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Social protection in Chile: Reforms to improve equity

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Abstract. *At the beginning of the 1980s, Chile pioneered the implementation in Latin America of structural reforms that fully or partially privatized pensions, health-care and social assistance systems. Implemented without prior social dialogue, these reforms – which subsequently influenced similar reforms in other countries of the region and elsewhere – led to reduced social solidarity and equity and intensified poverty and inequality. Over the past 18 years, however, democratic governments have corrected many design faults in the original reforms. The author examines the progress achieved and areas of persistent social inequality in terms of coverage, gender balance and funding, and identifies future challenges.*

In 1990, when democracy was re-established in Chile, the country had the best economic performance and the freest market economy in the region. However, a very high social cost had been paid during 17 years of military rule and, with their civil and political rights curtailed, workers and lower-income groups experienced worse poverty and greater inequality. The positive economic performance and fiscal stability, together with legal and political restrictions imposed on the return to democracy, led the "Concertation" (an alliance of the two leading political parties) to retain the previous pension model while making adjustments aimed at relieving poverty and improving social services – though not substantially reducing inequality (Mesa-Lago, 2000 and 2004).

Poverty[1] rose from 17 to 57 per cent between 1970 and 1976, then fell to 48 per cent in 1980 and to 39 per cent in 1990 (though this was still twice as high

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[1] In Chile, the "national poverty line" is equal to two basic baskets of goods, i.e. some 43,000 pesos per month per person in 2006 (about US$80); and the "national extreme poverty line" is the minimum income needed to obtain one food basket per person per month.

as prior to the military coup). Under democratic rule, the poverty rate fell further, reaching 13.7 per cent by 2006, which was lower than in 1970 and the lowest rate in the region. As to inequality, though the Gini coefficient[2] figures are not reliable before 1973, estimates for subsequent years under the military regime suggest a marked increase – to 0.554 in 1990 and still at 0.549 in 2006, similar to the figures for seven much less developed countries in the region (ECLAC, 1997–2007a).[3] The Human Development Index (estimated by the UNDP) ranks all the countries in the world, according greater weight to two social indicators (education and health) than to one economic indicator (GDP per capita). Chile was ranked fourth in the region in 1992, but by 2002–05 it had risen to second rank (40th world ranking), notably through increases in the economic indicator, but also through improvements in the social indicators (UNDP, 1993–2007/08).

The Chilean model's viability was high, but to maintain it and increase it, there needed to be greater equity and solidarity and less inequality, through reforms in health care, pensions and social assistance.

The large-scale Latinobarómetro survey of 2003 included two questions on respondents' perceptions of solidarity towards their co-nationals, and the replies showed that Chileans rated highest on feelings of solidarity (77 per cent, against a regional average of 54 per cent), but second lowest on readiness to sacrifice personal interests for the good of the country (only 1 per cent, against a regional average of 61 per cent). The countries displaying the greatest solidarity were those with vigorous social policy institutions and anti-poverty programmes (ECLAC, 2007b).

This article examines the social inequalities that existed in Chile, and the improvements achieved under a democratic regime through social dialogue and reforms in the health-care, pension and social-assistance systems. As Chile pioneered structural reforms in these areas from the early 1980s, it is important for other countries in Latin America, as well as other developing countries, to be informed of the adjustments made to the Chilean model over the past 18 years. In conclusion, the article sets out what has been achieved and the challenges that lie ahead.

Reform of the health-care system

The health-care reform introduced by the Government of Augusto Pinochet (without any prior public debate) created a dual system.

The public component of the system consists of the *Fondo Nacional de Salud* (FONASA – national health-care fund), the *Sistema Nacional de Servicios de Salud* (SNSS – national health services system), which provides the second

[2] A measure ranging between 0 and 1, where 0 represents absolute equality and 1 absolute inequality.

[3] Incomes of the richest quintile in the population were 13 times higher than those of the poorest quintile in 2006, but social expenditure reduced this differential to 6.8 (Consejo Asesor Presidencial de Trabajo y Equidad, 2008, p. 7).

and third levels of services, and the communes (local municipalities), which provide for primary health care. The armed forces have their own health schemes.

The private component of the system consists mainly of the *Instituciones de Salud Previsional* (ISAPREs, private health-insurance institutions), which collect contributions and co-payments[4] from their members and also run their own health services or subcontract them from independent private providers and public hospitals. No supervisory body existed for this system until the 1990s, but with the return of a democratic regime, a wide-ranging public debate took place, which led to a series of reforms implemented between 1991 and 2005 (see Mesa-Lago, 2005 and 2008, which are the sources for this part of the article).

In theory, every Chilean is free to choose between the public and the private health-care providers. In practice, however, upper- and upper-middle-income groups are affiliated to the ISAPREs because they can afford the co-payments, because they are not excluded for exposure to high risks, and because they are basically city-dwellers (there is no private provision in certain rural areas). Thus, the poor or those with inadequate incomes, exposed to high risks or living in certain rural areas do not really have a choice, and are affiliated to the national health-care fund (FONASA).

Inequality of coverage and access

The proportion of the population covered by the various health-care insurance schemes fell from 71 per cent in 1973 to 62 per cent in 1980, one year prior to the reform. During the 1984–2006 period, FONASA coverage fell from 83 to 59 per cent, but then rose to 70 per cent; coverage by the ISAPREs jumped from 3 to 26 per cent and then fell to 16 per cent; and coverage by the "others" category (the armed forces' scheme, private insurers and the non-affiliated) fluctuated around 14–15 per cent (FONASA, 2007). In 2006, 5.1 per cent of the population were unaffiliated, but only 0.5 per cent of the people in this group were genuinely poor and likely to be suffering from inadequate coverage, while the great majority of them bought private health insurance or services directly (based on the CASEN survey, 2007).

Although coverage is near-universal, there is significant inequality with regard to income, employment status, region, ethnic origin, access and gender; these aspects of inequality are more marked in the private system than in the public system, and various adjustments and improvements have been made under successive democratic governments. In 2006, 92 per cent of the poorest quintile and 89 per cent of the second poorest quintile were covered by FONASA, whereas 44 per cent of the richest quintile was covered by the ISAPREs. The share of FONASA members decreased in proportion to rising incomes, and the opposite was the case with ISAPRE members, holders of private insurance, and members of the armed forces' scheme. In all quintiles

[4] A system whereby the member must pay towards part of the health plan and/or of specific benefits granted by a provider.

(including the richest), coverage by the private system went down as age and health risks went up (owing to the increasing co-payments charged to older persons by the ISAPREs), whereas coverage by the public system increased (based on the CASEN survey, 2007).

Regarding employment status, although self-employed workers represent 20 per cent of the economically active, they represent only 9 per cent of all directly insured persons in the ISAPREs, most of whom are high-earning professionals. By contrast, 21 per cent of all directly insured persons in FONASA are self-employed and, as the poor and low-income workers can affiliate and get free or subsidized health care, 75 per cent of the self-employed are covered by the public system (based on the CASEN survey, 2007).

Coverage by FONASA varied across regions: 54 per cent in Antofagasta and 78 per cent in Maule in 2002; 58 per cent of persons insured with the ISAPREs lived in metropolitan areas though only 36 per cent of the population lived there (Superintendencia de Salud, 2007a). In contrast to the situation in other countries of the region, Chile's indigenous population represented only 6.6 per cent of the total population in 2000, but was largely to be found in the three regions that had higher rates of poverty and infant mortality, and a lower life expectancy than that of the non-indigenous population. Thus, 80 per cent of the indigenous population was covered by FONASA and 47 per cent of them were extremely poor. There were marked socio-economic disparities at local government level (in education, housing, drinking water supply, sanitation), with adverse effects on mortality and other health indicators; people used primary health three times as much in certain communes than in others, and emergency care four times as much.

Persons who had money enjoyed timely access to services, but the poor or those on low incomes had to wait a long time for care. In 2000, of those in the poorest quintile who fell ill or had an accident, 15 per cent received no medical attention because they had no money. The ISAPREs could restrict access to care by, for example, fixing periods during which there is no right to benefits or only up to a level of care lower than has been established; waiting or exclusionary periods for pre-existing illnesses or pregnancy; no coverage for certain pathologies or catastrophic events. Persons affiliated to FONASA are not subject to limitations, deductions, exclusion or periods of non-entitlement. However, in some settlements in the north and some very rural areas in the south, geographical, climatic and transport conditions impede access to emergency care and appropriate medium-level care, with long waiting lists at public hospitals or for complex medical procedures.

Gender inequality

In 2002, two-thirds of the persons affiliated to the ISAPREs were men, whereas the gender gap at FONASA was much smaller: 57 per cent of contributors were men and 43 per cent women; and in terms of the total number of beneficiaries (directly insured persons plus dependants), the gender gap closed altogether

(FONASA, 2007).[5] The discrimination against women could partly be attributed to external factors: a female labour force participation rate of 39 per cent (versus 73 per cent for men); a female wage amounting to one-third of the male wage; 45 per cent of economically active women working in the informal economy; and women's health care covered largely through their dependence on an insured man.

The gender gap was also due to significant inequality in the private sector. The cost of ISAPRE health plans had a discriminatory effect on women because of the greater risk factor associated with them – up to twice as high as that of men. In one ISAPRE, for example, for full maternity coverage a woman of reproductive age was charged a premium between 1.9 and 3.4 times higher than that charged to a man in the same age group (20 to 40 years); the cost of maternity coverage was met entirely by the woman but, even in health plans that excluded the maternity costs, the premium charged to women was higher than that charged to men of the same age.[6] For this reason, the vast majority of women of reproductive age are covered by FONASA, which grants subsidies to the ISAPREs for this purpose; moreover, at the annual renewal of an ISAPRE contract, the premium could be adjusted to take into account the woman's age and the number of her dependants. Up to 2002, the ISAPREs assumed maternity-leave costs and received a state subsidy of 2 per cent of taxable income despite their discriminatory practices.

Inequality in funding

Unequal funding and a lack of solidarity have long been problems in the Chilean health-care system. The ISAPREs engage in adverse selection, or "creaming-off" practices – i.e. they turn down persons at higher risk who are less profitable, and concentrate on persons at lower risk and with higher incomes – and they charge co-payments to insured persons, thus securing a significant part of available resources. The public sector takes charge of the groups involving higher risks and costs, and with lower incomes (therefore less profitable), and thus secures fewer available resources. In 2000, 20 per cent of the population was affiliated to ISAPREs but accounted for 43 per cent of total health costs, while 66 per cent of the population was affiliated to FONASA and accounted for 57 per cent of total costs, i.e. proportionately half of the costs accounted for by ISAPREs.

The reforms set a uniform contribution rate for workers, and increased it from 4 per cent of wages in 1981 to 7 per cent as from 1986 (the same percentage

[5] The differences between the schemes have since narrowed. According to figures for 2006, the male and female shares are, respectively, 61 and 39 per cent in the ISAPRE system, 60 and 40 per cent in FONASA, and 74 and 26 per cent in the private schemes. As regards total membership (directly insured persons plus dependants), the male/female ratios are 52/48 for ISAPRE; 47/53 for FONASA; and 60/40 for private schemes (based on the CASEN survey, 2007).

[6] Information provided to the author by Silvia Leiva Parra (Santiago de Chile), on 3 July 2008.

being deducted from pensions as from the time of retirement); a regressive wage ceiling on contributions was imposed; the employer's contribution was abolished, and the armed forces' scheme received generous tax subsidies. The medium- and high-income groups paid their 7-per-cent contribution to the ISAPREs with the result that FONASA lost its main contributory support while nevertheless having to take care of the elderly, women of reproductive age, the poor and low-income groups, all of whom suffer higher rates of illness. Contributions (to health care and pensions) to the public and the private systems were exempted from income tax, while co-payments to the ISAPREs were exempt from value-added tax (VAT), which favours higher-income groups. The administrative costs of the ISAPREs are, however, very high owing to their heavy marketing expenditure and the profits they make. A free-rider group, classified as poor (though it is not), receives free medical care through FONASA, while another group – though affiliated to the ISAPREs – is also cared for in FONASA (especially for emergencies, accidents, maternity, and serious illnesses identified as particularly costly to cure) because public services are easier to access and cost less than those provided by the private sector; both of these groups and the ISAPREs receive regressive tax subsidies. The ISAPREs increased the co-payments each year (there was no legal limit) in line with the degree of risk, and excluded or created barriers to patients who incurred heavier costs (the elderly, chronically or terminally ill patients, pregnant women), who were then obliged to seek medical attention in the public sector, thus increasing the latter's costs.

In 2006, only 5 per cent of persons aged over 60 were affiliated to the ISAPREs, whereas FONASA covered 90 per cent of them, of whom 72 per cent were poor or on low incomes. Incomes fall with the onset of retirement while health-care costs go up, which is why the ISAPREs increased the premiums due from retired affiliates and why many of them changed over to the FONASA. A man aged 60–65, belonging to an ISAPRE, for example, contributed nearly three times the amount contributed by a man aged 18–44; and a man aged over 75 contributed 5.5 times more.[7] Until 1996 there was a tax exemption on the employer's contribution of 2 per cent of the wages of their employees whose contribution was too low to affiliate to an ISAPRE, but the employer's contribution ended when the worker retired.

Even before 1998, there was one equity-promoting factor, which has been consolidated and expanded with the return to democracy. The FONASA provides free coverage to the poor and grants subsidies in inverse proportion to the remaining members' capacity to pay, according to the following four income groups (allowance is also made for family members dependent on the insured member):

[7] Information provided to the author by Silvia Leiva Parra (Santiago de Chile) on 3 July 2008. Though the elderly are at greater risk of illness, they do not receive any compensation for sickness leave (because they do not work), but this fact is not considered as relevant in calculating contributions.

(A) the poor who do not contribute and have access only to the free public health service;

(B) those whose income is lower than the minimum wage, who contribute and who receive free public health care;

(C) those whose income amounts to between 1 and 1.45 times the minimum wage, who must pay contributions plus a 10-per-cent co-payment in order to receive public health care;

(D) those whose income is above 1.45 times the minimum wage, who must pay contributions plus a 20-per-cent co-payment to receive public health care.[8]

The first two groups (who include indigenous populations) receive benefits worth a great deal more than their contributions, and the reverse occurs for the second two groups, so that transfers from the latter to the former have a progressive effect and thus improve equity. FONASA members receive the same benefits regardless of their income, contributions and risk factor; FONASA therefore redistributes resources from better-off members to those on lower incomes, and from the healthy to the sick.

The impact of health-care reforms on social equity

Successive democratic governments greatly increased public expenditure on health care, especially on infrastructure and capital equipment items. With the 1995 reform came a strengthened monitoring and supervisory function and measures to prevent fraudulent claims, and the Superintendency of the ISAPREs was established. This authority was charged with monitoring compliance with contractual regulations and regulating any exemptions therefrom; establishing a price index and maximum rates for the plans covering elderly persons and pregnant women; regulating medical treatment of pre-existing illnesses; standardizing information to enable comparison of the various health-care plans (of which there were 40,586 in 2006); and mediating conflicts between the ISAPREs and their members. In 1996, the tax exemption on the employers' contribution of 2 per cent of wages (intended to encourage affiliation to the ISAPREs) was abolished. Between 1995 and 2005, public expenditure on health care increased nearly four-fold in constant Chilean pesos; the share of this expenditure funded through taxation increased five-fold, and the amount of benefits per insured person went up by 66 per cent. Given that FONASA's contributions base is made up of relatively low wages, this proved insufficient to fund services, and for this reason the state contribution grew from 41 to 55 per cent over the 1990–2004 period, and the proportion of costs covered by contributions fell from 45 to 34 per cent. On average, the combined contribution and co-payment to the ISAPREs was 3.5 times higher than the average contribution to

[8] The figures for directly insured persons in 2006 broke down as follows: 30 per cent in group A, 35 per cent in group B, 20 per cent in group C, and 15 per cent in group D (CASEN survey, 2007).

the FONASA; however, if the state contribution was taken into account as well, this gap was reduced to 1.4 times. In 2006, 61 per cent of FONASA affiliates paid no contributions, i.e. 100 per cent of group A and 40 per cent of group B (FONASA, 2007).

In 2002 President Ricardo Lagos announced that a solution had to be found to the profound inequality in health-care provision in Chile, owing to the heavy financial burden then on all families and the gaping inequality in the speed and quality of health-care delivery (Chile, 2002). Two reform proposals worked out in 2002–04 were not accepted because of opposition from the conservative political parties, the ISAPREs and the Association of Physicians. The proposals aimed to establish a state solidarity fund to finance fully the "extreme-poor" contribution to the national fund (FONASA) – thus avoiding that access to and costs of health insurance should depend on a person's financial capacity and risk factor – and to create a fund to finance maternity leave under both systems (which would have been funded by a deduction of 0.6 points from the 7-per-cent contribution, as well as co-payments by middle- and higher-income groups and an increase in VAT). In 2002, the State assumed the costs of maternity leave,[9] regardless of the insurer and of the insured person's income level, thus removing the discrimination previously practised by the ISAPREs and abolishing the subsidies they used to receive. However, the maternity leave benefit is regressive as it is paid for by the public purse but consists of an amount proportional to the wage received: half the population receives 80 per cent of the expenditure, financed through taxes, many of them on consumption, which is a burden on the whole population.

Laws Nos. 19.937, 19.949 and 19.966, passed in 2004, reduced inequality further (Chile, 2004a, 2004b, 2004c). They strengthened the authority of the Ministry of Health and established the Superintendency of Health (which absorbed the ISAPREs superintendency) in order to streamline and reinforce control and supervision of the whole system. Measures taken to improve access to health services included free inoculation against influenza, free telephone calls to arrange appointments for primary health care and the new emergency services, shorter waiting lists in hospitals and short-stay centres, loans for health care, improved care for the poor and low-income groups, and subsidies to the poor to help them pay for water consumption and sanitation. The FONASA grants help on a "capitation index" based on a poverty measure favouring the poorest communes and helping to reduce inequality in health-care provision and pensions. Although some of these benefits did exist before (FONASA's A group received a partial subsidy for drinking water), the Chile Solidario scheme – first conceived in 2002, then set up by Law No. 19.949 (Chile, 2004b) and ex-

[9] Provision for maternity leave is six weeks of rest before the birth and 12 weeks after, on full pay; the woman's job is kept for her and she cannot be dismissed during the following 12 months (Biblioteca del Congreso, 2008).

tended in 2006 – is a multi-dimensional concept, focusing on extreme poverty,[10] which has introduced the following major innovations:

- Integration of cash transfers with service provision: guaranteed access for FONASA's A group, non-contributory pensions, education, larger subsidies for drinking water (which cover 100 per cent of consumption up to 15 cubic metres), etc.
- Checking means of subsistence (proof of income) using multiple indicators and voluntary participation by households, but conditional on registration with a scheme such as a health-care plan.
- Information on the right to public health care and access to 53 entitlements (health care, education, housing, employment, incomes) on leaving the scheme.
- Consolidation of the scheme's administration and budget within the Ministry of Planning.

In 2006, some 290,123 families and nearly one million persons benefited from the Chile Solidario scheme, and the aim is to abolish extreme poverty by 2010 (see Pérez, 2006; Chile Solidario, 2008; Ministry of Planning, 2008; and Barrientos and Santibáñez, forthcoming).

This new model encourages early diagnosis of certain illnesses and has equipped primary health care to deal with many emergency situations: the share of public health expenditure allocated to primary care increased from 12 to 21.4 per cent over the 1995–2005 period. Improvements in equality have been achieved by abolishing public-sector subsidies to the private sector and better monitoring of ISAPRE affiliates who use the public health services. Two new key entities are the so-called Universal Access to Health Care (AUGE – *Acceso Universal con Garantías Explícitas*) and the Solidarity Compensation Fund *(Fondo de Compensación Solidario)*, which are described below.

President Lagos stated in 2002 that "simply declaring the right to health care is not sufficient to preserve that right, rather it is necessary to establish explicit guarantees regarding access, opportunity, quality and financial protection […] every person residing within the territory, regardless of age, sex, educational level, ethnic origin, or income level must be able to have universal access to appropriate and timely health care" (Chile, 2002, pp. 3–4). The AUGE is a pioneering, comprehensive and guaranteed health-care plan. Set up by Law No. 19.966 (Chile, 2004c) and established in 2004–05, it provides all members of the FONASA and the ISAPRE system with a range of quality benefits (including maternity care). The AUGE plan is gradually being expanded to cover all high-mortality and handicapping pathologies (56 of them in 2007), regardless of the income level, age, sex and risk factor of the person insured. Furthermore, it

[10] Beneficiaries present worse indicators than the national average in a number of respects: older heads of families, women without any social protection, illiteracy; unemployment, work in agriculture or the informal economy; reduced access to the public network providing drinking water, and lack of social security and family allowances coverage.

establishes a maximum waiting period for the different health-care services and has improved the definition of "pre-existing illness". It is free to the poor and to older adults affiliated to the public system, whatever socio-economic group they belong to; the Superintendency sets a universal community premium (the same for everyone and fixed for three years) linked to the average annual cost of the scheme, and sets the maximum co-payments for affiliates of both schemes, with ceilings fixed according to family income. Users are entitled to demand payment of the guaranteed services from both the FONASA and the ISAPREs and to appeal to the Superintendency, which may impose fines, suspension or other sanctions on those who break the law. National opinion polls on the AUGE plan report that 50 per cent of respondents feel very protected or protected, 29 per cent have no feelings one way or the other, and 21 per cent feel unprotected or very unprotected; 51 per cent declare themselves highly satisfied, 38 per cent fairly satisfied and 7 per cent not satisfied; 72 per cent think that the AUGE plan guarantees access to health care, 58 per cent that it guarantees quality services, 56 per cent rapid service delivery, and 48 per cent financial protection (Superintendencia de Salud, 2007b).

The Solidarity Compensation Fund between the ISAPREs reduces discrimination over risks. All persons insured with an "open" ISAPRE[11] contribute to the Fund on an equal basis, yet their benefits are calculated according to their expected health costs: women of reproductive age and older persons thus benefit from contributions made by young men. This compensates the open ISAPREs for the difference between the universal premium and the risk-adjusted premium. The Superintendency fixes the amount of compensation due to each ISAPRE, which will allow its health risks to be standardized in the future; it also regulates rises in premiums, setting a ceiling on the annual readjustment determined within a price band. As a result of all these measures, ISAPRE profits fell from 7.7 to 4.3 per cent of income in 2006, although administrative costs per beneficiary were still twice those of the FONASA (Superintendencia de Salud, 2007a).

The pension reform of 2008 (Chile, 2008) requires the self-employed to affiliate to the health-care system as from 2016 and exempts the poor in receipt of a non-contributory pension from paying the 7 per cent contribution (for details of the effect of the pension reform on social equity, see below).

Neither beneficiaries nor workers participate in any active way in the administration of the Superintendency, the FONASA, the ISAPREs or the National Health Services System. Communes are expected to prepare an analysis and proposals, and a health-care plan, in consultation with the public, but in most of the country there is no local capacity to support such public participation because there are no consumer groups or citizens' health promotion

[11] These insurance companies are termed "open" in order to distinguish them from "closed" insurance companies that are tied to an enterprise or group of enterprises. In 2006 there were ten open ISAPREs and five closed ones, which are exempted from the Solidarity Compensation Fund, provided that most of their members are wage-earners (based on a 2007 Resolution).

groups. There are community representatives on the development councils of hospitals and clinics, but these bodies only have consultative status, and their decisions are not binding. Laws Nos. 19.937 and 19.966 (Chile, 2004a and 2004c) set up four channels for public consultation, one of them including a form of representation, namely, consumers' consultative councils, which are composed of five delegates from the local community and two from among the employees of the facility.

Social inequality and reforms of the pension and social assistance systems

The 1980 reform (which was also carried out without any public debate) closed down the public pay-as-you-go pensions system to new entrants, with its defined benefits and public administration, and replaced it with a private, fully funded individual system, with defined contributions, run by the new pension fund management companies (*Administradoras de Fondos de Pensiones* – AFPs), which are private, for-profit entities focusing exclusively on that activity. A short transition period was granted to allow insured persons at the time of the reform to decide whether to stay in the public system – unified under the control of the Institute of Social Security Standardization *(Instituto de Normalización Previsional)* – or move over to the new, private system; however all new entrants to the labour force were obliged to affiliate to an AFP. By 2006, 91 per cent of all insured persons were affiliated to the private system and only 9 per cent remained in the public system (CASEN survey, 2007). Thus, only a tiny part of the working population contributes to the Institute for Social Security Standardization, although the latter still pays most pensions, giving rise to an operational deficit that, together with other transition costs, was equivalent to 5 per cent of GDP in 2006 (Arenas de Mesa and Mesa-Lago, 2006). The Superintendency of AFPs regulated and supervised the private system until 2008, but various regulatory and supervisory functions were assigned to other entities. The private system was and still is devoid of solidarity, since minimum pensions and non-contributory pensions are partly and entirely financed by the State, respectively. The armed forces which implemented the reform actually excluded themselves from it, and have a separate scheme with better pensions, mostly financed by the public purse. Though changes were made to the private system, they were not substantial. AFPs wield considerable power because they managed pension funds worth 64 per cent of GDP in 2007 (AIOS, 2007), and succeeded in postponing any fundamental reform for 27 years.

The preceding paragraphs refer to contributory schemes, but even before the reform a non-contributory "social assistance" scheme (PASIS) was in operation, providing old-age and invalidity pensions to persons with no means of livelihood or pension provision, who met regularly updated eligibility requirements. Although these pensions depended on the availability of state funds and were subject to waiting lists, it is well established that non-contributory pensions are very effective at reducing poverty. One of the design failings of the private

system is that some insured persons do not meet the eligibility criteria for receiving either a minimum pension (because they have not contributed for the required 20 years) or a non-contributory pension (because they do not meet the income requirements), with the result that they remain unprotected.

Inequality of coverage

Coverage of the labour force (based on the number of labour force participants contributing to all the pension schemes) stood at 73 per cent in 1973 (the year of the military coup), fell to 64 per cent in 1980 (before the reform) and reached a low of 29 per cent in 1982; thereafter it rose, reaching 57 per cent in 1997 and stabilizing at that level until 2004 (Mesa-Lago, 2008). Based on household surveys, coverage was 58 per cent in 2003 and had reached 61 per cent in 2006 (CASEN survey, 2007). In the private system (the AFPs), there is a marked difference between coverage calculated on the basis of membership (registered members) and coverage calculated on the basis of contributors (members who had paid their dues the previous month). According to the first method, coverage of the economically active population was 113.6 per cent at the end of 2007[12] and, according to the second method, it was around 61 per cent; only about 46 per cent of members were active contributors (AIOS, 2007; Superintendencia de AFP, 2008). Over the period 1992–2003, around 76 per cent of the population aged 65 and over was covered by some form of pension scheme, though coverage by the contributory schemes declined, while that of the non-contributory (social assistance) scheme increased; coverage by the contributory schemes was projected to decline from 65 to 50 per cent between 2006 and 2020 (Chile, 2006, p. 6).

There is unequal coverage of the labour force in terms of incomes, education, employment status and sex. Coverage under the private system increases with each income quintile and level of educational attainment. Non-contributing members had the following characteristics in 2004: 66 per cent had very low incomes, 46 per cent were poor, 52 per cent had a very low level of education, and 75 per cent had not worked during the preceding three years. Persons who were not affiliated gave the following reasons for not having done so: membership not mandatory, lack of income, no knowledge of the scheme, lack of work, unstable employment situation, distrust of the private system, being a housewife, and considering the system very expensive (EPS, 2006).

In 2005, self-employment accounted for some 15 per cent of the urban economically active and 32 per cent of the rural economically active. Their participation in the pensions system is voluntary and, despite 27 years of reform,

[12] This statistical impossibility is due to the fact that there are members who registered then left the labour force, or went from the formal to the informal sector, or retired but continued working and occasionally contributed.

only a small percentage of the self-employed are affiliated and contribute, mainly professionals on relatively high incomes.[13] At the end of 2007, 96.6 per cent of AFP members were in wage employment and only 3.4 per cent were self-employed. The corresponding figures for contributing members were 98.3 and 1.7 per cent, respectively (Superintendencia de AFP, 2008).[14] Between 1986 and 2004, the proportion of self-employed members who did not contribute increased by 80 per cent. On average, self-employed members have less schooling, are older and have less social protection than do workers in wage employment; those who have always been self-employed display a much lower "contribution density" (the portion of their working lives during which they pay contributions) than do workers in wage employment (EPS, 2004; Bertranou and Vázquez, 2006). The main reasons they give for not being affiliated are: because it is not mandatory (37 per cent), lack of money (24 per cent) and lack of knowledge about the system (11 per cent). Regarding old-age pensions, the proportion of the self-employed working at subsistence level who expected to obtain a pension or had some savings or some security was much lower than amongst self-employed professionals and technicians and amongst workers in wage employment; the vast majority hoped to receive state or family aid and had not thought about the future (Subsecretaría de Previsión Social, 2008). The few countries in the region with laws requiring the self-employed to join a pension scheme have better and more effective coverage (Argentina, Brazil, Costa Rica and Uruguay, though not Colombia), especially where low-income workers receive state aid (Mesa-Lago, 2008).

At the end of 2007, 55 per cent of affiliates in the private system were men and 45 per cent women (the highest proportion in Latin America), but the corresponding levels for contributing members were 62 and 38 per cent, respectively (Superintendencia de AFP, 2008). In 2006, 63 per cent of women were not affiliated, whereas the general average for the population was 33 per cent (EPS, 2008). The widest inequalities between the coverage of women and men are mostly found in the lower-income quintiles (partly because of the characteristics of women's labour market participation); in social strata with little or no education; among domestic workers, unpaid family members and the self-employed, and in the 35–44 age group. In 2003, among those aged 65 and over, 57.2 per cent of women and 72.6 per cent of men were protected by contributory pensions (Mesa-Lago, 2008).

[13] The self-employed engaged in subsistence activities (79 per cent of the total) display much lower rates of membership, contribution and contribution density than do professionals and technicians, who represent 5.5 per cent of the total (Subsecretaría de Previsión Social, 2008).

[14] According to the Superintendency of AFP, the share of the self-employed who contribute is much lower than stated in the statistics of the Survey of Socio-economic Characteristics (*Encuesta de Caracterización Socioeconómica* – CASEN) or the Survey of Social Protection (*Encuesta de Protección Social*– EPS) because of how the self-employed are classified: if they change their employment status at some point in their working lives, this change is not indicated in the Superintendency's figures – something which needs to be corrected.

Gender inequality

In addition to inequality of coverage, women usually receive lower pensions than men, owing to a variety of discriminatory factors: a lower labour force participation rate combined with working lives interrupted by child-rearing (which entails reduced periods of contribution), higher unemployment, lower wages for equal work, and a higher share of employment in unskilled work, for lower pay and without pension coverage. On the other hand, on average women live for five years longer than men and can retire five years earlier, which means that their retirement lasts ten years longer, on average.

Public pension schemes usually mitigate such inequality with measures designed to promote solidarity, such as minimum pensions for persons with few years of contribution, calculation formulae based on the most recent years of working life, and "unisex" mortality tables which do not discriminate against women for their longer life expectancy (measures which transfer resources from men to women). By contrast, private pension schemes accentuate gender inequality: the number of years of contribution needed to obtain the minimum pension is increased, the pension amount depends on the funds accumulated in individual accounts (which, in turn, depend on contributions paid and contribution density), the risk factors vary for women and men, and sex-differentiated mortality tables are used (Bertranou and Arenas de Mesa, 2003; Montecinos, 2006). Women's contribution density was 42 per cent in 2006, and men's was 61 per cent (EPS, 2008); not only are fewer funds accumulated in women's individual accounts, but they must also stretch across a retirement period some ten years longer than men's, so that the pension amount and the replacement rate of previous remuneration are also lower.

The private system's replacement rate, estimated using life-expectancy tables differentiated by sex, is 35 per cent for women who retire at age 65, compared with 46 per cent for men of the same age, so that the rate for women is 24 per cent lower. According to some calculations, 35 per cent of the women aged 40–45 in 2004 would receive a retirement pension lower than the non-contributory pension, while the pensions of a further 10 per cent would be higher than the non-contributory pension but lower than the minimum pension; thus, 45 per cent would receive retirement pensions below the minimum pension (Arenas de Mesa and Mesa-Lago, 2006, pp. 163–165).

In 2005, the minimum pension under the private system was on average equivalent to 62 per cent of the minimum wage and to 23 per cent of the average wage; and since 1990 both of these percentages have shown a declining trend. It has been calculated that half the members of the AFPs will get the minimum pension: 35 per cent of men and 60 per cent of women. In 2000, the World Bank estimated that 30 per cent of women and 50 per cent of men living in Santiago de Chile would not meet the eligibility requirements to obtain a minimum pension, and that these percentages were probably higher at national level (Gill, Packard and Yermo, 2005, pp. 176–186). In 2020–25, 46 per cent of new retirees would receive a pension below the minimum pension, and 65 per cent of them would be women (Chile, 2006, p. 6).

Inequality in funding

The private pension system lacks solidarity, eliminates income redistribution between generations and insured persons, and transfers the functions of solidarity and redistribution to the State, which therefore has to fund non-contributory and minimum pensions. Furthermore, the private system also incorporates a number of features that exacerbate inequalities in regard to funding, namely:

(a) It abolished the employer's contribution and transferred it to the worker, who must pay 10 per cent of his/her wages or income; this fails to comply with the ILO's minimum standard that the worker's contribution should not amount to more than half of the total contribution.[15]

(b) In addition, the AFP charges workers a commission for managing the old-age pension scheme[16] as well as a premium, which is transferred to the private insurance companies covering the invalidity and survivors' contingencies. At the end of 2007, the total of these charges amounted, on average, to 2.44 per cent of wages, almost one-fifth of the total deduction of 12.44 per cent applied to the worker (AIOS, 2007). The total average commission in constant pesos increased by 4.8 per cent between 1982 and 2003 (Arenas de Mesa and Mesa-Lago, 2006, pp. 155–156).

(c) The reform set at 20 years the contribution period for eligibility for the minimum pension – a requirement very difficult to meet for at least half of those insured, especially those in unstable jobs, women and the self-employed.

(d) By contrast, the armed forces' scheme is a defined-benefit scheme, which enjoys very liberal eligibility conditions, benefits from substantial funding from the State as employer, and charges no commission to its members.

(e) The costs of transition are borne entirely by the State, which transfers resources to the minority of the population who are on middle and high incomes; these resources are provided by the whole population through taxes (mostly on consumption), which are also paid by the poor and those on low incomes, with a consequent regressive effect on them. These costs averaged 5.7 per cent of annual GDP in the period 1981–2004, still reached 5 per cent in 2006, and are projected to reach 4.7 per cent in 2010.

(f) In 2006, 1.3 per cent of GDP (one-quarter of the total cost) was spent on the armed forces' scheme, as against only 0.4 per cent on social assistance pensions for the poor and 0.1 per cent on minimum pensions.

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[15] Article 71, paragraph 2, of the ILO's Social Security (Minimum Standards) Convention, 1952 (No. 102) states: "The total of the insurance contributions borne by the employees protected shall not exceed 50 per cent of the total of the financial resources allocated to the protection of employees and their wives and children …".

[16] The fixed commission paid to some AFPs has a regressive effect, as it is the same for all insured persons irrespective of their earnings, which places a relatively heavier burden on those with low incomes.

(g) The private pension system increases labour market inequalities between members on different incomes: in 2004 there was a ratio of 8.6 between maximum monthly taxable income and the minimum wage, a ratio which increased to 9.3 between pensioners on the highest incomes and those on the lowest. Furthermore, this ratio rises to 13, if recent figures for contribution density broken down by household income quintiles are used: the replacement rate of insured persons who had earned the maximum taxable income was 14 percentage points higher than that of insured persons who had earned the minimum wage (Arenas de Mesa and Mesa-Lago, 2006, p. 165).

Finally, neither workers nor pensioners were represented on the Superintendency or on the AFPs, despite the fact that they owned the pension funds, with the result that the main stakeholders were unable to express their opinions, to oversee the operation of the system or to make suggestions about how to improve it.

The impact of pension reform on social equity

In spite of the pension system's multiple inequalities and other failings, its comprehensive reform was delayed for 27 years. Michelle Bachelet gave high priority to the issue in her electoral manifesto, and shortly after she became President established a widely representative Advisory Council to study reforms, to discuss them at numerous public meetings and to submit proposals. Some 90 per cent of the Council's recommendations were included in draft legislation completed at the end of 2006, laid before Parliament in 2007 and passed as the Law on Pension Reform, which came into force on 1 July 2008 (see Chile, 2006 and 2008; Garrido and Olivares, 2008; Superintendencia de Pensiones, 2008).

This law established a "System of Solidarity Pensions" *(Sistema de Pensiones Solidarias)* consisting of two components. The first is a basic, non-contributory old-age and invalidity pension (*pensión básica solidaria* – PBS), which replaced the social assistance pension with immediate effect. Funded by the State, this new pension is initially being granted to 40 per cent of the households with the lowest incomes (currently established by the so-called "social protection file"). Additional requirements are that applicants must not have contributed to the pensions system or be eligible for another form of pension and that they be over 65 years old and have lived in Chile for 20 years either uninterruptedly or discontinuously counting from the age of 20 (in both cases, for at least four of the five years preceding application for the pension). For the purposes of eligibility, the household is composed of the head of family, his/her spouse and children aged under 18 years or 18–24 years provided they are regular students. If the household's income does not reach the ceiling per capita, each adult member may receive a basic, non-contributory pension, so that two adults in the family unit may receive the benefit even though the household might not

be amongst the poorest.[17] The basic, non-contributory pension will gradually be extended to protect 45 per cent of the population on lower incomes by 2009, that proportion rising to 55 per cent in 2012 and to 60 per cent thereafter. The amount of the basic non-contributory pension will be 33 per cent higher than that of the social assistance pensions paid out in 2008, a proportion which will reach 67 per cent in 2009 and will be adjusted annually thereafter according to the rate of inflation over the preceding twelve months.

The second component of the 2008 reform is a solidarity-based top-up benefit, which implicitly replaces the minimum pension. This consists of state financial assistance to supplement the contributory pension of persons aged over 65 whose income is low, regardless of their contribution record. The final pension received by a member – even one who has contributed for just one month – will always be greater than the basic, non-contributory pension (PBS), the intention being to encourage contributions. There is a ceiling on the top-up benefit which will gradually rise between 2008 and 2012, until it reaches US$510 per month; the benefit decreases in line with the amount of the contributory pension and is not paid when the latter reaches a fixed ceiling.[18]

The eligibility conditions for the top-up benefit and the target beneficiaries are similar to those of the basic, non-contributory pension. In 2008, beneficiaries must belong to the poorest 40 per cent of the population, with coverage gradually increasing up to the poorest 55 per cent by 2012; and members of a household whose income does not exceed the ceiling per capita are entitled to this benefit. The amount of the maximum pension together with the top-up benefit may exceed the basic, non-contributory pension by up to 12 per cent in 2008 and 60 per cent in 2009, continuing to increase up to 2012. The top-up benefit will substantially increase pensions, encourage affiliation and contributions by active workers, and will act as a disincentive to anyone seeking to avoid making contributions and then requesting the basic, non-contributory pension. In addition, young workers' contributions will be subsidized for the first two years of their membership. The basic, non-contributory pension and the top-up benefit are expected to benefit 800,000 persons in 2009 and 1.3 million by 2012.

All mothers (regardless of their socio-economic circumstances) will receive a universal maternity grant, equivalent to 10 per cent of the value of 18 minimum wages for each child born alive. Women who are not entitled to the

[17] Two older persons living in the same household, even if they are living with their children who work and support them (and who, according to the definition of "household" given by the CASEN survey, need not be among the poorest 40–60 per cent in the population) will be able to receive the basic, non-contributory pension or the solidarity top-up benefit. Law No. 20.255 promotes that older adults be independent and not an economic burden on their working children, even if they are members of the same household, as defined by the CASEN survey.

[18] The largest pension (maximum pension plus top-up benefit) fixed in pesos per month will rise as follows, from June one year to the next: from US$140 in 2008–09, to 240 in 2009–10, 300 in 2010–11, 400 in 2011–12 and to 510 from 2012 onwards.

basic non-contributory pension or the top-up benefit, must have contributed to the system at least once in their life in order to qualify for this grant. The grant is credited to the mother's account on the child's date of birth, and annual interest then accrues from that date; the grant is cashed in when the woman reaches the age of 65, and thus adds to her pension. It has been estimated that 250,000 women who currently lack any form of old-age pension will receive a basic, non-contributory pension (60 per cent of all beneficiaries) and another 30,000 will receive the top-up benefit. Moreover, the invalidity and survivors' scheme makes separate allowances to men and to women: as women have a longer life expectancy than men, the probability that they will use this insurance is lesser; consequently, the surplus premium paid by women is credited to their individual accounts. Another innovation is that the invalid spouse of an insured woman will be entitled to a pension. Also, in the event of divorce, the amounts accumulated in the spouses' individual fund accounts during their marriage may be shared between them, subject to a maximum transfer of one-half from either to the other. These pension reforms will be backed up by a programme to establish childcare centres, which is intended to promote women's employment and improve family income and affiliation to the pensions and health-care systems, also in the interests of greater equity.

Coverage of the self-employed will become mandatory after a transition period beginning in 2012 (intended to limit a potential increase in the informal sector), during which they might decide not to join the system. In the mean time, they will be informed of the advantages of joining. They will initially contribute 10 per cent of 40 per cent of their annual taxable income, increasing gradually to 100 per cent of such income by 2014. Thus, as from 2015 every self-employed person without exception will have to contribute on all of his/her income (and in 2016 they will also have to contribute to the health system). There will be incentives: for example, the self-employed will be eligible for the family allowance, the compensation funds, statutory compensation for work-related accidents and the top-up benefit; but if they do not contribute, they will not receive the certificates or documents needed for certain legal procedures and will not qualify for tax exemptions on profits.[19] Consideration is being given to possible voluntary affiliation for persons who have no paid work of any sort.

Three additional innovations are being made: (a) voluntary collective savings plans, which consist of deposits on individual, fully-funded accounts negotiated by employers and workers (though only the employer may make contributions) and which have tax advantages (immediate payment of taxes or payment deferred to when funds are withdrawn); (b) "centres for comprehensive pensions provision" *(Centros de Atención Previsional Integral)*, which deal with enquiries from the public and grant benefits under the System of Solidarity Pensions; and (c) the Fund for Pensions Education *(Fondo de Educación*

[19] The main problem is that only a low proportion of the self-employed files income-tax returns, as most of them work in the informal economy.

Previsional), which is funded by the State and the AFPs to disseminate information and educate the public on pensions matters.

Administrative costs will be reduced through: biannual "auctions", whereby the AFP offering the lowest commission attracts the affiliation of some 200,000 persons entering the labour market each year (and the winning AFP has to apply the same commission to its existing members); the abolition of the fixed regressive commission; and authorization of the banks to compete with the AFPs to handle individual accounts (the Senate refused to allow bank participation in the investment of funds).

The Superintendency of the AFPs has been abolished and is replaced by a Superintendency of Pensions which oversees both the public system (the Institute of Social Security Standardization is replaced by the Institute of Social Security) and the private sector, as well as the System of Solidarity Pensions (removing the administration of minimum pensions from the AFPs), the centres for comprehensive pension provision, etc.

A Users' Committee has been set up, composed of five representatives, one from each of the following groups: workers, pensioners, AFPs, the Institute of Social Security, and academics (an academic will chair the committee), to comment on how the system is working, to monitor the application of the reforms and to steer strategies on education, information dissemination and communication with members.

The new benefits and administrative bodies will be paid for in various ways, including general taxation and resources saved by the termination of certain payments by the public system. The Exchequer will publish an annual report based on actuarial studies of the new system and allocate the necessary funds to guarantee the System of Solidarity Pensions, as required by the Budget Law.

Summary of progress on social equity and the challenges ahead

Table 1 summarizes the reforms carried out by successive democratic governments, which have redressed most of the previous inequalities, improved general indicators and increased protection and equity both in terms of health care and of pensions and social assistance.

The chief improvements brought about by the health system reforms carried out in stages since the 1990s, particularly in 2004–05, are:

- Broader effective access to the system, especially access by the poor and those on low incomes (emergency primary health-care services, shorter hospital waiting lists, subsidies for drinking water and sanitation), with a marked increase in public health expenditure and state contributions;
- Guaranteed universal benefits (the AUGE plan) gradually applied to the main pathologies, with maximum limits on waiting periods;
- Medical care granted free to the poor, and subsidized for persons on low incomes; state resources channelled to poor communes;

Table 1. Summary of changes and improvements in health care, social protection and equity in Chile before and after the return of democratic rule

Indicators	1980–1989	1995–2008
General		
1. Poverty index	39 per cent	14 per cent
2. Gini coefficient	0.554	0.549
3. UNDP Human Development Index	Ranked fourth in Latin America	Ranked second in Latin America
Health		
4. Regulation/supervision	Non-existent or very weak; ISAPRE abuses	Superintendency of ISAPREs, then replaced by the Superintendency of Health; regulates and controls the system
5. Public expenditure on primary health care	12 per cent of public health expenditure	21.4 per cent of public health expenditure
6. State assistance to the ISAPREs	Tax exemptions on employers' contribution to encourage affiliation to private system and maternity leave to be paid for by the ISAPREs; both receive state subsidies	Subsidies abolished. Maternity leave to be paid for by the State
7. Poverty	Inadequate, poorly focused attention to poverty	Chile Solidario channels resources to the poor and increases protective measures targeting them (see points 10–12)
8. Women	ISAPRE premiums charged to women of reproductive age several times higher than those charged to men	The Superintendency establishes a maximum premium chargeable to women of reproductive age (see points 1 and 13)
9. Elderly persons	ISAPRE charges premiums that increase as insured person's age rises	The Superintendency establishes a maximum premium for the elderly (see points 12 and 13)
10. Self-employed workers	Membership voluntary (only 9 per cent of total self-employed affiliated to ISAPREs)	Membership mandatory in 2016 and the poor exempted from contributing
11. Regions and communes	Marked inequality	The FONASA allocates greater per capita funds to the communes
12. Guaranteed universal rights	None	The AUGE plan guarantees access and quality benefits to the whole population, regardless of income, age, sex and risks. Free to the poor and older adults in the public system

Table 1. Summary of changes and improvements in health care, social protection and equity in Chile before and after the return of democratic rule *(concl.)*

Indicators	1980–1989	1995–2008
13. Discrimination due to risks (adverse selection)	The ISAPREs discriminate, the FONASA does not	The Solidarity Compensation Fund regulates premiums and reduces adverse selection; women and elderly "receive transfers" from younger men
14. Public participation	None	Four possible ways for public to participate
Pensions and social assistance		
15. Regulation/supervision	Superintendency of the AFP, but with fragmented functions	Replaced by Superintendency of Pensions, with jurisdiction over whole system
16. Solidarity	Does not exist in AFPs; some elements of solidarity provided by the State	Solidarity strengthened by the pension reform of 2008 (see below)
17. Poverty and social assistance	State social assistance pension (PASIS), but only for some of the needy and amount inadequate	Chile Solidario fights extreme poverty. Basic, non-contributory pension replaces the social assistance pension, help channelled to the poor, amounts increased
18. Minimum pension	Requires 20 years of contributions. It is estimated that half of current affiliates will receive this pension, and half of new affiliates an even smaller pension	Replaced by solidarity-based "top-up" benefit: this complements the contributory pension, and is not subject to years of contributions; it decreases as the pension amount increases, and stops when a ceiling is reached; targeted at lower-income groups
19. Women	The private system accentuates gender-based inequality; 45 per cent of current affiliates and 65 per cent of future affiliates may draw a pension lower than the minimum pension	Universal maternity grant available to all mothers, irrespective of income, increases the pension. The pension fund can be shared between spouses in case of divorce (see points 17 and 18)
20. Self-employed workers	Voluntary affiliation (only 3.4 per cent of total AFP membership)	Affiliation becoming mandatory between 2012 and 2015. Incentives to affiliate and disincentives to "free riders"
21. Administrative costs	19 per cent of total deduction on wage, paid by the worker	Measures to reduce costs and to improve competition
22. Public participation	None	Users' Committee and monitoring reforms are applied

- Coverage of the self-employed made mandatory as from 2016 and persons in receipt of the basic, non-contributory pension and on low incomes are exempted from contributing;
- Age- and gender-based discrimination in the open ISAPREs reduced (thanks to the Solidarity Compensation Fund), and resources transferred from younger men to women of reproductive age and elderly persons;
- Increases in the ISAPREs premiums now regulated;
- Subsidies by the public system to the private system reduced;
- Regulations, controls and sanctions strengthened and streamlined throughout the system, through the Superintendency of Health;
- Opportunities for users of the health services to participate in running the services.

For its part, the Law on Pension Reform (Chile, 2008) brought the following improvements:

- Provides universal protection to the poor and to low-income groups by means of the basic, non-contributory pension, without waiting lists or caps on expenditure;
- Establishes a legal obligation gradually to provide coverage of self-employed workers;
- Compensates for the lack of protection of members who were not entitled to either a minimum pension or a social assistance pension;
- Raises low pensions by means of a state contribution which complements contributory pensions below a certain ceiling; the contribution decreases in line with the total amount of the pension and ends when the ceiling is reached;
- Creates incentives to affiliate and to contribute;
- Provides a maternity grant to all women and other benefits intended to counter gender-based inequality;
- Establishes ways of reducing the administrative commission charged to workers;
- Promotes voluntary contributions by employers;
- Creates an entity designed to help apply the new benefits and to keep beneficiaries informed;
- Streamlines and strengthens supervisory controls over the system;
- Enables public participation in and education on pensions questions;
- Provides a solid financial base grounding the reform.

The few remaining inequalities are not easy to remove as they are rooted in the system, which for political and economic reasons is very difficult to change in a fundamental way; moreover, if further reforms are undertaken there could be diminishing returns and other adverse effects. For, as already explained, though most Chileans believe in solidarity, half of them are not prepared to

sacrifice their own interests to those of the general good, and this implies potential opposition.

In any case, a number of rights remain to be assured and there are matters still pending:

(a) continuing gradually to expand the number of pathologies covered by the AUGE plan and working towards ensuring real access to the whole population;

(b) start planning for the inclusion of the self-employed and take practical measures to bring about mandatory legal coverage;

(c) monitoring compliance by the Superintendencies of Pensions and Health with legal standards in force and preventing the ISAPREs from selecting on the basis of risk;

(d) actively promoting childcare centres and removing the regressive aspects of the maternity-leave programme;

(e) rooting out the "free riders" and channelling state subsidies towards those who really need them, using the social protection file and other, even more effective methods yet to be developed;

(f) improving the monitoring of reimbursement to the public system (FONASA) for services used by members of the ISAPREs, and ending the tax exemption of contributions and co-payments to the ISAPREs;

(g) ensuring real consumer involvement in the management of the health services, strengthening user participation in the consultative councils, as well as worker and pensioner representation in the pensions system through the Users' Committee.

It is crucial to raise the general public's very low levels of information and knowledge of the health and pension systems. Surveys of social protection show that 79 per cent of AFP members do not know the eligibility requirements for a minimum pension (54 per cent think that poverty is a requirement), 60 per cent are unaware of their monthly deductions – 56 per cent do not know the balance on their individual accounts – and only 11 per cent know that the amount of their pension will depend on the balance on their individual account. In general, women are less well informed than men (EPS, 2004, 2006 and 2008). Opinion polls conducted on behalf of the health-care system reveal that 45 per cent of interviewees did not know the provisions of the laws on reform; 58 per cent had a low level of general knowledge on the subject, 35 per cent an intermediate level, and 2 per cent a high level, with 5 per cent who "do not know"; only half were aware that the health-care guarantees of the AUGE plan covers both FONASA and ISAPRE members, and among those who noted problems with the implementation of the AUGE plan, 81 per cent pointed out the absence of information (Superintendencia de Salud, 2007b). The Fund for Pensions Education clearly has a crucial role to play in improving information and should consider extending its role to include health issues or creating a similar ad hoc fund for health matters. The Fund should disseminate simple and readily comprehensible

information on the new public rights established by the Law on Pension Reform, and also prepare comparisons of the performances of the AFPs and the ISAPREs as regards costs, yield, etc., and further simplify the presentation of the regular report on individual accounts (*cartola*). In Mexico, the Superintendency distributes small calculators which allow all members to work out their savings so that, with the figures on savings and wages, they can estimate the amount of the pension they will receive on retirement.

In order to root out persisting inequality in regard to funding, the state subsidies granted to the armed forces' health-care and pension schemes would have to be abolished or at least reduced, or their members obliged to join the general systems. However, this is only likely to occur if military power (already much diminished) is eroded further. If employers do not contribute adequately to the voluntary collective savings scheme,[20] some form of mandatory contribution to the pensions system could be envisaged; consideration could also be given to keeping part of ISAPRE members' 7-per-cent contribution in FONASA, on grounds of solidarity. In order to bring about a significant reduction in income inequality, there would have to be agreement on specific changes to the tax system.[21]

Gender-based inequality caused by the labour market must be addressed through the proper application of existing legislation – for example, the obligation to pay equal wages for equal work – and by encouraging women to enter the labour force and to acquire skills through training; childcare centres and other measures outlined below would help achieve these two aims (for other policies, see Montecinos, 2006).

In 2007, President Bachelet appointed an Advisory Council on Work and Equity, composed of 48 members drawn from all sectors, to respond to the challenges of social policy. This council's report, submitted in May 2008, states that "the social protection system attempts to reduce vulnerability" and points out, inter alia, that "a higher level of equality is needed" in public and private health care (Consejo Asesor Presidencial de Trabajo y Equidad, 2008, pp. 4–5). Nevertheless, the report does not mention the issues addressed in this article, probably because it considers that they have broadly been resolved by the reforms of successive democratic governments, as described here. However, it does suggest some measures relevant in this context: (a) a state subsidy to wages targeting the poorest quintile of the population, which would gradually decrease and stop when a certain level of monthly income is attained; (b) transfers targeted at children in the poorest quintile; (c) crèches funded by general taxation (for infants up to two years old), post-natal subsidies added to women's wages, and vocational training for women; and (d) a Council for Economic and Social Dialogue which would conduct labour market analyses, inter alia (ibid., 2008).

[20] Under the health-care system, voluntary contributions by employers amounted to only 2 per cent of the operational revenues of the ISAPREs in 2006 (Superintendencia de Salud, 2007a).

[21] See Borzutzky (2007) on the regressive nature of the Chilean tax system; as to forms of tax reform, see various contributions in Sojo and Uthoff (2007).

Chile has made great strides on the path towards social protection and equity over the first 20 years of renewed democratic rule; if economic growth is maintained and is accompanied by further advances in social equity, then an even better society will emerge in the future.

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