



# The 2019 crisis in Chile: fundamental change needed, not just technical fixes to the health system

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## Abstract

Chile has been viewed as an exemplar of social and economic progress in Latin America, with its health system attracting considerable attention. Eruption of widespread civil disorder marred this image in 2019. We trace the evolution of Chilean health policy and place it in context with developments in other sectors, pensions and education. We argue that much has been achieved, but further progress will necessitate politicians tackling the enduring power of elites that has prevented reform of a two-tier system enshrined in policies of the dictatorship.

**Keywords** Chile · Power · Elites · Health system reform · Democracy

## Differing views from near and far

In the 30 years since Augusto Pinochet's military dictatorship ended, Chile has come to be viewed as an exemplar of political, social, and economic stability in Latin America [1]. Democratic elections have led to peaceful transfers of power, and legislation, the *Plan AUGE (Plan de Acceso Universal con Garantías Explícitas en Salud)*, has expanded health care coverage. Its political parties have been lauded internationally for pragmatism, commitment to the rule of law, and effectiveness in achieving lasting social policy reforms [2]. Many observers, in Chile and worldwide, expressed surprise in late 2019 at eruption of a political and social crisis with large demonstrations accompanied by violence from police and protesters. Impressions of distant observers did not match first-hand experience of life in Chile.

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Chile's crisis offers an important lesson for others. Successive governments, from the left and right, committed to deliver high-quality health care to all. International observers considered Chilean politicians 'good students' for applying international best practice for inclusive public policies that achieved desired economic, social, and political outcomes, including universal health care (UHC). But something went wrong. We argue that the Chilean experience shows technical measures cannot succeed if bolted to a dysfunctional structure dominated by entrenched power of groups that resist reform.

## The crisis and its origins

The roots of the crisis that erupted in 2019 are much older. Chile legislated a national health service in 1952 promoted by then Senator Salvador Allende, a physician and a socialist—a step toward universal health coverage. That reform combined disparate programs that covered the poorest 70% of the population. It did not incorporate programs for the military, police, civil servants, and salaried private employees [3]. President Eduardo Frei Montalva, a Christian Democrat elected in 1964, implemented social reforms, progressive taxation and large investments in health care infrastructure [4] accompanied by marked improvements in health outcomes. Both the left and right criticized him—for doing too little or too much. Allende succeeded him in 1970, elected on an avowedly Marxist manifesto [5]. His reforms included strengthening health services for the poor. Powerful industrialists, foreign investors, and physicians in private practice immediately attacked [6]. A 1973 coup replaced him with a military dictatorship led by General Augusto Pinochet Ugarte. This government radicalized economic policy based on ideas from Milton Friedman and the Chicago school of economics, described by the Canadian author Naomi Klein as a “shock doctrine” [7]. It destroyed many institutions in place since the 1950s and transferred large areas of state activity to the private sector [8]. We show the effects by examining three sectors, pensions, education, and health.

## Pensions

The Pinochet regime privatized pensions [9]. It required workers to contribute 10% of monthly wages [10] to the Pension Fund Administrators (Asociación de Fondos de Pensiones) to promote individual responsibility. Pension fund administrators benefitted most, by charging excessive management fees and widening inequality among beneficiaries [11].

## Education

The regime transferred schools from the ministry of education to local authorities and instated a voucher scheme—moving away from funding based partially on need. Families could use vouchers for public or private schools; the money followed the child.



Subsequent analysis showed no improved educational standards but an increase in social stratification [12].

## Health

The Pinochet regime did not change the health system initially, though it progressively cut funding. Then in 1979 it replaced the Servicio Nacional de Salud with the Sistema Nacional de Servicios de Salud, and replaced a health fund, the Servicio Médico Nacional de Empleados (SERMENA) with a new one, the Fondo Nacional de Salud (FONASA). Employees contributed 7% of their gross income. The fund also covered unemployed persons and certain pensioners. But, as with schools, Chileans could, and the regime encouraged them to, opt out and obtain coverage from a highly subsidized network of private insurers, the Instituciones de Salud Previsional (ISAPRE). ISAPRE provided access to private facilities, thereby creating a two-tier health system. These were much more expensive and were seen as of higher quality than those affiliated to the FONASA system [13].

Next came a transition to democracy with a succession of governments from the center-right, initially (Patricio Aylwin, 1990–1994 and Eduardo Frei, son of the previous president, 1998–2000) and later the center-left (Ricardo Lagos, 2000–2006 and Michel Bachelet, 2006–2010, 2014–2018). They implemented reforms, including of taxation and social welfare. President Bachelet reformed pensions in the late 2000s to help the poorest 60% of the population. The reformed pensions did not depend on contribution history, but left core elements of the privatized scheme in place [14]. Education policies from the dictatorship also persisted despite a 2006 “Penguin Revolution”, when high school students revolted against the segregation of public and private schools and a 2011 revolt by university students demanding an end to the free-market approach to education [15].

In the health sector, President Lagos seemed to make substantive reforms in *Plan AUGE*, enacted in 2004. This required timely access to high-quality health care by public and private providers, along with financial protection, for a list of health conditions [16–18]. The initial list of 25 health conditions expanded incrementally to the current 85. President Sebastián Piñera announced inclusion of another 5 at the onset of the crisis of 2019. But he also left in place the inherited structures. He did not tackle widespread co-payments required of all except some groups (such as the unemployed, FONASA groups A and B). All others [ISAPRES and FONASA (Groups C and D)] pay from 0 to 20% of the total price of services [19].

The continued strength of conservative forces and, especially the military in the early years of democratic governments, represented a political consensus favoring minimal reforms without dismantling fundamental power structures [20].



## The crisis of 2019

Protests, which by of July 2020 were no longer on the streets but had merged into popular criticism of the government's pandemic response, began on 17 October 2019 when students jumped turnstiles in the Santiago subway system to protest against a 30 Chilean Peso (approximately 4 US cents) fare increase during peak hours [21]. The increase was small but imposed during growing discontent with overcrowded carriages and already high fares [22]. Protests soon escalated. Large crowds gathered in peaceful rallies to demand major changes to social protection policies including pensions, education, and health. Then violence erupted; the police were unable to control the situation, despite deploying considerable violence themselves. The government declared a State of Emergency on 19 October 2019, giving the Armed Forces responsibility to restore order in the capital [23]. The use of troops evoked the history of brutality by the Chilean dictatorship.

Deploying the military did not restore calm. On Saturday, 20 October 2019, the general in command declared a curfew from 10 pm to 7 am, the first during democratic rule in Chile [24]. Violence, including human rights violations, mushroomed [25]. On 23 October, President Sebastián Piñera responded to growing demands with an “*agenda social*” (social agenda), measures to alleviate concerns about the health system including a ceiling on out-of-pocket spending, an insurance plan to cover drugs, and an agreement between the *Central Nacional de Abastecimiento* (National Centre for Supply) and the most important private drugstore companies to reduce the price of medicines for those who obtained health care from public providers [26].

Despite this “*agenda social*”, peaceful rallies and violent protests continued, now nationwide. On 15 November representatives of almost all Chile's political parties represented in the bicameral Congress signed The Agreement for Peace and a New Political Constitution. It includes provisions for referenda, a first scheduled for 26 April 2020—then postponed to October because of the COVID-19 pandemic. It will ask Chileans if they agree to creation of a new constitution; and if so, who should prepare it? A new constitution would replace the one left by the Pinochet regime, which prioritized a market economy over social protection [27]. Piñera's government simultaneously escalated repressive measures. On 21 and 26 November 2019, Amnesty International and Human Rights Watch published reports on human rights violations in Chile since the start of civil disorder. Both reports included evidence of excessive force by police during protests—including use of shotguns loaded with rubber pellets blamed for more than 220 eyes injuries [28, 29]. The Inter-American Commission for Human Rights and United Nations Human Rights Office recommended changes to police practices [30, 31].

## Chile's health system: a success story?

Chile had been making progress economically and socially despite the lack of fundamental reforms. That is why the eruption of widespread public discontent surprised many. Chile boasts the highest per capita Global Domestic Product (GDP)



in South America, and, in 2010, was the first country from that continent to join the Organization for Economic Cooperation and Development (OECD). Social progress was especially apparent in the health sector. In 2010, the World Health Report described Chile as an “in the right way country”, highlighting its progress to Universal Health Coverage (UHC) [32].

Early analyses of implementation of the Plan AUGE, intended to improve access to facilities near peoples’ homes, reduced waiting times, improved quality, and caps on co-payments (maximum 20% of the price and no more than one month’s family income for the family in a year), reported a 30% increase in use of health services for conditions such as type 2 diabetes and hypertension [33] and improved survival after acute myocardial infarctions [34].

President Michelle Bachelet extended health coverage further during her second term, enacting the 2015 *Ley Ricarte Soto*. It established Financial Protection System for High-Cost Diagnostics and Treatments, not previously covered, and diagnostic investigations and treatments for oncological, immunological, and rare diseases [35]. The Law also established a commission to set priorities. It was made up of two members of patient organizations and twelve renowned specialists in public health, medicine, bioethics, economy, health law, and drugs named by the Ministry of Health [35].

While attribution of changes in health outcomes to a particular policy is always difficult, there are signs that these policies have improved access to health care facilities. The Health Access and Quality Index, part of the Global Burden of Disease program, measures deaths that should not occur with timely and effective care, adjusted for the risk profile of the population [36]. Despite starting at similar levels, Chile pulled ahead of Argentina and Uruguay after 2000. Use of health services for conditions covered by AUGE increased, in some cases dramatically [37].

## Problems remain

Health reform has been a high priority for Chile’s leaders in since Pinochet’s rule. Wide inequalities remain and benefits from reform have flowed unevenly to groups in the population [38–40]. Vásquez and colleagues showed that service utilization increased for all groups and inequalities narrowed, but by 2009 a pro-rich pattern of consultations with dentists, specialists, and other physicians persisted [38], findings that are supported by research on measures such as specialty visits, laboratory tests, and hospitalization. All demonstrate concentration of utilization by the most affluent households, and of emergency visits by those with fewest resources [41, 42]. Patients report continuing barriers to care, especially co-payments. Out-of-pocket spending is high by OECD standards [43] and many households experience catastrophic costs [44]. In 2018 Chile’s health expenditure per capita was US\$2182, one of the lowest among OECD countries; it has grown rapidly, at a rate among the highest of OECD countries [45]. As a percentage of GDP, spending increased from 6.8 in 2010 to 9.0 in 2019 [46]. Polling reveals persisting disaffection with health care [47, 48]. Wide inequalities persist in availability, affordability, and utilization of health services [49–51]. Death rates among those waiting for treatment of conditions



not covered by AUGE have increased [52]. Chile's economic system has made it one of the most economically unequal countries in the world, with a Gini coefficient of 0.49 [53]. Wealth inequality is harder to measure [54] but seems to be even higher, with the share of GDP owned by billionaires the highest in the world (excluding tax havens) [55].

## Where does the power lie?

The commitment of successive Chilean governments to implement change is not in doubt but they have been unable to make major changes to the two-tier system created by the dictatorship [13]. In the health sector, powerful private insurers remain unscathed [56]. Silva argued that a coalition of business leaders and landowners influenced policies of the Pinochet regime and their power persisted after the democratic transition. The legacy amounts to an implicit agreement between them and subsequent governments to permit democracy, but without challenging much of the status quo [57]. Chile is not unique in this; elsewhere fundamental political and economic reforms have left existing power relationships largely intact. Notable examples include the transition from communism in Europe, where many of the previous leaders transformed overnight into “democrats” [58] and the rapid recovery of slave owning families in the Confederate states after the American civil war [59]. Acemoglu and Robinson developed an equilibrium model to explain this, in which they distinguish the “elite” from the “citizens”. The former hold *de facto* power even though the latter have *de jure* power [60]. They show that changes in *de jure* power, such as those brought about by a transition to democracy, can be offset by changes in *de facto* power, especially where the stakes are high for elites.

## Conclusion

The Italian writer Giuseppe Tomasi di Lampedusa, in his novel *The Leopard*, described an aristocratic Sicilian family finding ways to retain influence during the Italian Risorgimento, delivering the famous quotation: “everything must change so that everything can stay the same” [61]. On the surface, everything has changed in Chile. But as to the distribution of power, everything has stayed the same. The recent crisis drew attention to weaknesses in the health system but, if our analysis is correct, to be effective the response will not just be a technical fix but a fundamental reassessment. Recently, Crispi and colleagues wrote: “Chile must decide if the time has come for a profound structural change, based on a different set of political and ethical principles” [62]. We agree.

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