The State of Education and Training in Integrated Care in Chile

By Dr Osvaldo Artaza

Country context

Chile is a unitary democratic republic. In the year 2023, the total population of Chile was 19,629,590. The population of individuals over 65 years old accounted for 13.5% of the total, with a ratio of 74.1 elderly individuals (65 years and older) per 100 individuals under 15 years old. The population of potentially active individuals aged 15 to 64 represented 68.4%, with a dependency ratio of 46.3 potentially inactive inhabitants per 100 potentially active inhabitants. The per capita income is US$15,355, and the poverty rate at the individual level is 6.5%. Estimates of multidimensional poverty incidence at the household level stand at 13.4%, with a Gini coefficient of 0.491.

The literacy rate is 99.2%, the unemployment rate is 8.7%, and the Human Development Index is 0.855. The percentage of the population with internet access was 90.2%. Life expectancy at birth for the year 2023 was 81.2 years. Infant mortality is 6.5 per 1000 live births. The maternal mortality ratio is 15 per 100,000 live births, and women, on average, have 1.5 children throughout their reproductive lives. The leading causes of mortality are non-communicable diseases such as cancer and cardiovascular diseases.

In Chile, 70% of the population aged 15 and older lives with multimorbidity, meaning the presence of two or more chronic conditions simultaneously. There is a high prevalence of obesity, hypertension, and diabetes in the country.

In Chile, since the military dictatorship (1973-1989) concluded with the termination of the National Health Service established in 1952, there exists a segmented, fragmented, and inequitable health system. Within this framework, a public insurance system covering 86% of the population (National Health Fund - FONASA) coexists with multiple private insurance schemes (ISAPRES) catering to 14% of the population. While the majority of health care provision in hospitals falls under the public sector, ambulatory care is evenly split between public and private providers.

The private sector operates on market principles, incentivising the consumption of healthcare services. On the other hand, the public sector faces challenges in addressing the needs of individuals and their communities due to various issues, including insufficient funding, organisational shortcomings, and the presence of a phenomenon known as multiple capture. This involves pressures from the healthcare market to generate increased service consumption, influences from clientelist interests of political parties, the presence of strong corporate interests, and the dominance of a hospital-centric biomedical paradigm.

Public expenditure on health represents 5.17% of the gross domestic product (GDP) and 15.47% of the total public expenditure. Out-of-pocket spending on health constitutes 28.87% of the total health expenditure. Only 23% of public spending is allocated to financing Primary Care, with the majority directed towards public hospitals.

In Chile, the delivery of health services constitutes a human resource-intensive economic sector, representing 46.3% of the public sector workforce (Annual Report on Public Employment 2012-2021 DIPRES). This sector is characterised by a highly feminised workforce (69%), with an average age. Currently, there is a rate of 3.1 doctors, 3.8 registered nurses, 2.0 physiotherapists, 1.5 dentists, 4.0 psychologists, and 12.4 higher-level health technicians per 1000 inhabitants. Approximately 24% of doctors are foreign nationals, with a preference for working in primary care (about 40% of first-level healthcare providers are foreigners).

As of December 2022, the staffing of the public network of Health Services and Municipal Primary Care totals 268,697 employees, showing a 96% increase from 2013 to 2022. Regarding the composition of the workforce as of December 2022, 59% is concentrated in the hospital network of Health Services (157,992 employees), and 41% corresponds to Municipal Primary Care (110,705 individuals). Due to the COVID-19 pandemic, the public health sector's workforce increased by 23%; however, significant gaps persist in the number and distribution of professionals, particularly in medical specialities, mental health professionals, and personnel for emerging areas such as rehabilitation, ambulatory major surgery, and home hospitalisation.

Given the limited oversight of the Ministry of Health over the labour market, health professionals, especially specialist doctors, tend to concentrate on areas with higher consumption of healthcare services. The Ministry of Health has insufficient capacity to alter the practices of health personnel and redirect their skills towards the new health challenges posed by demographic and epidemiological shifts.

Education and training focused on integrated care

During the dictatorship, higher education in Chile, which was primarily state-funded and free, transitioned to being predominantly private (83% of enrollment) and fee-based. Following the restoration of democracy in 1990, a system of state-backed bank loans was introduced to facilitate university access. Finally, in response to citizen pressure, particularly from student mobilisations, a tuition-free system was established in 2016 for students from households belonging to the lowest 60% of income earners in the country.

In Chile, higher education aims to prepare and educate students at an advanced level in sciences, arts, humanities, and technologies, as well as in the professional and technical fields. The prerequisite for admission is a secondary education diploma. Higher education instruction encompasses various levels of educational programmes through which it is possible to obtain degrees such as higher-level technician, professional titles, academic degrees, or university degrees and their equivalents. The higher education system is composed of the technical-professional subsystem and the university subsystem.

The university subsystem in Chile comprises 60 universities officially recognised by the state. It includes state universities established by law, non-state universities belonging to the Council of Rectors, and private universities recognised by the state. The technical-professional subsystem encompasses state technical training centres, as well as private professional institutes and technical training centres recognised by the state.

Professional education provides general and scientific training, leading to the attainment of a professional degree, a bachelor's degree, or both. Professional careers are offered at universities and professional institutes, with the majority having an approximate duration of five years. Certain professional degrees, as stipulated by law, require the prior acquisition of an academic degree, and in such cases, the degrees are conferred by universities.

Technical education is geared towards developing skills for employment in a specialized field either professionally or as a self-employed individual. Technical programs typically have a minimum duration of four semesters.

The total enrollment in higher education for the year 2022 is 1,301,925 students, considering undergraduate, postgraduate, and post-degree levels. In 2022, undergraduate enrollment constitutes 93.1% of the total enrollment, postgraduate enrollment is 4.2%, and post-degree enrollment is 2.7%. Based on the type of institution, in 2022, universities account for 59.3% of the total enrollment, followed by professional institutes at 30.5%, and, finally, technical training centres at 10.1%. Currently, state universities only represent 16% of the total enrollment.

In the year 2022, there were a total of 220,000 undergraduate students enrolled in health-related programs (45,000 in the first year, including 7,600 in nursing and 3,000 in the first year of medicine) The enrollment of first-year students in 12 health professional programs, between the years 2010 and 2022, has increased by a total of 9.5%, with the most significant growth observed in Obstetrics and Gynecology (+156.5%), Pharmacy and Chemistry (+103.6%), and Occupational Therapy (+94.1%).

Examining the progression of graduates, it is evident that all programs have shown an increase between the years 2010 and 2021, with an overall variation of 67.5%. Changes in the university offerings are influenced by market forces, given the limited regulatory influence of the Ministry of Health over universities.

The Ministry of Education, through the Higher Education Undersecretariat, formulates policies for higher education and coordinates the state entities within the system. However, this leadership is weak in comparison to the predominant influence of the market. The university system is primarily regulated by supply and demand, and the State has focused on ensuring the quality of the system through a robust National Quality Assurance System for Higher Education. This involves national qualifying exams, such as the National Medical Knowledge Examination (EUNACOM), and a national registry accrediting individual providers.

Enabling factors and barriers

Macro Level

The country expresses its commitment to integrated care through policies issued by the Ministry of Health, as guided by the current care model, legislation safeguarding patient rights, and a quality care accreditation system. This system is currently incorporating specific aspects related to person-centered care.

However, these efforts prove insufficient considering the market's impact on the training of healthcare professionals and the dominance of the hospital-centric paradigm within the Chilean healthcare system. Professional associations are more concerned with their participation in the market and the social and economic status of their members. Patient associations focus on issues related to access to diagnostic and therapeutic procedures, with some emerging to seek funding for high-cost health technologies, at times with questionable cost-effectiveness. Participation in healthcare is primarily formal, utilitarian, and often clientelist. Consequently, despite a declared intent to move towards integrated care, this objective has only been partially achieved.

Meso Level

At the intermediate level, processes of change are observed within academic groups, some health faculties, and numerous local efforts that have not yet been properly systematized and shared.

To strengthen the change process towards integrated care in Chile, the following aspects are crucial:

1. Ministry of Health's influence in defining the profile of health students' graduation and the subsequent adjustment of curricular frameworks.
2. Incentives for territorial work in primary care and for establishing genuine mechanisms for people's participation at all levels of the healthcare system.
3. Shifting the accreditation system for health education quality away from an exclusively biomedical perspective. National qualifying knowledge exams should adopt an integrated care perspective, and the accreditation system for providers should extend beyond patient safety considerations.

4. Aligning Chile's declared care model with structural transformations that support integrated care, including an increase in funding proportion for integrated action and care in the territories, incorporation of new disciplines and interdisciplinary capabilities, and ongoing training for human resources in integrated care capacities.

Micro Level

Professions maintain a monodisciplinary identity rooted in the biomedical paradigm, and the interpersonal practices among healthcare personnel, as well as their interactions with individuals and communities, remain highly traditional, hierarchical, paternalistic, and paternalistically oriented.

The pandemic served as a strong catalyst for a change in thinking that must be sustained over time. This necessitates political will, financing, and the persistent implementation of actions as state policies.

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United Kingdom
Annexe Offices
Linton Rd
Oxford OX2 6UD
United Kingdom

The Netherlands
The Base B
Evert van de Beekstraat 1-104
Schiphol Airport 1118CL
The Netherlands

Email: info@integratedcarefoundation.org
Linkedin: mylinkd.in/IFICInfo
Facebook: facebook.com/IFICinfo
Vimeo: vimeo.com/integratedcare
Bluesky: @IFICinfo

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