Defining Quality of Rheumatologic Care: Peru

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The Peruvian Healthcare System includes 5 subsystems: (1) the Department of Health, which in turn includes out-of-pocket paid care and health insurance funded by the government (SIS for Sistema Integral de Salud or Integrated Health System), (2) the Social Security Administration (EsSalud), (3) the Armed Forces Healthcare System, (4) the National Police Healthcare System, and (5) the private sector. The Instituto Nacional de Estadística e Informática (National Institute of Statistics and Informatics) in 2015, approximately 72% of the Peruvian population was covered by some form of health insurance, 40.0% by SIS, 25.7% by EsSalud, and 6.1% by the private sector, the Armed Forces, and the National Police combined; the remaining of the population was uninsured. By September 2016, however, the population covered by SIS had increased to more than 17 million or approximately 54% of all Peruvians; furthermore, in 2016, more than 68% of all medical encounters that took place in the Department of Health’s centers were covered by SIS (personal communication of Oficina General de Tecnologías de la Información [General Office of Information Technology] by e-mail).

Individuals of low socioeconomic status and without any other form of health insurance are covered by SIS, which, as noted, is financed by the government. EsSalud is financed entirely by the employers (9% of wages), and it covers the employees (including pensioners) and their dependents (spouses and children); it is supposed to be self-sustaining. Pensioners, however, pay 4% of their retirement income to remain covered. The Armed Forces and the National Police Healthcare Systems are similar to EsSalud but are financed by the Departments of Defense and Interior, respectively. EsSalud, the Armed Forces, and the National Police Healthcare Systems cover not only medical care, but also paid sick leave and disability.

These 5 systems provide care in the inpatient and outpatient settings and include all medications, ancillary studies, procedures, and imaging techniques available in each of them, without any additional cost to the patient. However, it is important to point out that some of these services or medications may not be available in all systems, forcing patients to seek care outside their system and having to cover their cost. For example, although SIS provides medical care for any symptom or medical condition to all its insurers, it provides them with only medications that are in the National Formulary; this is particularly the case for biologicals, although they may be covered through special authorization that demands additional time to the providers (vide infra). This problem is not limited to Peru; for example, according to a recent Pan American survey, almost 50% of 212 rheumatologists surveyed in Latin America consider the coverage for biologics for the treatment of rheumatoid arthritis to occur for less than 10% of patients in their public health care system, whereas a similar percentage considers it to occur in more than 90% of patients covered by the social security administration and private insurance systems. In Peru, there have been some concerted efforts to reduce the cost of all medications by doing a single public procurement, but this effort has been limited; in fact, initially, it included approximately only 20% of all medications; now it includes almost 60% of them.

It is also worth pointing out that communication within and between the different health systems is almost nonexistent, which is partially due to the lack of electronic medical records; furthermore, there are no common protocols, guidelines, and standards of care.

The private sector partially covers care in the inpatient and outpatient settings but provides unlimited access to all medications, procedures, ancillary studies, and imaging technologies approved for the condition being treated unless it was preexistent at the time the insurance took effect. Patients do pay a 10% to 20% deductible or copay for these services.

In theory, at least, the Peruvian Healthcare System and subsystems are supervised and monitored by the Superintendencia Nacional de Salud (or National Superintendence of Health) (SuSalud), so that they comply with the functions and obligations of the health care institutions and the institutions administering health insurances. In short, SuSalud’s mission is to protect the Health Rights of every Peruvian.
RHEUMATOLOGY PRACTICE IN PERÚ

According to a study from the United Kingdom, there should be at least 1 rheumatologist per 85,000 inhabitants in Perú, however, we have only half of this purported figure, or approximately 1 per almost 169,000 inhabitants. Furthermore, rheumatologists are concentrated in large cities, leaving some medium and small-size cities, towns, and the rural population without rheumatologists.

Rheumatology Practice in the Public Sector

The majority of rheumatologists around the world practice in the public and private sectors, and Perú is not the exception; thus, the majority of Peruvian rheumatologists work 6 hours per day in the public sector including the Department of Health, EsSalud, the Armed Forces, or the police’s inpatient and outpatient settings and approximately 4 hours in the private sector, doing so to supplement their income.

On average, a rheumatologist takes approximately 15 minutes to see a patient in Chile, whereas in Perú, the visit takes between 12 and 15 minutes. However, in the public sector, the demand is so large that rheumatologists are forced to reduce the time dedicated to each patient, which contributes to the patients’ dissatisfaction with the system and possible deleterious outcomes.

Medications are covered by the different insurances if they are in their formulary and approved for the condition being treated; however, there are some medications that are allowed only in the inpatient setting, such as intravenous antibiotics (eg, carbapenems) or intravenous immunoglobulin.

As noted, almost all public systems lack electronic health records, which contributes to the fragmentation of care within each health care system and the lack of communication between systems. Furthermore, there is no standard quality-of-care indicators that could serve as the basis for financial incentives; rather, the quality of care in the public sector is currently measured only by indices of external user satisfaction (patients); these indices have been developed by the Peruvian Department of Health.

Rheumatologists working in the public sector are salaried, which does not take into account the type, number, or complexity of the services provided; this may result in an uneven distribution of labor within practitioners of the same system. Furthermore, the salaries varied between the different public systems.

Rheumatology Practice in the Private Sector

Within this system, there are patients covered by private insurances, but there are others who pay out of pocket for their medical care. In both cases, there are no quality metrics, incentives, or penalties for the care these rheumatologists provide; the time spent on each patient is highly variable and to a certain extent functions as the number of patients scheduled for a given day. How the care these rheumatologists provide stands within the community at large is more a matter of “perception” than one based on facts. Thus, rheumatologists may become quite visible to the public because of their academic status or participation in public forums rather than by the quality of care they provide.

The proportion of the rheumatologist’s income derived from practicing in the public and private sectors is highly variable, depending on numerous factors (the specific public sector institution, the location of the private office, the prestige of the rheumatologist, to name but a few), so generalizations cannot be drawn.

HEALTH CARE PLANS FOR THE FUTURE

There are high expectations that with the new administration (inaugurated July 28, 2016) the Department of Health will establish a roadmap to improve the delivery of health care in a rational, efficient, and comprehensive way. However, such roadmap is yet to be disclosed by the department’s minister, and other pressing and urgent problems may delay its disclosure and implementation; in fact, at present, the Department of Health is under reorganization. Likewise, the roadmaps for armed forces and police health care systems have not been made public, although they all agree that the utmost priority is the delivery of quality care, which should take into account the patient being the axis or center of their endeavors.

As to EsSalud, until a few years ago, it paid a productivity bonus to each physician when a department fulfilled the number of patient visits planned per month. Although it is true that this may indicate efficiency, it does not necessary indicate quality. EsSalud therefore has planned to assess the quality in the delivery of health services aiming at the satisfaction of the insured with the treatment and care they receive. However, within this plan, there is no provision to evaluate the actual process of health care delivery.

A consideration needs also to be given to the significant growth of new and expensive diagnostic and treatment modalities for the conditions we and other specialists manage. However, these medical advances do not necessarily imply cost-effectiveness and quality improvement. For this reason, EsSalud has constituted the Instituto para la Evaluación de Tecnologías en Salud e Investigación (Institute for Health Technology Assessment and Research), whose aim is to optimize the use of health resources based on the best scientific evidence available, for example, the purchase of medications such as monoclonal antibodies with proven efficacy from well-conducted double-blind randomized trials. The actions taken by this organization will allow a better use of resources, which will improve the processes of patient care, therefore improving the quality of health care and the patients’ well-being.

REFERENCES


