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# Public-private relations in Chile's health system: regulation, funding and service delivery

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**Abstract** *This article analyzes the configuration of public-private relations in Chile's health system between 2000 and 2018, focusing on organization and regulation, funding and service delivery. The following data collection methods were employed: literature review, content analysis of official documents and secondary data, and semi-structured interviews. With regard to organization and regulation, the findings show a lack of institutional mechanisms to mitigate risk selection and that access to private services is intimately linked to ability to pay. The funding model is incapable of sustaining the public health system. With respect to service delivery, despite the implementation of strategies that suggest advances, the segmentation of the system is sustained by the fragmentation of care and purchase of private services. Our findings show that the nature of public-private relations in Chile's health system reinforces the segmentation of population groups produced by the market-oriented approach. Although the reforms implemented during the study period mitigate the effects of segmentation, they were unable to produce structural changes in the configuration of the health system.*

**Key words** *Health systems, Government regulation, Health system funding, Health care delivery*

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## Introduction

Understanding the relationship between the state, markets and families is important for comprehending social protection sytems[1], which are underpinned by the state's commitment to ensure the welfare of citizens in the face of the risks inherent in market societies[2,3]. Analyzing the configurations of social policies, Esping-Andersen[1] uses the concept of decommodification to indicate the varying degree to which state policy articulates transfers of social public resources and services to reduce citizens' dependence on the labor market.

Latin America is characterized by distinct social health protection arrangements[4]. Throughout the twentieth century, state intervention was oriented towards the implementation of health policies targeting formal sector workers, providing differential benefits in social security-based systems[5]. However, funding shortfalls, inequalities and *widespread informality* meant that a large part of the population were excluded from the system[6].

Neoliberal reforms in the region in the 1980s and 1990s affected both social protection and health systems[7]. According to the recommendations of international agencies, the state should concern itself with vulnerable individuals and families, reducing its role through the decentralization, targeting and privatization of social programs[8].

In the 1920s, Chile began to expand the coverage of its social security system and took steps to establish a more universal model of social security that was more independent from the labor market, including the creation of the National Health Service in the 1950s. In the opposite direction, in the 1980s, the military dictatorship implemented a neoliberal health reform based around a social security model emphasizing the involvement of the market[9,10].

This reform ushered in the most intense articulation between the state and the market yet seen in the health sector in Latin America. It created competition for contributors between the public and private subsystems and led to changes in the structure and functioning of the health system, creating a mixed system[11]. Implemented in the health sector in the face of the historical, political and institutional trajectory of policies, the characteristics of the articulation between the state and the market, and a private setor role shaped since the 1980s, the Chilean case is regarded as an example of a successful neoliberal model.

In the 2000s, the Lagos government initiated a health sector reform built around five projects, changing aspects related to the organization of the system and regulation of the private subsystem, broadening sources of funding and including new priority health problems in service provision[12], without altering the dynamics of the public-private mix.

This article analyzes the configuration of public-private relations in Chile's health system between 2000 and 2018, focusing on the different dimensions of organization, regulation, funding and service delivery. We describe the essential features of state-market relations and discuss the effects of these relations on the segmentation of the health care system and challenges in exercising the right to health.

## Method

We conducted a case study of public-private relations in the configuration of Chile's health system. We draw on the contributions of Immergut[13], who analyzed modes of government intervention in health policy in Europe, considering the participation of the state and markets across four dimensions: regulation and organization, funding, service ownership and employment of health workers[13]. We considered three core areas of analysis based on the work of the author: i) The organizational and regulatory aspects of the configuration of the health care system; ii) Public-private relations in funding; and iii) Public-private relations in service delivery.

In the first core area, we characterized health system structure and coverage, the government bodies and agencies that make up the system and their respective roles, and private subsystem regulatory and control instruments. In the second area, we focused on the composition of sources of funding, public and private health spending, out-of-pocket payments, health spending as a share of GDP and copayments. In the third, we concentrated on care delivery and the involvement of public and private care providers.

The study period was 2000 to 2018, which covers the beginning of the health setor reform initiated by the Lagos Government (2000-2006), which resulted in changes in the organization and regulation of the system, funding and care delivery, and the final year of the Bachelet government.

The following data collection methods were used: literature review, content analysis of official

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documents and secondary data and semi-structured interviews.

The document analysis included government and official agency documents, such as legislation and resolutions issued by the National Congress, Constitutional Court and President, technical reports published by the Ministry of Health, National Health Fund (FONASA), health insurance companies (ISAPREs), Health Superintendence and the Economic Commission for Latin America and the Caribbean (ECLAC).

Secondary data were obtained from information systems run by the Department of Health Statistics and Information and agencies linked to the Ministry of Health, FONASA and the ISAPRE system, and databases maintained by the Organisation for Economic Co-operation and Development (OECD), Pan American Health Organization (PAHO) and World Health Organization (WHO). We also used information gathered from semi-structured interviews conducted in 2019 with 14 key informants who were involved in health policy during the study period.

The study was approved by the responsible institution's ethics committee.

## Results

### Configuration of the health system: organizational and regulatory model

Chile is an economically stable developing country with approximately 19 million inhabitants. The country is a unitary democratic state with a functionally independent, decentralized territorial administration divided into 15 regions, 54 provinces and 346 communes.

Despite historic social inequality, a reduction in poverty rates was witnessed between 2013 and 2017[11], related to a rise in income and the expansion of social policies targeting vulnerable groups.

The country has seen gains in life expectancy since 1970, with a corresponding increase in the elderly population (12% of the overall population in 2018), and has shown good performance on economic, social and health indicators in comparison with the rest of Latin America (Table 1).

The health care system consists of a mix of public-private funding and service provision. The system's institutional framework and structure were developed during the reform implemented by the military government at the end of the 1970s. The public subsystem comprises the National Health Services System (SNSS), composed of the Ministry of Health and dependent bodies such as FONASA, which is responsible for public insurance and administering public health funding. The private subsystem is made up of "ISAPREs" (*Instituciones de Salud Previsional*), which are private health companies responsible for insurance and service delivery.

After the reconfiguration of the health system, the main features of the funding, service delivery and care model were established. Workers opt to join FONASA or an ISAPRE by paying compulsory contributions equivalent to 7% of their salary. However, depending on subscriber income and the subsystem, "copayments" are also be made.

The number of FONASA subscribers increased since its creation, standing at 78.0% of the population in 2017[17]. Subscribers are divided has into four groups, according to socioeconomic status, and two care schemes[18]. Group A consists of service users not employed in the formal labor market who are unable to pay contributions and enrolled in the institutional care scheme (MAI), under which medical care is provided by public services free of charge. Subscribers in groups B, C and D may opt either for the MAI or the "free choice" scheme (MLE), which allows them to choose private subsystem health professionals and services by making copayments (Chart 1).

Covering 14.4% of the population in 2017, the private subsystem is made up of 12 ISAPREs subdivided into six open ISAPREs (Golden Cross Commune, Cruz Blanca, Vida Tres, Nueva Masvida, Banmédica and Consalud), which are accessible to the general public, and six closed ISAPREs (San Lorenzo, Fusat, Chuquicamata, Río Blanco, Fundación and Cruz del Norte), which can only be used by specific groups of workers or companies[18]. The ISAPREs have three care schemes: free choice plan, closed plan (which is the most affordable) and preferred provider plan (Chart 1). Most ISAPRE subscribers (69%) belong to the group with a monthly income equal to or greater than US$ 1,100, live in Chile's metropolitan region (59.3%) and are male (634%) and aged under 40 years (47.4%)[19].

With regard to the coordination and management of the system, in 2005 the Health Authority and Management Act reorganized the functions of the Ministry of Health and related institutions (Chart 1) with the aim of promoting institutional strengthening and broadening the body's roles and responsibilities[20]. In addition, the Act created

**Table 1.** Selected key indicators (Chile and average for Latin America, 2016, 2020).

| Indicators | Chile | Latin America |
|---|---|---|
| Total population (millions) (2019) | 18,952,000 | 640,463,000 |
| GDP per capita (US$) (2018) | 22,874 | 14,428[a] |
| Annual growth GDP (2018) | 4.0 % | 1.4% |
| Gini coefficient (2018) | 0.45 | 0.46 |
| Life expectancy at birth (Total) (2019) | 80.2 | 75.6 |
| Men | 77.8 | 72.5 |
| Women | 82.4 | 78.8 |
| Proportion of population ≥ 65 years (2019) | 12% | 9% |
| Average schooling (Total) | 10.3 (2015) | 8.6 (2016) |
| Men | 10.5 | 8.5 |
| Women | 10.2 | 8.6 |
| Hospital deliveries (%) (2017) | 99.6% | 92.4% |
| Reported maternal mortality rate notified/100 000 live births (2017) | 17.3 | 69.3 |
| Reported infant mortality rate/1000 live births (2017) | 7.1 | 14.8 |
| Reported neonatal mortality rate/1000 live births (2017) | 5.5 | 9.3 |
| Prostate cancer mortality rateb (100,000 inhabitants) (2016) | 24.2 | 20.4 |
| Breast cancer mortality rateb (100,000 inhabitants) (2016) | 13.4 | 14.3 |
| Stroke mortality rateb (100,000 inhabitants) (2016) | 37.3 | 43.4 |
| Ischemic heart disease mortality rateb (100,000 inhabitants) (2016) | 48.4 | 87.8 |

Source: OPS, 2019[15]; OECD, 2019[16].

[a] Including the Caribbean.
[b] Age-adjusted.

the Under Secretariat of Care Networks and Under Secretariat of Public Health.

At regional level, oversight and regulation activities and service delivery are divided (coordinated by Regional Ministerial Departments and Health Services, respectively) and services are organized into care networks. At local level (in the communes), primary health care (PHC) facilities are run by Health Departments following guidelines produced by the Under Secretariat of Care Networks.

The Health Superintendence is responsible for regulating and overseeing public and private care providers. Its role includes the accreditation and certification of health facilities, definition of conditions covered by provider payments and ensuring compliance with the legislation on the rights and duties of users[21] (Chart 1).

In 2005, in the midst of the health reform, the Health Superintendence replaced the ISAPREs Superintendence, becoming responsible for regulating and overseeing both FONASA and the ISAPREs, ensuring compliance with Explicit Health Guarantees (GES). A key element of the reform, the latter aim to ensure that the public and private systems provide health care for a pre-defined list of priority health problems.

However, problems remain in relation to the regulation of the private subsystem, particularly with regard to care plan price control. In 2010, Chile's Constitutional Court declared that the article providing that the Health Superintendence shall be responsible for determining risk factors by sex and age group is unconstitutional[22]. The decision was based on a "lack of rationality" in the distinctions between age groups and sexes and the fact that the provision violated the right to health protection and social security.

### Public-private relations in funding

Health system funding comes from various direct and indirect sources, including: general and specific taxes, budgetary resources, compulsory and voluntary contributions, and copayments (Table 2)

Health spending as a share of GDP rose between 2000 and 2018, with public expenditure surpassing private expenditure in the period[20]. However, despite this increase, combined public and private health spending per capita is one of the lowest in the OECD, exceeding only Mexico and Turkey, and Chile is one of the lowest-ranked

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**Chart 1.** Political and institutional framework organizational aspects of Chile's health system, 2020.

| Dimensions | Description |
|---|---|
| Political and administrative framework | Unitary state -15 regions, 54 provinces and 346 communes |
| Constitutional health framework | 1980 – Constitution of the Republic - Article 19 No. 9, Duty of the State is to guarantee the execution of health actions, provided by public or private institutions. Possibility of mandatory contributions and citizen's right to subscribe to either the public or private system. |
| Social protection model and health system structure | Mixed model<br><br>Public<br>Care – partial coverage for the poor and people without access to social security. FONASA A<br>Social security– partial coverage for contributing workers and beneficiaries; copayments. FONASAB, C and D<br><br>Private<br>Social security– partial coverage for contributing workers and beneficiaries; voluntary additional payments and copayments. |
| Coverage (2017) | FONASA– 78% of the population (13,926,475 subscribers)<br>A –23.71%; B – 33.00%; C – 19.05%; D – 24.21%<br><br>ISAPREs– 14.4% of the population(1,628,152 subscribers)<br>12 ISAPREs:<br>Open – 97.1 %<br>Closed – 2.2%<br>Other – 7.6%<br>Armed forces and law enforcement – 2.8%<br>Private – 2.8%<br>Not informed– 2.0% |

it continues

countries when it comes to public spending per capita[16] (Figure 1).

With regard to FONASA, in 2018, funding of health spending came predominantly from general taxes (73%) and compulsory contributions (27%). The proportion of public spending derived from general taxes increased over recent years, from 42% in 2005 to 57% in 2010 and 59% in 2015. The restructuring of public expenditure enabled an increase in spending in the social and health spheres, leading to an increase in the share of spending on these areas within the government budget.

Funding of health spending in the ISAPREs came from compulsory contributions (72%) and additional voluntary payments (28%)[23]. Nine of the 12 ISAPREs showed a profit between 2012 and 2018.

Copayments for health care and medications made up a significant share of private spending on family health. Despite dropping from 42.8% in 2000 to 35.1 % in 2018, direct expenditure by households (out-of-pocket spending) in Chile was greater than the average of OECD member countries, behind only Mexico[16].

The payment of public primary care providers under the institutional care scheme is predominantly per capita, based on the number subscribers registered in health centers, followed by payment per service[17]. With regard to secondary and tertiary care, service payments are combined with future projections based on the history of care delivery in hospitals. Under the free choice scheme (both FONASA and ISAPREs), service payments are made on a post-delivery basis (Table 2).

Finally, public funding as a share of overall spending in the private free choice scheme and GES increased from 3.82% in 2012 to 3.92% in 2017, peaking at 4.12% in 2016[27].

**Chart 1.** Political and institutional framework organizational aspects of Chile's health system, 2020.

| Dimensions | Description |
|---|---|
| Care schemes | FONASA– Unified plan with package of services with two schemes.<br>Institutional care scheme (MAI) – service delivery in public facilities and PHC centers.<br>Free care – Groups A and B and over 60s<br>90% coverage – Group C<br>80% coverage – Group D<br><br>Free choice scheme – Groups B, C and D – voucher payments in public or private facilities. Lower coverage and larger copayment.<br><br>ISAPRES– different care models, bonuses, coverage and providers under the following schemes:<br><br>Free choice plan –subscriber chooses in the market and make copayments according to agreed coverage.<br><br>Closed plan – subscriber may only use certain services.<br><br>Preferred provider plan –subscriber receives services provided by the preferred provider (lower copayment) or provider of choice (larger copayment). |
| Health system structure and organization | National:<br><br>Ministry of Health: regulatory aspects and national coordination.<br><br>Under Secretariat of Care Networks: regulation and development of care network and regulation of health services.<br><br>Under Secretariat of Public Health: regulation, surveillance and oversight of health promotion, prevention and disease control<br><br>Health Superintendence: regulation and oversight of insurance and public and private providers, preservation of rights, promotion of care quality and safety.<br>Public Health Institute: laboratory assessment, disease surveillance, control of medications, cosmetics and medical devices, mental health, occupational health, vaccine production and quality control.<br><br>Regional:<br>Regional Ministerial Health Departments: compliance with standards, plans and national policies, tailoring them to the regional reality.<br><br>Regional Health Services: coordination, management and development of the care network to execute protection, recovery, rehabilitation and palliative care actions.<br><br>Local:<br>Local Health Departments: PHC service provision; administration of health centers in communes. |
| Regulation and control of the private subsystem | *Health Superintendence:*<br>*- Oversight and control of ISPAREs, FONASA and Explicit Health Guarantees scheme (GES).* |

Source: Authors' elaboration from various sources.

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**Chart 2.** Main features of health funding in Chile, 2018.

| Dimensions | Description |
|---|---|
| Selected spending indicators | Health spending as share of GDP: 8.9%<br>Public spending as share of health spending: 58.3%<br>Out-of-pocket payments as a share of health spending: 35.1%<br>Health spending by ISAPREs funded by FONASAa: 3.9% (2017) |
| Funding sources | **Public**<br>General budget (taxes).<br>Resources from the health and defense ministries.<br>Local government resources (PHC).<br>Companies' and workers' compulsory social security contributions – (7% of salary).<br><br>**Private**<br>Out-of-pocket payments: medical care copayments, medicines and private consultations.<br>Companies' and workers' compulsory social security contributions – (7% of salary).<br>Additional contributions from private insurance . |
| Service provider payment | **FONASA**<br>Public providers - MAI<br>Local PHC – Payment per capita and per service .<br>PHC dependent on Health Services – Payment per service; global budget, future projections based on the history of care delivery and per program.<br>Secondary and tertiary care – Global budget and future projections based on the history of care delivery; payment per service .<br><br>**Private providers – MAI**<br>Secondary and tertiary care: Payment per service; Payment per case<br><br>**Private providers – MLE**<br>Secondary and tertiary care: Payment per service<br><br>**ISAPREs**<br>Primary, secondary and tertiary care: Payment per service |

Source: OECD, 2019[16]; FONASA, 2018[17]; Minsal, 2019[20]; Clínicas de Chile, 2016[24]; Health Superintendence, 2020[25].
a Transfers made from three key programs: purchase of services by FONASA or Regional Health Services; Free choice scheme; GES Bonus Care.

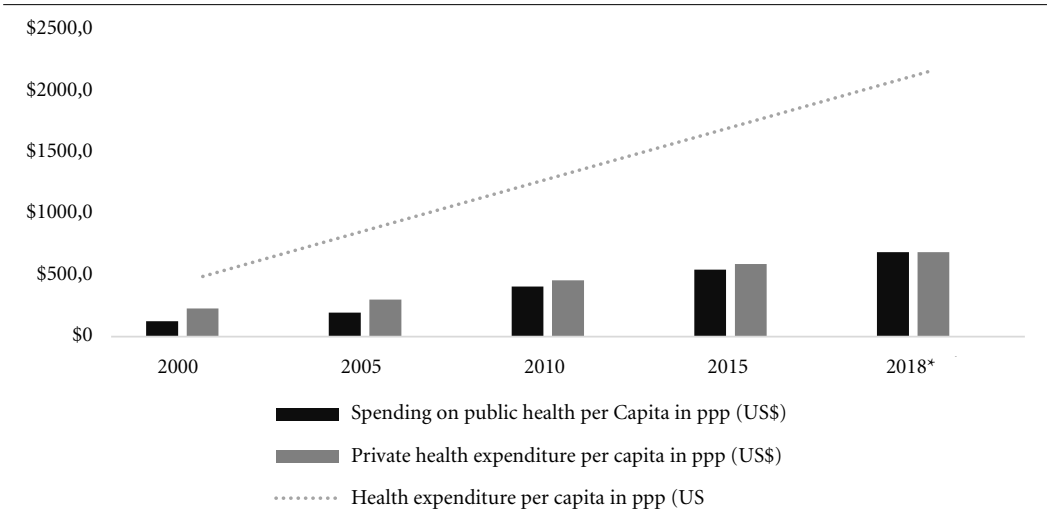
In 2017, the purchase of non-GES services covered mainly critical beds, hemodialysis and emergency services. The purchase of GES services covered cancer services and treatment related to the GES care bonus, a strategy introduced in 2010 that ensures FONASA subscribers treatment for GES priority health problems in private facilities[27].

### Public-private relations in service delivery

Outpatient and specialist services are provided by both public and private facilities. In 2005, the Lagos government introduced a change to the PHC model, through the implementation of the Comprehensive Family and Community Health Care Model. Almost a decade later, in 2014, the Integrated Health Services Network was created.

Public PHC facilities include Community Family Health Centers (CECOSF) (9.1%), Family Health Centers (CESFAM) (19.3%), Urban Health Centers (3.9%), Rural Health Centers (2.9%), Rural Health Clinics (52.7%) and Urgent Primary Care Services (SAPU) (12.1%) (Chart 2). After the reform, the government invested in improving the infrastructure of the public subsystem, building new hospitals and CECOSFs, PHC facilities close to the community that complement CESFAMs.

Private outpatient care and services under the free choice scheme are provided by 2,344 health facilities divided into Medical Centers (31.8%),




**Graph 1.** Evolution of total health spending and composition of public and private spending between 2000 and 2018.

Source: WHO, 202026.

* Data on public and private spending and out-of-pocket payments from 2017.

Dialysis Centers (0.7%), Surgical Clinics (9.2%), Laboratories (37.4%) and Image Centers (20.9%) (Chart 2).

Public tertiary care is operated by regional Health Services, which are responsible for coordinating, managing and developing the Care Network. Health Services coordinating offices are responsible for network integration[28]. FONASA hospitals include *Therapy and Diagnostic Centers* (CDT), Mental Health Centers (COSAM) and Health Referral Centers (CRS). Appointments are scheduled in response to PHC referrals.

Although Chile has increased the number of doctors, the doctor-population ratio is below the average in developed countries. In 2018, there were 2.6 doctors per 1,000 inhabitants, which is below the average for OECD member countries (3.4 in 2017). The number of doctor consultations per person increased from 2.4 to 3.6 between 2000 and 2016.

Over half (54.6%) of the county's hospitals (low, medium and high complexity care) are public and 23.9% are private. Mutual aid societies and institutional facilities account for 3.2% and 4.6% of hospitals, respectively. Beds are mainly public (68% of total beds). The private subsystem is responsible for 32% of the country's hospital beds (18% in private clinics, 9% in institutional facilities and 5% in other facilities). There was a slight reduction in the number of beds during the study period, more specifically psychiatric beds, which were cut by half in response to the mental health reform initiated in the 1990s. Average length of stay in hospitals rose from 5.8 to 6.0 days between 2000 and 2017.

With regard to diagnosis and treatment support, there was an increase in MRI and CT scan rates between 2011 and 2017 (from 4.1 to 12.3 per million inhabitants and 10.2 to 24.3 per million inhabitants, respectively).

Chart 2 summarizes the main features of service delivery in the health system.

## Discussion

This analysis of public-private relations in Chile's health care system reveals a persistent structural segmentation of the health system. The contradictions of the market-oriented model pose three major challenges for the health system.

The first challenge relates to health system organization and regulation. Mechanisms have not been developed to reduce the selection of risks among public and private scheme subscribers, especially those related to age and sex[11]. There

**Chart 3.** Main features of service delivery in Chile's health system between 2000 and 2018.

| Components | Description |
|---|---|
| PHC, outpatient and secondary care | Regional Comprehensive Family and Community Health Care Model with registration of users in PHC centers.<br>Team: Doctor, nurse, matron, social worker, admin assistant, community health worker.<br>Employment and remuneration: civil servants (majority) and temporary contracts; salary + performance payments (specific programs).<br>Secondary care: referral from PHC centers with interconsultation document; medical consultations; procedures; examinations; medicines and surgeries without hospitalization.<br><br>Outpatient care (2016)<br>Public<br>Total: 2,238<br>Community Family Health Center – 9.1%<br>CESFAM – 19.3%<br>Urban Health Centers – 3.9%<br>Rural Health Centers – 2.9%<br>Rural Health Clinics – 52.7%<br>SAPU – 12.1%<br><br>Secondary care<br>Public<br>Total: 109<br>Health Referral Center (CRS) – 9.2%<br>Therapy and Diagnostic Centers (CDT) – 13.8%<br>Mental Health Centers (COSAM) – 77.0%<br><br>Outpatient and secondary care<br>Private (free choice scheme)<br>Total: 2 344<br>Medical Centers – 31.8%<br>Dialysis Centers – 0.7%<br>Surgical Clinics – 9.2%<br>Laboratories – 37.4%<br>Image Centers – 20.9% |
| Hospitals (2016) | Facilities: 348<br><br>Public – 54.9% (low complexity-101; medium complexity-24; high complexity-63).<br>Private – 23.9%<br>Mutual Aid Societies – 3.2%<br>Psychiatric, geriatrics, recovery – 10.9%<br>Institutional (Armed forces, university students) – 4.6%<br>Outros – 2.5%<br><br>Beds/1000 pop. (2017): 2.1<br>Beds: 38,362<br>Public – 68%<br>Private – 18%<br>Mutual – 2%<br>Psychiatric and geriatric clinics – 3%<br>Institutional (Armed forces, university students) – 9% |

Source: OECD, 2019[16] FONASA, 2018[17]; Clínicas de Chile, 2016[24].

was no regulation, oversight or control of the operations of the private subsystem during the period between the creation of the ISAPREs and resumption of democracy. The ISAPREs were therefore allowed to classify and select the risks covered without government intervention for a period of approximately 10 years[29].

Under the private subsystem, payments other than compulsory contributions are made depending on coverage and plan type. Service coverage is intimately linked to the subscriber's or family group's ability to pay, as it is possible to reject subscriptions based on risk selection mechanisms that take into account socioeconomic status and family background[30]. In turn, FONASA A and B cover more than 50% of the most vulnerable and poorest segments of the population.

Although organizational changes have been made, such as the restructuring and separation of the functions of the Ministry of Health and subordinate bodies and broadening of the oversight and regulation role of the Health Superintendence, public and private subsystems still lack organizational mechanisms to ameliorate distortions in the social security system. The regulatory mechanisms created after the Lagos government reform did not address the problem and the following issues persist: pre-existing condition limitations, periodical increases in premiums, variations in copayments and benefits (for changing plans), risk-adjusted premiums etc[31]. Maintaining this type of organization may lead to restrictions in the public subsystem due to increased spending and funding shortfalls.

The second challenge refers to the funding model. Compulsory contributions allocated to FONASA are insufficient. Funds raised from general taxes grew steadily over the study period, accounting for 70% of funding in 2018. In turn, 75% of the ISAPREs have made a profit in recent years. Despite questions regarding compulsory contributions allocated to the private subsystem and legislative changes, broader changes to the structure of the structure of the health system has not achieved a broader change[32].

Despite a progressive increase in health spending over the study period, public spending on health per capita and as a share of overall health expenditure remains one of the lowest in the OECD[16]. Public spending as a share of GDP (4.8% in 2016) remained below the minimum level of 6% recommended by the WHO for developing countries in the Americas[33].

The persistence of this model has had negative consequences, including inequalities in access, coverage, care quality and funding. Despite an increase in public spending on health in recent years, public expenditure accounts for only 50% of overall health spending, despite the fact that the public system covers 78% of the population[30].

Out-of-pocket spending on health care in Chile (consisting mainly of purchases of medicines and copayments) was high (31.1% in 2016) in comparison to the average in the OECD and Latin America[34,15]. Funding shortfalls in the face of catastrophic health expenditures reveal an unequal and unfair system, especially for the most vulnerable segments of the population[30].

Care delivery is the third challenge faced by Chile's health system. Advances have been made in ensuring access to medical care, with the implementation of the Comprehensive Family and Community Health Care Model and integration of network-based health services. However, despite being strategies designed to guide care in the public health subsystem, there is a lack of integration with the private subsystem[28]. With regard to hospital care, most of the country's beds are in the public subsystem, forming a solid public structure, and diagnosis and treatment support services have been expanded, despite depending on the purchase of private services.

Another important step forward is the progressive increase in the number of GES priority health problems between 2005 and 2013. However, the allocation of compulsory contributions to FONASA and the ISAPREs has not been adjusted, meaning that resource distribution remains unequal[35]. On the contrary, in compliance with the legislation, the public sector needed to purchase services provided under the guarantees scheme, consisting mainly of cancer services and treatment related to the GES care bonus, a strategy created to reduce GES waiting lists[27].

The implementation of this scheme established a new type of fragmentation of care that favors curative medicine and reinforced the segmentation of the system, as service users who have GES priority health problems are legally guaranteed care while those who do not are not[36].

## Conclusion

Chile is a paradigmatic case of prioritizing health markets through public-private relations in regulation, funding and service delivery that reinforce segmentation between population groups.

It is worth highlighting that at the beginning of 2020, amid a political and institutional crisis

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stemming from widespread protests held in October 2019, the Chilean government tabled a proposal for the universal coverage of public health services with a predefined package of benefits[37]. Encouraged by international agencies focused on middle and low-income countries, the proposal emphasizes the subsidizing role of the state and strengthening relations with the market[38].

Apart from failing to address the problems arising from the lack of coordination between FONASA and ISAPREs, this proposal could perpetuate discrimination against people at greater risk and accentuate health inequities. It is up to the government and legislative branch to discuss a proposal for structural reform that reconfigures public-private relations, introduces mechanisms of solidarity between the subsystems, and reduces segmentation (of both coverage and funding) and fragmentation between different levels of care.

This reflection on the Chilean experience is important for understanding the effects of segmented arrangements with strong involvement of the private sector in unequal countries like those in Latin America. Comparative studies of health systems in the region focusing on different models of state intervention and public-private relations are needed to inform the development of effective and equitable health systems that contribute to the expansion of rights and reduction of social inequalities.

## Collaborations

SC Oliveira was responsible for study conception, the fieldwork and literature review, and writing the article and approving the final version to be published. CV Machado and PF Almeida contributed to study conception, writing the article, revising it critically for important intellectual content and approving the final version to be published. ARA Hein contributed to revising the article critically for important intellectual content and approving the final version to be published.

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