PERU

COMPETITION AND REGULATION: COMPETITION IN HEALTH SERVICES

I. MAIN FEATURES OF THE PERUVIAN HEALTH SERVICES SECTOR

I.1. Health service providers

The Peruvian health system is characterized by having various actors (in both service provision and public insurance) whose functions are not necessarily complementary; in fact, they present high degrees of overlap. The system is composed by EsSalud; the Ministry of Health; Regional and Local governments; the health services of the Armed Forces and the Police, and the private sector.

EsSalud is a mandatory medical insurance for salaried workers. By June 2011, 8,97 million people were affiliated to EsSalud, 47% of which belong to care networks of Lima.[1] According to the National Institute of Statistics and Information (INEI), EsSalud concentrates 19,2% of the population.[2]

The Ministry of Health is in charge of decentralized public national institutions which are specialized in maternity, pediatrics, mental health, rehabilitation, ophthalmology, cancer, among others.

During the last decade, functions and resources (human and financial) to provide public health services were transferred to Regional Governments. Furthermore, since 2007 the management of primary care is being transferred to Local Governments.[3]

Armed Forces and the Police also provide health services to their members. Considering holders, beneficiaries and others, these health services cover 1,4% of the population.[4]

Finally, the private sector also plays a role in the Peruvian health system. It includes both nonprofit and for-profit organizations and is extremely fragmented.[5] It should be mentioned that most of the biggest private sector institutions (clinics, specialized institutions and laboratories) are affiliated to the Private Clinics Association of Peru.

Public services and those of EsSalud are organized into geographically distributed care networks and by levels of complexity for the member population. They have general and basic hospitals, health centers and posts. The country has all clinical specialties and highly complex equipment but they are not equitably distributed, in fact, they are

[1] Source: National Superintendence of Health Insurance.
[2] National Household Survey of 2010.
[3] Responsibilities in the areas of water and basic sanitation are also being transferred to Local Governments.
[4] National Household Survey of 2010.
[5] PAHO (2007).

concentrated in the main cities of Peru and, especially, in Lima and Callao.[6] Table 1 presents the number of health facilities, by institution.

Table 1
PERU: HEALTH FACILITIES, BY INSTITUTION
(September, 2011)

Institution	Lima and Callao	Other regions	Total
Ministry of Health and Regional Governments	771	7 084	7 855
EsSalud	64	313	377
Police Health Service	30	125	155
Armed Forces Health Services	139	219	358
Private Sector[1/]	260	207	467
Total	**1 264**	**7 948**	**9 212**

1/ Includes only health facilities that are affiliated to a health plan in a Health Provider Organization. The total number of health facilities in the private sector is higher.
Source: National Superintendence of Health Insurance – Sunasa (2011).

I.2. Insurance

Insurance also plays an important role in the provision of medical services. In the case of Peru, it is important to mention the Comprehensive Health Insurance (CHI), which is a public insurer and financer created in 2002 and designed to facilitate free access to basic health care for poor and extremely poor people who are not covered by any other kind of insurance (in particular, the population under 18 years of age, pregnant women and targeted adult groups). This insurance only finances the cost of health services, patients receive medical care in institutions of the Ministry of Health and Regional Governments. The CHI covers 45,4% of the population (see Table 2).

Table 2
PERU: HEALTH INSURANCE COVERAGE

Health insurance	%
Comprehensive Health Insurance	45,4%
EsSalud	19,2%
Police and Armed Forces Health Insurance	1,4%
Private Health Insurance	1,2%
University Health Insurance	0,4%
Health Providers Organizations	0,3%
Other	0,3%
Not insured	32,9%

Source: National Household Survey of 2010.

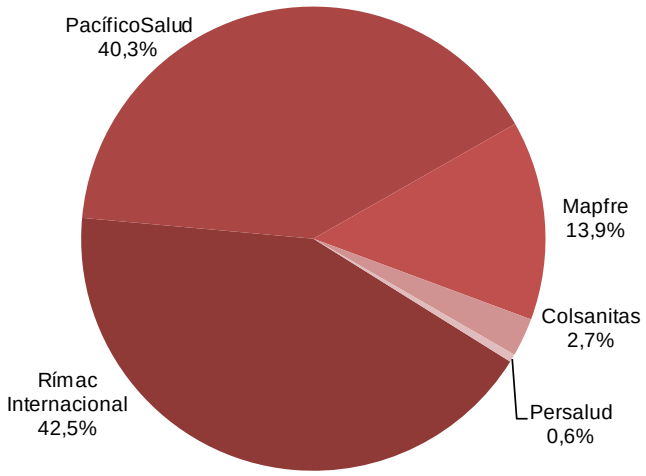
EsSalud is the second biggest insurer in the country. As mentioned before, EsSalud is a mandatory medical insurance for salaried workers and covers 19,2% of the population.

[6] Ibídem.

In 1997, a mixed insurance system was established. The reform included the participation of Health Provider Organizations (HPO), private sector organizations which should complement EsSalud through the provision of health services in their own infrastructure and/or with third party providers. Workers can choose if they are covered entirely in EsSalud or if they want to access a plan offered by a HPO. However, HPO members with catastrophic diseases can still be treated in EsSalud. By 2010, only 0,3% of the population was covered by a HPO. Nowadays, five HPO are operating in Peru and two of them (Rímac Internacional and PacíficoSalud) cover 82,8% of the HPO members (see Graph 1).

Graph 1

PERU: MEMBERS OF HEALTH PROVIDER ORGANIZATIONS



Source: Sunasa (2011).

The Police and Armed Forces Health Insurance, Private Health Insurance and other account for 3,3% of the population, while the remaining 32,9% of the population is uninsured.

II. COMPETITION AND REGULATION

II.1. Barriers to entry

Licensing and other restrictions on professional services are used to ensure quality when there is asymmetric information. This is the case in the health services sector: if consumers cannot determine the quality of medical care, then they cannot compare the quality of the medical services received and avoid less competent providers. Therefore, in order to avoid market inefficiencies and sub-optimal care, some countries have decided to certify medical applicants in order to ensure that they meet minimal requirements.

Even though some regulation is in place in the health services sector in Peru, there is no systematic registry of performance indicators of physicians (hours of surgery, for instance).

Another aspect that is important to analyze is the nature of demand for health services. Demand for health services is a derived demand: consumers (patients) cannot determine which services will be used for treating a disease; instead, the demand is determined by providers (physicians), who are entrusted with the decision because of their knowledge and experience. As a result, the demand for medical services is deeply influenced by the prestige gained by the medical institution, its equipment and the supporting staff. According to the preliminary results of an investigation carried out by the Economic Research Division of the National Institute for the Defense of the Competition and the Protection of Intellectual Property Rights – Indecopi[7], this is particularly true in the case of the treatment of catastrophic diseases, such as cancer. In fact, these characteristics may constitute a barrier to entry into the sector.

II.2. Main features of competition in the private sector

As mentioned before, provision of health services in the private sector in Peru is in charge of both nonprofit and for-profit organizations. The sector is extremely fragmented, particularly in the case of for-profit organizations.[8]

Private medical institutions (especially clinics) offer their services primarily to the population with higher income, leaving an unmet demand for health services in groups with lower income. Taking this into consideration, one of the main competition strategies of some clinics (such as Clínica San Felipe and Clínica Angloamericana) during the last few years has been to expand their presence in districts with higher average income, especially through small medical units, while the most complex medical services are derived to their bigger facilities. Nonetheless, other clinics (such as Clínica Ricardo Palma and Complejo Hospitalario San Pablo) have decided to expand to districts with lower average income, with quasi-independent service units that provide less complex health services.[9]

Another interesting feature of the competition in the private health sector is that the main source of income for most of the clinics is the sale of drugs.[10] In addition, the sale of drugs represents their source of revenue with highest net margins (14%).

Finally, it should be mentioned that in the last few years, competition in health services in Peru has been characterized by the presence of vertical integration between HPO and clinics. In fact, the largest HPO have been acquiring clinics and medical centers, either directly or through their shareholders (see Table 3). These acquisitions would reflect the fact that the management of insurance provides the amount of customers required to ensure operational self-suffiency; while the operation of clinics facilitate cost reductions.

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[7] Indecopi (2011a, 2011b, 2011c, 2011d).
[8] PAHO (2007).
[9] Apoyo (2005).
[10] According to Apoyo (2005), drugs expenses represent 42% of total medical services expenses of HPO.

Table 3
PERU: VERTICAL INTEGRATION IN THE HEALTH SERVICES SECTOR

HPO	Main shareholder	Clinics
Rímac Internacional	Rímac Internacional S.A. Compañía de Seguros y Reaseguros	Clínica Internacional
PacíficoSalud	El Pacífico – Peruano Suiza Compañía de Seguros y Reaseguros	Clínica El Golf Clínica San Borja 1/ Clínica Galeno 2/ Centro Médico Oncocare 3/ Centro Odontológico Americano 3/
Mapfre	Mapfre América S.A.	Clínica Italiana 4/

1/ 60% of shares.
2/ Clínica Galeno is located in Arequipa, all the other institutions listed in the chart are located in Lima.
3/ 80% of shares.
4/ Clínica Italiana has not operated since 1997. However, in 2006 its infrastructure was acquired by Mapfre, HPO that has manifested its interest in the construction and operation of medical centers.
Source: Apoyo (2011a, 2011b, 2011c, 2011d).

II.3. Anticompetitive practices

There is no record of anticompetitive practices among providers of health services in Peru. There is, however, one case of collusive practices among EsSalud's providers of medicinal oxygen. According to the analysis of the Free Competition Commission of Indecopi[11], Praxair Perú S.R.L., Aga S.A. and Messer Gases del Perú S.A. participated in market-sharing agreements during a series of procurement processes organized by EsSalud between January 1999 and June 2004. As a result, Aga S.A. was the winner of public procurement processes in the north of the country, Messer Gases del Perú S.A. in the center of the country, and Praxair Perú S.R.L. in the south of the country and in Lima, the capital city. Furthermore, prices of the winning bid were set close to 110% of the reference value set by EsSalud, while the competing bidders were always disqualified because they did not meet the price requirements set in the State Procurement Act.[12] Fines were set at US$ 4,89 million (Praxair Perú S.R.L.), US$ 1,70 million (Aga S.A.) and US$ 0,74 million (Messer Gases del Perú S.A.).

It should also be mentioned that a private clinic (Clínica Santa Teresa S.A.) has initiated four procedures in the Overseeing of Unfair Competition Commission of Indecopi against specialized public institutes. According to the claimant, the use of a differential tariff in specialized public institutes would not comply with the subsidiary principle of State's economic activities, as established in the Peruvian Constitution (see Box 1).

[11] Indecopi (2010a).
[12] According to the State Procurement Act, bids with prices that are higher than 110% of the reference value are disqualified.

Box 1: Subsidiary principle of the State's economic activities in the health service sector

Article 60 of the Peruvian Political Constitution of 1993 allows the participation of the State in the provision of goods and services in cases where market incentives alone are insufficient to ensure that these goods or services would be provided; as long as: (i) the State intervention is authorized by means of a special law, (ii) the Government activity is subsidiary, and (iii) there is an overriding public interest or manifest national benefit supporting the State intervention. The competition authority, through its Overseeing of Unfair Competition Commission, is in charge of guaranteeing the observance of this article.

The Defense of the Competition Chamber Nº1 of Indecopi has analyzed the subsidiary principle and, according to its interpretation, it applies to situations in which the participation of the State in business activities is tolerated because there is no real nor potential private provision of a good or service or because private provision is not sufficient to meet the needs of a certain group of consumers (see: Indecopi, 2010b).

In this context, Clínica Santa Teresa S.A. initiated four procedures against the use of a differentiated tariff in public institutes which are specialized in the treatment of cancer, pediatrics, ophthalmology and maternity and neonatology. These institutions provide their medical services to patients covered by the Comprehensive Health Insurance, patients derived from public hospitals because of the complexity of the disease and uninsured patients at relatively low prices. However, if patients want to receive medical services from these institutions with a lower waiting time, be attended by particular doctor or be hospitalized in a private room, they can get it by paying a higher price: the differentiated tariff. According to the plaintiff, services provided under the differentiated tariff constitute unfair competition from the State to private sector clinics, since they violate the subsidiary principle described above. The cases are currently under investigation.

II.4. Regulation of the pharmaceutical industry

One final aspect that should be reviewed is the pharmaceutical industry since drugs are one of the main inputs in the health services sector. In Peru, there are both producers of drugs (generic and national brand name) and laboratories that import and market drugs in the country. Nonetheless, the sector is highly concentrated.[13]

There is no regulation of drug prices since 1991, although some aspects of their commercialization are regulated. These regulations can be divided into four main categories:

- *Registration and inspections.* The registration of drugs is a requirement for their commercialization. Additionally, inspections to laboratories, importers and storage facilities are conducted in order to verify the compliance with Good

[13] Miranda (2004).

Manufacturing Practices and Good Storage and Dispensing Practices, as well as quality controls. Both activities are in charge of the General Office of Medications, Supplies and Drugs. According to some authors, control is relatively small and only a few laboratories comply with Good Manufacturing Practices.[14]

- *Public procurement.* Public procurement of drugs is regulated with the objective of acquiring quality drugs at the lowest possible cost. Regulations prioritize the use of auctions and include the use of a National Essential Drug Request for all institutions that belong to the public sector (Ministry of Health, Regional and Local Governments, EsSalud and the Police and Armed Forces Health Services).
- *Reduction of taxes and tariffs.* With the aim of reducing the final price of drugs, especially the ones used in the treatment of AIDS, cancer and diabetes, taxes and tariffs on drugs have been reduced. However, according to different studies, these measures have not achieved their goal and, instead, the marketing margin of producers and importers of drugs have increased.[15]
- *Commercialization.* The law also establishes minimum requirements in infrastructure and equipment which must be met by pharmaceutical establishments (pharmacies, drugstores and laboratories) in order to ensure the proper conservation and storage of drugs.

[14] Ibídem.
[15] See: Ministry of Health of Peru (2010), Meza (2011).

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