

Household Well-being and Health: A Comparison of (Lower-)Middle-Income Households in Chile and Costa Rica

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Abstract

Chile and Costa Rica's health care systems fare well regarding health indicators. They vary corresponding to their welfare regimes: liberal-informal and social-democratic-informal. We compare how households in precarious prosperity, which are particularly dependent on institutional arrangements, deal with health. We ask: to what extent do health care systems, visible in household strategies, affect socio-economic wellbeing; do health problems spill over to other life domains? Data consist of qualitative interviews with the same households in 2008, 2009 and 2013 in Chile and Costa Rica. In Chile households were worried about health and how to pay for it and other life domains were affected. In Costa Rica, the national health system limited the consequences of health problems into other life domains. The households' experience of health systems offers fresh avenues for health policy-making.

Introduction

Since 2000, the debate in the field of health in Latin America has focused on universal health care in terms of broader and more equitable coverage, access, benefits, and quality to improve health outcomes and lower social inequalities. These issues are discussed under the term “varieties of universalism in health care” or “health care universalism”. The way universal health care models are devised and work in practice vary substantially regarding the financial models, mode of access, and range of services. The debate is inconclusive as to whether this variation corresponds to the underlying principles of different welfare regimes. While universalism in health should lead to converging health outcomes on the aggregate level, according to the

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way universalism is devised, within-country health inequalities as well as the experience of the population with the health system may vary.

Chile and Costa Rica represent distinct types of welfare regimes (liberal-informal and social-democratic-informal). The health systems in Chile and Costa Rica correspond rather well to their respective welfare regimes. Both provide a universal health care system and have similar aggregate health outcome indicators. However, in Chile 9.2% of the population considers the health care system the most serious problem in the country, whereas in Costa Rica only 0.6% does so (Latinobarómetro 2013). Households experience the health system in different ways. Such differences and similarities make the two countries particularly interesting to investigate.

Much is known about how health systems are devised and what their health outcomes are, yet little is known regarding what households do, what strategies they pursue to satisfy their health needs and maintain their socioeconomic position, and to what extent health problems remain confined to the domain of health. To investigate the experience with the health care system in everyday life in Chile and Costa Rica, we pursue the following questions: how do the households experience the health system regarding their opportunities to deal with health? What strategies do households in precarious prosperity use to deal with their health needs? To what extent are health issues limited to the health domain or do they threaten socio-economic well-being? We limit our investigation to households in a comparable welfare position located in-between secure prosperity and consistent poverty (in terms of income poverty and poverty by deprivation with regard to a shared societal standard (Gordon 2006). Households in this position are particularly dependent on the country's welfare regime because they generally do not benefit from targeted programs.

In the following section, we describe the country context in terms of welfare regimes and health systems. In Section 3 we present the conceptual elements for the analysis of the welfare position of precarious prosperity and household strategies and guiding assumptions for the analysis. This is followed by information on the data and methods in Section 4. In Section 5, we present the analyses in light of the welfare regime principles within the health system in each country. Section 6 contains the comparison and conclusion.

Welfare regimes and health systems

Welfare regimes

Welfare regimes represent institutional and social class arrangements at the country level. They consist of the state, markets, families/households, and communities/non-profit organizations that distribute economic, social, and political resources to provide support and social protection. They reveal the country's social solidarity pattern. They provide people and population groups with distinct opportunities for welfare (Mackert 2010; Esping-Andersen 1999; Barrientos 2009) and mediate health inequalities (Coburn 2004), the perception of insecurities (Pacek/Radcliff 2008; Williams et al. 1999), and the opportunities to deal with the consequences of their position (Amacker et al. 2013). Such arrangements provide a sense of what the "normal state of affairs" is (Rothstein 1998). People deliberate and act in everyday life to

get by within the limits of these arrangements (Lister 2004; Pacek/Radcliff 2008; Williams et al. 1999).

Chile and Costa Rica represent two different welfare regimes in the second half of the 20th century: Chile under the dictatorship of Augusto Pinochet implemented a (neo-)liberal regime dismantling the state's comprehensive yet fragmented and stratified health system by cutting expenditures and reforming "to conform to the residual welfare model" (Ewig/Kay 2011: 71). After the return to democracy, public spending increased substantially, yet efficiency and equity issues remained. These were amended in that "some important equity-enhancing reforms were introduced, but in an incremental and fragmented manner" (Ewig/Kay 2011: 78). In contrast, Costa Rica consolidated the pillars of a social-democratic regime, many of which were initiated and pushed forward by President José María Figueres from 1948 onwards, even during the crisis of 2008. Due to financial constraints and to maintain quality treatment, Costa Rica has introduced liberal elements and rationing mechanisms: the contributions of the insured were increased, an official list of medicines was established and private suppliers in particular for the regions with the greatest needs were contracted (Del Rocío Sáenz et al. 2010).

Welfare regimes are considered to provide a "package of public policies that conforms to certain principles" (Kasza 2002: 272). Various scholars in the field of health have criticized this assumption and argued that one should rather expect "a contradictory and disjointed set of policies" (Kasza 2002: 272), that the approach might be too general for specific fields (Eikemo, Bambra, Judge et al. 2008; Eikemo, Bambra, Joyce et al. 2008), or that the specific fields might be more complex (Mesa-Lago 2005). As will be shown, Chile and Costa Rica's health systems conform well to the principles of the corresponding welfare regimes.

Health system: Chile

Chile's welfare regime was a pioneer in health care for a broader population. It followed the Bismarckian model. In the 1950s, Chile implemented the universal National Health Service (SNS, *Servicio Nacional de Salud*), which enabled a large proportion of the population to access government-delivered health care by the end of the 1960s. This produced a statist mentality of expecting the state to provide solutions rather than the private sector or individuals, at least for certain sectors of the population attached to the formal labor market. "In keeping with this mentality, Chileans rarely questioned the notion of quality health care as a fundamental right" (Bruce 2000: 70).

Chile was also a pioneer of implementing a market-oriented health-care system composed of a public and a private subsystem. After Pinochet's political takeover, Chile radically adopted market-oriented principles, privatized, cut down on public expenditures, and decentralized services in all domains (health, education, work, infrastructure). In the early 1980s, a strongly stratified public health system consisting of the National Health Fund (FONASA, *Fondo Nacional de Salud*) and private Health Insurance Institutions (ISAPREs, *Instituciones de Salud Previsionales*) was implemented. Both systems, public and private, managed their own clinics and hospitals. The private insurance companies, ISAPREs, largely unregulated under the Pinochet regime, could select their clientele (healthier population groups) and minimize costs. The national health system, FONASA, dealt with the cumulated health risks of the population

that could not afford or was not accepted by the ISAPREs (Ortiz Hernández/Perez Salgado 2014). Only since 2010 have the ISAPRES been required to eliminate their mechanisms for risk-adjusting premiums by age and sex in 2010 considered discriminatory. Still today, higher health costs and risks cumulate in the FONASA. The ISAPREs have adjusted premiums due to the demographic aging of the population: older people insured at an ISAPRE who cannot afford higher premiums have either had to return to the National System, to which they had previously not contributed or have contested the premium increases legally (Bossert/Leisewitz 2016). In 2012, ISAPREs covered about 17% of the population, the National Health Fund (FONASA) for the public sector covered about 74%, 2% belonged to the insurance of the army (CAPREDANA, *Caja de Previsión de la Defensa Nacional*, engl. *National Defense Insurance*) or the police forces (DIPRECA, *Dirección de Previsión de Carabineros de Chile*, engl. *Chilean Police Social Security Fund*), and about 7% were not affiliated (Ortiz Hernández/Perez Salgado 2014: 7).

Public services are financed by general taxation, contributions from municipalities, and co-payments made by FONASA affiliates (7% of wages; co-payments are additional), i.e. public insurance premiums are linked to income (Pardo/Schott 2013). FONASA users have access to two types of care: institutional Care (MAI, *Modalidad de Atención Institucional*) and the Free Choice Option (MLE, *Modalidad Libre Elección*). Institutional Care (MAI) corresponds to care in public institutions; it limits the user's choice and requires a co-payment of 10% to 20% of the price set by FONASA. The FONASA Free Choice Option (MLE) enables the use of private services; it is financed by a fixed amount provided by FONASA and is complemented with the insured person's co-payment to the private provider's price for the service (Becerril-Montekio et al. 2011).³ "Public health care providers must by law sell most of their services to the FONASA and are subject to tight limits on the kinds and volume of services they may sell to private patients and ISAPRE beneficiaries" (Gottret et al. 2008: 101). Apart from the public services, a private nonprofit system consisting of three mutual funds, established by law in 1968, provides medical care for work accidents and work-related illnesses.

The private sector is financed by premium contributions, fees, and co-payments that are either mandatory or voluntary from the ISAPRE affiliates. Generally, the private sector offers insurance schemes with more benefits than the public sector. Its premiums (not lower than 7% of wage level) vary according to health risk, risk coverage services on site, and contracts with other private providers or the public sector (Pardo/Schott 2013). The insurance may reject applicants.

Partly as a result of criticism toward the ISAPREs, a rights-based reform was implemented: the AUGÉ-GES (*Plan de Acceso Universal de Garantías Explícitas-Garantías Explícitas de Salud*, engl. *Universal Access to Care with Explicit Guarantees*). This scheme – devised to improve equity of access and treatment to medical care and to protect low-income households from catastrophic health expenditures – is inclusive and focuses on diseases (Erazo 2011). It guarantees quality treatment (from diagnosis through treatment to follow-up) in a preset period of time for a predefined list of diseases regardless of affiliation to private or public

³ For insurance modalities (in Spanish), see <http://www.supersalud.gob.cl/difusion/572/w3-printer-6444.html>

schemes (FONASA or ISAPRE); out-of-pocket expenditures are capped depending on income level, alleviating the financial costs (Ewig/Kay 2011). The AUGE scheme started with a list of 25 common diseases in 2005 and has expanded to about 80 diseases today⁴. Due to public health services' difficulties providing the right-based treatments within the preset time frame, vouchers for treatment in private facilities are distributed and private health services are contracted. Concentrating public services to treat the diseases listed under the AUGE scheme has led to neglecting other health issues and debilitating other public services and prevention (Bossert/Leisewitz 2016). Chile's universalism in health care is considered basic (Clark 2015).

The strongly stratified health system that takes into account the principle of subsidiarity, self-responsibility and the individual freedom of choice (Erazo 2011; Missoni/Solimano 2010) has commodified health care. Households have various opportunities to tailor their combination of insurances and modalities according to perceived or anticipated health risks or events, and the use of public and private services. The opportunities are dependent on the households' financial means.

Health system: Costa Rica

The Costa Rican health care system is one of the most encompassing in Latin America, offering universal coverage in terms of financial support and accessibility to services. The Costa Rican Social Security Agency (CCSS, *Caja Costarricense de Seguro Social*), founded in the 1940s, is a semi-autonomous institution with an independent budget in charge of the administration of three regimes: Sickness and Maternity Insurance (SEM, *Seguro de Enfermedad y Maternidad*), the Disability, Ageing, and Death Regime (SIVM, *Seguro de Invalidez, Vejez y Muerte*), and the non-contributory regime. Health insurance was created bottom-up for low-income urban workers and was continuously expanded to other population groups, including informal workers and immigrants (Rosenberg 1981). The expansion toward universal access, pushed forward by a law approved in 1961 and intended to reach universal coverage in 10 years, was addressed by means of primary health care (Ortiz Hernández/Perez Salgado 2014: 9). Dependent household family members (e.g., parents or children) may be insured indirectly through the insurance of an employed household member⁵. Elderly receiving non-contributory pensions have access to health services free of cost (Brenes-Camacho 2011). Poor or vulnerable populations were availed a non-contributory state insurance since 2006.⁶ The National Insurance Institution (INS) operates in the public and private sector and is responsible for covering occupational and traffic risks (del Rocío Sáenz et al. 2011). The private sector provides medical services, insurance companies, cooperatives, self-managed companies, and hospitals. They are sometimes contracted by the CCSS (Unger et al. 2008).

The CCSS provides medical benefits that range “from preventive to curative to rehabilitative care. Expensive and complex procedures like organ transplants are provided as dictated by individual physicians' decisions about medical need, not income or employment status”

⁴ For the list (in Spanish), see <http://www.supersalud.gob.cl/difusion/572/w3-propertyname-501.html>

⁵ Regulations of the health insurance <https://costarica.eregulations.org/media/reglamento%20del%20seguro%20de%20salud.pdf>

⁶ See the regulations of the health insurance (in footnote 3), articles 56 and 62, point 4.

(Clark 2015: 222). Costa Rica managed to resist implementing a parallel private and public health system in its negotiations with the World Bank in 1993 and decentralized primary health care instead: ambulatory care facilities, Basic Teams of Integral Health Care (EBAIS, *Equipos Básicos de Atención Integral en Salud*), and clinics are also provided in remote and scarcely populated areas (Martinez-Franzoni 2006, Rosero-Bixby 2004). The public health system is financed by tripartite contributions (employers, workers, and the state) and the national lottery revenue and provides contributory and non-contributory coverage. Health inequalities are low in comparison to the rest of Latin America (Gottret et al. 2008: 198). The CCSS is presently working to integrate the population without health coverage: micro-business workers, self-employers, and immigrants. Everyone may use the public maternity, pediatric, and emergency services (Clark 2015).

The system has not gone without threats of marketization. Competition has been introduced and additional health services and new insurance products⁷ are being devised for the more affluent population. Indeed, “recent data signal a stagnating affiliation and a drop in use of services by middle- and upper-income beneficiaries” and the government has failed “to fulfill its legally mandated financial contributions”; moreover, important indicators of health care quality declined between 1990 and 2004 (Bitran 2013: 252; Gottret et al. 2008). Marketization of complementary (private) products may put pressure on the CCSS in future. Nonetheless, the Costa Rican health care system has been able to remain universal, solidary and public; it is considered encompassing. Households are basically covered by the CCSS; they may complement the CCSS.

Comparison of selected indicators

Macro-level health indicators provide information about the country’s health care coverage, financial investment, people’s investment, health performance, and people’s assessment.

As Table 1 shows, we find similarities with regard to insurance coverage: 88.9% of people in Chile and 90.2% in Costa Rica have health insurance. Financial indicators provide information on the relevance of the health domain within a welfare regime. Costa Rica provides about three quarters of the per capita public health expenditure on total health expenditure in 1995 and 2014, whereas Chile provides about half; it increased slightly between 1995 and 2014 in Chile and declined in Costa Rica. Public health expenditure in percentage of GDP is about twice as high in Costa Rica when compared with Chile for 1995 and 2014. Per capita total expenditure on health at the average exchange rate indicating how expensive the health system is, has increased over time and remained more expensive in Chile than Costa Rica. Chile’s higher costs are attributed in part to “the inefficiency of the private sector”, “the use of unjustified medical procedures”, and the higher administrative costs (Ortiz Hernández/Perez Salgado 2014: 3).

Out-of-pocket expenditures indicate the burden individuals bear regarding health issues. They are a very inequitable and inefficient way to distribute health risks (Knaul et al. 2011). Catastrophic out-of-pocket expenditures are calculated as a proportion of health expenditures regarding a defined threshold (a poverty line, net of food spending, etc.). As a percentage of

⁷ <http://portal.ins-cr.com/portal.ins-cr.com/Personas/SegurosPa/INSMedical/>

private expenditure on health, out-of-pocket expenditure is more than twice as high in Chile than in Costa Rica; however, the proportion diminishes about 15% from 1995 to 2014 in Chile and increases about 5% in Costa Rica.

The proportion of households experiencing catastrophic health expenditures is low (0.7%) in Costa Rica and rather high in Chile (11%). The poor population is well protected in Costa Rica: public health spending is progressive, with “the poorest 20% of families [receiving] at least 29% of the public resources invested in health” in most regions (Gottret et al. 2008: 212).

The two countries present a rather similar picture regarding selected health indicators in Table 1 with the exception of maternal mortality rate (it has decreased substantially in Chile but increased somewhat in Costa Rica); however, the overall mortality rate is lower in Costa Rica than in Chile.

Substantial differences exist regarding the indicators of experienced quality of the health system and the population’s satisfaction. The population experiences the health system quite differently. In Chile, in 2006, 11.7% of the surveyed population reported having been denied a medical consultation due to lack of money, in comparison to less than 1% in Costa Rica. The proportion facing barriers to health care access is also higher in Chile than in Costa Rica (19.2% versus 9.4%). The proportion of the population with the opinion that the government should be responsible for health care is somewhat higher in Chile (71.1%) than in Costa Rica (67.5%). About 40% of Chileans are satisfied or very satisfied with the health systems, in comparison to 65% of Costa Ricans.

In sum, similarities are found among the aggregate outcomes in terms of health indicators and differences exist regarding the way universal coverage is achieved and what is invested. The mixed system of private and public insurance and services that prevails in Chile and the comprehensive universal health system in Costa Rica are reflected in the financial indicators measuring governmental health expenditure and the indicator for catastrophic health expenditures.

Reforms in Chile and Costa Rica have led to convergence in some indicators (e.g., health outcome indicators and denial of medical consultation due to lack of money); other indicators point toward a switch in position (e.g., the under-5 mortality rate or the maternal mortality reported). The quality and satisfaction indicators suggest that the public-private mix in Chile does not correspond to the population’s needs as does the public system in Costa Rica.

Table 1: Basic health and health spending indicators

Indicator	Year	Country	
		Chile	Costa Rica
Health coverage			
Percentage covered by health insurance	CL2005 ¹ CR2004 ¹	88.9%	90.2%
Financial indicators			
Total health expenditure as percentage of GDP	1995 ⁴ 2014 ⁴	5.2% 7.8%	6.5% 9.3%
Public health expenditure as percentage of GDP	1995 ⁴ 2014 ⁴	2.5% 3.9%	5% 6.5%
Public health expenditure as percentage of total health expenditure	1995 ⁶ 2014 ⁶	48.2% 49.5%	76.5% 72.7%
Per capita total expenditure on health at average exchange rate (US\$) (public and private)	1995 ⁴ 2013 ⁴	267 1137	217 970
Individual health expenditure			
Out-of-pocket expenditure as a percentage of private expenditure on health	1995 ⁷ 2014 ⁷	48.5% 31.5%	20.6% 24.9%
Catastrophic health expenditure calculated as out-of-pocket expenditures on health / total household expenditures net of food spending (standardized)	CL2005 ¹ CR2004 ¹	14.4%	0.4%
Catastrophic health expenditure calculated as out-of-pocket expenditures on health / total household expenditures net of international poverty line (standardized) ¹	CL2005 ¹ CR2004 ¹	11.0%	0.7%
Health indicators			
Life expectancy at birth	1990 ² 2015 ²	73.7 80.5	75.5 80.4
Under-5 mortality, estimated (per 1,000 live births)	1990 ² 2015 ²	19.1 8.1	16.9 9.7
Maternal mortality reported (per 100,000 births)	1990 ² 2010 ³	40 18.3	14.6 21.1
Overall mortality rate	2007-2009 ³	4.9	4.3
Experienced quality and satisfaction			
Denial of medical consultation due to lack of money	2006 ³ CL2011 ³	11.7% 4.2%	0.08%
Facing barriers to health care access	2007 ³	19.2%	9.4%
Quality of health care had increased	1998 ³	5.1%	41.2%
Should the government be responsible for health care	2012 ³	71.1%	67.5%
Satisfaction with health care: satisfied or very satisfied	2007 ³	40%	65%

Sources:

¹ Knaul et al. 2011: 90, using data from Chile 2005 (Encuesta Nacional sobre Satisfacción y Gasto en Salud (ENSGS)), and Data from Costa Rica 2004 (Encuesta Ingresos y Gastos (ENIG)) (ibid: 88).

² PAHO/WHO: accessed February 2016 http://www.paho.org/hq/index.php?option=com_content&view=category&layout=blog&id=2471&Itemid=2408&lang=en; Costa Rica: http://www.paho.org/hq/index.php?option=com_content&view=article&id=3222&Itemid=2408; Chile: http://www.paho.org/hq/index.php?option=com_content&view=article&id=3251&Itemid=2408

³ Data from the Latinobarómetro 2013 presented in Ortiz Hernández/Perez Salgado 2014: 17,18.

⁴ <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS/countries>

⁵ <http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS>

⁶ <http://data.worldbank.org/indicator/SH.XPD.PUBL/countries>

⁷ <http://data.worldbank.org/indicator/SH.XPD.OOPC.TO.ZS/countries>

Conceptual elements of the analysis and guiding assumptions

Having introduced the welfare regimes and health systems, we focus on the concepts *precarious prosperity* and *household strategies*. We expect to see institutional arrangements play out most clearly among the strategies of households in precarious prosperity. Household strategies link household resources and aims to the context's provision of opportunities and constraints (Wallace 2002).

The welfare position *precarious prosperity* lies in-between *secure prosperity* and *poverty* (Hübinger 1996; for Latin America see Hardy 2011). Households in precarious prosperity generally do not have the means to cushion health events financially, nor are they a target of poverty policies. In contrast to poverty, households in precarious prosperity dispose of more resources, so they can plan and realize opportunities within the range of their restricted resources (Budowski et al. 2010). This position is basically characterized by a combination of insecurity and potential (undesirable, downward) mobility (e.g., due to catastrophic health expenditures), yet does not exclude upward mobility. This location – precarious prosperity – within the social inequality order is where the welfare regime's opportunities and constraints play out most clearly.

Household strategies refer to the way households deliberate about and conduct their everyday life within a given context and how they deal with their everyday problems, opportunities, and constraints (Wallace 2002). Households make use of, resist, or struggle for other/more opportunities; their strategies are constrained yet not determined by the context. Household strategies reveal the perceived *marge de manoeuvre* in light of their resources, previous decisions, and experiences; they reflect the perceived ability (i) to influence the situation through action by means of habits and routines derived from the past, (ii) to construct perspectives for the future, and (iii) to “contextualize past habits and future moments within the contingencies of the moment” (Emirbayer/Mische 1998: 963). Household strategies provide a bottom-up perspective on the way health systems work. Evans refers to this interplay between broader structural characteristics of welfare regimes and households' resources and constraints as “bounded agency” (Evans 2007; Rubenson/Desjardins 2009).

Guiding assumptions: The literature review suggests that the principles of Chile and Costa Rica's welfare regimes structure the health system. Based on the conceptual approach, we assume that household strategies reveal both the experiences of households in precarious prosperity and the welfare regime principles at work by connecting everyday life and the health system. Taking households in precarious prosperity as a unit of analysis allows for elaborating patterns of strategies within each country and between the two countries.

The Chilean health system is stratified and requires resources. Households would feel responsible to manage their health risks and ponder on different ways to assure or acquire the financial means necessary for insurance, whether to use public or private services, whether they qualify for particular schemes, and how to obtain the (quality) treatments desired or required. This context bears the risk that health problems are not contained within the field of health and to spill over to other domains (deviation of resources from other domains) threatening wellbeing. In Costa Rica, access to health care is available to all when insured and for emergencies when not insured. It does not directly depend upon a household's resources sug-

gesting that health problems may be contained within the field of health and have less spillover to other domains. Households may ponder about how to ensure the quality of health care desired or to improve it so that it better satisfies the household members' needs.

Data and methods

Chile and Costa Rica provide interesting cases because they vary with regard to welfare regime and health system yet have comparable macro-level health outcomes. The households selected and located in precarious prosperity are considered to be comparable regarding their relative welfare position within the inequality order of each country and are suitable for revealing the opportunities and constraints of managing health risks.

The *qualitative sample* consists of households from three purposely selected neighborhoods in San José (Costa Rica) and Temuco (Chile). They were contacted by undertaking a random walk (Hoffmeyer-Zlotnik 2003). The households were then screened to identify whether they belonged to the welfare position defined as precarious prosperity. The welfare positions "poverty", "precarious prosperity", and "secure prosperity" were identified in 2008 by combining (i) an income measure (4th, 5th, or 6th decile of the income distribution) and (ii) a scale of deprivation⁸.

Standardized screening interviews were carried out with more than 50 households in both countries. More than 30 of these in each county belonged to the targeted welfare position. Thereof, a purposeful selection was made regarding the diversity of household composition and income sources. Finally, qualitative thematic interviews were carried out with 24 households in precarious prosperity in each country in 2008. Of these, 21 households in each country were re-interviewed in 2009 and again in 2013, on which this analysis is based. All interviews were recorded and transcribed verbatim. The transcriptions were indexed by a deductively elaborated coding scheme derived from the interview topic guide and inductively by in-vivo codes. Thematic charts (Ritchie and Lewis 2003, Miles and Huberman 1994) dealing with health issues were developed to elaborate general patterns.⁹

Results

We begin by presenting an overview of the *patterns of insurance*, an important structural feature that frames the use of public and private health services. This is followed by exemplifying strategies of households in each pattern. This analysis is used to elaborate the way the health system works for the interviewed households in precarious prosperity from their perspective.

⁸ In Chile the targeted income groups were located in the fourth, fifth, and sixth decile of the per-capita income distribution (Solimano 2008:11). The items for a scale of goods, activities, or services that could not be purchased due to financial reasons summed up to a deprivation scale. A household was considered deprived when the household lacked four or more goods, activities, or services for financial reasons (see Budowski et al. 2010).

⁹ The qualitative research design does not allow generalization; it is used to identify patterns of dealing with health. When refer to the selected interviewed households with "households in Chile" and "in Costa Rica" for reasons of legibility.

The combinations of insurances in Chile vary. Eighteen of the 21 households were insured by FONASA, four with the type “Institutional Care” (MAI) and fourteen with the type “Free Choice Option” (MLE). Two households combined FONASA and ISAPRE, and one household disposed of the CAPREDANA. Within the same household, various modes and combinations of insurance and schemes existed, e.g., of MLE and MAI, contributory and non-contributory mode, or benefiting from particular schemes (pensioners scheme, AUGE, PRAIS¹⁰). Some households complemented their public insurance with specific private insurances. All interviewed Chilean households incurred out-of-pocket payments for a variety of health-related expenses such as co-payments, medical exams, medicine not covered by insurance, or consultations with specialists.

The insurance mode frames the three patterns of the use of public and private health services emerging from the interviews in Chile: (i) thirteen households mainly used public and less private services¹¹; (ii) six households used both services more or less equally¹²; and (iii) two used mainly private services¹³. Amongst the households mainly using public services, approximately half had a positive assessment and half a critical assessment of the health system. The former were benefiting from a special scheme (PRAIS or a special scheme for pensioned people) or were insured by the non-contributory modality¹⁴. Households using both public and private services or mainly private services had a critical assessment. Most households incurred in private expenditures. Four had no issue with this, most experienced a moderate impact on their financial situation, and two households accumulated serious debts (one was confronted with legal debt recovery).

The situation of the households interviewed in Costa Rica was more homogenous. Twenty of 21 households had public insurance (CCSS), contributory or non-contributory, of which in two households, insurance was through another family member. In ten households, there was at least one member without health insurance, and in one household, no member was insured. Some of these households incurred out-of-pocket payments to obtain treatment or exams more quickly. However, whenever complicated health issues arose, the use of public services was not questioned. Household members without insurance avoided treatment, paid for their treatments, used emergency services (free of cost), or applied for non-contributory insurance from the state if they felt qualified for that support.

This distribution of combinations in the two countries reflect the opportunities of the health system but does not reveal much about how the interviewed households deal with health issues and the way the institutional arrangement functions for them from their perspective.

¹⁰ The PRAIS is the Program of Compensation and Full Health Care for Victims of Human Rights Violations introduced in 1991, which includes family members and provides health care free of cost.

¹¹ The households are numbered by country (e.g., CL01 refers to “CL”: Chile; “01”). Households in this pattern are CL01, CL04, CL05, CL07, CL09, CL10, CL15, CL16, CL17, CL18, CL24, CL20, and CL23.

¹² The households are as follows: CL02, CL04, CL03, CL11, CL19, and CL22.

¹³ The households are as follows: CL8 and CL14.

¹⁴ Special schemes: CL01, CL07, and CL15; non-contributive modality: CL17, CL20, and CL23.

As will be elaborated in the next section, the way households perceive this configuration and deal with health issues varies substantially. In Chile and, to a lesser extent, in Costa Rica, the households' resources and their experiences with the health system come into play.

A large variety of household strategies in Chile

In Chile, the combination of insurances, modalities within the FONASA and specific schemes for particular groups enabled a wide range of choices to address health issues.

Using public health services and only exceptionally private services to pursue a balanced budget. One household (CL16) exemplifying this pattern consists of a couple with university education. The husband is employed in a factory, and his wife is director of a childcare center. They have public insurance with the MLE. Their three children of primary school age have severe health problems. One requires constant medical attention (had an immature lung at birth and then was diagnosed with hemophilia and later Von Willebrand disease), and another required a larger medical treatment in 2009. This treatment led to large out-of-pocket expenses that profoundly anguished the couple.

At one moment, the costs were so high that they were out of reach for us [...] so from this point onwards we simply could not bear the costs anymore; we really became anxious [...] The doctor then said: you know what, this is covered by the AUGE and possibly you have access. (CR16, 2013, woman)

Access to the AUGE scheme brought back a certain financial stability, because it capped the costs at 20% of the total cost. The couple is extremely satisfied with the scheme and never thought they would benefit from such quality treatment (e.g. to accompany their child at a private hospital that was luxurious and receive explanations from the doctors). The AUGE scheme substantially contributed to lowering their anxiety, despite the high costs for medication it does not cover. Nonetheless, the household contains the costs by strategically prioritizing health expenditures to others. "[The medicine] is not covered by the AUGE; therefore, we prioritize health, I tell the children, before we buy a car" (CL16, 2013, woman).

The couple also takes care of the woman's mother, who has Alzheimer's disease since 2010. The woman works during daytime and cares for her mother at night; her husband works night shifts and takes over during daytime. Her medical needs are dealt with by means of public services and a private physician to obtain medicine not covered by public insurance. This entails additional costs and emotional strain for the household. The household experiences both a functioning health model for severe specific health problems and the inadequacy of public insurance for illnesses like that of the wife's mother.

Burdened by high medical costs, the household seeks various ways to contain them and maintain their welfare position. They apply for educational grants, health schemes, housing schemes or take the disadvantages of the public health system into account. They bemoan being excluded from governmental programs (e.g., housing schemes) that would help improve their living conditions and reduce their costs. Stability at work and an increase in salary has allowed them to make ends meet. Their informal household division of work makes it possible to carry the large health burden, child care, and elderly care.

Not all interviewed households using public health services have the ability to pursue a balanced budget due to co-payments or when suffering was so strong that they resorted to private services.

It takes an eternity [to consult a specialist]. You sometimes observe people that have died waiting, waiting for an appointment to get operated on or because they have to follow a rigorous treatment and they don't get an appointment and don't get an appointment. In such cases, you have to make a sacrifice [and pay privately]. (CL07, 2009, elderly couple with serious health problems; FONASA)

In such circumstances, health issues caused anxiety or spilled over into the financial domain. Various households incurred debts from the bank to pay for health, or from their families or the church. Other strategies were to come up for the health costs but leave out other rate payments, such as for education. In one neighborhood the community contributed by collecting money for the operation. One woman who was waiting for treatment in 2008 and feeling increasingly powerless and blocked due to a two- to three-year waiting list for an exam and operation in 2009 even wrote a letter to the president:

I thought I was ... could be in a depression, to not be able to ... to wait [...] I waited and waited [...] So one day I decided to write to the president, told her about my problem, and that really helped. The ultrasonic testing was quick; the paperwork took only a month and [...] now I am on the operation list. (CL04, 2009, couple of working age with two school-aged children; woman respondent with health problems, FONASA)

There were also some households, with few health problems or chronic health problems, who felt well cared for by the public services.

Opting for private health care incurring substantial debts. Six households fit this pattern. One household (CL03) consists of a couple with two daughters. They both have higher education, and he works as an informatics technician. For a long time, the couple made use of the public service FONASA with complementary private insurance (ISAPRE) for birth attendance. To benefit from better attention without incurring costs that were too high for the required co-payments, the woman changed to ISAPRE for the birth of her second daughter. Medical complications not included in the private insurance led to high out-of-pocket expenditures, so the couple returned to FONASA with MLE to limit costs. Having to resort to the public hospital for their daughter due to unaffordable private hospitalization was a harsh experience for the couple, so that they started to use private services more frequently again.

We used both private and public services; I did not want to leave her at the hospital [so we used private services], but once I had to leave her there because we did not have the money to pay for the private services anymore [...] she had cry attacks because I left, and she choked so that her asthma worsened. So, I preferred to put her in a clinic where I could remain and she stayed quiet [...] In any case, she did not receive the medicine [in the public hospital] she needed, [...] so we had to buy that and the antibiotics as well. (CL03, 2009)

To manage these higher health costs, the couple used credit cards for consumption to the point of legal recovery of debts in 2009. In 2013, the couple continues to incur debts to manage their health issues while trying to avoid the point of law enforcement.

The other households with this pattern recall negative experiences with the public health system. They apply a variety of strategies, complementing public with private insurance and paying out-of-pocket treatments. Because they want quality health services that they do not receive from the public system, health issues anguish them and compromise their financial situation moderately or strongly.

Combining public and private insurances strategically. Two households fit this pattern. One household (CL08) consists of a couple with higher education (she: technical higher education, he: secondary education) who are both in formal employment (in administration). Their son is of school age, and their daughter was born just after the second interview. The woman has FONASA and complements her public insurance with a private insurance for herself (for cancer), for the children (in case of an accident or an operation), or for birth attendance at a private clinic. Her husband disposes of a private insurance including his children thanks to a convention between the enterprise where he is employed and an ISAPRE. As they are employed full time, the couple says they cannot afford to be absent from work as long as the use of public services would require. Private services respond quickly and on weekends.

With regards to ISAPRE, in this sense, we know that children with complicated illnesses or complicated accidents will be equally well treated in the [public or private] hospital, but you get quicker service at the hospital Clínico or the Clínica Alemana [private hospitals], where I am insured for the medium-type priority illnesses they have: fever, diarrhea, whatever, infections (CL08, 2013, man).

Nonetheless, I have additional insurance for the children in case they have to be operated on [...]. If anything happens, I can take them to the private hospital where the insurance will pay [...], I also have insurance for myself for cancer [...] Yes, I pay additionally to be able to visit my private doctor. (CL08, 2013, woman)

The couple accepts the level of their expenditures for supplementary insurance, even though they use savings for co-payments and eventualities. Private insurance allows them to control the level of co-payments. Despite being satisfied with the the access to and use of private services, the couple criticizes the ISAPRE for basically being interested in selling insurances. They also criticize public health services because they do not take into account people's lives and suffering:

[...] So find people who are poorer than us, of a lower social class, [...] that have to wait [to be attended by public services] – I don't know how long – for a health issue. I find this humiliating, of course, we are talking about health, an existential topic of well-being of the person (CL08, 2013, woman).

But the worst of the worst is, but what beats everything is, ISAPRES' unabashed robbery because the question really is if you are not profitable anymore for them, then they just throw you out, if you had a too expensive illness, even if you get well [...] so they are actually working with you to rip you off. (CL08, 2013, man)

The couple acknowledges their resources – two stable jobs, good health, and sufficient income – to combine various types of insurances and use private and public services strategically. They continuously emphasize how lucky they have been with their health, reveal distrust towards the private insurance and the constant threat to incur debts. Their strategy depends on the way they manage the public and private insurance, the employers' convention with a private health care insurance, their being “lucky” to have good health and sufficient income from two stable jobs. Health issues have not spilled over to other domains.

In summary, the interviewed households in precarious prosperity in Chile apply various strategies to obtain quality health care; they feel responsible for themselves and actively seek ways to satisfy their health needs. They anticipate and cater to their risks, seek information, apply for health (and other) schemes to reduce their financial burden, balancing the pros and cons, or switching between or complementing public and private services. They mobilize substantial resources for health: savings, household internal support, credits, community support, or individual actions (writing to the president). A basic insecurity emerges from the health domain for most households and surfaces at various times, in particular, in acknowledging their luck of being in good health. Stable employment, a sufficient regular income, and within-household cooperation were important pillars for household strategies when dealing with health needs. The AUGE scheme that contains costs and provides quality care and the special scheme for pensioners alleviate the burden. Health issues spill over moderately into other domains.

More uniform opportunities for health care in Costa Rica and a variety of strategies

In Costa Rica, the insurance type varied with regards to contributory or non-contributory insurance and regarding whether households or individuals were insured. The way households made use of private services or sought treatment also varied among those who were not insured.

Relying solely on public services. Amongst these seventeen households, all members were insured in ten, some members were not insured in five, and some members were insured via another member in two households¹⁵. Eleven households evaluated the public services positively and four critically and two did not assess them.

One household (CR19) exemplifying this pattern consists of a couple with two daughters who were all insured. The husband is formally self-employed and pays health insurance, one daughter is formally employed, and the other studies at the university. The household's health problems are the respondent's diabetes, which requires regular control at the EBAS, and her husband's operation and neuropathic disorder. They rely uniquely on public services for controls, operations, and medication and defend the quality of the public services:

¹⁵ Households are labeled CR for Costa Rica and numbered. All members were insured in households CR02, CR07, CR12, CR13, CR14, CR19, CR22, CR03, CR04, and CR06; some members were not insured in CR09, CR10, CR11, CR21, and CR15; or were insured via a family member in CR05 and CR16.

Many people complain, but I would not be honest, because they [the public services], have really treated me well, very well. They have always given me everything I need. It was they who discovered my hypertension, and they have always been so friendly, thanks to God. They also treated my husband very well when he was in the hospital. (CR19, 2009, woman)

In 2013, this assessment was reinforced, even when mentioning the out-of-pocket expenses of the respondent's father for private services to diagnose of his cancer. If public services postpone certain exams too long, private services may become an option and cause out-of-pocket expenditures.

Well, I am very well, [...] we have been lucky that we never had to pay outside [the caja, i.e., seek private services]; we have always been treated well, and my father, he was cared for by an oncologist, my husband by a neurologist. They were all too, well, too good, and my doctor who treats me at the EBAIS is also excellent [...] Well, he [the respondent's father] has had quite some extra expenses [bastantes gastos extras]. (CR19, 2013, woman)

Household CR21 consists of the respondent of pension age and her husband and the respondent's daughter. The respondent and daughter are non-contributively insured and are strongly dependent on public health services; the respondent's partner has no health insurance. The respondent suffers from diabetes, kidney, and asthma and has had serious operations (backbone, amputation of toes); her daughter is bedridden due to a stroke. The respondent feels her daughter and herself have both been well taken care of by the public health services with the doctors strongly involved to maintain their health.

They were keeping me to amputate my foot, [...] but there they cut four [toes], and I thank God that the doctor struggled [and tried everything he could medically to limit the infection to the toes]. (CR21, 2013, woman)

Public services provide a sense of security even when health problems are severe¹⁶.

Receiving health care by means of insurance of a family member in the household. Two households fit this pattern¹⁷. The first (CR05) household consists of a man, who is informally self-employed as a carpenter. He and his wife have primary education and live together with two adult sons with incomplete secondary education. The two sons are employed but without a contract. The couple has been insured intermittently by one of their sons.

We were both insured a while by our older son, by his work, and now the younger one will do the same. (CR05, 2009, woman)

At times when they are not insured, the couple makes use of various opportunities that the EBAIS offers or alternative medicine.

¹⁶ This interpretation is supported when taking into account other interviewed households lacking resources for private services: many formulated similar feelings of being cared for by the EBAIS.

¹⁷ These households are CR05 and CR16.

I always benefit from the health fairs they organize; there they do everything from blood exams to sight exams, [...] they give you free medicine and all this is really good and they do all the exams and everything. [Regarding meniscus problems.] I will have to consult natural medicine. (CR05, 2009, man)

I do the papanicolaou test at the fairs. There are various fairs, one by the doctors, others in different areas and communities. (CR05, 2009, woman) [...] So we just travel to where the fair is. (CR05, 2009, man)

I broke my knee [a month ago and was operated] and if I would not have had insurance, I would have said I cannot pay, and they would have to attend to me. Yes, I have done so various times; once when I didn't have insurance, I went to the hospital, and they wanted me to pay so I said I cannot pay, so at that it remained. If someone does not have the money, the state has to take care of this (CR05, 2013, man)

The man is satisfied with the treatment received at the hospital for his knee and is expecting rehabilitation.

The second household (CR16), in which the couple is insured through their son, assesses public services less positively. In 2009, due to a long waiting time for an operation and the wrong diagnosis of their daughter's tumor and its follow-up monitoring too far in the future (2012), they made use of private services and continue to complain about the deterioration in public services in 2013:

[The quality of the public services] is not very good because the problem is that the CCSS [public insurance] is in such a bad condition, [...] most of the people who need such exams, what do they do is they get them done outside of the caja [CCSS] because the attention at the caja is fatal. Sometimes you go for medicine, and they have no medicine, [...] but you need the insurance in case of an accident, or if you are hospitalized, but the services are bad, awfully bad [...] they give people appointments in 2017 [...] and if the doctor writes a prescription, they [the pharmacies] give it [the prescription] back, they don't give it to you [...] because the caja ran out of medicine, they say. (CR16, 2013, woman)

Combining public and private services. Three households fit this pattern¹⁸. One household (CR23) exemplifying this pattern belongs to the more affluent among those interviewed and where all members are insured. It consists of a couple (approximately 50 years old) with incomplete secondary education and three adult children (aged 27, 23, and 21). The man is formally self-employed, and his eldest son works together with him (2009). The woman is informally self-employed; the daughter studied architecture, and the youngest son was unemployed. Consulting both public and private services in 2008 and 2009, the couple became aware of a local medical center in 2013 where both public and private services were available. They were attended there more quickly than at public centers and at lower costs than private centers.

¹⁸ These households are: CR01, CR20, CR23.

We go to the medical center [...] well, once they took me there for an emergency [...] because, if you have an emergency, [private] clinics are expensive; if you go to the medical center for an emergency, it is not expensive because it has a mixed medicine, so it is efficient for you. If a medicine is missing [...] or if a particular exam needs to be done, they can do it [where possible as a public service and where not as a private service], so it is a good price-service relationship. (CR23, 2013, woman)

This medical center bypasses waiting time and sometimes the lack of quality of public services. Waiting for an appendicitis operation in a public facility for almost 12 hours was intolerable. Nonetheless, the treatment was considered excellent.

We arrived around 11:00 a.m. in the morning; my daughter was with me, but nothing [...] and at 5:30 p.m., my daughter told them she was scared the appendix would burst, but it was only around midnight that they operated on me [...] I would be lying, [if I would not acknowledge that] the treatment was excellent and the doctor came in the morning and told me she had also found a problem in the uterus and treated that as well. (CR23, 2009, woman)

When the appendix burst open again due to coughing and vomiting, the women consulted a private doctor for quicker treatment. The household assures quality in public health care by using private services prior to (e.g., diagnosis) and/or following up (e.g., monitoring) public treatments. It is able and willing to pay for fast, quality treatment for health through private services.

No health insurance. This household (CR08) consists of a separated father with one teenage child in 2008). He resolved his health problems (alcoholism) by means of religious affiliation and the Alcoholics Anonymous mutual aid group, which shows the importance of community/third sector organizations for health. Not having had major health issues, the respondent did not make use of the health services during 2009 and 2013.

In summary, the interviewed insured households in Costa Rica applied strategies to reduce waiting time, which led to consulting specific medical centers, the use of private services for diagnosis, and follow-up monitoring. They rarely incurred debt. Being insured directly or indirectly through a family member did not make a difference for the use of health services. When uninsured, households sought ways to obtain insurance (through family members or with temporary non-contributive insurance organized by governmental employees) or resorted to natural medicine or community support. Even when not insured, most households counted on health care in case of emergencies and found ways to have medical exams performed free of cost. Nonetheless, a certain ambivalence emerged from the interviews: in general, households assessed public health care as being of sufficient quality, and the EBAS provided them with the feeling of being well cared for. However, acknowledging the quality of the CCSS yet being dependent on the speed of health care, they sometimes felt they did not receive the quality treatment required. Criticism referred to the households' experience of having to wait too long for appointments, diagnoses, follow-ups, emergencies, or the fragmentation of health services due to the lack of medical equipment, medicine, or specialists. Together

with a general feeling of protection for the worst case and claiming health care to be the state's responsibility, some accounts revealed a decline in confidence in the quality of public health. For the interviewed Costa Rican households, health issues remained contained to the health domain and did not spill over substantially to other domains.

Comparison and conclusion

The comparison of the health care systems reveals differences in organization, investment and assessment yet with similar or converging health outcomes. The pioneer neoliberal welfare regime implemented in Chile translated into policies in all domains including health that promote the development of the market, commodification, and an increase in "the market dependence of citizens" (Rudra 2007: 379). In response to public pressure to amend health inequalities and other cumulating problems, Chile also pioneered a rights-based health scheme (AUGE). Although the scheme was added to the prevalent health system, it has not substantially changed the underlying principles of the health care system. Health services have remained largely stratified due to (i) the capacity of the population to purchase health services or regularly pay for insurances, (ii) the access criteria for insurance opportunities (e.g., in terms of health risks), and (iii) the provision of and access to health services across public and private providers (Paraje P./Vázquez L. 2012).

Costa Rica is also a pioneer in the region. The country established a universal welfare regime and health system that is more solidary, universal and less stratified compared to most countries of the region. It was developed bottom-up and was steadily expanded to include more population groups. State-protectionist policies have "protected select individuals from the market" and have focused on policies for decommodification (Rudra 2007: 379). When economic constraints for health care emerged, Costa Rica sought new income sources instead of cutting back on services (del Rocío Sáenz et al. 2010). Until recently, integrated public provisions have characterized the health care system; the private sector does not yet play an important role. However, the recent difficulties to provide a financially sustainable health care system have led to various reforms, some of which could pose a threat towards this universal and solidary system, in particular, if specific private insurances allow the more affluent population to opt out of the existing insurance (Gottret et al. 2008; del Rocío Sáenz et al. 2010).

Assuming that welfare regimes structure the opportunities of different welfare positions within the inequality order, we argued that households in precarious prosperity constitute an appropriate group on which to focus when attempting to understand how a welfare regime works. Taking into account the household strategy's approach as a form of bounded agency, we further argued that households in precarious prosperity deal with health issues in light of the opportunities and constraints they perceive, their experiences within the welfare regime and health system, their resources, and their health needs.

The structural opportunities of insurance and coverage frame the households' opportunities. In Chile, the type of insurance that the interviewed households had was contingent upon their financial resources (most of the interviewed households had public or private insurance with the options of MAI or MLE). Some households benefited from particular governmental schemes targeted towards particular groups or diseases (e.g., for individuals of old age; the

PRAIS or the AUGE), specific insurances for armed forces or the police, or non-contributory insurances. The interviewed households actively identified their members' potential health risks, assessed their economic resources and qualification for special schemes, and anticipated the financial consequences when deciding on the combinations of insurances for their needs. The costs and out-of-pocket payments associated to such decisions often generated moderate to severe spillovers of health problems into the financial domain. The quality treatment of private insurances was valued but often evaluated as too expensive for the household or requiring "sacrifices". Due to the copayments or use of private health services, health issues threaten the interviewed Chilean households' welfare position and strain their finances leading to debt, incur arrears for monthly school rate payments, renounce other commodities, or save in case of "a catastrophic health event" (CL07, 2009). The interviewed households' experiences suggest that public health services often prolonged their suffering when they required health care (waiting time, costs, lack of medicine or treatments), and some felt that private insurances make a profit from their health. In many interviews the lack of confidence in the health system surfaced. Households benefiting from additional public health schemes – in particular the rights-based AUGE scheme – assessed the health system more positively than the others; such schemes contained costs and seemed to provide the interviewed households with a feeling of more equal treatment regardless of socioeconomic position. At the same time, households experienced the lack of support for people with non-listed illnesses and needs.

In Costa Rica, the opportunities for health care were more uniform yet the strategies to obtain care were also varied. Most interviewed households were insured by the CCSS (contributive or non-contributive modality) or indirectly through an insured family member. In quite some of the interviewed households, one member was not insured. Even when lacking insurance that was coupled with anxiety about health, there seemed to be a basic feeling of having the right to health care in case one could not afford it, or security that there would be a solution for the worst case. Households made use of various health care opportunities free of cost (e.g. free medical checkups at fairs or for emergencies). The public health system was praised for its quality services when received, and criticized for the waiting time, increasing lack of opportunities for medical diagnoses and medicine and reasonably timed follow-ups. This leads those households with sufficient financial means to make more use of private services (yet they continue to use public health services for complicated health problems or interventions). This situation may undermine the basic feeling of confidence towards the health system in the future.

Variations in the household strategies between the two countries concern the dependency on the households' financial resources, knowledge about whether a household qualifies for specific schemes and the feeling of having a right to health care. Self-responsibility for health care and the required finances were important issues in the interviews in Chile. This was much less an issue in the interviews in Costa Rica, even though various households made use of private services with extra private expenses for consultations or laboratory exams. The results of the interviews in Chile suggest that the options to deal with health problems declined when households had insufficient resources, leading some households to incur greater risks for financial debts when in need. This reflects the stratified Chilean health system. Health care

relies much less on the households' financial resources in the solidary and universal health system in Costa Rica. Stratification in access to the health services and insurances is less pronounced than in Chile.

Summing up, the interviewed households in precarious prosperity in Chile did indeed experience "market dependence" (Rudra 2007). The interviews and strategies bring to the fore the liberal principles of choice, self-responsibility and efforts of foresight, coupled with concerns about health, its quality and costs yet without a general feeling of protection for health risks. The rights-based AUGE scheme, in contrast, did provide some sort of protection.

The universal and solidary public health system based on socio-democratic principles of equality of treatment and inclusion in Costa Rica did provide the households in precarious prosperity with a feeling of basic security based on a right to health care when in need; they felt protected for the worst case. Out-of-pocket payments were a topic yet did not adopt the same extent of anxiousness experienced in Chile. Health problems were more confined to the domain of health in Costa Rica than in Chile, where they more easily spilled over to the financial domain.

In both countries the households' experiences of the health system are varied, some more positive, others less. The comparison reveals fundamental differences of the experience of the health systems. These are related to the importance of resources, the way health services rely on them, the confidence in the health system and the feeling of protection against health risks, i.e. the issue of rights to health care. The households' experiences and strategies touch upon the fragility of human life, with suffering and fate in situations where people are ill and dependent. The feeling of being protected – at least in the worst case – or of having a right to health care of acceptable quality alleviates the burden of dealing with health risks that go beyond households' strategic decisions to guard against them. The way universalism in health care is organized, thus, makes a difference for those households that are particularly dependent on the institutional arrangements of the health system.

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References

- Amacker, Michèle, Monica Budowski and Sebastian Schief (2013). Dealing with precariousness in Switzerland and Chile: household strategies between objective constraints and scope for agency. *Swiss Journal of Sociology*, 39(1), 103–128.
- Barrientos, Armando (2009). Labour markets and the (hyphenated) welfare regime in Latin America. *Economy and Society*, 38(1), 87–108.
- Becerril-Montekio, Víctor, Juan de Dios Reyes and Annick Manuel (2011). Sistema de salud de Chile. *Salud pública de México*, 53, 132–142.
- Bitran, Ricardo (2013). One-step, two-step tango in Latin America and the Caribbean. In: Preker, Alexandr S., Marianne E. Lindner, Dov Chemichovsky and Onno P. Schellekens (Eds.). *Scaling up affordable health insurance. Staying the course* (231–272). Washington, DC: The World Bank.
- Bossert, Thomas and Thomas Leisewitz (2016). Innovation and change in the Chilean health system. *The New England Journal of Medicine*, 374, 1–5.

- Bruce, Natalie (2000). The Chilean health care reforms: model or myth? *Journal of Public and International Affairs*, 11, 69–86.
- Budowski, Monica, Robin Tillmann, Wiebke Keim and Michèle Amacker (2010). Conceptualising “precarious prosperity” – empirical and theoretical elements for debate. *International Journal of Comparative Sociology*, 51(4), 268–288.
- Clark, Mary A. (2015). The meanings of universal health care in Latin America. *Journal of Health Politics, Policy and Law*, 40(1), 221–226.
- Coburn, David (2004). Beyond the income inequality hypothesis: class, neo-liberalism, and health inequalities. *Social Science & Medicine*, 58(1), 41–56.
- del Rocío Sáenz, María, Mónica Acosta, Jorine Muiser and Juan Luis Bermúdez (2011). Sistema de salud de Costa Rica. *Salud Pública de México*, 53, 156–167.
- del Rocío Sáenz, María, Juan Luis Bermúdez and Mónica Acosta (2010). *Universal coverage in a middle income country: Costa Rica*. World Health Report 2010 (Background Paper) No. 11. World Health Organization, Geneva. Retrieved February, 2016 from <http://www.who.int/healthsystems/topics/financing/healthreport/CostaRicaNo11.pdf>.
- Eikemo, Terje , Clare Bambra, Ken Joyce and Espen Dahl (2008). Welfare state regimes and income-related health inequalities: a comparison of 23 European countries. *The European Journal of Public Health*, 18(6), 593–599.
- Eikemo, Terje , Clare Bambra, Ken Judge and Kristen Ringdal (2008). Welfare state regimes and differences in self-perceived health in Europe: a multilevel analysis. *Social Science & Medicine*, 66(11), 2281–2295.
- Emirbayer, Mustafa and Ann Mische (1998). What is agency? *American Journal of Sociology*, 103(4), 962–1023.
- Erazo, Álvaro (2011). *La protección social en Chile El Plan AUGE: Avances y desafíos*. Serie financiamiento del desarrollo No. 238. Cepal. From http://repositorio.cepal.org/bitstream/handle/11362/5218/S1100415_es.pdf.
- Esping-Andersen, Gøsta (1999). *Social foundations of postindustrial economies*. Oxford: Oxford University Press.
- Evans, Karen (2007). Concepts of bounded agency in education, work, and the personal lives of young adults. *International Journal of Psychology* 42(2), 85–93.
- Ewig, Christina and Stephen J. Kay (2011). Postretrenchment politics: policy feedback in Chile's health and pension reforms. *Latin American Politics and Society*, 53(4), 67–99.
- Gordon, David (2006). The concept and measurement of poverty. The Millennium Survey. In: Pantazis, Christin, David Gordon and Ruth Levitas (Eds.). *Social exclusion in Britain* (29–69). The Policy Press: Bristol.
- Gottret, Pablo, George Schieber and Hugh R. Waters (Eds.) (2008). *Good practices in health financing. Lessons from reforms in low- and middle-income countries*. Washington, DC: The World Bank, The International Bank for Reconstruction and Development.
- Hardy, Clarisa (2011). *Estratificación social en América Latina: retos de cohesión social*. Santiago de Chile: LOM.

- Hoffmeyer-Zlotnik, Juergen H.P. (2003). New sampling designs and the quality of data. In: Ferligoj, Anuška and Andrej Mrvar (Eds.). *Metodološki zvezki: Developments in applied statistics* (205–217). Ljubljana: FDV.
- Hübinger, Werner (1996). *Prekärer Wohlstand: Neue Befunde zu Armut und sozialer Ungleichheit*. Freiburg im Breisgau: Lambertus.
- Kasza, Gregory J. (2002). The illusion of welfare ‘regimes’. *Journal of Social Policy*, 31(2), 271–287.
- Knaul, Felicia Marie, Rebeca Wong, Héctor Arreola-Ornelas and Oscar Méndez (2011). Household catastrophic health expenditures: a comparative analysis of twelve Latin American and Caribbean countries. *Salud Pública de México*, 53(2), 85–95.
- Latinobarómetro (2013). *Problema más importante en el país*. Online Database. Retrieved March 2016 from <http://www.latinobarometro.org/latOnline.jsp>.
- Lister, Ruth (2004). *Poverty (key concepts)*. Cambridge: Polity Press.
- Mackert, Jürgen (2010). Opportunitätsstrukturen und Lebenschancen. *Berliner Journal für Soziologie*, 20(3), 401–420.
- Mesa-Lago, Carmelo (2005). *Las reformas de salud en América Latina y el Caribe: su impacto en los principios de la seguridad social*. Santiago de Chile: CEPAL.
- Miles, Matthew and Michael Huberman (1994). *Qualitative data analysis: an expanded sourcebook* (2nd Edition). London: Sage Publications.
- Missoni, Eduardo and Giorgio Solimano (2010). *Towards universal health coverage: the Chilean experience*. Background Paper No. 4. World Health Organization, WHO, Geneva. Retrieved October 2014 from <http://www.who.int/healthsystems/topics/financing/healthreport/4Chile.pdf>.
- Ortiz Hernández, Luis and Diana Perez Salgado (2014). *Chile and Costa Rica: different roads to universal health in Latin America*. MSP Occasional Paper No. 23, May. Municipalservicesproject. Retrieved August 2015 from <http://www.municipalservicesproject.org/publication/chile-and-costa-rica-different-roads-universal-health-latin-america - sthash.qL2FYBt.dpuf>.
- Pacek, Alexander C and Benjamin Radcliff (2008). Welfare policy and subjective well-being across nations: an individual-level assessment. *Social Indicators Research*, 89(1), 179–191.
- Paraje P., Guillermo and Felipe Vázquez L. (2012). Health equity in an unequal country: the use of medical services in Chile. *International Journal for Equity in Health*, 11(81).
- Pardo, Christian and Whitney Schott (2014). Health insurance selection in Chile: a cross-sectional and panel analysis. *Health Policy and Planning*, 29, 302–312.
- Ritchie, Jane and Jane Lewis (Eds.) (2003). *Qualitative research practice. A guide for social science students and researchers*. London: SAGE Publications.
- Rosenberg, Mark B. (1981). Social reform in Costa Rica: social security and the presidency of Rafael Angel Calderon. *The Hispanic American Historical Review*, 61(2), 278–296.
- Rothstein, Bo (1998). *Just institutions matter: the moral and political logic of the universal welfare wstate. Theories of institutional design*. Cambridge: Cambridge University Press.
- Rubenson, Kjell and Richard Desjardins (2009). The impact of welfare state regime on barriers to participation in adult education. A bounded agency model. *Adult Education Quarterly*, 59(3), 187–207.

Rudra, Nita (2007). Welfare states in developing countries: unique or universal? *Journal of Politics*, 67(2), 378–396.

Solimano, Andrés (2008). *The middle class and the development process*. ECLAC / CEPAL, Santiago de Chile.

Unger, Jean-Pierre, Pierre De Paepe, René Buitrón and Werner Soors (2008). Costa Rica: achievements of a heterodox health policy. *American Journal of Public Health*, 98(4), 636–643.

Wallace, Claire Denise (2002). Household strategies: their conceptual relevance and analytical scope in social research. *Sociology*, 36(2), 275–292.

Williams, Fiona, Jennie Popay and Anne Oakley (Eds.) (1999). *Welfare research: a critical review*. California: UCL Press.