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THE STRUCTURE AND FINANCING OF THE CHILEAN HEALTH CARE SYSTEM

Melissa Rutigliano

Introduction

Health care is not merely an economic issue. Properly functioning health care systems are essential to the overall well-being of a country's citizens. Citizens may feel very vulnerable when illness and injury occur, and as a result they may blindly entrust a health care provider with decisions that may affect their future health and financial stability. In their role as protector and promoter of health, health care systems can provide citizens with a sense of security. A health care system can provide security for citizens by ensuring that they will have access to adequate and affordable care in times of need. Nevertheless, health care can be a source of potential discontent when citizens fear that they may not have access to adequate and affordable health care. This discontent can persist regardless of a country's general health status. (Lechner)

With the true importance of health care in mind, governments, payers, and providers must address issues sensitive to the needs of citizens as well as financial issues required to contain rising health care costs. For citizens, some major health care issues involve adequate access, quality, affordability, and flexibility in choosing a provider. For governments, payers, and providers, some major health care issues involve allocation of funds, provision of services, extent of coverage for services, cost-efficient resource utilization, technology acquisition, and quality assurance. Some of the issues paramount for governments, payers, and providers may conflict with the issues important to citizens. For instance, the issue of containing health care costs can involve limits in access, quality, and flexibility. (Fefer et al., p. 343)

Different countries have developed diverse methods to approach these health care issues. In the United States, health care is a privatized system. Private insurance companies provide a means for U.S. citizens to cover the costs of care. In theory, the market should
drive down prices and improve quality as providers and payers compete for beneficiaries in the private system. Nevertheless, the cost of health care in the United States is growing more rapidly than the rate of inflation. (Rutigliano) Managed care has evolved as a tool to help control the cost of care in the United States. The different types of managed care balance limitations on flexibility and service utilization with lower costs. The more flexible the program and the more services provided, the more expensive the program will be.

The U.S. government provides Medicaid coverage to ensure care for the impoverished and Medicare coverage to help the elderly cope with high-priced care. Medicaid and Medicare are financed through taxes on U.S. citizens.

A very different approach to health care was established in England in 1948. In the U.K., health care is nationalized. The system, known as the National Health Service, is financed through taxes. All citizens of the U.K. are entitled to free services under the National Health Service. Though most hospitals are public, private care is available for those who can afford it. The U.K. spends seven percent of its GDP on health care, only about half of what the United States spends. This restricted budget has produced limited services with out-of-date technology and inadequate staffing of clinics and hospitals. In 1991, reforms called for the decentralization of financing to the local level. As a result of these reforms, hospitals now have the responsibility to direct funds and resources to fit the needs of the patients. With this localized management, the government hopes competition will arise between public hospitals. (Santelmann, p. 42) In Chile, health care is a hybrid of private and public care. The private system is mirrored after the system of private insurance companies in the United States, and the public system is mirrored after the National Health Service in England.

In this article, I first provide a historical background of health care in Chile leading up to the creation of the current hybrid system of public and private care. I then discuss the current structure and financing of the public and private health care systems, the advantages of the two systems, the problems faced by the public and private systems, and reforms and proposals within the systems. I conclude with an analysis of the future of health care in Chile and a statement about features essential to properly functioning health care systems.

A Brief History of Health Care in Chile

In 1924 the Chilean government created the first national health insurance plan for workers. Chile was the first country in the Western Hemisphere to institute such a plan. Several years later, this plan evolved into separate plans for white-collar and blue-collar workers. Sermena (National Medical Service for White-Collar Workers) was initiated by the government as a health insurance plan in 1938 to provide comprehensive health care for white-collar workers, and the National Health Service (modeled after the British system) was created in 1952 for blue-collar workers. Reorganization of these plans in 1979 allowed all workers the freedom to choose facilities under either Sermena or the National Health Service. Like the British system, private care has always existed in Chile for citizens able to afford its high cost. From the 1930s through the 1980s, semi-private health care plans, known as cajas, existed to supplement or replace the plans of workers. The individual cajas were prepaid medical plans designed for specific groups of workers (such as bankers). The cajas offered services that were a step above public services in quality yet less expensive than private services. The cajas were semi-private due to heavy regulation by the Chilean government and partial financing through a subsidy from the Chilean government. Cajas were also the precursor to Isapres (private insurance companies) created during the reorganization of the 1980s. (Kritzer, p. 17) With the rise of the National Health Service in 1952 and the growing emphasis on public care, private care expenditures began decreasing. This decrease in private expenditure continued until the coup d'etat in 1973. (Scarpaci, pp. 223-26)

During the period of military rule under Pinochet, expenditures on public care rapidly decreased from 3.5 percent of GDP to 0.6 percent of GDP. ("Public Health Improvement. . .")
During the "wave of privatization" under Pinochet in the 1980s, the health care system of Chile underwent a reorganization into its current form. First, this reorganization resulted in the decentralization of the National Health Service into what is now known as the National Health Service System (NHSS). Second, the reorganization established Fonasa to administer and distribute financial resources to the NHSS. Finally, the reorganization resulted in the creation of Isapres. The current relationship between the private and public sectors of the Chilean health care system is complex. The private and public systems function largely as independent entities; however, some interdependence between the two systems is seen through the exchange of services. (World Bank, pp. 1-2)

**The Structure of the Public System**

The highest bureaucratic level in the public health care system is the Ministry of Health (MOH). As a branch of Chile's central government, the MOH has primarily bureaucratic responsibilities, such as forming policies, programs, and standards for the public health care system. The Subsecretariat of Health of the MOH manages five major agencies under the administration of the MOH: the National Health Service System (NHSS), Fonasa, the Central Supply Facility (which obtains and distributes medical supplies, food supplements, and pharmaceuticals), the Institute of Public Health (which monitors the quality of food and pharmaceuticals), and the Superintendency of Isapres (which oversees the operation of Isapres). (World Bank, p. 3)

The National Health Service System is the current version of the decentralized National Health Service. As of 1997, 60-70 percent of all Chileans were enrolled as beneficiaries of the NHSS. ("Fonasa to Compete. . .") The NHSS is composed of 26 Health Service Areas. The Health Service Areas are responsible for executing the policies, standards, and programs that originated in the MOH; however, the Health Service Areas are allotted only limited authority to alter decisions made by the MOH. Each Health Service Area is also responsible for management of the public hospitals within its defined region as well as supervision over primary care system facilities within its region. Public hospitals offer both outpatient and inpatient care and fall under one of four categories according to their location (rural versus urban) and level of technology. The primary care system is managed by municipalities and consists of urban and rural health clinics and rural health posts that vary according to the level of technology offered at the facilities. (World Bank, pp. 3-10)

Fonasa is a financial institution that distributes the funds of the NHSS. In addition, Fonasa maintains a Preferred Provider System (PPS) form of managed health care. Thirteen percent of Chileans benefit from Fonasa's PPS. Fonasa's PPS allows beneficiaries more flexibility since they are provided access to private facilities within the PPS network in addition to access to all public facilities. Chileans who elect to use the private facilities within the PPS network must provide a co-payment that is set for particular services. Fonasa sells vouchers that beneficiaries of the PPS can buy to cover their co-pay. These vouchers are redeemed by providers for services. (World Bank, pp. 4-5)

**The Current Financing of the Public Health Care System**

As the financial arm of the public health care system, Fonasa is responsible for the distribution of funds to the NHSS. The finances administered by Fonasa arise from several different sources. The two largest sources of funds are the seven percent payroll deduction, equivalent to a flat income tax for health care coverage, and contributions provided by the Ministry of Finance, a branch of the central government. Two other sources of funds are the sale of vouchers for Fonasa's PPS and the co-pay for services in public hospitals. The amount of co-pay required for services in the public hospitals depends on a citizen's income but can be no less than 40 percent of the cost of services for citizens able to pay. ("Fonasa to Compete. . .") No co-pay is required for services provided in the primary care system. In addition to these funds, individual hospitals or municipalities within the NHSS can apply for funds from the National Regional Development Fund (FNDR) and the Social Fund (SF) to help finance investments in new technology and equipment. (World Bank, p. 5)
Fonasa allocates these funds to the public hospitals and municipalities that comprise the NHSS. The public hospitals are reimbursed on a fee-for-service basis. The prices for services provided by public hospitals are set by Fonasa. This fee-for-service funding covers most hospital operating expenses. Fonasa also provides a separate public hospital budget to cover the salaries of workers in addition to most investments. Public hospitals also receive funding from services contracted with Isapres. The prices for these contracted services are set by the public hospitals. These prices can differ from the prices set by Fonasa for services to patients of the public system. Like public hospitals, municipalities were once funded through a fee-for-service system. As of 1997, municipalities have been funded by Fonasa on a per capita basis. This new system finances municipalities based upon the average number of patients the primary care clinics have examined over the past two years. ("Financial Crisis in Clinics...") Municipalities also have their own budget, which is set by the Ministry of Finance. This budget is an additional source of revenue for the municipalities. Each municipality is responsible for investment in new technology and equipment. Funding for such investments comes from the municipal budgets. Municipalities may also apply for additional funding from the SF or the FNDR to cover the cost of investments. (World Bank, pp. 5-6)

Advantages and Problems of the Public System

The general advantages of the public health care system include universality, organization, and the integrated role of the state in the provision of health care. The universality of public health care ensures that all citizens will receive health care coverage regardless of their income level. The organizational hierarchy of the public system aids the flow of resources to providers and services to beneficiaries. Additionally, decentralization of the NHSS in the 1980s has allowed the public health care system to improve care to fit local needs. (Scarpaci, p. 234) The role of the state in public health care is to ensure quality, access, and efficiency through health care policies and programs. The state can also help control the cost of care by setting the prices for services in the public system. (Fefer, et al., p. 345)

Despite these advantages, the public system is not without its problems. Most of the problems faced by the public system relate to financing issues. During the decentralization of the 1980s, primary care clinics began to be managed by municipalities. Until 1997, municipalities were funded on a fee-for-service basis. Early problems with the primary care clinics can be attributed to the fee-for-service financing system. For example, clinics would sometimes report a purposely inflated number of primary care exams, which are reimbursed at a higher rate than non-primary care services, to increase revenue. Early attempts to counteract this problem included a ceiling on the number of primary care exams performed, as well as guidelines describing what precisely constituted a primary care exam. The change to per capita funding of municipalities in 1997 has been the most recent attempt at a solution to the problems with primary care clinics. The mayors of municipalities have claimed that the switch from fee-for-service to per capita funding has reduced municipality funding by 20 percent. ("Financial Crisis in Clinics...") These limitations on funding demand that municipalities use cost-effective services and eliminate unnecessary services. Another early problem with the public system involved inadequate reimbursement of municipalities for services provided in clinics. The inadequacy of reimbursement compromised the ability of clinics to provide sufficient care. (Scarpaci, pp. 234-35)

The most significant problem in the public health care system today is underfunding. Underfunding affects both health care workers and patients. The discontent among health care workers in public hospitals and primary care clinics can be seen through the numerous strikes and strike threats over inadequate salary budgets and resources. For example, in September 1997 the municipalities threatened to relinquish control of primary care clinics to the national level if funding was not increased. The mayors of the municipalities claimed that they did not have adequate funds to continue running their clinics. ("Municipalities Cannot Return...") It is likely that the switch to per capita financing of
municipalities contributed to this underfunding. ("Financial Crisis in Clinics. . .")

The underfunding of the public health care system also has an impact on patients. Without adequate funds, facilities deteriorate, resources are over-stretched, and technology investments are limited. Resource scarcity has subsequently resulted in low quality service and long waiting lists for most procedures. Long waiting periods exist even for basic services, such as primary care exams. Though the exams may be brief, patients with morning appointments at clinics may wait all day to see a doctor. ("Underfunding at Health. . .") According to Sergio Aguilo, the Health Commission Chair for the Chilean government, the major complaint from both doctors and users of the public system is that resources are so scarce that facilities sometimes do not have proper or basic medications. (Aguilo) One example of the effects of resource scarcity in the public system occurred in June 1996, when delays in funding resulted in a shortage of beds in children's hospitals. The bed scarcity came at the time of Chile's traditional winter health crisis, when many children suffer from severe respiratory diseases. During this time, a Doctors' Union survey of six public hospitals found no beds in the intensive care units and only four in the other wards. ("Beds Are Scarce. . .")

The lack of funds within the public health care system is further exacerbated by cost shifting from the private system. Isapres often reject high-risk and, thus, high-cost beneficiaries or increase the premiums for these beneficiaries. As a result, these costly beneficiaries are often "dumped" into the public health care system. The disproportionate number of costly patients in the public system thus places a significant financial burden on public care. According to Alex Figueroa, the current Health Minister, Isapres will often not pay the costs when private beneficiaries cross over to public hospitals in emergencies. Sometimes private beneficiaries may even cross over to the public system and deny that they have Isapre coverage. In both cases, the public health care system pays the bill. Since both public and private patients benefit from public emergency care, the president of the Santiago Medical Association, Ricardo Pena, has suggested that a new fund be established for emergency care and that this fund be supported through contributions from beneficiaries of both the private and public health care systems. ("Medical Association Fears. . .")

Another important aspect of the underfunding problem involves management. Inefficient management of funds and resources can lead to resource shortages. Many problems with the current management in the public health care system have further aggravated the public system's underfunded state. One management problem involves the price list set by Fonasa for services provided in public hospitals. The price list is not based upon the full costs for providing services (some resource inputs are not included in the total price of services). Additionally, the prices for services have not kept pace with inflation. ("Public Health Care Charges. . .") The public system loses needed funds when the prices for services are set too low. A potential solution for the price list problem is to allow prices to change with the rate of inflation and to more closely match the prices with actual production costs. (World Bank, p. 123)

Another problem of management involves the classification system for income levels used to determine which patients must pay user fees in public hospitals. Due to a lack of information on the incomes of many Chilean citizens, the current classification system may not be accurate. As a result, many Chileans may be falsely classified as having lower incomes than they have in reality; therefore, a disproportionate number of Chileans are exempt from paying user fees. As of 1989, 76 percent of Chileans using the public system were classified as exempt from paying user fees. (World Bank, p. 124) Again, the public system loses a source of needed funds when a disproportionate number of Chileans are exempt from the co-payment in public hospitals. The potential solution to the problems with the classification system is to devise a scheme, based upon regularly updated information on Chileans' incomes, that will accurately gauge the ability of a citizen to pay the user fees in public hospitals. (World Bank, p. 124)

Another area where public hospitals lose funds is through accident insurance. The Association for the Aid and Transit of Accident
Victims claimed that public hospitals have lost U.S. $37 million in revenues over the last four years because of failure to collect on accident insurance. ("Medical Association Fears...") Improvements in public hospital administration, such as in accounting and billing, could help public hospitals recover revenue.

Management problems in public hospitals can also be attributed to the current fee-for-service reimbursement system. The fee-for-service system gives providers an incentive to increase the quantity of services provided, regardless of demand, in order to receive a higher level of reimbursement from Fonasa. This results in poor resource utilization and escalating health care costs. The MOH has begun designing a new system for financing the public hospitals. The proposed system is based upon a diagnostic related group (DRG) method of payment. The DRG method depends upon predetermined costs for defined groups of diagnostic and therapeutic services required for specific illnesses. Essentially, the DRG method limits the level of reimbursement public hospitals can receive based upon each case. The proposed system also includes a change that would combine the DRG reimbursements with the salary budget for health workers. Each public hospital would be required to pay its own staff from the DRG reimbursements. The purpose of this proposed system of payment is to eliminate unnecessary care and encourage the use of cost-effective services. (World Bank, pp. 125-28)

In an effort to improve the overall management of the public system by making management of services more responsive to local needs, the government has proposed decentralizing all administrative authority from the MOH to the 26 Health Service Areas. The MOH's new role would involve monitoring the provision and quality of services administered by Health Service Areas. (World Bank, p. 130) Even government and health care officials who argue for improved resource management generally agree that funding for the public system needs to be increased.

Additional problems with the public system include limited flexibility and access. Beneficiaries of the public system are restricted to using only public facilities, unless they are members of Fonasa's PPS. Transfer of patients to private facilities is only allowed during strikes in the public system and, in certain cases, to reduce waiting lists. ("Fonasa to Compete...") A further issue with public care is limited access. Restrictions in access can also be thought of in terms of the extensive waiting lists and long waiting periods that are characteristic of public facilities. Restrictions in access can also be thought of in terms of the limited care available in rural areas. In some geographically isolated areas, residents may have ready access only to rural health posts, which can only offer preventative care due to low level technology. (Herrera and Ringeling, pp. 8-9) On Easter Island, for example, there is only one medical center to serve all of its 2,770 residents. ("Easter Island Receives..."); Dr. Grant McCall)

Reforms and Proposals

In March 1990, Chile underwent the transition from a military to a democratic government. (World Bank, p. 13) Unfortunately, Pinochet's military government left its democratic successors with a dilapidated public health care system, due to years of gross underfunding and inefficient management of resources. In general, the reforms and proposals of the 1990s have been directed at rebuilding and revamping the public health care system, through addressing the problems discussed previously.

Social spending rose slowly during the early nineties. ("Social Spending...") With increased spending came the increased development of social programs. One social program developed in 1996 was the Support for Priority Areas Program. This program assists poor and rural areas through funding for preventative medicine and health education campaigns. ("PDC President Calls...") Two additional improvements of the public system in 1996 included the introduction of a credit card for beneficiaries of the public system and the introduction of a complaints service. The credit card makes it easier for patients to pay their co-pay for services in public hospitals, thereby allowing beneficiaries easier access to services. ("Health Care System to Undergo...") The complaints service creates a system that can formally address problems experienced by users of public facilities.

In 1997 the budget for health care rose
In 1998 the main issue in the public health care system debate was the decree signed by President Frei in July to cut U.S. $19 million from the health care budget. Government spending cuts were made across the board in the wake of the Asian economic crisis. About one-third of Chile’s exports and one-half of Chile’s copper exports go to Asia. (“Frei Signs Budget…””) As a result, Chile’s economy felt the impact of the difficulties in Asia during 1998. The health care budget cuts came out of funds set aside for future health programs. Additionally, the health care budget for 1998 was U.S. $110 million higher than in 1997. Consequently, a U.S. $19 million cut still left the budget U.S. $91 million higher than in 1997. (“Tension Mounts…””) Nevertheless, many health care workers and leaders remained outraged. (“Frei Signs Budget…””) The current president of the Medical Association, Enrique Accorsi, stated that health care budget cuts would result in layoffs of health care workers, despite the promise that the cuts were limited to future programs. (“Medical Associations Reject…””).

The Structure of the Private System

Though the public system provides care for the majority of Chilean citizens, the private system has been growing with respect to the numbers of beneficiaries and payers since its inception. As of 1997, 28.5 percent of Chileans were beneficiaries of the 34 Isapres comprising the private health care system. (“Complaints against Health Insurers…””) Isapres are structurally more similar to health maintenance organizations (managed care outfits) than to traditional private insurance companies in the United States. Like both traditional private insurance companies and many forms of managed care, Isapres require a monthly premium and provide a fixed percentage of coverage of the cost of services rendered in hospitals and clinics. In general, like managed care, Isapres integrate the provision and financing of health care. Specifically, Isapres are more similar to managed care because they offer services from providers in a limited network. This limited network is composed of services within facilities owned by the Isapres as well as services...
contracted with public and private providers. (Scarpaci, pp. 225-27; World Bank, p. 7) *Isapres* are classified as either open or closed. Open *Isapres* can enroll Chileans from any profession, whereas closed *Isapres* can only enroll Chileans from a specific profession.  

**The Current Financing of the Private Health Care System**

The main source of income for *Isapres* is the monthly premiums paid by beneficiaries. The cost of these premiums depends on the policy, but the average monthly premium as of 1995 was U.S. $40. These premiums are financed through the seven percent payroll deduction, a two percent payroll contribution from employers, and co-payments made by beneficiaries. In 1981, Law Decree 3626 allowed workers to transfer their mandatory seven percent payroll deduction for health care coverage into any *Isapre*. (Scarpaci, p. 226) Employers who contribute the additional two percent of payroll to supplement employees' premiums receive a tax deduction from the central government for their contributions. As a result, this two percent contribution is considered a government subsidy for *Isapres*. ("Law Betters the Lot...") The co-payments provided out-of-pocket by beneficiaries vary from 10-40 percent of the cost of services. The cost of these co-payments depends on the amount of the seven percent payroll deduction. Consequently, beneficiaries with high incomes and, thus, high contributions through the 7 percent deduction may pay no co-payments. (World Bank, p. 7)

Additional financing of *Isapres* arises from several subsidies provided by the central government. The controversial two percent subsidy allows low income employees or employees with large families access to *Isapres* by supplementing their premium contributions. Other government subsidies include funds for maternity leave payments as well as a free immunization program and nutritional supplements for all Chileans. (World Bank, p. 7) These subsidies help to lighten the financial burden placed on *Isapres.*

1As of 1997, the three largest open *Isapres* were Consalud, Cruz Blanca, and Banmedica, and the three largest closed *Isapres* were Banco del Estado, El Teniente, and Istel. ("*Isapres* Receive U.S. $1.2 Billion")

**Advantages and Problems of the Private System**

The advantages of the private system involve flexibility, the high quality of care, and the role of competition among *Isapres*. The flexibility of Chile's private health care system, in theory, allows citizens to choose the *Isapre* suited to their economic and health care needs. (Kritzer, p. 18) Additionally, the private system's flexibility allows beneficiaries access to both public and private health care providers within the *Isapre* network. ("Fonasa to Compete...") One major way the private system attracts potential beneficiaries is by offering high quality care. The high quality of care in the private system is evident through the acquisition of new technology and the maintenance of clinics and hospitals that provide patients with many amenities such as new and attractive facilities as well as private rooms in hospitals. (Aguila; Scarpaci, p. 226) Competition among *Isapres* for beneficiaries, in theory, drives down costs, thus allowing greater access to *Isapres* for those with lower incomes, and improves quality.

Though the private system has some advantages, it also suffers from many problems. Most of the problems faced by the private system relate to its restrictive practices. From the formation of *Isapres* in the 1980s until after 1985, *Isapre* growth was slow. This slow growth was due, in part, to the early concentration of *Isapre* facilities in high income regions. As a result of the income disparity in Chile, there were only a small number of wealthy Chilean citizens. With such a limited pool of citizens to draw from, early *Isapres* could not make a significant profit. *Isapres* also met early marketing resistance. Many potential users and providers had an aversion to making health care a market commodity. This aversion is still held by many Chilean providers today. An additional reason for slow *Isapre* growth in the early 1980's concerns competition with Fonasa's PPS. Fonasa's PPS provided the same quality of care in private facilities for lower prices. Slow *Isapre* growth can also be attributed to restrictive coverage, such as the refusal to cover women in the reproductive age (usually between the ages of 12 and 40). Restrictive coverage limits the number of people who can
executives, a woman in the reproductive age can spend her entire life’s contributions with just one pregnancy. (Casas) Health care for the elderly is expensive because it requires more long-term care and high level technology. Consequently, the elderly are often rejected from Isapre plans or are forced to pay a much higher premium than younger beneficiaries. (Aguilo) Another way that Isapres strive to reduce their losses is through the refusal to cover catastrophic illnesses such as cancer, serious heart problems, and AIDS. (Aguilo) Catastrophic illnesses tend to require expensive long-term care. In short, the restrictive practices of Isapres increase profit margins while greatly limiting access to the private system. One solution that would allow Isapre to be more inclusive while controlling costs is based upon a risk structure equalization scheme. In a risk structure equalization scheme, low risk/high income beneficiaries subsidize high risk/low income beneficiaries. (World Bank, pp. 150-51)

Access to Isapres is also limited due to income. Isapre set a minimum premium that beneficiaries must pay in order to obtain minimum benefits. Chileans with high incomes are at an advantage in the private system since better benefits can be attained by paying higher premiums. Recently, Alejandro Ferreiro, the Superintendent of Isapres, claimed that for the first time in history Isapres were seeing a reduction in the number of beneficiaries. According to Ferreiro, the reduction is due to an increase in costs and fees for beneficiaries, since health care prices are rising faster than salaries. ("Isapres Affiliates Fall") This rise in costs has pushed many low income beneficiaries from the private system back to the public system. (Kritzer, p. 18)

Chileans with access to Isapres are also confronted with problems hidden in the complex wording and fine print of contracts. The complexity of the contracts makes it very difficult for potential Isapre users to find a plan that truly fits their economic and health care needs. Many Chileans find following a serious operation that their Isapre does not cover as much of the hospital costs as they expected. (Aguilo) The complaint process itself has Isapre acting as “judge and jury” and is so time consuming and complex that beneficiaries are often dissuaded from pursuing complaints. ("Complaints Against Health Insurers...")

According to a 1997 report from the Superintendency of Isapres, which oversees the operation of Isapres, most complaints from Isapre users involved issues of exactly what services were covered, the level of co-pay required, and calculations of reimbursements. Most beneficiaries of Isapres complained that their benefits were too low. ("Complaints against Health Insurers...")
Another controversial problem in the private system involves the “guarantee check” required for treatment in private hospitals. The “guarantee check” is simply a signed blank check that patients must supply when they are admitted into a private hospital. If patients cannot supply such a check, they do not receive service. Even beneficiaries of Isapres must supply a blank check to receive treatment at private hospitals. The controversy surrounding the checks has erupted from emergency situations where patients requiring urgent treatment were turned away from private hospitals, since they did not have a check. For example, in 1997, a two-year-old boy died from acute appendicitis when he was turned away from a private hospital since his family did not have a check with them. In addition, in 1998 a man died from cardiac arrest after being turned away from a private hospital for not having a check. ("Mayors Prepare..."; "Girardi Proposes...")

Isapres attract potential beneficiaries by offering high quality care. In the long term, providing high quality care through high level technology and amenities is very costly. A possible solution to this problem is to have Isapres hire providers to provide services to their beneficiaries alone. Isapres would thus have more control over the provision of services to ensure cost-effective utilization. (World Bank, p. 130) Isapres currently contract with the public sector for use of facilities and equipment to help reduce investment costs. As competition among Isapres increases, the need to advance quality by acquiring new technology and facilities increases in order to attract and maintain beneficiaries. As a result, investment costs will increase. Again, by directly hiring providers, Isapres can help control these costs. (World Bank, p. 134)

Reforms and Proposals

Unlike the public system, few reforms and proposals of the private system have been mentioned in the news headlines of recent years. In 1995, a law was passed principally for the benefit of Isapres. This law allowed Isapres to reject claims from beneficiaries for coverage of pre-existing conditions. The law also required punishment by imprisonment for those who commit insurance fraud. Overall, the law helped Isapres deal with two issues that can be a financial drain. ("Law Betters Lot of Health Insurance...")

In 1997, the Health Minister, Alex Figueroa, called for the urgent passage of a bill that would eliminate the “guarantee check” requirement for private hospitals. In October 1998, the Party for Democracy Deputy, Guido Girardi, proposed to modify this bill. Girardi’s modification was to have Isapres cover the full cost of treatment in private hospitals. Girardi’s justification for this modification was based upon the claim that insufficient coverage of beneficiaries enrolled in Isapres has forced many beneficiaries to return to the public system when they can no longer afford the cost of services in the private system. Girardi claimed that this mass return of beneficiaries to the public system is a drain on the system’s resources and believes that having Isapres cover the full cost of treatment in private hospitals will secure the resources for low income Chileans who must use the public system. ("Girardi Proposes...")

Conclusion

The goal of the political right and some wealthy citizens is to continue what Pinochet began in the 1980s by completely privatizing health care in Chile. This privatized system would be a move from the current hybrid system of health care in Chile to a system mirrored after health care in the United States. Under a privatized system, all citizens in Chile would be members of Isapres. The theory behind complete privatization is that the health care system can be maintained through market strategies. As Isapres compete for beneficiaries, the costs of care should decrease and the quality of care should increase. To successfully make such a transition, Chile would have to develop a system analogous to Medicaid in the United States to cover citizens who cannot afford the premiums of any Isapres. (Aguilo)

On the other hand, the goal of the political center and left, of most providers, and of many citizens is to return to the days before Pinochet by completely nationalizing health care in Chile. Most proponents of complete nationalization have an aversion to making health care a market commodity, arguing that
health care is a service and not a good. The nationalized system would be a move from the current hybrid system to a system mirrored after health care in England. Under such a system, all Isapres would be eliminated. The decentralized structure of the public health care system would be maintained, since decentralization allows health care to better respond to local needs. Interestingly (and ironically), Pinochet recently was arrested while in England recovering from back surgery in a London hospital. The dictator who sparked the privatization of Chile’s health care system believed he could get better medical treatment under England’s nationalized system of health care. It is unknown whether complete privatization, complete nationalization, or the current hybrid system will prevail in the future. This issue will likely be a deciding factor in the next presidential election in Chile. (Aguilo)

Those who must decide the future of health care in Chile must be conscious of the importance of maintaining a properly functioning health care system. The key to a properly functioning health care system is finding the right balance between cost control and the provision of adequate care. When cost management is too stringent, as in the restrictive practices of Isapres, services and access to services are limited. As a result, the provision of adequate care is compromised to maintain costs. On the other hand, when cost management is too lax, as seen in some cases for both the private and public systems of Chile, the cost of health care can skyrocket. When costs become too high, the provision of adequate care is again compromised in the long-term, as health care payers struggle to maintain their financial well-being. In addition to finding the right balance between cost control and provision of care, a health care system must be able to adapt to a nation’s changing conditions to adequately serve the needs of the people.
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