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Research Article

Why Health Reforms Fail: Lessons from the 2014 Chilean Attempt to Reform

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CONTENTS

Abstract—In 2014, Chile started a process to reform its private health insurance scheme. A commission was created and released a report with recommendations, but no changes have been introduced yet. This article analyzes that reform process. The analysis included document review and interviews with key stakeholders involved in the process. Results show that although the Commission failed in producing the intended changes, it contributed to opening the debate regarding the Chilean health system, making explicit the different positions on the issue. The analysis shows that the reform did not advance because of the lack of basic consensus on the Commission's role, scope, and main purpose among stakeholders. Previous reforms highlight the relevance of time and information in creating a successful reform process.

INTRODUCTION

Health reform in Chile has a long tradition, dating from the 1920s when the state first adopted a prominent role in public health and continuing through efforts to achieve universal coverage and improve quality in the 2000s.[1–4] Despite these efforts, the Chilean health system still faces several challenges. One of its key features is the public–private mix in provision and insurance, which has generated a segmented system, in which most of the population (75%) is covered by the public insurance scheme (FONASA, or Fondo Nacional de Salud), 18% is covered by private insurers (ISAPREs or Instituciones de Salud Previsional), and the remaining 7% of the population is either covered by alternative schemes or remains uninsured. In terms of pooling, FONASA covers the riskier (based on age and gender) and poorer population, whereas ISAPREs offer insurance to those with less risk and more income.[5,6] The system has been called unfair and inefficient, based on its segmentation, inequality, and lack of solidarity.[7–14]

Keywords: Chile, health care financing, health care reform, health insurance, qualitative research

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Additionally, rising costs of health care have increased prices for health insurance, generating discontent particularly among affiliates of ISAPREs. Population complaints were echoed in 2010 when the Constitutional Court decided to examine the legality of some actions taken by ISAPREs. Specifically, the 38th article of the ISAPREs law was declared unconstitutional, because it violated the principle of equality (because prices were adjusted based on sex and age) as well as the right to property and the right to choose (because increases in premiums were used to indirectly drive people out of the private system).[15] Judicialization, in this case, the use of legal actions to stop the increase in health insurance premiums, became a problem for private insurers not only because it forbade them to raise premiums but also because they were forced to pay for the legal costs of the processes. In 2014, more than 99,000 lawsuits were presented against ISAPREs, with a total cost of roughly 44 million USD.[16]

In this context, President Michelle Bachelet signed Decree #71 in April 2014, creating the Presidential Advisory Commission for the Analysis and Proposal of a New Legal Framework for the Chilean Private Health System (hereafter "the Commission"). The goal of this group of 17 experts (including economists, physicians, lawyers, engineers, and managers with experience in public health and health financing in Chile) was to present the current situation and identify the main problems in the private health system; to collect evidence, including different perspectives; and to propose a new ISAPREs law.[17] In her speech announcing the creation of the Commission, President Bachelet stressed the need to reform an inherently discriminatory system, which produced barriers in access to health services and was highly inequitable. The idea of forming this Commission was born during the 2014 presidential campaign, and its creation during the first 100 days of the government was one of Bachelet's campaign promises, under the label "More solidarity to finance health and put an end to ISAPREs' abuses."[18]

The Commission concluded its work in October 2014, releasing a report with analysis, discussions, and recommendations for the Chilean health system. The work of the Commission not only included the debate among its 17 members but was enriched by contributions of other stakeholders that participated in the Commission's sessions. The report included several recommendations for changing the Chilean health system in both the short term and the long term, including the creation of a national single payer with a well-defined benefit package, a risk compensation fund, and reformulation of the sick leave fund, among others. Due to lack of consensus, the report shows different recommendations: one coming from a majority group and a different proposal from a minority group. More than four years after the report, few changes have been adopted. Why did this attempt at reform not produce the expected changes? The aim of this study is to analyze the processes and outcomes of the Commission—that is, what was done, how it was done, and what was achieved—in order to understand why the reform process led by this Commission did not generate the expected changes.

The analysis examines the process and its participants, understanding that both are factors relevant in the agenda-setting process.[19] First, in terms of the process, several stages of health reform, such as problem definition, diagnosis, planning, political decision, implementation, and evaluation, are considered.[20] In this case study, the emphasis is on identifying bottlenecks in the reform process that can help understand the reform's outcomes. The reform process can also be analyzed by illustrating the role played by key actors, in particular, interest groups, institutions, and change teams.[21] This case study will identify actors' opinions and influence and how their position and power can explain the outcomes of the process. Both approaches are complementary and guide the search to explain why this particular reform process did not produce changes.

Understanding what happened in this attempt to produce reform is relevant for several reasons. First, the literature is full of case studies and examples of successful reforms, but fewer examples are published about how and why reforms fail.[22–27] Analyses of failed reform processes are scarce, reflecting a type of publication bias in the literature.

Second, the Chilean experience could be valuable for health reform efforts in other contexts, considering that Chile has been a model for health and social security in the region.[3,28,29] Health systems are complex; they include multiple actors and interactions, as well as multiple areas of intervention. Health system reform is a permanent feature of many political agendas; several countries are trying or will try to pass reforms to improve efficiency and equity in their health systems. The Chilean experience of 2014 can be valuable in designing and implementing these upcoming reforms.

Finally, the analysis is relevant for improving the debate in Chile and increasing the likelihood of meaningful changes in the future. The 2014 process is not the first attempt to reform the system: in 2010 a presidential commission was also created to analyze the Chilean health system and make recommendations[30]; in June 2018, recently elected President Sebastián Piñera announced a new project to reform the

private health system, relaunching what seems like a never-ending debate.[31]

This article is structured as follows. The next section applies reform models to the Chilean case and describes the data collection strategy. The article then presents the results of the study, highlighting the stakeholders and their positions as well as the interviewees' perspectives on outcomes of the reform process. The next section examines the limitations of the analysis and presents a discussion on the use of commissions as a means for change and the likelihood of successful reform processes in the Chilean context. The last section presents the conclusions of the study.

METHODS

This analysis constitutes a case study; that is, an intensive study of a single unit with the purpose of understanding a larger class of similar units.[32] Its main goal is to understand why the 2014 reform process did not produce the expected changes. In order to perform this analysis, several clarifications are needed. First, regarding the use of the term *failure*, the studied process did produce some changes but it failed to introduce modifications to the law for the private health sector; because introducing legal changes in the health system was the main objective of the process, this is the indicator used to define its failure. Second, the use of the term *expected results* is not whimsical; as discussed later, ambiguity played a role in the entire process, setting a broad range of interpretations for the goal of the reform and, consequently, its measure of success. Third, the reform process reached only the first steps of the process described by Roberts et al.[20]—problem definition, diagnosis, planning—and the debate stopped before reaching the political decision stage. This limits analysis to the first phases, influencing the methodological choices.

Groups and Actors in the Chilean Attempt to Reform

In terms of the actors involved in the process, these can be identified as follows.[21]

Interest Groups

Interest groups include the advocates of the reform and the private health insurance industry, which is expected to be the actor most affected by the reform. Of note, many advocates of the reform obtained positions of power within the executive branch after Bachelet's electoral victory.

Institutions

In Chile, the legislative process involves two steps: formulation and approval of policies into law.[33] In its first step, the process involves two main players: the executive branch and the legislative branch. From the executive branch, two other players, in addition to the president's cabinet, are involved in the formulation of the policy: the ministries of health and finance. On the legislative side, congress can also propose new legislation but is crucial for the discussion and approval of initiatives. Two chambers comprise the Chilean Congress: the Chamber of Deputies (lower house) and the Senate (upper house). Generally, the discussion of a new law can start in either chamber in the legislative process, but there are specific laws that must begin in the lower house (such as taxes and budget), whereas others must begin in the Senate (such as amnesties).[34]

Another group includes public organizations that represent people's rights. The Superintendence of Health is the public institution that regulates the private health sector, and its mandate is to protect the people's right to health care in Chile. The courts are the entities that apply the laws in the country. Both institutions are formal channels in which people can express their demands about health issues in the country. Finally, academia plays a role in generating information and evidence for the debate and discussion of key issues in health.

Change Team

In this case, the Commission was the change team. It included members of various groups such as government, academia, and industry. Based on the presidential campaign, the Commission was created to lay the foundations for discussion about health care reform. Officially, the Commission had no role in the legislative process: the Commission instead served mainly as the executive branch's instrument to initiate the legislative process. The relevant ministries discussed the Commission's report to produce a proposal from the executive branch to congress, which awaited this proposal to start the legislative debate. Yet, in December 2016, the Senate announced its intention to stop waiting for the executive branch's legislative proposal and decided to restart the debate on the ISAPREs reform.[35]

Data Collection and Analysis

The timeline and actors' perspectives presented above were prepared using two complementary sources of information: published documents and interviews. The analysis of published documents reveals the positions of different actors and

the chronology of the process.[12,36] The availability of documents not only facilitated the analysis (particularly the final report and the Commission's sessions) but also shows how the whole process was carried out in a transparent way. This chronology was used to produce a broad panorama of the reform process, to identify themes and potential interviewees, as well as to provide input for the interviews' guidelines.

The document review was complemented with semi-structured interviews with key stakeholders. Semistructured interviews allow enough flexibility to balance two crucial dimensions needed to gather information: the conversation's fluency and control over the discussion.[37] The sampling strategy was based on both theory and judgment using the preconceived groups presented in the previous section but actively selecting the most productive sample to answer the research question within each group.[38] Interviewees included people who participated in creating the Commission, Commission members, and other stakeholders actively participating in the discussion after the end of the Commission.

Seven interviews were conducted during October 2016 and January 2017. The interviewees were selected to represent different players in the Chilean health system as shown in Table 1. It is important to note that these categories identify interviewees according to their primary position at the time the interviews were completed. Despite the small sample, the selection of interviewees permits a broad analysis, considering that they all had been involved in the Chilean health policy debate in the last decade, have had different roles throughout the years, and can be considered experts.[39] The group includes not only members of the Commission but also former authorities, civil servants in several health-related institutions, and people working in international organizations. Interviewees also had changed roles in the last ten years, moving mostly between academia and government and between different institutions within the public sector, meaning that the information arising from the interviews is richer than that depicted in Table 1. Unfortunately, no interviews were conducted with members of congress. However, as explained at the beginning of this section, the reform process did not reach congress and, consequently, the analysis was focused on the earlier stages.

Oral consent was obtained for every interview. Semistructured interviews (with an average interview length of one hour) were carried out in Spanish and interviewees were asked about their views on the Chilean health system, the reform process, and the work of the Commission.

Data were analyzed using grounded theory coding, which allows codes to emerge from the data instead of imposing them a priori. To better use the information derived from the interviews, the coding process started with the first interview. Then, codes were revisited once interviews were finished and during the process of reviewing notes and audios. This allowed for flexibility (open coding), constant comparison, and convergence as new information was added and revisited. The rationale for using grounded theory was to deal with theoretical gaps regarding the main research question and to allow for the emergence of new problems that could explain both the origin and result of this particular reform process.[39,40] This process helped structure the information from the interviews, facilitating its synthesis and analysis, building links within and between codes, and identifying consensus and disagreements between different interviewees. The study met the requirements for an institutional review board exception, reviewed in September 2016 by the Harvard T. H. Chan School of Public Health institutional review board office.

RESULTS

Results of the analysis of documents and interviews are presented in two parts: (a) different players are identified and grouped according to their roles in this specific reform process and (b) information is used to reconstruct the process and identify elements to explain why the reform did not produce significant changes. It is important to keep in mind, when interpreting the results, that the Commission's goal was to assess the state of the private health insurance sector in Chile, to gather evidence and articulate different points of view, and to propose changes to the Chilean private health system, in order to increase equity and solidarity.[12]

	Number of Interviewees
Industry	2
Government	2
Academia	3

TABLE 1. Interview Groups

Reform Chessboard: Players and Positions

The stage of the process and each actor's positions were used to identify groups of players and their roles in the process (Table 2). The actors have varied roles, positions, and influence in several stages of the process. As described before, the executive branch leads the early stages of reform, whereas congress is responsible for making legislative changes.

Actors from the health insurance industry form a critical interest group because the potential reform directly impacts them; they act primarily through their influence on the media and politicians. In this case, their main action was to advocate for a reform to solve the problem of judicialization. Although they cannot directly introduce legal changes, the industry group generated debate and pressure for the creation of the 2010 and 2014 commissions.

Decision makers, the second group, include the executive branch and congress. The executive designs and writes a proposal to be discussed in congress. As the key actor in this first stage, its role is to identify problems and solutions to be included in the reform but it can also influence congress during the decision stage.

Third, the people of Chile are represented through institutions whose role is to ensure the correct application and interpretation of the law. The Superintendence of Health is the regulator of private health insurers and providers in the system; the courts serve the broader goal of applying the current law and checking coherence between different legal bodies. Their role is more passive, but they proved to be relevant actors in the process.

A fourth group is academia. Like the insurance industry, academia has no legal role in the process, but it is expected to contribute to the debate, mainly by producing analysis and evidence for the decision-making process.

Finally, the Commission's role resembles that of the executive branch; it supports the government in identifying problems and solutions by developing informed and well-

	Defining Problem	Proposing Solution	Political Decision Making	Instrument to Exercise Influence	Perspective (Problem Definition)
1. Health industry 1.1 Providers 1.2 Insurance companies	Identify a condition and transform it into a problem[19]	No formal channel but influence through lobby	No formal role but influence through lobby	Media, political lobby	Judicialization and financial sustainability of the system
2. (Policy) Decision makers 2.1 Executive Branch 2.1.1 Ministry of Health 2.1.2 Ministry of Finance 2.1.3 Ideologist of the reform 2.4 Congress	Create consensus about the problem in the system	Align solutions and changes to the diagnosed problems	Produce a final draft of the law (executive) Introduce changes and approve the final text of the law (congress)	Media, law, political lobby	Fragmentation, solidarity, efficiency
3. System users 3.1 Superintendence of Health 3.2 Justice courts	Identify noncompliance in the current law	Align current practices to current legislation	Watch over the application of the law	Law	Compliance with laws and regulations
4. Academia	Produce evidence	Propose solutions	No formal role	Media, academic journals, classroom	
5. Commission	Create consensus about the problem in the system	Align solutions and changes to the diagnosed problems	No formal role	None	Fragmentation, solidarity, efficiency

TABLE 2. Actors and Their Roles in the Reform Process

debated recommendations for health care reform. The main difference is that it has no responsibility or power in the process. The Commission is a compelling actor that incorporates the voice of players not formally engaged in the legal process (industry, academia) and serves as a space to debate ideas and build consensus. The Commission's heterogeneity of members was intended to increase its validity by capturing broader perspectives into the debate.

Process Outcomes: Understanding the Results

Several themes were present in the discussion about the reform and the work of the Commission, as well as consensus and disagreement among different players. First, although the origin of the Commission was not clear to all interviewees, the Commission emerged from Bachelet's presidential campaign in 2013. Interviews and documents show that her campaign was focused on three reforms: education, taxation, and the constitution.[18] Although health was defined as a priority, reform was not identified as an objective. The campaign's brochure establishes the creation of a team of experts—during the first 100 days of the government—to write a draft for a new legal framework to regulate private health insurers.

This is the initial point of disagreement: whereas for some actors the process was disappointing because it failed to produce a regulatory or legal change, for others it fulfilled its objective because the Commission was indeed created during the first 100 days of the new administration. The disagreement focused on the intention behind the creation of the Commission: whereas some interviewees believed that the executive branch created the Commission simply to accomplish an electoral promise, others saw the Commission as the vehicle to implement a long-awaited reform of the private health insurance industry. This difference of opinion was found even among members of the Commission. Documents and speeches throughout the process support both positions: that the purpose of the process was only to create the Commission and, conversely, that the goal was to reform the system. A third intermediate position was identified between these extremes, and people in this center group were also divided in their views. One intermediate position sees the Commission as the government's instrument to show commitment to health while acknowledging that the reform was unfeasible. The other faction argues that the Commission was the first stage for future reforms. These differences arose during the interviews and are also evident from the proceedings of the Commission's sessions.[36] In fact, part of the Commission's first meeting was used to define its scope, showing how the decree that created the Commission was broad enough to allow different interpretations and thereby generated confusion about its role.

Although some actors assumed that creating the Commission was a goal in itself (a way to show quick results and gain political support), opinions and documents show that the Commission was intended to produce some changes in policy. Here is where the second disagreement comes into play: What was the Commission expected to produce? Despite its role, the Commission created different expectations among diverse actors of society. The Commission was projected to finish its work, release a report, and ultimately produce a new law for health private insurers. The problem arises because although the mandate of the Commission was clear, its limits were not.

This lack of consensus about the scope of the Commission is reflected in the opinion of several stakeholders and in the final report issued in October 2014. The report shows that members had different beliefs about the Commission's role and postreport expectations. On the one hand, there was no agreement about whether the process should focus exclusively on the private sector (the predominant industry perspective) or examine the entire Chilean health system (mostly supported by scholars). Additionally, it was unclear whether the results of the Commission were intended to produce short-term or long-term impacts. Table 3 shows the different expected outcomes of the reform process as shown by the analysis of this study.

Interviews suggest that the report was used to start the prelegislative process, but now, four years since its publication, the discussion still has not reached congress. Unfortunately, no clear reason exists as to why the process stopped at the political decision stage or what is the document's current status. Interviewees did report that a draft for the law—heavily based on the Commission's report—was produced, which suggests a lack of inter- and intra-institutional consensus (Ministry of Health, Ministry of Finance, and Congress) as the cause of inactivity.

Despite these disagreements, some points of agreement among the interviewees were also identified. Even though people could not agree on the goals of the Commission, they did acknowledge the process resulted in positive changes.

First, the process made public a discussion that formerly occurred behind closed doors. The Commission's format facilitated an exchange of opinions, expectations, and information for the public. The transparency of the process, including the publication of reports, sessions, and people participating in the Commission's activities, contributed to this result.

Second, interviewees agreed that the process produced an unintended positive outcome: recognizing the role of private health insurers as part of the health financing system in Chile. This implied an explicit recognition from some of

		Reform's scope	
		Private health insurance only	Health system
	Immediate	Release of the report	
Time horizon	Short-term/ improvement	Judicialization Selection among ISAPREs affiliates	Equal conditions for FONASA and ISAPREs
	Long-term/ structural	Relationship between multiple insurers Cost containment Competition	Fragmentation of the system Improvement in the network of public providers Payment mechanisms Role of private sector

TABLE 3. Expected Outcomes from the Commission about ISAPREs and the Chilean Health System

ISAPREs' critics that private insurers were part of the system. Concurrently, the industry had to see itself as a part of a social security system, which led to accepting their responsibility in providing services according to the principles of social security. In summary, ISAPREs were recognized as part of the health care system, sharing rights and duties with FONASA. All interviewees, including those representing private providers and insurers, emphasized this issue.

Third, interviewees agreed that Chile was unlikely to implement a health reform in the period 2014–2018. As stated before, political support was scarce in a government already facing complex reforms in other sectors. The lack of consensus at different levels reduced the chances of getting the needed support to undertake a serious legislative reform process.

Fourth, despite the general lack of consensus, interviewees agreed on the need to reform the Chilean health system. Although they also acknowledged reform as urgent, they shared a sense that implementing a major change quickly was highly unlikely. Most interviewees expressed the view that changes in government represent an opportunity to restructure the health system, but they were skeptical about the feasibility of reform. In addition, interviewees mentioned other factors could that deter future reform efforts: the processes and consequences of the current reforms (taxes, education) could discourage structural changes in the next period; the rise of new urgent issues could switch priorities away from the health sector; and complexities in the health system make it difficult to think about structural reform during a four-year government term.

Table 4 summarizes the results presented above, showing areas in which consensus was reached and those in which differences remained.

Finally, it is worth emphasizing an additional factor in this case: the fact that problems and solutions are usually confounded. As in its report, the Commission focused most of the discussion around the role of the private sector in health insurance and the debate over having a system with a single payer or multiple insurers.[12] Resources and arguments are presented in defending both positions, ignoring the fact that several countries have addressed some of the issues presented as problems in Chile—fragmentation, lack of solidarity, low financial protection, growth in health costs—using different health financing models. The existence (or absence) of multiple private insurers is presented as a problem per se, taking the focus of the discussion away from the problems and their potential solutions.

DISCUSSION

This analysis highlights the lack of basic consensus among the different actors in Chile over the reform process of the Commission. This problem seems to be part of Chile's particular history: a country still divided by ideology—after the dictatorship and the return of the democracy—that finds the health sector an arena for controversy. After the coup d'état in 1973, several reforms were introduced in the health system during the 1980s, giving a more active role to the private sector in health; these reforms have been criticized since the

Disagreement	Consensus
Commission's goals (release a report vs. produce inputs for a future reform vs. produce changes)	Commission's outcomes: transparent debate, establishing role of ISAPREs in the system
Commission's scope (private insurance vs. health system)	Likelihood of structural reform during Bachelet's government
Reform's goals (see Table 3)	Need for health reform

TABLE 4. Summary of Disagreement and Consensus between Stakeholders about the Reform Process

end of Pinochet's regime. International experience shows, however, that disagreement in health reform is the rule, not the exception.[41] The most salient characteristic of the process under study in this article is the use of a Commission as the means for change. As shown by experiences in the past, expert commissions have been widely used but rarely studied, raising questions about their ability to generate changes.[42,43] It is not surprising, then, to find people who were skeptical of the 2014 process in Chile; most of them accepted that substantial changes in the health sector were unlikely, and others believed the Commission was not a means to an end but a goal in itself. Both viewpoints support the idea of the Commission as a symbol of change (a tool to signal the intention to make changes) rather than a vehicle for reform.

Finally, this analysis has important limitations necessary to consider when interpreting the results. First, the study is based on a case study; it tries to understand a particular phenomenon—the attempt to reform the Chilean health system in 2014—but also intends to be applicable to other reform experiences, particularly future reforms in the health system. As shown by history, reforms in the Chilean health system are context dependent[1,8]; some lessons learned from this process can be useful in the future, but others can become outdated if the next reform process takes too long. Second, resources are a constraint in any research; in this case, the number of interviews is enough to capture the opinion of different stakeholders but the study would benefit from a larger and more diverse sample; selection of interviewees and the topic guide are the main challenges to ensuring variability in the sample and information to identify each group's (not each interviewee's) position. Third, the proposed framework is helpful to identify sources of information. It allows identifying positions and disagreements between stakeholders in order to explain why the commission process carried out in 2014 did not result in legislative changes as intended initially. However, it does not give specific guidelines to overcome these problems in the future. The study increases awareness of the relevance of these barriers in implementing health reforms, but additional research will be needed to explore potential solutions.

Despite the pessimistic scenario, hope still exists. Successful reforms were possible in the past and are possible in Chile today. The country has carried out at least two major reforms in the recent past: the AUGE health reform in 2005 and a structural reform of the pension system in 2008. Both examples illustrate the relevance of consensus in conducting transformation processes. The AUGE reform was a legal change that mandated coverage by public and private health insurers for selected medical interventions.[44] The process started with multiple meetings between scholars, policy makers, and health professionals, trying to generate a list of priorities, goals, and methods. After a couple of years, a proposal was submitted for discussion in congress, allowing for time to make comments and amendments.[45]

The case of the Chilean pension reform demonstrates valuable learning because it encompassed changes in the social security system, which also began with a commission: the Presidential Advisory Commission for the reform. The main factor explaining the success of this reform was the ability to build consensus based on technical elements, particularly in identifying the problems of the system, as a necessary step to think about solutions.[19,46,47] Academia played a fundamental role in this stage. The reform was possible through a more complex process of building political consensus and including social actors in the discussion but was cemented by the shared definition of a major problem.

Both examples are interesting to compare with the 2014 attempt to reform. First, as in the 2014 health reform, both processes included structural changes that were a priori difficult to achieve. Second, as in the case under analysis, a commission was selected as a reform mechanism. These success stories show that commissions can fulfill the role of pushing for change but other elements are required too. The common elements present in the AUGE and pension reforms were the consensus-building process that took several years and the inclusion of different actors in the process; in contrast, the reform of 2014 was successful in gathering different visions but did not allow for enough time to build consensus. In this case, the Commission worked for six months, not enough time to produce relevant information and reconcile positions. The lack of time and data for the debate pushed the discussion into the ideology arena, with a process that ended in a Commission divided into two groups and a report with more discrepancies than agreements. In this case, the Commission had a predefined limited time; the time needed for a full reform process was not available. More time to reconcile positions (either within or outside the Commission) would have been important to build the required consensus. The previous reforms showed that two key elements were absent in this process: relevant and objective information (highlighting the role of the academia in the reform) and time (emphasizing the responsibility of the government in assigning a short life to a process that requires maturation).

CONCLUSIONS

The aim of this study was to analyze the processes and outcomes of the Commission for the reform of the health system carried out in Chile in 2014, in order to understand why it did not produce significant legislative changes. The analysis was based on documents and interviews with key stakeholders and actors in the process. The information was collected and structured to understand the different positions related to the reform of the Chilean health system—with a special focus on the role played by the Commission—and how this configuration could be used to explain the reform's outcomes.

The analysis identified several themes of convergence as well as important disagreements with respect to the role of the Commission and the reform in the Chilean health system. The main result is the existence of a broad disagreement about the causes of the problems in the Chilean health system and, consequently, the goal of a future reform; because problems and solutions were mixed in the discussion, there was no consensus on what an eventual reform should look like. Despite the apparently irreconcilable positions, points of agreement also were identified: people recognized the need for reform (but not its goal) and agreed on several issues that need to be fixed (although not on their causes or the solutions to be implemented). In summary, it is fair to say that there was consensus about the need for reform; unfortunately, there was no agreement on why it was needed, what should be done, or how it should be implemented.[48]

The analysis provides several lessons for Chile and other countries. First, the case highlights the need to produce objective information and consensus among actors, particularly around the problem that the reform seeks to solve and its causes. The availability of evidence prevents turning the discussion into a debate of individual opinions, enhances transparency, and increases the likelihood of reaching an agreement. As stated before, there is an active role for academia in providing this information to decision makers. Second, it emphasizes the advantages of focusing the discussion on defining problems before proposing solutions. One of the main issues identified in the analysis was the existence of different opinions regarding the problem that the Commission was supposed to fix; this generated a debate with several starting points. As shown by the previous successful reforms, a well-defined problem restricts the set of possible solutions and helps to build consensus. Finally, the 2014 reform process shows the need for agreement, particularly at the political level, in order to secure adoption of a reform that requires more than one administration to be carried out.[19] A process intended to produce structural changes in the health system requires enough support to survive the political cycle. Conviction about the need for reform can help to bring additional supporters to the process. Building consensus about what the country wants from the Chilean health system is urgent; in the meanwhile, we see windows of opportunity for change closing.

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DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

No potential conflict of interest was reported by the author.

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