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Twenty Years of Mental Health Policies in Chile
Lessons and Challenges

ABSTRACT: Over the last 20 years, Chile has increased the mental health share of its public health budget and implemented policies that radically transformed psychiatric services in the country. Both national and international factors have contributed to this process. The implementation of two national mental health plans has led to downsizing mental hospitals and developing community alternatives, such as primary health care, community mental health teams, day hospitals, acute psychiatric beds in general hospitals, and group homes. The annual number of new persons starting treatment for mental disorders in the public sector has increased by 343 percent between 2004 and 2007, with depression being the condition that motivates the highest frequency of visits. The Chilean experience has been successful in terms of increasing availability and accessibility of services and demonstrating that with a modicum of political support, it is possible to implement an effective and efficient community-based network of primary and secondary care facilities. Notwithstanding the progress made in this country, the mental health treatment gap is still significant.

Explicit mental health policies provide governments with a powerful means to develop services and programs aimed at meeting the mental health needs of the
population in a humane fashion [1]. This prioritization is consistent with the burden of the disease, and the policies provide a general blueprint and broad objectives for future action and facilitate agreement among different stakeholders [1]. In Latin America and the Caribbean, mental health policies have been strongly influenced by the Caracas Declaration and its call to integrate mental health into primary care, shift to a community-based care paradigm, and protect the human rights of people with mental disability [2]. The momentum generated in the regional conference held in Caracas in 1990 was furthered through the Pan American Health Organization/World Health Organization (PAHO/WHO) Initiative for the Restructuring of Psychiatric Services whose goal was to promote and support mental health reform initiatives in Latin America.

Valuable lessons may be learned from analyzing the policy-making efforts set off by the Caracas Declaration. Although the obstacles have been varied, and the resources available for mental health are still insufficient and inequitably distributed, important progress has been achieved in several countries [2]. In 1990, the same year the Caracas Declaration was launched, Chile ended 17 years of right-wing dictatorship by electing a government open to social policies and to strengthening the public health system. These two historical landmarks and the leadership of a group of professionals advocating for community-based services were key drivers for increasing the mental health share of the public health budget [3] and the implementation of policies that radically transformed psychiatric services in the country [3, 4].

**Historical Background**

Chile’s enthusiastic embrace of the ideals put forth in the Caracas Declaration is rooted in three significant public health developments dating back to the early 1950s: a vigorous tradition of mental health epidemiological research, the implementation of a publicly funded health care system of national reach, and several earlier attempts to implement community-based mental health services. Starting in 1954 and led by the psychiatrists Juan Marconi and Jose Horwitz, Chilean researchers conducted epidemiological studies that used case ascertainment and random sampling methods to assess the prevalence of alcoholism and other mental disorders among Santiago residents [5, 6]. The military dictatorship put an end to this important public health endeavor, and it would take two decades for the second generation of epidemiological research in Chile to emerge [7].

With the implementation in 1952 of a publicly funded national health care system, Chile developed an extensive network of primary, secondary, and tertiary care facilities. This system was funded by tax revenue and payroll contributions, and covered more than 70 percent of the population, mainly blue-collar workers and indigent people, who received health care services and medication free of charge. Since its implementation, Chile’s health indicators improved progressively, reaching one of the best levels in Latin America. Infant mortality rates decreased from 136.2 per 1,000 live births in 1950 to only 55.4 in 1975, and general mortality
declined from 14.8 per 1,000 inhabitants to 7.2 in the same period [8]. The national health system also included the two mental hospitals existing in the country, and two others were added in the late 1960s through the reconversion of old hospitals (one previously used for infectious diseases and the other for tuberculosis).

Inspired by neoliberal doctrines and with the aim of fostering the privatization of large areas of the economy, the military dictatorship (1973–90) embarked on a series of radical reforms of the Chilean health care system [9]. Key among these reforms were the transformation of the public health system into a decentralized network of twenty-six autonomous territorial health authorities whose financial management was entrusted to a national health fund, the introduction of legislation to promote the privatization of the health care market, and the transfer of administrative and financial responsibility for primary care to municipalities. Public spending on health care was reduced, and the national system was fragmented into poorly coordinated sectors.

Earlier attempts to implement community-based mental health services occurred in the 1950s with the implementation of scattered psychiatric beds and outpatients departments in general hospitals and in the late 1960s with the formulation of a national mental health program. Although the latter program was never implemented in full because of a lack of political support and resources, it remains an important milestone because it espoused a public health approach to addressing the high burden of mental disorders. The program called for the development of a network of services based in primary care centers and general hospitals and for the implementation of day hospitals, group homes, and sheltered workshops. A few pilot trials were implemented in the country where psychiatrists, general practitioners, and other health professionals put some aspects of this program into practice [10, 11]. These pilot trials and many other public health initiatives were shut down in 1973 as a result of the military coup, and many of its leaders were killed, jailed, exiled, or forced out of the public health system. The only innovative services that survived through the dictatorship were ambulatory psychiatric services based in general hospitals and the treatment of alcohol dependence in primary care centers.

**First National Mental Health Policy (1993–99)**

The community orientation for delivering mental health services that was the bedrock of the Caracas Declaration found a receptive audience in Chile, a country that in 1990 was just returning to democracy, eager to finally begin to address long-ignored social problems. A second generation of community-oriented professionals emerged in Chile, influenced by the pre-1973 experience and the psychiatric reforms that were taking place in Western Europe and North America. The dissemination of the principles and practices of the psychiatric reform movement was further favored by the return to the country of mental health professionals who were in exile during the dictatorship.
In 1990, a Mental Health Unit was created within the Ministry of Health, and in 1993, the first national mental health plan was signed into law by the minister of health [12]. In each of the country’s twenty-six territorial health authorities, two or three staff members were charged with implementing the national policies, coordinating the local mental health services network, managing the mental health budget, planning for additional services, and evaluating the mental health care provided [13]. The advent of democracy led to improvements in the financing and organization of publicly funded health care and the invigoration of the then-languishing primary care. These developments provided a favorable climate for the new mental health initiatives.

The national mental health plan was implemented gradually over a period of 7 years. Service innovations included the creation of day hospitals to decrease the number and duration of hospitalizations, group homes to facilitate the process of deinstitutionalization, psychosocial rehabilitation programs to help persons with mental disability integrate into the community, and mental health programs in primary care to narrow the mental health treatment gap. The incorporation of psychologists to the primary care workforce in sixty of Chile’s 487 urban primary care centers was a successful—yet poorly sustainable—innovation that demonstrated the important role that mental health professionals can play in primary care when working alongside general practitioners.

The implementation of the plan did not occur flawlessly, however. Depending on the local political support and resources, the plan was implemented consistently only in some regions and localities; the coordination between primary care facilities and community mental health centers was weak, resulting in a duplication of some interventions, while others were not adequately provided by either setting; government contracts for various aspects of the plan were only issued on a year-to-year basis, making continuity of professionals difficult to ensure; and the mental health budget for community services was inadequate to the task of transforming a system that had been largely centered on psychiatric hospitals.

Second National Mental Health Policy (2000–10)

The lessons learned from the implementation of the first plan and the experience from psychiatric reforms in other countries, including a focus on evidence-based care and best practices, were important inputs to the development of a second national mental health plan during 1999. A draft written by the Ministry of Health’s Mental Health Unit was subjected to a process of extensive consultations and revisions that involved different stakeholders throughout the country. As a parallel development, advocates called for greater resources for mental health, arguing that the 1999 allocation of only 1.3 percent of the health budget for mental health care was vastly insufficient to meet the needs of the population.

The second plan was launched in 2000 and focused on seven priority areas: 1) promotion and prevention in mental health, 2) attention deficit hyperactivity
disorder in children and adolescents, 3) mental conditions associated with violence (domestic violence and violence associated with the dictatorship), 4) depression, 5) schizophrenia, 6) drug and alcohol abuse and dependence, and 7) Alzheimer’s disease and other dementias [14]. For each of these priorities, the plan provided service delivery guidelines specific to primary and secondary care. The main strategies utilized for the implementation of the plan were [4, 15–19]:

- Allocation of public sector funds for mental health with the goal being to gradually increase mental health care funds from 1.3 percent of the global health budget to 5 percent in 2010 and an increasing allocation of funds for primary care.
- Implementation of a comprehensive network of community-based services as an alternative to psychiatric hospitals.
- Participation of persons with mental disorders and their families in the planning and evaluation of mental health services at local and national levels.
- Primary care centers as the entry point for the treatment for all mental disorders and as the main providers of mental health care, the goal being that a much higher proportion of people with mental disorder should be treated in primary care than in secondary care.
- Augmentation of mental health expertise of primary care teams where all urban primary care centers would have at least one full-time psychologist and would receive consultation from psychiatrists, psychologists, or other mental health specialists through monthly visits primarily aimed at supporting the teams in their management of difficult patients.
- Implementation of a comprehensive program for the treatment of depression led by psychologists and general practitioners. The design of this program was patterned after traditional primary care programs such as those targeted to people with hypertension and diabetes, which had been successfully implemented years earlier. A more detailed description of this program is given in another paper in this issue by Alvarado et al. on the treatment of depression in Chile.
- Development of a decentralized ambulatory secondary care system with a larger number of psychiatric outpatient facilities, especially in the form of community mental health centers, and a larger number of day hospitals.
- Transformation of the structure of inpatient care where the main aims were a reduction of long-stay beds and an increase in the number of beds in acute general hospitals and in group homes. Toward this goal, the national health fund phased out the financing of new admissions to long-stay beds in 2001 and increased funding for community-based beds.
- Human rights protection for persons with mental disorders with or without disability. A new piece of legislation protecting the rights of persons admitted to psychiatric facilities was enacted, and national and regional commissions were implemented to ensure its application.
• Specification of the inputs needed to calculate average costs of the interventions recommended for each mental health priority, including estimates of the percentage of the population who would need the interventions annually, qualifications of the staff needed to deliver the interventions, duration of the interventions per person, and average number of interventions per person-year.

In 2004, a program of therapeutic health guarantees became law in Chile as part of the health reform process. According to this law, both the public health care system and the private health insurance industry must offer an explicit set of guarantees in terms of access, opportunity, financial coverage, and quality for fifty-six priority diseases. The guarantees are clearly specified for each disease, including the populations entitled to receive them, types of interventions, maximum waiting time, minimum qualifications of the providers, and ceilings for copayments. The treatment of schizophrenia (from first episode on), depression (age 15 and older), and substance use disorders (below age 20) have been included among the priority diseases.

As a result of the lack of specific funding allocation, the plan’s priority related to promotion and prevention had a low level of implementation until September 2007. That month, the Ministry of Planning in conjunction with the Ministries of Health and Education launched a primary care-based program with a strong mental health component aimed at fostering early child development. Its population target included pregnant women and young children up to age four. The program was named “Chile Grows with You” (“Chile Crece Contigo”), and it was part of the government’s goal to improve the social welfare system.

The process of implementing the second mental health policy has not been problem free. First, the integration of mental health activities in a traditional medical system encountered a certain amount of resistance. To address this problem, mental health professionals from the territorial health authorities had to work hard to persuade physicians and other professionals of the benefits of integration. Second, the specification of priorities created a perverse incentive for the shifting of resources from mental disorders without guarantees to priority mental disorders. As a result, persons with other disorders had poorer access to services and poorer quality of care. Third, specifying program goals solely on the basis of the quantity of services—number of persons who had received the interventions or volume of activities carried out by the primary care teams—promoted greater access to mental health services regardless of the quality of the care provided. Fourth, because most of the funding allocated to the implementation of the plan focused on therapeutic interventions, the potential for primary care to engage in mental health promotion and prevention has not been fully realized.

**Evaluation of Mental Health Policies**

Information from the Chilean Ministry of Health was utilized to evaluate the implementation of mental health policies in the public system during the last 20 years.
Available data included budget allocations for mental health, distribution of beds across different facilities, number of visits to outpatient facilities for a mental health condition, number of people utilizing mental health services, and participation in a quality improvement initiative.

**Mental Health Budget**

Over the last 20 years, there has been a large increase in the allocation of public sector funds for mental health from 1.3 percent of the global health budget in 1999 to 3.1 percent in 2009. At the same time, an enormous change has taken place in the allocation of the mental health budget to different facilities (Figure 1). Most of the new funds have been oriented to strengthening the role of outpatient and community-based facilities in the delivery of mental health services. Between 1996 and 2009, allocation of funds increased from 2 percent to 29 percent of the total mental health budget for primary care, from 19 percent to 30 percent for

**Figure 1**

*Percentage of the Public Mental Health Budget Allocated Yearly to Main Items in Chile, 1990–2009*

*Source:* Data from the Ministry of Health.
outpatient psychiatric centers, and from 1 percent to 9 percent for group homes. While the funding for psychiatric beds in general hospitals has maintained a similar percentage of the global mental health budget since 1990 (between 10 percent and 14 percent), the allocation of funds for mental hospitals have decreased from 74 percent in 1990 to 19 percent in 2009.

### Number of Psychiatric Beds

When the first mental health policy was formulated, the large majority of psychiatric beds in the public sector were placed in mental hospitals, and most of them were long stay, with the lengths of stay being measured in years or decades. In 1990, only 7 percent \((n = 239)\) of all psychiatric beds \((n = 3,399)\) were based in general hospitals. By 2010, the beds’ situation was dramatically different (Figure 2). The number of mental hospitals beds dropped by two-thirds, representing only 29 percent of all psychiatric beds. Further, their role in the continuum of mental health care was

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**Figure 2**

**Number of Beds in Different Mental Health Facilities in Chile, 1990–2010**

Source: Data from the Ministry of Health.
transferred to community alternatives: group homes for persons with severe mental disability lacking family support (37.5 percent of all beds), acute psychiatric beds in general hospitals (14 percent), and day hospitals to avoid or shorten hospitalization stays for persons with acute severe mental disorders (20 percent).

Number of Visits to Outpatient Facilities

With the implementation of the two mental health policies, the annual number of visits to medical doctors for a mental health condition in the public sector increased progressively from 1993 to 2010 (Figure 3). The visits rate reached 99.4 per 1,000 people in 2010, indicating a substantial improvement of the public sector’s capacity to manage mental disorders in the community. Consistent with the strategy of transforming primary care as the main provider of mental health care, the increase in the rate of visits to general physicians has been larger than that for psychiatrists. Since 2004, the number of mental health visits to general physicians has been higher than that for psychiatrists, and in 2007, the number of visits to general physicians was almost twice as large as the number of visits to psychiatrists (Figure 3). However, since 2007, the increase of visits to general physicians has remained constant.

Treated Incidence

The annual number of new persons starting treatment for mental disorders in the public sector increased dramatically between 2004 and 2007 (343 percent), although it has decreased gradually since then (Figure 4). This decrease has been mainly for depressive disorders, mirroring the decrease in number of mental health visits to general physicians in the same period. Depression is the most frequent reason for seeking ambulatory mental health treatment in Chile (41 percent of treated incidence in 2010), followed by anxiety disorders (24 percent), substance use disorders (9 percent), and attention deficit/hyperactive disorders (5 percent).

Treated Prevalence

Although the number of people receiving treatment for mental disorders in primary and secondary care has increased significantly since the second mental health policy was implemented in 2000, a large treatment gap remains in the Chilean public sector (Figure 5). Assuming an estimated 12-month prevalence of mental disorders of 22 percent [20], 73.3 percent of the beneficiary population with a mental disorder does not receive any treatment from this system. The treatment gap is largest for substance use disorders (91.0 percent) and lowest for depression (55.4 percent).

The treated prevalence of depression under the explicit health guarantees system was higher among people with no income (receiving social benefits) or low
Figure 3

Annual Number of Public Sector Visits to Medical Doctors for a Mental Health Condition by Degree of Specialization in Chile, 1995–2010

Source: Data from the Ministry of Health.

Income (making lower than US$379.21 per month) than among middle income people (Figure 6). The lowest treated prevalence in the guarantees system was for privately and self-insured people (mainly upper middle and high income). These findings may be explained by a higher prevalence of depression among people with low or no income, and/or better access to private mental health services among middle and high income people.

Quality Improvement

A comprehensive quality improvement program that was aligned with aims of the second mental health plan was implemented between 2002 and 2007. The program included quality standards definitions, extensive Internet-based educational programs for mental health professionals, and internal and external evaluations of mental health facilities. A key component of this initiative was the implementation of the principles of international accreditation programs in health care [22] aimed at fostering a managerial culture focused on quality improvement. While this
program was operational, the following facilities developed quality improvement plans after external evaluations:

- 89 group homes (67 percent of all the group homes)
- 42 day hospitals (100 percent)
- 19 outpatient centers (53 percent)
- 17 community mental health centers (68 percent)

**Discussion**

The Chilean experience demonstrates that it is possible in a Latin American country to implement policies that radically transform psychiatric services and narrow the mental health treatment gap. Throughout the implementation process, multiple initiatives either facilitated or hindered the achievement of the service development objectives defined by the two mental health national plans. Among the facilitating factors, international cooperation was one of the most significant. Following the Caracas Declaration, PAHO provided continuous technical and financial support to most American countries for strategic local initiatives. After a few years, the
experience of several Latin American and Caribbean countries with policy, legislation, service reforms, and development [2] generated a sense of collective learning, catalyzed by PAHO, which was very helpful for the Chilean process.

Like most other countries, Chile ratified the United Nations International Covenant on Economic, Social, and Cultural Rights, which provides the most comprehensive article on the right to health in international human rights law. In accordance with Article 12.1 of this Covenant, parties recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” In 2000, the United Nations Committee on Economic, Social and Cultural Rights (CESCR) interpreted this article through General Comment 14, stating that “the right to health is not to be understood as a right to be healthy … the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health” [23]. Because the right to mental health is one of the aspects of health most prone to transgression, we discuss the lessons and challenges of the 20-year Chilean experience with mental health policies following the essential elements of the right to health defined by the CESCR in the General Comment 14: availability, accessibility, acceptability, and quality.
Availability

The Chilean policies have demonstrated that a middle income country can adequately address this issue through two strategies: investment of small yet gradually increasing proportions of the global health budget on mental health services and allocation of new funds to develop geographically accessible decentralized services that meet people’s diverse needs. Among these services, Chilean policies have stressed the relevance of primary care for the treatment of common mental disorders (depression and anxiety); specialized outpatient centers to support primary care teams and to treat people with severe mental disorders; day hospitals and psychiatric beds in general hospitals to manage acutely ill persons and severe crises; and group homes to address the need for social supports for persons with severe mental disability, enabling them to exert their right to live in the community.

Source: Data from the Ministry of Health.
It is up for debate whether Chile has in fact developed a “sufficient quantity” of public mental health services and programs, according to the spirit of United Nation’s General Comment 14. No international standard exists that defines what is sufficient, so this benchmark may be variably interpreted. Is it sufficient, for example, to allocate 3.1 percent of the general health budget to mental health? Although it may be considered insufficient given the 2010 goal of 5 percent set in the second national plan of 2000, a percentage arrived at upon by calculating the cost of the priority interventions identified in the plan, it could be considered sufficient when compared with the budgetary situation of many other middle income countries [24].

Accessibility

The dramatic increase in the rates of treated incidence and treated prevalence for the most frequent mental health conditions suggests that the access-focused strategies pursued by the Chilean government have been effective. The Chilean approach to improving accessibility to mental health services provides a model for countries looking for similar results. The health guarantees system has had an especially remarkable effect on access for treating depression among low income people. However, after 20 years of relatively successful mental health policies, the treatment gap remains relatively high and is still a major challenge for the future.

Acceptability

No data is available at the Ministry of Health regarding the acceptability of mental health services to the general population, by gender and minority status. Future policies should aim to develop gender-, cultural-, and age-appropriate services. It will also be important to incorporate this dimension in the data collected by the public information system.

Quality

Although the quality improvement program that was implemented jointly with the second plan received positive evaluations by mental health teams and it led to improved quality of care, it did not receive political or funding support to continue beyond 2007. Currently, quality is not just a major challenge for mental health but for the whole public health system in Chile. Among the most critical quality challenges are early discontinuation of treatment among persons with depression or schizophrenia (see the two papers by Alvarado et al. in this issue), and under-use of guideline-concordant psychosocial interventions by both primary care and specialized teams. These quality problems may be related to deficiencies regarding quantitative and qualitative development of human resources with relevant skills to community mental health care. Despite being a major employer of these resources,
the public health system has not yet managed to decisively influence the training
they receive. One of the limitations of this paper is the paucity of country-specific
evidence on the mental health effects of the country’s larger social forces. Future
policy research should consider the impact of the country’s fast and unequal eco-
nomic development on the mental health of the population.

Conclusions

The Chilean experience with mental health policies in the public sector has been
successful in terms of increasing availability and accessibility of services, con-
tributing to humanely meeting the mental health needs of the population. With a
modicum of political support and a very modest budget, principles and models
exist and international cooperation is available for countries to implement an
effective and efficient community-based network of primary and secondary care
facilities.

Key factors that have contributed to the improvement of mental health ser-
vices in Chile include the strong public network of health facilities that serves
more than 70 percent of the population, the political commitment to narrow
the treatment gap for mental disorders, epidemiological and services research
conducted at universities and at the Ministry of Health, and strong advocacy by
several stakeholders. Notwithstanding the progress made in this country, the
mental health treatment gap is still significant. Critical areas of unmet need are
the mental health care of children, adolescents, and native peoples; mental health
promotion and prevention; and employment and social inclusion of persons with
mental disability.

References


