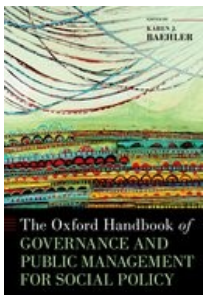

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CHAPTER

62 Healthcare and the Public-Private Mix in Mexico, Chile, and Peru

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Abstract

This chapter provides an overview of the development of the public-private mix in healthcare in Mexico, Chile, and Peru. It outlines the development of the private sector in the 1980s and 1990s when the public health systems in all three countries struggled to provide insurance coverage to the majority of their population as well as access to healthcare services. This situation prompted the coexistence of the public and private sectors in a system characterized by fragmentation. One of the main consequences of these fragmented systems is the high out-of-pocket expenditure citizens face. The governments of these countries have sought aid from private providers to guarantee access to healthcare services for their populations. However, the governmental purchase of private services still remains marginal in the three countries. The important role of the private sector in the healthcare systems of Mexico, Chile, and Peru in terms of provision, insurance, and funding resembles a common trend in the Latin American region.

Keywords: welfare mix, public-private mix, public health system, insurance coverage, fragmentation, Mexico, Chile, Peru

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The history of healthcare policy and administration in Latin America is at least partly a story of institutional fragmentation and churn, with different arrangements and varying results for the multiple subpopulations touched by this vital area of social provision. The development of healthcare systems in Mexico, Chile, and Peru—the focus of this chapter—has produced a complex mix of public and private sector insurance, service provision, and financing that includes substantial out-of-pocket expenditures by the uninsured. The good news is that overall healthcare spending and access has increased in these countries over time, while health outcomes have improved. Yet, concerns about state administrative capacity persist, especially with respect to the countries' abilities to serve their uninsured populations, including many who work in the informal C62.P1

p. 934 sector, and ↳ their abilities to supervise the quality of public and private healthcare services and address the suspected overutilization of services in the private system. These concerns have been further exacerbated due to the COVID-19 pandemic, which strained the public provision sectors and left many at the mercy of exorbitant prices charged at private clinics and hospitals.

This chapter chronicles the development of the public-private healthcare mix in Mexico, Chile, and Peru since the mid-20th century. Milestones during this period include the expansion of social security systems and further development of institutions for providing and funding healthcare protection to public sector employees and the expanding industrial sector from the late 1940s through the 1970s; market-oriented reforms in the late 1980s and 1990s that promoted the inclusion of private insurance companies into the social security systems in Chile and Peru, direct sale of private services to citizens who can afford them, and public purchasing of services from private providers; and, finally, the expansion of noncontributory insurance schemes in all three countries in the 2000s. C62.P2

Each of these phases of development has placed new demands on public governance, management, and policy. More recent developments raise serious concerns about equity and financial sustainability, with accompanying challenges for public sector institutions and policy designers and implementers. C62.P3

Social Security Systems and the Emergence of the Private Healthcare Sector C62.S1

In the mid-20th century, most Latin American countries began to develop public healthcare insurance schemes to protect formal workers. The Mexican Social Security Institute (IMSS) was founded in 1943 to provide coverage for formal workers, and the Institute for Social Security and Services for State Workers (ISSSTE) was founded in 1959. In Chile, the National Health Service for Employees (SERMENA) for white-collar workers was founded in 1942, whereas blue-collar workers and poor people were formally under the coverage of the National Health Service (SNS) since 1952. In 1979, these two institutions integrated into the National System of Health Services (SNSS) and a single financial entity, the National Health Fund (FONASA). In Peru, the Worker's Social Insurance was founded in 1936 to protect blue-collar workers, whereas the National Employees Social Security Fund for white-collar workers was created in 1948. In 1973, the two were integrated into a single social security system, named the Peruvian Institute of Social Security (IPSS) in 1980. C62.P4

The development of social security systems in healthcare were part of the import substitution industrialization path that the region was following (Filgueira 2005; Huber and Stephens 2012; Mesa-Lago 1978). Therefore, aside from public sector employees, it was mainly those employed by the industrial sector that had access to healthcare protection. In Mexico and Peru, like in most Latin American countries, there was a dual and poorly connected system of social security institutions and health ministries, with the latter p. 935 providing ↳ minimal subsidized coverage to those without jobs in the formal economy. Although in Chile the coverage of the poor was somewhat integrated within the social security system, in these three countries informal workers only had access to residual coverage that the ministries of health provided as their scarce resources permitted. C62.P5

When the world recession hit the region in the early 1980s, the health social security systems in these countries suffered financially due to cuts in public funding but also the loss of formal jobs, which led to a decline in contributions to the system. This situation led to demands for structural reforms (Fiedler 1996; McGreevey 1990; Mesa-Lago 1993). In some cases, these reforms to the health systems led to decentralization. In Mexico, the formation of the National Health System in 1984 involved the decentralization of the subsystem in charge of those outside the formal economy. The State Health C62.P6

Departments (*Secretarías de Salud Estatales*) came to be in charge of the State Health Services (SESA). The SESA, together with IMSS and ISSSTE, took care of the majority of the population as the available resources and infrastructure permitted. Given the increase in labor informality toward the end of the century, the main disparity in healthcare access was between formal workers covered by the social security system (via IMSS and ISSSTE), called "rights-holders" (*derechohabientes*), and the so-called open population (*población abierta*) without any insurance. The "rights-lacking" (*derechocarecientes*) population, as some sarcastically called them, received services when available at the SESA, paying symbolic prices.

C62.P7 These disparities, as well as the inefficiencies in public sector service provision, led to the growth of the private insurance and provision sectors in Mexico. Since the 1970s, Mexicans who can afford it have been able to acquire Insurance of Major Medical Expenses (GMM). This insurance policy allows them to choose between the public health institutions and private hospitals to receive medical attention. In the late 1980s, this type of health insurance saw sustained growth, with the number of private insurance policies growing by 300 percent between 1987 and 1992 (Mejía 1993). In 1999, a reform to the General Law of Insurance Institutions and Companies created the Insurance Institutions Specialized in Health (ISES). The key difference between the institutions that sell GMM policies and ISES is that the latter provide medical services for both treatment of diseases, like GMM do, and prevention. In terms of private provision, between 1991 and 1999, the private sector saw an increase of 64 percent in medical units and 43 percent in beds (Zurita and Ramírez, 2003).

C62.P8 The Chilean health social security system faced competition from the private insurance sector, for the first time, with the creation of the Health Insurance Institutions (ISAPREs) during Augusto Pinochet's military dictatorship. Since 1983, thanks to the 1980 Constitution, formal workers who were able to afford it could choose between being covered by the public system (FONASA) and being covered by private insurance from an ISAPRE. If they bought private insurance, their compulsory income contribution of 7 percent would go to
p. 936 an ISAPRE instead of FONASA, and they would access services in ↳ private clinics. They were also responsible for paying any additional copays the ISAPREs required. By 1996, almost 25 percent of the population had some type of private insurance (Arellano 2011). This rapid growth was attributed to the deterioration of infrastructure in the public system during the 1980s due to a lack of governmental investment (Azevedo 1998). The development of the private insurance sector was accompanied by 133 percent growth in private provision of services between 1990 and 2000 (Isapres 2016).

C62.P9 In Peru, the Institute of Social Security (IPSS) covering formal workers struggled with a lack of financial resources due to the economic recession of the early 1980s (Fiedler, 1996).[2] This situation, together with administrative inefficiency and public provision problems, prompted the growth of private insurance schemes (Mesa-Lago 1986). In the early 1990s, President Alberto Fujimori's government implemented a series of reforms that included the participation of the private provision sector. In 1991, IPSS affiliates who were waiting for three months or more to undergo relatively minor surgeries were allowed to use private services (refunded by IPSS).[3] By 1992, they could access ambulatory care with private physicians (Fiedler 1996). Those who were willing and able to pay for access to higher-quality services resorted to the private sector.

C62.P10 The 1997 Law of Modernization of Health Insurance produced a major change for the private insurance sector, allowing for private healthcare companies—since then called Health Provider Entities (EPS)—to compete with IPSS. Workers now had the option of buying health insurance schemes from EPS and thus using private services. Unlike in Chile, only 25 percent of the salary contribution of workers (9 percent) would go to EPS, while the remaining 75 percent would go to the public system (Ewig 2004). By 2007, just 3.5 percent of Peruvians had some type of private insurance.

C62.P11 As described, the public health systems in Mexico, Chile, and Peru were inefficient and underfunded, thus struggling to deliver insurance coverage as well as provision of services to their populations.[4] In response,

the governments passed reforms that allowed the incorporation of the private sector, prompting the expansion of private insurance and providers. Both private insurance and private clinics and hospitals saw rapid development in the 1980s and 1990s.

Coexistence of Public and Private Health Sectors C62.S2

In Mexico and Peru, unlike in Chile, but like in many other Latin American countries, the health social security systems for formal workers are disconnected from the systems for those outside the formal economy, which are run by the ministries of health. The first tend to be better funded than the second, p. 937 although the ministries of health cover at least three ↳ times more people (Ewig 2016; Garay 2016; Martínez Franzoni and Sánchez-Ancochea 2016). Even though the services provided by the social security systems, in general, tend to be of better quality, they still suffer from limited resources and hence serious inefficiencies leading to long waiting lists. The lack of satisfaction of the users of the public system, both insured beneficiaries and informal workers accessing subsidized services, has aided the growth of the private provision sector in Latin America. This dynamic was aggravated during the COVID-19 crisis as the public provision sector was unable to respond to the enormous demand for healthcare services. C62.P12

Fragmentation—in terms of insurance coverage, financing, and provision of services—is a defining characteristic of healthcare systems in Latin America. In Mexico, in the early 2000s, the population without any coverage was quite large (54 percent) as shown in Table 62.1, whereas the social security system (IMSS and ISSSTE) covered 44 percent of the population, and only a small minority had private insurance (2 percent). Meanwhile in Chile, only about one-tenth of people were without any type of insurance (9 percent). The public system (FONASA) covered those with formal jobs and the poor (70 percent), and the private sector (Isapres) offered alternative insurance schemes to those who could afford it (21 percent). In Peru, by 2007, those with formal jobs were part of the social security system (20 percent) through the Peruvian Social Insurance, EsSalud, or—for a small minority—via private Health Service Entities (EPS), while the rest of the population either bought private insurance (3 percent) affiliated to a special scheme for the poor provided by the Ministry of Health (24.5 percent) or just remained unprotected (50.5 percent).[5] C62.P13

Table 62.1 Formal Coverage: Percent (%) of Population without Insurance C62.T1

	Mexico	Chile	Peru
Before Reform*	51.6	16.4	39.5
2018	11.7	6.8	23.5

C62.P71

Sources: Mexico: OECD data (https://stats.oecd.org/Index.aspx?DatasetCode=INSIND#), Chile: Boletín Estadístico 2017–2018 from FONASA (https://www.fonasa.cl/sites/fonasa/documentos), and Peru: INEI Informe Técnico (http://m.inei.gob.pe/media/MenuRecursivo/boletines/condiciones-de-vida-ene-feb-mar2020.pdf)

* Before Reform years: 2003 for Chile and Mexico, 2009 for Peru.

Given the high number of those without access to healthcare at the turn of the millennium, Mexico, Chile, and Peru enacted healthcare reforms in the 2000s. During this third stage in the development of healthcare systems in Latin America, reforms expanding noncontributory insurance schemes sought to achieve p. 938 universal insurance coverage of ↳ the population. In Mexico, the right-leaning PAN government began the implementation of *Seguro Popular* in 2003, which would provide protection to those without insurance with a set package of benefits for certain health conditions. In Chile the center-left Concertación coalition started C62.P14

the implementation of Universal Access with Explicit Guarantees (AUGE) in 2004. AUGE had the main goal of bringing more equity to the system, which was to be achieved by giving rights and guarantees to patients for a prioritized set of health interventions. The right-leaning APRA government in Peru began the implementation of Universal Health Insurance (AUS) in 2009, which would also provide a guarantee of benefits and health services to those without insurance, thus generating equity between those under social security schemes and those under the scheme for the poor.

As we can see in Table 62.1, with the introduction of *Seguro Popular* the uninsured in Mexico declined to 11.7 percent of the population by 2018, with 42.2 percent of Mexicans affiliated to the *Seguro Popular*. A declining trend in uninsured can also be observed in Peru after the implementation of AUS, as well as in Chile after the introduction of AUGE. However, a problem that remains in the cases of Mexico and Peru is the difference in effective access to healthcare between those covered by the social security system and those under *Seguro Popular* and AUS. C62.P15

Table 62.2 Percent (%) of Population with Private Insurance C62.T2

	Mexico	Chile	Peru	C62.P72
2000	2.8	20	2	
2018	9.9	18	4	

Sources: Mexico: OECD data (https://stats.oecd.org/Index.aspx?DatasetCode=INSIND#), Chile: Boletín Estadístico 2017–2018 from FONASA (https://www.fonasa.cl/sites/fonasa/documentos), and Peru: Cuentas Nacionales de Salud Peru 1995–2012 and Superintendencia Nacional de Salud.

The private insurance sector has experienced different trends in the three countries. As we can observe in Table 62.2, while it has grown in Mexico, it has declined in Chile and remained small in Peru. In Mexico, one of the main constraints the private insurance sector faces is that the majority of those who can afford it are part of either IMSS or ISSSTE, systems that have broad coverage, albeit with inefficiencies. In this context, the Mexican Association of Insurance Institutions (AMIS) is looking to incorporate private insurance as a complement to *Seguro Popular*. In Chile, with the introduction of AUGE and the Inter-Isapres Compensatory Fund in 2005, which had the goal of correcting discrimination against people with high risk (such as women and the elderly) among Isapres's affiliates, the share of privately insured people has gone down from 20 p. 939 percent to 18 percent. In Peru, the population with private insurance has remained less than 5 ↳ percent. Nevertheless, the declining private insurance market in Chile and its limited size in Mexico and Peru should not be taken as an indication of the lack of importance of the private healthcare sector in these countries, where private healthcare expenditure is extremely important. C62.P16

The fragmentation of the health systems in Latin American countries is also present when we look at how these systems are funded. As shown in Figure 62.1, private health expenditure as a percentage of current health expenditure, which includes not only private insurance payments but also out-of-pocket spending, is quite high in the three countries and, on average, in the region.[6] It was over 58 percent in 2003 in Mexico and remained over 50 percent until 2010, continuing to slowly decline since. It has ranged between 64 percent (2000) and 50 percent (2017) in Chile, and between 51.7 percent (2008) and 36.4 percent (2017) in Peru. Since the late 2000s, government expenditure as a percentage of current health expenditure has increased in the three countries, representing over 45 percent of total health expenditure since 2009 in all of them. C62.P17

Private providers in Mexico have been targeting those with middle and high socioeconomic status who are either uninsured or want to avoid the wait times at IMSS and ISSSTE, as well as those with lower C62.P18

socioeconomic status who seek to escape from the precarious services provided through *Seguro Popular*. By 2008, the private sector provided services to 5.7 percent of the population (Flamand and Moreno 2014). By 2010, 29 percent of social security affiliates and 21.5 percent of *Seguro Popular* affiliates reported that they also regularly used private services, most of the time paying out of pocket (Laurell 2013).

The governmental purchase of private services for *Seguro Popular* interventions has not progressed as much as private providers would like. The states prefer to buy from their own public clinics and are reticent to buy private services.[7] For the Director of the National Association of Private Hospitals in Mexico, Alejandro Alfonso, selling services to the public system is a good opportunity as they are able to use their idle installed capacity and increase their volume of interventions and patients, which helps to attract new clients (Ponce de Leon 2020). The majority of the provision for those with and without insurance schemes remains public (Flamand and Moreno 2014). C62.P19

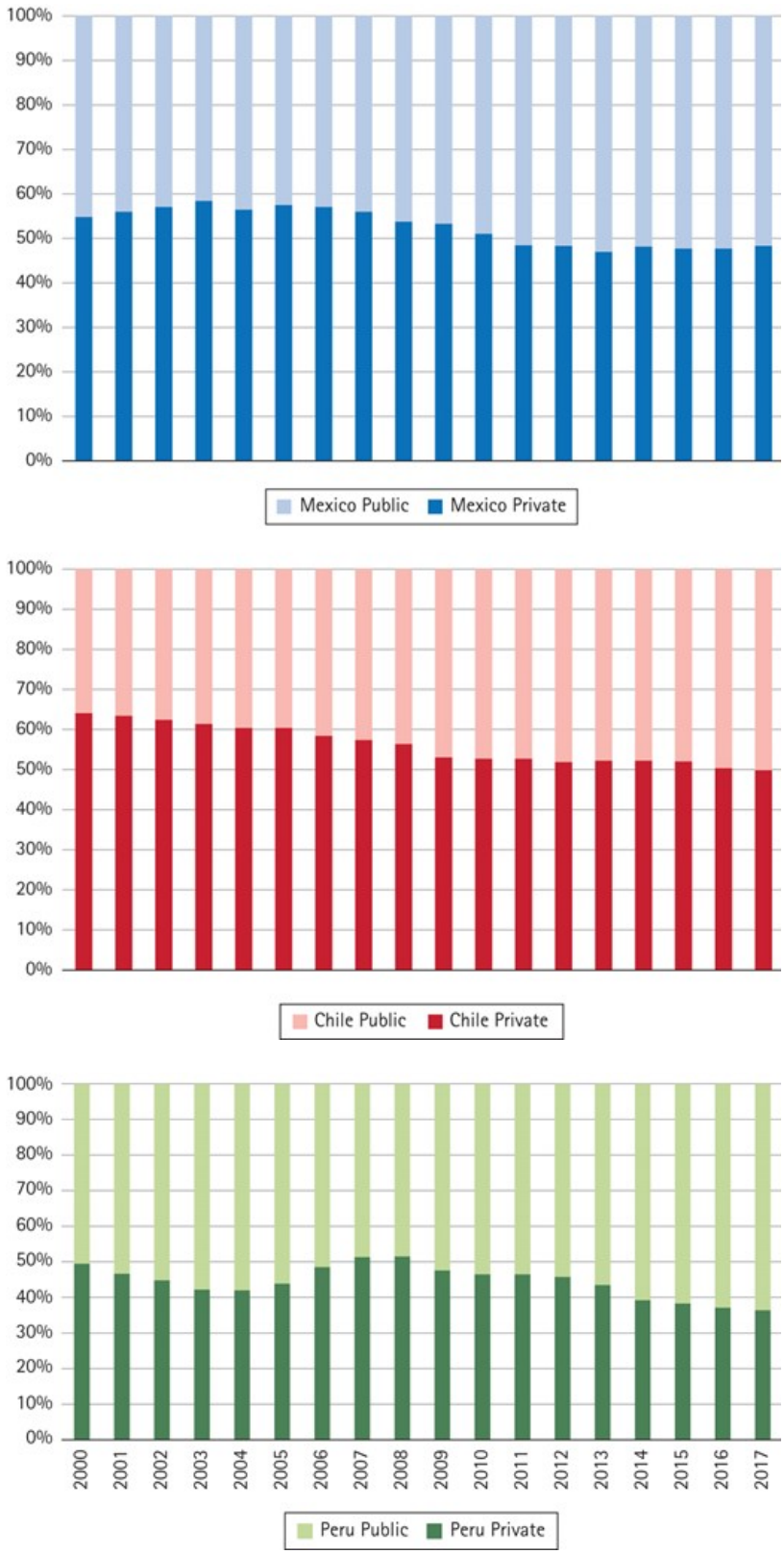
In Chile, the private clinics provide 45 percent of all the health services in the country, delivering attention to around eight million Chileans (nearly half of the population). Private clinics provide 58 percent of their services to Isapres affiliates and the remaining 42 percent to FONASA affiliates (mainly through the free election system in which ↳ C62.P20

p. 940
p. 941

↳

FONASA patients can choose to get attention in a private clinic with some extra payment). President Sebastián Piñera's first administration (2010–2014) introduced the Bono AUGE, a mechanism that allows AUGE patients on waiting lists to get attention through private providers.[8] The association of private clinics, *Clínicas de Chile*, was an important participant in the design of this mechanism.[9] Private clinics are not the only venue for private provision in Chile, and physicians have formed associations oriented to specific medical specialties (i.e., traumatology) that can sell their services to FONASA.[10]

Figure 62.1



Domestic Private and General Government Health Expenditure (% of Current Health Expenditure) C62.F1

Source: World Bank Data at https://data.worldbank.org/indicator/SH.XPD.PVTD.CH.ZS?locations=CL-PE-MX.

In Peru, private provision has also experienced steady growth. Whereas 32 percent of the population used private services in 2004, almost 40 percent did in 2012 (MINSA 2015). Not only have private clinics grown in C62.P21

numbers and users, but also pharmacies have become a common outlet to access health services. Many pharmacies offer people access to direct consultation with a healthcare provider at minimal cost or even for free. Although the users are free to then buy the prescribed medicine elsewhere, most of them will buy it in the same pharmacy. In 2012, 29.3 percent of the population reported use of these services (MINSA 2015). Whereas the use of private health services in private clinics is most common among people with higher incomes, the use of pharmacies is popular across income levels in Peru.

It is important to note that in Chile and Peru, but not in Mexico, there has been a process of vertical integration between private insurance companies and private provision clinics. In Chile and Peru, the same financial holding can own insurance companies and private clinics at the same time. Whereas this model can be highly beneficial for the private sector by reducing costs, it has been harshly criticized as it can increase insurance premiums and threaten the quality of services people receive. C62.P22

The healthcare systems of Mexico, Chile, and Peru, like in many other countries in the region, are characterized by fragmentation. Insurance coverage, funding, and provision are divided between the public and private sectors. Although private insurance has not taken off in Mexico and Peru, and has decreased in Chile, out-of-pocket expenditure (as a percentage of total current health expenditure) is high in all three countries, as Figure 62.2 shows. The private provision sector has benefited from the important segments of uninsured population that the public system did not manage to cover. Moreover, the dissatisfaction of public sector beneficiaries has also aided the growth of private providers. C62.P23

p. 942

Implications of the Public-Private Mix for Public Administration C62.S3

The growth of the private healthcare sectors in Mexico, Chile, and Peru has, in part, been nurtured by the people's dissatisfaction with the public sector and the resulting willingness of some to pay out of pocket to access timely and quality services. In addition, increasing purchase of private services by the public sector has enabled the private sector to use their previously idle installed capacity. Although the state's direct contracting of private services may be detrimental to the growth of private insurance, it increases the business of private providers. As a result, the private sector has become an important source of healthcare provision in the region. C62.P24

The growth of private markets for both insurance and provision has affected state capacity as well as healthcare access in Mexico, Chile, and Peru. In terms of state capacity, the lack of coverage and low quality of services in poorer areas continues to be a problem, more acutely in Mexico and Peru than in Chile. These deficiencies became more apparent with the COVID-19 pandemic, as disparate access to healthcare across different segments of the population (geographically and income-based) determined the different impact the Coronavirus had in these sub-populations. The state has deployed different strategies in order to tackle this problem, some of which directly affect or involve the private sector. C62.P25

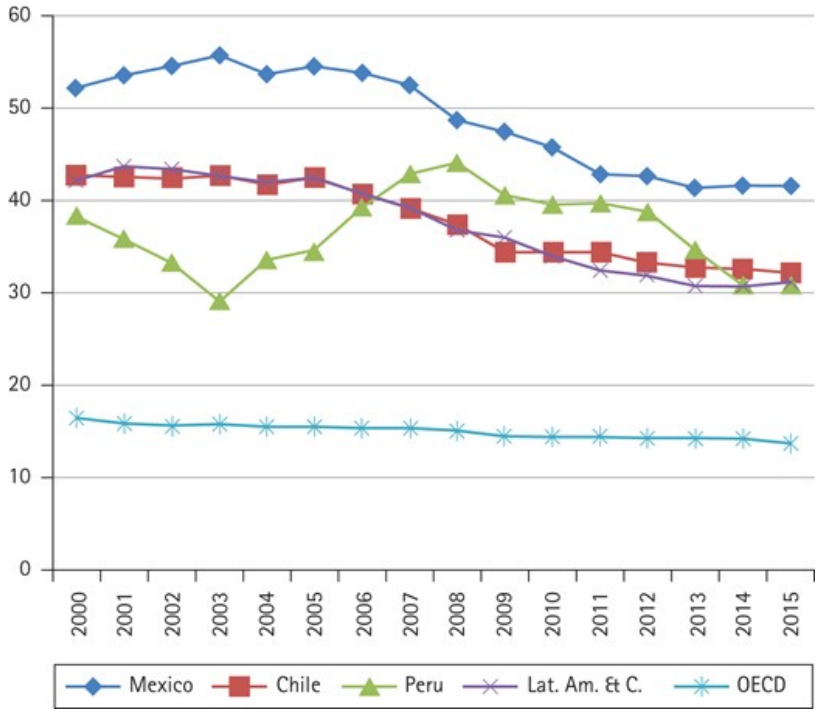
When these three countries embarked on reforms looking to extend healthcare coverage to their populations, they were, in some instances, unable to respond to the new demand for services due to the lack of infrastructure and human resources of the public system (Garay 2016; Ponce de Leon 2020; Pribble 2013). Under pressure to deliver what had been promised, the purchase of private services became a useful tool for the state as well as a beneficial business for the private provision sector. The practice has raised concerns, however, particularly with respect to its sustainability. If the purchase of private services was done in order to decongest the public sector because it could not meet demand, then the question arises as to whether continued private purchase will supplant investments in public healthcare infrastructure and further reduce state capacity to meet demand. A long-term trend toward public purchasing from private providers may become financially unsustainable if private healthcare prices per service continue to rise more steeply than public costs for the same services. C62.P26

Another strategy the state has employed to overcome the lack of provision resources in the public system are public-private partnerships (PPPs), through which the two sectors collaborate to construct and manage public hospitals. These partnerships can enable the state apparatus to reach areas (for instance, rural areas) that they were not able to reach before. This approach has been criticized for favoring private interests, which can act against efforts to bring equality in the distribution of the social determinants of health (Ruckert and Labonté 2014). C62.P27

The growth of the private sector has increased access to services, and reduced wait times in the public sector. At the same time, more uninsured people in Mexico, Chile, and Peru are funding their own healthcare in large measure, paying for private medical visits, ↳ services, and medicine out of pocket. Despite governmental attempts to reduce out-of-pocket costs with the expansion of noncontributory schemes through *Seguro Popular* in Mexico, AUGE in Chile, and AUS in Peru, high levels of out-of-pocket expenditure are still common in these countries. However, as Figure 62.2 shows, there was a declining trend beginning in the mid-2000s until 2012 in Mexico and Chile, with levels remaining stable since then. In Peru, there has been a donward trend since the late-2000s. C62.P28 p. 943

The Healthcare Access and Quality Index, a measure of healthcare access based on "amenable mortality" rates (mortality from causes that should not be fatal in the presence of effective medical care) shows a constant increase in access and quality (and decrease in amenable mortality) between 1990 and 2015 in Mexico, Chile, and Peru (GBD 2017). Although we lack evidence of how specific policy has aided this progress, it could be attributed to an increase in both public and private spending. C62.P29

Figure 62.2



Out-of-Pocket Health Expenditure (% of Current Health Expenditure) C62.F2

Source: World Bank Data at https://data.worldbank.org/

Increased access does not always correspond with better outcomes, however, as research by Arrieta and colleagues (2011) suggests. Using survey data from six Latin American countries, they found that the provision of prenatal healthcare services, measured as number of prenatal visits, was higher in the private sector. They also found that a higher level of prenatal visits did not improve birthweight, which according to C62.P30

the authors is an indication of unnecessary visits. As they point out, the additional prenatal visits could be a
p. 944 sign of overutilization of prenatal care in the private sector, which is a problem other studies ↳ focusing on Latin America have found regarding cesarean sections (Villar et al. 2006) as well as ambulatory and inpatient services (Ruiz et al. 2007).

Such findings may point to the need for better supervision of both public and private insurance and provision sectors; such supervision currently is in the hands of the same type of institution in both Chile and Peru. The Health Superintendency monitors FONASA and Isapres, as well as public and private providers in Chile. In Peru, the National Health Superintendency (SUSALUD) has the role of protecting the rights of all users of health services (insured and uninsured) by supervising both public and private health facilities and insurance entities. In Mexico, by contrast, the regulation of both public and private provision services is in the hands of the National Commission of Medical Arbitration (CONAMED), whereas the *Comisión Nacional de Seguros y Fianzas*, a dependency of the Ministry of Finance, supervises private insurance companies. Future research should seek to compare the impact of these different institutional arrangements on healthcare outcomes. This impact is also mediated by the funding these institutions receive as well as their extension across the different regions in each country. Whereas the Chilean Health Superintendency has offices throughout the country, in Peru and Mexico these offices are scattered. C62.P31

The expansion of private provision services in Mexico, Chile, and Peru has aided those states in their efforts to provide healthcare to their populations, particularly in areas where human resources and infrastructure deficiencies stood in the way. Although the private provision sector has gained importance in these countries, their governments have been cautious in the purchase of private services. Left-wing parties as well as health workers associations have denounced the privatization efforts of the government and see this process as unsustainable and inequitable. The growing presence of private provision in these countries has also demanded further development of the state apparatus for supervision of both public and private services and insurance institutions. C62.P32

Similar Challenges Across the Region C62.S4

In Latin America, the private sector plays an important role in terms of provision, insurance, and funding. Such is the case of Brazil, where the private provision sector has been growing rapidly. A key source of this growth has been the state's purchase of private healthcare services for the affiliates of the Brazilian National Health System (SUS) (Costa 2017; Hunter and Sugiyama 2009). Brazil also resembles Mexico, Chile, and Peru in terms of the importance of out-of-pocket expenditure as a percentage of total health expenditure. Although out-of-pocket spending decreased between 2000 and 2015 in Brazil (from 36 percent to 24 percent), it has remained stable since then. C62.P33

The constraints that the public sectors face in terms of infrastructure and resources are present across the Latin American region. Yet public spending in the region has increased (measured as domestic general government health expenditure as a percentage of current health expenditure), with the average for the
p. 945 region going from 42 percent in 2000 to 50 ↳ percent in 2019. This is in part thanks to the economic growth the region experienced, which permitted the allocation of funds for health, as well as other areas such as education and social protection. The trend has been moving downward since 2015 (World Bank 2022). C62.P34

In the majority of cases in the region, the private healthcare provision sector remains independent from the public sector (an important exception is the healthcare system in Costa Rica). Private clinics and hospitals provide access to services to an important sector of the population through the direct purchase of these services by users via prepaid private insurance schemes or through the state's purchase of services for public sector affiliates. A trend that is also not exclusive to Mexico, Chile, and Peru is the partnership between the public and private sectors (PPPs). Not only have such partnerships cooperated in the C62.P35

construction and management of public hospitals, but also in aiding the development of information technology and the provision of diagnostic imaging.

These three countries share with their counterparts in Latin America the global challenge of an aging population and the pressure that this trend imposes on public health system capacity. The percentage of the population aged 65 and above is growing rapidly across the region, almost doubling to 8 percent between 1990 and 2016. The private sector is devising strategies to take advantage of this opportunity, from nursing homes to aiding with home healthcare. Another global challenge faced by several countries is the sustained increase in prices of technology and medicines. Experts recommend that governments strengthen the primary care level in the public system in order to avoid high costs associated with hospital-based technologies and pharmaceutical treatments. Calls for increased investment in the primary care level have further increased due to the COVID-19 pandemic, which showed the importance of having a strong system of primary care. C62.P36

Conclusion C62.S5

Resembling most of Latin America before the 1980s, Mexico and Peru had a dual and poorly connected system of social security and health ministries giving minimal subsidized coverage to those in the informal economy. In Chile, although the coverage of the poor was somewhat integrated within the social security system, like in the other two countries analyzed in this chapter, informal workers only had residual coverage provided when scarce resources permitted. This fragmentation and scarce funding led to public health systems that struggled to provide coverage to their populations, which prompted market-oriented reforms in the late 1980s and 1990s. These reforms led to the growth of private services for citizens who could afford them, as well as the inclusion of private insurance options into the social security systems in Chile and Peru. Moreover, the dissatisfaction of the public system users (both insured beneficiaries and informal workers accessing subsidized services) assisted the growth of private providers. C62.P37

Fragmentation has been a defining feature of the healthcare systems in these countries, not just in terms of insurance coverage and provision but also financing. Out-of-pocket ↳ expenditure remains high, having declined only slightly in the last decade in the three countries of study. In the 2000s, the three countries embarked on reforms seeking to extend healthcare coverage to their populations and reduce out-of-pocket costs. The expansion of noncontributory schemes through *Seguro Popular* in Mexico, AUGE in Chile, and AUS in Peru faced a growing demand for services, which the infrastructure and human resources of the public systems were not always able to respond to. Purchasing private services became a useful tool for the state as well as a beneficial business for the private sector, which increased access to services and reduced wait times in the public sector. However, the sustainability of this process has been under scrutiny, particularly due to the lack of clarity of the governments regarding the long-term plan of this strategy. Will the private purchase of services eventually supplant investments in public infrastructure? Could this further reduce state capacity to meet demand? These are questions that governments, as well as future research, need to provide answers to. C62.P38 p. 946

The growing presence of the private providers as well as private insurance companies in several Latin American countries have demanded a further development of the state apparatus for the supervision of both public and private services and insurance. Future research should seek to compare the impact of the different institutional arrangements present in the Latin American region, particularly in the context of the COVID-19 pandemic. C62.P39

References

Arellano, J.P. 2011. *Equity and Sustainable Growth: Twenty Years of Social Policies, Chile 1990–2009*. Washington, DC: World Bank.
Google Scholar Google Preview WorldCat COPAC

Arrieta, A., A. García-Prado, and J. Guillén. 2011. "The Private Health Care Sector and the Provision of Prenatal Care Services in Latin America." *World Development* 39(4): 579–587.
Google Scholar WorldCat

Carlos Azevedo, A., 1998. "La provisión de servicios de salud en Chile: Aspectos históricos, dilemas y perspectivas." *Revista de Saude Publica* 32(2): 192–199.
Google Scholar WorldCat

Costa, N.D.R. 2017. "Brazilian Healthcare in the Context of Austerity: Private Sector Dominant, Government Sector Failing." *Ciencia & saude coletiva* 22(4): 1065–1074.
Google Scholar WorldCat

Ewig, C. 2004. "Piecemeal but Innovative: Health Sector Reform in Peru." In *Crucial Needs, Weak Incentives: Social Sector Reform, Democratization, and Globalization in Latin America*, edited by Kaufman, R.R. and Nelson, J.M. Woodrow Wilson Center Press, 217–246.
Google Scholar Google Preview WorldCat COPAC

Ewig, C. 2016. "Reform and Electoral Competition: Convergence Toward Equity in Latin American Health Sectors." *Comparative Political Studies* 49(2): 184–218.
Google Scholar WorldCat

Fiedler, J.L. 1996. "The Privatization of Health Care in Three Latin American Social Security Systems." *Health Policy and Planning* 11(4): 406–417.
Google Scholar WorldCat

Filgueira, F. 2005. "*Welfare and Democracy in Latin America: The Development, Crises and Aftermath of Universal, Dual and Exclusionary Social States.*" Paper prepared for the United Nations Research Institute for Social Development (UNRISD) Project on Social Policy and Democratization. Geneva: UNRISD.
Google Scholar Google Preview WorldCat COPAC

Flamand, L., and C. Moreno Jaimes. 2014. *Seguro Popular y Federalismo en México: Un análisis de política pública*. Centro de Investigación y Docencia Económica.
Google Scholar Google Preview WorldCat COPAC

Garay, C. 2016. *Social Policy Expansion in Latin America*. Cambridge: Cambridge University Press.
Google Scholar Google Preview WorldCat COPAC

GBD 2017 Healthcare Access and Quality Collaborators. 2017. "Healthcare Access and Quality Index Based on Mortality from Causes Amenable to Personal Health Care in 195 Countries and Territories, 1990–2015: A Novel Analysis from the Global Burden of Disease Study 2015." *The Lancet* 390: 231–266.
WorldCat

Huber, E., and J.D. Stephens. 2012. *Democracy and the Left: Social Policy and Inequality in Latin America*. Chicago: University of Chicago Press.
Google Scholar Google Preview WorldCat COPAC

Huber, E., and Z. Ponce de Leon. 2019. "The Changing Shapes of Latin American Welfare States." In *Oxford Encyclopedia of Latin American Politics*. Oxford: Oxford University Press. https://doi.org/10.1093/acrefore/9780190228637.013.1656, accessed May 2022.

Google Scholar Google Preview WorldCat COPAC

Hunter, W., and N.B. Sugiyama. 2009. “Democracy and Social Policy in Brazil: Advancing Basic Needs, Preserving Privileged Interests.” *Latin American Politics and Society* 51(2): 29–58.
Google Scholar WorldCat

Isapres de Chile, Febrero. 2016. “*El Sistema de Salud Chileno: Orígenes, Transformaciones y Desafíos*” *Serie de Informes Técnicos*. Asociación de Isapres de Chile.
Google Scholar Google Preview WorldCat COPAC

Laurell, A.C. 2013. *Impacto del seguro popular en el sistema de salud mexicano*. Buenos Aires: CLACSO.
Google Scholar Google Preview WorldCat COPAC

Martínez Franzoni, J. and D. Sánchez-Ancochea. 2016. *The Quest for Universal Social Policy in the South: Actors, Ideas and Architectures*. Cambridge: Cambridge University Press.
Google Scholar Google Preview WorldCat COPAC

McGreevey W. 1990. “*Social Security in Latin America: Issues and Options for the World Bank. World Bank Discussion Paper Number 110.*” Washington, DC: The World Bank.
Google Scholar Google Preview WorldCat COPAC

Mejía, P., 1993. “*Aspectos Relevantes del Seguro de Gastos Médicos Mayores en México.*” Documentos de Trabajo 28. Comisión Nacional de Seguros y Fianzas.
Google Scholar Google Preview WorldCat COPAC

Mesa-Lago, C. 1978. *Social Security in Latin America: Pressure Groups, Stratification, and Inequality*. Pittsburgh, PA: University of Pittsburgh Press.
Google Scholar Google Preview WorldCat COPAC

Mesa-Lago, C., 1986. “Comparative Study of the Development of Social Security in Latin America.” *International Social Security Review* 39(2): 127–152.
Google Scholar WorldCat

Mesa-Lago, C. 1993. “Ajuste, Re-estructuracion, Costo Social y Política de Seguridad Social en America Latina.” *Documento de Trabajo, Serie Seguridad Social*. San Salvador, El Salvador: FundaUngo.
Google Scholar Google Preview WorldCat COPAC

Ministerio de Salud (MINSA), Organización Panamericana de la Salud / Organización Mundial de la Salud. 2015. *Cuentas Nacionales de Salud Perú 1995–2012*. Lima: Ministerio de Salud.
Google Scholar Google Preview WorldCat COPAC

Ponce de Leon, Zoila. 2020. “Political Parties and Policy Reform: Expansion of Healthcare in Latin America.” *Unpublished manuscript.*
Google Scholar Google Preview WorldCat COPAC

Pribble, J.. 2013. *Welfare and Party Politics in Latin America*. Cambridge: Cambridge University Press.
Google Scholar Google Preview WorldCat COPAC

Ruckert, A., and R. Labonté. 2014. “Public–Private Partnerships (PPPs) in Global Health: The Good, the Bad and the Ugly.” *Third World Quarterly* 35(9): 1598–1614.
Google Scholar WorldCat

Ruiz, F., L. Amaya, and S. Venegas. 2007. “Progressive Segmented Health Insurance: Colombian Health Reform and Access to Health Services.” *Health Economics* 16: 3–18.
Google Scholar WorldCat

Villar, J., E. Valladares, D. Wojdyla, N. Zavaleta, G. Carroli, and A. Velazco. 2006. “Cesarean Delivery Rates and Pregnancy Outcomes: The 2005 WHO Global Survey on Maternal and Perinatal Health in Latin America.” The *Lancet* 367: 1819–1829.
Google Scholar WorldCat

World Bank Data. 2022. *Domestic General Government Health Expenditure (% of Current Health Expenditure) - Latin America & Caribbean.* https://data.worldbank.org/indicator/SH.XPD.GHED.CH.ZS?locations=ZJ
Google Scholar Google Preview WorldCat COPAC

Zurita, B., and T. Ramírez, T. 2003. “Desempeño del sector privado de la salud en México.” *Caleidoscopio de la salud*, 153–162.
p. 948 *Mexico DF*: *Funsalud*. ↳

Notes

2 In 1999, the Peruvian Social Insurance, EsSalud, replaced IPSS. C62.N2

3 IPSS would pay a fixed price previously arranged with qualifying private providers. C62.N3

4 Between 1980 and 1990, social expenditure as percentage of GDP went from 15.2 to 11.7 in Chile. It remained low in Mexico, going from 6.7 to 9.2, and very low in Peru, going from 4.1 to 4.5 (Huber and Ponce de Leon 2019). C62.N4

5 The remaining 2 percent was affiliated to the Military and Police Health System. C62.N5

6 The World Health Organization officially defines this indicator as the “share of current health expenditures funded from domestic private sources,” including “funds from households, corporations and non-profit organizations. Such expenditures can be either prepaid to voluntary health insurance or paid directly to healthcare providers” (World Health Organization Global Health Expenditure database, apps.who.int/nha/database). C62.N6

7 The purchase of private services for *Seguro Popular* interventions has mostly advanced in the states of Nuevo León and Jalisco, and later in Hidalgo. C62.N7

8 The copayments vary depending on the provider the patient chooses, and it is completely free for groups A and B (lowest income groups) of FONASA. C62.N8

9 For patients to have access to Bono AUGE, they have to claim it from FONASA, which many do not do in part because they do not know that the mechanism exists. C62.N9

10 If the public hospital cannot provide the required attention, either because of long waiting lists or lack of technology, physicians—who generally work for both the public and private sectors—can suggest patients to go to their private offices or even provide attention at the very same public hospitals during the afternoons. C62.N10