

REACHING THE POOR WITH HEALTH SERVICES

2008

Chile

Reaching the Poor with Health Services through Provision of Multidimensional Support

The Issue

Chile's *Solidario* Program has sought to ensure that the country's poorest families share more fully the benefits from the country's rapid development. During the 1990s, Chile's gross domestic product (GDP) had grown at close to 5% annually. This, combined with a stable pattern of income distribution, had led to a decline of over one-half (from 33% to 15%) of the population living in poverty. However, not all the poor had benefited equally. In particular, the poorest of the poor had largely been left out, as the proportion of extreme poverty remained stubbornly fixed, at around 5-6% of the population.

Such extremely poor people and families lacked much more than adequate income. They also had little education, lived in inadequate housing, and suffered from poor health. For example, children born to the 5% or so of women with no education experienced an infant mortality rate of around 35 per 1,000 live births, compared with a national average of less than 10.

These factors were reinforced by societal prejudices that helped exclude the poor from participation in society at large. The excluded also lacked the support and protection against risk typically provided by families, neighborhood community associations, and other informal networks. Beyond such material and social factors were psychological issues: a lack of confidence or self-esteem, a distrust of social institutions, and limited interest in forward planning.

To deal with the problems of poverty, the Chilean government had earlier put into place a set of means-tested social programs like state-funded family, water, health insurance, and pension subsidies for the poor. But the programs, while relatively effective when compared with those in neighboring

countries, were not reaching Chile's poorest households well enough to benefit them significantly. To a considerable degree, this resulted from the failure of the poorest people to come forward and participate in the programs, because of lack of knowledge about program existence or rules, a distrust of government services, and fear of discrimination. Another factor was the lack of significant incentives for the service-providing agencies, for which reaching the poor was but one of many mandates, to seek out difficult-to-reach indigent families.

The Approach

Soon after taking office in early 2000 Ricardo Lagos government decided to give high priority to overcoming these problems, in order to improve conditions among Chile's 225,000 poorest households. To this end, after considerable discussion and experimentation, it adopted a commonly-espoused but rarely-implemented approach: an integrated strategy that took seriously the multi-dimensional nature of poverty by simultaneously addressing the many different deprivations that afflict the poor. The resulting initiative was given the name *Chile Solidario* (Chile in Solidarity).

Identifying the Extreme Poor. As with other anti-poverty initiatives in Latin America and elsewhere, the households eligible to participate in the *Solidario* program were identified through a proxy means test: a quantitative approach based on information from a census or large-scale survey to determine which household characteristics are most closely associated with poverty. (For more on proxy means tests, see the Colombia brief in this series.) In the Chilean case, such a test



was already in place, with the necessary information collected through the government's biannual national socioeconomic household survey (known by its Spanish acronym CASEN). In the version used at the time of *Solidario's* establishment, responses to thirteen questions grouped in four areas—housing, employment, education, income/assets—were combined to provide a score for each household surveyed, and also a threshold or cut-off score dividing the poorest households that qualified for *Solidario* participation from the better-off ones that did not. The result was a checklist (named CAS, after its Spanish initials) incorporating these same thirteen questions. Field workers used the checklist to survey and score households, and invite households with scores below the threshold to participate.

Creating and Implementing a Household Development Plan.

The first step in participation was agreement by the heads of eligible household to work with a *Solidario* family support counselor in developing and implementing a household development plan covering all family members. The plan's objective was to achieve 53 minimum conditions in seven areas of household life. In addition to health, they are: personal identification (i.e. possession of basic identity documents), education, family dynamics, housing conditions, employment, and income. (Box 1 provides illustrations of the minimum conditions to be met with regard to health and the other six areas.)

The content of the household plans varied according to each family's situation. A plan for a well-educated family whose members are without jobs, for example, might give highest priority to the area of employment; one for a family suffering from severe internal discord might focus on family dynamics; etc.

Once a plan had been developed and agreed upon, the *Solidario* family support counselor worked to help the family implement it. At the core of the support provided was help with respect to the program's two principal components described further below: first, assisting the family members gain access to the broad range of government programs, many of them previously in existence, designed to help meet the members' needs; and second, enrolling the family for the regular cash payments that it was eligible to receive for the duration of its participation in the program.

The support was of limited duration, and took place in two phases. The first, intensive phase lasted for two years; the second, follow-up phase for three. During the first phase, the counselor visited the family regularly, once a week during the first two months, less frequently thereafter. During these visits, the counselor helped the family develop its plan, identify and access the services it needs, enroll for the cash payments; and provided other psycho-social support. During the second phase, support from the counselor ceased, but the families continued to have priority access to the needed services and to cash payments. After the second phase, by which time the family had participated in the program for a total of five years, all support came to an end; and, if the program has been successful, the family would be equipped to embark on an upward course leading out of poverty without further assistance.

Linking Participants to Programs and Services. As noted above, Chile already had in place many social programs intended to benefit poor people. But their approach had been largely passive, marked by a readiness to serve people who applied, but with little effort to reach out and encourage employment. Combined with the previously-reported lack of knowledge and distrust on the part of indigent families, such passivity led to low uptake.

A central responsibility of *Solidario* counselors was to change this, by ensuring that the families with whom they worked knew about and participated in the programs relevant to their needs. To this end, they acted as intermediaries between the families and the programs. For example, they worked actively to see that eligible families received the payments to which they were entitled from the several Government agencies offering subsidies to the disadvantaged. These included regular payments available to children and youth in especially poor families; and pension assistance for the elderly poor and for the disabled.

In the case of health, this meant enrolling indigent families in the Chilean Government's national health insurance program (Fondo Nacional de Salud, FONASA). Such enrolment entitled participants to free primary medical services provided principally through municipality health departments, with funds provided by the central government. Since these funds were provided largely on a per capita basis, increased enrolment of the indigent brought an increase of income for the service providers.

Box 1. Illustrative Minimum Conditions to Be Achieved by Chile *Solidario* Participants.

Health

- The family must be registered in the primary health care system
- Pregnant women and children under six years of age should have medical check-ups and other services according to Health Ministry guidelines
- Elderly family members and family members suffering from chronic diseases should be under the supervision of a doctor
- Family members with physical disabilities who could benefit from rehabilitation should be participating in a suitable rehabilitation program
- All family members should be provided with personal health care information

Other Areas

- *Personal Identification*: All family members should have an identity card issued by the Civil Registry (which is a prerequisite to the receipt of many social services)
- *Education*: Children of working mothers in households with no other adult caregiver available should attend a daycare program
- *Education*: Adults and children over 12 years of age should be able to read and write, or be participating in educational programs designed to impart these skills
- *Family Dynamics*: The family should have a daily custom of discussing topics like habits and schedules
- *Family Dynamics*: There should be a fair distribution of household chores
- *Family Dynamics*: The family should be aware of the community resources and development programs available through local networks like sports clubs, senior citizens' centers, and community organizations
- *Housing*: The legal status of the family's ownership or tenancy of their home should be clearly defined
- *Housing*: The family should have access to clean water, adequate energy, adequate sewage, and a satisfactory waste disposal system
- *Employment*: At least one member of the family should have a regular job that provides stable income
- *Income*: All family members entitled to government income support payments should be receiving them
- *Income*: The family should have an income adequate for it to emerge from extreme poverty
- *Income*: The family should have a budget compatible with its resources and priorities

Providing Participants with Special Cash Allowances. In addition to the subsidies available through regular Government program, *Solidario* participants were provided a special financial allowance if they make satisfactory progress toward implementation of the family plan adopted at the outset and described above. The allowances were modest, about a quarter of the size of those provided through the Mexico *Progresal/Opportunities* Program described in another brief. They began at the equivalent of around \$15 monthly, then taper down to about \$5 monthly toward the end of the initial two-year intensive phase. Families that successfully completed this intensive phase continued to receive payments during the following three-year follow-up period.

Administration

Administrative responsibilities for the program were spread across a wide range of government agencies. At the core were two entities at the central governments, and a unit in each of the more than 300 participating municipalities.

The first of the two central entities was Chile's Planning Ministry, which has overall responsibility for the program. The second was a national agency focused on poverty reduction: the Solidarity and Social Investment Fund (Fondo Solidario de Inversion Social, or FOSIS), which had been offering a wide range of community economic development and skill enhancement programs. As a first step, in early 2002 FOSIS organized a pilot project, the *Programa Puente* (Bridge Program) in four of Chile's thirteen regions. Encouraged by the results of the Program's initial experience, the Government decided shortly afterward to expand it throughout the country as Chile *Solidario*, with FOSIS and Puente leading the drive to involve municipalities.

In order to administer *Solidario* on the ground, each participating municipality established a Family Intervention Unit. Each unit first undertook a survey to determine the number of indigent families within the municipality, and then recruited the number of family support counselors needed to serve them. Some of these were staff from other municipality departments, deputed for *Solidario* work on a part-term basis. Others were full-time, employed by FOSIS. By mid-2004, some 2,500 family support counselors were at work, each with an average case load of 50-55 families.

In addition, the Family Intervention Units took responsibility for arranging participation of the several municipal departments responsible for the different services provided. They were aided in this by the frequent availability of extra funds through *Solidario* to cover the municipalities' extra costs, which proved quite useful in persuading reluctant municipalities to participate, and gave *Solidario* extra leverage to ensure adequate treatment of its indigent participants.

Accomplishments and Challenges

Within 18-24 months of its establishment, *Solidario* had contacted some 125-130,000 indigent families, and over 95% of the contacted families had agreed to participate. As can be seen from Figure One, the participants were heavily concentrated among the poor: the enrolment rate was 11% among the poorest 5% of the population, and declined steadily with economic level, so that almost no families in the country's upper-income groups were included. About 25% of the participating families were in the poorest 5% of all families, and about 45% in the poorest 10%.

Since then, the program has expanded greatly, and it has begun to evolve on the basis of experience with its initial years. For example, it has broadened its beneficiary identification approach to include vulnerability to impoverishment as well as poverty itself; and the Government has developed a broader child development program into which *Solidario* is being integrated.

The distributional results of these developments appear in Figure Two, which provides estimated enrolment rates as of 2006. These rates stood at around 20% among the poorest and the next-poorest 5% of the population with notably lower coverage at higher levels. In all, about 15-20% of the total program benefits accrued to the population's poorest 5%, around 55% of the benefits went to the poorest 20%. (While falling short of *Solidario*'s ambition to reach primarily the poorest 5%, this degree of focus appears to equal that of Mexico's *Progresal/Opportunities* Program, the most accurately targeted large-scale program on record.) In both urban and rural areas, preventive visits among children in *Solidario* households were significantly higher than among those in non-participating households; in rural areas, checkups for pregnant women were significantly higher as well.

Figure 1. Chile Solidario Participants by Economic Group, Late 2003.

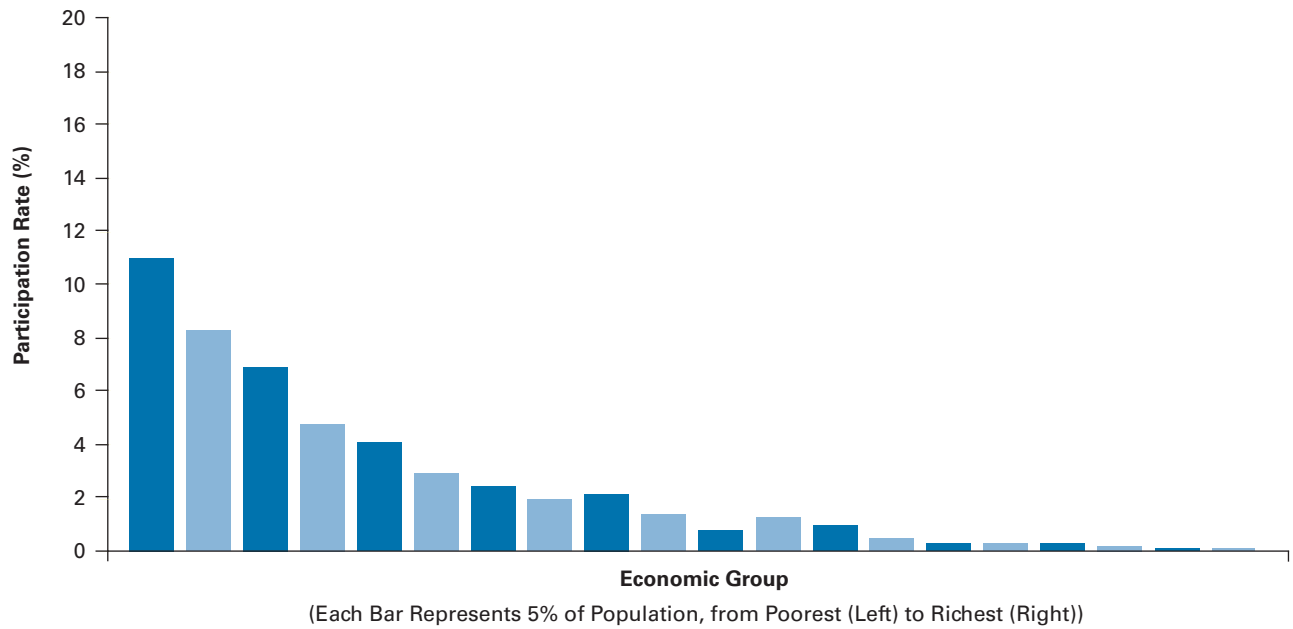
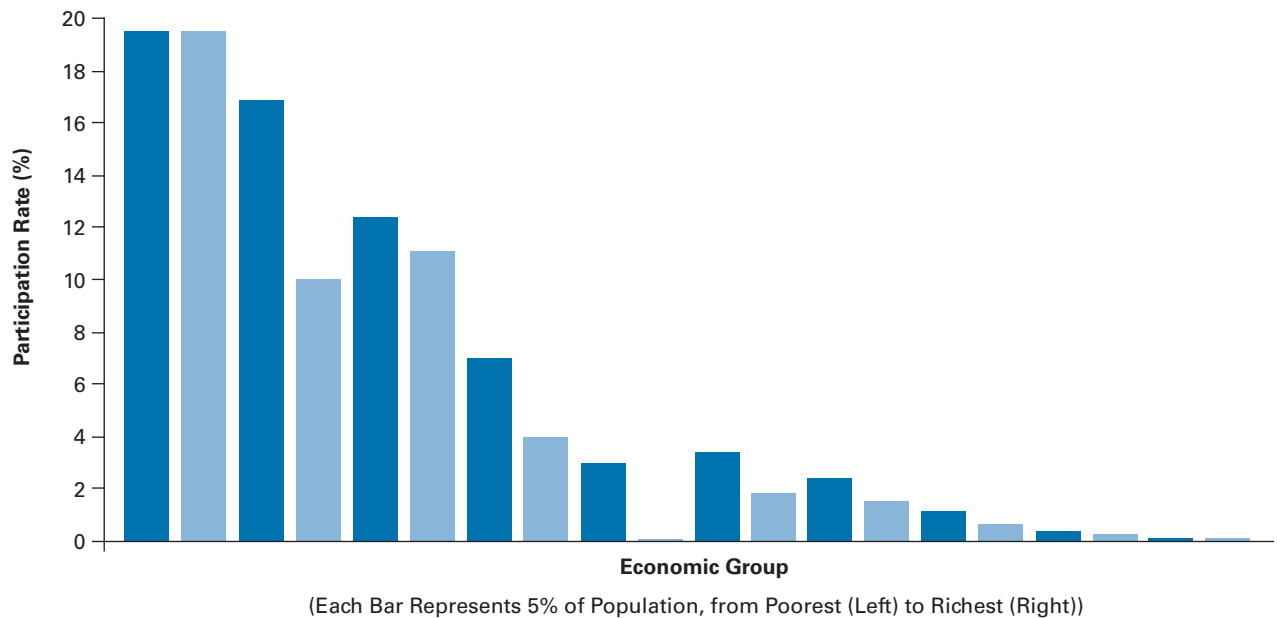


Figure 2. Estimated Chile Solidario Participants by Economic Group, 2006.



Source: Noirhomme et al., Health Policy and Planning, 2007

This brief is intended to summarize good practices in reaching the poor with health, nutrition, and population. It draws on many resources, most unpublished. Three of the most important were: Government of Chile, Fondo de Solidaridad e Inversión Social, “An Introduction to Chile Solidario—El Programa Puente,” paper prepared for the World Bank International Conference on Local Development, June 2004 http://www1.worldbank.org/sp/LDConference/Materials/Parallel/PS2/PS2_S13_bm1.pdf); Emanuela Galasso, “‘With Their Effort and One Opportunity’: Alleviating Extreme Poverty in Chile,” unpublished manuscript prepared

for the World Bank, March 2006. (<http://www.iadb.org/res/publications/pubfiles/pubS-001.pdf>); Julieta Palma and Raúl Urzúa, Anti-Poverty Policies and Citizenry: The “Chile Solidario” Experience.” UNESCO MOST (Management of Social Tensions) Program, Policy Paper No. 12, 2005. (<http://unesdoc.unesco.org/images/0014/001402/140240e.pdf>) While the editors alone remain responsible for this brief’s contents, they wish to thank Cristian Baeza, Emanuela Galasso, and Polly Jones for comments on an earlier draft, and for information provided through personal communications.

