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REFORM OF HEALTH FINANCING: POLICY OPTIONS

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Prepared for:

Luis Seminario, COTR
USAID/Peru Health Office
Av. Encalada s.n.
Lima - Perú

Submitted by:

Abt Associates Inc.
4550 Montgomery Avenue
Suite 800 North
Bethesda, MD 20814

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Executive Summary

The Health Financing Reform (HFR) Discussion Series produced by the USAID/Peru/Health Policy aim to provide technical inputs to policymakers in Peru on HFR issues to encourage discussion and debate. In the past two years, the project presented preliminary findings to key actors and experts regarding the following studies:

Vol. 1. Fiscal space of health in Peru: 2011-2013

Vol. 2. Changes in the performance of the Health Financing System in Peru: 2000-2009

Vol. 3. The absorptive capacity of financial resources within the public health sector: 2000-2009 (recently completed, in translation)

The aim of those specific studies is twofold. First of all, it seeks to provide evidence to support the design and implementation of a HFR in Peru to advance the process towards universal coverage. Secondly, those studies attempts to outline the fiscal and sectorial context for the implementation of the HFR in Peru, in terms of the budgetary room to raise additional financial resources to the health sector as well as of the health system capacity to use effectively the additional financial flows. The main findings are summarized below:

1. The analysis of fiscal space sources or pillars suggests that there are potential fiscal resources that could be created or released to cover partially the sector's financial gap. Considering the sources with greater technical and political feasibility □like the pillars associated with macroeconomic conditions, restructuring, and efficiency improvements□, by end-2013 the health sector could obtain additional resources between NS/ 2,104 million (minimum scenario) and 3,271 million (maximum scenario). These accumulated resources would allow the sector to cover between 33% and 52% of the financing gap for the health public subsector.

It should be noted that the greater health expenditures generated by higher economic growth and resources allotted to the sector (via releasing tax expenditures and/or reducing tax evasion) would have a direct impact on the overall fiscal position, i.e., reducing the surplus foreseen for 2013 from 0.4% of GDP to less than 0.2% of GDP . In sum, the greater fiscal space does not compromise macroeconomic stability, but the fiscal target established by the MMF would not be achieved.

2. The analysis of the shifts in the performance of the health financing system during 2000-2009 reveals improvements that have translated in a greater sectoral effort to mobilize resources and expand health financing. It also suggests favorable equity changes in resource assignment and health service utilization. However, this has not translated into greater financial protection for the population, mainly lower resource

segments. On the contrary, financial protection has decreased, limiting the system's capacity to guarantee these segments' health entitlements.

This contradiction puts into perspective problems that are not strictly monetary or financial, but associated with a set of problems regarding institutional design and organizational arrangements in the financing system, which are preventing the greater resources channeled to the system from translating into an improved financial protection to the population. Thus, problems associated with the ABSENCE OF CLEAR AND STABLE RULES for public financing and its distribution; CONFLICTING RULES or the misalignment between financing and insurance policies; INADEQUATE RULES to redistribute the financial burden among the population; or the ORGANIZATIONAL CAPACITY to improve the resolution capacity of health facilities, are contributing to damaging the population's health entitlements.

3. The analysis of the capacity of the public health system to absorb effectively additional resources show that absorptive capacity is a current problem in almost 10 Peruvian regions (Amazonas, Ancash, Ayacucho, Apurimac, Cajamarca, Huancavelica, Huánuco, Ica, Madre de Dios and Moquegua). The research shows that those regions are operating closer to its saturation point level and a number of obstacles are blocking the optimal utilization of increasing funding with negative consequences on the financial effectiveness. The major constraints relate to the poor management of human and physical resources and the quality of health governance institutions and policies. In the remaining regions, the evidence show that exist room to increase funding and still can achieve strong results. However, due to diminishing returns the effectiveness of additional resources will begin to taper off in the medium term.

In this context, mobilizing additional resources to improve health status of the population should therefore move in tandem with efforts to identify a suitable time profile of financial flows in regions which balances the need to quickly accelerate progress towards achieving universal coverage through expanded and improved public service delivery, with constraints on absorptive capacity and the way to progressively weaken these constraints.

This has implications for the pattern and sequencing of public health spending and resource allocation to regions. Regions specific plans are required to identify key constraints, identify bottlenecks to growth, clarify potential externalities, and formulate strategic plans to build capacity. This requires in-depth and regions-specific analysis to determine the appropriate sequencing of public health investment for each region.

