

207

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SECURITY SYSTEM:
THE PERUVIAN CASE**

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RESUMEN

Desde mediados de 1997 se ha implementado una reforma en la seguridad social en salud con el objetivo de mejorar la eficiencia en el sector, elevar la calidad de los servicios y extender la cobertura de la seguridad social a aquellos sectores poblacionales no cubiertos, todo dentro de un esquema de solidaridad y equidad. Sin embargo, después de más de tres años de su implementación, el sistema está aún lejos de cumplir sus objetivos. Las actuales estadísticas muestran que muchos peruanos no cuentan con un seguro de salud y que el actual esquema Público-Privado no es lo suficientemente amplio como para cubrir las necesidades de la población, especialmente los más pobres. Las compañías de seguros privadas (EPSs) aparentemente están orientadas a asegurar a trabajadores de empresas grandes, mientras que el seguro social de salud se estaría orientando a trabajadores de bajos ingresos. Otra característica de la reforma peruana es la escasa participación de las EPS en las provincias y su mínima participación en los seguros voluntarios. Estos hechos significarían que la reforma está aún muy lejos de alcanzar sus objetivos.

ABSTRACT

Since the middle of 1997, a health reform in the Peruvian social security system was implemented in order to improve the efficiency in the sector, to raise the quality of its services, and to extend its coverage to uncovered sectors, within a framework solidarity and equality. However, after almost three years of the implementation of this reform, the system is even further away from accomplishing these objectives. Current statistics show that many Peruvian citizens do not have a health insurance, and that the new Private-Public framework is not wide enough to cover the majority of the population, specially the poorest people. Private insurance companies (EPSs) seem to be oriented to insure large companies rather than small ones (the majority in Peru) while the public insurance would cover the low-income population. Other characteristics of the Peruvian reform are the scarce participation of these private insurance companies in the provinces and its minimum participation in voluntary insurance. Those facts would mean that the reform is still far away from accomplishing its objectives.

HEALTH REFORM IN THE SOCIAL SECURITY SYSTEM: THE PERUVIAN CASE*

Luis García Núñez¹

1. INTRODUCTION

Since the middle of 1997, a health reform in the Peruvian social security system was implemented in order to improve the efficiency in the sector, to raise the quality of its services, and to extend its coverage to uncovered sectors, within a framework of solidarity and equality. However, after almost three years of the implementation of this reform, the system is even further away from accomplishing these objectives.

Recent statistics show that many Peruvian citizens do not have a health insurance, and that the new Private-Public framework is not wide enough to cover the majority of the population, specially the poorest people. Private insurance companies (EPSs) seem to be oriented to insure large companies rather than small ones (the majority in Peru). Another problem is the scarce participation of these private insurance companies in the Peruvian market, especially in the provinces. In addition, the participation of EPSs in voluntary insurance has been very poor so far. In contrast, ESSALUD (the public institution) has been playing an important role in voluntary insurance.

According to those facts, there are other things that must be considered in order to analyze the Peruvian reform. First, the Peruvian Social Security System shows an intermediate degree of solidarity, but not as high as it should be. Solidarity is limited to the ESSALUD insured population, but not to the EPS insured population (or at least in a lesser degree). Second, our health system as a whole (Social Security System and the Public System) has problems of equity because very poor people with an independent job (informal) do not have access to the Social Security System because they cannot afford the primes of the voluntary insurance. Third, the principle of freedom of choice can not be exerted by most people, who do not have the same opportunities to choose their provider. Those opportunities vary, depending on the modality of insurance which people have or on the regime that the person is in.

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As a conclusion, even though the reform has tried to achieve its objectives, they are still far away from being accomplished. Unfortunately, in the near future they will not be achieved unless complementary reforms are instituted.

2. SOCIAL SECURITY BEFORE THE REFORM

Social security in Peru was developed in the twentieth century. Its beginning dates back to 1936 when the Labor and Domestic Employee Obligatory Insurance was created. Later on, in 1961, the Employee's Social Security was created in order to cover the formal employee sector. In 1973, both systems were merged through the Decree Law N°20212, which created the Social Security System of Peru. Later on, in 1980, by means of the Decree Law N° 23161 based on the Social Security, the Peruvian Institute of Social Security (IPSS, in Spanish) was created.

After the creation of the Social Security System, the health care system in Peru was mainly composed of two large subsystems: the Social Security –managed by the IPSS–, and the Public System –managed by the Ministry of Health. The second was aimed basically at the poorest sectors (which are most of the population) while the first was aimed at middle-class sectors. In addition, there were also (and there are still) private services, private insurance companies, military forces services and NGO's (See figure 1).

The IPSS was thought of as an autonomous and decentralized public institution, financed by means of contributions from the State, employers and workers. Its two key functions were granting retirement pensions and providing health care services to insured people (Delgado Aparicio 2000:26). For this objective, the IPSS and previous institutions built an extensive net of health centers nationwide, from Medical Posts to big National Hospitals.

The IPSS was the typical Latin-American Social Security Institution. It worked as a pay-as-you-go system, where health services and pensions were financed through contributions of insured employees and workers. Most of the insured people composed the “regular” category; they were employees and dependent workers who contributed 3% of their wages, while their employers contributed 6%. Besides the “regular” insurance, there was an “optional” insurance that was aimed at independent workers who contributed 9% of its revenues. The number of insured people through this second mode was fewer than the former. Both, the “regular” insured population and optionally insured population had the same benefits in health and pensions (see figure 2).

During the 80's, the IPSS suffered serious problems that led it to a situation of economic and financial uncertainty and that caused its future reforms. Besides the problems generated by the demographic transition, Peru, like most Latin-American countries, was hit by a severe economic crisis which translated into a reduction of IPSS's revenues and a larger demand for its services. Another problem that worsened the position of IPSS was its inefficient system fund management. In that decade a remarkable growth took place in its wage expenses and in its levels of employment, in addition to bad resource management (Durnbeck 1996:26,37; Remenyi 1993:11-12). Another problem that emerged was the deterioration of the ratio of the paying population to the insured (or protected) population; their rate was 40.1% in the mid 80's (Verdera 1996:359). This deterioration was caused by a remarkable increase in the coverage, mainly due to an increase in the health insured people who could also insure their relatives with no limits and with identical service rights to the regularly insured people had.

At the beginning of the 90's these problems caused a sharp deterioration in the quality of the service provided by the IPSS. This low quality of its services could be recognized by the very low per capita expense, whose index plummeted from 100 in 1985 to 44.7 in 1990, and to 85.1 in 1993 (Verdera 1996:399). Nevertheless, it was widely recognized that IPSS service quality was better than those of the public system, which were really deficient. Nevertheless this did not mean that IPSS services were good.

Regarding the nationwide coverage of the IPSS before the reform was never over one third of the population. According to Remenyi (1993:10), in 1988 it was 28.8% of the national population, although she states this figure was overestimated. According to Verdera (1996:362), that year the figure was of 24.6%. In 1996, the percentage was 26.6%, according to official figures (Delgado Aparicio 2000:434). It is also stated that there was a lack of coverage outside the capital city. Petrera and Cordero (1999:218) using data from a national survey estimated that the nationwide coverage percentage was 20.3% in 1997. This percentage rises to 29.5% in Lima City and 27.2% in the rest of urban areas, but diminishes to only 5.8% in rural areas.

Because of all these problems, during Alberto Fujimori's government and inside the framework of deep structural reforms, a reform in the Social Security was planned, which incorporated the private sector, following the Chilean model. In 1991, the Legislative Decree N° 718 was emitted thus establishing the Private Health System; however, the reform would only come true after many years, and the final result was different from the Chilean case.

3. THE REFORM

The transition from the old IPSS to the current Social Security of Health (ESSALUD) was carried out in several stages. The first one began in 1993 when the IPSS lost its paying function for pensioners, and the Office of Previsional Normalization (ONP, in Spanish) was created to pay pensions. Since then, the IPSS worked only as a health care provider for its insured population. Later on, in 1997 the subsystem of Health Care Providers Entities (EPS, in Spanish) was created through the Law No. 26790, “Law of Social Security Modernization,” and the Supreme Decree No. 009-97-INC. The EPS subsystem was created to complement IPSS's services. Finally, in 1999 the reform was supplemented with a new modification of the IPSS by means of the Law No. 27056, the “Law of Creation of the Social Security of Health”. This Law transformed IPSS now into the Social Security of Health or ESSALUD, an institution to which new functions and prerogatives were assigned. Both ESSALUD and the group of EPSs constituted the Social Security System.

These laws outlined the new structure of the Health System in Peru. The two parallel regimes were redefined. The first one is now the State Regime, composed by the public services in charge of assisting the low-income and non-insured population using the facilities of the Ministry of Health (of very low cost). The second one is the Social Security Contributory Regime, composed by the IPSS and supplemented by the private EPSs which would provide health care to those members who contribute to the system by means of both their employers' contributions and as the employees' voluntary contributions (see figure 3).

According to the reform, the main changes could be observed in the Contributory Regime of the Social Security in Peru², which shows four important modifications.

In the first place, two levels of assistance were defined according to the complexity of the illness and recovery costs linked to them. The first level is called the “Simple Layer,” which includes very frequent illnesses or ailments and whose recovery cost is relatively low. The second level of assistance is called the “Complex Layer” which includes those non-frequent illnesses or ailments but whose recovery cost is so high that it would risk the financial stability of the families.

² There are some important changes in the State Regime, but they are not discussed in this paper.

In the second place, the reform gives ESSALUD (former IPSS) insured dependent workers the opportunity to choose which entity will provide them “Simple Layer” services, either ESSALUD itself or an EPS. In case he or she chooses ESSALUD, contributions paid by employers will give them the right to receive “Simple Layer” services in ESSALUD’s network. On the other hand, if he or she chooses an EPS, they will receive “Simple Layer” services in private providers associated to each EPS. However, “Complex Layer” services will always be given in ESSALUD. The Law establishes that all the workers of the company should carry out the election of the EPS by means of vote. Also, the policies provided to workers of a company should have the same rights, independently of wages or the member's position in the company. This kind of insurance is called “regular insurance” (see figure 4).

In the third place, the reform allows independent workers –who then did not have any kind of insurance– to join the Social Security, choosing between ESSALUD or an EPS. In this case, the coverage of the insurance depends on which policy is chosen, a policy could cover fewer illnesses than the regular insurance. Besides that, all the services must be provided completely by a single company. This new insurance is called “voluntary”. It is important to note the differences between the old “optional” insurance and the “voluntary” insurance. The former had a prime of 9% of the declared revenues and offered unlimited coverage for his or her family; the latter has variable primes and the coverage depends on the amount of the prime. To accomplish this objective, ESSALUD closed the affiliation of new “optional” insured population, which should be replaced, gradually, by “voluntary” ones (see figure 4).

Finally, an autonomous regulatory organism, the Superintendence of Health Care Providers Entities was created. This institution has, among its functions, to authorize the operation of new EPSs, supervise the quality of the plans provided by the EPSs and their suppliers, and solve the conflicts that could emerge in the system.

With these measures, it can be inferred that the objectives that this reform aimed at were basically four (Garcia, 2001):

- Decreasing the crowds in ESSALUD’s services: insured workers who chose an EPS would not use ESSALUD’s services in the Simple Layer.
- The promotion of private investment and efficiency improvements: EPSs regimen promotes private investment in Health, both in medical facilities infrastructure and in insurance companies devoted to the field of health insurance. The private administration of health services should produce a better allocation of resources, in contrast to the Ministry

of Health (MINSA, in Spanish) or the old-fashioned IPSS, very large public entities with no efficiency incentives.

- Elimination of double insurance: Many insured employees in ESSALUD (former IPSS) never used this insurance due to the difficulties we mentioned; on the contrary, they or their companies hired other private insurances. With the new system, employees who choose an EPS do not need to hire additional insurances³.
- The expansion of the social security in general (ESSALUD and EPSs) to non-covered population: The EPS and ESSALUD by means of the modality of voluntary insurance aim at giving insurance services to non-dependent workers and informal workers. In Peru, independent workers compose a large number of the total amount of employed labor. According to the 1993 Census of Population and Housing, independent workers composed 35% of the employed population. (INEI, 2000) In this way, the low rates of insured population could be increased.
- Through competition, it improves the quality of the services: The law aims at generating competition in the health insurance market and in the related services market, competing by means of smaller bonuses and better quality services for the insured population. The competition should not only be limited to the EPSs subsystem but it should also take place between ESSALUD and EPSs, especially in voluntary insurance.

4. RESULTS OF THE REFORM IN PERU

In spite of the fact that reform was implemented only three years ago, the results obtained so far are still far away from achieving the objectives outlined by the policy makers. The key deficiencies found in the reformed system can be summarized as follows:

- Scarce participation of EPSs in the Peruvian market

In spite of the fact that EPSs have been given facilities for the opening and operation of the EPSs, since 1998 only four Health Care Service Providers were granted permission to work. In 1998, the operation of three EPSs was authorized: Rimac Internacional EPS, Santa Cruz EPS and Novasalud EPS. In October 1999, the company Pacíficosalud EPS joined them. Later on, in June,

³ Petrerá and Cordero (1999:220) show that in 1994, 1.5% of population hire two insurances: IPSS and a private insurance. This percentage diminishes to 0.6% in 1997, according to the surveys Encuesta Nacional de Hogares sobre Medición de los Niveles de Vida – ENNIV for 1994 and 1997. See also, Carbajal and Francke (2000:11).

2000, Rimac Internacional EPS acquired Santa Cruz EPS, this is the reason why only three EPS's operate now.

These Health Care Providers have concentrated their participation in Lima, the capital city of Peru, but they have had a scarce or minimum participation in the rest of the country. Moreover, it can not be observed that there is a desire of other companies to participate in this market since no new operation applications have been requested.

- Poor participation of EPSs in Voluntary Insurance

The statistics of the EPSs subsystem shows these companies have had an important growth in the regular insurance, however, they have had a poor performance in voluntary insurance (those aimed at independent workers). In the case of regular insurance, the first insurance was sold in February 1999. Since then the number of affiliated and insured population⁴ has grown steadily. By June 2001, there were 88,776 affiliated members and 239,390 insured people (see Chart 1). The situation is quite different in the case of the voluntary insurance. By June 2001 the number of voluntary insured people nationwide in the EPS subsystem was only 6,912, all of them insured by Novasalud EPS.

On the other hand, ESSALUD has had a different performance. Now this institution has 6.4 millions of regular insured people (almost all of them are the bequest of IPSS) up to December, 2000; and 249,767 voluntary insured people (see Chart 2). Most of the regular insured people were captured before the reform but voluntary insured population arose only after the reform. These statistics demonstrate the strong preference of people for the voluntary insurance provided by ESSALUD and not for the one of the EPSs. Also, ESSALUD has provided a large variety of voluntary insurances aimed at specific groups, such as university students, taxi drivers or agrarian workers.

⁴ Affiliated members are those people who pay for the insurance. The insured population includes all the people covered by the insurance.

- EPSs bias to large companies.

EPSs seemingly have as their objective to affiliate workers from large companies. According to statistics of the Superintendence of Health Care Service Providers (SEPS, in spanish), in December 2000 there were 969 companies affiliated to the EPS system. Fifty per cent of the total insured population belongs to the 30 largest companies that have an insurance contract with an EPS, and about 90% of the total belongs the largest 350 companies that have a contract with an EPS. In addition, the average of affiliated workers by work center is 248 people/work center. This shows an important bias of EPSs toward large companies despite the fact that most of the labor concentrates in small companies in Peru.

5. OTHER ASPECTS TO BE EVALUATED IN THE PERUVIAN REFORM⁵

In this section, the results of the reform in Peru will be evaluated according to the following points: the equity of the system, its solidarity, and the freedom to choose a service provider.

We state that, in the reformed Peruvian system, there are still equity problems, since most of the population –especially that of low income– has very few chances to receive good-quality services and to have a health insurance. The quality of the assistance they will receive will be in accordance to the amount they can pay or that the State can provide for them. In this way, there is an inequality in chances since high-income people can pay for private services while non insured low-income people only have one chance: being assisted in the public system of the MINSA. On the other hand, the insurance provided by ESSALUD and an EPS is within the reach of those people that have a dependent work, or those that can pay a voluntary insurance. In consequence, in Peru the health service one receives depends on the labor regime and on the level of revenues.

The Peruvian system also suffers of a lack of solidarity, which is limited to the Social Security insured population. This regularly insured low-income population that is affiliated entirely to ESSALUD has free access to expensive services that otherwise would be impossible to get. However, there is some solidarity for the regularly insured population in the mixed system ESSALUD-EPS since the EPS-insured population is registered in collective plans with identical coverage, independently of their income. In this way, in spite of wage gaps that could be found in companies insured populations receive the same services. Solidarity is weaker among voluntary

⁵ These topics were discussed in Garcia (2001).

insured population since the coverage of their insurance depends on the bonuses they pay. In the case of the State Regime (Public System), it is financed with funds of the Public Treasury and supplemented with direct payments from users. Here, there is almost no presence of crossed subsidies since services receive direct subsidies from the State. Finally, in other modalities, there are no elements of solidarity since each person receives the services he or she can pay for.

In the case of the freedom to choose of the health service provider, this varies depending on the modality of insurance that people have or depending on the regime that person is in. For those people with no insurance, the freedom to choose a health service provider depends on its economic possibilities. Very low-income people can only be served in MINSA's public facilities due to their very low rates. For them, in fact, there is no freedom of choice. On the other hand, the regular insured population that is entirely in ESSALUD also has problems in choosing the medical professionals they want. This institution forces its insured population to be served in certain hospitals or clinics of ESSALUD according to geographical approaches, with no chance to change the facility. As a result, a user that is not happy with the service that he or she receives can not choose another provider.

Those who are insured in the mixed system ESSALUD-EPS in the Simple Layer can exert freedom of choice. These people can choose among the diverse providers of the EPS itself or third parties' with which the EPS has subscribed agreements. On the contrary, in high complexity services (complex layer), there are very few alternatives (in fact only in ESSALUD) unless the insured population has the economic capacity to finance those services on its own or with its EPS. Finally, in the case of the voluntary insured population, this category also suffers the problem of lack of freedom of choice, since factors like age and gender, as well as the existence of previous illnesses limit this election. So, the freedom to choose will depend on the economic capacity of the insured population.

6. CONCLUSIONS

At the end of the 80's and the beginnings of the 90's, the Health System of Social Security experienced many problems, which forced a reform of the sector, both administratively and in its objectives. The main problems we found were the inability of the old IPSS to provide good-quality services and readiness in their provision, due to economic problems that were caused by the economic crisis and a bad management of the institution. Additionally, the IPSS had problems when trying to expand its coverage since it could only cover a quarter of the population.

For this reason, in the second half of the 90's a reform was implemented. It was aimed at expanding the coverage to uncovered sectors, to improve the efficiency with competition, to decrease the crowds in ESSALUD's services, to avoid double insurance and to promote private participation both in provision and financing of the services

After three years of its implementation, the reform in Peru has improved some aspects in comparison to the previous situation, but it has had problems the market has not been able to solve, like solidarity limitations, inequity and the limited freedom of choice. Therefore, in my opinion some changes should be carried out aiming at correcting these problems.

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Figure 1
The Health System in Peru before
the reform

Others*
Social Security IPSS
Public System MINSA

* Include insured to Military Forces, other private insurances and other non-insured people.

Figure 2
Structure of the Old Social Security
System in Health

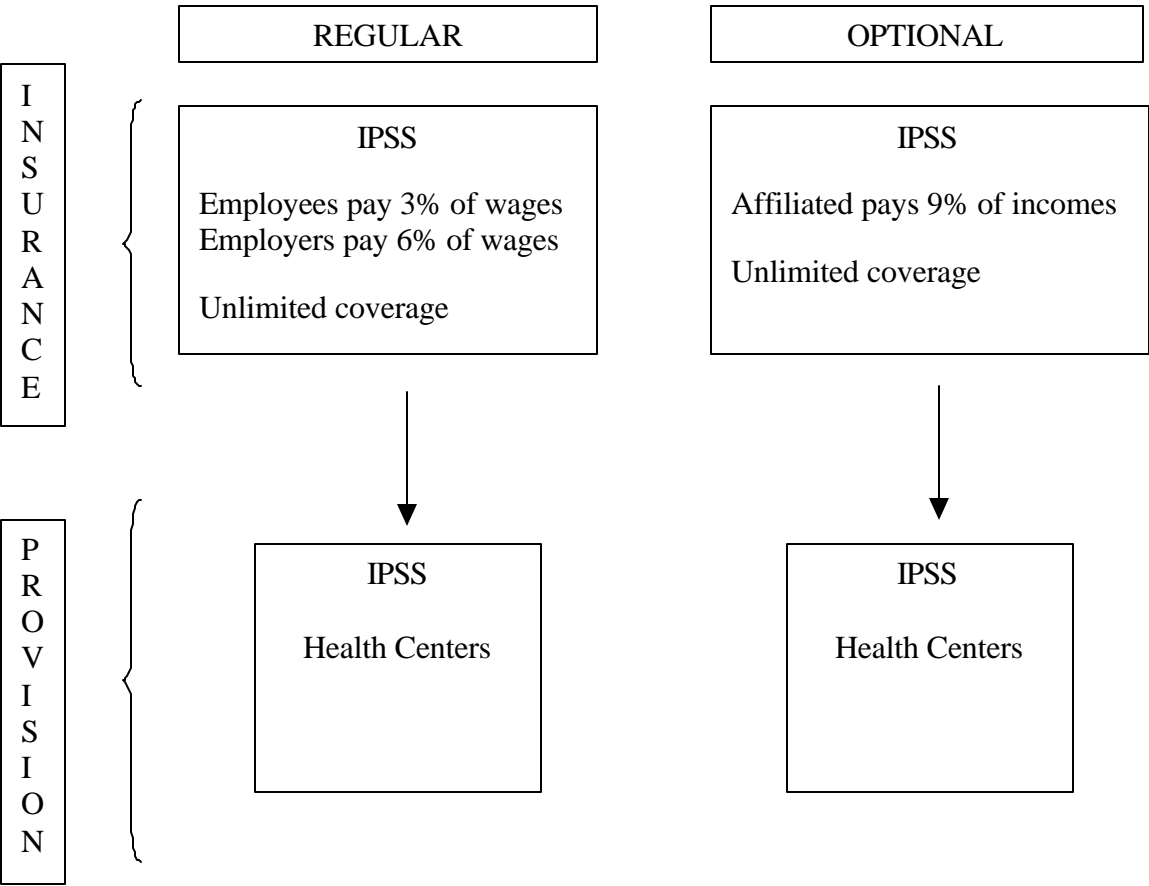


Figure 3
Current Organization of the Health
System in Peru

Others*
Social Security Contributory Regime ESSALUD and EPS
State Regime MINSA

* Include insured to Military Forces, other private insurances and other non-insured people.

Figure 4
Structure of the New Social Security
System in Health

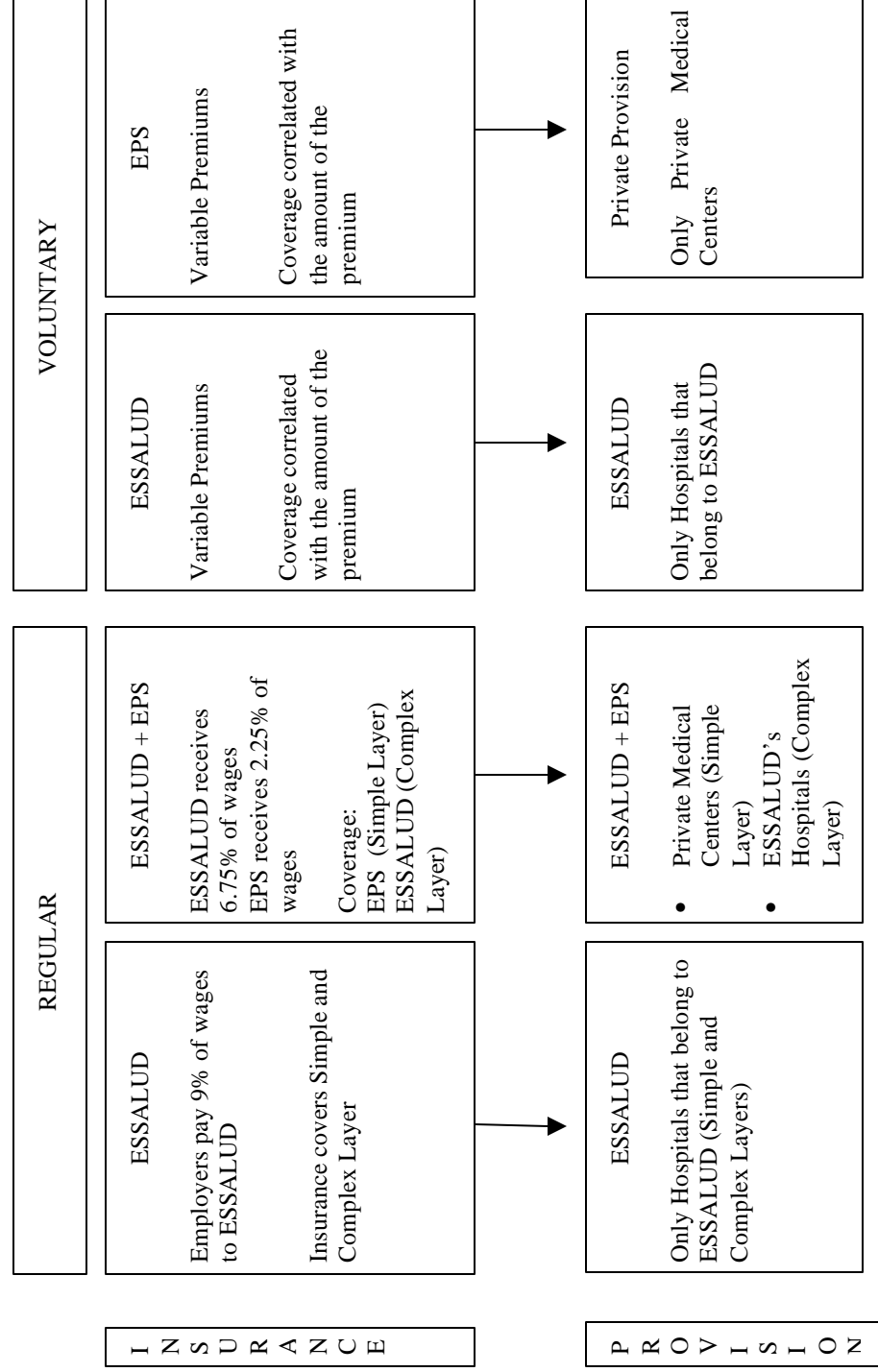


Chart N° 1
Affiliated and insured people by type of insurance in
EPS subsystem – June 2001

EPS	Regular		Voluntary	Total (A+B)
	Affiliated	Insured* (A)	Insured (B)	
Rimac Internacional	27,552	77,347	0	77,347
Novasalud	37,389	100,597	6,912	107,509
Pacificosalud	23,835	61,446	0	61,446
TOTAL	88,776	239,390	6,912	246,302

Source: Superintendencia de Entidades Prestadoras de Salud

* Include workers and their insured relatives.

Chart N° 2
Affiliated and Insured population of ESSALUD by type of
insurance – December 2000

Type of insurance	Affiliated	Insured
Regular insurance, special regimes and pensioners	2,633,134	6,405,123
Latent population*	27,512	67,597
Voluntary	203,668	249,767
TOTAL	2,864,314	6,722,487

* Includes those people who lost their jobs but are still insured for six months.

Source: ESSALUD