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WOMEN'S NEEDS AND THE RESPONSE OF HEALTH SECTOR REFORM EXPERIENCE IN CHILE

HEALTH INSURANCE AND WOMEN's COVERAGE[1]

The National Women's Service of Chile (SERNAM) hereby submits the findings of the study, "Health Insurance and Women's Coverage," to the 18th Session of the Subcommittee on Women, Health, and Development

The background presented is a summary of the Consultation on Health Insurance and Women's Coverage held by SERNAM in 1998. The purpose of the Consultation was to update the 1995 study on this topic that was submitted to this Subcommittee during the April 1996 session under the mutual collaboration agreement between this State Secretariat and the Ministry of Health, with a view to eliminating the inequalities and inequities in health for Chilean women. The reform of the Chilean health system was the occasion for this Consultation to explore the operations of the private health system, since the Chilean health system consists of both a public and a private sector.

The Consultation has made it possible for us to analyze and search for alternative mechanisms to reduce the inequities connected with the increased cost of women's coverage, since it clearly discriminates against women.

SERNAM is pleased to contribute with this study to the discussions of the Pan American Health Organization's Subcommittee on Women, Health, and Development.

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ISAPREs are private entities that, under the principle of “State subsidiarity,” intervene in the granting and financing of health services for their subscribers and beneficiaries. In fact, Chile’s national Constitution calls for free choice in the selection of health care providers; this is implemented through the decision to require workers to pay the health insurance premium, compulsory for salaried workers and voluntary for independent workers, to a private insurance entity in order to obtain the health services and benefits stipulated in its respective health plan.

Strictly speaking, the private health insurance system works as a social health insurance system without fully being one, since it does not meet the requirements and principles of social health insurance. It is "social" because, legally, it is one of the options from which salaried workers must choose to channel the compulsory premiums deducted from their wages—premiums that constitute a given percentage of their remuneration.

The ISAPREs, as the private entities that they are, pursue profits, seeking a wider utility margin for the risk assumed. Hence, they reject users who may pose a greater risk for relatively higher costs due to their demand for health care or else they increase their premiums. In this vein, there are three elements that determine the quality of coverage in the private system: age, sex, and the subscriber’s income.

The older the contributor, the greater the need for medical coverage and, accordingly, the higher the cost to the health insurer. Thus, older people pay higher premiums.

Women, in turn, are associated with maternity costs: maternity leave subsidy, medical leave associated with pregnancy, the puerperium, delivery care, and women’s disorders, all deriving from their biological profile, in addition to their greater longevity, which for the ISAPREs implies maintaining the contracted coverage for longer periods.

Finally, the subscriber’s income determines the quality of the health plan available. Actually, the ISAPREs offer a wide range of health plans. Each institution offers an array of pricing formulas, and each plan, in turn, operates with a given premium, based on the price of the health services, which determines the coverage offered. Each ISAPREs has "good" and "bad" plans in terms of the coverage provided. Thus, access to private coverage is directly dependent on the wage level of the subscriber.

Law 18.933, Article 38 establishes the operational mechanism whereby the ISAPREs differentiate subscribers by age or sex. ISAPREs are authorized to review health insurance plans once a year and are permitted to adjust their prices, services, and

the nature and monetary level of their benefits to the general conditions of the subscribers of a particular plan, with the exception of specific conditions agreed to with each subscriber at the time he/she joins the plan. Actually, increased risk is expressed in the premium collected from the subscriber by the ISAPREs. Strictly speaking, the health insurance contract includes a table with the price schedule for the health plan, broken down by age and sex of the subscriber and his/her beneficiaries. Applying the risk factor, the price of the coverage increases as a function of sex, age, and the number of dependents.

The law does not require ISAPREs to maintain the same level and type of medical coverage on a continuing basis. In fact, they are authorized to totally modify health contracts to keep pace with rising prices, whenever they deem that a member represents a higher cost than that anticipated at the time he/she joined, because of sex, age, or the number of dependents. The law imposes only one constraint on the ISAPREs in this review process: they must not discriminate among the beneficiaries of a particular plan, except for the special conditions agreed upon with each subscriber, and the changes cannot take the health status of the beneficiary into account.

Thus, each subscriber in the private system pays for the risk that he represents to the insurer through his own premium. This translates into situations of over-insurance and under-insurance. In effect, a young, unmarried, healthy male professional is in a position to gain access to a much higher level of insurance than he needs, while a mother herself must bear the cost of the increased risk associated with maternity care. Similarly, in old age the risk and the need for medical care increase, and the members themselves must bear the cost of this increase and, therefore, the policy, with their premiums. Thus, the system provides no regulation or mechanism to permit the redistribution of risks within the insurer, balancing the risks of all members.

However, with regard to women's coverage in the private health insurance system, women are not only discriminated against after they join the private system, in view of the discrimination that is sanctioned by law, but must pay higher rates when they enter the system, given the higher risk that they pose to the private insurer as a result of the medical costs exclusive to women: maternity and female disorders.

Other aspects should therefore be considered when adjusting health plans for increased risk; for example, a potential increase in the demand for health services; excessive care required, and the incidence of preexisting conditions.

The gender variable clearly operates against women here; their insurance coverage is more expensive because they directly bear the cost of reproduction. Therefore, this is a matter of concern and is the responsibility not only of mothers but society as a whole.

Law 19,381 of May 1995 on reform of the private health insurance system did not substantially alter this point. The authorization of ISAPREs to conduct and annual review of the price of health plans remained intact, but the law called for subscribers to be notified of this change not 30 days, but two months in advance.

The law also stated that if a subscriber rejects the modifications proposed by an ISAPREs, it must offer a new plan that maintains the price schedule based on sex and age that was used in the original health plan. If the plan does not meet these requirements, the subscriber can appeal to the ISAPREs Authority.

As can be seen, at this point the reform maintained the principle of allowing discrimination based on the level of risk posed by the member—the principle on which the activities of the ISAPREs are founded.

Here it is worth mentioning some reflections on the regulatory role of the State in private health insurance. By constitutional mandate, the State is responsible for the coordination and monitoring of activities in health, ensuring that they effectively fulfill the constitutional guarantee of free and equal access to health (Article 19, Section 9). This is accomplished through legislation and regulations; and through oversight agencies such as the ISAPREs Authority.

There is more reason than ever to support the original purpose of the labor laws and the Social Security System to provide protection for workers whose situation exposes them to unequal treatment. Working mothers are at a particular disadvantage. The law should protect their jobs during the period prior to and immediately after delivery; support the maternity subsidy as an instrument for wage continuity; and safeguard leave for the care and feeding of young children.

Social security guarantees access to comprehensive health care precisely to those who cannot provide it for themselves. Moreover, it provides coverage for all social risks—that is, events or situations that are the responsibility of society as a whole: disease, disability, occupational injuries and diseases, unemployment, maternity, dependent relatives, old age, and death.

However, these basic principles that have served as the foundation for the protective labor and social system have been enriched with new concepts involving other objectives. Thus, based on the broad recognition of fundamental rights contained in international declarations, an attempt is currently being made to ensure that the labor and welfare system promotes equal access to work and health insurance coverage for men and

women. It involves guaranteeing equal access to employment and social protection to the people most exposed to discrimination, who in the workplace and in health tend to be women.

In other words, it is no longer a matter of making woman's traditional role easier, but of reorienting the legal system toward the equitable distribution of family responsibilities, thereby guaranteeing equal opportunity and equitable access to employment and health insurance to men and women.

To this end, it is necessary to promote shared family responsibilities, child care, and the social role of human reproduction. In the workplace this implies sharing what have traditionally been considered exclusively women's responsibilities and in health insurance, guaranteeing equitable access by women to health care. This obviously translates into a challenge to introduce equity into current ISAPREs operations related to women's coverage.

Under these premises, the ISAPREs' practice of making women's coverage more expensive than men's is clearly discriminatory: it is based on the assumption that health care for women at all stages of their life cycle is more costly than for men, viewing women's reproductive function as the principal differentiating factor.

2. Costs Associated with Women's Coverage in Chile's Private Health Insurance System

It is common among the ISAPREs to claim that they fully finance all the health services of their subscribers. However, the private health insurance system has benefited from several public subsidies—some formal, some actual—that have left them on an unequal plane with the public system, to the advantage of the ISAPREs.

It is important to clearly distinguish the areas of women's medical care that are state subsidized from those supported entirely by the ISAPREs in order to unequivocally determine the *real* higher women's health costs that lead the ISAPREs to make such coverage more expensive.

2.1 *Public Subsidies to the Private Health Insurance System*

2.1.1 *Law 18.418. Transfer of Financial Subsidies for Maternity Leave to the Treasury*

In order to facilitate access by women to the private health system, the authorities opted to transfer the financing of subsidies for maternity leave to a public fund. One barrier to women subscribing to the private system was thus torn down.

Under Law 18.418 of 11 July 1985 the payment of subsidies for maternity leave, and leave to attend to sick children under 1 year of age became the responsibility of the State. The ISAPREs remained in charge only of the subsidies for the complementary pre- and postpartum leave.

This state subsidy allowed the ISAPREs to reduce their discriminatory practices against women, cutting the cost of women's coverage made it possible to view them as desirable subscribers and thus incorporate them in the private system.

However, as we have already seen, the system retained the mechanisms that differentiated beneficiaries by sex when granting the respective health plans, which enabled the ISAPREs to discourage membership by people considered a higher risk because of the higher cost of the medical benefits they are likely to demand.

2.1.2 *Law 18.566. Additional 2% Premium for ISAPREs Subscribers*

Giving workers greater leeway in terms of their right to opt for the private health system, Law 18.566 of 30 October 1986 decreed that salaried workers had the right to ask their employers to pay an additional premium for them of up to 2% of their taxable wages to the ISAPREs that they subscribed to. Companies could deduct this sum on their income tax declaration, thus lowering their taxes.

This was the second subsidy that the private system took advantage of to facilitate private system affiliation by workers who in principle would have been rejected because they were unprofitable for the ISAPREs. However, current figures reveal that the state contribution did not always result in real access to better levels of care for subscribers to the private system. Many of the workers who joined the system as a result of the additional 2% contribution did not have a high enough income to select good health plans. This means that they had access only to lower quality plans, which in practice meant resorting to the public system when they required more serious or complex care. Thus, the formal 2% subsidy increased through crossed care.

The draft legislation to reform the public health system, submitted to the Chamber of Deputies to begin the legislative process in January of the present year, provides for repeal of the additional 2% contribution to the ISAPREs.

The argument for this initiative is that the additional contribution constitutes a regressive mechanism. In fact, since this payment is a percentage of the taxable income of every worker, the contribution for lower-income subscribers is smaller than the one for

higher-income subscribers. Hence, as we pointed out earlier, lower-income subscribers to the private system cannot make the copayments stipulated in their plans and must turn to the public system for more complex care.

In addition, there are indications that the subsidy in itself entails the application of a discriminatory principle that militates against contributors to the state system who do not receive the subsidy; and within the private system itself, against independent workers who do not receive the subsidy either.

The draft legislation in question calls for the immediate repeal of the additional 2% premium for subscribers who join the private system after the law is enacted and its gradual elimination for current contributors within four and a half years, through periodic reductions in the additional percentage of premium.

2.1.3. *Crossed-care Subsidy*

Law 18.469, Article 26 allows people who are not beneficiaries of the public health system because they contribute or benefit from the private system to receive institutional medical care in emergencies, in the absence or poor quality of institutional services for the specialty in question, or the absence or scarcity of professionals in the specialty.

The ISAPREs provide greater coverage, particularly when it comes to low-cost, curative care. Private health insurance decreases as the degree of complications and the cost of the required care increase. In practice, therefore, most care at the second or third level is transferred to public facilities that are less expensive than private medical centers. Thus, ISAPREs subscribers turn to public health facilities, which are reimbursed by the private entity for a percentage of the cost of coverage for that care.

The public system is currently being modernized, which translates basically into upgrading its information systems and identifying patients at public health facilities by having them show their health insurance card and verifying their membership in an up-to-date database. This is intended to ensure that the reduction in the fee for services benefits FONASA patients exclusively and, accordingly, that beneficiaries of the private system who receive care in public facilities pay the full fee. This has made it possible to regulate the care provided to ISAPREs members in the health services, to keep track of the number of patients in the public system and their contributions, and to see to it that the ISAPREs actually pay on the basis of the real value of the care received by their beneficiaries.

2.2 *Direct Cost to ISAPREs for Women's Care*

2.2.1 *Subsidy for Supplementary Maternity Leave*

Law 18.418 transferred the financing of the subsidies for maternity leave to the Treasury; however, the special subsidies for supplementary leave in the pre- and postnatal periods are the responsibility of the ISAPREs—that is, those that apply if an illness occurs during pregnancy as a result of the pregnancy before the beginning of prenatal leave or if childbirth results in an illness that prevents the mother from returning to work once the postnatal leave ends.

2.2.2 *Delivery care*

Law 18,469 of November 1985 lists the minimum compulsory health services that the ISAPREs must provide without collecting an additional fee from subscribers.

For maternity care, these basic benefits include prenatal care and care up to the sixth month after childbirth, as well as care of the newborn up to the age of six, but not delivery care, which is subject to whatever coverage is stipulated in the health plan.

The ISAPREs used to include delivery care in the "waiting period," granting proportional coverage from the date the beneficiary joined the plan, based on the time remaining until delivery.

This practice became compulsory under Law 19.381 to reform the private system. That law stated that the health plan should provide proportional coverage of delivery based on the time remaining until the birth.

2.2.3 *Medical Leave*

Medical leave is a monetary benefit that allows workers temporarily prevented from working for reasons of health to enjoy relative continuity of wages. This benefit is the responsibility of the health insurance institute with which the worker in question is affiliated, either FONASA or an ISAPREs.

The regulations governing the granting of medical leave make it possible for the ISAPREs to operate with restrictive criteria, providing broad mechanisms to restrict, reduce, and ultimately invalidate medical leave.

Supreme Decree No.3 of 1984 laid down the rules for the requesting and granting of medical leave in both the public and private systems but failed to mention the criteria

that should be considered by health institutions for denying or reducing the leave requested by users. This left the field open for the ISAPREs to apply restrictive criteria to improperly shorten or deny applications for leave, under the premise of containing insofar as possible the costs associated with their members' coverage.

Added to this, Law 19.381 reforming the private health system conceded to the ISAPREs Authority the control of the procedures for appealing denials or reductions in medical leave, while denying the Authority control over the medical aspects of the benefits granted by the private sector. Thus, the oversight agency lacks the authority to decide whether the denial of medical leave by the ISAPREs is based on therapeutic criteria.

During a worker's medical leave, under Supreme Decree No. 3 the ISAPREs are authorized to review the efficacy of the medical leave through home visits to verify the condition of the worker. If the ISAPREs deems that the worker is not using this time to rest properly, it can immediately invalidate the leave.

Any appeal of the denial of medical leave must be filed with the Preventive Medicine and Disability Commission (COMPIN), which will issue a ruling on the handling of the medical leave by the respective ISAPREs. Thus, the law makes enables ISAPREs to postpone the utilization of leave, and it is up to the worker in question to request the intervention of the public agencies through a subsequent appeal within the allotted time frame.

Monitoring of the legality of ISAPREs actions should not depend on the diligence of the individuals affected or on the availability of the information media that they can access but should be applied preventively to such institutions.

The specific costs of women's coverage that must be directly paid by the ISAPREs are mainly linked to maternity benefits, except for medical leave, which the ISAPREs claim increases for women due to their degree of morbidity, more often than not linked to their reproductive function or to the care of children, even though the subsidy corresponding to leave to care for a sick child under one year of age is public.

Concerning the exclusive assignment of the additional cost of delivery care to women, it is necessary to analyze mechanisms that could make it possible to distribute that cost more equitably.

3. Possible Areas of Legislative Action to Secure Greater Rights for Users of the Private Health Insurance System

It is now time to tackle the analysis of eventual legislative reforms to the private health insurance system as instruments to secure greater rights for the users of the private system, foreseeing, insofar as possible, their impact on costs to the system.

By way of introduction, it should be recalled that to arrive at the current regulatory framework for the private health insurance system, it was necessary to travel down a long road plagued with legal and regulatory modifications that often put the process off track, turning to regulations that were in force years ago and to others that represented substantial innovations in the entire system.

The private system was first legally recognized in Decree-law 3.500 of 1980 regulating the new health insurance system, whose Article 84 stated that salaried workers could pay their compulsory health insurance premium, or a voluntarily higher one, to a private institution or entity other than FONASA that would grant the worker health services and benefits.

The regulations for the newly created private health insurance system subsequently became a reality with Legal Decree No. 3 of 1981, which organized the system, implementing the regulations through the ISAPREs under what was basically a conventional scheme: health services and benefits coverage was bound to a health insurance contract between the member and the ISAPREs, under clauses requiring compulsory disclosure and legal limits to the autonomy of the parties.

Law 18.469 of 1985 and its regulations, sanctioned by Supreme Decree that same year, instituted the new health services regime, thus repealing the earlier statutes of Law 6.174 of 1938 establishing the system of preventive medicine. This law indicated the basic health services that the ISAPREs must cover without collecting a fee over and above the subscriber's premium.

In 1990 Law 18.933 regulating the private system was promulgated. This is the legal framework currently in force. The ISAPREs Authority was created as a public agency in charge of the monitoring and control of these private health insurance institutions. It also strengthened the regulations governing the health plans and benefits financed by the private system.

Finally, in 1995 Law 19.381 reforming the private health system was published. This legislation bolstered some users' rights and regulated matters such as new functions for the Authority, the right of members to any surplus from premiums paid to the health plan contracted, improving users' access to information, coverage limits, and exclusions.

Since this is the current regulatory framework of the private health system, we will analyze the topics that are relevant to the operation of the ISAPREs, as key areas to consider in any legislative attempt to secure greater rights for the users of the system, starting out with the premise that not just any modification of users' rights will improve the coverage of women in the system.

It should be borne in mind that any initiative to alter the private system will have its correlate in increased operating costs for the ISAPREs, which will no doubt result in new barriers to access in the system, either through an increase in the price of health plans or a proportional reduction in coverage. In each case it is therefore a matter of anticipating the potential impact of every initiative for change on the operations of the system.

3.1 *Public and Private Health Insurance*

Although the ISAPREs are subsystem of health insurance that, together with FONASA, is responsible for providing social medical benefits, either through direct care or its financing, in practice it functions as private health insurance.

In fact, the private health insurance system works on an undeniably contractual basis, leaving it up to the parties involved to freely determine the health services and benefits that the ISAPREs will grant. Thus, it does not provide uniform, universal, ongoing, and adequate benefits, only those that can be financed with the compulsory or supplementary premium determined by the subscriber’s morbidity profile; this permits the ISAPREs to label the subscriber as profitable or unprofitable, based on the anticipated costs that his/her membership will entail. Thus, the system operates with lack of coverage, explicit exclusions, and preexisting conditions.

In addition, the ISAPREs system operates alongside FONASA, offering itself as a more efficient, higher quality alternative; in practice, however, the public system acts as a reinsurance system, since it covers all people who are partially or totally discriminated against by the private system because of the risk that they represent. Moreover, the public hospitals attend to private insurance-holders who are faced with high copayments when they require care.

For the moment, the coexistence of the public and private health insurance systems has already been addressed in actions aimed at ending the subsidies that the private system takes advantage of and that give it an advantage over the public system. This is the purpose of FONASA initiatives to prevent crossed-care subsidies and to draft legislation repealing the additional 2% premium for subscribers to the private system.

Moreover, the need to restructure the model for the private health insurance system, which is currently based on competition between multiple providers, has been discussed. The alternatives are geared toward the design of a "basic package or guaranteed universal coverage" that would include the entire population. This involves guaranteeing sufficient general coverage while permitting the freedom to choose among insurers.

A first alternative would be to design public insurance that provides a basic package of benefits that would be financed by the compulsory health insurance premium and state contributions, administered by a single insurer. Thus, a common social security umbrella for the entire population would be established that could be supplemented with additional private coverage financed directly by the interested parties or group plans. This initiative assumes that the ISAPREs or private insurers will no longer receive the compulsory premium and will be financed only with the supplementary premiums established for individuals or groups.

The variant of this proposal consists of dividing the basic health plan into two parts: the first covering frequent and common pathologies and financed with compulsory contributions and state subsidies, with competition among multiple public and private insurers; and the second, explicit reinsurance to cover catastrophic illness, administered by a single insurer and financed with a percentage of the resources of every insurer.

As can be seen, the existence of a common plan provides a "floor" of coverage for the entire population and determines the areas in which multiple insurers would compete.

These initiatives could be of interest as instruments to reduce the inequalities in the cost of coverage for women and men under the current private insurance system; this is especially true for the design of a basic health plan that could be complemented with freely chosen private insurance.

A single guaranteed plan for everyone, financed by all compulsory health premiums and state contributions would require a common fund to finance all medical benefits. Consequently, there would be no place in this single, general plan for age- or sex-based distinctions between users regarding morbidity risk. Under this scheme, the basic premise of the system would be solidarity—between income levels, young people and old people, the healthy and the sick. More important for us, however, would be the tendency of the system to distribute the cost of human reproduction among all of society.

Outside of these alternatives to modify the private health insurance system as a whole, this Consultation has not been able to obtain information on other initiatives that point in the same direction.

3.2 *New Functions for the ISAPREs Authority*

We are interested in analyzing the new monitoring and control faculties of the Authority, as instruments for securing greater rights for users of the private system.

The law governing the ISAPREs is significantly lacking in two basic areas that are key to every subsidized health insurance system: it does not oblige the ISAPREs to provide a minimum level of benefits—that is, minimum regulated coverage—and, by not establishing some mechanism for redistributing risk among all subscribers to the system, it permits situations of overinsurance and underinsurance vis-à-vis the level of risk posed by each subscriber, a circumstance that translates, as we already have seen, into discrimination against people that represent a higher level of risk.

Within this context, the functions of the ISAPREs Authority are limited to the current legal framework. The Authority cannot issue rulings or instructions with respect to the material content of the benefits financed for or provided to the beneficiaries of the system. Instead, it oversees the legality of the health plans marketed by the ISAPREs, ensuring that they meet the legal requirements.

Although strengthening the current oversight functions of the Authority did not seem especially relevant during the discussions on reforming private health insurance, it is indeed in the current context in which the ISAPREs tend to issue their subscribers closed or semi-closed medical plans—that is, plans that contain a package of benefits granted by a single or preferred provider.

This is the trend toward offering a health plan that covers all the services provided in a given health facility, which implies a reduction in the cost of care for the ISAPREs. While this also results in a reduction in the user's copayment, it also limits the freedom to choose a health care provider.

Under this modality, it seems clear that the term “health care provider” should no longer be understood as any individual or legal entity to which the user can recur for health services—in which case the ISAPREs is a mere intermediary in charge of paying for a service granted by a third party—but as an integral part of the health plan; hence, identification of the health care provider is an element of the health insurance contract.

Thus, it can be said that the ISAPREs, under a closed or semi-closed health plan, should guarantee that the benefits provided by the single or preferred health facility stipulated in the health plan should have a minimum level of quality, which implies oversight of their content and quality.

In addition, the Authority has noted the desirability of legally requiring the approval of health plans by its oversight entity before they are marketed by the ISAPREs. This would make it possible to ensure their legality before they are offered to the public, strengthening the work of the Authority in safeguarding the rights of the beneficiaries of the system.

This strengthening of the oversight function of the Authority would result in more transparent ISAPREs operations by requiring prior approval of the health plans and exercising control over the quality and nature of the benefits provided in closed or semi-closed plans.

However, none of this would improve the situation of women in the private system. Assessing the degree of morbidity attributed to women, the ISAPREs would continue to make women's coverage more expensive than men's.

3.3 Is It Possible to Prevent Discrimination against Women in the ISAPREs System?

Considered structurally, the private health insurance system does not permit limited reform that would imply an end to the differential treatment of women. The very design of the system dictates that ISAPREs will not stop considering women at higher-risk for medical care, since they require more medical care because of their morbidity profile and their greater longevity, and because the ISAPREs institutions are solely responsible for the cost of delivery care.

In other words, under the ISAPREs' current operational scheme equal coverage for men and women is not possible, since the system operates on the basis of assessments of morbidity risk.

It appears to be incontrovertible that, into old age, health coverage for women is more expensive than for men, a fact that cannot be changed without subsidies. Moreover, women live longer than men, which implies a longer period of care to be covered by the system.

However, concerning maternity costs charged exclusively to women, this is indeed a discriminatory practice grounded in gender-based assessments that militate against women. The gender variable clearly operates against women here; it directly increases the cost of health insurance, assigning the cost of reproduction exclusively to women. It is therefore a matter that concerns not only the mother but society, which must share the responsibility.

Efforts should therefore be made to redistribute the cost of coverage for maternity benefits to make all of society responsible for reproduction, either by establishing a separate fund with contributions from all members of the system or an additional premium consisting of a percentage of the wages of all ISAPREs subscribers.

One idea would be to introduce a social investment fund specifically to finance maternity benefits. This fund could be administered separately, providing equal financing for all beneficiaries of the system, under the premise of collective responsibility for costs of reproduction by all member, an idea that has already been proposed by the Service in the initiative to expand day care through tripartite financing.

Thus, the disparities between coverage for women and men in the private system would decrease but not disappear. The differential treatment of women in which they bear the cost of human reproduction would end, but that would not keep the differentiating factors of morbidity and women's greater longevity from operating.

It is important here to mention certain ISAPREs practices that already promote the sharing of maternity costs. ISAPREs offer “marital plans” or “compensated plans” that involve shared premiums between spouses for family coverage, but whether they generate a surplus for members is debatable. As can be seen, these shared financing plans do not reduce the additional costs of women’s coverage but, rather, distribute it more equitably in the family income.

In this same vein, there are also health plans that do not include delivery coverage. These are designed for women who are no longer in their childbearing years or, if they still are, plan to postpone maternity. In these cases, the cost of coverage is reduced through the expedient of eliminating benefits—in this case delivery care.

These ISAPREs initiatives, a clear example of their ability to diversify their product and adapt rapidly to new situations, can be viewed as progress, although, as we have already said, they are insufficient for improving the system, thinking structurally about the differentiation based on costs associated with maternity. Delivery continues to be considered a factor that increases the cost of coverage exclusively for women.

Concerning the users of the private system, it is customary for the ISAPREs to claim that the indiscriminate use of medical leave is a de facto subsidy to permit mothers to care for their children.

Medical leave is a complex topic in itself and goes far beyond the scope of the topic of women. In the first preliminary report of this Consultation, regarding the

monitoring of legalities in the granting or denial of leave by ISAPREs, we stated that their decisions are currently subject to eventual appeals to the COMPIN by the affected parties.

In practice, for the ISAPREs the decision on granting medical leave to a user implies verifying the validity of the attending physician's opinion through an opinion expressed by a physician who does not get to assess the patient, a questionable procedure. Moreover, the regulation governing medical leave—Decree No. 3 of 1984—allows the insurer, in this case the ISAPREs, broad discretion in monitoring the rest received by the worker during the leave, regardless of the real nature of the therapeutic rest involved. Thus, the leave can be rescinded leave if, in the opinion of the ISAPREs, the worker is not taking proper advantage of the time to rest.

However, excessive use of medical leaves also implies alteration of its natural objective, which is to serve as a monetary benefit to ensure wage continuity for workers unable to fulfill their customary duties for reasons of health.

In practice, the ISAPREs usually impose a monthly ceiling on subsidies for medical leave, tending to rescind that exceed the limit set.

The difficulties involved in proposing adequate reform of the system for granting medical leave are evident. There is an indisputable need to put the scattered regulations governing the granting of medical leave in order and to reorient oversight of the legality of the actions of private health insurers. On this point it would also seem reasonable to return to the efforts to strengthen the role of the Authority with in examining the decisions of ISAPREs that deny or reduce their users' medical leave.

4. Possible Alternatives to Regulation to Secure Greater Rights for Users of the Private Health Insurance System

This chapter attempts to trace possible lines of public action that the Service could undertake, in tandem with the eventual legal steps, to improve women's coverage in the private health insurance system.

We will attempt to schematically describe initiatives that, regardless of the legislative proposals put forward to modify the system, can have a positive impact, eliminating or impeding discriminatory practices against women in the ISAPREs system.

Improving coverage for women will inevitably become part in the overall effort to give greater rights to all users of the private health insurance system. Indeed, the aspects related exclusively to improving the situation of women is related to reducing the cost of delivery care and establishing a social investment fund to cover the medical aspects of

maternity care. However, the other topics that interest us—coverage in old age, access to information, evaluation of health plans—are related to improving the general situation of all users of the private system and, with that, system's subscribers and their dependents.

4.1 *Possible Reduction in the Cost of Delivery Care*

It is not difficult to deduce from the continuing practices of the ISAPREs that they regard delivery care as health care that necessarily requires the skills of a physician, no matter who else is present, whether midwife or nurse.

This practice is not necessarily guided by health needs or good outcomes in delivery procedures, but on economic factors when setting a value on the services provided to the users of the private system.

In fact, strictly speaking, it is appropriate to define medical care as a specific health service and not as the generic form of health care delivery. Until statistics are available on morbidity from the respective procedure, physicians should not be considered indispensable in delivery care.

Thus, distinguishing between a "health service" that can be provided by any member of a health team—e.g., nurse or midwife—and "medical care," that is, care provided strictly by a physician, it is possible to obtain a reduction in the cost of delivery care, which the ISAPREs take into account when determining differential treatment for women in the private system in terms of access and coverage.

It is possible, then, to state that the presence of a physician is not necessarily required in a normal delivery, which implies a health service of lesser value than that assigned to it by the ISAPREs, significantly reducing the costs associated with maternity.

Thus, we can think about designing ISAPREs health plans that allow for alternative types of delivery care: a plan that considers the formation of a team that can handle a normal delivery without a physician and another plan that includes one,

providing medical care if the case warrants it. In that circumstance, the plan health in question should view this emergency medical intervention separately, and not as a cost added to every delivery.

The main objection to this initiative is that reducing the cost of care should not adversely affect health, which leads some people to assert that the risk associated with childbirth makes the presence or supervision of a physician advisable in all deliveries.

Seeking an alternative, perhaps it would be more feasible to cut the cost of delivery care by reducing the post-partum hospital stay, a practice that in a normal delivery would result in greater inconvenience to the mother but would not endanger her health or that of the newborn.

However, as we underscored in the second preliminary report of this Consultation, these proposals should not forget that the gaps in the price of coverage for women and men will only decrease, not disappear, because apart from maternity costs, higher morbidity and the longer life span of women also make women's coverage more expensive.

4.2 *Possible Segmentation of the Users of Private Health Insurance Systems*

An interesting line of analysis, as yet unexplored, consists of informing the public about the way to take maximum advantage of their compulsory health insurance premium, opting to join either the public health insurance system or the private one. Can a real limit based on monthly wages be set that will make it possible to identify the universe of members for whom the use of FONASA or the ISAPREs system would be more desirable? The problem is inherently difficult, since many factors intervene in determining the real health coverage to which individuals can aspire based on their monthly wage level: the sex and age of the subscriber, family size, the health status of the users of the selected health plan, and existence of group health plans.

The first thing that must be considered is the effect of group health plans when defining the universe of subscribers to FONASA and another, larger one for the ISAPREs, based on monthly wages. Specifically, group health plans are instruments for improving coverage that, contracted individually, would be inadequate.

In practice, it would seem that the impact of agreements as instruments for keeping low-income subscribers in the private system is not very significant, considering that these users, even with group health plans, turn to public facilities when they need care, due to the poor coverage in their plans. That is, even with group plans, a material gap would remain because of the percentage of copayment the user would have to pay, causing lower-income subscribers to return to public facilities for care.

At the same time, it should be noted here, with regard to the free choice modality, ISAPREs coverage is generally better than that of FONASA, which means a smaller copayment for the user; under the free choice modality, FONASA subscribers must make a copayment equal to 50% of the value of the service received.

It will not be easy to undertake a definitive wage-based segmentation of workers all of a sudden that will make it possible to clearly define the universe of subscribers for whom affiliation with one health insurance entity would be preferable to another. In fact, neither FONASA nor the ISAPREs Authority has conducted studies in this regard.

Therefore, it would seem that before clearly and unequivocally setting a limit on the amount of monthly wages that workers must earn in order to opt for a given health insurance system, users of the public and private systems should be properly informed about the most inexpensive providers available. This will enable them to take advantage of the coverage provided by their health plans and keep from increasing the percentage of copayment.

5. Conclusions

5.1 *Considerations for Legislative Action to Improve the Coverage of Women in the ISAPREs System*

Under the current structure of the private system and bearing in mind the specific legal functions of the Authority, it is difficult to put forward a single regulatory solution for securing greater rights for the users of the private system. Instead, what appears to prevail is a broad reasoning that implies the resolution of new problems and complications arising out of the very operations of the ISAPREs, depending on what instruments they apply, their estimation of related costs, and the new types of health plans that they offer.

For this reason, the Authority tends to clear the way by issuing circulars and rulings to solve new problems, giving priority to certain areas depending on the way and direction in which they insinuate themselves into the ongoing operations of the ISAPREs.

There is a visible trend in the private system toward promoting affiliation with either closed or semi-closed health plans stipulating a single or preferred provider, or else, group health plans, all of which imply a reduction in costs for the ISAPREs and, in principle, better coverage for subscribers.

It is easy to see that competition in the sector has led some ISAPREs to launch initiatives that, in principle, facilitate coverage in areas that are especially sensitive for women. This is the case for marital health plans, which are shared premiums for spouses that make it possible to distribute maternity costs more equitably. There are also initiatives to provide coverage in old age through the premiums amassed during the years of subscribing to the respective ISAPREs, another interesting alternative.

However, it is impossible to unequivocally assess the impact of any of these contracting variables as long as their operation and practical application are not observed.

Nevertheless, there seem to be some potential areas of regulation that can be modified to achieve the general objective of securing greater rights for users of the private system, and specifically, improving the coverage of women.

Regarding the first objective, it is a matter of specific initiatives. The Authority itself determines what content is most suitable for these initiatives, based on its daily experience. From here come the ideas of strengthening the oversight agency to obtain control over the quality and nature of the benefits granted and financed by the system, especially those of the closed or semi-closed health plans; ensuring the legality of the health plans prior to their marketing; systematizing and organizing the regulations governing the granting of medical leave; and, providing clearer regulations on the cost of the health plans that the ISAPREs market.

These are initiatives, therefore, whose optimum design and implementation fall naturally to the Authority.

Concerning the objective referring to the different treatment of women in the private health insurance system, it seems clear that this can be approached only with a view to ending the gender distinctions that discriminate against women by preventing equal opportunities for men and women.

The goal is to end the practice of burdening women exclusively with the cost of maternity, which, as we have seen already, results in higher insurance premiums. To this end, collective considerations should be emphasized to encourage the practice of sharing the added cost of covering human reproduction among all members of the private system by creating a fund to cover the cost of delivery care for all female users. This fund would financed with a percentage of the health premiums of all ISAPREs subscribers.

5.2 *Considerations for Lines of Public Action to Improve the Coverage of Women in the ISAPREs System*

a) Mention has been made in this Consultation to cutting the costs of delivery care by using birth attendants other than physicians, except when complications arise. Comparative experiences in public health and maternity care support this alternative, and the trend has been in that direction, with positive results.

We should not lose sight of the fact that in the delivery care provided by FONASA, which could shed light on alternative modalities, despite the greater risk during delivery, physicians are not considered indispensable.

At the same time, health insurance plans can insist on reducing the length of the postpartum hospital stay as another measure for cutting the cost of delivery.

b) It is necessary to promote efforts to disseminate information on the legal rights of dependent relatives with respect to coverage in private health plans.. We have already seen that the current legal instruments guarantee extension of the health coverage obtained by the subscriber to all family members eligible for a dependency allowance. This would mean providing adequate information on both their right to appeal decisions and the procedures to follow in appeals, rather than initiatives to increase their rights.

It should not be forgotten, however, that any person who believes he has the legal right to take advantage of a health plan provided by an ISAPREs and who is not listed in the plan as a beneficiary must take his case to the courts, a process that involves difficulties and delays. It seems reasonable, then, to demand that, from the time a worker subscribes, ISAPREs health plans cover not only those whom the subscriber has declared as dependents, but all his/her legally recognized dependent relatives.

This would not be difficult to accomplish with the databases available in the public services. It would then be possible to consider coordination to provide such information to the ISAPREs, facilitating extension of the coverage contracted to all the legal dependents of subscribers, in compliance with the law.

c) Establishing a kind of market segmentation by wage level of the contributors as way of maximizing utilization of the compulsory deduction for the health insurance systems is difficult for the moment. Added to the factors that would influence the determination of which health insurance system would be most desirable for contributors are both the results of the draft legislation submitted to the legislature calling for the repeal of the additional 2% premium for members of the ISAPREs system and the effects of group health plans. These factors imply an increase in the price of the health premium (the additional 2%) or permit access to coverage—in principle, an additional group plan—altering any prior conclusions about an optimal private health insurance system that takes only the wages of subscribers into account.

Although this topic is pending, it can be stated that maximization of the contracted coverage largely depends on the ability to access a wide range of providers that

charge different prices for services, allowing members to choose the ones they consider most desirable in terms of price and quality.

d) We are not in a position to state unequivocally that group health plans substantially and in all cases improve the coverage that could be contracted individually. We can talk about general trends that enable us to say, in principle, the group health plans do appear to be a viable alternative for improving health coverage without indicating to what extent they do or whether the improvement is actually significant.

What is needed is further observation of the practical evolution of group profits and the administration of surplus premiums inside and outside the group plans. In short, comparative studies of individual and group plans must be conducted to get a clear picture of the degree of significant improvement.

e) During the course of this Consultation we have taken note of a variety of ISAPREs initiatives that offer special health plans to obtain a better share of the market. ISAPREs tend to diversify their supply to design health plans that are more attractive to certain subscribers.

In this regard, we have confirmed the existence of health plans that guarantee a basic coverage for old age, although the amount of the premium for pensioners is insufficient to sustain the plan and seniority as a subscriber in the respective ISAPREs is required; joint plans for spouses, in which the couple shares in the financing of the family plan; and health plans that openly exclude delivery coverage, permitting women to plan the cost of pregnancy or else to exclude the additional cost if they do not wish to be mothers or do not plan to have any more children.

In short, these are alternatives that, under the ISAPREs system—which we have already said functions as private insurance—may be more desirable to users and/or members. Use of these alternatives could become more common if subscribers or users of the ISAPREs were properly informed about them, in concert with the ISAPREs Authority, as a way of facilitating access in the private system to the best alternative for women's coverage among the health plans marketed by the ISAPREs. This notwithstanding evidence that the gender assumptions incorporated into the structure and operation of the coverage granted by the private health insurance system discriminate against women. The result is plans that make health care for women more expensive by placing the financial burden of reproduction squarely on them, thus violating the principle of equal opportunity for men and women.

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