

# **THE PRIVATIZATION OF HEALTH CARE IN THREE LATIN AMERICAN SOCIAL SECURITY SYSTEMS**

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## TABLE OF CONTENTS

	<u>Page</u>
List of Graphs and Tables . . . . .	ii
Acronyms . . . . .	iii
Executive Summary . . . . .	iv
I. Introduction: Social Security Health Care Systems Crises . . . . .	1
II. The Roots of Private Sector-Related Reforms in Three Latin American Countries . . . . .	3
III. El Salvador . . . . .	9
A. Introduction and Recent Developments . . . . .	9
B. Perceived Shortcomings and Consumer Dissatisfaction . . . . .	10
C. Partial Privatization of Specialized Ambulatory Care . . . . .	10
IV. Peru . . . . .	12
A. Growing Dissatisfaction with Access to and the Quality of Care . . . . .	12
B. Peru's Private Sector, Minor Surgery Program . . . . .	13
C. The Decentralized Ambulatory Care Program . . . . .	14
D. A Private Health System . . . . .	16
V. Nicaragua . . . . .	18
A. Introduction and Recent Developments . . . . .	18
B. INSSBI's New Role as Administrator, and Not Provider, of Health Services: The New Health Security Program . . . . .	18
C. MINSA's INSSBI Project . . . . .	20
1. The Mechanics of the INSSBI Program . . . . .	21
2. Anticipated Impacts of the MINSA INSSBI Project . . . . .	22
D. The INSSBI Professional Risks Program . . . . .	23
1. Administration of the Professional Risks Program . . . . .	23
2. The Mechanics of the Professional Risks Program . . . . .	24
VI. Conclusions and Lessons . . . . .	25
Bibliography . . . . .	30

## LIST OF GRAPHS AND TABLES

	<u>Page</u>
Graph 1: Social Security Coverage in Three Latin American Countries . . . . .	3
Graph 2A: Trends in Social Security Coverage and Real GDP: El Salvador . . . . .	5
Graph 2B: Trends in Social Security Coverage and Real GDP: Peru . . . . .	5
Graph 2C: Trends in Social Security Coverage and Real GDP: Nicaragua . . . . .	5
Graph 3A: Real GDP and Social Security Health Care Provision: El Salvador . . . . .	6
Graph 3B: Real GDP and Social Security Health Care Provision: Peru . . . . .	6
Graph 3C: Real GDP and Social Security Health Care Provision: Nicaragua . . . . .	6
Graph 4A: Trends in Real GDP and Social Security Health Expenditures: El Salvador . . . . .	7
Graph 4B: Trends in Real GDP and Social Security Health Expenditures: Peru . . . . .	7
Graph 4C: Trends in Real GDP and Social Security Health Expenditures: Nicaragua . . . . .	7
Table 1: Key Agencies/Actors and Indicators in Analyzing Potential Social Security Reforms . . . . .	28

## ACRONYMS

DGAA	Dirección General de Atención al Asegurado
FUSADES	Fundación Salvadoreña para el Desarrollo Económico y Social
INSSBI	Nicaraguan Social Security Institute/Instituto Nicaragüense de Seguridad Social y Bienestar
IPSS	Peruvian Social Security Institute/Instituto Peruano de Seguro Social
ISSS	Salvadoran Social Security Institute/Instituto Salvadoreño de Seguro Social
LIFAM 1	List of Charges for Ambulatory Medical Care/Listado de Facturación por Atención Médica Ambulatoria
LIFAM 2	List of Charges for Specialized Ambulatory Medical Care/Listado de Facturación por Atención Médica Ambulatoria Especializada
MIFIN	Ministry of Finance of Nicaragua
MINSA	Ministry of Health of Nicaragua
MOH	Ministry of Health
NAT	Notification of Work-Related Accident/Notificación de Accidente del Trabajo
NOPAT	Provisional Notification of Work-Related Accident/Notificación Provisional de Accidente del Trabajo
OSS	Health Service Organization/Organizaciones de Servicios de Salud
PAAD	Decentralized Ambulatory Care Program/Programa de Atención Ambulatoria Decentralizada
SPS	Private Health System/Sistema Privado de Salud

## EXECUTIVE SUMMARY

Most Latin American social security institutes are direct providers of medical care services to their beneficiaries. These systems have long accounted for a large proportion of total health care resources in many Latin American countries, yet they generally cover only formal sector workers and their dependents, who constitute a small proportion of the national population. As many of the institutes have developed serious financial problems over the course of the last decade and a half, they have come under increasing attack for: 1) exacerbating inequalities in access to and use of health care; 2) further heightening the geographic over-concentration of services; 3) focusing a disproportionate amount of resources on high technology and curative care, while nearly excluding primary health care; and 4) being administratively top heavy and, more generally, inefficient.

In response to these various problems and concerns, there have been a host of reforms in the social security systems of Latin American countries in the past few years. In an effort to draw lessons which may be useful to reform efforts in other social security systems, this paper analyzes recent social security reforms in El Salvador, Peru and Nicaragua, all of which involve some degree of privatization.

**El Salvador:** The first case study is a description of the Salvadoran Social Security Institute's (ISSS) partial privatization of specialty physician outpatient consultations introduced in 1991. This program was originally designed to eliminate ISSS specialty physicians' three-month backlog and then terminate after achieving this objective.

The scheme relies on physicians who generally work part-time for ISSS, but who are now providing private care to ISSS-insured patients. Initially, the program was limited to the first visit for a particular illness episode, and only enrollees living in the San Salvador Metropolitan Area were eligible to participate. Within one year of initiation, it became apparent that the program was both successful and popular among ISSS beneficiaries, providers and Institute officials; therefore, the program was modified to include follow-up consultations. Shortly thereafter, the program was implemented throughout the entire country. Initially the program assigned patients to particular physicians. In response to consumer demands, however, the program was modified to allow patients to select their own physician from a list of eligible, participating physicians.

The program only pays private physician fees; any required laboratory examinations, x-rays or prescriptions must still be obtained from ISSS facilities or paid for by the beneficiary. Participating in the program, therefore, can be cumbersome and time-consuming depending upon the nature of the consultation.

ISSS has concluded that the program is cost-effective. In 1993, the Institute declared the program to be a permanent feature of ISSS services. Most recently, the program has extended coverage for pediatric care to beneficiaries under five years old, who were incorporated into the ISSS system under recent reforms to extend coverage.

**Peru:** A second case study describes the Peruvian Social Security Institute's (IPSS) Minor Surgery and Decentralized Ambulatory Care Programs, introduced in 1991 and 1992, respectively. The Minor Surgery Program was intended to reduce the backlog of patients who were queued for up to three months to undergo relatively minor surgeries, thereby allowing the IPSS tertiary hospitals' resources to be dedicated to tertiary care provision. The program pays private hospitals and clinics a predetermined, fixed fee for providing the surgery. Facilities which IPSS accredits to participate in the program are listed in a pamphlet which is given to IPSS beneficiaries. Beneficiaries may go to any provider on the list to undergo any of the stipulated types of minor surgery without incurring direct costs.

The impact of the program on IPSS insurees has been to provide patients with: 1) greater choice in their selection of a provider, and 2) greatly reduce time delays in scheduling surgeries, thereby improving access to care. According to private health insurance industry representatives, the program has dampened the demand for private health insurance, while increasing the demand for private hospital services.

Encouraged by the relatively limited, but overwhelmingly positive, experience with the Minor Surgery Program, IPSS introduced a second private sector program, the Decentralized Ambulatory Care Program (Programa de Atención Ambulatoria Decentralizada or PAAD), in May of 1992. The PAAD aims to foster the development of a primary health care system based on a primary care provider/gatekeeper. The program is intended to improve access to IPSS-financed services by reducing travel, appointment, and waiting time delays, and by expanding consumers' choices of physician and service provision locations.

At present, the PAAD is limited to Lima and is a district-based program. There is a relatively simple certification process for private sector physicians wishing to participate. IPSS-insured patients are allowed to select any PAAD-participating physician in their district to be their primary physician and enroll in the program by simply filling out a form. The physician submits the form to IPSS and provides the patient with a PAAD identification card, which is used to track the individual's PAAD-related care provision. Under the program, the patient is entitled to specific, limited amounts of care.

After its first complete year in operation, the PAAD was providing approximately 60,000 consultations monthly. PAAD consultations accounted for about 50 percent of total IPSS-provided ambulatory consultations in the Lima Metropolitan Area and about 25 percent of total IPSS ambulatory care provided nationally. The rapid expansion of this low fee/reimbursement program testifies to the existence of excess capacity in the private sector. It also demonstrates the extent to which the demand for IPSS services has been bottlenecked by lack of service provision sites and consumers' perceptions of the unacceptable quality of care (a combination of the degree of access to care--travel time, waiting time and appointment time delay--and the technical quality of the care provided).

**Nicaragua:** The third country experience described is the complete contracting out of services by the Nicaraguan Social Security Institute (INSSBI), an approach which was

initially implemented in November 1993. In the Nicaraguan scheme, social security beneficiaries choose to join a qualifying public or private provider organization for one year, and, on behalf of the individual, social security pays the organization a fixed, annual, per capita fee to provide all health care for the enrollee.

INSSBI responsibilities in the new model are to: 1) accredit participating health care provider agencies; 2) pay 94.5 cordobas (US \$14.21, as of July 1994) per insuree per month to the designated health care source; 3) supervise compliance with the agreement; and 4) conduct medical audits of the quality of care provided.

To become accredited, provider organizations must demonstrate their capability to provide outpatient and inpatient services which meet specified standards. With only 5 percent of the country's total bed complement in private hospitals, this requirement has prompted the development of many public-private liaisons--specifically between groups of private physicians and Ministry of Health (MINSAs) hospitals. It is anticipated that the program will act to increase the hospital efficiency by increasing their occupancy rates, thereby spreading fixed costs over a larger number of patients and lowering unit costs. In addition, since it has already been legally established that the MINSAs hospitals will be able to retain the revenue generated from their participation in the program, the hospitals will be motivated to improve their efficiency and to institute stricter controls and supervision in the use of resources and the way services are provided. Annual recontracting will mean that hospitals can gain and lose partnerships with outpatient provider organizations by virtue of how well or how poorly they perform in any given year, adding further incentive for efficiency.

The paper also identifies political considerations and technical factors, including health care market characteristics, that have shaped these efforts and that condition their likelihood of success, including: the size, composition, level of capacity utilization, degree of organization and geographic distribution of private sector resources; the level of prices in the private sector; and the size and nature of the private health insurance market.

Before engaging in social security reform, it is imperative to identify the major problems, their root causes, and potential reform options associated with the particular health care market. A technical analysis of long-term trends and health sector indicators, including financing, coverage, and utilization of existing services, is a critical first step in preparing for reform. Next, consumer and provider satisfaction with social security health services should be analyzed. The experiences of Peru, Nicaragua, and El Salvador suggest that countries need to perform the following steps to shape the strategy, design, and implementation of social security reform: 1) perform a stakeholder's analysis to identify interest groups; 2) focus initially on a small-scale problem which has high visibility and/or probability of successfully being reformed; 3) gradually extend the domain of reform; 4) proceed slowly, so as not to politicize the process; 5) look for common ground, so as to diffuse opposition; 6) institutionalize changes as soon as possible; and 7) make participation of physicians and patients voluntary.

## **I. INTRODUCTION: SOCIAL SECURITY HEALTH CARE SYSTEM CRISES**

Social insurance to prevent loss of income and to provide medical care has existed in Latin America for 80 years. The majority of the social insurance programs in the region date from the late 1940s and early 1950s. While the nature and structure of these social insurance programs vary substantially by country, most consist of a combination of programs which include: 1) health care; 2) pensions for old age, disability and survivor; 3) cash benefits for work-related accidents and illnesses; and 4) unemployment compensation (Mesa-Lago 1989). Although this paper only focuses on the health care services component of these programs, we will refer to this component as "social security."

Traditionally, Latin American social security systems have been funded by earmarked payroll taxes and administered by semi-autonomous, parastatal institutions. The vast majority of the systems have had tripartite financing, with modern-sector employers, employees and the central government each contributing a fixed percentage of the individual worker's salary.

The advent of the severe worldwide recession in the early 1970s resulted in adverse macroeconomic conditions which eroded the traditional bases of social security in Latin America, (i.e. formal, industrial employees), leaving the systems financially devastated. The situation has been exacerbated by the erosion in the real salaries of those who have remained employed, and the rapid growth in the incidence of financially troubled employers and central governments who have fallen into arrears in their payments of social security taxes. Concurrently, the investment portfolios of many of the systems have been ravaged by business failures and precipitous falls in real interest earnings, all acting to reduce social security system revenues. There has been a simultaneously rapid growth in the costs of medicines and medical equipment. Squeezed between dramatically falling revenues and rapidly increasing costs, by the latter half of the 1980s many Latin American social security systems had run up substantial financial deficits and became actuarially imbalanced, prompting calls for structural reforms (McGreevey 1990, Mesa-Lago 1993).

Fundamental criticisms of Latin American social security systems that have contributed to the rising calls for reform have been prompted by other concerns, apart from their financing.

- In most Latin American countries, social security systems have very limited coverage. In Colombia, Peru, Ecuador, Bolivia, Paraguay, Guatemala, El Salvador, Honduras, Haiti and the Dominican Republic, for example, less than 25 percent of the population is covered.
- Membership in most Latin American social security systems is limited to modern sector wage earners, thereby excluding the poor and exacerbating the already marked inequalities characterizing most Latin American societies.
- Since the modern sector is generally concentrated in urban areas, most Latin American social security systems have concentrated their infrastructures in the capital city, thereby contributing to the marked geographic inequalities in the availability of health care services.

- Most Latin American social security systems' health components constitute separate, independent programs that are much more generously funded than and that often duplicate the Ministry of Health (MOH) systems. The MOH systems generally cover from three to six times more of the national population. The social security systems in these cases are inherently inefficient, and they perpetuate a labor elite.
- Social security's coverage and its expenditures wax and wane with the level of economic activity of the modern sector. The cyclical nature of social security means that when a country's macroeconomic performance falters, social security rolls contract, and there is an increase in the number of people without health insurance. Because they have recently lost their jobs, many of these people turn to the MOH system for care, rather than to the private sector. However, with low economic activity, the MOH's budget is, at best, being held constant, or more likely, is also contracting because of the recession. The result is a national health care crisis.
- Latin American social security health systems are overwhelmingly geared toward hospital-based, high-technology, curative care. Given the epidemiological profiles of most countries, this level of care is inappropriate, unnecessarily expensive, and reduces the potential impact of public health care expenditures on the health status of the population.
- Latin American social security health care systems have high administrative costs and have generally been inefficiently managed (McGreevey 1990).

In response to these various problems and concerns, there has been a spate of reforms in the social security systems of many Latin American countries in the past few years. The most radical of these changes has been Chile's municipalization project (Bossert 1993). Other major reforms have included: 1) the development of special programs in Brazil, Ecuador, Mexico and Costa Rica to develop primary health care services coverage for the rural poor; 2) the integration of the health care systems of the Ministry of Health and social security in Brazil, Nicaragua, Costa Rica, and the initiation of this process in Panama; and 3) a variety of piecemeal and (at least initially) more modest reforms, including a number of experiments in privatization which, in some instances, have been built upon and added to incrementally.

This paper analyzes recent efforts to reform social security health systems in three Latin American countries. While all three cases involve privatization, the degree of variation in which these countries embrace privatization is marked, providing insights for other Latin American and other developing countries. Arrayed in order, from the most modest to the most radical, the reforms discussed are:

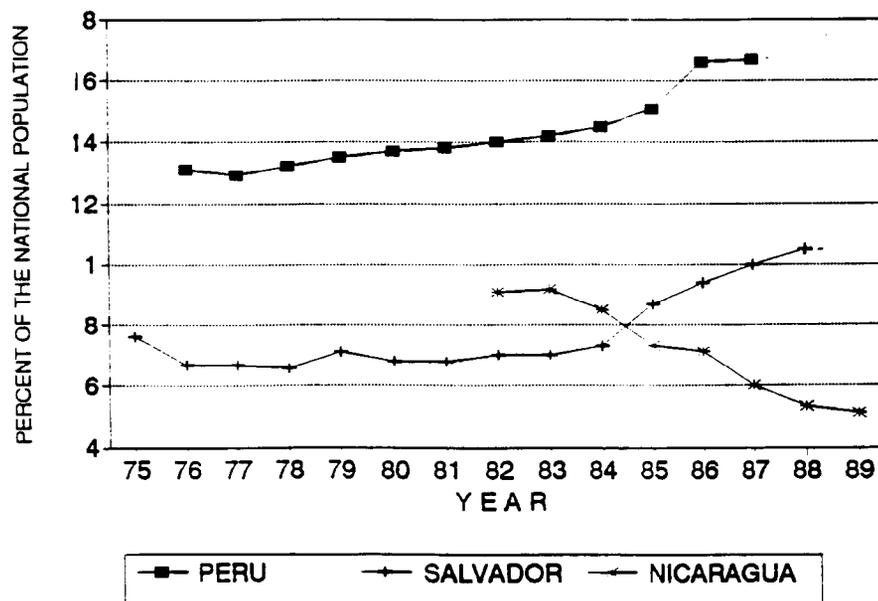
- 1) El Salvador's 1991 introduction of the option to select a qualifying private provider, for outpatient care only, who is paid a fixed rate per consultation on a fee-for-service basis (Fiedler 1994).

- 2) Peru's Minor Surgery Program and Decentralized Ambulatory Care Program, introduced in 1991 and 1992, respectively, which involve social security beneficiaries choosing a qualifying private provider who is reimbursed a predetermined fixed fee for services rendered. In addition, proposed health system organization reform, which would entail much more far reaching structural changes, will be discussed.
- 3) Nicaragua's complete contracting out of services, implemented in May 1994, whereby social security beneficiaries choose to join a qualifying provider organization for one year, and, on behalf of the individual, social security pays the organization a fixed, annual, per capita fee to provide all health care for the enrollee.

## II. THE ROOTS OF PRIVATE SECTOR-RELATED REFORMS IN THREE LATIN AMERICAN COUNTRIES

Historically, the social security system in each of the three study countries--El Salvador, Peru and Nicaragua--possessed most of the aforementioned characteristics of Latin American social security systems that have prompted calls for reform. As may be seen in Graph 1, the coverage of social security in all three of these countries has been very limited. Social security enrollees are the equivalent of about 16 percent of the national population in Peru, while total beneficiaries (enrollees and their eligible dependents) include roughly 5 percent of Nicaraguans and about 10 percent of Salvadorans.

GRAPH 1: SOCIAL SECURITY COVERAGE IN THREE LATIN AMERICAN COUNTRIES



Growing concerns about inequality in access to care and the inadequacy of coverage in Peru and El Salvador have spawned coverage-expanding reforms in recent years. The reforms weaken the relationship between GDP and coverage, as shown in Graphs 2A and 2B. For example, incremental changes in the domain of the system account for a surge in the proportion of the population covered by the Instituto Salvadoreño de Seguro Social (ISSS) in El Salvador beginning in 1989. Without the adjustments, the system would have contracted.

Peru also introduced reforms in the mid-1980s that expanded coverage. By how much, however, is not precisely known. The Instituto Peruano de Seguro Social (IPSS) does not have a mechanism for maintaining up-to-date enrollment records of its beneficiaries. The Peruvian data in Graph 1, depicting a long trend of slow growth, is a linear extrapolation of the economically active population adjusted for the probable rate of insuring. The uninterrupted, gradual upward trend in IPSS coverage, therefore, is a reflection of the method the Institute uses to estimate this bit of fundamentally important, but unavailable, information. There is little doubt but that IPSS coverage has been much more sporadic and that it has declined in recent years, as the performance of the economy has faltered, especially since 1987.

As Graph 2B shows, Peru's economic performance peaked in 1987, and subsequently fell dramatically. In Nicaragua, the economy grew modestly from 1980 to 1983, and then began to deteriorate (see Graph 2C). The pace of decline accelerated markedly in 1987. Not until 1990 did the situation start to stabilize. For both of these countries, 1987 constituted a benchmark year, marking the onset of particularly hard times.

The timing and direction of the turnaround in the macroeconomic performance of El Salvador and the implications for its social security system are different from that of Nicaragua and Peru. In El Salvador, the economy fell precipitously in 1982, and thereafter grew at a very slow, but accelerating pace.

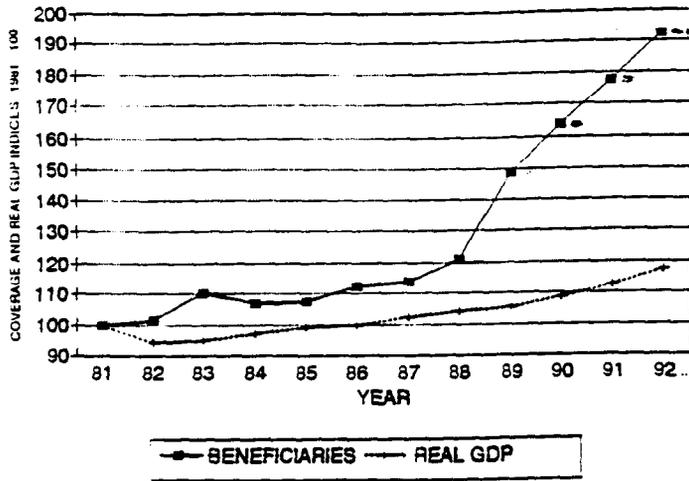
Graph 3A-C relate indices of GDP and three measures of annual social security health care services provision (number of inpatient days, number of hospital admissions and number of outpatient visits) for each country. All indices use 1987 as the reference year, and set the measures for a particular country for 1987 equal to 100. The index for other years' figures is calculated by dividing the particular year's figure by the base year figure and multiplying by 100. Thus the index value for any particular year may be interpreted as a percent of the 1987 figure.

The cyclical nature of social security is evident in comparing the trends in real GDP with those of the three services provision indicators (see Graph 3B) and with the real social security health expenditures (Graphs 4A-C).<sup>1</sup> Generally, the service provision statistics lag

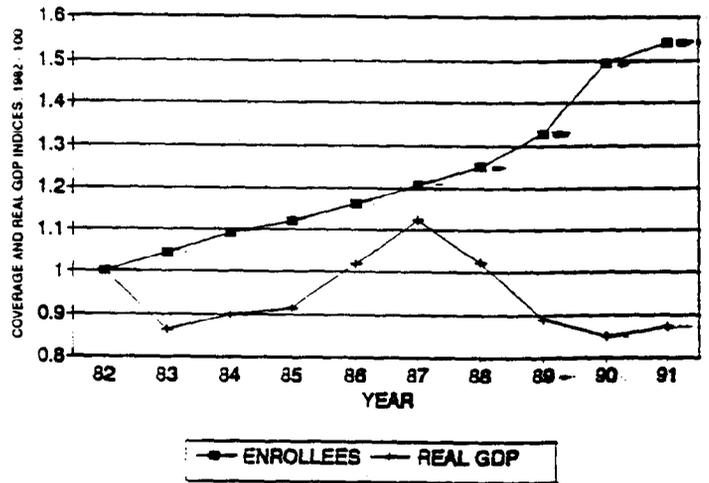
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Comparable service provision data are not available for Nicaragua during this era as the Sandinista Government integrated the Instituto Nicaragüense de Seguridad Social y Bienestar's health care delivery system with that of the Ministry of Health shortly after coming to power in 1979.

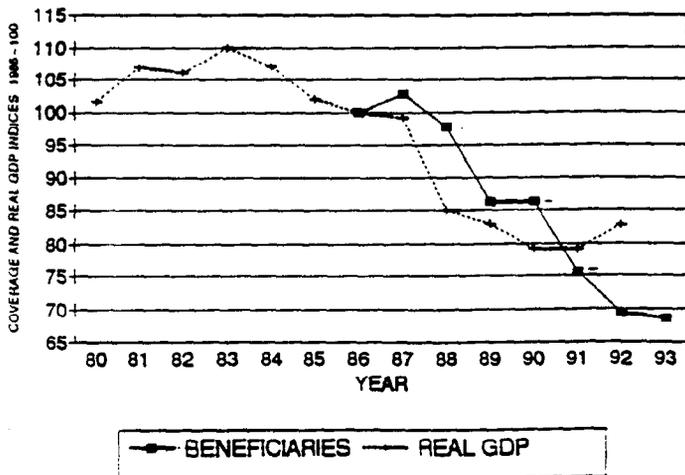
**GRAPH 2A: TRENDS IN SOCIAL SECURITY COVERAGE AND REAL GDP: ELSALVADOR**



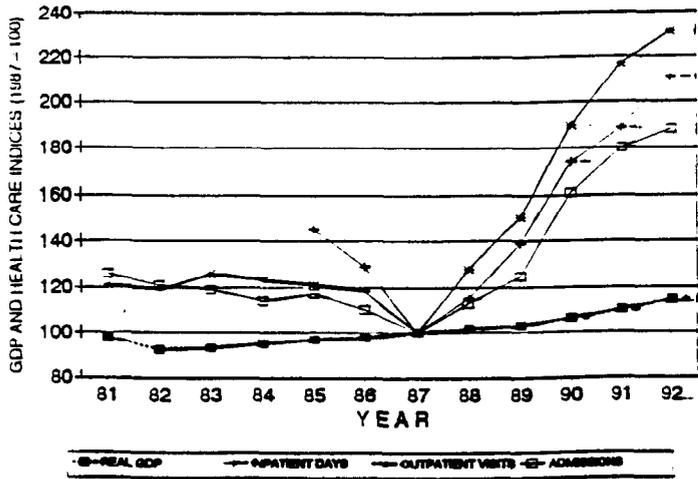
**GRAPH 2B: TRENDS IN SOCIAL SECURITY COVERAGE AND REAL GDP: PERU**



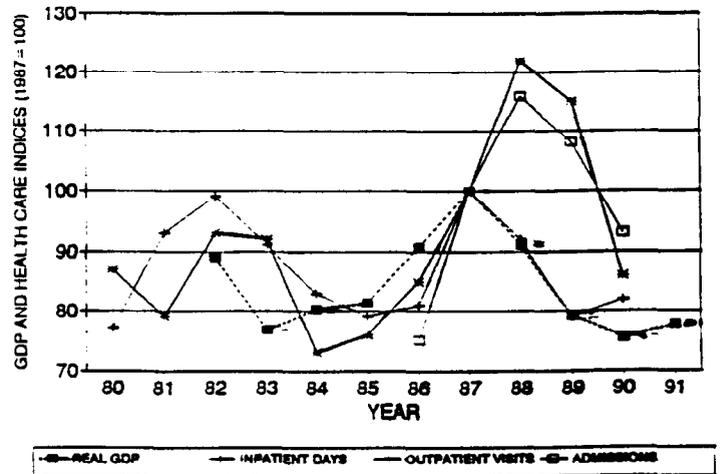
**GRAPH 2C: TRENDS IN SOCIAL SECURITY COVERAGE AND REAL GDP: NICARAGUA**



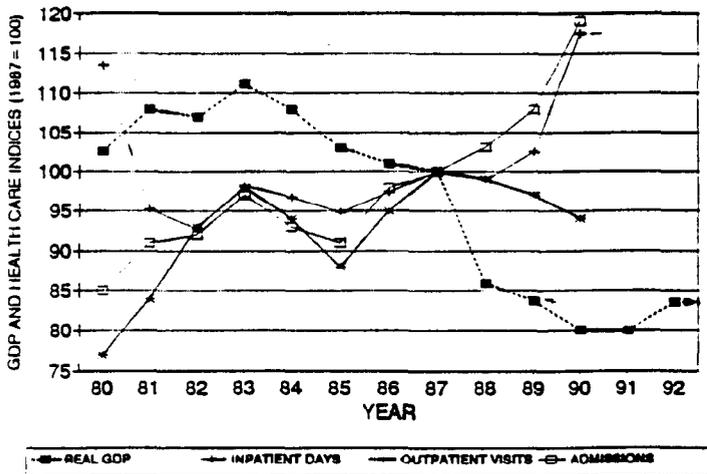
**GRAPH 3A: REAL GDP AND SOCIAL SECURITY HEALTH CARE PROVISION: EL SALVADOR**



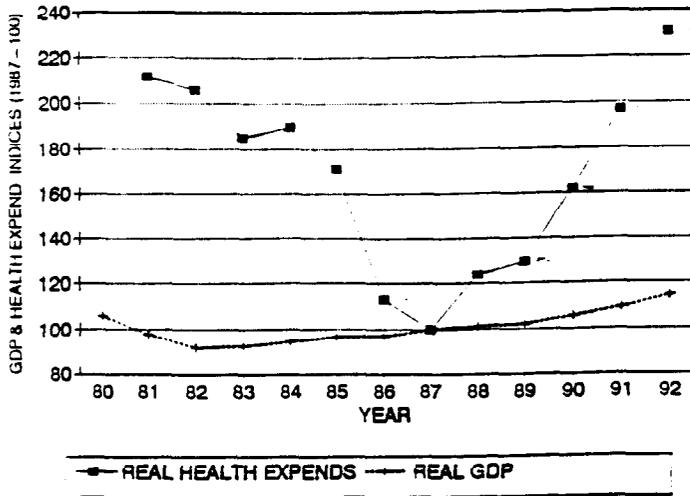
**GRAPH 3B: REAL GDP AND SOCIAL SECURITY HEALTH CARE PROVISION: PERU**



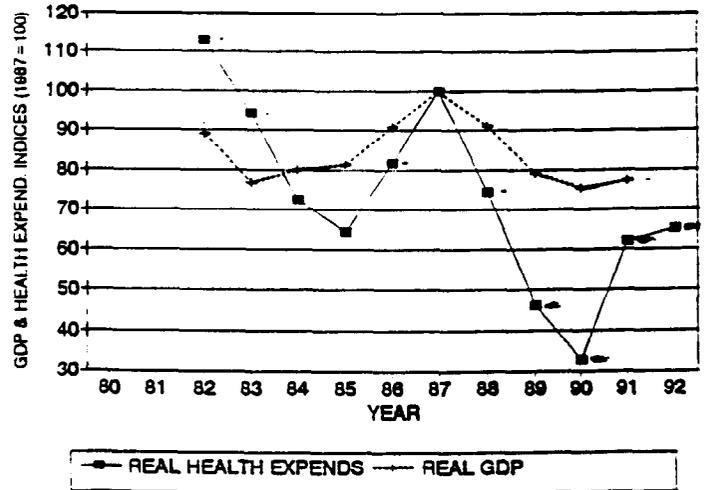
**GRAPH 3C: REAL GDP AND SOCIAL SECURITY HEALTH CARE PROVISION: NICARAGUA**



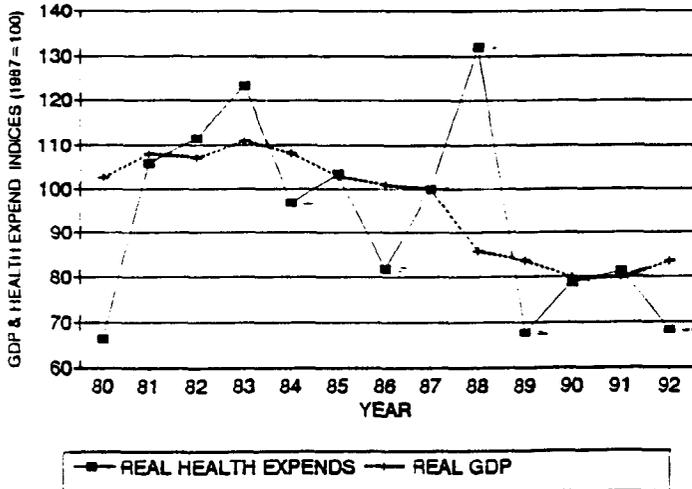
**GRAPH 4A: TRENDS IN REAL GDP AND SOCIAL SECURITY HEALTH EXPENDITURES: SALVADOR**



**GRAPH 4B: TRENDS IN REAL GDP AND SOCIAL SECURITY HEALTH EXPENDITURES: PERU**



**GRAPH 4C: TRENDS IN REAL GDP AND SOCIAL SECURITY HEALTH EXPENDITURES: NICARAGUA**



GDP by a year, due to the time lapse between the slow down of the general economy, the laying off of workers, and the workers subsequently losing their social security coverage. The direct relationship between service provision and GDP is particularly striking in Peru, where, in 1987, both real GDP and the social security institute's provision of inpatient days peaked. In the following year, the number of inpatient days fell by roughly 20 percent. Hospital admissions and outpatient consultations peaked the subsequent year, 1988, and then dipped by even larger proportions.

In El Salvador, 1987 was also a benchmark year, but a more propitious one. With GDP beginning to expand and ISSS expenditures making a big jump in 1987, El Salvador entered just the opposite phase as that of Peru. After falling every year since 1981, ISSS hospital admissions and total inpatient days both bottomed out in 1987, but then grew rapidly every year after that. Outpatient visits followed a similar course, reaching their low point in 1987, before rebounding decisively and going on to attain their zenith in 1992, 130 percent above the 1987 nadir.

The impact of the macroeconomic crises in Nicaragua and Peru on the revenues and expenditures of their social security health care systems is evident in Graphs 4B and 4C. IPSS's real expenditures peaked the same year that most of its service provision indicators did. In Nicaragua, too, there has been a public health financing crisis dating from about the same time. As may be seen in Graph 4C, between 1988 and 1992 INSSBI real expenditures fell by 48 percent, though in Nicaragua increasing financial constraints seemed to have quantitatively affected only outpatient, and not inpatient, care. (Information about qualitative impacts is not available, but anecdotal data strongly suggest that the quality of all care was deleteriously affected.)

In El Salvador, the procyclical nature of social security is also evident, though to a lesser extent. The Salvadoran story is a more heartening one, however, since its economy has been on the upswing, thereby helping to fuel expansion in the coverage and service provision of its social security system. In El Salvador, 1987 marked a decisive break with the past, as ISSS's total real health care expenditures grew by 27 percent and hospital admissions, inpatient days, and outpatient care provision expanded by 13, 15 and 28 percent, respectively.

The macroeconomic and social security crises of these countries have been compounded by a more general health sector crisis which social security has generally exacerbated. Since 1987, the social security institutes of Peru and El Salvador have become relatively more important actors in their respective health sectors, as measured by 1) the proportion of total public health care expenditures accounted for by social security, (defined as Ministry of Health plus social security), and 2) the proportion of total public health care services provided by social security. For example, in 1987 the ISSS in El Salvador spent 37 percent of the MOH expenditure level and provided 16 percent of hospital admissions and 41 percent of ambulatory visits. By 1992, the ISSS was spending 87 percent of the MOH expenditure level and providing 34 percent of hospital admissions and 84 percent of ambulatory visits.

The Ministries of Health in these countries are officially charged with providing care to 70-80 percent of the total population. While social security health care now accounts for a growing proportion of total public health care expenditures, social security coverage has expanded very modestly. This suggests that there have been rapidly growing inequities in the quantity and/or quality of social security beneficiaries' health care, relative to that of the rest of the population. Those who were fortunate enough to remain social security beneficiaries were in an increasingly privileged position, as judged by average health care expenditures per beneficiary. In the case of Peru, at least with respect to outpatient care, the disparity is particularly striking. As IPSS's budget relative to that of the MOH has steadily grown from 119 percent in 1987 to 184 percent in 1992, its share of total service provision has fallen, from 68 to 62 percent of total outpatient visits.

These growing inequities have been particularly troubling because each of these societies has been racked by widespread, violent political and social unrest throughout the decade of the 1980s. These crises are at once reflected in, and a major cause of, each country's macroeconomic performance. The socio-political and economic crises have fed off one another to heighten the national crises in each one of these countries. These events have given politicians the impetus and the need, as well as relatively greater leeway, to: 1) experiment with reforming their social security systems with the aim of, at minimum, opening them up to greater participation, and 2) begin exploring the possibility of introducing more fundamental structural changes.

In the following sections, the paper analyzes the private sector-related reforms of the social security health care systems in each country. The description of the reforms is preceded by a brief introduction to each system which highlights recent developments and the public's perception of the adequacy of care and, more generally, the acceptability of the status quo.

### **III. EL SALVADOR**

#### **A. Introduction and Recent Developments**

The Instituto Salvadoreño de Seguro Social (ISSS) was established in April 1954. ISSS provides care to enrolled workers and retirees, their spouses and, until relatively recently, children up to the age of six months. Initially ISSS coverage was limited to industrial, commercial and service establishments in only nine of El Salvador's 262 *municipios* (counties). It was not until 1973 that ISSS covered the entire national territory. ISSS enrollees remain heavily concentrated in the nine *municipios* in the San Salvador metropolitan area. In 1976, 64 percent of ISSS enrollees (*cotizantes*) were in the Metropolitan area which contains 26 percent of the national population. By 1992, this proportion had increased to 72 percent.

As a result of a recent series of modifications in the criteria for affiliation with ISSS, the Institute's coverage has steadily expanded since 1989. The most significant changes

of some of the most caustic criticisms of the ISSS. In response to this excess demand, ISSS changed clinic hours from eight to twelve hours per day. This measure, however, proved inadequate. Thus, starting in May of 1990, ISSS introduced what it intended to be a temporary and very focused program to eliminate the worst of the patient backlog: a program that relied on private physicians to provide ambulatory specialty care.

The privatization scheme relies on physicians who work for ISSS, but who are now acting in a private capacity in their own offices, to provide care to ISSS-insured patients. The physicians are paid 40 colones (US\$5.06) per consultation. This reimbursement rate has not been altered since the initiation of the program four years ago. Initially the privatization scheme was limited to the first visit for a particular illness episode and to enrollees living in the San Salvador Metropolitan Area. About one year after the initiation of the program, as it became apparent that the program was both successful (from ISSS's perspective) and popular (among ISSS beneficiaries), it was modified to include the second consultation. It was made effective throughout the entire country shortly thereafter.

ISSS beneficiaries cannot simply go to a private sector provider and have ISSS pay for the services received. Individuals must first visit a general ISSS physician. If they are then referred to a specialist and have to wait more than three days for an appointment, they become eligible for opting into the privatization scheme. Initially, persons who met this requirement and wanted a private consultation were assigned a particular physician. This practice was altered in 1993 in response to calls to increase consumer choice. Patients are now able to select their private provider from a list of participating physicians.

There have also been repeated calls to open up the system by allowing the participation of other than ISSS physicians. Thus far, ISSS officials have resisted, maintaining that restricting the program to physicians who work at least part-time for the ISSS obviates the Institute's having to train the participating physicians in ISSS's standards and norms of care and monitor them more closely than they might otherwise feel compelled to do. Sixty-six percent of the Institute's 226 physicians working in the Metropolitan Region participate in the privatization program.

The privatization program pays only private physician fees and does not cover any other charges, incurred as part of the consultation. ISSS beneficiaries participating in the program must still obtain any required laboratory examinations, x-rays or prescriptions from ISSS facilities or pay for them. Participating in the program, therefore, can be cumbersome and time-consuming, depending upon the nature of the consultation.

In the seven months of 1991 during which the program was in effect, 44,507 private specialty consultations were provided. In 1992, 66,000 such consultations were provided. Initially, this partial privatization scheme was intended to be a temporary program that would remain in effect for a limited time, only long enough to reduce the appointment backlog to an acceptable level. ISSS officials now state that the program is a permanent feature of the ISSS health system.

1984. Dramatically deteriorating real wages, widespread non-collection, especially the government's failure to pay its own employer contributions, eroded revenues while high administrative and personnel costs, inefficient hospital services and expensive outside contracting increased expenditures (Mesa-Lago 1987, p. 1).

From the patient's perspective, these managerial inefficiencies manifested themselves in a number of ways that further encouraged the growth of private health insurance. IPSS's hours of service, for example, were fairly restrictive. They coincided with the workday, and thus necessitated sick workers seeking IPSS medical care to be absent from work. In addition, waiting lines at IPSS facilities were long, and it was not uncommon for patients to not be seen after waiting several hours, only to have to return the next day to again seek care, yet without any assurance of successfully doing so. Patients seeking hospitalization services were commonly required to wait two or three months before being admitted. Not only was it difficult to obtain services, but those who were able to do so were commonly dissatisfied with the services they had received. Workers and employers alike, therefore, were motivated to look for alternatives.

Despite the fact that workers were obliged to contribute 3 percent of their salary, and employers to make a 6 percent matching contribution to the health services regime of the IPSS, dissatisfaction with IPSS's health services eventually grew to the point where, in addition to paying social security, purchasing private health insurance was overcome. In effect, these actors came to view IPSS contributions not as a type of mandatory health insurance, but rather as simply a tax.

On the basis of interviews with private insurance executives and private hospital directors, it is estimated that in mid-1990, nearly 1.1 million persons had some type of private health insurance in addition to their IPSS coverage.<sup>2</sup> This is the equivalent of nearly 30 percent of IPSS enrollees and roughly 20 percent of total IPSS beneficiaries, signifying a high level of general dissatisfaction with social security's health care services.

In response to both the socioeconomic and political crisis and the ever-growing criticisms of IPSS, in 1991 the Government of Peru embarked on a three-part private sector oriented reform of social security's health care program. The three reforms were the minor surgery program, the decentralized ambulatory care program and the health system organization reform.

## **B. Peru's Private Sector, Minor Surgery Program**

In 1991, the IPSS instituted the private sector Minor Surgery Program. The purpose of the program was to reduce the backlog of patients who were queued for up to three months to undergo relatively minor surgeries, thereby allowing the IPSS tertiary hospitals' resources to be

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This estimate includes commercial insurance carriers, self-insured corporations, and provider-sponsored pre-paid care plans.

limited amounts of care under the program, including a maximum of six consultations per year, two prescriptions per consultation, one urine and one blood exam per month, etc. The purpose of these controls is to avoid abuse of the system by either physicians or patients, and to keep the PAAD system functioning as it was intended: as a primary health care system. Thus, the treatment of chronic conditions which require more than the maximum allowable number of consultations are referred to IPSS specialists.

Physicians participating in the PAAD receive 3.50 soles per consultation (in 1992, U.S. \$1.00 equaled approximately 1.00 Peruvian sol nuevo). The program enables IPSS to greatly expand its service provision while avoiding the cost of acquiring new facilities.

The PAAD has increased access to IPSS care by greatly reducing the service provision bottleneck created by the limited number of service delivery sites. Access was also improved by markedly reducing appointment time delay for primary health care services. While no systematic studies have been conducted, the program has, without question, also improved consumers' perception of the quality of IPSS care and the acceptability of the IPSS system (which now, of course, is much more loosely defined and includes private sector services).

In its first six months in operation, the PAAD provided 150,000 consultations. Since beginning operations on May 4, 1992, the PAAD has observed monthly service provision increases. After its first complete year in operation, it was providing approximately 60,000 consultations monthly, the equivalent of about 50 percent of total IPSS-provided ambulatory consultations in the Lima Metropolitan Area, and about 25 percent of total IPSS ambulatory care provided nationally. The rapid expansion of this program and this market, with its low fee/reimbursement structure, testify to the extent to which there was excess capacity in the private sector, as well as the extent to which the demand for IPSS services has been bottlenecked by lack of service provision sites and consumers' perceptions of the unacceptable quality of care (a combination of the degree of access to care--travel time, waiting time and appointment time delay--and the technical quality of the care provided).

Another factor of unknown significance has been that some people who used to have private insurance are now exclusively covered through public insurance (IPSS), and they are using it for the first time. The PAAD manager explains that one rationale for establishing the PAAD centered on the serious and growing economic problems confronting Peru; many people were losing their private health insurance, thus increasing the demand for IPSS services. The PAAD was, in part, a strategy to deal with this increase in demand, since the IPSS services already had what many regarded as intolerably long in-office waiting times and appointment time delays.

According to the program's manager, the long-term PAAD plan is to incorporate some private laboratories into the system and to expand the program into a number of the major cities throughout the country. To date, no organized private sector providers participate in the PAAD, which is partially due to the low reimbursement levels of the program, but is also because the program is intended to be a vehicle for developing a primary health care network and not a hospital-based system of care.

The extent of this growth and how it will occur will depend on how the system is crafted.

Many private insurance officials confide that they do not anticipate a significant increase in the level of private sector service provision with the introduction of the SPS. Pointing out that in Chile the introduction of this same type of liberalization resulted in 25 percent of social security contributors opting into private systems, these officials maintain that the proportion is likely to be very similar for Peru. They go on to note that this means very little net change for the private sector, as this is (according to their estimates) only slightly more than the proportion of individuals who currently have private insurance (together with mandatory IPSS coverage). To these observers, it appears that the proportion of the economically active population who have the financial resources to afford private insurance, but are given the opportunity to participate in IPSS, are, for the most part, opting for private insurance. Thus, the plan alleviates relatively well off individuals (and their companies, to the extent that their companies contribute to the payment of the premium) from having to pay twice for health insurance, once to IPSS and once to a private plan.

Even if the magnitude of these estimates are accurate, however, it should be noted that the types of plans individuals may select to move into could significantly alter the composition of the private sector. Types of plans and individuals' selections depend on the enabling legislation and procedural rules, which have yet to be completed. Legislation may, for example, simply reaffirm the current commercial insurance and self-insured arrangements--as the agents cited above anticipate, or, alternatively, it could be that once the "rules of the game" become established, prepaid plans will try to capture a large portion of this market.

The Government has announced that it is postponing further consideration of the SPS until after the presidential elections scheduled for April 1995.

It would appear that the complacent attitude of these insurance company officials is not warranted: significant changes in the composition of the private sector could be in the offing. Insurance companies, not anticipating any changes, are doing little to prepare for the SPS. However, some of the more savvy brokers and several of the hospitals are taking steps to capture what they anticipate will be a sizeable new clientele.

Depending upon how it is designed and implemented, the SPS brings with it considerable potential for altering Peru's private sector health financing status quo and developing an area ripe for innovation in terms of the potential development of new private insurance plans and new types of relationships between broker/contractors and health care providers and/or their institutions.

In 1993, negotiations with private and public sector physicians and hospitals culminated in INSSBI entering into a new role as the administrator (as opposed to the administrator and provider) of INSSBI beneficiaries' health services.

The new scheme is organized by employer, and includes only employers whose workers are in the Integrated Regime (i.e., those with common illness and maternity benefits). Once each year, all of an employer's workers vote for the INSSBI-accredited, health care providing agency from whom they want to receive all of their INSSBI-insured care. For each employer, the single accredited agency that receives a plurality in the election becomes the sole source of INSSBI-insured care.

Agencies interested in participating in the new program are accredited by:

- meeting INSSBI-established minimal human resource and physical infrastructure requirements;
- agreeing to provide a basic package of medical and surgical services, including specifically itemized x-ray and laboratory examinations and particular medicines;
- agreeing to receive a per capita allotment as full payment for all of the itemized basic services demanded by insurees;
- agreeing to pay the economic subsidy INSSBI is required to pay sick and/or temporarily incapacitated insured workers (which is a percent of the worker's regular salary); and
- signing a contract agreeing to these terms.

Other INSSBI responsibilities in the new model are: 1) to pay 94.5 cordobas (US\$14.21 as of July 1994) per insuree to his/her designated health care source, 2) to supervise compliance with the agreement, and 3) to conduct medical audits of the quality of care provided.

Although the program has been in existence since November of 1993, its acceptance and growth has been relatively slow. The 63 work sites participating in the program as of July 1, 1994 have 7,255 enrolled workers which represent less than 6 percent of the total eligible participants. To date, the major bottleneck restricting the rate of growth in the program has been on the supply side: there are an inadequate number of health care organizations that are participating in the program. This is due principally to two reasons: 1) the various risks inherent in the program (further discussed below), and 2) the relatively atomistic and unorganized nature of the private sector. Although the private sector does provide a substantial amount of total consultations--accounting for 36 percent of the national total in 1992 (PAHO, 1992, page 10)--its inpatient capacity is minuscule (there are an estimated 130 private hospital beds in Managua and less than 250 throughout the entire country, representing approximately 5 percent of the country's total bed complement).

different types of services to the insuree (on demand) for one year. Health care services provision under the DGAA's auspices began in July 1994. The addition of MINSA service delivery capacity to the INSSBI program will quadruple its coverage to nearly one-quarter of eligible, social security-insured workers.

Relative to the agreements that have been struck with other health care provider organizations, the MINSA agreement contains several important conditions. First, during the first year, MINSA will enroll 22,908 Managua-based workers, primarily from the Ministries of Health and Education, rather than having to compete for insurees via the employer-specific worker balloting for preferred providers.

Second, MINSA will not have to pay economic subsidies (worker's compensation) to ill or injured workers; INSSBI will retain responsibility during the first year of the agreement. Third, the monthly per capita payment will be continually increased in direct proportion to any increase in the salaries of the workers covered by the agreement and may be subject to modification in the event that there is a devaluation of the cordoba vis-a-vis the dollar. The cumulative effect of these measures is to minimize MINSA's degree of financial risk, and will put it at a considerable competitive advantage. A single clinic, Policlínica Oriental "Carlos Arroyo Pineda," a former INSSBI facility, will serve as the hub of the system, providing all outpatient care. MINSA is negotiating contracts with its own hospitals to provide inpatient care under the INSSBI program. Whether or not capacity limitations of the program's outpatient facility will neutralize the impact of MINSA's competitive advantage on other participants remains to be seen.

#### 1. The Mechanics of the INSSBI Program

Every two months, an INSSBI medical care insuree is issued a *Comprobación de Pago y Derechos*, a card which provides testimony that he/she and his/her employer have made their full contributions to the Institute, and therefore is eligible for INSSBI benefits. This card must be presented along with the beneficiary's carnet (a photo identification card) in order to receive health services.

The organizing basis of the INSSBI Program will be the employer, or in the case of the public sector, individual agencies or operating entities (e.g., MINSA, the Ministry of Education, etc.). Once each year, all of the workers of each INSSBI-participating employer/agency will elect the primary health care provider from which they want to obtain their INSSBI-financed medical services for the coming year. In a few instances a single provider organization will provide all outpatient and inpatient care. This arrangement, however, will be relatively rare due to the size and nature of the private sector in Nicaragua, and the manner in which the public sector (MINSA) is planning to participate. In most instances, however, the primary health care provider will provide only outpatient care and will subcontract inpatient care. Each worker has a single vote, and the award of the contract is conditional upon a majority of workers selecting a particular provider. With workers able to change their health care provider every year, the long term viability of the MINSA INSSBI project will require that it be competitive with the private sector in terms of the types of factors that are likely to influence this selection decision, and,

especially MINSA hospitals--in a very different type of situation than they have ever been in, namely, at risk of financial loss. Given the nascent nature of the private hospital sector, it would seem that designated providers have relatively little choice, at least in the short run, but to turn to MINSA hospitals. MINSA hospitals, therefore, have considerable market power, which they should learn how to use constructively, including insulating themselves from the financial risks inherent in this program. At the very least, it would be advisable for MINSA hospitals--especially the most prestigious ones--to take advantage of their market position to try to negotiate some type of shared risk or stop-loss arrangement with any designated providers with whom they enter into a subcontract.

It is estimated that the INSSBI Health Security Program will annually generate in excess of 50 million cordobas, more than doubling MINSA's current total gross user fee revenues. This represents less than 10 percent of total MINSA expenditures. The MINSA Project and, more generally, the entire new INSSBI health insurance program, will probably increase the efficiency of MINSA (and private sector) hospitals by increasing their occupancy rates, thereby spreading their fixed costs over a larger number of patients and lowering their unit costs. In addition, since it has already been legally established that the hospitals will be able to retain the revenue generated by their participation in the INSSBI Program, the hospitals will be motivated to improve their efficiency. They will also institute stricter controls and supervision in the use of resources and the way services are provided. The lessons learned from this experience are transferrable to the rest of MINSA, and offer the greatest potential promise for the new program, by nurturing the development of a more competitive health care sector.

#### **D. The INSSBI Professional Risks Program**

The Professional Risks Program provides insurance coverage for employment-related accidents and illnesses for workers who are affiliated with either the "Common Illnesses and Maternity Health Services Program" or the "Disability, Old Age and Death Professional Risks Program," which together cover approximately 98 percent of INSSBI insured-workers.

INSSBI estimates that 82 percent of all work-related accidents require only ambulatory care, the remaining 18 percent requiring specialized care and/or hospitalization. Health care services financed through the Professional Risks Program are provided only by hospitals. The program requires participating hospitals to be accredited. The accreditation process consists of each hospital demonstrating that it has adequate, integrated capacity to resolve cases arising from work-related accidents. According to the Director of the Program, Dr. Marvin Lund, this consists primarily of the hospital having an adequately equipped and stocked emergency room. One-third of the MOH's 27 hospitals and three private sector hospitals were participating in the program as of June 1994.

##### **1. Administration of the Professional Risks Program**

Hospitals are reimbursed a predetermined amount per identified illness/injury, which, as part of the accreditation and contracting process, participating hospitals agree to accept as payment in

INSSBI): the *Listado de Facturación por Atención Médica Ambulatoria* (LIFAM 1) and the *Listado de Facturación por Atención Médica Hospitalaria Especializada* (LIFAM 2). These forms constitute the monthly invoices that the hospital submits to INSSBI for payment of all ambulatory care (LIFAM 1) and all hospitalizations (LIFAM 2). The forms are used to record the patient's name and INSSBI identification number, the level of complexity (used to identify the level of reimbursement), the date on which care was provided, the number of days the doctor recommends the patient should be convalescing and off work (during which time he/she is paid workman's compensation), and the name and INSSBI identification number of the patient's employer. About one week after a hospital submits its LIFAM forms to INSSBI, it receives a check for the health care services provided.

## VI. CONCLUSIONS AND LESSONS

Throughout most of Latin America, social security covers an important, but relatively small proportion of the national population. Nevertheless, these relatively well-funded systems, have a large impact on the national health care market structure, due to the significant amount of resources they command. Most public health systems in the region are characterized by a huge Ministry of Health and a mammoth infrastructure, which is charged with providing care to two-thirds or more of the national population. Combined with the social security health system, the structure has historically acted to discourage the development of the private health sector, particularly the more costly hospital subsector.

Many Latin American countries, and all three of the countries studied here, have a long history of producing large numbers of physicians. With the slowing, and in some cases, declining growth in the MOH and/or social security systems, and the derivative slow growth in public sector employment of physicians, many of these countries now have an excess supply of physicians. These conditions, while difficult for physicians, provide potentially important opportunities for reforming the public sector, most particularly, the social security system. More specifically, in conditions of excess physician supply, partial privatization schemes can be highly successful because they offer potential participation for all of the principal actors in these systems.

For the social security institute, the excess supply of physicians will encourage physicians to participate in the privatization scheme at low reimbursement rates, which are very possibly cost-effective, relative to the extension of social security services. This makes the privatization option attractive to the social security institute. In the case of El Salvador, and to a lesser extent Peru, privatization has been a method of improving consumer satisfaction and increasing efficiency, and doing so while maintaining the integrity of the Institute and its staff--at least initially in these conservative and limited experiments.

For the consumer (the social security beneficiaries), the introduction of a privatization scheme means more possible providers from whom to choose a physician. Consumers also benefit because of the reduced waiting time they confront in trying to obtain care.

Finally, the physicians who participate in these programs choose to do so. They are enticed to participate by the lure of being able to garner more patients and more income. Despite the fact that the experiences and reforms of the three Latin American social security systems discussed here are distinct, there are some common motivations for reforming the systems, as well as some common themes in the manner in which these reforms were designed and implemented.

In all three of the study countries, social security has been the subject of concern and criticism for many years and for many reasons, including: 1) its limited coverage, 2) its high cost of service provision relative to the MOH, 3) its narrow geographic base, 4) its limited focus on the formal employment sector, 5) its cyclical nature, which leaves growing numbers of persons without coverage when the economy falters, 6) its relative inaccessibility as reflected in long travel-, appointment-, and in-office waiting times, and in some cases, (7) the perception of deteriorating quality of care.

In Peru and El Salvador, and to a much lesser extent in Nicaragua, widespread dissatisfaction with the social security health care system has resulted in the proliferation of employment-based health care systems and the practice of employers purchasing health insurance for their workers, or directly paying for health care services received by their workers. The general level of dissatisfaction with social security health care has been so great that large numbers of employers and individual workers have been willing to make significant outlays, in addition to their social security contributions. In Peru and El Salvador, roughly 20 percent of all persons who are social security beneficiaries also have some type of private health insurance. The payments made by these persons to private sector entities--insurance companies, private clinics, hospitals and physicians--have nurtured the growth of the private sector, which has come to constitute an important actor in the health sector of both of these countries, despite the fact that both have large ministries of health which are charged with providing care to virtually the entire, non-social security-insured, national population. The social security reforms that have been implemented to date in both Peru and El Salvador have taken advantage of the considerable excess capacity that exists within both of these countries' private health sectors.

In Nicaragua, the situation has been somewhat unique, due in large part to its very different health care market structure. The existence of a minuscule private sector has circumscribed the social security institute's much more radical attempt to privatize its health care services. As a result, its efforts have moved ahead much more slowly, and INSSBI has been forced--by default--to work very closely with the Ministry of Health to implement its reform efforts, simply because the latter has such an overwhelming presence in the sector, while the private sector remains small and unorganized.

Generally, the approach that has been taken in El Salvador, and to a lesser extent in Peru, has been cautious and experimental in nature. Initial efforts have been exploratory, narrowly focused, and time-limited. Efforts have been designed to redress the most glaring, the most criticized and generally the most ostensibly tractable problems nagging the system. Generally, a pragmatic approach has been taken to try to address key problems in as non-threatening a manner as possible. The reforms, especially in their initial designs, have had something for everyone,

full for services rendered. This, in effect, puts the hospitals at financial risk should the Professional Risks Program cases they treat prove to be more costly than the agreed upon reimbursement rates. (There is an appeal process for particularly complex and/or expensive cases, whereby hospitals may present evidence of extenuating circumstances that merit special consideration and additional payment.)

The predetermined reimbursement rate for ambulatory care is 500 cordobas per case (U.S. \$75.18, as of July 1994). Specialty and/or inpatient care reimbursement depends upon the nature of the illness or injury and the INSSBI-stipulated indicated length of stay. The Professional Risks Program has published a "List of Complexity of Treatment and Complementary Instructions for Payment" document which groups illnesses/injuries into four levels of complexity, each with a maximum reimbursable number of days of hospitalization. The groups are organized into a combination of types of illnesses/injuries and medical treatment procedures, below which particular body parts or procedures are identified. Complexity Level I illnesses/injuries are estimated to require up to three days of hospitalization and are reimbursed 3,600 cordobas (U.S. \$541.33). Level II are for cases requiring up to 6 inpatient days and are reimbursed 6,600 cordobas (U.S. \$1082.67). Level III cases requiring up to 10 inpatient days are reimbursed 10,000 cordobas. Cases requiring more than 10 days of hospitalization, Level IV cases, are also reimbursed the Level III rate of 10,000 cordobas (\$1503.70). Starting on the eleventh day, additional payments are made for each bed-day, for additional medicines and materials, for medical consultations, and for x-ray and other complementary examinations.

## 2. The Mechanics of Professional Risks Program

In the event of a work-related accident, the employee must immediately notify the employer and identify two witnesses who can corroborate the report. The employer must then fill out, sign, and seal the Notification of a Work-related Accident (*Notificación de Accidente del Trabajo*, NAT) and give it to the injured worker. The injured worker then takes the NAT to an accredited hospital of his/her choosing. In cases of emergency, or when the accident occurs during inconvenient hours or circumstances, the shorter, more simple Provisional Notification of Work-related Accident (*Notificación Provisional de Accidente del Trabajo*, NOPAT), may be substitute for the NAT, with the understanding that a completed NAT will be submitted within 48 working day-hours.

Upon arriving at the hospital, the injured worker's INSSBI insurance status is confirmed by checking his/her INSSBI identification card together with his/her INSSBI verification stub (which INSSBI issues monthly), indicating that the individual's INSSBI contributions are up-to-date. The accredited hospital then provides whatever care is required, at no cost to the insured patient.

INSSBI employs two medical supervisors who monitor the quality of care received by INSSBI insurees. This quality assurance team is permanently assigned to making visits to accredited hospitals and reviewing medical records.

The administrative system of the program also includes two other forms (both supplied by

more generally, that they are responsive to their clientele and take steps to ensure that their members are satisfied with the organization and the quality of care they are receiving.

## 2. Anticipated Impacts of the MINSA INSSBI Project

The Director of one of the national referral hospitals in Managua expressed doubts that the INSSBI Project would result in increases in either the paying clientele or the income of the hospital in which he worked. For several years, on its own initiative, this hospital has entered into formal agreements with four large public and private companies. This is a fairly common practice of MINSA's national hospitals, though the contracts are few in number. Under these agreements, the private companies have agreed to a fixed, preferential price schedule for services provided to their workers. Once INSSBI starts providing its health insurance services, however, this hospital director expects the companies to terminate these special arrangements, as they will constitute paying twice for the same service. As a result, this physician believes his hospital will experience a net reduction in the revenues it receives from providing health care services to the workers of these companies. This seems unlikely, however, for several reasons.

First, under the new INSSBI arrangement, more than just the workers from these four companies are likely to use the hospital on a fee-for-service basis. Second, the workers of these four firms may not be willing to simply give up their special benefits. Whether or not they will do so depends, in part, on how similar the new INSSBI programs are to the special agreements and how powerful the workers are. It is also likely that at least some of the companies will maintain special arrangements for some services, especially in light of the fact that the INSSBI package, while comprehensive, is not all-inclusive. In an interview with the health care services director of one of the largest companies involved, it was learned that while a significant reduction in the company's direct out-of-pocket payments for health care services was anticipated after the introduction of the INSSBI program, the company still intended to maintain all of its direct contracts with hospitals. The company intends to continue providing comprehensive health services insurance coverage for its workers. Therefore, it was planning to purchase a more limited number and type of health care services from hospitals, as a type of supplemental health insurance policy.

The national hospital director's trepidation, however, is understandable on two accounts. First, whereas under the old system the individual could choose where to obtain care, under the new INSSBI system, the hospital either must be selected by the company's workers (voting as a group) to provide all ambulatory and inpatient care, or the hospital has to be subcontracted by the company's designated provider to provide hospital care. Thus, the workers' access to a particular hospital is likely to be somewhat more tenuous under the INSSBI scheme. Nevertheless, particularly for the more esteemed MINSA hospitals, the financial situation may not change appreciably.

Assuming that the hospital enters into a subcontractual arrangement with an INSSBI-designated provider, depending upon the terms of the subcontract, the hospital may not be paid on a traditional, fee-for-service basis, but rather on a per capita basis. This will put hospitals--

In contrast, factors on the demand side have been the impetus for growth in the program. Given that workers and employers have been paying their social security contributions, but since 1979 have not received any unique, identifiable benefit for doing so, it should be expected that there will be a clamor by both workers and employers to participate in the program. In some cases, however, it has been reported that the introduction of the new program has pitted some employees against their employers. This has been a common experience of employers who have avoided paying their INSSBI quotas, while their employees have paid theirs. The employers' non-payment renders the workers ineligible to participate in the program, and in many instances, has prompted workers to pressure their employers.

There are three principal risks involved confronting health care organizations interested in participating in INSSBI's new program. First, the health care organizations wishing to participate gain little by becoming accredited. Accreditation earns them only the right to be included on the ballot that the workers of a particular employer then use in selecting their source of health care. Thus, a health care organization interested in participating in the INSSBI program potentially runs the risk of incurring expenses associated with meeting the human resources and physical infrastructure requirements, and in developing whatever subcontracts required for accreditation, without being selected as an INSSBI health care provider.

Health care organizations interested in participating in INSSBI programs must also agree to be responsible for providing all of the basic service packages their insurees demand. Participating organizations may fulfill this responsibility either directly, by providing the services themselves, or indirectly, by financing the hiring or subcontracting of others to provide the care. Thus, although participating health care organizations can choose to provide only one type of care themselves, they are required to arrange and finance the rest of the package for their enrollees. To date, the primary contracting agencies have overwhelmingly been outpatient facilities, which are at risk, since they must provide all care demanded by their INSSBI enrollees, even if they lose money doing so. Indeed, it has been reported that two private sector multipractice clinics in Managua went bankrupt last year, owing principally to their having lost significant sums of money hospitalizing their INSSBI clientele.

The third risk health care organizations participating in the INSSBI program confront is that they, in addition to being responsible for providing or financing all health care, must also pay sick workers an economic subsidy or sick leave benefit. This is regarded by some as the single most onerous aspect of INSSBI's requirements, in part because this a new area for participants and would-be participants, about which they have little experience and little knowledge. The rationale for holding the health care organization directly responsible for the subsidy is to provide powerful incentives for carefully monitoring its dispensation.

### **C. MINSAs INSSBI Project**

MINSAs has developed a unit, the Dirección General de Atención al Asegurado (DGAA), that has recently (June 1994) signed a contract with INSSBI, accepting the INSSBI offer of 94.50 cordobas per insured person per year, in exchange for providing a specified minimum package of

## **V. NICARAGUA**

### **A. Introduction and Recent Developments**

The Nicaraguan Social Security Institute (Instituto Nicaragüense de Seguridad Social y Bienestar, INSSBI) was established in Nicaragua in 1957. In the first few years after the Sandinistas came to power in 1979, there were several major changes in the structure and operations of the Social Security Institute. First, the Sandinista Government established a single unified health care system, which effectively folded the INSSBI health care system into that of Ministry of Health (MINSA). INSSBI facilities were given to the MINSA, becoming indistinguishable from other MINSA facilities, and INSSBI staff became MINSA staff.

Another post-1979 change in INSSBI involved the revenues generated by social security contributions. When the facilities and staff of INSSBI were incorporated into MINSA, the legally-established MINSA share of the contributions (10 of the 17 percent of total INSSBI contribution-based revenues), were no longer transferred from the Ministry of Finance (MIFIN) directly to MINSA. Instead, MINSA continued to receive only Central Government allocated General Funds.

Presumably, the General Funds allocations that MINSA received had increased, since it now had the added responsibility of paying former-INSSBI staff and running former-INSSBI facilities. The absence of ear-marked monies, however, eliminated the one transparent mechanism by which social security enrollees could see that 59 percent of their contributions were used to provide health care services. Although MINSA's budget allocation reflected social security contributions, the new system financed the provision of health care services to a large population outside of contributors and their beneficiaries, fostering worker resentment. Workers soon began to decry that their social security contributions had been transformed into a type of indirect tax. The recent changes in INSSBI's modus operandi with regard to health care services (detailed below), are largely a response to pressure from these dissatisfied workers/contributors.

### **B. INSSBI'S New Role as Administrator, and Not Provider, of Health Services: the New Health Security Program**

In early 1993, INSSBI began work on the development of a new health care services role for itself. In late 1993, it announced the development of two new programs. In reality, neither of these two programs were new, but rather were reorganized and restructured versions of two traditional Social Security programs--the Common Illnesses and Maternity Health Care Services Program and the Professional Risks Program. More specifically, INSSBI would no longer be the direct provider of care in either program; rather, its role would now be limited to the financier and administrator of the programs. The new Professional Risks Program and the Common Illnesses and Maternity Health Care Services Program now contract with accredited health care organizations to provide care and insurance coverage, respectively. Implementation of both of these new programs began in November 1993.

#### **D. A Private Health System**

On November 10, 1991, Legislative Decree No.718 created the Private Health System (Sistema Privado de Salud, SPS), which is intended to complement the IPSS health care delivery system. While the details of this reform have yet to be specified, in general terms, this change provides workers with an option: for the first time they will be permitted to select a health system other than that of the IPSS.

Under the new proposed system, those electing to continue with traditional IPSS coverage will continue to pay three percent of their salary to IPSS for such coverage, and their employer's will continue to contribute six percent of the worker's salary. For those electing to be covered by a system other than IPSS, the employee contribution for the health care coverage will be increased to 8 percent of his/her salary, which will underwrite the entire cost of the worker's health insurance. The employers' share will be reduced to 1 percent of the worker's salary, but will not be used to underwrite the worker's health services coverage. Rather, the employer's share is intended to be a solidarity contribution to IPSS.

The SPS is to be administered by Health Service Organizations (Organizaciones de Servicios de Salud, OSS). The nature, functions, and operations of the OSS are currently being devised by an independent, technical committee to the Legislature.

Nevertheless, given the very fundamental structure that has been identified to date, as set forth in the Legislative Decree, some important characteristics of how the SPS will function, in a very general sense, can be identified. Perhaps most important and contentious is that the health services provided through the SPS (which will function as broker/contractors) will not be uniform for all participants. This will continue to be the case with IPSS-provided coverage. Instead, the workers' coverage and benefits will vary by the particular type of plan contracted with the health providing organization. For workers with low incomes, the 8 percent share will purchase a substantially less generous type of insurance coverage relative to one that may be purchased by a high-paid worker (Cuanto, marzo 1992, pp. 35-36).

To the extent that low paid persons opt into the SPS, it is likely that the introduction of this system will result in more people--specifically low-paid persons--being pushed for at least some of their health care needs into the low-priced MOH system. Most low-paid persons, however, are likely to stay within the IPSS health service system, particularly if they have chronic illnesses, or anticipate substantial medical care needs. This suggests that the average utilization of IPSS-covered workers may increase. If this impact--i.e., the potential for adverse selection into IPSS--is sufficiently great, it could conceivably jeopardize IPSS's long-term financial stability, and, therefore, will need to be carefully analyzed and taken into account in the design of the SPS.

Given that the SPS has yet to be defined in any detail, it is impossible to quantify the magnitude of the impact of this reform. Whatever its shape and content, however, there is no question but that the introduction of the private health system will encourage the growth of the private sector.

dedicated to tertiary care provision.

The program pays private hospitals and clinics a predetermined fixed fee for providing the service. IPSS has established a set of requirements for private sector entities wishing to participate in the program, consisting primarily of being able to provide specified minimum personnel and equipment. Hospitals and clinics that qualify and petition IPSS to become enrolled in the program are placed on a list of participating providers. This list is made available to IPSS beneficiaries, who may choose to go to any of the participating providers to undergo the stipulated, qualifying types of surgery, following the provision of a service. The participating private hospital then submits an invoice to IPSS.

This program has not attracted the participation of a large number of private hospitals or multipractice clinics to date. There is, however, one hospital which dedicates about 60 percent of its beds to the treatment of IPSS minor surgery program participants. The ward of the hospital dedicated to the Minor Surgery Program is reported to have had a near 100 percent occupancy rate since shortly after enrolling in the program.

More generally, the impact of the program on IPSS insurees has been to provide the would-be patient with 1) greater choice in their selection of a provider, and 2) greatly reduced times in securing appointments. The program has dampened the demand for private health insurance, while increasing the demand for private hospital services relative to what it would have been in the absence of the program.

### **C. The Decentralized Ambulatory Care Program**

Encouraged by the relatively limited, but overwhelmingly positive experience with the partial privatization of the minor surgery program, IPSS introduced a second private sector program, the Decentralized Ambulatory Care Program (Programa de Atención Ambulatoria Decentralizada, PAAD), in May of 1992. This program aims to foster the development of a primary health care system based on a primary care provider/gatekeeper. Access to IPSS-financed services will be improved by reducing travel, appointment, and waiting time delays, and by expanding consumers' choices of physician and service provision location.

At present, the PAAD is district-based and is limited to Lima. Private sector physicians who wish to participate in the program must apply and qualify by meeting the requirements set forth in the Reglamento del Programa de Atención Ambulatoria Decentralizada. For the most part, these are minimal requirements that deal with professional credentials, necessary equipment and the physical conditions of the physician's office. Participating physicians must also agree to specified reporting requirements.

An IPSS-insured patient is allowed to select any PAAD-participating physician in his/her district to be his/her primary physician and enrolls in the program by simply filling out a form. The physician submits the form to IPSS and provides the patient with a PAAD identification card which, is used to track the individual's PAAD-related care. The patient is entitled to specified,

The scheme has been extended to the pediatric care as well. As noted earlier, ISSS is in the process of amplifying its coverage of children. Since, historically, children were covered only for their first 6 months of life, the Institute has not had need for, and has not had, a large staff of pediatricians. To meet the growing demand for pediatricians, ISSS has extended the privatization scheme to pediatric visits.

According to ISSS estimates, its total cost per specialty consultation (including administration) was 53 colones in 1990 and 64 colones in 1991. The cost of the privatized consultation is 40 colones. These are not the full costs of the privatization scheme, however, as its administrative costs have never been quantified. If we drop the administrative costs, however, we find that the cost of a specialty consultation provided by ISSS was only 33 colones in 1990 and 46 colones in 1991, suggesting the privatization scheme may not have been a good financial deal for the ISSS (as has been universally acclaimed) at least through 1991. (More recent cost data are not available.)

In 1991, an influential, local non-profit think tank, the Fundación Salvadoreña para el Desarrollo Económico y Social (FUSADES), conducted a physician and consumer satisfaction survey of the privatization scheme and found overwhelming support for the program.

#### **IV. PERU**

##### **A. Growing Dissatisfaction with Access to and the Quality of Care**

Throughout the latter half of the 1970s, the quality of the services provided by the Peruvian Social Security Institute (Instituto Peruano de Seguro Social, IPSS) deteriorated markedly. First, the onset of significant inflation in Peru reduced the level of real financial resources available to provide IPSS health care. Later, in 1982-83, a severe economic recession eroded the number of IPSS-affiliated workers, further reducing the financial base of the organization, while minimally affecting the high fixed costs of its health services operations. Finally, the management of IPSS's health services in the post-1977 era deteriorated significantly, and losing its reputation for administrative efficiency and effective service delivery (Mesa-Lago, 1986). By the middle of the 1980s, it had become an institution regarded as seriously deficient both administratively and in terms of the delivery of acceptable quality health care services. A 1985 analysis concluded:

Medical coverage provided by the IPSS program is among the lowest and most unequally distributed in Latin America. Yet its costs are among the highest in the region. Despite legally mandated contribution rates for employers and employees exceeding the Latin American average, the program began operating at a deficit even when the Peruvian economy was relatively healthy and did so continuously from 1977 through

implemented were the extension of coverage to: 1) public sector employees throughout the country (previously they were covered in only 3 of the 5 administrative regions), 2) the male spouses of the insurees (up until 1989 only female spouses had been covered) and 3) children of ISSS enrollees under two years old (previously, only children up to 6 months of age had enjoyed coverage only). ISSS plans call for annually extending beneficiary status to progressively older children of enrollees. By 1996 enrollees' children up to the age of six years will be covered. The impact of these changes has been significant. In 1989, while the number of traditionally eligible ISSS enrollees fell by 2 percent, the increasing number of newly eligible enrollees and their dependents more than offset this decline, resulting in an expansion of ISSS enrollment. Furthermore, total ISSS beneficiaries grew by a record 23 percent in 1989. Since the economy began to pick up in 1990, the number of ISSS enrollees and of beneficiaries have increased steadily.

### **B. Perceived Shortcomings and Consumer Dissatisfaction**

Criticism of ISSS's health services has long been common throughout El Salvador. Because of the long delays involved in obtaining care, and the fact that ISSS does not adequately cover very young children, a substantial (but undetermined) number of business firms have opted to provide their workers with private insurance, while they continue to meet their legal obligation to pay their ISSS contribution. This decision is generally made on purely economic grounds; the value of work-time saved by providing workers with a more expeditious source of care outweighs the cost of the insurance premium. Other firms, driven by the same economic considerations, have established their own health care delivery capacity, generally hiring one or more health care providers to provide care at the work-site, on either a part-time or full-time basis. No systematic analysis has been done to identify the numbers and types of such arrangements. Clearly, however, they reflect perceived deficiencies in the ISSS service delivery system.

Although there are no definitive data about the number of persons carrying private health insurance in El Salvador, there is evidence that this market has been growing rapidly throughout the past decade. The total annual payments for private health insurance premiums grew at an average annual rate of 25.1 percent between 1980 and 1991, reflecting a high level of dissatisfaction with ISSS health services. Private health insurance plans in El Salvador are almost exclusively group policies, which are purchased by employers for all workers in their company. Private health insurance experts estimate that approximately 100,000 persons are covered by health insurance. This is the equivalent of nearly 20 percent of all social security beneficiaries--is a large proportion which reflects widespread and strongly felt dissatisfaction with the social security health care system.

### **C. Partial Privatization of Specialized Ambulatory Care**

From the time the massive 1986 earthquake destroyed ISSS's primary hospital, the Institute has had a large backlog of appointments. This backlog--particularly for specialty consultations--resulted in appointment delays of three months or more and became the source

helping to eschew the politicization of the efforts. Only after the first efforts have begun to prove successful and politically acceptable have they been modified to be institutionalized, or to more fundamentally restructure the operations of the social security institute.

While Nicaraguan reforms have been bolder and more far-reaching, they too have been implemented in such a manner as to minimize disruption of the extant system and opposition by those most directly affected by the reform. Still, some opposition exists in all three countries, especially on a philosophical basis. This is particularly true of Nicaragua, where the changes diametrically conflict with the Sandinista concept of the role of Government.

As these case studies have shown, different health care market structures provide different sets of opportunities, but they also entail different parameters restricting potential alternatives. For those entering into social security reform, therefore, it is imperative to be well-informed about the nature and functioning of the health care market in order to be able to precisely identify and understand: 1) the major problems, 2) their root causes, and 3) potential reform options. Thus the first thing that should be done in preparing for reform is to develop a detailed, technical analysis of the situation, quantifying long term trends in critical health sector indicators: the levels of financing, coverage and utilization of the social security institute, the Ministry of Health, and the private sector. Another essential component of this exercise is the identification of the level and nature of consumer and provider satisfaction/dissatisfaction with the social security institute, looking at any surveys which may have been performed (some social security institutes perform them routinely). Critical actors and agencies to interview and useful indicators to obtain in analyzing the potential for social security reforms are outlined in Table 1.

In addition, the particular lessons suggested by the experiences of these three countries in shaping the strategy, design and implementation schedule of social security reforms include:

- ▶ Perform a stakeholders' analysis: identify the size, and importance of the various groups of actors that will be involved in the reform decision-making process or who will be affected by it. (Much of this knowledge will be a product of the former activity.)
- ▶ Initially focus on a relatively small-scale problem that has high visibility and/or that has a high probability of being successfully reformed expeditiously. Time-limited efforts--such as the initial effort in El Salvador--may be of strategic importance.
- ▶ To the extent that it is deemed necessarily or desirable extend the domain of the reform, do so gradually.
- ▶ Go slow so as not to alarm the chief actors in the field and to minimize the politicization of the process.

**TABLE 1**  
**Key Agencies/Actors and Indicators in Analyzing Potential Social Security Reforms**

Area	Key Agencies/Actors to Interview	Indicators
Public Providers	Social Security Institute Ministry of Health	<ul style="list-style-type: none"> <li>• coverage of the population by institution</li> <li>• services provided per beneficiary, by institution</li> <li>• average waiting times, appointment time delays, by institution</li> <li>• prices of key services, by institution</li> </ul>
Private Providers	Physicians Association ( <i>Colegio Medico</i> ) Medical Schools Large Private Provider Organizations	<ul style="list-style-type: none"> <li>• coverage of the population by specialty</li> <li>• number of physicians</li> <li>• defined fee scale by specialty</li> <li>• rate of increase of physicians</li> <li>• prices of key services</li> </ul>
Hospitals	Hospital Association	<ul style="list-style-type: none"> <li>• capacity of public and private hospitals</li> </ul>
Private Insurance	Private Insurance Association Superintendancy of Insurance Chamber of Commerce	<ul style="list-style-type: none"> <li>• perceived obstacles to the expansion of private insurance coverage</li> <li>• names of companies selling coverage of private health insurance</li> <li>• amount of premiums</li> <li>• number of employers purchasing private insurance in addition to social security</li> </ul>

- ▶ Look for common ground--such as that found in the initial efforts in Peru--so as to defuse opposition and avoid unduly politicizing the effort.
- ▶ As changes are effectuated, institutionalize them as soon as possible.
- ▶ Structure the reform so that it is as free from coercion as possible; to the extent possible, make the participation of consumers/patients and physicians voluntary, not required--as in the Salvadoran privatization of specialty physician consultations.

In conclusion, the options available to a particular social security institute in terms of how it can most effectively privatize some of its care provision is dependent upon a host of political and technical factors. The most pertinent of the technical considerations are the social security institute's own administrative capacity and various aspects of the health care market structure, most notably the size, composition, degree of organization and capacity utilization of the private sector. These are important factors that other Latin American countries considering private sector-oriented reforms of their social security health care delivery systems would be wise to examine closely early-on in the design phase of their efforts.

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