Steps towards the health equity agenda in Chile

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Disclaimer

WCSDH/BCKGRT/25/2011

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**Glossary of terms and abbreviations**

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<td>CSDH</td>
<td>Commission on Social Determinants of Health</td>
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<td>WHO</td>
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<td>WHA</td>
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<td>ISAPRE</td>
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<td>SDRM</td>
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<td>IT</td>
<td>Information and Technology</td>
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<td>EMCONET-KN</td>
<td>Employment and working conditions knowledge network</td>
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<td>ENETS</td>
<td>National Survey on Employment, Work, Health and Quality of Life</td>
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<td>Priority Public Health Conditions</td>
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<td>Health Objectives for the Decade</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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Background

The Commission on Social Determinants of Health (CSDH) was convened by WHO in 2005 to provide advice to Member States on how to reduce health inequities. Following a three year process, the Commission released its final report in August 2008. The Commission made three overarching recommendations: to improve daily living conditions; to tackle the inequitable distribution of power, money, and resources; and to measure and understand the problem and assess the impact of action. Under these overarching recommendations, the Commission presented action areas and specific recommendations aimed at all sectors, including the World Health Organization (WHO) Secretariat, other multilateral agencies, national and local governments, civil society, the private sector and research institutions. Following consideration by Member States, Resolution WHA 62.14 was passed, entitled "Reducing health inequities through action on the social determinants of health", at the World Health Assembly in May 2009. It called on Member States, the WHO Secretariat and the international community to implement the recommendations of the Commission, highlighting areas such as measurement of health inequities, implementing a social determinants approach in public health programmes, adopting a health-in-all-policies approach to government, and aligning work on social determinants with the renewal of primary health care.

This paper summarizes the process and experiences to implement the “Steps toward an equity in Health agenda” in the Ministry of Health and Regional Health Authorities in Chile between 2008 and 2010 implemented in response to the recommendations of the WHO Commission on Social Determinants and Health and in the context of the Chilean Social Protection System.

The purpose of this agenda has been to move forward from a declaration of the ethical necessity of the right to health in Chile, toward concrete actions embodied in health policies and programs and in programs in other sectors, in order to reduce inequities in health, in the areas of intervention recommended by the Commission on Social Determinants of Health. To this end, efforts were made to adopt the approach of Social Determinants and equity in health, by means of concrete actions aimed at: a) identifying, quantifying, and monitoring health inequities in Chile; b) Assessing health policies and programs in relation to their specific effects on inequities in health; and c) Identifying starting points for specific interventions involving participation of the community and of other sectors.
This paper describes:

1. The main strategies of the Steps toward an Equity in Health agenda implemented in the Ministry of Health and Regional Health Authorities in Chile between 2008 and 2010. The challenges faced in going to scale on an Equity and Social Determinants of Health (SDH) strategy in the health sector at a national level. Specifically it will highlight:
   a. Some of the main challenges associated with managing policy change particularly in the area of public health programs that have had a long history of business as usual.
   b. The strategy used to manage intersectoral processes and to incorporate the community voice
   c. The competency development strategy used to secure and promote institutional sustainability

2. Discussion: Lessons learnt and future challenges
Introduction

Chile is an intermediate-development nation located in the southern cone of South America, with a population of 17,094,270 inhabitants for 2010. It is considered to be an intermediate development nation with an economy that has presented high levels of development over the last years. Per capita income has increased from US$ 3,000 in 1990 to near US$ 14,300 in 2010; the minimum wage rose to US$ 350 in 2010 and the current inflation and unemployment rates are 1.4% and 8.6% respectively. Chile scores high in several health indicators, such as life expectancy at birth (81.2 years for women and 78.1 years for men), infant mortality (8.3 per 1000 live births) and health services coverage, when compared to other countries of similar levels of development but still there are important inequities in income distribution, education, occupation and health and health access. The country is going through an epidemiological and demographic transition characterized by a decreasing percentage of the population under the age of 15 and increasing percentage of elderly population. Non-communicable diseases are on the rise in relative and absolute terms.

Overview of the health system

The National Network of Health Services was created in 1952 and has provided Universal Health Coverage to all Chilean citizens since then. Currently it is a decentralized system of 29 local Public Health Services that serve approximately 75% of the population. The other 25% of the population is covered by a private insurance and provision scheme administered by a number of private insurance institutions (ISAPRE) that provide mainly curative services mostly to those with the highest income, and of younger ages.

The Chilean health system has been studied extensively. Its current form is the result of two major reforms. The first one, undertaken by the Pinochet government following the coup d'état in 1973. Pinochet’s reform established competition between public and private health insurers and promoted private health services, following neoliberal principles. The second one in 2005, when the government passed a comprehensive health reform. The law mandated additional quality, timeliness and financial protection coverage by public and private health insurers for personal and non personal services related to fifty priority diseases and conditions. Two Deputy Secretaries of Health (Public Health & Service Delivery) were created and specific functions for the Regional Health Authorities where defined.
The public system controls a complex hospitals network, related outpatient clinics and a network of primary health care facilities administered by municipalities. Services are funded through a mix of prepaid employee mandatory health insurance contribution and from general tax revenues to cover services for vulnerable groups and uninsured population (unemployed or temporary employed). The employee mandatory contribution accounts for 7% of the salaries and goes to either the public insurance (Fonasa) or the private subsector.

The National Health Fund (FONASA, Fondo Nacional de Salud) manages public health insurance. All citizens in Chile are insured by Fonasa unless they choose to contribute to a private insurer (ISAPRE). Individuals covered by FONASA may receive health services from either public facilities or a preferred private provider. The Ministry of Health manages vertical programs, public health interventions, and the health care personnel from public facilities. In 1995, the Ministry of Health introduced capitation at the primary health care level, allocating 60% of total funding from capitation and 13% on a case-by-case basis. The remaining funds are provided by municipalities. The Ministry of Health allocates a prospective capitation rate for all registered beneficiaries. The rate covers the full cost of labor, administration, and a percentage of pharmaceuticals. The base capitation is adjusted by two variables, the geographic location of the health centers and the income level of the municipality, where a health center located in a rural area received an upward adjustment of 20% and a poor municipality 18%.

Health centers provide preventive and curative services, but complex interventions including childbirth are referred to secondary care. Most primary health centers services are clustered under the following programs: (a) Well-baby and Healthy Children, targeting children from 0-9 years, (b) Maternal Health, encompassing family planning and prenatal care with a coverage of more than 90%, and (c) Adult Health, preventing and managing risk factors among adults and the elderly aged ≥65 years, including programs dedicated to managing chronic diseases. In the public sector, health care services are relatively well organized, delivering free medical, dental, nursing and midwifery services at local health centres administered and owned by local municipalities. Secondary and tertiary care are provided by a network of public outpatient and hospital facilities with different levels of complexity. By contrast, the
private sector has neglected the development of primary care networks, focusing mainly on the delivery of curative services mostly secondary and tertiary care.

**Historical context leading to action on Social Determinants and Health Equity**

As of 1990, Chile together with recovering its democratic tradition and remaking its political system, began a process of strengthening social policies directed towards the abysmal deficits in living conditions and working conditions suffered by large numbers of the population, as a result of the implementation in the country of the neoliberal adjustment policies advocated by international organisations like the International Monetary Fund and the World These policies included privatisation of several previously public-owned major enterprises, goods, and social services, undistorted market prices, and limited government intervention. ¹

The return to democracy transformed State action on social matters, redefining the relationship between economic growth as a mean to achieve social objectives. Living conditions improved significantly over the next 20 years, particularly in terms of income, education, housing and health. These social advances were explained in part by the sustained economic growth during most of the 90’s, averaging 7.1% annually ², but were mostly due to the sustained political commitment to social equity and social justice. The four governments that followed until 2010 attempted to move social policies and strategies, from midstream, focused on improving averages, towards more upstream, focused on improving Equity.

**1990-2000**

Two streams of social policies were developed during the 1990’s. Firstly, sectoral policies, such as education, health and housing, centered on guaranteeing an adequate level of services and benefits for all the population in an equal opportunity perspective. Secondly, specific programs directed towards disadvantaged vulnerable groups to ensure access to the opportunities available through the sectoral policies, economic growth and development in general.

By the mid-nineties however, social policy innovation had resulted in a proliferation of new programs, often successful in regard to immediate objectives but limited to a specific sphere or group, and unable
to link to other programs in order to activate the synergies needed to effectively tackle complex social issues. Because of this, the debate around the goals of development and the role of the State re-emerged to shape the public agenda and precipitated new policy strategies focused on the articulation and integration of programs that were built to respond differentially to the specific individuals and families in need.

2000 -2010
Between 2000 and 2006 the emphasis was put in introducing programs to improve structural social determinants: improving neighborhoods conditions (Chile Barrio), diminishing extreme poverty (Chile Solidario) and others. All these programs had in common a policy and programmatic approach centered on the perceived needs of the person, in a family and in a community, rather than on the supply based normative needs, with services built around them on an integrated (intersectoral) manner.

The main changes have to do expanding the sectors that needed to participate in order to fully address the different dimensions of living and working conditions of the people.

“We intend to achieve a decent social welfare system that will accompany people throughout their cycle of life, protecting them in their first steps, ensuring them access to educational and work opportunities, covering them in case of illness or disability, and guaranteeing an adequate retirement. The construction of this system—with employment, educational, healthcare, housing and pension components—is a priority objective for my administration. This will be possible thanks to progress made in this country over the years.” (Bachelet 2006)

These words pronounced by President Michelle Bachelet in her first May 21st address before Congress in 2006, announced the consolidation of all social initiatives implemented over almost 20 by governments after dictatorship. She proposed a rights based intersectorial unifying welfare objective for the nation to decrease social inequities, based on the evident, but often forgotten truth, that all members of society share a common destiny. And thus, it became a presidential directive for
intersectoral integration for a broad social welfare objective. By doing so, the provided political support needed to advance the work on Social Determinants (including of health) during her mandate.

The landmark social program of President Bachelet’s term was the Chile Crece Contigo, described in detail in this report, that represents the most important a policy innovation to address equal opportunities from the start.

Given the presidential mandate to improve Equity in health as part of the broader objective of improving social Equity, in early 2008, the Chilean Ministry of Health decided to create the Executive Secretariat on Social Determinants of Health, as part of the Subsecretariat of Public Health. This Secretariat worked until March 2010 promoting a work agenda, the “13 pasos hacia la Equidad” initiative, aimed at improving the level and distribution of health within the population of Chile. As part of the agenda, six objectives were defined, each of them involving concrete actions aimed at contributing to equity in health in Chile:

**Specific objectives of the agenda:**

1. To contribute to the reduction of social inequalities which generate health inequities
2. To reduce inequities which restrict and limit access to health and health services
3. To implement actions for the “social inclusion” of excluded groups and territories
4. To develop competencies on equity and social determinants of health within the Ministry of Health staff
5. To generate tools for planning, monitoring and evaluation of the SDH and equity in the health sector
6. To establish bodies and mechanisms for the coordination and integration of various sectors to develop the necessary actions to reduce health inequities
**Objective 1:** To contribute to the reduction of social inequalities which generate health inequities

1. **Equity from the beginning: Chile Crece Contigo**

The story of Chile Crece Contigo began as the growing national debate on the problems of social equity, attributed to the economic model and the inability of focalized social policies to address them deepened at the beginning of the 2000 decade. So the government started to work on the design of an initiative for action that included the Rights of Children and the State’s responsibility to ensure them as a universal principle. They developed a proposal for a social protection system for children from 0 to 18 years of age (Plan de Acción Integrado a favor de la infancia y la adolescencia 2001-2010), in the context of an integrated system based on rights during the life course. The Ministries of Planning and Finances leveraged funding to investigate policy alternatives, systematize and evaluate innovative local projects and develop possible interventions, including pilot experiences. The evidence base of effective interventions, that the Ministry of Planning and other sectors were building, also looked at international experience.

In 2005 the Ministry of Planning invited the Ministries of Health and Education to conform working groups to review available benefits, identify innovative experiences, and order studies to explore policy alternatives. Intersectoral response was immediate and committed to formulate the new policy.

The idea of constructing a social protection system for children was then included in the Government coalition candidate’s program. The candidate was Michelle Bachelet a Pediatrician and Public Health Specialist. On her program government she said "*Equity and inequity are brewing since the early years. To transform Chile into a country more equitable, just and secure, we require policies that enhance and match the opportunities available to people from the beginning. To break the differences of origin of child and build the foundations of a safer society, will look at the first children a priority.*"

In 2005, the Ministry of Finance anticipated the implementation of the system, including in the 200 Budget Bill an item to increase child care and pre-kinder enrolment and other activities, as part of a group of new projects to strengthen the social protection system that already included other social protection programs.
On March 30, 2006 the newly appointed President Michelle Bachelet established by Presidential Decree a Council to reform social policies relating to children, integrated by 14 experts, representing a diversity of specialties, expertise, and a cross section of political views, from the Right to the extreme Left, with a petition to present a proposal by the end of June. The council worked at an intense pace, convoking 46 audiences with national and international experts, and more than 100 meetings with social organizations and community actors. Members also traveled to all the Regions and held public meetings in all the capital cities. It also opened the public consultation through a web page, which received the contributions of thousands of interested parties. The resulting document, reflected a broad social consensus on the need to create a social protection system for Chile’s children.

### Box: Why a social protection system?

The Council’s report to the President, *The future of children is always today*, posed this question and responded it with the following affirmations:

- Because boys and girls have equal rights
- Because early childhood has great opportunities (and risks) for human development
- Because all boys and girls should have equal opportunities to develop
- Because all boys and girls have the right to proper care, stimulation and education, while their parents work or study outside the home
- Because the investment in early child development is strategic for the country
- Because policies for children should be effective and efficient

(Presidential Council 2006)

In October 2006 President Bachelet announced the creation of the integrated and integral social protection system for early child development, called Chile Crece Contigo. Its social equity goal was ambitious and aimed to eliminate socioeconomic differences in achieving maximum development potential across the social gradient.
The system would accompany children and their families from gestation until they entered the school system in pre-kinder, age 4 years. Chile Crece Contigo would provide all boys and girls access to universal benefits and services to take care of their necessities and support their development in each stage of the life cycle, during early childhood. Additionally, it would contribute to induce basic conditions in the psycho-emotional and physical environment in order to favor harmonious and integral development, in accordance with the evolution of their life course.

During 2007 new programs were introduced that required integrated action by two or more sectors: Support for Biopsychosocial Development (Ministry of Health, Ministry of Development, the Fund for initiatives to support local child development initiatives (Ministry of Planning– municipalities) and Fund for Childhood Initiatives (Ministry of Planning – public, private and community agents).

### Box : Differential Support

Chile Crece Contigo offers different levels of support and guarantees for all boys, girls and their families. To each according to his/her specific needs.

1. Strengthened legislation and standards of protection for maternity and paternity for all population.
2. Free Nursery and Pre school access for the 60% of more vulnerable families
3. Improved quality in prenatal care.
4. Humanized birth (with participation of the father)
5. Improved well child care, especially for the first 2 years (Biopsychosocial support)
6. Strengthened access to health care for all boys and girls from the first prenatal control until entry into the school system
7. Increased support and guarantees for boys and girls from the 60% of homes with lesser income or in special situations of vulnerability.

**2008-2009: Incorporating Chile Crece Contigo into the**
Steps for Health Equity Agenda

The first stage of implementation began at the Ministry of Health with the creation of a coordinating team as part of the Social Determinants of Health and Health Equity Secretariat at the beginning of 2008, to lead the implementation of Chile Crece Contigo.

During 2007, the program was implemented in 160 municipalities on close collaboration between Ministries of Planning and Health. At the local level, the Director of each local Health Service was appointed as territorial manager to coordinate and support the Local Intervention Network. At the same time a detailed workplan for the period 2009-2010 was developed based on the findings of the initial situation analysis developed in all regions of the country. During 2010 the program completed its implementation in all the municipalities of the country.

At the level of the Local Intervention Network, the primary care center is the entry point for Chile Crece Contigo, beginning when the mother starts the prenatal control and continuing until the child reaches 4 year of age. The follow-up scheme and activities included are shown in the following figure:
Longitudinal Accompaniment Scheme during the child’s development

Universal Benefits
(Biopsychosocial Support Program)

Differenciated benefits, according to the needs of the child

To the health institution
To the basic municipal network
To the extended network

What is ChCC
Health control
Risk Checklist
Gestation Guide
Registry

Examples

1. Late start to prenatal controls
2. Low income family with unemployed adult and no social protection scorecard

Home visits

Health institution
Local ChCC Network
Basic municipal network
Extended network

Vulnerability score

Entry into Bridge Program
Receives Family subsidy
Apply social protection scorecard

The process of implementation of Chile Crece Contigo to date includes:

- Implementation of the program in all the Municipalities within the Country through generation of the local intersectoral networks in charge
- Progressive deployment of services included in the program beginning with pregnant women and children up to 4 years of age, since 2007:
  - More than 649,132 pregnant women have entered the program
  - Almost 75% of eligible births (non emergency) have occurred with the presence of the father since 2009.
  - More than 90,000 visits to the households of pregnant women with social risk.
More than 1,000,000 educational sessions to promote early child development (ECD) with families of children at risk.

More than 270,000 visits to the household of families with children at risk in their development.

Since September 2009, every child born in Chile receives a set of basic implements for initial child care including a cradle, a baby carrier, massage oil, diapers, and much information on first care needed by babies and infants.

Approval by the Congress in 2009 of Law N° 20.379, that creates Chile Crece Contigo as a guaranteed program for all children up to 4 years of age, which made the program mandatory to all municipalities in the country. The decree that accompanied the Law established a Committee of 9 Ministers, headed by the Minister of Planning and including Health, Education, Justice, Women’s National Service (SERNAME), Finance, Presidency, Labor, Housing. The national technical committee has also been expanded to include all the public services related to children. The preeminence of Health for early child development is expressed in a permanent working group. The Regional level is coordinated by the Intendente and the Regional Cabinet with leadership assigned to the Regional Ministerial Secretary of Planning, as coordinator. The Director of the Health Service is the territorial manager who coordinates and supports the primary care center. Ministry of Planning’s role in managing the system has also been consolidated and its leadership recognized by others.

Implementation of a standardized technological platform for monitoring and evaluation, the Registry, Monitoring and Reference System (Sistema de Derivación y Monitoreo SDM). The system includes software that is accessible to all the actors linked to the program. This allows the health team to check for every woman who arrives for her first prenatal control, her information on entitlements to social subsidies in order to have her access to the benefits immediately. The on-line monitoring is shared by all participants of the local network. The information system began with an operative demonstration model and it permits monitoring of the child from the entry of the mother to the program until 4 years of age, incorporating all relevant information. The information and technology (IT) system includes built in indicators to measure the process, intermediate results, and impact. Since the goal is social equity, the process of development included participation of all sectors with
Ministry of Planning’s help. The evaluation system also includes panel surveys that enable comparisons between participants and support for system management, with national supervision and regional operative coordination. The system facilitates opportune action, reduce bureaucracy, and strengthen communication as well as monitoring and evaluation of each sectoral interventions.

**Box: Chile Crece Contigo Law N° 20.379 approved by the Congress in 2009**

- Automatic transfer to the postnatal period of days not used in the prenatal, in the case of premature births

- Right to transfer up to the first three weeks of rest and prenatal benefits to the postnatal period

- Right of working mothers to nurse their children, independently of the existence of a nursery in the workplace

- Extension of postnatal leave to one year when the child is born with a disability

- Improved legislation for equal rights for adoptive parents in regard to adoption times, leaves and postnatal subsidies

The system of social protection for early child development is the maximum expression to date in Chile of the transformation in social policy and the role of the State, that a rights – based approach brings: if rights and entitlements across various sectors are guaranteed, strong integrated planning, implementation, monitoring and evaluation processes are necessary. The Health sector has a leading role in the system, not only in regard to the specific function of the primary care centers and healthcare networks, but also in disseminating knowledge on the underlying social determinants of health and
health equity to inform action and early childhood development by other sectors. Health concepts also inspire the focus on promotion, prevention, anticipating damage, reducing effects and rehabilitation.

2: Employment and working conditions that contribute to health equity

There is an emergent body of evidence on the impact of employment relations on health. Employment conditions are closely linked to material deprivation and have a strong effect on chronic diseases and mental health via several psychosocial factors, life-style behaviours, and direct physio-pathological changes. A country’s employment relations determine proximal exposures that affect workers’ health via two social causal pathways: compensation and working conditions. The specific pathways between employment and working conditions and health are context specific for each country based on its economic, political and cultural/technological characteristics. Not all workers are equally exposed to occupational hazards. Occupational health risks vary significantly according to many national and local factors including social determinants of health such as employment conditions, education, income, age, gender and race and factors such as the political tradition of each country, the economic activity and level of industrialization, the development of laws and regulations, the political tradition in industrial relations, and the level of power and involvement of unions.

Work-related injuries and diseases have a profound effect on the health of the working population, involving an enormous and unnecessary burden and suffering for workers’ families and communities, and a high economic loss for firms and countries. Occupational risk factors account for 37% of back pain, 16% of hearing loss, 13% of chronic obstructive pulmonary disease, 11% of asthma, 8% of injuries, 9% of lung cancer and 2% of leukemia. Furthermore, it is estimated that an average of 5 per cent of the workforce is absent from work on any given day, though this may vary from 2-10 per cent depending on the sector, type of work and management culture.

Since the mid-1980s, Chile has followed a free-market economic model, with scant State regulation on working and employment conditions. In addition, trade union membership has declined (10 per cent of salaried workers) and the unions are not very powerful. Collective bargaining in major conglomerates is
limited, and restricted to well-paid jobs, with individual rather than collective bargaining being the rule. Health and working conditions are not open to negotiation, partly because of the predominance in the country of a trade-union culture of focusing on wage claims. Concerning labour market provisions, two main flexibilisation strategies have been predominant in the country: subcontracting of work or personnel (35 per cent of salaried work) and the lengthening of the working day beyond its customary limits. Workers with no contract of employment make up 24 per cent of salaried workers. They are precarious in terms of income: their average wage is 60 per cent lower than that of workers with a formal contract of employment\textsuperscript{12}.

To study how employment relations, employment conditions and working conditions differently affect the health of populations in Chile we developed as part of the of the “13 pasos” a joint initiative with the Ministry of Labour and the Institute of Occupational Safety to carry out the First National Survey of working and employment conditions, quality of life, and health of workers in Chile. We used the framework developed by the CSDH Employment and Working conditions knowledge network (EMCONET KN)\textsuperscript{13} to explain and understand how the Chilean society structures labour relations and what are the social processes of production of employment relations and working conditions that affect workers’ health and quality of life.

The survey design, field work and analysis was led by the Ministry of Health, Departments of epidemiology and Occupational Health. In the design phase several actors, including industry, businesses and employers and unions representatives were invited to participate. This allowed for the incorporation of their views and specific questions and the survey and was also a strategy to overcome possible resistance to the survey. The cost of the survey was shared by the ministries of Health and Labour.

The aims of the survey were:

1. To provide a comprehensive description of key employment conditions in Chile described according to four employment dimensions: unemployment, precarious employment, informal Employment and child labour, taking into account several “axes”: gender, social class, migrant status, age, and ethnicity.
2. To analyse main links between employment and health inequalities.

3. To analyse the pathways and mechanisms linking employment conditions and health inequalities, as well as the potential magnitude of the impact of employment conditions on health inequalities in Chile.

4. To generate evidence on the effectiveness of employment and working related policies and interventions to reduce inequalities in health.

5. To translate this knowledge into health policy recommendations, disseminating the results and collaborating in the implementation of these recommendations.

Employment conditions were classified into five dimensions: unemployment, precarious employment, informal employment and informal jobs and child labour, working conditions as related to the tasks performed by workers, were classified based on the way the work is organized, the physical and chemical work environment, ergonomics, the psychosocial work environment, and the technology being used.

The survey covered a wide range of topics, including physical risks, working time, work organization, employability, work satisfaction, health outcomes, absenteeism, work sustainability, work–life balance, violence and harassment and job performance.
### Box: ENETS Survey Methodology

<table>
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<tr>
<th><strong>Design</strong></th>
<th>Face-to-face interviews with 29,680 workers in their homes</th>
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<tr>
<td><strong>Sample size</strong></td>
<td>9720</td>
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<tr>
<td><strong>Study population</strong></td>
<td>Population older than 15, employed and unemployed, living in urban and rural areas in all 15 regions of Chile</td>
</tr>
<tr>
<td><strong>Sampling frame</strong></td>
<td>All population older than 15 according to the latest National Population and Household Census</td>
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<tr>
<td><strong>Sampling method</strong></td>
<td>Respondents selected by multistage random sampling drawn to be representative of working population in all but 9 counties in the country</td>
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Field work

Since the very beginning of the inter-institutional agreement, inter-institutional work teams were set up whose main task was the discussion of the dimensions that ought to be taken into account in the Survey. In late 2008, a workshop was held to discuss the ENETS project, with workers representing various organizations, unions, federations, and productive sectors. During the same year, the first draft of the questionnaire was drawn up, along with a Manual for the field work. During 2009, the sampling plan was finalized and a pilot survey was carried out to validate the instrument. In August the stage of field work began. During 2010 and 2011 analysis and dissemination of results were completed.

Preliminary results

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• **Working weeks:** Of the respondents surveyed, almost two thirds work on weekends.

• **Working hours:** Mean weekly working hours are 52.8 for men and 47.6 for women. 42.2% of workers work more than 8 hours a day and 21.8% rarely or never have the free time they need.

• **Autonomy and control:** Two thirds of employees have their work schedules set by their company. They cannot choose, or change, the rate at which they work. Only 24% of employees can adapt their working times to their needs within certain limits.

• **Intensity of work:** When both paid and unpaid working hours are both taken into consideration, it is clear that women working part time work longer hours than men who work full time. While women generally work part time in order to devote more time to family and household tasks, men who work part time devote even less time to unpaid work than men who work full time.

• **Training:** Two thirds of companies decide on job training programs without consulting with workers.

• **Health effects:** Fifty three per cent of workers report that the lack of job security has a negative effect on their quality of life.

• **Violence and harassment:** Sixty nine per cent of workers report that they are not treated with due respect by their employers.

• **Job satisfaction:** With their current wages, two thirds of workers cannot afford unexpected expenses. One third cannot meet their basic needs, and have to resort to credit cards. Almost half of workers say they are worried about their level of debt.

• **Gender differences in wages:** Female workers’ wages are 67% of male’s salaries.

• **Workers rights:** Over 70% of workers can never take sick leave. Forty percent say they rarely or never have received layoff compensation.

• **Workers want more government involvement in regulation and supervision of occupational health policies:** Sixty three percent of workers are of the opinion that the State should adopt new laws and policies that protect workers’ health (28.7%), and supervise working conditions in order to improve occupational health (31.6%). For example, 61.2% of people surveyed say at least half their work-day is spent performing repetitive movements.

• **Workers want greater participation in decisions concerning occupational health:** Thirty per cent of workers say they fear being fired if they do not do what is asked of them.
ENETS (First National Survey on Employment, Work, Health and Quality of Life) is still being analyzed. It will generate much relevant information to deepen the understanding of the relation between health and work in Chile. This evidence will in turn facilitate the role of government, and contribute to the improvement of public policies on health and work.

By means of this effort, will be possible to learn – from the perspective of the workers themselves - about the real conditions of work and employment, and how these conditions affect their quality of life at national and regional level of representativeness. Its results will be used to identify and promote institutional changes and effective policies related to workers health that can improve equity in working and employment conditions that subsequently improve health equity.

**Objective 2: To reduce inequities which restrict and limit access to health and health services**

1. **Priority Public Health Conditions and Programs. Review and redesign.**

A wealth of evidence from countries supports the concept that the socioeconomic circumstances of individuals and groups are equally or more important to health status than are medical care and personal health behaviour. The weight of evidence suggests that the SDOH 1) have a direct impact on the health of individuals and populations, 2) are the best predictors of individual and population health, 3) structure lifestyle choices, and 4) interact with each other to produce health. In particular, disparities – the size of the gap or inequality in social and economic status between groups within a give population – greatly affect the health status of the whole. The larger the gap is, the lower the health status of the overall population.

The social and economic environments contribute to approximately 50% of a population’s health status. Nonetheless it is important to recognize that 25% of health inequities are due to a lack of access for some people to quality health care.
The influence of the SDOH is especially strong in the case priority public health conditions subjected to programs such as cardiovascular, maternal and child, mental, as well as some priority infectious diseases. In several of these diseases like for example cardiovascular, diabetes and others, the average prevalence and the gap between extreme socioeconomic groups are rising in most of the developed and middle income countries, with a higher frequency of complications and death in the most socioeconomically disadvantaged subgroups, despite the fact that most of the programs implement the internationally-recommended control strategies. In addition, for most of these diseases target for case detection and care are not being reached in an equitable way.

Even though most programs evaluate their performance as part of their routine assessment, they do not explore issues related to the extent of which access to care is equitable. A systematic methodology for assessing Equity in access to care for Priority Public Health Diseases control programmes in countries was developed by the PPHC KN as part of the work of the CSDH. The methodology is based on the Tanahashi framework.

Tanahashi proposes five domains of coverage measurement, based on his conceptual framework: availability coverage, accessibility coverage, acceptability coverage, contact coverage, effective
coverage. *Availability coverage* considers the resources available for delivering an intervention and their sufficiency, *accessibility coverage* measures how accessible resources are for the population in terms of physical access and affordability, *acceptability coverage* measures the proportion of people for whom services are acceptable and *contact coverage* measures the proportion of the population who have had contact with a health service provider.

The figure summarizes the components proposed for the evaluation of access. The framework defines *effective coverage* as the proportion of the population in need of an intervention who have received an effective intervention. This definition applies both to personal health services and non-personal public health interventions. The evaluation of coverage on the basis of this concept enables managers to identify bottlenecks for specific subgroups in the operation of the services, to analyze the constraining factors responsible for such bottlenecks and to select effective strategies for service development.

Based on this framework, in late 2008 a general assessment of equity in access to care was undertaken by six national healthcare programs: Child Health, Reproductive Health, Cardiovascular Health, Oral Health, Health of Workers, and Red Tide (a seafood-borne disease).

**The general objectives were:**

1. To describe the differential barriers and facilitators to prevention, case detection and treatment success for the six national healthcare programs included.

2. To provide guidelines for reshaping the existing prevention and control programs to improve equity in access to care.

**Specific objectives**

1. To define a methodology based on the Tanahashi framework to assess equity in PPHC programs jointly with all the national and regional program chairs.

2. To identify main factors related to access to care (demand and supply) for individuals demanding services to the different programs according to socio-economic conditions, gender, ethnicity and
place of residence; and to quantify the gap on access to primary prevention, case detection and treatment.

3. To identify barriers and facilitators for equitable access to care within the existing health program that may be amenable to change and redesign.

4. To develop specific recommendations to reshaping the programs to improve equity

5. To pilot the specific recommendations with inclusion of intersectoral and social participatory approaches.

6. To strengthen the skills of healthcare personnel, in order to consolidate a broad, intersectoral, and participative vision of public health.

In January 2009, integrated work teams were set up for each of the programs. Each of the programs summoned an interdisciplinary task force or “node”. The members of each node were selected by the chair of each program, based on expertise, knowledge, and level of responsibility within the program, should provide input on the analysis and reformulation of the program. Finally, each node was organized around a “nucleus group” of health care professionals from the program itself, which was in charge of coordinating, promoting, and documenting the work, and which also included other members of health programs, and personnel from the Subsecretariat of Health, Primary, secondary and tertiary levels of care, and Regional program staff.
The participation of professionals from the Regional Ministerial Secretariats and of executive Heads of programs (healthcare center professionals from neighborhood clinics, Family Health Centers, Community Centers and hospitals) in the nodes made it possible to benefit from the day-to-day experience of field personnel. It also helped to broaden the number of people becoming competent on the methodology and therefore benefiting all health care institutional levels. From the start, some nodes incorporated representatives of other sectors and civil society.

The methodology based on the Tanahashi framework to assess equity in PPHC was discussed and developed jointly with all the national and regional program chairs with the help of a Canadian expert on evaluation theories. National and international experiences were also examined. Five guidelines were

"Nodes" structure"
developed, based on the work of Sridharan i, to structure and systematize the programmatic assessment. The methodology is explained in greater detail later in the document.

During the review, barriers and facilitators for equitable access to care amenable to change and critical points for the redesign of programs were identified. For example, the Oral Health program reported that only 36.7% of the target population of 6 year-olds were requesting healthcare services (which are guaranteed by law), and that 6.4% were not even given an appointment. As a result, only 28% of the target population managed to complete the treatment. The main differences among socioeconomic groups were in access to information of program activities, conditions for access to specific subprograms, and access to tools for self-care. A pilot program stressing participatory mechanisms was implemented jointly with other sectors in pre-school vulnerable children from three vulnerable counties.

The Cardiovascular program identified males under the age of 55 as the main excluded group. Some of the barriers to access services were related to other social determinants like: unemployment and temporary employment, geographical factors (remote locations), and others to health care system characteristics like non flexible working hours at the health care centers. A contest was held to suggest and identify ideas for good practices in cardiovascular health. Sixty seven projects were presented, of which 18 were selected to be implemented as pilots. These good practices were used as input for the redesign of the Program.

The main barriers identified in the child health program were: geographical (distance from the health care center, geographical dispersion of the population); primary health care systems related factors (short, inflexible opening hours, long waits); cultural factors (feelings of being discriminated against, prejudices against the system); and financial barriers (cannot afford transport costs).

The Red Tide program controls and monitor water, sediments, and shellfish for contamination of toxic, naturally occurring microscopic plankton known as Red Tide, in all regions were the phenomenon appears in Chile. "Blooms" of the poison-producing plankton are coastal phenomena that frequently occur in the south of Chile, caused by environmental conditions, which promote explosive growth.

i Dr. S. Sridharan, Director of the Evaluation Program of the Center for Health Research, Urbana, and Associate Professor, Health Policy, Management and Evaluation, University of Toronto. He was a consultant to this initiative during 2009.
Shellfish, including hard-shell clams, soft-shell clams, oysters, mussels and scallops, are particularly prone to contamination by these toxins as they feed by filtering microscopic food out of the water. During red tide blooms, hard-shell clams, soft-shell clams, oysters, mussels, whelks, and moon snails harvested from areas affected by the blooms are not safe to eat, therefore if the action level of harvesting is achieved coastal sites are closed to shellfishing. Harvesting regulations for shellfish are strictly enforced in the country. Red tide occurrences have impact mostly on local fishermen with monetary and work related losses during the time the phenomenon occur.

The analysis carried out by the Red Tide program identified 6 districts where several social groups depended financially on the exploitation of bivalve mollusk resources, either for their own consumption or for selling, and whose means of livelihood are threatened when sanitary prohibitions are imposed on the use of these resources. The redesign pilot project included setting up local intersectoral committees and launching a study to generate qualitative information about the social, cultural, demographic, and economic factors that determine the social relations of seafood divers and shore gatherers in these districts.

Based on the findings from the review specific recommendations to reshaping the programs were developed. During 2010, all programs have piloted some specific recommendations with inclusion of intersectoral and social participatory approaches.

- Oral Health: Three pilot projects were implemented and evaluated in the Counties of Olmué, El Monte, and Paredones. A country-wide workshop was held to communicate the results of the pilot projects and of the redesigned Oral Health Program, as well as Regional workshops in the V, VI, and Metropolitan Regions, to share the in-depth analysis of the results, and to fine-tune the redesign.

- Red Tide: A qualitative study was undertaken to generate more knowledge related to social transfer programs that can be implemented to support fisherman during red-tide closures. The review of the program allowed the development of strategies for a more effective handling and reducing of the negative impacts of the phenomenon on the fishermen through temporary diversification and restructuring of working and employment conditions.

- Cardiovascular Health: The program disseminated and incorporated 67 good practice interventions identified and it has also assisted all Regional Health teams to develop specific action plans to put them into practice.
• Child Health: This program developed and validated, on-site, a methodology for detecting vulnerable children in terms of health results to expedite and prioritise their access to care.

• The Workers’ Health program and the Women’s program completed the process of review, and the development of pilot initiatives.

**Outputs included:**

• A description and documentation of prevention and control programs included in the review.
• A description and quantification of differential barriers and facilitators to prevention, case detection and treatment success, using the Tanahashi framework for effectiveness coverage.
• A set of indicators and methodologies for assessing equity of access that can be used as part of the evaluation of Priority Public Health Diseases Control Programs
• Strategies to reshape the existing programs to enhance equitable access to care and to improve targeting to disadvantaged groups not being reached by current strategies.

A detailed description of the whole process has been published elsewhere with an extended analysis of the challenges, implementation difficulties and how these were dealt with\textsuperscript{24}.

2. **Methodology for the review and redesign of priority public health programs**

The methodology that was developed to review and redesign the 6 priority public health program incorporated in the work involves three steps a) Equity checklist b) Review cycle and c) Redesign cycle
1. Equity checklist
In this step each program team quantify the main inequities in access to health and health care that result from the current way in which the program provides services to the target population. In other words the team assesses the equity effectiveness of the program including the process: goal and objectives, activities and outputs and outcomes. It involves two phases: Applying a standardized checklist instruments and quantifying gaps in health outcomes by equity stratifiers using specific indicators. The main product of this step is the identification of the program priorities to improve equity in health outcomes

2. Review cycle
During this step a detailed review of the program is performed. The process is illustrated in the following diagram:
The first task is to understand the program theory in order to identify the key programmatic stages from inputs to outcomes. The main questions to answer are: What is the underlying theory of the programs and what are the key steps included in the program for achieving the expected outcomes. The underlying program theory has been described by Rogers as the representation of the mechanisms by which it is understood that the program’s activities contribute to the expected outcomes, in the short, medium and long term. In other words: Why does the program’s existence make a difference? The information is then presented in a diagram or map of the program with its sequence of key stages.

The second task is to identify those who access and benefit in each key stage of the program and those who do not (subgroup analysis). Questions to be responded for the subgroup analysis include:

- Which subgroups by social stratifiers of the target population are important for the equity of the program?
- What information sources are available with data on the key stages?
• Which subgroups access and benefit in each key stage of the program?
• Which subgroups do not access? Or if they do, do not benefit from the program?
• Identification and characterization of groups in situations of inequity
• Which groups and why are a priority for program redesign?

The third task is to identify using the Tanahashi model of effective coverage the barriers and facilitators for each key stage in relation to each priority group (in situation of inequity). The questions to be responded are:

• What are the barriers to access and to benefiting at each stage of the program for disadvantaged subgroups? These barriers include structural social determinants like employment and working conditions, education, income, intermediate social determinants like risk factors, behavioral factors, cultural beliefs, and access to health system related factors like availability of and accessibility to services, including organizational dynamics and conditions of care.

• What are the facilitators?

The fourth task is to try to explain why certain barriers are mostly concentrated in determined groups or subgroups of the program? Questions to be addressed include:

• How the barriers and facilitators to access the program are related to the social conditions of the population social subgroups.
• Which barriers are specific to the health sector and which are related to other sectors?
• What are the mechanisms of the social determinants of health model through which the barriers and facilitators operate?
• What interventions to address the barriers emerge from this analysis?
• How can participation contribute to interventions on the barriers and ensure their sustainability

Finally the fifth task is to agree on the goals and priorities to be addressed in the program’s redesign.
• What changes should be introduced in the program to achieve greater equity, including work with other sectors and social participation?
• What changes must occur in the program to ensure access and outcomes for all social groups?
• What guidance for the redesign of the program emerges from the social determinants of health framework?
• Can a theory for intervention on health equities be arise from inequities in health, in addition to the theory of the program itself?
• What are the objectives and priorities for the redesign?

The second step after the review cycle is the redesign cycle. The process is illustrated in the following diagram:
The first task of the program redesign correspond to the fifth task of the review cycle.

The second task include the definition of intervention areas and levels. The specific changes for each intervention area are defined as well as the level (national, regional, local). Examples of intervention areas are:

- Modification of program contents
- Structural and organizational changes in program execution or service delivery
- Management and performance improvement by local, regional and national agents
- Central level actions to improve program management

The third task is the definition of possible mechanisms to engage with other sectors and the community. These include:

- Information: How the program will deliver balanced and objective information to other sectors and to the community to help them understand the problem and alternatives for action to improve the equity effectiveness of the program
- Consultation: How the program will obtain feedback from other sectors and affected people and communities about the program performance?
- Participation: How the program will work directly with other sectors and with the communities to ensure that their concerns and public aspirations are understood and considered.
- Collaboration: How the program will partner with other sectors and with the affected communities in all decision-making aspects, including development of intervention alternatives and solutions?
- Empowerment: How the program will support the communities in order to guarantee that they have the “last word” and ultimate control over the key decisions that affect their well-being

Finally, the team summarizes the redesign proposal based on the work of the three prior steps. At this stage is useful to compare the current and the redesign program in terms of: Components (key stages), target population, activities, mechanisms for participation, short medium and long term outcomes and monitoring and evaluation mechanisms and indicators.
**Objective 3:** To implement actions for the "social inclusion" of excluded groups and territories

1. To reduce barriers to access to health care in the 96 most vulnerable counties and 68 most vulnerable urban neighborhoods in the country

As part of the Equity in Health Agenda, a program to reduce barriers to access to care was implemented in the lowest quintile most vulnerable counties (96 in total) and urban neighborhood (68 in total, 44 in the Greater Santiago Region, 12 in Valparaíso Region, and 12 in Biobío Region) across the country. The goal of the program was to promote the reduction of inequities in health in the most disadvantaged counties and neighborhoods in Chile, by means of interventions aimed at the main barriers of access to health services and to the social protection system, which were identified and prioritized by the community itself. The initiative was led by the ministry of Health Regional authorities and cofinanced and coordinated locally by the Municipalities involved. It was based on the active participation of, and input from, the community and on the development of strategies of collaboration within health levels of care and with the other municipal sectors. The implementation of the program began in August 2008, and the first stage was completed in December 2009.

As a first step, all counties and main urban neighborhoods (from the three most populated urban regions Metropolitan, Valparaiso and Bio-Bio) were characterized based on a multidimensional deprivation Index that included socioeconomic, demographic and education and health status indicators. Data were drawn from routine demographic, income, education and health information and from several population-based surveys that routinely monitor social trends in Chile. Based on the index, the most deprived 96 counties and 68 neighborhoods, were selected as the focus of the intervention.

After selection, an in depth desk review of health and health equity indicators was undertaken with a focus on identifying supply-side barriers including availability of specific services, human resources and equipment. Geo-referenced information about rural health centers and available offer of public services was also produced. A first look showed that in these territories, equity in access to the various
social services made available by the State depends not only on the supply, but also on the empowerment of the population to use and/or demand services.

Community representatives and other sector officials were invited to interact and participate in the baseline diagnosis and definition of promising interventions that could be developed in each community. The work carried out during 2009 promoted the integration of various parties who design public policies in local and regional governments, and stressed community participation and territorial equity in health.

Community workshops were held to discuss the baseline assessment. Afterwards, communities identified demand-side barriers including such factors as distance, time and costs associated with using services, poor awareness and quality concerns, and social and cultural impediments. Over 9,000 community leaders, citizen’s groups, users’ groups, and representatives of social organizations took part in this process.

Based on the baseline assessment, the local teams and communities defined specific interventions to decrease the main identified barriers to access to care. Most of the strategies related to ways to improve intersectoral coordination and to implement specific equity-focused interventions. Some of the interventions were different levels of upgrade of selected facilities, others were aimed towards improving geographical and transport accessibility, and others focused on expanding the scope of outreach services provided to the communities for example adding specific home-care services, increasing the number of maternity ‘waiting homes’ etc. Some of the communities suggested innovative strategies to cover transport, and other indirect costs known to prevent them from utilizing health services, as well as strategies to enhance community involvement to promote care-seeking and healthy practices complemented by referring to social protection initiatives programs like Chile Crece Contigo and Chile Solidario (a conditional benefits transfer program to decrease poverty) for persons in greater need. The work on the spatially and socially segregated urban areas occurred by means of neighborhood health projects involving community participation, and learning from significant experiences in each territory.

The work done in the communities was based in the development of community health projects, which promoted the participation of neighbors. The process involved coordination of all social sectors at the
district and local levels by the municipal government, including local Health Services and teams, with the community itself to generate the projects that were subsequently funded by the Ministry of Health, other sectoral institutions and the local governments.

The interventions in the selected vulnerable neighborhoods were defined on the basis of participation, and discussion with the neighborhood community, through an iterative process of dialogue, discussion and exchange of information, through scheduled meetings, which became a fundamental asset, and made it possible to efficiently coordinate local community leaders/organizations with the health teams (District Health Councils, Local Health Development Councils, etc.).

Results

a) Vulnerable counties

- One hundred percent of the districts reported significant reductions in barriers to access to primary health services in rural health centers,
- Similarly, barriers to access to specialized care were reduced in all the prioritized counties by adjusting opening hours and modifying the process of requesting and receiving specialized health care. In the first 9 months of operation, waiting lists were reduced by 60%, (where previously people had to wait 120 days for ophthalmology, otorhinolaryngology, dermatology and neurology services). This was done with very limited extra budgetarian support. Financial support was only provided for sets of medical supplies, radiotelephone systems.
- Sets of medical supplies and basic equipment for screening and diagnosis, as well as oxymeters, were delivered to each of the rural health centers in the vulnerable districts.
- Staff from 419 rural health centers were trained on basic care for most frequent community diseases.
- The HF national radiotelephone health network system was improved or renewed by delivering long-distance communication equipment (200 km range), in a joint effort with the Subsecretariat of Telecommunications of the Ministry of Transport and Telecommunication.
• The agency in charge of primary school social assistance and scholarships (Auxilios Escolares and Becas) decided to redesign its program of oral health in schools in the vulnerable districts, and assigned special funds to children in these territories for oral health services.

• In terms of broadening public awareness and information about improved access to social and health protection, a total of 10,519 persons in vulnerable counties took part in information activities, while another 8,249 became beneficiaries of some of the various programs.

• With a view to reinforcing the work that was carried out, and to ensuring its future development, 15 regional vulnerable district committees and 5 provincial committees were established to continue the work in the future, composed of various governmental, regional, municipal, and community institutions, and coordinated by the regional public health authorities. A separate line was also incorporated in the negotiation of the annual Ministry of Health budget to assure continuity of support. Also, 96 county committees, coordinated by the local municipalities, were set up to apply the lessons and practices learnt, and to implement the action plans aimed at reducing barriers.

b) Vulnerable neighborhoods

Various initiatives were carried out dealing with the quality of life of the population from the perspective of Social Determinants of Health (for example, addressing the lack of community infrastructure, job security issues, unemployment, etc.). Initiatives were undertaken to improve infrastructure (e.g., installing open-air physical exercise equipment, rehabilitating underused public spaces, remodelling community halls, and installing garbage containers), and to increase best practices in health promotion through specific workshops (being a responsible pet-owner, recycling initiatives, healthy eating, exercise and health etc.). Social leadership workshops; incorporation of community members who were previously not involved in local health development councils; setting up venues for coordination between the community and the health care center; and coordination of the public offer of services related to investments in the territory, resulted in considerable social re-activation, which in turn strengthened social organization in the neighborhoods. Over 12,000 persons were directly involved in program activities across the 68 neighborhoods participating in the program to execute joint actions aimed at improving their quality of life. The community valued
the flexibility shown by the health care sector, which accepted neighborhood projects and non-health care interventions that satisfied many long-standing demands of neighborhoods and communities.

**Box: More Health, Better Health**

- 1,000,000 persons in rural or disadvantaged territories took an active part in the Vulnerable Counties Program which focused its resources on achieving the goals identified by local communities, in terms of health care and social protection services.

- The community, jointly with local health teams, updated their knowledge of social rights and became familiar with the programs that make up the government’s social protection system.

- The main barriers to access to health services were dealt with, and positive results were achieved by adjusting opening hours and the process of requesting/receiving specialized health care. Improvements were made in the provision of ophthalmology services by professionals and technicians. This means providing highly-specialized services in community centers, neighborhood committees, etc., which are easily reached by the local population, during the hours when people are free to use said services.

- The coverage of health programs was expanded to include persons who were not registered in the Chilean Public Health Insurance program (FONASA), and improvements were made in the coordination of health care services to meet the needs of disadvantaged groups.

- Intersectoral coordination was strengthened at the regional, provincial, and district levels, and the government’s social protection system was also improved, in terms of providing transportation solutions to healthcare centers.

- Many instances of lack of basic sanitation services – an issue which directly affects people’s quality of life - were resolved in these territories, such as access to drinking water, plans for cleaning up dumps, de-parasiting treatments for stray dogs, pest control in vacant lots, etc.

**Future challenges**

The main challenge is to make this initiative sustainable, so that access to health services, to the social protection system, to basic housing infrastructure and services, to basic sanitation services, and to
government subsidy programs to which citizens are entitled, can effectively be improved and maintained over time in Chile’s most vulnerable districts.

In terms of health care services, it is important to continue with the process of improving infrastructure and equipment of rural health centers, and increasing the frequency of round ground visits made by professional health teams to remote rural areas.

It is also imperative to provide continuous training for primary health staff, and to increase the number of workers in each rural health center, so that adequate flexible working schedules may be implemented. Permanent training to improve public health competences in staff need to be reinforced in areas such as, environmental promotion, sanitation, preservation of the natural environment, and programs that make up the social protection system.

It is also very important to continue the promotion of people’s empowerment by strengthening local organizations and ensuring that the community retains decision-making capacity for solving problems that affect their neighborhoods (including their legal incorporation), and learning from the experiences obtained during execution of the program.

Also related to social participation, the inclusion of more local leaders in the existing local health committees structures that oversee the management of health centers, should be promoted.

Ensuring that community agents have regular communication with local health teams and maintain mechanisms for intersectoral coordination within the municipal governments is also a priority for sustainability.
Box: Testimonials of Participants from Vulnerable Neighborhoods

“We value highly this program because (...) just look at this equipment, what an excellent idea, these exercise machines are very welcome because, for example, the Salvador Allende park used to be a meeting place for drunks. Now things have changed... there’s space in the square now, we value it and respect it, the plaza is now full of people. In the healthcare facilities (...) they’ve almost finished building the clinic..... it’s these concrete things, as I was saying, that we value, and obviously it’s an improvement in our quality of life, and is good for the self-respect of the people”. (a leader of the Los Copihues Neighborhood Committee, la Florida, Metropolitan Region).

“We held about 6 meetings before validating the project, before deciding what we were going to do with the money once it arrived, and in those six meetings we basically identified the problems we face and, on the basis of that, we designed the activities. All the activities that were carried out were proposed by local people”. (Monitoring agent, Chilectra sector, San Roque, Valparaíso)

“The monitoring agent did an outstanding job. The truth is, nobody imagined that things would be done so well (...) Because it was excellent... all the proposals she made, everything she agreed to do, she managed to put into practice and she got everything she put her mind to. As to how she did it, how she coordinated it, we don’t really know. The thing is, she was here in the morning, and at midday, and in the evening, and she’d say: “Alright, I’ll get a reply about this, one way or the other”.. and it would happen, so the whole project became a reality”. (A leader of the Chilectra Neighborhood Committee, San Roque, Valparaíso).

One of the main lesson learnt in the process is the importance of community engagement to strengthen utilization of services and promoting healthy practices and behaviors to reduce incidence of risk factors and diseases. Joining with the community has the potential to accelerate progress in health level and distribution and also help to address other entrenched and pernicious barriers, like discrimination on the basis of gender, ethnicity, disability, or others that serve to exclude vulnerable groups from vital services and protection.
Objective 4: To develop competencies on equity and social determinants of health within the Ministry of Health staff

1. To elaborate and implement a capacity building program on incorporating SDH and Health Equity in the Design and Development of Health Policies and Programs: Training the trainers

In order to deal with the challenges of reducing inequities in health, and of putting people’s real needs at the center of public services, it is necessary to strengthen and make visible the role of Public Health in society, expanding the personnel’s capacities for health planning, for coordination with other sectors, and to develop mechanisms for incorporating civil society as actors who deserve to be heard and to share in decision-taking and exercise social control. These challenges call for a process of institutional and public reflection, and for the development of skills to implement actions in public health that are pertinent to the needs of the disadvantaged territories and groups, and also pertinent to contemporary health realities.

The “Development of Competencies and Training in Public Health Program”, was one of the activities of the Equity in Health agenda implemented by the Subsecretariat of Health since 2008. The work included reviewing the institutional management model, making a baseline assessment of competencies needed and detecting the training needs according to the model. A training program was then developed tailored to the needs of specific staff jointly with the Andalusia (Spain) School of Public Health and the Andalusia Secretary of Health. Both of the institutions provided consultancy services for the design of an in-service training program and a three week course, to the Chilean ministry of Health, using the “train-the-trainer” model.

The training program involved sending 67 health care professionals to Andalusia during 2009 for three weeks to become acquainted with the Public Health model implemented by the Andalusia Secretary of Health and to improve their training in Public Health at the School of Public Health by means of a program specially developed for them based on the baseline competence diagnosis. Once back in Chile, these professionals helped organize and implement a nation-wide process of reflection and debate on public health, which in 2009 gathered 850 persons in training workshops held simultaneously in Chile’s 15 regions and in all of the provinces.
The train-the-trainer initiative aimed to create new capacities in the health professionals of Chile, and to launch a “snow-balling” type of training process similar to the one created in Andalusia, in order to ensure continuous training in public health, and to establish a venue for discussing, reflecting on, and analyzing the experiences. The purpose of the program was to create a space for the exchange and debate of experiences and to develop skills and capacities to meet emerging challenges in Public Health. During the process of exchange, public health practices were discussed as well as global and local challenges; concepts and frameworks related to the process of social production of health were also discussed, as well as concepts like Social Determinants of Health and Health Equity. Critical analyses of institutional practices, of current problems, and of emerging situations facing public health in the national and global contexts were also undertaken.

The visits to Andalusia were organized in three cycles: the first was held in February 2008, with 20 participants, mostly from the ministry of Health. Once back in Chile, this group was given the responsibility of beginning the design and organization work for the “train-the-trainer” program in the country.

The second group of participants included health care workers selected from each Region and of representatives from the Ministry and the Divisions and Departments of the Subsecretariat of Public Health. The third group was made up of candidates from all regions, who sent in their CV’s and were selected through a competitive process.

The final design of the training program to be replicated in Chile benefit from the experience of a Consultative team of Chilean public health experts with relevant backgrounds in public health, including Directors of higher education institutions which offer Master’s and other Post-Graduate programs, and former undersecretaries. The group suggested a modular methodology for the training and helped organize the contents of the program. They also suggested to divide the training program into two parallel programs: one for professional and technical staff, and the other for administrative and support-services personnel, so that all levels of health care personnel would have access to this training.
Contents and areas covered in each module:

**Public Health and Society.** This module dealt with the current context of public health, considering the existing stock of knowledge worldwide, and the Chilean history of health policies. It aimed to promote the debate on the foundations of Public Health in the context of contemporary society; to examine the essential functions of public health, the role of health authorities and the State, and the processes of social production of health. The specific contents were:  
   a) Public Health and globalization;  
   b) the essential Functions of Public Health;  
   c) Public Health in today’s world;  
   d) History of Chilean Public Health: Continuity and discontinuities;  
   e) the Chilean Development Model and its Implications for Public Health;  
   f) The process of Social Production of Health.

**Critical aspects of Public Health in Chile: “Intersectorality and Social participation”.** This module analysed the role of public health in contemporary Chilean society and in the State administration and provided managerial tools for public health. The specific contents were: Models of Social Protection and Health; Intersectorality and Social Participation; and models for decision-making in Health.

**From a System that Controls Illness to a System that Produces Health.** This module incorporated concepts about the essential functions of public health into health care administration, including developing Public Health Plans for specific territories, incorporating the role of information systems, surveillance in public health, and the role of contexts and social determinants of health in health level and distribution. The specific contents covered were:  
   a) Public Health assessment and strategic plan (Analysis of the health situation, monitoring and surveillance in health. Human Resources in Public Health. Critical aspects for improving the quality of life and access to social protection services. Health and work);  
   b) The territory and its integration into the Health care system. Primary health care and Public Health;  
   c) Information for planning;  
   d) Data analysis from the point of view of social production of health;  
   e) Evaluation in Public Health: evaluation of the impact on health, evaluation of public health programs.

During the training, debate revolved around the question of Social Determinants of Health, intersectoral action for health, social participation in decision-making processes, and health care planning. A total of 853 health care personnel took part in the training - equivalent to 30% of all personnel of Chile’s Public Health Authorities. They met with, and learned from, experts and authorities, and were provided with
background documents, DVDs and CDs with relevant bibliography and copies of presentations and lectures.

Health care concepts and priorities were discussed and brought up to date, in light of the emerging situations facing public health in the national and global contexts. Teams of professional, technical, and administrative staff from Chile’s 15 Regions took part in the debate, and analyzed, from a critical perspective, the performance of public health services in contemporary Chile.

A second stage of the training program was devoted to administrative and support-services personnel: the same Public Health contents were covered, using adult-education methodologies, and stressing the exchange of information and reflection on the real-life experience of the participants. This step was carried out in multi-Region, 3-day events. Participants with a great variety of backgrounds came from the North, South, and central regions of Chile, and made their contributions to the exchange of experiences and knowledge. In all, 150 administrative and support personnel from the 15 Regional Health Authorities took part in this exercise.

The Train the Trainer program stressed the exchange of experiences and opinions, as well as debate and critical analysis of selected subjects, starting with the study of relevant documents. Experts on each subject matter were brought in to hold seminars and to lead group discussions structured around work guidelines given to each participant.
Box: Activities of the Train-the Trainer program

- Program Design: Preparation of the program proposal by the administration team, with the help of experts in each of the basic subject matters covered in the training.

- Committee for Training in Public Health: A group of health professionals with recognized experience in public health and in public health training, who validated the contents and methodology, and proposed the list of authors to be included in the contents of each module.

- Invitations to authors of contents and panel members. Several external authors contributed and developed various specific contents for each module. They sent in presentations, bibliographies, and audiovisual material. The Committee on Training fine-tuned the proposed materials for their pedagogic and didactic use.

- Editing/Printing of Materials: Preparation of theoretical and group-work materials for each module.

- Preparation of a Briefcase containing all the bibliographic material for each participant in the program.

- Creation of a virtual platform: this network space makes available a great amount of teaching materials. The participants (900 health workers registered in the program) can upload their “homework” and take part in debates and exchange of opinions/information. This online space is part of the website www.equidad.cl (link: Desarrollo de Competencias).

- Training, Reflection, and Debate: Simultaneous nation-wide implementation of the work modules, including video conferences, National Days for reflection and debate, and delivery to participants of additional printed material.

- Inter-Regional Workshops for the exchange of experiences, and reflection on Public Health. This involves the same public health contents, and is given to administrative and support-services personnel from throughout Chile.

- Certificate of Training in Public Health, issued by the Ministry of Health and the Andalusia School of Public Health (30 teaching hours), for participants who put in the required hours of work in the modules and completed the requirements of the program.
The consolidation of the debates, experiences, case studies, and others has been published and disseminated by the Ministry of Health and a formal independent evaluation was conducted and published 27.

**Future challenges**

In light of the results and the evaluation of the program, the future challenges identified are:

- Consolidating the public health training program, by drawing on international experiences in Latin America and other countries that have implemented public health reforms.
- Establishing and maintaining cooperation and exchange agreements with international public health entities, including internships in Latin America, Caribbean, and Europe.
- Achieving sustainability for the online public health training program, improving its design and administration, and keeping the contents up-to-date.
- Implementing the program of developing transversal competencies in public health suitable to the needs identified by the work teams in the various regions.
- Making the program suitable for all personnel (professionals, technicians, administrative staff and support services).
- Consolidating a permanent program for internships of public health workers in other regions within Chile, as well as international internships.
- Making continuous training a permanent part of institutional processes, to adapt to the changes required by the evolving public health conditions in Chile.
- Permanently updating the contents of the online network.
Objective 5: To generate tools for planning, monitoring and evaluation of the SDH and equity in the health sector

1. To develop regional diagnoses on social determinants and Health equity in all regions in the country

“Studies of Public Health with a focus on Social Determinants serve to produce useful information for designing local policies and interventions aimed at reducing inequities in health”.

Inequalities in health are a reality throughout the world; socially disadvantaged people get sick and die more often than people from privileged groups. This is a critical issue for the most vulnerable groups, which have less access to health care services.

Although a large part of health problems can be linked to people’s socio-economic conditions, health policies in general have traditionally focused on treatment rather than on dealing with “the causes of the causes”. As a result, inequities in health and health care have increased.

The approach which focuses on Social Determinants of Health has acquired great relevance over the last few years, and was promoted by WHO first through the Commission on Social Determinants of Health. The Commission’s report titled “Overcoming inequalities in one generation: achieving Health Equity by working on Social Determinants of Health”, has identified crucial aspects of day-to-day living conditions and underlying structural factors which affect these factors. It is necessary to act upon these factors, and one of the recommendations made by the Commission is “to determine the dimensions of this problem, to analyze it, and to evaluate the effects of Health interventions”.

Chile’s economy has undergone sustained growth over the last few decades, and poverty has decreased substantially. Regarding public health, Chile’s relevant indicators have been among the best in Latin America for many years.

When the Public Health situation in Chile is analyzed by breaking down the population into socio-economically/culturally deprived or privileged groups, great inequities become evident. However the Chilean health information systems are not designed to generate, link, synthesize or disseminate data and information on social determinants of health, health inequities, or the associations between the two. These limitations are found within the health sector as well as across other social sectors that
contribute to health. A traditional focus on aggregate health outcomes – simple averages – combined with the chronic under-representation of marginalized or vulnerable sub-populations in data, contribute to keep health equity and its economic, social and political causes relatively invisible. Without an explicit picture of the distribution of health and its non-biological determinants, awareness and responsibility to reduce health inequities – absolute or relative – that are caused by the way the chilean society is organized, remains constrained; policies and programs within and across sectors are not accountable for; and monitoring and evaluation of the access to and impact of interventions remain silent on whether inequities increase, decrease or remain stagnant over time.

An operational approach to generate, link, synthesize and disseminate data and information on social determinants of health and health equity, and the associations between the two, appeared therefore as an imperative to report more comprehensively and systematically on these issues, as well as share information and direct capacity strengthening efforts in Chile.

Based on the WHO CSDH conceptual framework on social Production of Health, as part of the Equity in Health Agenda, and on the set of core indicators to monitor Social Determinants and Health Equity developed by the WHO Equity Poverty and Social Departments, during 2007, a concrete monitoring and assessment model based on the four components of the conceptual framework: structural determinants, intermediate determinants, differential access to health care and differential health outcomes was developed. Indicators were selected for each dimension of the core set proposed by WHO, to operationalize each of the framework’s components. These included includes a mix of existing and new indicators, to provide a systematic and comprehensive picture for monitoring and assessing the social determinants of health equity at regional level on a routine basis.

The indicators were built from existing routine data sources and used to construct Regional Health Diagnoses with a focus on Social Determinants and Health Equity. The final purpose was to help reduce inequalities in health through the use of available information that detect and quantify inequities existing at the regional level, and by producing useful information for the design of strategies and policies aimed at closing these gaps.
The regional health diagnoses has contributed to improve the local health teams’ capabilities to make informed decisions based on available information, to support the public health programs to perform more efficiently, to help the staff to decide on interventions to reduce equity gaps based on local evidence; to evaluate and monitor the overall health situation and distribution based on the CSDH analytical; and to quantify the results of programmatic interventions aimed at the most disadvantaged groups.

The initiative was launched in mid-2008, and it was carried-out jointly by Epidemiology Department of the Ministry of Health, in coordination with all Regional Epidemiology teams.

The review of existing bibliography and the preparation of the theoretical framework for the program begun in mid-2008, and was completed towards the end of that same year. The selected bibliographic material was obtained and systematized during the first semester of 2009. The indicators to be used at the regional level were defined and calculated. The main criterion for selection was that they incorporate all domains of the framework: Structural determinants, intermediate determinants, health outcomes and consequences and equity gaps.

During the second semester of 2009 the regional data sheets were produced, with the defined indicators that made it possible to compare the overall health situation, the degree of inequities, and the main determinants, among the regions. This was followed by the creation of data sheets at county level, for each of the counties in each region.
During the first semester of 2010, all the 15 regional health diagnostics were completed, while the district health diagnostics for 45 priority districts will be completed by the end of 2010.

The steps for the development of regional diagnoses included: defining and agreeing on a plan of analysis for social determinants of health and their consequences in health level and distribution; the collection of available regional and district information; making the regional diagnostics; making the district diagnostics and communicating / disseminating the results.

The process was faced with two fundamental challenges. In the first place, the need to develop an analytical perspective capable of linking two separate axes: one based on risk factors and negative consequences in health; and the other, which is transversal to the first one, is focused on detecting and making visible the inequities linked to specific structural determinants, such as gender, ethnic group, and the social position of the individuals. This was done by integrating into one core set, indicators...
related to structural and intermediate determinants, health systems determinants and impact on health using geographical and counties as the main dimension for equity analysis.

A second challenge was increasing the level of coordination with and between Chile’s various regions, and expanding the contents of the online training material in accordance with local needs, as well as sharing, disseminating, using, and regularly updating said documents and data bases. This was overcome by incorporating into the design and implementation the staff in charge of routine epidemiological monitoring from all regional health authorities and by the development of a series of training workshops and meetings during the process.

The building of the indicators is currently incorporated into the routine work of the Regional Health authorities and they will be updated on an annual basis. All the regional and county health diagnoses are accessible through the Ministry of Health website (www.diagnosticoregional.cl/)

Achievements

• For the first time ever, indicators have produced information on the negative health effects and inequalities at a regional and district level in Chile.
• The regional and district data sheets for the country’ 15 regions are currently available from the website www.equity.cl as well as from the Ministry of Health website.
• The regions now have data bases of the indicators used in the preparation of the regional data sheets. Therefore, modifications can be made in accordance with local information priorities.
• There is now an online tutorial to support a process of knowledge management on the part of local health teams, and to help them analyze the diagnostics.
• There is a separate website for the Regional Diagnostics, which makes the products of this project accessible to the public.
Box: Example of comparative analysis for a region

<table>
<thead>
<tr>
<th>AREA</th>
<th>INDICATOR</th>
<th>Highest third</th>
<th>Middle third</th>
<th>Worst tertile</th>
<th>Region comparison</th>
<th>Best region</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% total living in poverty</td>
<td>17.7</td>
<td>13.7</td>
<td>20.7</td>
<td>6.3</td>
<td></td>
</tr>
<tr>
<td>Structural</td>
<td>Unemployment rate</td>
<td>5.9</td>
<td>7.5</td>
<td>10.2</td>
<td>3.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>households with lack of sanitation (%)</td>
<td>14.4</td>
<td>8.7</td>
<td>24.2</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Life style</td>
<td>% workers without signed contract</td>
<td>24.0</td>
<td>19.9</td>
<td>26.3</td>
<td>14.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% tobacco consumption</td>
<td>37.3</td>
<td>39.5</td>
<td>45.6</td>
<td>35.0</td>
<td></td>
</tr>
<tr>
<td>Mental and violence</td>
<td>% with symptoms of depression</td>
<td>27.2</td>
<td>22.3</td>
<td>27.2</td>
<td>10.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% households victim of crime</td>
<td>30.8</td>
<td>35.3</td>
<td>46.5</td>
<td>15.0</td>
<td></td>
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<tr>
<td>Health Systems</td>
<td>Nº critical care beds per 100.000</td>
<td>10.4</td>
<td>13.7</td>
<td>9.6</td>
<td>26.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% beneficiaries of public insurance</td>
<td>65.2</td>
<td>74.5</td>
<td>55.6</td>
<td>74.5</td>
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<tr>
<td></td>
<td>% children under 6 in control</td>
<td>90.3</td>
<td>69.1</td>
<td>47.3</td>
<td>90.3</td>
<td></td>
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<tr>
<td>Health outcomes</td>
<td>Average grade of satisfaction with health system (1-7)</td>
<td>5.2</td>
<td>5.3</td>
<td>5.1</td>
<td>5.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mortality rate</td>
<td>5.9</td>
<td>5.2</td>
<td>6.2</td>
<td>4.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LE at birth</td>
<td>76.9</td>
<td>78.1</td>
<td>76.2</td>
<td>79.4</td>
<td></td>
</tr>
</tbody>
</table>
**Objective 6:** To establish mechanisms for the integration of the community to develop the necessary actions to reduce health inequities

**Health Forums**

_During 2009, approximately 50,000 Chileans from all the country’s regions cooperated with the Ministry of Health in preparing proposals for improving the health of the general population during the next decade. The results of this work were incorporated into the preparatory work for defining the Health Objectives for 2011-2020, and into Regional Health Planning._

The health of a community is a social product. The forum project called “Let’s Build Better Health for Everyone” created a venue for concrete participation that lets the community become involved, propose, and decide on the planning of public policies and programs aimed at improving equity in health for everyone during the coming decade. The main goal was to trigger a process of participation in the choosing of health priorities, with a view to providing inputs for regional health planning and for defining Health Objectives for the decade of 2011–2020 based on people’s expectations.

The process involved 4 stages: the first was hearing different opinions and collecting information, with 57 forums held throughout Chile during the second half of 2009, including the participation of community organizations and groups, professionals, community leaders, health workers, etc. During this stage, over 13,000 survey questionnaires were handed out. The second stage was devoted to classification: a group of specialists analyzed and arranged the totality of the proposals received. The third stage involved returning the proposals to the communities for validation, and holding new forums in each region to submit the resulting analysis to the people who had taken part in the previous meetings. And finally, the community proposals were incorporated into the Health Objectives for the Decade of 2011-2020, and into the 2010 Regional Health Planning.

This process required the preparation of concrete proposals for solving the main health problems of each region, the identification of the social actors who will be responsible for implementing said actions in seven different levels: My Health, Community, Health Services, Education, Work & Employment,
Territory, and the State, which are consistent with the conceptual model behind the Social Determinants of Health.

In the year 2000, Chile for the first time defined the Health Objectives for the Decade (OSD), which serve as the fundamental guidelines for health planning. The evaluation carried out halfway through that period (2005), showed that several of these objectives would not be achieved, especially those related to equity in health – which is more dependent on living and work conditions that on the performance of the health care system.

In light of that analysis, and faced with the need to prepare the Health Planning for the next ten years, three general directions were taken into account. First, defining the strategy for action on the basis of Social Determinants of Health, which implies implementing social policies consistent with the fact that equity in health is socially created. Second, intensifying and perfecting intersectoral cooperation and action. Finally, creating venues for citizen participation which will effectively influence Health Care Management, and will not be limited just to the transfer of information, in order to achieve a dynamic and effective relationship between the health sector and the community, which lives with inequities in health on a daily basis.

In accordance with the results of the process of consultation with communities, and of the proposals made by community organizations and by personnel of the health care sector, it has been possible to orient the work of the Ministry of Health toward the following challenges:

a. Equity in health must be a universally recognized value and an explicit goal, as well as a model of development for the State administration.

b. It is absolutely necessary to take into account the opinions and proposals of community leaders in the construction of their health.

c. It is necessary to create a permanent venue that will permit the community to participate in the design and execution of the policies, programs, and activities of a variety of public and social sectors, which are aimed at achieving the 2011-2020 Health Objectives.

d. It is important that the 2011-2020 Health Objectives be supported by an administration system that has adequate planning and budgetary policies, and monitoring systems.
e. It is an important priority to strengthen the organizational model of the public health system in order to achieve greater effectiveness in the delivery of health services, and to ensure that patients always receive polite treatment.

f. The intensive use of ICTs and other means of communication will make it possible to position the policy of equity in health, in a decentralized and participative way.

g. It is necessary to organize local follow-up events (at the regional, provincial, and district level) so that the community may assess the impact of their decisions in terms of helping achieve the 2011-2020 Health Objectives and equity in Health.

**Proposals of the Equity Agenda**

The consultation process produced extremely valuable information for designing and implementing social policies in accordance with the expectations of the community. Specifically, the participative process and the proposals point to seven aspects that are directly related to the equity agenda being promoted by the Ministry of Health. They are:

1. **Precision and feasibility of the proposals.** The majority of proposals made by the community and the healthcare workers are sensible, feasible, and well thought-out. Although many other proposals were either of a conformist nature or they amounted to complaints, the conceptual framework and the methodology used in the forums made it possible to transcend the discourse of welfare-type demands, and to consider an ideal model for the public services: innovative, efficient, inclusive, and oriented toward social justice.

2. **Playing down the concept of health exclusively as absence of disease.** Although the majority of the proposals have to do with health care services, the fact that people were consulted about the milieu where they live or work made it possible to overcome the fixation on access to medical care, and to recognize the factors and determinants that affect health. Although it cannot be said that the community has overcome the dominant discourse on health, there are clear signals pointing to the great potential benefits of the conceptual framework of Social Determinants and equity in health.
3. **Participation.** The communities and the health workers said they wanted to increase their participation in social policies: not only in the health sector but in several other sectors, and they demanded information and training in order to be able to exercise some social control over the design and implementation of these policies.

4. **Multisectorality.** Multisectorality is recognized as a basic strategy for achieving better health for everyone, on the basis of concrete proposals, with clearly identified parties responsible for implementing them, such as representatives of the health sector, other sectors of public administration, the private sector, and the community itself.

5. **Positive assessment of the public health system.** There was an absolute absence of proposals for the privatization of health care. Although there are critical comments contained in the proposals, they are aimed at promoting and improving the work of the health services.

6. **Improving the way users are treated in health care services.** One of the most recurrent comments contained in the proposals concerns the way users are treated, and people considered this to be one of the most significant aspects of the health care system. A closely-linked issue is that of waiting times, lack of personnel, difficulties faced in obtaining access to medical treatment, and the work conditions of health care workers.

7. **Recognizing prevalent diseases as top priorities.** In a way that is consistent with studies of work loads generated in the healthcare system by specific illnesses, and with studies of social priorities, the community is aware that epidemiological profiles have been changing, and that there is an urgent need to deal with obesity, and drug and alcohol abuse. In general, people are aware that the actions needed to prevent and reduce health problems are of a social nature.
II. Discussion: Lessons learnt and future challenges

Despite the advances in integrated action, during the implementation phase of the “13 pasos” agenda tension occurred when the need to respond to needs meant modifying technical criteria, changing administrative procedures or adapting services or goods to the population demands.

Several aspects of the experience should be emphasized as levers to keep continuous engagement and sustainability a) the participative methodology of work used by all the specific initiatives of the Equity agenda seemed to promote staff empowerment and engagement in the program, b) the investment made in competency building of the public Health staff, including a short term program of training at the School of Public Health in Andalucía, attended by 60 professionals in three waves and followed by a process of capacity in “snowball” using them as seeders to subsequently train almost 1000 professionals throughout the country.

With regard to intersectoriality the “13 pasos” agenda provided evidence that earmarking budget in the annual budget that goes for discussion by the Congress is a good strategy to promote sustainability of work with other sectors, mainly because money request goes with the understanding that these initiatives are a priority for the health sector, in doing so, this priority

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Box: Testimonials of participants in Health Forums

“...we can’t let the Government face this all by itself, because we are the ones who know the reality of each community...”

“...it seems to me that we are incorporating into the debate, into the conversation, several elements that are usually not picked up by the central administration. In that sense, this has been a very valuable process, because it also lets us understand, in a very straightforward and practical manner, that health isn’t just something that is associated with a Government Ministry...”
becomes also recognized by other sectors. Subsequently it is more likely that others will also put resources to maintain them.

Another strategy for sustainability is not to separate strategic, managerial and technical staff for the participation in the process. It is basic that coordinators of each component lead in a participatory way, recognizing that leadership has to do with values, with maintaining noble objectives, with being recognized by the others without imposing and recognizing capabilities of others.

Taking advantage of contextual factors (windows of opportunity) is also important. For example we used the growing national debate on the problems of social equity, attributed to the economic model and the inability of social policies focalized on deficiencies and vulnerabilities to show this agenda as a response (contribution) of the Health sector to the broader social objective of social protection set by President Bachelet.

The “13 pasos agenda” story reaffirms the importance of generating a broad base of consensus on the problems and the solutions, before embarking on new initiatives. Its design was the result of convergence on objectives and key pillars of action, within the ministry of Health, despite ideological perspectives that could have resulted in greater discord, enriched by public discussion that involved thousands of participants. It is also an example of a different style of leadership exercised by mid-level managers that remain in the institutions through political changes

**Lessons learned**

The 13 pasos agenda is also one of few experiences in Chile where the Ministry of Health has been able to play a true leading role. The process of developing and implementing the “13 pasos” agenda influenced the philosophy of people within the ministry of Health but also from other sectors. During the process, we learned some lessons that could be generalizable to others that are involved in similar processes.
Lesson 1: In order to strengthen health equity, there must exist explicit political commitment at the highest level

One of the main lessons from the work in Chile is that in order to strengthen health equity, there must exist explicit political commitment at the Minister of Health and also at the government level. The political will in the Chilean case was translated into programmatic and financial levers for change that formed the basis for institutionalization. These included:

- an ad-hoc commission under the direct mandate of the Undersecretary of Health
- a detailed workplan for implementation of the agenda on SDH & equity
- a separate budget line
- an information platform

The political leadership necessary to initiate and sustain these actions also involves building support with like-minded actors based inside and outside the health sector and government through:

- looking for evidence on differences in health status between areas and populations;
- framing issues in terms that promote broad-based support for health equity to be built.
- engaging, motivating and leading the staff within the public health sector in support of health equity goals and actions; and
- identifying opponents and obstacles, working around them strategically and countering their influence.

Lesson 2: The need for an explicit agenda with incentives

The second important lesson is the need to define an agenda with specific goals, objectives and time frame that can be evaluated. This agenda must be linked to organizational, capacity building and financial objectives. Setting explicit health equity policy goals and objectives can be used as a driver for wider action by a) giving a clear institutional mandate and linking them to results that help build an epic
as well as provide a good basis for institutional and individual evaluations and b) encouraging implementation processes that stimulate innovation and learning in pursuit of health equity goals.

**Lesson 3: Building trust is a must**

In order to pursue an Equity agenda at MOH it is imperative as a first step to build trust-based teams, drawn from actors across levels, who together combine the range of skills to develop, implement and evaluate initiatives, manage communication and negotiation processes; and build relationships with local or national leaders from the community and other sectors. It is important the co-ordination of decision-making responsibilities related to the Equity and SDH agenda across levels of the health system; and to empower and enable local level public sector managers to re-orient the routine practices of health.

**Lesson 4: Intersectoral relationships are crucial**

The Equity agenda must include a clear strategy to mobilize intersectoral relationships in order to take action on improving equity in health. IAH is a complex political process, where contextual and structural factors related to the organization and budget allocation across and between sector often act as obstacles. IAH is time-consuming and resource-intensive, therefore, the engagement must be based in specific joined initiatives where health is a partner with the other sectors involved, take the strategic needs of the other sectors into account, framing objectives in ways that are commonly understood and sharing responsibilities and rewards. Even when it is not possible to engage in IAH activities to improve equity with other sectors, the health system has to advocate for health equity as a social goal with the other sectors in government. The first step of the strategy is to map the key actors’ positions on, and concerns about, general and specific health equity issues and policies, and to consider the contextual influences over them. In the case of Chile, intersectoral action and community participation were the weakest aspects of the programs, and still are. To this respect health services need to adapt and change their model of “business as usual”, but unfortunately this is easier said than done.

**Lesson 5: The community is essential**

The Equity agenda must include clear opportunities and mechanisms to engage the community in decision-making and action, especially at the local level related to objectives, entitlements, human
resources and funding of interventions to improve Equity in Health. The Ministry of Health, must facilitate context specific social empowerment strategies. In particular, it is important to contact and support social networks and civil society organisations. For this local health systems have to be adequately resourced and provided with incentives for community action and communication. Our experience in the Health Forums showed us that facilitating social empowerment for health, especially for relatively powerless groups who bear the burden of health problems is also an intervention strategy per-se to improve their health and health equity. Social empowerment expose and redress power imbalances that harm opportunities for health in disadvantaged groups through the explicit recognition of the people’s rights to be informed and to participate in the definition of policies, including those related to resource allocation, that affect their health, and by establishing mechanisms to hold the health system accountable to the community for its policies and commitments. Social empowerment strategies need to be adequately resourced to allow for direct participation of the community.

**Lesson 6: Training as a strategy for institutionalization**

Finally, another critical step of a strategy to institutionalize change in the processes of developing and implementing policies to address the social determinants of health inequity is to strengthen local health competencies by training, motivating and creating competences of managers, as we did in our experience with the Andalucia School of Public Health, and by establishing local information systems that support action on health inequity, as was done with the Regional and county health equity and SDH diagnoses, using the WHO framework. Policy implementation of the health equity agenda has to be sustained over time so that it become part of the taken-for-granted practices within the health system. To achieve this integration of policy and practice, the value basis, relationships and management of health systems (that is, their organisational culture) need to be re-framed to support health equity. Public sector managers can be empowered to lead such change through mentoring and training processes that nurture and develop the values and skills for such leadership; and by supportive leadership from the senior authorities of the Ministries of Health.
The Challenges for the future and how they will be addressed?

Most of the initiatives of the “13 pasos” agenda remain in place more than one year after the change of government. Maintaining the work on social Determinants and Health equity is an ongoing task.

The main challenge and objective for the future is sustainability of the work. In order to achieve this, one priority task, has been to make visible this agenda and its opportunities to the new authorities and obtain their explicit commitment to continue the work over the next 4 years. Having said that, this is important but not necessarily crucial for sustainability because of the institutionalization of the approach within mid-level stable technical staff that have control over their budget and because of the ongoing active participation of the community in the process, institutionalized through formal channels (like Boards and others). The disposition to participate of various people with different institutional cultures, objectives and experiences do not depend on institutional support. Building institutional commitment shaped by shared objectives, goals and results and supported by concrete mechanisms to safeguard them are key elements not only for success but also for sustainability. Ministers can be changed, support can vanish, programs shelved but if shared objectives remain, new policy windows of opportunities continue to open.

The systematization of the experience and sharing with other countries and with the scientific community is an important mechanism for sustainability, and visibility. It introduces evidence as a driver for change and provide the opportunity for broader consensus at regional and global level. In this regard, leadership of global agencies is key to implementation and sustainability in countries.

Working together changed the way we related to one another within the professional teams involved in the process. Rights - based approaches and democratic valued demand a culture of respect and of institutional social capital. In our experiences where action was proactive but not an order, actors were invited and not forced, and duties and obligations were negotiated; we believe that sustained commitment, and development of institutional social capital are enduring objectives achieved that will be put to test on the years to come.

Finally, the story of Chile’s “13 pasos” agenda will be one of persistence. We shaped the problem so that it busted upon the agenda, we moved forward by gathering evidence, we repeated and repeated
until we achieved agreement and we failed and failed and tried again. We remain optimistic that the agenda will continue and that this effort has acted as a “yeast” in the production of a community of knowledge and action that dialogues, is organized, makes proposals, and that mutually supports itself.
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