The brutal rationale of privatisation

Ana María Arteaga[1]

«Beyond euphemisms, privatisation of health, social security and education operated by neo-liberals has imposed a brutal rationale: depending on the amount of money you have, you will have so much health care, quality of education for your children and pension upon retirement. If you are privileged, you will have access to privileged services. If you are poor, you will have to make do with what the public system is able to give you.»[2]

Basic social benefits: a question of the market

The paragraph quoted above is an illustration of the effects on the majority of Chileans of the wide-ranging reforms of the health, education and social security systems introduced in the eighties by the military regime (1973-1989). These changes involved breaking away from the orientation of social policies that had been in force since the twenties which were mainly aimed at lessening social inequalities through the redistribution of income, widening of social security and extension of the primary school, secondary school and university systems.

This radical change was made by the military government based on a two-fold argument: on the one hand, attributing to the State historical inefficiency as a resource management and distribution entity and, on the other hand, maintaining that economic growth is the only way of improving the welfare of the population. Seeking the maximum reduction of social expenditure, cutbacks in benefits and incorporation of the market as a supplier, the State fulfilled a subsidiary role, only intervening in situations of structural deficiency in specific sectors left to satisfy their most basic needs by themselves. In fact, the economic dimension was imposed as the fundamental criteria when applying social policies.

The military government's postulates resulted in two substantive actions: focalisation of social expenditure and the entry of private companies and the market into areas that traditionally had been the State's responsibility: education, health, social security and housing. In all these areas, funding and access mechanisms were changed, restoring the idea of the «consumer» as a basic element of the system, who would have freedom of choice within the spectrum of possibilities offered by the market. For this purpose it became essential to promote individualism – a concept totally opposed to the culture of collectivity and social participation that the previous governments had promoted – an objective that was made easy with the dissolution of the various existing organisations and the prohibition by decree of any form of social organisation.[3]

Education: the increase of social stratification

During the eighties, adopting the perspective of a «subsidiary State», the military regime handed over all public primary schools to the municipalities; promoted the participation of the private sector through per-capita subsidies equivalent to those delivered to public schools; changed funding of higher education; facilitated the establishment of private universities; and transferred most of the technical education centres to business associations.[4]

Although the reforms effectively managed to reduce the burden of education on government expenditure and achieved a more efficient management of the system, they dramatically increased segregation and unequal opportunities for the school population because of the difference in resources and equipment existing in the municipalities themselves and the advantages given to private operators. Private schools, in addition to the per capita subsidy equivalent to that awarded to public schools, were authorised to select the type of students to be admitted and to collect part of the tuition from agents, which led to their recruitment being focused on the sectors of better-off families. As a result, public establishments have increasing concentrations of students from lower income sectors (87.22% of their total enrolment), while in subsidised private schools this percentage is barely over 56% of their students.[5]

In fact, school performance assessments made by the Ministry of Education point to the existence of a close correlation between the socio-economic level and school performance. The assessment established that, in spite of the special programmes applied by the last three democratic governments to improve the quality of education in the low-income student population, a considerable gap remains between results obtained by students from higher and lower income homes.[6]

These findings may be added to those obtained this year from the Academic Aptitude Test, which secondary school students take if they want to enter university, showing that among students with the lowest results, 61% came from public schools. This situation shows that although progress has been made in terms of making basic and secondary education universal, it is not leading to a democratising effect in higher education.

The dramatic differences existing in the quality of education have increasingly resulted in families avoiding public education as an option for their children (in spite of the fact that it is the only free education available), as it is considered to limit access to higher education and, therefore, the possibility of the social mobility this usually entails. This is shown in a survey carried out among parents of school-age children faced with the alternative of having to choose, in which 60% declared that they preferred a private, subsidised establishment rather than a public school.[7] This option has led to private, subsidised education increasing its enrolment from 15% in 1981 to 35.8% at present, while public education has decreased its coverage from 78% of total enrolment to 53.7%.[8]

Although since the mid-nineties public expenditure on education has doubled and important reforms have been introduced in the educational system, in practice, policies explicitly aimed at achieving greater equity have been scant and the results fairly poor. Therefore, the central problem no longer resides in the coverage of the school system – for decades now quite satisfactory concerning basic education (98.6%) and secondary

1 The autor is thankful to Josefina Hurtado (Colectivo CON/SPIRANDO) and Lorena Fríes (Programa Ciudadanía, Corporación La Morada) for their collaboration.

2 Fernando De Laire. «El discurso del 21 de mayo y los debates emergentes» *Revista Mensaje*, July 2002.

3 See: Javier Martínez and Margarita Palacios. *Informe sobre la Decencia*, Ediciones SUR, Santiago, Chile, 1996.

4 Among other measures, registration fees were substantially increased, students were granted loans and a system of competition for state funds was created. Until the reform, only state bodies provided higher education.

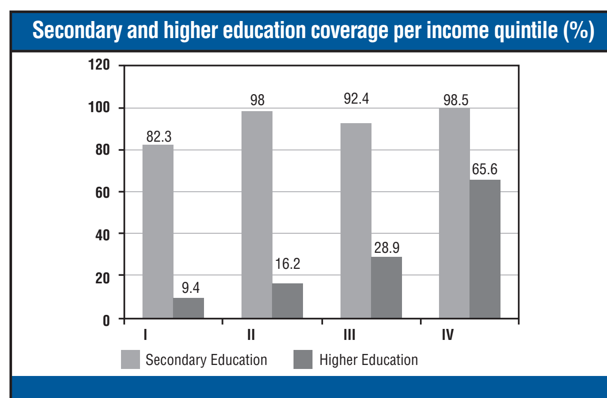
5 Ministry of Planning, CASEN Survey, 2000, Santiago, Chile.

6 The MECE Programme (Improvement of Quality and Equity in Education), which focused on all public schools, has been the most successful so far. Current programmes «900 Schools» and «High-School For All» aim at improving school performance and access to higher education for poor students.

7 CEP (Centre for Public Studies) Survey, Santiago, December, 1996.

8 Ministry of Education, *Compendio de Información Estadística 2000*.

CHART 1



education (90%).[9] The major challenge that the authorities must face today consists of reverting something that global coverage rates do not fully show: an increasing segregation and inequality of opportunities generated by the system due to the differences in the existing quality of education. Definitively, the model continues to be deficient regarding the criteria of equity, as so far it has been unable to prevent the worst provision of education being found in the sectors of greatest material and cultural poverty.

Health system: private interests for public services

The insecurity and mistrust regarding the educational system is shown equally for the health system that together with the pension system comprised the so-called «modernisations» of the social area introduced at the end of the seventies. This was seen in a national survey on Human Security, showing that the majority of the population is neither confident it will receive timely attention nor in a position to pay health care costs in the event of a serious illness.[10]

Until the reform, the country had a national health service managed by the State, on which the most important health establishments and facilities depended. The system – recognised for its competence – provided a wide coverage to the population while a small number of private services and clinics were aimed at the higher income sectors.

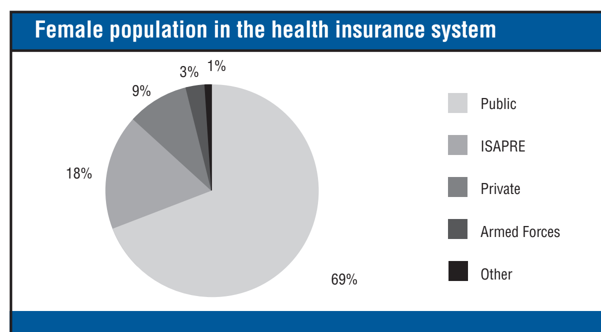
The reform carried out at the end of the seventies essentially consisted in decentralising the official system and in privatising an important part of the services. Following the reforms in the system, each wage-earning person had to choose between the official system or entering some Health Insurance Institution (ISAPRE), where he/she was obliged to pay a percentage (7%) of his/her total remuneration and freely contribute additional resources according to each person's capacity. In practice, each health plan is unique, and the quality of benefits and coverage largely depends on the insured person's level of income. In fact, the ISAPRE is not a health insurance system – although it has this status – but a system of private health insurances where the variables of sex, age and state of health determine the price of the premium.[11]

In Chile where a high percentage of the population lack resources to personally face the costs of health care, the ISAPRE system has proved to be particularly discriminatory against women.[12] Firstly, access to the system depends on the income of each individual, and thus women are manifestly in a situation of inequality due to their lower earning capacity (in proportion they earn 40% less than men); also, the majority of women are outside the remunerated workforce and therefore excluded from a direct relationship with the social security system.[13] Secondly, the system significantly increases the cost of health care for all benefits associated with pregnancy, childbirth and maternity.

In fact, the insurance policy for a woman worker of childbearing age may cost between 3 and 4 times more than a man's policy at the same age. That is, women's reproductive life is penalised.[14] The discrimination is of such magnitude that some ISAPRE have even reached the point of proposing «without uterus plans,» urging women to avoid pregnancies and thus not increase their health costs.[15] Discrimination is not limited to women: it also affects people over 50. Thus, people with over 20 years of contribution to the same ISAPRE will progressively see the cost of their premiums increase as they grow older, and their plan can become 8 times more expensive than when they entered the system.[16]

Costs in the private health care system have been critical in the evolution of the ISAPRE system, and membership has decreased consistently from 1.7 million people since 1977, to 1.3 million people in June 2001. The participation of women was 34.4% of the June 2001 total, a figure very similar to the rate of women's participation in the workforce. It should also be noted that the growth rate in numbers of women beneficiaries has consistently dropped over the past decade, going from 20.8% in 1991 to 1.7% in 1997, and has even shown a significant percentage of withdrawals from the system, which in June 2001 reached 5.5%.[17]

CHART 2



Recently, the discussion on gender discrimination in health care systems has taken on particular relevance – and placed the women's movement on maximum alert – because of the government's proposal to fund part of the AUGE Plan (Universal Access with Explicit Guarantees) for health care reform with resources that the State uses to pay maternity leave.[18] In active rejection of the proposal, the movement has insisted to the authorities and the public on the error committed by confusing labour rights with health rights, due to the fact that the wrongly called «maternal subsidy» is no more than a maternity salary allocated to pre- and post-natal leave, a right consecrated in Chile since 1924 and internationally recognised in international conventions on workers' rights.[19] As declared by specialists from the Centre for Studies on Women (CEM), «…the country needs a reform of the health system. The main objective in terms of gender equity is to eliminate the various discriminations women are subject to in the ISAPRE system.»[20] ■

ACTIVA <activa@terra.cl>
Area Ciudadanía, Corporación La Morada
Centro de Estudios de la Mujer (CEM)
Colectivo CON-SPIRANDO
Colectivo EN-SURANDO (Valdivia)
EDUK
FORO, Red de Salud y Derechos Sexuales y Reproductivos

9 Ministry of Planning, CASEN Survey, 2000, Santiago, Chile.

10 CEP-PNUD 1997 Survey, in: *Desarrollo Humano en Chile. Las paradojas de la modernización*, UNDP, 1998.

11 See: Apolonia Ramírez C. «Situación de la mujer trabajadora en el sistema de ISAPRES», in: *Economía y Trabajo en Chile*, Annual Report No. 7, Labour Economy Programme (PET), Santiago, Chile, 1998.

12 In Chile, 20.6% of the population (3.81 million) lack the monthly income necessary to buy a basic food basket. Ministry of Planning, CASEN Survey, 2000.

13 According to INE (National Statistical Institute) only 36.1% of women belong to the economically active population (EAP) compared to 74.9% of men.

14 The public health care system is not exempt from this type of situation. For example, it does not allow the woman partner of a member to be a dependent, demanding that the couple be legally married, nor does it allow a woman to have a man as family dependant.

15 Centro de Estudios de la Mujer (CEM). *Argumentos para el Cambio* No. 52, June, 2002, Santiago, Chile.

16 Newspaper *El Mercurio*, 19 October, 2002.

17 Apolonia Ramírez. «Género y Sistema de ISAPRES», in: *Género, equidad y reforma de la Salud en Chile. Voces y Propuestas desde la Sociedad Civil*; OPS, MINSAL, SERNAM, Santiago, March, 2002.

18 The AUGE Plan is an important part of the reforms being promoted by the government to broaden the right and access to health care.

19 See: «Propuestas para la Reforma de la Salud en Chile», Parlamentos de Mujeres por la Reforma de la Salud, 28 May 2002.

20 *Argumentos para el cambio*, CEM, *op. cit.*