Is Anybody Listening? Ignoring Evidence in the Latin American Health Reform Debates

A Health Note

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The following paper has emerged from viewing health sector reform debates throughout Latin America and the Caribbean, particularly in the last 6 years. In the course of those years, I have learned a great deal from many people whose ideas and encouragement have contributed directly and indirectly to these observations. In the case of this paper, comments from Gustavo Zuleta and Philip Musgrove were particularly important and welcomed. Any errors that remain are my own.

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Is Anybody Listening?
Ignoring Evidence in the Latin American Health Reform Debates

Throughout Latin America and the Caribbean, in fact throughout the world, countries are in the midst of debates about their health systems. Frequently, the characteristics of reforms in one country are used to promote or criticize particular proposals in another. Despite the great importance and potential from learning from external models, evidence frequently makes very little difference to the way models are perceived and described in the political and social arena.

To illustrate this point, imagine going to a country to do an evaluation of the health system's degree of equity. Imagine that you are trying to decide if this is a model that your country would like to emulate. You might find the following information.

First, the country has a health model in which almost 100% of the population has access to health services and a form of public health insurance that allows individuals to use private medical services with some limitations. The working-age population with incomes above a certain level pays for its own health insurance premiums in full; while the public sector covers those over 65 and those whose incomes fall below a certain level. In the actual system, the financing and expenditures are as shown in Table 1.

Apparently, only 4% of general revenues are used to finance care for those who are employed and have incomes above the poverty level. Almost 50% of the coverage for the elderly and poor are financed from general revenues, and another 33% from payroll taxes. The next question might be to ask about the 19% of co-payments for those covered by the public system – whether or not that keeps the poor from using health services. Further investigation reveals that people in the poorest income class pay no fees for using the public services, but

Table 1

	Private	Public
Total Spending (US$/year)	1,118mn (44%)	1,040mn (56%)
Source Shares		
General Revenues	4%	48%
Premiums paid out of payroll taxes	82%	33%
Copayments	14%	19%
Spending per Beneficiary (US$/year)	297	205

do have co-payments if they seek private care. Access is one thing, but what about health outcomes? Evidence shows that professional birth attendance is almost universal, and infant mortality rates are low for all income classes.

Is there anything horribly anti-social about this system? Well, this is Chile, a country whose health reform has been widely decried as the most horrible of neo-liberal health reforms. I myself wrote an article in 1996 in which I pointed out elements of the system that promoted inequality.[1] As it turns out, once I started looking at data, I was wrong. What happened?

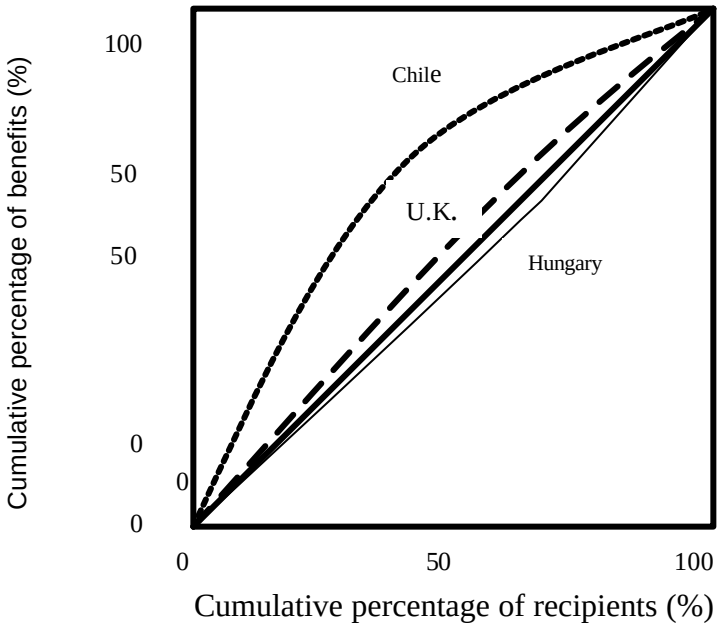
The main problem with earlier critiques of the Chilean system is that they focused on payroll taxes, and the fact that wealthier Chileans were extracting themselves from the public system and shifting these taxes to premiums going to private insurers.

What we missed was the fact that these same people continue to pay taxes, proportional to their income, and these tax revenues subsidize the public system. As a consequence, Chile has one of the most progressive health systems in the world when measured by the combination of tax incidence and public health spending.

This conclusion is not the result of some isolated study or ideological position. Evidence for the progressivity of the Chilean system was available as early as 1989 with data from 1987 in Haindl, Budinich, and Irarrazaval (1989). Milanovic (1995) took the Chilean data to use for comparison with Eastern European countries. When Milanovic compared Great Britain, Hungary, and Chile, only Chile had markedly progressive health spending. (See Figure 1).

[1] See Savedoff (1998). The data from Table 1 were reported in the same book in an article by Miranda and Paredes (1998).

Figure 1
Distribution of Public Sector Benefits in Health Services

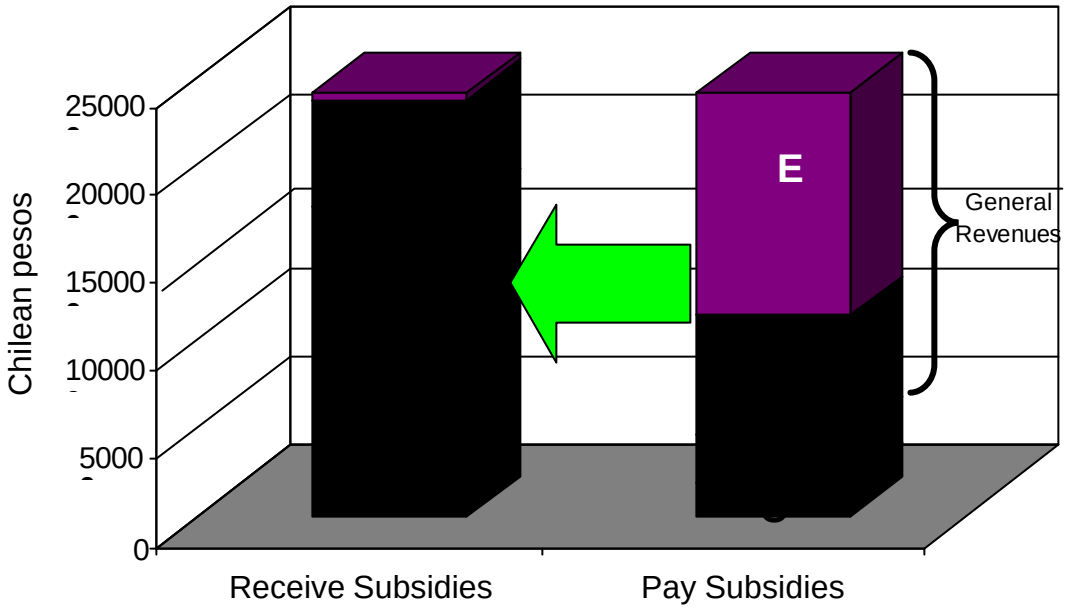


Source: Adapted from Milanovic (1995), p. 507.

Further confirmation can be found in Bitrán (1998) in which the actual flow of public expenditures was analyzed by income class. Bitrán found that 72% of the public health system beneficiaries were from income groups earning less than US$144 per month. These two groups received subsidies equivalent to US$590 million in 1995. Of this amount, US$488 million came from the government's general revenues, and another US$115 million came from cross-subsidies from FONASA beneficiaries with incomes over US$145 per month (See Figure 2).

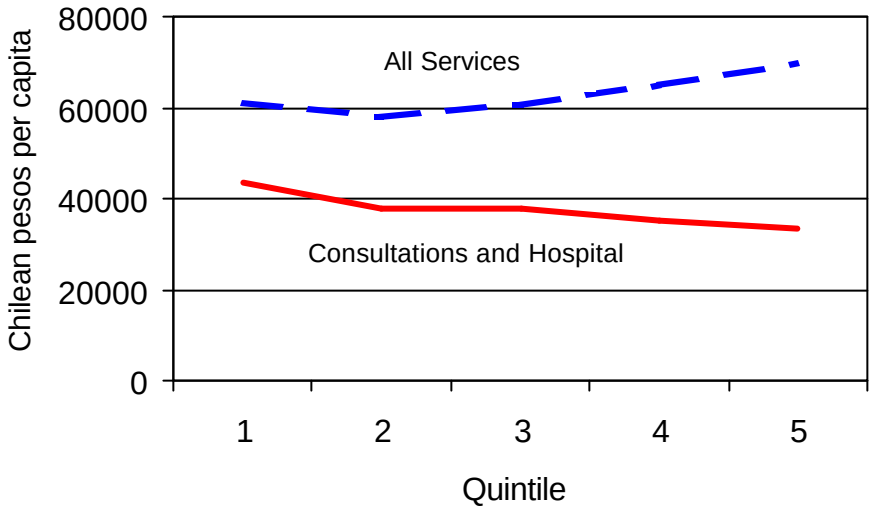
Yet another study came to a similar conclusion using different data. Sapelli and Vial (1998) use a method developed by Wagstaff and Van Dorslaar (forthcoming) to analyze European countries, in which health service needs are estimated across income groups and compared with actual utilization. They write, "The results show that the Chilean health system is similar to an average European health system. That is, there is no relation between income and utilization if we consider medical visits and days of hospitalization." (See Figure 3). Looking at both financing and expenditures, then, Chile's health system is at least reasonably progressive and by Latin American standards remarkably progressive.

Figure 2
Who Pays and Who Receives Subsidies?



Note: Classification is based on FONASA, in which Class A is indigent, Class E is covered by ISAPRES, and Classes B, C, and D are of increasing income level.
Source: Adapted from Bitrán (1998), with additional information regarding tax incidence.

Figure 3
Expenditures on Services by Income Quintile



Source: Sapelli and Vial (1998).

One reason people criticized the Chilean system is that the reform of the early 1980s was implemented by a brutal military regime. It became difficult for people to separate the reform and its actual impact from its origins. Also, the reform was followed by 10 years of stagnant funding for FONASA on a per capita basis. However, since the late 1980s and through the 1990s, health service financing has increased substantially and the distributional impact of the health system has shown itself to be remarkably progressive.

Today, one of the key reasons that leads people to think that the Chilean system is inequitable is that they interpret domestic critiques of the Chilean system as if those arguments were directly applicable to their own countries. But a Chilean style system in a country where the public health services are universally available is very different from a country with low coverage (as is true in most other parts of Latin America). Losing private insurance coverage in a country with a public safety net is much different than in a country with no net at all.

This can be illustrated by the varying interpretations of how the elderly are affected by the current system. Most Chileans retiring from the labor force, can no longer afford private insurance premiums, and consequently, they move to FONASA. This has been attributed, correctly, to the fact that there is no legal restriction that keeps private insurers from canceling contracts. Since FONASA does not have to provide services based only on the payroll tax

"premiums", but receives large subsidies from general revenues, it can provide protection for the elderly. If the elderly had no other options, or if FONASA did not receive subsidies from the public treasury, then the shift of the elderly from ISAPRES to FONASA would indeed represent a problem. But the existence of these public subsidies mean that FONASA is operating as an appropriate public "safety net" for those in retirement.[2]

Everything is not rosy. Chile's health system does continue to have problems. Chileans are aware of a great waste of resources, particularly when benefit packages are not standardized and premiums are fixed as a percentage of income. By fixing payroll contributions in percentage terms without a cap, ISAPRES are able to reap premiums far in excess of the costs of needed medical care. This leads to wastefulness that could be addressed through capping contributions or taxing excess contributions. Neither of these would be popular with the ISAPRES, but the first measure would at least be supported by upper income households.

The critical issue in terms of financial equity is to make sure that, once the upper income households have paid fully for their insurance premiums, the taxes generated from their income and sales taxes are used to adequately finance an effective and high quality public safety net. In this regard, Chile is in the forefront among Latin American countries because its public services are relatively well-financed, virtually universal, and generally adequate.

The key problem is that the poor are treated unequally in one key respect: unlike wealthier Chileans, they are constrained to use the generally poorer quality public services. This is the core inequity in the Chilean system, and to solve it requires either that the public system improves substantially or that the poor are given the option to select ISAPREs through subsidized premiums. The latter alternative is favored by many Chileans who see it as a way to integrate the two systems.[3]

Misinterpretation of Chile's domestic debates continues to feed the common view in Latin America that Chile's system is highly unequal. For example, Colombia's health reform is regularly criticized by domestic opponents as representing the "Chilenización" of Colombia's health system. Yet the actual evidence regarding Chilean health outcomes and progressivity of its public health system are rarely, if ever, cited. If the actual evidence ever entered the discussion, perhaps the good elements of that system could be recognized and good policies could be enacted.

[2] Another concern arises with regard to the effect of the aging of the population on Chile's public health system. A recent study (World Bank, 2000) showed that the aging of the population will have very little impact on FONASA's financial condition since it already receives the majority of elderly and its revenues come primarily out of general taxation.

[3] For an appreciation of current conditions and debates in Chile on this issue, see Sánchez and Zuleta, 2000.

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