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Health policy in the *concertación* era (1990–2010): Reforms the chilean way

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ABSTRACT

The Chilean health system has experienced important transformations in the last decades with a neoliberal turn to privatization of the health insurance and healthcare market since the Pinochet reforms of the 1980s. During 20 years of center-left political coalition governments several reforms were attempted to regulate and reform such markets. This paper analyzes regulatory policies for the private health insurance and health care delivery market, adopted during the 1990–2010 period. A framework of variation in market types developed by Gingrich is adopted as analytical perspective. The set of policies advanced in this period could be expected to shift the responsibility of access to care from individuals to the collective and give control to the State or the consumers *vis a vis* producers. Nevertheless, the effect of the implemented reforms has been mixed. Regulations on private health insurers were ineffective in terms of shifting power to the consumer or the state. In contrast, the healthcare delivery market showed a trend of increasing payers' and consumers' control and the set of implemented reforms partially steered the market toward collective responsibility of access by creating a submarket of guaranteed services (AUGE) with lower copayments and fully funded services. Emerging unintended consequences of the adopted policies and potential explanations are discussed. In sum, attempts to use regulation to improve the collective dimension of the Chilean health system has enabled some progress, but several challenges had persisted.

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1. Introduction

In 1990, Chile returned relatively peacefully to a democratic regime after being ruled by a military government for almost 17 years. The *Concertación*, a center-left political coalition of Christian Democrats, Socialists and other progressive parties, controlled the executive branch of government for the next 20 years. Critics have commented on the *Concertación's* inability to revert the nefarious effects of the reforms implemented in the Chilean Health System under Pinochet's rule (Ewig and Palmucci, 2012; Homedes and Ugalde, 2005; Unger et al., 2008). The critique has focused on the superficiality of the reforms aimed chiefly at regulating the private health insurance market rather than structurally steering the system towards universality. However, in the 20 years the coalition was in power, policymakers were able to pass their fair share of legislation related to the healthcare system and to implement a series of administrative initiatives that reshaped the Chilean Health System (Letelier and Bedregal, 2006; Manuel, 2002; Ossandón, 2008; Savedoff and Gottret, 2008).

On the other side of the debate, supporters of neoliberal reforms have described the introduction of private health insurance and the consequent boost of the private providers' market as an example to follow for other middle-income countries, especially in Latin America. Following the logic of the 1993 World Bank *World Development Report: Investing in Health*, some have argued that, in low and middle income countries, well-regulated insurance markets are instrumental in creating the conditions to achieve universal healthcare coverage and free public funds to cover the poor (Sekhri and Savedoff, 2005).

Critics of the Chilean Health System apparently have the upper hand; in 2007 Mesa-Lago reported that in Latin America "the private sector covers only from 13 percent to 25 percent of the population in the countries with the most advanced degree of privatization" (Mesa-Lago, 2007).

In this paper we will analyze the main reforms advanced by the

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Concertación administrations and analyze them using Gingrich's framework of variation in market types (Gingrich, 2007). According to Gingrich "markets vary in both how services are distributed to citizens (the allocation dimension) and how competition shapes the relative power of the different agents (the production dimension)" (Gingrich, 2007). When introducing private markets for the provision of welfare services, policymakers face acute trade-offs on the aforementioned two dimensions: allocation (whether responsibility for allocation is collective or individual) and production (how control is structured over production) (Gingrich, 2007).

The **allocation dimension** deals with a dichotomy. Are price and selection mechanisms the way through which services are allocated in the market? If so, allocation is individual rather than collective. Alternatively, if there is a "strong collective guarantee of funding and access", then responsibility for allocation is collective (Gingrich, 2007). We use the term "access" as realized utilization of services, i.e. being insured in the health insurance market and actually using healthcare services in the healthcare delivery market. In terms of financing, high copayments, means testing, incentives for private consumption, insufficient funding and low quality of services will burden the individual with greater costs thus making the market more individual-oriented. Weak regulation to ensure access of services has the same effect; in this case private firms will engage in cream-skimming behavior that will impose a higher burden on high-risk individuals(Gingrich, 2007).

The **production dimension** is related with the structure of competition and the degree that this feature of the market grants control to the state, consumers or producers. When the state is an effective principal it achieves the provision of services at the lowest cost possible. To be able to achieve this objective, the state needs to be able to clearly define the outcomes, give managers the autonomy to produce these outcomes, be able to monitor the result and sanction non-compliant providers and retain its ability to renegotiate contracts to deal with the issue of incomplete contracts(Gingrich, 2007). When users are effective principals they strive to achieve higher quality and are somewhat insensitive to costs especially if there is a third payer involved. To be able to be effective principals, users need to preserve the right to "exit" (being able to change providers if they are dissatisfied), have the money follow them (i.e. "link funding to their choices") and be able to "monitor and discipline producers" ensuring mobility within the system. This behavior enhances competition among producers. Producers have market control every time the two other actors do not have it and they will seek profits by overcharging consumers and cutting down costs, potentially at the expense of lower quality (Gingrich, 2007).

The interaction between these two dimensions yields six ideal types of markets (Table 1.) Consequently, there are state-driven markets in which the state retains the control. If the allocation of services is realized using prices and selection, we are looking at a *Managed* market where the state uses the regulation tools previously described along with few price signals while impeding that producers shift their costs to consumers. *Austerity* markets on the other hand, allow cost shifting to consumers thus incentivizing them to consume fewer services. In the case of consumer-driven markets, *consumer controlled* markets "match greater user choice with collective financing" impeding cost shifting to users while *Two-tiered* markets impose more costs on users or higher risk on individuals. Finally, in producer-driven markets there can be a strong mandate for collective funding thus constituting a *Pork barrel* market where producers strive to seek funds from the state. In a *Retrenched Rights* market producers are less able to seek public funds so they shift their costs to consumers and are able to cut costs as a way to maximize their profit (Gingrich, 2007). The term "retrenched" in this context is used to portray people's diminished capacity to exercise, for example, the right to health.

Reforms may "move" a market from one cell to another. Gingrich's analytical framework is particularly amenable to the Chilean case since it postulates, "different goals of parties on the Left and the Right, conditioned by the particular environment they are operating in, explain this variation in market structure" (Gingrich, 2007). Leftist political coalitions can introduce anti-market reforms such as banning private health insurance in a country. However, Leftist governments in Western industrialized countries have introduced market reforms that either shift the responsibility for access to services to the collective or take away control from producers and transfers it to the state or consumers –in other words, up and to the left of the table. We will be analyzing health policies in Chile that dealt with health insurance and healthcare delivery markets. The outcome of interest is the movement from one market type to another or the creation of a certain type of market.

In the following section we will describe briefly the Chilean health system before Pinochet in order to explain how the reforms under an authoritarian regime deviated from the path taken by the Chilean society in previous decades. Then, we will describe the main reforms to the health system; namely the creation of a private health insurance market and the decentralization of primary care. Finally, policies implemented in the *Concertación's* era will be analyzed in terms of the two dimensions previously described: allocation and production. The aim of this work is to answer two main questions:

1. Could the *Concertación's* policies have been expected to move the targeted market to a collective responsibility in access and to state or consumer control?
2. Did the actual implementation of the policies move the market to a collective responsibility in access and to state or consumer control?

The first question will allow us to verify if the reforms advanced by the *Concertación* could have reasonably been expected to move

Table 1
Variation of market types.

		Production Dimension: Who has Effective Control?		
		State: "Efficiency Aims"	Consumers: "Quality Aims"	Producers: "Profits and Rents"
Allocation Dimension: Responsibility For access	Collective	Managed Market Ex. Recent English contracting in education	Consumer Controlled Market Ex. Swedish health care market in the early 1990s	Pork Barrel Market Ex. English elderly care market in 1980s
	Individuals	Austerity Market Ex. Dutch health care markets	Two Tiered Market Ex. English education market	Retrenched Rights Market Ex. English elderly care market since mid-1990s

Source: Gingrich, 2007.

the markets inherited from the dictatorship up and to the left of the table, i.e. towards a collective responsibility of the provision of public services and/or to a higher degree of state or consumer control of the market.

The answer to the second question, if negative, could help explain in part why health policy analysts in Chile have been critical about the *Concertación's* performance in the health policy arena.

1.1. Brief history of the Chilean Health System before 1973

The first Law that defines the role of the Chilean State in healthcare concerned basic sanitation and certain preventive health programs was passed in 1918. Shortly afterwards, in 1924, the Social Security Law secured the provision of healthcare services to workers, laying down the foundations of a *Bismarckian* healthcare system (de la Jara and Bossert, 1995). The Chilean health system was never universal in the strict sense of the word; before 1952 the poor had access to healthcare services only through charity clinics and hospitals; blue-collar workers had access to the social security health system and white-collar workers were covered by a fund created in 1942 -the Servicio Médico Nacional de Empleados, SERMENA. In 1952, only four years after the materialization of the original National Health Service (NHS) in the United Kingdom, charity and social security healthcare providers were unified and formed the Chilean NHS (Servicio Nacional de Salud - SNS) (de la Jara and Bossert, 1995). The fact that the name of this institution is the literal translation of the name of its British counterpart has been the source of some confusion and the Chilean health system before Pinochet has been described as a *Beveridge* model (Homedes and Ugalde, 2002). Unlike the UK experience, this National Health System did not cover everyone in the country. The SERMENA remained a separate entity maintaining social segmentation within the Chilean health system (Pribble, 2010). In 1968, the SERMENA was allowed to cover services provided in the relatively small private healthcare sector (de la Jara and Bossert, 1995).

1.2. Pinochet's health reforms

The authoritarian regime of Augusto Pinochet was the perfect environment for neoliberal reformers, known as the “Chicago boys”, to implement a series of reforms that would privatize a portion of the services that up to that point had been mostly publicly provided such as healthcare, education and pensions (Ossandón, 2008; Taylor, 2003). In 1979, public financing and provision of healthcare services were effectively separated. The SERMENA and the financing component of the NHS were transformed into FONASA (Fondo Nacional de Salud) (Holst et al., 2004), the Chilean version of the public option. FONASA segmented the insured population into four tiers. Indigent people were assigned to category “A”, allowing them to have free access to healthcare services provided only by the public healthcare system. Workers that contributed to the fund were assigned progressively to categories B, C and D, allowing them to have access to publicly provided services or to a preferred provider private network (Gideon, 2001; Viveros-Long, 1986) through a voucher system that involved considerable user fees. Later in 1986 cost-sharing, in the form of copayments, was introduced for public providers for some income brackets (C and D) (Pribble, 2010).

The healthcare provision component of the NHS was decentralized into a network of 26 geographically defined units denoted Health Services (Servicios de Salud) that together formed the National Health Services System (Jost, 1998). Furthermore, “devolution of primary care centers' administration from the SNSS to the 341 municipalities” occurred throughout the country (Manuel, 2002). The payment mechanism for primary care clinics and hospitals changed from a fixed budget to a fee for service scheme with a cap (Gideon, 2001; Manuel, 2002).

In 1981, a private health insurance market was created. Private health insurance companies –ISAPRE (*Instituciones de Salud Previsional*)- were financed by mandatory payroll taxes of the workers that chose them as their health insurance provider. The first couple of years ISAPRE were totally unregulated; yet, this incentive was not enough to promote the growth of the nascent private enterprises (Ossandón, 2008). Since ISAPRE determine their premium based on individual risk, the majority of Chileans found their fees impossible to pay (Viveros-Long, 1986). Consequently, Pinochet's government introduced five measures to further help the newly created industry (Ossandon, 2008; Pribble, 2010)

- A new bill (18.186) allowed retired people who were under the coverage of the old public pension system, to use their retirement funds in order to have access to private health insurance.
- Women maternity leaves were financed with public funds but administered by private insurers, facilitating the enrollment of a group that would have been otherwise excluded due to their high health expenditure associated with the utilization of reproductive healthcare services
- In 1983 mandatory withholding was expanded from 4% to 6%, and in 1986 to 7%, changing dramatically the number of people who were able to afford premiums. Employer contributions toward health insurance were eliminated.
- In 1986 a 2% subsidy was instituted, which targeted middle-income populations who were close to being able to afford the private health insurance premium, increasing their ability to access the private insurance system.

The final push for the emerging private health insurance market was a decrease of public health spending as a percentage of the GDP throughout the 1973–1990 period (Viveros-Long, 1986). In absolute terms the decrease was even more dramatic if one considers the fact that Chile entered a long period of economic recession in 1973–1977 and again in 1982 (de la Jara and Bossert, 1995). The meager flow of funds to the public sector produced a “major deterioration in the public infrastructure” (Unger et al., 2008) and in working conditions for healthcare workers in the public system. Public provision of healthcare services was severely limited (Unger et al., 2008) so people had the incentive to leave the public insurer if they could. It is interesting to note that short-term analysis after the implementation of such neoliberal reforms already showed an increase in out-of-pocket expenditures (OOP) and worsening of relevant health indicators (Scarpaci, 1985)

Even with all the political support from the regime, the private health insurance sector has never covered more than one third of the Chilean population and current trends show that ISAPRE membership has stabilized[1] (Fig. 1). The fact that “an overwhelming majority of Chileans continued to use the public health system is an important legacy because it created (after 1990) clear electoral incentives for improving public sector care”(Pribble, 2010), at least theoretically.

1.3. The Concertación era: two main health policy arenas

The newly created healthcare markets required regulations because private markets that provide welfare services suffer from a series of problems. For example, several market failures had been

[1] ISAPRE membership peaked in 1996 (26% of the population) and was steadily decreasing until 2008 when 16% of population ascribed to this insurance system. Recently there has been a slight increase in ISAPRE membership.

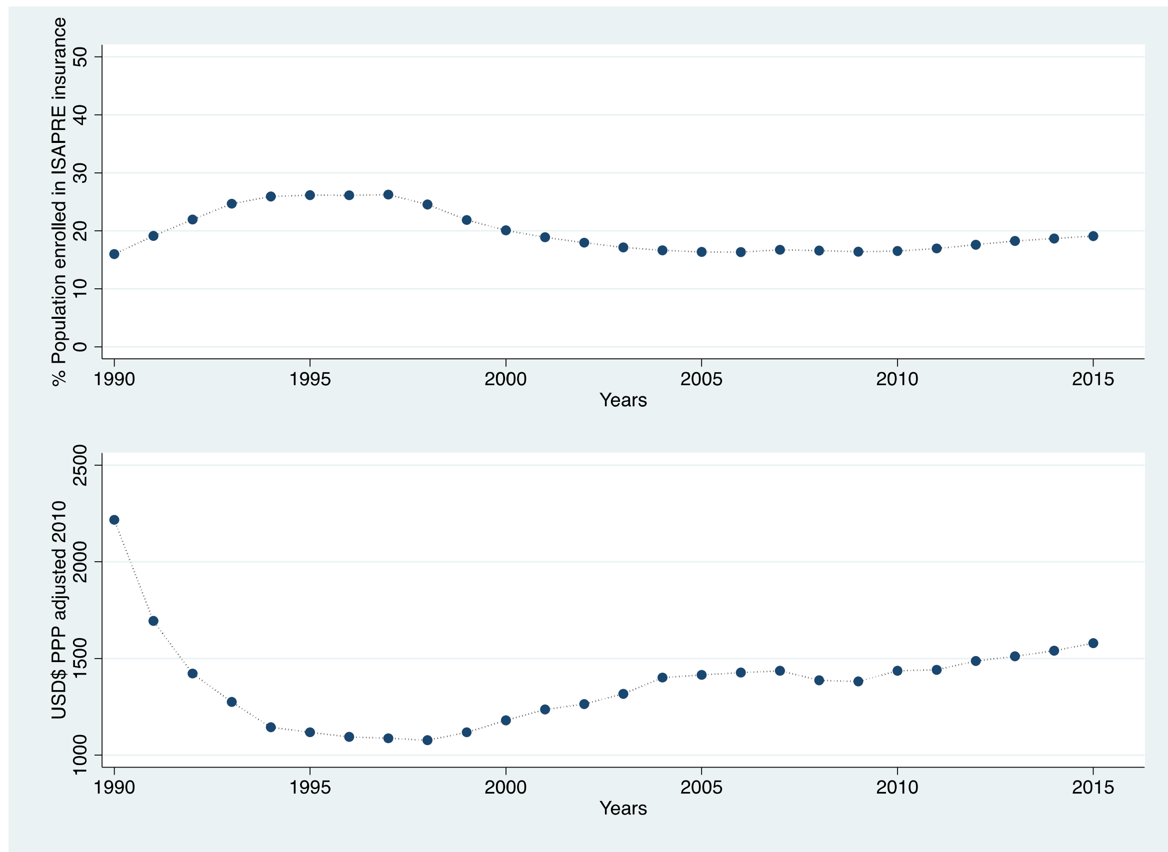


Fig. 1. Trends in ISAPRE membership and evolution of health plan prices 1990–2015, Chile.
The population enrolled in ISAPRE insurance is presented as percentage of the total population. Premium average prices adjusted by inflation and purchasing power parity (2010 US Dollars). Data source: Superintendencia de Salud, Instituto Nacional de Estadísticas.

identified in the health financing market such as adverse selection, risk selection, monopolistic/oligopolistic behaviors and moral hazard which are well-characterized phenomenon (Hsiao, 1995). Risk selection and cream-skimming behavior result in a lack of insurance coverage for high-risk individuals (e.g. poor, elderly and disabled), affecting risk pooling, allowing excess profit for companies and inefficiencies at the societal level. The presence of public and merit goods in health care markets, such as the case of preventive services or paternal leave benefits, are typical examples of externalities in healthcare provision. Incapacity to predict all future contingencies in a context of important information asymmetries and uncertainty bring further abnormalities to health care markets (Arrow, 1963). Multiple principal-agent relations between patients, physicians, institutional providers (e.g. hospitals) and payers (e.g. insurance or government) preclude self-interest rational choices, a condition expected in competitive markets.

In this context, the Chilean reformers faced several challenges to address. One of the first initiatives of the newly elected *Concertación* administration in 1990 was to increase public health spending (Unger et al., 2008) injecting new resources to the weakened public healthcare system, rising from 2% to 3% of the GDP in less than a decade (Barrientos, 2002). In the following decade, that percentage remained over 3%.[2] Secondly, the government faced the market failures of the growing private health markets. We will analyze two main policy areas that were under reform, with more or less success, during *Concertación* administrations. The first one is the health insurance market created by the military dictatorship. Efforts in this area were directed at regulating the market to address the public's concern about some ISAPREs practices that were deemed systematically unfair. The second area of analysis pertains to regulation imposed on the healthcare delivery system.

1.3.1. Regulation of the private health insurance market

Welfare services are generally, at least in part, publicly financed. This practice is based in the inefficiencies derived by markets failures in private health insurance markets. When introducing private markets for the provision of welfare services, policymakers face acute trade-offs on two dimensions: allocation (whether responsibility for allocation is collective or individual) and production (how control is structured over production) (Gingrich, 2007)

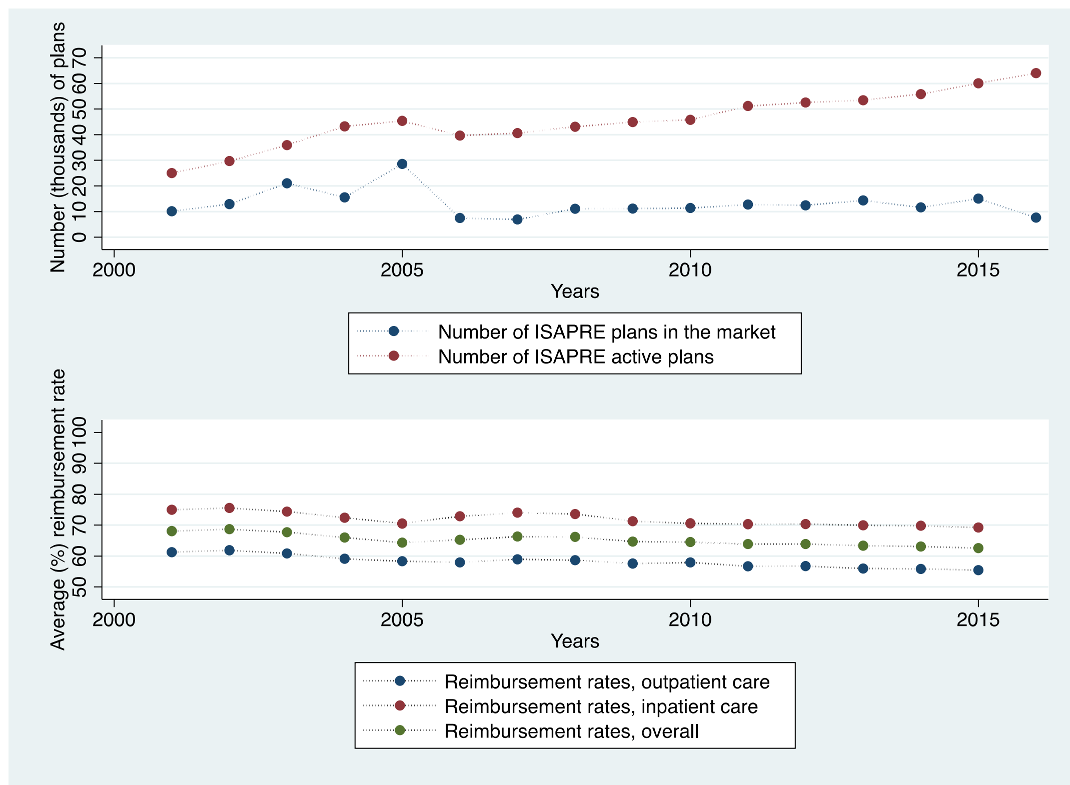
The Chilean private health insurance market circa 1990 was comprised by the public option (FONASA) and several ISAPRE.[3] The private submarket showed the characteristics of a **retrenched rights market**. On the allocation dimension the responsibility for allocation was almost exclusively individual. Although insurance could be purchased using payroll taxes, the copayments i.e. the disbursements that a family had to make to supplement the tax

[2] FONASA. Boletín Estadístico 2009–2010. https://www.fonasa.cl/sites/fonasa/institucional/archivos.

[3] There is a portion of the population (approximately 30% throughout the last decade) that does not participate in the health insurance market since they are either covered by the armed forces insurance scheme or they cannot afford to a health insurance premium so they are covered by the public option but are not allowed to use private providers (FONASA A).

amount in order to afford an ISAPRE premium, was considerable (Viveros-Long, 1986). Copayments for actual health services in the ISAPRE system were quite high and remained like that throughout the last 15 years (Fig. 2). As was already discussed, there were certainly incentives for private consumption and public services were underfunded and of low quality, incentivizing the wealthy to opt-out of the public insurance option, which is consistent with the growing affiliation to ISAPRE during the first years of the 90s (Fig. 1). On the production dimension neither users nor the state were effective principals. By design, the state was not supposed to establish contracts with ISAPRE. Consumers did not have the right to exit and thus had no real way to monitor and discipline producers that did not respond to their choices, especially when they became a high-risk individual. In that case, more than a right to exit they had the right to be kicked-out of the private health insurance market (by means of high insurance premiums) and had to seek insurance in the public fund. Consumers were able to link funding to their choices; however, these choices were less than informed since product options were remarkably obscure. In the last decade, around 10,000 plans were being offered any given year in the private health insurance market (Barrientos, 2002) (Fig. 2). At that time, ISAPRE were also extremely deficient in protecting the individuals from the events that they were supposed to. In 1990, at the beginning of the *Concertación* era, privately insured individuals had good coverage for routine health care but did not cover “catastrophic diseases”, exactly the type of risk that should be covered by an insurance scheme (infrequent and disastrous for the life of a person) (Fischer et al., 2003). Congruent with Gingrich's postulates, this market was introduced by the political Right with relative ease since the political debate in Pinochet's dictatorship was totally censored. Given that neither the state nor the consumers were effective principals, ISAPRE had no incentives to offer better value-for-money services.

In 1990, two sets of regulations for the health insurance markets were put in place. In terms of the production dimension, the first set of regulations gave more control to the state and included the creation of the ISAPRE Superintendence (*Superintendencia de ISAPRE*), a regulatory body that was in charge of “developing specific regulations (from general laws); producing statistics and rankings about the function of the market and the different firms involved; and mediating conflicts between insurers and users (something which had been resolved privately or judicially in the past)”(Ossandón, 2008). A second initiative strengthened access to health insurance services by regulating the contracts between an ISAPRE and a consumer. Up to that point contracts were valid for one year; the ISAPRE could unilaterally end the contract after that period without any justification, giving the insurers a totally unregulated risk selection capacity. Under the new regulation ISAPRE could not end a contract unless the client did not pay the premium in a timely manner. They also could not modify the premium or the benefits that were offered in the plan without changing them for every member of that plan (Manuel, 2002). During the period immediately following these regulations, the cost of the premiums decreased significantly in real prices (Fig. 2). Afterwards, the ISAPRE



Note: No data is available for the average reimbursement rates for the period before to 2001. Data source: Superintendencia de Salud.

Fig. 2. Number of plans in the private insurance market and coverage of the private health insurance market in Chile, 2001–2015.
Note: No data is available for the average reimbursement rates for the period before to 2001. Data source: Superintendencia de Salud.

would find a way around that regulation. They increased the premium of the plan to all beneficiaries and then offered low-risk beneficiaries a newly created similar plan with a lower premium (Fischer et al., 2003).

Interestingly enough, in 1993–1994 the ISAPRE Association embarked in self-regulatory actions and announced that they had agreed to not exclude the treatment of certain high-cost diseases from their plans (Savedoff and Gottret, 2008).

In 1995 a package of reforms was passed whereby a standard format was implemented to help consumers compare health plans specifically regarding their benefits and prices of medical provisions potentially covered (Ossandón, 2008) thus addressing the existing information asymmetry in this market. To deal with incomplete contracts, the package also limited exclusions and dealt with reduced coverage of pre-existing conditions (Ossandón, 2008). Minimum coverage was established; any private policy should guarantee at least the coverage given by public insurance, however, "no determination of the extent of the financial coverage was made … [in] theory, an ISAPRE fulfilled the legal obligations when it paid one peso for any service used by its beneficiaries. In practice, they defined an obligatory coverage of 25% of the costs" (Holst et al., 2004). The package also established that excess contribution, i.e. the positive difference between the premium and the mandatory 7% payroll tax, if any, was the property of the beneficiary and would be kept in a health savings account that could be used to pay for healthcare costs when needed (Manuel, 2002; Ossandón, 2008).

In 1999 the 2% subsidy to buy ISAPRE health plans for low-income workers was eliminated (Manuel, 2002; Ossandón, 2008). ISAPRE membership rates decreased from 24,5% to 21,8% of the population between 1998 and 1999 (Fig. 2).

In the year 2000, the Supreme Court in Santiago clearly specified a minimum coverage for private health plans; they should cover at least 50% of what FONASA covered in its "free-choice" scheme (payment system from FONASA to a preferred private provider network) (Holst et al., 2004). This is the beginning of the increasing regulatory effect of the judicial power in Chile in response to consumer interest. The same year ISAPRE agreed collectively to offer additional catastrophic disease coverage, again responding to state and consumer pressure (Savedoff, 2009).

The last big health reform was implemented in 2005 under the Ricardo Lagos Presidential administration. Its main initiative was the *Plan de Acceso Universal Garantías Explícitas en Salud* (General Guarantees in Health) – the AUGE Law that created a "system of explicit guarantees in predefined health conditions for access, opportunity, quality of services and financial protection" for the whole population[4] (Letelier and Bedregal, 2006). The plan was created to improve access and opportunity of care for users of the public healthcare delivery system, along with introducing, very timidly at first, a quality guarantee which was meant to improve healthcare delivered by public providers. The financial guarantee was supposed to address problems of high copayments in the private health insurance market. For a predetermined list of conditions the user has information about the treatment plan that will be applied and how much she or he will have to pay as a user fee,[5] therefore making the products (plans) in the market more homogeneous and diminishing the problems related to incomplete contracts for a list of prioritized health conditions. Another two laws are specifically related to the health insurance market. First, the Private Health Insurance Solvency Law ("short ISAPRE law") was passed to ensure the stability of the private system and protect beneficiaries from ISAPRE bankruptcy, after one case affected several thousand people (Letelier and Bedregal, 2006). The Private Health Insurance Law ("long ISAPRE law") aimed to improve transparency and expands the Superintendent's role to oversee the public fund (FONASA) and public and private providers (Letelier and Bedregal, 2006). Some of the main provisions of this Law are: 1) private health insurance contracts are to be standardized following the basic format of a document known as "general conditions of the contract" 2) the exclusion of young women from certain policies or the limitation of maternal health benefits are explicitly prohibited (Ossandón, 2008) 3) risk selection is limited; the premium can still be adjusted by sex and age but other risk factors are eliminated from the underwriting process. Legal price ranges were established and an inter-ISAPRE compensation fund was instituted to finance the General Guarantees plan for ISAPRE beneficiaries (Ewig and Palmucci, 2012), with the purpose of adjusting the different risks of the private insurance portfolios, increasing risk pooling at least within the private insurance market.

So, how did these reforms fare *vis a vis* Gingrich's two dimensions? In terms of the allocation dimension, copayments or in this case the supplemental contribution of funds to purchase a health insurance policy from an ISAPRE were not addressed in the regulatory changes that were introduced during the *Concertación* administrations. The only incentive for private consumption that disappeared is the 2% subsidy for low-income people. Public services (insurance and provision) improved with the AUGE plan, thus disincentivizing in some ways the purchase of private insurance (Fischer et al., 2003). Nevertheless, at the end of the *Concertación* era, the private system continued to be an attractive and growing alternative especially for users that were expecting to demand services from private providers that did not contract with the public fund or users that would have probably only demanded ambulatory and (relatively) cheap healthcare because of better accessibility in the private system. In parallel, both public subsidies for maternal leave and the 7% contribution stayed the same.

Regulations were less than successful at stopping cream-skimming behavior. As it was mentioned before, private insurers successfully circumvented the requirement of offering life-long contracts since they continued increasing the premiums as a mechanism to exclude certain high-cost groups. Initiatives such as "the limitations on premiums set by the government were broad enough that private insurers pushed the outer bounds of these, and increased rather than diminished premium rates"(Ewig and Palmucci, 2012). In this case, Ewig et al. shows how the 2005 reform (or the ISAPRE reaction to it) increased the proportion of elderly people that continued to be privately insured but *decreased* the proportion of women enrolled in ISAPRE, mainly due to a relative increase in premiums (compared to men). Not only that, but reimbursement rates for women were also affected negatively after the reform (Ewig and Palmucci, 2012).

In terms of the production dimension, the structure of competition has evolved in negative and positive ways. At least theoretically, the use of rankings, the overall improvement of the information that consumers have about the market, and the possibility of requiring the arbitration of the *Superintendencia* in case of conflict should be expected to increase competition and grant market control to the consumer by making it easier to: 1) link funding to choice and 2) to monitor and discipline ISAPRE. However, there has not been a formal evaluation of these initiatives and their effect over competition in the private health insurance market. Furthermore, during the selected period, market concentration

[4] In reality, the guarantees are valid for the population that is covered by FONASA or ISAPRE i.e. 93.1% of the total population in 2011.

[5] ISAPRE′ beneficiaries that have one of the guaranteed health conditions can chose to be covered by the AUGE plan in which case they are assigned to a preferred healthcare provider or to be covered by their usual health insurance policy retaining freedom of choice of provider but losing the guarantee aspect of the plan.

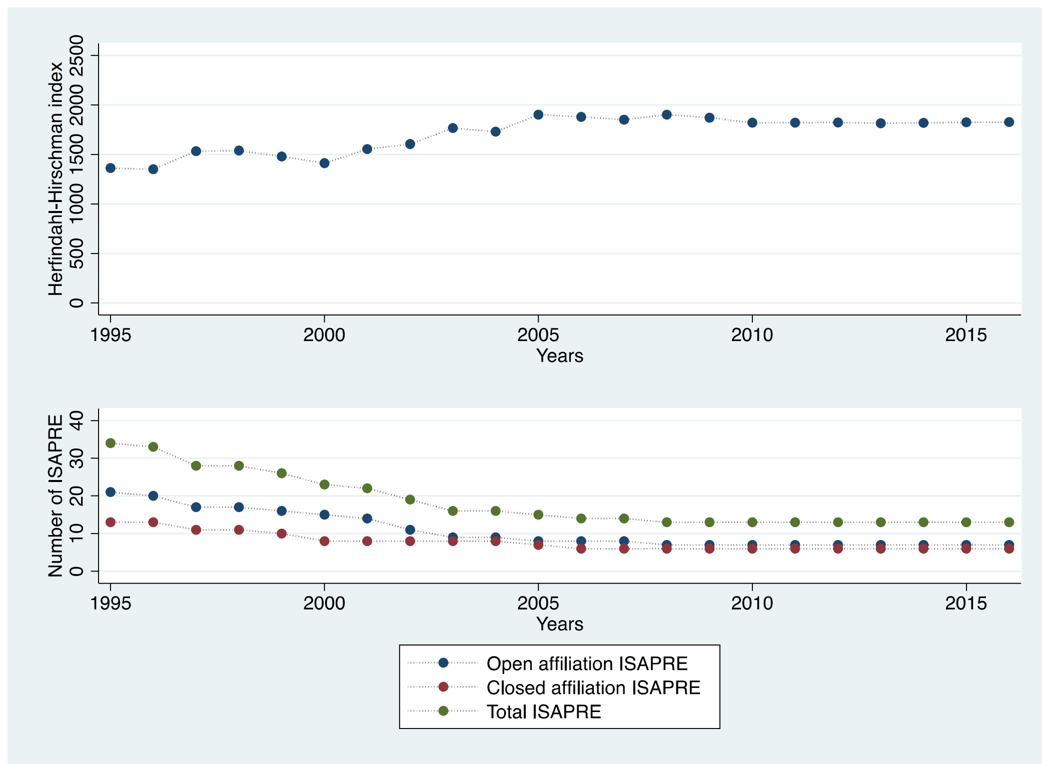
increased; the Herfindahl-Hirschman Index stayed above 1500, indicating a moderately concentrated market, in a context of a declining number of actors in the market (Fig. 3). Stricter regulations and higher entry barriers could explain this trend, paradoxically increasing the power of the producers in a less competitive market.

The judiciary was another force shifting control to the consumer and it made its debut in this period, although they cannot be considered as *Concertación*'s policies. On the other side, there is evidence of three phenomena that had been decreasing consumer control in the market. First, the imposition of life-long contracts effectively locked-in some of the high-risk consumers to their ISAPRE and specifically to their plan decreasing even more their right to exit. Users will tolerate a substantial increase in premiums simply because they risk being rejected by the private market for being high-risk patients. The general trend of rising premium prices (Fig. 1) in a context of diminishing reimbursement rates (Fig. 2) could be at least partially explained by this phenomenon. Second, as it was already highlighted, all the regulations previously described lead to a concentration of the market (Savedoff and Gottret, 2008). The concentration of the market lead to oligopolistic behavior; in 2005 the Chilean Competition Authority sued the ISAPRE when they decreased their plan coverage (Agostini et al., 2011) "arguing that it caused a reduction in the quality of the product that was being offered, without decreasing its price or giving better options; in other words, they would be acting as a "cartel"" (Ossandón, 2008). Third, in 2010 the number of plans offered continued to be several thousand (Fig. 2), hindering the capacity to compare and make informed decisions by consumers. Consequently, in terms of competition, the overall effect seems to be negative or at least neutral.

In conclusion, the private health insurance market remained a retrenched rights market, where insurers continue to hold the upper hand, however most of the regulations implemented in this period could have been expected to move the market towards collective responsibility and consumer control.

1.3.2. Regulation of the healthcare delivery market

Private healthcare delivery in Chile received an important boost with the creation of ISAPRE in 1981 (Unger et al., 2008). This market has never been as intensely regulated as the health insurance market and only the 2005 reform explicitly addressed the regulation of private healthcare providers under a "quality guarantee". The implementation of this guarantee was the slowest (Bastias et al., 2008) and its full implementation was delayed until the first semester of 2016. This guarantee includes new certification and accreditation requirements for both public and private providers but the extent to which these mechanisms will prove to be powerful tools to increase either state or consumer control is still to be seen.



Note: Open ISAPRE refers to private insurers were affiliation and health plans are publicly offered.

Closed affiliation ISAPRE strictly enroll workers of a certain company or institution. Data source:

Superintendencia de Salud.

Fig. 3. Concentration of the private health insurance market in Chile. 1995–2015.
Note: Open ISAPRE refers to private insurers were affiliation and health plans are publicly offered. Closed affiliation ISAPRE strictly enroll workers of a certain company or institution. Data source: Superintendencia de Salud.

The access and opportunity (waiting time) guarantees which deal with a person having access particularly to a specialist in a determined period of time have put a lot of pressure on the public healthcare delivery system but provided the private healthcare delivery system with a steady flow of subsidized clients coming from the public sector. During the 2005–2015 period the hospital installed capacity of public providers had decrease in 10,8% at the same time that increased in 33% in private providers, with increasing private shares of production in the overall delivery market peaking at 48% in recent years (Clínicas de Chile, 2016).

Regarding the allocation dimension, copayments were extensively used both in the public and the private healthcare delivery markets at the beginning of the period (Holst et al., 2004; Pribble, 2010). In 2004 Holst found "remarkable evidence that (in Chile) user charges expose households to large and unexpected expenses and represent a regressive mechanism of health care financing" (Holst et al., 2004). AUGE decreased the copayments for covered health conditions and introduced a new benefit: complete coverage of medications included in the standard treatment plan, which would have reduced OOP for medications. Services in the AUGE plan are fully funded through a financing law that was passed at the same time as the AUGE law.

Nevertheless, OOP remained high throughout the period and real coverage decreased in both inpatient and outpatient services in the private sector (Fig. 2). Cid et al. showed that OOP as a percentage of the total expenditure in health actually increased 0,1 percentage point (Cid and Prieto, 2012). Even at the end of the period, OOP for both publicly and privately insured individuals was high compared to other OCDE countries. The main driver of OOP continued to be pharmaceuticals; 30,8% of the total OOP was associated with this item in 2010 (Castillo-Laborde and Villalobos Dintrans, 2013) Catastrophic health expenditures decreased slightly after AUGE implementation but rose higher than the 1997 baseline in the following years, affecting 4% of the Chilean households in 2012 (Ministerio de Salud, 2015).

Since FONASA coverage continued to be means tested, the magnitude of copayments remained dependent on individual's income tier (Unger et al., 2008). Additionally, there were incentives for private consumption since the public fund would cover some private services through a voucher system and satisfaction with the public healthcare delivery system was significantly lower than with its private counterpart (35% versus 63% respectively in 2010). (Superintendencia de Salud, 2010).

Providers did not target low-cost users of services on a regular basis. There was one form of cream-skimming that was resolved in 2009 when private hospitals were prohibited to require a blank check as a guarantee in order to provide emergency care to anyone that required their services, thus essentially discriminating the poorest and most vulnerable populations (Biblioteca Congreso Nacional, 2009).

Currently, copayments have decreased especially in services provided by the AUGE plan. Means testing and cream skimming have remained the same and services in the public system have improved significantly (Fischer et al., 2003).

In terms of the production dimension, in 1990 the state was not an effective principal for the ambulatory private healthcare delivery market. The presence of vouchers issued by FONASA for consumers to use in the private system transferred control to them since they had the right to exit and the ability to link (very concretely) funding to their choice. They were and still are somewhat less able to monitor and discipline providers since the quality guarantee was not fully implemented until 2016. For the inpatient private system, FONASA developed payment mechanisms based on fixed payment for the resolution of a health problem, which has allowed a clear specification of the outcome and has a built-in monitoring and disciplining system. If the hospital does not provide high-quality low-cost services it will lose money.

ISAPRE, as payers in the private healthcare delivery market, are potentially powerful principals since they establish contracts with private providers. They can, to a certain extent, define the outcomes and give autonomy to healthcare providers to achieve the outcome. Also, they monitor and discipline providers implicitly since the rescission of a contract with any ISAPRE would decrease substantially the provider's market base (especially given the concentration of the ISAPRE market). Reforms in this period did not address a major failure within this market namely vertical integration between ISAPRE and providers in a context of unregulated premium prices, which severely affects the competitiveness of an already concentrated market such as the health insurance market. Consequently, vertical integration hinders competitiveness in the providers' market since ISAPRE do not have incentives for pressuring providers to be more efficient. The users also had some control over the producer since for the most part (excluding AUGE services) they retained the right to exit, and can link funding to choice.

After the implementation of the AUGE plan, the state had more control over the healthcare delivery system since, at least for the health conditions covered in the plan, it contracts services with providers and is able to specify the outcome, give autonomy and monitor and discipline them through FONASA. Furthermore, ISAPRE beneficiaries retain their right to exit if they do not like their contracted AUGE provider and can use the provider of their choice through their regular health plan.

In conclusion, before the 2005 reform, the ambulatory private healthcare delivery market financed by FONASA was a two-tiered market where individuals bear a great proportion of the cost of services but have tools to control the market. The private healthcare delivery market financed by the ISAPRE corresponded to an austerity market since the payer (ISAPRE) retained control over the market but responsibility was assigned to the individual since copayments in this sub-system were considerable high and few incentives for cost containment were imposed on payers.

AUGE increased payer control in the market and steered the market toward collective responsibility of access by funding services, exactly what is expected of a Leftist government. However, both ambulatory and inpatient private healthcare delivery markets did not move from the previous positions in Gingrich's table. Additionally, the reform created a private provider market for guaranteed services associated to certain health conditions that can be described as a managed market. What had been unexpected, and important to notice, is a continuously growing flow of cash-transfers from the public fund to private providers, which increased 329% in the 2005–2013 period.[6] This unexpected effect of the health reform fostered the expansion of private providers and diminished the investing capacity of public health sector.

2. Discussion

The center-left coalition in government during the 1990–2010 period faced major market failures in the private market. They attempted to use regulation to improve the collective dimension of the Chilean health system where some level of progress had been achieved; nevertheless, several challenges in terms of access and control of individuals persisted.

Overall, the results we find explain to a certain extent the debate we presented in the beginning of this paper. In terms of the private

[6] Information from the association of private hospitals informed that in 2005 the annual payments were $CLP 31.377.163. Data from the Government for the year 2013 estimated this payments in $CLP 134.687.177.

health insurance market, reforms were designed mostly to increase consumer power, but their implementation did not yield the expected fruits. The public has not seen a lot of improvement and was expecting probably a set of reforms that would steer the market towards collective responsibility of access and state or consumer control. The creation of a Presidential Committee to reform this market while President Sebastián Piñera was in office and of another one during President Michele Bachelet's second term, are proof that politicians perceive that the country is not satisfied with the role ISAPRE play in the social security arena.

Future research can address the question: why did not *Concertación* administrations pursue more aggressive reforms to steer the market towards collective responsibility and away from producers' control? Does the power resources theory, which states that the three types of welfare states result from different levels and configurations of working class mobilization (Esping-Andersen, 1998), explain this behavior? Maybe the weakness of unions after the military government coupled with a weak Center-Left coalition, more worried about political stability than about reforming the welfare state, can explain this result. Or is there a policy legacy story (Pierson, 1993) in which policy feedbacks in the form of resource and incentive effects created powerful interest groups who have been successful at blocking any major reform to the health insurance market? The creation of the private health insurance market generated new political actors such as ISAPRE and private providers who have financial motives (resources incentives) to maintain producer control in the corresponding market. For example, the "spoils" that the ISAPRE get from the health insurance market are enormous, even after the 2005 reform. Repetitively, ISAPRE make the headlines by reporting record profits. For example, in 2012 ISAPRE increased their profits by 36.1% in one year. As an example of the difficulties that the public sector has to regulate the ISAPRE we can look at the epilogue of the elimination of the risk-factor tables in the ISAPRE underwriting process. In 2010, the Supreme Court declared the risk factor table used by the ISAPRE (that allowed them to risk-adjust by age and gender) unconstitutional. In March 2011, the *Superintendencia* froze the risk-factor table used by the ISAPRE and since them courts have ruled in favor of the users almost every time regarding price increases, somewhat reshaping the scenario (again) via the judicial power. However, it is important to remember that premium prices have been steadily increasing in the last decade. As Ewig points out, "the implementation of the 2004 Chilean health reforms demonstrates that once for-profit providers (of insurance) are stake-holders in social policy systems, it may be very difficult to reverse their inequitable effects" (Ewig and Palmucci, 2012). It is interesting to note that, although regulatory reforms were mildly effective to extract control from the ISAPRE, they still led to a contraction of the market. It may be the case that effective regulations in this area may make a healthy competitive health insurance market unviable (Savedoff, 2009). The evident tension between the market or pseudomarket solution *vis a vis* the abnormal economics of health care sector that require governmental interventions are clearly delimited in the Chilean case.

On the other side, we show evidence that the *Concertación*, in the case of the healthcare delivery market, has been striving to transfer responsibility of access to the collective and control to the payer (the State – through its public option, FONASA - or ISAPRE) and the consumer, creating a guaranteed list of services, which is located "up and to the left" in Gingrich's table. Further research is needed to explore the degree in which consumers and payers have actually experienced a greater level of control. Nowadays, a new reform of the private health insurance system is in the political agenda. Lessons from the limitations of the efforts conducted in previous decades could be of great relevance in such attempt.

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