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**HEALTH SERVICES SYSTEM PROFILE OF PERU**

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ORGANIZATION AND MANAGEMENT OF HEALTH SYSTEMS AND SERVICES  
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## **EXECUTIVE SUMMARY**

The Republic of Peru has a unitary, representative, and decentralized government, organized according to the principle of the separation of powers. The country is divided into 24 departments, 188 provinces, and 1,793 districts. In accordance with its Constitution, it has a decentralized government. The *municipios* (provincial and district) have little political, economic and administrative autonomy to carry out development plans in certain areas, notwithstanding they have available a Framework Decentralization Law. Serious political difficulties both prior to and following the change of government in July 2000 prompted the Congress to remove the previous president in November 2000 and establish a Constitutional transition government. The general elections were held on April 8, 2001 and the change in government will take place at the end of July.

The health services system is fragmented. It is comprised of two subsectors: the public and the nonpublic subsectors. In 1999, the former had 6,687 health establishments (89% of the national total), including 6,208 establishments of the Ministry of Health (MINSA), 321 establishments of the Social Security System (ESSALUD--formerly called IPSS), and 158 health units of the Armed Forces and National Police. During that same year, the remaining 11% of the health facilities pertained to the nonpublic subsector. According to the 1997 National Standard of Living Survey, only 23.5% of the population had health insurance, in 1997, mostly through social security. By the year 2000, of the total number of people who reported that they had symptoms of a disease or had been involved in an accident and thought they needed medical attention, 31% could not gain access to the health services, primarily because of a lack of economic resources. Only 8% received attention through noninstitutional services such as pharmacies or a traditional healer. Therefore, only 69% received medical attention provided by a health professional. From the functional standpoint, the Ministry of Health exercises the steering role within the sector and is in charge of issuing policy guidelines as well as the technical standards and procedures to regulate sectoral activity. Coordination among the institutions of the sector is limited due to the lack of permanent consensus-building agencies. The transitional government established a consultative committee to advise the Minister of Health on critical aspects of sectoral policy. The institutions of the sector organize their services by levels of care; however, referral and cross-referral mechanisms are still deficient. The model of care includes individual and collective health activities, which are being reviewed in order to bring them in line with the new legal framework established by the General Health Law (LGS) and the Law on Modernization of Social Security (LMSS), enacted in 1997.

In 1998, the system was funded by the following sources: government, 25%; households, 38%; companies, 35%; and external funds, 2%. Total health expenditure that year was the equivalent of 4% of GDP, and per capita health expenditure was US\$99.

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The health sector reform (SR) implemented by the previous government had guiding principles based on the "Health Policy Guidelines 1995–2000" and a new legal framework. The work agenda emphasized several points: restoration of the problem-solving capacity of the first level of care by increasing public social spending; reform of Social Security to open the first level of care to private providers; development of programs that ensure care for targeted vulnerable groups, such as insurance for schoolchildren and maternal and child insurance (still in the pilot stage); and community participation in the management of primary care facilities through Local Health Administration Committees (CLAS). Although the subject of institutional restructuring was proposed in the agenda, it did not move forward. Despite its problems, Peru has made progress during the last six years. There was an increase in the coverage of institutional care of the total number of people with symptoms of disease or injuries from accidents from 32.2% (1994) to 43.5% (1997) and to 49.3% (2000). The Ministry Of Health increased its share of total institutional coverage from 16.3% (1994) to 25% (1997) and to 29.5% (2000), thanks to increased resources allocated for primary care.

## 1. CONTEXT

**1.1. Political Context:** In accordance with its Constitution (article 43), the Republic of Peru has a unitary, representative, and decentralized government, organized according to the principle of the separation of powers. The Legislative Branch has a single chamber in charge of enacting laws. The Executive Branch, led by the Head of State, is responsible for carrying out laws and taking the initiative in the drafting of them. The Judicial Branch administers and dispenses justice in accordance with the Constitution and the laws. The country is divided into 24 departments, 188 provinces, and 1,793 districts. Although according to its Constitution Peru has a decentralized government, the *municipios* (provincial and district) have little political, economic and administrative autonomy to execute matters within their purview. Serious political difficulties both before and following the change of government in July of 2000 prompted the Congress in November 2000 to remove the previous president and establish a Constitutional transitional government until July 28, 2001.

Since the government deactivated the National Planning Institute in 1993, there has been a vacuum in terms of national and sectoral planning. Since the final years of the last decade, the Ministry of Economy and Finance has gradually assumed some planning functions. In 2000, the Law of Fiscal Prudence and Transparency established the Multi-year Macroeconomic Framework, and directives were issued to carry out sectoral and institutional strategic plans. Social development policy is formulated by an Interministerial Council on Social Issues (Ministries of the Presidency, Education, Health and Promotion of Women and Human Development). The Ministry of Health (MINSA) rules the health sector, and its functions include the drafting of sectoral policy. Sectoral activity falls within the purview of State reform, which has been in progress since 1995. Its objective is to restructure the general and specific functions of the State and to define public-private and interinstitutional consensus building of the various agents in the health sector. The principal political and social problems that influence the delivery of health services are linked to poverty, the lack of opportunities for employment and low salaries, the highly diverse ethnic and cultural profile, the dispersion of the population, and centralization.

**1.2. Economic Context:** Real GDP per capita decreased during 1998 and 1999, with a slight recovery in 2000. Until 1997, economic growth was sustained through fiscal and monetary austerity, the restructuring of public spending, reintegration into the international economy, and incentives for private investment, fostered by the reestablishment of peace in the country and market deregulation. Starting in 1998, economic activity contracted strongly due to internal social and political problems. Added to this were external problems such as sudden capital flight associated with international financial crises, El Niño, and variations in the prices of principal export products. The negative balance of the second half of the decade has been common in countries of the Andean Community (CAN), while MERCOSUR countries registered a 4% increase.

**SELECTED ECONOMIC INDICATORS**

<b>Indicator</b>	<b>1991</b>	<b>1992</b>	<b>1993</b>	<b>1994</b>	<b>1995</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>
GDP per capita (US\$)*	1,922	1,858	1,768	2,152	2,505	2,527	2,659	2,551	2,271	2,180
Economically active population, in thousands	N/A									
Inflation*	139.2	56.7	39.5	15.4	10.2	11.8	6.5	6.0	3.7	3.7
Total public spending (% of GDP)**	28.6	31.3	29.2	30.4	31.0	29.0	26.2	25.9	27.2	N/A
Public social spending (% of GDP)***	N/A	N/A	3.6	4.0	6.0	6.0	5.7	6.5	7.1	7.9
Total health expenditure (% of GDP)****	N/A	N/A	N/A	N/A	4.4	4.2	4.0	4.4	N/A	N/A

\*National Institute of Statistics and Informatics (INEI). \*\*Includes current and capital expenditure of the general government. National Institute of Statistics and Informatics (INEI). \*\*\* Includes expenditure on education, health, programs for extreme poverty, and other social spending. \*\*\*\* Preliminary National Accounts of Health in Peru. Database. MINSA-PAHO. N/A = unavailable.

**Sources:** Prepared on the basis of: a) Cuanto, S.A. Statistical Yearbook. Peru in Numbers 2000. Tables 18.5; 17.2; 30.18; 30.37; b) MINSA-PAHO. Preliminary National Accounts of Health of Peru, 1997-1998. Database. Lima, 2001.

Per capita GDP for 2000, estimated at US\$2,180, was similar in real terms to that of 1985 and 10% less than that of 1980. According to the structure of GDP for the new base year (1994), economic activity relies heavily on services. The primary sector (agriculture, fishing, and mining) represented 14%; manufacturing, 21%; construction, 6%; electricity and water, 2%; trade, 15%; transportation and communications, 8%; the government, 6%; and other services, the remaining 28%. The reduction of public spending as a percentage of GDP was due to State restructuring, while public social spending continued to increase, doubling the amount of expenditure during the first half of the decade: from 3.9% of GDP in 1993 (US\$91.30 per capita) to 7.9% of GDP by 2000 (US\$180.20 per capita). The share of total public sector financing represented by external financing is not known.

**1.3. Demographic and Epidemiological Context:** The estimated total population of Peru at mid-year 2001 was 26,090,330, of which 33% is under 15 years of age, and 5% over 64. The population is concentrated in the large coastal cities, especially Lima, which is home to nearly a third of the population. Annual population growth, estimated at 1.7% for 2000, continued to fall as a result of declines over the past decade in total fertility, the birth rate, and mortality.

The total fertility rate (TFR), however, shows differentials of 2.3 for urban areas and 4.6 for rural areas. There is a wide variance depending on the educational level of women, with TFRs of 6.9 for women without education, 5.0 for women with primary education, 3.0 for women with secondary education, and 2.1 for women higher education.<sup>1</sup> In addition, life expectancy by department ranges from 72 to 77 years for Lima, Callao, and certain coastal departments, to from 57 to 63 years for the Andean departments. The crude death rate in 2000 was estimated at 6.3 per 1,000 population, a figure that also declined from 12.8 in the 1970s to 9.0 in the 1980s.

**Comparison of Selected Demographic Indicators, 1990 and 2000**

	<b>1990</b>	<b>2000</b>
Urban population (%)	70.3	72.3
Annual population growth (%)	1.9	1.7
Crude birth rate (per 1,000 pop.)	29.0	23.7
Total fertility rate (children per woman)	3.7	2.9
Life expectancy at birth (years)	65.6	69.1
Crude death rate (per 1,000 pop.)	7.2	6.3
Infant mortality (per 1,000 pop.)	61.6	39.0
Maternal mortality (per 100,000 pop.)	N/A	265 *

\* Corresponds to 1996.

Sources: INEI. Peru: Estimates and Projections of the Population by Calendar Year and Basic Age, 1970-2025. Lima: INEI; 1995. INEI. Status of the Peruvian Population 2000. Lima: INEI; 2000.

The official estimate of infant mortality (IMR) in 2000 was 39 per 1,000 live births,<sup>2</sup> while the preliminary finding of the 2000 Demographic and Family Health Survey (ENDES, 2000) is 33.1 per 1,000 live births. There are major differences between regions of the country, with levels of below 20 per 1,000 live births in Lima and Callao, and above 60 in Apurímac, Ayacucho, Cuzco, Huancavelica and Puno. In general, the IMR in rural areas is double that of urban areas. According to the 1996 ENDES, infant mortality of boys was greater than that of girls, and the mortality differentials increase the lower the age of the mother and the shorter the intergenetic period. On the other hand, children of mothers without education have a three times greater risk of dying than children of mothers with a higher education.

Analysis of the causes of death in Peru is influenced by underreporting of deaths, which was estimated at 43% in 1998. Furthermore, of reported deaths, only 79% were certified by a physician. Respiratory tract diseases, particularly pneumonia and chronic obstructive pulmonary disease continue to be the leading cause of total mortality. The number of deaths from neoplasms and cardiovascular problems increases every year. Violent deaths increased between 1990 and 1998 due to traffic accidents. Among children under 1 year old, neonatal illnesses, acute respiratory infections (ARI), and acute diarrheal diseases (ADD) or intestinal infections accounted in 1998 for 39%, 21%, and 6% of the causes of death, respectively. For children from 1 to 4 years old, ARI, ADD, and external causes together accounted for 56% of the causes of death.<sup>3</sup> ADD, ARI, meningitis, malaria, septicemia, vaccine-preventable diseases, and nutritional deficiencies accounted for 42% of the causes of death for children under 5. This share ranges from 50-60% for Puno, Piura, and Huancavelica, to 25-30% for Moquegua, Lima, and Callao. Maternal mortality has not declined significantly in the last 36 years, showing rates (MMR) of 400, 318 and 265 deaths per 100,000 live births in 1960, 1980 and 1996, respectively.<sup>5</sup> As a result, reducing maternal mortality is considered a national priority. It is estimated that 1,670 women die each year as a

consequence of complications from pregnancy, childbirth, and puerperium, with 15% of them young pregnant women. However, the standard registry of the Ministry of Health has only reported 492, 366, and 378 deaths per 100,000 live births for the years 1996, 1997, and 1998, respectively.<sup>7</sup> The national MMR average masks major differences between regions, socioeconomic strata, and population groups. In 1996, the MMR in Huancavelica was greater than 400 per 100,000 live births, while in Lima it was less than 40. Rates in rural areas are double those of urban areas. For women without education, the MMR was 489 deaths per 100,000 live births, while for women with higher education it was 49. The MMR for adolescents from 15-19 years old was 362, much higher than the national average. The risk of dying for women from 15-44 years old was 35.4 times higher in Stratum V (population with more unmet basic needs than in Stratum I (the population with less unmet basic needs)). Most maternal deaths are due to direct and avoidable causes such as hemorrhages (44.8%), complications from puerperium (10.9%), and complications from abortion (12.3%). It is estimated that 270,000 unwanted pregnancies annually end in abortion, accounting for 30% of total pregnancies.

With regard to morbidity, communicable diseases continue to be a national priority. In 1998, among the population from 12-64 years old, 44.5% consumed tobacco during the past year, 79.6% alcohol, 0.7% marijuana, 0.6% cocaine paste, and 0.1% cocaine.<sup>4</sup>

**1.4. Social Context:** The 2000 Human Development Report<sup>5</sup> indicates that in 1998, Peru's human development index was 0.737, placing the country in 80<sup>th</sup> position in the world. In the gender-related development index, Peru was 71st. These levels were similar to those of 1997. As of the end of 2000, of the 11.9 million people who made up Peru's economically active population (EAP), 10.2% were unemployed, 50.8% underemployed, and only 39% adequately employed.<sup>6</sup> The targeting of spending was the central objective of social policy in 2000. The goal was to reduce extreme poverty by 50% from 1991 levels, when 26.8% of the population lived in extreme poverty. By 2000, that figure was 14.8%, a reduction of 45%. Nevertheless, poverty has persisted: it declined from 57.4% to 50.7% between 1991 and 1997, and then increased to 54.1% by 2000. Poverty continues to predominate in rural areas in relative figures, although in absolute figures there are more poor people living in urban areas. Extreme poverty continues to be concentrated in rural areas.<sup>7</sup> Despite the increase in social spending and improvements in some social indicators mentioned above, there remain institutional weaknesses that have prevented more progress in areas that have otherwise improved. There are problems with intersectoral coordination and duplication of efforts; absence of a steering role capacity in the social sectors; deficient targeting; regressive expenditure; little transparency; lack of state planning; poor management of social programs; postponement of serious decentralization; functional weakness of the Interministerial Council on Social Issues; and a lack of coordination between social and economic development policies.<sup>8</sup> Between 1994 and 1997, income concentration as measured through the Gini coefficient increased from 0.469 to 0.484, with the income ratio between the highest and lowest quintiles rising from 10.7 to 13.9.<sup>9</sup>

The principal social and political problems that affect health are linked to poverty, the lack of adequate employment, ethnic and cultural diversity, and population dispersion, particularly in the Andean and Amazon communities. Although there is no precise data on how the population is distributed among the different ethnic groups, the 2000 National Standard of Living Survey reported that 16.5% of the population do not speak Spanish as the mother language, but rather the Andean languages (14%) such as Quechua and Aymara, and to a much smaller measure (2.5%), Amazon languages.<sup>10</sup> In 1996, 10.6% of the population was illiterate. Illiteracy in rural areas was five times greater than in urban areas (23.7% and 4.5%, respectively). Between 1993 and 1996, female illiteracy declined from 18.3% to 15.2%; the level of secondary instruction rose from 31.4% to 40.7%; and the percentage of people with higher education increased from 10.8% to 18.7%.

## 2. HEALTH SERVICES SYSTEM

*2.1 General Organization:* Health services in Peru are grouped into two subsectors: the public and the nonpublic. The first is comprised of the Ministry of Health, ESSALUD, and the services of the Armed Forces and the National Police. The public subsector has 51% of total hospitals, 69% of health centers, and 99% of health posts, located in remote rural areas and marginal urban areas. The Ministry of Health is the institution with the greatest number of establishments and the greatest national presence.

**Health Establishment by Subsector and Institution, 1999**

Institution	Type of establishment			
	Hospitals	Health centers	Health posts	Total
<b>Public subsector</b>				
Ministry of Health	139	1,115	4,954	6,208
ESSALUD	91	38	192	321
Armed Forces and Police	20	81	57	158
<b>Subtotal</b>	<b>250</b>	<b>1,234</b>	<b>5,203</b>	<b>6,687</b>
<b>Nonpublic subsector*</b>				
Private	224	440	16	680
Others	12	104	18	134
<b>Subtotal</b>	<b>236</b>	<b>544</b>	<b>34</b>	<b>814</b>
<b>Total for health sector</b>	<b>486</b>	<b>1,778</b>	<b>5,237</b>	<b>7,501</b>

Source: a) MINSA: Segundo Censo de Infraestructura Sanitaria y Recursos del Sector Salud, 1996. Lima: Oficina de Estadística e Informática; 1996. b) ESSALUD. Estadísticas de Prestaciones de Salud 1999. Lima: Gerencia Central de Finanzas. En preparación; 2000. c) MINSA. Infraestructura Sanitaria de Salud 1999. Lima: OGEI. In progress. 2000.

\* The information for the nonpublic health sector is for 1996.

The Ministry of Health is the predominant health provider for the poor population that does not have insurance (ESSALUD). ESSALUD covers formal sector workers, and its establishments are located mainly in urban areas. The services of the Armed Forces and National Police only cover their workers and immediate family members. The private subsector concentrates its resources on the principal cities and is comprised of clinics, physician's offices, and, to a lesser extent, NGOs.

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The central level of the institutions of the sector issues guidelines on policy, standards, and technical procedures. Coordination among the institutions does not take place on a regular basis, since there are no permanent consensus-building agencies. At the start of 2001, an Advisory Committee on Health was established to advise the Minister of Health on critical aspects of sectoral policy.

The central structure of the Ministry of Health has a high-level management entity (Minister and Vice Minister), as well as entities that provide oversight and advisory services (Planning; Legal Advisory Services; Epidemiology; and the Office of Financing, Investments, and International Cooperation), support (Administration and Statistics and Informatics), and guidelines (Health Care; Environmental Health, and Medications, Inputs and Drugs). There are also two types of deconcentrated bodies: specialized institutes (Mental Health, Rehabilitation, Child Health, Neoplastic Diseases, Neurological Sciences, Ophthalmology, and Maternal-Perinatal) and the regional or Regional Health Departments. The latter are assigned the functions of oversight and sanitary control, as well as the delivery of zoned services through administrative units whose names vary from region to region. Decentralized public agencies consist of the National Institute of Health, the National School of Health, the National Institute of Traditional Medicine, the National Institute of Environmental Protection, and the Superintendency of Institutional Health Care Providers. Public subsector institutions organize their services by level of complexity. However, these operations have problems: the first level is not always where people enter the health care system; there are no adequate referral mechanisms between the different levels; establishments neither share resources nor coordinate in order to work together as networks; and there is an imbalance in the allocation of resources among the levels of care. Furthermore, the fragmentation of information hinders timely and integrated decision-making. The funds provided by households and employers for health insurance in 1998 represented 6% of total financing and 40% of private for-profit expenditure.<sup>11</sup>

In short, there are several health care subsystems in Peru, with limited functional coordination at the national and subnational levels. At the same time, a significant segment of the population still does not have regular and permanent access to these levels. The public care networks are based on local and provincial coordination among the health post, the health center, and the respective support hospital. Integration with other providers, whether private or the social security system, is minimal, as is the integration of those local and provincial networks with service providers of greater complexity. The private providers concentrate on Lima and the departmental capitals and are not explicitly organized into a services network mode. With regard to the private sector, there is no information available on which are the principal insurers and/or service providers, either for-profit or nonprofit; on their legal status; or on their principal sources of financing. Neither is there information available on the appropriate human and technological means for the delivery of services, nor on how they purchase health services.

## 2.2 Resources of the System

**Human resources:** Between 1992 and 1996, there was an increase in the different categories of personnel per 10,000 population. Figures ranged between 40% and 100%. In the case of dentists and radiologists, for example, the variation was between 80% and 100%, and even so there still is unsatisfied demand for them. In 2000, 23 physicians attended the third year of the specialty in radiology, while there were 39 physicians in the first year of the program. The number of physicians, nurses, and pharmacists increased by 41%, 36%, and 50%, respectively. Although measures have been put in place to make the distribution of personnel more equitable, these measures are still insufficient. For financing reasons, updating information for 2000 through the Third Census on Health Sector Infrastructure and Human Resources was postponed.

**Human Resources in the Health Sector, 1992-1999**

Type of Resource	Years							
	1992	1993	1994	1995	1996	1997	1998	1999
Physicians per 10,000 pop.	7.3	N/A	N/A	N/A	10.3	N/A	N/A	N/A
Nurses per 10,000 pop.	4.9	N/A	N/A	N/A	6.7	N/A	N/A	N/A
Dentists per 10,000 pop.	0.6	N/A	N/A	N/A	1.1	N/A	N/A	N/A
Mid-level laboratory technicians per 10,000 pop.	0.9	N/A	N/A	N/A	1.1	N/A	N/A	N/A
Pharmacists per 10,000 pop.	0.2	N/A	N/A	N/A	0.3	N/A	N/A	N/A
Radiologists per 10,000 pop.	0.1	N/A	N/A	N/A	0.2	N/A	N/A	N/A
No. of post-graduates in public health	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

**Sources:** First Census of Health Sector Infrastructure and Human Resources. Office of Statistics and Informatics, Ministry of Health, Peru, 1992. Second Census of Health Sector Infrastructure and Human, Office of Statistics and Informatics, Ministry of Health, Peru, 1996.

Information on the number of post-graduates in public health is not available. In 2000, there were 21 Master's programs, of which five were created in the last five years, as well as a recent Doctorate program. In 1996, the Second Census of Health Sector Infrastructure and Human Resources reported 956 professionals with a specialty in public health working in the sector. Between 1992 and 1996, the rate of general practitioners versus specialized physicians stayed at 0.36 for the overall system.

In 1996, the Medical School of Peru reported 27,692 active physicians, as opposed to 24,708 reported by the Second Census of Health Sector Infrastructure and Human Resources. The difference could be explained by the census not having considered those physicians devoted exclusively to education and to independent private practice. However, the number of unemployed physicians could also be underreported. The School of Nursing refers to an unquantified migration of nurses over the last decade, particularly to Italy, Spain, the United States, and Chile.

**Human Resources of the Principal Public Sector Institutions, 1999**

Institution	Total	Type of resource					
		Physicians	Nurses	Nursing auxiliaries	Other workers	Administrative personnel	General services
Ministry of Health *	84,662	11,157	9,862	N/A	N/A	11,261	9,886
ESSALUD **	31,631	5,237	5,259	N/A	N/A	10,235	N/A
<b>Total</b>	<b>115,293</b>	<b>16,394</b>	<b>15,121</b>			<b>21,496</b>	<b>N/A</b>

Source: \* Ministry of Health Office of Statistics and Informatics, Lima, January, 2001. \*\* ESSALUD, Central Management of Human Resources, Lima, 1999

At the beginning of the 1990s, remuneration of Ministry of Health physicians was on par with that of ESSALUD (then IPSS). This was managed through a legal mechanism that was only partially put in place. In 1996, the monthly salary of a physician recently hired by the Ministry of Health was US\$683, and by 2000 it was US\$600. Over those same years, the salary of a nurse went from US\$272 to US\$240, respectively. In ESSALUD, the productivity of services is measured periodically (but not the individual performance) in terms of the goals set by the institution, for which there is an incentive payment available (between 0 and 22% of the wage), as determined by the chief of the service. The number of consultations in primary care facilities in 2000 was between two and three per medical hour (the index it is calculated through the total number of contracted medical hours, and corresponds to the Basic Health for All Program). This index shows an improvement in comparison to the first years of the program (1996), when there were some 1.5 consultations per medical hour.

**Drugs and other health products:** Peru does not have a national drug policy. Nevertheless, the General Health Law (1997) includes a chapter on pharmaceutical products and natural therapeutic resources, which covers aspects related to the registration, manufacture, importation, marketing, quality, and use of drugs.

Since 1991, there has been an increase in the number of registered products as a consequence of legal measures that facilitated the registration process. The total number of registered drugs increased from some 4,950 products in 1990 to 11,241 in 1999, with imported products accounting for 65% of this total. On the other hand, only around 22% of the drugs registered in 1999 were marketed nationally. The share of generic drugs among the total number of registered drugs varied little during the 1990s, with the exception of 1991, when 80% of generics were registered thanks to legal measures pushed through by the government.<sup>12</sup>

There have been no price controls in Peru since the end of 1990. According to the Intercontinental Marketing Service (IMS) in February 1999 and the KAIROS Journal of December 1999, the five most widely sold products in 1999 (and their corresponding average prices) were the following: a mix of diclofenac and paracetamol (US\$0.37 per tablet), naproxen sodium (US\$0.49 per 500 mg tablet), a

product with components of the Vitamin B. and orotic acid (US\$0.56 per tablet), amoxicillin (US\$0.41 per 500 mg tablet) and a dermal cream with clotrimazole, dexamethasone and gentamicin (US\$3.86 per 10 gram tube).

**Availability and Expenditure on Drugs in Peru, 1991-1999**

Indicator	1993	1994	1995	1996	1997	1998	1999
Total no. of registered pharmaceutical products(*)	1,694	1,289	2,203	1,519	959	1,669	2,066
Percentage of brand name drugs(*)	67.2	76.1	70.0	73.1	72.5	64.0	64.8
Percentage of generic drugs(*)	32.8	23.9	30.0	26.9	27.5	36.0	35.2
Total expenditure on drugs (sales price to the public)	N/A	N/A	811.1	724.1	799.2	793.5	N/A
Per capita spending on drugs (sales price to the public in US\$)	N/A	N/A	34.5	30.0	32.8	32.0	N/A
Percentage of Ministry of Health expenditure for drugs	N/A	N/A	10.0	10.4	10.6	10.8	N/A
Percentage of Social Security (ESSALUD) expenditure for drugs	N/A	N/A	15.4	16.7	16.5	17.5	N/A

**Source:** Calculated on the basis of the General Directorate on Medications, Inputs and Drugs (DIGEMID). The Ministry of Health; and the Ministry of Health-PAHO. Cuentas Nacionales de Salud de Perú. 1997-1998. Preliminary. Dat abase. Lima, 2001.

A National List of Essential Drugs that was reviewed and approved in 1998, and although it is not updated on a regular basis, a new list was proposed for approval in January 2001. The 1998 list contains 330 different active ingredients and it is compulsory for the Ministry of Health establishments. Social Security (ESSALUD) has its own list (75% of which corresponds to that of the Ministry of Health), required both for procurement of medicines and for medical prescriptions. Despite the lack of reliable data on access of the population to essential drugs, a recent study (1999)<sup>13</sup> estimated that only around 65% of patients served by Ministry of Health services could acquire all the essential drugs prescribed for them. The remaining 35% could not obtain the drugs mainly for lack of purchasing power. Since 1994, there has been a decentralized drug supply program (PACFARM) at the level of the Regional Health Departments for the Ministry of Health's primary care establishments. The program operates on the basis of revolving funds. The Ministry of Health provides drugs free of charge for national programs aimed at priority problems such as ARI, ADD, TB, EPI and malaria, as well as for the free School Insurance Program established in 1997 and for the Maternal-Child Insurance Program that is being implemented. ESSALUD and the Institutional Health Care Provider entities provide drugs for their beneficiaries. There is an explicit national blood policy for which guidelines for blood donation were established in 1998. The Ministry of Health's National Hemotherapy Program and blood banks report that for 1999, the total number of donated units of blood was 332,800, of which 1.7% corresponded to remunerated donors. Donations by family members or by replacement accounted for 80.1% of the donations. In public

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hospitals, health centers, and health posts, treatment protocols are applied for the principal diseases prevalent in the country. The presence of a pharmacist is legally required in private hospitals and pharmacies, but that requirement is only partially complied with.

**Equipment and technologies:** There are 1.17 beds per 1,000 inhabitants. The public subsector has 0.93 and the private subsector, 0.24. The health sector has 781 clinical laboratories, 100 blood banks, and 2,462 units of radio-diagnostic equipment.<sup>14</sup>

**Availability of Equipment in the Health Sector per 1,000 Inhabitants, 1996 and 1999**

Sector	Type of Resource			
	Beds	Clinical laboratories	Blood banks (1999)	Radio-diagnostic equipment *
<b>Public subsector</b>				
Ministry of Health	16,983	517	48	778
ESSALUD	5,435	98	20	308
Armed Forces and National Police	1,947	20	04	147
<b>Subtotal</b>	<b>24,365</b>	<b>635</b>	<b>72</b>	<b>1,233</b>
<b>Nonpublic Subsector</b>				
Private	5,851	130	28	1,219
Others	504	16		10
<b>Subtotal</b>	<b>6,355</b>	<b>146</b>	<b>28</b>	<b>1,229</b>
<b>Total</b>	<b>30,720</b>	<b>781</b>	<b>100</b>	<b>2,462</b>

\*Includes radiology and ultrasound equipment.

Sources: MINSA: II Censo de Infraestructura Sanitaria y Recursos del Sector Salud. Lima, 1996. MINSA: Programa Nacional de Hemterapia y Bancos de Sangre.

**Availability of Equipment in the Health Sector by Level of Care, 1996\***

Sector	Type of resource					
	Delivery rooms		Clinical laboratory		Diagnostic imaging equipment	
	1st Level	2nd Level	1st Level	2nd level	1st Level	2nd Level
<b>Public subsector</b>						
Ministry of Health	1,021	N/A	104	413	209	569
ESSALUD	N/A	N/A	49	49	35	273
Armed Forces and National Police	N/A	N/A	11	9	108	39
<b>Subtotal</b>			<b>164</b>	<b>471</b>	<b>352</b>	<b>881</b>
<b>Nonpublic subsector</b>						
Private	N/A	N/A	70	60	817	402
Others	N/A	N/A	12	4	10	-
<b>Subtotal</b>			<b>82</b>	<b>64</b>	<b>827</b>	<b>402</b>
<b>Total</b>	<b>N/A</b>	<b>N/A</b>	<b>246</b>	<b>535</b>	<b>1,179</b>	<b>1,283</b>

\* Most recent data available.

Source: MINSA: II Censo de Infraestructura Sanitaria y Recursos del Sector Salud. Lima, 1996.

Ministry of Health data from February 1999 showed that 15% of the 8,315 of the most complex equipment acquired and delivered to the establishments in the services network between 1995 and 1998 no longer functioned. By 2002, it is estimated that figure will rise to 42%, since the equipment has a maximum lifetime in terms of use of between four and seven years. The studies concluded by criticizing

the maintenance of equipment by the Ministry of Health, emphasizing that the budget allocated for maintenance was on average US\$1.14 (in a range from \$US0.69 to \$US1.88) per bed-day in the hospitals evaluated, while the estimate of the budget required ranged from US\$4.73 to US\$11.59.<sup>15</sup> The capacity for technological management of the Ministry of Health's medical equipment and devices is currently being strengthened. There is no information available on the distribution of high-technology units or equipment by territory, or in the public versus the private subsector.

### ***2.3 Functions of the Health System***

*Steering role:* Under the General Health Law, the Ministry of Health is the highest-ranking health authority. It is responsible for providing guidance to the sector, for orienting and managing national health policy, and for overseeing adherence to this policy, in accordance with the general policy of the government. The regulatory role is assigned to the Ministry of Health, while the decentralized bodies are delegated functions of sanitary regulation, prevention, and control, as well as other functions specific to their field of activity. The General Health Law stipulates that the State is responsible for providing public health services to the entire population, that individual health is a responsibility shared by the individual, society, and the State, and that the State is responsible for partially or totally subsidizing medical care for people with limited resources who do not have public or private health insurance. The essential public health services include immunization; basic and environmental sanitation; health information, education, and communication; control of communicable diseases; protection of food and health inputs; epidemiological surveillance; and mental health. Through the General Health Law, the Ministry of Health is vested with the authority to conduct periodic evaluations, oversight, and auditing of health establishments and services, regardless of their nature or type of management. This function is not carried out regularly, however, because the Regional Health Departments lack resources. Supervision and control of Ministry of Health establishments is primarily of a budgetary/accounting nature. In the case of ESSALUD, the Ministry of Health does not carry out supervision and control, except in the field of accreditation of health facilities. Private health insurers are overseen by the Superintendency of Banking and Insurance. It was hoped that the Ministry of Health's National Health Information System (HIS/MISES) that began to be implemented in 1993 would function as the single registry of ambulatory and other primary health care activities. However, as of the beginning of 2001, there were several unintegrated information systems. Information on national-level programming and budgetary execution is not available because when that information pertains to health departments outside the Department of Lima, it goes through the Ministry of the Presidency. Consolidating that information takes a long time and requires additional interinstitutional consensus building. In recent years, the preparation of the National Accounts in Health for 1995, 1996, 1997, and 1998 has provided sectoral information for these years. However, it should be pointed out that information on private suppliers comes from a sample of suppliers rather than from all of them. Information on health system physical supply is updated every four

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years through the National Census on Health Sector Infrastructure and Human Resources. Household surveys conducted periodically make it possible to study the demand for and use of health services.

Even though human resources have been identified as a strategic element for the sector, the Ministry of Health has not sufficiently exercised its steering role in determining the quantity, composition, or quality of these resources. In addition, there is not enough coordination among training institutions and service providers in order to tailor professional and technical education to human resource needs. This translates into cost overruns for retraining and inefficiencies in the overall system. The School of Public Health, the regulatory body of the Ministry of Health for human resources, was in the process of restructuring at the beginning of 2001. Through a commission, the different programs and projects of the Ministry of Health coordinate the training, which is still piecemeal. There is no national system of quality assurance as such, although since 1998 the Ministry of Health has operated an Accreditation Unit for Health Establishments, which applies current accreditation standards to all the subsectors, with an emphasis on infrastructure standards. As of the beginning of 2001, five hospitals (one public and four private) had been accredited and more than 150 hospitals were in the process of self-evaluation, the step prior to accreditation. Since 1976, there has been a National Commission on Medical Residency (CONAREME) that regulates the training of the country's medical specialists. In July 1999, a law was enacted institutionalizing the accreditation of medical schools. In the case of the health professions, there is a self-regulatory model carried out by professional associations. In 1999, the Medical College began the recertification of professionals through the Continuing Education Program. The Ministry of Health, both at the central level and through its decentralized entities, carries out intersectoral coordination, particularly with the sectors for education, water and sanitation, nutrition, and promotion of women and human development. There is no specific data available on how these actions and/or programs are linked with institutional health service providers of the public and private subsectors. There are no national agencies to assess health technology. Treatment protocols in clinical practice are prepared in accordance with criteria defined by each institution and are not regulated by any explicit policy. There is no information available on whether the health authorities, and specifically the Ministry of Health, have information systems on the status of health, health financing, insurance, or the delivery of reliable and timely services, or whether such information systems are used effectively for decision-making.

***Financing and expenditure:*** According to preliminary figures from the National Accounts in Health for 1997-1998, Peru directed about 4.4% of its GDP to health in 1998. This amounts to US\$99 per capita. However, it is possible that private financing has been underestimated. Latin American countries with similar GDP levels devote a larger percentage to health.<sup>16</sup> Peru's health expenditures are below the average.

The principal sources of financing are households, contributions from employers for declared and permanent workers, and the government. The reduction in the household share of financing between 1995

and 1998 was due to the elimination of the 3% contribution by workers (households) to the 9% Social Security contribution. This implied an increase in the contribution of the employer from 6% to 9%.

**Distribution of Health Financing in Peru, 1995-1998**

<b>Sources of financing</b>	<b>1995</b>	<b>1998</b>
Total (millions of US\$)	2,446	2,652
Households (%)	43.3	38.5
Government (%)	26.7	24.8
Employers (%)	27.7	34.1
External (%)	1.5	1.8
Donations (%)	0.8	0.7
<b>Total</b>	<b>100%</b>	<b>100%</b>

**Source:** MINSAL-PAHO. Cuentas Nacionales de Salud de Perú. 1997-1998. Preliminary. Database. Lima, 2001.

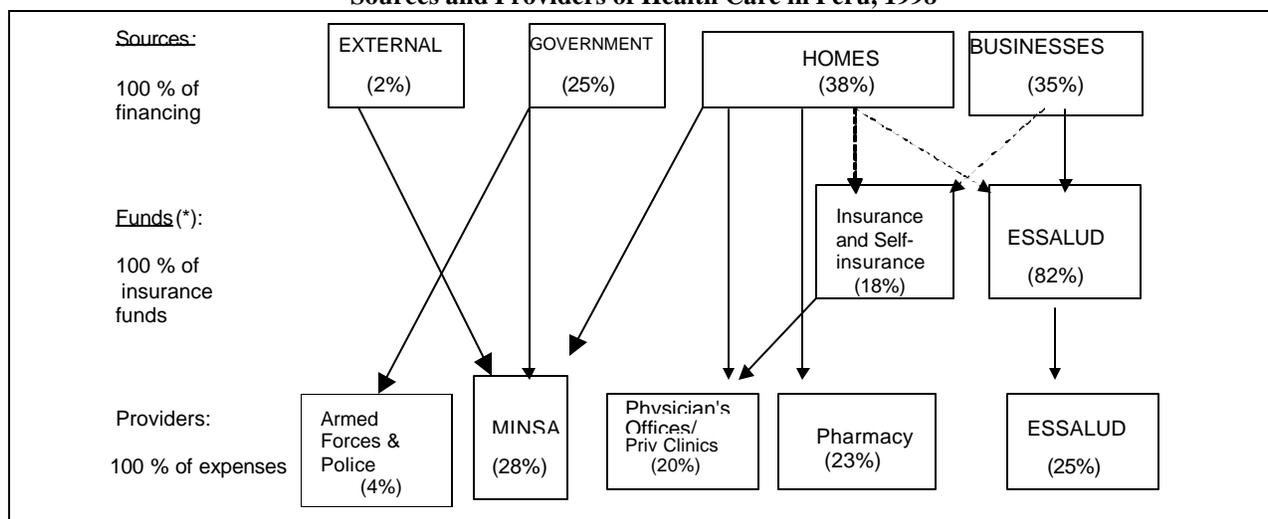
**Distribution of Total Health Expenditure in Peru, 1995-1998 (In percent)**

<b>Expenditure by provider</b>	<b>1995</b>	<b>1998</b>
Ministry of Health	26.1	27.9
Other public(*)	0.8	0.4
Armed Forces and National Police	5.1	3.8
ESSALUD	23.8	25.1
Private for-profit	16.0	18.6
Private nonprofit	1.5	1.7
Pharmacy	26.6	22.5
<b>Total</b>	<b>100%</b>	<b>100%</b>

**Source:** MINSAL-PAHO. Cuentas Nacionales de Salud de Perú. 1997-1998. Preliminary. Database. Lima, 2001. (\*) Largely by municipalities.

Government resources are channeled through the main offices of the Ministry of Health and Regional Health Departments through the regional transitory governments. This often results in problems related to a lack of coordination. Household resources tend to be used for purchasing drugs, often without any involvement of the health services, and for the payment of fees for private or public care. Few households pay for voluntary insurance to ESSALUD or buy private health insurance policies directly. Employers pay premiums to ESSALUD to insure their declared and permanent workers, and, to a lesser extent, contract with private insurance companies. Health insurance funds include resources obtained by Social Security (ESSALUD) and private insurance. Although external financial cooperation is very small as a percentage of total financing of the sector (around 2%), it plays an important role in the design and implementation of health sector reforms, which gives this financing a certain strategic value. This role of external cooperation could become a vulnerability in the future if it is not sustained by public funds.

Sources and Providers of Health Care in Peru, 1998



Arrows with dotted lines indicated less of a flow. (\*) Only 36% of the financing comes in the form of a Fund. Source: Based on MINSA-PAHO. Cuentas Nacionales de Salud de Perú. 1997-1998. Preliminary. Database. Lima, 2001.

The Ministry of Health led all providers in total expenditure in 1998, given that it receives additional income from fees its charges households and through external funds. The pharmaceutical category includes sales of drugs outside the establishment of the provider. Much of this category represents direct purchases from pharmacies, an expenditure that does not involve the provider. The composition of health expenditure indicates that 83% is for the delivery of health services (human resources, services, and inputs), of which 28% is for drugs, 8% for administration and regulation, and 5% for investment.

Composition of Health Expenditures in 1998 (In percent)

Description	Ministry of Health	ESSALUD	Sector total
Health services delivery (*)	60.2	66.2	55.6
Drugs	6.6	10.5	27.8
Administration and regulation	22.5	6.3	7.9
Administration of Social Security plans	-	9.7	2.4
Other services related to health (**)	2.1	-	1.7
Investment	8.6	5.2	4.7
Total	100%	100%	100%

(\*) Includes final and intermediate health services. (\*\*) Includes health education, human resource training, certification, inspections, licencing, animal control, and residual sales.

Source: MINSA-PAHO. Cuentas Nacionales de Salud de Perú. 1997-1998. Preliminary. Database. Lima, 2001.

Since 1993, public spending by the Ministry of Health has increased, although that has halted in recent years due to fiscal problems resulting from the political crisis and the economic recession. In 1999, 80% of total expenditure by the Ministry of Health was financed by the public treasury, 16% by fees collected from users, 2% by foreign debt, and the remaining 2% by donations. Studies on the composition of expenditure by levels of care suggest that around 40% of the public health subsidy of the Ministry of Health (defined as expenditures less user fees and the expenditure of the central administration of the Ministry of Health) is allocated to hospitals, while the remaining 60% goes to primary care (health centers and health posts).<sup>17</sup> The distribution of this expenditure by income quintile has shown a clearly regressive

pattern in hospital expenditure (especially in rural areas) and a significant progressive pattern insofar as spending on urban health centers and health posts is concerned.<sup>18</sup> Until 1996, the budget was allocated according to historical patterns and without taking into account service production and the achievement of objectives. From 1997 on, budget allocations were based on expected results. In the economic and financing area, studies are conducted to harmonize budgetary programming with the achievement of goals and objectives, as well as to improve the identification of beneficiaries and the formulation of payment policies. A pilot project that involves changing payment mechanisms began in a hospital in northern Peru in 2001.

**Sources of National Health Financing by the Ministry of Health, 1995-99 (In thousands of US\$)**

	1995	1996	1997	1998	1999
Public treasury (ordinary resources):	566,083	598,477	605,45	615,191	581,852
Own funds (resources collected directly)	79,452	92,220	106,186	115,458	113,965
Foreign debt (External credit)	20,014	38,041	25,243	24,639	14,834
Donations and transfers	360	198	5855	14306	13.119
<b>Total</b>	<b>665,909</b>	<b>728,936</b>	<b>742,330</b>	<b>769,594</b>	<b>723,770</b>
MINSAs national expenditure as % of total central government spending	5.3	5.0	5.0	5.4	5.4
% of GDP represented by total MINSAs expenditure	1.2	4.2	1.3	1.3	1.3

Sources: MINSAs Database; Ministerio de Economía y Finanzas, Dirección Nacional de Presupuesto Público; Base de Datos de los Organismos Públicos Descentralizados (SEPS, ENSAP, INS, INMETRA, INAPMAS); Instituto Nacional de Estadística e Informática.

**Health insurance:** There are three types of health insurance: social security (ESSALUD), the Armed Forces and National Police, and private insurance. With regard to ESSALUD, employers pay the equivalent of 9% of the monthly wage of their workers, and the number of contributors depends on the trends in the formal sector of the economy. In addition to dependent workers--who in December 2000 constituted 95% of active insured contributors--Social Security has tried with little success since the 1970s to expand insurance to workers who are not dependents. The insurance of the Armed Forces and the National Police exclusively covers the personnel of these services and their immediate family members and is financed by government. Private health insurance tends to be contracted by families and, to a lesser extent, directly by employers. The principal differences between the benefits offered by the Ministry of Health and those by Social Security involve the fact that beneficiaries of the latter receive care and drugs free of charge, while people who use Ministry of Health services pay for consultations, hospitalization, diagnostic tests and other care, as well as for drugs. The exceptions are some health programs such as those for tuberculosis, school insurance, and maternal and child insurance in pilot areas. These programs provide free care and medicines, since there is no basic or joint plan of health benefits to which all citizens have a right. Up until the beginning of 2000, Social Security maintained joint benefits for all its members regardless of the level of their income/contribution and regimen (there are regular

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beneficiaries and special insured regimens). Since then it has developed health plans with varying degrees of coverage for the beneficiaries of special regimens, which are independent beneficiaries (referred to as optional) and their families. The growing informalization of the economy and flexibility in the labor market (even in the public sector), along with the limited increase in real wages, has resulted in a significant reduction in the proportion of the population with health insurance--from 37.7% in 1994 to 23.5% in 1997. The gradual increase in private insurance premiums has also contributed to this phenomenon. Of the total number of beneficiaries in 1997, 86.5% were affiliated with ESSALUD and only 6.8% had private insurance. In addition, 2.5% were doubly insured (ESSALUD and private insurance).<sup>19</sup> The percentage of people insured ranged from 35.9% in metropolitan Lima to 6.2% in rural areas.

### **Health Insurance, 1997**

<b>Insurance status</b>	<b>Total</b>	<b>Metropolitan Lima</b>	<b>Other urban</b>	<b>Rural</b>
Not insured	76.5%	64.1%	69.4%	93.8%
Insured	23.5%	35.9%	30.6%	6.2%
	(100.0%)	(100.0%)	(100.0%)	(100.0%)
- ESSALUD	(84.0)	(77.5)	(88.4)	(92.1)
- ESSALUD and private insurance	(2.5)	(4.8)	(0.6)	(1.3)
- Private insurance only	(6.8)	(9.1)	(4.6)	(5.8)
Private individual	(5.0)	(7.1)	(2.9)	(4.9)
Private company	(1.8)	(2.0)	(1.7)	(0.9)
Police/Military	(6.8)	(8.5)	(6.4)	(0.7)

Source: Petrerá M, Cordero L, El Aseguramiento Público en salud y la Elección del Proveedor. En Pobreza y Economía Social. Cúanto SA.

Preliminary information on the National Accounts in Health for 1997-98 shows that in 1998, funds from households and employers for health insurance represented 1.4% of GDP, 36% of total health financing, and 40% of private for-profit health expenditure. Of this amount, ESSALUD handled 82% and private insurance the remaining 18%.<sup>20</sup>

### ***Delivery of Services***

*Public health services:* National coverage of the Expanded Program on Immunization (EPI) in 1999 was as follows: polio, 95.8%; DPT, 98.9%; measles, 92.5%; and BCG, 96.9% in children under 1 year of age.<sup>21</sup> In addition, preliminary results of the 2000 ENDES indicate that prenatal care by trained staff was provided for 82.5% of pregnancies, and that 57.3% of deliveries were attended by trained health professionals. Furthermore, 50.3% of cohabitant women in 2000 used modern contraception methods.

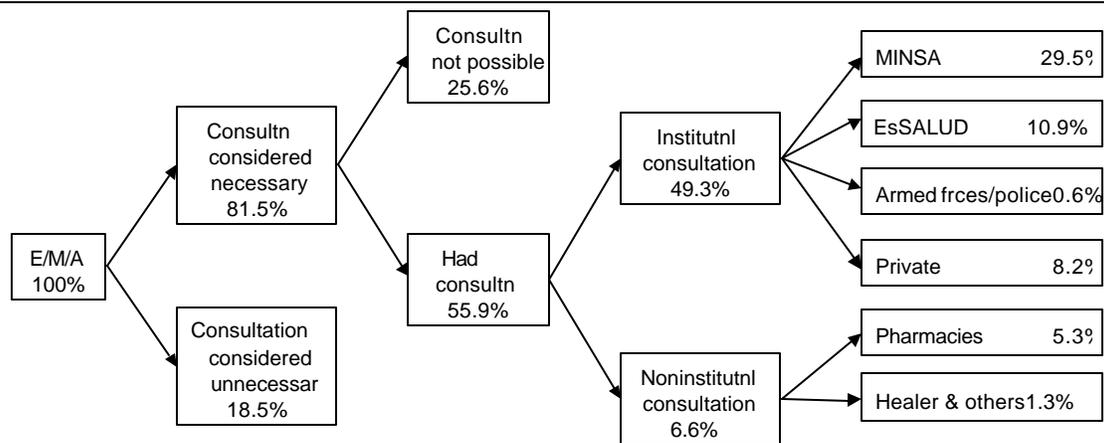
The delivery of health services is being reoriented using health promotion criteria, incorporating preventive-promotional aspects, sociocultural factors, and community participation. Furthermore, some 30 provincial and district municipalities have formed local "healthy community" networks in the north (Tumbes and Piura), south (Arequipa), and center (Lima and Callao) of the country. These networks give priority to four areas: healthy and safe motherhood, prevention and control of domestic violence, care for

the elderly, and a healthy environment, particularly as regards the physical environment. Health promotion has been incorporated into education sector activities through the National Program of Municipal Schools (5,000 at the national level) that provide space for training, participation, organization, and involvement of children and adolescents. One of the strategies of the program is to develop schools that promote health by incorporating aspects of health promotion and prevention into the school and family environment.

*Individual health services:* In 2000, 25.2% of the population reported being ill or experiencing health problems or accidents in the four weeks prior to the survey. Of the total number of persons in this group, 81.5% thought that they needed medical attention. Of those that considered it necessary, 25.6% did not have access to this attention, primarily because they lacked the economic resources to do so. Of the 55.9% who sought medical attention, 6.6% received it from non-professional personnel, most often through someone in a pharmacy. Only 49.3% of those who had health problems received professional care. Of this group, 29.5% went to Ministry of Health establishments; 10.9% to ESSALUD; 8.2% to the private sector; and 0.6% to health establishments of the Armed Forces and National Police. A comparison with the 1994 and 1997 utilization levels<sup>22</sup> indicates that the increase in institutional coverage was strongly facilitated by the Ministry of Health, whose share in treating the total number of people with symptoms of illness/accident increased from 16.3% (1994) to 25% (1997) and to 29.5% (2000). This was due to the increase in primary care in health centers and health posts, which coincided with the largest expenditure, which targeted the Basic Health for All Program.

Due to fragmentation of the health system, the lack of opportunity, and the centralization of data, consolidated national information on the production of services and on morbidity is not available broken down by the different networks of services. In the case of mortality, reporting is better, as is the flow and analysis of information, which facilitates more informed decision-making at the national level. Between 1987 and 1997, there was no substantial change in the pattern of the leading causes of mortality. Tuberculosis and Septicemia were dropped from being among the 10 leading causes of mortality, and infectious intestinal diseases went from second to seventh place. On the other hand, cerebrovascular disease rose to third place, despite a slightly diminished rate, and acute respiratory infections remained the leading cause of death by far for any of the periods. Communicable diseases are preeminent, although urinary tract diseases were also significant, as were hypoxia, birth asphyxia and other respiratory conditions of the fetus or newborn. Nutritional deficiencies and anemia remained among the leading causes of mortality.

### **Levels of Health Service Utilization, 2000**



Source: MINSA-SEPS-PAHO. Equidad en la Atención de Salud en Perú. 1997.

*Technical quality:* Since no national system of quality control has been established, no information has been reported on the percentage of hospitals with quality control programs or established and functioning ethics committees. Nor is there information on the percentage of cesarean sections out of the total number of deliveries, on the index of hospital infections or the percentage of hospitals with established and functioning infections committees, on the percentage of deaths for which autopsies are carried out, or on the percentage of cases of maternal and infant deaths that have been investigated.

*Perceived quality:* The study on equity in health care<sup>23</sup> explores the satisfaction perceived by area (rural, urban, Metropolitan Lima), gender, and type of provider for each quintile of persons admitted. The study found the following: a) In all quintiles, satisfaction is greater with private providers, and the differences between providers increases as income rises; b) In the case of public providers, the highest level of satisfaction is with the first level of care (health centers/posts) in all quintiles, which coincides with the increase in governmental expenditure at this level; c) Satisfaction with ESSALUD is lowest in all income strata, in contrast to the higher level of satisfaction (with respect to the Ministry of Health) with these establishments in previous surveys; d) Levels of satisfaction in the rural population tend to be lower than those in the urban population and the population of Metropolitan Lima; and, e) Gender is important in explaining a certain relative preference by women for hospitals at the first level of care.

### **3. MONITORING AND EVALUATION OF THE REFORM**

#### ***3.1. Monitoring of the Process***

*Monitoring of the dynamics:* Since 1995, the previous government had been implementing changes in public administration as part of the process of State reform in order to gradually reduce its involvement in the administration of goods and services and to strengthen its steering and regulatory role. This has led to the modernization of various sectors, the health sector among them. As a result, health sector reform was part of a process administered centrally by Ministry of Health authorities, as opposed to a process that

involved negotiation with the various actors in the sector. Although the general guidelines for the process were widely disseminated (Health Policy Guidelines, 1995-2000), the agenda, plans of action, and possible criteria and evaluation mechanisms were held back. Financing for experiences in the field and for implementing the process was provided through national projects with the Inter-American Development Bank (IDB-World Bank), the government, and international technical cooperation. Given the political circumstances--the sudden change in government in May 2000, the subsequent designation of a transition government in November, and the calling of general elections for April 2001--the process of State reform, and thus health sector reform, has become a subject for upcoming national and sectoral management.

*Monitoring of the contents:*

Legal framework: The legal framework for the health sector has been amended by two basic laws: The Law on Modernization of Social Security (LMSS, May 1997) and the General Health Law (LGS, June 1997). The LGS is the framework law for the sector. The LMSS relaxed the public monopoly on the delivery of medical services to IPSS beneficiaries in order to improve the quality and coverage of services, opening the possibility that 25% of contributions could be transferred to private providers. Equity is not defined as an explicit principle of the LGS, although the law does indicate that "it is the responsibility of the state to promote conditions that guarantee adequate health service coverage to the population in terms of safety, opportunity, and quality that is in the public interest." There are no legal changes that promote an intersectoral approach to health, except for the creation of multisectoral commissions on such issues as food and nutrition, prevention of domestic violence, education, and health.

The right to health care and health insurance: The sector reform seeks to extend coverage of basic care through insurance mechanisms that will permit health services to be provided free of charge to the poor. In 1994, the Ministry of Health defined basic packages of care for children, adolescents, women of childbearing age, and the adult population, which were promoted with government funds through the Basic Health for All Program. In 1997, School Health Insurance covering integrated care (consultations, drugs, and diagnostic testing) for public schoolchildren at all levels went into effect, and in 1998 a pilot program for Maternal and Child Health Insurance was introduced to meet the needs of pregnant women, provide care in childbirth and the puerperium, and meet the needs of children up to two years of age.

Steering role and the separation of functions: The principles of the reform envisage the separation of functions, but this process has still not been implemented. There is no evaluation available on the steering role in terms of health.

Decentralization modalities: In July 1999, the previous President announced the administrative decentralization of health and education services to the municipal level, and several drafts of legislation were presented on this subject to the Congress of the Republic. The political crisis has resulted in this issue being postponed for further study by the new Congress and government.

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Social participation and control: There are two lines of work in this area: the CLAS (establishments administered by Ministry of Health authorities and the community), and the processes of accountability, although they are still being developed. Social participation is an explicit objective of the sectoral reforms.

Financing and expenditure: A policy is in place to identify beneficiaries in order to defend the principle of equity and to target public subsidies based on the criteria of poverty/need/effectiveness of care. The reliability of certain methods for identifying beneficiaries of the subsidy is currently being tested. Various payment mechanisms that could be alternatives to traditional methods are being tested, with a view to gradually shifting from a subsidy based on supply to one based on demand, productivity, and efficiency. Various capitation systems are being developed and applied within hospitals.

Service provision and care models: In recent years, priority has been given to financing the first level of care in the Ministry of Health's services network. This has contributed to reorienting the system toward promotion and prevention. Primary health care activities have been predominantly oriented on risk and harm criteria, although the recent trend has been to work through population groups using a comprehensive care approach (children, adolescents, women, adults, and the elderly). The goal is to improve the targeting of the health subsidy through a system of exemptions as well as through the operation of the free School Insurance Program and pilot programs for Maternal and Child Insurance. The hope is for a unifying process that moves toward subsidized public health insurance. An additional effect of the policy to promote the development of primary care has been the reduction in public financing for the second and third levels of care, limiting access of the poor to them. In the case of Social Security, a new model of comprehensive care has been proposed that aims to increase access of beneficiaries to primary care and to implement an adequate patient referral and counter-referral system. The model is still in the design phase. In the private sector, the experiences are very diverse. Services are offered at all levels of care, with a predominance of those of greater complexity.

Management model: In addition to the management commitments with five departmental health offices, health sector reform seeks to develop a model of care based on networks of health establishments and services that permit the mobilization of users and resources through a variety of problem-solving capabilities, as indicated by the complexity of the medical need. The relationship between public providers and private ones is still minimal. Some public health facilities, especially hospitals, have begun to organize themselves in accordance with managerial criteria. This has been a consequence mainly of the insufficient transfer of resources for their operations. Nevertheless, the absence of an explicit hospital policy hinders the definition of institutional objectives. Since it was created, the Superintendency of Institutional Health Care Providers has promoted the development of care guidelines for private facilities in accordance with those of the Ministry of Health and Social Security.

Human resources: Although some schools and universities for health professionals are beginning to adapt training curricula to the needs of sectoral modernization, the changes have not been significant at the national level. Flexibility in the labor market has modified and diversified working conditions, expanded causes for dismissal, and generated restrictions on unionization and collective bargaining. In 1988-89, 77.6% of physicians who worked in public institutions and 29% of those in private ones had lifelong appointments. In 1996, the proportion of physicians appointed to the health sector was 50.3%. At the beginning of 2001, the Ministry of Health enacted a law to change personnel contracted for a fixed term to permanent status, and to equalize the duration of the workday of all workers, regardless of their type of labor. With regard to changes in professional practice, some interdisciplinary experience has been acquired over the last five years through Project 2000 in the field of maternal and child care, and through the IMCI strategy. Nationally, mechanisms for certification of health workers have not changed, except those for recertification that the Medical School of Peru has had under way for general practitioners since 1999, and for specialists since May 2000, both through a continuing education program. Health workers have not participated actively in the reform process. Proposals by the Federation and the Medical School, as well as the Association of Social Security Physicians, were presented but not welcomed. There have been some modifications in the planning and management of human resources in the public subsector through the Basic Health for All Program, which covers the requirements of both professional and technical personnel in primary care facilities in depressed areas. There currently are 12,288 health workers (70% contracted directly and 30% through CLAS), of which 14% are physicians, 19% nurses, 18% other professional staff, and 49% technical personnel. Only a small number (about 700) of them are regular staff who receive an economic incentive for overtime. For the remainder, the contracting modality is for non-personnel services, for six months for SBPT, and for one year for CLAS. The latter group receives social benefits. The contracts respond to pre-established productivity goals. In the case of CLAS, those responsible are in a position to hire personnel with the organization's own resources and to meet their needs. They themselves negotiate the conditions of employment. There is no sectoral policy on human resources development, nor any performance incentives, except for ESSALUD, which has a productivity incentive that is nevertheless interpreted by staff more as compensation for low wages than as a performance incentive. With regard to training, diverse approaches are being introduced, especially through major projects. These approaches include in-service training, with an emphasis on continuing education, problem-solving methodologies, internships, and distance learning, among others.

Quality and assessment of health technologies: Even though there are groups of researchers interested in evaluating the health technologies within the institutions of all the subsectors, there are no public or private agencies to carry this out. There is an increasingly strong movement to promote the preparation and use of treatment protocols and clinical practice guidelines in order to improve the quality of care and

to rationalize expenditure. The Ministry of Health has designed and disseminated protocols and guidelines for most health programs.

### ***3.2.Evaluation of Results***

Equity: Health reform is part of the State reform process and was preceded by an increase in public social expenditure to promote the Basic Health for All Program. Therefore, the results achieved cannot be attributed to sector reform alone, but rather to the entire set of policies, which, moreover, were accompanied by an economic recovery between 1993 and 1997.

There has been some progress only in primary care (health posts and health centers), whereas hospital care is regressive. The reasons why people do not seek care include the lack of money, the distance from facilities, slow service, and mistrust of the service.<sup>24</sup>

Strictly speaking, it is not still possible to evaluate the impact of the reform on equity in the coverage, access, and use of health services.

Effectiveness and quality: Although some progress has been made in development of the legal framework, accreditation of facilities and human resources, regulation of the private sector, preparation of treatment protocols, auditing, and assessment of user satisfaction, it is still not possible to evaluate the impact of the reform because there is still no national quality control system.

#### Efficiency:

In the allocation of resources: As part of the Basic Health For All Program launched in late 1994, targeting criteria for expenditure were applied to primary care facilities based on regional poverty levels. Subsequently, the Program Budgeting System (SPP) has started in all regions of the country. Under the system, financial resources are allocated based on the annual goals of the plan. Several methodologies for financing services and diagnostic testing are also being developed.

In resource management: Budget programming, execution, and monitoring methodologies have been introduced that stress decentralization, and there has been progress in standardizing management procedures and equipping health establishments. However, administrative complexity and the lack of an incentive system have slowed and even impeded advances in these areas on a large scale.

Sustainability: Financial constraints pose a serious threat to the viability of the reform process. The recessionary economic context that began to emerge in 1998 is bringing significant budget cuts that are putting attainment of expected results at risk. A central argument in favor of the legitimacy of the reform is the significant increase in the coverage of primary care provided through the Ministry of Health for the poor and vulnerable population.

Participation and social control: Community participation in organization and management has been developed through Local Committees for Shared Administration (CLAS) in 20% of first-level establishments. Civic participation through CLAS is believed to ensure better management of these establishments and social control of resources.<sup>25</sup> When implemented in areas with developed social

networks that adopt the proposal, this results in an improvement in the productivity of human resources and the quality of care. This type of community participation in health management is regarded as a tangible expression of user “empowerment,” and is a concrete example of users exercising their rights.

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- <sup>23</sup> The database used corresponds to the 1997 National Standard of Living Survey (ENNIV) designed and carried out by the Instituto Cuánto, SA with the technical assistance of the World Bank. The ENNIV is a representative sample at the national level of 3,843 households, divided into the following areas of study: Metropolitana Lima, Callao, urban coastal, rural coastal, rural Sierra, urban Sierra, urban jungle and rural jungle. For each area, probability, multi-stage and independent attributes are compiled. MINSa-SPS-

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