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9. ABSTRACT

The American Public Health Association, under a contract with the Agency for International Development, has designed a program in public health improvement which is called the Development and Evaluation of Integrated Delivery Systems (DEIDS). The activity is designed to assist countries to demonstrate how to establish health delivery systems within seven years. Such projects include, but are not limited to, Maternal and Child Health and Family Planning and Nutrition. The projects are to cover large populations in predominantly rural areas. They are to utilize in-country resources for the service component, although external assistance organized by DEIDS is available for planning, evaluation, training, and limited amounts of essential equipment. It is expected that successful health delivery systems can be subsequently replicated in the country or in the region.

These are phases through which DEIDS projects proceed:

- a) Phase I -- reconnaissance within a specific country or region, to gather information about disease patterns, health services as currently organized, local resources, cultural aspects, community involvement, the potential for integration of various parts of public health, opportunities for innovation, current and potential staffing, training, supervision, emphasis upon preventive services, outreach, cost, and evaluation
- b) Phase II -- Detailed planning. This phase begins if the survey in Phase I recommends it, and involves experts from the host country as well as experts assigned by DEIDS.
- c) Phase III -- Pilot Project Operations, which continue for as long as eight years.

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**Field Survey Report**  
**of**  
**National Voluntary Health Organizations**  
**in**  
**Argentina, Brazil, and Chile**

A collaborative project undertaken by the  
American Public Health Association  
and the  
World Federation of Public Health Associations

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**Submitted to:**

**The United States Agency for  
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## I. Introduction

The survey of national voluntary health organizations (VHOs) in Argentina, Brazil and Chile, represents the second half of the South American phase of the study. This survey is a continuing part of the APHA/WFPHA worldwide study entitled, "The Roles of National Voluntary Health Organizations in Supporting National Health Objectives." The survey was carried out by Mr. Russell E. Morgan, Jr., in August 1973. The first half of the South American study was completed in July 1971 by surveying national VHOs in Venezuela, Costa Rica, and Colombia.

In each of the countries surveyed, there was a resident who assisted the project as the local representative or Project County Representative (PCR). In addition to many other activities, the PCR distributed project questionnaires and arranged the interview schedule, prior to the survey. Frequently, the PCR joined in the interviewing and provided valuable analysis thereafter. The overall effect was quite successful and resulted in a high rate of questionnaire return from our basic group of 12 VHOs. Occasionally, some of the voluntary organizations in the basic group were temporarily on recess or not found to exist in these countries. A summary sheet of VHO characteristics from each country is found in Appendices A, B, and C.

Dr. Murillo Belchior, President of the Medical Council in Rio de Janeiro, assisted the survey in Brazil. In Brasilia, the survey was also assisted by Dr. Claudio Penna, President of the Brasilia Medical Association, and in Sao Paulo by Dr. Geraldo de Silva Ferreira, Director of the Sao Paulo Hospital Association. A total of 30 interviews were held between July 20 and August 1, 1973 (Rio de Janeiro - 17, Brasilia - 7, and Sao Paulo - 6).

In Argentina, Dr. David Sevlever,\* former Director of the School of Public Health, University of Buenos Aires, assisted the survey. From August 2 to August 8, twenty-three interviews were held; questionnaires were also obtained from every voluntary organization interviewed.

In Chile, Dr. Jose Ugarte, Director of Medical Education for the Chilean Medical Association, assisted the survey between August 9 and August 14, 1973 by arranging sixteen interviews.

A complete list of all the organizations and individuals interviewed is found in Appendices D, E, and F.

It should also be mentioned that, during the period of this survey, several of the countries were under severe political and economic strains. The ability of the PCR to obtain interviews and project data under these conditions attributes to their success.

The national VHOs surveyed fell into two major categories: (a) Voluntary Health Agencies, and (b) Health Professional and Institutional Association. As much as possible, these organizations had certain common characteristics. They are:

1. Private, that is, non-governmental;
2. Operated on a nonprofit-making basis;
3. Organized democratically, that is, meet periodically to elect their officers and determine policy;
4. Independent in action, to some degree;
5. National in their scope, concentrating their efforts on preventative health measures, although some include curative or rehabilitative measures as well.

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\* Dr. Sevlever also assisted in formulating the suggestions on page 25 of this report

It is important to remember that nearly all these voluntary agencies and professional associations function under the legal supervision of some governmental agency. A great proportion of these VHOs receive some financial support from the government. The amount and level of financial assistance varies by country.

All the voluntary health organizations which provide medical care fulfill their specific tasks in accordance with the prescribed medical ethics of their country. For this purpose, it is often required that the Technical Director be a graduate, licensed health professional.

Many of the health services provided by the VHOs are given free to the poor or at a very low fee.

It is interesting that frequently programs undertaken by a VHO represent specific action in a health area and precede governmental initiative. Today, many of the VHOs are fulfilling their work as a para-official agency with some independence.

The VHOs are particularly conscious of the importance of their contributions to public health education. Several VHOs are also involved in the training of auxiliary personnel and in providing support for basic and related biomedical research.

The prevalent tendency of these VHOs is to get an independent financial life. In practice, they operate in many instances with the contributions received from their own members, private donors, legates and, in the past, from minimal fees received for services. But mainly, they depend in some degree or another on governmental financial assistance.

Many professional associations in the health field devote a great deal of their attention to social and economic problems. Of special importance are those problems created by disease and those resulting from handicapped individuals. The continuing objective of these organizations is to contribute in a substantial manner to improving the present systems of medical care.

## **II. General Conditions**

### **A. Demographic Data**

Argentina, Brazil, and Chile represent three advanced countries in South America. Such a statement is reinforced by the high level of literacy found in each of the countries: 91%, 67%, and 84%, respectively.

Economically, all three countries are rapidly expanding their industrial and agricultural sectors. National development plans have been constructed and are now being implemented. The gross national product in these countries is also rising; with the most rapid increase occurring in Brazil. Income distribution, however, is somewhat skewed. This is partially due to the rapid rate of migration from the rural to urban industrialized areas where the economic development has been most concentrated.

The health statistics data of the three countries show that in some sectors there exists a good level of health care. But the governments in all three countries are aware of the increasing demands being placed on their services, the corresponding few resources available to meet these demands, the scarcity of health care manpower, and the need to reinforce their system of national health care so that the highest scientific and technical levels of care are available to the total population.

The information on the following pages provides a summary of the present health statistics in these countries.

**ARGENTINA****Statistical Data**

Land Area	2,776,889 per km <sup>2</sup>
Density of Population	9 per km <sup>2</sup>
Population (1970)	23,364,431
Population Estimated (1971)	24,824,000
Population Projection (1980)	28,218,000
Birth Rate (1971)	21 per 1,000
Death Rate (1971)	8 per 1,000
Infant Mortality (0-1 yrs) (1970)	56 per 1,000 live births
Life Expectancy at Birth (1971)	68
Population under 15 years (1970)	29%
Rate of Natural Increase (1971)	1.3%
Urban Population (1970)	81%
Gross Nat. Product per capita (1970)	U.S. \$1,055
Percent Literate (1970)	91
Food, Calories per day and person (1967)	2,810
Food, Animal Protein and Person (1967)	34 grams
Health facilities: governmental and non governmental (1965)	3,308
Health facilities: Number Hospital Beds (1965)	141,888
Health facilities: Population per Bed Hospital (1965)	151
Health Personnel Physicians (1969)	45,340
Health Personnel Dentists (1969)	12,954
Health Personnel Midwifery (1969) only in hospitals	2,905
Health Personnel Pharmacists (1971)	11,000
Health Personnel Nurses (1972)	45,000
Health Personnel per Physician (1969)	504

Information from "Statistical Year Book" 1971 -(Published by the U.N.) and "Populations Program Assistance" 1972 (Published by U.S. Agency for International Development)

**BRAZIL****Statistical Data**

<b>Land Area</b>	<b>8,511,965 per km<sup>2</sup></b>
<b>Density of Population</b>	<b>11 per km<sup>2</sup></b>
<b>Population at 1970</b>	<b>93,204,379</b>
<b>Population Estimated (1972)</b>	<b>99,988,000</b>
<b>Population Projection (1980)</b>	<b>124,000,000</b>
<b>Birth Rate (1971)</b>	<b>37 per 1,000</b>
<b>Death Rate (1971)</b>	<b>9 per 1,000</b>
<b>Infant Death (0-1 Year) (1970)</b>	<b>94 per 1,000 live births</b>
<b>Life Expectancy at Birth (1971)</b>	<b>63</b>
<b>Present Population (Under 15 Years) (1970)</b>	<b>42%</b>
<b>Rate of Natural Increase (1971)</b>	<b>3.2%</b>
<b>Urban Population (1970)</b>	<b>56%</b>
<b>Gross National Product per Capita (1970)</b>	<b>U.S.\$ 364</b>
<b>Literate Populations</b>	<b>67%</b>
<b>Food – Calories per day and person (1966/68)</b>	<b>2,540</b>
<b>Food – Animal Proteins per day and person</b>	<b>16 grams</b>
<b>Health Facilities – Governmental Hospitals (Only) (1967)</b>	<b>3,238</b>
<b>Health Facilities – Hospital Beds (1967)</b>	<b>294,683</b>
<b>Health Facilities – Population per Bed</b>	<b>284</b>
<b>Health Personnel – Medical Doctors (1969)</b>	<b>47,250</b>
<b>Health Personnel – Population per Physician (1969)</b>	<b>1,953</b>
<b>Health Personnel – Dentists (1969)</b>	<b>26,611</b>
<b>Health Personnel – Pharmacists (1969)</b>	<b>14,026</b>
<b>Health Personnel – Nurses (on hospitals) (1969)</b>	<b>28,003</b>
<b>Health Personnel – Midwifery (1969)</b>	<b>1,992</b>

**Information from Statistical Year Book (1971)**

**(Published by the United Nations) and Population Program Assistance (1972)**

**Published by U.S. Agency for International Development**

**CHILE****Statistical Data**

Land Area	756,945 per km <sup>2</sup>
Density of Population	13 per km <sup>2</sup>
Population (1970)	8,834,820
Population Estimated (1972)	9,597,000
Population Projection (1980)	11,000,000
Birth Rate (1971)	28 per 1,000
Death Rate (1971)	9 per 1,000
Infant Mortality (0-1 year) (1970)	92 per 1,000 live births
Life Expectancy at birth (1971)	63 years
Population under 15 years (1970)	40%
Rate of Population Increase (1971)	1.8%
Urban Population (1971)	74%
Per Capita Gross National Product (1970)	U.S.\$ 794
Health Facilities Number of Hospitals (1969)	234 (Governmental Only)
Health Numbers of Hospital Beds (1969)	33,667
Health Population per Bed	284
Food – Daily Calories per Person (1964/66)	2,520
Food – Daily Animal Proteins (1964/66)	18 grams
Health Personnel Physicians (1969)	3,917 (in hospitals only)
Health Personnel Dentists (1969)	984 (in hospitals only)
Health Personnel Nurse (1969)	15,832 (in hospitals only)
Health Personnel Pharmacist (1969)	305 (in hospitals only)
Health Personnel Midwife (1969)	887 (in hospitals only)
Health Personnel Population per Physicans (1969)	2,443

## B. Delivery of Health Services in Brazil, Argentina, and Chile

The variations that exist in delivering health services in each of the three countries surveyed warrants that each be described somewhat independently. In doing so, however, no attempt is being made to judiciously explain the systems to their finest detail. Rather, the descriptions are focused in setting the framework in which the national VHOs must function. Emphasis has been placed on identifying relationships which would be useful in understanding the role of the national VHOs.

The Brazilian Government has centered its interest on a progressive development of health services provided directly or indirectly by the governmental agencies.

For many years Chile has had a socialized form of national medical services. In both countries, therefore, the health coverage of a great proportion of their population is through the national system of medical care. As always happens, the bulk of the budgets is concentrated in curative health care, which results in the hospital services absorbing most of the funding.

The Argentine Government is actively studying a Comprehensive Plan of Medical Care under the principle of integration and coordination of all the existing governmental, profit, and nonprofit private medical services.

In Brazil, the tendency has been to provide medical services through its Social Security Institutions. The rapidly expanding economy, coupled with the increase in population and urbanization, have resulted in the major portion of government-sponsored health care being provided in urban areas.

Many ministries in Brazil are involved in health activities, but the bulk of the health care programs are the responsibility of the Ministry of Labor and Social Security, (MOL/SS) and the Ministry of Health (MOH). Excluding funds for sanitation programs, these two ministries provide approximately 55% and 4%, respectively, of the 1973 expenditure which amounted to approximately 9.5 billion Cruzeros.

The Social Security Systems in Brazil started 25 years ago. Today, the country's population is nearly 100 million and, of this, 85 million people are covered by the Social Security schemes which are broken down in the following manner:

<b>Social Security Schemes</b>	
<u>Type</u>	<u>Coverage</u>
Government	40 Million Urban 40 Million Rural
Private	5 Million Urban

Total = 85 Million pop. covered by S.S.

The Government scheme is based on contributions from the employee (8%), the employer (20%), with the Government paying the salaries and overhead of the administration. By law, Social Security must provide curative health services including hospitalization, drugs, and dental care. Health care, however, is not yet uniform, and it was estimated that of the 4,014 counties in Brazil, approximately 1,500 have less than minimal health care facilities. Social Security has 25 of its own hospitals or 12,000 beds, all in urban areas and many in teaching hospitals. The remainder of the services are purchased under contract, mainly from nonprofit sources totaling 3,500 hospitals or 380,000 beds. Fees for these services are regulated by government. Private services are also purchased at fixed fee rates. In addition, Social Security gives direct grants to some voluntary organizations for their services.

**Social Insurance has, therefore, become the single largest financing agency of health care in Brazil.**

**The Ministry of Labor and Social Security has also established a “nonprofit organization structure,” the Fundacao Legiao Brasileira de Assistencia (LBA), as part of its service. LBA is a foundation, attached to the MOL/SS. It was started in 1922 to help the children of soldiers’ families. Today, LBA provides health and social care to the children and mothers of indigent families. The Government selects the staff and, although there are no “dues paying” members, LBA does have a local board of citizens in each state. The annual budget of LBA is approximately US \$30 million\* of which 40% is derived from lottery profits, the remainder coming from fees paid for services. LBA has extensive medical care, which is also achieved by contracting with nonprofit hospitals or clinics. In 1973, there were nearly 800 contracts. The most significant factor from the survey’s viewpoint is that LBA, a quasi-governmental organization, uses existing nonprofit organizations at the local level to provide health services to the low income members of the community. LBA has a central staff of 5,000 employees. Recently, they estimated that their services reach 10 million people.**

**The Ministry of Health functions at several different levels – the Federal, State, and Municipal. Financially, there are imbalances; for example some state ministries have more funds than their counterparts at the Federal level.**

**The MOH is not only responsible for preventative health but, by law, is also responsible for “health policy.” The recent expansion in MCH programs reflects one of the new directions of this policy. At the Federal level, the MOH is organized in the following manner:**

**The Secretary of Public Health is responsible for the control of endemic diseases and other preventative health measures. The Secretary of Medical Care is responsible for overseeing the major health institutions including Mental Health, Cancer, Maternal and Child Care, and others. In the Office of Medical Care, there is a specific division in which all voluntary health agencies with health institutions must register.**

**There are apparently few philanthropic foundations in Brazil. This circumstance, it was explained, is due to the great amount of personal and industrial income taxes that are deducted.**

**The Foundation “Special Public Health Service” (SESP), financed initially in great part by foreign funds (U.S. 90%), has been attached since 1960 to the Ministry of Public Health. SESP is not a voluntary organization today, but several health units of outstanding importance are running under SESP control. The Foundation gives priority to the following aspects of health research and activities:**

- a) control of communicable diseases;
- b) increase health units’ productivity;
- c) expanding health units.

**The two largest quasi-governmental foundations, SESP and The Oswaldo Cruz Foundation, are an essential part of the design for, like the foundations of the MOL/SS, they allow the MOH to be somewhat flexible. Under the “New Health Policy” now being prepared, more emphasis will**

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\*All amounts stated are in U.S. dollars.

be placed on utilizing the capabilities of the "foundation mechanism." This concept in administration is typically Brazilian and found frequently at the other levels of government.

The role of private practice in providing health care is rapidly disappearing. It was estimated by the Government that in 1973 almost 95% of all doctors are paid by Social Security. Private health cooperatives, however, play an important role, especially in the urban areas. One of these groups, the Servicio Social da Industria (SESI), is located in every state. In Gunnabara State, SESI has 5,300 industrial members, representing 420,000 employees. These groups are legally established as private, nonprofit organizations.

Health manpower development in Brazil is currently undergoing serious review. The identified need at this time is to build an adequate, economically supportable infrastructure of health workers. Although there is no noticeable "brain drain" at present, the recent increase in the number of medical schools to seventy-three, will result in nearly 5,000 graduates per year. This in itself may cause some serious problems in the near future. Few of the health workers go into public health because of the rather low salary scale. A legislative bill is now being prepared to remedy this problem.

Brazil has over 1,200 charity hospitals. These institutions vary in size from 40 to 1,500 beds. The larger ones were constructed as asylums for orphan children and for old, poor people. The aim of these efforts was to help socially the unprotected groups. Today, the general feeling in these institutions seems to be that the social insurance programs are always a better solution when the institutions cannot get substantial subsidies or adequate philanthropic support from the general public.

The Brazilian government believes in national plans as a chief means in solving the country's health and social problems. The integration of the people with the public institutions is an objective that is currently receiving serious study.

In Argentina, the present mechanisms for delivering health services are in a state of hiatus following the recent political normalization. As part of this reorganization, there is no longer a Ministry of Health but rather a Secretariat of Public Health under the Ministry of Social Welfare.

A new health scheme is now being prepared for implementation in 1974. Part of this scheme reportedly involves the increased use of the private, nonprofit organizations. In particular, the government would like to see the voluntary organizations bring the community into closer contact with the medical care facilities.

The brain drain is well recognized in Argentina. It was reported by the Medical Syndicate that more than 2,000 Argentine doctors are still in other countries after successive years of emigration.

In Argentina, health care is financed by many private insurance schemes which, by law, must provide specific protection for both urban and rural workers, especially regarding accidents and occupational diseases. In addition, individuals over 65 years of age in many areas are protected by retirement laws which give them free medical care on a domiciliary basis and free hospital care. These services protect the family of the retired person.

Due to the highly centralized patterns of economic development in Argentina, over 35% of the entire country's population lives in the greater Buenos Aires metropolitan area. Health services, like other services, are therefore concentrated in this immediate region. To understand the current manner of health care, it is essential to review the tradition and influence placed on the social and health institutions in Argentina.

Care for the poor and handicapped persons (orphans, aged, mentally ill, etc.) was always considered the responsibility of the local authorities, provincial or federal. Special agencies were created to achieve these goals, but mainly this occurred in the largest cities. Very often, these services were given by voluntary organizations. In all cases the principal support came from public, that is governmental, funds. At the federal, provincial and municipal levels, there exist separate department to cope with the different health, social, and medical problems. Sometimes they take the direct administration of a health institution, such as a hospital, asylum, or nursing home. But practically all of the voluntary health institutions, although administered independently, receive financial support from the government.

Frequently, the existing overlapping of health institutions with similar medical purposes under federal, provincial, municipal, and private (profit or nonprofit) jurisdiction, in the past created the necessity for a coordinated and integrated regional system of health care.

The private physician was until very recently the principal source for medical care for the wealthy groups of the population. For serious illness and surgical care, this group was treated in private institutions owned by physicians (i.e., private clinics or hospitals called "Sanatoria Privado").

Poor people had free medical assistance in the public governmental hospitals, for outpatient and inpatient treatment. There were also some charity hospitals run by voluntary religious groups (Hospitales de Caridad), many of which were eventually transferred to the governmental authorities. In all these governmental institutions, the physicians were appointed with a token salary or without salary at all. Even today, there are still some physicians working in these hospitals, receiving only an honorarium.

Emergency and ambulance services are free public services provided by the government hospitals.

For many years, there existed a special kind of private nonprofit medical care in Argentina, organized initially by some ethnic or occupational groups (mainly representing the middle class of the population). These nonprofit health organizations were called "Mutual Aid Societies" (or, "Mutuals"). Their service covered practically all the medical care needs of the members of these nonprofit organizations.

Similar kinds of nonprofit medical care institutions exist in Argentina for workers and employees of the different governmental departments and ministries under the name of "Obras Sociales." The support of these organizations is secured through contributions from the employees and the governmental agency in different proportions. The services are obtained under contract with private physicians and private, profit hospitals (Sanatorios Privados). The medical syndicates control the agreements between both parties in reference to the fees paid for services and the maintenance of the principle of "free election of doctors" by the patient.

The above information concerning these free, governmental services, "mutuals" and the "Obras Sociales," which are supported by the employees or workers, and the industrial and governmental agencies, explains why voluntary health organizations in Argentina are prone to be more interested in prevention than in the general curative aspects of medicine.

Chilean health services are administered by the Ministry of Health which receives support from the sophisticated Social Security System and the Government. Chile was the first country in the Americas to have a Social Security System (September 8, 1924) which, by law, gave the

worker health security in case of illness, invalidity, old age, or death. Dr. Jose Ugarte, PCR in Chile, describes in detail the history of the system in his article, "Medical Care in Chile" found in Appendix G.

The Government Social Security funds are obtained from donations from the employee (approximately 10% of salary) and donations from the employer (approximately 39% of salary). This scheme varies slightly for private employees. In May 1973, a law was passed making it compulsory to belong to the Social Security System. In addition, there are more than 20 Mutuels, or private, nonprofit insurance schemes, which are also regulated by the Government.

The Ministry of Health, the overall administrative unit for health, subdivides its health services into two units: the National Health Service (SNS) and the National Medical Association for Employees (SERMENE). The former unit serves the "blue collar" workers. The historical development of each unit accounts for its separate nature although, today, there is effort to unite the two under the new policies of the "Unique Health Service" plan now being organized.

The MOH receives its budget support in the following manner:

Sources of MOH Budget

Source	Estimated Percentages
Social Security	12%
National Budget	80%
Service Fees	<u>8%</u>
	100%

Chile is divided into 13 administrative *zones* covering the entire country. Within each zone there are *local health areas*, totaling 54. At a minimum, the health area contains one hospital with facilities for general medicine, surgery, and pediatrics as well as obstetrics and gynecological care. Attached to each local health area is at least one health center. These centers are usually capable of providing primary medical care via non-physicians. Today, this system is reportedly covering the entire country. At the local level (villages, towns, etc.), the Government has established "local health committees." The purpose of these groups is "to highlight the importance of the democratic process in health development, by bringing together the organized community and the Government, in an effort to find solutions to local health problems." This statement is very significant and must be considered in any discussions regarding the role of national voluntary health organizations in Chile. The use of the local health committees has proved very successful in short term manpower assignments which have a specific focus, such as mass vaccinations. Such groups, however, have proved not to be effective agents in stimulating community interest in health.

The philosophy guiding the delivery of health services under the MOH systems was stated in the following manner: "Today medical care is more expensive; government is taking over all responsibility and private participation is rapidly disappearing. The relationship is no longer between just the patient and his physician but rather between the patient and the *health team*. A team in which each member has a special talent, all of which function as a unit. There is a need for new incentives, not money!"

Complementary to this view is also the way in which the Government determines its health budget, not by diseases per se, but rather by the age group and the relative health priorities in that group. The NHS, therefore, divides its US \$60 million annual budget in the following way: Children – 25%; Working Adults – 45%; Old People – 10%. The remaining 20% is divided among special broad range programs (mass immunization) and research. (Note: Changes in this system have accrued since August 1973).

The brain drain has affected Chile, most noticeably in the nursing field. Foreign hospitals and private groups were reported to frequently come to Chile offering excellent financial opportunities for health workers in the foreign country.

As a result of the historical background in Chile, the prevalence of voluntary health organizations today is rather small. There is no voluntary association in the tuberculosis field, for example.

One of the major voluntary health agencies, which fell outside the parameters of our project but which is doing excellent work, is Caritas Chile, part of the Caritas International – associated with the Catholic Church. This organization provides great quantities of emergency food supplies to needy areas throughout the country.

### **III. Factors Affecting Voluntarism and VHO Development**

#### **A. Government Laws and Regulations**

The most important influence on the development of national VHOs is the governmental Laws and Regulations. In all three countries, the trend of the government policy is to have defined legal requirements for the VHOs; the governments also appear to be developing more comprehensive techniques for monitoring the VHO activities.

In all three countries, the legally registered VHOs do not pay taxes on their incomes. Likewise, private contributions to the VHOs have been deductible for the donor. In the last few years, however, this policy has been altered. In Chile, for instance, there are no longer tax deduction incentives for private contributors to the VHOs. In Argentina before 1973, private donations to VHOs were 100% deductible for the donor. Today, they have been reduced to 20% deductible. In Brazil, deductible donations may not exceed 5% of the individual's net income. The overall effect of these legal changes has resulted in a decrease in private contribution to VHOs.

By law, there are also specific steps through which any VHO must pass in order to qualify as a recognized, nonprofit voluntary organization. This usually involves the Ministry of Justice approving the organization as a "civil utility." In Brazil, this occurs at both the federal and state levels. Lack of this approval severely limits the activity of a VHO. This is one of the major reasons why the family planning VHOs have taken so long to become formally active. In Brazil, it took the family planning organization 5 years to receive legal recognition; 7 years in Argentina and 4 years in Chile. Normally, this process takes two to four months to complete.

Other Ministries, such as Finance and Foreign Affairs, often must give their approval if the VHO is to receive money from the government or import foreign goods without paying duty.

Once approved, the VHOs are then subject to specific regulations. It is interesting that these regulations are more stringent in Brazil and Argentina than in Chile. In the former countries, the VHOs must submit an annual activity report to the government together with a financial

statement. In addition, inspectors are sent by the Ministers to investigate the VHO activities "to assure that the proper standards are being met." In Chile, however, the VHOs have remained rather independent of such governmental controls.

High government officials are generally prohibited by law from holding positions as elected officers in the VHOs. Government workers, however, may belong to the VHOs, and in many instances are the key motivators of these organizations.

Perhaps the most significant restriction about to be placed on the VHOs is a proposed government regulation in Chile. As of September 1973, all VHOs in Chile were to have restricted their service activities to curative health programs, turning all their preventative health programs over to the government. The immediate VHO reaction to this proposed regulation was that this was a political move to eliminate the VHOs, since none of them had sufficient financial resources to carry out extensive medical care activities.

The overall effect of these governmental laws and regulations placed upon the VHOs has produced a situation of general concern among the VHOs, who have reacted by limiting their activities so as not to conflict with the governmental policies.

#### **B. Environmental Influences**

Economic conditions are improving in the three countries surveyed, yet this effect as a positive stimulus to voluntary organizations has been diminished by both inflation and the increasing tax rates on personal and industrial income.

Political conditions, although presently stable, have been vacillating over the past year. This situation has affected the continuity of government personnel who, in some instances, were key officers in the voluntary organizations. In several instances, however, it has been the voluntary organizations which have remained stable throughout these political transitions, preserving continuity in a particular national health program.

For example, following a recent political situation in one of the countries, a national VHO was the only group having a complete set of medical records for a particular health problem; all others had been destroyed.

In all of the countries, there was the well defined trend of the people wanting the government to take all responsibility in solving their problems; an attitude which seemed to reflect an enjoyment of paternalism. The governments, however, were working to reverse this trend, and involve the people in solving their own problems.

In many instances, the voluntary organizations are viewed by the governments as an essential part of the present health system. It is not uncommon to hear senior government officials applaud the work of the VHOs, when the VHO work complements the government's objectives. For example, VHOs were viewed as important because they could cover areas where Government had no services, often providing the services at less expense and with staff who were chosen because of their qualifications and dedication. Governments also see the VHOs as an important mechanism for establishing a common spirit toward national development, an element considered crucial to the successful implementation of national health programs. Governments morally support and encourage such VHO activities.

Other factors also influence the VHOs in these countries. The Catholic Church and the heterogeneous cultures in these countries are the two most important social factors influencing

the role of the VHOs, particularly voluntary health agencies. Traditionally, the Catholic Church established *Beneficencias* as a means of providing health care for the "less fortunate." Individual members of the Church were asked to contribute financially to this cause, but almost never were the same individuals involved in providing the services. The Church undertook these services utilizing its own manpower. The domination of the Church in these activities, therefore, has left the community in a secondary position in knowing how to solve local problems.

The three countries surveyed also have heterogeneous culture resulting from mass migrations of ethnic groups. Many of these groups continue to retain their individual identities.

Together, the two factors of paternalism and heterogeneous culture have produced a situation in these countries in which it is very difficult for the VHO to function because of the lack of community support. Often the comment is made that the people in these countries are not "joiners"; they are individualists. In spite of this, however, VHOs do exist and many are effective.

The majority of successful VHOs in these countries are the product of highly influential individuals, both men and women. Often the individuals have sufficient political and economic influence that they can successfully encourage other people to work with them.

In Argentina, for example, charisma also plays an important role in influencing VHO development. The death from cancer of the patriotic leader Eva Peron had a profound effect on stimulating the community consciousness of an unsolved problem, with the subsequent formation of numerous voluntary agencies particularly in the field of cancer detection and prevention.

New health problems which are not yet being emphasized by government are also stimulating the formation of new VHOs. In Brazil, organizations have been recently established in the field of solid waste and air pollution to help find "Brazilian solutions" to these problems.

#### **IV. The National Voluntary Health Organization**

##### **A. Membership and Community Involvement**

The professional associations in these countries generally have larger memberships than the voluntary agencies. This is partially due to their function as syndicates for their professional members. Voluntary agencies have fewer members, and tend not to use these members in their activities except as financial donors. The only major exception to this is found in Argentina, where female members of voluntary agencies are actively involved in the programs of the VHOs.

Although many of the VHOs in these countries were established more than twenty-five years ago (e.g., Brazilian Nurses Association, 1926; Argentina Tuberculosis Association, 1901; Chilean Public Health Association, 1947), their members are concentrated mainly in large urban areas and represent the expanding middle economic level of the society.

The largest number of voluntary health organizations appear to exist in Brazil. In all three countries, however, there is a general pattern of the national level of a VHO being weaker than its state or local counterpart. It was frequently explained that the purpose of the national VHOs was to provide a point for international contact. As such, many of the national organizations are composed of affiliated or institutionalized members.

Only in Chile is membership in the Medical and Nurses Associations compulsory by law. Compulsory registration of dentists, nurses, and physicians is required in countries, but this is supervised through a quasi-governmental body.

## **B. Finances**

The major portions of the national voluntary health agencies' budgets come directly or indirectly from government. Family planning agencies are the only major exception, receiving nearly all their financial support from foreign sources.

The professional associations receive their major support from membership dues.

The relative level of income from membership dues is generally much higher for the professional associations than the voluntary agencies, as is indicated in the charts in Appendix H.

The financial amounts which the governments provide to the VHOs vary considerably. In Brazil, the MOH estimated that it channeled approximately \$1.5 million in 1972 to the national voluntary health agencies which manage medical care institutions. Occasionally, financial assistance is also issued to the professional associations to support their conferences.

Other methods of acquiring finances have been developed by the VHOs. Voluntary organizations that provide health care in Brazil are often reimbursed directly for their services by the Ministry of Social Security. The Red Cross in Brazil, for example, earns an estimated 90% of its income via this method.

In Brazil and Chile, congressmen in the different states and provinces are allocated a fixed sum of money each year which they distribute to the VHOs. In Brazil, this is about \$16,000 per congressman/per year.

In Argentina and Chile, profits from the government lottery and horse races are selectively distributed to voluntary health agencies. Likewise, a percentage of the ticket sales in the government-run casinos in Argentina is distributed to a group of voluntary health agencies. In Chile, a small portion of the "Fireman's Tax" is donated to the Red Cross. The firemen in Chile are all volunteers, financially supported by a national tax.

The Family Planning Association in Brazil is embarking on an energetic fund raising drive in which prominent individuals donate their time to personally contact potential philanthropic and industrial donors. The 1976 goal is to raise approximately \$200,000 locally, enabling the organization to become 50% self-sufficient.

Some of the professional associations have developed cooperative fund raising projects. These involve a foreign counterpart organization allowing the local organization to translate, publish, and sell a book, the royalties of which go to support the local organization.

Several of the voluntary agencies have seals printed and sold at different times of the year. The Cancer Association of Argentina uses this method not only to involve the general public, but also to educate them.

In Argentina, more than in the other countries, women are key fund raisers for the VHOs. Social benefits are common and successful. The President of the Blind Association has worked for 8 years at such activities, and has now brought the organization into prominence by acquiring its own building.

Although numerous methods exist for VHOs to generate income, unquestionably the role played by governmental support is crucial to the survival of many of the voluntary health agencies. As taxes and inflation increase, the percentage of private donations have decreased, bringing governmental assistance into a more strategic position. This trend continues to be more true as foreign donations decrease, as they have in separate instances over the past few years.

### C. Administration, Leadership, Facilities and Branches

The majority of VHOs have either full or part time paid staff to carry out their organization's *administrative* functions. It is not uncommon in many of the *national* VHOs that the staff are shared with the *local* branch, located in the capital city.

In a few of the voluntary agencies the staff receive their salary from government.

Rarely is the Executive Director a full time (i.e., exclusive time), fully paid individual. In fact, in many organizations, the Executive Director is only part time, either receiving a small honorarium or volunteering his services.

Salary levels of the paid staff are usually on the same scale or below the governmental rates. In the latter case, there have been some problems recently in which the workers have requested the government to take over the VHO so wages could be increased. Although these efforts have been resisted thus far, they may be an important problem for the VHOs in the very near future. Only the family planning associations seem to be paying their staff adequate salaries.

Volunteers working for the VHOs include both men and women. Men appear to become more involved with the political aspects of the VHOs, while women are involved in the service activities and public relations. Well developed systems of utilizing volunteers only exist in a few organizations. More often, these organizations are directed by women.

*Leadership* is a major problem encountered by many of the VHOs. Several are presently endowed with a charismatic individual, but there are serious questions about the organization's ability to survive once such a person has resigned.

The organizational framework of the Red Cross in Brazil is currently undergoing an almost complete internal revision. In the process, an entire set of by-laws have been written. An outstanding woman is being trained at the Superior War College, the first woman to do so, and she will eventually head the organization's community programs.

In another example, the leadership of the Brazilian Family Planning Association has revised the Association's organizational structure so that it can be more accountable to its foreign donors. The formerly autonomous state organizations have now been replaced. Today, a centralized system exists in which a paid national organization staff supervisor works at the state level with a prominent local volunteer. This system, it is said, minimizes some of the potential political problems. Annually, there is also a meeting of the state supervisors who work at the national office for one month during the year.

There appear to be no organized training sessions for developing leadership in the national VHOs. More frequently, the chief administrators of the VHOs are individuals who have worked their way into such positions as a result of a long period of involvement with the organization. Also, these leaders often represent an older age group of the population, some beyond retirement.

The leaders of the VHOs often exhibit strong personalities; many are politically influential and economically wealthy. Generally speaking, the leadership of the VHOs is not affected by political revolutions, even though some are government workers. None of the elected officers in any of the VHOs were simultaneously senior officials in government. Many of the VHO leaders, including both men and women, have had experience in the United States where they have learned much about the functioning of a VHO. Unfortunately, today, there seems to be little opportunity for young individuals to receive this foreign exposure and, thus, the development of new, young leadership is very sparse.

The *Facilities* of the national VHOs vary considerably from humble small rooms, provided freely to the organization by a generous donor, to a large impressive office building owned by the association.

The general trend in these countries is for a VHO to own its headquarter's office space or building. In several instances, VHOs have purchased a condominium office space in the strategic location of the capital city. The only consistent variation in this trend is with the family planning VHOs which always rent their office space.

A unique situation exists in Brazil where the government has offered free land in Brasilia to national VHOs if the VHOs build their headquarters building within a fixed time period. Thus far, only the Nurses Association has had the financial and political ability to undertake this opportunity. Many of the other VHOs were considering asking the government to build a single, multi-story office building in Brasilia from which they could buy condominium office spaces.

Many of the national VHOs are hard pressed for financial resources since they often depend on affiliate dues to support their activities. In many instances, there is a joint agreement between the national VHO and the local branch, in which staff, facilities, and overhead items are shared.

The majority of the VHOs surveyed had *branches* or subdivisions scattered throughout the country. Often, as in the cases of the voluntary *agencies*, these subdivisions represented health facilities run by the organization. The number of subdivisions vary from 2 to 227, and they may be organized by either political or geographical boundaries.

It appeared from observations and discussions in these countries that the most influential and productive VHOs were those which had a network of subdivisions throughout the country. Unfortunately, though, there appears to be a general lack of coordination and cooperation between the various branches in the VHOs. Rather, it is more common that the branches compete against one another. The resultant effect is often duplication of effort (e.g., individual monthly journals), and a dilution of political unity. Often sectionalism and regional pride are basic factors causing these situations. This is, perhaps, most noticeable in Brazil. There is a strong need in these countries for the branches to unite at the national level, and provide a unified effort in developing solutions to the problems facing their health interests.

#### **D. Coordination of Inter-relationships with other Organizations**

Perhaps the single most common problem identified by the VHOs is the lack of formal, non-governmental mechanisms which would enable them to coordinate their interests, and interact on common problems. Only in Argentina are there specialized councils for voluntary agencies. There is also a newly formed council of professional associations. Unfortunately, however, professional membership in this council is restricted to the medical, dental, and pharmaceutical associations, most of which are composed of male members.

Many of the VHOs act independently, and thereby try to avoid formal contacts with other organizations unless there are political problems which mutually affect their interests. In such cases, informal relationships at the "leadership" level enable the organizations to combine resources in solving their problem. These might occur in problems such as a cutback in government grants or a revision in tax laws.

Independence and competitiveness is the more common spirit under which the VHOs operate. As mentioned before, this situation often results in duplication and inefficient utilization of scarce resources. However, it does provide spirit and innovation. Some of the smaller professional associations, for example, have tried to jointly publish journals and hold meetings.

Fund raising from private sources is also carried out on an independent basis; no Community Chest type of campaign is being used.

It is interesting to show the excellent initiative taken in Argentina by the VHOs to coordinate their work. A formal coordinating council, CONDECORD ("Coordinating Committee of Organizations for Social Welfare") has been established. CONDECORD has six major divisions and a series of division members totaling more than 200 organizations, each with headquarters in Buenos Aires. Each of the six divisions coordinates the activities of the voluntary agencies which come under its interest:

- a. BIENSO (Coordinacion de Obras Privadas de Bienestar Social)—for Social Welfare;
- b. CAESPO (Comite Argentino de Educacion para la Salud de la Poblacion) - for Public Health Education;
- c. CIVHA (Coordinacion de Instituciones con Voluntarios Hospitalarios de la Argentina) - for Hospital Volunteers;
- d. COR (Coordinacion de Obras Privadas de Rehabilitacion) - for Rehabilitational Institutions;
- e. INCISO (Intercambio Civico Social) - for Social Exchange;
- f. OPAM (Obras Privadas de Asistencia al Menor) - for Assistance to minors.

A complete diagrammatic presentation of this complex of coordinating organizations is found in Appendix I.

Special mention must be made of CAESPO which is the mechanism to bring together voluntary health organizations undertaking health education activities.

CAESPO is a non-governmental, nonprofit independent body. It has central offices in Buenos Aires, with office space loaned to the organization in a government building. In addition, there are 14 regional offices.

Prior to 1955, voluntary organizations in Argentina had a difficult time surviving. Between 1955 and 1972, however, the private organizations began to expand and multiply in number. The private coordination groups, such as CAESPO, were established at that time with the help of government.

Today, CAESPO receives 75% of its \$8,000 annual budget from Government. At the national level, there are 4 paid staff members, and a voluntary Executive Director managing the activities. The organization feels it needs an exclusive-time, fully-paid Executive Director to administer its activities and collect private funds for its support. Steps in this direction are now being developed.

CAESPO has three major areas of health education activities:

- a. *Health Education of the Public* – via coordinating the efforts of member associations, and using radio, television, and other mass media.
- b. *Course for Training Health Educators* – focused particularly at primary and secondary school teachers.
- c. *National Seminars* – designed to educate a specific group of people about a particular health problem, such as family planning or nutrition.

Often, CAESPO's activities receive the joint technical support of the World Health Organization, UNESCO, and other international organizations.

Although the Association prepares a plan of annual activities which it submits to the government for approval, it still considers its activities as independent of governmental control. This policy was recently tested when CAESPO presented its new national programs for sex education. These programs will be televised on the national network and will include family planning information. This is being done despite the fact that government does not have a national policy promoting family planning.

Coordination between the indigenous national VHOs and foreign groups occurs mostly at the informal, personal levels. It is indeed very unfortunate that there are few formal relationships between the VHOs in different countries in the Western Hemisphere. Some regional organizations exist, but their activities are sporadic and not well supported.

In the section on finances, it was mentioned that books or other technical materials have been shared by national VHOs and their foreign counterparts; but, again, the examples are very few in number.

The Nurses Association in Brazil was the only organization to report that it had received a grant (1957) from a United States (Rockefeller) Foundation to undertake a manpower survey in the nursing field. Unfortunately, this study has not received additional local support to update the statistics.

#### **E. Coordination and Inter-relationships with Government**

In all three countries, specific mechanisms have been established by the government to coordinate the national VHOs. In Brazil and Argentina, these administrative units were well organized. In Argentina, although the units exist, a survey of their activities was difficult due to the recent revision in administration within the Secretariat of Health. These coordinating mechanisms focus on overseeing the program and financial aspects of the VHOs.

In Brazil, the Ministry of Health has two coordinating bodies to supervise those VHOs which provide direct medical care services. Both mechanisms come under the office of the Secretary of Medical Assistance. The first, the Division for Coordinating Medical Hospital Assistance, is

responsible for registering all VHOs which provide hospital care. The Division also analyzes grants given by the MOH to the VHOs, and attempts to integrate the system. The second unit is the Division for Coordinating Maternal and Child Care. In nearly each state, there are specific voluntary associations at the local level organized to "Protect Mothers and Infants." These groups are given grants by this Division, which again attempts to provide these services on a coordinated basis. Each of these divisions has inspectors who go out to the field to investigate the programs and financial accounts of the voluntary agencies. In some cases, VHO abuses result in the government closing down the organization.

The other major VHO coordinating body in Brazil is the National Council of Social Services. The Council is a statutory body under the Ministry of Education and Culture, and is responsible for registering and certifying the "legitimacy" of voluntary organizations. In addition, the Ministry of Justice is responsible for certifying the legal status of all VHOs.

Once a voluntary organization is registered and approved by the Council, two important policies take effect:

1. The voluntary organization may receive grants from government.
2. The voluntary organization is exempt from paying Social Security on its employees.

There are 20,000 voluntary organizations, both state and federal level, registered in the Council's files. Every two years each organization must re-register. The Council itself has funds which it distributes to the voluntary organizations. Annual certified financial records and other administrative reports must be sent to the Council. During the first four months of 1973, the Council reviewed over \$10 million expended by these organizations.

In Argentina, the Ministry of Health also has a special office which is responsible for overseeing all voluntary organizations that provide medical programs. Several of the voluntary agencies reported that inspectors from the Secretariat of Health visited the organization once or twice a year.

In Chile, the government also has a coordinating office for VHOs which undertake direct medical care programs. This office is a special division of the National Health Service and is called "Seccion de Asistencia La Social Privada." Of the 2,500 private institutions registered, only 800 are considered nonprofit. As in Brazil, congressmen in Chile are also allotted an annual sum from the national budget which they distribute to the VHOs. This is done on an independent basis.

In July 1973, two major reforms relating to the VHOs have been recommended by the government of Chile. Both reforms were proposed by the Seccion. The first recommendation was to have all of the congressional money channeled through government, thus making it more accountable. The second recommendation was to eliminate all private organizations from preventative care and focus their efforts on curative health activities. The latter recommendation created severe concern on the part of the VHOs. Many felt the implementation of the recommendation would severely hinder, and in the future possibly stop, their activity since the funds to carry out such programs would have to come from uncertain governmental sources.

Other formal and informal methods of coordination exist for the VHOs and government. The Brazilian Hospital Federation, for example, has a formal representative on the government's Price Control Board, which is responsible for setting fee scales for medical services.

The head of the Family Planning Association of Chile is also the Chief of the National Assistance to Women Division in the National Health Service. As such, numerous contracts have been made between the two organizations which directly enable the government to use the VHO to fill in gaps in the governmental system and do things which government itself cannot do because it lacks adequate finances.

Government frequently provides "in-kind" assistance to the VHOs, loaning office space, equipment, and even personnel. Such activities are carried out on an individual VHO basis, and are often the direct effect of the personal relationship between the president of the VHO and government.

## F. Activities

### 1. Supporting National Health Objectives

In each of the three countries surveyed, the degree and types of activities undertaken by the VHOs are greatly influenced by the attitude of government. The VHOs must work within this framework.

The voluntary health *agencies* are focusing their resources on two major types of activities: providing direct health services, and providing health education on the public. The *professional* associations are primarily engaged in activities designed to influence health legislation and health policy formation.

The following description of the VHO activities is only a highlight of the numerous programs undertaken by the VHOs in these countries. It was virtually impossible to see every program of every VHO. The selected sample, therefore, does provide a reasonable idea of those VHO activities which are currently being emphasized.

The idea of *Demonstrating and Pioneering with New Ideas, Including Research*, is an activity which many VHOs would like to undertake, but which they do not because of their lack of adequate financial resources.

Some of the family planning associations are conducting individual research projects, financed by foreign funds. In Brazil, for example, a demonstration project in a leprosarium enables families to have access to family planning services and thus prevent unwanted children. In Argentina, experiments are being conducted by the Health Education Council to develop techniques for presenting family planning information on national television.

Hardly any of the professional associations are carrying out demonstration projects or research. In Chile, the Nurses Association is beginning a demonstration project by assisting the government to establish an alcoholism rehabilitation program.

The major activity of the VHOs in Argentina is *health education of the public*. This emphasis is mainly due to the view of the government that the role of the VHOs is to educate the community to be aware of its health needs. Much of this attitude has been influenced by the older health professionals who have been trained in the United States and Europe. Coordination of the health education activities is through CAESPO.

Cancer prevention is perhaps the major field of VHO health education in Argentina. The Association for Cancer Prevention has extensive health education campaigns in factories, schools, and offices. These are then followed up by medical examinations staffed by

volunteer physicians and trained volunteer ladies. Today, 15,000 people have received these medical examinations. Although these services are utilized mostly by the middle class, they are available to everybody. The close coordination between the Association and government has been an important element in the organization's success.

CELAM, the Association for the Prevention of Breast Cancer is smaller, but through its volunteer support conducts 50 lectures and training sessions per year in factories, schools, and on television. Over 4,000 women have used the organization's services since its opening in 1965. In 1972 alone, over 3,000 medical referrals were made. Recently, the Association undertook a complete evaluation of its activities.

Professional associations also carry out health education activities. The Dental Association has an annual Dental Health Week, with information displayed on television, on radio, and in the newspapers. The Pharmacists Association provides its members with health posters to display in their stores.

In the other countries, health education is not well developed. Aside from family planning associations, few other groups carry out these activities.

The formal *training of health workers* is a rather minor activity of most VHOs in these countries. In Chile, the close relations between the government and the Family Planning Association enable the Association to train government workers in new techniques in delivering family planning services. Likewise, the Red Cross in Chile has an auxiliary nurse training school.

Nearly all of the professionals hold conferences or other types of technical meetings which are designed to educate their members to new developments in the health field. Several of the voluntary agencies do this well. It was explained in one interview with a voluntary agency official, that the most difficult task which the organization had was educating the physicians to be aware of the community health problems.

Although each of the governments expressed the specific desire to have the national VHOs *assist government in planning national health programs, and in identifying problem areas*, very few organizations engaged in the activity. Likewise, very few mechanisms exist to encourage such involvement.

In Brazil, the Red Cross is working with its international counterpart and the Ministry of Health, with the purpose of developing a plan for providing health services to the Indians in Amazonia. Also in Brazil, the MOH has a National Health Policy Committee which is constructing the new health development plan. At this moment, only the Medical Association is represented on the Committee. A similar situation exists in Argentina, again with only the Medical Association participating.

In Chile, planning health services is the function of government.

The second major activity of the VHOs in the region is *providing personal health services*. This is most developed in Brazil, where governmental financial support, via grants and contract reimbursements, encourages the activity.

It was jointly estimated in Brazil by the MOH and the Hospital Federation that in 1973 there are 4,008 hospitals representing 352,150 beds. Approximately 270,000 of these beds are in private hospitals, one-half of which are in nonprofit hospitals. The largest single group of nonprofit hospitals are the "Santa Casas." When asked why such a large

number of hospital beds had not been turned over to government the reply was, "There are several very special reasons. First, the government hospitals are more bureaucratic. Second, government may not use 'free or voluntary' services (Note: in many of the private, nonprofit hospitals, it is an honor to be on the staff and many physicians do this as a voluntary service). Third, in the nonprofit hospitals the salary levels are not fixed." It was further explained that if government were to take over all the nonprofit hospitals, the expenses would be too great and impossible to absorb. As a result, the government prefers to use these hospitals because the government gets more value for its limited budget. Frequently, the voluntary hospitals are the only organizations providing service to a community. It was further explained, "If all of the VHO medical care facilities were to be eliminated, this would put the government into a major crisis."

The LBA, which is a part of the Ministry of Social Security, has 800 contracts with VHOs to provide medical care to individuals in the rural parts of the country.

In Argentina, the Mental Health Association provides medical examinations, treatment, and rehabilitation at its health centers. So, also, do the Tuberculosis, Red Cross, and Cancer Associations. The Family Planning Association has 60 clinics throughout the country. Some of the most important services in Argentina are those of CORDIC, the national blood collecting confederation.

CORDIC was started in 1962, as a result of a group of concerned citizens, who joined together to attack the problem of foreign profit-making firms coming to Argentina to collect blood. These foreign groups paid only \$5 per pint, and then sold it to other countries at a highly inflated profit. The situation became so critical in the early 1960's that there was a serious shortage of blood in Argentina. Today, the confederation of 40 groups around the country supplies more than 200 institutions, one-half of which are governmental, with blood. In Buenos Aires, there are over 9,000 registered volunteer donors. Today, one-half of the association's budget comes from government, the remainder from private donations. The work of CORDIC and many other VHOs in Argentina is of vital importance to the nation's health program. It has also been shown by many of the VHOs that they can often provide limited health services at less expense than government.

In Chile, aside from the fifty out-patient clinics, the blood bank of the Red Cross, and the clinics of the Family Planning Associations, there are few VHOs with health services. Government, as a general policy, has been reducing the number of VHOs with hospitals - by assuming administrative responsibility. The apparent trend for the future is that none of the VHOs will be delivering personal health services.\*

None of the professional associations interviewed in the countries provided medical care services.

*Assisting the governments in evaluating national health programs* is an activity in these countries almost entirely devoid of VHO involvement in a formal manner. The only group concerned with such activities are the hospital associations. Frequently, they work independently of government; reviewing technical standards, distribution of drugs and equipment, planning of new facilities, etc. Often the conclusions of these reviews are incorporated into resolutions or recommendations which are then sent to the governments.

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\*As a result of more current political conditions, this trend will apparently be reversed. In a recent letter from the Ministry of Health, it was stated that, "the Private (profit and voluntary) Health Agencies will naturally play their complementary role to the public institutions - as part of the National Coordinated Health System now being developed."

**The process of *influencing health legislation and health policy formation* is most often undertaken by the professional associations. Although the direction of these activities may be sometimes in the interest of the organization's membership, the overall goal is to provide an improved level of health care for the country.**

In all three countries, there are variations on the role of the professional associations with relation to these types of activities. In general, the professional associations, which have rather large memberships (medical), have a separate syndicate for labor negotiations. Members of the financially weaker associations (nurses) belong to private employees' unions.

Often, though, the political strength of the professional association lies not in the syndicate association, but in the scientific association. In Chile, for example, once the number of registered members of a voluntary association achieves two-thirds of its profession, it can apply for "colegio" status, making it a professional scientific association. Thereafter, membership in the organization is compulsory. Thus, in Chile, the professional associations are not only concerned with their scientific affairs, but also with the labor and welfare conditions of their members.

The Medical Syndicate of Brazil, begun in 1925 and considered one of the oldest unions in the country, with 8,000 members is a particularly active political group. However, its views often do not coincide with those of the Medical Association (Scientific). Aside from participating in government conferences, the Syndicate works directly at influencing members of Congress by keeping them in constant contact. Recently, when a legislative bill was proposed which would have decreased salary levels of health workers, the Syndicate spent \$900 in telegrams, successfully defeating the bill.

Strikes, as a means of influencing political decisions, are more common in Argentina and Chile. The informal interrelationships between the different professional organizations are the key element in the strength of these public reprisals to governmental policy.

Many of the VHOs carry out legislative activity through their legislative committees. In Argentina, for example, the Dental Association helped sponsor a bill which made school dental examinations a compulsory policy. Likewise, the same group is sponsoring legislation to promote the national use of fluorides. The Diabetic Association of Argentina has shown its political influence by lobbying for the passage of a bill which enables diabetic children to attend public schools.

These and numerous other examples exist, indicating that in this region the VHOs are, as a group, a rather important political influencing agent. None of the VHOs, however, appear to be writing specific legislation for congressmen as is done in some of the other countries surveyed.

Aside from the family planning associations, which may import supplies and distribute them to governmental or other organizations, there are indeed only a few VHOs which have any additional amount of *financial resources which they use to help other organizations*.

The Cancer Association of Argentina is one of these few groups. On several occasions, they have given money and equipment to government and private hospitals to improve cancer detection capabilities.

**The activity of *stimulating community participation in health programs* is one of the least developed VHO activities. There are several explanations for this. For one, there**

appears to be a real question in the minds of the VHO leadership as to how to use the community effectively in the VHOs activities. Although this may differ in the voluntary agency and professional association, little is known about the methods of how to do it.

The Cancer Association in Argentina has trained volunteers to work in the hospitals but to date, this is done on a limited scale. One explanation is that many more women are working today and therefore do not have as much free time.

In Chile, the Family Planning Association is developing a program to work with the local health units, and to educate local volunteers. The immediate problem they encountered was the fluctuating levels of individual interest and constant migration of the local population in rural areas. These factors have made any type of long-range, coherent program nearly impossible with these local community committees.

## 2. Self-Interest

All of the VHOs have self-interest types of activities which are directed toward stimulating the continuing interest of the membership in the organization and its activities.

Professional associations have scientific meetings, special committees, journals, and other types of communicating techniques. At the national level, however, most of these types of activities are weak, if not nonexistent. This is a major problem which many of these organizations would like to overcome, but for which they lack leadership and/or resources.

The voluntary agencies are less inclined to develop these self-interest activities except for fund raising or public relations purposes.

## V. Conclusion and Suggestions

Finally, as we look back over all the material presented, it is impressive to see the important role being played by the VHOs. Undoubtedly, they have many problems and weaknesses which they are trying to overcome. The atmosphere in which they are working has many changing facets. The population is becoming more affluent, more educated, and more self-sufficient. The health conditions are improving as government and private sectors expand their services. Yet, many of these same people are aware that the community must involve itself with the decisions that determine their future. The voluntary health organizations are a recognized mechanism for such community involvement. Although the current trend in governmental policies is to regulate the environment surrounding the VHOs, the independent nature of the VHOs will assure their survival.

It is not a very simple task to organize a voluntary health agency or professional association. The humanitarian feeling, the idealistic attitude, must be present all the time. But to achieve definite objectives and to make a positive contribution toward improvement of man's health, some realistic approaches are presently needed to perfect these voluntary organizations.

The careful study of the documents and information gathered during the present survey, concerning the development and organization of some of the VHOs in Argentina, Brazil, and Chile, coupled with the experience acquired during the interviews with outstanding presidents, executives, and members of the organizations visited, have enabled us to better understand the nature of the national VHOs in these countries. In an effort to make our experiences meaningful to VHOs, we have prepared a synthesis of our observations and presented them below as a series of suggestions. We believe these suggestions identify areas where VHOs can be strengthened.

1. The purposes, objectives and goals of a VHO must be enunciated clearly, taking into consideration the particular social, economic, and political environment where these purposes, objectives, and goals will be implemented.
2. We are now living in a growing scientific and technological world. An institution cannot accomplish its goals without using an adequate methodology which permits design of concrete and progressive programs. National VHOs must fit the pattern as well.
3. A VHO must be run by a significant number of active members of the community with open minds and positive social and personal prestige.
4. The continuity and perseverance in the purpose enunciated by a VHO must always be accompanied with the possibility of incorporating a newer and younger group of enthusiastic and imaginative members. Such a policy will avoid the ankylosis of the institution.
5. Independence and a comfortable place to work and meet is very advisable for a VHO.
6. Many functions and actions of a VHO can be undertaken directly by the members of the organization, but a minimum of qualified and adequately paid technical, professional, and secretarial personnel hired on an exclusive time basis are needed if the organization is to function effectively.
7. The employees of a VHO should be paid according to the actual salary standards for other professional and worker groups.
8. All kinds of provisions must be employed to get the participation of the members in the promotional work of a VHO. Much of this promotion can be done by staff.
9. The financial support of the members, even when substantial, does not exempt the members of a VHO from providing a certain amount of their personal time in support of the institution and the people it serves.
10. The capacity to become a useful volunteer in the different fields of health care must be acquired through well organized regular courses. Members should participate in courses as student at every age. VHOs can coordinate their activities to provide these learning experiences.
11. VHOs must make every effort to form and encourage community leaders who are qualified in sophisticated health activities in rural areas. The national VHOs must utilize these leaders to develop permanent rural VHOs which would work independently but in coordination with the urban ones.
12. Strong and adequate local private financial contributions for the accredited VHOs should be recognized as part of a sound health policy, indicating the existence of good management.
13. Governmental agencies must learn how to utilize the tremendous potential possibilities of the community in a modern world. This is especially true for health purposes, and can be obtained in both urban and rural areas by participation with the national VHOs.
14. The establishment of permanent and friendly relations with VHOs of the similar interest around the world is one of the best means of perfecting the efficiency of the national organizations.

**It is understood by many of the voluntary health organizations that in solving health problems, curative medicine is not enough. There must also be the intellectual, technical, scientific, and social resources of the community. Comprehensive health care must include the preventative, social, and educational solutions.**

**It is also understood that an adequate public health program cannot be achieved by the government without a permanent community contribution, not only financially, but also with the personal effort of each of its members. This is a role which the VHOs can do well.**

**APPENDIX A**

**Major Characteristics of National Health Organizations (VHOs)**

**Interviewed in Argentina**

QUESTIONNAIRE RETURNED	ORGANIZATION NAME/YEAR FOUNDED	DEFINITIONS					ORGANIZATION STRUCTURE												
		NON-GOVERNMENT	NON-PROFIT	DEMO. ORGANIZED			BOARD		EXECUTIVE DIRECTOR		ADMIN. STAFF		WORKERS						
				MEET PERIODICALLY	ELECT OFFICERS	DETERMINE POLICY	PAID	VOLUNTARY	PAID	VOLUNTARY	PAID	VOLUNTARY	PAID PROFESSIONAL	VOLUNTARY PROFESSIONAL	PAID NON-PROFESSIONAL	VOLUNTARY NON-PROFESSIONAL			
	HEALTH AGENCIES																		
✓	1. Blind Association 1969	✓	✓	✓	✓	✓	✓	✓		✓				✓	✓	✓	✓		
✓	2. Breast Cancer Association (CELAM) 1965	✓	✓	✓	✓	✓	✓	✓		✓				✓	✓				
✓	3. Cancer Association 1921	✓	✓	✓	✓	✓	✓	✓		✓				✓	✓	✓			
✓	4. Diabetes Association 1964	✓	✓	✓	✓	✓	✓	✓		✓				✓	✓				
✓	5. Family Planning Association	✓	✓	✓	✓	✓	✓	✓		✓				✓	✓				
✓	6. Heart & Blood Association (CORDIC)	✓	✓	✓	✓	✓	✓	✓		✓				✓	✓	✓			
✓	7. Leprosy Association 1927	✓	✓	✓	✓	✓	✓	✓		✓				✓	✓	✓			
✓	8. Mental Health Association	✓	✓	✓	✓	✓	✓	✓		✓				✓	✓	✓	✓		
✓	9. Red Cross 1880	✓	✓	✓	✓	✓	✓	✓		✓				✓	✓	✓	✓		
✓	10. Tuberculosis Association 1901	✓	✓	✓	✓	✓	✓	✓		✓	✓			✓	✓	✓	✓	✓	
	PROFESSIONAL ASSOCIATIONS																		
✓	11. Dental Association	✓	✓	✓	✓	✓	✓	✓		✓	✓			✓					
✓	12. Medical Federation (Syndicate)	✓	✓	✓	✓	✓	✓	✓		✓	✓			✓	✓				
✓	13. Nursing Association	✓	✓	✓	✓	✓	✓	✓		✓			✓						
✓	14. Occupational Therapists 1964	✓	✓	✓	✓	✓	✓	✓		✓	✓			✓					
✓	15. Pharmacists Association	✓	✓	✓	✓	✓	✓	✓		✓	✓			✓					



**APPENDIX B**

**Major Characteristics of National Voluntary Health Organizations (VHOs)**

**Interviewed in Brazil**





## **APPENDIX C**

### **Major Characteristics of National Voluntary Health Organizations (VHOs)**

#### **Interviewed in Chile**



MAJOR CHARACTERISTICS OF NATIONAL VOLUNTARY HEALTH ORGANIZATIONS (VHO's)

Interviewed in CHILE from August 9 to August 14, 1973

PROGRAMS																	FUNDING						ANNUAL BUDGET														
TRAINING			EDUCATION			HOSPITALS/ CLINICS		SERVICES			OTHERS								NATIONAL			INTER- NATIONAL			1970 AMOUNT IN LOCAL CURRENCY (EQUIVALENT U.S. DOLLARS) \$1.00 U.S. = _____	PERCENTAGE FROM											
VOLUNTEERS	PAID WORKERS	OTHERS	FORMAL COURSES	FELLOWSHIP GRANTS	TEXT BOOK PROGRAM	BUILD	FINANCIALLY SUPPORT	ADMINISTER	PAID BY THE CLIENT	PAID BY THE ORGANIZA- TION	PAID BY THE GOVERNMENT	DISTRIBUTION OF COMMODITIES	DISTRIBUTION OF INFORMATION	FINANCIAL CAMPAIGNS	EMERGENCY/DISASTER RELIEF	REHABILITATION	MEETINGS/RESOLUTIONS	RESEARCH	LICENSING	MONEY GRANTS	WORKING WITH GOVERNMENT TO DEVELOP PROGRAMS	INFLUENCE NATIONAL LEGISLATION	DIRECT SUBSIDIES	TAXES			INDIVIDUAL CONTRIBUTIONS	INDUSTRIAL CONTRIBUTIONS	SERVICE PROJECTS	LOTTERY	STAMPS	BILATERAL	MULTILATERAL	OTHER			
✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓					✓	✓		✓	✓	✓	✓		✓				(\$70,000)			
✓	✓	✓	✓				✓	✓	✓	✓		✓	✓				✓	✓		✓		✓	✓			✓				✓				(\$600,000)	98%		
✓			✓			✓	✓	✓			✓	✓	✓		✓							✓	✓	✓	✓	✓	✓							(\$7,000)			
			✓									✓	✓					✓	✓	✓		✓	✓			✓	✓							*			
✓			✓	✓									✓					✓	✓	✓		✓	✓			✓	✓							*			
													✓									✓	✓			✓	✓								(\$1,000)		
																							✓			✓										(\$100)	
✓	✓		✓			✓	✓	✓	✓	✓		✓	✓		✓							✓		✓	✓										(\$4.1 m.)	✓	

\*Amounts are not reported or unavailable

**APPENDIX D**

**Interview Schedule, Argentina**

## INTERVIEW SCHEDULE

### ARGENTINA

(August 2 to August 8, 1973)

<b>August 2</b>	11:00 am	Dr. Francisco Martinez President	Liga Argentina contra la Tuberculosis (Tuberculosis Association) Santa Fe 4292 – Tel. 774-9145 Buenos Aires
	2:00 am	Dr. Jose Luis Locci, President Dr. Oliveira Esteves, Vice President	Liga Argentina de Higiene Mental (League of Mental Hygiene) Luis Saenz Pena 259, 2 <sup>o</sup> Piso, Dto.A Tel. 41-7481 Buenos Aires
	3:30 pm	Dr. Vicente Piscitelli Manager Secretary	Confederacion Medica de la Republica Argentina (Argentine Medical Confederation) Hipolito Irigoyen 2028 – Tel. 47-3892 Buenos Aires
	3:30 pm	Mrs. Eva del Rio de Rojas, President Prof. Dr. Mario Brea, Vice President	Asociacion Argentina de Lucha contra el Cancer (Cancer Association) Araoz 2380 – Tel. 72-8139 Buenos Aires
<b>August 3</b>	10:00 am	Mr. Christian Fynjete Salverda Vice President of Board of Directors  Mr. Atilio Gomez Executive Director	Confederacion Cordic (Confederation against cardiac disease) Cordoba 1432, 6 <sup>o</sup> Piso, Dto.B Tel. 49-5344 Buenos Aires
	3:00 pm	Mrs. Flora S. de Entelman President  Dr. Marin, Technical Director	Centro de Educacion de las Enferme dades de la mama (Breast Cancer) Pueyrredon 1361, 5 <sup>o</sup> Piso, Dto. B Tel. 80-2109 Buenos Aires
	5:00 pm	Mrs. Josefa Blaquier de Leloir President  Dr. Raquel v. de Pinéro Secretary	Patronato del Enfermo de Lepra de al Republica Argentina (Leper Patients) Jose Evaristo Uriburu 1018 Tel. 83-3345 Buenos Aires

	7:00 pm	Mrs. Alicia Torres, President Mrs. Monica Krapelun, Secretary  Miss Marta Suter, Vocal	Asociacion de Terapistas Ocupacionales (Occupational Therapists) Av. Belgrano 1734, 4 <sup>o</sup> Piso Buenos Aires
August 4	3:00 pm	Prof. Dr. Julio C. Gasende President  Dr. Juan Hannouche Medical Director	Asociacion Argentina de Proteccion Familiar (Family Protection) Maipu 471, Piso 13, - Tel. 392-7075
August 6	9:30 am	David R. Gunn, Executive	Ford Foundation Ayacucho 2151, 4 <sup>o</sup> Piso, - Tel. 41-7990 42-2756  Buenos Aires
	11:00 am	Edward Betzig Agency for International Development Representative	Agency for International Development Sarmiento 663 - Te. 46-9917 Buenos Aires
	3:00 pm	Dr. Luis Carlos Ochoa	Pan American Health Organization Marcelo T. de Alvear 684, 4 <sup>o</sup> Piso Tel. 32-5301, 31-9151 Buenos Aires
	4:00 pm	Dr. Domingo Liotta Sub Secretary	Ministry of Health
	5:00 pm	Mrs. Raquel Haydee C. de Swindon President  Dr. Pedro J. Vernocchi Secretary	Liga Argentina de Proteccion al Diabetico (Diabetes Association) Tucuman 1584, planta baja A, Tel. 40-8185 Buenos Aires
August 7	10:00 am	Dr. Jose Manuel Lueje President  Dr. Jose Trilnik Vice President	Confederacion Odontologica de la Republica Argentina (Dentist Confederation) Junin 959 - Tel. 83-9309 Buenos Aires
	11:15 am	Mrs. Gordillo, President  Miss Silvia Daneri General Secretary	Federacion Argentina de Enfermeria (Nursing) Cordoba 2250, 8 <sup>o</sup> Piso, Tel. 41-7732 or 82-6041
	12:15 am	Dr. Delmar	Argentina Committee for Public Health Education

	3:00 pm	<b>Carlos Isidore, President</b>	<b>Confederacion Farmaceutica y Bioquimica Argentina (Pharmaceutical and Biochemical) Castro Barros 92 – Tel. 86-6274 Buenos Aires</b>
	4:30 pm	<b>Carlos Ernesto Weihmuller</b>	<b>Cruz Roja Argentina (Red Cross) Hipolito Irigoyen 2068 Buenos Aires</b>
	6:00 pm	<b>Maryvonne Bardin de Seguin President</b>	<b>Blind Association</b>
<b>August 8</b>	10:30 am	<b>Dr. Jorge E. Molinero Treasurer</b>	<b>Argentina Public Health Association School of Public Health</b>
	11:30 am	<b>Mr. Edward Betzig</b>	<b>United States Agency for International Development</b>
	1:00 pm	<b>Dr. David Sevlever (Project Country Representative)</b>	

## **APPENDIX E**

### **Interview Schedule, Brazil**

**INTERVIEW SCHEDULE**

**BRAZIL**  
(July 20 to August 1, 1973)

<b>DATE</b>	<b>TIME</b>	<b>PERSON(S) INTERVIEWED TITLE(S)</b>	<b>ORGANIZATION NAME/ADDRESS AND TEL. NO.</b>
July 20	2:00 pm	Dr. Corinha Fischer Executive Director	Fundacao Servico Especial de Saude Publica (SESP) Av. Rio Branco 251-12º andar Rio de Janeiro, Tel: 247-2630 232-8066
	4:30 pm	Lucymar Costa Lima First Secretary	Federacao Eunice Weaver (Leprosy Association) Av. Calogeras 15 - 11º andar Rio de Janeiro
July 23	9:00 am	Dr. Walter Rodrigues Executive Secretary Dircelia Faria Macedo Director of Fund Raising	Sociedade Cevil Bem Estore Familiar no Brasil (BEMFAM) (Family Planning Association) Ruas das Laranjeiras 308 Zc 01 - 2000 Rio de Janeiro, Tel: 225-9065
	11:00 am	Dr. Hugo Alqueres Secretary for Medical Assistance	Ministry of Labor-Division of Social Security Av. Presidente Antonio Carlos - 11º andar Rio de Janeiro, Tel: 232-2280
	1:30 pm	Almirante Edgar Pereira de Beauclair President/Secretary-General	Cruz Vermelha Brazileria (Red Cross) Praca Cruz Vermelha 10-12 Rio de Janeiro, Tel: 232-2280
	4:00 pm	Dr. Edmundo Blundi, President	Federacao Brazileria das Sociedades de Tuberculose (Tuberculosis) Rua de Resende, 128 Rio de Janeiro - (GB)
July 24	10:00 am	Dr. Oswald de Costa Dean Dr. Mario A. Sayeg Chief, Department of Human Resources	Fundacao Instituto Oswald Cruz Instituto Presedente Castello Branco (School of Public Health) Leopolds Bulhoes, 1480 Manguimhos, Rio de Janeiro Tel: (011) 230-1318

July 24	2:00 pm	Dr. Oswaldo Campos, President	Associaçai Beneficiente de Reabihilacão (ABBR) (Rehabilitation) Rua Jardin Botanico 660 Rio de Janeiro Tel: (hospts) 246-0412 (office) 227-6345
	3:30 pm	Sergio Martins, Director	Fundacao Legiao Brasileira de Assistencia (LBA) (Legal Aid Society) Av. General Justo, 275 - 5º, andar Rio de Janeiro
	4:30 pm	Dr. Charles Naman Damiair Executive Director, President	Sindicato dos Medicos de Rio de Janeiro (Medical Union of Rio) Av. Churchill, 97-9º andar Rio de Janeiro, Tel: 232-9541
July 25	9:00 pm	Dr. Edward Ja Cruz Ferreiras President of Rio Branch	Associacao Brasileira de Odontologia (Brazilian Dental Association) Av. 13 de Maio, 13 10º andar 5/100/6 Rio de Janeiro
July 26	10:00 am	Dr. Nelson Moraes Secretary of Public Health	Ministry of Health Praia de Flamengo, 122 - 2º andar Rio de Janeiro
	12:00 Noon	Mrs. Adalegisa Matos President of Rio Branch Mrs. Tedu Barreira Castro Vice President - Rio Mrs. Herdy Vieira Secretary - Rio	Brazilian Nurses Association (Rio Branch) Hospital dos Servidores de Estado Rua Sacadura Cabral - 128 Rio de Janeiro
	2:00 pm	Dr. Edward Saad Administrative Director Dr. Yser Cardoso Medical Director	Servico Social de Industria (SESI) (Industrial Social Services) Rua Ipiranga 75 Rio de Janeiro
	3:00 pm	Dr. Orivaldo Benites de Carvalho Luna, Executive Director Dr. LUCillo Feliciano de Castilho 1st Secretary Dr. Murilo V. Bastos Assistant Director	Associacao Brasileira de Hospitais (Hospital Association) Avenida Rio Branco, 185 (Grupo 625), Rio de Janeiro

July 26	4:30 pm	<b>Dr. Murillo Belchoir, President (Project Country Representative)</b>	<b>Conselho Federal de Medicina (Medical Council) Avenida Rio Branco Nº 18-18º andar Rio de Janeiro - G.B. Tel: 243-2736 or 236-6429</b>
	6:00 pm	<b>Dr. Lucio Costa, President Dr. Walter Silva, Vice President</b>	<b>Sociedade Brasileira de Hygiene (Health Society) Av. Rio Branco, 185 gr 1818 20.000 Rio de Janeiro, G.B.</b>
<b><u>Brasilia</u></b>			
July 27	12:00 Noon	<b>Dr. Claudio Penrra President</b>	<b>Associação Medicina Brasilia (Brasilia Medical Association)</b>
	3:00 pm	<b>Mr. Olympio Cascaes Subchief of Cabinet</b>	<b>Ministry of Health Esplanada dos Ministerios Blvas 11, 8º andar Brasilia, D.F., Brazil</b>
	5:00 pm	<b>Dr. Manuel Sirvant Ramos Chief of Zone V</b>	<b>Pan American Health Organization Ministry of Health</b>
July 30	8:30 am	<b>Dr. Howard Lusk Program Office</b>	<b>United States Agency for International Development Brazil</b>
	10:00 am	<b>Dr. David Boianoves, Professor Association</b>	<b>University of Brasilia Department of Community Medicine "Sobordinho Community Health Project Ford Foundation MCH Nutrition Survey" Legiao Brasileira de Assistencia (LBA) Sobordinho</b>
	3:00 pm	<b>Dr. Share Simoes Secretary of Health (Federal District) President (FHDF) Dr. Celso Generoso Pereira Executive Director (FHDF)</b>	<b>Fundacao Hospitalar do Distrito Federal (Hospital Foundation) Ed. Pioneiras Sociais 8º andar Brasilia, Brazil Tel: 24 63-59</b>
	6:00 pm	<b>Dr. Heic Pereira Viegas President</b>	<b>Conselho Nacional de Servicio Social (National Council of Social Services) Ministry of Education and Culture, Brasilia</b>

Sao Paulo

July 31	3:00 pm	Prof. Reinaldo Chiaverini President	Fundo de Aperfeiçoamento e Pesquisa de Sociedade Brasileira de Cardiologia (FAPEC) (Heart Fund) Rua Itapeva 500 Bella Vista 10º – LO c Sao Paulo Tel: 288-45-77
	6:00 pm	Dr. Geraldo da Silva Ferreira Director Drs. Jose Gabriel Borba, Osvaldo Galster, Cid Gumares, S. Gonzaga Mosbach, and Jusrez Querros Campos Board Members	Associacao Paulista de Hospitais Sao Paulo (Sao Paulo Hospital Association) Avenida Reboucas – 1205 Rio de Janeiro, Tel: 282-2620
August 1	9:00 am	Dr. Julian Czapski Secretary General	Federacao Brasileira de Hospitais (Brazilian Hospital Association) Av. Ipiranga 919- c. 1101 Sao Paulo, Tel: 34-4027
	10:30 am	Ms. Veridiana Arb, President Ms. Moena Quadros Sassi MOH – Mental Health Coordination	Associacao de Terapeutas Occupacionais de Brasil (Occupational Therapists Association) Rua Veneza, 50 Sao Paulo
	12:00	Dr. (Prof.) Glette Alcantara President Prof. Circe Mello Ribeiro Dean, School of Nursing (SP)	Associacao Brasileira de Enfermagem (Nurses Association) Av. Eneas Carvalho Aguiar 400 C.P. 5751, Sao Paulo
	2:00 pm	Prof. Walter Engracia de Oliveira Dean	Faculdade de Saude Publica, Universidade de Sao Paulo (Public Health Faculty of the University of Sao Paulo) Avenida Dr. Arnaldo 715 Sao Paulo, Tel: 81-21-35

## **APPENDIX F**

### **Interview Schedule, Chile**

**INTERVIEW SCHEDULE**

**CHILE**  
(August 9 to August 14, 1973)

<b>DATE</b>	<b>TIME</b>	<b>PERSON(S) INTERVIEWED TITLE(S)</b>	<b>ORGANIZATION NAME/ADDRESS AND TEL. NO.</b>
August 9	9:00 am	Dr. Arturo Giron Minister of Health	Ministerio Salud Publica (Ministry of Public Health) Monjitas 689 5 <sup>o</sup> Piso
	10:30 am	Dr. Alejandro Sotelo Representative	Pan American Health Organization Monjitas 689 3 <sup>o</sup> Piso
August 10	10:00 am	R.F. Baldo Santi Vice President	Caritas – Chile Erasmus Escala 1822 2 <sup>o</sup> Piso
	12:00 Noon	Dr. Hugo Behm Director, Department of Public Health and Social Medicine	Escuela Salud Publica (School of Public Health) Universidad de Chile Correo 4. Santiago
	2:30 pm	Dr. Alvaro Yanez del Villar Medical Officer TBC Program	Servicio Nacional de Salud (National Health Service) Seccion Epidemiologa, SNS Monjitas 665 6 <sup>o</sup> Piso
	4:00 pm	Dr. Norman Voullieme Vice President	Servicio Medico Nacional de Empleados (National Medical Service for Employees) Bandera 72 5 <sup>o</sup> Piso
August 13	9:00 am	Mr. Judd Kessler United States Agency for International Development	Alameda B. O'Higgins 1146 10 <sup>o</sup> Piso
	10:00 am	Dr. Agustin Denegri Vice President	Asociacion de Directores de Hospital (Association of Hospital Directors) Av. Luis Pasteur 5576
	11:00 am	Dr. Gildo Zambra President	Asociacion Chilena Proteccion de la Familia (Association to Protect the Family) Valentin Letelier 96 Of. 95

<b>August 13</b>	<b>12:30 pm</b>	<b>Miss Gladys Peake Secretary General</b>	<b>Colegio de Enfermeras (Nursing Association) Miraflores 563</b>
	<b>3:00 pm</b>	<b>Mrs. Ana Maria Urrutia Administrative Director</b>	<b>Sociedad Pro Ayuda Nino Lisiado (Handicapped Children) Huerfanos 2681</b>
	<b>5:30 pm</b>	<b>Dr. Aeustin Inostroza President Dr. Mariano Bahamonde Vice President</b>	<b>Cruz Roja Chilena (Red Cross) Providencia 2093 5° Piso Santiago de Chile</b>
<b>August 14</b>	<b>9:00 am</b>	<b>Dr. Mariano Requena Technical Director</b>	<b>Servicio Nacional Salud (National Health Services) Monjitas 541 5° Piso</b>
	<b>10:30 am</b>	<b>Dr. Miguelina Serrano President</b>	<b>Sociedad Chilena de Solubridad (Public Health Association) Av. Vitacura 6480 Casa 2</b>

**APPENDIX G**

**“Medical Attention in Chile”**

**An Article by Dr. Jose Ugarte**



## I. HISTORY

Medical development in Chile, as far as its concept and structure are concerned, may be divided into two periods. The first period would be from Independence Date (1810) until 1924, and the second from 1924 to the present time.

### A. First Period (1810-1924)

Medical care during this period may be described as consisting of services without charge (particularly to the poor) and administered at hospitals which were always operated by the Church. Doctors used to work for little or no compensation at these hospitals. Private practice by physicians was largely for the upper classes.

In 1832, the government created the "Junta Central de Beneficencia y Salud Publica," the purpose of which was to administer the country's hospitals. Later, the local institutions in various provinces were created for the same purpose. These boards ("Juntas") handled administrative matters, but the government approved budgets and appointed employees. A large part of the funds received by these charity boards came from private individuals. This gave the impression that medical care at these hospitals was private, when in reality, hospitals depended upon the government. Private donations only supported hospital maintenance. This situation remained until 1932, when Law No. 5115 was enacted. This law established the "Junta Central" to administer all "Servicios de Beneficencia," and gave the Junta Central authority over the "Juntas Locales." In this way, hospital care is fundamentally provided by the state.

In 1886, the law for "Policia Sanitaria" created the "Junta Central de Salubridad" and "Juntas Departamentales de Salubridad" to give assistance during epidemics and to finance general prophylaxis programs. In 1891, the city governments were given responsibility for community sanitation (i.e., control of food, drugs, slaughterhouses, etc.)

The first Sanitary Code, passed in 1918, divided the country into four health zones and created the "Direccion General de Sanidad" under the "Ministerio de Interior." In 1925, a new health code (called the Long Code) withdrew the public health appropriations from the city governments and concentrated the authority on the General Health Director. This health code was not carried out in a satisfactory manner so, in 1931, a new code was devised which gave far-reaching power to the Servicio Nacional de Salubridad. This code was modified in 1968 in order to bring it up-to-date on technical and administrative matters, since health organizations experienced important changes during the last decades.

### B. Second Period (1924-1973)

During this period medical experiments produced substantial changes in matters of doctrine and organization of services. In general, it could be said that the principal characteristics of this period were:

1. Progressive development of the "integral health" program, adding the concept of promotion, protection and rehabilitation to that of recovery;
2. Opening the hospital to the community in order to comply with the concept of an integral health program;

3. Creation of several laws relating to Social Security (i.e., payment in case of illness, invalidity, old age, family support, etc.);
4. Creation of medical services in several private institutions in order to provide medical care to their members. This allowed for greater diversity in the type of medical care as well as in matters of payment;
5. Unification of the principal state services which gave medical care to the community;
6. Alterations in the way of delivering medical care, in the sense that the doctor-patient relationship is principally based on public health care. This means that the doctor receives compensation for the care he gives to a person.

From a legal and structural point of view, these changes followed a certain process. Law No. 4054, which provided benefits for social health security, invalidity and old age, was enacted on September 8, 1924. This made Chile the first South American country to have such a law. This law provided care for workers in case of illness, invalidity, old age or death. Working women were offered maternity care, a rest period before and after childbirth, midwife care, and relief during the nursing period.

The "Caja de Seguro Obrero Obligatorio" was called upon to carry out this law, and it established various clinics throughout the country to provide medical care to insured persons. Agreements were made with the "Junta Central de Beneficencia" for the hospitalization of patients, since this latter organization had over 85 percent of all hospital beds in the country.

Later, in 1935, the Caja de Seguro Obrero Obligatorio extended care to the pregnant woman and her child, creating the Department of Mother and Child, which will take care of the wife of the insured and of his children up to the age of two. This allowed the "Caja" to care for approximately two-thirds of newborn children and their mothers, giving them economic protection, medical care, and increased nutrition via delivery of milk.

Also in 1924, Law No. 4055 introduced the concept that employers should assume responsibility for employees' accidents that occur while on the job. The amount of indemnity was fixed, with consideration being given for sanitary conditions and industrial security.

Other security institutions were started in 1924. For instance, the "Caja de Empleados Publicos, Particulares, Ferrocarriles, Fuerzas Armadas," etc. had different rules pertaining to medical care and relief.

In 1938, the Law for Preventative Medicine reduced the risk of contracting certain diseases such as tuberculosis, cardiovascular disease, and syphilis. For this purpose, the "Servicio Medico Nacional de Empleados" was created to provide care for public and private employees. The "Caja de Seguro Obligatorio" created its own organization for the same purpose, performing medical examinations upon the families of insured persons who are ill.

Medical care for schoolchildren was started in an organized manner in 1910, through the Ministry of Education. Later in 1929, the provision of this care became dependent upon the Servicio Nacional de Salubridad and, in 1942, it became independent under the "Direccion General de Proteccion a la Infancia y Adolescencia" of the "Ministerio de Salubridad."

During 1936 and until 1950, several conventions were held by the Medical Society. Progressive changes were made on ideas concerning medical care. The following principles were established to guide the medical organization:

1. Integration principle of medical care should cover every stage of life, as well as promotion and protection of health;
2. Concentration of efforts to give medical care during the most important stages of life;
3. Principle of single technical command with legal authority and which periodically plans health actions;
4. The achievement of the state's obligation to protect health through appropriations and legislation, but the state should delegate its own authority of supervision and control.

These principles led to a reorganization of public health services and the formation of a doctors' union.

Three basic laws were enacted:

1. Law of the "Colegio Medico" which took effect in 1948 and which unified the physicians into a union and a professional organization.
2. The "Estatuto del Medico Funcionario," in 1951, reclassified physicians as public employees, thus granting them certain economic guarantees.
3. Law of "Seguro Social y Servicio Nacional de Salud," legislated in 1952, and made possible the administration of integral medical care.

The Servicio Nacional de Salud is composed of the following organizations:

1. Servicio Nacional de Salubridad;
2. Junta Central de Beneficencia y Asistencia Social;
3. Caja de Seguro Obrero Obligatorio (for medical assistance);
4. Direccion General de Proteccion a la Infancia y Adolescencia;
5. Direccion General de Trabajo (industrial security and health);

6. Instituto Bacteriologico; and,
7. Servicios Medicos y Sanitarios de las Municipalidades.

The Servicio Nacional de Salud is a public organization, legally sanctioned, autonomous in administration, and with its own authorities. It is funded by the "Contraloria General de la Republica" and must comply with the "Estatuto Administrativo" and other rules, which are enforced by the Contraloria.

The Servicio Nacional de Salud formulates policies on the following medical and administrative matters:

1. Technical and administrative autonomy.
2. Centralization of the authority for establishing general policies on health and norms, and the execution and evaluation of health programs.
3. Decentralization of executive authority, thus providing local autonomy for program formation and execution.
4. Integration of actions and services for promoting, protecting, and re-establishing health.
5. Public relations to actively promote participation of the community in the solution of health problems.

The Servicio Nacional de Salud is structured as follows:

1. General Administration, headed by the General Director, the National Council, the Director of the "Departamento Tecnico," "Departamento de Recuperacion, de Fomento y Proteccion de la Salud," various subdepartments in charge of specific tasks, and the Technical Council.
2. Health Zones. There are 13 health zones in the country, plus a subzone within Arica. These correspond to geographic regions, whose resources are sufficient to conduct health activities. Each of these zones has its own administrator.
3. Health Areas. These areas, where health activities at the local level are actually carried out, correspond to the health zone. Each has a base hospital and peripheral clinics. There are approximately 54 health areas in the country.

Medical Services through the Servicio Nacional de Salud takes the following form:

1. Health recovery – Medical care, ambulatory as well as in hospitals, to all people insured through "Seguro Social"; this also means their wives and children under 15. For the insured themselves, relief in case of illness is included.
2. Medical care to the poor.

Altogether, this means about 75 percent of the population gets the benefits which have been mentioned above.

Until 1968, medical care of public and private employees was primarily through the "Servicios de Bienestar," which is the welfare service. This service receives payments from employees and provides them with medical and hospital services, as well as loans.

Public employees used to receive medical aid, childbirth help, and nursing care through the Servicio Medico Nacional de Empleados, but these were not very extensive.

About 1960, employees desired improved medical benefits and looked for a proper solution. Therefore, in 1968 a new law was created, the "Ley de Medicina Curative de Empleados." Through this, payments by the employer and employee established a fund providing ambulatory medical care to the employees and their families. Loans for hospitalization, surgery, and dental care are also available under this plan. In 1972, smaller industries were included in the law, thus extending coverage to about 2.2 million people.

Progressive developments of the organizations providing medical services to large segments of the population have instituted important changes in the type of care they provided. Although physician-patient relations are still direct and personal, the physician receives a salary based on the time he works and is scheduled for a more or less fixed work program. Certain fringe benefits were added to the salary, taking into account years of service, special risks, night or holiday shifts, and special circumstances. The physician may work on contract up to eight hours a day under certain conditions, for a maximum of 44 hours a week. This system is controlled through the "Ley del Estatuto del Medico Funcionario," and is administered by various agencies (Servicio Nacional de Salud, Fuerzas Armadas and Carabineros, some welfare organizations). These cover about 7.3 million people.

The law of "Medicina Curative de Empleados" established a different remuneration system for medical care. This system allows the insured party to choose his own physician on the condition that the physician is duly registered for this kind of service. The insured receives a voucher with which he pays the physician according to a fixed fee schedule. This voucher is later redeemed by the physician through the Colegio Medico de Chile. In a way, this system replaced private medical care, which has progressively decreased since the development of Social Security agencies.

## **II. ORGANIZATIONS WHICH GIVE MEDICAL SERVICES – POPULATION COVERED**

The above explanation demonstrates the strong role that government plays in providing medical care, particularly where physicians working as public employees are concerned, and in other Social Security agencies through which additional reimbursement systems provide medical assistance to a large segment of the population. The number of people covered by assistance is as follows:

Agency	Population Covered	Percentage
Servicio Nacional de Salud (Insured through Seguro Social including family)	7,000,000	66.6%
Armed Forces and Police	200,000	1.9%
Ley Medicina Curative de Empleados	2,000,000	19.0%
Welfare organizations (Public & Private)	50,000	0.5%
Poor people (covered through "Servicio Nacional de Salud")	800,000	7.7%
Private medical attention (liberal)	450,000	4.3%
	10,500,000	100.0%

These figures are only approximations since some of the agencies mentioned do not give assistance to all the people they are expected to assist. The Servicio Nacional de Salud, then, does not cover the entire eligible population, primarily because of a lack of resources. This situation is more evident within the rural sector, which includes about 30 percent of the total population. Moreover, the Servicio Nacional de Salud only satisfies part of the working people's requirements for medical assistance since it focuses attention on the people insured by it. So, some people must seek private medical care, which often causes them economic hardships. In addition, the legal barriers which block these people from receiving complete insurance coverage are too difficult to overcome.

### III. VOLUNTARY HEALTH ORGANIZATIONS

When reviewing the development of medical care in Chile, it is easy to understand how voluntary health organizations evolved.

At the beginning of this century, these organizations were created by churches. Small clinics, many of them near the churches, were established. Medical care was free of charge and the physician received no salary. One of the first organizations of this kind was the "Patronato Nacional de la Infancia" established for the protection of mother and child, especially among the poor. In 1911 this same organization created the "Gotas de Leche," the purpose of which was to care for pregnant women and their unborn.

Some years later, the "Cruz Roja Chilena," a branch of the International Red Cross, started its activities. This group trained personnel to assist its physicians and nurses and established clinics to aid the poor. Later, they signed an agreement with the Servicio Nacional de Salud to supply personnel and facilities for peripheral clinics.

During the 1950's, Caritas-Chile (a branch of Caritas International) became active, particularly in supplying equipment and food for private clinics. At present, their principal activity consists of the training of personnel to assist physicians.

At the same time, the "Sociedad Pro Ayuda del Nino Lisiado" became operational. This society provided child rehabilitation, particularly for children with neurologic difficulties. They also organized training classes for those with orthopedic devices.

During the following years, two more private institutions were founded, and both of them provided treatment for mentally ill children i.e., the "Fundacion Cottolengo" and "Fundacion Donnebaum." These child care institutions have only a very limited effect because their financial resources are absolutely insufficient to meet the great need.

It may be said that voluntary health organizations in Chile are few and of limited activity, primarily covering specific diseases or problems, like the three institutions mentioned above. This is due to the increasing influence of governmental medical assistance programs. Therefore, the role of voluntary health agencies is decreasing every day. Another reason for this is the high cost of medical care, a fact which limits the activities of these organizations because of their lack of funds. The role of professional associations, however, has become increasingly important.

In general, about 2,000 private hospitals with very limited capacity exist in Chile. The majority of them are used for hospitalization of patients requiring surgery, or for childbirth. These hospitals are of a commercial nature and generally work on agreements between the patients and the Servicio Nacional de Salud or Medicina Curative de Empleados. In the same way, welfare services from some private organizations and banks are operated on a commercial basis, as they give medical assistance to their members through professional health personnel. These services are financed through payments made by their members.

**APPENDIX H**

**Income From Membership Dues  
for Professional and Voluntary  
Organizations**

**National Voluntary Health Agencies**

<b><u>Organization/Country</u></b>	<b><u>Estimated Number of Members</u></b>	<b><u>Annual Dues in U.S. Dollars</u></b>	<b><u>Estimated Budget 1973</u></b>
1. Leprosy Association (Brazil)	100	\$.25 to \$200	N.A.
2. Family Planning (Argentina)	250	\$2.50	\$225,000
3. Diabetes (Argentina)	1,500	\$2.40	\$ 6,000
4. Physically Disabled (Chile)	80	\$1.20	\$ 70,000
5. Family Planning (Chile)	1,000	\$1.20	\$600,000

**National Professional Health Associations**

1. Dental Association (Brazil)	15,000	\$12 to \$60 (Dues in Branches)	\$ 4,000
2. Public Health (Brazil)	400	\$4.00	\$ 3,000
3. Pharmacists (Argentina)	10,000	Affiliated Formula (\$8/month & 1 yr./member)	\$ 18,000
4. Medical Association (Argentina)*	35,000	\$1.50	\$ 72,000
5. Nurses Association (Chile)	2,400	\$15 to \$20 (compulsory membership)	\$ 25,000
6. Public Health (Chile)	300	\$1.50	\$ 500

(\*Confederacion Medicina)

**APPENDIX I**

**Schematic Diagram of the Coordinating  
Committee of Organizations for  
Social Welfare (CONDECORD)**



C A E S P O  
Argentine Committee of Education for the Health of the Population

