SPECIAL ARTICLE

MEDICINE, SOCIALISM, AND TOTALITARIANISM: LESSONS FROM CHILE

HOWARD WAITZKIN, M.D., AND HILARY MODELL

Agradecemos al Dr Howard Waitzkin por haber colaborado en este número y haber autorizado esta reimpresión

Abstract Under Salvador Allende (himself a physician), Chile's socialist government achieved health reforms that emphasized nutrition, maternal and infant care, environmental health, increased services for the poor, and improved distribution of care. The government also encouraged worker and consumer control over health policy in neighborhood health centers and hospitals. The Chilean medical profession opposed democratization in the health system, participated in periodic strikes and work stoppages, and criticized the government for shortages of medical supplies and consumer goods that resulted from an international boycott of new loans and credits to Chile. The present totalitarian regime has dismantled the health system; political repression has severely affected physicians and other health workers. Three implications for health care and social change in the Third World emerge from the Chilean experience: that health care is inextricably linked to a nation's political and economic systems; that conflicts within the health system mirror the inherent conflicts of a stratified society; and that incremental reforms in the health system have little meaning without basic change in the social order. (N Engl J Med 291:171-177,1974)

WITH the military coup d'état of September 1973, 41 years of constitutional democracy in Chile came to an end. The purpose of our paper is to analyze (1) some of the changes that occurred in the Chilean health system during the government of Salvadore Al- lende, * (2) the political and economic constraints that limited the viability of the socialized health system in Chile, and (3) the dismantling of the health system that has occurred under Chile's present totalitarian regime.

The implications of the Chilean experience for health care and social change in the Third World are clearly evident: health care is inextricably linked to a nation's political and economic systems; conflicts within the health system mirror the inherent conflicts of a stratified society; and incremental reforms in the health system have little meaning without basic change in the social order.

From the departments of Medicine and Sociology, Stanford University (address reprint requests to Dr. Waitzkin at the Department of Medicine, Stanford University Medical Center, Stanford, Cal. 94305).
Supported in part by a grant from the Robert Wood Johnson Foundation (Clinical Scholars Program).

*The government that Allende served as President was a coalition government, composed principally of representatives of the Socialist and Comrnunist Parties and referred to as *Unidad Popular* (UP, Popular Unity).

This account is based on available written sources as well as observations of Chilean citizens and foreign visitors. One of us (H.M.) worked from 1971 to 1973 as a member of a health team in Chile, under a program sponsored by the UP government; she was present in Chile during the September coup. Current information depends largely on foreign journalists and observers, as well as witnesses who left the country after the coup."

Abbreviations Used

UP:	Unidad Popular (Popular Unity)
NHS:	National Health Service
NHC:	neighborhood health center
LHC:	local health council

'The official position of the Chilean medical profession and the current military junta (which conflicts little with the present account in factual pres· entation although forwarding a different interpretation) has been prepared by the Chilean Embassy in the United States.' For the sake of greater impartiality, we attempt to rely on the reports offoreign observers and international commissions - rather than only the accounts of Chilean refugees who themselves supported the UP government, or the official positions of the junta.

Reprinted from the *New England Journal of Medicine*
291 :171-177 (July 25), 1974

SOCIALIZED HEALTH SYSTEM, BOURGEOIS PROFESSION

The conflicts and opposition that Allende-himself a physician" - encountered in his attempts to modify the Chilean health-care system mirror in miniature the problems that ultimately led to the downfall of his government. Allende tried to introduce broad structural changes that would redistribute services to the poor and increasingly would bring medical care under popular control. At the same time, he scrupulously avoided compulsory measures that would limit the free choice of health professionals or patients.

Because the majority of Chilean physicians derived from bourgeois class origins and valued the financial rewards of private practice, Allende's proposals often threatened the class interests of doctors. Also, as an economically underdeveloped country, Chile was highly dependent on foreign nations like the United States for manufactured products, including medical supplies and general consumer goods. Chile's position of economic dependency led to severe shortages of medical products when foreign countries imposed an economic boycott of new loans and credits to Chile; this boycott was a reaction to the UP government's nationalization of such key industries as copper mining." Shortages of medical supplies and consumer goods, coupled with the structural changes in the health system that the UP government encouraged, fostered persistent and crippling opposition from the medical profession.

Achieved Reforms

The UP government instituted a series of well publicized programs to distribute health care more equitably. These measures, most of which involved increased government spending for health services, did not In themselves evoke much opposition. In setting its goals, the government paraphrased the World Health Organization's unified concept of health: "The concept of health has been defined as a state of complete physical, mental, and social well-being of the individual, and not only as the absence of disease." [4*] Most of the government's programmatic innovations followed Allende's 1970 political platform, which aimed at ensuring "medical and dental attention, preventive and curative for all Chileans, to be financed by the State, landowners and welfare institutions.'?" These programs where to be carried out mainly by the Chilean National Health Service (HS), which Allende had helped establish during the 1950's.

During the first two years of socialist government, several programs improved the distribution and quality of care available to the Chilean people. In line With Allende's long standing interest, [6,7] these programs emphasized nutrition. All children and pregnant or nursing mothers received 0.5 liter of free milk per day. The government instituted public educational campaigns, informing families about the nutritive value of milk.[8-11] To reduce Chile's high rate of infant and pennatal mortality, the government established a system of maternity clinics in small towns and worked to institutionalize the principle of free medical care in all hospitals! Recognizing the importance of environmental health, the government began aggressive programs to improve housing conditions and sanitation. The NHS also organized an emergency-care system that guaranteed emergency services, free of charge, for all Chi leans.[4,12] The government moved quickly to require innovation in copper mining and similar industries to reduce the incidence of occupational diseases like silicosis."

Facing a severe maldistribution of health care, which favored wealthier areas in cities while rural areas and low-income urban districts suffered from shortages of facilities and personnel, the government tried to increase inpatient and ambulatory services in rural provinces." In addition, a government-sponsored "health train" toured the southern provinces, treating 30 thousand people.[10,14] To combat alcoholism, the Ministry of Health established alcohol treatment centers in many cities and rural areas; the government tried to develop a popular consciousness about alcoholism and other health problems by publishing comic books that addressed public-health issues in a humorous medium.[9,15]

Democratization and Decentralization

None of these reforms were particularly threatening to the Chilean medical profession. However, Allende also encouraged changes in the health system that promised important shifts in financing and power. It was these modifications to which health professionals reacted with anger and opposition that ultimately crippled many of the more politically neutral~ reforms. Although Allende's actions were sometimes inconsistent, in general the government supported increased worker and consumer control. In the industrial sector, this policy led to a number of factories administered by organized workers, especially after several companies (for example, textiles, automotive repair industries, and metallurgical enterprises) were nationalized.[9,16] In the health-care system, consumer-worker control gradually emerged at two levels: the neighborhood and the hospital.

Neighborhood level. Even before the UP government took office, the Ministry of Health had divided Chile into geographical health "zones" and each zone into several health "areas." For example, in Santiago there were four major health areas, each having at least one base hospital that served the entire area. Within the area were a number of smaller localities, each encompassing a population of 50 to 75 thousand and served by one neighborhood health center (NHC). Generally the NHC's were located in the low-income residential communities *(poblaciones).* These NHC's were administratively dependent upon an area hospital for personnel medical supplies, and financing.

Part of the UP program was to decentralize medical care by putting greater emphasis on the NHC's. The

*Unless otherwise noted, translations from Spanish are by H. W.

goal of decentralization, together with efforts to democratize the health system and encourage greater community participation, led to the enactment of *Decreto 602,* a govern men t decree providing a structure for active participation by health workers and community representatives. In Santiago *Decreto 602* created four different councils, two on the NHC level and two parallel councils on the level of the area hospital. Figure 1 presents a simplified diagram of the relations among these advisory councils, the NHC's, and the area hospitals.

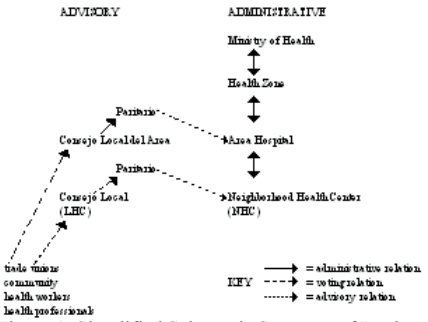

Figure 1. Simplified Schematic Structure of Regional and Local Health Care under the Unidad Popular Government.

On the NHC level, local health councils *(consejos locales de salud,* hereafter referred to as LHC's) were formed by representatives of all organized groups in the community (unions, schools, women's groups, youth groups, etc.), the union of nonprofessional health workers (aides, janitors, etc.), the union of professional health workers (laboratory technicians, social workers, psychologists, etc.), the separate category of medical professionals (physicians, dentists, and pharmacists), and the medical director of the NHG The tasks of the LHC were to discuss the health problems of the community, suggest solutions, co-operate in the promotion of health campaigns (anti-diarrhea, bronchopneumonia prevention, garbage collection, etc.) and act as an advisory link between the NHS and the community.

Still on the NHC level, a second council acted as an executive body *(paritario).* This group included representatives elected from the LHC, in addition to the director of the NHG The purpose of the *paritario* was to act upon the suggestions of the LHC, although ultimate decisions remained in the hands of the medical director.

Analogously, at the area hospital level, parallel councils *iconsejos locales del area)* and executive groups *paritarios)* were also established, with similar tasks and advisory functions. In addition, the area councils participated in comprehensive health planning and the co-ordination of services and facilities throughout the area.

As a supplement intended to broaden the provisions of *Decreto 602,* the NHS also initiated a Program of Sociocultural Development. The Program provided for an integrated health team to work with community members in identifying each locality's basic needs. Cooperating with local organizations, the health team encouraged collective action to combat the diverse problems facing local residents, offered health information, and emphasized people's direct participation as knowledgeable LHC members. In general, the health team attempted to raise the level of medical and political consciousness among the people, as well as to foster active participatory involvement.

Decreto 602 provided a first step toward structural changes in the health system. It promised a shift in existing power structures and encouraged community organization. On the other hand, these innovations contained important weaknesses. As established, the councils and health teams did not provide a real change in power relations. Although they included a relatively low proportion of doctors (10 to 20 per cent), the LHC's and *paritarios* remained basically advisory in nature. The actual decision-making power stayed in the hands of the medical directors of the NHC's.

Many health workers and community members thoroughly understood these weaknesses. In several 10-calities, the LHC's consolidated their power by mobilizing popular support. Community pressures led to a number of concrete accomplishments. For example, one teaching hospital of the Faculty of Medicine of the University of Chile responded to community demands by sending physicians to understaffed NHC's." Other popular goals during this period encompassed a more equitable distribution of existing medical supplies, community control over the hiring and firing of health personnel, extension of NHC hours, and the training of community leaders to perform health-related functions.

As community participation became stronger in late 1972 and early 1973, many LHC's also integrated themselves into other broad-based organizations concerned with food distribution, transportation, local security, and industrial production. When available health facilities appeared inadequate, LHC members took part in autonomous "committees to defend health." These groups became increasingly viable forms of popular power. They also provided a basis for the massive efforts needed to maintain health care during the periodic strikes and boycotts by the medical profession. [9,18,19]

Hospital leuel. Paralleling these changes on the neighborhood level, comparable democratization of decision making occurred in many large hospitals, especially those affiliated with the medical colleges. Within each specialty department (medicine, surgery, pediatrics, etc.) a governing council was formed. This council included elected representatives of nonprofessional workers (such as janitors, aides and orderlies), as well as health professionals (doctors and nurses). The governing council made administrative and staffing decisions that had formerly fallen under the exclusive jurisdiction of high-ranking professionals. The influence of the departmental councils extended to the governance of

the hospital as an Institution, since the departmental councils elected representatives, including nonprofessional workers as well as physicians, to the council that made policy for the entire hospital. The restructuring of power relations in hospitals reflected the conscious thrust toward democratization that occurred also in other Chilean institutions such as industrial enterprises and the universities. These attempts to reduce professional dominance" ultimately led to organized opposition against the UP regime by a majority of the Chilean medical profession.

The Medicopolitical Reality

These potential changes in medical power structure occurred with very few compulsory controls. Since the establishment of the NHS in 1952, physicians could voluntarily choose to work for the NHS. On the other hand, they could remain in full-time private practice or could pursue private practice in addition to their employment in the NHS. Under certain circumstances, doctors could use NHS hospitals or clinics to see private patients on a fee-for-service basis, in addition to their NHS duties. Ultimately, approximately 90 per cent of Chilean physicians worked at least part-time for the NHS.[4.21.22]

The parallel existence of public and private systems, however, created great inequities. The financial incentives of private practice led physicians not to work full-time for the NHS or, if they did, to neglect responsibilities for NHS patients by extending time and energy to see additional private patients. In reality, the failure of the NHS was so widely acknowledged that separate health services were established for the armed forces, the railroad industry, and white-collar workers such as teachers, lawyers, and bureaucratic officials *(empleados).*[23] The NHS itself developed a huge bureaucracy, which became notorious for its size (by 1967 there were 40,656 administrative employees as compared to 6487 medical professionals") and severe inefficiencies in delivering needed services.

In contrast to other countries with socialist governments, Allende made no direct attempt to suppress private practice, by either legal or economic means. The Chilean government continued to underwrite medical education, providing free tuition for medical students, but did not require any standardized postgraduate period of national service. Allende's Ministry of Health lamented the country's distributional problems and the costliness of competing public and private sectors. The national agency for health planning envisioned the future creation of a Unified Health Service *(Servicio Unico)* that would centralize the existing resources and redistribute them among the population."
Except for the accomplishments of the LHC's and hospital councils, however, the government's plans for a restructured health system lacked practical force. Private practice continued to be organized according to the preferences of individual practitioners. In general, physicians worried about the direction of national policy, whereas the concrete conditions of their work changed very little. The government applied compulsory measures only to the distribution of pharmaceutical supplies; it established a national drug formulary and temporarily assumed managerial control of a pharmaceutical firm owned by an American company. [5,9,24] Despite the government's public intention to restructure the health system, little change occurred in the day-to-day details or control of private practice.

Although fundamental changes in private practice remained more a fear than a reality, physicians became increasingly anxious about the general democratization and decline of professional dominance that the UP regime encouraged. The LHC's and hospital councils in several instances requested the removal of physicians employed by the NHS, on the grounds that these individuals' private practices outside the NHS interfered with their NHS duties. Doctors feared that the NHS would exert tighter control over the proportion of private patients they could see, especially within NHS facilities. The government's intention of training more paraprofessional health workers also potentially threatened professional dominance. In late 1972, some community organizations began training their own members in various medical tasks. Organized medicine viewed this democratization of expertise with great apprehension. Moreover, within the curriculum of Chile's medical schools, aided by the support of the UP government, the social sciences came to occupy a more prominent place. Because the social sciences fostered a deeper social consciousness and more critical attitude in young professionals, established physicians feared that their younger colleagues would provide an impetus toward more fundamental changes in the organization of practice.

Physicians' irritation with the UP regime, however, transcended these prospective and largely hypothetical changes that might affect medicine per se. As members of Chile's middle and upper classes, physicians suffered from the same shortages of goods and services that plagued the entire country during the last part of the UP government. Individual physicians and especially the Chilean Medical Association tended to blame Allende personally for the country's troubles. Low-income people, who traditionally had suffered from inaccessible goods and services, did not seriously object to the rationing policies that the government imposed to deal with shortages.

The middle and upper classes perceived these inconveniences as intolerable. In 1972 the Chilean Medical Association began a vigorous campaign against the UP government. Many doctors complained bitterly that while their incomes had remained stable or even had increased, their ability to purchase consumer goods had declined drastically. Although approximately 30 per cent of the profession continued to support Allende's goals, the Medical Association released a series of public denunciations. During the paralyzing "strike" of October, 1972, which began as a lockout by the owners of the trucking industry, the majority of physicians refused to see NHS patients except on an emergency basis. The work stoppage by physicians led

to a severe tension between professionals and paraprofessionals that persisted for the duration of the UP government. Paraprofessional health workers (nurse's aides, midwives, laboratory technicians, etc.), nonprofessional workers, and administrative personnel did not support the work stoppage. The hospitals and NHC's continued to function through a combined effort by community residents, the LHC's, paraprofessional and nonprofessional health workers, and a minority of pro-government physicians.[9,25]

Meanwhile, anti-government doctors continued to see wealthier patients in their private practices." During the weeks immediately preceding the military coup of September, 1973, a doctors' strike organized by the Medical Association incapacitated the Chilean health-care system. [18,19] The medical profession, threatened by a redistribution of power and inconvenienced by economic instability, helped lay the groundwork for military dictatorship.

CHILEAN TOTALITARIANISM AND ITS IMPLICATIONS

With the military coup of September, 1973, Chile has entered a period of totalitarian rule that eyewitness observers liken to fascism.[27-29] Although information has been limited by the dictatorship's censorship and restrictions on travel, several outcomes of the coup - verified by multiple written accounts and personal eyewitnesses - no longer remain controversial.

This totalitarianism has had an enormous impact on physicians and other health workers." Former directors of the NHC's in the *poblaciones* have been detained in the National Stadium with other political prisoners. At least 35 physicians have been executed or have died after torture. [31,32] Former medical-school professors, as well as general practitioners, have been imprisoned; torture has been used routinely against doctors and other health workers. [33-35] The regime's brutality has received condemnation from a series of international delegations to Chile, including the International Commission of Jurists, the Assembly of Catholic Jurists, and the Commission on the Rights of Man.[36,37]*

After the coup, the junta's Ministry of Health developed three categories by which medical personnel were to be classified: politically trustworthy; uncertain (to be judged by hospital boards); and politically dangerous ("irredeemable").[32,38] The secretary general of the Chilean Medical Association has acknowledged that physicians supporting the junta have participated in denunciations of their leftist colleagues." Generally, denunciations are directed against physicians who opposed the doctors' strike of August, 1973.[32] In addition, there are numerous reports that some military physicians have co-operated in the administration of torture, particularly by supervising the use of drugs during torture sessions.[32]

The dictatorship has reversed almost all the changes in the medical system that occurred under Allende's government. In the *poblaciones* and in rural areas, the new regime has closed nearly all NHC's and has transferred their functions to hospitals that are frequently located at great distances. As a result, low-income Chileans again experience severe difficulties in obtaining needed care.[40] The LHC's and consumer-worker councils that governed hospital departments have been disbanded. Control of the nation's hospitals has returned formally to the Chilean Medical Association, which consistently has supported the junta. Most of the preventive health programs (such as free milk distribution to children) have been discontinued or taken over by private entrepreneurs.

The dictatorship has closed most departments of preventive medicine, public health, and social science at the country's medical schools. Faculty members teaching these disciplines have been summarily dismissed; medical students who worked electively in community health programs or who professed leftist political beliefs have been permanently expelled.[33,35] It is estimated that approximately 12 thousand of the 45 thousand members of the union representing nonprofessional health workers have been fired without compensation for prior support of the UP government; similarly, 6 thousand of the 18 thousand members of the union of nonphysician health professionals have lost their jobs (unpublished data). The Chilean NHS has become a paper structure, since the health system has reverted almost exclusively to the control of private practitioners.

If for no other reason, the UP experiment was necessary to show that those who hold professional dominance (as well as economic and political dominance) will not permit a real redistribution of wealth and power without a fight. Though deeply disappointing to adherents of nonviolence, the Chilean experience documents that a medical elite generally will uphold orderly legal processes only while these processes do not
threaten the elite's dominant position in society. The actions of Chile's dictatorship demonstrate the tactics needed to suppress a people's movement toward a reconstruction of the health system.

ANALYSIS: HEALTH CARE, THE STATE, AND SOCIAL REVOLUTION

Three general themes emerge from the Chilean experience. These themes concern linkages between health care and a nation's political and economic systems, the inherent conflicts of a stratified society that are mirrored in the health system, and the problem of incremental reforms in health care versus fundamental change in state power and the social order.

In the first place, in all societies, but especially in the Third World, health care is inextricably linked to a nation's political and economic systems. Medical underdevelopment is a necessary feature of economic underdevelopment. Despite many progressive reforms in the health system, the UP government was continually hindered by the limited economic resources available for health care and other public-welfare functions. As several analysts have pointed out, Chile and similar countries could spend the same proportion of their wealth for health care as

*The Chilean junta has given its own account of arrests and other events affecting the health system.[1]

in a developed country like the United States, but the effect necessarily would be restricted by the underdeveloped country's much lower level of wealth. One Chilean analysis concludes: "Consequently every health policy should be narrowly united with the general policy regarding development of the country."[41] In this view, the effectiveness of a socialized health system in Chile or other nations of the Third World depends in large part on the level of economic development.

Poor nations are especially vulnerable to forces that drain the limited resources that they do possess. Like many countries of the Third World, Chile occupies a position of dependency on developed nations." Throughout the last 25 years, Chile has depended on the United States for loans and credits, to purchase needed industrial equipment and consumer goods. In the health sector, vital products like medical instruments and drugs have been imported or have been manufactured in Chile by subsidiaries of American corporations. When the UP government tried to nationalize certain industries, international economic interests created economic havoc in Chile, by heavily restricting loans and credits to this highly dependent country. This economic boycott led to the shortages of medical supplies that were so irksome to health professionals.

In addition to dependency, countries like Chile witness the direct extraction of human and natural resources by foreign countries that are more highly developed economically. In the health sector itself, a net flow of resources occurs from the Third World to developed countries. Doctors trained in countries like Chile frequently migrate to developed nations like the United States, leading to an extraction of human resources and an actual loss of capital for the poorer country. Several analysts estimate that because of the flow of physicians trained in the Third World to the United States, Latin America incurs an annual loss of $200 million, an amount that is equivalent to all the medical aid that the United States gave to Latin America for the decade 1960-1970 or equivalent to Chile's total education budget for the year 1970,[43-45] In the context of dependency and capitalist exploitation, when human and natural resources leave the country in vast quantity, no Third World nation like Chile can expect a real improvement in health care.

A second general lesson from the Chilean experience is that *conflicts within the health system mirror in miniature the inherent corfiicts if a stratified society.* Any socialist government must confront the problem of social class. Either by birth or by occupational mobility, health professionals are members of the bourgeois upper or upper-middle classes. As such, they hold class interests that often impede progress toward a more egalitarian distribution of goods and services.

Doctors, like bankers and corporate managers, possess economic advantages and customary life styles that they do not willingly sacrifice on behalf of the masses of people trapped in an existence of poverty. Besides economic interests, health professionals hold dominant positions in the institutions where they work. Because of their technical expertise, physicians believe that professional dominance over health policies is justified.[20] Any innovations that tend to reduce the profession's power to control the conditions of practice are perceived as threatening.

The Chilean medical profession worked against the UP government's attempts to bring equity and democratization to the health system. Objects of the profession's opposition included the training of paraprofessionals, the reduction of the length of medical education, the encouragement of immigration by foreign doctors, and the development of greater consumer and worker control over health policy.[17,22,41] As members of the upper and upper-middle classes, health professionals also value the acquisition of personal consumer goods, which Chile has imported or manufactured largely through foreign loans and credit. The medical profession was acutely sensitive to the economic pressures that reduced available consumer goods. Thus, the UP government faced inherent and continuing conflict with the interests of a bourgeois profession.

Thirdly, and most importantly, *the Chilean experience shows that incremental reforms in health care have Little meaning without basic change in the social order.* Since Allende had assumed the presidency through constitutional electoral procedures, he lacked true state power. That is, the coalition government remained heterogeneous and did not hold statutory control over the military, judiciary, legislature, and professions.[26,46,47] In the case of medicine, the lack of state power left Allende and his admirers impotent in their attempts to restructure health care, The UP government recognized that the persistence of private practice in Chile hindered the achievement of an equitable health system. The government, as well as its leftist critics, acknowledged the costliness and inefficiency of coexisting private and public sectors in health care. Analysts have estimated that under Allende the NHS received 40 per cent of Chile's total health expenditures to serve 80 per cent of the population, whereas 60 per cent of Chile's total health expenditures went to private practitioners caring for 20 per cent of the people.[22] The strength of the private sector also continued to encourage a massive mal distribution of health personnel and facilities, favoring wealthier parts of cities as compared to rural or low-income urban areas. Despite the government's best efforts, 60 per cent of the nation's physicians remained in the capital of Santiago; within Santiago, wealthier areas commanded approximately six times the resources and personnel of low-income areas.[22]

Although the government instituted a series of programmatic measures to improve the people's health, none of these led to enduring modifications in the health system. Distributing milk to mothers and children falls far short of the structural alterations needed to assure adequate care. Allende and his advisors recognized the inherent inequities of the private-public duality, a schizoid arrangement that always favors the financially advantaged at the expense of the poor. It is difficult to see how Chile's huge problems of maldistri-

bution could be solved without some compulsory restriction of private practice. Similarly, equity could not be achieved without some requirement that all physicians devote at least several years of their careers to national service in urban or rural areas lacking needed personnel. Because the Allende government lacked true state power, it made no real attempt to nationalize the health system. The government's intentions of rectifying the inequalities of the private-public duality remained almost entirely theoretical.[48]

Ultimately, Allende viewed his presidency as a transitional period in which a series of reforms would culminate in a true socialist restructuring of society. The government encouraged the establishment of LHC's, workers' organizations, and other new groupings whose eventual purpose was a thorough transformation of power relations in Chilean society. With occasional exceptions, however, these organizations did not achieve their goals of power redistribution. Even in the LHC's, designed to include community residents and health workers broadly in setting health policy, real decision-making power remained in the hands of the medical directors.[22] Al though professional dominance persisted, mass mobilization of the people did occur to a limited degree. Nevertheless, despite the government's encouragement of popular control, a basic reordering of traditional power structures remained an elusive reality.

The Chilean experience demonstrates that dominant groups in society do not surrender power peacefully. In this light it appears that a fundamental transformation of power structures is a precondition for popular control of health care. In Chile, where the potential for peaceful socialism and a democratized health system perhaps was greater than anywhere else in the world, Allende's hope that popular control could evolve by peaceful means proved a vain dream. More than ever before, health workers and consumers may learn that the struggle toward a humane health system cannot succeed without a concomitant struggle toward fundamental change in the social order.

We are indebted to Sherry Girling and Robert Girling for advice and criticism, as well as to several Chilean friends and colleagues who need to remain anonymous. Part of this work was done under the auspices of Non-Intervention in Chile, Berkeley, Cal.

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