1

States or Markets? The Reform of Health Insurance in Chile, 1981–1994

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This paper analyzes the creation of private health insurance funds in Chile between 1981 and 1994. It describes the dual-track health care system which has emerged in Chile over the course of the last decade, and assesses the implications for equity, access, efficiency, and cost control. The paper then outlines three alternative sets of reforms for the provision of health insurance in Chile.

Over the course of the last decade, efficiency in the provision of services has often been taken to mean a reduction in the role of the central government. Worldwide, the public sector has come under assault for its inefficiency, rent-seeking behavior, and corruption. Demands to restructure the public sector "so that it runs more like a business" have proliferated. This new emphasis runs counter to much of the received wisdom in less developed countries. Indeed, services such as basic education and basic health had been loosely termed "public goods" for decades—and the central government had been regarded as the most efficient provider of both. And yet, encouraged by donor organizations and by some in the academic community, many countries have scaled back the role of the central government in the education and health sectors.

This paper analyzes one such transformation: the creation of private health insurance plans begun in Chile in 1981. This reform of the health sector in Chile was not an isolated occurrence. Rather, the privatization of health insurance was part of an all-encompass-

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ing attempt to redefine the fundamental tenets that had guided the Chilean economy for decades. Encouraged by the neoliberal recipes of the so-called "Chicago Boys," the military junta which ruled Chile between 1973 and 1990 deregulated the economy, freed up prices, slashed tariffs, and seriously cut back the role of the central government in the provision of education, health and nutrition, pensions, and housing.

Reforms in the health sector had two main thrusts. First, the provision of basic health was decentralized: municipalities were made responsible for the delivery of most primary services, while the central government continued to provide the bulk of the revenues (Heyermann 1994). This, it was argued, would bring about improvements in internal efficiency and accountability. Second, the government encouraged the participation of the private sector: private insurance companies, the Instituciones de Salud Previsional (known in Chile by their acronym as ISAPREs), were allowed to collect the 7 percent payroll tax which all Chileans have to pay for health services, and to insure the public directly; large companies could also run private insurance plans limited to their own employees. This, it was believed, would foster competition and further improve efficiency. By the mid-1980s the reforms had "transformed Chile's health-care system from a centralized public-operated one to a decentralized one allowing for private sector participation" (Castañeda 1992, 68).

This paper focusses on the second aspect of these reforms: the creation of private health insurance plans. The paper is divided into four sections. The first section gives a brief description of the financial flows in the public and private health sectors in Chile as they stand today. The second analyzes the implications of the Chilean system for equity, access to health care, efficiency, and cost containment. The third gives an account of the changes in the health-care market effected by the democratic government of Patricio Aylwin between 1990 and 1994, and assesses the efficacy of these minor reforms. The concluding section outlines two alternative strategies for the provision of health insurance in Chile.

Financial Flows in the Health Sector in Chile

Chile operates a dual-track health insurance system. All employed or pensioned Chileans must contribute 7 percent of their payroll toward health insurance for themselves and their dependents. This

payroll tax is collected by a state collecting agency, the Fondo Nacional de Salud (FONASA), which disburses funds to insurers in the private sector, or to health providers in the public sector.

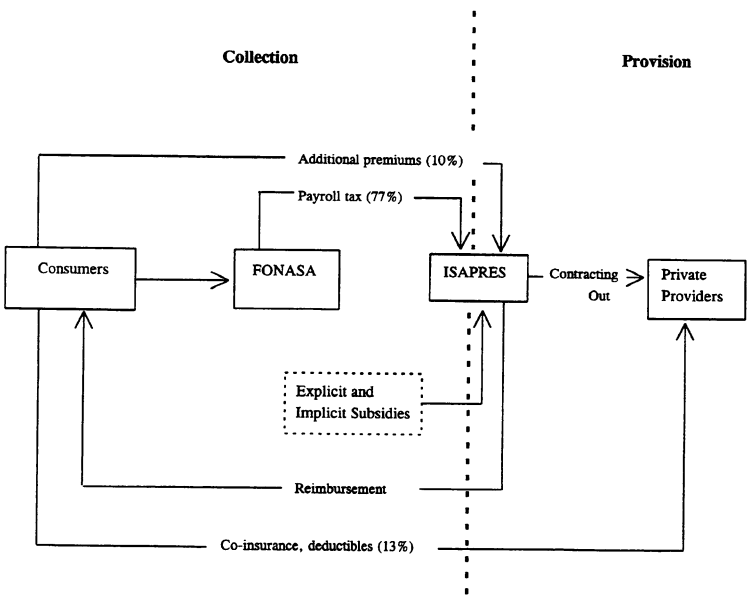
Private Sector

As Figure 1 shows, ISAPREs collect funds through three "pipes."[1] First, when consumers enroll in a private insurance plan, FONASA transfers the 7 percent payroll tax to the relevant ISAPRE. This is therefore the effective minimum that an ISAPRE can charge its members. The lion's share of ISAPREs' revenues (77 percent) comes from the payroll tax. ISAPREs can supplement this with additional premiums (10 percent), and a combination of copayments and deductibles (13 percent) (Oyarzo 1992, 10).[2] In addition, ISAPREs receive various explicit and implicit subsidies from the government.

ISAPREs disburse these funds by providing medical services directly with their own doctors, by contracting out services to doctors with whom they have an agreement, or by reimbursing their members for a visit to a doctor of their own choice. ISAPREs

FIGURE 1

REVENUE FLOW: PRIVATE SECTOR



Note: percentages are a proportion of total revenue flows in the private sector

vary wildly with respect to the price of their insurance package, the services they offer, and the method of health-care delivery.

Public Sector

As Figure 2 shows, FONASA collects money from two pipes to pay for the provision of health for those not enrolled in an ISAPRE: the 7 percent payroll tax (45.4 percent of the total flow of revenues in the public sector), and treasury allocations (another 40 percent). Another 13.9 percent of revenues flows from consumers directly to the providers of medical services in the form of copayments (Oyarzo 1992, 8).

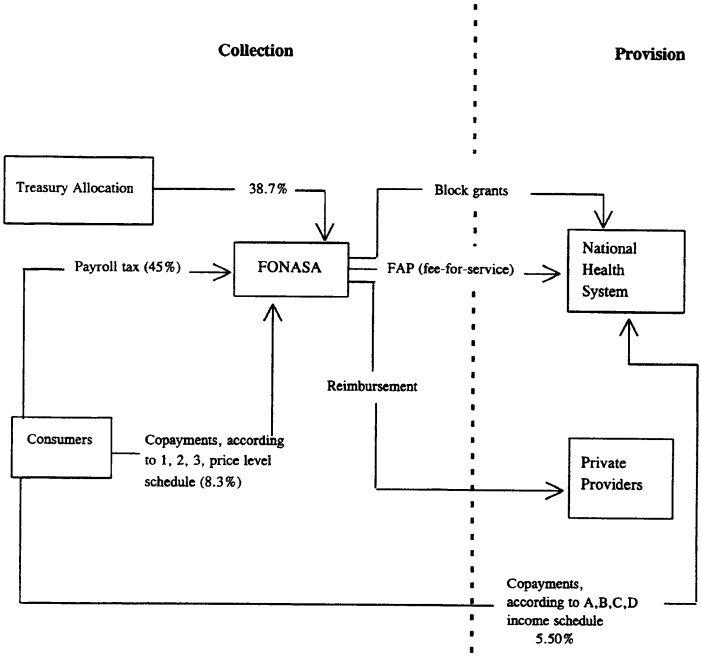
Chileans who do not belong to an ISAPRE may rely directly on the National Health System (NHS), or they may visit a private doctor of their choice under the Preferred Provider System (PPS). In either case, FONASA covers only part of their medical costs. Consumers must pay the rest directly.

The system which establishes copayment levels for the NHS and the PPS is quite complicated. Patients serviced by the NHS are assigned to one of four income brackets: income bracket A (for the indigent), B (for those employed at the minimum wage or less), C (for those who earn less than one and one-half times the minimum wage), and D (those who earn more). For patients in income brackets A and B, there is no copayment; for those in income bracket C, copayment is 25 percent; and for those in income bracket D, copayment is 50 percent (Castañeda 1992, 80–84).

Copayment levels in the PPS also vary—but according to the doctor visited, rather than the patient's income. All doctors servicing PPS patients in Chile must choose one of three price levels fixed by the Ministry of Health and must then adhere to it for all of their transactions: level 1 (a base), level 2 (the base plus 30 percent), or level 3 (the base plus 60 percent). Patients in the PPS receive a voucher from FONASA before visiting a doctor and use this voucher to pay for part of their medical services. Out-of-pocket payments for a voucher are 50 percent for services performed by a level-1 doctor, 60 percent for a level-2 doctor, and 69 percent for a level-3 doctor (Castañeda 1992, 84–86). By making copayments a function of the physician's price level, the PPS is set up to discourage the use of more expensive doctors.

FIGURE 2

REVENUE FLOW: PUBLIC SECTOR



Note: percentages are a proportion of total revenue flows in the public sector

The provision of health in Chile is thus highly fragmented. In 1990, 15.1 percent of Chileans were covered by an ISAPRE, 68.7 percent used the NHS, and 12.1 percent used the PPS; the remaining 4.1 percent were covered by special regimes, such as that which insures the armed forces.

Equity, Access, Efficiency, and Costs in the Chilean Health System

Equity

Uwe Reinhardt has predicted that the United States will eventually move to a three-tiered health-care system: well-to-do Americans in the top tier will enjoy unlimited access to medical services on a fee-for-service basis; the middle classes in the middle tier will increasingly be enrolled in capitated health maintenance organiza-

tions; and the poor and near-poor in the bottom tier will be relegated to under-funded public hospitals (Reinhardt 1994a). In Chile the method of delivery may be different, but a three-tiered health system is well on its way: the upper and upper-middle classes are enrolled in the ISAPREs; white-collar workers tend to use the Preferred Provider System; and blue-collar workers and the indigent have no choice but to remain in the National Health System.

As Table 1 shows, the ISAPREs have segmented the market by income level. Over 80 percent of Chileans in the lowest two income quintiles, but only 37.2 percent of those in the highest income quintile, were enrolled in the NHS in 1990. Conversely, only 2.5 percent and 5.4 percent of Chileans in the lowest and second-lowest income quintile, respectively, were insured by an ISAPRE, as compared to 44 percent of those in the highest income quintile.

Table 1: Form of Health Coverage by Income Quintile, 1990

Income quintile (by households)	National Health System	Preferred Provider System	ISAPREs	Other	Total number of beneficiaries
1	84.5%	10.3%	2.5%	2.6%	3,080,425
2	80.5%	11.1%	5.4%	3.0%	2,857,388
3	71.3%	13.7%	11.1%	3.9%	2,595,618
4	58.6%	13.4%	22.3%	5.7%	2,293,510
5	37.2%	12.7%	44.0%	6.1%	2,083,006
TOTAL	68.7%	12.1%	15.1%	4.1%	12,909,947

Source: Ministry of Planning, 1991

It should come as no surprise that, in 1992, 16 percent of the population (those enrolled in an ISAPRE) used 43 percent of the resources spent on health care, while 84 percent (those enrolled in the NHS or the PPS) used 57 percent of the resources. Put differently, each member of an ISAPRE spent four to five times as much on health care as did each member of the public health system (Oyarzo 1992, 35). The private sector in Chile offers quality service, modern technology, and the health-care amenities one might find in a wealthy country. By contrast, the public sector uses outdated, run-down equipment, and provides poor quality service. Public hospitals suffer from serious under-investment: the Chilean Minis-

try of Planning estimates that around 5 percent of the yearly health budget should go toward investment "under normal circumstances"; on average, that figure was barely 2.4 percent in the 1980s. Now, an estimated US $77 million is necessary to bring hospitals in the NHS back to working order (Mideplan 1991a, 66–67).

Health care in the public sector is rationed by monetary and nonmonetary means. Queues are prohibitive, and patients may be denied health care outright. Copayment levels have gone up in the NHS—because services were free before 1986, regardless of income—and in the PPS—because fee schedules have not kept up with inflation, and doctors have compensated by moving up price levels (Oyarzo 1991, 70–71)[3] recent government attempts to extract even more copayments from patients in the NHS would be one more step toward stricter rationing. This may all be evidence of "the successful transfer of costs from the public sector to the private sector" (Ardito-Barletta, preface to Castañeda 1992). It is also, however, making it more and more difficult for the poor and the near-poor to receive even a minimum level of health care.

Before the reforms of the 1980s, the Chilean health-care system was redistributive. The mandatory 7 percent payroll tax ensured that the wealthy paid more for their health care than the poor. The creation of the ISAPREs fundamentally changed this relationship: it provided those who "overpaid" with an incentive to leave the public sector, while those who "underpaid" had an incentive to stay. Ironically, what cross-subsidization is now left in the system (other than that represented by the shrinking proportion of FONASA's revenues, which comes from the general government budget)[4] transfers resources from the middle classes to the poor. The Chilean Ministry of Planning has estimated that income brackets C (those who are making less than one and one-half times the minimum wage) and D are net contributors to FONASA; that is, they pay more for health care than they consume (Mideplan 1991a, 66). A system in which the lower-middle classes are evermore burdened with the costs of others' health care, whereas the wealthy are not, can hardly pride itself on being equitable.

Access

Access to health care is hard to measure directly. Occasionally, data from surveys in which consumers themselves report on "access" can be used (Freeman et. al. 1987) More often, access is

proxied by a measure of frequency (such as the number of visits to a physician per capita), or a measure of output (such as the health status of the population).

Both the total number of visits to a doctor and the total number of hospital days have risen steadily since the creation of the ISAPREs (Oyarzo 1992, 23–25). But here too there are substantial differences between the private and public sectors. In 1987 ISAPRE members paid an average of 3.73 visits to a physician, as compared to 1.56 for those covered by the public sector. ISAPRE members were also three times as likely to have surgery, and three times as likely to be admitted into a hospital—though the average length of hospital stay was much shorter for those enrolled in an ISAPRE (Jiménez de la Jara 1990, 390); furthermore, these figures do not take into account the quality of the care received, which was surely lower in the public sector than in the private sector.

Numerous indicators show that the health status of the Chilean population improved substantially during the 1980s. Life expectancy at birth increased by ten years between 1970 and 1988; infant mortality fell from 74 deaths per 1,000 live births in 1973 to 20 deaths per 1,000 live births in 1987; and the profile of Chilean mortality changed from that found in most less developed countries, with a preponderance of waterborne and infectious diseases, to that found in industrialized countries, with most deaths due to cardiovascular diseases, cancer, and accidents (Castañeda 1992). It is not clear, however, to what extent these reductions are a result of improved nutrition and sanitation, of targeted programs to improve prenatal and infant health, or of privatization per se. It is, therefore, hard to make a definitive statement about the effect that the creation of the ISAPREs has had on access to health care in Chile.

Efficiency

Privatization of service delivery is often regarded as a way of increasing efficiency. Indeed, much of the rationale for the reforms carried out in Chile was that the health sector suffered from all of the inefficiencies associated with a monopolistic, publicly-operated system: low worker productivity, suboptimal mix of inputs in production, lack of technological innovation, and limited accountability because of the absence of alternative providers. It was thought that these shortcomings would be solved with the introduction of private health insurance plans (Miranda 1993, 8).

The reforms of the 1980s almost certainly improved efficiency on some of these counts. These efficiency gains have been stressed by many observers, and it seems pointless to reiterate them once again. Notably, however, consumer dissatisfaction in 1993 was almost as widespread among those serviced by an ISAPRE as it was among those serviced by the National Health System (Centro de Estudios Públicos 1993). In addition, the reforms introduced a multitude of new flaws into the Chilean health care system.

Mandatory Payroll Tax

Once the mandatory 7 percent payroll tax ceased to function as a system of cross-subsidies from rich to poor, and from healthy to ill, it lost much of its raison d'être. Specifically, the payroll tax has become a source of inefficiency on two counts. First, many consumers in the ISAPRE system are forced to overinsure. Given that they have to disburse 7 percent of their income for health insurance, Chileans opt for the plan that most closely matches their contribution; had they been free to decide how much insurance to buy, consumers might have chosen less. Indeed, the mandatory payroll tax encourages the well-off to insure even against predictable, low-cost medical expenses (such as dental work or eyeglasses), a form of insurance which is generally thought to be inefficient. Second, when an individual enrolls in a private insurance plan FONASA automatically transfers his or her payroll tax to the relevant ISAPRE; if the price of the plan is less than the amount transferred, the ISAPRE keeps the difference (Jiménez de la Jara 1992, 143). Such institutionally protected economic rents have allowed ISAPREs to keep administrative overheads above 20 percent of total costs (Sánchez 1990, 420), while making profits of about 20 percent per year as well—where profits are defined as after tax-earnings divided by capital and reserves (Trabajo de Asesoría Económica al Congreso Nacional 1992). Put differently, the proportion of premiums paid by consumers in the ISAPRE system, which is actually used for the production of medical outputs—the so-called medical loss ratio—has hovered around 70 percent. High administrative costs and persistently high profit levels are both a source of inefficiency, which can only be justified if for-profit health insurance leads to substantial savings elsewhere (Reinhardt 1994b, 117).

Tax-Exempt Status

Contributions by employers and individuals to ISAPRE premiums above and beyond the 7 percent mandatory payroll tax are tax-exempt. This has also encouraged overconsumption of health. Since ISAPRE members are generally in a higher income quintile than those serviced by the public sector, such favored tax treatment is inequitable as well.

Transparency

It has often been pointed out that consumers of health care in a competitive market are faced with a bewildering array of plans with different premiums, different deductibles and copayment rates, and wildly different benefits packages. At best, this is an "information cost" for consumers; at worst, it makes the concept of "consumer choice" meaningless. Most consumers do not even understand much of what is specified in a health insurance contract. This is certainly the case in Chile, where the absence of a standard package of benefits keeps consumers of health care from making rational choices based on reasonably good information. Matters are made worse by the fact that every ISAPRE tries to tailor a particular benefit package to each individual consumer, to allow him or her to spend as close to the 7 percent payroll tax as possible (Sánchez 1990, 425–26).

Lack of Coordination between Sectors

Only recently have ISAPREs been allowed to contract for services with the public sector (Oyarzo 1992). Previously, they had to use their own facilities, or they had to come to agreements with private hospitals or doctors. This deprived the public sector of a valuable source of revenue; it also led to a duplication of structures, and to the underutilization of public hospitals in many parts of the country (Castañeda 1992).

Market Segmentation

Biased risk selection is the most flagrant source of inefficiency in the Chilean health-care system. When the ISAPREs were created, no legislation was written to force them to insure particular individuals or groups. By law, the state was "an insurer of last recourse" (Miranda 1993, 7). This allowed the ISAPREs to segment the market, skimming it for good risks and leaving bad risks to the public sector.

Indeed, since ISAPREs could legally terminate contracts at the end of each year, they often insured people when they were young and healthy, and refused to do so when they were older or chronically ill (Trabajo de Asesoría Económica al Congreso Nacional 1992). This was a particularly galling state of affairs, since those dumped onto the public system had not contributed to the public health coffers during their active years.

In 1990 only 3.4 percent of those enrolled in an ISAPRE were 60 years or older, as compared to 11.2 percent of those enrolled in the public sector. Also, the proportion of dependents per salaried worker or retiree in that same year was much higher in the public than in the private sector; this was due both to different demographic characteristics among income quintiles, and to the fact that ISAPREs often set higher premiums for those with numerous dependents (Mideplan 1991b, 19). Until 1986 most ISAPREs would not even insure women of childbearing age. This changed only when the government decided to pay for maternity leave, and pre- and postpartum care for all women (Castañeda 1992, 101). Since governmental transfers were computed on the basis of income, 62.5 percent of them were given to women in the highest income quintile, and only 1.8 percent to women in the lowest income quintile (Mideplan 1990, 184–86). To make matters worse, these funds came directly out of FONASA's budget, so that only those enrolled in the public health system had paid for them (Mideplan 1991a, 66). Government intervention on this count has therefore been highly regressive.

To summarize, it would be difficult to measure whether the reform of health insurance in Chile in the 1980s led to an efficiency gain or to an efficiency loss. The creation of the ISAPREs did introduce many new sources of inefficiency—many more, perhaps, than had originally been anticipated. This should be a caution to those who hail private health insurance as an unambiguous step toward greater efficiency.

Cost Containment

Containment of health-care costs is much less of a concern in Chile than it is in OECD countries. Some estimates have concluded that health-care expenditures in Chile have remained roughly constant as a proportion of GNP over the course of the last decade (Oyarzo 1991, 60). The World Bank has written, however, that

"escalating health spending" in Chile could soon "crowd out other sectors of the economy" or "raise the cost of labor" to a point where it threatens the country's international competitiveness (World Bank 1993, 122).

If this is true, cost escalation has certainly been driven by the private sector. Between 1980 and 1990 real per capita costs in the public sector went down. Meanwhile, real per capita costs in the ISAPRE system went up by 27 percent between 1986 and 1990 (Oyarzo 1992, 33). This should hardly be surprising, given that there is very little incentive for the ISAPRE system to contain costs. ISAPREs service the upper echelons of the health-care market, where insurance premiums are mandated to be high by law; closed ISAPREs can reasonably assume that health-care premiums above the 7 percent payroll tax will be passed off to employees in the form of lower wages; deductibles and copayment levels in the ISAPREs are low—as mentioned previously, they account for only 11 percent of the financial flows in the ISAPRE system as a whole; and finally, physicians who have an agreement with an ISAPRE are reimbursed on a fee-for-service basis—this allows physicians to induce demand, and tends to encourage overconsumption of health.

It has often been said that a publicly operated health-care system can contain costs more effectively than a system of private insurance (World Bank 1993, 122). As it stands now, the ISAPRE system in Chile seems singularly incapacitated to deal with the issue of rising costs. It would be most inequitable, however, if the problem of cost control were to fall exclusively on the public sector, simply because it is better equipped to handle it. That would only further aggravate the already alarming quality differentials between the private and public sectors.

The 1990s: Perfunctory Adjustments

The government of Patricio Aylwin attempted to resolve problems in the Chilean health-care system with an increase in expenditures on public health (Mideplan 1991a) and with interventions targeted at the sources of inefficiency described above.

Mandatory Payroll Tax

The government established that henceforth only 6.1 percent of the payroll tax paid by ISAPRE members would go toward current health insurance; the remaining 0.9 percent would be deposited in

a private fund to provide health coverage upon retirement—when consumers' contributions were expected to be lower and their medical costs higher. These funds would be administered by the Administradoras de Fondos de Pensiones (AFPs), the private pension plans which have operated in Chile since 1981. Also, ISAPREs would no longer keep the difference between the 7 percent payroll tax and the price of the premium. They would have to return this surplus to consumers in one of three ways: by offering better coverage, by allowing consumers to use it toward their copayments, or by investing above and beyond the 0.9 percent in their members' old-age health insurance funds.

Both adjustments have relieved the problem of over-insurance, and are thus steps in the right direction. But there are two matters to consider. First, those who can barely pay for an ISAPRE plan with their full 7 percent contribution might no longer be able to afford it; these consumers—an estimated 200,000 of them—would be returned to the public system (Trabajo de Asesoría Económica al Congreso Nacional 1992). Second, the law stipulates that ISAPRE members who transfer to the public system can take the full amount in their old-age health insurance fund and use it toward their pension plan; these contributions would therefore not have to be used for medical expenses. If, as is likely, consumers were to transfer from the private to the public system when their health costs are higher than their contributions, they would be a net drain on the public system. Under these circumstances, it would make more sense for accumulated savings in the fund to be transferred to FONASA instead.

A more sensible approach would be simply to do away with the 7 percent mandatory payroll tax for those covered by a private insurance plan. This would have to be coupled with a mandated minimum level of insurance—one that does not take into account income levels; otherwise, healthy individuals might not insure at all and fall back on the public sector at times of catastrophic illness. Still, abolishing the 7 percent mandatory payroll tax for ISAPRE members seems a more efficient way of resolving the issue of over-insurance than the reforms of the last few years.

Transparency

In 1990 the government created the Superintendencia de ISAPREs, a regulatory body to supervise private insurance plans. The Superintendencia has moved to make the insurance market more

transparent in three ways. First, it has mandated that all ISAPREs provide a basic package of benefits to be specified by the Ministry of Health (Miranda 1993); unfortunately, to date this basic package is very limited and quite ill-defined. Second, to keep ISAPREs from hoodwinking their customers, the Superintendencia has standardized the format of contracts offered by private insurance plans (Jiménez de la Jara 1992, 144–45). Third, the Superintendencia has been instructed to publish information "on any matter of interest to the public" (Miranda 1993, 60); this information includes reports on consumer satisfaction with different ISAPREs.

The creation of the Superintendencia de ISAPREs is doubtlessly a positive development, but it is still beset by two problems. First, it has lacked teeth to enforce many of the regulations with which it is charged; as of yet, there is very little legislation to punish ISAPREs for noncompliance with the Superintendencia's norms (Trabajo de Asesoría Económica al Congreso Nacional 1992). Second, in the absence of a mandated common-relative-value scale, it will continue to be all but impossible for consumers in the private sector to make well-informed choices. Common-relative-value scales express fees for all medical procedures in terms of the fee of some base unit—such as, say, a set of chest X-rays (Reinhardt 1993b, 15–16). In Chile—as elsewhere where there is private provision of health insurance—the market could be made more transparent if the Superintendencia were to mandate such a common-relative-value scale. Each insurance company would then establish a conversion factor—the monetary value assigned to the base unit. With a common-relative-value scale, Chileans shopping around for private health insurance would have to keep track of only one number for each plan—the conversion factor; they could then use that number and information about quality published by the Superintendencia to make an informed choice to best match their preferences. The Superintendencia could thus "force all providers of health care into highly transparent statistical fishbowls that would be carefully monitored . . . and exhibited . . . to the general public" (Reinhardt 1994b, 111).

Common-relative-value scales have one more advantage: they tend to push prices toward uniformity and could thus be an important tool for cost containment of health expenditures (Reinhardt, 1994b). If this were deemed insufficient, the government could also bracket the permissible conversion factor.

Market Segmentation

The government has enacted minor reforms to encourage ISAPREs to keep their members once they are old or chronically ill (Trabajo de Asesoría Económica al Congreso Nacional 1992); all of these have been ineffective. This should not be surprising: ISAPREs will only stop dumping the old and ill onto the public system when it is very costly to do so. This means that consumers and producers alike have to be nudged toward lifetime insurance.

In Germany, a country which operates a dual-track health insurance system, it is very difficult and very costly to transfer from the private to the semi-public sector. Indeed, this can only be done when an individual lapses into extreme poverty (Reinhardt 1993a). The German example holds a lesson for Chile: if the public system is not to attend to all expensive patients with a shrinking budget, legislation must be passed to prohibit transfers from one system to the other. Of course, consumers would have to be made aware, perhaps by the Superintendencia de ISAPREs, that were they to choose a private insurance plan they would have to remain in the private system for life. Insurance companies worldwide have been extremely reluctant to offer lifetime insurance at a fixed premium—in part because changing technology makes it very difficult to estimate future medical costs. Consumers in the private sector could therefore expect ever-rising insurance premiums in their old age; properly informed, they could weigh relative prices and relative quality of care in the private and public systems and make a decision accordingly.

Alternatives for a More Unified Health Insurance System

The previous section has proposed additional changes to the Chilean health insurance system which would keep the flavor of the current regime. The main feature of this regime is that it offers consumers a choice between the public and the private sectors. Reforms to abolish the 7 percent payroll tax for ISAPRE members, to put in place common-relative-value scales, and to make it all but impossible to transfer from the private to the public system, would simply grease the wheels of two-track health insurance. This would do away with many inefficiencies, but not with the inequity that is perhaps the most salient feature of health care in Chile today.

It is sensible to ask oneself whether such a dispersed system for

the provision of health insurance is better than the alternatives. If it is not, it may be time to reassess the basic tenets of health care in Chile. The 64,000-dollar question then becomes: Should the private or the public sector assume the leading role in the provision of health insurance? In answering this question, policymakers dissatisfied with a dual-track system might reconsider one of two options: a publicly operated, national health system of the sort in place in the United Kingdom; or a privately run, pooled-risk insurance system of the kind which was under consideration in the United States before the 1994 debacle.

The creation of a unified national health system in Chile would mean that all payroll taxes would once again go into a common public health pot. In return, everyone would be eligible for health care in an upgraded version of the current National Health System. Of course, consumers could still visit a private physician of their choice, but they would have to pay for the full amount out-of-pocket. Perhaps, a voucher scheme by which the government reimbursed these patients up to the amount it would cost to provide the same service in the public sector could be put in place—though this arrangement might be administratively cumbersome.

Whatever the economic arguments may be, a return to a mandatory system of public health insurance in Chile is not politically viable. It is unlikely that anyone in the government of President Eduardo Frei other than the minority Socialist Party would invest political capital to do away with private health insurance. Parliamentary opposition to the current centrist, reasonably pro-business governing coalition comes from a right-wing front which would not countenance any such change. This opposition would, no doubt, label any attempt to revive a unified public health system a socialist ploy to return the country to the mayhem of the last year of the Allende presidency. With the military still waiting in the wings, this is one controversy that Chilean democracy cannot afford.

A reform of the health sector which moved toward a pooled-risk, privately run insurance system might be an easier political sell in Chile. Pooled-risk systems can take any one of a number of forms—all of which would share two common features: they would be financed on a capitated basis, and they would make use of group buyers of health care—so-called sponsors (Enthoven 1988). Capitation is important because it turns every hospital or physician from

a "profit center" into a "cost center" (Reinhardt 1994b, 113). Since revenues in a capitated plan are fixed (they are the product of the number of consumers enrolled and the cost of the average premium) while costs are variable (they depend on the amount of health care provided, and on the unit cost of this health care), all profit-maximizing insurance plans have an incentive to limit the amount of health care delivered. Properly channeled, this stimulus could be a powerful vehicle to contain costs. Mandatory use of sponsors is equally important because it keeps insurance companies from segmenting the market by offering every consumer an actuarially fair premium. This could be a reasonable solution to the problem of biased risk selection.

Beyond these common features, privately run pooled-insurance systems can vary considerably. The obligation to purchase a minimum level of health insurance can be placed on the individual—a so-called individual mandate. Risks can then be pooled with the mandatory use of uniform community ratings, or with the framework of "managed competition" which briefly became so popular with American policymakers. Alternatively, the obligation to purchase a minimum level of health insurance can be placed on employers—a so-called employer mandate. Alas, employer mandates are probably not workable in Chile because a substantial part of the population still works in agriculture, in the informal sector, or is unemployed (Portes and Schauffler 1993).

The basis of community rating is simple: different health insurance companies vie for the insurance of a "community" (defined as a small administrative unit, such as a borough, or a specialized district, as is often done with education). The community then selects that benefits package which best matches its preferences, and all members of the community have to purchase the chosen insurance policy.

Despite its intuitive appeal, community rating of this sort has a number of built-in problems. For one thing, it presupposes that there would in fact be more than one insurance company in an area; such an assumption may not be entirely unreasonable for urban Chile, but it will certainly not hold in rural areas. Community rating is also inequitable in the way that decentralization is inequitable: benefits packages would be a reflection of each community's wealth. Poor communities would only be able to pay for very basic

insurance, while rich communities would be able to pay for much more lavish coverage. Moreover, if communities were made up of individuals with different economic backgrounds, the poorest members might not be able to afford the insurance policy which had been selected; these members would have to be subsidized, or they would have to move. Nor is it clear what would happen were an individual to move; unless methods were devised to transfer benefits packages, or to allow individuals to enroll in a plan once an insurance cycle had begun, community rating could serve as a powerful deterrent to worker mobility—with all of the consequences this would have for the smooth functioning of national labor markets. Yet schemes to transfer plans or to allow for mid-cycle enrollment could quickly become a bureaucratic nightmare.

Perhaps the most serious shortcoming of community rating is that it would encourage an unstable, downward-pressing equilibrium in the health-care market. As early as 1956, Charles Tiebout hypothesized that a decentralized system would encourage different jurisdictions to provide different tax-service combinations: some would opt for a "high tax-high service" level, and others for a "low tax-low service" level. Consumers would then "vote with their feet," and settle in that jurisdiction which best matched their preferences. In the aggregate, this exercise in public choice should increase welfare. If, however, services are redistributive (which health insurance inevitably is, transferring resources from the healthy to the chronically ill, and from the rich to the poor), all jurisdictions have an incentive to provide an artificially low level. In this situation, the final equilibrium level of services provided is likely to be lower than it would have been in the absence of perverse incentives. To the extent that this is the case, there is an efficiency loss.

How is this theoretical model relevant to the health insurance market? After all, cynics might argue that a downward-pressing equilibrium is just what is needed to contain health-care costs. Alas, such an unstable, hit-or-miss method to slow down costs hardly seems ideal. Moreover, a high proportion of those who would move to communities which offered generous benefits packages would inevitably be consumers for whom health care costs are highest: that is, the chronically ill. By encouraging this kind of migration, community rating is at best an imperfect solution to the problem of adverse selection.

Managed competition is a more complicated solution which allows individual consumers to choose their preferred health plan. Both the number of potential sponsors and the number of insurance companies offering benefits packages are multiplied. The former can now include large employers, unions, local governments, or a health insurance purchasing cooperative (HIPC) set up expressly for that purpose. In the simplest model, competing insurance plans offer a clearly specified, standard benefits package to all of the residents in an area.[5] Sponsors then collect a premium from every consumer equal to the price of the cheapest insurance plan. Consumers select any one of the plans offered to the sponsor, and pay the difference between the price of the cheapest plan and the price of the plan they have chosen. This monetary disincentive, it is argued, should encourage consumers to enroll in the cheapest plan—and should thus help contain aggregate costs (Reinhardt 1994b, 109–13).

Managed competition is probably an improvement on a system of uniform community rating. Consumers have a good deal of choice—between competing insurance plans and between separately priced perks which could be added to the basic package of benefits. Also, by offering different price-service combinations within a single jurisdiction, managed competition somewhat reduces the incentive to move to follow health-care plans. Yet managed competition does not solve many of the problems inherent in a system of pooled-risk, privately provided insurance. For one thing, it is not as equitable as direct provision of health insurance by the government. Nor is it really practicable where there is not a well-developed, competitive insurance market. Managed competition is therefore no more than a partial solution for a country like Chile: if there is now two-track private and public health care, managed competition would produce a two-track urban and rural health-care system. It is not clear that this would yield a better outcome in terms of equity and efficiency than the revamped dual-track system I proposed in the previous section.

It is, finally, easy to see how the complexity of a system of managed competition could undermine its effectiveness. Indeed, its most vocal supporter concedes that "the complex and subtle tasks that must be carried out by sponsors in a system of managed competition might lead some to conclude that it is all too complicated for either the public or the private sector" (Enthoven 1988,

319). Administrative constraints could be a crippling problem for a country where managerial capacity is still much more limited than it is in the United States.

Conclusion

Whether markets or the state should be charged with the provision of health insurance is a debate that has raged for years. Like many ideologically charged debates, this one has generated more heat than light. Peculiarities of the health care market itself—such as adverse selection, moral hazard, or information asymmetries between producers and consumers—have engendered much confusion. But the discussion has also been plagued by a lack of clarity as to what it is that should or should not be provided by the private and public sectors. The distinction made by Uwe Reinhardt between the two facets of health-care financing is enlightening here: the first facet involves the extraction of funds from private households, while the second facet involves the disbursement of these funds to the providers of health care (Reinhardt 1993a, 44).

When an unregulated private sector is charged with responsibility for the extraction of funds for health insurance, the result is unacceptable in terms of equity. This is because private insurers will always have an incentive to separate good risks from bad risks and to offer actuarially fair premiums. The government must therefore continue to have a leading role in this facet of health care—either by collecting all insurance premiums itself or by regulating insurance funds to ensure that risks are pooled. The case for involving the private sector in the disbursement of funds is much stronger. Competitive pressures in the delivery of health care should lead to an increase in efficiency—though government intervention may still be necessary to mandate a minimum package of benefits and to make the market more transparent. Costs, too, may have to be controlled—with the introduction of budget caps or fee schedules, or with the transformation of three-cornered fee-for-service markets into capitated ones. Creative solutions to these problems can—and have—been found. But it seems that these subtleties were not appreciated by the Chilean government when it first encouraged ISAPREs to enter the health-care market. Or, perhaps, they were all too well appreciated. Cynics might say that a right-wing government had used the chimeric pursuit of efficiency as a Trojan horse: it had helped the wealthy rid themselves

of their responsibility for the well-being of the poor.

Chile has made great economic strides in the last 15 years or so. Its upcoming accession to NAFTA (or, more accurately, AFTA) is a confirmation of this hard-earned progress. Indeed, Chile has consistently kept ahead of the economic curve—first, by realizing the limitations of a state-led, inward-looking growth strategy, and then, by providing safety nets for the most disadvantaged. Not surprisingly, it has become the envy of many of its neighbors. But a greater reliance on the market in the provision of health insurance has not served Chile well.

Notes

[1]I have borrowed this framework from Uwe Reinhardt (Reinhardt 1993a).

[2]Figures for the public and private sectors are for 1990

[3]In 1983, 49 percent of doctors were registered in level 1, 34 percent in level 2, and 17 percent in level 3; by 1989 these proportions were 9 percent in level 1, 25 percent in level 2, and 66 percent in level 3. For hospitals, a similar, if less dramatic trend can be observed. In 1983, 42 percent were registered in level 1, 46 percent in level 2, and 12 percent in level 3; by 1989 these proportions were 34 percent in level 1, 74 percent in level 2, and 11 percent in level 3.

[4]In 1980, 54.5 percent of financing for the public health system came from treasury allocations; by 1989 this proportion had fallen to 35.2 percent (Oyarzo 1992, 22).

[5]Alternatively, the system could be set up in such a way that insurance plans offer different premiums to reflect the risk profiles of different groups in the population. Alain Enthoven has argued that this would reduce the incentive for insurance companies to keep the chronically ill from enrolling, and that the sponsor could offset any resulting inequities with the use of cross-subsidies—effectively making the premium that consumers pay to the sponsor uniform (Enthoven 1988). This refinement may seem appealing, but it allows consumers to skim the market for a suitable sponsor: low-risk consumers will prefer sponsors who are less equitable (that is, where premiums are closest to being actuarially fair), while high-risk consumers will prefer those who are more equitable (that is, where premiums are farthest from being actuarially fair).

References

Castañeda, Tarsicio. 1992. *Combating poverty: Innovative social reforms in Chile during the 1980's.* San Francisco: International Center for Economic Growth.

Centro de Estudios Públicos. 1993. El sistema de salud chileno: un problema pendiente, *Puntos de Referencia* 123 (September 1993).

Enthoven, Alain. 1988. Managed competition of alternative delivery systems, *Journal of Health Politics, Policy and Law* 13 (Summer).

Feldstein, Paul J. 1993. *Health care economics.* Albany, N.Y.: Delmar Publishers.

Freeman, Howard E., Robert J. Blendon, Linda H. Aiken, Seymour Sudman, Connie F. Mulliniz, and Christopher R. Corey. 1987. Americans report on their access to health care, *Health Affairs* (Spring): 6–18.

Heyermann, Beatriz. 1994. *Municipio, descentralización y salud.* Santiago de Chile: Naciones Unidas, Instituto Latinoamericano y del Caribe de Planificación Económica y Social, Documento de Trabajo Numero 1.

Jiménez de la Jara, Jorge. 1990. Subsistema mutuales de seguridad.. In *Eficiencia y calidad del sistema de salud en Chile,* ed. Maria Inés Romero. Santiago de Chile: Corporación de Promoción Universitaria.

———. 1992. Gestión del desarrollo social chileno: el sector salud. In *Gestión del desarrollo social chileno: el primer año del gobierno democrático, 1990–1991,* ed. Mercedes Auba. Santiago de Chile: Corporación de Promoción Universitaria.

Krueger, Alan B. 1993. *Observations on employment-based government mandates, with particular reference to health insurance.* Princeton: Center for Economic Policy Studies.

Luft, Harold S. 1991. Translating the U.S. HMO experience to other health systems. *Health Affairs* (Fall): 172–86

Ministerio de Planificación y Cooperación (Mideplan). 1990. *Programas sociales: su impacto en los hogares chilenos.* Santiago de Chile: Alfabeta Impresores.

———. 1991a. *Un proceso de integración al desarrollo: informe social, 1990–1991.* Santiago de Chile: Alfabeta Impresores.

———. 1991b. *Los sistemas previsionales de salud: cobertura y perfil de los beneficiarios.* Santiago de Chile: Alfabeta Impresores.

Miranda, Ernesto. 1993. Un análisis de la propuesta de modificación a la Ley de ISAPREs (Ley 18.933). Santiago de Chile: Centro de Estudios Públicos, Documento de Trabajo 194.

Oyarzo, Cesar. 1991. Análisis crítico de las transformaciones financieras del sector salud en la década de los 80 y propuesta para una reforma. In *Chile: sistema de salud en transición a la democracia,* ed. Jorge Jiménez de la Jara. Santiago de Chile: Alborada.

———. 1992. Financiamiento del sector salud en una situación de crisis: El caso chileno. *Serie Investigacion,* no. I-58. Santiago: Programa Post-Grado de Economia de ILADES (November).

Pauly, Mark V. 1988. Is medical care different? *Journal of Health Politics, Policy and Law* 13 (Summer).

Phelps, Charles E. 1992. *Health economics.* New York: Harper Collins.

Portes, Alejandro, and Richard Schauffler. 1993. Competing perspectives on the Latin American informal sector. *Population and Development Review* 19 (1993): 33–60.

Reinhardt, Uwe. 1985. The theory of physician-induced demand: Reflections after a decade. *Journal of Health Economics* 4 (1985): 187–93

———. 1993a. Reorganizing the financial flows in American health care. *Health Affairs* (1993): 43–64.

———. 1993b. An all-American health reform proposal. *Journal of American Health Policy* (May/June): 11–17.

———. 1994a. Congress likes health—for the rich. *Newsday*, 30 September.

———. 1994b. "Managed competition in health care reform: Just another American dream, or the perfect solution? *The Journal of Law, Medicine & Ethics* 22 (Summer).

Sánchez, Hector. 1990. Análisis subsistema ISAPREs: periodo 1981–1989. In *Eficiencia y calidad del sistema de salud en Chile*, ed. Maria Inés Romero. Santiago de Chile: Corporación de Promoción Universitaria.

Shortell, Stephen M., and Uwe E. Reinhardt, eds. 1992. *Improving health policy and management: Nine critical research issues for the 1990's.* Ann Arbor: Mich.: Health Administration Press.

Trabajo de Asesoría Económica al Congreso Nacional (TASC), 30. 1992. Modificaciones a la actual legislación del sistema de ISAPRE.

World Bank, The. 1993. *World development report 1993: Investing in health.* N.Y.: Oxford University Press.