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An Overview of Health Care Privatisation in Latin America

by Dominique Hierro & Peter Wrede

The privatisation of social security systems is an exciting experience for a country's insurance industry. Not only does it almost always increase the industry's growth potential by a significant degree, but it also changes the regulatory environment, customer needs, and the market place in general. The intent of this article is to show the diversity of results brought about by partial privatisation of social security health care systems in four major Latin American insurance markets.

Mexico

The Mexican Social Security Institute (IMSS) was created in 1943 and was operated by the state. Benefits were financed by contributions made by

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International Opportunities for Stable Value

by Paul J. Donahue

Stable Value and Its Foundations

Stable value is among the defined-contribution plan options most popular with participants. In 1998, despite the dilution caused by six years of booming equity values, stable value options contained 11.7% of corporate defined-contribution plan assets.[1]

Key to the popularity of stable value is its offer of a guarantee of principal with higher returns than those available in money market funds. What makes a guarantee of principal possible for stable value, as for money market funds, is accounting for assets at amortized cost and accrued interest ("book value"). Credited interest is determined in a way that reduces return volatility, which is another characteristic investors find highly desirable. The foundation for book value accounting for defined-contribution plan assets is compliance with the American Institute of Certified Public Accountants Statement of Position 94-4 ("AICPA SOP 94-4").[2]

Characteristics of the Market Demand for Stable Value

Stable value is an option popular both with conservative investors and with investors who want to moderate the overall volatility of the return of their portfolios.[3] This fits the return profile of investors outside the United States far better than it does domestic investors, especially since the equity boom of the middle and late '90s has dramatically increased the degree of comfort individual investors have investing in equities.

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In This Issue

article, which will be continued in the next newsletter edition, several different aspects of the Chinese insurance industry are addressed: industry growth, products, distribution and management issues.

The second part of Chiu-Cheng Chang's and Geraldine Chen's article "A Social Security System for the 21st Century," appears in this issue. The authors first review summarized significant secular trends that will continue into the next century, which was covered in depth in the June 1999 *International Section News.* Then they proceed to document the drawbacks of pay-as-you-go social security systems in the context of these trends and describe the essential characteristics of social security programs well suited for the 21st century.

The final topic to be addressed in this column is not a new one. I would like to take advantage of one last opportunity to encourage Section members to contribute material to be published in the newsletter. My discussions over the years with actuaries involved in the international arena have convinced me that many Section members have expertise and experiences that would be of great interest and value to readers of this publication. As stated in the last edition, while we frequently have a significant amount of very good material, we never have an excess of articles for the newsletter. Please consider submitting an article to *International Section News.*

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An Overview of Health Care Privatisation

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employers, employees and the government, and it was designed to cover health, maternity, short and long term disability, old age pensions, etc.

Although the IMSS law originally provided for employers to opt out of the system in favor of a private organization-sponsored program, only a few companies took advantage of this provision. The most notable exception was commercial banks that gained this concession in 1957. Other companies opted out of the IMSS either because they already had an organized health care service program for their employees prior to the appearance of the IMSS (e.g. the state oil company PEMEX), or because they operated in remote areas where the IMSS had no facilities (e.g. mining companies). Entities that emerged after the creation of IMSS and that offer health services to well-defined sectors included ISSSTE (for government employees) and ISSFAM (Military Forces). People with the lowest incomes who were not affiliated with any of the organizations above could approach public health institutions such as SSA (Secretaría de Salubridad y Asistencia), the Red Cross, or INI (for indigenous people).

In 1996 the social security law was reformed. As a result, some of the contributions collected for pensions are now administered by private sector AFORES (Retirement Funds Administrators), where every member has a personal account for retirement. This reform has increased the financial strain on the IMSS administration since funding for health services is insufficient and had been subsidized by retirement funds. Furthermore, due to the lack of cost control measures, inflation in drug, medical equipment, and hospital costs continues to increase in Mexico at a rate of 15% or more per year.

New measures are necessary to improve the quality of health care services available to all citizens of Mexico. Patients and providers lack confidence and trust in the health care system. Although theoretically every citizen is covered by public health services, an important percentage of the total population has no access.

In April 1999, the Mexican government developed legislation that (1) describes how qualified organizations should establish themselves as insurance companies in order to offer comprehensive health coverage, and (2) stipulates which authorities will regulate their management. By the middle of 2001, these companies must be working as independent entities that offer health services. This proposed legislation has been approved by the House of Representatives, but not yet by the Senate. Even so, in early 1999, one of the health insurance market leaders had already set up an independent company offering comprehensive health insurance coverage on an individual and group basis. Once this law is approved, the Mexican government, in coordination with the IMSS, will establish rules to regulate the exit of individuals or groups from the IMSS health care program, a process referred to as "subrogation of services with fee reversal" ("reversión de cuotas"). This could take place after the presidential elections in 2000.

It is difficult to predict the extent to which privatisation of Mexico's health care system will fuel the market for private health care plans, health care insurance products, and reinsurance coverages. However, as the number of private major medical expense policyholders now represents less than 3% of the total population of Mexico, health care privatisation is likely to bring enormous opportunities to industries involved in health care.

Currently, the market for major medical expense insurance on an individual basis has 522,466 lives insured, with US$200 million in premiums, which is an average annual premium of about US$400 per member. On a group basis there are approximately 1.8 million lives insured, producing US$270 million in

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premiums, at an average annual premium of about US$160 each. Employees who have the IMSS coverage often also receive a private group major medical expense policy from their companies, and instead of using the IMSS facilities, prefer to pay for their own private elementary care not covered by the group policy. This indicates that these persons are likely to be favored by the health privatisation initiative that will give them comprehensive medical care coverage at a level more in line with their socio-economic situation. Obviously, this can be expected to have an impact on the market for group medical expense insurance.

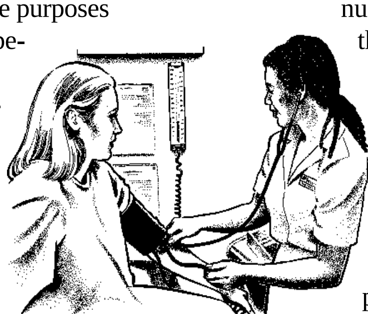
Since 1995 the main insurance companies in Mexico and the newly created health care network administrators have offered comprehensive health coverages similar to U.S. health maintenance organisations (HMOs) to banking institutions which formerly managed their own health plans and networks. One of the purposes of this activity was to gain experience and expertise before subrogation of the IMSS services. Insurance companies not yet involved in comprehensive health care programs will undoubtedly consider participation, and foreign enterprises are finding attractive new opportunities for investments in Mexico.

Chile

Chile is well known for early privatization of the state pension system, as it inspired many other countries in Latin America to do likewise. Chile was the first Latin American country to privatize the public health system in 1981. It created a system which, unlike the pensions model, has not been copied anywhere, possibly because of some very unique features.

Chile's health system has not been completely privatized. Rather, it allows individuals to opt out of the social security public health system FONASA (Fondo Nacional de Salud) if they contract private cover with a so-called ISAPRE (Institución de Salud Previsional), without the public system being abolished. The advantages of private cover include freedom of choice, better hospitalization standards, and no waiting lists.

Both FONASA and ISAPRE require individuals to make the same contribution, namely, 7% of their salaries, with an upper limit. Whereas FONASA is a typical pay-as-you-go system, the same amount of contribution is used to fund actuarially calculated individual premiums with the ISAPREs. This is what makes Chile's private system unique: while contributions are based on salary, premiums are calculated according to risk factors like age and sex. The scope of cover becomes the only variable parameter if the premium is pre-determined, i.e., if 7% of a person's salary is not enough to buy fully comprehensive cover because of, for instance, advanced age or number of children, then the cover obtained for this fixed contribution is reduced accordingly. This has compelled the 36 operating ISAPREs to offer thousands of rates in a country with a total population of less than 15 million, which differ according to the scope of cover, age, sex, dependents, and state of health. As can be expected, this diversity has an impact on the product administration of the providers and on the degree of information required by buyers.



The extent of cover differs mainly with regard to the inclusion of dental or psychiatric cover, the maximum number of hospital or intensive care unit (ICU) days paid for, percentage of co-payment, etc. Therefore, if a contribution does not allow for a very comprehensive plan, the contributor can be left with a significant share of the cost in case of a serious illness. Moreover, if the contributor's income does not increase in line with the annual risk premium, health benefits will reduce over the years, and cover that was once comprehensive may become insufficient.

The unique Chilean model has not entailed major inconveniences for the covered population for a number of reasons:

- People are free to make additional contributions, subject to underwriting, if they feel that 7% of their salary will not buy adequate cover.
- Access to FONASA is not always strictly supervised. This allowed individuals with less than comprehensive private cover to receive treatment without having paid for it from the public system, which has a good reputation for treatment of serious diseases.
- People can switch back to social security on retirement, as their risk premiums increase more steeply with age or they cease to be eligible for a group scheme (which tends to have a greater degree of "solidarity" than individual plans).

Furthermore, the situation has created a market for supplementary insurance aimed at covering gaps in individuals' ISAPRE cover. However, the existence of supplementary insurance to cover co-insurance payments under the ISAPRE plan negates the desired influence on customer behavior that was the intent of this cost-sharing element of product design. Thus, ISAPREs are not always happy with this interference. These covers, which are obviously difficult to price due to the wide variety of ISAPRE plans, are generally offered by insurance companies, usually include significant deductibles and co-insurance over and above that which is paid for by the ISAPRE, and are rather inexpensive.

This could be read to imply that ISAPRE cover is generally sufficient. Yet, reported cases of inadequate health coverage can generate spectacular publicity in the media, fueling the population's worries about the adequacy of their protection and a demand for additional insurance. One of the peculiarities of the system is a subsidy to lower income earners, which has made the system available to most socio-economic groups despite the possible incongruence between an individual's actuarially derived premiums and salary-based contributions. Today 3.9 million persons have ISAPRE cover, almost 30% of the population. Therefore, the adequacy of cover is repeatedly questioned and studied by different groups, and several suggestions have been made, such as marketwide jointly financed catastrophe funds, without an indepth reform as yet.

Another aspect which has received attention both by the media and study groups is that ISAPREs do not charge level premiums for a cover supposed to be whole-of-life, but yearly risk premiums instead. These increase steeply with age, endangering the affordability of coverage for the elderly. Studies in 1995 indicated that this is not a serious problem because as they grow older, people have paid up their mortgages and have stopped paying for their children's health insurance and are thus able to afford higher health insurance premiums. However, the system is relatively new and most of its members are young and healthy, as currently, only 4% are above age 60. In addition, investment returns in the privatized pensions system were excellent until the mid-1990s, making Chilean pensioners relatively affluent. These factors will have influenced the result of the studies and it is therefore likely that the level premium approach to health insurance, as in Germany, for example, will receive further attention.

Colombia

The decision to amend Colombia's social security system, which was comparable to Mexico's, was driven by growing discontent, as a large part of the population was not really covered. An indepth restructuring of social security was undertaken in 1993, with the intention of offering adequate health care for everyone.

The core of Colombia's new health system is the Plan Obligatorio de Salud (POS), which intends to provide comprehensive coverage using efficient, although not necessarily leading edge, technology. Use is made of treatment protocols, diagnosis-related groups, generic drugs, and an emphasis on preventive medicine, while excluding experimental and cosmetic treatments.

Adherence to the new system is through either the "regimen contributivo" (contributory subsystem) or the "regimen subsidiado" (subsidized subsystem). Employees, pensioners, and the self-employed are compelled to join the contributory system if their incomes are sufficient. The contribution is 12% of salary, limited to a maximum, 8% of which is paid by the employer. This includes family members who are covered without additional cost. For those without the means to make contributions, the system provides subsidies financed by one percentage point of the contributory system's revenue, through a "solidarity fund," and then by direct transfer from the state. This external funding of the regimen subsidiado aims at granting comprehensive coverage to the whole population by the year 2001.

"Another measure to safeguard EPS stability is the obligation to (re-) insure the cost of treatment in respect of a defined set of serious diseases like cancer or cardiac surgery..."

Two fundamental elements in the organization of health care and maintenance are the EPS (Entidades Promotoras de Salud) and the IPS (Instituciones Prestadoras de Servicios). The IPS is an organization of providers who can have ties with the EPS while maintaining their technical and financial autonomy. EPS companies are the real backbone of the system's organization, as they guarantee to provide their members with health care in exchange for a per-capita payment known as UPC (Unidad de Pago por Capitación). The UPC, including a margin of 15% for EPS administration, amounted to approximately US$130 per person per year in 1999 and is intended to cover the average POS cost. Although the above mentioned contributions are collected by the EPS, they are funded by the UPCs according to their affiliations. If the contributions they collect are more than this amount, the excess has to be transferred to the solidarity fund—from which they would otherwise get the difference—in the event the contributions fall short of the required UPCs.

This element of cross-subsidization shows one paradigm of the system: the user's freedom of choice (between competing EPSs as well as between different IPS providers who have agree-ments with one EPS) which is intended to promote quality through competition. As may be expected in the social security context, EPSs are not allowed to reject applicants, unilaterally cancel affiliations, or apply loadings or other "discriminatory" measures to individuals. There are, however, different co-payments as a means of cost control, and additional funding dependent on the person's salary. There are also waiting periods for some treatments in order to prevent a financial crisis in the still-young EPS system. Another measure to safeguard EPS stability is the obligation to (re-)insure the cost of treatment in respect of a defined set of serious diseases like cancer, cardiac surgery, neurosurgery, major trauma, congenital disease, chronic kidney failure, and others. This has created a vast market for excess of loss insurance and for reinsurance, as local insurers tend to retain little or no risk.

Apart from providing the POS health care, the EPS are responsible for maternity leaves, short term disability, workers' compensation health care, and promotion of health. There are certain areas of health care not covered by EPSs, e.g., vaccination, drug abuse prevention, various traffic accidents, and catastrophes. On the other hand, they are free to sell complementary insurance to cover superior hospitalization services, state-of-the-art diagnostic technology, and treatment abroad, which can only be bought by persons already affiliated with an EPS.

Due to their different backgrounds and history (e.g., pension liabilities), the former social security public hospitals are in

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a unique situation. As these hospitals are expected to compete against other IPSs in the provision of services, the whole public hospital sector is undergoing changes aimed at improving its competitiveness through technical and financial autonomy, and at contributing to a geographically comprehensive supply of services; there is also some subsidization here.

Affiliation to the EPS started in 1995. Since then, 47% of the population of 38 million is said to have joined the system, of which 66% belong to the contributory system. This shows that the Colombian privatisation of health care, a very ambitious and unique project, is still in a state of transition towards complete implementation. Even so, it has brought about a radical change involving not only the (former) social security sector and health care providers, but also the insurance industry.

Brazil

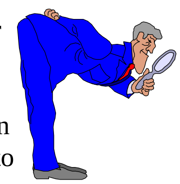
Although not really privatisation as such, the changes to Brazil's health system are worth mentioning. It has not been stipulated that anyone covered by the social security health system can actually opt out of it, but recent political efforts are directed towards relieving the social system by ensuring that the 40 million persons who have (additional) private health care will receive truly comprehensive cover. A motivation for this is the poor funding situation of the public system (SUS, Sistema Unico de Saúde), which has not been noticeably relieved by measures such as a tax on financial transactions introduced several years with the intent of collecting additional revenue for the SUS.

The core of the recent reform package is proper supervision of non-insurance health care providers and an obligation to offer truly comprehensive protection. For historical reasons, service provider associations and other companies offering products comparable to insurer's policies have not been subject to the same degree of supervision; now, similar solvency, reserving and auditing regulations as for insurance companies will apply to all. The augmentation of coverage includes removing upper limits to covers (which used to apply to the duration of hospitalization or intensive care unit stays, among others), as well as the compulsory acceptance of any applicant. Originally, all health care providers were compelled to offer a choice between a two-year exclusion of pre-existing conditions or a loading. This is a measure which exemplifies the political reasoning, although it did not always coincide with the insurance industry's point of view. In fact, as loadings were generally not used in health insurance in Brazil, companies usually did not know which loadings to apply, which led to some insurers charging exaggerated loadings just to prevent customers from choosing that option. As a consequence, the measure has been postponed until next year. Other examples of the impact of political reasoning are the requirements that premiums must be level for ages above 60 (they may increase only through adjustments for inflation, but not for age alone), and that premiums for this most expensive age class may not be more than six times those of the lowest cost age class. Both rules have raised criticism from the industry's actuaries.

The rationale of these measures may be viewed as a way (1) to relieve the social system by motivating those with private cover to avoid using SUS, despite the fact that they continue to contribute to the public system, and (2) to possibly induce more people to rely upon the now well supervised private system.

Obviously, imposition of more generous cover resulted in increased premiums (increases were subject to specific rules), but this increase does not seem to have driven many individuals to cancel their private cover, although new business growth was considerably suppressed. To some extent, cost increases have to be absorbed by the carriers through a narrowing of their margins and the use of more sophisticated cost-containment measures. Generally, the reform has had less impact on insurance companies, who had already been subject to reserving, solvency and pricing supervision rules, and who had generally offered quite comprehensive cover. Large insurers also had easier access to "managed care" cost-containment techniques. For the small to medium carriers, the reform brought about an increased need for risk transfer and assistance, which can be satisfied by insurers and skilled professional reinsurers.

Outlook



Changes in several other markets including Argentina and Peru confirm that privatisation of health systems tends to be specific to each country, but it is still worth studying experience elsewhere when designing a country's approach (as shown by the Colombian influence in Peru). Even countries not considering privatisation continue to reform their health systems (e.g., certain countries in Europe) because the provision of ad-equate health care for all citizens is a major challenge for every government. Therefore, international experience is highly valuable, either to participate in the design or reform of a country's health system, or to anticipate consequences to the insurance industry of any envisaged changes to the system.

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