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Reform of Healthcare and Pension Systems in Chile (Conclusions for Poland)

Abstract

Health reform in Chile attemps to improve healthcare of the citizens. The authorities of the country managed to combine both the private (ISAPRE) and public systems FONASA). The biggest success was the creation of AUGE (state subsidies for 66 diseases). The unsolved problems are as follows: long waiting lists and shortages of beds in public hospitals, shortage of medical doctors and specialists. As far as the pension reform is concerned Chile was the first state in the world which in 1981 totally privatized the public pension system. Unfortunately, the fruit of changes in Chile is less optimistic (extremely low pensions) than it was initially assumed. According to specialists the only chance for a correct work of the pension system is introduction of the system which would combine two forms, i.e. a state intergenerational agreement and capital system.

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Reform of health care system in Chile

1. Introduction

Organization of healthcare under the state control has its origins in the 19th century, when elements of social policy were initially introduced during the Industrial Revolution. In the places where first bigger workers' settlements appeared the state wanted to provide some healthcare. This process had various forms worldwide. In South America at the beginning of the 20th century healthcare system was based on colonial patterns. Hospital were founded mainly in larger settlements. They were usually run by religious congregations and medical doctors were not paid. A richer part of the society used private medical practice, while a poor one – charity clinics. The development of social care in Chile started after the first world war. In 1918 the first Health Code *Codigo Sanitario* was introduced, pursuant to which the Department of Public Healthcare (*Servicio Nacional de Sanidad)* was established. Then they introduced "Obligatory Insurance Regulations for Working Class" (*La Ley de Seguro Obrero Obligatorio)*, which served as the basis for the development of healthcare in outpatient clinics. In 1924 the Ministry of Hygiene, Protection and Social Aid was founded which initiated integration of healthcare system , and gave citizens a right to treatment and hospitalization. In 1932 the Main Council of Benefits and Social Aid (*La Junta Central de Beneficencia y Asistencia Social*) was established, and five years later they introduced Law of Preventive Medicine (*La Ley de Medicina Preventiva)*, introducing the obligation of conducting systematic health tests among all workers.

2. Characteristics of population in Chile

According to the National Statistical Institute (INE, *Instituto Nacional de Estadisticas)* in 2010 the population of Chile was 17,1 million (49. 5% - men and 50.5%- women). Age structure is as follows: people below 15 – 22.3%, between15 and 60 - 64,8% and people over 60 – 12.9%. Almost 90% of the population lives in towns and more than 40% of them is concentrated in the Santiago region (Region Metropolitana). One may easily deduce from the data that Chile is approaching the living standards of developed countries with a growing income per capita.

A decline in occurrence of infectious diseases can be observed, but as in developed countries the amount of chronic diseases is growing. Chile is undergoing intensive epidemiological transformation. According to statistical data of the WHO income or life expectancy indicators are close to the ones in the countries with a high income per capita. The epidemiological situation in Chile is more optimistic than in the countries with similar economic indicators. Thanks to early plans of HIV/AIDS prevention and control which are accessible to all those in need and asking for help, this disease remains on a very low level with a low mortality rate[1].

According to *Superintendencia de Salud* about 72.7% of population benefits from the public health system, while 16.8% - the private one. About 10% is not covered by any system. It is a big difference if compared to developed countries, because e.g. in Norway, Sweden and Great Britain the health is free and funded by the state. On the other hand, in Germany, France and Japan social insurance system is based on social and private care at the same time. Only the United States can be compared to Chile, as there a significant part of the population is not included in any category of state care (Medicare or Medicaid) and does not have any insurance or right to health care (1/6 of the US population).

3. Demographic and socio-economic characteristics of FONASA and ISAPRE beneficiaries

In the beginning it must be pointed out that in Chile income per household is very unequal and GINI index is 0,58 (in 2009 Polish index was 0.39). Despite a general decline in poverty of the Chilean society (although in 2009-2010 a subsequent trend reversal was observed and the rise of the amount of the poorest Chileans up to 2.5 million citizens, especially after the earthquake) in the last twenty years, divisions and inequalities on the poor - the rich line has increased.

The recent research shows that the healthcare system in Chile, as opposed to the situation in the past, is on the level adequate to the economic development. The Chilean society is growing old. It leads to a new epidemiological situation and brings about the necessity of further investments and changes in the health system. On the other hand, due to a high level of

[1] Le Monde Diplomatique (version chilena), La Salud en Chile, March 2010.

absolute poverty there are problems and growing divisions in the area of education, nutrition quality, access to labor market, standard of living and households. In addition a very strong earthquake of 27 February 2010 caused big damage in some regions and worsened the situation of the population living there. A big number of victims and the injured, serious health problems and real lack of medical services brought about by the sheer size of the disaster increases the amount of those in need of immediate medical aid.

4. Human capital in healthcare

One of the most important factors which influences the capability to meet the society's needs is providing competent care by qualified and skilled staff.

The table below contains approximate data concerning the amount of working hours and the distribution into social and private services (the data were gathered according to physicians' declarations):

Table 1. Amount of working hours within and outside SNSS, Chile 1995-2006

Year	Approximate number of staff	Working hours for SNSS	Working hours outside SNSS	% - within SNSS
1995	15.334	353.482	321.208	52.4%
1999	17.479	361.606	407.470	47.0%
2003	21.563	355.472	593.300	37.5%
2006	23.394	379.046	674.050	36.0%

Source: Ipinza M., Presentacion a la Comisión Investigadora de la Crisis Hospitalaria de la Camara de Diputados de Chile, 2008.

These data show that *a growing number of physicians spends more and more time working outside the public healthcare system.* This percentage keeps increasing as the staff acquire specialized knowledge, more experience and better remuneration.

According to the Health Ministry in Chile in 2004 there were 2259 pediatricians, 1961 GPs, 1495 obstetricians and gynecologists, 726 psychiatrists for adults who are appropriately certified as specialists in their areas. Undoubtedly shortage of specialists in some areas (ICU, geriatrics, anesthesiology, oncology) is significant. For this reason there is a strong social pressure to develop and introduce the national scheme which would work in cooperation with university centers and contribute to elimination of this deficit. Concerning remaining medical professions certainly there are not enough male and female nurses in public centers and this number amounts to at least 600

people in ICUs. As far as outpatient clinics are concerned, the research conducted in 2002-2008 shows a critical state due to a shortage of practically all specialists.

Table 2. Current number and needs for medical staff in individual medical areas in regional outpatient clinics

Professions	Actual number	Need	Deficit	Deficit in %
GPs	1.428	2.911	1.483	50.9
Orthodontists	909	1.742	833	47.8
Nurses	1.232	2.228	996	44.7
Obstetricians	1.153	1.853	700	37.8
Nutritionists	600	1.059	459	43.3
Social aid	512	1.054	447	42.1
Psychologists	193	882	685	77.7
Kinesiologists	244	971	727	74.9

Source: Health Ministry Chile, October 2002.

As it can be noticed staff shortages are even bigger outside Santiago, in some cases they amount up to about 80% of specialists (e.g. psychiatrists and psychologists).

The research conducted in 2005-2009 shows that there was a significant rise of general numbers of hours spent on medical care in regional outpatient clinics (APS), where in the last two years thanks to scholarship programs students have actively contributed their time, providing medical services. The program which involves medical students who work for half a day in health centers is piloted by the Department of Medicine at the University of Chile. Its objective is to strengthen the weakest healthcare centers by finding a bigger number of medical staff. It is important that an amount of medical students is growing every year. In theory in Chile in the next few years a number of qualified medical staff is going to grow. Surely there will not be enough nurses, as there is a huge deficit in this profession. Of course it is hard to say how competent young doctors will be and what education they will receive. According to specialists an optimistic phenomenon is the introduction of new regulations, which oblige universities and medical academies to get accreditation for their syllabi from a specially created commission (CNA – Chile), if they apply for funding from the state budget. Since 2010 they demand a medical internship in public healthcare centers and an obligatory uniform examination

covering medical knowledge from all students from Chilean universities and immigrants who want to join the system (EUNACOM)[2].

5. Attempt to evaluate National Health Service in Chile

An important event in the history of healthcare was the creation of the World Health Organization in 1948. In Chile in 1948-1952 the first measures were taken to reform the healthcare and in 1952 the National Health System (NHS) was established (*Sistema Nacional de Salud* - SNS), where competent doctors, such as , Salvador Allende, played an active role. The Act (pursuant to which the NHS was founded) united various institutions related to healthcare, including charity and workers' insurance organizations. Three institutions controlled the whole reform: the government, Medical Collegium and University of Chile. This system covered all types of treatment and it was to be financed by state funds. The NHS provided equal access of all citizens to healthcare and all its workers were state officials. Its network covered the whole territory of Chile. The activities conducted by the NHS had various forms, including treatment, prevention, health care and physiotherapy. Generally it was holistic care. On its basis more detailed state health programs were created, we should mention here gynecological care, prenatal care (maternity and infant hospitals were established), TB, heart and vascular diseases protection schemes. Those activities contributed to a significant reduction of maternal and infant mortality and reduced a number of diseases.

The NHS became a perfect model of state healthcare, where the state can be called a "donor". Thanks to strong relations with the University of Chile, an important institution with seats in main national centers, a scientific- medical cooperation was initiated with very positive influence on the healthcare system. It is worth mentioning here that in 1931 nationwide only 33.5% of births were delivered in state hospitals, the rest took place at homes under the care of family or midwives. In 1951 the amount of hospital births almost doubled reaching 60.2%. In 1975 this indicator was 87.4% nationwide, and fifteen years later it grew to 97.8% to reach 99,7% in 2000.This level is maintained up till now.

[2] Data from the Health Ministry in Chile for 2000-2009.

6. Reforms under military dictatorship

Coup d'etat of 1973 for several years had no bearing on the healthcare system. In 1979 pursuant to the government decree a reorganization of the SNS was conducted and the foundations of present the State Healthcare System (*Sistema Nacional de Servicios de Salud* (SNSS) were laid. Twenty-seven decentralized healthcare centers were established, which formally were continuation of SNS and of National System of Workers' Health (*Servicio Medical Nacional de Empleados (SERMENA)* which had been in existence since 1937. Since then funding health centers and outpatient clinics was dependent on a new institution - the National Health Fund (*El Fondo Nacional de Salud* (FONASA). In this way the healthcare system became uniformed and decentralized.

The reform of healthcare system which was carried out in Chile in 1980s (also under the pressure from other governments in South America to increase the share of private institutions in the insurance market) gave workers the possibility of choice: employees could designate an obligatory premium for private or social insurance. It is worth pointing out that private insurers accepted only the rich, whose premium was equivalent to the assessed risk.

The Decree of 1980 led to a transfer of assets and property of primary care centers under the management of competent regions and municipalities.

In 1981 Health Insurance Institutions were established (*Instituciones de Salud Previsional* (ISAPRE) rendering private medical services to all those who pay premiums, which contributed to the development of private medical care centers. An obligatory premium for all workers in the amount of 7% of every taxable salary was determined. People who wanted to join the private healthcare system paid their premiums for ISAPRE, while the rest was insured only in FONASA. *In this way a mixed system was founded, which consists of two simultaneously working though separate subsystems: a social one and a private one, while ISAPRE is definitely more advantageous for the insured.*

In ISAPRE healthcare of an individual is dependent on the amount of premiums and bonuses, on the risk related to their work, health, sex and on a number of family members of the insured. Health service schemes in ISAPRE take into account a specified initial premium, which is usually modified according to the above mentioned factors and may exceed 7% of the salary. The insured must complete their premium with an additional contribution. The scope of medical services is different for every scheme.

FONASA within the uniform premium of 7% gives to all its members a universal scheme, which is either institutional or it is based on free choice.

These activities led to the restructuring of the whole healthcare system, transforming the "state as the donor" system into an auxiliary healthcare organ. *On the other hand an open market of medical services was established*. With the return of democracy in 1990 the legal pattern of healthcare system in Chile remained unchanged, as amendments to the Acts require the agreement of 2/3 of the Parliament or, in other words, of the qualified majority.

At the beginning of 1990s the healthcare worsened. This tendency gradually increased. Deficit of ward beds, lack of medical equipment and materials, generally poor technical conditions and insufficient amount of medical staff – which was additionally increased by the earthquake in 1985 - had significant influence on deteriorating conditions of the state medical care. It should be mentioned here that at that time expenditure on health from the state budget was the lowest for many years.

7. System reform under Concertación government

In response to conditions of healthcare and growing social dissatisfaction in 2002-2005 democratic Concertación governments suggested a total reform of the healthcare system. Four Acts provided for the introduction of gradual changes. Their effects can be noticed now. Basic rules of a new system are determined in such Acts as: *Law and Management of Healthcare* and *General Regulations of Health Guarantee Ley de Autoridad Sanitaria y Gestion y Ley de Regimen General de Garantias en Salud,* which are commonly referred to as AUGE and which were published in 2004.

The first Act separated the function of medical care from regulations and supervision of medical care standards. It established administrative care departments and auxiliary nets *(Las Subsecretarias de Salud Publica y las Redes Asistenciales, Superintendencia de Salud*), creating a territorial division of public healthcare units and the auxiliary nets. It transformed healthcare into the "guardian" of the auxiliary net and promoted bigger flexibility of those net management.

AUGE Act was introduced in July 2005 and established the system of quite clear rules and guarantees, access to services, of quality and financial protection; it determined the set of the most important principles for effectiveness of healthcare in the public and private sectors. Initially it covered 25 diseases, currently this number is 56. The next 24 are to be introduced up to the sum of 80. It is interesting that the reform did not introduce any changes concerning public healthcare centers belonging to and dependent on individual

regions and municipalities. It leads to significant disparities between the work of the centers in rich and poor regions. Administrative expenditure has increased, it is difficult to provide medical services with uniform quality and effectiveness.

Many medical consultations were conducted within AUGE. A big differentiation within AUGE took place. There were shortages of medical equipment, beds and personnel. It is significant that in public healthcare centers *there is a 50% deficit of medical doctors and generally of medical staff.* It is particularly acute in regional outpatient clinics (APS) and moreover it leads to rotation of personnel between various regions. About 40% of doctors in regional centers stays there for a little more than a year, while 60% of doctors do not stay there for more than 3 years.

Undoubtedly during the center and leftwing Concertación government public healthcare was successful, its infrastructure significantly developed, medical healthcare provided better services and legal regulation system of the private sector improved.

8. State budget and healthcare system

In 1974-1990 there was a definite fall of state expenditure on healthcare in Chile. While in 1974 3.3% of GNP was designated for this goal, in the 1990s less than 2%. Reduction of GNP together with disintegration of social healthcare system, centralization of social funds in FONASA and establishing ISAPRE led to deep underfunding of public healthcare at the beginning of 1990s. Democratic governments in 1990 – 1999 led to subsequent rise of budgetary means for that sector, reaching in the last stage of this period the amount of 2.9%. In 2008 a share of GNP designated for healthcare reached the level of 1974.

Total ISAPRE and FONASA services amount now to about 5.5% GNP. Out of this amount 47% is designated for ISAPRE, the system providing care to 17% of the population. The public FONASA system spends 53% of this amount on 73% of the population. Per capita it constitutes half of the amount allotted by ISAPRE for their customers and half of the amount spent on healthcare by the countries with a similar level of economic development (according to the OECD data of 2009 the United States of America spend on healthcare 15.3% of their GNP, France – 11.4%, Japan – 8% (2007).

According to the latest research and data presented by the Statistics and Information Department of the Health Ministry in Chile (2009), units belonging to SNSS with regional outpatient clinics include:

- 183 hospitals (9 highly specialized hospitals, 24 – medium specialized and 100 remaining),
- 7 diagnostic and treatment centers,
- 4 other healthcare centers (Centros de Referencia de Salud),
- 1805 medical advisory centers, primary care, including: 1167 municipal outpatient clinics, 191 Family Health Centers, 127 rural outpatient clinics and 200 centers urgent first aid (equivalent of Polish emergency ward - URGENCIA).

Within this infrastructure under the democratic government (1990-2009) they built 44 hospitals, out of which 14 are already completed and active, while 8 are in the developmental stage. Besides they are about to finish 90 Family Health Centers, 165 Municipal Family Health Centers (CECOF), out of which 73 centers started to work in 2006, and 51 were to open in March 2010. In 2009 the number of accessible ward beds was 26,202 which means that there were 2.1 beds for 1000 people. If Chile wanted to reach the Canadian ratio of 3 beds for 1000 people (comparing her to Canada, a highly developed country, but with the lowest amount of beds for 1000 people), they would have to create 10,542 beds, which means building 26 hospitals with 400 beds each.

Unfortunately medical centers and infrastructure were badly damaged during the last earthquake of 27 February 2010: 25 hospitals were destroyed, 7147 beds cannot be used any more, the remaining 9339 must be renovated. Looking at consequences of the earthquake from the financial perspective – the damage reaches the sum of 2.77 billion dollars, which amounts to the half of healthcare budget for 2010[3].

9. Future challenges

The public healthcare system in Chile has standards and indicators which can be internationally recognized, such as long life expectancy, low infant mortality, professional help at childbirth, etc. A large part of the society is covered by health insurance. According to the Health Ministry in Chile there is still much to be done and next challenges must be met, aiming at improving the public system, where many imperfections can still be seen.

What future goals do the Chileans set?

[3] Ipinza M., Presentacion a la Comisión Investigadora de la Crisis Hospitalaria de la Camara de Diputados de Chile, año 2008.

- It is necessary to raise budget expenditure on healthcare and solve such problems as lack of financial means on healthcare institutions, improvement of conditions and technologies in hospitals and education of medical staff.
- It is necessary to increase the net of healthcare centers in order to reduce medical equipment deficit and reach the amount of 4 beds for 1000 people.
- It is necessary to implement such healthcare policy which is sensitive to epidemiological and demographic changes and in particular focuses on the care of the elderly.
- In response to the society's needs they should aim at the creation of a strong team of qualified medical staff paid from the state funds.
- They should introduce regulations of liability for monitoring medical schools and academies, whose graduates should be able to provide medical care which meets citizens' expectations.
- Syllabi binding in all schools, universities and medical academies should prepare students holistically and provide good medical care, in particular focusing on educating competent staff in deficit specializations.
- Educating and granting degrees to specialists should eliminate problems of rendering services by unskilled medical staff.

Unfortunately, in Chile living in poor areas still negatively affects your health. There is higher crime, worse nutrition, lack of work and living means, poor healthcare, inadequate medical equipment and often pathological family life. It is not difficult to prove that the poorer majority still receives worse medical services.

Pension system reform in Chile

An adequate social protection should be one of the most important tasks of any administration. Practically all the countries worldwide are making or have just made an attempt to reform their pension systems. A similar process took place in Latin America, where in the last two years the states have carried out many social reforms, including the ones relevant for the pension system. It is known today that the pension system based on a generational agreement is insufficient, due to for example a decreasing demographic rate and aging societies (in developed countries). Moreover, redistributive systems are very sensitive to periodical fluctuations of economic conditions.

Chile was the first state worldwide which in 1981 totally privatized the public, i.e. intergenerational pension system. Before the reform the premiums paid by workers were interest free and used to finance current pensions. In most cases the reforms introduced capital pension system through establishing

individual saving accounts belonging to the institutions called AFP. It seemed that the new solutions would be more transparent. Benefits derived from paying premiums and direct relation of the insured with his individual pension account would be enough to encourage citizens to take advantage of the new solutions. The next incentive to transfer from the old system to the new one were state "acknowledgement coupons". Everyone entering the new system received such a coupon which was deposited on their account. This coupon was the state treasury bond and acknowledged the pension rights which had been so far acquired together with the interest rate in the amount of 4% p.a. above the inflation rate. The state treasury was to pay off this bond when a worker reached his pension age.

The state intended to create the situation when the insured would treat premiums not as taxes but as savings. It was assumed that the system would enable citizens who paid a monthly premium in the amount of 10% of a salary to receive pensions in the amount of about 80% of a previously received remuneration[4] due to investments in the capital market (up to salaries in the amount up to 2000 USD)[5]. It is worth pointing out that as those investments were low risk they increased the value of accumulated funds only a little. The first reforms of the pension system took place in Chile under Pinochet, when it turned out that a previous PAYG ("pay as you go") system encountered such difficulties as inflation, budget deficit or low value of benefits.

An important disadvantage of the old system was its imbalance due to the increase of unemployment, inflation or economic crisis. The Chile government decided to transfer from the intergenerational agreement[6], which had led to the state budget deficit and did not guarantee payment of decent benefits. The research conducted by Ziviene and Packard shows that without that reform Chile would have reached a deficit of 211% by 2050. On the other hand it was explained that the society was not ready and did not trust the public systems. All those factors as well as structural problems in the labor market, low saving capability and small advantages from paying premiums resulted in the deficit and insufficiency of the redistributive system. The system functioned badly also due to its very structure and fragmentation. At the same time there were too many schemes with various conditions and modes of participation and with different advantages. Besides in many situations the system was abused by the privileged social groups, neglecting a poorer part of the society. *For those*

[4] Serie de Documentos de Trabajo - Docuemnto de Trabajo N 8, Gobierno de Chile, 2009.

[5] THE CHILEAN PENSION SYSTEM – OECD report, 2010.

[6] Financiamiento del desarrollo, Cepal, Santiago de Chile, march 2009, the Latin America Experience in pension system reform.

reasons it was decided then to carry out the pension reform. Unfortunately, after 30 years of its implementations it gives rise to many justified doubts.

The capital system which was introduced in Chile aimed at strengthening confidence and stabilizing the labor market. At the same time they wanted to reduce the state responsibility for paying off the premiums, which was to lead to stabilization of the budget and of the system itself. During the first years the person insured in the old system could return to it. Everyone entering the new one received an individual account, where their premiums were accumulated. In Chile they amount only to 10% of remuneration (a minimal salary is only 200 euro) and the premiums are capitalized. Of course the sum of future benefits depends on the value of accumulated capital. Information about the account balance is presented to the insured at least three times a year.

Investment Funds are totally private institutions. Their activities are supervised though by a state institution, the so called Superintendencia[7]. The pension system reform in Chile occurred as follows. In 1980 an old PAYG system was closed to new members. The elderly stayed there, while those in middle age and professionally active got a short period to make a decision to which system they wanted to belong. The majority moved to a new capital one because they received many incentives, such as a lower cost of new premiums or acknowledging previous payments for PAYG. Unfortunately, even with those solutions the budget deficit was increasing, because the system had lost its income, while the premiums were distributed between PAYG and Pension Saving Account systems, assuming that it was necessary to pay pensions to those who remained in the system before the reforms. One of the basic challenges in Chile was making a decision about the government's obligations to those workers from PAYG, who moved into the individual account system. It was obvious that they had to get profits from previously paid premiums. Finally, the government acknowledged and transferred those premiums into a new system, practically without any upper limit.

A minimal pension was guaranteed for everyone in the capital system, also for those who could not set aside enough means to obtain a higher pension than a statutory minimum. The so called PASIS was also provided, i. e. an auxiliary pension for the poorest who are not covered by the capital system. This pension was, however, significantly reduced in order to control the state deficit, so many people did not receive it although they qualified. This system did not cover military services.

[7] http://www.safp.cl/573/channel.html

Transition from one system into the other one brought about a long interim and consequently some cost and unsolved problems. Depending on the economic development level the interim may last 40 – 60 years. The cost and resulting budget deficit is growing due to the active pay and go system. This deficit results from the fact that after the reform this pillar was maintained by very low premiums, while out of it they had to pay pensions to the people who stayed in the old system.

In comparison to other Latin America countries the cost of the interim was huge in Chile. After the reform two systems existed side by side, as they had to pay pensions to the people who were previously in PAYG, as well as to the middle-aged who decided to remain there. The state expenditure significantly increased. In 1980, before the reform, it amounted to 1.8% of GNP, while in 1984 it grew to 4.7%. Presently (according to Informe de Diagnostico para el Consejo Asensor para la Reforma Previsional 2009) it only totals to 1.5% of GNP. The next component of transitional cost was acknowledgement of previous premiums in the PAYG system and granting coupons, which were transformed into a public debt falling due on the day when one retires. On that day the amount was transferred onto the individual account. Thus, expenditure resulting from those obligations was put off in time (from 0.1% of GNP in 1982 they reached 29%of the public debt in 2000). It is worth pointing out that some people who do not qualify to receive a minimal pension from the capital system take advantage of an auxiliary pension, which consequently influences the growth of the budget deficit (from 0.20% of GNP in 1981 to 0.44%GNP in 2010). This is guaranteed by the Chilean state. Theoretically this pension is designed for those who have worked for 20 years but the means accumulated on their account are not sufficient to pay a minimum statutory pension. The latest research shows that for that reason in the coming years GNP may lose a subsequent 1%, as in the future about 30% of the society are going to seek this kind of social protection.

Therefore, before introducing any reform, every state should in the beginning analyze how the deficit is going to grow and think about financing the interim. Even if the reform is to bring about positive changes there are always factors contributing to the state deficit.

Unfortunately the fruit of changes in Chile is less optimistic than it was initially assumed. Of course the basic aim was to increase pensions, which did not succeed[8]*. In some South American countries, including Chile, pension benefits have been lowered. Concerning Chile, it is estimated that after 30 years*

[8] La protección social de cara al futuro, CEPAL 2006 páginas p. 114 – 149.

of this system about 55% of people owning a pension fund will not receive even a minimal pension because they will not have 240 months of paid premiums, as required by the system. Out of the remaining 45% of citizens, about 80% are going to receive a minimal pension, i.e. in the amount of 180 dollars a month, the rest (20%) are going to get a higher pension[9].

Moreover, this system is definitely less attractive and less protective for women who as a rule in South America work less than men or have longer breaks in their professional life. This results from the fact that they want to have children and take maternity leaves. In a capital system continuity plays the most important role and the amount of premiums which are set aside. There are also huge differences concerning protection of city dwellers and those who live in the country, not to mention people who work illegally. Generally such people do not pay any premiums, and the workers earn so little that they have no capability to save for future pension or health insurance. One can observe the trend that if in a rich households salaries grow, the value of pension benefits also increases, contrary to the situation in poor households. *Obviously richer social elites are generally more content with the implemented reform and besides they can invest capital in an additional pillar (APV).*

However, what is the future going to look like for those who have limited capability to save, i.e. for about 30% of the society? If one takes into consideration unstable labor market, it will turn out that many people are in fact not going to get any pension or are going to receive a minimal, even ridiculous sum, because they will not be able to work for a basic period or set aside sufficient funds on their accounts.

In case of Chile we must bear in mind that the society has a strictly class character. The person, who was born in a poor family in the country, gets little chance to attend good school and in future to obtain a good job and earn a good salary. Examples of fortunate social promotions are here very scarce. Generally speaking, it can be said that individual saving accounts deprive those people of chance to receive a decent pension[10].

When it became obvious that social majority has no "access" to any pension or that the value of a "new pension" is very low, it was decided to introduce a project of "fight against poverty among the elderly Chileans". For this reason in 2008 under President Bachelet a next reform was carried out. Before 2008 everyone who did not qualify for standard pension received the so

[9] Inserción laboral, mercados de trabajo y protección social", D. Titelman y A. Uthoff (comps.), Fondo de Cultura Económica, 2008.

[10] Chile's Next Generation Pension Reform, Social Security Bulletin 2008.

called PASIS, an auxiliary salary. As it has been mentioned earlier, most people in the final stage did not receive even this symbolic salary because the government reduced its payment. On the other hand, a guaranteed minimal pension was granted only to those who on their accounts had insufficient means to receive a pension above the statutory minimum.

However so as to receive that benefit one had to pay premiums for at least 20 years. According to the statistics about 50% of population did not meet this criterion. An attempt to solve this problem was the next reform in January 2008. Those two mentioned benefits were eliminated and replaced by a basic pension which is financed from a general income tax.

About 60% of the poorest Chileans takes this pension and it amounts to 140 USD. The people who get some benefits related to their pension may apply for the so called "allowance" whose sum depends on the pension. The allowance equals zero if one receives a pension above 410 USD. Moreover, the reform aims at gradual integration of majority of the society into the system, e.g. the self-employed. Within the reform women over 65 were given an extra bonus for every child they gave birth to. For the first time, then, the financing criterion was not only age but also social environment and the amount of children in a household. Bachelet's reforms had a task to provide more competition between AFP funds and to reduce huge administration costs.

Despite many contradictory opinions (from negative to positive ones)[11] it seems that those reforms did not fulfill their task adequately[12]. The whole situation must be examined from the perspective of the continental characteristics and strong social stratification. Surely the reform failure was affected by the fact that in South American countries the poverty level is overwhelming and labor market - generally informal. On this continent there are many cases of huge contrasts between the rich and the poor. Governments of individual states introduce subsequent reforms but still differences between social groups remain great and most people do not have any insurance.

Labor market formalization and unemployment reduction have significant influence on the success or failure of the reforms. Only activities in those areas can give a positive result. From its very beginnings the reform encountered critical structural limitations, which are not derived from the pension system itself but they more refer to incapability to pay premiums by some social groups

[11] http://biurose.sejm.gov.pl/teksty_pdf_98/r-135.pdf,
http://www.portalemerytalnypl/index.php?n=okiemeksperta_artykul&kat=44&idk=45&ida=22

[12] La protección social de cara al futuro, CEPAL, Santiago, 2006.

mainly due to instability of the labor market and the fact that nowadays people rarely work all their life in the same company.

According to specialists the only chance for a correct work of the pension system is introduction of the system which would combine two forms, i.e. a state intergenerational agreement and capital system. The government cannot leave without any living means this part of the society which is incapable to set aside money for their pension while state aid programs are insufficient. Besides due to the whole chaos the state anyway takes over additional cost which accompanies the reforms, even if the system is privatized. Labor market formalization is a key though insufficient solution to provide adequate insurance level. According to the International Labor Organization in 2006 informal sector in Chile covered 31.9% of the employed. It is doubtful if their premiums are paid regularly (if at all), as only under this condition workers can after many years receive a decent pension. It may be particularly painful for those who work with breaks or start working much later. Their pensions are very low or they get them for a specified shorter period. It is visible now that in Chile in 2005 – 2025 workers set aside and are going to set aside on their accounts the means which are far too insufficient to receive a statutory minimal pension.

*From the point of view of the Chilean budget and economy we can undoubtedly talk about the success of the new system***.** Pension Saving Accounts have already accumulated over 25 billion dollars. This is an unusually high amount of the capital generated from individual savings for a country with a still developing economy. One of the key successes of the new system was increasing capital efficiency and general economic growth rate. Pension Saving Account system made the Chilean stock exchange more effective and helped it grow in the last fifteen years. An additional contribution to the development of the Chilean economy was the development of national credit ratings of companies, whose shares and bonds were bought by AFP companies.

Moreover AFP companies often get involved in the management of the companies, whose shares they buy. Of course we can take into account optimistic rankings who are satisfactory for the rich part of the society, omitting the majority who does not receive any benefits. For those people the only source of maintenance is often the family's help.

Conclusion

1. Health reform in Chile attempts to improve healthcare for all the Chileans. It aims at reduction of inequalities, health improvement among the

population, prolonging life expectancy without diseases, improving the situation of poorer citizens, regulation of rights and obligations of citizens and medical service providers, both public and private. Generally they managed to combine both the private and public systems of healthcare, namely ISAPRE and FONASA.

2. It is commonly stressed that the biggest success of the reform was creation of AUGE (Acceso Universal a Garantías Explícitas), which is one of the effects of the medical system reform. Thanks to it, people avoid spending money on medical consultations, medicines and operations, particularly in cases of such illnesses as AIDS, hypertension, diabetes, arthrosis, Parkinson, SM, etc. The AUGE list currently includes 66 diseases.
3. The remaining unsolved problems are as follows: long waiting lists for operation, shortage of beds in public hospitals. The situation is improving gradually due to investments from the state and from the owners of the centers with emergency wards. The other problem is lack of choice of the physician and place where a patient would like to be treated and shortage of medical doctors and specialists. After the earthquake in February 2010 the situation of hospitals has deteriorated due to damage in 17 hospitals. The public sector possesses 200 hospitals and 1400 outpatient clinics and the Provision Center (distributing medical equipment and pharmaceuticals). The state investment plan for 2010-2012 allocates the amount of 3.5 billion USD (on building 10 hospitals, healthcare centers, renovations of existing hospitals, increasing the number of beds, etc.). The private sector in 2010-2015 intends to spend 1.1 billion USD on infrastructure, increasing the number of beds and on technological innovations[13].
4. Unfortunately the result of changes of pension reform in Chile is less optimistic than it was initially assumed (pensions are extremely low).
5. Chilean experts think that the only chance for a correct work of the pension system is introduction of the system which would combine two forms, i.e. a state intergenerational agreement and capital system. The government cannot leave without any living means this part of the society which is incapable to set aside money for their pension while state aid programs are insufficient.

[13] The author's evaluation based on the analysis of press and conversations.

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Streszczenie

REFORMA OPIEKI ZDROWOTNEJ I SYSTEMU EMERYTALNEGO W CHILE (WNIOSKI DLA POLSKI)

Reforma zdrowia w Chile miała na celu poprawę opieki zdrowotnej obywateli. Kolejnym rządom chilijskim udało się połączyć prywatny (ISAPRE) i publiczny system opieki zdrowotnej (FONASA). Za największy sukces tej reformy uważa się utworzenie AUGE, czyli systemu subsydiowania 66 głównych chorób społecznych ze środków publicznych. Do głównych nierozwiązanych spraw należy zaliczyć m.in.: długie listy

oczekiwania i brak łóżek w szpitalach publicznych, brak doktorów medycyny i specjalistów.

Jeśli chodzi o reformę emerytur to Chile było pierwszym krajem na świecie, który całkowicie sprywatyzował publiczny (międzypokoleniowy) system emerytalny. Niestety, rezultaty tych reform są mniej optymistyczne (bardzo niskie emerytury) niż jeszcze do niedawna sądzono. Według chilijskich specjalistów właściwe funkcjonowanie systemu emerytalnego wymaga efektywnego połączenia międzypokoleniowego systemu publicznego oraz systemu kapitałowego (prywatnego).