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THE CHILEAN HEALTH CARE REFORMS: MODEL OR MYTH?[1]

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The privatization of key industries under the military rule of Augusto Pinochet amounted to a complete transformation of the Chilean economy and social landscape. In this paper, I analyze how market forces have affected the health care system. Chile's initiative, which has become known as the Chilean model, has set an example for much of Latin America. This model involved drastic spending cuts to public health care expenditures, decentralization, and privatization. While development indicators point to the system's modernization under the model, resultant inequality across income and rural and urban spheres have left many Chileans unable to afford the higher cost, higher quality private care. I define the basic conditions for the model's success and question its applicability to other national contexts, specifically in Latin America. Because of extreme income disparity in Chile (and throughout Latin America), countries considering this model of health care reform should strategically address this issue and weigh domestic forces when accessing the value of replicating this model.

INTRODUCTION

The 1981 Chilean health care reforms implemented under the military dictatorship of Augusto Pinochet amounted to a complete transformation of the public health system. As with reforms in other key industries of the economy, the privatization of the public health care system and promotion of market-oriented private health insurance plans were consistent with the

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government's comprehensive attempts to reverse the legacy of active state intervention in Chilean economic and social affairs. In the 1920s, Chile established an expansive social security system in response to the alarming social and economic inequalities that were developing because of industrialization. Over time, this system empowered certain sectors, i.e., organized urban workers, civil servants, and the military, which increasingly resisted changes to the status quo because of the social benefits they received. Statism promoted a mentality that reinforced reliance on the state for solutions rather than on the private sector or on individuals. In keeping with this mentality, Chileans rarely questioned the notion of quality health care as a fundamental right. Following the bloody coup against President Salvador Allende, Pinochet assumed power in 1973. Advised by staunch free-market economists educated at the University of Chicago, he privatized many recently nationalized and government-run industries within the Chilean economy. In the health system, this translated into significant cuts to public health expenditures, decentralization, and the creation of private health insurance funds, ISAPREs (Institutos de Salud Previsional), to augment the public health insurance plan, Fondo Nacional de Salud (FONASA).

While Chile's economic development under Pinochet was impressive, problems stemming from the country's unequal income distribution remained. With poverty a critical problem for 25 percent of the Chilean population, particularly in the country's rural regions, the disparities between rich and poor replicated themselves within the health system. The rural population remains plagued by diseases related to malnutrition and poor sanitation, while diseases and epidemics, common to developing countries, no longer affect the urban population. Because many regions lack the necessary investment incentives to attract ISAPRE funds, Chile's impoverished must rely on under-financed public hospitals that are unable to adequately address their needs.

Despite these market failures, many observers have applauded what has become known as the Chilean model. Inspired by the success of the Asian model of economic development, government leaders, along with international lenders, shared the ideological fervor necessary to transplant the model to Latin America. A cursory reading of Chile's health and development indicators presents initial evidence that the system has modernized and improved the quality of care. The centralized and authoritarian regime, the high level of expertise by medical professionals, the parallel market-based reforms in other key economic industries, the political and economic stability, and the supportive international ideological environ-

ment provided the necessary conditions for the reform's success. Yet a closer analysis reveals the confounding effect of drawing conclusions about the total population without regard to income distribution or access to quality care. Problems related to income distribution were less pronounced within the Asian model because of a lower income inequality before and after their reforms. Because of the persistent problems of inequality and the prerequisite conditions, which guaranteed the perceived success of the Chilean model, policy makers considering this model should evaluate local conditions before attempting to transplant it to other social, political, and economic environments.

This paper is divided into five sections. In the first section, I review the development of the statist government structure of Chile to provide the background for Pinochet's reforms. The second section will analyze the actual health care reforms and its processes. The third section evaluates the successes and failures of the reforms and discusses the disparities of access to care between the public and private systems and rural and urban systems. I then examine the sustainability of the reforms in a post-Pinochet Chile. The existence of a powerful government apparatus able and willing to quell all opposition seemed to figure prominently in the Chilean model. With the return of democracy, we must be able to explain why subsequent changes to the health care system established under the Pinochet government have been slow and incremental. In the final section, the applicability of the "Chilean model" is assessed. What conditions are necessary for its success? What, if any, is its usefulness for policy makers in other countries?

Evolution of Public Health Care in Chile

Chile has historically inspired a model for health care administration for other Latin American countries. During the colonial period, the state established itself as the leader of health care policy and provider of services. Events that marked the beginning of last century such as the cholera and smallpox epidemics, the development of a large semi-industrial workforce, the emergence of powerful and influential labor unions, socialist, and communist parties, and international ideological support from progressive regimes, like Bismarckian Germany, prompted the active debate and legislation of social reforms by the Chilean government. As a result, it became the first country in the Western Hemisphere to develop a public medical insurance policy for a select group of civilian workers.

The role of practitioners in public health also worked to strengthen the state's role. Trained in the United States at Johns Hopkins and Columbia

Universities, a group of Chilean physicians founded the Chilean School of Public Health as an international center for health research, planning, and training. These socially minded leaders believed that greater state involvement in health care was crucial to addressing larger issues, such poverty alleviation and the reduction of income inequality. The election of the leftist Popular Front coalition government provided the moral support and resources health leaders needed to develop and maintain their ideologically driven programs.

With the Preventive Health Law of 1938 and its later consolidation in 1968, white-collar workers from the public, financial, and manufacturing sectors established their own health program, SERMENA (Servicio Médico Nacional de Empleados). SERMENA evolved into a government administered health insurance plan that was payable to private physicians. It served approximately 20 percent of the population (Viveros-Long 1986). In 1968, SERMENA was reformed to allow its beneficiaries to apply their benefits toward partial payment of private care (primarily ambulatory care). This reform was significant as it encouraged the creation of a limited private market and promoted acceptance of public funds as payment for private services.

During the fourteen years following the 1938 law, the Chilean system remained largely a mix of private charitable institutions and public facilities. However, in 1952 Chilean legislators created the National Health Service (Servicio Nacional de Salud, SNS), modeling it after the National Health Service of Great Britain. The development of the SNS placed the financing and delivery of health care services under public control. Funded by social security contributions and other tax revenues, the system boasted wide coverage and homogenous quality of service for all income levels through a nationally organized and managed system of public hospitals and clinics engaged in preventive medicine, health education, sanitation services, and eradication of infectious diseases. Significant amounts of resources were devoted to maternal and child health, in the form of prenatal care, family planning, and maternity hospitals, in an effort to lower morbidity and infant mortality. Steady economic growth from import substitution industrialization policies in the 1960s facilitated the system's expansion by supplying the government with needed revenues. Despite a consolidation of state control of the health care system, a 1968 national income survey reported that 10 percent of the population still relied primarily on the private health sector. This sector supplied 33 percent of total outpatient care and 10 percent of all inpatient care and consumed 57 percent of total health expenditures.

Financing of the privately run practices relied on a direct fee-for-service system at market prices or through SERMENA subsidized payments (Viveros-Long 1986).

It can be argued that Chileans associated the state's increased role in health care administration and finance with their belief that access to health care was a basic human right. Not only was the state responsible for the delivery of basic services, but also for guaranteeing universal access to an acceptable minimum standard of preventive and curative care. Individuals from lower-income groups, who were unable to contribute to the national fund through taxes and worker contributions, received a government subsidy. Opposition was minimal, as the business community recognized the value of a healthier labor force in promoting higher worker productivity. In sum, the general health of the population was closely linked to national strategies of development.

Following his presidential election in 1970, Dr. Salvador Allende, a trained physician and former Minister of Health, accelerated the process toward socialized medicine by increasing fiscal spending rather than making structural changes to the system. Income redistribution, he believed, would occur through the expansion of free health care. At the time of his election, the system covered 71.9 percent of the population, but the costs of supporting this expansive system had become increasingly difficult to maintain due to growing international debt and fiscal deficit burdens.

Pinochet Reforms and The Reform Environment

Because of the popularity and widespread use of state run health care, Joseph Scarpaci persuasively argues that Pinochet delayed the privatization of the health care system until he could prove privatization's success within other, less political, sectors (1988a). Given the highly repressive and ruthless tactics with which Pinochet's authoritarian regime targeted potential opposition, his hesitation reveals the high regard the public had for state involvement in the health sector.

Pinochet was acutely aware that if he was to change Chile's path of economic development successfully, he needed to fundamentally reengineer the way people viewed the role of the state. Ideologically, the regime represented devout capitalists and anticommunists who believed the state's sole responsibility was to guard the national patrimony and not to intervene in economic production and service delivery. As such, his regime actively promoted the creation and development of a dynamic and diversified private sector within the commercial, finance and banking, transportation, housing, health care, telecommunications, and utility

industries. According to Pinochet and his economic advisors, the state had manipulated, distorted, and stunted competition by favoring public over private actors in the economy. Measures aimed at enhancing equity had weakened market mechanisms, reduced investments and profits, and therefore depressed growth. Of the 460 state enterprises in 1973, only 23 were publicly run in 1980 (Ffrench-Davis 1982). Furthermore, in his first ten years of the presidency, Pinochet reduced public employees by 25 percent (Martínez and Tironi 1982) and cut the SNS physician-to-population ratio by one-fifth (Medina and Kaempffer 1982). Specifically, the health care sector reforms followed a three-prong approach: budgetary and funding cuts, decentralization, and privatization.

Public Health Expenditures

Spending cuts translated into drastic reductions in capital investment, operational expenditure and personnel. Prior to 1973, per capita levels of GDP and public health care expenditures were highly correlated. After Pinochet assumed power, this association was reversed and available funds shifted away from working class recipients to more marginalized sectors of society. Because of the attention given to primary health care in the past, specifically maternal and child health care, and the Pinochet government's need to promote an appearance of success, the government increased expenditures to these targeted sectors of society. This helps to explain the significant drop in child mortality during his administration.

Decentralization

The 1980 decentralization of the system involved the devolution of the policy-making, executive, and financial functions to various public entities. The Ministry of Health, which took over the SNS' policy-making authority, issued central directives to the newly formed national system of 13 regional and 26 local health service divisions, which assumed administrative responsibility over medical personnel. In turn, each of these decentralized regional and local operations, or SNSS (Sistema Nacional de Servicios de Salud), were responsible for the executive functions of implementing curative and preventive services. In 1979, FONASA assumed the financial functions of collection, administration and distribution of resources of the former SNS and SERMENA.

Privatization

In 1981, the development of privately run ISAPRE insurance plans sought to provide greater incentives for private sector investments and to relieve

the high demand for underfinanced services in the public sector. Despite the private administration of these plans, funds were appropriated from private and public wage withholdings, employer contributions, monthly premiums and co-payments made at the time of service delivery.

After addressing the concerns of neoclassical government economists, military authorities, and the somewhat marginalized, yet still powerful, Chilean Medical Association2, the final legislation enacted a mixed system of health financing which is still largely intact today. FONASA insurance funds are publicly managed and allow patients to receive health services in either public or private facilities. ISAPREs serve as private prepaid health insurance plans (the largest ones under foreign management) that offer both outpatient and inpatient care on a cost-sharing basis that resemble American health-maintenance organizations (HMOs) or they are under contract with private or public providers. To support the system financially, workers are required to contribute 7 percent of their salary to FONASA or an individual ISAPRE fund. As a result of the reforms, financial responsibility shifted to the individual, and, in large part, the type of care (private or public) was determined by income.

The economic recession of the early 1980s and popular resistance complicated the use of ISAPREs. As analyzed by Joseph Scarpaci (1988a), four factors explain the slow ISAPRE growth between 1981 and 1985. First, popularly held beliefs against the application of market forces to the health care field adversely affected marketing efforts. Second, the devaluation of the Chilean peso in November 1981 was devastating to the ISAPRE funds as it doubled their debt and forced them to appeal more to higher-income patients, which compounded their exclusionary image within Chilean society. Third, the restrictive ISAPRE subscriber guidelines, especially for women of reproductive age, ran counter to Chile's extremely progressive coverage for women. Fourth, upper-income FONASA patients were eligible to receive care of equal quality as the underdeveloped ISAPRE funds through the public system at a lower cost. In 1986, the state assumed several ISAPRE costs and, as a result, saved them from bankruptcy. Because the reforms were determined outside electorate and congressional debate, the final substantive content did not have to address union, provincial, political party, or occupational group demands. Interestingly, the ISAPRE bailout and initial problems revealed the limit of the military regime's coercive power to impel public compliance and acceptance.

Examination of The Reform's Successes and Failures

Health care reform in Chile has not been without controversy. Supporters point to improved health and development indicators, increased foreign investment and private capital expenditures, and the growing support for ISAPREs as evidence of the health system's successful modernization. Opponents argue that the reforms have intensified the country's highly unequal income distribution and have overburdened the under-financed public system with the sickest and poorest sectors of society.

Health status improved following the privatization campaign. In 1970, 82.2 babies per thousand died in infancy, as compared with 17 babies in 1990. This decrease, coupled with improvements in nutrition and sanitation, increased life expectancy from 63.6 years in 1970 to 71.8 years in 1990. In terms of child mortality, David Hojman's multiple regression analysis (1989) strongly confirms that the declines in child mortality resulted primarily from a fall in the demand for children, and therefore lower birth rates, because of the increase in unemployment.

As of October 1998, the percentage of health insurance revenues as a portion of GDP was 3 percent (Harris 1998). Foreign insurance providers like Aetna International, Principal, and Cigna have rushed into the largely deregulated Chilean insurance market in hopes of receiving high investment returns, and Chileans have responded. In 1981, 62,000 Chileans were covered by ISAPREs. By 1998, nearly four million of the nation's 12 million population had enrolled in the plans.

Despite these improvements, issues of inequality plague the success of these reforms. While the 1980 Constitution established that all Chileans have the right to health protection, this right is exercised when one chooses to either contribute mandatory payroll deductions to FONASA or an individual ISAPRE plan. For those who are unable to contribute, the government will subsidize treatment in public facilities. Based on available data from the World Bank (The World Bank Group 1997) and the Interamerican Development Bank (Iglesias 1999), Latin America as a region has the most unequal distribution of income in the world, and Chile, with a GINI coefficient of 56 in 1994, had the most unequal income distribution on the continent after Brazil. Since Chilean insurance funds rely heavily on worker contributions, many are unable to benefit from ISAPRE funds given their inadequate salaries and the higher user fees charged by private health care facilities.

Unofficial estimates from the World Bank in the late 1980s stated that ISAPREs consumed approximately 70 percent of all wage and salary

withholdings yet provided health care services for fewer than 10 percent of the national population (Scarpaci 1988a). More recently, in December 1997, private health insurers covered the wealthiest 25 percent of the population and consumed annual budgets of about U.S.$1.8 billion. In contrast, the annual public health budget was approximately U.S.$1.9 billion for the remaining 75 percent of the population (Sagaris 1997). The high cost of private care is a direct result of greater competition among private insurers. Efforts to capture subscribers have forced private carriers to invest in state-of-the-art equipment and technology. Yet escalating costs have excluded a significant portion of ISAPRE members, as 24 percent of patients who are covered by ISAPREs rely on public clinics and hospitals because they cannot afford the rising costs of private treatment (Stocker, Waitzkin, and Iriart 1999). Grossly underfinanced and overburdened, public facilities have been unable to compete. The enormous resources available to the small minority of privately insured subscribers attest to the inequity in medical care financing.

In addition to the disparities that exist between the country's rich and poor, impoverished regions and localities also face critical problems stemming from lack of public funding. Chile is classified as an "intermediate status" country. This means that the health problems of underdeveloped countries, such as infectious respiratory, enteric and contagious diseases, and malnutrition, plague the rural areas. Simultaneously, the urban population, particularly in the capital, suffers from problems associated with developed countries, such as cardiovascular diseases, cancer, and accidental death. In a highly urbanized country like Chile, where 43 percent of the national population lives in the capital city of Santiago and 84.3 percent of the population lives in urban areas (Pan American Health Organization 1999), problems of limited resources and diverse patient needs complicate the priorities of the system. Because of the ISAPRE bias toward the problems facing urban centers and the lack of incentives to enter the rural markets, ISAPREs are centered predominantly in the country's urban areas, leaving the rural areas within the domain of the public system (see Table 1). In 1994, per capita revenues for health ranged from US$78.55 in Biobío to US$249.17 in Iquique (Scarpaci 1988a). The difference of resources has translated into a deterioration of care. Qualified personnel have left for higher wages and better resources elsewhere, which has forced many public clinics to rely primarily on nurse and midwife care in an attempt to cut costs (Ringeling and Herrera 1992). Indicative of these problems, caloric intake of the bottom fifth of the population fell by more than 23 percent from 1,925 to 1,474 calories per day while Pinochet was in power.

Table 1

Percentage of Rural and Urban Membership in the Private and Public Health Care Systems in Chile as Compared to Percentages of Total Population in 1990 and 1998.

	1990			1998		
System	Urban	Rural	**Total**	Urban	Rural	**Total**
Public	64.2	83.1	**67.7**	58.2	83.2	**61.9**
Armed forces	2.9	0.5	**2.5**	3.3	0.6	**3.0**
ISAPRE	17.6	3.6	**15.0**	26.3	4.2	**23.1**
Individual	12.3	10.2	**11.9**	10.9	11.2	**10.9**
Other	1.4	0.8	**1.5**	0.4	0.2	**0.3**

Source: MIDEPLAN, Encuestas CASEN 1990 and 1998

Despite the active Pinochet campaign to address primary care, infant mortality rates reveal gross inequalities among regions that civilian rule has been unable to remedy. In 1994, infant mortality in the Western Santiago Health Service, which provides services to the rural and most impoverished population, was 11.4 per 1,000 live births, as compared with 7.6 per 1,000 live births in the Eastern Metropolitan Health Service, which serves a higher-income population (Pan American Health Organization 1998). Available epidemiological information shows that communities with the largest concentrations of indigenous populations have higher infant mortality rates than the rest of the country (see Table 2).

Table 2

Average Infant Mortality Rate from 1988–1992 in Highlighted Indigenous Communites:

Indigenous community	Infant Mortality Rate (per 1,000 live births)
Aymará	40
Atacameños	57
Rapa Nui	32
Mapuche	34
National Average	**16.2**

Data source: Pan American Health Organization, 1999

The decentralization of the public health care system has also caused problems. Problems of accountability arose when the Ministry of Health transferred the administration of its primary health care budget and a significant portion of its personnel to the municipal level. Because the military government appointed local officials, the loyalties of municipal health officials lay with the central government and not with the needs of the local population that they were supposed to serve. Staff transfers created job insecurity and a deterioration of staff morale. Not surprisingly, in 1983, an independent, ministry-appointed panel found more mismanagement and inefficiency in maternity and infant care programs in decentralized facilities under municipal administration than in those that the National Health Service System operated (Scarpaci 1988a). As such, many municipalities tended to over-refer patients to hospitals that were still publicly funded. While decentralization was supposed to address the different needs and priorities of the local population, financial shortcomings, mismanagement, and inefficiency left many municipalities unable to address local health problems sufficiently.

Finally, discriminatory risk-adverse ISAPRE selection criteria have favored high-income patients with low health risk. In particular, women of reproductive age and the elderly have been systematically refused coverage because of their perceived high risk. More than 70 percent of ISAPRE patients are less than 40 years old, and only 2 percent are more than 65 years old (Bertranou 1999). In response, Alejandro Ferriero, a government official who supervises health insurance in Chile, said, "the current system of risk selection is based on economic logic, but this does not make political or social logic" (Freudenheim and Krauss 1999, 1[C]).

Sustainability of Pinochet Reforms Under Civilian Rule

While it is convenient to credit popular compliance of Pinochet's reforms to his repressive and authoritarian legacy, this analysis must address why the structure of the system remains intact after a decade of civilian democratic rule. Reforms addressing issues of regulation, financing, and inequity occurred in 1991 and 1995. As a result, ISAPREs are now more closely regulated and public health budgets have been greatly expanded. However, problems regarding risk aversion in membership criteria are still ongoing. These reforms answered opposition demands concerning social inequality. Hence, the government appeared sensitive to these concerns without having to engage in a wholesale reversion back to earlier or alternative frameworks.

Public agitation surfaced in October 1992 when physicians threatened to resign from the public sector if demands for improved working conditions and benefits were not met. In a settlement negotiated by the Colegio Médico and the Minister of Health, the government appointed a new Minister of Health. Despite this negotiated settlement, 15 percent of Chile's physicians have since left the country for jobs elsewhere. As a result, public clinics face shortages of doctors and supplies, and patients must face lengthy waiting periods for appointments and operations. However, the reason that civilian leaders have not reversed the earlier reforms lies in the population's current political apathy and its fear of affecting the massive capital investment that is supporting the private system. Benefiting from high growth rates, many people have seen a positive personal return from market-oriented policies. Those who have not shared in the system's success remain too powerless and fragmented to effect change. Moreover, since returning to civilian rule, Chileans have stunned the world in their ability to "forget" the atrocities of the past. In their efforts to display their economic prowess to potential foreign investors, Chileans have highlighted the economic progress of the Pinochet regime rather than the era's social repression. According to Cathy Schneider, in her 1993 analysis of the political situation in Chile:

> The fragmentation of opposition communities has accomplished what brute military repression could not. It has transformed Chile, both culturally and politically, from a country of active, participatory grassroots communities, to a land of disconnected, apolitical individuals. The cumulative impact of this change is such that we are unlikely to see any concerted challenge to the current ideology in the near future (30).

Those memories were "erased" because remembering them had the potential to provoke unwanted instability (Moulian 1998).

With respect to investment returns, international insurance corporations have rushed into Latin American markets, and, in particular, Chile because of its relatively diversified health industry. High profit margins and revenues within the Latin American insurance market as compared with the mature market in the United States motivate these corporations. According to the American International Group, its revenues in the region are seeing average annual growth rates of 20 percent (Freudenheim and Krauss 1999). Currently, insurance executives have stressed the market's financial rewards over concerns of preventive care and quality of care. However, goals supporting education and research, which have been historically valued by some companies in the United States, are absent in

the exportation of managed care structures (Stocker, Waitzkin, and Iriart 1999). Given the strong international financial presence and the fragmented nature of opposition movements, it is unlikely that revolutionary change seeking to reverse privatization will occur.

Meanwhile, the new president-elect, Ricardo Lagos, represents the ruling coalition Concertación de Partidos por la Democracia (PPD). Campaigning on a leftist, quasi-Socialist platform, his election may provide an outlet of expression for the largely unorganized opposition, namely the nation's poor. Health care has come to symbolize the system's inequality and may be one of his administration's first priorities. However his ability to implement extensive changes successfully within the democratic arena will be complicated by powerful opposition interests. Chile in 1999 is a markedly different country than it was in 1973, both in terms of its economic development and its political activism. The likelihood that Mr. Lagos' victory could usher in the same degree of political radicalization as the Allende regime is highly unlikely (Weyland 1999).

Conclusion: Is There A Chilean Model Worth Replicating?

Other countries in Latin America, namely, Peru, Colombia, Argentina, and to a lesser extent, Brazil and Mexico, have recently attempted to replicate the Chilean model of health care reform in their respective countries. As the first Latin American country to institute comprehensive market-oriented strategies, Chile provides a useful case to assess and evaluate the costs and benefits of the neoliberal model of health reform and how the policies have affected economic and political stability, growth, development, and social equity. Observing the problems of inequality and discriminatory selection criteria, Latin American countries are trying to learn from Chile's mistakes. Concerns over the applicability of the model, therefore, have emerged.

At its most basic level, the health care reforms under the Pinochet government depended on the following five prerequisites:

1. A centralized leader able to prevent potential opposition/stakeholders from influencing the policy debate with their demands;

2. A high level of expertise and medical education by health care practitioners;

3. Privatization of key industries outside of the health care field;

4. Political and economic stability; and,

5. An international environment conducive to neoliberal reforms.

Because policy-making power was highly centralized under Pinochet, his policy goals and strategies did not reflect concessionary adjustments that addressed opposition demands within and outside of the policy-making arena. First, centralized presidential power within the government facilitated a top-down command structure that solidified Pinochet's power. Second, the repressive tactics used by the military apparatus succeeded in fragmenting and intimidating organized opposition and therefore alienated them from the policy making process. In comparison, strong unionized labor opposition in Argentina has blocked attempts at increasing competition and has limited the participation of private insurance funds (Bertranou 1999). Reform can adversely affect powerful sector interests, as was the case among Chile's working classes, therefore successful implementation of neoliberal reforms, to the extent they were applied in Chile, mandate that the government control powerful actors.

Second, if the health care sector is to improve quality of care and delivery of services, there must be a minimum level of expertise among medical practitioners. Owing in large part to its historic organization, the powerful Colegio Médico had successfully improved quality of education within Chilean medical schools. Since the return to civilian rule, the formation of CLAISS (Centro Latinoamerica de Investigaciones en Sistemas de Salud), an independent market oriented health care think tank engaged in the study and analysis of health systems in Latin America, has improved health management, financing, and public health research (Latin American Center for Health System Research 1999). In terms of patient perception of the system, the influence of this factor gains enhanced importance (Scarpaci 1988b). Of particular interest is the 1984 Villa O'Higgins study, which indicated that patients distinguish between care they received from individual doctors and care from administrative procedures. The endemic problems of long waiting lines (often averaging more than four hours) conflicts with ancillary personnel, and a lack of resources are compensated by the widespread perception of good physician treatment. This study showed the importance of qualified physicians in the patient's perception of medical quality. Social infrastructure permitted a high degree of confidence both within the country and internationally to lenders and foreign investors.

Third, decentralization and privatization of the health care industry was part of a larger development strategy that affected the entire Chilean economy. It was reasoned that market forces would correct previous inefficiencies and eradicate the psychological dependence citizens had felt on the state. Pinochet was aware that these goals would not be realized unless the country's long and significant legacy of health and social security as a basic right was reversed. Administrative success required that similar and consistent structures existed across the socioeconomic landscape.

Fourth, political and economic stability reduces potential interference by unforeseen forces during implementation. Under conditions of stability, policy makers can specifically target how best to attract capital investment. When reforms seek to transform the system fundamentally, as Pinochet's did, key variables must be held constant to avoid becoming counterproductive. In the case of Chile, foreign capital was crucial to Pinochet's reform formula. Prior development strategies had stunted indigenous growth of the Chilean private sector. Because the public sector had historically dominated the Chilean economy, private capital, particularly from foreign investment, needed to realize the potential of private markets. This hypothesis is consistent with the fact that popular participation and foreign direct investment within the private health system prospered after the economic recession of the early 1980s had ended. If the private sector were to become dynamic and superior to the historically dominant public sector, private capital was needed.

Fifth, the ideology of international donor and lending agencies was highly conducive to the Pinochet reforms. Promotion of privatization (and/or private management of health care and social security frameworks) and decentralization complemented International Monetary Fund (IMF) and World Bank policies that advocated that health care was a private matter. Regardless of their shared interests, Pinochet was unable to secure significant foreign aid during most of his rule because most countries found it increasingly difficult to justify their support in light of Chile's atrocious human rights record. Without the benefit of aid, domestic interest groups understood the futility of petitioning money from the government and began their transformation toward self-help (Codevilla 1993). Meanwhile, the government diligently worked to promote incentives for the private sector to account for losses in aid and loan revenue. In 1990, the desperate problems associated with ten years of underfinancing became the burden of civilian president Patricio Aylwin. Encouraged by the smooth transition of power and the perceived success

of the "Chilean miracle", international aid agencies and lenders generously granted the new government badly needed financing. In addition to a $200 million World Bank loan to cover capital costs within the public health sector in 1991, foreign assistance also came from France, the United States, Italy, Germany, and Japan (Reichard 1996).

Given these five factors, policy makers should weigh domestic conditions carefully before attempting to export the Chilean neoliberal development strategies in the health care field to other Latin American countries. In theory, privatization seeks to promote greater efficiency and better management. Policy makers seek to utilize foreign capital and expertise to develop high quality local health care systems for their populations. Yet in the case of Chile, extreme income inequality denies high quality care to a large portion of the population who cannot afford the high user fees of private insurance companies. Inspired predominantly by ideological tenets, the reforms clearly modernized the private health care system, yet they failed in their inability to address issues of inequality. As a result, the Chilean model should not be exported to the rest of Latin America unless insightful adjustments can first be made that specifically address income inequality.

The future of the private health care sector in Chile relies heavily on the behavior of international investors. Strides toward regulation have taken place during civilian rule, but future governments should aim to strengthen these laws within the boundaries that these laws continue to promote international investment. As long as the organization of the health care system seems unlikely to change, these laws and boundaries need to be discussed openly among key actors and reflect a democratic sentiment that was absent earlier.

Notes

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2 In 1979, the military government enacted Law Decree 3601, which reduced the legal status of the professional society to a voluntary association. In doing so, it stripped the organization of its former ability to participate in medical policy matters, such as fiscal allocations, fee schedules for ambulatory and hospital care, and administrative concerns (Scarpaci 1988b, 42). The elimination of mandatory physician membership in the society has had ethical consequences. An estimated 20-30 percent of practicing physicians are not members and are

therefore outside of the association's regulatory control (Pan American Health Organization 1998).

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