

## THE NATIONAL HEALTH SYSTEM IN CHILE<sup>1</sup>

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*The growing demand for more and better care in health services, despite limited manpower and material resources, calls for effective coordination of the agencies responsible. The article discusses the measures taken by the Government of Chile with a view to integrated action and the coordination of all services in the public health sector.*

Everyone in Chile recognizes the progress made by the country in regard to health with the establishment in 1924 of the Compulsory Insurance Fund. This body, now called the Social Security Service, for the first time provided the working sector of the population with an organized medical system.

A look back (1) at the evolution of the general and child mortality indices between 1924 and 1968 reveals clearly how much progress has been made over these 45 years in the history of social security in Chile. In 1924, the general death rate in the country was 28.4 per 1,000 inhabitants, and child mortality 242.2 per 1,000 live births. Over the first 15 years of the period, progress was very slight, and until 1939 general mortality indices continued to fluctuate around 23 and child mortality around 210. A period then began around 1939 in which there was a spectacular and sustained drop in both rates, so that by 1953 the general death rate had dropped to 12.0 and child mortality to 99.5. This is the period of the impact of sulfa drugs and antibiotics, but for us it also marks an important advance in maternal and child care provided by the Medical Services of the Workers' Insurance Fund. During the next decade, general mortality leveled off at a rate of about 12, while child mortality tended to rise slightly; but from 1964 a new downward trend began which by

1969 had brought the general death rate down to 8.9 and child mortality to 79.0.

The evolution of social security in Chile had very special characteristics. After the Workers' Insurance Fund was set up, new groups in the community were incorporated gradually into welfare arrangements, and legal coverage was extended, so that at the present time it reaches 92 per cent of the population. Thus the benefits of medicine were brought within the reach of virtually the whole community, but the proliferation of welfare bodies brought with it complex administration problems and lack of coordination. However, the Worker's Insurance Fund, which organized its own medical service, had the good sense not to embark on a policy of building hospitals of its own, preferring to enter into agreements with the Welfare Service to which the large majority of the country's hospitals were attached. It is important to point this out, because it constituted a precedent for other welfare bodies set up later and because it made for the integration of resources which led to the establishment of the National Health Service (SNS) in 1952.

The SNS was the outcome of the fusion of the Health Service, the Welfare Service with its hospitals, the medical service of the Worker's Insurance Fund, the Childhood Protection Authority, the medical services of the municipal districts, the industrial accident section of the Ministry of Labor, and the Bacteriological Institute. Thus a single institution took over the whole responsibility for health protection (preventive medicine) in respect of the entire population of the country, and for health

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promotion and medical care for workers, *campesinos*, small artisans, and manual workers generally, and their spouses and children up to the age of 15, representing in all 70 per cent of the population. The National Health Service is also responsible for the health care of the indigent and their families. Its importance is easily understood if we consider that it administers 86.8 per cent of all the hospital beds in the country and provides 87.1 per cent of medical care in outpatient units (1967), the rest being taken care of by the Armed Forces, police, universities, private clinics, etc.

The provident funds for public and private employees set up among them a joint medical service known as the National Medical Service for Employees (SERMENA), organized initially around the provisions of the Preventive Medicine Act which provided care for its impressive numbers of tuberculosis, venereal disease, cancer, cardiovascular and other cases, and also took care of maternal and child health. Its activities have recently been extended to the over-all health care of active and retired employees and their families through a system of free choice of physician and hospital financed partly by social security and partly by the beneficiaries themselves.

On 10 December 1948, Chile voted in the General Assembly of the United Nations for the Universal Declaration of Human Rights, which covers not only civil and political rights but social rights as well. Article 25 stipulates that: "(1) *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services* and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control. . . (2) *Motherhood and childhood are entitled to special care and assistance*. All children shall enjoy the same social protection."

This is the pledge we have given. Nevertheless, important sectors of the population still have no coverage in implementation of these

rights, for a variety of reasons including shortage or inadequate distribution of resources; inaccessibility of population groups; lack of coordination between the various health agencies; and ignorance on the part of certain sectors as to their right to claim welfare benefits.

The situation is rapidly being corrected, as is proved by the increase in the number of medical service consultations, an increase far exceeding the natural growth of the population.<sup>4</sup> The opening up of new highways (2,156 km of new roads between 1965 and 1967), growing urbanization, the spread of education, and the increasing awareness of the importance of health are factors exerting more and more pressure on the health services, which are in fact faced by an acute increase in demand while at the same time they are trying to extend their action to sectors of the population not yet covered. In the past, and particularly in the last few years, the Chilean Government has made strenuous efforts to improve the financing of the health sector without losing sight of the fact that a balance must be maintained with the other factors affecting levels of living which in the long run likewise affect health, e.g., education, housing, well-paid work, etc.

The magnitude of this effort can be appreciated if we glance at Table 1, which shows current and capital expenditure on health services in various countries in 1961 as a percentage of total national product and total national expenditure. Table 2 shows the trend in public expenditure under three social sector heads (health, housing, and education) for 1964, 1965, 1966, and 1967 as a percentage of total expenditure. Table 3 shows the real index of growth of total expenditure in the public sector and the health, housing, and education subsectors during the same period, 1964 to 1967.

Since there will never be enough resources to cover the whole of the constantly growing

<sup>4</sup>Increase in population 1963-1967: 10.7 per cent; increase in medical services 1963-1967: 24.6 per cent.

TABLE 1—Expenditure on health services as a percentage of the gross national product (GNP) and national expenditure, 1961.

Country	% GNP	% National expenditure
Canada	6.0	7.9
United States of America	5.8	7.1
Chile	5.6	6.9
Australia	5.0	6.2
Finland	4.8	6.0
Yugoslavia	5.0	5.9
United Kingdom	4.2	5.2
Poland	3.7	4.3
Czechoslovakia	3.6	4.3

Source: (2)

TABLE 2—Consolidated expenditure<sup>a</sup> for the public sector on health, housing, and education, as a percentage of total expenditure, Chile, 1964-1967.

Public sector	1964	1965	1966	1967
Health <sup>b</sup>	7.3	8.4	7.3	7.2
Housing <sup>c</sup>	6.3	7.3	7.6	6.5
Education	9.3	9.5	10.0	10.4

<sup>a</sup>Disregarding transfers.

<sup>b</sup>Not including social welfare costs.

<sup>c</sup>Not including urbanization costs.

needs in the health sector if they continue to be used in accordance with the commitments of particular institutions and not in the light of an over-all national policy—which really means that the health infrastructure potential is not used to capacity—in 1965 the Ministry of Public Health urged the pressing need to obtain higher returns on resources through the effective coordination of all the agencies working in the health sector (4, 5).

Before a consolidated health service—which would appear to be the ideal final solution—can be achieved, a difficult preliminary stage must be passed involving education and persuasion, and ultimately the subjection of the vested interests and privileges of certain sectors of beneficiaries, and of professionals, to the common good.

On the other hand, coordination could not

TABLE 3—Real index of growth of total expenditure for the public sector and subsectors of health, housing, and education at constant currency rates (1967), Chile, 1964-1967.<sup>a</sup>

Public sector	1964	1965	1966	1967
Health	100	141.3	142.3	156.6
Housing	100	142.5	172.1	165.3
Education	100	125.1	151.9	177.2
Total	100	122.2	141.3	158.3

Source: (3)

<sup>a</sup>Base, 1964. Index 100.

be left to chance or to the uncertain degree of initiative shown by institutions or individuals. For this reason it was decided to organize a national health system, embracing all the agencies of the public sector responsible for health activities, which, while respecting the particular purpose for which each institution was set up, would concentrate all functions and all efforts on improving the care of the national community.

In July 1967 the National Advisory Council on Health was established by a Government Decree issued in April 1967 and ratified by a law enacted in May 1968, as an organ responsible for the promotion and consolidation of the national health system.

The Council is presided over by the Minister of Public Health, and consists of the senior chiefs of the public health sector (SNS, SERMENA, Armed Forces, police organization, railways, prisons system, etc.), the Dean of the Medical School of the University of Chile, a representative of the Association of Medical Schools, the presidents of the professional associations of doctors, dentists, and pharmaceutical chemists, the Administrator of the Society for the Construction of Hospital Establishments, and representatives of workers and employees.

The functions and privileges of the Council under the law are as follows:

a) It acts as adviser to the Ministry of Public Health in the orientation, promotion, program-

ming, coordination, evaluation, and integration of health activities at the national level;

b) It assesses demand based on the population's health status and the health needs manifested by the community;

c) It determines the nature and volume of the resources needed to cover health activities;

d) It evaluates the return on such activities and the utilization of resources in the public and private sectors;

e) It collaborates in the formulation of the national health plan, evaluates it periodically and brings it into line with the national development plan;

f) It proposes technical regulations with a view to greater uniformity, coordination, efficiency, and integration of health activities carried out by public and private bodies;

g) It obtains from public and private institutions or agencies any records and information it requires; and

h) It submits to the President of the Republic such legal and administrative reforms as it deems necessary.

Any attempt at coordination for the purposes mentioned must be the outcome of careful programming undertaken in the light of what is nationally feasible. In other words, the national development plan must be the basis of any action by the National Advisory Council on Health in its task of establishing a national health system (6).

Accordingly, the first measure taken by the Ministry was to organize the Planning and Budget Office, fusing at the sectoral level the planning offices of the National Health Service and the National Medical Service for Employees, and to place it at the disposal of all the institutions belonging to the Council.

The National Advisory Council on Health meets once a month, apart from extraordinary sessions which are held whenever circumstances so require. There is a secretariat whose task is to implement the Council's decisions. It comes directly under the Minister and has ready access to his office, an important factor in efficient administration.

Experience has shown that the establishment of Council committees, composed of its members or their representatives, is one of the most effective coordination devices, having the

virtue of bringing together those in charge of the same type of programs in different institutions. To date, six standing committees have been set up, to deal with cancer, tuberculosis, rehabilitation, technical assistance and fellowships, dental health, and graduate and refresher courses. They are made up of the chiefs of the programs covering these subjects in the institutions constituting the Council. One of the principal functions of the committees is to act in an advisory capacity to the Ministry and the Council, especially in working out national plans of action and assigning to each institution its responsibility and its share in the execution of programs, and to evaluate the resulting productivity.

One important factor limiting all expansion of health activities is the availability of professional staff. To create new services without at the same time increasing personnel or improving their productivity is merely to establish an unproductive form of competitiveness among the institutions.

The Council recognized this from the outset, and one of the first things it agreed to do was to undertake a study of health manpower, based on a national survey of the demand for medical and dental services, covering 50,000 people, and an investigation of professional productivity and of health services. Side by side with that, a survey was made of the economic capacity of the country to cope with the increasing demand for services and personnel and their future expansion. This was helped by financial support from all the bodies making up the Council and by technical advice and contributions from PAHO and the United States Agency for International Development. The study began in 1967 and is in the analysis stage; it was hoped to publish the conclusions by mid-1970.

Because of its concern for personnel training, on the initiative of the Ministry the Council set up a committee on graduate and refresher course training whose purpose is to establish the national policy relating to the training of specialists, including of course the task of determining the country's needs in this respect.

An important objective which the Council has to attain if food coordination is to be obtained is that of standardizing the system of purchasing drugs, instruments, and equipment. Each of the agencies making up the Council has in the past had its own purchasing system. The larger institutions, in particular SNS, were in a position to make much more satisfactory transactions than the others because of the enormous volume of their purchases. Approval of the national purchase order form, which is compulsory for the public sector, considerably simplified the coordination of purchase, industrialization, and supply of what seemed a very complex matter, namely drugs.

As a result of the Council's studies, SNS has placed its supply center at the disposal of the other institutions in the public health sector in accordance with rules drawn up by the Council. This has made it possible for those using it to procure supplies at substantially reduced prices.

One problem which has seriously concerned the Government, and especially the Ministry of Public Health, is drinking and alcoholism. The Council spent several sessions discussing the subject, listened to the views of leading specialists on the matter, and set up a commission to make concrete proposals for a concerted government policy. The commission submitted to the Council a draft bill for legislation, which was approved by the Council. It was passed on to the Ministry of Public Health, which has finally sent it to Congress for approval.

Similar concern has been shown by the Ministry and the Council about malnutrition, a problem difficult to tackle because of its multisectoral nature. A committee set up by the Council is at present working on a project to coordinate all interested sections; this will probably also call for legislative action.

It has been pointed out that an invariable feature of the policy of the Chilean social welfare institutions has been not to organize hospital services of their own, but wherever possible to use the facilities of the SNS. The Armed Forces, the police, the State railways, etc., likewise have built only a few hospitals in areas where their personnel are most highly

concentrated; elsewhere in the country they use the SNS hospitals. The current contracts signed over the years were extremely varied, establishing discrimination which it is difficult to understand and even more difficult to justify.

The uniform use of resources such as hospital beds, and in general of medical services and access to them by the entire community throughout the country on an equal footing, has always been one of the prime objectives of the National Health System. Hence it is not surprising to find that this has been one of the aspects of greatest concern to the National Advisory Council on Health. In November 1968, the Council adopted a resolution recommending institutions to cancel the service contracts in force and to work out new contract forms based on the SNS medical care regulations. These regulations are approved by the Council; they have been adopted by the Ministry; and hence they now apply uniformly throughout the entire public health sector.

The fruits of this policy have not been long in maturing. Under pressure from employee groups and associations, the National Medical Service for Employees had been seriously considering building hospitals for employees in the city of Santiago, where undoubtedly the problem for its beneficiaries was acute. In fact it had considerable funds from the welfare organizations for this purpose. The matter was brought before the Council and studied by it in the context of the regulations referred to above, and it was decided to build a hospital in one of the expanding districts of the city with no hospital of its own, and to hand over the administration to SNS, which would run the hospital for the benefit of the entire population. It was arranged that the construction costs would be financed with assistance from the employees, who were liberally admitted to the SNS hospitals throughout the country in accordance with the regulations in question. This arrangement was accepted in all quarters, and is now proceeding smoothly.

In its concern to find ways and means of making better use of the available resources, the

Council recently approved a pilot project for integrated medical care in a small sector of the city of Santiago with some 20,000 inhabitants who are beneficiaries under various types of welfare schemes. The idea is to provide medical care for the entire population without distinction, using the manpower and material resources furnished by all the participating institutions under a joint direction. If as is hoped this method proves itself, the experience will have incalculable value for the future.

One of the results, largely imponderable but not any less important on that account, of the establishment of the National Health System is that for the first time the heads of all the public health services, universities, and representatives of professional associations have been given an opportunity to meet regularly around a table for the purpose of thrashing out and analyzing common problems, not in an institutional spirit but on a broad national basis. In the course of the Council's studies and deliberations, the policy, interests, problems, resources, and limitations of the various participating bodies have been brought to light. Such a bird's eye view would never have been possible, nor would the opportunity have arisen to analyze it from all angles, if there had been no Advisory Council.

This brief account of the results achieved since the National Health System was established confirms the validity of the thesis propounded by the Ministry of Public Health. The Ministry has received considerable backing from a Study Group convened in August 1969 by PAHO to analyze the coordination of medical care. The Group recommended that "the ministry of health should be the promoter of coordination among all the institutions operating in the health sector, including the

private area." To put this into practice "the Group recommended that health councils or commissions be established at the highest administrative and political level and with sufficient legal authority to advise the ministry of health on the framing of a health policy and on administrative coordination at the operational level." (7)

The conclusions of the Study Group were confirmed during the Technical Discussions on Financing of the Health Sector held in Washington during the XIX Meeting of the Directing Council of PAHO in October 1969, when it was decided that "A reorganization of the institutional structure of the health sector is therefore urgent. This would result in an increase in productivity, which is more important than a mere increase in sectoral financing." (8)

### Summary

The improvement in the general and child mortality figures in Chile over the last 45 years has been spectacular. The authors trace the evolution of the health system, up to and since the establishment of the Chilean National Health Service in 1952, with the fusion of a number of disparate, sometimes excellent but uncoordinated medical, social security, and welfare bodies. Despite the noteworthy success of the efforts, the Chilean health authorities have realized that there is little possibility of achieving total coverage of the population's health needs unless the limited manpower and material resources are used to capacity and with maximum efficiency. For this reason, in 1967 the Government set up the National Advisory Council on Health, a high-level organ comprising all the main institutions in the country concerned with health. The article describes the legal basis, the organization, the functions, and the not inconsiderable achievements of the Council since its inception. □

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