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ORIGINAL RESEARCH

Insights from Ecuador's journey towards universal health coverage: Lessons from recent health system reform

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ABSTRACT

Introduction: In 2007, the Ecuadorian government initiated comprehensive social and political reforms aimed at improving citizens' well-being and reducing inequalities. The health system underwent structural changes designed to expand coverage and eliminate financial barriers. This qualitative study therefore examined how key health professionals perceived the facilitators and barriers to implementing the health system reform 2007-2017 to achieve universal health coverage (UHC) in Ecuador.

Methods: Eleven stakeholders directly involved in the reform process were interviewed. Data were analyzed using inductive and latent thematic analysis to identify key themes.

Results: Four interrelated themes shaping the implementation of Ecuador's health system reform were identified: (i) strong political commitment, facilitated the expansion of free services and infrastructure, but was undermined by political interference and financing challenges; (ii) the introduction of a renewed healthcare model rooted in primary care and intercultural principles enhanced access but impeded from inadequate training, weak territorial planning, and limited community engagement; (iii) efforts to reduce system fragmentation through mechanisms like the Comprehensive Public Health Network (CPHN), which improved referral pathways but failed to fully integrate services across public and private subsystems; and (iv) leadership reforms within the Ministry of Public Health sought to strengthen governance; but were hindered by centralised decision-making, high leadership turnover, and weak intersectoral coordination. These findings highlight a dynamic and complex reform process marked by ambitious goals and persistent structural limitations.

Conclusion: Ecuador's 2007–2017 health reform expanded universal coverage by removing fees, strengthening primary care, and promoting intercultural health. Yet, weak referrals, inconsistent implementation, and poor planning limited impact. Political will advanced reforms but created resource imbalances. CPHN reduced some fragmentation but segmentation and weak public–private integration persisted. Leadership changes improved governance foundations, though high turnover and poor collaboration undermined progress. Future reforms require stable governance, clear local roles, stronger community engagement, and greater system integration.

Keywords: Health systems, reform, coverage, qualitative, inequalities, Ecuador.

Abstract in Español at the end of the article

INTRODUCTION

The implementation of health system reforms to achieve universal health coverage (UHC) in Latin America and the Caribbean has long been a challenge [1-3]. Several countries in the region – which have diverse systems for health care, from fully public models to mixed public-private ones – have attempted reforms in the last two decades, with variable results [4,5]. UHC, which is based on Primary Health Care (PHC) principles such as equity, community participation, intersectoral collaboration, and comprehensive care, aims to ensure access to essential health services without financial barriers across healthcare levels [6]. However, no country has yet achieved complete UHC [5,7,8]. Indeed, several reforms have privileged health care marketisation, thus creating barriers in access to services, particularly among socially disadvantaged populations [9-11].

In Ecuador, the National Constitution, renewed in 2008, was the result of a long-term political crisis characterised by intense corruption, weak governance, and economic instability. The new Constitution made health a right guaranteed by the State and linked it to other rights to improve citizens' wellbeing. Several social, health, educational and labor reforms were thus progressively implemented between 2007 and 2017 and framed in a National Development Plan [12].

The Ecuadorian Ministry of Public Health (MoPH) in 2008 began a restructuring of itself following the primary health care principles to transform the health sector by ensuring full and free access to all MoPH services [13]. From this date onwards, several strategies were implemented to expand population coverage and enhance quality care services, particularly in rural areas [14,15]. The free provision of health services established in the constitution generated a greater demand, therefore new infrastructure and workforce were expanded. Comprehensive health care teams at the community level, led by a family physician and supported by a nurse and a primary health care technician, offered increased care and conducted regular household visits. These initiatives reduced waiting times, increased service use, and facilitated early detection of preventable diseases [15]. Likewise, the government also undertook a territorial reorganisation and grouped all 24 provinces into nine coordination zones with programmatic, administrative, and budgetary capabilities to implement the reforms. Local citizen committees were also formed to promote social participation in the health system.

An interinstitutional agreement established in 2011 between public providers created the Comprehensive Public Health Network (RPIS in Spanish: Red Pública Integral de Salud) to optimise coverage and minimise fragmentation and segmentation. The network implementation addressed fragmented services and improved coordination among public providers by reducing duplication and uncoordinated actions. Similarly, free healthcare helped standardise public service delivery for all users, promoting universality and equity in the health system. In 2012, a reoriented comprehensive health care model (MAIS, in Spanish: Modelo de Atención Integral de Salud) focused on promotion and preventive services was officially implemented [16]. Furthermore, recognizing that Ecuador's Indigenous populations often encounter discrimination, language barriers, and limited culturally appropriate health services, the MAIS promoted intercultural medicine combining biomedical care with Indigenous practices, aiming to improve health equity through cultural respect and increased community trust [17].

As a result of these reforms, sensitive indicators moved in a positive direction: financial resources increased progressively each year while poverty rates decreased (the poverty headcount ratio at national poverty line in 2007: was 36.7 and 21.5 in 2017), and the income inequality gap (the Gini index was reduced from 53.4 in 2007 to 44.7 in 2017) narrowed [18]. In terms of health care, the number of consultations increased from 16 million to 45 million during this period, the mortality rate decreased, and the quality of health services improved considerably [19]. However, despite these significant improvements, there was a need to reduce health inequalities more sustainably, as evidenced by sensitive indicators such as HIV rates, immunization coverage, and malnutrition specially in disadvantage social groups [20].

While some studies have evaluated Ecuador's most recent health system reform, showing increased access to healthcare services and certain reductions in social health inequalities [21-23], no research has explicitly examined the diverse forces, factors, and mechanisms that facilitated or hindered the reform's implementation. This study therefore examined how key health professionals perceived the facilitators and barriers to implementing the health system reform 2007-2017 in order to achieve universal health coverage (UHC) in Ecuador.

METHODS

The setting

Ecuador's health system is primarily governed by the public sector. The MoPH covers approximately 65% of the uninsured population directly, while social security schemes, predominantly the Ecuadorian Institute of Social Security (IESS), cover around 30% of the uninsured population. The rest of the population relies on the private sector for health care services [24].

The allocation of resources from the Ministry of Finance (MoF) to the MoPH was partially affected by the reform, since the MoPH submitted funding requests according to programs and projects with defined targets, which the MoF financed in accordance with budgetary ceilings and fiscal revenues. Social security institutions are funded through monthly member contributions [25].

Study design and data collection

This qualitative study was conducted in Quito, Ecuador, between August 2022 and June 2023. Partici-

pants were invited based on their relevant experience within the health system and involvement during the design and/or implementation of the reform. Initially, 13 potential participants were contacted by the principal investigator through e-mail or phone, of which 11 (seven women and four men) agreed to participate; there was essentially equal representation of the public and private sectors among the participants. Interviews were conducted either face-to-face or online (via Zoom) in Spanish (Ecuador's official language). The interview location and schedule were selected by participants; interviews lasted 40-60 minutes. Participants were not compensated for their time.

Contestants were informed on the study's objectives and content before the interviews, as well as measures to guarantee confidentiality and their right to decline to participate. Written consent was obtained from each participant. To provide context, a brief overview of the health system reform process and relevant study findings from 2007 to 2017 were shared. The structured interviews included open-ended questions focusing on facilitators and barriers encountered in implementing the reform, particularly in terms of coordination mechanisms, community involvement, organisational structure, planning, human resources, and financing. Detailed notes and observations of non-verbal cues (discomfort, nervousness, exaltation, annoyance, joy, disappointment) were registered during the interviews for analysis. The interview guide was developed, piloted, and refined by the primary author to ensure the relevance and clarity of the questions (see Appendix 1). Interviews were digitally recorded with participants' consent and transcribed verbatim.

Data analysis

Reflexive thematic analysis using inductive and latent approaches was applied to identify central themes from the raw data [26]. Several steps were taken to address these limitations and ensure the rigor of the findings. Coding was data driven and conducted manually using paragraph interpretation, marginal notes, and highlights in the text of the individual interviews. The coding process was conducted using the original Spanish transcripts, which enabled more nuanced conceptualization and interpretation of the themes. Following the code generation phase, the codes were sorted into initial themes by meaning, concordances, connections, and contributions to the research question. Once the conceptualisation of the topics reached saturation during the analysis stage, no additional participants were incorporated. Specific understandings derived from the raw data were verified with participants during the interviews to ensure accuracy. Additionally, two authors (EQ and MSS) reviewed the transcripts to identify and correct any misinterpretations, overstatements, or errors. Finally, the research group analysed and discussed the initial preliminary themes to define the final domain themes.

RESULTS

We identified four themes, each of which encompassed the facilitators and barriers of reform implementation towards UHC (Table 1). The government's strong commitment to prioritising the health care sector, a revamped health care model focused on primary health care principles, efforts like the RPIS to decrease fragmentation and improve integration, and the MoPH's leadership revival were acknowledged as supportive factors. Conversely, notable constraints included the rise of health policies favouring the health market driven by the private and political sector, insufficient coordination and comprehension among actors and institutions regarding care model to ensure seamless care provision, and an ineffective administrative decentralisation. Each theme is developed below and supported by quotations from the participants that reflect their viewpoints.

Strong political commitment but persistent influence of private and political interests

The interviewees identified government commitment and political will as the key drivers of the reform. The country's favourable economy and ample financial resources also supported implementation. Many noted that significant political resolve enabled structural changes in the health system.

> *"I believe Correa's government took a political decision to strengthen the social sector. Furthermore, the constitutional mandate to allocate resources for health was a crucial element during the reform."* (P1, female)

The government declared a health emergency and allocated funds to improve infrastructure and hire more health professionals. Participants noted that these policies helped to increase access and reduce disparities in health care.

> *"Increased resource allocation to the health sector enhanced service provision. New and upgraded health facilities were established across all levels of care. Hospitals received additional medical equipment, staffing levels were boosted, and the availability of medications and devices improved significantly."* (P3, male)

Some participants also affirmed that the government prioritised health by eliminating financial barriers to accessing essential services. Free of charge access to all MoPH services was highlighted as a fundamental component of the reform.

> *"An important issue was free services; this led to significant access to different health care services and ensured continuity of care."* (P1, female)

However, the interviewees also pointed out that the implementation of free of charge health services should have been gradual based on the availability of resources and with realistic future sustainability.

Table 1. Themes with their facilitators and barriers for the health reform implementation, 2007-2017.

Themes	Facilitators	Barriers
Strong political commitment but persistent influence of private and political interests	• Improving the social sector • Financing to improve services • Free services to improve access • Financing to improve the quality	• Soft/Silence corruption • Demobilization of social organizations • Health market
Good health care model in place but weak implementation	• Model to improve access •Implementing model with resources • Model to prevent diseases Increasing quality in services • Bringing communities closer • Looking for universal coverage • Planning to improve access • Strengthening healthcare services	• Weak territorial planning of services • Persistent medical model • Lack normative health legislation • Lingering bureaucracy • Lack of continuity of care
Innovating coverage mechanisms amid fragmentation	• Innovating to improve access • Reducing health system segmentation • Strengthening governance • Supporting legal framework • Improving efficiency health system	• Lingering weak articulation services • Segmentation increasing inequalities • High segmentation in health systems • Growing healthcare market • Weak organization of healthcare level
MoPH leadership was a struggle for governance	• Implementing two vice ministries • Constitution recovery leadership • Regulatory body in health	• Weak MoPH structure inside and outside • Leaders´ turnover at all administrative levels • Intersectoral actions • Weak information of services

> *"Free of charge was the path that was followed and that is fine. Even so, it should have been accompanied by a definition of what coverage or benefits will be granted to better organise the provision of health services."* (P9, female)

Financial sustainability remained a challenge. Although health sector funding rose during the reform, administrative and routine health activities such as care, community visits, and vaccination campaigns saw little to no budget increase.

> *"I would think that it is not enough to address what must be accomplished: no one likes to address the issues of financing and financial sustainability of the system since they are the most critical."* (P9, female)

Political groups posed another hurdle, as they often interfered with the functioning and stability of the health system. In Ecuador, local politicians commonly sought public administrative roles and insisted on prioritising investments in their regions in return for political backing at the local and national levels. Consequently, the government frequently directed substantial resources to areas or provinces based on the demands of local political parties.

> *"In this case, there was a political impact in deciding where to locate health centres, but the organisation of health services seemed very rational in practice. On the one hand, there was centralism and, on the other, favouritism and political expediency."* (P2, female)

Similarly, participants mentioned how the private sector influenced some public health policies in order to receive financial support. For example, the 0.5% "SOLCA tax" introduced in 2014 for cancer prevention and treatment, provided financial support to private institutions such as SOLCA (Sociedad de Lucha Contra el Cáncer in Spanish), but reduced resources for public hospitals with equivalent healthcare capacity.

Good health care model in place but weak implementation

The renewed health care model was also considered "good" and essential to improve access. Primarily, the model was reoriented to switch from a traditional disease-focused health care delivery to a community, intercultural, and family approach focused on prevention and promotion.

> *"The MAIS brought family physicians into homes. Without a doubt, I visited many houses and went to many neighbourhoods in the rural area."* (P2, female)

Among other benefits, the model sought to enhance social involvement and preventive actions by boosting prevention efforts like vaccination and promoting physical activity. Many low-income individuals viewed these initiatives positively, which led to increased satisfaction and trust in health care services, as noted by one participant:

> "*We had a good friendly process with promotional activities such as plays to address and improve the right to health; we also held health fairs with the population and the municipality.*" (P2, female)

Additionally, the model led to greater investment in infrastructure, catering, equipment, transport which were supported by major investments in new staff. Many health workers, including family doctors and specialists, received targeted training, which allowed to broaden healthcare coverage and services.

> "*There was an urgent need to carry out a project to strengthen human resources, and the project was funded with 242 million governmental funds. Thus, progressively, health care providers were trained.*" (P2, female)

On the other hand, a significant limitation of the healthcare model reform was the restricted timeframe for its implementation. Although it was officially introduced in 2012, following the commencement of broader reforms in 2007, there was only a five-year period allotted for its full implementation. Within these constraints, factors such as inadequate training for healthcare professionals, suboptimal territorial planning, and high staff turnover, hindered the effective adoption of innovative health strategies. Interviewees emphasized that a superficial understanding of the model's objectives represented a substantial obstacle to transforming care approaches and addressing critical health challenges. Despite the model's emphasis on primary health care principles, service delivery remained predominantly oriented towards curative interventions.

> "*I would think that, to date, they (health workers) have not fully understood what the new health care and administrative model are looking for; they do not understand that we are a diverse country to provide services.*" (P7, male)

Furthermore, limited citizen participation in the reform process was identified as another obstacle. Although the so-called Local Health Committees were created during this period, the absence of a genuine connection between social determinants and the health status of individuals, families, and communities meant that collaborative efforts with these committees to shift the focus of the health system towards prevention and health promotion were only partially achieved. A key reason for this was the lack of clarity regarding the real role of users in achieving the model's objectives. Some interviewees pointed out that the health committees only wanted large infrastructure projects in their territories, such as new hospitals and health centres. This generated greater individual visibility for community leaders, reinforcing public trust in the government and providing them with local political capital.

> "*During several meetings with the health committees, I questioned the objectives of those involved in health plans and programs. Their focus appeared to be on gaining political visibility.*" (P7, male)

Innovating coverage mechanisms amid fragmentation

Participants noted that RPIS implementation improved access and reduced fragmentation. The network effectively integrated subsystems, particularly in the public sector, by standardising medical care packages to reduce disparities in the quality of care. Patients also experienced quicker referrals between subsystems, which supported the continuity of care as outlined in the healthcare network agreement.

> "*With the RPIS established in the constitution, fragmentation in health care was eliminated, because the framework agreement forced us to serve people who were not our members.*" (P4, female)

To achieve better coordination and recovery cost of referred patients, purchasing and payment mechanisms based on a fee for service model were implemented within each public subsystem. Payments to both public and private providers underwent a medical-technical and economic audit process to ensure effectiveness and transparency, ensuring that medical expenses incurred by patients were recovered regardless of the public subsystem to which they belonged.

> "*The MoPH created the technical instrument for the sector through the purchase of services between the public and private sectors.*" (P4, female)

However, several challenges limited adequate performance of the reform; for example, participants mentioned the weak coordination between levels (primary and hospital care) and among private and public subsystems. Persistent bureaucratic processes (e.g, paperwork, confirmation of health insurance coverage, delayed referral codes) also limited the continuity of care. Moreover, the RPIS was also recognised to have contributed to the growth of the private sector.

> "*We continue to have a fragmented public health system with few links, so each fragment has a population segment that does not have the same benefits as the others.*" (P6, female)
>
> "*One of the limitations that I have always considered is the fragmentation inside and outside the MoPH, so the reform was impossible to consolidate due to fragmentation.*" (P5, female)

Although the health network was formally designed to eliminate fragmentation, many interviewees highlighted that it persisted in practice, for some this was a step forward, for others it remained as a limitation. Thus, while some actors recognised that efforts had been made to strengthen the three-tiered health care services, they also noted the continued presence of a weak patient referral and counter-referral system within and between levels and sub-systems.

> "*In many places, an enormous effort was made to integrate the first level of care with the other levels of care (hospitals). Even so, a real referral system has not yet been established.*" (P3, male)

MoPH leadership was a struggle for governance

The most relevant issue regarding governance recognised by participants was the role of the MoPH in leading the national health system. During the reform, two vice ministries (Governance and the Comprehensive Care Delivery Services) were created to strengthen the Ministry's leadership capacity. The first aimed to improve the quality of services and regulatory bodies in the health sector, while the second focused on access, delivery, and coordination between health care levels.

> "*Basically, in talking about the MoPH, it seems that there was quite an effort to strengthen the MoPH as rector of the National System; I believe that the Ministry's leadership was strengthened, which was an essential step.*" (P3, male)

However, several barriers were identified in this area. Centralised decision-making, particularly within the MoPH, constrained administrative autonomy in the territorial model implementation. This hierarchy also led to frequent personnel changes in management roles at both the local and national levels, including health ministers, which caused continuous delays in programme and policy implementation.

> "*Regarding changes in personnel and ministers, this was a problem with the different administrations, because it became a limitation that did not guarantee the continuity of the programmes and the model implementation.*" (P10, male)

Participants emphasised the need for the MoPH to have a greater role in addressing social determinants of health at the local level in coordination with municipal governments and through robust community participation. While one strategy involved establishing local health committees with community leaders and users, participants noted the unclear objectives and connections with social organisations, which were often manipulated for political purposes. Additionally, the failure to implement intersectoral actions with other ministries was recognised as a constraint in tackling major public health issues.

> "*It had to be articulated with local governments (municipalities, parish councils); they provide drinking water, sewage and garbage collection, reducing disease among the population.*" (P1, female)

DISCUSSION

This qualitative study explored the facilitators and barriers to achieve UHC by the latest health system reform (2007-2017) in Ecuador. While similar reform processes in the Latin America and the Caribbean region have induced positive changes in terms of coverage, it is important to reflect on the strengths and weaknesses to encourage more effective implementation [27]. Our results identified themes involving facilitators and barriers related to political commitment, structural changes, coverage challenges, and governance leadership of the public agenda.

The strong political commitment during the reform period, which facilitated its effective implementation, has been emphasized in other studies [28]. During this time, the government significantly increased the health budget, enhancing the supply and infrastructure of health facilities and eliminating out-of-pocket payments at the point of care. Additionally, other studies have highlighted a notable increase in domestical general government health expenditure as a percentage of GDP, which rose from 1.86% in 2006 to 4.61% in 2016 [29]. However, the proposed financing model proved to be unsustainable due to the significant overutilization of services and the reliance on government revenues from oil sales to fund these activities. Consequently, alternative purchasing and payment mechanisms should have been considered [30]. Furthermore, other studies have suggested that the government leveraged its political commitment to enhance political party legitimacy and maintain control over the electorate [31,32].

The renewed healthcare model, offering free-of-charge services, was another key policy that improved access and reduced patients' costs, particularly for vulnerable groups. Studies have demonstrated that disadvantaged populations can quickly benefit from such policies, leading to significant improvements in their health status [33,34]. However, community-based research and demographic surveys have also revealed that missed doctor appointments and unavailable medications can increase out-of-pocket expenses and catastrophic health expenditures, particularly in rural and uninsured households [35]. Similarly, our findings, along with other studies, highlight tensions between the government and social organizations, especially among farmers and indigenous groups [36]. The literature suggests that reform initiatives deeply connected to community leadership and incorporating broad social participation enhance healthcare utilization, particularly among the most disadvantaged social groups [37].

Our findings indicate that the implemented health model played a pivotal role in reducing system fragmentation by enhancing access to public and private services, regardless of the subsystem to which users belonged, in alignment with the principles of universal health coverage (UHC) [38]. While many interviewees acknowledged the persistence of fragmentation due to the presence of multiple subsystems, the MoPH intro-

duced numerous technical regulations aimed at progressively lowering barriers to access [39]. For instance, a 2014 study reported that Ecuador had moderately reduced systemic fragmentation through the coordination and standardization of health packages and the provision of information on health insurance status to facilitate patient referrals between the MoPH and the Ecuadorian Institute of Social Security [14]. However, challenges remained, including the need to reduce the number of public-sector insurance entities, implement effective cost recovery mechanisms, and ensure operational access to health services. Furthermore, other national studies have highlighted that private hospitals and health insurance companies accrued significant economic benefits from patient referrals from the public to the private sector [40-41].

The persistent centralized and hierarchical structure of the government constrained the effective implementation of these policies by the MoPH. Decision-making authority remained concentrated at the national level, while bureaucratic processes hindered the capacity of decentralized zonal and district entities. Consistent with findings from other studies, these limitations may have contributed to ongoing social inequalities in the provision of health services [9]. On a more positive note, our findings emphasized that ministerial leadership was revitalized following the adoption of the 2008 National Constitution. Nevertheless, an inadequate legal framework continued to restrict the MoPH's ability to improve performance in critical areas such as access, financing, and sustainability.

This research presents both strengths and limitations that warrant acknowledgment. First, the close professional ties of the primary author with some participants facilitated their willingness to participate in interviews—a task that is typically more challenging for external researchers. This rapport also encouraged a higher level of openness from the interviewees, enabling them to freely share their thoughts, emotions and insights about the analysed period. However, it is important to note that the interviews involved only national actors who were closely working at the Ministry of Public Health (MoPH) during the reform period, which could introduce a bias toward supporting the Ministry's initiatives while potentially overlooking alternative perspectives. Additionally, some participants may have exercised caution and discretion in expressing their views due to their involvement in the reform process and their familiarity with the primary author. Furthermore, as the study focused on the period from 2007 to 2017, subsequent events may have influenced the interviewees' responses retroactively. At the same time, the participants´ perception of the reform may have been influenced by recall bias. Finally, the inclusion of both male and female stakeholders from diverse roles within the reform process helped balance gender perspectives and provided a range of viewpoints.

Conclusion

Ecuador's 2007–2017 health reform advanced universal health coverage by abolishing user fees, expanding primary care, and introducing an intercultural health model. However, its impact was limited by inconsistent implementation, weak referrals, fragmented planning, and resource allocation bias. Governance reforms laid important foundations, but high leadership turnover and limited intersectoral collaboration constrained sustainability. These findings underline the need to consider both facilitators and barriers when pursuing health reforms. Political will can drive change, yet accountability mechanisms are essential to safeguard equity goals against political and financial interests. Free service provision should be phased in line with available resources, while stronger coordination among stakeholders and greater community engagement are critical for success. Future reforms must adopt a comprehensive approach that consolidates achievements, addresses persistent challenges, and strengthens governance to ensure equitable and sustainable progress toward universal health coverage.

DECLARATIONS

Publication Consent

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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Author contributions

EQ proposed the main research idea, and together with MSS, conceived the study. EQ analyzed the data, with support from MSS and CM. ET and AMPB commented on the results and discussion. EQ drafted the initial manuscript, and all authors reviewed and approved the final version.

Data availability

Anonymised transcripts of the qualitative interviews can be provided by the corresponding author upon reasonable request.

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Ethical approval

The San Francisco of Quito University ethics committee approved the ethical application (code CEISH-USFQ: 2022-058TPG). Written informed consent was obtained from all participants prior to the interview.

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ABSTRACT IN SPANISH

Perspectivas del camino de Ecuador hacia la cobertura universal de salud: Lecciones de la reforma reciente del sistema de salud

Introducción: En 2007, el gobierno ecuatoriano inició amplias reformas sociales y políticas orientadas a mejorar el bienestar de la ciudadanía y reducir las desigualdades. El sistema de salud experimentó cambios estructurales diseñados para ampliar la cobertura y eliminar las barreras financieras. Este estudio cualitativo examinó cómo profesionales de la salud clave percibieron los facilitadores y obstáculos para la implementación de la reforma del sistema de salud 2007–2017 con el fin de alcanzar la cobertura universal de salud (CUS) en Ecuador.
Métodos: Se entrevistó a once actores directamente involucrados en el proceso de la reforma. Los datos se analizaron mediante un enfoque temático inductivo y latente para identificar temas clave.
Resultados: Se identificaron cuatro temas interrelacionados que moldearon la implementación de la reforma del sistema de salud en Ecuador: (i) un fuerte compromiso político que facilitó la expansión de los servicios gratuitos y la infraestructura, pero que se vio debilitado por la interferencia política y problemas de financiamiento; (ii) la introducción de un modelo renovado de atención sanitaria basado en la atención primaria y en principios interculturales, que mejoró el acceso, pero se vio limitado por la falta de capacitación, una débil planificación territorial y una participación comunitaria insuficiente; (iii) los esfuerzos para reducir la fragmentación del sistema a través de mecanismos como la red pública integral de salud (RPIS), que mejoraron los circuitos de referencia pero no lograron integrar plenamente los servicios entre subsistemas públicos y privados; y (iv) las reformas de liderazgo en el Ministerio de Salud Pública que buscaron fortalecer la gobernanza, pero que se vieron obstaculizadas por la toma de decisiones centralizada, la alta rotación de autoridades y la débil coordinación intersectorial. Estos hallazgos evidencian un proceso de reforma dinámico y complejo, marcado por metas ambiciosas y limitaciones estructurales persistentes.
Conclusiones: La reforma sanitaria en Ecuador (2007–2017) amplió la cobertura universal al eliminar tarifas, fortalecer la atención primaria y promover la salud intercultural. Sin embargo, las debilidades en los sistemas de referencia, la implementación inconsistente y la escasa planificación limitaron su impacto. La voluntad política impulsó los avances, aunque generó desequilibrios en la asignación de recursos. El RPIS redujo parte de la fragmentación, pero la segmentación y la débil integración público-privada persistieron. Las reformas de liderazgo mejoraron las bases de la gobernanza, aunque la alta rotación y la escasa colaboración intersectorial socavaron los resultados. Futuras reformas requieren gobernanza estable, roles claros para los actores locales, mayor participación comunitaria e integración efectiva del sistema de salud.

Palabras clave: Sistemas de salud, reforma, cobertura, cualitativa, desigualdades, Ecuador.

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