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"The Rise and Fall of Welfare Health Legislation in 20th Century Chile: A Case Study in Political Economy of Law"

Jaime Llambias-Wolff

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**THE RISE AND FALL OF WELFARE HEALTH
LEGISLATION IN 20TH CENTURY CHILE:
A CASE STUDY IN POLITICAL ECONOMY OF LAW**

JAIME LLAMBIAS WOLFF

A DISSERTATION SUBMITTED TO THE FACULTY OF
GRADUATE STUDIES
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
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ABSTRACT

This dissertation analyzes the economic and political dynamics of health legislation in Chile throughout the 20th century. Law is understood as a process, in which legislation is the consequence of the political interaction between different stakeholders within a specific socio-economic and political reality. Law thus performs as a function of its political dynamics. This case study discusses lawmaking in its multifaceted character fulfilling different roles, understanding health legislation in Chile as the expression of how society articulates and represents different interests and how health reforms are determined by the influence and capabilities of interest groups. The legal framework is situated within a broader national social, economic and political context, mediated by international influences and the strategic role assumed by the state.

Empirically, the dissertation analyzes how economic and political variables have shaped different legal transformations in a country that has experienced significant, paradigmatic changes in health law, moving from a basically charitable system, inherited from the Spanish colonial power, to a strong and profoundly European welfare system—the second oldest national health service in the world—to a radical neo/liberal market model introduced in the late 1970s, and finally, towards a mixed public-private system, still present.

DEDICATION

To my wife Judith Meunier, who supported me with patience in this “lovely foolish” return to Law after 4 decades, which permitted me to appreciate and enjoy legal research much more and allowed me to close the circle after my graduation from the University of Chile’s School of Law, when I was 22 and trying to understand.

Jaime L Lambías-Wolff

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First, I wish to express my gratitude to my supervisor, Professor Liora Salter, for listening to my story about my early involvement with law when I was an undergraduate law student in Chile and for all her helpful advice during seminars and during my legal research. It was back in 1968 when, with many of my fellow Chilean law school comrades of our generation, I wanted “to be realistic and demand the impossible” in our long journey for important structural transformations. I wanted law to be an active profession, engaged in the pursuit of social and legal change. Only five years later, I was suddenly in Canada as a political refugee, and those aims and visions came to an abrupt end. Along with many others, I had to start all over. Law became merely a framed diploma on a basement apartment wall, thanks to family who saved it from being burned along with other books and dreams.

Too many years later, already recycled in Sociology, Liora listened to “my story” and suggested: “You should go for another PhD, but this time in Law.” And here I am. Thank you, Liora!

Next, I would like to thank my co-supervisor, Professor Ruth Buchanan. She probably does not know, but we do, that her study group energized students week after week. I re-discovered all the theoretical

legal material I had long forgotten about or mostly never read, and I enjoyed my weekends reading and preparing for discussions. It was a revelation for me, as after dedicating 40 years to sociological thought, I had the opportunity to draw connections and approach legal research from an interdisciplinary perspective. She knows that I had to bring myself back on track more than once. The process was an effort, but at the same time, a real pleasure. Thank you, Ruth!

I also would like to thank Professor Shin Imai, a member of my dissertation committee, who encouraged me to continue on this path of close involvement with social change. His personal understanding of Latin America, his fluent Spanish and his legal experience were an important support for me in this endeavour. Thank you, Shin!

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Jaime LLambías-Wolff

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**THE RISE AND FALL OF WELFARE HEALTH LEGISLATION
IN THE 20TH CENTURY CHILE:
A CASE STUDY IN POLITICAL ECONOMY OF LAW**

PRESENTATION AND INTRODUCTION

The dissertation examines how economic and political variables have shaped different legal transformations in a country that has experienced significant and paradigmatic changes in health legislation. I will provide accounts of health legislation and health reforms with respect to the various interests they uphold, seeing people not as autonomous individuals but as actors in specific social locations and relationships. I am interested in law as a process, as a movement that occurs in the context of the historical development of Chilean society, where the Rule of law, based on the liberal tradition, is tied to the modernizations of the 20th century. I will explore how the law and the legal system are embedded in the transformations of the health sphere and the different models of health care applied in Chile.

In these chapters, law is understood as a system of rules; namely, legislation, decrees-laws and government regulations. My research also includes governmental policies, as these offer useful insight into the legislation under examination. For the purpose of this study, I do not consider any jurisprudence or court decisions. Health reform is defined as a process that introduces regulatory changes in the health field; it is a product of the interplay of interests. It is ultimately reflected in the resulting discourse, policy implementation and legislation.

I intend to apprehend law in “its transformational state through a focus on actors, norms, and processes”¹ and analyze legislation as the result of the interaction between different stakeholders in the political, ideological and economic process of lawmaking. I will pay attention to how power is distributed and how conflicts are resolved. Through this case study, I study if and how lawmaking and the Rule of law can be multifaceted and fulfill different roles. The Rule of law,² as an expression of politics in its broad sense, and lawmaking, as the outcome of processes of negotiation, can both maintain the social and political order and be instrumental in promoting social change.

In this dissertation I will argue that law is the expression of politics. I intend to capture law in what I consider are its temporal and spatial contradictions. I hold that law, in both its creation and its representation, is simultaneously situated in different times and spaces, with a plurality of identities and different roles. In its temporal dimension, law is synchronic and diachronic. In its creation, I consider that law undergoes contradictions between its essence and its appearance; that is, between how it is created and how it is presented. This is where the conflict-consensus duality is made manifest, which then becomes

¹ See Peer Zumbansen, “Lochner Disembedded: The anxieties of Law in a global context”, (2012) *Indiana Journal of Global Legal Studies* at 1

² Rule Law as “ ... a dynamic concept for the expansion and fulfilment of which jurists are primarily responsible and which should be employed not only to safeguard and advance the civil and political rights of the individual in a free society, but also to establish social, economic, educational and cultural conditions under which his legitimate aspirations and dignity may be realized”, International Commission of Jurists, *The Dynamic Aspects of the in Modern Age*, Geneva (1965), 15 in Vilhelm Aubert, “The Rule of law and the Promotional Function of Law in the Welfare State”, in Gunther Teubner (ed.), *Dilemmas of Law in the Welfare State*, (Berlin & New York, Walter de Gruyter, 1986) at 30

formalized and makes the law appear to have its own identity, and even autonomy. If the liberal state was founded upon compromise, that has crucial implications for the law,³ consensus on a law is only a transitional compromise, produced in a given space and time and an undetermined period, whose limits are defined by the political dynamics.

This is because consensus is the pursuit of consent. Consensus by no means expresses unanimity, nor a majority agreement, but rather an agreed upon way to seek agreement. Consensus minimizes the level of conflict, postponing it, temporarily neutralizing it, but it cannot eliminate or destroy an opinion or minority point of view. From the point of view of negotiation and conflict management, consensus does not require the active consent of those involved. It is enough for those who oppose a decision to attenuate their disapproval and tolerate dissidence. In this sense, a decision by consensus is an acceptance of non-refusal. This reasoning, which is part of the origin of Greek democracy, of which we are heirs, means that in processes of conflict-consensus negotiation, it is fundamental to agree on the fact that we must not disagree. Consensus is not on content but on form. In other words, we do not need to agree on a decision, we only agree on the fact that we have to reach a solution: we agree to not disagree.

³ Roberto Mangabeira Unger (1976), *Law in Modern Society. Toward a Criticism of Social Theory*, (New York, The Free Press, 1976) at 75

This is why I believe it is necessary not only to uncover how this conflict-consensus dialectic develops, but also to clearly differentiate between statutory or enacted law (*lex*) and the principles of law (*jus*). This is where the concept of hegemony is fundamental. Throughout this dissertation I seek to articulate the notion of hegemony as the dynamic produced between coercion and consensus; that is, where consent to not prevent the possibility of reaching an agreement culminates in a consensual compromise, which is ultimately achieved or promoted through non-coercive domination. Although domination does not disappear, it coexists with a form of acceptance of the power of those who exercise it. The ideological and cultural acceptance of the tacit or explicit exercise of power shapes and sustains the political and social system in order to maintain and perpetuate a state of homogeneity and the status quo, which is historically temporal and is reproduced or modified in the same way as the conflict-consensus dialectic. Finally, in its rational dimension and its roles, I hold that the law can both maintain and reproduce the relations of power and create or facilitate social change.

Therefore this research is guided by the theoretical assumption that legal changes are the normative outcome of the political process expressed in negotiations between a web of economic, political and social actors. Most of these changes are rooted in legislative reforms of one form or another and have been obviously affected by these major transitions. I intend to explain how health legislation is achieved through negotiations infused with political dynamics,

involving agents not only in relation to each other, but also in relation to economic and political structures. Thus, to understand health legislation reforms in Chile, I situate the legal framework within a broader political context, in which specific changes to the health care system must be considered in light of broader social, economic and political factors. It is in this context that I analyze and discuss the endogenous and exogenous factors that historically influenced health legislation; namely, the influences of the various political actors (stakeholders, political parties, civil society, unions and professional associations); the political process itself and its dynamics; the state and its role as an agent of transformation in the context of a national project; and finally, the impact of international influences throughout the historical time period of this work.

Chile has moved from a basically charitable system, inherited from the Spanish colonial regime, to a strong and profoundly European welfare system with the second oldest national health service in the world, to a radical neo/liberal market model, introduced in the late 1970s, and finally, towards the current mixed public-private system. The time periods that characterize these different health models are as follows: the beginnings of the welfare state model (1924-1938); towards the National Health Service (1939-1952); the welfare state during three different political administrations (1952-1973) and the market model (1973-1989).

My research is guided by the following questions: How has Chilean socio-economic development influenced and shaped the different health models and

reforms? What have been the political economic purposes of these reforms, and how have they translated into health legislation during the different models under study? What were the ideological, economic and socio-political factors behind health legislation reforms? How have political dynamics and the roles of different actors been expressed in health legislation? Does law collaborate in supporting the status quo, or can also generate social change? What can we learn about the role of legislation reforms in social change from studying the Chilean health care system over decades?

This dissertation is divided into four chapters. Chapter one introduces a theoretical framework for the analysis of law within a specific political and economic reality. Chapters two and three, the corpus of the dissertation, contain the qualitative empirical content, its analysis, and discussions of health legislation in 20th-century Chile. Chapter four “Overall analysis and conclusion”

Chapter one, “The legal theoretical framework and health legislation”, analyzes legal theory, how legal processes are embedded in political transitions, and how the law evolves and is transformed. I discuss the legal system as an “ongoing process” and the law as a system that entails an understanding not only of its nature, but also of how it is processed, dictated and legitimized. Thus, I theoretically explore how the law behaves as a function of its own dynamics, and, in particular, its political dynamics. Lastly, I am interested in identifying how health legislation is framed by development policies, international influences and the strategic role assumed by the state.

Chapter two, “Health legislation and legal changes during the welfare state model”, investigates the beginnings of the welfare state model (1924-1938), the development of the National Health Service (1939-1952), the incremental reforms leading to the National Health System and the welfare state during three different political administrations (1952-1973). It discusses health legislation in Chile as the outcome of an incremental process of health reform negotiated over the course of the century.

Chapter three, “Legal and institutional changes in the establishment of a market model of health: 1973-1989”, discusses health legislation within the process of creating a neoliberal market approach, which represented a rupture to the welfare state and the introduction of a new rationality. Following this new logic, social consciousness around health issues was being neutralized, making health concerns an individual problem, which facilitated the atomization of society and stimulated the business of health care. This chapter analyses the principles, doctrine, legislation and regulations that permitted and promoted the establishment of a market model for health care in Chile after the 1973 coup d'état and demonstrates how the legal changes were aimed at the following objectives: the partial withdrawal of the state from the health sector, the creation of a market favourable to the flourishing of the private sector, and finally, the growth and development of the operational structure of the private health sector. This section covers the period from 1973 to 1989.

Chapter four, “The rise and fall of welfare health legislation over decades: overall analysis”, discusses how legal processes are embedded in political transitions and how law evolves and is transformed. I examine legislation as an “ongoing process” that reflects not only the nature of the legal system, but also how the law is processed, dictated and legitimized. My analysis of the legal transformations of the health sector in Chile is grounded in my understanding of law as a process of transformation.

CHAPTER ONE

LEGAL THEORETICAL FRAMEWORK AND HEALTH LEGISLATION

INTRODUCTION

I will argue that law is the expression of politics. In its multivalent character, law is the result of its own dynamics¹ and the outcome of negotiations mediated by unequal actors in a political scenario of power relations. When the impersonality, neutrality and uniformity of the law is discussed, it is only a representation and an illusion, because at its essence is the creative process, which is not homogeneous and contains both authoritarian and liberating elements,² as the very legal system reveals the contradictory nature of social life.³

The law disguises its internal contradictions and develops a dialectical and fetishist identity, taking on a life of its own, independent of how, when and in what context it was created. The negotiations and mediations that influence the creation of law are not independent from the relationship between the different interests at play in each historical and political context. They make the process of law creation possible and/or feasible.

To analyze legal changes in the health sector, I discuss law as a process. I will argue that law and legality have different dimensions and different moments. Their dimensions of value and their ideological, political and rational dimensions would seem to exclude one another, but they do not. In this process, the individual is present and absent from different moments of the law and the

¹ Refers to actions that take place at the moment they are needed rather than in advance.

² Jurgen Habermas, *Legitimation Crisis*, (Boston, Beacon Press, 1974) in Peters, "Law as a Critical Discussion", in Gunther Teubner (ed.), *Dilemmas of Law in the Welfare State*, (Berlin & New York, Walter de Gruyter, 1986) at 261.

³ Lelio Basso, *Geseellschaftsformation und Staatsform*, (Frankfurt, Suhrkamp, 1975) in Peters, *Id.*

legal system makes the individual both appear and disappear. The individual appears in the content of the law, but disappears in its formality, when *jus* becomes *lex*. That is, the individual is an active part of the creation of the law and is yet passive in the face of legal formality.

From a theoretical perspective, I explore the relation between law and politics, understanding lawmaking as the outcome of processes of struggle that either maintain the social and political order or promote change. Analyzing the dynamics of legal processes is essential for comprehending how the law has been embedded in the political sphere (via conflict and consensus) and in ideological debates. It is in this sense I will claim that law is both an expression of politics and the result of its own dynamics.

The law is finally the result of interaction between different individuals in the political, as well as in the cultural-ideological and the economic level, but the law ultimately makes them equal: “we are all equal before the law.” In other words, the law denies individuals their autonomy and transforms them, making them all equal even when they are not, but at the same time it gives them autonomy and presence by making them subjects of law endowed with rights, epitomized in the doctrine of the Rule of law. This is very important in processes of lawmaking in general and health legislation in particular, as the impersonality of the law thus formalizes the equality of the unequal and suggests that any particular law cannot embody the interests of specific people or any particular group.

The chapter is organized in three sections. The first section: *Law and its identity*, examines the law and the legal system as a “process in motion”, with references to the German, French and Spanish traditions, which have two notions of the law (German: *Gesetz* and *Recht*; French: *loi* and *droit*; and Spanish: *ley* and *derecho*). *Recht*, *droit* and *derecho* refer to a whole body of laws, principles, and institutions in the sense of Roman law (*jus*) and therefore explain the law in its abstract and foundational meaning, which involves the principles that determine positive law, as opposed to statutory or enacted law, or *lex*, when law becomes law. In the second section of this chapter: *Law and political dynamics*, I undertake a theoretical examination of how the law follows *its own* dynamics, particularly its own political dynamics. That is, I explore how the law behaves according to the articulation of interests between classes, social sectors and pressure groups, in processes that both shape and modify health legislation. I also present the need to analyze the concept of hegemony and its impact on the legal system at the institutional, political and ideological levels. In the third section of this chapter: *Law and the welfare state*, I examine how health law and health legislation are part of development policies. I examine the role historically exercised by the state, and its ties to the international variables and influences that had an impact on development policies and social and health legislation.

1. THE LAW AND ITS IDENTITY

*“One knows that one does not know why the law functions; but one also knows that one can act precisely because it functions”.*⁴

A. The law: to be or not to be

All societies have their own mythology and evolve and invent themselves in accord with their own beliefs. Durkheim identified law as a factor of social integration; Weber as a mechanism in the exercise of power; Parsons as a social subsystem and Marx as an element of the superstructure of society.⁵ Law, with its multifaceted nature, moves from conceptualization to implementation and is validated as a regulatory mechanism. As Jenkins writes, “Law is now intervening in areas that it has hitherto steered clear of; it is imposing its opinions and principles upon other social bodies, it is settling questions that were formerly thought of as being political economic, or moral, rather than legal, in nature; and it is issuing detailed directives about the ordering of various aspects of society and social life.”⁶

Zumbansen indicates that the law has several definitions or interpretations. It can be an institutionalized system of rule enforcement, a means of stabilizing expectations, a means of oppression, a hope and also an empty

⁴ Christian Joerges, “Die Überarbeitung des BGB-Schuldrechts, die Sonderprivatrechte und die Unbestimmtheit des Rechts” 20, *Kritische Justiz*, 1987, 166-82 in Gunther Teubner, *Law as an Autopoietic System*, (Oxford & Cambridge, Blackwell, 1993) at 7.

⁵ Csaba Varga, *Law and Philosophy: Selected Papers in Legal Theory*, (Budapest, Faculty of Law of Loránd Eötvös University, 1994) at 44-45.

⁶ Iredel Jenkins, *Social Order and the limits of Law*, (Princeton, Princeton University Press, 1980) in Jan M. Broekman, “Legal Subjectivity as a Precondition for the Intertwinement of Law and the Welfare State”, in Teubner (ed.), *Dilemmas of Law in the Welfare State*, supra note 2 at 76 & 77.

parasite. “Law, legal analysis, legal argumentation altogether constitute society’s self-reflection and as such contribute to the formation of society.”⁷ He writes that the first definition (law as an institutionalized system of rule enforcement) is likely to overburden the legitimacy promises of the state, and the second definition (law as a means of stabilizing expectations) runs the risk of everything becoming law. The third and fourth definitions (law as a means of oppression, and law as a means of hope) focus on the anxiety surrounding the “why” of law, its purpose and function.⁸ Finally, in his fifth definition, the law as an “empty parasite” operates and proliferates, but it does not acquire proper content. It remains open, and this is why it is recognized in a very pluralistic way. “It is through the lens of the fifth definition that the preceding four definitions reveal the deeply political, sociological and cultural dimension of law.”⁹ Zumbansen specifies that, “Law’s extreme functionalization is a necessity and as such is an inevitable by-product of an increasingly differentiated, complex and pluralistic society”.¹⁰

Law exists in itself, but it has no value until it is inserted or interpreted in its own history. It is primarily economic factors, along with social factors, that determine (or at least influence) legal strategies and how the law is conceptualized in a given society. It has the ability to be and to exercise a function and a role, but it is not self-sufficient, neither in its genesis nor in its reason to exist. As argued by Csaba Varga, “law is also the imprint of the whole

⁷ Peer Zumbansen, “The Future of Legal Theory”, (2010) *06 Research paper Osgoode Hall Law School 38* at 4.

⁸ *Id.* at 5.

⁹ *Id.* at 8.

¹⁰ *Id.* at 9.

history and culture of the nation. The norms are only signs which by themselves mean nothing: they become alive only in the living practice of society.”¹¹ “The result of this process is that the concept of law becomes burdened with sociological content (a socialized concept of law) and it is also formulated in rather general terms.”¹²

Law is thus an element of power, but it is also a formal and rational reality, an expression of will, which in principle represents or purports to represent everyone. Unger indicates that the law imposes a particular and historical form of social order upon human groups and reflects the profound social structure of society.¹³ Buchanan would argue that law creates the society from which it draws its authority, but that society also brings law into reality.¹⁴ This is why law cannot be understood in isolation from other social phenomena and processes, but only through its connections to these phenomena.¹⁵

According to Unger, the law continues to be a forum for political and ideological debate.¹⁶ It is therefore important to determine how law, using normative systems, filters social problems and social reality. Commaille specifies

¹¹ Varga, *Law and Philosophy*, *supra* note 5 at 54.

¹² Broekman, “Legal Subjectivity as a Precondition”, *supra* note 6 at 77.

¹³ Roberto Mangabeira Unger, *The Critical Legal Studies Movement*, (Cambridge, MA, Harvard University Press, 1986) in John J. A. Burke, “The Political Foundation on Law and the Need for Theory with Practical Value: The Theories of Ronald Dworkin and Roberto Unger” (San Francisco, Thesis, Faculty on Law, University of Fribourg, 1992) at 43.

¹⁴ Ruth Buchanan, “Reconceptualizing Law and Politics in the Transnational: Constitutional and Legal Pluralist Approaches”, (2006) *57 Northern Ireland Law Quarterly* 654.

¹⁵ Alan Hunt, “Exploration in Law and Society: Towards a Constitutive Theory of Law”, in P. Barrios, *Liberal Environmentalism and the International Law of Hazardous Chemicals*, Thesis, Ph.D. Philosophy, (University of British Columbia, 2007).

¹⁶ Roberto Mangabeira Unger, *The Critical Legal Studies Movement*, (Cambridge, MA, Harvard University Press, 1986), *supra* note 13 at 163.

this in reference to Jean Carbonnier's statements when he argues that politics is the direction and law is what allows it to float,¹⁷ recognizing the role and the function of ideology. The ideological role of law is, then, to disguise its process of creation.

This is why once the law is made law, once it is resolved, it validates itself, from within. This, as Teubner says, is in line with the Luhmannian interpretation that there is no law outside the law and, therefore, positive law is a self-produced law.¹⁸ However, Luhmann's autopoietic law, as a structuralist functionalist approach framed in postmodernist currents, has the problem of being a system that is closed "and loosely integrated with the other social institutions."¹⁹ As his interpretation is self-referential, only the law can change the law. This is both true and false. That is, while it is true in the formal sense, it doesn't fully capture the social embeddedness of law's context. This does not prevent the legal system from reproducing. In other words, the law may seem self-referential and circular, but in its essence it is not. The internal organization of the law may be circular, but it is in a causal relationship with external influences, which are much more complex. In particular the law understood as *process* and *dynamics*.

From an approach that looks at law as process, the neutrality of the law is also fictitious, as the procedure is inseparable from the result. That the process of lawmaking necessarily embodies values and incorporates ideas and notions

¹⁷ J. Commaille, *L'esprit sociologique des lois*, (Paris, Presses Universitaires de France, 1994) at 23.

¹⁸ Teubner, Law as an Autopoietic System, *supra* note 4 at 2 & 3.

¹⁹ Max Travers, *Understanding Law and Society*, (Oxon, Routledge, 2010) at 51.

about how power is distributed and how conflicts are resolved. It is probably correct to say that without circularity, the perspective with which the Rule of law was founded cannot be justified,²⁰ but laws' justification and its legitimation are different concepts.

Law's distinctive feature is its transmutation, only once it has been formalized and not before. This transformation phenomenon of identity that law undergoes is important, because the different "moments" of the law's own process are contradictory. On one hand, it confers it autonomy and, as discussed above, it makes it seem self-produced, while on the other hand, it denies the dynamics (or it seems to be denying the dynamics) of its own creation. We may ask, then: Can law occupy an autonomous mode, with its own internal structure? Is law eminently political; a primary outcome of disputes for self-interest?

B. Law, legitimation and autonomy

The problem of legitimacy for liberal law is legal rationality and not its specific content that lends the law its legitimacy. From the liberal tradition legal legitimacy derives from its rationality, its internal logic, more than from its moral or ideological value. Faced with liberal society's predicament of ensuring the impersonality of power, the Rule of law is based on two assumptions: that the most important powers are concentrated in the government and that power can

²⁰ Roberto Mangabeira Unger, *Law in Modern Society. Toward a Criticism of Social Theory*, (New York, The Free Press, 1976) at 180.

be constrained by norms,²¹ as well as by the role exercised by the state. As Bobbio points out: “It is true that law...consists of a set of rules of conduct which, whether directly or indirectly, are formulated and validated by the state.”²² Bobbio opposes a minimal state (liberal) to a maximal state (absolutist), and indicates that democracy is not possible without a legal framework and invalid if it is not accompanied by political pluralism.²³ The question of legitimacy becomes crucial, challenging the foundations of liberal legal rationality. Autonomy and the Rule of law are parts of this identity process, as law is politics, or it is a form of politics. For Marxist theory, the law has direct ties to the state, but it displays autonomy with respect to the state and reflects economic relations. It has the potential to be coercive, manifests the interests of the dominant classes both directly and indirectly and legitimates the system in which it is produced and reproduced. The law thus fulfills the role of legitimating the product and the result of its own creation and the values of the hegemonic classes and powers.²⁴ Critical structural Marxists²⁵ suggest that the law has its own history (the concept of the “relative autonomy” of the law). The law is understood as independent of

²¹ Roberto Mangabeira Unger, *Law in Modern Society*, *id.* at 17.

²² N. Bobbio, “Sur le positivisme juridique”, in *Mélanges Paul Roubier*, (Paris, Dalloz, 1961), Vol I, 53-73, 61-62, 67-68 in Jacques Lenoble & Marc Maesschalck, *Democracy, Law and Governance*, (Farnham, Ashgate Publishing Limited, 2010) at 32.
<http://biblio.juridicas.unam.mx/libros/6/2792/14.pdf>

²³ Luis Antonio Córdoba Gómez, “Liberalism and democracy from Norberto Bobbio’ perspective”, (2008) 48 *Convergencia* at 19-38.

²⁴ Alan Hunt, “Marxist theory of law”, in Jules L. Coleman & Brian Leiter, “Legal Positivism”, in Dennis Patterson (ed.), *A Companion to Philosophy of Law and Legal Theory*, (Cambridge, Blackwell, 2010) at 355 & 361.

²⁵ Louis Althusser, “The object of Capital”, in L. Althusser & E. Balibar (eds.), *Reading Capital* (New York, Pantheon, 1970) in Steven Spitzer, “Marxist Perspectives in the Sociology on Law”, (1983) 9 *Annu. Rev. Sociol. by York University* 103-124 at 107.

the economic system, but dependent in a sense.²⁶ It is precisely this “sense” that has kept alive the debate to ultimately determine the degree of autonomy. Poulantzas, for example, arguing with Althusser, proposes that the law is not necessarily the “state’s ideological apparatus”, but rather organizes and sanctions the real rights of the dominated classes, despite the fact that these rights are invested in the dominant ideology and that these rights therefore are or can be illusory.²⁷

In relation to legitimation and according to Unger, modern liberal law has three essential properties: 1) Rule of law; 2) legal justice and 3) formalist adjudication.²⁸ In addition, law at the legislative and judicial level must profess the properties of generality, uniformity and impersonality.²⁹ The law is legitimated in its standardization and is applied to all, independently of their class condition or power. This allows the law to validate itself without privileging one interest over another and consolidates or ensures the functioning of the Rule of law in the modern liberal state.³⁰ This is why the Rule of law has also been described as an “accepted measure ... of governmental legitimacy”³¹ and an essential pillar upon which any high-quality democracy must rest.³²

²⁶ *Id.*

²⁷ Nicos Poulantzas, *Political Power and Social Classes*, (Londres, New Left Books, 1973) in Steven Spitzer, “Marxist Perspectives in the Sociology on Law”, (1983) 9 *Annu. Rev. Sociol.* 103-124 at 108.

²⁸ Unger, The Critical Legal Studies Movement, in Burke, “The Political Foundation on Law and the Need for Theory with Practical Value” *supra* note 13 at 32.

²⁹ Unger, The Critical Legal Studies Movement, *supra* note 13 at 33

³⁰ *Id.* at 164 & 31-32.

³¹ Brian Z. Tamanaha, *On the Rule of law: History, Politics, Theory*, (Cambridge, Cambridge University Press, 2004) at 3 in Mohsen Al Attar, “Third world approaches to international law and the rethinking of international legal education in the 21st century”, (Toronto, Dissertation, Faculty

The law thus develops its relative autonomy, upheld by the legal system, which is to say, by its formality. In other words, the Rule of law and the legal system both bring the law to life and make it autonomous. The law is formalized and made “objective”, and the Rule of law guarantees the neutrality of the state with respect to its citizens. In this sense, the law is politics in its historical liberal form,³³ despite its contradictory principles (content and form) that also reflect the inconsistencies characteristic of liberal society.³⁴ This is why it is not the autonomy of the law “per se” or its capacity to reproduce itself that is important, as Luhmann³⁵ suggests with his legal thesis.³⁶ That the law can be autopoietic, that it can reproduce itself, is not ultimately decisive, as the law is both essence and presence. Teubner positions the law in a “hypercycle”, writing that it is “...only when the system has created the necessary conditions for hypercyclical linking by describing and producing its own components that the actual autopoiesis of law can begin.”³⁷ Cycles link together to form a hypercycle of self-referential systems.³⁸ He refers to legal procedure, the legal act, the positivity of law, the legal norm and legal doctrine as the components of a higher cycle of links that precede the possibility of self-reproduction of the law. Yet it is my view that as the law takes on a life of its own in the formal sense, it does not cease to

of Graduate Studies, York University, 2012) at 205.

³² Guillermo A O’Donnell, “Why the Rule of law Matters”, (2004) 15 *Journal of Democracy* 4 at 32 in Mohsen Al Attar, *Id.*

³³ Unger, *The Critical Legal Studies Movement*, *supra* note 13 at 43.

³⁴ Roberto Mangabeira Unger, *Knowledge and Politics*, (New York, The Free Press, 1975)

³⁵ Niklas Luhmann, “The Self-Reproduction of Law and its Limits”, in Teubner, *Dilemmas of Law in the Welfare State*, *supra* note 2 at 25.

³⁶ Alberto Febrajo, “The rules of the Game in the Welfare State”, in Teubner, *Id.* at 131.

³⁷ Teubner, *Law as an Autopoietic System*, *supra* note 4 at 42.

³⁸ Michael King, “The ‘Truth’ About Autopoiesis” (1993) 2 *Journal of Law and Society* 20 at 460.

be a reflection of society. "Law is part of [society], everywhere exposed to and in communication with it."³⁹ For Teubner autonomy and autopoiesis are best understood as a matter of degree, by examining the extent to which that system manages to 'constitute its own components, action, norm, process, identity - into self-referential cycles'. When these cycles link together to form a hypercycle of self-referential systems, the legal system can be said to be totally closed or autopoietic.⁴⁰

C. Law and its dual identity: status quo and change

Hobbesian rationale understands law to be at the centre of the relationship between humans confronted by conflicts of interest. However is law by its nature conservative or progressive? Are there structural social changes that can "determine" legal change?⁴¹ Can the Rule of law be multifaceted; that is, can it fulfill different roles as a function of the different historical moments of law and legality? Can the law's autonomy and the Rule of law maintain the social and political order at certain historical moments and protect citizens from arbitrariness or even be instrumental in promoting social change at other moments? According to Spitzer, "Law is thus always structure and praxis," but he asks, "How we do

³⁹ Peer Zumbansen, "Law after the Welfare State: Formalism, Functionalism and the Ironic Turn to Reflexive Law", (2008) *04 CLPE Research Paper 03* at 39.

⁴⁰ King, "The 'Truth' About Autopoiesis", *supra* note 46 at 459/460 and Teubner, Law as an Autopoietic System, *supra* note 5 at 5.

⁴¹ Teubner, Dilemmas of Law in the Welfare State, *supra* note 2 at 5.

decide whether that practice is expressive, repressive or both?” “How can law both support and inhibit the transformation of (class) societies?”⁴²

From an orthodox Marxist perspective, the structuralist theses were criticized for the relative autonomy they attributed to the legal, political and ideological superstructure, considered to be a form of sociological pluralism that blocked an understanding of power relations.⁴³ However, the law has a large degree of indeterminacy, in addition to its dual role, being able to be both an agent of the status quo and an instrument for change. In asking about the indeterminacy of law in its process and dynamism, there is certainly a factor of uncertainty, tied to the very dynamics of historical and political contexts and the relationship of the actors defending their interests, negotiating, maintaining conflicts and generating consensus.

Habermas indicates that development toward a social and democratic constitutional state can be understood as a form of constitutionalizing relations of power. Changes in social legislation linked to working hours, union organization, wage improvements, layoff protection, social security and other benefits are instances of the juridification of the balance of power within legal action.⁴⁴ The distinctive characteristic of a legal system is not the confirmation of the status

⁴² Steven Spitzer, “Marxist Perspectives in the Sociology on Law”, *supra* note 27 at 109.

⁴³ Roberto Fine & Sol Picciotto, “Law Marxist Critique of Law”, in Grigg-Spall, Ian & Ireland, Paddy (eds.) (1992), *The Critical Lawyers’ Handbook*, (London, Pluto Press) at 16-22. See also Lance Hamilton Selva, “Toward a Critical Legal Theory: Development of an oppositional legal discourse under late capitalism”, (Dissertation, Ph.D. School of Criminology, Florida State University, April, 1985) at 49.

⁴⁴ Jürgen Habermas, “Law as Medium and Law as Institution”, in Teubner, *Dilemmas of Law in the Welfare State*, *supra* note 2 at 208.

quo, but rather the recognition that things can change. In fact, legal theorists have called attention to the relationship between law and social change,⁴⁵ questioning such matters as the role of law as a stimulant for progressive social change and the methodology of legal tactics used by social movements in promoting social justice. Some authors argue that legal tactics are futile for bringing about social change.⁴⁶ Others point out that legal tactics can empower social movements, offering them a venue for greater mobilization capacity.⁴⁷ Those that identify with the Critical Legal Studies⁴⁸ movement adopt a rather pessimistic stance, arguing that legal doctrines partially support the status quo.⁴⁹

In this sense, I believe liberal legalism embodies the belief that social reality is defective, but that it may be reformed.⁵⁰ As is argued by Thomson, “critical legal theorists assert that law is far from obvious primarily because its

⁴⁵ I. Kostiner, “Evaluating Legality: Toward a Cultural Approach to the Study of Law and Social Change”, (2003) *37 Law & Society Review* 2.

⁴⁶ Gerald Rosenberg, “The Hollow Hope: Can Courts Bring About Social Change? In Kostiner, *Id.* at 324.

⁴⁷ Michael Mc Cann, “Rights at Work: pay Equity Reform and the Politics of Legal Mobilization”, in Kostiner, “Evaluating Legality: Toward a Cultural Aproach”, *supra* note 45 at 324. Helena Silverstein, “Laws, Meaning, and the Animal Rights Movement”, in Kostiner, *Id.*

⁴⁸ According to Kostiner, *Id.* at 326, these studies see the use of standards and legal tactics as a way of preventing or co-opting the struggles of marginalized groups. He refers to: Peter Gabel, “Reification and Legal Reasoning”, in P. Beirne & R. Quinney (eds.), *Marxism and law*, (New York, John Wiley & Sons, 1982); Peter Gabel & Duncan Kennedy, “Roll over Beethoven”, (1984) *36 Stanford Law Rev* 1; Alan Freeman, “Racism, Rights and the Quest for Equality of Opportunity: A Critical Legal Essay”, (1988) *23 Harvard Civil Rights-Liberties Law Review* 295; Alan Freeman, “Antidiscrimination Law, The view from 1989”, in D. Kairys (ed.), *The Politics of Law: A progressive Critique*, (New York, Pantheon Books, 1982); Mark Tushnet, “An Essay on Rights,” (1984) *62 Texas Law Review* 1363; Michael Perry, “Taking Neither Rights-Talk nor the ‘Critique of Rights’ Too Seriously”, *Id.* at 1405; Staugthon Lynd, “Communal Rights”, *Id.* at 1417 & Michael Tigar, “The Rights of Property and lawghts of Property and law of Theft”, *Id.* at 1443.

⁴⁹ David Kairys, *The Politics of Law: A progressive Critique*, 2nd edition, in Kostiner, “Evaluating Legality: Toward a Cultural Approach”, *supra* note 45 at 326. Mark Kelman, “A Guide to critical Legal Studies”, in Kostiner, *Id.*

⁵⁰ Peters, “Law as a Critical Discussion”, *supra* note 2 at 250.

relation to power is not obvious.”⁵¹ The law can be used as an element of change, as a possibility for gradual reform, to the extent that it can be understood as a dynamic process for extending or modifying rights and not only as a self-referential mechanism with which it reproduces itself. Social changes imply cultural changes (outlooks, perspectives, attitudes) that entail new demands and their corresponding legal transformations.⁵²

That the law can be an agent of change does not deny or refute that ultimately, it is embedded in the economic and political structure of society and reflects economic relations, particular class interests, and is ideologically transformed to appear neutral. As indicated by Zumbansen: “Law has and obviously does in many cases serve as a weapon of hope and emancipation – but also the opposite is possible and frequently the case: with reference to existing laws, great deeds of injustice are committed, a tight grip of oppression over society maintained and law deprived of all its sense of political inconclusiveness, openness and critique.”⁵³

“For the legal system in particular the notion of self-reproduction seems difficult to reconcile with the fact that law is determined to a considerable extent by political influences, economic structures, and social factors.”⁵⁴ The legal order thus reflects the social order, a product of social and class conflicts. In any case,

⁵¹ Alan Thomson, “Critical Approaches to Law Who Needs Legal Theory” in Alan Thomson, “Foreword: Critical Approaches to Law”, in Grigg-Spall, Ian & Ireland, Paddy (eds.) (1992), *The Critical Lawyers’ Handbook*, *supra* note 43 at 3

⁵² Febrajo, “The rules of the Game in the Welfare State”, *supra* note 36 at 17.

⁵³ Zumbansen, “The Future of Legal Theory”, *supra* note 7 at 6.

⁵⁴ Teubner, Law as an Autopoietic System, *supra* note 5 at 21.

Zumbansen,⁵⁵ citing Wechsler⁵⁶ and Lobel,⁵⁷ indicates that the disenchantment with the extension of “rights” to address issues related to social injustice and the neutrality of legal processes are also reasons for dissatisfaction with the law as an instrument for social change. As a product of human activity, the law reflects the uncertainties of social existence⁵⁸ and is therefore contradictory and can be an agent of change and of oppression. Yet particularly with respect to health care, it is interesting to note that the law invites us to discuss how to reconcile interests, how to correct injustices, but it does not invite us to question basic principles of transforming health into a right, like the right to property or to freedom of expression. Constitutional and universal access to health care services is not enshrined as a right, but private property and market economy appears to be.⁵⁹ Perhaps, “like religion in previous historical periods, the law becomes an object of belief which shapes popular consciousness toward a passive acquiescence or obedience to the status quo.”⁶⁰

The law does not only play a role as itself and as an institutional relation with and with respect to the state. The law is also embedded in the social and articulates the interests of political dynamics. As mentioned above, it can be used

⁵⁵ Peer Zumbansen, “Law after the Welfare State: Formalism, Functionalism and the Ironic Turn to Reflexive Law”, (2008) *04 CLPE Research Paper 03* at 18

⁵⁶ Albert M. Wechsler, “Toward Neutral Principles in Constitutional Law”, (1959) *73 Harvard Law Review 1* in Zumbansen, *Id.*

⁵⁷ Orly Lobel, “The Paradox of Extralegal Activism: Critical Legal Consciousness and Transformative Politics”, *120 Harvard Law Review 937, 942-48* (2007) in Zumbansen, *Id.*

⁵⁸ Spitzer, “Marxist Perspectives in the Sociology on Law”, *supra* note 27 at 117-118.

⁵⁹ Thomson, “Critical Approaches to Law”, *supra* note 51 at 19.

⁶⁰ Peter Gabel & Paul Harris, “Building power and breaking images: critical legal theory and the practice of Law”, (1982-1983) *11 Review of Law and Social Change 369-411* at 374.

by powerful interests to preserve inequalities and status quo, and it can be used by less powerful groups as a mechanism for avoiding manipulation by private or government power.⁶¹ That is, “by juxtaposing ‘arbitrary power’ and the ‘Rule of law’ it may be argued that law can operate against the state as well as in its service.”⁶² It is the historical contexts and political dynamics that articulate the conflicts and consensus that also forge the identity of the law.

2. THE LAW AND POLITICAL DYNAMICS

A. The political nature of the legal process and the law as praxis.

Every society creates its own legal system and legal rationality, and it becomes difficult to disassociate law from the culture from which it emerges specifically. Law as a product of negotiation processes between several stakeholders defending their interests is embedded in the social fabric and the political and economic structures of society. It is the expression of how society organizes itself and articulates and represents different interests and worldviews in a given historical context.

Law and the state, from the Hobbesian philosophy of the social contract to the present, are connected – directly or indirectly, only formally or overtly – to a

⁶¹ Unger, *Law in Modern Society*, *supra* note 20 in Hamilton, “Toward a Critical Legal Theory”, *supra* note 43 at 39 & 40.

⁶² See E. P. Thomson, *Whigs and Hunters: The origins of the Black Act*, (New York, Pantheon, 1975) in Spitzer, “Marxist Perspectives in the Sociology on Law”, *supra* note 27 at 112.

discourse of power.⁶³ Using a reflexive interpretation that sees a role for the law in the resolution of conflicts in certain contexts and that makes the law receptive to a range of rationalities, one can study the law as it is materialized at different points in time as a dynamic ungoing process. The legal system interacts in a large public arena in which as part of different contending interests intervene and are reflected and the social order is legitimized: "...the law is never monolithic (...) Its function differs, deepening on the relative strength of the social forces which struggle around and within it, and on the balance between these forces. The law is not a thing but a relation. Its formal rules can be given a different social and economic content in different historical moments and at different periods of struggle."⁶⁴

Althusser, in his structural Marxist paradigm, proposed law as a part of the ideological apparatus of the dominant classes,⁶⁵ but Poulantzas, much closer to Gramsci, saw the law in broader and more dynamic terms, in that it also "organizes and sanctions certain real rights of the dominated classes (even, of course, these rights are invested in the dominant ideology and are far from corresponding in practice to their juridical form)."⁶⁶ While neither Gramsci nor Althusser focused their studies on the law, they did not minimize its role. They

⁶³ Broekman, "Legal Subjectivity as a Precondition", *supra* note 6 at 105.

⁶⁴ S. Hall & P. Scraton, *Law Class and Control*, at 492 in M. Fitzgerald, G. McLennan & J. Pawson (eds.) *Crime and Society: Reading in History and Theory*, London, Routledge and Kegan Paul, 1981: 460-497 in Roman Tomasic, *The Sociology of Law*, (London, SAGE Publications, 1985) at 15.

⁶⁵ Louis Althusser, *Lenin and Philosophy and Other Essays*, (New York, Monthly Review Press, 1971) in Spitzer, "Marxist Perspectives in the Sociology on Law", *supra* note 27 at 108.

⁶⁶ Nicos Poulantzas, "Law", in P. Beirne and R. Quinney, (eds.) *Marxism and Law*, (NY: Wiley, 1982) in Spitzer, "Marxist Perspectives in the Sociology on Law", *supra* note 27 at 108.

understood it as a cultural institution that exercised strength and power through the police and the courts. This means that discovering the hidden meaning of legal texts could also be understood as a form of political struggle against the established order, in this case the capitalist order.⁶⁷ Poulantzas broadened the debate to a more active notion of the law. A more dynamic law, in movement, less one-dimensional, like the structuralists proposed. Law could be understood not only as a receptacle of values and priorities determined outside of society, but also as part of a complex social whole that society constitutes and where it is constituted,⁶⁸ as the law is essence and appearance, content and formality. Though for Poulantzas, the law obscures the real differences behind a facade of formalism,⁶⁹ classes and social groups have many different determinations, which consequently require a negotiation of interests. Poulantzas sees these interests manifested as a block that “constitutes a contradictory unity of politically dominant classes and fractions, under the protection of the hegemonic fraction.”⁷⁰ Referring to Althusser, Sumner, a legal sociologist, suggests that, “Legal enactments must be seen as reflections of contemporary culture and as reflections of political manoeuvre as well as reflections of economic structure.”⁷¹ It is interesting to note that these structuralist interpretations (Poulantzas, Althusser) are criticized from both the orthodox Marxist perspective and post-

⁶⁷ Travers, *Understanding Law and Society*, *supra* note 19 at 72.

⁶⁸ David Kairys, “The Politics of law: a Progressive Critique”, Alan Thomson, “Foreword: Critical Approaches to Law”, in Grigg-Spall & Ireland, *supra* note 43 at 14.

⁶⁹ Hamilton, “Toward a Critical Legal Theory”, *supra* note 43 at 51.

⁷⁰ Poulantzas, “Political Power and Social Classes”, *supra* note 27 at 188.

⁷¹ C. Sumner, *Reading Ideologies: An investigation into the Marxist Theory of Ideology of Law*, (London, Academic Press, 1979) in Tomasic, *The Sociology of Law*, *supra* note 64 at 13.

modernism. In the debate between structuralism and contemporary post-modernist interpretations, structuralism contributes to explaining and understanding the power relations behind the law, while post-modernism warns us about the deterministic risks of trying to explain everything through the lens of economic and political structures.⁷² In the 1980s, other theorists indebted to cultural Marxism, such as the Frankfurt School or the critical legal studies movement, also sought to reveal the deep linkages between legal texts and political contexts. Following Gramsci, the critical legal scholars suggest that the law cannot be understood by means of its own self-referential introspection, but rather through its political relations in order to identify the law's interpenetration with other social processes.⁷³ E.P. Thomson⁷⁴ most profoundly explores this thesis, suggesting that the law is both inside and outside, with both visible and invisible legal structures. Though Merritt⁷⁵ suggests that this thesis could be seen as "cultural reductionism", Thomson proposes that the distinction between the superstructure and the infrastructure levels out, as the law not only influences the basis of society, but also becomes a part of it.⁷⁶

⁷² Thomson, "Foreword: Critical Approaches to Law", *supra* note 51 at 9-10.

⁷³ Alan Hunt, *Explorations on law and Society; towards a Constitutive Theory* (New York, Routledge, 1993) at 303 in Al Attar, "Third world approaches to international law", *supra* note 31 at 102-103.

⁷⁴ Thomson, Whigs and Hunters, *supra* note 51 at 109.

⁷⁵ A. Merritt, "The nature of law", 7 *Br. J. Law & Society* 194-214 in Spitzer, "Marxist Perspectives in the Sociology on Law", *supra* note 33 at 109.

⁷⁶ Spitzer, "Marxist Perspectives in the Sociology on Law", *supra* note 27 at 109.

B. Conflict, consensus and hegemony

It is not law that defines power or guarantees the autonomy of legal institutions, but rather it is the political process that ultimately determines the legislative process (laws) and its legitimization. The rule exists because it is accepted as a matter of convention, and convention is based on consensus (as opposed to disagreement). Therefore, it could be argued that part of social cohesion is also the result of a respect for the legitimacy that law confers. I do not wish to understate the importance of the fact that legal rationality has a meta rationale that is the result of its own process of legitimization, reinforced by the ideological discourses and by the institutions that promote and support it. This could probably be termed “hegemonic consensus”.⁷⁷ This condition is the product of the equation between the social and/or political forces that compete to defend their interests and, at the same time, influence the processes of law creation. There is a circular argument at play: legal rationality is dependent upon the power structure in which legality is embedded, and, simultaneously, this legal rationality legitimizes the character and environment of power relations.

Unger indicates, “interest-group pluralism, as we may call it, represents law as the product of bargaining among organized interest groups. In a democracy the primary but far from the sole locus of this lawmaking activity is legislation, with its background in electoral party politics.”⁷⁸ Unger further argues

⁷⁷ The military Coup of 1973 and the restructuring of the State, which passed to play a subsidiary role, altered one of the keys to Chilean social history, characterized by negotiated legislation.

⁷⁸ Roberto Mangabeira Unger, *What should Legal Analysis Become?*, (London & New York, Verso, 1996) at 53.

that, “Interest-group pluralism...is not a sociology of lawmaking, but rationalizing legal analysis itself, a prescriptive discourse, providing an account of how law becomes legitimate and how it should be represented.”⁷⁹ For functional pluralist traditions as well as for Marxist perspectives, power is dispersed in society in individuals, classes or organizations. However Pluralists, unlike Marxist traditions, deny that a particular group could dominate another, pointing out that everyone has some power and that nobody can have too much. There are pressure groups and interest groups that compete with each other, without any of them having control of the state. In other words, power is disperse. For some, the state is neutral with respect to the resolution of conflicts, and for others it certainly is not.⁸⁰ The differences with respect to the role of the law are not insignificant, as for some it is an articulator for conflict resolution and for others a mechanism of domination for the interests of the dominant classes, in which the essence of the law hides the real differences with the facade of universal formalism.⁸¹

Within the conceptual and theoretical framework of the law, when we refer to the debate between *conflicts or contradictions of interest and consensus* and models of legitimation, we can distinguish between conformist models and critical models. Peters indicates that the critical model has both a *static* operating mechanism, that is, “formal compliance with established law or accepted

⁷⁹ *Id.* at 53-54.

⁸⁰ Hamilton, “Toward a Critical Legal Theory”, *supra* note 43 at 37-41.

⁸¹ *Id.* at 51.

principles” and a *dynamic* operating mechanism, which is “justification through rational arguments in critical discussion.”⁸² It is true that in cultures where harmony is highly valued and consensus is encouraged for resolving conflicts, these encounters may be rejected.⁸³ However, the pursuit “of consensus” does not have to respond only to the functionalist tradition, in which “law answers to requirements, customs and necessities emerging from social practice or crystallizing out of public deliberations.”⁸⁴ The law is not only an instrument for achieving a social, political or economic objective, but also the result of the action and the concrete dynamics and outcome of a cyclical process with its own political dynamics. It is not, as Nonet and Selznick⁸⁵ suggest within the notion of “responsive law”, that citizens must appropriate the law in order to arrive at a consensus around the direction of society. This formalist consensus, as Zumbansen explains, idealizes the forces of cohesion in a society that is profoundly complex and fragmented. “Therein lies, to be sure, the great danger for law, for political, in particular democratic theory and for grand-scale social theory.”⁸⁶

Though the liberal state was founded, as Unger points out, upon compromise, and this compromise has crucial implications for the law,⁸⁷ consensus on a law is only a conjunctural compromise, produced in a given

⁸² Peters, “Law as a Critical Discussion”, *supra* note 2 at 270.

⁸³ *Id.* at 270.

⁸⁴ Zumbansen, “Law after the Welfare State”, *supra* note 55 at 14.

⁸⁵ Philippe Nonet & Philip Selznick, *Law and Society in Transition, Toward Responsive Law*, (New Jersey, Transaction Publishers, 1978) in Zumbansen, *Id.* at 19.

⁸⁶ Zumbansen, *Id.* at 20 & 21.

⁸⁷ Unger, *Law in Modern Society*, *supra* note 20 at 75.

place and time but for an undetermined period, whose limits and timing will be those defined by political dynamics. Even Luhmann, as a systemic functionalist, explores the complex interdependence between conflict and the law, concluding that a theory of law is related to a theory of conflict.⁸⁸ Conflict is productive for law, as it gives the legal system the opportunity to open itself up to the environment, and it is with respect to conflict that the law makes expectations widespread, evolves as a system, fulfills its role in society and attains unity and identity.⁸⁹ Conflict and consensus are not necessarily diametrically opposed or extremes of a process. Both are contradictory, both are dialectic, both are circumstantial and both are inevitable. One does not exist without the other, and they are not fixed in time. Neither is more conservative or liberal than the other. Christodoulides illustrates this very well when he indicates that, “Conflict theory and consensus theory are too often seen as seeking their departure from gaining leverage from, and positing some kind of teleology to, mutually exclusive alternatives. This in turn has occasionally led to simplistic equations of consensus to social structure and conflict to social dynamics.... Conflict is as much inimical to social structures as it is intrinsic to them. Co-operation contains conflict as it does consensus.”⁹⁰

As discussed above, the process of law creation is an expression of the articulation and negotiation of interests in a given social context, producing the

⁸⁸ Niklas Luhmann, *Ausdifferenzen des Rechts: Beiträge zur Rechtssoziologie und Rechtstheorie*, (Frankfurt: Suhrkamp, 1981) in Emiliios A. Christodoulidis, *Law and Reflexive Politics*, (Dordrecht, Kluwer Academic Publishers, 1998) at 130.

⁸⁹ Christodoulidis, *Id.*

⁹⁰ *Id.* at 102.

dynamics of struggles for hegemony and power. Law, as the result of a process of conflict, is, as Szabo puts it, “a condensed or concentrated” product of social relations.⁹¹ Therefore, law is hardly ever, except during revolutions that generate ruptures or dictatorships, imposed without some form of negotiation. It is even possible that organized and critical players, as a result of their ability to induce legal change without altering the existing order, may defend the status quo in order to adopt standards that will achieve change in their respective social contexts. It is in this sense that not only are the dynamics of law determined by endogenous and exogenous factors, but the law itself can be understood as an agent in such processes, hiding the conflicts of interest generated in its own creation. Hence, law is a synthesis of both the dynamics that create it and the results.

This debate about the political dynamics at play between conflicts of interest and consensus seems to be in opposition with the concept of hegemony. I say that it seems to be, as they are not contradictions per se. As Litowitz indicates, “the concept of hegemony deserves broader consideration from the legal academy because it is a critical tool that generates profound insights about law’s ability to induce submission to a dominant worldview.”⁹² This does not mean that submission to a dominant worldview is necessarily imposed. Political dynamics, like all movement, are cyclical and indeterminate, in action, and with

⁹¹ Imre Szabo, *Les Fondements de la Théorie du Droit*, (Budapest, Akadémiai Kiadó, 1973) at 334.

⁹² Douglas Litowitz, “Gramsci, Hegemony, and law”, (2000) *Brigham Young University Law Review* 515.

results that are temporary and can even be contradictory. As these are not neutral but rather the result of political dynamics themselves, the concept of hegemony is crucial for identifying the mechanisms of power and the role of ideologies in shaping the law, as a product of consensus. Law is legitimated in its formality and accepted and validated as a temporary product of the result of consensus, even when we know that this is devoid of content, contradictions or hegemony.

All legal systems evolve as political practice in the exercise of power and the construction of hegemonies. They depend upon or change in accordance with the social and historical conditions associated with a society. "If we theorize the notion of change in relation to the evolution of power relations, and the concept of hegemony about constructing alliances, integrating rather than simply dominating to win consent,"⁹³ we realize that law is achieved through the dynamic and mutable processes of the construction of hegemony. Therefore, the notion of "alliance" is important if we want to "associate" social sectors with a specific worldview, in this case the hegemonic worldview. The concept of hegemony thus becomes critically essential, since it fundamentally expresses a form of domination, originating in lawful practices, exercised in diverse ways and invariably linked to relations of influence and the power structure in a given society. While social organizations induce and influence social and human activity, hegemony is concerned with the reproduction of social structure, and

⁹³ Norman Fairclough, *Discourse and Social Change*, (Cambridge, Polity Press & Blackwell Publishing Inc., 1992) at 92.

more importantly, with the need to secure conditions for this reproduction. Law has the ability to be and to exercise a function and a role in this process, but it is not self-sufficient, neither in its genesis nor in its reason to exist.

Gramsci, when placing the concept of domination outside the state apparatus and the economic sphere, conceptualized that the superstructure may be autonomous with respect to the structure,⁹⁴ and introduced the concept of hegemony as organized consensus. Social groups can be subordinated to others, but the basis of hegemony is always acceptance of the relation.⁹⁵ This organized consensus promotes a dominant worldview that is ultimately supported by the majority of the social classes, with the law contributing to the development of the mechanism for securing hegemony under the aegis of the dominant class.⁹⁶

When the legitimacy of the legal system is in crisis, new political economic variables are introduced and new forms of political negotiation are developed that minimize the universal nature of formal legality and open up new opportunities and dimensions that require the legal and political spheres to be reconciled in order to preserve hegemony.⁹⁷ Furthermore, as the principal characteristic of the law is its formal legitimacy, this legitimacy also bears normative strength, but

⁹⁴ Antonio Gramsci, *Selections from the Prison Notebooks*, (London, Lawrence & Wishart, 1971) at 336 & 337.

⁹⁵ Anne Showstack Sasson, "Globalisation, Hegemony and Passive Revolution", (2001) 6 *New Political Economy* 5 at 11 in Al Attar, "Third world approaches to international law", *supra* note 31 at 46.

⁹⁶ A. Claire Cutler, "Gramsci, Law and the Culture of Global Capitalism", (2005) 8 *Critical Review of International and Social Political Philosophy* at 536 in Al Attar, *Id.* at 141.

⁹⁷ Alan Wolfe, *The limits of Legitimacy: Political Contradictions of Contemporary Capitalism*, (New York, Free Press, 1977) and Habermas, Legitimation Crisis, *supra* note 2 in Hamilton, "Toward a Critical Legal Theory", *supra* note 61 at 273.

since the content of law changes, it can also be manipulated to reflect specific interests. It is in this process that structural biases are normalized.⁹⁸

3. LAW AND THE WELFARE STATE

A. Law, development and the state

The state, unlike the government (the administrative body of the executive power) and the nation (an ethno-cultural concept), is understood as the political unit of a geographically delimited, organized human community with social, economic, sovereign and coercive political organization. Public institutions in this political unit are controlled by the citizens and organized into the state powers, which are legislative power in order to legislate, executive power to administer legislation, and judicial power to administer justice and enforce the law. The latter also falls to the action of the police, which along with the armed forces, hold a monopoly on legitimate physical force. For this research in particular, I prioritize the intervention and action of the legislative power in its lawmaking processes and of the executive power that administers the implementation of laws, leads processes of social and economic development, executes social and economic policy and must guarantee social rights, the accessibility of public health care services and the regulation of private services.

The notions of development and health are sometimes elusive, but they are closely linked to politics and the economy, and they are distinctive in their

⁹⁸ See Al Attar, “Third world approaches to international law”, *supra* note 31 at 104.

capacity to have both a conservative and progressive impact. Economic and social policies are based on both endogenous and exogenous factors. The former include economic and social development policies, the function and evolution of the state, the development of the welfare state, social structure, political representation, and the behaviour and action of political parties and organized civil society (stakeholders). Finally, foreign influence on economic and public policymaking and the country's involvement in and links to the world have been critically important in the shaping of the different health models.

Health issues, usually associated with medicine, chemistry and biology, are addressed with science- and evidence-based practices, while their “political” character in influencing policies, reforms and legislation remains neglected.⁹⁹ As Raphael argues, it is relatively uncommon to acknowledge the importance of the social determinants of health, and it is even less frequent to consider the political, economic and social factors related to health issues,¹⁰⁰ yet there is a reciprocal, synergistic and close interconnection between health and development.¹⁰¹ In the case of the Third World or developing countries, the notion of development is much more closely linked to questions of political economy than it is in the developed world. Third world countries are less stable, more externally influenceable, political scenarios are more diverse and development policies have

⁹⁹ See Buse, Kent; Drager, Nick; Fustukian, Suzanne & Lee, Kelley (2001), “Globalization and health policy trends and opportunities”, in Kelley Lee (et al.) (eds.), *Health Politics in a Globalizing World*, (Cambridge University Press) at 256

¹⁰⁰ Dennis Raphael, “Social Determinants of Health: Present Status, unanswered questions, and future directions”, (2006) *36 International Journal of Health Services* 4 at 651.

¹⁰¹ David Phillips & Yola Verhasselt, *Health and Development*, (London & New York, Routledge, 1994) at 4.

more divergent options. At the same time, law is central to development, since it involves policy choices and distributive objectives, which contribute to development.

It could be argued that a social system that is sensitive to and dependent on the outside world and international influences loses stability and leaves a significant part of society without protection, subjecting them to the fluctuations of external processes. On the other hand, an autonomous system under its own control and its own logic that privileges formalism can be resistant to change and less flexible for adapting to the times. Health policies are thus the result of changes in economic relations, the action of political forces but also growing international influence, which were also modifying the nature and role of the state.

Unger points out, the state must profess neutrality and impersonality and seek harmony. It must be the ruler and different from any other group in the system of domination and dependence,¹⁰² but it is also particularly interesting to note that the state can be involved in the negotiating process¹⁰³ of articulation, adaptation, re-articulation and resistance to change. The state is legitimized in and with the will of its citizens, while social sectors or groups are also coopted by the state with specific social benefits as a form of seeking political support.¹⁰⁴

¹⁰² Unger, *Law in Modern Society*, *supra* note 20 at 61.

¹⁰³ W. Ratliff, "Development and Civil Society in Latin America and Asia", (1999) *565 Annals of the American Academy of Political and Social Science* 91 at 91.

¹⁰⁴ This phenomenon is particularly common and illustrative with populist policies, when the state coopts middle social sectors (civil servants, professionals, white-collar workers) and educated sectors and/or those with political strength in order to thereby neutralize other social groups.

It is in this political process that the state is configured as a product of its own dynamics and historical conjunctures. It has a contradictory identity and legitimates itself as an entity that intervenes in order to maintain order and the Rule of law and to promote the economic and social changes for which society “reached a consensus” in the political sphere and that it legitimized in the formal sphere. In this context of political dynamics and development, the interventionist state plays a double role: it neutralizes social movements through intervention, and it promotes social change to contribute to social and economic development, thus forming the welfare state¹⁰⁵ for a large part of the 20th century.

B. The welfare state

An analysis of social democratic models of social development considers the welfare state resulting of political struggles over state intervention aimed at benefiting the working class, and it is interested in the process of how demands were articulated and their impact on electoral politics.¹⁰⁶ The welfare state

Carmelo Mesa-Lago, *Social Security in Latin America. Pressure Groups, Stratification, and Inequality*, (Pittsburgh, University of Pittsburgh Press, 1978) at 8.

¹⁰⁵ It is particularly interesting to note that the active participation of interest groups - in their various expressions - in national health reforms, began at the opening of the XXth century, before the modern Welfare State. The concept of social welfare emerged in the world in the 1945s, most developed capitalist countries adopted the doctrine sustaining the Beveridge Report along with Keynesian economic policy. We should recall that Beveridge, while trying to cope with the circumstances of war, attempted to ease social inequality through social security and other government subsidies.

¹⁰⁶ Walter Korpi, “Power, Politics and State Autonomy in the Development of Social Citizenship”, (1989) *American Sociological Review* 54 309-28 / Michael Shalev & Walter Korpi, “Working Class Mobilization and American Exceptionalism”, *Economic and Industrial Democracy* 1 31-61 in Chikako Usui, “Welfare state development in a world system context: event history analysis of first social insurance legislation among 60 countries 1880-1960”, in Thomas Janoski & Alexander M. Hicks, *The Comparative Political economy of the Welfare State*, (Cambridge, Cambridge University Press, 1994) at 256.

improved income distribution, but it also influenced and affected the accumulation of capital. Furthermore, it brought about changes in labour productivity and broadened many of the values and rights that certain workers have acquired over time. Yet it is important to point out that the concept is not necessarily straightforward and creates historical contradictions. Some associate it, perhaps mistakenly, with the concept of “*Socialstaat*”, which is also a social option or social intervention for the economic and political problems of capitalism. “*Socialstaat*”, based on the Bismarckian policies of the 19th century, comes from the Weimar Republic and Constitution,¹⁰⁷ which explicitly protected the labour force and regulated or restricted the economy in pursuit of social justice in early 20th-century Germany.¹⁰⁸ It is also correct to say that this “*Socialstaat*” and the policies of Bismarck were not progressive in the strict sense and sought to neutralize the social movements in 19th-century Europe that threatened the established order.¹⁰⁹ This is why this concept of the social state is comparable,

¹⁰⁷ The Weimar Constitution was the Constitution of the German Reich during the Weimar Republic, between 1919 and 1933. It declared Germany a democratic parliamentary Republic. Public education was provided by the state. The economy had to conform to the principles of justice and securing economic freedom. Article 161 established “*that in order to maintain health and the ability to work, in order to protect motherhood and to prevent economic consequences of age, weakness and to protect against the vicissitudes of life, the Reich establishes a comprehensive system of insurance based on the critical contribution of the insured*”. <http://www.ria.ie/getmedia/a0686b61-acc4-4331-acd2-6b95c900fe00/Comparison-between-the-Weimar-Constitution-1919.pdf.aspx>

¹⁰⁸ Ulrich K. Preuss, “The Concept of Rights and the Welfare State”, in Teubner, *Dilemmas of Law in the Welfare State*, *supra* note 2 at 22-23.

¹⁰⁹ In 1871 he wrote: “*The action of the state is the only means of arresting the Socialist movement. We must carry out what seems justified in the Socialist programme and can be realized within the present framework of the state and society*”, Alan J.P. Taylor, *Bismarck: The Man and the Statesman*, (New York: Vintage Books, 1955) at 78 in Peters, “Law as a Critical Discussion”, *supra* note 2 at 276.

but not equivalent, to the evolution of the welfare state and the implementation of Keynesian economic policies starting in the second half of the 20th century.¹¹⁰

In fact, both right and moderate left-wing political parties supported Keynesian theory, which proposed mitigating the effects of economic depression by stimulating demand through the state and influenced what we now call the welfare state, with its most ardent defenders being the social democratic governments. The welfare state system encouraged markets and industrialization and promoted peace, social stability and social consensus. The welfare state has not only improved the distribution of income and influenced the accumulation of capital, but has also induced changes in labour productivity and enhanced the values and rights gained during an individual's lifetime. Although what we define today as a welfare state stems from different conceptions, of both philosophical and moral in their socio-historical genesis, the role and position of the state has been unquestioned in its position at the epicentre of social, economic and political processes within this model.¹¹¹ This is particularly evident in Latin

¹¹⁰ John Maynard Keynes, *The General Theory of Employment, Interest and Money*, published in 1936, during the great depression, arguing that macroeconomic outcomes required active responses by state intervention.

¹¹¹ See J. Picó, "Modelos sobre el Estado de Bienestar. De la ideología a la práctica", in R. Casilda & J. Tortosa (eds.), *Pros y contras del Bienestar*, (Madrid, Tecnos, 1966) in Mario Parada, (2004) *Evolución del sistema de protección social de la salud en Chile: un análisis sociológico* (Ph.D. diss., Universidad Autónoma de Madrid, Spain. See also J. Picó, *Teorías sobre el Estado del Bienestar*, (Madrid, Siglo Veintiuno de España Editores, 1999) in Mario Parada, *Id.* at 23.

America, where the state became more interventionist in order to ensure emerging social rights.¹¹²

The welfare state thus seeks to balance the structural imbalances, inequalities or inequities generated by political power and market interests. The welfare state has also brought about important transformations in society. In particular, by extending individual and collective rights to social welfare, it has modified political struggles, seen new groups and collectives with demands emerge, broadened the concept of democracy and ultimately reformulated the state-society relation.

The welfare state has also been at the centre of criticism from all political and ideological sectors. Conservative interpretations present it as an obstacle to economic growth (seen clearly today with neoliberal policies), as it limits individual liberties and strengthens the role and interventionism of a state seen as inefficient and controlling. Classic or orthodox Marxist theory considers the welfare state to be an action carried out by the dominant sector to neutralize and coopt workers or to include them with less resistance in processes of capitalist accumulation. Between these extremes, there are less radical variations, but these present the welfare state in its contradictory nature, understanding that while having conciliatory effect upon capital and labour, it is no less true that it has an impact on social progress and that its effect on the social structure is

¹¹² Sonia Fleury, "Reforming Health Care in Latin America: Challenges and Options" in Sonia Fleury, S. Belmartino & E. Baris (eds.), *Reshaping Health Care in Latin America*, (Ottawa, IDRC, 2000) Chap. 1.

ambivalent, maintaining both egalitarian tendencies and the preservation of the status quo.

There are valid reasons for maintaining that the legal system of the welfare state contributes to the very dynamics of economic growth¹¹³ understood from the point of view of the development of capitalism, in that the social measures contribute and are functional to growth policies. However, as Unger notes,¹¹⁴ contemporary law, through legislation, administration and the adjudication and action of the courts, is also important for monitoring economic control and unjust accumulation and for keeping markets competitive or determining if an agency is acting in the public interest.

Today, the significant structural differences between the *Socialstaat* and the welfare state in its Keynesian version are fading, and it must be recognized that the latter is instrumental to mass democracy.¹¹⁵ According to a critical interpretation, social conflicts between capital and labour transformed into conflicts over the distribution of the gross national product. This reconciliation between capitalism and democracy is the main reason that the welfare states worked following the Second World War.¹¹⁶

From a strictly theoretical point of view, critical analyses present the welfare state as an instrument for realigning capitalist accumulation policies or as

¹¹³ Preuss, "The Concept of Rights and the Welfare State", in Teubner, *Dilemmas of Law in the Welfare State*, *supra* note 2 at 155.

¹¹⁴ Unger, *Law in Modern Society*, in Bill Scheuerman, "The Rule of law and the Welfare State: Toward a New Synthesis", (1994) 22 *Politics & Society* 2 195-213 at 199.

¹¹⁵ Preuss, "The Concept of Rights and the Welfare State", *supra* note 2 at 154.

¹¹⁶ Claus Offe, "Competitive party Democracy and the Keynesian Welfare State: Factors of Stability and Disorganisation", (1983) 15 *Policy Sciences* 225 in Preuss, *Id.* at 154.

a form of attaining political and social consensus without structurally altering hegemonic relations. This interpretation has also changed following the implementation of neoliberal economic policies that have rearranged capital-labour relations and the role of the state. “The transformation of the western welfare state in the latter half of the twentieth century is marked by a significant transformation of the role of the state in the establishment and provision of formerly ‘public’ services.”¹¹⁷

It would seem that the neoliberal view, unlike its liberal alma mater, seems to favour a legal system that guarantees more the expression of economic freedoms than justice, social inclusion and even the constitution and stability of the Rule of law. In this context, it would appear that a central dilemma of democracy, depending on how it is interpreted or defined, is the disjunctive between freedom and justice. “Whereas much of the twentieth century was characterized by the central role of the state...present contentions of functionalism emphasize the values of market freedom and competition as endangered by state intervention”.¹¹⁸

The contemporary options of deregulation and privatization are reflections of the neoliberal perspective that presents this tradeoff between freedom and justice. Of the two concepts, already ideologized, neo-liberalism favour freedom, and, hence, reject state intervention. However, as Scheurman puts it, “...we may

¹¹⁷ Peer Zumbansen, “The Conundrum of Order: The Concept of Governance from an Interdisciplinary Perspective”, (2010) *06 Research paper Osgoode Hall Law School* 37 at 85.

¹¹⁸ Zumbansen, “Law after the Welfare State”, *supra* note 55 at 6.

not need to choose either formal law or the welfare state, either the Rule of law or greater social and economic equality. The view advanced by so many authors that there is a dramatic decision that needs to be made either for freedom or equality is overstated.”¹¹⁹

Nevertheless, the last decades are demonstrating a metamorphosis of the welfare state. Social policies are commercialized, and their function is no longer complementary to processes of accumulation; instead, they are directly part of this process. This has been thoroughly demonstrated with policies privatizing health services and pension systems. Some, such as Peters, estimate that even the modern welfare state has very subtly come to introduce major processes of alienation, expressed as a “subjectivization of critical thought” in which freedoms today are part of consumption.¹²⁰

¹¹⁹ Bill Scheuerman, Scheuerman, “The Rule of Law and the Welfare State...”, supranote 114 at 204.

¹²⁰ Peters, “Law as a Critical Discussion”, *supra* note 2 at 277.

CHAPTER TWO

HEALTH LEGISLATION AND LEGAL CHANGES DURING THE WELFARE STATE MODEL

INTRODUCTION

The development of social policies in Chile has been unequal and closely tied to the trajectory of social struggles and the ability of mostly class-based social movements to effectively voice their demands. Defining social movements is clearly complex due to the relativity and historicity of the concept. A definition cannot be transposed onto a given reality without understanding the reality and circumscribing the definition to a given social, political and, of course, historical context. For the purpose of this research, social movements are principally understood as being associated with the labour movements and their protests, as was the case in Latin America and Chile since the end of the 19th century. Later, Latin America saw other expressions of social movements, tied to struggles of national liberation, revolutionary movements and political and popular movements. The common denominator was political struggle itself, in national causes closely tied to political life and the political parties. In the final decades of the 20th century, other social movements also started to influence political, cultural and popular life, distancing themselves from the traditions of the labour movement and the primarily Marxist political parties with interpretations that were critical of capitalist society. This was theoretically developed in analyses of post-industrial society, where social movements are seen to go beyond the context of the class struggle.¹ Social movements also broadened with globalization

¹ See Alain Touraine, *La Voix et le regard, Sociologie des mouvements sociaux* (Paris: Seuil, 1993) and Claus Offe, "Los nuevos movimientos sociales cuestionan los límites de la política institucional" in *Partidos políticos y nuevos movimientos sociales* (Madrid: Ed. Fundación Sistema, 1992).

processes and the socio-political impacts of neoliberalism, such as the exclusion, atomization and marginalization of large sectors of society. Growing social and economic inequity, despite relative economic growth, and the emergence of other social and cultural concerns tied to the feminist movements, already more consolidated, and the environmental, indigenist, sexual diversity, ethnic, student and other movements began to have an influence on organized social expressions.

Nonetheless, it is important to note both the historical importance that the labour movement had for protest in Chile and the fundamental significance of the political parties. It is probably due to the extent of the labour and union movement's organization and political tradition that social movements in Chile were principally linked to this movement, which I prioritize in my analysis of social policy in this dissertation.

The pension system, health care services and the education system all became fragmented and developed in dissimilar ways as fractions of the middle class, the working class,² private interests, the church, medical doctors, health professionals and health workers, the armed forces, and organized civil society succeeded to varying degrees in pressuring the state to extend coverage.

This is why, in order to analyze the welfare state, it is necessary to understand how political struggles have been articulated and how the state,

² G. Walt, "Implementing health care reform: a framework for discussion", in R. B. Saltman, J. Figueras & C. Sakellarides (eds.), *Critical Challenges for Health care Reform in Europe*, (Buckingham, Open University Press, 1998) at 24.

whose role has been decisive, has intervened. The articulation of social demands has an impact on electoral politics and, subsequently, on legislative processes.³ As discussed in the previous chapter, the welfare state has improved social conditions and income distribution, and at the same time it has influenced the economic structure and stimulated labour productivity. The Chilean welfare state was built with a corporatist approach, following the European model, with the active but uneven participation of all actors and stakeholders involved in the various stages of its development over the course of the century.

The health system and its hierarchical provision of services was always in a process of transition, in which health legislation and health reforms were the result of an ongoing process of negotiation between actors and the various interests at play.⁴ Reforms have an element of indeterminacy, due to the fact that they are the result of this complex system of interactions among a plurality of social actors, and this makes attention to process as important as attention to content.⁵

³ Walter Korpi, "Power, Politics and State Autonomy in the Development of Social Citizenship", (1989) *American Sociological Review* 54 309-28 / Michael Shalev & Walter Korpi, "Working Class Mobilization and American Exceptionalism", (1980) *1 Economic and Industrial Democracy* 1 31-61 in Chikako Usui, "Welfare state development in a world system context: event history analysis of first social insurance legislation among 60 countries 1880-1960", in Thomas Janoski & Alexander M. Hicks, *The Comparative Political economy of the Welfare State*, (Cambridge, Cambridge University Press, 1994) at 256.

⁴ Eldabi Tillal, Irani Zahir & J. Paul Ray, "A proposed approach for modeling health care systems for understanding" in Conrado Adolfo Gómez, "Influencia de los grupos de interés", (2005) *4 Revista Gerencia y Políticas de Salud* 9 62-80. CIESS, "Conferencia Interamericana de Seguridad Social, 2004", "Informe anual sobre la seguridad social en las Américas 2005", "Fragmentación y alternativas para aumentar la cobertura del seguro en salud" in Conrado Adolfo Gómez *Id.* at 75.

⁵ Guido Giarelli, "Convergence or Divergence? A Multidimensional Approach to Health Care Reforms", (2004) *14 International Review of Sociology* 171 at 183.

In this chapter, I analyze health legislation in Chile as the outcome of an incremental process of negotiated health reforms, and I discuss the role of the state and its relationship to economic and political development during different economic and political contexts and governments between 1924 and 1973. The chapter covers the following periods: the beginning of the welfare state (1924-1938); the process towards the establishment of the National Health Service (SNS)⁶ (1939-1952); the first decade of the National Health Service (1952-1963); and the welfare model during three different political administrations, a) the first decade of the National Health Service (1952-1963) and the conservative government; b) the centrist Christian Democratic government (1964-1970) and c) the socialist model of the Popular Unity government (1970-1973).

In order to analyze the process of reforms and health legislation over these years, I have adapted Walt's⁷ conceptual framework, also modified by Giarelli,⁸ which includes four components: a) the context (political system, macroeconomic situation, ideological and society values); b) the social actors (stakeholders, political parties, unions, professional associations and civil society); c) the content (strategies, type of reforms, nature of the legislation and d) the process (dynamics of the legislation process and its implementation). This chapter explores and discusses health legislation in the context of the interaction of these four components, allowing an analysis and evaluation of health

⁶ Servicio Nacional de Salud.

⁷ Walt, "Implementing health care reform", *supra* note 2 at 365-384.

⁸ Giarelli, "Convergence or Divergence?", *supra* note 5.

legislation during the period in which the welfare state was developed and implemented in Chile.

1. THE BEGININGS OF THE WELFARE STATE MODEL: 1924-1938

Pressure to introduce significant social reforms mounted in the early 1920s. President Arturo Alessandri (first presidency 1920-1924), who enjoyed the support of reformist Radicals and Democrats, formed the so-called Liberal Alliance. While he received strong support from the middle and working classes as well as from provincial elites, he was nevertheless unable to introduce the social reforms he advocated. Congress was dominated by the rural landowning elites, who pressured the government and forced continuous cabinet changes. Yet, while Alessandri's efforts to introduce reforms were resisted by the conservative Congress, reform legislation gained popularity in the Congress thanks to pressure from younger military officers who were unhappy about the neglect of their armed forces and dissatisfied with the political backbiting, social unrest and sharply rising inflation.⁹

Finally, under pressure from a faction within the military¹⁰ and with President Alessandri's consent, Congress approved a wide-ranging set of laws. For the most part, authorities were simply responding to pressures exerted by a

⁹ Rex A. Hudson (ed.), *Chile: A Country Study*, (Washington, GPO for the Library of Congress, 1994).

¹⁰ The officers moved to the periphery of the National Congress and struck their swords on the floor in protest. The event has come to be known as the "Swords Movement".

growing number of workers' organizations and a long series of strikes.¹¹ Ultimately, a context of political and socio-economic crisis, exacerbated by the failure of parliamentary action, facilitated the entry of the military onto the political scene. In 1924, due to a decisive political change, a fraction of the army seized political power and pressured the more conservative members of Parliament to implement more reforms. This military coup forced the resignation of President Alessandri, and a military junta, headed by the Minister of Internal Affairs General Altamirano, called on Congress to finally approve these changes. The 1924 coup thus radically altered the social landscape, ratifying a long list of reforms that brought about a major change in the nature of the state, which now adopted the charitable perspective from which the welfare state would emerge. The determinants of the military action were numerous, including the officers' demands for a speedy approval of the pending labour and social reform bills.

The most important of these social laws was Law 4,054,¹² which created the Workers' Insurance Fund, then known as the compulsory Security Fund and

¹¹ The Chilean Labor Federation (preceded by other experiments) had already been founded in 1909. By the early 1920s, the Federation had approximately 80,000 members. Its charter stated that its purpose was "*to defend life, health and the moral and material interests of workers of both sexes*".

¹² **Law 4,054: Workers' Compensation Act 4054, Sickness and Disability (Recasting of Act 4054 of September 8, 1924)** This Act declared and provided for compulsory sickness and invalidity insurance for anyone less than 65 years of age who had no other income or means of subsistence, wage or salary, not exceeding eight thousand Chilean pesos (year 1926) annually. Applicants or apprentices in any job, industry or occupation were also entitled to some kind of assistance even if they had no wage or salary. All workers, artisans and artists working independently, traders or those directly serving the public, in the streets, squares, gates, warehouses, small businesses, and small traders or trolleys, were also covered under this Act even if their average yearly income did not exceed eight thousand Chilean pesos (year 1926) annually.

later renamed Social Security Services (SSS)¹³. The medical branch of the Workers' Compulsory Insurance Fund provided homecare and consultations for workers and their families. It also offered inpatient and outpatient services, created general hospitals and implemented an agreement with the "Charity"—a body that controlled most of the hospitals in the country—using payments allocated from the Workers' Insurance Fund.¹⁴ The creation of the Workers' Compulsory Insurance Fund was an expression of the changing political reality, which included the increasing social role of the state within a context of political and ideological struggles and the emergence of a tripartite political spectrum (right, centre and left parties), thus restructuring the political scene. In comparison with the personal savings of the former Social Insurance Fund and the benefits of the Civil Servants' Savings Fund, the Workers' Insurance Fund pursued a different objective. Administratively defined as a semi-autonomous state agency, the Fund received its revenues from employer and worker contributions as well as from state coffers.

A particularly noteworthy aspect of the reforms implemented during this period is the autonomy that was granted to the Fund to either establish in-house services or to outsource them. The practice that prevailed was to pay the Charity hospitals for services rendered to the insured at cost price, according to prices set by the Fund, without having to negotiate with doctors. This regulation was

¹³ SSS, Servicio de Seguro Social.

¹⁴ Fernando Rodríguez, "Estructura y características del sector salud en Chile", in M. Livingstone & D. Raczynski (eds.), *Salud pública y bienestar social*, (Santiago, CIEPLAN, 1976) at 66.

crucial in the shaping of the Chilean health system. As the Security Fund lacked its own hospitals, it did not become isolated or dissociated from the rest of society. Instead, it was thought of as dependent upon Charity hospital services. This facilitated the recruitment of more professionals and better-qualified health personnel. The organizational structure also allowed the Fund to immediately draw attention to the need to integrate and rationalize services, which was specifically addressed in subsequent draft legislation. Before its enactment, though, Law 4,054 faced several important challenges. Prior to its implementation, employers launched an open boycott of compulsory contributions, and business owners threatened to close down factories. The law was finally promulgated on 8 September, 1924, along with a series of other reforms, with little discussion and brought before the legislature at military gunpoint.¹⁵

The new social welfare legislation was approved under a new conceptual differentiation between “working” people and “the indigent”, providing new grounds for legitimating waged labour that would become the essence of the working class vis-à-vis the state.¹⁶ The Ministry of Hygiene, Welfare, Labour and Social Welfare was created in 1924 to carry out the new legislation, naming Dr.

¹⁵ The following bills were thus approved without almost any parliamentary discussion: National Budget (1924); Nominations for Army personnel, promotions and retirements; Salary increases for junior officers of the Armed Forces and Police; Police reorganization; Reform of the Armed Forces’ Pension Fund; Granting legal standing to the Army factory; Labor Code amendments with respect to unionization, labor contracts, right to strike, arbitration, tribunals and cooperatives; Social Security coverage for disability, sickness and labour accidents and Law that was part of the Labor Code.

¹⁶ M. Illanes, “En Nombre del Pueblo, del Estado y de la Ciencia...”, *Historia Social de la Salud Pública. Chile 1880-1973*, (Santiago, Colectivo de Atención Primaria, 1993) at 197.

Alejandro del Río as minister, who distinguished himself with advanced public health proposals. With this nomination, the country officially recognized for the first time the superior role of medical science in ensuring the physical and moral welfare of its citizenry.¹⁷ The new ministry was responsible for public health, for coordinating and administering all medical services and for monitoring the institutions related to health care and social protection. Public authorities recognized the interrelationships between health issues and socio-economic conditions, the right of the population to receive curative care and the state's sense of responsibility for health care. This translated into the need to give priority to the protection of disadvantaged sectors of the population.¹⁸

The following year, in March 1925, the organization of health services became formally regulated with the creation of the Division of Social Hygiene.¹⁹ The historical importance of this legislation is indisputable, given the magnitude of its social reach and the significant role that it gave to the state. Indeed, the law involved all of Chilean society in health control measures, while the state took on an important responsibility, becoming a highly centralized overseer.²⁰ The political aim of this welfare project was twofold: first, to restore the bonds between the population and the ruling class, and second, to incorporate the working class into the national public realm. It thus focused on the most

¹⁷ *Id.* at 204-07.

¹⁸ Rodríguez, "Estructura y características del sector salud en Chile", *supra* note 14 at 66-67.

¹⁹ División de Higiene Social.

²⁰ Illanes, "En Nombre del Pueblo, del Estado y de la Ciencia...", *supra* note 16 at 219-21.

interesting aspect of the welfare state, which was to attend to, maintain and restore the health of the working force—the pillars of the productive process.²¹

Although the state had no intention of taking over or reducing private health care, it planned to consolidate its centralized vision and policy vis-à-vis the socio-political organizations, such as the municipalities, that had considerable jurisdiction over public health matters. These were regulated by the Health Code, which the new law would modify. It is in this context that the new Ministry of Hygiene, Welfare, Labour and Social Welfare transferred all public health services from the municipalities to the Division of Social Hygiene.

These changes in the distribution of health care responsibilities were also of great conceptual significance, as health became increasingly present in the public agenda in terms of regulating working conditions, making health care savings compulsory and extending the role of the state in public policies. Social legislation gained enormous political, economic and social prestige and contributed to social stability, as it helped to ensure the contributions of a stable and healthier workforce to the process of economic growth and development. In October 1925, Decree-Law 576 created the Retirement Fund and Social Security for all municipal employees in municipalities and provincial assemblies. Employees who were fifty-five years old and had completed thirty years of service could retire with an entitlement to the rights guaranteed by this statute.²²

²¹ *Id.* at 141.

²² The Retirement and Municipal Employees Social Security Fund was exempt from all tax. The discount was a mandatory 5% of the earnings of each employee. The Fund could acquire real

Although, as mentioned above, the law appears to be a hybrid of politics and ideology and a means for controlling social practice,²³ it is also closely linked to negotiation processes to approve legislation related to social benefits, pursuits of equity and protection from (arbitrary) state intervention.²⁴ In these cases, the relation between the law and social change encourages or at least facilitates the mobilizing capacity of actors²⁵ to promote legislative changes.

While organized labour had its own position with respect to the reforms,²⁶ the medical intelligentsia supported the overall model of the welfare state in its construction of a new and modern concept of “welfare”, a successor to the concept of charity. The reforms were also a result of pressure from the large contingent of workers migrating to cities following the marked decline of mining

estate on behalf of a request received by it, and could also provide mortgage loans on property within its unique domain.

²³ C. Sumner, *Reading Ideologies: an investigation into the Marxist Law Theory of Ideology and Law*, (London, Academic Press, 1979) in Roman Tomasic, *The Sociology of Law*, (London, SAGE Publications, 1985) at 13.

²⁴ D. Grimm, “Der Wandel der Staatsaufgaben und die Zukunft der Verfassung” in D. Grimm (ed.) *Staatsaufgaben*, (Frankfurt: Suhrkamp, 1996), 613-646 and E.-W. Bockenforde, “The rise of the state as a process of secularisation”, in E.-W. Bockenforde (ed.), *State, Society and Liberty Studies in Political Theory and Constitutional Law*, (Trans. J.A. Underwood, New York and Oxford, Berg, 1991), 26-46 in Peer Zumbansen, “Governance: an Interdisciplinary Perspective”, in David Levi-Faur (ed.), *Oxford Handbook of Governance*, (Oxford, Oxford University Press, 2012) at 86.

²⁵ Michael Mc Cann, “Rights at Work: pay Equity Reform and the Politics of Legal Mobilization”, in Kostiner, “Evaluating Legality: Toward a Cultural Approach to the Study of Law and Social Change”, (2003) 323 *Law & Society Review* 2 at 324. Helena Silverstein, “Laws, Meaning, and the Animal Rights Movement”, in Kostiner, *Id.*

²⁶ The workers’ organizations did not offer unconditional support to all the new reforms. They did not, for example, support the Workers’ Security Fund (Law 4.054). They criticized the reforms as a “fraudulent attempt to legally rob the workers of their wages”. The organizations added that workers would never be able to enjoy their pensions, as their miserable conditions would not permit them to live to the required age to obtain the pension. They also argued that while employers contributed to the Fund, eventually and ultimately the workers would suffer due to poor living conditions. They concluded that the creation of the Ministry of Ministry of Hygiene, Welfare, Labor and Social Welfare Hygiene, did not necessarily support the interests of the working class. In contrast, the medical intelligentsia supported the overall model of the welfare state in its construction of a new and modern concept of “welfare”, successor to the concept of charity.

operations in the northern regions of Chile between 1910 and 1920. This entailed the need for social policies that could alleviate growing concerns about the struggle for subsistence. In this context of social turmoil, the working class began to take on an important political significance as a force of electoral support. At the same time, new movements within the military faction called for a Constituent Assembly. Alessandri was recalled to the presidency to complete his agenda of reform, beginning with a new constitution that was ratified in September 1925.

The new constitution reflected international changes and global trends, such as a tendency to recognize individual rights and a growing acceptance of the state's obligation to ensure social rights. Essentially, it gave the executive branch broad administrative powers, increasing the presidential term from five to six years, with direct election. The 1925 Constitution deprived the Chamber of Deputies of the authority to impeach ministers, but it upheld its right to indict ministers and the president of the Republic for abuse of power. It also established the incompatibility of the position of minister with that of a member of Parliament. It determined the separation of the church from the state and guaranteed freedom of religion and conscience, while ensuring civil liberties and individual guarantees. The protection of labour, industry and social welfare was ensured. The new constitution also helped create the Electoral Court and the Central Bank.

These legal provisions also sought to protect workers' right to social welfare, decent housing and satisfactory socio-economic conditions and to

guarantee the health of the population. That same year, Decree-Law 379²⁷ approved the final text of Law 4,055²⁸ on workplace accidents. Under this new law, the definition of “workplace accidents” did not change, but now the onus of proof fell on the employer and not on the employee, as in the past, employees had to demonstrate that they had suffered an accident at the workplace (theory of fault liability or tort). Since the new law followed contractual theory, it was a significant advance from the previous legislation.

Notwithstanding these social advances, the conservative opposition and labour unions were, for different and even opposing reasons, strongly against to these changes and reforms. The same year, 1925, the Social Republicans’ Front²⁹ was created, with the aim of safeguarding social legislation. Among its leaders were workers, employees, and two medical students.³⁰ The importance of this Front lies in its reconceptualization of the corporate welfare state—a

²⁷ **Decree-Law L 379 (1925). Work Accidents.** The employer's responsibility also extended to diseases resulting indirectly from the exercise of the profession or the work undertaken by the employee, and which caused the disability. Without prejudice to the responsibility of the employer, the accident victim, or those who are entitled to damages, can also claim from third parties responsible for the accident, the total compensation for the damage suffered in accordance with the requirements of the law. When it came to a case where a third party, having caused the accident, was required to pay, this law absolved the employer of all responsibility towards paying the compensation. The law provided for full coverage of occupational injury and illness (medical benefits in cash and in kind).

²⁸ **Law 4,055 (1924). Reformed the Law of Industrial Accidents.** An industrial accident meant any accidental injury suffered by the worker or employee during work or in any way related to his/her work, and resulting in disability. The employer was liable for accidents and injuries sustained by their workers or employees. However, the employer was not liable for accidents that occurred in bizarre circumstances, unrelated to the work and intentionally caused by the victim. No. 5 of Article 574 of DFL 178, Social Welfare, published on May 28, 1931, along with other laws relating to work, merged into a single text of this law, and finally repealed this rule.

²⁹ Frente Social Republicano.

³⁰ J. Flores, *La Dictadura de Ibáñez y los Sindicatos (1927-1931)*, (Santiago, Dirección de Bibliotecas, Archivos y Museos, 1993) at 79.

model that would subsequently be taken up by Chile's Social Republican Union of Employees.³¹

In 1926, the Workers' Federation of Chile³² and employee unions supported by the Communist Party³³ organized national strikes and protests demanding the immediate dissolution of Law 4,054, the elimination of the newly formed Ministry of Hygiene, Welfare, Labour and Social Welfare and the end of the welfare state model.³⁴ González Cortés, a deputy at the time, expressed what was being disputed by workers' organizations with great clarity: "...the Compulsory Insurance will smoothly and rationally generate social peace, a friendly alliance between the two major factors of production [i.e. capital and labour], today deeply divorced due to the sad and real misery of those who work and to the blind and senseless hatred that the professionals of the revolution and their crazy dreams are condensing in them."³⁵

³¹ Unión Social Republicana de Asalariados de Chile

³² Federación de Trabajadores de Chile (FTCH).

³³ The Communist Party was founded in 1922 and which began to have a strong presence in the organization of Chilean working class activities. Until then, these had been organized and coordinated by the Democratic Party, led by Luis Emilio Recabarren considered the father of the Chilean labor movement.

Luis Emilio Recabarren was born in Valparaiso in 1876, from very poor parents and worked from a young age as typographer. With formal schooling, he was self-taught. In 1894 he joined the Democratic Party of Chile. He became an ardent public speaker and founded several organizations and newspapers to foment solidarity within the workers. Became director and editor of the *El Trabajo* (Work) newspaper. Later he became the publisher of the *La Vanguardia* (Vanguard) newspaper. Recabarren was elected Member of Parliament in 1906, representing the Democratic Party, but he was prevented though from assuming his position because he refused to be sworn on a bible. He was very involved with the Labor movement and was prosecuted to exile in Argentina. In 1910, after returning from Europe he was arrested and sent to jail. He founded the Socialist Party in 1912 and founded several other politically engaged newspapers. In 1918 he contributed to the foundation of the Argentina's Communist Party and later in the 1922 the Chilean Communist Party. He lost the presidential election in 1920, while being in jail.

³⁴ Illanes, "En Nombre del Pueblo, del Estado y de la Ciencia...", *supra* note 15 at 228.

³⁵ Chamber of Deputies, Session Bulletin, 25th Special Session, May 19, 1922. Bill declaring

However, the expanding welfare state continued to enact new laws and regulations, extending social legislation. The second Health Code was created along with the Higher Council for Child Welfare³⁶ and the Central Board of Welfare and Social Assistance,³⁷ which was an autonomous entity with technical and financial resources. This semi-public institution was responsible for the management, administration and construction of hospitals, shelters, asylums, mental institutions and orphanages. Two years later, in 1927, charitable services, medical services and compulsory insurance were centralized and regulated by Decree 2,101, and Decree 581 also approved a set of laws on occupational diseases.

Numerous social measures resulted from the new institutions founded in the 1920s, which sustained the increased action of the welfare state. The functions that Decree-Law 689 of October 17, 1925 prescribed for the Council for Social Assistance and Welfare Departmental Boards were subsequently moved to the Central Board of Charities.³⁸ Decree with Force of Law (DFL) 178³⁹

compulsory Sickness and Invalidation insurance submitted by Exequiel González Cortés. Also processed the Act that created the Fund for Private Employees based on the individual capitalization system enacted in 1925.

³⁶ Consejo Superior para la Protección de la Infancia.

³⁷ Junta Central de Beneficencia y Asistencia Social.

³⁸ The Central Board of Charities served the Welfare Services and Social Welfare under the authority of the President of the Republic. It was composed of the following members: The Social Welfare Minister who presided over the board; the President of Charity Services of Santiago, the Director General of Health, two members of the Council of Welfare, and the Dean of the Faculty of Medicine. The Central Board appointed the presidents of the Charity Services- both, Provincial and Departmental. Medical assistance as in the Compulsory Insurance Act 4054, and which was granted to individual employees, eventually came under the jurisdiction of the Central Board of Charities. The President had to decree the regulations for the operation of Charitable Services and Social Welfare.

³⁹ **Decree-Law (DFL). 178 (1931). Created the Labour Code.** Merged laws and decree-laws promulgated between 1917 and 1931.

created the first Labour Code in Chile, and in terms of social security, it is worthy of note that employers were obliged to take all necessary steps to effectively protect the lives and health of their workers and employees. They were responsible for all hygiene and safety measures in the workplace and for facilitating timely and adequate medical, pharmaceutical and hospital care.⁴⁰

At the end of 1927, the new Chilean political landscape again witnessed major changes. President Alessandri resigned due to lack of support from General Carlos Ibáñez del Campo, who had previously brought him to the presidency in the 1924 military revolt. Alessandri went into exile, and the government was taken over on an interim basis while General Ibáñez, without the support of the political establishment, announced his candidacy for the presidency. Finally, Emiliano Figueroa, the sole candidate for the Liberals, Conservatives and Radicals, won by a large majority, but he was rapidly subjected to pressure by the now Minister of Internal Affairs, General Ibáñez. A

⁴⁰ Injury: referred to an accident that the worker or employee had suffered on account of or in connection to his work. The employer was liable for accidents caused to their workers and employees, except for accidents occurring under bizarre circumstances, those unrelated to work, and those intentionally caused by the victim. The onus of proving the exceptions stated above fell on the employer.

Notwithstanding the foregoing, the victim of the accident or anyone entitled to compensation could claim compensation from third parties for the damage suffered. The employer was held responsible for a disease caused directly by the exercise of the profession or work performed by the worker or employee, which caused the worker's disability. There were three types of Disabilities: temporary, permanent-partial and permanent-total. If the accident resulted in Death, the relatives and other persons mentioned in the Code were entitled to compensation. Other important issues to be highlighted are the following:

Pregnant workers were entitled to have a six weeks break before birth and six weeks after. The employer was required to reserve the working position and had to pay a subsidy. The working places had to have independent adjoining facilities, where mothers could breastfeed their children and leave them there while they were at work. In the warehouses, shops, bazaars and other similar commercial establishments, the employer had to maintain a sufficient number of seats and chairs and make them available to the dependents or employees.

new election ultimately brought the general to power, and he ruled in a dictatorial fashion from 1927 to 1932, suspending Parliament and administering the country with decree-laws. The repression led to arrests, and many of his former allies and partners were forced into exile. His aim was to institutionalize a “foundational state” through a project of “national salvation”. This came as a response to his desire for a strong government that would put an end to government corruption and public disorder and rebuild political parties, Parliament and the concept of the free vote. With an anti-oligarchic discourse, Ibáñez sought to contain the ruling class and resolve what he saw as the moral crisis of Chilean society.

Ibáñez sought the support of a fraction of workers attracted by the idea of non-politicized policies free of class distinctions, put forward by the Republican Confederation of Civic Action (CRAC, 1929-1931).⁴¹ & ⁴² His main political instrument and argument was social legislation, which allowed him to delimit the boundaries of social conflict in legal terms.⁴³ He also created new social and health-related institutions, like the Biological Society of Chile⁴⁴ founded in 1928. Shortly afterward, in 1929, the Bacteriological Institute⁴⁵ was established, which

⁴¹ Flores, “*La Dictadura de Ibáñez y los Sindicatos (1927-1931)*”, *supra* note 30 at 127 in Mario Parada, (2004) *Evolución del sistema de protección social de la salud en Chile: un análisis sociológico*, (Ph.D. Thesis, Universidad Autónoma de Madrid, Spain) at 159.

⁴² Confederación Republicana de Acción Civil.

⁴³ Ibáñez requested the elaboration of the Work Code, promulgated in 1931.

⁴⁴ Sociedad Biológica de Chile.

⁴⁵ The Bacteriological Institute of Chile, created by the Act 4556 was designed to accomplish the following: 1) A forum for bacteriologists, who were dedicated to research and other working needs required in the country; 2) The development of serums, vaccines, biological products and biochemical in general; and 3) Control of the manufacture and sale of bacteriologist products, in accordance with the guidelines issued by the Directorate General of Health. The Bacteriological Institute of Chile was also legally entitled to carry out manufacturing and sales. The Institute was dependent on the Ministry of Education, notwithstanding the technical supervision exercised by

was responsible for the development of biological and chemical products, scientific research and the training of hygienists. That same year, the Superior Council of Hygiene⁴⁶ was also created, and in 1931, Law 5,515⁴⁷ created the Central Board of Charities.⁴⁸

Ibáñez's uncertainty concerning the implementation of a refounding of the state, along with his indifference to workers' claims, the economic crisis of 1930 and the fatigue across the political spectrum caused by indiscriminate repression,⁴⁹ led to the failure of his corporatist projects. His initiative to unify, without consultation and by decree, all health care services under a new super-ministry of social welfare sparked the fury of professionals, teachers and students in the medical field. Ultimately, the dictator-president resigned due to pressure from a large civic movement, with doctors and medical students playing a major role.⁵⁰ There ended the advancement of corporatist initiatives, but not their underlying ideology, which remained latent in the conservative mind until their comeback in the mid-1960s.

the Ministry of Social Welfare, through the Directorate General of Health. A Director who was appointed by the President of the Republic headed the Institute. It comprised of the following departments: Biochemistry, Bacteriology, and Control. A Board of Directors, consisting of the Director and Heads of Departments, formed the management. The Institute had to supply their products to all the institutions designated by the Government. It conducted free examinations, and provided bacteriological, immunological and entomological support.

⁴⁶ Consejo Superior de Higiene.

⁴⁷ **Law 5,515 (1932). Created the Central Board of Charities.** Appointed the Board's members and executive officers and outlined the conditions for electing the remaining members, including the vice-president. According to this law, the president of the Board was the Minister of Social Welfare.

⁴⁸ Junta Central de Beneficencia.

⁴⁹ Persecution, banishment and exile of prominent figures like Arturo Alessandri and Dr. Exequiel González Cortés.

⁵⁰ Contributed to the death of a medical student in the riots during the civil insurrection against Ibáñez.

In the 1930s, a new phase in the conceptual development of Chilean medicine began. A series of new principles was being applied in the organization of care services, such as periodic planning, comprehensive treatments, multiple-cause diagnoses, a concentration of efforts towards the most vulnerable people, the creation of a public technical authority and the ongoing responsibility of the state in social matters. Along the same lines was the growing state involvement in pension policies. In 1930, blue-collar workers and journalists saw the creation of the National Public Employees and Journalists Fund⁵¹ as an autonomous institution and a legal entity in itself. The Fund, among other functions, was responsible for managing the payment of pensions and allowances, which the law provided for by means of a Trust Fund established specifically for this purpose along with life insurance allocations when needed.⁵² The country already had the necessary legal basis for state intervention, reinforced by the 1925 Constitution and the 1931 Health Code.⁵³ The provisions of the Health Code governed all matters relating to public health in the country.

At the same time, the impact of the global economic crisis of the 1930s and disputes within the Chilean working class led to the creation of the Socialist Party in 1933. Later, 1937 saw the introduction of free distribution of milk to

⁵¹ **Decree-Law (DFL) 1,340 Bis (1931). Creates the National Public Employees and Journalist Fund.** Caja Nacional de Empleados Públicos y Periodistas (CEPP)

⁵² All employees appointed by the President or any other competent authorities, and those being paid out of public funds, were subject to the provisions of this Act. In terms of benefits, they were entitled to retirement or a disability pension, a family subsidy and a life insurance. Medical services and the possibility of applying for loans from the fund were additional benefits.

⁵³ **Law 226 (1931). Established the Public Health Code.** (Código Sanitario). The Health Code also created the National Health Service under the responsibility of a General Manager who necessarily had to be a doctor.

children under two years of age, and in 1938, Law 6,174⁵⁴ established the principles of preventive medicine with the aim of defending and restoring the productive capacity of the workforce, which suffered from tuberculosis, rheumatism, syphilis and cardiovascular diseases, as well as many other disabilities and illnesses caused by poor working conditions. This law came as a response to the fact that the curative system was not adequately protecting the population, as both visible morbidity and hidden (cardiovascular) morbidity were having a serious impact on workers and their families. The law thus ordered the implementation of regular health check-ups for workers. The Workers' Insurance Fund, through its own medical services, offered medical care, allowing the Fund to monitor the health conditions of its members and prevent the onset of chronic disease, along with detecting the causes of occupational diseases. The Fund also created the Mother and Child Division for workers and their wives during pregnancy (a preventive measure) and for the children of the insured up to two years of age (a combined measure of prevention, care and protection).

Chile's social and health laws up to 1938/1939 already illustrated the state's involvement in health and welfare. However, the multiplicity of institutions that were created, then modified, subdivided or merged, in addition to the

⁵⁴ **Law 6,174 (1938). Established the Department of Preventive Medicine.** Established that all provident funds to be covered by Act No. 5.802, would come under the purview of the Ministry of Health, Welfare and Social Assistance, and Mutual of Police. It provided for preventive medical services to monitor the health status by imposing and adopting measures aimed at discovering, and preventing the early development of chronic diseases such as tuberculosis, syphilis, rheumatism, diseases of the heart and kidneys, as well as work related diseases: lead poisoning, anthracnose, silicosis, hookworm, and others of the same nature.

fragmentation of family coverage (i.e. different members of a family were covered by different services or divisions), caused the curative and preventive services to become both expensive and complex. Furthermore, the welfare state model had failed to resolve the lack of access to public services for the middle classes. Hence, the universal right to medical care became the great challenge of the Popular Front, which took office in 1938. It was in this new political scenario that the minister of health of the time, the socialist Salvador Allende, emerged as the architect of the relationship between politics, social medicine and the medical movement.

The Socialist Party joined the Communist Party and the Radical Party (sectors linked to the petite bourgeoisie, the middle classes and professionals) to form the Popular Front,⁵⁵ which won the 1938 presidential elections and accelerated the process of industrialization and the increased involvement of the state in social affairs.⁵⁶ A major earthquake in 1939 placed a number of additional demands upon the health sector, and therefore the administrative

⁵⁵ The Popular Front in Chile was an electoral and political left-wing coalition from 1937 to February 1941, made up of the Radical Party, The Communist Party, the Socialist Party and the Radical Socialist Party. Two of the Popular Front presidents belonged to the Radical Party (a middle-class, liberal party). Other organizations, such as the Confederation of Chilean Workers (*Confederación de Trabajadores de Chile*), the native Mapuche movement (*Frente Único Araucano*) and the women's movement (*Movimiento Pro-emancipación de las Mujeres de Chile*), also joined the Popular Front. The Popular Front candidate, Pedro Aguirre Cerda, won the presidential elections in 1938 and governed until his death in 1941. The Front was then transformed into the Democratic Alliance, which also won the 1942 presidential election, with Gabriel González Videla as president.

⁵⁶ Carolina Tetelboin, (1980) *La práctica médica en Chile*, (Thesis, Universidad Autónoma Metropolitana-Xochimiloho, México) at 46-47.

harmonization of different health-related services became an imperative of the times.^{57 & 58}

2. TOWARDS THE NATIONAL HEALTH SERVICE (SNS): 1939-1952

The Popular Front administration brought the Socialists and Communists into the already established bargaining system for political negotiations, transforming potentially revolutionary forces into relatively moderate participants in legal institutions. The newly elected President Pedro Aguirre Cerda⁵⁹ pursued a model of state capitalism in which the government collaborated with private enterprise in the construction of a mixed economy. The Popular Front promoted import substitution industrialization along with welfare measures for the urban middle and working classes.

Early in 1941, the Socialist Party withdrew from the Popular Front coalition because of its animosity towards the Communist Party, its rival in its claim to worker loyalty and Marxist inspiration. Because the Conservatives and Liberals blocked nearly all legislation in Congress, little social reform was accomplished,

⁵⁷ Roberto Belmar & T. Hall, "Evaluation of Chile's Health Care System 1973-1976", (1977) 7 *International Journal of Health Services* 532.

⁵⁸ T. Hall & P. Díaz, "Social Security and Health Care Patterns in Chile", (1971) 1 *International Journal of Medical and Sanitary Services* 364.

⁵⁹ Pedro Aguirre Cerda was born in 1879. He became a Spanish teacher in 1900, and in 1904, a lawyer. He completed law studies at the Sorbonne in France and later became president of the National Society of Teachers. He was also a member of Parliament, a deputy and a senator, and he was the first dean of the new economics school at the University of Chile. As a member of the Radical Party, he was the minister of Public Instruction and of Internal Affairs, serving two presidents (Juan Luis Sanfuentes and Arturo Alessandri). He was also an active politician against the dictatorship of Carlos Ibáñez del Campo. In 1938, he won the presidential election to become president with the Popular Front under the slogan, "To govern is to educate", promoting technical and industrial schools, creating thousands of new regular schools and encouraging the growth of the university system to cover the entire country.

except for improvements in housing and education. The greatest achievement of the Popular Front was the creation, in 1939, of the Corporation for the Promotion of Development and Production.

In January 1941, Law 6,640 was merged with Law 6,334 (1939) and the revised text approved creating the Corporation for Reconstruction, Relief and Development of Production. This new law subsequently created two separate entities: the Corporation for the Promotion of Development and Production (CORFO)⁶⁰ and the Corporation for Relief and Reconstruction. The CORFO was founded to promote domestic production in order to raise the population's standard of living by exploiting the country's natural conditions, lowering production costs, supplying credit to new enterprises, especially in manufacturing, and improving Chile's international balance of payments.

The CORFO mission also included maintaining a geographic balance in the development of mining activities, agriculture, industry and trade, thereby ensuring the satisfaction of the economic needs of different regions. The Corporation also collaborated in the manufacture and import of machinery and other elements of production. It put forward proposals and helped in the adoption of measures to increase domestic consumption, and it advocated a greater participation of Chilean interests in industrial and commercial activities. Finally, CORFO oversaw the various means by which the general developmental and

⁶⁰ Corporación de Fomento de la Producción (CORFO).

production plan was being financed, and it tracked the direct funding of various planned works and granted loans according to the law.

In terms of health care, this historical period saw trade unions' demands and petitions for improved universal medical care and comprehensive health care services. They called for such services to be coordinated and integrated in order to facilitate workers' access to medical benefits. There was also the support of the medical profession, which, lacking alternatives, was eager to advance the project that sought to unify and better coordinate work opportunities and professional development.

These transformations in health services took place while a whole new economic sector was developing: the large mining industry. This spawned new types of social organizations, increasing the unionization of workers and stimulating active state intervention in labour-capital relations. In a move towards the preventive and curative integration of health services, coverage slowly broadened to include workers' families, directed more towards a specific class, or its sub-groups, than towards the individual. Funding for the new administration of these services was obtained through contributions from beneficiaries, employers and the state, while the medical profession was increasingly demanding better planning.⁶¹

Once political conditions were more appropriate for a deeper reform, the Popular Front government submitted a bill to Congress known as the "National

⁶¹ Haydee López, "Proposición para una evaluación de la experiencia chilena", *II reunión científica sobre los sistemas de salud*, INTA, Universidad de Chile, Santiago, 1981 at 3.

Health Service Bill”, which was the first of its kind in Latin America and only the second in the world, after the British National Health Service.⁶² However, President Aguirre Cerda established two conditions for the bill: it had to be accompanied by a “down-to-earth” development program and by sound economic studies, assuring the availability of resources. The approach was based on a formula according to which all of society contributed to the funding of the service with a solidarity-based system.

The proposal incorporated the original objectives for establishing a professional corporation, but considerably widened the scope and influence of such a corporation. The project boasted a laudable mission—to strongly protect public health and maintain a high level of professional ethics, thereby promoting the public medical profession and punishing those doctors who did not comply with these ethical principles. In this new scheme, the role and activities of the profession remained the responsibility of the Medical College. Holding onto these responsibilities was intended to assure physicians a central position in the health system. Accordingly, it was proposed that physicians should also get involved in legislative reform and procedures, as well as in the administration and control of public health services, private medical institutions and all or part of the health

⁶² “The British National Health Service was established in 1948 in accordance with the Beveridge Plan, implying an overall reform of the welfare system in order to widen citizens’ protection by the state; it represents the fulfillment of the Welfare state comprehensive philosophy in the health care domain in order to increase the population coverage of health care by means of a universal and free at the point of services access to health care, equal delivery of services among social classes and different territorial areas, democratic planning and management of the health care services”. R. Titmuss, *Essays on the Welfare state*, (London, Allen & Unwim, 1958). See too Giarelli, “Convergence or Divergence?”, *supra* note 5 at 177.

sector.⁶³ However, entrusting these responsibilities to physicians displeased parliamentarians, particularly lawyers, who expressed their concern at the provision that physicians' disciplinary tribunals would have the power to administer justice on economic and ethical issues related to their professional practice. Ultimately, the project was deemed to be extremely flawed and was rejected by Parliament. President Aguirre Cerda died of tuberculosis on November 25, 1941, and a new president, Juan Antonio Ríos, was elected in 1942.

The same year, as a result of the merger between the Central Department of Maternity Protection and the Department of Infant Health, the General Directorate for the Protection of Maternal Health, Children and Adolescents (PROTINFA)⁶⁴ was created. This Directorate carried out preventive activities for mothers and children who were not benefiting from the services provided by the Workers' Insurance Fund. Despite a limited budget that severely restricted its work, PROTINFA offered preventive and curative maternal care, childcare, dental care, maternity clinics, hospitals for children with special needs and orphanages. It thus sought to protect and assist mothers from the early stages of pregnancy up to the end of the breastfeeding period and then to assist children through to adolescence.⁶⁵

⁶³ Chamber of Deputies, *Session Newsletter*, 30th extraordinary session of January 7, 1941; 54th extraordinary session of April 2, 1941 & 1st extraordinary session of April 14, 1942.

⁶⁴ Dirección General de la Protección de la Maternidad, de la Infancia y de la Adolescencia (PROTINFA).

⁶⁵ Hernán Romero, "Desarrollo de la Medicina y la Salubridad en Chile", (1972) *100 Revista Médica de Chile* 897.

Also in 1942, the Employees' National Health Service (SERMENA)⁶⁶ was created and tasked with providing medical and dental benefits to public and private employees. SERMENA was founded by merging the health departments of the National Fund for Public Employees and Journalists (CEPP)⁶⁷ and the Private Employees' Prevention Fund (EMPART).⁶⁸ These were semi-autonomous public administrative entities whose funding came from the contributions of employees and manual workers (who had a different contractual legal status and public benefits) and from state funds. The SERMENA, as a new system, offered enhanced benefits for private and public employees and constituted an innovative body in Chilean health care. It offered a free-choice system (services could be paid for with vouchers provided to beneficiaries) for private and public employees of the Social Security Services (SSS), and for retirees and their families. Later, in 1968, the SERMENA was restructured under Law 16,781,⁶⁹ which aimed to reorganize curative medicine.

⁶⁶ The Employees National Health Service (SERMENA) was a semi-public institution with a legal personality of its own. It coordinated with the government through the Ministry of Health, without prejudice to the powers granted to the Social Security Superintendent. This service was also exclusively responsible for the Preventive Medicine of several Family Allowance Compensation Funds. The SERMENA performed the following functions entrusted by law: a) It provided preventive medical services according to Law No. 6.174; b) The payment of the time-out subsidies and other economic benefits imposed by law was its responsibility; c) Through a controlled fee, it provided dental care to family members affiliated to the Service; d) It had to sanction medical and dental loans for the passive and active affiliates; and e) It was responsible for building, acquiring or leasing suitable facilities to cater to the clinical and hospital requirements of its beneficiaries. This Act also created an Advisory Council comprised of fourteen members.

⁶⁷ Caja Nacional de Empleados Públicos y Periodistas (CEPP).

⁶⁸ Caja de Previsión de Empleados Privados (EMPART).

⁶⁹ **Law 16,781 (1968). Curative Medicine Act.** The law was established to provide medical and dental assistance to beneficiaries, retirees, the unemployed of the institutions listed in Article 2 of Decree-Law No. 286 of 1960, dependents, and those receiving widows' and orphans' pensions. The beneficiaries of the Social Welfare Fund of the Municipal Workers, the Crew section of the Pension Fund for the National Merchant Navy and the staff of the National Health Service and

Chile went through different stages in its socio-economic development and was also subject to significant international influence, which shaped its social model and its health system. In the mid-20th century, the country was embedded in the economic traditions characteristic of “Third World” models, as mono-exporters of raw materials and natural resources. As in other countries in Latin America, attempts were made to apply alternative economic and social (“developmentalist”) models that implemented the Import Substitution Industrialization (ISI) strategy, with an emphasis on Keynesian economic policies and a welfare state. This was even further developed during the Popular Front governments between 1938 and 1941 and in the years that followed.

Health policies were also highly influenced by changes in domestic economic relations and by the influence of the international context of the period. For example, a partnership between the School of Sanitation and the Rockefeller Foundation was included among the objectives of the Division of Health and Hygiene at the Institute of Inter-American Relations. The Institute, created in 1942, pursued military, political, productive and moral objectives. Its political objectives were to improve health conditions in zones considered strategic for the

their dependents were excluded from the purview of this law. In accordance with Article 65 of Decree-Law No. 338 of 1960, all those who could be considered as dependents of parliamentarians - serving and retired - were entitled to the benefits prescribed by this law. The administration of the health care system created by this law, and in particular, the Medical Assistance Fund that would fund all or part of the benefits, was entrusted to the National Medical Service for Employees (SERMENA). The Medical Assistance Fund granted a number of benefits, including, medical consultation, surgery, several medical tests and examinations, hospitalizations, emergencies, and obstetric and dental care. The benefits were granted by the SERMENA under the "free choice" protocol (the beneficiaries could choose the provider of the medical service). The SERMENA had the power to sign agreements with the National Health Service or any other public or private entity. The law also created the National Advisory Council on Health in the Ministry of Public Health.

United States and its allies. In practical terms, its goal was to be instrumental in the growth and development of the industrial sector by stimulating improvements in productivity, obtained principally by improving the health of the workforce. The Institute's moral objective was to demonstrate the tangible benefits that resulted from democracy in action and to gain the support of the working population. Collaboration with the United States came in the form not only of funding for hygiene programs, but also of training for medical doctors and human resource development.

In 1943, the School of Public Health⁷⁰ at the University of Chile was created in response to the urgent demands of public sector health institutions. The new school offered specialized training in techniques that could provide responses to the needs and concerns of health institutions. Two years later, the National Health Board created the Health Units,⁷¹ which were inspired by the United States Health Centers. These units were preventive in nature and constituted the first attempt to implement a holistic type of medicine at the municipal level. Hence, the distinction between preventive and curative medicine was re-evaluated, and access to medical services in suburbs and underprivileged neighbourhoods was ensured.⁷² A considerable number of Latin American physicians were trained in different public health schools in US universities and later served in several Chilean public health departments. It thus became

⁷⁰ Escuela de Salubridad.

⁷¹ Unidades Sanitarias.

⁷² Rodríguez, "Estructura y características del sector salud en Chile", *supra* note 14 at 70.

possible to articulate a particular conception, paradigm or understanding of public health and its role in Latin America, and this conception was promoted, spread and implemented in several countries in the region.

Also in 1943 and despite numerous objections to the “excessive medical dictatorship”, the National Health Service Bill was finally approved and sent to parliamentary committees. Once again it suffered setbacks, which continued for another four years until 1947, when a controversial article regarding doctors’ authority on wages for professionals working in the public sector was eliminated. A swift final vote in Congress approved the bill. On that occasion, the then senator Allende stated that for the first time in the history of Chile, doctors and senators agreed. It is worth noting that the mandate of the Popular Front’s health experts was to ensure compulsory social welfare managed under government control, delivering preventive and curative physical and mental health care. The overall strategy was threefold: a) a social medical program aimed essentially at improving health and nutrition, b) a national campaign against pests and viruses, and c) improved housing standards for families.⁷³

At the international level, at around the same time as the creation of the United Nations in 1945, the World Health Organization (WHO) was founded. A process of redesigning existing regional entities was also taking place, such as the reconfiguration of the Pan-American Health Organization (PAHO) and the

⁷³ Chamber of Deputies, *Session Newsletter*, 17th extraordinary session of December 30, 1942; 19th extraordinary session of January 5, 1943 & 20th extraordinary session of January 6, 1943. In Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 40 at 183

Economic Commission for Latin America (ECLA, now ECLAC). Also, during this time, innovative changes were taking place throughout the region with respect to health and its relationship to economic development. According to the new conception, health was not simply the “absence of disease”, but according to the WHO definition, it was also “the complete state of physical, mental and social well-being”. Meanwhile, the Chilean state was praised for playing an important role in the planning of health actions and their integration with national development.

In this historical context, the Popular Front government introduced a new bill to bring the management of all hospitals under a single government agency. These hospitals were classified into three broad sectors: 1) private charity hospitals, which received government subsidies; 2) social security medical services, and 3) state-run health care organizations, such as the Board of Health and the Directorate for the Protection of Maternal Health, Children and Adolescents (PROTINFA), which provided primary-level care and delivered preventive health programs. The bill would eliminate at least six state agencies, which would be merged into one new organization. At the time, the eradication of the divisions of Public Health, Charity and Security appeared to be a significant political loss for the purposes of allocating government posts, which went against the traditional pursuit of the support necessary to remain in power. The growth of the state bureaucracy since the 1930s indicates an unnatural expansion, especially in the social realm. This is a reflection of ongoing agreements and

circumstantial political settlements more than any actual requirements or real or legitimate technical or institutional needs.⁷⁴ The bill took ten years to become law.

The reality in Chile and the long history of negotiations between political actors and civil society was a reflection of the complexity of the situation and of a society that was very fragmented, highly politicized and with a great degree of participation in public life. As Zumbansen indicates, the forces of cohesion in a society are profoundly complex and fragmented: *“The reason for the growing regulatory challenges to modern law was and continues to be the rising complexity of society. To address a multiplicity of values, interests and rationalities with a dedication to democratic governance ultimately to result in consensus idealizes the forces of cohesion in a society that is actually deeply complex and fragmented.”*⁷⁵ However, this context was not only a great challenge; it was also, as demonstrated above, what enabled actors to express themselves and citizens’ voices to be heard during the legislative process. Referring to Zumbansen, this offers *“great hope for to better identify the potential of law to play a distinct role in the complex array of voices and forces.”*⁷⁶

In the 1946 elections, the Radical Party candidate, Gabriel González Videla, won with 40.1% of the total vote and, according to the Constitution,

⁷⁴ There is consensus in pointing out that the Socialists also participated in the proportional system, but the excessive division of its leaders offset its efficacy. As to the Communist Party, it was opposed to participating in coalition governments except during the six months it joined the first cabinet of González Videla.

⁷⁵ Peer Zumbansen, “Law after the Welfare State: Formalism, Functionalism and the Ironic Turn to Reflexive Law”, (2008) *04 CLPE Research Paper 03* at 20 & 21.

⁷⁶ *Id.*, at 21

required Congress to ratify his election. Without sufficient parliamentary support, González Videla was forced to redefine his alliances and make pacts with the Liberals. This entailed a major constraint for the centre-left coalition that had originally proposed and supported his candidacy. It even gave way to the unprecedented occurrence of Communist leaders taking on three ministerial portfolios. But later, in 1947, after municipal elections that increased support for the Communists, the Liberals refused to work with the Communist ministers and demanded their expulsion from government.⁷⁷ This situation was exacerbated in the context of the Cold War and, in response to pressure exerted by the United States and Great Britain, González Videla denounced a Communist conspiracy against the established order.

Chile quickly became enmeshed in the Cold War, as Moscow and especially Washington meddled in its affairs. As a result, González Videla also launched a parliamentary debate that culminated in the 1948 enactment of the Law for the Defence of Democracy, otherwise known by the opposition as the “damned law”. He expelled the Communist Party from his cabinet and then completely banned them from participating in politics under the new law. Although González Videla feared Communist intentions and respected the wishes of the United States government, he also turned against the Communist Party for several other reasons, including his wishes to mollify right-wing critics of

⁷⁷ The rise of the Communist Party to power reaped significant electoral dividends for the Chilean Communist Party since the municipal elections of 1947, when it secured its highest historic vote (17% of the vote) and emerged a virtual threat to the ruling classes.

his government, especially landowners, to whom he promised a continuing moratorium on peasant unionization. He also sought to remove any ideological justification for a military coup.⁷⁸ For the following ten years, the so-called “damned law” proscribed the Communist Party.⁷⁹ In addition to the repressive repercussions, this provoked popular protests and ultimately led to the fragmentation of the party system.⁸⁰

Meanwhile, the protection model developed in Europe was attracting enormous interest around the world, including in Chile, which sent legal and health professionals off to Europe to study it in the field. In their report, two specialists (Pinto Santa Cruz, an attorney and Dr. Viel, a medical doctor) introduced the “ought to be” concept of social protection, illustrating it with the successful British model and comparing it to the Chilean situation. Their report showed that the country was able to reach a “higher state of consciousness” with respect to social rights with the same legal, institutional and technical elements already in place. They put forward three lines of action that would be necessary in order to achieve these objectives: 1) address/reduce risks that affect productive capacity (epidemiology, sanitation, safety and hygiene) in coordination with a sanitary housing plan; 2) provide curative care for the population, including

⁷⁸ Country Studies, online: U.S. Library of Congress, retrieved (November 23, 2011) <http://countrystudies.us/chile/26.htm>

⁷⁹ González Videla betrayed the promise that “there will be no human and divine power capable of breaking ties” linking it with the Communist Party and the people. See also M. Aylwin (et al.), *Historia del Siglo XX*, (Santiago, Emisión, 1986) at 159.

⁸⁰ A section of the Radical Party issued a manifesto denouncing the treachery of González Videla to the Council of the party because of the monstrous “*damned law*” and economic policy favoring the capitalists. See *Journal of the Senate*, 39th session, ordinary Session, August 31, 1948, at 233.

periodic check-ups, early diagnosis, clinical treatment and rehabilitation; and 3) provide monetary subsidies for citizens when deprived of income due to illness, disability, unemployment, etc.

The development of these lines of action involved a dual structure—one that could maintain workers' economic security while protecting their “physical and biological” integrity. Policies developed under these lines of action also had to be in harmony with the imperative to maintain purchasing power, fair income distribution and the productive capacity of the population. In summary, the model clearly reflected a way of organizing services that was based on a notion of solidarity. It was postulated that to be effective, the new social system should be considered along with other important measures. Among these were wage increases and a comprehensive social protection plan based on the principles of unity, consistency, continuity and universality in the legal protection of all people, at all stages of life and independent of a person's occupational activity. With regard to the administration of the system and given the characteristics of Chilean insurance and medical care, the distinction between “commercial services” and “personal services” was to be highlighted.⁸¹ Personal services included medical services offered to all members of the community, not as charity, but as a right guaranteed by law and implemented by the National Health Service.⁸²

⁸¹ The separation is important because the Chilean health system granted financial aid for common illnesses and Maternity.

⁸² Pinto & Viel (1950) illustrate the chaos of Chilean Health Care with the following example: The Charity institution receives the workers not as rightful recipients, but as indigents. If the head of a

This entailed a significant break with previous policies and demonstrated how the health system was being reformed and health legislation was being articulated as a function of new socio-economic and political conjunctures, in response to competing interests and the local importance of international influence. The most important consequence of social policy reforms was the re-conceptualization of the social functions of the modern state, bringing various inter-linked institutions together under the same welfare principle. However, although these different institutions shared similar objectives and functions, they were not governed by any national guidelines, coordination or planning. Moreover, the beneficiaries of the different services were completely dispersed due to the fragmentation of both public and private-public institutions. The duplication of roles was common, and comprehensive family care was suffering. Laboratory and radiological examinations, for example, were conducted when a patient first consulted with a doctor, and then repeated in the hospital when the patient was subsequently hospitalized.⁸³ The atomization of services and a lack of coordination contributed to the need to create a single health care service at the national level. In addition, some experiences of collaboration between different services, such as the “coordinated fight against venereal diseases,” demonstrated the possibility and effectiveness of a single national health service.

household is sick, the Insurance Fund protects him, but it is the Charity that hospitalizes the patient on behalf of the Fund. Francisco Pinto & Benjamín Viel, *Seguridad Social Chilena: Punto para una Reforma*, (Santiago, Editorial del Pacífico, 1950) at 40.

⁸³ Jorge Mardones, “Origen del Servicio Nacional de Salud”, (1977) *105 Revista Médica de Chile* 656.

Ultimately, tight budgets and administrative barriers limited the efficiency of all existing services.

The Radical Party⁸⁴ and the centrist *Falange Nacional* Party disagreed on proposals regarding the future implementation of the National Health Service. This divergence further postponed the adoption of the law while also highlighting major differences between the government and the opposition. This became evident with regard to certain articles in the bill addressing the feasibility of merging services and concerns about the future of preventive medicine.⁸⁵ Another key issue was the future of curative medicine, which, according to the government and to conservative political forces, should be in the hands of either the public or the private sector.⁸⁶

Further, the importance of other factors that also delayed the reform cannot be overlooked. These were related to the government's economic plan, which, as indicated, sought to align economic policies with the national program of import substitution industrialization. Given the political strength of the right-wing parties in Congress, doubled by the de facto power of the conservative forces, which controlled most of the media and business, negotiations on the

⁸⁴ Partido Radical.

⁸⁵ Chamber of Deputies, *Session Newsletter*, 29th month, extraordinary session, December 28, 1950.

⁸⁶ The existence of a large number of medically qualified parliamentarians in the 1940s would have facilitated the passage of the bill of the SNS. However, existing data on the number of doctors in parliament indicates no differences in the adoption of Health legislation during that period. Moreover, the proposed Pension reform and Health went through the most radical medical representation in Congress without it being approved as it had been in 1942. See also the law relating to the Order of Architects and Pharmacists in Labra, (1997) *Política, Saúde e Interesses Médicos no Chile (1900-1990)*, (Ph.D. thesis, Instituto Universitário de Pesquisas do Rio de Janeiro, Rio de Janeiro) at 158.

economic program significantly limited social reforms, which would have imposed even greater tax burdens on capital. President González Videla was in a minority position and did not respect the commitments of the same political parties that had put him into the presidency. Changes in the political discourse before and after the election were considered serious and unacceptable. The crisis led the president to veer to the right in exchange for support from conservative political forces. Moreover, strict bicameralism demanded a verdict from both houses, thus further delaying the legislative process.

The lawmaking process was also subject to a likely presidential veto, thus making the elimination of the entire National Health Service Bill even more probable. As deliberations about the SNS continued, in December 1948, DFL 9,263^{87,88} created the Medical College, thus converting the Chilean Medical Association into a professional body that granted doctors official representation, allowed them to participate as official interlocutors with state authorities and ensured their ethical and professional regulation. Membership in the Medical College was mandatory for physicians, which contributed to control by peers and

⁸⁷ Senate, *Daily sessions Journal*, 39th month, ordinary session, August 31, 1948. The Senate quickly discussed bill No. 9.263, which was promulgated on November 15, 1948. The law was regulated by the Ministry of Health Decree No. 940 (April 3, 1951). The Medical Officer status, that will be discussed later, was enacted in December 1951.

⁸⁸ **Decree-Law (DFL) 9,263 (1948). Created the Medical College of Chile.** The law created and established the Medical College of Chile as an institution with a legal capacity of its own. The objectives of the college objectives were to improve the economic and social protection, and the supervision of medical doctor- surgeons. Its members were authorized to organize themselves into Federations with their own regulations. Patients had the right to complain to the Medical College if they felt unfairly treated by a professional. The respective Council was empowered to impose sanctions on the doctor founded guilty of any act bringing dishonor to the profession, abusive exercise or incompatible with the dignity and culture of the profession. These sanctions as such could vary from a reprimand, or censure, to a suspension from the practice of the profession for a period of not more than six months.

reinforced the credibility of the health care institutions. This legislative change, however, revealed important disputes within the medical profession, whose political action on specific social issues reflected divisions along party lines. The Medical College thus failed to reach unanimity on a professional vision of the economic and labour demands of doctors and other health professionals. Given the growing political and economic importance of the middle class and the strengthening of corporatism, it was not possible to ignore or easily overcome the vagueness and lack of consensus that plagued the physicians' decisions.⁸⁹

Debate over the need to extend curative care to the entire population continued. Senator Allende indicated that the impact of the SNS was immense. He also declared that he was convinced that these ideas, for which he had fought for so many years along with workers and technicians, employees, professionals and intellectuals, would become a reality and would constitute an advance in social legislation.⁹⁰ To appease right-wing opposition to the SNS Bill, the article on public care for work-related accidents was removed, and it was proposed that this responsibility remain in the hands of private insurers. For their part, the Liberals supported the "free-choice" format in order to give greater options to patients and to encourage physicians to fulfill their "mission" and "cease thinking of the patient as just statistics".⁹¹ On another front, through political transactions,

⁸⁹ María E. Labra, "Padrões de formulação de políticas de saúde no Chile no século XX", (2000) *43 Dados* 153.

⁹⁰ Senate, *Daily sessions Journal*, 33rd ordinary session, September 6, 1951. In Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 41 at 181

⁹¹ Chamber of Deputies, *Session Newsletter*, 8th month, extraordinary session of November 23, 1950.

a political agreement was reached to include the SERMENA in the SNS. This suggestion was incorporated into the bill that government sent to Congress, but President González Videla soon vetoed it. The health minister explained that instead, a provision would be introduced into the law allowing the president to decide, by simple decree and whenever deemed appropriate, to include the SERMENA in the SNS.⁹²

With a “national consensus” cabinet formed by members of the Radical Party, the Liberal Party and the Conservative Party, the government faced a very difficult economic and social situation. Finance Minister Jorge Alessandri balanced fiscal accounts and increased the salaries of civil servants, but he soon had to propose special legislation imposing measures to stabilize prices and wages, causing major popular upheavals. In January 1950, the Chilean National Board of Employees⁹³ sparked a general standstill with a series of strikes. The ambiguity of the Radical Party led it to support the strikers against the president, forcing him to meet popular demands. Almost immediately the press accused him of leading “a government that works for the unions”. Only a month later, the government changed the composition of its alliances by calling on Radicals, Social Christians and Falangists to join a cabinet focused on “social sensitivity”.⁹⁴ The new cabinet received political support from across the political spectrum,

⁹² Chamber of Deputies, *Session Newsletter*, 6th and 7th months, ordinary session of June 11, 1952.

⁹³ Junta Nacional de Empleados de Chile (JUNECH).

⁹⁴ This was a response to reports issued by the *Falange Nacional* Party, affirming that the cabinet was “socially insensitive” and that only a “political earthquake” could bring an end to national unrest.

and, as a result, it was able to move forward on the social policies demanded by many different actors.⁹⁵

It is important to note that social legislation progressed only when the Social Christian wing of the conservative political forces and the also conservative *Falange Nacional* group joined the “social sensitivity cabinet”.⁹⁶ Senator Allende was instrumental in this process, given his reputation as a great speaker, respected physician and outstanding political leader.⁹⁷ This facilitated the development of a more extensive and inclusive health plan,⁹⁸ along with clarifying the country’s social protection principles and the association between “biological protection” and “economic security”, thus defending for the first time the idea of health insurance reform.

As changes to health care were, then, an expression of the articulation of interests, there was no reason for them to be merely functional. The law was not only an instrument for achieving a social, political or economic objective, but also

⁹⁵ It seems that it was only in 1947 (once González Videla's government separated from the Communist Party), that the political context permitted legislation on pension and health reforms, along with the government's positive response to the physicians' demands. This political shift facilitated the restructuring of agreements and alliances with conservative forces, which felt included and hence less suspicious of the proposals and reforms under discussion. It also postponed conflicts over limited resources, thus enabling right and left to compromise. Political institutionalization and accommodation prevailed, partly because the unorganized urban poor and especially the rural poor were excluded from political affairs.

⁹⁶ In the parliamentary elections of 1949, the National Falange elected three deputies who played a crucial role in building the new position on the social question. Then, in November 1950, González Videla reiterated the urgency of the proposed amendment to the Workers' Compulsory Insurance. The “Falangists” were able to introduce motions and a set of articles to unify the public health services and medical care into a National Health Services— called SNS— that was similar to Britain's National Health Service.

⁹⁷ Allende held several leadership positions such as Chairman of the committee on Hygiene and Sanitation; Assistant to the Senate representative on the Council of the Social Security Fund; President of the Medical School; President of the Pan American medical conference; and President of the Senate, where he served for many years.

⁹⁸ Health medical project.

the result of political dynamics, which were reconceptualizing the notion of health and models of health care administration. Conflict and consensus are not necessarily opposites or extremes. Law is a conjunctural compromise that is made manifest at a given place and time, and its timing is determined by political dynamics. As discussed by Christodoulidis “*Conflict is productive for law in a very important way. Conflict provides the legal system with an occasion of openness to the environment. It is in litigating conflict that the law perceives the social environment and it is in communicating about conflict that law links operations to previous operations and exists as a system*”.⁹⁹

Social demands, slow economic growth and an increasingly heated political arena characterized the 1950s. In addition, the accelerated mobilization, polarization, and radicalization of ideologically opposed parties placed more stress on the state to compromise and reconcile demands and projects. The legislative process was, hence, the result of political and corporate agreements that made the projects viable. At the same time, an influential and interventionist state was clearly already developing by the middle of the 20th century, which would have not only an important economic mission, but also a strategic role in the social and health sectors. The state was given a strategic role as the key “national plan” for social and health policies. This certainly contributed to guaranteeing greater social and political stability, as by promoting social development and improving living conditions, social movements were

⁹⁹ Emiliós A. Christodoulidis, *Law an Reflexive Politics*, (Dordrecht, Kluwer Academic Publishers, 1998) at 130.

simultaneously neutralized. Also, while state intervention brought about unquestionable progress in the improvement of the health of the population, it also contributed to maintaining the privileged position of medical professionals within the biomedical paradigm. Chilean democracy advanced by means of political agreements that were constantly making exceptions for certain groups. This is how extensive legislation, a multiplicity of institutions, various regulations and a range of procedures created legal confusion and greater difficulties for financial oversight.¹⁰⁰ This situation still has consequences today, as is evident in the popular belief that good health is mainly associated with access to free or low-cost medical services.

In this reform process, the conservative political forces were hegemonic, but parliamentary discussion allowed “windows of opportunity” for various actors. Taking advantage of one such window of opportunity, on 23 November, 1950, Parliament unanimously approved new health insurance legislation, with a landmark article based on a report stating the need to create a National Health Service responsible for protecting public health with hygiene activities and preventive and curative medical care. Clearly, pressure was mounting and a consensus was being built to meet the country’s health needs in a comprehensive way. The creation of the SNS, initially proposed years earlier, was seen as a necessary step toward these ends.

¹⁰⁰ Carmelo Mesa-Lago, *Social Security in Latin America. Pressure Groups, Stratification, and Inequality*, (Pittsburgh, University of Pittsburgh Press, 1978) at 14.

During discussions about the creation of the SNS, the medical body went on strike several times, using the “collective resignation of public office” as a powerful threat to force the government to send new draft legislation to parliament that would regulate physicians’ working conditions, remuneration and professional development as well as the labour relations of health professionals. In response, the government presented the Medical Employees’ Act.¹⁰¹ In its defence, Senator Allende emphasized that “only a great sense of responsibility and an incredible amount of tolerance have enabled doctors to continue working,” because they had been “violently harassed” by the economic reality.¹⁰² He argued that the suspension of their services was the only means with which to “shake up the lack of national awareness,” and that there was an urgent need to consider “a new conception of our public health.”

When the SNS proposal was finally presented to Parliament in September 1950, Allende also spoke in favour of passing the Medical Employees’ Act, stating the need for a comprehensive plan that would transform society in support of the defence of human capital and a social conception of medicine. He added that all doctors were already committed to this mission, and it was only their physical working conditions that still needed to be improved. His purpose was to establish parameters that would go beyond a corporatist vision and seek ways to integrate physicians into a more comprehensive and holistic medical

¹⁰¹ Estatuto de Medicina Funcionaria.

¹⁰² Senate, *Daily sessions Journal*, 8th extraordinary session of November 28, 1950. In Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 41 at 185

approach, which would facilitate and promote the health of the population. During the discussion of the Act, a great doctrinal and ideological dispute arose regarding the care model the country needed. Parliamentary debates featured strong arguments that endeavoured to make it politically acceptable for doctors within the public health sector to receive preferential treatment. This proposal involved high fiscal spending and hence, the assurance of adequate funding was required, which meant a 73% increase in public health expenditures.

With this parliamentary approval, a global solution to the doctors' problems had been found. They were well remunerated for six hours a day in the public sector, with the possibility of complementing their income in private practice. The Act initially focused on physicians, who were soon joined by dentists and public-sector pharmacists, excluding all other health professionals, including university-trained nurses.¹⁰³

The right-wing sectors argued that they feared that the same groups of professionals who requested the project's approval would eventually turn against the law, as they would find that their professional freedom, the only true stimulus ensuring the high quality of medical professionals, was disappearing.¹⁰⁴ In contrast, the Communist MPs argued that the project brought privileges to physicians but did not consider the situation of all health workers at large. Law

¹⁰³ Communist senator and labour leader, Elías Lafertte, argued that the benefits should be extended to nurses, social workers and practitioners. Senate, *Daily sessions Journal*, 8th extraordinary session of November 28, 1950.

¹⁰⁴ Chamber of Deputies, *Sessions Newsletter*, 45th ordinary session of August 28, 1951. In Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 41 at 186

10,223¹⁰⁵ finally established the Medical Employees' Act on December 17, 1951. It was an extensive and detailed legal instrument that became increasingly complex with multiple modifications over time to accompany changes in the professional activity of medical work.¹⁰⁶ The Act fixed wages, limited professional working hours to 36 hours a week and controlled the distribution of hours to be worked in different institutions. Just as the National Health Service would soon be created as a new employer of medical doctors, the Medical Employees' Act finally secured their individual and corporate rights. An important result of this new legislation was that doctors were now grouped into one body, as Law 10,323 made membership in the Medical College a compulsory requirement in order for doctors to practice. This enabled them to gain great bargaining power, propose initiatives, defend their corporate interests and regulate the relations between themselves, the public and the state.

However, other problems arose. The Medical Employees' Act granted proportionally more incentives based on seniority than on merit, which dispirited public service employees and led doctors to seek private patients while refusing to perform public service in the future SNS. Furthermore, the Act did not ensure

¹⁰⁵ **Law 10,223 (1951). Established the Medical Employees' Act.** For surgeons, pharmacists and dentists, who were denominated "professional officials". This law was regulated by Law 8,282, which created the Act for the Public Administration of the State.

¹⁰⁶ In those years, there was a diversification of the professional market for physicians due to the creation of new public programs, and the entry into operation of the free choice option model for employees (SERMENA) as well as private medical practices. This expansion was however insufficient to absorb the existing unemployment. There were thus real problems that the physicians wanted to resolve through the creation of a unified and extended health service, claiming that the public authorities should make serious efforts to extend and repair hospitals, urban health centers, rural jobs and relief houses. Along with that, they requested for an increment, and regulation of the entry and advancement in the medical profession.

the economic security of professionals, as inflation was rampant and the wage increases stipulated in the Act were not granted. Finally, on August 8, 1952, Law 10,383¹⁰⁷ was promulgated, establishing (article No 63) the National Health Service¹⁰⁸ as an independent legal and administrative entity for ensuring public health and health care for the population. This law modified Law 4,054¹⁰⁹ on compulsory insurance, making insurance against sickness, invalidity, old age and death compulsory for all workers earning a wage. It also covered workers, applicants or trainees in any job, industry or occupation. Those self-employed as artisans, artists, small manufacturers and fixed or mobile shopkeepers or people who performed jobs and provided services directly to the public on the streets or in squares or warehouses, were insured as long as their total annual income did not exceed the annual living wage.

The onus of implementing the policy and the law fell on two institutions: the Compulsory Health Insurance and Disability Fund, which was eventually renamed the Social Security Service (SSS), and the National Health Service. The SNS reported to the Ministry of Health, which remained responsible for protecting

¹⁰⁷ **Law 10,383 (1952) modified Law 4054 (1924) relating to Compulsory Insurance.**

¹⁰⁸ The National Health Service was responsible for the protection of health through health activities, as well as social, preventive and curative medical care. It was an autonomous self-governed body, dependent on the Ministry of Health. It was subject to administrative and technical control, under the Health Code, and the General Directorate of Social Welfare. The Director General along with the National Health Council, comprising of twelve members, headed the senior management.

A Board consisting of eleven members administered the Social Security Service. Its main function was to administer and monitor the service, receive their funds, manage their assets, deliver benefits, patron and resolve requests from policyholders and employers. The SSS granted insurance benefits covering diseases (medical care, examinations, dental care etc.), Maternity benefits, Invalidity benefits, Old-Age benefits, Survivors' pension (including death benefits).

¹⁰⁹ See *supra* note 12

the health of the entire population and was also mandated to improve and promote the health of workers, their spouses and their children up to 15 years of age.

Despite all these up and downs, doctors successfully concluded the first phase of a lengthy legal battle in support of their ongoing professional activities. They first secured the creation of the Medical College in 1948, and then they continued with the unification of the medical workforce under the SNS. They finally secured their own labour and economic regulation with the Medical Employees' Act in 1951.¹¹⁰ With all these prerogatives, the medical corporation was now prepared to actively participate in the formulation and implementation of health policies. Thus, the creation of the Medical College in 1948 and the Medical Employees' Act were actually two "parallel laws", adopted as a direct response to physicians' demands. Together, they contributed to the creation of the National Health Service in 1952 (Law 10,383).

3. THE WELFARE STATE DURING THREE DIFFERENT POLITICAL ADMINISTRATIONS

A. The first decade of the National Health Service (SNS): 1952-1963 and the conservative government

By the middle of the 20th century, the Chilean State had already assumed a predominant role in the health sector, greatly impacting the well-being of the population. The state was responsible for implementing programs for health protection and recovery, and the National Health Service (SNS) developed

¹¹⁰ They also won a majority in the National Health Council (NHC – *Consejo Nacional de Salud*).

policies for prevention and promotion, health education and eradication of infectious diseases. It also employed all new graduates from medical schools, offering them a career within the country-wide SNS. It also emphasized its social commitment and provided opportunities for improving the quality of care.¹¹¹

The principles that guided this philosophy, on which the actions of the National Health Service were based and which outlined the structure of the welfare state, were the following:

- A. People are more than mere biological units. They are natural beings who create families and communities and live in ways that are favourable or detrimental for their health.
- B. Individuals contribute to their collective well-being with their physical and intellectual energy. Health is a component of economic development, which exists in a relationship of dependence with other factors that condition one's standard of life.
- C. Health results from an ecological balance. The country requires a single, centrally-administered service and integrated health care actions.
- D. Both the SNS and the organized community at large are responsible for health.
- E. The main goal of the SNS is to reduce the risks of disease and death. Integrating health care actions under appropriate and systematic programs to meet health priorities fulfills this objective.

¹¹¹ Fernando Lolas, "Beyond the Anglophone World. On the goals of medicine: a Chilean perspective", (1966) 43 *Social Science and Medicine* 1 at 125.

The SNS responded to the extensive demands of the population in an effort to make health care a social right. It was the synthesis of specific, articulated interests as well as social and political contradictions and disparities.¹¹² With the creation of the SNS, the following organizations were merged into a single health authority: the Charity and Social Assistance Office,¹¹³ the Workers' Insurance Fund Medical Service,¹¹⁴ the National Hygiene Service,¹¹⁵ the Office for the Protection of Children and Adolescents,¹¹⁶ the Technical Hygiene and Industrial Safety Section of the Labour Department,¹¹⁷ the Bacteriological Institute of Chile and the municipal health and medical services.¹¹⁸ Thus, 90% of public-sector medical resources were integrated into a single entity, leaving out only the SERMENA, the health departments linked to national defence institutions, universities and railway employees.¹¹⁹

The institutional and legal organization of the SNS¹²⁰ followed that of the SSS: it was a public legal entity that functioned autonomously and was administered by the Ministry of Public Health. During the discussion of Law 10,383 around the creation of the SNS, the spirit of the bill was that the National Health Council would oversee the administration and supervision of the financial resources of the Service. Nevertheless, Parliament did not legislate accordingly

¹¹² Tetelboin, *La práctica médica en Chile*, *supra* note 56 at 49.

¹¹³ Dirección General de la Beneficencia y Asistencia Social.

¹¹⁴ Servicio Médico de la Caja de Seguro Obrero.

¹¹⁵ Servicio Nacional de Salubridad.

¹¹⁶ Dirección General de la Protección a la Infancia y a la Adolescencia.

¹¹⁷ Sección técnica de higiene y seguridad Industrial de la Dirección General del Trabajo.

¹¹⁸ Instituto Bacteriológico de Chile.

¹¹⁹ Rodríguez, "Estructura y características del sector salud en Chile", *supra* note 14 at 71.

¹²⁰ A Director General, who was appointed by the president and administered by the National Health Council (Consejo Nacional de Salud, CNS), led the SNS.

and refused to provide the CNS with these capacities. Instead, it turned the CNS into a merely administrative advisory organ of the SNS Director General. Initially, the Council only included representatives from the business sector; later however, in response to a proposal by the “Falangista” MPs (later the Christian Democratic Party),¹²¹ labour representatives were also incorporated. This was a significant change, as for the first time in history, non-health and non-medical professionals, who had typically been considered outsiders, were able to participate legally in the closed circle of technical decision-making. After several adjustments, the Council was made up of fifteen members with the right to vote, ten of whom were doctors and two of whom were labour representatives.¹²²

Over the years, the SNS Director General accumulated a large amount of power, making him the most important public official in the health sector; even above the minister of health.¹²³ This led to political disputes, which did not end until 1979 with the dismantling of the SNS. In these disputes, the Medical College insisted that physicians’ rights be respected, in particular with regard to fixed remuneration and flexible daily hours of work.

¹²¹ Political party based on Christian principles in a democratic regime. It is a reformist party as opposed to a left revolutionary party. In Europe many Christian democrats have formed the government or have govern in a coalition with other parties.

¹²² The composition of the Council went through many changes. Its members, according to **Decree No. 856 (April 21, 1953)** were: the Minister of Public Health and Social Welfare; Director General of the SNS (SNS); Director General of the SSS; two professors from the Faculty of Medical Sciences; two representatives of the Physicians Professional Association; two representatives (elected) of the employers institutions; two representatives of the workers (nominated); two Senators; and two Deputies, plus the Superintendent of the SSS (non-voting).

¹²³ Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 40 at 188.

The Service was also charged with supervising the municipalities to ensure proper safety standards within each jurisdiction and the Surgeon General, who received public subsidies and was responsible for the supervision and technical protection of private charitable health-related services. SNS officials were divided into technical and administrative officers and technical assistants. The country was divided into provinces, and each province had a chief physician. The SNS mandate included establishing centres to prevent and protect the public from health risks. Its activities included: a) immunization against communicable diseases; b) monitoring pregnant women, infants and children; and c) providing pre-nuptial consultations in order to prevent hereditary diseases. The SNS was also tasked with education and the promotion of the means and conditions to protect health throughout the country. Its main tasks were to disseminate information about health practices and to connect the public with services for the protection of collective and individual health. It also relied on its adequate and stable infrastructure and excellent human resources, all of which were influenced by the labour movement's social demands and by the European experience.

To accomplish its objectives, the SNS was structured in eight health care units¹²⁴ and guided by five structural principles: a) technical, administrative and

¹²⁴ The health care units in the SNS were divided into 8 categories: 1) Hospital Class A, which included almost all medical and surgical specialists and technical examination and treatment services; 2) Hospital Class B, which included some medical and surgical specialists and some examination and treatment services; 3) Hospital Class C, other specialized medical services including obstetrical and gynaecological care; 4) Hospital Class D, which was responsible for general medicine; 5) Health Care and Medical Care Offices in specific geographical areas; 6)

financial autonomy; b) formal and functional integration; c) normative centralization; d) executive decentralization; and e) definition of priorities and program planning. It was structured around three main organizational levels: a) a central level, including the office of the Director General and its departments, in charge of the regulations, inspection and evaluation of the service; b) an intermediate level consisting of health zones with essentially a coordinating function, responsible for supervision and inspection and c) a peripheral or executive level, constituted by hospitals and other establishments that directly executed health actions.

As a state system and central authority for medical services and public health interventions, the SNS contributed enormously to mitigating the differences between the various social security funds, which were eventually eliminated, creating the same entitlements for all formal workers and their dependents. The SNS granted medical services to individuals and their families organized in several categories: a) individuals covered by the SSS (Law 10,383);¹²⁵ b) workers covered by the commercial marine fund law (Law 10,662);¹²⁶ c) municipal employees; d) victims of work-related accidents, covered

small, local community clinics with nursing services and close links with community organizations, permitting the decentralization of specific health care actions; 7) small, local emergency units mostly linked to police departments in isolated areas; and 8) general hospitals with limited health care services.

¹²⁵ The Social Security Service was a public institution in charge of the implementation of the **law 10 383 (1952) of social security for blue-collar workers.**

¹²⁶ **Law 10,662 (1952). Occupational hazards of merchant seamen.** The law allocated a section in the Insurance Fund of the National Merchant Navy, with the intention of insuring the crew of merchant ships and maritime workers against occupational hazards. All salaried workers were entitled to coverage. . The main prerequisite for eligibility under this law was that all claimants had to be employed as crew members of ships, docks, boaters and other maritime

by the Service of Social Insurance; e) civil servants, retired employees of the SNS and the indigent, with the exception of individuals who had completed military service in any branch of the armed forces; f) firefighters who suffered accidents in the line of duty; g) seniors 65 years of age and older without social insurance; h) students in primary, secondary and technical schools, colleges, tertiary training institutes and universities; i) patients protected by infant and maternal care programs; j) patients participating in venereal prevention and rheumatic fever prevention programs; k) affiliates of institutions with agreements with the SNS, whose expenses were covered by their institutions, and finally, l) all individuals without any type of insurance coverage and not included in any of the preceding categories. Overall, while the indigent already had access to free services, the SNS tripled the number of non-indigent people able to receive free medical services in the new institution's hospitals and clinics.

The SNS provided curative care to 4,200,000 people, representing 70% of the population. The SNS also took on other responsibilities related to disease prevention and social protection, such as the free milk-distribution program and the payment of indemnities to workers in case of illness, which was administered by the Social Security Service.¹²⁷ In addition, the SNS was responsible for providing social assistance to seniors and retirement residences as well as

trades. They had to be serving Chilean ship owners, ship operators, maritime industries, domestic and foreign companies, state enterprises, semi-public and public corporations, or individuals, and directly or indirectly performing maritime operations, in the ocean, rivers or lakes.

¹²⁷ Servicio de Seguro Social.

minors in need of special services.¹²⁸ The SNS thus became a fundamental pillar in the public health sector, providing resources and performing key activities under its mandate. Its creation meant a revolution in the health sector in legal terms, while the changes it brought to the structure, organization, programs and objectives of health care caused a true upheaval.¹²⁹

The new health legislation of the 1950s thus shaped the direct intervention of the state in medical care and public health and facilitated free access to medical services, which gained the status of a social right. This right was internalized by the population and attained total legitimacy with the SNS. The state became the neuralgic centre of health care and was the target of demands made by health professionals and the general public. Therefore, the socialization of health services, demands for greater state involvement and state responsibility for responding to health needs and guaranteeing the right to medical services were the historical “leitmotiv” when it came to health for the great majority of the population. The presence of the state also allowed for the professionalization and development of a highly scientific, first-rate hospital infrastructure, following the recommendations of the Flexner Report¹³⁰ from the early 20th century in the United States.

¹²⁸ Rodríguez, “Estructura y características del sector salud en Chile”, *supra* note 14 at 72.

¹²⁹ *Id.*

¹³⁰ The Report called on North American medical schools to enact higher admission and graduation standards, and to adhere strictly to the protocols of mainstream science in their teaching and research. It also managed to institutionalize in medicine a paradigm that conceived the human body as the sum of a series of interconnected elements, and reinforced the need for research and scientific knowledge in the treatments of diseases.

Nonetheless, Chilean society was clearly differentiated into three socio-economic classes: a) the business sector, self-sufficient in the satisfaction of their social and health care needs; b) employees and professionals, with stable incomes and economic situations based on their capacity to accumulate savings and c) workers and farmers, who required legal protection as a result of their low remuneration. SNS legislation reinforced this class differentiation.¹³¹ It consolidated the SNS as a service that reconciled interests, distancing it from the health reformist utopias promoted by Chile's very brief so-called "Socialist republic", which held power for only 100 days in 1932.¹³² However, despite its strong orientation towards a social concept of medicine, the Service maintained the exclusion of those social groups not covered by the health insurance policy implemented in 1924.¹³³ It is interesting to note that the nature of the health services, the type of medical practice, the technology applied and the definition of health and illness were rarely criticized.

Despite its beginnings and its unique, innovative and internationally recognized development, the SNS gradually distanced itself from the model that had inspired it. This was the result of several factors, the most critical being the continuous redefinition of its mandate due to ongoing changes in the government. The SNS also faced serious operational limitations and inefficiencies caused partly by the successive attempts by authorities and

¹³¹ Labra, *Política, Saúde e Interesses Médicos no Chile (1900-1990)*, *supra* note 89 at 84.

¹³² Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 41 at 188.

¹³³ Seguro de enfermedad.

physicians to modify the legal bases of its structure as well as the health system at large. Furthermore, slow economic growth and pressure to reign in increasing medical expenses did not allow the SNS to grow as quickly as the needs of its beneficiaries.

By the end of the 1950s, Chile was still facing an economic and development stalemate. As the crisis intensified, it became increasingly evident that conservative President Jorge Alessandri (1958-1964) was unable to deal with the economic and the social problems facing the country. At the same time, the economic and social proposals of the so-called “developmentalist” approach, which included agrarian reform, a national program for marginal urban populations and the creation of various community organizations, were gaining momentum. These benefited from the expansion of the “Alliance for Progress” promoted by President Kennedy in the United States, aimed at limiting the impact of the Cuban revolution in the region.¹³⁴ In this context and with the 1964 presidential elections in mind, Jorge Alessandri’s government proposed a new health law to Congress in an attempt to respond to the demands of the middle class.

Due to the high cost of medical services for middle-income groups, who received no benefits from the SNS,¹³⁵ the government proposed the creation of

¹³⁴ Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 41 at 193.

¹³⁵ Already in March 1964, the publication of **Law 15,565 renamed the Social Welfare Fund** of the Municipal Workers of Santiago, as the Social Welfare Fund for Municipal Workers of the Republic. It was a semi-public institution. Under this law, the country’s municipal workers started

an alternative and complementary service to the SNS. Approximately 1.5 million people would benefit from the new law. This bill aimed to develop a less bureaucratic system and to resolve several limitations of the current system, including offering employee health care benefits (for active and retired employees and their families) in the same SNS institutions, but under a free-choice model. This system ¹³⁶ entailed extending SERMENA preventive measures (created in 1942) by fusing the health departments of the Fund for Public Employees and Journalists and the Government Social Security Fund for Private Employees.

As part of the bill, the SERMENA would be reorganized to offer free choice in curative care to public employees and individuals belonging to different funds of the Social Security Service along with the retired and their families. Initially, SERMENA benefits and health care services were offered exclusively in SERMENA facilities, but later a series of agreements were signed so that SNS establishments could also be used. Something worthy of note in this initiative is the way it was negotiated, which was unlike previous lengthy negotiation processes. For the project presented to parliament in 1961, no consensus was reached, in spite of the existence of the National Health Council,¹³⁷ medical conferences and ongoing discussions with stakeholders.

to contribute to the Social Security Fund of the Municipal Workers. The National Health Service was in charge of the medical and hospital services.

¹³⁶ The benefits provided were medical visits, examinations, hospitalization, surgery, obstetric care and medical emergencies.

¹³⁰ Consejo Nacional de Salud.

In September 1964, MPs passed an imperfect piece of legislation, leaving the most controversial parts of the basic legislative discussion unaddressed. Similar to what had occurred in 1952, the main obstacle for this initiative was insufficient clarification about where the extra and necessary funding required for the SNS would come from. It is also interesting to note that the Medical College, as a powerful and prominent lobby, was already disappointed with the predominance of the socialized medicine approach at the time. The College was determined not to increase the number of SNS health care services included in physicians' salaries and advocated instead a free open model, where payments would be received for medical consultations.¹³⁸

Later in 1963, when the Christian Democratic Party proposed its "Revolution in Freedom"¹³⁹ program as part of its political platform, the country was facing a critical internal political crisis. The "Revolution in Freedom" program was a development model that combined capitalist growth with social development and the strengthening and reinforcement of popular participation.

¹³⁸ This was especially true when the Ministry of Health insisted on modifying the Medical Act to reinforce the law that would increase the physicians' workday to eight hours. The College expressed its opposition to this change of policy and sought instead to impose a type of payment that was fee-based, instead of salary-based.

¹³⁹ His Christian Democratic Party – largely Catholic – was the first liberal religious party in Latin America. The Catholic Church in Chile, which had supported rural conservatism, had become reformist and was encouraged in this by the Second Ecumenical Council. For President Frei: *"There are two principal roads-capitalism and communism (...). Man is sacred. He is greater than the system. He has the right to life, liberty and to his own personality. No system has the right to deprive him of his rights. Both principal systems do this (...). Capitalism by dehumanizing him (...) and communism by making the good of the state more important than the good of the individual"*. Eduardo Frei M. in Gross, L., (1967) "The last, best hope: Eduardo Frei & Chilean democracy", New York: Random House, retrieved (May, 10, 2013) <http://book.filipinofutures.com/christian-democracy/revolution-in-freedom-eduardo-frei-montalva>.

The program was endorsed by both centre and right-wing parties, primarily to avoid a division and to defeat the political forces of the Popular Front (composed of the Socialist Party, the Communist Party and the middle-class Radical Party), headed by Salvador Allende, who was leading the polls as the likely winner of the 1964 presidential elections. In 1964, Eduardo Frei Montalva was elected president and became the first Christian Democratic candidate to win presidential elections in Latin America. His victory resulted in the modification of health policies such that the idea of health became a basic right to which all citizens should have access, and the 1925 constitutional principles were fully respected, recognizing that the state was fully responsible for providing the resources necessary to implement a national health plan.

B. The centrist Christian Democratic government (1964-1970)

With the beginning of President Frei's administration, Chile witnessed the appearance of two major health paradigms. The first was influenced by the Cuban socialist model, which was implemented after the victory of the Cuban revolution in 1959. The second paradigm was based on a flexible liberal model with a social orientation, close to the German social market economy model. The new Christian Democratic government supported the second approach, hoping to reinforce state responsibility in the health sector while, simultaneously, stimulating private health-related initiatives. In order to increase popular support

for the government and to include the population in the decision-making process, the government implemented a series of measures to increase popular participation.¹⁴⁰ With the creation of the “Revolution in Freedom” program, which would correct Chile’s extreme inequities without the need for violent political struggle, the possibility for real and global health reform was closer than ever. Employee participation became an issue of national interest for President Frei. His government intended to create a National Health System for all citizens that would be universal, complete, self-sufficient, efficient, appropriate, community-oriented, equitable and respectful (to human dignity).¹⁴¹ For the first time, the country was seeing health reforms proposed that aimed to overcome the existing deficiencies and to put an end to two-tier medicine wherein one system catered to blue-collar workers and the other to white-collar workers.

This proposed system was not much different from the Unified Health System¹⁴² proposed later by the Popular Unity coalition that replaced the Christian Democratic government in 1970.¹⁴³ The desire to restructure the SNS was due to its internal limitations and to overall changes in the health sector and the medical profession after six years of a conservative regime. The government hoped to implement a deep reform, with the ideal of unifying all health care

¹⁴⁰ Eduardo Morales, “Sistema político, planificación y políticas públicas. La política de salud en Chile 1964-1978”, (1981) *110 Documento de trabajo FLACSO* 11.

¹⁴¹ Senate, *Daily sessions Journal*, 16th session of April 10, 1965, statements by the Minister of Health Dr. Ramón Valdivieso.

¹⁴² Servicio Único de Salud.

¹⁴³ R. Valdivieso & B. Juricic, “El sistema nacional de salud en Chile” in (1970) 63 “Boletín de la Oficina Panamericana de Salud” 480, in Livingstone & Raczynski (eds.), *Salud pública y bienestar social*, *supra* note 14 at 9.

services under one single umbrella. This was clearly demonstrated in the parliamentary debates of 1964, when the Director General of the SNS avowed that the government policy was to move towards the creation of a National Health System with a standardized funding and management mechanism. To supporters of the initiative, the National Health System seemed to be an ideal and definitive solution. However, a significant amount of public opinion had to be swayed, along with tough negotiations with many stakeholders, especially the Medical College, beneficiaries and other health care professionals.¹⁴⁴

As soon as President Eduardo Frei assumed his mandate, he established a Compulsory Insurance Fund to meet the needs resulting from the high numbers of work-related accidents and illnesses.¹⁴⁵ The Frei Government also attempted to extend the role of the SNS, elaborating a policy of national planning that was adapted to limited resources and addressed the high infant mortality rates and the relatively short life expectancy of the population. On the other hand, there was a political consensus that public resources and health benefits were insufficient and unevenly distributed, socially and geographically. Also, with the objective of incorporating other social groups into the economic and social process, the government reinforced the role of peripheral health care services and rural clinics. Due to the increasing enrolment rates in nursing, medical and

¹⁴⁴ *Id.*

¹⁴⁵ The initiative to legislate on industrial accidents was excluded from the reform of 1952. During the Frei administration, Decree-Law No. 16.764 (February 1, 1968) was promulgated, providing insurance against risks from accidents and occupational diseases.

obstetrical schools, the quality of health assistance and human resources improved.¹⁴⁶

In terms of the problem of accessibility, availability and payments of medical services for employees, President Frei indicated in his first presidential message that the solution was to make the SNS a genuine health care provider at the national level, covering all sectors of the population. He added that any alternative solution had to be considered only temporary, since it was not possible to accept two classes of medical care (one for blue-collar workers and another for white-collar workers). In this respect, between 1966 and 1967 the Ministry of Public Health emphasized several important initiatives, as follows:

- a) The Decennial Health Plan (1966–1975), following the lead of the Pan-American Health Organization (PAHO), whose methodology emphasized the need for greater efficiency in the provision of health care services, better coordination of existing health care instruments and a more rational use of the resources available;¹⁴⁷
- b) The creation of the National Planning and Budget Office for the health sector;¹⁴⁸
- c) The creation of the National Consultative Health Council¹⁴⁹ (CNCS, replacing the CNS)¹⁵⁰ and of Community Health Councils¹⁵¹ and

¹⁴⁶ Morales, “Sistema político, planificación y políticas públicas”, *supra* note 140 at 50.

¹⁴⁷ OPS-OMS (1965). The planning method advocated the rationalization of resources according to priorities. These were associated with costs, and were established taking into account the extent of health damage, the importance of the targeted social group, their vulnerability and other specific actions to evaluate against the backdrop of specific circumstances.

¹⁴⁸ Oficina Planificación y Presupuesto del sector Salud.

¹⁴⁹ Consejo Nacional Consultivo de Salud.

¹⁵⁰ The constitution of the National Health Advisory Council was enacted in April 1967, and incorporated in 1968 in accordance with Law No. 16.481 pertaining to curative medicine.

¹⁵¹ The Community Councils (Consejos Comunitarios de Salud) were representative organizations that worked at the community level in areas linked to health care institutions and

- d) The completion of a national study on the availability of human resources, with the support of the PAHO and the United States Agency for International Development (USAID).

In summary, the Decennial Health Plan attempted to target the most critical problems, developing political programs to extend health care and benefits and focusing on improving the integration of services.¹⁵² The new National Consultative Health Council was mandated to support the Ministry in all aspects of the planning, coordination, and integration of health actions at the national level. The CNCS acquired the mission of establishing the National Health System, intended to serve the entire community equally.^{153,154} Its primary objective was to promote public awareness, educate the population on health issues and facilitate prevention programs, but its interventions were clearly insufficient. The 80 community health councils created by the end of the Frei administration did not accomplish their mission, primarily due to their organizational limitations and their lack of political direction.¹⁵⁵

On the other hand, the Medical College noted that this new scenario was actively modifying medical practice in public institutions, with an emphasis on

hospitals. In 1970, eighty community councils were operating in the country (Emanuel De Kadt, "Las desigualdades en el campo de la salud" 133 in Livingstone & Raczynski (eds.), *Salud pública y bienestar social*, *supra* note 13. As they had to be convened by a delegate of the Ministry of Interior, their development was hampered by bureaucratic procedures.

¹⁵² Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 41 at 196.

¹⁵³ Most of its members were directors of services (SNS, SERMENA, armed forces, police, gendarmerie etc.), to which were added the Dean of the Faculty of Medicine of the University of Chile, representatives of the Association of Faculties of Medicine, professional associations (doctors, dentists and pharmacists), and one representative of the workers and other employees.

¹⁵⁴ Valdivieso & Juricic, "El sistema nacional de salud en Chile", *supra* note 143 at 9.

¹⁵⁵ Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 41 at 196-197.

providing assistance for those needing social assistance. The Medical College also emphasized the need for medical doctors to migrate to rural and isolated areas. The College stressed the need to preserve a totally professional and ethical approach to health care, independent of political interference.¹⁵⁶ However, the health sector did not receive resources proportional to the growth of the population, and these restrictions and the uneven distribution of health professionals and resources for doctors ultimately limited its capacity to improve the country's health indicators.

Public health legislation, in place since 1931, was also modified in 1967. The new Public Health Code¹⁵⁷ took on a great mission: to resolve all issues under the SNS mandate related to health protection and to supervise public hygiene under the umbrella of municipal services. In addition, it contemplated offering coverage to pregnant women and mothers during the first six months post-partum, as well as free dental service to students in public schools. At the same time, the new code regulated the compulsory reporting of some diseases, imposed regulations on food storage and preparation and was responsible for regulating sexual education, controlling venereal diseases, vaccinating the entire population and supervising laboratories and the pharmaceutical industry. The new Public Health Code also regulated the actions of the SNS with respect to

¹⁵⁶ See *14 Vida Médica* (1952), *Revista del Colegio Médico* in *Id.* at 192.

¹⁵⁷ **Decree-Law (DFL) 725 (1968). Modified Law 226 (1931) that Established the Public Health Code**

monitoring the mental illnesses of alcoholics and drug addicts, the sanitation of cemeteries and the hygiene of public spaces (including public transportation).¹⁵⁸

However, the Curative Medicine Bill, 16,781¹⁵⁹, presented by the previous government in 1961, continued to move through the parliamentary debate process despite the change in government, as it was already too late to reverse the process. In addition, all physicians and their employers were in favour of a free-choice model, in direct conflict with the principles of universality, integration and equity advocated by the Frei Government.¹⁶⁰ This proposal divided the population of employees into three income groups, where each group had different access to medical care. The cost of the service was established according to specific tables. This way, the payment structure included an already complicated financial equation that attempted to balance several interests: the government's need to reduce costs; users' requests for a reduction in the cost of co-payments; and professionals' wishes to maximize their incomes.^{161,162}

The new social and political scenario following the election of the Christian Democrats was reflected in the parliamentary debates about Bill 16,781. This

¹⁵⁸ Romero, "Desarrollo de la Medicina y la Salubridad en Chile", *supra* nota 65 at 885-886.

¹⁵⁹ See *infra* note No 172.

¹⁶⁰ The Medical College publicly contradicted the President by claiming that they were not consulted. They rejected the government's proposal of the universal Right to Health mentioning that throughout the world, Health was in crisis due to the cost of medicines, thus creating the need to find ways to assume these costs according to the society's economic capacity to adequately compensate physicians. (See (1965) 7 *Vida Médica*).

¹⁶¹ The issue of co-payments was the most controversial because of the harsh economic reality of the employees. According to the Ministry of Health data, 70% had an income equivalent to two monthly minimum wages, thus fulfilling the same criteria as the workers who received free care by law. Hence employees considered the co payment to be a kind of discrimination. (See (1965) 7 *Vida Médica*).

¹⁶² Parada, Evolución del sistema de protección social de la salud en Chile, *supra* note 41 at 197.

time, however, representatives with various interests were involved in the process, not only physicians and the bureaucratic elite. The decision-making process was open and democratic, with diverse organizations represented, thus altering the nature of the debates. The energetic demands of the employees and health workers weakened the powerful influence of the Medical College and forced the government to modify its purely technocratic position.¹⁶³ Declarations made by public employees in the Senate highlighted the issues that were at play, affirming that this project was a long-held aspiration of employees because their low incomes were not sufficient to cover their medical expenses.¹⁶⁴ As a result, the employees not only supported the physicians' demands, but they also requested that the free-choice model of health care be extended to all, without any differentiation based on economic status.¹⁶⁵ All this clearly demonstrated how the passing of laws and especially their implementation required the collaboration of intermediate bureaucrats and health authorities, who could either facilitate or block the reforms.¹⁶⁶

The conflicts of interest increased in 1966, when the opposition, led by the "gremialista"¹⁶⁷ group, supported the physicians by demanding a socialized

¹⁶³ These views were articulated by the Confederation of Private Employees (CEPECH) and the National Association of Public Employees (ANEF), whose president, Tucapel Jiménez, was an important leader who was later assassinated by agents of the Pinochet dictatorship. In Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 41 at 199

¹⁶⁴ Senate, Daily sessions Journal, October 24, 1964.

¹⁶⁵ Funding through the pension institutes, the construction of hospitals for employees, and the auditing of the SERMENA' accounting by an employee's representative, was also sought. (See *Vida Médica 14*, 1965).

¹⁶⁶ Stephan Haggard & Robert R. Kaufman, *Development, Democracy and Welfare States*, (Princeton, Princeton University Press, 2008) at 197.

¹⁶⁷ Not to be mistaken with the right-wing "gremialista movement" during the Allende Government,

model of medicine. This group, along with more conservative sectors, argued that the SNS was moving away from a modern conception of health care and endangering the practice of medicine. They held that the SNS had gained too much power and was putting health care in danger, as the profession was not able to delegate responsibilities or revise the fundamental principles or payment structures proposed in 1952.¹⁶⁸ Rather, their proposals had to be sent to Parliament for review, and they had to request that their demands be heard by the Medical College before any decisions were made.^{169 & 170}

At a more general level, the Curative Medicine Bill articulated three logics that had been associated with the health system since its very beginnings: a) the political logic of universal, free access to health care and professionals paid by salary; b) the social logic of middle-class values, such that white-collar workers would accept sharing the same services that blue-collar workers received, in equal conditions; and c) the corporative logic, which attempted to impose market flexibility on the public-private relationship, following a free-choice model. These interrelated logics corresponded to three contradictory fronts of change: a) the institutional front, led by technocrats wishing to sustain the transformation and rationality of the Decennial Health Plan; b) the corporative front, which tried to

which was the critical intellectual elite behind the pro-Pinochet Unión Demócrata Independiente Party. "Gremialismo" is a conservative current of thought closely linked to sectors of the Opus Dei in the Catholic church. In Chile, gremialismo was the ideological support for the political party Unión Demócrata Independiente (UDI, Independent Democratic Union).

¹⁶⁸ *Vida Médica* 4 (1966), *Revista del Colegio Médico* in Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 41 at 199 & 200.

¹⁶⁹ *Vida Médica* 7 (1965) in Parada, *Id.*

¹⁷⁰ The Medical College initiated a "hard line" policy and undertook a wide mobilization against the curative medicine project. They also reinforced their ties with the employees' associations.

accommodate the interests of the SNS; and c) the socio-political front, which expressed the new face of Chilean society in an active process of democratization and mobilization for more and better services and social participation.¹⁷¹

The government was thus losing control of social dynamics, while physicians faced unexpected changes to their profession, such as the greater autonomy of non-medical doctors and the spread of popular awareness in favour of health rights. The Curative Medicine Act^{172 & 173} presented by the conservative government in 1961 was finally passed in 1968. The same year, at the end of President Frei's mandate, despite the growth of the social medicine model and the influential role of the SNS, a difficult scenario of complex political and ideological orientations took shape. These orientations facilitated some structural

¹⁷¹ Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 40 at 198.

¹⁷² **Law 16,781 (1968) Curative Medicine Act** The law was established to provide medical and dental assistance to beneficiaries, retirees, the unemployed of the institutions listed in Article 2 of **Decree-Law 286** of 1960, dependents, and those receiving widows' and orphans' pensions. The beneficiaries of the Social Welfare Fund of the Municipal Workers, the Crew section of the Pension Fund for the National Merchant Navy and the staff of the National Health Service and their dependents were excluded from the purview of this law. In accordance with Article 65 of Decree-Law No. 338 of 1960, all those who could be considered as dependents of parliamentarians - serving and retired - were entitled to the benefits prescribed by this law. The administration of the health care system created by this law, and in particular, the Medical Assistance Fund that would fund all or part of the benefits, was entrusted to the National Medical Service for Employees (SERMENA). The Medical Assistance Fund granted a number of benefits, including, medical consultation, surgery, several medical tests and examinations, hospitalizations, emergencies, and obstetric and dental care. The benefits were granted by the SERMENA under the "free choice" protocol (the beneficiaries could choose the provider of the medical service). The SERMENA had the power to sign agreements with the National Health Service or any other public or private entity. The law also created the National Advisory Council on Health in the Ministry of Public Health.

¹⁷³ It was called so in relation to the law of Preventive Medicine (Cruz-Coke Law) that was benefiting employees with the creation of SERMENA in 1942.

changes and resulted in a more liberal reorientation of the health sector.¹⁷⁴ As already indicated, the SERMENA¹⁷⁵ was responsible for the implementation of the Curative Medicine Law, which benefitted two million people. Thus, the SNS and the SERMENA¹⁷⁶ became the fundamental pillars of the National Health System.¹⁷⁷ At the same time, health policy overall was becoming more technocratic, more interested in the management and efficiency of health care and less interested in the principles of socialized medicine in Chile.

The new Curative Medicine Law attempted to solve two problems at once: the shortage of medical assistance for employees and the demands of physicians trying to reorganize their working conditions according to their professional and economic interests. The SNS thus began to incorporate the free-choice system, with beneficiaries responsible for co-payments. This funding

¹⁷⁴ Labra, (1997) *Política, Saúde e Interesses Médicos no Chile (1900-1990)*, *supra* note 89 at 158.

¹⁷⁵ The SERMENA, according to the definition established by the **Decree-Law 286** (March 31, 1960) was a semi-public institution, endowed with a legal personality, whose relations with the government were maintained through the Ministry of Public Health. Its fundamental role was to provide exclusive curative services and preventive medicine to contributors in the various insurance institutions. Its sources of funding were the transfers from workers' and employers' salary contributions. Another source of revenue came from the direct sale of the bonds of curative medicine to patients. (Francisco Ortiz, "El sector salud y sus recursos financieros análisis de la década", in Hugo Lavados (ed.), *Desarrollo Social y salud en Chile*, (Santiago Corporación de promoción universitaria, 1980) at 174-177).

¹⁷⁶ The Employees National Health Service (SERMENA) as a semi-public institution with a legal personality, coordinated its activities with the government through the Ministry of Health. The service was also exclusively responsible for the Preventive Medicine of several Family Allowance Compensation Funds. The SERMENA performed the following functions entrusted by Law: a) It provided preventive medical services according to **Law 6,174**; b) The payment of the time-out subsidies and other economic benefits imposed by Law was its responsibility; c) Through a controlled fee, it provided dental care to family members affiliated to the Service; d) It had to sanction medical and dental loans for the passive and active affiliates; and e) It was responsible for building, acquiring or leasing suitable facilities to cater to the clinical and hospital requirements of its beneficiaries.

¹⁷⁷ In 1968, the Chilean population was distributed as follows: manual workers (blue collar) 47.9% and white-collar workers, 20.6%. In total 27% of the population was not covered by any social security scheme.

mechanism coexisted with the traditional system and was established in Law 15,076,¹⁷⁸ which regulated the professional work of surgeons, biochemists, dental surgeons, pharmacists and chemists. This legislation, along with Law 16,744¹⁷⁹—implemented on February 1, 1968, creating “*mutuales*” or workers’ insurance associations to cover accidents in the workplace and occupational illnesses—consolidated the free-choice model and contributed to the increase of private health care providers.¹⁸⁰ The *mutuales* established a compulsory

¹⁷⁸ **Law 15,076 (1962). Revised the text of the Statute for medical-surgical, pharmaceutical or chemical-pharmaceutical, bio-chemical and dental surgeons (Law 15,021[1962]).** The medical-surgical, pharmaceutical or chemical-pharmaceutical, bio-chemical and dental surgeons, who were enrolled in their respective professional colleges, and exercised professional duties in office or as paid employees, were called “public officials.” This law did not apply to the private exercise of the profession of public officials.

The provisions of the law applied to the National Health Service, the Services of Public Administration, Public, semi-Public or Autonomous institutions and, in general, to any natural or legal entity. The professional staff serving in the Armed Forces or the *Carabineros de Chile* (Police) was subject to the laws governing the armed service or the Corps of Carabineros de Chile, respectively. The National Health Service and the State Universities (or those recognized by it) could grant scholarships for the development of a proprietary form of training grants or scholarships for nursing homes.

¹⁷⁹ **Law 16,744 (1968). Established rules on occupational accidents and occupational diseases.** The Law declared that Social Insurance against risks of accidents and occupational diseases should be made mandatory. This Insurance was compulsory for employees, public servants, and also employees from the municipal and de-centralized State administration. This law covered students who had a source of income from their respective institutions, as well as self-employees and family workers. The law ensured that all students were insured against accidents suffered during their studies, or in carrying out their professional practice.

For the purpose of this law, an accident meant any injury that occurred to a person in the workplace or in connection with the work, and that resulted in disability or death. Work accidents also referred to accidents that occurred in the direct path (one way or return) between the bedroom and the workplace, and those occurring in the direct path between two places of work, but corresponding to different employers. Occupational accidents were also considered under this law. Occupational accidents comprised those accidents suffered by union leaders in the performance of their union duties. Interestingly, this law did not entertain accidents caused by circumstances unrelated to the work or intentionally inflicted by the victims. Occupational diseases included those caused directly during the exercise of the profession or work, resulting in disability or death. Benefits were provided for temporary incapacity, disability, survival and death. However, “death” was eliminated in 1979. The administration of the Insurance came under the purview of the Social Security Service, the National Health Service, the Welfare Funds and the Employers Mutual.

¹⁸⁰ Jorge Jiménez, online: Escuela de Medicina Pontificia Universidad Católica de Chile, retrieved (November 23, 2011) <http://escuela.med.puc.cl/publ/medamb/OrganizacionSanitaria.html>, at 2.

insurance plan to which employers were required to contribute 0.9% of the taxable wages they paid and could optionally make an additional contribution based on the risk and the business activity of the company, up to a maximum of 3.4% of taxable remuneration. Law 16,744 covered the following individuals: a) all the self-employed; b) public servants in the central government as well as in decentralized public institutions and municipalities; c) students who worked for their educational institutions; d) employees and their families and e) students in public and private schools who suffered accidents while in school or in internships.¹⁸¹ DFL 163¹⁸² regulated social security and the extension of compulsory insurance. This enactment fixed the text of Law 10,383 from August 8, 1952 and Law 16,840 from May 24, 1968, making it compulsory for all persons indicated by law to receive insurance against sickness, invalidity, old age and death.¹⁸³

As already highlighted, the curative medicine legislation was clearly the outcome of a dispute of interests between white- and blue-collar workers, where the latter were displeased with their dependence upon public services like the SNS.¹⁸⁴ The law also resolved conflicts between the Medical College and the SNS Association of Employees, preventing the SNS from becoming the sole

¹⁸¹ *Id.* at 8.

¹⁸² **Decree-Law (DFL) 163 (1968). Social Security and extension of compulsory insurance**

¹⁸³ In compliance with this enactment, the Mandatory Insurance Fund (Caja de Seguro Obligatorio), which was renamed the Social Security Service (Servicio de Seguro Social), and the National Health Service (Servicio Nacional de Salud) were set up as was established by **Law 10.383**. The Social Security Service was also responsible for compliance with the severance benefits of services, and family allowances for workers.

¹⁸⁴ Morales, "Sistema político, planificación y políticas públicas", *supra* note 140 at 52-53.

employer in the health sector.¹⁸⁵ These two groups had clearly different views and understandings of the payment mechanisms in the public health system, with the physicians preferring a free-choice system paid for through service fees and the Association of Employees preferring salaries. The Curative Medicine Law regulated the use of SNS facilities during hours that did not conflict with the medical attention of legal beneficiaries and also allowed the possibility of offering public health care services in private clinics in order to avoid the construction of expensive health centres.¹⁸⁶

The SERMENA coordinated its operations¹⁸⁷ with many of the health professionals' associations, enabling beneficiaries to purchase subsidized "coupon-cheques" to pay for their medical care.¹⁸⁸ As white-collar workers and the middle class frequently complained about the lack of accessible services, which forced them to pay to access the private system or wait for long periods for an appointment in the free, public system, the law introduced a new option that transcended this two-tier medical system. With the new free-choice model,

¹⁸⁵ The Medical College was responsible with registering the professionals who wished to join the free choice system and with determining prices for all medical acts that were to be covered.

¹⁸⁶ The funding of these activities came from several sources, the most important being employee contributions of 1% of their taxable income and a contribution of 2% by the insurance fund. The law also gave the SNS the power to regulate work schedules, resources and the hiring policy for all its personnel, including physicians.

¹⁸⁷ Since the SERMENA and other public and compulsory insurance institutions were also involved in the implementation and administration of services under the Curative Medicine Law, an advisory council was created to coordinate and control the system, to determine the mechanisms for payment and to oversee the remuneration of health care professionals.

¹⁸⁸ The services provided by the SERMENA were diverse in nature, and included hospital care, private home visits, referrals, medical appointments, surgery, laboratory exams, X-rays, hospitalizations, dental treatments, obstetrical care, emergency care and specialized treatment. R. Gutiérrez, "Acceso de obreros y empleados a los beneficios de la medicina socializada" in Livingstone & Raczynski (eds.), *Salud pública y bienestar social*, *supra* note 14 at 96.

patients¹⁸⁹ were able to choose their doctors from a list of all registered doctors, with the possibility of using some specially allocated hospital units. However, this new option also placed new constraints on the infrastructure, which had previously been used largely by only blue-collar workers.¹⁹⁰

Despite the new Curative Medicine Law's acceptance of the free-choice model, which the Medical College had been advocating, the College manifested its opposition. In particular, according to the physicians the new law gave doctors very little power to co-administer the new system, with only modest flexibility in the fixing of prices for medical services and remunerations. They also objected to the lack of financial stimuli offered by the new system and to an increase in their workload. Hence, the Medical College increased its lobbying capacity, pressuring the government both to change the law and to meet its economic demands.¹⁹¹ The Medical College penetrated all the layers of the SNS, forming a control pyramid with the leaders at the top and the base of the organization spread throughout the country.¹⁹² This facilitated the College's links with other stakeholders, especially the National Federation of Health Workers (FENATS).¹⁹³ With these connections and corporate relationships, they were able to form a vast movement within the health sector, which became very aggressive and

¹⁸⁹ The figures drawn from the National Survey of Family Income in 1968 illustrated that the average income of the SERMENA beneficiaries was twice as high as the beneficiaries of the SNS (SNS).

¹⁹⁰ Illanes, "En Nombre del Pueblo, del Estado y de la Ciencia...", *supra* note 16 at 197.

¹⁹¹ The Medical College announced that it would eliminate from the "free-choice option records" all doctors who did not comply with the rules of the General Council. *Vida Médica* 10 (1968) in Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 41 at 200.

¹⁹² Parada, *Id.* at 201.

¹⁹³ Federación Nacional de Trabajadores de la Salud (FENATS).

conservative. In this context, the opposition to the Christian Democratic government, the corporate “*gremialista*” movement and the historical supporters of social medicine shared the College’s demands until their ideological differences were brought to the surface in the presidential elections of 1970, when physicians divided into two irreconcilable factions.¹⁹⁴

The Curative Medicine Law did not try to incorporate white-collar workers into the SNS, nor did it create a parallel system just for them. Instead, the SERMENA was based on an intermediate formula that offered similar benefits to those offered by the SNS, and, unlike the SNS, operated on the free-choice model, with some restrictions. In general terms, although the Curative Medicine Law was contested and patients were presented with two public models, the law finally allowed white-collar workers to have access to free medical care and transformed the SNS, which became a great pillar in the health system, covering almost 90% of the population. It was complemented by hospitals, university hospitals and medical care for the armed forces, railroad workers and the police. The private sector, however, covered 10% of the population and was organized around private clinics, doctors’ offices, assistance services provided by large corporations and different popular and traditional medical practices. Although the

¹⁹⁴ The symptoms of the crisis were many and diverse. The government did not report their plans, and tried to reform the SNS excluding the Medical College. It wanted to implement an administrative reform, which required a commitment of eight working hours, destroying the gains obtained in the past. The honorariums for physicians were not respected. Foreign doctors were entering the country (to meet the shortage of nationals). The Minister of Finance discriminated against the Medical College, which forced the physicians to go on a strike, or move on “turtle operations”, to reduce their involvement. Labra, *Política, Saúde e Interesses Médicos no Chile (1900-1990)*, *supra* note 89 at 158.

free-choice model did not meet the interests of the majority of doctors and only 25% of physicians registered with this system, the number of patients who opted for health care under this new model increased exponentially.¹⁹⁵ More than one million people already benefited from the SERMENA between 1964 and 1972. The number of medical services increased yearly, jumping from 27,100 in 1964 to 2,356,900 in 1972.

COMPARISON BETWEEN THE SNS AND SERMENA

CARACTERISTIC	SERMENA	SNS
BENEFICIARIES	Private employees and public servants	Manual workers, farmers, peasants, artisans, craftsmen, clerks, employees and the poor.
COVERAGE	20% of the population	48% of the population as direct beneficiaries and approximately 17% of the population due to indigence.
INFRASTRUCTURE	Very limited. Beds located in private institutions and in SNS facilities.	Hospitals and clinics in a fully regionalized system.

¹⁹⁵ The Minister of Health requested the Medical College for a wider dissemination of information on the curative health system, as "many professionals throughout the country were not interest to enroll in the free choice option believing it was against their interests." *Vida Médica* 3 (1970) in Parada, Evolución del sistema de protección social de la salud en Chile, *supra* note 41 at 205.

TYPES OF SERVICES	Diagnostic and therapeutic care, preventive screenings.	Comprehensive preventive and curative care. Public health care for the entire population.
COST FOR THE PATIENT	Co-insurance; patients pay part of costs.	Free for services covered by the law.
HEALTH PERSONNEL	Employees and contract workers	Salaried employees

Source: Adapted from T. Hall & P. Díaz, "Social Security and Health Care Patterns in Chile", (1971) *1 International Journal of Medical and Sanitary Services* 364.

In general terms, criticism of the Christian Democratic government's health policy came from different political and social sectors, which caused conflicts between the workers' unions and professional associations and the state as the regulator of the health reforms. According to the government, popular participation increased, wages improved, bureaucratization was reduced and medical services were extended. Critics, however, argued that the increase in popular participation was insufficient, as community participation in the management process was considered to be weak, superficial and symbolic, even when recognizing the presence of such participation in the advisory councils. In addition, they noted that during this time there was a lack of innovation in the

practice of medicine, which continued to be developed under the same dominant and orthodox model. The biomedical model controlled by medical doctors persisted, based on the health-disease paradigm, despite evidence that pointed to the benefits of a wellness paradigm.

In terms of statistics, public health expenditures increased by 68% between 1964 and 1970—a 49% per capita increase. The number of people working for the SNS also rose from 42,165 in 1964 to 55,173 in 1970, representing a 31% increase. Finally, the percentage of total expenses used to pay wages increased from 50.2% to 61.5% during the same period.¹⁹⁶ Of all the deficiencies of the SNS, the inequities in the services provided to the rural population and the poor were the most critical. Furthermore, the system was still very bureaucratic, and funding was inadequate. The distribution of resources was also uneven, with 40% of resources concentrated in the private sector.

On the national political scene, society was demanding the democratization of public institutions, beginning with the University of Chile, accused of supporting the country's conservative forces, which were resistant to social change. As a result, in 1968 the country embarked upon a university reform process. All medical educational institutes were questioned and criticized for their inability to train enough professionals to meet the demands of the public health system. In order to address these problems, the curriculum in the medical schools was reformed, introducing social science courses and opening a

¹⁹⁶ National Institute of Statistics, (Instituto Nacional de Estadística); (1970). Annuary of Nacional Health Service (Anuarios del Servicio Nacional de Salud); Ministerio de Hacienda.

Community Medicine Department as well as emphasizing research based more on a social-medicine approach.¹⁹⁷ With the participation of the Medical College, a new joint educational committee was formed to produce professionals with critical skills, social awareness and active involvement in the community.¹⁹⁸ Ultimately, the Medical College decided to partake in the new changes to make up for lost opportunities in previous attempts to assert technical and economic autonomy.¹⁹⁹ Furthermore, the salary model of payment for health care services positioned doctors against public employees, which privileged but also constrained the doctors' professional development.

Meanwhile, non-medical health workers organized themselves in the combative National Federation of Health Workers (FENATS), which did not believe in the supposed technical and rational superiority of the bureaucracy or that the altruism of the medical profession would lead to an advance towards a model of social medicine. Disillusioned, the FENATS decided to push for the democratization of services to fracture the rigid professional hierarchy. They protested that they had neither control nor representation in the SNS, adding that if they had some influence, several problems in the health sector that had been

¹⁹⁷ Parada, Evolución del sistema de protección social de la salud en Chile, *supra* note 41 at 202-203.

¹⁹⁸ E. Villarroel, & G. Venturini, "La contribución del Colegio Médico a la educación médica chilena", (1972) *100 Revista Médica de Chile* 844.

¹⁹⁹ In previous historical periods the Medical College was unable to influence significantly in the outcome of health reforms or legislative changes. For instance, in 1924 and 1930, the Medical College was poorly organized and did not trust the postulates of the leftist-progressive medical union of Valparaiso. In the 1950 and 1952 health reforms, physicians lost another opportunity to influence a more comprehensive medical education curriculum and to promote decentralization at the local level. This was the result of its desire to gain control over the SNS and also a consequence of the hegemony of the specialization paradigm within the profession.

reported to the authorities and the public would have already been resolved.²⁰⁰

The health workers went on several strikes with the support of the Workers' Central Union (CUT)²⁰¹ and launched a campaign for the democratization of the SNS and a socialized form of medicine. Among other demands, they called for the direct participation of workers, via their representatives, in the administration and management of all public institutions and state corporations. During these demonstrations, the FENATS claimed that the SNS was not providing health but selling it, denouncing that the Curative Medicine Law was an incentive to return to the old liberal system. They pointed out the serious wage disparities: 10% of health care workers (4000 physicians) received 55% of all wages, whereas the other 45% of wages were distributed among 40,000 non-medical health care workers (blue- and white-collar workers).

The political context was already highly charged. In addition, President Frei failed in his attempt to create a National Health System, and following several strikes, the Decennial Health Plan collapsed. The Christian Democracy administration completed its final year amidst great political, ideological and social turmoil, enormously frustrating the health sector. The government was paralyzed and isolated. Its own party was divided, giving rise to radicalized sectors such as the "MAPU"²⁰² and, later, the Christian Left.²⁰³ However, many of its reformist efforts were not in vain, as it had accomplished significant progress

²⁰⁰ Morales, "Sistema político, planificación y políticas públicas", *supra* note 140 at 59.

²⁰¹ Central Única de trabajadores (CUT).

²⁰² Movimiento de Acción Popular Unitario (MAPU).

²⁰³ Izquierda Cristiana.

in agrarian reform, industrial modernization, technological innovation, the partial nationalization of the copper mining industry,²⁰⁴ education reforms and the unionization of farmers. In the health field, despite political, financial and administrative difficulties and little cooperation from medical doctors, access to services was extended and the basic indicators of health improved. The democratization process was furthered, and the accessibility of health care services for the middle-class improved as a result of the predominance of the middle class and parties of the political centre.

However, by 1970, forces of the political left wished to revert the capitalist model of development and further expand the process of democratization in order to build a new society based on the premises of socialism. This was the socio-political project known as the “Chilean road to socialism”, under the leadership of Salvador Allende, the former health minister and senator. This political program was widely supported by a coalition of parties, headed by the Socialist and Communist Parties. Their coalition, known as “Unidad Popular” (Popular Unity), was elected in the presidential elections of 1970, making Salvador Allende the first president of Marxist inspiration to be democratically elected in the world.

²⁰⁴ A semi nationalization of the mining industry, without any expropriation.

C. The socialist model of the Popular Unity government (1970-1973)

The Popular Unity government's goal was to reorient economic development and re-direct the process of capital accumulation to satisfy the basic needs of the workers, peasants and middle class. Its primary objective was to reduce the high degree of concentration of foreign and domestic monopoly capital. Beginning in 1970, the Popular Unity government implemented the nationalization of strategic enterprises (especially mineral resources), a vast agrarian land reform, the control of foreign trade and the financial market, price controls and wage increases. Although the Popular Unity program and political platform facilitated a series of fundamental changes and transformations in the socio-economic structure, these changes were not mere reforms or amendments to the productive system, nor were they merely measures to reduce the social inequalities that were structurally linked to economic underdevelopment. With these reforms, the government sought to ensure state control over economic processes in order to restructure the economy and transform the existing model of development.²⁰⁵

The formation of the Popular Unity government marked a new advance and a further strengthening of the state apparatus and a qualitative change in the nature of government intervention in society. The purpose of ensuring state control was not to destroy the state apparatus,²⁰⁶ but rather to establish a

²⁰⁵ Pilar Vergara, *Las transformaciones del Estado chileno bajo el régimen militar*, (Mimeo, 1980) at 7.

²⁰⁶ As in the Marxist approach.

revolutionary process²⁰⁷ that would change the living conditions for the vast majority of the population—people who had traditionally been ignored. The Allende government developed a political and socio-economic platform to found Chile's first socialist society.

The government's economic policy had four main objectives: a) the redistribution of income; b) the expansion of government programs and services; c) state control of key and strategic industries and d) the expansion of agrarian reform. At the same time, its social policy aimed to strengthen the process of wealth distribution through reforms in the fields of education, housing, social welfare, health and employment. The proposed changes also attempted to profoundly transform the health sector. According to the minister of health, the implementation of the aforementioned reforms, such as the control of natural resources and the main and strategic means of production, along with extensive land reform and income redistribution, would result in the improvement of overall living conditions, thus impacting health determinants and the well-being of the population.

The doctrine of the Popular Unity government and its proposal for the transformation of the health sector were presented in the first presidential message to Congress. In this message, President Allende insisted on the necessity of extending public and universal health care to combat important

²⁰⁷ The replacement of the economic, social and institutional capitalist foundations of the country was the result of decades of struggle by several generations of activists, who were finally able to take advantage of suitable historical conditions. Salvador Allende, second Presidential Address, May 1972.

social and medical problems—a position he had been advocating since the 1930s. He recalled the important role played by the left-wing political parties and himself in the creation of the National Health Service, following the health definitions and principles proposed by the World Health Organization. He also linked his political principles to the Cuban revolution, arguing that health was a dialectical biological and social process, a result of the interaction between individuals and the environment, both of which are influenced by the relations of production in a given society. These were, as he highlighted, the overall determinants that influenced the level of wellness in society, including physical and mental health.

For Allende and his government, health was strictly correlated to the economic and social structure and the improvement of individual living conditions within society. The close relationship the government saw between health determinants and socio-economic development permitted it to situate health within the complex relationship between the individual and the environment. As a result, improving the health status of the population was related to bringing an end to the old capitalist mode of production and building a socialist society. It was in this context that Allende expressed his commitment to defend and promote the right to full access to health care and preventive and public health services for the general population. The government asserted that health was an inalienable human right and that its full realization was the state's responsibility. The government declared its full responsibility for encouraging revolutionary changes

to challenge traditional policies that were hindering the construction of a more equitable, efficient and adequate health system.²⁰⁸

As previously indicated, the National Health Service was already a key form of government intervention in health, and its creation was the culmination of a historical process of state legitimation in the health field, in which Allende himself had been a key figure. The work of the SNS included the administration of physical and human resources in order to implement national programs and to evaluate and assess the impact of its services. In addition to environmental control programs and the monitoring of infectious diseases, the population had access to ongoing services that controlled the spread of communicable diseases, ultimately contributing significantly to reducing the morbidity and mortality rates of the population. Regardless of the diversity of the successive governments and the resistance of a great number of physicians, and despite political, financial, technical and managerial limitations, the SNS always sought and encouraged active community participation in the implementation of health activities. It is interesting to note, for instance, the progress made in preventive medicine by means of the implementation of health education programs that promoted awareness and facilitated a better understanding of health-related issues and prevention strategies.

According to one of Chile's most respected physicians, Dr. Alejandro Goic,²⁰⁹ the SNS was instrumental in the development of educational programs

²⁰⁸ Salvador Allende, third Presidential Address, May 1973.

that drew on the expertise of professionals, technicians and specialists. The SNS also had a regulatory function, facilitating a more equitable distribution of medical resources throughout the country. The mission of the SNS, coupled with the organizational principles of decentralization and the training of professionals according to humanist and social principles, helped to develop a more all-inclusive medical approach²¹⁰ and an appreciation of the value of teamwork.²¹¹ The SNS thus encouraged professionals to engage in superior practice through training programs, to focus on specializing, to participate in clinical and experimental research and to undertake epidemiological work.²¹² Most of the physicians who worked in public hospitals for a certain number of hours per week allocated their remaining time to working in a private practice. Their involvement in the public sector was motivated by their social vocation and by the benefits their involvement entailed, such as prestige, access to the hospital infrastructure for experimental research and the opportunity to share knowledge and experience with colleagues.

Despite all the improvements in the health field, the SNS still had notable gaps and weaknesses. It was most criticized for its excessive administrative centralization and slow decision-making process. These two basic problems not only limited its effectiveness, but also served as a barrier for the establishment of

²⁰⁹ Alejandro Goic, "Visión crítica del S.N.S.: 1978", (1978) 273 *Mensaje* 626.

²¹⁰ Comprehensive medical care meant that all the medical services were provided to a population not exceeding 25,000 inhabitants in a care center (clinic) located near their center of work, in order to facilitate the accessibility, planning and organization of the services.

²¹¹ A health team was a group of professionals, technicians and volunteers who worked in groups to accomplish common goals and objectives.

²¹² In this regard, the Education Unit and the SNS Care played a key role.

regional or local authorities and complicated the rational and prompt redeployment of resources. Another criticism often levied against the SNS was related to its enormous magnitude, which allowed it to control nearly all the hospitals, nursing homes and urban and rural clinics in the country. Critics held that its size, coupled with its oversized staff, transformed the SNS into a giant with a heavy and complex administrative system. Moreover, the rigid funding structure (due to the elaborate bureaucracy) and the reduction in the funding of services also affected staff salaries, which were generally below that of other public-sector employees. Finally, the most radical criticism of the SNS came from defenders of private medical practice and targeted the very concept of socialized medicine.

In the public system, patients had to accept the hospital, the medical professionals and the available and accessible resources without almost any choice. This situation was not acceptable to many physicians, who called instead for the right to “free choice”. This prerogative was continuously requested by the Medical College, despite its strong interest in facilitating medical careers within the SNS that simultaneously preserved the possibility to engage in private medical practice. The victory of the Popular Unity coalition in the 1970 presidential election even further radicalized these different health care models.

Without suppressing the activities of the private sector, the government took action to allocate the majority of public sector expenditures through a redistribution of taxation and a reorganization of social security. The health policy

was aimed at implementing three major reforms: a) the development of greater and improved capacity for the provision of health and medical services; b) the expansion of democratization and popular participation in the implementation of health actions and activities and c) the establishment of a Unified National Health Service with greater centralized capacity and the inclusion of the SERMENA.

The new paradigm for implementing these policies entailed a transformation of the organizational structure by centralizing the decision-making process and decentralizing the level of execution. Improving access to medical services was part of the government's Six-Year Health Plan (1970-1976), in line with its Six-Year Economic and Social Development Plan. The Health Plan emphasized the need for planned structural changes. This was reinforced with the establishment of an ad hoc Ministry of Health office within the SNS and the transformation of the CNCS into the Council for the Development of the Health Sector.²¹³

The Health Plan identified the resources and funds allocated annually to the SNS and redirected them as needed to meet the new demand for services. It was believed that the demand for services would increase, not only because of the new awareness, educational programs and enhanced popular participation process, implemented to promote the right to health, but also because of the incorporation of marginal and economically weak social sectors into the system and the income redistribution called for in the Six-Year Development Plan.

²¹³ Consejo de Desarrollo del Sector Salud.

The Six-Year Health Plan included the following objectives: a) to meet the quantitative and qualitative health needs of the population; b) to increase the number and accessibility of services; c) to enhance the effectiveness of resources and funds and d) to improve the quality of medical services in order to optimize health indicators.²¹⁴ Another aspect of the Six-Year Health plan was the development of local health centres and satellite clinics tasked with administering outpatient services²¹⁵ and attracting specialists, community volunteers and medical students. A local “health team”, which constituted an excellent opportunity for medical students to gain experience, offered services 7 days a week, 24 hours a day. Health teams shared their expertise with their communities and also participated in community training and education, especially with respect to the prevention and control of disease. This program permitted newly qualified students to practice and assist those in greater need in remote areas. Overall, the program helped to provide medical services to two million people and reduced the long wait times and denials of medical assistance by the SNS.²¹⁶ Despite its shortcomings, the SNS had come to embody the principle of social responsibility in the health field, moving towards offering

²¹⁴ Oficina de Planeamiento SNS, “Plan Sexenal de Salud: modelo de programación vigente para 1973” in Ortiz “El sector salud y sus recursos financieros: análisis de la década”, *supra* note 173.

²¹⁵ These new out-patient services were primarily performed in large urban areas such as Santiago, the capital, and the southern city of Concepcion. Greater Santiago, for example, had 83 health centers, located primarily in the poorest sectors. In addition, the country already had special programs for the provision of rural health care services, and despite the large and historical concentration of resources in big cities, an internship program for general practitioners was created.

²¹⁶ J. Kandell, “Chile’s poor get more medical aid”, (March 31, 1973) *New York Times*.

comprehensive and socialized medicine, which was noteworthy in a developing country like Chile.

In general, and despite its inefficiency, lack of resources, and financial and organizational shortcomings, the political establishment and the general population never questioned the state's involvement in the health sector. The extensive coverage of the SNS throughout its large network of hospitals, urban clinics, rural clinics and dispensaries permitted the extension of health care and health-protection services to 100% of the population, covering 90% of all hospitalizations and 60% of all ambulatory services. No more than 10% of the population was covered by the private sector. Indeed, this responsibility of the public sector and the growing importance of state intervention in the health sector was also part of the overall trend towards an increased role for the state in ensuring the country's socio-economic development.

The evolution of the Chilean economy reflected the increasing amount of state intervention in all economic areas, which started as early as 1939, when the state became the economic engine of the development process. As previously discussed, this permitted the creation of large public companies, not only in unprofitable areas of the private sector, but also in critical economic areas of the industrial sector that were devoted to the production of intermediary products like pulp, petrochemicals, metal products and rubber. The state also played a significant role in investing in public works, providing a boost to the overall economic process and expanding the availability of social services.

The new organization of health services as presented in the Allende administration's Health Plan was informed by a belief in democratization as the main instrument necessary for transforming the structure of the SNS. This was considered to be a fundamental reform "that would allow citizens to participate in the implementation of the program's objectives, as their participation would ensure the appropriate use of resources to satisfy their health care needs."²¹⁷

Politically, the Popular Unity health reform sought to democratize services in a broader sense than that entailed in the concept of decentralization advocated by physicians. Full participation and responsibility were expected from all staff and citizens in evaluating the role of management and monitoring the performance of each of the services, as well as in critically evaluating the steps taken to meet policy objectives. To enable this democratization process and secure the participation of health workers and the user population in the decision-making process and power structure, the government promulgated Decree 602 on September 21, 1971.²¹⁸ This decree created local and multi-stakeholder health councils. It also modified the structure of existing health councils and

²¹⁷ Salvador Allende, first Presidential Address, May 1971.

²¹⁸ **Decree-Law 602 (1971). Created the Local Health Council and Council of Local Health Areas.** The Decree created Local Health Councils in every National Health Service institution, formed the Council of Local Health Areas, modified the structure and remedied the deficiencies of the community councils that had been created during the previous administration. A designated person from the Local Health Council was to investigate the problems affecting the health of the community. He was expected to offer prompt and effective solutions, and promote the interest of the population in actively participating in the solutions to their detected problems. He assisted in the dissemination of health plans, and presented the anomalies that emerged during the execution of those actions. In addition, each health facility had a joint (employer and employee) council directly responsible for carrying out the duties and powers assigned to the Local Health Boards. Members of the Local Health Councils and Joint Boards had to be appointed democratically by constituencies.

remedied the deficiencies of the community councils that had been created during the previous administration, though the health councils started to enjoy much greater decision-making capacity than the community councils.²¹⁹ Between September 1971 and December 1972, 269 local councils and another 207 multi-stakeholder health councils were created across the country. Approximately a third of these units belonged to the province of Santiago, where the population already enjoyed better health conditions than the national average.

These health councils constituted additional political forces as the administration dealt with physicians' strikes, which had sabotaged medical services, and they allowed a reasonable level of service to be maintained in the face of the civil disobedience movement and ongoing opposition to government policies. They were also instrumental in redesigning the nature of curative services by establishing a direct link between patients and medical personnel.

The intention was to coordinate joint action and initiatives by the popular health

²¹⁹ Under the law (Article 1), in every SNS establishment in which one or more health actions were performed, it was mandatory to have a Local Board of Health, regardless of the number of territorial districts. The Councils were mandated (Article 2) to examine the health problems affecting the community; achieve solutions through prompt and effective action; promote the interest of the citizens to participate actively in the solution of health problems and concerns; assist in the dissemination of health actions; and represent the anomalies that appeared in the execution of those actions. Furthermore, according to Article 4 of the Decree, the Local Board of Health had the following functions:

- 1) Propose effective and ongoing coordination between the local health authority, the health workers and the public;
- 2) To be aware of health problems through the information provided by the Director of the Health care unit and members of the Council, and propose corrective measures to ensure the accomplishments of the proposed programs;
- 3) To encourage the active participation of the community in collecting basic information, detecting problems and needs, and assisting in the prioritization and implementation of the health programs through volunteer work; and
- 4) To promote the integration between the local health authorities, the health workers and the population in the evaluation process of the programs.

councils and the local and multi-party health councils, bringing together representatives of trade unions, neighbourhood organizations, youth organizations, sports clubs and women's organizations.²²⁰

During this time, many health actors were actively involved in political struggle. Medical students, for instance, expressed their commitment to labour organizations as well as their willingness to work exclusively in the public sector. They also supported reforms to create a Unified National Health Service, in which physicians would share with each other and with other actors the mission of delivering public and popular medical services.

Along with its democratization policies, the government introduced regulations to reduce the bureaucracy of the SNS. This restored political and administrative power to the local level to allow for better planning in line with the social needs of each community or region. Without a doubt, the democratization process seemed promising. This was palpable, for instance, in the successful organization of the Health Brigades, which were supported by the Social Development Council and composed of volunteers. In the region of Santiago alone, these Brigades had 2,800 "health volunteers". The Brigades' actions reached different neighbourhoods in an attempt to identify citizens with health risk factors. These moves to promote the participation of the general public were recommended and adopted by participating states during the Third Special

²²⁰ Gustavo Molina "El gobierno de Allende y los médicos", (1970) *11 Vida Médica* 13.

Meeting of Ministers of Health of the Americas.²²¹ At this meeting, the region's physicians expressed their scepticism about the efficacy of purely technocratic planning measures due to structural inefficiencies at the national level. They also demanded that the concept and function of public health once again be rethought.²²²

Despite its promise, the program's countless efforts to encourage democratization ultimately achieved more modest results than expected, especially at the management level. A study of the democratization process²²³ demonstrated that in the local health boards in the Santiago area, community participation was essentially limited to women, particularly through the centres for mothers. The limited participation of the broader public resulted in a lack of qualitative change in the nature and kind of medical services offered. It provoked instead the criticism of users demanding increased services, better coverage and greater accessibility, while the public did not question the dominant paradigm or the administration of medical services. As a consequence, there was a lack of innovation at the conceptual or paradigmatic level, and no new discoveries were made regarding how to deliver health care services in the future. We can hypothesize that the lack of qualitative changes was due to the lack of creativity

²²¹ A. Pérez Miravete, "Papel de la OPS y la OMS en relación con las políticas nacionales de investigación", (1981) 15 Educ. Med. Salud 1 8.20. <http://hist.library.paho.org/Spanish/EMS/5740.pdf>

²²² B. Breuer & D. Schwefel, *Organización de servicios descentralizados de sanidad pública en América Latina*, (Berlín, Centro de Seminarios de Desarrollo Económico y Social, Fundación Alemana para el Desarrollo Internacional, 1973) at 56.

²²³ Sepúlveda, Celis & Neuhauser, "Estudio del proceso de democratización en unidades de salud del SNS", in Livingstone & Raczynski (eds.), *Salud pública y bienestar social*, *supra* note 14 at 25.

and autonomy in the public participation process. It appeared that planners, administrators and politicians drove public participation from the outside, with goals that were not always equally shared.²²⁴

Despite the shortcomings and limitations of the popular participation program, though, it made visible the relationship between health issues and social determinants such as housing, drinking water, hygiene, sanitation and nutrition. Furthermore, some programs improved health conditions, such as those implemented to combat childhood diarrhea, improve nutrition (a campaign provided children with a half-litre of milk per day), fight alcoholism and intensify preventive health measures. At the same time, the greater financial, human and material resources devoted to the health care system permitted an increase in staffing and in the number of contracted doctor-hours. This directly benefitted mothers and children, but at the same time prioritized hospital care over ambulatory services. In the end, just as with the previous Frei administration, the geographical redistribution of human resources was insufficient, despite all the decentralization efforts.²²⁵

The third major reform in the Popular Unity administration's health policy was the establishment of a Unified National Health Service (SUS).²²⁶ The purpose of the unified service was to ensure the "right to health" for all citizens, and this meant that the SUS had to be more comprehensive, with the capacity to

²²⁴ Breuer & Schwefel, Organización de servicios descentralizados, *supra* note 222 at 60.

²²⁵ Emanuel De Kadt, "Políticas y programas de salud en Chile: 1964-1973", in Livingstone & Raczynski (eds.), Salud pública y bienestar social, *supra* note 14 at 150.

²²⁶ Servicio Único de Salud, (SUS).

provide “efficient, timely, equitable, ongoing, adequate and free” medical care. In addition, as previously indicated, the SUS aimed to integrate all health institutions, including the public services created by the SNS under the umbrella of the employees’ medical system (SERMENA), which was primarily accessible to the middle class.²²⁷ This proposed change was not insignificant, since it was clearly perceived as an end to the two-tiered system, with a free-choice system for employees (the middle class) and the public system for blue-collar workers and peasants. The free-choice system covered about 25% of the population, paid for with patients’ pre-payments and supplemented with subsidies from both the private system (30%) and the SERMENA public system (70%).

According to the minister of health, the cornerstone of the health policy was a significant change in the structure and organization of the sector. With the creation and the development of a Unified National Health Service, the country was seeing historic measures being taken in the health field. In this context, health sector planning took on an entirely new meaning, streamlining decision-making processes and improving and rationalizing the use of resources.²²⁸ The government attempted to coordinate health activities and maintain positive relations with various universities, professional associations and other organizations as a result of its belief that these institutions were essential partners. Similarly, the administration relied on the active participation of health

²²⁷ Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 41 at 214.

²²⁸ Health Minister interview, (July 30, 1971) *La Prensa*, in Morales, “Sistema político, planificación y políticas públicas”, *supra* note 140.

volunteers, whose associations functioned much like unions and community organizations, willing to contribute mainly in the most remote and marginalized areas of the country.

The obstacles were not insignificant, as the overall objectives were extremely challenging, aiming not only to improve the quantity and quality of services, but to enhance the degree of humanization in the services offered and to promote decentralization, democratization and popular participation. For Allende, this was a revolutionary process that required health workers to be united in their “cohesion, fervour, charisma and sacrifice in the performance of their duties”.²²⁹ He insisted that the revolution had to start with the very people who participated in the process.

In October 1972, after the country came to a standstill due to mass protests against the Allende administration, the government was finally able to progress further in terms of its administrative reforms, as all negotiations with the opposition to change legislation had become impossible. The government amended the Curative Medicine Law, establishing a partnership between the SNS and the SERMENA and abolishing the process of direct payment from patient to doctor. This lowered the final cost of health care services and granted employees access to the SNS, providing coverage to at least two and a half million employees. The differences between government authorities and the Medical College on the establishment of the SUS, along with widespread political

²²⁹ Salvador Allende, third Presidential Address, May 1973.

opposition to the government, made it exceedingly difficult to implement legal changes to reform the health sector. The SNS-SERMENA agreement was thus presented as an administrative measure intended to prevent a complete paralysis of the reform process.

The Medical College took great offense to this administrative act and reacted vigorously to oppose the measure, as it modified the principle of free choice. The new procedure replaced the “bonus cheque” pre-payment that had been administered by the Medical College with a referral that directly linked the patient to public SNS services. According to the government, this measure allowed the public sector to secure increased funding, improve health care and more rationally redistribute financial, material and human resources. As a result, the monetary value of each medical service was also reduced, and the SERMENA had to pay the SNS for the use of its infrastructure and resources.

As we have seen, this measure sought to increase the capacity of the public sector and improve the quality of care while also limiting to some extent the private practice of medicine. These two goals were intended to reduce inequalities in the distribution of health care services. The limitations on the private practice of medicine were strongly criticized by the Medical College. Physicians were also irritated by other measures, such as calling upon doctors for eight-hour shifts and the extension of working hours to 9:00 p.m.,²³⁰ and they

²³⁰ Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 41 at 214.

were displeased with the unprecedented open and participatory interaction encouraged between health workers and the community.

Between November 1970 and October 1972, the tension between physicians and the government intensified considerably. It is astonishing to observe that within less than two years, the Medical College went from honouring President Allende “for his extensive and brilliant performance in public life, especially in the field of social medicine, and the merit of being the first physician elected as president of the Republic,”²³¹ to serving as a strong and active opponent in 1972 as a leader of the professionals against the government.

Even so, during that time the Allende government had been able to transform the health system into a more equitable, efficient and unified organization through negotiation and consensus building. Many of the problems in the SNS were caused by more liberal visions and approaches within the medical sector, opposed to the socialist views of the Allende government. The government exaggerated its revolutionary discourse and, overall, the almost irreconcilable ideological viewpoints deepened the crisis and accentuated the fear felt by health professionals. Physicians favouring a more open or a more blended private-public health care system refused to accept the changes toward a model of socialized medicine, which they feared would alter their status by positioning them as state medical employees. In October 1972, the Medical College took over the leadership of all professional associations, joining the opposition

²³¹ *Vida Médica* 3 (1970) in Parada, *Id.* at 218.

movement to promote the paralysis of the country and signing its so-called “Chile petition”.²³² Finally, in August and September 1973, the College called for the indefinite suspension of medical activities and demanded the resignation of President Allende. Among the government’s supporters, the most radical sector called for a deepening of the political, economic and social changes underway. The parties that formed part of the coalition began to clash, which limited the president’s capacity to govern.

However, the situation was even more complex, as beginning in October 1972, some government political parties and their supporting social movements called for the creation and implementation of a “people’s power” movement composed of non-traditional territorial organizations, aimed at defending the government and facilitating unified actions between the Popular Unity coalition parties and the popular movement.²³³ This movement, with its radical political discourse, clashed with the cultural universe of the middle class and its attachment to order and security. The People’s Power movement was politically criticized and rejected on the basis of its extremity and provocative ideas and found almost no support from the parties in the government. The Chilean road to socialism clashed with the middle class, whose ideology was based on the naturalization of social inequalities and a rejection of unrest, instability and turmoil.

²³² Pliego de Chile.

²³³ Poder Popular.

The health sector was witnessing the same political turmoil as the country at large, with a growing inability of the political class to negotiate and accommodate the interests of several actors and stakeholders in order to reach a consensus on the urgent reforms the country needed. The country was thus faced with the limitations of its economic model, the inability to implement equitable and redistributive policies within its economic paradigm and a social crisis with profound structural, social, and political contradictions. At the same time, stiff resistance from employers exacerbated the decline in industrial production and fuelled the shortage of consumption goods, creating critical food shortages and increasing the opposition's antagonism with respect to the Popular Unity government. Accusations that the government was engaging in illegal and incompetent behaviour gained favour in the public opinion, while authorities interpreted these signs as merely technical problems that would be overcome and resolved through the revolutionary process. It is particularly interesting to note how even though the changes were carried out within the same constitutional order inherited from previous governments (the 1925 constitution), the Allende government was accused of circumventing the legal system.

Another element of the crisis was the growth of the opposition movement, including several business organizations in the areas of trade, transportation and construction. This also created a new political context and new political dynamics for the opposition movement. The increasingly hard line of the opposition is exemplified by the refusal of the president of the Senate and of the House of

Representatives²³⁴ to even speak to President Allende. The physicians' support for the "Chile petition" made it close to impossible for them to negotiate with the government, as their endorsement implied a belief in the illegitimacy of the government, as the opposition charged. The government, however, relied on the apparent support of the Armed Forces and the revitalization of its own political parties, which had gained popular support and saw electoral growth in the previous municipal elections. It agreed to resume dialogue with the unions, but with each union separately, and only after they put an end to the strike. The government's legal, constitutional and political systems were still able to regulate conflicts and reduce tensions while awaiting the outcome of the parliamentary elections scheduled for March 1973. The results of these elections were not unlike those of 1970 and 1971, and opposition parties won a parliamentary majority²³⁵ to impeach the president and to compel the Popular Unity to negotiate.

Between March and September 1973, a series of events took place that once again modified the political scene, deepening the political crisis. Important legal changes introduced by the government included the implementation of: a) the Unified National School (ENU);²³⁶ b) the Social Property Area (industries that were transformed into public properties through government intervention,

²³⁴ Cámara de Diputados.

²³⁵ Chile has a presidential system where governments can still govern and stay in power until the next scheduled presidential elections and are not forced to resign even if they don't have the support of the Parliament or the Senate, as is the case in a parliamentary system.

²³⁶ Escuela Nacional Unificada.

nationalization or expropriation); and c) new forms of popular organization. These three changes generated even more resistance from the opposition to the Allende administration. In June 1973 there was an attempted military coup that was considered a trial run for future intervention. This crisis and the country's intense emotional climate allowed opposition forces to escalate their threat of a military solution to the crisis. The collapse of the democratic process and the fall of the elected government became the only way for the opposition to re-establish its hegemony over the political and economic process.

Due in part to the bitter struggle waged by the opposition and the intensification of terrorist actions against the government, the legitimacy of the military hierarchy and the democratic process itself continued to erode. However, neither the violence nor the failure of talks between the Popular Unity government and the Christian Democrats frustrated Allende's efforts to reconstitute his cabinet, surprisingly incorporating the Armed Forces as well. But a new general strike against the government, led by the professional associations, was supported with military discourses invoking the need for an authoritarian government with a strong and impersonal character. The message to the Armed Forces was clear: control all political instability and overthrow the government. The discourse of the oppositional political elite reflected the conservative ideology that the Armed Forces constituted "the moral reserve of the Nation".

As a consequence of this turbulence and instability, on August 22, 1973, Parliament declared that the elected government was illegal, setting the stage for the military coup²³⁷, of September 11, 1973 (euphemistically called a “military intervention”) that brought a brutal end to the government elected in 1970. The new military dictatorship radically altered the economic, social and political processes underway in the country. These changes had a profound impact on health policy, as the new regime imposed a new liberal market approach to health care, bringing drastic changes to the social welfare system that Chile had known since the beginning of the century.

²³⁷ On 11 September 1973, the combined Chilean Armed Forces (the Army, Navy, Air Force and the Carabineros (Police) overthrew the democratically elected Allende's government in a coup. Augusto Pinochet, a highly ranked Chilean general became the commander in chief of the army, later the chief of the Military Junta and finally the self-nominated President of the Republic, with the support of the other military branches. The military junta held the executive role until 17 December 1974, after which it remained strictly as a legislative body, when the executive powers were transferred to Pinochet.

CHAPTER THREE

LEGAL INSTITUTIONALITY IN THE ESTABLISHMENT OF A MARKET MODEL OF HEALTH CARE IN CHILE: 1973–1989

INTRODUCTION

This chapter explores and analyzes health legislation during the development of the neoliberal market approach implemented after the 1973 coup d'état in Chile. The beginning of the military regime marked the beginning of a legal and institutional crisis characteristic of a country in a dictatorship. In 1974, Decree-Law 788 was enacted, specifying that constitutional, legislative and executive powers would be exercised via supreme decrees issued by the Military Junta. In addition to concentrating legislative and executive powers in a single body, constitutional power, which in democracy lies with the citizens, was “legally” eliminated. This decree declared that when supreme decrees were contrary to the existing constitution, the constitution was thereby modified,¹ violating the basic principles of law and granting the Military Junta a constitutional authority that nobody had ever conferred it. This “legalization” of the dictatorship illustrates the rationality of the legal and institutional procedures that made possible the military regime’s transformations of economic, political and social sectors.

The end of the republican regime and democratic rule had come to be seen as the only viable way for the hegemonic bloc to restore the balance of power and create the economic conditions to bring health and welfare into a business model. The economic and social reforms of the socialist Allende government, elected in 1970, were considered to be interfering with the historical

¹ **Decree-Law (DFL) 788** (1974): “a - f” & art. 1,2 7 3. Regulates the exercise of constitutional power.

reproduction of the capitalist model of development and economic growth. A true neoliberal economic revolution was in the making, which, given the long-standing and broad societal consensus on maintaining the welfare state, could only be carried out by dictatorial rule.

The state was thus transformed, focusing its action on ensuring the free exercise of market activities, becoming a product of the market. The liberal state was said to have overstepped its original theoretical and legal frameworks, as it intervened arbitrarily in the economy, breaking the rules of economic freedom.² The idea was to revive or adapt the liberal economic theses of economists like Rustow, Misses and Hayek and modify them to suit the final decades of the 20th century. In Chile, this materialized in the decisive influence of the “Chicago boys” based in the University of Chicago, and particularly that of Milton Friedman and Harold Harberger.

The neoliberal Chicago School was opposed to governmental intervention, rejecting market regulations and Keynesianism and adopting monetarism, except for interventions to save the market and the banks (like in the Chilean financial crisis in the 1980s,³ which put the new economic model in jeopardy). The influence of this neoliberal school within the Chilean government and the particular role played by the “Chicago boys”, as well as the policies of the International Monetary Fund and the World Bank, were decisive in bringing about

² Pablo Dávalos, “*Neoliberalismo político y Estado social de derecho*”, <http://www.puce.edu.ec/documentos/NeoliberalismoyEstadosocialdederecho.pdf> at 5

³ The crisis in Chile that began in 1981 and lasted until 1986 saw inflation rise to almost 30% and caused a currency devaluation of 40%, which created a serious debt problem, exacerbated by a significant drop in the price of copper, the principal source of foreign exchange.

this shift in the economic model. The new model imposed a new logic, and social consciousness around health issues became defused, making health concerns an individual problem and stimulating the atomization of society and the promotion of health care as business.

On August 26, 1976, the US magazine *The Nation* published a long article by Orlando Letelier, Allende's minister of defence and then ambassador to the United States, in which he presented his theory that the application of the new neoliberal model is only possible under a dictatorship: "The economic plan now being carried out in Chile realizes an historic aspiration of a group of Chilean economists, most of them trained at Chicago University by Milton Friedman and Arnold Harberger. Deeply involved in the preparation of the coup, the Chicago boys, as they are known in Chile, convinced the generals that they were prepared to supplement the brutality, which the military possessed, with the intellectual assets it lacked"⁴ & ⁵. One month later, Letelier and his American secretary were assassinated in Washington by the Chilean secret police (DINA) when their car was blown up.⁶

To sum up, the process of lawmaking in the absence of democratic institutions resulted in the forceful rupture of the welfare state, which would not

⁴ Orlando Letelier, "The Chicago Boys in Chile: Economic Freedom's Awful Toll," *The Nation*, August 28, 1976.

⁵ The US Senate Select Committee on Intelligence has disclosed that CIA collaborators helped plan the economic measures that Chile's junta enacted immediately after seizing power ("A Draconian Cure for Chile's Economic Ills", *Business Week*, January 12). Id.

⁶ <http://www.washingtonpost.com/wp-srv/zforum/globalfocus/pinochet112598.htm>. After the return of democracy, in 1989, the chief of the secret police was sentenced to life in prison for this and several other crimes.

have been possible under other circumstances. This is why it is important and essential to analyze the context in which it was possible to “legislate”, by force, the profound transformation of the health system, enacting legislation that did not have to go through the legal and institutional process.

This chapter analyzes the principles, doctrine, legislation and regulations that permitted and promoted the establishment of a market model for health care. The doctrinaire principles behind the model were that health care was a service to be acquired individually and that people had a personal responsibility in this process. This approach went in exactly the opposite direction from the public, solidarity-based system that Chile had been building for decades. The health system could not remain invulnerable to changes in its broader political landscape. Health policies were adapted to the new political and economic reality and formed a part of this new process of economic liberalization. The development of the new health model and its policies had a clear and coherent rationality, based on a) the partial withdrawal of the state from the health sector; b) the creation of a market for private health care; and c) the growth of the structure and autonomy of the private health sector.

To meet the objectives of restructuring the public sector and developing the private sector, the regime restructured public services to play a subsidiary role. This meant that only those activities that could not be exercised by the private sector or those in which the action of the state was justified as a

“substitute” for the private sector should be left in the hands of the public sector.⁷ Economic freedom was seen as a guarantee of “real freedom”, while the military regime was simultaneously promoting a non-liberal but authoritarian state that suppressed political freedom. Liberalizing the market and giving the state a subsidiary role in socio-economic affairs and an authoritarian role in the political sphere modified the traditional role of the Chilean state. State involvement increased significantly in the political sphere in domestic affairs, defense, culture, communication, education and social organization, but was limited in the economic and social spheres.

With respect to creating a market for the private sector in health care, legislation was introduced to privatize curative services and develop mechanisms for the population to allocate a portion of their wages to private health insurance. This increased the amount of circulating capital that could be capitalized by the private sector in the business of curative health. Finally, with respect to the growth of the structure and autonomy of the private health sector, legal provisions allowed the restructuring of public curative services by municipalizing and decentralizing them and transferring them to private corporations. The legislation also privatized complementary services in public institutions and incentives for private clinics.

⁷ Ministry of Health, *Political Economy, financing Health*, (Chile, 1979) at 8.

1. THE PRINCIPLES, OBJECTIVES AND LEGAL CHANGES FOR A MARKET MODEL OF HEALTH CARE

There are eleven legal and theoretical documents produced by the military regime that can serve as a reference for an understanding and analysis of the principles, doctrine and reforms brought forward in the field of health between 1973 and 1989. The first four documents outline the general ideological framework and political principles that influenced the different spheres of life after 1973.

They are:

- “Declaration of Principles of the Government of Chile” (March 1974)⁸
- “National Objective of the Government of Chile” (December 1975)⁹
- “The Constitutional Acts” (September 1976)¹⁰
- “Constitution of Chile” (March 1981)¹¹

The other seven documents guided development strategies as well as health policy and regulations:

- “Presidential Guidelines for the Ministry of Health” (December 1972)¹²
- “Directive from the President of the Republic to the Minister of Health” (November 1975)¹³

⁸ “Declaración de Principios del Gobierno de Chile” (March 1974).

⁹ “Objetivo Nacional del Gobierno de Chile” (December 1975).

¹⁰ “**Actas Constitucionales**” (**September 1976**) / In particular: **Decree-Law 1,319 Constitutional Act No. 1** created the state Council as the supreme advisory body to the President on matters of Government and Civil Administration. It was composed of former Presidents of the Republic, in its own right, and by other individuals, appointed by the President. **Decree-Law 1,551, Constitutional Act No. 2** expressed the essentials of Chilean Institutions. It affirmed that the Chilean state was a unitary entity, and that the country was divided into regions with a decentralized territorial administrative apparatus.

¹¹ **Constitución de Chile** (March 1981).

¹² Orientación Presidencial para el Ministerio de la Salud (December 1972).

- “Complementary Orientations from the President of the Republic to the Minister of Health” (December 1976 and July 1979)
- “Decree-Law 1,552 Constitutional Act No. 3 (September 1976)¹⁴
- “Health Policy” (January 1977)¹⁵
- “Health Restructuring” (February 1979)¹⁶
- “Political Economy and Financing of Health” (October, 1979)¹⁷

The official discourses articulated by those with authority to implement health policies during the military regime recognized the definition of “health” put forward by the World Health Organization, which stated that, “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”¹⁸ At the same time, the conceptual consideration on which

¹³ Directiva del Presidente de la República al Ministro de la Salud (November 1975).

¹⁴ This Constitutional Act guaranteed all people a long series of rights. The most relevant rights pertaining to the health of people were:

- The Right to Life and personal integrity.
- Equality before the Law.
- The Right to personal freedom and individual security.
- The Law respected and protected the privacy and honor of the individual, and his family. It guaranteed the inviolability of domestic and private communication.
- The Right to Education. Parents have the primary right to educate their children, and the ability to choose the educational establishment. Basic education was compulsory.
- The Right to Live in an environment free of contamination.
- The Right to Health was guaranteed. The state assumed responsibility for ensuring free and equal access to promotion, protection, and restoration of health and rehabilitation of the individual.
- The freedom to work was protected by this Act.
- The Right to Social Security was ensured so that the state could formulate national policy on Social Security, control the system’s operation and ensure the preferential right of members to make their choices.

¹⁵ “The President of the Republic’s additional guidelines to the Health Minister” (December 1976 and July 1979).

¹⁶ “Health Restructuring” (February 1979).

¹⁷ “Political Economy and Financing of Health” (October 1979).

¹⁸ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference (New York, 19-22 June 1946); signed on 22 July 1946 by the representatives

the regime based its health policy was that illness was not the result of the action of a specific agent, but rather the convergence of innumerable elements in a complex ecological context. The military government thus proposed quite a global and interdisciplinary conception of health, which made it possible to imagine a progressive and modern vision for further reforms.

The fundamental principles that were to govern its health policy were, in summary, the following:

- Health is defined as the overall physical and psychological state of welfare of the people and of society, and not merely as the simple absence of illness.
- Health as such is a value that human beings require for their own personal fulfillment, and it is both an element of and a means for societal development.
- Health is a national heritage and, consequently, an irrefutable responsibility of the state.
- Health is a human right as established in the political constitution.
- The right to health is acquired from the moment of conception and must be guaranteed throughout life, independently of social status, age, religion or sex.
- The right to health is exercised through free and egalitarian access to the services provided to this effect.
- Health acts are defined as the activities of promotion, protection, healing and rehabilitation, which must be integrated, coordinated and provided in a timely, continuous, effective and manner.
- All citizens must contribute financially to the system based on income.

of 61 states and entered into force on 7 April 1948 (2 *Official Records of the World Health Organization* 100).

- Public, private and mixed sectors take part in health activities in a coordinated fashion.
- The people must be free to choose which sector will provide them with the medical care they need.

Health objectives focused on four elements: a) accessibility to services; b) social security; c) restructuring of the public sector and d) new incentives for the private sector. With respect to access to services, official governmental declarations underlined the need to extend the coverage of public services, with the aim of guaranteeing free and equal access to health services with a better and more efficient organization of resources. As for social security, the plan was to separate health services from social security benefits in such a way that would determine the type of curative services needed. Such services depended solely on the principle of necessity. It was only after this was guaranteed that the financial capacity to pay for health care was to be considered.¹⁹ Nevertheless, as we shall see below, it was not demonstrated in practice that the changes imposed by the military government privileged the needs of the people over their capacity to pay. A document issued by the Ministry of Health on health care funding declared “that the state assumed a subsidiary role, executing health acts through specialized institutions only when the person had no access, through any other means, to public, private or mixed health.”²⁰

¹⁹Alejandro Medina-Lois, “Estrategias de Salud en Chile hasta el año 2000”, (1980) *18 Seguridad Nacional* at 53.

²⁰ Ministry of Health, Political Economy, financing Health, *supra* note 7 at 7.

With respect to health policy, confining the state to a subsidiary role meant contradicting the regime's own statement about the fundamental role of the state in ensuring the health of the whole population and not only in a subsidiary fashion, while it also failed to guarantee free and equal access to medical and health care services. In parallel with this restructuring, the regime gave the state a role that could be qualified as "negative intervention" (no intervention). In other words, it meant to limit its own capacity and jurisdiction as well as to stimulate the private sector. Thus, although the military regime's declaration of principles and its health doctrine reflected a wide-ranging and commendable vision of what health policy should be, in practice it became clear that the implementation of reforms contradicted those same principles they were supposed to sustain.

In response to constant criticism and accusations that the military regime was compromising basic and fundamental health principles, the government and supporters of the market model of health care fiercely denied that the policy was to privatize health care. Authorities argued instead that the purpose was to guarantee freedom of access to curative services and to promote efficiency. It was obviously difficult to understand this contradictory discourse, which masked the hidden agenda that was progressively transforming the health sector, reducing the role of the state and promoting a neoliberal conception of health more related to the principles of freedom of choice than to those of satisfying the needs of individuals. In effect, the regime considered that "access to medical acts

had to be the result of a free decision on the part of the person, freedom that included choosing where and by whom the service was to be provided.”²¹

Within the broader context of the political and economic changes introduced by the military regime, the health care system clearly could not remain unaffected. It was necessary to adapt the health sector to the new conditions to include it in this process of capitalist liberalization. To achieve this integration, the regime moved to expand the market, stimulate the operational capacity of the private sector, dictate decrees and laws and legislate in favour of a rapid privatization process and the diminishing of the public sector, as will be discussed in the next sections of this chapter. These changes occurred in different phases. The last of these phases, as we shall see, was characterized by the resolution of conflicts of interest and different approaches within the regime, the neutralization of lobby groups and, finally, the fulfillment of several final prerequisites for the implementation of health reforms.

We must look to the history of Chilean society and its profound inequalities to understand why the majority of the population was unable to exercise this “freedom option”. The government initially believed that the real freedom of individuals would be guaranteed by the subsidiary role of the state, as individual and personal relations with curative services would be strengthened. To privatize social security and to alter the responsibility of the state in the services sector meant to transform “social concern” into an “individual concern”. This change

²¹ Sergio Molina, “La nueva política económica”, (1974) 266 *Mensaje* at 7.

was also politically interesting given the traditional strength of the health sector as a force of organization and popular cohesion.

It is, in effect, with respect to health issues that people may develop a “social consciousness” about the problems that afflict individuals. This consciousness allows them to share similar claims and channel forms of social struggle. Castells²² defines these processes of politicization as a “socialization of claims” where collective consciousness focuses on collective action. In contrast, the neutralization of claims and the atomization of society stem precisely from the individualization of interests, when health issues become individual problems and not social concerns. This particular scenario also echoed the global health care crisis, characterized by fiscal limitations to expanding socialized medicine and the barriers to accessing care in increasingly expensive health care scenarios. In the face of the increasing cost of care and the significant financial impacts of chronic diseases that accompany an aging population, the high demand for pharmaceuticals and more demanding specialized technology, reforms and potential solutions focused mainly on organizational and financial measures to contain costs, improve efficiency and transfer the responsibility to patients. The crisis of modern, specialized medicine, accelerated by demographic and epidemiological transitions, was also revealing how the patient was becoming the

²² David B. Clarke, *Consumer Society and the Post-modern City*, (New York, Routledge, 2003) at 102 and Manuel Castells, “Análisis marxista de la crisis del capitalismo”, in Hugo Mercer & José C. Escudero, *Políticas de Salud en los Estados capitalistas de excepción: Argentina, Chile y Uruguay*, (UAM-Xochimilco, México, Editorial Mimeo, 1979).

target to blame in the health-illness process²³ and the source of revenue in the health care business.

Doctors did not reach a full consensus on the health policies being implemented by the military regime. Some tried to de-dramatize the discourse, suggesting that health care could not be considered part of a social market economy since no goods were at stake. Others argued that to apply some elements of the market economy to the health sector was neither mercantilism nor merely a way of making profit, but rather a strategy for maximizing efficiency through honest and healthy competition.²⁴ But the ideologues of Chile's long tradition of public health and state responsibility argued that most technical needs and their alternatives are better solved through public services. This was even the model applied by the Armed Forces for their own medical care services, and it seemed inconsistent to replace their efficient public service with cooperatives offering private services.²⁵

As we shall see, the military regime finally established a new legal framework that redefined the public system, creating open competition between medical establishments. According to promoters of the model, this new "healthy and effective competition in health care services" was a correction to the state's ineffectiveness as a provider of medical services and a solution for the "financial

²³ Robert Crawford, "You are dangerous to your health: the ideology and politics of victim blaming", (1977) 7 *International Journal of Health Services* at 663.

²⁴ Interview to Osvaldo Artaza, (1974) 2037 *Revista Ercilla* at 11.

²⁵ Ernesto Medina-Lois, "La Salud: necesidad social del mundo actual", (1975) 103 *Revista Médica de Chile* at 461.

anarchy” of distributing resources and establishing costs.²⁶ They reiterated that the reform process not only imposed regulations on the public sector to improve its effectiveness, but also brought renewed economic dynamism to the management of curative services, which would result in “increased income for health professionals”, “more new sources of employment”, “a new boost to the investment-deprived sector” and “reduced health costs.”²⁷

Behind these notions, there was a metamorphological vision of the meaning of freedom, in that it did not constitute an end per se, but rather a mechanism for achieving efficiency and a discourse for promoting the privatization of services. In addition, the hypothetical increase in users’ abilities to pay was not related to improved performance or to the extension of services, but rather to the economic need to create a market for the private sector. These changes in the dismantling of the public sector were a logical outcome of the excessively flexible new health care model, which was necessarily in tune with the economic model being imposed by the military government.

However, despite the government’s principles and objectives, transformations in the health sector were not easy to implement and did not take place as quickly as expected. Although supporters of the model continued to try to implement a broad, market-driven approach, others within the same military regime were more cautious and preferred to keep the state as the principal actor

²⁶ El Mercurio, Editorials 2, 6, 10 & 22 May, 1981.

²⁷ El Mercurio, Editorials 8 & 29 May, 1981.

responsible for the health sector. The internal dissent and conflicts between health professionals slowed down the Ministry's action plans and brought modifications to the proposed health model. The public sector had historically been considered to play a fundamental role in health care, with a role too critically important to be suddenly modified. Thus, the government was forced to continuously defend itself from its critics, indicating that it did not want to implement "either a cold market model or a state model". Its polemical pragmatic discourse favoured a combination of market policies and policies based on the responsibility of the state. The regime labelled it a "social market economy", probably following the liberal German model. The idea was that the private sector and the market would invigorate social development, while the subsidiary role of the state would protect fundamental social interests.

Social policy reforms were outlined in a document called "El ladrillo",²⁸ which outlined seven modernization principles as a general guide for action. These included decentralization as well as reforms in agriculture, education, health care, labour, social security and the judicial system. However, major changes did not occur until 1979, mainly because of resistance by the physicians' lobby, as well as the Air Force, which had control over social policy and was not fully in favour of the market-oriented reforms. The doctors' professional association, the Medical College, approved of the decentralization process but rejected the municipalization plan to download health care

²⁸ "El Ladrillo" (the brick), became the economic policy blueprint for the military Junta. It was published only in 1992, after the reestablishment of democracy in Chile.

responsibilities to the municipalities on the basis that it was being imposed from above without consulting the principal actors.

To move the reform process forward, General Pinochet dismissed Air Force Commander General Leigh along with another 18 Air Force generals using a provision of a decree that allowed the military junta to remove a member “not able to fulfill his duty”. In this way, Pinochet consolidated his power and brought the technocratic “Chicago Boys” into the government. Later, in February 1981, the military regime lifted another main obstacle to lobbies with Decree-Law 3,621²⁹, which transformed professional associations into corporate associations³⁰ and eliminated mandatory affiliation. Physicians, like other professionals, were excluded from all policy development, breaking with the traditional system of professional participation in policy formation in place since the late 1940s.³¹

The health care reforms introduced by the military regime after 1981 created a dual public and private system, in which the private sector received considerable support and stimulation. The public component was composed of

²⁹ **Decree-Law 3,621 (1981) regulated the professional associations into corporate associations.** These corporate associations were regulated by Decree-Law 2,757 (1979). The professional colleges became union associations and were subject to the norms dictated in Decree-Law 2,757 (1979), which sought to eliminate monopoly systems and did away with the obligation to belong to a professional college in order to exercise a profession or trade. The professional colleges’ power to resolve conflicts was abolished by decree, and the courts became the only bodies authorized to enforce the sanctions contemplated in the respective College’s Organic Law and to penalize any breaches of professional ethics.

³⁰ Asociaciones gremiales.

³¹ Rosanna Castiglioni, “The politics of Retrenchment: The Quandaries of Social Protection Under Military Rule in Chile, 1973-1990”, (2001) 43 *Latin American Politics and Society* at 55.

the National Health Fund (FONASA),³² the National Health Services System (SNSS)³³ and local municipal services, mainly for primary health care. The Armed Forces and the Police³⁴ continued to have their own health care institutions. The private component consisted of private health insurance institutions (ISAPRES),³⁵ funded by salary deductions and private contributions as well as co-payments by affiliates. The ISAPRES were legally established with Decree-Laws No. 3 (1981) and No. 3,626.³⁶ They were created as a financial mechanism to draw private capital into the health sector and represented an alternative to the FONASA (National Health Fund), administering at first 4% of workers' salaries, and later up to 7%.

As indicated above, several of the health principles and objectives seemed to be aimed at bringing progress to the health sector, yet in practice, this was far from the case. The health field and the country underwent an ideological rupture in sharp contrast to the incremental reforms and changes that had contributed to the building of a welfare state in Chile. The re-conceptualization of the notions of freedom, need and common good and the introduction of "social

³² Fondo Nacional de Salud, FONASA.

³³ Sistema Nacional de Servicios de Salud, SNSS.

³⁴ Carabineros.

³⁵ Institutos de Salud Previsional, ISAPRES, created by **Law 18,933 (1990)** which also derogated DFL no 3 (1981)

³⁶ **Decree-Law 3,626 (1981) introduced amendments to Decree-Law 3,500 (1980) and Decree-Law 824 (1974).** In particular, there were amendments related to employers' and independent workers' contributions to the AFPs, contributions not made in a timely manner and the auditing role of Labour Inspection and the AFP Superintendence. It established procedures for calculating the capital in contracts between the AFP and its affiliates, and it regulated contractual disengagement, instances of the death of a worker and the sanctions brought against the AFPs for infringement of the law.

market economy” principles resulted in an overall dominance of the “market” over the “social”. An analysis of the economic rationality of this model will allow us to better understand these policies.

2. THE POLITICAL, ECONOMIC AND LEGAL RATIONALITY OF THE MARKET MODEL

*Health is one of the most difficult cases to insert into the social market economy as planned by government, but it will not be able to escape.*³⁷

*Free initiative and competition will offer better services to users...*³⁸

*Decentralization, freedom of choice and the actual development of private initiatives... reflect the true aspiration of the Chilean people...*³⁹

The development of the new health model and its policies had a clear and coherent rationality, based on a) the partial withdrawal of the state from the health sector; b) the creation of a market for private health care; and c) the stimulation of the autonomy of a vigorous private health care system. Within this same rationale, however, there were disputes and contradictions between different perspectives and ideological approaches. In particular, the militarists, mostly from the Armed Forces, concerned with internal security; the right wing “*gremialistas*”, mainly old student leaders from the Catholic University with traditional values; and finally the neoliberal “Chicago Boys” trained in the neoliberal Department of Economics at the University of Chicago.

³⁷ Francisco Herrera Latoja, Health Minister, in *El Mercurio*, 13 October 1974.

³⁸ Dr. Arriagada, Director of the S.N.S., in *El Mercurio*, 8 November 1973.

³⁹ *El Mercurio*, 12 November 1973 at 25.

A. Partial withdrawal of the state from the health sector

According to Milton Friedman—ideologist of the Chicago school of economic thought and source of inspiration for the Chilean neoliberal model—there were only two ways to coordinate the economic activity of the state. The first was centralization, which required coercion, and the second was the free market, which could be achieved with voluntary cooperation.⁴⁰ Friedman maintained that *authoritarian decisions* can only come from an entity with the power to dictate them; that is, the state. In other words, power resided in those who control the state. Contrary to expectations, the larger the field for authoritarian decisions, the higher the risk of losing control of power. Thus, Friedman’s neoliberal reasoning was also that state intervention in social life did not improve the social welfare of the population at large. Economic freedom in an authoritarian political system and a liberal market economy with the state as subsidiary modified the traditional role of the Chilean welfare state. Interventionism increased significantly in the political sphere in domestic affairs, defence, culture, communication, education and social organization, while the state presence was limited in the economic and social spheres.

⁴⁰ Milton Friedman, *Capitalism and Freedom*, (Chicago, The University of Chicago Press, 1962) at 13.

This conception of the role of the state, while consistent with the goal of a capitalist reorganization of the economy, did not respond to the needs of those who depended upon state support—the vast majority of the population.

Despite all this, the military regime was, although not without difficulty, headed towards the dismantling of this system and the withdrawal of the state from the health sector. The arguments invoked to carry this out were linked to criticisms that the public sector was excessively centralized, with an inefficient and exaggerated bureaucracy and a disorganized planning structure. The military regime focused its initial actions on denouncing the problems caused historically by strong state intervention in health matters. In addition to this discourse, the regime made clear its perception of the particular shortcomings that were preventing a satisfactory distribution of health services among different groups of the population, such as bureaucracy, lack of initiative, low levels of innovation, lack of accountability, etc.⁴¹

Although these criticisms of the shortcomings of the public health system were valid, the level of social and economic development of the country precluded the possibility that free, open and business-like market laws would be able to care for the well-being of the population. The debate about the advantages of a liberalized health system compared to those of preserving the social responsibilities of the state may have been relevant in a society where

⁴¹ It is interesting to note the ongoing claims by the media to damage the image of the public health sector—their reporting on the ill treatment, unjustified waiting time, inadequate care, intra-hospital infections, poor emergency services, etc.

resources were abundant and where the population had real options for exercising their freedom of choice. In a country like Chile, though, this debate was irrelevant, as for the vast majority of the population, the satisfaction of health needs was only possible through the public sector, including the middle class. This situation was even more critical in the area of preventive medicine.

The most acute cases were found in the rural sector and among the self-employed. Waged workers were much better protected than the self-employed, as they had free access to public health care. Such access, however, was available to less than 25% of the population, and more than half of the population was not having its health care needs met.⁴² A shrinking state presence in the area of health services even further aggravated this situation.

The decline in public health expenditures by the military government was reflected in reduced capital investment in public health personnel such as decreased wages, less spending on training, fewer hirings, etc. While in 1969, capital investment represented 12.8% of public health expenditures, it amounted to only 2.8% ten years later, in 1979.⁴³ By the early 1970s, there was already great disparity in the distribution of qualified health care workers in the health system. The later cuts to financial and human resources in the public sector made it even harder for the population to access medical and health care. In addition, the stimulus provided to the private health care sector further skewed

⁴² Cortázar, "Necesidades básicas y extrema pobreza", (1977) 17 *Estudios CIEPLAN* at 59.

⁴³ Jorge Marshall, Nota Técnica sobre "Gasto Público en Chile, 1969-1979, Metodología y Resultados", (1981) 33 *CIEPLAN*, in Ana María Viveros-Long, "Changes in the Health Financing: The Chilean Experience", (1986) 22 *Social Science & Medicine* at 384.

the already uneven distribution of services and the concentration of medical personnel in large cities and the richer municipalities, where the middle and upper classes resided. According to Ortiz, the number of personnel in the public health care sector dropped from 75,694 to 66,969 employees in 1978 alone, accompanied by a decrease in the real value of wages throughout the entire public sector.⁴⁴

Four basic aspects of the public health care system—policy, service provision, financial management and primary care—were reorganized. Decree-Law 2,763⁴⁵ (August 1979) re-organized the Ministry of Health and created the National Health Service System,⁴⁶ the National Health Fund,⁴⁷ the Public Health Institute of Chile⁴⁸ and the Central Supply Centre of the National Health

⁴⁴ Francisco Ortiz, “El sector salud y sus recursos financieros: Análisis de la Década” in Hugo Lavados Montes (ed.), *Desarrollo Social y Salud en Chile*, (Santiago, Corporación de Promoción Universitaria, 1981) in Viveros-Long, *Id.* at 394.

⁴⁵ **Decree Law 2,763 (1979). Regulations for the Ministry of Health, National Health Service System, National Health Fund, Public Health Institute of Chile and Central Supply Centre of the National Health Service.** In addition, it established the foundations for a deregionalized National Health Care System. It established a Ministerial Health Secretariat for each of the country’s regions and created Health Services authorized to delegate tasks to the universities, unions, employers’ associations and other bodies with technical capacities for the activities assigned to the Health Services. The funding would come from the National Health Fund, which was the legal successor to SERMENA and the SNS.

⁴⁶ Each Service was under the charge of a director, responsible for the supervision, coordination, and control of the facilities and services of the system.

⁴⁷ The National Health Fund was a functionally de-centralized public service, with a legal capacity and financial resources of its own. Legally, it was a continuation of the National Health Service for Employees and the National Health Service, for the purpose of carrying out administrative and financial actions.

⁴⁸ The Public Health Institute of Chile was created as a functionally de-centralized public service, also with a legal capacity and financial resources of its own. It contributed to the national laboratory, and was a referential source for the fields of Microbiology, Immunology, Pharmacology, Clinical Laboratory, Environmental Pollution and Occupational Health. It was the legal continuation of the National Health Service with respect to its relation with the Bacteriological Institute of Chile and the National Institute of Occupational Health.

Service.⁴⁹ According to Decree-Law 2,763, health service agencies were functionally de-centralized, with independent legal capacities and their own resources for fulfilling their duties. They were charged with the implementation of integrated development, protection and restoration of health and the rehabilitation of sick people. Policy-making power was transferred from the SNS back to the Ministry of Health, and the executive power to implement curative and preventive services was decentralized in the new National Health Services System. Thirteen regions and twenty-seven semi-autonomous local health systems were created across the country, which finally became the legal successors to the National Health Service and the National Health Service for Employees (SERMENA). The health service agencies, the National Health Fund, the National Council for Food and Nutrition, the Public Health Institute of Chile, the Central Supply and the National Health Service were also brought under the ambit of the Ministry of Health.⁵⁰

This was a major change from the historically centralized structure of the SNS. Furthermore, financial management was unified in a single agency, the

⁴⁹ The Supply Center of the National Health Service came into being as a functionally de-centralized public service, again, with a legal capacity and financial resources of its own. It provided the medicines, instruments and other supplies that may be required by the agencies, organizations, institutions and persons affiliated to the Health System, for the implementation of incentive measures, protection or restoration of health, and the rehabilitation of sick people. The Supply Central was the legal successor of the National Health Service.

⁵⁰ The Ministry of Health was responsible for formulating and implementing the health policies. It had to perform the following functions: direct and guide all government activities relating to the health system; lay out the internal technical, administrative and financial regulations to be followed by the agencies, and institutions of the health system; and supervise, monitor and evaluate the implementation of policies and health plans.

FONASA,⁵¹ and the regime began transferring primary care responsibilities to the municipalities. However, because of the severe economic crisis that followed the “second oil shock” in 1979, by 1982 only 20% of the centres had been transferred and the process was not complete until 1987.⁵² The partial withdrawal of the state from curative services and the limitations suffered by the public sector in general constituted a loss of decades of progress and experience.

What would happen to this vast sector of the population as a result of privatizations? As the great majority of the population used the public sector, the new policies needed to determine how to satisfy this demand in a shrinking public sector with declining resources. The response lay precisely in the other axes of the market model; namely, the formation of a market for the private sector and the growth of the structure and autonomy of the private health sector, which I analyze below.

B. The creation of a market for the private sector

Social policy was guided by market-oriented principles, including the reduction of state intervention, the strengthening of the private sector, the adoption of free-market and stabilization policies and the privatization of public corporations and state companies and industries. Social policy had to be

⁵¹ Viveros-Long, “Changes in the Health Financing”, *supra* note 43 at 382.

⁵² Castiglioni, “The politics of Retrenchment”, *supra* note 31 at 41.

consistent with economic rationality.⁵³ Promoting private medicine and making it profitable necessarily implied extending its market potential by increasing the consumption of private medical services. The disbursement of financial resources was redirected from subsidizing the supply of health care services to subsidizing the demand for such services. The previous system of direct budget allocations distributed by the SNS was replaced with production criteria.⁵⁴ Thus, the direct allocation of public funds to health care institutions via an annual budget was reduced in order to increase the allocation of funds as reimbursement for actual services rendered, creating competition between institutions. Until the sanction of Law 2,575 in 1979, only 16% of the budget was allocated according to production criteria and 63.7% by direct budget allocation, with another 20% coming from direct income and donations.⁵⁵ Decree-Law 2,575⁵⁶ (1979) extended the benefits of Law 16,781 to the beneficiaries of the National Health Service.

This policy of subsidizing demand even further weakened the capacity and the image of the entire public sector and stimulated the growth and legitimization of the private sector. Need-based access to services was replaced with access

⁵³ Castiglioni, "The politics of Retrenchment", *supra* note 31 at 55.

⁵⁴ Viveros-Long, "Changes in the Health Financing", *supra* note 43 at 382.

⁵⁵ Ricardo Bize, "Asignación de Recursos Financieros a las regiones de Salud y Sistema de Costos Hospitalarios", in Lavados, Desarrollo Social y Salud en Chile, *supra* note 41 at 382.

⁵⁶ **Decree-Law 2,575 extended the medical and dental benefits of Law 16,781 (1968) to the beneficiaries of the National Health Service.** The legal beneficiaries of the National Health Service were eligible for the health care system under Law 16,781, without prejudice to the care that they were entitled to of that service in accordance with Law 10,383 and its amendments. The National Health Service had to pay the amount equal to the percentage paid by the Medical Assistance Fund, as established by Law 16,781. Any difference between the amount funded by the National Health Service and the total value of the benefit was charged to the beneficiary.

based on an individual's capacity to pay prices that depended on real demand as determined in a market economy,⁵⁷ in which health care was just another commodity. The "demand" for health care was not actually the result of an individual's decision to use medical services based on his or her medical needs; rather, it was the result of several other factors, such as the capacity to pay and the accessibility of services.⁵⁸ Additional factors taken into consideration by patients included the subsequent cost of follow-up treatments and drugs⁵⁹ as well as the loss of income during recovery. Given these constraints, which were not insignificant, increasing the capacity of patients and users to pay became one of the financial challenges of the new liberal health care model. This situation was further exacerbated when the principles of cooperation and coordination between different services and institutions were replaced with inter-institutional competition. There was also a tendency to reorganize the availability of services to target the most profitable types of medical specializations.

Since the only way to guarantee the freedom of choice for health services

⁵⁷ Alfredo Bravo, "Principios básicos para la organización de un sistema de servicios de salud: el caso chileno" in Lavados, *Desarrollo Social y Salud en Chile*, *supra* note 44 at 394.

⁵⁸ Emanuel de Kadt, "Las desigualdades en el campo de la salud" in Livingstone & Raczynski (eds.), *Salud Pública y Bienestar Social*, (Santiago, CIEPLAN, 1976) at 31-32.

⁵⁹ In developed countries, drug expenses represented between 9% and 10% of the budget destined for health services. These figures more than doubled in underdeveloped countries. These numbers were even more eloquent in Chile, as it was reported that pharmaceutical expenses comprised of almost a third of all expenses recorded in the health sector. Ernesto Medina & Ana María, Kaempfer, "Análisis crítico de la metodología de planificación de salud", (1968) *Revista Médica de Chile* 455. The concentration of the pharmaceutical industry in Chile demonstrated that in 1977, out of 57 active companies, 24 were foreign and the 5 largest of these already controlled 32% of the market. The leading 25 companies controlled 80.5% of the total market and 18 were foreign multinationals. Also, since foreign pharmaceutical companies hold patents rights the possibility of transfer of technologies was very limited. At the same time, this allowed artificially high pricing, sales linked to the purchase of other products and finally restrictions in domestic exportation. See Constantine Vaitos in Meredith Turshen, "An analysis of the medical supply industries", (1976) 6 *International Journal of Health Services* at 275.

was to extend users' capacity to pay, the government established mechanisms that would permit users to exercise this freedom, including subsidizing the demand for services and privatizing social security. The goal was to facilitate the transfer of savings to private insurance institutions, thus increasing the users' capacity to choose services and simultaneously stimulating the private practice of medicine and the development of private clinics and, eventually, hospitals. The new market approach to resource allocation was clearly reflected in the type, efficiency and variety of services offered, which now had to incorporate time as a variable to maximize profit. Furthermore, artificial demand was created with the introduction of more screening appointments, excess consumption of non-essential medical services and the promotion of greater drug use, all part of, as described by the regime, a sophisticated approach to medical care.

The creation of this private sector would supposedly guarantee freedom of choice. The ISAPRES could contract out their health care services or run their own health care institutions.⁶⁰ The purpose was to provide the people with a free choice as to whether to make their mandatory contributions into either the public fund or the private sector. Each ISAPRE had several predetermined health plans that affiliates could choose from according to their health care needs, the benefits offered and the monthly premiums. Both parties signed the contract, but the ISAPRE had the right to reject the affiliate or to deny the renewal of the contract,

⁶⁰ Carmelo Mesa-Lago, "Social protection in Chile: Reforms to improve equity", (2008) 147 *International Labour Review* at 379.

allowing clients to be selected according to the level of risk they presented.⁶¹ While the FONASA and the former SERMENA covered up to 85% of the population, the private ISAPRES started with a modest 2% coverage, but climbed to 26% before later falling to 16% of the population. Coverage by the FONASA decreased to 59% of the population as ISAPRE coverage increased. By 2006, FONASA had recovered to about 70% of the population.^{62,63}

The military government increased the share of the health care on individuals and eliminated the employer contribution. The mandatory contribution started at 4% of taxable income, which was raised to 6% in 1983 and then to 7% in 1986. The same year a reform introduced co-payments to the public sector. In 1985, Law 18,469⁶⁴ created the General Benefits Regime,⁶⁵ which defined the rights and responsibilities of citizens in the public sector and established the grounds for the relationship between the ISAPRES and the public sector (FONASA and SNSS).⁶⁶ This law governed the exercise of constitutional rights to health protection and created a regime of health benefits. The constitutional right to health protection included the free and equal access to the promotion,

⁶¹ Annick Manuel, "The Chilean Health System: 20 years of Reforms", (2002) 44 *Salud Pública de México* at 65-66.

⁶² Mesa-Lago, "Social protection in Chile", *supra* note 60 at 379.

⁶³ Viveros-Long, "Changes in the Health Financing", *supra* note 40 at 382.

⁶⁴ **Law 18,469 (1985) defined and regulated the constitutional right to health coverage and created a general health benefits regime.** It also established the freedom to choose either the public or private health care system. The Health Services could not deny care to those who requested it nor make care conditional upon the prior payment of fees. Affiliates and dependent and independent workers would become beneficiaries in accordance with certain requirements, and pregnant women, children up to 6 years of age and the indigent would be covered even if they were not beneficiaries or affiliates. The law outlined the types of financial services available for those dependent and independent workers that required them.

⁶⁵ Régimen General de Prestaciones.

⁶⁶ Annick, "The Chilean Health System: 20 years of Reforms", *supra* note 61.

protection and restoration of health, as well as to actions related to the rehabilitation of the individual. It guaranteed the freedom to choose between a private and public health system. The agencies in the National Health Service were responsible for the implementation of these health actions. The Health Benefits Regime's affiliated members included public and private workers, those who received family allowances from dependent workers,⁶⁷ independent workers included in any legal pension plan, volunteers in any legal pension plan and individuals entitled to social security pensions, disability allowance or severance. This law also recognized pregnant women and children up to six years of age. Lastly, all those who lacked resources and received welfare pensions and family subsidies were also beneficiaries of the regime. Incorporation into the regime occurred automatically upon fulfilling any of the criteria listed above. Members had to make contributions to the National Health Fund, which was used to fund the health benefits.⁶⁸ However, the law classified those insured by FONASA according to their income levels. This is why all FONASA affiliates (except for low-income beneficiaries) had to make additional co-payments based on their income,⁶⁹ unlike ISAPRE beneficiaries who could make additional payments according to their subscription plan.

⁶⁷ Dependents of workers listed on any independent legal pension fund system, and complying with the same qualifications and requirements as prescribed by the Law to receive family allowance of a dependent worker, were eligible for benefits under this regime.

⁶⁸ The beneficiaries were entitled to medical examinations, tests, preventive medicine, and curative medical and dental care. In addition, all pregnant women had the right to good medical care, also the right to birth control. Newborns and children up to six years of age had the right to health protection and public health controls. In general, the Law guaranteed the beneficiaries with the right to choose the place for their treatment and the health professional. The Law also ensured cash benefits for non-professional diseases, and maternity leave for working women.

⁶⁹ Castiglioni, "The politics of Retrenchment", *supra* note 31 at 42.

Later, in 1989, Law 18,566⁷⁰ required an additional contribution to the ISAPRES, this time by employers. This tax-deductible contribution was fixed at 2% of the taxable income of each affiliate subscribed to a health plan and was to be paid by the employer, supposedly as a means to allow the middle class to gain access to the private health care sector.⁷¹ However, everybody had the right to opt not to contribute to any ISAPRE and to select instead the public system fund (FONASA), a choice often made by low-income earners in order to obtain access to free health care across the full range of services. Those with higher incomes could also use the public system, but were charged by FONASA for a portion of their hospital costs. Alternatively, they could use the private system and pay the difference between the basic amounts that FONASA covered and the amount being charged for the private service.⁷²

Lastly, Law 18,933,⁷³ passed in March 1990, created the Superintendence of Health, which had a legal capacity and financial resources of its own. Its main function was to supervise and regulate the health institutions (ISAPRES),

⁷⁰ **Law 18,566 (1986) made permanent the transitional article No. 3 of Decree Law-3,501 (1908), which increased salaries and health contributions.** It established pension taxes and determined a pay scale for staff and contract civil servants. It defined the upper limit for additional employer ISAPRE contributions, and it determined that independent affiliated workers had to make (continuous or discontinuous) payments for at least 6 months within the last 12 months in order to have access to the rights offered by the system.

⁷¹ Annick, "The Chilean Health System: 20 years of Reforms", *supra* note 61.

⁷² Colin Gillion & Alejandro Bonilla, "Analysis of a national private pension scheme: the case of Chile", (1992) *131 International Labour Review* at 171.

⁷³ **Law 18,933 replaced Decree-Law 3 (1981). It created the Superintendency of Health Insurance Institutions** for the legal and financial oversight of the ISAPRES and to resolve conflicts with affiliates, notwithstanding legal action. The ISAPRES would provide health services and benefits—at the cost of legally-mandated health contributions or a higher, agreed-upon amount—for those people indicated in article 5 of Law 18,469. It also established the procedures for medical contracts and licenses.

replacing FONASA in this role, and to determine the minimum coverage to be offered by the ISAPRE health plans. The Superintendence was charged with the registration of the ISAPRES and was also responsible for providing general instructions⁷⁴ that would clarify health contracts and agreements.⁷⁵ All the supervision of the legal and financial matters of the ISAPRES came under the purview of the Superintendence of Health. If any disputes arose between the ISAPRES and its affiliates or beneficiaries, it was the Superintendence that could intervene to resolve the crisis. This law also replaced the yearly ISAPRES contracts with life-long contracts, eliminating the possibility that the renewal of the policy would be denied unless the affiliate defaulted on payments. However, the ISAPRES could re-establish the benefits and the cost of the policies on an annual basis, provided that the new conditions applied to the affiliates did not lead to discrimination or involve unacceptably high costs for members.⁷⁶ In 1990, 16% of citizens were beneficiaries of an ISAPRE, climbing to 25% by 1995.

These transformations in the privatization of the health sector cannot be analyzed separately from what was a similar privatization process in the pension and social security sector. From a health perspective, it may seem to be a

⁷⁴ It had to provide guidelines and commands of general application, and issue orders for their implementation.

⁷⁵ People who chose to make their contribution to the ISAPRES had to sign a health contract or agreement, which the institution had to report to the Superintendent, and also the entity responsible for payment of the pension or the employer. In this contract, the parties could freely agree on the granting, the modalities, and conditions of the health services and benefits. The ISAPRES were not allowed to establish exclusive health plans for certain age and the contributions of those affiliated to an institution providing health insurance had to be declared and paid at this institution by the employer, the entity responsible for payment of pensions, or the self-employed.

⁷⁶ Annick, "The Chilean Health System: 20 years of Reforms", *supra* note 61.

different and not necessarily related issue, and this may indeed be the case in the context of a welfare state, but not in the context of the formation of a market for the private sector. The logic of individual contributions to private health insurance was also applied to pensions. A private pension system opened the way for an immense capitalization mechanism for private business. Politically, this approach allowed the transformation of social concerns (including forms of social struggle) into separate, individual problems creating a personal and private pension fund, which contributed to the atomization of society's concerns (Castells'⁷⁷ anti anti-thesis). Thus, the main reforms included opening up the market to the new private health insurance companies (ISAPRES) and privatizing the pension systems (AFP),⁷⁸ which should also be taken into account in this discussion.

In this process of privatizing pensions, the opposition was much more disperse than it was for other policies, because Chile had no national organization capable of lobbying against the transformation of the pension system. Although there was no labour or professional resistance to the social security reforms, some military officers opposed privatization, especially of the Armed Forces fund. The first important regulation was implemented in 1979 with Decree-Law 2,448,⁷⁹ which created a standard minimum retirement age of 65 for

⁷⁷ Clarke, *Consumer Society and the Post-modern City*, *supra* note 22.

⁷⁸ The Administradoras de Fondos de Pensiones (AFP), were created by Decree-Law 3,500 (1980) establishing a private pension system, carried by individual capitalization, obtained through salary deductions.

⁷⁹ **Decree-Law 2,448 (1979) amended the pension criteria.** In all the pension schemes and for

men and 60 for women, eliminating pensions based on the number of years of service. Another social security reform was implemented in November 1980 with Decree-Law 3,500.⁸⁰ This law created a system in which old-age pensions and disability and survivorship benefits were derived from individual savings. The capitalization was carried out through the Pension Fund Administrators (AFP). These private institutions administered the Pension Fund, providing benefits for those covered under this law. The Fund was independent and separate from the other assets of the AFP, which had no rights over the individual pension funds (the principle of separation of assets). On the other hand, all affiliated members of the AFP could transfer the value of their shares to another AFP by giving notice to their employer for the transfer of funds, when applicable (the principle of the personal freedom of pension savings).

Each AFP was authorized to administer only one fund and to collect contributions to be deposited in capital accounts for the purpose of making investments. The AFPs were entitled to remuneration based on a commission for

all legal purposes, all pensions were to be regarded as age-related pensions, excluding only Disability, which prescribed an age requirement, and the Survival pensions. The age criterion for the Disability pensions was sixty-five years for men and sixty for women.

⁸⁰ **Decree-Law 3,500 (1980) regulated old-age pensions and disability and survivorship benefits.** It created a system of old-age, disability and survivors' pensions based on individual capitalization through the AFPs, and corporations would administer the Pension Fund and provide the services. They had to ensure a minimum rate of return for the funds collected. The state guaranteed minimum pensions for those affiliated, adding to the supplementary state contribution if the accrued pension was less than the established minimum pension. All workers who began working had to start to contribute to an AFP, which could not reject membership applications. All workers could deposit an additional amount in their individual capitalization accounts. For independent workers, it was established that affiliation to an AFP would take effect as of the first payment. The fund's resources could be invested in General Treasury of the Republic securities, the Central Bank and letters of credit issued by financial institutions, among other entities. The AFP Superintendency was created to regulate the AFPs and tasked with their oversight and control.

the fees paid by affiliates, which were deducted from their individual accounts. The state guaranteed a minimum old-age pension and disability and survivorship benefits to all members of the health system who fulfilled the criteria mentioned under the law. Without prejudice to the rules for independent workers, employed workers were automatically affiliated and had to choose which AFP they wanted to contribute to in order to build their pension.⁸¹ With this, these workers acquired membership status with a legal relationship between the worker and the pension system, which led to rights and obligations; namely, the right to benefits and the obligation to contribute. Membership was unique, permanent, and persisted throughout the life of the member.

Decree-Law 3,500, which brought an end to the pay-as-you-go system, went through several amendments.⁸² Further revisions were introduced by new

⁸¹ Affiliated men who turned sixty-five years of age, and women who turned sixty years of age, were entitled to Old-Age pension, notwithstanding the possibility of them retiring prematurely, and failing to meet certain requirements. Members who did not fulfill the criteria for eligibility to the Disability Pension could still avail of its benefits on the basis of sickness, intellectual or physical weakness, or if they had lost at least two-thirds of their working capacity. Also, this Law helped create a Survivors' pension for the members of the family. Workers affiliated to the system were required to contribute ten per cent of their wages or taxable income to their individual capitalization account. In addition, workers were required to make an additional contribution, expressed as a percentage of their monthly wages or taxable income, to fund the Disability and Survival pension system. The Administrator fixed the value of this contribution. Apart from this, each worker could make voluntary contributions. Finally, the Law guaranteed that the Administrator could not underperform the average pension fund, regulated by articles 38 to 40 of the Law.

⁸² Most relevant amendments to **Decree-Law 3,500** include:

- During periods of incapacity to work, members must make mandatory contributions (10% of his salary or taxable income), which were withheld owing to the payment of subsidies.
- The monthly rent was paid to the member under Insurance or Annuity withdrawals as per Article 62 (pension age), and that were subject to income taxes levied on pensions, salaries and wages.
- The Pension Fund Administrators (AFP) could not carry any advertising prior to the date that started up to the public.

legislation. Decree-Law 3,501⁸³ established a new Social Security Contribution System, whereby all existing welfare institutions required a legislative provision to establish new benefits or to make transfers of funds that would reassign the affiliates' contributions and their indexation. Decree-Law 3,502⁸⁴ created the Institute of Pension Normalization (INP)⁸⁵ as an autonomous body with a legal capacity and funding of its own. It was linked to the government through the Ministry of Labour and Social Welfare. Its purpose was to study and propose policies and measures to the government that would ensure the timely implementation of pension commitments that the state or the institutions dealing with pensions had incurred prior to the enactment of this law or were going to incur in the future. This law also created the Pension Trust Fund.⁸⁶ Ultimately, the

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- The Administrator must send notifications to the homes of each of its members regarding their individual accounts, indicating the number of registered shares, their value and the date of investment.
 - In case of bankruptcy or dissolution of the Administrator, the obligation to pay fell on the insurance company in which the Administrator was hired, and the Disability Insurance at the time the pensions originated.

⁸³ **Decree-Law 3,501 of 1980 established that a tax be paid by employers on the taxable wages of all workers**, regardless of the pension system which was in effect. The tax rate was 3% until 31st December 1981, 2% until 31st December 1982 and 1% until 31st December 1983. This Law established that as of 30th October 1986, a permanent tax would be charged at the rate of 2%. Later the Law 18,566 declared the former transitory article No 3 of the Decree-Law 3,501, to be permanent.

⁸⁴ **Decree Law 3,502 (1980) created the Pension Normalization Institute (INP)**. Its principal functions included studying and proposing policies and measures to guarantee compliance with the pension commitments that the state or pension institutions had made prior to this law taking effect or would make in the future, in addition to administering the Pension Finance Fund. The Fund had to finance the recognition bonds referred to in Decree-Law 3,500 (1980), the retirement payments that were part of the pension institutions' significant liabilities and the pensions of those opting to remain in the pension institutions affected or that would be affected by Decree-Law 1,263 (1975).

⁸⁵ Instituto de Normalización Previsional.

⁸⁶ Pension Trust Fund, had to fund: a) the credit bonds (Decree-Law 3,500 of 1980); b) the retirement benefits of passive affiliates to pension institutions; and c) the pensions of people who choose to stay in the pension institutions affected by Decree-Law 1,263, of 1975.

Law was fully amended by Decree 3,626⁸⁷ and Decree-Law 101.⁸⁸ This legislation created the new pension model that remains in place today.⁸⁹

These regulations changed the pension system's financial mechanisms, moving from an inclusive system to a system based on individual savings, administered by the AFPs, which are private, profit-oriented funds. This new pension system was not implemented for the Armed Forces and the Police, which continued with the old, not-for-profit system. The AFPs were created to institutionalize a private pension system, with workers contributing 10% of their insured wages, up to an upper limit, to any of the private AFPs on the market. After deducting their commission, the AFPs invest the remaining money on behalf of the workers and collect the proceeds in a separate account for each affiliate. Upon retirement, the accumulated sum can be used to purchase an indexed annuity or to provide a pension. Neither the state nor the employer contribute to the plan, and the worker cannot borrow or draw from the personal pension account until retirement.⁹⁰ The private pension system is regulated by the state and audited by the AFP Superintendency.⁹¹ Regulations are strict in order to protect the workers and to provide transparency in terms of the investment portfolio. There are no restrictions in terms of AFP ownership, and in fact the largest ones are still owned by foreign multinationals. However, the law

⁸⁷ **Decree-Law 3,626 (1981) introduced amendments to Decree-Law 3,500 (1980) and Decree 824 (1974).** See *supra* note 29.

⁸⁸ **Decree-Law 101 (1980) established the statute for the Pension Fund Administrators (AFP).**

⁸⁹ Castiglioni, "The politics of Retrenchment", *supra* note 31 at 40.

⁹⁰ Gillion & Bonilla, "Analysis of a national private pension scheme", *supra* note 72 at 172.

⁹¹ Superintendencia de Administradoras de Fondos de Pensiones.

does impose restrictions on the composition of the portfolio, and the distribution of investments is regulated to avoid speculation and excessive risk. Most of the funds are invested in Central Bank bonds, and the proportion of funds invested in equities is limited. At first, funds were not allowed to be invested overseas, but this restriction was later lifted.⁹² Overall, coverage for health care and pension investments represent between 19.5 and 20.7% of personal earnings.

This economic rationale for the formation of a market for the private sector, when implemented, immediately stood in stark juxtaposition to the noble objective of health for all, reinforcing the two-tier system in which a large proportion of the population with little capacity to pay for private health care services was excluded from a public system that became more and more limited. Not surprisingly, during the implementation of the market model of health, health workers, doctors and even ministry officials began to dispute the characteristics of such a peculiar restructuring of the health system.⁹³ Much criticism was focused on negative externalities, such as the growth of specialization, the concentration of medical professionals in wealthier urban areas, the reinforcement of competition and the reduction of resources. Most importantly,

⁹² Gillion & Bonilla, "Analysis of a national private pension scheme", *supra* note 72 at 177.

⁹³ The NHS should end up being a national embarrassment. A modern country like Chile should not have a public organization that provides very poor services, and one that is largely responsible for the public deficit (Emilio Sanfuentes, *Revista Qué Pasa*, February 1, 1975). "The new system must satisfy at any price the sensitive vast majority of physicians in order to ensure the possibilities of constant professional development. It should also ensure that this new system will be more efficient, cheaper, more human, and will provide medical benefits to the whole population regardless of their income" (...) "The NHS (SNS) is not a national disgrace. Like all institutions in Chile, there are shortcomings, but also virtues". (Doctors Artaza & Salvestrini, leaders of the Medical College, *El Mercurio*, February 26 1975).

critics believed that the majority of the population would eventually have limited access to curative services.

In 1974, in an attempt to minimize or eliminate the negative externalities, the Medical College presented an alternate restructuring program. This program clearly responded to the early concerns and interests of doctors who were worried about the proposed modifications to the health system. The proposal consisted of maintaining and centralizing public planning while decentralizing the public sector's operations. It also aimed to maintain the same level of health spending in the budget, as doctors thought it unlikely that private infrastructure could be established that would be capable of replacing the state infrastructure.⁹⁴

C. The growth of the structure and autonomy of the private health sector

Beginning in 1974, different visions of health care in the country resulted in numerous controversies and conflicts, and two opposing tendencies divided the government and medical sectors. While one vision called for the rapid and drastic privatization of the sector, the other preferred a transition process that would support an important state presence until there were optimal conditions for a transfer to the private sector. In December 1973, the military regime dictated Decree-Law 212, which created the National Commission of Administrative

⁹⁴ El Mercurio, August 5-6 1974 at 2 & La Patria, August 5 1974, at 3.

Reform (CONARA).⁹⁵ Its duty was to study and propose the necessary provisions and legal and administrative regulations for bringing about administrative regionalization in the country. Regionalized services were operationally decentralized, becoming legal entities in their own right, with an independent structure. The CONARA depended directly on the Military Junta. All public services, autonomous or self-governed state enterprises, public legal institutions and public enterprises had to provide reports and information as well as the technical and administrative cooperation requested by the CONARA. The Commission closely supervised the entire country and enforced its presence and action nationwide.⁹⁶

One of the first measures to improve the structure, functioning and autonomy of the private sector was a series of regulations that decentralized and “municipalized” public health services. Even though in theory the decentralization of curative services to the municipalities could have been interpreted as a positive measure to streamline and reduce the bureaucracy of services, in practice this was not the case at either the organizational or the financial level, especially for those municipalities with scarce resources. The municipalization of primary health care facilities had major drawbacks, including a lack of

⁹⁵ Decree-Law 212 (1973). Created the National Commission of Administrative Reform (CONARA). Comisión Nacional de Reforma Administrativa.

⁹⁶ Since the Constitution of 1925, Chilean territory was divided into provinces, which came under the charge of appointed Governors. The Provinces were then divided into municipalities under the charge of elected mayors and council members. Regional Ministerial Secretariats (SEREMI), Planning Secretariats, represented the central government and other departments that coordinated with the different managerial levels, provided supervision, and were in charge of the budgetary control and management of the Regional Development Fund.

coordination with other health care institutions and the Ministry of Health and the deterioration of working conditions and wages, as workers were now covered by the Labour Code as employees of private institutions and no longer as public servants. Furthermore, the fee-for-service method of payment,⁹⁷ which was supposed to cover all of the municipalities' health care costs, did not reflect the real cost of services. As a result, municipalities were under-reimbursed, while expenditures increased and not all prevention services were compensated.⁹⁸

At the national level, this reorganization was critical, as the historic National Health Service (SNS) and the SERMENA were replaced with the National Health Services System (SNSS). The new structure integrated twenty-six regional services, which were each dependent upon their respective Regional Ministerial Secretariat (SEREMI).⁹⁹ The country's new administrative structure was instrumental in the process of decentralizing and privatizing health care services, both directly and indirectly, by transferring the administration of public institutions to private or semi-private jurisdictions. Municipalities became legal entities with independent structures, authorized to contract services with not-for-profit private corporations, and they occupied a dominant role in rationalizing public expenditures¹⁰⁰ as well as in the deepening of the privatization process. Thus, the responsibilities and traditional functions of the municipalities expanded

⁹⁷ Payment for Rendered Services per Municipality System, FAPEM.

⁹⁸ Annick, "The Chilean Health System: 20 years of Reforms", *supra* note 61.

⁹⁹ Secretaría Regional Ministerial (SEREMI).

¹⁰⁰ Julio Ruiz, "Municipios y servicios sociales. La experiencia chilena (1980-1993)", in ILPES-OMS/OPS-Ministry of Health, *La Municipalización de Servicios Sociales en Chile* (Santiago, 1995). See also Mario Parada, (2004) *Evolución del sistema de protección social de la salud en Chile: un análisis sociológico* (Ph.D. thesis, Universidad Autónoma de Madrid, Spain) at 238.

to include specific domains in the area of social policy, including the administration of primary and secondary education and primary health care services.¹⁰¹

The SNS also transferred financial resources to the National Private Social Development Corporation (CNPDS)¹⁰² to cover the operating costs of the clinics, buildings, facilities and equipment so that this private corporation could manage and provide the medical and health care services required by the population.¹⁰³ Financial surpluses were to be re-invested to enhance services and/or to be handed over to the SNS. At the same time, efforts were made to increase professional efficiency, with a higher level of administrative support available to improve the quality of services.¹⁰⁴ However, although the private sector could offer “more comfortable” and “more personal” services, these were not necessarily of better quality. Private hospital management was not less costly, and experience showed that transferring hospital management to the private sector led to some duplication of hospital and technological resources, thus significantly increasing the country’s overall health expenditures.¹⁰⁵

¹⁰¹ The transferred services included staff that was contracted at market salaries. As a result, they lost all rights and benefits as civil servants, and suffered significant decrease in wages. As for assistance programs, the municipalities identified potential beneficiaries and distributed aid according to their needs. They were monitored by the “CAS Card” that provided a database of extreme poverty in the country.

¹⁰² Corporación Nacional de Desarrollo Social.

¹⁰³ The 1975 transfer of three public health-care clinics belonging to the SNS (Maipú, Chucunco and Cerrillos) to the CNPDS was the first measure to implement this new conception of the municipality.

¹⁰⁴ Ministerio de Salud, *El Mercurio*, December 25, 1975.

¹⁰⁵ Alejandro Goic, “Fundamentos médicos de una organización social de la medicina” in Lavados, *Desarrollo Social y Salud en Chile*, *supra* note 44 at 70.

Beginning in July 1980, the intention was to transfer medical and sanitary establishments to the municipalities in a loan-type agreement for a period of five years. The target was to transfer 30% of the country's consultation offices and clinics to the municipalities, granting them both direct and indirect responsibility for providing curative services. Decree with force of law (DFL) 36 (1980)¹⁰⁶ established and regulated the agreements between the Health Service and other entities. The provisions of the decree applied to all agreements between the Health Service, universities, organizations, unions, employers or workers in general and any natural or legal person on health actions to be executed on behalf of the Health Service. This decree thus governed those agreements under which a body, entity or person replaced the Health Service in the execution of one or more actions for the promotion, protection and restoration of health or rehabilitation of patients, without prejudice to the care that could be provided to others under the agreement. Health actions subject to the agreement had to be identified and detailed, and the obligations under the agreement could not be transferred or entrusted to third parties without prior approval from the Health Service and the Ministry. No agreement could include those actions that by their very nature had to be exercised directly by Health Service authorities. As a general rule, agreements were drawn up for a period of one year.

¹⁰⁶ **DFL 36 (1980) established and regulated the agreements between the Health Service and other entities.**

However, to consolidate the private sector as the neuralgic axis of the neoliberal model in a health system that was still considered not fully organized under the market model, it was necessary to invigorate the health infrastructure in order to be able to respond to the new demand. This, as already discussed, was stimulated by legislation that granted new financial resources to the ISAPRES through income deductions and voluntary contributions. The private sector's ability and legal capacity to operate thus became a necessary condition for its further development and incremental expansion. State non-intervention encouraged the normal growth of private structures and facilitated the partial withdrawal of public involvement in health activities. Legislation with these ends was present from the very beginning of the military regime, permitting the outsourcing of ambulance services, maintenance operations, laundry, hotel-related services and the manufacture of certain products, creating financial incentives to open and operate more private clinics and liberalizing imports for the medical industry. In addition to these measures, agreements were signed between the Health Ministry and private entities to transfer health care services out of the public sector. This normative deregulation process, instrumental to the growth of the private sector, was euphemistically termed the "alternative system".

Eventually, privatization advocates within the regime, who initially controlled the decision-making process, lost their initiative, ultimately becoming more predisposed to a transitional and gradual process. The Health Minister acknowledged that it was the state's responsibility to guarantee free access to

health care by taking on full leadership and control, adding that the state could not neglect any part of the health sector in the hope that private ventures would eventually fully develop and take control. However, he further indicated that the state should or could pull out of those areas appropriately covered by the private sector, though it had the obligation to maintain its responsibility and authority when essential health needs were not met.¹⁰⁷ Although these ministry proposals did somewhat moderate the wave of privatizations, contradictions between the principles and the practice were evident. It was no coincidence that public health expenditures, whose growth had outpaced that of the population at first, began to decrease substantially from 1979 on, while the participation of the private sector in services (housing, health care and education) was constantly stimulated. By March 1981, thirteen health care institutions had been transferred to the private sector. The CNPDS received these establishments and their assets under a long-term borrowing agreement. According to legislation, they were charged with providing the same services as the former SNS and SERMENA had offered to their affiliates.¹⁰⁸ In 1977, the minister of health explained that the rationale for stimulating such activity was to:

- a) Reduce pressure on the public system;
- b) Complement the resources of the national health plans with agreements with both private and public entities;

¹⁰⁷ Fernando Matthei, "Política de Salud", Ministry of Health document in (1977) *Revista de la FACH* 22.

¹⁰⁸ **Resolution No. 803 of the Directorate of Central Health Service, Ministry of Health (March 3, 1981) and Decree-Law 36 (1 July, 1980)** about the rules that apply to the contracts approved by the health services.

- c) Ensure state curative health care services for patients, either individually or collectively;
- d) Purchase, sell and exchange services at cost between the public system and the alternative (transferred) system.

Making health a part of the municipal agenda was rationalized as a decision to prioritize the provision of medical care in health clinics instead of hospitals. This was in line with a program to expand primary health care, initiated in 1977 and financed by the Inter-American Development Bank (IDB) and the Pan-American Health Organization (PAHO). The objectives were to make services more accessible, to gain greater efficiency, to improve control by management, to promote social participation and to facilitate privatization.¹⁰⁹ It was expected that municipalities would also seek meaningful social participation in the area of health management in order to reduce governmental intervention and the management apparatus, thus allowing for an efficiently regulated, better-adapted investment, with more resources and an overall better service for the community. The regionalization and municipalization model was one of central control, though it was territorially de-concentrated.¹¹⁰ In fact, this was part of a process of decentralization, sustained by the central government with support for

¹⁰⁹ The Health Deputy Health Minister, Hernán Buchi, said that by decentralizing the health services management, it was more likely to facilitate the gradual transfer of public actions to the private health sector in the future. See Beatriz Heyermann, "Municipio, Descentralización y Salud" in ILPES-OMS/OPS-Ministry of Health, *La municipalización de los servicios sociales en Chile*, (Santiago, 1995) at 158. See also Parada, *Evolución del sistema de protección social de la salud en Chile*, *supra* note 96 at 250.

¹¹⁰ Ruiz, "Municipios y servicios sociales. La experiencia chilena (1980-1993)", *supra* note 97. See Mario Parada, *Id.* at 238.

local development and the transfer of new financial resources and flexible management mechanisms to the municipalities.

A dual control structure was created, as municipalities took over the funding and administration of health services (locally incorporating personnel under the Labour Code instead of according to administrative regulations), while the services—the health programs themselves—remained under the technical supervision of the Ministry of Health. It was a matter of providing the municipality with a new role based on its close ties to the population. The municipality was thus granted a power that converted it into a springboard to state concessions, to the benefit of the private sector.¹¹¹ As the mayor of Valparaíso defined it in 1981, “The municipalities are skilled and effective institutions designed to transfer municipal goods and services to the private sector.”¹¹² & ¹¹³ By 1988, the municipalization process of the health system was considered complete. Excluded from the process were the hospitals, their related medical services, specialized and emergency services and large medical clinics that covered more than fifty thousand inhabitants. These institutions and services all remained

¹¹¹ **The DFL 1-3063 (1980) regulated the application of paragraph 2 of Article 38, DL N° 3,063 (1979).** This regulation contained the general rules which governed the investments of the Municipal Common Fund, with respect to the following: a) temporary or permanent transfer of public sector services, and its resulting transfer of assets, financial and human resources, and financial management rules; b) control of the allocation of the Fund's resources; and c) temporary suspension of the allocation of the Fund's resources. The municipalities responsible for these funds were subjected to technical supervision and control as indicated by the Law.

¹¹² Francisco Bartolucci, Alcalde de la ciudad de Valparaíso, en *El Mercurio*, 15 May 1981.

¹¹³ The situation is the same with regard to the "municipalization" of schools. The mayor of Chillán, Luciano Cruz, informed the press in March 1981 that he was convinced that the municipalities will transfer the management of these schools to private Law corporations who requested it... (Hernán Pozo, “La situación actual del municipio chileno y el problema de la municipalización”, Working paper 7, (Santiago, FLACSO, 1981) at 54.

within the SNSS.¹¹⁴ The pursuit of economic profitability and the creation of favourable economic conditions for the development of the private sector stimulated outpatient medical centers, clinics, diagnostic centres, laboratories and the private practice of medicine in order to capture the demand traditionally met by the public sector.

The transfer of responsibilities previously held by the state over to the private sector¹¹⁵ was creating increasingly unequal access to curative services, according to social class, the capacity to pay, the patients' source of income, and their capacity to make co-payments via income deductions for private health care. This inequality deepened, partly because of the reduced allocation of public resources, and partly because of the private sector boom in new health care offerings targeted at the middle- and high-income strata in the major cities. This meant more effective services for a minority of the population, to the detriment of

¹¹⁴ The type, number and percentage of transfer of facilities were as follows: 178 urban clinics (92%); 117 rural clinics (100%), 993 rural health posts (100%), 74 school dental clinics (100%); 491 rural medical stations (38%), which were functioning as health teams where the population was scattered and provided services to schools or community centers, etc.

¹¹⁵ By the end of 1981, the private sector had made a series of agreements with public and private institutions such as the San Bernardo Hospital, the Missionary Hospital of Panguipulli, the San José Hospital of Puerto Varas, the University of Chile Hospital, the Catholic University, the German Clinic, the National Copper Corporation, the Bethlehem Iron Company, the Red Cross, the National Petroleum Company (Empresa Nacional de Petróleo, ENAP), Customs, the "*Colonia Dignidad*", the Military Hospital, the Pucón Hospital and the psychiatric clinics and seniors' residences. Ministerio de Salud y Oficina de Planificación Nacional (ODEPLAN).

Colonia Dignidad, today Villa Villa Baviera, was situated in the town of Parral in the Maule Region. It was founded by a group of fundamentalist Germans emigrants led by ex-Nazi Paul Schafer in 1961. At its greatest extent, Colonia Dignidad had around three hundred German and Chilean residents. The main economic activity of the colony was agriculture but it also contained a school, a free hospital, two airstrips, a restaurant, and a power station. The colony was secretive, surrounded by barbed wire fences and searchlights and a watchtower and also contained secret weapon. It was described alternately as a cult of "eccentrics", but it was later revealed that Colonia Dignidad was also used to indoctrinate people, commit sexual abuses to children and served as a torture camp during the Pinochet dictatorship. See: http://www.archivochile.com/Chile_actual/16_hue_dict/chact_huedict0024.pdf

the majority that depended upon imperilled public services. However, the government repeatedly avowed that its intention was not to privatize the health sector, but rather to increase its effectiveness. The opinion of the health workers (regrouped in the National Federation of Health Workers (FENATS)¹¹⁶ was substantially different. They considered health to be a part of the national heritage, and hence, they believed that the role of the state should be reinforced, as the state's subsidiary role was clearly insufficient. Health workers did not believe that normative and regulatory actions exercised by the state could protect the public interest without having negative effects on its support of the private sector.¹¹⁷

These changes implied a revolution in the health field, where traditionally 90% of the Chilean hospital infrastructure had been owned by the state, 5% belonged to university institutions and to the Armed Forces, and the other 5% was private. Along with these transfers and the privatization of services, other factors also contributed to the growth of the private sector. First, doctors' low remunerations in public hospitals and staff layoffs drove doctors to regroup in private medical centres or to find managerial or salaried work in private clinics. Many physicians also welcomed this opportunity to practice in private medical centres or clinics, as it allowed them to share the costs of a private practice and enjoy the benefits of a more sophisticated technical infrastructure.

¹¹⁶ Federación Nacional de los Trabajadores de la salud (FENATS).

¹¹⁷ FENATS, (1979) *Revista de la Federación nacional de Trabajadores de la Salud*.

It is interesting to note that the process of privatizing the public health care sector did not affect the staff of the armed forces and the police in the same way. The type of privatization developed in the ISAPRES system, which was based on each contributor's individual capitalization, the private administration of medical and health care services, and free choice by the patient, was not applied for the armed forces and the police. Health care funding had three sub-systems: the public system, the private system and the system for the armed forces and the police. Like health care services for all other workers, the latter system was funded with contributions equivalent to 7% of monthly wages as well as direct state funding. The funds allocated to the armed forces and the police covered the operation of the ten military hospitals and health care coverage for their personnel and their families, which made up close to 13% of the population.¹¹⁸

As discussed above, this system concentrated people according to their income, such that those with lower incomes and greater health risks went to the public sector, while those with high incomes and low health risks went to the private sector, which was less crowded and much faster.¹¹⁹ However, the case of the hospitals for military and police staff was quite distinct, as while their coverage came from public funding, they were considered autonomous

¹¹⁸ Camilo Cid Pedraza, "Inequidad y segmentación del financiamiento del sistema de salud en Chile,"

http://www.medicosaps.cl/Portals/15/files/congresos/conferencias_4to/seminario_aps_ccp.pdf

¹¹⁹ O. Larrañaga, "Eficiencia y equidad en el sistema de salud chileno," *Revista de la Cepal* No. 49, 11-12.

institutions, with privileges that the public sector did not enjoy but the private sector did. First, access to this system was restricted to military and police staff and their families. Second, these entities could enter into agreements with public health services to reduce costs and use their infrastructure.

The privatization process was based on a very clear economic rationale for why and how to impose and implement the new liberal market model in the health sector, which, as indicated above, included an articulated process to reduce the public sector, stimulate the growth of the private sector and lastly, expand the market for the private sector. This was precisely in line with neoliberal political and economic principles, according to which private sector interests and market laws become the impulse for development. In summary, these political-economic policies in the health field were no guarantee of better health care; rather, they were tools to increase the profitability of the “business” of medicine and the medical-industrial complex.

CHAPTER FOUR

THE RISE AND FALL OF WELFARE HEALTH LEGISLATION IN CHILE OVER DECADES: OVERALL ANALYSIS

INTRODUCTION

Ideas, discourses and practices that dominate or subvert relations of power are not free-floating, health reforms and health legislation need to be analyzed in relation to ideological determinants mediated by the diversity of these actors, wherein health legislation is an outcome of the articulation of political practices and negotiations. Once created and enacted, the law adapts to the political context in which it resides, it employs its own particular normative discourse, and it promotes its “exchange value” as being “equal”, “neutral” and “blind”, hence becoming its own agent. Therein lies its fetishism,¹ which ensures that legal rationality supplants those who have created the law and acquires the capacity to transform them into objects of its own creation.

Law can be circular, and only the law can create law. This interpretation, put forward by Luhmann in his autopoietic theory and closely connected to biology and the functioning of ecosystems, has the limitation of not capturing the law in terms of its own movements, capturing it only in its formalization. However, it is important to understand the law as a function of its own dynamics. Law is circular in its formalization, but not in its creation or prior to having a life of its own. In this sense, it is probably closer to physics, relativity, chaos theory and indeterminacy. This is perhaps why legal systems function in an unpredictable way but require predictability. They appear to be stable because they function in

¹ Term linked to 19th-century anti-formalism, used to describe an excessive attachment to the letter of the law in contradiction with logic, convenience, and justice. Relates law to politics, and the gap between formal legality and its application. See Julieta Lemaitre, “Legal Fetishism Law, Violence, and Social Movements in Colombia”, (2007) Paper, Universidad de los Andes, Bogota. http://www.law.yale.edu/documents/pdf/sela/JulietaLemaitre_English_.pdf at 2-3

the realm of positive law, but law has its own dynamics, and the system works precisely because it does not necessarily work, even though it must: the rule of law. This is why we must understand the law in its synchronic and diachronic moments.

Peters indicates that the formalization of the law – that is, its legalization – makes explicit what was implicit, and, in the legalization process, social relations, interests and objectives are conceived or re-conceived. In this sense, the author suggests that legalization contributes to the transparency of social reality and to the rationality of social action.² That is, the law in its own dynamics is directly related to the exercise of power and dresses in the clothes of legality. Legalisation pretends the impartiality of the law and neutrality in its genesis and simulates a process of mediation among equals who are not equal. Accepting legalization as an instrumental *ex post facto* conflict-resolution mechanism is different from interpreting it as an element of transparency in social reality.

It is with this identity, now recognized as formal, that law is legitimized. When the exercise of the conflict-consensus dialectic is guaranteed, this legitimation, and even more importantly the acceptance of this legitimacy, is expressed in the collective acceptance of the legalization of the law. Its *ex post facto* recognition facilitates the symbiosis between *lex* law and *jus* law. Here, the

² Peters, *Law as a Critical Discussion*, in Gunther Teubner, *Dilemmas of Law in the Welfare State*, (ed.) (1986) (Berlin & New York, Walter de Gruyter) at 253.

Western Kantian notion of “being” (Sein) and “should-be” (Sollen) as the fundamental quandary in the construction of Kelsen’s pure theory of law and development of positivism is not irrelevant to the problems of the legitimization of legal rationality. In this case, the formal validity of the legal text depends on the rationale that validity is the result of a procedure that takes place in an appropriate body. So, we may argue or question who or how we can validate the procedure, so the law becomes legitimate within its own legal rationality.

With respect to the law’s economic and political interrelations in Marxist theory,³ the law is simultaneously a means for exercising power and for promoting ideas or ideological values.⁴ Law and the power of law are thus largely ideological, transforming power relations into seemingly fair and legitimate relations by making them seem beyond power:⁵ “the ideas of the ruling class are in every epoch the ruling ideas.”⁶ In this sense, the law loses its dynamic role and becomes the merely formal result of the exercise of power, which is able to adulterate itself, presenting itself as something it is not. Legislative decisions are validated as a result of procedures that are then legitimated because all interest groups can be represented and can compete for influence or, even more,

³ Gunther Teubner, *Law as an Autopoietic System* (Oxford & Cambridge, Blackwell, 1993) at 11&35.

⁴ Max Travers, *Understanding Law and Society*, (Oxon, Routledge, 2010) at 75.

⁵ Alan Thomson, “Foreword: Critical Approaches to Law. Who Needs Legal Theory?”, in Ian Grigg-Spall & Paddy Ireland (eds.), *The Critical Lawyers’ Handbook*, (London, Pluto Press, 1992) at 4 & 5.

⁶ Karl Marx & Frederick Engels, “Ideology, State and Law”, in Yash Ghai, Robin Luckham & Francis Snyder (eds.), *The Political Economy of Law. A Third World Reader*, (Delhi, Oxford University Press, 1987) at 183.

because citizens are made equal by choosing the laws that will govern them.⁷ The population must be persuaded that the existing order is just and that it is they who want it to be as it is.⁸

Legal processes are embedded in political transitions, and law evolves and is transformed. When we speak about political dynamics and their implications for the law, we understand law as praxis. That is, “law-making as praxis,” (and not necessarily in its abstract notion), tied to a structure in which the community participates in bringing the law to life.⁹ This means recognizing “the role played by all social actors, including even oppressed individuals and groups, in the constitution of the legal order.”¹⁰

I have discussed legislation as an “ongoing process” that entails an understanding not only of the nature of the legal system, but also of how the law is processed, dictated and legitimized. This reading of the law as a process in which actors intervene in the pursuit of a consensus on interests in order to transform them into legal texts (*lex*) is part of the very dynamics of the legal system should not necessarily be understood in the “tradition of consensus” in legal theory.

As already indicated this dissertation argues that law has a dual rationality or role. It preserves the social order, or, in Durkheim’s language, it provides

⁷ Unger, “The critical legal studies movement”, *supra* note 15 at 565.

⁸ Peter Gabel & Paul Harris, “Building power and breaking images: critical legal theory and the practice of Law”, (1982-1983) *11 Review of Law and Social Change* at 372.

⁹ Steven Spitzer, “Marxist Perspectives in the Sociology on Law”, (1983) *9 Annu. Rev. Sociol. by York University* 103-124 at 108.

¹⁰ A. Fraser, “The legal theory we need now”, *Socialist Review* 40-41 at 147-187 in Spitzer, *Id.*

“cohesion and integrity”, while on the other hand, it contributes to social change. From a critical perspective, the law is also clearly an element of authority that supports the power concentrated in the government, in the family, in the market and in the workplace,¹¹ and, as vehicle for the reproduction and legitimation of the dominant elites.¹² However law can also assume this dual role, as it can respond or react to a situation of social and political change or even generate and promote change. In this case the Rule of law, which has become essential in Western democratic and legal theories, was associated with the procedures characteristic of citizen participation,¹³ yet this citizen participation is incomplete, not necessarily representative or inclusive, and furthermore, often an instrument for the political legitimation of the established order. Nonetheless, within its process and dynamics, the Rule of law has also permitted and facilitated important changes in the evolution of the state, and in particular the welfare state, such as social benefits, struggles for equity, the awarding of civil liberties and protection against (arbitrary or authoritarian) state intervention.¹⁴ Therefore,

¹¹ Unger, *Law in Modern Society*, *supra* note 22 at 179.

¹² Yves Dezalay & Bryant Garth, “Chile: Law and the Legitimation of Transitions: From the patrimonial State to the international neo-liberal State”, (1998) *American Bar Foundation* 9709 at 1.

¹³ D. Grimm, “Der Wandel der Staatsaufgaben und die Zukunft der Verfassung” in D. Grimm (ed.) *Wachsende Staatsaufgaben-Sinkende Steuerungsfähigkeit des Rechts*, (Baden-Baden: Nomos, 1991), at 291-306 in Peer Zumbansen, “Governance: an Interdisciplinary Perspective”, in David Levi-Faur (ed.), *Oxford Handbook of Governance*, (Oxford, Oxford University Press, 2012) at 86.

¹⁴ D.Grimm, “Der Wandel der Staatsaufgaben und die Zukunft der Verfassung” in D. Grimm (ed.) *Staatsaufgaben*, (Frankfurt: Suhrkamp, 1996), at 613-646 and E.-W. Bockenforde, “The rise of the state as a process of secularisation”, in E.-W. Bockenforde (ed.), *State, Society and Liberty Studies in Political Theory and Constitutional Law*, (New York and Oxford, Trans. J.A. Underwood, Berg, 1991), at 26-46 in Zumbansen, *Id.*

by analyzing the law in its different dimensions and in its contradictory nature, we can understand it as an agent of control or as an instrument for change.

The analysis here has captured law as a process of transformation, focusing on actors, norms and movements in relation to the legal transformations of the health sector in Chile.

Latin America, including Chile, has created highly fragmented health systems.¹⁵ According to Frenk, a health system can be understood as “a set of relationships among major groups of actors: health care providers, the population, the state as a collective mediator, organizations that generate resources, and other sectors that produce services with health effects.”¹⁶ From a comparative perspective, all countries have similar concerns, but the economic, political, ideological and epidemiological reasons behind them differ.

It is difficult to classify them as purely public or private, due to the complex arrangements and negotiations that are the result of political choices.¹⁷ Systems of social protection, different in each country, have been formed through diverse historical processes, resulting from a combination of economic, political and cultural forces. These forces, along with unique sets of social values shared by the local population, form a complex web of institutions “responsible for financing, organizing and providing social service delivery”, defining “who is entitled to

¹⁵ Eldabi Tillal, Irani Zahir & J. Paul Ray, “A proposed approach for modeling health care systems for understanding” in Conrado Adolfo Gómez, “Influencia de los grupos de interés”, (2005) 9 *Revista Gerencia y Políticas de Salud*. CIESS, “Conferencia Interamericana de Seguridad Social, 2004. Informe anual sobre la seguridad social en las Américas 2005. Fragmentación y alternativas para aumentar la cobertura del seguro en salud” in Conrado Adolfo Gómez, *Id.* at 62.

¹⁶ Julio Frenk, “Dimensions of Health System reform”, (1974) 27 *Health Policy* 19.

¹⁷ Arnold Heidenheimer et al., *Comparative Public Policy* (New York, St. Martin's Press, 1990).

benefits and services”.¹⁸ There are four pressure groups that have had an influence on social security policies in Latin America. In order of political significance, Mesa Lago identifies: 1) the military, 2) political administrative groups, 3) economic and market groups and 4) unions. These groups have had different sources of power at different times in their history. They are certainly not homogeneous; they can be subdivided into subgroups, and their power has varied over time. We must also, as we shall see below, add the role played by the state and the action of the political parties.

My analysis of health care legislation is situated within its relationship to the economic structure and political variables, wherein the negotiation process in lawmaking is the result of political and economic choices, motivated by contrasting ideologies and mediated by a diversity of political actors and civil stakeholders. Changes in health legislation have taken place where and when political parties, stakeholders and organized civil society have prompted transformations and applied strength and pressure to legislate.

1.HEALTH LEGISLATION AND THE ROLE OF THE ACTORS IN CHILE

The development of a positivist liberal legal system in Chile gradually led to progress in social legislation and, following its own dynamics, gave shape to the different health models in the country. This certainly leads us to ask about the

¹⁸ Sonia Fleury, “Reforming Health Care in Latin America: Challenges and Options” in Sonia Fleury, S. Belmartino & E. Baris (eds.), *Reshaping Health Care in Latin America*, (Ottawa, IDRC, 2000) Chap. 1 at 1.

possibility of interpreting or considering the law as a mere instrument of the status quo for maintaining and reproducing the progressive system or as a factor of change or, perhaps, as both. The health reforms implemented in Chile have therefore been the result of political and economic choices, motivated by various ideologies and negotiated by a variety of actors.

Their legitimation was not the result of the imposition of one group over the rest, but rather the articulation of interests through the development of a consensus, or, more specifically, what I have called “hegemonic consensus”. In essence, this scenario has allowed for an understanding of the interplay of interests that has led to major changes in health reforms as well as permitting an understanding of the negotiation process between a web of economic, political and social forces that contributed to the health laws in Chile during the 20th century.

The conflict-consensus dialectic is part of the process of law creation and is not only embedded in the dynamics of law itself, but also gives it life and makes it real. It is not that consensus is positive and conflict negative, nor is it true the other way around. We may judge the results, we can have opinions about conflict and consensus based on our values and ideologies, but neither conflict nor consensus can exist without the other, as suggested by the Hobbesian thesis, according to which society is in constant flux and made up of contradictory elements.

In the specific case of the health sector, we can see that reforms in Chile specifically and Latin America generally — have been strongly determined by the influence and capability of mobilizing interest groups through the articulation of conflicting interests in the political arena, which has been mediated by the political strength and the mobilization capacity of political actors and organized civil society, as well as the church and the armed forces. Governments have bargained separately with labour factions, urban workers, employees, the police and the armed forces, ultimately resulting in a very heterogeneous structure, in which the rights and benefits of the different factions have come to depend on the negotiation power of the different groups.¹⁹ This means, as mentioned above, that health legislation is the result of a negotiation process in which the strength and interests of actors are confronted.²⁰ This is why changes to health legislation have been neither easy nor linear, but rather the outcome of political struggles and the action of social movements, currents of opinion and ideological confrontations in a given economic and political context. Most of these changes are rooted in legislative reforms, achieved through negotiations²¹ and consensus within the prevailing political dynamic.

¹⁹ C. J. Murdock, "Physicians, the State and Public Health in Chile, 1881-1891", (1995) 27 *Journal of Latin American Studies* 551. See also R. Trumper & L. Phillips, "Give Me Discipline and Give Me Death: Neoliberalism and Health in Chile", (1996) 37 *Race and Class* 19.

²⁰ W. Ratliff, "Development and Civil Society in Latin America and Asia", (1999) 565 *Annals of the American Academy of Political and Social Science* 91.

²¹ Rony Lenz, "Proceso político de la reforma AUGE de la salud en Chile: algunas lecciones para América Latina. Una mirada desde la Economía Política", (2007) *Serie Estudios Socio/Económicos CIEPLAN* 38 at 8-11.

It is particularly interesting to note that although organized civil society and political parties usually promote change, the state too can be involved in the negotiating process to articulate and frame transitions. An examination of the policy actors (individuals, social groups and power relationships), the policy process (forms of interaction and policy outcomes) and policy content (content issues related to health policy reforms and agenda)²² is essential for an analysis of the dynamics of health reforms and health legislation. The complexity of political equilibrium, the historical outlook, social needs and external intermediaries are thus relevant for an analysis of social legislation.²³

Roemer²⁴ was perhaps the first to identify these pressure groups (that he called “social classes”) in Latin America with respect to the type of health system that covered them.²⁵ In the case of Chile, using Roemer’s typology, the groups are made up of four sectors, extensively reflected in the different health-care subsystems that covered them: 1) the military and the police; 2) civil servants, including journalists as well as municipal, railroad and bank employees as important subgroups; 3) white-collar workers and 4) blue-collar workers. Pressure groups like pensioners, unions, professionals and especially the groups

²² Kent Buse, Nick Drager, Suzanne Fustukian & Kelley Lee, “Globalization and health policy trends and opportunities”, in Kelley Lee et al. eds. *Health Politics in a Globalizing World*, (Cambridge University Press, 2001) at 252.

²³ Alberto Febrajo, “The rules of the Game in the Welfare State”, in Gunther Teubner (ed.), *Dilemmas of Law in the Welfare State*, (Berlin & New York, Walter de Gruyter, 1986) at 132.

²⁴ Milton Roemer, “Medical Care and Social Class in Latin America”, 1964 *The Milbank Memorial Fund Quarterly*, 54-64 in Carmelo Mesa-Lago, *Social Security in Latin America. Pressure Groups, Stratification, and Inequality*, (Pittsburgh, University of Pittsburgh Press, 1978) at 9.

²⁵ 1) The elite of landowners, large merchants, industrialists, and upper-level professionals; 2) military men, policemen and civil servants; 3) white-collar workers and small entrepreneurs; 4) manual industrial workers; 5) peasants, peons and urban underemployed and 6) the Indians. Roemer, “Medical Care and Social Class in Latin America”, in Mesa-Lago, *Id.*

tied or linked to the state apparatus, such as service providers, bureaucrats and technocrats are important stakeholders in processes of change. Institutional reforms and the implementation of legal changes require the collaboration – or at least a lack of active opposition – from mid-level bureaucrats and health authorities. These actors may have only limited or very circumscribed influence when legislating, but they can be facilitators of or obstacles to the implementation of reforms.²⁶

The rest of society not incorporated into these groups and subgroups relied on the public systems, charities or privately assumed the cost of their health care expenses.²⁷ Every group had ad-hoc legislation with specific benefits, as well as particular mechanisms for financing these benefits. The proliferation and multiplicity of institutions, regulations and procedures created a legislative maze, with enormous difficulties to control and supervise them as well as high administrative costs for those covered.²⁸

This very stratified health care system granted social security benefits to workers in the formal labour sector, while the rest of the population received services provided by the state, thereby creating differences and inequities. Latin America's fragmented systems had their origins in the profound economic, political and cultural changes that accompanied the process of industrialization and urbanization in the mid 20th Century. This pattern of structured social

²⁶ Stephan Haggard & Robert R. Kaufman, *Development, Democracy and Welfare States*, (Princeton, Princeton University Press, 2008) at 197.

²⁷ Mesa-Lago, *Social Security in Latin America*, *supra* note 12 at 30.

²⁸ Mesa-Lago, *Id.* at 14.

interactions also led to several other characteristics, such as the stratification and/or exclusion of certain population groups, the disintegration of institutions, a narrow and fragile financial basis and strong actors with vested interests represented in the political arena.²⁹ Health reforms and health legislation were clearly “process-oriented”, including the organizational structure for reorganizing relations between the public and private sectors, managers, policymakers, providers and consumers.³⁰

2. THE DEVELOPMENT OF THE WELFARE STATE AND HEALTH LEGISLATION AND THE POLITICAL PROCESS

By the mid-19th century, Chile had already witnessed the implementation of social legislation, thus leaving behind the Spanish colonial regime and embracing the consolidation of a liberal republic. Later, and inspired by the German system pioneered by Otto von Bismarck, first Chancellor of the German Empire (1871-90),³¹ Chile began to transform its social protection system in a process marked by vigorous political turmoil, social disputes and military interventions alongside substantial legislative changes. As early as 1890, the

²⁹ Fleury, “Reforming Health Care in Latin America”, *supra* note 18.

³⁰ T. Horev & Y. Babad, “Healthcare reform implementation: stakeholders and their roles – the Israeli experience”, (2005) *71 Health Policy* 1.

³¹ The compulsory German Bismarckian social insurance model was a prototype; it was the first to be devised and implemented in a Western country. It was established in 1883 as an integral part of a broader welfare system that included unemployment, accident, disability and maternity coverage, as well as social security laws. Guido Giarelli, “Convergence or Divergence? A Multidimensional Approach to Health Care Reforms”, (2004) *14 International Review of Sociology* 171 at 176

creation of an agency in charge of public hygiene and sanitation initiated state involvement in public health.

Workers were able to access social rights, basic benefits and public health care services from a variety of sources, financed by salary deductions, employers' contributions and public state funds. However, the funding for these social and health benefits was associated with specific segments of the labour market and different occupational organizations, thus the benefits perceived by individual workers varied according to their occupations and occupational affiliations.³² This diversity did not contribute to greater equality, but only served to reinforce inequalities based on occupational status. There was no clear consensus amongst the different sectors involved: the business elite was opposed to state intervention and new additional tax policies; the workers wanted to entrust the administration of the newly created social institutions to the labour unions; and physicians demanded the creation of a strong corporatist entity to lobby for and protect their interests.

During the late 19th century and the early 20th century, the expansion of capitalism in Chile profoundly transformed labour relations. A proletariat linked to mining activity emerged, along with the incipient process of industrialization and greater urban activity related to the extension of cities and ports and increased economic development. A number of laws, decrees and policies intended to regulate capital and labour relations were promulgated. At the same time, the

³² Fernando Lolas, "Beyond the Anglophone World. On the goals of medicine: a Chilean perspective", (1966) 43 *Social Science and Medicine* 125.

growth of the state apparatus and the process of industrialization led to an increase in both blue- and white-collar workers. These changes in the composition of the work force were marked by conflicts that led to new social movements and, ultimately, social reforms, as the workers struggled to consolidate new, comprehensive legislation that would clearly regulate contracts and protect workers in the case of illness or work-related accidents, tolerate unions and legal strikes, and create mechanisms for conflict resolution.³³

The modernization of public institutions originated in the late second and third decades of the 20th century, with President Arturo Alessandri Palma. During his first and second mandates, Chile promulgated a new constitution and a new Labour Code, Tax Law, Sanitary Law and Social Security Law, all in anticipation of several aspects of global trends having their origins in the treaty of Versailles and the International Labour Organization. The government provided health services to workers and their families,³⁴ and the state assumed an active role with universal health care and the consolidation of state responsibility in public health. Social security was extended in a program that benefitted railway employees, and the mid-1920s witnessed the creation of organizations like the National Public Employees Fund (CANAEMPU)³⁵ and the Fund for Private Employees (EMPART).

³³ Memoria Chilena, online: DIBAM
<http://www.memoriachilena.cl/temas/index.asp?id_ut=origenes
delaleislacionlaboralenchile:1924-1931> (data accessed: November 23, 2011).

³⁴ Jorge Jiménez de la Jara & T. Bossert, "Chile's Health Sector Reform: Lessons from Four Reform Periods", (1995) 32 *Health Policy* at 155 - 157

³⁵ CANAEMPU, Caja nacional de empleados públicos.

The year 1924 (the year of a military intervention) marked a new stage in the history of social legislation in Chile, because it was from this date that the first social laws began to be enacted. Employers, workers and physicians welcomed them. Health legislation and the reforms that followed were not intended to reduce the activities of private aid, but rather were aimed at consolidating a centralized body for social and health policies. The creation of Workers' Compulsory Insurance, or Social Security, in 1924 became a central piece in the history of public health in Chile. These events suddenly transformed the medical profession into a privileged actor in the construction of the state and radically changed the morphology of its labour market.³⁶ Finally, the new constitution (1925) reflected global trends as it increased individual rights and the obligation of the state in ensuring social rights, subjected the right of ownership to what was considered the "rule of social progress", protected labour and industry and enforced social welfare and legal protection for workers. It also proclaimed that public health services were a state obligation. The most important of these social laws was the creation of the Workers' Insurance Fund, which later became known as the Social Security Service (SSS).

In this context, the state has always been of enormous importance in the structure and administration of Chilean society and has assumed a leading role, becoming the most important agent of the production and reproduction of society

³⁶ Mario Parada, (2004) Evolución del sistema de protección social de la salud en Chile: un análisis sociológico, (Ph.D. Thesis, Universidad Autónoma de Madrid, Spain) at 154.

and legislation. Health care services became fragmented and developed in dissimilar ways as fractions of the middle class, the working class, private interests, the church, physicians and health workers, the armed forces and organized civil society succeeded to varying degrees in pressuring the state to extend coverage.

After the world economic crisis of the 1930s, the state began to penetrate the full range of social and economic sectors in Chile. The crisis was a stimulus for the state to allocate important resources to the industrial sector, to the construction of infrastructure and to the legal protection of labour benefits. Accelerating the industrialization process was crucial, resulting in economic growth and remarkable social improvement actions. This gave the state the role of welfare provider, thus enabling it to assume a clear function in legitimating the process of growth and accumulation. Also, we cannot ignore the influence of the bureaucracy, which in some countries has also played a decisive role, acting as a significant pressure group to justify the stratification of social security.³⁷ This can also be applied to health systems and especially their diversification in different subsystems, which is what occurred in Chile throughout the 20th century.

Later, in 1938, the Popular Front government (led by Pedro Aguirre Cerda), which looked favourably upon democratic socialist ideas, implemented the Law of Preventive Medicine, which allowed all blue- and white-collar workers to be screened for contagious and chronic diseases. In 1939, Dr. Salvador

³⁷ Mesa-Lago, *Social Security in Latin America*, *supra* note 23 at 9.

Allende, then the Minister of Health (who would later become president in 1970), wrote a book that furthered Virchow's research as he advocated that social rather than medical solutions were necessary in order to combat current health problems. *The Chilean Socio-Medical Reality*, "conceptualized illness as a disturbance of the individual fostered by deprived social conditions"³⁸ and focused on specific health problems that were generated by the poor living conditions of the working class: maternal and infant mortality, tuberculosis and sexually transmitted diseases. At that time, these suggestions were considered not only innovative, but also absolutely revolutionary.

The period between 1917 and 1939 established the state's responsibility in matters of health and welfare. However, the multiplicity of institutions that were created resulted in costly health care service. An integrationist and centralized movement began to develop a new reform process at the end of the 1930s, which reached its peak in 1952. In 1940, the Popular Front government presented a bill that clearly indicated that a more comprehensive form of coverage was needed to reduce health care inequities and centralize the management of all hospitals under a single government agency.

It was a process that was developed through negotiations between governments, unions, health workers and the medical profession, each representing their own political, economic and corporate interests.³⁹ The outcome

³⁸ H. Waitzkin, C. Iriart, A. Estrada & S. Lamadrid, "Social medicine then and now: lessons from Latin America", (2001) *91 American Journal of Public Health* 1592.

³⁹ Roberto Belmar et al., "Enseñanzas de la salud pública y de la medicina social", (1977) *Revista Médica de Chile*.

was the establishment of the National Health Service (SNS)⁴⁰ in 1952, which was the major health provider in Chile for four decades. The National Health Service, created in 1952 by Law 10,383 and established as an independent legal and administrative entity, was not only created as a direct and mechanical response to class interests, but also as a result and probably the synthesis of specific, articulated interests as well as social and political contradictions and disparities.⁴¹ At the same time, the different insurance regimes and the dispersion of funds were maintained. The SNS provided curative care to 70% of the population and took on responsibilities related to disease prevention and social protection. Greater state involvement in satisfying health care needs became part of public policy independently of the government in power, and the SNS continued to develop and consolidate its position over time.

Like in Western Europe, full employment provided the ideological cement for hegemonic order throughout social democracy. In the case of Chile, the welfare state provided the legal framework for social and health reforms, including labour protection, social stability and a more Keynesian state involvement in economic development. Although capitalist development in industrialized countries was characterized by the progressive establishment of a welfare state within a political context of so-called liberal democracies with protectionist social policies, the historical reality of “Third World” economies was

⁴⁰ *Servicio Nacional de Salud.*

⁴¹ Carolina Tetelboin, (1980) *La práctica médica en Chile* (Thesis, Sociology, Universidad Autónoma Metropolitana-Xochimiloho, México) at 49.

and has been considerably different. In developed capitalist societies, the social policies of the welfare state, such as public education, wide-ranging public health actions, public health care services, social security and unemployment insurance contributed to the formation and development of human capital by improving the overall well-being of the population. In doing so, these social policies helped activate the economic process of circulation, thus stimulating consumption and economic growth. The Chilean welfare health system developed through negotiations between different social, political and economic forces, political parties, labour unions and social organizations played a redistributive role, reducing inequalities and protecting the low-income population and those residing on the margins of society.

These processes of political negotiations in the 20th century facilitated the formation of a state based on compromises. It is through these negotiations that the Chilean state managed to progressively resolve its conflicts while preserving relative autonomy and permitting significant institutional development. The state exercised its power to act as an agent of transformation, intervening directly in all social, economic and political spheres. The state assumed the role of benefactor for the most disadvantaged social sectors and took leadership in the overall orientation of social and economic policy.

Beginning in the 1960s, however, Chilean society came to be affected by two basic phenomena: a structural stagnation of the capitalist economic model, which was incapable of promoting and stimulating development, and a socio-

political context of increasing democratization, due to the actions of social movements and very active political parties. As Chilean development was characterized by the failure of industrial and financial capital to promote economic and social development, the industrialization process began to lose its initial dynamism. Added to this was a limited market, a deficit in the balance of payments and recurrent inflationary spirals getting increasingly out of control. In 1964, the Christian Democratic Party led by President Eduardo Frei Montalva proposed the “Revolution in Freedom” program, which blended capitalist growth with social development and the reinforcement of popular participation. The government’s intention was to improve, extend and improve the efficiency of the national health system following six years of a conservative regime. The government expected to implement vast reforms to create a more unified health care service.

In response to pressure from the growing middle class, the centrist Christian Democracy government (1964-1970) took the initiative to develop a new program for white-collar employees (SERMENA). It permitted users to select their physicians, stimulated a semi-public insurance system and created primary and preventive care clinics and laboratories for the middle class that were no longer fully covered by the public system. These so-called “harmony ideology” reforms were the culmination of an incremental process rather than a rupture with the past, and the government was the dominant group, able to dictate reform

policy despite the objections of opposing interest groups in civil society.⁴² As analyzed by Fleury, “the social policies that have developed in most Latin American countries are rooted in a similar development model. They are responsible for some of the most significant features of the relationship between the State and society, as well for the incorporation of a particular power structure into an institutionalized system.”⁴³

The Medical College manifested its desire to preserve a totally professional approach to health care, independent of political interference. The government lost control of social crescendos, while physicians faced unexpected changes to their profession, such as the greater autonomy of non-medical health care professionals. The SNS thus began to incorporate the free-choice system, while at the same time popular awareness of health rights became more widespread. The economic policies of President Eduardo Frei Montalva’s Christian Democrat government (1964-1970) were greatly insufficient, and by 1967, plummeting economic indices, unresolved inequalities, unsatisfied social demands and unmet salary demands for labour and the lower middle class stimulated significant political agitation. President Frei concluded his final year amidst great political, ideological and social turmoil.

This complex economic, social and political context constituted the prelude to the victory of the popular forces, headed by Salvador Allende as leader of the Popular Unity coalition in 1970. Between 1970 and 1973, the

⁴² Jiménez de la Jara & Bossert, “Chile’s Health Sector Reform”, *supra* note 22 at 160-161.

⁴³ Fleury, “Reforming Health Care in Latin America”, *supra* note 18 at 1.

“*Unidad Popular*” (Popular Unity) government introduced reforms to democratize and centralize the organizational structure of the National Health Service.⁴⁴ Hoping to resolve gaps in health benefits, the Popular Unity government aimed to restructure health services, streamline medical care, increase access, coordinate activities, and, in turn, repackage them within a dynamic and effective national plan. This task was entrusted to the Single Health Service.⁴⁵ The new organizational structure was called upon to incorporate public institutions and to absorb the health institutions responsible for providing health care services to the different segments of the middle class.

This major policy change resulted in a radicalization of the social significance of health and a more visible state presence. Despite its promise, the program’s numerous efforts to support democratization ultimately attained more modest results than projected, particularly at the management level. Nonetheless, several policies enhanced health conditions, such as those related to contagious diseases, maternal health, childhood diarrhea, nutrition and preventive health measures.

Between November 1970 and October 1972, the tension between physicians and the government increased substantially. In the end, the Chilean road to socialism came up against the traditional conservative elite and the middle class. The health sector went through the same political turbulence, with

⁴⁴ Jorge Jiménez de la Jara (ed.), *Medicina Social en Chile*, (Santiago, Ediciones Aconcagua, 1977). S. K. Tedeschi, T. M. Brown, et al., "Salvador Allende: Physician, Socialist, Populist, and President", (2003) 93 *Journal of Public Health 2014 in Fleury*, "Reforming Health Care in Latin America", *supra* note 18

⁴⁵ *Servicio Único de Salud*.

the mounting inability of the political class to negotiate the interests of several stakeholders in order to reach a consensus. The outcome of this turmoil and uncertainty was the military coup of September 11, 1973, bringing a brutal end to the government elected in 1970. The military dictatorship (1973-1989) replaced the public-oriented system with a market-oriented approach, transferring important responsibilities to the private sector, curtailing benefits and reducing state involvement in the funding of public policies and their administration.⁴⁶

3. HEALTH LEGISLATION, DEVELOPMENT POLICIES AND INTERNATIONAL INFLUENCE

Over the time period explored in this dissertation, Chile went through several different stages in its development and responded to different economic models, which corresponded to historical processes and international influences. The country participated in global and regional economic traditions, first linked to the models typical of Third World countries as mono-exporters of raw materials and natural resources, and then to the contemporary market models of the 1980s based on the neoliberal theses tied to the Washington Consensus.⁴⁷ Between these two extremes, the developmentalist models linked to processes of domestic industrialization and import substitution rose to popularity, such as the

⁴⁶ R. Castiglioni, "The politics of Retrenchment: The Quandaries of Social Protection under Military Rule in Chile, 1973-1990", (2001) *43 Latin American Politics and Society* at 37.

⁴⁷ The term Washington Consensus, describes the economic policy prescriptions that constituted a reform package promoted for the economic crisis facing the developing countries in the late 80's. The World Bank, the International Monetary Fund and the US Treasury Department, in Washington, supported the plan. It touched economic areas like as macroeconomic stabilization, economic opening to trade and investment, and the expansion of market forces within the domestic economy.

more CEPALian models,⁴⁸ with a large emphasis on Keynesian economic policies and states closely based on welfare models.

Among these models was the dependency school in the 1960s and 1970s, which had a large impact on the Third World and Latin America.⁴⁹ The dependency thesis described the structural dependency between the economies of the Third World and the capitalist countries, requiring the former to adapt and respond to the interests of the metropolis, jeopardizing their domestic economic growth and playing a very decisive role in the international division of labour, where the Third World and especially Latin America was assigned the role of exporting raw material with no value added and consuming manufactured goods and technology from the economically developed world. The CEPALian proposals also sought to improve financial management, and their developmentalist models advocated the necessity of foreign exchange controls, which entailed intervening in the exchange market, applying protectionist measures through high tariffs and introducing forced savings policies.⁵⁰ They sought inward development and political initiatives aimed at reducing or minimizing domestic weaknesses and eliminating the obstacles that made these economies tightly controlled from abroad.

⁴⁸ Proposed by the CEPAL, (Economic Commission for Latin America) from the United Nations.

⁴⁹ Ex.: Theotonio Dos Santos, Samir Amin, Andre Gunder Frank, Osvaldo Sunkel, Raúl Prebisch, Fernando H. Cardoso, Enzo Faletto, Paul Sweezy, Paul Baran and laterly Immanuel Wallerstein.

⁵⁰ Colin Lewis, "Estado, mercado y sociedad: políticas e instituciones de acción económica y social en América Latina desde 1900", in Alicia Puyana & Guillermo Farfán (coords.), *Desarrollo, Equidad y Ciudadanía. Las políticas sociales en América Latina*, (México, FLACSO, Plaza y Valdés, 2003) at 48.

Haggard and Kaufman's analysis of development, democracy and welfare statism during the 20th Century indicates that, "These structuralist ideas emphasized the stimulative effects of generous wage settlements, social entitlements, and labour protections. Welfare protections and job security were sustained not only because of the pressure of national-populist political coalitions, but also because the ISI strategy (Import Substitution Industrialization) made them tolerable to dominant segments of the business elite as well."⁵¹ This model, which emerged slowly but surely following the global economic crisis in the 1920s, was implemented throughout Latin America. It was a protectionist economic policy that increased the price of foreign products in order to stimulate national production, with the aim of increasing demand, stimulating job creation, reducing unemployment and promoting economic growth.⁵²

From a social perspective, dependency theorists maintained the need to promote inward development, invest in public works, regulate the economy and expand rights and social benefits. There were also important currents of "*dependentista*" structural thought that were much more critical or radical, which advocated the need to mobilize anti-capitalist or socialist revolutionary processes. In synthesis, these "developmentalist" proposals were closely associated with the construction of the state, right from the 1930s and with the social policies following the Second World War.

⁵¹ Haggard & Kaufman, Development, Democracy and Welfare States, *supra* note 26 at 64.

⁵² Mohsen Al Attar, "Third world approaches to international law and the rethinking of international legal education in the 21st century", (Toronto, Dissertation, Faculty of Graduate Studies, York University, 2012) at 3.

This occurred in various countries in Latin America. In Argentina, for example, during Irigoyen's first presidency (1916-1922), and in Mexico during the Cárdenas government (1934-1940), national policies were implemented to encourage economic productivity, increase public spending on infrastructure and improve social services such as education, social security and retirement. These actions could be called populist today, but ultimately they constituted an important economic response for economic and social development.⁵³

In the Chilean case, this model had ups and downs, but it did generate a broad consensus. It was further strengthened during the popular governments, such as that of the Frente Popular (Popular Front) between 1938 and 1941, as well as later on. These Keynesian policies also enabled significant public investment in the economy and the creation of important public corporations such as the production development corporation CORFO (*Corporación de Fomento de la Producción*)⁵⁴ in 1939 and companies like the national electricity company (ENDESA, *Empresa Nacional de Electricidad*), the national oil company (ENAP, *Empresa Nacional del Petróleo*), the Pacific steel company (CAP, *Compañía de Acero del Pacífico*), the national telecommunications company (ENTEL, *Empresa Nacional de Telecomunicaciones*) and the national sugar industry (IANSA, *Industria Azucarera Nacional*). All these companies were later privatized in the 1980s with the implementation of neoliberal policies.

⁵³ Lewis, "Estado, mercado y sociedad", *supra* note 50 at 37-38.

⁵⁴ The CORFO (Corporation for the promotion of economic development) created in 1939.

International influence on development policies and health legislation was no less significant. Developmentalist, populist and socialist policies were criticized and in many cases did not solve the economic and social crises, sometimes even exacerbating them, as in the 1960s and 1970s. In Chile, mixed social policies were not only aimed at protecting the workers, promoting the market and ensuring jobs, but also at responding to the economic and social demands of a growing middle class. This was all made possible by social organizations and union demands.⁵⁵ Important social benefits were also secured, as it was in 1952 with the creation of the National Health Service, the cornerstone of public health, analyzed in detail in chapter two of this dissertation.

It is interesting to note the role that international academic institutions like the German Friedrich Ebert foundation and the U.S. Ford Foundation and Rockefeller Foundation played in these policies. The latter, for example, funded many economics programs at the two main Chilean universities (the University of Chile and the Catholic University), and the number of economists in Chile grew from 120 in the early 1960s to more than 700 one decade later.⁵⁶ The same thing happened in the field of sociology, also with the Ford Foundation, as well as with German and Belgian institutions. International research centres were established in Chile, including most prominently the Latin American Faculty of Social Sciences (FLACSO, *Facultad Latinoamericana de Ciencias Sociales*).

⁵⁵ Al Attar, "Third world approaches to international law", *supra* note 52 at 3.

⁵⁶ Yves Dezalay & Bryant Garth, "Chile: Law and the Legitimation of Transitions.. *supra* note 12 at 27-28.

The move to neoliberalism in the 1980s was also highly influenced from abroad, even though Chile was the first to apply it, even before the Washington Consensus and the neoliberal policies of the Thatcher government in the United Kingdom and the Reagan government in the United States. The strong influence and pressure of the International Monetary Fund and the World Bank⁵⁷ was decisive in this respect, as was the role played by universities in the United States, particularly the University of Chicago,⁵⁸ which was instrumental in the implementation of neoliberal policies in Chile. Morgan, for example, in her analysis of transnational law and universalizing neoliberalism, discusses “how the processes of state regulation are increasingly guided by supranational norms ‘such that a particular form of economic rationality becomes part of the taken-for-granted ways of policy making’ ”.⁵⁹

Along similar lines, the support and close ties between the United States and the armed forces of countries in Latin America, including Chile, paved the way for the coups d’état that disrupted the democracies in the region, imposing authoritarian and dictatorial regimes that allows these models to be advanced. The effects on social and health policies were powerful, shrinking the public sector and stimulating market models for social and public policy, all with the resulting impact and effect on economic policies of accumulation that were

⁵⁷ Lewis, “Estado, mercado y sociedad”, *supra* note 50 at 55.

⁵⁸ In particular the role played by the “Chicago boys”, technocrats inspired by the neoliberal doctrines of Milton Friedman and Harold Harberger, Haggard & Kaufman, *Development, Democracy and Welfare States*, *supra* note 26 at 108.

⁵⁹ Bronwen Morgan, “The Economization of Politics: Meta Regulation as a Form of Nonjudicial Legality” (2003) *12 Social and Legal Studies* 4 at 489-490 [Morgan, “The Economization of Politics”] in Al Attar, “Third world approaches to international law”, *supra* note 52 at 89.

consistent with and instrumental to the neoliberal model, as it was analyzed in detail in chapter three.

4. HEALTH LEGISLATION AND THE ROLE OF THE STATE IN CHILE

Neo-Gramscian analysis examines hegemony as a territory of struggle in which dominant social thought must be constantly articulated and rearticulated at various levels of the social structure.⁶⁰ But ultimately, the concept of hegemony is a concept that expresses a form of domination, which is exercised in different ways, originates lawfully, and is invariably linked to power relations and the power structure in a society. For this reason, it is also essential to discuss how the state acts and reacts in this process in which hegemony is exercised. This is why transitions in health legislation, health reforms and changes to the health care system must be considered in light of broader social, economic and political factors.

Analyzing the evolution of health legislation necessarily involves understanding how legislation is embedded in development processes and social policies. As already discussed social and health policies in Latin America have generally reinforced different mechanisms of redistribution and social

⁶⁰ See Stephen Gill, "Epistemology, Ontology and the 'Italian School'", in Stephen Gill (ed.), *Gramsci, Historical Materialism and International Relations*, (Cambridge, Cambridge University Press, 1993). Mark Rupert, "Alienation, Capitalism and the Inter-State System: Towards a Marxian/Gramscian Critique" in Stephen Gill, *Id.* in P. Barrios, *Liberal Environmental Law and the International Law of Hazardous Chemicals*, (Thesis, Ph.D. Philosophy, University of British Columbia, 2007) at 21. Enrico Augelli & Craig Murphy, "America's Quest for Supremacy and the Third World: A Gramscian Analysis", in Mark Rupert, *Id.* in Gill, *Id.* in Barrios, *Id.* at 32.

stratification, with effects on political and social stability and the reinforcement of public and/or private health care, as well as the direct stimulation of capital accumulation, which in the case of the neoliberal approaches, includes primarily private pension and health insurance systems. Social and health policies have thus been rooted in a relationship between the state and society with social, economic and political characteristics that both influence and determine health legislation.

In fact, social reforms are often ambiguous. In the process of deepening social reforms, we are confronted with a plurality of objectives that correspond to different interests. This process has also a paradoxical, but probably necessary, dialectical nature: it facilitates equity, promotes protection and democratizes society, while also legitimizing the state and a system of power that has created its own inequality and lack of protection. As indicated by Fitzpatrick in relation to the development of the welfare state: “since a welfare democracy would require a more egalitarian distribution of power and resources than exists at present, we need an account of those from whom power and resources would need to be redistributed.”⁶¹

In Chile, like in other countries in Latin America during the 20th century, a state took shape based on the Rule of law (*Rechtsstaat*), that is, a legal state or a state of rights, where the exercise of power is constrained by the law, also emphasizing the concepts of just or what is legally right and in conformity with

⁶¹ T. Fitzpatrick, “In Search of a Welfare Democracy”, (2002) 1 *Social Policy & Society* 1.

that which is lawful or fair. The power of the state was thus limited to protecting citizens from the arbitrary use of authority and guaranteeing the exercise of civil liberties and political rights. Chile, along with Brazil, Argentina and Uruguay, are the countries in the region that gave the state the role of “national project”, and Chile, like Mexico, adopted the practices of an interventionist state with extensive programs of educational reform and the extension of social security and labour legislation. National institutions were therefore created to promote and foster economic development, and programs for social benefits were strengthened.⁶² In Chile, Argentina and Uruguay, this political vision of creating a national state was completed in the 1930s.

The models and transitions of the state in Chile are characteristic of the evolution of a patrimonial state, as a legacy of colonialism. After the depression of the 1930s and the Second World War, the state became gradually consolidated as a strong and interventionist state, enabling the consolidation of a solid Rule of law (*Rechtsstaat*) and thereby promoting economic and social development.⁶³ Given the characteristics of Chilean society, especially its class composition, its past as a patrimonial state and its large social differences, the development of the Rule of law – despite its limitations, ambiguities and injustices – constituted a real possibility for extending rights and gradually promoting greater social justice, neutralizing arbitrariousness and limiting the

⁶² See Jan M. Broekman, “Legal Subjectivity as a Precondition for the Intertwinement of Law and the Welfare State”, in Teubner (ed.), *Dilemmas of Law in the Welfare State*, *supra* note 2 at 40.

⁶³ Dezalay & Garth, “Chile: Law and the Legitimation of Transitions”, *supra* note 12 at 1.

indiscriminate exercise of political, economic and religious power. In a formal, legal and more stable system, power relations are expressed with less intensity than they are under a system with diffuse, unclear or ambiguous legislation.⁶⁴

In the case of health legislation and as discussed above, although health reforms were determined by the dynamics of the power struggle between the classes and social actors and their ability to mobilize their goals and forge alliances to create temporary social consensus,⁶⁵ the state became more interventionist in order to secure emerging social rights.⁶⁶ Consequently, it is the implementation of policies from above (the state) that generated a period of unprecedented economic growth and ensured a standard of living that provided employment and basic social services (health, education, retirement) for the people of the countries that adopted such a pathway. For Fleury, "The concept of social protection in Latin America rested on social and institutional mechanisms of differentiation. Nevertheless, this political give-and-take constituted the first instance in which the demands of the working class were considered in the political arena and incorporated in the government agenda. Social protection was rooted in a political system wherein the state played a key role in the

⁶⁴ See for the account of American Welfare state in relation to the New Deal-era reforms Bill Scheuerman, "The Rule of Law and the Welfare State: Toward a New Synthesis", (1994) 22 *Politics & Society* 2 195-213 at 207.

⁶⁵ Fleury, "Reforming Health Care in Latin America", *supra* note 18. Tedeschi, Brown, et al., "Salvador Allende: Physician, Socialist, Populist, and President", *supra* note 44.

⁶⁶ Fleury, *Id.*

industrialization process by combining industrial protectionism with a controlled political incorporation of urban workers' demands."⁶⁷

5. THE PARADOXES OF THE LAW BETWEEN LEGALISATION AND LEGITIMATION AND THE CHILEAN CASE

The theories of legal realism, which marked the beginning of the emergence of social scientific legal study,⁶⁸ have demonstrated the political nature of the legal process⁶⁹ and recognize, despite their regret, the possibility of the indeterminacy of law. This regret disappears in critical theories such as critical legal studies, in which the indeterminacy of law is not only recognized but accepted: "The rules do not determine results and cannot explain whatever ability legal practitioners have to predicts results."⁷⁰ This is not insignificant, as it is precisely this indeterminacy that gives the law its nature as a political practice, and it is for this reason that for critical legal studies, it is essential to be able to uncover the political implications of the indeterminacy of the law.⁷¹ This is why the law assumes this ambivalent and contradictory identity.

⁶⁷ *Id.* at 2.

⁶⁸ See J. H. Schlegel, "American Legal Realism and Empirical Social Science: From the Yale Experience", (1979) *Buffalo Law Review* 28 459-588.

⁶⁹ See Morton J. Horowitz, *The Transformation of American Law, 1870-1960: The crisis of legal orthodoxy*, (New York, Oxford University Press, 1992) in Neil Duxbury, *Patterns on American Jurisprudence*, (New York, Oxford University Press, 1997) at 103, 263, 307. Jules L. Coleman & Brian Leiter, "Legal Positivism", in Dennis Patterson (ed.), *A Companion to Philosophy of Law and Legal Theory*, (Cambridge, Blackwell, 2010) at 291.

⁷⁰ D. Kennedy, "A semiotics of legal argument", *Law Review*, 1991, 42:75. J.Balkin, "The crystalline structure of legal thought", (1986) 39 *Rutgers Law Review* 1 in Guyora Binder, "Critical Legal Studies", in Coleman & Leiter, *Id.* at 281.

⁷¹ See Duxbury, *Patterns on American Jurisprudence*, *supra* note 69.

This indeterminacy of law became clear in the ongoing political and legal conflict faced by the Popular Unity government. Formally, the law was the same, as it had been enacted by previous governments. Yet in this new and revolutionary historical and political context, it acquired not only different functions, but also conflicting ones. This is why those that had never questioned the legitimacy of the law did so now. It was not feasible to declare the laws illegal, but it was possible to challenge their legitimacy. This situation became critical in the final years of the Allende government, which as we know did not complete its constitutional term of office.

The socialist government declared its commitment to bringing about revolutionary transformations to confront old-fashioned policies that were obstructing the construction of a more equitable, efficient and suitable health system. The government also implemented reforms to increase public involvement in health care, to control the pharmaceutical industry, to encourage citizen participation in health care management and to achieve health care equity by creating a Unified National Health Care Service (SUS).

During the Allende administration, the democratization process deepened, allowing an increasingly stronger presence of popular forces in economic, political and social life. Not only were these popular forces involved in a broad range of claims and political and social issues, but their agenda also consisted of a concrete political program based on transforming the economic system in order to promote social development. The principal objective of Salvador Allende's

government was to implement radical economic and social changes to the capitalist economic model and to establish the foundation for a future socialist society, through the “Chilean way to socialism”. The economic mechanisms for the implementation of this alternative were principally the nationalization of natural resources, the extension of the so-called “social property” sector in the economy—including all state owned companies and corporations—and the acceleration of agrarian reform.

As expected, the new revolutionary program further accentuated the incompatibility between the capitalist economic model and the democratization of the Chilean political system. In short, the coming to power of a coalition of parties and popular movements, including two Marxist parties (the Communist Party and the Socialist Party), combined with the increasing democratization of the political system, further deepened the crisis of capital accumulation. The legal economic measures of the Allende government—such as the nationalization of foreign companies, the nationalization of the entire mining industry, the expropriation or intervention of monopolistic companies, the extension of agrarian reform, the regulation of foreign trade, intervention in banking and distribution networks and substantial wage increases—were redirecting economic surpluses normally collected by capital. Furthermore, the rifts between industrial and financial capital and between national small- and medium-sized companies and national and foreign multinational corporations became even more acute and politically critical.

Due to its minority position in Parliament, the popular government executed its socialist economic and social program within the confines of the 1925 Constitution and under the existing legal system. Some of the most radical reforms were legally legitimized through the unabridged legal texts from the hundred-day “Socialist Republic” in 1932 and the legal faculties associated with the jurisdiction of a presidential regime. This is why Allende’s government was labelled “the revolution in legality”. The same legal system that had legitimized the political control of conservative forces in the past was now instrumental in allowing legal reforms against their economic interests.

In Gramscian terms, for the dominant class that controlled the corporations, the media and strongly influenced the judicial system, the country was witnessing a rupture of the historic bloc.⁷² It was in this context that Allende declared that what hurt the dominant class the most was that the government was fighting the grand bourgeoisie with their own laws. In these circumstances, the role played by the state was extremely critical, as it faced challenges in a struggle for power and control.⁷³ In this sense, the Chilean state had been co-opted by different groups with opposing or conflicting agendas.⁷⁴

For example, this phenomenon was particularly interesting in Chile in the 1970s due to the explicit relationship between the law, the legal system, political factors and the political dynamics themselves. This made the interesting

⁷² Gill, ed., Gramsci, Historical Materialism and International Relations, *supra* note 60 at 56.

⁷³ Jonathan Joseph, “A realist Theory of Hegemony”, (2000) 30 *Journal of the Theory Social Behaviour* 183.

⁷⁴ Jonathan Barton, “State Continuismo and Pinochetismo: The Keys to Chilean transition”, (2002) 21 *Bulletin of Latin American Research* 358.

relationship and contradictions between formality and substance deeper and more transparent in the process of “the law becoming law”. During this historical period, there was an atypical but revealing change in the content and meaning of the law, which led to or made even clearer the contradictions within legal rule itself.⁷⁵ During the three years of Allende’s government, the “ revolution in legality” (called also the Chilean way to socialism) had at its very core the contradictions between the different dimensions of law and their interpretation and/or use.

The formality of law was legitimated no longer as an instrument of the status quo but as an agent of change, while resistance to this made no allusion to the essence of the change itself, but rather to its supposed illegality. Furthermore, the legal formalism of drawing on legal provisions from the 1930s (laid down in another era with different realities) that were instrumental for strategic economic transformations became a *tool for change*. I refer here to the decree-laws, dictated in 1931 and reused in the 1970s that allowed the state to intervene in private companies and put them temporarily under its control. In other words, forty years later, the content or essence of the legal provision (dictated in a different economic and political context) changed without modifying its form (positive formalism), as it was applied in a different context.⁷⁶

⁷⁵ Joan Garcés, *El Estado y los problemas tácticos en el Gobierno de Allende*, (Madrid, Siglo XXI Editores, 1974) at 233.

⁷⁶ *Id.* at 230-233.

In the case of Chile, as indicated above, the notion of respect for legality was valued as an important part of the political tradition, and this legality was the result of historical commitments, both unspoken and formal, to channel economic and social transformations within the Rule of law. In this sense, while the legal system reproduced itself, the origin of this reproduction (or self-reference) was not in the essence of legal formality but in the political agreements that upheld it. As discussed above, in the 1970s, the government of President Allende, which called itself a “revolution in legality,” is undoubtedly the clearest example of the country’s legalist political tradition, even though there was not much in the existing law that could be used within the confines of existing legal legitimacy and tradition.⁷⁷ It is therefore not surprising that the legal revolution led by President Allende was unable to find much legal “inspiration”, despite the long tradition of respect for the Rule of law.

The Rule of law, once instrumental in the exercise of power and its legitimization, was now playing a counter-hegemonic role. Political debate could no longer take refuge in the “neutrality” of the law. The Allende government’s economic and social reforms and the political conjuncture limited the possibilities for social and ideological reproduction, restricted the process of capital accumulation and interfered in the process of legitimation that reinforced the status quo and the capitalist model of development.

⁷⁷ Dezalay & Garth, “Chile: Law and the Legitimation of Transitions”, *supra* note 12 at 39.

If the Rule of law is seen as an ideology that legitimizes and conceals power relations,⁷⁸ it is interesting to see how in the case of Chile, the Rule of law was also instrumental for changing power relations. This created a major legal debate, as the Allende government was implementing revolutionary changes within the same legal order that it had inherited. As it was very difficult and practically unsustainable to oppose the transformations by a government that had been elected fairly and democratically to lead such changes, the opposition addressed the government in legal terms, arguing and debating that it was violating or circumventing the legal system and the Rule of law.⁷⁹ This phenomenon, which in Gramsci's terms can be called counter-hegemonic,⁸⁰ was particularly interesting from the point of view of law and politics. Throughout all the years of the Allende government, the debate about the legality of the government's acts and respect for the Rule of law persisted. The government

⁷⁸ Roberto Mangabeira Unger, *The Critical Legal Studies Movement*, (Cambridge, MA, Harvard University Press, 1986) in John J. A. Burke, "The Political Foundation on Law and the Need for Theory with Practical Value: The Theories of Ronald Dworkin and Roberto Unger" (San Francisco, Thesis, Faculty on Law, University of Fribourg, 1992) at 5-14.

⁷⁹ This political phenomenon was criticized on the grounds that it demonstrated that the law was considered "legal" when it served the interests of the dominant sectors and illegal when it went against them.

⁸⁰ [Counter-hegemony is organized social challenge that eventually replaces the former political order]. Owen Worth, "The Janus-like Character of Counter-hegemony: Progressive and Nationalist Responses to Neoliberalism", (2002) *16 Global Society* 3 at 300. [Neo Gramscian theorist Nicola Pratt has described counter-hegemony as the creation of an alternative hegemony on the terrain of civil society in preparation for political change]. Nicola Prat, "Bringing Politics back in: examining the link between globalization and democratization," (2004) *11 Review of International Political Economy* 2 at 332. [Carroll and Ratner have argued that besides providing alternative hegemony, counter-hegemony offers a viable political alternative backed by a coalition of societal forces], William Carroll & R.S. Ratner, "Between Leninism and Radical Pluralism: Gramscian Reflections on Counter-Hegemony and the New Social Movements," (1994) *20 Critical Sociology* 2 at 3-26l, in Sanjay Ramesh, *Hegemony, Anti-hegemony and Counter-hegemony: Control, Resistance and Coups in Fiji*, (Sydney, Thesis, Ph.D. Philosophy, University of Technology, 2008), retrieved (April 1, 2013)

<http://epress.lib.uts.edu.au/research/bitstream/handle/10453/20249/Whole02.pdf?sequence=2>

repeatedly expressed that the Rule of law was a tangible reality and that legal norms were scrupulously observed and respected. The opposition pointed out that constitutional norms had been breached and that legal norms were circumvented or legal loopholes were used astutely, such as, according to the opposition, had occurred with the nationalization of companies.

The law can thus serve different purposes in different economic, political and historical contexts and has many dimensions that are not unequivocally perceptible, given its synchronic and diachronic aspects. There are laws that have had one purpose and, in a different context, serve different purposes, such as Roman civil law during slavery, for example, which later served the modern ideological purposes of capitalist economic organization.⁸¹ In the case of Chile in particular, these laws from the 1930s⁸² were instrumental for initiating processes of socialist transformation during the Allende government between 1970 and 1973. We can see, then, that the functions of the law are historically contingent; that is, they can fulfill different functions and serve different masters over the course of time.⁸³

Hence, breaking the Rule of law once it was no longer instrumental was, for the opposition, only a matter of time. Put in Gramscian terms, once the crisis becomes extremely delicate and dangerous, radical solutions and “unknown

⁸¹ Spitzer, “Marxist Perspectives in the Sociology on Law”, *supra* note 9 at 118.

⁸² The Salvador Allende government divided the economy into three areas: social, mixed and private. The transfer of large companies to the state was rejected by Parliament, thus the government issued a decree authorizing the expropriation of any industry considered fundamental for the economy. This method was criticized by the dominant economic sectors as a legal loophole.

⁸³ Spitzer, “Marxist Perspectives in the Sociology on Law”, *supra* note 9 at 118.

forces, represented by charismatic ‘men of destiny,’⁸⁴ become visible. Gramsci’s “men of destiny”, or Engels’ “heroes”,⁸⁵ were the Armed Forces, while the unknown forces were no other than the conservative right-wing political parties along with multinational companies and the United States government, represented by the Secretary of State and the Central Intelligence Agency.⁸⁶

6. THE FALL OF THE WELFARE STATE IN CHILE

In Chile, the breakdown of democracy in 1973 appeared as a precondition for the restoration of the factors that would allow the reinstatement of the liberal economic model, earlier threatened by economic changes undertaken during the government of the *Unidad Popular* (Popular Unity). Incremental health reforms were disrupted by the military dictatorship, and the implementation of a new health model that altered the previous reforms and plans challenged the welfare state and opened the way for a neoliberal market model.⁸⁷

⁸⁴ Enrique Peruzzotti & Martin Plot, eds., *Critical Theory and Democracy: Civil Society, Dictatorship, and Constitutionalism in Andrew Arato's Democratic Theory*, (Routledge, 2012) at 25.

⁸⁵ See Frederick Engels, Introducción de “Las luchas de clases en Francia de 1848 a 1850”, in K. Marx & F. Engels, *Obras Escogidas*, (Moscú, Editorial Progreso, 1973). <http://citasmarxistas.blogspot.com/2012/04/el-maestro-engels-sobre-el-uso-de.html>

⁸⁶ The United States Senator Church Report concluded that, while the US had not directly participated in the 1973 coup, it had supported an attempted coup in 1970, and had directed money to anti-Allende elements, including possibly terrorist groups, during the period 1970–1973. Frank Church et al., “Covert Action in Chile”, in *Select Committee to Study Governmental Operations with Respect to Intelligence Activities. Covert action in Chile: 1963-1973*, (Washington, D.C., Government Printing Office, 1975), at 144-209. See also (Biblioteca del Congreso Nacional de Chile), “Intervención de la CIA en Chile”, *611 Servicios Legislativos y Documentales*.

⁸⁷ M. Chossudovsky, “Human Rights, Health and Capital Accumulation en the Third World”, (1979) 9 *International Journal of Health Services* 61. See also M. Taylor, “The Reformulation of

Until 1973, Chile had been a pioneer in Latin America in terms of social policy, developing one of the most universalistic systems on the continent. This rupture of democracy, by means of a military coup, was more significant than a mere tactical action or transitory military solution to restore the “ancient regime”. A true neoliberal economic revolution was in the making, which, given the long-standing and broad societal consensus on maintaining the welfare state, could only be carried out under dictatorial rule. Legality was politicized in the discourses of those who had always predicated the contrary. As Engels had already written in 1895: “...if we are not so crazy as to let ourselves be driven to street fighting in order to please them, then in the end there is nothing left for them to do but themselves break through this dire legality.”⁸⁸

After the coup, the end of civil liberties, the limitation of democratic rights, the end of trade unions and professional associations like the Medical College, the closure of political and partisan activities, the control of the mass media, interventions in university affairs and the burning of critical books—all put in place to prevent any possibility of resistance or opposition—were legitimized with legal and political mechanisms and validated with dictatorial norms, regulations and laws. This way, it was now possible to impose legislation on labour relations, wages, disputes and strikes without the need for a system of negotiations or a consensus between different social actors. The use of violence and political

Social Policy in Chile, 1973-2001. Questioning a Neoliberal Model”, (2003) 3 *Global Social Policy* 21.

⁸⁸ Engels, Introducción de “Las luchas de clases en Francia de 1848 a 1850”, *supra* note 85.

repression facilitated the imposition of new regulations intended to stimulate and sustain the accumulation process.⁸⁹

Legislation included lifting all price controls, allowing the free movement of foreign capital, privatizing most public corporations and companies, liberalizing foreign trade and wage controls and introducing new labour laws. The neoliberal economic revolution that immediately followed the 1973 coup demonstrated how the Chilean Armed Forces took on the “political representation” of monopolistic capital, directly linked to transnational companies. It also revitalized the political interests of conservative forces, which had been neutralized for a decade (since the end of the Alessandri administration in 1964).

In terms of social and health policy, the consequences were dramatic and put an end to Chile’s welfare system. Chile had been considered a pioneer in Latin America in terms of social policy, developing a large universal and inclusive system of social welfare.⁹⁰ The military dictatorship fundamentally transformed the economic, social and political processes, giving rise to radical changes to the social welfare system and eventually the dismantling of the National Health System.

The increased and progressive involvement of the state in public and health-related activities was now replaced with a neoliberal, market-oriented form

⁸⁹ Chossudovsky, “Human Rights, Health and Capital Accumulation in the Third World”, *supra* note 87.

⁹⁰ Carlos Mesa-Lago, *Changing Social Security in Latin America: towards the Alleviation of Social Cost of Economic Reform*, (Boulder, Lynne Rienner, 1994) at 115. Dagmar Raczynski, “Social Policies in Chile”, (1994) *4 Working Papers Kellogg Institute, University of Notre Dame*. Castiglioni, “The politics of Retrenchment”, *supra* note 46

of economic development, with all the social implications that such a shift entails.⁹¹ Under the new model, health care was understood as a commodity or service to be bought. The financial responsibility for health care was left to individuals, who contributed a proportion of their income, leaving the state to support the poor and the blue-collar workers covered by social security.⁹² This innovative version of the “social market economy”, in which the “social” was only in the branding, imposed freedom by denying it to civil society and the political sphere.

As is extensively discussed in chapter three, health legislation was altered in three significant ways: first, in terms of reduction of the public health care funding; second, the creation of private pre-paid health institutions (ISAPRES), mainly for the middle, upper-middle and upper class; and third, the transfer of public health clinics to county (municipal) management, to reduce state bureaucracy and state-financed care.⁹³ These changes minimized the state’s responsibilities and stimulated the development of private health care, health insurance and the pharmaceutical industry. This was a logical step for incorporating health into a liberal economic framework.⁹⁴

⁹¹ Ana María Viveros-Long, “Changes in the Health Financing: The Chilean Experience”, (1986) *22 Social Science & Medicine* 379.

⁹² *Id.* at 382

⁹³ See also J. L. Scarpaci & D. D. Bradham, “A three-tiered Health System and its inherent cost inflation: the case of medical care inflation in Chile 1979-1983”, (1988) *10 Health Policy* 65.

⁹⁴ Barbara & John Ehrenreich, *The American Medical System: Power, Profit and Politics*, (Random House, 1970). M. Livingstone & D. Raczinsky (eds.), *Salud Pública y Bienestar Social*, (Santiago, CIEPLAN, 1976). Nicolás Flaño, “Planificación o mercado en el sector salud enfoque teórico con aplicación al caso de Chile, (1979) *19 Apuntes CIEPLAN*. Ministerio de Salud, *Política Económica y financiamiento de la salud*, (Chile, 1979). Alfredo Bravo, “Sistemas y

These neoliberal reforms changed the relationship between state and society, either by replacing a political logic with market principles or by creating new forms of control and participation.⁹⁵ International financial institutions have played, and continue to play, a significant role in the formation of social policy, particularly in health and pension programs. Social security reforms have been promoted by World Bank loans within a neoliberal framework, in which the market has become responsible for providing health and pensions. Neoliberalism was able to initiate the dismantling of the welfare state and its underlying historical bloc.⁹⁶

Although these reforms were presented as an appropriate strategy for the rationalization and modernization of the health care system (as they were believed to improve efficiency and effectiveness, while reducing cost and bureaucracy), they were criticized for both their inequities and their prioritization of market expansion.⁹⁷ There is little evidence that these reforms have reduced inequities and inefficiencies. It has fragmented health care among social classes, and co-payments represent a heavy economic burden for those with lower

modelos de Organización de Salud" in Hugo Lavados (ed.), First part of *Desarrollo Social y Salud en Chile*, (Santiago, Corporación de Promoción Universitaria, 1980). Peter Ruderman, "Economic Adjustment and the Future of Health Services in the Third World", (1990) *Journal of Public Health Policy*. Viveca Nocvak, "The other Drug Lords", (1993) *23 International Journal of Health Services* 2. N. Bruce, "The Chilean Health Care Reforms: Model or Myth?", (2000) *11 Journal of Public and International Affairs* 69. C. Sapelli, "Risk Segmentation and Equity in the Chilean Mandatory Health Insurance System", (2004) *58 Social Sciences and Medicine* 259.

⁹⁵ Fleury, "Reforming Health Care in Latin America", *supra* note 18 at Chap. 9.

⁹⁶ Giovanni Berlinguer, "Globalization and Global Health", (1999) *29 International Journal of Health Services* 579.

⁹⁷ S. Isaacs & G. Solimano, "Health Reform and Civil Society in Latin America", (1999) *42 Development* 70. S. J. Kay, "The Perils of Private Pensions", (2000) *118 Foreign Policy* 21. Taylor, "The Reformulation of Social Policy in Chile", *supra* note 87. Sapelli, "Risk Segmentation and Equity", *supra* note 94.

incomes.⁹⁸ The model has also reformed social security and private health care insurance in order to stimulate capital accumulation⁹⁹ as a necessary instrument for the development of the private health care sector.¹⁰⁰ The reforms and health legislation introduced since the return of democracy in 1989 have focused on reducing inequalities and establishing a new balance between the private and public health care sectors.

To sum up, the consequences of the end of the welfare health system following the 1973 coup were dramatic, especially in a country considered a pioneer in Latin America in terms of social policy. This restructuring of the welfare state in Chile, as further discussed in chapter three, went through different stages. This first stage, in the 1970s, was to minimize the presence and participation of the state in the health sector and reduce public spending and the second stage, in the 1980s, was to reorganize the state in line with the principles and objectives of a market model, which was advanced with deregulation and privatization policies. This model, like the previous one with respect to social policies, became an international reference point, but this time for its neoliberal and privatizing changes to health and social security.¹⁰¹

Although the objective of this research is not to analyze the post-

⁹⁸ A. Ugalde & N. Homedes, "America Latina: la Acumulación de Capital, la Salud y el Papel de las Instituciones Internacionales", (2007) 3 *Salud Colectiva* 33.

⁹⁹ Patricio Meller, *Adjustment and Equity in Chile*, (OECD, 1992).

¹⁰⁰ Héctor Sánchez, *Análisis evolutivo del Sistema de Salud chileno*, (Universidad de Chile, INTA, 1981). Gary Teeple, *Globalization and the Decline of Social Reform*, (New Jersey, Homsinties Press & Toronto, Garamon Press, 1995).

¹⁰¹ Haggard & Kaufman, *Development, Democracy and Welfare States*, *supra* note 26 at 108-109.

dictatorship periods, especially the final years of the 20th century, I wish to outline a few aspects that deserve attention and that lasted for many years. The privatization process, as pointed out above, affected the health care system and continued to economically constrain the public system, reducing its efficiency, efficacy and performance. The boost to the private system did not undergo significant changes and continued to develop. In some cases, the state ended up discriminating against its own public hospitals in benefit of the private sector, which received better prices for the same services. This created a vicious circle in which fewer resources were given to the public system and then it was made to compete against a private system that received more revenue.

Nonetheless, reforms were implemented to expand public sector services and correct the inequities created by the processes of privatization. The AUGE and GES (*Garantías Explícitas* [Explicit Guarantee]) plans were not intended to modify the system, but they improved it. New pathologies were covered by public services or covered in private institutions with public funding in an effort to establish a new balance between private and public health care providers and revitalize welfare state policies. While it is true that the private sector continued to grow, the Concertación governments' plans advanced very slowly towards the option of a mixed public-private system. Actually the "Chile's health care system was dualistic in its design, with a minority group using the private sector and the

majority of the population relying on public care".¹⁰² The return of democracy, then, in 1989, allowed new legislation to progressively increase support for the public sector and increase the state's involvement in the health sector. The first the Concertación government (1990-1994) and the second one (1994-2000) significantly increased funding for public health care services also initiated adjustments for regulating the private care services as well as the private insurance market.¹⁰³

Paradoxically, what happened in Chile was historically analogous to the destruction of the welfare state in the Weimar Republic in Germany. From the point of view of legal doctrine, it is interesting to note how the state intervenes in order not to intervene and how economic liberalism or neoliberalism re-ideologizes the legal system and dismantles the very foundations of legal liberalism, the foundations of positivism and the Rule of law, essential to the legal and political regime they historically constructed.

¹⁰² Jennifer Pribble, *Welfare and Party Politics in Latin America*, (Cambridge University Press, 2013) at 43

¹⁰³ *Id.* at 46

CONCLUSION

" Art is politics. Everything is politics"
Ali Weiwei

It was only as I finished this research, and really only as I wrote the last lines, thanks to my supervisors' valuable criticisms to clarify my arguments and ideas and refine this dissertation, that I began to close the gap between what I was saying and what I wanted to say. This process of analysis and—why not say so, introspection—brought me into the past.

It was in January 1973 when, as a fresh graduate from the University of Chile's Law School and now a researcher at the Centre for Studies of the National Reality (CEREN), affiliated with the Catholic University in Chile, I was asked to participate in the Executive Committee for the *International Seminar on State and Law in a Period of Transformation*.¹ More than forty law professors, judges, lawyers, intellectuals, members of parliament, ministers and academic researchers from 10 countries were invited to deliver talks and papers to a large audience of participants in the Seminar. Chile was going through a unique political period and was engaged in an important debate on the roles of the state and of law. Salvador Allende's elected socialist government and the coalition of parties that sustained it, Popular Unity, was trying to carry out a social and economic revolution within the parameters of liberal democracy, current legislation and a constitution that went back to 1925. This process was

¹<http://biblioteca.clacso.edu.ar/ar/libros/osal/osal22/APC22Seminarario.pdf>

internationally known as “the Chilean road to socialism”, which was essentially a “legal revolution”.

In this context, those of us who were intellectually associated with law and politically involved in social and economic change could no longer only theorize about law and the state. We were obligated, by the country’s historical circumstances, to address the fundamental problems of the legal and institutional structure. Questions about the law as a guarantor of the status quo and about the state as a reflection of material conditions were not enough. There was a theoretical and legal gap to be addressed, with no historical precedents for our experience. We were learning how to understand, or perhaps to invent, the institutional order as a process and synthesis of modern society.² Our theoretical relationship with law was challenged by politics and by the interaction between politics and law. We learned that these dynamics were essential for understanding law in terms of its creation, its role and its representation.

Months after the International Seminar, the government was overthrown in the military coup, which in addition to the known atrocities committed in violation of human rights, was not only illegitimate but illegal. In a matter of mere days it wiped out five decades of legal institutions, repealing the constitution and taking constitutional power away from the citizens to submit it to a junta of three

² International Seminar on “*Estado y Derecho en un período de transformación*” (Buenos Aires: CLACSO, 2007) Year VIII, Nº 22, September.

generals and an admiral. As Cicerón had said, without a constitution, not only are there bad governments, but also law and the state disappear.³

I have provided explanation of how economic and political variables have shaped different legal changes in the Chilean health system, one that has experienced substantial transformations in health legislation. I have explored how the law and the legal system are embedded in the transformations of the health sphere and analyzed legislation as the outcome of the interface between different stakeholders in the political, ideological and economic process of lawmaking. To sum up, through this case study, I have studied how lawmaking as an expression of politics and as the outcome of processes of negotiation can both maintain the social and political order and be instrumental in promoting social change. In doing this study, I have learned once again that law cannot be invented, nor theorized, nor applied, in abstraction from politics.

This dissertation allowed me to deepen the interdisciplinarity of my research activities. My initial training in law, which continued in sociology and then the political economics of health care, has thus returned to law. It has allowed me to branch out into socio-legal studies and make a contribution to knowledge from this perspective, according to which not only can the law not disregard the society in which it is embedded, but it must be understood as closely related both to society and to its history.

³ José Antonio Vieragallo, *Tiranía y derecho*, *Revista Chile-América*, Roma, 1974, No 3, at 15, in Jorge Witker, "Chile: Constitución y Dictadura", Retrieved from <http://biblio.juridicas.unam.mx/libros/2/847/13.pdf> at 253.

Interdisciplinary research presents difficulties characteristic of contemporary scientific research and its growing specialization, which can limit the understanding of social phenomena. This research, which builds on my interest in interdisciplinary analyses in the social sciences, also allows me to reflect on the importance of investigating the theoretical and epistemological needs of this interdisciplinarity. This undoubtedly entails difficulties, especially since, unlike in the exact sciences, which develop out of dominant or hegemonic paradigms, various paradigms coexist in the social sciences.

This is why further epistemological reflection seems to be increasingly important for developing and legitimating theoretical discourse and developing interdisciplinary syntheses. This interpretation is especially interesting in terms of health care, in a context in which health care systems worldwide are experiencing confounding dilemmas that critically impact both private and public health sectors, making them unsustainable in the face of the significant financial impacts of chronic diseases that accompany an aging population, high demand for pharmaceuticals, and the lack of affordable specialized technology.

Attempting to contribute to research from a kaleidoscopic perspective – analyzing and trying to understand reality in a comprehensive way and at the same time understand its movement and see it from different perspectives – is a significant epistemological challenge. Personally, in the legal field I am interested in further exploring the epistemology of law and globalization, law and politics in

21st-century society and legal pluralism. In the field of health, I wish to pursue research on health care systems and the paradigmatic crises for envisioning the future, requiring us to build knowledge from an interdisciplinary perspective develop a comprehensive analysis of the relationships between health, political economy and epistemology and how they impact the design of health policies, and identify alternative options for emerging health paradigm.

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