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Opting out from public services and the social contract in Latin America

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Opting Out from Public Services and the Social Contract in Latin America

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Pilar Manzi (Northwestern University)

Background chapter prepared for LACIR

2023

Abstract

The seemingly upward trend in opting out from public services and the segregation of income groups in public and private education and health systems has raised concerns about the future of an already fragmented social contract in Latin America. In this chapter, we examine the evolution of the use of private education and private health insurance in selected countries during the first two decades of the 2000s. We also examine the socio-demographic correlates of the decision to opt out, and the association it has with attitudes that are relevant to understand the foundations of the social contract in the region. Overall, the evidence suggests that scholars' concerns about the fragility of the social contract are justified, but with some nuances. Wealthy households are mostly opting out of the public education system, and the middle-class is split with a substantial proportion of households opting for private schools. On the other hand, opting out from public health is only prevalent among wealthy households, and even within that group the share of households who are paying for a private health insurance is much smaller than the share of households who opt for private education. For both policy domains, however, we find that people who use private services have worse evaluations of public services, express less support for the public provision of those services, and more generally, are less supportive of redistribution compared to people inside the public systems. We discuss the implications of these descriptive statistics for the sustainability of the public provision of services and the social contract.

Keywords: opting out; education; health; inequality; social contract; inequality; Latin America.

JEL: I1; I2; I3.

Introduction

It has been argued that the social contract in Latin America is fragmented. One sign of such fragmentation is that households in many countries opt out from public services that are essential for human development, when they can afford to do so. The sustained increase in the demand for private services and the segregation of income groups in public and private systems, which is happening after significant expansions of access to public services, has raised concerns about the sustainability of the public provision of services and, more generally, about the future of an already fragmented social contract in the region (Ferreira et al., 2013; CEPAL, 2014; Elacqua et al., 2018; Gasparini et al., 2014; López-Calva et al., 2014).

To what extent are Latin Americans opting out from public services? What are the socio-demographic characteristics of households who opt out of public services? What are the consequences of these choices for the social contract? In this chapter, we aim to shed light into these questions by examining the evolution of the use of private services in two policy domains: education and health. In both cases, we consider people's decision to use and pay for private services (private schools and private health insurance) as a proxy of their intention to opt out. That said, as we explain below, we are quick to acknowledge that measuring opting out from public health care systems is more challenging than in the case of education.

We begin with a description of private school enrollment rates and payment of private health insurance in selected countries from early 2000s to 2018 drawing from household surveys. These descriptive statistics document that, even though a majority in all countries in the region use the public systems, there has been an increase in use of private services over time in urban areas. We also show country-specific trends pointing to substantive variation across countries.

Second, we estimate the socio-demographic correlates of enrollment and use of private services. We show that income is one of the most important factors influencing the decision to opt for private services, but also that the opting out of public services, particularly education, is taking place across the income distribution in several countries in the region. Moreover, when we focus our analysis on the upper- and middle-classes, as defined by the World Bank (F. Ferreira et al., 2013; López-Calva et al., 2014), it becomes clear that the former is mostly out of the public education system, and the latter is split with a substantial proportion of households opting for private schools. On the other hand, opting out from public health is only prevalent among upper-class households, and even within that group the share of households who are paying for a private health insurance is much smaller than the share of households who opt for private education.

Finally, drawing from public opinion polls in various countries, we examine whether opting out from public services undermines the social contract. Building on previous academic work, we explore three possible mechanisms through which this may occur: an institutionalized exit mechanism (Hirschman 1978), which postulates that dissatisfaction with a public service leads people to exit it and pay for a private alternative when they see other dissatisfied people exiting as well. This creates a sorting mechanism which weakens demands for accountability from within the public system. The second mechanism relates to a fiscal trap created because people who opt out of public services prefer less spending and less taxes to fund those services (Bénabou, 2000; F. H. G. Ferreira, 2001; López-Calva et al., 2014). The third mechanism relates to the social distance between different socio-demographic groups. As the segregation of income groups in public and private services increases, it is postulated that social affinity decreases.

This, in turn, can impact attitudes that matter for the social contract (Bjorvatn & Cappelen, 2003; Lupu & Pontusson, 2011; Shayo, 2009).

We find that scholars' concern that the trend towards private services undermines the social contract is justified (Ferreira et al., 2013; López-Calva et al., 2014). The use of private services generates a sorting mechanism in which people outside of public systems of education and health have worse evaluations of public services, express less support for the public provision of those services, and more generally, less support for redistribution compared to people inside the public systems. We also find substantive differences across the policy domains suggesting that the opting out from public education may have more serious consequences compared to opting out from the public provision of health. This cross-policy differences might be explained by education's more intense socialization component compared to health care, but they might also be related to the more porous boundary between public and private demand for health services.

The chapter proceeds as follows. Section 1 employs harmonized household surveys from Argentina, Bolivia, Brazil, Colombia, Mexico, Peru, and Uruguay to document the enrollment in private schools and the use of private health plans over time. This section also presents the sociodemographic correlates of opting for private services. Given the theoretical and practical importance of the middle-class in accounts of the politics behind public versus private provision of education and health, Section 2 provides descriptive statistics of the extent to which the upper- and middle-classes are outside of the public systems using harmonized household surveys. Section 3 describes three mechanisms related to the consequences of the opting out for the social contract and examines public opinion data from eighteen countries in the region to evaluate some

of their implications. Section 4 concludes with a discussion of our findings and implications of our results.

Section 1. The use of private education and health care services in Latin America

In this section, we begin with a discussion of our definition of opting out from public services. Then, we employ data from harmonized household surveys from early 2000s to 2018 in seven countries: Argentina, Bolivia, Brazil, Colombia, Mexico, Peru, and Uruguay¹ to examine trends in opting out from public education and health care systems and the socio-demographic characteristics that correlate with households' decision to pay for private services. Among all correlates, we devote special attention to the association between income and the use of private services given the theoretical and practical importance of the former. Other characteristics included in the analysis are the student's age, whether the household is in a rural or urban area, and three characteristics of the head of the household: education, employment category, and whether she (or he) works in the formal sector of the economy.

Our definition of opting out from public services draws from Hirschman's influential work (1970, 1978). In his framework, members of an organization have two options when they are not satisfied with the organization's performance: use their voice to try to exert change or exit the organization. Applied to the public education system, Hirschman explains that, when exit is a viable option, parents who are not satisfied with their public school would remove their children from the public system and enroll them in a privately funded school. The exit option is

¹ Harmonized household surveys come from the Inter-American Development Bank.

particularly appealing to parents who can afford to pay private tuition because demanding improvements from within the system might not be effective. Although Hirschman refers to a transition from one school to another, the more fundamental aspect of opting out for us is people's decision to use and pay for a private service. In the case of education, it is straightforward to see that parents who enrolls their children in a private school are, *de facto*, opting out from the public system in the sense that they are not taking the spot available to them in the public system. Thus, we employ enrollment in private schools as a proxy of opting out from public schools. Our analysis focuses on enrollment decisions at the elementary, middle, and high school levels (children and teenagers between 6 to 18 years old).²

For the domain of health care, we also conceptualize and measure opting out in terms of people's decision to use and pay for private services. We consider the decision to pay for private health insurance as a strong manifestation of people's desire to opt out from the public health care system. For the cases in which data allow us, we also measure use of private services. That said, we are quick to acknowledge that measuring opting out from public health care systems is challenging.³ First, the boundaries between public and private health care are porous, particularly

² We recognize that higher education may have a different dynamic. In many countries, the share of low-income students who reach college is substantially smaller compared to the share of middle- and upper-class students that do so. Hence, at the higher education levels, the public systems have not experienced the same increases in demand from a broad sector of the population. On the other hand, since middle- and upper-class students attend public universities, they might be more willing to continue to support public spending allocated towards higher education.

³ Most health systems in the region have three subsectors: public non-contributory, contributory, and private. The non-contributory healthcare system is publicly financed and is more likely to be accessed by low-income people working in the informal sector of the economy. The contributive sector is financed by social security contributions, which are a mix of employee, employer, and state financing. In some cases, this contributive sector is composed of

in countries where the contributory systems include public and private providers.⁴ Second, in most cases, people who pay for a private health insurance still have coverage in the public system (either in the contributory or non-contributory subsectors). Finally, even if they do not pay for a private health insurance, people in many cases pay out-of-pocket for services in the private sector (for example, when they want to circumvent waiting lists, restricted choice of specialist and gatekeeping (Bancalari et al., 2023)). For these reasons, using and paying for a private health insurance is not an ideal measure of opting out, but its advantage is that it allows us to capture the desire to “exit” in a way that coverage in public and private health care providers would not.⁵ We employ household surveys from four countries that include a question that allows us to distinguish people who pay for a private health insurance (Bolivia, Colombia, Peru, and Uruguay).⁶ Table A. 1 in the appendix documents the questions we use to measure private health insurance in each country.

both public and private providers. Finally, the purely private sector is that in which individuals pay out-of-pocket, either for insurance or for services. Particularly in countries with contributive systems, this purely private sector tends to be small. Please see Bancalari, A. et al (2023) for a fuller description of health systems in the region.

⁴ For example, in Brazil the public insurer contracts with both public and private health care providers, and in Argentina there are multiple insurers, including more than 300 non-profit insurance funds (Bancalari, A. et al (2023)).

⁵ There are two cases, Chile and Uruguay, where people who want to exit the public health care system can withdraw their contributions to the contributory systems and transfer them to the private system (Bancalari et al., 2023). In such cases, opting out is clearer. However, public systems with this option are very rare in the region.

⁶ Colombia’s regular household survey does not ask about private health services, so we instead use the *Encuesta Nacional de Calidad de Vida*

Section 1.1 Opting out of public education

The twenty first century in Latin America is a period with a mixed balance in terms of the provision of public education. Statistics about access to primary and secondary schooling paint a picture of progress. Enrollment rates in primary school have been above 90% since the 2000s.⁷ And, in the last decades, access to secondary schooling has expanded from 60% to 78%.⁸ On the other hand, some have speculated that the expansion of access lowered the instructional quality of public schools (Elacqua et al 2018, Ferreira et al 2013, Lopez-Calva et al 2014, OCDE 2010).

In parallel to the access trend, the share of school-aged children enrolled in private schools is on the rise (UNESCO, 2022). At the regional level, between 1999 and 2011, the annual increase in private school enrollment among primary-level students was 3 percentage points, and 1 percentage point at the secondary level (CEPAL, 2014). The upward trend is perhaps more concerning for the social contract when considering that the share of school-aged children enrolled in private schooling is high in Latin America compared to other regions (Gasparini et al., 2014). For example, by 2018, private elementary school enrollment was 20% in Latin America, whereas it was 14% in high income countries in other parts of the world.⁹ Moreover, as Fernández et al. (2023:1) show “school attendance in private schools is among the most socio-economically segregated in the world”.

⁷ According to UNESCO Institute for Statistics available in the World Bank Indicators, in the last 30 years, secondary schooling has been on the rise, growing from 60% to 78%.

⁸ UNESCO Institute for Statistics accessed through World Bank Indicators.

⁹ UNESCO Institute for Statistics, accessed through World Bank Indicators.

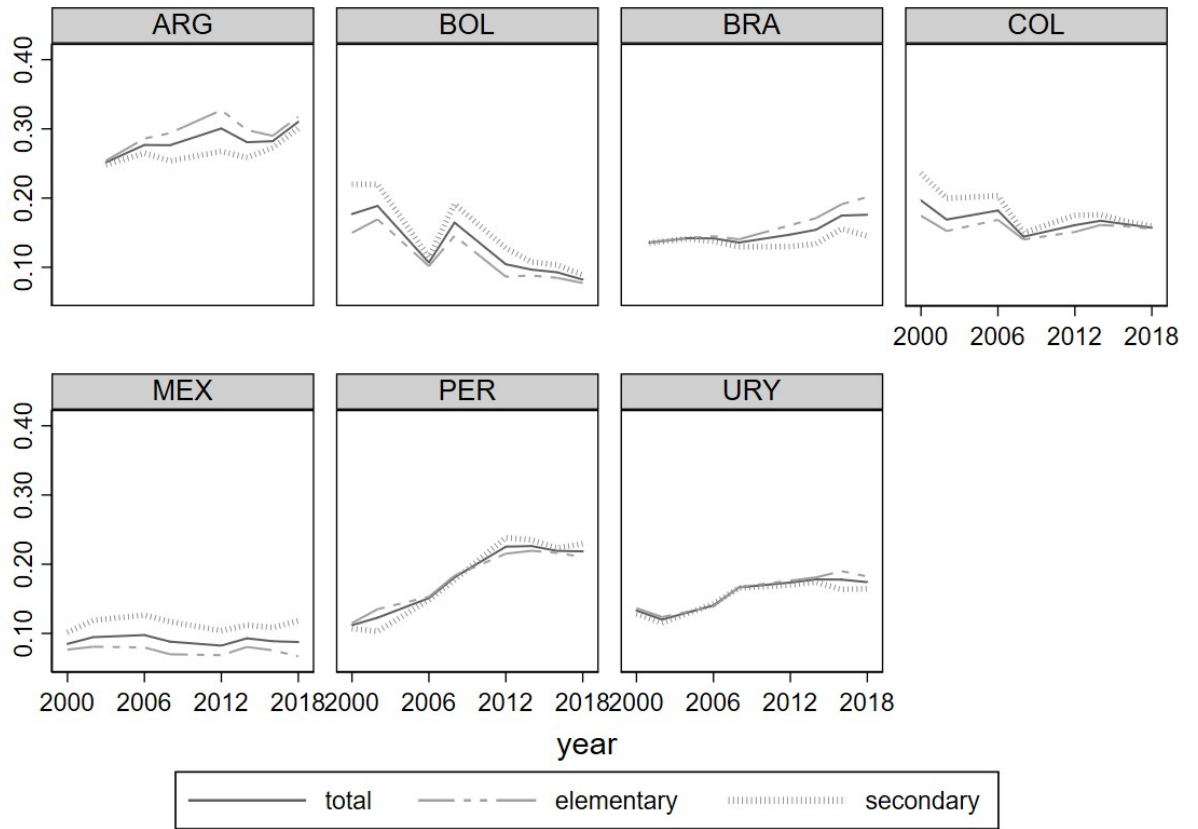
While the regional trend points to a steady increase in the share of students enrolled in private schools, the aggregation masks important variation across countries. Figure 1 reports the share of students in elementary and secondary grades enrolled in private schools from 2000 to 2018 by country. The first thing to note is that private school enrollment rates have not increased uniformly across all countries in this sample. While Argentina, Bolivia, Peru, and Uruguay show signs of an upward opting-out trend, this is not the case in Bolivia, Colombia, or Mexico.

Argentina stands out for having a comparatively high private school enrollment rate since the early 2000s. This can be explained by the large proportion of private schools in Argentina, mainly religious ones, which are subsidized by the state, making their fees accessible to low-income families (Verger et al., 2018). At least half of private schools are between 80 and 100% subsidized (Elacqua et al., 2018). Because of its already notable starting point, its increase is less pronounced than in other countries. The case of Peru is worth noting because of its sustained increase in private school enrollment, which duplicated in the 20-year period. This is likely due to the expansion of low-fee private schooling, which boomed in the early 2000s partly as a result of weak education regulations and a decreased ability of the public sector to absorb higher demands for education (Balarin, 2015; Verger et al., 2018). In Uruguay, the increase occurred mostly in the early 2000s, and has remained relatively steady since then, reaching private school enrollment rates of almost 20%. In Brazil private school enrollment rates began increasing after 2010, particularly among primary-level students.

On the other hand, we do not see an opting-out trend in Bolivia, Colombia or Mexico. Mexico is the country with the lowest private school enrollment rates, where only around 10% of students attend an educational institution not operated by the government, and even less so at the elementary level. Mexico's current enrollment rates in private schools are comparable to those in

Bolivia and Colombia. Yet, both in Bolivia and Colombia, private school enrollment decreased in the period under study. The downward trend in opting out is more noticeable in Bolivia, where the share of students in private schools decreased by 10 percentage points between 2000 and 2018. In Colombia, the decrease in opting out is concentrated between 2000 and 2010, after which it has remained stable-at around 15% for the remaining of the period.

Figure 1. Latin America (selected countries): Share of students enrolled in private schools over time (2000, 2006, 2012 and 2018).



Source: Authors' calculations using harmonized household surveys from various years by country.

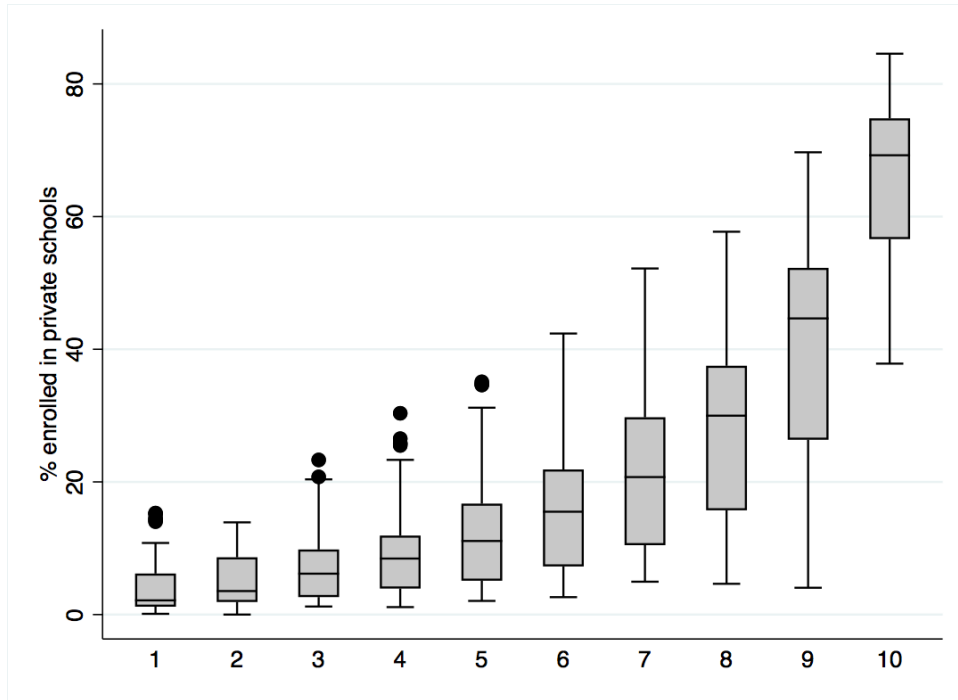
In sum, although the rates of student enrollment in private schools is high in the region, there are important differences across countries. In some cases, like in Peru, a substantial share of households has increasingly opted for private schools since the 2000s. Other cases display a more constant pattern, like in Mexico. Finally, in Bolivia and Colombia, the share of students in private schools has decreased since the 2000s.

Section 1.2 Correlates of the opting out from public schools

The trajectories and current levels of opting out from public schools are the result of a myriad of factors, which affect the demand and supply of public and private education in the region. On the demand side, a wide-spread view is that the use of private services is disproportionately a middle- and high-income household phenomena (Ferreira et al, 2013, CEPAL 2014, Elacqua et al 2018, Gasparini et al 2014, Lopez-Calva et al 2014). To be sure, household's income is positively correlated with enrollment in private schools around the world (Checchi & Jappelli, 2003; Goldring & Phillips, 2008). Still, in Latin America socio-economic groups seem to be segregating in public and private schools at higher levels than other parts of the world (Fernandez et al, 2023).

We find that the correlation between income and enrollment in private schools confirms prior accounts of a region where children from low-income and high-income households attend different types of education systems. Figure 2 shows the average share of students who are enrolled in private schools in selected countries in Latin America by income deciles. The latter is calculated by adding labor and non-labor income for all members of the household and dividing it by the total number of household members. This is then converted to constant \$US PPP 2011. Whereas 4% of households in the first income decile send their children to a private school, 65% of households in the top income decile do so, on average in the countries in our sample. In addition, Figure 2 suggests that the relation between income deciles and private school enrollment is not linear, as the percentage of households sending their children to a public school increases at higher rates among the top income deciles.

Figure 2. Latin America (selected countries): Enrollment of students in private schools by income deciles in selected countries in Latin America.



Source: Authors' calculations using harmonized household surveys from various years by country.

Note: Average from the seven countries used in this study: Argentina, Bolivia, Brazil, Colombia, Mexico, Peru, and Uruguay

As in the previous subsection, we disaggregate the analysis to get a better sense of the cross-country variation in the correlation between income deciles and enrollment in private schools.

We employ the household surveys in two points in time (early 2000s and 2018) to also observe if that correlation has changed over time. We estimated a linear probability model for each country-year. The dependent variable is whether a school-age children attends a private school or

not.¹⁰ The independent variable is the household's income decile. We present models with a set of controls later in this section.

Figure 3 shows the probabilities of attending private school for school-aged children according to their household income decile. The first thing to note is that the probability of attending a private school is positively correlated with income in all countries. Moreover, in 2018, in most of the countries in our sample, over 70% of children from the tenth income decile attend private school. Bolivia and Mexico are two exceptions, where this probability falls to 42 and 49%, respectively.

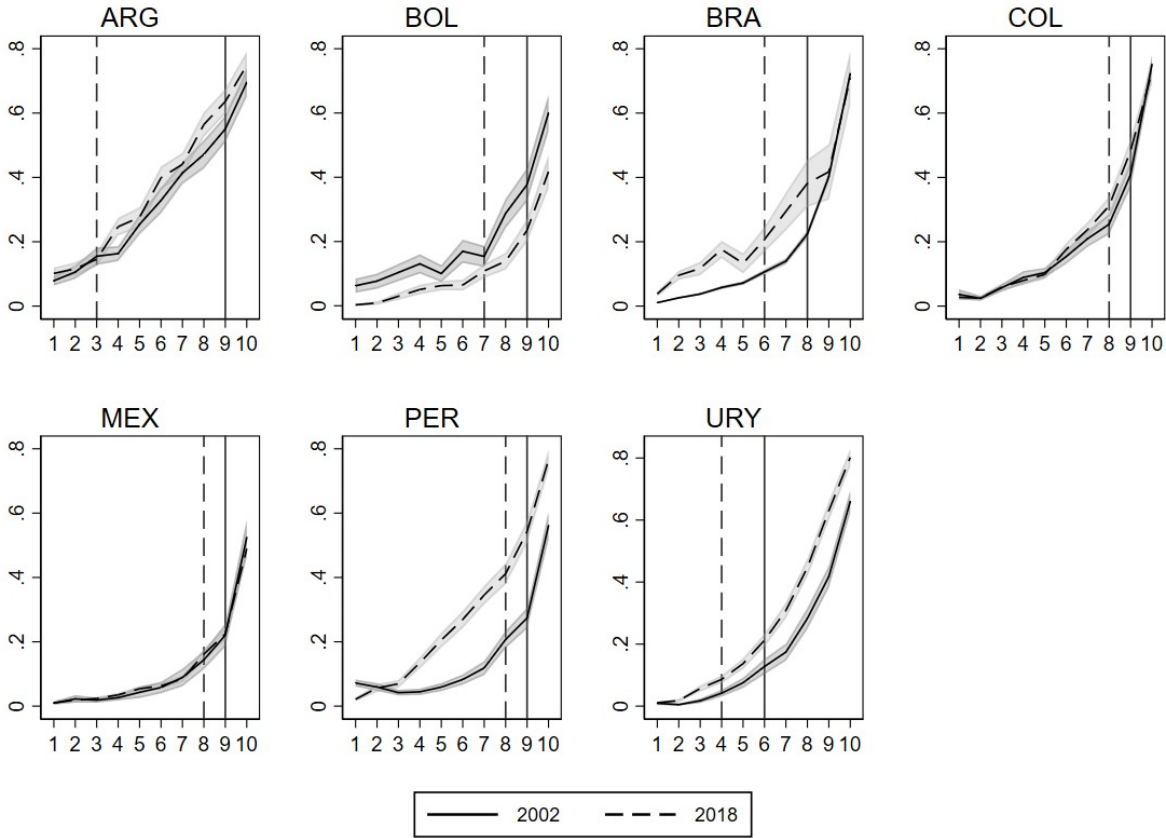
Although the effect of income on private school enrollment is positive in all cases, the extent to which children in households from the middle of the income distribution are enrolled in private schools varies across countries. Focusing on the models for 2018, in Argentina, Peru and Uruguay, the relationship between income decile and private school enrollment is more linear than in other cases. That is, private school enrollment increases steadily as household income increases. In Colombia and Brazil, the relation seems less linear: the probability of attending a private school increases more between the fifth and the sixth income decile, and even more so between the ninth and the tenth income decile. For example, in Brazil, 42% of students in the ninth income decile attend private school compared to 71% of the children in the tenth decile. In Mexico and Bolivia, we see the least linear relation between income and private school attendance. In Mexico, private school rates remain below 10% across income deciles 1 through

¹⁰ Because our outcome is binary (attending private school or not) we use a Linear Probability Model. We choose this over a Logit because of its simpler interpretation (Gomila, 2021; Huntington-Klein, 2022). Still, our results hold if we use a logit specification.

7. It is only at the eighth decile that we see a more pronounced increase in private school enrollment rates: from 16% in decile 8 to 49% in decile 10.

Over time, the probability of attending a private school by income deciles has increased for households in the middle of the income distribution in Peru, Brazil, and to a lesser extent in Uruguay. The most startling difference are found in Peru: less than 5% of children in the fourth income decile attended private school in 2000, but this proportion tripled in 2018 reaching 14%. For households in deciles 6 and 7, there is a 20-percentage point difference between 2000 and 2018. Although less pronounced, lower-middle income children have also increased their private school attendance in Brazil and Uruguay. Yet in the latter country, the most pronounced increase has been among the top deciles. For example, private school enrollment at the top decile was of 66% in 2000s, and 80% in 2018, which is the highest rate in our sample.

Figure 3. Latin America (selected countries): Income deciles and enrollment in private schools in 2002 and 2018.



Source: Authors’ calculations using harmonized household surveys from various years by country.

Note: the vertical lines represent the lower threshold to be considered middle class (daily income at or above \$13 2011 PPP

Other correlates that affect the demand side of private education include the head of the household’s education, employment category, and whether she (or he) works in the formal sector of the economy.¹¹ Figure 4 summarizes the results of the multivariate linear probability models.

¹¹ As a reminder, we also control for the children’s age in the models, and whether the household is urban or rural. We will discuss these latter results at the end of this section.

Parents' education correlates positively with children's enrollment in a private school. As with income, the level at which parents' education starts making a substantial difference on private school enrollment varies across countries. In Mexico, Bolivia, and Brazil, it is mostly students with a parent with tertiary level education for whom the probability of attending private school increases. For instance, in Mexico, a student in a household where a parent has attained a secondary-level education is only 2 percentage points more likely to attend private school compared to a student in a household where a parent attained primary education. However, a child whose parent completed tertiary education is 13 percentage points more likely to attend private school (controlling for income and other covariates). In Uruguay, Argentina, and Peru, parents with secondary schooling have a significantly higher chance of sending their children to private school compared to parent with primary schooling. For example, in Uruguay and Argentina, parents with tertiary education and secondary education are 13 and 26 percentage points more likely to opt for a private school compared to parents with primary education, respectively.

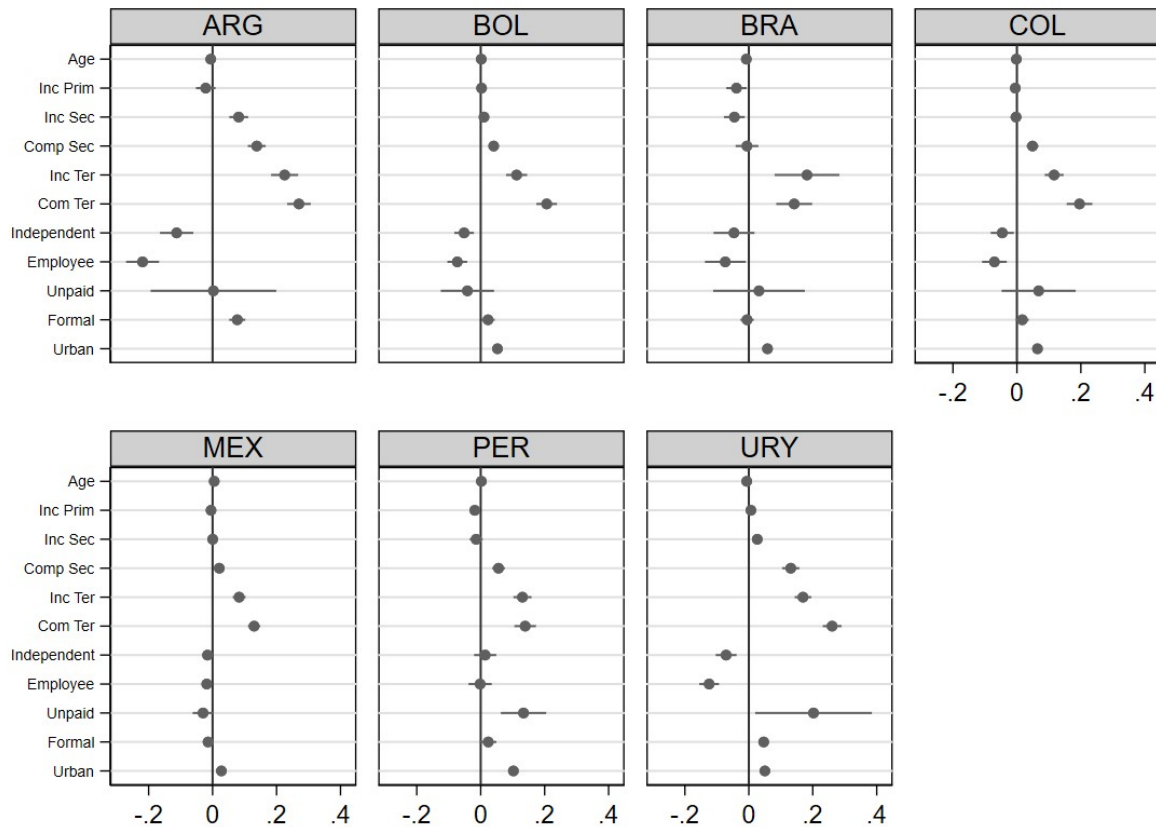
In most countries, children have a higher probability of attending a private school if the head of the household is a business owner, as opposed to an employee or a self-employed worker. However, in some countries the effect is small or not precisely estimated (eg. in Mexico or Peru). The coefficients are largest in Argentina where a child whose head of household is an employee is 21 percentage points less likely to attend private school compared to business owners. In most other countries, this coefficient is between 7 and 12pp.

Related to the last point, whether the head of the household works in the formal sector of the economy, as opposed to the informal sector, correlates positively with enrollment in private schools. The positive correlation is present in most countries, which is surprising considering

that the models are controlling for income and employment type, as well as other household characteristics. The correlation varies from 2 to 7.7 percentage points. Mexico is the only country where the coefficient is negative and small in magnitude (1pp).

On the supply side of the opting out, in our data we see that private school enrollment rates are practically zero in rural areas in many countries, which is consistent with the lack of supply of private schools in those areas. For example, in Bolivia, Colombia, Brazil, and Mexico, it is less than 2%. Only in Uruguay private school enrollment in rural areas is higher (6%) than in rural areas in other countries in our sample. Our models confirm that households in more urban areas have a higher probability of enrolling their children in private schools, with the highest effect taking place in Peru. That said, the opting into private schools is not just a mega-cities/capital cities phenomena. A more nuanced analysis that distinguishes capital cities from other urban areas in our sample suggests that in capitals and in other urban areas, households who can afford it are opting into private schools. Although capital cities tend to have higher rates of private school enrollment, other urban areas still have significantly higher rates than rural areas (see **Error! Reference source not found.** in the appendix).

Figure 4. Latin America (selected countries): Correlates of enrollment in private schools.



Source: Authors' calculations using harmonized household surveys from various years by country. The models include income deciles, but for presentation purposes we do not include them in the figure. Please see Figure 3 for income related results.

Section 1.3 Opting out of public health

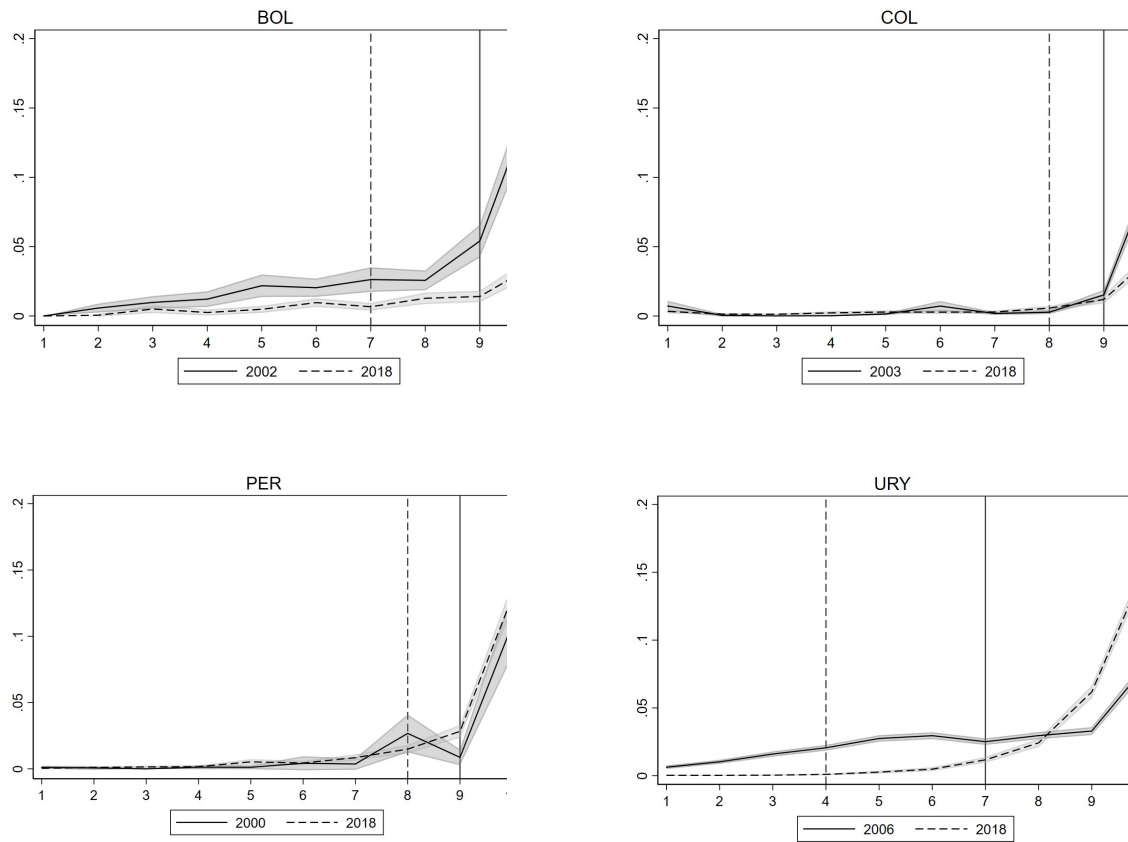
In this section, we turn our attention to health care. As a reminder, we focus on whether people pay for private health insurance as a proxy for people's preference to opt out of the public health care system. In Bolivia and Colombia, we also measure people's use of private health care providers. Drawing from household surveys, this section documents that only households in the top income deciles are paying for a private health insurance in our sample. Moreover, there

seems to be little change over time. When looking at out-of-pocket expenditures, more households opt for some private services across the income distribution. Still, the percentage of households paying out-of-pocket remains small relative to the share of households who opt of the public education system.

Figure 5 shows that affiliation to private health plans is low, averaging less than 2%, in all the countries under study. Although the rate of households with private health insurance increases with household income, the rate of affiliation to a private health care plan increases substantively at the top of the income distribution, where in average 15% of households pay for a private health care insurance.

Over time, the affiliation to private health plans has remained stable, with some exceptions. In Bolivia and Colombia, affiliation to private health plans decreased between 2002 and 2018 across the income distribution. The decrease among households in the top income decile is particularly pronounced (10 percentage points in Bolivia, and 7 percentage points in Colombia). On the other hand, Uruguay has experienced changes across the income distribution: private health insurance declined among households in the first through the eight-income decile. Still, it increased among households in the top deciles from 8% in 2006 to 15% in 2018.

Figure 5. Latin America (selected countries): Private health insurance by income deciles.



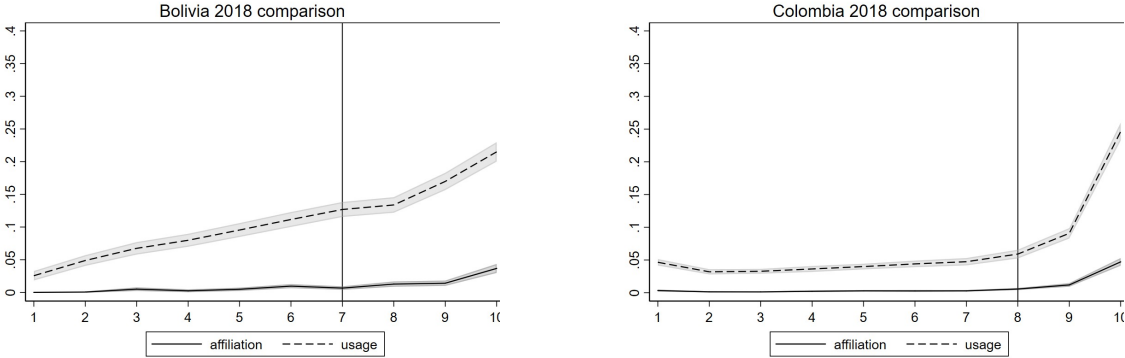
Source: Author's calculations using household surveys.

Note: the vertical lines represent the lower threshold to be considered middle class (daily income at or above \$13 2011 PPP).

In two countries, Colombia and Bolivia, we can compare the rates of private health care *affiliation* versus the *usage* of these services. Household surveys asked respondents in those countries whether they used a private health care service in the past year. Figure 6 compares the rates of affiliation and usage of private health care services by country. In both cases, usage is higher than affiliation across the income distribution. In Bolivia, the share of households who use private services increases steadily with income decile, and the uptick at the highest income decile

is not as noticeable. Compared to affiliation rates, usage is 10 percentage points higher on average. The gap is still highest among decile 10, where usage reaches 21.5% and affiliation is less than 5%. In Colombia, although usage is higher than affiliation among all income deciles, the difference between them is most pronounced at the top of the income distribution, where affiliation is 5% and usage is 25%. Hence, in the health care domain the opting out of public health care is for the most part driven by high-income households.

Figure 6. Comparison of affiliation to a private health insurance and usage of private health care in Bolivia and Colombia.



Source: Authors’ calculations based on Bolivia: National Household Survey 2018, Colombia: Encuesta Nacional de Calidad de Vida 2018

As with education, we estimate a multivariate model to analyze the correlates of private health care insurance, including whether the household is in a rural or urban area, and two characteristics of the head of the household: education, and whether she (or he) works in the formal sector of the economy.¹² For the most part, we find that these factors correlate in a similar

¹² In this model we do not include employment categories, as in the case of education, because this information was not available in all surveys with the relevant health usage questions.

direction to both private education and private health care insurance. Yet, we find smaller correlations for the latter compared to the former policy domain.

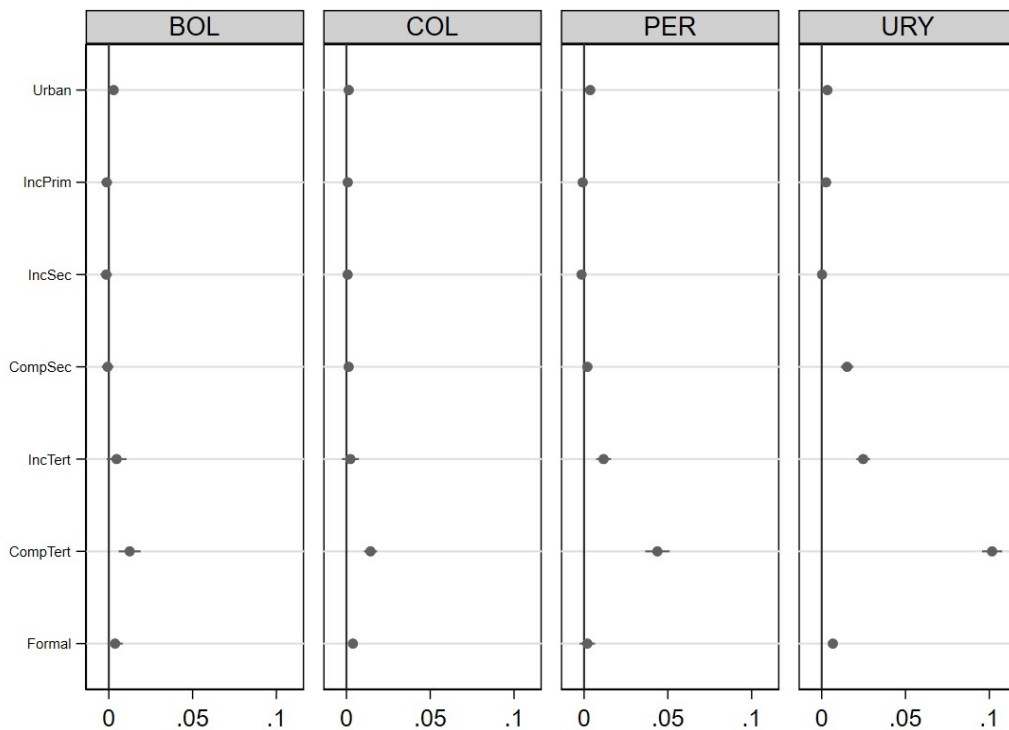
The head of the household's educational attainment associates positively with paying for a private health insurance in all our sample. But, the difference in insurance rates between those who attained a tertiary education compared to those with primary education vary from 10 percentage points in Uruguay, 4 percentage points in Peru, and 1.5 percentage points in Bolivia and Colombia (1.5 percentage points). Also, the level of education at which the probability of paying for health insurance increases more noticeably is lower in Peru and Uruguay (incomplete tertiary education), than in Bolivia and Colombia (tertiary education or more).

People working in the formal sector of the economy should be covered by the social security system, and as such they should not *need* to buy private insurance. This implies that we should see a negative correlation between formality and paying for private health insurance. However, our model shows no evidence of such negative correlation. Indeed, we find that formality is not associated in a statistically significant way with paying for private health insurance in Bolivia and Peru. Moreover, in Colombia and Uruguay, where we find a statistically significant correlation, but it is in the opposite direction (see Figure 7). Hence, if anything, working in the formal sector has a small positive effect on opting out from public health systems, which goes in line with the positive association we discussed earlier between formality and opting out from public education.

Lastly, opting out from public health is a more urban phenomenon, as was the case with education. Our model suggests that people living in urban areas are more likely to have private health insurance. But, this correlation, although statistically significant, is smaller than the correlation between attending a private school and living in an urban area. One possibility to

account for the smaller effect of urban residence on health insurance is that households may use health care services less often than education services. So, distance to health care institutions and travel considerations might be less decisive when it comes to choosing healthcare providers. Another possibility, which we consider less plausible, is that there is more offer of health care services compared to private schools in rural areas.

Figure 7. Correlates of private health insurance in Bolivia, Colombia, Peru and Uruguay.



Source: Authors' calculations based on 2018 Household Surveys (Bolivia, Peru, Uruguay) and *Encuesta Nacional de Calidad de Vida* (Colombia).

In sum, the descriptive results in these sections offer evidence in support of the view that, among households who can afford it, an important share of them are opting into private services. In particular, households in the top income deciles are, for the most part, out of the public education systems and are opting out from public health systems at higher rates than households

elsewhere in the income distribution. We also showed that opting out from public services is an urban phenomenon, which goes beyond the capital cities in the region. And we show that people who work in the formal sector are opting out from public services at higher rates compared to people who work in the informal sector, which is a surprising result considering that our models account for differences in income and education.

We get a more mixed picture about the extent to which households in the middle of the income distribution are opting out from public services. While we see more variation in terms of attendance to private schools across income deciles in some countries, there is a more consistent low level of private health insurance use in the middle of the income distribution in our sample. That said, the analysis so far has used income deciles to sort households into income groups, which means that the results depend on the relative position of households in the income distribution of their country. Still, some of the concerns about the opting out from public services center on the possibility that the middle-class, defined in absolute terms, is exiting the public systems. We turn to this point in the next section.

Section 2. Is the middle-class opting out from public services?

Prior academic work examining the politics of the public provision of education has traced cross-national differences in spending on public versus private education to stable distributive coalitions, in which the middle-class is considered pivotal. In brief, the argument is that poor voters tend to stay in the public school system because the benefit they obtain is much higher than the private investment they could be able to make (Ansell, 2010). Conversely, upper class voters choose private schools because privately funded education systems provide significant barriers to less affluent children and raise the returns to education for the well-off

(Busemeyer & Iversen, 2014). Therefore, while the latter group prefers less spending on education, the former prefers more spending. The resulting system depends on the middle class who may ally with the upper class if they perceive that a privately funded system would reduce their burden of financing education for the poor. Or they may ally with the poor if a privately funded system requires investments that are prohibitively high.

More structurally, however, it has been argued that macro-level factors shape the middle-class' decisions regarding which type of system to support (Castles 1989; Busemeyer 2007; Ansell 2010). For example, electoral institutions seem to be decisive. Proportional regimes (PR), because they force consensus building, create a coalition between the middle class and the poor in favor of public education. On the other hand, majoritarian (MJ) regimes tend to produce a coalition between the middle and upper classes in favor of private education (Ansell, 2010; Busemeyer & Iversen, 2014). In this strand of work, distributional coalitions become stable because the type of education system they create shapes individuals' preferences, reinforcing the public-private equilibrium (Busemeyer & Iversen, 2014).

Since most Latin American countries include in their electoral systems a proportional representation component, it would follow that the middle-class ought to ally with poor voters in a coalition in support of public systems. To what extent is this happening across countries? How strong is the inter-class coalition sustaining the provision of public education and public health care in the region? To shed some light into these questions, we examine enrollment in private

school and payment of private health insurance by social class, as defined by the World Bank (F. Ferreira et al., 2013; López-Calva et al., 2014).¹³

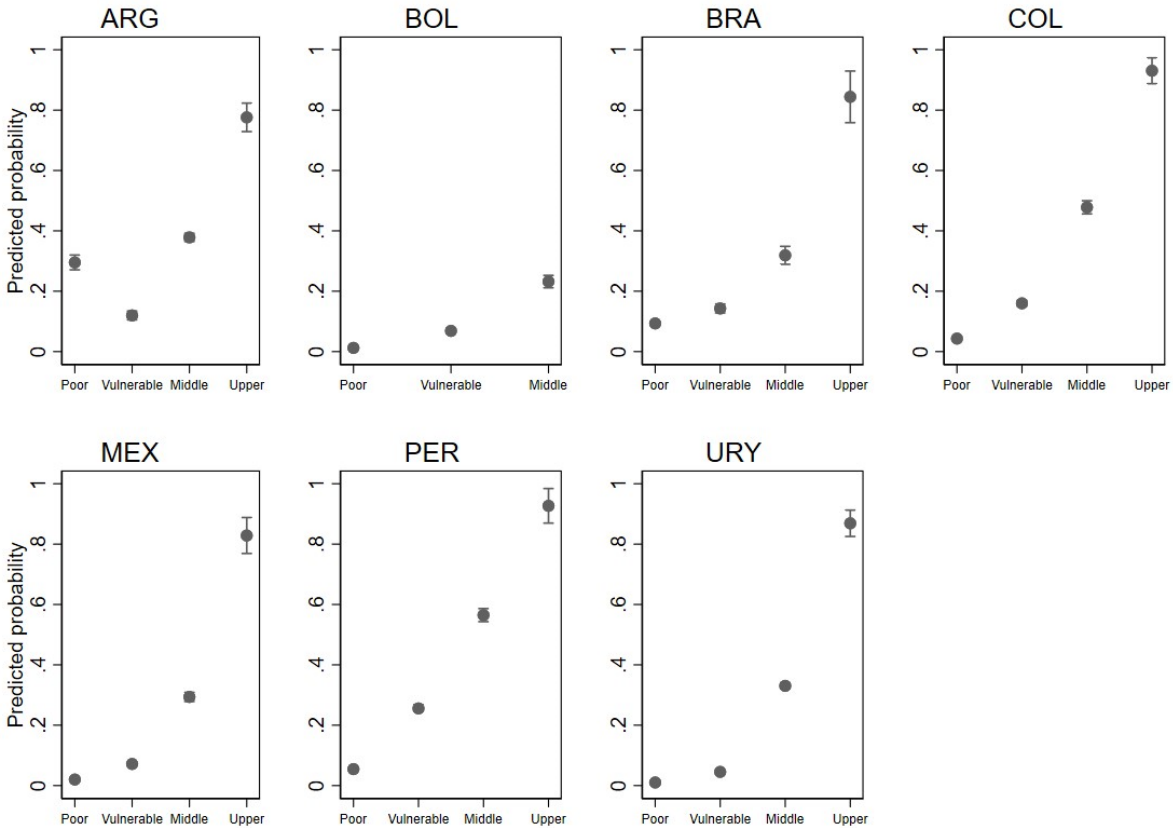
One thing to note before delving into our analysis is that the middle-class, defined as the group of households in a country with an income between \$13 and \$70 dollars per day, does not necessarily include households from the middle-income deciles. Indeed, in most countries in our sample (Bolivia, Brazil, Colombia, Mexico and Peru), the middle-class begins in the sixth to the eighth income deciles. Only in Argentina and Uruguay the middle-class begins in deciles 3 and 4, respectively. The horizontal lines in Figure 3 and 5 mark the lower bound of the middle-class in each country in two points in time. In these figures, it is already evident that the middle-class is choosing private services at higher rates than the vulnerable class in most of our sample.

In the analysis that follows, we model the probability that a student attends a private school as a function of their households' classification as either poor, vulnerable, middle-class or upper-class (F. Ferreira et al., 2013; López-Calva et al., 2014). In every country in our sample, a student from an upper-class household has at least an 80% chance of attending a private school. The probability of attending a private school is lower for students from the middle-class compared to students from the upper-class. Still, in many countries middle-class households have a high probability of sending their children to private schools. For example, in Peru this probability is close to 60%, whereas in Argentina, Brazil, Colombia, and Uruguay is close to 40%. Even in Mexico and Bolivia, the two countries with the lowest enrollment in private schools in our sample, a student from the middle-class has a 30% and 20% probability of

¹³ The original formulation of the middle-class definition uses 2005 PPP. We follow Fernandez et al., (2023) and use the 2011 PPP measure. See Ferreira et al. (2013) for a thorough discussion around this measure.

attending a private school, respectively. Hence, this analysis suggests that the opting into private education is widespread among the upper-class and, to various degrees, is a prevalent behavior among middle-class households too.

Figure 8. Latin America (selected countries): Enrollment in private schools by class, 2018



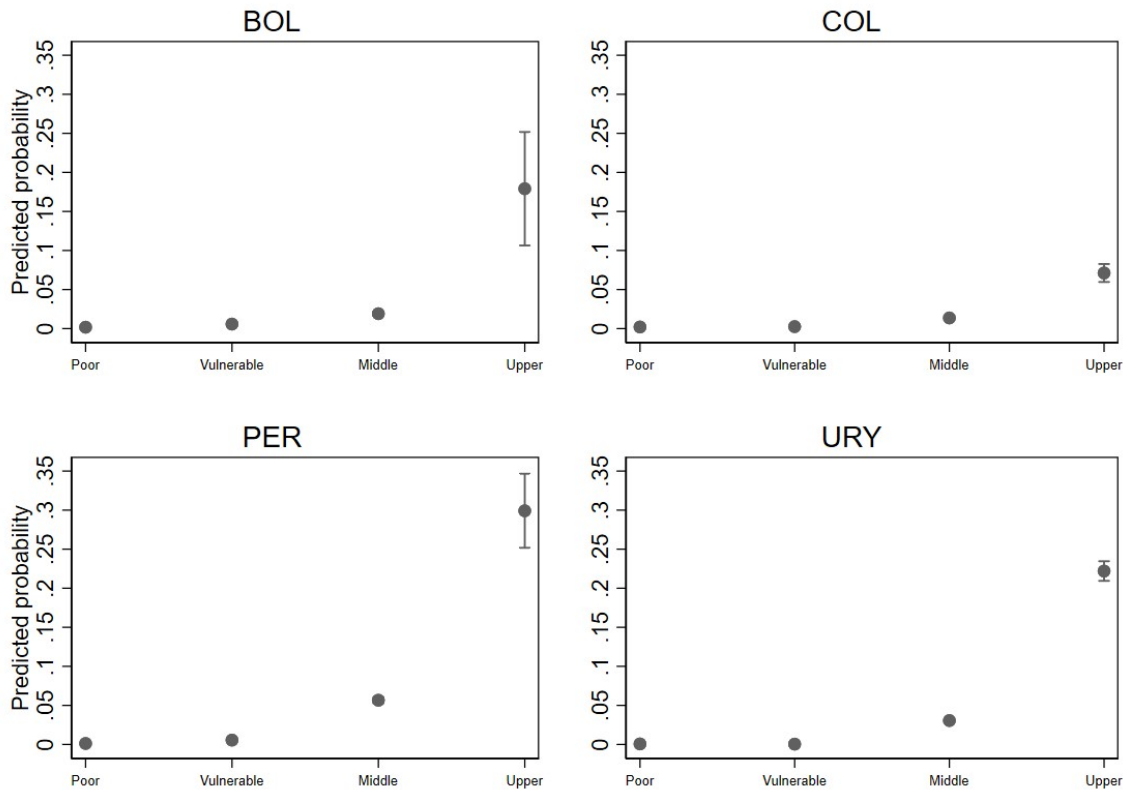
Source: Authors' calculations using harmonized household surveys from 2018 by country.

Note: in PPP 2011, Poor (< \$5.5), Vulnerable (\geq \$5.5 and < \$13), Middle Class (\geq \$13 and < \$70), Upper Class (\geq \$70)

Turning our attention to health care, the analysis that follows shows that paying for a private health insurance is, for the most part, a behavior of the upper-class. But, even among the wealthiest group, paying for health insurance is not as widespread as it is opting into private

schools. The probability that a household in the upper-class pays for health insurance is around 10% in Colombia, 20% in Bolivia and Uruguay, and 30% in Peru. Households in the middle-class have a low probability (less than 5% in most cases) of paying for a private health insurance.

Figure 9. Latin America (selected countries): Enrollment in private health insurance by class, 2018



Source: Authors' calculations using harmonized household surveys from 2018 by country.

Note: in PPP 2011, Poor (< \$5.5), Vulnerable (\geq \$5.5 and < \$13), Middle Class (\geq \$13 and < \$70), Upper Class (\geq \$70)

In Colombia and Bolivia, we can also examine the use of private services (typically covered by out-of-pocket expenditures). As one might expect, in both cases there is a higher probability of households using private health services compared to paying for a private health

insurance. Still, in both cases, use of private services is more common among households in the upper- compared to the middle-class. In Bolivia, around 15% of the middle-class uses private health services, but the rates of usage is almost doubled in the upper-class. The gap in usage of private services between the upper- and middle-class is even wider in Colombia, where less than 10% of the middle-class pays out of their own pocket for services, compared to 35% among the upper-class (see Figure A. 2 in the appendix).

In sum, the upper-class and a substantial share of the middle-class in our sample have opted out from public education. On the other hand, opting out from public health is mostly prevalent among upper-class households, and even so the share of households who are paying for a private health insurance is much smaller than the share of households who opt for private education. These descriptive patterns have implications for the distributive coalitions that could help support the public provision of these services. For education, in particular, the fact that the middle-class is split, with a range of 20 to 60% of households in private schools in the countries in our sample, highlights the possible fragility of the inter-class distributive coalition that might support and sustain the public provision of this service. In the case of health, there seems to be more room for the kind of broad inter-class coalition to support the system.

Section 3. What are the consequences of opting out from public services?

In the previous sections, we have shown that in many countries in Latin America an important proportion of the population has opted to send their children to private schools, and a smaller (but not trivial) proportion of the population opts for private health services. Moreover, we have shown that income correlates positively with the use of private education and health services. For both services, the probability that a household in the top income decile opts for private versus

public services is considerably higher compared to households in the middle and bottom of the income distribution. We also show that the middle-class is split, with a substantial proportion of households out of the public education system. That said, we also documented that the opting out from public services varies across countries and across services, with a clearer trend towards the private services in education compared to health.

Considering the strong correlation of income and the use of private services, as well as the results related to the middle-class, we now examine the possible associations between use of private services and attitudes and perceptions that are relevant to understand the social contract in the region. We group our analysis into three possible mechanisms through which opting out from public services may impact citizens' attitudes: institutionalized exit, fiscal trap, and social affinity. Although we discuss these mechanisms separately, we acknowledge that they are likely to coexist and, given the data we use in this chapter, it is difficult to disentangle them.

To explore the attitudinal consequences of opting out, we use public opinion data from *Latinobarómetro* and Americas Barometer (LAPOP). In the case of education, our goal is to examine differences between those who attended private school during their schooling years compared to those who attended public schools. In 2011, *Latinobarómetro* asked respondents across 18 countries in the region whether they attended public or private school for their secondary education. Similarly, the 2016 LAPOP in Chile, Ecuador, and Uruguay asked what type of institutions respondents attended during primary and secondary schooling: public, private, or both. Crucially, the questions we are using to measure the type of school respondents attended temporally separate the “treatment” (attending private school) with respondents' current attitudes and perceptions. This may attenuate some concerns of endogeneity, though we still make no claims of causality, as we do not have the means to eliminate unobserved sources of

confounding, and perhaps more importantly, we acknowledge that sorting is an important factor explaining the associations we find in this section. In the case of health, we have a wider availability of surveys. *Latinobarómetro* asks in many of its waves “How do you generally cover your health expenses?”, to which respondents may choose between public, private insurance, or both. We group respondents that report “state” or “both state and private insurance” to distinguish respondents that use private services. That said, our results are robust to grouping respondents who report using both private and public health services. Although we have more surveys, the questions about health care do not have the same temporal distance between using private services and the attitudinal responses as it is the case of education.

We explore three sets of variables that tap into perceptions and attitudes regarding public services, the role of the private sector, and support for redistributive measures. In our OLS models, we include as controls: highest level of education of parent (head of household), ethnicity, urban/rural residence, and country fixed effects. When considering private education as the main explanatory variable, we do not include controls related to current income or education levels because these are post-treatment variables. To keep the analysis consistent across policy domains, we also exclude these variables from the health models.¹⁴ Similarly, political ideology, a key predictor of perceptions and attitudes towards the public sector, could be argued to be post-

¹⁴ Importantly, the decision to contract a private insurance may be contemporaneous and correlated with other factors associated with the outcome variables (the most obvious being socio-economic status). We re-run our analysis with additional covariates (respondent’s level of education, ideology, and an SES proxy) and we find practically identical results (see **Error! Reference source not found.****Error! Reference source not found.** - **Error! Reference source not found.** in Appendix).

treatment, so we do not include it in the main set of regressions. Still, the results hold when these variables are included.¹⁵

Section 3.1 Institutionalized exit

The first mechanism we consider relates to Hirschman's (1978) argument, which explains that, when people are dissatisfied with a public service they have two options: voice their discontent and pressure service providers from within the system to make changes or exit the public system altogether in search for a private service of (perceived) superior quality. Moreover, when some dissatisfied people opt out of public services, their exiting behavior can influence the decisions of other dissatisfied people, leading to the institutionalization of exiting services (Hirschman, 1978). This argument implies that people who have opted out from the public systems ought to have worse evaluations of the public services compared to people who remain inside the public systems.

In line with the institutionalized exit argument, we find that people who attended private schools or pay for private health insurance report worse evaluations of the public services compared with people who use public services. Starting with education, *Latinobarómetro* has three questions that tap into satisfaction with public schooling. The first is a general evaluation of public schools, the second asks respondents if they think teachers in public schools have the knowledge to teach the subjects they teach, and the third asks whether respondents think teachers

¹⁵ See (Error! Reference source not found.- Error! Reference source not found.) in appendix for regressions with full set of controls.

in public schools have the capacity to teach students.¹⁶ For comparison purposes, we also look at a question about general perception of private schools.

For all these questions, respondents that attended private schools have worse perceptions than those who attended public school. As Figure 10 shows, overall evaluations of public schools are 3 percentage points lower among private school graduates (which represents a 5% decrease off the base evaluation among public school graduates). Interestingly, those who attended private school do not have significantly different evaluations of the quality of private schools compared to those who attended a public institution. With respect to perceptions of public-school teachers' preparation and capacity, private school graduates have lower evaluations of these dimensions as well (with an approximately 4 percentage points decrease in each question).

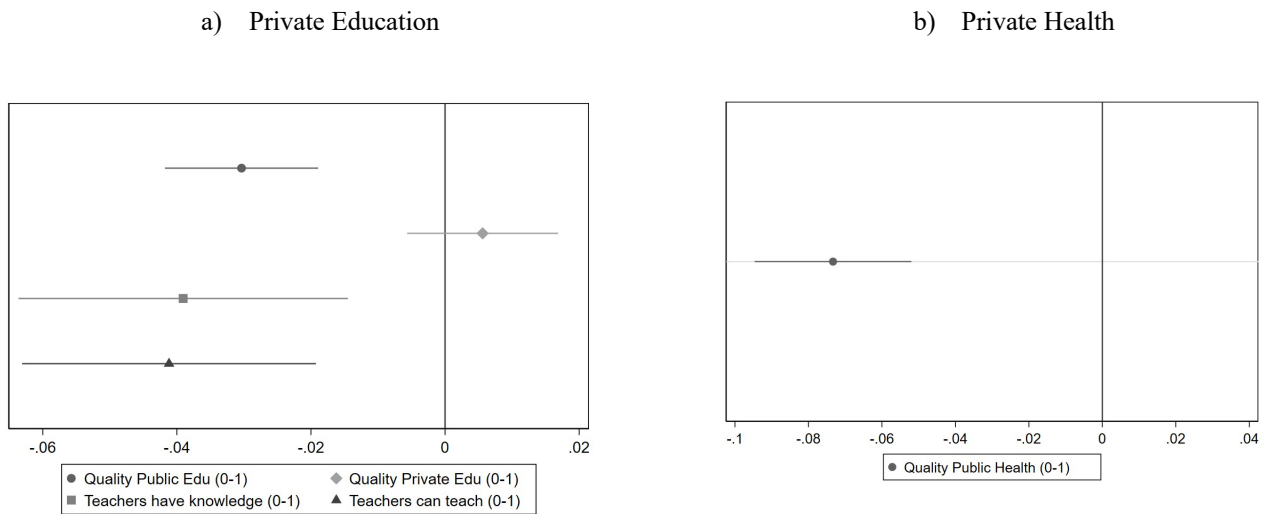
We find similar results for the association of paying for a private health insurance and evaluations of the public service. Respondents who pay private insurance are 7 percentage points less likely to be satisfied with the quality of public health care (which represents a 17% decrease off the base evaluation among people who use public services). As we noted earlier, this association could be the result of evaluations of the public service influencing people's decision to pay for a private health insurance, and the latter reinforcing the former too.

As Hirschman predicted, the opting out of public services creates a sorting mechanism through which people who are discontent with the system exit it if they can afford it. On the other hand, people who remain in the system have more positive evaluations of the system. To be

¹⁶ The first has a scale of 1-10. The second and third questions are ordinal (very bad, bad, good, very good). We have grouped the "good" and "very good" together. For ease of illustration, we have then standardized all questions into a scale of 0-1.

sure, we can't rule out the possibility that respondents are employing a form of motivated reasoning that helps them justify their decisions about the use of public or private services. That said, if motivated reasoning biases respondents' evaluations of services, it is likely that this bias occurs both in the context of answering the survey and, more generally, in people's lives.

Figure 10. Association between use of private services and perceptions of quality of public services



Source: Authors' calculations using *Latinobarómetro* 2011 (Panel A) and 2015 (Panel B)

Note: Data for 18 Latin American countries

Section 3.2 Fiscal trap

The second mechanism we examine relates to a fiscal trap created by the opting out of public services. There are two pieces to this argument. First, it is argued that households who do not use public services prefer less spending and less taxes to fund those services. Second, the correlation between use of private services and preferences for less funding for public services leads to a less equal distribution of opportunities in contexts where political power is unequally distributed (Bénabou, 2000; F. H. G. Ferreira, 2001; López-Calva et al., 2014). The reason for this is that

higher income voters, who have more political power, set a lower public endowment for the provision of public services that are essential to social mobility, like education and health, which in turn will limit inter-generational mobility. With the data available to us, we can shed additional light to the first part of the argument, which by itself can impact the social contract if a large proportion of voters exit public services. We will come back to the second part in the discussion.

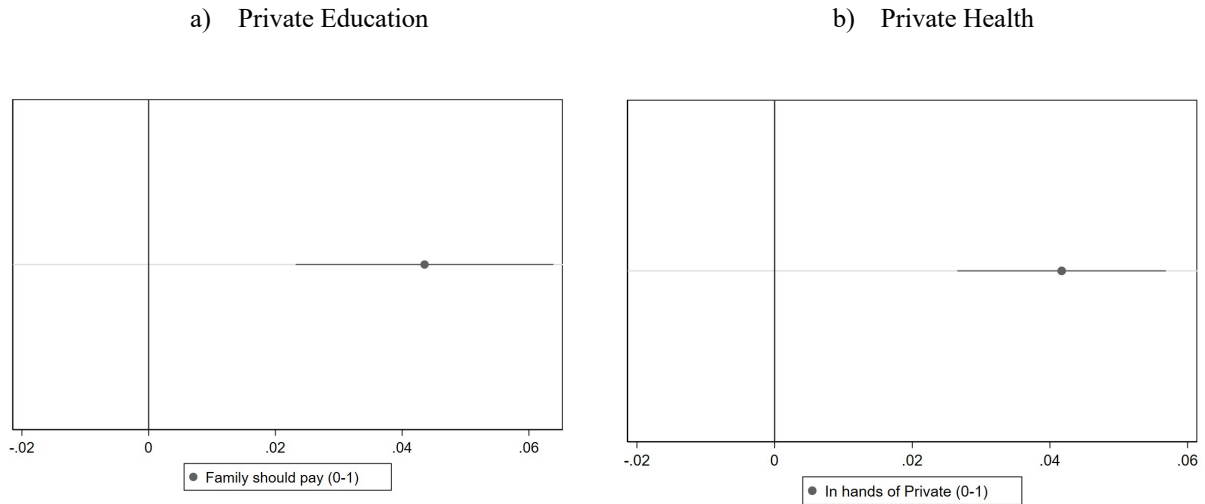
Certainly, prior academic work has documented that use of private services correlates negatively with willingness to pay for public services. For example, it is well documented that in Western Europe, people with private insurance are less likely to support the public health system (Costa-Font & Jofre-Bonet, 2008; Hall & Preston, 1998; Martinussen & Magnussen, 2019; Propper, 2000). The scant evidence for Latin America points in the same direction. In particular, Castañeda et al., (2020) find that people who pay for private health insurance have low tax morale in Mexico. With combined methodology of list experiments and observational data, they show that those that opt out of public health services are more willing to evade taxes. They conclude that “individuals do not simply evade taxes when the expected benefits are low; individuals evade taxes after they distance themselves from state-provided goods and opt for privately provided substitutes” (Castañeda et al., 2020).¹⁷

¹⁷ A small number of experimental studies has also found evidence in favor of the reciprocity argument (Carrillo et al., 2017; Castro & Scartascini, 2015; Ortega et al., 2016), which is closely related to the argument at hand. That is, when people have access to public goods (such as, roads and other public infrastructure), they are more willing to pay taxes.

Consistent with prior work, we find that people who attended private schools have stronger beliefs that families, and not the state, should pay for education.¹⁸ More specifically, there is a 4.4 percentage points increase in the belief that the family should be responsible for financing education when the respondent attended a private school compared to when the respondent attended a public school (which corresponds to a 30% increase off the base response of people who attended public schools). A somewhat similar question is asked regarding healthcare: whether it should be mostly in hands of the private sector or the state. We find that those with private health insurance are 4.2 percentage points more likely to think the health system should be mainly in the hands of the private sector (which corresponds to a 46% increase off the base of the response of people who do not have a private health insurance).

¹⁸ The questions can take on the following values: “state”, “state more than the family”, “the family more than the state”, “the family”. We create a dummy variable pairing the first two vs the last two categories.

Figure 11. Association between use of private services and perceptions of whether they should be in hands of the state



Source: Authors' calculations using *Latinobarómetro* 2011 (Panel A) and 2008 (Panel B)

Note: Data for 18 Latin American countries

A caveat to the fiscal trap mechanism is that it does not contemplate the possibility that people with political influence can be influenced by the potential negative externalities of poor service provision. Self-interested voters might have reasons to support public spending if they experience the negative externalities of poor public service provision. For example, Xu (2023) shows that in socioeconomically integrated neighborhoods in Brazil, middle-income people prefer to support public goods and public services to avoid negative externalities of impoverished neighborhoods.

Section 3.3 Social affinity

The third, and final, mechanism we examine is a more sociological one. Public services, in particular public education, offer a space where people interact with each other. When upper-

and middle-class households opt for private services, opportunities for social contact with less affluent households decreases. The consequences of reduced inter-group contact and fewer shared experiences span from misinformation about the distribution of income and opportunities in society (Condon & Wichowsky, 2020; Cruces et al., 2013; Minkoff & Lyons, 2019) to a decrease in empathy and more prejudice towards the out-groups (Bjorvatn & Cappelen, 2003; Lupu & Pontusson, 2011; Shayo, 2009). Through all these paths, less inter-class contact is thought to be associated with less support for redistribution among middle- and upper-class voters.

Empirical work in this area has used various proxies for social distance. For example, Lupu and Pontusson (2011) use differences in income between low-, middle- and high-income groups as a proxy for social distance. They find that redistribution is higher when the difference in income between middle- and upper-class is higher than the difference in income between middle- and lower-class. Other studies have employed geographic segregation of income groups to approximate the more general concept of social distance. For example, Franko and Livingston (2022) show that residents living in highly segregated areas are less likely to favor redistributive government policy.

Yet, schools probably have as big of an impact on social distance as other proxies used in the literature (Kaztman, 2013; Rossetti, 2014). For example, Londoño-Vélez (2022) shows that when students share experiences with lower income students, their support for redistribution increases. Along these lines, Alan et al. (2021) show that school programs oriented to build social cohesion in ethnically mixed schools in Turkey significantly improve prosocial behavior,

including trust, reciprocity, and altruism toward each other, as well as toward anonymous out-school peers.

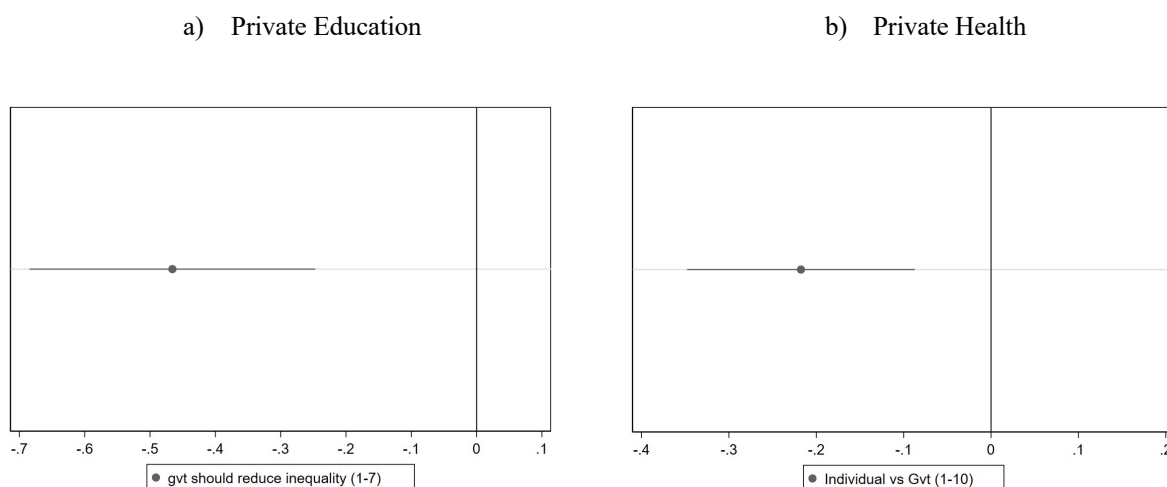
We contribute to this literature by examining whether people who attended private schools and people who pay for a private health plan express less support for redistribution. We expect that when households with higher income choose private services, the social distance between them and lower income households increases, which, in turn, impacts redistributive preferences. We also expect to see some differences across the education and health services because the former involves a more intense form of socialization and contact between people compared to latter. While schools are places where parents, teachers and students interact frequently, health care facilities are less prone to offer the same opportunities for interaction among users. Schooling, then, is a more intense socializing experience, which can have more meaningful impacts on attitudes and behaviors compared to health care. In addition, as we mentioned before individuals may choose to come and go from public/private health services (i.e. having public insurance but paying out of pocket for a private medical appointment). Thus, we do not expect to find the same magnitude of differences across policy domains.

For education, LAPOP contains one key question that is widely used to tap into redistributive attitudes. The question asks whether the state should implement firm actions to reduce inequality. As expected, respondents who attended private schools are half a point less likely to support that statement, on a scale of 1 to 7, compared to respondents who did not attend a private school, which corresponds to an 8% lower average off the base response of public school graduates.

For the analysis focusing on health, we employ a survey item in *Latinobarómetro* that approximates redistributive attitudes, although it is not the same item we found in LAPOP.

Respondents are asked to evaluate, on a scale of 1 to 10, how much individuals (as opposed to the government) should take responsibility for their own welfare. Crucially, this survey item asks about a more general perception about the role of the state than the survey items we used in the fiscal trap section, which are specific to the policy domain in question. According to the social affinity theory, we would expect that those that pay for private health plans have less interaction with lower income individuals, and they will have less of a sense of the lived experiences of people who use the public health care system, which could lead to less empathy. Indeed, Figure 12 shows that the direction of the association between paying for a private health plan and attitudes towards the responsibility of the state over individuals' welfare is as expected: individuals with private insurance are more inclined to say individuals, as opposed to government, should look after their welfare. Also as expected, the size of the coefficient is smaller than the coefficient of private education on attitudes towards redistribution (-0.22, on a scale of 1 to 10, which represents a 4 percent decrease off the base evaluation of users of public health services).

Figure 12. Association between use of private services and attitudes towards the redistributive role of the state



Source: Authors' calculations using LAPOP 2016 (Panel A) and *Latinobarómetro* 2013 (Panel B)

Note: LAPOP data includes Chile, Ecuador, and Uruguay. *Latinobarómetro* data includes 18 Latin American countries.

Section 4. Discussion and Concluding Remarks

A trend towards opting out from public services has been pointed out as a risk for the sustainability of the welfare state (CEPAL, 2014) and the social contract in Latin America (F. Ferreira et al., 2013; López-Calva et al., 2014). In this chapter, we aimed to shed light into this issue by analyzing the levels and trends of the use of private education and private health insurance in various countries in Latin America, as well as the associations between opting out from public services and a set of socio-demographic characteristics and attitudes that are central for the social contract.

Drawing from household and public opinion surveys, our descriptive results show that wealthy households are, for the most part, out of the public education systems and are opting out from public health systems at higher rates than households elsewhere in the income distribution. The middle-class, defined in absolute terms (F. Ferreira et al., 2013; López-Calva et al., 2014), is split with a substantial proportion of households out of the public education system, although most of them continue to rely on public health care systems. Lastly, low-income households continue to be users of public services. In terms of attitudinal differences, we find that people who attended a private school in their formative years have worse evaluations of the public education system, are less supportive of the role of the state in providing this service, and, more generally, are less supportive of state-led redistribution. Our results for health care point in the same direction, although the magnitude of the effects is smaller for support of the role of government in promoting people's welfare.

These results suggest at least three pathways through which the opting out from public services could be detrimental to the public systems. First, as Hirschman (1978) argued, when people who are discontent with the system decide to exit, the voice within the system pushing for better services is weaker. In our data we see that those who opted out of public systems indeed have worse evaluations of the systems than those who remain inside. Second, that wealthy households are out of public education systems, and a portion of them is out of public health systems, is problematic to the extent that this group has disproportionate political power in many countries in the region. If wealthy voters prefer less spending on public services, and they use their political power to lobby for lower taxes and less spending for the public sector (Propper & Green, 2001), the quality of the public service may fall. In turn, public services of worse quality produce unequal opportunities for those who remain in the systems, which may create an

inequality trap. Finally, that many middle-class households are not sending their children to public schools might lead to an increase in the social distance between them and lower-income households. More social distance might, in turn, lead to less affinity between social groups, which might explain why we see in our data that users of private services not only prefer less spending on those services, but they prefer governments who do less to redistribute opportunities and income, and who do less to guarantee human welfare.

Through all three pathways, the collective aspect of the opting out is such that as parents opt out of public services, the more other parents with a similar socio-demographic profile will have an incentive to opt out as well (Busemeyer and Iversen 2014). The self-reinforcing nature of this social problem makes it very difficult to reverse the trend towards private institutions, unless massive positive or negative shocks modify households' perceptions and resources.

Although our results are in line with the expectation that opting out from public services is trending upwards in the region, we present a more nuanced description of the problem at hand. While some countries in our sample have experienced increases in opting out from public education (Peru, Argentina, Brazil, and Uruguay), in other cases there has been little change in enrollment to private schools from the early 2000s to 2018 (Colombia, Mexico, Bolivia). Also, the extent to which households in the middle of the income distribution, as well as middle-class households, are opting for private schools varies across countries. Finally, the two policy domains that we study display very different patterns, with health care experiencing much lower levels of opting out, much more stability over time, and with wealthy households being (almost) the only group paying for a private health insurance.

Future research could explore the cross-country differences in opting out from public education. Both national-level factors, such as changes in the regulation of private schools and

policy interventions, and individual-level factors, which might affect people's calculations of the costs and benefits of using public systems, seem to be at play.

Unpacking the rationale behind families' decision to opt out from basic public services is essential to unravel the cascading effects we discussed earlier. Although the academic literature on school choice is vast, it remains an open question why some parents in the region choose private schools with lower attainment according to standardized tests compared to the public schools available (Guarin, Medina and Posso 2018). Without diminishing the importance of instructional differences (i.e. teachers, teacher-to-pupil ratio, curriculum)¹⁹, it seems that other dimensions, including, for example, length of the school day, proximity to home, size of the school, security issues (i.e. risk of contact with gangs, bullying, etc.) are relevant to account for the opting out trend (Balarin, 2015). Moreover, perceptions of opportunities for social mobility might be important in countries with high inequality (Álvarez-Rivadulla et al., 2022; Cárdenas et al., 2021; Méndez & Gayo, 2019).²⁰ For health, it seems more straightforward to account for desire to opt out from public systems, which may involve longer waiting times, less options, and more gatekeeping (Bancalari, et al. 2023). Even so, it remains understudied whether households

¹⁹ It is well-understood that the demand for private services is related to perceptions about the differences in quality of public and private providers. See, for the case of education: Kraushaar, 1972; Smrekar & Goldring, 1999; Checchi & Jappelli, 2003; Dowding & John, 2008; Bukhari & Randall, 2009, and for the case of health care: Costa-Font & Zigarette, 2016; Pianori et al., 2020; Pinilla & López-Valcárcel, 2020.

²⁰ The desire to "join" a higher social class and access its networks is not unique to Latin America. See also Bifulco & Ladd, 2007; Crozier et al., 2008; Lankford & Wyckoff, 2001; Riedel, Andrea et al., 2010; Willms et al., 1992.

are influenced by their peer's decisions to pay for private health insurance or use private health services.

Finally, our study focused on education and health services, but prior work has detected opting out from a more comprehensive set of services. For example, private security solutions are becoming more frequent in many Latin American cities. Considering the results we showed, it is imperative to examine to what extent households are opting out from public security and other services, as this phenomenon has important implications for the cohesiveness and sustainability of the social contract in the region.

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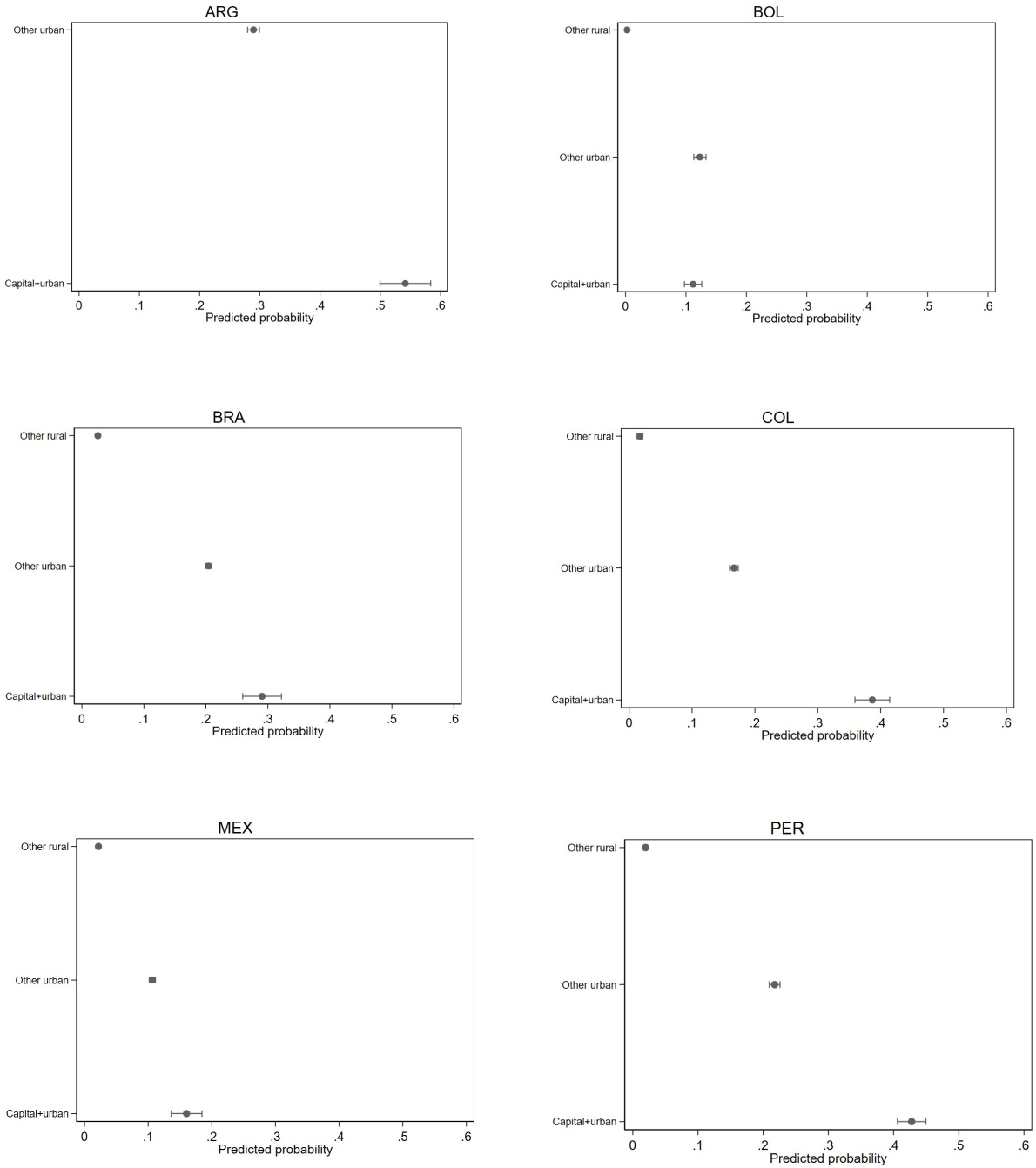
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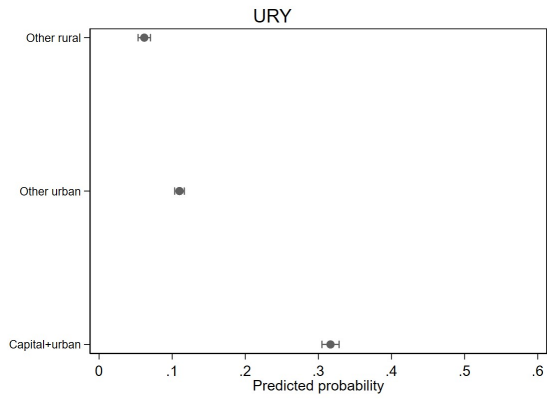
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Appendix

Figure A. 1. Predicted probability of attending private school by region





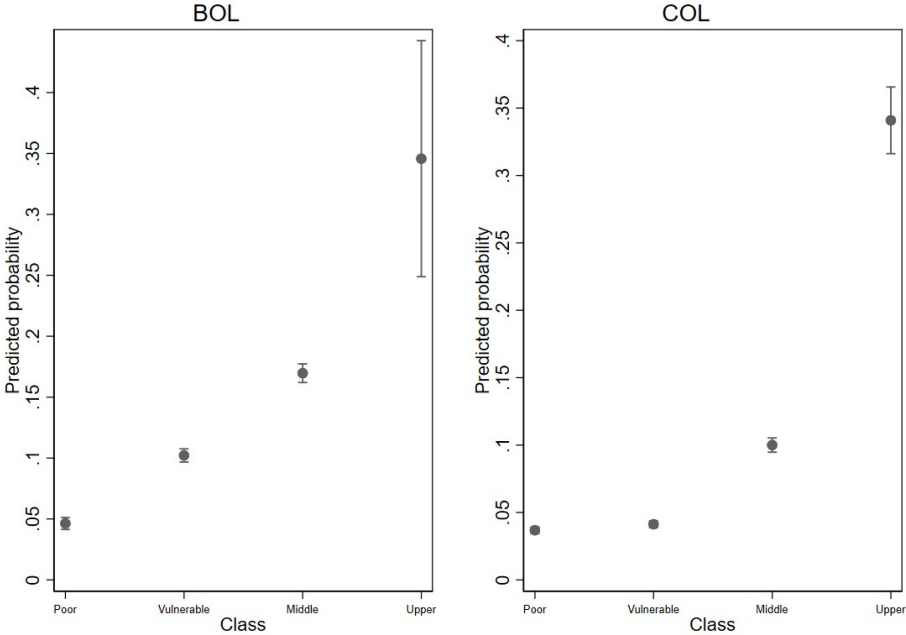
Source: Authors' calculations using harmonized household surveys from 2018 by country.

Table A. 1. Information about questions about health insurance in household surveys

| Survey | Question Insurance | Answer coded as private |
|---------------------------|---|---|
| Uruguay (ECH) 2006 | <i>“¿Tiene derechos vigentes en algunas de las Instituciones de Asistencia a la Salud?”</i> | Seguro privado de salud parcial médico, seguro privado de salud parcial quirúrgico, seguro privado de salud total |
| Uruguay (ECH) 2018 | <i>“¿Tiene derechos vigentes en algunas de las Instituciones de Asistencia a la Salud?”</i> | Seguro médico privado |
| Peru (ENAH) 2002 and 2018 | <i>“El sistema de prestaciones de salud al cual ud. está afiliado actualmente es:”</i> | Seguro privado de salud |
| Bolivia (EH) 2018 | <i>“¿Está (...) registrada/o o afiliada/o a alguno de los siguientes seguros de salud:”</i> <i>En los últimos 12 meses, por problemas de salud, ¿acudió o se atendió en...</i> | Seguros privados Establecimientos de salud privados |
| Bolivia (EH) 2002 | <i>“¿Está (...) asegurado o cubierto por algún seguro de salud?”</i> | Privado |
| Colombia (ENCV) 2003 | <i>Además de estar cubierto por _____, tiene afiliación como cotizante o beneficiario a otra EPS o ARS?</i> <i>¿CUÁLES de los siguientes planes o seguros de salud tiene ?</i> | Medicina prepagada ALT: Medicina prepagada & Plan complementario de salud con una EPS |
| Colombia (ENCV) 2018 | <i>¿Cuáles de los siguientes planes o seguros COMPLEMENTARIOS de salud tiene?</i> | Medicina prepagada ALT: Medicina prepagada & Plan complementario de salud con una EPS |

| | | |
|--|--|---|
| | <p><i>Alt usage:</i></p> <p><i>“A donde acude por prevención?”</i></p> | <p>Acude de forma particular a un médico general, especialista, odontólogo, terapeuta o profesional de la salud</p> |
|--|--|---|

Figure A. 2. Predicted probability of usage of private health services, by class



Source: Authors’ calculations using harmonized household surveys from various years by country.

Note: in PPP 2011, Poor (< \$5.5), Vulnerable (>= \$5.5 and <\$13), Middle Class (>= \$13 and < \$70), Upper Class (>= \$70)

Table A. 2. Perceptions of Public Education, w/ full set of controls

| | (1) Public Edu Quality | (2) Private Edu Quality | (3) Teachers can Teach | (4) Teachers have Knowledge |
|--------------|-------------------------------------|----------------------------------|------------------------------------|------------------------------------|
| Private Edu | -0.0300*** (0.00649) (0.0405) | 0.00559 (0.00635) (0.0394) | -0.0393*** (0.0140) (0.0868) | -0.0400*** (0.0124) (0.0770) |
| Constant | 0.709*** (0.0438) | 0.580*** (0.0428) | 0.786*** (0.0939) | 0.527*** (0.0833) |
| Controls | Yes | Yes | Yes | Yes |
| Country FE | Yes | Yes | Yes | Yes |
| Observations | 7,911 | 7,635 | 7,753 | 7,777 |
| R-squared | 0.161 | 0.047 | 0.064 | 0.068 |

Source: Authors' calculations based on *Latinobarómetro* 2011

Notes: Controls include parent's highest level of education, size of town, ethnic identity, ideology, socio-economic status, and level of education

Table A. 3. Perceptions of state responsibility, w/ full set of controls

| | (1) Family Should Pay for Education | (1) Gvt should reduce inequality |
|--------------|--|-------------------------------------|
| Private Edu | 0.0360*** (0.0117) | -0.326*** (0.121) |
| Constant | 0.264*** (0.0777) | 5.711*** (0.279) |
| Observations | 7,349 | 2,603 |
| Country FE | Yes | Yes |
| Controls | Yes | Yes |
| R-squared | 0.081 | 0.074 |

Source: Authors' calculations based on *Latinobarómetro* 2011 and LAPOP 2016 (Chile, Ecuador, Uruguay).

Notes: Controls include parent's highest level of education, size of town (urban/rural in LAPOP), ethnic identity, ideology, socio-economic status (income in LAPOP), and level of education

Table A. 4. Perceptions of public health and state responsibility, w/ full set of controls

| | (1) Satisfaction with Public Hospitals | (1) Health in Hands of Private Sector | (1) Gvt vs Individual Responsible for Welfare |
|----------------|--|---|---|
| Private Health | -0.0642*** (0.0123) | 0.0329*** (0.00853) | -0.180** (0.0733) |
| Constant | 0.779*** (0.0880) | -0.188*** (0.0563) | 5.276*** (0.657) |
| Country FE | Yes | Yes | Yes |
| Controls | Yes | Yes | Yes |
| Observations | 8,421 | 8,235 | 8,707 |
| R-squared | 0.130 | 0.043 | 0.045 |

Source: Authors' calculations based on *Latinobarómetro* 2015, 2008, and 2013 (in order of DVs/columns)

Notes: Controls include parent's highest level of education, size of town, ethnic identity, ideology, socio-economic status, and level of education