Exclusion, fragmentation and lack of political will

Four out of five Paraguayans do not belong to any health insurance scheme. The reasons for this high rate of exclusion include the fact that the system is geared to salaried workers, evasion of mandatory contributions, and inequities stemming from income levels. Meanwhile, only three out of ten older adults receive a retirement pension. The radical restructuring of the social security system requires a broad consensus among the whole population, and a series of medium-term measures are urgently needed.

DECIDAMOS, Campaña por la Expresión Ciudadana
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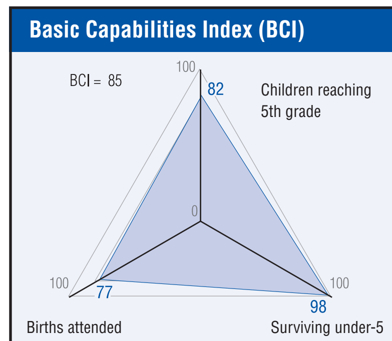
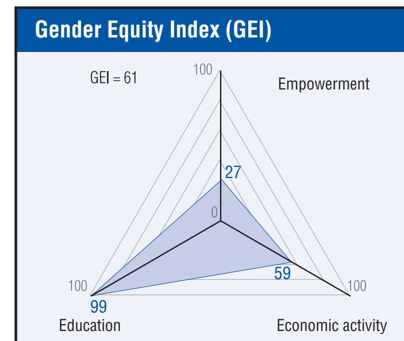
Basic Capabilities Index (BCI)



Gender Equity Index (GEI)



More than 10 years ago there were proposals to reform the social security system, and the main objectives were equitable access to health services, universal primary coverage and structural reforms (Barreto and Ramírez, 1997). In subsequent years a series of reports showed that, in terms of rights, there are wide gaps caused by exclusion and inequity in the system, and by the government's failure to honour its constitutional and international commitments as regards social security (Amarilla, 2003).

In 2003 Holst diagnosed the main problems in the social security system, and the list included low coverage, a poor ratio between contributions and benefits, high rates of evasion, discontinuity of contributions, increasing informality in the labour market, the financial deficit, high costs and inefficient administration. To a large extent this situation was rooted in both longstanding shortcomings in the local system and the problematic characteristics of employment and increasing poverty that are common to many Latin American countries.

The weaknesses that Holst identified are still with us. It is true that in recent years the way that social security and health care provision are managed has improved – mainly in terms of efficiency – but these changes have been merely parametric and not structural.

In this report we outline the problems that still need to be tackled. Our study is based on an analysis of recent statistical data, interviews with key actors in the social security administration in Paraguay and documentation from the Social Security Institute (IPS).

Social security in health

Lack of protection and inequity

In Paraguay only one person in five has any kind of medical insurance. This means that four out of every five Paraguayans, 78.5% of the population to be exact, have no insurance at all. In certain sectors the situation is even worse: 91% of the rural population and 98% of the very poor are without coverage (DGEEC, 2005; PAHO, 2003). Data from the General Statistics, Surveys and Census Board (DGEEC) show that rates of non-protection have always been high, and between 2000 and 2005 IPS coverage increased slightly, from 10.9% to 12.5% of the population (DGEEC, 2005).

Coverage is low for various reasons: the system is geared to workers employed in enterprises, there are high rates of evasion of the compulsory regime, and many people are excluded because of inequities in society stemming from income inequality. Some 1.4 million Paraguayans cannot join the public health insurance system because they are self-employed, unpaid family workers, employers, peasants or indigenous people (DGEEC, 2005).

Domestic employees have only limited social security coverage, and in the capital city only 10% of these workers are effectively eligible for benefits (Soto, 2005). Social security for domestic workers was initiated in 1967 but only for accidents, illness and maternity, and coverage for long-term contingencies was explicitly excluded. Also expressly excluded from social security are *criaditos*,[1] housewives, and anyone else who does domestic work within the family (Valiente, 2005).

In the last three years the IPS authorities have submitted proposals to parliament for bills to incorporate central administration employees into the system, and also some independent employment groups including taxi drivers. These initiatives have received international recognition, but as yet the legislature has not even considered them.

It has been estimated that some 70% of Paraguayans evade the compulsory social security regime (Holst, 2003). In the last three years direct contributions to the IPS increased by 33%. This rise might be partly because the records are now being kept more correctly, but there is no doubt that it is mainly due to the effective incorporation of new contributions, and this is confirmed by the increase in IPS income and the IPS budget (IPS, 2006).

Another factor here is that at no time since the IPS was set up in 1943 has the state made its full financial contribution to the system, so in fact, although it might seem paradoxical, the worst offender when it comes to evading IPS contributions is the state itself.

Inequality and exclusion from coverage stand out more starkly when we consider social security contributions by level of income. In the lowest income quintile only 3.1% of working people contribute to the system, while in the highest income quintile the figure is 22.7% (ECLAC, 2006). The fact that a person has public or private medical insurance does not necessarily mean that they make use of it.

The extent to which services are utilized in the case of illness differ depending on the kind of insurance in question, income level and geographical area, and rates of inequality and exclusion differ not only between different sectors but within sectors. Thus, although people in the rural sector and in the poorest population quintile are in greater need of medical attention, their levels of insurance and the rate at which they consult medical services (when these are available) are considerably lower.

There is no doubt that the pressing need in the field of health care provision is to remedy this situation.

1 Adolescents who do domestic work in exchange for board and lodging and (in some cases) education.

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The fragmentation of the system: a structural problem

The social security organizations and their service providers tend to be rather fragmented, and there is little coordination among the institutions or the main actors involved (Flecha *et al*, 1996).

Explicit insurance is mainly handled by the IPS in the public sector and by pre-paid medical care enterprises in the private sector. Only 21.5% of the population has health coverage, and this is divided between the IPS (12.5%) and other kinds of insurance (9%) (DGEEC, 2005). It is estimated that in the latter category, 7% have private medical coverage and the rest are in various institutional systems like the military, the police, cooperatives and community insurance schemes (Holst, 2003).

Medical attention for population sectors with lower purchasing power and without access to the IPS is provided by the Ministry of Public Health and Social Welfare (MSP) as an implicit insurance mechanism. However, up to 40% of the uninsured population do not consult the public medical care services in the case of illness (DGEEC, 2005).

In recent years there have been several community insurance initiatives in areas of the country outside the capital, and some have been successful, like the Fram community insurance and Caazapá integrated health insurance schemes. This is an encouraging trend, but these initiatives have very limited scope in the context of the country as a whole (Güemes *et al*, 2005).

The IPS is by far the most important social security system in Paraguay. It is the only organization whose provision model covers the whole range of health services with medicines, pensions, retirement pensions, and payments for illness, maternity and workplace accidents. What is more, when it comes to certain illnesses, the IPS range of benefits is seen as the most viable option in economic terms among the explicit insurance systems, and in some cases as the only possible option.

The IPS insurance model is financed by tripartite contributions from salaried workers (up to 9% of pay, depending on the employee's profile), employers (14%) and the State (1.5%). Private insurance coverage is more limited and geared to the population with greater purchasing power. To bring it up to a benefits level similar to the IPS, people would have to pay the equivalent of 20% or even 50% of the current minimum wage, depending on the insurance company and the kind of insurance plan acquired. This contrasts with the 9% mentioned above in the public social security system.

Unlike the IPS, private insurance schemes do not provide coverage for epidemics, congenital conditions, pre-existing illnesses, alcoholism, psychiatric illness or accidents. Nor do they cover haemodialysis. Intensive therapy can be provided, depending on which plan is chosen, but coverage is rarely total. The provision of medicines and disposable supplies is very limited; it varies depending on the plan and there is a period in which payments must be made but the user is not yet eligible for the service. Chemotherapy, immunosuppressants and other high-cost medicines are not included. All this means that, for some illnesses, the people insured still have to meet high hospitalization charges and pay for very expensive medicines (PAHO, 2006).

It is common for workers to contribute to both the IPS and a pre-paid medical system because they have more than one job, or a preference for the perceived quality of the care provided, or because treatment for certain illnesses is limited in the private sector. However, when this is the case no compensation is paid for services used.

Health insurance is also unsatisfactory in Paraguay when it comes to global health problems. Neither the IPS nor the private insurance schemes treat people living with HIV/AIDS. This is handled exclusively by the PRONASIDA programme, which is run by the MSP with support from international cooperation agencies and civil society organizations.

Only one organization, the MSP, plays a role in preventive health care. The explicit insurance systems take no practical measures to promote prevention for their members. For example, the IPS only recently undertook to purchase contraceptives for 2007. It also transfers 1.5% of its income to the MSP for preventive programmes and for the fight against malaria. Between 2003 and 2006 the amount involved came to around USD 12 million (IPS, 2006).

The poor quality of public services

Reports in the local press and complaints from users suggest that the perceived quality of public sector services is inferior to that of systems geared to population sectors with more purchasing power.

A recent World Bank study (2005) showed that there are no significant differences between the rich and the poor on an index to evaluate doctor-patient interaction (duration of consultations, questions, checks). But on the other hand, the same study reveals that IPS doctors perform more poorly, with approximately five minutes, five questions, and two checks less in social security system centres than in MSP health centres.

To improve its organizational quality, the IPS has taken a series of measures that include strengthening outlying clinics, incorporating more human resources, setting up a computerized management system with a single registration using the identity card, and a new scheme to make appointments by telephone. This initiative began in 2004 and was consolidated in 2006, and it covers around 13% of all appointments made (IPS, 2006). The real impact of these innovations on processes and results has not yet been evaluated.

Retirement and other pension systems

Segmentation, non-reciprocity and inequality in contributions

In Paraguay there are at least eight contributory schemes working alongside each other. The most important are the retirement scheme for public officials employed by the central administration and the IPS system for private sector employees and people working in decentralized organizations.

This loose and uncoordinated structure makes for inequality. For example, there is great variation in the time period of contributions to qualify for a retirement pension, from 10 years in the pension scheme for members of parliament to 30 years in the general IPS regime for all workers. The age requirement also varies: women teachers can retire on a pension when they are 40 years old but men and women in the general IPS regime can only do so at 60.

Very often people will work for different employers during their active lives and move from the public system to the private or vice versa. However, contributions to different systems are not recognized under the current law, so a sector of workers who are helping to maintain the system with their payments will not receive the corresponding retirement pension even though they have been making contributions for the required number of years or more.

To tackle this problem, and in line with ILO recommendations and the Mercosur Social Security Agreement, a bill to reform the current legal framework has been submitted to parliament. This is aimed at establishing reciprocity among the various pension schemes and giving a worker who is 65 years old the right to a retirement or disability pension that is proportional to the number of years of contribution (Frutos and Ferreira, 2007).

Low coverage: exclusion from the model

Only three out of ten older adults are covered by a retirement pension system. In 2005 there were only 93,000 people in the country receiving retirement or other pensions, and only 22% of the economically active population is contributing to this segmented system (Frutos and Ferreira, 2007).

There are differences in access to retirement pensions that depend on socioeconomic level and geographical area, and these follow much the same pattern as in the case of health service provision.

However, the main determinant of exclusion is that the social security model is exclusively geared to salaried employees, which automatically excludes 60% of the economically active population (DGEEC, 2005).

In the last three years the IPS has undertaken administrative and legal initiatives aimed at widening the coverage it provides, not only by reducing evasion from the compulsory contribution regime in the private sector, but also by incorporating into the system excluded sectors of the population. However, these initiatives have not led to any legislative changes and in some cases they have not even been considered.

Conclusions and suggestions

The government has made and reaffirmed commitments to the universal right to social security, but in practical terms very little has been achieved. Retirement pensions and health services are still fraught with low levels of coverage, exclusion and inequity.

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To rectify this situation there will have to be structural reforms in the social security system. This is easy to say but it will not be a simple process; it will call for policies that are based on a wide consensus among citizens of the country at all levels.

While this major process of change is taking shape, there is no reason to postpone intermediate measures like the different pension schemes granting each other reciprocal recognition, excluded groups being systematically incorporated into the system, the legislature dealing with the dozen or so bills on these matters that have been shelved, the state meeting its financial obligations to the social security system, the coordination of services between sectors, and the implementation of policies to cater to lower income sectors and unpaid workers.

For the system to really serve the whole population there will have to be a complete change of approach. ■

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Final note

The long-term solution to poverty in the Philippines is robust, *equitable and broad-based* sustainable economic growth. Even if the Philippine economy seems to be shifting to a rapid-growth track, there are few social mechanisms in place that could pull the rest of the population out of economic and social deprivation. The reality for the vast majority of poor people is that social services are unavailable, or are skewed towards the needs of the rich, or are dauntingly expensive – and this drives up social inequality.

Yet social protection contributes immensely to economic development, and the nice thing about it, according to Obermann *et al* (2006), is that it can be implemented independently of the current economic situation. For starters, they suggest merging the national programmes with community-based health care financing schemes, and creating the environment for high quality care and improved physical access. Aside from reforms in contribution and benefit structures to remove inequities and expand coverage to the informal sector, tighter oversight in the management of social insurance funds would be necessary.

As the Human Development Network observes, the government has a huge job to do in terms of facilitating reliable information, standard-setting and rationalization of involved government agencies, more vigorous encouragement of private insurance and pension plans for overseas workers, and pushing for bilateral agreements that protect Filipino workers' interests abroad (UNDP, 2002).

Social protection for all Filipinos is well within grasp: money and know-how are not what is lacking. Rather, the commitment to act is needed to challenge the status quo. The will to reform is key to making social protection work, and to do this the government must feel the heat. Civil society organizations and private companies can pick up some of the pieces, but only the government can reach the scale necessary to provide universal access to services that are free or heavily subsidized for poor people and geared to the needs of all citizens – including women and minorities, and the very poorest. Sadly, it is failing to meet this essential need. ■

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