Health system privatization, the pandemic and deprivatization under discussion

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Abstract

This article analyses the privatization processes that have been implemented in the health systems of Argentina, Brazil, Chile and Colombia. It describes and characterizes the participation of the public and private components of each of these systems, and analyses the politics of the public policies involved in these privatization processes. The results reveal the presence of multiple public-private relationships that adopted different forms over time. The article also analyses some of the responses provided and the challenges faced by the health systems during the coronavirus disease (COVID-19) pandemic, along with the role played by private entities in particular. This analysis aims to examine the trajectories of the studied policies and to identify their limitations as well as potentialities for reversing privatization processes.

Keywords

Health, privatization, health services, health policy, laws and regulations, right to health, public sector, private sector, pandemics, Argentina, Brazil, Chile, Colombia

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I. Introduction[1]

The public-private relationship is central to the analysis of public health policies, and public policies are considered to have played a crucial role in expanding the market for health plans and insurance. Nonetheless, market dynamics are seen as imposing a clear constraint on the application of universal public health policies.

Against this backdrop, this paper studies health system privatization processes in four Latin American countries: Argentina, Brazil, Chile and Colombia. It identifies and analyses the national contexts, especially the political scenarios in which government policies were formulated and implemented, which promoted or limited the expansion of the market for private plans and insurance in health systems. Privatization is understood as a process that expands the participation of entities that sell health and insurance plans. Consequently, the public sector retreats, as its regulatory capacity is reduced and government spending declines. However, as noted by Paul Starr (1988), increased public spending may generate privatization processes, contrary to expectations. Drawing on the approach of that author, who sees privatization as describing a direction of change rather than a specific origin or destination, the present article attempts to analyse the trend of policies, in order to determine how the public-private relationship has evolved in the selected countries' health systems.

The proposal consists in comparing the political dimension of the policies, with the aim of facilitating a more comprehensive understanding of the privatization processes in the region, and potentially leading to explanations that will identify the causes of the singularities and common features of the processes studied.

This study is based on a review of literature on the four countries' health systems, considering the period spanning 1980–2016.[2] The outbreak of the coronavirus disease (COVID-19) pandemic, in March 2020, made it necessary to include, within the framework of the approach used in this study, a section that analyses some of the responses that the health systems provided to confront the health emergency. This analysis revealed that in 1980, entities selling health and insurance plans were well established in the four countries (Bahia, 1999; Tetelboin, 2013; Belmartino and Bloch, 1993). At the same time, policies were implemented that aimed to reverse or slow down the expansion of this sector, such as the Unified Health System (SUS) in the specific case of Brazil. In 2016, serious attempts were made to introduce reforms, of varying structural intensity, promoting privatization processes. These reforms were implemented either explicitly, targeted to the health sector by the government, or else implicitly, through indirect measures that stimulated market expansion. The former category is exemplified by the reforms introduced in the following countries: Argentina, where Universal Health Coverage (CUS) was approved in 2016 through Decree No. 908/2016 (although this was never implemented because of the change of government); Chile, where the creation of the FONASA Plus national health fund was proposed and disseminated as a national plan to enable the public sector to compete more effectively with health insurance institutions (ISAPREs); and Brazil, where, among other measures, the Popular Health Insurance Project was implemented as a strategy to reduce spending in the sector and increase individual participation in financing (Bahia and others, 2016). These measures were never implemented, despite strong impetus from government circles and various private entities. In the case of measures in the second category, referred to as indirect, these reflect the general underfunding of the public sector, the lack of control or compliance with existing regulations governing increases in the premiums of health plans and insurance, and the subsidies and tax benefits granted to the firms, among other issues affecting the sector.

[1] This article presents the results of the author's doctoral thesis, titled "Los procesos de privatización de los servicios de salud en cuatro países de América Latina: Argentina, Brasil, Chile y Colombia. Semejanzas y singularidades en los recorridos y los resultados" (Luzuriaga, 2016).

[2] The time limit was defined so as to comply with the completion date of the doctoral thesis.

This article consists of five sections, the first being the introduction, which describes the importance of the topic and the organization of the study. Section II presents the main theoretical references and the theoretical-methodological approach proposed for studying the public policies that drove the health system privatization processes. This section also explains the methodological choices made in the selection of cases and policies, the dimensions of analysis and the data sources used. Section III reports the main findings in terms of the features of the selected public policies that stimulated or constrained the health system privatization processes. The different cases are then compared to provide a more comprehensive analysis of the privatization process in the region. Section IV describes the main responses of the health systems, focusing specially on the role played by entities selling health plans and insurance, and on the government actions that targeted this subsector during the pandemic. Lastly, section V offers provisional thoughts on the opportunities and challenges faced by health systems today in terms of reversing the current privatization processes.

II. Theoretical and methodological considerations

1. Case selection

Argentina, Brazil, Chile and Colombia were chosen for the study because each one displays key characteristics for analysis, spanning greater private sector participation, a mixed system, and one in which the public sector is more important. Moreover, in the four countries analysed, some of the organizations that participate in the market for health plans and insurance are among the leading firms in the country and have maintained this position during the period analysed. A recent study by Goyenechea and Ruiz (2020) reveals the growing participation by multinationals in Latin American health systems and warns that their involvement in different countries has affected the capacity of the systems to provide a public response.

Another criterion considered when selecting the countries was the uniqueness of each one during the health reform processes implemented in the 1980s and 1990s. In Chile, a pro-market health reform was implemented that was considered pioneering; but it had consequences, in terms of systemic inequities, that persist to this day. Ten years later, a privatizing reform was introduced in Colombia that attempted to avoid the adverse effects observed in the Chilean reform; but this objective was not achieved. Brazil has one of the largest markets for private health plans and insurance; but it is also one of the few countries in the region to have implemented a universal health system. Lastly, Argentina is positioned between the foregoing cases. Although a pro-market structural reform was proposed in the 1990s, its content was amended in response to fierce resistance from the trade union movement. Nonetheless, since the late 1990s, prepaid medicine firms have expanded their presence in the health system, with various interruptions as discussed in Section III.

2. Analysis of the political dimension of the policies to understand health-care privatization

The theoretical framework mainly involves a comparative analysis of the health system privatization processes, starting by identifying the scenarios that made them possible, the actors involved, and the situations that either hindered or stimulated them.

A central aim was to understand the ways in which public and private elements were involved in the four countries' health systems. Several authors have stressed the importance of studying privatization processes in contemporary health systems, placing more emphasis on measuring the practical effects

of these processes on systemic performance, such as expanding access and enhancing the quality of the services provided (Maarse, 2006; Saltman, 2003; Mackintosh and others 2016; Alkhamis, 2017; André, Batifoulier and Jansen-Ferreira, 2016; Vargas Bustamante and Méndez, 2014). It is also generally accepted that designating a given health system configuration as predominantly public or private has become highly ambiguous, since in this classification the ideological component has been imposed on an analysis based on conceptual developments and systematic empirical data (Starr, 1988; Maarse, 2006; Saltman, 2003; Sestelo, 2012). In terms of recommendations for future research, the aforementioned studies highlight key issues such as: the need to define what is understood by public and private, the cases in which a privatization process can be identified and the frames of reference that are most effective for identifying the multiple and dynamic boundaries between public and private.

To this end, the article considers a number of studies applied to public policies, and to the health sphere in particular. The central focus was on the political dimension of public policies, as conceived by Theodore Marmor in *The Politics of Medicare* (2000), which centred on understanding the political process unleashed during the Medicare programme, using a variety of approaches and theoretical strategies.

In that work, the author set out to revisit the major debates that took place, beginning with the process of drafting the Medicare programme through to its implementation. The aim was to understand the key changes that were made to the content of this health policy, the main achievements, the conditions under which it was possible to maintain the central contents until approval, the intensity of the debates that were generated by it, the interest of the major pressure groups involved, and the speed and effectiveness with which the programme was implemented. The most salient issues include the key political actors and the interests and values at stake that have turned the Medicare programme into one of the central policies of United States politics for three decades.

Accordingly, the focus was placed on the political dimension of the policies studied, and, in the case of the Medicare programme, the author defined units of analysis according to their stage of policy development. These units included: government actions; the organizational behaviour of the major groups involved; bargaining strategies, both of the groups and of individual actors; and bureaucratic cycles. In all cases, an attempt was made to identify the constraints and opportunities that impinged on the progress of the policy.

In keeping with the proposal of this study, the political dimension of the public policies involved in the health service privatization processes was analysed on the basis of five analytical moments, which, depending on the specific dynamics of each of the policies analysed, were not necessarily separated in time. The first moment is the context, which refers to the sociopolitical and economic situation in which the policy under study began to be formulated. The second moment is the origin of the policy, in which the objectives and foundations of the policy are analysed, as well as the reasons why it was tackled ahead of other competing projects. In the third moment, which concerns the development of the policy itself, the focus is on the organizations that participated in the debate, the negotiation processes, the sequence of proposals presented and the alternatives to the main project. In the fourth moment, implementation, the analysis focuses on the more bureaucratic dimension and on identifying the factors that enabled or hindered implementation of the policy. Lastly, in the fifth moment, the aim is to take stock of the results achieved, by evaluating the distance between the initial proposal, the sanctioned policy and the results achieved.

3. Selection of the public policies and sources used

In each of the cases studied, the policies were selected for their impact on the reconfiguration of the public-private relationship in the health system, whether in terms of financing, service provision, management or investment (Maarse, 2006).

Another selection criterion was the relevance and depth of the debates on health system privatization processes that were triggered during the formulation and implementation of the respective policies.

The sample comprised a total of 13 public policies, which were analysed according to the dimensions described above. It is important to clarify that the selected policies included two cases related to judicial decisions: the ruling handed down in 2010 by the Constitutional Court of Chile against the Table of Risk Factors; and Decision No. T-760 of the Constitutional Court of Colombia, issued in 2008. While neither of these rulings is public policy per se, they have generated intense political debates on structural aspects of health systems, involving a wide range of social actors. Moreover, the rulings were used as a basis for developing health reform projects in both countries. For these reasons, and because it was possible to analyse them using the theoretical and methodological approach being proposed, the rulings in question were included in the study. Tables 1, 2, 3 and 4 below present the policies analysed in this study.

Table 1
Argentina: policies selected to study the health system privatization process, 1990–2016

Year	Public policy	Stages	Social actors and institutions
1993–1997/1998	Decree No. 9/1993, which provides that the beneficiaries of union-based health-care schemes (*obras sociales*) regulated by Laws Nos. 23660 and 23661 shall be entitled to change their social welfare fund.	Context Origin Development Implementation Results	Ministry of Economy World Bank General Confederation of Labour (CGT) Ministry of Health and Social Action Latin American Economic Research Foundation (FIEL) Novum Millenium Foundation
2011	Act No. 26682, which establishes the regulatory framework governing prepaid medicine firms.	Context Origin Development Implementation Results	Undersecretariat of Consumer Protection Consumers and Users Association of Argentina (ACUDA) Medical Confederation of the Argentine Republic (COMRA) Argentine Confederation of Private Clinics, Sanatoria and Hospitals (CONFECLISA) Civil Association of Integrated Medical Activities (ACAMI) Chamber of Health-care Institutions of the Argentine Republic (CIMARA) Association of Private Medicine Institutions (ADEMP) Superintendency of Health Services)

Source: Prepared by the author.

Table 2
Brazil: policies selected to study the health system privatization process, 1980–2016

Year	Public policy	Stages	Social actors and institutions
1990	Act No. 8080 creating the Unified Health System (SUS).	Context Origin Development Implementation Results	Social movements Left-wing political parties Preventive medicine departments Medical movements (Brazilian Medical Association, National Academy of Medicine, etc.) Student movements Universities Health movement Municipal mayors (*Prefeitos*) Progressive parliamentarians Chambers of commerce Representatives of private hospitals and clinics Economic bureaucracy
1998	Act No. 9656 regulating private health plans and insurance.	Context Origin Development Implementation Results	Superintendency of Private Insurance (SUSEP) Brazilian Association of Group Medicine (ABRAMGE) Consumer advocacy organizations Legislative branch Ministry of Health Ministry of Economy National Association of Private Hospitals (ANAHP) Brazilian Medical Association Unions
2015	Act No. 13097, which permits direct or indirect participation by foreign firms or capital in health-care activities.	Context Origin Development Implementation Results	ANAHP Antares Consulting Chamber of Deputies

Source: Prepared by the author.

Table 3
Chile: policies selected to study the health system privatization process, 1980–2016

Year	Public policy	Stages	Social actors and institutions
1980	Political Constitution of the Republic of Chile, Decree with Force of Act No. 3 of 1981, and regulations that amend or complement it. Creation of health insurance institutions (ISAPREs).	Context Origin Development Implementation Results	Ministry of Economy Undersecretariat of Planning and Cooperation Commission for the Study of the New Political Constitution of the Republic of Chile (Ortúzar Commission) Social Security Bureaucracy Chicago Boys Medical Association Doctors Union
1986–2002	Act No. 18566 related to the 2% subsidy granted to ISAPREs.	Context Origin Development Implementation Results	Executive Branch Association of Chilean Insurance Firms (AICH)
2004	Act No. 19966 and regulations that amend or complement it. Universal Access to Explicit Guarantees Plan (Plan AUGE-GES) or Reform of the Reform.	Context Origin Development Implementation Results	Ministry of Health Ministry of Finance Legislative Branch National Health Fund (FONASA) Trade Unions Medical Associations AICH Clinicas de Chile A.G.
2010	Constitutional Court Ruling No. 1710-INC, against the table of risk factors (Art. 38 ter of Act No. 18933).	Context Origin Development Implementation Results	Judiciary
2014–2015	Ministry of Health Decree No. 71 of 2014. Creation of the Presidential Advisory Commission for the Study and proposal of a new model and legal framework for the private health system.	Context Origin Development Implementation Results	Presidential Advisory Commission composed of representatives and experts from the different health sectors.

Source: Prepared by the author.

Table 4
Colombia: policies selected to study the health system privatization process, 1990–2016

Year	Public policy	Stages	Social actors and institutions
1993	Act No. 100, which created the General Social Security Health System.	Context Origin Development Implementation Results	World Bank World Health Organization (WHO) Colombian Medical Union Association (ASMEDAS) Colombian Medical Association Colombian Medical Federation Unified Workers Confederation of Colombia (CUT) Unión Patriótica Academic groups National School of Public Health of the University of Antioquia Foundation for Higher Education and Development Seventh Commission of the Senate: responsible for social security Colombian Association of Medical Schools (ASCOFAME) National Trade Union National Association of Workers and Public Servants of Health, Comprehensive Social Security and Complementary Services of Colombia (ANTHOC) National Association of Nurses of Colombia (ANEC)
2008	Ruling No. T-760, ordering the government to make structural reforms to guarantee compliance with the right to health.	Context Origin Development Implementation Results	Constitutional Court People's Health Movement (PHM) Office of the Ombudsperson
2015	Statutory Act No. 1751, which aims to guarantee the fundamental right to health, regulate it and establish its protection mechanisms.	Context Origin Development Implementation Results	Constitutional Court Executive Branch National Medical Board National Board on the Right to Health

Source: Prepared by the author.

In the cases analysed, the study considered the academic output of the main references on the subject in each of the countries. The primary sources used were official documents (administrative records of the various State institutions tasked with supervising and overseeing the entities that sell health plans and insurance); specific legislation related to each of the policies; news on the selected policies published in the main national commercial newspapers; specific sectoral output of organizations selling health plans and insurance; institutional briefings, transcripts of debates in legislative commissions or parliamentary sessions related to the policies studied; presidential platforms and messages, and also policy announcements; business and economic journals and specialized publications on the entities that sell health plans and insurance.

III. Results

As indicated at the start of this article, the aim of the study was to provide theoretical and empirical elements to gain a more secure understanding of the extent to which it is feasible to envisage limiting or rolling back the health system privatization processes. Accordingly, an attempt was made to improve understanding of the factors that prevented universal public health policies from being formulated and becoming established. It is argued that the growing presence of private actors in the health system further undermines the principle of solidarity. Evidence of this includes the increased participation of private actors —health promotion entities, prepaid medicine firms, health insurance institutions and firms that sell health plans and insurance— in the management of social security funds in the countries studied. A private sector logic is thus introduced into the system, based on the individualization of contributions and the segmentation of benefits by ability to pay. This eliminates any possibility of organizing a health system based on the principles of comprehensiveness and universality, targeted to the population's health needs.

In line with the foregoing, studies have been carried out in the region that analyse the irregularities that exist in systems dominated by firms selling private health plans and insurance. In particular, case studies on Chile and Colombia warn of the high degree of judicialization present in the health systems, arising from various types of non-compliance related to denials of access, and restrictions thereon, imposed by private organizations (Rodríguez Garavito, 2012; Yamin and Parra Vera, 2009; Zamora Vergara, 2012; Goyenechea and Sinclaire, 2013; Luzuriaga, 2018). Most of these studies also warn of the weakness of government regulations that are intended to prevent such violations. In both the Chilean and the Colombian systems, numerous policies and projects have been developed to correct problems of access to health care associated with practices of segmentation, exclusion and reduction of benefits, as well as other abusive practices that are common in health systems where there is a major presence of firms and business groups. This diversity of problems generated by private health plans and insurance is largely explained by features inherent to the dynamics of the sector itself, as exemplified by Pollock (2016) in relation to the North American health system:

> […] risk selection and avoidance [undermine] the goal of access and universality. The United States […] denies more than one in five of its population access to health care. Overtreatment and denial of care, catastrophic costs and spiraling health expenditure are the hallmark of United States health care. [...] Markets operate through selection and exclusion, the transfer of risks and costs to service users, and the denial of care to those who need it most.

Several recent studies on the privatization of health systems, both in the countries of the region and elsewhere, highlight the onward march of this process and its impact on increasing inequality in access to health services and the use made of them, and also on the deterioration of the population's health status (Unger and De Paepe, 2019; Rahman, 2020; Turino and others 2021; Milcent and Zbiri, 2022; Bahia, 2022).

The assumptions made in the study include the uniqueness of the different privatization processes and how government policies stimulated expansion of the market for health plans and insurance in the four countries. The main findings that confirm the assumptions made and contribute to the proposed reading of the subject under study are presented below.

1. Constraints on privatization processes

Although a privatization process can be said to have taken place in all of the cases studied, the process has been subject to restrictions. Pursuant to the analytical proposal of Maarse (2006), contextual and political constraints were identified, along with constraints imposed by competing policies (which were brought before the legislature and could therefore be processed and debated in Congress), by sector-specific policies and by resistance from social actors who were able to bring pressure to bear on the decision-making process.

The contextual constraints stemmed from structural problems in the policies of the four countries, such as unemployment, the informal labour market and income levels. Policies that acted as constraints on privatization include political decisions to expand health-care coverage. In this situation, it is worth mentioning the Universal Access to Explicit Guarantees Plan (AUGE-GES Plan),[3] which reveals the complexity of the subject, since it served both as a constraint and as a stimulus to privatization. It acted as a constraint because it curbed the growth of the number of people covered by the health plans sold by ISAPREs; at the same time, it led to an increase in the number of people affiliated to public social security (FONASA). It also stimulated privatization because public funds were transferred to private facilities (which, through the vertical integration process, mostly belonged to ISAPREs), partly to ensure that the guarantees required by the AUGE-GES plan could be met.

Factors that hinder the health system privatization process include greater State control over the financing of social security, the strengthening of the public health insurance system, and greater control over the quality of health services (Okma and others, 2010; Lenz, 2007; Hertel-Fernandez, 2009).

Nonetheless, a number of studies warn that the AUGE plan intensified the privatization trend (Tetelboin, 2013; Goyenechea and Sinclaire, 2013; Parada and others, 2014). These studies mention issues such as the creation of a new inequality between beneficiaries who had pathologies covered by AUGE and those who did not, as well as the introduction of a privatizing logic that allowed private clinics to be contracted in the system when public services could not respond to the demand of those needing care, given the legal requirements of the AUGE Plan. According to Tetelboin (2013), the AUGE plan established a new form of public-private interaction in the health system that led to greater privatization. Similarly, Goyenechea and Sinclaire (2013) note that the process of contracting the private network meant that it received large transfers from the State.

Among the key actors in this process, the judiciary played a fundamental role in setting a limit on privatization policies, especially in Colombia and Chile. In Colombia, the Constitutional Court played a key role in the process of mobilization and social demand in relation to the right to health by various social organizations. It is worth mentioning the importance of Ruling T-760/08, which, based on the compilation of a series of cases involving health-promotion entities' failure to respect this right, ordered the government to implement structural measures to guarantee effective access to the system (Abadía and Oviedo, 2009; Rodríguez Garavito, 2012; Borrero Ramírez, 2014). It also created the Commission for the Follow-up of Ruling T-760 of 2008 and the Structural Reform of the Health and Social Security

[3] The AUGE-GES Plan was one of the central policies of the government of President Lagos (2000–2006); it was initially presented in 2004 as the Explicit Health Guarantees (GES) regime, and came into force in 2005. It defined a minimum set of benefits of mandatory provision by both public and private health-care managers (FONASA and the ISAPREs, respectively). Initially, the plan covered 56 pathologies; today it covers 85. Analyses of the policy suggest that the results had positive aspects; but to gain approval, the government had to make significant concessions that led to key aspects of the original project being altered.

System (CSR). The commission comprised organizations drawn from the academic, political and social sectors; and it played an essential role in the legislative follow-up of the ruling and in designing the reform of the system. This was approved in 2015 through Statute No. 1751. In the case of Chile, Ruling 1710-INC of 2010, handed down by the Constitutional Court, which was initiated ex officio to decide on the constitutionality of Article 38 ter, on risk factors, has been used widely as jurisprudence by both the judiciary and the regulatory body. As in the case of Colombia, it was also one of the foundations of the health system reform proposal formulated in 2014 during the government of Michelle Bachelet.

In both countries, rulings by the Constitutional Court, in the case of Colombia, and the Constitutional Tribunal, in the case of Chile, have forced governments to develop effective policies aimed at establishing greater economic protections and enhanced access for the clients of entities that sell health plans and insurance, as well as tighter restrictions and controls on the activities of the firms in question (Luzuriaga, 2018).

There have also been constraints on privatization associated with policies that competed with those selected in this study. The privatization of the social security system and the labour flexibilization law in Argentina, which took centre stage in the political debate, relegated the project of competition between union-based healthcare schemes to a lower priority. In the midst of the crisis of union legitimacy, De Fazio (2013) highlights the central role that the union leadership played in the sanctioning and application of the laws on labour market flexibilization and social security privatization, and also in limiting the structural reform of the health system which had been proposed by the Ministry of Economy. According to De Fazio (2013, p. 310):

> The defeat in the domain of labour regulation during those years can be understood as payback for the increased funding that the leaderships would obtain to finance their social services. Thus, some unions became shareholders in the privatization of public firms, and in retirement and pension fund administrators (AFJPs), among other benefits, which resulted in this new union strategy being called "business unionism".

It is argued that the temporary coexistence of these policies in the legislative and political debate hampered the government's ability to negotiate with the trade union movement. At the same time, the progressive weakening of the union leaderships, which were further delegitimized after the two aforementioned laws were passed, contributed to the General Confederation of Labour (CGT) adopting a more radical position. Lastly, there is no underestimating the risk that the progress of the reform project, and free competition with prepaid medicine firms, entails for trade unionism in terms of the loss or reduction of control over the funds of union-based health schemes.

The project to totally deregulate union-based health coverage was abandoned, and the reform that was implemented had input from the trade unions. The first general strike by CGT took place when the government attempted to liberalize competition between union-based health schemes and prepaid medicine firms. This resulted in Decree No. 9/1993, which established competition only between the union-based health-care entities themselves (De Fazio, 2013). This type of constraint on the privatization process was not observed in the other countries studied.

2. Incentives to privatization processes

The incentives to privatization include arguments put forward by representatives of the entities selling health plans and insurance, and there are similarities in this regard in the four countries studied. These include the following: the inability of the government to respond to needs in terms of using and accessing health services; the government's failure to serve the entire population; models considered virtuous, such as those of Chile and Colombia; the fear of nationalization; the public sector's incompetent resource management; and the lack of understanding or knowledge about private and public sector

roles among individuals and the government. These arguments are particularly germane to the analysis of the impact of public policies, given the positions of power that private sector actors have occupied through their associations and organizations, and their ability to exert pressure on decision-making bodies regarding sectoral policies.

All countries have legal rules for allocating public funds to the private health sector (to firms and business groups that sell health plans).[4] The regulations in question are expressed in policies that stimulate the supply of and demand for health plans and insurance. Clear examples of this type of policy are the free choice policy in Argentina and the tax deductions and exemptions granted to firms that contract health plans and insurance and to the individuals who buy them in Brazil. In addition, credit lines, loans and subsidies are granted to these firms and business groups in all four countries.

3. Common aspects of the privatization processes

In terms of the general issues that are common to all the cases, the following topics recur in the content of the legislation: regulation of minimum coverage; mechanisms to reduce the various forms of adverse selection (classification, segmentation, risk selection);[5] control of premium hikes; attempt to improve or create registration and information systems that are better adapted to the reality of the sector and to users' demands; and proposals to improve or implement a hospital cost recovery system that would allow for expenses incurred by the public sector to be reimbursed when providing services to affiliates who have private coverage.

The regulations include expressions such as "free choice" or "free option", mainly in relation to the regulatory framework governing firms that sell private health and insurance plans. These expressions need to be questioned, since freedom of choice does not exist as such in any of the cases. In Argentina, not everyone who has a job can choose where to direct their contributions. By contrast, Chile and Colombia have an obligatory component whereby a percentage of the wage is automatically deducted for social security.

The arguments of the entities that sell health plans and insurance are another common feature in the four cases. These arguments include the following: indignation at judicialization; a belief that the role played by the private sector in the health system is misunderstood, both by the public and by the government; emphasis on their own capacity and efficiency, as well as the innovative component that they bring to the system; mention of public institutions' lack of capacity as a basis for their own participation and excessive regulation which makes the activity unviable. Also interesting is these organizations' comment on the right of individuals to have differentiated access if they can pay for it. In one case, they illustrate this with the metaphor of an airliner with different seat classes. They also vehemently dispute the rules that require the extension of mandatory coverage and restrict the possibility of choice on whether to admit persons with chronic diseases. They also denounce rules governing premiums as unconstitutional measures that threaten the freedom of private enterprise and the survival of the sector, stressing that they are demagogic and reflect total ignorance of the sector.

In general, the medical associations have cooperated in policies promoting privatization, specifically the expansion of entities that sell health plans and insurance. A recurring argument has been that these organizations provide an indispensable source of employment. However, there has also been resistance. In Chile, the medical association and the doctors' union mobilized when the AUGE plan was implemented initially, warning of the risks posed by the privatizing elements of the plan. In the

[4] Although the main activity of the firms and business groups studied is the marketing of health plans and insurance, in some cases these entities also participate in other markets, such as hospital management, medical supplies, diagnostics and medical education, among other health-care areas. Some also have interests in other domains, such as the audiovisual sector.

[5] For an analysis of the "adverse selection" category in the health-care market, see Bahia (2018).

case of Colombia, Act No. 100 of 1993 also triggered resistance from the medical associations, which participated actively in the various debates on the statutory law.

Organizations representing private clinics and hospitals participated in the coalitions and in the debates, and they adopted a clear position regarding the policy of promoting technical administrative control by the State.

Labour unions acted by setting a clear limit on privatization measures, as was seen in Argentina and Colombia, and to a lesser extent in Chile. In Brazil, these unions expressed support for entities selling health plans and insurance.

Government agencies also clearly played an important role in the policies analysed. Some have been more active, such as the Undersecretariat for Consumer Protection in Argentina when the law on prepaid medicine firms was formulated. In all cases, government supervisory and oversight bodies were created when the health plan and insurance sector was already well established, and some were created during the regulatory process.

The various institutions tend to naturalize the existence of the market.[6] In all cases, there is fluid circulation between the senior managers of the entities that sell health plans and insurance and those of the institutions that supervise and oversee the sector. This prevents effective control over the former because the roles of supervisor and supervised become blurred. This phenomenon has been called the "revolving door" or "public-private circulation".[7]

A previous study (Luzuriaga, 2018) argued that the increasing trend towards judicialization in the countries studied reveals legislative gaps and limited State capacities to regulate the sector. As noted in that study, which drew on primary and secondary data, a similar profile of complaints is observed, including premium hikes, the denial of certain benefits or coverage restrictions, and the unilateral amendment of contractual conditions.

This phenomenon is not exclusive to the countries studied or to the region, since similar results are obtained from European health systems where private insurance is present, as noted in studies such as André, Batifoulier and Jansen-Ferreira (2016). This provides empirical data to challenge the response of various international agencies that recommend expanding the coverage of private health plans and insurance to improve the conditions for the population to gain access to their benefits.

Considering the legislative branch, the account of the debates does not reveal any polarization. The exception seems to have been the debate on the health chapter of the Brazilian Constitution of 1988. Moreover, the Brazilian judiciary adopted a strong position in favour of the rights of clients of health plans and insurance. In some cases, as in Colombia and Chile, the judiciary played an active role, demanding that the executive branch adopt structural measures to solve the recurrent problems of access and denial of coverage to the population. In Colombia, participation by social organizations was fundamental for putting the Constitutional Court ruling into effect, by making sure debate on the Colombian health system's structural problems, and the key aspects thereof, were established and kept visible.

[6] For Brazil, a recommended reference is Sestelo, Souza and Bahia (2013).

[7] According to Castellani, the "revolving door" is defined in this way in the literature on elites (Gormley, 1979; Eckert, 1981; Cohen, 1986; Che, 1995), and it can be observed when analysing the multiple post-holding and circulation by members of the economic elite in the private and State sectors (Castellani, 2016).

IV. Health system responses and challenges in the face of the pandemic

The outbreak of the COVID-19 pandemic revealed countless situations that reflect the shortcomings and weaknesses of Latin American institutions and policies, especially their health systems. As noted in various studies, the health systems of Argentina and other countries in the region are highly fragmented, segmented and underfunded; and their capacity to respond to the population's health needs reproduces and magnifies their societies' structural inequalities.

Clearly, in a context of increasing inequality, efforts should not be the same for all, as this would be a denial of societal inequality and an act of social injustice. During the pandemic, it became increasingly evident that not everyone suffers from the crises in the same way: as noted in a recent Oxfam report (Ruiz, 2020, cited in López and Sturla, 2020), the wealth of the richest and highest-income economic groups has increased significantly.

As discussed in this article, the region's private sectors have played a leading role in defining health policy in their countries. As a result of the pandemic, these sectors were the main beneficiaries of various types of subsidies, and in all the cases analysed they have managed to resist government attempts to temporarily integrate health resources to provide a more effective response to the crisis.

In the United States, where the health system has a greater preponderance of firms selling private plans and insurance, the firms in question reported an increase in their profit margins during the pandemic (Abelson, 2020). In the second quarter of 2020, firms such as Anthem, Humana and UnitedHealth Group all reported higher earnings than in the year-earlier period (Abelson, 2020; Andrietta and others, 2021, p. 8).

Accordingly, in the context of the COVID-19 pandemic, it is important to know what role the representatives of this sector are willing to play and what costs they are willing to assume, given the magnitude and seriousness of certain events, such as the health emergency that a pandemic entails. The following represent some of the attitudes that were propagated at the onset of the pandemic in Argentina, based on statements made by the main spokespersons of the prepaid medicine firms: "Today we are all links in the public health chain";[8] "Dealing with this crisis requires commitments and responsibility from all social and political actors for the common good";[9] and "There is no room now for speculation or pettiness".[10]

Private-sector participation, especially in actions aimed at providing a coordinated response and supporting government policies, was insignificant relative to the demands and requirements expressed since the start of the pandemic. For example, there was a failed attempt in the first half of 2020, when the former Minister of Health of Argentina, Ginés González García, announced that a project was being studied to formulate a Decree of Necessity and Urgency (DNU). This aimed to integrate public and private health resources as a public good, in order to provide the national government with greater steering and coordination capacity to cope with the pandemic. The project was never presented and was soon abandoned. Some sectoral organizations denounced the proposal as a "health populism" measure.[11] In this context, the private health sector benefited from various subsidies, lower taxes and a reduction in expenses owing to the reduced demand for studies, consultations and treatment during the lockdown periods. An analysis made by the Argentine Centre for Political Economy (CEPA) on the performance of prepaid medicine firms during the pandemic shows that the main players —Galeno,

[8] See Fortuna (2020).

[9] See Infobae (2020a).

[10] See Infobae (2020b).

[11] See La Nación (2020).

Medicus, Medifé, Omint, OSDE and Swiss Medical— generated average revenue of US$ 6.8 billion per year in 2015–2020, and accumulated US$ 44.4 billion between them. These six firms account for 76% of the slightly more than six million affiliates (direct or indirect) of prepaid medicine. The report also states that the trend is similar in terms of per capita revenues, which range from about US$ 1,000 to US$ 1,500, without much variation between the different firms. Income per capita declined in 2017 and 2019 before recovering strongly in 2020 (CEPA, 2022).

A recent study formulated a conceptual framework to classify the performance of different countries in responding to the pandemic. In line with what has been expressed in this article, the role of politics and the importance of time in government decision making is of interest when evaluating the results. The study argues that health system response capacity is fundamental, but not sufficient, to respond to the pandemic; that political containment measures and their timely enforcement play a central role; and that the differentiated presence of these three dimensions and their interrelationship give rise to different scenarios and outcomes. These determine different pandemic outcomes, as measured by community spread of the virus and the incidence of cases and deaths when vaccines and treatments are absent (Herrero and Belardo, 2020). These authors suggest that interactions between the aforementioned variables determine the evolution of the epidemic in each country. The analysis of the variables in different countries enabled them to classify countries in three groups —"denialist", "gradualist" and "strict"— according to their response to the pandemic.

Based on the measures it adopted, Argentina was placed in the strict group. According to the authors, countries in this group grasped the new reality immediately and adopted drastic measures rapidly: "no one hesitated and they gradually closed borders; and they banned mass events, the presence of students in classrooms and travel by people to their jobs" (Herrero and Belardo, 2020, p. 110).

Lastly, in the Argentine case, the challenges set by the government include the proposal announced by the Vice-President in late 2020, in which she expressed the need to integrate the health system and called on everyone to participate in constructing the Integrated National Health System:

> We have to move towards a national health system that integrates the public, private and social security systems to optimize resources. The pandemic gave us the opportunity to reformulate the health system in record time, but we need to make a different effort (Página 12, 2020).

Brazil, by contrast, was classified in the denialist group. As occurred also in the United States, the United Kingdom and Mexico, Brazil denied the seriousness of the pandemic for a long time and focused its concerns on the economic paralysis. The pandemic has enabled the Unified Health System (SUS) to gain great social legitimacy.[12] As noted by Bahia (2022), the expression "If it were not for SUS, things would be much worse" is a way of manifesting respect and appreciation for this universal public policy.

Strategies aimed at blocking the spread of the virus were rendered inaccessible, owing mainly to the four factors mentioned by Bahia:

> Minimization of the magnitude of the pandemic and the discrediting of scientific guidelines; the adoption of a misleading official programme of "early treatment" (use of ineffective drugs) [...]; insufficient and intermittent policies of emergency cash assistance and delay in expanding the installed capacity of intensive care beds; and, lastly, administrative discontinuities and financial mismanagement in the Ministry of Health, compounded by the inaction of the crisis committees (Bahia, 2022, p. 2).

[12] The Unified Health Service is one of the universal public policies most widely recognized and supported by Brazilian society and by a broad political spectrum, despite having its scope reduced by budgetary and political constraints (see Escorel (1999) and Paim and others (2011)).

Firms selling health plans and insurance in Brazil did not play a leading role in actions to control the spread of COVID-19. As noted in Andrietta and others (2021, p. 19), they did not promote health protection actions, nor did they guarantee the differentiated care recommended by the Ministry of Health, in terms of performing specific examinations.

Brazil's scientific institutions and civil society movements promoted a debate aimed at unifying the use of public and private resources for the health care of seriously ill patients. The debate reached Congress and the judiciary, but did not progress further. On the contrary, the National Supplementary Health Agency adopted measures that expressed the protection of sectoral interests and issued recommendations aimed at maintaining selective procedures and incentives for preserving contracts (Andrietta and others, 2021).

What has been seen since the start of the pandemic is a lack of cooperation and a refusal to collaborate by firms selling health plans and insurance, and the continuity of public policies to ensure that public resources continue to flow to the private sector.

The aforementioned study by Herrero and Belardo classified Chile in the gradualist group. This is defined as countries that applied physical isolation measures gradually, and in some cases very timidly, until the progression of the disease and the exponential increase in deaths became evident (Herrero and Belardo, 2020, pp. 105–106). The health systems of these countries collapsed rapidly, because of the delay in implementing lockdown and mitigation measures.

An analysis of the challenges faced by Chile should not lose sight of the intense left-wing social mobilizations that have vehemently challenged the neoliberal policies and the governments that came after the Pinochet dictatorship, for their inability to reduce structural inequality. The main demands and claims include, in particular, inequalities in the health system and the recurrent failure of the ISAPREs to provide adequate health care, despite being a very lucrative sector that benefits from public policies.

This context of large-scale mobilizations led to the election of a government with strong popular support. In his first speech as president, on 11 March 2022, Gabriel Boric highlighted the role of the social mobilizations and the central place that the gender and human rights perspective will have in his policies:

> [...] they are protagonists in this process. The Chilean people are protagonists. We would not be here without the social mobilizations. We arrived here to commit ourselves body and soul. "I have seen your faces" said Boric, before going on to enumerate the LGBTI+ community, indebted students, persons searching for disappeared detainees, children, among others. "It's you that have my commitment" (*El Mostrador*, 2022).

Announcing his first measures, Boric referred to the health sector:

> The pandemic proceeds on its course, continuing to cause loss of life [...]. We need to embrace each other in society, we need to smile again. It's so important to love each other. We succeed together (*El Mostrador*, 2022).

In the context of analysing possibilities for transforming the Chilean health system, the current government has worked continuously, since taking office, to develop a reform proposal to construct a single health system in which the National Health Fund (FONASA) would play a central role in the financing and control of the system as a whole.

This context opens up the possibility of building a universal health system, in which the public sector will be strengthened and financed from general taxation. It should be remembered that a similar proposal was made at the start of the Bachelet administration, but it failed to gain parliamentary status to be debated. If the current proposal is implemented, it will be a very important reference for the whole region, especially since Chile has been a pioneer in the implementation of several privatization policies, in the health system particularly.

V. Selected considerations and questions

This analysis aimed to draw attention to the contradictions and tensions that exist in some of the leading academic explanations of health systems and policies in the region, and also in the health system privatization processes. An additional and more oblique aim was to analyse the relevance or explanatory capacity of certain analytical categories that have been used repeatedly to explain the success or failure of health policies.

The policies studied in the different cases reveal similarities and coincidences in the nature of conflicts, the actors involved, the viewpoints and arguments put forward, and the legislative content. The similarities include the existence of limits to privatization, caused by market and regulatory failures, and structural constraints. As noted throughout this work, the market for health plans and insurance is determined by the labour market; and, in the countries studied, the behaviour of this market is characterized by major instability and informality.

The theoretical framework used in this study reveals issues that have scarcely been mentioned in the debate on health systems in Latin America, especially with regard to privatization. Most published studies view privatization as a shortcoming of the system, an unintended consequence. As a result, it is not treated as a set of ideas and intentional projects in which the State and the various institutional organizations have played a central role.

Based on the assumptions and results presented above, new analytical strategies need to be developed to steer and support the complex and shifting movements of public-private relations in health systems. Based on rigorous and systematic knowledge in this line of research, it is possible to find significant spaces to design actions that will make it possible to influence proposals for more egalitarian and solidarity-based health models. As noted in a recent article (Luzuriaga and others, 2021), the content of the debate should aim at exchanging ideas on the following issues, among many others:

- What is the appropriate size of each of the subsectors and what differences between them are permissible?
- What characteristics would the private subsector need to adopt to act in solidarity and contribute to the equity of the system?
- What differences in access to health care are socially acceptable?
- How could integration be achieved to allow for more adequate cost compensation?
- How can resources be used rationally without compromising service quality and coverage?
- How can resource allocation be made more transparent?
- How can the information systems existing in the subsectors be integrated to enable adequate planning and decision-making?
- How can the extraordinary revenues earned by some subsectors be adjusted?
- How can the entire population be assured adequate access to the health system?
- How can resources be distributed more equitably?

Structural changes are rare and do not occur in power vacuums, particularly when they aim to expand rights and redistribute, and especially in societies where business groups and sectors with higher levels of income and wealth have hindered or prevented such policies from advancing. For this reason, and for all of the above, the creation of partnerships and common agendas focused on priority policies, such as the construction of a universal, egalitarian and comprehensive health system, can and should be a banner, alongside other demands, that strengthens the collective struggle of the region's countries.

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