



Chile: New health and institutional challenges in a country in transition*

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ABSTRACT

Public health policies have been a priority issue in Chile since 1950. Major progress has been made in basic aspects of public health, such as drinking water coverage and the prioritization of primary health care, leading to communicable disease control, the reduction of maternal and child mortality, and the elimination of malnutrition. Through a mixed health care model, Chile has met the commitment in the Declaration of Alma-Ata to attain an “acceptable level of health for all people”, achieving the best health and socioeconomic indicators in Latin America.

However, attaining an acceptable level of health in the population is an open-ended goal, and progress in this direction appears to have stalled in Chile. The challenge is therefore to define new health goals for the country, which is no longer a low-income country but an upper middle-income country with a different profile of health problems. Specifically, Chile must continue to improve health care for its population through health policies focused on noncommunicable diseases (such as cardiovascular disease and cancer), health promotion, and disease prevention. To accomplish this, the Ministry of Health must modernize its management and resume its role as the overseer of health objectives, a role that has been eclipsed by its administrative responsibilities. It must do so without losing the complementarity achieved between the public and private sector in order to minimize the current limitations of the public system.

Keywords

Health care; noncommunicable diseases; risk factors; health status indicators; social indicators; public health; Chile.

The objective of this study is to present Chile's achievements and shortfalls in the area of health, as reflected by health and socioeconomic indicators. Rather than simply remain content with the progress made, the challenge is to find the way forward in the area of public health. Chile

has stalled and needs to get back on track to achieve the health standards found in more advanced countries, where concerns are focused on noncommunicable chronic diseases and disease prevention and health promotion, including the reduction of health risk factors.

In order to reliably measure certain health conditions using similar methods, the indicators published by recognized international organizations such as the Pan American Health Organization (PAHO) and the Organization for Economic Cooperation and Development

(OECD) were used. The study is organized as follows: the current health system in Chile is described, followed by a discussion of how it has evolved and how the country ranks with respect to other countries of Latin America and the OECD. The final section presents conclusions and describes the challenges the country faces.

Brief description of the Chilean health system

The Chilean health system is mixed, with public and private participation in

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health care insurance, financing, and delivery. This segmentation of the system originated with the 1980 Chilean Constitution, which allowed workers to choose where they would send their compulsory health contributions (7% of taxable income): either to the public insurance institution known as FONASA (*Fondo Nacional de Salud*, National Health Fund) or to one of the private health insurance institutions, collectively known as ISAPREs. In return, these institutions coordinate care and finance health services, with different levels of coverage. They also process and pay—on behalf of the employer—employees' incomes when they suffer from an illness that prevents them from working. Currently, 75% of the entire Chilean population is covered by FONASA, 19% by the ISAPREs, and 6% by the health systems of the Armed Forces and *carabineros* [national police] or private insurance other than ISAPREs (1-3).

FONASA offers a single plan with two care modalities, one in the public network (MAI, the institutional modality) and one in the private network (MLE, the free choice option). These modalities differ in provider type and level of financial coverage (people with limited or no resources do not have access to the MLE). The MLE is mostly used for out-patient services, since hospital coverage is limited. With the ISAPREs, beneficiaries can choose from a multitude of plans, which are open-ended contracts with a minimum established by law.

In FONASA, one-third of financing comes from workers' mandatory contributions, with the remainder covered by fiscal and municipal contributions (4). In the ISAPRE system, two-thirds of financing comes from the mandatory contributions and the rest is from voluntary contributions provided by members when the mandatory contribution is insufficient to pay for the selected health plan (5). In the ISAPREs, approximately 80% of the portfolio receives additional funding: the average contribution is 10% of the worker's salary.

This indicates that freedom to choose health insurance is only possible for people who can finance their own health care in the private sector; that people pay for a health plan based on what they can afford; and that the existence of a segmented system based on socioeconomic level is partly due to the fact that only FONASA receives a government subsidy.

Furthermore, there are significant differences between the public and private systems with respect to access to timely, quality care, which is reflected by waiting lists in the public sector, lower rates of use of the public system compared to the private system, and a lower general opinion of the public system. In FONASA, more than 2.3 million people have to wait for a specialty consultation, surgery, or both (6). Recent surveys conducted by Cadem (7) show that 67% of the respondents feel that the quality of private health care in Chile is good or very good, while only 15% feel it is good or very good in the public sector. This indicates that the priority for improving the quality of the care should focus on increasing the number of specialists and reducing wait times in the public sector (8).

Even though FONASA's per capita expenditure for health care has doubled over the last ten years and is now very similar to expenditure in the ISAPREs (9), no major improvement has been observed in terms of satisfaction of public system users. This reveals serious management problems and a lack of financial control in this sector, which translates into deficient clinical services and the inability to make primary care decisions, among other problems. This leads to ongoing dissatisfaction on the part of members who cannot find timely, quality solutions in the public health care networks. FONASA is a public institution that is not self-governing (due to legal restrictions on management) and does not have management incentives or the ability to negotiate important variables such as employee salaries.

Meanwhile, the development of the ISAPRE system has led to a substantial expansion of private medical activity, increased investment in hospital and outpatient infrastructure, which is available both to ISAPRE and FONASA users: 42% of the services offered by private providers is for FONASA patients (10). However, the criticism leveled at private insurance providers is that they should work toward a model closer to social security principles, with a single, flat-rate plan, and mobility for both healthy and sick people. In short, Chile offers coverage to its entire population, but still needs to improve timely access for all in order to achieve universal health coverage.

The evolution of the health situation in Chile

Until the middle of the 20th century, Chile was one of the most backward countries in the Region, with 60% of its population in poverty and nearly 25% illiterate. Health indicators were not good either: in 1950, the infant mortality rate was 150 per 1,000 live births, neonatal mortality was 27 per 1,000 live births, and maternal mortality was 276 per 100,000 live births. In addition, 63% of children under the age of 6 were malnourished, and life expectancy at birth was only 39 years. In the area of sanitation, drinking water coverage was 52%, with 21% for sewerage systems (3, 11-18) (Table 1).

However, this scenario started to gradually change in the second half of the 20th century, first with the creation of the National Health Service (SNS) in 1952, followed by the creation of FONASA and the ISAPREs in 1980 (the SNS

TABLE 1. Evolution of some of Chile's health and socioeconomic indicators

Indicators	1950-52	1980	1990	Last year with data
Population	6,081,931 (1950)	11,174,173	13,178,782	18,373,917 (2017)
Per capita GDP based on PPP (US\$)	NA	NA	4 589	23,960 (2016)
Poverty (%)	60.0	40.3	38.6	11.7 (2015)
Urban drinking water coverage (%)	52.0	91.4	97.4	99.9 (2014)
Urban sewerage systems (%)	21.0	67.4	81.8	96.7 (2014)
Acute malnutrition in children < 6 years (%)	63.0	11.5	8.0	0.5 (2014)
Infant mortality (per 1,000 live births)	150.0	33.0	16.0	6.9 (2015)
Neonatal mortality (per 1,000 live births)	27.4	16.7	8.5	5.1 (2015)
Maternal mortality (per 100,000 live births)	276.0	55.0	40.0	15.5 (2015)
Life expectancy at birth (years)	39.0	67.9	72.9	79.9 (2015)
Per capita health expenditure PPC (USD)	NA	NA	601 (2000)	1 977 (2016)

NA, Not available; GDP, gross domestic product; US\$, United States dollars; PPP, purchasing power parity.

Source: Prepared by author based on references (3) and (11-18).

later became the National Health Services System, or *Sistema Nacional de Servicios de Salud* - SNSS). This was complemented by improvements in health conditions such as housing, water, and solid waste disposal. As pointed out by Boj et al (16), the SNS and subsequently the SNSS expanded health care coverage, which paved the way for national health infrastructure that was able to penetrate every strata of society, especially low-income groups. Free preventive medicine and health care services, prenatal and postnatal visits, childbirth services in maternal homes, healthy child checkups with vaccination coverage, and food delivery programs for mothers and children were offered. In short, successful maternal and child health programs and programs to eradicate childhood malnutrition were developed. In the area of sanitation, drinking water and sewerage coverage was expanded.

These health policies led to a significant change in the country's health and socioeconomic indicators (Table 1). Chile's current population is 18.4 million, and the poverty rate has dropped to 11.7%. Childhood malnutrition is practically non-existent, and infant mortality has fallen to 6.9 per 1,000 live births. Furthermore, maternal mortality declined to 13.5 per 100,000 live births, and neonatal mortality to 5.2 per 1,000 live births. Meanwhile,

life expectancy at birth has risen to nearly 80 years, and almost the entire population has drinking water and sewerage service (3, 11–18) (Table 1).

Chile's health ranking in Latin America

The changes in health policies also led to Chile becoming one of the leading countries in Latin America in terms of health and socioeconomic indicators, as illustrated in Table 2 (13, 14, 19–22) and Table 3 (17, 22–23). In particular, Chile has the highest per capita income adjusted by purchasing power parity in the Region, i.e. US\$23,960 (13). It also has the second lowest poverty rate (11.7%) (14) of all Latin America countries.

Health indicators reflect a similar situation. Only five countries have a single digit infant mortality rate and the lowest rate is in Chile (6.9 per 1,000 live births) (22). The same holds true for malnutrition, which has practically been eradicated in Chile, unlike the rest of Latin America (22). Furthermore, better hygiene conditions and access to health and housing have made Chile one of the Latin American countries with the longest life expectancy (22). Despite these positive health outcomes, Chile does not top the list of Latin American countries with higher levels of health expenditure as a percentage of GDP (8.1%), although it is above the

average in the Region (7.0%) and has shown rapid growth in recent years (18, 23).

Chile's health ranking among the member countries of the OECD

Chile has achieved significant health outcomes and should now take on new challenges to attain health standards similar to those of the most advanced countries. Table 4 (18) shows existing gaps between Chile and the average in OECD countries in certain health indicators related to health care resources. The data show that Chile has age-standardized mortality rates somewhat below the OECD average (18). The leading causes of death in the country are circulatory system diseases and malignant tumors. Life expectancy at birth is 79.9 years, almost a year below the average of 80.8 for the OECD (18). Chile is a country of adults transitioning to old age, with 11% of the population age 65 or older. This is below the OECD average of 17% (18), but Chile is still one of fastest aging countries in South America, along with Uruguay (15%) and Argentina (11%) (24).

With regard to health care resources, the number of doctors and nurses per population in Chile is low compared to the OECD average. Chile has 2.5 doctors per 1,000 population, below the OECD average of 3.4 (18). This difference is even more pronounced in the case of nurses, with only 2.7 nurses per 1,000 population in Chile, compared to the OECD average of nine (18). Of the 41,623 registered physicians in Chile (49% general doctors and 51% specialists), 52% practice in the private sector (62% if hours of medical work are considered), with the remaining 48% working in the public sector (10). Chile has 2.1 hospital beds per 1,000 population, compared to the OECD average of 4.6 (18). In the year 2016, Chile had 38,362 beds, 68% of which were in the public sector, 18% in private clinics, 9% in institutional facilities (Armed Forces, etc.), and 5% in other facilities (mutual, geriatric, psychiatric, etc.) (10). The number of medical devices, although higher than before, is still below the OECD average. Chile has 12 magnetic resonance units and 24 computerized axial tomography (CAT) scanners per million population, while the OECD average is 16 and 26, respectively (18).

TABLE 2. Some health and socioeconomic indicators in selected countries of Latin America

Country	Per capita GDP based on PPP (current US\$, 2016)	Poverty		Education		Availability of clean drinking water in the home (%), 2015
		%	Year	%	Year	
Argentina	19,934	NA		NA		99
Bolivia	7,236	32.7	2013	9.9	2013	92
Brazil	15,127	16.5	2014	8.9	2014	97
Chile ^a	23,960	11.7	2015	11.6	2013	99
Colombia	14,157	28.6	2014	9.2	2014	96
Ecuador	11,286	29.8	2014	9.5	2014	91
Paraguay	9,576	42.3	2014	9.4	2014	95
Peru	13,022	22.7	2014	9.8	2014	84
Uruguay	21,626	4.4	2014	10.3	2014	99
Latin America^b	13,197	31.8	9.2	88	13,197	31.8

GDP, gross domestic product; US\$, United States dollars; PPP purchasing power parity.

a. Until 2011, Chile used ECLAC's methodology to calculate poverty. The Chilean Ministry of Social Development then changed the methodology, which is why ECLAC's poverty figures (7.8%) and Mideplan's figures (14.4% 2013, 11.7% 2015) differ, starting in 2013.

b. Latin America has 20 countries: Colombia, Venezuela, Ecuador, Peru, Bolivia, Paraguay, Uruguay, Chile, Argentina, Brazil, Cuba, Dominican Republic, Haiti, Guatemala, Salvador, Honduras, Nicaragua, Costa Rica, Panama, and Belize. The Latin American average includes 19 countries for per capita GDP, 15 countries for poverty and years of education, and 20 countries for drinking water.

Source: Prepared by the author based on references (13), (14), and (19–21).

TABLE 3. Some indicators of health and health expenditure in selected countries of Latin America

Country	Life expectancy at birth (years), 2017	Infant mortality rate (per 1,000 live births)		Malnutrition in children < 5 years		Total health expenditure (% of GDP), 2015
		%	Year	%	Year	
Argentina	76.7	9.7	2015	2.3	2005	6.8
Bolivia	69.5	50.0	2008	3.4	2016	6.4
Brazil	75.7	15.1	2015	2.2	2007	8.9
Chile	79.9	6.9	2015	0.5	2014	8.5 ^a
Colombia	74.6	17.2	2014	3.4	2010	6.2
Ecuador	76.6	8.9	2015	5.1	2014	8.5
Paraguay	73.2	14.2	2015	1.3	2016	7.8
Peru	75.2	15.0	2015	3.1	2016	5.3
Uruguay	77.6	8.0	2016	4.0	2011	9.2
Latin America^b	74.8	17.3		4.3		7.0

GDP, gross domestic product.

^a For the year 2016.

^b Latin America is the average of the 20 countries that make up the Region.

Source: Prepared by the author based on references (17), (22), and (23).

TABLE 4. Table comparing the health indicators Chile and the OECD

Indicator	Chile		OECD		Ranking among OECD countries
	Value	Year	Value	Year	
State of health					
Life expectancy at birth (years)	79.9	2016	80.8	2016	27 of 36
Aging (% population > 65 years)	10.9	2017	17.3	2017	33 of 35
Infant mortality rate (per 1,000 live births)	6.9	2015	3.9	2016	3 of 36
Mortality rate ^a	787.0	2015	799.6	2015	14 of 36
Cancer mortality rate ^a	193.2	2015	204.2	2015	24 of 36
CVD mortality rate ^a	225.7	2015	286.4	2015	22 of 36
Health care resources					
Number of physicians ^b	2.5	2016	3.4	2016	30 of 35
Number of nurses ^b	2.7	2016	9.0	2016	34 of 35
Hospital beds ^b	2.1	2016	4.6	2016	34 of 35
Magnetic resonance units	12.3	2017	16.4	2016	20 of 34
CAT scanners ^c	24.3	2017	26.6	2016	13 of 34
Health care					
Medical consultations (per person)	3.5	2015	6.8	2016	33 of 35
Magnetic resonance scans ^b	20.1	2015	62.8	2016	29 of 30
CAT scans ^b	89.3	2015	141.7	2016	25 of 31

OECD, Organization for Economic Cooperation and Development; CVD, cardiovascular disease; CAT, computerized axial tomography.

a. Based on age per 100,000 population.

b. Per 1,000 population.

c. Per million population.

Source: Prepared by the author based on reference (18).

With regard to health care resources, the number of medical consultations and exams per person in Chile is also low compared to the OECD average. In the case of medical consultations, people in Chile see a physician 3.5 times a year, compared to the OECD average of 6.8 (18). Twenty magnetic-resonance and 89 CAT scans are performed per 1,000 population, while on average 63 and 142 are performed, respectively, in the OECD countries (18). In the ISAPREs, beneficia-

ries see a doctor an average of 4.5 times a year (2, 25), while 95 magnetic resonance scans and 148 CAT scans are performed per thousand beneficiaries (26), which is within OECD standards.

Table 5 (18, 27-29) compares Chile with the OECD in the area of risk factors and prevalence of certain noncommunicable diseases. With regard to risk factors, the rate of smokers in Chile (33%) is twice that of the OECD (18.5%), although in the last seven years the percentage of

smokers dropped almost seven percentage points in Chile, which may be due to the tobacco control laws of 2006 and 2013 (27,18). Nevertheless, much remains to be done, especially in educating the public about the health problems associated with smoking, and in expanding health team interventions to get patients to quit smoking. Alcohol consumption in Chile continues to be quite high (11.7%), especially among adolescents and young adults (27).

The prevalence rates of noncommunicable chronic diseases associated with a poor diet and a sedentary lifestyle, such as hypertension, obesity, or diabetes, are higher than the OECD average. These diseases are occurring with increasing frequency and represent a significant risk to the population's health. This is the main area that the health authority should address; otherwise, these diseases will become an unsustainable social and economic burden for the country. Obesity levels are particularly concerning (31%, 74% if overweight and morbidly obese people are included), and the prevalence of diabetes (12.3%) continues to rise, especially in children (27). Meanwhile, the rate of suspected hypertension is nearly 28% (27).

The inclusion of 14 cancers in Chile's Explicit Health Guarantees (known as *GES*) has led to more timely access to cancer treatment for low-income patients. However, much remains to be done in terms of prevention and increasing timely access to quality care in the public health sector, since there is a major need for investment in medical equipment and specialized personnel such as oncologists and radiologists. Chile has eight of these specialists per million population (compared to 32 in Argentina and 26 in Brazil, 26). Of Chile's 148 oncologists and radiologists (versus 1,400 in Argentina and 5,500 in Brazil), 72 are working exclusively in the private sector and 76 in the public health sector. A serious problem is that Chile does not have good statistical records on cancer patients, which makes it difficult to develop public health programs and allocate resources. For this reason, the creation of a national cancer registry (to identify patients by type of cancer, sex, age, and geographic location) is urgently needed in order to develop an effective national anti-cancer program to promote the early detection of this disease (especially at the primary care level), and so that cost-effective investments can be made in equipment and specialized personnel (30).

TABLE 5. Health risk factors and prevalence of some noncommunicable chronic diseases

	Chile		OECD Average
	ENS 2009-2010 (%)	ENS 2016-2017 (%)	2016 (%)
People who smoke (daily/occasionally)	39.8	33.3	18.5
Passive tobacco exposure in the home	31.0	15.2	NA
Passive tobacco exposure at work/school	24.8	20.3	NA
Hazardous alcohol consumption	12.7	11.7	8.8
Sedentary lifestyle ^a	88.6	86.7	NA
Overweight (BMI 25-29.9)	39.3	39.8	NA
Obesity (BMI 30-39.9)	22.9	31.2	23.5
Morbid obesity (BMI ≥ 40)	2.2	3.2	NA
Total BMI > 25	64.4	74.2	NA
Suspected hypertension ^b	26.5	27.6	22.6
Suspected diabetes mellitus ^c	9.0	12.3	7.0

OECD: Organization for Economic Cooperation and Development; ENS, National Health Survey; BMI, Body Mass Index; NA, not available.

a. Sedentary lifestyle: in the past month, did not exercise for at least 30 minutes, 3 or more times per week.

b. People with self-reported and/or treatment of hypertension or blood pressure > 140/90.

c. Fasting blood sugar level of ≥ 126 mg/dL.

Source: Prepared by the author based on references (18) and (27-29).

CONCLUSIONS

Chile, with a mixed health model, has made significant progress in basic health areas such as access to drinking water and sewerage systems and in the prioritization of primary health care. This has made it possible to control communicable diseases such as measles, tuberculosis, and diphtheria, and improve people's health and quality of life. Furthermore, it has positioned the country's indicators as among the best in Latin America.

However, Chile appears to have stalled and the challenge is to define new health goals for the country, which is no longer a low-income country, but a middle-to-high-income country with a different profile of health problems.

Specifically, Chile must continue to improve health care for its population through health policies focused on non-communicable diseases such as cardiovascular disease and cancer, as well as disease prevention and health promotion. In Chile there is little control of health risk factors such as a sedentary lifestyle, obesity, diet, smoking, and excessive alcohol consumption, which contributes to the increase in noncommunicable chronic diseases such as hypertension and diabetes.

To achieve these goals, the Ministry of Health should be released from its administrative responsibilities so that it can play its role as public policy-maker. The

Ministry of Health is the entity that should set public health objectives and effectively oversee and verify their achievement. It should ensure that FONASA and the ISAPRES, as well as public and private providers, promote healthy behaviors and prevent complications of chronic diseases.

To move forward in the area of disease prevention and health promotion, collaboration is needed among all actors involved in health, including the government and private citizens, as well as all public and private actors associated with health and healthy living. This should be done without losing the complementarity that has been achieved between the public and private sectors, since only then can there be timely access to health for all Chileans, bringing the country closer to true universal health coverage. Chile has not been very effective in reducing health risk factors or overseeing the health of its population to ensure the timely detection of diseases, halt their progress, and minimize their consequences. Early detection and prevention (screenings, vaccination, etc.) saves lives and resources that could be used more efficiently and with greater social return.

To achieve this, Chile must work toward providing comprehensive health care for the population, culminating in a universal health plan that can be accessed by all Chileans. Only an appro-

prate financing mechanism and contributions, including subsidies and a risk compensation fund, will achieve true integration of the different systems and give people the right to choose between them. However, both systems first need to modernize their management and find strategies that add value to health expenditures. In particular, the public sector should modernize its management, improve its coverage guarantees, and improve the quality of the services provided. To this end, changes must be made in the institutional framework of the public health care network; networks should be organized with clinical interoperability between primary, secondary, and tertiary levels of care; the corporate governance of public hospitals should be modernized through systems that evaluate management and require accountability, and public health services should be given greater autonomy. The ISAPRES should work with providers and move toward payment mechanisms with shared financial risk, so that insurers and providers alike have incentives to contain costs. Furthermore, FONASA should operate as a true public insurance entity and the health authority should have greater autonomy and independence from government administration.

This model would lead to a strong public-private collaboration and ease the stress on the public health sector, which is bogged down in administrative responsibilities and has minimized its role as public health policymaker and regulator. In this way, the government could direct its efforts toward primary prevention work, which is urgently needed in our country, in order to serve the most vulnerable population and safeguard the right of all Chilean citizens to health care, regardless of their type of insurance.

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RESUMEN**CHILE: NUEVOS DESAFÍOS
SANITARIOS E INSTITUCIONALES
EN UN PAÍS EN TRANSICIÓN**

En Chile, desde 1950, las políticas públicas sanitarias se transformaron en un tema prioritario. Se lograron importantes avances en aspectos sanitarios básicos—como cobertura de agua potable—y priorización de la atención primaria de salud, lo que permitió controlar enfermedades transmisibles, reducir la mortalidad materno-infantil y eliminar la desnutrición. Chile, con un modelo mixto de salud, logró el cometido de la Declaración Alma-Ata de “alcanzar un mejor nivel de salud de los pueblos” y obtuvo los mejores índices sanitarios y socioeconómicos de América Latina. Sin embargo, proveer un mejor nivel de salud a la población es una meta que nunca llega a su fin y pareciera ser que Chile quedó estancado. En este contexto, el desafío es plantearse las nuevas metas sanitarias que tiene el país, ya no como un país de ingresos bajos, sino como un país de ingresos medios-altos, cuyas problemáticas de salud son otras. En concreto, Chile debe avanzar en perfeccionar la atención y cuidado de la salud de las personas, con políticas sanitarias enfocadas en enfermedades no transmisibles—como afecciones cardiovasculares y el cáncer—y enfocadas en la prevención y promoción de la salud. Para ello, el Ministerio de Salud debe modernizar su gestión y retomar su rol de gestor de metas sanitarias, que ha sido absorbido por tareas administrativas. Todo ello sin perder la complementariedad alcanzada entre los sectores público y privado, de modo de aminorar las limitaciones que tiene hoy el sistema público.

Palabras clave

Atención a la salud; enfermedades no transmisibles; factores de riesgo; indicadores de salud; indicadores sociales; salud pública; Chile.

RESUMO**CHILE: NOVOS DESAFIOS
INSTITUCIONAIS E EM SAÚDE
EM UM PAÍS EM TRANSIÇÃO**

A partir dos anos 1950, as políticas públicas de saúde passaram a ser uma questão prioritária no Chile. Um grande progresso foi alcançado nos aspectos básicos da saúde, como o abastecimento de água potável, e na priorização da atenção primária à saúde, que permitiu controlar doenças transmissíveis, reduzir a mortalidade materno-infantil e eliminar a desnutrição. Com um modelo misto de saúde, o Chile cumpriu a missão da Declaração Alma-Ata de “atingir o mais alto grau de saúde dos povos” e obteve os melhores índices socioeconômicos e de saúde da América Latina. Proporcionar um nível melhor de saúde à população é uma meta permanente e parece que o Chile ficou estagnado. O desafio neste contexto é estabelecer novas metas em saúde, não como uma nação de baixa renda, mas como um país de renda média a alta com outros problemas de saúde. O Chile precisa progredir para atingir um nível superior de atenção e assistência de saúde às pessoas com políticas de saúde dirigidas a doenças não transmissíveis, como as doenças cardiovasculares e o câncer, com ênfase na prevenção e promoção da saúde. O Ministério da Saúde do Chile precisa de uma gestão mais moderna e retomar o papel de gestor das metas de saúde, que se perdeu em meio ao trabalho administrativo, preservando a complementariedade entre os setores público e privado a fim de diminuir as limitações atuais do sistema público.

Palavras-chave

Atenção à saúde; doenças não transmissíveis; fatores de risco; indicadores básicos de saúde; indicadores sociais; saúde pública; Chile.