SALUD COLECTIVA, Buenos Aires, 7(1):21-33, January - April, 2011

Systemic governance for a human rights approach to health. An analysis based on the Chilean case

Gobernanza sistémica para un enfoque de derechos en salud. Un análisis a partir del caso chileno

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ABSTRACT The article analyzes organizational, managerial, and institutional challenges in the development of systemic governance for the implementation of policies with a human rights approach, taking as a case study the Chilean health reform initiated with that approach in 2004. The study integrates a qualitative analysis of legal norms, of managerial instruments and of 40 interviews conducted in 2009 with health executives in three regions of Chile. The findings show that in this reform there is a close connection between incentives and calculations of personal benefit that does not favor agency interdependence. The prevalence of this trait tends to undermine the values of mutual aid and cooperation needed to achieve the integral solutions to social problems that a human rights approach demands. The conclusions reached state, in part, that an uncritical acceptance of management and organization methods inherited from previous institutional reforms often creates contradictions in the development of a governance structure conducive to a human rights approach.
KEY WORDS Health Care Reform; Human Rights; Management/organization & administration; Public Policies, Chile.

RESUMEN El artículo analiza los nudos y desafíos organizacionales, de gestión e institucionales de la construcción de gobernanza sistémica en la implantación de políticas con enfoque de derechos. Adopta como caso la reforma sanitaria chilena iniciada bajo ese enfoque en el año 2004. La metodología integró un análisis cualitativo de normas legales, de instrumentos de gestión y de 40 entrevistas en profundidad efectuadas en 2009 a directivos de salud de distintos establecimientos en tres regiones de Chile. Los hallazgos muestran que en la reforma prevalece una conexión entre incentivos, cálculos privados de beneficios personales y mediciones que no favorece la gestión de las interdependencias y tiende a debilitar los valores de ayuda y cooperación mutua necesarios para alcanzar la integralidad en la solución de las problemáticas que los derechos interpelan. Se concluye, entre otros aspectos, que una aceptación acrítica de los modos de gestión y organización heredados de reformas institucionales previas, genera contradicciones con la necesidad de construir gobernanza para un enfoque de derechos.
PALABRAS CLAVE Reforma Sanitaria; Derechos Humanos; Gerencia/gestión administrativa; Políticas Públicas; Chile.

SALUD COLECTIVA, Buenos Aires, 7(1):21-33, January - April, 2011

INTRODUCTION

In contrast to the health care models developed in the majority of European countries, most Latin American health systems were initially aimed at specific social strata in the population, leading to social segmentation and consequently to stratification in the exercise of health as a right (1). In this context, the institutional reforms that have taken place in the public sector over the past 30 years, particularly in Chile, have tended to reinforce the fragmentation of the health system by separating the insurance, funding and provision of health care services, by increasing participation of the private sector in the provision of services and by a decentralization process that shifts the responsibility for primary care to the municipalities. These measures have been governed by the rationale that the main institutional incentive to be adopted by the public sector is the development of results-oriented competition to obtain funding.

At the same time, during the last decade, the Public Policies with a Human Rights Approach (PPED, from the Spanish *Políticas Públicas con Enfoque de Derechos*) (2-6), have gained renewed relevance. PPEDs emphasize the notions of universality, non-discrimination and enforceability of social rights but also the importance of a holistic or integral approach to ensure the enjoyment of a right, which makes it crucial to consider the attributes that create governance in the institutions in charge of the implementation of a PPED.

The Chilean health care reform, which started in 2004 (a), included as a key feature the progressive guaranteeing of enforceable health rights — Explicit Health Guarantees, (GES, from the Spanish *Garantías Explícitas de Salud*) — for both the public and private social security system, comprising coverage rights, the application of maximum wait times for receiving care, financial protection, and a quality standard for the treatment of a number of severe, expensive and frequently-occurring health problems — 66 to date — which account for a large portion of the burden of disease. At the same time, in the public system, the reform sought to adapt the primary care model to a family health model. Moreover, the institutional restructuring caused by the legal framework of the reform withdrew the functions of the Sanitary Authority from the twenty-nine health care services — which from that moment on deal exclusively with the management of the health care network to provide health services within their jurisdiction — and vested those powers in fifteen Regional Ministerial Health Secretariats (Seremis, from the Spanish *Secretarías Regionales Ministeriales de Salud*). At the ministerial level, this separation of duties was evidenced by the creation of two undersecretariats (or viceministries), the Undersecretariat for Health Care Networks and the Undersecretariat for Public Health. Figures 1 and 2 show the structure of the health care sector before and after the reform. These figures illustrate both the emergence of new actors and the increasing complexity of relations.

The argument herein developed is that the implementation of the Chilean health care reform, despite being grounded in a human rights approach, has adopted organizational and management schemes that respond to the hegemonic pattern of institutional changes, and, therefore, are not necessarily consistent with the demands of governance imposed by the legal framework of the PPED. Therefore, the aim of this article is to provide an analysis of the implementation problems that complements traditional perspectives. Such perspectives usually only focus on financial issues (7,8) or on the analysis of the political economy of the changes (9,10) (conflicting interests, resistance strategies of the actors that may stand to lose, consistency of the government coalition, etc.) or on technical deficits, but do not emphasize the fact that organizational and management schemes are not politically harmless, as they contribute to the establishment of ground rules which have an impact on balances of power and values and, therefore, on the development of governance.

THE CONCEPTUAL BASE: SYSTEMIC GOVERNANCE FOR A HUMAN RIGHTS APPROACH TO HEALTH

As has been previously noted (11), the concept of governance sheds light on the limits of

SALUD COLECTIVA, Buenos Aires, 7(1):21-33, January - April, 2011

governing through one single actor and emphasizes that the *quality of the interactions* created by a particular institutional scheme is as important as the efficiency. In the implementation of policies with a human rights approach, the focus on finding integral solutions specifically involves different public actors concerned with health issues, making governance a necessary feature that can complement such concepts as Integrated Health Service Networks (RISS, from the Spanish *Redes Integradas de Servicios de Salud*) (1). The situation is different in the private sector, which although involved in the implementation of a human rights approach, operates in the buying and selling of services both internally (buying) and with the public sector (basically selling) (b).

The concept of *systemic governance* (11,13), in contrast to the use other authors have given it (14), refers to the alignment and integration of public actors for the effective protection of an established right. According to this perspective, systemic governance exists when at minimum the government actors involved in the exercise of a civil right maintain authentic and sustained relationships of cooperation in order to generate integral solutions to the problems addressed by this right.

Based on the different contributions provided by the specialized literature on this subject, it is assumed that at least three dimensions must be addressed in order to ensure that systemic governance becomes a feature of public administration: the instrumental, the spatial and the value-related dimensions.

According to the literature, relations are built (or hindered) through these three dimensions, which simultaneously interact with and shape one another. These dimensions, then, implicitly define a *strategy of governance*, providing a group with directionality and consistency with regard to certain purposes.

The spatial dimension considers that cooperation is more effective when based on trust rather than on authority and stresses the importance of developing spaces of mutual communication among the different actors involved in the implementation of the PPED, so as to trigger processes of shared meaning and knowledge production (15,16), as well as to increase awareness of their interdependency. This dimension is also grounded in extensive literature highlighting the need for developing deliberative processes to increase mutual understanding and to help cope with different interests and perspectives, which are particularly significant in the public sector (17-20). It is also based in research conducted on intersectoral management, which suggests that such spaces are especially important in the implementation of public policies regarding multidimensional social problems that demand not only appropriate coordination among several government sectors but also the existence of shared views and the articulation of resources and knowledge among the sectors (21,22).

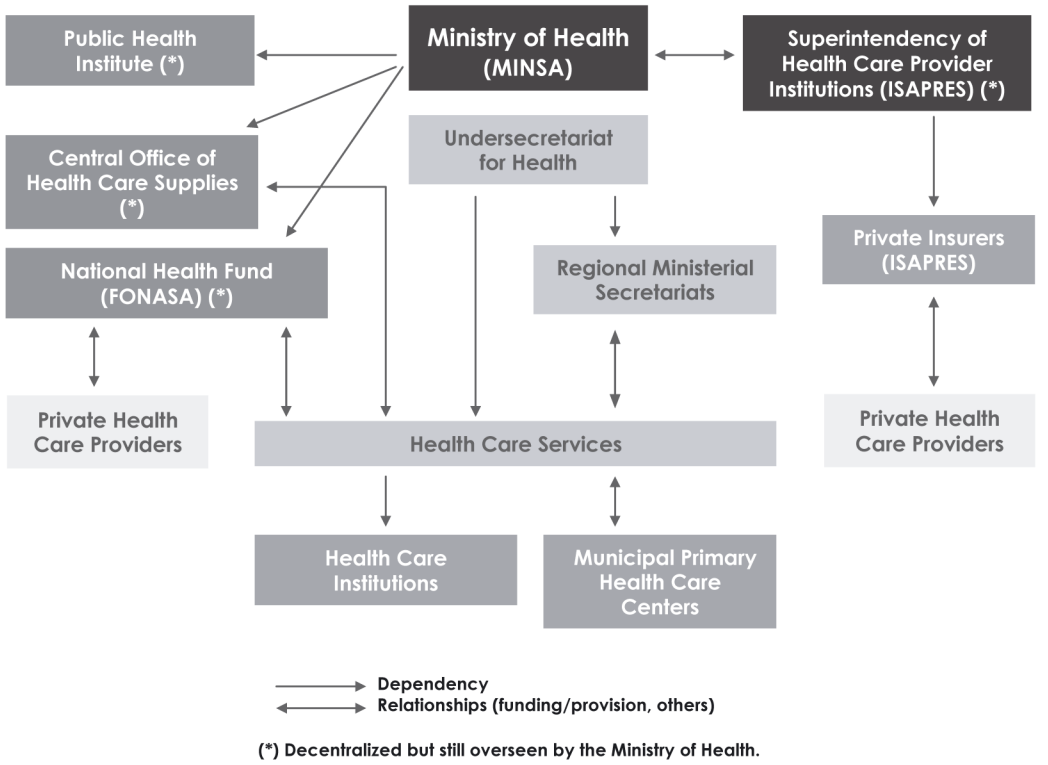
The instrumental dimension refers to the potentiality of planning, budget-making and evaluative instruments to promote the necessary articulations among actors, so as to make the established right feasible. The idea here is that spaces of mutual communication alone will not lead to integration if the managerial instruments are not themselves integrative. The best example of this is the ineffectiveness, in general, of spaces of interinstitutional coordination which operate on the basis of unilateral planning and budget-making processes. The importance of these elements has been indirectly underscored by the literature specialized in network and relational administration (23-25), as well as by more recent literature concerning health (1,26).

The value-related dimension underlies the other two previously mentioned dimensions. In particular it stresses the consistency between result-oriented goals established by the managerial instruments and the value of mutual cooperation, in view of the interdependency existent between values and institutions (27-29).

In light of these dimensions, it is suggested that the existence of systemic governance requires the development of institutional incentives to manage the change towards *comprehensive and deliberative management* within the relevant government sector and with the other sectors involved in the results of a PPED (including, of course, the financial sectors). This idea is particularly pertinent to the health care sector, given the fragmentation of the system.

SALUD COLECTIVA, Buenos Aires, 7(1):21-33, January - April, 2011

Figure 1. Network of relationships in the health sector before the Chilean health care reform in 2004.



Source: own elaboration.

The practical expressions of systemic governance are, at minimum, the following: a) institutionalized spaces of mutual communication (deliberation) among actors, in order to ensure integrity; b) instruments and processes of networked management which aim at a comprehensive handling of the PPED both within and among sectors; and c) value criteria consistent with networked budget-making, programming and evaluation processes and, in general, with the development of governance.

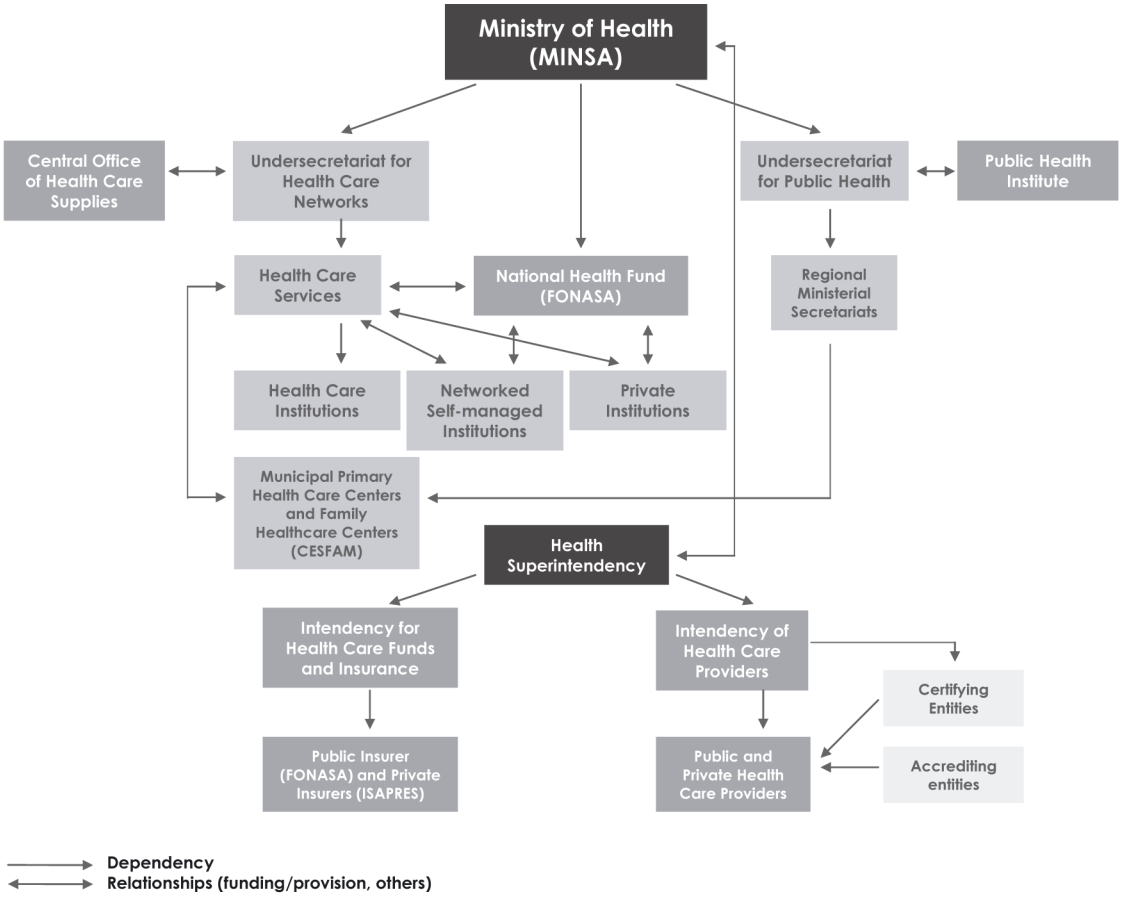
MATERIALS AND METHODS

Using the abovementioned conceptual framework, this investigation adopted as its unit of analysis the relations promoted within the Chilean public health system to implement the health care reform. This qualitative study involved a documentary analysis of primary and secondary sources in order to identify, first of all, the managerial instruments (planning, budget-making, coordination and evaluation) which hold the different actors in the health sector responsible for the achievement of results-oriented goals in the implementation of health policies. These instruments were classified according to the following three criteria:

1) The nature of the instrument, according to the directionality of the action in health: health care provision or promotion and prevention;
2) The origin of the instrument: external or internal to the health sector;
3) The scope of the instrument: external transversal instruments covering the entire public sector, internal transversal instruments related to the health sector as a whole, or specific instruments dealing with the operation of a certain field.

SALUD COLECTIVA, Buenos Aires, 7(1):21-33, January - April, 2011

Figure 2. Network of relationships and functions in the health sector after the Chilean health care reform in 2004.



- **Ministry of Health (MINSA)**: Supervision, formulation of the Explicit Health Guarantees (GES), establishment of standards, determination of the systems of accreditation and certification of specialties.
- **Undersecretariat for Health Care Networks**: Health care service provision to public system beneficiaries at the institutional level.
- **Undersecretariat for Public Health:** Health authority, epidemiological surveillance, environmental and work supervision and public health actions.
- **National Health Fund (FONASA)**: Collection, administration and distribution of funds; purchasing of health care services.
- **Central Office for Health Care Supplies**: purchase of materials, drugs and supplies for medical institutions.
- **Public Health Institute**: National Laboratory, drug quality control.
- **Health care services**: Management of the health care network.
- **Regional Ministerial Secretariats**: Health promotion programs.
- **Health Superintendency**: Related to the President through the Ministry of Health; control and supervision the ISAPRES and the National Health Fund regarding benefits and GES; monitoring of public and private health care providers regarding matters of accreditation, certification and maintenance of standards.

Source: own elaboration.

Secondly, the study sought to identify and characterize the aspects of coordination included in the design of the legal and regulatory frameworks.

The documentary analysis was complemented by 40 in-depth interviews with health care executives held between November and December 2009, with the purpose of assessing the existence of systemic governance in the institutions in charge of the implementation of human rights policies, and to determine the critical organizational and institutional factors

SALUD COLECTIVA, Buenos Aires, 7(1):21-33, January - April, 2011

involved in the development of governance. Both top-level executives (Undersecretary for Health Care Networks and Health Superintendent) and local health network executives and their institutions were included. To this effect a three-stage sample was developed. The first stage included the selection of three regions in the country, two predominantly urban and the other markedly rural, for their high population density. Two Health Services (SS, from the Spanish *Servicios de Salud*) were randomly selected within each region, as they represent the key node of the health care networks within the different areas. Within the jurisdiction of each SS, the executives of the health care networks joined by the SS were interviewed. Specifically, those interviewed were: the executives of a high-complexity hospital and a medium-complexity hospital; the executives of two Health Corporations or Municipal Health Departments corresponding to a municipality with high urban concentration and another defined as vulnerable by the Ministry of Health; and within them, at random, the executives of a Family Health Center (CESFAM, from the Spanish *Centro de Salud Familiar*), an ambulatory primary care center which operates under a family health care model. All the executives interviewed gave their informed consent, previously validated by an Ethics Committee, both for the interview and the study. The information gathered from the interviews was structured into dimensions, processed using the program AtlasT1 and compared to the findings from the documentary analysis. It should also be mentioned that the information presented here is solely a part of the more extensive results obtained (13).

RESULTS

Communication channels and their effects on governance

A review of the legal norms and regulations regarding the formal connections among actors generated by the reform shows a clear intention to incorporate consultation mechanisms through diversely composed councils, committees and other similar bodies. However, the only entity specifically created to coordinate the operation of the public system has been a Council for the Integration of the Health Care Network (CIRA, from the Spanish *Consejo de Integración de la Red Asistencial*), an advisory body organized by the relevant health care service.

Every *health service director* interviewed acknowledges the usefulness of the CIRA as a channel of articulation in the health care network, except for an interviewee that expressed that its prestige has been gradually lost. In contrast, the opinion of the hospital directors is mostly negative, either because of the tendency to "plan according the services available" or because it is a "symbolic" channel. The *municipal health directors* refer to the CIRA as the only health care communication channel in which they have formally participated since the reform, but only in the municipalities where the SS has innovated by granting decision-making powers to the CIRA, do the executives acknowledge its usefulness. For executives of the CESFAM, what is valued is the possibility of increasing the decision-making capacity of these centers. Inasmuch as the CIRA does not fulfill this function, its efficacy is called into question.

It is surprising to discover that the reform did not create cross-sector communication channels which could connect the different government sectors concerned with health care provision. In fact, the only cross-sector articulation channels at the local level — the Life Committees Chile (*Comités Vida Chile*) — date back to the 1990s. These Committees seek to connect different sectors, but they are not mentioned by *health service directors* (managers of the health care network). The only mention made of them is that, because each Committee applies independently for projects, the resulting mix of different unconnected projects further reduces their impact. The *hospital directors* make practically no mention of cross-sector communication channels. However, this is not the case with *municipal health directors* (primary care), who highlight the influence of cross-sector communication channels in their activities.

With regard to the *tactics of interinstitutional relations with other relevant actors*, the stress is placed on the use of the territories defined by the corresponding regional government so as to facilitate a more focused

SALUD COLECTIVA, Buenos Aires, 7(1):21-33, January - April, 2011

outreach at the territorial level. The *directors of high complexity hospitals* highlight the use of lobbying to leverage initiatives. *Directors of community hospitals* (low complexity hospitals) and of CESFAM emphasize connections forged with *carabineros* (policemen), firefighters, the judicial branch and the municipality in order to expand the reach of public health goals; these connections demonstrate the creation of networks that are highly instrumental, with the objective of obtaining the economic benefits related to such goals.

In conclusion, the spatial dimension of systemic governance, expressed in mutual spaces of communication among the public actors involved in the implementation of the PPEDs, does not seem to be explicitly acknowledged by the institutional authorities in charge of implementing health care PPEDs. Only certain actors, who have chosen to make a more political use of these channels by including deliberative processes and civic participation, recognize that they have been able to generate processes of shared meaning and knowledge production and increase the awareness of their interdependency. Let us now examine the results regarding the instrumental dimension of governance.

Managerial instruments in the Chilean health care sector, their values and impact in systemic governance

The first findings of the documentary analysis show the great variety in the origins and nature of managerial instruments that affect the types of relationships existing in the health sector, beyond those that have been formally predetermined.

There is a predominance of *external transversal instruments*, especially of performance indicators and Management Improvement Programs (PMG, from the Spanish *Programas de Mejoramiento de la Gestión*) (c). These instruments were created by the Ministry of Finance and implemented throughout the Chilean public sector nearly two decades ago as part of a results-oriented management logic related to the institutional reforms emphasizing the relationship between economic incentives, calculations of personal benefit and performance measurements. These instruments involve all public health care institutions, but are basically negotiated at the central level. Generally, they contain a monetary incentive to foment their fulfillment, which the involved services do not always access, as in the case of some PMG. They also do not contain performance evaluation criteria regarding the processes of *management of change towards an integrated system* for the implementation of the PPEDs. In addition to the already mentioned instruments, there are others of a more political nature that establish commitments to the major government priorities and to the creation of opportunities for civil participation that must operate in the entire Chilean public sector.

Other relevant elements are the *internal transversal instruments of management in the health sector* referring to public health goals and the GES; the latter are defined by the legislation.

Within the different regions there are no formal instruments of articulation between the Health Authority represented by the Seremis and the health care services, which suggests that the new institutional design neither facilitates the connection between public health functions and the planning of the provision of health care services, nor contemplates any instruments for the adaptation of the GES and the health goals in the region. On the other hand, the existing relationships prioritize the supervision and control of the fulfillment of general public health goals rather than the expression of goals and health achievements relevant to the regional level.

Regarding the *managerial instruments of health care networks*, the normative frameworks underlying the reform update and consolidate the functions of health care services and emphasize the idea of "health care network management" over that of "health care service direction," which includes the appointment of an director (now called "network manager") who signs an agreement of "High-level public direction" with the Civil Service Bureau (*Dirección de Servicio Civil*, which is part of the Ministry of Finance) after gaining his or her appointment through a competitive public application process; however, these agreements have been criticized because even though they encourage executives to focus on achieving

SALUD COLECTIVA, Buenos Aires, 7(1):21-33, January - April, 2011

results during their administration, they make use of the PMG indicators and, therefore, do not permit a focus on the results of the actual work of administration.

However, progress is being made in the decentralization process by reaffirming the autonomy of health services and granting them powers to make agreements with different local health care providers.

The management agreements between health care services and municipalities seek to restore coordination in health care goals, including the GES. The counterpart to this phenomenon is that there are virtually no formal agreements between health care services and hospitals; even though the portfolio of services provided by a hospital must be approved by the director of the relevant health care service, no production goals for each kind of service are formally established in each hospital. This delicate situation is further threatened by the emergence of *networked self-managed hospitals*, which are granted administrative powers previously conferred to health care services.

Regarding the *managerial instruments concerning public health*, other than environmental inspection instruments or specific programs, the Seremis have no managerial instruments with which to institute their policies in the regional system (prevention, promotion, regulations). In fact, adherence to public health policies is basically promoted by means of management agreements and results-oriented incentives generated by the health care network, which are not part of the kind of actions, areas of responsibility and resources involved in public health management. This inhibits, particularly at primary health care level, a change in focus from individual to collective health actions.

Similarly, the perceptions of different types of actors regarding the efficacy of the instruments involved in the development of systemic governance tend to confirm the conclusions derived from this analysis of managerial instruments and provide new evidence; in the following paragraphs these perceptions will be explained.

The *directors of health services* mention that the great diversity of goals to be achieved by these services, either directly or indirectly, hinders their performance as managers of the health network and their ability to focus on issues relevant to their territories.

The *directors of high complexity hospitals* reflect constantly upon the issue of management and its restrictions, as well as on resources difficulties. There is an evident lack of understanding of the criteria and mechanisms for transferring resources used by the National Health Fund (public insurer), to the point that such mechanisms are seen as arbitrary, unfair and discouraging of good hospital management. At the same time, these actors point out that the Ministry of Health frequently demands new requirements of different types, outside the scope of and often inconsistent with established performance agreements. Some directors describe an atmosphere of imposition rather than of negotiation in the sector. They also state that the budget formulation process at the hospital level is unclear, and there are questions surrounding budget implementation all throughout the fiscal year.

When interviewing the *directors of local or low complexity hospitals*, the GES appear as the clearest commitment, because they are related to performance bonuses for government officials, even though they are not subject to negotiation. This implies that the entire hospital system — administrators and groups of government officials — prioritize the follow-up and monitoring of the fulfillment of these goals. According to the actors, these priorities are sometimes at odds with the main tasks required of a hospital to provide its services.

The interviews with the *directors of local health corporations or departments* show that 80% to 90% of planned activities of the local health teams are focused on fulfillment of the GES, central programs, public health goals and Primary Health Care Activity Indicators (IAPS, from the Spanish *Indicadores de Actividad Primaria de Salud*), leaving little room for attending to the specific needs of their local contexts. In small municipalities, the adaptation is almost complete, causing tensions in the readjustment of the local system in order to meet the demands required to implement the family health care model, which is, according to every person interviewed, a national policy weakly integrated in its goals.

SALUD COLECTIVA, Buenos Aires, 7(1):21-33, January - April, 2011

In addition, the local directors interviewed also refer to the lack of dialogue about what the health goals and IAPS should measure, as well as the absence of reliable, easily accessible information. In general, when negotiating goals, an official rationale prevails that prioritizes the creation of conditions to obtain bonuses rather than a rationale aimed at ensuring quality in local health management. The Local Health Care Plan, designed at the primary care level, is an unvalued instrument as it does not contemplate the phases of development typical of the planning process. On the other hand, the interviewed *CESFAM directors* notice a dichotomy in the process, in which "you win" if the efforts are focused on the fulfillment of the commitments established by the central instruments and "you lose" if the efforts are focused on the shifting health care actions toward the family health care model.

One top executive of the public system summarizes what the analysis of the managerial instruments reveals as a critical central node:

> *...management of the change at the health care network level has been insufficient. Health services before the reform were "totipotent or toti-functional"* [...] *the reform took away from them all authority in health and basically transformed them into a holding of health care providers, some of which are part of the health service and some of which are not. For this reason the management of networks is the issue of fundamental importance.*

In order to support this argument, among other concepts he explores, this executive upholds that:

> *...When examining the performance evaluations that each health service director has committed to achieve, and when looking at how much these are aligned with network management, the truth is that in these achievement commitments network management is not noticed at all.*

In conclusion, both the documentary analysis and the results from the interviews show a dense network of instruments and an existing tension between the logics of external transversal instruments, which have a stronger development and a more general application, yet are less sensitive to the requirements of comprehensiveness of the PPED (except in relation to the indicators of fulfillment of the GES), and the internal transversal instruments that have a stronger development in the poles Ministry/health care services (management commitments), National Health Fund/Undersecretariat for Health Care Networks/ health care services (health care provision services agreements) and health care services/municipalities (Local Health Plan or Networked Programming), a weaker development in the relationship between health care services/hospitals and a nonexistent development between health care services /Regional Ministerial Health Secretariats. In any case, the predominance of external instruments, particularly those from the Budget Bureau (*Dirección de Presupuestos*), guided principally by a sector-based logic, demonstrate that ministerial goals and performance indicators are rarely conceived as "comprehensive" and, therefore inter-institutional, goals. Besides, the evaluations are generally associated with the annual quantitative budget procedure, rather than with mid- and long-term qualitative-programmatic achievements, as is generally the case with transformations related to public health.

In summary, the management of the network is limited by two factors: on the one hand, by the weight of transversal instruments, organized under the legal framework of the GES and the public health goals, which align the institutions hierarchically; on the other hand, by an incomplete institutional adjustment of managerial instruments specific to the health care network needed in order to generate coordination mechanisms throughout the continuum of services provided.

Moreover, the people interviewed suggest that the series of managerial instruments impose rationales and values which are not always in tune with the normative framework of the human rights approach that the current health care reform attempts to promote. It is clear that goal negotiation (when it exists) privileges the creation of conditions for achieving bonuses rather than considering public interests and reinforcing recognition of institutional interdependencies.

SALUD COLECTIVA, Buenos Aires, 7(1):21-33, January - April, 2011

Therefore, there also seems to be little consideration of instrumental and value dimensions in order to develop systemic governance, especially if we take into account that the recent literature previously mentioned suggests that governance is not only associated with the *contractualization* of relationships of responsibility, but also with the negotiation of commitments and performance goals, with performance-related incentives that align and integrate the different actors involved, and with the bidirectional character of information systems.

CONCLUSIONS

Systemic Governance in the health sector has been attempted to be built basically starting from custom transversal instruments that seek to adapt institutional activities, from the central level to the local one (municipalities and local family health centers), passing through health services and hospitals. As acknowledged by the health service directors interviewed and other sources (10,30), although rights have been excluded in other fields, this process has resulted in more equity insofar as it is certain that the arbitrariness has been taken out of the election of pathologies to treat, and it has generated a greater sense of responsibility within the medical attention provided, creating new health care access opportunities to a group of people affected by severe, expensive and frequent diseases.

This achievement has been influenced by three major elements: the recognition of human rights guaranteed by a legal framework (GES) that makes their enforcement mandatory; the value-related support offered by some health administrators; and the instrumental adherence of health workers, related to the need for the better salaries resulting from the bonus incentives.

However, there remain some issues critical to the consolidation of the PPED, both in terms of projection and sustainability:

a) Networked management, a main component of systemic governance, was incompletely addressed in the reform; the institutional character needed for its development, although contemplated in the spirit of the law, does not have the necessary conditions (particularly the instruments and channels conducive to a deliberative and integrated management) for the performance of their functions throughout the country.
b) The regulatory application of the reform, which should have addressed the spirit of the legal framework, consolidated the fractures of the systemic network as it failed to expand the roles, functions and authority of the institutions and channels which could have played a role in developing that perspective.
c) The model of allocation of resources and incentives directed at fulfilling public health goals and the GES which align the institutions tends to postpone the development of other elements of the reform, such as a family health focus, the role of the Health Authority in the different regions and actions in public health. Such elements are not properly integrated in the process of accountability of the local actors and cannot be duly addressed by the Seremis, which have neither authorization nor sufficient instruments with which to influence the network.
d) The number of external managerial instruments also plays a role against the systemic governance of the sector. Many of these instruments have rationales and values that generate tensions difficult to ameliorate. In this sense, the fact that the Ministries of Finance establish the ground rules not only on budget issues but also on global performance standards should not be overlooked.

Within this framework, it is important to consider that while the goals sometimes coincide, they also create incentives for destructive competition, that is, they do not integrate. It is clear that the problem not only lies in suppressing the incentives which contradict the principles of a PPED, but also in ensuring goals expressly aimed at developing governance.

Generally speaking, one of the most important lessons on systemic governance that the Chilean health care reform offers to other PPED is likely its multifaceted character. On the one hand, it implies successfully aligning different actors to fulfill the obligations arising

SALUD COLECTIVA, Buenos Aires, 7(1):21-33, January - April, 2011

from the recognition of a certain right, which is only possible by legal requirement under the category of "compelling orders." On the other hand, it demands that actors work in an integrated way within a value-related framework that promotes the mutual understanding of institutional interdependencies, a concept of the public sphere and the respect for diversity.

From this perspective, our research suggests that a non-critical acceptance of the management and organization methods inherited from the institutional reforms that have taken place since the 80s may generate conflicts with the need to develop governance within the health care sector and, therefore, may threaten the comprehensiveness particularly required to implement a PPED. Such reforms establish a connection between incentives and private calculations of personal benefits which not only fails to address the management of interdependencies but may also result in a weakening of the general values underlying mutual aid and cooperation needed to achieve comprehensive solutions.

Therefore, the institutional and organizational challenge seems to be to combine alignment with integration, resorting for this purpose not only to legal requirements but also to relationships of accountability that create ground rules consistent with the legal framework of a PPED and with territorial specificities. It is also important to highlight that the partial exercise of human rights within a context of scant resources signals the need to discuss investments and funding mechanisms in health.

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END NOTES

a. The health sector in Chile is divided, from an insurance or social security point of view, into a public and a private sector, both partially or completely funded by employee contributions (Bismark model) and, in the case of the public sector, by a state contribution from the nation's general resources (Beveridge model). These two sectors operate according to different logics: the former charges its services according to the risks involved and the latter distributes these risks. The health care reform was structured according to the following of laws, listed in order of their enactment: 1) Act 19888 of 2003, "on Funding," established increases in the Value Added Tax and on other specific taxes in order to fund the Regime of Explicit Health Guarantees (AUGE plan) and other programs; 2) Act 19895 of 2003, "ISAPRES Short Act," established financial solvency legislation for Health Care Provider Institutions (ISAPRES, from the Spanish Instituciones de Salud Previsional) — *ad-hoc* private health insurers — and the transfers of affiliate portfolios among them; 3) Act 19937 of 2004, "on Health Authority," separated the functions of public health from those concerning the provision of services, which resulted in the creation of the Public Health and the Health Care Network Undersecretariats and, at the territorial level, in the transferring of public health functions from the health care services to the Regional Ministerial Secretariats. Within the health care services, defined as "managers of networks," the Act created the figure of Networked Self-Managed Hospitals. The Act also extended the powers of the ISAPRES Superintendency by granting it the supervision of the National Health Fund (public health insurer) and the regulation of health providers to assure the quality of the Explicit Health Guarantee Plan; 4) Act 19966 of 2004, the "AUGE Plan," established a mandatory health care plan for FONASA and ISAPRES — Health Explicit Guarantee Plan (GES), initially named "AUGE" —

SALUD COLECTIVA, Buenos Aires, 7(1):21-33, January - April, 2011

comprising diagnostic procedures and standardized treatments for a group of diseases prioritized on account of their public health and social impact. This is the core of the reform and its key characteristic is the enforceability of rights, in terms of access, opportunity, quality and financial coverage of the services; 5) Act 20015 of 2005, "ISAPRES Long Act," regulates the annual adjustment of contracts, price increases and risk factor tables by age and sex and establishes the Compensation Fund for the GES, which implies resource transfers among all the ISAPRES, based on risk differentials in their affiliate portfolios. The reduction of this fund to the GES and of its operation to include only the ISAPRES demonstrates an unaccomplished element of the reform, according to its original design, which implied the development of a solidarity fund.

b. A small percentage of services granted by private insurers (ISAPRES) are supplied by public service providers. In 2008, for example, 2.6% of services billed used public infrastructure for both inpatient and outpatient care. A total of 6% of outpatient care granted by the ISAPRES system was supplied by public providers, according to information from the Health Superintendency (12).

c. The PMGs seek to develop transversal administration systems (for example, systems of managerial control, human resources, etc.) and they associate such systems to goals related to economic benefits.

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