3 Health, Nutrition and Infant Mortality

All the indicators suggest that the provision of health care in Chile has made important progress over the long term, in a matter of a couple of generations. There is also evidence of needs that stay unattended, and of a highly concentrated pattern of distribution of access to health care. There are also questions as to the overall efficiency of the health services provided by both the public and the private sectors. The persistence of malnutrition is a particularly interesting example of both difficulties in dealing with a serious problem, and unevenness in access to well-being. The success in fighting infant mortality highlights the complex way in which socio-economic, health care, demographic, educational and other variables interact.¹

The inequalities in access to health benefits are possibly best illustrated by the distribution of nutrition and malnutrition in the population. In 1968–69, a family living on 300 US dollars or more per month spent over three times more on food than a family surviving on 75 dollars or less. Food represented a quarter of total expenditure in the first family, and half of it in the second one. For many decades, the average number of calories and proteins consumed by the population as a whole has been equal to or higher than the minimum requirements: about 2,400 calories and 65 grams of protein per day for adults. There is no overall, aggregate shortage. But how is this aggregate distributed? About one third of the population has been below the required standard, and this situation neither improved nor worsened for a very long time. Between 1935 and 1960 the proportion of the nutritionally vulnerable remained practically constant. Those consuming less than 1,500 calories amounted to a stable 11–13 per cent of the population, and those consuming between 1,500 and 2,000 calories, to a stable 24–27 per cent (Hakim and Solimano, 1978). This stability is in sharp contrast with the evolution of infant mortality, which by 1960 had fallen to less than half its value in 1935 (from 251 to 120 deaths in the 0–1 age group, per 1,000 live births).²
THE NATURE OF THE ECONOMICS OF HEALTH CARE

Not all aspects of health care can be reduced to human capital analysis. For instance, the health care of old age pensioners or the terminally ill is undertaken either on ethical grounds, because society as a whole has decided that this should be done, or because insurance against sickness was bought by pensioners or the terminally ill earlier during their working lives.

Some expensive treatment of children, or of adults of working age, may be undertaken on similar grounds, even if the cost of this health care is not matched by its contribution to increased human capital stocks and productivity. There are, however, some aspects of health care or the prevention of sickness which can be assimilated to forms of investment in human capital. This is the case of severe malnutrition in young children. Selowsky and Taylor (1973), working with data for the late 1960s, concluded that eliminating severe malnutrition in children in the age group 0–3 should double their earnings during adult life, and the contribution of this to GDP might be higher than 1 per cent.

But there are a number of aspects in which the nature of health care is specific, and cannot be assimilated to any form of human capital investment. The head of an individual household can predict when his or her children will require schooling, and of what type, but people are unable to predict when they will be taken ill, or how seriously (even if a central authority can forecast the statistical incidence of a particular disease in the future). But even a central authority may find it difficult to assess the seriousness of the threat of, and the cost of dealing with a new disease, or the impact of new scientific and technological developments. Two other problems are also specific to health care. One, possibly the easier to deal with, is that the provision of care through a centrally managed national health service, either for the population as a whole or for those who cannot afford other forms of care, is that freely or very cheaply supplied services are bound to face unlimited demand. The second problem is that once a particular amount of resources is allocated to health care, the conflicting demands of different types of care, some of which become increasingly more expensive as pure and applied medical science develops, are practically impossible to reconcile. How do you decide between allocating more resources to any one out of a number of conflicting, equally worthy claims? Today, some diseases can be treated which were impossible to deal with a generation ago, or even just a few years ago, but only at a large and in some cases huge cost, forcing decision-makers to all sorts of undesirable choices. Some examples of expensive, conflicting claims are public information campaigns geared towards sick-