The privatization of health care in three Latin American social security systems

JOHN L FIEDLER
Consultant, Social Sectors Development Strategy, Wisconsin, USA

Most Latin American social security institutes are direct providers of medical care services to their beneficiaries. 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 (a) exacerbating inequalities in access to and use of health care, (b) further heightening the geographic overconcentration of services, (c) focusing a disproportionate amount of resources on high technology, curative care to the near total exclusion of primary health care, and (d) being administratively top heavy and, more generally, inefficient.

In the past few years, many Latin American countries have begun searching for methods to ameliorate these problems. This paper analyzes three recent efforts, all of which involve some degree of privatization: (1) El Salvador's partial privatization of specialty physician outpatient consultations, (2) Peru's minor surgery and its decentralized ambulatory care programme, and (3) Nicaragua's 'administrative services only' approach wherein social security beneficiaries choose to join a certified 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.

The paper also identifies political and technical considerations, as well as 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; relative prices in the private vis-a-vis the public sector; and the size and nature of the private health insurance market. Other Latin American countries would do well to examine these factors and characteristics before embarking on efforts to reform their own social security health care delivery systems.

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 programmes in the region date from the late 1940s and early 1950s. While the nature and structure of these social insurance programmes vary substantially by country, most consist of a combination of programmes 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 the focus of this article is on just the health care services component of these programmes, we will refer to just this portion 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 and employees, and the Central Government each contributing a fixed percentage of the individual worker's salary.

Starting with the advent of the severe world recession in the first years of the 1980s, many Latin American social security programmes have been financially devastated by adverse macroeconomic conditions which have eroded the traditional bases of these systems, i.e. formal, modern sector industrial employees. 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 which 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 simultaneously been a rapid growth in the costs of medicines and medical equipment, resulting in escalating costs. 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).

More fundamental criticisms of Latin American social security systems, that have contributed prominently to the crescendo of calls for reform, have been prompted by other than financial concerns.

1. In most Latin American countries, social security systems have very limited coverage. In Colombia, Peru, Ecuador, Bolivia, Paraguay, Guatemala, El Salvador, Honduras, Haiti, Nicaragua, and the Dominican Republic, for example, less than 25% of the population is covered.

2. 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.

3. Since the modern sector is generally concentrated in urban areas, and most Latin American societies are characterized by urban primacy, 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.

4. The health systems of most Latin American social security systems constitute separate, independent systems that are much more generously funded than, and that duplicate, the ministry of health (MOH) systems which generally cover from 3 to 6 times more of the national population. The social security systems in these cases are inherently inefficient, while they create a labour elite.

5. Social security’s coverage and its expenditures wax and wane with the level of economic activity of the modern sector. The procyclical nature of social security means that when a country’s macroeconomic performance falters, social security rolls contract, and there is an increase in persons without health insurance. By virtue of their having just lost their jobs, many of these persons turn to the MOH system for care rather than the private sector, at just the time that the MOH’s budget is, at best, being held constant, or more likely, is also contracting because of recession. The result is a national health care crisis.

6. Latin American social security health systems are overwhelmingly geared toward hospital-based, high-technology, curative care, which, given the epidemiological profiles of most countries is inappropriate, unnecessarily expensive and reduces the potential impact of public health care expenditures on the health status of the population.

7. Latin American social security health care systems have high administrative costs, and in general, have 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 (see Bossert 1993). Other major reforms have included: (1) the development of special programmes 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, to become something more than modest.

This paper analyzes recent efforts to reform social security health systems in three Latin American countries. While all three 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 to be discussed are:

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

2. Peru’s minor surgery programme and its decentralized ambulatory care programme, introduced in 1991 and 1992, respectively, both of which involve social security beneficiaries choosing a qualifying private provider who is reimbursed a predetermined fixed fee for services rendered.

3. Nicaragua’s administrative services only approach, 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.

Private sector-related reforms in three Latin American countries

The roots of the reform movements

Historically, social security in all three of the study countries – El Salvador, Peru and Nicaragua – had most of the aforementioned characteristics of Latin American social security systems that have prompted calls for reform. As may be seen in Figure 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% of the national population in Peru, while total beneficiaries (enrollees and their eligible dependents) include roughly 5% of Nicaraguans and about 10% of Salvadorans.

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 which have served to obfuscate the otherwise more direct relationship between GDP and coverage, which nevertheless can still be discerned in Figure 1.

The macroeconomic and social security crises of these countries have been compounded by a more general health sector crisis which, due to its procyclical nature, 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 (a) the proportion of total public (defined as ministry of health plus social security) health care expenditures accounted for by social security and (b) the proportion of total public health care services provided by social security. In El Salvador, for instance, while in 1987 ISSS (Instituto Salvadoreno de Seguro Social) spending was 37% that of the MOH, providing for 16% of combined MOH and social security hospital admissions and 41% of combined MOH and social security ambulatory visits, by 1992 ISSS spending has risen to 87% that of the MOH, providing for 34% and 84% of combined MOH and social security hospital admissions and ambulatory visits, respectively.
The ministries of health in these countries are officially charged with providing care to 70-80% of the total population, while social security health care has come to account for a growing proportion of total public health care expenditure at the same time that social security coverage has expanded only very modestly. This suggests that there have been rapidly growing inequities in the quantity and/or quality of the health care of social security beneficiaries vis-a-vis 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 situation is particularly troubling. As IPSS's (Instituto Peruano de Seguro Social) budget relative to that of the MOH has steadily grown from 119% in 1987 to 184% in 1992, its share of total service provision has fallen, from 68% to 62% of total MOH and social security 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, their macroeconomic performances. The politico-social crises and the economic crises have fed off one another to heighten the national crises in each one of these countries. These crises have given politicians the impetus and the need, as well as relatively greater leeway (a) to experiment with reforming their social security systems with the aim of, at minimum, opening them up to greater participation and (b) to begin exploring the possibility of introducing more fundamental, structural changes.

The discussion turns to an analysis of the private sector-related reforms of the social security health care systems in these three countries. 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 general acceptability of the system.

El Salvador
Introduction and recent developments
The Instituto Salvadoreño de Seguro Social (ISSS) was established in April 1954. ISSS provides care to its enrolled workers and retirees, their spouses and, until relatively recently, children up to the age of 6 months. Initially ISSS coverage was limited to industrial, commercial and service establishments in only 9 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 9 municipios in the San Salvador metropolitan area. In 1976, 64% of ISSS enrollees (cotizantes) were in the 9-county, Metropolitan area which contains 26% of the national population. By 1992, this proportion had increased to 72%.

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 implemented were the extension of coverage: (1) to public sector employees throughout the country (previously they were covered in only three of the five administrative regions), (2) to the male spouses of the insurees (until 1989 only female spouses were covered), and (3) to children of ISSS enrollees less than two years old (previously they were covered only up to 6 months of age). With this year’s extension of coverage to 6-year-olds, ISSS completes a five year programme of phasing-in coverage to progressively older children of enrollees.

The impact of these changes has been significant. In 1989, while the number of traditionally eligible ISSS enrollees fell by 2%, the increasing number of newly eligible enrollees and their dependents more than offset this decline, resulting in an expansion of ISSS enrolment. Furthermore, total ISSS beneficiaries that year jumped by its largest single year total ever, a hefty 23%. Starting in 1990, as the economy began to pick up, each year the numbers of ISSS enrollees and beneficiaries have reached all-time highs.

ISSS’s perceived shortcomings and consumer dissatisfaction
Criticism of ISSS’s health services regime 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 especially 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 mandate 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 ever been done to identify the numbers and types of such arrangements. Clearly, however, they reflect perceived deficiencies in ISSS services 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% between 1980 and 1991. Private health insurance plans in El Salvador are almost exclusively group policies purchased by employers for all workers in their company. Private health insurance experts estimate that approximately 100,000 persons have health insurance. This is the equivalent of nearly 20% of all social security beneficiaries; a large proportion, reflecting widespread dissatisfaction with the social security health care system.

ISSS's partial privatization of specialized ambulatory care

From the time that 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 of some of the most caustic criticisms of the Institute. ISSS responded first by increasing clinic hours from 8 to 12 hours per day. When that proved inadequate, in May of 1990 it introduced what was intended to be a temporary and very focused programme to eliminate the worst of the patient backlog: a programme 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 programme 6 years ago. Initially the privatization scheme 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. About one year after the initiation of the programme, as it became apparent that the programme was both successful (from ISSS's perspective) and popular (among ISSS beneficiaries), it was modified to include the second consultation, and made nationwide 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 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 for increasing 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 programme to physicians who work at least part-time for the Institute obviates the Institute's having to train the participating physicians in ISSS's norms of care or having to monitor the programme closely. Two-thirds of the Institute's 226 physicians working in the Metropolitan Region participate in the privatization programme.

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

In the 7 months of 1991 during which the programme 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 programme that would remain in effect only long enough to reduce the appointment backlog to an acceptable level. ISSS officials now state that the programme is a permanent feature of the ISSS health system.
The scheme has been extended to paediatric care as well. As noted earlier, ISSS is expanding its coverage of children. Since historically children were covered only up to 6 months old, the Institute has not needed, and has not had, a large staff of paediatricians. To meet the growing demand for paediatricians, ISSS has extended the privatization scheme to paediatric visits.

According to ISSS’s 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 of a consultation provided directly by ISSS, however, we find that the cost of the in-ISSS provided consultation 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, a highly respected, non-profit think tank, the Fundacion Salvadorena para el Desarrollo Economico y Social (FUSADES), conducted a physician and consumer satisfaction survey of the privatization scheme and found overwhelming support for the programme.

Peru
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 reduced the number of IPSS affiliated workers, further eroding the financial base of the organization. Finally, in the post-1977 era IPSS management lost 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 the delivery of an acceptable quality of health care services. A 1985 analysis concluded:

Medical coverage provided by the IPSS programme 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 programme began operating at a deficit even when the Peruvian economy was relatively healthy and did so continuously from 1977 through 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 would-be 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 required workers seeking care to be absent from work. In addition, waiting lines 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 doing so. Patients seeking hospitalization services were commonly required to wait two or three months before being admitted. As a result, the use of IPSS health care services reduced worker productivity. Furthermore, those who were admitted were commonly dissatisfied with the services they had received. Workers and employers alike, therefore, were motivated to seek out alternatives.

Despite the fact that workers were obliged to contribute 3% of their salary, and employers to make a 6% matching contribution to the health services regime of the IPSS, dissatisfaction with IPSS’s health services eventually grew to the point where this very considerable economic disincentive to purchasing private health insurance was overcome. In effect, these actors came to view IPSS contributions not as a type of mandatory health insurance, but simply as 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.¹ This is the equivalent of nearly 30% of IPSS enrollees and roughly 20% of total IPSS
beneficiaries, signifying a high level of general dissatisfaction with the social security 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 the social security health care programme. The three reforms were the minor surgery programme, the decentralized ambulatory care programme and the health system organization reform.

**PERU's private sector, minor surgery programme**

In 1991, the IPSS instituted a new private sector programme, the minor surgery programme. The purpose of the programme was to reduce the backlog of patients who were waiting for up to three months to undergo particular types of relatively minor surgeries, thereby allowing the IPSS tertiary hospitals' resources to be dedicated to tertiary care provision.

The programme pays private hospitals and clinics a predetermined fixed fee for providing the service. IPSS has established a set of minimal personnel and equipment requirements. Hospitals and clinics that petition IPSS to become enrolled in the programme and that qualify, are placed on a list of participating providers. This list is made available to IPSS beneficiaries who may choose to go to any provider on the list to have one of the stipulated types of surgery performed. The participating private hospital submits an invoice to IPSS following the provision of the service.

This programme 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% of its beds to the treatment of IPSS minor surgery programme participants. This programme-dedicated portion of the hospital is reported to have had a near 100% occupancy rate since shortly after enrolling in the programme.

The programme has provided IPSS-insured would-be patients with: (1) greater choice in their selection of a provider, and (2) greatly reduced delays in appointment time. According to hospital administrators and health insurance company executives, the programme has dampened the demand for private health insurance, while increasing the demand for private hospital services, relative to what it would otherwise have been (Fiedler 1993).

**The Decentralized Ambulatory Care Programme (PAAD)**

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

At present, the PAAD is limited to Lima and is a district-based programme. Private sector physicians who wish to participate in the programme must apply and qualify by meeting the requirements set forth in the Reglamento del Programa de Atencion Ambulatoria Descentralizada. 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 enrols in the programme 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. The patient is entitled to specified limited amounts of different types of care under the programme: a maximum of 6 consultations per year, two prescriptions per consultation, one urine and one blood examination 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; namely as a primary health care system. Thus, the treatment of chronic conditions which require more than the maximum allowable number of consultations is referred to IPSS specialists.

Physicians participating in the PAAD receive 3.50 soles (US$1.70) per consultation. The programme enables IPSS to greatly expand its service provision without having to pay for feasibility studies of the
need for and location of new facilities, or capital expenditures for new facility construction.

The PAAD has increased access to IPSS care by removing the bottleneck to service provision that its limited number of service delivery sites constituted, and by markedly reducing appointment time delays for primary health care services. While no systematic studies have been done to date, the programme 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 6 months in operation, the PAAD provided 150,000 consultations. Since beginning operations on 4 May 1992, each month the PAAD’s service provision totals have increased. After its first complete year in operation, it was providing approximately 60,000 consultations monthly, the equivalent of about 50% of total IPSS-provided ambulatory consultations in the Lima Metropolitan Area and about 25% of total IPSS ambulatory care provided nationally. The rapid expansion of this programme despite its low fee/reimbursement structure testify to the excess capacity in the private sector and the extent to which the demand for IPSS services has been pent-up by the combination of limited 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 is that some persons who used to have private insurance, now have only public (IPSS) insurance, and they are using it for the first time. Indeed, the manager of the PAAD explains that one of the rationales for establishing the PAAD was that, with the serious and growing economic problems confronting Peru, many persons were losing their private health insurance and increasing the demand for IPSS services. Thus the PAAD was, in part, a strategy to deal with this increase in demand at the same time that IPSS services already had what many regarded as intolerably long in-office waiting times and appointment time delays.

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

Nicaragua
Introduction and recent developments
The Nicaraguan Social Security Institute (Instituto Nicaraguense de Seguridad Social, INSS) was established in 1957. In the first few years after the Sandinistas came to power in 1979, there were several major changes in its structure and operations. First, the Sandinistas established a single unified health care system which effectively folded the INSS health care system into that of the Ministry of Health (Ministerio de Salud, MINSA). INSS facilities were given to MINSA, becoming indistinguishable from other MINSA facilities, and INSS staff became MINSA staff. At the same time, the legally-earmarked health services component of social security contributions (10% of the 17% payroll tax) was to be transferred directly to MINSA. This portion of the agreement was not adhered to. Instead, these funds were no longer earmarked, and MINSA continued to receive only General Funds allocations.

While the General Funds allocations that MINSA thereafter received increased, discontinuing the practice of earmarking the social security health care monies, however, eliminated the one transparent mechanism by which social security enrollees could see that 59% of their contributions were still being used to provide health care services. Moreover, to the extent that the level of MINSA’s budget allocation actually did reflect social security contributions, the fact that it was used to finance the provision of health care services not only to the contributors and their beneficiaries, but to a substantially larger number of persons, many of whom were not required to contribute anything for the services, fostered worker resentment. Workers soon began to decry their social security contributions being transformed into a type of indirect tax. The recent changes in INSS’s modus operandi with regard to health care services (detailed below) are largely a response to pressure from these dissatisfied workers/contributors.
INSS’s new role as the administrator (only) of health services

In early 1993, INSS began work on the development of a new health care services role for itself. In late 1993 it announced the development of two ‘new’ programmes. In reality, neither was new: what was new was that the two Social Security programmes – the common illnesses and maternity health care services programme and the professional risks programme – were to be made distinct operating programmes, and both were to be significantly reorganized and restructured. More specifically, INSS was no longer to be the direct provider of care in either programme. Its role was now to be limited to being the financier and administrator of the programmes. Both programmes contract with accredited health care providing organizations to provide care, in the case of the professional risk programme, and insurance coverage, in the case of the new common illnesses and maternity health care services programme. Implementation of both of these programmes began in November 1993.

The new health security model (Modelo de Salud Previsional)

The new scheme is organized by employer, and includes only those 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 INSS-accredited, health-care-providing agency from which they want to receive all of their INSS-insured care. For each employer, the single accredited agency that receives a plurality in the election becomes the sole source of INSS-insured care.

Health-care-providing agencies interested in participating in the new programme are accredited by:

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

Other INSS 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 programme has been in existence since November of 1993, its acceptance and growth has been relatively slow. The 63 participating work sites as of 1 July 1994 have 7255 enrolled workers who represent less than 6% of the total eligible participants. To date the major bottleneck restricting the growth of the programme has been on the supply side: too few health care organizations are participating in the programme. This is due principally to: (1) the various risks inherent in the programme (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% of the national total in 1992 (OPS 1992: page 10), its inpatient capacity is minuscule (there are an estimated 130 private hospital beds in Managua and fewer than 250 throughout the entire country, representing approximately 5% of the country’s total complement).

In contrast, factors on the demand side have been the impetus for growth. 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 clamour by both workers and employers to participate in the programme. In some cases, however, it has been reported that the introduction of the new programme has pitted some employees against their employers. This has been a common experience of employers who have avoided paying their INSSSI quotas, while their employees have paid theirs. The employers’ non-payment renders the workers ineligible to participate in the programme, and in many instances has prompted the workers to ‘push’ their employers to pay-up.

There are three principal risks confronting health care organizations interested in participating in INSS’s new programme. First, the health care organizations wishing to participate are guaranteed nothing 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 INSS programme...
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potentially runs the risk of incurring expenses in meeting the human resources and physical infrastructure requirements and in developing subcontracts in order to be accredited, and then never being selected as an INSS provider.

A second risk is that, as already noted, to be accredited, they must agree to be responsible for providing all of the services their insurees demand that are included in the mandated benefit package. 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 be exclusively outpatient care providers, or exclusively in-patient providers, they are required to arrange and finance the ‘other half’ of the care 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 INSS 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 INSS clientele.

The third risk for health care organizations is that, in addition to being responsible for providing or financing all health care, they must also pay sick workers an economic subsidy or sick leave benefit. This is regarded by some as the single most onerous aspect of INSS’s requirements, in part because this is a new area about which they have little experience and little knowledge. The rationale for holding the health care organization directly responsible for the subsidy is to encourage careful monitoring of its dispensation.

Discussion, conclusions and lessons

Whilst the experiences of these three Latin American social security systems and their reforms 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, as in many other Latin American countries, social security has been the subject of concern and criticism for many years 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 limiting formal employment sector focus; (5) its procyclical nature, which leaves growing numbers of persons without coverage when the economy is slipping; (6) its relative inaccessibility as reflected in long travel, appointment, and in-office, waiting-time delays; and in some cases (7) 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 their health care services. The 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% of all social security beneficiaries also have some type of private health insurance. The payments made by these persons to insurance companies, private clinics, hospitals and physicians have nurtured the growth of the private sector, which has come to be an important actor in the health sector of both 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 implemented to date in both Peru and El Salvador have taken advantage of the considerable excess capacity that exists in the private health sector.

In Nicaragua, the situation has been unique, due in large part to its very different health care market structure. The existence of only a minuscule private sector has circumscribed and delayed the social security institute’s much more radical attempt to privatize its health care services. At the same time, it has forced INSS, by default, to work very closely with the Ministry of Health in order to implement its reform efforts, simply because the MOH has such an overwhelming presence in the sector, while the private sector remains small and unorganized.

As in many other Latin American countries, all three of the countries studied here, have a long history of producing large numbers of physicians. With the slowing and in some cases the reversal of the growth in the MOH and/or social security systems, there has come to be an excess supply of physicians in many of these countries. 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 something for all of the principal actors.

For the social security institute, the excess supply of physicians means physicians will be more willing to participate in the privatization scheme at inexpensive reimbursement rates, very possibly making this approach cost-effective relative to the extension of social security services. 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 introduction of a privatization scheme, means more possible providers from whom to choose a physician. Consumers also benefit because of the reduced waiting time. Finally, the physicians who participate in these programmes are enticed by the lure of more patients and more income.

The approach to reform 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, designed to redress the most glaring and most ostensibly tractable problems in the system. Generally, the approach has been to address key problems in as non-threatening a manner as possible. The reforms, especially in their initial designs, have had something for everyone, as the adage of ‘do no direct harm’ has been adhered to. This has helped to avoid politicization of the efforts. Only after the first efforts have begun to prove successful and politically acceptable have they been modified to make them more permanent (institutionalized) or to fundamentally restructure social security institute operations.

While Nicaraguan reforms have been bolder and more far-reaching, they too have been implemented so as to minimize both disruption of the 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 (which remains an important reference point for much of the populace, even though the Sandinistas were ousted from power in 1991).

These observations suggest some lessons about the strategy, design and implementation schedule for other countries embarking on similar such reforms:

1. Perform a stakeholders’ analysis: identify the size and importance of the various 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.)
2. 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.
3. To the extent that it is necessary or desirable to extend the reform, do so gradually.
4. Go slow and look for common ground so as to defuse opposition and to avoid unduly politicizing the effort.
5. As changes are effectuated, institutionalize them as soon as possible.
6. 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.

As these case studies show, different health care market structures provide different sets of opportunities and potential alternatives. The options available to a particular social security institute to privatize some of its care provision are dependent upon a host of political and technical factors. The most pertinent of the technical considerations are 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 any similar such effort.

Endnote

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

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Biography

John Fiedler, PhD, is a health economics consultant who has worked in international health for more than 15 years. He currently works as a consultant in health care financing, privatization, health planning, project design and evaluation. Previously, he worked as a health planner and program evaluator at the State of Wisconsin and taught economics at the University of Wisconsin-Eau Claire. He has worked primarily as a freelance health economist since 1989.

Correspondence: John L Fiedler, Social Sectors Development Strategy, 229 North Tenth Place, Sturgeon Bay, WI 54235, USA.