Total hip replacement in people with severe osteoarthritis of the hip (65 years of age or more) | 39. Newborn respiratory distress syndrome  |
| 13. Cleft palate  | 40. Orthosis and aids (65 years of age or more)  |
| 14. Cancer (under 15 years of age)  | 41. Deafness (65 years of age or more)   |
| 15. Schizophrenia   | 42. Ametropia (65 years of age or more)  |
| 16. Testicular cancer (15 years of age or more)   | 43. Eye trauma   |
| 17. Lymphoma (15 years of age or more)  | 44. Cystic fibrosis  |
| 18. HIV/AIDS  | 45. Severe burns   |
| 19. Ambulatory care lower ARI (under 5 years of age)  | 46. Alcohol and drug dependency (10 to 19 years of age)                                  |
| 20. Ambulatory pneumonia (65 years of age or more)  | 47. Pregnancy and delivery integral care   |
| 21. Primary or essential arterial hypertension  | 48. Rheumatoid arthritis   |
| 22. Epilepsy (non-refractory) (1 to 15 years of age)  | 49. Knee arthrosis (55 years of age or more) and hip arthrosis (60 years of age or more) |
| 23. Prevention and education for oral health (6 years old)  | 50. Intracranial aneurysm and venous malformation rupture                                |
| 24. Prematurity-Retinopathy of prematurity-Deafness of prematurity                                  | 51. Central nervous system tumors  |
| 25. Conduction disturbance for those with pacemakers (15 years of age or more)                      | 52. Herniated nucleus pulposus   |
|   | 53. Dental emergencies   |
|   | 54. Dental care (65 years of age or more)  |