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Economic, social and cultural rights and the internet

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CHILE

THE SALUD + DESARROLLO E-HEALTH PROGRAMME AND ITS IMPACT ON THE MOST MARGINALISED POPULATION GROUPS

Derechos Digitales
Valentina Hernández
www.derechosdigitales.org

Introduction

Ever since Chile joined the Organisation for Economic Co-operation and Development (OECD) in 2010, national health indicators have improved. Life expectancy is near the OECD countries' average and public health spending has increased. However, the Chilean healthcare system is far from perfect, with the quality of service being lower compared to other OECD countries, and its financing characterised by demanding high contributions to the payment of costs from patients.[1]

Chile is among the first countries in Latin America to develop a public policy on digital technologies.[2] In the last decade the potential of technology has been incorporated into different sector plans. In the field of the right to healthcare, the Chilean Economic Development Agency (CORFO)[3] launched "Salud + Desarrollo"[4] ("Health + Development"), otherwise known as S+D. This is a strategic national programme that aims to strengthen the development of healthcare services and management.

This report will discuss regulations concerning the right to health, the main problems that the public health system faces, and how they affect the exercise of the right to health by the most vulnerable in the population. Given the problems and shortages that the public healthcare system constantly faces, the introduction of e-health can be useful to help improve the situation and improve the country's indicators; however, it may also may create new challenges and risks.

The right to healthcare in Chile

Chile signed and ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1972, though it only became law officially in 1989.

The UN High Commissioner for Human Rights has elaborated on the right to health as supported in the ICESCR, stating that the right contains entitlements such as:

- The right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health.
- The right to prevention, treatment and control of diseases.
- Equal and timely access to basic health services.

The UN also states that all services, goods and facilities must be available, accessible, acceptable, of good quality and provided without discrimination.[5]

At a national level, the right to healthcare is recognised in Article 19 No. 9 of the Chilean constitution.[6] However, the constitutional protection of this right is incomplete. As one of the consequences of the changes to the Chilean economic structure during the Pinochet regime, the exercise of the right to receive healthcare is often limited by the resources of each person. Unlike other rights guaranteed in the constitution, the right of access to healthcare cannot be directly demanded from the state through judicial action, except for the right to choose a public or private health insurance provider.[7]

Chile has confronted the public healthcare system's problems with several public policies and strategies. Although public expenditure on healthcare has grown, it is still below most OECD countries.[8] Expenditure constitutes close to 8% of Chile's GDP.[9] The most important challenges of the public healthcare system are: meeting the needs of an ageing population, access to and

1   OECD. (2015). *Health at a Glance 2015: How does Chile compare?* https://www.oecd.org/chile/Health-at-a-Glance-2015-Key-Findings-CHILE.pdf

2   Katz, R. (2009). *El Papel de las TIC en el Desarrollo. Propuesta de Latinoamérica a los Retos Económicos Actuales*. Barcelona: Ariel.

3   www.english.corfo.cl

4   www.saludmasdesarrollo.cl

5   OHCHR & WHO. (n/d). *The Right to Health*. www.ohchr.org/Documents/Publications/Factsheet31.pdf

6   www.leychile.cl/Navegar?idNorma=242302

7   The state does not guarantee actual access to the promotion, protection and recovery of the health of a person and his or her rehabilitation, as established in the first paragraph of Article 19 No. 9. However, the case law is changing due to the AUGE Plan, a scheme that guarantees a set of healthcare services with no payment for a limited list of health conditions. See Zúñiga, A. (2011). Justicia y racionamiento sanitario en el Plan AUGE: dilemas bioéticos asociados a la distribución de recursos escasos. *Acta bioethica, 17*(1).

8   OECD. (2015). Op. cit.

9   static1.squarespace.com/static/55dc9136e4b05820bf029511/t/560ae7d8e4b003b5f30add04/1443555288010/Informe++mesas+de+trabajo.pdf

quality of healthcare, infrastructure (facilities and staff), efficiency and coordination between units and private-public systems, and leadership and coordination.[10] For example, there is a scarcity of equipment and medical personnel in many healthcare facilities (there are only 10.3 physicians per 10,000 inhabitants) and indigenous populations and people living in rural areas live far from the services, making transportation costs unaffordable.[11]

Healthcare in Chile is provided by public and private entities. The public healthcare system provides service to 78.3% of the Chilean population[12] not affiliated to private insurers (or ISAPREs). With limited resources and an enormous demand, efficiency in the public system is crucial. The S+D programme defines the need for efficiency as one of its pillars. As the manager of the programme, Aisen Etcheverry, told us, there is the will in all public agencies involved to improve the healthcare system's coverage and quality, and the use of information and communications technologies (ICTs) to do this is key.[13]

The challenge of providing better healthcare to the underserved

The public healthcare system is available to all of the population; however, most people in higher income groups prefer private insurance. Along with most of the lower income population, the public system is also available to the most vulnerable of the Chilean population, which stands at 17.8 million in total.[14] In order to determine the type of insurance, patients are divided into four different groups according to their monthly income. Public health insurance covers the first two groups without charge. These groups include people who do not have an income (a total of 3,296,448 people, including minors) and those who earn under the minimum wage (4,746,623 people). The third group is made up of people who barely earn more than the minimum wage (2,307,435 people), and the fourth (almost half the population) is people who earn above the

minimum wage but stay in the public system.[15] Although the groups are mostly all divided among very low income brackets, the grouping allows for determining the amount of payment for a service in the public system, or the rate of co-payment if attending a private healthcare centre.

All of the people are most probably going to need healthcare service at some point in their lives. The government's Universal Access to Explicit Health Guarantees (AUGE) Plan[16] establishes the minimum conditions of service, including maximum waiting times, financial protection for patients, and quality of service, as defined by the Ministry of Public Health, for a list of 80 health conditions that is regularly revised.[17] However, it is important to note that wealth is not equally distributed across Chile; the higher percentages of poverty are located in the regions farthest from Santiago, which are also the most isolated. This poses challenges for meeting the right to health of the most vulnerable.

In this context, the role of the government is to give universal access to health, which is a constitutional right. The government develops policy and coordinates and controls implementation plans, all within the available resources.

Given the challenges that the healthcare system faces – in particular a shortage of medical personnel and the difficulty in accessing services for indigenous and rural populations – Etcheverry says that telemedicine a good option to improve the current circumstances. Even if the systemic shortage of medical professionals is not going to be solved easily, at least routine medical exams can be performed on patients living in isolated areas and sent to a physician for analysis. Patients can also access the services of specialists using the internet (or through tele-consultation).

The use of ICTs in healthcare is effective for multiple reasons. First, it reduces the costs associated with procedures. Etcheverry told us that one of the inefficiencies a programme like S+D tries to address is the lack of centralised medical records for each patient. If a patient goes to a public hospital located in the north of Chile and then goes to another in the south, a doctor in the latter might not know about the tests, diagnosis and prescriptions given by the first doctor. It is likely, for example, that tests will have to be performed more than once, and the

10 Taylor, E. A. et al. (2016). *Developing a Strategic Program for Chilean Health Information Technology: Environmental Scan and Key Informant Interviews*. Santa Monica, CA: RAND Corporation. www.rand.org/pubs/research_reports/RR1358z1.html .

11 Ibid.

12 Ministerio de Desarrollo Social. (2015). *Informe de Desarrollo Social 2015*. www.ministeriodesarrollosocial.gob.cl/pdf/upload/IDS2.pdf

13 Interview with Aisen Etcheverry, manager of the S+D programme, 20 June 2016.

14 Lezaeta, M. (2014, 4 September). INE establece que población chilena asciende a 17,8 millones de personas en 2014. *EMOL*. www.emol.com/noticias/nacional/2014/09/04/678578/ine-establece-que-poblacion-chilena-asciende-a-178-millones-de-personas-en-2014.html

15 Clínicas de Chile A.G. (2016). *Dimensionamiento del Sector de Salud Privado en Chile: Actualización a cifras año 2014*. www.clinicasdechile.cl/wp-content/uploads/2016/04/Dimensionamiento_sectorprivado_cifras2014.pdf

16 auge.fonasa.cl

17 www.supersalud.gob.cl/difusion/572/w3-propertyvalue-3130.html

whole process of diagnosis and treatment repeated. In theory, not only would the treatment be faster with a centralised database of health records, but it would also free up resources to be better used elsewhere.

However, the implementation of e-health solutions faces new problems:

- First, primary care units (especially the ones located in rural areas) have poor or no connectivity. Some do not even have computers or electricity.[18]

- Second, while centralised health records reduce costs, this comes with its own challenges. For example, public and private systems have created their own technical solutions and they will have to be compatible. Moreover, even within the public system, ICT systems that are not compatible with each other have been developed by different centres (many of them are, according to Etcheverry, also unstable systems). The interoperability of systems is crucial to allow the reciprocal flow of information. To improve interoperability, S+D plans to create a certificate of approval for the IT solutions the plan will finance.

- Third, current data protection provisions are outdated and lack proper enforcement. S+D's certificate of approval should consider standardised high data protection exigencies given how sensitive health data is.

According to Etcheverry, the above challenges mean that the roles of the government and private sector are important. The government needs to define the problems the healthcare system faces and coordinate both the solutions to these problems and their technical requirements. It also needs to make sure that all solutions are compatible with each other.

Because of resource limitations, there must be some criteria to know which e-health projects should be financed first. This can be answered by examining the technical skills and innovations of each proposal, something that falls under CORFO's expertise, and matching those with the needs of the healthcare system, which is the responsibility of the Ministry of Public Health. Etcheverry added that even if S+D cannot know if the final product will be sold to and used by the private or public sector, it does know that the government is an important purchaser, and therefore can request certain standards in the solutions produced and bought, thus ensuring quality and interoperability.

In a country with remote towns and communities very far away from the capital, access to the internet is crucial and the implementation of e-health initiatives depends heavily on communications infrastructure. Even if the difference of access between urban and rural areas is about 30%,[19] Etcheverry said that a growing number of public healthcare centres have access to the internet. She mentioned that there are governmental policies focused improving connectivity, especially in regions far from the capital, Santiago.[20] She added that medical staff have been receiving IT training for almost a decade, and that the S+D programme includes more resources to strengthen the capacity of personnel, and even to improve the computer literacy of patients.

Conclusions

The duty to provide healthcare derived from the right to health depends on the available resources each country has. Chile's expenditure on public health has been growing in the last few years and although the country is behind the OECD's average, the situation is slowly improving.

However, in a highly unequal country like Chile, access to and quality of healthcare is unequal. People with higher incomes can choose to be covered by private healthcare insurance and attend private health centres; people with lower incomes most of the time will go to a public health centre. People who live in distant rural communities are in the worst position: they normally have lower incomes than the rest of the country and the location of their homes makes it very difficult to receive medical attention. They have to wait a long time to see a doctor and travel long distances.

The use of technology is key in bridging this healthcare divide, but this also requires access to technology and the capacity among medical staff to use it. Technology is not a panacea, and its use does not solve some traditional inefficiencies in public services. The S+D programme recognises the potential of IT in the public health service, not only as a way of using the available resources better, but also as a means of improving access to healthcare for many Chileans.

18   Taylor, E. A. et al. (2016). Op. cit.

19   Stäger Koller, M., & Núñez Tissinetti, J. L. (2015). *Uso de internet en Chile: la otra brecha que nos divide.* Santiago: Fundación País Digital. paisdigital.org/wp-content/uploads/2015/07/Brecha-Digital-Internet-Estudio-Pa%C3%ADs-Digital-CASEN.pdf

20   For instance, the National Infrastructure Plan by the Undersecretariat of Telecommunications: www.subtel.gob.cl/quienes-somos/plan-estrategico

Finally, the exercise of the right to health ideally includes the participation of the population in health-related decision making. Top-down programmes might find it difficult to provide an adequate response to social demands. It is still a question whether there will be room for improvements in this area in the future.

Action steps

Regarding the use of the internet and technological tools to improve public healthcare, the following action steps are suggested:

- Research healthcare needs properly, especially those involving marginalised groups. Include these groups in the decision-making process to establish priorities for the realisation of the right to health. Include a discussion of preventive health needs in this process.

- Build capacities and educate people in the use of the internet, among other tools, to obtain information on government services in general and healthcare services in particular. Provide personalised assistance to groups and persons unwilling or reluctant to use the internet.

- Improve internet connectivity, especially in rural areas and in isolated communities and regions, to allow greater access to public services.

- Implement high data security standards, especially if both the public and private sectors are going to process health information. Consolidate criteria regarding both the implementation of technology and security standards for private and public healthcare services.

- Establish clear coordination in terms of policies that relate to deployment of ICTs and fulfilment of governmental duties, including those related to healthcare.

Economic, social and cultural rights and the internet

The 45 country reports gathered here illustrate the link between the internet and economic, social and cultural rights (ESCRs). Some of the topics will be familiar to information and communications technology for development (ICT4D) activists: the right to health, education and culture; the socioeconomic empowerment of women using the internet; the inclusion of rural and indigenous communities in the information society; and the use of ICT to combat the marginalisation of local languages. Others deal with relatively new areas of exploration, such as using 3D printing technology to preserve cultural heritage, creating participatory community networks to capture an "inventory of things" that enables socioeconomic rights, crowdfunding rights, or the negative impact of algorithms on calculating social benefits. Workers' rights receive some attention, as does the use of the internet during natural disasters.

Ten thematic reports frame the country reports. These deal both with overarching concerns when it comes to ESCRs and the internet – such as institutional frameworks and policy considerations – as well as more specific issues that impact on our rights: the legal justification for online education resources, the plight of migrant domestic workers, the use of digital databases to protect traditional knowledge from biopiracy, digital archiving, and the impact of multilateral trade deals on the international human rights framework.

The reports highlight the institutional and country-level possibilities and challenges that civil society faces in using the internet to enable ESCRs. They also suggest that in a number of instances, individuals, groups and communities are using the internet to enact their socioeconomic and cultural rights in the face of disinterest, inaction or censure by the state.

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