

Managing Access and Timely Care for Critically Ill Patients in Chile

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Background

There is still a marked shortage of hospital beds for critically ill patients in Chile. In 2003, a study by the Chilean Society for Intensive Care Medicine and the Ministry of Health found that the gap between the recommended number of beds for critical adult patients and the actual number was approximately 500, a figure that has not significantly changed in recent years.²

In the countries of the Organization of Economic Cooperation and Development (OECD), there are 6 intensive care unit (ICU) beds and 12 intensive treatment/therapy unit (ITU) beds per 100,000 population. In Chile, by contrast, there are 3.38 ICU beds and 5.06 ITU beds per 100,000 population. Moreover, intensive care specialists in Chile are scarce (less than 1 intensive care specialist per 100,000 population). Current calculations indicate a deficit of approximately 250 intensive care specialists.

In addition to these shortcomings in the health system, Chile is following demographic and epidemiological characteristics, which will result in a growing need to increase the scant number of critical beds:

- The Chilean population is steadily and rapidly aging. The number of older persons (>60 years of age) is currently almost 1.9 million, or 12.9% of the country's total population. Over the next 10 years, this percentage is expected to increase to 17.3%, or more than 2.7 million people.
- In comparison with 2003, the 2009-2010 National Health Survey showed that not only have the prevalence of risk factors associated with a chronic disease morbidity profile failed to improve, they have stagnated or even worsened.

Aging population and increased morbidity mean more demand for the scarce resource of beds.

The Chilean health system is mixed and segmented: Public and private entities actively participate in both service funding and service delivery. The management of patients that are critically ill and/or require urgent care is an example of public-private interaction: These patients are now able to seek care at any emergency room, be it in a public or private hospital.

The main purpose of the legal-administrative framework (known as the Emergency Act) governing this matter was to guarantee *access* to urgent clinical care by prohibiting the need for proof of ability to pay as a condition for care. Thus, the law ensured access to emergency care for all Chileans with health insurance coverage, and guaranteed

¹ Disclaimer: This case study does not necessarily reflect the position of the Ministry of Health of Chile on this issue.

² Guías 2004 de organización y funcionamiento de unidades de pacientes críticos. *Revista Chilena de Medicina Intensiva*. 2004, vol 19(4):209-223.

payment to health facilities for emergency services by transferring financial responsibility to the insurance carriers.

An operating procedure has been established, whereby patient beneficiaries of the public system first admitted and treated in a private facility are transferred back into the public network once they have been stabilized (that is, once their vital signs are stable).

Case description

The number of hospital beds in Chile (about 2.3 per 1,000 population) has remained virtually unchanged in the last years. Thus, both access and the *timeliness* of care for critical patients are severely challenged by the reduced capacity in terms of intensive care beds. This is particularly critical during the winter, when there is a high incidence of acute respiratory infections, which are particularly serious among children and older persons.

Under these conditions, patients flock to emergency rooms in public and private hospitals alike and the race to find ICU beds begins—starting first at the health center where the patient originally sought care. However, if no beds are available (in the case of patients covered by the public system), this means coordinating a search to find a bed at another public hospital—and if that is not possible, then making the decision whether to transfer the patient to a private hospital.

Time is crucial in the management of critically ill patients. Conditions that could have had a good prognosis at the time of the initial medical assessment, may hours later require greater, more intensive technical and human efforts to ensure survival. The use of triage protocols as an objective, individualized clinical process has not yet been embraced by emergency room (ER) services as part of their day-to-day practice in decision-making—especially for ordering admission to an intensive care unit.

The aforementioned Emergency Act guaranteed that access to clinical care for critically ill patients would not depend on their ability to pay. Yet the removal of financial barriers does not solve the problem caused by the shortage of beds, but allows for all patients in need of critical care are to compete on the same footing for the available beds.

Moreover, the public system is supposed to facilitate the prompt transfer of publicly insured patients who have been hospitalized in private centers as soon as they have been *stabilized*. A regulatory center is in charge of this procedure. It further oversees and monitors round the clock any change in critical bed space in the public network. However, the public network suffers additional problems: Its admission procedures are slow and sometimes even obstructed because the public hospitals cannot meet the existing demand, especially during the season with a high incidence of respiratory infections. Therefore, patients end up staying longer at private centers, thus imposing higher costs to the public system, which has to pay the private sector for the costs of treating these patients.

Furthermore, public hospitals do not prioritize admitting patients who are being transferred out of private. Instead, their first priority is the patients waiting for a bed within the same hospital. Their second priority is the patients waiting for a bed in

another public hospital. Patients coming from private facilities are their third priority because they already have a bed.

Additionally, in October 2012 Chile enacted a law on patients' rights and responsibilities that explicitly recognizes a right to *timely* health care provision. In practice, this right cannot be fulfilled. Nevertheless, the declaration of this right has further empowered patients and citizens to pressure the government to actively seek an effective solution for the problems involved in the access and care of critically ill patients.

Discussion

While the Emergency Act removed the financial barriers for the access to care by critically ill patients, that does not solve the shortage of beds for these patients, or, in general, the inability within the public system to meet the current demand for urgent care, which is further expected to increase given the country's demographic and epidemiological characteristics. So far, the government's approach has been to increase the efficiency in the management of beds, yet it seems obvious that this strategy is not satisfactory. It is also leading to higher expenditures on the public system, while it is the lack of resources that caused the problem in the first place.

How should this problem be addressed? Given that resources are limited, what obligations does the health authority have to critically ill patients in terms of access and timely clinical care, and how can these obligations be met? How should urgent needs be balanced against long term needs, such as strengthening the public health system so it can meet current and future demands? Assuming a long term solution was in the works, and what should be done now to meet the current needs given the current constraints of resources?