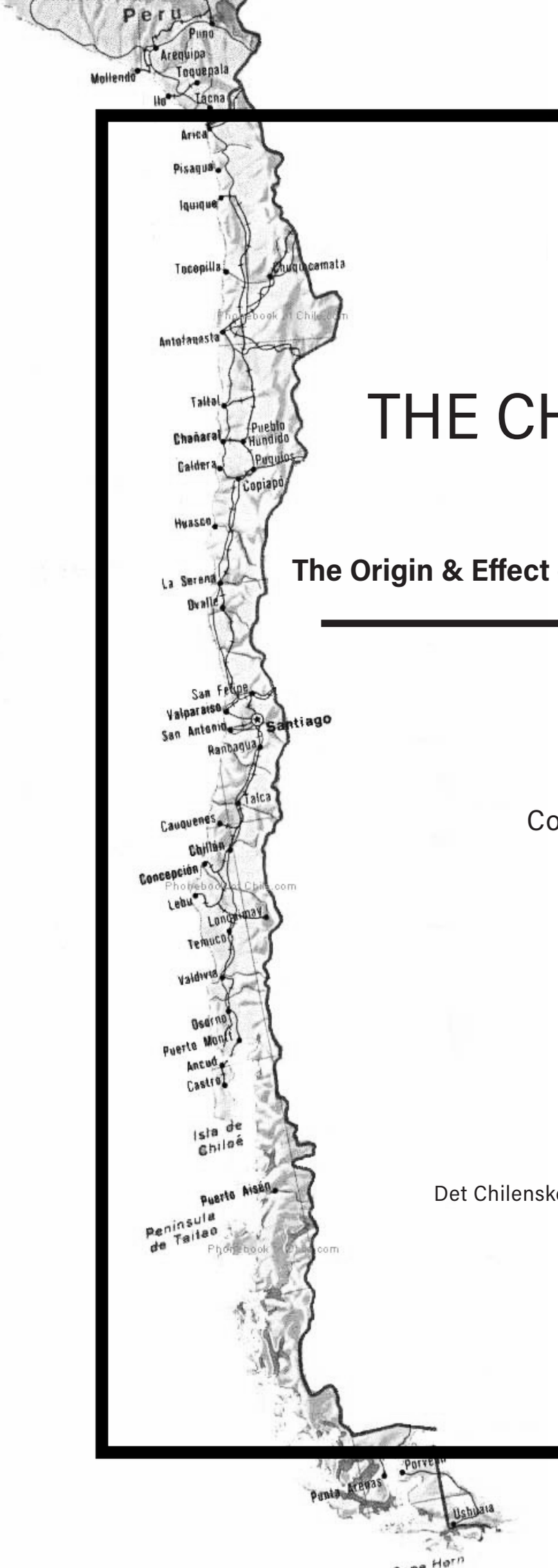

THE CHILEAN HEALTH CARE SYSTEM

The Origin & Effect of the Public-Private Dichotomy

Kandidatafhandling

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Copenhagen Business School (CBS)

Det Chilenske Sundhedssystem - Oprindelsen og Effekten af den Offentlige-Private Dikotomi

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RESUMÉ

Nærværende speciale fokuserer på Chiles todelte sundhedssystem, der siden diktaturet i 1980'erne har været opbygget af en offentlig og en privat sektor. De senere år har debatten i de chilenske medier taget til og der er stor uenighed omkring strukturen af sundhedssystemet, da kritikkerne hævder, at ikke alle har lige mulighed for at vælge mellem de to systemer.
Specialet har som formål, at undersøge de økonomiske og ideologiske strukturer og principper, der ligger til grund, henholdsvis for den privatisering af sundhedssystemet, der fandt sted i 1980'erne og den efterfølgende genimplementering af demokratiet i 1990'erne. Hernæst vil specialet undersøge hvilke effekter denne opståede dikotomi har haft på det chilenske samfund i forhold til ulighed i adgang til sundhedssystemet målt på følgende faktorer: Betaling, udbydere, kvalitet, geografi, regulering, information og finansiering.

Primært er der anvendt en kvalitativ empirisk metode, hvor datasættet består af tre kvalitative interviews. Informanterne arbejder alle inde for lovgivning og regulering af sundhedssystemet. De har bidraget med deres viden og erfaring til at opklare, hvorfor denne opdeling af den chilenske befolkning i forhold til sundhed, er opstået. Sekundært er der anvendt en bred vifte af videnskabelige artikler i et forøg på at give en bred forståelse af problemstillingen.

Resultaterne tyder på, at privatiseringen i 1980'erne har været præget af en stærk neoliberal overbevisning, og at dette har været med til at ekskludere en stor del af befolkningen fra det private sundhedssystem, som stadig varer ved i dag. Desuden viser resultaterne, at genimplementeringen af demokratiet i 1990'erne har medført mere statslig indblanding i sundhedssystemet i et forsøg på, at udviske disse neoliberale strukturer. Dog viser resultaterne også, at denne indsats har vist sig at være en midlertidig løsning og at opdelingen af sundhedssystemet har resulteret i en stor ulighed i adgang til sundhed samt diskrimination af bl.a. ældre, kvinder og syge.

Den private sundhedsplan er opbygget som en ordinær forsikringsaftale, hvor prisen på produktet afhænger af ens sygehistorie, køn og alder. Dette betyder at for nogle er prisen så høj, at de ikke har friheden til at vælge mellem de to systemer – hvilket oprindeligt var det ideologiske grundlag under neoliberalismen i 1980'erne. Til gengæld har denne investering i den private sektor medført store forbedringer i den chilenske befolknings sundhed, dog en forbedring som ikke alle kan deltage i.

ABBREVIATIONS

AUGE - Regime of Explicit Health Guarantees (*Régimen de Garantías Explícitas en Salud)*

CR – Critical Realism

FONASA - The National Health Fund (*Fondo Nacional de Salud)*

IPC - Consumer Price Index *(Índice de Precios al Consumidor)*

ISAPRE – Health Insurance Institutions *(Instituciones de Salud Previsional)*

MINSAL – Ministry of Health *(Ministerio de Salud)*

NHS – The National Health Service *(Servicio Nacional de Salud)*

NHSS - The National Health Services System *(Sistema Nacional de Servicios de Salud)*

PDC – Cristian Democrats *(Partido Demócrata Cristiano)*

PPD – Party for Democracy *(Partido Por la Democracia)*

PS – Socialist Party – *(Partido Socialista de Chile)*

SERMENA - The National Medical Service for Employees *(Servicio Médico Nacional de Empleados)*

UF – Unit of account *(Unidad de Fomento)*

UP – Popular Unity *(Unidad Popular)*

WHO – World Health Organization

1 INTRODUCTION

1 INTRODUCTION

"(...) the power of markets is enormous, but they have no inherent moral character. We have to decide how to manage them (...) For all these reasons, it is plain that markets must be tamed and tempered to make sure they work to the benefit of most citizens. And that has to be done repeatedly, to ensure that they continue to do so" (Stiglitz, 2012: 21).

To what extent the government should intervene in the economy has always been a central issue in economics. Some of the typical arguments against government intervention is that it causes an inefficient allocation of resources, it deprives the people of personal freedom and that it generally results in costly and inefficient outcomes. On the other hand, the free market forces have been criticized for only generating more wealth among the wealthiest, for making the poor worse off and forgetting issues such as climate change, unless there is a profit motive. Some public goods would simply not exist if it was not for government because it does not imply a profit incentive and some industries are better off being run by the private sector as it can often guarantee a higher quality and efficiency. But what about something as fundamental as health care? And what exactly is a good health care system? According to The World Health Care Organization a good health care system:

"*(...) delivers quality services to all people, when and where they need them. The exact configuration of services varies from country to country, but in all cases, requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well-maintained facilities and logistics to deliver quality medicines and technologies."* (WHO 2).

In the following, Chile will be used as a case study and two important reforms of the Chilean health care system will be investigated and discussed on this background. Per 2015, Chile had a population of 17,9 million people and a GDP of 240 billion dollars. It was the first Latin American country to join the OECD and according to the World Bank, Chile is one of the fastest growing economies in the region[1]. Despite this growth, Chile still has a huge gap between rich and poor and in many areas, including the health care sector, the country seems to be divided between those who can pay and those who cannot. This thesis will seek to analyze the health care sector of Chile and the transformations that it has undergone during the past decades focusing on two periods: The creation of a private health care sector during the military rule in the 1980s and the democratic reforms of the system during the return to democracy in the 1990s. The reforms carried out in these

[1] (The World Bank)

historical periods will be analyzed based on neoliberal theory by Milton Friedman who advocates for minimum government intervention and reliance on free markets and on the other hand public sector theory by Joseph Stiglitz, who is an advocate for government intervention in the health area. Prior to the analysis however, a description of the Chilean health care system before 1979 will also be provided as it serves as important background information for the following analysis.

The structure created under the military rule persists today and the Chilean health care system is still built upon a public-private dichotomy. The public health care system *Fonasa* covers approximately 80 % of the population, whereas about 18 % of the Chileans have chosen one of the private health insurance companies, *Isapres* (Becerril-Montekio, 2011: 132). With help from three qualitative interviews and secondary data sources this thesis will highlight the pros and cons of the two systems and look at how this public/ private dichotomy affects the Chilean society today.

1.1 Relevance

For years, Chile has been considered a pioneer in the Latin American region due to the country's rapid and stable economic growth. At the same time, Chile seems to have a health care system that is getting obsolete, as it is based on persisting structures from the dictatorship that ended in 1990. Within the last few years, health care has been a hot topic in public debates and still more non-profit organizations have appeared claiming that the system needs radical reform and that it is fundamentally unequal and discriminating.

A publication released in 2014 by the Ministry of Health contains suggestions on how to improve the Chilean health care system. It is pointed out that one of the current problems in the system is the asymmetry of information that exists in the system as the health care provider possesses more information than the patient, which has resulted in the providers offering services according to what is more profitable for them (Universidad Católica, 2014). This makes the discussion about the Chilean health care sector today, relevant.

1.2 Motivation

Besides being a student of American Studies I have always had a huge interest for other cultures and societies with focus on the inequality in access to, what we in the West, consider fundamental human rights. Furthermore, I have spent the last two years living in Santiago in Chile, working at the Danish Embassy, which gave me personal experience with the Chilean health care system. I have found myself in the situation of having to choose between the public and the private health care system and I discovered that many hours of research was necessary to be able to make the right decision. This experience had me thinking about the health care that we sometimes take for granted

in Denmark, and it made me want to look further into the ideological background behind the system in Chile to understand the structure and the origin better.

When I was to make the choice between the public and the private system, I sought help and advice from friends and colleagues. At first it was a very difficult task. The people I talked to, had very different opinions and experiences with the two systems. Some were using the public health care system because they could not afford the private system and others I met, that earned well above average, were in the public system for ideological reasons. Overall, I realized that making my decision would take more work that I had expected at first, which made me curious about this dichotomy that exists today in the Chilean health care system.

I had never paid for a health care plan before, and something that I had always taken for given and considered a human right in a modern society, was now pure business.

I often saw TV-commercials by health insurance companies trying to get new customers. I found that many of the commercials were almost identical and I started to wonder how the Chileans make a well-informed decision when choosing health care.

Finally, when I had made my choice (the private system) I ended up spending hours the first time I wanted to use my insurance, trying to find the cheapest doctor's office or a doctor who had an agreement with my insurance company to avoid paying too much.

Another factor that made me choose this subject for my thesis, was the street I lived on in Santiago Centre. This is the part of the city, where you see the socioeconomic inequality the most because of the contrast between rich and poor. The country's biggest public emergency room *Posta Central* was located just down my street. The Danish Embassy on the other hand, was located one hour away from where I lived in a beautiful and expensive area. Every day on my way to work I had to walk down my street about five blocks to get to the metro. On my way, I passed the public emergency room and outside I always saw many people sleeping on the street, in tents or on mattresses. I finally understood that many of these people were homeless and were waiting for treatment as the waiting lists in the public system can be very long. A serious disease can end up costing you your house, if you do not have the right insurance.

All of this awakened my interest to look deeper into to the public and the private health care system in Chile, and to find out the differences between the two to understand why so many people were left outside of the system.

1.3 Research Question

Following the identified research field above the aim of this study will be to identify the economic

and ideological principles that laid grounds for the health care reforms of the Chilean health care sector throughout the past decades and to critically discuss the pros and cons of both the public and private health care sector, and of the structure that we see today as a result of these reforms. The research is led by the question:

What were the ideological and economic principles behind the privatization of the health care system in Chile both under Pinochet, and the subsequent reforms when democracy was reinstated in the 1990s? How have these reforms influenced the access to the health care system?

1.4 Research Scope & Delimitations

This thesis will seek to identify how the privatization of the health care system in Chile has affected the access to and the quality of, the health care sector. This will be done based on the theoretical framework and the three qualitative interviews conducted for the purpose. The structure and the scope of the thesis will therefore take its form according to these results. The analysis has been structured based on the answers of the interviewees and will touch upon following themes related to access to health care: *Payment, providers, quality, geography, regulation, information,* and *financing.* Each of the themes in the analysis could be elaborated further but for this purpose they will be developed to the point necessary in order to answer the problem statement above.

The Chilean health care sector has a very complicated structure, therefore only the necessary parts of the system will be explained based on what is relevant for this purpose. The interviewees chosen for the interviews conducted prior to this thesis are all, or have been, part of public regulatory institutions in Chile. Talking to people from either the public or the private health care system resulted complicated due to either economic interests or fear of losing their jobs. I therefore chose to go higher in the hierarchy to interview someone with influence on the structures and regulation of the Chilean health care system today.

1.5 Purpose of This Study

The purpose of this thesis is to investigate and analyze the health care reforms that have taken place during different political governments in Chile and the economic and ideological principles behind these. Because of these reforms, Chile's health care system became divided into two sectors and the purpose is furthermore to examine the pros and cons of both the public and the private health care sector to figure out if it is a good thing to have government regulation in this area or if Chile is better off with having a strong private health care market. Finally, the purpose will be to look at the

effects that this change has had on the Chilean society in terms of access to the two systems.

1.6 Audience

I believe that people with a general interest in Latin America or health care could find this research interesting. Also, policy makers and investors could benefit from these findings as Chile has been considered one of the most successful countries in the region for many years. The history behind the structure of the Chilean health care system can help us understand how such a development could take place and use it as inspiration on good and bad, to improve health care models in other Latin-American countries. This is a research area that opens many discussions and I believe that academia could find the thesis suitable for further research in this area.

1.7 Structure

The thesis begins with chapter 1, which introduces the research area and the problem field, followed by chapter 2 explaining the methodology used throughout the thesis. In chapter 3 the historical context will be presented and in chapter 4 the theoretical background for the analysis will be elaborated. Chapter 5 contains the analysis and discussion and finally in chapter 6 the conclusion will be presented together with suggestions for future research.

2 METHODOLOGY

2 METHODOLOGY

In this chapter, the scientific research design for this thesis will be explained, and I will argue for my considerations and decisions during the writing process. The purpose of this chapter is to illustrate how the chosen approach and the combination of the different theoretical and methodological techniques together form a valid basis to ensure a reflective and clear answer to the chosen problem statement. The primary empiric data comes from three qualitative interviews and I will therefore give a more detailed description of the elaboration and application of these interviews together with a presentation of my three interviewees. Afterwards, a description of the methods used for data collection will be given, as this thesis has been conducted using both qualitative and quantitative data. Both primary and secondary literature has been used as data sources and a description of the collection and limitations to this process will be provided. Finally, a description of the analytical approach will give a complete picture of the theoretical and methodological choices made during the writing process of the thesis.

2.1 Research Approach

The thesis takes its point of departure in the classic economic discussion about the free market and the size of the state, and thereby a classic discussion about how markets work. Two contradicting standpoints on having a private health care sector in contrast to a public health care sector will be studied using both theory by Joseph Stiglitz and Milton Friedman. I will use Chile and the reforms of the Chilean health care system as my case. The approach has been to investigate historical sources at first and later to apply the theories as well as the answers and opinions of my three interviewees. Therefore, the methodological study design is described as a qualitative empirical case study. In the following sections of this chapter, the methodological choices will be described in detail.

2.1.1 Philosophical Paradigm

The perspective of the thesis is grounded in the critical realist (CR) paradigm as the strategy of analysis. In the 1970s English philosopher Roy Bhaskar developed the critical realism approach and it has since been considered an interesting alternative to both social constructivism and positivism (Alvesson & Sköldberg, 2009: 38). The philosophy behind CR is that you cannot reduce statements about the world (ontology) to knowledge about the world (epistemology). The traditional ontology sees the world as an undifferentiated and unchanging entity whereas CR has a new view on reality seeing it as a structure that is changing and differentiating (Alvesson & Sköldberg, 2009: 38).

This notion of *reality* consists of three domains: *The empirical domain*, which is narrower and

relates to what we can observe *the actual domain* which relates to the researcher or the observer of the observed, and lastly *the real domain,* which is related to the mechanisms that have produced certain events (Alvesson & Sköldberg, 2009: 39). *"According to critical realism, the task of science is to explore the realm of the real and how it relates to the other two domains (...) to investigate and identify relationships and non-relationships, respectively, between what we experience, what actually happens, and the underlying mechanism that produce the events in the world"* (Danermark in Alvesson & Sköldberg, 2009: 40).

As in positivism, CR is concerned with the objective world and finding patterns and causalities but it also seeks to investigate the mechanisms of a deeper dimension as you cannot reduce the world to observable objects and facts (Alvesson & Sköldberg, 2009: 41). Therefore, I have not aspired to find concrete and static conclusions but to illustrate some tendencies and patterns between the events studied in this thesis.

The reality exists independently of and is distinct from researchers' perceptions and descriptions of it (Alvesson & Sköldberg, 2009: 40-41). As opposed to positivism, which seeks exact relations between cause and effects, CR find this relation more complicated and the outcome tend to be tendencies rather than specific measurable conditions (Alvesson & Sköldberg, 2009: 42).
CR is compatible with a wide range of methods, and goes well with case studies. Sayer, in Easton (2010), considers two different types of method; *extensive* and *intensive*. The *extensive* method includes quantitative data for example large scale surveys or statistical analysis and allows us to generalize, whereas the *intensive* method uses more qualitative data for example in the form of interviews focusing on individual agents, where the findings are limited to the specific situation studied (Easton, 2010, 123). In accordance with this distinction case studies generally use the intensive method, which is consistent with the convictions behind CR, and which does not fit well with positivism as it does not work with generalization, but in a smaller scale. It also fits well with the method of this thesis with relies primarily on personal interviews. CR also acknowledges, like social constructivism, that the world to some extent is a social construct, but where social constructivists rejects the possibility of knowing reality, CR claims that reality exists and at some point, kicks in (Easton, 2010: 122).

When it comes to the research question it must imply *what caused the events associated with the phenomenon to occur"* (Easton, 2010: 123). I argue that in thesis the research question identifies the phenomenon public-private dichotomy in the Chilean health care sector and asks what causes this to happen. The result is the identification of the mechanisms behind the cause of the events

(Easton, 2010: 128).

2.1.2 Case Study Design

To draw scientific conclusions one must choose a research approach (Creswell, 2014: 10). To respond my problem statement, I have chosen to use a deductive approach using Chile as a case study. Deduction takes its point of departure in a general principle and thereafter you draw conclusions about individual events (Andersen, 2003: 39). The reason for this choice is that I have used the general theory by Stiglitz (2010) about the rationale for government intervention in the health care sector as well as the classical theory of neoliberalism by Milton Friedman and chosen to apply them to the specific case of Chile. Hereby I will be testing the theory to see if it applies in the case of the implementation of a private health care system in Chile.

This method stands in contrast to the inductive method that takes its point of departure in a single specific case and from there it seeks to draw generalizations or create new theory (Andersen, 2003: 39). A third approach could be the abductive method which allows the scientist to go back and forth between empirical observations and theory but this method does not fit well in this case as the goal is not to modify the original framework nor to develop the theory further.

The design of this thesis is a holistic single-case study because this method allows for an in-depth understanding of a specific phenomenon, and because the case is concentrated around one single unit of analysis (Yin, 2003: 40). The strength of the case study approach is that it gives the scientist a good possibility to examine the specific circumstances and complexities of a problem area (Yin, 2003: 41).

According to Yin (2003) a case study is of great benefit when we want to explore *how* and *why* in order to answer our problem statement. These questions are *explanatory* and are useful when you are studying an event that needs to be traced over time as opposed to frequencies or incidents (Yin, 2003: 6). In order to answer the problem statement of this thesis a *descriptive* strategy has also been used, as specific historical events have been studied as well of the consequences of these events over time.

On the other hand, the case study method is often criticized for being too specific. It can be hard to generalize the produced empirical data as it varies from case to case (Thomas, 2016: 4). This point of view is not entirely backed up by Yin who states that *"(...) case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes"* (Yin, 2003: 10). In

the case of this specific event in Chile my investigation and findings will be very country specific and it would be difficult to generalize from it. There may be similar cases of countries that have privatized their health care and you might be able to be inspired by the findings from this thesis. But as Yin (2003) states it will be impossible to generalize directly to other universes, why a separate case study would be advisable.

2.2 Primary Empirical Data: Qualitative Interviews

I found that conducting interviews was a good way to answer some of the more specific questions that I had and to get in-depth knowledge about the subject as well. The following section will mainly rely on literature by Brinkmann and Kvale (2015). This will help me explain what kind of interviews I have conducted, who my interviewees are and what considerations I had about cultural differences and validity of my methods afterwards.

2.2.1 Research Interview

To be able to discuss the problem area from different angles I have chosen to conduct qualitative interviews, because this method provides a good opportunity to get closer to the specific circumstances. I have used the interviews to develop my problem statement further and to get the informants' professional perception as well as opinion on the issue. Qualitative interviews focus on conversation and not on measurable things such as numbers and statistics.

The research interview as a method is based on everyday conversation and is a conversational relation between the interviewer and the interviewee, producing new knowledge in their interaction with each other. But an interview is, although a conversation between two parts, the interviewer, and the interviewee, not an *equal* conversation as the interviewer is leading and controlling the conversation from a structure, carefully elaborated beforehand (Brinkmann & Kvale, 2015: 6)." *An interview is a conversation that has a structure and a purpose. It goes beyond the spontaneous exchange of views in everyday conversations and becomes a careful questioning and listening approach with the purpose of obtaining thoroughly tested knowledge." (Brinkmann & Kvale, 2015: 5-6).*

An important part of doing interviews begins long before the moment of the actual interview. Preparation is a crucial part of conducting a successful interview which can include thinking through the method you are going to use and make sure you have some knowledge of the topic of study beforehand (Brinkmann & Kvale, 2015: 125). Before conducting the interviews, I gathered

knowledge about the work of my interviewees and about the institutions that they work for, and on that background, I wrote my interview questions. This preparation process allowed me to answer very specific questions as I already had the background knowledge.

2.2.2 Structure of the Interview

My data set for the thesis consists of two so called *semi-structured life world interviews* conducted in person and one interview conducted per email. The semi-structured interview is relevant when you possess theoretical and practical knowledge about the investigation topic, but also are open to new information and opinions. This type of interview does not follow a strict structure, but the interview guide elaborated beforehand, serves as a guideline to ensure that you touch upon all the important themes for your further investigation. Basically, you can choose to have a list of themes together with some suggested questions. That way you leave room for change and follow up questions, in case the interview develops in an interesting direction for you (Brinkmann & Kvale, 2015: 149-154).

I attempted to make the questions as open and objective as possible, to avoid influencing my interviewees too much. The structure of the in-person interviews that I had, is therefore neither a closed questionnaire nor a completely open conversation between me and the interviewees, but were carried out based on an interview guide (see Appendices A and B). It should be mentioned that both interviewees asked to see the questions beforehand. The questions and answers from the email interview can be found in Appendix C.
I have translated all the quotes used from the interviews from Spanish into English. Translation together with the original quotes can be found in Appendix D.

2.2.3 Interviewees

To validate the outcome of my interviews, a presentation of each interviewee and their educational and professional background will be presented below.

My first interview was with Carlos M. Carrasco Moyano (Carrasco), the chief of the Department for Regions, Public Attention, and Citizen Participation in the Health Regulatory Agency of Chile (*Superintendencia de Salud).* Carrasco studied Social Work and Local Development at the Universidad Católica Raúl Silva Henríquez. He also holds a master's degree in Public Management from the Ortega & Gasset Foundation in Madrid, Spain. I got in contact with Carrasco through an intern at the Embassy who was arranging a Business Council meeting with various stakeholders

within the health care sector in Chile. I chose Carrasco as my interviewee because he has a good insight mainly in the regulation area but also other parts of both the public and the private sector. As opposed to someone from either an Isapre or Fonasa I also assessed that he would be less biased to the subject. (The whole interview can be found on the USB drive; Audio 1).

My second interview was with Doctor Andrea Srur Colombo (Srur), head of the Department for Non-Transmissible Diseases in the Division for Disease Prevention and Control in the Ministry of Health in Chile. Srur has studied medicine in the Universidad Mayor in Chile, and has a master's degree in Management and Organizational Innovation from the Queen Mary University of London. During her study period, she received two acknowledgment rewards from her university. She has had various administrative positions and since 2014 she has worked in the Ministry of Health. I came to know Srur through my work at the Danish Embassy where she was our main contact in the Ministry. I chose her because I was aware of her professional character and because she has a good insight in the medical world, being a doctor herself. (The whole interview can be found on the USB drive; Audio 2).

My third and last interview is an email interview with the ex-director of the Health Regulatory Agency, Doctor Manuel Inostroza (Inostroza). He holds a master's degree in Public Health with a major in Finance and Management from the Johns Hopkins University in Maryland, the United States. Among his most prominent positions can be mentioned advisor of the General Secretariat of the Presidency in the Division of Modernization of the state and as Chief Executive Officer of two former Ministers of Health in Chile. Currently he works at the University of Andres Bello as director of the Public Health Department, president of the Academic Council and as consultant of the Institute of Public Health, among others. Inostroza is a well-known critic of certain aspects of the Chilean health care system and he often appears on national television for interviews and debates about the current health situation in Chile, which also is how I became familiar with him and decided to contact him. Unfortunately, he was not available for an interview before I moved back to Denmark, which is why the interview was conducted per email (see Appendix C).

2.2.4 Intercultural Interviews

It is worth considering that I did the interviews in Spanish, *interviewing subjects across cultures* as Brinkmann & Kvale (2015) put it. By doing cross-cultural interviews, you must be aware of many cultural factors and habits that you usually do not think about. I was already familiar with the Chilean culture as I had spent almost two years in the country before doing the interviews. Some of

the challenges that I found, was that Danish people are much more direct than Chileans, so I had to consider this to avoid seeming disrespectful to my interviewees and to not create misunderstandings. Furthermore, Spanish is my third language, so although I manage it well, I am not familiar with all the idioms and slang words used in the Chilean language.

The advantage for me was, that while doing the interviews, we were in a formal context in my interviewees' offices, but as the conversations went along the language became more relaxed and informal. But I see it as an advantage that I could conduct the interviews myself and not having to use an interpreter as this could have caused more issues (Brinkmann & Kvale, 2015: 168-169).

2.2.5 Reliability and Validity

An often-occurring question when doing interviews is whether the person conducting the interview can be objective or not. It is important to be critical about one's findings and try to estimate if the interviews can be categorized as reliable and valid.

Reliability relates to the trustworthiness of the findings, for example if an interviewee changes their mind during the interview or if the interviewer asks leading questions which ultimately can influence the answers that the interviewee gives (Brinkmann & Kvale, 2015: 278-282). My interviewees did not seem to change their mind during the interview, although Carrasco was a lot more formal and seemed to avoid certain questions when other people came into his office during the interview. He also seemed to repeat his answers quite a lot and not go into depth with the issues as much as Srur did. He focused on highlighting the good job that his and his colleagues have done to eradicate discrimination in the health care system.

Validity refers to the strength and correctness of a statement, for example if the interviewee uses strong or weak arguments in the explanation of their point of view (Brinkmann & Kvale, 2015: 278-282). I found that both my interviewees had strong arguments to back up their statements. It is their area of expertise so I felt confident that they knew what they were talking about.

2.3 My Role as a Scientist in the Interview

It is important to note that my role as a scientist doing the thesis will always influence my empirical findings and that I can never be 100 percent objective even though I try.

By using the qualitative interview as a method, the scientist can never avoid influencing the empirical data. The interviewer will already in the initial phase of identifying the themes that they

want to work with, have assumed certain connections between the different factors (Brinkmann & Kvale, 2015: 200). For example, instead of asking *if* there is a connection, they might ask *how* this connection manifests itself, and thereby assuming something to be true.

The outcome of an interview will always reflect the individual's perception of a certain problem area within his or her life world. In qualitative methods, you also work with the assumption that the scientist actively influences the creation of the new data which is created in the moment when the scientist meets the interviewee. The interview method is not bound by the fact that the data must fit into a standardized model or that it should be quantified, which makes room for interpretation and a wider use of the empirical data in general (Bjerg & Villadsen, 2006: 23-24). During the interview processes, I found the interview with Srur went from a formal interview situation to a more informal conversation between me and her where keeping the objectivity was more difficult. One can argue that the informal context and subjectivity could produce more honest answers. To validate the results from my interviews, a small questionnaire sent out to various experts on the area could have been a possibility. That way my findings would have been backed up by more than just two people and the thereby have become more reliable.

2.4 Secondary Data Sources

An extensive amount of data is available online about the reforms of the Pinochet era and about the Chilean health care sector, and lately there has been a lot of public debate in Chile about the health care system and the pension system created under the military rule. I have looked for data at the library as well as on the internet and I mainly found sources in Spanish, but sources in English are also available. The sources in English though, do not study this problem from the angle that suited the purpose of my study, and I think the discussion about government versus state in the health care system is also a very relevant debate for many developed countries.

2.4.1 Data Collection & Critical Observations

For this thesis, I have used history books to explain the historical development of the Chilean health care system. These books only contain very little information about health care, so I complemented these with online medical journals. I found that some of the online journals were a challenge to read as I am not a medicine student, and medicine is very far away from my field. Furthermore, I have used public studies and articles from international organizations such as the World Health Organization, The World Bank but also from Chilean institutions such as the Ministry of Health and the Regulatory Health Agency among others. I tried to use both international data and data from Chile to avoid a biased point of view. These sources have been complemented with various articles

and online journals about health care in Chile. There is a vast amount of information available on the history of Chile online so I did not have any problems finding the material that I was looking for.

I use a theory by American economist Joseph E. Stiglitz. Stiglitz' focus is mainly on the United States and through his book he gives various descriptions and examples that are very specific to the US. I argue that the more general part of the book about the role of government in health care and failures of government and markets can be applied to Chile as well. Chile and the United States have in common that the health care sector in the United States is also built upon a public-private dichotomy, but the facilities in the US are to a larger degree owned by private enterprises than in Chile (WHO 1). However, the two countries have different demographical structures so direct comparisons between the systems cannot be made.

Some of the data sources are directly from the websites of the public and the private health care system. One must keep in mind that the private insurance companies have a profit motive and that therefore their data could be biased. Regarding the chapter *Theoretical Background,* I have used both primary and secondary literature to get a broader understanding of the theories.

2.4.2 Data Limitations

It has not been without challenges, gathering qualitative empirical data for this thesis. In relation to the interviews conducted, it was easy to get the first two interviews because the interviewees were contacts of the Embassy where I worked. I had scheduled five more interviews but unfortunately, I only got one more email interview out of it. This might be due to the massive focus on the health care system in Chile recently, especially in the media. The Isapres are for-profit companies that are interested in selling a product and are not interested in getting a bad reputation. There has been a lot of criticism of the private health care insurance companies lately, and no one that I contacted from these companies was interested in an interview. This was a limitation but as there are many interviews available online and a lot of research on the area I decided that it was still worth choosing this subject.

Besides my qualitative interviews, it has been relevant for me to use statistics, to be able to compare the three historical periods (pre, during and post Pinochet era) on demographical factors.

2.5 Analysis Method

My analysis and discussion in chapter 5 is divided into two parts.

Part 1

Part 1 of the analysis is based mainly on my secondary data set, which are books and various academic articles. The focus is the economic and ideological principles behind the health care reforms and a following discussion of market versus state. The chapter is based on historical sources analyzed from a theoretical point of view. Relevant articles have been included and comments from the interviewees have been included to a smaller degree.

Part 2

I chose mainly to use my primary empirical data set for part 2 of the analysis to be able to evaluate the effects that the implementation of the Isapres has had on the Chilean society from my interviewees' point of view. This part is divided into the themes that my informants talked about and these themes are analyzed based on the theoretical framework as well. It also contains a discussion about whether the medical market should be treated like any other financial market, based on the theory by Joseph Stiglitz.

3 HISTORICAL CONTEXT

3 HISTORICAL CONTEXT

” (...)and in spite of their natural selfishness...They are led by an invisible hand to make nearly the same distribution of the necessaries of life, which would have been made, had the earth been divided into equal portions among all its inhabitants...” (Smith, 1759: IV.I.10).

This chapter will look back at the origins of the market versus state discussion initiated by Adam Smith and later criticized by John Maynard Keynes. With these two contradicting points of view in mind, and using Chile as a case study, we will look at the historical development of the Chilean health care system, starting with the creation of the national health care service, moving on to the socialistic presidency of Salvador Allende further up until the military take-over in 1973 inserting General Pinochet as the new leader of the Republic of Chile.

It will be described how the Chilean health care system has changed, from being a state controlled institution, to being a dual system with a public sector on one side and a strong private health care sector on the other side, because of the creation of the private health care insurance companies under Pinochet. Finally, a description of how the Chilean health care system looks today will be provided.

This following historical background will help us understand why the Chilean health care system looks like it does today, and provide an understanding for the ideological mindset behind the transformation.

3.1 The Market and The State

Before the military take-over in 1973, Chile's health care system was based on a socialistic and solidary mindset, and the state was the primary provider of health care. Later throughout the 1980s Chile adopted a set of neoliberal policies which became highly reflected in the health care system as well. The mindset changed from favoring a strong government to favoring a minimum of government intervention and relying on automatic regulation by the market forces.

When we are talking about free market forces versus government intervention in general, it is inevitable to look back at the classical economists to find the origin of these two contradicting visions. This section will provide us with a classical framework dating back to the origin of liberalism beginning with the economist Adam Smith, continuing with the thoughts by John Maynard Keynes who argued against Smith and questioned the market’s ability to always being

able to recover itself.

3.1.1. Adam Smith

When Adam Smith published the book *Wealth of Nations in 1776* he basically laid the base for modern economics and the ongoing discussion about the size of the state. Before Smith the most widespread belief was that a big and active government was the only way to serve the interest of the public. He primarily wrote this book as a response to the 18th century mercantilists, who saw the government as the main promoter of trade and industry (Stiglitz, 2000: 56).

Smith is said to have discovered the market and is often referred to as the father of liberalism. Although he favored a free market with free competition, Smith also acknowledged the positive functions of the state such as abolishing positions of privilege and maintaining order in the society, but always with the end of maximum freedom for the individual (Wilson & Skinner, 1976: 113).

Smith's ideas were based on the principle of a self-regulating market that does not need government intervention to recover from economic downturns. Smith claimed that the most important factor in a society was economic stability, and that this was achieved without interfering and letting the market regulate itself through the *invisible hand* (cf. initial quote).

In accordance with this conviction, everything from employment to production and prices of goods and services would be regulated automatically by supply and demand. The fundamental idea by Smith, was that every individual in society acts primarily on the grounds of their own self-interest (Kurrild-Klitgaard, 2004: 60-64).

Smith attempted to demonstrate that it is difficult to assure that those in charge of governing a country will pursue the public interest. On the other hand, competition, and the fact that individuals are pursuing their own private interest having a profit motive, would be beneficial for the public (Stiglitz, 2000: 56). This prevailing point of view was later challenged due to unforeseen worldwide economic crisis and wars.

3.1.2. John Maynard Keynes

After the international economic crisis and the Great Depression in the 1930ies that hit especially hard in Latin America due to their economic dependency relationship with The United States, some economists started to doubt the previous assumption that the market was perfect and self-regulating.

Attitudes towards government started to change and the market was suddenly seen as being fragile. One of the economists that stated that the market was prone to failure was John Maynard Keynes (Jespersen, 2014: 16-18). In 1936, he published *The General Theory of Employment, Interest, and Money,* where he set forward his doubts about whether the market could restore itself after a downturn.

Keynes' theories was basically a recipe for how to get out of the Great Depression, although it did not gain foothold until after the Second World War. He described how you should increase government spending in times of crisis and reduce the spending during good times which stands in contrast to the theory of Smith. That way you could cure unemployment and prevent great unwanted busts of the business cycle (Markwell, 2006: 1-3).

Although Keynes was not against free trade, he argued that in times of economic crisis, the government should make sure that certain conditions are fulfilled such as full employment to get back to the foundation of classical theory. In other words, government intervention to some extent was necessary in order to restore the free market forces due to the fact that the economy had proven to not always be self-adjusting (Markwell, 2006: 163-164).

Keynes saw capitalism as being vulnerable and argued that laissez-faire could not solve the problems of the economy but that a middle way had to be found. *"Keynes sought a path between individualistic capitalism and socialism, combining economic efficiency, social justice, and individual liberty"* (Markwell, 2006: 174). The Second World War, which began shortly after the publication of his book, seemed to validate the beliefs of Keynes.

3.2 Development of the Chilean Health Care System in the 20th Century

" The distressing demographic and sanitary outlook of the country requires a deep reflection from all Chileans, rich and poor, left and right, governors and governed. National health is one of those problems which has consequences for everyone. No social class, however prepared biologically, can feel immune from epidemics or safe from contagious diseases" (Allende, 2006: 153).

With these two classical economists in mind, focus will now be on Chile as a specific case, as the development of Chile's health care sector has gone from first having a pro government point of view, then to having a pro market point of view and then to going back to more government intervention.

To describe the development of the Chilean health care system, it can be helpful to divide its history into three important milestones of the 20th century: The 1952 reform and the creation of The National Health Service (NHS), the military regime and the privatization of the 1980s, and finally the return to democratization in the 1990s.

To give a full picture of this development I have chosen to divide the historical context into the following three sections: *The Chilean Health Care System before 1979*, *1980s: Leading the Way for a Private Health Care System* and *1990: Democratization of the Health Care System.* The latest comprehensive health care reform of 2005 will also briefly be touched upon as it has implemented guarantees of treatment and can be mentioned as an initiative seeking to even out some of the inequalities that we see in the Chilean health care system today.

I will not go into detail with all the different laws and the changes that the health care system has undergone as this would require more pages. The idea is to give the reader an idea of how the system looked like before the military regime of Pinochet, what happened to the system during the dictatorship and finally how the system looks today.

3.2.1. The Chilean Health Care System Before 1979

A brief description of how the Chilean health care system looked before 1952 will give a better understanding of the background for the creation of The NHS in 1952, which laid the building blocks for the public health care system that Chile has today. This section is included to give a background for the military overthrow and to understand better the two periods analyzed later in the thesis.

In the beginning of the 20th century, the health care conditions in Chile were like those of most Latin American countries at the time. According to The National Statistics Institute the mortality rate in Chile was almost as high as the birth rate. In 1900 Chile had an annual birth rate of 110.697 persons and a mortality rate of 106.812 persons and therefore were close to having demographic involution (Appendix E).

Furthermore, the increasing poverty in the cities, due to stagnation in the mining sector, led to a series of public social initiatives and a great number of health organizations based on public charity were created. The Chilean health care system at that time was therefore mainly based on non-for-profit facilities and The National Public Welfare Commission, created in 1877, was in charge of coordinating all health care initiatives (De Azevedo & Mardones-Restat, 2006: 505).

Another important institution at the time was the Chilean Medical Society created in 1873 which, with its social focus, played a significant role in the creation of the NHS later. In the beginning of the 20th century many actions were taken to improve the country's health care conditions such as the creation of The Chilean Health Code in 1918 and the creation of The Ministry of Hygiene, Health Care, and Social Security in 1924. Already in 1939 during the administration of President Pedro Aguirre Cerda the first proposal for a reform to create the NHS was laid forward by Dr. Salvador Allende, who at the time, served as the Minister of Health and Social Welfare. In the publication, *The Chilean Social Reality,* Allende expressed his concern about the urgent need for a health care reform (cf. initial quote). Despite his suggestion there was not any progress regarding this project for the following ten years and a real health care reform was not made until 1952. The reason could be found in the difficulty of increasing social contributions and taxes without meeting too much resistance from the public (De Azevedo & Mardones-Restat, 2006: 505-506).

After the global economic crisis in 1929 Latin America discovered its vulnerability to outside crisis due to their single led export model, exporting raw materials to the developed countries in return for manufactured goods. Together with the rest of the region this had been their way of entering the world market but the model showed to be vulnerable in times of international economic crisis. The closure of the American and European markets after the crisis ruined this export strategy of the region and the State assumed a new role in society. Most countries in the region adopted the Import Substitution Industrialization (ISI) model, as part of the new protectionism strategy but the thesis will not go further into detail with this model. From 1924 to 1973 there existed a Benefactor State (welfare state) in Chile which appeared because of increased public spending and thereby the state got more influence on the society. After the crisis, the Chilean society was in need for more social protection especially for its workers in this period which paved the way for the welfare state. Between 1930 and 1964 the population increased significantly from 4,5 million to 8 million inhabitants. This was mainly due to the decrease in mortality rates because of improved sanitary conditions (Collier, 1996: 289).

The 1952 reform

In 1952 all previous public health care institutions fusioned and with law number 10.383, the NHS was established. This was the creation of a state organism whose purpose was to protect the health of the Chilean population, focusing mainly on workers and indigent people. This is considered the most important event in Chilean public health history as it initiated a list of programs designed to confront some of the major health issues in Chile at the time such as infant malnutrition, vaccinations and more (Goic, 2015: 774).

Paying to the NHS was obligatory and free election of doctor or hospital did not exist at the time. The main funding for this institution came from employer-, worker- and tax contributions. Soon after the creation of the NHS, investments in rural hospitals and primary health care clinics were initiated (MINSAL 1 + Aedo, 2001).

The creation of the NHS meant an increase in the health care benefits which lead to rising standards of health quality. Until 1925 most of government's social expenditures was spent on education, but by 1955 health care had become one of the most expensive posts on the budget. Chileans lived longer than before but the population still struggled with issues such as malnutrition (Collier, 1996: 289).

To sum up the Chilean health care system consisted of four central institutions before 1973: The Ministry of Health (MINSAL), The National Health Service (NHS), The National Medical Service for Employees (SERMENA) and the private sector (see Appendix F for organization chart of the system before Pinochet).

Neither MINSAL nor the private sector had a huge role at the time, as the main administrative and operational functions laid within the NHS, so you can argue that the public health care system was divided into two parallel systems until the end of the 1970s. One part, The NHS, was mainly in charge of blue-collar workers as well as the unemployed and was financed through taxes and payroll contributions. The other part, SERMENA, was in charge of white-collar workers and was financed through payroll contributions and out-of-pocket payments from beneficiaries. A very small part of the population was not in either system as they were covered by the military health system. This group accounted for about 5 % of the population (Manuel, 2002: 63).

Salvador Allende

During the sixties and early seventies this fusion of institutions creating the NHS showed to have had positive effects on society such as the decrease in the infant mortality rate. During the presidency of Salvador Allende this positive development continued (Infante, 2006: 1). Allende was president of Chile from 1970 until 1973. Before becoming a president, Allende studied medicine, and during his studies he became aware of the medical situation and poor conditions for the poor in Chile. During the 1930ies he became well known within the Socialist Party and in 1939 he was elected as Minister of Health. In 1945 he became senator and in 1970 he finally moved into La

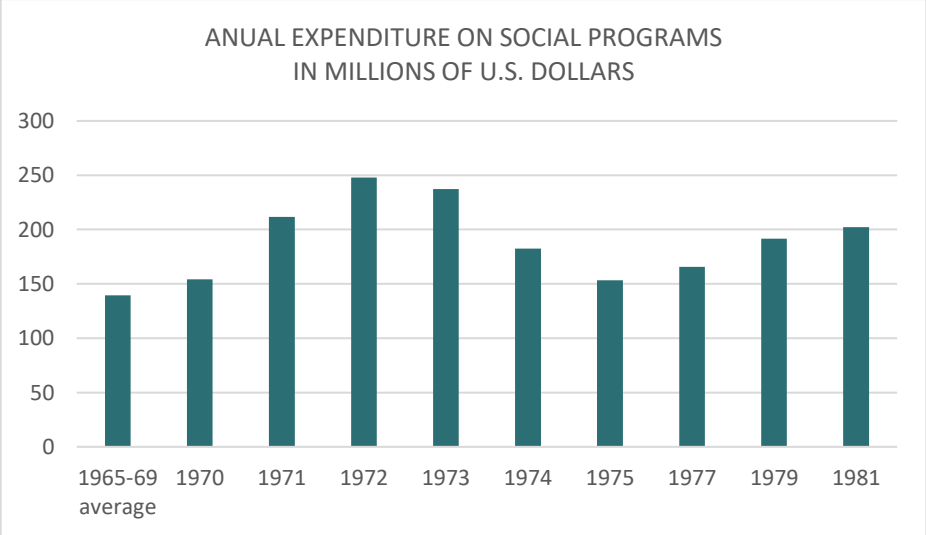
Moneda[2] as the new president of Chile. The period of Allende's presidency is referred to as *The Chilean Road to Socialism* (Collier, 1996: 330).
Allende's political party UP (*Unidad Popular*) aimed to nationalize many industries in Chile eradicating all large private corporations. Among these were the banking sector and the cobber mines. Overall the UP government followed a Keynesian strategy and they sought to provide employment and improve the conditions for those who were worst off (Collier, 1996: 341-344).

The idea behind Allende's socialism was to create full employment and redistribution of income but according to critics he failed to accumulate capital which resulted in a rise in inflation, increasing dependency on the outside world and food shortages which in turn led to strikes and dissatisfaction among the population (Mamalakis, 1976: 99).

On the other hand, expenses on social security in Chile rose to 15 % of the total GDP and covered almost all accidents and risks and was the main reason for the improvement of health in Chile at the time. From 1930 to 1972 Chile experienced a huge increase in the population covered by the social security system. In 1960 63 % of the population was covered, a number that rose to 72 % in 1971. The quality of the services varied though, depending on which security institution you belonged. With this social security system Allende sought to ensure a more fair and equitable distribution of benefits (Mamalakis, 1976: 198-199).

Expenditures for social programs before, under and after Salvador Allende:

Figure 1



Source: Own elaboration based on table in (Collier, 1996: 331)

[2]La Moneda: The Presidential Palace in Santiago, Chile.

We can see from the table above that the amount allocated for social expenditures goes up during the presidency of Allende from 1970 to 1973 and then falls drastically in 1974 after the military take-over. It increases again about the time of the creation of the Isapres[3].

During the decades from the 50ies to the 70ies the Chilean health care improved a lot in general. The mortality rate fell from 32,9 per 1000 inhabitants in 1921, to 15 in 1950 and to 8,56 in 1970. Infant mortality also fell significantly from 338 pr. 1000 live births in 1890 to 234 in 1930 and 77,52 in 1970 (Mamalakis, 1976: 197).

3.2.2 1980s: Leading the Way for a Private Health Care System

The military take-over in 1973 meant structural changes in the government, turning the economy in a neoliberal direction.

From 1973 to 1981 a group of technocrats from the University of Chicago, who later became known as the Chicago Boys, were appointed to be central economic advisors of the Pinochet military rule. Their thoughts and ideas were based on the political philosophy of economist Milton Friedman, which meant emphasis on a free market economic system with minimal government intervention.

They imposed a neoliberal monetarist program, which became known as a neoliberal shock therapy. Advocates of free market based economies called this period *The Miracle of Chile* (Huneeus, 2007: 271). The military reduced the socioeconomic role of the state significantly by privatizing state owned enterprises including health services (Remmer, 1989: 5).

During the 1980s all the Latin American countries engaged in heavy borrowing and they were especially dependent on borrowed money from the United States and Europe. A mix of an international recession in 1980 and the excessive borrowing, led the whole region into a debt crisis also known as *The Lost Decade* (Coerver & Hall 1999: 170). The major international economic players such as the World Bank and IMF set forward a set of strict neoliberal macroeconomic and structural reforms that the Latin American countries had to follow to borrow more money or get their debt rescheduled. These included reducing state expenditures and deregulation, opening the economy to foreign investment trade and the privatization of enterprises among others (Coerver &

[3] ISAPRES: Private Health Care Institutions.

Hall, 1999: 173-174). These reforms became known as the Washington Consensus (WC), but in this thesis no further elaboration on these politics will be made as Chile had already implemented neoliberalism by the time of the WC. This brief background information serves to give an understanding of the international context that the military regime worked within.

The foundations of the health care system that we see today in Chile were laid during the military regime. The health care reforms of the Pinochet era focused on two areas; *decentralization* and *privatization* of the health care sector. At the end of 1979 the role of the NHS, which before had been the main provider of health, was dissolved and the NHS and the SERMENA were merged into a single institution called The National Health Services System (NHSS).

The role of The Ministry of Health was redefined and they were now in charge of coordinating actions between all the different institutions of the health care sector and defining health policies and programs. The decentralization led to the creation of 27 autonomous regional health services which were each in charge of a certain region, and in 1981 the 341 municipalities regained the administration of primary health care centers. One of the benefits of the decentralization of the system was the elimination of bureaucracy, but on the other hand there were a huge difference in resources among the different municipalities and the poorer ones had a hard time living up to the standards of before (Isapres, 2016: 7).

The current public health care system, Fonasa was created in 1979 as part of the NHSS and was now in charge of all financial services which included collecting, administering, and distributing the financial resources of the public sector. The role of the state went from being central in providing health care to the public, to playing a subsidiary role, based on a pro-private principle, which meant that the state had less influence than before and that every Chilean taxpayer now had the whole responsibility of his or her own social protection (Manuel, 2002: 63-64).

The military regime's reliance on the Chicago Boys meant that that they had a great emphasis on the development of the private sector. Citizens were now offered a choice between paying the obligatory contribution of their salary to the private system instead of the public system as before. The military regime claimed that this would ensure the freedom of choice for the population, which is highly valued according to neoliberal thinking. Also, the management of health resources would now rely on competition, making it more efficient.

The goal was to lessen the influence of the state and to lessen the tax burden, which resulted in the

creation of the private health insurance institutions, referred to as *Isapres* On March 19 1981, with the publication of Decree law number 3, Isapres were created and workers could now choose freely among the different Isapres if they preferred, instead of paying to the public system (Collier, 1996: 373).

In the beginning the Isapres received a state subsidy of 2% of the workers' salary to incorporate more people into the system. But this subsidy was removed again in 1999, which meant that almost one million workers had to change from Isapres to Fonasa as they were not able to pay their monthly contribution any longer (Isapres, 2016: 8). After this change the Isapres did not receive any subsidies from the state but operated within a system of free competition. They were based on an insurance scheme, where people paid a monthly contribution and in return get funding for their health care costs (Health Regulatory Agency 1). The monthly contribution increased from 4% of the taxable income to 7% and the membership was exclusively for the worker registered in the Isapre. The Isapres still work like that today, and a more detailed description will follow later.

3.2.3 1990: Democratization of the Chilean Health Care System

In the 1990s Chile got its first democratic government since 1973 when president Patricio Aylwin took office. Although General Pinochet continued as commander in chief of the army until 1998, Chile could unite political institutions and thereby produce democratic order once again (Huneeus, 2007: 449). The following twenty years after the reimplementation of democracy in Chile a centre-left coalition known as the *Concertación* remained in power. The coalition primarily consisted of the Christian Democrats (PDC), the Socialists (PS) and the Party for Democracy (PPD).

Slowly Chile initiated a recovery process of its institutions including a reintegrating process of the health system. Many primary care units had been detached from the specialized facilities under the Ministry of Health, but through the democratization process the municipalities began to strengthen their reliability and management skills and this began to change (De Azevedo & Mardones-Restat, 2006: 509). The dismantling of all the authoritarian institutions was a long process that continued through the presidencies of Frei Ruiz-Tagle (1994-2000) and Ricardo Lagos (2000-2006). The health care system created under the military rule was modified but the structure from the military dictatorship remains today where the private health care system and the Isapres still exist (Huneeus, 2007: 449).

In 1990 there was an extensive reform of the public health care system Fonasa. The reform focused

on increasing the public expenditure on health care. In the same year, an Isapre Regulatory Agency (*Superintendencia de Isapres*) was created to regulate the administration of the 7 % contribution paid by the users of the private health care system. In 2005 as part of the health reform, it changed name to Health Regulatory Agency (*Superintendencia de Salud)* and its role was widened to include regulation of the public sector as well (MINSAL 1). Today the Health Regulatory Agency has a clear mission to protect and promote health care rights of all individuals in relation to Fonasa, the Isapres and the health care providers as well (Health Regulatory Agency 1). It is important to note that even though changes were made to the health care system, the basic structure created under Pinochet continued to exist and persists today.

3.3 The Chilean Health Care System Today

Chile today has a mixed healthcare system which is constituted of the public institution, Fonasa on one side and the private healthcare institutions, Isapres on the other. Both sub-sectors are partially financed by 7 % of their members' income but with a ceiling of 4,2 UF[4] a month. See Appendix G for an organization chart of how the health care system is structured today.

3.3.1 FONASA

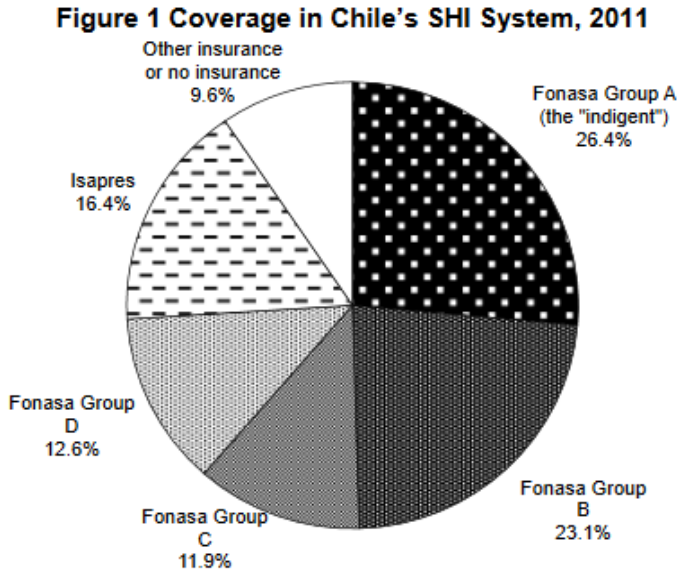
The National Health Fund (*Fondo Nacional de Salud*, FONASA) is the public institution responsible for granting healthcare to most the Chilean population. Fonasa forms part of the NHSS and underlies laws and regulations from the Ministry of Health.

The public health care system is based upon a principle of solidarity, which means that they do not refuse beneficiaries for any reason such as preexisting conditions or age for example, and if a beneficiary is not able to pay the obligatory 7 % of their income, they will receive a subsidy from the state (Health Regulatory Agency 1).

In Figure 2 below, taken from a World Bank report, it is illustrated how the Chilean population is divided into those who belong to Fonasa, those who belong to an Isapre and those who either have another insurance or do not have an insurance at all. The beneficiaries of Fonasa are divided into group A, B, C, and D (see distribution in Figure 2). The group you belong to depends on your income. See Appendix H for a detailed overview of the differences between an insurance plan in Fonasa and one in Isapre, and for a detailed explanation of the different groups within Fonasa.

[4] See Abbreviations

Figure 2



Source: (Bitran, 2013: 2)

3.3.2 ISAPRE

Instituciones de Salud Previsional (ISAPRE) are private Health Insurance Institutions and currently there are thirteen of these institutions in Chile, seven of which are" open" and six which are" closed". An open Isapre means that it is open to the public and that anyone can call to get an offer on a health insurance plan. The closed Isapres are reserved for workers that belong to a certain company or institution (Health Regulatory Agency 2).

The private health care system in Chile operates within an insurance scheme where the beneficiaries pay for different health care plans, whose value is determined by factors such as gender, age, and medical history. The last-mentioned can be the reason for posing limitations in the chosen health care plan or in some cases it can be the reason for the rejection of a beneficiary by the insurance company. Beneficiaries of an Isapre also pay a minimum of 7 % of their taxable income, but often pay an additional fee depending on the mentioned factors (Becerril-Montekio, 2011: 136).

3.3.3 Distribution of the Population in the Public and the Private System

In 2011 Chile had a population of approximately 17,2 million people. The non-profit state controlled Fonasa, provided health to about 13,2 million people, which is more than three-quarters of the country's population or about 80 % of the population. The thirteen private-owned for-profit insurance companies, Isapres, covered about 2,9 million Chileans which is approximately one-sixth

of the population or about 17 % of the total population. The remaining 1,1 million Chileans were insured though other welfare systems for example the Armed Forces or the Police, or did not have any insurance at all (Benavides et al., 2013: 9). Those without an insurance are often those who have a higher income, as they have the possibility to pay individually for their treatments. The ones without income usually are registered in Fonasa (see Appendix I for distribution of population in the two system according to income).
The table in Appendix I shows the population and what health care system they belong to, based on their income. The population in the table is divided in quantiles where number 1 represents the poorest part of the population and those without income or income up to less than the minimum wage. Quantile 5 represents the wealthiest part of the population.

Moreover, as beneficiary of an Isapre you have available various private health care providers to which the Fonasa beneficiaries have limited access. Likewise, the beneficiaries of the Isapres have limited access to the public health care providers. This is mainly because by law, public hospitals have limits on how many hospital beds they can make available to non-Fonasa beneficiaries but also partly due to the fact that through their own health care plan in an Isapre they have access to treatment of a higher quality (Bitran, 2013: 3).

3.3.4 Health Care Reform of 2005

The latest big health care reform in Chile was implemented in 2005 and is called Regime of Explicit Health Guarantees (*Régimen de Garantías Explícitas en Salud,* RGES) or more commonly referred to as Plan AUGE. This reform was built within a social guarantee framework for both beneficiaries of Fonasa and Isapre. With this plan the population is guaranteed treatment within a certain time period, and if the public system cannot live up to this guarantee, they can get treatment in the private system. Basically, the plan is a mechanism which prioritizes prevention, treatment and rehabilitation of specific diseases that pose the greatest health risk for the population. Initially the guarantee included 56 pathologies but since 2005 it has been expanded to cover 80 different pathologies (Bitran, 2013: 6).

4 THEORETICAL FRAMEWORK

4 THEORETICAL FRAMEWORK

"Many believe that no individual, regardless of his income, should be denied access to adequate medical care (..) This view holds that medical services are different from clothes, movies, automobiles, and most other commodities. Just as the right to vote should not be subject to the marketplace" (Stiglitz, 2000: 321).

In the following chapter two different views on state and market will be presented.

In many developed countries, there has been disagreement for a long time about whether the state or the forces of the free market should be in control of the important institutions of society, including the health care system. One point of view argues that government intervention is needed to have a stable health care system because the market can fail and therefore we need to control it to some extent. To represent this point of view I have chosen public sector theory by American economist and professor at Columbia University, Joseph E. Stiglitz who is also a former vice president and chief economist of the World Bank and a Nobel prize winner.

In contrast to this theory, stands Neoliberalism, which was implemented in Chile during the dictatorship of Augusto Pinochet between 1973 and 1991. In this period, Chile took on many neoliberal reforms, opening the country to free trade and privatizing many public companies and institutions including the health care sector. To represent this point of view I have chosen to focus on the economic theory by another Nobel prize winner, Milton Friedman. Milton Friedman was chosen as he formed part of the *Chicago Boys* who influenced the economic policies of Pinochet under the military regime in Chile.

These two theories will together serve as a theoretical background to understand the political and economic changes that Chile has undergone during the last decades and to understand the development of the Chilean health care sector has taken as a result.

The two concepts will be discussed in the following:

4.1 Joseph E. Stiglitz - Rationale for a Role of Government in the Health Care Sector

To represent the advocacy for statism, I have chosen American economist Joseph Stiglitz.
The term *statism* can take many forms from democracy and socialism to communism or even totalitarianism. According to the Oxford Dictionary, it is defined as: *"A political system in which*

the state has substantial centralized control over social and economic affairs" (Oxford Dictionary 1).

Furthermore, *state* can be defined as: *"A nation or territory considered as an organized political community under one government."* (Oxford Dictionary 3).

In the word *statism* lies the notion that the state plays a major role in the economy, either directly through state-owned enterprises (SOEs) or indirectly through management of the economy. The state intervenes in the development process of a country and the allocation of resources rather than leaving it up to the free market. This expansion of statism and SOEs also occurred in Chile and this development was inspired by Keynes and occurred after the depression of the 1930s and two world wars (Barry Jones 1, 2001: 1475-1480).

Stiglitz is well known for his critique on the market economy, as he claims that the free market does not always work perfectly and that in general it fails to create efficient outcomes and social justice. His most essential contribution to modern economic thinking has been proving that the market participants not always possess the same amount of information which creates an asymmetry between who knows what. Therefore, the state must play a role to create transparency and to correct the errors of the free market (Joseph Stiglitz Official).

The role of the government has changed a lot in the 20th century, and in his work *Economics of the Public Sector (2000)* Stiglitz puts forward a discussion about the role of government in modern economies and specifically in the health care sector. First, I will describe his view on the strengths and weaknesses of both the free market and the government to understand Stiglitz' standpoint better, and finally I will look at his opinion on having a private health care sector.

Government is defined as: *"The group of people with the authority to govern a country or state; a particular ministry in office."* (Oxford Dictionary 4)

But what defines government as an institution and sets it apart from a private institution?

4.1.1 Government Versus Private Institutions

According to Stiglitz (2000), there are two important differences. The first one is the fact that a politician holding an important position in the government has legitimacy through the electoral process. In a democracy, the people who work within the government are people who have been elected by the public, or appointed by someone that was elected. On the other hand, people who run

a private company are chosen either by the leadership or the shareholders of that company, which means that there could be an economic interest in the election process.

The second major difference that Stiglitz highlights is that government has other rights than private institutions, or *powers of compulsion* as he calls it such as governments' right to forcing you to pay taxes and seize your private property if you fail to do so (Stiglitz, 2000: 13). This shows that the government is fundamentally different from other institutions, which in some cases makes it stronger, but which also can turn out to be a weakness as will be described below.

4.1.2 Government Failure

Market failures have been the reason for many major government interventions in the economy but not all government-led market-interventionist programs were successful which led economists to investigate in the failures of government. Stiglitz highlights four reasons as to why government intervention fails:

Limited information

According to this argument government does not possess the information necessary to achieve its objectives. It can be difficult to foresee the whole future cost of a government program, and often extra costs occur making the program a lot more expensive than anticipated (Stiglitz, 2000: 9).

Limited control over private market responses

The second reason is the fact that government has limited control over its actions. If government for example sets a price for a specific service in the hospitals, it cannot control the total level of expenditures as the patients and the doctors will determine which services are being provided and used (Stiglitz, 2000: 9).

Limited control over bureaucracy

The Congress is the main actor in designing new legislation whereas government later gets the primary responsibility in implementing the laws. According to Stiglitz this can become a problem when government agencies are not able to carry out the law as intended by Congress. His explanation for this is, that government bureaucrats might lack the incentive to carry out the will of the Congress (Stiglitz, 2000: 9-10).

Limitations imposed by political processes.

His last argument is related to political interests and how these can raise difficulties for the government. It can be the influence of interest groups, or the fact that politicians often look for simple solutions which can influence government decisions (Stiglitz, 2000:10).

4.1.3 Market Failure

Not only government can fail. When the allocation of goods and services is not sufficient, we have a so-called *market failure*.

Under perfect circumstances the market result in Pareto efficient outcomes. *Pareto efficiency* assumes that in resource allocation no one can be made better off without someone else being made worse off. Pareto efficiency occurs when there are no more transactions that can take place to improve the lot of at least one of the parties involved. If someone could be made better off without hurting someone else, Pareto inefficiency exists. Both parties do not necessarily have to be made better off. Only one person must be made better off as long as the other person is not made worse off (Stiglitz, 2000: 57).

The belief that such improvements can be made is called the Pareto principle. Sometimes a combination of changes is necessary to reach a Pareto improvement. For example, compensating the person that was made worse off with something else that makes him better off as well. Changes that make rich people better off and does not affect poor people are desired. Therefore, Pareto efficiency does not necessarily result in an equal distribution of resources and it does not consider equality at all (Stiglitz, 2000: 57-59).

Stiglitz claims that the economy can only be Pareto efficient under certain circumstances, and there are six cases in which markets are not Pareto efficient which will be described briefly below.

1. ***Failure of competition***

One of the requirements to achieve Pareto efficiency is to have perfect competition. The issue is that in some industries there is only one or a few big actors that hold a large scale of the market, and then we have oligopoly or monopoly which are not the ideal of perfect competition (Stiglitz, 2000: 77-78).

2. ***Public goods***

The second requirement relates to the insufficient production of some products. There may be some products that are not supplied at all by the market or some that are not produced in a sufficient

quantity. These products that the private market fail to provide adequately are referred to as *pure public goods.* It is in no one's interest to provide these goods, and if they do, they only think of how the outcome can benefit them and not everybody else (Stiglitz, 2000: 79-80).

3. Externalities

In some cases, the action of one individual or one company can affect other individuals or companies. Stiglitz talks about positive and negative externalities. An example of a positive externality could be planting beautiful flowers in the garden, which is also nice for the neighbors to watch and therefore benefit them indirectly. An example of a negative externality could be driving a car without a pollution control device which indirectly imposes an extra cost on other people. In case of these externalities, resource allocation will not be efficient as all individuals will not enjoy the benefits of a certain activity. People act in their own self-interest so we need government intervention to prevent high pollution for example (Stiglitz, 2000: 80-81).

4. Incomplete markets

The private market also fails to provide other products than just *pure public goods*, even though the cost of production is lower than what the public wants to pay. We see this in the insurance market for example, where government has had the primary role in providing unemployment insurance and some health insurances, where there is an incentive for the private market to keep some people out as they are too risky. The same applies to the capital market. This can be explained by a lack of *innovation*, high *transaction costs*, *asymmetry of information* or *high enforcement costs.* Under these circumstances a market will not exist. Sometimes there is a lack of a complementary market, which means that each producer would not be able to pursue the public interest along but only acting together with another producer (Stiglitz, 2000: 81-82).

5. Information failure

Sometimes the private market supplies little or inadequate information and when that is the case government intervention is needed. Some examples could be labelling of food products or alcohol. In other cases, the cost of gathering information about a specific area can be costly for the consumers and the government can then can serve as the supplier of the information. A sector that is highly affected by the lack of information is the health care sector, which will be elaborated later in this chapter (Stiglitz, 2000: 83-84).

6. Unemployment, inflation, and disequilibrium.

Finally, in time of high unemployment for example you can argue that there is a role for

government, but no further emphasis will be made on this area in this thesis.

Even though all these conditions are met and the market is Pareto efficient, there can be an argument for government intervention, according to Stiglitz. As mentioned above this principle does not consider equality, and therefore the gap between rich and poor can increase immensely even though the poor are not made worse off per se. Another argument for government intervention is that even fully informed consumers make bad decisions and do not always act in their own best interest.

Stiglitz advocates for government regulation in many areas such as the health care sector, which will be described in the next section below.

4.1.4 Stiglitz' View on The Health Care Sector as an Economic Market

Stiglitz talks about the challenges of having a private health care sector, and argues that the government should play a role in this area given that the health care market is not a typical financial market. He describes four market failures as an argument for government intervention in the health care sector, and he hereby sheds light on the fact that the medical markets and standard competitive markets are very different. Even without these market failures there might be a role for government he argues, as some people have such a low income that they would not be able to pay for health care at all.

Imperfect information.

The first market failure that Stiglitz describes is that of imperfect information. He talks about a fundamental problem that faces all of us as consumers when we must choose a doctor or a health insurance: "*When consumers go to a doctor, in large measure they are buying the doctor's knowledge and/ or information. As a patient, the consumer must rely on the doctor's judgment as to what medicine is required or whether and operation or other procedure is advisable"* (Stiglitz, 2000: 309). It can be very difficult for patients to assess whether a doctor is qualified or not, because they simply do not have the same education and therefore they must rely blindly on the doctor's advice. A successful experience with a doctor may even depend on his or her personality or social skills which can influence your experience in a negative or in a positive way. (Stiglitz, 2000: 309).

On the contrary, when going to the supermarket to buy groceries or other types of repeated everyday purchases, it is easy to quickly see price and quality of the products you wish to buy, and

compare it to other supermarkets. As a consumer, you are therefore well-informed, and additionally there is huge competition in this area which means that it is easy to choose a supermarket or a product that fits your needs. Most types of surgeries are something that you get only once in your life, so you do not build up a knowledge based on continuous purchasing as you do with groceries or clothes (Stiglitz, 2000: 309). This leads me to Stiglitz' next argument.

Limited Competition

The basic rules in competition does not apply to the medical world due to the lack of information or imperfect information described before." *Imperfect information decreases the effective degree of competition"* (Stiglitz, 2000: 309). No one other than the doctors themselves can estimate the quality of a specific treatment, and the patients are left without the ability to determine where they can get the best value for their money. On the free market, prices are usually regulated according to supply and demand, but in this case lowering the prices is not necessarily the best way to attract new patients, whereas lowering the price on a standard commodity immediately will attract customers as they can compare the price to that of other stores selling the same product. Low prices imply that a certain doctor is not in demand, which indicates that it might be a bad doctor. Furthermore, the quality of medical services can vary from patient to patient and the best treatment for patient A may not be the best treatment for patient B although they suffer from the same disease. This makes it almost impossible to compare price and quality and thereby giving the patients the information they need (Stiglitz, 2000: 310).

Absence of profit motive

The role of non-for-profit organization in the medical market is also an important factor that distinguishes it from a standard competitive market. These institutions do not view their main goal as maximizing their profit or minimizing the cost of production. On the other hand, for-profit hospitals might be more efficient as they have an incentive for providing health care of high quality to the consumers (Stiglitz, 2000: 310).

After having clarified Stiglitz' view on government and free market, we can go on and look at the neoliberal point of view represented by Milton Friedman.

4.2 Milton Friedman – Rationale for Minimum Government Intervention

"A society that puts equality before freedom will get neither. A society that puts freedom before equality will get a high degree of both" (Friedman 3, 1980)

To represent the advocacy for free market forces and neoliberalism and thereby the opposite view to that of Stiglitz, I have chosen economist Milton Friedman.

Up until the Great Depression, the prevailing economic conviction had been inspired by Adam Smith who advocated for a free market without government intervention. After the Wall Street crash and the Great Depression, Keynesianism started to gain foothold among economists (cf. *Historical Background*, chapter 3.1). From the economic crisis of the 1980s and up until the financial crisis of 2008 neoliberalism dominated government politics in many Latin-American countries. But what exactly is neoliberalism?

The concept *neoliberalism* suggests that it is a revival or a development of the classic liberalistic thinking after it has been absence as a political ideology for some time. From the following quote, you can read that neoliberalism is perceived as an ideology descending from but not identical to classical liberalism:

"Neoliberalism represents a set of ideas that caught on from the mid to late 1970s, and are famously associated with the economic policies introduced by Margaret Thatcher in the United Kingdom and Ronald Reagan in the United States (...). The ˊneoˊ part of neoliberalism indicates that there is something new about it, suggesting that it is an updated version of older ideas about ˊliberal economicsˊ which has long argued that markets should be free from intervention by the state. In its simplest version, it reads: markets good, government bad" (Campbell et al., 2005: 100, line 4-11). Also, The Oxford Dictionary describes neoliberalism as: *"A modified form of liberalism tending to favour free-market capitalism"* (Oxford Dictionary 2).

There are some key concepts of neoliberalism which were reflected in the political and economic reforms made in the Pinochet era under the influence of Milton Friedman. The first and most important one when talking about the reform of the Chilean health care system is *privatization*:
"Privatization describes the process of rendering private or bringing into the private sector the production of goods and services previously owned and delivered by the state" (Barry Jones 1, 2001: 1273-1274).

Another essential action taken by the Pinochet government was the expansion of market forces within the domestic market. The Cambridge Dictionary offers the following definition to *market forces: "The forces that decide price levels in an economy or trading system whose activities are*

not influenced or limited by government" (Cambridge Dictionary).

Milton Friedman was against the welfare ideology that since the 1930ies had claimed that the state should regulate the market when necessary, in order to create jobs (Perregaard, 1982: 131). Friedman acknowledged the positive functions of the government to enforce law and order in the society in general, as well as in a business context. But he was against state intervention in most other areas.

In the following a brief and general introduction to the economic and political convictions of Friedman will be provided followed by a description of his view on the functions of the government, reasons for government failure and finally his view on the government's role in the health care sector. Friedman's theories and works reach way beyond what is described in this chapter, as focus has only been on areas relevant for the following analysis and discussion.

4.2.1 Friedman's Economic Keywords

A keyword in Friedman's political philosophy is *decentralization* as he claimed that decentralization is a prerequisite to ensure economic freedom for the producer as well as the consumer. Political and economic freedom for each citizen is the primary goal with having a decentralized society according to Friedman.

Another important keyword is *monetarism.* This economic term is mainly associated with Milton Friedman and it was also introduced in Chile from the late 1970s through the 1980s when Friedman introduced his liberal policies to the Chilean government. Monetarism consider the money supply as the most important factor in determining economic activity and emphasizes the role of government in controlling the amount of money in circulation. Monetarists argue that, targeting the quantity of money is the most efficient tool to target the rate of growth. This economic belief was also embraced by the British and US central banks under the governments of Margaret Thatcher and Ronald Reagan (Barry Jones 2, 2001: 1035).

Furthermore, Friedman is known for his modification of the classical Philips curve related to Keynesian economics. The Philips curve claims that there is a short-run trade-off relationship between low inflation and low unemployment, which meant that they are mutually exclusive. Friedman discovered what he called the NAIRU, which is a natural level of unemployment and developed the so called long term Philips curve. He argued that that inflation could be high or low but that the unemployment rate would always come back to its natural point, a point that was

independent of the inflation rate. By expecting inflation instead of letting it come as a surprise, you could calculate it into your economic decisions and calculation of prices and wages (Puttaswamaiah, 2009: 135-136).

4.2.2 Friedman and The Four Functions of Government

Friedman's critique of the public sector concerns how public measures often lead to the exact opposite of the original intention behind it. Like everything else government action do also experience unforeseen effects and government also fail sometimes (Butler, 2011: 94).

Milton Friedman agreed with the three functions of the government originally identified by Adam Smith, and he later added a fourth one. The first function is to *protect the society from invasion or violence of other independent societies*. To this Milton Friedman argued that the government does not necessarily have to employ police and military, but like any other service these should be bought from private suppliers. The second function is to *resolve disputes* which means to protect individuals from the injustice or oppression of another member of the society which also relates to the protection of private property. To the second function Friedman added what he believed to be a related duty, a fourth one, which is not mentioned by Smith. He argued that the government should protect people who cannot be regarded as *responsible*. This included children and people with severe mental illnesses. The last duty of government, and the third one mentioned by Smith was providing and maintaining public institutions that are useful to society and which cannot be provided privately (Butler, 2011: 92-93). In Milton Friedman's words, this means a recognition of the government's role in these four cases, to enforce the rules of the game but not to hinder the forces of the free market. He thereby advocated for a bigger government than Smith did, but for Friedman the four duties of government were all necessary means to ensure freedom of the individual, which was always the most important goal in his opinion.

In a broader sense, Friedman was against too much involvement of the state and in his work *Capitalism and Freedom (1962)* he lists various areas where he saw no role for the government. But this thesis will not go further into detail with these.

In a famous quote, Friedman argues that the prosperity of societies does not come from big government but comes from individual greed:
"(...) is there some society you know that doesn't run on greed? You think Russia doesn't run on greed? You think China doesn't run on greed? What is greed? (...) the world runs on individuals pursuing their separate interests. (...) In the only cases in which the masses have escaped from the

kind of grinding poverty you're talking about, the only cases in recorded history, are where they have had capitalism and largely free trade. (...) there is no alternative way, so far discovered, of improving the lot of the ordinary people, that can hold a candle to the productive activities that are unleashed by the free-enterprise system" (Friedman 1, 1979).

From this quote one can derive that to improve the condition of all people, the free-enterprise system is the only way. People act in their own self-interest which in turn gives the best results for society. So, what is Friedman's view on government?

4.2.3 Why Governments Fail

It is relevant to look at Friedman's view on why a big government can never be successful. He shares the view of most classical liberals who perceive the human being as imperfect. All individuals, our rulers included are imperfect beings, why *it is wise to limit the harm they can do with their concentrated power* (Butler, 2011: 94). In the following section, three of Friedman's arguments against government will be presented.

The first argument is that, like everyone else, the politicians as well as government officials have their own private interest which they are pursuing. Lobbyists and campaign funds can be mentioned as good examples. These bureaucratic interests may not always be equivalent to the interest of the public. To avoid abuse of the citizens' rights committed by the state, Friedman argues that a division of political and economic power is the best solution. An example of what will happen in the absence of this division, is a worker who has a different political opinion than the authority in power of the government, but wishes to express his opinions freely. This worker will need to have a job to be able to survive. But if the political authorities control the labor market it may be hard for the worker to find a job. Even though he manages to suppress his opinions when he is working, out of fear of losing his job, he will never be able to express and communicate his political point of view if he wishes to do so, i.e. freedom to express personal political opinions which undermines the people's freedom of expression in general (Perregaard, 1982: 134-135).

Friedman's second argument against government interference is that government programs tend to last a long time and they also tend to expand in time. This can be a problem if we end up having almost as many beneficiaries as taxpayers, as this may result in increasing tax rates which will make taxpayers complain. Government should grow as the population grows, but government tends to grow at a faster speed and we end up having a government with an enormous power (Butler, 2011: 97).

The third and last argument is the huge cost that is related to the government, not only the financial cost for the state, but also the individual cost in form of income taxes, social insurance taxes, property taxes, sales taxes etc. Friedman then goes further to argue that what government spends, it spends ineffectively. Because of government intervention, growth is slowed down and at the same time the incentives to work, save and invest are ruined (Butler, 2011: 97).
Friedman illustrates his opinion of government spending in the following quote from an interview with Fox News from 2004:
"There are four ways you can spend money. You can spend your own money on yourself. (...) then you really watch out that you're doing, and you try to get the most for your money. Then you can spend your own money on somebody else. For example, I buy a birthday present for someone. Well, then I'm not so careful about the content of the present, but I'm very careful about the cost. Then, I can spend somebody else's money on myself. (...) then I'm sure going to have a good lunch! Finally, I can spend somebody else's money on somebody else. (...) I'm not concerned about how much it is, and I'm not concerned about what I get. And that's government. (Butler, 2011: 98).

The arguments and quotes above represent Friedman's view in general on government intervention. We will now look at his opinion on government intervention specifically in the health care sector.

4.2.4 Friedman's View on The Health Care Sector

Milton Friedman believes that the government should not interfere in the medical care field, just like it should not interfere in any other economic sector:

"In my opinion there is no special role for government in the medical care field. With the exception of the public health activities of government where there is a special problem, but I am now talking about private medical care..." (Friedman 2, 1980).

Friedman recognizes that government has a minimum role in the medical care field, which is the same role that it has in any other field. This means that the government should only help people who are in dire distress (c.f. the fourth duty of the state in section 4.2.2). He compares medical emergencies with people that have lost their homes in a hurricane. Only in these emergency situations should the government play a role, and never in the regulation of the private health care sector.

In a lecture from 1978 Friedman advocates for the elimination of government control in the medicine industry in the United States as he claims that the government is executing monopolistic practices. He also argues that doctors' licenses should be eliminated as this is also a sign of government intervention in a field where free market forces should be in control. Friedman argues that the doctors' licenses is no assurance of quality unlike a private business that will assure the highest quality to be able to stay in business.

"In my opinion it would provide for better medical care, more widely available, at lower cost for the bulk of the people and that it would be the only effective way of preventing what seems to be a flood tide towards a complete socialization of medicine" (Friedman 2, 1980).

Even though Friedman is talking about the specific case of the United States his statement gives a good picture of his opinion on government intervention in the medical field.

4.3 Final Comments

To quickly sum up chapter three, Milton Friedman was a strong advocate for the preservation of the free market and the individual freedom of the people. He believed that intervening in the health care sector could do more harm than good. On the other hand, Joseph Stiglitz is arguing that the health care sector is not a usual economic sector and therefore cannot be treated like one.

At the end of the day all policies will have, what is considered positive effect to some and negative effects to others, and this might depend not only on our political stand point or how competitive you think that the economy is but it also depends on your values:

" ...there are frequently trade-offs: a policy may increase national output but also increase inequality; it may increase employment but also increase inflation; it may benefit one group but make another group worse off. Any policy, in other words, may have some desirable consequences and some undesirable consequences" (Stiglitz, 2000: 22, line 28-32).

5 ANALYSIS & DISCUSSION

5 ANALYSIS & DISCUSSION

The following analysis and discussion is divided into two parts. The first part will go back to the historical framework and analyze the ideological and economic principles behind the two major reforms in the health care system: The privatization reform under Pinochet in the 1980s and the following democratic reform in the 1990s. These will be analyzed using the theories presented in *Theoretical Framework* and to a smaller degree by using statements from the qualitative interviews. Part two will go into depth with the differences between the public system Fonasa and the private system Isapre. The pros and cons of the two systems will be identified, analyzed, and discussed based on selected themes mentioned in section 1.4, using the three conducted interviews. Furthermore, the effects that the implementation of the Isapres have had on the Chilean society in terms of equal access and quality, will be analyzed. Finally, a discussion will be provided about the challenge of treating the health care market as any other financial market.

PART 1

5.1 Historical Flashback

In each of the historical periods identified before, economic, and ideological principles have shaped the nature of the Chilean health care system. In this section these three periods will be analyzed using the theoretical framework and the empirical data. First the system before Pinochet will be briefly touched upon and will serve as background. The two following sections: *Privatization & Free Market* and *Democratic Reforms of the 1990s* will go deeper and analyze the effects that these economic and ideological principles have had on the reforms of the Chilean health care system. Finally, we will look at contemporary Chile and the latest health care reform of 2005 which implemented the Plan AUGE and discuss what effects this has had on the health care system today.

5.1.1 Before the Dictatorship

As we have seen earlier, the Chilean health care system was founded upon public health and historically the Chileans have valued the collective needs of society which also became reflected in the way they have conducted their strategy for health care.

"Social values permeate a society and all of its institutions… such values are responsible for the forms that these institutions take…health services are no exception to this rule" (Avedis Donabedian in Reichard, 1996: 81).

The quote expresses well the government of Salvador Allende. State interventionism was highly

accepted by his government as the route to economic stability and growth. The social security institutions such as the health care sector reflected the social values of the Allende administration which were solidarity and responsibility for the weak in the society (Taylor, 2006: 26).

Before Allende the system had been divided into social security programs for blue- and white-collar workers, civil servant, the military, and the police. The foundation and structure of the system was therefore basically created upon a division according to the income of the people. But in 1952, various health care institutions merged into one single entity, the NHS. From then on, it was the responsibility of the state to take care of the workers and the indigent. The state took on an even bigger role than before which corresponded well to the new ideologies of the outside world where the influence of the economic principles of Keynes became stronger. The theoretical principle was the importance of a strong government to secure the stability of a nation.

5.1.2 Privatization and Free Market

"As the conduction of the nation's economic policies came under the control of the neoliberal economists, social security reform and the other modernizations were based on the market ideology (...) These reforms enhanced the role of the private sector and reduced the administrative functions of the state" (Borzutzky, 2005: 664).

From the 1930ies and onwards, the political economy of Chile was characterized by the formation and expansion of state owned institutions, but with the implementation of neoliberalism this trend was reversed and focus was now on the expansion of the private sector. The market should be free from government interference to be able to regulate itself which would promote freedom to the people and economic prosperity. It was a transformation of the relationship between state and society where the state slowly let go of its central role in the health care system (Taylor, 2006: 2).

The neoliberalist reforms of Pinochet undermined the hitherto socialistic mindset by moving focus away from the collective and it brought with it a new ideological framework that restructured the health care foundations laid during the Allende administration (Reichard, 1996: 81).
Pinochet was determined to transform the economic structure of the country and the new reforms were based on free-market and privatization to lessen the role of government in the economy and undermine the government's role in providing health care (Borzutzky, 2005: 665). The monetarist policies conducted by the Chicago Boys reduced inflation and attracted FDI which sent the economy into a boom (Taylor, 2006: 64).

In 1981 the Isapres were created and they were considered a response to the necessity for more investment in the health sector. The Pinochet government sought to improve the health care for the people and had a wish to strengthen the private sector, and this reform was designed to do exactly that. Private business men that sought new opportunities could at the same time improve the technology and the quality of medical attention, money that could not be found in the public system. About the creation of the Isapres Manuel Inostroza says:

"(...) the private sector was introduced as an alternative to Fonasa without assuming the rules of social security, but with the logic of individual short-term insurances associated with each person's risk. And that is very strange if we look at regulation of health care systems in the world." (Appendix D: 82).

Even though health care is part of social security, the Isapres were based on the same logic as any other insurance company, which excluded a huge part of the population. About the effects of the privatization initiated by the dictatorship of the health care system, Inostroza stated: *"(...) it showed to be fundamental in the ideological polarization of the debate about health care."* (Appendix D: 82).

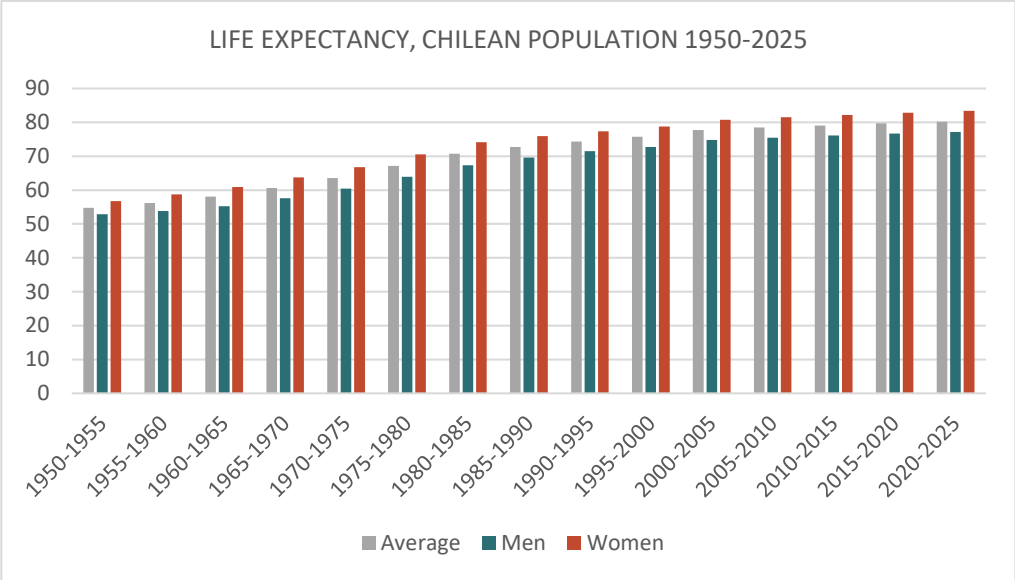
Basically, the privatization created a clear polarization ideologically that persists today, which demonstrates how Pinochet's reform was strongly based upon neoliberal ideology and how the structures of that ideology still is essential in the Chilean health care system today.

An important key word in the economic policies of Pinochet was *decentralization,* also a main concept of the theories by Milton Friedman. This decentralization was obvious all throughout the economic policies and recommendations of the Chicago Boys also regarding the health care sector.

There was an opening to foreign trade and decentralization of the market in general, which was also seen in the way that the health care system was restructured during the 1980s. The decentralization reform was initiated in 1980 and was based on a deconcentrating structure creating separate regional health services which was a way to eliminate bureaucracy. The downside of it was that the regions of Chile do not have the same resources as some regions are poorer than others which resulted in unequal access to health care. This point will be elaborated further in Part 2 of the analysis.

The logic behind Pinochet's private health care system was something never seen before in the world according to Manuel Inostroza (Appendix D, 82). A social security system based upon the logic of a common insurance company, separating the clients into high-risk and low-risk categories. But the reform of the health care system also meant new investments in the health care area and in machinery.

Figure 3



Source: Own elaboration based on data from the Ministry of Health, Department for Statistics and Health Information (DEIS). (Minsal 2, 2014)

Figure 3 shows the life expectancy of the Chilean population from 1950 up to 2025, the last years of which there has been an estimate of what the life expectancy might be. It is evident that there has been a clear increase in the life expectancy over the years especially around the time of the dictatorship. This could be ascribed the neoliberal health care reform which brought with it investments in modern technology in the health care area. There is no doubt that the reform of Pinochet has had positive effects in private health care, but these positive changes were not available for everyone.

Friedman argues that there is a clear benefit in elimination of government control in the health care system because government spend too much money and spends it ineffectively, which was why the responsibility and administration of health should be transferred to the hands of private enterprises. The competition and the free market principles that the Chicago Boys believed in, obviously meant that the new system had to bring with it some sort of profit for the private investors. This goal was met by making health care plans based solely on personal health risks by analyzing the medical history of each individual before enrollment. This was basically an exclusion of the people with

high risks because their health care plans would be too expensive, and the people with a lower risk could get cheaper plan.

This exclusion of some people, goes against the neoliberal principle of freedom and theory of Milton Friedman stating that decentralization causes economic freedom for the producer as well as the consumer, because not everyone had the freedom to choose. The goal of Pinochet's reform had been based on the idea of Milton Friedman by seeking to improve the freedom of the individual to choose. One can argue that the system of the Isapres did indeed achieve that, the problem lied in the fact that not all people were able to take advantage of this new opportunity. The fourth duty of the government according to Friedman was protecting those who cannot be regarded as responsible. This was an acknowledgement of minimum government intervention in the health care sector but there was a huge middle class with low paid jobs that still was not able to be a part of the private system due to an inadequate level of income. This left a huge part of the working population with no other choice than to stay in the public system where investments became fewer.

Also, one can argue that the one of the main purposes with neoliberalism is to reduce the size of the state and to minimize its influence in the economic markets. But with the creation of a private health care system that only the privileged classes could access, a huge part of the population was left outside high quality health care and the burden of the public system was increasing.

The neoliberalist mindset created an unequal access to high quality health care. People with low income and high risk had to stay in the public system which was now getting less resources with the reduction in public spending under Pinochet and people with high income and low risk could go to the private system and get high quality health care. With the democratic reforms in the 1990 the government sought to correct these inequalities, which will be discussed in the following section.

5.1.3 Democratic Reforms of the 1990s

"[the option red.] *was between market-determined, private, individualistic and inegalitarian models on the one hand, and market-correcting, public, solidaristic, and egalitarian models on the other."* (Evelyne Huber in Taylor, 2006: 172).

As the quote indicates democracy, reimplemented in 1990, meant that focus returned to some of the solidarity and fairness principles of the 1950ies. Reforms were based on the *right to health* approach and to reduce inequalities in the system.

There were two main areas of focus: Restoring the network of public health facilities and strengthening the regulation of private health insurers (World Health Organization, 2012: 29). During the dictatorship, investments in the public sector were basically zero, but with the political coalition *La Concertación* in power, investments increased. Between 1999 and 2009 the capacity of the public hospitals based on number of hospital beds increased with about 12 % but the public hospital debt had also increased significantly (WHO 3, 2012: 31).

Even though public expenditure increased it seemed like it was not sufficient. Fonasa pays an amount of money to the public hospitals which varies depending on the IPC[5], but some argue that the amount does not coincide with the actual expenditures that the hospitals have, which means a deficit for the public health care providers. In the transition, back to democracy the government found various problems in the health care sector because of these neoliberal reforms and it became clear that the public infrastructure in health care had worsened during the dictatorship due to a decline in public health expenditures (Goyenechea & Sinclaire, 2013 & Benavides, 2013: 25).

Public investment in health care had gone from 50 % in 1980 to 40 % in 1990, while the payment of the beneficiaries had gone from 36 % to 47 % in the same period. The decentralization of the regional health services had resulted in a lack of coordination, poor information, and an inefficient allocation of resources (Manuel, 2002: 65).

About the effect of the privatization process under Pinochet Manuel Inostroza explains:
"Our aspiration for recovery of democracy became synonymous with the NHS as a health care system of the past or the role of the state in health care with its consequent expansion of spending and the dictatorship became synonymous with containment and restriction of spending and privatization of health care. Despite the years that have passed since the recovery of democracy this has polarized the society and made it impossible to make agreements within health care." (Appendix D: 82).

As mentioned earlier, an important action taking by the government in 1990, was the creation of the Isapre Regulatory Agency (later known as the *Health Regulatory Agency*) because this was an attempt by the state to impose controls on the private sector, which was against the neoliberal mindset of before. The structure from the privatization remained, but the state wanted more control

[5] See Abbreviations.

and the power to regulate the Isapres.

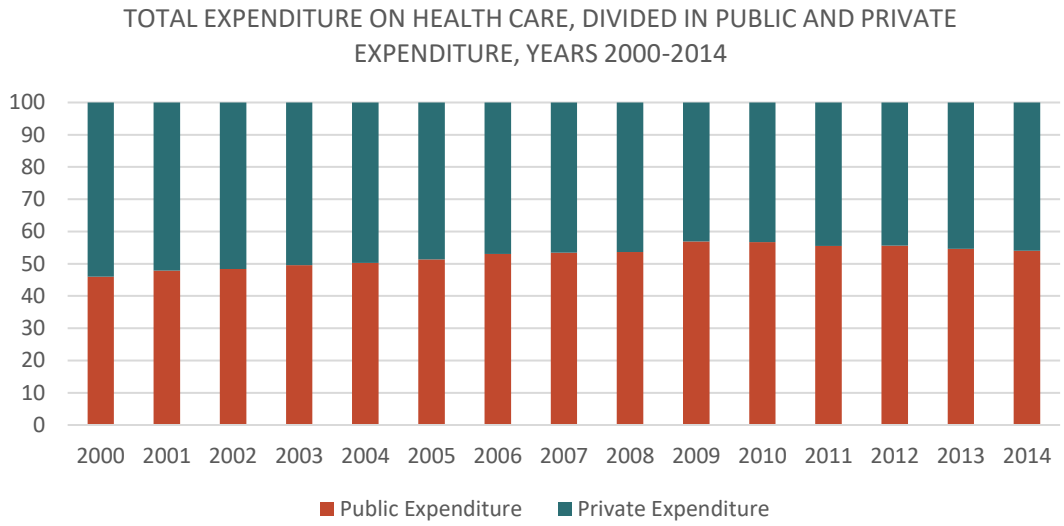
From the 2000's and onwards, neoliberalism lost more of its hold in Chile. The implementation of the Plan AUGE, means that whenever the public system cannot live up to its guarantees, in terms of shorter waiting lists, the beneficiary is send to the private system, and the public system pays part of their treatment.
This change has resulted in more state intervention and has softened up further the neoliberal structure of the system created under Pinochet. The plan has a socialistic character as it seeks to provide coverage guarantees to everyone and builds on the idea of universal health care. The purpose of the Plan AUGE has not been to eliminate the duality of the health care system created during the Pinochet era, but to soften the effects of this period by guaranteeing equal access to treatment of the same quality to all the population.

After the reimplementation of democracy in Chile we have seen a comeback of the solidary principles from before the dictatorship although to a smaller degree. The principle of universal health guarantees is somewhat related to the mindset that we saw under Allende and the wish for universal health care has returned.

Although the Plan AUGE guarantees certain rights for the population, each person still must pay more to receive the treatment. Prices in the private system are higher and the public system only still pays a percentage of that price. This excludes some people with very low salaries.
Andrea Srur states that since the AUGE was implemented more people have gained access to treatment but at the same time she calls it a temporary solution. Due to long waiting lists in the public system the private system receives more money in order to assure the right of treatment for the beneficiaries of the public system. Basically, you are transferring money from the public system to the private system instead of improving the public system. This does not solve the core of the problem, which is a lack of resources (Audio 2).

Srur further explains in the interview that every three years, an AUGE committee reevaluates the pathologies that are included in the plan and look at the results. The committee are also involved in the economic financing of the plan, and basically, they have a fight every three years to get more money for the AUGE which can be difficult. But up until now she says that the plan AUGE has had positive results in health care although this does not mean that the quality in the treatment is the same as that of the private system (Audio 2).

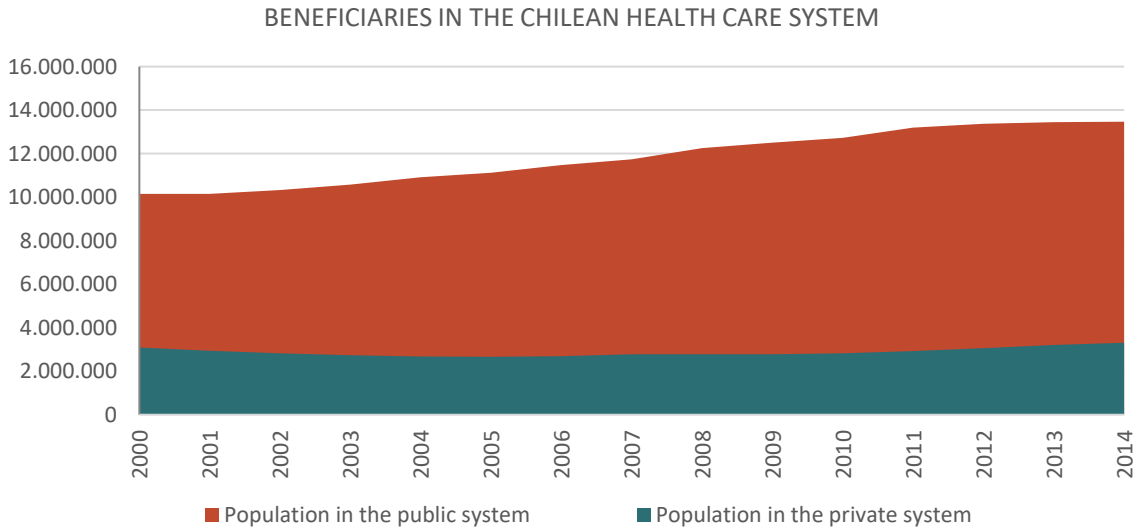
Figure 4



Source: Own elaboration based on data from Fonasa, The Research Department, (Fonasa 1, 2014)

In Figure 4 above we can see the total expenditure in health care from 2000 to 2014 divided into the expenditure in the public and in the private sector. Before 2004 the total private expenditure was larger than the public one, but after 2004 we can see that the total public expenditure has gone up due to the Plan AUGE. But more importantly it is to notice that the expenditure for the public and the private system has been almost at the same level. Here we must keep in mind that the public system covers almost 80 % of the population whereas the public system only covers about 18 %, which is illustrated below in Figure 5.

Figure 5

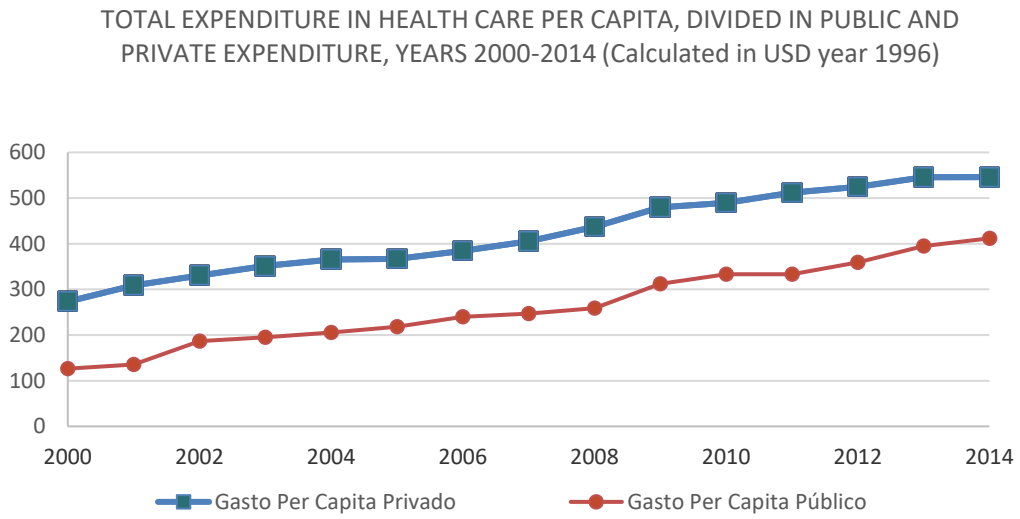


Source: Own elaboration based on data from Fonasa, The Research Department, (Fonasa 2, 2014)

To be able to compare the numbers better we can look at the expenditure of the two systems per

capita below in Figure 6. The illustration is made from data that shows the total expenditure in millions of dollars, the number of people in each system for each year and finally the expenditure per capita in thousands of dollars. The public system has between three and four times as many beneficiaries and they also spend more. But when we look at the expenditure per capita as illustrated below we can see that the private system spent a lot more per person per year than the public system.

Figure 6



Source: Own elaboration based on data from Fonasa, The Research Department, (Fonasa 3, 2014)

5.2 Free Market versus Government

As described in *Theoretical Framework* this thesis takes its onset in two different views on free market and government intervention.

In the following I, will look at Stiglitz' critique on the free market and Friedman's critique on the government to see if I can draw some parallels to the Chilean health care system.

Stiglitz

One of the general critiques Stiglitz made of the market forces was, that it seeks to achieve Pareto efficiency and that this only is possible when certain criteria is fulfilled. One of these criteria is *competition*. When there is no competition on the market, Pareto efficiency will not apply. In the case of the public and private health care sector, Pareto inefficiency might be the case because it is hard for Fonasa to compete with the Isapres. Within the last years though, there has been a debate about how to improve the public health insurances to be able to compete better with the Isapres. A radical reform and an enforcement of the public sector will improve the competition between the

two systems (Sandoval, 2016).

Another argument related to what Stiglitz calls *pure public goods.* In health care, there will inevitably exist some expenditures that are not in the interest of the private companies as they do not generate profit. Prevention programs for certain diseases can be mentioned as an example. This area is in the interest of the government in the long run, but for the private companies this will cost a lot of money in the short run and is not a good business for them (Stiglitz, 2000: 81). We see this in the private insurance market in Chile because there exists an incentive to keep some people out because they are too risky.

The next condition that must be fulfilled to obtain Pareto efficiency is *complete markets.* In the health care for example there are certain areas where the private sector fails to complete the market. The free market has the incentive to keep people out that are too risky, which means that there is a big role for government to cover those who cannot afford private health care.

Another argument is related to *information failure*, and applies in this discussion of public and private health care. The government takes the role of acknowledging the quality of doctors, labelling food products and informing the population on health risks, as this can go against the interests of the private companies.

So, should the market or the government then have a central role in the economy? Stiglitz argues that *markets often fail, but governments often do not succeed in correcting the failures of the market* (Stiglitz, 2000: 10, line 22-23). Basically, he claims that among American economists today, there is an understanding that the market should have a central role in the economy, while the government should have a role in creating full employment and eradicating the worst poverty in the society.

Stiglitz argues that the solution to this disagreement may lie in accepting that both the market and the government has its shortcomings and look for a balance where the two can work together. It all depends on how serious you consider the government failures versus the market failures (Stiglitz, 2000:10). This argument by Stiglitz relates very well to the politics after 1990s. The *Concertación* maintained the neoliberal institutional forms created under the dictatorship but sought to combine neoliberalism with a commitment to an equitable social development. They supported private enterprises but also saw a necessity to increase public expenditure in health care to help marginalized groups (Taylor, 2006: 197).

Friedman

Friedman argues that there are four functions of government but that in the health care sector there is no place for government intervention. Only in very extreme cases where people cannot take care of themselves the government must intervene. One of the reasons to this belief, is that society runs on greed like everything else. People are driven by their own self-interests and the most efficient way to create productive outcome is to leave business up to the free-enterprise system. Friedman may be right at least to some extent, as we will see later in Part 2, as it seems that the implementation of the Isapres has brought with it modernization and efficiency.

Another one of his arguments relates to how government programs often last a long time and are too expensive. Stiglitz has a point about government failure saying that government has limited control over its actions. Looking at the Plan AUGE with these two last arguments in mind one can argue that the AUGE is an attempt to even out some of the inequalities that the public-private dichotomy of the system has created due to failed neoliberal policies in this area. It seems to have helped, as many people are using the system but it is also expensive and the government cannot control how many people use the system, as the doctors and the patients have a huge role to play in this. The outcomes of the Plan AUGE will be investigated more in detail in Part 2.

5.3 Sub Conclusion Part 1

After looking over the three historical periods, we can see that during the rule of Pinochet some of the main economic and ideological principles were: Less government intervention in health care, more personal freedom to choose, free market approach, privatization, and decentralization. In 1980 the Isapres were introduced as an alternative to the public health care system, but did not assume the logic of social security but health care based on personal health risk. These changes caused lack of coordination, lack of information, lack of proper allocation of resources, an increasing public burden and exclusion of the poorest in society. On the other hand, it seems to have caused general improvement in health care such as increase in life expectancy.

In the 1990s the *Concertación* sought to go back to the principles of fairness, equality, right to health and solidarity. The same principles had existed before the take-over of Pinochet, and now they returned, but to a lesser degree as the neoliberal structure and institutions were maintained but combined with equitable social development. The public expenditure on health care has been increased again, but the public and the private system continue to have similar amounts of expenditure even though the public system covers about 80 % of the population.

Just as Friedman, the Chicago Boys did not see a specific role for government in the health care sector. There was only a minimum role for the government to take care of those who could not take care of themselves. Fonasa continued to have this role but due to reductions in investments in the public sector the quality also worsened.

PART 2

5.4 Comparison of Fonasa and Isapre

In the following section, focus will be on the differences between the public and private system. First a brief description of what factors are essential when people face the choice between Fonasa and Isapre will be provided and afterwards the pros and cons of each system will be analyzed with point of departure in the three interviews. Finally, an analysis of the effect that the privatization reform has had on the possibilities of access for the Chilean population will be made.

5.4.1 How to Choose Between Fonasa and Isapre?

To understand the change that the implementation of a private health care system in Chile had, I find it inevitable to look at the choice that people now face when they must choose between Fonasa and Isapre. The following section is based on an interview with ex-director of the Health Regulatory Agency, Doctor Manuel Inostroza on Chilean national television, explaining pros and cons by choosing either the public or the private health care system.

There are two fundamental differences in the characteristics between the public system, Fonasa and the private health care system, Isapre that ultimately helps you chose one or the other. The first one, considers the resources you and your family have, and the second one considers the types of providers that you wish to use.

The first characteristic has to do with economy. If you have a low salary, for example close to the minimum wage, it might not be convenient for you to have Isapre. One reason is that most plans are more expensive than the obligatory 7 % of your salary, especially if you are a woman or older of age. So, you can end up paying a huge part of your salary to health and you will not be left with enough to pay rent and food. In the Isapres you also must pay for each family member that you wish to be part of your plan, whereas including family members to your plan is free of cost in Fonasa. You always pay 7 % no matter what and those who cannot pay, will receive a subsidy from

the state. In Chile, it is common for the parents to have their children as part of their plan until they turn 18, in some cases the children can stay in their parents' plan until they turn 24, if they can prove that they are studying and thereby do not have an income (Inostroza, 2011).

The second characteristic that you must consider when you choose system, is the access to the different providers. If you have Fonasa, you have access to all the public doctors' offices and after a new law adopted with the health care reform in 2005, you can now under some circumstances choose to go to a private clinic instead, and Fonasa is going to pay a good part of the cost (Inostroza, 2011).

When it comes to hospitals though, Fonasa has very bad coverage for private hospitals, so if you are going to get surgery or some other major intervention you must go to a public hospital which often has longer waiting lists and may not have the same resources.

Basically, being in Fonasa is cheaper and there is only one type of health care plan. If you are in an Isapre you can choose from numerous plans, all with different percentage in coverage for different pathologies. It requires some hours of studying the different health care plans to select an adequate one for you and your family.

Your health also plays a role. If you have had a serious disease, for example cancer, the private health care system will not accept you. In some less serious cases they might accept you, but they will not cover you for the same disease in the future because you have preexistence.
Finally, if you do not have a job and never took a decision about your health care, you will automatically be covered by Fonasa, you just must go and register at their office. Whereas if you wish to enter an Isapre, you must sign four different documents: An inscription form, a health declaration with all your previous diseases, the health care plan that you chose and finally a contract with the company. One can therefore argue that the privatization of the system was meant a worsening in health care treatment for the poorer sector of the Chilean society, whereas the richer have benefitted from it (Inostroza, 2011).

5.4.2 What are the Pros and Cons of the Two Systems?

As we saw above, you basically choose system depending on your financial situation and preference of health care providers. With that in mind, the pros and cons are individual because people have different preferences and are in different situations, but according to two of my

interviewees, Andrea Srur and Carlos Carrasco, there are some broader generalizations that can be made. The following section will analyze the pros and cons and look at the most recent actions in the health care system. The analysis is divided into the following themes: *Payment, providers, quality, geography, regulation, information, and financing.*

Payment

Payment refers to the monthly contribution that you make to either the state or to a private owned health care insurance company in return of a health care plan, and to the direct payment of specific health care services. Srur states that there is a fundamental difference in the way that the beneficiaries pay to either the public or the private system:

I think that the pros that Fonasa has is that Fonasa is basically a solidary system. Solidary means that the amount you pay depends on your income. The person that has a lower income basically pays less and the public system pays more, and the person that has a higher income pays more and the public system pays less. (…) In Isapre on the other hand, I pay what I have to pay. I am obligated to pay that certain percentage." (Appendix D: 82-83).

One can argue that the difference in the two systems is grounded in the different ideologies behind them. As we saw in *Historical Flashback* the public health care system was created based on solidarity and collectivity whereas the Isapres were created based on neoliberalist principles.
Srur continues by stating that in terms of service quality and waiting lists the Isapres have an advantage. The Isapres can ensure their beneficiaries a certain quality of service and they also attend people faster. In the public system on the other hand people sometimes must wait several months or sometimes even years.

Carlos Carrasco talks about how the Health Regulatory Agency have improved the rights of the patients in terms of payment up front, when you come to a clinic or a hospital with an emergency:

"The Health Regulatory Agency has made a huge effort when it comes to the rights of the patients…for example the Emergency Law that says that you cannot force a person in the state of emergency to pay in cash or to leave a blank check…it is an illegal guarantee…if you are dying or if you are going to have permanent damage to your organism…if you do not pay us, if you do not guarantee this payment, we will not treat you…before in our country there was a time when a lot of people were refused medical attention because they did not leave a blank check." (Appendix D: 83).

Carrasco mentions this effort by the Health Regulatory Agency as one of many to secure equal treatment of the citizens of Chile. This expresses the for-profit mentality that the system has had to larger degree before and that now are changing little by little.

Providers

In terms of health care providers, the private system has the advantage in form of the newest modern technology and the best equipment according to Andrea Srur. She explains that the private providers have access to all the modern technology and knowledge. Carlos Carrasco talks about the standardization of the clinical processes. Basically, he states that by law the public and the private system must have the same standards and same clinical processes. About this he says:

"The idea behind this is the principle of equity. Why the principle of equity? Because it means that you, whether you are in the public or the private system the provider must comply with the same standard of performance." (Appendix D: 83).

But he also agrees with Srur saying that this standardization does not mean that they have the same level of equipment:

"Well I am in Fonasa and I go to my hospital where they must have the same standards that a private clinic has. The difference could be the quality when it comes to food, beds etc. One system has better installations than the other. Maybe the walls are painted better, there is television, maybe in the other one the conditions are not that good, but the standard of the clinical processes have been met continuously. So, for example we have had very important clinics that have lost their accreditation because they did not comply with these processes. And we have had more simple hospitals in very populated sectors that did comply with their accreditation." (Appendix D: 83-84).

Srur mentions later in the interview, that the accreditation of the clinics is based on having certain clinical processes but that the quality of those processes varies a lot. This can be considered a directly effect of the implementation of the Isapres in the 1980s.

From the above, one can argue that the idea of the equity aspect is positive because there is a wish to give everybody the same level of treatment. But we can also see that the focus is on the clinical processes, standards that are possible to meet even though you have fewer resources and the other way around. Carrasco further argues:

"The infrastructure may be different but we do not give accreditation according to infrastructure,

or according to quality of beds and food, we are giving accreditations for clinical processes and despite this accreditation the quality in a hospital may be very simple." (Appendix D: 84).

If the public hospitals and the private clinics live up to these standards of processes put forward by the Health Regulatory Agency they can have very basic interior and service. The private clinics have the money and better resources and you can argue that they have a bigger incentive to provide their beneficiaries with good installations, as they might get a bad reputation otherwise. This can be considered a good effect of the privatization of the health care system under Pinochet. There was a huge investment in health care, just only in the private sector.

The public hospitals might not have the economy to improve in this area, and they do not have to worry about losing customers either. This leads me on to the next theme, quality.

Quality

Andrea Srur talks about the quality of the medical attention. She explains how the quality is worse in the public system than in the private.

"I buy my own medicine. I go to the pharmacy to buy my medicine. It is a lot more expensive…on the other hand people in the public system receive the medicine they need from the public system, but it is probably a lower quality. It is basically about the quality, the type of medicine and the type of technology." (Appendix, D: 84).

Both Carrasco and Srur explained the accreditation process for a doctor in the health care system. There are certain exams and accreditations that they need to have which in the end assures that the quality of their work is very equal. Srur also states that when we still see inequalities in the quality of treatment this is due to the structure of the system and thereby the structure that follows the doctor in his or hers work, and is not due to low quality doctors (Audio 2).

Geography

"The concentration of specialists and doctors is definitely in the Metropolitan Region (...) when you come out of medical school you can apply for the so-called Rural Doctors (...) so I get out of medical school and how the system is at the moment I have to work three years in the public system in order to apply for a specialization scholarship (...) to be a cardiologist or something like that (...) they can send me to all over Chile. The further away I am the more points I get to apply for a residence scholarship of three years, or six years more (...) The more time I am away and the

further I am away from Santiago the more point I get." (Appendix D: 84-85).

Srur continues explaining that before the universities administered the scholarships, so if the university in your hometown had paid for your specialization scholarship, you had to return to that city for six years afterwards to work. Srur tells that she was in Iquique (North of Chile), and that they paid her three years of specialization but that it was a low wage. She calls this a temporary solution, because the people are forced to move away from Santiago and after the six years they always move back. Another downside is that the hospitals in some of the other regions might not have the newest and necessary technology available, which prevents the doctors in developing the specialization that they just achieved, further. This system forces people to move, and according to Srur there should exist other types of incentives, not necessarily associated with money. However, they pay you an extra salary, or a bonus for the time you are away (Audio 2).

Another issue related to geography can be the fact that your health care plan often includes an agreement with a specific hospital or clinic unless you have the free election mode. But this is often very expensive, which I will come back to later in chapter 5.5.
Srur states that if something urgent happens to you far away from where you live, or in another region of Chile they must stabilize you before sending you to your own hospital. The quality might be a lot worse than what you are used to but they are obligated to treat you and they cannot reject you even if you do not belong to that specific sector. She also talks about the rich and the poor regions. The reason for the huge difference in economic resources is due to the fact that the Ministry of Health gives a certain budget, but the municipalities also must finance a part themselves, per citizen in that municipality:

If there is a medical consultation that has more money and receive less people, there are going to have better facilities than the medical consultation that receives two million people and receive very little. It is absolutely inequality. (Appendix D: 85).

This difference is illustrated below in Table 1, which shows the distribution of health care providers by regions in the country. Chile is divided into 15 regions and to understand the economic difference between these, Appendix J gives us a list of GDP per region for the past few years.

Table 1

TYPE OF PROVIDER / Region Code	NUMBER OF PROVIDERS 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Total
Sanitary Authority					2							2	1		1	6
Chilean Army			3													3
Experimental Establishment													3			3
Municipality	34	39	42	147	174	129	238	332	262	254		21	382	98	19	2171
Other Institutions	3				5	1	3	5	7	6		1	18	7	2	58
Private Provider	28	60	30	41	52	52	36	99	54	55	7	16	235	33	27	825
Public Provider	4	4			9	1	3	3	2	3	2	5	14	2	2	54
Public Health Service	8	14	8	12	39	23	21	63	43	40	43	6	78	18	7	423
Total	**77**	**##**	**83**	**200**	**281**	**206**	**301**	**502**	**368**	**358**	**52**	**51**	**731**	**158**	**58**	**3543**

Source: Ministry of Health, Department for Statistics, and Health Information (DEIS). – (Minsal 3, 2012)

Appendix J also contains a list with the names and numbers of the regions. Looking at these tables it is evident that there is a huge difference in the GDP of each region. One must keep in mind that these regions also have differences in the size of population. To make a comparison we can take region 6, *Del Libertador General Bernardo O'Higgins* and region 7, *De Los Lagos* as they have almost the same size population. According to Appendix J region 6 has a larger GDP than region 7. According to Table 1 region 7 has almost twice as many public municipal installations and region 6 has more private health care providers. This can give us an indication that the wealthier regions have more private health care providers whereas the poorer regions rely more on public providers. This results in huge inequality of the treatment that the population gets as it depends highly on where they live. The Isapres are only present where there is a market for them.

Regulation

The next theme is related to regulation of the public and private system. Andrea Srur tells that there does not exist any type of regulation of the private health care companies, Isapres:

There does not exist regulation of the Isapres, (...) there is no regulation of Isapres, so they can increase the cost of your plan 500% if they want to. Now there is something called the "judicialization" of Isapres, which means that as a user I can sue my Isapre if they increase the cost

of my plan. And the Isapre has to cover the cost of that. (Appendix D: 85).

Srur explains this tendency of suing the Isapres as the reason that many Isapres today have economic problems, which will be elaborated under *financing.*

Carlos Carrasco on the other hand talks about how both the public and the private health care providers must live up to certain requirements. It is the job of the Health Regulatory Agency to supervise the contract and processes to assure that they are following the law. He mentions the Administration of Providers *(Intendencia de prestadores).* It is a department that controls all public and private providers making sure that they live up to the accreditation that they have. The accreditation process is divided into different level and the hospitals and clinics are fulfilling these requirements little by little. In terms of clinical processes there do exist regulation of both the public and the private health care providers, but Srur explains that there is no regulation related to how the private system manage the cost of health care plans, which can result in higher and higher prices.

Information

Stiglitz argues that, the market often fails to provide sufficient information to the people, especially in health care because it is not always in their best interest. That is one of the reasons that he sees a role for government in proving the population with the adequate information. In Chile MINSAL has the job of labelling foods for example. But when it comes to health care plans there is so much information that it makes it almost impossible to figure out which Isapre or which health care institute is best for you and your family. The Isapres work like any other for-profit company, and inform the public through TV-commercials and campaigns, which do not always show the whole truth, but the truth that they want you to see. Also, using your health care insurance when you have found one can be quite complicated.

Andrea Srur touched the issue of complexity in the health care system stating that: *The people learn out of necessity. You learn or you die in the process* (Appendix D: 85).

Personally, I became acquainted with this election process during my stay in Chile. A girl from an Isapre came to my house to present the different four different plans that they had. I asked for a different plan than the ones that she had showed me, as I wanted a greater coverage. She then found a few more on computer and then later a few more. I basically got the feeling that she was showing me only a very little part of what they had to choose from. At the end, it can be difficult to make a well-informed choice. This obviously seems like they are withholding information from the

consumers. They are presenting only the plans that benefit their business the most.

The problem with health care is that without the adequate education you do not have a chance to figure out who is a good doctor and who is not or what is the latest technology within the medical field. According to my second informant Carlos Carrasco, currently there exist thousands of different health care plans. He told me that in the Health Regulatory Agency they are working on narrowing down the choices so the people end up with three categories to choose from. This will make it a lot easier for a person without a medical background to choose an adequate health care plan. But this, argues Carrasco, will also be the most difficult task for the Health Regulatory Agency so far.

This related to what Stiglitz calls *imperfect information* (cf. Theoretical Framework). Stiglitz argue that this is a problem in the medical industry, both because you lack the education to assess whether a doctor is doing a good job, but also because you do not go to the doctor or to a hospital that often in comparison to when you shop at the supermarket. The medical industry, and in this case the private health care system, can show you and tell what they want the customers to know, and the customers do not have a very good change of knowing whether it is true or not.
On the other hand, Friedman argues that a large selection of providers fosters greater competition, and the market forces will eventually lead people to buy the best health care insurance.
At the moment, I do not see the market forces working in the desired way in the Chilean health care, as the prices still prevent a large part of the population in participating in the private health care market.

Financing

The public and the private system are financed differently as the public system mainly is financed by general taxes and the private system mainly is financed by the monthly contributions of its beneficiaries (cf. Appendix G). Manuel Inostroza talks about a recent issue in the Isapres caused by an increase in private spending:
"(...) the Chilean private sector spurred a medical science of high complexity and quality, that has contributed to the health of the Chileans, but now the sector is facing inflationary phenomena in private spending because it has lacked incentive and capability of sharing and managing the risks of the population. This added to the logic of individual insurance has left almost 3.5 million people (19 % of the population) unhappy and willing to sue because of the price increase of private health care plans." (Appendix D: 85-86).

In the public system, he also sees an issue related to the spending:

"Because of its vertical integration logic, the public sector has stimulated the containment of spending, which it does very cost effectively as a country. But as a provider in the micro level it is very inefficient and it has enormous problems of quality of care which is reflected in the treatment and the huge waiting lists." (Appendix D: 86).

Likewise, Srur mentions the problem of increasing health care plans and mentions another downside to the way that the Isapres are financed. She says that an Isapre, like any other company, can go bankrupt. She says that in that case will be the state's job to take care of beneficiaries that are left without health care, which means that they will all be transferred to Fonasa. In some cases, the people might be able to change Isapre, but if you have preexistence or are older you might never be able to get back into the private system. She mentions three Isapres that are predicted to go bankrupt next year: Más Vida, Vida Tres S.A and Banmédica.

Table 2

CUADRO Nº 1
ESTADÍSTICAS BÁSICAS DEL SISTEMA ISAPRE
AGOSTO 2016

Cód.	Isapres	Nº de Cotizantes (1)	Nº de Cargas (2)	Cotización percibida (mill. de $) Legal (7%)	Adicional voluntaria	Otros períodos	Nº total de suscrip-ciones	Nº de desahucios voluntarios	isapre	otros	Nº total de desa-hucios	Porcentaje de beneficiarios con CAEC (3)
67	Colmena Golden Cross	324.284	227.767	25.982	14.490	3.069	6.870	3.968	997	163	5.128	98,9%
78	Cruz Blanca S.A.	404.327	300.619	29.590	17.167	3.281	7.626	7.044	2.082	162	9.288	100,0%
80	Vida Tres	75.907	66.903	6.250	6.114	914	1.086	737	171	9	917	100,0%
81	Optima S.A.	20.343	2.167	404	79	126	610	952	3	38	993	100,0%
88	Masvida S.A.	315.630	256.108	24.767	7.409	2.579	5.058	5.022	690	895	6.607	100,0%
99	Isapre Banmédica	375.756	312.435	27.613	14.332	2.973	6.535	4.765	1.131	43	5.939	100,0%
107	Consalud S.A.	378.842	288.208	24.314	10.522	2.712	7.669	5.489	1.284	15	6.788	99,9%
	Total isapres abiertas	1.895.089	1.454.207	138.920	70.114	15.654	35.454	27.977	6.358	1.325	35.660	99,8%
62	San Lorenzo	934	1.502	96	34	1	0	2	0	0	2	0,0%
63	Fusat Ltda.	11.786	13.791	980	533	48	22	18	29	0	47	100,0%
65	Chuquicamata	11.995	19.221	1.226	901	36	34	25	13	0	38	0,0%
68	Río Blanco	1.973	3.641	218	66	1	3	6	1	0	7	0,0%
76	Isapre Fundación	15.381	11.616	1.139	418	48	54	23	29	0	52	0,0%
94	Cruz del Norte	736	1.186	58	17	0	25	1	2	0	3	0,0%
	Total isapres cerradas	42.805	50.957	3.715	1.969	133	138	75	74	0	149	4,3%
	Total sistema	1.937.894	1.505.164	142.635	72.083	15.788	35.592	28.052	6.432	1.325	35.809	97,8%

Fuente: Superintendencia de Salud, Archivos Maestros de Beneficiarios, Contratos y Cotizaciones.
(1) Cotizantes vigentes en el mes.
(2) Cargas vigentes en el mes.
(3) Beneficiarios que tienen incorporado en el contrato la cobertura adicional de enfermedades catastróficas (CAEC).

Source: (Health Regulatory Agency 3, 2016)

Table 2 shows the latest statistics on Isapre members from August 2016 and is from the website of the Health Regulatory Agency. Together the three Isapres that Srur mentions have a total of 767.293 beneficiaries and 635.446 people that are covered through the plan of their spouse or parent or another family member. If Srur's prediction about the bankruptcy of these three Isapres is right, this will affect more than 1,4 million people in Chile. This is not something that happens often but it is a financial risk with huge consequences for many people. As mentioned earlier more people are suing

their Isapres for increasing the cost of their insurance, which now are causing financial problems for the companies, according to Srur (Audio 2).

5.5 Effects on Society

Based on the above we can now go further and analyze the effects that the implementation of the private health care system in the 1980s has had on the Chilean society today in terms of possibilities and access to these two systems. As we also saw in section 5.4.1 it is not beneficial for a person with a low income to be in the private health care system.

As mentioned earlier, the Isapres calculate the cost of the health care plans based on factors such as sex, age, and medical history. About this Srur says: *"(...) the system of the Isapres at the moment is very discriminating. For example, to the women, the women pay more. The elderly in the Isapres also pay more. This does not happen in Fonasa."* (Appendix D: 86).

She continues by explaining that the people with the highest income usually choose an Isapre whereas those with lower incomes are in Fonasa, as the table in Appendix I also shows. She states that there exists inequality in the system.

Carrasco mentions the discrimination related to men and women. Women pay a lot more than men and they receive a lower health care coverage for it. Before pregnancy was even on the list of preexistence: *"The Isapres had pregnancy on the list of illnesses and we eliminated that (...) pregnancy is not an illness it is a human condition."* (Appendix D: 86).

The Health Regulatory Agency has eliminated pregnancy on the list of illnesses that prevent you from signing a contract with an Isapre. He explains that it is only one step in the right direction.
Carrasco reveals that he has chosen to be in the public system Fonasa, whereas Srur has chosen to be in an Isapre. Carrasco tells me that the reason for his choice is not based on his economy as he has the means to pay a private insurance company, but that it is based on a sense of solidarity. Srur tells me that her choice is based on the fact that she prefers the clinics with the latest and most modern technology. Her choice could reflect the fact that she is a doctor and knows the difference that modern equipment can do versus older equipment. Carrasco's choice could be related to the fact that he prefers to pay less money to health care and have more money for the other items in his budget. Between those who have higher salaries it is always a personal choice whether to be in one system or the other.

The reason for the discrimination against women and the elderly is simple. The prices are based on an insurance scheme and they are the most expensive clients. A woman in the late twenties with a boyfriend but no children will be very expensive for the insurance company whereas a man in his late twenties will be able to get the cheapest health care plan with the best coverage.

When I was in Chile I bought my health care plan with a private insurance company together with my boyfriend. He paid 0,8 UF per month and I paid 3,5 UF[6] monthly even though I had chosen a plan that did not cover in case pregnancy or giving birth. Furthermore, my plan included an agreement with one single clinic. For being admitted to the hospital my plan covered 90 % of the cost and for a medical consultation it covered 70 % both without a maximum UF, if I used that specific clinic (see Appendix L). My boyfriend had a plan of free election which means that he could get attended anywhere in the country with a 100 % coverage on admissions and a 90 % coverage on medical consultations, with a maximum amount, only in a few cases (see Appendix K). The cost of my boyfriend's plan was lower than the obligatory 7 % of his salary, so the money that exceeded from the payment he could use to buy medicine at the pharmacy. My plan was more expensive than 7 % of my salary so on top of paying for my plan I had to pay my medicine in case of illness. This is a single event, but it shows the insurance risk mindset that the Isapres use when setting prices on the health care plans.

5.5.1 Health Care as a Common Commodity

When health care plans and treatment is provided by the private sector, an interesting discussion arises – whether health care is a common commodity or not. In Chile, there are 13 Isapres in total and therefore there is a lot of competition on the market. It can be difficult to see the difference between the companies and between the different health care plans that they offer.

When looking at the theory by Stiglitz, there are three theories of market failures relevant in this context, that argues for government intervention: *Imperfect information, limited competition and the absence of profit motive.*

Imperfect information

This first market failure mentioned by Stiglitz applies to the reality of the health care system in Chile. Andrea Srur recognized this problem when I interviewed her. She said that the system is very complicated to understand, but that all the information about the role of the Ministry, and the health care guarantees is available online. She also mentioned a mobile application that can explain in

[6] See Abbreviations. As reference 1 UF per 30/06/16 was CLP 26.052 (DKK 265).

which cases the Plan AUGE covers you.
The Ministry of Health is a public institution whose work is to inform the public. The Isapres on the other hand are interested in getting more beneficiaries.

Stiglitz talks about how we are buying the doctor's knowledge when we are sick, and how we must rely on his or her judgment as we ourselves are not qualified to make such a decision. He mentions that your experience with a specific doctor can be perceived as good or bad depending on other factors than his or her medical background. For example, their personality and if you get along with them can play a huge role. So, you are not evaluating the product you buy based on what you are actually paying for which are: Expert skills within an unknown area for you.

When you buy other products, for example clothes, you can feel the quality and you are well informed as a consumer because you base your decision on repeating purchases.

Limited competition

About limited competition Stiglitz argues that the medical market does not follow the usual logic of the free market which is supply and demand. If a doctor is not in demand or have very low prices you are prone to think that something is wrong with his or her services and you might choose someone else at the end. In contrast Milton Friedman talks about that the market forces should help you decide which product, or in thin case doctor, is better. Review based selection for example could result in higher quality of health care since it would provide an even greater incentive for clinics to deliver good service.

Absence of profit motive

Finally, Stiglitz advocated the importance of non-for-profit organizations in the medical market, who does not have profit maximization as their main goal. Both Carlos Carrasco and Andrea Srur talked about the profit motive in the Isapres. What makes a market efficient is the presence of supply and demand but according to Stiglitz this does not exist in the traditional form in the health care market which is why this market cannot be characterized and treated like a common economic market.

5.6 The Future

My interviewees were asked about the biggest current challenge for the Health Regulatory Agency and the Ministry of Health respectively. Srur points to the Plan AUGE. She talks about how they

negotiate the plan every three years and that she is fighting to include more and more pathologies in the guarantee. This can reduce the inequality in access to treatment for the Chilean population. Her wish for the future is that the Plan AUGE will include all pathologies and not only a few as it does now (Audio 2).

Carrasco says that in his work, the major challenge today is to continue eliminating the inequality and discrimination that exists in the health care system. A discrimination that exists due to the for-profit mentality of the private health care sector. The Isapres work based on an insurance scheme and the price of your health care plan is evaluated based on your medical history, age, gender, etc. This basically means that it is legal for the Isapres to exclude people based on these factors and that is the focus for the Health Regulatory Agency today (Audio 1).

It is evident that the health care system has undergone changes since the privatization reform of the Pinochet regime, but the Isapres remain, and the structure of the system remains. Manuel Inostroza states that there exists an issue of inequality and discrimination in the health care system today and he suggests that a new reform must be made both in the public and the private system. It must be a reform that is implemented gradually in stages, and within a period of minimum 15 years (Appendix C).

The report by The Ministry of Health stating that there exists asymmetry of information in the health care sector in Chile today (Universidad Católica, 2014) is consistent with what we saw in the theory by Stiglitz. Another issue in the publication is the fact that the Plan AUGE which seeks to even out inequities is only a temporary solution, which Srur also stated in the interview. The plan was created to confront an urgent need for treatment in some parts of the society, but it has not lived up to the expected results and there has to be found a more permanent solution for the future (Universidad Católica, 2014: 9).

5.7 Sub Conclusion Part 2

From Part 2 of the analysis we can conclude that within the themes discussed above there exist some issues due to the public-private dichotomy that was created under Pinochet. For example, that Fonasa is based on a solidary payment system whereas the Isapres work according to a traditional insurance scheme. In term of health care providers and quality in treatment it seems that the public system is falling behind due to a lack of resources. Geographically we also see a division because some regions in Chile have more resources than others. There does not exist a government entity to

regulate the Isapres which can result in huge cost increases in health care plans and this in turn has resulted in many people suing their company which is why three of the biggest Isapres are foreseen to go bankrupt next year, leaving over 1 million Chilean without health care coverage.

Finally, the Isapres have created a system based on discrimination of the sick, the elderly and of women. This has created an inequality in access to the health care system in Chile. In theory, everyone has the same opportunities and personal freedom to choose between the two systems, but not everyone is in a position that allows them to embrace that opportunity, and therefore the poor are forced to be in the public system where facilities and medicine is of poorer quality.

6 CONCLUSION & FUTURE RESEARCH

6 CONCLUSION & FUTURE RESEARCH

In this section the two sub conclusions will be united in order to find an answer to the problem statement:

What were the ideological and economic principles behind the privatization of the health care system in Chile both under Pinochet, and the subsequent reforms when democracy was reinstated in the 1990s? How have these reforms influenced access to the health care system?

At the end of my research it has become clear that the privatization of the Chilean health care system in the 1980s brought with it investments and modern technology in the health care sector. Statistically it shows positive effects demographically, keeping in mind that such statistics always are influenced by more than one factor. The idea was freedom to choose, which only became true for some part of the population as not everybody had the financial means to choose the private system. Economic and ideological principles influenced the privatization of the health care system such as: Minimum government intervention, more personal freedom, less solidarity, more free market, and decentralization. These principles were reflected in the way that the private health insurance scheme was designed around the institutions of Isapres.

The democratic reforms of the 1990s sought to soften up the neoliberal structure and the economic and ideological principles behind them were: Fairness, equality in access, right to health, solidarity, and responsibility. The Plan AUGE is one of the actions made that still fights for more equality in access to health care, but it seems to be only a temporary solution. We saw a return to government interventions principles from before Pinochet, although to a lesser degree.

Some of the effects of the privatization in the 1980s are inequality in access and discrimination, which we still see in Chile today. The inequality lies in the quality of health care that the people have access to. After talking to my interviewees, it became clear that still today the Ministry of Health and the Health Regulatory Agency are aware that the structure created under the Pinochet era persist in the Chilean health care system today. It became evident after looking at the pros and cons in the list of themes analyzed there is a huge difference between the public and the private system.

Considering the theories used throughout the thesis, it seems like neoliberalism and free markets is not a bad thing as privatization brought with it efficiency and capital. On the other hand, the

principles of solidarity and justice that was essential in the social insurance created before Pinochet were eliminated and replaced by an approach focusing on the individual and personal freedom to choose.

The structures created under Pinochet seem to have created an ideological polarization in the debate about the health care sector in Chile. Ideology seems to have played too big a role in the creation of the Isapres. Sick people cannot work, so it is not in the interest of society to leave out a huge part of the population from quality health care. The core issue seems to be a lack of resources in the public sector. As stated in the introduction a good health care system according to the WHO delivers quality services, quality medicines and quality technologies to all. The Chilean health care system is not bad and it does possess these qualities, but only in the private part of it, to which not everybody has access.

A keyword in neoliberalism is individual freedom and in the case of Chile this only applies to some and not to all which contradicts the intention behind it. Free markets improve competition and create efficiency which are good for the society. On the other hand, one can argue that access to health care is a human right and that it is also in society's best interest that the population has access to quality health care, which is why it can be discussed whether free market principles and profit motives should not be part of a health care sector or not.

Future Research

An interesting perspective that I did not elaborate in this thesis is the Chilean culture's emphasis on family and equality between men and women in the labor market. It would be interesting to investigate how a country so pro-family, that gives bonuses to families for having children, discriminate against women in the health care system, because they can get pregnant.

Another aspect that I briefly touch upon in this thesis is the Chilean pension system's connection to the health care system. In Chile, you are obligated to pay 11 % of your salary to a private pension company and you cannot be a member of an Isapre unless you are a member of one of the pension companies. It would be interesting to go further into detail with this relationship.

Finally, during my research, I have come across the fact that many directors of the Isapres also are owners of the private clinics. Those who sell you the health care plans are the same people that sell you the treatment or the medicine later. This network shows that the Chilean health care in many aspects that just the one investigated in this thesis, runs on economic interests.

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8 APPENDICES

8.1 Appendix A: Interview guide Carlos Carrasco

Áreas de enfoque	Preguntas de entrevista	Pregntas extras/ comentarios
Sobre la Superintendencia de Salud (SS) y sus objetivos	• En su página web dice que la tarea principal de la SS es regular y fiscalizar a los seguros y prestadores de salud del ámbito público y privado. ¿Cómo cumplen con este objetivo? ¿A través de qué medidos? • ¿Cómo se aseguran que los ciudadanos reciben el mejor tratamiento? • ¿Cuáles son los requisitos y el proceso de contratación para un médico que quiera trabajar en el sistema de salud en Chile, existe diferencia en el proceso de selección para un médico que trabaja en el sector público versus un que trabaja en el sector privado? • ¿Cuáles son los pro y contras de la forma en que se financian tanto el sistema de Isapre como el sistema de FONASA? • ¿Existe el riesgo que una Isapre quiebre? ¿Qué hace la Superintendencia en	• Pensando en FONASA e ISAPRE ¿Cuál es la diferencia entre una entidad financiada por subsidio del Estado y una entidad que funcione dentro de un sistema con libre competencia y a base de un esquema de seguros? ¿Existe pro y contras por los dos? • Intereses económicos?

	este caso? • ¿Cuál es el mayor desafío para la SS hoy en día?	
Sobre (des)igualdad entre los dos sistemas de salud	• Un 73 % de los chilenos están inscritos en Fonasa y sólo un 18 % de chilenos son miembros de una Isapre. ¿Por qué la diferencia es tan grande?	• Las Isapre son empresas con fines de lucro. Su negocio consiste en administrar el riesgo de los usuarios. De esta forma tienen incentivo a otorgar mejores prestaciones a usuarios menos frecuentes del sistema. Perjudicando por ejemplo a mujeres en la edad fértil, personas con enfermedades preexistentes. • ¿Cómo la Superintendencia se encarga de alinear estos objetivos comerciales con los objetivos sociales? (La lógica contraria).
Opiniones personales de Carlos Carrasco	• ¿Encuentra usted, que hay una desigualdad entre la calidad de tratamiento en el sistema público y el sistema privado? • Según su opinión personal, los chilenos tienen todos las mismas oportunidades y reciben todos la misma calidad de tratamiento? Y si no, qué factores influyen la	Recientemente ha sido comentado el alza de los planes de salud. ¿Qué opinión le merece este tema? ¿De qué manera la Superintendencia de salud ejerce su rol frente a esta problemática?

	calidad de la tratamiento que reciben?	

8.2 Appendix B: Interview guide Andrea Srur

Áreas de enfoque	Preguntas de entrevista	Pregntas extras/ comentarios
Sobre MINSAL y su trabajo	• El Ministerio de Salud tiene la obligación de garantizar a todos los ciudadanos el acceso libre e igualitario a todos los programas y servicios de salud. **¿Cómo MINSAL se asegura esto?** • **¿Cuáles son los pros y contras de la forma en que se financian tanto el sistema de Isapre como el sistema de FONASA?** • Los ciudadanos que están en FONASA, también puede usar instalaciones y clínicas privadas. De esta manera, las ISAPRES reciben el dinero para el tratamiento – pero **¿Por qué el Estado no usa este dinero para invertir en el sistema público para mejorar sus instalaciones?** • Cuéntame un poco del Plan AUGE. **¿Ha logrado sus objetivos desde la implementación en 2005?** • **¿Cuál es el mayor desafío para MINSAL hoy en día?**	• Que una entidad se financia a través de subsidios del Estado y la otra trabaja dentro de un esquema de seguros pensando en la posibilidad de intereses económicos?
Sobre (des)igualdad entre los dos sistemas de salud	• Un 73 % de los chilenos están inscritos en Fonasa y aprox. un 18 % de chilenos son afiliados de	

una Isapre. ¿Por qué la diferencia es tan grande?

- Las Isapres son empresas con fines de lucro. Su negocio consiste en administrar el riesgo de los usuarios. De esta forma tienen incentivo a otorgar mejores prestaciones a usuarios menos frecuentes del sistema, perjudicando, por ejemplo, a mujeres en la edad fértil, personas con enfermedades preexistentes.**¿Cómo MINSAL se encarga de alinear estos objetivos comerciales con los objetivos sociales?**

- En 2007 el gasto total en salud en Chile fue un 6,2 % del PIB. 58,7 % del gasto total correspondió al sistema público y el resto al sistema privado. Era casi 50/50 pero el sistema público tiene que atender 80 % de la población y el sistema privado solo tiene que atender un 17,5 %. Parece que el sistema privado tiene más dinero y más recursos que el sistema público. **¿Qué significa esto para el tratamiento que recibe la gente?**

- **¿Qué hacen para prevenir la concentración de médicos en la Region Metopolitana?**

- A veces parece muy complicado navegar entre toda la información sobre Isapres y diferentes planes. **¿Cómo aseguran que la población está bien informada en todo el país?**

Opiniones personales de Andrea Srur	• **¿Encuentras, que hay una desigualdad entre la calidad de tratamiento en el sistema público y el sistema privado?** • **¿Según tu opinión personal, los chilenos tienen todo las mismas oportunidades y reciben todos, la misma calidad de tratamiento? ¿Y si no, qué factores influyen en la calidad del tratamiento que reciben?**

8.3 Appendix C: Email interview Manuel Inostroza

¿Qué efecto cree usted, que la privatización del sistema de salud durante la era de Pinochet, ha tenido a la sociedad chilena?

"Muchas porque resulto fundamental para polarizar ideológicamente el debate del sector salud."

"*Nuestra aspiración de recuperación de la Democracia paso a ser sinónimo del SNS como sistema de salud del pasado o del rol estatal en salud con su consecuente expansión del gasto y Dictadura paso a ser sinónimo de contención y restricción del gasto y de la privatización en salud, lo que a pesar de los años que han pasado desde la recuperación de la Democracia ha polarizado e imposibilitado las posibilidades de acuerdos en salud."*

¿Todavía podemos ver las consecuencias de esta reforma hoy en día?

"Por cierto porque el sector privado se introdujo como opción al Fonasa sin asumir las reglas de la seguridad social, sino que con la lógica de un seguro individual de corto plazo asociado al riesgo de cada de una de las personas y eso es muy extraño cuando miramos la regulación de sistemas de salud en el mundo."

¿Cuáles son las diferencias (positivas y negativas) entre tener un sector de salud privado y tener un sector de salud público?

"Con todo, el sector privado chileno estimulo en la prestación una medicina de alta complejidad y calidad, que ha aportado a la salud de los chilenos, pero ahora está enfrentando fenómenos inflacionarios en el gasto privado, porque se ha mostrado sin los incentivos, capaz de compartir y gestionar mejor los riesgos de su población, lo que sumado a su lógica de seguro individual tiene disconforme a los casi 3,5 millones (19% de la población) y judicializando las alzas de precios de los planes de salud privados."

"En el sector público por su lógica de integración vertical estimula la contención del gasto, lo que lo hace como país muy costo efectivo, pero con un sistema prestador muy ineficiente en lo micro y con enormes problemas de calidad de atención que se reflejan en problemas de trato y de enormes listas de espera."

¿Según su opinión personal, qué podría ser una solución a estos problemas?

"Por ende se requieren nuevas etapas de reforma en salud tanto en lo público como privado, pero definidas gradualmente por etapas e un periodo que no tomara menos de 15 años."

8.4 Appendix D: Original quotes

The following quotes are listed according to appearance in the thesis. ENG indicates my own translation from Spanish into English, which also are the quotes used throughout the thesis. Some quotes are slightly rephrased to make it understandable.

Manuel Inostroza:

"(…) resultó fundamental para polarizar ideológicamente el debate del sector salud."

ENG: *"(…) it showed to be fundamental in the ideological polarization of the debate about health care."*

Manuel Inostroza:

"Nuestra aspiración de recuperación de la Democracia paso a ser sinónimo del SNS como sistema de salud del pasado o del rol estatal en salud con su consecuente expansión del gasto y Dictadura paso a ser sinónimo de contención y restricción del gasto y de la privatización en salud, lo que a pesar de los años que han pasado desde la recuperación de la Democracia ha polarizado e imposibilitado las posibilidades de acuerdos en salud."

ENG: *"Our aspiration for recovery of democracy became synonymous with the NHS as a health care system of the past or the role of the state in health care with its consequent expansion of spending and the dictatorship became synonymous with containment and restriction of spending and privatization of health care. Despite the years that have passed since the recovery of democracy this has polarized the society and made it impossible to make agreements within health care."*

Manuel Inostroza:

"(…) el sector privado se introdujo como opción al Fonasa sin asumir las reglas de la seguridad social, sino que con la lógica de un seguro individual de corto plazo asociado al riesgo de cada de una de las personas y eso es muy extraño cuando miramos la regulación de sistemas de salud en el mundo."

ENG: *"(…) the private sector was introduced as an alternative to Fonasa without assuming the rules of social security, but with the logic of individual short-term insurances associated with each person's risk. And that is very strange if we look at regulation of health care systems in the world."*

Andrea Srur:

"Yo creo que los pros que tiene el por Fonasa es que Fonasa en un sistema solidario en el fondo. Solidario significa que se dividen los pagos según tu ingreso. Él que tiene menos ingreso en el

fondo paga menos y el sistema público cubre más y él que tiene más ingreso paga más y el sistema público cubre menos. (…) Isapre en cambio yo pago lo que tengo que pagar. Estoy obligada de pagar eso cierto porciento".

***ENG:** "I think that the pros that Fonasa has is that Fonasa is basically a solidary system. Solidary means that the amount you pay depends on your income. The person that has a lower income basically pays less and the public system pays more, and the person that has a higher income pays more and the public system pays less. (…) In Isapre on the other hand, I pay what I have to pay. I am obligated to pay that certain percentage."*

Carlos Carrasco:

"La Superintendencia se ha hecho mucho esfuerzo para el derecho del patiente. … por ejemplo que tiene que ver con la Ley de Urgencia, a que ninguna persona aca se tenga que exegir ante una urgencia - dinero en efectivo o un cheque en blanco … es una garantia illegal… si se usted se esta muriendo o va a tener un daño permanente en su salud en su organismo …si usted no nos paga no nos asegura este pago nosotros no la vamos a atender…Antes hubo un tiempo en nuestro país de que mucha gente era nagada su atencion porque no dejaba un cheque en blanco."

***ENG:** "The Health Regulatory Agency has made a huge effort when it comes to the rights of the patients…for example the Emergency Law that says that you cannot force a person in the state of emergency to pay in cash or to leave a blank check…it is an illegal guarantee…if you are dying o of if you are going to have permanent damage to your organism…if you do not pay us, if you do not guarantee this payment, we will not treat you…before in our country there was a time when a lot of people were refused medical attention because they did not leave a blank check."*

Carlos Carrasco:

"El objetivo que está detras de esto es el principio de equidad. Por qué el principio de equidad? Porque quiere decir que tu independiente de que estés un sistema público o privado el prestador tiene que cumplir con el mismo estándar de prestaciones."

***ENG:** "The idea behind this is the principle of equity. Why the principle of equity? Because it means that you, whether you are in the public or the private system the provider must comply with the same standard of performance."*

Carlos Carrasco:

"Ya, entonces yo estoy en FONASA y voy a mi hospital en el cual tiene que estar el mismo estándar que lo tienen en una clinica privada. Lo diferente puede ser lo de hotelería. Que uno tiene mejor hotelería que otro. Está mejor pintado los muros, hay televisor quizas en este otro no está tanto las

condiciones pero los procesos clínicos se han ido cumpliendo en estaps. Entonces por ejempo aquí hemos tenido clinicas muy importantes que han perdido la creditación porque no cumplen con los procesos. Hemos tenido unos hospitales más sencillos super complejos en sectores populares, que sí cumplen con la acreditación".

ENG: *"Well I am in Fonasa and I go to my hospital where they must have the same standards that a private clinic has. The difference could be the quality when it comes to food, beds etc. One system has better installations than the other. Maybe the walls are painted better, there is television, maybe in the other one the conditions are not that good, but the standard of the clinical processes have been met continuously. So, for example we have had very important clinics that have lost their accreditation because they did not comply witacredih these processes. And we have had more simple hospitals in very populated sectors that did comply with their accreditation."*

Carlos Carrasco:

"La infraestructura puede ser dinstinto pero nosotros no estamos acreditando por infraestructura, por hotelería, estamos acreditando procesos clínicos y los procesos clínicos, nuesta acreditación puede ser muy sencillo, el equipamiento de un hospital."

ENG: *"The infrastructure may be different but we do not give accreditation according to infrastructure, or according to the quality of beds and food, we are giving accreditations for clinical processes and despite this accreditation the quality in a hospital may be very simple."*

Andrea Srur:

"Yo me compro mi farmaco. Yo me voy a la farmacia a comprar mis remedios. Me sale mucho más caro…en cambio la gente en el sistema público se los da el sistema público el remedio que necesitan, pero probablemente es de menor qualidad. Va a la calidad de atención en el fondo, el tipo de farmaco, el tipo de technología."

ENG: *"I buy my own medicine. I go to the pharmacy to buy my medicine. It is a lot more expensive…on the other hand people in the public system receive the medicine they need from the public system, but it is probably a lower quality. It is basically about the quality, the type of medicine and the type of technology."*

Andrea Srur:

"La concentración de especialistas y de médicos claro está en la Region Metropolitana (…) cuando uno sale de la escuela de medicina puede postular a los denominado Medicos Rurales (…) entonces yo salgo de la escuela de medicina y como ahora es el sistema hay que estar tres años en el sistema público trabajando para poder postular a una beca de especialización (…) para ser

cardiólogo o cualquier cosa (…) me mandan a todo de Chile. Mientras más lejos estoy, más puntajes gano para poder postular a una beca de residencia en tres años más o seis años más (…) Mientras más tiempo afuera estoy, mientras más lejos estoy de Santiago, más puntos tengo."
ENG: *"The concentration of specialists and doctors is definitely in the Metropolitan Region (…) when you come out of medical school you can apply for the so-called Rural Doctors (…) so I get out of medical school and how the system is at the moment, I have to work three years in the public system in order to apply for a specialization scholarship (…) to be a cardiologist or something like that (…) they can send me to all over Chile. The further away I am the more points I get to apply for a residence scholarship of three years, or six years more (…) The more time I am away and the further I am away from Santiago the point I get."*

Andrea Srur:
"Si tengo un consultorio que tiene más plata y tiene menos gente va a recibir mejor recursos que el consultorio que tiene dos millions de personas y que recibe super poco. Inequidad absolutamente."
ENG: *"If there is a medical consulting that has more money and receive less people, there are going to have better facilities than the medical consulting that receives two million people and receive very little. It is absolutely inequality."*

Andrea Srur:
"No existe ningun tipo de regulación sobre las isapres, (…) no hay regulación de las isapres, te pueden subir plan 500% si quieren. Ahora hay un tema que se denomina la "judializacion" de las isapres, yo como usuario puedo demandar a mi Isapre si me sube el plan. Y la Isapre tiene cubrir esto costo de la demanda que yo estoy haciendo."
ENG: *"There does not exist regulation of the Isapres, (...) there is no regulation of Isapres, so they can increase the cost of your plan 500% if they want to. Now there is something called the "judicialization" of isapres, which means that as a user I can sue my Isapre if they increase the cost of my plan. And the Isapre has to cover the cost of that."*

Andrea Srur:
"Yo creo que la gente aprende por necesidad. Uno aprende o uno muere en el camino."
ENG: *"The people learn out of necessity. You learn or you die in the process."*

Manuel Inostroza:
"(…) el sector privado chileno estimulo en la prestación una medicina de alta complejidad y calidad, que ha aportado a la salud de los chilenos, pero ahora está enfrentando fenómenos

inflacionarios en el gasto privado, porque se ha mostrado sin los incentivos, capaz de compartir y gestionar mejor los riesgos de su población, lo que sumado a su lógica de seguro individual tiene disconforme a los casi 3,5 millones (19% de la población) y judicializando las alzas de precios de los planes de salud privados."

ENG: *"(...) the Chilean private sector spurred a medical science of high complexity and quality, that has contributed to the health of the Chileans, but now the sector is facing inflationary phenomena in private spending because it has lacked incentive and capability of sharing and managing the risks of the population. This added to the logic of individual insurance has left almost 3.5 million people (19 % of the population) unhappy and willing to sue because of the price increase of private health care plans."*

Manuel Inostroza:

"En el sector público por su lógica de integración vertical estimula la contención del gasto, lo que lo hace como país muy costo efectivo, pero con un sistema prestador muy ineficiente en lo micro y con enormes problemas de calidad de atención que se reflejan en problemas de trato y de enormes listas de espera."

ENG: *"Because of its vertical integration logic, the public sector has stimulated the containment of spending, which it does very cost effectively as a country. But as a provider in the micro level it is very inefficient and it has enormous problems of quality of care which is reflected in the treatment and the huge waiting lists."*

Andrea Srur:

"(...) el sistema de Isapre en este momento es bien discriminatorio. Por ejemplo, a las mujeres, a las mujeres las cobran más, pagan más. El alto mayor en las Isapres paga más. Eso no pasa en Fonasa.".

ENG: *"(...) the system of Isapre at the moment is very discriminating. For example, to the women, the women pay more. The elderly in the Isapres also pay more. This does not happen in Fonasa."*

Carlos Carrasco:

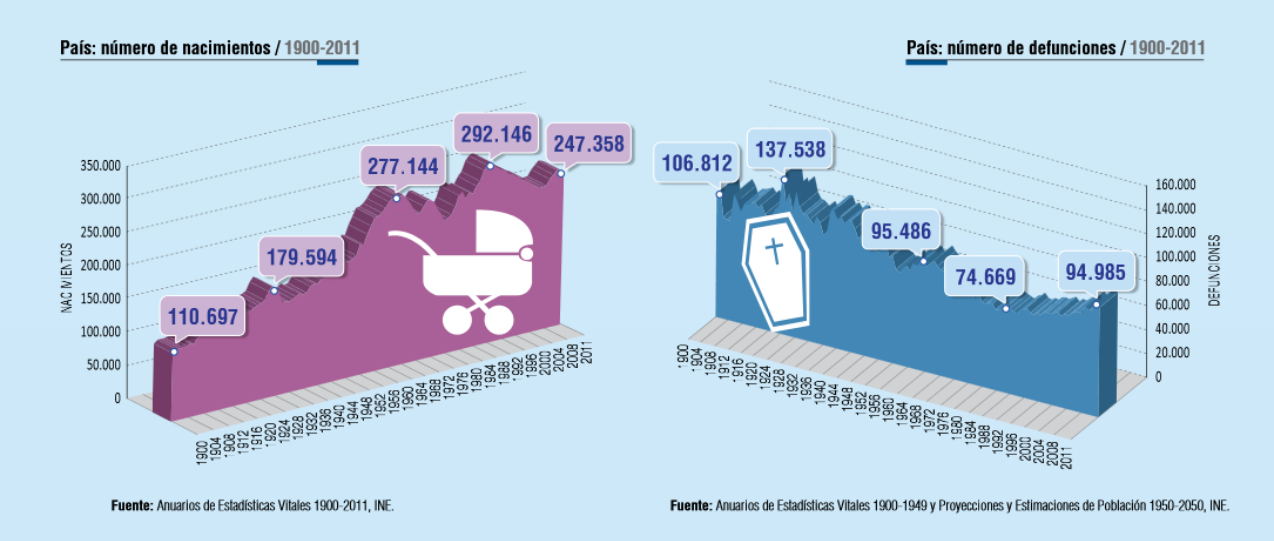
"Las Isapres tenían como enfermedad el embarazo y eso las quitamos(...) el embarazo no es una enfermedad, es una condición humana."

ENG: *"The Isapres had pregnancy on the list of illnesses and we eliminated that (...) pregnancy is not an illness it is a human condition."*

8.5 Appendix E: Birth and mortality rate 1900-2011

The figure illustrates number of births and deaths pr. year for the whole Chilean population between 1900 and 2011.

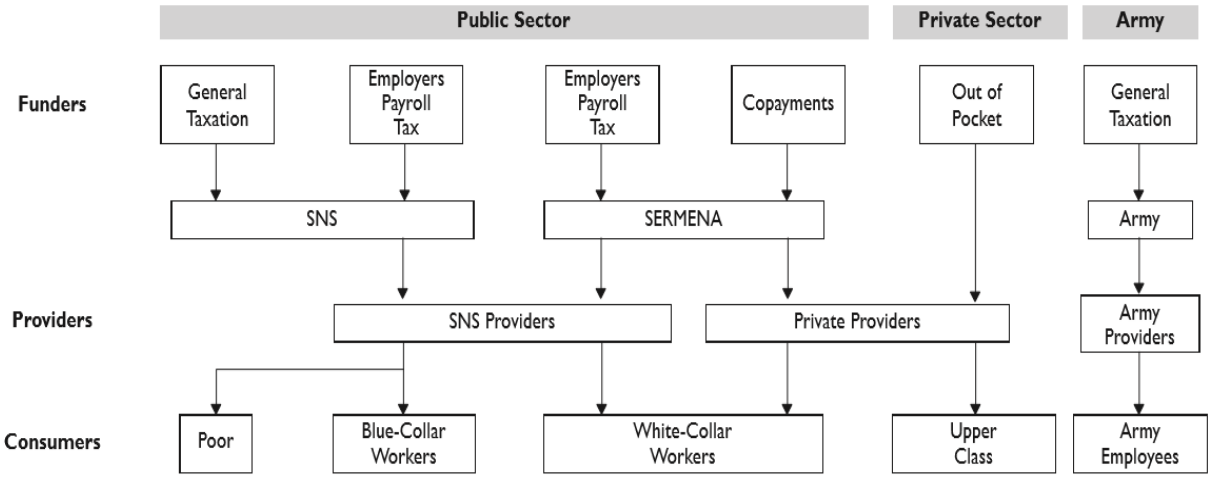
To the left: Birth rate 1900-2011.
To the right: Mortality rate 1900-2011.



Source: The Chilean National Statistics Institute (Instituto Nacional de Estadísticas): http://www.ine.cl/canales/menu/publicaciones/calendario_de_publicaciones/pdf/infografia_estadisticas_vitales_13_2014.pdf - retrieved 14-09-2016 at 12:53.

8.6 Appendix F: Organization chart before Pinochet

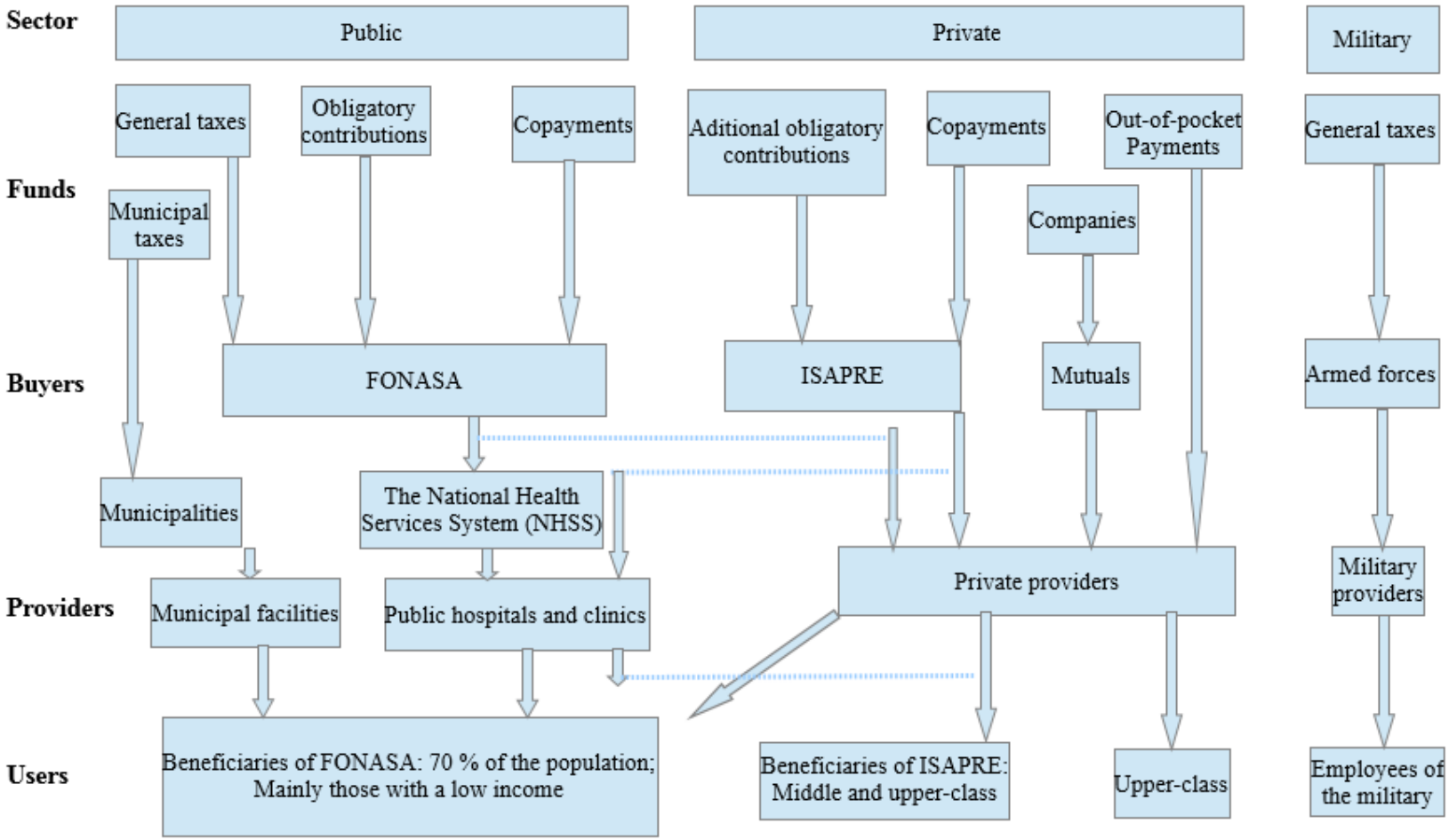
Organizational chart showing the structure of the health care system before Pinochet.



SNS: Servicio Nacional de Salud (National Health Service)
SERMENA: Servicio Médico Nacional para Empleados (National Medical Service for Employees)

Source: (Manuel, 2002: 63)

8.7 Appendix G: Organization chart today



** Own elaboration based directly on chart from article: (Becerril-Montekio, 2011: 133). Translated from Spanish.*

8.8 Appendix H: Differences Fonasa and Isapre

All dependent workers are required to allocate 7 % of their gross salary to a health insurer. Below you will find a comparison of the public and the private system, on chosen key areas.

	FONASA	**ISAPRES**
Type of institution	Fonasa is a public institution responsable for granting health care coverage to all Chileans.	Isapres are private health insurance companies.
Who are considered the beneficiaries?	The beneficiaries of Fonasa are the people who pay 7 % of their monthly salary including their legal co-insured such as children and those who have few resources and thereby are covered by state subsidies.	The beneficiaries of an Isapre are those who pay 7 %, their legal co-insured and other co-insured that are accepted by the Isapre as part of the plan.
Enrollment	If you chose Fonasa and are a dependent worker (with a working contract), the enrollment is automatic. Fonasa classifies its affiliates in the following groups according to their taxable income: • A: Lack of resources and therefore do not pay for the medical care they receive. • B: Less than minimum wage and do not pay for enrollment either. • C and D: For those with a salary above the minimum wage. Members of these groups pay 7 % of their salary.	Enrolment in an Isapre is done by signing a private contract, which is subject to the rules established and supervised by the Health Regulatory Agency. To become a member, you must fill out a health declaration form which will be evaluated by the Isapre in case of any coverage limitations, preexistences – which can ultimately lead to a rejection of a person or its family members.
The contract	It does not require filling out a contract to be a member of Fonasa.	To join an Isapre you must fill out a contract stating the exact benefits you have and the beneficiaries included in the plan. It is highly recommended not to sign the contract before the respective Isapre has reviewed your health declaration and have confirmed that they do not have any inquiries.

Contributions (the amount of money that your pay to your health insurer)	Being a member of Fonasa you must pay 7 % of your monthly taxable income (unless you are in category A or B).	Being a member of an Isapre you must pay 7 % of your monthly taxable income. If the plan you wish to buy is more expensive than 7 % of your monthly income you must pay an additional fee.
As a beneficiary, you can be covered in various ways...	**Institutional care mode (MAI)** Benefits given to you in public health care institutions or primary care clinics: • Group A, B, and citizens over 60 years of age: Medical attention is free. • Group C: Fonasa covers 90 % of the medical cost. • Group D: Fonasa covers 80 % of the medical cost. **Possibility of free choice (MLE):** This means that in some cases you can get medical care in private clinics. Only if you are in group B, C, or D you can use this service, and Fonasa will cover a lot less than if you use the public system so your own payment will be higher.	The Isapres have the following rules for medical attention: • **A plan with free choice** which means that the beneficiary can chose their medical attention freely according to what the free market offers, and pay the co-payments according to what is in their plan. • **A closed plan** is a cheaper choice, and it limits the beneficiaries only to use the specific health providers in their plan. If they chose to go to another provider, the Isapre will not cover anything. • **A plan with preferred providers** is a combination that gives the beneficiary the possibility of choosing between preferred provider, specifies in their plan. They can also go to another non-preferred provider but then their co-payment will be a lot higher.
Health care plan	Fonasa only has one health care plan with two modes of operation: Free choice mode (MLE) and Institutional care mode (MAI)	The Isapres have plan based on different health care models, with different coverage percentage and services. It is important to note that a health care plan does not necessarily imply coverage to all services, as some might be excluded.
Payment methods	In the free choice mode, you pay through bonds (bought in the clinic or hospital) and the price of these vary according to which group you belong.	The different possibilities of payment: Before medical care is carried out you must buy a bond (cost according to

	Fonasa also has other programs such as Payment Partner Diagnosis (PAD) and Associated Emergency Payment (PAE). Fonasa does not have a system of money refunds once you have used the medical service.	health care plan). After realization of the medical attention a refund can be made sending the receipt to your insurance company. In some case bonds can be paid for after realization of medical attention, for example in the case of certain surgeries.
Benefits or health care services. (Health benefits are established according to tariffs).	In Fonasa the different health benefits are identified with a certain code which then has a valued related to it. A part of the health benefit is financed by Fonasa. This amount is determined according to which group you belong (A, B, C, or D).	The health benefits in Isapre are based on the different plans that its members can chose from. In the contracts the coverage is identified with a specific tariff, each with their respective value. The value of each provision is specified in either, Chilean pesos, UF or VA. And the co-payment for each service depends on the plan that each affiliate have with their Isapre. Before choosing your plan, it is important to ask for a document called" Choosing valued benefits" in each Isapre, in order to compare the different tariffs as the coverage for the same service can vary even though the plans cost the same.
The subsidy (bono) that you can obtain...	Every health service has a subsidy, or an amount of money that is financed by the insurance. When you know the value of the service or care that you receive you should find out how much is covered by Fonasa. This depends mainly on, to which group you belong or the bonus level 1, 2 or 3 (free choice mode).	All services that are covered in your plan, has a subsidy (bonus). You must check with the different Isapres to know the values of the subsidies asking for a specification document. Here you can see the percentage that the Isapre covers and the maximum that they will cover for each service. This allows you to compare the coverage of the different plans before choosing. If you are already member of an Isapre

		and do not know how much you are covered for a specific health care service, you can request a budget before buying the service.
Your insurance coverage...	In MAI, Fonasa covers the citizens that pay 7 % of their monthly taxable salary, but it also covers those who lack the resources to pay with a direct subsidy from the state. The percentage covered by Fonasa depends on the group that the beneficiary belongs to. This is determined by their income. • Group A, B, and people over 60: medical attention is free. • Group C: Fonasa covers 90 %. • Group D: Fonasa covers 80 %.	Your Isapre is obligated to grant you the coverage according to your health care plan and it must be at least 25 % (or correspond to the coverage that Fonasa gives in free choice mode (MLE). This means that they cannot have a lower subsidy that Fonasa has in MLE. Not all health care services have subsidies, as the Isapres are only obligated to incorporate the services that Fonasa also covers so there may be some services that are not covered unless this is specified in the plan.
Limits...	It is very important to bear in mind that the subsidies often have limits. This could be a maximum of 30 medical consultations pr. year for example.	The Isapres have different limits depending on your chosen plan. For example, if a health care service is covered 70 % but only up to a certain amount in total. So, when you reach that maximum you are outside of coverage. They also have annual coverage limits per beneficiary.
Restrictions...	Fonasa do not impose coverage limits according to your disease history.	The Isapres have restrictions on their coverage due to preexisting health conditions.
Pre-existing conditions...	Fonasa does not consider pre-existing conditions at the time of admission nor do they use it to limit the coverage on these diseases.	In case that the beneficiary or any of his/hers co-insured have a pre-existing health condition, this must be disclosed in the health declaration for the Isapre to decide whether a person can be a member. But if the beneficiary gets a disease after signing the health declaration, the Isapre cannot terminate the contract or limit the coverage for this reason.
Emergency care...	Medical emergencies must be addressed, ideally in a public health facility.	Ideally emergency care must be addressed by the preferred provider according to your health care plan, to get the best coverage.

	If you go to a private health care provider in the case of a severe emergency this provider must notify the Emergency Center Regulation to get the patient transferred to the public network to continue the hospitalization once they are stabilized.	
Medical licence...	The independent workers should present their medical licenses in COMPIN (Commission of Preventive Medicine and Disability). If you are a dependent worker your employer will do this for you.	The Isapres receive the medical licenses for authorization or rejection. In some cases, they can also modify the requested license period. Furthermore, they are obligated to pay a fee for lost working hours, if the license is for more than three days.
Catastrophic insurance...	In case of certain diseases Fonasa offers a catastrophic insurance, which covers 100 % of the cost as long as you use the establishments proposed by Fonasa.	Some Isapres (not all) offer insurance that covers diseases that are extremely expensive and considered catastrophic (CAEC). This insurance covers 100 % of the cost as long as you use the establishment recommended by the Isapre.
Termination of contract by the insurer...	In Fonasa there are no grounds for terminating a contract.	The Isapres are entitled to terminate a contract if: - The beneficiary has submitted false information in the health declaration, unless this happened by mistake. - The beneficiary does not pay the monthly contribution. - In case of termination of the contract because the beneficiary loses his/her job, the Isapre will end the contract one month after notice from the employer.

Source: The Health Regulatory Agency: http://www.supersalud.gob.cl/difusion/665/w3-printer-6444.html

8.9 Appendix I: Population according to health care system and income

The table shows in which health care system the Chilean population is, according to their quintile 1-5 (group based on income)

INCOME QUINTILE PER CAPITA	FONASA		MILITARY		ISAPRE		NONE		OTHER SYSTEM		DON'T KNOW		Total	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
I	3.499.738	25,9	26.267	7,1	72.978	3,0	86.226	18,7	19.772	14,0	64.616	20,3	3.769.597	21,8
II	3.492.054	25,9	44.103	12,0	153.038	6,2	95.798	20,8	27.018	19,1	66.476	20,9	3.878.487	22,5
III	3.035.462	22,5	80.718	21,9	259.824	10,6	103.546	22,5	32.719	23,1	73.189	23,0	3.585.458	20,8
IV	2.372.394	17,6	111.104	30,1	545.756	22,2	95.666	20,7	40.402	28,6	67.374	21,2	3.232.696	18,7
V	1.108.846	8,2	106.322	28,9	1.426.722	58,0	79.903	17,3	21.562	15,2	46.626	14,6	2.789.981	16,2
Total	13.508.494	100,0	368.514	100,0	2.458.318	100,0	461.139	100,0	141.473	100,0	318.281	100,0	17.256.219	100,0

Source: Ministry of Social Development, Social Observatory Division, Casen survey 2013

8.10 Appendix J: GDP according to region and list of regions

Region Code	Region (listed geographically)
15	De Arica Parinacota
1	De Tarapacá
2	De Antofagasta
3	De Atacama
4	De Coquimbo
5	De Valparaíso
13	Metropolitana de Santiago
6	Del Libertador Gral. B. O'Higgins
7	Del Maule
8	Del Bíobío
9	De La Araucanía
14	De Los Ríos
10	De Los Lagos
11	De Aysén del General Carlos Ibañez del Campo
12	De Magallanes y de la Antártica Chilena

Source:Ministry of Health, Statistics & Health Information Department - http://www.deis.cl/estadisticas-recursossalud/

CUADRO 1
Producto interno bruto por región, anual, precios corrientes
(Millones de pesos) (1)

	2012	2013	2014	2015
PIB				
XV De Arica y Parinacota	710.765	791.498	869.116	959.560
I De Tarapacá	2.876.974	3.168.317	3.407.355	3.352.673
II De Antofagasta	13.067.578	13.003.959	14.599.244	13.723.754
III De Atacama	3.450.909	3.499.799	3.226.718	2.810.529
IV De Coquimbo	3.910.770	3.890.534	4.218.551	4.188.618
V De Valparaíso	10.298.164	10.915.352	11.547.504	12.505.625
RMS Región Metropolitana de Santiago	57.311.273	62.063.296	65.741.064	71.856.593
VI Del Libertador General Bernardo O'Higgins	5.390.168	5.575.893	6.148.225	6.593.112
VII Del Maule	3.611.430	3.801.272	4.129.021	4.653.510
VIII Del Biobío	8.514.152	9.015.214	9.921.945	10.853.256
IX De La Araucanía	2.633.999	2.894.314	3.092.659	3.459.674
XIV De Los Ríos	1.420.100	1.584.472	1.765.517	1.909.142
X De Los Lagos	3.061.183	3.473.659	4.179.041	4.544.680
XI Aysén del General Carlos Ibáñez del Campo	609.297	671.118	799.922	833.115
XII De Magallanes y de la Antártica Chilena	1.009.766	1.067.713	1.134.035	1.245.057
Subtotal regionalizado	117.876.530	125.416.409	134.779.917	143.488.900
Extrarregional (2)	92.063	89.170	102.667	139.533
IVA, derechos de importación	11.058.960	11.723.997	12.685.524	13.882.288
PIB	129.027.553	137.229.576	147.568.108	157.510.721

Source: The Central Bank of Chile, Regional GDP 2015 - www.bcentral.cl

8.11 Appendix K: Health care plan 1

Plan EMPRENDEDOR JEM 14

FECHA: _____ CODIGO: 5184

F.U.N. Nº: _____ INDIVIDUAL: X

Plan con Cobertura Reducida en prestaciones Obstétricas y de Neonatología

PRESTACIONES	% Bonificación sobre Valor Real de la Prestación	TOPE DE BONIFICACION U.F. o Veces Arancel (1)	TOPE MÁXIMO Año Contrato por Beneficiario en U.F. (2)	TOPE BONIFICACION Internacional (3)	AMPLIACIÓN DE COBERTURA (4)
HOSPITALARIAS Y CIRUGÍA MAYOR AMBULATORIA					
Día Cama (Ver Anexo Plan de Salud Complementario (**)).	100%	100% SIN TOPE		14,00 UF	
Día Cama Cuidados Intensivos o Coronarios	100%			24,00 UF	
Día Cama Cuidados Intermedios	100%			15,00 UF	
Día Cama Sala Cuna	100%			6,90 UF	
Día Cama Incubadora	100%			14,00 UF	
Exámenes de Laboratorio	100%			6,80 VAM	
Imagenología	100%			6,80 VAM	
Kinesiología	100%			6,80 VAM	
Derecho de Pabellón	100%			13,00 VAM	
Medicamentos (Por evento durante la Hospitalización) (***)	100%			400,00 UF	
Materiales e Insumos Clínicos (Por evento durante la Hospitalización) (***)	100%			300,00 UF	
Procedimientos	100%	3,85 VAM			
Honorarios Médicos Quirúrgicos	100%	14,85 VAM			
Visita por Médico Tratante	100%	1,75 UF			
Visita por Médico Interconsultor	100%	1,75 UF			
Traslados Médicos	100%		2,10 UF		
Quimioterapia	100%		155,00 UF		
Prótesis y Ortesis y Hementos de Osteosíntesis	100%		13,50 UF		
AMBULATORIAS					
Consulta Médica	90%	90% SIN TOPE		3,30 UF	
Consulta Oftalmológica	90%			4,00 UF	
Exámenes de Laboratorio	90%	3,90 VAM			100% Nivel I, II y III (*)
Imagenología	90%	3,90 VAM			
Procedimientos	90%	3,20 VAM			
Kinesiología	90%	2,95 VAM	4,93 UF		
Fonoaudiología	90%	2,95 VAM	4,78 UF		
Radioterapia (Incluye Insumos)	90%		39,00 UF		
Quimioterapia	90%		155,00 UF		
Prótesis y Ortesis	90%		13,50 UF		
Lentes con Fuerza Dióptrica	90%		1,80 UF		
Atención Integral de Enfermería	90%	0,70 UF	2,10 UF		
Atención Integral de Nutricionista (****)	90%	0,70 UF	2,10 UF		
Prestaciones Dentales (PAD) (*****)	90%	1,00 VAM			
Honorarios Médicos Quirúrgicos	100%	14,85 VAM			
Box Ambulatorio (por menos de 4 horas)	100%	3,90 UF			
Pabellón Ambulatorio	100%	12,00 VAM			
PRESTACIONES RESTRINGIDAS					
Día Cama Psiquiatría	100%	3,30 UF	49,50 UF		
Psicoterapia y Procedimientos Psiquiátricos y/o Psicológicos Hospitalarios	100%	3,85 VAM	6,60 UF		
Consulta Psiquiátrica	90%	7,50 VAM	7,40 UF		
Consulta Psicológica	90%	7,50 VAM	7,40 UF		
Psicoterapia y Procedimientos Psiquiátricos y/o Psicológicos Ambulatorios	90%	2,95 VAM	3,94 UF		

VAM : VECES ARANCEL MASVIDA

CLAUSULA ESPECIAL PARA PLANES CON COBERTURA REDUCIDA DE PARTO, CESAREA O ABORTO

Durante la vigencia del presente Plan, ISAPRE MASVIDA S.A. estará obligada a aceptar el cambio que el(la) cotizante le solicite, a condición que en la Declaración de Embarazo que éste(a) deberá suscribir con este solo objeto, se consigne que la cotizante o beneficiaria, según sea el caso, NO se encuentre embarazada.

El(la) cotizante tendrá derecho a optar, al menos entre los siguientes planes de salud:

a) Un Plan de salud que mantenga la equivalencia en precio con aquel que se reemplaza y que satisfaga la cobertura de parto requerida, caso en el cual podrán efectuarse los ajustes que correspondan en relación a los restantes beneficios del nuevo plan.

b) Un Plan de salud que mantenga los beneficios del Plan que se sustituye y que otorgue o aumente la cobertura de parto, caso en el cual podrán realizarse los ajustes pertinentes en relación al precio del nuevo plan.

OTRAS COBERTURAS

COBERTURA INTERNACIONAL: BONIFICACION DE ACUERDO A LOS TOPES EXPRESADOS EN LAS COLUMNAS (1) Y (2). PARA EL CASO DE LAS PRESTACIONES SIN TOPE SE BONIFICARA EN BASE A LOS TOPES EXPRESADOS EN LA COLUMNA (3).

COBERTURA DENTAL EN EL PLAN COMPLEMENTARIO:
La Isapre cubre aquellas prestaciones dentales contenidas en el arancel de prestaciones de Isapre Masvida.
El resto de las prestaciones dentales ofrece descuentos entre un 30% y 60% del Arancel del Colegio de Odontologos de Chile con prestadores que mantengan convenio vigente con la Isapre Masvida. El listado de prestadores y Arancel están disponibles en las oficinas de atención de público de la Isapre.

8.12 Appendix L: Health care plan 2

Plan PLENO PREFERENTE
PLCLL 54

FECHA: _____ CODIGO: 5843

F.U.N. Nº: _____ INDIVIDUAL: X

Plan con Cobertura Reducida de Parto, Cesárea, Aborto Espontáneo, Neonatología en Cirugías Bariátricas, Fotorrefractivas y/o Fototerapeúticas y Cirugías Rinoplásticas.

PRESTACIONES	% Bonificación sobre valor real (o valor factura)	COBERTURA PREFERENTE (•) AMPLIACIÓN DE COBERTURA EN CLINICA LAS LILAS DE SANTIAGO (1)	COBERTURA PREFERENTE (•) TOPE MAXIMO DE BONIFICACION U.F. por Beneficiario/año (2)	COBERTURA LIBRE ELECCION TOPE DE BONIFICACION U.F. o Veces Arancel (3)	COBERTURA LIBRE ELECCION TOPE MAXIMO DE BONIFICACION U.F. por Beneficiario/año (4)
HOSPITALARIAS Y CIRUGÍA MAYOR AMBULATORIA					
Día Cama	90%	90% SIN TOPE CLÍNICA LAS LILAS de Santiago (Hospitalización en Habitación Individual más simple con baño privado). (b) Médicos de Staff	SIN TOPE	4,00 UF	SIN TOPE
Día Cama Cuidados Intensivos o Coronarios	90%			7,00 UF	
Día Cama Cuidados Intermedios	90%			4,10 UF	
Exámenes de Laboratorio	90%			1,30 VAM	
Imagenología	90%			1,30 VAM	
Kinesiología y Fisioterapia (b)	90%			1,30 VAM	
Derecho de Pabellón	90%			3,60 VAM	
Procedimientos (b)	90%			1,40 VAM	
Honorarios Médicos Quirúrgicos (b)	90%			3,80 VAM	
Visita por Médico Tratante (b)	90%			0,35 UF	
Visita por Médico Interconsultor (b)	90%			0,35 UF	
Medicamentos (Por evento durante la Hospitalización)(***)	90%	90% 40,00 UF de Tope (Hospitalización en Pieza Individual). (**)		10,00 UF	
Materiales e Insumos Clínicos (Por evento durante la Hospitalización) (***)	90%	90% 20,00 UF de Tope (Hospitalización en Pieza Individual). (**)		4,00 UF	
Traslados Médicos	90%	Sin Cobertura Preferente			1,50 UF
Quimioterapia	90%				30,00 UF
Prótesis y Ortesis y Elementos de Osteosíntesis	90%				10,80 UF
AMBULATORIAS					
Consulta Médica (c)	70%	70% Sin Tope en Staff de Centro Médico Clínica Las Lilas de Santiago (c)	SIN TOPE	0,45 UF	SIN TOPE
Consulta Oftalmológica (c)	70%			0,50 UF	
Procedimientos (c)	70%			1,30 VAM	
Exámenes de Laboratorio	70%	70% Sin Tope en Centro Médico Clínica Las Lilas de Santiago (*)		1,30 VAM	
Imagenología	70%			1,30 VAM	
Kinesiología y Fisioterapia	70%	Sin Cobertura Preferente		1,10 VAM	2,64 UF
Fonoaudiología	70%			1,10 VAM	2,50 UF
Radioterapia (Incluye Insumos)	70%				23,60 UF
Quimioterapia	70%				28,00 UF
Prótesis y Ortesis	70%				9,00 UF
Lentes con Fuerza Dióptrica	70%				0,45 UF
Atención Integral de Enfermería	70%			0,57 UF	1,71 UF
Atención Integral de Nutricionista (****)	70%			0,57 UF	1,71 UF
Prestaciones Dentales (PAD) (*****)	70%			1,00 VAM	SIN TOPE
Honorarios Médicos Quirúrgicos (b)	90%	95% SIN TOPE Clínica Las Lilas de Santiago. (b) Staff Clínica Las Lilas		3,80 VAM	SIN TOPE
Box Ambulatorio (por menos de 4 horas)	90%			1,00 UF	
Pabellón Ambulatorio	90%			3,60 VAM	
PRESTACIONES RESTRINGIDAS					
Día Cama Sala Cuna	90%	Sin Cobertura Preferente	SIN TOPE	1,30 UF	SIN TOPE
Día Cama Incubadora	90%			1,30 UF	
Día Cama Psiquiatría	90%			1,00 UF	15,00 UF
Psicoterapia y Procedimientos Psiquiátricos y/o Psicológicos Hospitalarios	90%			1,60 VAM	2,70 UF
Honorarios Matrona	90%			1,60 VAM	SIN TOPE
Consulta Psiquiátrica	70%			1,70 VAM	1,80 UF
Consulta Psicológica	70%			1,70 VAM	1,80 UF
Resonancia Nuclear Magnética Ambulatoria	70%			1,30 VAM	SIN TOPE
Scanner y Ecografías Ambulatorias	70%			1,30 VAM	
Psicoterapia y Procedimientos Psiquiátricos y/o Psicológicos Ambulatorios	70%			1,10 VAM	1,90 UF
Consulta Institucional de Urgencia (a)		COPAGO MÁXIMO de 25% Sin Tope en Clínica Las Lilas de Santiago		Consulta de urgencia Libre Elección se bonificará de acuerdo a modalidad Libre Elección	

PRESTADOR DERIVADO: HOSPITAL DEL PROFESOR Y CLÍNICA AVANSALUD PROVIDENCIA, (Hospitalización en Habitación Individual).

VAM : VECES ARANCEL MASVIDA

TIEMPOS MAXIMOS DE ESPERA (En días corridos)

Exámenes | 10 días

RENUNCIA A LOS EXCEDENTES DE COTIZACION EN PLANES INDIVIDUALES COMPENSADOS:
De acuerdo a lo dispuesto en el inciso primero del articulo Nº 188 del DFL Nº 1 de 2005, modificado por la ley Nº 20.317, Isapre Masvida otorgará a cambio de la renuncia de excedentes los siguientes beneficios adicionales:

	% Bonificación sobre Valor real de la Prestación	Topes de Bonificación expresados en Unidades de Fomento
Consulta Médica	70%	0,52
Consulta Oftalmológica	70%	0,58

Se deja constancia que el aumento en los topes de bonificación regirá siempre y cuando el afiliado renuncie expresamente a los excedentes de cotización.

OTRAS COBERTURAS COBERTURA INTERNACIONAL
BONIFICACION DE ACUERDO A LOS TOPES EXPRESADOS EN LAS COLUMNAS (3) Y (4).

COBERTURA DENTAL EN EL PLAN COMPLEMENTARIO:
La Isapre cubre aquellas prestaciones dentales contenidas en el arancel de prestaciones de Isapre Masvida.
El resto de las prestaciones dentales ofrece descuentos entre un 30% y 60% del Arancel del Colegio de Odontologos de Chile con prestadores que mantengan convenio vigente con la Isapre Masvida. El listado de prestadores y Arancel están disponibles en las oficinas de atención de público de la Isapre.

(•) Ver Notas Explicativas del Plan de Salud, para la aplicación de la Cobertura Preferente.