


Public expenditures with hospital and out-of-hospital services in Chilean community model of mental health

Gasto público en prestaciones hospitalarias y extrahospitalarias en el modelo de salud mental comunitaria en Chile

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Abstract

The following study analyzes public spending on Mental Health within the framework of the implementation of the community model in Chile. It examines the financing mechanism and the allocation of financial resources in Mental Health, considering the resources executed in hospital and out-of-hospital services in the public health system during the period 2014-2018. In general, an increase in the number of hospital and out-of-hospital services is observed, as well as in the expense derived from them. The largest increases in monetary investment refer to the application of electroshock, rehabilitation programs type 2, full bed-day psychiatric/diurnal treatments and full bed-day hospitalization/short-stay. It is concluded that the validity of the asylum model, the biomedical predominance and the excessive medicalization in Mental Health support an inequity in the valuation of services as well as an unequal distribution of public resources. This situation requires a reorientation of state spending towards community services that guarantee citizenship rights and the promotion of well-being.

Keywords: Mental Health; Health System; Public Expenditure; Community Model; Chile.

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Resumen

El presente trabajo analiza el gasto público en salud mental en el marco de la implementación del modelo comunitario en Chile. Para ello, examina el mecanismo de financiamiento y la asignación de recursos financieros en salud mental considerando los recursos ejecutados en prestaciones hospitalarias y extrahospitalarias en el sistema público de salud en el período 2014-2018. En general, se observa un aumento del número de prestaciones hospitalarias y extrahospitalarias, así como en el gasto derivado de las mismas. Los mayores incrementos de inversión monetaria refieren a la aplicación de electroshock, programas de rehabilitación tipo 2, día cama integral psiquiátrico diurno y día cama hospitalización integral corta estadía. Se concluye que la vigencia del modelo asilar, el predominio biomédico y la excesiva medicalización de la salud mental sustentan una inequidad en la valoración de las prestaciones, así como una desigual distribución de los recursos públicos, siendo necesario reorientar el gasto estatal hacia servicios comunitarios que garanticen derechos de ciudadanía y la promoción del bienestar.

Palabras clave: Salud Mental; Sistema de Salud; Gasto Público; Modelo Comunitario; Chile.

Introduction

In Latin America, the development of comprehensive mental health policies and the strengthening of a community-based service model have been promoted. The Caracas Declaration of 1990 was a historic landmark in the region, emphasizing that the focus on psychiatric hospital care should be replaced by a community mental health model that is decentralized, participatory and integrated (OPS, 2009). In accordance with these guidelines, public mental health policies in Chile have been characterized by the creation of territorial services, reducing the welfare role of psychiatric hospitals and increasing the number of people in community and primary care facilities (Minoletti; Zaccaria, 2005; Minoletti et al., 2018). The integration of psychiatry into the health system as a specialty and the extension of an outpatient care network with interdisciplinary teams diversified the range of services offered and increased public funding for mental health, promoting access to this kind of care for the population (Minoletti; Sepúlveda, 2017).

Nowadays, despite the progress in the availability of mental health services under a community model, psychiatric hospitals still in force. Important gaps remain in the quality of care and in the users' rights (Cea-Madrid, 2019; Minoletti et al., 2015) and there are growing indicators of social dissatisfaction and subjective discomfort among the citizens in general (Aceituno Morales; Miranda Hiriart; Jiménez Molina, 2012; Quijada et al., 2018). Along with this, organizations have promoted collective actions for the defense of rights, potentializing the public debate in the field of mental health (Cea-Madrid, 2018b).

In this context, institutional actors argue that the percentage of public health expenditure allocated in mental health has not increased according to the proposed objectives and that resources would be insufficient in light of the demands for care (Errázuriz et al., 2015; Minoletti et al., 2018). However, limited studies addressed the mechanisms of distribution of public expenditure in mental health, looking at the various forms

of care, the allocation of financial resources and their effective use in the health system. In this regard, this publication examines trends in public investment on mental health in the implementation of the community model, analyzing the number of implementations and the amounts of funding for hospital and out-of-hospital services in the Chilean public health system in the period 2014-2018. This perspective aims to contribute to the current debate on the state of implementation of the community approach, allowing the advances and achievements of the mental health care system to be visualized from the perspective of income distribution, as well as to critically analyze the gaps and disparities in the allocation of resources in the Chilean community mental health model.

Mental health system and community model in Chile

The mental health system refers to the set of public services that provide mental health care to the population. In Chile, this system is characterized in recent years by an increase in the number of facilities providing mental health care, an expansion of mental health care coverage in primary care, and a duplication of general hospitals with psychiatric hospitalization units (Minoletti et al., 2018). In this perspective, the Chilean mental health system developed a network of care under the guidelines of the community model, which integrates outpatient care, acute hospital care in general hospitals and residential care based on the community (Barbui; Papola; Saraceno, 2018). This approach led to a higher rate of outpatient care than closed care and a higher percentage of outpatient services than residential services (MINSAL, 2014).

One of the main factors that favored the implementation of the community model is the provision of a growing budget for mental health, mostly allocated to the new community services and with cost definitions for the different services (Minoletti et al., 2018). In addition, the Community approach in Chile is linked to the new model of public management, which establishes the importance of meeting quantifiable objectives

that make it possible to evaluate the effectiveness of services. In this regard, the potential of the community model to reduce treatment gaps, increase coverage and improve inequality in access to care is emphasized, among other services (Minoletti et al., 2018). However, the formation of a health system oriented to the fulfillment of goals and results favors the offer of services over the demands of the population and reinforces the standardization of care processes, configuring financing and resource allocation mechanisms that contradict the principles of the community model in terms of equity, participation, quality of care, and respect of rights.

Firstly, there is a predominance of the biomedical model and pharmaceutical coverage in the mental health care processes. In this respect, psychiatric diagnosis is positioned as the axis and starting point for all policy and intervention in this area (Encina, 2014). On the other hand, beneficiaries of the public health system have free access to essential psychotropic drugs and the adequate availability of these drugs in ambulatory care centers increased from 78% in 2004 to 97% in 2012 (MINSAL, 2014). Thus, rehabilitation and community support programs in mental health have a strong biomedical component in their care processes and are developed under the pharmacological paradigm (Castillo-Parada, 2018; Cea-Madrid, 2018a). At the same time, limitations concerning the frequency and diversity of benefits in the different components of the mental health network are described, highlighting the implementation of a higher percentage of psychosocial and community interventions in community mental health centers than in outpatient psychiatric units, affecting the equity and integrality of territorial based care (MINSAL, 2014).

Secondly, the institutional reform of psychiatric hospitals has been insufficient to ensure their closure and replacement. The asylum model remains in place with four psychiatric hospitals at the national level: El Peral; Hospital Psiquiátrico del Salvador; Dr. Philippe Pinel and Dr. José Horwitz Barak, institutions that currently make up the public health system and maintain a hegemonic presence in the central zone of the country.

Although the number of beds in psychiatric hospitals has decreased, especially at the cost of fewer hospital beds for long-term care, there are indicators of human rights violations based on involuntary admission procedures, mechanical containment measures, confinement in isolation wards, overmedication, maltreatment, punishment, physical and sexual abuse. Also described is the lack of information regarding the number of people admitted and the reasons why they remain in a situation of abandonment and exclusion, as well as the absence of mechanisms to safeguard rights in these facilities (INDH, 2017).

Thirdly, with regard to respect for the rights of users of outpatient psychiatric services, the right to an independent life and to be included in the community are described as having a low level of compliance at the national level (Minoletti et al., 2015). It is also noted that residential support devices (homes and residential facilities) have restrictive rules that limit the ability of residents to make decisions in basic areas of their lives (Grandón Fernández et al., 2015). In this regard, it has been suggested that protected homes and houses, although they have played a central role in the implementation of the community model, reproduce asylum practices because they are highly regulated places with continuous staff supervision. Places with activities considered as routine and with little linkage to the local network, keeping residents away from the community, which sustains transinstitutionalization logics (Bouey-Vargas; Cuarán-Collazos, 2019; Chuaqui, 2015).

Fourth, the promotion and prevention actions implemented by users' organizations and mutual support groups do not receive funding from the health sector, and therefore do not have economic support for their development. On this point, an evaluation found that only 18% of health services at the national level carried out regular activities with groups of users, family members, and other community organizations, which indicates insufficient prioritization of this kind of action (Minoletti et al., 2018). On the other hand, the generation of opportunities for education, employment and social welfare has been derived

to the intersector (external services of the health area) with little collaboration and networking, so there are no economic resources for these initiatives from the health area too. In this sense, actions aimed at access to work, education, and social participation promoted by the community have remained outside the mental health system and its financing mechanisms.

In short, the hegemony of the biomedical model, the extension of the pharmacological paradigm and the reproduction of manicomial logics in ambulatory and residential care modalities are the main challenges to the development of the community model in Chile. Moreover, the mental health system has presented restrictions to guarantee actions aimed at the exercise of rights and the promotion of citizenship, in accordance with the community approach. Therefore, it is relevant to analyze critically the financing of services in the public health system in relation to the implementation of the community mental health model, highlighting the barriers and limitations in this area.

Methodology

In Chile, the health system is mixed, composed of funds by public and private providers (Vergara-Iturriaga; Martínez-Gutiérrez, 2006). The public sector is organized into 29 health services, covering all regions of the country and providing care to 78% of the population. Its funding body is the National Health Fund (FONASA), which operates as a public health insurance provider and obtains its resources from the mandatory health contributions of workers who choose it as health insurance plus state subsidies (Minoletti; Zaccaria, 2005; Vergara-Iturriaga; Martínez-Gutiérrez, 2006).

As the financial entity in charge of collecting, managing, and distributing public funds for health in Chile, FONASA finances the health services of its beneficiaries. It has a record of the number of services provided and the resources implemented associated with them on an annual basis, creating a statistical record that makes it possible to obtain objective data about the actions carried out in the public health system. Although FONASA uses

a set of payment mechanisms (budget by items according to specific categories, payment per capita in municipal primary care, etc.), monetary investment through payment for valued benefits (PPV) represents the largest amount of resources in mental health (about 60%), therefore, payment per action provided represents a relevant indicator to analyze trends in public spending in this area. Thus, in order to approach this area of study, in June 2019 via the public information access portal, the National Health Fund (FONASA) was asked to provide the number and effective payment of eight hospital and out-of-hospital mental health services implemented in the Chilean public health system in the period 2014-2018.

This period of investigation includes the last year of publication of the second report "Chile's mental health system" (MINSAL, 2014) and the second year of the most recent "National Mental Health Plan" (MINSAL, 2017), providing updated information about the development and operation of mental health services from the perspective of financial resource allocation. As to the terminology proposed - hospital and out-of-hospital mental health services - these are analytical categories used in studies referring to public spending trends in this area (Gonçalves; Vieira; Delgado, 2012; Nunes et al., 2019).

For this research, the selected hospital and out-of-hospital services represent the most significant actions with financial support from the secondary and tertiary level of mental health care in Chile. Although all the benefits analyzed are within the public system, some out-of-hospital actions have been carried out by foundations, by corporations and family organizations that manage psychosocial rehabilitation centers and/or residential facilities, through agreements with the health services and with public insurance funds (FONASA).

We understand as hospital services the actions that are developed in closed care modalities in psychiatric hospitals or psychiatric services in general hospitals. Within this framework, the following benefits are considered:

Full bed-day hospitalization in psychiatry sector/short-stay: action defined as

the care of persons who, as a result of a psychiatric illness, present symptoms or behavioral alterations that severely disrupt their well-being and family or social life, requiring specialized treatment that can only be carried out in a complete hospitalization, or who represent a danger to themselves or others. The maximum period of hospitalization for this benefit is 60 days. (FONASA, 2009, p. 14-15, our translation)

This service is provided in general hospitals and psychiatric hospitals.

Bed-day hospitalization in psychiatry sector/mid-stay: service

for patients with severe psychiatric pathology and/or psychosocial disability or resistant to usual procedures. These patients must be treated initially in a short-stay service, until a maximum time of 60 days, and then they can stay in the mid-stay service, until completing a maximum period of hospitalization of 12 months. (FONASA, 2009, p. 15, our translation)

This service is provided in psychiatric hospitals, with 198 beds nationwide (MINSAL, 2017).

Full bed-day hospitalization in psychiatry sector/chronic: corresponds to the

care of patients with chronic psychiatric disorders, with mental disabilities who were admitted to this type of service before the entry into force of the exempt resolution that approved the fee for the year 2000 and who are not in a clinical condition to be cared for in a lesser degree of institutionalization. (FONASA, 2009, p. 15, our translation)

This service is provided in psychiatric hospitals, with 372 beds nationwide (including 146 beds in the Raquel Gaete Clinic, under an agreement with the Dr. José Horwitz Barak Psychiatric Institute) (MINSAL, 2017).

Electroshock: also called Electroconvulsive Therapy is a psychiatric procedure that involves the application of electrodes on the head for the purpose of transferring electricity to the brain to

cause a seizure, is used “for extremely severe cases or as a rescue scheme in situations when other pharmacological or psychotherapeutic interventions failed” (MINSAL, 2000, p. 7-8).

On the other hand, we understand as outpatient services the actions carried out in out-of-hospital care modalities aimed at rehabilitation and social inclusion associated with day hospitals, day centers, community mental health centers and residential in protected homes. In this respect, the following benefits are considered:

Bed-day hospitalization in a protected home: this benefit can be charged

when the beneficiary stays in a community housing facility authorized to receive no more than 15 patients and that is duly accredited by the Ministry of Health. This benefit is for patients who are compensated for their psychiatric illness, who are not able to live independently, and who have no family, or their family is unable to support them. It includes basic care by technical staff with professional supervision and accommodation and food costs. (FONASA, 2009, p. 15, our translation)

Full bed-day hospitalization in psychiatry sector/diurnal: This service

corresponds to each day of hospitalization in a general or psychiatric hospital, provided with clinical services suitable for the treatment of these patients. It includes all diagnostic, therapeutic and psychiatric rehabilitation procedures performed on the patient during the stay in the facility. It will be charged when the beneficiary remains at least 6 hours in the facility and without an overnight stay. In case of a stay of less than the established time, this benefit will not be charged. (FONASA, 2009, p. 16, our translation)

Rehabilitation program type 1: This service consists of

the regular and continuous provision of a package of psychosocial rehabilitation activities for eight to fourteen hours a week, at least three days a week, for a maximum period of two years, for a group of

between six and ten persons with mental illness and psychosocial disability, including medication and examinations. The activities of the rehabilitation program include personalized follow-up, individual sessions, family and group sessions aimed at recovering and reinforcing capacities and skills for an autonomous life, in the community and for social and labor reinsertion. (FONASA, 2009, p. 22, our translation)

Rehabilitation program type 2: This service consists of

the regular and continuous provision of a package of rehabilitation activities for eighteen to thirty hours a week, over a minimum of four days, for a maximum period of two years, of a program of rehabilitation activities for a group of between five and seven persons with mental illness and a higher level of psychosocial disability, living with their relatives or residing in protected homes. It includes medication and examinations. The activities of the rehabilitation program include personalized follow-up, individual sessions, family and group sessions aimed at recovering and reinforcing capacities and skills for an autonomous life, activities focused on daily life inside the home, in the community and social and labor reinsertion. (FONASA, 2009, p. 22, our translation)

In accordance with these definitions and the data obtained, the amounts of hospital and out-of-hospital services financed by FONASA and executed in the public health system in the period 2014-2018 are presented below.

Hospital and out-of-hospital services in mental health in Chile (2014-2018)

Based on the information obtained about hospital services financed by FONASA between 2014 and 2018, Table 1 describes the number of actions carried out and the monetary values associated with each service in the period evaluated.

Consequently, with the data presented above, Table 2 specifies public expenditure for this type of service between 2014 and 2018.

Table 1 – Amount and values of hospital benefits on mental health 2014-2018 (Chilean pesos)

Year	Full bed-day hospitalization in psychiatry sector/ chronic		Bed-day hospitalization in psychiatry sector/ mid-stay		Full bed-day hospitalization in psychiatry sector/ short-stay		Electroshock	
	N	Value	N	Value	N	Value	N	Value
2014	121.685	21.340	61.620	33.690	255.264	33.400	374	638.610
2015	137.709	21.980	73.711	34.700	318.834	34.400	494	657.770
2016	122.451	22.820	70.931	36.020	318.722	35.710	438	682.770
2017	121.373	23.500	77.387	37.100	354.678	36.780	529	703.250
2018	106.815	24.110	71.278	38.060	335.921	37.740	530	721.530

Source: FONASA (2019)

Table 2 – Public expenditure on mental health hospital services 2014-2018 (Chilean pesos)

Year	Full bed-day hospitalization in psychiatry sector/ chronic	Full bed-day hospitalization in psychiatry sector/ mid-stay	Full bed-day hospitalization in psychiatry sector/ short-stay	Electroshock
2014	2.596.757.900	2.075.977.800	8.525.817.600	238.840.140
2015	3.026.843.820	2.557.771.700	10.967.889.600	324.938.380
2016	2.794.331.820	2.554.934.620	11.381.562.620	299.053.260
2017	2.852.265.500	2.871.074.500	13.045.056.840	371.316.000
2018	2.575.309.650	2.712.840.680	12.677.658.540	382.410.900
Total	13.845.508.690	12.772.599.300	56.597.985.200	1.616.558.680

Source: FONASA (2019)

In 2014, public spending on mental health hospital services financed by FONASA amounted to \$13.437.393.440 (Chilean pesos). In 2018, public spending for this type of benefit amounted to \$18.348.219.770 (Chilean pesos). Thus, there is a 36.5% increase in monetary investment in hospital benefits from 2014 to 2018. In this regard, within each item, the increase of 60.1% of monetary investment in the application of electroshock is highlighted, the increase of 48.6% of the full bed-day hospitalization/short-stay, the increase of 30.6% of the full bed-day hospitalization/mid-stay in psychiatric sector, as well as the decrease of 0.8% of

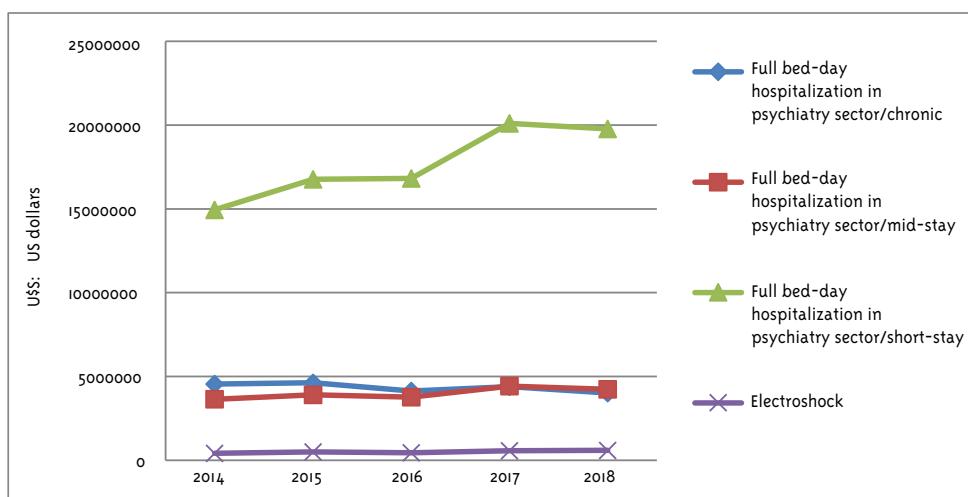
the full bed-day hospitalization of chronic patients in psychiatric sector.

Graph 1 shows the trends in public spending on hospital services between 2014 and 2018, in US dollars.

With respect to out-of-hospital services financed by FONASA between 2014 and 2018, Table 3 describes the number of actions carried out and the monetary values associated with each service in the period indicated.

According to the data presented above, Table 4 details public spending on this type of benefit between 2014 and 2018.

Graph 1 – Public expenditure on mental health hospital services 2014-2018 (US dollars)



Conversion of Chilean pesos to US dollars observed, in its average value for each year according to data from the Internal Tax Service (SII), Chile.
Source: FONASA (2019)

Table 3 – Amount and values of out-of-hospital mental health services 2014-2018 (Chilean pesos)

Year	Protected homes		Full bed-day hospitalization in psychiatry sector/ diurnal		Rehabilitation program type 1		Rehabilitation program type 2	
	N	Value	N	Value	N	Value	N	Value
2014	300.938	12.880	123.228	14.000	129.394	3.930	160.574	9.230
2015	395.131	13.270	143.467	14.420	184.400	4.050	196.901	9.510
2016	380.036	13.770	149.160	14.970	173.522	4.200	205.182	9.870
2017	412.953	14.180	161.768	15.420	159.402	4.330	223.539	10.170
2018	371.799	14.550	162.291	15.820	142.970	4.440	212.212	10.430

Source: FONASA (2019)

Table 4 – Public expenditure on out-of-hospital mental health services 2014-2018 (Chilean pesos)

	Protected homes	Full hospitalization bed-day in psychiatry sector/ diurnal	Rehabilitation program type 1	Rehabilitation program type 2
2014	3.876.081.440	1.725.193.000	508.518.420	1.482.098.020
2015	5.243.388.370	2.068.794.140	746.820.000	1.872.528.510
2016	5.344.653.760	2.232.925.200	728.918.400	2.025.146.340
2017	5.885.673.540	2.493.999.960	690.210.660	2.273.391.630
2018	5.409.675.450	2.567.443.620	634.786.800	2.213.371.160
Total	25.759.472.570	11.088.355.920	3.309.254.280	9.866.535.660

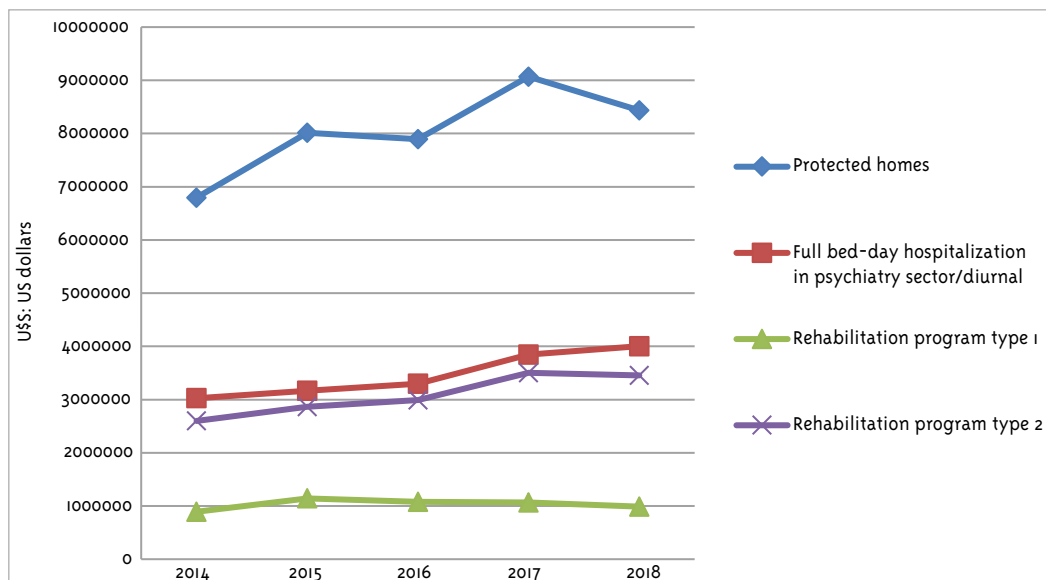
Source: FONASA (2019)

In 2014, public spending on out-of-hospital mental health services funded by FONASA had a monetary value of \$7.591.890.880 (Chilean pesos). In 2018, public spending for these benefits increased to \$10.825.277.030 (Chilean pesos). Thus, there is a 42.5% increase in money spent in out-of-hospital services from 2014 to 2018. In this regard, within each item, the increase of 49.3% in public

expenditure on type 2 rehabilitation programs, 48.8% in full bed-day hospitalization in psychiatry sector/diurnal, 39.5% on financing for protected homes and 24.8% on type 1 rehabilitation programs are highlighted.

Graph 2 shows the trends in public spending in out-of-hospital services for the period 2014-2018, in US dollars.

Graph 2 – Public expenditure on out-of-hospital mental health services 2014-2018 (US dollars)



Conversion of Chilean pesos to US dollars observed, in its average value for each year according to data from the Internal Tax Service (SII), Chile. Fuente: FONASA (2019)

Based on these results, it should be pointed out that the FONASA funding mechanism analyzed in this section includes services actually provided, which are mostly individual, focused on treatment or rehabilitation, executed by mental health teams and implemented in health or social services. Thus, the public expenditure on mental health reviewed in the numbers above does not refer to the total mental health budget or to the set of services that compose the mental health programs between 2014 and 2018, but to the limited framework of services referred to in the methodology.

Final remarks

According to the results obtained, in general there is an increase in the number of hospital

and out-of-hospital mental health services, as well as in the expenditure derived from them between 2014 and 2018 in the public health system. Although there is a higher percentage of out-of-hospital than hospital services between 2014 and 2018, the volume of resources invested shows an inverse trend, indicating overall inequality in the assessment of mental health services and an unequal distribution of resources within the framework of the implementation of the community model. The results indicate that there was no decrease in public spending on mental health in accordance with the revised services in the period 2014-2018. Therefore, the debate regarding the lack of financing should be redirected towards the discussion about the effective execution of the budget, where and how the resources are used.

In this regard, the increase in public spending on hospitalization in psychiatry sector/mid-stay and the limited funding for hospitalization in psychiatry sector/chronic indicate that mental health policies have not been focused on the closure and replacement of psychiatric hospitals. Minoletti and Sepulveda (2017) report that the number of total beds in psychiatric hospitals gradually declined from 3,160 in 1990 to 1,063 in 2012. This decrease implied a similar decrease in the percentage that these hospitals represent in the total mental health budget of the public system, from 74% in 1990 to 16% in 2012. However, of the hospital services analyzed for the period 2014-2018, 32% of public funding for psychiatric internment is concentrated in chronic and mid-stay hospitalization, which emphasizes the strong presence of psychiatric hospitals in obtaining state resources and the full validity of an asylum paradigm centered on confinement and isolation.

Thus, the reconversion of asylum psychiatric care has been limited to a reduction in the number of vacancies without a significant decrease in public spending on the services provided in psychiatric hospitals. Even the increase in the number of places in protected homes and residences is compatible with the permanence of persons in medium and long term stays in these institutions. Therefore, the segregation of persons and their custody in mental asylums is associated not only with the lack of vacancies in protected homes and residences that would allow them to leave (INDH, 2017) but also with the continuity of new admissions (even of young people under 18), long periods of internment and an increase in the rate of turnover. This is the “revolving door phenomenon”: people entering and leaving the psychiatric wards, a slow decrease in the number of vacancies and the opening of forensic psychiatry units, factors that give a significant role to monovalent psychiatric institutions in obtaining public resources in mental health. This is accentuated by the fact that psychiatric hospitals not only obtain funding for hospitalizations, but also provide outpatient care and administer residential facilities in the community.

In this sense, the results show that Chile has not met the objectives of psychiatric

deinstitutionalization and reconversion of public resources as other reform processes aimed at replacing the asylums have proposed (Cohen; Natella, 2013; Rotelli, 2014), but rather has sustained a heterogeneous expansion of public spending between hospital and out-of-hospital services involving the continuity of psychiatric hospitals.

On the other hand, in the period 2014-2018, the increase of public expenditure in electroshock procedures and hospitalization in psychiatry sector/short-stay is explained by the expansion of these services in closed care units in general hospitals, in addition to these actions that are also carried out in psychiatric hospitals. It is important to emphasize that the public resources allocated to hospitalization in psychiatry sector/short-stay between 2014 and 2018 represent a little more than the total funding for out-of-hospital services as a whole in the same period, reflecting the lack of a guiding principle that would allow for greater equity in the execution and distribution of resources for services aimed at full social inclusion and participation, in line with the community model.

As to out-of-hospital services in the period 2014-2018, 51% of public resources were allocated to protected homes, mainly due to the increase in the number of residential places in the community. However, the data indicate that those places have not been allocated as a priority to people in long stay services in psychiatric hospitals in order to achieve their discharge, based on effective support strategies for the return to community life as described in the Brazilian psychiatric reform (Dimenstein, 2013; Moreira; Guerrero; Bessoni, 2019). The logic of financing protected homes, in turn, directs public resources to the managing entities and not to the direct beneficiaries. It reinforces relationships of dependence within long-term, non-transitory residential services, which are established as custodial institutions, limiting people’s freedom to choose where and with whom to live, the development of life projects and autonomy in decision-making (Bouey-Vargas; Cuarán-Collazos, 2019; Chuaqui, 2015).

Public resources for psychosocial rehabilitation programs are allocated to specialized centers and

focused on professional care, which restricts the development of work activities that allow the generation of economic income based on solidarity and cooperative projects, as has been proposed in the Italian context (de Leonardis; Mauri; Rotelli, 1995; Rotelli, 2014). In this way, the financing system for out-of-hospital services favors the transfer of public resources to private entities and limits the development of key aspects of community life beyond health borders: work participation, inclusive education, access to accommodation, among others, from the each individual involvement to the recovery of citizenship rights (Cea-Madrid, 2019).

Consequently, the mental health system in Chile is characterized by the coexistence of a biomedical and psychosocial paradigm. This mixed configuration of the care model reflects disparities in the distribution of resources, as well as the presence of structural barriers in the health system that make it difficult to make public investment more consistent with the community approach; a parallelism that also generates tensions with the persistence of the asylum model and the transversality of the pharmacological paradigm. In short, the community approach is reduced to a management model without material basis or financial support, since it is inserted in a rigid and stratified mental health system based on service financing that fragments the care processes for resource allocation. These conditions inhibit the development of more flexible and localized care responses based on community capacities and resources around mutual support groups, the provision of services managed by users/ex-users and other alternative services (Dillon et al., 2017; Lehmann, 2013; Naciones Unidas, 2019).

Finally, it is important to emphasize that the definitive closure of asylums at the national level is a pending challenge. As to psychiatric hospitals, it is necessary to ensure the effective redistribution and gradual transfer of their resources to community services that will practically replace them and guarantee citizenship rights. Based on a questioning of the biomedical predominance and the excessive medicalization of mental health, a structural change in financial

allocation is required in order to reorient state spending towards social determinants in the promotion of well-being (Cea-Madrid, 2018a; United Nations, 2019). In this sense, for the full implementation of the community model, a network of care resources is not enough, but a culture of rights that allows mental health to be reinvented under the principles of the common good and social justice.

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