REVUE INTERNATIONALE DE POLITIQUE DE DÉVELOPPEMENT

**International Development Policy | Revue internationale de politique de développement**

**14 | 2022**
**Governing Migration for Development from the Global Souths**

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OpenEdition Journals

**Electronic version**
URL: https://journals.openedition.org/poldev/4980
DOI: 10.4000/poldev.4980
ISSN: 1663-9391

**This article is a translation of:**
Política de salud de migrantes internacionales en Chile, 2014-2017 - URL : https://journals.openedition.org/poldev/5090 [es]

**Publisher**
Institut de hautes études internationales et du développement

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**Electronic reference**
Jossette Iribarne Wiff, Andrea Fernández Benítez, Marcela Pezoa González, Claudia Padilla, Macarena Chepo and René Leyva Flores, "The National Health Policy for International Migrants in Chile, 2014–17", *International Development Policy | Revue internationale de politique de développement* [Online], 14 | 2022, Online since 12 May 2022, connection on 08 June 2022. URL: http://journals.openedition.org/poldev/4980 ; DOI: https://doi.org/10.4000/poldev.4980

# The National Health Policy for International Migrants in Chile, 2014–17

*La politique nationale de santé pour les migrants internationaux au Chili, 2014-17*

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*The authors' acknowledgements go to all those migrants, civil society organisations and officials of the Ministry of Health, Human Rights, Superintendency of Health, and FONASA, as well as academia, and other government and social sectors who participated in the formulation process and who continue to participate in the implementation of health policy. The Chile-Mexico Cooperation Fund, a collaboration between the Chilean Agency of International Cooperation for Development (Agencia Chilena de Cooperación Internacional, or AGCID) and the Mexican Agency of International Cooperation for Development (Agencia Mexicana de Cooperación Internacional para el Desarrollo, or AMEXCID) contributed to the technical and scientific exchange necessary for the development of the NHPIM.*

## 1. Introduction

1 Numerous initiatives have been conceived at the global level with the goal of promoting and protecting the rights of international migrants and their families (UNGA, 1990). This complex web of declarations and strategies includes the Universal Declaration of Human Rights (UNGA, 1948), International Covenant on Economic, Social and Cultural Rights (UNGA, 1966b), International Covenant on Civil and Political Rights (UNGA, 1966a), International Convention on the Elimination of All Forms of Racial Discrimination (UNGA, 1965), International Convention on the Elimination of All Forms of Discrimination against Women (UNGA, 1979) and Convention on the Rights of the Child (UNGA, 1989). International political consensus has targeted guaranteeing the

exercising of the rights of population groups that, for diverse reasons, have had to abandon their birth communities, often in search of a better quality of life.

2 The United Nations 2030 Agenda for Sustainable Development promotes greater visibility of and attention to the needs of historically marginalised groups, and may contribute to transforming the public health landscape. Its 17 Sustainable Development Goals (SDGs) are integrated and indivisible, and encompass economic, social and environmental action areas. International migration is specifically addressed (under SDG 10: Reduced inequalities), with the primary migration-related target being to achieve the facilitation of orderly, safe, regular and responsible migration. This target is closely related with other goals, including SDG 3, Good health and well-being, which comprises multiple dimensions including universal healthcare coverage, protection against financial risks, and access to quality, essential health services, medicines and vaccines (UNGA, 2015). The aspirational nature of the SDGs is reflected in the fact that the majority of governments—whether their countries are principally sites of origin, transit, or destination for migrants—do not allocate resources specifically to these commitments, with certain exceptions, including Canada (Government of Canada, 2020).

3 The exercising of rights, in any given social space, is a key element in the reduction of pre-existing gaps and in the construction of a culture of mutual respect (Penninx, 2005). This has critical implications for the well-being and health of society given that the groups with only a limited capacity to exercise their own rights are also those that experience greater social, economic and health risks (Bronfman et al., 2002; Black, Natali and Skinner, 2005; Devaux, 2015). Social and political action is one clear pathway to creating conditions that favour the assurance of these rights (Soss, 1999; Guarnizo, Portes and Haller, 2003).

4 Latin America has a long history of experiences that have put the rights of its people to the test (Zapata, 1986). Nonetheless, the past few decades have seen some Latin American societies consolidate their capacity to demand the promotion and respect of basic rights; among them Chile, which has demonstrated steady progress towards reducing social inequity across multiple social and economic spaces (National Library of Congress of Chile, 2020).

5 From the start of the current century, Chile has attracted significant global attention as a destination country for migrants, particularly for the populations of neighbouring countries (Peru, Bolivia, Colombia, Venezuela, Argentina and Ecuador) but also for those of more distant countries, including Haiti, the Dominican Republic, Mexico, or European and Asian countries, who see in Chile the opportunity to develop and exercise their skills and abilities (Martínez Pizarro, 2003). Thus, the proportion of international migrants in the total population of Chile rose from just 1.3 per cent in 2002 to nearly 4.4 per cent in 2017 (National Institute for Statistics of Chile, 2018a), and recent estimates indicate that this figure may have reached 7.8 per cent by 2019 (an estimated 1,492,522 individuals) (Department of Foreign Affairs and Migration of Chile, 2020).

6 In 2017, the socio-demographic characteristics of migrants in Chile, as compared to the general Chilean population, reflected a difference in age (the former are younger) and a higher level of formal education among migrants; the migrant population demonstrates a greater frequency of poverty and overcrowded living conditions (Table 14.1).

**Table 14.1 Socio-demographic characteristics of migrants in Chile and of the general Chilean population, according to the CASEN Survey 2017**

| | Migrants (CI* 95%) | Chileans (CI 95%) |
|---|---|---|
| Estimated population size | 777,407 inhabitants (4.4%) | 16,843,471 inhabitants (94.6%) |
| Sex (female) | 51.4% (49.0–53.7) | 52.5% (52.3–52.8) |
| Age | 31.7 (30.9–32.4) | 37.4 (37.1–37.6) |
| Years of formal education (for adults ≥18 years of age) | 13.1 (12.8–3.4) | 11.1 (11.0–11.2) |
| Multidimensional poverty | 24.6% (20.1–29.8) | 20.5% (19.8–21.2) |
| Occupation (response to the question: *'In the last week, have you worked at least one hour, not counting housework or daily maintenance?'*) | 73.7% (70.6–76.7) | 51.8% (51.4–52.2) |
| Overcrowding (moderate or critical) | 26.9% (23.8–30.1) | 9.1% (8.6–9.5) |

* Confidence interval

Source: Ministry of Social Development of Chile (2020a). CASEN Survey: Databases, http://observatorio.ministeriodesarrollosocial.gob.cl/casen-multidimensional/casen/basedatos.php (accessed on 10 January 2021).

7 The Chilean government and society in general have been sensitive to this change in the socio-demographic and social dynamic of their country, and in 2014 a process was initiated to simultaneously formulate and implement and test and adjust the National Health Policy for International Migrants (NHPIM) in Chile. The Policy, published near the end of 2017, constitutes a response to the challenges international migrants—particularly those who are economically disadvantaged or who have irregular migration status—face in accessing social services, including those associated with health. This chapter aims to analyse the processes involved in formulating the Policy and their short-term results considered as part of the process of designing, testing and adjusting the NHPIM, during the period 2014 to 2017.

## 2. Methods

8 The processes of formulating and implementing the NHPIM in Chile between 2014 and 2017 were analysed through a document review of the technical reports from a series of consultative forums related to social participation processes called '*Diálogos Ciudadanos*' (Citizen Dialogues), and of meetings held by health professionals for the revision of the technical, legislative, and legal aspects of the formulation (Intersectoral

Board on Migrants and Health, 2015; Ministry of Health of Chile, 2015b, 2015d, 2015c, 2016, 2017, 2018a, 2018b, 2018c; Division of Healthy Public Policy and Promotion, 2017). Participating actors were identified, as was the specific contribution of each to defining the legislative, legal, and financial aspects of the Policy. The information that guided the present work is in the public domain.

9 Given the simultaneous nature of the processes (design–testing–adjustment) that went into the development of the NHPIM, short-term results were measured on two dimensions. The first was financing, which included legislative or legal changes related to financial coverage provided through public sector health insurance via the National Health Fund of Chile (Fondo Nacional de Salud, or FONASA), nominal coverage of migrants by FONASA, and the effective use of FONASA. This measurement was based on hospital discharges in cases where patients had FONASA coverage as an indicator, considering that inpatient hospital care implies the highest cost of any type of medical attention. The second dimension was access to and use of healthcare services by migrants. Barriers to effective access to services were estimated using the proportion of individuals who reported difficulties obtaining a medical appointment. Healthcare service use was measured using the following indicators: the population who reported any health problem and who accessed healthcare services (according to the CASEN Survey); rate of general use of healthcare services including general medical check-ups, emergency care, and specialist and dental care (according to the CASEN Survey); proportion of women aged 18 and older who reported being a beneficiary of programmes providing family planning measures or prenatal care (Department of Health Information Statistics of Chile, 2020a); and the proportion of hospital discharges by nationality (Chilean or migrant) during the period 2014 to 2019 (Department of Health Information Statistics of Chile, 2020b).

10 Information regarding access to and use of healthcare services is available to the public through the CASEN Survey for the years 2013, 2015, and 2017, precisely in those chapters specific to migration (Ministry of Social Development of Chile, 2020b). The survey is representative of the national population residing in private households across the 16 regions of the country, both urban and rural. The present analysis considers the general population, and the subpopulation of migrants. To calculate rates for the year 2016, estimates of the population size by group within the CASEN 2015 and 2017 were used, as was data on the number of international migrants in Chile according to the National Institute for Statistics (Department of Foreign Affairs and Migration of Chile, 2020), and estimates of and projections for the Chilean population between 1992 and 2050 (National Institute for Statistics of Chile, 2018b). Given the high mobility of the migrant population in Chile during the years covered by this analysis, it is possible that the number of migrants entering the country in the months prior to or following the CASEN Survey was under-reported, leading to distorted estimations of FONASA coverage, which could in turn have limited access to the information needed to register migrants under FONASA. Data on accessing and using outpatient and inpatient hospital services are from the CASEN Survey for each year during the period of interest; they are self-reported measures, which may imply memory bias (not estimated) in outpatient service data (three months prior to the survey) and for those who used inpatient services (one year prior to the survey). In both cases, the effect of this data on the results presented here may be an underestimation of healthcare service use. The data from hospital outpatients and users of family planning and prenatal services are

derived from publications of the Department of Health Information Statistics of the Health Ministry of Chile.

11 Finally, regarding the quality of the data presented in this study, information on FONASA coverage, inpatient and outpatient health service access and use, hospital discharges, and family planning and prenatal care is all from verifiable, publicly available sources. The CASEN Survey, meanwhile, is among the instruments with the greatest scientific rigour with regard to an evaluation of the socio-economic conditions of the inhabitants of Chile.

## 3. Results

12 The formulation of the NHPIM began in 2014 as a response to increased migrant flow, reports of human rights violations and studies revealing equity gaps (Demoscopica, 2009; Liberona Concha, 2012; National Institute for Human Rights of Chile, 2013; González, 2014; Scozia Leighton et al., 2014). Furthermore, the current Chilean government, as part of its political platform, decided it was necessary to formulate a national migration policy that would operate within a framework of respect for human rights and the promotion of social integration for migrants, which would become the basis of the NHPIM (Sandoval, 2017). This decision was supported by Ministry of Health officials, who proposed that evidence was needed regarding the experiences of migrants in the community and in the context of healthcare services, as well as regarding the primary actions necessary to facilitate healthcare service access; these would both contribute to the basis of the NHPIM (Ministry of Health of Chile, 2015d). These events gave rise to a series of analyses, with the participation of different government sectors (those responsible for external relations and migration, human rights, and health), the United Nations International Organization for Migration (IOM) and civil society organisations that directly serve migrant communities.

13 As part of this initial process of the critical analysis of healthcare service access for migrants, it was necessary to formulate the Policy around the new socio-demographic reality represented by the significant increase in migrant numbers in Chile (Ministry of Health of Chile, 2015d). To this end, in September 2014, the Sectoral Advisory Board of Immigrants of the Ministry of Health was created (made up of representatives from the Public Health Subsecretariat, Aid Networks Subsecretariat, FONASA and Health Superintendency) with the goal of developing the legislative, legal, technical, financial and administrative guidelines necessary to construct the NHPIM.

14 Rapidly, without introducing legislative discourse that could prolong the process, the Ministry of Health released a memorandum (Bulletin 6, 2015) (Ministry of Health of Chile, 2015a) that explicitly decoupled healthcare service access and migratory status (residency permits), and instructed healthcare providers to provide all care required by children, adolescents up to age 18 and pregnant women, and the following services to all: emergency care, universal public health services (such as emergency contraceptives, vaccines, and care related to communicable diseases including tuberculosis, HIV and other sexually transmitted diseases) and health and hygiene education. Furthermore, this memorandum established that all irregular migrants ‘lacking in resources’ would be incorporated into FONASA as non-contributory beneficiaries with free access to all healthcare services offered. This was among the

most significant stipulations that immediately served to guarantee financial protection for the health of migrants, especially those with an irregular migration status.

15 This memorandum was further endorsed in 2016 by the national government of Chile through the publication of Decree No. 67 (Ministry of Health of Chile, 2016), which institutionalised the circumstances and mechanisms under and via which migrants could be classified as 'lacking in resources'. This measure provided a normative backstop and allowed progress to be made in the implementation of the legislative framework around healthcare service access with financial coverage for migrants, independently of their migration status. In addition, specific funding was allocated to the creation of the Healthcare Access Programme for Migrants (Programa de Acceso a la Atención de Salud de Personas Migrantes), which allowed resources to be channelled to municipal-level actions aimed at diminishing access gaps (the hiring of operational personnel, professional training, activity development for promoting health and human rights, and other aspects of primary care). With these normative and budgetary foundations, a more expansive regional intervention, both sectoral and multisectoral, was set in motion, with the participation of social and migrant-formed organisations, in order to identify barriers to healthcare service access and propose solutions.

16 This process became known as the Health Pilot for International Immigrants (Piloto de Salud de Inmigrantes Internacionales) (Ministry of Health of Chile, 2015d). It involved testing and adjusting the design of the Policy, already in its initial development stages, with the goal of measuring short-term results at the territorial level (municipalities and regions) that would serve as evidence enabling health inequities in the immigrant population to be addressed.

17 The pilot was developed and ran from 2015 to 2017 in the Chilean regions with the largest migrant populations: Arica Parinacota, Tarapacá, Antofagasta, and the Metropolitan Region (Santiago). Results were analysed through qualitative studies known as National Interim Monitoring and Evaluation Campaigns (Jornadas Nacionales de Monitoreo y Evaluación Intermedia), which had the main objective of identifying and disseminating achievements and lessons learned in the pilot (Ministry of Health of Chile, 2018c).

18 Notable achievements were identified: the institutionalisation of actions relating to migrants by their becoming the responsibility of the Department of Health of Indigenous Peoples and Interculturality; the identification of gaps in healthcare access at each level of the healthcare system; improvements in health data collection for evidence generation; the reporting and resolution of complaints, together with the intersectoral working groups; and the explicit acknowledgement of 'intercultural' gaps in healthcare for migrants. Furthermore, 'substantial improvements' were documented in the 'reduction of health access gaps for the migrant community' and it was noted that 'clear guidelines and vision exist to orient efforts towards migrant health' (IOM, 2015; Division of Healthy Public Policy and Promotion, 2017; Superintendence of Health of Chile, 2019).

19 Analysis and evaluation of these results was carried out through Citizen Dialogues (ten public analysis forums) in 2017, with the participation of 1,500 individuals, including migrants and representatives of national civil society, as well as health officials and authorities (Division of Healthy Public Policy and Promotion, 2017). The Dialogues were a platform from which to revise and discuss the approach, principles and guidelines of the Policy, while also serving to provide feedback on the necessities and barriers faced

by migrants both inside and outside the health arena (Región XV; Division of Healthy Public Policy and Promotion, 2017; Regional Government of Tarapacá, 2017). The analysis highlighted multiple barriers to receiving care (particularly at the hospital level), discrimination, poor treatment in health institutions and limited information regarding their functioning, and the challenge of responding to a highly multicultural society. One recurring topic was poor labour conditions and injuries and abuses suffered by migrants in the workplace, alongside general discrimination, xenophobia and racism in Chile and their effect on the mental health of migrants (Ministry of Health of Chile, 2018c).

20 Within this framework, the National Health Policy for International Migrants in Chile was created as an institutional response to both voluntary and forced international migration with the aim of guaranteeing migrants the right to health under the same conditions as the national population and acknowledging them as subjects protected by the law. The main goal of the NHPIM is to 'contribute to achieving the maximum health conditions possible for international migrants, with equity, under the human rights approach' (Ministry of Health of Chile, 2017, 30).

21 The Policy was established under the principles of civic engagement, equity, equality, and non-discrimination, and those of integrated healthcare (sectoral and multisectoral), multiculturality, gender, social cohesion and universality. As a whole these features are meant to engage a health sector response that accommodates the social conditions faced by migrants and seeks the resolution of key obstacles in order to ensure access to and use of necessary healthcare services.

22 The following strategies were proposed in order to achieve the Policy's goals:

23 Unification and adaption of the corresponding legal framework. This strategy used the pre-existent normative advancements as a reference point (Decree No. 67, on the financial protection of migrants' health through FONASA coverage) (Ministry of Health of Chile, 2016).

24 Development of a system sensitive to migrants, one that ensures accessibility as a path to exercising the right to health and seeks acceptance of available service options. This included actions to confront language barriers. In this way, a novel new sector was conceived around sociocultural action for health, which has allowed the incorporation of migrants as health service personnel, as intercultural mediators, and as linguistic facilitators. This contributed decisively to improving the quality, acceptability and interculturality of health services in Chile.

25 A comprehensive approach to health for international migrants. This strategy acknowledged the multideterminant nature of health and illness, and the subsequent need for a response that engages different social and government sectors with a territorial approach, and adjusts to the diverse living conditions of the population.

26 A shift towards a transnational approach to the health of international migrants within health programmes and interventions. This strategy allowed the insertion of migration into all different healthcare and health promotion programmes: notably, in those programmes related to life course, indigenous populations, mental health, communicable disease prevention, and the detection and management of chronic degenerative diseases.

27 - Work, health and migration. This was a key issue within the intersectoral health response given the significant contribution of migrants to economic development in

Chile. In order to address this, the Ministry of Health promoted the prevention of workplace accidents and illnesses that affect physical, mental and social integrity and require action in the legislative, regulatory, executive, auditing, and health promotion spheres.

28 - Communication and action against discrimination, xenophobia and the stigmatisation of migrants. Health is considered key to facilitating cohesion through participatory processes, social networks and positive attitudes to migration. In this way, step-by-step results are expected, beginning in the healthcare system itself and then developing concurrently within other government sectors and in the Chilean society, thereby contributing to reducing or eliminating xenophobic attitudes and the stigmatisation of migrants.

29 - Monitoring, evaluation and health data. Since the implementation of the Policy, health information regarding migrants in Chile has been included in the Chilean health information system. It is now possible to characterise the health situation of the migrant population, evaluate and analyse trends, and identify distinct groups and differences among diverse migrant populations and well as between them and the Chilean population. Thus, the health system has the information necessary to guide evidence-based decision-making.

30 Within this framework of legislative changes, and as part of the process of policy design, testing and adjustment, some short-term results are available. These serve to demonstrate the translation of political declarations into practice, and the contributions of these practices to economic and social development aligned with the SDGs of the 2030 Agenda.

31 In Chile, the contribution of migrants to national economic and social well-being is well-documented, representing USD 4 billion, 4 per cent of the gross domestic product (GDP) (Urria, 2020). Furthermore, migrant remittances have made a significant contribution to countries of origin: USD 1,520,000,000, as documented in 2018. Colombia, Peru and Haiti together received 65.6 per cent of this total, followed by Bolivia, the Dominican Republic, Ecuador and China, among others (Central Bank of Chile, 2020).

32 In the health field, the following sections show the contributions of the NHPIM in Chile (Ministry of Health of Chile, 2017), which are directly linked to the creation of conditions that allow the effective exercise of the right to health, in line with SDG 3 (Good health and well-being) through the following dimensions: universal health coverage, including protection against financial risks, and access to essential and high-quality health services (including sexual and reproductive health, neonatal and child care, and communicable and non-communicable disease care).

33 Health insurance coverage is shown in Table 14.2 in the form of the distribution of health insurance coverage (self-reported beneficiary status with regard to any public or private health insurance) for the Chilean population and the migrant population in Chile. The proportion of the migrant population covered by FONASA remained steady without significant variation during the period of interest; nonetheless, the net number of migrants covered by this public insurance doubled between 2013 and 2017. In total, 81.1 per cent of migrants reported coverage by some form of public or private health insurance in 2017.

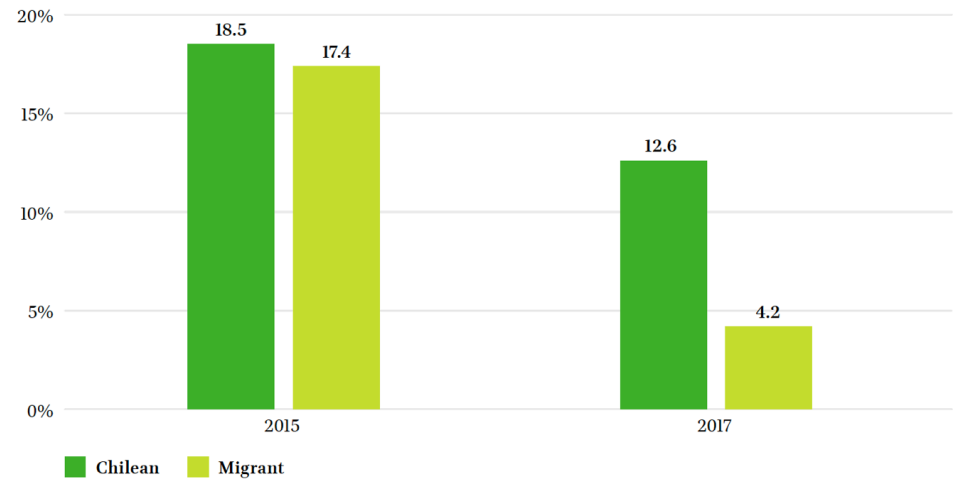
**Table 14.2 Distribution of health insurance coverage (public and private) for the Chilean population and the migrant population in Chile, 2013–17**

| | 2013 | | 2015 | | 2017 | |
|---|---|---|---|---|---|---|
| | n | % | n | % | n | % |
| Chilean | | | | | | |
| FONASA | 13,116,511 | 78.6 | 13,189,144 | 77.7 | 13,248,136 | 78.7 |
| Private | 2,361,099 | 14.2 | 2,542,521 | 15.0 | 2,419,529 | 14.4 |
| Other | 493,162 | 3.0 | 492,232 | 2.9 | 476,681 | 2.8 |
| None | 422,224 | 2.5 | 459,799 | 2.7 | 378,239 | 2.2 |
| Migrant | | | | | | |
| FONASA | 243,599 | 68.7 | 288,539 | 62.0 | 506,353 | 65.1 |
| Private | 64,095 | 18.1 | 81,733 | 17.6 | 114,039 | 14.4 |
| Other | 8,088 | 2.2 | 13,409 | 2.9 | 12,378 | 1.6 |
| None | 31,535 | 8.9 | 73,071 | 15.7 | 123,013 | 15.8 |

Source: Ministry of Social Development of Chile (2020a). CASEN Survey: Databases, http://observatorio.ministeriodesarrollosocial.gob.cl/casen-multidimensional/casen/basedatos.php (accessed on 10 January 2021).

34 The collective levels of barriers to health service access are shown in Figure 14.1. Public sector outpatient health services use a scheduled care agenda; the population was surveyed on their ability to schedule a care appointment at a date and time that met their needs. A comparison between migrants and Chileans between 2015 and 2017 demonstrates important changes in the frequency of perceived problems in scheduling timely care in both populations; these changes were more favourable for migrants than for the general Chilean population.

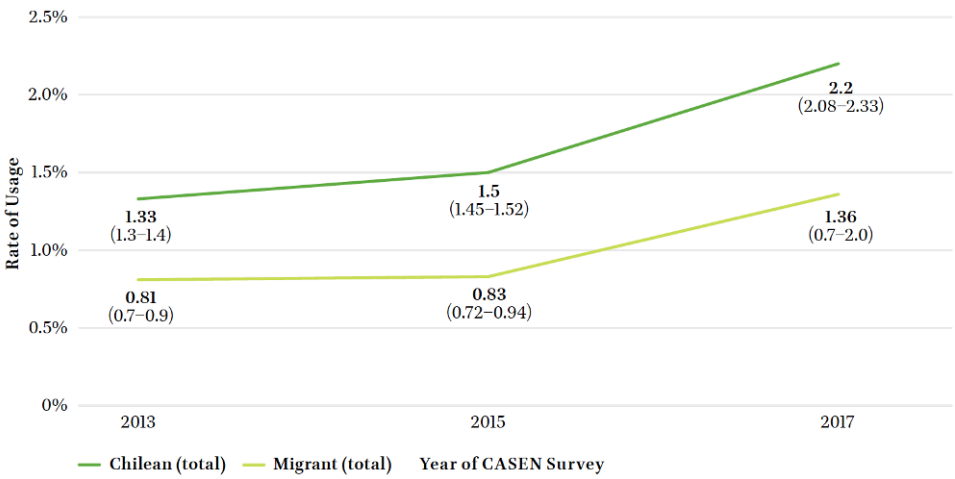
**Figure 14.1 Proportion of patients who received healthcare services and declared experiencing a problem obtaining a medical appointment, 2015–17**




Source: Ministry of Social Development of Chile (2020a). CASEN Survey: Databases, http://observatorio.ministeriodesarrollosocial.gob.cl/casen-multidimensional/casen/basedatos.php (accessed on 10 January 2021).

35 The rate of general healthcare service usage increased across both populations (Figure 14.2). With regard to effective usage, however, a considerably lower rate is observed for the migrant population than for the general Chilean population throughout the period.

**Figure 14. Rate of general healthcare service usage* for the Chilean population and the migrant population in Chile, 2015–17**



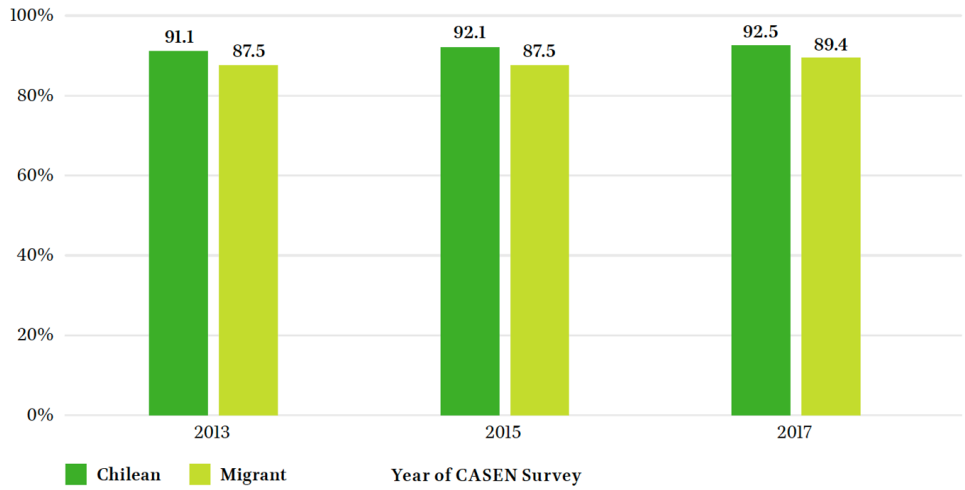

Source: Ministry of Social Development of Chile (2020a). CASEN Survey: Databases, http://observatorio.ministeriodesarrollosocial.gob.cl/casen-multidimensional/casen/basedatos.php (accessed on 10 January 2021).

*Rate of general healthcare service usage: number of instances of care provided by outpatient services for general medicine, emergency, mental health, or specialisations including dental, over the total population for each year according to the CASEN Survey (CI 95%).

36 Healthcare provision for health issues (receiving medical attention for a health issue in the three months prior to the survey) is addressed in Figure 14.3. A reduction was

observed in the gap between Chileans and migrants during the period 2013 to 2017, the figure falling from 3.6 per cent to 3.1 per cent.

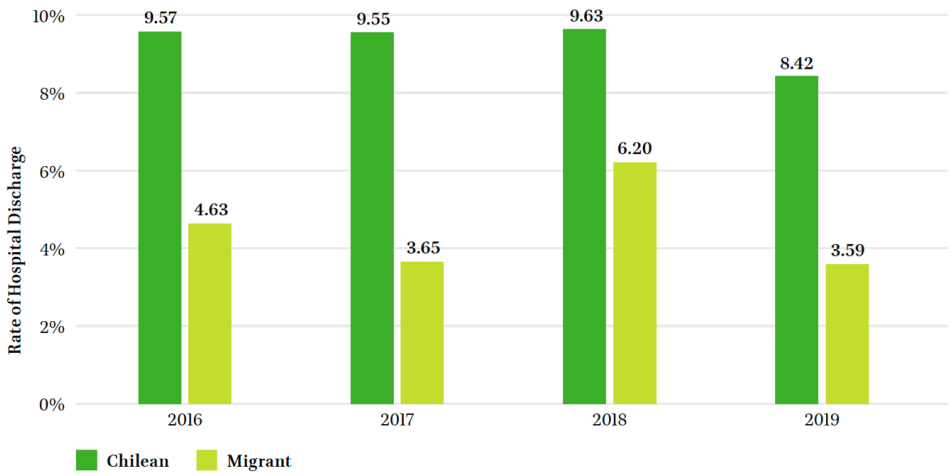
**Figure 14.3 Percentage of Chileans and migrants in Chile who received healthcare services for a health issue in the past three months, 2013–17**




Source: Ministry of Social Development of Chile (2020a). CASEN Survey: Databases, http://observatorio.ministeriodesarrollosocial.gob.cl/casen-multidimensional/casen/basedatos.php (accessed on 10 January 2021).

37 Figure 14.4 shows rates of hospital discharge. The rate of hospital discharge in the general Chilean population was over twice that in the migrant population across the full period of interest.

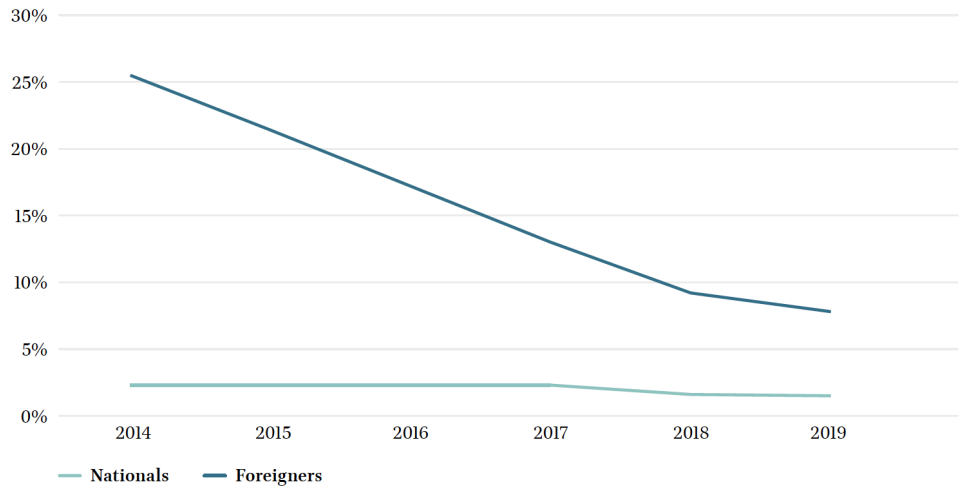
**Figure 14.4 Rate of hospital discharge for the Chilean population and the migrant population in Chile, 2016–19**




Source: Department of Health Information Statistics of Chile (2020a). 'Statistics of hospital discharges at the country level by year; Statistics of hospital discharges at the country level by primary diagnosis at hospitalisation, sex, age group and forecast; Statistics of hospital discharges at the country level by year and nationality'.

38 The differences observed in the rate of hospital discharge may be attributable to, among other factors, the structure of the populational pyramid of migrants in Chile as compared to Chileans instead of to economic obstacles to direct payment for hospital services. This may be affirmed by the proportion of discharged patients who were not covered by health insurance, which fell from 25 per cent to 7 per cent of total migrant hospital discharges from 2014 to 2019 (Figure 14.5).

**Figure 14.5 Proportion of patients discharged from hospital who were not covered by any health insurance, by nationality, 2014–19**




Source: Department of Health Information Statistics of Chile (2020b). 'Statistics of hospital discharges at the country level by year; Statistics of hospital discharges at the country level by primary diagnosis at hospitalisation, sex, age group and forecast; Statistics of hospital discharges at the country level by year and nationality'.

39 Finally, as far as access to healthcare services providing family planning and prenatal care to Chilean and migrant women between 2015 and 2017 (Table 14.3), a remarkable change was observed in the number of female migrants using these healthcare services. The number of pregnant women receiving prenatal care more than doubled, representing a 1.23-fold increase as compared to the total of migrant women from the age of 15 to 49 in the same period. The number of migrant women who reported using family planning services increased by 76 per cent during the period of interest, reflecting improved service access. In Chilean women, no significant changes were observed in either the number or proportion of users of family planning services.

**Table 14.3 Access to prenatal and family planning services for the general Chilean population and the migrant population in Chile, 2015–17**

| Year | | Pregnant women with prenatal care (n) | Proportion of pregnant women/ total women 15–49 years of age | Women 15–49 years of age using contraceptives (n) | Proportion of women 15–49 years of age using contraceptives | Estimated population (women of reproductive age: 15–49 years old) |
|---|---|---|---|---|---|---|
| 2015 | Chilean | 91,349 | 2.3 | 1,412,898 | 42.3 | 3,343,206 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Migrant | 4,795 | 3.98 | 17,955 | 14.9 | 120,521 |
| 2017 | Chilean | 79,842 | 2.47 | 1,417,464 | 43.8 | 3,238,403 |
| | Migrant | 10,302 | 4.88 | 31,623 | 15.0 | 211,125 |
| Difference between figures 2017/2015 | Chilean | -0.13 | 1.07 | 1.00 | 1.04 | -3.13 |
| | Migrant | 2.15 | 1.23 | 1.76 | 1.01 | 75.18 |

Source: Department of Health Information Statistics (2020a). Service moments of the public aid network, monthly statistical summaries DEIS. The population was estimated using the CASEN Surveys of 2015 and 2017 for each age group range (Ministry of Social Development of Chile, 2020a).

# 4. Discussion

40 The protection of human rights is a principle established mainly within instruments that require only voluntary governmental compliance, which frames it as a humanitarian action. Under such conditions, highly varied discourses around migrant rights have multiplied, but concrete mandates are rarely obligatory given that they generally remain subject to good will and current political interests.

41 The present analysis explores the formulation and implementation processes, and the short-term results, of the National Health Policy for International Migrants in Chile. The formulation of the NHPIM was based on evidence generated through an extensive participatory process involving social organisations, co-operative entities, academic institutions and government, and constitutes one of only a few examples globally that demonstrates a path to translating political discourse into social practices related to the protection and promotion of migrants' right to health. It is not a policy designed within the four walls of a government office, but one that was crafted and almost simultaneously put to the test by those working alongside the populations represented by the various participating institutions. Its formulation drew certain criticisms, which then enabled the reconsiderations that were necessary to adjust its content to the current needs of society. The migrant population is part of the new social dynamics in Chilean society; the country's institutions create and recreate guidelines that favour the functioning of organisations and society as one, and the health policy for migrants is an instrument that helps facilitate processes based on the acknowledgement of migrants as having equal rights with the non-migrant population. Consequently, the NHPIM represents a significant advancement towards facilitating the guaranteeing of migrants' rights and ensuring migrants' access to public sector health services, which has frequently been either restricted or denied to them in their countries of origin. Today, the legislative and legal status of the Policy, as well as the regulatory and financial documents that support it, must be acknowledged by the greater overarching framework (laws) in order to minimise discretional interpretations and implementation practices (Stefoni, 2011; Liberona Concha and Mansilla, 2017; Larenas-Rosa and Cabieses, 2018).

42 The process of formulating the Policy had three elements that enabled the representation of different interests and perspectives of society regarding migrant

health. First, it was established as a collective construction process with participation by migrants and health professionals in the field who performed participatory diagnostics and created solutions relevant to the territory in question, using an intersectoral approach. Second, the creation of the Policy was part of a creative space designed to be a laboratory for the exchange of ideas, which aimed to incorporate strategies for reducing healthcare service access barriers and to test and monitor them through public campaigns in the follow-up period in order to adjust the Policy to specific conditions as needed.

43 The NHPIM took on structural barriers that are key determinants of healthcare service access: first, the legislative and legal aspects of public sector health insurance coverage, and second, the financial resources necessary to cover institutional costs associated with healthcare service use across different areas (health promotion, risk prevention, care for damages and rehabilitation). The Policy integrates guarantees previously established in Decree No. 67 (Ministry of Health of Chile, 2016), applying the principles of equality and non-discrimination by incorporating migrants in the list of groups recognised as experiencing the greatest conditions of vulnerability, and recognising them as subjects of equal rights under the law and as legal beneficiaries of FONASA. It acknowledges 'equality of rights between migrants and [Chilean] nationals', which forms a structural condition necessary to support the exercising of the right to health (Ministry of Health of Chile, 2017). This process of institutionalisation has enabled progress to be made in specific programmes such as the Healthcare Access Programme for Migrants, which began in just five *comunas* (the smallest national legal division of territory) and has, at the time of writing, expanded to over 24 municipalities (*El Nacional*, 2019).

44 One of the most important adjustments to the organisation and functionality of the public sector health system has been the inclusion of sociocultural diversity through the incorporation of 'intercultural mediators', mostly migrants themselves, into healthcare services; this has been especially impactful for Haitian communities, who encounter significant language barriers. The actions of these intercultural mediators have been critical, not only in translation and the social interpretation of language but also to spark social interaction in healthcare spaces, considering that cultural diversity is a core value and as such represents a resource and not an obstacle. Nonetheless, it has been noted that this initiative requires increased budget allocations and formal consolidation within the health sector (Sepúlveda and Cabieses, 2019).

45 The observed short-term results include ample coverage of the migrant population by FONASA. This coverage remained steady across the period of interest, despite the increase in the net number of migrants at the national level (this figure nearly doubling). Nevertheless, the proportion of migrants who reported not having health coverage also remained steady, thereby demonstrating a challenge in incorporating the growing number of migrants. It is possible that the population who reported not having FONASA coverage is one of more recent migrants, who have spent one year or less in Chile. Nevertheless, this lack of coverage is not a result of legislative or legal barriers, but may be related to information access barriers or the complex processes involved in insertion into social networks. Furthermore, the increase in nominal health coverage by FONASA does not necessarily imply corresponding use of services, especially for high-cost services including those provided by hospitals. The present analysis revealed a 3.2-fold decrease in the proportion of hospital discharges without

FONASA health coverage, while the rate of hospital discharges remained constant across the study period. The trends in this indicator reveal one of the most significant results with regard to more effective financial protection for healthcare services, with an important impact and relevance for the economy and the lives of migrants in Chile.

46 Furthermore, both the general healthcare service usage rate and the percentage of migrants with any health issue who received healthcare showed a remarkable increase across the period of interest. In both cases, the gap observed at the beginning of the study period was reduced, although a difference remained between service usage rates among migrants and among the general population, with migrants reporting lower rates. This difference may be related to other socio-demographic factors (age, for example) or cultural factors, as well as to factors related to information and stigma. It does not, however, appear to be attributable to economic (direct payment for services), legislative, or legal factors (Benítez and Velasco, 2019). One hypothesis is that despite the high proportion of the migrant population with financial coverage through FONASA, this did not translate into excessive health service demand and usage; on the contrary, it would appear that the socio-demographic features of the migrant population (younger than the Chilean population) determine service usage patterns distinct from those of the general population.

47 As far as healthcare service usage goes, the primary level of care (including the population receiving prenatal care and family planning services) also reflected important changes related to service access improvements for migrants. The number of pregnant women in the prenatal care programme more than doubled, and there was a 76 per cent increase in the number of women accessing contraceptives. Changes in these highly sensitive indicators could be associated with other factors such as behavioural changes; however, they also reflect improved access to healthcare services for migrants in Chile.

48 Finally, the response of the healthcare system to the demands of the migrant and general Chilean populations demonstrates very favourable changes, from a migrant perspective. According to the CASEN Survey, the proportion of individuals receiving healthcare services who also declared having experienced problems making an appointment or scheduling care between 2013 and 2017 decreased sharply for migrants over the period; that is, those seeking care obtained a medical appointment with far fewer issues. One possible explanation for this is that dissemination activities such as the distribution of flyers, communication campaigns, intercultural mediators, etc. effectively reached the target population. Another important factor that could contribute to an understanding of this gap is the differential capacity for the exercise of rights between migrants and native-born Chileans; although in both cases an improvement can be seen, this improvement is greater for migrants (Intersectoral Board for Migrants and Health, 2015; Ministry of Health of Chile, 2015d, 2015c; Health Services of Viña del Mar, 2017).

49 The greatest area of challenge and opportunity was related to rejection and discrimination. Although the qualitative study of the systematisation and evaluation of pilot studies described a perceived improvement in healthcare, with a positive evaluation of strategies such as the provision of intercultural mediators (Ministry of Health of Chile, 2018c), evidence exists showing stigmatisation, discrimination and poor treatment of migrants within the health system (Chepo et al., 2019; UNICEF, 2020). Reports reveal that the most vulnerable groups in this regard are Afro-Latinos,

pregnant and postpartum migrant women, and migrant children and adolescents. It is critical to continue advancing the principles of the NHPIM, and to work towards culturally relevant health and intersectoral action, as well as the design of permanent mechanisms for the promotion, monitoring and oversight needed for migrants to receive dignified care.

50 The scientific literature on migration and health in Latin America, and at a global level, reveals only limited advancements in migrants' access to and effective use of financially protected healthcare services (Leyva-Flores et al., 2015; Larenas-Rosa, Astorga-Pinto and Cabieses, 2018). In contrast, the NHPIM addresses precisely the conditions that have attracted attention within numerous scientific publications, including barriers to healthcare system access (Hacker et al., 2015), financial obstacles (Magalhaes, Carrasco and Gastaldo, 2010) and cultural (Fleischman et al., 2015; Hacker et al., 2015) and other (Winters et al., 2018) barriers. For this reason, the Chilean experience, based as it is in evidence supporting the value of health promotion and the protection of rights, is a reference for the design and implementation of health policy around international migrants, especially those experiencing the greatest social vulnerability.

## 5. Conclusions

51 The National Health Policy for International Migrants in Chile guarantees migrants access to healthcare with conditions equal to those applicable to the general population and provides evidence of the remarkable contributions made with regard to goals related to gender equity, maternal and infant health, reducing financial (FONASA coverage) and sociocultural (intercultural mediators) barriers to healthcare service access, and more. It also brings to light migrants' economic contributions to destination countries (in the form of tax revenues) and to their countries of origin (in the form of remittances), which combined support the economic development of Chile and that of migrants' countries of origin, in line with the UN 2030 Agenda.

52 The experience of formulating this evidence-based policy, with the participation of different governmental and societal sectors, has allowed legislative and legal changes that formally separate migratory status from migrants' right to health. These changes have facilitated the emergence of public sector financing, through FONASA, which covers the costs of outpatient and inpatient care, and of other financial resources necessary for the development of activities related to culturally relevant health promotion. The reduction of legislative, legal, financial and cultural barriers was clearly demonstrated through evidence of the use of inpatient and outpatient services and of significant reductions in high-cost hospital discharges without FONASA coverage.

53 Finally, evidence shows that migrants in Chile are on average a young population, and that these improvements have not translated to excessive demand for or use of high-cost services, even though there may be sufficient financial protection for migrants to do so. Assertions to the contrary are only one of the many aspects of stigma present in societies that are traditional destinations for migration, and in Chile ignore evidence that migrants contribute to the economic development of the country.

54 The Sustainable Development Goals of the UN 2030 Agenda were founded on guiding principles including 'leave no one behind' and 'guarantee human rights for all'.

Globally, evidence regarding the inclusion of migrants within the framework of these principles is scarce. Experiences in Chile, however, show that it is possible to translate aspirational discourse into concrete social practices that favour human rights. This process is not free of the social tensions fuelled by stigma and discrimination, and these must be consistently monitored and addressed. When it comes to migration, Chile is currently confronting new realities, changes in styles and forms of government, global epidemiological crises, and problems with stigma and discrimination, all of which can only be addressed with the active participation of both Chilean society and migrants in Chile.

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## ABSTRACTS

At the global level, the equal recognition of migrant rights is among the most important challenges for modern society. This chapter aims to analyse the formulation and implementation processes of the National Health Policy for International Migrants in Chile (NHPIM), as well as its short-term results, from 2014 to 2017. It is based on a review of the literature on and deriving from the consultative processes performed in communities with high mobility and residency rates for international migrants, and key documents related to the Policy. It analyses public sector health coverage from the National Health Fund of Chile (*Fondo Nacional de Salud*, or FONASA), health service usage, and fulfilment of health needs, comparing the general Chilean population to the migrant population in Chile using data from the National Socioeconomic Characterization Survey (CASEN Survey) from 2013, 2015 and 2017.
The formulation of the NHPIM was a response to evidence generated through consultation and social participation. It eliminated legislative and legal barriers, and favoured financial protection through coverage by FONASA. Over the period analysed, the number of migrants with FONASA coverage doubled (from 243,000 to 506,000); the rate of healthcare service usage increased (from 0.81 to 1.36 per 100 migrants); the rate of hospital discharges remained steady (3.2 per 100 migrants), although the net number of discharges doubled; and the proportion of migrant hospital discharges without FONASA coverage fell from 25.5 per cent to 7.8 per cent. The protection of the right to health for international migrants in Chile is a prime example of the effective translation of political discourse into concrete social practice.

Au niveau mondial, un des défis les plus importants pour la société moderne est de reconnaître de manière égale les droits des migrants. Ce chapitre analyse la manière dont la Politique nationale de santé pour les migrants internationaux (PNSMI) a été élaborée et mise en œuvre au Chili, ainsi que ses résultats à court terme, de 2014 à 2017. Il s'appuie sur une revue de la littérature sur et découlant des processus consultatifs réalisés dans les communautés à fort taux de mobilité et de résidence de migrants internationaux, ainsi que sur des documents clés liés à cette politique. Il analyse la couverture sanitaire du secteur public par le Fonds national de santé du Chili (FONASA), l'utilisation des services de santé et la satisfaction des besoins en matière de santé, en comparant la population chilienne générale à la population migrante au Chili, à l'aide des données des enquêtes nationales de caractérisation socio-économique (enquête CASEN) de 2013, 2015 et 2017.La formulation du NHPIM a été une réponse aux données résultant de la consultation et la participation sociale. Elle a éliminé les obstacles législatifs et juridiques et a favorisé la protection financière par la couverture du FONASA. Au cours de la période analysée, le nombre de migrants bénéficiant d'une couverture FONASA a doublé (de 243 000 à 506 000); le taux d'utilisation des services de santé a augmenté (de 0,81 à 1,36 pour 100 migrants); le taux de sorties d'hôpital est resté stable (3,2 pour 100 migrants), bien que le nombre net de sorties ait doublé; et la proportion de sorties d'hôpital de migrants sans couverture FONASA a diminué de 25,5 % à 7,8 %. La protection du droit à la santé des migrants internationaux au Chili est un excellent exemple de traduction efficace du discours politique en pratique sociale concrète.

## INDEX

**Geographical index:** Chile
**Keywords:** governance, migration, migration policies, global south, health, human rights, social protection

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