



Universal Health Coverage Assessment

Peru

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Global Network for Health Equity (GNHE)

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Introduction

Continued economic growth over the last 15 years has resulted in a better quality of life for Peruvian citizens. During this period, improved economic performance and the implementation of social programmes have resulted in significant progress towards fulfilment of the Millennium Development Goals. Despite these improvements, Peru still has poor health indicators in comparison to other countries in the region, such as Chile and Colombia.²

This document provides a preliminary assessment of aspects of the Peruvian health system relative to the goal of universal health coverage, with a particular focus on the financing system. It focuses on the situation prior to 2013 when the country embarked on new reforms. It is still too early to assess the impact of these reforms.

In the 2010 World Health Report, universal health coverage is defined as providing everyone in a country with financial

protection from the costs of using health care and ensuring access to the health services they need (World Health Organisation 2010). These services should be of sufficient quality to be effective.

This document presents data that provide insights into the extent of financial protection and access to needed health services in the country.

Key health care expenditure indicators

This section examines overall levels of health expenditure in Peru and identifies the main sources of health financing (Table 1).³ In 2012, total health expenditure accounted for 5.1% of the country's GDP, an amount that was lower than the average of 6.1% for other upper-middle-income countries and substantially lower than the global average of 9.2%.

Table 1: National Health Accounts indicators of health care expenditure and sources of finance in Peru, 2012

Indicators of the level of health care expenditure	
1. Total expenditure on health as % of GDP	5.1%
2. General government expenditure on health as % of GDP	3.0%
3. General government expenditure on health as % of total government expenditure	18.3%
4a. Per capita government expenditure on health at average exchange rate (US\$)	198.7
4b. Per capita government expenditure on health (PPP \$)	326.7
Indicators of the source of funds for health care	
5. General government expenditure on health as % of total expenditure on health*	58.9%
6. Private expenditure on health as % of total expenditure on health	41.1%
7. External resources for health as % of total expenditure on health	0.5%
8. Out-of-pocket expenditure on health as % of total expenditure on health	35.7%
9. Out-of-pocket expenditure on health as % of GDP	1.8%
10. Private prepaid plans on health as % of total expenditure on health	4.0%

*This includes social security.

Source: Data drawn from World Health Organisation's Global Health Expenditure Database (http://apps.who.int/nha/database/Key_Indicators/Index/en)

² For instance, these countries have higher rates of births attended by skilled health staff and lower levels of chronic malnutrition (see <http://databank.worldbank.org/data/views/reports/tableview.aspx#> and <http://www.unicef.org/statistics/>).

³ The data quoted in this section all derive from the latest (2012) data in the World Health Organisation's Global Health Expenditure Database (<http://apps.who.int/nha/database/Home/Index/en>). Comparisons with other countries are based on figures expressed in terms of purchasing power parity. The country's income category is determined from the World Bank's classification for the same year (<http://data.worldbank.org/about/country-and-lending-groups>).

Public allocations to fund the health sector (including the social security scheme⁴) were around 18% of total government expenditure in 2012. This was considerably higher than the 12% average for other upper-middle-income countries. This share of government spending was above the 15% target set by the Organisation for African Unity’s 2001 Abuja Declaration (which was the same as the global average for 2012).

Despite this, government health expenditure translated into 3.0% of GDP, below the upper-middle-income average of 3.4% and well below the global average of 5.3%. Per capita government expenditure on health, which was around \$327 (in terms of purchasing power parity) in 2012, was a little lower than the upper-middle-income country average of \$371 and around half the global average of \$652.

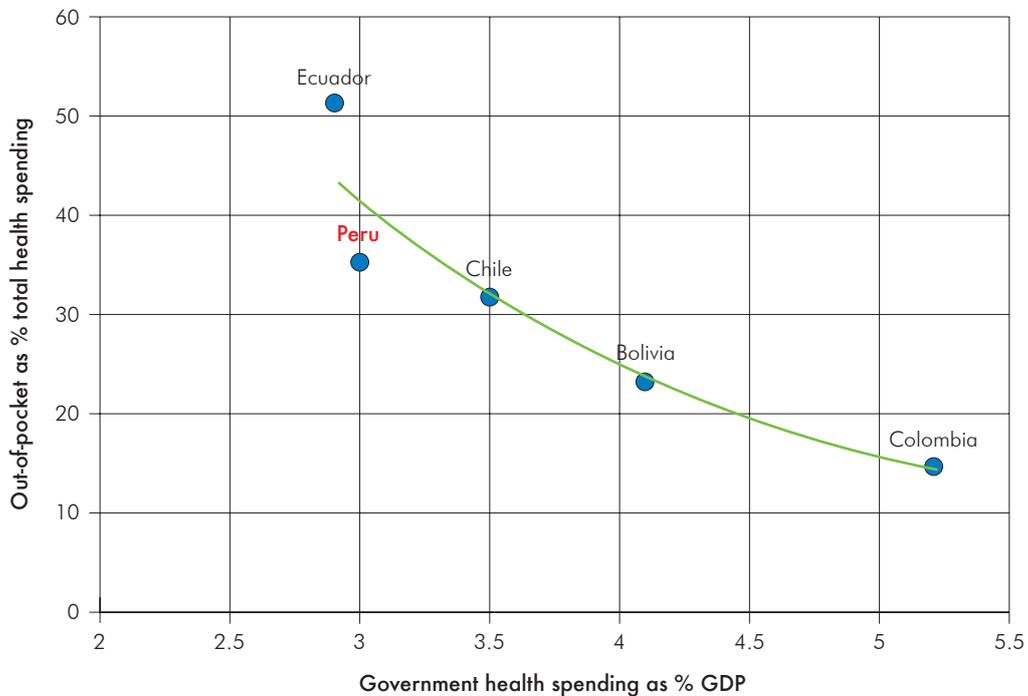
As in most upper-middle-income countries, the contribution of donor financing played a very small role (0.5%). With respect to private sources, private prepaid plans accounted for only 4% of total health expenditure in 2012, which was less than the upper-middle-income country average of 7%. On the other hand, out-of-pocket payments represented over a third of total health funds (36%). This was similar

to the upper-middle-income country average but high in global terms (where the average was 21%), and above the 20% limit suggested by the 2010 World Health Report to ensure that financial catastrophe and impoverishment as a result of accessing health care become negligible (World Health Organisation 2010).

Figure 1 illustrates the strong inverse relationship between government spending on health as a percentage of GDP and the share from out-of-pocket payments, and shows that, in 2012, Peru’s government expenditure on health as a percentage of GDP was one of the lowest proportions in the region. This is an important feature to recognise when considering how the Peruvian government can achieve its 2009 goal of achieving universal health coverage.

In recent years, Peru’s public health expenditure has increased (by 60% between 2010 and 2013),⁵ and it is expected to grow by USD 862 million annually until at least 2016. This may shift Peru’s position along the curve towards the right, reducing its reliance on out-of-pocket spending. However, as discussed further below, there are other problems, such as the fragmentation of financing sources, the lack of risk pools, and problems with the provision of health services that may limit this effect.

Figure 1: Relationship between dependence on out-of-pocket payments and government spending on health care in some Latin American countries (2012)



Source: Authors’ calculations based on Global Health Expenditure Database (<http://apps.who.int/nha/database/Select/Indicators/en>).

⁴ Different countries use the terms ‘national health insurance,’ ‘social health insurance’ and ‘social security’ differently to describe different types of mandatory health insurance. In each country assessment in this series, the term applied is the one commonly in use in the country in question. Peru uses the term ‘Comprehensive Health Insurance’ (called SIS) for a government scheme financed by general taxes. The term ‘social security’ is used for a scheme (called EsSalud) that is financed by compulsory insurance contributions. While the country is aiming for universal coverage, the current system has different schemes serving different segments of the population with a large percentage remaining uninsured, as described in the main text.

⁵ Source: Ministry of the Economy Database (<http://apps5.mineco.gob.pe/transparencia/mensual/>).

Structure of the health system according to health financing functions

Figure 2 provides a summary of the structure of the Peruvian health system, depicted according to the health care financing functions of revenue collection, pooling and purchasing. Each block represents the percentage share of overall health care expenditure accounted for by each category of revenue source, pooling organisation and purchasing organisation in 2012.⁶ Although data are not available on the distribution of expenditure between different types of health care provider, provision issues are discussed in the accompanying text.

Revenue collection

The health sector in Peru is highly fragmented, consisting of a poorly integrated set of sub-systems serving different sections of the population (Bitrán and Asociados 2009, Díaz and Valdivia 2009). The public sector is comprised of the Ministry of Health, including the Comprehensive Health Insurance for vulnerable populations (SIS), the health directorates of regional governments, the social security agency's health insurance for formal sector workers (EsSalud), and insurance schemes for the police and armed forces.

In 2009 the Peruvian Congress approved a universal health insurance framework law. This law provided for a mandatory health insurance system based on the coexistence of a range of schemes that, amongst them, would cover the entire population. The different schemes are supposed to expand gradually to reach their full target populations.

In addition, the law determined the existence of three modes of health insurance financing – contributory, semi-contributory and subsidised. Under a contributory system, members are affiliated to a scheme through payments that they make directly or through their employer. Under a semi-contributory system, members are partially financed by government and partially by their own, or their employer's, contributions. Under a subsidised system, members are funded completely through public financing.

The contributory system is based mainly on EsSalud, which is the social security agency's mandatory scheme for the formally employed and their families. The employers of EsSalud beneficiaries make a mandatory income-based contribution of 9% to EsSalud.

Commercial insurers and prepaid health services are also contributory in nature but operate privately within regulatory guidelines. According to Apoyo Consultoria (2012b), there are ten private insurance companies that provide health insurance in Peru. In addition, there are nineteen entities providing prepaid health services. Most of them are private clinics that serve their own members. Prepaid services, therefore, are involved in both financing and provision, even when they are on a small scale.

The semi-contributory system is made up of a minority of SIS beneficiaries. It is oriented to: i) independent workers that are not poor but cannot afford private insurance and ii) employees from micro- and small enterprises that are not affiliated to EsSalud. It is financed by general taxes and voluntary contributions. In order to increase the number of people insured under this system, the government established free affiliation for a group of low-income individual and company tax-payers that register voluntarily with what is known as the NRUS (or Single Simplified Regime) in order to pay a pre-set monthly tax, thereby avoiding long income-tax statements.

The subsidised system is made up of the majority of SIS beneficiaries, representing vulnerable populations. The subsidised component of SIS has been expanding its target population. It started in 1997 by covering children in public schools and women during pregnancy, childbirth and the postpartum period. It then progressed to include poor and extremely poor populations and, since 2013, other vulnerable populations.

As part of SIS financing, the government created the Intangible Solidarity Fund for Health (FISSAL) in 2012. Since 2013, FISSAL has actually increased its budget significantly (from USD 6.9 million in 2012 to USD 61.7 million in 2013). It manages an approved plan that includes seven high-cost, cancer-related pathologies and corresponding procedures, treatment for kidney diseases, and rare and orphan diseases.

By 2012, according to the National Household Survey (ENAHU by its Spanish acronym), almost two-thirds (62%) of the population had insurance, which is a considerable improvement over the figure of 36% in 2005. Thirty-one per cent of the population (mainly the poor) belonged to SIS and 24% to the social security scheme (EsSalud). Over a third (38%) had no insurance at all: 9% were estimated to be poor and should have been covered by SIS while the other 29% were mostly lower-middle and low-income people working in the large informal sector. This is the most neglected segment of the population in terms of

⁶ All figures in this section are the author's calculations based on the World Health Organisation's Global Health Expenditure database and the Ministry of the Economy's database.

health insurance cover because they are not eligible for social security. Due to a large informal sector, the ability of the health system to insure non-poor, independent or informal workers is limited.

In Peru, any person – regardless of insurance affiliation – can seek care at a public facility. While SIS members are exempt from payments, everyone else has to pay a subsidised fee. EsSalud members get free care in EsSalud facilities. Private insurance members need to make co-payments. People with no insurance have to pay out-of-pocket for care.

As already mentioned, in 2012 just over a third of total financing derived from out-of-pocket payments. Another quarter (24%) was from social security financed through mandatory pay-roll contributions, 35% from general taxation and only 4% from voluntary contributions (see Table 4).

Pooling

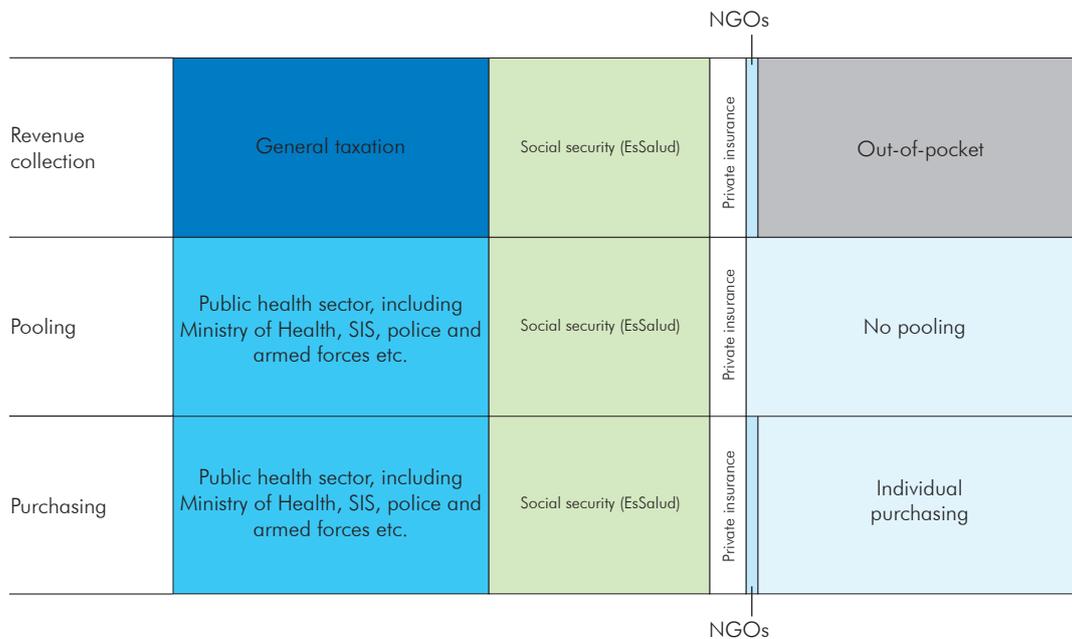
As Figure 2 shows, a significant proportion of the total financing system in Peru is not pooled because of the high level of direct out-of-pocket payments.

SIS and the health insurance schemes of the armed forces and national police are not really health insurance schemes in the classic sense. They do not have earmarked insurance funds that are linked to defined contributions. Their funding is therefore neither protected nor related to a specific population and set of benefits (Chong and Montañez 2011) and is therefore not adjusted when these change (Class et al. 2014). However, as they purchase health services for their beneficiaries, allowing them to avoid out-of-pocket expenditure, they do pool financial risks to some degree.

However, funding for SIS, EsSalud and the insurance schemes of the Armed Forces and National Police is pooled separately. This means that each of these institutions has its own financial risk pool (Class et al. 2014).

In the Peruvian health sector, therefore, risk pools are fragmented. Considering that the most efficient health systems avoid fragmentation in pooling and, by this, make it easier to achieve equity goals (WHO 2010), the integration of the funds should be a goal of health system reform. In order to start moving from the current situation to integrated risk pools, or eventually to a unitary risk pool, it is critical for SIS to become a health insurance scheme with a defined health plan and a predictable budget based on estimated per capita costs.

Figure 2: A function summary chart for Peru (2012)



Notes: Although shown as solid blocks, the public health sector and private insurers represent fragmented risk pools. Unfortunately data are not available to distinguish expenditure on public, not-for-profit and for-profit providers.
 Source: Author’s calculations based on the World Health Organisation’s Global Health Expenditure database.

Purchasing

SIS purchases health services from public facilities of the Ministry of Health and regional governments. Similarly, FISSAL purchases health services from public specialized institutes and hospitals, mainly from the National Institute of Neoplastic Diseases. In recent years, SIS has begun to change its provider reimbursement system, moving from fee-for-service towards implementing a capitation scheme for the primary and secondary care levels, with an adjustment for risk based on the Human Development Index. In addition, contractual agreements include a list of performance indicators that carry a value of 20 per cent of the reimbursement. In hospitals, the payment is by procedure. Challenges include the lack of information about population health needs, cost-effective interventions and their costs, and difficulties in implementing strategic purchasing (through the capitation system, DRGs etc.).

There is also an important percentage of uninsured people who receive healthcare in public establishments by paying a subsidised fee. Public health care networks are therefore financed by three sources of revenue: ordinary resources from the public budget, oriented mainly to funding salaries, infrastructure, equipment, maintenance and management; resources collected from SIS and FISSAL, which only pay variable costs; and the user fees of uninsured people.

EsSalud purchases health services from its own, separate facilities. The same applies to the armed forces and national police health insurance schemes which use their own facilities. These institutions therefore both provide insurance to their workers and dependents, and purchase health services from their own network of health facilities.

In the case of private insurers, they usually purchase health services from private providers; however, in some cases, they own their own networks of health services.

Provision

In spite of increased investment in infrastructure by the Peruvian government, public health services still face severe problems. These include the scarcity and age of health facilities, lack of good quality equipment and poor basic services (Apoyo Consultoría 2012a). Thus, according to ENAHO 2012, only 30% of sick SIS beneficiaries were attended to in a Ministry establishment and only 36% of beneficiaries that needed medication got it, at least in part, through the SIS.

As part of recent health reforms, the government has prioritized the expansion of the capacity of almost 750 facilities – named ‘strategic establishments’ – that will receive an injection of resources through a joint effort between the public and private sectors. Through these strategic establishments, the government seeks to improve health care access, especially in rural zones.

EsSalud attends to its insured population in its own network of services, which include almost 380 facilities. Many of these are located in cities (SUNASA 2013). Consequently, EsSalud’s insured population faces a restricted supply of services. EsSalud has been widening its network in recent years through agreements and contracts with other providers. Major access problems faced by patients are long waiting lines, delayed appointments, problems with the quality of treatment, and incomplete drug delivery (Petretera and Seinfeld 2007).

Recently the Peruvian government has promoted the exchange of health services between the establishments financed by SIS and EsSalud, including through legislation. Although the exchange of health services is a step forward in the integration of the health sector, its application is still limited by normative and operational restrictions.

‘Sistema Metropolitano de Solidaridad’ (SISOL) is an organisation within the Lima metropolitan municipality. SISOL operates under a private-public partnership scheme. It has twenty-one hospitals and ten medical services in the Lima metropolitan area, and seven hospitals in areas outside Lima. SISOL attended three million people in 2012, making it the third largest provider of health services after the public and EsSalud health networks (Ugarte 2013). SISOL represents an important initiative to address the gap in the supply of health services in Lima, especially in the provision of specialist care. Nevertheless, it is important to understand that SISOL is mainly financed by out-of-pocket payments.

Due to a recent health services provision contract with SIS, SISOL has started receiving funds from SIS for SIS patients that it serves. A similar contract was signed with EsSalud, although it has not yet been implemented.

Another initiative to improve the provision of services was the creation of service provider entities (known as EPSs) to alleviate the demand for less complex care in the EsSalud provider network (Bitrán and Asociados 2009). Formal sector workers and employers choose to affiliate to an EPS to receive care from private sector providers, in the hope of receiving better and faster care. When workers join an EPS, a quarter of their 9% compulsory contribution to EsSalud is paid directly to the EPS.

Nowadays, the EPS system is made up of four companies that contract private institutions to provide health services (SUNASA 2013). Recently the two main EPS companies were vertically integrated so that each now has its own network of establishments (Apoyo Consultoría 2012b).

Private providers include specialized and non-specialized private clinics, medical centres and polyclinics, medical and dental offices, laboratories, diagnostic imaging services, pharmacies and drugstores, and the health establishments of companies (mining, oil and sugar refineries mainly). They are financed by out-of-pocket direct payments and private insurance companies.

Finally, beneficiaries of the armed forces and national police face the same problems as the beneficiaries of SIS and EsSalud with respect to accessing quality services. Furthermore, corruption and non-transparent practices are associated with these services.

It is apparent from this description that the provision of health services in Peru is fragmented. This leads to difficulties in accessing services as well as irrational and inefficient use of available resources. Recent reforms include a strategy to create integrated health service delivery networks focused on primary and secondary care, but hitherto there has been no progress in the implementation of these networks.

Financial protection and equity in financing

A key objective of universal health coverage is to provide financial protection for everyone in the country. Insights into the existing extent of financial protection are provided

through indicators such as the extent of catastrophic payments and the level of impoverishment due to paying for health services. This section analyses these indicators for Peru and then moves on to assess the overall equity of the health financing system.

Catastrophic payment indicators

Using the 40% threshold of non-food household expenditure for assessing catastrophic payments, Table 2 shows that 5% of Peruvian households incurred catastrophic health expenditures in 2012. The Catastrophic Payment Gap Index reveals that, in those households with catastrophic payments, out-of-pocket payments represented a massive 80% of non-food household expenditure. Finally, as expected, the negative concentration index for the Headcount Index suggests that the poorest households were more vulnerable to catastrophic health expenditures.

It should be remembered that this method of assessing the level of financial protection yields figures that are difficult to interpret. It under-states the actual problem because it does not capture the reality that there are people who do not utilize health services when needed because they are unable to afford out-of-pocket payments at all (Wagstaff and van Doorslaer 2003).

Impoverishment indicators

While the extent of catastrophic payments indicates the relative impact of out-of-pocket payments on household welfare, the absolute impact is shown by the impoverishment effect. In Peru, 7.5% of Peruvian households lived in extreme poverty in 2012 (ENAHO 2012). After deducting

Table 2: Catastrophic payment indicators for Peru (2012)*

Catastrophic payment headcount index (the percentage of households whose out-of-pocket payments for health care as a percentage of household consumption expenditure exceeded the threshold)	5.4%
Catastrophic payment gap index (the average amount by which out-of-pocket health care payments as a percentage of household consumption expenditure exceed the threshold)	42.4%
Concentration index of the headcount index (this is a measure of socio-economic equality with a negative index indicating that lower-income groups carry the burden of catastrophic payments relatively more)	-0.23

Notes:

* Financial catastrophe is defined as household out-of-pocket spending on health care in excess of the threshold of 40% of non-food household expenditure.

Source: Authors' calculations based on ENAHO 2012.

household payments for health care, the poverty headcount increased by almost one percentage point (see Table 3). Thus, due to household payments for health care, more than 75,000 households became poor.

The normalised poverty gap (also shown in Table 3) measures the percentage of the poverty line necessary to raise an individual who is below the poverty line to that line. The difference between the prepayment and the post-payment poverty gaps was very low at 0.02%. This proportion might be very low due to the fact that the methodology only captures those who access health care services, excluding those already very poor individuals who cannot afford to pay for health care.

Overall, these results suggest that financial vulnerability as a result of health expenditure in Peru is not only due to large out-of-pocket payments but also as a result of small out-of-pocket payments made by poor people.

Equity in financing

Equity in financing is strongly related to financial protection (as described by the indicators above) but is a distinct issue and health system goal. It is generally accepted that financing of health care should be according to the ability to pay.

A 'progressive' health financing mechanism is one in which the amount richer households pay for health care represents a larger proportion of their income. Progressivity can be measured by an index called the Kakwani index, but this is unfortunately not available for Peru. However, Table 4 provides an overview of the distribution of the likely burden of financing in the Peruvian health system. A positive sign

in the Table means that the mechanism is progressive; a negative sign means that poorer households pay a larger proportion of their income and that the financing mechanism is therefore regressive.

As Table 4 shows, in Peru the public budget for the health sector does not allow one to distinguish the percentage of health expenditure funded through direct and indirect taxes (like VAT, selective taxes and import and export duties). Lack of information also makes it difficult to do a deeper analysis in terms of the equity of various financing mechanisms.

Nevertheless, as a preliminary assessment, it is likely that public financing sources are progressive overall, especially because of the progressive nature of social security. Private financing sources, as they are in countries with a high percentage of out-of-pocket payments, are regressive. This underlines the importance of increasing the percentage of people affiliated to social security, not only for the achievement of efficiencies but also to improve equity.

Equitable use of health services and access to needed care

This section considers how benefits from using different types of health services are distributed across socio-economic groups. One measure of this is a concentration index, which shows the magnitude of socioeconomic-related inequality in the distribution of a variable. In Table 5, if the concentration index has a positive (or negative) value, the distribution of the use of the health service is considered to benefit the richest (or poorest) respectively.

Table 3: Impoverishment indicators for Peru in 2012*

Pre-payment poverty headcount	7.5%
Post-payment poverty headcount	8.5%
Percentage point change in poverty headcount (pre- to post-payment)	1.0%
Pre-payment normalised poverty gap	0.1%
Post-payment normalised poverty gap	0.1%
Percentage change in poverty gap (pre- to post-payment)	0.02%

Note: The poverty line is defined as the average cost of the basic food basket per capita. The National Institute of Statistics and Informatics (INEI) names this poverty line "the extreme poverty line." In 2012 its value was USD58 per capita per month. A household is considered poor when its income is lower than the basic household food basket. Source: Authors' calculations based on ENAHO 2012

Significantly, only the use of Ministry of Health non-hospital facilities is pro-poor in Peru, probably because almost three-quarters of these are located in rural areas (Du Bois, Chavez and Cusato 2004). This is in contrast to the overwhelmingly urban nature of hospitals: according to the last survey available, 97% of hospitals are located

in urban areas, along with the wealthier segments of the population. While non-hospital utilization is pro-poor there are challenges with respect to the quality of services, for example when primary care establishments do not have the required expertise or are not linked to an efficient network of referral hospitals and other specialized institutions.

Table 4: Incidence of different financing mechanisms in Peru (2012)

Financing Mechanism	Percentage share	Likely progressivity	Considerations
Direct taxes (personal and company)	No info	++	In Peru, due to a large informal sector, only a small proportion of the population pays direct taxes. Furthermore, income tax in Peru has a progressive structure.
Indirect taxes	No info	?	The poor are exempt from VAT. VAT evasion is high among both poor and rich people.
General tax revenue (direct and indirect)	34.7%	?	As it is not possible to differentiate between direct (progressive) and indirect taxes, it is impossible to define whether general tax revenue is regressive or progressive overall, especially as indirect taxes account for 50% of total tax revenue.
Social security	24.3%	++	This only covers formal sector workers. More than 50% of the population affiliated to social security belongs to the three wealthiest deciles.
Total public financing sources	58.9%	+	Public financing is likely to be progressive given the progressivity of direct taxes and mandatory health contributions, but it is not possible to assess the extent.
Commercial voluntary health insurance	4.0%	+	Private health insurers only provide cover to those able to pay the premiums, which makes it progressive overall. However, a flat rate is charged to everyone on the same plan which means that, amongst members, less well-off members pay relatively more.
NGOs serving households	1.3%	?	These are mainly financed by international aid.
Out-of-pocket payments	35.7%	-	Out-of-pocket payments tend to be regressive overall. Nevertheless, in Peru, as there is segmentation of the health market, wealthier people pay more expensive fees than the poor.
Total private financing sources	41.1	-	
Total financing sources	100%	?	It is necessary to define the likely progressivity of general taxes to be able to define the likely progressivity of the overall financing.

Key: ++ = very progressive; + = progressive; ? = insufficient information to make a judgement; - = regressive; -- = very regressive.

Source: Author's calculations of percentage share based on the World Health Global Health Expenditure Data Base available at <http://apps.who.int/nha/database/Select/Indicators/en>

Table 5: Concentration indexes for utilization incidence of health service use in Peru (2012)

Type of Service	Concentration Index*
Public facilities	0.004
Ministry of Health	-0.15
Hospital	0.07
Non-Hospital	-0.21
Social security (EsSalud)	0.32
Hospital	0.33
Non-Hospital	0.28
Private facilities	0.33
Hospital	0.40
Non-Hospital	0.27
Total services	0.09
No services	-0.07

Note: Estimates are based on per capita household expenditure.
Source: Authors' calculations based on ENAHO 2012.

Table 5 also shows that the higher concentration indices correspond to the utilization of private and social security hospitals. This means that the utilization of facilities of better quality is more concentrated amongst richer households. These data highlight the need to improve the efficiency and quality of the general health system, especially in areas serving vulnerable populations.

It is generally agreed that individuals' use of health services should be in line with their need for care. The universal coverage goal of promoting access to needed health care can be interpreted as reducing the gap between the need for care and actual use of services, particularly differences in use relative to need across socio-economic groups. The utilization incidence results discussed above do not link use with need and it is therefore not possible to draw a categorical conclusion about whether the distribution is equitable or not.

Petrera (2012) found that affiliation to SIS, in contrast to those without any insurance, increased the possibility of access to health care. However, according to the same study, affiliation to SIS did not guarantee protection against catastrophic diseases. In response to this problem, in 2012 the government launched the Plan Esperanza to improve comprehensive cancer care and access to cancer services in Peru. It also increased the budget of FISSAL, which, as mentioned before, provides health insurance against the most common cancers, chronic renal failure and rare or orphan diseases to SIS beneficiaries.

In 2011, the Peruvian Health Demographic Survey (ENDES by its Spanish acronym) showed, for example, that, while in urban areas 94% of pregnant women received professional

medical attention, in rural areas the equivalent figure was only 58%. Only 51% of women in the lowest income quintile had access to institutional care in contrast to 97% of women in the richest quintile. In Table 5, the negative value of the concentration index for the category 'no services' confirms that the poorest tend not to use health services when needed more often than the richest. Seinfeld and Besich (2011) found that while 9.4% of the poorest (first quintile) population did not utilise services for financial reasons, only 2% of the richest (fifth quintile) population gave this reason for not accessing health services.

Conclusion

As described above, the health sector in Peru is fragmented, consisting of a non-integrated set of sub-systems aimed at serving different segments of the population. The strategies proposed by the Peruvian government to reach universal health coverage have not been sufficient as yet. Despite the universal framework law that was approved in 2009, over a third of the population remains uncovered and out-of-pocket payments account for over a third of health care financing. More than 75 thousand households are impoverished annually as a result of health care payments.

One of the most neglected segments of the population in terms of health insurance is the one including lower-middle and low-income individuals. This segment is not classified as poor and thus cannot access subsidized insurance through the publicly financed SIS. At the same time, they mostly work in the informal sector and therefore

are not able to access the insurance scheme for formal sector workers, EsSalud. They also have no access to private insurers as they cannot afford the premiums. They therefore do not enjoy any form of financial protection.

There are several problems that account for this state of affairs. These include the large informal labour market, the fragmentation of the health system, the poor responsiveness of health services (especially in the public sector), difficulties in implementing strategic purchasing, bottlenecks resulting from integration of the purchasing and provision of health services, the absence of a risk-pooling mechanism for different insurance plans, and the inefficient and inequitable distribution of human resources. Additionally, the public health sector has fragmented and inadequate funding.

Meanwhile, due to institutional limitations, mandatory health insurance for the formal sector (EsSalud) has not managed to re-organize and separate its provision function from its financing function. As Figueras et al. (2005) note, the movement from an integrated, command-and-control model of publicly operated health care services towards a purchasing-based model requires keeping health purchasers organisationally separate from health providers.

In response to these problems, in 2013 the Ministry of Health announced a comprehensive reform of the public health sector. The reform seeks to improve the health status of the population. It consists of the reorganization of the sector and public agencies, the modernization of the management of public investments in the sector, and the modernization of the national health system - for instance, it is supposed to change the model of care, from one focused on disease, acute care, and hospital-based treatment to one focused on promotion, prevention and early detection. Apart from this, a comprehensive remuneration policy is being developed, and the funding of SIS and EsSalud will be strengthened.

This document is not in a position to assess the impact of these changes. However, it is able to identify some important areas that need attention with respect to promoting financial protection. The definition of an explicit benefit package and actuarial projections about its costs are pivotal. Further, apart from increasing public expenditure, the Peruvian health system needs to improve the efficiency of available resource use. Thus, any budgetary increase must be justified by the increased ability of the government to attain its health objectives.

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GNHE is a partnership formed by three regional health equity networks – SHIELD (Strategies for Health Insurance for Equity in Less Developed Countries Network in Africa), EQUITAP (Equity in Asia-Pacific Health Systems Network in the Asia-Pacific, and LANET (Latin American Research Network on Financial Protection in the Americas). The three networks encompass more than 100 researchers working in at least 35 research institutions across the globe.

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