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## Progress in the Universal Health Insurance Implementation Process

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## Acronyms

AUS	Universal Health Insurance
CTIN	National Implementation Technical Committee
CTIR	Regional Implementation Technical Committees
DGSP	General Directorate of People's Health
DIGEMID	General Directorate of Medical Products and Supplies
EPS	Health Provider Entity
EsSalud	Social Security Institute
FESE	Socio Economic Scorecard
FISSAL	Intangible-Solidarity Fund for Health
IAFAS	Institutions Administrators of Health Insurance Funds
IPRESS	Institutions Providers of Health Services
JUNTOS	National Program of Direct Support to the Poor
LPIS	SIS Priority List of Interventions
MOH	Ministry of Health
OGPP	MOH General Directorate of Planning and Budget
PAN	Nutrition Articulated Health Program
PARSALUD	MOH Program in Support of Health Reform
PEAS	Health Insurance Essential Plan
PYMES	Small and Medium Business
RENIEC	National Registry for Identification and Vital Statistics
SEG	Free Students Insurance
SERUMS	Rural and Marginal Urban Health Service
SETEC	CTIN Technical Secretariat
SIS	Comprehensive Health Insurance
SISFOH	Household Targeting System
SISMED	MOH Information System of Medical Products and Supplies
SMI	Maternal and Child Insurance
SMN	Mother Newborn Health Program
SUNASA	National Health Insurance Superintendent Office
PAN	Nutritional Articulated Program
VRAE	Valley of the Apurimac and Ene Rivers

## Executive Summary

In the context of health reform that Peru has been developing, the Framework Law of Universal Health Insurance, Law No. 29344 set forth the right to quality and timely health care; a change that will have a deep significance in the social reform. In this regard, this report aims to inform about the progress and difficulties in the implementation of Universal Health Insurance, where the National Implementer Technical Committee (CTIN) had the role of coordinator of the implementation at the national level.

Furthermore, the Framework Act establishes the following as objectives of the Universal Health Insurance policy: i) families shall be protected from the risks, entailed by impoverishment, that are associated with disease events, ii) improvement of health results, and iii) contribution to the improvement of the nation's manpower productivity. To fulfill these, four specific objectives have been identified: i) consolidate and expand the coverage of the Universal Health Insurance (AUS), ii) strengthen the health service supply for the provision of the Health Insurance Essential Plan (PEAS), iii) manage the AUS funding; and, iv) strengthened the leadership of AUS at national, regional and local levels.

The implementation was done in a phased manner and priority areas have been established gradually. First, considering social inclusion criteria, the CTIN determined to start the insurance process in 7 pilot areas: the departments of Apurimac, Ayacucho, Huancavelica, the province Sánchez Carrion in La Libertad and districts of Salas in Lambayeque, of Bajo Piura, of the Commonwealth of Bajo Huallaga in San Martin, and of the Valley of the Apurimac and Ene Rivers (VRAE) in Junín and Cusco. Later, were incorporated the provinces of Condorcanqui and Bagua in the Amazon and the constitutional province of Callao. Finally, the inclusions of the province of Datem del Marañón in Loreto and Metropolitan Lima were approved.

**Expanding Coverage:** During the period of analysis, the most noticeable outcome is the significant increase in the coverage of insured population. In just 2 years, the percentage of the population that has some health insurance has increased by 10 percentage points, reaching 64% in 2010. About 3.5 million people that were not protected by insurance, back in 2008, are enjoying it in 2010.

However, the implementation of the insurance policy would not be the most important cause of this growth as it is found that the greatest growth occurred in 2008, when institutions responsible for this implementation started to plan it, yet not implement it *per se*. Another indication of this is that the growth in priority areas, where the implementation process focused its work, was not significantly higher than that of the rest of the country. Therefore, one can assume that this growth is more consistent with a national policy to expand social programs and initiatives - such as *JUNTOS* - and even the policy for extending identification and vital records processes instead of the implementation of universal insurance policy.

The main insurance program in the country is the Comprehensive Health Insurance (SIS) which contributes 90% of the growth of the total horizontal coverage. It is somewhat encouraging that this increase was higher in rural areas and among the poorest population. Thus, we find that between 2008 and 2010, the growth in rural area coverage was 15

percentage points, reaching 75% coverage of the population living in these areas. Likewise, the population living in extreme poverty experienced a similar growth, recording 80% coverage in 2010.

Thanks to these advances in coverage, now the challenge is to extend the coverage of the semi-contributory scheme. This implies the establishment of a set of incentives that promote voluntary membership as well as compulsory mechanisms. Moreover, considering that the population corresponding to the subsidized system is almost completely covered, most of the uninsured population is not poor and belongs to the semi-contributory and contributory schemes.

**Strengthening Supply:** The biggest obstacle to implement the PEAS is the response capacity of health services in various departments of the country. There is a gap in the provision of services that hinders the assurance made to the insured population regarding the coverage of 140 insurable conditions as set out in the PEAS. Between 2005 and April 2011, a little over S/ 4 billion were expended in the health sector in all government levels of the public sub-sector. Moreover, in recent years, a significant percentage of this expenditure was focused on priority areas of the AUS. Also, between 2008 and June 2011, EsSalud executed approximately S/ 1.7 billion.

Manpower is also important to ensure the provision of the PEAS to the insured population. In this regard, the Ministry of Health (MOH) has adopted the policy of driving the Rural and Marginal Urban Health Service (SERUMS) and the medical residency program towards AUS's priority areas. This is how the department of Apurimac and the District of Salas in Lambayeque have the required human resources. The largest gap is in Bajo Piura and VRAE districts, where the gap exceeds 50%.

According to the regulations of Law 29344, this year the PEAS should be updated. This implies that new insurable medical conditions and interventions may be included in the plan. However, given the low response capacity of health services in various areas of the country, the supply of existing services must be considered to perform this update. In this sense, it is recommended to improve the content of the 140 currently listed conditions mainly through the strengthening of preventive components and the promotion of the PEAS regarding individual health.

**Funding AUS:** In 2010, the public expenditure amounted S/ 5,477 million. MOH, as the largest contributor, was accountable for a little less of S/ 2.8 billion, while regional governments contributed about S/ 2.5 billion. In the case of the subsidized system, there was a 7% increase in SIS's budget amounting S/ 28 million between 2008 and 2011. Furthermore, strategic programs with *ad-hoc* budget structure showed a budget growth over 50% between 2008 and 2010, while the resources for the PEAS only grew by 7%.

However, the horizontal coverage growth exceeded the financing of the subsidized system (SIS). This implies that the *per capita* subsidy has been reduced by S/ 4 in just two years reaching S/ 36.2 by 2010. In this regard, the financing law, whose regulations must soon be developed, could correct this problem. By guaranteeing *per person* funding, based on a premium that reflects the cost of the PEAS, the coverage growth will not be translated into a reduction in the financial protection of the insured parties or in their access to services.

Also, the establishment of an *ad-hoc* budget structure that reflects the activities of the PEAS as a new strategic program is suggested so as to ensure that the AUS has a real priority focus. Also, in the very short term, significant progress can be achieved by adjusting the tariff structure of the SIS.

On the other hand, the recently approved Financing Law also stipulates certain organizational changes to the Intangible Solidarity Fund for Health (FISSAL) considering that it is important to match the funding for high-cost diseases with the PEAS's, because otherwise they would risk the financial protection of the population outside the AUS area operation.

**Leading the Implementaton Process:** Several institutional arrangements have been made pursuant to the AUS Framework Act. For instance, the National Implementer Technical Committee (CTIN) was created and installed in June 2009, as well as its Technical Secretariat (SETEC) and Regional Implementation Technical Committees (CTIR) for each priority area.

However, the greatest achievement was the creation of the National Health Assurance Superintendent Office (SUNASA), which has been adapting its structure and undertaking its new roles. SUNASA has been developing a set of proposals for monitoring, recording, issuing regulations - including the authorization for the organization and operation of the Institutions Administrators of Health Insurance Funds (IAFAS) and Institutions Providers of Health Services (IPRESS)-, dealing with claims and complaints, violation and penalties, regulations on contracts, agreements or conditions for the provision of services that will be part of the contracts entered into by the IAFAS, among others.

At the regional level, Regional Implementation Technical Committees (CTIR) has developed a planning work that has led to the development of goals and strategies/actions for the implementation process. However, planning the implementation at national and regional levels has not been smooth. The CTIN has not been able to effectively fulfill its technical assistance and coordination role in both levels, this is perhaps due to the misbelieve that the regional level is a subdivision of the Ministry of Health that does not contribute but just executes. Additionally, the CTIR discussion, and its relationship with the national level, was focused on the debt owed by the Comprehensive Health Insurance (SIS) to the health providers of the public sub-sector. These financial distresses hindered the progress at regional level.

Therefore it is recommended to support the continuation of the institutional arrangements being made by the SUNASA. Also, as MOH does not has an area responsible for monitoring the implementation, it is advisable to create a division within the organizational structure of the Ministry of Health that is directly responsible for the AUS, its implementation and progress, or to assign this responsibility to any existing division. Furthermore, a body similar to CTIN that allows the coordination between the various health institutions and that facilitates the conduct of the implementation at the national level should be created.

Finally, we must emphasize that, given these developments in the specific objectives of the insurance policy, the biggest challenge in implementing the AUS is found in its higher-level objectives. To further up and achieve the main objectives of the policy, the emphasis should

be shifted away from the objectives of a particular health plan. The country's coverage increase and the strong investment must go hand in hand with the increase of the access to health services, equity in access to health services and, ultimately, financial protection for households, considering that these are the indicators where progress has been slower, and has even regressed.

## 1. Introduction

Peru has been developing a health reform process whose primary goals are to improve the health of the population through the access to health services that provide greater equity, efficiency, effectiveness, timeliness and quality.

The Law of Universal Health Insurance<sup>1</sup> “represents the most important event in Peruvian public health in recent decades... because, for the first time, the State recognizes the right to timely and quality health care, from birth to death, for all Peruvians. This right was not exercised throughout the country and by passing this law a milestone is marked, characterizing universal health insurance as an in-depth social reform towards a more fair and equitable society.”<sup>2</sup>

By means of the Universal Health Insurance (AUS) “the entire population residing in the national territory will have a health insurance that will allow them to have access to a range of preventive, promotional, recuperative and rehabilitation health care benefits, under suitable conditions of efficiency, equity, timeliness, quality and dignity, based on the Health Insurance Essential Plan (PEAS).”<sup>3</sup> This clearly states the purpose of the AUS.

The State, through the AUS policy seeks to:

- ensure the rights of all people to health care in terms of access, timeliness, quality and financing;
- protect families from the risk of impoverishment associated with disease events;
- improve health outcomes; and,
- enhance the productivity of human capital of the nation.

All of these consolidate the basis of the National Plan for the Implementation of the Universal Health Insurance, which sets forth the objectives of this implementation process valid throughout the duration of the National Implementer Technical Committee (CTIN), as follows:

- Consolidate and expand the AUS coverage
- Strengthen the supply of the health service sector to grant the PEAS
- Manage the AUS’s funding
- Strengthen AUS’s leadership at national, regional and local levels

The plan also sets out the strategic actions and their corresponding activities.

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<sup>1</sup> Law No. 29344.

<sup>2</sup> Ugarte Ubilluz, Oscar (Minister of Health) (2009). Revista Peruana de Medicina Experimental y Salud Pública. Vol. 26, No. 2, April – June 2009.

<sup>3</sup> Idib.

This report aims to assess the progress and difficulties in the implementation of Universal Health Insurance. Therefore, this report considers the objectives of the AUS implementation plan, which are presented in separate sections. But, before tapping into said topics, there is a section describing the background of the AUS and the advancements made in its implementation process up to this date. Also, a section has been added to compile the information related to the outcome of the insurance process, this is: the access to services, the equity achieved through said access, and the financial protection achieved by the AUS. The paper ends with the main conclusions that emerge from this analysis.

## 2. Implementation of Universal Health Insurance in Peru

The implementation of AUS started back in April 2009 with the enactment of the Framework Law. However, the health insurance in Peru has a greater history. The following briefly describes the backgrounds, objectives and the implementation process of this law since its enactment until the last days of Alan Garcia's administration in July 2011.

### 2.1 Background

In 1936, Peru implemented its health insurance with the creation of *Caja Nacional del Seguro Social del Obrero* during the administration of General Oscar R. Benavides.<sup>4</sup> Subsequently the *Caja del Seguro Social del Empleado*<sup>5</sup> was created and both efforts were merged creating the Instituto Peruano de Seguridad Social<sup>6</sup> during the government of General Juan Velasco. The purpose of this integration was to cover the uninsured, especially those formally employed workers and their dependents through a comprehensive plan of benefits, including preventive, promotion, recovery and rehabilitation services and financial and social benefits. This institution later became today's Social Security Institute (EsSalud),<sup>7</sup> whose efforts to expand coverage for certain population groups have been insufficient due to structural problems beyond the scope of the institution itself, and the health sector.

#### 2.1.1 General Health Law and the Modernization of Social Security Law

During the nineties, the General Health Law<sup>8</sup> and the Modernization of Social Security Law<sup>9</sup> were passed. The first states that "everyone has the right to free access to health services and to choose the pension system of their choice." On the other hand, the latter and its regulations laid the foundations of the current social security structure in health.

These laws define a dual system based on two parallel schemes: the Public regime and the Contributive Social Security regime. The first, under the lead of the Ministry of Health (MOH) has for main objective to give comprehensive health care to low-income population, which is funded by contributions made by the Treasury. However, this system does not use insurance schemes. The second is made up by the Seguro Social de Salud (EsSalud) and is complemented by the Health Providers Entities (EPS).

EsSalud, EPS and the insurance companies are the basis of the AUS's contributory regime.

#### 2.1.2 Free School Insurance and Maternal and Child Insurance

Between 1997 and 1998, the Ministry of Health established two programs aimed at expanding health coverage through the stimulation of the demand for health services:

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<sup>4</sup> Created by Law No. 8433.

<sup>5</sup> Created by Law No. 13640.

<sup>6</sup> This merger was approved by Decree Law No. 20212.

<sup>7</sup> In 1999, Law No. 27056 was enacted, creating EsSalud under the Instituto Peruano de Seguridad Social and repealing Law No. 24786, Decree Law No. 25636 and Decree Law No. 20808.

<sup>8</sup> Law No. 26842.

<sup>9</sup> Law No. 26790 and its regulation which was passed by Supreme Decree No. 009-97-SA.

Seguro Escolar Gratuito – SEG (Free Student Insurance) for all students between ages 3 and 17, enrolled in public educational institutions; and the Seguro Materno Infantil – SMI (Maternal and Child Insurance) aimed at women during their pregnancy and the postpartum and children under 4 years residing at prioritized departments that were selected under geographic targeting criteria. Both programs have the objective of providing a package of comprehensive health care services designed specifically for each target population.

### **2.1.3 Comprehensive Health Insurance**

The Seguro Integral de Salud – SIS (Comprehensive Health Insurance) was created in 2002<sup>10</sup> from the SEG and the SMI, but extended its coverage to cover all school-aged children, removing the limitations of being enrolled in a public school and pregnant or postpartum mothers and children under 5 years, without geographical restrictions. Along with the decentralization process, the SIS was the only significant reform initiative introduced in this decade. The SIS was designed as a health insurance mechanism that subsidizes and facilitates public access to vulnerable population.

Any individual wishing to enroll must undergo an economic assessment, which consists in the evaluation of the asset holdings of his family made through a single instrument: Sistema de Focalización de Hogares - SISFOH (Household Targeting System). Before the creation of this system, the SIS itself applied the Ficha de Evaluación Socio Económica – FESE (Socio Economic Scorecard), similar to the one used by the SISFOH. These instruments are intended to determine whether the person is eligible for the SIS or not.

The SIS operates as Public Expending Unit attached to the Ministry of Health. Its main function is to administer the funds used to finance individual health benefits of Peruvians who do not have health insurance and that meet eligibility characteristics: vulnerable population in poverty and extreme poverty conditions.

Thus, the SIS aims to: i) increase the coverage of health services, ii) to focus attention on the population in poverty, extreme poverty and those affected by social exclusion; iii) improve the allocation of public resources, and iv) increase the supply of services and investment in public health services.

As part of the Universal Insurance Law, the SIS operates the subsidized and semi-contributive insurance schemes.

### **2.1.4 Agreements preceding Universal Health Insurance**

In recent years several large, multiparty and democratic agendas have been drafted characterizing the AUS as the mechanism that will guarantee the right of access to unlimited health services (regardless of the socioeconomic level of the citizen and his family). First, the signing of the National Compact reflects the importance assigned by the Peruvian society to the AUS when it undertakes to “ensure universal access to comprehensive, quality, free, continuous and timely health care services by expanding and strengthening

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<sup>10</sup> Law No. 27657

health services... and promoting the development of a national integrated and decentralized health care system.”<sup>11</sup>

On this basis, the sectorial policy guidelines for the period 2002-2012 set forth as leading sectorial guidelines "to achieve universal insurance to guarantee access to health services and prevent the neglect of families in contingencies (mainly the poor and extremely poor)."

In 2005, the first Agreement of the Political Parties in Health Matters was signed. This reflects a consensus to achieve this goal. Sixteen political parties and groups committed to the progressive universalization of social security in health. Specifically, they pledged to "promote, in the long run, a single fund that will add up public, private and mixed funds from taxes, contributions and other sources to achieve the universalization of social security, the coordination between the different services subsectors (MOH, EsSalud, National Police, Armed Forces, private sector, etc.), the establishment of a fund to cover catastrophic events, as well as, the expansion of the health insurance offer for self-employed and informal workers as one of the strategies for achieving universal social security."

Finally, civil society and regional governments approved the National Concerted Health Plan 2007-2020. This plan sets as policy guideline that "all Peruvians will have access to health insurance through a health plan that guarantees for all a range of health services, regardless of their affiliation to any insurance system." Furthermore, it also states that "universal health insurance will be gradual starting with the population in poverty and extreme poverty to continue with the other segments of the population, seeking the coverage of the health risks of all insured citizens, and to substantially reduce the percentage of health spending in the country. For this, the SIS as insurance and public financing body should strengthen its affiliation, auditing and financial transferring capabilities." The plan goes further and sets an affiliation goal for 2011: to increase health insurance, through the SIS, from 4 to 11 million people in poverty and extreme poverty conditions and that 40% of the self-employed population joins a health insurance plan with guaranteed coverage.

## 2.2 Implementation process

On April 9, 2009 the AUS Framework Law was enacted marking a milestone in the Peruvian health system. Although the regulations of the Law were approved almost a year later - on April 2, 2010 - the enactment of the Law kicked off a long implementation process that achieved some success throughout its first two years of existence, but also experiencing some difficulties.

Subsequently, on June 13, 2009, the National Implementer Technical Committee (CTIN) was created as a driving body of the AUS at national level. The CTIN was comprised by members representing Peruvian health system institutions such as the Minister of Health, who is the chairman, the Minister of Defense or his representative, the Minister of Interior or his representative, the CEO of EsSalud, a Regional President on behalf of the National Assembly of Regional Governments, the president of the Association of Private Clinics in

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<sup>11</sup> The signing of the National Compact was in July 22, 2002.

Peru, and the Head of the SIS. Then, the Superintendent of SUNASA and a representative of the Ministry of Economy and Finance - specifically in charge of the SISFOH - were included as members.

The conformation of CTIN also led to the creation of a Technical Secretariat (SETEC) for the preparation of technical reports requested by the CTIN and drafting the proposals of their initiatives. On October 7, 2009 approving the bylaws of the SETEC were approved and 12 subcommittees were formed according to the selected topics: drugs, emergency care, infrastructure, human resources information network, quality of patient services, communications, exchange of benefits; identification, certification and affiliation, strengthening SUNASA, funding, and coordination of the regions.

One of the principles set forth in the Law was its gradual implementation process. That is, the universal insurance would be implemented in stages. This principle affects two levels. First, the definition of PEAS responds to a gradual increase in the number of insurable conditions. Thus, by the suggestion of the Ministry of Health, the CTIN considered convenient to define this number considering the study of disease burden in the country and to extend this coverage every two years, when the PEAS is updated as per law. Specifically, the coverage of 140 insurable conditions representing 65% of the disease burden was first identified. Based on these health conditions, the definition of PEAS began and was finally approved on November 28, 2009. This plan contains the prioritized list of insurable conditions and interventions that are funded, at least, for all insured by the IAFAS. Then, the explicit guarantees of timeliness and quality for all beneficiaries, which are included in the PEAS benefit plan, were defined.

Second, the definition of territorial pilots was considered for the implementation of the AUS. The pilots have increased steadily between 2009 and 2010. The analysis of the information on the progress concludes that the definition of the pilots, and the consequent affiliation of new people, has taken the greatest interest of the institutions responsible for implementing the AUS, especially those related to the subsidized regime.

This definition was made on the basis of poverty and exclusion criteria of health services, thus the CTIN shortlisted the departments of Apurímac, Ayacucho and Huancavelica. At the same time, a set of local governments applied for their inclusion in the first stage of implementation: the province Sánchez Carrión in La Libertad, Salas District in Lambayeque, the districts of Bajo Huallaga (Pongo de Caynarachi and Barranquita of the provinces of Lamas and Chipurana, El Porvenir, Huimbayoc, Papaplaya of the province of San Martín) in San Martín and the districts of Catacaos, El Tallan, La Arena and La Unión in Piura.

Relevant information was collected from these pre-selected areas so as to make the decision regarding the inclusion of these as pilot areas. Such information included epidemiological information, insurance coverage - specifically per insurance scheme -, access and services offered, among others. Part of this information is contained in the paper entitled "Disease Burden within the framework of the Universal Health Insurance Pilot Plan Implementation Project: regions of Apurímac, Ayacucho and Huancavelica" which was approved on February 9, 2010.

Besides of using this information in the decision to incorporate the areas as a pilot, it was also useful for defining the insurance baseline.

In December 2009, after analyzing the information gathered, these areas were approved as first priority areas (AUS 1 areas) for the implementation of the AUS. Thus, on December 19, 2009 the implementation process was officially kicked off in the preselected AUS pilot areas to which, under the political light, the localities of VRAE area were added. In practice, the inclusion of the VRAE as a pilot area only meant to consider some of the districts of Cusco and Junín as priority areas, since the department of Apurímac was already considered holistically.

Also, in late 2009 and early 2010, the SIS carried out a series of administrative changes that allowed the adjustment of the implementation process. For example, a new tariff was approved and authorized the SIS to implement a payment mechanism that was best suited for those services which are not within the Priority List of Interventions (LPIS) and who are covered by the PEAS. However, there are some inconsistencies and absences among these instruments and the PEAS.

On January 8, 2010, at the request of the Regional Government of Callao, the village of Pachacutec, in the district of Ventanilla, Callao was formalized as a pilot area of the Universal Health Insurance. The criteria that prevailed in this selection were the assumption that Callao had no funding gap for covering its total population that is eligible for the subsidized regime. Likewise, the inclusion of the provinces of Bagua and Condorcanqui in the Amazon was officialized. These areas formed the AUS 2 area.

This inclusion in the priority area led to consider Metropolitan Lima as a possible pilot. After analyzing the relevant information, Metropolitan Lima was officially included as pilot area expanding the priority area to the entire Constitutional Province of Callao on July 14, 2010. Earlier, on May 14, 2010, the province of Datem del Marañón in Loreto was included. Both provinces were considered as AUS 3 areas and closed the list of priority areas up to this date.

Along with the definition of priority areas, the CTIN considered other agenda items. One was the development of the AUS Implementation Plan. It has 4 objectives: i) to consolidate and expand the population coverage of AUS, ii) to strengthen the supply of health services for granting the PEAS iii) to manage AUS funding, and iv) to strengthen the conduction of the AUS at national, regional and local levels. The plan defines a number of strategic actions and activities for each objective. Most of them have not been fulfilled, except for those related to the first objective.

The approval of a priority area involves the formation of the respective Regional Implementation Technical Committee (CTIR). These were installed in a manner similar to CTIN: setting up internal rules, formulating a regional implementation plan, and even setting up implementation stages (sub-priority areas) in the case of Apurímac, Ayacucho and Huancavelica. However, the debate at the regional level has been captured by the

discussion on the debt payment requested by the execution units to the SIS.<sup>12</sup> This perception of the existence of a debt for health benefits provided to SIS policyholders seriously hindered the implementation process, since it is natural that healthcare service providers refuse to increase the coverage of a program that does not have the required funding, especially if a program owes significant amounts of resources.

Also, a major change in the rules of insurance, particularly private insurance, is the exclusion of preexisting conditions. The enactment of Law No. 29561, on July 17, 2010, establishes the continuity of the coverage of pre-existing conditions in the health plan of the Instituciones Administradoras de Fondos de Aseguramiento en Salud – IAFAS (Institutions administering Health Insurance Funds). Thus, if a person was affiliated to the SIS, loses his eligibility and wishes to continue with a private insurance, the private insurance cannot exclude the conditions that the person developed while assured by the SIS from their health plan.

The AUS implementation process also involved the adequacy of a set of operational tools. Thus, a set of changes was issued to facilitate this implementation. Among them, new affiliation mechanisms were established for the subsidized regime. Particularly, Emergency Decree 048-2010 established that in order to affiliate someone a consultation should be made to the SISFOH and to EsSalud database so as to avoid duplication of insurance programs and leaks to the SIS. On November 24, 2010 the mechanisms leading to compulsory affiliation to the Universal Health Insurance were approved. SIS promotes the implementation of these mechanisms and initiates a re-enrollment process by which each regional government must apply these mechanisms to all newly insured and those who were already insured by the SIS. It stimulates the implementation of this re-affiliation as a request against the use of additional resources that were sent to the respective executor units. This re-affiliation was initiated by regional governments between May and June 2011.

On August 11, 2010 the Committee of Technical Assistance for the AUS implementation is created internally by the MOH formed by one representative of the MOH, one representative appointed by the Head of the SIS, the General Coordinator of PARSALUD, one representative appointed by the General Directorate of People's Health (DGSP), one representative appointed by the General Directorate of Infrastructure, Equipment and Maintenance, one representative appointed by the General Directorate of Human Resources Management, and one representative appointed by the General Office of Planning and Budget (OGPP).

For its part, EsSalud has also initiated a process for implementing the AUS. This is reflected mainly in matching optional benefit plans to PEAS. Thus, EsSalud has been working on an 'independent PEAS' and 'PEAS plus'. The first is a plan that takes the PEAS as a base plan for offering voluntary insurance plans targeting self-employed workers and their families. On the other hand, the 'PEAS plus' is a supplemental benefit plan, which mainly contains high-cost interventions.

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<sup>12</sup> This debate focused in the debt generated throughout 2008 due to a cut in the general budget for the public sector caused by the international crisis internacional.

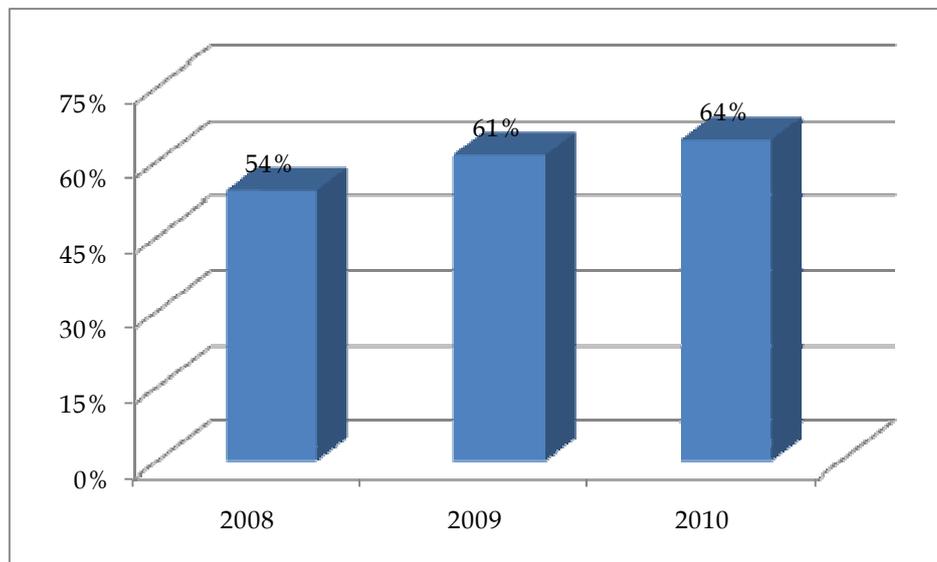
Finally, in July 2011 the Law for funding the subsidized and semi-contributory AUS was enacted. This Law seeks to establish clear rules, which is of paramount importance, as it is essential to reduce the discretion in the allocation of public resources, to have a continuous funding and to enable the insurance policy. The Law establishes the allocation of funding to these schemes on the basis of a PEAS benchmark premium and the affiliation goal, which is established by a multisectoral commission. The Law also states that the SIS can hire health services from private or mixed-capital institutions so as to provide healthcare assistant to policyholders on both schemes with a founding that is not limited to variable costs. Finally, the amendment to the FISSAL was set forth, now it is an executing unit.

The following sections of this paper discuss the progress in implementing the AUS in relation to each objective of the implementation plan. However, it is observed that the implementation has focused on extending the number of insured and has put aside other goals. This is shown in the will of the members of CTIN to increase the number of priority areas and the neglect of other key aspects, such as increased funding, improved service delivery, among others. This focus has been blind to the low funding increase, less in proportion to the increase in coverage, accumulated debts of the SIS with the sub-system of public services and other constraints.

### 3. Population's Universal Health Insurance Coverage

The AUS policy's best result is the increase in horizontal coverage; the population's percentage with health insurance has grown considerably in 2 years: about 10 percentage points or 3.6 million people. In 2008, prior to the enactment of the Universal Health Insurance Framework Law, 54% of the population had some health insurance. Two years later, in 2010, this figure has greatly increased reaching 64% of the population, although, as shown later on, there is no certainty that this increase is due to the universal insurance policy. For example, Chart No. 1 shows that the greatest increased in coverage was between 2008 and 2009, reaching a little more than 7 percentage points. During this period, the institutions in charge of implementing the AUS were planning the implementation and there were only a few actions executed regarding this policy to achieve this expansion.

Chart No. 1  
Insurance coverage evolution, 2008 – 2010



Source: ENAHO

Another conclusion from Chart No. 1 is that as December 2010, there is still a large gap between people without any financial protection against a negative health event and those who do. More than 35% of the population doesn't have any health insurance. The AUS efforts shall be directed largely to this population, so that, it is progressively covered by any type of coverage scheme.

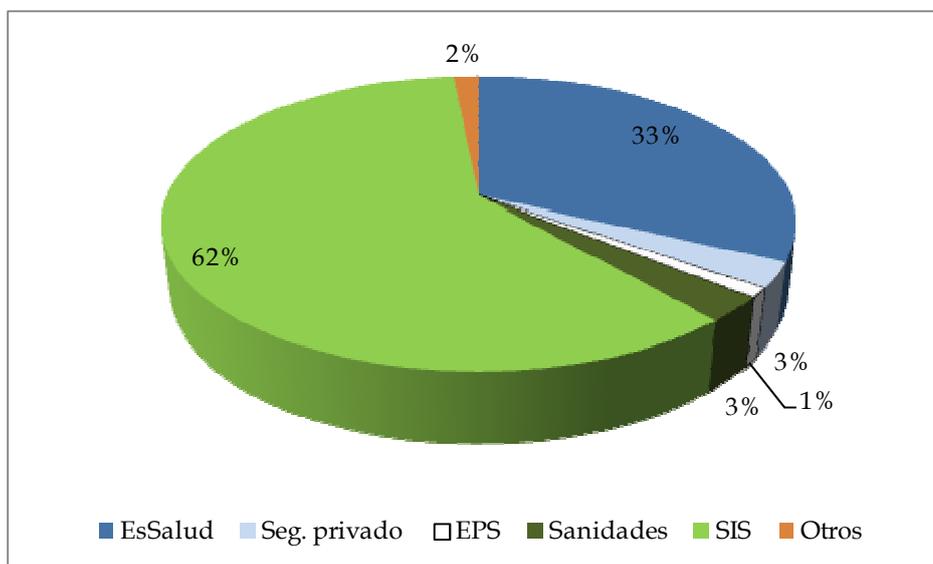
Of the total insured population (about 19.6 million people), the majority is covered by the SIS: 62% of the insured population is covered by the SIS<sup>13</sup>. The SIS's official figures show

<sup>13</sup> Chart No. 2 shows figures that add up more than a 100%. This is because the percentages have the insured population as a reference. But it shall be considered that a certain percentage of the population with more

that 12.6 million people were covered by the SIS in 2010. EsSalud is the second biggest insurer, covering 33% of the insured population. In 2010, EsSalud reported the official figure of 8.5 million people insured under all regimes. The other insurance schemes, mainly private, cover a small percentage of the population; the EPS report a total of 1.25 million<sup>14</sup>, while the Sanidades de Salud a total of 1.1 million<sup>15</sup>. This could be interpreted as a precarious previsual culture in the country becoming an important challenge towards reaching universal insurance. On the other hand, it could be expected that the increase would be more dynamic once the mechanisms making the health insurance mandatory operate effectively and freelancers with paying capacity seek some insurance scheme.

Chart No. 2

Insurance structure, 2010



Source: ENAHO

Likewise, the SIS has been the main contributor to the great increase in coverage in such short time. In 2008, 31% of the population was insured by the SIS, and increased 9 percentage points in 2 years. The other insurance schemes haven't had any increase as important. Chart No. 3<sup>16</sup>, shows that the population covered by EsSalud and other insurers has increased by 1.2 and 0.3 percentage points respectively.

than one health insurance. For example, someone affiliated to an EPS, is also affiliated to EsSalud; counted once for the first chart, but twice for the second one.

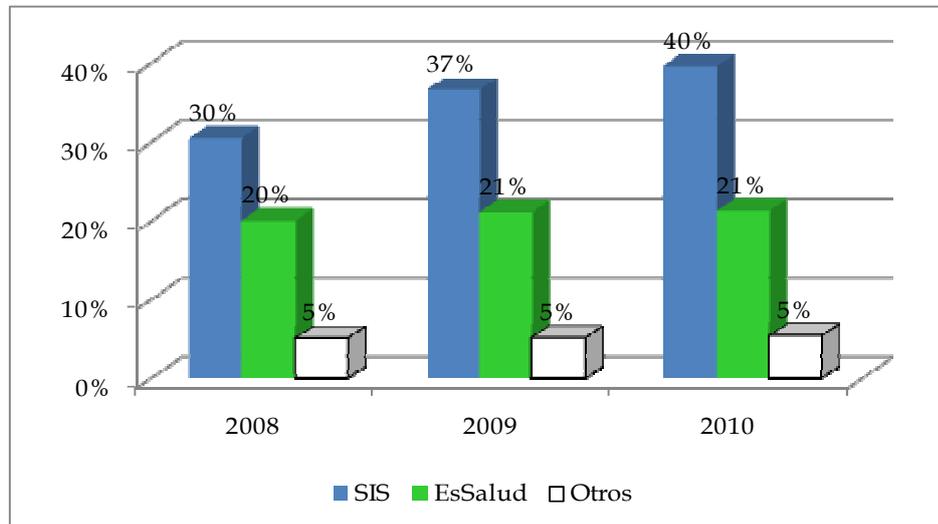
<sup>14</sup> Report as of April 2011, taken from the SUNASA.

<sup>15</sup> Report as of 2010's third trimester, taken from the SUNASA.

<sup>16</sup> The figures presented in this chart also differ from those presented in Chart No. 1 for the same reason explained. In this case, the sum of the percentages of Chart No. 3 is greater than figures from Chart No. 1.

Chart No. 3

Insurance coverage evolution according to type of insurance, 2008 – 2010



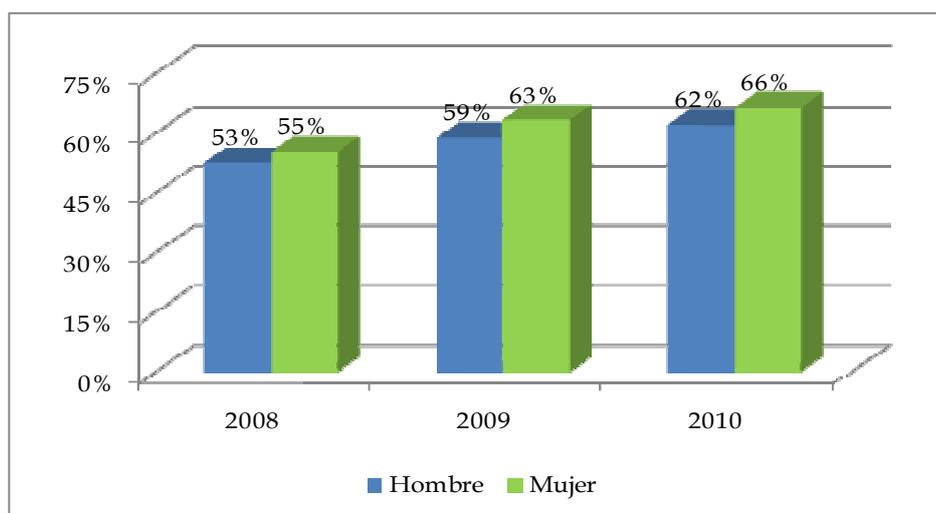
Source: ENAHO

### 3.1 Characteristics and evolution of the insurance

This sub-section tries to characterize the insurance and its increase according to some individual characteristics of people insured. For example, women have a greater coverage. Moreover, the increase in coverage during the last 2 years has been greater in this population group: 11 percentage points among women, while only 9 percentage points among men.

Chart No. 4

Insurance coverage evolution according to gender, 2008 – 2010



Source: ENAHO

As for age groups, the greater percentage of people insured is among the youngsters; 50% of the insured population is under 25. This could be explained by the SIS formation over the basis of public insurances prioritizing this population, greatly influencing the services plan established: LPIS. However, the percentage of this population that has health insurance is the one that has increased the less, or even decreased. For example, among children aged 2, 3 and 4 years the percentage of insured ones went from 78.8% in 2008 to 78.6% in 2010; while the percentage of people insured among those of 40 and 44 years-old went from 44.5% to 61.8% during the same period. Table No. 1 shows these results.

Table No. 1

Insurance coverage evolution according to age group, 2008 – 2010

Age group	2008	2009	2010
0 year-olds	76.9%	73.8%	73.6%
1 year-olds	80.9%	79.4%	79.1%
2 - 4 year-olds	78.8%	81.4%	78.6%
5 - 9 year-olds	75.2%	77.7%	78.6%
10 - 14 year-olds	70.9%	74.5%	74.9%
15 - 19 year-olds	50.5%	56.9%	60.3%
20 - 24 year-olds	34.5%	42.6%	47.0%
25 - 29 year-olds	37.8%	48.3%	53.6%
30 - 34 year-olds	43.9%	54.9%	59.1%
35 - 39 year-olds	46.3%	56.1%	61.2%
40 - 44 year-olds	44.5%	56.2%	61.8%
45 - 49 year-olds	45.2%	55.3%	59.6%
50 - 54 year-olds	45.8%	55.1%	59.3%
55 - 59 year-olds	48.7%	56.1%	59.5%
60 - 64 year-olds	48.8%	59.5%	63.4%
65 - 69 year-olds	53.4%	60.6%	67.2%
70 - 74 year-olds	53.9%	65.4%	70.1%
75 year-olds and over	55.6%	65.0%	69.2%
<b>Total</b>	<b>54.0%</b>	<b>61.1%</b>	<b>64.3%</b>

Source: ENAHO

The results of the increase in insurance coverage vary among departments. The greatest increase in these two years has been in Ancash, Apurímac, Cajamarca, Huancavelica, Loreto, Pasco and San Martín; above 15 percentage points. This increase makes Apurímac and Huancavelica the departments with the greatest insurance coverage in the country. The case of Puno is interesting, as there has only been an increase of 2 percentage points between 2008 and 2010. Tacna and Tumbes also show a small increase in comparison with the other departments' average.

Table No. 2

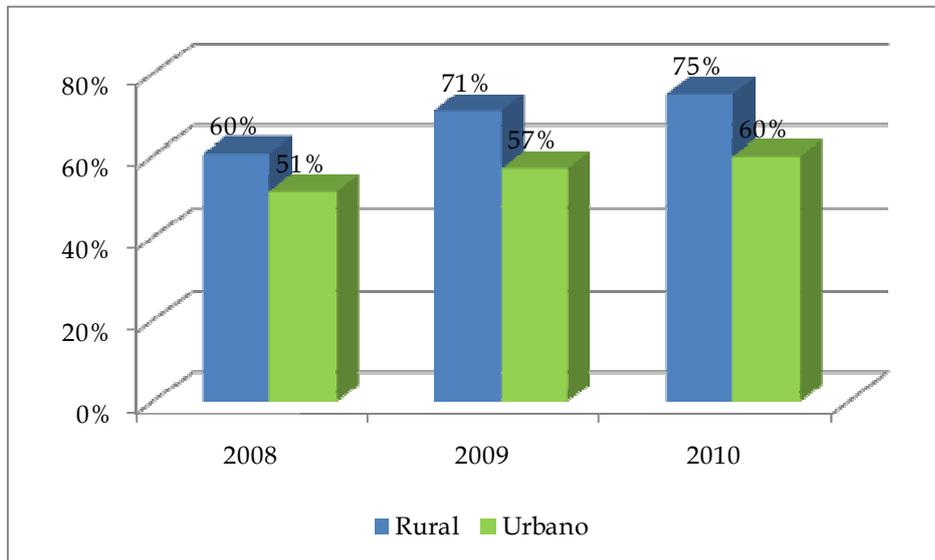
Insurance coverage evolution according to department, 2008 – 2010

	2008	2009	2010
Amazonas	56.2%	64.0%	70.4%
Ancash	45.3%	56.8%	65.4%
Apurimac	72.1%	83.8%	89.9%
Arequipa	52.8%	57.5%	62.2%
Ayacucho	75.1%	83.5%	86.6%
Cajamarca	58.6%	69.9%	75.9%
Callao	54.1%	61.1%	64.1%
Cusco	58.8%	66.2%	70.1%
Huancavelica	64.9%	84.1%	89.0%
Huánuco	71.1%	79.0%	82.9%
Ica	49.7%	56.5%	59.8%
Junín	43.8%	46.4%	53.1%
La Libertad	57.5%	67.0%	67.8%
Lambayeque	59.6%	67.3%	66.6%
Lima	48.2%	52.4%	53.6%
Loreto	66.0%	76.3%	83.5%
Madre de Dios	44.4%	50.1%	52.5%
Moquegua	53.3%	61.4%	66.4%
Pasco	45.9%	55.9%	60.9%
Piura	51.2%	63.2%	66.7%
Puno	54.3%	58.4%	56.0%
San Martín	59.2%	67.7%	75.4%
Tacna	46.7%	47.6%	52.7%
Tumbes	59.1%	65.2%	65.2%
Ucayali	58.0%	65.4%	68.6%
<b>Total</b>	<b>54.0%</b>	<b>61.1%</b>	<b>64.3%</b>

Source: ENAHO

An important finding is that the rural population with insurance is greater than that in urban areas, 75% and 60% in 2010, respectively. Just as important is that the increase in insurance horizontal coverage has favored rural areas more than urban ones. The percentage of people insured went from 60% to 75% between 2008 and 2010 in rural areas, whereas in urban areas went from 51% to 60% in the same period.

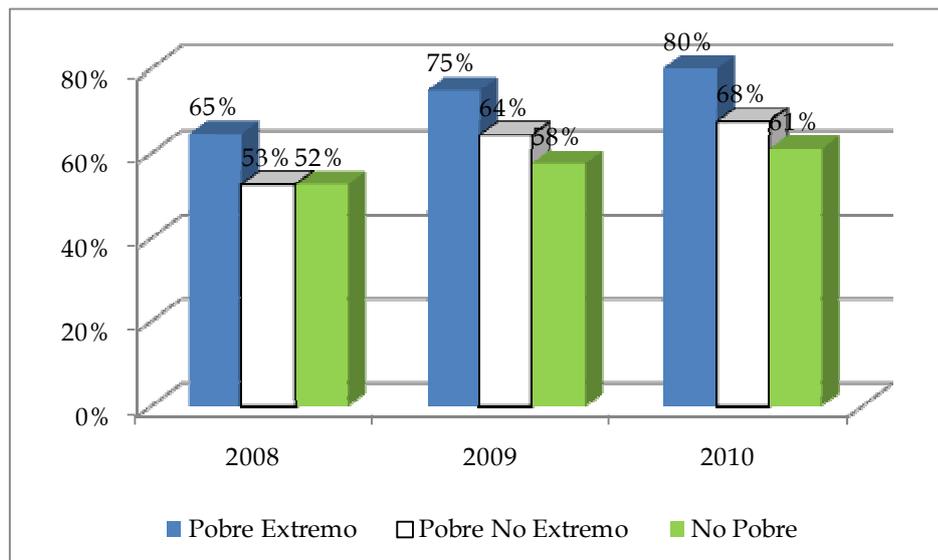
Chart No. 5  
Insurance coverage evolution according to area of residence, 2008 – 2010



Source: ENAHO

Chart No. 6 shows that there's a consistent result when analyzing the horizontal coverage and its evolution in the last 2 years according to poverty level. The increase of people insured is greater among the poor population than among the non-poor population; 15 percentage points compared to 9 among the non-poor population.

Chart No. 6  
Insurance coverage evolution according to poverty level, 2008 – 2010



Source: ENAHO

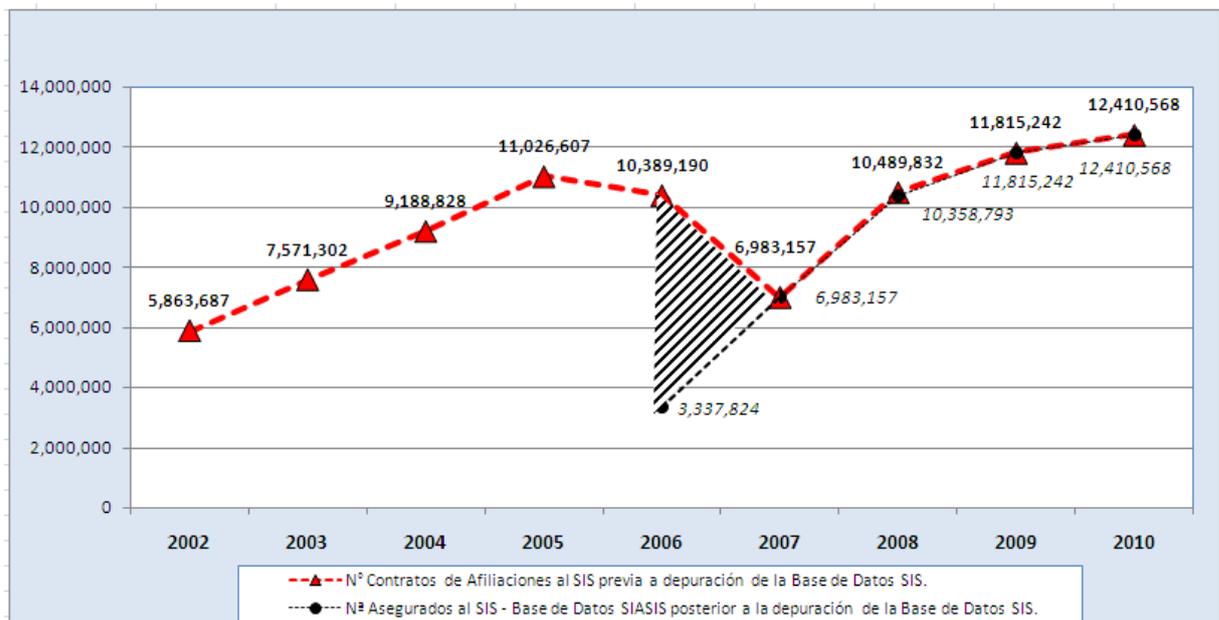
### 3.2 The engine of expansion in insurance coverage: the SIS

As mentioned before, the great increase in insurance coverage in the last years has been achieved thanks to the SIS's affiliation advances. Between 2008 and 2010, the percentage of the population insured by the SIS went from 31% to 40%. This way, when analyzing the advances in the insurance coverage, it is impossible to omit a detailed analysis about the changes registered in the insurance by the SIS.

From 2002, the SIS began a path of progressive increase in affiliations that has intensified in the last years. The official statistics are difficult to analyze, due to the methodological changes existing in the count of affiliates/members to/of the SIS. Previously, the number of affiliation contracts was counted, even though someone insured could register more than one contract. Consequently, there was no correspondence between the number of contracts and the number of people insured. In 2006, the methodology changes and there is a breach in the statistics shown on Chart No. 7. Furthermore, from the publication of the Framework Law, the approval of the PEAS and the Law Regulations, a new process of re-affiliation began improving the quality of the official information by the SIS, even though this process is currently limited to priority areas.

Chart No. 7

People insured by the SIS according to the year, 2002 – 2010



Source: SIS's Database

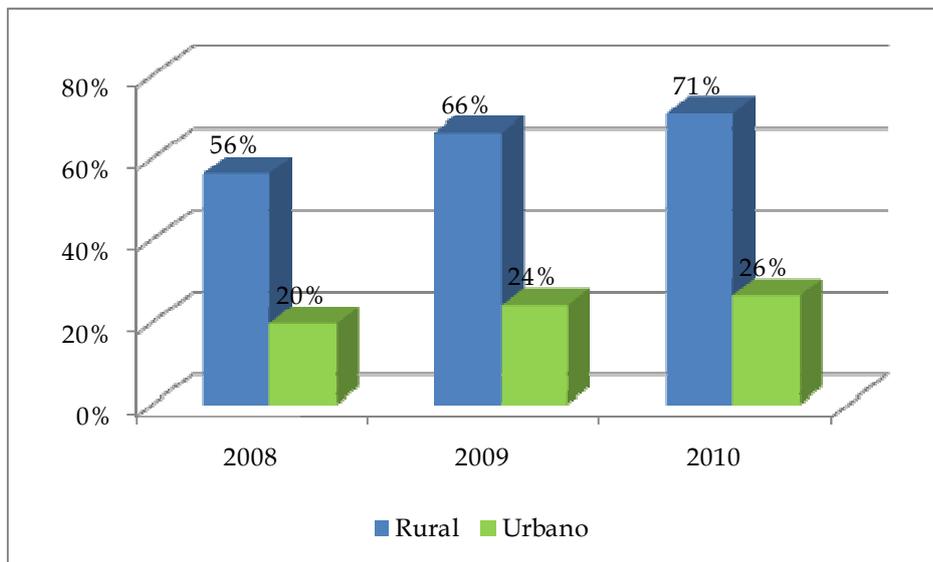
The results of the people insured in terms of gender, department and age group are similar to those found and discussed for all people insured: women have a greater insurance coverage and a greater increase in the last years (10 percentage points in that case of women and 8 in the case of men); the departments where the SIS has a greater coverage are Apurímac (81% of the population) and Huancavelica (79%), and, next to Ancash,

Cajamarca, Loreto and San Martín, those are the departments with greater increase since the enactment of the Framework Law on Universal Health Insurance, above 15 percentage points in 2 years; those under 20 years old have a greater coverage, above 40% of the population, but they had the smallest increase and even decrease in these 2 years. This similarity occurs because the SIS has become the main tool to achieve the AUS; since the approval of the Framework Law on Universal Health Insurance, the SIS has generated the country's changes in insurance.

In the case of the affiliation to the SIS according to area of residence, it is shown that the SIS provides greater coverage to the rural population; in 2010, 71% of the rural population was insured by the SIS, whereas only 26% of the urban population had that coverage. Likewise, the horizontal coverage has increased more among the rural residents; 15 percentage points compared to 6 in urban areas.

Chart No. 8

SIS's coverage evolution according to area of residence, 2008 – 2010



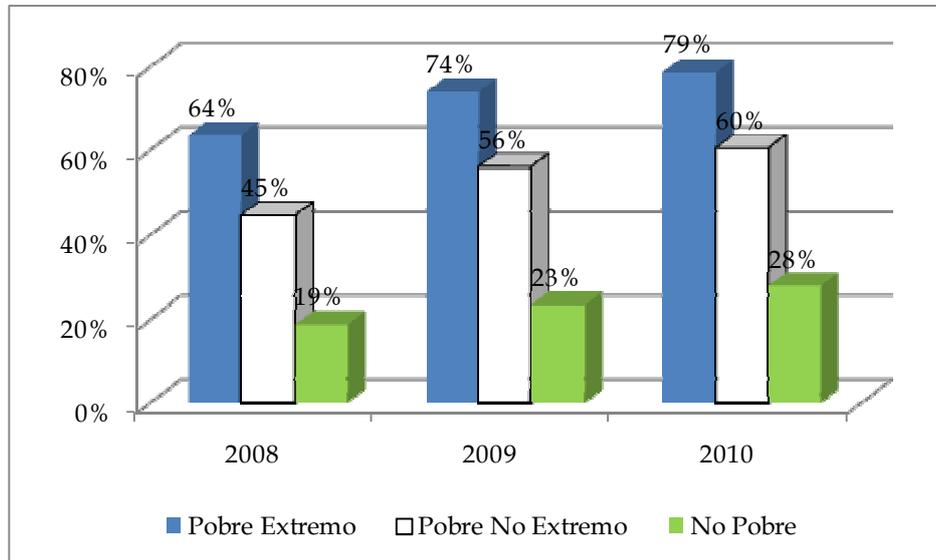
Source: ENAHO

A similar situation is found regarding the poverty level: the poor population has a greater coverage and a greater increase between 2008 and 2010. Chart No. 9 shows that almost 80% of the population in extreme poverty is insured by the SIS, whereas only 28% of the non-poor population has the same health insurance. It is worth noting that this figure does not necessarily show filtrations by the SIS, as the source of information does not give the

nature of the contributory scheme<sup>17</sup> and the poverty level measured in this survey is different than that use by SIS, as well as other social programs, to determine a family's eligibility<sup>18</sup>.

Chart No. 9

SIS's coverage evolution according to the poverty level, 2008 – 2010



Source: ENAHO

Precisely, the increase in insurance by the SIS has not only been through its subsidized regime, but also through the semi-contributory. Although there are still some difficulties when encouraging the population to voluntarily contribute to get health insurance, the SIS have reached about 50 thousand people affiliated to the semi-contributory regime. According to official figures from the SIS, in general, the population insured by the SIS is related to the number of inhabitants in each department. Lima is the exception, because it represents about 30% of the population but it only represents 13% of the people insured by the SIS. However, in the case of the semi-contributory regime, Lima is the region with the most potential.

<sup>17</sup> The SIS has two insurance schemes: the subsidized, for poor and vulnerable population, and the semi-contributory, for non-poor population with moderate paying capacity.

<sup>18</sup> The poverty line is based on household spending, which is a short-term poverty measurement, whereas the system used by the SIS, the SISFOH, bases its results in the household characteristics, mainly its assets, making it a long-term poverty measurement.

Table No. 3

Number of people insured by the SIS according to regime and region

Region	Regime		Total
	Subsidized	Semi-contributory	
Amazonas	354 619	1 030	355 649
Ancash	581 015	655	581 670
Apurímac	315 608	305	315 913
Arequipa	336 170	5 147	341 317
Ayacucho	488 249	113	488 362
Cajamarca	1 033 618	352	1 033 970
Callao	216 202	3 045	219 247
Cusco	768 999	584	769 583
Huancavelica	329 744	64	329 808
Huánuco	712 871	1,72	713 943
Ica	170 379	506	170 885
Junín	460 222	344	460 566
La Libertad	869 734	1 526	871 260
Lambayeque	545 774	491	546 265
Lima	1 606 634	25 597	1 632 231
Loreto	878 570	460	879 030
Madre de Dios	48 572	201	48 773
Moquegua	40 067	305	40 372
Pasco	124 009	1 210	125 219
Piura	984 493	1 162	985 655
Puno	593 727	466	594 193
San Martín	568 409	1 748	570 157
Tacna	77 872	502	78 374
Tumbes	102 306	1 072	103 378
Ucayali	298 307	261	298 568
<b>Total</b>	<b>12 506 170</b>	<b>48 218</b>	<b>12 554 388</b>

Source: SIS's Database

According to the AUS Framework Law, the SIS shall operate as an IAFA in charge of the subsidized regime and of the semi-contributory regime. This adjustment process has begun, but to fulfill the Law provisions and to offer both regimes the SIS shall improve its efficiency and avoid filtrations, because they don't only mean an inadequate use of the public subsidy but also a lower profit for the institution itself. Therefore, the SIS shall find a better balance between both regimes and have the support of the National Registry for Identification and Vital Statistics (RENIEC) and the Household Targeting System (SISFOH) in order to speed the process of re-affiliation.

### 3.3 Priority areas for implementing the universal insurance<sup>19</sup>

As part of AUS's gradual implementation, it was established that the insurance process would begin in 7 pilot areas suggested by the MOH: Apurímac, Ayacucho, Huancavelica; Salas district in Lambayeque; Sánchez Carrión province in La Libertad; five districts in Bajo Piura; and six districts in Bajo Huallaga, San Martín. The definition of these pilot areas was mainly based on the criteria of social exclusion, poverty and unmet demand of health services. These areas are considered the AUS 1 area.

Subsequently, the incorporation of the Junín and Cusco districts making up the Valle de los Ríos Apurímac y Ene (VRAE)<sup>20</sup>, Callao, at the request of the regional government itself<sup>21</sup>, and the Condorcanqui and Bagua provinces in Amazonas is planned. These areas are considered the AUS 2 area.

This year, the national Government ordered the incorporation of the *Datem del Marañón* province in Loreto and the incorporation of Lima Metropolitana. These are considered the AUS 3 area.

The greatest insurance efforts and results are in this priority area of implementation. Likewise, it is in these areas where the Regional Implementation Technical Committees (CTIR) were installed.

To the naked eye, the insurance and its increase in the priority areas have been less than in the rest of the country: in 2008, 53% of the population in these areas was insured, whereas 55% of the rest of the country also was; these percentages increased by 8 and 12 percentage points, respectively. However, when separating the Datem in Loreto and Lima Metropolitana (AUS 3 area), because these were the last areas to be incorporated into the priority area, the opposite happens. As seen in Chart No. 10, in the AUS 1 and 2 areas, the insurance reaches 79% in 2010, with a 15-percentage-points increase since 2008; whereas in the rest of the country 66% of the population has health insurance, increasing by 12 percentage points during the same period. However, the fact that in the priority areas the increase was no much more than in the rest of the country is a sign of this increase in the horizontal coverage is due more to a national policy of the social programs' expansion than to a universal insurance policy.

It is worth noting that all the AUS priority areas have a high insurance coverage. The only areas that don't reach 80% of the population covered with health insurance are the districts of Bajo Piura, the districts of the VRAE in Cusco, el Callao, Lima Metropolitana and the provinces of Amazonas.

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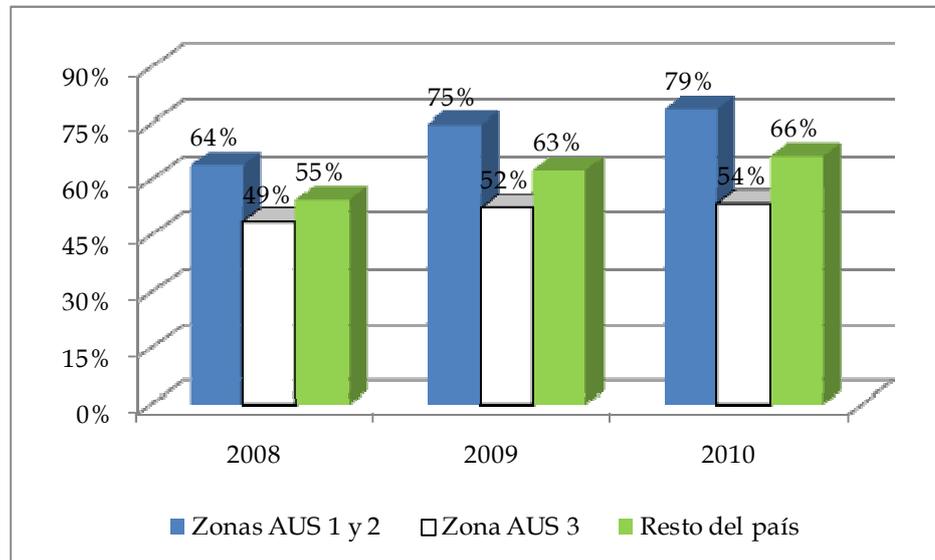
<sup>19</sup> The figures obtained from the ENAHO (National Households Survey) for the AUS areas have a representativeness level different from that reported by departments. This is because some of the pilot areas are provinces or districts that don't have an "acceptable" representativeness level according to the survey's design. By combining the results from all areas of AUS implementation, this problem is mitigated, but the average is lower for the whole than for the department level.

<sup>20</sup> Supreme Decree No. 021-PCM-2009.

<sup>21</sup> At the request of the Regional Government of El Callao, Pachacútec Citadel's admission to the AUS was made official on January 8, 2010.

Chart No. 10

Insurance coverage evolution according to geographic priority, 2008 – 2010

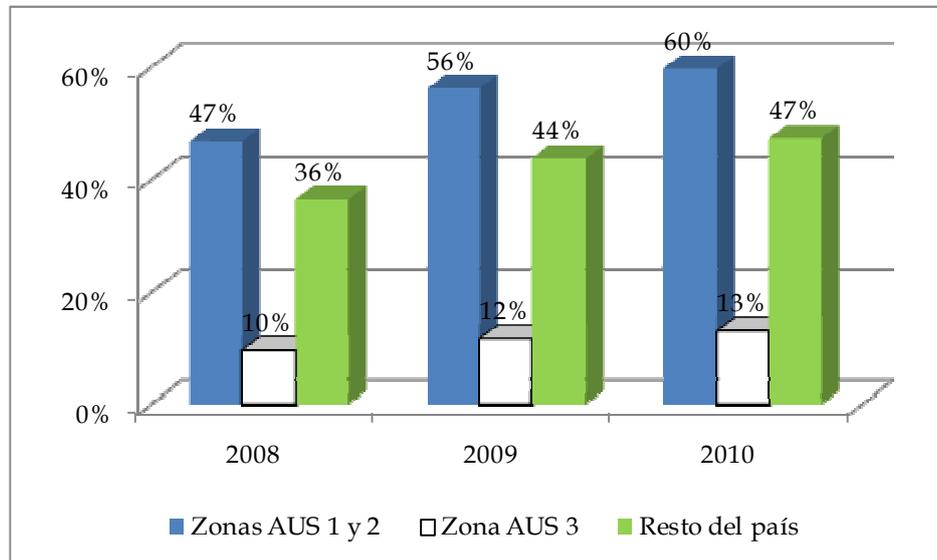


Source: ENAHO

As in the whole country, the SIS has been the engine of growth for health insurance coverage in these priority areas. In the 1 and 2 areas, the population affiliated to the SIS increased in 13 percentage points reaching 60% in 2010. In comparison, the non-priority areas, where 47% is covered by the SIS, had an increase of 11 percentage points. Finally, the population insured by the SIS in the AUS 3 area, that includes Datem del Marañón and Lima Metropolitana, went from 10% to 13% during the same period. This is because the SIS's coverage in Lima Metropolitana is relatively low; in 2010 only 12% of the population living in the capital has health insurance covered by the SIS.

Chart No. 11

SIS's coverage evolution according to geographic priority, 2008 – 2010



Source: ENAHO

### 3.4 Extension of the EsSalud coverage

EsSalud covers a little more than 8.6 million people insured by the end of 2010. In the case of EsSalud, the changes in the insurance coverage do not depend on the institution itself, but on the economy's structure aspects that are very difficult to change. That way, it is thought that this increase is due to the evolution of the formal employment mainly in Lima Metropolitana and in other major cities in the country.

EsSalud's regimes and types of affiliation are: the popular regime, the agrarian regime and the optional regime, according to the Law and AUS regulations, all types of insurance must include the Plan Esencial de Aseguramiento en Salud – PEAS (Health Insurance Essential Plan) as minimum. It is not easy for EsSalud to adapt their existing benefit plans to the PEAS; this plan rather provides an important mechanism for the development of new insurances attracting freelancers or Small and Medium Business (PYMES)' workers.

Table No. 4 shows the number of people insured by EsSalud according to gender and age group. It also shows a high concentration of the population insured in the youngest age groups, although in a low ratio than in the SIS.

Table No. 4

Number of people insured by EsSalud according to gender and age group, 2010

Grupo etario	Femenino	%	Masculino	%	Total	%
00-04	373,803	8.9	388,156	8.8	761,959	8.8
05-09	315,523	7.5	328,606	7.4	644,129	7.5
10-14	253,667	6.0	262,872	5.9	516,539	6.0
15-19	272,999	6.5	295,694	6.7	568,693	6.6
20-24	251,787	6.0	315,780	7.1	567,567	6.6
25-29	382,786	9.1	433,004	9.8	815,790	9.5
30-34	401,843	9.5	442,863	10.0	844,706	9.8
35-39	365,816	8.7	392,350	8.9	758,166	8.8
40-44	313,306	7.4	327,055	7.4	640,361	7.4
45-49	264,511	6.3	267,097	6.0	531,608	6.2
50-54	225,104	5.3	221,378	5.0	446,482	5.2
55-59	191,947	4.6	182,302	4.1	374,249	4.3
60-64	161,915	3.8	151,273	3.4	313,188	3.6
65-69	129,553	3.1	125,006	2.8	254,559	3.0
70-74	108,370	2.6	103,978	2.4	212,348	2.5
75-79	87,081	2.1	81,722	1.8	168,803	2.0
80 a más	108,779	2.6	100,629	2.3	209,408	2.4
<b>Total</b>	<b>4,208,790</b>	<b>48.8</b>	<b>4,419,765</b>	<b>51.2</b>	<b>8,628,555</b>	<b>100</b>

Source: Statistical Bulletin – SUNASA

Because the EsSalud insurance depends on the level of formality in the employment market, the people insured is concentrated in the departments with higher comparative advantages, especially in Lima Metropolitana; in Lima and Callao, there is 47% of the people insured by EsSalud.

Table No. 5

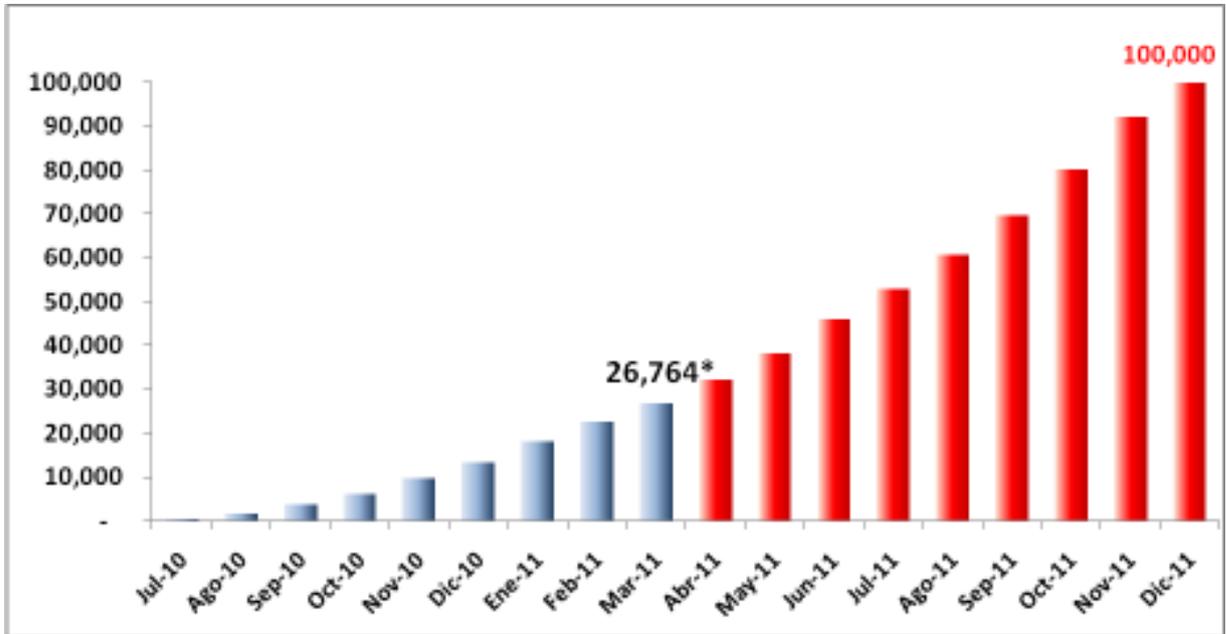
Number of people insured by EsSalud according to region and type of insurance, 2010

Red Asistencial	Asegurados	Porcentaje
Amazonas	56,233	0.7%
Ancash	267,863	3.1%
Apurímac	63,626	0.7%
Arequipa	498,101	5.8%
Ayacucho	118,658	1.4%
Callao - Sabogal	1,313,504	15.2%
Cajamarca	131,505	1.5%
Cusco	251,357	2.9%
Huancavelica	71,594	0.8%
Huánuco	130,535	1.5%
Ica	340,222	3.9%
Junín	292,837	3.4%
La Libertad	488,187	5.7%
Lambayeque	443,285	5.1%
Lima - Almenara	1,224,962	14.2%
Lima - Rebagliati	1,530,008	17.7%
Loreto	155,677	1.8%
Madre de Dios	26,623	0.3%
Moquegua	85,767	1.0%
Pasco	87,711	1.0%
Piura	434,464	5.0%
Puno - Juliaca	113,500	1.3%
Puno - Puno	94,656	1.1%
San Martín - Moyobamba	34,055	0.4%
San Martín - Tarapoto	93,416	1.1%
Tacna	129,684	1.5%
Tumbes	53,721	0.6%
Ucayali	95,611	1.1%
Extranjeros	1,193	0.0%
<b>Perú</b>	<b>8,628,555</b>	<b>100.0%</b>

Source: Statistical Bulletin – SUNASA

As a consequence of the Framework Law, EsSalud has developed a new insurance plan called EsSalud Independiente. Unlike other EsSalud plans, this plan has limited its attention to the 140 conditions established in the PEAS and some additional conditions. There are three modalities of access to this insurance plan: individual, family or group. In March this year, almost 27 thousand people were affiliated to this insurance and it is projected that by the end of 2011, there will about 100 thousand people covered by this insurance. As expected, the market with the greatest development potential for this insurance is Lima Metropolitana.

Chart No. 12  
Affiliation to EsSalud Independiente



Source: SAS Report

## 4. Strengthening the Health Services' Supply to Grant the Health Insurance Essential Plan

The MOH has determined that the insurable conditions in the first implementation stage of AUS are 140. These conditions represent 65% of the burden of disease in the country. These 140 conditions represent a minimum level of coverage that any health insurance must offer. From these conditions, PEAS has been defined and all IAFAS are obliged to offer this plan as a minimum; they may add conditions or supplementary plans, but not to exclude those set forth by PEAS.

Currently, EsSalud benefit plans, and those of EPS<sup>22</sup>, cover health services relating to these 140 conditions. On the other hand, before the promulgation of the AUS framework law, the benefit plan was governed by the Priority List of Health Interventions (LPIS), which it included preventive, recovery and rehabilitation interventions, but also considered certain specific exclusions. On PEAS's effective date, this list has been replaced by it. The transition between LPIS and PEAS is being carried out gradually for new affiliates and re-affiliates to SIS, following the registration procedure and the SISFOH classification to determine if the insured party is entitled to the subsidized or partial regime. However, SIS has not updated its payment rate to providers according to PEAS and keeps the previous rate which belongs to LPIS.

The new benefit plans that SIS, EsSalud, EPS and the private insurers put in the market to attract new members, mostly self-employed people with solvency, should include the PEAS as minimum benefit plan. The challenge for them is to offer some additional conditions that make the plan attractive, but not to significantly increase the premium, given the fact that there is competition between these IAFAS for certain market segments.

However, the greatest difficulty at hand is the lack of supply in the health service networks in many parts of the country. Currently, many of these networks do not have the response capacity to offer many services contained in PEAS. In this way, insured parties cannot be guaranteed a minimum treatment to the insured for these 140 health conditions.

For example, in many provinces of the country, the public health network does not have the infrastructure capacity, equipment or human resources, to ensure delivery of PEAS. Currently, PEAS's 140 conditions may only be delivered in the province of Lima, Callao and in a few of the most important cities of the country. The rest of the national territory registers deficit in infrastructure, equipment, health staff, among other relevant aspects.

In the case of the health provider EsSalud, there is emphasis on the curative, recovery and rehabilitation aspects; then its biggest challenge lies in the field of promotion and preventive health care.

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<sup>22</sup> The EPS requested a 6-month period for adjustments of their benefit plans to the PEAS in November 2010. b<sup>o</sup>+f67855

As EPS mainly use private health services, they have it hard to ensure the supply of services set out in their benefit plan. Given this, there is the alternative of purchasing services from other providers, like the public sub-sector that works with SIS. But this also faces some difficulties: the public network also has low levels of response capacity in some areas of the country, low levels of health networks organizations and it is not clear who is the contractual counterpart.

Given this great difficulty, it is necessary to conduct a complete census inventory that records and determines the situation and operations of all health facilities in the country to determine this deficit. Based on this diagnosis, the necessary investments should be planned in every area, so that PEAS may be offered within the geographical scope to ensure timely access to health services.

The country, in the years to come, will require investing in new health infrastructure, in re-equipment and spending more on maintenance. This investment must be made on the basis of this census information and it should aim at ensuring the coverage of PEAS and the 140 conditions it sets forth. For the matter, it is important to establish investment priorities and schedule it in the medium term, for the next 10 years. In the case of public health network, the implementation of this investment requires close coordination between the Ministry of Health and regional and local governments.

#### **4.1 Investment in infrastructure**

In recent years, the State has made great effort in the construction of new infrastructure, equipment and recruitment of health staff, in particular to improve the primary care level.

##### **4.1.1 Investment in health facilities infrastructure, equipment and maintenance**

It is estimated that around S/ 3 billion are needed to close the infrastructure gap and equipment in health; S/ 2.4 billion, in the construction of new facilities and S/ 593 million are needed for the rehabilitation of existing facilities<sup>23</sup>. This estimate is based on an approximation of the demand for health services in the country. It notes that despite concentrating the highest proportion of population in the country, Lima does not concentrate the greatest need for investment. This is due to the fact that the region has the largest health infrastructure and equipment in the country at more complex levels: hospitals and national institutes of health. Departments that require greater investment in new health care facilities are Cajamarca, Junín, Piura, Puno and San Martín. In this way, it is demonstrated one of the most important challenges of universal insurance: the availability of health services supply to ensure the care of the insured parties.

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<sup>23</sup> CIUP (2010). *Balance de la inversión pública: avances y desafíos para consolidar la competitividad y el bienestar de la población*. MEF – BM. Page 102.

Table No. 6  
Required investment

Department	Construction	Rehabilitation	Total
Amazonas	128,595,388	29,764,692	158,360,080
Ancash	134,485,863	27,871,563	162,357,426
Apurímac	99,484,978	25,229,164	124,714,142
Arequipa	70,340,901	24,649,247	94,990,148
Ayacucho	100,177,299	23,337,961	123,515,260
Cajamarca	224,230,678	51,572,603	275,803,281
Cusco	129,656,905	28,530,973	158,187,878
Huancavelica	77,150,357	24,506,279	101,656,636
Huánuco	99,140,644	21,019,618	120,160,262
Ica	34,262,897	14,041,010	48,303,907
Junín	166,560,316	30,401,244	196,961,560
La Libertad	68,415,635	20,878,212	89,293,847
Lambayeque	60,496,888	17,698,955	78,195,843
Lima	154,655,299	72,909,382	227,564,681
Loreto	85,286,244	25,778,746	111,064,990
Madre de Dios	28,725,451	8,071,189	36,796,640
Moquegua	14,971,768	5,731,314	20,703,082
Pasco	61,519,522	16,285,879	77,805,401
Piura	160,371,688	33,890,291	194,261,979
Puno	239,957,386	41,356,845	281,314,231
San Martín	163,465,825	26,145,473	189,611,298
Tacna	14,826,169	6,075,021	20,901,190
Tumbes	15,847,646	4,647,665	20,495,311
Ucayali	56,534,895	12,681,161	69,216,056
<b>Total</b>	<b>2,389,160,642</b>	<b>593,074,487</b>	<b>2,982,235,129</b>

Source: MEF

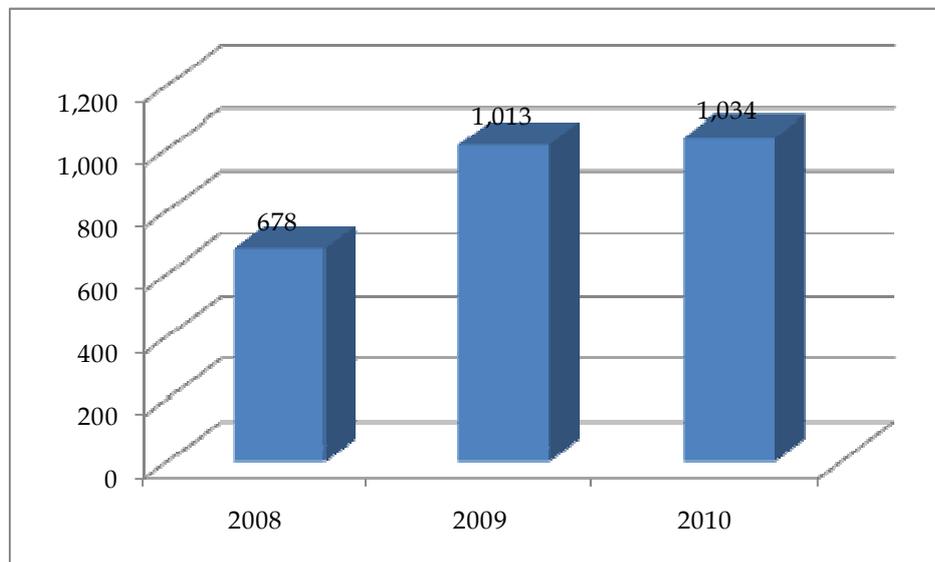
### The public sub-sector

This gap has been closing continuously in recent years. Investment in health, especially in infrastructure and equipment, has grown significantly in recent years. In this way, the investment of public health, including all levels of government, was S/ 678 million in 2008, it increased in approximately S/ 336 million in a year and S/ 21 million the following year<sup>24</sup>.

<sup>24</sup> These figures consider all sources of budget financing, including directly collected resources. When excluding the latter, the figures are reduced to S/ 668, S/ 966 and S/ 981 million in 2008, 2009 and 2010, respectively

Figure No. 13

Health Investment carried out by the public sector, 2008 – 2010



Source: MEF, Friendly query

A significant portion of this investment, more than 60%, has focused on the priority AUS areas, also where the biggest increase of investment occurred. In particular, a number of emergency decrees have been approved for the purpose of allocating resources in these areas to facilitate the improvement of the supply of services. It should be mentioned that the investment in the Department of Lima has increased significantly; in 2008 it was approximately S/ 68 million, and increased S/ 166 million and S/88 million in 2009 and 2010, respectively; whereas 2010 registered a lower investment than in 2008 in Amazonas (S/ 6 million), Apurímac (S/ 7.6 million), Cusco (S/ 10.4 million), Junín (S/ 5.4 million), La Libertad (S/ 12.8 million), Lambayeque (S/ 20.5 million), Loreto (S/ 2.7 million) and Piura (S/ 7.4 million).

Table No. 7

Health Investment carried out by the public sector per department, 2008-2010

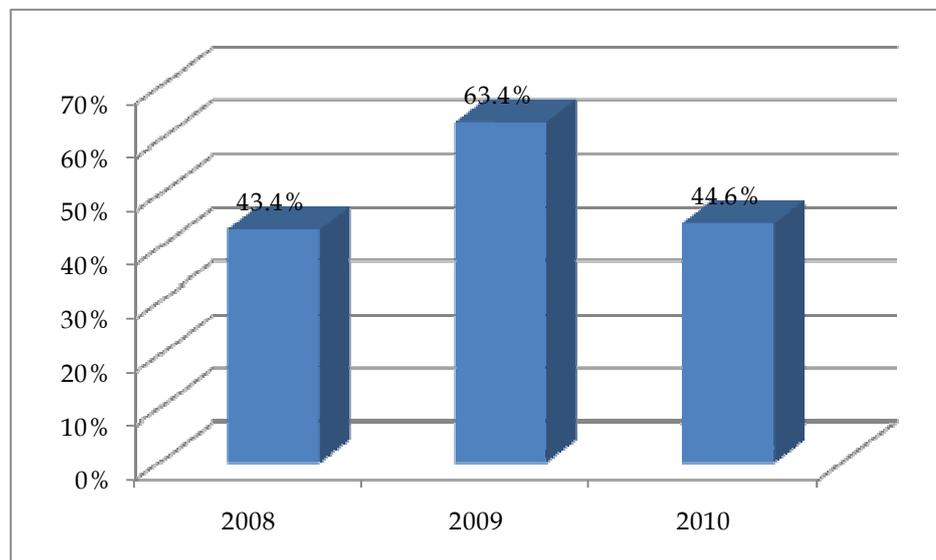
Department	2008	2009	2010
Amazonas	17,681,451	18,825,919	11,662,675
Apurímac	29,026,264	19,891,533	21,458,107
Ayacucho	13,947,087	30,981,035	63,214,160
Callao	17,844,398	50,760,463	21,508,837
Cusco	66,536,400	63,372,681	56,099,697
Huancavelica	31,601,948	33,969,830	38,518,220
Huánuco	11,472,336	19,885,866	24,761,377
Junín	24,003,644	17,252,970	18,586,496
La Libertad	44,573,362	30,303,677	31,806,428
Lambayeque	36,430,872	56,314,353	15,936,093
Lima	67,757,664	233,429,199	321,024,690
Loreto	17,161,653	24,307,208	14,506,898
Piura	19,586,230	26,705,167	12,142,224
San Martín	5,829,203	13,670,525	11,635,385
AUS Priority Zones	403,452,512	639,670,426	662,861,287
Ancash	52,808,747	62,407,218	34,153,359
Arequipa	35,773,564	33,097,370	29,266,505
Cajamarca	25,751,836	72,911,224	78,772,806
Ica	45,486,570	85,874,784	74,245,528
Madre de Dios	7,869,109	3,614,315	3,011,788
Moquegua	17,172,657	33,706,639	17,010,479
Pasco	17,102,387	24,344,976	16,388,724
Puno	26,213,191	25,766,901	35,285,225
Tacna	33,137,249	20,476,284	24,867,745
Tumbes	6,488,191	1,956,015	41,773,667
Ucayali	6,346,381	9,302,278	16,173,200
Rest of the country	274,149,882	373,458,004	370,949,026
<b>Total</b>	<b>677,602,394</b>	<b>1,013,128,430</b>	<b>1,033,810,313</b>

Source: MEF, Friendly query

An indicator of performance of special interest to evaluate investments is the percentage of implementation with regards to the amounts approved<sup>25</sup>. In this sense, we can see that greatest spending capacity was presented in 2009, when they managed to run 63% of the total number of approved resources; whereas for years 2008 and 2010, this figure was found around 44%.

<sup>25</sup> In this case, it regards the modified institutional budget, as it includes the budget extensions carried out during the year, and the approved emergency decrees.

Figure No. 14  
Implementation capacity of the health investment, 2008-2010



Source: MEF, Friendly query

The same pattern of increase in the capacity of implementation between 2008 and 2009 and a decrease the year after is observed for the whole of the priority AUS areas; although by the year 2010 the ability of investment in these areas was higher by almost 9 percentage points. Lima, Loreto are the only priority departments which had a continuous increase in its implementing capacity, to reach 66% and 77%, respectively, in 2010. The departments of Ayacucho, Callao, Huánuco, Lambayeque, Loreto and San Martín had a implementing capacity above the average of the priority areas in all the years presented.

Table No. 8  
Implementation capacity of the health investment per department, 2008-2010

	2008	2009	2010
Amazonas	62.9%	86.9%	33.2%
Apurímac	79.7%	49.2%	19.7%
Ayacucho	53.4%	69.5%	50.2%
Callao	53.9%	75.1%	71.0%
Cusco	61.1%	57.4%	45.9%
Huancavelica	68.0%	67.7%	46.4%
Huánuco	74.4%	79.3%	54.6%
Junín	47.7%	62.7%	42.4%
La Libertad	72.6%	56.7%	44.3%
Lambayeque	89.5%	93.8%	61.8%
Lima	16.6%	57.0%	65.8%

Loreto	44.7%	67.3%	76.7%
Piura	51.9%	70.2%	45.4%
San Martín	75.7%	80.3%	77.9%
AUS Zones	43.0%	63.9%	53.4%
Ancash	33.7%	54.1%	9.8%
Arequipa	55.3%	73.5%	68.2%
Cajamarca	35.7%	78.3%	57.2%
Ica	63.4%	72.1%	46.9%
Madre de Dios	39.8%	81.5%	55.8%
Moquegua	36.5%	72.8%	43.9%
Pasco	34.2%	44.2%	74.0%
Puno	70.1%	65.5%	28.6%
Tacna	46.7%	41.0%	41.7%
Tumbes	57.1%	44.1%	36.8%
Ucayali	29.3%	37.2%	59.9%
Rest of the country	44.0%	62.6%	34.4%
<b>Total</b>	<b>43.4%</b>	<b>63.4%</b>	<b>44.6%</b>

Source: MEF, Friendly query

However, despite this investment made in recent years, it is highly probable that the response capacity to provide PEAS has not reduced in the same magnitude. PEAS was approved at the end of November 2009 and considering the time of maturity of an investment project until his execution, in 2010 there are very few investments that have been carried out that deliberately had PEAS as a reference to define the project. This process will be provided with the recently approved multi-year investment planning guidelines. This document seeks to link the investments decisions with the physical requirements to provide PEAS for a period of 4 or 5 years.

### EsSalud

EsSalud has also implemented a significant investment in the improvement of its service offerings. We notice that between 2008 and the first half of 2011, it executed a total of S/ 1,7 million whose detail is presented in Table 9. We notice that the greatest amount of these investments focused on the purchase of medical equipment. For example, they invested S/ 226 million in this equipment, while S/ 148 million went to infrastructure, the second most important category of investment.

Table No. 9  
Budget executed in EsSalud investments, 2008-2011

Item	Executed budget			
	2008	2009	2010	2011 <sup>1/</sup>
Pre-investment	64,000	901,600	382,400	0
Technical file	5,970,188	2,244,777	11,243,150	1,274,999
Land / Real estate	9,334,105	1,240,000	1,543,920	0
Infrastructure	197,841,680	161,558,177	147,863,222	36,496,230
Linked equipment	4,731,133	102,360,990	48,373,009	16,558,671
Investment projects	217,941,106	268,305,544	209,405,701	54,329,900
Assistance equipment	309,939,346	241,051,746	225,882,418	60,727,015
IT equipment	44,596,934	11,139,433	42,915,139	766,352
Administrative equipment	4,075,640	2,019,712	1,550,365	487,346
Assorted capital goods	11,965,937	3,768,594	3,142,457	2,576,037
Capital expenditure not linked to projects	370,577,857	257,979,485	273,490,379	64,556,751
<b>Total</b>	<b>588,518,963</b>	<b>526,285,029</b>	<b>482,896,080</b>	<b>118,886,650</b>

1/ Amount as of June 2011

Table 10 shows detail of the geographical allocation of this investment, which presents the information of the departments that contain priority AUS areas. As it is expected, Lima concentrates the largest investment in the country; near S/ 200 million were invested in Lima by the year 2010. In contrast, Amazonas received the lowest investment in this period; S/ 788 thousand in the same year.

Table No. 10  
Budget executed in EsSalud investments per department, 2008 – 2011

	2008	2009	2010	2011 <sup>1/</sup>
Amazonas	1,793,997	1,398,442	788,019	108,225
Apurímac	4,965,857	713,187	31,620,945	468,471
Ayacucho	14,230,419	23,552,372	1,205,190	63,919
Callao	51,150,044	36,231,994	19,153,617	5,038,795
Cusco	2,110,985	2,866,777	6,311,612	0
Huancavelica	1,876,505	1,826,194	1,324,790	278,422
Junín	19,825,269	32,465,639	23,795,502	28,658,336
La Libertad	7,746,568	14,602,356	28,906,048	4,461,913

Lambayeque	21,110,288	38,157,702	17,723,812	1,382,847
Lima	364,403,919	236,612,135	197,767,644	59,196,854
Loreto	2,080,954	3,317,544	2,783,055	1,343,852
Piura	3,930,133	5,791,668	3,500,214	190,054
San Martín	3,928,057	2,041,744	2,221,909	331,226
<b>Total</b>	<b>588,518,963</b>	<b>526,285,029</b>	<b>482,896,080</b>	<b>118,886,650</b>

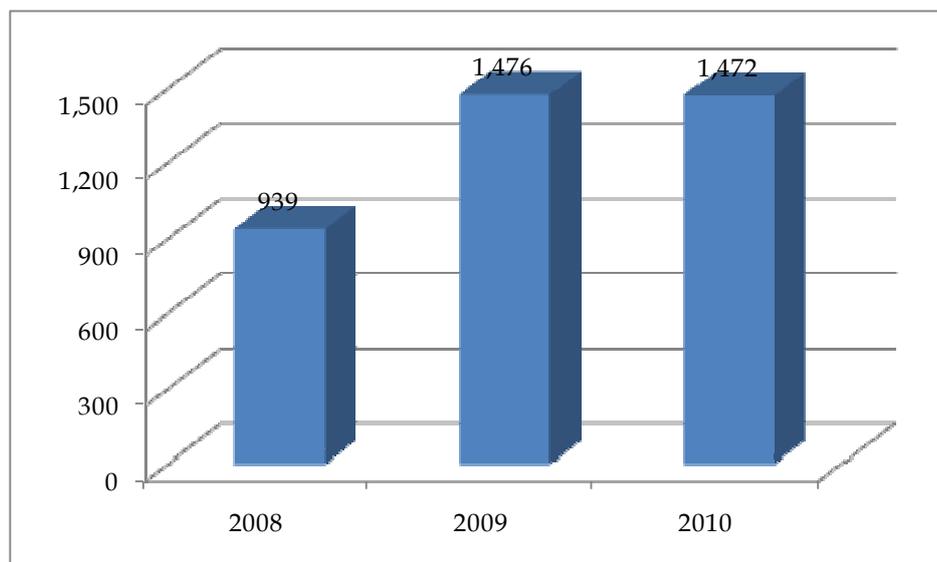
1/ As of June 2011

As in the case of the public sub-sector, it is not possible to verify whether these investments were made with the aim of closing the gaps in infrastructure and equipment to provide PEAS. However, it is highly likely that this has not happened. While the technical document of multi-year investment planning is a document primarily aimed at the public sub-sector, EsSalud could use it as a tool to help its future investments to search for ways to increase its response capacity to ensure compliance with PEAS and its guarantees.

## 4.2 Increased availability of human resources

In all subsectors there has been an increase in health personnel, particularly in the public sector. The MOH with a view to facilitating the process of the AUS has been in the past three years, increasing the supply capacity in priority AUS areas in a progressive manner. To do this, MOH has appointed professionals to Rural and Marginal Urban Health Service (SERUMS) towards these areas. Figure 15 shows a significant increase between the years 2008 and 2009.

Figure No. 15  
SERUMS supply in priority areas AUS, 2006 – 2010

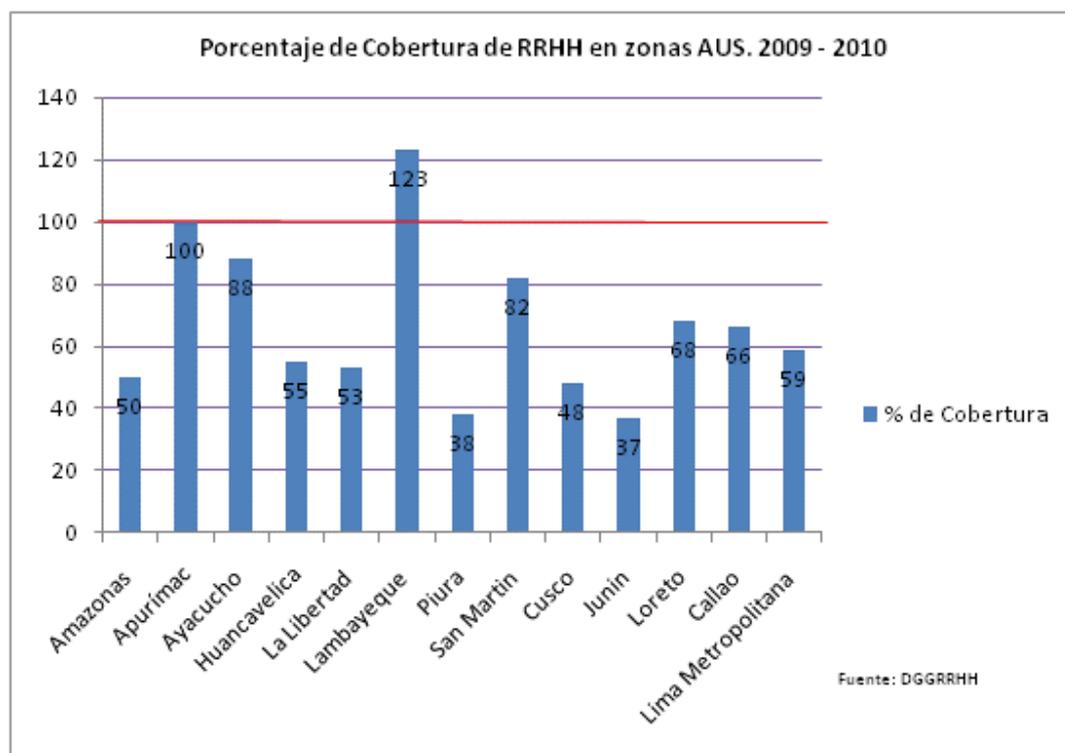


Source: DGRH – MOH

In the year 2010, a total of 1,472 SERUMS professionals were designated to these areas, especially the regions of Apurímac, Ayacucho and Huancavelica, where 1,211 professionals were appointed. Also, regular training for these professionals has been adapted and now it includes a process of awareness in the General guidelines of AUS.

Gradually, they have sought to close the human resources gap on the basis of the needs of health services of the population in priority AUS areas. Further progress was obtained with nurses and obstetricians that have been covering 70% of the identified gap. 50% has been covered in the case of doctors. With resources allocated by Supreme Decree 229-2010-EF in the framework of the implementation of AUS, the gap in human resources for health for the primary care level has declined. Out of priority AUS zones only the Lambayeque district of Salas and the Department of Apurímac have not found a gap of human resources in their health facilities. On the other hand, Bajo Piura and VRAE, Cusco and Junín districts, have a gap of 50% or higher.

Figure No. 16  
Human Resources coverage in AUS areas

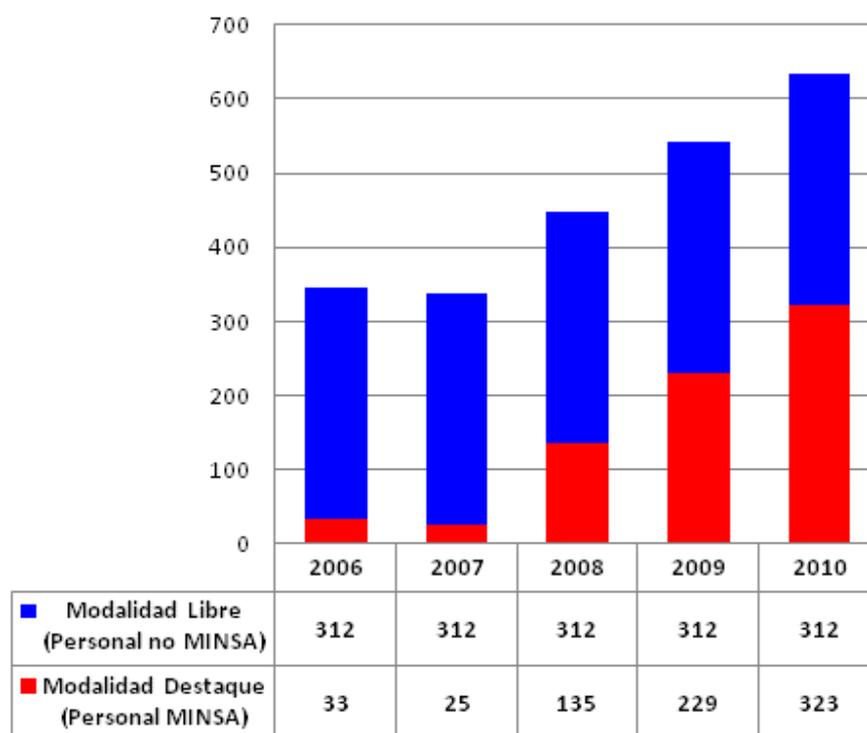


Source: DGRH – MOH

In addition, the allocation of new specialists has been addressed towards priority AUS areas. In the year 2010, the recruitment of a set of specialists<sup>26</sup>, was approved, out of which 20 were designated for hospital care in AUS priority zones<sup>27</sup>. On the other hand, as requested by MOH, the national committee on medical residence has implemented the modality of "captive vacancy". This form of income assigns a number of vacancies for each department based on criteria like maternal mortality, infant mortality, unsatisfied basic needs, in universal health insurance areas and areas other than headquarters of medical residence training. This modality has allowed increasing medical residents from 33 in 2006 to 323 in 2010.

Figure No. 17

Medical residence positions per modality. 2006- 2010



Source: DGRH – MOH

### 4.3 Improvement in the supply of medicines

In order to assess the access to critical medicines to meet insurable conditions of PEAS, the availability of medicines essential for childbirth care has been considered as a tracer indicator. Specifically, it is estimated the availability of oxytocin and sodium chloride, which should be used for all birth delivery care according to the existing technical standards.

<sup>26</sup> Supreme Decree No. 229-2010-EF.

<sup>27</sup> It is worth mentioning that the hiring of 215 specialists was authorized, but due to their deficit in the labor market, only 20 were actually hired.

This indicator is based on the relationship between stock and historical consumption, so that what is measured is the number of months for which the found stock will last. For the purposes of the estimation we have worked with the database (SISMED) the General Directorate of Medicines (DIGEMID). AUS priority areas have been selected and, within them, health centers (category I–IV) and hospitals (II-1 and II-2). For the calculation of this indicator, the stock has been considered in the month and it has been compared with the adjusted average monthly consumption of the 5 previous months.

The standard for this indicator is 3 months. In other words, if the current stock can cover 3 months of regular use, we consider that there is an adequate availability of medicines in the facility. However, bear in mind that this standard is not fixed and it can be more or less if there is or not a center for nearby supplies, among other factors.

The results presented in table 11 show that in the regions of the priority areas, there is an appropriate availability of medicines, whose stock allows covering consumption for 3 or more months. The only exception is Loreto, where the indicator is 3 or less in all months of evaluation. Given the remoteness of Loreto from a supply center, it is precisely there where the standard must be at least 3 months. However, we find it very likely, because of this remoteness; this Department has a stock that only allows covering the consumption of 2 months (and some weeks).

Table No. 11

Availability of medicines for child delivery care per regions, October 2009 - October 2010

Regions	2009			2010										Avg.*
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
Amazonas	3.2	4.1	3.0	3.1	4.2	3.1	4.3	3.3	2.5	2.4	3.5	6.1	4.0	3.6
Apurímac	5.2	4.3	5.8	4.7	5.1	6.4	5.9	5.5	4.7	5.6	5.2	4.3	3.6	5.1
Ayacucho	6.7	6.4	6.0	6.7	7.8	7.1	6.6	6.9	6.5	5.9	6.3	5.9	5.6	6.5
Callao	39.5	38.2	20.3	12.6	11.3	13.5	10.9	12.4	17.1	17.3	16.1	15.0	14.8	18.6
Huancavelica	3.9	5.3	5.9	5.8	6.1	4.2	4.8	4.1	4.4	4.3	3.6	3.9	3.4	4.6
La Libertad	6.9	6.9	6.4	5.5	7.0	5.7	7.2	6.1	7.1	6.6	7.2	6.2	9.2	6.8
Lima	5.5	6.2	7.0	6.4	6.6	6.2	5.8	4.7	5.2	4.8	5.0	5.8	5.8	5.8
Loreto	2.5	2.5	2.3	2.3	2.7	3.0	3.7	2.9	2.8	2.1	1.6	2.1	1.9	2.5
San Martín	3.2	3.5	3.5	3.3	2.7	2.1	2.1	2.9	4.9	4.2	4.9	6.1	6.3	3.9
<b>Average*</b>	<b>4.6</b>	<b>5.0</b>	<b>5.0</b>	<b>4.7</b>	<b>5.3</b>	<b>4.7</b>	<b>5.1</b>	<b>4.5</b>	<b>4.7</b>	<b>4.5</b>	<b>4.7</b>	<b>5.1</b>	<b>5.0</b>	<b>4.8</b>

Source: SISMED database. \*The average excludes Callao as the result is extreme.

As you can see, in most of the assessed areas, the availability at the end of the period is the same or higher than at the beginning of the period and, in general terms, it has remained in acceptable levels. Special case is that of Loreto for the whole period had low availability values. Notorious is the difference in availability between Callao and the rest. If you exclude Callao, showing availability data over 95 percentile, the general average of availability at the beginning of the period was 4.6 months and the average at the end was 4.8 months.

## 5. Financing of the Universal Health Insurance

The financing of health in Peru is one of the lowest in the region. Despite the noticeable increase in expenditure on health in recent years, approximately 43% between 2006 and 2009, Peru has one of the lowest expenditures in health in the region: in 2009, it reached approximately 4.6% of the GDP or US \$201<sup>28</sup>. This situation draws a real challenge to achieving the goal of 7% of the GDP agreed in various political spaces.

Table No. 12

Health expenditure in South America, 2009

	% DGP	US\$
Argentina	9.5%	730
Bolivia	4.8%	85
Brazil	9.0%	734
Chile	8.2%	787
Colombia	6.4%	323
Ecuador	6.1%	255
Paraguay	7.1%	159
Peru	4.6%	201
Uruguay	7.4%	698
Venezuela	6.0%	686

Source: World Bank

It is with this under financing that AUS is implemented and reflects that it is perhaps its greatest challenge: the generation of the necessary financial resources.

### 5.1 The structure of health expenditure

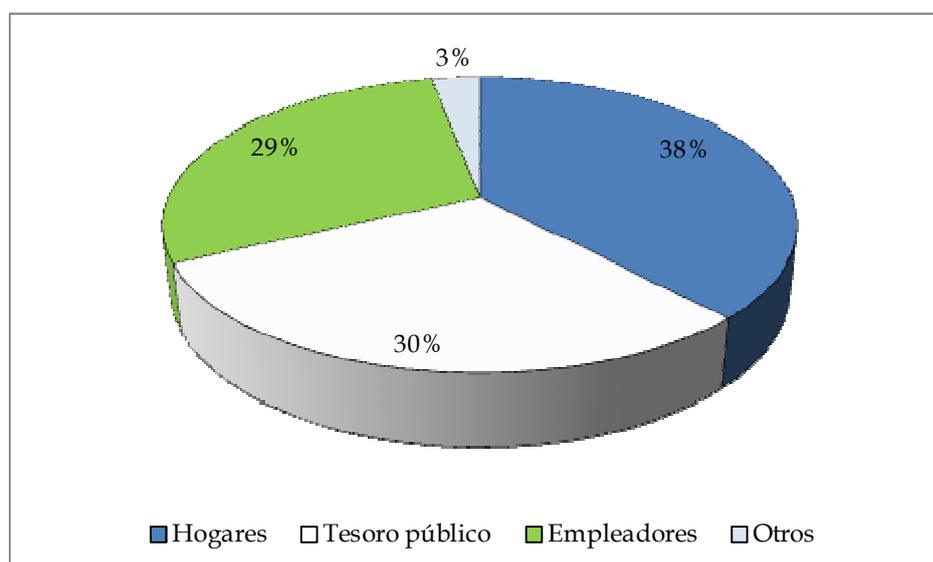
Historically, the out of pocket expense has been the main source of financing of health in Peru. National health accounts tend to reflect this fact<sup>29</sup>. It is estimated that by 2009, homes financed 38% of expenditure on health<sup>30</sup>. The public treasury and employers contributed 30% and 29%, respectively, while the rest comes from other sources.

<sup>28</sup> Excerpted from <http://data.worldbank.org/indicator/SH.XPD.TOTAL.ZS> y <http://data.worldbank.org/indicator/sh.XPD.PCAP>. Last entry date: 7/8/11.

<sup>29</sup> MOH and CIES (2008). Domestic Health Accounts. Peru, 1995 – 2005. Lima: MOH. Pp. 112.

<sup>30</sup> This estimate does not follow the rigorous methodology of the Domestic Health Accounts, but is an updated and approximate calculation for them.

Figure No. 18  
Structure of Health Expenditure, 2009



Source: ENAHO, SIAF, EsSalud, SEPS and SBS

### Public sector expenditures<sup>31</sup>

In recent years, the increase in public expenditure on health has been notorious. Given the expenditure by all levels of Government, we find that by year 2010 this expenditure exceeded the amount of 2008 approximately S/ 1,085 million; thus, in 2010 the public expenditure reached the S/ 5,477 million. MOH provides the largest amount, S/ 2.8 billion, while regional governments around S/ 2.5 billion.

Table No. 13  
Public resources per government level, 2008 – 2010<sup>1/</sup>

	2008	2009	2010
MOH	2,252.4	2,744.7	2,762.2
Regional governments	1,706.0	2,217.0	2,466.3
Local governments	434.0	193.5	248.8
<b>Total</b>	<b>4,392.4</b>	<b>5,155.2</b>	<b>5,477.4</b>

Source: SIAF

1/ In million Nuevos Soles

<sup>31</sup> This report refers to public resources as those that come from tax collection. In this sense, it excludes directly collected resources and others from cooperation and international banking.

We find that due to the largest number of inhabitants and level of complexity of their health facilities, Lima concentrated most of this expenditure; S/ 2.3 billion in 2010. The only department where public resources declined in this period is Moquegua, which registered a decrease in S/ 6 million.

Table No. 14

Public resources per department, 2008 - 2010<sup>1/</sup>

	2008	2009	2010
Amazonas	56.4	61.2	72.6
Ancash	143.0	163.8	153.7
Apurímac	97.9	95.4	114.6
Arequipa	170.4	167.4	198.4
Ayacucho	97.9	119.9	168.4
Cajamarca	117.5	169.3	213.8
Callao	171.3	193.4	181.2
Cusco	176.1	176.3	200.6
Huancavelica	80.3	85.1	102.9
Huánuco	93.3	104.6	125.2
Ica	121.2	165.0	154.1
Junín	132.7	132.7	161.0
La Libertad	160.5	155.5	188.1
Lambayeque	105.2	125.5	160.3
Lima	1,915.9	2,414.4	2,303.1
Loreto	107.9	121.2	140.7
Madre de Dios	31.2	41.3	34.4
Moquegua	54.8	60.5	49.1
Pasco	44.0	52.8	54.9
Piura	136.5	145.6	167.8
Puno	128.6	161.5	199.1
San Martín	88.4	84.3	97.2
Tacna	77.9	67.2	78.8
Tumbes	37.3	29.6	74.8
Ucayali	46.4	61.6	82.6
<b>Total</b>	<b>4,392.4</b>	<b>5,155.2</b>	<b>5,477.4</b>

Source: SIAF

1/ In million Nuevos Soles

Finally, we notice that financing in each department comes primarily from the respective Regional Government. Regional Governments concentrated around 65% or more of the public expenditure on health in all departments. The exceptions are Ica, due to the

reconstruction after the earthquake of 2007, and Lima, because the financial transfer of the facilities to metropolitan municipality has not been made yet.

Table No. 15

Public resources per department and government level, 2010<sup>1/</sup>

	MOH	Regional Governments	Local Governments	Total
Amazonas	18.6	50.4	3.7	72.6
Ancash	25.9	109.2	18.7	153.7
Apurímac	26.2	81.9	6.5	114.6
Arequipa	29.1	158.8	10.5	198.4
Ayacucho	37.7	118.4	12.4	168.4
Cajamarca	41.9	150.3	21.7	213.8
Callao	41.3	135.0	4.9	181.2
Cusco	41.0	132.9	26.6	200.6
Huancavelica	16.5	73.9	12.4	102.9
Huánuco	37.4	81.0	6.8	125.2
Ica	58.6	88.9	6.6	154.1
Junín	30.1	123.3	7.7	161.0
La Libertad	39.0	128.7	20.3	188.1
Lambayeque	28.8	125.1	6.4	160.3
Lima	2,129.3	148.9	25.0	2,303.1
Loreto	38.3	98.9	3.5	140.7
Madre de Dios	1.8	32.2	0.4	34.4
Moquegua	2.5	41.1	5.4	49.1
Pasco	5.8	41.1	7.9	54.9
Piura	37.1	123.8	6.9	167.8
Puno	27.2	156.7	15.3	199.1
San Martín	22.8	70.7	3.7	97.2
Tacna	6.5	63.8	8.6	78.8
Tumbes	4.4	68.0	2.4	74.8
Ucayali	14.6	63.3	4.7	82.6
<b>Total</b>	<b>2,762.2</b>	<b>2,466.3</b>	<b>248.8</b>	<b>5,477.4</b>

Source: SIAF

1/ In million Nuevos Soles

## 5.2 Effective reduction of funding for the subsidized regime

Between the years 2008 and 2010, the State has increased the financing of health services through the SIS in S/ 28 million, about 7% in 2 years. In year 2008 they transferred around

S/ 420 million to various health care providers, while in 2010 reimbursed about S/ 448 million.

But this increase in the allocation of resources has not been uniform. We find that in the same period, resources allocated to the Department of Lima and Callao Province have increased in S/ 49 million, despite the slight reduction in 2009, while in the other departments which are priority AUS areas it decreased S/ 9 million, despite the increase in 2009. The reduction is greater in the rest of the country, where 2010 funds were S/11 million less than in 2008.

Table No. 16  
SIS transfers per priority area, 2008 – 2010<sup>1/</sup>

	2008	2009	2010
Lima and Callao	118.5	116.2	167.6
Other AUS areas	184.7	198.0	175.4
Rest of the country	116.4	121.1	105.0
<b>Total</b>	<b>419.6</b>	<b>435.3</b>	<b>448.0</b>

Source: SIAF

1/ In million Nuevos Soles

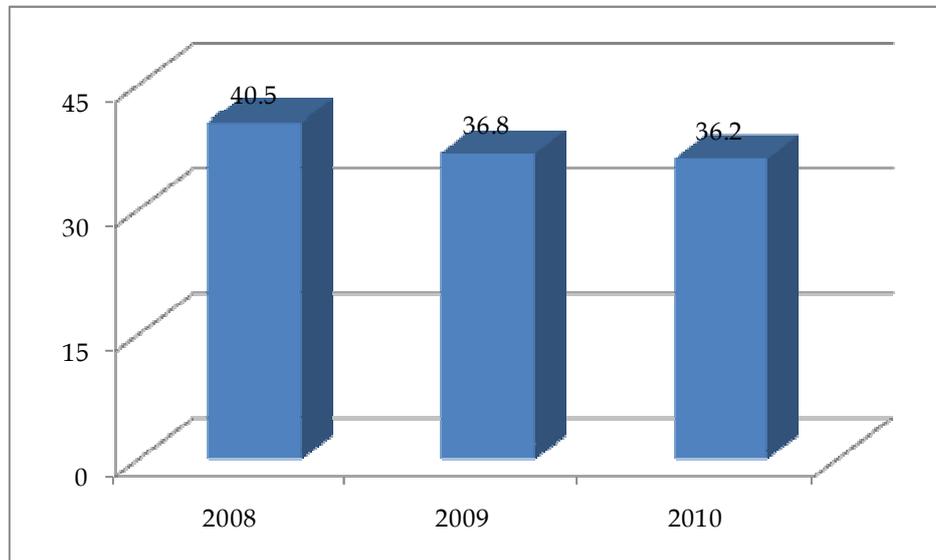
However, the total amount of funding is not the best indicator in this case, as it can for example be distorted by other variables, such as changes in the number of affiliates. In this regard, an important indicator is the subsidy per affiliate. While the financing of SIS to health services is partial, this indicator reflects, to some extent, the financial coverage for everyone included in SIS.

In this way, we find that although the total financing of SIS rose S/ 28 million between 2008 and 2010, the number of affiliates increased by a greater proportion, around 2 million people<sup>32</sup> in the same period. We find that in 2008 an affiliate had S/ 40.5 subsidy on average, while in 2010 the average subsidy was reduced to S/ 36.2<sup>33</sup>.

<sup>32</sup> In both cases, the source of information is official and institutional.

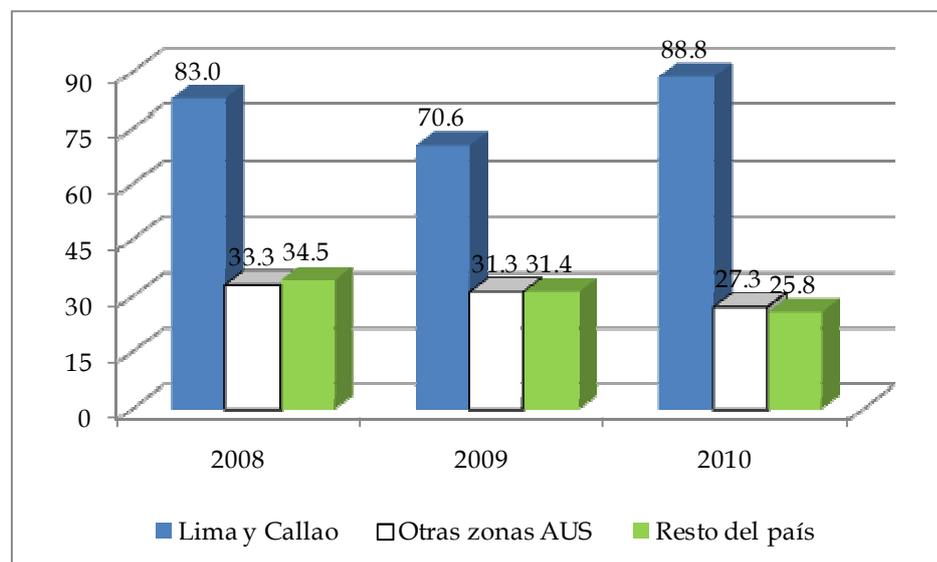
<sup>33</sup> These amounts are in current Nuevos Soles. A comparison in real terms would show a greater difference.

Figure No. 19  
Subsidy per SIS affiliate, 2008 – 2010



Source: SIS

Figure No. 20  
Subsidy per SIS affiliate per geographical priority, 2008 – 2010<sup>1/</sup>



Source: SIS

1/ In million Nuevos Soles

Much like analyzing the total amount of transfers, this decrease in the average subsidy has not been uniform among the various departments of the country. We find the largest subsidy per affiliate in Lima and Callao, above S/ 80. This because in these regions, there are found more complex and costly health facilities. In addition, is only in these departments where

there was an increase in the subsidy of almost S/ 6 for affiliate, while in other priority areas and the rest of the country it declined in S/ 6 and S/ 8.7 respectively.

The heterogeneity is even greater when analyzing each department where there are priority areas of implementation of AUS. The largest increase between 2008 and 2010 is located in Callao, where each affiliate moved from a subsidy per capita of S/ 59 in 2008 to S/ 82 in 2010. Ayacucho and Lima were the only other departments where there was an increase, S/ 2.7 and S/ 3.7 respectively. The largest reduction in a little more than S/ 12 per affiliate occurred in Loreto. Lambayeque, Piura, Amazonas and San Martín also had larger reductions than S/ 7 per affiliate.

Table No. 16

Subsidy per SIS affiliate per priority department, 2008 – 2010<sup>1/</sup>

	2008	2009	2010
Amazonas	37.6	28.6	28.9
Apurímac	49.6	56.3	49.6
Ayacucho	29.3	41.9	32.0
Callao	59.3	60.3	82.2
Cusco	33.5	35.0	33.3
Huancavelica	23.3	25.6	20.3
Junín	30.9	32.7	25.1
La Libertad	31.5	28.9	26.1
Lambayeque	35.5	29.0	26.4
Lima	85.9	71.9	89.6
Loreto	40.6	36.6	28.4
Piura	27.9	21.2	18.8
San Martín	30.3	24.5	23.0
<b>Total</b>	<b>40.5</b>	<b>36.8</b>	<b>36.2</b>

Source: SIS

1/ In million Nuevos Soles

### 5.3 Prioritizing public expenditure allocation: the budget per results strategic programs

Budget per results was introduced in 2008 budget period; it established certain goals that focused public intervention and the allocation of public resources into priorities set at the national level. In the case of health, it defined the strategic Mother Newborn Health Program (SMN) and the Nutritional Articulated Program (PAN)<sup>34</sup>. These two strategic programs, and

<sup>34</sup> As of fiscal year 2011, other strategic health programs were implemented, but in the relevant analysis period for this report, only these two were priority.

activities related to them, concentrated a strong priority in budgetary allocation and hence in the operation of health services.

The public resources devoted to PAN went from S/ 1,035 in 2008 to S/ 1,653 in 2010, while those intended for the SMN went from S/ 352 to 525, respectively. This means a growth over 50%, while the growth of SIS resources was less than 7%..

Table No. 17

Public resources allocated to strategic programs, 2008 – 2010<sup>1/</sup>

	2008	2009	2010
Nutritional Articulated Program	1,035	1,217	1,653
Mother newborn health	352	474	525

Source: SIAF

1/ In million Nuevos Soles

As it is expected, this growth is not uniform among the various departments of the country. For example, resources for PAN in Callao almost tripled in this period, while in Moquegua they decreased.

Table No. 18

Public resources allocated to the Nutritional Articulated Program, 2008 – 2010<sup>1/</sup>

	2008	2009	2010
Amazonas	24	27	43
Ancash	54	54	86
Apurímac	56	55	77
Arequipa	12	18	34
Ayacucho	72	74	107
Cajamarca	118	133	182
Callao	6	7	20
Cusco	71	68	96
Huancavelica	61	59	83
Huánuco	87	81	102
Ica	5	4	15
Junín	40	44	71
La Libertad	76	80	116
Lambayeque	25	23	40
Lima	127	269	234
Loreto	27	28	56
Madre de Dios	3	14	5
Moquegua	4	4	3
Pasco	8	9	17

Piura	48	54	91
Puno	61	61	94
San Martín	24	29	41
Tacna	8	8	14
Tumbes	2	1	4
Ucayali	15	14	21
<b>Total</b>	<b>1,035</b>	<b>1,217</b>	<b>1,653</b>

Source: SIAF

1/ In million Nuevos Soles

Table No. 19

Public resources allocated to the Mother Newborn Health Program, 2008 – 2010<sup>1/</sup>

	2008	2009	2010
Amazonas	3	8	4
Ancash	7	9	8
Apurímac	11	14	15
Arequipa	13	24	26
Ayacucho	19	26	33
Cajamarca	12	25	24
Callao	10	14	21
Cusco	17	21	22
Huancavelica	6	8	8
Huánuco	11	13	19
Ica	3	4	4
Junín	10	19	11
La Libertad	21	19	25
Lambayeque	13	16	15
Lima	129	168	207
Loreto	8	11	11
Madre de Dios	2	3	3
Moquegua	3	2	1
Pasco	2	4	3
Piura	14	17	17
Puno	12	14	15
San Martín	10	18	14
Tacna	10	10	13
Tumbes	1	1	1

Ucayali	4	6	6
<b>Total</b>	<b>352</b>	<b>474</b>	<b>525</b>

Source: SIAF

1/ In million Nuevos Soles

In the context of competing priorities for public budget, we find that the subsidy allocated to the insurance has not had the same level of priority that these strategic programs. Clearly, there is need to establish rules and explicit mechanisms in the formulation of the public budget that grant the true priority nature to the national policy of health insurance.

#### **5.4 Defining rules for public resources allocation: the Financing Act**

On July 6, 2011 it was approved the law on public financing of subsidized and semicontributive regimes of the universal health insurance. This law seeks to establish a set of rules in the allocation of public subsidy for both regimes, as well as to adjust some settings to finance high-cost diseases.

While the regulation of the law shall establish the specific steps for the calculation of the financing of both regimes, the law establishes that the public subsidy will be allocated on the basis of the calculation of a premium per insured party and the target coverage of affiliation to be established for the year, as well as the ratio of public financing in the case of the semi contributive system.

This premium will be proposed by SIS and will be calculated on the basis of an actuarial study of the total cost of PEAS. The premium will be updated in a period which shall be defined in the regulation of the law. The premium to be adopted by Supreme Decree will be the subsidy per affiliate that the State must provide to each insured party through the subsidized regime.

On the other hand, the goal of insurance coverage will be defined by the multi-sector Committee of Universal Insurance. This Committee will be formed by representatives of the MOH, regional governments, SIS and the Ministry of Economy and Finance. For the definition of this goal, it should be considered mainly the financial sustainability; that is, it will expand the coverage of the insurance of both regimes to the extent that public resources allow it.

With this definition of the public subsidy, we expect that SIS budget, as with regard to the subsidized regime, is the value of this premium multiplied by the goal of the number of members of this regime. In the case of the semicontributive system, this formula adds the coefficient of public financing, which reflects the proportion of the premium that is funded by the State. In this way, it is expected that these rules resolve the previously identified problem of the imbalance between the length of the horizontal coverage and its financing. To the extent that each insured party is "guaranteed" a fixed amount of the subsidy, determined by the premium, there would be no reduction in the funding per affiliate, as it occurred between 2008 and 2010.

The law also establishes that SIS can recruit health services of mixed or private facilities for the attention of its members to both regimes and it does limit to fund the variable costs. Both

aspects pose new challenges for SIS, so it must perform the relevant institutional arrangements to carry out said attributes.

Finally, the Act amends the FISSAL, for the financing of high cost diseases related to subsidize and semicontribute plans. In this sense, FISSAL becomes an executive unit which receives funds from the State, owns resources from the sale of insurance plans for this type of disease, donations and transfers from other levels of Government.

## 6. Strengthening the national, regional and local leadership for the Universal Health Insurance

The implementation process of AUS has involved a set of policy actions, communication, dissemination, technical assistance to the regional directorates of health, institutional adjustments, finance management, improvement of the services supply as well as a reorientation in the plans and activities of the various institutions involved in the process.

To initiate this process there was the need for a strategic planning that oriented the work of the so-called agents that would play a crucial role in this great national effort. To do so, they formulated the National Plan for the implementation of the universal health insurance. As mentioned above, this Plan develops the strategic axes and strategies to give effect to the policy objectives of the AUS.

Likewise, the assessment of the situation carried out by the Plan finds important limitations of funding and services supply. This reinforces one of the characteristics of the process identified in the AUS framework law, that the implementation of universal insurance follows a gradual and continuous sequence.

### 6.1 The creation of the National Implementing Technical Committee

On June 13, 2009 it was provided the National Implementing Technical Committee (CTIN)<sup>35</sup> as a collegiate body of conduction of AUS at the national level. It is assigned a set of functions, including: design, coordinate, direct and evaluate the general guidelines for the implementation of AUS at the national level; approve the implementation plan of AUS; formulate guidelines for the phased implementation of AUS in accordance with the plan approved by the Committee, which includes the implementation, monitoring and evaluation; articulate with the governmental authorities of the national, regional and local level institutions, health services providers and insurance institutions; propose the supplementary rules necessary for the better implementation of AUS; propose mechanisms for interim protection of the rights of the insured parties.

This Committee is comprised by:

- The Minister of Health, who chairs it.
- The Minister of Defense or his representative;
- The Minister of the Interior or his representative;
- The Executive Chairman of sSalud;
- A Regional Chairman on behalf of the National Assembly of Regional Governments;
- The President of the Association of private clinics of Peru,

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<sup>35</sup> Supreme Decree No. 011-2009-SA.

- The head of the SIS.

The CTIN was established on June 20, 2009, and since that date it has conducted session every fifteen days, in which policy proposals that make possible the implementation of AUS have been approved. There have been a total of 32 meetings, where approximately 104 agreements of diverse nature<sup>36</sup> have been taken. The importance of these agreements is that they are binding for SIS, EsSalud, the armed forces and national police, the private providers of health services, insurance companies, health entities that offer pre-paid services, self insurance, health funds and other forms of public insurance, private funds, or mixed other than those specified, as well as health care providing institutions, whether public, private or mixed.

## 6.2 The Technical Secretariat

It also created the technical secretariat of CTIN (SETEC) which is chaired by the Vice Minister of Health and formed by the General Directorate of People's Health at MOH, the national police, the Ministry of Defense, the central manager of EsSalud, a technical director of the private insurance companies and a technical director of the Association of private clinics.

The functions and powers of the technical secretariat are normed in the rules of procedure of CTIN. Among the most important are: assess PEAS produced by the MOH and the feasibility of its implementation; assess the value of the economic benefit of PEAS; described high cost diseases and determine the priority list of high cost diseases to be financed by FISSAL; evaluate the active ingredients of essential medicines to be used in the provision of PEAS; assess the regional implementation of AUS plans and provide technical assistance; determine the form and conditions of operation of subsidized and semicontributive regimes; analyze and evaluate the reports submitted by SUNASA and recommend technical and administrative audit of the implementation process of AUS; prepare the annual report on the evolution of the process; coordinate the implementation of the necessary technical studies for the implementation of AUS; and submit to CTIN evaluated proposals of different strategies considered necessary for the process of implementation of AUS.

SETEC has had a total of 74 sessions since its formation. For the performance of its duties, SETEC has organized 11 sub committees to address the priority areas for the implementation of AUS.

## 6.3 Implementation at regional level

Each Regional Government set up a technical implementer Regional Committee (CTIR) with multi-sector character, in charge of designing, executing and coordinating at the regional level the specific implementation strategies of AUS in the regions and the evaluation in accordance with CTIN directives. These committees were formed in heterogeneous manner. In some regions ad-hoc committees were formed, while in others as in the case of

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<sup>36</sup> As of June 31, 2011.

Lambayeque the functions of CTIR were commissioned to already existing instances as the Regional Council of Health. However, in all cases, the real responsibility to launch CTIR fell on directorates or regional managements of health.

Much like the national level, one of the first works that CTIR did was the elaboration of its rules of procedure and the development of regional implementation plans. Currently, the regional Governments of Apurímac, Ayacucho, Huancavelica, La Libertad, Lambayeque, San Martín and Cusco have implementation plans approved by their respective regional presidencies. It should be noted that CTIN was in charge of the implementation in Metropolitan Lima and Callao, and this was the one that drew up the implementation plan.

These implementation plans were developed based on specific information that was collected in each priority area. Thus, the plans established goals of extending the coverage of insured persons at the regional and priority local levels, since no region opted for a departmental implementation, but geographically focused. Also, the plans set financial requirements and the goals of implementation of the explicit guarantees of quality and timeliness. The strategies of these plans are usually organized according to the perspective they represent: the user processes, learning and growth, and financial resources. Finally, for the most part, these plans include indicators for monitoring implementation, which facilitate the evaluation of results of the process in each region.

Despite this work, CTIR operations have been limited significantly by the discussion of the financial debt of SIS to the executing units of the public sub-sector. It is reasonable that health service providers question the implementation of this policy, when financial imbalances in the current insurance plans are found. It is difficult to sustain the universal extension when we see there are no resources to meet the demand of the currently insured parties.

## 7. Results of Health Insurance Implementation

Health insurance is not an end in itself. It is an alternative for the achievement of objectives that the health system and the Peruvian Government, have planned. This way, beyond the measurement of progress on the objectives of the universal insurance policy, it is important to measure the changes generated from the implementation of AUS on some tracer indicators: access to services, equity in access and financial protection.

### 7.1 Access to services

One of the main reasons why insurance in Peru is implemented is to increase access to health services without restrictions based on payment capacity. It is expected that once a person has health insurance, they increase the use of health services. This has been found in almost all countries where some insurance plan has been implemented. Through insurance, one of the most important barriers to access to health services is reduced: the economic barrier.

In Peru, an insured person has greater chance of access to health services when perceiving the need of them. In the year 2004, being affiliated to SIS gave a pregnant woman a 27% chance further to deliver in a health facility<sup>37</sup>. In the case of other insurance, EsSalud, private health plans, found an effect of 23% on this probability. These results indicate that health insurance increases the likelihood that a person has to go to a health facility and receive attention; this is a causal relationship that reveals the benefits of the insurance.

On the other hand, in more general terms, in the year 2010, 38% of the population that had some health insurance and perceived some discomfort, disease, a chronic relapse or had an accident, had a health attention for this reason. In contrast, only 21% of the population without insurance, but with the same characteristics, also gained access to a health facility.

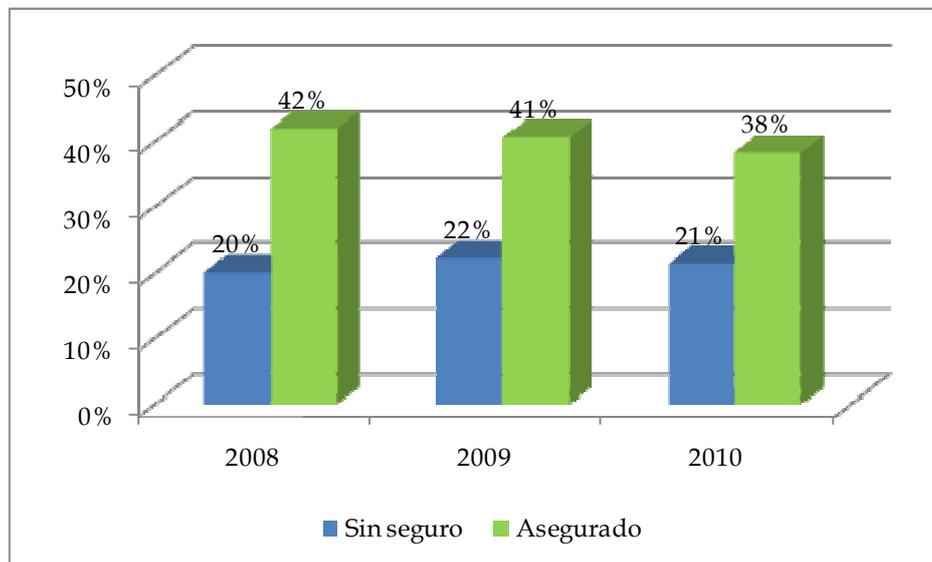
Figure 21 shows, however, a result that draws our attention: access to health services has decreased for the insured parties in the past two years. Indeed, 2008 found that 42% of the insured population entered consultation, 4 percentage points above those found in 2010. On the contrary, access between those without health insurance has increased slightly, by 1 percentage point, in the same period.

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<sup>37</sup> Parodi, Sandro. Evaluando los efectos del SIS sobre la equidad en la salud materna en el contexto de barreras no económicas al acceso a los servicios. Lima: GRADE. Page 30.

Figure No. 21

Progress of health service access per insurance status, 2008 – 2010



Source: ENAHO

This result may have several explanations. It is possible that those who acquired a new health insurance in this period were less prone to use health services or considered that consultation wasn't necessary, so the average might have fallen. However, there is also the possibility that this decline in access to health services is due to the fact that increased insurance coverage has not been accompanied by the required financing. In this way, despite having health insurance, a person can find new barriers that limit their access to services.

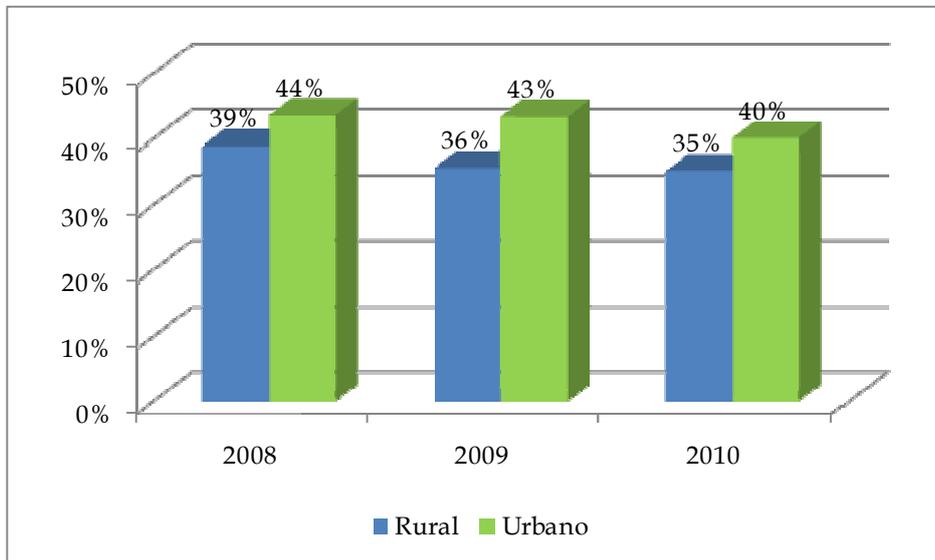
Precisely because it is not possible to explain the causes of this result, we demonstrate the need to deepen in its nature. These results show that the implementation process of AUS presents several challenges and that it is of utmost importance to continually analyze some indicators for policy decisions and adjust the strategy of implementation in a timely manner.

## 7.2 Equity in service access

It is hoped that access to health services is not an equitable feature; the population with greater capacity to pay will have greater access. The increased availability of payment, proximity to a health facility and information on their health condition, are some of the reasons that may explain this relationship.

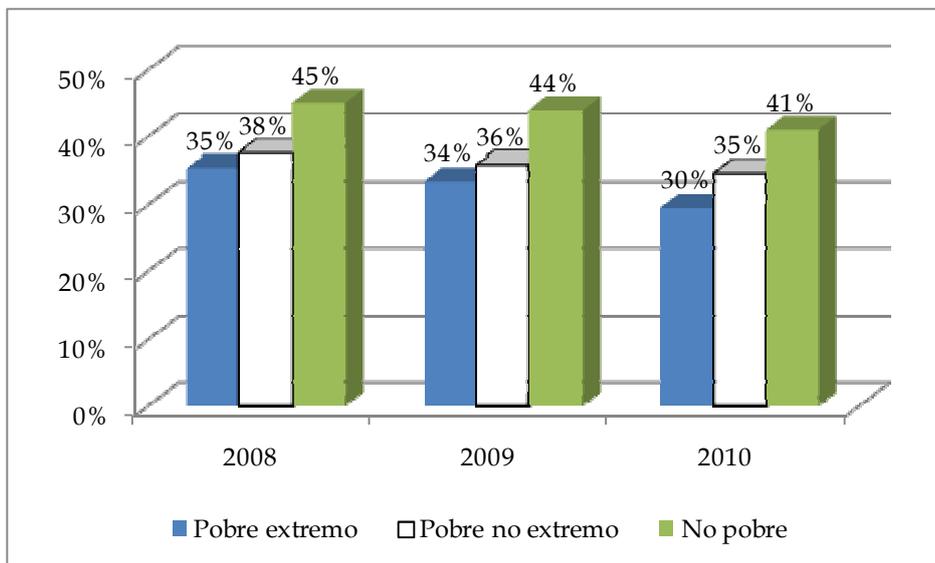
In Peru, we find that the higher level of poverty and rural population is less likely to access a service when in need. In 2010, 35% of the insured population residing in rural areas managed to receive consultation when needing it. This percentage was 5 percentage points higher among residents in urban areas. The same year, 30% of the population living in extreme poverty accessed to a service when needing it, while 41% of the non-poor population managed to have this access.

Figure No. 22  
 Progress of health service access per residence area, 2008 – 2010<sup>1/</sup>



<sup>1/</sup> Results are limited to the insured population.  
 Source: ENAHO

Figure No. 23  
 Progress of health service access per residence area, 2008 – 2010<sup>1/</sup>



<sup>1/</sup> Results are limited to the insured population.  
 Source: ENAHO

However, the most important thing is that this access has reduced more for the poorest people in the last 2 years. In 2008, 35% of the insured population living in extreme poverty accessed health services; 5 percentage points more than in 2010. In contrast, the non-poor population only reduced their access by 4 percentage points.

This last result indicates not only insured population has less access to health services, but the reduction is slightly higher among the most destitute. Again, it is necessary to deepen the nature and causes of these findings, in order to take corrective measures.

### 7.3 Financial Protection

According to the World Health Organization, the financial protection of the population against the economic risk associated with health is one of the major health system-wide objectives. This protection can be understood as the mechanisms to protect people from the possibility of impoverishment given an adverse and unexpected event to their health. In this regard, the Peruvian Government has chosen the insurance as the main mechanism by which this objective can be achieved.

The first step on financial protection is the horizontal coverage. As discussed previously, the percentage of the population that is covered by some health insurance has increased significantly in recent years: by 10 percentage points between 2008 and 2010 to reach 64% of the population in 2010.

In a country with high levels of poverty, such as Peru, this indicator must be complemented by a measurement on the level of subsidy to the poor. In 2009, only 46% of the poor population that is affiliated with SIS and uses health services receives a total subsidy; the remaining 54% must pay out-of-pocket to complete their health care financing<sup>38</sup>. This result is quite low, since it focuses only on the population living in poverty.

But it is noteworthy that in four years this percentage has been reduced by 24 percentage points; in 2005, 70% of the poor members of SIS using the public network health services did not have to make any payment for his attention<sup>39</sup>. This finding may be a reflection of a policy of extending coverage without a proportional increase in the financing of SIS. In other words, the constraints in the allocation of budget to SIS can be significantly reducing the positive effects of this insurance. Moreover, they put the insurance policy at risk.

Also, 24% of households had a catastrophic spending on health, i.e. a health spending exceeding 10% of total household expenditure. This percentage is very high by international standards. But in this case, we also note an increase of 4 percentage points compared to the year 2005<sup>40</sup>.

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<sup>38</sup> Madueño, Miguel. La convergencia hacia la cobertura universal: movilizand recursos adicionales para la transición. In edition.

<sup>39</sup> Ibid.

<sup>40</sup> Ibid.

## 8. Conclusions and recommendations

Universal health insurance is a legal reality and has begun its process of implementation to turn it into an economic, financial and social reality. To make this happen, it is required to ensure the process through legal mechanisms of the higher hierarchy. An example of this is the law of public financing of subsidized and semicontributive regimes of AUS recently approved by the Congress of the Republic. This standard seeks to establish a set of institutional rules that allow financing progressively to make sustainable the right of all Peruvians to a plan of protection against diseases and access to health services of quality in a timely manner. Similarly, other devices complementary to the framework law of AUS have been enacted and its models, designs and organizational arrangements are being made in the institutions involved in this process.

The balance of the implementation of the universal insurance in Peru leaves as his most notable achievement the significant increase in the coverage of insured population. From year 2008 that enacted the framework law of AUS, the number of insured people increased by 10 percentage points, or about 3.5 million people, being SIS the engine of this increase. This result highlights the strategic role of the public sector in this reform. However, the contribution of the insurance policy in this growth is somewhat uncertain, the strongest growth occurs in moments in which these implementation institutions begin planning it. Furthermore, it is observed that the growth in priority areas is not significantly higher than that of the rest of the country, which is more consistent with a national policy of expansion of the programs and social initiatives, like Juntos, Crecer, and even the policy extension of identity and civil status, than with the AUS policy itself. These facts create doubts about the relationship between this growth and the politics of AUS.

However, and despite the increase in the public budget allocated to health and insurance, this increase in the number of insured has not had financial correspondence. For example, the increase in the SIS budget has been S/ 28 million, approximately 7% between 2008 and 2010, which is not proportional to the 10% increase in the number of affiliates. This is more critical when growth in public resources per affiliate destined to SIS is concentrated in Lima and Callao, while in the rest of priority areas these have decreased. This imbalance between the affiliation and financing puts AUS at risk, since it has been observed a decrease in the subsidy for affiliates during the period under analysis. The recently adopted law on funding seeks to establish rules on the allocation of budget that would make it possible to solve this potential problem.

The priority characteristic of AUS draws attention when compared it with the budget per results strategic programs. One way to analyze this characteristic is through the allocation of resources. In this sense, when there are priorities that compete for the budget, the priority feature is only exercised if there are arrangements and budgetary mechanisms that reinforce the policy. The institutionalization of a priority occurs if there are administrative mechanisms to facilitate the operation of the policy or plans. In this way, the strategic programs of MEF, which have a ad-hoc structure budget, had a budget growth greater than 50% between 2008 and 2010, while the resources for AUS only grew by 7%.

This increased in coverage has brought together an increase in the budget and public investment in health, especially between the years 2010 and 2011. Despite this, the infrastructure, equipment and health personnel are insufficient to fully comply with PEAS in various regions of the country. Despite guarantees granted by IAFAS in various areas of the country, especially where there is extreme poverty, as the provinces of Datem del Marañón, Condorcanqui, Bagua, the VRAE zones, there is no capacity to cater for all health services provided for in PEAS.

Consequently in the coming years more financial resources at the various levels of Government should be allocated to agreed programs and coordinated in investment in infrastructure and equipment and specialized staff for health services. These efforts should focus on areas that present greater difficulties among those prioritized for the implementation of AUS.

These coordinated efforts require the strengthening of the national leadership of AUS. MOH as the highest authority of the health system should strengthen its enacting and guiding role of universal insurance and implement a system to monitor its development. It is in the State where the greatest responsibility lies for the implementation of this reform.

Also, MOH should monitor and support the full functioning of the National Superintendence of insurance in health (SUNASA), ensuring the proper allocation of resources to perform the functions as per law.

While there has been greater insurance coverage, the imbalance with the funding and the gaps in health services hinder the increase in access to health and financial protection services. These are the true purpose of this reform and AUS is the best mechanism to achieve them. There is a slight reduction in access and some indicators suggest a decrease in the level of financial protection; however, these are results that take some years to happen. To the extent that the Financing Act achieves its objective and investment in health closes the gaps in services, it is expected to see an improvement in these results. It also hoped that these limitations are resolved through greater inter-agency collaboration and a scheduled and agreed approach by the agencies at the national level in order to give appropriate guidance and technical assistance with greater intensity and duration than those provided so far.

It is particularly evident the need for greater dissemination, explanation and communication of the law of AUS: what it aims at, its agents and the role incumbent to each of them. This must be accompanied by the promotion of the right to health. The necessary commitment to the regional authorities to encourage and lead the process of AUS still is not desirable. It is necessary to promote a conscientious citizen on the right to health and that it is the people that should claim this right.

The understanding of the new authorities on the importance of supporting AUS for the benefit of the population is a crucial element for the achievement of the objectives of this State policy. This must be the basis of articulation and joint work to ensure the stable growth of insurance in the next few years and a greater support of regional and local investment to improve the supply of services and increasing resources for insurance funds. Finally, we

should not lose from sight the true objective of this reform: to ensure access to quality health services in a timely manner to any person who resides in Peru.