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Health policies in Chile (2000-2018): trajectory and conditioning factors

Políticas de saúde no Chile (2000-2018): trajetória e condicionantes

Políticas de salud en Chile (2000-2018): trayectoria y condicionantes

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Abstract

In the 1980s, during the military dictatorship, Chile was a forerunner in Latin America in radical health system reform, expanding the private sector's participation in health insurance and services provision and influencing reforms in other countries of the region. The article analyzes health policies in Chile from 2000 to 2018, in the context of four democratic government administrations, considering continuities and changes in the policies' development and their conditioning factors. The analytical reference drew on contributions from historical institutionalism. Literature and document searches were performed, besides semi-structured interviews with national policymakers from the period under study. Analysis of the trajectory of health policies in Chile during the democratic period revealed continuities and changes in the agendas and strategies adopted by governments with different political positions. Incremental reforms throughout this period produced progress and improvements in health services access and provision. However, reform proposals to alter the health system's public-private arrangement encountered resistance, and the dual and segmented structure shaped in the 1980s was maintained, with strong private participation. Historical-structural, institutional, and political conditioning factors in State-market relations and the health system's configuration under the dictatorship hindered comprehensive changes in public-private relations in health, producing an example of path dependence and corporate interests' power in the health sector.

Health Care Reform; Health Systems; Health Policy

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Introduction

Chile is an upper-middle-income country and a forerunner in the adoption of neoliberal reforms in Latin America. From 1973 and 1990, during the dictatorship, structural changes were introduced in the Chilean economic, political, and social systems that exacerbated the country's inequalities, characterized by emphasis on the private sector in the provision of public services, market liberalization, and deregulation of the economy [1].

The period from 1920 to 1950 had been marked by the development of an occupation-based protection system according to the social security model. The creation of the *Servicio Nacional de Salud* (SNS) or National Health Service in 1952, inspired by the English NHS, allowed a new institutional arrangement and resulted in the expansion of health services to more vulnerable segments of the population [2]. Although the universalization of the SNS was interrupted by the military coup in 1973, actions developed until that point allowed building a public institutional legacy and a broad network of government health services [3,4]. The military dictatorship reconfigured the Chilean health system by establishing a dual model that consolidated the segmentation and broke with the solidarity between the public and private systems [5].

In the last three decades, health reforms were implemented in the context of democratization. This article analyzes Chile's national health policies from 2000 to 2018, addressing the follow questions: to what extent have the reforms led to structural changes in the health system? Were there significant differences between the agendas and strategies adopted by the successive governments?

The study's goal was to analyze the changes implemented by the democratic governments that aimed to reform the configuration of the health system built during the military dictatorship, as well as the continuities and changes in the policies' trajectory and their conditioning factors.

Methodology

The theoretical reference was historical institutionalism, which values the time dimension, the sequence of choices and events, and the institutional legacy in the policies' trajectory [6]. From this perspective, radical changes in critical scenarios generate a "path dependence", reinforcing previous choices and hindering comprehensive changes in subsequent scenarios. In addition to radical reforms in critical scenarios, Mahoney & Thelen [7] highlight that incremental and gradual changes in policies can, over time, result in relevant transformations.

In this study, the analysis of the trajectory of health policies from 2000 to 2018 considered three basic lines: (i) the political-institutional context, which refers to social policies' political, economic, and legislative scenario; (ii) the governments' agenda, constituting a set of health priorities announced by government officials, policymakers, and official documents; and (iii) the strategies that are adopted, concerning the set of health policy measures and actions.

The study focused on the following presidential terms: Ricardo Lagos (2000-2006); Michelle Bachelet (2006-2010); Sebastián Piñera (2010-2014); and Michelle Bachelet (2014-2018). Since the theoretical reference of historical institutionalism values the time dimension, we briefly contextualize the previous health policy history in Chile, based on a literature review.

The search involved various methodological strategies, featuring an analysis of official documents from 1999 to 2018, such as: legislation, government programs, reports, and resolutions. In addition, 14 interviews were held with individuals that occupied key positions during the four governments. Four of these individuals also participated in the Presidential Advisory Commissions for health sector reform in the Piñera (2010-2014) and/or Bachelet Administrations (2014-2018). The interviews, held in 2019 and lasting approximately one hour each, were recorded and transcribed. We then proceeded to an analysis of the thematic content of the documents and interviews using the Nvivo Pro Student software (https://www.qsrinternational.com/nvivo/home), according to the study's analytical lines.

In the presentation of the results, to ensure the interviewees' anonymity, the interviews were coded in parentheses, as shown in Box 1.

The study was approved by the respective Institutional Review Board (CAAE n. 79979317.3.0000.5240).

Box 1

List of health policymakers interviewed for the study. Chile, 2019.

GOVERNMENTS	AGENCY	CODE
Ricardo Lagos (2000-2006)	Ministry of Health	E1
	Ministry of Health	E2 *
Michelle Bachelet (2006-2010)	Ministry of Health and Presidential Advisory Commission	E3 *
	Ministry of Health and Presidential Advisory Commission	E4 *
	Under-Secretariat of Public Health	E5 *
	Under-Secretariat of Healthcare Networks	E6 *
	Under-Secretariat of Public Health	E7 *
	Health Superintendency	E8 *
Sebastián Piñera (2010-2014)	Under-Secretariat of Public Health	E9
	Health Superintendency	E10
	Institute of Public Health	E11 *
Michelle Bachelet (2014-2018)	Ministry of Health	E12 *
	Health Superintendency	E13 *
	Ministry of Health and Presidential Advisory Commission	E14 *

* The interviewee held various positions in these governments. The analysis considered the most relevant position for the purposes of this study.

Trajectory of the health policies

The military dictatorship and radical health sector reform (1973-1989)

The pioneering and radical nature of the Chilean case in the adoption of liberal policies during the dictatorial period altered the direction of the country's economic and social policies [1,3,8,9]. The reforms under the military regime in the 1970s were characterized by fiscal adjustment, privatizations, market opening, and containment of public spending to an unprecedented degree in Latin America [10].

The radical reforms in the health sector aimed to decentralize the public system and strengthen the private sector. A dual health system was created in which the public and private segments functioned simultaneously with distinct logics in their financing, entitlement, and services provision. The public sector, represented by the *Fondo Nacional de Salud* (Fonasa) or National Health Fund, was based on the occupational social security model, with sharing of services provisions and the promotion of solidarity based on distribution of the risks among beneficiaries. Meanwhile, the *Instituciones de Salud Previsional* (Isapre), or Health Insurance Institutions, furnished supplementary health plans and copayments based the person's sex, age, individual risks, and purchasing power [11].

In 1985, based on socioeconomic criteria, four groups were established in the public sector (A, B, C, and D), in addition to two modalities of care. In the institutional care modality (MAI, in Spanish), targeted to the population that could not afford to make regular payments (group A), medical care was provided in the public health services network. In the free choice modality (MLE, in Spanish), reserved for the other Fonasa groups, individuals were allowed to choose the health professional or service from the private sector to provide the services [12]. The institutionalization of MLE expanded the free choice system created in 1968, which served a small portion of the population.

The democratic transition began in 1990 after Patricio Aylwin of the Christian Democratic Party won the presidential elections, supported by a broad political coalition.

First governments of the Concertación: health takes back stage (1990-2000)

The *Concertación de Partidos por la Democracia*, or Coalition of Parties for Democracy, which supported Aylwin's candidacy, was formed in 1988 with 17 political parties. Established to confront the rightwing candidate supported by Pinochet, Büchi Buc, the coalition was characterized by its political diversity. The Aylwin Government's main objectives were the creation of macroeconomic protection, economic growth, employment, investment in human capital, and decreasing poverty [13]. The priorities in the political field were stability and strengthening of democracy.

President-elect Aylwin faced several roadblocks when he took office, especially due to the presence of Pinochet, who maintained political, military, and institutional influence as Commander of the Army until 1998 and later as senator for life [14].

Some of the obstacles in the health sector were the deterioration of the public infrastructure and the poor quality of services, resulting from dwindling investment under the military dictatorship [15]. The strategies for dealing with these problems under the governments of Patricio Aylwin and his successor Eduardo Frei Ruiz-Tagle aimed to recover public investment in health services and intensify the decentralization under the military regimen in order to overcome the regional inequalities.

Innovations were introduced in the health system, such as the creation of the per capita payment system for persons enrolled in the primary care centers and the implementation of the Primary Care Statute, submitted during Alwin's Government and regulated by Frei, standardizing the rules for administration, financing, and coordination of primary healthcare (PHC) [15].

Measures to regulate the private sector were started at the end of the dictatorship and adjusted during Chile's re-democratization. The *Superintendencia de Isapre*, created in 1990 for regulation of the private sector, was amended in the Frei Government through more rigorous rules on the functioning and provision of health services by the Isapre [16,17].

Despite the understanding that health reform was necessary, the priorities during the first two Concertación governments focused on other areas such as economic and political stability [14].

Nearly 30 years after Salvador Allende's election and after the two governments of the Christian Democratic Party, socialist candidate Ricardo Lagos was elected President of Chile in 1999.

Ricardo Lagos Government: the incremental reform of Acceso Universal de Garantías Explícitas en Salud (2000-2006)

Lagos, the Socialist Party candidate under the Concertación, carried the 1999 presidential election, winning in a second round against Lavín Infante of the rightwing coalition *Alianza por Chile* (Alliance for Chile).

The Lagos Government, the third in the Concertación, was characterized by its preoccupation with macroeconomic stability, fiscal discipline, and the pursuit of growth, preserving the previous government's economic policies [18]. During the first year of his term, he attempted to build a political base with the centrist parties.

Lagos' commitments in the social area featured social policies for the poor population. Health reform entered the agenda of priorities at the beginning of his government, although there was no specific proposal for the health sector (interviewees E2; E4). One of the Lagos Government's objectives was to conduct a reform that would guarantee health as a right protected by the State (E1).

Two important measures were launched by the Ministry of Health in 2000. The first established the health goals for the decade from 2000 to 2010 [19]. Four targets were set for the improvement of health indicators and services, to deal with challenges related to population aging and to decrease the country's health inequalities. The second measure was the creation of an inter-ministerial commission to draft a health sector reform proposal [20].

Michelle Bachelet of the Socialist Party was named Minister of Health and was responsible for conducting the reform, together with the Ministers of Finance and Labor and Social Security and the Chief of Cabinet. The Commission included an Executive Secretariat headed by surgeon Hernán Sandoval and a team of experts [14]. The broad discussion of the reform featured the National Congress and the Constitutional Court. Alternatives were debated, such as the return of the SNS and the creation of funds for guarantee of provisions (E2).

The Commission produced two reports that became bills of law. The first, submitted by Bachelet in 2001, dealt with patients' rights and duties [21]. This consisted of four bills of law submitted in 2002 and 2003 and the AUGE Plan, later renamed the *Régimen de Garantías en Salud* (GES) (Health Guarantees Regimen), which provided a list of diseases based on an epidemiological survey (E2; E5). For each disease, a clinical protocol was established for the various levels of care with guarantees of access, quality, financial protection, and timeliness [20].

The GES and the four bills (Box 2) were developed by Sandoval and his team and submitted by Osvaldo Artaza, Bachelet's alternate in the Ministry of Health. Artaza was succeeded in 2003 by Pedro García, who proceeded with the negotiations in Congress (E1; E8). In drafting the reform proposal, the experts drew on the *Plan Garantizado de Beneficios de Salud*, which proposed services provisions guaranteed by the State, drafted under the Eduardo Frei Government by then-Minister of Health Carlos Massad [20].

Despite resistance by the *Colegio Médico* to the proposal to link the public and private sectors in the GES reform, splitting the proposal into separate bills facilitated approval by Congress and attenuated the clashes with the medical profession [18,22]. However, this division displeased part of the Concertación, contending that the proposal was insufficient to meet the health system's needs (E2; E8).

Four of the five bills submitted to Congress, described in Box 2, pertaining to the reform's financing, reorganization of the health authority's and administration's roles, regulation of the Isapre, and the GES Plan, were passed before the end of Lagos' term.

The bill on patients' rights and duties, the first submitted by then-Minister of Health Bachelet, had not been passed by the end of the Lagos Government in March 2006. Following debates with different stakeholders and social groups, the bill was redrafted and resubmitted in July 2006 by Michelle Bachelet, now as President of Chile.

The GES was negotiated with Congress, allowing political agreements for a long-term reform consistent with the population's needs in terms of the right to health (E1; E2). Based on a pilot

Box 2

Health reform legislation in the Ricardo Lagos Government. Chile, 2000-2006.

LEGISLATION	CONTENT	SUBMITTED TO CONGRESS	APPROVED
Financing Law (n. 19,888)	Establishes an increase in Value Added Tax for Financing Health Reform.	June/2003	July/2003
Solvency Law for Isapre or Brief Isapre Law (n. 19,895)	Establishes rules for protection of beneficiaries in case of solvency of insurance companies and in case of cancellation of Isapre's.	June/2003	August/2003
Health Authority and Management Law (n. 19,937)	Reorganizes the roles of the Ministry of Health. Divides and establishes roles of regulation and health provision.	July/2002	January/2004
Explicit Health Guarantees Law (GES) (n. 19,966)	Creates the general system of guarantees for access, quality financial protection, and timeliness for certain health provisions.	May/2002	August/2004
Law on Isapre or Expanded Isapre Law (n. 20,015)	Regulates the Isapre's in terms of costs and benefits in case of closure; determines increases in prices and list of plans; and introduces the Solidarity Compensation Fund between Isapre's.	July/2002	May/2005
Law on Patients' Rights and Duties (n. 20,584)	Regulates the rights and duties of persons in relation to healthcare activities in public or private providers.	June/2001	April/2012

Isapre: Health Insurance Institutions (*Instituciones de Salud Previsional*).
Source: Prepared by the authors based on information from the website of the Chilean Library of Congress (https://www.bcn.cl/index_html).

experience with the GES Regimen in 2002, the explicit guarantees were implemented over the course of three years in the Lagos Government. More diseases were added to the GES by subsequent governments.

In addition to the reforms implemented with the above-mentioned laws, the Lagos government carried out an important reform in the PHC model, a priority in the health policy. The *Modelo de Atención Integral de Salud Familiar y Comunitario* (Comprehensive Family and Community Healthcare Model) was implemented in 2005, oriented towards the renewal of PHC according to the *Declaration of Alma-Ata* [23,24]. During the first governments of the Concertación, Chile was one of the pioneering countries in reorienting PHC, especially for Fonasa groups A and B.

Despite the strides in private sector regulation, the Lagos Government was unable to eliminate the effects of the private sector's segmentation and discrimination. Some measures even expanded these effects, such as the authorization for the Isapre to create additional contributions to the mandatory contribution [25].

First Bachelet Government: strengthening the GES (2006-2010)

Michelle Bachelet of the Socialist Party, the first woman to be elected President of Chile, proceeded with the main economic and social policies of the Lagos Government. The two governments linked macroeconomic orthodoxy to redistributive social reforms, stepping up efforts in social protection, especially in health, social assistance, social security, and education [13,26,27].

The measures affecting the social determinants of health and social protection of Chilean families were expanded and became State policy (E12). These featured the inter-sector program *Chile Crece Contigo* (Chile Grows with You), under the Ministry of Social Development and the Family, dedicated to early childhood.

In the health sector, policy priorities expressed the predominance of continuities in the previous government's agenda (E3; E4). The Office of the President and the Ministry of Health maintained the emphasis on PHC as the basis for the public healthcare model (E2). Budget funds were allocated for building the Family Health Community Centers to complement the Family Health Centers [28].

The GES system was a priority strategy for planning and executing the public health sector's policies (E4; E6; E8), exemplified by the expansion in the number of diseases and procedures covered by the GES system (E3) and in the investments in health centers and hospital infrastructure. From 2006 to 2007, the list of diseases increased from 25 to 56 (Box 3) [29].

The series of expansions in the GES received criticisms, since many treatments were included due to lobbying by organized groups (E8). In 2009, health sector experts and the GES Advisory Board itself advised the Ministry of Health not to further increase the number of diseases covered by the GES, but to expand the basket of treatments that were covered. This advice was rejected by the Ministry of Health, which expanded the number of diseases to 69 in 2010 [30].

According to Huber et al. [13], the GES represented a turnaround in targeted and pro-market policies established under the dictatorship and a step towards more accessible medical care. However, it did not succeed in correcting the flaws in segmentation or in adjusting the unequal allocation of mandatory contributions to the health system.

During the first Bachelet Government, several key political leaders left the Socialist Party [31] amid criticisms of ideological weakening of the Concertación parties. These breaks in political ties undermined the candidacy of former President Frei, and after 20 years, the coalition of center-left parties in the Concertación was defeated by Sebastian Piñera of the center-right alliance *Coalición por el Cambio* (Coalition for Change).

Box 3

List of diseases in the Health Guarantees Regimen (GES) system under the different governments, 2005 to 2013.

LAGOS GOVERNMENT (2000-2006)	BACHELET GOVERNMENT (2006-2010)	PIÑERA GOVERNMENT (2010-2014) *
Start of GES Regimen with 25 diseases (2005)	Inclusion of 15 diseases (2006); 16 diseases (2007); 13 diseases (2010)	Inclusion of 11 diseases (2013)
1. End-stage chronic renal disease 2. Operable congenital cardiopathies in children under 15 years 3. Uterine cervical cancer 4. Pain relief in advanced cancer palliative care 5. Acute myocardial infarction and chest pain management in emergency units 6. Type I diabetes mellitus 7. Type II diabetes mellitus 8. Breast cancer in persons 15 years or older 9. Diagnosis and treatment of spinal dysraphism 10. Surgical treatment of scoliosis in individuals under 25 years 11. Surgical treatment of congenital and acquired cataract 12. Total hip replacement in persons com 65 years or older 13. Cleft lip and/or palate 14. Cancer in individuals under 15 years 15. First episode of schizophrenia 16. Testicular cancer in persons 15 years or older 17. Lymphoma in persons 15 years or older 18. Acquired immunodeficiency syndrome (HIV/AIDS) 19. Acute lower respiratory infection with outpatient management in individuals under 5 years 20. Community-acquired pneumonia with outpatient management in persons 65 years or older 21. Primary or essential arterial hypertension in persons 15 years or older 22. Non-refractory epilepsy in persons from 1 year to 15 years of age 23. Comprehensive oral healthcare in children 6 years of age 24. Prematurity 25. Cardiac impulse and conduction disorder in persons 15 years or older who require pacemaker	26. Preventive cholecystectomy vis gall bladder cancer in symptomatic adults 35 to 49 years of age 27. Gastric cancer in persons com 40 years or older} 28. Prostate cancer in persons 15 years or older 29. Refractive disorders in persons com 65 years or older 30. Strabismus in children under 9 years 31. Diabetic retinopathy 32. Rhegmatogenous retinal detachment; 33. Hemophilia 34. Depression in persons 15 years or older 35. Surgical treatment of benign prostate hyperplasia in symptomatic persons 36. Orthosis (technical assistance) for persons 65 years or older 37. Ischemic stroke in persons 15 years or older 38. Chronic obstructive pulmonary disease in outpatient treatment 39. Moderate or chronic asthma under 15 years of age 40. Neonatal respiratory distress syndrome 41. Leukemia in persons 15 years or older 42. Severe eye trauma 43. Cystic fibrosis 44. Burns 45. Harmful alcohol and drug consumption and dependence in persons under 20 years 46. Anesthesia during labor and childbirth 47. Bilateral hearing impairment in persons 65 years or older who require hearing aids 48. Rheumatoid arthritis 49. Clinical treatment in persons 55 years or older with mild to moderate hip or knee arthrosis 50. Subarachnoid hemorrhage secondary to ruptured cerebral aneurysms 51. Surgical treatment of primary tumors of the central nervous system in persons 15 years or older 52. Surgical treatment of medulla oblongata hernia 53. Outpatient urgent dental treatment 54. Comprehensive oral healthcare in individuals 60 years or older 55. Severe polytrauma 56. Urgent care for moderate to severe head trauma 57. Retinopathy of prematurity 58. Bronchopulmonary dysplasia in premature infants 59. Bilateral neurosensorial hearing impairment in premature infants 60. Non-refractory epilepsy in persons 15 years or older 61. Bronchial asthma in persons 15 years or older 62. Parkinson's disease 63. Juvenile idiopathic arthritis 64. Secondary prevention of end-stage chronic renal disease 65. Hip dysplasia with luxation 66. Comprehensive oral healthcare in pregnancy 67. Recurrent remittent multiple sclerosis 68. Chronic hepatitis B 69. Hepatitis C	70. Colorectal cancer in persons 15 years or older 71. Epithelial ovarian cancer 72. Bladder cancer in persons 15 years or older 73. Osteosarcoma in persons 15 years or older 74. Surgical treatment of chronic aortic valve lesions in persons 15 years or older 75. Bipolar disorder in persons 15 years or older 76. Hypothyroidism in persons 15 years or older 77. Treatment of moderate hearing impairment in children under 2 years 78. Systemic lupus erythematosus 79. Surgical treatment of chronic mitral and tricuspid valve lesions in persons 15 years or older 80. Eradication treatment of *Helicobacter pylori*

Source: prepared by the authors based on information from the Chilean Ministry of Health.

* In October 2019, in the second government of Sebastián Piñera, five more diseases were included in the GES system: lung, thyroid, and renal cancer and multiple myeloma in persons 15 years or older and Alzheimer's disease and other dementias.

First Sebastián Piñera Government: the new health sector reform proposal (2010-2014)

Sebastián Piñera's first term focused on political stability and strengthening Chile's democracy, as in the governments of the Concertación, maintaining inflation under control and with growth of production and consumption [32].

At the beginning of the Piñera Administration, public demonstrations, especially related to education, challenged the social foundations on which Chilean society was built and forced the government to change the social policy agenda [33]. However, the main social protection strategy of the Bachelet Government, *Chile Crece Contigo*, suffered discontinuities and less public visibility during the Piñera Government [34].

In health, the Piñera Government's plan determined five priorities: infrastructure improvement based on the construction of hospitals and clinics under a concessions system; modernization of health administration with the construction of self-administered hospitals; establishment of contracts with health service providers with targets and models for assessment; elimination of waiting lists for the GES diseases; and linkage between the public and private sector through the *Bono de Garantía AUGE*, with the objective of ensuring care for vulnerable persons in public or private institutions of their choice [35].

The *Bono de Garantía AUGE* aimed to include in the free choice modality approximately 3.5 million Fonasa group A beneficiaries, enrolled in the institutional care modality and that had only been accessing public healthcare establishments. This proposal was criticized by the opposition and did not materialize (E12). Another measure that faced opposition and claims of fraud was the publication of government data on the elimination of GES and non-GES waiting lists [30]. An analysis by the Federal Comptroller's Office revealed that documents on patient referrals to specialists had disappeared.

Meanwhile, there were limitations on private sector regulation, such as the unconstitutionality ruling by the Constitutional Court in 2010 as to the power of the Superintendency of Health to define risk-factor tables according sex and age in health plans. The Court ruled that this prerogative violated the principle of equality, the right to health, and social security [36], and that the issue required specific legislation by Congress.

Measures related to prevention and health promotion were implemented during this period, featuring the program called *Elige Vivir Sano* (Choosing to Live Healthy). The Tobacco Control Law, one of the program's nine goals for 2011-2020, set restrictions on tobacco consumption, sales, and advertising (E9).

This period also featured the creation of the *Agencia Nacional de Medicamentos* (AnaMed) (the National Drug Agency) and the regulation of the New Drug Law, previously not addressed by governments of the Concertación, and considered a successful policy under this government, since it favored guaranteeing quality medicines for the Chilean population (E11; E8). In addition, after 11 years of review, *Law n. 20,584* of 2012 was regulated, establishing patients' rights and duties.

The first rightist government since the dictatorial period continued the implementation of the GES. The list of diseases implemented by Bachelet in 2010 was maintained, and the number of diseases was expanded from 69 to 80 in 2013, corresponding to the protection of 60% of the burden of diseases in the Chilean population [37], as shown in Box 3. However, the expansion of the GES list led to underfinancing of the public system, since the funds were not adjusted or expanded proportionally to the coverage [30].

Health sector reform was on the policy agenda in the Piñera Government, but its repercussions were limited. In the first year of Piñeras's term, a Presidential Commission was assembled with 13 public health experts and which submitted two reform proposals. The first, supported by a majority of the commission, proposed a structural reform based on a multi-insurance system with a risk compensation fund between the public and private sectors. The second, by a minority of the commission, only referred to the private sector and to the introduction of public subsidy portability (E8). The first proposal was rejected by the Ministry of Health, which set up a new commission. In 2011, this commission in turn presented a report to Congress that only referred to the Isapre (E8). Since it failed to meet the interests of the Executive, Congress, and other groups, the draft remained in Congress awaiting an alternative proposal (E10; E8), which only came in 2019 during Piñera's second term.

In the 2013 elections, nine candidates ran for President, and Michelle Bachelet was elected to her second term.

Second Bachelet Government: health reform obstructed (2014-2018)

Michelle Bachelet ran in the 2013 elections with the support of the *Nueva Mayoría* (New Majority) party coalition, proposing to implement three structural changes: educational, fiscal, and constitutional [38]. Her government's program included important changes in relation to her first term. The renewal of the foundations for democracy, with the introduction of politically progressive proposals, indicated a change in the political, economic, and institutional structure inherited from the dictatorial period [39].

Besides prioritization of the three reforms, the program included 50 measures from different sectors to be implemented in the government's first 100 days. By the end of this period, 91% of the measures had been implemented, including: the creation of the Presidential Advisory Commission to analyze and propose a new legal regimen for the private health system and the delivery of the National Plan for Public Health Investments, 2014-2018 [38].

Other commitments by the government involved building and equipping urgency primary care services, agreements with municipalities for dispensing free medications to chronic patients, hospital construction, and funding for hiring specialists [39].

Priorities of previous governments were maintained, such as strengthening PHC, restructuring hospital infrastructure, regulation of food labelling, and decreases in waiting times, especially for specialists (E6; E7; E12).

One of the government's first measures for the health sector was the creation of an "Advisory Commission for the Study and Proposal of a New Model and Legal Framework for the Private Health System" [40]. The commission, consisting of 18 specialists and led by economist Camilo Pedraza, drafted a proposal in 2014 for radical health sector reform [41]. As short-term measures, mechanisms were established to eliminate payments associated with individual risks, including the same prices for premiums, regardless of sex and age. Long-term measures included the creation of a Single Fund for National Health Insurance and the preservation of voluntary complementary private insurance [40]. Box 4 compares the reform proposals presented by the Presidential Commissions of 2010 and 2014, emphasizing aspects pertaining to financing, services provision, and regulation.

The proposal by the Presidential Advisory Commission, considered a radical and structural project, met with criticism by sectors connected to the Isapre (E14). Besides, the second Bachelet Government was marked by the introduction of reforms in various areas such as taxes and education in addition to the proposal for a new Constitution. The contextual analysis by the President and the Ministry of Health concluded that the political conditions were insufficient for implementing another radical reform such as that idealized by the Commission (E12; E13; E14). There were also reports of corruption involving Bachelet's son in the second year of her term, exacerbating the political weaknesses and fueling clashes that jeopardized negotiations over the reforms, including the health reform (E7; E12).

As for incremental changes, in 2015, following widespread popular mobilization, the Ricarte Soto Law was passed, granting coverage for high-cost diseases for individuals enrolled in the public and private systems. As of late 2019, 27 high-cost diseases were covered, and as with the GES system, various groups were lobbying to incorporate new diseases.

In the last year of the Bachelet Government, another controversial topic was prioritized, namely the decriminalization of voluntary termination of pregnancy (E12). Despite resistance by conservative sectors of Congress and criticism by religious institutions, in 2017 the government regulated the law on decriminalization in three situations: risk to the mother's life, pregnancy resulting from rape, and fatal fetal impairment. Passage of the law was one of the last important health measures by the Bachelet Government (E12).

Box 4

Health sector reform proposals by the Presidential Commissions of the Piñera Government (in 2010) and Bachelet Government (in 2014), according to selected characteristics.

	PIÑERA GOVERNMENT PROPOSAL BY THE PRESIDENTIAL ADVISORY COMMISSION (2010)	GOVERNO BACHELET PROPOSAL BY THE PRESIDENTIAL ADVISORY COMMISSION (2014)
Minister of Health	Jaime Mañalich	Hélia Molina
Review of bill in Congress	Bill submitted to Congress, and still under review in the Senate at the end of the Piñera term *.	Not submitted to Congress.
Financing	PMajority proposal: Creation of a Universal Health Plan and creation of a universal per capita health premium; Single national job disability insurance; Possibility of choosing public or private social security entity; Creation of State subsidies, adjusted by income levels and individual risk; Creation of a Risk Compensation Fund; Possibility of hiring Voluntary Additional Insurance. Minority proposal: Creation of a Mandatory Health Insurance Plan (PSSO); Solidarity quotas adjusted by family group risk; Quotas for self-employed workers and others according to real or presumed earnings.	Establishment of a single and universal Social Security Plan with mandatory contribution and copayments; Creation of an additional per capita community premium; Creation of a Universal Joint Fund between Fonasa and Isapre; Creation of an Inter-Isapre Fund adjusted by health risks; Creation of a Job Disability Subsidy Fund with tripartite financing.
Services provision	Separation between public and private provision, including in relation to preventive and curative activities.	Public and private providers, without exclusiveness, may offer services to various insurers, guaranteeing the right to free choice of the provider.
Regulation	Standards set by the Superintendency of Health for regulation, management, and implementation of the insurance bidding process.	Expansion of roles in the Superintendency of Health in relation to regulation of insurers, providers, and complementary insurance.

Source: Prepared by the authors based on information provided in the Final Reports of the 2010 [43] and 2014 Commissions [40].

* Alternative bill to the proposal submitted to Congress in April 2019 in the Piñera Government.

Box 5 summarizes the principal characteristics of the institutional political context, agenda, and strategies for the health sector in the governments analyzed here.

Conditioning factors in the health system's configuration

The analysis of the trajectory of health policies in Chile reveals three groups of conditioning factors in the relations between State and market and in the health system's configuration during this period, namely structural, institutional, and political conditioning factors.

The structural conditioning factors involve the characteristic capitalist model of peripheral economies that reinforces social inequalities and the historical nature of social protection systems that reiterates the segmentation by social groups, as observed in the majority of Latin American countries [8].

One structural conditioning factor concerns the radical reform implemented by Pinochet's authoritarian government, which transformed State-market relations in health. A dual system was established with strong private participation and that gained a solid institutional basis and mobilized the interests of various political and economic organizations and actors [2]. The free choice system, expanded under the military regimen, ensured the presence of the middle class in the public sector,

Box 5

Political and economic context, governments' priority agendas, and strategies adopted in the health policy sphere in Chile, 2000 to 2018.

GOVERNMENT	POLITICAL AND ECONOMIC CONTEXT	GOVERNMENT AGENDA	STRATEGIES ADOPTED
Ricardo Lagos (2000-2006)	**Economic** • Maintenance of liberal economic policies; • Signing of free trade agreements with European Union, USA, China, and other countries; • Urban infrastructure development through public-private partnerships; • Governments of the *Concertación*: Highest annual per capita growth (4.2%) in Latin America from 1990 to 2005. **Political** • Heterogenous and pluralist center-left coalition; • First president under the Socialist Party since Salvador Allende; • Approach with centrist parties and agreements with rightwing parties to approve reforms. • Political crisis – Corruption scandal involving Ministry of Public Works and the company *Gestión Territorial e Ambiental*; • Non-legislative agreement for implementation of measures to modernize the State, transparency, and the promotion of growth; • Federal Constitution of 1980 – implementation of 58 changes.	**Social policies** • Focus on decreasing social inequalities; • Expansion of labor rights; • Action on social determinants of health through redistributive policies - Chile Solidarity System; • Creation of system for financing higher education with State subsidies. **Health** • Comprehensive Health Reform; • Charter of Rights and Duties in Health; • Creation of a Solidarity Fund with funds from the State and the population; • Strengthening of regulation and inspection of private and Isapre providers; • Guarantees in terms of access, timeliness, and quality at all levels of care; • Modernization of the public health system; • Elimination of waiting lists in public clinics.	• Progressive increase in fiscal transfers to the public sector; • Establishment of Health Goals, 2000-2010; • Implementation of the Comprehensive Family and Community Healthcare Model in PHC; • Incremental Reform – AUGE/GES System (Universal Care with Explicit Guarantees); • Implementation of four laws to support the public policy; • Creation of a Solidarity Compensation Fund between the open Isapre.

(continues)

Box 5 (continued)

GOVERNMENT	POLITICAL AND ECONOMIC CONTEXT	GOVERNMENT AGENDA	STRATEGIES ADOPTED
Michelle Bachelet (2006-2010)	**Economic** • Greater State interventionism and regulation; • Maintenance of positive economic indices and fiscal adjustment; • Policies for confronting the international crisis at the fiscal, foreign exchange, and foreign trade levels; • Chile joins the Organization for Economic Cooperation and Development (OECD). **Political** • Coalition obtains majority in both houses of the Chilean Congress; • Weakening of political coalition, important figures leave the Socialist Party, and end of the Concertación; • Reform and modernization of the State.	**Social policies** • Strengthening of the social protection network; • Social Security Reform – creation of solidarity pillar financed by the State in the Social Security system and concession of solidarity pensions for old age and disability, complementary to the private system; • Establishment of new framework in the educational field with changes in the educational community's rights and duties, minimum requirements for levels of education; among others; • Action on social determinants of health through redistributive policies – Chile Crece Contigo (Chile Grows with You) Program. **Health** • Effective compliance with the explicit guarantees in the AUGE Plan; • Continuity in the institutional changes produced by health reform; • Creation of the self-administered hospitals regimen; • Budget allocation for non-AUGE diseases; • Reinforcement of PHC; • Introduction of more competition in the private sector based on standardization and simplification of plans; • Expansion of free healthcare in the institutional modality for elderly and development of a training program in geriatrics.	• Modernization of the public health system and construction of hospital infrastructure and primary care centers; • Expansion of GES regimen and inclusion of new diseases; • Reduction of waiting lists in hospitals and primary care centers; • Improvement in infrastructure and quality of care in urgency services with hiring of human resources and ambulance services throughout the country; • Regulation of the Universal Donor Law for persons over 18 years of age; • Prohibition of conditioning healthcare on payment in the act; • Regulation of legislation on information, orientation, and services provision related to regulation of fertility.

(continues)

Box 5 (continued)

GOVERNMENT	POLITICAL AND ECONOMIC CONTEXT	GOVERNMENT AGENDA	STRATEGIES ADOPTED
Sebastián Piñera (2010-2014)	**Economic** • Strategies for overcoming international financial crisis and its economic and social effects; • Maintenance of economic model generating concentration and inequalities; • End of period: inflation controlled, production growing, dynamism in internal consumption and domestic and foreign investment; **Political** • Center-right coalition *Coalición por el Cambio* • Social and student demonstrations (2011/2012): demands for broad educational reform and questioning of the pillars of Chilean society built during the military dictatorship; • Decrease in party identification with and adherence to democracy; • Adoption of measures aimed at promoting democracy in the country such as voluntary voting and automatic voter registration.	**Social policies** • Benefits for training youth and women – *Bono de Capacitación e Subsídio de Empleo de la Mujer*; • Extension of maternity leave from three to six months; • Creation of Ethical Family Income that defines bonuses and conditional transfers for families in extreme poverty. **Health** • Decrease both in waiting lists for healthcare and in inequalities; • Creation of a Presidential Advisory Commission for private sector reform – Proposal submitted to Congress; • Increase in PHC budget and reform; • Expansion of free choice modality to include Fonasa group A; • Food labelling law; • Creation of National Medicines Fund.	• Suspension of mandatory contribution for pensioners receiving benefits from the *Pensión Básica Solidaria or Aporte Previsional Solidario*; • Decrease from 7% to 5% in the pension contribution by age, disability, work accidents, and occupational illnesses, among others; • reation of the National Drug Agency; • Investment in hospital infrastructure and clinics; • Creation of self-administered hospitals; • Implementation of the program for promotion and prevention "*Elige Vivir Sano*"; • Regulation of the Law on Rights and Duties in Health (*Law n. 20,584/2012*); • Implementation of Tobacco Control (*Law n. 20,660/2013*); • Low-complexity fertility treatment for couples enrolled in Fonasa; • Increase in coverage of diseases in GES from 56 to 80 diseases, from 2010 to 2013.

(continues)

Box 5 (continued)

GOVERNMENT	POLITICAL AND ECONOMIC CONTEXT	GOVERNMENT AGENDA	STRATEGIES ADOPTED
Michelle Bachelet (2014-2018)	**Economic** • Low economic growth; • Drop in copper prices (main export commodity); • Decrease in foreign investment; **Political** • Shaping of a new center-left political coalition, *Nueva* Mayoría structured by educational, fiscal, and constitutional reform proposals; • Criticism over the amount of commissions and planned reforms; • Regulation of tax reform (*Law n. 20,780/2014*); • Strengthening representativeness in the National Congress (*Law n. 20,840/2015*): replacement of the *sistema binomial* with the proportional electoral system, creation of women's quotas in the party slates, and incentives for creation of political parties; • Political and institutional crisis (2015) – corruption scandals and financing of politicians directly and indirectly affecting the government, decrease in government's popular support and paralysis of reforms; • Social mobilization (2016) for social security reform.	**Social policies** • Creation of Presidential Advisory Commission for Social Security Reform and elaboration of Report with proposals; • Elaboration of National Policy for Childhood and Adolescence: comprehensive system of safeguards for the rights of children and adolescents, 2015-2025; • Creation of *Permanent Family Stipend* for families that receive other social benefits; • Civil union agreement equalizing rights of homosexual couples to those of heterosexual couples; • Educational Reform (*Law n. 21,040/2017*); **Health** • Establishment of a Presidential Advisory Commission for health reform – Proposal not submitted to Congress; • Construction of infrastructure for hospitals and PHC centers; • Creation of High-Resolution Primary Care Services and purchases of equipment; • Expansion of dental care coverage to include women in vulnerable socioeconomic groups; • Creation of a Special Fund for High-Cost Drugs.	• Launch of the National Plan for Public Investments in Health 2014 – 2018: hospital construction; strengthening of PHC with the creation of new Family Health Centers (CESFAM); Community Family Health Centers (Cecosf), and Urgency and High-Resolution Primary Care Services (SAR); • Implementation of the Program *Mas Sonrisa para Chile* (More Smiles for Chile); • Creation of the Plan for Recruitment, Training, and Retention of Physicians and Specialists for PHC; • Universal Guarantee of High-Cost Treatment (or Ricarte Soto Law) – *Law n. 20,850/2015*; • *Law n. 20,606/2016* on food labeling, amendment to the Food Safety Regulations; • Creation of *Law n. 21,030/2017* on decriminalization of voluntary termination of pregnancy in three situations.

Source: prepared by the authors based on literature and document search and interviews.

but represented a central element in the private sector's predominance in services provision [36,42]. Workers' compulsory contributions to the private sector in the free choice modality became part of the health system's institutional arrangement. These factors raised obstacles to proposals for comprehensive structural transformations of the health system during the democratic period.

The dictatorship's tactic for breaking with the mechanisms of solidarity between the public and private systems created, as an institutional legacy, a radical segmentation that persisted as a characteristic of the Chilean health system [3]. The rules defining the dual structure and their respective interests hindered the introduction of radical changes in the health system, even with the proposals by the democratic governments. The current study corroborates the analysis by Labra [3] that identified the difficulty in the introduction of structural changes in health systems after the historical consolidation of a given institutional format. The Chilean case illustrates a situation of "path dependence", since governments with different political positions were unable to implement reform proposals, while the structural configuration of the health system adopted by Pinochet was maintained.

The implementation of incremental reforms such as GES have generated another segmentation in the system, aggravating the difference in access and waiting times between Chileans without and without GES coverage [12,24,36]. GES is financed by a regressive tax, and the system is limited by the demand for services that exceeds the public capacity to supply them.

Despite the contradictions produced by the GES reform, its continuity has been a priority healthcare strategy in governments of different political positions, with incremental adjustments (Box 3), in addition to its relevance for the improvement of conditions in healthcare access by the population in the public and private sectors, suggesting the importance of gradual institutional changes for achieving significant transformations in times of stability [7]. The Health Authority and Management Law, regulated in 2004, which reorganized the roles of health oversight, management, regulation, and provision, can be an important strategy from this perspective (Box 2).

Finally, in relation to political conditioning factors, proposals for health sector reform remained on the agendas of two consecutive governments after the implementation of GES. Still, the Piñera Government's reform proposal [43], more limited to the private sector, stalled in Congress. Meanwhile, the proposal drafted in the second Bachelet Government [19], more radical, was not even submitted to Congress (Box 4), since resistance to it had been identified and other conflicting reform bills were being negotiated at the same time, such as the educational reform bill.

In addition, the heterogeneous and pluralist nature of the center-left parties comprising the Concertación and later the *Nueva Mayoría* created obstacles, especially in the governments of Michelle Bachelet, affiliated with the Socialist Party, with a reformist profile [38].

In the second Bachelet Government, the existence of structural reform proposals in different areas and the President's dwindling political support base jeopardized negotiating a reform focused on reorientation of the health system from a more comprehensive social welfare perspective.

Conclusion

In Chile, following re-democratization, the reform proposals that aimed to alter the health system's structure to regulate the private sector and strengthen the public sector, especially those presented by center-left governments, encountered structural, institutional, and political limits, creating an example of path dependence on the structural reform carried out under the military dictatorship.

There were elements of continuities and changes throughout the governments of different political positions. In terms of continuities, the democratic governments were unable to implement sweeping health reforms, but they did adopt incremental changes that expanded health services access and provision, such as the incremental changes in PHC and the GES strategy.

The reform agendas under governments of various political positions differed from each other in some ways. Despite the limited effects of the proposals' materialization, the agendas generally featured initiatives to strengthen the public sector on the agenda of center-left governments and a focus on the private sector in the agenda of the center-right government.

The study prioritized the analysis of official documents and interviews with policymakers that worked in the National Executive, but did not include other government officials or nongovernment actors. Further studies are need for a more in-depth analysis of public-private relations in the organization, financing, and provision of health services, as well as their effects on the health system's results.

In Latin America, the Chilean model inspired reforms focusing on greater private sector participation in health. Still, this model showed signs of exhaustion, expressed in late 2019 in the wave of protests that culminated in the promise of a new National Constitution and that refueled the debate on health sector reform in academia, professional societies, and civil society. The new scenario has opened possibilities for redirecting health policies in Chile. It remains to be seen whether the Chilean people's aspirations will win out over the interests of economic and political groups that have benefited from the Chilean health system's dual structure.

Contributors

S. C. Oliveira was responsible for conducting the fieldwork and for the article's conception, literature review, writing, and approval of the final version. C. V. Machado and P. F. Almeida participated in the article's conception, writing, critical revision, and approval of the final version. A. A. Hein participated in the article's critical revision and approval of the final version.

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Additional informations

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Resumo

Nos anos 1980, durante a ditadura militar, o Chile foi o precursor na América Latina na realização de uma reforma radical do sistema de saúde, que expandiu a participação do setor privado no asseguramento e prestação de serviços, influenciando reformas em outros países da região. O artigo analisa as políticas de saúde no Chile de 2000 a 2018, no contexto de quatro governos democráticos, considerando continuidades e mudanças na trajetória das políticas e seus condicionantes. O referencial analítico baseou-se em contribuições da abordagem do institucionalismo histórico. Realizou-se análise bibliográfica, documental e entrevistas semiestruturadas com gestores envolvidos na política nacional no período estudado. A análise da trajetória das políticas de saúde no Chile no período democrático mostrou continuidades e mudanças nas agendas e estratégias adotadas por governos de diferentes orientações políticas. Reformas incrementais realizadas ao longo do período produziram avanços e melhorias no acesso e prestação dos serviços de saúde. Porém, propostas de reforma que alterariam o arranjo público-privado do sistema de saúde sofreram resistências, e manteve-se a estrutura dual e segmentada conformada na década de 1980, com forte participação privada. Condicionantes histórico-estruturais, institucionais e políticos das relações entre Estado e mercado e da configuração do sistema de saúde instituída no período ditatorial dificultaram mudanças abrangentes nas relações público-privadas em saúde, configurando um exemplo de dependência de trajetória e do poder dos interesses empresariais no setor saúde.

Reforma dos Serviços de Saúde; Sistemas de Saúde; Política de Saúde

Resumen

En la década de 1980, durante la dictadura militar, Chile fue precursor en América Latina en la realización de una reforma radical del sistema de salud, que expandió la participación del sector privado en el aseguramiento y prestación de servicios, influenciando reformas en otros países de la región. El artículo analiza las políticas de salud en Chile desde el año 2000 al 2018, en el contexto de cuatro gobiernos democráticos, considerando continuidades y cambios en la trayectoria de las políticas y sus condicionantes. El marco referencial analítico se basó en contribuciones del enfoque del institucionalismo histórico. Se realizó un análisis bibliográfico, documental y entrevistas semiestructuradas con gestores implicados en la política nacional durante el período estudiado. El análisis de la trayectoria de las políticas de salud en Chile durante el período democrático mostró continuidades y cambios en las agendas y estrategias adoptadas por gobiernos de diferentes orientaciones políticas. Reformas incrementales realizadas a lo largo del período produjeron avances y mejoras en el acceso y prestación de los servicios de salud. No obstante, las propuestas de reforma que alterarían el acuerdo público-privado del sistema de salud sufrieron resistencias, y se mantuvo la estructura dual y segmentada, conformada en la década de 1980, con una fuerte participación privada. Condicionantes histórico-estructurales, institucionales y políticos de las relaciones entre el Estado y el mercado, así como de la configuración del sistema de salud instituido durante el período dictatorial, dificultaron cambios de gran alcance en las relaciones público-privadas en salud, configurando un ejemplo de dependencia de trayectoria, así como del poder de los intereses empresariales en el sector salud.

Reforma de la Atención de Salud; Sistemas de Salud; Política de Salud

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