

Healthcare systems and nursing practice: a comparative study between Brazil and Chile

Sistemas de saúde e atuação da enfermagem: estudo comparativo entre Brasil e Chile

Sistemas de salud y práctica de enfermería: estudio comparativo entre Brasil y Chile

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ABSTRACT

Objective: to compare health systems and the implications for the role of nurses between Brazil and Chile. **Method:** documentary study with a qualitative approach, based on consultation with official open-source documents. Data were analysed using content analysis. **Results:** both countries respond to the general guidelines of the World Health Organization regarding health promotion and disease prevention throughout the life cycle, in individuals, families and communities. Differences related to health systems were evidenced, especially regarding the form of financing, legislation, and the nurses' work process. **Conclusion:** although there are similarities because the countries belong to the same geographic region, differences can be seen in Primary Health Care, especially regarding to the health systems' structure, financing and in some areas, such as care management and nurses' role.

Descriptors: National Health Systems; Primary Health Care; Nurses; Nursing Care; Professional Practice.

RESUMO

Objetivo: comparar os sistemas de saúde e as implicações para a atuação do enfermeiro entre o Brasil e o Chile. **Método:** estudo documental com abordagem qualitativa, elaborado a partir da consulta a documentos oficiais de fonte aberta. Os dados foram analisados mediante análise de conteúdo. **Resultados:** os dois países respondem às orientações gerais da Organização Mundial da Saúde no que tange à promoção da saúde e prevenção de doenças ao longo do ciclo de vida, nos indivíduos, nas famílias e nas comunidades. Evidenciaram-se diferenças referentes aos sistemas de saúde, sobretudo a respeito da forma de financiamento, legislação e processo de trabalho do enfermeiro. **Conclusão:** embora existam semelhanças por serem países pertencerem à mesma região geográfica, pode-se constatar diferenças na Atenção Primária à Saúde, principalmente no que se refere à estruturação dos sistemas de saúde, financiamento e em algumas áreas, como a gestão do cuidado e atuação do enfermeiro.

Descritores: Sistemas Nacionais de Saúde; Atenção Primária à Saúde; Enfermeiras e Enfermeiros; Cuidados de Enfermagem; Prática Profissional.

RESUMEN

Objetivo: comparar los sistemas de salud y las implicaciones para el trabajo del enfermero entre Brasil y Chile. **Método:** estudio documental con enfoque cualitativo, elaborado con base en la consulta de documentos oficiales de código abierto. Los datos se analizaron mediante análisis de contenido. **Resultados:** ambos países responden a los lineamientos generales de la Organización Mundial de la Salud en cuanto a la promoción de la salud y la prevención de enfermedades a lo largo del ciclo de vida, en los individuos, las familias y las comunidades. Se evidenciaron diferencias relacionadas con los sistemas de salud, especialmente en cuanto a la forma de financiación, la legislación y el proceso de trabajo de los enfermeros. **Conclusión:** si bien existen similitudes ya que los países pertenecen a la misma región geográfica, se perciben diferencias en la Atención Primaria de Salud, especialmente en lo que respecta a la estructura de los sistemas de salud, la financiación y en algunas áreas, como la gestión del cuidado y el papel del enfermero.

Descriptores: Sistemas Nacionales de Salud; Atención Primaria de Salud; Enfermeras y enfermeros; Atención de Enfermería; Práctica Profesional.

INTRODUCTION

The United Nations' 2030 Agenda for Sustainable Development presents 17 Sustainable Development Goals (SDGs), with emphasis on the health of the population as a contributing strategic factor for all objectives proposed¹. This is due to the breadth that the concept of health has acquired in order to encompass a "well-being" state in its physical, psychological, social and environmental spheres².

Given this multidimensionality of having health and being healthy, Nursing has gained increasing prominence on the international scene, as they represent the largest share of health professionals, assuming an important role in universal health care coverage¹⁻³.

This paper was carried out with the support of Coordenação de Aperfeiçoamento de Pessoal de Nível Superior - Brazil (CAPES) - Funding Code 001.

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Scientific Editor: Cristiane Helena Gallasch; Associate Editor: Mercedes Neto

However, the role of Nursing changes according to the configuration of the health system in each country. It is also more broadly influenced by economic, political, legal and regulatory conditions in society. Many problems related to care models and advances in professional practices are related to funding difficulties and political obstacles^{1,3,4}.

In the South American context, Brazil and Chile have stood out in the discussion and implementation of strategies for better living conditions and health of their populations.

Data from the 2020 United Nations' Human Development Programme (UNDP), for example, indicate that Chile has the best Human Development Index (HDI) in Latin America (0.851)⁵, being considered very high⁶. Brazil ranks sixth in the region with HDI=0.762⁵, corresponding to a high index⁶. It has the highest Gross Domestic Product (GDP) in the region, while Chile has the best *per capita* GDP⁶.

As for Nursing, in Brazil nurses play a prominent role in assistance, promotion, prevention, protection and recovery of health, including management of care and health services⁷. In Chile, Nursing is a regulated profession but with weaknesses in the definition of professional duties, which can contribute to vulnerability in some aspects of the health system and teamwork⁸.

Comparing the performance of Nursing in different countries is valuable for exchanging experiences, learning about health policies, identifying gaps and areas for improvement, professional development and influence on health policies. These benefits contribute to enhancing the profession and the promotion of better health outcomes on a global scale.

Thus, the guiding question of this study was defined as follows: Which are the main differences and similarities of the health systems and the role of nurses between Brazil and Chile? Based on the above, the objective of this study was to compare the health systems and the implications for nurses' performance between Brazil and Chile.

METHOD

This is a documentary and descriptive study of the narrative type and with a qualitative approach, which used comparison as an analytical resource, developed during an academic discipline from a *scrito sensu* graduate course in Nursing on policies, management and evaluation of health and nursing care. The methodological rigor guidelines set forth in the *Standards for Reporting Qualitative Research* (SRQR) were followed⁹.

The study was carried out from September to November 2021 through an exhaustive reading of official, consecutive and openly published documents, available both in print and electronically and aimed at professionals linked to health systems and management.

The documents were produced by the World Health Organization, the Pan American Health Organization, the Brazilian and Chilean Ministries of Health, professional training institutions and authors associated with the respective institutions. Documents that are no longer in effect were excluded.

Data analysis followed the content analysis precepts¹⁰. From pre-analysis of the documents, the health models/systems and the nurses' practice in both countries emerged as analysis units. From deepening on the readings, the aforementioned analytical units were adopted as categories in order to explore elements related to the following: historical-political context, characteristics of the health system, considering the model of health, of PHC and of how nurses' work is incorporated. For data discussion, current scientific literature related to the topic identified in online databases and meta search engines was used.

As this is a documentary research, all information used in this study is freely accessible and in the public domain. Thus, appraisal by a Research Ethics Committee was waived. However, the ethical aspects of authorship and referencing were respected.

RESULTS

The documents and laws consulted to develop the study, which are regulations currently in force in the respective countries, are shown in Figure 1.

Brazil	Chile
Health Legislation	
1988 Federal Constitution.	Primary Care Statute (Law No. 19,378) of April 1995
Laws No. 8,080 and No. 8,142 of 1990, creation and principles of the SUS and its operation.	Health Authority Law No. 19,937 of February 2004.
Funding: Decree No. 7,508/2011, L.C. 141/2012.	Law No. 19,888 for Funding, 2003.
National Primary Care Policy: Ordinance No. 4,236/2017.	Law No. 19,966 General Regime of Health Guarantees (GES), 2004
Primary Care Funding: 2,979/2019.	Law No. 20,584 Patients' rights and duties, 2012.
Nursing Legislation	
Law No. 7,498/86 - It provides for the regulation of the Nursing practice and other dispositions. Decree No. 94,406/87 - It regulates the law on the professional Nursing practice. Nursing categories: Nurse, Nursing Technician, Nursing Assistant and Midwives.	Health Code, article 113: "the professional services provided by nurses include the management and care related to health promotion, maintenance and restoration, prevention of illnesses or injuries and execution of actions derived from diagnosis and medical treatment and must ensure the best administration of resources for the patient". Category: only nurses.
COFEN - Federal Nursing Council - Professional Registration.	Registration with the Health Superintendence
Code of Ethics for Nursing Professionals (COFEN)	Code of Ethics of the Chilean College of Nurses, based on the Code of Ethics of the International Council of Nurses (ICN)

FIGURE 1: Health and Nursing Legislation in Brazil and Chile. Florianopolis, SC, Brazil, 2021.

The results are structured and presented in two categories: Health Systems and Nursing Performance.

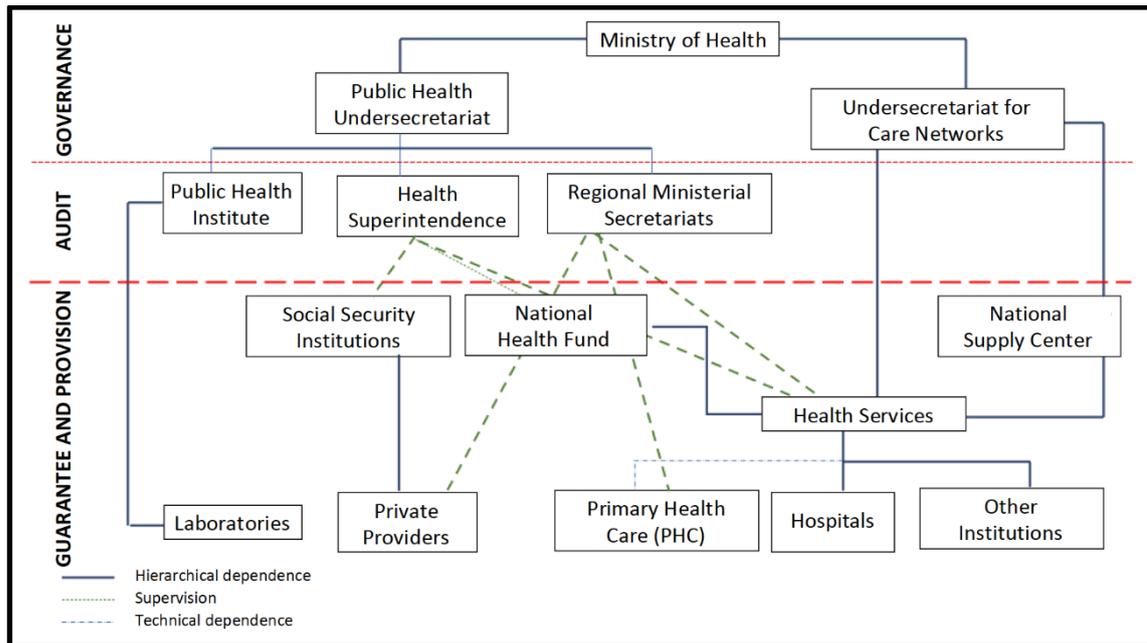
Health Systems

Brazil is a federative republic comprising 26 states, a federal district and 5,568 municipalities, with several political parties and three autonomous levels of government. The health system is made up of a complex network of public and private providers. The logic of the system is based on the 1988 Constitution and on Laws No. 8,080 and No. 8,142 that regulate the Unified Health System (*Sistema Único de Saúde, SUS*), in addition to Decree No. 7,508 of 2011, regulating Law No. 8,080. Decentralization of the system was the logic adopted, as well as participatory management, which gave rise to several regulations linked to its operation¹¹.

In this process, Brazil also went through several models, with evidence of care fragmentation based on models of acute conditions for a long period and, since 2010, through the implementation of the Health Care Networks (*Redes de Atenção em Saúde, RAS*), which are presupposed to be a "set of actions and health services articulated at levels of increasing complexity, with the purpose of guaranteeing health care integrality"¹¹.

Currently, the care networks are the Care Model proposed by the Ministry of Health (*Ministério da Saúde, MS*) in Brazil. In this model, the RAS components have similar importance, differing in terms of technological densities. The main objective is that care coordination is carried out by PHC¹².

Direction and regulation of the Chilean health system are shown in Figure 2.



Source: "Structure and functioning of the Chilean health system". University of Development, Chile, 2019.

FIGURE 2: Structure of the Chilean health system. Florianopolis, SC, Brazil, 2021.

Its realization is carried out by the Health Authority represented by the Ministry of Health (*Ministerio de Salud*, MINSAL), whose function is to formulate and define the health policies that are developed in the national territory. Also, part of the Health Authority is the Public Health Undersecretariat, in charge of health strategies that allow improving the health of the population, exercising regulatory, normative, surveillance and inspection functions, as well as health promotion, prevention and disease control. In turn, the undersecretariat for the care networks regulates and supervises the operation of health networks through the formulation of policies, norms, plans and programs for their coordination and articulation^{13,14}.

Supervision of the compliance with national standards, plans, programs and policies is in charge of three institutions: Regional Ministerial Secretariats (*Secretarías Regionales Ministeriales*, SEREMISs), which represent the MINSAL in the 16 regions in which they operate; the Public Health Institute (*Instituto de Salud Pública*, ISP), which acts administratively as a national reference laboratory, and the Health Superintendence, whose main functions are to supervise and control the Social Security Institutions (*Instituciones de Salud Previsional*, ISAPRESs) and the National Health Fund (*Fondo Nacional de Salud*, FONASA), ensuring compliance with the obligations imposed by law, in addition to overseeing all public and private health providers regarding their accreditation and certification¹⁴⁻¹⁶.

Finally, the function of guaranteeing and providing services, which is made up of the public and private sectors. The first covers 80% of the population, including FONASA as insurer and funder of the public network, the National System of Health Services (*Sistema Nacional de Servicios de Salud*, SNSS) and its network of 29 Regional Health Services and the Municipal Primary Care System. Another 3% are covered by the Armed Forces Health Services and the remaining 7% are self-employed workers and their families who do not contribute to FONASA and who, if necessary, resort to public services. The remaining 20% include the private for-profit system. According to their economic resources and preferences, the citizens are assigned to one of these subsystems¹⁵⁻¹⁷.

Thus, the Chilean health system is defined as one based on Primary Care, where, from the Comprehensive Care Model for Family and Community Health, the principles that guide the work of health teams in the health care network are established, from anticipating harms to rehabilitation, in the family and community spaces. These inalienable principles include a "People-Centered" model, "Comprehensive Care" and "Care Continuity"¹⁷.

In Chile's health network, specifically, the primary level includes Family Health Centers (*Centros de Salud Familiar*, CESFAMs), rural health centers, urban general clinics, rural posts and Emergency Primary Care Services (*Servicios de Atención Primaria de Urgencia*, SAPUs), dependent on the municipalities. Primary care institutions are organized based on the territory and have a management team and professionals and technicians in support units across the different territories. At this level, basic health programs are carried out with a focus on prevention and health promotion, in conjunction with the other two care levels^{13,17}.

Figure 3 presents comparative information between Brazil and Chile, considering historical and political aspects, demographic issues, characteristics of the health systems and their funding.

	Brazil	Chile
Health System	Universal System	Universal Coverage
Health Model	Polyarchical Network	Hierarchical Network
Population	213,728,093 inhabitants (est. 2021)	17,574,003 (2017 census)
Life Expectancy	80.2 years old ♀, 73.2 years old ♂	82.1 years old ♀, 73.3 years old ♂
Population aging	9.83% (2020)	11.4%
Governmental regime	Democracy since 1985, former military dictatorship	Democracy since 1990, former military dictatorship
Health funding: <i>Per capita</i>	US\$ 1,282	US\$ 2,182
% GDP	8%	
% of public spending	43%	50%
% of health spending in total public spending	10%	17%
Distribution of health spending		
Direct government:	43%	2%
Compulsory health insurance:	28%	58%
Voluntary health insurance:	27%	6%
Private ("out-of-pocket")	2%	34%
Health planning		
Periodicity:	Every 4 years	Every 10 years
Coverage:	Municipal, State and National	National
Indicators:	Some are mandatory, but there are local, regional and state indicators according to epidemiological data.	National
PHC duties	Access Care integrality Focus on the family Continuity Care coordination Community guidance	User-centered Comprehensiveness Family focus Continuity
Density of Nursing professionals/ 100,000 inhabitants	More than 100	More than 100

FIGURE 3: Historical-political, demographic, health system and funding information. Florianópolis, SC, Brazil, 2021.

As a care coordinator in the SUS, PHC should primarily be the first contact between the population and the health services, as it offers broad and open care supported on the needs of the community, normally meeting from 80% to 90% of the demands of the population throughout life^{12,18}.

With a view to meeting all the needs of the population and based on the guidelines that underlie PHC, multiprofessional teams are necessary. In Brazil, the Family Health team (FHSt) is the priority health care strategy and aims at reorganizing Primary Care in the country, in accordance with the SUS precepts. An FHSt should at least consist of: a physician, preferably with a specialty in family and community medicine; a nurse, preferably a specialist in family health; a nursing assistant and/or technician; and community health agent (CHA). An endemic disease combat agent (*Agente de Combate às Endemias*, ACE) and oral health professionals may be part of the team: dental surgeon, preferably a specialist in family health; and an oral health assistant or technician.

In Chile, the General Regulation is based on Law No. 19,378/95, which grounds organization on the Community Health Plan and on the Care Model defined by the Ministry of Health. The PHC teams consist of a nurse, physician, psychologist, social worker, occupational therapist, community manager, paramedical technician (mid-level assignment), nutritionist, midwife (*matrón(a)*), dentist, speech therapist and physiotherapist (kinesiologist). The distribution and number of these professionals vary according to municipal guidelines, provided for by the laws that guide the decisions involving funding, in addition to the characteristics of the population^{14,19}.

Nursing Performance

In Brazil, Nursing is divided into higher and mid-level categories: Nurse (higher level), Nursing Technician, Nursing Assistant and Midwives (mid-level); these categories are insured by the Federal Nursing Council (*Conselho Federal de Enfermagem*, COFEN), which is responsible for standardizing and supervising the professional practice, ensuring the quality of the services provided and compliance with the Professional Practice Law; all professionals should register with the Regional Nursing Council (*Conselho Regional de Enfermagem*, COREN) in the state where they practice their profession. This body has the function of regulating, disciplining and supervising the professional practice, in addition to serving as an ethical court²⁰.

In Chile, Nursing training exists at a higher level, regulated by the Health Code of the Country, article 113, and by the Code of Ethics of the College of Nurses, which is based on the Code of Ethics of the International Council of Nurses²¹. There is no specific Class Body, registration is made at the Health Superintendence.

In the Brazilian context, with regard to assistance in PHC, nurses' duties are also outlined by the National Primary Care Policy (*Política Nacional de Atenção Básica*, PNAB), as professional's members of the multidisciplinary team and enabled to work in all health programs established by the MS and at different levels, from assistance to management of health services¹².

Although in Chile the Health Code includes regulation of Nursing as a profession, some Nursing functions are sometimes performed by other related professions, generating implications for strengthening the Nursing profession and labor conflicts.

In the same Chilean context, care for women and newborns is shared between Obstetrics and Nursing professionals. The former is responsible for women during pregnancy and postpartum, for healthy newborns and for women's sexual and reproductive health. In turn, Nursing is linked to the care of newborns with some health disorder and throughout their entire life cycle from then on, the same in the case of women¹⁹.

DISCUSSION

The results found evidenced differences and similarities in the structure of both health systems, linked to funding and service organizations with regard to professional Nursing activities in the Chilean and Brazilian contexts.

Universal systems inspired by the right to health have faced countless barriers throughout their history. Brazil has universal access to health in its conception of a health system and Chile presents a system linked to universal health coverage. They underwent several changes and reorganizations in order to be improved. Latin American countries ground their health systems on the principle of universality, although they have gone through periods of ascension and financial imbalance, strengthening the private health system¹¹.

The Chilean public health system is unitary and centralized, with its own budget, responsible for integrating the network, provision and management of hospital specialties and services. It is characterized by its dual choice of contributions to private or public insurance, and its funding comes from different sources, direct and indirect, public and private subsidies^{22,23}. The Chilean PHC has its *per capita* funding system, that is, according to its population registered in its territory.

Brazil has tripartite public funding, where the federal funding model is in the process of being modified, which seeks to merge *per capita* funding about the population registered in PHC services, added to the team's performance coefficient for financial transfers, with the purpose of expanding access and greater equality in PHC²⁴.

In this perspective of improvement and reorganization of the health sector, the PHC reform process in the Latin American context focuses on the attempt to effectively establish health care integrality. This synergy of changes enables the transformation of health models^{22,25}.

Although there are care models centered on the person, comprehensive care and care continuity, the Chilean health system has a care model with hospitals playing a leading role in structuring its networks. Therefore, there is a struggle for greater recognition and development of the *Modelo de Atención Integral de Salud Familiar y Comunitario*²² (Comprehensive Care Model for Family and Community Health).

Throughout their histories, Brazil and Chile have gone through several changes in their health models, from the one of acute conditions to that of chronic health conditions. In this way, both were required to face the difficult path of transition from a fragmented system to an integrated care system²².

Important aspects evidenced in the documents analyzed are linked to the context of the teams working in PHC, and mainly with regard to nurses' work process and regulation in these countries, as presented in the "Nursing Legislation" item. Referring to the differences regarding regulation of the Nursing profession, there is no specific Law regulating this activity in Chile. In Brazil, on the contrary, it has a professional practice law, which is supervised by the Professional Nursing Council²⁰.

Thus, it is imperative to expand the population's access to health services provided by qualified professionals to work in PHC in a comprehensive and equitable manner. In addition to that, it enables professionals, such as nurses, to carry out a work process autonomously, supported by the professional practice law, the PNAB, and federal and municipal care protocols^{20,26-28}.

Chile seeks to strengthen the teams working in PHC, as they are responsible for the health of the population. In addition to that, there are countless problems linked to these teams, such as high turnover of professionals, especially physicians. The Chilean teams are made up of midwives (*matronas*), nutritionists, physiotherapists (kinesiologists), psychologists, occupational therapists, social workers and dentists, as well as physicians, nurses and paramedical technicians (mid-level professionals)^{12,22}.

In the Chilean reality, nurses play a key role in PHC, developing health promotion and prevention actions practically in the entire population, with the exception of public policies related to women's health. This specific area is responsibility of practically midwives (*Matronas/Matróns*), professionals who are part of PHC and work at different care levels, but exclusively linked to women and newborns, thus limiting nurses' role in the service²⁷.

Therefore, when nurses manage the work process in the team linked to the clinical care process, they exert a positive impact on organization of the actions in PHC. Thus, they are potential contributors to the consolidation of the Primary Care principles and to attaining new and resolute ways of organizing services^{28,29}.

Therefore, although there are significant differences between these two countries with regard to their health systems in the PHC context, mainly regarding nurses' role and regulation of the professional activity, the similarities are also evident, as the health models in force in both countries are based on the WHO, but one with universal coverage and the other not. The work modality developed is integrated by health networks and organized into territories, with services that rely on the work of responsible teams. In addition to that, their guiding principles are similar in that they aim at person-centered care, integrality, care continuity and funding. In addition to that, both have a funding modality based on the enrolled population.

Study limitations

The study limitations include the existence of few official documents in Chile that describe and regulate nurses' work process, mainly in PHC, as well as making a better comparison of what was proposed. Thus, it is suggested to carry out field research studies to better understand the context and deepen on the theme.

CONCLUSION

When comparing the health systems and Nursing practices in Chile and Brazil, it is possible to perceive similarities and differences related to the structure of the systems and to nurses' role in primary care. Both countries respond to the WHO's general guidelines, with their own and distinct regulations, within the framework of health promotion and disease prevention throughout the life cycle in individuals, families and communities.

Although these similarities are a reality because both countries belong to the same geographic region, differences can be seen in PHC, mainly with regard to the structure of the health systems, funding and in some areas such as care management and nurses' performance.

Especially in relation to nurses' work, these professionals' autonomy is consolidated in both countries, with their differences, such as financial appreciation in Chile. However, the absence of an exclusive regulatory body for the profession in this country exerts an impact on difficulties regulating and supervising the professional practice. In relation to women's health actions, in Chile there is overlapping of roles between nursing and midwives (matrons). Consequently, there are disputes between these professionals about who the care of women and children "belongs" to.

Thus, it is evident that, both in Brazil and in Chile, the nurses' work process is influenced over time, by economic and political variations and by labor division, both from a social and technical perspective. In addition to that, the organizational model tends to impact on and interfere with the care model. Therefore, this study can contribute to expanding the field of knowledge about the reality of nurses' work in other countries.

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