

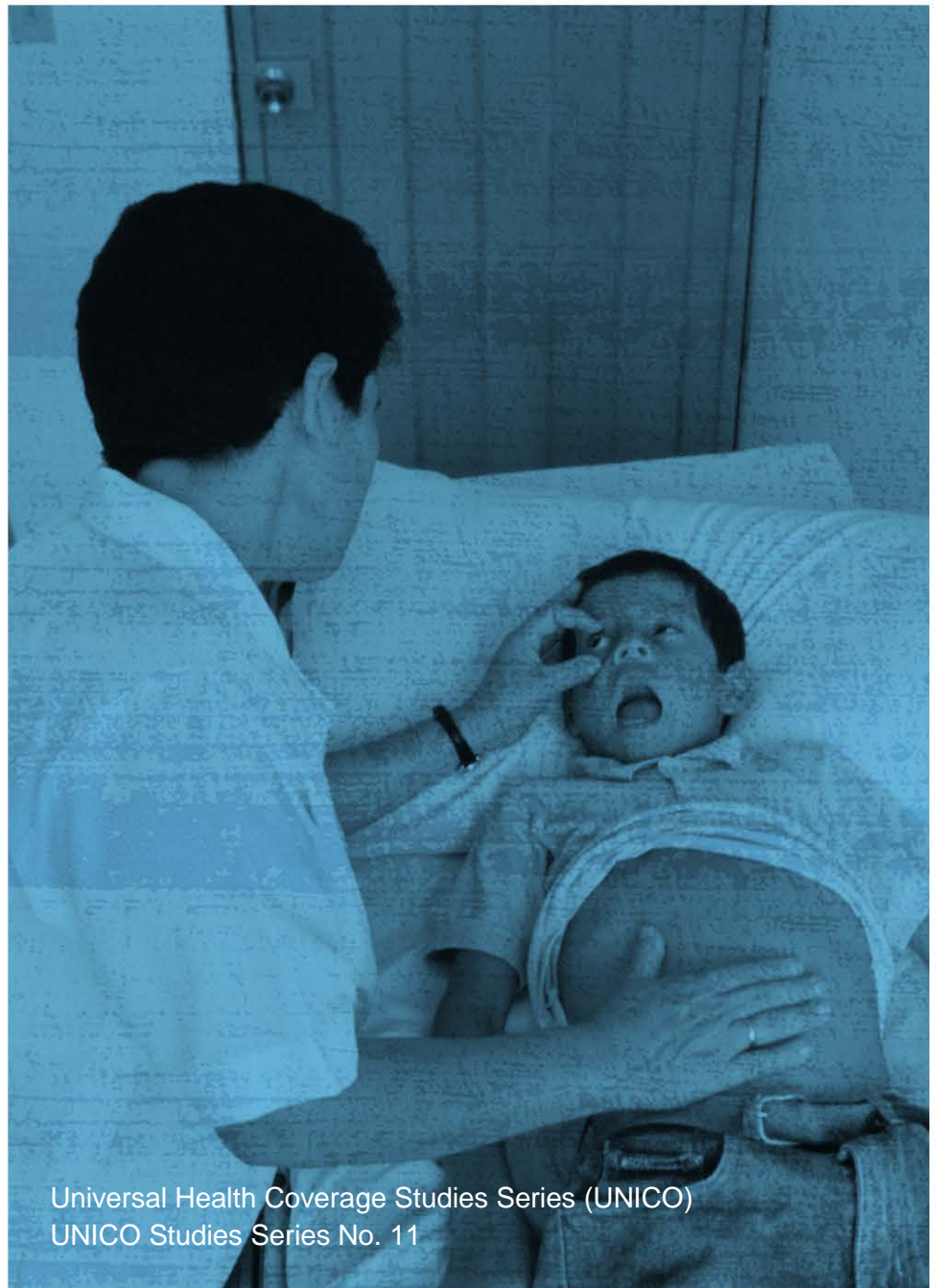


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Peru's Comprehensive Health Insurance and New Challenges for Universal Coverage

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The World Bank’s Universal Health Coverage Studies Series (UNICO)

All people aspire to receive quality, affordable health care. In recent years, this aspiration has spurred calls for universal health coverage (UHC) and has given birth to a global UHC movement. In 2005, this movement led the World Health Assembly to call on governments to “develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them.” In December 2012, the movement prompted the United Nations General Assembly to call on governments to “urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services.” Today, some 30 middle-income countries are implementing programs that aim to advance the transition to UHC, and many other low- and middle-income countries are considering launching similar programs.

The World Bank supports the efforts of countries to share prosperity by transitioning toward UHC with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, successful implementation requires that many instruments and institutions be in place. While different paths can be taken to expand coverage, all paths involve implementation challenges. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Study Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the *nuts and bolts* of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol consists of nine modules with over 300 questions that are designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following: (a) manage the benefits package, (b) manage processes to include the poor and vulnerable, (c) nudge efficiency reforms to the provision of care, (d) address new challenges in primary care, and (e) tweak financing mechanisms to align the incentives of different stakeholders in the health sector. To date, the *nuts and bolts* protocol has been used for two purposes: to create a database comparing programs implemented in different countries, and to produce case studies of programs in 24 developing countries and one high-income “comparator,” the state of Massachusetts in the United States. The protocol and case studies are being published as part of the UNICO Studies Series, and a comparative analysis will be available in 2013.

We trust that the protocol, case studies, and technical papers will provide UHC implementers with an expanded toolbox, make a contribution to discussions about UHC implementation, and that they will inform the UHC movement as it continues to expand worldwide.

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UNICO Studies Series Task Team Leader
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Abbreviations

AUS	Universal Health Insurance Law
CLAS	Local Health Administration Committees, Comités Locales de Administración de Salud
DIRESAs	Regional Directorates for Health
EsSalud	the social security system (Peru)
GDP	gross domestic product
JUNTOS	Peru's conditional cash transfer program
LAC	Latin America and the Caribbean
MEF	Ministry of the Economy and Finance
MOH	Ministry of Health
PEAS	Essential Health Assurance Plan, Plan Esencial de Aseguramiento en Salud
SAMU	Mobile Urgency Medical Care, Servicio de Atención Médica de Urgencias
SERUMS	the mandatory program in Peru that requires graduates who want to work in the public system to serve in rural areas
SIS	Comprehensive Health Insurance, Seguro Integral de Salud
SISFOH	National Household Targeting System
SUNASA	National Superintendent of Health

Executive Summary

In the last two decades, Peru has made significant progress in improving maternal and child health, although health inequities remain in rural areas and among indigenous populations. The epidemiological transition toward noncommunicable diseases poses challenges, as well. Peru's health system is segmented, and it is comprised of public facilities administered by the decentralized Ministry of Health (Ministerio de Salud, MOH), the social security system, and the private sector, which accounts for 40 percent of spending. Established 10 years ago in parallel—although uncoordinated—with the country's decentralization reforms, the Comprehensive Health Insurance (Seguro Integral de Salud, SIS) has been Peru's major effort to expand health coverage.

The SIS aims to reduce economic barriers through the elimination of user fees for a package of services. Although its budget has been low, the SIS has played an important role in the reduction of maternal and child mortality. However, the improvements expected to the overall health system have not materialized. Meanwhile, when the decentralization process transferred funds and authority to the regions, it did so in a context of weak management capabilities, and it failed to clearly define the relationship between the national and regional governments.

What is needed is a substantial and sustained effort to improve coverage with a comprehensive approach—one that integrates national and regional health priorities but that allows for flexibility within networks and health facilities and establishes clear incentives as a means to achieve desired results. The SIS appears to be the best vehicle through which to achieve this approach, and it would be feasible to incorporate into it the “Health Strategies.” Indeed, the SIS has the advantages of a broad package and the use of instruments that provide greater administrative flexibility, and it has the potential to use incentives.

The inequity of basic care demands a special effort to improve the coverage and effectiveness of care in rural areas, where one-quarter of Peru's population lives. In these areas, it is necessary to integrate SIS efforts with adequate human resource policies.

In Lima, where 30 percent of the country's population lives, the challenge is no longer providing basic care, but rather responding to noncommunicable diseases through promotion, prevention, and early detection. To achieve this, the following strategies are necessary: (a) increased noncommunicable disease awareness; (b) integrated public health programs that are designed to address all stages of prevalent chronic diseases; and (c) a single purchaser, like the SIS, to procure services from multiple providers.

A major effort to strengthen the technical capacity of the MOH should accompany the strategies outlined above. This effort should emphasize a review of health priorities, the design of effective interventions within a fiscally sustainable benefits package, and the introduction of incentives and new payment mechanisms at hospitals and other health facilities.

1. Introduction

This case study analyzes the progress of Peru's Comprehensive Health Insurance (SIS) and evaluates the challenges that remain to achieving universal health care coverage.

Peru is an upper-middle-income country with a gross domestic product (GDP) per capita of just over US\$10,000 (purchasing power parity). The country has grown rapidly in the last decade; the average growth rate was 6.5 percent. However, 28 percent of the population lives in poverty (2011), which is estimated with regionally differentiated poverty lines between US\$1 and US\$2 per capita per day. In addition, only one in four individuals has employment with social security coverage.

Income inequality measured by the Gini Coefficient is close to 0.60, and there are high inequalities in human development indicators (education and health) and in access to basic services, such as water and sanitation. The Human Opportunity Index ranks Peru 13th out of 17 countries in the region. Inequalities in income, human development indicators, and access to services are present both among socioeconomic strata and among regions (the coast compared to Sierra and Amazon, urban compared to rural). Discrimination against women and the exclusion of indigenous populations is also a problem.

As an upper-middle-income country, Peru's mortality indicators (under 1 year = 14.9, under 5 years = 19.2, maternal mortality = 67) and life expectancy (73.8) are within the average for countries with similar economic indicators (2010 data). Advances in child mortality have been great in the last decade. The country, however, lags in child malnutrition, which reached 28.2 in 2010, and is associated with poverty, inequality, and a lack of access to basic services. In all these indicators, regional differences are large. In Huancavelica, a poor mountainous region, life expectancy is 61 years, whereas in Metropolitan Lima it is 79; chronic malnutrition is 41 percent in rural areas and only 7.5 percent in urban Lima; and infant mortality is 10 per 1,000 in the highest-income quintile but 42 in the lowest.

After Haiti, Peru has the second-highest incidence of tuberculosis in the Latin America and Caribbean (LAC) region, and many cases are multi-drug-resistant and extra-drug-resistant. However, the epidemiological transition has already advanced, and 60 percent of deaths are the result of noncommunicable diseases.

Health service coverage is similar to other average upper-middle-income countries in terms of basic care, such as immunizations (93 percent), prenatal care (95 percent of women make at least one visit), and contraceptive use (73 percent), but is lower than expected when it comes to more complicated services such as institutional deliveries (84 percent). Primary care has been the focus of programs for several decades, which may account for these statistics. However, there have been fewer resources designated for the health system, in general, with a total expenditure of only 5 percent of GDP. Just 54 percent of this expenditure goes to the public system. The number of doctors, nurses, and beds per capita are considerably lower than average upper-middle-income countries, and there is a general shortage of medical specialists. Resources are also heavily concentrated in Lima and in other cities, so that there are deficits in care in the highlands and in the Amazon and among indigenous populations.

The health system is segmented and is composed of the parallel and low-funded MOH and social security systems and the private sector. Spending in the private sector represents 40 percent of all health spending, and this spending is primarily on pharmaceuticals (Francke, Arroyo, y Guzmán 2006). Through its decentralized Regional Directorates for Health (DIREAS), the MOH has the largest network of hospitals and primary care health centers that provide health care for the poor. Coverage in rural areas is more limited, however, and, given the low funding for the public system, there is high out-of-pocket spending on medicines.

Established in 2002, Peru's SIS was designed to expand health coverage by reducing economic barriers through the elimination of user fees for a package of services. The SIS also implemented policies and management systems that centered on results and incentives. Originally, the SIS was considered a marginal reform, and its budget—less than 10 percent of the total directed for the MOH/DIREAS—reflected this. While the SIS has played an important role in the reduction of maternal and child mortality, it has failed to make the reforms to the system that were initially expected. Consequently, a new policy, Universal Health Insurance (AUS), was approved in 2009 and 2010 and was intended to be a more holistic approach to health reform. To date, there has been little progress in the implementation of the new policy.

This case study will discuss in detail the interaction between Peru's decentralization reforms and the SIS, and will specifically highlight how this interaction has altered the health system's regulation capacity and the purchase and delivery of services.

The decentralization of the country's health system occurred in 2004 and 2005, during which the administration of public health facilities and the ability to implement health policy was transferred from the central MOH to the regional governments. Facilities in Lima, however, continued to be administered under the central MOH. While the introduction of the SIS was intended to strengthen and modernize the MOH's oversight of the public health system, the decentralization reforms ultimately weakened the ministry because they failed to clearly outline the relationship between the central MOH and the DIREAS. Meanwhile, EsSalud, the social security system, remains separated from MOH and centralized.

See Annex 1 for an overview of Peru's health system, including financing and delivery.

2. Institutional Architecture of the SIS

Brief Description of the SIS

The SIS was implemented on the heels of a change in government with the fall of Alberto Fujimori and the subsequent return to democracy in 2001. Civic groups—such as the Medical Society and the Civil Society Forum on Health—emerged during this time and advocated for policies promoting the right to health and the reduction of user fees (Conferencia Nacional de Salud 2003; Francke 2006). The SIS was ultimately based on two consolidated but strengthened existing programs: the Maternal-Child and Scholar Schemes.

The SIS aims to eliminate direct user fees in public health facilities. These fees posed—and still pose—a major economic barrier in health service access (Ewig 2012). The SIS introduces a new

financial mechanism to pay for public health care and drug delivery, transferring funds to hospitals and public health networks under a scheme of payment for services, which are defined within a care plan (there is a small part of the payment that is not related to care). Payment for service is calculated only to cover the variable costs of inputs, and does not include capital (infrastructure and equipment) or staff, whose costs are covered by other budget lines.

The SIS is obligated to provide to affiliates free care of the risks and services included in the insurance scheme. Hospitals and health centers are not permitted to charge user fees for providing the benefits package for SIS beneficiaries, and instead they receive payment from the SIS. Thus, the incentive to charge user fees is diminished or even eliminated. In addition, the SIS incentivizes public hospitals and health centers to orient their services to those included in the insurance scheme's benefits package.

SIS and Health Outcomes

The SIS has augmented the demand for health services that are included in the benefits package. Indeed, the inclusion of childbirth has increased the incidence of institutional delivery. In 2000, only 24 percent of births in rural areas and only 58 percent in urban areas occurred in health facilities. Today, 58 percent of rural and 85 percent of urban births take place at a medical institution (INEI 2012). This increase in institutional delivery has been associated with a significant reduction in Peru's maternal mortality ratio; in the last 10 years, the maternal mortality ratio has decreased by almost half. However, other factors have contributed to these results.

One of the factors is the economic growth registered in the last decade. Since 2001, Peruvian GDP growth has been one of the greatest in LAC (a 5.8 percent average compared to the LAC 4.2 percent average), while maintaining one of the lowest rates of inflation in the region (a 2.5 percent average compared to 8.0 percent in LAC) and accumulating a substantial amount of international reserves. Mainly due to GDP growth, since 2007 poverty has declined from 42 percent to 28 percent (2011). While in rural areas poverty has only been reduced from 74 percent to 56 percent, mean per capita expenditures of rural households have grown by 25 percent. The reduced poverty allows families to more easily cover transportation and other opportunity costs, increasing demand for health services and improving access to drugs, food, and shelter.

Also, there have been advances in the education of women and subsequent declines in the fertility rate that also contribute to decreases in maternal mortality.

Finally, health services have been reinforced in rural areas. Institutional deliveries require physicians, safe blood transfusions, inputs, and medication in rural areas where supply and response capacity have been weak. International aid organizations and the Peruvian government (using some of the increased fiscal revenues brought in by economic growth) have introduced initiatives, such as PARSALUD, which have aimed to improve maternal care through infrastructure, equipment, human resources and the incorporation of culturally sensitive birthing practices.

The rapid expansion of coverage and the reduction of maternal mortality demonstrate that it is possible to improve health services of medium complexity in rural areas. The increase of programs to improve the supply of maternal care and the increase in demand via the SIS have proven to be a winning combination. (See Annex 2 for a description of public health, primary care, and supply efforts.)

Targeting, Identification, and Enrolment of Beneficiaries

The law that created the SIS established that the target populations of the program were the poor and vulnerable. Indeed, the objective of the SIS is “to promote equitable access to quality health services with priority given to uninsured individuals and vulnerable populations living in poverty and extreme poverty.” A targeting procedure is therefore required when individuals register with the SIS and, depending on their income, they become affiliated with either the fully subsidized or semicontributory regimes.

Individuals that want to become affiliated to SIS apply at health facilities. To identify the socioeconomic level of families, health facilities use the Socio-economic Evaluation Sheet (Ficha de Evaluación Socioeconómica), which is a proxy means test that distinguishes between the poor and the extreme poor and then categorizes the new affiliates into the semicontributory and fully subsidized regimes, accordingly. There is little supervision or quality control over the application process, however, and the categories of exclusion from the SIS—such as affiliation with EsSalud, the social security system, or even a microloan—have been criticized as inadequate.

The SIS did make a concerted effort to target poor, rural districts that the government had prioritized in 2007 and 2008. These targeting efforts, however, have not been applied broadly.

The nonpoor are allowed to join the SIS but must pay a fee and enroll in the semicontributory scheme. In addition, they are required to register at the SIS’s regional office—the ODSIS—rather than at a health establishment. These enrolment requirements, combined with a generally low quality of service and the relatively unfamiliar concept of insurance, leaves the portion of SIS policyholders that contribute to the system at less than 2 percent.

As a result, the SIS has fairly good targeting indicators for the Peruvian context, with 15.6 percent undercoverage and 12.1 percent leakage (Arróspide, Rozas, and Valderrama 2009). A study examining the concentration indexes of various social programs and health care found that in 2004, the SIS had a concentration index of -0.08 compared with an average of the MOH of +0.09 (where hospital care is the least redistributive). These statistics were similar to programs like Glass of Milk, but were less redistributive than the average welfare expenditure of -0.18 (World Bank 2007).

In the future, the SIS will use the National Household Targeting System (SISFOH), a single targeting mechanism that the government uses for different social programs. Implementation of the SISFOH is proceeding slowly, however, and is being used in the poorest regions for the country’s noncontributory pension scheme (Pensión 65) and its conditional cash transfer program (JUNTOS). In order to exclude middle-income households and prevent leakages, the

SISFOH has compiled a database of households in Lima. Implementation problems have prevented the SIS's broad use of this database, however.

The Administration of Public Funds and Budget Management in the SIS

The public budget in Peru is managed on the basis of an annual budget, particularly in relation to current expenditure programs, like the SIS. The Ministry of Economy and Finance (MEF) formulates the budget that is approved by Congress but cannot make additions to it. The MEF manages the budget by transferring monthly allotments into the bank accounts of public entities. These allotments fall within the budget ceiling, which may not be exceeded. Like the rest of the public sector, the SIS is funded in this manner.

Within each institution, there are restrictions on the use of public funds. The amount designated for salaries, for example, cannot be increased, and funds allocated for investments cannot be transferred to expenditures. Resources obtained through user fees are much more flexible, allowing each entity to add them with few limitations on the budget.

The SIS was created as an autonomous entity with a budget allocated directly from the MEF without requiring previous MOH approval, and can manage its budget autonomously. This arrangement allows the MEF to maintain the ability to assess and decide how much funds allocate to the entire health sector, and gives it the power to decide how much of the public health budget to allocate to autonomous SIS. The MEF, thus, retains control over the SIS's possible expansion.

Subsequent developments show that the MEF has not clearly endorsed the SIS. Rather, it has expanded its budget only when there has been ample fiscal space. The SIS, consequently, has on several occasions run arrears on payments indebted to hospitals and health centers. This can be understood as the MEF's response to a program, like the SIS, which generates financial risks (increasing high-cost provider services, for example), a response, moreover, that clearly signals that the MEF is unwilling to take the burden of such risks.

Does the SIS Allow for Greater Flexibility in the Management of Funds by Health Services?

Relative to the regular budget (funds from the treasury), the SIS does provide some additional flexibility in the management of funds. Specifically, it allows implementation units (that comprise a hospital and/or a network of health centers) to flexibly incorporate funds into their budgets throughout the year and thus permits spending on the items that are considered necessary. These budget transfers require several bureaucratic procedures.

However, the SIS's additional budget transfers partly replace the funds previously generated from user fees. The revenue from user fees can, in general, be used much more flexibly than the SIS's resources, because the MEF does not need to control those expenditures since they do not affect the fiscal deficit (the expenditures are backed by their own incomes). In addition, the SIS's resources go to implementation units (provincial administrative headquarters) and not directly to the health facilities. User fees, conversely, are often used directly by health facilities, although the law requires them to be sent to the administrative headquarters where they are supposed to be

distributed to rural facilities where input is low. By replacing user fees with fiscal transfers, and given the limitations described above, it cannot be asserted that the SIS has improved administrative flexibility in the management of health services.

It is important to compare the effects of the SIS with those of the Local Health Administration Committees (CLAS). The CLAS model was promoted from 1994 to 2002, and accounts for a third of all public health facilities in Peru. The committees were composed of six community leaders and the health center director. The CLAS received MOH funds in exchange for proposing, signing, and implementing a local health plan. Moreover, the CLAS could spend the funds flexibly—similarly to a private company—prioritizing certain items and making buying and hiring decisions outside the rules that govern the public sector (Cotlear 2006).

This flexibility given to CLAS was greater than that of the SIS and the general budget rules for the health facilities. The greater flexibility that the CLAS model gave to health centers and posts (hospitals were not included) coupled with citizen participation improved accountability (Francke 2007) and increased efficiency and quality, as several studies have confirmed (Cortez 1998). In the last 10 years, however, the CLAS model has lost much of its autonomy, and hiring decisions must abide by the inflexible civil service rules that apply throughout the public sector. In addition, the MOH has withdrawn its support of the CLAS, and the model, consequently, is no longer an element of health reform.

The Road to Reform: From the SIS to the AUS and Beyond

SIS reform has only been “at the margin” rather than a structural health system reform (Ewig 2012). Three issues support this evaluation. The rates paid by SIS do not include capital or human resource costs. The SIS benefits package applied more generally, the Prioritized List of Health Interventions, covers only 20 percent of the calculated disease burden. Until mid-2012, the SIS interacted only with MOH or DIRESA health facilities, excluding those from the social security system or the private sector.

Even as a marginal reform, the SIS has initiated substantial change, especially in the realm of payment—transitioning from payment for inputs as budget items, to payment for services rendered. Prior to the SIS, and with the MOH as the regulator, the capacity to adopt these payment changes was nonexistent. In addition, providers—hospitals, health centers, and networks—experienced extended user fees and did not yet have the protocol requirements and quality audits that the SIS has since required.

Seven years after implementation of the SIS, the Universal Health Insurance Law (AUS) was approved in 2009 and regulations issued in 2010. The AUS is focused on a general reform of the health system and included (a) establishment of a minimum for all insurance plans (including those from the private sector and the social security system), (b) creation of a public supervisory body to monitor the quality of insurers and providers (SUNASA), and (c) the possibility that the SIS or another public insurance scheme purchase services from private providers. The MOH later approved the Essential Health Assurance Plan (Plan Esencial de Aseguramiento en Salud, PEAS), which established an insurance minimum and required that it cover approximately 65 percent of the causes of morbidity (compared to the 20 percent of the Prioritized List of Health

Interventions). The MOH also set forth an eight-year, progressive implementation plan of PEAS that began in the poorest regions and included Chilean-style “explicit guarantees.” These guarantees affirm that if the state cannot provide the services within the plan, SIS policyholders can access services from another provider and be reimbursed.

The AUS has advanced very little, however. The budget increase necessary to finance the PEAS has not materialized, and the MOH/DIRESA allocates less than 10 percent of the budget to the SIS—approximately the same percentage that the country’s only cancer hospital receives. In 2010, and with the general elections on the horizon, President García changed course and decided to first implement the PEAS in Lima, rather than in the poorest regions. The procedures to integrate individuals from the SIS’s Prioritized List of Health Interventions to the AUS’s PEAS have been confusing and have thus advanced slowly.

In addition, the government that came to power in 2011 has prioritized neither the AUS nor the SIS. The main improvement of SIS is that it has recently begun to purchase services from providers other than the MOH/DIRESA, a new policy launched in the context of a physician’s strike that opens the way for a broader role of the SIS as an insurer that buys services and promotes efficiency and competition in the market. The SIS now purchases services from the Municipality of Lima’s Solidarity Hospitals.

In the main health services government initiative, Plan Esperanza, for cancer patients, SIS plays a marginal role, since another government body (the National Cancer Institute, Instituto de Enfermedades Neoplásicas) has the main responsibility for it. The other initiative in public health that the government launched, the Mobile Urgency Medical Care (SAMU), was also not linked to SIS and has advanced slowly. Plan Esperanza begins to address the burden of noncommunicable diseases brought by the epidemiological transition; however, it has the great challenges of integrating both curative and preventive interventions and of reaching poor regions and rural areas where response capacity to diagnose and treat cancer is almost nonexistent. A greater issue is whether Plan Esperanza will be the beginning of a more comprehensive approach to noncommunicable diseases or will follow the path of multiplying uncoordinated health programs.

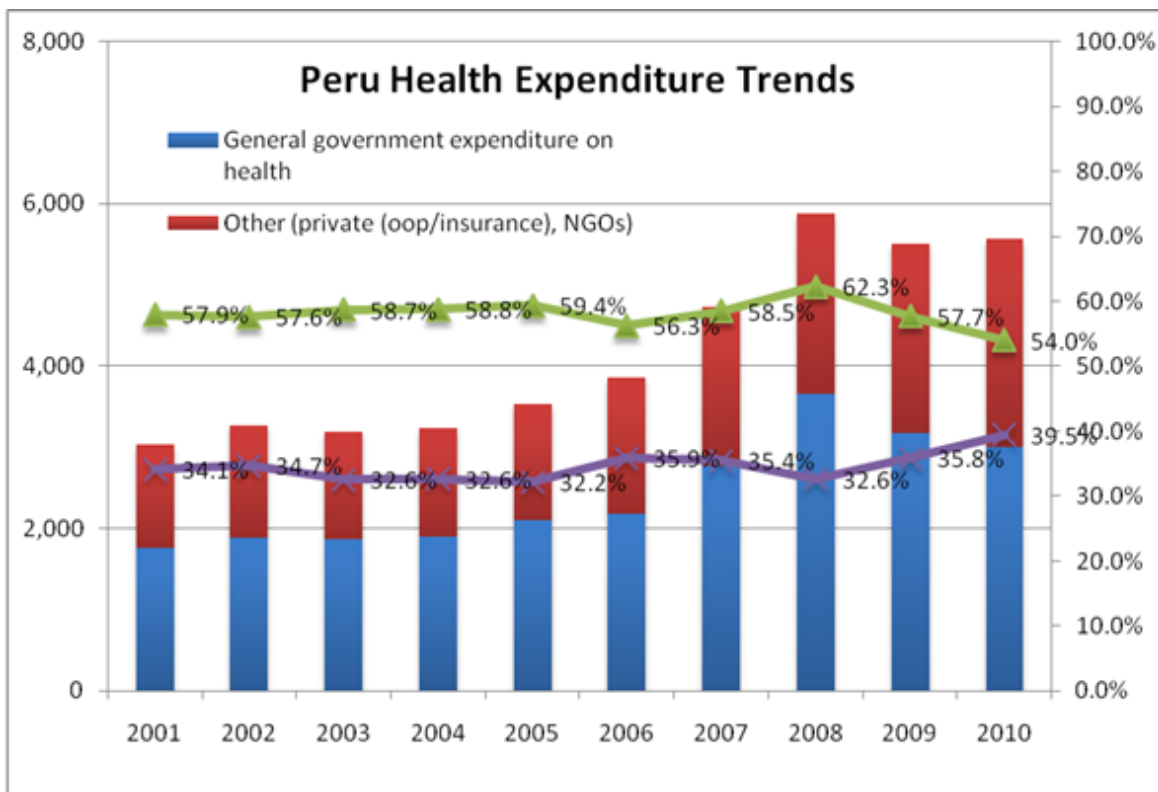
3. Why Has SIS Failed to Grow into a Broader Program?

In contrast to the MOH/DIRESA budgets, which have increased over time, the SIS has not had a significant backing of funds (less than 1 percent nonfinancial public spending, and 8 percent of the health budget). The SIS’s budget has been unstable and actually decreased in nominal terms from 2005 to 2006. The SIS’s budget has also failed to respond to expansions in its benefits package.

Figure 1 illustrates the evolution of public spending on health between 2001 and 2010. The figure shows that, following implementation of the SIS in 2002, public expenditure on health (including spending on EsSalud and the MOH) did not increase significantly in the subsequent two to three years—years that were marked by fiscal constraints due to low economic growth. The crowding out of private spending, which could be expected due to the SIS’s offer to increase low-cost or free services, did not occur.

Public spending on health increased between 2006 and 2008. These were years of high growth, which boosted social security contributions and expanded fiscal space, thus increasing the SIS's budget from 270 soles in 2005 to 440 million soles in 2008. The 2008–09 international economic crisis halted economic growth in 2009, which also slowed the expansion of the SIS's budget. The decreased public spending on health during 2009 and 2010 was primarily due to a government policy that reduced social security contributions by 14 percent, a decision taken in the aftermath of the international financial crisis of 2008.

Figure 1 Evolution of Public Spending on Health, Peru, 2001–10



The fact that SIS has not had a significant budget nor improved public health financing must be analyzed in the broader context of MEF decisions on budget priorities and procedures. Since 2006 or 2007, the MEF has pursued an initiative for improving the budgeting process first called “Budgeting for Results” and now called “Quality Spending.” This initiative aims to promote public programs that have defined objectives and logical frameworks and indicators, and that emphasize monitoring systems and conducting independent evaluations. This initiative, however, has not altered the mechanism by which the MEF allocates resources due to a lack of incentives on the part of both the MEF and the programs that are allocated funding. However, as a result of this initiative, in health the MEF has allocated funds to programs with more specific goals, such as maternal and child health, tuberculosis, and malaria, rather than to the SIS with its broadly defined benefits package. Consequently, these vertical programs have a budget for 2012 that is three times greater than the SIS's budget.

So, the legal approval of SIS and its benefits package, formally supported by several presidents and governments, has not resulted in significant funding or in a substantial increase of public health expenditures. How this contradiction can be explained?

Management of SIS's Benefits Package

A first question to ask is by what process has the benefits package been defined, a decision that logically should be closely correlated with the budget allocated to SIS. The truth is that definite timelines and procedures to review the SIS's benefits package do not exist. In addition, the initial package and also the posterior broadened packages were not based on complete, explicit, or well-defined criteria. They tend to exclude complex diseases and high-cost treatments. A new law, however, is considering the addition of these diseases and treatments to the SIS's benefits package.

The MOH defined the SIS's benefits package with little coordination with the MEF. Initially, there were several partial packages for different age groups (especially mother and child and adolescents) and special populations. Several years later, the SIS established its first comprehensive benefits package called the "Prioritized List of Health Interventions," which covers an estimated 20 to 25 percent of the disease burden.

In general, the determination of the benefits package has not ensured a balance among risk, included services, and the budget (Forosalud 2005). Furthermore, there is no relationship among the number of SIS affiliates, the cost of the benefits package, and the provided funds. The SIS budget is historically based, and the initial budget was determined without calculating the cost of the benefits package.

How were (and are) these decisions made? The Peruvian Constitution requires that the Congress approve the SIS budget. However, Congress has never amended the budget or examined whether the budget allocated by the MEF is sufficient to cover the costs of the SIS's benefits package. Moreover, the Constitution prohibits Congress from approving additional expenses to the budget. Thus, any proposal to expand the budget to cover the costs of the SIS's benefits package would require MEF approval.

How, then, is the equilibrium between SIS's budget and services provided restored? To contain costs, some health services are excluded and reimbursement rates are defined explicitly for public health establishments. Nevertheless, there are no beneficiary caps or payment mechanisms that promote efficiency or effectiveness. Fee-for-service, conversely, which actually incentivizes spending, exists at hospitals. The existence of a maximum budget results in implicit (not explicit) budget caps, and regional administrators must implement cost-control measures, such as ceasing to provide certain services, medicines, tests, and procedures. Such measures often result in the practice of informal payments and copayments.

A new benefits package, the Essential Health Services Plan (PEAS), was defined in 2010 and is estimated to cover 65 percent of the disease burden. With the support of international agencies, the PEAS package did use costing as a basis; calculations included epidemiological estimates of high-risk conditions based on a previous study of the disease burden, the standard care for

packages associated with these conditions, and the cost of direct inputs plus an approximation of indirect costs. The lack of coordination among the defined benefits package, the implementation plan, and the budget process, however, has hindered effective implementation of the PEAS.

The effects of an increased budget and package for SIS must also take into account supply constraints. In poor and rural areas, there is a deficit of health services to effectively cover the broader PEAS package, which includes inpatient hospital services. This is particularly important because expenditure distribution studies clearly indicate that while care at health centers in rural areas is progressive, hospital care is actually regressive because it primarily reaches only urban populations. Increasing the SIS package to complex services and increasing its budget but without considering the rural supply constraints might easily be a way to canalize resources not to the poorest and neediest but to the urban middle classes.

To make the SIS into a mechanism to achieve universal health care, its benefits package must also include complex care. In addition, access barriers in rural areas must be addressed. These barriers include facilitating patient transfers, covering the costs of waiting for care (hotel stays) and family accompaniment, increasing response capacity of specialists in rural areas, expanding diagnostic equipment, and training physicians in new techniques for outpatient surgery. These same barriers also hinder the new government's efforts to implement a national cancer program.

Balance of Power within the Government

However, to fully understand why SIS has not become a broader program, a broader view of national institutions must be included in the analysis. While the Minister of Health is politically responsible, the head of the SIS is appointed by the President of Peru, and the Minister of Health has administrative and budgetary autonomy (the MOH cannot provide those funds for other uses). Given its autonomy, the SIS has the potential to become the "champion" of health coverage extension. However, this has not happened in practice, and the head of the SIS regularly reports to the Minister of Health and has not become a strong independent authority.

The SIS is not the only autonomous body of recent creation in public health. With the AUS law in 2009, the National Superintendent of Health (SUNASA) was created, with the task of monitoring the quality of both health services and insurance plans. While separating the duties of the SIS and the SUNASA is intended to strengthen the supervision of service and plan quality, this division of steering and supervisory duties has just been initiated, and the coordination between SIS and SUNASA is a challenge and the outcome of this policy is still to be seen. Until now, the SIS has not played an active role in the effort to improve the quality of health services, and has not established requirements or incentives for the payment of services based on quality improvements.

Another important institutional issue is that, due to decentralization, regional health directorates outside of Lima have been separated from the direct administrative authority of the MOH, and its regulation is weak. This separation has not been accompanied by new mechanisms that ensure compliance with the governing and regulatory role of the MOH. The SIS, therefore, could become one of the main operating arms the MOH employs to guide and regulate the supply of

health services at public facilities. However, as already mentioned, the MEF has not endorsed SIS, and the MOH has other mechanisms to relate with the regions.

One political consequence of the decentralization in health without a clear division of responsibilities between central and regional governments is that electoral accountability of health outcomes becomes blurred. Citizens cannot establish whether the performance of health services, including SIS, is to be assigned to central or regional governments, so the heads of these divisions of government do not have strong incentives to improve them.

Citizen Empowerment and the Right to Health

By law, the SIS established the right of the poor and excluded populations to join the scheme and their right to receive free health services. However, mechanisms to promote these rights do not exist or are very weak. Institutions and organizations, such as the National Ombudsman and the Civil Society Forum on Health, have conducted studies that highlight the serious deficiencies that still exist within SIS, including cases of discrimination at hospitals against SIS affiliates because hospitals prefer fee-paying patients. And while the MOH has an Office of Health Advocacy and Transparency, it has very little power in Lima and practically none in the regions.

In addition, the Peruvian judiciary system is quite slow and expensive, and in general, it does not promote confidence and is not viewed or used as a means to ensure the free health services that the SIS promises (CARE-OXFAM 2005). The Constitutional Court, while backing some isolated and special claims, has not ruled strongly in favor of the right to health, and the Peruvian Government has not complied with rulings by the Inter-American Commission on Human Rights (CIDH).

4. The SIS and Health Governance in the Context of Decentralization and Epidemiological Transition

In 2002, the Peruvian health system underwent two major, parallel reforms: the creation of the SIS and the decentralization of public health services. SIS was launched in 2002 and has gradually expanded to a bigger (but still reduced) package. Decentralization has been a major reform of public management across sectors; it was initiated in 2002 with the election of autonomous regional governments to which funds, regulations, and services were gradually transferred. The decentralization process of public health was completed between 2004 and 2006. Since then, MOH has direct oversight and administrative power over health care in Lima, while the autonomous regional governments manage health care in the regions through the DIRESAs (ForoSalud 2005).

It is important to evaluate these reforms in the context of the country's epidemiological transition. The transition clearly indicates that maintaining basic public health activities—such as immunizations or tuberculosis treatment—is still essential, but that the country faces the new challenges of noncommunicable diseases, such as diabetes, cardiovascular disease, and cancer (Lavadenz et al. 2011). Noncommunicable diseases require health-promotion and disease-prevention programs, early detection efforts, attention and periodic checks (secondary prevention) if the patient is high risk, and complex interventions in more advanced stages of the disease.

Peru's rural areas, meanwhile, face challenges in providing adequate maternal and child health care as evidenced by the high levels of infant mortality and malnutrition, which require community and intersectoral interventions. Meeting the unique needs of the country's transition, therefore, requires strengthening the entry points to the health system by adding specialists and better, additional testing, and services that are regulated by protocols that establish comprehensive care throughout the health system while containing costs.

Decentralization and Stewardship

Decentralization was supposed to have simultaneously increased and modernized the MOH's regulatory capacity. However, clear mechanisms for defining priorities and policies within MOH's relationship with the DIRESAs were not established.

Today, this relationship operates through two mechanisms: (a) the supply of inputs and medicines linked to the DIRESAs' Health Strategies, which must follow established protocols; and (b) the funding from the SIS to cover the services within the care package is borrowed. For the poorest regions, investment and technical support is also provided by PARSALUD. In addition, ministers from the regions hold meetings with the Minister of Health to discuss the direction of health policy, but any agreements made during these meetings are not legally binding.

The decentralization reforms also came into conflict with the MOH's national programs—Health Strategies—which were once the principal operating arms of the institution, and whose operational and management capacity was diminished after the reforms. Health Strategies today cover a wide range of health problems, but are weak on newer priorities, like mental health and noncommunicable diseases. This is especially true regarding their operating mechanisms. Operationally, the Health Strategies have employed centralized purchasing of supplies and drugs and have weak regulations and supervision.

These Health Strategies are superposed to the MEF's Results Based Budget (Presupuesto por Resultados) initiatives, which provide direct funding to the central and regional governments (specifically to the DIRESAs) without MOH intervention or supervision. The MEF's direct budget transfers to these strategies thus actually weaken the MOH's oversight role. As a result, programs such as TB control have suffered from weaker management capacity, and the pace at which incidence of TB has been reduced has decreased.

Decentralization, moreover, was implemented without clearly defining the roles of the national and regional governments, and was carried out within a context of weak management capacity in many poor regions. The decentralization reforms also failed to establish clearly how national policies would be applied regionally. In this context, previous alternatives that aimed to improve the MOH's governance of hospitals and networks, such as management agreements, were weakened until they disappeared altogether. Other reforms that had improved equity and efficiency, like increased local participation through the CLAS, have suffered a similar fate.

While decentralization reduced the governance capacity of MOH in the regions, the implementation of SIS gave MOH a new tool for establishing priorities and regulating health

services. The SIS budget remains centralized, and is transferred to regional governments following the priorities established in the care package and following the conditions (tariffs, quality controls, budget caps, administrative procedures) approved by SIS.

However, this partitioned system, with SIS and Health Strategies acting separately, clearly weakens the MOH's steering capacity. Furthermore, despite the fact that they are both MOH initiatives, there are coordination problems between the SIS and the Health Strategies. Moreover, the funds directed for health that the MEF provides to the regional governments are not subject to the planning, priorities, standards, and supervision of the MOH. So, the institutional design resulting from the decentralization process reduces the MOH's steering capacity.

Challenges in Rural Areas

In rural Peru, where more than a quarter of the population still lives, there is high inequity in basic care, with much lesser coverage and worse health outcomes than urban areas. Expanded effective coverage would help address these problems (Lavadenz et al. 2011). In these areas, it is necessary to balance the supply of care with the demand and to integrate SIS's efforts with human resource needs.

While significant progress has been made, approaches aimed at promoting demand, such as the SIS and JUNTOS (Francke and Mendoza 2006), face supply deficiencies in rural areas where there is a general lack of professionals and equipment. A special effort to improve health care in rural areas should be a national policy, one developed by the MOH in alliance with regional governments and the DIRESAs.

A key challenge in this regard is to ensure that rural and remote provinces have doctors and nurses, although incentives now draw them to cities. In these areas, salaries are the same as they are in urban areas, while the quality of life is lower and the opportunities for training and additional jobs are fewer. Rural areas, therefore, face big difficulties in recruitment and have low staff retention.

Is it possible and desirable to integrate human resources policy into the SIS? Thus far, human resources policy and the SIS have been seen as separate things. However, if the SIS is to be the tool used to modernize health care management in Peru—a modernization tool that might include new payment mechanisms and better incentives—human resource policy should be integrated into any reform efforts.

Fees paid by SIS only include “variable costs” and do not cover costs associated with human resources or equipment. It is assumed that these costs are already covered in another line of the budget, which is unrealistic in rural areas. A proposal that could be considered is to establish higher payment rates for the SIS in rural areas and to allow some of these additional funds to be used as incentives for health professionals, thus permitting some margin of autonomy for regional governments while following a national human resources policy. This policy proposal prioritizes rural areas and aligns the SIS with decentralization. Peru has had good experiences in the past with incentives to human resources working in rural areas. The Basic Health for All Program in the 1990s, in which health professionals in rural areas received a bonus, enjoyed

success, and so did the CLAS with a similar policy, but with this local health boards in charge of contracting and paying. One path to explore is to use these successful experiences as a basis to fund transfers based on the SIS and in accordance with advances in coverage.

Lima: Meeting New Epidemiological Challenges

In Lima, which has a population of about 9 million (30 percent of the national total), the situation is quite different from in the rural areas. Health services remain dependent on the MOH, and there is a more advanced epidemiological transition (Lavadenz et al. 2011) toward noncommunicable diseases. In addition, the population is wealthier, so private insurance and health services are much more developed. Municipalities have also begun to provide specialized outpatient services by expanding the “Solidarity Hospital” model, a new form of public-private partnerships with small firms.

The use of sporadic consultations designed to address acute episodes of illness, predominant today, is highly inefficient in this context. Public health services are provided by health centers that have little capacity to adequately meet diagnostic needs. These services are also unable to focus on the prevailing disease burden.

Health policy must respond to Lima’s epidemiological transition and address the challenges of chronic diseases with health promotion, prevention, and early detection campaigns, and with efforts to reorganize health networks and services to meet these demands.

At the same time, however, Lima has the advantage of having many MOH health facilities, the EsSalud, the Hospitals of Solidarity, and other municipal and private services. The great challenge then is to (a) increase health promotion for noncommunicable diseases, (b) design public health programs and services that address the new and prevalent chronic diseases from early detection to end-stage care, and (c) use multiple providers and implement a single purchaser, like the SIS.

5. Pending Agenda

The fundamental policy question is whether the Peruvian government will launch a substantial and sustained effort to improve health coverage, whether this effort will include an insurance scheme with a broad benefits package, and whether the SIS will be the institution to implement it.

Until now, SIS has not had the funding and political backing to become the spearhead of increasing coverage and health reform, and both of these objectives have advanced slowly. The new government initiative of Plan Esperanza for cancer has begun to address the challenges of coverage of the burden of noncommunicable diseases, but in a piecemeal way, not as part of a comprehensive package, and not within the SIS.

This fundamental policy question is related to another one: what tools will be used to strengthen health governance within the MOH’s relationship with the DIRESAs? Now, health governance institutions are divided into three operating arms: the Health Strategies and the SIS in MOH, and the budget allocation to regions and health programs by MEF. The new Plan Esperanza for

cancer relies mainly on another government organization, the National Cancer Institute. Coordination problems between these agencies weaken the steering capacity of health authorities.

A new way to set priorities and guide health services is needed that would comprehensively address a variety of issues and promote national stewardship within the decentralized system. What is needed is a global vision comprising policies that integrate public health priorities with incentive-based care and flexibility at the health-facility level. The SIS seems to be the mechanism that could bring this global vision to reality; it can easily incorporate the Health Strategies into its policies, its benefits package includes several diseases and services, and it includes some incentives and allows for administrative flexibility.

A comprehensive approach should be stressed over one that is constituted by many disease-specific or vertical programs. While the vertical programs seem to achieve good results, they are actually inefficient because they address only a small percentage of the disease burden and because they incur diseconomies of scale in a “joint production” like the one that prevails in health facilities. Such programs, moreover, all use different funding and monitoring mechanisms, increasing the administrative burden on health practitioners.

Changes to policy should be accompanied by a major effort to strengthen the technical capacity of the MOH and the SIS. The review of health priorities, the design of effective interventions that link the different levels of care, the breadth and depth of benefits packages, the use of staff incentives, and new payment mechanisms, are some of the issues that deserve attention.

Public Health and Incentives in Primary Care

The MOH’s stewardship on public health issues is still weak, and is particularly weak on health promotion policies that should advocate behavior changes among various actors, including individuals and families, businesses, communities, schools, and institutions. As for the supply of health services, basic infrastructure for primary care does exist, but it has little response capacity, which leads to a serious shortage of coverage in rural areas and to expenditures in hospitals in urban areas concentrated on general practice.

The main problem of health care in remote and poor rural areas is that of human resources and absence of staff incentives. The second and third problems are the provision of inputs and the renovation and maintenance of equipment, and are due to problems associated with budget shortages, greater transportation times and costs, and difficulties in monitoring and supervision of legal mechanisms of transparency and accountability in rural areas.

In this context, the SIS promotes stewardship in prioritizing the public health care services that are included in its benefits package and in reducing the economic barriers that adversely affect coverage. Allocating funds on a targeted, pro-poor basis helps to strengthen primary care, although it ultimately depends on the design and management of the benefits package. The SIS helps provide flexibility in the management of service networks, although administrative systems and political institutions tend to reinforce urban priorities at the expense of rural ones.

Two issues are critical in the area of public health and primary care: (a) the relationship between the SIS and the Health Strategies and other social programs that impact health, like JUNTOS;

and (b) financing and payment mechanisms that should establish incentives for promotion and prevention for the poor and rural areas. Addressing these two challenges will enable SIS to focus mainly on primary care and on current epidemiological priorities. In addition, staff incentives must be implemented, and the organization of health networks must provide early detection, monitoring, and specialized and hospital care when necessary.

The Institutional Architecture of the SIS and its Interaction with the Rest of the Health System

The SIS can be instrumental in the implementation of important reforms and can thus be a way to establish incentives for improvements in the coverage and efficiency of the health system. At present, however, the strength of the SIS's stewardship capacity is weak. Indeed, the SIS's payment mechanisms do not provide sufficient incentives and are not well targeted. In addition, the SIS gives limited autonomy to networks and facilities without clearly establishing the financial responsibilities of the DIREAS, and its monitoring capacity and information utilization is deficient.

To resolve incentive-related problems, the SIS's role vis-à-vis the MOH and the DIREASs needs to be better defined. The challenge is to improve the rural areas' management mechanisms in terms of efficiency and effectiveness, and to ensure that the SIS's incentives prioritize primary care and reach strongly to facilities. The MEF and the MOH should view the SIS as a key to the relationships of national health policies with the DIREASs, and use it as the vehicle to integrate the different programs that are linked to "Quality Spending" budgeting and the Health Strategies, and to promote changes at the national level.

Ultimately, it is necessary to develop the SIS into an insurer—one that promotes managed competition and articulates a diverse supply of public, social security, municipal, and private services in providing prioritized interventions to the poor with a cost containment strategy.

Targeting, Identification, and Enrolment of Beneficiaries

The SIS's targeting mechanism primarily relies on the application of the Socio-economic Evaluation Sheet at health facilities. This alternative is inefficient and a drain on the capacities and administrative processes of health facilities. The best alternative is a single targeting system for all social programs. While this alternative, the SISFOH, has already been approved, its application has been slow, especially in larger cities where individual targeting is most needed.

This system could, importantly, improve the mechanisms for reviewing and updating SIS affiliations, and target cases in which a catastrophic illness could lead a family to fall into poverty. The SISFOH, therefore, could be improved if it included a mechanism to identify households that have health problems that could result in catastrophic costs, and a subsequent mechanism to reclassify them as poor and in need of financial assistance or other social protection.

In addition, in a context of budgetary and resource constraints, the pre-allocation of budget ceilings for regions and hospitals can be used as an explicit way to improve targeting and to

clearly establish decentralized management responsibilities of the insurance scheme. Thus, the budget should be prioritized for poorer regions and for primary care.

The Administration of Public Funds and Budget Management in the SIS

There are no mechanisms to prioritize transparently the allocation of funds while ensuring a balance between budget and demand for health care. When this happens, rationing occurs in an unplanned and discretionary way. Other problems also arise; fees associated with the SIS do not cover the costs of infrastructure, equipment, and personnel, which are covered by other budget lines and are not necessarily planned according to needs. In many parts of the country, and especially in rural areas, there are serious deficiencies in infrastructure, equipment, and personnel, which require establishments contracting out to meet the additional demand. The cost differentials between urban and rural areas also hamper the expansion of the coverage in rural areas.

Finally, because SIS funds are transferred to implementation units that may be distant from health facilities and centered in hospitals, they may only marginally help in giving more autonomy to primary care networks, limiting the strength of the incentives that may contain payment mechanisms.

The main challenges in this area are as follows: (a) SIS rates need to be reviewed so they include higher costs in rural areas to take into account existing deficiencies in infrastructure, equipment, and personnel; (b) new mechanisms need to be established for the delivery of funds, such as the CLAS system, which would give more management flexibility to health networks and primary care facilities, while reinforcing incentives to achieve health outcomes and promote citizen participation; and (c) the SIS should be allowed to be used for special staff incentives, especially in rural areas.

Management of the SIS Benefits Package

At present, the benefits package has no defined review procedures, is not based on costing studies or calculations, and does not include the participation of civil society or the state in its discussion or approval. There is also little correlation between the benefits package and the budget.

The benefits package must be adjusted to reflect Peru's epidemiological transition, and should therefore include primary and secondary prevention of noncommunicable diseases in an integrated way. At the same time, however, the SIS benefits package must account for regional differences in epidemiological profiles, supply of skills, demand for services, and cost.

Managing the benefits package requires greater coordination through a special committee composed of representatives from the MOH, SIS, and the MEF. The committee must ensure that a multiyear budget can effectively cover the benefits offered, and guarantee that no other risks or benefits will be added without a corresponding budget. An annual or biannual review of the benefits should be mandated, and the review should include established calculation procedures that approximate the cost-effectiveness of the package and an evaluation of the effect of incentives on efficiency.

Annex 1 Overview of Peru's Health System, including Financing and Delivery

The MOH is the governing body that oversees the nation's public health. The National Superintendent of Health (SUNASA), an autonomous entity, supervises and monitors the health system, including public and private providers and insurance.

The public health system (MOH/DIRESAs) is the principal means by which the state provides health care to the general population. In Lima, this system includes 17 specialty and general hospitals, 180 health network centers, and 168 health posts that are under the direct control of the MOH. In regions outside the capital, public providers are run by regional governments, and each region has at least one regional hospital, a few local hospitals, and dozens of health network centers and health posts.

The MOH health services outside of Lima were transferred to the 25 regional governments during the decentralization process in 2004 and 2005, and are currently managed by the DIRESAs. In total, the public system through the MOH/DIRESAs has 155 hospitals, 5,906 health centers, and 1,321 health posts (2009 data), and covers almost all districts in the country. The public system is the primary provider in rural areas and small towns. The system's funding comes from the national treasury, and to a lesser extent, from user fees (especially from SIS nonmembers who purchase medicines and supplies). These fees constitute a significant economic barrier to access for the poor. Regional governments do not collect taxes and depend on transfers from the public treasury.

EsSalud, the social security system for health, serves about a quarter of the population, and this population is primarily located in cities, where work in the formal sector is available (employees pay a mandatory 9 percent of their salary to contribute to the system). Also, EsSalud covers only a small proportion of independently insured individuals. There are 384 EsSalud establishments nationwide, and the hospitals are primarily located in large cities. EsSalud is governed through a centralized administration, and has not gone through a process of decentralization. Legally, EsSalud insures against all risks to health without limitations of any kind, and covers loss of wages due to illness and maternity leave. EsSalud contracts with few private providers, although it recently initiated a contract for the construction and operation of two large private hospitals that should eventually serve 500,000 policyholders. The National Police, the army, the navy, and the air force have their own insurance and providers.

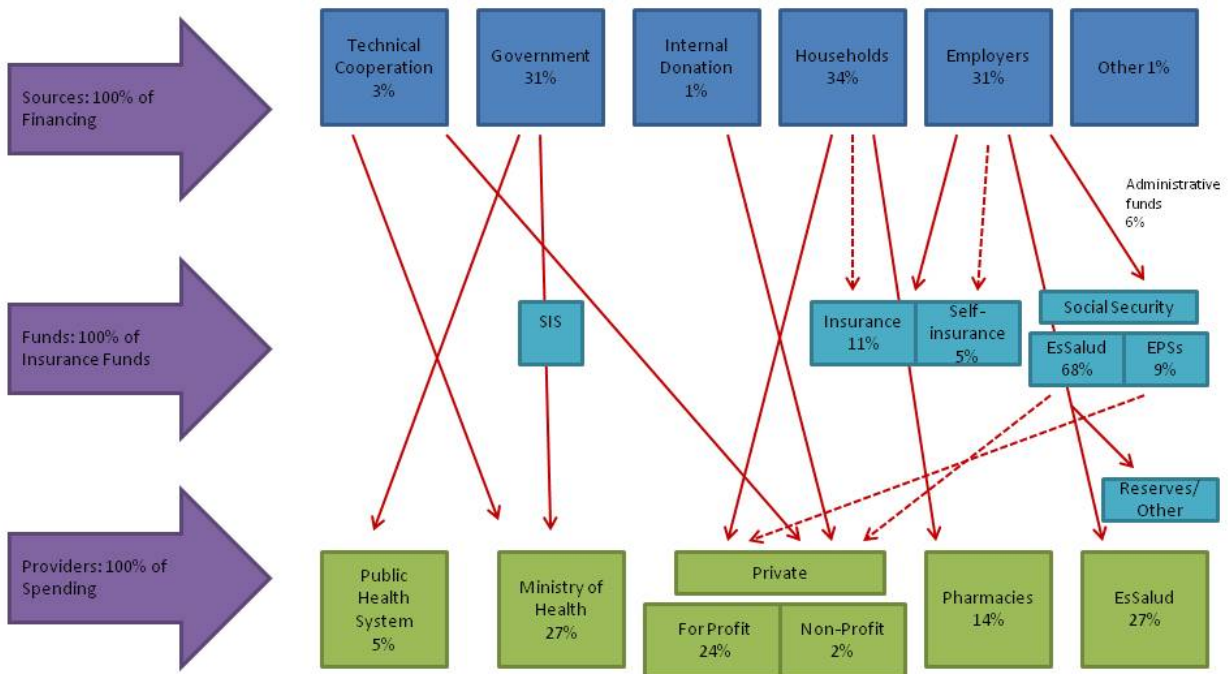
The private sector is emerging and expanding primarily in urban areas due to strong economic growth in the last decade. Services in the private sector are mainly financed through out-of-pocket payments. For nonserious illnesses, a large proportion of the population goes to private pharmacies for medical consults, where they can also get prescription drugs without a prescription (although this illegal).

Private insurers cover a small percentage (3 to 5 percent) of the population, but coverage is expanding. In addition, the Social Security Health Act allows workers in the formal sector to contract with a private insurer (Empresas Prestadoras de Salud) and contribute a quarter of the mandated contribution to social security (2.25 percent of their monthly salary). The Empresas Prestadoras de Salud contribution covers only a basic amount of care to its members—who are

primarily middle class—and many choose to pay an additional amount to obtain broader risk coverage.

Figure A1.1 displays the financial flows within the health system (MINSA 2008). Total health spending is 5 percent of GDP, below what is expected for an upper-middle-income country. A high percentage (approximately 35 percent) of this is private spending, mostly out-of-pocket. The contribution of employers to EsSalud accounts for another 31 percent of spending, and financing from the national treasury accounts for another 31 percent.

Figure A1.1 Financing Flows of Peruvian Health System, 2005



Annex 2 Brief Description of Public Health, Primary Care, and Supply Efforts

Primary care is provided through a network of health centers and posts and is quite expansive, reaching many rural populations. While the health posts generally lack a physician, the health centers have a general practitioner and basic equipment. However, they do not have the capacity for inpatient or emergency care. Thus, while the incidence of immunizations and prenatal care is high at 95 percent, the rate for institutional deliveries in rural areas is still below 60 percent. Hospitals provide outpatient care, (including general and specialized medicine), diagnostic tests, hospitalizations, and surgeries. The collection of fees (at subsidized prices) for the services is widespread and largely unregulated, and medicines are sold at cost. The referral system is weak, and patients can usually go directly to the hospital. Visiting a health center prior to the hospital does not give a patient preference in receiving care, and often tests that were conducted at the health center are unnecessarily repeated.

A major effort to improve the supply of services in poor areas has been the Health Strategies, (formerly “national” or “vertical programs”). The Health Strategies are MOH initiatives that reinforce the strength and capacity of certain services by buying and distributing critical inputs, establishing protocols, providing training to health professionals, and monitoring epidemiological trends. The primary Health Strategies are:

- Broad coverage of the immunization program. In recent years, primary health care strategies have been broadened to cover a greater number of diseases, which has resulted in a reduction in the number of people covered.
- The tuberculosis program achieved important successes in the 1990s, but its strength and effectiveness decreased in the last decade. The country now faces challenges associated with the growth of multi-drug- and extra-drug-resistant cases.
- The family planning and reproductive health program has received international support for many years and has been effective in achieving broad access to contraception and in tackling HIV/AIDS.
- The maternal health program has aimed to expand coverage and improve the quality of deliveries.

Despite these efforts, public health care in rural areas is poor and weak. There are difficulties in retaining health professionals due to the lack of bonuses or other incentives. And while there is a mandatory program (SERUM) that requires recent medical school graduates who want to work in the public system to serve in rural areas, it is not strictly enforced. Rural areas also often lack medicine, safe blood, equipment, and ambulances. Since its inception, the SIS has been viewed as a mechanism to support primary health in rural areas, because it covers the costs of supplies, materials, and services in the benefits package.

The government has a special program, called PARSALUD, which funds investments in health infrastructure and equipment in rural areas. Supported by the World Bank and the Inter-American Development Bank, PARSALUD aims to improve the responsiveness of health service networks for obstetric and neonatal emergencies in the nine poorest regions of Peru. The budget for PARSALUD II is approximately US\$170 million, which includes technical assistance

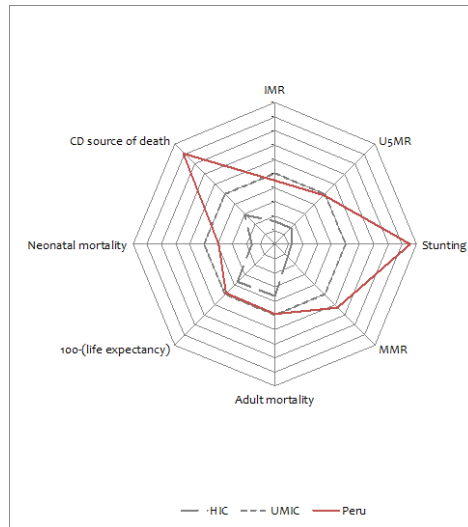
activities. Regional and local governments also make investments in health infrastructure and equipment.

In rural areas, mobile brigades, called ELITES, composed of doctors, nurses, and other professionals, provide service in remote areas. In addition, in rural and poor urban areas, health promoters do community outreach and provide health education and minor health services.

One challenge in the poor, rural areas of Peru is the adaptation of health services to cultural norms. Many of these areas have concentrated Quechua, Aymara, or other indigenous populations. The state's efforts to address this problem have thus far been relatively few and localized to the southern highlands, where efforts have focused on institutional deliveries.

Annex 3 Spider Web

I. Outcomes comparisons: Peru and Upper Middle Income Countries



Note on interpretation:

In this plot 'higher' is 'worse' – since these indicators are positive measures of mortality / morbidity. Life expectancy is converted to be an inverse measure.

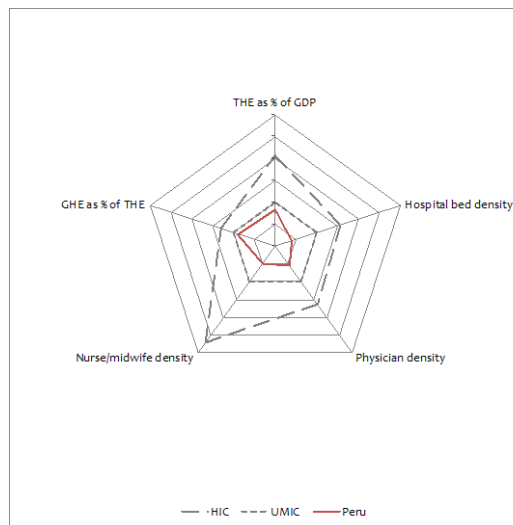
The values on the radar plot have been standardized with respect to the average upper middle income country value.

The table below summarizes outcome comparisons with the average upper middle income country (UMIC).

Country Data	Peru	UMIC	% Diff.
GNI pc (2000 USD)	2005.9	1899.0	5.6%
IMR	14.9	16.5	-9.7%
U5MR	19.2	19.6	-2.2%
Stunting	28.2	14.8	91.1%
MMR	67.0	53.2	25.9%
Adult Mortality	158.5	160.6	-1.3%
100-Life Expectancy	26.2	27.2	-3.4%
Neonatal Mortality	9.0	11.4	-21.1%
CD mortality	40.0	22.0	81.8%

IMR: Infant mortality rate (2010). U5MR: Under-5 mortality rate (2010). Stunting: prevalence of low height-for-age among children under 5 (2010). MMR: Maternal mortality rate (2010) per 100 000 live births. Adult mortality: Adult mortality rate per 1000 male adults (2010). [100-(life expectancy)]: Life expectancy at birth (2010) subtracted from maximum of 100. Neonatal mortality: Neonatal mortality per 1000 living births. CD as cause of death: Communicable diseases as cause of death (% total). All data from World Bank's World Development Indicators. Income averages for stunting calculated by Bank staff and are unweighted.

II. Inputs comparisons Peru and Upper Middle Income Countries



Note on interpretation:

This plot shows indicators which measure spending on health or the number of health workers per population.

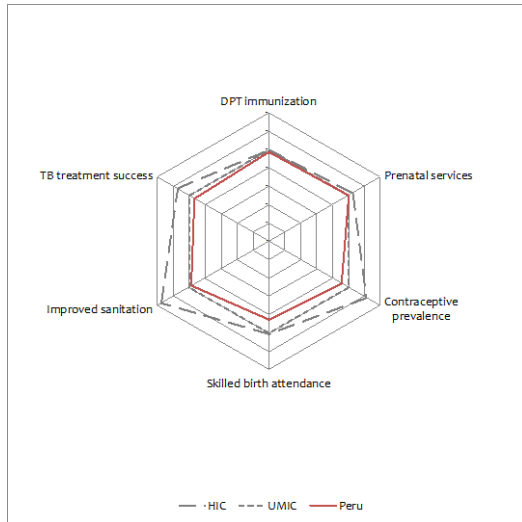
The values on the radar plot have been standardized with respect to the average upper middle income country value.

The table below summarizes inputs comparisons with the average upper middle income country (UMIC).

Country Data	Peru	UMIC	% Diff.
GNI pc (2000 USD)	2005.9	1899.0	5.6%
THE %GDP	5.1	6.1	-16.9%
Hosp. bed density	1.5	3.7	-59.1%
Phys. density	0.9	1.7	-45.5%
Nur./midwife dens.	1.3	2.6	-51.3%
GHE %THE	48.3	54.3	-11.0%

THE as % of GDP: Health expenditure, total (% of GDP) (2010). Hospital bed density: Hospital beds per 1,000 people (latest available year). Physician density: Physicians per 1,000 people (latest available year). Nurse/midwife density: Nurses and midwives per 1,000 people (latest available year). GHE as % of THE/10: Public health expenditure (% of total expenditure on health) (2010). All data from World Bank's World Development Indicators.

III. Coverage comparisons Peru and Upper Middle Income Countries

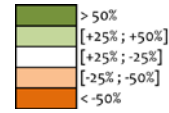


Note on interpretation:

In this plot 'higher' is 'better' – since these indicators are positive measures. In this case, all are percent of the population receiving or having access to a certain health related service.

The values on the radar plot have been standardized with respect to the average upper income country value.

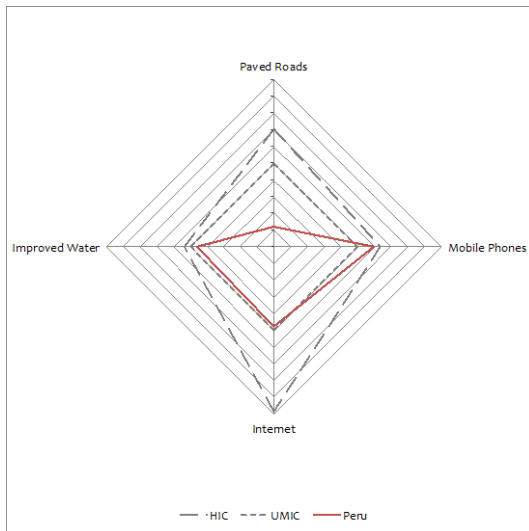
The table below summarizes coverage comparisons with the average upper middle income country (UMIC).



Country Data	Peru	UMIC	% Diff.
GNI pc (2000 USD)	2005.9	1899.0	5.6%
DPT	93.0	95.8	-2.9%
Prenatal	94.7	93.8	1.0%
Contraceptive	73.2	80.5	-9.1%
Skilled birth	83.8	98.0	-14.5%
Sanitation	71.0	73.0	-2.7%
TB success	81.0	86.0	-5.8%

DPT immunization: % of children aged 12-23 months with DPT immunization (2010). Prenatal services: % of pregnant women receiving prenatal care (latest available year). Contraceptive prevalence: % of women ages 15-49 using contraception (latest available year). Skilled birth attendance: % of all births attended by skilled health staff (latest available year). Improved sanitation: % of population with access to improved sanitation facilities (2010). TB treatment success: Tuberculosis treatment success rate (% of registered cases). All data from World Bank's World Development Indicators.

IV. Infrastructure comparisons Peru and Upper Middle Income Countries

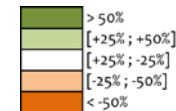


Note on interpretation:

In this plot 'higher' is 'better' – since these indicators are positive measures of provision of certain good / service, and a measure of urban development.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

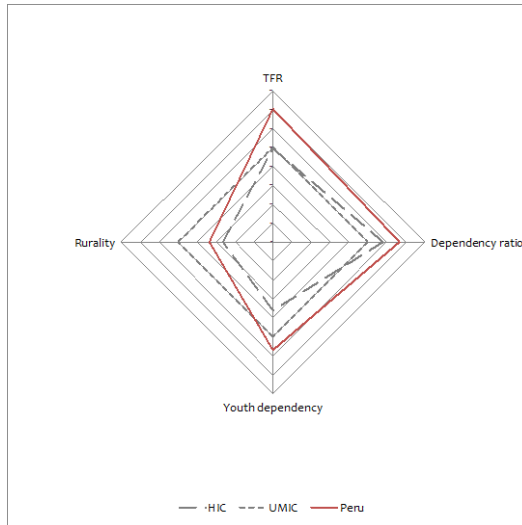
The table below summarizes infrastructure comparisons with the average upper middle income country (UMIC).



Country Data	Peru	UMIC	% Diff.
GNI pc (2000 USD)	2005.9	1899.0	5.6%
Paved roads	13.9	57.6	-75.9%
Mobile phones	110.4	92.3	19.6%
Internet	36.5	38.3	-4.8%
Water	85.0	92.6	-8.2%

Paved roads: % of total roads paved (most recent). Internet users: users per 100 people (2010, with some estimates from prior years). Mobile phone users: mobile cellular subscriptions per 100 people (2010). Access to improved water: % of population with access to improved water source (2010). All data from World Bank's World Development Indicators.

V. Demography comparisons Peru and Upper Middle Income Countries

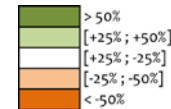


Note on interpretation:

Indicators here measure births per woman, the extent of rurality, and the number of dependents.

The values on the radar plot have been standardized with respect to the average upper middle income country value.

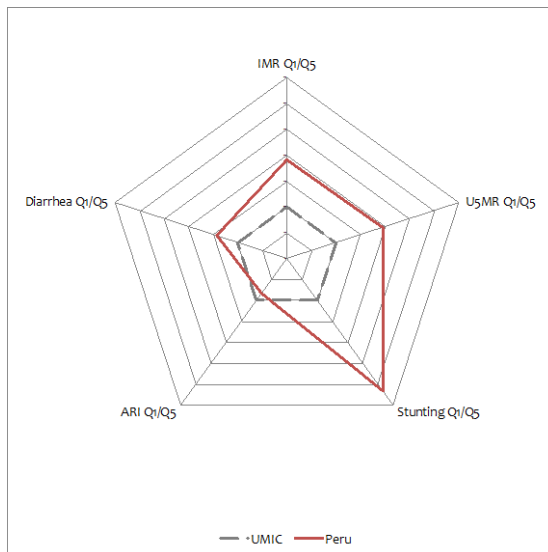
The table below summarizes demographic indicators comparisons with the average upper middle income country (UMIC).



Country Data	Peru	UMIC	% Diff.
GNI pc (2000 USD)	2005.9	1899.0	5.6%
TFR	2.5	1.8	41.2%
Dependency (Total)	56.4	42.2	33.4%
Youth share	83.1	73.0	13.9%
Rural pop.	28.4	42.6	-33.3%

TFR: total fertility rate (births per woman), 2009. Dependency ratio: % of working-age population (2010) aged less than 15 or more than 64. Youth dependency: % of working-age population (2010) aged less than 15. Rurality: % of total population in rural areas (2010). All data from World Bank's World Development Indicators.

VI. Inequality comparisons Peru and Upper Middle Income Countries

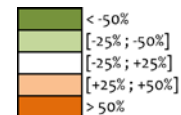


Note on interpretation:

In this plot 'higher' is 'inequal' and indicators here measure inequalities in selected health outcomes by taking the ratio of prevalence between Q1 and Q5.

The values on the radar plot have been standardized with respect to the average upper middle income country value. Data are not available for high income countries (HIC).

The table below summarizes inequality indicators comparisons with the average upper middle income country (UMIC).



Country Data	Peru	UMIC	% Diff.
GNI pc (2000 USD)	2005.9	1899.0	5.6%
IMR Q1/Q5	4.6	2.4	90.3%
U5MR Q1/Q5	5.3	2.7	94.9%
Stunting Q1/Q5	10.4	3.3	216.5%
ARI Q1/Q5	1.2	1.4	-17.1%
Diarrhea Q1/Q5	2.4	1.7	42.9%

All indicators measure the ratio of prevalence between the poorest (in Q1, the first wealth distribution quintile) and the richest (in Q5, the fifth wealth distribution quintile). The data (latest data available) are taken from HNPstats (<http://data.worldbank.org/data-catalog/HNPquintile>).

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The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.



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