International Standard-Setting and Innovations in Social Security

Edited by

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CHAPTER 33

Privatization of Chile's Pension and Health Care Systems

Carmelo Mesa-Lago*

§33.01 INTRODUCTION

Chile was a world pioneer in 'structural reforms' or privatization of pension and health care (in 1980s), promoted by the World Bank in Latin America and elsewhere;[1] as well as in their 're-reforms' (in 2004–2008) in order to correct significant flaws in the original designs. This chapter provides a brief overview of the state of privatization in pension and health care in Latin America; discusses Chile's privatization of both programmes in 1979–1981, as well as the re-reforms implemented by democratic regimes in 1990–2008; evaluates the effects of both types of reforms, and pint points remaining challenges and recommendations.

§33.02 THE STATE OF SOCIAL SECURITY PRIVATIZATION IN LATIN AMERICA

In Latin America, structural pension reforms were introduced in eleven countries following three different models. The substitutive model in Chile, Bolivia, Mexico, El Salvador and Dominican Republic closed the public system (not allowing new affiliates) and fully privatized it. The parallel model in Peru and Colombia retained the public system, created a private one and allowed the two to compete. The mixed model

* The author gratefully acknowledges valuable comments/suggestions from Ulrich Becker, Alberto Arenas de Mesa (former Chief of Budget, Ministry of Finance Chile), and Fabio Bertranou (Senior Social Security Specialist, ILO Office, Buenos Aires).

1. World Bank, *World Development Report: Investing in Health* (Oxford U. Press 1993) and World Bank, *Averting the Old-Age Crisis: Policies to Protect the Old and Promote Growth* (World Bank & Oxford U. Press 1994).

in Argentina, Uruguay, Costa Rica and Panama combined a public first pillar that grants a basic pension and a private second pillar that offers a supplementary pension. Argentina in 2008 and Bolivia in 2010 shut down their private systems and moved all the insured persons and funds to the public system, whereas Chile maintained the private system, albeit with substantial changes.

Structural health care reforms in Latin America have been less radical and much more diverse than their pension counterparts, and it is difficult to describe them in relatively simple models. Most countries have three sectors: public, social insurance and private; the reforms expanded the private sector at least until early in the twenty-first century.[2]

Table 33.1 shows the current degree of social security privatization in Latin America, in pensions measured by the percentage of the economically active population (EAP) covered by the private system, and in health care measured by the share of private expenditure in total health expenditure.[3]

Table 33.1 Degree of Privatization in Latin America, 2007–2010

Pensions (2008–2010)	*% EAP*	*Health Care (2007)*	*% Exp.*
1. Mexico	100.0	1. Argentina	25.4
2. Costa Rica	100.0	2. Brazil	23.0
3. Chile	98.6	3. Chile	19.3
4. El Salvador	98.6	4. Dominican R.	14.0
5. Dominican R.	93.5	5. Uruguay	9.0
6. Peru	71.9	6. Peru	8.6
7. Colombia	56.1	7. Colombia	8.1
8. Uruguay	43.1	8. Panama	6.1
9. Panama	1.0	Rest (11 w/o Cuba)	0.7–4.7
Others (11 public)	0	20. Cuba	0
Average region	34.0	Average region	7.1

Source: Pensions from Mesa-Lago;[4] health care based on expenditures from WHO, 2010;[5] non-weighted averages by author.

The degree of privatization is much higher in pensions (averaging 34% of EAP) than in health care (7% of total expenditure). In pensions, privatization in eight countries ranged from 43% to 100%, whereas eleven retained (or returned to) public systems. In

2. C. Mesa Lago, *Reassembling Social Security: A Survey of Pension and Health Care Reforms in Latin America* (Oxford U. Press 2008).
3. Statistics on private health coverage of the total population are more difficult to compile, but coincide with figures in Table 33.1: 24% in Brazil and 16% in Chile.
4. Mesa-Lago, *Reassembling Social Security* (n. 2), and C. Mesa-Lago, *World Crisis Effects on Social Security in Latin America and the Caribbean: Lessons and Policies* (Inst. Study Americas, U. London 2010).
5. World Health Org., *World Health Statistics* (World Health Org. 2004, 2010).

health care, privatization in eight countries oscillated from 6% to 25%. Chile's coverage by private health insurers (ISAPRES) fell from 26% to 16% of the total insured in 1997–2010, as coverage of the public sector expanded and improved.

There were multiple reasons for the re-reform of privatized systems. The premise that there was a universal paradigm that fitted all, regardless of significant differences among countries (economics, labour and capital markets, social and political contexts), failed in practice, as it worked in some cases and failed in others. Second, many assumptions of the reformers did not materialize, for example, coverage did not expand, competition did not work in several countries, and hence, administrative costs remained high, and the investment portfolio remained concentrated in most countries. Significant flaws in the original design of structural reforms contributed to serious problems, for instance, the private system was geared towards an urban, formal labour market, whereas in several countries the informal and rural sectors were predominant, therefore the majority of the labour force was excluded. The key premise that in pension reforms the ownership of the individual account and private management would preclude state intrusion proved to be false; the state nationalized private funds in order to pay the external debt (Argentina in 2008).

§33.03 THE PENSION SYSTEM

[A] Reform and Re-reform

In 1979 the Pinochet military government unified thirty-three out of thirty-five independent pension schemes; standardized their entitlement conditions and unified their management in the Institute of Social Security Standardization *(Instituto de Normalización Previsional: INP*), but left the powerful armed forces and police schemes untouched. In 1980, without public debate, the public system was closed to new entrants, and replaced with a defined contribution, fully-funded system, based on individual accounts and managed by private for-profit companies dedicated solely to pension administration (*Administradoras de Fondos de Pensiones:* AFP). The insured in the public system were given a short period to decide whether to remain in the system or move to the private system; all new entrants to the EAP were obliged to join an AFP.[6]

In 2009, 98.6% of all insured were in the private system and only 1.4% remained in the public system.[7] The Superintendence of AFP regulated and supervised the private system until 2008. AFP had enormous power (they managed pension funds worth 64% of GDP in 2007) and succeeded in obstructing any fundamental reform for twenty-seven years, despite growing criticism of the flawed system.

In 2008, the new President Michelle Bachelet gave high priority to pension reform in her electoral programme and had a new law adopted in March 2008 preceded by a

6. C. Mesa-Lago, *Changing Social Security in Latin America: Towards the Alleviation of Social Costs of Economic Reform* (Lynne Rienner 1994).
7. Superintendencia de AFPs/Superintendencia de Pensiones (SAFP), *The Chilean Pension System* (4th ed., Santiago 2009b).

wide debate.[8] I will compare the structural reform (by the Pinochet government) and the re-reform (by the Bachelet government) in the following sections.

[B] Reform and Re-reform Effects on Social Security Principles or International Standards

The effects of the structural reform and the re-reform are evaluated on five social security principles or international standards: (1) universal coverage; (2) benefit sufficiency; (3) social solidarity and gender equity; (4) efficiency, moderate administrative costs and social representation; and (5) financial sustainability.

[1] Universal Coverage

[a] Reform

The reform provided mandatory coverage to the formal sector (employees in the public and private sector), voluntary coverage to the self-employed and excluded unpaid family workers and others in the informal sector. Long-term unemployed were not covered if payment of contributions was interrupted too long; the permanently disabled could be eligible for a pension, provided they had accumulated enough contributions and passed the required medical examination.

Supporters of privatization argued that it would increase coverage of the EAP because of the incentives provided by insured ownership of individual accounts, better pensions and more efficient private management.[9] Table 33.2 demonstrates that such assumptions did not materialize. In 1973 (the year of the military coup) coverage based on statistics on affiliates contributing to all pension schemes was 73% and fell to 64% in 1980.[10] After the reform, coverage is limited to the private system: it shrank to 29% in 1982 (during the economic crisis), and increased from 46.8% to 61.2% in 1990–2007 (13 percentage points less than in 1973 and 3 percentage points less than in 1980). Based on household surveys, coverage fell from 62.2% to 61.4% in 1990–2006.[11] EAP coverage calculated on the basis of affiliates (who may have paid only one contribution) is considerably higher than based on contributors (affiliates who paid their contributions in the last month): 116.5% and 60.3% in 2009, respectively.[12] The

8. Law 20.255 of 11 March 2008 *Diario Oficial* (Santiago, March 17).
9. J. Piñera, *Principios y Fundamentos del Sistema Privado de Pensiones en Chile*, in *Análisis del Sistema Privado de Pensiones en Chile* (R. Cruz ed., Congreso Iberoamericano de la Asociación de Administradores de Pensiones 1991) and World Bank, *Averting the Old-Age Crisis* (1994).
10. Mesa-Lago, *Reassembling Social Security*, *supra* n. 2.
11. Adding in those covered in the public sector (1.6%), total EAP coverage was 62.8%, hence, equal to the 62.7% of the 2006 survey. The SAFP (2009a) estimates total coverage based on 'affiliates covered in the private system and contributors in the old [public] system' as 74.6%, 12 percentage points more than the survey.
12. Asociación Internacional de Administradoras de Fondos de Pensiones (AIOS), *Boletín Estadístico AIOS* 1-23 (June 1999-June 2010).

percentage of affiliates who contributed in the last month decreased from 73.6% to 51.7% in 1982–2010, and averaged 59% in the entire period (Table 33.2).

Table 33.2 Pension Coverage of the EAP and the Population Aged 65 and Over, and Contributing Affiliates in Chile, 1973–2010 (in percentages)

Years [a]	*EAP coverage based on:*		*Contributors/* affiliates [c]	*Coverage of population 65+*
	Statistics [b]	*Surveys*		
1973	73.0			
1980	64.0			
1982	29.0		73.6	
1990	46.8	62.2	61.2	73.0
1992	51.8	61.1	60.7	66.5
1994	51.8	62.3	57.2	68.2
1996	55.7	62.4	55.7	65.9
1998	53.4	58.9	52.8	62.2
1999	54.0		53.4	
2000	52.9	58.0	50.9	63.7
2001	55.9		53.6	
2002	54.6		51.1	
2003	55.8	58.7	51.8	63.9
2004	52.6		50.4	
2005	55.5		51.2	
2006	58.0	62.7	51.5	61.7
2007	61.2		53.8	
2008	62.8		54.6	
2009	60.3		51.7	
2010	60.3		54.5	

[a] December of each year.
[b] Since 1982 based on affiliates that contributed in the last month. [c] Percentage of affiliates that contributed in the last month.

Source: Statistics from SAFP,[13] updated with AIOS.[14] Surveys and coverage age 65 from Rofman et al.[15] Contributors/affiliates author's calculations based on SAFP and AIOS.

Several reasons explain the inflated estimates based on affiliates: some register, pay a few contributions, and then leave the EAP (become unemployed, emigrate, and, in

13. Superintendencia de AFPs (SAFP), *The Chilean Pension System* (4th ed., Santiago 2009b).
14. Asociación Internacional de Administradoras de Fondos de Pensiones (AIOS), *Boletín Estadístico AIOS* 1–24 (June 1999–December 2010).
15. R. Rofman, L. Lucchetti & O. Guzmán, *Pension Systems in Latin America: Concepts and Measurements of Coverage*, SP Discussion Paper, No. 0616 (World Bank 2008).

case of women, raise children); shift from the formal to the informal sector; their employers evade or delay payment of contributions; the insured contribute until they accumulate enough in their individual account to gain the right to a minimum pension.[16]

In 2009, self-employment accounted for 17.7% of the urban EAP.[17] In 2009, 98.1% of total contributors were salaried workers, while only 1.9% were self-employed.[18] Self-employed did not participate because: 37% said it was not mandatory, 24% lacked the funds and 11% were not acquainted with the system.[19]

The population aged 65 and over covered by some pension scheme declined from 73% to 61.7% in 1990–2006, in tandem with the decline in EAP coverage (Table 33.2). Actually, coverage by the contributory scheme fell, whereas that of the non-contributory (social assistance) scheme rose; the former was projected to decline from 62% to 50% between 2006 and 2020.[20]

[b] Re-reform

The re-reform expanded coverage to several vulnerable groups.[21] The self-employed are mandatorily affiliated as from 2012. As an incentive for affiliation, they will be eligible for health care, family allowance, coverage of employment injuries, and the state solidarity contribution. Conversely, if they fail to contribute, they will not be granted certificates needed for legal procedures and tax exemptions.

To promote the affiliation of young people, the re-reform provided a state contribution to their individual accounts, as well as a subsidy to employers for each young low-income worker hired. Voluntary affiliation was opened for persons without paid work, such as housewives.

The number of beneficiaries increased from 600,000 in 2008 to 950,000 in 2009, and this is projected to reach 1.9 million in 2025. EAP coverage rose from 58% in 2006 to 60.3% in 2009–2010 (61.6% including those in the public system). Contributory and non-contributory coverage of the elderly is projected to reach 97% by 2025 (Table 33.2).[22]

16. I. Gill, T. Packard & J. Yermo, *Keeping the Promise of Social Security in Latin America* (World Bank 2005) and Mesa-Lago, *Reassembling Social Security*, *supra* n. 2.
17. ECLAC, *Social Panorama of Latin America* (Santiago 2010).
18. SAFP, *Boletín Estadístico* (Santiago 1 (May-June 1981) to no. 207 (January-June 2009)).
19. EPS, *Encuesta de Protección Social, 2002, 2004, 2006, 2008* (Santiago 2004, 2006, 2008, 2010); F. Bertranou (ed.), *Trabajadores Independientes y Protección Social en América Latina* (ILO 2009); Mesa-Lago, *Reassembling Social Security*, *supra* n. 2; C. Mesa-Lago, *Social Protection in Chile: Reforms to Improve Equity*, 147 Intl. Labour Rev. 377–402 (2008).
20. Gobierno de Chile, *Presidential Message* No. 558–354 of 15 December 2006 to the Chamber of Deputies proposing a bill to improve the pension system (Santiago 2006).
21. Law No. 20.255 of Mar. 11, 2008; A. Arenas de Mesa et al., *La Reforma Previsional Chilena: Proyecciones Fiscales 2009-2025* (Gobierno de Chile, Estudios de Finanzas Públicas 2008).
22. A. Arenas de Mesa et al., *La Reforma Previsional Chilena*, *supra* n. 21.

[2] Sufficiency of Benefits

[a] Reform

Prior to 1979, ages of retirement varied among the thirty-five pension schemes. The structural reform increased and standardized ages to 65 for men, and 60 for women. Those who accumulate a certain amount in their individual accounts can retire before the statutory age.[23]

The private non-defined pension level depends on three factors: the amount of the contributions deposited in the individual account during the working life of the insured person; capital returns on the invested funds in such accounts, contingent on exogenous factors like economic growth/stability and capital market performance (hence, risks shift from the collective to the individual); and life expectancy and gender. The pension can be paid as an annuity, programmed withdrawal, or a combination of both.

Most schemes prior to 1979 granted a minimum pension with a relatively small number of contribution years; this was increased to twenty by the reform. If the insured have not accumulated enough in their individual accounts, but meet all other requirements, the state makes up the difference. Also, before the structural reform, a non-contributory – social assistance – pension (PASIS) was granted to those aged 65 and over, the disabled, the poor and those lacking a contributory pension. PASIS was means-tested and financed by the state, but limited by available fiscal resources and to a fixed list of beneficiaries. The reform retained it without a significant expansion in coverage.[24]

In 2005, the minimum pension under the private system averaged 62% of the minimum wage and 23% of the average wage; and since 1990 both percentages have been declining. About half of the affiliates were projected to get the minimum pension: 35% of men and 60% of women. In 2000, the World Bank estimated that 30% of women and 50% of men living in Santiago would not meet the requirements to obtain a minimum pension, and that these percentages were probably higher at the national level.[25] Between 2020 and 2025, it was projected that 46% of new retirees would receive a pension below the minimum pension, 65% of them being women.[26]

[b] Re-reform

The re-reform established a System of Solidarity Pensions with two components. The first is a basic, non-contributory old-age and disability pension (*Pensión Básica Solidaria*: PBS), which immediately replaced PASIS. Financed by the state, the PBS was

23. Mesa-Lago, *Changing Social Security*, *supra* n. 6 and Mesa-Lago, *Reassembling Social Security*, *supra* n. 2.
24. F. Bertranou, C. Solorio & W. Van Ginneken (eds.), *Pensiones no Contributivas y Asistenciales: Argentina, Brasil, Chile, Costa Rica y Uruguay* (ILO 2002).
25. Gill, Packard & Yermo, *Keeping the Promise of Social Security*, *supra* n. 16.
26. See *supra* n. 21.

initially granted to 40% of the lowest income households, and was gradually extended to reach 60% by July 2011. In addition, the old-age PBS requires the recipient to be aged 65 or over, to lack another pension and to have lived in Chile for twenty years since the age of 20 (and for at least four to five years before applying for the pension). Disability benefits are granted for those aged 18–65 who have a five year period of residence. In 2009, the PBS was 67% higher than PASIS, and it is adjusted annually to the rate of inflation in the preceding twelve months.

The second component is a state solidarity contribution (*Aporte Previsional Solidario:* APS) that will replace the minimum pension by 2023, and supplements the contributory pension of those aged 65 and over whose income is low, regardless of their contribution history. In order to encourage contributions, the pension received by an insured person –even if he has contributed for just one month – is always higher than the PBS. The APS has a ceiling that gradually rose to USD 510 per month in 2012; the benefit decreases with the amount of the contributory pension, and is stopped when the latter reaches a fixed ceiling.

Eligibility conditions for the APS are similar to those of the PBS. The amount of the maximum pension plus the APS could exceed the PBS by up to 12% in 2008, and 60% in 2009, continuing to rise until 2012. This benefit will substantially increase pensions, will encourage affiliation and contributions and will be a disincentive to stopping contributions when the fund accumulated in the individual account can finance the minimum pension. Young workers' contributions will be subsidized for the first two years of their affiliation.

The combination of coverage expansion and new benefits reduced extreme poverty in 2006–2009.[27]

The re-reform strengthened the third pillar, creating voluntary collective savings plans: deposits on individual accounts negotiated by employers and workers (though only the employer may make contributions) with tax deferred to the time of pension withdrawal.

[3] Social Solidarity and Gender Equity

[a] Reform

The private system was devoid of social solidarity, since minimum and non-contributory pensions were respectively partly and entirely financed by the state. Some insured persons did not meet the eligibility criteria for receiving either a minimum pension (because they had not contributed for the required twenty years) or a non-contributory pension (because they did not meet the income requirements), and hence, remained unprotected.

The private system was afflicted by significant inequality in coverage. In 2006, EAP coverage increased by income quintiles (47% in the poorest and 72% in the

27. Ministerio de Trabajo y Previsión Social, *Encuesta de Protección Social, 2006, 2008* (Santiago 2008, 2010).

wealthiest), education level (49% in primary and 74% in higher), rural *versus* urban residence (53% and 64%), and enterprise size (34% in small and 92% in large). Coverage gaps were generally wider among those aged 65 and over,[28] thus 70.6% of men but 54.9% of women received pensions in 2006.[29] Women receive lower pensions than men, partly due to discriminatory labour market factors: a lower participation rate (39% compared to 73% for men), aggravated by interruptions to raise children (hence, reduced contribution density); higher unemployment; female wages were equal to one third of the male wage for the same tasks; and 45% of economically active women working in the informal sector. Furthermore, on average, women live five years longer than men and can retire five years earlier, which leads to a ten-year longer retirement period.

The private system accentuated gender inequality. The required number of contribution years for a minimum pension was increased (more difficult to be met by women), the pension amount was based on the funds accumulated in individual accounts (depending on contributions paid and contribution density), it used sex-differentiated mortality tables, and when men divorced or abandoned their wives, the latter were left without any right to the husband's pension.[30] Women's contribution density was 42% in 2006, and men's was 61%.[31] Based on life expectancy tables differentiated by sex, the private system replacement rate was 35% for women retiring at age 65, compared with 46% for men at the same age.[32]

[b] Re-reform

To cope with the previous problems, the re-reform granted mothers (affiliated to the private system or beneficiaries of a PBS or survivor's pension), regardless of their socio-economic situation, a maternity grant equal to 10% of eighteen minimum wages for each child born alive. The grant was credited to the mother's individual account on the birth of the child, thereafter accruing annual interest, and cashable at 65, thereby increasing her pension. In 2009, 65% of PBS beneficiaries were women, and that share will increase by 2025. In the contributory scheme, female old-age pensioners made up 52% of the total, but, by early retirement, the proportion decreased to only 14%, because few women had accumulated enough in their individual accounts.[33]

The disability survivors' scheme, now paid by employers, charges one single premium for men, but as women have a lower risk incidence and use this insurance

28. SAFP, *Boletín Estadístico* (Santiago 1 (May-June 1981) to no. 207 (January-June 2009).
29. Rofman, Lucchetti & Ourens, *Pension Systems in Latin America*, *supra* n. 15.
30. F. Bertranou & A. Arenas de Mesa (eds.), *Protección Social, Pensiones y Género en Argentina, Brasil y Chile* (ILO 2003). Mesa-Lago, *Social Protection in Chile: Reforms to Improve Equity*, 147 Intl. Labour Rev. 377–402.
31. Ministerio de Trabajo y Previsión Social y Centro de Micro Datos de la Universidad de Chile (EPS), *Encuesta de Protección Social, 2002, 2004, 2006, 2008* (Santiago 2004, 2006, 2008, 2010).
32. A. Arenas de Mesa & C. Mesa-Lago. *The Structural Pension Reform in Chile: Effects, Comparisons with other Latin American Reforms, and Lessons*, 22 Oxford Rev. Econ. Policy 149–167 (2006); Mesa-Lago, *Social Protection in Chile*, *supra* n. 19.
33. Still in 2009, only 45.6% of total affiliates were women, and 39.4% of total contributors (SAFP, 2010), *Boletín Estadístico* (Santiago 1 (May–June 1981) no. 207 (January–June 2009)).

less, the surplus premium paid by women is credited to their individual accounts. Male spouses are now entitled to a survivor's pension. In the case of divorce, a judge can order the transfer of funds accumulated in the individual account during the marriage, from one spouse to the other (usually the female), up to a maximum of 50%. Housewives may have voluntary affiliation and receive contributions from their spouses or their own rental income.

[4] Efficiency, Moderate Administrative Costs and Social Representation

[a] Reform

It was assumed that the structural reform would improve efficiency, through competition and free choice of AFP by the insured, hence reducing administrative costs.[34] Table 33.3 shows that the number of AFP rose from twelve in 1982 to twenty-one in 1994, mainly due to authorization granted to trade unions to organize AFP. Since 1995 AFP have closed and merged, declining to only five in 2008–2010. Concentration of contributors in the biggest three AFP rose from 63.6% to 86.4% in 1982–2009. The insured may change AFP about twice annually; transfers climbed from 6.7% to 27.3% of affiliates in 1986–1997. The Superintendence restricted free choice because a large and growing number of salesmen working for AFP on commission promoted transfers, and then transfers steadily fell to 3.2% in 2010. Another problem is the lack of knowledge of the system and skills to select the best AFP on the part of the insured.[35]

The total commission charged to the insured rose from 2.44% to 3.36% in 1981–2010, and as a percentage of the deposit in the individual account climbed from 24.4% to 33.6% (Table 33.3). Neither workers nor pensioners had representation on the Superintendence board or the AFP, despite them owning the pension funds; the main stakeholders were unable to oversee the operation of the system or make suggestions to improve it.

[b] Re-reform

The re-reform introduced mechanisms to increase competition, reduce administrative costs, improve education and give a voice to the insured. In annual bidding, the AFP offering the lowest commission wins the affiliation of some 200,000 new workers entering the EAP, and must charge the same commission to its existing affiliates. Data show a significant raise in the premium in 2009 but a decline in 2010 (see Table 33.3).

34. J. Piñera, *Principios y Fundamentos del Sistema Privado de Pensiones en Chile* (n. 9); World Bank, *Averting the Old-Age Crisis* (1994).
35. Surveys show that AFP affiliates are not aware of key issues: 89% that the amount of their pension will depend on the balance of their individual accounts, 79% the eligibility requirements for a minimum pension, 60% their monthly deductions, and 56% the balance of their individual accounts, see EPS, *Encuesta de Protección Social, 2002, 2004, 2006, 2008* (EPS 2004, 2006, 2008, 2010).

Table 33.3 Competition and Administrative Costs in Chile's Private System, 1981–2010

Years [a]	*Number* of AFP	*Concentration* in 3 biggest [b]	*Annual AFP* changes [c]	*Commissions charged* [d]			*T. Commission/* deposit [f] (%)
				Old age	*D & S* [e]	*Total*	
1981						2.44	24.4
1982	12	63.6				2.66	26.6
1986	12	64.0	6.7			3.40	34.0
1988	13	66.4	9.6			3.54	35.4
1990	14	71.9	10.4			2.93	29.3
1992	19	68.9	14.0			2.93	29.3
1993	20	68.3	18.6			2.98	29.8
1994	21	67.5	19.4			2.99	29.9
1995	16	67.1	25.0			3.00	30.0
1997	13	67.2	27.3			2.90	29.0
1998	9	72.1	11.7			2.61	26.1
1999	8	77.4	8.0	1.90	0.65	2.40	25.5
2000	8	76.5	4.1	1.61	0.70	2.31	23.1
2001	7	78.0	3.7	1.77	0.67	2.26	24.4
2002	7	78.2	3.4	1.76	0.67	2.26	24.3
2003	7	79.2	3.9	1.55	0.71	2.26	22.6
2004	6	77.5	3.0	1.51	0.75	2.26	22.6
2005	6	77.7	3.2	1.54	0.76	2.30	23.0
2006	6	77.9	3.0	1.64	0.73	2.37	23.7
2007	6	77.4	4.2	1.71	0.73	2.40	24.4
2008	5	87.2	4.3	1.74	0.94	2.68	26.8
2009	5	86.4	3.5	1.50	1.87[h]	3.42	33.7
2010	6[g]		3.2	1.49	1.49[h]	2.98	29.8

[a] December of each year, June in 2010.
[b] Percentage of total contributors.
[c] Based on total affiliates; no data available prior to 1994.
[d] Percentage of taxable income; not disaggregated until 1999.
[e] Disability and survivors' premium transferred to insurance companies.
[f] The deposit is always 10% of taxable salary; total commission as percentage of deposit deduction.
[g] New AFP created in July.
[h] Since 2009, a single premium, but the surplus paid by women is credited to their individual accounts.
Source: Author's estimates based on SAFP, AIOS.[36]

36. SAFP, *The Chilean Pension System* (4th ed., Santiago 2009); SAFP, *Boletín Estadístico* (Santiago: 1 (May-June 1981) to 207 (January-June 2009); Asociación Internacional de Administradoras de Fondos de Pensiones (AIOS), *Boletín Estadístico AIOS* 1–23 (June 1999–June 2010).

Freedom of choice is expected to improve with more education: Centres for comprehensive pension provision deal with enquiries of the insured, and a Fund for Pension Education, financed by the state and the AFP, disseminates information and educates the public on pension matters.

A Users' Committee has been established, composed of five representatives, one each from workers, pensioners, private and public pension systems and scholars. The Committee evaluates the system performance, monitors the implementation of the re-reforms and steers strategies on education and information dissemination. The new Superintendence of Pensions strengthens regulation and supervisory control over the system.

[5] Financial Sustainability

[a] Reform

The structural reform abolished the employer's contribution and shifted it to the worker, who pays 10% on taxable income from work plus all commission, a breach of the ILO Convention 102s standard stating that the worker's contribution should not exceed 50% of the total contribution (see Chapter 34).

Annual capital returns have fluctuated widely, ranging from 29.7% in 1991 to 18.9% in 2008 during the global crisis. Those retiring in the midst of a crisis might be affected by a decrease in the value of the fund and the pension. However the creation of a multi-fund mechanism attenuated that problem.[37] The average annual real capital return since the inception of the system has been quite good, albeit decreasing from 20.6% in 1982 to 9.3% in 2010 (Table 33.4).

Table 33.4 Fiscal Deficit in the Transition, and Accumulated Fund and Capital Returns of the Private Pension System in Chile, 1981–2010

Years	*Fiscal Cost (% of GDP)*[a]	*Accumulated* Fund(% GDP)	*Real Capital Returns (%)*	
			Last Year	*Since Start*
1981	-3.8	0.8	12.8	12.8
1982	-6.4	3.9	28.5	20.6
1983	-7.1	5.9	21.2	20.9
1984	-7.6	7.7	3.6	16.6
1985	-6.7	10.0	13.4	15.9
1986	-6.7	12.2	12.3	15.3
1987	-6.1	13.6	5.4	13.9
1988	-5.4	14.3	6.5	13.0

37. There are various portfolios with diverse risks and capital returns; insured persons approaching retirement are expected to move from high risk and capital returns to safer and less profitable instruments.

Years	*Fiscal Cost (% of GDP)*[a]	*Accumulated* Fund(% GDP)	*Real Capital Returns (%)*	
			Last Year	*Since Start*
1989	-5.4	17.4	6.9	12.3
1990	-5.4	23.1	15.6	12.6
1991	-5.3	29.4	29.7	14.2
1992	-5.1	29.1	3.0	13.2
1993	-5.3	35.2	16.2	13.4
1994	-5.2	38.6	18.2	13.8
1995	-4.9	36.5	-2.5	12.7
1996	-5.2	37.4	3.5	12.2
1997	-5.2	39.0	4.7	11.7
1998	-5.5	40.2	-1.1	11.0
1999	-5.9	49.1	16.3	11.3
2000	-6.0	50.6	4.4	10.9
2001	-6.0	53.2	6.7	10.7
2002	-5.9	54.9	3.0	10.3
2003	-5.8	57.7	10.6	10.3
2004	-5.5	58.1	8.9	10.2
2005	-5.2	57.9	4.6	10.0
2006	-5.1	60.6	15.8	10.2
2007	-5.0	64.4	5.0	10.0
2008	-4.9	52.8	-18.9	8.8
2009	-4.8	65.3	22.5	9.2
2010	-4.7	68.7	12.0	9.3

[a] Projections in 2005–2010.
Source: Columns 1 from Arenas de Mesa and Mesa-Lago;[38] columns 2 and 3 from SAFP; AIOS;[39] column 4 author's estimates.

[b] Re-reform

The re-reform shifted the disability survivor's contribution paid by the insured to the employer, thereby reducing the worker's burden, but still not complying with the ILO minimum standard of a maximum of 50% paid by workers. The strengthening of the voluntary pillar prompted employers to contribute to their employees' individual accounts.

38. Arenas de Mesa et al., *The Structural Pension Reform in Chile*, *supra* n. 32.
39. SAFP, *The Chilean Pension System* (4th ed., Santiago 2009). Asociación Internacional de Administradoras de Fondos de Pensiones (AIOS), *Boletín Estadístico AIOS* 1–23 (June 1999–June 2010).

The new benefits and agencies demand more fiscal resources than any other social programme implemented since 1990; they are expected to be financed through general taxation and resource savings made by the termination of some payments by the public system. Total fiscal costs of the re-reform are projected to increase 20% annually.[40] Yet, such costs are substantially less than those of the structural reform transition period.

The re-reform has set the basis to ensure its long-term financial sustainability. A Reserve Pension Fund was created to finance the new benefits and a projection was made of the fiscal costs between 2009 and 2025. The Superintendence and the Ministry will publish actuarial reports every five years to assess the effects of demographic, financial and affiliate behaviour changes on replacement rates and financial needs. In March 2010 a report from the University of Chile confirmed that the system was indeed in actuarial equilibrium.[41]

§33.04 CHILE'S HEALTH CARE SYSTEM

[A] Reform and Re-reform

The structural reform of health care implemented in 1981 created a dual system with public and private components.[42] The public component consists of a National Health Care Fund (*Fondo Nacional de Salud:* FONASA) that finances the system, a National Health Services System (*Sistema Nacional de Servicios de Salud:* SNSS), which provides the second and third levels of care, and municipalities (*comunas*), in charge of primary care.

The private component of the system consists mainly of health insurance Institutions (*Instituciones de Salud Previsional:* ISAPRE), which collect contributions and co-payments from their affiliates, and either run their own health services or sub-contract them to independent private providers and public hospitals. A major objective of the structural reform was to expand private insurance and free choice of the insured, under the idea that it would improve efficiency, quality of service, reduce costs and be financially sustainable. The role of the state was downsized by cutting budget resources, letting public facilities decline by personnel being underpaid relative to the private sector, and by ensuring that no public supervisory agency of the system existed.[43]

40. A. Arenas de Mesa et al., *La Reforma Previsional Chilena, supra* n. 21.
41. A. Arenas de Mesa, *Historia de la Reforma Previsional Chilena: Ena Experiencia Exitosa de Política Pública en Democracia* (ILO 2010).
42. Departing from most of Latin America, where three separate health sectors operate (public, social insurance and private), Chile merged the public and social insurance sectors into one made up by FONASA, SNSS and municipalities.
43. Mesa-Lago, *Reassembling Social Security* (n. 2); Mesa-Lago, *Social Protection in Chile, supra* n. 19.

With the return to democracy, a wide public debate took place, which led to a series of reforms gradually introduced between 1991 and 2005. Thus, as opposed to one fundamental re-reform of pensions in 2008, there were several re-reforms in health care. The state role was expanded with a steady rise in budgetary allocations and the creation in 1995 of the Superintendence of ISAPRES to oversee and control abuses of the private sector. But the three most important re-reforms were enacted in 2004 under the Presidency of Ricardo Lagos: a new Superintendence of health care and increased citizen participation were introduced. *Chile Solidario,* a programme of conditional cash transfers partly for health care and targeted at the poor, was launched; universal guarantees for a series of expanding health care benefits and actions for all citizens were created.

[B] Reform and Re-reform Effects on Social Security Principles

[1] Universal Coverage

[a] Reform

The proportion of the total population affiliated to multiple social insurance health care schemes fell from 71% in 1973 to 62% in 1980, one year before the structural reform.[44] Table 33.5 shows that FONASA coverage fell from 83.4% to 58.8% in 1984–1997, whereas the ISAPRE share jumped from 3.1% to a peak of 26.1%. Thereafter, both trends reversed: FONASA expanded to 73.5% in 2009, while ISAPRES contracted to 16.3%. The category of 'others' comprises the armed forces scheme, private insurers and the non-affiliated whose proportion is not disaggregated; 'others' shrank from 16.9% to 10.2% in 2002–2009. In 2006, 5.1% of the population was unaffiliated, but only 0.5% in this group was poor and probably suffered from inadequate coverage, while the great majority bought private health insurance or direct services from physicians and hospitals.[45]

Table 33.5 Health Care Coverage of Total Population by Public, Private and 'Others' in Chile, 1984–2009 (in percentages)

Years	*Public (FONASA)*	*Private* (ISAPRE)	*Others* [a]	**Total**
1984	83.4	3.1	13.5	100.0
1991	69.5	18.9	11.5	100.0
1992	63.7	21.8	14.5	100.0
1993	60.9	24.5	14.7	100.0
1994	60.6	25.7	13.7	100.0

44. Mesa-Lago, *Reassembling Social Security*, *supra* n. 2.
45. CASEN Survey, *Encuesta de Caracterización Socioeconómica 2006* (Ministerio de Planificación 2007).

Years	*Public (FONASA)*	*Private* (ISAPRE)	*Others* [a]	**Total**
1995	59.6	26.0	14.4	100.0
1996	59.0	25.9	15.0	100.0
1997	58.8	26.1	15.2	100.0
1998	60.5	24.4	15.1	100.0
1999	61.5	21.7	16.8	100.0
2000	65.6	20.0	14.4	100.0
2001	64.9	18.8	16.4	100.0
2002	65.2	17.9	16.9	100.0
2003	66.1	17.0	16.9	100.0
2004	67.4	16.6	16.0	100.0
2005	68.0	16.3	15.7	100.0
2006	69.5	16.3	14.2	100.0
2007	70.4	16.6	13.0	100.0
2008	72.7	16.5	10.8	100.0
2009	73.5	16.3	10.2	100.0

a. Armed forces, private insurance, and non-affiliated.
Source: 1984 from Mesa-Lago,[46] rest from FONASA.[47]

Although the self-employed accounted for 18% of the EAP in 2009, their share in total contributors in ISAPRE was only 3.3% (a small increase from 2.3% in 2000) – most of them well-paid professionals.[48] A similar proportion were contributors to FONASA, however, because poor and low-income workers can affiliate with, and get free or subsidized health care in, the public sector, 75% of the self-employed were covered by it.[49]

[b] Re-reform

The re-reforms significantly improved the quality of public care and those enacted in 2004 expanded coverage to poor and low-income people through targeted cash transfers (*Chile Solidario*) and the universal guaranteed benefits and services. Table 33.5 shows that these reforms substantially expanded FONASA coverage, whereas that of ISAPRE and 'others' steadily declined. The pension re-reform of 2008 requires the self-employed to affiliate to the health care system as from 2016, which should further expand FONASA coverage.

46. Mesa-Lago, *Reassembling Social Security* , *supra* n. 2.
47. FONASA, *Afiliación* and *Estadísticas* (Santiago 2007–2010) (http://www.fonasa.cl).
48. Superintendencia de Salud, *Boletín Estadístico 2006 to 2010* (Santiago 2006–2010).
49. CASEN Survey, *Encuesta de Caracterización Socioeconómica 2006* (Ministerio de Planificación 2007).

[2] Sufficiency in Benefits

[a] Reform

Prior to the re-reforms, the wealthy enjoyed timely access to services, but poor and low-income persons had to wait a long time for care. In 2000, twenty years after the structural reform, out of those in the poorest quintile who were ill or had an accident, 15% received no medical attention because of a lack of money. ISAPRE could restrict access to care by imposing waiting periods without a right to benefits, or only up to a certain level of care; imposing waiting or exclusionary periods for pre-existing illnesses or pregnancy; and providing no coverage for several diseases or catastrophic events. On the other hand, FONASA affiliates are not subject to limitations, deductions, exclusions or waiting periods. However, in some settlements in the north and very rural areas in the south, geographical, climatic and transport barriers impede access to emergency care and appropriate medium-level care, with long waiting lists at public hospitals or for complex medical procedures.

[b] Re-reform

Chile Solidario (2004, and extended in 2006) introduced a multi-dimensional approach to poverty by trying to break its intergenerational vicious cycle, and targeting extreme poverty households, particularly children and women. Its beneficiaries display worse characteristics than the average population: older heads of families, women without social protection, higher illiteracy, unemployment, work in agriculture or in the informal economy, more limited access to drinking water, and a lack of social security and family allowance coverage. To tackle these problems, the programme introduced several major innovations: the integration of cash transfers into social service provision – this guaranteed access for the poor group covered by FONASA to health care; non-contributory pensions; education; subsidies for drinking water that cover 100% of consumption (with a limit); transfers conditional on registration with a health care centre, school and other basic services; early diagnosis of certain illnesses and the equipment of primary care facilities to deal with many emergency situations; a means-test using multiple indicators and voluntarily checked by households in the neighbourhood. On graduation from the programme, beneficiaries are informed of their rights to access fifty-three benefits in health care, education, housing, employment, etc. In 2006, there were 290,123 families and about one million beneficiaries; in 2011 the number of beneficiaries had risen to 1.45 million.[50]

50. A. Barrientos & C. Santibáñez, *New Forms of Social Assistance and the Evolution of Social Protection in Latin America*, 41 Journal of Latin American Studies 409–424 (2009); A. Barrientos, *Social Protection and Poverty* (UNRISD 2010); Ministerio de Planificación (MIDEPLAN), *Informe Final Auditoría a Chile Solidario* (Santiago, March 2011) see also Ministerio de Planificación (MIDEPLAN), *Incremento de la Bonificación* (Santiago 2011); In 2011, a family allowance programme was also established including a basic allowance, and vouchers for control of children's health, school registration and attendance, and labour insertion of women.

The programme of Universal and Guaranteed Access to Health Care (*Acceso Universal con Garantías Explícitas:* AUGE) was enacted by law in 2004 and was implemented in 2004–2005. All affiliates in FONASA and ISAPRE, regardless of their socio-economic and health status are guaranteed a wide range of quality benefits (including maternity care), which are gradually being expanded to cover all high mortality and disabling diseases. It is free to the poor and the elderly affiliated to FONASA. Users are entitled to demand payment of the guaranteed services from both FONASA and ISAPRE, and to appeal to the Superintendence, which may impose fines, suspension or other sanctions on those who break the law. AUGE limits the waiting-period for various health care services and has improved the definition of pre-existing illness. The Superintendence sets a universal community premium (the same for everyone and fixed for three years) according to the average annual cost of AUGE, and sets the maximum co-payments for affiliates in both the public and private sectors, with ceilings set according to family income.[51] According to national opinion polls on AUGE 50% of respondents feel very protected or protected, 29% have no feelings one way or the other, and 21% feel unprotected or very unprotected; 51% are highly satisfied with services, 38% fairly satisfied and 7% not satisfied; 72% think that AUGE guarantees access to health care, 58% quality services, 56% rapid service delivery, and 48% financial protection.[52]

[3] Social Solidarity and Gender Equity

[a] Reform

Although coverage was almost universal, there were significant inequalities regarding income, employment status, region, ethnic origin, access and gender, which were more marked in ISAPRE than in FONASA.

The indigenous population accounted for only 6.6% of the total population in 2000, but was mainly found in the three regions with higher rates of poverty and infant mortality, and lower life expectancy than those of the non-indigenous population. Thus, 80% of the indigenous population was covered by FONASA and 47% of them were extremely poor. There were marked socio-economic disparities at the municipal – *communes* – level (in education, housing, drinking water supply, sanitation), with adverse effects on health indicators; people used primary health three times as much in certain *communes* than in others, and emergency care four times as much.

In 2001, 65% of contributors to ISAPRE were men and 35%, women, whereas the FONASA gender gap was smaller – 57% and 43% respectively; regarding the total number of beneficiaries (contributors and their dependants), the gender gap virtually closed in both. In 2006 the proportions were quite similar.[53]

51. Gobierno de Chile, Ley No. 19.966 de 25 agosto de 2004, *Diario Oficial* (Santiago, September 3).
52. Superintendencia de Salud, *Informe Final. Estudio de Opinión* (Santiago 2007).
53. FONASA, 2006; SAFP, *Boletín Estadístico.* Santiago 1 (May-June 1981) to 207 (January-June 2009).

ISAPRE charged up to twice as high per premium to women than to men because of the maternity risk.[54] The cost of the latter was met entirely by women but, even in health plans that excluded maternity coverage, the female premium was higher than that charged to men of the same age. Furthermore, at the annual renewal of a contract, ISAPRE could adjust the premium to take into account the woman's age and number of her dependants. Until 2002, ISAPRE covered maternity leave costs in exchange for a state subsidy of 2% of taxable income, despite their discriminatory practices. For all of these reasons, most women of reproductive age were, and still are, covered by FONASA, which hence transferred subsidies to ISAPRE.

[b] Re-reform

Various adjustments and improvements were made by the re-reforms. In 2002, the state took care of maternity leave costs, regardless of the insurer and of the insured's income level, thus eliminating the previous discrimination practised by ISAPRE as well as the 2% fiscal subsidy they received. Nevertheless, the maternity leave benefit is regressive because it is paid by the state, but its amount is proportional to the wage of the recipient: 50% of the beneficiaries are paid 80% of expenditure, financed through taxes, many of them on consumption goods (VAT), which burdens the entire population.[55]

The re-reforms of 2004 reduced inequality. *Chile Solidario* abolished FONASA subsidies to ISAPRE and introduced better monitoring of the latter affiliates who use public health care services.[56] The re-reforms also strengthened the authority of the Ministry of Health and established the Superintendence of Health (which absorbed the Superintendence of ISAPRE) in order to simplify and reinforce control and supervision of the entire system. Measures taken to improve access to health services included free vaccinations against influenza, free telephone calls to make appointments for primary care, shorter waiting lists in hospitals and for complex procedures, loans for health care, improved care for poor and low-income groups, and fiscal subsidies to the poor to help them pay for water consumption and sanitation. FONASA grants are based on poverty, thus favouring the poorest *communes* and helping to reduce inequality in provision.

The re-reforms also established the Solidarity Compensation Fund (*Fondo de Compensación Solidario*) between 'open' ISAPRE to reduce risk discrimination.[57] All insured with an 'open' ISAPRE contribute to the Fund on an equal basis, yet their benefits are calculated according to their projected health care costs: women of reproductive age and the elderly hence benefit from contributions made by the young

54. In one ISAPRE, the premium for maternity coverage of a reproductive age woman (20 to 40 years) was between 1.9 and 3.4 times higher than that charged to a man in the same age group.
55. Mesa-Lago, *Social Protection in Chile*, *supra* n. 19.
56. Beneficiaries of *Chile Solidario* are 54% women and 46% men.
57. 'Open' ISAPRE do not have entry restrictions, whereas 'closed' ISAPRE are tied to an enterprise or group of enterprises. In 2006 there were ten open and five closed ISAPRE (but shares of affiliates were 93% and 7% respectively); closed ISAPRE are exempted from the Solidarity Compensation Fund, provided that most of their affiliates are wage earners.

and men. This compensates the open ISAPRE for the difference between the universal premium and the risk-adjusted premium. The Superintendence fixes the amount of compensation due to each ISAPRE, which should standardize its health risks in the future; it also regulates rises in premiums, setting a cap on the annual readjustment within a price band.[58]

In 2006, 92% of the poorest quintile and 89% of the second poorest quintile were covered by FONASA, whereas 44% of the richest quintile was covered by ISAPRE. The share of FONASA affiliates declined in tandem with rising incomes, and the opposite occurred with ISAPRE affiliates, holders of private insurance, and members of the armed forces scheme. In all quintiles (including the wealthiest), coverage by ISAPRE declined as age and health risks increased (due to the increasing co-payments charged to older persons by ISAPRE), whereas coverage by FONASA increased.[59] Gender data on contributors to FONASA in 2009 were not available, but in ISAPRE the proportions continued to be 65% male and 35% female.[60]

In 2008, President Bachelet appointed an Advisory Council on Work and Equity, which submitted a report pointing out that despite the reduction in social vulnerability, a higher level of equality was needed in public and private health care, and suggesting several policies: a fiscal subsidy to wages targeting the poorest quintile of the population, which would gradually decrease and stop at a given level of monthly income; transfers targeted at children in the poorest quintile; childcare facilities financed by general taxation; post-natal subsidies added to women's wages; and vocational training for women.[61] Some of these measures are in the process of implementation.

[4] Efficiency, Moderate Administrative Costs and Social Representation

[a] Reform

In theory, all Chileans are free to choose between FONASA and ISAPRE. In practice, however, high and upper-middle income groups are those actually affiliated to ISAPRE because they can afford the co-payments, can endure lesser risks and are mostly urban residents (there is no private provision in certain rural areas). Conversely, the poor cannot afford the co-payments, are exposed to higher risks, live in rural areas, hence are affiliated to FONASA.

58. Superintendencia de Salud, *Boletín Estadístico 2006 to 2010* (Santiago 2006–2010).
59. CASEN Survey, *Encuesta de Caracterización Socioeconómica 2006* (Ministerio de Planificación 2007).
60. Superintendencia de Salud, *Boletín Estadístico 2006 to 2010* (Santiago 2006–2010).
61. Consejo Asesor Presidencial de Trabajo y Equidad, *Hacia un Chile más Justo: Trabajo, Salario, Competitividad y Equidad Social* (Santiago 2008).

Table 33.6 Competition, Administrative Costs and Profits of ISAPRES in Chile, 1994–2010

Years	*No. of ISAPRE*	*Concentration* In 6 biggest (%)	*Administrative costs (%)*[a]	*Profit* (%)[a]
1994	36	48.0	18.7	3.9
2000	25	74.1	17.7	1.8
2001	22	76.5	15.9	1.8
2002	19	82.2	14.7	1.4
2003	18	82.2	14.4	2.4
2004	17	86.4	13.6	5.0
2005	15	92.6	14.5	5.8
2006	15	92.7	14.8	4.7
2007	14	93.8	14.1	2.5
2008	13	96.0	13.8	2.9
2009	13	95.9	12.5	2.0
2010	13			

[a] Percentage of income.
Source: Based on Mesa-Lago, updated with Superintendencia de Salud, 2011.[62]

The participation rate of ISAPRE in terms of insured persons is much greater than of AFP: 13 and 5 in 2010 respectively. But over time the number of ISAPRE has decreased sharply. In 1994–2010 the number fell to one third, from thirty-six to thirteen (Table 33.6), and some experts predict that the number will decline further to eight. Furthermore, concentration of the insured in the eight biggest ISAPRE rose from 48% to 95.9% in the period. A comparison with pensions is technically not possible, but concentration in number of funds seems to be higher in health care. On the other hand, the number of health care plans was 45,784 in 2009.[63] ISAPRE administrative costs are very high owing to their heavy marketing expenditure (vendors, publicity, personnel) and the profits they make. Joint administrative costs and profits were 22.6% of income in 1994 and 17.7% in 2000, before the most important re-reforms (Table 33.6). The lack of knowledge of the system and skills on the part of the insured obstructs an adequate selection of ISAPRE as well as claims to AUGE benefits.[64]

Neither beneficiaries nor workers participate in any active way in the administration of the Superintendence, FONASA, ISAPRE or the National Health Services System. *Communes* are expected to prepare an analysis, proposals and a health care

62. Mesa-Lago, *Reassembling Social Security*, *supra* n. 2.
63. Superintendencia de Salud, *Boletín Estadístico 2006 to 2010* (Santiago, 2006–2010).
64. Opinion polls reveal that 45% of interviewees do not know the provisions of the health care system; 58% had a low level of general knowledge; only 50% were aware that the AUGE guarantees cover both FONASA and ISAPRE affiliates, and among those who noted problems with the implementation of AUGE, 81% pointed out the absence of information, Superintendencia de Salud, *Informe Final. Estudio de Opinión* (Santiago: 2007).

plan in consultation with the public, but in most of the country there is no local capacity to support such public participation because there are no consumer groups or citizens' health promotion groups. There are community representatives on the development councils of hospitals and clinics, but these bodies only have consultative status, and their decisions are not binding.

[b] Re-reform

The 1995 reform established the Superintendence of ISAPRE that strengthened monitoring and the supervisory function, controlled some of ISAPRE abuses, and imposed measures to prevent fraudulent claims. This authority was charged with monitoring compliance with contractual regulations and regulating exemptions; establishing a price index and maximum rates for the plans covering the elderly and pregnant women; regulating medical treatment of pre-existing illnesses; standardizing information to enable comparison of the various health care plans (of which there were 40,586 in 2006); and mediating conflicts between ISAPRE and their affiliates.

As a result of the re-reforms, ISAPRE administrative expenditures decreased from 15.9% of income in 2001 to 12.5% in 2009, whereas profits fell from 5.8% to 2% in 2005–2009. Still, administrative costs per beneficiary were twice those of FONASA.[65]

The re-reforms of 2004 failed to ensure representation of the insured and users in FONASA, ISAPRES or on the Superintendence of Health Care. However, they set up some channels for public consultation; for instance, users' consultative councils in hospitals are composed of five delegates from the local community and two from employees of the facility. AUGE has an advisory council of nine professionals, but also has users' consulting councils with five representatives from the community and two health officials. Claims and consultations from ISAPRES affiliates increased from 59,030 in 2001 (36% of them granted by courts) to 91,636 in 2009 (61% granted by courts).[66]

[5] Financial Sustainability

[a] Reform

ISAPRE practiced adverse selection or 'creaming off', turning down persons at higher risk who were less profitable, concentrating on those at lower risk and of higher incomes, and charging co-payments to the insured, thus securing a significant part of health care resources. The public sector took charge of the groups involving higher risks and costs and those of lower incomes, and therefore was less profitable and obtained fewer available resources. In 2000, 20% of affiliates to ISAPRE accounted for

65. Superintendencia de Salud, *Boletín Estadístico 2006 to 2010* (Santiago 2006–2010).
66. *Ibid*.

43% of total health costs, while 66% of affiliates to FONASA accounted for 57% of total costs, proportionately half of the ISAPRE costs.[67]

The structural reform set a uniform contribution rate for workers, and increased it from 4% of wages in 1981 to 7% in 1986; a regressive wage ceiling on contributions was imposed; the employer's contribution was abolished; and the armed forces scheme received generous tax subsidies. The medium and high-income groups shifted to ISAPRES and transferred their 7% contribution, therefore FONASA lost its higher contributors while taking care of the elderly, women of reproductive age, the poor, and low-income groups, all of whom are more prone to illness. Contributions to both systems were exempted from income tax, but co-payments to ISAPRE were also exempted from the value added tax, which favoured high-income affiliates.

A group of affiliates to ISAPRE resorted to FONASA for health care (especially for emergencies, accidents, maternity, and complex and costly illnesses) because public services were easier to access and cost less than those provided by the private sector, hence those affiliates and ISAPRE received regressive tax subsidies. ISAPRE increased co-payments annually according to risks, and excluded or created barriers to patients who incurred heavier costs (the elderly, chronically or terminally ill patients, pregnant women), who were then obliged to seek medical attention in the public sector, thus increasing the costs of the latter.

In 2006, only 5% of persons aged 60 and over were affiliated to ISAPRE, whereas FONASA covered 90% of them, of whom 72% were poor or were of low-income. Health care costs go up with age, and ISAPRE increased the premium of retired affiliates and many of them shifted to FONASA. For example, a man aged 60–65, affiliated to ISAPRE, contributed nearly three times the amount paid by a man aged 18–44, and a man aged 75 and over contributed 5.5 times more. Until 1996, employers contributed 2% on wages of their employees who did not have enough resources to affiliate to ISAPRE (as an incentive to do so); such contributions were tax exempted and terminated when the workers retired.

The structural reform, however, introduced a financial equity factor, latter expanded by democratic governments. FONASA provides free coverage to the poor and grants subsidies in inverse proportion to the other affiliates' capacity to pay, according to four income groups: (A) the poor who do not contribute and who only have access to the free public service (including indigenous people); (B) those with an income lower than the minimum wage, who contribute and receive free public health care; (C) those with an income of between 1 and 1.45 times the minimum wage, who must pay contributions plus a 10% co-payment in order to receive public health care; and (D) those with income higher than 1.45 times the minimum wage, who must pay contributions plus a 20% co-payment to receive public health care.[68] Groups A and B receive benefits of a value considerably higher than their contributions, and the opposite occurs in Groups C and D, hence generating transfers from the latter to the

67. Mesa-Lago, *Social Protection in Chile*, *supra* n. 19.
68. In 2008, FONASA beneficiaries were distributed as follows: 32% in Group A, 33% in B, 18% in C, and 17% in FONASA, *Afiliación* and *Estadísticas* (Santiago 2007–2010) accessed at http://www.fonasa.cl.

former that have a progressive effect and improve equity. FONASA affiliates receive the same benefits regardless of their income, contributions and risk factor, therefore redistributing resources from higher to lower income affiliates and from the healthy to the sick.

[b] Re-reform

The re-reforms improved financial equity and sustainability. In 1996, the tax exempted employers' contribution of 2% to stimulate ISAPRE affiliation was abolished. Voluntary contributions by employers to the health care system are encouraged, but amounted only to 2% of ISAPRE operational revenues in 2006.[69]

In 1995–2005, real public health expenditure increased nearly fourfold; the share of this expenditure financed by taxation rose fivefold, and the amount of benefits per insured person increased by 66%. FONASA contributions come from relatively low wages, hence that revenue is insufficient to fund the services, and the state subsidy grew from 41% to 55% in 1990–2004, whereas the proportion of costs funded by contributions fell from 45% to 34%. On average, the combined contribution and co-payment to ISAPRE was 3.5 times higher than the average contribution to FONASA; however, when taking into account the state subsidy, that gap was reduced to 1.4 times as high.

The distribution of total health expenditure by sector improved considerably: in 2001, 41.6% was in the public sector and 58.4% in the private sector. In 2007, the public share rose to 58.7% and the private decreased to 41.3% and 19.3% in ISAPRE and private insurance (WHO, 2004 and 2010).

In 2008, 62% of FONASA affiliates paid no contributions: 100% in Group A and 47% in Group B, and the proportion of these two groups in total affiliation was 65% (FONASA, 2010). However, 14% in Group B and 9% in Group D did not contribute, and there were other indications of moral hazard.

As a result of *Chile Solidario*, the share of public health expenditure allocated to primary care increased from 12% to 21.4% in 1995–2005, whereas in FONASA the number of consultations at the primary level rose from 33.6% to 59% in 2007–2009 (FONASA, 2011).[70] The pension re-reform of 2008 exempted poor beneficiaries of the non-contributory pension (PBS) from paying the 7% contribution.

§33.05 RELATIONSHIP WITH INTERNATIONAL PRINCIPLES

The re-reforms implemented by democratic governments have corrected or ameliorated many flaws in the original design of the structural reforms in pensions and health care, improving both systems by re-establishing or enforcing international social security principles and reinforcing the role of the state.

69. Superintendencia de Salud, *Boletín Estadístico 2006 to 2010* (Santiago 2006–2010).
70. FONASA, Sections on *Afiliación* and *Estadísticas* (Santiago 2007–2010).

[A] Pensions[71]

(1) *Universal coverage.* The reform resulted in a decrease and a later stagnation in coverage, and although awarding a social assistance pension to the poor elderly, limited it by a waiting list and available fiscal funds. The re-reform has laid the foundation for expansion of coverage by stipulating that legal compulsory affiliation should gradually cover the self-employed and extending several benefits. In addition, it granted universal protection to the poor elderly and low-income by the PBS, eliminated waiting lists and expenditure caps, and it compensated affiliates who were not entitled to either a minimum pension or the PASIS.

(2) *Sufficiency of benefits.* Under the reform, the minimum pension was insufficient. The re-reform improved the pensions through a state contribution that raises the benefit of the lowest income group.

(3) *Social solidarity and gender equity.* The private system lacked social solidarity and gender inequality was accentuated by the system. The re-reform infused social solidarity into the system, and improved gender equity.

(4) *Efficiency, moderate administrative costs and social representation.* The reform did not achieve the expected competition among AFP due to the high concentration of insured persons in the biggest two AFP and the restrictions imposed on freedom of choice, meaning administrative costs remained high and stagnant. There was no representation of workers and employers in the administration of pensions. The re-reform introduced annual bidding between AFP and assigned new workers to that offering the lowest commission, as well as collective bidding for disability survivor's insurance premiums instead of by individual AFP. Participation of insured persons and pensioners is facilitated by a User's Committee. The new Superintendence of Pensions strengthens regulation and supervisory control over the system.

(5) *Financial sustainability.* The reform eliminated the employer's contribution and charged the workers with all the contributions and administrative commission, hence violating the ILO minimum standard. The re-reform transferred the disability survivor's premium from workers to employers, and promotes voluntary contributions of employers to the optional savings third pillar.

[B] Health Care

(1) *Universal coverage.* Under the reform, total population coverage decreased, the share of the public sector declined, whereas the private share rose, and coverage of the self-employed was minimal. In the re-reform legally mandatory coverage of the self-employed was introduced and proportional

71. For a more detailed analysis of adherence to international standards in Chile's pension system, see Chapter 34.

expansion of coverage in the public sector. Broader effective access to the system is provided through free or subsidized provision to the poor and low-income groups.

(2) *Sufficiency of benefits.* Under the reform, ISAPRE restricted access imposing waiting periods, excluding pre-existing illnesses, pregnancy, several diseases and catastrophic events. The re-reforms created *Chile Solidario* that targets the poor, guaranteeing access and granting cash transfers.

(3) *Social solidarity and gender equity.* The reform aggravated inequalities in access and quality of service by income, education, region, ethnicity and gender, particularly in the private sector where only 35% of affiliates were women. The re-reforms reduced age and gender-based discrimination in open ISAPRE (the vast majority) through the Solidarity Compensation Fund, transferred resources from younger men to women of reproductive age and the elderly, set maximum rates for fertile women, and the state took over maternity leave and abolished the 2% subsidy to ISAPRE.

(4) *Efficiency, moderate administrative costs and social representation.* The reform restricted freedom of choice. Beneficiaries and the insured had no administrative representation or oversight. Under the re-reforms the new Superintendence of Health strengthened regulations, controls and sanctions throughout the system and established users' consultative councils in hospitals.

(5) *Financial sustainability.* The reform abolished employers' contributions and almost doubled those of the insured. Under the re-reforms, two thirds of FONASA affiliates do not pay contributions (the poor, those of low-income and beneficiaries of the universal pension), the share of the public sector in total health expenditure (and state targeted subsidies) increased sharply and the share of pocket expenses reduced, the 2% contribution was eliminated, whereas employers' voluntary contributions were encouraged (with little results), and the state took over maternity leave costs regardless of the insurer's and affiliate's income. Despite targeted subsidies there are still some free raiders.

[C] Pending Challenges and Recommendations

- Continue the gradual expansion of the number of diseases covered by AUGE and work towards guaranteeing real access to the entire population.
- Eliminate moral hazard (free riders) and channel state subsidies towards those who really need them, using the social protection file and even more effective methods.
- Start planning the inclusion of the self-employed and design measures to bring about mandatory legal coverage.
- Further reduce gender inequality caused by labour market discrimination through proper enforcement of legislation and encouraging women to enter the EAP and to acquire skills through training.

- Actively promote childcare centres and remove the regressive aspects of the maternity leave programme.
- Monitor compliance by the Superintendencies of Pension and Health Care with legal standards in force and prevent ISAPRE from selecting on the basis of risk.
- Take additional steps to reverse the declining number of AFP and ISAPRE and their increasing concentration, as well as to further reduce AFP administrative costs.
- Extend the regulatory/overseeing powers of the Superintendencies of pensions and health care to the separate pension and health care schemes of the armed forces.
- Consider a mandatory contribution to the health care system or transfer to FONASA part of the 7% contribution to ISAPRE, as a tool of social solidarity and to help public sector financing.
- Improve the monitoring of reimbursement to FONASA for services used by ISAPRE affiliates and terminate the tax exemption of contributions and co-payments to ISAPRE.
- Abolish or at least reduce regressive fiscal subsidies to the schemes of the armed forces.
- Strengthen users' participation in the consultative councils, as well as worker and pensioner representation in the pensions system through the Users' Committee.
- Improve the levels of information and knowledge of the insured and the general public regarding the pension and health care systems.
- Extend the role of the Fund for Pension Education to include health issues or create a similar fund for health matters.
- The Fund for Pension Education: disseminate readily comprehensible information on new rights and benefits, develop easy comparisons of AFP performance on administrative costs and capital returns and further simplify the quarterly report on individual accounts.

Three decades of democratic governments and social security re-reforms in Chile were successful in correcting or ameliorating original flaws in the designs of pension and health care structural reform, enforcing and improving international social security principles and standards. New generations should tackle the remaining problems with similar professionalism, respect for the law, and social dialogue.