What Does Chile Mean: An Analysis of Events in the Health Sector Before, During, and After Allende's Administration

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An analysis is made of the events in Chile before, during, and after the Allende administration, through the mirror of the Chilean health sector. The paper is divided into three sections. The first shows how the underdevelopment of Chile and the country's concomitant maldistribution of health resources are brought about precisely because of the existence of factors which make up the Rostowian assumptions for development, i.e., (1) the cultural, technological, and economic dependency of Chile, and (2) the economic and political control of resources by specific interests and social groups – the national lumpenbourgeoisie and its foreign counterparts. Moreover, these two factors bring about the so-called dual economy in Chile, with an urban, technologically based economy, and a rural, underdeveloped one.

The second section describes and analyzes the three main policies of Allende's government in the health sector. These policies were (1) to change the priorities in the health sector to emphasize community and rural medicine, (2) to democratize the health institutions with citizens' and workers' control of those institutions, and (3) to establish a classless health service.

The third section deals with an analysis of the events that led to the downfall of the Allende government and describes the policies instituted by the junta, which represents the interests, both within and outside the health sector, of those classes and groups whose behavior determines and explains not only the underdevelopment of health in Chile but also the sickness of underdevelopment.

> To all those in Chile and in the rest of Latin America who are persecuted because they believe that the way to break with the underdevelopment of health is to break with the sickness of underdevelopment.

On September 11, 1973, at nine o'clock in the morning, two battalions of infantry surrounded the Chilean presidential palace in Santiago. From ten o'clock until two o'clock, the troops bombarded the building, killing most of the staff, including the President of Chile, Salvador Allende.[1] Just a few yards from the palace can be found the most luxurious hotel in

[1]For an accurate report of the events that took place during and after the coup, see the dispatches from Santiago by the correspondents of the Washington *Post* and *Le Monde*, and by J. Kandell (1973a–e) of the New York *Times*. The Santiago correspondents of the *Wall Street Journal* are notoriously inaccurate. For an excellent detailed critique of the misinformation provided by the *Wall Street Journal*, see Birns (1973).

Santiago, the Careras Hotel, which is owned by the U.S. Sheraton chain. The New York *Times* correspondent in the city reported that in that hotel, as in very many places at that time in Chile, the maids, cleaners, and blue-collar workers gathered in the basement in fear and anger over the fall of what they considered their government. Up on the top floor, meanwhile, the hotel manager invited his patrons to drink champagne with him, to celebrate the military coup and the fall of the Unidad Popular government (Kandell, 1973a). Not very far away, in the Medical College building, the Chilean Medical Association sent a telegram of support for the coup (El Mercurio, 1973a). Meanwhile, in most health centers and hospitals, and in most working-class and rural communities, the health workers, the blue-collar workers, the low-income peasantry, the unemployed, and the poor, that sector of the Chilean population that Neruda had defined as the "disenfranchised majorities," were presenting resistance to the military takeover. The strength of the resistance is evidenced by the fact that today, ten months after that morning in September, the country is still in a state of siege (Gott, 1974). And the military has had to establish a repression defined by the correspondent of *Le Monde* in Santiago as "the carnage of the working class and of the poor" (Le Monde, 1973:12). Thousands of miles away, according to the Washington correspondent of *Le Monde Diplomatique*, the atmosphere in the "corporate corridors of power in Washington was one of cautious delight, with some embarrassment" (Le Monde Diplomatique, 1973:7).

Why all these events? How were they linked? And more important, what is the meaning of those events in Chile for Latin America as a whole at the present time?

In this presentation I will try to give you my perception of what happened to Chile's health sector and why it happened. And I will attempt some tentative conclusions. Also, and since it is my assumption that the health sector in any society mirrors the rest of that society, I will try to describe the evolution of Chile's health services within the over-all parameters that define the general underdevelopment of Chile.

By Way of Introduction

In order to explain the events in Chile, both within as well as outside the health sector, we should first look at the causes of underdevelopment in Chile, which, as I have postulated elsewhere (Navarro, 1974), are the same determinants that shape the structure, function, and distribution of resources in the health sector.

Indeed, the causes of underdevelopment, not only in Chile, but also in most of Latin America, are not due (as is believed in most of the leading circles of government and academia of developed countries and in the international agencies) to (1) the scarcity of the proper "values" and technology in the poor countries, (2) the scarcity of capital and resources, and (3) the insufficient diffusion of capital, values, and technology from the developed societies to the cities of the underdeveloped countries and from there to the rural areas. Quite the opposite of that interpretation of underdevelopment, the causes of underdevelopment are precisely the existence in Chile — as well as in the rest of Latin America — of those "conditions of development," that is (1) too much cultural and technological dependency on the developed countries, and (2) the underuse and improper use of the existing capital by the lumpenbourgeoisie and its foreign counterparts.

Actually, the highly skewed distribution of both economic and political power in Chile, with control of that underused and improperly used capital by the national bourgeoisie and its foreign counterparts, is at the roots of Chile's underdevelopment. To some of you, accustomed to the classless approach of sociological research prevalent in American sociology, this may sound very sketchy and even like a slogan. If this is the case, I would suggest you read my paper, "The Underdevelopment of Health or the Health of Underdevelopment" (Navarro, 1974), where I try to present evidence to support this theory. I should add that the present paper is a further extension of that previous article.

To understand the underdevelopment of health resources in Chile, then, we have to start with a description of the skewed distribution of economic and political power between the different classes in Chile. And, although each class contains different groups with different interests, there is still a certain uniformity of political and economic behavior within each class which allows us to break Chilean society into basically three classes.[2]

At the top, we have 10 percent of the population, who control 60

[2]The upper class includes the monopolistic bourgeoisie, the large agrarian bourgeoisie, the large landowners, the large urban non-monopolistic bourgeoisie, and the small and medium urban bourgeoisie. The middle class includes the petite bourgeoisie, the professionals, the white collars, state civil servants, and large sectors of the middle echelons of the armed forces. The working class includes the workers in monopolistic and large industries (the best-organized and most politicized workers in Chile), the workers in small and medium-sized industries, and the subproletariat. The peasantry includes the farm workers and sharecroppers. For an excellent description of each class, see the Popular Action Unity Movement (MAPU) pamphlet, "The Character of the Chilean Revolution," published as Chapter 10 in Johnson (1973).

percent of the wealth (income and property) of that society, and who determine the pattern of investment, production, and consumption in Chilean society. Because their economic, political, and social power, however, is dependent on the power of the bourgeoisie of the developed countries, Frank (1973) adds the expression "lumpen" to the term bourgeoisie. Dependent on the lumpenbourgeoisie are the middle classes, who, in Latin America, as a UN-ECLA report states, "improved their social status by coming to terms with the oligarchy" (United Nations Economic Council for Latin America, 1970:79; quoted in Frank 1973:134). Far from being a progressive force, as the middle classes were in the developed societies following the industrial revolution, the middle classes in Latin America were and are a mere economic appendage to the lumpenbourgeoisie.

Below these two classes is the majority of the population, the blue-collar workers, the peasantry, the unemployed, and the poor, representing 65 percent of the Chilean population and owning only 12 percent of the wealth of that society (Petras, 1970).[3]

The Structure of Health Services in Chile

Not unexpectedly, the class structure of Chile is replicated in her health services. Thus, the governmental health service or National Health Service (NHS) covers the working class, peasantry, the unemployed, and the poor — groups which, together with a small fraction of the lowest-paid white-collar workers also covered by the NHS, represent approximately 70 percent of the Chilean population; voluntary health insurance (SERMENA) covers the middle class, who represent approximately 22 percent of the Chilean people; and the fee-for-service, out-of-pocket, "market" medicine covers the lumpenbourgeoisie, approximately 8 percent of Chileans. And, again, not unexpectedly, expenditures per capita are lowest in the government sector, higher in the insurance sector, and much larger in the private sector. Actually, expenditure figures show that the top two groups, the

[3]In terms of income distribution, in the 1960s this was as follows: "five percent of the population, composed mainly of urban owners of capital, receives 40 percent of national income; twenty percent of the population, mainly urban employees, receives 40 percent of national income; fifty percent of the population, mainly urban workers in industry and trade, receives 15 percent of national income; and twenty-five percent of the population, mainly rural agricultural workers, receives 5 percent of national income" Frank (1969:106).

lumpenbourgeoisie and middle classes, while representing 30 percent of the Chilean population, consumed 60 percent of Chile's health expenditures in the time period from 1968 to 1969, while the working class, peasantry, unemployed, and poor, representing 70 percent of the population, consumed only 40 percent of those national health expenditures (Chilean Ministry of Public Health, 1970:93, 183, and 186; quoted in Gaete and Castanon, 1973). Moreover, and reflecting the increasing income differential between the upper and lower classes, those differences of consumption have been increasing, not decreasing. Indeed, while private-sector consumption in 1958 represented 41 percent of the national health expenditures, by 1963 that percentage had grown to 57 percent, and by 1968 to 60 percent (Gaete and Castanon, 1973:10). Thus, the private sector of consumption increased from 2.0 percent of the gross national product in 1960 to 3.7 percent in 1968, while public sector consumption actually decreased from 3.2 percent in 1960 to 2.5 percent in 1968. This expansion in private-sector health consumption was due primarily to increased consumption per capita in the private sector, since the percentage of the population in both the lumpenbourgeoisie and middle classes has remained practically the same (Petras, 1970). In summary, then, the distribution and consumption of health resources in Chile reflects Chile's class distribution, and this leads to a situation in which family expenditures for health services in the lower classes are a tenth of the amount spent by the upper classes (Diaz, 1966; quoted in Gaete and Castanon, 1973).

However, as important as the knowledge of the present distribution of resources in the health sector may be, it might be still more important to know how this distribution of resources, reflected in the class system, came about. Actually, it is worth noting that, while in the evolution of the Chilean health services we find some elements that are unique to the Chilean situation, there are also quite a number of characteristics which are similar to those seen in other countries, including our own. For a succinct historical review of the main historical events in Chile during this century, see Scientists and Engineers for Social and Political Action (1973).

The concept of health care as a human right was accepted in Chile as far back as 1925, when it was written into the Chilean Constitution that health is a human right and that the state has the responsibility of guaranteeing health care for its citizens. The gap between theory and practice was a wide one, however, and it was not until 1952 that a National Health Service was established, initially to take care of the blue collar workers, and then, in successive stages, other

sectors of the population such as the peasantry, the unemployed, and the poor.[4] There are several reasons, as many as there are theories, for the creation of the National Health Service at that time. One reason is the situation of the Chilean economy in the thirties and forties. In the Depression which hit the world economy in the thirties, international demand for raw materials and primary products fell off markedly, creating a major crisis in dependent economies such as Chile's, where the main exports were those goods. It was not until the forties, during World War II, that the demand for Chile's products, and primarily for copper, Chile's main export, began to revive. It was at this time that the lumpenbourgeoisie and its foreign counterparts saw an opportunity to develop the sluggish economy according to their own schemes, with industrialization as the main stimulant for that development. Because they wanted to build up the economy, it was to their advantage to have a healthy work force, particularly in the industrial sector. In fact, a major aim of the National Health Service was to "produce a healthy and productive labor force" (Gaete and Castanon, 1973:12), and the statutory law establishing the National Health Service actually states that a prime objective of the Service is to "guide the development of the child and the young, and the maintenance of the adult for their full capacity as future and present producers" (Chilean Ministry of Public Health, 1950).

The intended industrialization of the country required great sacrifices and, as has occurred in most countries, the burdens of these sacrifices fell not on upper- but on lower-class shoulders. It was during the decade 1940–1950 that a large regressive distribution of income took place at the expense of the lower-income groups. Wages during that period fell from 27 to 21 percent of the national income, and the economic gap between the classes increased dramatically. These developments were accompanied by great repression, with the intent to destroy the working-class-based parties. Not surprisingly, this period of Chilean history was marked by worker and peasant uprisings, and great social unrest. And the threatened lumpenbourgeoisie responded to this not only with repression but with social legislation. This reaction was not unlike that of Bismarck during the previous century in Germany, with, besides repression, the creation of social security and the founding of a National Health Insurance scheme to care for the blue-collar workers, and later the peasantry, unemployed,

[4]Before 1952, the labor insurance and the welfare systems were in charge of the care of the blue-collar workers (although not the workers' families) and the poor.

and poor. The intent of these changes was to co-opt the unsettling forces. But the concession of one class was the gain of the other. Naturally the working-class-based parties not only supported but fought for the creation of the National Health Service. And it was none other than the late President Allende, at that time a member of the Chilean Senate for the Socialist Party, who introduced and sponsored the law establishing the National Health Service.

In that respect the Chilean experience in the 1950s repeated the experience with social security in other countries. Indeed, here let me quote Sigerist, that great medical historian and professor of medical history at Johns Hopkins back in the 1940s. I believe his words, spoken in his Heath Clark Lectures at the London School of Hygiene, the same year—1952—that the National Health Service was created in Chile, are relevant not only to the Chilean situation of the 1950s but also to our present debate on national health insurance here in the United States (Sigerist, 1956; quoted in Terris, 1973:317):

> Social-security legislation came in waves and followed a certain pattern. Increased industrialization created the need; strong political parties representing the interests of the workers seemed a potential threat to the existing order, or at least to the traditional system of production, and an acute scare such as that created by the French Commune stirred Conservatives into action and social-security legislation was enacted. In England at the beginning of our century the second industrial revolution was very strongly felt. The Labour Party entered parliament and from a two-party country England developed into a three-party country. The Russian revolution of 1905 was suppressed to be sure, but seemed a dress rehearsal for other revolutions to follow. Social legislation was enacted not by the Socialists but by Lloyd George and Churchill. A third wave followed World War I when again the industries of every warfaring country were greatly expanded, when, as a result of the war, the Socialist parties grew stronger everywhere, and the Russian revolution of 1917 created a red scare from which many countries are still suffering. Again social-security legislation was enacted in a number of countries.
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> Every historical pattern we set up is to a certain extent artificial and history never repeats itself unaltered. But patterns are useful because they help us to understand conditions. When we look at the American scene we find the need for health insurance and a red scare that could not be stronger, but America has no Socialist party, no politically active labour movement that could bring pressure upon the Government. The existing order is not threatened from any side and conservative parties do not feel the need for action on these lines.

How applicable this quotation is to our present situation in the United States is for you to decide. As for its applicability to the Chilean situation in the 1950s, it is clear that the creation of social security and the National Health Service was also a response by the right to claims and threats from the left.

The middle and upper classes continued in the private sector on the fee-for-service, direct payment to physicians, following the market model in which health services are sold and bought like any other commodity.

The attitude of the medical profession toward the National Health Service has been ambivalent. On the one side, they need it, since the consumer power for the majority of the population covered by the National Health Service was, and continues to be, very low indeed. And the National Health Service has always been an important source of income for the 90 percent of Chile's physicians who work for it either on a part- or full-time basis (Gaete and Castanon, 1973:9).

On the other hand, the medical profession maintained profound reservations about the National Health Service because they feared government intervention. This explains why, as their conditions of acceptance of the service, they asked (1) that the Chilean Medical Association be appointed, by law, as the watchdog of the National Health Service, to defend the economic and other interests of the medical profession, and (2) that there still be private practice, on a fee-for-service basis, for private patients, who would be able to use National Health Service facilities.[5]

It was not until the 1960s, when an economic depression hit Chile and the costs of health care increased, that both the consuming middle classes on the one side, and the physicians on the other, began a movement that led to the creation in 1968 of a health insurance plan (SERMENA) similar to our Blues, to cover both hospitalization and ambulatory care, with maintenance of the fee-for-service payment to the physicians. As with our Blues, the creation of SERMENA was very much a result of concern by the providers that the increasing costs of medical care were threatening to force their private clientele out of the market. The Frei administration, whose main constituency

[5]Full-time physicians working for the National Health Service are supposed to work, in theory, six hours a day, being paid on a salary basis. The arrangements for the part-time physicians are similar to those in the National Health Service in Britain, with privileges for "amenity beds" for the physicians' private clientele within the National Health Service hospitals.

was the middle classes, approved and stimulated the creation of this insurance, which covers the majority of professionals, small owners, petite bourgeoisie, and white-collar workers.

With the establishment of SERMENA, then, the Chilean class structure was formalized and replicated within the health sector, with the National Health Service taking care of 70 percent or the majority of the population, the blue-collar workers, peasants, unemployed, and poor, and the health insurance scheme (SERMENA) taking care of the middle classes (20 percent) and increasing sectors of the lumpenbourgeoisie (2 percent). (For a historical review of the health services in Chile, see Laval, 1944; Laval and Garcia, 1956. Both articles are in Spanish.)

The Distribution of Resources by Regions

Related to this maldistribution of resources by social class, there is a maldistribution of resources by regions, depending on whether the areas are urban or rural. Chile, a long, narrow country that is 2,600 miles in length, is 75 percent urban and 25 percent rural, and 30 percent of the population lives in the capital, Santiago. Analyzing the distribution of resources, we find that the number of visits per annum per capita in Santiago (three) is twice that of the rural areas, while the personal expenditures for health services in Santiago ($38) are over four times those in the rural areas ($9), for both ambulatory and hospital care. (For an excellent review of the distribution of health resources in the National Health Service in Chile, see Hall and Diaz, 1971.) Santiago, although it only has a third of the Chilean population, also has 60 percent of all physicians and 50 percent of all dentists. In terms of environmental services, 80 percent of the water supply and 65 percent of the sewerage system is considered adequate in the urban areas, compared with only 20 percent and 9 percent, respectively, in the rural ones (Requeña, 1971).

As I have explained elsewhere (Navarro, 1974), these rural areas are not marginal areas that the modern sector has not reached. In fact, quite the contrary, their poverty is due to their link to the modern sector, and the wealth of the urban areas is partially based on the poverty of the rural ones. However dramatic this statement may sound, the evidence shows that a significant part of the wealth of the urban-based lumpenbourgeoisie comes primarily from the extractive

industries and agriculture, which are situated where most of the poverty in Chile is — in the rural areas. (For a detailed and excellent explanation of this argument, see Frank, 1969: 1 – 120.)

Why This Maldistribution

In the paper referred to earlier (Navarro, 1974), I attempted to analyze some of the reasons for this maldistribution, which are rather typical of most Latin-American countries. And, as I indicated earlier, we cannot understand the maldistribution of resources in the health sector without analyzing the distribution of economic and political power in these societies, i.e., the question of who controls what and whom, or what usually is referred to in political economy as who controls the means of production and reproduction.

In Chile, as in most Latin-American countries, the lumpenbourgeoisie controls most of the wealth, property, and income in the society. Thus, they are the ones who do most of the saving, who direct the investments and greatly influence the different affairs of state, and who primarily control the workings of the executive, legislative, judicial, and military arms of government. Above all, they control the distribution of resources in the primary, secondary, and tertiary sectors of the economy. In the tertiary sector, they influence the distribution of resources in the health sector by (1) expounding the "market model" system of allocating resources, whereby resources are distributed according to consuming rather than producing power, i.e., upper-class, urban-based consumer power; (2) influencing the means of reproduction, i.e., urban-based medical education; and (3) controlling the social content and nature of the medical profession, as a result of the unavailability and inaccessibility of university education to the majority of the population. Actually, the medical students come primarily from the professional and lumpenbourgeoisie classes, which represent less than 12 percent of the Chilean population. Let me illustrate this point with figures on the father's occupations of the 264 first-year students in the School of Medicine of the University of Chile in 1971: managers and professionals (70.4 percent); white-collar workers (16.0 percent); blue-collar (4.1 percent); and others (9.5 percent). The category "others," incidentally, does not include peasants. The peasantry, 30 percent of the labor force, had not a son or a daughter in the main medical school of Chile (Sepulveda, 1973:4).

Another mechanism of control used by the lumpenbourgeoisie in

the health sector is their influence, tantamount to control, over the highly centralized, urban-based state organs, so that the public sector, controlled by the different branches of the state, is made to serve their needs. Until 1970 the executive, legislative, and judicial branches were all controlled by those political parties that represent the lumpenbourgeoisie and the middle classes. In the election of 1970, however, the executive, though not the other branches of the state, changed hands and passed partially into the control of the working-class-based parties. For a detailed explanation of this point, see the series of articles edited by Cockcroft et al. (1972: Part II).

Consequences of This Control: The Priorities in the Health Sector

This control by the bourgeoisie of the means of production in the health sector leads to a pattern of production aimed primarily at the satisfaction of the bourgeoisie's patterns of consumption. And this pattern of consumption of the lumpenbourgeoisie, the setters of tastes and values of these societies, mimics the patterns of consumption of the bourgeoisie of the developed countries.

Not surprisingly, then, we find a pattern of production in the health services of Chile that is very similar to the pattern of production in most health services of developed countries, i.e., a system of health services that is highly oriented toward (a) specialized, hospital-based medicine as opposed to community medicine; (b) urban, technologically intensive medicine in contrast to rural, labor-intensive medicine; (c) curative medicine as different from preventive medicine; and (d) personal health services as opposed to environmental health services. Needless to say, considering the type of health problems prevalent in Chile, where malnutrition and infectious diseases are the main causes of mortality and morbidity, the best strategy to combat the problems which affect the majority would be to emphasize precisely the opposite patterns of production to those currently prevalent in the health sector. This would imply emphasis on rural, labor-intensive, and community-oriented medicine, while giving far greater priority to the preventive and environmental health services than to personal health and curative services.

This mimic behavior of the lumpenbourgeoisie is explained by their interest in having the "latest" in medicine, with a concomitant growth of open-heart surgery units, coronary-care units, organ trans-

TABLE 1
Percentage Distribution of Physicians by Some Specialties

Country	*Year*	*General Practice*	*Public Health*	*Surgery*	*Pediatrics*
Chile	1972	14.0	3.2	18.2	10.0
United States	1970	17.8	0.8	20.0	6.0

Source: Adapted from Department of Human Resources, Pan American Health Organization (1973).

plants, and the like, representing the "Cadillac" or "Rolls Royce" medicine, an order of medical priorities that is bad enough in developed countries and even worse in developing ones. Indeed, this order of priorities diverts much needed resources from the production of health services aimed at the care not of the few, but of the many.

Control by the few of the production of health resources also determines a pattern of reproduction in Chile's medical education that determines a distribution of specialties which follows very closely, by types and percentages of specialties, that in the developed countries. Table 1 shows the percentage distribution of physicians in certain specialties. You can see that surgery, for example, the typical technological, hospital-based specialty, represents the top specialty by percentage of physicians, with pediatrics and public health being the lowest categories. It should be obvious that in a country with 38 percent of the population under 15 years of age, and with a type of morbidity caused by environmental and nutritional deficiencies, there is an oversupply of the former and an undersupply of the latter.

Table 2 shows that expenditures per capita on environmental health services are a very small fraction of total expenditures in the health sector, with the majority of resources going to curative services and the largest percentage to hospitals. The well-known economist de

TABLE 2
Estimated Expenditures of the Chilean Health Sector in Medical Care and Water and Sewerage Supply Per-Capita and by Percentages of Total Health Expenditure, in 1969

Medical Care		Water and Sewerage	
Per Capita Expenditure (US $)	*%*	*Per Capita Expenditure (US $)*	*%*
24	94	1.5	6

Source: Sepulveda (1972).

Ahumada (1968), Navarro (1974), and very many others (see Navarro and Ruderman, 1971) have emphasized that the health services required for a developing country are services that are not technological, but labor-intensive, not hospital- but community-oriented, not curative but preventive, and aimed not at personal but environmental health services. This suggested order of priorities is precisely opposite to the one followed in Chile and in the majority of Latin-American countries, which, as I have explained, is a result of the pattern of economic and political control in those countries.

The Election of the Unidad Popular (UP) Government

Having detailed the situation before the coming of Allende's government, let me now define what a government whose main constituencies were precisely the disenfranchised blue-collar working classes and peasantry, did, and intended to do, in the area of health services. As a song, popular among the upper class during the Allende administration, said (quoted by Feinberg, 1972:169):

> Under Alessandri [National Party], gentlemen governed,
> under Frei, the noveaux riches [and not so rich],
> and now, with Allende, govern the ragged ones.

The Unidad Popular government, which took office in 1970, was a coalition administration, a popular front government of very different parties with no one in a clear position of leadership.[6] Interparty struggles were part of the daily political scene, with cabinet positions given according to the relative importance of each party within that coalition. The Ministry of Public Health, not a basic post within the government (or, I would add, in most governments and in most countries), was given to a minority party, the Radical Party, whose constituency was a small sector of the middle class. The major health policies, however, were defined by the Cabinet, chaired by President

[6]The parties of the coalition included the Socialist and Communist Parties, the most powerful within the coalition, the Radical Party (a lower-middle-class party), MAPU (United Popular Action Movement), and the IC (Christian Left). These two last parties were split-offs from the Christian Democratic Party (PDC), the main bourgeoisie party. To the left of the UP coalition parties, there were the MIR (Revolutionary Left Movement) and the PCR (Revolutionary Communist Party), two very small radical left parties which did not participate in, but supported, the UP government.

Allende, with a Socialist and Communist majority. President Allende, himself, incidentally, a physician by profession, had long been acquainted with the development of the health services, both as a member of the Senate for thirty years and as the youngest Minister of Public Health during the Popular Front government in 1938. It is thus not surprising that although the distribution of health resources was not the top issue within the administration, it was not at the bottom either. Moreover, the evolution of events in the health sector did mirror the over-all series of events that took place in Chilean society as a whole during the period 1970 to 1973.

The three main commitments that the Allende administration made in the health sector were the integration of the different branches of the health services (with the exception of the armed forces health service) into one health service, the democratization of the health services institutions, and the change of priorities in the health sector, placing greater emphasis on ambulatory care and preventive services. Let me start by looking at the third of these commitments and examine ambulatory and preventive services.

The Change toward More Ambulatory and Preventive Services

The National Health Service in Chile had been organized following a regional system back in 1958, during the Alessandri administration, a conservative administration that was committed to "clean" and "efficient" government. This regionalization further developed during the years of the Frei administration from 1964 to 1970, and was strengthened during Allende's time. There were three levels of care: a primary-care or health-center level, looking after a population of approximately 30,000 people; a secondary-care or community-hospital level, looking after a population of approximately a quarter to half a million; and a tertiary-care or regional-center level, in charge of the care provided to a population of one to one and a half million people.

This regionalized National Health Service during the Alessandri and Frei administrations has been characterized as being largely centralized, bureaucratic, and very hospital-oriented (Requeña, 1971:7). Actually, not unlike the situation in the United Kingdom and the United States, for instance, a very large percentage of all National Health

Service expenditures, close to 50 percent, went to hospitals. The Allende administration tried to reverse these priorities by shifting the emphasis toward the health centers through the allocation of more resources to those centers. One example of this shift was that, out of the six hours a day physicians worked in the NHS, during the Allende administration at least two or the equivalent had to be spent in the health centers. Another example is that the Compulsory Community Service, whereby all physicians had to work for a period of three years in an urban or rural health center (either when their degrees were granted, or at the end of their residencies), was expanded to five years. Also, the number of hours in which the health centers were open to the community was expanded into the late hours of the evening, and, in some communities, such as Santiago, they were even open twenty-four hours a day. During the night hours, the centers were staffed with final-year medical students, under the over-all supervision of available physicians (Chilean Ministry of Public Health, 1972).

Needless to say, none of these changes endeared the Allende administration to the majority of physicians. The policies were, however, very popular with the majority of the population, since they increased the accessibility of resources to the population, providing services where people lived (i.e., in the communities). Actually, following the implementation of these policies, immediately after Allende took power, one result was that there was a large increase in the consumption of ambulatory services, primarily among children. Indeed, the over-all number of ambulatory visits by children increased in just the first six months of 1971 by 17 percent over the whole country, and by 21 percent for the city of Santiago (Requeña, 1971:11). Also, and as part of this new orientation toward the community, preventive-service activities such as immunization, vaccinations, prenatal care, and others, were emphasized. These preventive activities, incidentally, were provided not as separate programs, but as part of the usual services of the health centers. Another change, by the way, was to expand the distribution of half a liter of milk per day, previously provided to children under five, to include children up to 15 years of age.

While these activities were far from uniformly successful, they seem to have stimulated popular support and popular involvement in the delivery of health services. And this leads me to what may be considered one of the most important achievements in the health sector during the Allende administration: the democratization of the health institutions.

The Democratization of the Health Institutions

The National Health Service in Chile has been referred to as a mammoth bureaucracy that was not very responsive to the needs of the citizenry in general and to the local consumers and communities in particular. However, the increase in working-class political consciousness as a result of the continuous economic crisis of the 1960s, besides making the working-class parties more powerful, also created, at the community level, a demand for popular participation in social and economic areas. This growing demand explains the creation by the Frei administration of the Community Health Councils, which were aimed at stimulating the participation of the communities in running the health institutions, either at the primary-, secondary-, or tertiary-care levels (Gaete and Castanon, 1973:14). Not unlike our health advisory councils here in the United States, and the newly established district community councils in Britain, these early councils were supposed to be merely advisory to the director of the institution who was appointed by the central government.[7] The councils seem not to have been very successful as a mechanism for community participation in the health sector. They were perceived by the working class as a co-opting mechanism. Indeed, as indicated by the First Congress of the Trade Unions of Chilean Health Workers (1971; quoted by Gaete and Castanon, 1973:23–24):

> with community participation [equivalent to our American consumer participation], our bourgeoisie gives our workers a feeling of participation, but without an actual and authentic power of decision . . with this policy the decisions that are taken by the bourgeoisie are legitimized by the participation of the workers, who not only don't have any power of decision, but do not have the right to complain afterwards about those decisions either, since, in theory, the workers did participate in those decisions.

It was felt that, as another writer pointed out, "community participation is an intent of cooption of the community dwellers and legitimization of the power of the bourgeoisie" (Germana, 1970:15).

Responsive to a demand not for community participation but for community control, the Allende administration committed itself to the

[7]There is voluminous literature in both the United States and the United Kingdom on consumer participation. For a representative view in the United States, see Sheps (1972) and in the United Kingdom, see Weaver (1971). For a description of the roles of the district community councils, see Great Britain, Ministry of Health (1972).

democratization of the health institutions, stating in their political platform dealing with the health sector that "the communities — people — are the most important resources in the health sector, both as producers and as decision makers" (Unidad Popular Party, 1970). Democratization, incidentally, took place in other areas besides the health sector, although in that sector it did go further. A likely reason for this may have been that most of the health institutions, health centers, hospitals, and the like, were already in the public sector and thus were amenable to government influence. The majority of economic institutions, on the other hand, remained during the Allende administration in the private sector.

The democratization of the health institutions took place via the executive committees, which, as their name suggests, were the executive or top administrative authorities in each institution. They had a tripartite composition, with a third of the board elected by community organizations (trade unions, Federation of Chilean Women, farmers' associations, etc.), another third elected by the workers and employees working in that institution, and one third appointed by the local and central government authorities. Each level elected the level above itself, so that the executive committees of the health centers elected the executive committees of the community hospitals and these elected the executive committees of the regional hospitals. Their authority was limited to an over-all budget for each institution, and it had to be spent within the guidelines established by the planning authorities, which were in turn accountable to the central government.

How did this democratization work? Before replying to this question, I should point out that democratization was a result of popular and community pressure on the one side and the commitment of the ruling political parties to implement it on the other. A key element for that implementation was the civil servants of the National Health Service, who mostly belonged to the opposition parties and whose outlook, like that of most civil servants in any country I know of, be it socialist or capitalist, tended to be conservative. By a large majority, 86 percent to be precise, they were in favor of community participation but against community control (Albala and Santander, 1972:68).

Let me explain what I mean by the conservative attitude of the civil service. Civil servants, or, as Miliband (1969) defines them, the "servants of the state," tend to defend the status quo and thus tend to be in general conservative. As Crossman (1972) has said for the Labour Party in Britain, and Myrdal (1960) has said for the Social Democrats in Sweden, both parties have always encountered the un-

spoken resistance of the civil service in trying to implement their policies. And even in China, after thirty years of Communist Party rule, as the need to have a cultural revolution showed, the civil service opposed the changes advocated by powerful sectors of the ruling party (Robinson, 1969). Chile, then, was no exception.

Needless to say, another group that did not welcome democratization of the health institutions was the medical profession, and this added to the long list of grievances that the medical profession had against the Allende administration. The democratization, however, proved to be quite popular among the citizens of the communities, and in a survey carried out for a doctoral thesis (Albala and Santander, 1972), the majority of community representatives interviewed expressed "satisfaction" to "active satisfaction" with the democratization of the institutions. And, not surprisingly, the communities' involvement with their health institutions did increase, side by side with the increased politicization of the population which was the main characteristic of the period during 1970 to 1973.

Another example of community participation was the Councils for Distribution of Food and Price Controls (JAP), neighborhood committees created by communities to avoid speculation and oversee the distribution of popular items to consumers.[8] Also, the community-control movement was parallel and went hand in hand with the movement of workers' control, another commitment of the Allende administration. Indeed, in the 320 enterprises that were in the public sector during Allende's 34 months as President, the management in these businesses was run by an administrative council composed of five worker representatives (three blue-collar workers, one technical person, and one professional person), five state representatives, and one state-appointed administrator. Let me add something here that my business school colleagues will very likely not believe. It is that an American scholar in Chile found, in a multivariate analysis of productivity in a sample of factories, that productivity in the factories was related to participation by both workers and employees in the process of decision making. The variable of the political consciousness of the factory workers was more important in explaining increased participation and production than were other variables such as capital-labor ratio, technological complexity, technological type,

[8]The JAPs originated in 1971 to assist in the distribution process, making sure that local shopkeepers did not charge above the official prices and that they did not divert items to the black market (Zimbalist and Stallings, 1973).

size of the vertical or horizontal integration, and others (Scientists and Engineers for Social and Political Action, 1973:26–28; Zimbalist and Stallings, 1973).

All these related movements of community and worker control grew parallel to the politicization of the population and increased very rapidly after the first abortive attempt at a military coup on June 29, 1973, when, spontaneously, twenty factories were taken over and directly managed by both the workers and the communities. And it was in response to the first owners' strike in October 1972 that the workers themselves took over the management of the factories. As Steenland (1973:18) has indicated:

> the October offensive of the bourgeoisie further polarized the Chilean political scene. Every organization and almost every individual was forced to take a position for or against the government.

It was at this time that the Industrial Strife Committees were established to coordinate the management of all factories located within a vicinity or community and to set up committees within each factory in charge of production, distribution, defense, and mobilization. Also, these committees stimulated the creation at the community level of the Neighborhood Commands, broadly based community committees in charge of the coordination of the community social services, including health, and the mobilization of the population (North American Congress on Latin America, 1973b:5).

These movements of community and worker control, stimulated at first by the Allende government, grew and achieved a momentum of their own, until they expanded into the main sectors of the economy and forced a hesitant government into a defensive position. As Sweezy (1973) has indicated, the government went from a leadership position to one of a follower, far behind, and hesitant to grant what was being requested and demanded in those movements. And, as both Sweezy (1973) and Petras (1973) point out, it was this hesitancy that seems to have partially stimulated the downfall of the Unidad Popular government.

And speaking of hesitancy, let me describe the third characteristic of the Allende government in the health sector, the one in which it showed greatest hesitation and the one that brought about the greatest opposition: the policy of ending two-class medicine, with integration of both the National Health Service and SERMENA into just one system. In the health sector, this policy was Allende's Achilles' heel.

The Intent of Creating a Classless Health Service

Allende had a commitment, as part of his political platform, to the creation of one national health service that would have integrated both the National Health Service and the voluntary health insurance of SERMENA (Requeña, 1971). Interestingly enough, it was never intended to include within this integrated system the health services for the armed forces. Actually, a characteristic of the Allende administration was his efforts not to antagonize the military, allowing and even encouraging the granting of special privileges to those in uniform (Rojas, 1973).[9]

How that integration of health services was to take place was not spelled out either in the Unidad Popular platform or in subsequent policy statements once Allende was in power. Also, fearful of further antagonizing the lumpenbourgeoisie, the middle classes, and the medical profession, the UP government kept postponing the implementation of the commitment for a more propitious time.

Opposition to the integration measure was expected from the lumpenbourgeoisie and middle classes because integration could have meant the leveling off of their consumption, with the consumption of the majority of Chileans being cared for by the National Health Service. Indeed, those classes feared absorption of their health services by the National Health Service, with the resources they had always enjoyed having to be shared with the majority of the population.

The medical profession opposed integration for both professional and class reasons. Among the former reasons was the fear of losing the much desired fee-for-service and "private practice" type of medicine typical of SERMENA. In addition, they feared integration in the National Health Service would mean the loss of their independence and of their economic power. Among the class reasons was the

[9]This policy was part of a deliberate intent by Allende to co-opt the military, which traditionally has had very strong ties with the U.S. military. It is interesting to note that in 1973, at the height of the economic blockade against Chile, Chile's armed forces remained, along with Venezuela's, the main recipients in Latin America of U.S. aid for training officers. And, when no other public agency or department within the UP government could get international loans and credit, the Chilean military received credit to buy F5E supersonic jets (North American Congress on Latin America, 1973b:8). Actually, the U.S. granted to the military in Chile a total of $45.5 million in aid during fiscal years 1971 to 1974, double the total granted in the previous four years. As Admiral Raymond Peet testified before the Senate Appropriations Committee, "One of the big advantages that accrues to the United States from such a foreign sales program is the considerable influence we derive from providing the support for these aircraft" (North American Congress on Latin America, 1973b:9; Monthly Review, 1971).

increasing curtailment of consumption that both the lumpenbourgeoisie and the middle classes were exposed to in the Allende administration as a result of an alleged scarcity of resources both outside and within the health sector.

Since much has been written on that scarcity of resources, allow me to dwell on this point for just a moment. There is a widely held belief in some sectors of our academia and press that the cause for this scarcity of goods, commodities, and services, and even for the fall of the UP government, was the incompetence of the economic advisers to the Allende administration. As one of the representatives of this belief, Paul N. Rosenstein-Rodan (1974:E12), recently wrote in the New York *Times*, "undergraduate economic students would have known better" than the economists advising the Chilean government. According to this interpretation of the scarcities and of the fall of Allende, other possible explanatory factors, such as the U.S.-led economic blockade, the boycott of the production of those goods and services by U.S. and Chilean economic and professional interests, and the manipulation of the international market by those interests to damage the Chilean balance of payments, are easily dismissed as mere "left wing demonologies." Actually, in the widely publicized article by Rosenstein-Rodan quoted before, these possible alternate explanatory factors are not mentioned once. And since the acceptance of the idea of "economic incompetence" absolves the powerful economic and professional groups both internationally and in Chile of any major responsibility for the events in Chile, this interpretation of the scarcity of resources and of the fall of Allende is the most widely held, supported, and circulated view, not only, of course, among those economic groups, but also among those sectors of the U.S. press and academia sympathetic to those groups.

Because this view is so frequently expressed both outside and within the health sector, let me then present other alternate explanations for the scarcity of goods, commodities, and services under Allende.

When the UP government took office, 47 percent of the population were undernourished (North American Congress on Latin America, 1972:17), 68 percent of the nation's workers were earning less than what was officially defined as a subsistence wage, and there was an unemployment rate of 6 percent in Chile as a whole and a rate of 7.1 percent in Santiago (Scientists and Engineers for Social and Political Action, 1973:14 – 19). The poorest 60 percent of Chilean families received only 28 percent of the national income, while the richest 6 percent received 46 percent (Steenland, 1973:9). Over one

quarter of the population of Santiago lived in flimsy shacks without running water. Meanwhile, industrial production was running at only 75 percent capacity (Steenland, 1973).

Just one year after the UP took office, the industrial production went up to 100 percent capacity, unemployment went down to 3.8 percent (5.5 percent in Santiago), workers received a 20 – 30 percent increase in real wages, and the percentage of the national income in wages went up from 51 percent in 1970 to 60.7 percent in 1971. Meanwhile, inflation was kept down to 22 percent in 1971, as compared to an average 26.5 percent in the years 1965 – 1970.

This dramatic increase of the purchasing power of the majority of the population and the larger availability of resources to all, not only to a few, created a great increase in the demand for goods and services, which, as I indicated before, was also reflected in the consumption of health services, primarily ambulatory health services.[10]

Because of the increase in demand for basic goods such as food, the UP government had to import more than the usual 60 percent of food that Chile had to bring in from abroad. Indeed, Chile, like the United Kingdom, has to import most of the food that it eats. This increase in imported commodities, plus the decline by 28 percent in the international price of copper, which represented 80 percent of the Chilean foreign-exchange earnings, created a rapid shortage of foreign exchange and a rapid worsening in Chile's balance of payments.

Compounding this situation, there was the "invisible" economic blockade, which started immediately after the UP government took office. As Steenland (1973:10) points out, to fully understand the meaning of this economic blockade, you have to realize that in Chile, a country with a gross national product of about $10 billion, a government budget of about $700 million and exports of about $1 billion, United States investments also amounted to a sizable $1 billion, controlling 20 percent of the Chilean industry, with participation in another 7 per cent. Steenland (1973:14) continues:

> In the dominant industries, foreign interests controlled 30.4 percent and participated in another 13.2 percent . . . And aside from outright control through ownership, Chilean industry used largely U.S. machinery and

[10]One of the goods whose consumption increased most as a result of the growth in purchasing power of the working class and peasantry was beef. Under the Alessandri administration (1958 – 1964) a worker had to labor five hours, 35 minutes to buy a kilo of stewing beef; under Frei, four hours, 53 minutes; but under the UP, a worker had to labor only two hours to buy the same amount (North American Congress on Latin America, 1972).

> was dependent on the U.S. for technology. This dependency was greatest where the industries were most modern, and in industries which were growing rapidly — rubber, electric machines, refinement of metals, and lumber. In addition to U.S. control through technology and ownership, the U.S. government also exercised great indirect economic power through international finance institutions.

Not surprisingly, then, when the Allende government nationalized the U.S.-dominated mining industry, the United States pressured the international lending institutions to deny new credits to the Chilean economy, with the result that the total loans and credits fell in just one year — 1971 — from $525 million to just over $30 million. For an excellent and detailed account of the economic blockade, see North American Congress on Latin America (1973a). The Santiago correspondent of the Washington *Post* (1973c:1,14), writing just after the coup described how the economic blockade helped to cripple Allende:

> Since 1970, the Allende government has been the target of economic policies that have squeezed the fragile Chilean economy to the choking point. These policies were conceived in an atmosphere of economic strife between the Allende government and a group of large U.S. corporations whose Chilean holdings were nationalized under the terms of Allende's socialist platform. The instruments for carrying out the sustained program of economic pressure against Allende were the U.S. foreign aid program, the Inter American Development Bank, the U.S. Export Import Bank, the World Bank and also private U.S. banking institutions [one example of this blockade is that] one of the first actions under the new policy was the denial by the Export Import Bank of a request for $21 million in credit to finance purchase of three Boeing passenger jets by the Chilean government airline, LAN-Chile. The credit position of the airline, according to a U.S. official familiar with the negotiations, was an excellent one.[11]

These credits were needed to buy not only foodstuffs, but also machinery, equipment, etc., and also to pay off the $3 billion foreign debt that the Frei government had left the nation, which made Chile the second most indebted country per capita in the world, after Israel (Steenland, 1973:14). The lumpenbourgeoisie, dependent on foreign capital, joined the external boycott with an internal one together with explicitly political strikes, increasingly aimed at causing the fall of the UP government or triggering a military coup. One part of this boycott

[11]As a footnote to this report, incidentally, I might add that the credit to buy these Boeing jets was granted just two weeks *after* the coup (Washington Post, 1973d).

was the truck owners' strike that paralyzed the system of transport and hindered food distribution, thus compounding existing scarcities (Steenland, 1973:16).

It was thus the greatly increased demand for basic goods and services plus the politically motivated shortages, the result of both the international blockade and the lumpenbourgeoisie boycott, that determined the need to ration those basic goods. And not unlike rationing in other countries, the ones more opposed to that rationing were the upper rather than the lower classes. For the lower classes, the "free market" supported by the wealthy was in itself a form of rationing where the criteria for the distribution of food was based on the consumer power of the rich. Thus, the lower classes were far more sympathetic to formal rationing, where the criteria for the distribution of resources were defined by a government that was, at least in theory, sympathetic to their needs. And according to an opinion pool published in the weekly paper *Ercilla* (1973), which was of anti-UP sympathies, the success of the Allende government distribution policies was shown by the fact that while 75 percent of those lower-class householders polled said that essential goods had become easier to obtain, 77 percent of middle-class and 93 percent of high-income households were finding them less accessible. The medical profession, very much a part of these latter classes, were among those who were finding the essential goods less accessible.

As a Chilean folk song says,

> sharing the riches, my son, is for some to have less and for others to have more.

And the period 1970 – 1973 in Chile saw an attempt to redefine this idea of sharing. Not surprisingly, the medical profession and the classes they belonged to, the lumpenbourgeoisie and the middle classes, did not want to have their class and professional privileges redefined. Nor were they willing to tolerate the integration of health services into one system that would have determined the sharing of their resources with the majority of Chileans.

The Fall of the Allende Administration

As I have explained, it was in the delay in bringing about the integration of the two-class medicine into one health system that the UP

government showed its greatest hesitancy in the health sector, although this hesitancy seems to have been a "trademark" of the Allende administration in other areas as well. Actually, as Sweezy (1973) has noted, the political strategy of the UP government seems to have been to increase its popular support while trying to avoid or postpone the confrontation with the lumpenbourgeoisie and middle classes. This strategy seemed a valid one in the first year of the administration, when the parties forming the UP coalition, which had polled 36.3 percent of the vote in the presidential election, just five months later, in April 1971, increased their share of the vote to 51.0 percent, in a municipal election run in terms of support or opposition to the UP government (Steenland, 1973:10).

The weakness of this strategy, however, was that it meant postponement not only of the integration of the health services, but also of promised policies in other sectors, and this gave the medical profession and other groups and classes the time to organize their opposition, first, during the year 1972, legally, and later, in 1973, illegally. Indeed, as Sweezy (1973) and Petras (1973) have indicated, the UP seems to had underestimated the power of the response of the national bourgeoisie and its international counterparts. A summary list of events shows this. (For a detailed list of events during the Allende administration, see Steenland, 1973; Zimbalist and Stallings, 1973; Scientists and Engineers for Social and Political Action, 1973; North American Congress on Latin America, 1973a and 1973b.)

In October 1972, the truck owners staged their first strike against the government, in theory to delay any attempt by the administration to nationalize transport, but in practice to force the resignation of the government. The medical profession, following a call by the Chilean Medical Association, followed with a strike that was in theory to protest the lack of availability of equipment in the health sector, but, again, in practice, it was meant to force the Allende government to resign. In fact, organized medicine did call for the resignation of Allende at this time. A passing but interesting note here is that the public health physicians, with a great number of faculty and students from the School of Public Health, as well as the majority of the trade unions of health workers, came to the support of the government. Their rallying call, which was to become a slogan later on, was the very unsectarian one of "this government is shit, but it is our government." The strike did not succeed.

The second great moment of difficulty for Allende's government was in July 1973, when the second strike of the truck owners took

place with the explicit aim either of causing the fall of Allende or stimulating a military coup. The medical profession joined in with renewed requests for Allende's resignation. And, in an almost unanimous resolution, the Chilean Medical Association decided to expel President Allende from its membership. Dr. Allende, I might mention here, had been one of the first officers of the association when it was founded.

Meanwhile, from the end of 1972, as was recently announced by the present military leaders and reported by the New York *Times* (Kandell, 1973c), the truck owners, the professionals (including the Chilean Medical Association), the Chilean Chamber of Commerce, and other groups representative of the economic interests, national and international, had been planning, together with the military leaders, the final military coup of September 11, 1973, which achieved what they had been asking for, the fall of the Unidad Popular government.[12] The Chilean Medical Association was the first professional association to send a telegram of support to the junta, applauding their "patriotism."

It seems, then, that the fear and hesitancy of the Allende government also brought about its end. The leadership's belief that time and, thus, evolution were on their side apparently proved, ultimately, a self-defeating strategy.[13] The dramatic successes of the first year and the great popularity of the government during that first year were not used to advantage, to implement in each sector of the economy such policies as the integration of the health services that, by strengthening UP aims and policies, would have weakened their opponents.

The Response of the Reaction[14]

Not surprisingly, the military junta, the voice of those interests which were curtailed during the Allende administration, including those of

[12]It has been said, particularly by conservative voices, that the military coup was a necessary response to the "lawlessness of the masses," which seems to be their code name for the mass mobilization of the lower classes. This argument deliberately ignores the documented fact, recognized even by the junta itself, that the military started planning the coup as early as six months after Allende's administration took office and one year before the spontaneous mobilization of the working class took place. Moreover, the first mass mobilization occurred, as indicated in the text, after, not before, the first (unsuccessful) coup took place. In that respect, the historical sequence shows that the mobilization was a response by the working class to the military and strike threats from the lumpenbourgeoisie and the armed forces, not vice versa.

[13]The main architect of this evolutionary strategy within the coalition of the Unidad Popular parties was the Communist Party.

the medical profession, has undone most of the advances that the working class and peasantry achieved during the period 1970 – 1973. This has taken place both outside as well as inside the health sector. Let me list some of the most important changes brought about by the junta.

First, the project of integrating the two-class medicine has been abandoned, with a declared commitment by the junta to leave the fee-for-service system of payment in SERMENA untouched. There has even been talk within the military circles of changing the system of payment to physicians within the National Health Service from salary to fee-for-service (Chilean Ministry of Public Health, 1973b). A colonel has been appointed Minister of Health and the treasurer of the Chilean Medical Association has been appointed Director General of the National Health Service.

In other sectors of the economy, the junta has returned to the initial owners, to the private sector, most of the industries nationalized during the UP administration (Washington Post, 1973e), and said that it would pay for the remaining ones on generous terms (Kandell, 1973e). According to an interview with General Pinochet, the head of the junta, published in *La Prensa* (1973b:14), the leadership wants to open negotiations with the U.S. ex-owners of the nationalized copper mines on terms favorable to the U.S. companies, since "it is not ethical that we Chileans take over what does not belong to us." Also, an economic policy has been established aimed at encouraging foreign investments on very favorable and generous terms to foreign capital (La Prensa, 1973b). Furthermore, a policy has been instituted that is deliberately aimed at welcoming foreign investments, mimicking the "brotherly regime of Brazil" (Washington Post, 1973i:12). And just one month after the coup, the World Bank (which had denied loans to Chile for three years), together with the Inter American Bank, loaned $260 million to the new government that the Allende administration had tried to get unsuccessfully for three years (Rubin, 1973). As the president of the Chilean Bank, General Eduardo Cano, has said, "the World Bank and international financial circles were well disposed to the new military government in Chile" (Washington Post, 1973h: A32). Further proof of this good will is that the Latin American De-

[14]Information published in this section relies very heavily on the dispatches from the correspondents in Chile of the New York *Times,* Washington *Post,* and *Le Monde,* as well as information from Chilean and other witnesses who were part of these events. Additional information is from Sweezy (1973); Petras (1973); Scientists and Engineers for Social and Political Action (1973); North American Congress on Latin America (1973a; 1973b).

velopment Bank, which turned down every request made by the Allende government, is now about to award a development loan to the junta that is almost five times the size of all the loans received during the Allende administration (Birns, 1973).[15] One month after the coup, the Nixon administration in the United States approved a $24 million credit to the junta, for the purchase of 120,000 tons of wheat. This credit, as Senator Kennedy indicated on the floor of the U.S. Senate (Washington Post, 1973g:A11):

> was eight times the total commodity offered to Chile in the past three years when a democratically elected government was in power.

Second, the coup, which was a bonanza for the Chilean lumpen-bourgeoisie and middle classes and their international counterparts, meant belt-tightening for the working class and peasantry in the health sector and other sectors of the nation.

In the health sector, institutional democracy was automatically discontinued a week after the coup. And the Minister of Public Health, a colonel, declared that in matters of policy the military would rely "very heavily on the good judgment and patriotic commitment of the Chilean Medical Association" (Chilean Ministry of Public Health, 1973c). At the same time, the Chilean Medical Association sent a delegation abroad to several foreign countries, including Uruguay, Brazil, and the United States, to strengthen a scientific exchange with their professional colleagues and equivalent organizations in those countries. The Chilean Medical Association also reassured the military junta of its complete support (El Mercurio, 1973c).

Outside the health sector, the junta discontinued the workers' control of the management of the factories, returning it to the previous managers (Kandell, 1973d), and, at the same time, banned trade unions, incarcerating the national leaders of the trade unions, including those of the health worker unions (Kandell, 1973b). In addition, all political party activities were forbidden, and all working-class-based parties were outlawed (Washington Post, 1973b). Only those the junta defines as "patriots" are entitled to any form of civil rights. The narrowness of their definition may be best reflected by the declaration of General Pinochet, head of the military junta, accusing "the U.S. Senate of being

[15]Also, according to *U.S. News and World Report* (1973), U.S. bankers have decided to provide short-term loans to private and government banks totaling $39 million, to aid the Chilean economy.

under the influence of international communism'' (La Prensa, 1973a:14).

Third, the junta changed the priorities in the health services. The amount of resources available to the health centers was reduced and the amount available to the hospitals increased. The number of hours that physicians have to spend in health centers was halved, and the hours the centers are open to the public were shortened to the 8:00 A.M. to 4:00 P.M. schedule of pre-Allende times. Moreover, the milk-distribution program was discontinued (Chilean Ministry of Public Health, 1973d, e, f).

Outside the health sector, price controls were discontinued and the goods desired by the upper and middle classes are now plentiful in the stores. The working class and peasantry, meanwhile, as reported by the New York *Times* (Kandell, 1974:10), are going through very tough times of tight budgeting.

Fourth, all opposition was outlawed and persecuted, and in the health sector a campaign of repression was begun against those physicians and health workers who did not join the physicians' strike against Allende's government, who were considered sympathetic to Allende, and whose names were provided to the police authorities by the Chilean Medical Association (Argus, 1974). Also, a campaign of repression was started against the public health movement, which, by and large, supported the Allende administration. The budget of Chile's only school of public health, which is situated in Santiago and is the most prestigious school of its kind in Latin America, was slashed by three-quarters, and 82 faculty members out of a total of 110 were fired and some imprisoned (American Public Health Association, 1973). As the Chilean Ministry of Public Health (1973a) says, ''Very many public health workers were misguided and their activities were subversive of the traditional medical values.'' In Chile, also, the medical schools and all other university centers have been placed under military control. All presidents and deans of academic institutions are now military men. As Dr. E. Boeninger, the last president of the University of Chile, said, ''The Chilean University is in the hands of the military'' (El Mercurio, 1973b:12).

Known results of this repression in the health field are that 21 physicians have been shot, 85 imprisoned, and countless others dismissed (Chilean Medical Doctors in Exile, 1974).

Outside the health sector, the junta has instituted a campaign of repression that has been defined by Amnesty International as the most

brutal that that association has ever surveyed, more brutal even than the repression in Brazil in 1965, Greece in 1968, and Uruguay in 1972 (New York Review of Books, 1974). Today, ten months after the coup, the state of siege continues (Gott, 1974).

Epilogue

It may be too soon to make a post mortem of performance of the Allende administration in the health sector. But still, enough knowledge of those years has been accumulated to entitle us to draw some conclusions. And perhaps one important interpretation of these events may be that Chile seems to show, once again, what Brazil, the Dominican Republic, Uruguay, Paraguay, Bolivia, and many, many other Latin American countries have shown before — that there is a rigidity in the economic, political, and social structures of most Latin American countries that makes change almost an impossibility, however slow or gradual that change may be. The lumpenbourgeoisie and their foreign counterparts offer extremely strong opposition to any movement that might imply the curtailment of their benefits, however slow or minimal this curtailment may be. They perceive that any concession has a momentum of its own and that it might escalate, according to the sadly famous "domino theory," to the final destruction of their privileges.

The reaction of these groups to the UP government in Chile is an example of this. Actually, in spite of the alarm that the Unidad Popular administration created in many U.S. corridors of power, Allende's government was not a "radical" one. As the pro-UP economist Alberto Martinez indicated, even if all the programs for nationalization that the UP government called for had been implemented, it would have meant state control of only 25 percent of industrial production outside of the mining sector, which is less than the control of that production by U.S. interests, estimated to be close to 30 percent (quoted by Steenland, 1973:12). In fact, Allende (Washington Post, 1973f:C1) himself argued:

> I want to insist that Chile is not a socialist country. This is a capitalist country and my government is not a socialist government. This is a popular, democratic, national revolutionary government — anti-imperialist.

Indeed, he emphasized that the UP was an "anti-imperialist and

anti-monopolistic government, more than a socialist one'' (Debray, 1971:85). And, again, he held that it was ''not a socialist government, rather, there is a government that is going to open the path, to blaze the path for socialism'' (Allende, 1971).

The major economic decisions taken by Allende were the nationalization of the copper industry and the takeover of the control of banking and most of the foreign commerce, measures that were more of an anti-oligarchy and nationalist than of a socialist nature. Concerning his interior policies, a UP economist (Monthly Review, 1971:17) has explained that Allende's economic policy was of the nature that we in the United States

> would call the New Deal type [since] it combines a policy of large-scale public works (especially housing and related services) with fiscal and monetary measures designed to stimulate popular purchasing power . . . [and with] strict price controls [which] would keep these gains from being dissipated as has regularly been the case in the past, through inflation.

Not surprisingly, Allende has been called the Léon Blum of Chile. And, actually, his reforms could hardly be accused of being an intrinsic threat to the capitalist system. In spite of this, however, the national and international interests perceived his programs as being the beginning of the end for them. And the opposition to those UP economic policies was formidable, showing how, inside the parameters of underdevelopment and within the present structures, the possibilities for change, however limited, are very small indeed. It does seem as if Allende underestimated this opposition. The gradualism and the faith of the leadership of the UP in the ''uniqueness'' of the Chilean phenomenon (considered by some to be unhistorical), together with their postponement of outright decisions that would have weakened their opponents, apparently allowed time for the massive opposition of the national and international interests to organize.[16] The postponement of the integration of health services is a fitting case in point.

In that respect, Allende's delays may have also caused his downfall. And, contrary to prevalent belief in some sectors of the U.S. press, Allende's downfall may have been brought about not so much

[16]As an ITT memorandum indicated, ''a realistic hope among those who want to block Allende is that a swiftly deteriorating economy . . . will touch off a wave of violence, resulting in a military coup'' (Washington Post, 1973a:A2).

because he went too fast, but because he went too slowly. Indeed, as Oskar Lange (1938; quoted in Monthly Review, 1971:40) said almost forty years ago, if

> a socialist government . . . declares that the textile industry is going to be socialized after five years, we can be quite certain that the textile industry will be ruined before it will be socialized . . . [during those five years] no government supervision or administrative measures can cope effectively with the passive resistance and sabotage of the owners and managers.

It is my belief that this observation applies to the health sector as well as to other areas. Indeed, in the health sector, many proposals for national health insurance schemes and/or national health services have been frustrated because of delays in their implementation and because of final compromises with the medical profession and with other interest groups in the health sector. Actually, the Chilean experience only reflects previous experience in other countries, be they socialist or capitalist: when a political party or group is committed to a national health program intended to benefit the citizenry and to curtail the privileges of the providers, its chances of implementation are inversely related to the length of time required for implementation. We can see that, in Chile, the longer the delay, the more time there was for the interest groups to organize and achieve compromises that diluted and subtracted from the program. And these compromises, I might add, can only benefit the providers, not the consumers, the majority of the citizenry.

There are certain conclusions, then, that we can derive from the events in Chile. One is that the present political structures in most of Latin America (and, I would add, in most of the underdeveloped world) hinder, rather than foster, any opportunity to bring about a change that would benefit not just the few, but the many. The national and international economic elites control those political structures to maintain outdated and grossly unjust political, social, and economic privileges in opposition to the popular demands of the majority of the population. A second conclusion would be that gradualism by those parties and groups in underdeveloped countries that are committed to change weakens the possibilities for change in the health sector and in other areas. The Chilean workers and peasants, the real heroes of the tragedy that was played out in Chile, clearly understood this when they kept urging the Allende government to proceed with reform at a

faster pace. And when, after the first, unsuccessful, military coup, Chilean society began increasingly to polarize, the working class and peasantry, in their working places, their factories, their hospitals and health centers, and in their communities, began to mobilize and to prepare themselves for the coming second coup. In a battle against time, they have lost for the time being, and the privileged classes and their military brute force have won. As Neruda (1963:111) said almost forty years ago, on the day that another military coup took place, in Spain, hope lived in the hearts of the people

> Till one morning everything blazed:
> one morning bonfires
> sprang out of earth
> and devoured all the living;
> since then, only fire,
> since then, the blood and the gunpowder,
> ever since then.
>
> Bandits in airplanes
> and marauders with seal rings and duchesses
> black friars and brigands signed with the cross, coming
> out of the clouds to a slaughter of innocents.

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