

Reforming health insurance in Argentina and Chile

ARMANDO BARRIENTOS¹ AND PETER LLOYD-SHERLOCK²

¹University of Hertfordshire, Hertford and ²School of Development Studies, University of East Anglia, Norwich, UK

The paper examines the recent reforms of health insurance in Chile and Argentina. These partially replace social health insurance with individual insurance administered through the private sector. In Chile, reforms in the early 1980s allowed private health insurance funds to compete for affiliates with the social health insurance system. In Argentina, reforms in the 1990s aim to open up the union-administered social insurance system to competition both internally and from private insurers. The paper outlines the specific articulation of social and individual health insurance produced by these reforms, and discusses the implications for health insurance coverage, inequalities in access to healthcare, and health expenditures.

Introduction

Globally, the social insurance principle of welfare programmes appears to be losing ground to individual insurance and private provision. In Latin America this trend has been much in evidence, especially in the area of pension reform. The retrenchment of social insurance has been slower in the area of healthcare, but the reforms are equally profound and their effects are more immediate. This paper examines recent reforms implemented in Argentina and Chile aimed at partially replacing social insurance with individual health insurance. In Chile, reforms in the early 1980s resulted in the establishment of the *Institutos de Salud Previsional* (ISAPREs), which provide health insurance on an individual or group basis, in competition with the *Fondo Nacional de Salud* (FONASA), the social health insurance system. In Argentina, successive reforms in the 1990s aim to open up the union-run *Obras Sociales*, hitherto monopolistic health insurance schemes for specific groups of workers, to competition from each other and from private insurance.

The study of health reforms in Chile and Argentina provides for an interesting and fruitful contrast. Chile's reform featured a sharp break with social insurance principles and institutions, which have shown greater resilience in Argentina. The decade or so gap existing between the reforms in Chile and Argentina, and their commonality of objectives, help to project and evaluate the unfolding of the reform in Argentina. The health reforms in Chile and Argentina are also important in themselves. The Chilean health reform has had a wide impact in Latin America and beyond, and the IADB recently described the Argentine reforms as '... the greatest transformation of a healthcare system in Latin America during the 1990s' (IADB 1998).

The paper focuses on the articulation of social health insurance and individually contracted insurance which results from these reforms. By social health insurance we refer to schemes organized under principles of solidarity, where entitlements depend upon earnings-related payroll contributions,

and where contributions finance the benefits provided. This is in contrast to health insurance plans negotiated on an individual or group basis with private or not-for-profits insurers. These two different forms of organizing health insurance have specific advantages and disadvantages which have been identified and discussed in the literature (Abel-Smith 1992; WHO 1993; Besley and Gouveia 1994; Normand 1999). Of particular interest here is the articulation of these two forms of health insurance in Chile and Argentina, and their impact on coverage, equity and cost control.

Reform of health insurance in Chile and Argentina

The Chilean and Argentine health insurance systems before the reforms

In the majority of Latin American countries' welfare programmes were built on social insurance principles (Mesa-Lago 1991). In contrast to European countries, social insurance was never universal, but was instead arranged for specific groups of workers through Insurance Funds (*Cajas de Previsión*). These collected earnings related contributions and paid benefits for specified contingencies. Initially the *Cajas de Previsión* focused on funeral costs, old-age pensions, and industrial injury compensation, but later they expanded the range of benefits to cover unemployment and family benefits, as well as preventive and curative medicine. In addition, governments provided a limited range of publicly funded services for the non-insured, although these were usually of a low quality and failed to reach much of this population. Social insurance provision and coverage expanded in the post-war period, with the more developed countries, such as Argentina and Chile, reaching levels of welfare provision, at least for the urban formal sector, comparable to that of some European economies.

In Chile the earlier social insurance funds date from the 1920s, and were set up to provide pensions for distinct groups of workers. In the 1940s and 1950s, the range of

contingencies covered expanded to include first preventive medicine, and later curative medicine. In 1942 the *Servicio Médico Nacional de Empleados* (SERMENA) was created to cover preventive medicine care for white-collar workers, and in 1968 curative medical care was added. Blue-collar workers were covered by the *Servicio Nacional de Salud* (SNS) created in 1952 (CIEDESS 1994). Healthcare provision was stratified along blue/white-collar worker divisions. Blue-collar workers received direct care from the SNS providers, while white-collar workers could opt for direct provision by SERMENA institutions, or from approved private providers. This created the conditions for a rapid expansion of private provision.

Argentina's health insurance system has its roots in the late nineteenth century, and several key features can be traced from that time through to the 1990s (Katz and Muñoz 1988; Belmartino 1991). There were a large number of separate funds (over 300 by the 1990s), most of which were administered by unions. These funds had monopolistic rights over demarcated sectors of the labour force, as workers were not entitled to choose which fund they affiliated to. Given the fragmentation of the social insurance sector, most funds were too small to provide services, and so they contracted out to private clinics and hospitals, creating a large private provision sector. This purchaser-provider split was unusual in Latin America, but rather than promote efficiency and competition, it gave rise to a chaotic and unaccountable system of contracting and sub-contracting. In large measure, this was due to a virtual absence of state regulation. Another peculiar feature of health insurance in Argentina is the existence of a separate fund for elderly people: the *Programa de Atención Médica Integral* (PAMI). This fund is financed through a separate wage tax and provides a relatively generous range of services to all insured people aged 60 or over and, in theory, non-insured aged 70 or over (Lloyd-Sherlock 1997).

Private health insurance first emerged in Argentina in the late 1960s, but did not become significant until the mid-1980s. The industry consists of two sectors, organized on a for-profit and not-for-profit basis (*Pre-pagas* and *Mutuales*). These provide voluntary schemes mainly for high-income groups, supplementing the cover they are obliged to take with *Obras Sociales*. Private insurers are extremely varied in terms of size and the degree to which they rely on third party providers. There is no regulatory framework and *Pre-pagas* have been criticized for high operating costs and a lack of transparency (World Bank 1995).

The health reforms in Chile and Argentina

Table 1 summarizes the key features of health reforms in Chile and Argentina.

Reform of health provision and financing began to be implemented in Chile in the early 1980s, as part of the structural reform of the national economy and welfare programmes (Miranda 1994; Miranda et al. 1995; Larrañaga 1998). The main objectives were to expand the role of the private sector in provision and financing, and to improve resource allocation

and promote decentralization within the publicly funded sector.

The first set of reforms extended the option to use private providers to blue-collar workers, while at the same time decentralizing the SNS into 27 regional groups, and transforming its healthcare institutions into self-managed independent units. This reorganization of public provision prepared the ground for the introduction of private insurers, the ISAPREs, which began operating in 1981. Affiliates were given the option of leaving the social insurance system and arranging private insurance from the ISAPREs. This created two parallel sectors for financing and provision.

Legislation implemented at the beginning of 1986 consolidated the new framework. It eliminated remaining differences in provision for white- and blue-collar workers, by setting up a uniform compulsory health insurance contribution of 7% of earnings. The *Fondo Nacional de Salud* (FONASA) was established to collect contributions from those affiliated to the public sector, and to allocate these resources to providers. Responsibility for provision for non-contributing employees and for inactives remained within the public sector (Miranda 1989).

In Argentina, the reform of welfare programmes began a decade later than in Chile. Prior to the 1990s, attempts by successive governments to reform healthcare had proved unsuccessful in the face of powerful opposition lobbies (Belmartino and Bloch 1994). However, industrial decline and several years of neo-liberal adjustment had reduced the influence of unions and public sector workers and called into question traditional principles of corporatism and social insurance.

The main goal of the social insurance reforms has been to introduce competition into the sector. The reforms have been introduced in a series of steps. They began with measures designed to liberalize and clarify contract negotiations between union insurance funds and private providers. Legislation enacted in 1991 and 1993 gave the *Obras Sociales* greater freedom to negotiate contracts with healthcare providers (Panadeiros 1996; Bour 1997; Belmartino and Bloch 1998). In November 1996 the government defined a basic package of services (with an estimated cost of US\$40 per person per month), which all funds are obliged to provide. From the following January all insurance affiliates were given the right to select their funds and from January 1998 private insurers were to be permitted to compete for these affiliates on an even footing. Union resistance was largely overcome through a policy of divide and rule. Selected government-friendly unions benefited through the US\$150 million from the World Bank and US\$120 million from the Treasury, which had been made available for pushing through the insurance reforms. A separate set of reforms has been developed for the publicly funded sector. Their main thrust has been to increase the financial independence of hospitals and to recover costs from insured groups using public facilities (IADB 1998).

Argentina's health care reforms are not yet fully implemented. In late 1997 it became apparent that the final stage

Table 1. Key features of healthcare reforms in Chile and Argentina

	Chile	Argentina
Situation pre-reform:		
Insured	Financed through payroll contributions; provision by SERMENA plus private providers (white-collar) and SNS (blue-collar).	Financed through payroll contributions to union insurance funds <i>Obras Sociales</i> ; provision by public sector and private providers.
Non-insured	SNS	Public sector
Date and scope of reform	1981–86 allowed free choice of affiliation and introduced ISAPREs (private health insurers).	1991–98 gradual reforms defined basic healthcare package, allowed free choice of affiliation and private health insurers.
Financing	7% of earnings to either FONASA or ISAPREs; public healthcare financed by FONASA contributions and general taxation (35 and 65%, respectively in 1996).	8% of earnings (employees 3% and employers 5%); public healthcare financed from general taxation.
Health risks covered:		
(1) public health insurance	All subject to budget limits.	All subject to budget limits.
(2) private health insurance	Basic package plus additional risks individually negotiated.	Basic package plus additional risks individually negotiated.
Population covered:	(1998)	(1996)
(1) social insurance	62%	53% (includes 4% w/private)
(2) private	33% (23% ISAPREs, 10% other)	9% (only private)
(3) other	2% (AAFF and Police) covered by FONASA	–
(4) non-insured	–	38%
Health expenditures/GDP:		
(1) total	4.22% in 1996 excluding pharmacy and copayments (2.89% in 1987)	7.5% in 1995
(2) private	1.7% in 1996	3.01% in 1995 (excluding <i>Obras Sociales</i>)
Administrative costs:		
(1) public	1.8% of expenditure	–
(2) private	18% of expenditure	–
redistribution	FONASA progressivity through copayments	<i>Fondo Solidario de Redistribución</i>

Data sources: CIEDESS 1994; Panadeiros 1996; IADB 1998; Larrañaga 1998.

of the insurance reform would be delayed and possibly modified, since few *Obras Sociales* were yet deemed competitive, and as mid-term elections had increased the weight of political opposition. Also, private insurers were not prepared to accept the new regulatory framework. Their reluctance was surprising, given the opportunities that the reform offered them. However, private insurers have been able to penetrate the protected social insurance sector without submitting to regulatory constraints.¹ In a Trojan horse strategy known as ‘triangulation’, *Obras Sociales* started to contract out their administrative functions, and, in some cases, effectively served as fronts for private health insurers. If this process continues (and there is no indication of it slowing), it will lead to a new insurance hybrid, which may dominate the market.

Health insurance reforms in Chile and Argentina have a common purpose in seeking to extend the role of individual insurance and, to a lesser extent, private provision. This has been achieved through the introduction of health insurance plans offered by private providers, which individuals are free to join. The reforms do not seek to provide an integrated healthcare system, but to pitch individually selected healthcare plans and private provision in direct competition with

social insurance and publicly funded provision. The next section examines the impact of these reforms.

The implications of health insurance reform for coverage, inequality and health expenditures

Health insurance coverage

In Chile health insurance is provided by FONASA, the ISAPREs and special social insurance funds (the largest being the fund covering the armed forces and police). FONASA also retains the role of financing basic services for the uninsured. Table 2 shows health insurance coverage in 1998. Since the 1981 health reform, the ISAPREs have expanded to cover just under one-quarter of the population, with FONASA insuring the majority of the population, around two-thirds.

Within FONASA, coverage is stratified into four groups according to economic status. Category A and B members are the unemployed or inactive, and low-income workers, respectively.² Both these groups only have access to services provided by public hospitals and clinics (clinics provide primary healthcare on a first-come, first-served basis; hospitals provide secondary and tertiary care). Category C and D

Table 2. Health insurance coverage in Chile, 1998

	Health insurance plan					Total
	FONASA ^a	ISAPREs	Armed Forces	Other Private	Other ^b	
Population coverage (%)	61.8	23.1	3.0	10.9	1.2	100
By age group (years)						
0–1	66.4	24.7	2.3	5.9	0.7	100
1–4	65.3	24.6	2.6	6.8	0.7	100
5–14	64.4	23.7	2.6	8.4	0.9	100
15–24	58.3	22.4	2.7	14.8	1.7	100
25–49	56.5	27.2	2.5	12.5	1.4	100
50–64	65.0	19.4	3.8	10.7	1.1	100
65+	80.4	6.7	5.7	5.9	1.2	100
By quintile of per capita household income						
1st	86.2	4.0	0.5	8.5	0.9	100
2nd	73.9	13.2	1.7	10.1	1.2	100
3rd	62.4	21.3	3.5	11.3	1.6	100
4th	47.1	33.0	5.4	13.1	1.4	100
5th	26.0	55.4	4.9	12.6	1.2	100

^a FONASA includes those not contributing to any health insurance plan.

^b Other includes don't knows.

Data from Mideplan (1999).

groups are higher earnings groups. These also have the option to use private health providers.

The coverage of health contingencies varies across health insurance groups. For workers insured by the ISAPREs, the coverage of contingencies is defined by the individually negotiated contract, and is therefore related to ability to pay, with larger premiums securing more comprehensive cover. For those workers insured by FONASA, the contingencies covered depend on the type of provider. Access to private providers by FONASA members is regulated both in terms of the treatments that are reimbursable, as well as the tariffs on which reimbursements are calculated. The range of contingencies covered by public providers, on the other hand, is restricted by the resource policy of the public institutions, and by supply restrictions. These coverage limits apply especially to the low earnings groups in FONASA and the uninsured, groups for whom this is the only healthcare available.

The fraction of health expenditures covered by insurance is another important dimension of coverage. Care provided by public institutions is fully covered by insurance for Category A and B affiliates, but Category C and D workers are required to make a copayment of 10 and 15% respectively. FONASA covers only 50% of private provider charges. ISAPREs have a structure of copayment varying according to the medical intervention provided, up to a maximum ceiling for both specific benefits and for annual aggregate claims.³ Costs in excess of this ceiling are fully financed by the insured.

Since the health insurance reforms in Argentina have been far more recent, any assessment of their impact on coverage is inevitably more tentative than in Chile. Table 3 shows health insurance coverage status for 1996/7. The group without a health plan is large at 37.4%. Among those covered

by a health plan, just under one half of the population is covered by an *Obra Social* alone, 8.6% are covered by a private plan alone, and a further 3.8% supplement their *Obra Social* plan with a private plan. As indicated by the figures, there is some overlap between the two main types of insurance providers.

There is evidence that affiliation to the *Obras Sociales* had fallen significantly in the years immediately preceding reform. The *Administración Nacional de Seguro de Salud* (ANSSAL), the official health insurance regulator, calculates that between 1990 and 1995 the total number in *Obras Sociales* declined from 18.8 million to 16.2 million. And *Superintendencia de Servicios Sociales*, which took over from ANSSAL, estimates that in 1999 there were only 8.9 million affiliated to *Obras Sociales*. The causes for this decline mainly relate to trends in the labour market. Despite the economic boom of the 1990s, many workers lost insurance protection because of a shift to short-term contracts and part-time employment. Also, there were massive reductions in public sector jobs and open unemployment reached unprecedented levels. If current labour market trends continue, it is likely that affiliation to this sector will continue to drop. By contrast, there are strong indications that private health insurance affiliation has increased substantially both before and after the reforms. Individual insurers have reported large increases in membership, and the market has been increasingly penetrated by US HMOs and Chilean ISAPREs. As private insurers 'triangulate' with *Obras Sociales*, it is possible that the overlap in coverage reported in Table 3 may fall.

The range of services offered and the levels of copayment levied by *Obras Sociales* and private insurers have been very broad, reflecting the relative wealth of the occupation groups or individuals covered. For example, per capita spending on

Table 3. Health insurance coverage in Argentina, 1996/7

	Health insurance plan					Total
	No plan	<i>Obras Sociales</i> (OS)	Other Private (OP)	OS plus OP	Other	
Population coverage (%)	37.4	48.8	8.6	3.8	1.3	100
By age group (years)						
0-1	52.1	37.4	8.1	1.6	0.9	100
1-4	47.5	41.9	6.8	2.8	9.9	100
5-14	43.2	46.0	7.5	2.3	1.1	100
15-24	45.8	41.7	8.2	2.7	1.7	100
25-49	38.7	46.1	10.4	3.4	1.4	100
50-64	27.9	54.3	11.2	4.9	1.7	100
65+	7.3	78.0	4.1	9.7	0.9	100
By quintile of per capita household income						
1st	72.8	24.5	2.0	0.4	0.4	100
2nd	47.7	45.4	4.2	1.5	1.2	100
3rd	34.6	54.9	5.9	2.8	1.9	100
4th	23.8	58.9	11.6	3.8	1.9	100
5th	17.6	55.2	17.0	9.1	1.2	100

Own elaboration from Encuesta Nacional de Gastos de los Hogares 1996/7 data.

pharmaceuticals by different *Obras Sociales* varied 13-fold before the reform. The imposition of a basic package of services may lead to some reduction in these disparities, and may also encourage provision of primary-level services by the union funds. However, it has been reported that many funds are yet to comply with this measure.

In both Chile and Argentina, social insurance and private health insurance cover around two-thirds of the population. Affiliation to private health insurance has risen in both countries, at the expense of social health insurance coverage. In each country the publicly financed sector remains the provider of last resort for large sections of the population.

Inequality in health insurance

Health reform in Chile has resulted in segmentation in financing and provision (Miranda 1989; Larrañaga 1998). The ISAPREs cover just under a quarter of the population, but their membership is predominantly from high-income groups, with low health risks. Table 2 shows that in 1998, FONASA concentrated health insurance coverage for both younger and older groups. Both ISAPREs and private health insurance providers focus on middle-aged groups, and their coverage of older groups is particularly low. Comparing health insurance coverage across household income quintiles shows that 55.4% of individuals in the top quintile belonged to ISAPREs, but only 4.0% of the lowest quintile did so. FONASA has retained the low to middle income groups in the formal sector and informal sectors, but it also covers the overwhelming majority of the lowest two quintiles.

The ISAPREs focus on providing insurance cover for high frequency, low cost, services for high income, low health risk, groups. Their marketing efforts are aimed at these groups.⁴

This is facilitated by the compulsory earnings-related health insurance contribution. A fixed contribution level is in line with redistributive objectives of social insurance, but in the context of private personal insurance it has the effect of encouraging the exit of high earners to the ISAPREs where they are able to secure a better health insurance package. A different outcome would follow if workers were mandated to secure a minimum health insurance package regardless of cost.

The dynamics of the parallel health insurance systems show a structural zero-sum predicament. The failure by the private sector to provide health insurance cover for low-income groups, and for old-age-related and catastrophic illnesses, concentrates high health-risk groups within FONASA, reinforcing service demand pressures on the publicly funded sector. Improved provision in the public sector directly undermines the ability of the private one to attract and retain affiliates. It is therefore unlikely that, under the current framework for providing and financing healthcare in Chile, the two parallel sectors could be successful at the same time.⁵

Argentina's pre-reform healthcare system contained significant segmentation both between the insurance and non-insurance sectors as well as within them. Table 3 shows, not surprisingly, that those not covered by a health plan are predominantly the very young, and those in the lowest income quintile. Compared with the situation in Chile, coverage among the old is strong in Argentina, a measure of the success of PAMI. Affiliation to the *Obras Sociales* and private health plans is highest among those of working age and higher incomes. There is also segmentation within the *Obras Sociales* sector. Earnings-related mandatory contributions ensured the revenues of the *Obras Sociales* mirrored the earnings capacities of their respective occupational groups. In 1994 it was found that average revenue per beneficiary ranged

from under US\$5 a month in the poorest fund to over US\$80 in the richest. Not surprisingly, those *Obras Sociales* with poorer affiliates provided markedly inferior benefits than richer ones, both in terms of quality and quantity. Also, poorer funds were forced to levy higher rates of copayment.

In 1970 a mechanism was established to redistribute income from the richest funds to the poorest ones, the *Fondo de Redistribución*. Ten percent of health insurance contributions to the *Obras Sociales* were diverted to ANSSAL, who, after deducting its operation costs, managed this fund. In addition, 50% of extra health insurance contributions negotiated through collective bargaining were added to this Fund. In practice, the fund has been used to cover deficits in *Obras Sociales*, and to support client groups (Panadeiros 1996), and was criticized by the World Bank as operating according to a principle of 'reverse solidarity' (World Bank 1987). The health reforms will replace this fund with a *Fondo Solidario de Redistribución*, which will subsidize low-income workers directly.

The current reforms will do little to reduce inequalities in health insurance and provision in Argentina. Under competition, profits are maximized if higher income workers can be attracted. Of the 362 000 affiliates who changed fund during 1997, it is reported that the great majority chose small insurers, specializing in services for high-income groups (*Clarín Digital*, 8 October 1997; Bertranou 1999). It is probable that a combination of targeted marketing and the erection of indirect obstacles against less attractive groups will provide the basis of an effective cream-skimming strategy. A further development is that most new union-private hybrid providers offer affiliates a range of packages with different premia.

The unpaid use of public sector services by insured groups is still widespread in Argentina, although as hospitals have become financially autonomous there is a stronger incentive to recoup costs from insurance funds. Perversely, public hospitals may now have an incentive to treat as many insured individuals as possible, to the detriment of the rest of the population, since recovered costs are not usually deducted from their core budgets. It is clear that the reforms, as is the case in Chile, do nothing to resolve the pre-existing problems of segmentation and could well make them worse.

Healthcare expenditures and cost containment

An important question is whether the reformed health systems in Chile and Argentina will prove more effective in containing costs. In Argentina health expenditures as a proportion of GDP were 7.2% in 1995, as against a 7.9% average for the OECD countries in 1990 (Oxley and MacFarlan 1994). In Chile, reported healthcare expenditures as a proportion of GDP appear lower at 4.22% in 1996. This difference is mainly because over-the-counter pharmacy expenditures and copayments are omitted.

In Chile, where the reforms have had a longer run, private health expenditures as a proportion of GDP have risen from 0.38% in 1985, to 1.27% in 1990, and to 1.77% in 1996. By contrast, public health spending rose in the early 1990s, but

has thereafter stagnated at around 2.4%. Private health expenditures are driving the overall rise and the ISAPREs have not demonstrated effectiveness in containing costs. In part this is due to their marketing focus on low health risk groups, but also because they have not developed facilities of their own, and rely instead on a burgeoning private sector, which is reimbursed on a fee-for-service basis. These ensure that cost-containment incentives remain weak.

In Argentina, the impact of the reforms on cost containment is likely to be mixed. On the one hand, increased competition between the *Obras Sociales* would be expected to increase efficiency. By 1999 the total number of *Obras Sociales* had fallen from 320 to around 200, and most of those which disappeared had small client bases and relatively high administration costs. However, the experiences of Chile and the US prove that competition between insurers is not guaranteed to ensure cost containment, since price is rarely the prime consideration in consumer choice. The financial difficulties faced by many *Obras Sociales* have prompted them to shift away from fee-for-service to capitation payment mechanisms, which are widely viewed as more effective in controlling costs. However, most private insurers continue to use fee-for-service payments. The growth in this sector has been largely motivated by dissatisfaction with the quality of care offered by *Obras Sociales*, particularly among high-income groups. Moreover, the same factors that have reduced the effectiveness of ISAPREs in containing costs in Chile apply to Argentina. To date private insurers have displayed little interest in less affluent groups. The cheapest packages currently offered start at US\$100 a month – well beyond the means of the majority of Argentines.

Conclusion

Health reforms in Chile and Argentina have sought to expand the scope for private sector participation in health insurance and to partially replace social health insurance. In Chile, reforms in the early 1980s opened up the way for the ISAPREs to compete for affiliates with the social health insurance. In Argentina, reforms in the 1990s have created the conditions for greater competition both among *Obras Sociales* and with private health insurance providers.

In both countries, the private health insurance sector has expanded in terms of the proportion of the population covered. However, overall access to health services remains high because the public healthcare sector continues to be the provider of last resort. As regards the coverage of contingencies, in the case of private healthcare providers in both Chile and Argentina this is limited to the negotiated healthcare plans. In the *Obras Sociales* the contingencies covered, beyond a basic healthcare package, are determined by the wages of the occupational groups covered. In the case of FONASA, coverage of contingencies is determined by supply restrictions.

Health reforms have reinforced segmentation in health insurance. Mandatory payroll contributions encourage the migration of higher earning workers to private health insurers. Private insurers attract high-earning, low health-risk groups.

Social insurance and public healthcare providers cover low-income, high health-risk groups. In addition to reinforcing inequalities in access to healthcare, this segmentation limits social insurance's capacity to pool risks.

The evidence indicates that the reformed health insurance systems will not prove to be more adept at cost containment. The marketing strategy and purchaser role of private insurers reduce their effectiveness in containing health expenditures, especially as they mainly rely on private provision financed on a fee-for-service basis. The private sector accounts for a disproportionate, and rising, share of total health expenditures (around 42% for both countries in 1996).

These are not the outcomes envisaged by the reformers. Instead, improvements in coverage, equity and cost containment are more likely to be achieved by moving in the direction of health systems in which the social insurance principle, and that of individual provision, can be integrated and complement each other.

Endnotes

¹ A further incentive for private insurers to operate through *Obras Sociales* is the possibility of escaping a 22% VAT levy on *Prepagas* introduced in early 1999.

² In 1990, of those covered by FONASA, 38.8% were category A, 30.6% category B, 9.2% category C, and 9% category D.

³ The average ISAPRE copayment was estimated at 26.7% in 1994 (Fischer et al. 1998).

⁴ It is only to be expected that private insurers would attempt to discriminate low from high health-risk groups and concentrate on attracting the former.

⁵ There are also other problems arising from shortcomings in the implementation of reform. Whereas ISAPREs can collect directly from employers' payroll, FONASA has to rely on collection by the *Instituto de Normalización Provisional* (INP). There is evidence of significant under-reporting of earnings to avoid health insurance contributions. Further, as anyone can seek medical attention from public institutions as indigentes, this facilitates evasion by workers, and fraud by those insured by ISAPREs who wish to avoid claims, resulting in premium increases (Economist Intelligence Unit 1998).

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Biographies

Armando Barrientos is Principal Lecturer in Economics at the University of Hertfordshire. He has conducted research on pension and health care reforms in Latin America and Britain.

Peter Lloyd-Sherlock is Lecturer in Social Development at the University of East Anglia. Previously he held lectureships at the London School of Hygiene and Tropical Medicine and the University of Glasgow. He has a doctorate from the London School of Economics. His main areas of research interest are health financing in Latin America and the impact of population ageing.

Correspondence: Peter Lloyd-Sherlock, School of Development Studies, University of East Anglia, Norwich, Norfolk NR2 7TJ, UK.