Analysis of the Chilean health system and its structure in social participation

Análisis del sistema de salud chileno y su estructura en la participación social

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DOI: 10.1590/0103-11042022E407I

ABSTRACT The political-economic development that Chile has had in recent decades has allowed the evolution of its health institutions, where hospital coverage, management, and infrastructure have been improved. The health policy organization is highly centralized and structured by the State, and this has allowed the rapid implementation of several programs. On the other hand, participation is maintained within the spaces allowed by institutionality. However, there is permanent pressure from non-governmental groups asking for different governance. Therefore, moving from a participatory reactivity in health matters to permanent proactivity is desired, although this requires a constant dialogue between the State and citizens. This paper analyzes the Chilean health system and how it relates to subsequent citizen participation, highlighting the elements that, under the current social reality, require a change to satisfy the population adequately.

KEYWORDS Public health. Citizen participation. Access to healthcare.

RESUMEN *El desarrollo político-económico que ha tenido Chile durante las últimas décadas ha permitido la evolución de su institucionalidad sanitaria, donde se ha mejorado la cobertura, gestión e infraestructura hospitalaria. La organización de la política sanitaria es altamente centralizada y estructurada desde el Estado, ello ha permitido implementar con rapidez diversos programas. La participación, por otro lado, se mantiene dentro de los espacios que la institucionalidad permite, sin embargo, existe una permanente presión de grupos no gubernamentales que piden una gobernanza diferente. Se desea, por lo tanto, pasar de una reactividad participativa en materias sanitarias a una proactividad permanente, aunque ello requiere de una permanente conversación entre el Estado y la ciudadanía. En el artículo se analiza el sistema sanitario chileno y cómo se relaciona con la participación ciudadana subsecuente, evidenciando los elementos, que bajo la realidad social actual, necesitan de un cambio para satisfacer adecuadamente a la población.*

PALABRAS-CLAVE *Salud pública. Participación ciudadana. Acceso a la atención de salud.*

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Chile: Social participation within the framework of the socio-institutional model

Chile has been characterized by strong economic development and notorious stability in democratic processes in recent decades, which has also facilitated the substantial improvement of access and care for the middle sectors of the population, reaching a developed country standard. The model rapidly curbed extreme poverty rates and allowed productive diversification, the globalization of its economy, and the control of several endemic pathologies in the health field, among many other examples. This situation was built by innovating and adapting development strategies in the national context, planned from expert circles, but with little socialization that strained the social system over time, exerting pressure above all for greater understanding and participation. However, changes have been coming slowly, primarily based on criticism of the system's foundations.

From this context, we ask ourselves: How has the sociopolitical system influenced social participation in institutional terms? In general, we observe that participation has been established through formal and institutionalized channels in the last 30 years under a traditional logic where the construction of participation paths was settled mainly in the political parties especially in the political parties, especially when establishing a civic behavior that pays back in specific social actions[1,2]. This participation was also manifested in Catholic and Evangelical religious communities, whose penetration in society had been sustained during the 1990s and 2000s.

This type of traditional participation, which channels specific social concerns in an orderly manner, excluded the rest of the population, who marginally observed the developing social events. Citizen participation is limited according to the Organization for Economic Cooperation and Development (OECD), given that only 49% of the electoral roll voted in the 2013 general elections, representing one of the lowest rates in the OECD countries[3]. The participation rate was 34.9% in the 2016 municipal elections, coinciding with a low confidence level in public institutions, and few Chileans are aware of national events[3].

An even more specific question emerges within this setting: What has the social and health participation model been like in recent decades, in which particular elements are observed that determine a logic that extends ineluctably in the expressions of general social participation? Once again, when observing recent history, a passive reception is established by the user of those health policies that resulted in their short- and long-term contingency. This position is typical of non-participant observation and based on the assignment of expectations and attributes to the political representatives who operated at formal partisan levels.

In this regard, two ways could be observed in which these expectations were made evident in the social imaginary: the first of them can be defined under the observance of assistance in the public sector, which had little user participation, and resignation to policies that permanently required an update and the incorporation of more resources. This expectation gradually generated the foundations for a social malaise oriented specifically towards emergency health care but also the need for care in severe surgical interventions. The second type of expectation was established in the private sector. A market in which quality implied a higher associated expense prevails, with little participation from users who had to adopt clauses of complex interpretation in health insurance.

The health system: the tension between the health structure and the need for participation

A change in health governance will occur in the national context after addressing a modification in the social participation policy that generates the necessary levels so that subjects can contribute democratically to constructing a health system per the social contingency. In Chile, the socio-cultural change was generated before the political modification, which has altered the bases of what was considered normatively correct, raising the probability of potential modifications toward still unknown directions.

So, does the political organization of Chile influence citizen participation in the health system? The answer is complex, mainly because we observe a sectoral replication of the model of political administration and allocation of resources at the national level in this field. The advantages of this model lie in the unitary vision of health policies, which allows the homogeneous establishment of several programs that are highly successful in epidemiological campaigns such as childhood vaccination or against seasonal epidemics, for example[4,5]. The drawback lies in the lack of contextuality of these policies, which are planned in the country's capital and have an urban nuance, suffering from the rurality exposed in most country's cities.

The Chilean social and health system has unique features that have made it efficient before particular historical demands, although it shares the deficiencies of global health systems. This struggle between the control of social determinants associated with health and the epidemiological health organization with political-economic problems gives it a specific analytical richness worthy of study.

Access to Chilean health: Institutional organization and participation

Access to Chilean health is formalized under identifiable structures maintained over time, establishing improvements and gradually adapting to social and technological changes. Participation, therefore, is channeled through formal means depending on the level or relevant theme[6]. Although more is needed to establish new health governance, it does allow organized participation in some aspects of decision-making in specific public policies. One must first know the associated organizations to effectively understand access to health in Chile, as follows:

• The National Health System includes all persons and public or private entities that perform functions related to the structure, financing, insurance, and operation of the system as a whole[7,8]. The incorporation of citizen participation is articulated at this level through the Civil Society Council, the users' committee, the participatory public account, and the comprehensive citizen care and information system[9].

• The National Health Services System (SNSS) is a public entity with a clear regulatory framework focused on providing care services to the population. It has decentralized regional or subregional health services with a healthcare network. Also participating in the SNSS institutions ascribed through agreements, highlighting the municipalities and the delegated services[10]. Therefore, participation remains within the institutional sphere, linking with study centers or the academy, as appropriate.

• The public system is organized in the National Health Fund (FONASA), which implies solidary insurance that guarantees

access to medical care types. In 2017, its coverage reached 77% of the national population, configuring itself as the primary subsystem for the provision of medical services in the country[5,11], and the one that requires resources the most and has the most significant conflicts for this reason. Citizen participation is channeled through the Civil Society Council. This council establishes links between the management of health establishments and the community's needs. However, it does not have decision-making power. We also have the level of the Participatory Public Account, which is a space for accountability and dialogue between the National Director of FONASA and civil society representatives, allowing the delivery of a management summary[12].

• In the private health system, the administration of the same healthcare position is considered for the Social Security Institutions (ISAPRES). Citizen participation in the private system exists only through the feedback generated through particular studies carried out by said institutions regarding the health needs of the population they serve. In public and private cases, the contribution to the health system corresponds to 7% of each worker's taxable income. However, it can reach up to 10% on average[13] in the case of workers who depend on the private system, a situation also questioned by citizens, although it has yet to be successfully fueled through political channels.

Foundations of citizen participation in health in Chile

Policies for citizen participation in the health context imply, from the formal viewpoint, a joint evaluation of the existing problems, establishing shared goals within certain deadlines[14]. Within the framework of the structuring of a policy of citizen participation integrated into health decisions at the national level, we should consider stages in which this is made visible, generating the mobilization of the system's resources towards a specific problem, and, in this regard, we could ask ourselves: "*What are the social factors that influence the development of social participation in health at the national level?*". Before which we witness the emergence of a multidimensional setting that permanently dialogues between the context and its participants. Against this, in the Chilean context, we can establish some points such as:

– Participation as an expression of a specific health need: before which communicative links are established between groups with an organization that responds to a specific health issue. However, the results can be extended to health areas that transcend their first initiatives. This type of organization has been permanent in the last 30 years. However, it has been strengthened by social networks in the last decade, generating agile and rapidly evolving digital governance.

– Participation as a sub-political expression of health derives from what was stated above, although it has an additional organizational component that implies independence from a traditional health institutional structure. The sub-political concept, typical of the risk society, incorporates conceptual elements that allow this organization's governance to be structured per its rules and purposes. The objective is to reach a goal by constantly evaluating new ways to obtain the resources to solve the problem, which is where organizations seeking the legalization of marijuana for medicinal purposes or aiming to obtain specific medicines for rare diseases are found.

– The organizational articulation for formal participation with traditional health institutions is the last identifiable

way that observes a feasible type of participation in generating health policies at the national level. This type of participation implies accepting the regulations imposed by traditional health institutions, occupying the spaces allowed for achieving consensus around several health issues.

Socially, using the three organizational forms for citizen participation in health shows the occupation of the participatory niches available for communication on specific aspects at the health level. Sociologically, we observe that communication acquires different interactive forms, organizing itself per the needs and circumstantial facts to respond to a social need. In this case, health is evident and urgent.

Thus, we can ask ourselves: what is participation in health in Chile? Discovering distinctions that generate recognizable semantics at the moment of defining it. In this regard, participation initially harbors an element of individuality, in which the conscious subject is affected by events and risk factors, and social conditions that institutionally do not account for adequate support for the solution of their problems[14,15], which leads to a second stage in which a collective definition linked to health rights and policies is established.

So, as a social fact, health participation is not only conceptually defined as a governance mechanism, but in practice, it democratizes knowledge around a specific health issue and in the actions that society perceives as necessary for its resolution[14]. In the Chilean case, this participation has demanded attention to several topics ranging from the visualization of pathologies not covered by the public and private health system and the financial questioning of public and private health protection policies in the country. In the last five years, the civil society organization has achieved activism that has revealed several issues currently being discussed in legislative bodies.

The theoretical proposal and contingency in the participation in the health system

Social participation policies move from a paternalistic model that ensures access to information to one that is consultative and whose characteristic lies in collecting the demands and proposals of several organizations to establish policies that adequately satisfy this population[14,15]. According to the Chilean Ministry of Health (MINSAL)[14], the participation of citizens contributes:

- To developing people as active subjects in managing the conditions that favor comprehensive development, well-being, and quality of life.

- To establishing communities with the capacity to dialogue with the public policy sector at its different activity levels.

- To building citizenship that can express demands felt like an entire democratic exercise.

- To building citizenship that acts in solidarity against common problems.

- To exercising social control over public management and the administration of fiscal resources.

From the state health reflection, participation in the various systems is essential for their updating, besides integration with related institutions. Moreover, social participation guarantees that primary care services provide solutions to people's health problems[16], which must reflect a new form of relationship between the State and citizens grounded on the recognition of the value of the other and their legitimacy to decide on their health[17]. In Chile, it is

theoretically intended that the same people become active participants who control their health determinants.

However, in practice, participation within these health systems is not permanent, nor is it expressed in an evolutionary continuum towards total governance; instead, it responds to the political and contingent processes in the country. This situation leads to a setting in which citizen participation, in the Chilean case, has a non-linear and reactive character in the face of evident shortcomings in the system itself or in the policies that support it.

Citizen participation from a historical perspective

In 1998, the MINSAL launched its First National Plan for Health Promotion per the country's epidemiological profile and with the international drive for health promotion and the Primary Health Care (PHC) strategy. The National Council for Health Promotion *Vida Chile* is established from 28 public and private institutions throughout the country, whose function is to advise the ministries on the development of health policies and coordinate an intersectoral strategic action plan[18]. The interaction of these authorities in the territory produces communication channels in which the adoption of specific participation measures is allowed, albeit always restricted to the configurative frameworks of the central health institution.

The *Vida Chile* communal councils have a network of local councils. They are participatory and include representatives of social and community organizations, municipal authorities, local public services, and private entities that collaborate with the participatory diagnosis of health and quality of life and participate in the formulation, implementation, and evaluation of the Community Health Promotion Plan[19].

Between 2006 and 2010, the Pro-Citizen Participation Agenda developed a set of guidelines that express the public policy guidelines to promote participation, the exercise of citizen rights, associationism, and respect for diversity, a policy with four defined axes that encompass the participatory components of public policies[14]:

a) Citizen Right to public information

b) Participatory Public Management

c) Strengthening of Civil Society

d) Non-discrimination and respect for diversity.

The political period in which this agenda was installed focused on the formal structuring of political communication in a society that included a partisan organizational nuance. Long-term effectiveness became relative as other areas of the country's social development were emphasized. An essential element that also influenced the priorities of a participation agenda was the 2010 earthquake that redefined social policies (including health) around reconstruction for several years.

The legal and institutional aspects of social participation in health

Despite the aforementioned, participation initiatives that resulted in regulations and laws that attempted to systematize social action through channels defined by the central authority and thereby maintain an organizational order that facilitates communication between systems were established. Law Nº 20.500 on Associations and Citizen Participation in public management institutionalizes Citizen Participation, whose mission is:

> Encouraging citizen participation to promote a culture of shared responsibility, strengthening

communication spaces between the government and citizens, and increasing the transparency, efficacy, efficiency, and effectiveness of public policies[14].

In the context described, participation in Chile has been institutionalized either through the Health Authority Law, the Assistance Network Integration Councils, the Advisory Councils of the Regional Ministerial Health Secretariats, or the Advisory Councils of Self-managed Hospitals. The integration and articulation mechanisms of the care network in which decision-making in matters of public health and provision of services is expressed to a certain extent[14,15]. The structures mentioned above systematize the information collected by the population, allowing formal channels in which the socialization of information can easily pass to the relevant authorities. However, said information is only part of the total the central institution incorporates for final health decisions.

The foregoing is vital since it politically guides the issues and bodies that the State Administration must commit to implementing actions regarding citizen participation, co-responsibly to advance the improvement of services to citizens. All of this must go hand in hand with the idea of active citizenship, "that can express the demands to the State and effectively incorporate into the public sphere"[20]. Despite the exclusion and social fragmentation usually associated with the prevailing sociopolitical model, inequality, and globalization, it hinders the path to this actual participation. It is, thus, intended to incorporate more comprehensive and equitable definitions of social cohesion from the theoretical to the practical aspects, which ideally affect state decisions for the generation of new reflective and organizational spaces. From the purely institutional viewpoint, we should consider that participation has some distinct components within the national health policy, as follows:

– Participation can be developed in specific spaces. However, the judicial and political nature of the organization of the Chilean State prevents the establishment of horizontality in which any non-governmental organization can directly influence public policies.

– The levels of participation are linked to public health, above all because the State promotes it. Participation has a different dimension in the private sector. Therefore, health-oriented non-governmental organizations need the appropriate spaces to develop their ideas and recommendations.

– Public health plans derive from the systematic study of the health conditions that affect the population in that area and are printed in the law of the Republic. In this context, citizen participation can exist under formal levels or through legislative consultation with various non-governmental or academic organizations. However, it can also be exclusive initiatives of the Executive or legislature initiatives. In the private sector, health insurance depends on economic health studies supervised by the Superintendence of ISAPRES.

As discussed, communication between government institutions and citizens can be organized in two dimensions that represent both the possibilities granted by the state to join the health discussion and the need for health governance that accounts for the population's needs. The dimensions are therefore described in the following points:

– The first is institutional, preconfigured at the central level, where the authority grants spaces to citizen organizations so that they can actively participate in certain decision-making levels in health. This type of participation has been traditional for the last 30 years and has been promoted by several

national governments. The advantage lies in the organization this configuration allows, communicatively structuring the information within the authority's margins. Also, this type of communication coexists adequately with other political levels without standing out or being prioritized when engaging in discussions on specific issues. The disadvantage lies in how restrictive it is for ordinary citizens, given that the subject not affiliated with a non-governmental organization could hardly participate in these levels. A type of basic representativeness is required for this logic to work.

– The second type of participation is based on the ability of organizations to mobilize information per their health objectives. This type of action is opposed to the centralized communicational structure proposed by the State, which leads to a communicational confrontation in which the perseverance of the organization and the type of integration of its members will be essential to achieve its objectives. This type of participation has predominated in the last five years, which with a high level of activism and the proper use of the media, has managed to generate public health policies that sanction specific elements such as the increased penalization of driving under the influence of alcohol or budget for the treatment of rare diseases among other causes.

At the primary level, participation is institutionalized so that communication is very fluid and integrated into final decisions. The connection between conceptualization and praxis is sought. Therefore, the Community Health Plan is configured, for which some measures and conditions favoring joint and participatory work[14] are suggested. The Communal Health Plan is built from 'Participatory Diagnosis' and based on the proposals and priorities of the local communities, where the latter participate in the local planning process, that is, the diagnosis, programming, implementation, and evaluation[14]. This type of participation is mainly associated with chronic non-communicable diseases, local management and control, the evaluation of community claims, and the development of binding and deliberative participation strategies[14].

Policies for the protection of vulnerable groups and participation

Vulnerability extends to various social groups and encompasses a wide age range across all genders. Protection policies are aimed at several vulnerable groups whose access is limited by different circumstances. In general, they may show higher poverty rates and lower inclusion than other populations in the country[21] and, on the other hand, have some exemptions from health care payment in the public system. Public protection policies have been subject to historical circumstances and contextual needs, although this relationship is only sometimes adequately coordinated, increasing inequality in the country's different populations. In Chile, multiple actions have been developed aimed at these sectors. Among those groups, some stand out for their proactivity in allowing policies to be developed around their demands. The demands of these groups can be summarized in the following points:

a) Intercultural Health Policies: The health panorama is complex[22], given the differences between ethnic communities due to their organizational peculiarities, their reticence towards the prevailing allopathic health system, and the understanding of health from an ethnic perspective. Currently, the Special Program for Indigenous and Peoples' Health (PESPI) is in force throughout the country. It aims to incorporate the participation of indigenous peoples in formulating and evaluating different intercultural health plans in

the health network services through local roundtables[23]. Interculturality has underpinned the political discussion given the 2019 mobilizations, so profound changes in the field are feasible in the medium term. The development of this type of policy is strengthened by international treaties that promote this type of health culture in the population to prevent its obsolescence and extinction. In this sense, participation occurs through what the stakeholders establish as their health authorities while dialoguing with the structural institutions of the Chilean political system[22]. After the protest movements of 2019, an essential space has been established for this type of health participation through the configuration of social organizations independent of the State that seek to generate a definitive space in the Constitution being drafted.

b) Health Situation in the LBGTI population: Currently, no public health policies address the needs of this population in a consistent and structured manner, and social movements have not dedicated efforts in this field either, concentrating their energies on achieving equal marriage[24]. The lack of campaigns to promote condom use and responsible sex education has again made Chile one of the countries with the highest incidence of AIDS in Latin America. This disease mainly affects the heterosexual young adult population and the homosexual population. The short-term social participation agenda remains within the demands of social policies, inevitably postponing everything related exclusively to health. Notably, a large part of the actions generated by the organizations that work on this issue has been oriented explicitly toward political elements and Human Rights, the vindication of the association between subjects, inheritance, and legal aspects. Therefore, a gap is established between the objectives achieved in socio-political matters and primary health needs.

c) Abortion policies: Currently, abortion is regulated by the Penal Code, arts. 342 to 345, and by the Health Code, arts. 119, 119 bis. The changes establish that women must expressly state in advance and writing their will to interrupt their pregnancies, and a legal representative is required if they suffer from cognitive impairment. In the case of interruption of pregnancy for adolescents aged 14-18, the procedure is reported to their legal representatives[24]. The policies generated in this field stem from a strong citizen demand articulated in non-governmental organizations that systematized said health problem in actions that developed into the necessary political pressure to generate the law. The participation of non-governmental organizations that claim the right to abortion is linked to highly mobilized feminist movements that effectively use several mass media to express their ideas. Certain health guarantees have been achieved under this rationale, which has allowed the country to break with those who have criminalized all kinds of abortion, as occurred a few years ago.

Immigration and the impact on the health system

Migration to Chile has constantly been increasing in the last 30 years, which brings with it a series of aspects to consider in terms of migration policy. Permanent residence permits of 2016 show a 9.8% increase against 2015 and 25% compared to 2014[25], with Peruvians leading this ranking. However, the presence of Haitian, Venezuelan and Colombian citizens experienced the most significant increase in the last two years.

Chile has ensured the right to health and education for migrants by keeping international agreements in force[26]. In this regard, MINSAL created in 2014 the Immigrant Health Sector Advisory Team, with representation in the Undersecretary of Public Health, Undersecretary of Care Networks, FONASA,

and the Superintendence of Health, whose objective is to develop the Immigrant Health Policy. Citizen participation is channeled through non-governmental organizations where migrants are informed and assisted, guiding them in the steps to access the health system.

Citizen participation in migration policies is a pending issue at the national level, especially since the recent migration boom. However, it is consistently high compared to previous years' means. Therefore, no organizations actively monitor this issue, but reactive initiatives are observed.

Final thoughts

The Chilean health policy system has developed from a long health tradition that has effectively overcome the different governments, thereby maintaining a successful and structural coherence. The national health policy has effectively managed to control pathologies and prevent or control emerging epidemics.

However, Health depends on a rigid and centralized structure directed by the Ministry of Health, preventing integration and external cooperation, primarily if it influences the normal functioning of its planning. In this setting, social participation is challenging due to the few spaces the system provides for communication outside the official structure. Social participation is restricted to formal spaces determined by the authority through policies, which, although hardly known, have allowed the niche to be effectively occupied.

The cultural change in the country, boosted by the irruption of information and communication technologies, constantly puts pressure on the health system to increase transparency and develop new participation levels, especially regarding access and therapies. Participation in health should emphasize community work that supports this participation, based on trust and communication. Participation, therefore, has the following characteristics:

• It is observed in two dimensions. One implies citizen participation within institutional frameworks, which derives from laws and materializes in various institutional health bodies. In this sense, participation is regulated and articulated by social organizations. A second dimension consists of the free organization of the subjects that constitute pressure groups. Several communication methodologies are used in this dimension to make particular health causes visible.

• Participation occurs mainly in primary care. At the municipal level, citizens can act within the proper levels, albeit limited to the budgets of said institutions.

• Advisory councils allow participation in various levels of the health institution.

• There is no citizen participation in the private sector. It is established in laws, regulations, and supervision only.

• We have defined vulnerable groups, although health participation is limited or non-existent, increasing their problems in this field.

• The accreditation of health institutions is regulated by law, and experts perform this task. Citizen participation does not participate in it, although the expert can evaluate it within the framework established by law.

Therefore, Chile's health goal no longer lies only in establishing fixed and perennial health objectives that span several decades but should also incorporate short- and medium-term health strategies and policies that are alert to the constant variations of the national and international political and epidemiological setting. The country's challenge regarding citizen participation falls into three fundamental axes:

• First, it is necessary to define the type of participation linking it to developing new governance in the health sector.

• Improve coordination between the different health agencies, generating new spaces and financing mechanisms that facilitate their development and maintenance over time.

• Strengthen coordination linked to the generation of information demonstrating citizen participation strategies' impact.

The attempt to achieve a vision and State policies around Health matters has been an achievement of governments in recent times. However, daily reality requires more effort in planning and resource allocation.

Collaborators

Mella PFO (0000-0002-2319-3840)* and Narváez CG (0000-0001-6645-8717)* have participated in the design, acquisition, analysis, and interpretation of the information, writing and critical review and approval of the final version, and will be accountable for the work. ■

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Received on 09/06/2021
Approved on 02/01/2022
Conflict of interests: non-existent
Financial support: non-existent